Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 1 November 2023 at 2.00 pm**

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

Contact: **Mr. E. Walters (0116 3052583)**

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Membership

Mr. J. Morgan CC (Chairman)

Mr. M. H. Charlesworth CC	Ms. Betty Newton CC
Mr. D. Harrison CC	Mr. T. J. Pendleton CC
Mr. R. Hills CC	Mrs B. Seaton CC

Please note: this meeting will be filmed for live or subsequent broadcast via You Tube at https://www.youtube.com/@committeemeetingsatleicest9269/playlists

Item		Report by
1.	Minutes of the meeting held on 13 September 2023.	(Pages 5 - 24)
2.	Question Time.	
3.	Questions asked by members under Standing Order 7(3) and 7(5).	
4.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.	
5.	Declarations of interest in respect of items on the agenda.	
6.	Declarations of the Party Whip in accordance with Overview and Scrutiny Procedure Rule 16.	
7.	Presentation of Petitions under Standing Order 35.	

8.	Winter Plan 2023/24.	University Hospitals of Leicester NHS Trust	(Pages 25 - 76)
9.	Outcome of consultation on the Leicester, Leicestershire and Rutland Joint Living Well With Dementia Strategy 2024-28.	Director of Adults and Communities	(Pages 77 - 122)
10.	Intermediate Minor Oral Surgery	Integrated Care Board	(Pages 123 - 164)
11.	Review of Homeless Support Service.	Director of Public Health	(Pages 165 - 258)
12.	Whole School Approach to Food and Nutrition.	Director of Public Health	(Pages 259 - 262)
13.	Physical Activity Programme.	Director of Public Health	(Pages 263 - 268)
14.	Director of Public Health Annual Report.	Director of Public Health	(Pages 269 - 300)
15.	Noting the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee.		(Pages 301 - 304)

16. Date of next meeting.

    The next meeting of the Committee is scheduled to take place on Wednesday 17 January 2024 at 2.00pm.

17. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Governance and Scrutiny website www.cfgs.org.uk. The following questions have been agreed by Scrutiny members as a good starting point for developing questions:

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Members are reminded that, to ensure questioning during meetings remains appropriately focused that:

(a) they can use the officer contact details at the bottom of each report to ask questions of clarification or raise any related patch issues which might not be best addressed through the formal meeting;

(b) they must speak only as a County Councillor and not on behalf of any other local authority when considering matters which also affect district or parish/town councils (see Articles 2.03(b) of the Council's Constitution).

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Agenda Item 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held at County Hall, Glenfield on Wednesday, 13 September 2023.

PRESENT

Mr. J. Morgan CC (in the Chair)

Mr. M. H. Charlesworth CC
Mr. D. Harrison CC
Mr. R. Hills CC
Ms. Betty Newton CC
Mrs B. Seaton CC

In attendance
Mrs. L. Richardson CC – Cabinet Lead Member for Health.
Rachel Hall, Deputy CEO, Falcon Support Services (item 20 refers).
Sarah Prema, Chief Strategy Officer, Integrated Care Board (item 21 refers).
David Williams, Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust (item 21 refers).
Rachna Vyas, Chief Operating Officer, NHS Leicester, Leicestershire & Rutland (item 22 refers).
Alison Buteux, NHS Midlands and Lancashire Commissioning Support Unit (item 22 refers).

13. Minutes of the previous meeting.

The minutes of the meeting held on 14 June 2023 were taken as read, confirmed and signed.

14. Question Time.

The Chairman reported that the following questions had been received under Standing Order 34:

Questions asked by Giuliana Foster

1. What assurances can be given that the proposed clinics will actually be instated at Feilding Palmer Community Hospital and not just ‘pop up – temporary’, given the extensive plans for outpatient clinics at Market Harborough and Hinckley?

2. If FPCH is to lose its beds, we must ensure that the proposals are adequate for the people of Lutterworth, so we need guarantees that these clinics will be reinstated. The residents of the Lutterworth area are being asked to lose 10 inpatient beds in exchange for what?

3. How often will each proposed clinic will be held? For example, 1 x month or 3 times a week.

4. The ICB have stated that the £5.3m is capital (presumably for all the refurbishment and installation of equipment) so where is the annual spending on services coming from?

Reply by the Chairman:

1. I have sought a response from the Integrated Care Board regarding the query raised and they have provided me with the following information:

   The proposed plans for more community procedures and outpatient clinics at FPCH have been developed based on current evidence of need for the local population. The LLR ICB are committed to delivering additional clinics from Feilding Palmer on a permanent basis recognising the need for flexibility to meet changing demands in health needs.

2. The proposal is to permanently close the 10 inpatient beds to provide an enhanced procedure suite and 6 consultation rooms.

3. The Integrated Care Board has informed me as follows:

   The proposal sets out a wide range of specialities and procedures that could be delivered from FPCH. We are currently working with UHL and wider providers to determine the exact procedures and clinics that will be provided recognising that there does need to be a degree of flexibility so that the offer can adapt to meet the changing needs in demand. It is likely that the clinics will operate ranging from 2 to 6 sessions per week dependent upon demand.

4. The estimated capital for the refurbishment is £5.8m, the revenue costs will be funded through system finances.

Supplementary questions from Giuliana Foster:

1. Where has the ICB gained its evidence regarding the needs of the local population?

2. What is an enhanced procedure suite and are the 6 consultation rooms only for outpatient clinics or are there other uses in mind?

3. The ICB said “The proposal sets out a wide range of specialities and procedures that *could* be delivered from FPCH”, they did not use the word ‘can’. What assurances can the ICB give that outpatient diagnostic clinics will be instigated at Feilding Palmer, in view of what the diagnostic plans are for Hinckley and Market Harborough?

4. Regarding the £5.8 million funding identified required for the refurbishment how confident is the ICB they will be able to secure this money? Given the funding for Hinckley Community Diagnostic Centre was dependent on demonstrating extra capacity at Hinckley, will plans for Feilding Palmer have to meet the same criteria as Hinckley did in order to secure the funding?

The Chairman undertook to ensure that written answers to the supplementary questions would be provided after the meeting.

Questions asked by Rachel Hall (Falcon Support Services):

With respect we would like to raise some concerns in relation to the homeless support service consultation and feel the information provided to cabinet has been inaccurate.

The Cabinet Report on 23rd June 2023 and Health Overview and Scrutiny Committee on 18th January 2023 assert that the Homelessness Contract does not fund the hostel itself and therefore the contact value would have no impact on the Falcon Centre, but this is incorrect.

We are disappointed to see Leicestershire County Council saying they have not contracted accommodation and would like to draw you to the current **Contract** that specifies there is a *"30 bed requirement throughout the contract"*. We would also like to draw you to **ITT Schedule Service Specification** that we tendered for the contract that requires the *"service to deliver emergency accommodation to support adults in times of housing-crisis".* The service description clearly states on *1.1 "The provision is for at least 30 units of accommodation in Leicestershire either through direct provision by the Service Provider or through partnership arrangements with a housing provider. The specific location and configuration of accommodation within the county is flexible in that a proportion of the units may be delivered as 'move on' or dispersed accommodation."*

The **Aspect of the Service** details*: "The Service Provider should make available a minimum of 30 hostel-based beds for adults experiencing acute homelessness or housing-crisis and requiring emergency housing."* And **Service Standards** state *"The hostel premises must be complaint with national and local building and housing regulations".*

The recent **Audit** on the contract in January 2022 clearly states, *"The Falcon Centre are contracted to provide accommodation for those who are homeless and non-priority needs."*

1. Is it accurate to say the current contract excludes accommodation?
2. Has an Impact Assessment been conducted?

The current contract for "provision of at least 30 units of accommodation" ends 31st March 2024 and has been re-commissioned repeatedly over the past 10 years. We believe that the focus of the consultation should be on decommissioning the homeless service, rather than improving First Contact Plus and Local Area Co-ordinators.

3. Is the consultation being targeted on the right thing?
4. Has the proposed model of First Contact Plus and Local Area Co-ordinators been evaluated for its impact on homelessness? Has its operational effectiveness, resource implications and capacity been scoped out?

We are concerned about the fairness and equality of the consultation process. Most people experiencing homelessness lack internet access, digital skills and literacy, including the ability to fill in surveys. Service users requested to submit written letters for staff to scan in and send to the consultation email, but this was declined in writing by Leicestershire County Council. The first half of the consultation period residents could not submit the online survey from the same computer a survey had already been submitted from, this was rectified but only left a shorter window for consultation.

During the online Information Session held for people who have or are currently using the service, including friends, relatives and carers of people facing homelessness the

sessions were muted and left only with the Q&A chat function which did not work on some of the computers.

We requested face-to-face consultation meetings through the consultation email and/or focus groups for service users, as per previous consultations we have been through, but this was declined by Leicestershire County Council. We have been informed that service user consultation was completed in January 2022, over 18 months before the proposal and consultation were live, when Public Health completed at the Falcon Centre audit. One-to-one interviews were completed with service users about the current service and gaps in the current provision. Service users answered these questions with no knowledge funding was going to be withdrawn for their homeless support service and provided no consent for this data to be used as part of a consultation in relation to funding cuts. No face-to-face consultation or workshop sessions have been held with Service Users since the current proposal came out.

5. Did Leicestershire County Council fulfil their GDPR requirements as service users did not give consent for their data collected from one-to-one interviews in an audit 18 months ago, to be used in a different context than they had agreed?

6. Has an Equality Impact Assessment been completed on the impact of the decommissioning of the current service and proposed new model? If so, why wasn't this shared upon request?

7. Did Leicestershire County Council adhere to their Equalities Policy Statement in minimising disadvantages and advancing equality of opportunity? Was the format of the consultation format inclusive and accessible, ensuring the voices of those experiencing homelessness were heard?

8. Has the internal Transformation Team at Leicestershire County Council explored alternative savings to assist with the need for budget cuts?

Reply by the Chairman:

1. The service specification stipulates that in-reach (hostel based) support is linked to accommodation equivalent to 30 bed spaces across Leicestershire. In order to provide support in a hostel setting, the provider is required to have access to this type of accommodation. This is not the same as saying that the funding should pay for the accommodation itself. Any Provider could have bid for this service without owning or running a hostel. The service is based in a hostel setting and the Provider could have access to the service users in any hostel or hostels in Leicestershire. (It is Falcon Support Services that are the Provider not the Falcon Centre)

2. A draft Equality Impact Assessment has been completed and the impact of a change in service model will be informed by the outcome of consultation and a final EIA will be produced. This will be presented to Cabinet in November. Initial findings based on the draft proposal indicate that the new offer will have a wider reach and be able to offer additional support. It is not standard practice to share a draft EIA. However, Falcon Support Services submitted an FOI requesting a copy of the draft EIA. This was completed on 30 August 2023. The FOI has been published and is available here: https://leicestershire.disclosure-log.co.uk/results?month=8

Also, within the survey that was available during the consultation, some questions were asked to ascertain impact of the proposal on those with protected characteristics and other relevant cohorts. Responses to these questions will inform the final EIA.

3. As referred to under point 1, the contract is for the provision of support services not the provision of units of accommodation. The consultation documentation is consistent with this and clearly states the following: *'The proposal is for the county council to cease funding a dedicated homeless support service, and instead to provide support via the council's existing public health services where a wider number of people are eligible for support'* This clearly sets out the Council's intentions while also ensuring the language is simple and easy to understand to support a successful public consultation.

4. The Homelessness Reduction Act 2017, places new duties on housing authorities to intervene earlier to prevent homelessness and to take reasonable steps to relieve homelessness for all eligible individuals, **not just those that have priority need**. Locally, and in line with the legislation referred to, this responsibility sits with district councils not the county council. As such, the proposed model is not centred around reducing homelessness. The focus is on improving the health and wellbeing of Leicestershire residents. The proposal may indirectly lead to a reduction in the risk of someone becoming homeless but the approach is that Local Area Coordinators can address the circumstances that cause people to experience chaotic lifestyles and consequently struggle to cope rather than only dealing with the housing issue on its own. It is also difficult to fully assess capacity, resource etc. until the final model is developed and approved, informed by the outcome of the consultation. This process will start now that the consultation has closed and will be presented to Cabinet in November 2023. If the proposal is approved by the Cabinet, further work will take place between December 2023 and March 2024 to implement the approved model. This will include a detailed assessment of resource and a communications and engagement plan to support the transition. The council will also work closely with the incumbent providers to ensure a robust exit strategy is in place if the decision is made to proceed with the proposed model.

5. The service commissioned by the county council is an externally commissioned service. As the contract was ending on 31st March 2024, it provided an opportunity to review the existing provision and consider options for the future. This included output from focus groups and 1-2-1s with staff and service users from all 3 incumbent providers without using any personally identifiable information. The Council is of the view that individuals participating in these events would have done so in the knowledge that information would be used by the council to shape future service provision. This is standard practice for all public health commissioned services to ensure services continue to meet local need and to ensure value for money. As part of the review of existing provision the public health department reviewed performance data, statistical information available through national and local data sources, and conducted some engagement work with professionals and service users. All of this information was utilised to develop a suite of options with a review of strengths, weaknesses, risks and financial implications of each option in order to put forward a recommended draft proposal. This draft proposal was presented to Cabinet for approval to consult. As such, at the time of reviewing the provision and conducting an engagement exercise, the options would not have been known.

The Council is satisfied that its usage of this information has been compliant with its GDPR obligations at all material times. In particular, the Council is satisfied that it has a lawful basis to process the personal information of service users. The Council believes that officers were explicit about the reasons for which the information was being collected *(i.e. to inform the undertaking of a review of homelessness services)* and the service users willingly consented to their views being recorded and used. Indeed, even without the consent of the Data Subjects, the Council is entitled to rely on the following grounds as a lawful basis for the ongoing processing of personal information: -

(a) That processing is necessary for compliance with a legal obligation,[1] for example, to comply with the Council's Public Sector Equality Duty[2] and to understand the impact of the proposal on any persons who may have a protected characteristic.

(b) That processing is necessary in order to protect the vital interests of the data subject[3] for example, the Council accepts that understanding the views of service users and the possible impacts of any decisions is necessary to protect the vital interests of those data subjects.

(c) That processing is necessary for the performance of a task in the public interest,[4] for example, it is in the public interest that decisions which may affect homeless persons are made on an informed basis.

(d) That processing is necessary for the purposes of the legitimate interests pursued by the controller,[5] for example, the Council has a legitimate interest in making informed, evidence- based decisions.

The Council is satisfied that the continuing processing of personal information is lawful and in accordance with Data Protection principles. In particular, the Council is satisfied that:

(a) information is being processed lawfully, fairly and in a transparent manner.[6] It should be noted that the information was provided on a consensual basis and its usage helps decision makers to make informed decisions taking into account the views and needs of service users. The Council's decisions are transparent and open to scrutiny.

(b) Information was collected for specified, explicit and legitimate purposes and not processed in a manner which is incompatible with those purposes.[7] It should be noted that the Council collected the information to inform a review of homelessness (which is clearly a legitimate purpose) and the usage of information is linked to the review which was originally discussed with service users.

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[1] Article 6(1)(c)
[2] S149 Equality Act 2010
[33] Article 6(1)(d)
[4] Article 6(1)(e)
[5] Article 6(1)(f)

[6] Article 5.1(a)

[7] Article 5.1(B)

(c) Personal information is being….kept in a form which permits identification of data subjects for no longer than is necessary.[8] It should be noted that the review of support services is under active consideration and the council will not retain such personally identifiable information that has been collected once the review and any related decisions have been taken.

6. Please see response to question 2 - '**Has an Impact Assessment been conducted?'**

7. Consultation was approved by Cabinet on 23 June 2023. The consultation launched on 28 June 2023 and ran for 10 weeks (closed on 3 September 2023) to seek feedback on the proposed model. The survey was accessible online on the County Council's website and available as a hard copy on request with a freepost return option. Early analysis indicates the council has received 251 survey responses. Approximately 25% of responses were from service users, 24% were from staff working within the homeless sector and 5% were from a family member/carer of a service user. These figures do not take into consideration responses received through the information sessions and other channels. The last consultation exercise that took place for this service was in 2019 when the council received a total of 46 survey responses.

Supporting information to accompany the survey was accessible online. An easy read version of the supporting information was also available online and as a hard copy on request.

Face to face and online information sessions were held to talk though the proposal and provide information on how individuals could have their say. A total of 5 sessions were held during the consultation period (3 online sessions and 2 face to face sessions). These were spread out over July and August, on different days and at different times of the day. Over 130 participants attended these sessions. At the face to face sessions which took place at Loughborough library, hard copies of consultation packs were disseminated to participants. County council staff were also available to support completion of the survey on-site. Space was also made available at Loughborough library for participants to complete a survey.

Following communications received during the consultation period, the council produced some FAQs online and these were available as a hard copy on request.

In addition to the provision of an online survey, Falcon Support Services received 50 paper copies of the survey in the post. These were posted on 4th July (the consultation went live on 28th June and ran for 10 weeks). After Falcon Support Services flagged issues with submitting multiple responses from one computer, the Council contacted them with a resolution on 27th July. This resolution didn't appear to work and so a few days later the Council emailed Falcon with a list of other options to try and resolve the issues. One option provided was a separate inputter link which we had tested and was working. At this point there were still more than 5 weeks left of the consultation period. Since providing the separate inputter link, the public health department received 2 consultation responses directly via this route. Falcon Support Services contacted public health again on 7th August to say that the

[8] Article 5.1(e)

word limit was restricting their ability to respond. The department responded on 8th August by removing the limit.

600 copies of the survey were printed and made available to Local Area Coordinators and Community Recovery Workers to disseminate to their service users.

Paper copies of the consultation pack were provided to the incumbent providers.

The public health department had a dedicated email for any queries and all queries were responded to in a timely manner. A phone number was also made available for any queries and the administrative team were on hand to complete any surveys over the phone if required.

As well as receiving responses to the survey, the public health department has received responses via the dedicated email address and via the information sessions which will be analysed alongside the survey responses.

Promotion of the consultation to stakeholder organisations and individuals took place through emails, letters, newsletters and social media posts. These were repeated throughout the consultation.

8. The transformation team have been involved in the MTFS proposal work and they continue to be involved in this work. The review of homeless support services was conducted as the contract was ending on 31st March 2024 and there was an opportunity to do things differently that better aligned with the duties of the council and local need. Financial benefits was an additional factor but not the sole nor the main factor.

Please be assured that the Committee will explore all these issues more fully during the later agenda item on the Review of Homeless Support Service (item 8) and will submit comments to Cabinet.

Supplementary questions from Rachel Hall:

1. The answer to question 1 states that “the service specification stipulates that in-reach (hostel based) support is linked to accommodation… however this is not the same as saying that the funding should pay for the accommodation itself”. However, I would like clarification on this because there are a number of other statements that have led us to infer that the funding has included accommodation, things like ‘hours of operation for supported accommodation is 24/7 365 days a year’ and we must employ all staff for safe running of the supported accommodation and the hostel premises must be compliant.

2. Has an impact assessment been carried out on the impacts of decommissioning the service and the wider impacts of the proposal?

3. Did any face-to-face focus groups take place and if so is there any evidence of this?

4. I appreciate that one of the factors behind the proposals is the need for LCC to save money, but what other factors are behind the proposals? How has it been

established that the proposed model will better align with the duties of the Council and local need?

Replies to supplementary questions:

1. The service specification stipulates that in-reach (hostel based) support is linked to accommodation equivalent to 30 bed spaces across Leicestershire. In order to provide support within any setting, the Council requires assurance that the setting is safe and compliant for those being supported. This is not the same as saying that the funding should pay for the accommodation itself.

2. There was no legal requirement to undertake an overall Equality Impact Assessment of the proposals, though an impact assessment has been carried out and when the final proposals are presented to Cabinet the report will set out alternative options.

3. Face-to-face sessions did take place at Loughborough Library.

4. In addition to the County Council's Medium Term Financial Strategy the decision also took into account cost pressures on the Public Health Grant through the NHS pay award. The County Council has no duties under housing regulations but does have a duty under Public Health regulations to take steps to improve the health and wellbeing of the population and the homeless population is included in that. The proposed new model is believed to be a more efficient way of improving the health and wellbeing of the homeless population.

The Chairman undertook to ensure that further, written, answers to the supplementary questions would be provided after the meeting.

15. Questions asked by members.

The Chairman reported that four questions had been received under Standing Order 7(3) and 7(5).

Questions by Mrs. Rosita Page CC:

My questions relate to the proposals for Feilding Palmer Hospital in Lutterworth and the upcoming public consultation on the proposals. We are aware that a business case is to be submitted to Government to secure funding to enhance the services at Feilding Palmer Hospital.

We are aware and accept that the 10 beds in the Feilding Palmer Hospital will be removed but we always understood that the business case was going to be made to enhance the existing provisions provided to the community, being mindful that South Leicestershire has a large aging population and that the plans for the Lutterworth East Strategic Development Area (SDA) when implemented will have a further impact on the population of the area. It is therefore important to ensure the long-term sustainability of healthcare for Lutterworth residents.

We understood that the business case would build on existing clinics, to provide diagnostics so the need for lengthy travel to attend health appointments would be cut down not only for convenience but also to lower the carbon footprint. However, on closer

scrutiny of the proposals it appears that the Lutterworth community will actually be short changed at the loss of approximately 9 clinics.

1. Please explain what the money will be used for, should the bid be successful?

2. I understand that the NHS (within all 43 Trusts) is committed to reducing its carbon footprint – and they are having a big ‘push’ on this. Therefore, why is Corby Community Hospital referred to on the draft consultation document? It is 30.4 miles away from Lutterworth and totally inaccessible to those Lutterworth residents without their own transport as there are no bus routes.

3. With reference to the chart comparison for Outpatient/diagnostic clinics being proposed (see accompanying chart below), Lutterworth has actually lost 8 clinics over the years but it is stated in the business case they are being offered extra services.

   I have already made the following request to the Integrated Care Board but I would like it formally on record that I have asked for this information. Please provide a basic chart setting out what services Feilding Palmer Hospital is providing now and what the enhanced /proposed future provisions are going to be.

OUT-PATIENT CLINIC COMPARISON CHART FOR GILMORTON RD SITE LUTTERWORTH

CLINICS/DIAGNOSTICS	Proposed clinics for 2023 Consultation	Out - Patient Clinics FOI March 2023	Out -Patient Clinics FOI February 2020	Out - Patient Clinics FOI 2017
AAA Screening	x			
ADHD	x	x		
Cardiology	x			x
Dermatology	x		x	
Dietary	x	x		x
ECHD	x			
General Internal Medicine	x			
General Surgery	x			x
Gynaecology	x	x		x
Heart Failure	x	x	x	x
Mental Health	x	x	x	x
MSK Physiotherapy	x		x	x
Ophthalmology	x			
Out of Hours	x	x	x	
Paediatrics	x		x	x
Parkinson's Care	x	x		x
Psychiatrics	x			
Psychiatric Nurse	x			x
Pulmonary and Cardio Rehab	x	x		
Respiratory Medicine	x			
Rheumatology	x			
Speech and Language	x	x	x	x
Stoma	x			x
Trauma and Orthopaedics	x			
Urology	x			
Walking Aid Clinic	x	x		
Memory Clinic				x
Midwifery Clinic			x	
In Health Scans			x	x
Podiatry			x	
Upper Abdominal				x
Cytology				x
Physical Therapies			x	
Baby feeding/Parent group		x		
Total	26	11	11	16

4. Please clarify why and on what exactly are we having a costly and lengthy public consultation?

Reply by the Chairman:

1. NHS Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) is undertaking a Pre-Consultation Business Case (PCBC) in regard to maximising access to services for the local community in Lutterworth. A PCBC provides an assessment of any proposals against the government's five tests of service change, and NHS England's best practice checks. If following the discussion with the NHS England team, the LLR ICB can evidence they have sought and acted upon the feedback, they can progress to public presentation of the proposals.

   The PCBC is not seeking capital funding of the proposals for Lutterworth. Depending on the decisions made in regard of the proposals after the public consultation the LLR ICB we will use LLR System capital to fund the scheme. The investment would fund the internal refurbishment of Feilding Palmer Hospital.

2. The LLR ICB have reassured me that they are committed to reducing the carbon footprint. The increase in the number of outpatient and diagnostic services at Feilding Palmer Hospital is estimated to reduce the number of miles travelled by patient by 377,492 per year. The draft consultation document, co-produced with the Lutterworth Public Consultation Task and Finish Group, does list a number of hospitals, clearly stating their proximity to Lutterworth in terms of miles and journey times. The purpose of listing them is to illustrate that the plans will reduce the burden of travel and provide more care closer to home, avoiding the need for people living in Lutterworth to travel a distance to receive some care.

3. The Pre-Consultation Business Case (PCBC) has been drafted and has only been shared with NHS England. It will go into the public domain, along with other key documents, when LLR ICB has approval to commence a public consultation. A draft consultation document has been co-designed with the Lutterworth Consultation Task and Finish Group. It lists the services provided from Feilding Palmer Hospital pre-pandemic and those currently provided. Under the proposals both the number of conditions treated would increase, as well as the number of appointments provided. Therefore, the consultation document also lists the services it is proposed to provide which include the provision of 17,000 outpatient and diagnostic appointments each year in over 25 branches of medicine.

The table below shows the current and proposed outpatient activity.

SERVICE WE ARE CONSULTING ON	HOW IT IS PROVIDED NOW	HOW WE PROPOSE TO PROVIDE IT
rease the number of outpatient activity providing in Lutterworth	The following services are provided at Feilding Palmer Hospital or were provided pre-pandemic: • Abdominal Aortic Aneurysm screening • Attention Deficit Hyperactivity Disorder support • Dermatology • Dietary • Echocardiogram or ECHO • Heart Failure • Mental Health • Musculoskeletal or MSK Physio • Out of Hours • Paediatrics (children) • Parkinsons care • Psychiatrics • Psychiatric nurse • Pulmonary and Cardio Rehabilitation • Speech and Language Therapy - Adult and Children • Stoma • Walking aid clinic Other diagnostic and outpatient services are provided outside of Lutterworth e.g. acute hospitals	We would expand the current services providing approximately 325 patient appointments per week at Feilding Palmer Hospital or at a location in Lutterworth. The services are: • Abdominal Aortic Aneurysm screening • Attention Deficit Hyperactivity Disorder support • Cardiology • Dermatology • Dietary • Echocardiogram or ECHO • General internal medicine • General surgery • Gynaecology • Heart Failure • Mental Health • Musculoskeletal or MSK Physio • Ophthalmology • Out of Hours • Paediatrics (children) • Parkinsons care • Psychiatrics • Psychiatric nurse • Pulmonary and Cardio Rehabilitation • Respiratory medicine • Rheumatology • Speech and Language Therapy - Adult and Children • Stoma • Trauma and orthopaedics • Urology • Walking aid clinic

4. The NHS has a duty to involve people in any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.

   Using Cabinet Office principles for public consultation (updated January 2016) and NHS England guidance 'Planning, assuring and delivering service change for patients' (published in November 2015), the Lutterworth proposals have been assessed on their specific attributes and would require a public consultation to meet the NHS duties.

   The range of legislation that relates to the LLR ICB decision making has also been taken into account including:

- Equality Act 2010;
- Public Sector Equality Duty Section 149 of the Equality Act 2010;
- Brown and Gunning Principles;

- Human Rights Act 1998;
- NHS Act 2006;
- NHS Constitution;
- Health and Social Care Act 2012;
- Communities Board Principles for Consultation.

The NHS would in any public consultation pay due regard and consciously consider the equality duty: eliminate discrimination, advance equality of opportunity and foster good relations.

16. Urgent items.

There were no urgent items for consideration.

17. Declarations of interest.

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

Mrs. M. E. Newton CC declared a Non-Registrable Interest in agenda item 10: Health Performance Update as she had two close relatives that worked for the NHS.

Mrs. B. Seaton CC declared a Registrable Interest in agenda item 10: Health Performance Update as she was a member of Silverdale Medical Centre Patient Participation Group.

18. Declarations of the Party Whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

19. Presentation of Petitions.

The Chief Executive reported that no petitions had been received under Standing Order 35.

20. Review of Homeless Support Service.

The Committee considered a report of the Director of Public Health which sought the views of the Committee around the proposed homeless support offer as part of the consultation. A copy of the report, marked ‘Agenda Item 8’, is filed with these minutes.

The Chairman welcomed to the meeting for this item Rachel Hall, Deputy CEO, Falcon Support Services and invited her to make a representation before he took any questions from members.

Rachel Hall explained that the Falcon Centre had had a long-standing good relationship with the County Council over the years. The Falcon Centre had been aware that the current contract was coming to an end and understood that this would provide an

opportunity to review the service. However, the Falcon Centre was not expecting that the review would result in a proposal to cease commissioning this specialist service.

Rachel Hall reiterated the concern raised in her questions (minute 14 refers) that the Cabinet had been provided with inaccurate and misleading information and suggested that the Falcon Centre would like an opportunity to work with all parties involved to find a solution to protect the most vulnerable. She suggested that the proposed changes to how the service was provided would result in a worse service.

In response to questions from Members, Rachel Hall responded as follows:

(i) The Falcon Centre could support 30 people at any one time and the accommodation was always fully occupied with a waiting list. In a typical year there would be a total of 100 different residents and the average length of stay was 4 months, in line with the Falcon Centre's role as a provider of supported accommodation. There were other accommodation centres for homeless people in Leicestershire such as The Carpenter's Arms in Loughborough and a rehabilitation facility in Hinckley. The Carpenter's Arms was much larger than the Falcon Centre.

(ii) The County Council had been commissioning the homeless support service provided by Falcon Support Services for 10 years. The contract value was £300,000 per annum and the contract would end on 31st March 2024. The £300,000 was a small part of the overall budget for the Falcon Centre. However, the Falcon Centre was of the view that the homeless support service enabled it to be an exempt organisation in terms of housing benefit, which made the value of the contract significantly higher.

Rachel Hall also acknowledged that she had had a sufficient opportunity to raise concerns and questions.

Arising from discussions the following points were noted:

(iii) In response to a question as to what proportion of the people that the Falcon Centre supported were from Leicestershire and what proportion were from outside of the county boundary, it was agreed that this information would be provided to members after the meeting.

(iv) It was queried whether, given that the Falcon Centre was submitting that it was financially reliant on the funding from Leicestershire County Council and at risk of closure should the funding not be received, questions should be raised as to the financial sustainability of the Falcon Centre as a charity and whether further checks needed to be carried out regarding its status.

(v) In response to a question from the Chairman as to how the County Council audited the provision of the services it commissioned it was explained that the Public Health department did not specify exactly how the funding should be spent, they were mainly concerned about whether the overall aims were being achieved. The contract with the Falcon Centre included Key Performance Indicators which the Falcon Centre was required to provide data on. Quarterly contract management meetings were held with the Falcon Centre. When contracts were coming to an end a full review was carried out and any new issues would be covered in future contracts with that provider. However, reassurance was given that Public Health

were always looking to improve and refine contract management processes and would take suggestions on board.

(vi) Leicestershire had the largest team of Local Area Co-ordinators (LACs) in the country with a total of 35. There would be no new LAC roles created to provide the homeless support service. The work would be carried out by the existing team of LACs. Given how large the team was there was flexibility to move LACs to where they were most needed, however under the new model for homeless support extra LACs would not be moved to the Loughborough area as the aim was for the service to be more equitably distributed across the county. There was a lot of national interest in the way LACs were being used in Leicestershire including interest from government. Members commended the work LACs carried out in Leicestershire and welcomed the proposed use of LACs in the new model for homeless support.

(vii) It was felt that one of the benefits of using LAC to provide the homeless support service was that they would support people for as long as they need and would also monitor service users effectively to ensure that they accessed the services that they had been signposted to.

(viii) The Director of Public Health and the Cabinet Lead Member for Health strongly refuted the claims of Falcon Support Services that the Cabinet report of 23 June 2023 contained inaccuracies and made it clear that Cabinet had not been misled.

RESOLVED:

(a) That the draft revised model for the delivery of homeless support be noted, and the proposed use of the Local Area Coordination service as part of the model be welcomed;

(b) That officers be requested to take on board the comments now made by the Committee as part of the consultation process;

(c) That officers be requested to provide a further report for the Committee at its meeting on 1 November 2023 regarding the results of the consultation and the recommendation that Cabinet will be asked to approve.

21. <u>Public Consultation - Proposed changes to maximise access to health services for the local community in Lutterworth.</u>

The Committee considered a report of Leicester, Leicestershire and Rutland Integrated Care Board (ICB) which informed of a consultation on the plans to make changes to the usage of Feilding Palmer Hospital in Lutterworth to maximise access to health services for the local community. A copy of the report, marked ‘Agenda Item 9’, is filed with these minutes.

The Committee welcomed to the meeting for this item Sarah Prema, Chief Strategy Officer, Integrated Care Board and David Williams, Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust.

Arising from discussions the following points were noted:

(i) It was not proposed to demolish the Feilding Palmer Hospital building. Instead, the interior would be refurbished with the space remodelled and an extension would be

built. In response to a question from a member as to the precise timescale for the implementation of the proposals it was explained that the first building works would likely start in spring 2025 but a full timetable would be provided to members after the meeting.

(ii) The £5.8m capital for the proposals was coming from the local budget which meant that the ICB would not have to go through time-consuming national processes. The funding had already been confirmed and was available for use.

(iii) Prior to the Covid-19 pandemic there had been 10 inpatient beds at Feilding Palmer Hospital. One of the beds was in a suite and was used for palliative care. All these beds were closed during the pandemic as they did not meet the Infection, Prevention Control Inpatient standards and they remained closed for that reason. A member raised concerns that the new proposals for Feilding Palmer Hospital did not include inpatient beds and stated it was important for beds to be available locally to enable friends and relatives to visit patients easily. In response it was explained that the approach of modern healthcare was to treat patients in their own home as much as possible so that they could be kept mobile and did not suffer as much muscle degeneration as they would in a hospital bed. Virtual wards were being used to monitor patients at home.

(iv) Replacing the inpatient beds would be 6 consultation rooms and an enhanced procedure suite for day-case procedures carried out without general anaesthetic.

(v) The proposed plans for more community procedures and outpatient clinics at FPCH had been developed based on current evidence of need for the local population. The information on need had been collected from local engagements and consultations. The NHS also held data on which services residents from Lutterworth post codes most commonly accessed and used this to inform future planning.

(vi) In response to a concern raised about Feilding Palmer Hospital being able to cope with the large housing growth projected for the Lutterworth area and the amount of elderly people, it was explained that it was predicted that the housing growth would actually increase the amount of younger people living in the area. Therefore outpatient clinics were likely to be the most appropriate type of provision.

(vii) In response to a question as to what impact the new proposals would have on waiting times it was explained that the proposals were not specifically designed to tackle waiting times but there were many other initiatives being put in place in Leicestershire which would deal with that problem.

RESOLVED:

(a) That the proposed consultation on the plans to make changes to the usage of Feilding Palmer Hospital in Lutterworth to maximise access to health services for the local community be noted;

(b) That officers be requested to take on board the comments now made by the Committee as part of the consultation process.

22. Health Performance Update.

The Committee considered a joint report of the Chief Executive and the Integrated Care Service (ICS) Performance Service which provided an update on public health and health system performance in Leicestershire and Rutland based on the available data in August 2023. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Chairman welcomed to the meeting for this item Rachna Vyas, Chief Operating Officer, NHS Leicester, Leicestershire & Rutland, and Alison Buteux, NHS Midlands and Lancashire Commissioning Support Unit.

Arising from discussions the following points were noted:

(i) Members asked that future performance reports contain regional and national benchmarking data to enable the Committee to assess Leicestershire's performance in the wider context. In response it was confirmed that this type of data was now available and could be included in future reports. Members also asked that the performance reports provide greater clarity on the direction of travel for the metrics i.e. whether performance was improving or not over a period of time. It was agreed that links to online performance data would be circulated to members after the meeting.

(ii) With regards to the Accident & Emergency metric of admission, transfer, discharge within 4 hours, 99% of LLR Urgent Care Centres were meeting the target and for the Emergency Department the target was being met with 61% of patients. One of the reasons performance against this metric was not better was a lack of beds and problems with flow of patients through the wider hospital. Some of the patients arriving at the Emergency Department did not need to be there and could have been dealt with elsewhere. In response to a question from a member it was clarified that according to data received at system level, it did not appear that staffing numbers were a problem, a lot of recruitment had taken place and workforce numbers in the Emergency Department were as per plan.

(iii) In response to a question about the impact of strike action on Leicestershire's performance data it was explained that acute care had been prioritised and the main impact had been on elective care. However, partnership working was taking place across the system to tackle the elective care backlog and GPs were assisting with some elective procedures.

(iv) Members raised concerns that whilst bowel cancer screening coverage had improved, coverage for breast cancer and cervical cancer had declined. It was questioned which sections of the population were not coming forward for screening and what could be done to encourage them. It was acknowledged that there needed to be better communication with the public about screening programmes and the ICB agreed to provide documentation on screening to members after the meeting which could be circulated to the general public.

(v) Members welcomed that Leicestershire was in the top quartile for the metric 'Percentage of people who are resident in the HWB, who are discharged from acute hospital to their normal place of residence'.

(vi) With regards to the metric 'Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000

population' the aim was to move into the second quartile when compared to similar authorities. There was confidence that this target would be met due to the large amount of partnership work taking place particularly the Home First initiative where patients were assessed to see what they needed to help them with reablement. It was also reassuring that the high level of performance against the metric had been maintained through the winter periods.

(vii) With regards to Improving Access to Psychological Therapies (IAPTs) there had been a recent performance improvement which was significant as performance had been stagnant for a long period of time.

RESOLVED:

That the update on public health and health system performance in Leicestershire be noted.

23. Noting the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee.

The Committee considered the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee, a copy of which, marked 'Agenda Item 11', is filed with these minutes.

RESOLVED:

That the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee be noted.

24. Date of next meeting.

RESOLVED:

That the next meeting of the Committee be held on Wednesday 1 November 2023 at 2.00pm.

2.00 - 3.45 pm CHAIRMAN
13 September 2023

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Agenda Item 8

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 1 NOVEMBER 2023

WINTER PLANNING UPDATE

REPORT OF THE CHIEF EXECUTIVE OFFICER OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Purpose of report

1. The purpose of this report is to summarise planning to manage Winter pressures across LLR in 2023/ 2024 and provide an update on the COVID-19 and flu vaccination programme for the eligible population resident within Leicester, Leicestershire and Rutland

Policy Framework and Previous Decisions

2. At the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board meeting on 10 August 2023 the Board approved the Winter Plan for 2023/24. The Leicester, Leicestershire & Rutland Integrated Care System - Delivery plan for recovering urgent and emergency care services is appended to this report.

Background

2. Winter planning is an annual responsibility of health and social care organisations, in order to cope with the anticipated increase in demand for care as a result of weather conditions and seasonal illnesses.

3. Across the health and social care system, winter planning is co-ordinated to ensure that there are robust arrangements to cope with demand and surges in activity, and that agencies are working together to manage pressures to ensure that residents continue to receive safe and appropriate care.

4. Urgent and emergency services have been through the most testing time in NHS history with a perfect storm of pressures impacting the whole health and care system but causing the most visible problems at the ‘front doors’ of our services such as General Practices, 111 services and Emergency Departments.

5. Nationally staff prepared extensively for winter, putting in place thousands more same-day appointments, thousands more beds, more call handlers, 24/7 care control rooms and respiratory hubs, and often working at the limits of their endurance.

6. Despite their best efforts, increasing length of stay, alongside the demands of flu and COVID peaking together, has seen hospital occupancy reach record levels. This means patient 'flow' through hospitals has been slower.

7. In the last 12 months, LLR has made significant progress in its Urgent and Emergency Care performance, including a sustained improvement in ambulance handover times – with over 90% less time lost to ambulance handover delays when compared to 2022.

Winter Plan for 2023/24

8. Sustaining the improvement of the last 12 months will require focus in five areas:

9. Increase capacity, to help deal with increasing pressures on Leicester hospitals which see 19 in 20 beds currently occupied.

- Dedicated revenue and capital for additional capacity at Glenfield and 52 (25 new) community beds as part of the permanent bed base for next winter/spring.
- New ambulances will be available across the East Midlands, the majority of which will be on the road by next winter.
- 'Same day' emergency care services will be in place across Leicester Royal Infirmary and the Glenfield hospital, so patients avoid unnecessary overnight stays.
- Grow the workforce, as increasing capacity requires more staff who feel supported.
- More clinicians will be available for 111 online and urgent call services to offer support, advice, diagnosis and, if necessary, referral. From this April we will launch a new targeted campaign to encourage retired clinicians, and those nearing retirement, to work in 111 rather than leaving the NHS altogether.
- We will grow the workforce with more flexible ways of working and increase the number of Emergency Medical Technicians next year to respond to incidents and support paramedics.

10. Speed up discharge from hospitals, to help reduce the numbers of beds occupied by patients ready to be discharged.

- At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial footing. Locally this includes Adult Social Care funding of £4.77M to increase the Better Care Fund in 2023/24, and the new Adult Social Care Market Sustainability & Improvement Fund of £9.65M.
- We will further enhance our integrated care hub for our bed base ahead of next winter. This will support faster discharge to the right setting, so that people do not stay in hospital longer than necessary.
- We will continue to embed new approaches to step-down care, so for example, people who need physiotherapy can access care as they are being discharged from hospital before they need to be assessed by their local authority for long-term care needs.
- New discharge information will be published, with new data collected from this April.

11. Expand new services in the community, as up to 20% of emergency admissions can be avoided with the right care in place.
    - Ahead of next winter we will offer more joined-up care for older people living with frailty; this includes ensuring 100% of our patients able to access urgent community response within 2 hours, 80% of our frail patients having clear, accessible and proactive care plans and falls services will cover the whole LLR footprint – meaning the right people help you get the care you need, without needing an admission to hospital if it's not necessary.

    - Greater use of 'virtual wards', which allow people to be safely monitored from the comfort of their own home, will be achieved by an extra 199 beds to provide 236 beds in total by this autumn.

12. Help people access the right care first time, as 111 should be the first port of call and reduce the need for people to go to A&E.
    - By April 2024, urgent mental health support through NHS 111 will be universally available.

    - From this April, new data will allow the public to easily see and compare the performance of their local services.

    - We will also tackle unwarranted variation in performance in the most challenged local systems.

    - We will continue to embed our clinically led programme to reduce unwarranted variation, working with our 20 practices where we note the highest levels of variation. Intensive support will be in place for those neighbourhood areas struggling the most.

13. To support the recovery of urgent and emergency care services, the LLR system has committed to targeted funding in both acute services and the wider system. This includes:

    - £14.3M of dedicated funding to support capacity in urgent and emergency services, building on the national funding used over winter 2022/23 to support an increase our overall capacity.
    - £4.7M of additional social care discharge funding over 2023/24 (with 2024/25 to be confirmed), building on the £500 million Adult Social Care Discharge Fund and £200M funding for step-down care during winter 2022/23, to be pooled into the Better Care Fund and used flexibly on the interventions that best help discharge patients to the most appropriate location for them – part of social care investment of up to £7.5 billion over the next two years.

Progress with Winter Plan to date

14. Given the way we collate, process and publish data, a verbal update on progress against plan will be given at the meeting.

Vaccinations and Immunisations

Autumn / winter 2023/24 vaccination campaign: Eligible cohorts

15. The Joint Committee for Vaccination and Immunisation (JCVI) has agreed the 2023 seasonal vaccination programme. The groups to be offered vaccinations are:

Cohort	COVID Booster	Flu
Residents in older adult care homes & their staff	Yes	Yes
Adults aged 65 years & over (note: all those that turn 65 by 31 March 2024 are eligible for both COVID & flu vax)	Yes	Yes
6 months to 64 years in clinical at risk group i.e. asthma, serious mental illness, epilepsy, learning disability, etc	Yes	Yes
Frontline health and social care workers	Yes	Yes
Household contacts of immunosuppressed patients (contacts aged 12 to 64 years)	Yes	Yes
Carers aged 16 to 64 years (registered / unregistered)	Yes	Yes
Pregnant women	Yes	Yes
2 and 3-year-olds (turn 3 years by 31/08/23)	No	Yes
Children and young people (reception to year 11)	No	Yes
Working aged adults in long-stay residential care homes and their staff	Yes	Yes

Campaign timing

16. To maximise and extend protection during the winter and through the period of greatest risk in December 2023 and early January 2024, health systems will follow a campaign timeline:

Flu

17. 2 and 3-year-olds, school age children (reception to age 11) and children in clinical risk groups to start from 1st September 2023

18. Ideally delivery will be completed by 15th December, however some groups i.e. pregnant women, will continue to be offered a vaccination up to the end of March 2024.

COVID-19 & flu

- Start date 2nd October – Care Homes for flu and COVID-19
- Start date 7th October – all cohorts for flu and COVID-19
- National booking system will open for the public from 2nd October for appointments from 7th October 2023
- End date 15th December, although some inequalities work will continue to end January 2024. Short 10-week campaign
- Care homes a priority – aiming to complete visits to all within first 4 weeks of campaign.

Vaccination campaign

19. The Vaccination campaign for 2023/24 in Leicester, Leicestershire and Rutland (LLR) will comprise:

    - Encouraging greater co-administration of COVID-19 and flu;
    - Tackling health inequalities and areas of low uptake as a priority, using a variety of initiatives i.e. mobile vaccination units, super vaccinators, supporting events/activities i.e. Steady Steps (activity programme);
    - Delivering plans that are informed by needs of local communities and co-developed with local partners, i.e. local authorities, community, voluntary and social enterprises

20. Not all GPs will be offering COVID-19 and flu vaccinations, however, additional community pharmacies are being recruited via an 'expression of interest' process, to ensure there is sufficient coverage across LLR. Gaps in provision will be covered by mobile vaccination units/teams.

21. We currently await confirmation of vaccine types for autumn/winter 2023/24.

22. New model for vaccine supply will automatically replenish provider's vaccine stock on a 3-day cycle.

Tackling health inequality

23. To tackle health inequality, we will implement:

    - Roving health care unit available for:
        - out-reach, hyper local vaccination opportunities and health care inequality Making Every Contact Count (ECC) initiatives.
        - additional health and care capacity i.e. unit located in surgery car park or as close as possible to a surgery.
    - Assistance with promoting additional and out-reach clinics, including:
        - texting patients, via NHS and partners networks.
        - promoting health and care opportunities via social media i.e. Facebook, etc.
        - telephoning eligible patients and booking them directly into clinics.
        - additional vaccinating staff to assist with capacity.

Improving MMR (measles, mumps and rubella) uptake to eliminate measles

24. Measles is a highly contagious disease caused by a virus. It spreads easily when an infected person breathes, coughs or sneezes. It can cause severe disease, complications and even death.

25. Measles can affect anyone but is most common in children. Being vaccinated is the best way to prevent getting sick with measles or spreading it to other people. The vaccine is safe and helps the body fight off the virus.

26. We are working to improve MMR uptake by:

- Working with primary care to promote a global offer for MMR across LLR;
- Promoting a vaccination offer to be targeted to communities and vulnerable population groups, known for low vaccination uptake;
- Working with stakeholders to scale up accessible, convenient offers i.e. promoting to university students and delivering offer on campus;
- Promoting to local families to promote the 'check and confirm' vaccination status of their children;
- Working with VCSE organisations to advocate the importance of vaccination/immunisation and codesigning accessible delivery channels, i.e. dedicated vaccination clinic offered within alternative community setting;
- Frontline health and care staff encouraged to check and confirm vaccination status with mop-up clinics to be offered via occupational health teams.

Update

27. **LLR Provider Network for Autumn/Winter 2023/24 Vaccination Programme**
    - 91 Community pharmacies with a further 15 expected to join the programme, subject to NHSE approval;
    - 21 Primary Care Networks representing 82 GP practices.

Programme Timings

28. This year's autumn flu and Covid-19 vaccine programmes started earlier than planned in England as a precautionary measure following the identification of a new Covid variant, BA.2.86, which was first detected in UK in August.

29. The Covid vaccination programme was originally supposed to start on 2 October with care homes initially, however the start date was brought forward to September to align with the flu programme. Covid vaccinations began on 11 September for those most at risk, including adult care home residents and people who are immunosuppressed.

30. From 18 September, other eligible patients were able to take up vaccination offers from their GP practice or could book a vaccination appointment via the National Booking System.

31. The Covid vaccination programme is due to finish on 18 December 2023, whilst inequality work involving Covid vaccinations can continue until 31 January 2024. The flu vaccination campaign is due to finish on 31 March 2024.

County Flu Vaccination Uptake by Cohort (figures correct at 18 October 2023)

Flu Cohorts	Eligible Population	Doses Administered	% Vaccinated
Over 65 years	146,108	92,643	63.41%
Care homes	3,502	2,599	74.21%
Children aged 2 & 3 years	12,792	3,682	28.85%
At risk	85,441	26,843	31.42%
Frontline HCSW (ESR)	12,140	2,986	24.60%
Frontline HCSW (self-declared)	9,498	1,412	14.87%
Frontline social care workers	8,183	1,018	12.44%
Household contact of IS patients	18,154	616	3.39%
Pregnant women	3,100	135	4.35%
Primary school	51,087	9,935	19.45%
Secondary school	38,315	3,868	10.10%
TOTAL	**388,290**	**145,737**	**37.53%**

Inequalities Offers

32. The inequalities offers are as follows:

- **6 months to 4 years at risk:** Vaccination invitations have been issued for UHL specialist clinics and GPs can refer eligible patients, who have not had an invitation.
- **5 to 11 years at risk:** Patients can book direct into the specialist UHL clinics via the National Booking System. A further four satellite clinics, located around the county are expected to be operational shortly. GPs are being encouraged to forward eligible patient list to LLR's Central Booking Team for proactive contact / booking
- **Allergy pathway:** Patients previously referred via Prism/allergy service will already have access to the VidPrevtyn Beta vaccine via UHL specialist allergy vaccination clinic. New patients thought to have PEG allergy can be referred by GP via PRISM to allergy clinic for assessment. Patients who do not suffer anaphylaxis/allergy to PEG but who are clinically severely intolerant of mRNA vaccines may be eligible for VidPrevtyn Beta and GPs can refer their eligible patients
- **Learning disability patients:** Dedicated provision is being scoped to provide a specialist service with dedicated learning disability nurses in attendance
- **Free transport offer:** To help eligible patients, who live in rural areas, access their vaccination offers, free transport is being provided from their homes to/from vaccination clinics. The service also assists patients to book their appointments too
- **Mobile vaccination units:** To make Covid and flu vaccinations as accessible and convenient as possible, two mobile vaccination units (operational in city and county respectively) are deployed to target communities of low vaccination uptake.

MMR / Measles Elimination Plan

33. The LLR ICB has devised a measles elimination plan to outline a series of actions that are required to reduce the risk posed by measles. Since 2022 there has been an increase in measles cases both globally and in the UK. Measles and rubella can be eliminated, and congenital rubella infections prevented by achieving high uptake of the combined measles, mumps and rubella (MMR) vaccine in national childhood immunisation programmes. This plan aims to mitigate the risk of measles, by the ICB working collaboratively with other agencies, undertaking a series of initiatives to increase uptake & reduce health inequalities.

34. Since 2022, measles activity has been slowly increasing. To achieve & maintain measles elimination, the World Health Organisation recommends that a 95% uptake with two doses of MMR by 5 years of age and by using all opportunities to catch up older children and adults who missed out when they were younger. Unfortunately, current UK performance for the second dose is sub-optimal at around 88%. Due to the national concern of increasing cases, this plan aims to address any current issues, plan future objectives and be proactive at tackling this challenge.

35. The objectives of the plan are:

Primary Objectives

1. Ambition to achieve and sustain ≥ 95% coverage with two doses of MMR vaccine in the routine childhood programme (5-years-old) by 2025;
2. Ambition to achieve ≥ 95% coverage with two doses of MMR vaccine in older age cohorts through opportunistic and targeted catch-up (>5 years old) by 2025;
3. Improvement in uptake in key priority groups eg students (the 'Wakefield cohort'), traveller communities, women of childbearing age, underserved communities and ethnicity groups with the lowest uptake, new entrants, etc.

Secondary Objectives

1. Provide leadership and public health expertise to address the decline in MMR vaccination;
2. Bring together partners to develop a multi organisational approach to increasing MMR uptake;
3. Develop engagement activities that seek to understand why some people are not taking the MMR vaccination offer;
4. Develop a communications campaign that will raise awareness about the risks associated with measles and promote positive messages about the importance of vaccination uptake;
5. Develop innovative interventions that will support increased MMR vaccination uptake, tailored to the differing needs of the population;
6. Respond to the potential change in age of delivery of MMR2 (likely from 2025 approximately) and work with stakeholders including GPs to identify potential issues and develop appropriate capacity and engagement plan at that time.

Circulation under the Local Issues Alert Procedure

36. Not applicable.

Appendices

Appendix A - Leicester, Leicestershire & Rutland Integrated Care System - Delivery plan for recovering urgent and emergency care services

Officer(s) to Contact

Richard Mitchell, Chief Executive Officer,
University Hospitals of Leicester NHS Trust
Richard.Mitchell@uhl-tr.nhs.uk

Rachna Vyas, Chief Operating Officer
NHS Leicester, Leicestershire & Rutland
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APPENDIX

Delivery plan for recovering urgent and emergency care services

Leicester, Leicestershire & Rutland Integrated Care System

Final v4.0 / 31 July 2023

Contents

Our commitment to the public in publishing this plan is to improve waiting times and patient experience. We will:

Increase capacity, to help deal with increasing pressures on Leicester hospitals which see 19 in 20 beds currently occupied.

1. Dedicated revenue and capital for additional capacity at Glenfield and 52 (25 new) community beds as part of the permanent bed base for next winter/spring.
2. New ambulances will be available across the East Midlands, the majority of which will be on the road by next winter.
3. 'Same day' emergency care services will be in place across the LRI and the Glenfield hospital, so patients avoid unnecessary overnight stays.

Grow the workforce, as increasing capacity requires more staff who feel supported.

4. More clinicians will be available for 111 online and urgent call services to offer support, advice, diagnosis and, if necessary, referral. From this April we will launch a new targeted campaign to encourage retired clinicians, and those nearing retirement, to work in 111 rather than leaving the NHS altogether.
5. We will grow the workforce with more flexible ways of working and increase the number of Emergency Medical Technicians next year to respond to incidents and support paramedics.

Speed up discharge from hospitals, to help reduce the numbers of beds occupied by patients ready to be discharged.

6. At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial footing. Locally this includes Adult Social Care funding of £4.77M to increase the Better Care Fund in 2023/24, and the new Adult Social Care Market Sustainability & Improvement Fund of £9.65M.
7. We will further enhance our integrated care hub for our bed base ahead of next winter. This will support faster discharge to the right setting, so that people do not stay in hospital longer than necessary.
8. We will continue to embed new approaches to step-down care, so for example, people who need physiotherapy can access care as they are being discharged from hospital before they need to be assessed by their local authority for long-term care needs.
9. New discharge information will be published, with new data collected from this April.

Expand new services in the community, as up to 20% of emergency admissions can be avoided with the right care in place.

10. Ahead of next winter we will offer more joined-up care for older people living with frailty; this includes ensuring 100% of our patients able to access urgent community response within 2 hours, 80% of our frail patients having clear, accessible and proactive care plans and falls services will cover the whole LLR footprint – meaning the right people help you get the care you need, without needing an admission to hospital if it's not necessary.

11. Greater use of 'virtual wards', which allow people to be safely monitored from the comfort of their own home, will be achieved by an extra 199 beds to provide 236 beds in total by this autumn.

    Help people access the right care first time, as 111 should be the first port of call and reduce the need for people to go to A&E.
12. By April 2024, urgent mental health support through NHS 111 will be universally available.
13. From this April, new data will allow the public to easily see and compare the performance of their local services.

    We will also tackle unwarranted variation in performance in the most challenged local systems.
14. We will continue to embed our clinically led programme to reduce unwarranted variation, working with our 20 practices where we note the highest levels of variation. Intensive support will be in place for those neighbourhood areas struggling the most.

Executive summary

Urgent and emergency services have been through the most testing time in NHS history with a perfect storm of pressures impacting the whole health and care system but causing the most visible problems at the 'front doors' of our services such as General Practices, 111 services and Emergency Departments.

Nationally staff prepared extensively for winter, putting in place thousands more same-day appointments, thousands more beds, more call handlers, 24/7 care control rooms and respiratory hubs, and often working at the limits of their endurance.

Despite their best efforts, increasing length of stay, alongside the demands of flu and COVID peaking together, has seen hospital occupancy reach record levels. This means patient 'flow' through hospitals has been slower.

As a result, patients are having to spend longer in A&E and waiting longer for ambulances. Hospitals are fuller than pre-pandemic, with 19 out of 20 beds at UHL beds (occupancy in Apr 2023 is 94%) occupied; up to 200 beds occupied by an LLR patients who are clinically ready to leave UHL, LPT or an out of area bed each day in April 2023 and the number of the most serious ambulance call-outs has been at times up by 12.9% on pre-pandemic levels. These pressures have also taken their toll on our staff, who have had to work in an increasingly tough environment.

The challenge is not just in ambulances or emergency departments, and so neither are the solutions. Recovery will require different types of providers working together and joining up care better for patients, led by local systems and backed by additional investment. We also know this is not unique

to Leicester with many similar challenges faced by regions and nations across the UK and across the world.

To support recovery, this plan sets out our ambitions, including:

- Patients being seen more quickly in our emergency department: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.

- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

These ambitions would represent one of the fastest and longest sustained improvements in emergency waiting times in the local NHS's history. Meeting these ambitions provides a focus for recovery, but they will not be enough on their own. Successive analysis has demonstrated the importance of looking at multiple metrics to support better outcomes for patients. We will therefore begin to publish more data on time spent in A&E, including 12 hour waits from time of arrival, and we are working with social care partners on a better measure of discharge to ensure we are measuring the whole patient journey in hospital. Performance against these metrics will fluctuate in response to COVID and other viral illness, as well as the usual seasonal pressures.

But even before the pandemic, pressure on urgent and emergency care had been growing, with changes in demographics and new types of care available, meaning the need for services has been growing every year. And looking forward, our growing and ageing population will see this continue.

We also need to reform and provide a genuinely better experience for patients. Our plan builds on the investment and evidence-based actions taken during winter 2022/23 to increase capacity and resilience, by taking steps to embed what works for patients while also creating space for people to innovate. It also builds on the experience during COVID, which brought out the best in our local NHS and care services – with new services scaled quickly, genuine innovation focused on improving patient care, and better working across different types of care provider centered on the needs of patients.

Through partnerships between acute, community and mental health providers, primary care, social care and the voluntary sector, our ambition is to create a sustainable system that provides more, and better, care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

This plan sets out how the NHS and partners across Leicester, Leicestershire & Rutland will make this a reality and continue to transform patient care at scale.

Meeting this challenge will require sustained focus on five areas:

- **Increasing capacity** – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow.

- **Growing the workforce** – increasing the size of the workforce and supporting staff to work flexibly for patients.

- **Improving discharge** – working jointly with all system partners to strengthen discharge processes, backed up by more investment in step-up, step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter. Work closely with providers to increase P0 discharges and reduce lost and delayed discharges.
- **Expanding and better joining up health and care outside hospital** – stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.

- **Making it easier to access the right care** – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

To support the recovery of urgent and emergency care services, the LLR system has committed to targeted funding in both acute services and the wider system. This includes:

- £14.3M of dedicated funding to support capacity in urgent and emergency services, building on the national funding used over winter 2022/23 to support an increase our overall capacity.

- £4.7M of additional social care discharge funding over 2023/24 (with 2024/25 to be confirmed), building on the £500 million Adult Social Care Discharge Fund and £200M funding for step-down care during winter 2022/23, to be pooled into the Better Care Fund and used flexibly on the interventions that best help discharge patients to the most appropriate location for them – part of social care investment of up to £7.5 billion over the next two years.

Delivery will require prioritisation at a system level, but also local flexibility within each place. There will not be a one size fits all solution, and local places, working with social care and other partners continue to develop local plans reflecting local needs across LLR.

Why we need a UEC Recovery Plan

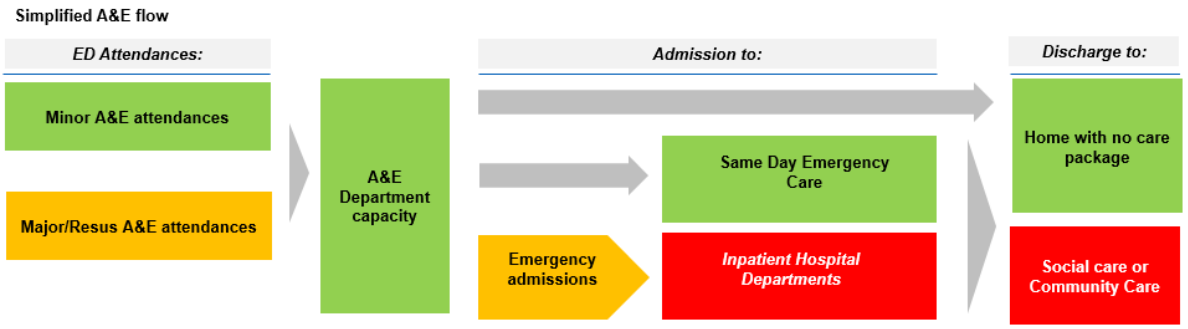
A. Why are we seeing pressures on Urgent and Emergency Care?

Current pressures

COVID is having a lasting impact on NHS services. Throughout 2022 there were never less than 3,800 people in England in hospital with COVID on any given day, with more than 9,000 on average across the year. This means not just more patients, but also knock-on impacts on the length of time patients are in hospital and more beds closed for infection control.

Occupancy levels for general and acute hospital beds have risen in recent years and have been persistently high over 2022, with around 94% of beds at Leicester Hospitals and 92% (LPT) of beds at Leicestershire Partnership Trust filled on average. High bed occupancy is a key driver of worsening A&E performance, which in turn has a direct impact on ambulance 'handover' and response times. This is because when hospitals are fuller it is harder to find free beds for patients that need to be admitted from the emergency department, which means it is harder to bring new patients into the emergency department.

The figure below provides a simplified picture of A&E patient flow, highlighting the current constraints in hospital.



As set out in the diagram, the key driver for performance is high occupancy, with difficulty discharging patients, both internal and external factors, resulting in increased length of stay and knock-on difficulties admitting people as inpatients to hospital departments.

From April 2021 to October 2022, average length of stay in Leicester Hospitals increased by 5% (from 12% to 17%) compared to the national increase of 18%. The UHL average length of stay for emergency admissions was 9.6 days in the rolling six months up to March 2023 compared to the peer median of 10.3 days and provider median of 10.6 days in the same time period.

There were an average of 742 patients with >7day LOS at UHL each day in February 2023. Long length of stay has also significantly increased in mental health inpatient care, reflecting increased acuity and

challenges around discharge, with 20% of all people staying for more than 60 days. Increasing length of stay is driven by several factors including:

- Increasing complexity of care with patients having more comorbidities, in part linked to COVID.
- Delayed discharge: while the majority of people are treated and discharged within 48 hours of an emergency admission, for some discharge is more challenging. There are around 200 UHL, LPT and OOA beds occupied by LLR patients who are clinically ready to leave (April 2023) compared to 195 each day in April 2022 (an increase of 2.5%). Nationally, there have been up to 14,000 inpatients who do not clinically need to be in hospital, increasing by more than 10% over the last year – accounting for around 13% of occupied beds. This challenge exists across all settings, including mental health.

As set out in the diagram, the number of attendances is not the thing primarily driving performance, but they do create additional pressure. Following a reduction in activity at the start of the pandemic as fewer people came forward for care, demand has been consistently rising. Attendances have recently been just above pre- pandemic levels: Nationally, December was the busiest month on record for emergency departments in England with nearly 2.3 million attendances, 18,000 higher than the previous high. Locally, we saw 22,657 A&E attendances at UHL in Dec 22 compared with 22,536 in Dec 19. The ambulance service also responded to 18% more category 1 calls nationally in December compared to a 12.9% increase seen locally. We have continued to see admissions from COVID as well as other respiratory illnesses, with more than 350,000 COVID admissions since this time last year nationally, with 5,388 of these within LLR.

Taken together, even though there are more beds open now than immediately before the pandemic, occupancy remains very high, reducing patient 'flow' through hospitals and creating longer delays for patients at the front door and in the community. That said, evidence-based interventions put into place as part of our local winter planning have shown positive impact:

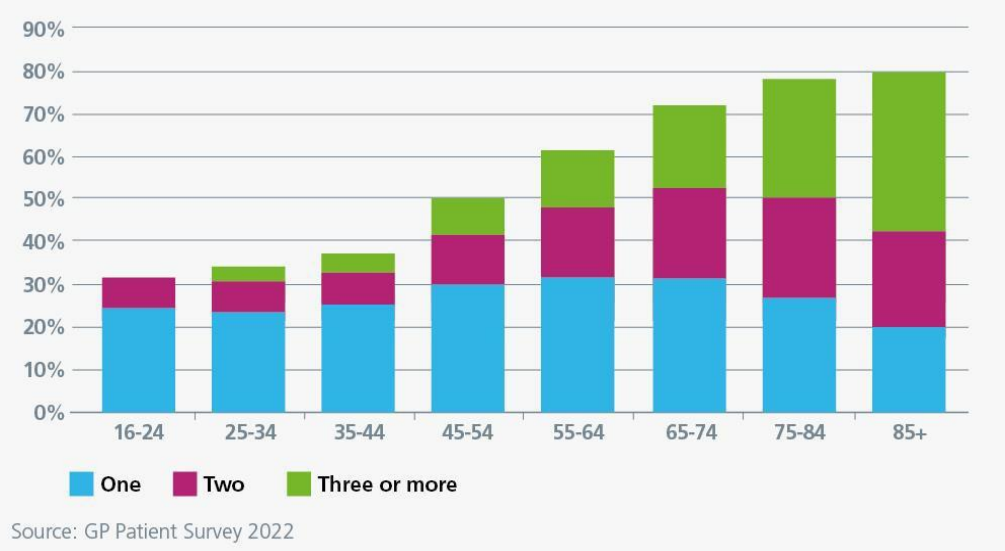
- Attendances at our Emergency Department have stabilized since the introduction of patient streaming with an average of 26 patients streamed into booked community slots instead
- Our community based Acute Respiratory Hubs have seen 8,971 patients in the period December 2022 to March 2023.
- Our General Practices have provided 12% more appointments during winter 2022/23 than in winter 2019/20.
- The numbers of complex patients (Pathways 1-3) awaiting a discharge plan has fallen from 228 (31/12/2022) to 192 (26/04/2023) over winter, despite over 192 additional bedded or non-bedded services being open.
- Since the revised ambulance assessment process at the Leicester Royal has been in place, ambulance handovers delays over 60mins have reduced from 38% in Dec 22 to 6% in Feb 23, with an average clinical handover of just over 30 mins in March 2023.

However, we know constrained UEC performance has a disproportionate impact on those who experience health inequalities. In 2021/22 NHS Digital reported that patients who live in the 10% most deprived areas (3.0 million people) were twice as likely to attend ED departments in England when compared to people living in the 10% least deprived areas (1.5 million people). Locally we know that for LLR, the 1.7% of patients living in most deprived areas have a 33% chance of an emergency admission in the next 12 months, compared with 1.3% of those living in least deprived. Our plans therefore must include action on equity and preventative services for these populations.

Longer term trends

The immediate challenges for UEC services come on top of longer-term trends. The need for health and care is continuing to increase as a consequence of population growth, ageing in the population and greater numbers of people living with long- term conditions. The number of people aged over 85 could increase by 55% over the next 15 years. More than 25% of the adult population in England now lives with two or more long-term conditions, increasing the likelihood of admission to hospital. [ii] In 2019, 33% of people over 18 were estimated to be living with complex multimorbidity, having doubled from 15% in 2004.[iii]

Proportion of age cohorts living with long-term conditions



Around 8% of people aged 50 or over are estimated to be frail, as high as 16% in parts of England.[iv] England is not the only country facing these challenges, countries across Europe are seeing rising levels of multimorbidity.

A growing and ageing population, with rising morbidity means that the need for UEC services rises every year:

- Demand for NHS 111 has continually increased, with annual growth of 6% a year in 111 calls received in the five years before the pandemic.

- Pre-pandemic ambulance services have faced the challenge of 4% increase in demand year on year.
- A&E including emergency departments and urgent treatment centres have seen rising demand in terms of acuity, with faster growth rates for older age people. Demand for major emergency departments has risen gradually but consistently since 2003.
- In 2019 there were 25.6 million A&E attendances (2.1 million a month), 20% more than in 2011. Emergency admissions grew by 28% over the same period to 6.5 million nationally. For UHL there has been an increase of 24.1% for A&E attendances from 205,561 in 2011/12 to 255,106 in 2019/20. For admissions there has been an increase of 31.1% from 76,348 in 2011/12 to 100,128 in 2019/20
- There are constraints and waits in social care, for service users to receive assessments and reviews in the community. The delay creates a risk of individuals moving into unplanned services as their needs are not addressed in a timely way.

The need for UEC mental health services is also growing. Community-based crisis services have seen a sustained increase in referrals since before the pandemic. Long waits for people with mental health needs in A&E are increasing, and people with mental health needs often report poor experiences relating to long waits. LPT are trialing some dedicated crisis inpatient beds, for people who need a short stay to stabilise their mental health and are quickly discharged back into the community for ongoing support.

B. What we will deliver for patients and the public

Our vision for UEC is for patients to have access to the right care, in the right place, at the right time. Our hospitals will be appropriate for some seriously ill patients but are often not the best place for many people whose needs are better met in a different way. Delivering this ambition will mean supporting more strengths-based, patient-centred, personalised care, accessed closer to, or at, home – but also more integrated services.

We will take the opportunity of new and existing technologies to enable people to access care in different ways and support staff in the NHS to deliver better care. New digital technologies provide the opportunity to change the way in which services are provided, but also transform the way in which people access services. We will support patients to manage their own health as they build on their knowledge and skills to improve their confidence.

We recognise that patients want better communication on time spent in A&E, want a better understanding of how to access the right care to avoid multiple handovers between services, and want greater continuity of care so that they do not have to repeat their story as they go through the system.

We will ensure that services reflect the needs of different groups of people, including all age groups, people with mental health issues and dementia and people with learning disability and autism. The

plan takes proactive steps to tackle known inequalities, particularly for groups who are disproportionate users of UEC services.

The plan sets out how we will achieve headline ambitions of patients spending less time in emergency departments, and ambulances getting to patients more quickly. While these ambitions provide an immediate focus, they are only part of the patient journey. We will also need to ensure focus across the pathway, including on long waits in emergency departments, on discharge and access to proactive care in our general practices, as we deliver this plan.

Achieving these ambitions in the next two years will be challenging. However, local partners are committed to this plan and the partnership approach needed to drive sustainable transformation. We recognise that delivering this vision will not happen overnight but we also recognise we are not starting from scratch. We will learn from and adapt our collective experience from winter 2022/23 and scale up the things we know will enable transformative change.

We know that urgent and emergency care is part of a more integrated health and care system; therefore, this plan will align fully with the principles of the Fuller Stocktake report as well as our planned improvements in access to general practice across the LLR footprint in line with the Access Improvement Plans our Primary care Networks are developing.

Meeting this challenge will require sustained focus on the five areas in the rest of the document:

1. Increasing capacity
2. Growing the workforce
3. Improving discharge
4. Expanding care outside hospital
5. Making it easier to access the right care

These actions consider the views of a wide range of stakeholders, from our clinicians and practitioners across the LLR footprint to our patients and our communities. It draws on a diverse range of opinion and experience, as well as views of patients and users, with each intervention being evidence-based and locally piloted.

1. Increasing urgent and emergency care capacity

We will need to increase the number of beds and ambulances if we want to reduce time spent in A&E and ensure hospitals are not as full. We will also work to make the most of the capacity we do have, with better processes and faster spread of best practice. We will increase capacity and reduce waiting times through:

A. Additional hospital bed capacity
B. Increasing ambulance capacity
C. Improving processes and productivity

A. Additional hospital bed capacity

Ambition:
There is a well-established link between high bed occupancy rates in hospitals and worse A&E performance.[vi] When hospitals are busy, it becomes more difficult to ensure patients get the care they need and can lead to longer time spent in A&E. Worsening A&E performance in turn has a direct impact on ambulance handovers and response times. We therefore need to reduce the current bed occupancy, which over 2022/23 has consistently been above 95%, back towards the 92% level which is safer and more efficient as it improves flow through hospitals.

Hospitals have tended to have higher occupancy levels in England compared to other countries, despite historically lower lengths of stay. The need for acute care will continue to increase over the coming years, and ongoing levels of COVID are creating additional pressures on hospital capacity. While we will act across all parts of health and care, increasing the number of staffed hospital beds to lower our occupancy levels ahead of next winter will be a fundamental part of the plan.

Through the additional funding for winter 2022/23 and through the year, Leicester Hospitals and Leicestershire Partnership Trust have already increased the number of staffed hospital beds by 79:

Ashton	24
Ward 22	16
Pre-Transfer Hub	12
Coalville W4	27

This increase in capacity is to be maintained for 2023/24 and we will also put in place further physical beds ahead of next winter

How we will deliver:
Compared to the originally planned levels of beds in 2022/23, there will be at least 52 additional staffed beds in 2023/24.

This additional bed capacity needs to be in the places that will deliver the greatest benefit to patients - based on our local demand and capacity modelling, we will put into place the following (subject to receipt of capital funding):

- Additional beds in UHL by Q4 2023/24.
- 52 additional beds (25 new) at LPT by Q3 2023/24.

We will work in partnership to ensure that the new beds are put in place as sustainably as possible, to reduce the impact of surge periods on other services, including theatres and research facilities.

B. Increasing ambulance capacity

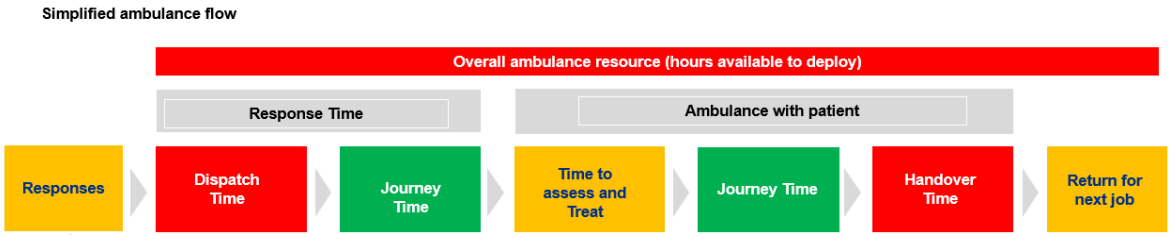
Ambition:

One of the main causes of longer waits for ambulances is delays handing patients over from the ambulance crew to hospital staff because the emergency department is full. On average more than 187 hours a day were lost to handover delays in December 2022 across LLR. Whilst this has reduced to an average of 32 hours per day in February 2023 since the introduction of an expanded ambulance assessment area at the LRI, this is still time when ambulances could be back on the road.

Therefore, on its own, reducing A&E waiting times will lead to an improvement in ambulance responses as flow improves out of, and therefore in to, emergency departments.

However, analysis of ambulance response times indicates that handover delays are not the only cause of slower ambulance response times. We have seen increases in sickness and other staff absence. We have also seen the complexity of ambulance crews' work increase meaning each incident is taking longer: the number of the most serious ambulance callouts has, at times, increased by one third since before the pandemic and there has been a long-term increase in the time ambulances are spending at the scene as crews provide more care directly with the patient. Therefore, additional ambulance capacity, not just additional beds, is needed to meet next year's 30-minute ambition for Category 2 ambulance response times.

The simplified ambulance flow diagram below shows the importance of handover times to ambulance performance, and the wider range of factors involved.



As well as increasing capacity, we need to ensure that ambulance services focus on emergency incidents and where ambulance services can add most value. In some cases, it may be more appropriate for other services, including urgent community response or mental health crisis teams, to respond to patients on scene.

How we will deliver:

To respond to these pressures, grow the fleet and better support the workforce, NHS England will ask ambulance services and lead commissioners to determine, by March 2023, their capacity plans

for 2023/24 and identify gaps. As part of that process ambulance services will look at ways to reduce sickness absence and how additional support could be given to staff.

This additional capacity will be largely delivered through more crew hours on the road, but we will also release capacity through better health and wellbeing for staff meaning a reduction in sickness absence, productivity gains, and through better links between the ambulance service and community services.

New ambulances will be available during 2023/24 across the East Midlands footprint, with the majority expected to be available ahead of winter, as part of ongoing improvement and replacement of our fleet.

The LLR system will work with East Midlands Ambulance Service and related partners such as DHU Healthcare to increase capacity and ensure patients receive the most appropriate care, including:

- **Single point of access for paramedics**: To ensure consistent and rapid access to clinical advice and alternative services, and to reduce unnecessary conveyance, we will implement a single point of access for paramedics. Single points of access provide a single, simple route for referrals to hospitals. They are staffed by qualified clinicians, able to ensure patients get referred to the most appropriate service for their needs.
- **Call assessment, triage and streaming via our unscheduled care hub:** By autumn 2023, we will work with EMAS to increase clinical assessment of calls in our Nottingham ambulance control and directly link this to our local Unscheduled care hub. This additional clinical input will ensure that the sickest patients are prioritised for ambulances and that patients who do not need a face-to-face response can be transferred quickly to services more appropriate for their needs via the UCH. This will include urgent community response, urgent treatment centres, same day emergency care (SDEC), mental health services, social care and primary care.
- **Forecasting:** We will work with EMAS improve forecasting of call demand and further develop the 'Intelligent Routing Platform' to manage the distribution of calls throughout England when individual services are under pressure and therefore reduce 999 call answering delays.

Right place, right time, right care: Navigating mental health pathways

Partners across health and care have developed a multi-agency approach to supporting patients with urgent mental health needs.

Mental health professionals have been embedded in the LLR unscheduled care hub since November 2022. A mental health dispatch pathway has been developed so that all appropriate 999 mental health calls, whether they are police/fire or ambulance calls, are routed into the mental health

professional in the hub. This allows partnership working across health and care to determine the most appropriate response for the patient and supports the 999 service.

This has meant more people with mental health needs have their needs met over the phone or are conveyed to more appropriate services. By February 2023, approximately 72% of calls directly handled by the mental health desk could be managed over the phone, without the need for ambulance dispatch. Patient and carer feedback has been excellent, with notable positive feedback from both ambulance and teams working in the hub as well.

C. Improving processes and standardising care

Ambition:
We know from patients how important it is to have a smooth experience in hospital, and to not experience too many unnecessary delays in situations like waiting for your test results or moving to a different part of the hospital. There is still significant variation between processes in hospitals, showing an opportunity to learn from where things are being done best and have a less confusing experience for patients. As we increase capacity, we will use existing capacity as effectively as possible by standardising processes so that patients get the right care at the right time, including when moving between organisations.

We will reduce variation in care when patients arrive at A&E, ensuring greater consistency in direct referrals to specialist care, and access to same day emergency care (SDEC) so patients avoid unnecessary overnight stays. We will also standardise the first 72 hours in hospital so that patients are assessed, get any required scans, and start their treatment as soon as possible.

We will continue to make effective use of our 'system control centre' (SCCs). These pioneering centres use data to respond to emerging challenges and bring together experts from across the system to make better, real-time decisions. They will continue to ensure the highest quality of care possible for the LLR population by balancing the clinical risk within and across acute, community, mental health, primary care, and social care services.

We will also work towards implementing new response time standards for people requiring urgent and emergency mental healthcare in both A&E and in the community, to ensure timely access to the most appropriate, high-quality support.

How we will deliver:
By April 2023, we will adopt and adapt the new improvement programme to support standardisation of care, working with clinical leadership to set out common principles for providers, including developing professional networks to support peer- to-peer learning and challenge, leadership and

best practice. This programme will be supported by national 'improvement collaboratives' as a mechanism for systematically adopting good practice.

Same day emergency care (SDEC) means shorter stays for patients and fewer unnecessary delays to leaving hospital. Current pressures often mean hospitals need to use their same day emergency care staff and space for other emergency care. We will spread best practice to ensure greater resilience ahead of next winter so that Leicester Hospitals provide appropriate SDEC seven days a week with a minimum opening of 12 hours per day, including for medical and surgical services as outlined in the 'SAMEDAY' strategy. Other SDEC services opening hours are designed to meet patient need.

We will work in partnership with our Primary Care Networks to design and deliver acute frailty services and SDEC, both of which will support reducing avoidable admissions and provide smoother care for patients, using the new frailty Commissioning for Quality and Innovation (CQUIN) incentive to support delivery of frailty services and link funding to quality improvement.

Paediatric early warning systems provide a consistent way of recognising deterioration in a child's clinical status, enabling early intervention and referral to alternative services if needed. We will implement the standardised paediatric early warning system for our inpatient settings by June 2023, which will be expanded into A&E, community, ambulance and primary care services, to deliver a cross-system approach.

We will provide streamlined pathways for mental health patients who need to remain in acute settings until their care can be transferred, with particular reference to better working with children and young people's mental health services, working-age adults and older adults, including people with dementia.

This will be supported by access to 24/7 liaison mental health teams (or other age- appropriate equivalent for children and young people) that are resourced to be able to meet urgent and emergency mental health needs in both A&E and on the wards, within one hour and 24 hours respectively.

We will fully embed year-round, our system control centre (SCCs) ensuring that it is appropriately resourced with autonomous clinical decision making across the system. The SCC will enable us to work with local authorities and other partners to ensure capacity, including in care providers, is used effectively and that the NHS provides support where needed.

We will implement digital tools that support decision making in near real time, including an electronic bed management system. We will work with NHS England as they continue to develop and roll out the A&E Admissions Forecasting Tool.

2. Increase workforce size and flexibility

Ambition:
NHS staff have faced immense pressures in recent years during the pandemic, and recovery will impose new ones. The COVID pandemic showed the remarkable flexibility of our staff to step into new roles, but it has also led to fatigue. While leaver rates reduced at the height of the pandemic, we know there are critical staff shortages across LLR, with a combined NHS Provider vacancy rate of 12.1% (excluding primary care). GPs and nurses in Leicester City have also seen a declining trend. Staff shortages have been an increasing issue since Covid-19 and exacerbated by winter pressures, surge conditions and industrial action.

Staff in post are under enormous pressure and experiencing high stress levels, due to this situation - this is borne out by the latest Pulse Survey, whereby 21.7% of respondents reported feeling negative, due to a high workload, competing demands, and being overworked. The net result is a high turnover of staff and an increase in sickness/absence, due in part to low morale, burnout, and psychological issues.

LLR has a variety of initiatives in place to address some of the above issues:

LLR is an Exemplar for the NHS England Retention Programme and a short to medium term plan is in place to mitigate some of the above issues, this includes for example: promotion and expansion of non-pay benefits and cost of living support available, development of a retention metrics dashboard, supporting improved understanding of the workforce and monitor change and improvements.

LLR has a well-established Care Workstream, delivered by LLR Academy, which include national and regional health and wellbeing programmes.

The LLR Academy also delivers Quality Improvement programmes, including the development of an LLR-wide QI Network, and Inclusive Culture and Leadership programmes.

Delivering the ambitions in the plan will require not just an increase in workforce, but also a change in the way that people work and opportunities for people, including recently retired clinicians, to return to work. We know that the scaling of out of hospital care requires rapid expansion of the community workforce and the development of more flexible and integrated teams. Key priorities are transforming primary and community care pathways, to reduce emergency attendances, hospital admission, including training community nurse in urgent and emergency care. Within our primary care workforce strategy is a focus on integrated teams, wrapped around a population and ensuring the combined skills of an MDT approach across health and are, will ensure the person is seen by the right time, right intervention, in the right place and by the right person.

LLR has a well-established apprenticeship programme, which will be expanding into targeted parts of the system, to ensure we are developing a future workforce pipeline. We also host an excellent Work Experience Portal, which can be used by existing health and care staff, those wishing to start a career in the NHS or Social Care and employers and education organisations looking for placements or to recruit staff.

How we will deliver:
While all areas of the NHS workforce are under pressure, we know that there are specific areas of the UEC workforce which we need to expand. Key priorities include the following:

Development of 'One Workforce' – a sustainable, long term, system-wide, integrated solution (strategic priority), through partnership working and co-production-based on complete health and care pathways (e.g, Home First, Discharge). Charnwood Pilot: Heart Failure Collaborative Intermediate Care Model-streamlining hospital discharge to community and social care provision, with rapid assessment within 48 hours post-discharge, supporting the principle of Right care, Right time, Right Place- will be implemented post-pilot. Charnwood MDT training taken place to enhance the skills and wellbeing of the team, thereby supporting portfolio and career pathways, leading to improved retention of those staff)

- **Paramedics** – Paramedics /Trainee Paramedics have consistently grown since March 2022. Ongoing recruitment of Primary Care ARRS roles, including Paramedics, continue to ensure that projected paramedic workforce gaps are mitigated through undergraduate student intakes, apprenticeships, and a focused retention improvement plan, to be developed in partnership with East Midlands Ambulance Service (EMAS) as part of the current strategic planning approach.

  Longer term planning for workforce growth in this area will be achieved through collaborating with Health Education Institutions and medical schools to ensure our approach to multi-year education and training investment planning is aligned to the health population needs and sit as part of the future workforce requirements.

- **Advanced practice** – we will continue to increase the numbers of advanced practitioners in priority areas including in emergency care. Advanced practice enables clinicians to take on expanded roles, supports the standardisation of same day emergency care and helps make the most effective use of multi-disciplinary teams.

- **Mental health** – we will continue to expand the mental health workforce within UEC and mental health services. Continued progress towards our local ambition of 75 peer support workers (further 20 planned in 23/24). Progression of peer support workers into further career roles has commenced and been encouraged (increasing reflection of local users).

We will continue to develop the workforce mix in community services, including physiotherapists, occupational therapists, speech and language therapists and dieticians to support people to participate in daily living. We will continue the development of advanced and consultant roles alongside the development of a strong and well-trained therapy and rehabilitation support and associate practitioner workforce.

As well as growing the workforce, we will support staff to work more flexibly. Flexible temporary workforce is an area of focus across LLR organisations, offering opportunities for retaining staff currently in post, flexing their skills across into areas of service need. We are well-skilled in doing this across LLR, with recent examples noted in the implementation of LLR Workforce Bureau, bank staff model, Care Homes Mutual Aid, facilitated by the LLR Workforce Sharing Agreement and development of the Digital Staff Passport.

For our work to scale virtual wards, we will work with NHS England to develop a national workforce recruitment capacity and capability plan. 7 out of 11 virtual wards have been mobilized (in addition to existing COVID & COPD VWs) with 100 beds open so far. This integrated workforce model is positively impacting the ability to discharge patients safely. These models have proven attractive to applicants and provided opportunities for advanced care practitioners.

Our 5-year workforce plan with a key component of Emergency Flow expansion - for example the staffing of 3 additional wards at Glenfield, over 2 years staffed through a mix of temporary and substantive workforce. Ongoing successful recruitment of international nurses-1100 recruited since 2017 and healthcare support workers. Additional workforce will be recruited to the Transit Hubs which will contribute to safe staffing over the ED floor as currently staff are redeployed to cover gaps in the transit hubs. Four separate hubs will be created at Glenfield and the LRI sites undertaking functions such as cohorting and discharge. The multi-organisational practices of discharge hubs are being enabled by innovative workforce practices to enable the sharing of staff across organisational boundaries.

Example: LLR Virtual wards

Workforce across a range of disciplines remains a significant challenge for the LLR system and this has had an impact to enhance the Virtual Wards Model.

Geriatrician capacity is limited and therefore alternative roles as GPs with special interest (GPwSI), consultant ACPs, and senior nurse roles have been implemented for the frailty Virtual Ward. 2 x Advanced care Practitioners have been recruited for the Frailty Virtual Ward and these models have been attractive to applicants and provided more opportunities for alternative role and skill mix within the team.

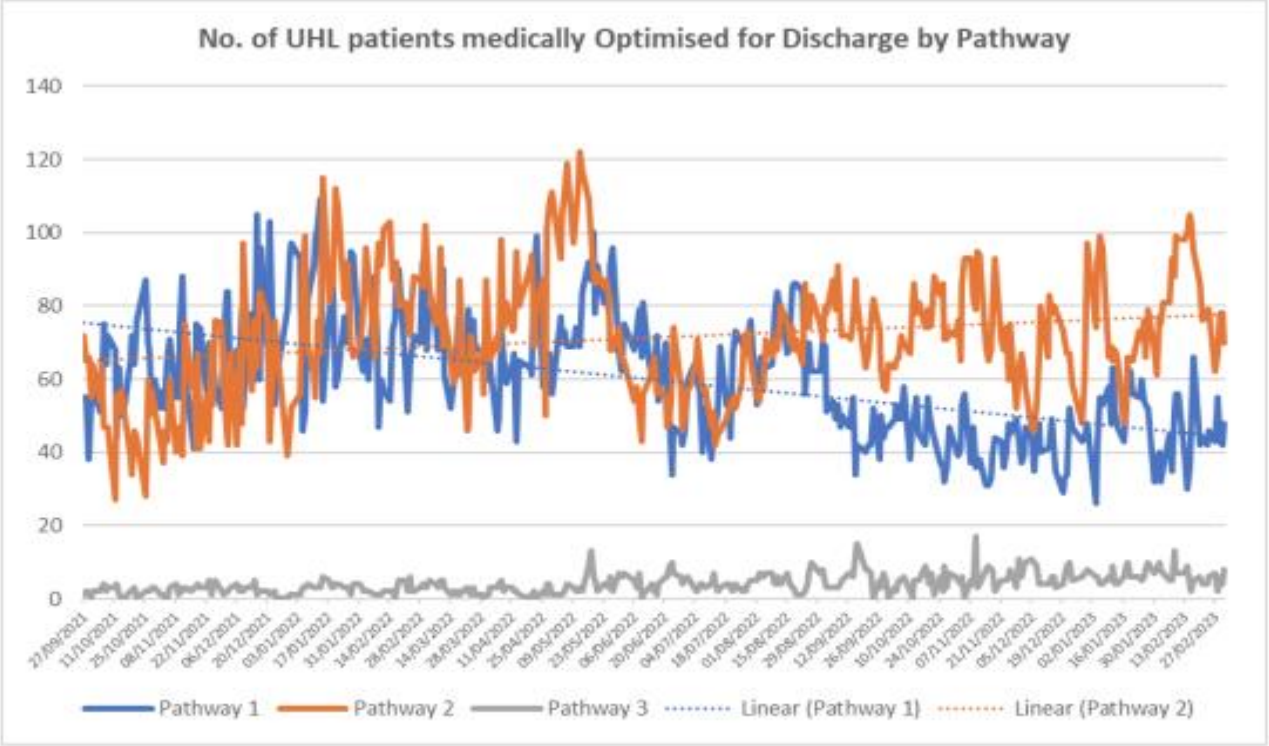
3. Improving discharge

Although having more hospital beds and more staff will help, it is also important to make sure patients are not in hospital for longer than necessary. We know that long stays in hospital are not good for patients or their independence and can lead to poorer health and economic outcomes.

Whilst discharge delays increased significantly over the pandemic, we have seen a significant and sustained improvement locally.

That said, there is much more to be done; we know both delays in discharge processes and shortages of capacity in social care and community care are making it more challenging to discharge patients from hospitals and mental health services. There are currently around 192 patients (including all UHL, LPT and out of area) patients remaining in hospital who no longer need to be there. On average, around 24% of patients with delayed discharges are awaiting the start of home-based care, 16% are awaiting residential or nursing home placements and 24% are waiting to begin intermediate care.

In order to deliver the 92% occupancy UHL has a bed gap of circa 350 beds. The bed bridge model closes the UHL gap by 248 beds by March 2025.



(Data taken from LLR Discharge Hub data Summery February 2023)

Current Discharge Status

	Total pts MOFD on S1	Patients with a planned discharge for today	Patients with a future plan	Patients awaiting an outcome
UHL	140	21	3	116
LPT	39	3	1	35
OOA	13	3	2	8
Total	**192**	**27**	**6**	**159**

(Data taken from S1 Sitrep 26.04.2023)

To improve discharge there must therefore be a sustainable increase in capacity in step-down services ('intermediate care') and social care, especially domiciliary care, and an improvement in discharge processes within hospitals and between hospitals, community services, local authorities and social care.

We will therefore improve discharge by:

A. improving joint discharge processes
B. scaling up intermediate care
C. scaling up social care services.

A. Improving joint discharge processes

Ambition:
As well as increasing capacity and improving the pathway within hospitals, we need to ensure that people are not in hospital unless they need to be and to improve the experience of patients when they leave hospital.

Discharge planning should begin when patients are admitted to hospital to ensure that people can get home or to a more appropriate setting as soon as possible, with services in place if needed.

We will work in collaboration with social care partners to ensure appropriate processes are in place to facilitate prompt discharge in NHS settings, including in community and mental health trusts. These processes should include early access to senior decision-makers to ensure patients get specialist advice sooner, removing avoidable delay.

We will work with our local government partners and the social care sector to ensure an integrated approach to building capacity, so that patients have rapid and reliable access to the joined-up health and care services they need when leaving hospital.

How we will deliver:

We will continue our implementation of the best practice interventions set out in the '100-day discharge challenge' across NHS settings. We have seen good progress so far, with the number of hospital process-related delays reducing by 25% since this approach was rolled out. This has now been extended to community and mental health settings.

The average daily P1-3 allocations for UHL, with detail of the discharges that did not occur:

	May	June	July	August	September	October	November	December	January	February	Trend
Average Number of discharge plans provided to UHL Mon to Fri	46	49	44	44	49	46	49	51	51	48	
Average Number of discharge plans provided to UHL Sat and Sun (Inc. Bank Holidays)	21	24	23	25	23	25	28	26	26	20	
Average Number of UHL patients with a same day plan becoming unwell	3	3	3	2	3	4	5	4	4	3	
Average Number of UHL patients experiencing a delayed discharge	8.5	11	11	10	13	11	11	12	8	6	

Systematic discharge planning between health and social care should start from the point of admission by identifying patients with complex discharge needs, setting an expected date of discharge, and working with families and carers to plan discharges. Everyone admitted to an inpatient bed should, on admission, have an estimated discharge date. Systems for discharge planning and delivery need to ensure timely transfers of care throughout the week, including evenings and weekend. IDT to work with UHL and LPT to reduce daily lost discharges.

Since COVID we have had a virtual discharge hub in place. We are now working towards implementing a 'care transfer' hub through an Integrated Discharge Team (IDT) to ensure that patients who do not need a hospital bed are discharged in a safe and timely way, either to their home or to a place in which long-term care decisions can best be made with rehabilitation and recovery support. The IDT will ensure:

- Clear plans for delivery, across all partner organisations, including agreed outcomes and data sharing arrangements.
- In reach support across Front Door wards
- A shared process to work with patients, their families and carers, and all professionals from admission, with all staff in the IDT sharing responsibility for delivering safe and timely discharge. The IDT will be focused on the most complex discharges and working to ensure that any assessments for long-term care are not completed in an acute setting.
- Strong and shared leadership at all levels, with clear accountabilities and responsibilities. We know this works best where there is a clearly identified senior leader accountable for flow across all partner organisations.
- A multidisciplinary staff mix, including social workers, case managers and clinical staff co-located in the IDT, who are empowered to make autonomous and accountable decisions that are respected across all partner organisations.
- Real-time evidence and insight into capacity and demand management planning across the local health and social care system.

Right place, right time, right care: LLR Integrated Discharge Hub

LLR's integrated discharge hub delivers an integrated service across seven days with a commitment from health and social care partners to cover 8am to 8pm, seven days a week.

Plan

- Reintroduce IDT on site from March 2023
- Increase IDT ward and board round attendance
- Increase voluntary services presence on wards from April 2023
- Ward therapist to be trusted assessors for ASC reablement services – commenced March 2023
- Ward therapist to act as trusted assessors for patients requiring low level ASC support, reducing triage time -planned June 2023
- UHL Discharge Specialist Team to review patients face 2 face and recommend short term care on behalf of MLSCU reducing triage time/delays -planned June 2023
- Increase usage of reablement pathways to support appropriate reduction of maintenance packages of care
- Increase pathway awareness with discharge teams and wards staff to encourage timely discharge
- Regular development and education sessions for IDT staff
- IDT to focus and reduce number of lost discharges daily
- Supporting consistent utilisation of criteria led discharge

B. Scaling up intermediate care

Ambition:

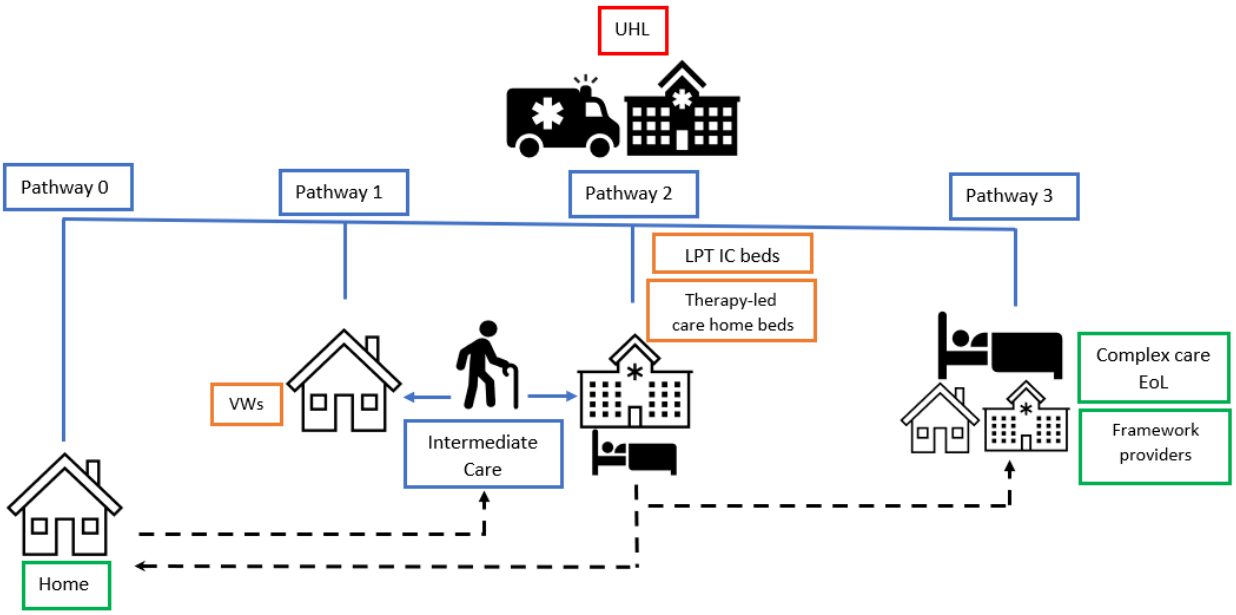
NHS England has begun a programme of work to develop and pilot a new approach to intermediate care, working with local authorities and voluntary and community partners. This expansion of 'step-down' care is designed to help people move from hospital into more appropriate settings for their needs, with the right wrap-around support for their rehab and reablement. This needs to be accompanied by growing the workforce, to ensure that we can deliver more care packages and good flow through community beds where required.

As an example, for people who need physiotherapy to regain their muscle strength, assessments of any longer-term care needs would take place after this initial recovery period and could take place in the person's own home.

Chapter 4 'Expanding care outside hospital' further details action to bolster 'step up' care (designed to help prevent hospital and emergency admissions) and 'step down' care (supporting timely and appropriate discharge).

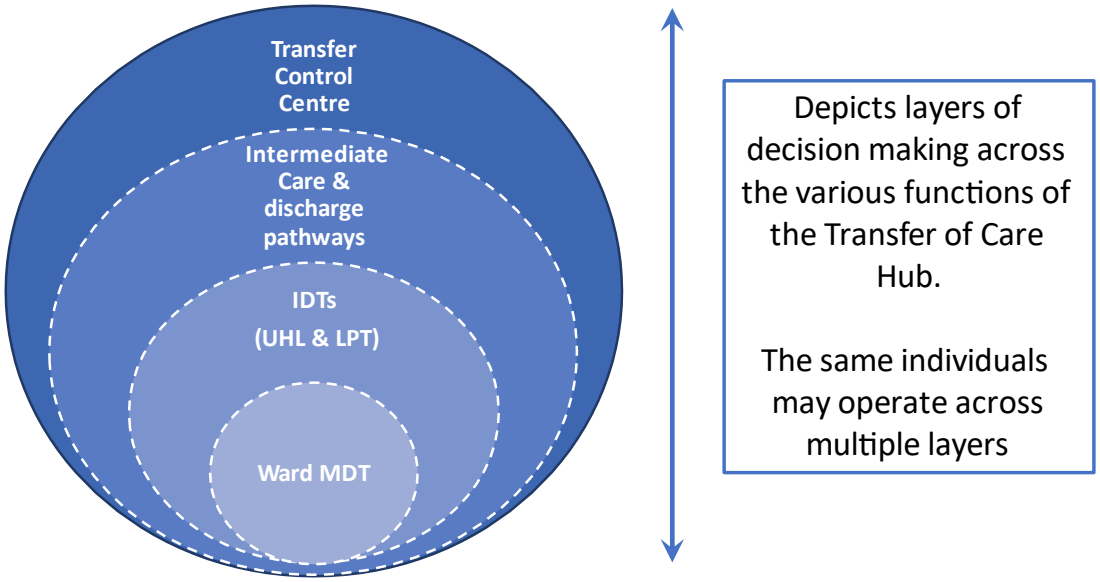
How we will deliver:

The LLR vision is to adopt a consistent Home First approach, underpinned by intermediate care, that ensures people are supported to remain independent, in their usual place of residence, for as long as possible.



The vision will be achieved through the establishment of a refreshed 'transfer of care' hub with four distinct functions:

1. Ward-based MDT: patient facing clinical decision-making; implement C-LD
2. Integrated Discharge team: focus on complex discharges – F2F reviews
3. IC and discharge pathways: ensure right care, right place, right time.
4. Transfer Control Centre: Discharge BI and operational coordination across the system



Development of this model will be coordinated through the Intermediate Care Delivery Group and will focus on the following:

1. Retain focus on reducing unwarranted variation in P0 discharges across 7 days.
2. Aspire to have no more that 20% of patients placed in spot-purchased residential P2 placements by November 2023.
3. Ensure consistent data collection of people discharged into long-term maintenance home care packages (P3) across LLR.
4. Revisit, with the support of Newton Europe, LLR demand and capacity modelling to right size P1 ensuring all patients discharged home are assessed for home-based intermediate care (intake model).
5. The LLR Intermediate Care Delivery Group undertake focused work for LPT beds to become the predominent destination for P2 discharges/transfers.
6. Continue to work with strategic workforce colleagues to facilitate recruitment of sufficient reablement and rehabilitation capacity in community settings.
7. Refocus MDT/IDT discharge support to LPT to mitigate risk of increased MOFD and ensure good flow.

8. LPT bed demand and capacity modelling to determine capacity required for a step-down intermediate care model. Once this model is in place, explore options for step-up.

C. Scaling up social care services

Ambition:
Alongside these improvements to discharge processes and intermediate care, local government, the NHS and the social care sector will work together to improve access to social care, with a particular focus on domiciliary care, supported by the Better Care Fund, additional social care funding and the government's reforms to adult social care.

How we will deliver:
At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to put the adult social care system on a stronger financial footing. This will support an increase in capacity and improve the quality of and access to care for many of the most vulnerable in society.

Locally, the funding includes:

- Adult Social Care Discharge funding of £2.26m for Leicester City Council, £2.48m for Leicestershire County Council and £0.03m for Rutland Council. This will increase the 'Better Care Fund' in 2023/24 to build additional adult social care and community-based reablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals.
- the new Adult Social Care Market Sustainability and Improvement Fund of £3.68m for Leicester City Council, £5.65m for Leicestershire County Council, and £0.32m for Rutland Council to make improvements to target areas of activity including
    - Increasing fee rates paid to adult social care providers in local areas
    - Increasing adult social care workforce capacity and retention
    - Reducing adult social care waiting times

The government is also allowing local authorities to increase the adult social care precept up to 2% per year in 2023/24 and 2024/25.

4. Expanding care outside hospital

The challenge of recovering urgent and emergency services also presents an opportunity. For decades we have known that many patients can receive better, safer, more convenient care outside hospital. We have seen in the pandemic the NHS's ability to design and expand new types of care and provide better care in people's homes. We know that backing those models that have been shown to work can give a better experience for patients and avoid unnecessary admissions and improve discharge. We will do this by:

A. expanding and better joining up new types of care outside hospital
B. expanding virtual wards.

A. Expanding and better joining up new types of care outside hospital

Ambition:

People's care needs can often be best met outside hospital. We know that up to 20% of emergency admissions are potentially avoidable with the right care in place. Care closer to, or at, home without the need for hospital admission is not only often more convenient for patients, but through timely access can help to avoid the deconditioning and prolonged recovery that can accompany a hospital stay.

Personalised care approaches such as supporting self-management, shared decision-making and one-off personal health budgets, alongside providing patients with the right information and support to make decisions, can enable them to manage their own care and avoid the need for hospital care for longer.

Community health services, including therapy services, help keep people well at home and in community settings close to home, and support people to live independently. When community services are delivered in combination with personalised care, they can reduce pressures on hospitals and emergency services by supporting patients at home and in the community, as well as provide them with greater choice and control, leading to improved patient experience and outcomes.

Falls are the number one single reason why older people are taking to the emergency department, and around 30% of people 65 and over will fall at least once a year.[ix] Care outside hospital is of particular importance for older people living with frailty, who are much more likely than younger people to be admitted to hospital, and likely to have a longer stay when they are admitted. Through better joint working and sharing of information between services we can help improve care for people who fall or are living with frailty.

Continued focus on mental health crisis prevention and a joined-up community response will ensure people are accessing the best service for their needs in a timely way, reducing avoidable admissions to hospital.

Making use of new technology and better collaboration, including between ambulance services and community care, will enable care that would often currently be delivered in a hospital to be delivered closer to people's homes. For example, the use of 'NHS @home' approaches can support people to recover, keep well and manage their health and wellbeing at home, and help reduce the need for hospital care due to supported condition management at home.

Adult social care plays a vital role in working with health services to provide the community support that prevents unnecessary admissions. Working in partnership with acute and community health services, the voluntary and community sector and care providers, our local authorities will continue to promote wellbeing and prevent unnecessary hospital admissions.

How we will deliver:
Many people can be best supported by a quick response from services in their community. Urgent community response (UCR) teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, people who urgently need care can get fast access to a range of health and social care professionals within two hours. Locally, these services are well embedded at place level, and regular exceed national standards.

Ahead of next winter, our aim will be to improve use of UCR including consistently meeting or exceeding reaching 80% of patients referred within two hours, with a service that operates for at least 12 hours a day in each of our three place footprints.

The population has aged and has increasingly complex conditions, and so we will make sure services are better joined up – with healthcare that works for patients.

We will immediately scale up falls and frailty services based on our learning from winter 2022/23, and help these services be better joined up with ambulances and existing UCR services so they can work together to provide a network of support for patients. Our UCR services will work in partnership with the Unscheduled Care Hub to implement a step up model into care and with the Integrated Discharge hub to provide speedy access to step down care – all designed to prevent or minimize stays in our acute bedded services where appropriate.

We will also roll out adult and paediatric Acute Respiratory Infection (ARI) Hubs to provide timely access to same day urgent assessment, preventing hospital attendance and ambulance conveyances through Winter 2023/24. Our ambition is that a longer-term community-based model of care is

established, integrated across primary, secondary and community care, and will be a key point of referral for, or to, virtual wards.

We will continue the transformation of community mental health services and build on the recent expansion of community-based crisis services to ensure that our patients have a range of open-access age-appropriate services which meet local population needs, alongside 24/7 Crisis Resolution and Home Treatment provision.

We will continue to roll out High Intensity User Services, adopt good practice in supporting patients who are experiencing homelessness or rough sleeping, and embedding family support workers in A&E settings to provide additional support to children and families presenting with non-urgent issues.

High frequency users of services can also be supported to tackle social and practical issues that affect their health and wellbeing through working with social prescribing link workers, who can link them to a range of community assets depending on their needs and preferences. This may include help to stay active, make social connections, and manage their health conditions.

Right place, right time, right care: Pre-transfer clinical discussion and assessment service
Our Pre-Transfer Clinical Discussion & Assessment service joins up hospital-based secondary care expertise and a dedicated GP-led assessment service, linked to the urgent community response pathway. This provides an integrated service that aims to keep people with frailty safe and well at home, avoid hospital admission if possible, and provide a seamless transition to secondary care if it becomes necessary.

Our EMAS crews are able to contact the PTCDA service whilst with the patient at their home, followed by a triage consultation with Consultant Geriatrician or GP input. The most suitable outcome for the patient is agreed, for example inclusion on a virtual ward for observation and monitoring and/or further face-to-face assessment by a consultant or community advanced clinical practitioners.

So far, this has led to an 80% reduction in ambulances conveying frail patients to ED (from care homes in particular) and gives frail older adults an alternative to hospital admission. Where necessary, patients are then stepped up into further care as required, care plans and ReSPECT plans are updated and shared with carers and /or family and the patient's GP is informed of any changes.

B. Expand virtual wards

Ambition:

One example of better, more convenient care for patients is hospital care at home through 'virtual wards', which are bridging the gap between hospitals and patients' homes. Virtual wards combine technology and face-to-face provision to allow hospital-level care including diagnostics and treatment, using many of the same staff that work in hospitals. In some cases, virtual wards can replace the need for admission, and in others facilitate people being able to safely leave hospital sooner.

Virtual wards enable patients to remain in their own home supported by family or carers to recover more quickly in a more comfortable environment. The evidence base for virtual wards is growing, with clinical evidence to show that virtual wards are a safe and efficient alternative to NHS bedded care, particularly for patients living with frailty.

Our ambition is to scale up capacity ahead of next winter to 236 virtual ward beds with a longer-term ambition of reaching 40-50 virtual wards per 100,000 people. As well as continuing to increase capacity, we need to increase utilisation of virtual wards to 80% by September 23 so we make more of the capacity we already have.

How we will deliver:
Through winter 2022/23, we have rolled out 8 virtual ward pathways with 110 beds through investment in community provision for conditions including respiratory conditions, palliative and EoL and heart failure.

We will have 11 virtual wards by July 2023 and will aim to increase utilisation to 80% by September 23 across a broader range of conditions, with less variation and so more people can receive high-quality care from their own home.

We will increase utilisation of virtual wards from around 50% to 80% by September 2023. We will work with our local clinical and operational teams to ensure standardisation across their area to enable referrals, build patient engagement and benefit from economies of scale.

Implementation of a centralised hub to monitor and support patients to capture deterioration and offer treatment at its earliest point.

- Manage patients virtually who may otherwise need to be seen in ED
- Reduce unplanned admissions by detecting and dealing with deterioration early in disease trajectory
- Reduce length of stay on planned acute admissions, increasing throughput through both virtual and physical virtual wards.
- Reduce 90-day readmission rate by proactively monitoring for early decline
- Streamline patients into Virtual Wards for further diagnosis/treatment ensuring high utilisation of virtual wards expected from NHSE

Build on the Level 3 component (proactive care) to ensure maximum utilisation of Level 4 (Virtual wards)

This would include:

- Proactive monitoring for at risk admission groups
- Home First + model
- Tech Enhanced Living Service (e.g., in care homes)

We will support systems to build on the expansion of Home Treatment teams for people with acute health needs, with a focus on the quality of provision and therapeutic offer, underpinned by technology and data to better manage and plan care to avoid deterioration and unnecessary hospital admission.

5. Making it easier to access the right care

Ambition:
We need to ensure that the urgent and emergency care system is responsive to the needs of patients, and so people receive the right care in the right place, and in a timely way. NHS 111 is crucial to this, and we know that it can reduce demand on emergency care and be convenient for patients, especially with clinical input and oversight. But we also know that the percentage of 111 calls abandoned increased significantly during winter 2022/23 as pressures grew, and so we will need to provide more resilience to improve access for patients and reduce demand on UEC services.

Over the past ten years we have seen increased need for UEC services across all age groups and have heard in our engagement with patients that UEC services are complex to navigate.

We will make it easier for patients to access the care they need without feeling they have to go to A&E or call 999 and help make 111 online and calling 111 the first port of call so that patients can easily access the appropriate advice and be directed to the most effective care. The Fuller Stocktake recommendations, and the widespread commitment to them, provides an opportunity for services to integrate closely with all parts of primary care, so that people get the care they need, regardless of how they contact services.

Many patients will need clinical advice, and we know that can make a difference to patients, and so we are looking to better use clinicians in 111 for the patients who will benefit most. New technologies should help people to get clinical advice and be directed to the most effective care. Clinical advice to NHS 111 underpins our plan to assess and direct patients to the most appropriate point of care,

whether that be self-care, pharmacy, general practice, advice from a paediatrician, mental health crisis centre, an urgent treatment centre, or another setting.

How we will deliver:
Over the pandemic we have seen the advantages of 111 online and we will further expand it through its continued promotion and development. It will be further connected with other services to mean patients are better directed to the right place. We will work to integrate 111 online with the NHS App.

We know from our engagement the importance of 111 to families. We will expand advice offered through NHS.UK and NHS 111 online to provide dedicated paediatric advice and guidance for families to support decision making around care options.

We will roll out paediatric clinical assessment services to ensure specialist input for children and young people is embedded within 111.

NHS England will undertake an extensive review of 111 services, including intensive trials of '111 First' following lessons learnt in the 2019 pilot. It will test the models and their effectiveness at directing patients to the clinicians and services who can best meet their needs with the minimum possible delay. This review will be aligned with priorities for primary care, including for community pharmacy, the forthcoming GP access recovery plan and implementation of the Fuller Stocktake report. The review will also explore the potential to incorporate advancements in technology, including AI and machine learning, within 111 services and we will work with NHS England to tailor these for our local populations.

NHS England will work with ICBs to increase 111 clinical input where it will have most impact, including to confirm which care setting is best for the patient – providing better care for patients and reducing demand on emergency services. We will ensure the clinical assessment of a greater proportion of NHS 111 Category 3 or 4 ambulance dispositions by April 2024.

Right place, right time, right care: The LLR Unscheduled care hub

The LLR system has established a system-wide Clinical Assessment Service (CAS) to remotely assess EMAS and 111 calls.

The CAS is staffed by experienced clinicians including clinicians with experience in General Practice, Integrated Urgent Care, Paediatrics, Mental Health and Emergency Medicine who are able provide the most appropriate response and where necessary direct the patient to the best care for them.

As a result, they've seen real positive outcomes on patient care, including 94% of patients who would have received a Category 3/4 ambulance response being clinically assessed as able to have their care needs met elsewhere in the community. Both patients and clinicians feel its benefits, with 93% of patients extremely likely or likely to recommend to friends and family, and 97% of clinicians would recommend working within the CAS due to the multi-disciplinary approach, the ability to learn from others as well as welcoming more hybrid roles.

We will do more to support people to access mental health support. Urgent mental health support will be universally accessible by using NHS 111 and selecting 'option 2' by April 2024. We will continue with our plans to sustain and enhance our 24/7 CCAP service, providing open access, freephone urgent mental health support for all ages, accessible using NHS 111. This will be further supplemented by future provision of 24/7 crisis text lines, which we will integrate into our local open access crisis pathways. We plan to introduce a local Mental Health Response Vehicle service by January 2024, which will work closely with EMAS to reduce inappropriate conveyance to ED.

The Directory of Services enables referrals into the most appropriate urgent care service from 111 and 999, supporting better management of patients. A platform rebuild will make it easier for staff in the NHS to direct people to the appropriate services and supports faster innovation of new services.

Some patients that come to emergency departments would get better, quicker care if they are navigated to an Urgent Treatment Centre. Locally, our clinicians have designed and implemented a consistent approach for patients who walk into the Emergency Department, which supports our patients to be seen in the most appropriate setting. Approximately 60 patients a day are being streamed to a booked appointment at a local UTC, with non-urgent patients also booked into out of hours or next-day services where appropriate. We will grow this offer through 23/24. Patients requiring minor injury or minor illness treatment will also have the option to go through to the MIaMI (Minor Illness and Minor Injury) unit for treatment, which supports our on-site UTC provision.

Right place, right time, right care: Streaming into community-based services

Streaming non-urgent patients from LRI ED to a booked appointment has been established as BAU from November 2022 at an average of 804/month from December 2022 to March 2023 with a trajectory to extend as additional sites mobilise. The profiling for introduction on a phased plan is detailed below.

Total Capacity for ED re-direction / increased acuity at Oadby	UHL/111 avg capacity (Nov 22 - Mar 23)	UHL avg capacity (Apr 23 - Jun 23)	UHL avg capacity (Jul 23 - Sep 23)	UHL/111 avg capacity (Oct 23 - Mar 24)	Un-utilised daily capacity 22/23 (yr avg)	CPCS enabled - GP referrals to CPCS (yr avg)
Oadby UTC	59	24	24	83		
Merlyn Vaz UTC	n/a	0	6	11	11	0
Merlyn Vaz OoH	9	12 (Jun 2023)	12	20	18	2
City Hub Westcotes	n/a	15	15	40	22	18
City Hub Saffron	n/a	n/a	Discussion required	10	4	6
City Hub Belgrave	n/a	n/a	Discussion required	14	7	7
TOTALS	**68**	**51** (was 77)	**57** (was 119)	**178**	**62**	**33**

- UCC and Extended Access Hub services will receive booked appointments from NHS111, UHL LRI ED Front Door or GP practice clinical triage recorded in the medical record.
- Capacity can be flexed across the wider system to minimise the number of unused appointments daily.
- Noting that streaming involves more than one contact point, it does support patient education on choice at their next time of need.

We will improve streaming from ED, urgent care services and NHS111 into Community Pharmacy services:

- CPCS baseline participation – 217/229 LLR community pharmacies
- CPCS activity baseline - 14,961 (LLR 2022/23)
  - 9,479 (Leicester City)
  - 5,482 (County & Rutland)
- CPCS trajectory – activity growth of 1% by March 2024

6. Delivering this plan

We will deliver this plan by putting in place the fundamentals that are essential to successful local delivery: a clinically led plan, accountability at every level, genuine transparency, on- the-ground support, and mechanisms to spread good practice and innovation.

A. Accountability at all levels

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Delivery of the UEC recovery plan will reflect the new NHS operating framework, with alignment through the national, regional and local level, including DHSC and local authorities to ensure full involvement of social care. The LLR Integrated care board will be accountable for delivery across health, able to draw together different partners and provide a cross-system view of the interventions required for delivery.

The LLR ICB will be accountable for the relevant metrics outlined in the Operational Plan, through the services that we commission, recognising links to all parts of the system that have an impact on UEC.

Through each place-based governance structure, the LLR ICB and our local authorities will work with our provider partners to undertake systematic capacity and demand planning, with the aim of understanding the expected levels of need for social care and intermediate care services across LLR and develop shared plans to meet this need.

Local delivery

The delivery of this plan will sit with the LLR UEC Partnership and Richard Mitchell, Chief Executive of Leicester Hospitals will be the Senior Responsible Officer. The executive lead for this plan is Rachna Vyas, Chief Operating Officer of the LLR ICB.

The partnership will delivery all facets of value associated with this plan – performance improvements, equity, quality, financial improvements and resource utilization and partnerships. Advice / actions from colleagues from across the health and care system will be sought as needed.

Delivery of local plans will be also monitored by regional and national teams, providing oversight, support and intervention as appropriate to ensure delivery of the plans.

Appendix A contains the UEC Partnership Terms of Reference.

Appendix B contains the activity planning and budgets schedule.

B. Transparency

Transparent, high-quality data are important for improvement, providing insight across the whole journey but also identifying unwarranted variation.

To ensure greater transparency, more data will be made available to the public. This will be published by the LLR Integrated Care Board area by April 2023, and new metrics to monitor the effectiveness of discharge will be put in place. We will publish data on 12-hour delays from time of arrival in A&E from April, to support prioritisation of long waits as part of delivery. The public will be able to more easily see and compare the performance of their local services.

We will use data to help manage periods of high demand and increased pressure across systems and enable urgent system action. 'Faster data flows' will bring together data in a way that will reduce burdens on providers, and allow a more granular understanding of patient flow to support improvement.

C. Tiered intervention

Through national and regional teams, we will continue to work with NHS England to support and challenge ourselves to deliver this plan.

Building on experience from elective recovery and improvement in ambulance handovers, NHS England is developing three tiers of intervention, to be in place by April 2023:

- **Tier one: intensive support** – for systems off-target on delivery, support including on-the-ground planning, analytical and delivery capacity, "buddying" with leading systems and executive leadership.
- **Tier two: light touch** – for systems largely on-track, support including regional reviews and deep-dives to diagnose challenges and drive improvement.
- **Tier three: core offer** – universal support offer for systems on track, including specialty guidance, peer review and sharing of best practice.

The LLR ICB has been confirmed as Tier Three. We will work with NHS England through this approach; as with existing tiering arrangements these tiers will be reviewed frequently, and tiers will be publicly available information.

D. Reducing unwarranted variation

We will continue to embed a complementary, clinically and professionally led programme to reduce unwarranted variation. This programme will increase standardisation of what works across different areas of urgent and emergency care.

This programme will be supported by a stronger approach to improvement collaborative development. Building on the approaches of the Acute Winter Collaborative and Discharge “100 Day Challenge”, subject-specific improvement collaboratives will be established to co-develop across systems and share emerging good practice, drawing on teams of experts.

E. Supporting innovation

We know that evidence is needed where innovative care is being developed. Through the national collaborative, we will work with regional and national teams to showcase where an approach is being trialed and work together to understand the benefits of scaling for spread and adoption.

Early priority areas for further exploration include models of remote clinical assessment including rehabilitation expertise, intermediate care models and virtual wards.

Vaccinations and Immunisations

Autumn / winter 2023/24 vaccination campaign: Eligible cohorts

The Joint Committee for Vaccination and Immunisation (JCVI) has agreed the 2023 seasonal vaccination programme. The groups to be offered vaccinations are:

Cohort	COVID Booster	Flu
Residents in older adult care homes & their staff	Yes	Yes
Adults aged 65 years & over (note: all those that turn 65 by 31 March 2024 are eligible for both COVID & flu vax)	Yes	Yes
6 months to 64 years in clinical at risk group i.e. asthma, serious mental illness, epilepsy, learning disability, etc	Yes	Yes
Frontline health and social care workers	Yes	Yes
Household contacts of immunosuppressed patients (contacts aged 12 to 64 years)	Yes	Yes
Carers aged 16 to 64 years (registered / unregistered)	Yes	Yes
Pregnant women	Yes	Yes
2 and 3-year-olds (turn 3 years by 31/08/23)	No	Yes
Children and young people (reception to year 11)	No	Yes
Working aged adults in long-stay residential care homes and their staff	Yes	Yes

Campaign timing

To maximise and extend protection during the winter and through the period of greatest risk in December 2023 and early January 2024, health systems will follow a campaign timeline:

Flu

2 and 3-year-olds, school age children (reception to age 11) and children in clinical risk groups to start from 1st September 2023

Ideally delivery will be completed by 15th December, however some groups i.e. pregnant women, will continue to be offered a vaccination up to the end of March 2024.

COVID-19 & flu

- Start date 2nd October – Care Homes for flu and COVID-19
- Start date 7th October – all cohorts for flu and COVID-19

- National booking system will open for the public from 2nd October for appointments from 7th October 2023
- End date 15th December, although some inequalities work will continue to end January 2024. Short 10-week campaign
- Care homes a priority – aiming to complete visits to all within first 4 weeks of campaign.

Vaccination campaign

The Vaccination campaign for 2023/24 in Leicester, Leicestershire and Rutland (LLR) will comprise:

- Encouraging greater co-administration of COVID-19 and flu
- Tackling health inequalities and areas of low uptake as a priority, using a variety of initiatives i.e. mobile vaccination units, super vaccinators, supporting events/activities i.e. Steady Steps (activity programme)
- Delivering plans that are informed by needs of local communities and co-developed with local partners, i.e. local authorities, community, voluntary and social enterprises

Not all GPs will be offering COVID-19 and flu vaccinations, however, additional community pharmacies are being recruited via an 'expression of interest' process, to ensure there is sufficient coverage across LLR. Gaps in provision will be covered by mobile vaccination units/teams.

We currently await confirmation of vaccine types for autumn/winter 2023/24.

New model for vaccine supply will automatically replenish provider's vaccine stock on a 3-day cycle.

Tackling health inequality

To tackle health inequality, we will implement:

- Roving health care unit available for:
    - out-reach, hyper local vaccination opportunities and health care inequality Making Every Contact Count (ECC) initiatives.
    - additional health and care capacity i.e. unit located in surgery car park or as close as possible to a surgery.
- Assistance with promoting additional and out-reach clinics, including:
    - texting patients, via NHS and partners networks.
    - promoting health and care opportunities via social media i.e. Facebook, etc.
    - telephoning eligible patients and booking them directly into clinics.
    - additional vaccinating staff to assist with capacity.

Improving MMR (measles, mumps and rubella) uptake to eliminate measles

Measles is a highly contagious disease caused by a virus. It spreads easily when an infected person breathes, coughs or sneezes. It can cause severe disease, complications and even death.

Measles can affect anyone but is most common in children. Being vaccinated is the best way to prevent getting sick with measles or spreading it to other people. The vaccine is safe and helps the body fight off the virus.

We are working to improve MMR uptake by:

- Working with primary care to promote a global offer for MMR across LLR
- Promoting a vaccination offer to be targeted to communities and vulnerable population groups, known for low vaccination uptake.
- Working with stakeholders to scale up accessible, convenient offers i.e. promoting to university students and delivering offer on campus.
- Promoting to local families to promote the 'check and confirm' vaccination status of their children.
- Working with VCSE organisations to advocate the importance of vaccination/immunisation and codesigning accessible delivery channels, i.e. dedicated vaccination clinic offered within alternative community setting.
- Frontline health and care staff encouraged to check and confirm vaccination status with mop-up clinics to be offered via occupational health teams.

Agenda Item 9

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE
1 NOVEMBER 2023

OUTCOME OF CONSULTATION ON THE LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT LIVING WELL WITH DEMENTIA STRATEGY 2024-28

JOINT REPORT OF THE DIRECTORS OF ADULTS AND COMMUNITIES AND PUBLIC HEALTH

Purpose of the report

1. The purpose of this report is to present the outcome of the consultation on the draft Leicester, Leicestershire and Rutland (LLR) Joint Living Well with Dementia Strategy 2024-28 following a formal consultation exercise. The draft Strategy is attached as Appendix A.

2. The Committee is invited to make comments prior to presenting the outcome of the consultation and seeking approval of the final LLR Joint Living Well with Dementia Strategy and delivery plan for Leicestershire to the Cabinet on 24 November 2023.

Policy Framework and Previous Decisions

3. The relevant policy framework includes:

   a) National legislation and guidance:
   - The Care Act 2014;
   - The White Paper - People at the Heart of Care: adult social care reform - December 2021;
   - The Mental Capacity Act 2005;
   - The NHS Long Term Plan 2019;
   - The Challenge on Dementia 2020.

   b) County Council policies/strategies:
   - Leicestershire County Council Strategic Plan 2022-2026: the Dementia Strategy has relevance to all five outcomes of the Strategic Plan, but contributes particularly to the 'Keeping People Safe' outcome.
   - Adults and Communities Department Ambitions and Strategy for 2020–2024: the Dementia Strategy demonstrates how the Council will promote wellbeing for people with dementia, and prevent, reduce, delay and meet need for formal adult social care.
   - Leicestershire Joint Health and Wellbeing Strategy 2022-2032, which states that the partners will provide joined up services that support people and carers to live independently for as long as possible, including those with dementia.

- Medium Term Financial Strategy (MTFS), which sets the financial context for delivery of the Dementia Strategy in Leicestershire.

4. The Adults and Communities Overview and Scrutiny Committee considered a report on the draft Strategy and proposed consultation at its meeting on 5 June 2023. Comments were received from members, including recommendations that accommodation for people living with dementia should be featured in the Strategy. This has now been added into the draft Strategy. Other comments received suggested that more focus should be given to dementia diagnosis rates and the disparity between City and County. It was confirmed that this issue would be picked up through the place-based strategy delivery plans.

5. On 23 June 2023 the Cabinet approved a formal 10 week consultation exercise.

Background

6. The third LLR Living Well with Dementia Strategy which, following public consultation and approval will cover the period 2024-2028, is underpinned by the guiding principles from the NHS Well Pathway for Dementia.

7. The current Strategy running from 2019-2022 was approved by the Cabinet on 16 October 2018. Due to the unprecedented circumstances caused by the pandemic, the joint LLR Dementia Programme Board decided to extend the existing Strategy by an additional year to 2023.

8. The previous Strategy generated a number of LLR wide actions, most of which have progressed, and others which are proposed to continue into the next Strategy.

9. Achievements of the current Strategy include:

- Continuation of a strong partnership approach through the LLR Dementia Programme Board with LLR councils, the ICB, Leicestershire Partnership NHS Trust (LPT), University Hospitals of Leicester (UHL), the voluntary sector and other allied professionals.
- Dementia risk factors are part of primary care health checks.
- Primary Care practices are using a tool to assist them develop dementia-friendly GP practices.
- A Joint Strategic Needs Assessment (JSNA) chapter on dementia has been completed which informs the new Strategy.
- Information and advice supporting people living with dementia has been promoted across the area, particularly through the Dementia Support Service (DSS) and the LLR Dementia Friendly Guide.
- There has been successful procurement and operation of the advice and guidance Dementia Support Service in Leicester and Leicestershire provided by Age UK LeicesterShire and Rutland.
- A small group of people with lived experience supported the procurement of the Dementia Support Service and the drafting of the new Strategy and have become members of the Dementia Programme Board.
- The local dementia-friendly community network continues to support dementia awareness and is linked closely with the Dementia Programme Board.
- Living well activity and awareness raising has been prioritised in most of the neighbourhood plans for LLR.

- A small team of Admiral Nurses (specialist dementia nurses) worked within UHL to provide inpatient expertise to staff and patients living with dementia as well as a meaningful activities team.
- The County Council's Positive Behaviour Support team has begun a new approach to supporting care providers concentrating on managers and employers to develop best practice in supporting people who present challenges through developing policy, support tools, training and culture change.
- Additional expectations were added to the new Home Care for Leicestershire contracts to improve and monitor the quality of care for people with dementia.

10. Areas of activity which have proven challenging are:

- Diagnosis rates have reduced substantially as a result of services closing due to the pandemic. There is also a disparity in the diagnosis rates in the County compared to the City. Currently the diagnosis rates for the LLR area are; West Leicestershire 59.1%, East Leicestershire and Rutland 58.7% and Leicester 74.7% against a national target of 66.7%. This disparity is thought to be partly as a result of the diagnosis clinics being run exclusively at Glenfield Hospital in the Leicester conurbation, and therefore difficult for people living in less accessible or rural areas of the County to reach. In response, LPT has committed to running diagnosis clinics in County locations as opposed to solely at the Memory Assessment Service in Leicester. There is a focus on "seldom heard" groups in the revised Strategy and this will include rural communities in Leicestershire.
- Admissions avoidance, admissions and discharge pathways and post-discharge support for people with complex dementia remain a priority.
- Ensuring people and professionals have access to the tools they need to be confident and competent to live with or care for someone with dementia remains a priority.
- Activity that supports people to remain independent, requires further improvement with communities and in neighbourhoods.

The revised Strategy for 2024-2028

11. The revised draft Strategy, attached as Appendix A to this report, has been developed by a subgroup of the Dementia Programme Board which comprises the County Council, Leicester City Council, and Rutland County Council, the ICB and voluntary sector organisations.

12. From November 2022, the co-production group of the Dementia Support Service provided insight into the action points as well as offered advice on the content and layout of the Strategy from the perspective of having dementia or caring for someone with dementia.

13. Healthwatch LLR surveyed over 250 people living with dementia across LLR that attended social groups or completed a written survey. The feedback, which has informed the Strategy and which will shape the delivery plans of the partner organisations can be summarised as:

- There are inconsistencies across LLR with variations in the speed and types of diagnostic pathways.
- Despite multiple channels of information, there are inconsistencies in people's experiences of access to, and appropriateness of it.

- There is an inconsistent provision of, and access to support services with many different barriers to be addressed.
- People living with dementia and their carers who had access to services provided by Admiral Nurses, Age UK, Voluntary Action South Leicestershire (VASL) and the Alzheimer's Society highly value the support and information they receive.
- There is poor recognition of the needs of those with early onset dementia.
- There were suggestions supporting the need for a single point of access, such as a hub, to improve information and access to services.

14. A younger onset dementia event in November 2022 included a facilitated focus group engagement activity with 19 people under the age of 65 living with dementia.

15. The Council's Engagement Panel was informed of the Strategy and officers will report back periodically to update through the consultation period.

16. In addition to this engagement, local and national intelligence was used including:

- The JSNA for Dementia 2018-2021.
- Feedback from surveys and interviews with officers, providers and people using day services on the impact of the COVID-19 pandemic and carer needs.
- Contract and commissioning meetings with the Dementia Support Service provided by Age UK on current needs and issues facing people receiving their service.
- Feedback from members of the LLR Dementia Programme Board who either commission or provide dementia specific support.
- Feedback from other voluntary organisations supporting people living with dementia particularly around access to support from diverse communities.

17. The revised Strategy is intended to be implemented from January 2024 (subject to the Cabinet's approval and similar governance processes in Leicester City and Rutland Councils). It is proposed that this Strategy is set for a period of five years. There is scope through the Dementia Programme Board to measure the Strategy's actions against any new and emerging health and social care national policy and amend local delivery plans if required. Any substantive changes to the Strategy would be subject to Cabinet approval.

18. The Strategy will be presented as pages on each of the three Councils' websites or as a link from each of the three Councils' websites to one host website, and therefore design and formatting are minimal at this stage.

Consultation

19. Consultation on the draft Strategy took place between 17 July 2023 to 22 September 2023 hosted by Leicester City Council, on behalf of LLR partners, on their Citizens Space web portal.

20. The consultation was accessible online with printed copies available on request. Dementia focused community groups were also able to request attendance from LLR commissioners to present the draft strategy and consultation questions to facilitate group responses from people living with dementia and their carers.

21. Partners promoted the Strategy amongst their networks such as care support provider networks, Dementia Programme Board, social media avenues, Your Leicester publication and available resources beyond what was initially planned such as display screens at GP surgeries. People were able to call a listed phone number or email with any queries. Paper copies of the consultation were also made available upon request. The County Council's communications service designed a press release which was featured across print media, including the Leicester Mercury.

22. Direct engagement was undertaken with community groups across LLR, featuring focus groups with 'Jamila's Legacy', Age UK LeicesterShire and Rutland, Alzheimer's Society and the Carers Centre. Commissioners proactively reached out to Voluntary Community and Social Enterprise (VCSE) sector organisations offering to attend their sessions to talk about the Strategy consultation. The Leicestershire Equalities Challenge Group were also consulted as part of the consultation.

23. In total there were 319 unique online responses across LLR. Of these, 206 were specific to Leicestershire, 91 specific to Leicester and 61 specific to Rutland, with some consultees providing responses covering the whole of LLR. Leicestershire responses show an expected split between the district and boroughs of the County, with Harborough being the area with the most responses and Melton the lowest. Harborough has a very active dementia support group and is usually a district that provides consultation responses related to dementia matters. An LLR wide consultation report will be produced, but the attached report (Appendix B) focuses on the 206 responses that were specific to Leicestershire.

24. Overall, responses to the consultation indicated that there is broad agreement with the aims identified through the Well Pathway for Dementia (Preventing Well, Diagnosing Well, Supporting Well, Living Well and Dying Well) with the majority of respondents agreeing that the actions listed in the Strategy are beneficial.

25. Concerns were raised in relation to the first two questions asked in the consultation, namely, "Do you think that the health and social care services that support people living with dementia work well together?" and "Do you think staff are confident and competent to support people with dementia?" The responses for these questions demonstrate that respondents perceive that there is a lack of join up between health and social care (64.3%) and that staff are not confident and/or competent to support people with dementia (40%). Comments were made detailing lack of consistency in staff, removal of Admiral Nurse provision and uncoordinated discharge planning between health and social care.

26. Some of the key themes that have emerged from the responses are as follows:

- Admiral Nurse provision in the county, which ceased earlier in 2023, leaves a significant gap (originally funded through Dementia UK and discontinued by Primary Care Networks when Voluntary, Community Social Enterprise (VCSE) funding was removed);
- Memory Assessment Service (provided by LPT) should refer all people to the Dementia Support Service (DSS) on diagnosis. This could lead to increased referrals into the DSS although this referral pathway should already be in place and the DSS provider (Age UK) have been requesting for the referral to be mandatory;

- More support is required to fill the gaps between people being diagnosed and developing eligible adult social care needs;
- Recognised standard of training for staff working with people living with dementia;
- More training required on co-morbidities (e.g. diabetes).

Resource Implications

27. There is no additional investment attached to this Strategy with a view to each organisation tailoring their associated budgets in accordance with the priorities in the Strategy.

28. The Director of Corporate Resources and Director of Law and Governance have been consulted on the content of this report.

Timetable for Decisions

29. A report will be presented to the County Council's Cabinet on 24 November 2023 to seek approval of the draft Strategy and Leicestershire County Council action plan.

30. Subject to respective governance processes across LLR partners for final approval of the Strategy, the intention is to launch the Strategy in January 2024.

Conclusions

31. The priority actions described in the document are high-level as they must cater to all of the organisations involved. Each statutory organisation will therefore have a delivery plan addressing its specific priorities against the Strategy action plan.

32. The Dementia Programme Board will monitor the progress of the action plans and will support organisations to set targets for each year, underpinned by their delivery plans. The Board expects organisations to work collaboratively to achieve the overarching Strategy actions. This includes working at a neighbourhood and place-based level and co-dependencies with other workstreams.

33. For adult social care the key actions are contained within the 'supporting well' section of the Strategy, and the 'living well' section is relevant to activity within Public Health and Adults and Communities more broadly. NHS commissioning and service provision, whilst also relevant to support, living with dementia and the end of life, has a responsibility for prevention and diagnosis.

34. In order to ensure that the priorities for the Council are delivered, a refreshed Dementia Strategy Delivery Group has commenced to develop the Council's Delivery Plan and collaborations required with NHS Trusts, ICB and the Health and Wellbeing Board.

35. Response rates to the consultation have demonstrated significant interest from a wide range of stakeholders and the comments received have provided valuable information for commissioners on areas of dementia support that can be improved.

36. Many of the comments received focus on issues within healthcare provision, namely the funding for Admiral Nurses and potential improvements to the Memory Assessment Service provided by LPT. There is also work to be undertaken on the

join up between health and social care provision and on the training provided to staff working with people with dementia and their carers.

Recommendation

37. The Committee is invited to comment on the draft Strategy and consultation findings prior to presenting the outcome of the consultation and seeking approval of the final LLR Joint Living Well with Dementia Strategy and delivery plan for Leicestershire to the Cabinet on 24 November 2023.

Background papers

LLR Living Well with Dementia Strategy 2019-2022
https://resources.leicestershire.gov.uk/sites/resource/files/field/pdf/2018/12/24/LLR-Living-Well-with-Dementia-Strategy-2019-2022.pdf

The Prime Minister's Challenge on Dementia 2020
https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

NHS Well Pathway for Dementia https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Joint Strategic Needs Assessment chapter for dementia https://www.lsr-online.org/uploads/dementia.pdf?v=1649162842

Leicestershire County Council Strategic Plan 2018-22 https://bit.ly/3Pe6nh5

Delivering Wellbeing and Opportunity in Leicestershire – Adults and Communities Department Ambitions and Strategy for 2020-24 https://bit.ly/3swoTaI

People at the Heart of Care: Adult Social Care Reform White Paper https://bit.ly/3w7FfsE

NHS Long Term Plan https://www.longtermplan.nhs.uk/

Leicestershire Joint Health and Wellbeing Strategy 2022-2032
https://politics.leics.gov.uk/documents/s166738/Appendix%20A%20JHWS.pdf

Leicestershire County Council Medium Term Financial Strategy (MTFS)

Report to Adults and Communities Overview and Scrutiny Committee: 5 June 2023 – Leicester, Leicestershire and Rutland Joint Living Well with Dementia Strategy 2024-28 – https://politics.leics.gov.uk/ieListDocuments.aspx?MId=7108

Report to the Cabinet: 23 June 2023 - Leicester, Leicestershire and Rutland Joint Living Well with Dementia Strategy 2024-28 - https://politics.leics.gov.uk/ieListDocuments.aspx?MId=7077

Circulation under the Local Issues Alert Procedure

38. A copy of this report will be circulated to all members of the County Council.

Equality Implications

39. As this is an LLR Strategy the Equality Impact Assessment for the whole draft Strategy has been developed jointly with key Council and ICB colleagues and led by Leicester City Council, and therefore used the City Council template. However, to ensure alignment with County Council processes the information has also been transposed onto the Council's template and where required to reflect Leicestershire's demographic information has been added, and attached to this report as Appendix C.

Human Rights Implications

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

Appendices

Appendix A Draft Living Well with Dementia Strategy 2024-28
Appendix B Summary report of Leicestershire Responses
Appendix C Equality Impact Assessment for Leicestershire

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APPENDIX A

Leicester, Leicestershire and Rutland Joint Living Well with Dementia Strategy 2024-2028

APPENDIX A

Section 1: Introduction

Supporting and helping those living with dementia and their carers remains a priority for Leicester, Leicestershire and Rutland's (LLR) health and social care organisations. Our strategy sets out Leicester, Leicestershire and Rutland's ambition to support people to live well with dementia. It continues to reflect the national strategic direction outlined in the latest Prime Minister's Challenge on Dementia which details ambitious reforms to be achieved by 2020. The NHS Pathway for Dementia guides the priorities within the strategy; however we are conscious of the Long Term Conditions strategy being published in the near future and will take this into account. The strategy is written for people affected by dementia either directly or as a carer and for the professionals who work to support them.

Leicester, Leicestershire and Rutland's Living Well with Dementia Strategy was developed in 2019 and has since been refreshed to reflect our priorities for 2024-2028. The strategy has been developed in partnership between local health, social care and voluntary sector organisations and informed by people with lived experience of dementia.

An important focus of our strategy is to continue to deliver personalised and integrated care. We have used the NHS England Well Pathway for Dementia to give us a framework that puts the individual and their carer at the centre of service development and implementation across health and social care. We acknowledge that by collaborating in this way, efficiencies across the wider health and social care system will also be realised.

As a partnership, we are committed to minimising the impact of dementia whilst continually improving dementia care and support within the communities of Leicester, Leicestershire and Rutland, not only for the person with dementia but also for the individuals who care for someone with dementia whether it is family members or professional carers. We will continue to actively encourage a person centred and strength-based approach. We also aim to improve access to diagnosis and support services for all patients and people drawing upon support especially those from seldom heard groups who currently do not access services.

Section 2: What is dementia?

Prime Minister's Challenge on Dementia 2020: "Dementia describes a set of symptoms that include loss of concentration and memory problems, mood and behaviour changes and problems with communicating and reasoning. These symptoms occur when the brain is damaged by certain diseases, such as Alzheimer's Disease, a series of small strokes or other neurological conditions such as Parkinson's disease."

All types of dementia are progressive. The way that people experience dementia will depend on a variety of factors therefore the progression of the condition will be different.

People of any age can receive a dementia diagnosis, but it is more common in those 65 years old and over. Early onset dementia refers to younger people with dementia whose symptoms commence before the age of 65. Due to the life stage differences amongst younger people with dementia in comparison to the older population, different social issues are experienced.

No two people with dementia are the same and therefore the symptoms each person experiences will also differ.

Section 3: Our approach

We aim to create a health and social care system that works together so that every person with dementia, their carers and families have access to and receive person centred compassionate care and support not only prior to diagnosis but post-diagnosis and through to end of life.

This strategy has been guided by principles developed by NHS England in their transformation framework. This 'Well Pathway for Dementia' is based on NICE guidelines, the Organisation for Economic Co-operation and Development framework for Dementia and the Dementia I-statements from The National Dementia Declaration.

Our vision is that Leicester, Leicestershire and Rutland are all places where people with dementia can live well through the following NHS England guiding principles:

- Preventing Well
- Diagnosing Well
- Supporting Well
- Living Well
- Dying Well

Furthermore, following the pathway as part of ongoing business we will focus on:
Leading, Integrating, Commissioning Training, and Monitoring Well

Section 4: National Picture

There are currently around 900,000 people with dementia in the UK. This is projected to reach 1.6 million people in the UK living with dementia by 2040 (Alzheimer's UK, 2019). The majority of people living with dementia are aged 65 and over, however there is a small portion of people under 65 living with dementia, approx. 40,000 (Alzheimer's Society, 2014).

Figures published by the Alzheimer's Society, Alzheimer's Research UK, Public Health England and WHO show that:

- there are over 25,000 people with dementia from black and minority ethnic groups in England and Wales, and this is estimated to rise to nearly 50,000 by 2026
- there are 209,600 new cases of dementia in the UK each year
- worldwide, around 50 million people are currently estimated to have dementia and there are 10 million new cases each year
- two thirds of people with dementia are women and over 600,000 women in the UK are now living with dementia. The condition is the leading cause of death in women in the UK.
- There are over 700,000 unpaid carers of people with dementia in the UK. Women are more likely to take on unpaid caring roles for people with dementia and are two and a half times more likely than men to provide intensive, 24-hour care.

Section 5: Local Picture

There are currently over 9,000 diagnosed people living with dementia across Leicester, Leicestershire and Rutland.

- As nationally, similar rates of males and females have a diagnosis of dementia across LLR, however this shifts with more females having a diagnosis of dementia in age categories above 80.
- Largest ethnic group to have a diagnosis of dementia across LLR is 'White', this is followed by 'Asian/Asian British', however there is significant gap in the rate of diagnosis between the two groups.

The risk factors for dementia are complex and we are conscious of health inequalities factors that contribute to prevalence. We will be targeting these in our delivery plans.

There was a total of over 14,000 people predicted to be living with dementia across Leicester, Leicester and Rutland in 2020 and data projections show that this number is estimated to increase to over 13,000 in County, 3,000, in City and 900 in Rutland by 2030 (POPPI).Currently, in October 2023, it is estimated that over 13,000 people aged 65+ living with dementia however only over 8,000 of these people have a dementia diagnosis (NHS Digital).

1 in 14 of 65s and over in Leicester, Leicestershire and Rutland is thought to have a dementia, which is reflective of the national trend. It is estimated that there are 105,000 carers across Leicester, Leicestershire and Rutland, although specific data for how many people care for those with dementia is not available. For further information relating to carers, please see the Leicester, Leicestershire and Rutland's Joint Carers Strategy 2022-2025 'Recognising, Valuing and Supporting Carers in Leicester, Leicestershire and Rutland'.

Section 6: National Context and background

In February 2015, the Department of Health published the Prime Minister's Challenge on Dementia 2020, to support the National Dementia Strategy of 2009. This detailed why dementia remains a priority and outlined the challenges the United Kingdom continues to face in relation to dementia. The priorities identified within this are to improve health and care, promote awareness and understanding and research. The Challenge continues to promote the Well Pathway for Dementia and therefore this local strategy uses the same structure as a guide.

There are a number of other national drivers that shape and influence the way we can support people affected by dementia. Some are listed below:

- Care Act 2014: sets out a framework of how local authorities should protect and care for adults within their locality.
- Equality Act 2010: protects people from discrimination in the workplace and wider society.
- Health and Care Act 2022: new legislative measures aim to make it easier for health and care organisations to deliver joined-up care for people who rely on multiple different services.

- Mental Capacity Act 2005: provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions.
- Human Rights Act 1998: sets out the fundamental rights and freedoms everyone in the UK is entitled to.
- People at the Heart of Care: adult social care reform White Paper: 10-year vision on how support and care will be transformed
- Living Well with Dementia 2009: a national dementia strategy sets out a vision for transforming dementia services with the aim of achieving a better awareness of dementia, early diagnosis and high-quality treatment at whatever stage of the illness and in whatever setting.
- NHS Adult Social Care Outcomes Framework: measures how well services achieve the outcomes that mean the most to people.

Section 7: Local Context and Background

How dementia support currently looks
The Dementia Support Service is the commissioned post diagnostic service, it aids people's understanding of what and where support is available. Anyone affected by dementia can self-refer into the Dementia Support Service and there are also standard referral pathways for professionals. These services are commissioned by the Councils and NHS and are subject to competitive tender legislation so the provider may change over time. The commissioned service at point of publication of the strategy is Age UK Leicester Shire and Rutland. Rutland County Council combine this support with their Admiral Nurse service.

There is a range of services and support available for people living with dementia across Leicester, Leicestershire and Rutland. Some of these services are provided by local community groups and the voluntary and independent sector and some is provided or commissioned by NHS and Local Councils. Some of this support is subject to an assessment of need. The main method of receiving health support for people with dementia is through their general practice and the two NHS Trusts, Leicestershire Partnership Trust and University Hospital Leicester. Different Councils have slightly different arrangements for accessing and delivering social care, but work to the same national eligibility criteria. More detailed information including contact details is contained within the online LLR Dementia Friendly Guide and the Dementia Support Service can also help with access. The NHS website also describes services and access to these.

Local policies that influence our work
Locally, a number of policies and approaches are informing our strategic thinking. This is important to consider as the support offered for people living with dementia and their carers often intersects with other parts of health and social care offers. We are mindful of collaborative working and wider considerations of where our strategy sits. Some areas of specific considerations are:
- Leicester, Leicestershire and Rutland Joint Carers Strategy Refresh 2022-2025: establishes priorities in order to provide better support to carers locally.
- Joint Health and Wellbeing Strategy 2019-2024 sets out health priorities for Leicester and provides details of objectives for improved health outcomes.
-Leicestershire Dementia Joint Strategic Needs Assesment 2018-2021 : explains dementia through focusing on local concordance with other issues and demographics.
Rutland main strategic plans
City All Age Commissioning Strategy : outlines commissioning priorities across Leicester City Social Care department.

Leicestershire County Council Strategic Plan 2022-2026

How the strategy is governed

The Leicester, Leicestershire and Rutland Living Well with Dementia Strategy is managed by the Leicester Leicestershire and Rutland Dementia Programme Board. This is part of the overall systems that are in place to improve health and wellbeing for the citizens of the area. The following shows how specific Statutory Partnership Boards connect.

Leicester, Leicestershire and Rutland Health and Wellbeing Partnership (LLR HWP).
This is a statutory committee bringing together an alliance of partners who are concerned with improving the care, health and wellbeing of the local population. Each local authority area has a Joint Health and Wellbeing Plan. These feed down to local area Health and Wellbeing Plans. The Dementia Strategy enables these boards to consider activity that specifically addresses the local needs of people living with dementia.

Leicester, Leicestershire and Rutland Mental Health Collaborative Board
This board ensures a focus on Mental Health and Dementia at a high level particularly with services delivered by Leicestershire Partnership Trust in collaboration with all statutory partners.

Leicester, Leicestershire and Rutland Dementia Programme Board
Sitting under the Mental health Collaborative is the Dementia Programme Board which has specific responsibility to ensure the implementation and monitoring of the Dementia Strategy.
Membership

- Admiral nurses
- Age UK Leicester Shire and Rutland
- Alzheimer's Society
- Dementia UK
- Healthwatch
- Leicester City Council
- Leicester, Leicestershire and Rutland Dementia Friendly Community
- Leicestershire County Council
- Leicestershire Partnership NHS Trust
- Local Universities
    - De Montfort University
    - University of Northampton
- National Institution of Health Care Research
- NHS Leicester, Leicestershire and Rutland Integrated Commissioning Board
- Rutland County Council
- University Hospitals of Leicester NHS Trust

Section 8: What people have told us

Healthwatch Leicester, Leicestershire and Rutland spoke to a range of people through focus groups, 1 to 1 interview and a large-scale survey to learn about the views of people living with dementia and their carers. This focused on people's experiences regarding the support that they have been in receipt of and their overall dementia journey from pre diagnosis. Overall, approximately 350 people were engaged with through 36 focus groups, 34 through semi structured interviews and 126 through survey responses, these counts include people with dementia, carers and professionals. Some useful feedback was given for example, inconsistencies around access to support and information as well as waiting times. Some

suggestions for how support could be improved were made. This research is of great value to us and have informed our priorities for this strategy.

People with younger onset dementia are often underrepresented and can have varying priorities to those 65 years old and over. DPB members arranged an event in November 2022 which focused specifically on the support for people with younger onset dementia and encouraged befriending and advice sharing between them and their carers. During the event 3 focus groups were held in which people with younger onset dementia and their carers were encouraged to share their experiences and advise on what support could be offered to improve their dementia journeys. This information is also of great value to the Dementia Programme Board and has been used to inform our priorities.

Both of these engagement exercises are reflected in Section 9 of this strategy.

Section 9: What we are planning to do 2024-2028

We aim to provide and develop specific activity using the well pathway to meet our overall approach. Some areas will continue to be part of our usual day to day business and some we will aim to refocus and refresh and so have higher priority. This strategy identifies the high-level actions which will be specifically addressed by each organisation's delivery plan. The organisational plans can also focus on place and neighbourhood to ensure specific support is provided where needed. Each organisation is responsible for drafting, following, and maintaining their delivery plan and reporting annually on its progress to the Dementia Programme Board. The expectation is that the delivery plans will be SMART (Specific, measurable, achievable, relevant, time bound) and organisations are accountable to the DPB governance to ensure high-level actions are being met.

This strategy does not have specific financial investment allocated in order to deliver the high-level priorities cross organisationally. Each organisation is responsible for ensuring that the activity and objectives are met using existing resources through allocated budgets by each organisation e.g. the Dementia Support Service is commissioned by Leicester City Council and Leicestershire County Council, these organisations had allocated a budget for the service, this ensures our 'Living Well' objective is met. Members of the Dementia Programme Board will continue to explore opportunities for funding through potential government allocated grants, however the priorities outlined are aimed to be achieved irrespective of extra funding being allocated.

<u>Leading, Integrating, Commissioning Training, and Monitoring well</u>
The overarching themes in the Well Pathway are important to address in this Strategy and relate to how we work as a health and social care system with our key partners.

The Dementia Programme Board (DPB) will continue to take responsibility for the following activities:

<u>Leading, Integrating and Commissioning Well</u>

- Promote practice that develops a strength-based approach to supporting families living with dementia
- Support and respond to the development of neighbourhood or place-based plans and other interdependent projects that impact on this Strategy
- Respond and adapt the strategic action plan as required to address any local or national policy change that impacts on people living with dementia
- Refresh the health and social care pathway for people living with dementia from Diagnosis to End of Life to ensure they are effective and efficient. We will aim to prioritise diagnosis and hospital discharge pathway.
- Use Public Health lead Joint Strategic Needs Assessments to support the commissioning of dementia friendly services for people with dementia. We will consider opportunities for joint commissioning and continue to jointly commission the Dementia Support Service.

Training well - Quality Improvements and workforce competency

- Ensure the quality aspects of personal care for people living with dementia are monitored within NHS and ASC contracts and work with providers to address any gaps.
- Identify, promote and support access to good quality dementia training.

Monitoring well

- Report progress of the Strategy to the Mental Health Collaborative Board at least annually.
- Review the systems in place to implement, monitor and report on the Strategy adapting as required at least annually.
- Support local and organisational focused delivery plans, within which system wide actions will be agreed and implemented. System wide means across health, social care and housing responsibilities.

Well Pathway

Preventing Well

There is increasing awareness of the role of prevention in addressing dementia, particularly vascular dementia. Locally there are still gaps in understanding the connection between healthy living and dementia and opportunities with the public and patients to raise awareness. People have told us that there seems to be a grey area between a natural forgetfulness of ageing and the recognition of the onset of dementia and younger people have told us that dementia is also confused with depression. We have raised awareness of the risks of dementia through activity during Dementia Action Week such as through local publications, and a BBC Radio Leicester feature. Furthermore, Dementia Friendly Community Networks encourage dementia friendly work cross organisationally. Health promotion activity was reduced during the Covid pandemic due to the need to use available resources for public health infection control measures.

We will continue to

- Screen for risk factors for dementia and raise awareness of them
- Raise awareness of dementia and its symptoms

We will aim to

- Promote dementia prevention methods such as lifestyle behaviour changes
- Promote the Global Council on Brain Health's message: 'What is good for the heart is good for the brain', meaning a healthy diet, exercise and lifestyle are good for both body and brain
- Encourage people to get involved in research and promote the advantage of early diagnosis
- Encourage opportunities for community engagement and a reduction in loneliness and social isolation

Diagnosing Well

Research suggests that timely diagnosis of dementia is important to enable the start of appropriate treatment and support. From recent engagement from Healthwatch people indicated they waited on average 1-2 years before seeking help some as long as five years. We also know that people from South Asian communities are underrepresented in the figures we hold about diagnosis.

Government aspirations are that there is 6-week average wait between referral from GP to initial assessment and starting treatment. There is also a national target of 67% people with dementia having a diagnosis. Memory Assessment and Diagnosis services were severely disrupted during the Covid Pandemic both locally and nationally and referrals from GPs also declined. Locally, we were doing well before the pandemic and had reached the diagnosis targets across areas with Leicester reaching 85%. Unfortunately, the impact of the pandemic lead to these falling by 13% across all areas. Annual NHS dementia care plans are also lower than the expected national average.

Local NHS Diagnosis Rates [i] are recorded by clinical commissioning group areas and are:

- West Leicestershire 57.9%
- Leicester City 72.5%
- East Leicestershire and Rutland 56.5%

The percentages represent the proportion of people living with dementia that have a formal diagnosis as of January 2023.

We will continue to

- Use pharmaceutical treatments and a range of treatment options that have proven benefits to people with dementia.

We will aim to

- Refine the dementia assessment pathway with the aim to reduce diagnosis wait times.

- Improve patient access to the pre and post diagnosis Dementia Support Service.
- Improve the diagnosis experience particularly for people from underrepresented communities.
- Explore culturally appropriate dementia diagnosis tools.

Supporting Well

National and local guidance reinforces the importance of having person centred support in place for individuals living with dementia and their carers. This is the ethos and working practice in this area and we continue to promote, influence and commission support aimed at both health and social care as well as within the voluntary sector. We aim to ensure this support is of good quality and meets the needs of individuals accessing these services. People have told us there are some barriers experienced by people accessing support.

We know that dementia is a progressive condition so people are likely to have increasing health and social care needs over time and most people will need personal care support in the later stages of dementia. They may also have other health conditions or frailty associated with old age. There are national criteria and assessment processes in place for Adult Social care and Continuing Health Care so some people will be required to self-fund their care.

The Covid pandemic had a substantial effect on families living with dementia, visiting care settings was restricted, people with dementia were particularly vulnerable to infection and informal carers, where possible, were providing an increased level of care and support. People living with dementia were also affected by changes in routines and increased isolation. Priority actions remain in place to discharge people safely from hospital as soon as they are medically fit for discharge and the stresses on informal carers and professional organisations who are providing care remain. Not all people with dementia have complex needs but where this is the case there are additional challenges to meeting their care, particularly where there are changes in behaviours that challenge the person and those caring for them.

We will continue to

- Improve the hospital experience for people with dementia
- Apply the Leicester, Leicestershire and Rutland Carer Strategy actions to support people with dementia and their carers
- Raise awareness of support available for people with dementia and their carers

We will aim to

- Review with the goal to improve processes and avoid unnecessary hospital and care home admissions
- Review with the goal to improve hospital discharge pathways and post discharge support that assist people returning home or into their residential care home

- Support, review with the goal to improve and manage pathways for people who have complex needs including where there are behaviours that challenge
- Promote the development of 'dementia friendly' accommodation including in the community and residential care sectors
- Review with the goal to improve the pathways and person-centered support for seldom heard groups such as younger onset dementia, diverse ethnicities, people with a learning disability, prison populations, rural and farming communities and armed forces
- Promote and develop good risk reduction methods that keep people safe and promote independence

Living Well

Living well with dementia relates to staying active healthy and connected to families and your community. It is also about a strengths-based approach (which focuses on strengths and not deficits, SCIE) to dementia both for individuals and communities. There is some research that both leisure activities and activities specifically for the brain can delay the progress of dementia. During the Covid Pandemic, we saw a surge of community spirit and neighbourliness as well as people feeling more isolated and for some this seems to have hastened the progression of their dementia. We also note that using video calling became a regular feature of communications. Since the end of lockdown, we have seen a resurgence of social groups in local communities able to meet the needs of people with dementia, both within dementia only and generic leisure and social groups.

Through the Dementia Support Service in Leicester and Leicestershire provided by Age UK Leicester Shire and Rutland people are supported to live well with dementia pre and post diagnosis. The service has a dedicated team of staff, volunteers and a co-production group including people affected by dementia, who have all contributed to shaping and developing its various elements. This includes specific post diagnosis information and advice sessions, 1-2-1 carer learning sessions and or group support. Many social groups developed have been launched with the view of offering a wide variety of activities to support people to live well with their dementia, including walking, music, gardening and woodwork groups as well as cognitive stimulation therapy. In Rutland the dementia support service is jointly provided by Admiral Nurses and a Dementia Support Worker providing a range of similar support as well as additional clinical support from the Admiral Nurses. There are also a range of other groups and activities run by a range of voluntary and public sector organisations aimed at supporting people with dementia, many can be found in the Dementia Friendly Guide. Furthermore, the LLR Living Well with Dementia Grant recently has helped local voluntary organisations to fund 29 community-based projects aimed to support people living with dementia and their carers. An event for people with Younger Onset Dementia was put together by LLR commissioners in 2022 to offer people an opportunity to learn about support available to them and share their experiences.

People have told us that there is some variation in the availability and access to living well activities across Leicester, Leicestershire and Rutland. We know that people find it hard to access information about living well with dementia even though there are many good sources of information available. We also know that planning ahead can aid people to live well but also plan for potential changes in their abilities as their dementia progresses and manage crisis. Discussing “planning ahead” can be a difficult conversation and this is an area that needs more development.

We will continue to

- Provide information and advice about living well with dementia that is accurate, timely, accessible, and joined up across Leicester, Leicestershire and Rutland
- Develop and promote dementia-friendly communities, dementia support services and other living well support
- Use funding opportunities when they are available, to develop living well activities especially in areas that are less well-served

We will aim to

- Engage with people living with dementia and their carers including people with lived experience, to be involved in strategy development and to inform our work
- Support people with dementia to plan and live well by promoting crisis contingency planning, advanced care planning and the benefits of appointing lasting power of attorney

Dying Well

We know that having early conversations with those affected by dementia, about advanced decisions and care planning can help both the person, their family and care providers at end of life. There are good practise models that look at dying well and the guidelines about RESPECT. According to the national census an estimated 65% of people with dementia die in care homes and 23% in hospital so these are the two care settings we aim to support good dying well practice in.

We will aim to

- Promote and develop good practice including strengthening the link with end-of-life pathways and the ReSPECT process (the ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices)

Section 10: Useful links

https://www.nhs.uk/conditions/dementia/

APPENDIX A

https://lightbulbservice.org/
https://loros.co.uk/
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf
LLR Carer Strategy https://www.healthandcareleicestershire.co.uk/refreshed-joint-carers-strategy-highlights-commitment-to-supporting-carers/
https://www.england.nhs.uk/publication/dementia-friendly-health-and-social-care-environments-hbn-08-02-2/
https://www.nice.org.uk/guidance/ng97
https://www.resus.org.uk/respect/respect-patients-and-carers
https://www.ons.gov.uk/peoplepopulationandcommunity/

[i] This is the method of Dementia Diagnosis Rate recording at present. We will update this section upon any changes.

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Appendix B

Summary Report of Leicestershire Responses to Public Consultation and Engagement on the

Leicester, Leicestershire and Rutland's Living Well with Dementia Strategy 2024-2028

1. Purpose of the report

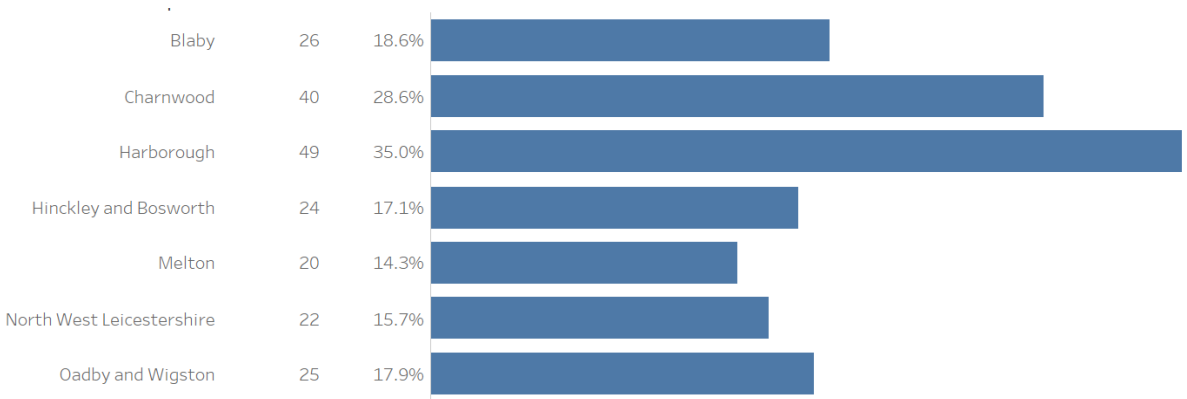
This document provides a summary of the findings from Leicestershire respondents on the public consultation undertaken between 17 July-22 September 2023 on the draft **Leicester, Leicestershire and Rutland's Living Well with Dementia Strategy 2024-2028.**

The overall LLR Consultation report will be presented to the Dementia Programme Board on the 21 November 2023. The information gathered during this consultation will be used to inform the way forward and the final version of the strategy and associated, place-based action plans.

The total responses relating to LLR was 358, 206 Leicestershire only, 91 who responded in regard to Leicester and 61 in regard to Rutland. This is a high number of responses when compared to previous Dementia Strategy consultations and other similar consultations and demonstrates the effort from officers to consult as widely as possible.

Areas people stated they were responding in relation to (more than one area could apply)

Figure one.



2. Key Themes Emerging for Leicestershire

The key positives identified in the analysis of this consultation are:

- The draft strategy was welcomed by the majority of respondents and overall respondents agreed that the aims of the draft strategy were the right ones.

- People noted that the process of having an assessment and diagnosis had changed and was improving. The process now involves a CT scan followed by face-to-face assessment
- A consistent positive theme in the feedback was the development of specific community activity groups for people living with dementia and their carers.
- Whilst there were concerns raised about some examples of poor care in health and social care services, there were also some very dedicated professionals and good services available in Leicestershire.

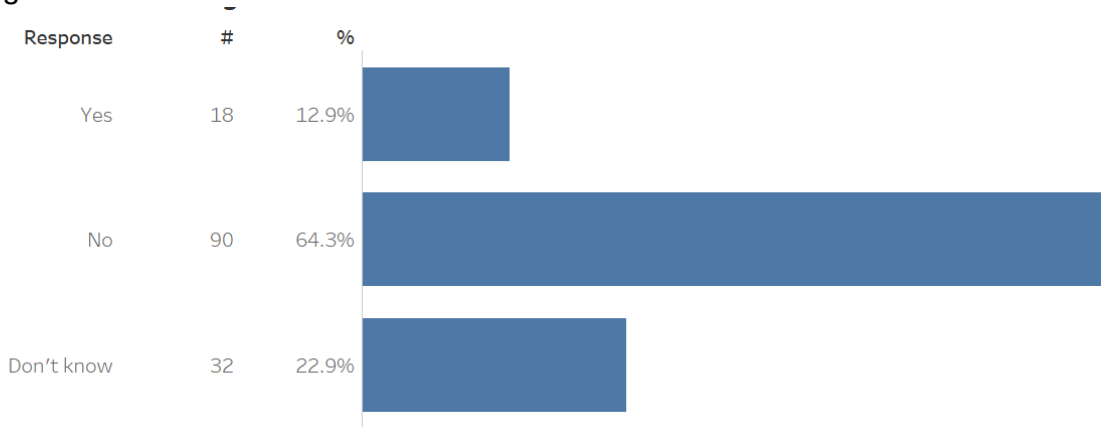
Key findings from the responses in terms of where things need to improve are:

- The developments listed in the strategy require a ring-fenced budget to achieve all this and the consultation and associated documentation indicates there is no budget attached to this.
- Too much jargon in Strategy and action plan
- The Action Plan only has “aims” and uses words like review and support. It does not provide a clear measurable Action Plan on how this is going to be achieved.
- Concerns were expressed over the communication and care planning between NHS Primary and Hospital Care and Local Authority Social Care Services
- Referral from the Memory Assessment Service to the local Dementia Support Service run by Age UK should be mandatory
- Staff in all areas need better and specialised dementia training and is to a clear and monitored agreed standard.
- Concerns were raised over the removal of funding for Admiral Nurses support and there were numerous comments praising the specialist knowledge and supportive nature of Admiral Nurses.
- Need Admiral Nurses across the County
- Comments were received that suggested screening and supporting people based on risk – those who live alone, have dementia in family history, are less likely to connect with services.
- Therapeutic activity and support after a diagnosis isn’t available for all in all areas.
- Don’t discharge to care homes or with home care that cannot support the person well or adequately
- All people should have access to meaningful activity whether in a care home or at home or going to activities locally
- Support informal carers better at all stages of the person’s dementia. Informal carers felt overwhelmed, alone and find it hard to get the support they need.
- Provide Transport to local activities, as people loose licence, income and rurality means no buses
- Have conversations early and support staff to sensitively to discuss Advanced Decisions and record the RESPECT form on shared records.

3. Overview of Responses and Themes Relating to Each Question

Respondents to the consultation were first asked, **"Do you think that the health and social care services that support people living with dementia work well together?"** The responses were as follows:

Q6 – Figure 2

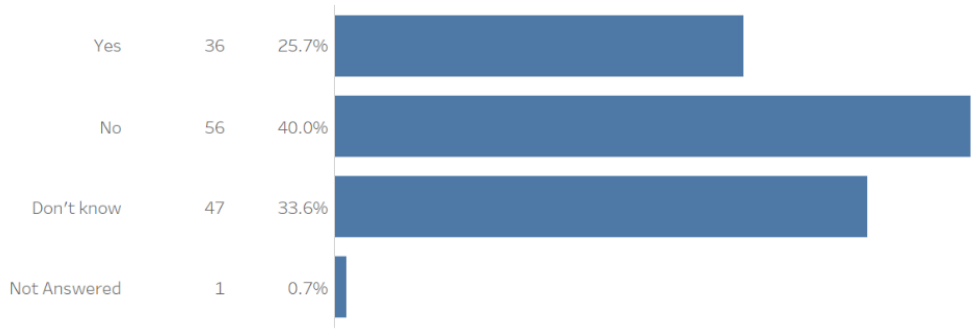


Where respondents said no to this question, they were asked to provide comments. Some of the key comments responses were:

- Not one professional coordinating so people don't know who is doing what
- Very confusing trying to find out what is available and who does what
- Hospital care and discharge poor regarding communication and quality
- Support from General Practice inconsistent needs to be face to face for someone with dementia and also include their main carer
- Admiral Nurses were the only ones supporting and coordinating care but they have been stopped
- People are at risk of falling through the net especially those living alone
- Hospital discharge and treatment in hospital poor
- Reliance on online information not helpful for someone with dementia
- Dementia patients in the main are not properly supported in hospital and in care home due to lack of understanding, poor training and monitoring.
- People with dementia who live alone are bypassed unless they have family or friends who contact services

Next, people were asked, "**Do you think staff are confident and competent to support people with dementia?**". The responses said that:

Figure 3.



Once again, where people said no, they were asked to provide comments. Key themes emerging from this were:

- Staff seem overwhelmed
- Staff in all areas need better and specialised dementia training
- Admiral support removed and they did have specialist knowledge
- Is there an agreed LLR approach to the standard of training for dementia and how is this monitored?
- Informal carers having to training paid carer on how to communicate and look after person
- Agency staff less well trained on wards
- Stressful sourcing care and finding care that is competent to care for people with dementia
- No help or support for carer or patient
- Better when nurses and medics have specialised role in dementia
- Training doesn't cover values as much as needed- ie people with dementia are not treated as people with a past and feeling
- Loss of mental capacity used when person has capacity to delivery care

The consultation survey then went through the key areas of the strategy, focused around preventing, diagnosing, supporting, living and dying well with dementia.

Key Actions Preventing Well - We Will Continue to

- Screen for risk factors for dementia at health checks and raise awareness of the risk factors for dementia
- Raise awareness of dementia and its symptoms

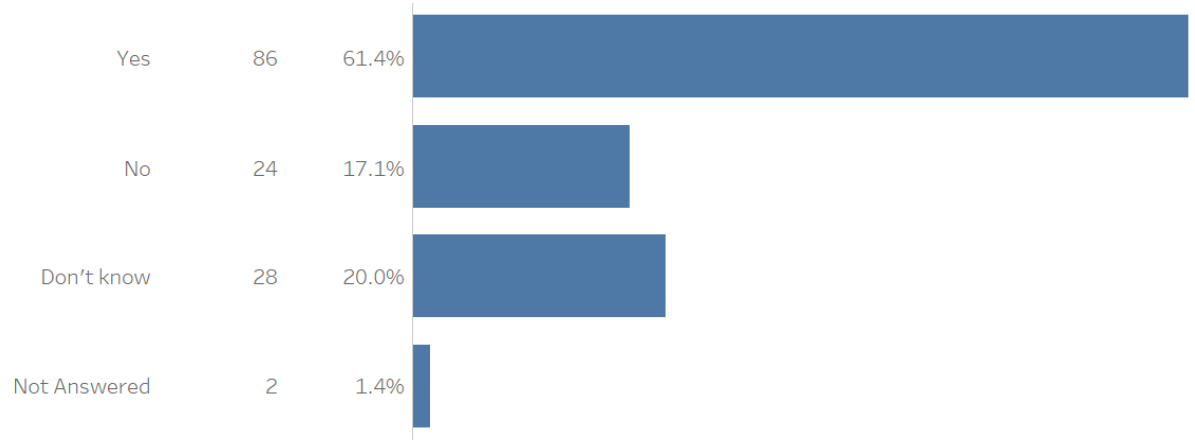
Key Actions Preventing Well - We Aim to

- Promote dementia prevention methods such as lifestyle behavior changes
- Promote the Global Council on Brain Health's message: 'What is good for the heart is good for the brain', meaning a healthy diet, exercise and lifestyle are good for both body and brain

- Encourage people to get involved in research and promote the advantage of early diagnosis

Figure 4

Q8. Do you think these actions will help reduce or delay the onset of dementia?



Q8a. If no, give reasons why

This answer includes common comments including from people who answered yes

- People do have healthy diets etc but still get dementia, People also make poor lifestyle choices at an early age
- Told its hereditary so lifestyle change won't help
- Only some dementias could be prevented by lifestyle change, could lead to blaming the victim

Q8b. Is there anything else we could do to reduce or delay the onset of dementia?

- More therapeutic activities for the brain and wellbeing that are cognitively stimulating and in in all areas- Brain gym, Cognitive Stimulation Therapy (CST), Singing for brain, in community centres and village
- Early screening at health checks
- Access to assessment and support earlier
- Change processed food laws
- Promote awareness of "game changing drugs" currently coming to end of successful trails
- Promote people getting involved in research

<u>Key Actions- Diagnosing Well - We will continue to:</u>

- Use pharmaceutical treatments and consider a range of treatment options that have proven benefits to people with dementia

Key Actions- Diagnosing Well - We aim to:

- Reduce diagnosis wait times
- Refine the dementia assessment pathway to ensure that people are diagnosed in a timely manner
- Improve patient access to the pre- and post-dementia support service
- Improve the diagnosis experience for people from underrepresented communities
- Explore culturally appropriate dementia diagnosis tools

Q9. Do you think these actions will support reducing waiting times and ensure a timely diagnosis?

Figure 5

Q9a. If no, please give reasons why:

This answer includes common comments including from people who answered yes

- Waiting times are a big concern, as they delay the use of drugs and other therapeutic activity that can delay progress of Alzheimer's Disease
- New process for CT scanning noted though some concern about getting these results and the wait for the follow up assessment, but have noticed improvements
- Admiral Nurse services lost
- Referral from the Memory Assessment Service to the local Dementia Support Service run by Age UK should be mandatory
- Rarer dementias not well served at Diagnosis and after care

Q9b. Is there anything else we could do to diagnose dementia better?

- Refine diagnosis pathway to make it as efficient as possible
- Ensure access to all people in all areas to pre and post diagnostic interventions – medication, advice, emotional support and therapeutic activities that delay progress of dementia.
- Continue to raise awareness of dementia across both public and professionals

- Screen earlier all people at risk- Consider prioritising people who live alone, who have dementia in family and those communities where stigma may be higher to come forward for a diagnosis
- GPs have face to face consultations to screen for dementia and time to listen to person and family, also do the Annual Health Care plan.

Q9c. Is there anything else we could do to improve diagnosis and raise dementia awareness amongst Black, Asian, Minority Ethnic (BME) and hard to reach groups?

- Work closely with community leaders and promote in places of worship and community centres
- Translate information into different languages.

Q9d. Is there anything else we could do to improve the diagnosis experience for people with learning disabilities, prison populations, rural and farming communities, younger onset dementia, armed forces and other seldom heard communities?

- Provide information in different formats, not just on-line,
- Train and link with specialist services for these groups so they understand symptoms, how to support and how to access a diagnosis and support
- Target training and support to those doing Health checks in primary care for over 50s

Key Actions- Supporting Well - We will continue to:

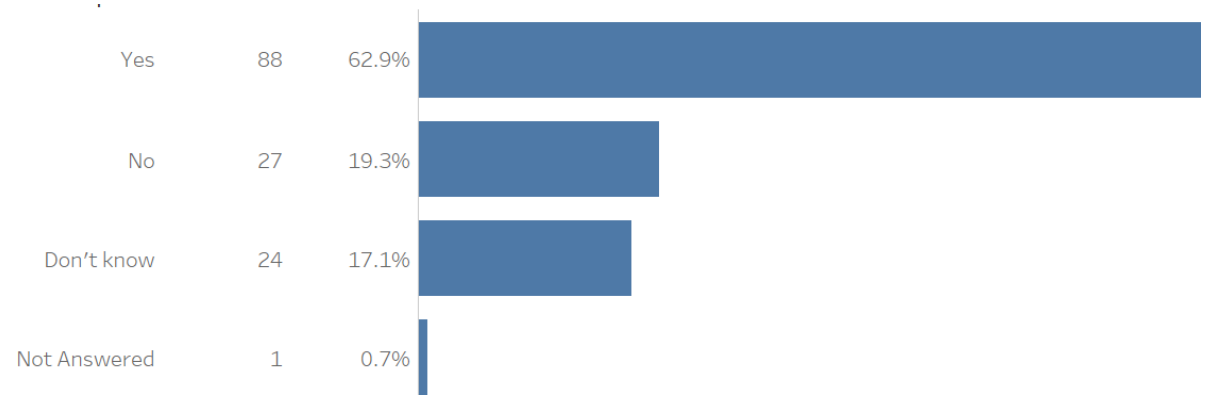
- Improve the hospital experience for people with dementia
- Apply the Leicester, Leicestershire and Rutland Carer Strategy actions to support people with dementia and their carers
- Raise awareness of support available for people with dementia and their carers

Key Actions- Supporting Well - We aim to:

- Review how we can avoid unnecessary hospital and care home admissions
- Review hospital discharge pathways and post discharge support that assist people returning home or into their residential care home
- Support, review and manage pathways for people who have complex needs including where there are behaviours that challenge
- Promote the development of 'dementia friendly' accommodation including in the community and residential care sectors
- Review pathways and person-centred support for seldom heard groups such as younger onset dementia, diverse ethnicities, people with a learning disability, prison populations, rural and farming communities and armed forces
- Promote and develop good risk reduction methods that keep people safe and promote independence

Q10. Do you think these actions will support people with dementia and their family and carers to have safe, high-quality health and social care?

Figure 6



Q10a - If no, please give reasons why:

This answer includes common comments including from people who answered yes

- Don't discharge to care homes or with home care that cannot support the person well or adequately
- Work with families about end stage care rather than seeing care homes as something to be feared, if that is what is needed
- Avoid care home admissions when people can be supported at home
- Value paid carers more, train and pay them more
- More ongoing training across board including hospital staff
- Social services ask about money first and if this is above limit don't give you any help
- Clearer pathway and support for more challenging conditions needed
- You need Admiral Nurses
- Carers left to try and find support alone
- Day care is desperately needed
- People who live alone could be overlooked
- What are the dementia training standards, how is this enforced?
- Things in the Enhanced Care in Care Himes introduced like nutrition so why are people avoidably admitted- who enforces?
- No detail of what will be done or how this will be achieved
- Monitor Care homes better and more regularly
- More support for younger people with dementia

Q10b- Is there anything else we could do to support people with dementia and their family and carers?

- Ensure Dementia specialist training is done to a clear standard for dementia care
- Honest open discussions with person and family about what can be done and what is advised and why.

- Have access to support, information and activities for person and family in all areas of County.
- Real practical support not just someone to listen
- Support informal carers better as this would help avoid crisis and admissions
- Help increase voluntary drivers and transport options who have training in dementia
- More support to fill gaps between diagnosis and when people have social care needs
- More respite for carers, more funded day care.
- Help informal carers and people with dementia not to feel so alone dealing with this
- Boards must have people with dementia on them “Nothing about us without us”
- Training in co morbid conditions like diabetes needed
- Fund more specialist care
- Reinstate Admiral Nurses across Leicestershire
- Create Dementia Specialist Centres for day services/Carer support / advice and information and therapeutic activity all under one roof. Too much time is spent by carers trying to access information and help from too many agencies.
- Explain what happens after sectioning and DOLS
- Regular reviews at least every 6 months by medical staff
- Stop carers having to wait hours for telephone calls or in telephone queues
- Level of profit for private business should be set nationally
- We were able to make massive change quickly during Covid why does it take many years to see improvement here?
- Mandatory referral from Memory Assessment service to local Dementia Support Service run by Age UK

Key Actions- Living well - We will continue to:

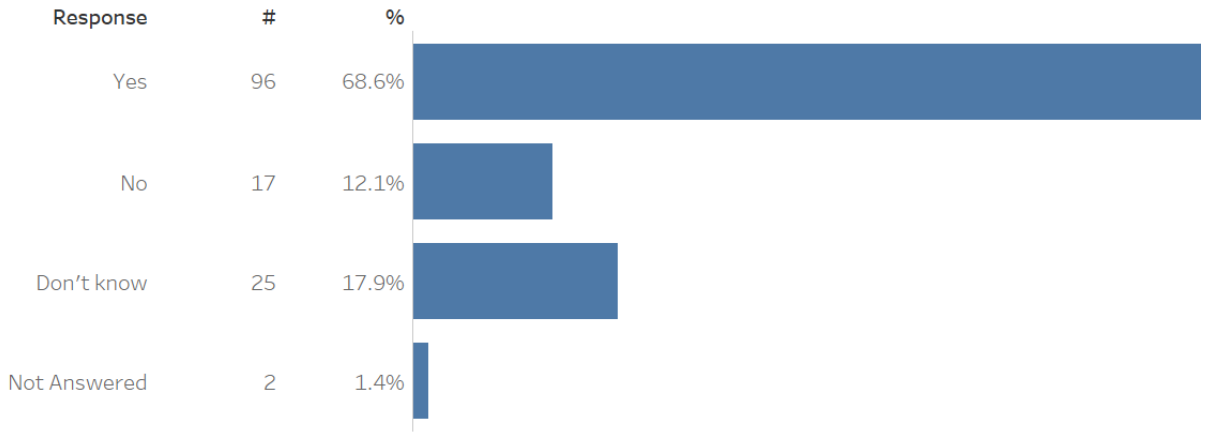
- Provide information and advice about living well with dementia that is accurate, timely, accessible, and joined up across Leicester, Leicestershire and Rutland
- Develop and promote dementia-friendly communities, dementia support services and other living well support
- Use funding opportunities when they are available, to develop living well activities especially in areas that are less well-served

Key Actions- Living well - We aim to:

- Engage with people living with dementia and their carers including people with lived experience, to be involved in strategy development and to inform our work
- Support people with dementia to plan and live well by promoting crisis contingency planning, advanced care planning and the benefits of appointing lasting power of attorney

Q11. Do you think these actions will support people with dementia to continue living well for as long as possible?

Figure 7



Q11a. If no, please give reasons why:

- All people should have access to meaningful activity whether in a care home or at home or going to activities locally
- On line survey and poster inaccessible
- Action not more leaflets
- Professionals are not consulting with LPA holder and especially in GPs.
- More information and activity at early stages noted, so is better than previous years

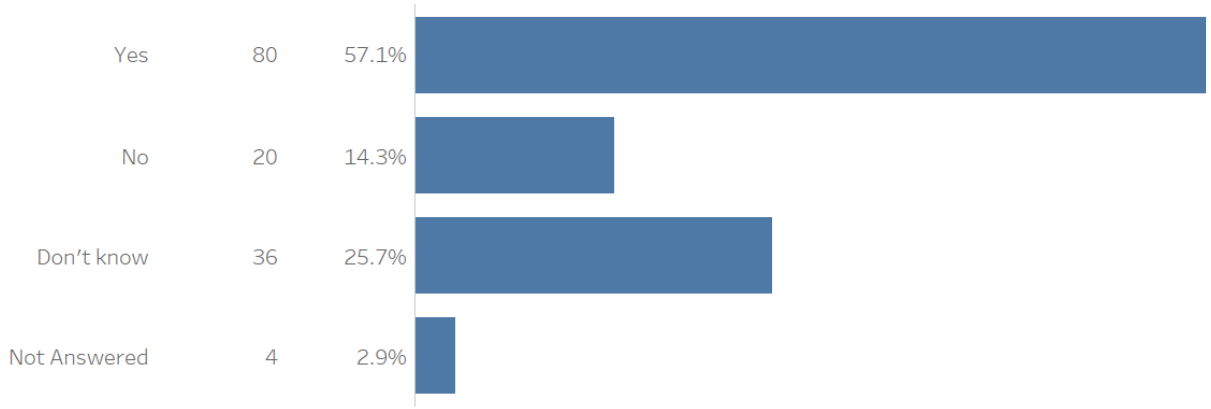
Q11b. Is there anything else we could do to support people with dementia to live well?

- Support informal carers better at any stage of the person's dementia
- Improve the quality of care especially in care homes
- Provide as much information as possible to families
- Use resources together and in a coordinated way- ie Social Prescribers, LAC, Age UK, range of Voluntary sector activities.
- Fund VSE permanently not just through short term grants
- Memory Hubs/ Meeting centres in all areas
- Transport to access services as people lose their licences and no public transport
- Some of the services in community mentioned as great example of early help – like Musical Memory Box, ADRE in Lutterworth. Brain Gym, Falls prevent for dementia, Informal learner training, memory cafes - Build on these
- Need all area to have access to activities and support.
- Have Admiral Nurses across Leicestershire
- More day care and transport to these
- More supported housing instead of residential care homes

Key Actions - Dying Well - We Aim to:

- Promote and develop good practice including strengthening the link with end of life pathways and the ReSPECT process (the ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices)

Q14. Do you think this action will support people with dementia to make decisions about their end of life plan?
Figure 8



Q15. If no, please give reasons why:

This answer includes common comments including from people who answered yes

- Not the resources to do this work in Statutory services
- Needs to have clear processes to support advanced decisions early with person and their family, when person has lost mental capacity, it is too late.
- People don't know what RESPECT is
- Some asked about this at each medical appointment others never.
- Too much jargon in this point for people to respond to question
- Compassionate care at end of life does need improving
- These are difficult conversations to have so need training and support to do this

Q15a. Is there anything else we could do to support people with dementia to make an informed choice around their end-of-life plan?

- Have these conversations early and support staff to sensitively do this
- Ensure RESPECT form in place before emergency and ensure it is shared with all medical professional
- That all medical professionals using it consistently and are trained
- Promote LPA and ensure records note this is in place and contacts both NHS, ASC and Care Providers
- Be clear and share between professional and family when someone is now on an "End of Life Plan"

- Support people to die at home if this is theirs's and family's choice.

Additional Information

The Consultation was hosted by the City Council with links provided on the County Council and ICB websites to the online survey. The City Council also ensured that printed copies were available on request. Partners were encouraged to support people they work who were affected by dementia fill in the survey. In addition, the Adults and Communities Department sent an "all user" email internally and sent out over 600 emails to care providers, local networks, housing and voluntary sector providers seeking their assistance with publishing the survey.

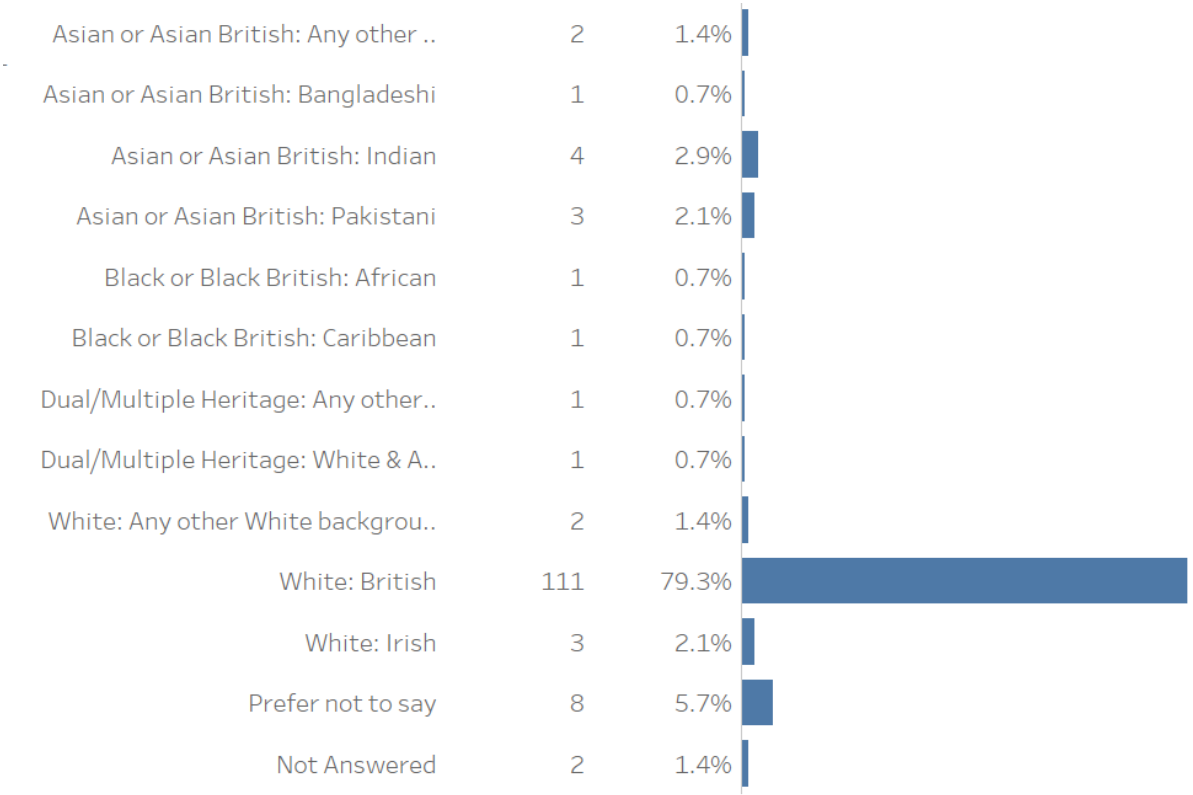
Additional consultation meetings were provided on request for people affected by dementia. Four meetings were attended by County Council Officers at which people were encouraged to fill in individual surveys.

Appendix 1 - Equality Monitoring Information

The tables below refer to demographic information from people who stated they were:

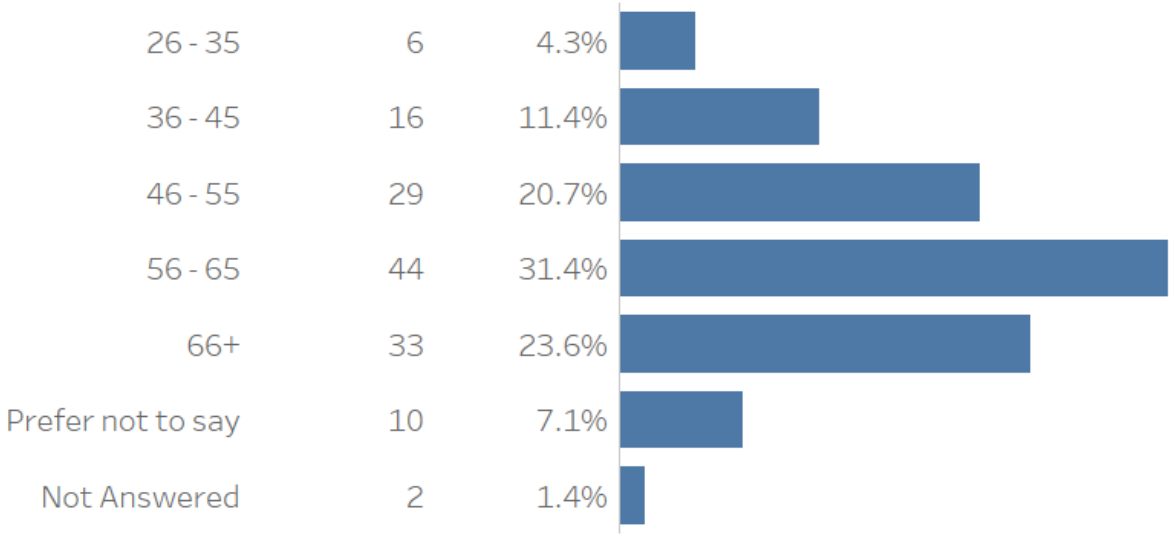
Ethnic Background

Figure 9



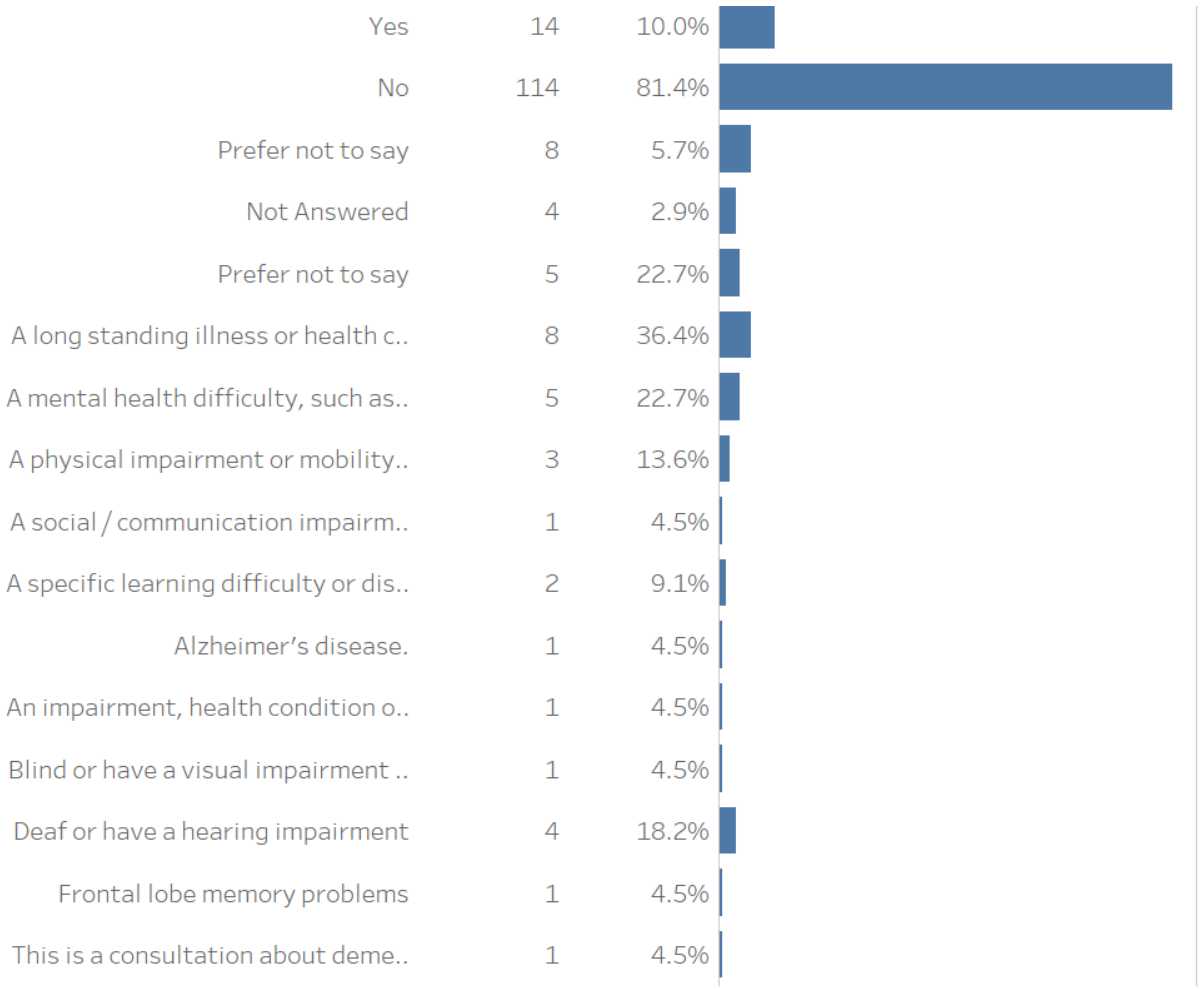
Age

Figure 10



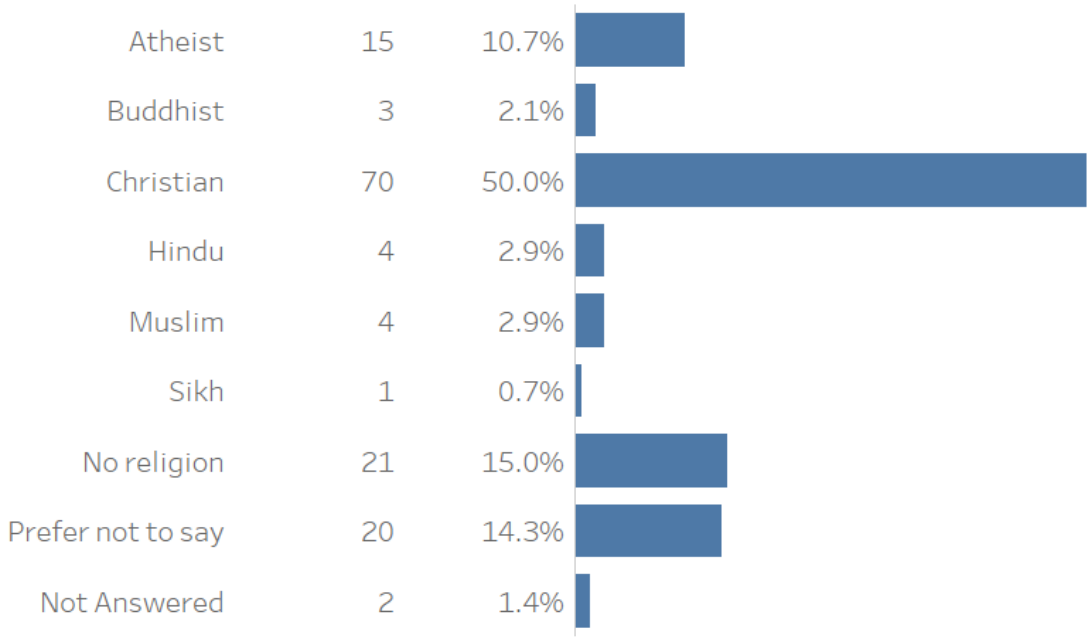
Disability

Figure 11



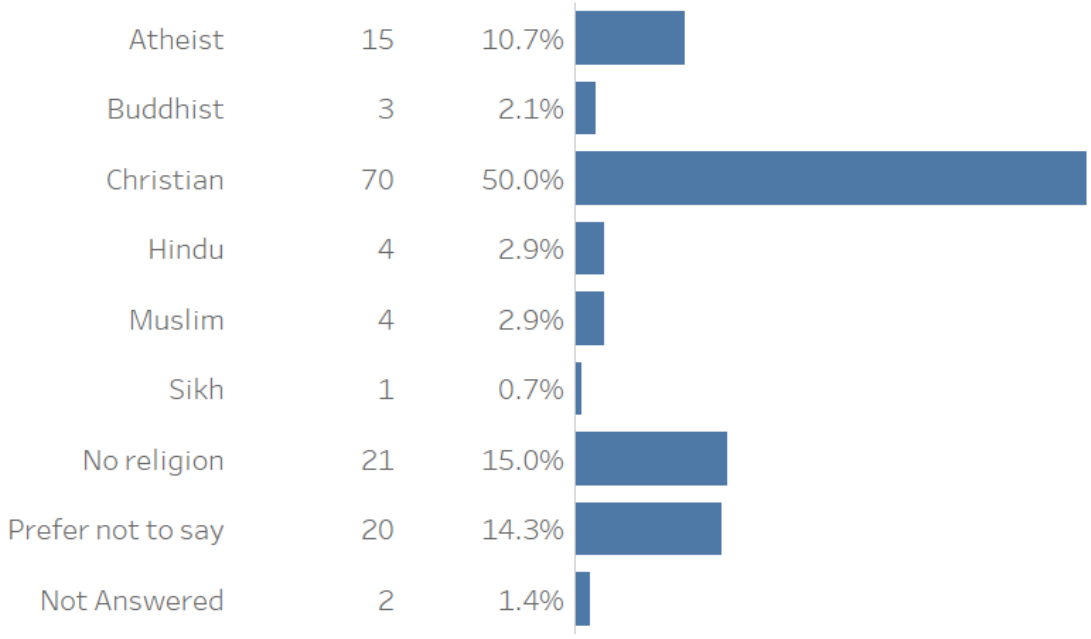
Religion

Figure 12



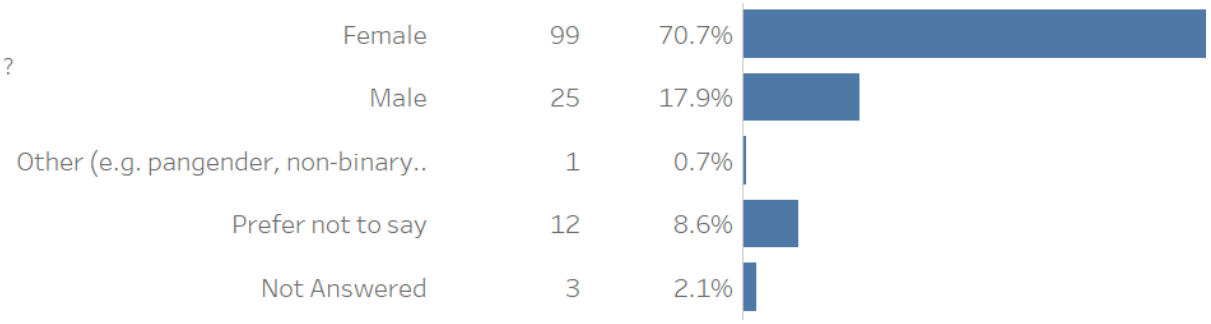
Sexual Orientation

Figure 13



Gender

Figure 14



Appendix C: Leicestershire Equality Impact Assessment

Name of policy: Leicester, Leicestershire & Rutland Living Well with Dementia Strategy 2024-2028

Department: Adults & Communities

Who has been involved in completing the Equality Impact Assessment: Sharon Aiken, Leicestershire County Council.
Diana Dorozkinaite, Leicester City Council.

Relevant contact information for those involved: sharon.aiken@leics.gov.uk
diana.dorozkinaite@leicester.gov.uk

Who is completing the EIA:

First name	Surname
Ben	Smith

Email:

Email address
ben.r.smith@leics.gov.uk

What is the proposal?: The Leicester, Leicestershire and Rutland's (LLR) Living Well with Dementia Strategy 2024-2028 sets the priorities across LLR for ways Social Care and Health services can support people living with dementia and their families and carers. The strategy has been developed in partnership between the Integrated Commissioning Board, the 3 Local Authorities, NHS Provider Trusts and local voluntary sector organisations.

What change and impact is intended by the proposal? : The strategy confirms the priorities across LLR for ways Social Care and Health services can support people living with dementia and their families and carers.

What is the rationale for this proposal?: It reflects the national strategic direction outlined in The Prime Minister's Challenge on Dementia which details ambitious reforms to be achieved by 2020 (version not updated) and supports the requirements of the Care Act 2014 for local authorities and health partners to work in partnership and integrate services where possible, in order to provide seamless support, avoid duplication and achieve best value for money.

What equalities information or data has been gathered so far?: The strategy proposal considers the impact dementia has on people's lives and the intersection of protected characteristics with dementia. All of the protected characteristics are considered and research has been undertaken both through already existing resources and through first hand engagement to understand how support can be improved for people with dementia and carers.

What does it show?: Data has been sourced from Joint Strategic Needs Assessments undertaken by Leicester City Council (to be published) and Leicestershire County Council (2018-21). Integrated Commissioning Board collected diagnosis data and undertook engagement with professionals.

There are currently over 9,000 diagnosed people living with dementia across Leicester, Leicestershire and Rutland.
- As nationally, similar rates of males and females have a diagnosis of dementia across LLR, however this shift with more females having a diagnosis of dementia in age categories above 80.
- Largest ethnic group to have a diagnosis of dementia across LLR is 'White', this is followed by 'Asian/Asian British', however there is significant gap in the rate of diagnosis between the two groups.
There was a total of over 14,000 people predicted to be living with dementia across Leicester, Leicester and Rutland in 2020 and data projections show that this number is estimated to increase to over 13,000 in County, 3,000, in City and 900 in Rutland by 2030 (POPPI&PANSI).

What engagement has been undertaken so far?: Healthwatch Leicester, Leicestershire and Rutland undertook a wide scale engagement exercise featuring people with dementia and their carers in order to identify challenges that people with dementia experience and how they can be best supported. In all, they spoke to 34 people in semi-structured interviews, attended 36 different focus groups and collected 126 survey. A wide range of recommendations concerning strategic priorities have been made and these were imperative in the development of the strategy. Some focus groups with people with younger onset dementia were also held during a younger onset engagement and networking event. This helped commissioners develop some focus on the priorities unique to this demographic that experiences dementia and learn how they can be better supported

Also, some desk research around specific challenges experienced by people from various underrepresented backgrounds was also undertaken by commissioners. The intention of this was to gather already existing research findings and use this as a way of informing our strategic priorities. The report was developed by officers and shared with the Dementia Programme Board at early stages of the dementia strategy review.

What does it show?: The officers report focused on compiling research studies and online articles around the challenges people from various seldom heard groups face in the UK. The groups in question are: prison population, traveller and gypsy communities, LGBT+ Communities, learning disability and underrepresented ethnic groups. Commissioners believe that developing the holistic background knowledge of the issues that the seldom heard communities face will help ensure the strategy is accessible and conscious of issues experiences by people in these communities.

The Healthwatch engagement exercise produced a final report with 16 recommendations focused around pre-diagnosis, diagnosis, support following diagnosis and access to health and social care. All of the recommendations have been considered whilst developing the refreshed strategy.

Age:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
The majority of people diagnosed with dementia are 65+. Many of the carers of people with dementia are also likely to be over 65. The Strategy's main	Yes	In this instance, as the majority of people diagnosed with dementia are 65 years old and over it is imperative that our engagement and service

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
aim is to support a local health and social care system that works together so that every person with dementia their carers and families have access to and receive compassionate care and support not only prior to diagnosis but post diagnosis and through to end of life. Through the action plan within the Strategy, statutory and voluntary sector organisations demonstrate how they will work together to support people affected by dementia and their families and carers. Younger people with dementia require different advice and support- services such as the Memory Assessment Service and our Dementia Support Service (feature specialist younger onset dementia support worker) have been commissioned to ensure that this advice / support is received across the area but organisations must ensure younger people feature in their delivery plans as well. Some engagement was undertaken exclusively with people diagnosed with dementia at less than 65 years old and their carers. This helped us identify how we can address their needs within the Strategy and local delivery planning.		response considerations also focus on under 65s. The two age groups have different challenges that they experience due to different life stages upon diagnosis and may differ in the onset of symptoms. It is important to consider how people age under 65 can be integrated into mainstream services which are dominated by old age services. We have considered the impact of age when developing our strategy. The public consultation will be promoted across organisations and people will be encouraged to share their views through completing an online form. Accessibility is a consideration in this, and the Dementia Programme Board members will be encouraged to promote the consultation and to encourage services to support people with completing the feedback form where possible. The Dementia Programme Board who oversees the Strategy will continue to influence and promote age-appropriate services and support from Statutory provision and commissioned services like inpatient care, home care and residential care and monitor delivery of the Strategy. Individual place based and organisational delivery plans will be shared with the DPB.

Disability:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
Dementia is a major cause of disability, affecting personal care, everyday cognitive activities and social behaviour. As dementia is progressive and eventually effects all functioning managed by the brain people will become increasingly disabled both cognitively and physically. Older People with dementia often have co morbid conditions. The strategy is intended to improve support available to people diagnosed with dementia and their carers. Improving awareness and access to support will also improve outcomes for people with disabilities or health conditions which increase their likelihood of developing dementia such as learning disabilities. Furthermore, effective and timely diagnosis is another consideration within the strategy and some key objectives circle around this. Reducing waiting	Yes	The aim of the strategy is to have a positive impact on disability as a result of dementia. It is also worth to consider concordant disabilities and how these can be supported to ensure that they do not prevent people from accessing dementia support. Some research has been conducted on Learning Disabilities (LD) and dementia by commissioners and partners. Some generic service provision may not be aware of the Strategy or their responsibilities to ensure the needs of people with dementia are met. The strategy aims to ensure inclusivity of all people living with dementia and their carers and specialises support where needed. Ensuring people are not discriminated due to concordant disabilities is essential and the strategy supports this. The Strategy will be widely communicated and supported by the DPB, who will

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
lists for assessment and diagnosis would allow people to receive post diagnostic support earlier potentially slowing down the progression of the illness. The Strategy support actions addressing living and supporting well activity and this includes activity that maintains people's health, independence, social connections and reduces the risk of harm. The Strategy also has actions that aim to support people who have increased health and social care needs including those whose behaviours present challenges and people coming out of hospital.		work with commissioners and providers of mainstream services and interdependent workstreams to ensure these are inclusive of people with dementia. The consultation will be accessible to people with dementia and other disabilities through accessible text and visual impairment adaptations. Commissioners met with a dementia co-production group in which advise on how to ensure the consultation is accessible was sought. Advice regarding text content, font and colour given.

Race:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
There is some evidence to suggest that people from certain ethnic communities are at higher risk of dementia than others, and that there is lower take up of dementia support services and diagnosis rates amongst ethnically diverse communities. This can lead to people with dementia not receiving the support that may be helpful to them and their informal carers. The Strategy seeks to recognise and be responsive to the needs of people from minority ethnic groups, which may be different from those of the majority population for example to meet first language needs, culturally appropriate activity and support, connection with communities as well as ensure paid carers have awareness of race and dementia in order to meet identified needs. In some areas there may be a case for specific services for specific communities. The Strategy also aims at promoting strong partnerships between statutory, voluntary and community groups. Person centred plans are integral in commissioned support, and this requires viewing the holistic background of a person including their ethnicity and culture.	Yes	Not considering the discrepancy in diagnoses and attendance to support services, can further create a gap to service access for people from certain communities. This could lead to people presenting in crisis who have no or little previous involvement with services, families in crisis and under strain without the knowledge and support to provide care as the person with dementia condition progresses. The strategy if not being accessible to people from diverse backgrounds holds potential for exclusion and prevents appropriate access to support. Furthermore, not considering the impacts of race, ethnicity and culture can lead to exclusions from consultation processes for the strategy development. The DPB expects services to be flexible and ensure that people from all backgrounds are well supported. It will be expected that local and place-based delivery plans address the specific needs of people from diverse backgrounds. The commissioned Dementia Support Services will continue to be supported to develop its services with and for different communities. The ICB and Memory Assessment Service are implementing specific assessment tools for South Asian communities. All other contracts and internal services will continue to be monitored in relation to access and use. The DPB will promote tools and resources that specifically relate to working with a diverse population

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
		through its networks. The Strategy will continue to promote partnership with the healthcare practitioners and VCS organisations and local communities to ensure resources are allocated to promoting dementia awareness in ethnically diverse communities. Commissioners have undertaken secondary research to learn about unique challenges people from migrant and ethnic minority backgrounds may face e.g. culture difference and language difference and will use this to support future additional commissioning.

Sex:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
More women than men are diagnosed with dementia and also more women than men become carers of a person with dementia, however, take up of current Dementia Support Services is disproportionate in relation to male carers. The Strategy is designed for anyone affected by dementia regardless of their gender. Specific initiatives intended to support proportionate take-up of services have already been incorporated into commissioned services across LLR. Contract performance information is reviewed by commissioners to monitor proportionality of service delivery and impact of any targeted initiatives.	Yes	Not considering the impact of gender can lead to missing ways support can be targeted to be more accessible to underrepresented groups. Furthermore, there is some complexity as males are less represented, however they also have lower rates of dementia diagnoses and are less likely to be carers. The nuances of gender representation are considered by commissioners when developing the strategy. Specific initiatives intended to support proportionate take-up of services have already been incorporated into commissioned Dementia Support Services across LLR. Contract performance information will continue to be reviewed by commissioners to monitor proportionality of service delivery and impact of any targeted initiatives, to inform ongoing service improvement.

Gender Reassignment:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
There may be a number of people in the target group who have undergone reassigned gender. The Strategy	Yes	Demographic data regarding gender reassignment for people with dementia is not collected using our local data sources so specific numbers of people affected by gender reassignment

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
will be equally available to those people and services are expected to be sensitive to their needs.		cannot be sourced. However, this is expected to be a low number due to how rare gender reassignment is in cohorts featuring older people. The unique challenges faced by people that have undergone gender reassignment have been identified in the secondary research undertaken by commissioners and presented to the dementia programme board at the beginning of the strategy review. Commissioners are aware of these challenges and will ensure that the support delivered and promoted as a result of the strategy will be conscious of specific needs that this demographic may have and will cater to these.

Marriage and Civil Partnership:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?
The strategy is designed for anyone affected by dementia regardless of their marriage or civil partnership status. As informal carers may be partners the Strategy links closely with the LLR Carer Strategy. Partners may also be acting for the person under a Lasting Power of Attorney or as next of kin. Due to the dementia relationships may be strained between partners and this is considered when thinking about carer support.	No

Sexual Orientation:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
The consultation and the final strategy actions will be equally accessible and appropriate to people in LGBTQ+ groups and will be required to address any specific needs and ensure staff supporting people have good equality training.	Yes	Ignoring this protected characteristic may lead to services that do not understand or recognise LGBTQ+ people backgrounds, relationships and life history. They may feel they are not able to express themselves and fear the reactions of heterosexual carers, family and other people they encounter. This could lead to people not feeling comfortable in for example group activities and leading to accessing support at time or crisis or at a later time than heterosexual people. The consultation and the final strategy will be equally accessible to LGBTQ+ people and will be required to be not discriminate and address any specific needs. Specifically the consultation will be promoted to the local LGBTQ+ Centre, as well as internal LGBTQ+ staff groups. Councils are also members of Stonewall and Commissioners are expected to have good equality training. Commissioners conducted secondary research to learn about challenges for people form LGBTQ+ communities and dementia

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
		which has informed the Strategy and will inform local delivery plans. The Strategy expects that all services used by people with dementia are accessible and aware of the potential LGBTQ+ discrimination including language and assumptions about life styles that can be predominantly heterosexual, that negative attitudes are challenged and positive images and activity is LGBTQ+ inclusive within services

Pregnancy and Maternity:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?
It is highly unlikely that there will be any people living with dementia affected by pregnancy or maternity directly. Some carers may be affected.	No

Religion or Belief:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
Religion and beliefs often intertwine with culture. Some professionals may not be aware of how people's religion and beliefs may impact on decision making at different stages of dementia. The Strategy seeks to raise awareness of the needs of people with dementia from different religious backgrounds and seldom heard groups and this work is linked to the work covered under section F Race. Dementia is a terminal and life limiting condition where increase medical care is needed, and people may not have mental capacity to make decisions or communicate their wishes.	Yes	Not considering the impact of religion or belief will omit the need for person centred support and could potentially exclude some groups from receiving dementia diagnoses and interventions as well as receiving care that is appropriate to their religion and belief. The Dying well actions contained in the Strategy aim to ensure that end of life decisions and medical interventions are cohesive with people's religion and beliefs. This will be monitored via local delivery plans to the DPB. Within the strategy there is a section relating to living well where there will be a focus on supporting people from seldom heard groups as with race, the Strategy seeks to recognise and be responsive to the needs of people from a variety of religions or belief systems, which may be different from those of the majority population and may require specific person-centred support. On top of the actions covered in section f around expectation and partnership

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?	What are the identified risks or concerns and how they will be mitigated?
		working, local organisational and placed based plans will address this need where they consider there are gaps.

Other groups: e.g., rural isolation, deprivation, health inequality, carers, asylum seeker and refugee communities, looked after children, deprived, armed forced, or disadvantaged communities:

What are the benefits of the proposal for those from the following groups?	Is there any specific risks or concerns?
The specific work referenced earlier regarding a focus on under represented groups will provide an opportunity to further develop services to meet the needs of all people in LLR affected by dementia.	No

Action Plan:

What concerns were identified?	What action is planned?	Who is responsible for the action?	Timescale
Poor data around people living with dementia broken down by protected characteristics.	Ensure that the local delivery plans have an appropriate focus on under represented groups broken down by protected characteristics.	Commissioners in each Local Authority.	First 6 months of strategy (as a part of delivery plan development).

How will the action plan and recommendations of this assessment be built into decision making and implementation of this proposal?: the action plan and recommendations of this assessment will be a standing agenda item in the meetings of the Leicestershire Dementia Strategy Delivery Group.

How would you monitor the impact of your proposal and keep the EIA refreshed?: Through the above meeting and also through the LLR Dementia Programme Board.

Date of completion: 2023-05-16

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 1 NOVEMBER 2023

INTERMEDIATE MINOR ORAL SURGERY

REPORT OF THE LEICESTERSHIRE AND RUTLAND LOCAL DENTAL COMMITTEE

Purpose of report

1. The purpose of this report is to make the Health Overview and Scrutiny Committee aware of the dental profession's concerns about the discontinued recommissioning process for Intermediate Minor Oral Surgery (IMOS) in Leicestershire and the risks associated with a rerun of the tendering process. The Committee is asked to listen, consider and respond as it feels appropriate. This could include raising concerns with the commissioners (the Integrated Care Board (ICB) and NHS England).

Policy Framework and Previous Decisions

2. Intermediate Minor Oral Surgery (IMOS) has been a referral service for over 16 years and is provided within a community setting. The service provides specialist treatment e.g. complex dental extractions by a clinician with enhanced skills and experience that is either on the oral surgery specialist list or accredited in line with national guidance. Treatment may be provided under local anaesthetic and the clinician may use quality behavioural management techniques or provide treatment under conscious sedation where appropriate for minor oral surgery procedures. Once the one-off treatment has been completed, the patient is then returned to the referring General Dental Practitioner.

3. From 1 April 2023, the ICBs have been responsible for commissioning NHS Dental Services e.g. primary, community and secondary care to meet the local population needs.

4. The East Midlands Minor Oral Surgery Needs Assessment was refreshed in December 2021 to support with developing commissioning intentions to meet population need.

5. A Midlands IMOS service specification has been developed in line with the NHS England Oral Surgery Commissioning Guide to standardise the service model, payments and reduce inequalities in access/treatment under conscious sedation, where appropriate. Approval was obtained to enable new Personal Dental Services Agreement with a contracting term of 10 years (7 years with the option to extend for a further 3 years).

6. The IMOS procurement process was published on 25 August 2022 following market engagement webinar and due to the large scale of the procurement exercise being undertaken, bidders would be notified of the outcome in May 2023. The new contracts to commence on 1 December 2023 following a 6-month mobilisation period. All bids were assessed to determine they were compliant e.g. all sections

have been completed to enable them to pass through to the evaluation phase. As part of the evaluation, bids were required to pass mandatory questions and meet a quality threshold of 60% and the bidder with the highest score for each individual lot who met this criteria would be identified as the preferred bidder.

7. The commissioners have said that the general quality of bids was poor with a surprisingly high level of bids which failed at various gateway stages of the process. They have taken the decision to abandon the procurement in its entirety and not to award any contracts.

8. Bidders were notified of the outcome of the procurement process on 30 August 2023 and assurance has been given that the strategic need to recommission IMOS services across the East Midlands has not diminished or changed.

Background

9. Due to the outcome of the previous procurement exercise, the commissioner has agreed to extend existing IMOS services across the Leicestershire and Rutland for and initial period of 1 year and then up to 2 years in 6-month intervals, if required, to maintain patient access to the specialist tier 2 IMOS service. This will enable the commissioners to use lessons learned from this process to engage in pre-procurement market engagement activities to support potential providers, in order to support and educate on the tendering process in a way that the commissioners hope will significantly increase the quality of bids received. The commissioner is planning to launch a second procurement exercise in November 2023.

10. The dental profession is concerned that without recognition and correction of flaws within the procurement process and the design it is likely that the outcome of any further process will result in bidders again failing to meet the requirements of the procurement. We also believe that as currently designed this procurement will reduce access for to Intermediate Minor Oral surgery services for residents within Leicestershire & Rutland, with the four existing sites being reduced to one.

Proposals/Options

11. The commissioners plan to rerun the procurement, starting in November 2023, prior to this they are running two webinars in October 2023 support and educate potential bidders on the tendering process.

12. The LDC would like to see: -

    - a further pause before any new procurement.
    - revaluation of the lot design.
    - A review of the process document.
    - more time given to bidders to complete the procurement.
    - a cost analysis of the costs involved to providers in delivering the service.

Consultation

13. A professional and public consultation was held by NHS England prior to the original procurement.

Resource Implications

14. NHS dentistry in England is funded by a combination of payments from NHS England and NHS Improvement (via the NHS Business Services Authority) and patient charges. Some groups of patients are entitled to free dental treatment.

15. Currently providers are paid £174 for a typical case, a fee which has remained unchanged since 2012. This will be reduced to £141.42 under the new contracts.

Timetable for Decisions

16. A rerun of the procurement is due to commence on 1st December 2023.

Conclusions

17. Multiple concerns were raised by the dental profession in December 2021 about the design of this procurement. Whilst some additional lots were introduced the procurement otherwise went ahead as originally planned, in August 2022. Contracts were due to be awarded in May 2023. The award was postponed several times, and the process was discontinued in August 2023. The stated reason is that the general quality of bids was poor with a surprisingly high level of bids which failed at various gateway stages of the process.

18. The commissioners plan to repeat the procurement later this year. The dental profession is concerned that all blame for the outcome is being directed at the bidders, with no recognition of the flaws within the procurement process. We are also concerned that without radical change to the design of the procurement outcomes will remain unchanged.

Appendices

Appendix A – NHS Brief for Health and Wellbeing Board
Appendix B – Letter to current providers
Appendix C – Public Consultation report

Officer to Contact

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APPENDIX A

Intermediate Minor Oral Surgery East Midlands Stakeholder Briefing

1 Introduction

The purpose of this briefing paper is to provide an update to Health and Wellbeing Boards, Overview and Scrutiny Committees and key stakeholders on the East Midlands Intermediate Minor Oral Surgery (IMOS) services procurement process and next steps.

2 Background Information

From 1 April 2023, the five East Midlands ICBs are now responsible for commissioning NHS Dental Services e.g. primary, community and secondary care to meet the local population needs.

Intermediate Minor Oral Surgery (IMOS) is a referral service for over 16 years and is provided within a community setting. The service provides specialist treatment e.g. complex dental extractions by a clinician with enhanced skills and experience that is either on the oral surgery specialist list or accredited in line with national guidance. Treatment may be provided under local anaesthetic and the clinician may use quality behavioural management techniques or provide treatment under conscious sedation where appropriate for minor oral surgery procedures. Once the one-off treatment has been completed, the patient is then returned to the referring General Dental Practitioner.

The IMOS contracts are commissioned using a Personal Dental Services (PDS) Agreement, the earliest of which commenced in 2008/09 and are due to expire. The existing contractual agreements have no Units of Dental Activity (UDA) contracted activity nor financial value, financial payments are made in arrears based on claims submitted for cost per case for either assessment, assessment and treatment or assessment, treatment and sedation.

There are 36 IMOS providers across the East Midlands area, which cover Northamptonshire, Leicester, Leicestershire & Rutland, Lincolnshire, Derbyshire and Nottinghamshire. Due to historic contracting arrangements, the service arrangements are on different contracting terms and payments rates. Within the existing contracting arrangements treatment may be provided under conscious sedation in Derbyshire and Nottinghamshire, however, there is limited access in Lincolnshire/Northamptonshire and no access in Leicester, Leicestershire and Rutland. In 2019/20, the service accepted approximately 37,000 referrals and treated 33,000 patients.

A Midlands IMOS service specification has been developed in line with the NHS England Oral Surgery Commissioning Guide to standardised the service model, payments and reduce inequalities in access/treatment under conscious sedation, where appropriate. Approval was obtained to enable new Personal Dental Services Agreement with a contracting term of 10 years (7 years with the option to extend for a further 3 years).

An East Midlands Minor Oral Surgery Needs Assessment was refreshed to support with developing commissioning intentions to meet population need. Engagement and consultation processes were undertaken to seek feedback from patients and public, dental profession and key stakeholders. The consultation proposal sought views on 10 proposed locations across the East Midlands. The feedback was considered, and the proposed locations were revised from 10 to 17.

3 Procurement Process and Outcome

The IMOS procurement process was published on 25 August 2022 following market engagement webinar and due to the large scale of the procurement exercise being undertaken, bidders would be notified of the outcome in May 2023. This is to enable sufficient time for bids to be evaluated. The new contracts to commence on 1 December 2023 following a 6-month mobilisation period. All bids were assessed to determine they were compliant e.g. all sections have been completed to enable them to pass through to the evaluation phase. As part of the evaluation, bids were required to pass mandatory questions and meet a quality threshold of 60% and the bidder with the highest score for each individual lot who met this criteria would be identified as the preferred bidder. A project group of Subject Matter Experts evaluated the bids.

Bidders have been advised there has been a slight delay regarding outcome notification. There has been a 3-month delay to notifying bidders of the outcome of the procurement exercise to enable internal governance processes to be undertaken.

We can confirm that there was sufficient interest shown across all 17 Lots (new contracts), however, upon evaluating submissions the general quality was poor with a surprisingly high level of bids which failed at various gateway stages of the process. The commissioners have therefore taken the decision to abandon the procurement in its entirety and not to award any contracts in respect of any of the 17 lots on the basis that to commission any of these IMOS services on a piecemeal basis, and to continue with this procurement, would result in an unworkable and unmanageable mixed economy of old and new service models, which would negatively affect equity of access for patients and increase budget pressures.

Bidders have been notified of the outcome the procurement process on 30 August 2023 and assurance has been given that the strategic need to recommission IMOS services across the East Midlands has not diminished or changed.

4 Next Steps

Due to the outcome of the procurement exercise, it has been agreed to extend existing IMOS services across the East Midlands for and initial period of 1 year and then up to 2 years in 6-month intervals, if required, to maintain patient access to the specialist tier 2 IMOS service. This will enable the commissioners to used lessons learned from this process to engage in pre-procurement market engagement activities to support potential providers, in order to support and educate on the tendering process in a way that the commissioners hope will significantly increase the quality of bids received. The commissioner is planning to launch a second procurement exercise within the next 12 months.

We will continue to update Health and Wellbeing Boards, Overview and Scrutiny Committees and key stakeholders on our recommissioning plans.

APPENDIX B

Ref: 2023 08 30 EM IMOS Provider Let v1.2

Addressed to:
East Midlands IMOS Providers

Working on behalf of the 5 Integrated Care Boards in the East Midlands Dental Team
County Hall
Leicester Road
Glenfield
Leicester
LE3 8RA

Email address: england.em-pcdental@nhs.net

30 August 2023

Dear Provider

East Midlands Intermediate Minor Oral Surgery Services

We are writing to all East Midlands Intermediate Minor Oral Surgery (IMOS) Services Providers to provide an update on the future arrangements.

As you are aware, we extended all the existing IMOS services until 30 November 2023 whilst we undertook an East Midlands IMOS procurement process. The procurement process has concluded.

We can confirm there was sufficient interest shown in all the seventeen lots across the East Midlands. However, a surprising high level of bids failed at various stages of the process which meant the quality was not high. Therefore, the Commissioners have taken the decision to abandon the procurement in its entirety and not to award any contracts in respect of any of the seventeen lots on the basis that to commission any of these IMOS services on a piecemeal basis, and to continue with this procurement, would result in an unworkable and unmanageable mixed economy of old and new service models, which would negatively affect equity of access for patients and increase budget pressures.

To support patient access to services, we have obtained approval to extend all existing IMOS PDS Agreements for an initial 12 months with the option to extend in periods of 6 months up to a maximum of 24 months. This ensures that access to tier 2 IMOS services is maintained across the East Midlands whilst we undertake a further procurement process within the next 12 months. We hope you will agree to extend your agreement with us. A contract variation will be drafted and shared with you for signature shortly.

If you have any further queries, please contact us via our generic inbox at england.em-pcdental@nhs.net. We would like to take the opportunity to thank you and your teams for continuation of provision of IMOS services for patients across the East Midlands.

Yours Sincerely

Caroline Goulding
Head of Primary Care Services (East Midlands)
Working on behalf of 5 Integrated Care Boards

Intermediate Minor Oral Surgery services in Leicester, Leicestershire and Rutland

Public Consultation Report

February 2022

Contents

Introduction

Intermediate Minor Oral Surgery

Oral surgery is surgical treatment in the mouth. This includes the removal of teeth. Most oral surgery is undertaken in general dental practices, although some patients are referred elsewhere for treatment. The most complex oral surgery is undertaken in hospitals. Sometimes the treatment required is beyond the remit of a general dental practice, but not sufficiently complex to be undertaken in a hospital. In these instances, treatment may be undertaken by an Intermediate Minor Oral Surgery (IMOS) service.

IMOS services treat patients aged 16 years and over who are referred by their regular dentist for specific oral surgery treatment. Sometimes this involves conscious sedation, which is the use of medication to help patients to relax during treatment. When the treatment has been undertaken, patients return to their regular dentist for ongoing care. IMOS services do not offer general dental services or treatment for children.

Background

The contractual arrangements for the current IMOS services in Leicester, Leicestershire and Rutland will soon end, along with those for the other IMOS services across the East Midlands. These contracts are time-limited and cannot be extended. New IMOS services are being developed to meet Leicester, Leicestershire and Rutland's current and future needs, with the views of stakeholders playing an integral part in this process.

An online engagement exercise for IMOS patients, the public and dental professionals was undertaken in mid-2021. This was followed by a market engagement exercise for current and potential IMOS service providers. These jointly constituted the first stage of the consultation process on the new IMOS services. A proposal for the new services was subsequently developed, informed by a needs assessment.

Public Consultation

A public consultation was undertaken to capture feedback on the proposal for the new services, forming the second stage of the process. The consultation ran from 23 November 2021 to 21 December 2021, with responses to the questions submitted via a dedicated online portal. The information and questions were also available in alternative formats on request.

The public consultation was promoted via the following channels:

1. NHS England and NHS Improvement consultation website
2. NHS England and NHS Improvement consultation App
3. NHS England and NHS Improvement Twitter feed
4. Patients referred to an IMOS service in Leicester, Leicestershire and Rutland; 20% of recently referred patients were invited to participate using the contact details associated with their referral. This was deemed a sufficient proportion of patients to constitute a representative sample
5. Primary care dental bulletin
6. Local Dental Network bulletin
7. E-mail to dental professionals, with QR code links to the public consultation
8. Dental professional webinar
9. Engagement sessions for Integrated Care System and Clinical Commissioning Group representatives

A number of stakeholders also cascaded the details of the consultation to maximise its reach.

The Proposal

The proposal was for IMOS services to operate from one location in Leicester, Leicestershire and Rutland:

1. Leicester

The detail of the proposal is in Appendix 1.

Respondents

A total of 74 responses were received (Table 1, Table 2, Table 3, Table 4).

Table 1. Respondent type

	Number
Patient	20
Member of the public	29
Carer	0
Dental professional	17
Non-dental healthcare professional	1
Voluntary sector representative	1
Other	5
Prefer not to say	1
Not answered	0
Total	**74**

Table 2. Sex of respondents

	Number
Female	44
Male	24
Non-Binary	0
Prefer not to describe myself	2
Prefer not to say	4
Not answered	0
Total	**74**

Table 3. Age of respondents

	Number
16 - 24	0
25 - 34	6
35 - 59	37
60 - 74	22
75+	4
Prefer not to say	5
Not answered	0
Total	**74**

Table 4. Disability status of respondents

	Number
Yes	10
No	53
Prefer not to say	9
Not answered	2
Total	**74**

Responses

The responses received were analysed thematically under the headings below, alongside selected quotations pertinent to the themes. The quotations are verbatim, although in some instances they do not represent entire responses in the interests of brevity and the preservation of respondent anonymity.

Location

Location featured in many responses and comments on a single IMOS location in Leicester were generally negative. The area was considered too large for just one location, with concerns raised about congestion, the time required to reach the city and its distance from some of the rural areas it would serve. Respondents felt travelling to Leicester would be inconvenient and stressful, with several local locations preferred.

A reduction in the current number of IMOS services in Leicester was viewed as prudent, although it was highlighted that the proposal deprived large parts of the county of easy access. Some responses suggested service locations elsewhere in Leicestershire and Rutland, including Melton Mowbray, Loughborough and Oakham. Alternative proposals included a single out of town location with good road links, and a model with five locations, two of which would be in Leicester.

Several respondents stated that those living in Rutland typically found it more convenient to access services in Peterborough or Stamford than in Leicester. The proposal was however deemed to be at odds with increasing the services available in Rutland, the subject of a heath strategy that was under consultation.

"Patients rarely request being referred to Leicester, choosing other locations to avoid the City."

"Providing one venue in Leicester is not really suitable in such a large area."

"Travel into Leicester is often slow due to traffic."

"It's seems it's great for central Leicester people but anyone else it's going to be a real struggle."

"Whilst I agree that there is a need to rationalise the service, which is currently top-heavy in Leicester, these proposals go too far. They will deprive large parts of the county of easy access to the IMOS service"

"Why not have one for Leicestershire, one for Leicester and one for Rutland to minimise travel and therefore time required for appointments."

"Agree with combining to a single location, providing an out of town location can be found, which has fast road links."

"Rutland County Council presently consulting on their health strategy which talks of bringing services into Rutland, so your proposal is at odds with this."

Travel and Transport

Travel was a recurring theme throughout the responses. Bus and train services were considered slow and inadequate, and irrelevant for patients following conscious sedation for whom parking was deemed essential.

It was stated that the proposed service model promoted car usage and that patients from rural areas would either drive – or be driven – to appointments. Some respondents were not comfortable driving in Leicester on account of the congestion and difficulty parking.

The environmental impact of travel was mentioned, with car sharing schemes suggested to mitigate this. The impact of the time spent travelling on childcare arrangements and the possibility that travel costs could deter patients from having treatment were also cited.

"Patients having sedation will not be able to take public transport home- so it is irrelevant if its close to Train, bus and car parking is in this situation essential"

"You are encouraging people to use cars as the journey to Leicester is problematic from here, either bus to train station, train to Leicester, bus to access Leicester site - if there is one from the station, otherwise taxi."

"parking and traffic congestion cause huge issues"

"Patients will be travelling more using more fuel and time increasing carbon emissions at a time when we are all very mindful about reducing our carbon footprint."

"You need to look at making car schemes available to patients. making patients aware of such."

"It's not just about cost - it's about time, childcare etc. It will take many hours to get there, have treatment and get back again"

"This will result in unreasonable transport costs for some who will not be able to afford it and will result in them not having treatment when needed."

Service Provision

The proposed service model was perceived as the creation of a monopoly that would limit choice, capacity and resilience. Operating services across multiple locations was believed to be best, not only ensuring choice and resilience, but improving quality through increased competition.

There was a feeling that with a single IMOS location the waiting time for appointments would rise, along with the number of missed appointments. The latter was considered likely to increase the number of emergencies presenting in hospital settings. A single location was also said to compromise the management of post-treatment complications.

Other feedback included a perception of a move towards private services and the importance of making information on free care available. The inclusion of provision

for children and the merging of IMOS services with general dental services to streamline management were suggested.

> *"I feel it is inappropriate to have one single provider responsible for the delivery of all IMOS services within Leicester. Patients will not have choice and empowers one single provider."*
>
> *"for resilience you should have several providers so that reliance is not on one contractor"*
>
> *"You need to state what and how to go about receiving care free of charge this money would be needed to pay for travel."*

Referrals

It was expressed that clarity was needed regarding the criteria for referrals to IMOS services. Operating a two-level IMOS service, with dentists with a special interest (DWSI) in oral surgery at one level and specialists at another, was put forward. It was suggested this two-level model would improve the triage process and reduce the burden placed on hospital services.

Competition between providers for referrals was raised as a criticism of the current model, with a centralised service considered more appropriate to manage this. It was highlighted that at present the encouragement or discouragement of referral patterns were incentivised and this activity was viewed negatively.

> *"Clear criteria is required to referral"*
>
> *"to improve triaging, it would be worthwhile considering have 2 levels for tier 2- one for DWSI and the other for OS specialists , again to reduce the burden on the hospital service"*
>
> *"Agree that it would be better to centralize the service to one point for the region. Will reduce tactics from competing MOS providers to encourage or discourage referrals to be sent to particular sites. Some are known for borderline illegal practices and incentives"*

Conscious Sedation

Many respondents remarked on conscious sedation. Thoughts on its availability ranged from limiting its provision to a single, central location, to offering it only within a hospital setting. The requirement for a pre-conscious sedation assessment, a chaperone and recovery facilities were noted. Patients' anxiety regarding treatment and safety concerns also featured in responses.

The need for a minimum of 50 conscious sedation cases to be annually for the maintenance of a clinician's skills was raised, as was the potential for demand to increase in line with availability.

> *"It would be beneficial to have a central location that offers sedation but on the whole it is not needed to be provided at every location."*
>
> *"I believe if we were to provide sedation services openly, it would increase the number of visits a patient needs to make, they would have to be seen preoperatively and for the procedure itself. If services are offered then it has been shown that the service uptake will rapidly increase to fill the service"*
>
> *"if sedated will need a chaperone"*

Workforce

Recruiting the workforce required for the operation of IMOS services was seen as a potential challenge, particularly the attraction of clinicians from other services. Establishing centres of excellence so the area can gain recognition for its training and increasing the number of oral surgeons outside of specialist services were suggested.

> *"create centres of excellence so that the area is established as a beacon for dental training around the UK and the world"*
>
> *"There needs to be an increase in the number of oral surgeons who are willing to work in primary NHS care."*

Population

A few responses referenced specific population groups, with a view to ensuring they could access IMOS treatment. These were the elderly, disabled, those with mobility difficulties and health conditions, and single parents. The impact of attending appointments for those in employment and education was raised.

> *"A lot of patients needing oral surgery are elderly"*
>
> *"Removing current provisions will put additional stress on the elderly, disabled and single parents who will have to find extra time and resources to get to and from appointments"*
>
> *"If children need to access your service, this will probably necessitate missing a whole day of school. Also this in full-time employment."*

Current IMOS Services

The current IMOS services drew comments from some respondents. These referred positively of appointment availability, the management of complications, and the value of familiar premises. It was acknowledged that the COVID-19 pandemic had increased the waiting times for appointments, although the efforts of staff had since seen these reduce.

The services were commended nationally for their role in reducing the number of oral surgery cases requiring hospital care. Patient experiences were mixed, with both positive feedback and communication issues reported. The services' reputation was praised, yet they were considered inefficient. The commissioners' approach to managing the services, along with provider-level governance issues, were associated with extant issues and failings.

"We are able to see patients early morning and late evenings under the current system. We currently have very little if any issues with patients unable to access the service due to appointment times."

"wait times have been reduced since the pandemic to 8-10 weeks due to the hard work of all the performers"

"Never contact about the referral still waiting. received a text just as if the procedure had been completed and still waiting to hear. nothing heard yet."

"Many of my patients travel specifically to see me due to previous experience all reputation"

"I'm also under no dissolution that the current service is not the best or the most efficient service out there. But I believe firmly that this is an issue of how the service is managed and policed by the commissioners and potentially the governance within each site. Call robust feedback systems for the providers and performers could address many of the issues and failings of the current system."

Patient Survey

An IMOS patient survey had been undertaken across multiple services in the area; it received 53 responses. A service-level survey had also been undertaken and received 31 responses. The themes within both have been analysed under the headings above. Regional surveys that found high levels of patient satisfaction with the current services were also mentioned, but the responses were not quantified.

Other Themes

A number of responses covered themes that were not relevant to the consultation. These were previous and forthcoming procurement processes, the selection of future service providers, the credentials of particular premises with a view to future service delivery, business sponsorship opportunities and maternity services.

Consultation Process

A broad range of feedback was received on the consultation process. Some respondents stated how they learnt of the consultation; family members, healthcare pressure group, communication from the local dental committee, pre-consultation event, Facebook, a Member of Parliament's social media account and an app were all mentioned.

It was highlighted that local medical and dental services and the local press had not promoted the consultation and it was felt that leaflets about it should have been distributed to houses. It was hoped that participation in the consultation would be substantial, but there was uncertainty concerning how wide awareness of it was and consequently how representative the responses would be. Others felt that the consultation was secret to avoid objections to the proposal, or that the decision had already been taken.

The format of the consultation was both applauded and criticised, in the latter case because of the potential for digital exclusion.

Several respondents felt the consultation process was too short and its timing was considered sub-optimal on account of pressures imposed by Christmas and COVID-19. Some expressed a preference for more information or felt that the nature of the consultation meant that only limited feedback was possible. Greater scope to provide input into the proposals, in particular from current service providers, would have been appreciated. The lack of opportunity to provide feedback at a consultation event was also raised.

It was requested that the results of patient satisfaction surveys be included when making decisions about future IMOS services and that previous IMOS patients be contacted for their views.

Selected quotations from the comments on the consultation process are included below. They are verbatim, but as with the quotations above some have been shortened in the interests of brevity and anonymity.

“Saw this news on my MPs social media.”

“I was informed by email”

“I only found out about this consultation as I am on a mailing list for a local healthcare pressure group. I have seen no other advertising for it at all, even from my local surgery where I have signed up for communications.”

“I hope the participation in this survey is substantial.”

“Should be a leaflet drop to each house affected”

“Fine to be informed.”

“I feel that the consultation has been too short in timescale. It has been started in the run-up to the Christmas holidays which for many practices is a particularly busy time and is very difficult to organise patient questionnaires and surveys.”

“Far too brief information which does not include why it will be any better than the poor service we all receive at the moment.”

Outcome

NHS England and NHS Improvement express their gratitude to all the respondents to the public consultation on IMOS services in Leicester, Leicestershire and Rutland. The broad respondent profile and the range of themes considered provided an invaluable insight into the perspectives and priorities of the local population.

The proposal in the public consultation was designed to align IMOS service provision with Leicester, Leicestershire and Rutland's current and future population and its oral health needs, as identified by a needs assessment. While the modelling undertaken verified the proposal's clinical, logistical, and financial viability, there were clear benefits to developing an alternative model based on the consultation feedback.

The alternative model reflects the consultation feedback, remains aligned with current and future needs and is clinically, logistically, and financially viable. Within the alternative model, IMOS services would operate from four locations in Leicester, Leicestershire and Rutland:

1. Coalville
2. Leicester North West
3. Leicester East
4. Leicester South

The alternative model enhances patient choice and resilience, with services at four locations. Retaining the majority of clinical provision in Leicester facilitates equity, while ensuring those from elsewhere in Leicestershire and Rutland do not have to travel into the city centre to access care.

With respect to waiting times, Leicester, Leicestershire and Rutland's projected population growth has been used to model future IMOS service capacity. The number of appointments will be increased, to ensure provision is adequate and that patients receive treatment within 18 weeks of referral. The contractual framework

within which the new IMOS services will operate has also been designed to address the concerns cited around referral activity. NHS England and NHS Improvement will continue to monitor IMOS waiting times and referral activity closely, so potential issues may be identified and overcome.

Conscious sedation is not currently provided within IMOS services in Leicester, Leicestershire and Rutland. However, experience from other areas has indicated that its provision is advantageous, and it will therefore be available for patients at all new IMOS services. It is acknowledged that while many patients will not require conscious sedation for IMOS treatment, its availability at all services will obviate the need for onward referral for those who do.

Regarding concerns about the cost of travel, patients on low incomes who incur travel costs when accessing IMOS services can claim reimbursement through the Healthcare Travel Costs Scheme (HTCS)[1]. The HCTS reimburses the cost of public transport, fuel, parking, taxi fares (where agreed in advance) and travel costs for escorts where it is medically necessary for patients to be accompanied. In response to feedback, NHS England and NHS Improvement will work on increasing awareness of the HCTS, so the cost of travel does not restrict access to IMOS services.

The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013[2] detail the requirements that the NHS must comply with in the commissioning of services. Developing a service model in a fair and transparent way, that ensures quality and efficiency, is central to the process. Based on this premise, a comprehensive review of all relevant factors, and the necessary governance processes and approvals, it has been decided to proceed with the alternative IMOS service model outlined above.

It is anticipated the new IMOS services in Leicester, Leicestershire and Rutland will be operational and treating patients from April 2023.

[1] https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/
[2] https://www.legislation.gov.uk/uksi/2013/500/contents/made

Appendix 1. Public Consultation Information

Have your say on Intermediate Minor Oral Surgery services in Leicester, Leicestershire and Rutland

Public Consultation

What are Intermediate Minor Oral Surgery Services?

Oral surgery is surgical treatment in the mouth. This includes the removal of teeth. Most oral surgery is undertaken in general dental practices, although some patients are referred elsewhere for treatment. The most complex oral surgery is undertaken in hospitals. Sometimes the treatment required is beyond the remit of a general dental practice, but not sufficiently complex to be undertaken in a hospital. In these instances, treatment may be undertaken by an Intermediate Minor Oral Surgery (IMOS) service.

IMOS services treat patients aged 16 years and over who are referred by their regular dentist for specific oral surgery treatment. Sometimes this involves conscious sedation, which is the use of medication to help patients to relax during treatment. When the treatment has been undertaken, patients return to their regular dentist for ongoing care. IMOS services do not offer general dental services or treatment for children.

Why is the consultation taking place?

The contractual arrangements for the current IMOS services in Leicester, Leicestershire and Rutland will soon end, along with those for the other IMOS services across the East Midlands. These services were established in 2011 when Leicester, Leicestershire and Rutland's population and its oral health needs were different to those today. A new IMOS service is being developed to meet Leicester, Leicestershire and Rutland's current and future needs. Feedback on the proposed changes is important and this consultation is your opportunity to share your views.

What are the current IMOS services in Leicester, Leicestershire and Rutland?

The **current** IMOS services operate from ten locations in Leicester, Leicestershire and Rutland:

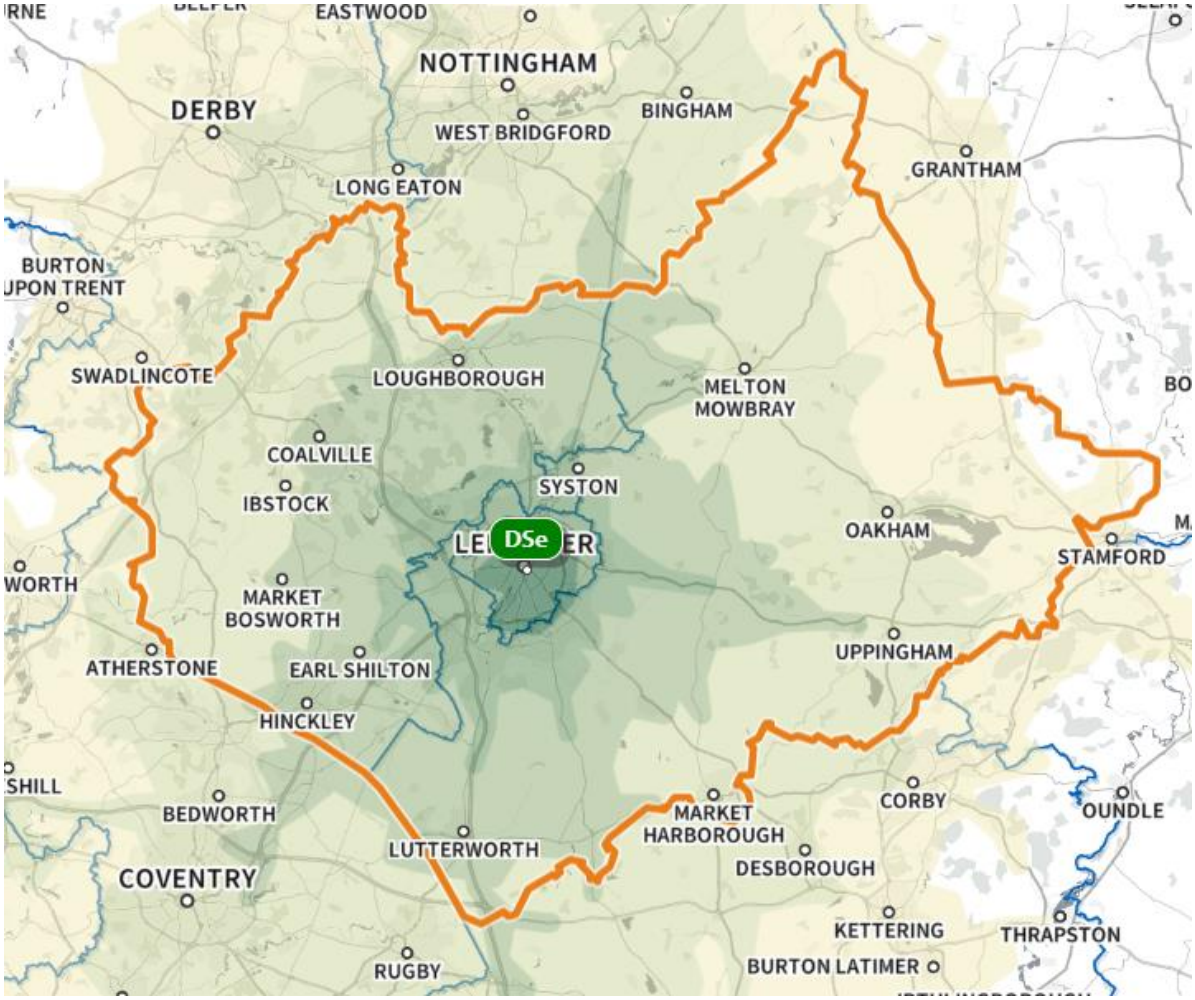
1. Six locations in Leicester
2. Coalville
3. Hinckley
4. Market Harborough
5. Loughborough

What is the proposed IMOS service in Leicester, Leicestershire and Rutland?

The **proposed** IMOS service would operate from one location in Leicester, Leicestershire and Rutland:

1. Leicester

The map below shows the proposed location and off-peak journey times by car. The proposal is for the service to be located no more than 2.5km (1.55 miles), as the crow flies, from the main railway station.



DSe Proposed IMOS service location

10 20 30 45 60 Off peak journey time by car, in minutes, from the proposed IMOS service locations

What are the benefits of the proposed IMOS service?

- Location will be accessible by car, train and bus
- Choice of appointment times will be improved
- Treatment will be undertaken within 18 weeks of referral
- Conscious sedation will be available
- Scope for managing complications following treatment will be improved

- Service resilience will be improved

What factors were considered in developing the proposed IMOS service?

A broad range of factors were considered, to ensure the proposed service meets Leicester, Leicestershire and Rutland's current and future oral health needs. These included:

- Population and projected population growth, to ensure sufficient service capacity
- Population oral health, to align the service location with the area where oral health is poorest and the need for the service is greatest
- Deprivation, as those living in deprivation have the poorest general health and oral health and the greatest need for treatment
- Ethnicity, on account of differences in general health and oral health between ethnic groups
- Travel time by car, train and bus, for accessibility
- Current IMOS service usage, to identify areas from which patient numbers are lower than expected
- Feedback from previous IMOS engagement exercises, to incorporate the views of those who engaged
- Guidance on the commissioning of oral surgery services, to ensure best practice is adopted
- Financial provision, so that best use may be made of all available funding

Are the patient charges for the proposed IMOS service the same as for the current IMOS services?

Yes. The standard NHS charge for assessment and oral surgery treatment will apply. This is currently £65.20. There will continue to be no charge for patients who are exempt from patient charges.

How can I provide feedback?

By clicking the link below, you will be directed to a series of questions. All feedback is important, and it will be analysed and shared after the consultation closes.

If you have a query, or if you require the information or questions in an alternative format, please contact england.em-dentalengage@nhs.net.

Leicester, Leicestershire and Rutland Integrated Care Board

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 1 NOVEMBER 2023

INTERMEDIATE MINOR ORAL SURGERY SERVICES

REPORT OF THE LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Purpose of report

1. The purpose of this report is to provide information on the 2022/23 East Midlands Intermediate Minor Oral Surgery Services procurement process outcome and next steps to recommission services.

Policy Framework and Previous Decisions

2. Key stakeholder briefings on the commissioning intentions have been shared for information.

3. The East Midlands Intermediate Minor Oral Surgery Procurement process complied with Public Contract Regulations 2015.

4. The service was developed in line with NHS England's Oral Surgery Commissioning Guide, 2015, Commissioning Dental Services: Services Standards for Conscious Sedation in a primary care setting and Society for the Advancement of Anaesthesia in Dentistry (SAAD) standards.

5. Intermediate Minor Oral Surgery performers are required to adhere to NHS England's Level 2 Accreditation commissioning guidance.

Background

6. NHS England was responsible for commissioning of NHS Dental Services until the end of March 2023. Since 1 April 2023, the East Midlands Integrated Care Boards (ICBs) have taken on the responsibility for commissioning NHS Dental Services e.g., primary, community and secondary care to meet the local population needs as part of delegation arrangements.

7. Intermediate Minor Oral Surgery (IMOS) is a referral service for over 16 years and is provided within a community setting. The service provides specialist treatment e.g., complex dental extractions by a clinician with enhanced skills and experience that is either on the oral surgery specialist list or accredited in line with national guidance. Treatment may be provided under local anaesthetic and the clinician may use quality behavioural management techniques or provide treatment under conscious sedation

where appropriate for minor oral surgery procedures. Once the one-off specialist treatment has been completed, the patient is then returned to the referring General Dental Practitioner.

8. The IMOS contracts are commissioned using a Personal Dental Services (PDS) Agreement, the earliest of which commenced in 2008/09 and was due to expire at the end of November 2023. The existing contractual agreements have no Units of Dental Activity (UDA) contracted activity nor financial value. Financial payments are made in arrears based on claims submitted for cost per case for either assessment, assessment and treatment or assessment, treatment and sedation (where commissioned).

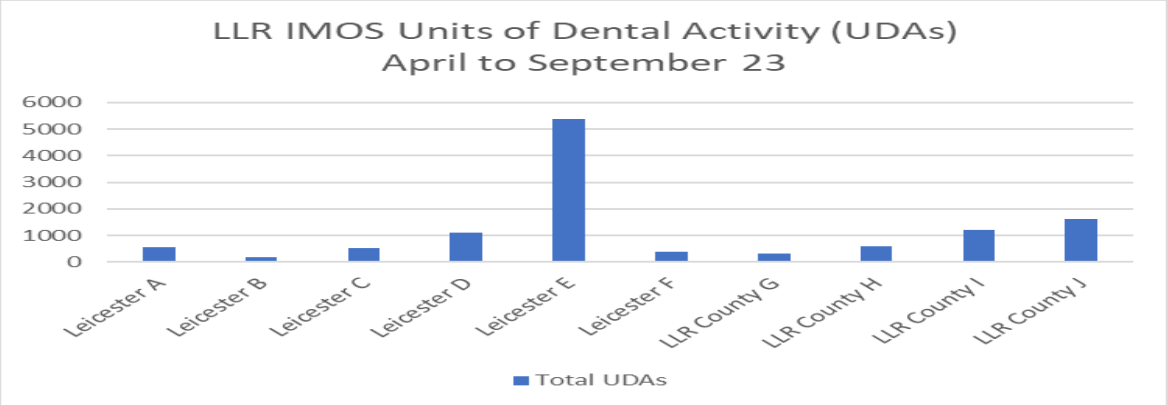
9. Due to historic contracting arrangements, the service arrangements are on different contracting terms and payments rates across the East Midlands. Within the existing contracting arrangements treatment may be provided under conscious sedation in Derbyshire and Nottinghamshire. However, there is limited access in Lincolnshire/ Northamptonshire and no access in Leicester, Leicestershire and Rutland. In 2019/20, the East Midlands service accepted approximately 37,000 referrals and treated 33,000 patients.

Current Service Provision

10. There are currently 36 IMOS providers across the East Midlands area which cover Northamptonshire, Leicester, Leicestershire and Rutland (LLR), Lincolnshire, Derbyshire and Nottinghamshire. Within LLR there are 10 providers, as shown in the table below.

Area	Existing Locations
Leicester, Leicestershire and Rutland	Leicester x 6 Coalville Hinckley Loughborough Market Harborough

11. However, the majority of activity is being delivered by one provider within Leicester, resulting in patients travelling into the centre of Leicester to access specialist one-off IMOS treatment. Within the existing arrangements there is no shared agreement for patients to flow between different ICB areas. The chart below sets out the LLR IMOS Units of Dental Activity (UADs) April to September 2023 summary.



12. All IMOS PDS Agreements have been extended until end of November 2024, with the option to extend for a further 6 months plus 6 months, if required to maintain access to specialist services whilst new services are recommissioned. We can confirm all existing IMOS providers across LLR have accepted and returned the signed Contract Variation.

13. There are currently 1,274 patients on the IMOS pathway for LLR and 536 patients waiting over 6 weeks to access treatment. The LLR ICB have supported a non-recurrent investment scheme to address the waiting list backlog. The waiting list position is being monitored on a monthly basis and this is reducing month on month.

Intermediate Minor Oral Surgery Health Needs Assessment

14. An East Midlands Intermediate Minor Oral Surgery Health Needs Assessment was refreshed to support with developing proposed commissioning intentions for formal consultation. The needs assessment is based on addressing and meeting local health needs and was published in February 2022. Analysis was undertaken utilising a wide breadth of data fields e.g.:

- Population;
- Deprivation;
- General and Oral Health;
- Ethnicity;
- Fluoridation;
- Current service; travel, clinical activity and remuneration;
- Stakeholder feedback.

15. The Commissioning intentions considered the following recommendations:

- The locations of IMOS services should be aligned to population oral health need, with resources targeted at the areas where need is greatest, as a means of reducing oral health inequalities.
- All IMOS services should offer a full range of Level 2 Oral Surgery procedures and conscious sedation.
- All IMOS services should have sufficient levels of clinical activity to ensure they are clinically, logistically and financially viable.
- All IMOS services should have scope to support workforce development, including the attainment and maintenance of competency in oral surgery and conscious sedation.
- All IMOS services should have robust quality assurance and quality improvement measures in place.

Contracting Arrangements and Service Model

16. A Midlands IMOS service specification has been developed in line with NHS England's Oral Surgery Commissioning Guide to standardise the service model, payments and reduce inequalities in access/treatment under conscious sedation, age criteria.

17. The new services will include key performance indicators and will have an annual contract value, subject to the Doctors and Dentists Renumeration Board (DDRB)

uplift and an annual activity target. The East Midlands ICBs have agreed that patients can flow across ICB borders.

18. Approval was obtained to enable new Personal Dental Services Agreement with a contracting term of 10 years (7 years with the option to extend for a further 3 years) to provide stability for patients and providers.

19. The standardised price was benchmarked across the Midlands and other regions to determine the Midlands IMOS rates, that demonstrates value for money. IMOS services have been successfully commissioned in the West Midlands at the standardised rate and similar or lower rates have been adopted to commission IMOS services elsewhere in England.

20. The table below sets out the IMOS new locations, which are based on the Minor Oral Surgery Needs Assessment and feedback received from engagement and consultation processes:

Area	**New Locations**
Leicester, Leicestershire and Rutland	Leicester North West Leicester East Leicester South Coalville

2022/23 Procurement Outcome

21. The IMOS procurement process was published on 25 August 2022, following a market engagement webinar and due to the large scale of the procurement exercise being undertaken, bidders were told they would be notified of the outcome in May 2023. This was to enable sufficient time for bids to be evaluated. The new contracts were due to commence on 1 December 2023, following a 6-month mobilisation period. All bids were assessed to determine their compliance e.g., all sections have been completed to enable them to pass through to the evaluation phase. As part of the evaluation, bids were required to pass mandatory questions and meet a quality threshold of 60% and the bidder with the highest score for each individual lot who met this criterion would be identified as the preferred bidder. A project group of Subject Matter Experts evaluated the bids.

22. Bidders were advised of delays regarding publishing the outcome notification to enable this to be considered by the new ICB governance process following delegation of commissioning responsibility from NHS England to ICBs.

23. On 30 August 2023, the IMOS procurement process outcome was published to the dental market explaining that the Commissioners had decided they would be abandoning the procurement in its entirety.

24. There was sufficient interest shown across all 17 Lots, however, upon evaluating submissions the general quality was poor with a surprisingly high level of bids which failed various gateway stages of the process.

25. After considering the process undertaken very carefully and after receiving legal advice, the Commissioners took the decision to abandon the procurement in its entirety and not to award any contracts in respect of the 17 lots on the basis to

commission any of these IMOS services on a piecemeal basis and to continue with this procurement would result in an workable and unmanageable mixed economy of old and new service models, which would negatively affect equity of access for patients and increase budget pressures. The notification published complied with the duty set out in Regulation 55 of the Public Contract Regulations 2015.

26. Assurance has been given that the strategic need to recommission IMOS services across the East Midlands has not diminished or changed.

Proposals/Options

27. Due to the outcome of the procurement exercise, it has been agreed to extend existing IMOS services across the East Midlands for an initial period of 1 year with the option to extend for 6 months plus 6 months, if required, to maintain patient access to the specialist tier 2 IMOS services. This will enable the commissioners to use lessons learned from this process to engage in pre-procurement market engagement activities to support potential providers, in order to support and educate on the tendering process in a way that the commissioners hope will significantly increase the quality of bids received. A second procurement exercise in Autumn 2023 is being planned.

28. Two market engagement events have been held on 12 and 19 October 2023 to provide support to the dental market on how they can improve the quality of their bid submissions. These have covered the five high level themes to support improving the quality of bid submissions, which were:

- Financial standing;
- Premises;
- Information governance;
- Core questions;
- Not responding to clarification question within the given deadline.

29. These have been recorded so these can be uploaded onto an ICB platform to enable the dental market to access. A financial self-assessment tool has been developed to support potential bidders to complete to identify if they would meet the financial standing required prior to bid submission. A questions and answer document will be collated and shared with the dental market along with the presentation slides and the example self-assessment tool.

30. Additional feedback has been obtained from discussion with the Local Dental Committees to support improving the process to support the dental market and this is being considered when finalising the procurement timeline and process.

31. As part of preparing for the next procurement process, we are undertaking the following:

- The timeline is being reviewed and will take on board feedback from the dental profession to enable bidders additional time to develop their tender submission. However, we cannot delay commencing procurement process, as we need to enable sufficient time to undertake the East Midlands wide procurement process and enable preferred bidders 6 months to mobilise services to secure future services to meet the population needs, address

inequalities in access to treatment due to varying age criteria and treatment under conscious sedation, whilst also demonstrating value for money.

- A Project Group will refresh the invitation to tender documentation, taking on board lessons learned to continually improve tender processes. Within the published documentation a tailored financial self-assessment tool will be included to enable bidders to assess whether they would meet the financial standing criteria prior to submission, along with high level price bench marking information.
- A further market engagement event detailing the commissioning intentions, lotting and procurement timeline will be advertised prior to launching the new procurement process.

Consultation/Patient and Public Involvement

32. As part of the pre procurement planning, a two-stage engagement and consultation process was undertaken to seek views and feedback from patients, public, dental profession and key stakeholders.

33. A four-week patient, public and dental profession engagement process was undertaken in May/June 21. Approximately 5,000 patients across the East Midlands who had received treatment under the IMOS pathway were contacted to complete the online engagement survey. Communications were sent to Healthwatch, Local Authorities and other voluntary organisations requesting their support to promote the public engagement and all East Midlands dental providers, Oral Surgery Managed Clinical Network, IMOS providers received communications regarding the engagement survey.

34. A public consultation was undertaken to capture feedback on the proposal for the new services, forming the second stage of the process. The consultation ran from 23 November 2021 for 4 weeks, with responses to the questions submitted via a dedicated online portal. The information and questions were also available in alternative formats on request.

35. The public consultation was promoted via the following channels:

- NHS England and NHS Improvement consultation website;
- NHS England and NHS Improvement consultation App;
- NHS England and NHS Improvement Twitter feed;
- Patients referred to an IMOS service in Leicester, Leicestershire and Rutland; 20% of recently referred patients were invited to participate using the contact details associated with their referral. This was deemed a sufficient proportion of patients to constitute a representative sample;
- Primary care dental bulletin;
- Local Dental Network bulletin;
- E-mail to dental professionals, with QR code links to the public consultation;
- Dental professional webinar;
- Engagement sessions for Integrated Care System and Clinical Commissioning Group representatives.

36. In addition, a number of stakeholders also cascaded the details of the consultation to maximise its reach. A follow up webinar in March 2022 was delivered to the dental profession to provide feedback on the consultation process and advise on proposed commissioning intentions.

37. The feedback received supported a reduction in the current number of IMOS services in Leicester and this was viewed as prudent, along with considering access for patients across the county and patients close to ICB borders preference, is to seek services in neighbouring ICB areas. As a result, the proposed one central location within Leicester was revised following consideration of the engagement and consultation feedback. The commissioning intentions determined 4 locations, 3 within Leicester and 1 based in Coalville. The locations have been determined using a public health algorithm to ensure these are in areas of greatest need, within a reasonable travel distance for LLR patients, sufficient activity to enable performers to maintain their clinical competencies and demonstrating value for money. The engagement and consultation processes confirmed that patients are willing to travel a reasonable distance to access specialist one-off treatment. A link to the published engagement and consultation documentation is included in the background papers section of the report.

Resources

38. Existing contract arrangement have been extended on existing terms and conditions.

39. The proposed annual agreement value for each Lot will be based on the standard price per Unit of Dental Activity (UDA) multiplied by the number of UDAs being commissioned for that Lot.

40. The benchmarked Price (based on 2022/23) is as follows:

Type of Treatment	**Price £**	**Unit of Dental Activity (UDA)**
Assessment only	49.38	1
Assessment and treatment	148.14	3
Assessment and treatment under conscious sedation	312.78	3

41. The pricing shown will be adjusted to reflect the Doctors' and Dentists' Review Body (DDRB) Uplifts.

42. The proposed Lotting details, developed from evidence-based needs assessment for LLR are:

Lot Details	Lot 9 Leicester North West	Lot 10 Leicester East	Lot 11 Leicester South	Lot 12 Coalville
Total number of UDAs per annum	8,413	7,346	8,668	3,715
Number of Patients for Conscious Sedation per annum	137	120	141	60
Maximum income per annum (£)	£437,989.62	£382,502.28	£451,240.08	£193,325.10

Conclusion

43. Due to the outcome of the 2022/23 East Midlands IMOS procurement process to abandon due to poor quality bids, services have been extended to ensure access is maintained for patients across the East Midlands. To support the dental market to improve the quality of bid submission, education market engagement events have been held. The presentation slides and finance self-assessment tool example have been shared and recordings of the sessions will be uploaded to enable the dental profession to review. Procurement plans are being developed to enable this to be rerun from Autumn 2023. The invite to tender documentation will be refreshed taking on board lessons learned, and additional feedback received from the dental profession regarding additional time to develop bids and sharing price benchmarking. The Commissioner will regularly update key stakeholders on procurement plans and outcome.

Background Papers

Intermediate Minor Oral Surgery Health Needs Assessment:
https://www.england.nhs.uk/midlands/wp-content/uploads/sites/46/2022/03/East-Midlands-Intermediate-Minor-Oral-Surgery-Needs-Assessment-2022.pdf

Intermediate Minor Oral Surgery Engagement and Consultation Reports:
https://www.england.nhs.uk/midlands/information-for-professionals/dental-care-in-the-midlands/east-midlands-imos-public-consultation-reports/

Equality Implications

44. An Equality Health Quality Impact Assessment was completed as part of the pre-procurement planning process. Due consideration has been undertaken as part of developing commissioning intentions. This will be revisited and refreshed where required prior to relaunching the procurement process.

Human Rights Implications

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

Other Relevant Impact Assessments

Health Implications

46. As part of the pre-procurement planning process an Equality Health Quality Impact Assessment was completed.

Partnership Working and associated issues

47. The proposed recommissioning of IMOS services is across the East Midlands and will provide regular updates to key stakeholders.

Risk Assessment

48. Identified risks and mitigations will be monitored as part of the recommissioning of services.

Officer to Contact

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Agenda Item 11

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 1 NOVEMBER 2023

REVIEW OF HOMELESS SUPPORT SERVICES

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of report

1. The purpose of this report is to inform the Committee of the outcome of the consultation on the proposed delivery model for homeless support and to present the recommendation that Cabinet will be asked to approve.

Policy Framework and Previous Decisions

2. The Medium Term Financial Strategy 2023/24 – 2026/27 (agreed by the Council on 22 February 2023) includes a target of saving £300,000 by 1 April 2024 through a review of homeless support services.

3. In June 2023, a paper with a recommended draft service model, and request for permission to consult on the proposed model was presented to the Cabinet. This was approved and formal consultation commenced on 28 June 2023.

4. The proposal is aligned with the Public Health Strategy ”Delivering good health and prevention services 2022-2027”, the Leicestershire Joint Health and Wellbeing Strategy 2022-2032 “Staying Healthy, Safe and Well”, and the County Council’s Strategic Plan 2022-26, in particular the outcome keeping people safe and well: ensuring that people are safe and protected from harm, live in a healthy environment and have the opportunities and support they need to live active, independent and fulfilling lives.

Background

5. The Homelessness Reduction Act 2017 amended the Housing Act 1996 to place duties on housing authorities to prevent homelessness (referred to as the prevention duty) and to provide homelessness services (referred to as the relief duty) to all those affected.

6. Locally, these responsibilities sit with district councils as the Housing Authority. Funding through the Homelessness Prevention Grant has been provided by The Department for Levelling Up, Housing and Communities (DLUHC) to support district councils to deliver against these responsibilities. The total allocation for 2023/24 is £1,176,448 and for 2024/25 is £1,210,843. In addition, DLUHC has provided housing authorities with long-

term funding to support those sleeping rough or at risk of rough sleeping (Rough Sleeping Initiative 2022-25). The total allocation for 2022-25 is £1,773,687.

7. It is not a statutory responsibility for the County Council to provide specific services for individuals who are homeless, and the Council is not a recipient of grant funding that is focused on preventing or relieving homelessness.

8. The County Council has a statutory responsibility to take appropriate steps to improve the health of people living in Leicestershire, including the provision of health improvement information and advice and support services aimed at preventing illness.

9. People experiencing homelessness have far worse health and social care outcomes than the general population. The average age of death for people sleeping rough is 46 for men and 42 for women, compared with 78 and 82 respectively for the general population. People experiencing, or at risk of, homelessness are therefore one of several populations of concern for the County Council in terms of their health and wellbeing.

10. The County Council's Medium-Term Financial Strategy 2023/24 – 2026/27 includes a target of saving £300,000 by 1st April 2024 through a review of homeless support services.

11. The Council currently commissions, on a discretionary basis, a homeless support service which aims to improve the health of this population by providing support to adults who are homeless or at risk of becoming homeless. This is provided for the Council by Falcon Support Services (Falcon) and Nottingham Community Housing Association (NCHA). The contract value is £300,000 per annum and ends on 31st March 2024.

12. This provides an opportunity to review the need, existing service provision, and responsibilities of the County Council, and propose a recommended future service delivery model.

Review of Existing Provision

13. The support commissioned from FSS and NCHA is aimed at adults who are homeless or at of risk becoming so. The key elements of provision include:

    - A referral hub – to process and assess all referrals received to determine the most appropriate course of action.
    - In-reach support – provided within hostel accommodation across Leicestershire.
    - Outreach support – provides services such as telephone support, group work, benefits advice surgeries, signposting, and one-to-one support.

14. The aim of the service is to improve the health and wellbeing of those that are homeless or at risk of homelessness. This is achieved by supporting access to health and wellbeing services and by building the resilience of this cohort, by supporting independent living. It should be noted that the funding does not pay for the running of homeless hostel buildings. The funding is for the support provision outlined in paragraph 13.

15. Public Health assessed the associated challenges identified around the current provision which were analysed and summarised in the table below:

Provision	Description of provision	Challenges
Referral hub	Service users and professionals refer into the service via telephone or email. An assessment is carried out and the service user is assigned a case worker.	The service holds a waiting list leading to delays in service users accessing support. There is an eligibility criterion; only those that have a non-priority need can access the in-reach hostel based support.
Hostel based (in-reach) support	Support provided within hostel accommodation across Leicestershire.	Limited to 30 service users at any one time. Support offer is concentrated within the Falcon Centre in Loughborough. Support offer is concentrated towards non-priority need individuals. Service is underutilised due to slow move-on of service users into alternative accommodation. Support offer is more focused on welfare rights and tenancy rather than health and wellbeing.
Outreach support	Case worker works with a service user on a short-term basis on any areas where they require support.	Predominantly focused on signposting and providing information and advice. Specialised support on areas such as substance misuse is not provided.

Review of need

16. A period of engagement on current service provision across Leicestershire for homeless individuals took place in spring 2022 in preparation for a potential redesign of services. This involved service users, service providers and stakeholders, which included district representatives, homeless support providers, domestic abuse services and substance misuse services. It is important to note that the scope of this engagement exercise included all services available for homeless individuals in Leicestershire, not just the service described within this report. This was on the basis that the County Council intended to work with district housing leads via the Chief Housing Officers Group to potentially pool resources and co-design services across Leicestershire, but despite showing initial interest, districts were not in a position to pursue this option further at the time.

17. There were a number of areas of work that were identified as working well. These include:
    - accessibility of services e.g., drop-in sessions, face to face support, open door day centres, access to hostels;
    - types of support available e.g., support to complete application forms, support to maintain living situation, move-on support, bespoke support for street homeless;
    - links with the substance misuse service.

18. Areas of work that were identified as a gap or requiring improvement included:
    - lack of suitable and affordable housing;
    - access to health care, particularly mental health services;
    - access to dental care;
    - access to social care;
    - need for multi-agency working including better data sharing;
    - need for Leicestershire wide support;
    - need for a flexible offer;
    - need for greater emphasis on life skills and resilience building.

19. Data from DLUHC on support needs of households in Leicestershire that are owed a prevention or relief duty showed that in 2022/23, 24% of households identified mental health as a support need, 15% identified physical ill health as a support need, 4% identified alcohol use as a support need, and 3% identified drug use as a support need. This highlights a gap in accessibility of healthcare services for this cohort.

20. A report published by the Local Government Association in 2022 - 'Making the case for investing in homelessness prevention' recognises the importance of upstream cross-service prevention work in local homelessness systems. In addition, the Kerslake Commission on Homelessness and Rough Sleeping calls for action to address rapidly rising rates of homelessness with one of the key principles focusing on preventing people from becoming homeless.

Consultation

21. A public consultation was approved by Cabinet on 23 June 2023. The consultation launched on 28 June 2023 and ran for 10 weeks (closed on 3 September 2023) to seek views on the proposed model which is for the County Council to cease funding a dedicated homeless support service, and instead to provide support via the Council's existing public health services where eligibility is wider.

22. The consultation was aimed at the general public, users of the service, service providers, and a range of additional stakeholders including NHS service providers, district councils, voluntary sector providers, and Leicestershire Police. The consultation was promoted through several routes, including social media, council website, current providers, emails to key stakeholders, and through newsletters.

23. The consultation comprised of an electronic questionnaire and supporting information that was accessible on the County Council's website with hard copies (with a freepost return) and easy read options available on request. A telephone line and email address were provided to enable all residents and stakeholders to ask questions about the

consultation if they needed to. The consultation documentation can be viewed here: https://www.leicestershire.gov.uk/have-your-say/you-said-we-did/engagement-2023

24. The views of professional and partner stakeholders, as well as current and previous service users and support workers, was captured through:

    - Discussions at face to face and online information sessions to talk though the proposal, listen to views and provide information on how individuals could have their say. A total of 5 sessions (3 online sessions and 2 face to face sessions) were held during the consultation period.
    - Responses to the questionnaire (paper copy and online copy)
    - Responses received via the consultation email address

25. The information sessions were spread out over July and August, on different days, at different times of the day, and for different audiences, to provide a suite of options for people to attend at their convenience. The sessions aimed at professionals were held via Microsoft Teams and those aimed at service users were held both online and face to face.

26. Following queries/comments received during the first half of the consultation period, a set of FAQs were produced and available on the consultation webpage and as a hard copy on request.

27. Hard copies of the questionnaire were provided to the incumbent providers. This included 50 hard copies provided to Falcon Support Services. Hard copies of the questionnaire were also made available to Local Area Coordinators and Community Recovery Workers to disseminate to their service users.

28. After it was flagged that there were issues with submitting multiple responses from one computer, a separate inputter link was provided which successfully resolved the issue. 2 responses were received via this route. A request to increase the word limit for the questionnaire response was also made. This was actioned by removing the character limit.

29. At the face-to-face sessions which took place at Loughborough library, hard copies of the consultation information were made available to attendees. The information packs included: questionnaire with free post return, supporting information, easy read version of supporting information, and a set of Frequently Asked Questions. County council staff were also available to support completion of the questionnaire on-site. One individual accepted this offer. Space was also made available at Loughborough library for participants to complete a questionnaire.

30. The questionnaire asked for people's views on:

    - impact/s of the proposal;
    - access to other sources of homeless support;
    - awareness of existing county council services;
    - alternative suggestions to provide support.

31. A total of 251 individuals/organisations completed the questionnaire and 131 individuals attended the information sessions. Out of these, 20 existing or previous service users attended the face to face sessions. Alongside this, the consultation included feedback via 2 letters from service users, and feedback from this Scrutiny Committee (see paragraph 39), Chief Housing Officers Group (attended meeting on 9 August 2023 and formal response received via email), and Charnwood Borough Council (formal response received via email). The proposal was also presented to the Leicestershire Equalities Challenge Group on 8 September 2023 to provide information on the consultation and seek advice on any potential equalities issues.

32. Most of the questionnaire responses were from someone who has been or is being supported by the homeless support service (25%), followed by an employee, volunteer or provider of support services (24%). In addition, the majority of respondents were male (56%), aged 55-64 (27%), white (87%), and live (68%) or work (35%) in Charnwood.

33. 74% of questionnaire respondents disagreed with the proposal. Out of those who disagreed with the proposal, the greatest proportion of responses came from an employee, volunteer or provider of homeless support service (29%), followed by someone who has been or is currently being supported by the homeless support service (22%).

34. Though concerns were expressed about the impact of a change to the service model (described in further detail in paragraph 35), one of the main concerns was expressed in relation to potential closure of the Falcon Centre (a homeless hostel provided by Falcon Support Services) in Loughborough. It should be noted that the funding does not pay for the running of homeless hostel buildings but in June 2023 (**before** a draft proposal on homeless support services had been presented to the Cabinet), Falcon Support Services distributed a survey amongst local stakeholders. The content of the survey gave the impression that the County Council funds the Falcon Centre and therefore sought views on the impact of closure of the centre e.g., impact on anti-social behaviour, increased rough sleeping etc. The survey also described a raft of services provided by Falcon Support Services that would potentially stop if the council's proposal is approved e.g. food parcels, emotional health and wellbeing support, dental checks and eye checks. These services are not funded by the County Council. As such Falcon Support Services' survey may have had an impact on responses to the County Council's consultation.

35. Key themes arising from the consultation are described below along with commentary that responds to the points made. A report summarising feedback from the consultation can be viewed in appendix A.

Theme	**Commentary**
Recognition of the need to focus more effort on preventing homelessness	The proposed model aims to achieve this through using First Contact Plus as the single point of contact and through strengthening links with existing public health services.

Recognition of the need to provide wider access to support i.e., wider geographical coverage, wider range of support that goes beyond housing	The proposed model aims to provide coverage across Leicestershire with a greater focus on improving health and wellbeing.
Recognition of the benefit of having a simplified single point of contact, streamlining the approach of obtaining support and avoiding potential duplication of service provision	The proposed model aims to achieve this through using First Contact Plus as the single point of contact.
Recognition that current provision is good and therefore there is a desire to keep services as they are Current offer is highly valued (with particular reference to Falcon Centre) with many respondents referencing their own personal experiences and the ways Falcon Centre has helped them, their loved ones, or the people that they supported.	Challenges with the current model are described in paragraph 15.
Potential negative impact on the Falcon Centre e.g., closure of centre, loss of housing benefit	The funding does not (and should not) pay for the running of Falcon Centre. National guidance indicates that for a claim to be treated as an 'exempt accommodation,' the care, support and supervision provided must be 'more than minimum'. A specific quantity is not stipulated. Falcon Support Services provide additional care, support and supervision that is provided in collaboration with other partners e.g., police, NHS, probation services, Turning Point which should qualify for exempt accommodation. Alternatively, eligibility for housing benefit can be determined on a case-by-case basis for each resident. Providers of accommodation can apply to become a registered social housing provider. One of many benefits of this approach is achieving 'exempt' status for Housing Benefit purposes which in turn provides Providers with greater financial stability. If the service was recommissioned with the same/similar model as it is currently, the tender would be an open tender process inviting bids from any interested bidder. As

	such there are no guarantees that Falcon Support Services would be the successful provider in the future. It is the responsibility of the Provider to ensure they have robust contingency plans in place as part of their business model.
Lack of awareness of services such as First Contact Plus and Local Area Coordinators, and existing homeless support services - Less than half of survey respondents (48%) were aware of First Contact Plus or Local Area Coordinators	This will be addressed during the implementation period subject to the proposed model being approved by the Cabinet. The approach is described in paragraph 49.
Impact on accessibility/barriers of the proposed service e.g., loss of face-to-face support, digital front door, loss of 1-2-1 support, loss of drop-in service, loss of 24/7 support	Referrals into the proposed service can be made by individuals directly or on their behalf (e.g., by professionals or family members). Referrals can be made 24/7. Current outreach support offer isn't 24/7 and this will remain unchanged. If the initial assessment indicates that face to face and/or 1-2-1 support is required, this will be provided through existing services e.g., Local Area Coordinators, substance misuse service etc. Local Area Coordinators provide drop-in sessions based on need. The sessions focus on health and wellbeing needs. Further information on impact is detailed within the Equality Impact Assessment (Appendix B).
Concerns regarding capabilities and capacity of the workforce delivering the future service	The proposal includes two well established teams that have extensive experience in working with individuals and communities to improve health and wellbeing.
Lack of multi-agency / partnership approach in relation to homelessness	A robust communications plan will be developed and implemented to strengthen the join up between the proposed model and existing services.
Lack of evidence base for the proposed offer	The evidence base is described in paragraphs 20 and 45.

Loss of targeted / specialised support e.g., housing/tenancy support	Targeted/specialised support in relation to housing needs is the responsibility of housing authorities. The proposed model addresses the provision of specialised support to improve health and wellbeing of this cohort through its direct links with health and wellbeing services, including public health services.
Impact/additional pressures on other services e.g., police, social care, district services, increased homelessness	The proposal provides greater focus on prevention of homelessness through improving the health and wellbeing of the population, thus aiming to reduce pressures on acute services. Colleagues from Adults & Communities will play a key role in the implementation of the proposed model.
Lack of support for those with complex needs / chaotic lifestyles / complex mental health needs	The current model focuses on low to medium needs and wasn't designed or intended to support those with complex needs e.g., those individuals requiring complex healthcare support who would be expected to receive support from NHS services.
Concerns over reduced investment in homeless services and the risk of homelessness increasing	External sources of funding are detailed in paragraph 6. The proposal provides greater focus on prevention of homelessness through improving the health and wellbeing of the population, thus aiming to reduce the risk of crises occurring.
Lack of support for those who are rough sleeping	Support for those who are rough sleeping is funded through the Rough Sleeping Initiative and provided by The Bridge.
Lack of focus on housing	This legal responsibility sits with district councils not the county council.
Confusion over district responsibilities versus county council responsibilities, and responsibilities of health care services - confusion over county council homeless support service and district housing offer - homeless strategy / policy	A robust communications plan will be developed and implemented to strengthen the join up and awareness of the proposed model and existing services. Development of a homeless strategy is the responsibility of housing authorities (district councils).
Lack of impact assessment	Information on impact is detailed within the Equality Impact Assessment (Appendix B).
Concerns over accessibility and awareness of consultation	Consultation process is described in paragraphs 21 to 30 and Appendix A and

	highlights the various methods used to promote the consultation and to engage with target groups. There was a good response rate to the consultation questionnaire and good take-up of the information sessions. Nearly half of responses were from someone who has been or is being supported by the homeless support service, or from an employee, volunteer or provider of support services, which highlights that the target groups were successfully reached.

36. During the consultation period, two letters were received from Falcon Support Services that were written by service users residing at the Falcon Centre. Both individuals included examples of the great support that the Falcon Centre provides and wrote about their own personal experience. One letter explained how the Falcon Centre had helped them gain qualifications, secure permanent housing and a job, and feel like a valued member of the community. The other letter mentioned that the help from the Falcon Centre had enabled them to gain confidence, secure housing, look forward to the future and change their life for the better.

37. The consultation questionnaire asked about alternative sources of help if the current offer was not available. Most respondents identified multiple sources of support with 68% stating they would seek support from a local charity/voluntary sector organisation, 63% said they would seek support from their local housing authority, 34% said they would seek support from family or friends, 30% said they would seek support from a health professional, and 24% said they would seek support from a social worker. This highlights the various sources of help that individuals would access in the absence of this service.

38. The consultation questionnaire asked the public for alternative suggestions for a service model. Some responses to this question deviated away from providing alternative suggestions and instead focused on impact of the proposal. Key themes arising from the responses, including commentary that responds to the suggestions made are described below.

Alternative suggestion	**Commentary**
Keep the offer as it is / no change	Challenges with the current model are described in paragraph 15.
Greater focus on accommodation	This is the responsibility of district councils
Greater focus on preventative services	The proposed model aims to achieve this through using First Contact Plus as the single point of contact and through strengthening links with existing public health services.

Increase awareness of existing services, including services provided by local charities	This will be addressed during the implementation period subject to the proposed model being approved by the Cabinet. The approach is described in paragraph 49.
Strengthening partnership working, including between housing authorities	A robust communications plan will be developed and implemented to strengthen join up between the proposed model and existing services.
Provision of bespoke / targeted services based on need e.g., better support for people with dual diagnosis (mental health and substance use), dedicated teams for each district	A robust communications plan will be developed and implemented to strengthen the join up between the proposed model and existing targeted services.
Workforce development and increased pay for those working with individuals who are homeless	This responsibility sits with each individual organisation. A strengthened partnership approach may support with workforce development.
Increase funding in this area / lobbying government for fairer funding	Paragraph 6 provides details on existing sources of national funding.
Utilise feedback from those with lived experience on a regular basis to shape service provision	This will be addressed during the implementation period subject to the proposed model being approved by the Cabinet.
Having multi-agency hubs within district areas	This requires the development of a partnership approach in the first instance to explore suitability and doesn't address the challenges in the interim period.
Need for a homeless policy/strategy across Leicestershire	This responsibility sits with district councils.
Transfer budget to district councils to enable direct delivery or to enable the commissioning of accommodation-based / floating support services	Paragraph 6 provides details on existing sources of national funding that has already been made available to district councils. One of the expectations of the use of the homelessness prevention grant is to prevent homelessness of single people. Other housing authorities across the country have used the grant to fund initiatives such as: outreach work for 21-35 year olds, safe accommodation and support, rough sleeper outreach, homeless prevention service for single individuals and childless couples.
Review the service specification and refine expectations to allow a service model that better meets needs and is more closely	The proposal presented in this report was developed following: - a review of existing provision

aligned to commissioners' priority outcomes.	- a review of need - a review of roles and responsibilities of the county council

39. In September 2023, the Health Overview and Scrutiny Committee considered the new service model as part of the consultation process. The Committee supported the draft revised model for the delivery of homeless support and particularly welcomed the proposed use of the Local Area Coordination service.

Proposed new service model

40. Based on a review of need, existing service provision, responsibilities of the County Council, and a review of consultation responses, the recommended proposal is for the County Council to cease funding a dedicated homeless support service, and instead to provide support via the Council's existing public health services where eligibility is wider.

41. This will be achieved primarily through the universal offer of First Contact Plus and the Local Area Coordination service as opposed to a bespoke offer specifically for individuals who are homeless or at risk of becoming homeless.

42. First Contact Plus helps adults in Leicestershire to access information, advice, help and support on a range of services. Referrals to First Contact Plus are made via an online form. For those individuals who may have difficulties in self-referring via an online platform, a referral can be made on their behalf by a professional or friend/family member/carer. Local Area Coordinators work with individuals who may be vulnerable or at risk of crisis by building a supportive community around them thereby reducing social isolation.

43. The principles of the future approach centre around the following:
    a. Coverage across the whole of Leicestershire.
    b. Eligibility that includes any individual who is currently homeless or at risk of becoming homeless, irrespective of whether they fall under the priority need group or not.
    c. Access to support via a central point of access.
    d. Support that is tailored to the needs of each individual with no defined timescales for the support offer.
    e. Greater focus on improving the health and wellbeing of individuals.

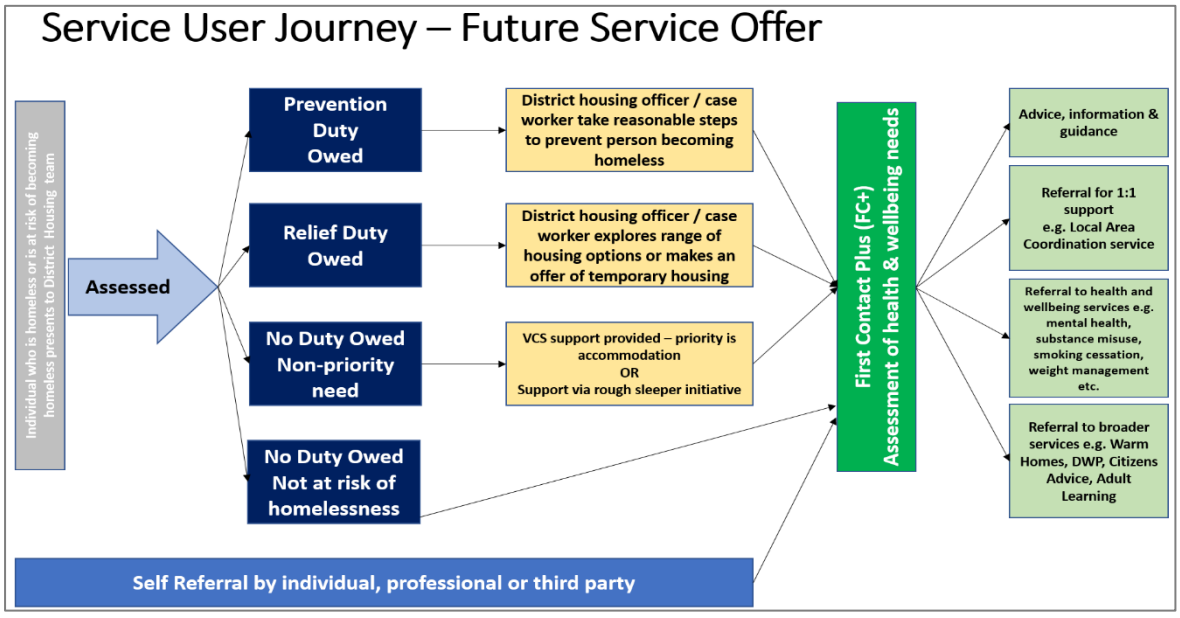
44. This model will include using First Contact Plus as the referral hub into services which include the following:
    - Department for Work and Pensions for support to access the right benefits.
    - Citizens Advice for debt management support.
    - Community Recovery Team and Local Area Coordination Team for one-to-one support.

- Warm Homes Service for support on housing issues such as damp, mould, draught proofing, and signposting to funding for energy efficiency measures.
- Health and wellbeing services such as smoking cessation, drug and /or alcohol misuse, healthy weight, physical activity, and sexual health services.
- Mental wellbeing services such as Vita Minds (a talking therapies service for low level mental health support).
- Services provided by the Council's Adults and Communities Department, including community support workers and social care.
- Adult Learning and Multiply for support on accessing learning and educational courses, including support on budgeting. Multiply is a programme aimed at helping adults to improve their numeracy skills.

45. Where one-to-one support or face to face support is required, the Local Area Coordination service is well established within communities and so can meet this need through their links with community groups, drop-in sessions and through the direct provision of one-to-one support. Other services commissioned by Public Health such as the substance misuse treatment service and the sexual health service already provide outreach services on a one-to-one basis. A report on Local Area Coordination (*Catalyst for a System Wide Prevention Approach*) highlights how the service can assist in reducing some of the potential causes of future homelessness by addressing the circumstances that cause people to experience chaotic lifestyles. The report also describes how Local Area Coordination can support housing workers to be more preventative in their approach, with a focus on self-help and solution finding rather than service and crisis management.

46. A key strength of this proposal is that links can be made to a broader range of health and wellbeing services therefore providing a more holistic support offer for individuals. In addition, this approach enables better links into existing public health services and wider onward referrals including to the district housing authorities.

47. A process map describing a service user journey under the proposed model is shown below.



Implementation

48. If the proposal is approved following a decision by Cabinet on 24 November 2023, the County Council will work collaboratively with districts councils and other key stakeholders with the aim of developing strong and robust referral pathways into the service ensuring a joined-up approach to meet people's needs. The Council will also work with the current providers to ensure a robust exit strategy is in place and implemented.

49. Feedback from the consultation highlighted limited awareness of First Contact Plus and Local Area Coordination Services. If the proposal is approved, the Council will develop a robust communications plan to increase awareness of the service offer and to strengthen referral pathways into and out of the service.

Resource Implications

50. The proposed model is expected to achieve savings of £300,000 per annum which would contribute to the Medium Term Financial Strategy (MTFS) savings target.

Timetable for Decisions

51. A report will be presented to the Cabinet on 24 November 2023 on the outcome of the consultation and to seek approval of the recommended service model.

52. The existing contract ends on 31 March 2024. If the proposal is approved following a decision by Cabinet, the County Council will work collaboratively with districts councils and other key stakeholders with the aim of developing robust referral pathways into and out of the service ensuring a joined-up approach to meet people's needs. The Council will also develop a robust communications plan to increase awareness of the service offer. The new offer will be in place from 1 April 2024.

Background papers

Report to the Cabinet - Medium Term Financial Strategy 2023/24 - 2026/27 - 22 February 2023 https://politics.leics.gov.uk/ieListDocuments.aspx?CId=134&MId=6913

Report to the Cabinet – Review of homeless support services - 23 June 2023 https://politics.leics.gov.uk/documents/s177126/2023.06.23%20Cabinet%20Report%20Homelessness%20Consultation.pdf

Report to Health Overview and Scrutiny Committee – Review of homeless support services – 13 September 2023
https://politics.leics.gov.uk/documents/s178338/Homeless%20scrutiny%20paper%20Sept%202023.pdf

Circulation under the Local Issues Alert Procedure

53. None

Equality Implications

54. Under the Equality Act 20210 the County Council is required to have due regards to the need to:
    a. Eliminate unlawful discrimination, harassment and victimisation
    b. Advance equality of opportunity between people who share protected characteristics and those who do not; and
    c. Foster good relations between people who share protected characteristics and those who do not.

55. An Equality and Human Rights Impact Assessment (EHRIA) has been completed and updated using feedback from the consultation (Appendix B). Specific actions have been included to ensure awareness of the offer and on accessibility of the offer.

Human Rights Implications

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

Health Implications

57. It is intended that the proposed model will enable individuals to access a broader range of health and wellbeing services therefore providing a more holistic support offer for individuals.

Appendices

Appendix A – Summary report of public consultation
Appendix B – Equality and Human Rights Impact Assessment (EHRIA)

Officer(s) to Contact

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APPENDIX A

Summary report of a public consultation on the proposed changes to the homeless support service in Leicestershire

2023

Contents

Acknowledgements

We would like to take this opportunity to express our gratitude and sincere thanks to everyone who has taken the time to provide their views and feedback as part of the consultation process.

Purpose of this report

This document provides a summary of the findings of a public consultation undertaken between Wednesday 28 June and Sunday 3 September, on the review of the homeless support service commissioned by Leicestershire County Council's Public Health Department. This report reflects the findings of the formal consultation questionnaire, information sessions and additional responses received during the consultation period.

Background

Leicestershire County Council commissions a service that supports adults who are facing homelessness, or who are homeless, to gain the skills needed to either live independently or live in supported accommodation. The service comprises of:

- A referral hub – to process and assess all referrals received to determine the most appropriate course of action.
- In-reach support – provided within hostel accommodation across Leicestershire.
- Outreach support – provides services such as telephone support, group work, benefits advice surgeries, signposting, and one-to-one support.

The current contract for homelessness support services will end in March 2024.

Leicestershire County Council (LCC) is facing growing financial pressure alongside increasing demand, so there is a need to look at providing services in a different way.

Following a review of the current service, and the financial challenges facing the council, LCC is proposing to change the way support is provided to individuals who are facing homelessness or who are homeless.

The proposal is to stop funding a dedicated homeless support service, and instead to provide support through the council's existing public health services where a wider number of people are eligible for support.

Consultation methods

The formal consultation ran from Wednesday 28 June to Sunday 3 September seeking views from residents and stakeholders on the proposed model. The consultation documentation detailed the proposed change and was available through the Leicestershire County Council Have Your Say webpage. This documentation included:

- a webpage introduction (Appendix A),
- a supporting information booklet (Appendix B),
- a questionnaire (Appendix C),
- an Easy Read version of the supporting information (Appendix D).

Additionally, after two information sessions, a set of Frequently Asked Questions were developed and added to the webpage (Appendix E).

A telephone line and email address were provided to enable all residents and stakeholders to ask questions about the consultation if they needed to.

The consultation invited the general public; service users both past and present; people facing homelessness; friends, relatives and carers of people facing or experiencing homelessness, and stakeholders (e.g., providers working directly with homeless individuals, district councils, healthcare providers, county council departments, and Voluntary and Community Sector organisations) to provide their views on the proposed changes and alternative ideas for providing support. This was captured through:

- Discussions at face to face and online information sessions. A total of 5 sessions were held during the consultation period (3 online sessions 2 face to face sessions).
- Responses to the questionnaire (paper copy and online copy)
- Responses received via the consultation email address

A detailed communications plan was developed to support promotion of the consultation. . The consultation was promoted through several routes, including social media, council website, current providers, emails to key stakeholders, and through newsletters. These were repeated throughout the consultation.

The information sessions were spread out over July and August, on different days, at different times of the day, and for different audiences, to provide a suite of options for people to attend at their convenience. The sessions aimed at professionals were held via Microsoft Teams and those aimed at service users were held both online and face to face.

At the face-to-face sessions which took place at Loughborough library, hard copies of the consultation information were made available to attendees. The information packs included: questionnaire with free post return, supporting information, easy read version of supporting information, and a set of Frequently Asked Questions. County council staff were also available to support completion of the questionnaire on-site. Space was also made available at Loughborough library for participants to complete a questionnaire.

Hard copies of the questionnaire were provided to the incumbent providers. Hard copies of the questionnaire were also made available to Local Area Coordinators and Community Recovery Workers to disseminate to their service users.

After it was flagged that there were issues with submitting multiple responses from one computer, a separate inputter link was provided which successfully resolved the issue. 2 responses were received via this route. A request to increase the word limit for the questionnaire response was also made. This was actioned by removing the character limit.

Overview of responses

The questionnaire asked for people's views on:

- impact/s of the proposal
- access to other sources of homeless support
- awareness of existing county council services
- alternative suggestions to provide support

There was a total of 251 individual responses to the survey (204 were online and 47 were from paper copies).

In addition:

- 114 individuals attended the information sessions
- 2 letters were received from residents
- responses were received via email from Charnwood Borough Council and the Chief Housing Officers Group (CHOG)
- feedback was received from the Health and Overview Scrutiny Committee and the Leicestershire Equalities Challenge Group.

Survey responses

In total, 251 responses were received (204 online and 47 paper/postal responses).

Results have been reported based on those who provided a valid response, i.e., excluding the 'don't know' responses and no replies from the calculation of the percentages, where applicable.

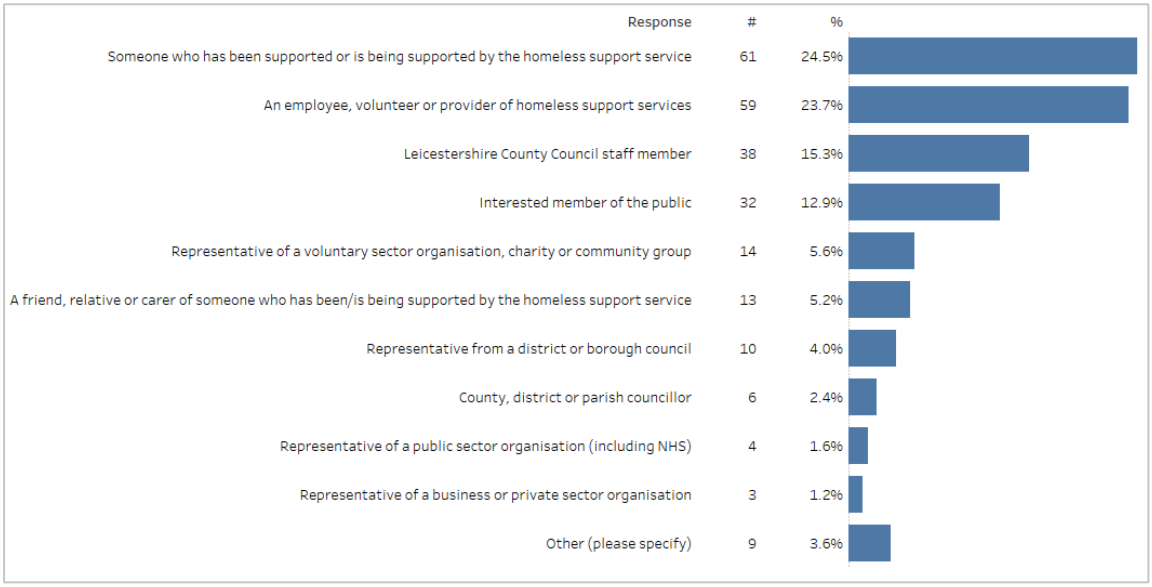
About the respondents

The majority of responses were from someone who has been or is being supported by the homeless support service (25% of responses), followed by an employee, volunteer or provider of support services (24% of responses).

Where respondents chose 'other' the following detail was provided:

- Housing Association
- Previously been homeless
- Previous employee of a homelessness organisation
- Volunteer at a soup kitchen
- Staff member within adult social care
- Partner's ex has received support

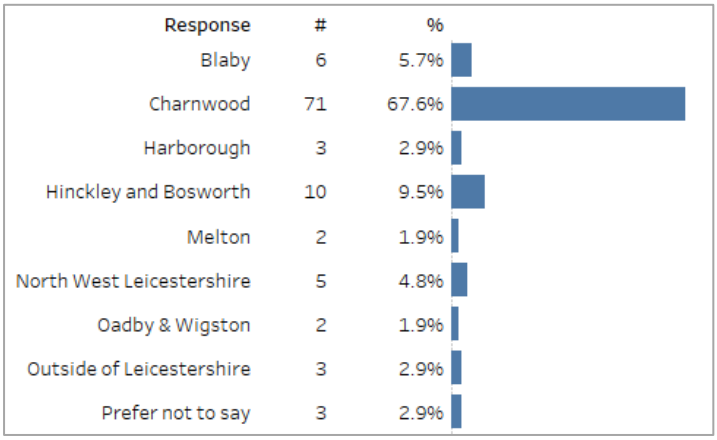
In what role are you responding to this consultation?



Respondents who had indicated their role as service users, their family/friends/carers, and interested members of the public were asked a series of demographic questions, of which:

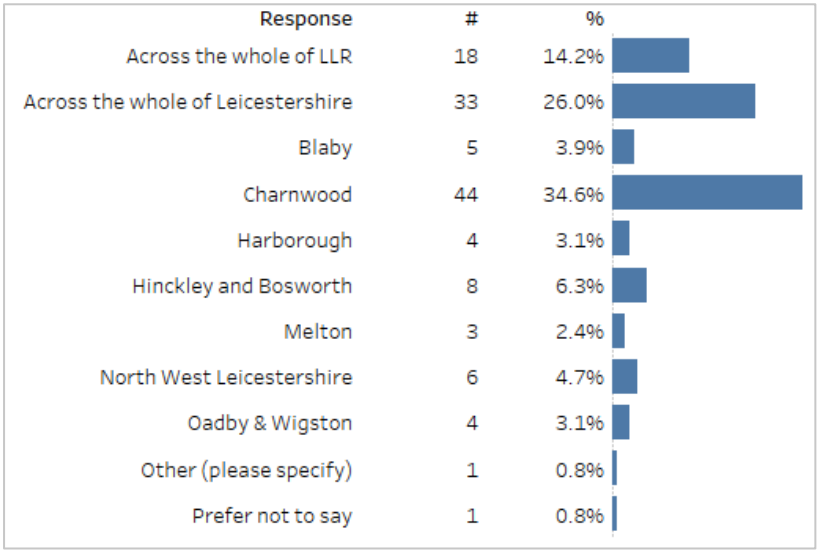
- 56% of these respondents were male and 41% were female
- The highest proportion of these respondents were aged 55-64 (27%)
- Half of these respondents said they had a long-standing illness, disability, or infirmity (50%).
- Most of these respondents identified as white (87%). A tenth of these respondents (10%) identified with a Black and Minority Ethnic group
- Just over two-thirds (68%) of these respondents said they lived in Charnwood

Which area do you live in?



Staff of homeless support services, Leicestershire County Council staff and representatives of organisations and businesses were asked which area they worked in. Just over a third of respondents (35%) said they worked in Charnwood. Just over one-fifth of respondents (26%) said they worked across Leicestershire and 14% said they worked across Leicester, Leicestershire and Rutland.

Which area do you work in?

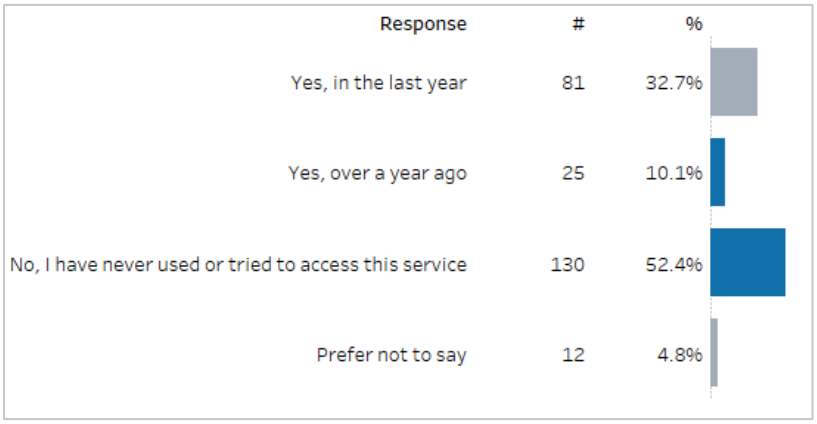


Response	#	%
Across the whole of LLR	18	14.2%
Across the whole of Leicestershire	33	26.0%
Blaby	5	3.9%
Charnwood	44	34.6%
Harborough	4	3.1%
Hinckley and Bosworth	8	6.3%
Melton	3	2.4%
North West Leicestershire	6	4.7%
Oadby & Wigston	4	3.1%
Other (please specify)	1	0.8%
Prefer not to say	1	0.8%

Accessing the current homeless support service

Respondents were asked whether they had used or tried to access the current homeless support service. 43% of respondents said they had used or tried to access this service, and just over half of respondents (52%) said they had never used or tried to access this service.

Have you used or tried to access the homeless support service?



Response	#	%
Yes, in the last year	81	32.7%
Yes, over a year ago	25	10.1%
No, I have never used or tried to access this service	130	52.4%
Prefer not to say	12	4.8%

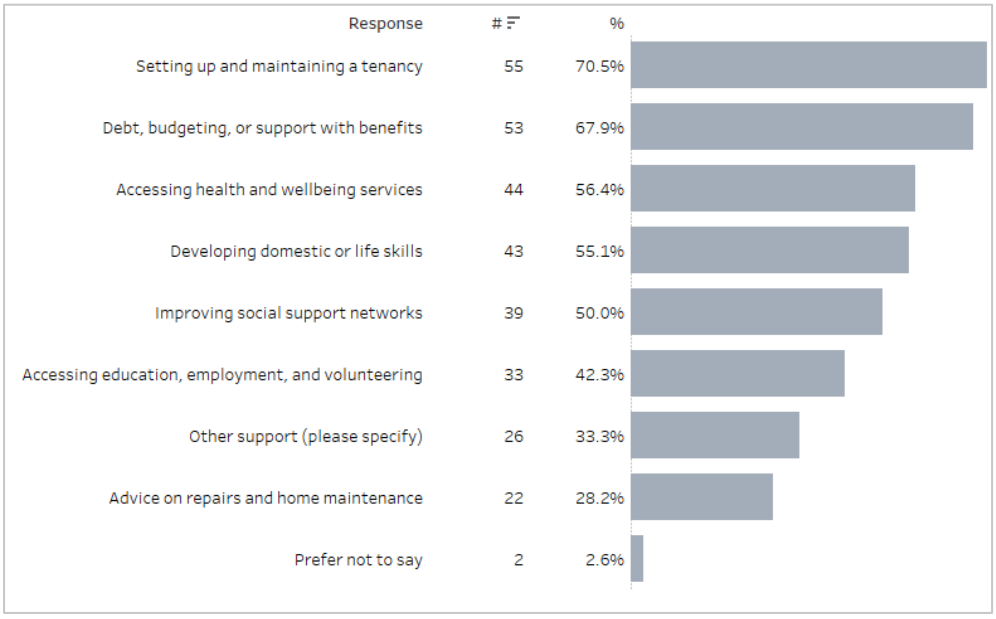
Of those that said they had used or tried to access the service (106 respondents):

- Just over three quarters (76%) said they had used or tried to access the service in the last year and 24% said they had used or tried to access the service over a year ago.
- A notable proportion were from those who had previously indicated that they were employees, volunteers and providers of homeless support services (16%) and representatives of businesses or organisations (9%).
- When asked which support offer/s they had used or tried to access in the last year, the highest proportion of respondents said, 'setting up and maintaining a tenancy' (71%) and 'debt, budgeting or support with benefits' (68%). Over half of respondents said they had accessed health and wellbeing services (56%).

Where respondents chose 'other' the following detail was provided:

- Housing advice including tenancy rights and searching for accommodation
- Employment support
- Working for the service
- Homeless support via accommodation
- Self-esteem assessment & confident building to look for work
- Scanning & copying documents when required
- Duty of care & welfare
- Food parcels
- Signposting to other services
- Make referrals into the service
- Substance misuse support
- One-to-one support
- Access to leisure services
- Mental health support

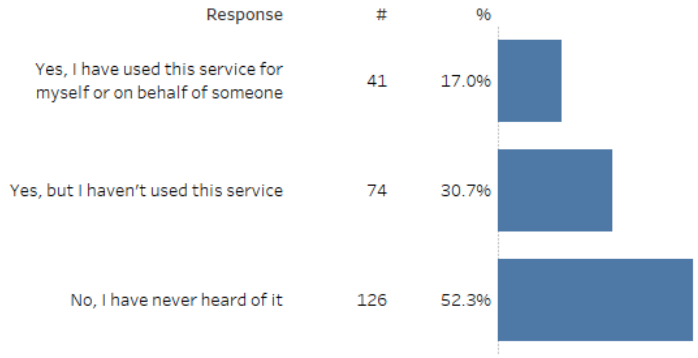
Which, if any, of the following support offers did you receive or try to access from the homeless support service?



Awareness of county council services

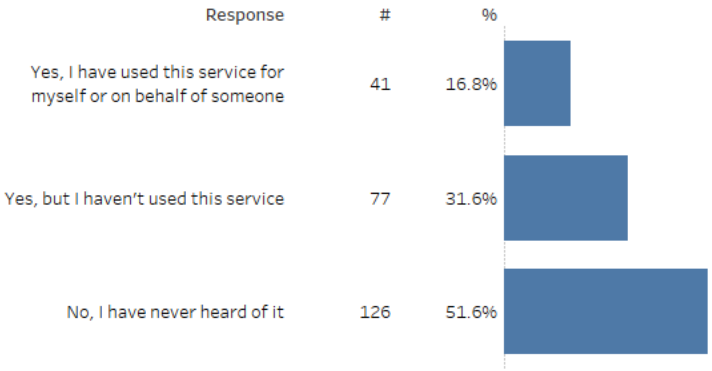
When asked whether they were aware of the county council's First Contact Plus service, 48% of respondents said they were aware of this service, while 52% said they had never heard of this service. Of the 115 respondents that said they were aware of the service, 36% said they had used the First Contact Plus service themselves or on behalf of someone else and 64% said they were aware of the service but had never used it.

Are you aware of the county council's First Contact Plus service?



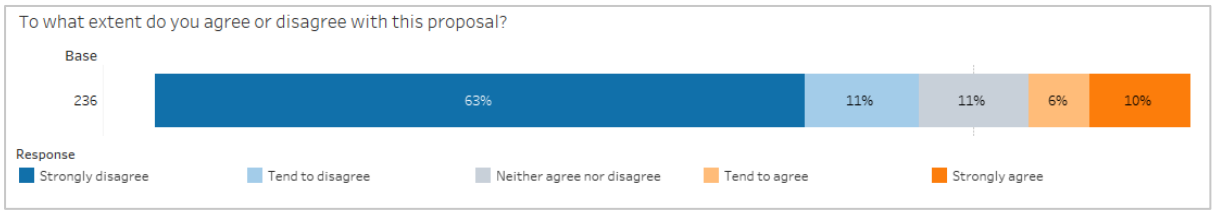
When asked whether they were aware of the county council's Local Area Coordination service, 48% of respondents said they were aware of this service, while 52% said they had never heard of this service. Of the 118 respondents that said they were aware of the service, 35% said they had used the Local Area Coordination service themselves or on behalf of someone else and 65% said they were aware of the service but had never used it.

Are you aware of the county council's Local Area Coordination service?



Views on the proposals

Respondents were asked the extent to which they agreed or disagreed with the proposal. Almost ¾ of respondents (74%) said they disagree with the proposal, while 16% of respondents said they agree with the proposal and 11% said they neither agree nor disagree with the proposal. Out of those who disagree with the proposal, the greatest proportion of responses came from an employee, volunteer or provider of homeless support service (29%), followed by someone who has been or is currently being supported by the homeless support service (22%).



Respondents were asked 'Why do you say this?' Key themes of the responses are described below:

- It would make efficiency savings while maintaining support for homeless people.
- It would streamline the process of obtaining/providing support and also enable access to help for other issues that people facing homelessness might be experiencing.
- Positive move forward if homeless people can get the support and help they need to be able to not be homeless
- Current offer is highly valued (with particular reference to Falcon Centre)
    - many respondents referenced their own personal experiences and listed the ways Falcon Centre has helped them, their loved ones, or the people that they supported.
    - proposal is not comparable to existing provision
    - Falcon Centre is well established and working well
    - Falcon Centre provides a safe place
    - why change something that is already working well
    - benefits to society
    - Falcon Support Services is a lifeline to many people
    - easy to access
    - supportive staff
- Impact on levels of homelessness
    - current offer is keeping the local homeless situation under control
- Need for evidence base to support the changes
    - lack of data showing impact of the proposal
    - lack of research showing impact of the proposal
    - lack of evidence and data that the proposal will reduce homelessness
- Accessibility
    - people who are homeless or are facing homelessness often have no reliable access to phones or internet so the service will be difficult to access
    - people who are homeless or are facing homelessness require a consistent worker for trust and regularity
    - lack of 24/7 support
    - lack of face to face support
    - lack of 1-2-1 support
    - lack of out of hours support
    - negative impact on those living in rural areas
    - risk of people falling through the net
    - loss of support within an individual's place of residence
    - unsuitable for those for whom English is not their first language
    - unsuitable for those with poor literacy
    - loss of drop-in services
- Loss of targeted / specialised provision
    - increase in unmet needs among the homeless population
    - loss of practical support
    - not person-centred
    - need for localised support rather than a centralised service
- Absence of a homelessness policy / strategy
- Skills / qualifications / experience / recruitment of staff providing the new service
    - lack of expertise on homeless legislation
- Short-sighted approach

- focus is on savings rather than evidence base or human beings
- need to increase resources/funding rather than withdrawing them

- Impact on acute services e.g., housing need, social services
  - requests for suitable accommodation will increase
  - service users may have to rely on police or ambulance services as local mental health services are not fit for purpose
  - impact on other services not clear
  - impact on healthcare services
- Risk of closure of Falcon Centre
  - loss of 30 beds
  - increased risk of rough sleeping
  - increased risk of anti-social behaviour and crime
  - impact on out of area service users
  - loss of other services provided within the centre e.g., needle exchange, food parcels, laundry service
- Need for multi-agency / partnership approach
  - First Contact Plus should be one of the services but not the only one.
  - would support proposal as long as GP practices are informed of the new service, and it is easily accessible / easy to refer into
- Doesn't address support for individuals with complex needs
  - service will not work for chaotic individuals or those with complex needs.
  - lack of support for individuals with substance misuse issues who are in crisis.
  - lack of support for entrenched rough sleepers
  - lack of flexibility
- Housing should be the priority
  - proposal doesn't address lack of affordable housing
  - proposal doesn't address lack of suitable housing
- Poor quality services provided by district housing teams / confusion of roles and responsibilities of the County Council versus district offer
  - district councils lack resources and engagement
  - lack of connection with district council housing team
  - lack of support from district council
- Lack of awareness of First Contact Plus and Local Area Coordinators
- Lack of awareness of existing homeless support service

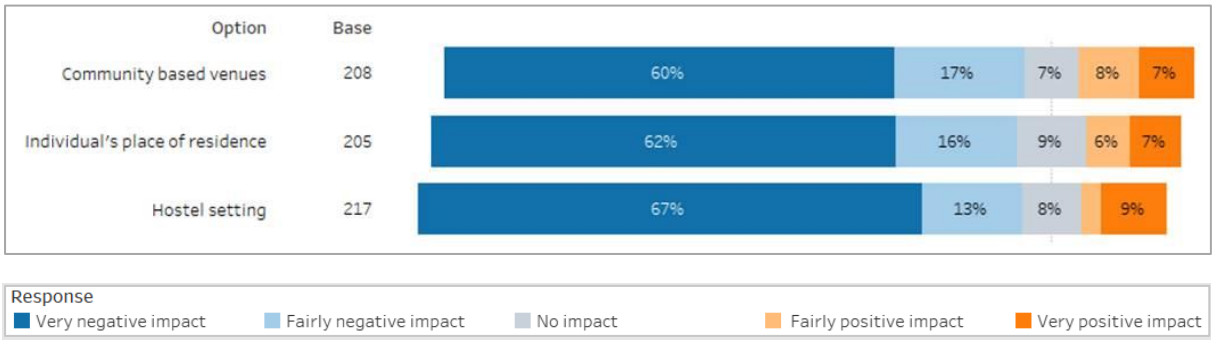
Impact of the proposal

Respondents were asked what impact they think there would be on support within various settings, as a result of the proposal.

- 81% of respondents said they think the proposal would have a negative impact on hostel settings while 12% said there would be a positive impact and 8% said there would be no impact.
- 78% of respondents said they think the proposal would have a negative impact on an individual's place of residence while 13% said there would be a positive impact and 9% said there would be no impact.

- 77% of respondents said they think the proposal would have a negative impact on community-based venues while 15% said there would be a positive impact and 7% said there would be no impact.

As a result of the proposal, what impact, if any, do you think there would be on support within the following settings?



Respondents were asked 'Why do you say this?' Responses were similar to that of the previous question. Key themes of the responses are described below:

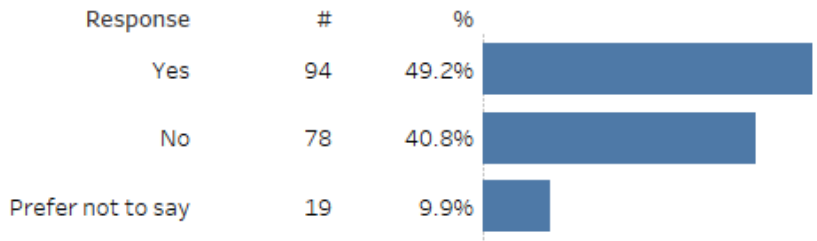
- Current offer is highly valued (with particular reference to Falcon Centre)
    - many respondents referenced their own personal experiences and listed the ways Falcon Centre has helped them, their loved ones, or the people that they supported, with particular reference to the mental and physical support provided
    - Falcon Centre is well established and working well
    - Falcon Centre staff understand the needs of this cohort
- Proposal will add to existing service provision
- Local Area Coordinators are already out in the community which is a benefit
- Need for evidence base to support the changes
- Accessibility
    - People who are homeless or are facing homelessness often have no reliable access to phones or internet so the service will be difficult to access
    - Challenges with rapport building and trust
    - services that signpost are not suitable for this cohort
    - Lack of 24/7 support
    - Loss of face to face support
    - Lack of 1-2-1 support
    - loss of drop-in services will impact on rough sleepers and means loss of support such as opening bank accounts, registering with health services, homeless applications, mental health support etc.
    - Loss of support for single men who are usually deemed low priority
    - risk of long wait times
- Loss of targeted / specialised provision
    - not person-centred
    - need for localised support rather than a centralised service
    - will worsen inequalities
- Skills / qualifications / experience / recruitment of staff providing the new service
- Short-sighted approach

    - need to increase resources/funding rather than withdrawing them
    - cutting services at a time of increased need is not the way forward
- Impact on acute services e.g., housing need, social services
    - impact on policing services
    - impact on ambulance services
    - impact on healthcare services
- Risk of closure of Falcon Centre due to loss of housing benefit
    - Loss of 30 beds
    - Increased risk of rough sleeping
    - Increased risk of anti-social behaviour and crime
    - Loss of other services provided within the centre e.g., needle exchange, food parcels, laundry service
    - safeguarding issues
    - health and safety issues
    - loss of 24/7 support
    - need more beds / accommodation not less
    - loss of familiarity
- Doesn't address support for individuals with complex needs
    - Service will not work for chaotic individuals or those with complex needs.
    - Lack of support for individuals with substance misuse issues
    - Lack of support for entrenched rough sleepers
    - impact on health and wellbeing / exacerbate health inequalities
- Each district council interprets the homelessness guidance differently
- Lack of awareness of where people can go to for support
- Need to explore how to provide the existing service more cost effectively
- Community based services are rooted in local communities
- No route for individuals to move onto independent living

Use of the First Contact Plus service

When asked whether they have had or anticipate having any difficulties with using the First Contact Plus service, 41% of respondents said no and 49% said yes.

Do you have (or anticipate having) any difficulties with using the First Contact Plus service?



Those who answered 'yes' were asked to explain the barriers they have or anticipate having with the First Contact Plus service. Key themes of the responses are described below:

- Digital exclusion, with concerns around access to smart phones, the internet and credit.
- Suitability of services to homeless individuals. For example, vulnerable people trying to access a telephone and website-based service and the need to contact a service at a convenient time due to challenges related to being homeless.
- Access issues due to factors such as older age, hearing loss, literacy, language, poor mental health and disability.
- Anxieties around using the telephone
- Unanswered phone calls and wait times for services provided by First Contact Plus
- Lack of face to face support
- Issues with using the website
- Service users having to make the calls to First Contact Plus without support, difficulty understanding the information provided on the telephone
- The need to retell experiences could result in re-triggering individuals and impact negatively on their mental health
- Lack of awareness and/or familiarity with First Contact Plus processes
- Past negative experience with First Contact Plus and a lack of trust in the services
- Concerns regarding recognition of transgender identities
- The service is not person centred

Respondents were asked whether they were aware of any barriers or difficulties that other people may have with the current or proposed service. Responses focused on issues around accessibility of the proposed service for individuals, the key themes being:

- Proposed services not accessible or appropriate for those experiencing homelessness with complex needs
- Lack of reliable access to a telephone or mobile, internet, or credit to pay for accessing the internet or phone calls
- Digital exclusion and the need for further support e.g., completing online forms.
- Communication barriers, for example, disability including hearing impairment, learning difficulties, literacy and language (including individuals whose first language is not English)
- Challenges related to accessing an online or telephone service for individuals with complex physical and mental health issues
- Lack of awareness and understanding of public health services e.g. First Contact Plus
- Lack of trust, which requires time to develop.
- A lack of confidence may prevent individuals from accessing this service
- Concerns about the need for kind and non-judgmental treatment
- Concerns that retelling experiences may result in re-triggering individuals and impact negatively on their mental health
- Concerns relating to telephone waiting times / staffing capacity
- Concerns that information on the website could be out of date
- Lack of 24/7 support
- Issues with travelling
- Loss of dedicated worker
- Lack of evidence that the service will meet the needs of homeless individuals

Some respondents identified ways to overcome potential barriers. These were:

- Ensuring face-to-face contact was made available for those with complex needs and having a dedicated worker who could provide this type of contact
- Making the First Contact Plus service easy to access
- Ensuring First Contact Plus staff are trained to communicate with this cohort
- Raise awareness of the First Contact Plus service

Other sources of support

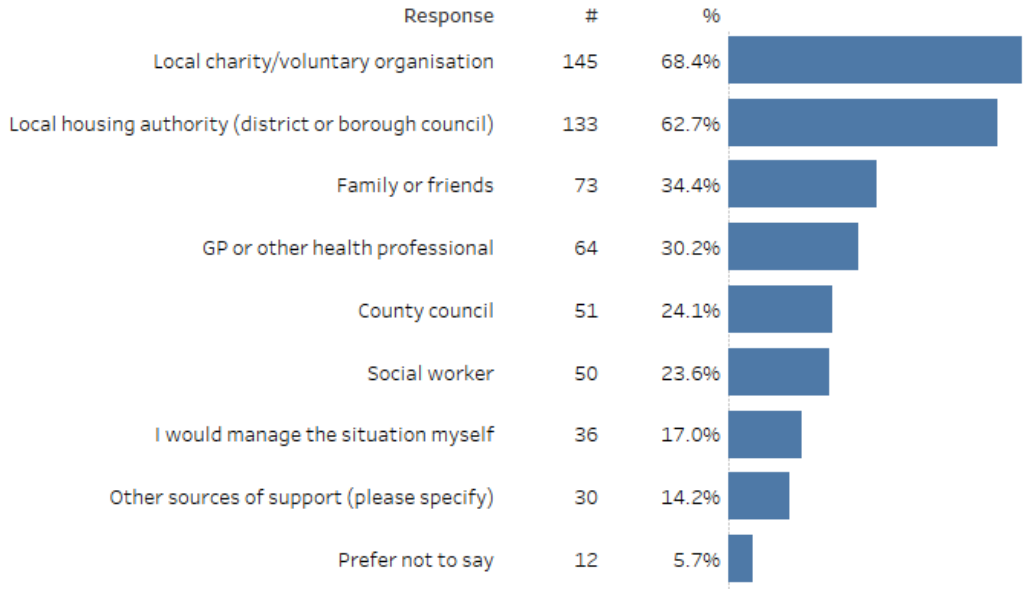
Respondents were asked if the homeless support service commissioned by the county council was not available, which other sources of homeless support would they consider.

The majority of respondents said they would consider support from a local charity/voluntary organisation (69%) or from a local housing authority (63%). This was followed by family/friends (34%) and a health professional (30%).

Where respondents chose 'other' the following detail was provided:

- Public Health
- Falcon Support Services / homeless charity / The Bridge
- Hotel / B&B
- Community centre
- No support would be accessed / be on the streets
- Housing Association

If the homeless support service commissioned by the county council was not available, what other sources of homeless support would you consider?



Alternative suggestions for future support

Respondents were asked whether they had any thoughts about how support could be provided in a different way in the future for individuals facing homelessness or who are homeless. Responses are summarised below:

- Accommodation
  - provision of a direct route into temporary accommodation
  - access to supported accommodation for complex cases
  - more temporary accommodation
  - improve standard of accommodation
  - keep Falcon Centre open
  - converting cargo containers into suitable accommodation
  - an easier system to bid for houses
  - purchase a low budget hotel where homeless people can sleep, have breakfast and use the internet
  - more suitable accommodation e.g., pet friendly

- Preventative services
  - grass roots level interventions
  - libraries to hold education/learning/employability workshops
  - education and support for people before they become homeless
  - promote public health / health improving services
  - more work could be done to prevent homelessness in the first place
  - support groups providing information on education, support with job applications, interview support
  - implement a trauma informed approach

- Awareness raising
  - raise awareness of existing offers, including services provided by local charities

- Collaboration
  - greater join up between district housing departments
  - one stop mobile hub that includes partner agencies from different teams e.g., mental health, police, housing advisors
  - collaboration across partner organisations and pooling of resources with the county council taking the lead
  - need for a long term homeless strategy

- Bespoke services
  - intensive VARM (Vulnerable Adult Risk Management) offer
  - community hubs / a one stop information and support hub
  - better support for people with dual diagnosis (mental health and substance misuse)
  - strengthen mental health services
  - a 24 hour helpline available to community services/places that provides a rapid response to those in danger
  - dedicated teams for each district to support the homelessness demands
  - bespoke provision for those who are not a priority

- more in house support / face to face support
- provision of drop ins away from hostel accommodation

- Workforce development
  - increase the number of trained outreach workers
  - adequate pay for staff providing homeless services

- Other suggestions
  - prioritise homelessness
  - lobby the government for adequate funding
  - more funding for charities that support homeless individuals
  - keep the existing offer as it is
  - speak to those who have experienced homelessness to explore their needs
  - foodbanks that offer food that doesn't need to be cooked
  - social investment for payment by results

Any other comments

The consultation survey also asked for any other comments about the proposal. The majority of responses to this section included content that had been mentioned in response to previous questions, so these have not been repeated. However, there were 2 additional themes. The first was a criticism of the consultation process, particularly in relation to accessibility for those with lived experience. The second theme was on the (perceived) lack of an impact assessment.

Additional consultation feedback - Information Sessions

The purpose of the information sessions was to ensure that all individuals who wished to comment on the consultation were well informed of the proposals. Each session began with the same presentation to talk through the proposal and give information on how individuals could comment on the proposals. After the presentation, LCC listened to the views and comments of individuals and spent time answering questions as best as possible given the complexities of homeless service provision.

The information sessions were spread out over July and August, on different days, at different times of the day, and for different audiences, to provide a suite of options for people to attend at their convenience. The sessions aimed at professionals were held via Microsoft Teams and those aimed at service users were held both online and face to face.

Due to the large numbers who registered, an additional face-to-face session was held. These sessions took place in Charnwood as this is where the highest proportion of services users currently reside. Loughborough Library was chosen as the location as it was deemed to be a neutral space which service users are familiar with and is also accessible to the general public.

Details of information sessions

Date	Time	Location	Who this is for
Monday 10 July	2pm to 3pm	Online	Professionals who support people facing or experiencing homelessness
Wednesday 12 July	1pm to 2pm	Online	People who have or are currently using the service Friends, relatives, and carers of people facing homelessness
Monday 7 August	10am to 10.45am	Loughborough Library, Granby St, Loughborough, LE11 3DZ	People who have or are currently using the service Friends, relatives, and carers of people facing homelessness
Monday 7 August	11am to 11.45am	Loughborough Library, Granby St, Loughborough, LE11 3DZ	People who have or are currently using the service Friends, relatives, and carers of people facing homelessness
Wednesday 9 August	10am to 11am	Online	Professionals who support people facing or experiencing homelessness

In total 131 individuals attended the sessions. Attendees on 12 July were a mix of both services users and professionals. Only service users attended the sessions on 7 August and only professionals attended on 10 July and 9 August.

At the face-to-face session, 60 paper copies of the survey and all supporting information were offered as a pack to all attendees. Members of LCC staff offered to support individuals to complete the survey. One individual accepted this offer.

Key themes arising from the information sessions are summarised below.

- Accessibility and awareness of consultation
    - concerns regarding accessing the consultation enabling service users to 'have their say' including inputting links and lack of focus groups.
    - service users expressed their confusion over the objective of the face-to-face information sessions. Some individuals reported that they were led to believe the sessions were arranged to 'save the Falcon Centre'.
- Accessibility of proposed service
    - concerns accessing the proposed service digitally and over the phone highlighting that homeless individuals lead chaotic lives, do not have phone credit or access to technology.

- Awareness of provision and roles and responsibilities of commissioning organisations
    - confusion over the responsibility of support for this cohort e.g., LCC, districts/boroughs, NHS, the funding streams available e.g., budgets & grants available etc. and how the funding should be distributed.
    - not understanding the disconnect between the floating support services and the 30-bed hostel, referencing the specification.
    - concerns over lack of detail on the new proposal e.g., how the proposed offer will be accessed and delivered if removed from the Falcon Centre, how the new referral system will work, how signposting and 1:1 support will be offered and whether the new service will be available 24/7.
    - recognition that other parts of the county do not have an equivalent offer to the Falcon Centre.
- Potential impact on Falcon Centre / risk of closure
    - most service users expressed they value the Falcon Centre and commend the support workers, particularly 'harm reduction workers' and 'peer mentors' for their continuity of care/support, describing the Falcon Centre as a 'family'
    - concerns if Falcon Support Services lost exempt housing benefit status that the Falcon Centre would close, beds would reduce or disappear, wraparound support and other services Falcon provide would be lost and staff lose their jobs.
    - risk of an increase in homelessness, street homeless, mental health issues, trauma and crime etc. therefore putting a strain on other services e.g., police, NHS and other public services
    - query regarding whether future plans have been put in place if the Falcon Centre were to close.
    - concerns regarding losing harm reduction workers and the needle disposal service.
    - concerns regarding providing support for those individuals with high needs or are high risk.
- Impact on homelessness
    - concerns that homelessness is increasing and may worsen if funding is cut
    - concerns on whether impact work has been done, data analysis, how many individuals will be impacted, impacts on other services, work with other commissioners and if an EIA had been completed.
- Need for evidence base to support the changes
    - concerns whether the new model is evidence based and if research has been carried out to prove it is effective including cost benefit analysis and what is affordable etc.
- Skills / qualifications / experience / recruitment of staff providing the new service
    - concerns over how LAC support would be delivered, and whether the staff have the knowledge and skills to deal with complex needs, and the capacity to meet demand.
- Need for multi-agency / partnership approach
- Doesn't address support for individuals with complex needs
- Lack of awareness of First Contact Plus and Local Area Coordinators / services

Additional consultation feedback – Responses via the consultation email address

In addition to the survey, separate submissions were received by email from Charnwood Borough Council and the Chief Housing Officers Group (CHOG). The submissions received by email were identical, however CHOG provided additional detail at the end of their response.

Both groups said they strongly disagreed with the County Council's proposal and provided the following reasons for this response:

- The First Contact Plus does not directly provide housing related support, unlike the existing arrangement
- The First Contact Plus service is based on online systems, which could pose a barrier for many customers
- District housing authorities have a duty to provide individuals with advice and assistance, but do not have a duty to provide individuals with temporary or longer-term accommodation, therefore the onward referral mechanism for practical housing related supports that exists under the current arrangement will be lost
- If the contract ends, rates of homelessness and rough sleeping are likely to increase across the area, which could increase the risk of associated community safety issues, negative public health outcomes and demand on other services (e.g., social care, health, the police and district housing authorities)
- A change in delivery model increases the risk of the Falcon Centre closing with related consequences such as rough sleeping in Loughborough town centre, across the county and across the city.

Both groups responded to the survey question regarding the level of impact there would be on support within various settings. Both groups:

- Thought there would be a very negative impact on 'hostel settings'. Although they understood that the County Council currently provide a relatively low amount of support funding for the Falcon Centre to access housing benefit under the existing arrangement. Both groups felt that if the support funding were to be removed then the risk of hostel closure and closure of community-based services could increase
- Said there was likely to be a fairly negative impact on 'community-based venues' due to demand transfer. They said these venues may not be able to provide support services tailored to the client group and felt that it was unclear how the support will continue to operate under the current proposals
- Felt the proposal would have a very negative impact on an 'individual's place of residence', as less practical direct housing support will be provided which could increase the risk of tenancy failure and increase demand for homelessness services.

When asked about the barriers or difficulties that people may have with the current or proposed service, both groups:

- Re-emphasised that the existing support is not being replaced with a similar service

- Felt that the existing client group will be less able and/or willing to access First Contact Plus due to the online systems acting as a barrier
- Raised that there is no option for telephoning on the First Contact Plus website
- Mentioned that district authorities had trialled a technological solution for accessing housing support in the past, where there were challenges for the client group engaging with it
- Felt a remotely provided service would be less accessible for clients with vulnerabilities, such as learning difficulties
- Were concerned that the floating support element of the current service, which works closely with local authorities and housing providers to agree sustainable arrangements, would be lost

Both the CHOG and Charnwood Borough Council provided thoughts about how support could be provided in a different way in the future, for individuals facing homelessness. The following were mentioned:

- Concerns that the proposals are a reduction in funding to the whole homelessness system, which is already under strain with increasing demand, lack of accommodation options and complexity of customer needs
- At the time that a recent Joint Strategic Needs Assessment (JSNA) has recognised homeless people as a vulnerable group, it has been proposed to remove funding from services for this group. The CHOG felt it was difficult to see how a proposal that will remove housing related support and the sole accommodation option for excluded households can support the aim outlined in the JSNA
- The proposed Local Area Coordination service does not provide the accommodation service that the Falcon Centre provides
- District Housing authorities cannot deliver/commission the services that are delivered under the current contract without additional funding
- As service demands / service costs are likely to increase, housing authorities will therefore have a continued need to prioritise services for individuals who are owed a duty under Part 7 of the Housing Act 1996 (as amended).
- It was suggested that the current funding be passed to district housing authorities to enable direct delivery or to enable the commissioning of accommodation-based / floating support services
- A need for a systems approach to the provision of support to homeless customers, with all partners contributing to the different levels of need and support required – maximising the budget available
- Engagement with stakeholders in a structured way, with a view to exploring possible solutions
- Reviewing the service specification and refine expectations to allow a service model that better meets needs and is more closely aligned to commissioners' priority outcomes.

During the consultation period, two letters were received from Falcon Support Services that were written by service users residing at the Falcon Centre. Both individuals included examples of the great support that the Falcon Centre provides and wrote about their own personal experience. One letter explained how the Falcon Centre had helped them gain qualifications, secure permanent housing and a job, and feel like a valued member of the community. The other letter mentioned that the help from the Falcon Centre had enabled them to gain confidence, secure housing, look forward to the future and change their life for the better.

Additional consultation feedback – Health and Overview Scrutiny Committee

The Health Overview and Scrutiny Committee considered the new service model as part of the consultation process. In supporting the proposed model, the Committee noted that the draft revised model for the delivery of homeless support be noted, and the proposed use of the Local Area Coordination service be welcomed.

Thematic summary of the consultation

The information gathered from this consultation will be used to shape the final proposal.

A summary of key themes is described below:

- Efficiency savings can be made while maintaining support for homeless people.
- Process of obtaining/providing support would be streamlined which would enable access to help for other issues that people facing homelessness might be experiencing.
- Proposed model (First Contact Plus and Local Area Coordination service) is in place and working well
- Positive move forward to focus on prevention
- Proposal will add to existing provision
- Potential for a negative impact on levels of homelessness
- Need for evidence base to support the changes
- Concerns regarding accessibility of the proposed service
- Concerns regarding loss of targeted / specialised provision
- Concerns regarding skills / qualifications / experience / recruitment of staff providing the new service
- Concerns that the approach is short-sighted
- Concerns over impact on acute services
- Risk of closure of Falcon Centre
- Need for multi-agency / partnership approach
- Concerns over loss of targeted support for individuals with complex needs
- Concerns over lack of focus on housing needs
- Current offer is highly valued
- Confusion of roles and responsibilities of the County Council versus district offer
- Lack of awareness of First Contact Plus and Local Area Coordinators
- Lack of awareness of existing homeless support services
- Need to explore how to provide the existing service more cost effectively

A summary of suggestions for how support could be provided in a different way is provided below:

- Keep the offer as it is / No change
- Greater focus on accommodation
- Greater focus on preventative services
- Raise awareness of existing offers, including services provided by local charities
- Greater collaboration

- Provision of bespoke / targeted services based on need
- Workforce development
- Increase funding
- Utilise feedback from those with lived experience on a regular basis
- Transfer budget to district councils to enable direct delivery or to enable the commissioning of accommodation-based / floating support services
- Review the service specification and refine expectations to allow a service model that better meets needs and is more closely aligned to commissioners' priority outcomes.

Appendices

Appendix A – Webpage introduction

Appendix B – Supporting information

Appendix C – Questionnaire

Appendix D – Easy Read version of supporting information

Appendix E – Frequently Asked Questions

Appendix A – Webpage introduction

Homeless support services

Have your say on proposed changes to homeless support services across Leicestershire

This consultation runs from 28 June until midnight on Sunday 3 September 2023

Leicestershire County Council is committed to helping people, and we have a wide range of support in place for those needing it.
Like councils across the country, we are facing growing financial pressure alongside increasing demand, so we need to look at providing services in a different way.
The current contract for homelessness support services ends in March 2024.

About the proposals
Following a review of the current service, and the financial challenges facing the council, we are proposing to change the way we provide support to individuals who are facing homelessness or who are homeless.
The proposal is for the council to stop funding a dedicated homeless support service, and instead to provide support through the council's existing public health services (mainly First Contact Plus) where a wider number of people are eligible for support.

Have your say
A public consultation is taking place from **28 June to 3 September 2023,** seeking views on the proposed changes**.**

This consultation is open to everyone in Leicestershire. We are particularly keen to hear from:

- people facing homelessness
- people who have or are currently using the homeless support service
- friends, relatives, and carers of people facing or experiencing homelessness
- professionals who support people facing or experiencing homelessness

Homeless support services – consultation supporting information document

Online survey [link] Please read the supporting document before completing the survey.

This consultation is about the homeless support service paid for by Leicestershire County Council. Any support or services provided by other agencies such as district and borough councils, is not part of this consultation.

Information sessions

There will be information events taking place during the consultation. Staff from the council will be available to present the proposal and answer any queries.

To attend, individuals should register their interest by emailing their name and preferred date to phconsultations@leics.gov.uk or by calling 0116 305 0705.

Events for people who have or are currently using the service, or friends, relatives, and carers of people facing homelessness

- Wednesday 12 July, 1pm – 2pm: Online Microsoft Teams Meeting
- Monday 7 August, 10am – 1pm: Loughborough Library, Granby St, Loughborough, LE11 3DZ

Events for professionals who support people facing or experiencing homelessness

- Monday 10 July, 2pm – 3pm: Online Microsoft Teams Meeting
- Wednesday 9 August, 10am – 11am: Online Microsoft Teams Meeting

Alternative formats

If you're able to, please complete this survey online using the link above.

For alternative formats of the survey, including paper copies please email phconsultations@leics.gov.uk or call 0116 305 0705

An easy read version of the consultation will also be available on this webpage shortly.

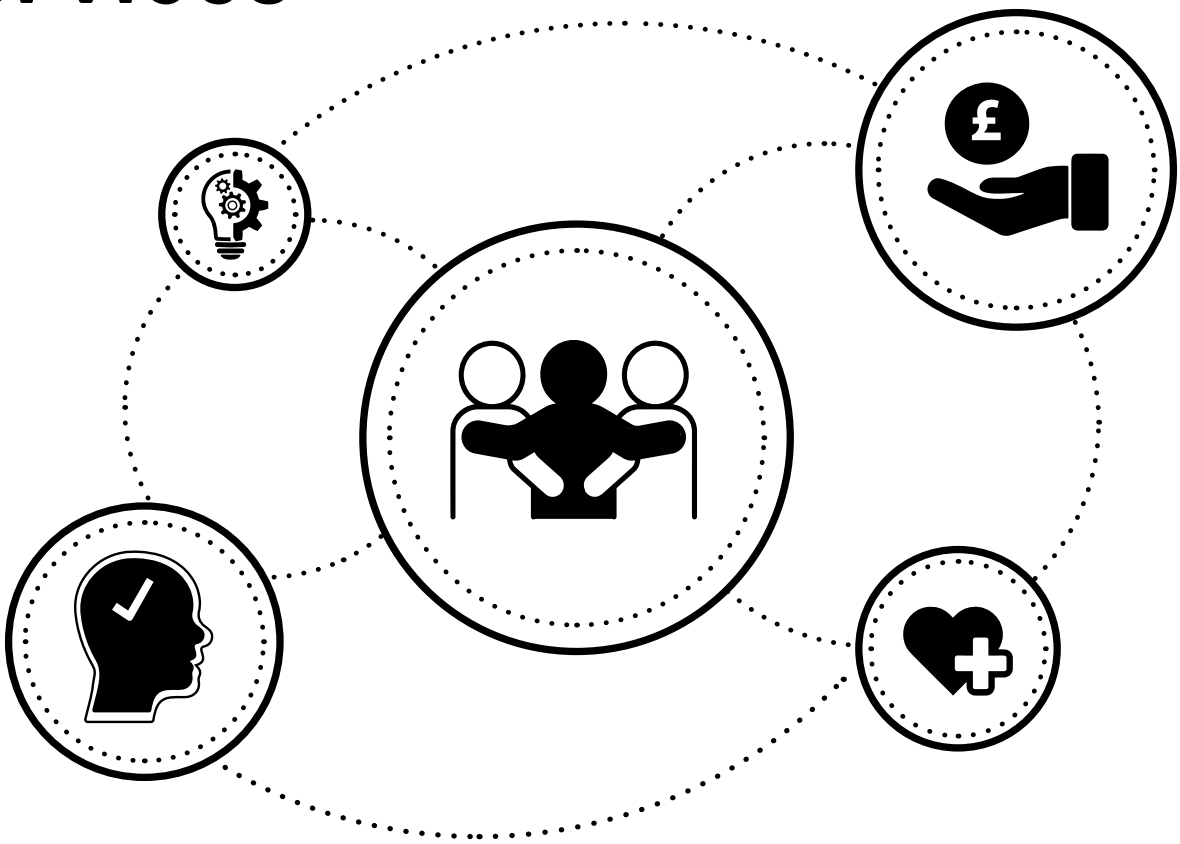
The **closing date** to complete the questionnaire is **midnight on 3 September 2023**.

What happens next

After the consultation closes in September, we'll analyse the results, and a report will be presented to the council's cabinet in winter 2023.

Leicestershire County Council

Have your say on proposed changes to homeless support services



Tell us how this might affect you

Online: leicestershire.gov.uk/homeless-consultation

For general enquiries or comments about this consultation, email phconsultations@leics.gov.uk

Public consultation: Please submit your views by midnight on **3 September 2023**

Introduction

Leicestershire County Council commissions a service (previously known as Housing Matters) that supports adults who are facing homelessness, or who are homeless, to gain the skills needed to either live independently or live in supported accommodation.

The support is provided within:

- hostels: mainly within Falcon Centre (located in Loughborough)
- community based locations: Syston Community Centre, Hinckley Salvation Army, Blaby Baptist Church, The Symington Building (Market Harborough), Wigston Salvation Army, The Centre - Mary's Place (Melton), George Smith Hub, Holy Trinity Parish Church (Ashby)
- an individual's place of residence

Examples of support include:

- setting up and maintaining a tenancy
- developing domestic or life skills
- debt, budgeting, and benefits
- support to engage with local community resources
- accessing health and wellbeing services
- accessing education, employment, and volunteering
- improving social support networks
- advice on repairs and home maintenance
- safeguarding vulnerable individuals

Why we are consulting

Following the introduction of the Homelessness Reduction Act 2017, The Department for Levelling Up, Housing and Communities has provided district and borough councils (as the housing authorities) with money, through the homelessness prevention grant, to provide support for individuals who are homeless or at risk of being homeless.

Leicestershire County Council's current contract for homelessness support services ends on 31 March 2024. Like councils across the country, we are facing growing financial pressure alongside increasing demand, so we need to look at providing services in a different way.

Our support to people who are homeless, or facing homelessness was an area which was identified for review, as part of our budget plans, which we consulted people on last winter.

The county council is committed to helping people, and we have a wide range of support in place for those needing it, as you'll read later on in this document. The end of this contract gives us the chance to review the support we have and make sure it will meet the needs of those who need help, wherever they are in the county.

Proposal

Following a review of the current service and the financial challenges facing the council, we are proposing to change the way we provide support to individuals who are facing homelessness or who are homeless.

The proposal is for the county council to cease funding a dedicated homeless support service, and instead to provide support via the council's existing public health services where a wider number of people are eligible for support.

The principles of the proposed approach centre around the following:

- Providing coverage across the whole of Leicestershire.
- Eligibility that includes any adult who is facing homelessness or at risk of becoming homeless.
- Access to support via a central point of access.
- Support that is tailored to the needs of each individual.
- Greater focus on improving the health and wellbeing of individuals.

The principles will be achieved mainly through the universal offer of First Contact Plus and the Local Area Coordination service as opposed to a bespoke offer specifically for individuals who are homeless.

First Contact Plus is an online tool which helps adults in Leicestershire to access information, advice, help and support on a range of services. Examples include:

- Department for Work and Pensions for support to access the right benefits.
- Citizens Advice for debt management support.
- Community Recovery Team and Local Area Coordination Team for one-to-one support.
- Warm Homes Service for support on housing issues such as damp, mould, draught proofing, and signposting to funding for energy efficiency measures.
- Health and wellbeing services such as smoking cessation, drug and /or alcohol misuse, healthy weight, physical activity, and sexual health services.
- Mental wellbeing services such as Vita Minds (a talking therapies service for low level mental health support).
- Services provided by the Council's Adults and Communities Department, including community support workers and social care.
- Adult Learning and Multiply for support on accessing learning and educational courses, including support on budgeting. Multiply is a programme aimed at helping adults to improve their numeracy skills.

The offer is delivered by the county council in partnership with GPs, the police, voluntary groups, health organisations, social care departments, and district / borough councils to help adults across the county. Referrals can be made by the person needing support, by a friend or family member on the persons behalf or by a professional.

Local Area Coordinators work with individuals who may be vulnerable, or at risk of crisis, by building a supportive community around them thereby reducing social isolation. Where one-to-one support is required, the Local Area Coordination service is well established within communities and so can meet this need through their links with community groups, drop-in sessions and through the direct provision of one-to-one support at a suitable location.

The county council has other contracts where people can get support. For example, we have a service that supports people who are homeless because of domestic abuse. We also have a service that provides substance misuse support.

A key strength of the proposed approach is that links can be made to a broader range of health and wellbeing services.

Further information on First Contact Plus and the Local Area Coordination Service can be found here:

First Contact Plus

firstcontactplus.org.uk

Local Area Co-ordination

www.leicestershire.gov.uk/local-area-co-ordinators

Who should fill in the questionnaire?

This consultation is open to everyone. We are particularly keen to hear from:

- people facing homelessness
- people who have or are currently using the service
- friends, relatives, and carers of people facing or experiencing homelessness
- professionals who support people facing or experiencing homelessness

How will the consultation work?

This consultation is about the homeless support service commissioned by Leicestershire County Council. Any support or services provided by other agencies such as district & borough councils, is not part of this consultation.

The consultation begins on 28 June 2023 and will end at **midnight on 3 September 2023**.

We ask that you complete the online version of the questionnaire if you can. However, we understand that this is not always possible, so a paper copy is available on request by calling 0116 305 0705 or emailing phconsultations@leics.gov.uk

To submit your views, please fill out the consultation questionnaire and make sure it reaches us by **midnight on 3 September at the latest**.

The survey is available online at www.leicestershire.gov.uk/homeless-consultation

We advise that you regularly refer to this document when completing the questionnaire.

Public Engagement

Information sessions have been arranged where staff from the county council will be available to present the proposal and answer any queries you may have. Information on how to respond to the consultation will also be available. Dates, times, and locations of the information sessions are indicated below. If you would like to attend an information session, please register your interest by emailing your contact details and preferred date to phconsultations@leics.gov.uk and we will send out an invite to you. Alternatively, you can register your interest by calling 0116 305 0705.

Date	Time	Location	Who this is for
Monday 10 July	2pm to 3pm	Online	Professionals who support people facing or experiencing homelessness
Wednesday 12 July	1pm to 2pm	Online	People who have or are currently using the service Friends, relatives, and carers of people facing homelessness
Monday 7 August	10am to 1pm* *This session will begin with a short presentation on the proposal.	Loughborough Library, Granby St, Loughborough, LE11 3DZ	People who have or are currently using the service Friends, relatives, and carers of people facing homelessness
Wednesday 9 August	10am to 11am	Online	Professionals who support people facing or experiencing homelessness

Further Information

Responses will be confidential, and findings shared will not contain any personal identifiable data.
If you have any questions or queries on this consultation, please email phconsultations@leics.gov.uk

Glossary of terms

Contract: a legal document that states and explains a formal agreement between two or more organisations.

Commissioned service: care, support or supervision that has been arranged and paid for on an individual's behalf by a public authority, like a council.

Statutory duty: functions that the council has a legal obligation to provide.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો
0116 305 0705 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ
0116 305 0705 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে
0116 305 0705 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں
0116 305 0705 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

假如閣下需要幫助, 用你的語言去明白這些資訊, 請致電
0116 305 0705, 我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku,
zadzwoń pod numer 0116 305 0705, a my Ci dopomożemy.

Leicestershire County Council

Appendix C - Questionnaire

Have your say on proposed changes to homeless support services in Leicestershire

Leicestershire County Council commissions a service (previously known as Housing Matters) that supports adults who are facing homelessness or who are homeless, to gain the skills needed to either live independently or live in supported accommodation. The support is provided within hostels, community-based locations and within an individual's place of residence.

Following a review of the current service and the financial challenges facing the county council, we are proposing to change the way we provide support to individuals who are facing homelessness or who are homeless. The proposal is for the county council to cease funding a dedicated homeless support service, and instead to provide support via the council's existing public health services where a wider number of people are eligible for support.

This consultation is open to everyone. We are particularly keen to hear from:

- people facing homelessness
- people who have or are currently using the service
- friends, relatives, and carers of people facing or experiencing homelessness
- professionals who support people facing or experiencing homelessness

This consultation is about the homeless support service commissioned by Leicestershire County Council. Any support or services provided by other agencies such as district & borough councils is not part of this consultation.

Further information on the proposals can be found here:
http://www.leicestershire.gov.uk/homeless-consultation

Please read the supporting information provided before completing the questionnaire. It is also advised that you regularly refer to the supporting information when answering the questions.

For general enquiries or comments about this consultation, please email PHconsultations@leics.gov.uk

Thank you for your assistance. Your views are important to us.

Please note: Your responses to the main part of the survey (including your comments) may be released to the general public in full under the Freedom of Information Act 2000. Any responses to the questions in the 'About you' section of the questionnaire will be held securely and will not be subject to release under Freedom of Information legislation, nor passed on to any third party.

Q1 In what role are you responding to this consultation? Please select the option from the list below that most closely describes your role.
Please select one option only.

☐ Someone who has been supported or is being supported by the homeless support service	**Continue to Q2**
☐ A friend, relative or carer of someone who has been supported or is being supported by the homeless support service	**Continue to Q2**
☐ Interested member of the public	**Continue to Q2**
☐ An employee, volunteer or provider of homeless support services	**Continue to Q2**
☐ Leicestershire County Council staff member	**Continue to Q2**
☐ Representative from a district or borough council	**Go to Q3**
☐ Representative of a public sector organisation (including NHS)	**Go to Q3**
☐ Representative of a voluntary sector organisation, charity or community group	**Go to Q3**
☐ Representative of a business or private sector organisation	**Go to Q3**
☐ County, district or parish councillor	**Go to Q6**
☐ Other (please specify)	**Go to Q6**
☐ Prefer not to say	**Go to Q6**

If 'Other', please specify

Q2 Which area do you **live in**?
Please select one option only.

- [ ] Blaby
- [ ] Charnwood
- [ ] Harborough
- [ ] Hinckley and Bosworth
- [ ] Melton
- [ ] North West Leicestershire
- [ ] Oadby & Wigston
- [ ] Outside of Leicestershire
- [ ] No fixed address
- [ ] Don't know
- [ ] Prefer not to say

Now please go to Q6.

Q3 Which area(s) do you **work in**?
Please select one option only.

- [ ] Blaby
- [ ] Charnwood
- [ ] Harborough
- [ ] Hinckley and Bosworth
- [ ] Melton
- [ ] North West Leicestershire
- [ ] Oadby & Wigston
- [ ] Across the whole of Leicestershire
- [ ] Across the whole of Leicester, Leicestershire and Rutland (LLR)
- [ ] Other (please specify)
- [ ] Prefer not to say

If 'Other', please specify

If you are responding on behalf of a business, community group or other organisation, please continue to Q4.

Otherwise please go to Q6.

Q4 Please provide your details

Name:

Role:

Organisation:

This information may be subject to disclosure under the Freedom of Information Act 2000

Q5 Are you providing your organisation's official response to the consultation?
Please select one option only.

- [ ] Yes
- [ ] No

Current service

Leicestershire County Council commissions a service (previously known as Housing Matters) that supports adults who are facing homelessness or who are homeless. The support is provided within hostels (mainly within the Falcon Centre located in Loughborough), community based locations (Syston Community Centre, Hinckley Salvation Army, Blaby Baptist Church, The Symington Building, Wigston Salvation Army, The Centre - Mary's Place, George Smith Hub, Holy Trinity Parish Church [Ashby]), and within an individual's place of residence.

Examples of support include: setting up and maintaining a tenancy, developing domestic or life skills, debt & budgeting support, support with accessing benefits, support to engage with local community resources, accessing health and wellbeing services, accessing education, employment & volunteering, improving social support networks and advice on repairs and home maintenance, and safeguarding.

Q6 Have you used or tried to access the homeless support service?
Please select one option only.

☐ Yes, in the last year	**Continue**
☐ Yes, over a year ago	**Go to Q8**
☐ No, I have never used or tried to access this service	**Go to Q8**
☐ Prefer not to say	**Go to Q8**
☐ Don't know / can't remember	**Go to Q8**

Q7 Which, if any, of the following support offers did you receive or try to access from the homeless support service? Please tick all that apply.

- ☐ Setting up and maintaining a tenancy
- ☐ Developing domestic or life skills
- ☐ Debt, budgeting, or support with benefits
- ☐ Accessing health and wellbeing services
- ☐ Accessing education, employment, and volunteering
- ☐ Improving social support networks
- ☐ Advice on repairs and home maintenance
- ☐ Other support (please specify)
- ☐ Prefer not to say
- ☐ Don't know / can't remember

Please specify the 'other support' you have received from the service

Our proposal

The county council are proposing to change the way we provide support to individuals who are facing homelessness or who are homeless. The proposal is for the council to cease funding a dedicated homeless support service, and instead to provide support via the council's existing public health services where a wider number of people are eligible for support.

This means support will be mainly provided by First Contact Plus and the Local Area Coordination service. In addition, the council has other contracts where people can continue to get support.

Further details on the proposal are available within the supporting information.

Q8 Are you aware of the county council's First Contact Plus service?
Please select one option only.

- [ ] Yes, I have used this service for myself or on behalf of someone
- [ ] Yes, but I haven't used this service
- [ ] No, I have never heard of it
- [ ] Don't know

Q9 Are you aware of the county council's Local Area Coordination service?
Please select one option only.

- [ ] Yes, I have used this service for myself or on behalf of someone
- [ ] Yes, but I haven't used this service
- [ ] No, I have never heard of it
- [ ] Don't know

From 1st April 2024, our proposal is to provide support to individuals who are facing homelessness, or who are homeless, mainly through the existing First Contact Plus service.

Q10 To what extent do you agree or disagree with this proposal?
Please select one option only.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
☐	☐	☐	☐	☐	☐

Why do you say this?

Q11 As a result of the proposal, what impact, if any, do you think there would be on support within the following settings?
Please select one option per row only.

	Very positive impact	Fairly positive impact	No impact	Fairly negative impact	Very negative impact	Don't know
Hostel setting	☐	☐	☐	☐	☐	☐
Community based venues	☐	☐	☐	☐	☐	☐
Individual's place of residence	☐	☐	☐	☐	☐	☐

Please could you provide reasons for your answers above

We want to make sure the services we provide are accessible to all. We want to understand if our current services or proposed changes may present barriers for some people.

Q12 Do you have (or anticipate having) any difficulties with using the First Contact Plus service? This might be for any reason such as (but not limited to) age, sex, sexual orientation, disability, gender reassignment, pregnancy and maternity, race, religion or belief or marriage and civil partnership.
Please select one option only.

- [ ] Yes
- [ ] No
- [ ] Prefer not to say
- [ ] Don't know

If yes, please explain the barriers (e.g. what services you have (or anticipate having) difficulties with, and what would overcome these)

Q13 Are you aware of any barriers or difficulties that other people may have with our current or proposed service?

Q14 If the homeless support service commissioned by the county council was not available, what other sources of homeless support would you consider?
Please tick all that apply.

- [ ] Local housing authority (district or borough council)
- [ ] County council
- [ ] Local charity/voluntary organisation
- [ ] Social worker
- [ ] GP or other health professional
- [ ] Family or friends
- [ ] I would manage the situation myself
- [ ] Other sources of support (please specify)
- [ ] Prefer not to say
- [ ] Don't know / can't remember

If 'Other sources of support', please specify

Q15 Please tell us if you have any thoughts about how support could be provided in a different way in the future for individuals facing homelessness or who are homeless.

Q16 If you have any other comments about the proposal, please tell us below.

Please continue if you said in Q1 that you are responding as any of the following:

- Someone who has been supported or is being supported by the homeless support service
- A friend, relative or carer of someone who has been supported or is being supported by the homeless support service
- Interested member of the public

Otherwise, please skip to the instructions at the end of the survey.

About you

Leicestershire County Council is committed to ensuring that its services, policies, and practices are free from discrimination and prejudice, address the needs of all sections of the community and promote and advance equality of opportunity.

Many people face discrimination in society because of their personal circumstances and for this reason we have decided to ask these monitoring questions.

We would therefore be grateful if you would answer the following questions. You are under no obligation to provide the information requested, but it would help us greatly if you did.

Q17 What is your gender?
Please select one option only.

- [ ] Male
- [ ] Female
- [ ] I use another term
- [ ] Prefer not to say

Q18 Is the gender you identify with the same as your sex registered at birth?
Please select one option only.

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

Q19 What was your age on your last birthday? (Please enter your age in numbers not words)

Q20 Do you have a long-standing illness, disability or infirmity?
Please select one option only.

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

Q21 What is your ethnic group?
Please select one option only.

- [ ] White
- [ ] Mixed
- [ ] Asian or Asian British
- [ ] Black or Black British
- [ ] Other ethnic group
- [ ] Prefer not to say

Thank you for completing this survey. Your views are important to us.

When the consultation closes on 3 September 2023, we will report the results back to Cabinet in November 2023.

Please return your completed survey to:

Homelessness Support Services Consultation
Room G58, Public Health
Leicestershire County Council
Have Your Say
FREEPOST NAT18685
Leicester
LE3 8XR

Data Protection: Personal data supplied on this form will be held on computer and will be used in accordance with current Data Protection Legislation. The information you provide will be used for statistical analysis, management, planning and the provision of services by the county council and its partners. Leicestershire County Council will not share any personal information collected in this survey with its partners. The information will be held in accordance with the council's records management and retention policy. Information which is not in the 'About you' section of the questionnaire may be subject to disclosure under the Freedom of Information Act 2000.

Leicestershire County Council

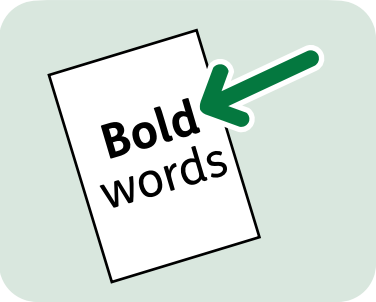
Changing how we support homeless people

What do you think?

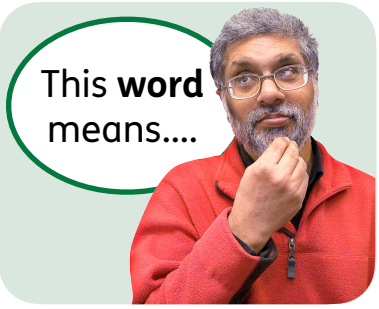
Easy Read

This is an Easy Read version of some information. It may not include all of the information but it will tell you about the important parts.

This Easy Read booklet uses easier words and pictures. You may still want help to read it.



Some words are in **bold** - this means the writing is thicker and darker.



These are words that some people will find hard. When you see a bold word, we will explain it in the next sentence.

Blue and underlined words show links to websites and email addresses. You can click on these links on a computer.

What is in this booklet

About this booklet

Leicestershire County Council is looking at ideas to change how we support homeless people, and people who may become homeless.

Before we make our decisions, we want to know what you think.

Please tell us what you think by taking part in our questionnaire online, or by post.

You can ask us to send you a questionnaire by:

- Phoning us: 0116 305 0705

- Emailing us: phconsultations@leics.gov.uk

We need to have your answers to the questionnaire by midnight on Sunday, 3 September 2023.

How we help homeless people

At the moment, we pay for a service to help support homeless people, and people who may become homeless.

The service helps homeless people to live independently or live with support.

The service helps people in:

- Hostels.

- Some local community places.

- Their own homes.

The service helps people to:

- Learn how to look after themselves.

- Look after their money.

- Find activities to do in the local area.

- Get the health services they need.

- Get support to find a job or training.

- Look after their home.

- Keep safe.

Why change?

Leicestershire County Council has to look at the services it offers.

The current homeless support service ends on 31 March 2024.

We want to look at other options to support homeless people, and people who may become homeless, from 1 April 2024.

Our idea for change

Instead of paying to carry on the current service, we plan to support homeless people, and people who may become homeless, using the public health services we already provide.

This would mean that:

- We would support people all across Leicestershire.

- We would include any adult who is homeless or who might become homeless.

- People would get the support that is right for them.

- The support would focus on improving people's health.

- People would be able to access their support through one main service.

Leicestershire County Council provides First Contact Plus which is a service that is available to all adults in Leicestershire.

First Contact Plus helps people find support with things like:

- Health and wellbeing.

- Money advice.

- Work and training.

- Learning.

Tell us what you think

Please tell us what you think by either:

- Completing our online questionnaire.

- Asking us to send you a questionnaire by post.

You can ask us to send you a questionnaire by:

- Phoning us: 0116 305 0705

- Emailing us: phconsultations@leics.gov.uk

We need your answers to the questionnaire by midnight on Sunday, 3 September 2023.

We are also going to have some information sessions where people can speak to us directly about the changes.

Online

There will be an online information session on Wednesday, 12 July - from 2pm to 3pm.

Click here to register to take part in the online information session.

Face-to-face

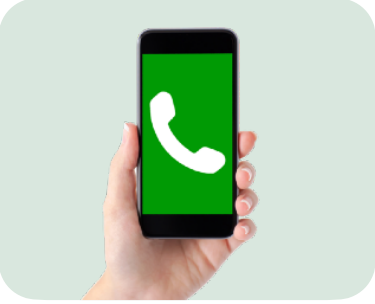
There will be a face-to-face information session on Monday, 7 August - from 10am to 1pm at:

Loughborough Library
Granby Street
Loughborough
LE11 3DZ

Click here to register to take part in the face-to-face information session.

Find out more

You can look at our website here:
www.leicestershire.gov.uk/homeless-consultation



You can contact us by:

- Phone: 0116 305 0705

- Email: phconsultations@leics.gov.uk

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The booklet includes images licensed from Photosymbols & Shutterstock.

AUGUST 2023

Leicestershire County Council

Proposed changes to homeless support services

Frequently Asked Questions

Q) We are not able to submit multiple responses for people via a public computer. How can we rectify this?

A) If individuals have their own log in details for a public computer then the same computer can be used by each individual to submit a response.

Alternatively, the cache on a computer will save previous answers. If you search 'clearing the cache' on the internet it will give you instructions on how to clear the cache after each submission which will enable different individuals to submit a response from the same computer.

Alternatively, paper copies of the questionnaire can be requested by calling 0116 305 0705.

Q) Has any impact work been done around the proposal?

A) A draft Equality Impact Assessment (EIA) has been completed and the impact of a change in service model will be informed by the outcome of consultation. This will be presented to Cabinet after the consultation closes. Initial findings are that the proposal will have a wider reach and be able to offer additional support.

Q) Is there any evidence about the effectiveness of the model that you're proposing?

A) A report produced by the Local Government Association (LGA) which includes a research report, highlights the importance of focusing on homelessness prevention for example through supporting with financial stability, social connections, opportunities, and good health. The model that we are proposing takes a stronger focus on prevention of homelessness and therefore has a wider reach than the current offer. Further information on the LGA report can be found here www.local.gov.uk/publications/re-thinking-homelessness-prevention

Q) How does the proposal address support for those with higher levels of need?

A) The proposal we have put forward takes a stronger focus on prevention of homelessness. This includes aspects such as supporting with financial stability, social connections, education & training opportunities, and good health. Where individuals require support with housing, this responsibility would fall under district & borough councils, and where individuals require support with complex health issues, this responsibility would fall under health services.

Q) How do individuals who are going to be street homeless access support?

A) Any person who is rough sleeping can utilise the Rough Sleepers Initiative (RSI) which is provided by 'The bridge'. The Rough Sleeper Initiative is funded by the Department for Levelling Up, Housing and Communities to support people who are rough sleeping. Further information can be found here: www.thebridge-eastmidlands.org.uk/services/rapid-rehousing-project

Q) How will the proposed service be promoted and advertised?

A) After the consultation closes in September, we will analyse and use the results to develop a final proposal. This will be presented to the council's cabinet in winter 2023. If the proposal is approved, we will commence work to implement the new offer which will include a communications plan to the public and stakeholders to raise awareness and promote the offer.

Q) How are service users being reached to find out the impact on them?

A) Many different organisations have been contacted regarding the consultation. We have asked for these organisations to disseminate the information to their service users.

Social Media is being used to engage with the public and encourage as many responses as possible.

Paper copies of the questionnaire have been sent to current providers of the service and are available upon request.

Information events have been hosted by Leicestershire County Council to inform service users of the proposal and to encourage all individuals to submit their views.

Q) The current homeless support service includes provision within a 30-bed hostel. Why isn't the 30 bed provision being considered in your proposal?

A) An element of the current service includes support to individuals residing in hostel accommodation. The support aims to help individuals to live independently and to access local health and wellbeing support.

It should be noted that the funding does not pay for the running of homeless hostel buildings.

The proposal being put forward is to provide support to all adults across Leicestershire rather than limiting the support to those staying in a homeless hostel.

Q) Is the proposed service available 24 hours a day 365 days a year as homelessness is not between 9-5 Monday to Friday?

A) As before, referrals into the First Contact Plus service for support and advice can be made at any time online at www.firstcontactplus.org.uk

All referrals aim to be responded to within two working days. If you require emergency assistance, you should contact the relevant emergency service.

Q) In the proposed offer, who will support those in their own properties?

A) Who or which service supports those in their own home will depend on the individual's needs.

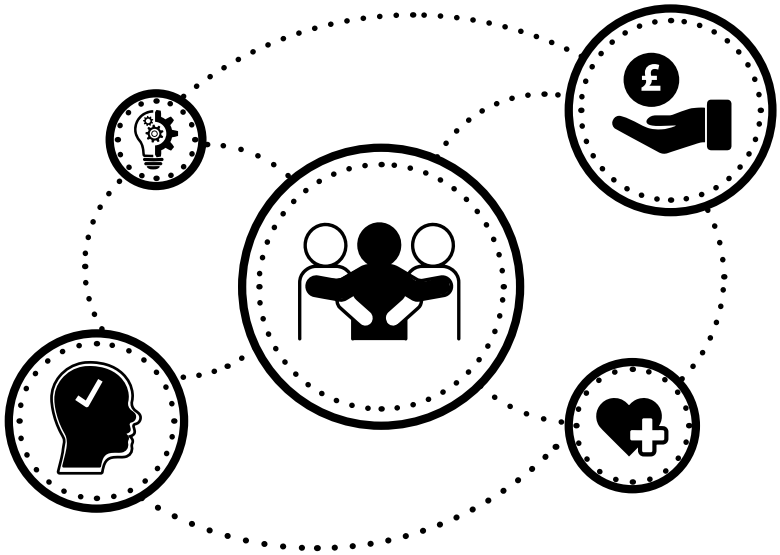
The First Contact Plus service will contact the individual requiring support to assess their needs and provide advice.

If the assessment identifies that one-to-one support is required, this may be provided by the Local Area Coordination Service or an alternative suitable offer if this is available.

Q) The proposal is to support a homeless person over the phone rather than face to face support. How do you propose providing support over the phone?

A) The First Contact Plus service will contact the person requiring support by phone to assess their needs and provide initial advice. This assessment takes place over the phone to help advisors understand whether ongoing support is required.

If ongoing support is required, First Contact Plus can make the referral directly into the most suitable service/s. For example, if the initial assessment identifies that a person requires support for alcohol misuse, First Contact Plus can refer the person to the substance misuse treatment service where face to face support can be provided.



X0319

Equality Impact Assessment Form

Before completing this form, please refer to the supporting guidance document and alert the Policy Team (Insert email).

The purpose of the assessment is to identify risks and the following actions should be taken to treat any known equality risks

- Remove risks: abandon the proposed policy or practice
- Mitigate risks – amend the proposed policy or practice so that risks are reduced
- Justify policy or practice in terms of other objectives

Public Sector Equality Duty

Compliance with the equality duties ensures Leicestershire County Council can demonstrate it is making decisions in a fair, transparent, and accountable way by considering the needs and rights of different members of the community. The Public Sector Equality Duty (PSED) in the Equality Act 2010 places the County Council (or a third-party exercising function on its behalf) under a duty to have "**due regard"** to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between persons who share a relevant protected characteristic and those who do not. The nine protected characteristics are: age; disability; gender reassignment; pregnancy and maternity; race, religion, or belief; marriage and civil partnership, sex, and sexual orientation. The fact that others outside these protected groups are also affected by any decision, does not affect the operation of the PSED.

The requirement to advance equality of opportunity requires the decision-maker to have due regard to the need to remove or minimise disadvantages suffered by persons who share a relevant protective characteristic, take steps to meet their needs and encourage them to participate in public life or in any other activity in which participation is disproportionately low. Fostering good relationships requires the decision-maker to have due regard to the need to tackle prejudice and promote understanding. The statutory framework recognises that compliance with the public sector equality duty may involve treating some persons more favorably than others.

Leicestershire County Council

1- Policy details	
Name of policy	Review of Homeless support provision
Department and service	Public Health
Who has been involved in completing the Equality Impact Assessment?	Kirsty Walton, Strategic Lead for Health-Related Harm (Substance Misuse and Homelessness)
Contact numbers	0116 305 9211
Date of completion	September - October 2023

2- Objectives and background of policy or practice change

Use this section to describe the policy or practice change

Leicestershire County Council

What is the purpose, expected outcomes and rationale? Include the background information and context	
What is the proposal?	**<u>Proposal</u>** The proposal is for the County Council to cease funding a dedicated homeless support service, and instead to provide support via the Council's existing public health services **where eligibility is wider**. This will be achieved **primarily** through the universal offer of First Contact Plus and the Local Area Coordination service **as opposed to a bespoke offer specifically for individuals who are homeless or at risk of becoming homeless**. First Contact Plus helps adults in Leicestershire to access information, advice, help and support on a range of services. Referrals to First Contact Plus are made via an online form. For those individuals who may have difficulties in self-referring via an online platform, a referral can be made on their behalf by a professional or friend/family member/carer. Local Area Coordinators work with individuals who may be vulnerable or at risk of crisis by building a supportive community around them thereby reducing social isolation. The principles of the future approach centre around the following: a) Coverage across the whole of Leicestershire for anyone 18 years and over. b) Eligibility that includes any individual who is currently homeless or at risk of becoming homeless, irrespective of whether they fall under the priority need group or not. c) Access to support via a central point of access. d) Support that is tailored to the needs of each individual with no defined timescales for the support offer. e) Greater focus on improving the health and wellbeing of individuals.

	This model will include using First Contact Plus as the referral hub into services which include the following: • Department for Work and Pensions for support to access the right benefits. • Citizens Advice for debt management support. • Local Area Coordination Team for one-to-one support. • Warm Homes Service for support on housing issues such as damp, mould, draught proofing, and signposting to funding for energy efficiency measures. • Health and wellbeing services such as smoking cessation, drug and /or alcohol misuse, healthy weight, physical activity, and sexual health services. • Mental wellbeing services such as Vita Minds (a talking therapies service for low level mental health support). • Services provided by the Council's Adults and Communities Department, including community support workers and social care. • Adult Learning and Multiply for support on accessing learning and educational courses, including support on budgeting. Multiply is a programme aimed at helping adults to improve their numeracy skills. Where one-to-one support is required, the Local Area Coordination service is well established within communities and so can meet this need through their links with community groups, drop-in sessions and through the direct provision of one-to-one support. Other services commissioned by Public Health such as the substance misuse treatment service and the sexual health service already provide outreach services on a one-to-one basis. A key strength of this approach is that links can be made to a broader range of health and wellbeing services therefore providing a more holistic support offer for individuals. In addition,

	this approach enables better links into existing public health services and wider onward referrals including to the district housing authorities.
What is the rationale for this proposal?	The Homelessness Reduction Act 2017 amended the Housing Act 1996 to place duties on housing authorities to prevent homelessness and to provide homelessness services to all those affected. Locally, these responsibilities sit with district councils as the Housing Authority. Funding through the Homelessness Prevention Grant has been provided by The Department for Levelling Up, Housing and Communities (DLUHC) to support district councils to deliver against these responsibilities. It is not a statutory responsibility for the County Council to provide specific services for individuals who are homeless, and the council is not a recipient of grant funding that is focused on preventing or relieving homelessness. The County Council has a statutory responsibility to take appropriate steps to improve the health of people living in Leicestershire, including the provision of health improvement information, advice, and support services aimed at preventing illness. People experiencing homelessness have far worse health and social care outcomes than the general population. The average age of death for the homeless population is around 30 to 40 years lower than for the general population. People experiencing or at risk of homelessness are therefore one of several populations of concern for the County Council in terms of their health and wellbeing.

	The County Council's Medium-Term Financial Strategy 2023/24 – 2026/27 includes a target of saving £300,000 by 1st April 2024 through a review of homeless support services. The Council currently commissions, on a discretionary basis, a homeless support service which aims to improve the health of this population by providing support to adults who are homeless or at risk of becoming homeless. This is provided for the Council by Falcon Support Services (Falcon) and Nottingham Community Housing Association (NCHA). The contract value is £300,000 per annum and ends on 31st March 2024.
What change and impact is intended by the proposal?	The intention of the proposal is to ensure that the population of Leicestershire has the opportunity to access the support offer. A key strength of this approach for individuals is that links can be made to a broader range of health and wellbeing services therefore providing a more holistic preventative offer. The proposed offer has a wider reach than the current offer. Rural inequalities are lessened with the offer being both online and accessible through multiple internal and linked providers and the option to attend drop in sessions throughout the county, which could lead to one-to-one support. Having an online form and allowing third party referrals which include family members, is a good offer for those who have learning disabilities, sight issues or where English is not their first language. Third party referrals will also enable those that have limited or no access to technology to be referred into the service. It has also been identified that those that are less likely to engage with a face-to-face drop-in service are more likely to utilise the online self-referral. This could include anyone, but characteristics mentioned have been those with mental health issues, gender reassignment, maternity etc. I.e., those that would avoid face to face interaction with fear of discrimination or those that have difficulties getting to a location, be that physical or mental barriers.

Leicestershire County Council

3- Evidence gathered on equality implications - Data and engagement What evidence about potential equality impacts is already available? This could come from research, service analysis, questionnaires, and engagement with protected characteristics groups	
What equalities information or data has been gathered so far? **What does it show?**	Prior to consultation, a period of engagement on current service provision for homeless individuals took place in spring 2022. Engagement took place which included several online sessions with stakeholders; this included Menti-meter questions as well as open discussions. Stakeholders were from a broad range of areas which included district representatives, homeless support providers, domestic abuse services, substance misuse services, and voluntary sectors organisations. It is important to note that the scope of this engagement exercise included all services available for homeless individuals in Leicestershire, not just the service described within this report. There were a number of areas of work that were identified as working well. These include: Key strengths of the existing offer were reported as follows: • Accessibility of services e.g., drop in sessions, face to face support, day centres, access to hostels. • Types of support available e.g., support to complete application forms, support to maintain living situation, move-on support, bespoke support for street homeless • Links with the substance misuse service Areas of work that were identified as a gap or requiring improvement included: • Lack of suitable and affordable housing • Access to healthcare, particularly mental health services • Access to dental care • Access to social care

- Need for multi-agency working including better data sharing
- Need for Leicestershire wide support
- Need for a flexible offer
- Need for greater emphasis on life skills and resilience building

Consultation was approved by Cabinet on 23 June 2023. The consultation launched on 28 June 2023 and ran for 10 weeks (closed on 3 September 2023) to seek feedback on the proposed model.

The consultation was aimed at the general public, users of the service, service providers, and a range of additional stakeholders including NHS service providers, district councils, voluntary sector providers, and Leicestershire Police. No single characteristics were singled out. The survey was accessible online on the County Council's website and available as a hard copy on request. An easy read version of the supporting information was also available online.

The views of professional and partner stakeholders, as well as the general public, current and previous service users and support workers, was captured through:

a) Discussions at face to face and online information sessions to talk though the proposal and provide information on how individuals could have their say. A total of 5 sessions were held during the consultation period. At the face-to-face sessions, paper copies of the consultation information were made available to attendees. The information packs included: questionnaire with free post return, supporting information, easy read version of supporting information, and a set Frequently Asked Questions.

b) Responses to the questionnaire (paper copy and online copy)
c) Responses received via the consultation email address

There were 251 responses to the questionnaire. The majority of responses were received from service users (25%) and employees or volunteers of homeless support services (24%).

Demographic data from the consultation results for service users, family, friends, and interested members of the public showed that 56% were male with 41% female. 50% stated that they had a form of disability, with 9.8% preferring not to say. Of those that answered 86.5% were white, with 5.8% stating mixed as their ethnicity.

There was general confusion and potential misconception amongst stakeholders of the offer that is currently funded. This was overcome by ensuring that the correct information was cited and although some of the feedback received via the consultation responses was not quite relevant to the proposed offer, it has been detailed and actioned where possible in the 'Concern' section of this EIA.

The key issues identified through consultation relating specifically to equality are as follows:

- Accessibility of the service
  - Digital exclusion and the need for further support e.g., completing online forms.
  - Communication barriers, for example, disability including hearing impairment, learning difficulties, literacy and language (including individuals whose first language is not English)
  - Challenges related to accessing an online or telephone service for individuals with complex physical and mental health issues

	• Awareness of the service - Lack of awareness and understanding of other public health services e.g. First Contact Plus • Concerns about the need for kind and non-judgmental treatment The outcomes of the consultation will be reported back to the Health and Overview Scrutiny Committee at its meeting on 1 November 2023 and will inform the final proposal put forward to the Cabinet on 24 November 2023.
Which protected characteristic groups or organisations have been engaged with so far?	The consultation was designed to ensure that it was all encompassing. Current providers were encouraged to promote the consultation to their service users. Internal community-based teams were utilised throughout the process to reach the wider population which included those at risk of becoming homeless. Those currently using the service were invited to two face to face information sessions and one online session to provide an opportunity to have their say. The proposal and consultation were presented at the Leicestershire Equality Challenge Group, which included representatives from different protected characteristic groups. Paper copies, online surveys and support over the phone were offered to any persons to ensure that there were minimal exclusions. Face to face and online information sessions were offered to ensure that people understood the consultation and had the chance to have their say – this was for stakeholders, the general public and service users (current and previous). The offer is open to ANY person within Leicestershire over 18. No single characteristics have been singled out and those that have been in contact with the homeless provision have been asked

	about their needs as a cohort rather than individual characteristics. Varying adults ages, and genders have been engaged with via the current contracts; with the service predominantly being white males within the hostel support.

4- Benefits, concerns and mitigating action

Please 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 benefits and concerns including any barriers.
Use this section to demonstrate how risks would be mitigated for each affected group

Group	**What are the benefits of the proposal for those from the following groups?**	**What are the concerns identified and how will these affect those from the following groups?**	**How will the known concerns be mitigated?**
Age	All ages will be able to access the provision, including care leavers who are 18+ All cohorts will be able to access FC+ as they do now, the offer is specifically via an online form.	Care leavers or elderly persons may not be aware of the offer	Referrals can be from any third party and clear communications will continue with referring agencies of the process and offer to support residents. A specific communications plan can be added to ensure that all relevant partners are aware of the offer and how they can support their cohorts to interact.
Disability	Positive impact – Having an online offer rather than physical drop-in sessions may positively impact physically	Accessibility and engagement could potentially be an issue.	Additional support could be offered to promote access and engagement if this is an issue; this

	disabled person as they will not need to travel. Those individuals that require additional support would be supported to refer by any agency, this would include visually impaired and those with learning disabilities.		would need to be within the current services and could include linked services to support such as Local Area Coordinators or Community Recovery Workers.
Race	The proposal is open to all races and is a culturally appropriate service.	N/A	N/A
Sex	The offer is open to men and women. The support that is required may differ although the service takes a person-centred approach and takes into account issues of gender and responds appropriately.	N/A	
Gender Reassignment	The offer may have a positive effect to those that have had gender reassignment where there is as perceived stigma. Physical location issues would be taken away with residents more likely to reach out and access the offer. Person centred approach that would work with the person's needs and a person would not be turned away if they were transgender. It is an accessible service.	N/A	N/A

Marriage and Civil Partnership	None	N/A	N/A
Sexual Orientation	The LGBTQ+ community will continue to have equal access to First Contact Plus. The offer may have a positive effect as perceived stigma and physical location issues would be taken away with residents more likely to reach out and access the offer. Person centred approach for referral and access which is ensuring accessible for all.	N/A	
Pregnancy and Maternity	The offer may have a positive effect as perceived stigma and physical location issues would be taken away with residents more likely to reach out and access the offer. Women would not need to physically attend a location whilst pregnant or with a small child which will be of benefit to them. Having an offer for them, when they want access to it rather than specific times and location is beneficial and could result in increased uptake.	N/A	N/A

Religion or Belief	None	N/A	N/A
Other groups: e.g., rural isolation, deprivation, health inequality, carers, asylum seeker and refugee communities, looked after children, deprived, or disadvantaged communities	All districts will have access to the same level of support. Use of the Local Area Co-ordinators, and the First Contact Plus services will provide wider links across Leicestershire. This will remove existing geographic barriers. Domestic Abuse victims will have easy access to the offer with it being online. Children and Family Leads have been engaged to ensure that Care Leavers are able to access the services provided. Those requiring additional support can have a third party make the referral for them into the service, this could include language barriers. There is a correlation between homelessness and health and wellbeing, particularly mental health and substance misuse. The offer provided by	Providers and residents may not be aware of the offer or utilising as much as they could do.	Wider interaction with relevant stakeholders will ensure that the offer is being promoted and access monitored through leads of the service; as well as a comprehensive communications plan during implementation.

	First Contact Plus will have a positive impact for this cohort. Having an online offer that allows online referrals may be beneficial and have a positive impact to those where English is not their first language. They would be able to get support to fill in the online referral form. Ex armed force are at a greater risk of homelessness and the service will support persons with their specific needs where appropriate.		

5- Action Plan and Recommendations

Use this section to describe concerns further

Produce a framework to outline how identified risks/concerns will be mitigated.

What concerns were identified?	What action have you taken or planned?	Who is responsible for the action?	By when
Awareness of the service	First Contact Plus is an established offer that is advertised widely – this work will continue and be advertised	The Homeless Project Delivery Group will ensure that an effective and comprehensive communications plan is put in place and acted upon during	Implementation plan to be delivered from January 2024 with a clear communications plan to ensure awareness of the offer in

	to wider networks that were specifically linked to the commissioned service via a detailed communications plan	implementation. Following implementation, it will be the service leads.	preparation for April 2024; Although to note that the offer is currently available to all.
Accessibility of the service	First Contact Plus allows third party referrals, be this via family, friends or other services / providers. This is via the online referral form. This can be any service linked to the service user and the intention is to ensure the offer is advertised wider to relevant services. This would support those that do not have direct access to the internet. Once assessed, First Contact Plus allocates the relevant offer for the person. This could be utilising Local Area Coordinators as an onward referral option which could involve face to face interaction. A number of drop-in locations for wider services are available where linked providers can refer for residents. As well as local libraries	The Homeless Project Delivery Group will ensure that an effective and comprehensive communications plan is put in place and acted upon during implementation. Following implementation, it will be the service leads.	This is an offer that is already in place that is being utilised by numerous residents of Leicestershire. Ensure that the communications plan is clear and details the offer.

	supporting people to access the service where they will be supported to complete the online form.		
Concerns about the need for kind and non-judgemental treatment	Staff are trained and work currently with a variety of residents. The team are professional, empathetic, compassionate and mindful of the needs of service users. Concerns are potentially raised by persons not aware of the service and the already agreed communications plan will detail the offer which may relieve concerns. The offer is via a person-centred approach that is available to all regardless of any particular protected characteristic. The service has access to relevant training and support to ensure this.	N/A	N/A

6- Way forward

How will the action plan and recommendations of this assessment be built into decision making and implementation of this proposal?	If the proposal is accepted, any additional requirements identified will be added during the transition period. This would include clear communication to all persons that currently link with the previous service and ensuring that the proposal of utilising First Contact Plus is in the required format to reach all persons. Wider linked services will also be given clear instructions as to how they can link in with the service and what the referral process is.
How would you monitor the impact of your proposal?	The impact of the proposal will be monitored via the First Contact Plus team's current review process; this includes dashboards and data to check demographics of those utilising the offer. Where there is low uptake, work will take place to ensure that communications are clear with those areas and cohorts not engaging where possible. The dashboard figures are presented quarterly at the Public Health departmental Senior Leadership Team meetings.
Sign off by DEG Chair/Director or Head of Services	
Review Date	

Agenda Item 12

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 1st November 2023

WHOLE SCHOOL APPROACH TO FOOD & NUTRITION

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of report

1. The purpose of this report is to seek the views of the Committee on 'Whole School Approach to Food and Nutrition' (WSAF&N), known to schools as the Food for Life (FFL) programme, as part of engagement on a new offer.

2. As the proposal involves a potential change to the service offer for WSAF&N, an engagement exercise is underway with primary schools to inform a final decision by the Cabinet in the new year.

Policy Framework and Previous Decisions

3. The WSAF&N programme is a key part of the public health approach to tackling obesity in children and young people. It is an embedded approach to the Leicestershire Healthy Weight Strategy strategic objective 2; Support settings to prevent obesity and increase healthy weight in adults, children and families.

4. The proposal is aligned with the following policy frameworks:

   a. Public Health Strategy "Delivering good health and prevention services 2022-2027 – promoting healthy living and healthy places principle";
   b. the Leicestershire Joint Health and Wellbeing Strategy 2022-2032 "Staying Healthy, Safe and Well", and
   c. the County Council's Strategic Plan 2022-26, in particular the outcome of
      i. 'Keeping people safe and well: ensuring that people are safe and protected from harm, live in a healthy environment and have the opportunities and support they need to live active, independent and fulfilling lives'.
      ii. Improving opportunities: 'Every child gets the best start in life'

5. The County Council's Medium-Term Financial Strategy 2023/24 – 2026/27 (agreed by the Cabinet in February 2023) includes a target of saving £150,000 by 2024/25 through a review of the WSAF&N programme.

6. The service is offered to all primary schools but with additional emphasis on those with high levels of obesity. It fits well with several local and national programmes and strategies and the National Food Strategy signposts local authorities to adopt the model, indicating a desire to make the approach mandatory in the future.

Background

7. The WSAF&N programme was first commissioned in 2013 and the service is provided by the Soil Association. The programme is referred to by schools as the 'food for life' programme and has been running in the county for approximately 10 years. Extensions to the contract have been made annually in line with the initial award and are now at the maximum extension permitted with the current contract due to expire on 31st May 2024.

8. The aim of the programme is to:

    - adopt a supportive healthy food culture, from sourcing fresh sustainable food to creating opportunities for social contact through food
    - build confidence in children and their families in developing good food choices and maintaining a healthier lifestyle.
    - reflect food nutrition and healthy eating in every-day life in a school setting
    - reach out beyond the school gates into the community with activities such as gardening becoming part of the school curriculum.

9. The Public Health departmental management team have reviewed an options appraisal for achieving the MTFS saving from the WSAF&N. Some aspects of the current offer are valued by schools and are aligned to work that forms an important part of the public health offer, particularly in relation to obesity.

10. The WSAF&N offer sits within a broader food and nutrition approach within the Public Health department that would benefit from a review. It is therefore proposed that a different approach to food and nutrition in schools is offered for 2 years to allow time for a thorough review of the wider public health food and nutrition offer including evaluation of whether WSAF&N is an essential part of this. This will be funded via Public Health reserves and therefore the full MTFS savings target can still be achieved.

Proposals

11. The current offer provides officer support to primary schools looking to achieve the bronze, silver, and gold level standards, with online support and training in addition.

12. The proposed new approach will focus on supporting primary schools to achieve bronze level. The proposed offer will include:
    - Access to an online training platform for all schools regardless of level of award.
    - Officer support at bronze level, targeted at schools with high levels of obesity only
    - Schools not identified with high levels of obesity and those wanting to achieve the silver and gold awards can still do so, without additional cost using the online support and training.

Engagement

13. A targeted engagement exercise is underway with primary schools to gather views on the proposed changes. The engagement process began on the 4th October and will run until 21st November 2023, to obtain the views on the programme and to understand the potential impact of the new approach.

14. Views are being sought via an online survey with primary schools, asking about the impact of the programme, the impact of the proposed changes and gathering wider views about food and nutrition from a school's perspective to inform the future review.

15. This report forms part of the engagement and HOSC members are asked to provide feedback on the proposed new approach.

Resource Implications

16. The new proposal has been costed at £70,000 which will be funded via Public Health reserves, therefore, MTFS saving can still be achieved.

Timetable for Decisions

17. The engagement closes on the 21st November 2023. Feedback received will be reported as part of a report for final decision by the Cabinet in the new year, anticipated in January 2024.

18. The current contract will end in May 2024. The outcome of the Cabinet decision will inform next steps.

Conclusions

19. To summarise, MTFS savings are required from the WSAF&N. Some aspects of the current offer are valued by schools and are aligned to work that forms an important part of the Public Health offer, particularly in relation to reducing obesity in children and young people.

20. The WSAF&N offer sits within a broader food and nutrition approach within Public Health that would benefit from a review. It is therefore proposed that a new approach to FFL is taken for the next 2 years, allowing time for a thorough review of the wider food and nutrition offer including evaluation of whether WSAF&N is an essential part of this.

21. The new service would continue to offer the FFL programme to all primary schools to achieve bronze level award with officer support targeted on those schools identified with high levels of obesity. Schools will be able to achieve 'Silver and Gold' accreditation via the Soil Association themselves without additional cost should they wish.

22. HOSC members are asked to consider the proposed new approach to whole school approach to food and nutrition and provide feedback as part of the engagement process.

Background papers

23. Report to the Cabinet - Medium Term Financial Strategy 2023/24 - 2026/27 - 22 February 2023 https://politics.leics.gov.uk/ieListDocuments.aspx?CId=134&MId=6913

Circulation under the Local Issues Alert Procedure

24. None

Equality Implications

25. Under the Equality Act 20210 the County Council is required to have due regards to the need to:
    - Eliminate unlawful discrimination, harassment and victimisation;
    - Advance equality of opportunity between people who share protected characteristics and those who do not; and
    - Foster good relations between people who share protected characteristics and those who do not.

26. A draft Equality Impact Assessment (EIA) has been completed on the proposal. The impact of a change in service model will be further informed by the findings of the engagement exercise with schools.

27. The post-engagement EIA will be presented to the Cabinet to be considered as part of the decision.

Human Rights Implications

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

Officer(s) to Contact

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Agenda Item 13

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 1 NOVEMBER 2023

PHYSICAL ACTIVITY PROGRAMME REDUCTIONS

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of report

1. The purpose of this report is to seek views of the Committee around the proposed reductions to physical activity programmes as part of the consultation.

Policy Framework and Previous Decisions

2. The Medium-Term Financial Strategy 2023/24 – 2026/27 (agreed by the Council on 22 February 2023) includes a requirement to save £250,000 from 1 April 2024 through a review of physical activity services.

3. The proposal is aligned with the Public Health Strategy "Delivering good health and prevention services 2022-2027", the Leicestershire Joint Health and Wellbeing Strategy 2022-2032 "Staying Healthy, Safe and Well", and the County Council's Strategic Plan 2022-26, in particular the outcome keeping people safe and well: 8.3 People enjoy long lives in good health.

4. The Cabinet at its meeting on the 8 February 2019 considered a report "Active Lives Survey 2018 - Physical Activity Levels in Leicestershire" and supported the need for a co-ordinated and coherent approach to improving physical activity levels. This report has informed the revisions to the delivery model for physical activity programmes set out in this report.

5. The Cabinet at its meeting on the 15 September 2023 gave approval to consult on this revised delivery model.

Background

6. The Council has a statutory duty to improve the health and wellbeing of the population and receives a ring-fenced grant for that purpose to be spent on public health functions including physical activity programmes.

7. In Leicestershire, 1 in 4 adults (21-26%) do less than 30 minutes of physical activity per week (are inactive) and 1 in 3 residents do not meet the Chief Medical Officer guidelines for physical activity (150 minutes per week of moderate to vigorous physical activity).

8. There are significant inequalities associated with inactivity whereby people from marginalised groups, with disabilities, older people, women and those living in material disadvantage are least active. Barriers to inactivity include the cost of

programmes and equipment, proximity of opportunities to area of residence, quality of the environment, beliefs, confidence and self-efficacy and cultural appropriateness of programmes.

9. It is important therefore that programmes exist that address the known barriers to physical activity, are local and targeted to those at highest risk of inactivity.

10. In Leicestershire, the Public Health grant funds the delivery of physical activity programmes via an annual grant to district councils and School Sports and Physical Activity Networks (SSPANs) and core funding to Active Together, the Active Partnership. The Public Health budget for physical activity is £1.146 million in total; of this £692,986 is allocated to district councils, SSPANs and central coordination of programmes via Active Together.

11. The Medium-Term Financial Strategy 2023/24 – 2026/27 (agreed by the Council on 22 February 2023) includes a requirement to save £250,000 by 1 April 2024 through a review of internal infrastructure physical activity grant-funded programmes (budget lines PH5SR and PH10SR).

Current Service Provision

12. The current public health-funded delivery model for physical activity is set out in **Table 1** below. It comprises four levels of delivery for adults (levels 1-4) and three for children (levels 1-3), delivered by district councils and SSPANs (in schools):

- Level 4: Specialist health condition specific programmes
- Level 3: Physical activity referral and specialist provision
- Level 2: Targeted community / setting-based sessions
- Level 1: Population level interventions, brief advice, sign posting self-help

Table 1 – Current delivery model for physical activity

	Children*	**Adults**
Level 4 (specialist programmes)	Not applicable	Specialist instructors and referral systems to deliver specialist level 4 programmes for people with e.g. cancer or cardiopulmonary problems. These programmes interface with NHS-funded services and ensure a 'step down' pathway into continued physical activity.
Level 3	Specialist provision by SSPANs for: • Fundamental Movement Skills, helping children develop the skills they need for lifelong physical activity (e.g. balance, catching a ball, hopping etc) • HE-HA children's weight management services delivered by Public Health	Contribution to leisure centre-based exercise referral programmes aimed at people who are inactive and have a health condition. Specified evidence-based level 3 interventions. Programmes include: • Steady Steps plus (falls prevention programme) • Escape Pain (for osteoarthritis of the back, hip and knee)
Level 2	School-based programmes targeting least active children.	Locally-specified targeted programmes based in the community
Level 1 (universal programmes)	Leadership support for a whole school approach to physical activity, health and wellbeing ambassadors, link to healthy schools, Let's Get Moving Active Travel officer jointly funded by the Environment and Transport Dept who supports schools to encourage journeys to and from school through active modes	Utilisation of campaign materials (via Active Together), signposting to local provision, advocacy work with other departments e.g. planning Delivery of centrally-specified programmes such as Walking for Health, to meet local need
	Population Interventions, brief advice, signposting, self-help, 'Let's Get Moving' comms delivery	
Other	Graduate Training programme to build the physical activity workforce	

* This is in addition to the statutory requirement for schools to offer PE provision and the School Games provision through the SSPANs, funded by the Youth Sports Trust

Proposal

13. The proposed changes are summarised in **Table 2** below and reductions are indicated in red.

Table 2 – Summary of proposed revised delivery model for physical activity

	Children*	**Adults**
Level 4 (specialist programmes)	Not applicable	Specialist instructors and referral systems to deliver level 4 programmes for people with, for example, cancer or cardiopulmonary problems.
Level 3	Specialist provision by SSPANs for: • Fundamental Movement Skills, helping children develop the skills they need for lifelong physical activity (e.g. balance, catching a ball, hopping etc.) • HE-HA children's weight management services delivered by Public Health. [new provision] Children's exercise referral programme	[removal of] Contribution to leisure centre-based exercise referral programmes aimed at people who are inactive and have a health condition. [new provision] Community-based exercise referral options Specified evidence-based level 3 interventions. Programmes include: • Steady Steps plus (falls prevention programme) • Escape Pain (for osteoarthritis of the back, hip and knee)
Level 2	[removal of] School-based programmes targeting least active children*.	[removal of] Locally-specified targeted programmes based in the community
Level 1 (Universal programmes)	Leadership support for a whole school approach, health and wellbeing ambassadors, link to healthy schools, Let's Get Moving Active Travel officer jointly funded by the Environment and Transport Dept. supports schools to encourage journeys to and from school through active modes	Utilisation of campaign materials (via Active Together), signposting to local provision, advocacy work with other departments e.g. planning Delivery of centrally-specified programmes such as Walking for Health, to meet local need
	Population Interventions, brief advice, signposting, self-help, 'Let's Get Moving' comms delivery	
Other	[removal of] Graduate Training programme to build the physical activity workforce	

*Schools have a statutory requirement to offer PE provision and primary schools have access to the school PE and sport premium funding which can be used in a targeted way. The government has published the School sport and activity action plan to support more pupils with access to PE (https://www.gov.uk/government/publications/school-sport-and-activity-action-plan). There is also School Games provision through the SSPANs, funded by the Youth Sports Trust.

Consultation

14. The consultation was approved by Cabinet on the 15 September 2023 and launched on 20 September 2023. It will conclude after six weeks on the 1 November 2023. This report forms part of the consultation.

15. The consultation is seeking the views of the general public, users of existing services, service providers, and a range of additional stakeholders including NHS service providers, district councils and voluntary sector providers. It includes a survey, accessible online on the County Council's website and available as a hard copy on request. The survey is being promoted on social media and through printed material in community locations, through circulars and newsletters.

16. At the time of writing this report [16/10/23], 205 responses to the survey had been received. The responses had been received by members of the public (77%) and other organisations (9%).

17. Current feedback indicates: 43% strongly agree or tend to agree with the proposal and 49% strongly disagree or tend to disagree (the remaining 8% neither agree nor disagree).

18. Whilst analysis is still underway, some of the key points are as follows:
    - there is strong support for physical activity as a preventative, physical and mental health promoting measure that is important to fund from the public health budget.
    - Whilst respondents did not necessarily agree with funding being reduced, there is some support for focusing the remaining budget on those at highest risk of inactivity and its consequences (targeted, secondary prevention) and also continuing to promote physical activity to all (universal, primary prevention).
    - Some comments referred to estates and delivery that is not funded by public health (e.g. leisure centres and school PE) and is therefore out of the scope of this consultation.
    - Many respondents commented on the long-term benefits of physical activity for individuals and for preventing costs to the health and care systems and the support and encouragement that some people need to be active.
    - There is strong support for continuing to fund programmes for children.
    - Overall 71% of people strongly agreed or tended to agree that programmes for people with long-term conditions should be prioritised.

Resource Implications

19. The proposed model is expected to achieve savings of £250,000 per annum which would contribute to the Medium-Term Financial Strategy (MTFS) savings target.

20. The Director of Corporate Resources and the Director of Law and Governance have been consulted on the content of this report.

Timetable for Decisions

21. It is intended that the outcome of consultation and proposed final model will be submitted to the Cabinet on 19 December 2023.

Conclusions

22. In conclusion, members of the committee are invited to comment on the proposed revisions to the delivery model for public health-funded physical activity programmes, noting in particular a removal of funding from the Level 2 programmes for children and adults, but a continuation of funding for level 1 (universal), 3 and 4 (targeted) programmes.

Background papers

23. Report to the County Council Cabinet on the 15 September 2023 “Physical Activity Programme Reductions” https://politics.leics.gov.uk/documents/s178502/Cabinet%20Report%20-physical%20activity%20MTFS%20Sept%2023_cleanFinalDraft.pdf

24. Report to the County Council on 22 February 2023 - “Medium Term Financial Strategy 2023/24 - 2026/27” and minutes of that meeting - https://politics.leics.gov.uk/ieListDocuments.aspx?CId=134&MId=6913

25. Report to the County Council Cabinet on Friday 8 February 2019 on “Active Lives Survey 2018 – Physical activity levels in Leicestershire” https://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MID=5600#AI58606

Circulation under the Local Issues Alert Procedure

26. None

Equality Implications

27. An Equality Impact Assessment (EIA) has been completed and the impact of a change in service model will be informed by the outcomes of consultation. Local data shows that there are existing inequalities in how active groups with protected characteristics are compared to the others. Inactivity increases with age, is higher in women and in people who are socioeconomically disadvantaged, identify as LGBTQ+, are in Asian or Black ethnic groups, have Hindu or Muslim faiths, have a disability or are pregnant or with a child under one.

28. Initial findings of the EIA on the proposed model are that the impact of funding reductions have been mitigated by focusing remaining resources on the provision of programmes for people with protected characteristics. There is a loss of provision of Level 2 programmes, but these are less targeted towards inactive people or people with existing long-term conditions. The post-consultation EIA will be presented to the Public Health Departmental Equalities Group for approval.

Human Rights Implications

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

Officer(s) to Contact

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Agenda Item 14

Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 1st NOVEMBER 2023

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH. LEICESTERSHIRE'S HEALTH – WHAT THE HEATH AND WELL BEING BOARD'S DASHBOARD TELLS US

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of report

1. The purpose of this report is to present the Director of Public Health's Annual Report for 2023. The Director of Public Health's (DPH) Annual Report is a statutory independent report on the health of the population of Leicestershire.

Policy Framework and Previous Decisions

2. The report is published annually and is presented to the Health Overview and Scrutiny Committee as part of the publication process for the report.

3. The last 'annual' report made a series of recommendations on physical activity and was considered by scrutiny at its meeting of 13th November 2019. This report includes an update on progress against the recommendations made in that report.

Background

4. The purpose of a Director of Public Health's annual report is to improve the health and wellbeing of the people of Leicestershire. This is done by reporting publicly and independently on trends and gaps in the health and wellbeing of the population and by making recommendations for improvement to a wide range of organisations.

5. One of the roles of the Director of Public Health is to be an independent advocate for the health of their population. The Annual Reports are a way by which Directors of Public Health make their conclusions known to the public.

Consultation

6. The report is the independent report of the Director of Public Health.

Resource Implications

7. Implementation of the recommendations of the report may need to be addressed through the commissioning and budget setting cycle of partner organisations. For

public health, the council receives a grant, ring fenced to promote action on public health functions and priorities.

Timetable for Decisions

8. The Annual Report will considered by the Health Overview and Scrutiny Committee on 1st November and by the Cabinet on the 24th November. It will be considered by the County Council at its meeting on 6th December.

Conclusions

9. This year's report presents data on the health of the population across Leicestershire. The data underpins the Health and Wellbeing Strategy of Leicestershire's Health and Wellbeing Board. A dashboard of over 100 indicators looks at each stage of what is known as the life course, from birth and the early years of life, through working age life to older age and, eventually, death. Performance is compared against the national average and against other comparable areas in the country.

10. Good health is dependent on a complex set of circumstances including 'lifestyle' behaviour, social and community networks, living and working conditions and broader socio-economic conditions with lifestyle behaviour and socio-economic factors being the primary drivers of 'good health'.

11. Overall, Leicestershire enjoys good health with over half of the indicators in the dashboard being above that of the national average performance and only around one indicator in eight being below the national average performance.

12. Comparing Leicestershire against a basket of 15 comparable authorities, there are 30 indicators where Leicestershire's performance is in the top three when compared with similar authorities, and 14 where performance is in the bottom three compared with neighbouring authorities.

13. Smoking prevalence, childhood obesity in year 6, vaccination coverage in early years, homelessness and a number of indicators relating to child development are worthy of note. Life expectancy overall is better than average and inequalities in life expectancy at birth is performing well. Mental health indicators suggest that Leicestershire has comparatively good public mental health.

14. Looking at the 'big' public health lifestyle behaviours where national and comparative performance leaves room for concern, the two big issues the department needs to give more focus to are:
    i. Physical Activity, where both the percentage of physically active adults and the percentage of adults walking for travel need improvement and;
    ii. Diet, where the percentage of adults aged 16 and over meeting the '5-a-day recommendations requires improvement.

15. The wider determinants of health clearly influence our health. Locally the data shows air quality (measured by the level of PM2.5) and the 'winter mortality index' to be an area of relatively poorer performance.

16. Public health needs to play its role in supporting other agencies to improve performance in indicators that are primarily the responsibility of other organisations. The department will work with partners to improve the uptake of vaccination, immunisation and screening – particularly the shingles and HPV vaccines.

17. Overall population health status may mask areas or sectors of the population that have poorer health status. A further report is needed to examine the detail of how health is experienced by different parts of the population.

Circulation under the Local Issues Alert Procedure

18. None

Equality Implications

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

Human Rights Implications

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

Background papers

The dashboard used to inform the Annual Report is available via https://www.lsr-online.org/uploads/2023-dph-annual-report-dashboard.pdf?v=1697714149

Appendices

Annual Report of the Director of Public Health 2023.

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Leicestershire County Council

APPENDIX

2023 Annual Report of the Director of Public Health, Leicestershire

Leicestershire's Health

What the Health and Wellbeing Board's dashboard tells us

PEOPLE PROMOTE PROTECT PROVIDE PARTNERSHIP

Foreword

Welcome to my annual report for 2023. It has been a little while since I last published an annual report, for what I hope are understandable reasons. It was always my intention for the 2020 annual report to focus on the response to COVID and for the 2021 report to focus on recovery from COVID and addressing important non-COVID issues.

Of course, life didn't pan out like that, with COVID continuing to dominate the work of the public health department throughout 2020 and 2021.

Even then, the past year or so has been remarkable for the number of other health protection related incidents that have drawn the local authority into to being part of the health protection response. Monkeypox, heatwaves, the dispersal of asylum seekers to temporary accommodation and Strep A being four issues for which the Council is not resourced to respond to in public health terms but has stepped up to do so. Not forgetting that COVID has never gone away completely and still requires an amount of resource from the department.

As such, it feels like it is only now that we are beginning to have the space to consider the health of the population more generally and get back to something approaching 'business as usual'.

Going back to my last report in 2019, I examined physical activity in a report entitled "Leicestershire's Health – Physical Activity – Moving to a Whole System Approach".

The report has helped move our approach to physical activity to one where all parts of local government, the NHS and communities are engaged in helping make the right choice the easy choice. An update on progress against the key recommendations can found elsewhere in this report.

In this year's report I have gone back to the specified purpose of a DPH annual report to be a paper that describes the health of our communities. I want to focus on some of the big issues that drive how healthy we are. In doing so I will use the report to ensure that the public health department's work is fully aligned with the Government's emerging major conditions strategy and focusses its efforts on those topics that do most to improve our health and Wellbeing.

I would like to thank all my colleagues that have helped in producing this report, particularly Victoria Rice from the Strategic Business Intelligence Team for her work in constructing the data and narrative that underpin this report and Jenna Parton and Liz Orton for their input.

I would also like to take this belated opportunity to place on record my thanks to my colleagues throughout the Public Health Department, the Council, the NHS, blue light services, district councils and the voluntary sector for their part in responding to the challenges of COVID. Thank you for keeping going day after day in stressful circumstances.

Mike Sandys DL, BA Hons, MA, MSc, (Hon) DUniv, FFPH
Director of Public Health

Contents

Introduction

Directors of Public Health have a statutory duty to write an Annual Public Health Report that describes the state of health within their communities.

It is a major opportunity for advocacy on behalf of the population and, as such, can be used to help talk to the community and support fellow professionals, providing added value over and above intelligence and information routinely available such as that contained within health profiles or the Joint Strategic Needs Assessment (JSNA).

It is intended to inform local strategies, policy and practice across a range of organisations and interests and to highlight opportunities to improve the health and wellbeing of people in Leicestershire. The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and thereby serve their local populations. It is also a key resource to inform stakeholders of priorities and recommend actions to improve and protect the health of the communities they serve.

Within this report, data is presented on the health of the population of Leicestershire. The content should be used by commissioners and providers of services to respond to changes in the health of Leicestershire residents.

The data itself is that that underpins the Health and Wellbeing Strategy for Leicestershire, which is the strategy of Leicestershire's Health and Wellbeing Board.

The board monitors progress by way of a dashboard of over 100 indicators looking at each stage of what is known as the life course, from birth and the early years of life, through working age life to older age and, eventually, death.

Performance is compared against the national average and against other comparable areas in the country, enabling the Health and Wellbeing Board to assess absolute and relative performance against its objectives.

The recommendations made largely relate to actions for the Public Health Department. Specific recommendations for departments of the County Council or partner organisations haven't been made in this report although there is an expectation that these will follow through discussion at the Health and Wellbeing Board.

Summary and recommendations

The vast majority of what makes us healthy and keeps us healthy are factors outside of the remit of the NHS. Over two thirds of what contributes to good health outcomes are socio economic factors (things like education and employment) and lifestyle behaviours such as whether we smoke tobacco or drink alcohol excessively.

The Health and Wellbeing Strategy for Leicestershire takes a life course approach, taking action across four 'life stages'; Best Start of Life, Staying Healthy Safe and Well, Living and Supported Well and Dying Well. The strategy also supports action on two cross cutting themes; mental health and tackling health inequalities. To make health improvements across the life course requires concerted action by all partners of the Health and Wellbeing Board.

A 'dashboard' of 108 indicators helps the Health and Wellbeing Board assess progress. Of those 108, 100 indicators have data available and show 52 indicators where Leicestershire's performance is above the national average, 35 similar to the national average and 13 below the national average.

Summary

By each life stage and the cross cutting themes Leicestershire's overall performance is as follows:

Best Start for Life

- 26 indicators are better than the national average, 13 are similar to the national average and three below average

Staying Healthy Safe and Well

- 14 indicators are better than the average, nine are similar to the national average and nine are below the national average

Living and Supported Well

- Three indicators are better than the national average, six are similar to the national average and no indicators are performing worse than the national average

Dying Well

- Of the three indicators, one each are above the national average, similar to the national average and below the national average.

Mental Health

- Six indicators are performing better than the national average, four are similar to the national average and no indicators are below the national average

Health Inequalities

- Of the four indicators for which data is available, two are performing in Leicestershire above the national average, and two are similar to the national average.

The dashboard also enables the Board to assess performance against the local authorities most comparable to Leicestershire (Appendix A to this report lists those authorities).

Overall, there are 30 indicators where Leicestershire's performance is in the top three when compared to our similar authorities, and 14 where our performance is in the bottom three compared with our neighbouring authorities.

Overall, Leicestershire is a comparatively healthy place with health status, generally, above the national average.

There is much to commend in the performance of a number of indicators. Smoking prevalence, childhood obesity in year 6, vaccination coverage in early years, homelessness and a number of indicators relating to child development are worthy of note. Life expectancy overall is better than average and inequalities in life expectancy at birth is performing well.

Similarly, the mental health indicators suggest that Leicestershire has comparatively good public mental health, but that shouldn't hide mental health as a prime concern.

Recommendations

For my own department there are specific recommendations, both for things that we lead and for things where we can support others.

Looking at the 'big' public health issues where national and comparative performance leaves room for concern the two big issues the department needs to give more focus to are:

- Physical Activity, where both the percentage of physically active adults and the percentage of adults walking for travel need improvement and;
- Diet, where the percentage of adults aged 16 and over meeting the '5-a-day' recommendations requires improvement

I will review the work of the department to ensure we are providing a comprehensive range of measures on these big lifestyle behaviours, not only providing high quality services but a broader range of measures in areas such as physical activity and diet.

The wider determinants of health clearly influence our health. Locally the data shows PM2.5 to be an area of concern. We have made big strides in this work over the last three years but there remains much to do. Working with partners to improve air quality will remain a focus of the public health department.

Performance against the 'winter mortality index' data shows tackling excess winter deaths should receive more priority. The County Council, through public health provides a range of grant funded activity. I will work with partners to understand the totality of work in this area and review the scope and ambition of our plans.

Public health needs to play its role in supporting other agencies to improve performance in indicators that are primarily the responsibility of other organisations; we will work with partners to improve the uptake of vaccination, immunisation and screening – particularly the shingles and HPV vaccines.

Overall population health status may mask areas or sectors of the population that have poorer health status. A further report is needed to examine the detail of how health is experienced by different parts of the population, be it geographically, socio-economic status or by protected characteristics where data is available. The next DPH Annual Report will look in detail at this.

What makes us healthy?

If one were to ask the average punter what keeps them healthy, the first thing they might say is ‘the NHS’. They then might say something about individual behaviours such as whether we smoke, how much we exercise we do, or what we eat.

If further questioned, people might recognise that the kind of work they do, where they live, and how much money they have are the sorts of things that help keep them healthy.

The answer is, of course, that all of that is right.

Whitehead and Dahlgren (1991)Figure 1 provides a well known model of the relationship between people, their quality of life, their health and their environment.

This shows that our personal characteristics occupy the centre of the model and include things like our sex, our age, our ethnicity and hereditary factors. Then we recognize that individual ‘lifestyle’ factors including behaviours such as whether we smoke, drink alcohol excessively, how physically active we are and what we eat plays, a part in our health.

Moving beyond that our social and community networks, including family and wider social circles, living and working conditions, housing, access to green space and education all make a difference to our health. It is widely recognised that, taken together, these factors are the principal drivers of how healthy people are.

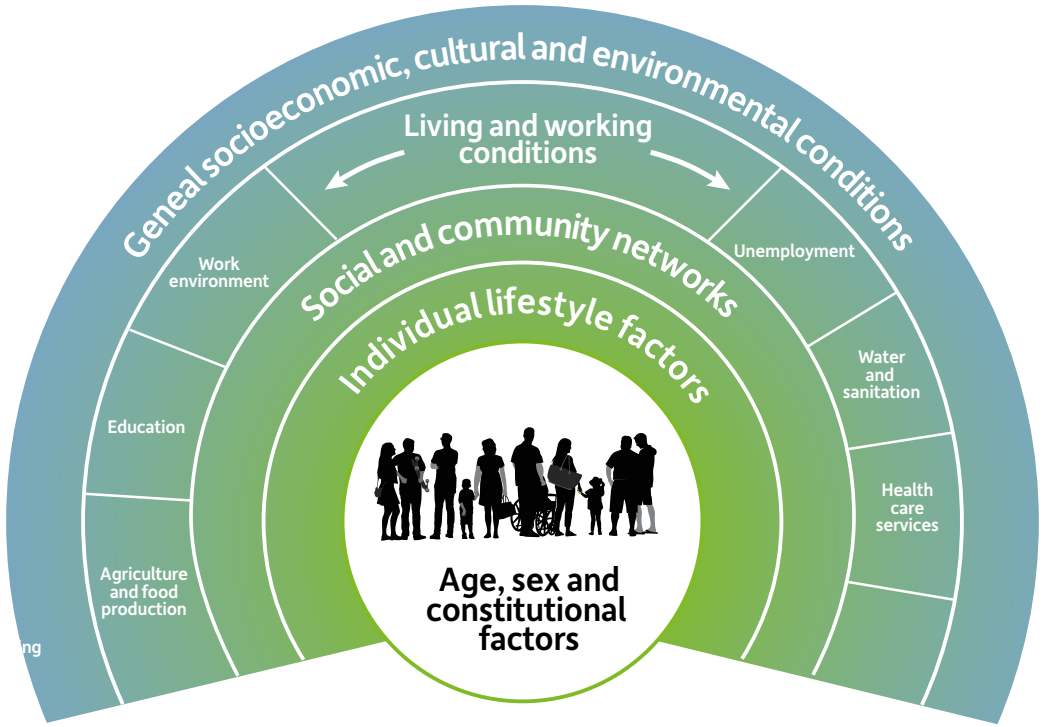


Figure 1. The Dahlgren and Whitehead model of health determinants

Source: Dahlgren and Whitehead (1991)

Lastly, broader national and international socio-economic conditions can affect our health.

These broad social and economic circumstances which together influence the quality of the health of the population are known as the ‘social determinants of health’. Howthese social determinants impact on both mental and physical health are complex and inter-related, often acting over a long period of time.

Having seen that there are a range of factors that influence health it is important to think about ’how much’ of a particular issue has an effect. Figure 2 shows research by the Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute published in 2014.. As the diagram shows over two thirds of what contributes to good health is driven by our health behaviours (30% of the total) and those broader socio-economic factors (40%). Smoking and diet remain the two single biggest lifestyle factors with education income and employment being on an equal footing to smoking and diet.

The NHS, either through the quality of care or access to care actually accounts for just one fifth of what contributes to good health and the built environment 10%

Contributors to health outcomes

Health behaviours 30%	Socioeconomic 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%		

The Major Conditions Strategy

The recently published Major Conditions Strategy of HM Government is an important policy driver that will help shape the of the department. A brief summary of key points is provided here for information.

Together, six groups of major health conditions drive over 60% of mortality and morbidity in England, and it is increasingly common for patients to experience 2 or more of these conditions at the same time.

The six groups are:

- cancer
- chronic respiratory disease
- dementia
- cardiovascular disease (including stroke) and diabetes
- musculoskeletal disorders
- mental ill health

The strategic framework of the Major Conditions Strategy focuses on:

- primary prevention - acting across the population to reduce risk of disease
- secondary prevention - halting progression of conditions or risk factors for an individual
- early diagnosis - so we can identify health conditions early, to make treatment quicker and easier
- prompt and urgent care - treating conditions before they become crises
- long-term care and treatment - in both NHS and social care settings

To have the greatest impact, the Government will prioritise change in 5 areas:

- rebalancing the health and care system towards proactive prevention by managing personalised risk factors
- embedding early diagnosis and treatment in the community
- managing multiple conditions effectively - including through aligning generalism and specialism
- better connection and integration between physical and mental health services
- shaping services and support around people, giving them more choice and control over their care

The focus of the strategy on primary and secondary prevention and the well established evidence base showing how action on lifestyle behaviours can make a difference to five of the six major conditions, present a major opportunity for our public health work to be front and centre of the national strategy.

Leicestershire's Health and Wellbeing Strategy

Leicestershire Health and Wellbeing Strategy 2022-2032 is a long term ten year plan of the Leicestershire Health and Wellbeing Board to improve the health of residents.

It sets out an overall vision of;

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

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

The strategy recognises that not everyone achieves the same level of health and wellbeing across Leicestershire and there is a gradient of health and wellbeing outcomes linked to deprivation and specific characteristics or communities. The board will work to 'level up' this gradient and ensure everyone has an equitable opportunity to support their health and wellbeing.

This report won't dig into the detail of the proposed actions in the strategy (although I would urge you to read the full strategy and action plan) but it does look at the detail of the indicators of health considered by the Board and assesses Leicestershire performance.

Leicestershire's Health and Wellbeing Strategy takes a life course approach, with an action plan addressing priorities sat each stage of life. These stages are:

- The Best Start for Life
- Staying Healthy, Safe and Well
- Living and supported well
- Dying Well

Additionally, there are two cross cutting themes of;

- Good mental health
- Tackling Health Inequalities

For each of these stages and sections the Health and Wellbeing Board has a series of sub-groups to make progress on these areas with an indicator dashboard to guide them.

Leicestershire's Health and Wellbeing Board dashboard

Best Start for Life

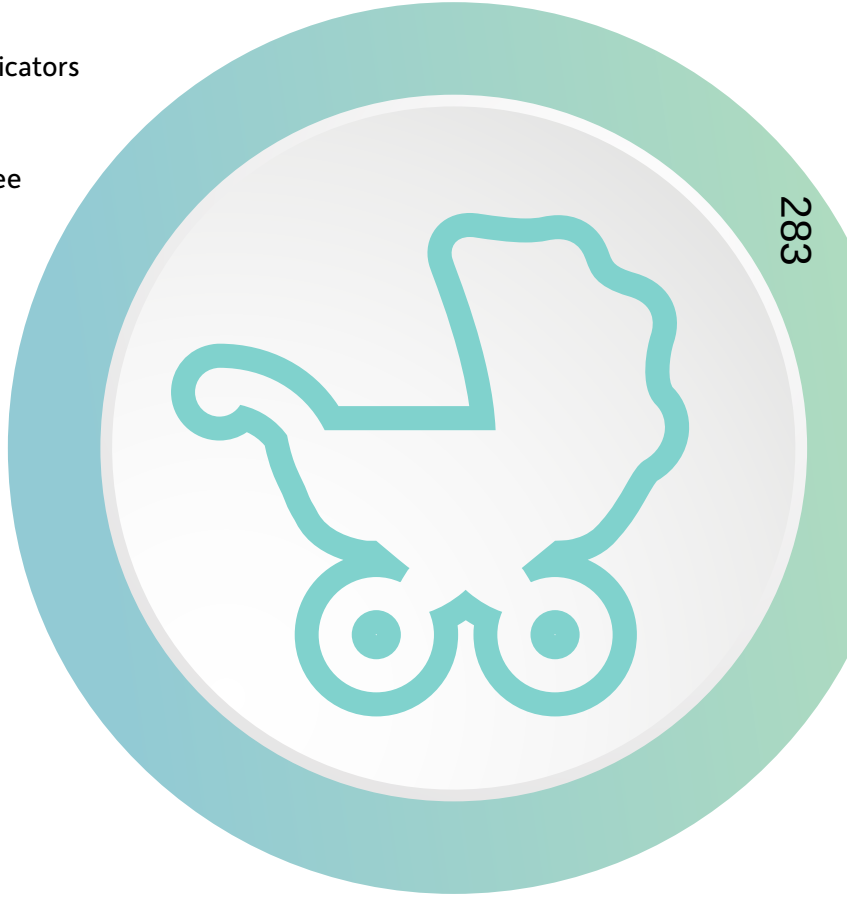
Performance Summary

- Out of all the 42 comparable indicators presented for Best Start for Life, three are significantly worse than the national average or benchmark, 13 are similar and 26 are significantly better.
- Looking at 'trend over the last five time periods', where available six indicators show deteriorating performance, five indicators have no significant change, and three indicators are improving.
- Leicestershire ranks first (best performing) when compared to its similar neighbours for the following indicators:
  - Hospital admissions as a result of self-harm (10-24 years) - Persons
  - Hospital admissions as a result of self-harm (10-24 years) – Males

- Leicestershire ranks in the top three (best performing) compared to our comparator authorities in nine indicators:
  - Hospital admissions as a result of self-harm (10-24 years) – Person, Males and Females
  - Population vaccination coverage – Dtap/IPV/Hib (1 year old)
  - Percentage of children achieving a good level of development at 2 to 2 and a half years – Persons and Females
  - Year 6: Prevalence of overweight (including obesity)
  - 16 to 17 year olds in education, employment or training (NEET) or whose activity is not known – Persons and Females

- There are currently three where Leicestershire's performance is worse than the national average:
  - HPV Vaccination coverage – Males and Females
  - Caesarean section %

- There are currently four indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing) of our comparator authorities:
  - Caesarean section %
  - A&E attendances (under 1 year) – Persons and Males
  - Low birth weight of term babies



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

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

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
	Caesarean section %	F	All ages	2021/22	38.2	15/15	30.6	38.2	34.7	—	
	Infant mortality rate / 1,000	P	<1 yr	2019 - 21	3.2	7/15	2.2	5.5	3.9	—	
	Neonatal mortality and stillbirth rate / 1,000	P	<28 days	2020	6.0	9/15	4.3	8.3	6.5	▶	
1001 Critical Days	A&E attendances (under 1 year) / 1,000	P	<1 yr	2021/22	1,094.3	14/16	447.0	1,105.4	1,094.5	—	
		F	<1 yr	2021/22	974.1	13/16	387.9	1,022.3	1,001.1	—	
		M	<1 yr	2021/22	1,217.6	16/16	502.3	1,217.6	1,183.7	—	
	Low birth weight of term babies	P	>=37 weeks	2021	2.7	14/15	1.7	2.8	2.8	▶	
	Population vaccination coverage: Dtap / IPV / Hib (1 year old)	P	1 yr	2021/22	95.9	3/15	96.7	93.7	91.8	▼	
	Proportion of New Birth Visits (NBVs) completed within 14 days	P	<14 days	2021/22	91.0	4/15	95.3	34.8	82.7	▼	
	Smoking status at time of delivery	F	All ages	2021/22	8.3	4/15	6.1	12.6	9.1	▶	
School Readiness	Percentage of children achieving a good level of development at 2 to 2 and a half years	P	2-2.5 yrs	2021/22	80.7	12/15	88.3	75.5	81.1	—	
	Percentage of children achieving a good level of development at the end of Reception	P	5 yrs	2021/22	67.6	3/15	70.7	62.3	65.2	—	
		F	5 yrs	2021/22	74.8	2/15	77.6	68.2	71.9	—	
		M	5 yrs	2021/22	61.2	5/15	64.0	56.6	58.7	—	
	Percentage of children with free school meal status achieving a good level of development at the end of Reception	P	5 yrs	2021/22	47.1	7/15	50.1	43.0	49.1	—	
		F	5 yrs	2021/22	54.7	7/15	59.8	47.8	56.6	—	
		M	5 yrs	2021/22	39.9	8/15	43.6	34.4	41.9	—	
	Percentage of children achieving the expected level in communication skills at 2 to 2 and a half years	P	2-2.5 yrs	2021/22	89.3	7/15	92.3	81.3	86.5	—	
	Percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years	P	2-2.5 yrs	2021/22	92.6	8/15	95.2	85.0	91.1	—	
	Reception: Prevalence of overweight (including obesity)	P	4-5 yrs	2021/22	21.1	5/15	18.5	25.0	22.3	▶	
	Year 6: Prevalence of overweight (including obesity)	P	10-11 yrs	2021/22	33.2	3/15	32.1	37.8	37.8	▶	

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

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

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

Produced by Business Intelligence Service, Updated September 2023

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

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

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Preparing for Life	16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	P	16-17 yrs	2021	3.2	3/15	2.4	7.9	4.7	▼	
		F	16-17 yrs	2021	2.8	3/15	2.2	7.1	4.1	▼	
		M	16-17 yrs	2021	3.5	4/15	2.7	8.4	5.3	▼	
	A&E attendances (under 18 years) / 1,000	P	<18 yrs	2021/22	380.0	9/16	280.8	464.9	439.8	–	
		F	<18 yrs	2021/22	354.9	9/16	259.0	443.5	412.7	–	
		M	<18 yrs	2021/22	403.6	10/16	301.7	485.5	465.6	–	
	Hospital admissions as a result of self-harm (10-24 years) / 100,000	P	10-24 yrs	2021/22	265.6	1/15	265.6	765.7	427.3	–	
		F	10-24 yrs	2021/22	433.6	2/15	428.4	1,361.5	711.4	–	
		M	10-24 yrs	2021/22	111.7	1/15	111.7	232.1	153.8	–	
	Under 18s conception rate / 1,000	F	<18 yrs	2021	10.7	5/15	8.1	16.2	13.1	–	
	A&E attendances (0 to 4 years) / 1,000	P	0-4 yrs	2021/22	696.2	11/16	387.2	792.9	762.8	–	
		F	0-4 yrs	2021/22	627.1	11/16	347.2	714.4	690.3	–	
		M	0-4 yrs	2021/22	760.9	11/16	424.7	868.0	831.9	–	
	Children in care / 10,000	P	<18 yrs	2022	49.0	4/15	36.0	77.0	70.0	–	
	Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	F	12-13 yrs	2021/22	78.3	5/16	84.9	63.4	69.6	▼	
		M	12-13 yrs	2021/22	71.1	5/16	78.9	55.1	62.4	–	
	School pupils with social, emotional and mental health needs: % of school pupils with social, emotional and mental health needs	P	Primary school	2021/22	2.5	7/15	1.8	3.2	2.6	▲	
			School age	2021/22	2.8	6/15	2.3	3.9	3.0	▲	
			Secondary school	2021/22	3.0	7/15	2.3	4.8	3.2	▲	
		F	School age	2021/22	1.7	8/15	1.4	2.4	1.8	–	
		M	School age	2021/22	3.7	4/15	3.2	5.3	4.1	–	
	Average Attainment 8 score	P	15-16 yrs	2021/22	49.4	6/15	51.8	46.3	48.7	–	

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

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

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

Produced by Business Intelligence Service, Updated September 2023

Staying Healthy, Safe and Well

Performance Summary

- Out of the 32 comparable indicators presented for Staying Healthy, Safe and Well, nine are significantly worse than the national average or benchmark, nine are similar and 14 are significantly better.
- Looking at the 'trend over the last five time periods' where available, seven indicators are getting worse, four indicators have no significant change and two indicators are getting better.
- Leicestershire ranks first (best performing) when compared to its similar neighbours for the following indicators:
  - Homelessness: households owed a duty under the Homelessness Reduction Act
  - Percentage of people in employment – Persons and Females

- Compared to our comparator authorities there are eight indicators where our performance is in the top three in comparison with our comparator authorities:
  - Homelessness: households owed a duty under the Homelessness Reduction Act
  - Percentage of people in employment – Persons and Females
  - Chlamydia detection rate per 100,000 aged 15 to 24 – Persons and Males
  - Smoking Prevalence in adults (18+) - current smokers (APS) – Persons, Males and Females

- There are nine indicators where Leicestershire's performance is worse than the national average:
  - Adults in contact with secondary mental health services who live in stable and appropriate accommodation – Persons, Males and Females
  - Percentage of adults walking for travel at least three days per week
  - Chlamydia detection rate per 100,000 Adults aged 15-24 – Persons and Females
  - HIV testing coverage
  - Population vaccination coverage, shingles vaccination coverage

- There are currently seven indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing):
  - Adults in contact with secondary mental health services who live in stable and appropriate accommodation – Persons, Females and Males
  - Air pollution: fine particulate matter (new method – concentrations of total PM2.5)
  - Gap in the employment rate for those who are in contact with secondary mental health services & on the Care Plan Approach, & the overall employment rate – Persons
  - Percentage of physically active adults
  - Percentage of adults aged 16 and over meeting the '5-a-day' recommendations

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

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

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
	Adults in contact with secondary mental health services who live in stable and appropriate accommodation	P	18-69 yrs	2021/22	11.0	16/16	53.0	11.0	26.0		
		F	18-69 yrs	2021/22	11.0	16/16	54.0	11.0	26.0		
		M	18-69 yrs	2021/22	12.0	16/16	55.0	12.0	27.0		
	Percentage of adults walking for travel at least three days per week	P	16+ yrs	2019/20	11.7	10/16	15.4	10.4	15.1		
	Sickness absence: the percentage of working days lost due to sickness absence	P	16+ yrs	2019 - 21	1.1	10/15	0.5	1.8	1.0		
	Air pollution: fine particulate matter (new method - concentrations of total PM2.5)	N/A	Not applicable	2021	7.7	13/14	6.2	7.9	7.4		
	Child Poverty, Income deprivation affecting children index (IDACI)	P	<16 yrs	2019	10.6	4/16	9.9	15.5	17.1		
	Homelessness: households owed a duty under the Homelessness Reduction Act	N/A	Not applicable	2021/22	4.4	1/15	4.4	12.1	11.7		
	Percentage of adults cycling for travel at least three days per week	P	16+ yrs	2019/20	2.3	4/16	7.4	1.0	2.3		
Building Strong Foundations	Fuel poverty (low income, low energy efficiency methodology)	N/A	Not applicable	2021	11.0	4/13	7.0	15.8	13.1		
	Gap in the employment rate for those who are in contact with secondary mental health services & on the Care Plan Approach, & the overall employment rate	P	18-69 yrs	2020/21	70.9	15/16	54.6	72.6	66.1		
	Percentage of people in employment	P	16-64 yrs	2021/22	81.1	1/15	81.1	74.4	75.4		
		F	16-64 yrs	2021/22	78.6	1/15	78.6	70.8	71.8		
		M	16-64 yrs	2021/22	83.5	4/15	85.3	76.4	79.1		
	Violent crime - violence offences per 1,000 population	P	All ages	2021/22	26.6	7/15	23.0	37.7	34.9		

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

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

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

Produced by Business Intelligence Service, Updated September 2023

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

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

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Enabling Healthy Choices and Environments	Cancer screening coverage: bowel cancer	P	60-74 yrs	2022	73.7	8/15	76.5	71.4	70.3	▲	
	Cancer screening coverage: breast cancer	F	53-70 yrs	2022	69.7	8/15	74.7	62.9	65.2	▼	
	Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	F	25-49 yrs	2022	73.8	5/15	77.6	65.7	67.6	▼	
	Chlamydia detection rate per 100,000 aged 15 to 24	P	15-24 yrs	2022	1,553.9	3/13	1,756.1	716.3	1,680.1	▼	
		F	15-24 yrs	2022	1,934.2	4/13	893.4	2,256.6	2,110.0	▼	
		M	15-24 yrs	2022	1,122.4	3/13	1,179.2	526.2	1,111.6	▼	
	HIV testing coverage, total (%)	P	All ages	2021	40.8	6/15	59.5	21.2	45.8	▼	
	Percentage of adults (aged 18 plus) classified as overweight or obese	P	18+ yrs	2021/22	64.1	6/15	60.0	68.2	63.8	—	
	Percentage of physically active adults	P	19+ yrs	2021/22	66.8	15/15	73.4	66.8	67.3	—	
	Successful completion of drug treatment: opiate users	P	18+ yrs	2021	4.9	11/15	9.7	3.3	5.0	▶	
	Admission episodes for alcohol-related conditions (Narrow)	P	All ages	2021/22	432.5	6/15	363.0	669.7	494.0	—	
		F	All ages	2021/22	311.9	6/15	228.0	528.9	341.3	—	
		M	All ages	2021/22	565.2	6/15	512.2	826.5	663.5	—	
	Over 25s abortion rate / 1000	F	25+ yrs	2021	14.6	7/16	11.6	18.8	17.9	▲	
	Percentage of adults aged 16 and over meeting the '5-a-day' recommendations	P	16+ yrs	2021/22	33.2	14/15	39.7	29.9	32.5	—	
	Percentage of adults who feel lonely often or always or some of the time	P	16+ yrs	2019/20	21.1	8/15	17.0	24.2	22.3	—	
	Population vaccination coverage: Shingles vaccination coverage (71 years)	P	71	2021/22	49.8	5/16	55.7	38.0	44.0	—	
	Smoking Prevalence in adults (18+) - current smokers (APS)	P	18+ yrs	2022	9.4	2/15	9.3	14.0	12.7	—	
		F	18+ yrs	2022	8.8	1/15	8.8	14.2	10.9	—	
		M	18+ yrs	2022	9.9	2/15	9.1	15.7	14.5	—	

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

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

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

Produced by Business Intelligence Service, Updated September 2023

Living and Supported Well

Performance Summary

- Out of the nine comparable indicators presented for Living and Supported Well, three are significantly better than the national average or benchmark and six are similar.
- There are two indictors where, in comparison with our comparator authorities, our performance is in top three:
  - Emergency hospital admissions due to falls in people aged 65 and over – Persons and Males

- There are currently two indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing):
  - Winter mortality index – Persons and Females

Leicestershire Joint Health and Wellbeing Strategy - Living and Supported Well

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

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Up scaling prevention and self care	Emergency hospital admissions due to falls in people aged 65 and over	P	65+ yrs	2021/22	1,686.4	3/15	1,658.3	2,314.9	2,099.9		
		F	65+ yrs	2021/22	1,916.2	4/15	1,870.4	2,623.7	2,360.0		
		M	65+ yrs	2021/22	1,388.8	3/15	1,334.6	1,893.8	1,749.6		
	Hip fractures in people aged 65 and over	P	65+ yrs	2021/22	549.2	8/15	452.0	607.4	551.2		
		F	65+ yrs	2021/22	642.8	6/15	562.6	707.6	661.5		
		M	65+ yrs	2021/22	424.4	11/15	315.5	505.6	401.1		
	Winter mortality index	P	All ages	Aug 2020 - Jul 2021	38.7	13/15	20.6	61.1	36.2		
		F	All ages	Aug 2020 - Jul 2021	37.7	14/15	18.7	64.1	36.0		
		M	All ages	Aug 2020 - Jul 2021	39.6	12/15	17.3	58.2	36.5		

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

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

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

Produced by Business Intelligence Service, Updated September 2023

Dying Well

Performance Summary

- Out of all the comparable indicators presented for Dying Well, one indicator is significantly higher, one indicator is similar, and one indicator is significantly lower when compared to the national average.
- Looking at 'trend over the last five time periods', where available, one indicator is significantly increasing, one indicator is significantly decreasing, and one indicator has no significant change.
- There is one indicator where our performance is in the top 3 compared with our 16 comparator authorities:
  - Percentage of deaths that occur in care homes
- There is currently one indicator where performance in Leicestershire is worse than the national average:
  - Percentage of deaths that occur at home
- There is currently one indicator where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing):
  - Percentage of deaths that occur at home

Leicestershire Joint Health and Wellbeing Strategy - Dying Well

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

	Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Normalising end of life care plan	Percentage of deaths that occur at home	P	All ages	2021	32.8	15/16	25.6	34.1	28.7	▲	●
	Percentage of deaths that occur in care homes	P	All ages	2021	20.7	3/16	18.8	28.5	20.2	▶	●
	Percentage of deaths that occur in hospital	P	All ages	2021	40.7	10/16	36.4	47.2	44.0	▼	●

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

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

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

Produced by Business Intelligence Service, Updated September 2023

Mental Health

Performance Summary

- Out of all the comparable indicators presented for Mental Health, four are statistically similar and six are significantly better than the national average.
- Looking at 'trend over the last five time periods', where presented, one indicator is decreasing and getting worse, and one indicator has no significant trend.
- Leicestershire ranks 1st (best performing) when compared to its similar authorities for the following indicators:
  - Suicide rate – Persons and Males
  - Hospital admissions for mental health conditions – Persons, Females and Males

- Overall, there are eight indicators in the mental health theme where our performance puts Leicestershire in the top three compared to our comparator authorities:
  - Suicide rate – Persons and Males
  - Hospital admissions for mental health conditions – Persons, Males and Females
  - Estimated prevalence of common mental disorders: % of population aged 16 & over
  - Estimated prevalence of common mental disorders: % of population aged 65 & over
  - Percentage of looked after children whose emotional wellbeing is a cause for concern

- There are currently no indicators where Leicestershire's performance is worse than the national average.
- There are currently no indicators where, when compared to similar areas, Leicestershire performs in the bottom three (worse performing).

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

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

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Estimated dementia diagnosis rate (aged 65 and older)	P	65+ yrs	2023	59.3	9/15	68.2	52.5	63.0	▼	
Estimated number of children and young people with mental disorders – aged 5 to 17	P	5-17 yrs	2017/18	12,440.3	7/16	9,914.4	27,062.5	Null	—	
Estimated prevalence of common mental disorders: % of population aged 16 & over	P	16+ yrs	2017	13.7	2/16	13.5	16.2	16.9	—	
Estimated prevalence of common mental disorders: % of population aged 65 & over	P	65+ yrs	2017	8.6	3/16	8.5	10.2	10.2	—	
Self reported wellbeing: people with a high anxiety score	P	16+ yrs	2021/22	23.6	12/15	18.4	26.6	22.6	—	
Suicide rate	P	10+ yrs	2019 - 21	8.7	1/15	8.7	15.1	10.4	—	
	F	10+ yrs	2019 - 21	5.1	6/15	3.7	7.6	5.2	—	
	M	10+ yrs	2019 - 21	12.3	1/15	12.3	22.8	15.9	—	
Hospital admissions for mental health conditions	P	<18 yrs	2021/22	56.9	1/15	56.9	182.7	99.8	—	
	F	<18 yrs	2021/22	80.6	1/15	80.6	290.3	143.4	—	
	M	<18 yrs	2021/22	34.5	1/15	34.5	85.1	58.1	—	
Percentage of looked after children whose emotional wellbeing is a cause for concern	P	5-16 yrs	2021/22	36.0	3/15	26.0	64.0	37.0	▶	

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

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

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

Produced by Business Intelligence Service, Updated September 2023

Health Inequalities

Performance Summary

- Out of all the comparable indicators presented for Health Inequalities, two are statistically similar, and two are significantly better when compared to the national average.
- There are two indicators in the health inequalities theme where Leicestershire's performance is in the top three when compared to our comparator authorities:
  - Inequalities in life expectancy at birth – females and males

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

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

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Healthy life expectancy at birth	F	All ages	2018 - 20	63.6	12/15	69.4	60.0	63.9		
	M	All ages	2018 - 20	62.9	12/15	68.0	61.5	63.1		
Inequality in life expectancy at birth	F	All ages	2018 - 20	4.9	3/15	4.3	7.8	7.9		
	M	All ages	2018 - 20	6.0	2/15	5.7	9.3	9.7		
Life expectancy at birth	F	All ages	2018 - 20	84.1	8/15	84.9	82.6	83.1		
	M	All ages	2018 - 20	80.5	6/15	81.5	79.2	79.4		

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

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

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

Produced by Business Intelligence Service, Updated September 2023

Feedback on recommendations from 2019

The 2019 report highlighted the need for a whole systems approach to physical activity. Like everything else COVID put a spanner in our work but nonetheless, good progress has been made in pursuing the recommendation in that report. Having said that, that the current report continues to highlight physical activity as an area where we must do better is a concern.

The 2019 report said:

"Policy makers and public sector organisations should adopt the seven components set out here as the basis of thinking about their approach to improving physical activity levels. In doing so the 'magnificent seven' should be underpinned by strong systems leadership, active policy and partnerships and research. The seven components are:

- Active travel
- Active environment
- Active early years and schools
- Active people and families
- Active workplaces and workforces
- Active communities
- Physical activity as medicine

Although all seven needed to be considered together by policy makers and stakeholders, the report prioritised three in particular. They were and the progress against them are as follows.

1. **We need to work towards a future where active design principles are embedded in planning policy and are central to planning decisions across Leicestershire. This would be facilitated by the development of healthy planning design guidance being adopted by all district local authorities. Further work is also needed to promote the use of our green assets for physical activity purposes.**

> Progress: Leicestershire Public Health team and Active Together are working closely with all district local authorities to embed active and healthy design principles throughout their Local Plans. Support to create standalone health and wellbeing policies and associated policies focusing on health impact assessment is ongoing throughout the development of Local Plans. Health Impact Assessments will allow the opportunity to explore how Developers have considered active design, design and use of green and blue space and connectivity with existing green assets within relevant planning applications. A Healthy Placemaking website is now live which hosts a plethora of national best practice and guidance around healthy and active design, with health impact assessment expectations and processes embedded within this. Health Impact Assessments will accompany published Local Plans to summarise the health opportunities and risks within the scope of the plan

2. **In future, we want to work more closely with local planning authorities to increase provision of active travel and high-quality walking and cycling infrastructure in new developments. Newly built areas should ideally prioritise cycling and walking as the preferred means of transport and the adoption of 20 mph limits/zones where appropriate.**

> Progress: The Leicestershire Public Health Team and local district Planners have been working closely to agree a common approach to Health Impact Assessment regarding new development within the county. This will allow early conversations with potential Developers masterplanning and design of new developments, where inclusion of cycling and walking infrastructure through design can be explored based on local need and best practice recommendations and guidance. Local Plan Health Impact Assessment thresholds based on size and local health data will then require these assessments to be submitted with relevant planning applications, providing a record of benefits and risks to health and wellbeing and recommendations around these.

3. **We need to prioritise those programmes aimed at families. For example, Leicestershire County Council, working in partnership with the Home Start Charities, District Councils and Leicester-Shire and Rutland Sport (LRS) have been successful in securing funding from Sport England to help low income families become more active together. The programme works directly with families to assess their physical activity needs, and co-produce bespoke activity plans with achievable, time related goals.**

> Progress: Families receive weekly visits from volunteers who review their physical activity plans and help with difficulties they've faced, if necessary, attending activity sessions with families to boost their confidence and help them develop manageable routines. The programme ensures that there are free and low-cost family friendly physical activities in the community using outdoor gyms, parks and other green spaces. We need to learn from this programme to help identify and better target opportunities to promote affordable and flexible physical activity through culture and leisure services.

Appendix 1

Similar areas to Leicestershire

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

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

Leicestershire County Council

Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee
Work Programme – 2023/24

18 December 2023

Agenda item	Organisation/Officer responsible
1. Workforce challenges across the health and care system. Recruitment and retention issues. How do you build talent in LLR? Announcement from Prime Minister on NHS Long Term Workforce Plan.	UHL/LPT/ICB and Directors of Social Care
2. UHL Reconfiguration Update. To include consultation on relocation of hearing and balance service from the LRI to the LGH.	UHL
3. Elective care - waiting times across specialties. Report to also cover absenteeism and which specialties are most affected.	UHL/ICB
4. ICB Finances and MTFS Report to cover how much health services affected by inflation.	ICB
5. Care Quality Commission report into maternity services at the University Hospitals of Leicester NHS Trust.	UHL
6. UHL Corporate Strategy **(Information only report. Not presented)**	UHL
7. EMAS - Clinical Operating Model and Specialist Practitioners update. Five year strategy and clinical strategy. **(Information only report. Not presented)**	EMAS

27 March 2024

Agenda item	Organisation/Officer responsible
CAMHS data and analysis	LPT

Future agenda items	Organisation/Officer responsible	Notes
1. Transfer of pharmacies from NHS England to ICB on 1 April 2023 plus optometrists and dentistry. Change to pharmacists prescribing medication.	ICB	
2. Update on Dental Services. From 1 April 2023, all Integrated Care Boards took on responsibility for commissioning dental services from NHS England	ICB	This item was presented in July 2021 and September 2021 and June 2022 on the recovery of dental services following COVID and general access to dentistry across LLR.
3. UHL Finances and Accounts for 19-20 and 20-21	UHL	On 16 November 2022, a number of information requests were sought, and it was requested that a further report be brought back in 2023.
4. Maternity Services (including Black Maternal Healthcare and Mortality)	UHL	An item on maternal healthcare (Kirkup and Ockenden reports) was taken in June 2022, with a view to receive future updates.
5. Leicester, Leicestershire, and Rutland Integrated Care System	ICS	This item was last taken in February 2023. Further updates to be scheduled accordingly.
6. Corporate Complaints Procedure	UHL	This item was taken in November 2022. It was requested that a full report setting out how the complaints procedure works, how the procedure has moved on including the patient experience and learning from complaints together with performance trends and dashboard data be provided to a future meeting.
7. Re-procurement of the Non-Emergency Patient Transport Service (NEPTS). Contract	ICS	Might be worth giving ERS Transition Ltd time to settle in before scrutinising them.

Future agenda items	Organisation/Officer responsible	Notes
awarded to ERS Transition Limited in June 2023		
8. Transfer of Haemodialysis Unit	UHL	Unit moved building in March/April 2023. A paper to be brought later in 2023
9. Transforming Care – Learning Disabilities and Autism Update	ICB/LPT	A further paper was sought for early 2024 following the report taken to JHOSC in February 2023.

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