Leicestershire County Council

Meeting: **Health Overview and Scrutiny Committee**

Date/Time: **Wednesday, 6 March 2024 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 17 January 2024.	(Pages 5 - 12)
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.	LLR Vaccination & Immunisation Programme.	Integrated Care Board	(Pages 13 - 28)
9.	Healthwatch Leicester and Leicestershire	Healthwatch	(Pages 29 - 82)
10.	Health Performance Update.	Chief Executive and ICS Performance Service	(Pages 83 - 100)
11.	Noting the work programme of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee.		(Pages 101 - 104)

12. Date of next meeting.

    The next meeting of the Committee is scheduled to take place on Wednesday 5 June 2024 at 2.00pm.

13. 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, 17 January 2024.

PRESENT

Mr. J. Morgan CC (in the Chair)

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

In attendance

Mrs. L. Richardson CC – Cabinet Lead Member for Health
David Williams, Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust (agenda item 50 refers).

41. Minutes of the previous meeting.

The minutes of the meeting held on 1 November 2023 were taken as read, confirmed and signed.

42. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 34.

43. Questions asked by members.

The Chief Executive reported that the following questions had been received under Standing Order 7(3) and 7(5):

Questions by Mrs. Amanda Hack CC:

I understand that the winter is the busiest time across the Hospitals, but I have been hearing more and more on the doorsteps, through friends and colleagues about the way within which older people are managed throughout Leicestershire Hospital Trust. Leicestershire has 8 Community Hospital facilities, to look after people once they no longer need treatment at the main hospitals. I am hearing that many patients are being moved from a city centre location that they feel they can access to community hospitals that they do not.

1. **Does the transition into the community hospital location include considerations about the patients home location and the ability to assist the transition back to home?**
2. **What proportion of patients are moved into community hospitals that are actually further away from their home and support network than the 3 main hospitals.**

3. **How are families, that are important for the recovery and care of the patient post discharge kept informed of decisions and considered as part of the decision making process?** I heard just last week of a patient that was supposed to be transferred to Hinckley (a location that was fairly easy for the family to access) to Market Harborough and the family was only informed when the carer called to check the ward they had been moved to that the patient was not where they expected. Why would this happen? And why was the family not informed in advance?

Within the acute hospitals, it has been raised with me that a family agreed on a care path for their family member. Only for that care path to change, but also that their family member was being moved from one acute hospital to another.

4. **How are families communicated with and what is the expected level of communication when alternative care decision have been made but also when a patient has been moved?**
5. **What is the standard of care provided on keeping the patient mobile whilst in hospital?**

Reply by the Chairman:

I have received the following response from the NHS:

"Leicestershire has eight Community Hospital facilities, to look after people once they no longer need treatment at the main hospitals. I am hearing that many patients are being moved from a city centre location that they feel they can access to community hospitals that they do not.

1. Does the transition into the community hospital location include considerations about the patients home location and the ability to assist the transition back to home?

Due to the demands on the LLR system, including both UHL acute settings and EMAS provision for patients requiring assistance in the community - it is vital for LPT community beds to be fully utilised at the earliest opportunity for patient recovery and rehabilitation.

Therefore, for patients transferring from UHL to LPT wards, consideration is given by UHL to the patient's home location, but the final decision is often dependent on where capacity is available.

We appreciate that for some families, the location of community hospitals is more difficult than for others. If a family/patient is experiencing difficulties we do our best to assist them by – where possible - moving the patient to a more convenient location. The decision is often based on the individual needs of each patient, and moving them is not always possible for every patient.

2. What proportion of patients are moved into community hospitals that are actually further away from their home and support network than the three main hospitals?

We are unable to provide figures on the proportion of patients who are moved to a community hospital that is further away from their home than one of the acute hospital locations.

3. How are families, that are important for the recovery and care of the patient post discharge kept informed of decisions and considered as part of the decision making process? I heard just last week of a patient that was supposed to be transferred to Hinckley (a location that was fairly easy for the family to access) to

Market Harborough and the family was only informed when the carer called to check the ward they had been moved to that the patient was not where they expected. Why would this happen? And why was the family not informed in advance?

It is good practice to ensure that both patients and families are aware of discharge plans. As the referring hospital, UHL promotes early discharge conversations with patients and families from when they are admitted to hospital. There is a “supporting your discharge” booklet which explains the process – which is currently under review due to the changes where the beds are provided.

Families may not be informed in advance if the patient has 'capacity' and is able to inform their own relatives of plans, or if there are difficulties in getting through to the nominated support person.

There have been a few occasions where a bed has been allocated but the patient may not end up being discharged – this could be because they become medically unwell. This can lead to another available bed in another part of LLR being reallocated to that patient. Again, the referring hospital will be informed and be required to update/communicate with the patient/family.

4. Within the acute hospitals, it has been raised with me that a family agreed on a care path for their family member. Only for that care path to change, but also that their family member was being moved from one acute hospital to another. How are families communicated with and what is the expected level of communication when alternative care decision have been made but also when a patient has been moved?

Due to the current emergency pressures facing UHL, additional wards have been opened at the LGH site to provide care to patients whilst they await their discharge destination. These areas provide care that reflects their changing and improving needs and allows the LRI site to care for patients arriving through the Emergency department who are in the acute phase of their admission.

The nurse or a member of the multi-disciplinary team caring for the patient will involve the patient and update them in decisions about their care. If the patient is unable to advise their relatives, then the most appropriate member of the team would. This may not occur overnight - it is dependant on the change to the care pathway so communication would be at the soonest appropriate time.

5. What is the standard of care provided on keeping the patient mobile whilst in hospital?

Some patients will experience a loss in their physical condition whilst in hospital. We are currently promoting early movement with patients across our wards in recognition of this, and to help prepare them to get home earlier. We are at looking at how we communicate this out to our patient and families and are promoting DrEaMing (drinking, eating and mobilising) after surgery. We have recently employed a number of ward-based therapists and meaningful activity coordinators who are working with patients earlier in their journey to promote early ambulation.”

Supplementary question from Mrs Amanda Hack CC

Mrs Hack noted the important role the families of patients played to keep patients out of hospital and she asked how much communication the hospitals had with the families (particularly where the patient had dementia) and what was being done to prevent those cases where families were not informed of changes to the patient's care.

Reply by Chairman

The Chairman agreed that a further written answer would be provided to Mrs Hack after the meeting.

44. Urgent items.

There were no urgent items for consideration.

45. 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 and Mrs. B. Seaton CC both declared non-registerable interests in all agenda items as they had close relatives that worked for the NHS.

46. Declarations of the Party Whip.

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

47. Presentation of Petitions.

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

48. Public Health Medium Term Financial Strategy 2024/25 to 2027/28.

The Committee considered a joint report of the Director of Public Health and the Director of Corporate Resources which provided information on the proposed 2024/25 to 2027/28 Medium Term Financial Strategy (MTFS) as it related to Public Health. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Chairman welcomed Mrs. L. Richardson CC, Cabinet Lead Member for Health, to the meeting for this item.

Arising from discussions the following points were noted:

(i) The Public Health Department had 118 members of staff and this figure included the inhouse services that the department provided such as the Quit Ready scheme. Members commended the work that had been carried out by Public Health with that level of staffing.

(ii) Members welcomed the role the Public Health department played in adding value to the work of other County Council departments and the NHS. It was emphasised that more needed to be done to publicise this.

(iii) Members noted the large amount of savings that were projected for the MTFS period 2024/25 to 2027/28 and queried whether these numbers were achievable. In response it was explained that most of those savings had already been achieved for example with the difficult decisions that had been made around the homelessness support service, sport and physical activity programmes and school food.

(iv) A member queried whether Public Health was spending the correct proportion of its budget on tackling obesity. In response the Director of Public Health acknowledged that more needed to be done in this area particularly as the percentage of adults aged 16 and over in Leicestershire that were meeting the '5 a day' recommendations was not as good as hoped. However, there were budget constraints and core costs such as the health visiting service had to be met. The weight management service received more Public Health funding than general obesity campaigns. On the whole the Director of Public Health felt that the balance was the correct one under the circumstances.

(v) In 2023 a procurement process had taken place for the Integrated Sexual Health Service. Whilst there had been expressions of interest at the soft market testing stage, no providers had bid at the final stage. Therefore a decision had been made to extent the contract of the current provider for a further 12 months.

RESOLVED:

(a) That the report and information now provided be noted;

(b) That the comments now made be forwarded to the Scrutiny Commission for consideration at its meeting on 29 January 2024.

49. Vaping and Young People.

The Committee considered a report of the Director of Public Health regarding work that was being carried out relating to vaping and young people in Leicestershire. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Arising from discussions the following points were noted:

(i) Vaping was originally intended to be a safer alternative to smoking and a way to stop people smoking. However, it had now become a problem in itself and had been linked to some lung complaints. The full extent of the impact of vaping on the body was not yet known. Vapes contained nicotine which was addictive. Members were of the view that all this information needed to be better communicated to the public, particularly to parents of children that were vaping.

(ii) In November 2022 a survey was conducted to gain feedback on the use and prevalence of E-cigarettes amongst young people in Leicestershire. There were 1100 respondents, and it was found that 25% of children used vapes. Some of the children vaping had previously smoked tobacco whereas others had started vaping without any previous smoking history. Members welcomed the numbers that responded to the survey but were extremely concerned about the findings.

(iii) Leicestershire Trading Standards reported receiving a total of 84 complaints regarding vapes, 63 relating to children under the age of 18 years old being sold

vapes. Members raised serious concerns that selling vapes to children was illegal but giving them out for free was not.

(iv) Vapes were attractive to young people because the packaging used bright colours and there were different flavours. Action needed to be taken to change the way vapes were being marketed.

(v) The Government was intending to create the first smokefree generation by passing legislation to prevent children turning 14 from ever being legally sold tobacco products. Members emphasised that these proposals also needed to cover vaping. There was no national direction on what support should be available to help young people stop vaping. Members felt that tackling the problem of vaping required a more strategic approach supported by legislation.

(vi) It was suggested that vaping could be made available by prescription only, which would ensure that only the appropriate people were able to vape.

(vii) Between October and December 2023 the Government had carried out a consultation regarding creating a smokefree generation and tackling youth vaping. The proposals to tackle the problem of vaping included restricting the number of different flavours, requiring vendors to have a licence, and imposing a duty on the sale of vapes. Both the Public Health and Trading Standards departments at Leicestershire County Council had responded to the consultation.

(viii) Funding had been allocated to Local Authority Stop Smoking services through the Smokefree Generation Programme, resulting in an additional estimated £716,000 being allocated to Leicestershire Public Health from 2024/25 to 2028/29 in line with the grant conditions. Leicestershire Trading Standards were also being allocated some of the Smokefree Generation Programme funds in order to tackle illicit products arriving in the county at East Midlands Airport.

(ix) Were schools and parents to have any information or concerns about the underage sales of vapes and tobacco they should make contact with Trading Standards by reporting via the anonymous helpline.

(x) In the past Leicestershire Trading Standards carried out test purchasing in stores using underage children to see if the shops would sell products that they should not to people of that age. However, Trading Standards no longer had the funding and resources to carry out test purchasing. Therefore, Trading Standards now had to take a more reactive approach and only visit premises where intelligence had been received that the shop was making illegal sales. In those cases, Trading Standards would give a warning to the establishment, and if there was sufficient evidence take enforcement action. Prosecutions were now being carried out much more quickly by way of a fixed penalty notice rather than requiring the person to attend court.

(xi) Adults were provided with vapes as part of the smoking cessation service but they were given the information to enable them to make an informed decision and required to provide identification. These people were then monitored.

RESOLVED:

(a) That the contents of the report be noted with concern;

(b) That the Chairman be authorised to write to all Leicestershire MPs on behalf of the Committee raising concerns about vaping and asking for help with regards enacting legislation to tackle the problem.

50. LLR LeDeR Annual Report 2022/23.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided a summary of the Leicester, Leicestershire and Rutland LeDeR Annual Report 2022/23 and key actions from learning for all partners. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item David Williams, Group Director of Strategy & Partnerships, LPT.

Arising from discussions the following points were noted:

(i) One of the key learning points that had arisen related to widespread misuse of the Mental Capacity Act where decisions were being made by care providers around medical interventions. On occasions it was being assumed that a patient did not have the capacity to consent when in fact they did or vice versa. This was a particular problem with regards decisions being made on whether to resuscitate a patient. All services and care providers needed to review their practices to ensure compliance with the legislation.

(ii) A total of 83 deaths were notified to the LeDeR Programme during 2022/23 of which 70% of the patients were male. The disparity towards males was likely because learning disabilities were more easily identifiable in males due to the way the disability manifested itself in males. There was likely to be more females with learning disabilities that were not diagnosed.

(iii) Whilst people with learning disabilities did not undergo a different type of medical screening to the rest of the population, they did have medical checks more frequently.

(iv) Work was taking place with GP Practices to better understand why patients with learning disabilities did not attend appointments.

RESOLVED:

(a) That the contents of the report be noted;

(b) That officers be requested to provide a further report to the Committee regarding the LeDeR Programme at a future date.

51. 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.

52. Date of next meeting.

RESOLVED:

That the next meeting of the Committee be held on Wednesday 6 March 2023 at 2.00pm.

2.00 - 3.38 pm CHAIRMAN
17 January 2024

NHS
Leicester, Leicestershire and Rutland

Leicestershire Health Overview and Scrutiny Committee

LLR Vaccination & Immunisation Programme

Mike Sandys, Director of Public Health & Kay Darby, Chief Nurse, LLR ICB

Purpose of report

- To update the committee on changes in the responsibility for Vaccination and Immunisation within the NHS and the implementation of the national Vaccination strategy
- To brief the committee on actions to increase the uptake of HPV vaccination
- To provide further detail to the committee on childhood immunisations uptake and associated improvement actions more generally
- To update on measles cases and COVID

Childhood Immunisation Changes and Improvements

- General Practice deliver most childhood vaccinations, supported by School Aged Immunisation Service (Leicestershire Partnership Trust) for in-school programmes.
- Currently commissioned and led by the Regional NHS England Screening and Immunisation Team, transfer to ICB will take place in April 2025
- 2024/5 is a transitional year with new local governance arrangements being set up from April 2024 (see later)
- New Child Health Information Service provider from March 2024, working with practices with low childhood immunisation uptake and longest waiting lists
- Initiatives developed for Covid-19 vaccination are being expanded to improve vaccine uptake across all programmes:
    - Super vaccinators - upskilled nurses that can offer the full range of childhood vaccines (as well as seasonal and adult vaccines)
    - Roving vaccination vehicles - to offer ease of access, convenience and help address immunisation coverage across all communities
    - Central booking service to signpost and book appointments by telephone, for patients that don't want to book on-line
    - Tailored clinics for key groups such as learning disability, immunosuppressed children
    - Community transport to improve access

National Vaccination Strategy

- Published December 2023, the strategy aims to:
  - Build on the success of the NHS COVID-19 vaccination programme
  - Increase overall uptake and coverage of vaccinations (life-course, seasonal programmes and outbreaks)
  - Reduce disparity in uptake, so that every community in the country has the protection it needs.
- To be achieved by:
  - Delegation of commissioning responsibility to transfer from NHS England to ICBs by April 2025
  - Offer of outreach vaccination services in convenient locations, to support uptake in underserved populations i.e. shopping centres, supermarkets and community centres as well as GP and Community Pharmacy.
  - Provide multiple vaccinations for the whole family i.e. covid and flu alongside opportunistic HPV and MMR
  - Multi-disciplinary teams providing wider health advice and interventions (blood pressure, diabetes checks, or mental health and dental information) to make every contact count
  - An increased role for Community Pharmacy with an expansion in the range of vaccinations offered by community pharmacies.
  - Improved access to information via the NHS app that will be expanded allowing patients to book appointments, see invitation alerts and get appointment notifications.
- To be delivered by 2025/6

NHS England » NHS vaccination strategy

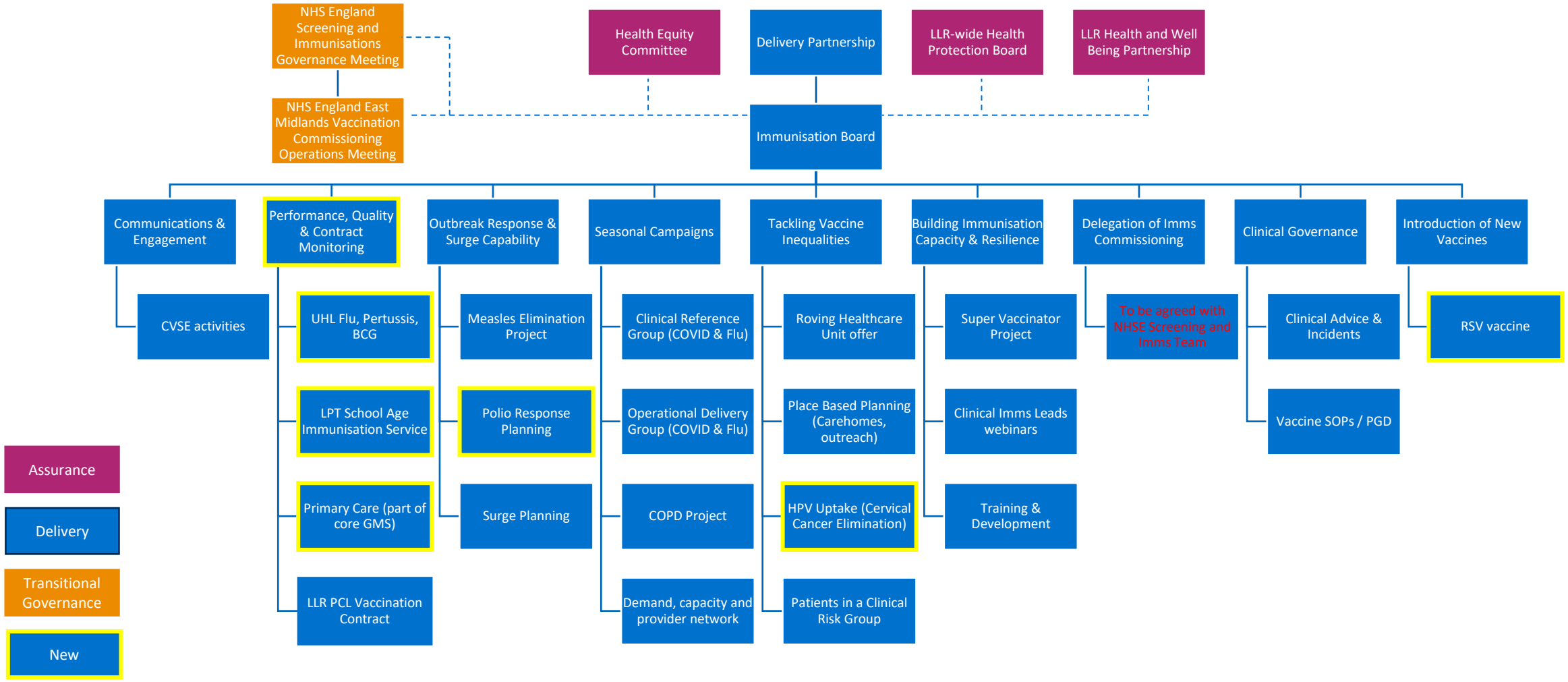
Local Implementation

New LLR Immunisation Board to be set up from April 2024, to build of the success of the Covid-19 vaccination programme and include all vaccinations:

- have oversight of all vaccination programmes (life-course, seasonal campaigns and outbreaks).
- provide leadership to support improved vaccine coverage and uptake for all communities.
- ensure local oversight of the delegation of commissioning responsibilities from NHS England to the ICB by April 2025.
- engagement and contribution from all key stakeholders.
- fit with the wider prevention agenda in the System to ensure community interventions focus on more than just vaccination delivery.
- a reporting mechanism into the corporate governance structure of the ICB, as well as the wider system architecture.

Membership will include representation from across the system, including Directors of Public Health and associated representatives.

Proposed Immunisation Governance Structure



HPV Vaccination Uptake

	Leicestershire			
Consent platform	E-consent			
	Denominator	Vaccinated	% Uptake	Outstanding
2020/21 HPV				
Girls Cohort 18 - HPV 1	4,134	3,577	86.5%	557
Girls Cohort 18 - HPV 2	4,134	3,189	77.1%	945
Boys Cohort 2 - HPV 1	4,538	3,705	81.6%	833
Boys Cohort 2 - HPV 2	4,538	3,216	70.9%	1,322
2021/22 HPV				
Girls Cohort 19 – HPV 1	4,049	3,170	78.3%	879
Girls Cohort 19 – HPV 2	4,049	2,029	50.1%	2,020
Boys Cohort 3 – HPV 1	4,500	3,200	71.1%	1,300
Boys Cohort 3 – HPV 2	4,500	2,055	45.7%	2,445
2022/23 HPV	Note – pending validation, published data may vary			
Girls Cohort 20– HPV 1	4254	3457	81.3	
Girls Cohort 20 – HPV 2	4254	2723	64.0	
Boys Cohort 4 – HPV 1	4556	3356	73.7	
Boys Cohort 4 – HPV 2	4556	2454	53.9	

Note: schedule has now changed to being a single dose

Improving HPV uptake

- HPV awareness video being recorded by local GP and 2 students at Beauchamp college on 11th March.
- HPV Leaflets (in several languages) being taken to all awareness events the Cancer team are attending between now and vaccination period.
- 2 vaccination and awareness events being delivered on 4th April (Haymarket) and 5th April (Beaumont Leys Leisure Centre and shopping centre)
- School Aged Immunisation Service vaccination team will circulate materials to school Head Teachers to send on to parents.
- School Aged Immunisation Service vaccination team will commence routine HPV delivery in senior schools throughout summer term
- Uptake data will be reviewed once received, to inform some targeted support to schools where uptake is particularly low.
- System level Cervical Cancer Oversight Group recently established to lead longer term action plan to eradicate cervical cancer by 2040:
  - Two workstreams to underpin this: Cervical Screening and HPV
  - Data collection and analysis, delivery model scoping and action planning underway

Childhood Immunisation: 12 months

Cohort	Indicator	Standard	Area	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/24	Q2 2023/24
12 months	12m Denominator	N/A	England	144864	146059	151502	145098	140604	147953	158919	154232	142761	144242	151101
			Leics City	1856	1768	1776	1643	1659	1856	1105	1170	1085	1112	1122
			Leic'shire	1609	1614	1723	1554	1634	1639	1786	1781	1692	1608	1730
			Rutland	72	80	76	82	79	81	75	93	70	72	70
	12m DTaP/IPV/Hib %	95	England	91.6	91.5	91.3	92.0	91.9	92.0	92.1	91.9	91.6	91.5	91.3
			Leics City	92.4	91.6	90.3	91.1	90.5	91.9	93.7	91.4	90.9	91.3	92.4
			Leic'shire	96.0	96.0	95.9	96.5	95.5	96.2	96.2	96.5	95.9	94.9	94.0
			Rutland	94.4	97.5	98.7	96.3	97.5	96.3	96.0	95.7	95.7	88.9	95.7
	12m PCV %	95	England	93.4	93.7	93.3	94.1	94.1	94.0	94.1	94.0	93.6	93.6	93.4
			Leics City	94.7	94.2	92.5	93.3	93.8	94.1	96.7	94.3	93.9	94.3	94.8
			Leic'shire	94.7	97.4	97.1	93.3	97.0	97.7	97.1	97.4	96.0	96.5	95.7
			Rutland	98.6	97.5	100.0	98.8	98.7	96.3	97.3	97.8	96.9	91.7	95.7
	12m Rota %	95	England	90.0	90.2	89.2	90.4	90.5	89.3	89.0	89.3	89.0	88.7	88.2
			Leics City	89.7	89.6	84.6	89.2	85.6	85.5	88.0	86.4	86.7	86.9	85.8
			Leic'shire	94.7	94.5	94.3	89.2	94.6	94.8	93.4	96.6	93.7	92.5	91.7
			Rutland	87.5	93.8	92.1	98.8	97.5	95.1	94.7	94.6	92.9	86.1	94.3
	12m MenB %	95	England	91.8	91.7	91.5	92.0	92.0	91.8	91.9	91.6	91.2	91.2	91.0
			Leics City	91.8	91.3	90.6	91.5	89.6	91.2	93.2	90.7	89.9	89.7	91.4
			Leic'shire	96.1	96.2	96.1	91.5	95.3	96.1	96.0	96.1	95.7	94.9	94.0
			Rutland	97.2	97.5	98.7	96.3	97.5	96.3	97.3	94.6	95.7	88.9	95.7

Childhood Immunisation: 24 months

Cohort	Indicator	Standard	Area	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/24	Q2 2023/24
24 months	24m Denominator	N/A	England	148863	153721	160838	153378	147510	149055	154388	149108	144469	151846	163654
			Leics City	1139	1174	1206	1099	1103	1139	1205	1146	1030	1007	1134
			Leic'shire	1614	1695	1851	1745	1655	1681	1766	1613	1694	1692	1880
			Rutland	88	78	91	72	78	85	80	82	83	80	69
	24m DTaP/IPV/Hib3 %	95	England	94.0	93.8	93.4	93.0	93.0	92.9	92.9	93.0	93.0	92.8	92.9
			Leics City	94.4	94.2	93.4	93.1	93.2	93.9	92.1	92.9	91.8	92.6	94.3
			Leic'shire	96.5	97.1	96.5	96.8	96.5	96.5	96.3	96.3	95.8	96.5	96.6
			Rutland	97.7	96.2	98.9	97.2	97.4	96.5	97.5	98.8	97.6	97.5	95.7
	24m PCV Booster %	95	England	94.0	93.8	93.4	93.0	93.0	92.9	89.4	88.5	89.3	89.0	88.8
			Leics City	88.7	89.6	87.8	86.3	87.7	88.1	88.1	87.4	84.3	86.0	89.2
			Leic'shire	95.1	96.0	95.1	95.0	94.6	95.4	94.7	94.5	95.0	95.2	95.0
			Rutland	97.7	96.2	98.9	95.8	97.4	91.8	97.5	92.7	97.6	92.5	94.2
	24m Hib/MenC booster %	95	England	89.1	88.9	88.3	88.3	89.1	89.3	89.5	88.9	89.2	89.5	89.2
			Leics City	88.7	89.8	88.1	86.7	88.2	89.2	89.2	88.0	85.8	87.9	90.0
			Leic'shire	82.0	96.0	95.1	94.9	94.9	95.8	94.6	95.0	95.1	95.6	95.3
			Rutland	96.6	96.2	98.9	94.4	97.4	91.8	97.5	92.7	97.6	93.8	92.8
	24m MMR1 %	95	England	89.3	89.0	88.6	88.9	89.7	89.7	89.7	89.0	89.5	89.5	89.4
			Leics City	89.3	89.4	88.5	88.2	88.5	89.2	89.8	88.6	87.5	88.4	90.1
			Leic'shire	95.1	96.0	94.8	94.7	94.7	95.5	94.7	95.0	95.1	95.7	95.1
			Rutland	95.5	96.2	98.9	93.1	96.2	92.9	97.5	92.7	97.6	93.8	94.2
	24m MenB Booster %	95	England	88.5	88.5	88.1	88.1	88.6	88.5	88.6	87.8	88.4	88.1	88.0
			Leics City	87.3	88.1	87.2	84.5	86.0	86.7	87.1	85.7	83.5	84.3	88.4
			Leic'shire	94.1	95.1	94.9	94.8	93.8	94.8	94.3	94.0	94.0	94.7	94.6
			Rutland	95.5	96.2	98.9	91.7	96.2	91.8	97.5	93.9	96.4	92.5	94.2

Childhood Immunisation: 5 years

Cohort	Indicator	Standard	Area	Q4 2020/21	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/24	Q2 2023/24
5 years	5y denominator	N/A	England	167046	171806	178424	169957	162668	168324	175293	170920	160488	166198	172370
			Leics City	1189	1299	1370	1279	1215	1234	1343	1251	1198	1225	1195
			Leic'shire	1932	2031	1902	1924	1828	1822	2052	1986	1788	1960	2041
			Rutland	87	103	129	91	86	108	103	113	96	91	81
	5y DTaP/IPV/Hib %	95	England	95.3	95.1	94.6	94.6	94.5	94.0	93.5	93.5	93.3	93.1	92.8
			Leics City	95.6	95.5	95.1	94.4	94.9	95.1	92.9	92.7	93.9	91.5	92.8
			Leic'shire	98.4	97.9	97.7	97.5	97.9	98.2	96.2	97.1	96.8	96.8	96.1
			Rutland	100.0	98.1	98.4	95.6	98.8	98.1	100.0	95.6	99.0	95.6	95.1
	5y MMR1 %	95	England	94.3	94.1	93.7	93.5	93.5	92.9	92.9	92.9	92.7	92.5	92.3
			Leics City	94.8	95.6	94.2	92.5	92.8	94.2	93.6	93.3	93.7	91.8	91.4
			Leic'shire	98.0	97.5	97.2	96.6	97.4	97.6	96.7	97.5	97.0	92.2	96.3
			Rutland	100.0	97.1	96.9	94.5	96.5	96.3	97.1	97.5	96.9	96.7	96.3
	5y MMR2 %	95	England	86.4	86.3	85.5	85.5	85.9	84.4	84.7	85.2	85.0	83.9	83.8
			Leics City	86.8	84.4	83.4	80.8	82.9	80.6	79.6	79.9	81.5	79.5	79.3
			Leic'shire	95.4	95.2	93.8	93.5	94.5	95.9	91.6	92.2	92.3	91.2	91.1
			Rutland	98.9	97.1	92.2	93.4	95.3	92.6	91.3	93.8	86.5	91.8	90.1
	5yDTaP/IPV Booster %	95	England	85.1	84.8	84.0	84.2	84.6	83.0	83.4	84.0	84.0	82.8	82.7
			Leics City	85.1	82.1	80.8	78.3	80.6	76.7	76.7	77.9	78.8	75.3	75.6
			Leic'shire	94.3	93.9	93.1	92.6	92.1	94.0	90.0	89.9	84.4	89.6	89.2
			Rutland	96.6	93.2	93.0	91.2	95.3	98.1	95.1	86.7	91.3	95.6	95.1
	5y HibMenC Booster %	95	England	92.5	92.6	92.0	92.0	92.0	91.3	91.2	91.0	90.7	90.5	90.2
			Leics City	89.4	89.8	88.0	86.3	87.4	86.7	88.0	86.7	86.0	82.2	82.1
			Leic'shire	96.5	95.9	95.9	95.1	95.5	91.7	95.1	95.9	94.4	95.1	94.2
			Rutland	98.9	97.1	93.8	91.2	94.2	96.3	97.1	95.6	92.7	94.5	96.3

Measles Outbreak

- Rising number of cases in Leicester
- Majority of cases are in unvaccinated children <16 years
- In each case notified by UKHSA following risk assessment, the ICB vaccination team make the following rapid response:
    1. alert the patient's GP practice and practices in the immediate vicinity of the patient's home address
    2. offer the patient's school a roving vaccination unit visit, supplemented with a webinar for the pupils' parents
    3. offer the notified GP practices use of the roving unit to take MMR vaccinations into the heart of their communities.

Summary of Activity Undertaken During Measles Outbreak

Activity	Lead
Alerts / messaging associated with reported cases e.g. warn & inform letters	UKHSA
Webinars delivered to primary care to raise awareness & encourage additional capacity	ICB
Meetings with individual practices in affected communities to offer bespoke support, resources & encourage local collaboration	ICB
Webinars delivered to community pharmacies, health and care staff, clinical leads, schools and parents to raise awareness of signs & symptoms & signposting	ICB
Community messaging & awareness raising & national/regional/local media activities	ICB / Public Health
School alerts / messaging & on-going communications	Public Health
Communication with imams & other faith leaders	Public Health
Ordering cap eased porcine-gelatine free MMR vaccine for practices	NHSE
Commissioned roving healthcare unit & clinical provider to offer 2 clinics per week during February & March	ICB
Leicester IMT established with several “cells” underneath to ensure an effective, collaborative approach	ICB / Public Health
Immunoglobulin inpatient & community pathways confirmed	ICB / UHL
GPs provided with direct phone line into the LRI emergency department to alert of potential cases being directed to hospital	UHL
Opportunistic MMR vaccination team in LRI emergency department providing vaccinations to patients at clinician’s request	UHL

COVID-19 & flu vaccination uptake AW 2023/24

LLR AW 2022/23 COVID-19 closing uptake: 61.3%

Location / COVID-19	Booster eligible population	Booster doses given to eligible population	% Booster doses given
LLR (31/01/24)	398,089	207,302	52.1%
Rutland (31/01/24)	17,184	11,439	66.6%
City (31/01/24)	122,035	46,813	36.4%
County (31/01/24)	261,513	161,144	58.2%

LLR AW 2022/23 Flu closing uptake: 53.4%

Location / Flu	Flu eligible population	Flu doses given to eligible population	% Flu doses given
LLR (20/02/24)	618,139	323,814	52.4%
Rutland (20/02/24)	24,267	16,514	68.0%
City (20/02/24)	213,877	86,763	40.6%
County (20/02/24)	379,970	220,537	58.0%

(Source: Foundry)

COVID-19 Spring 2024 Eligible Cohorts

Eligible Cohorts
1. Adults aged 75 years & over
2. Residents in a care home for older adults
3. Individuals aged 6 months & over who are immunosuppressed (as per tables 3 & 4 in the Green Book) due to health condition or treatment, eg: • Chemotherapy, radiotherapy, solid organ transplant, bone marrow/stem cell transplant, HIV infection, genetic disorders affecting immune system • Treatments involving systemic steroids • History of haematological malignancy including leukaemia, lymphoma & myeloma • Long-term immunosuppressive treatments for conditions eg rheumatoid arthritis, inflammatory bowel disease, psoriasis • Children due to receive planned immunosuppressive therapy & those with auto-immune diseases

COVID-19 Spring 2024 Vaccination Campaign: Key Dates

- 27 February: Expression of interest process open for new community pharmacists interested in joining the vaccination programme
- 29 February: NHS England mobilisation guide due
- 15 April: Commence care home vaccinations
- 15 April: NHS 119 telephone lines open and first invites are scheduled to be received by eligible patients
- 22 April: Vaccinations commence for all other eligible cohorts
- 30 June: Final day for spring COVID-19 vaccinations.

HEALTH OVERVIEW AND SCRUTINY COMMITTEE
6 MARCH 2024

REPORT OF HEALTHWATCH LEICESTER AND HEALTHWATCH LEICESTERSHIRE

TOGETHER: WE ARE MAKING CARE BETTER REPORT

Purpose of report

1. Healthwatch Leicester and Healthwatch Leicestershire (HWLL) is your local health and social care champion. If you use GPs and hospitals, dentists, pharmacies, care homes or other support services in your area, we want to hear about your experiences.

2. As an independent statutory body, we have the power to make sure NHS leaders and other decision-makers listen to local feedback and improve standards of care. We can also help you to find reliable and trustworthy information and advice.

3. The purpose of this report is to present HWLL activities and their impact over the last 12 months.

Recommendation

4. It is recommended that the Health Overview and Scrutiny Committee note the report and presentation.

Policy Framework and Previous Decisions

5. The County Council, following the Health and Social Care Act 2012, is required to directly commission a local Healthwatch. The local Healthwatch in turn has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinising the quality of provision of local services and a seat on the Health and Wellbeing Board.

Background

6. The purpose of HWLL is to promote improvements in local health and social care services – improving outcomes for local people in Leicester and Leicestershire. HWLL believes that the best way to do this is by designing local services around the needs and experiences of local people.

7. The presentation contains details on the statutory activities undertaken over the last year and demonstrates the impact that these activities have made on the commissioning, provision and management of local health and social care services.

Patient and Public Involvement

8. Examples of activities undertaken this year:

Living with Dementia
Local people shared their views and experiences of Dementia services in our report 'Living with Dementia in Leicester, Leicestershire and Rutland'.

In the report, we have identified wide inconsistencies across Leicester, Leicestershire and Rutland (LLR) in the way diagnoses are made and what services are available and accessible for people living with dementia from the first suspicions of memory problems onwards.

We heard from more than 350 people living with Dementia, their carers and families. Thanks to people sharing their experiences we have identified wide inconsistencies in the way in which services are available and accessible for people living with dementia.

Supporting and helping those living with dementia and their carers remains a priority for LLR's health and social care organisations which includes the Dementia Programme Board. The LLR Dementia Programme Board aims to address all the recommendations and the report findings will inform the development of the revised Dementia Strategy in 2024.

Dentistry
Change takes time. We often work behind the scenes with services to consistently raise issues and bring about change. Over the years, we have been raising the issue of access to dentistry. We have continued to work with the NHS Local Dental Committee (LDC) and provide concerns from patients. We have advocated for clear advice for patients and details of local NHS provision. We have produced up-to-date advice which has meant people who need urgent treatment know their options and have clear information.

Asylum seekers' experiences with local health and care services
Our access to health care project is to listen and explore how people have been accessing their health care and what that experience has been like for them. We have identified groups and seek to listen and outline what the specific issues are for those communities. Our focus for this engagement was to engage with asylum seekers who have been accommodated in hotels in Leicester and Leicestershire.

We aimed to listen to people's experiences of accessing primary care services, mental health support and their awareness and access to health services. The aim of the visits was not intended to provide an in-depth analysis of the situation, but rather to gain insight from people into the pressing issues and common themes.

Key findings
Barriers to Access: The reports identify barriers that hinder asylum seekers' access to essential health and care services. These barriers include language barriers, lack of cultural competency among healthcare providers and insufficient awareness of available services.

Mental Health Challenges: Asylum seekers often face heightened mental health stress due to the uncertainties surrounding their status. The report highlights the

importance of tailored mental health support within local healthcare systems.

Recommendations for Improvement: To address the identified challenges, the reports offer a set of practical recommendations for local health and care services. These recommendations emphasise the need for language support and increased collaboration between service providers and community organisations.

Read our reports

9. Details of current work planned across Leicestershire.

LGBTQ+ Survey

We are engaging with LGBTQ+ communities in Leicester and Leicestershire to listen to their experiences of local health and care services. We are working in partnership with Trade Sexual Health to reach people to understand their views on services.

www.smartsurvey.co.uk/s/HWLGBTQ/

Supported Living

We are liaising with supported living teams to hear from recipients, caregivers and advocates for Supported Living Services.

The project aims to:

- Develop an overarching understanding of what services are in place currently across Leicester and Leicestershire.
- Understand more about how good these services are.
- Speak with service users to find out what is important to them and if their needs are being met.

What Matters Most

From February 2024, we will be consulting with the people of Leicestershire to allow them to share their views about what key themes they would like to see us focus on in the next 12 months. We will have face-to-face and online opportunities for people to engage.

www.smartsurvey.co.uk/s/HWPriorities2024

Following this, we will compile our priorities and engagement activities for 2024-25.

Local Healthwatch Funding

10. Across England, there are 152 local Healthwatch services. The Department of Health and Social Care (DHSC) fund our work. DHSC gives money to local councils so they can commission an effective local Healthwatch service.

11. To enable the Government to track what is happening to its investment, Healthwatch England (HWE) ask local Healthwatch every year how much funding they expect to receive and publish this information.

12. HWE published a report that looks at the funding for each local Healthwatch in 2022-23, how funding has changed over time and the potential impact this is having.

Key findings

13. The 152 Healthwatch services in England reported that they collectively received £25,400,000 from local authorities to carry out their statutory activities in 2022-23.
14. Although funding in cash terms was projected to increase slightly on the figures reported in 2021-22, once inflation is taken into account, overall funding has fallen by £3.7 million.
15. Seventy-five local authorities have not fully passed on the funding they received from DHSC for local Healthwatch.
16. Most local Healthwatch services have received an in-year real terms funding reduction.
17. When local Healthwatch started work in 2013, the Department of Health and Social Care allocated £40,500,000 to fund local Healthwatch services. When adjusted for inflation, the real-term funding for local Healthwatch is now only 49% of what was initially allocated.
18. Funding reductions risk impacting the ability of some local Healthwatch to carry out their statutory functions.
19. HWE have made several recommendations to the Secretary of State for Health and Social Care. These include enabling us to escalate concerns related to specific councils, updating local authorities' commissioning guidance and exploring a more sustainable funding model for the local Healthwatch network.
20. Healthwatch England have not yet produced their report for 2023-24 however the following information is available:

Healthwatch Leicester and Healthwatch Leicestershire funding (joint)

2022/23 funding £	2023/24 funding £	Contract duration	Current year of contract
299,990	299,428	3 + 1 + 1	Year 1

List of Appendices

Appendix A - Together: we are making care better presentation
Appendix B - Local Healthwatch funding 2022-23 report

Officer to Contact

Gemma Barrow – Healthwatch Manager
Healthwatch Leicester and Healthwatch Leicestershire
Tel: 0116 257 4999
Email: gemma.b@healthwatchll.com

Relevant Impact Assessments

Equality and Human Rights Implications

21. HWLL is aware that the Public Sector Equality Duty (PSED) applies to all functions of public authorities that are listed in Schedule 19 Equality Act 2010. Schedule 19 list does not include Healthwatch England or Local Healthwatch organisations, however as bodies carrying out a public function using public funding we are subject to the PSED general duty.

22. Voluntary Action LeicesterShire (VAL)/ HWLL is committed to reducing the inequalities of health and social care outcomes experienced in some communities. We believe also that health and social care should be based on a human rights platform. We will utilise the Equality Act 2010 when carrying out our work and in influencing change in service commissioning and delivery.

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APPENDIX A

Together

We're making health and social care better
March 2024

healthwatch Leicester

healthwatch Leicestershire

What is healthwatch?

- A national and local patient champion to give people and communities a stronger voice to influence
- An independent body with statutory functions
- Set up by the Health & Social Care Act 2012
- Challenges how health and social care services are provided
- Healthwatch England (influences national policy & guidance and provides leadership, guidance & support to local Healthwatch)
- Local Healthwatch (currently over 150 throughout England)

Our vision

To bring closer the day when everyone gets the care they need.

Our mission

To make sure that people's experiences help make health and care better.

Our values

- **Listening** to people and making sure their voices are heard.
- **Including** everyone in the conversation especially those who don't always have their voice heard.
- **Analysing** different people's experiences to learn how to improve care.
- **Acting** on feedback and driving change.
- **Partnering** with care providers, Government, and the voluntary sector – serving as the public's independent advocate.

Working nationally and locally

The Healthwatch network is present in every community.

Nationally

40

staff work with the public, policymakers and partners to improve care

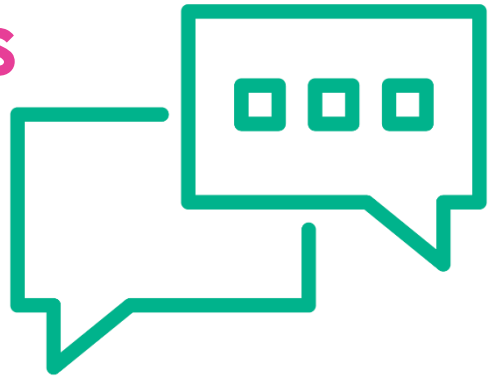
Locally across 153 services

595 Full-time equivalent staff deliver the Healthwatch service for local communities

3,700 Volunteers kindly give up their time to understand local people's views, provide advice and help improve services.

4 On average each local Healthwatch has four full-time equivalent staff.

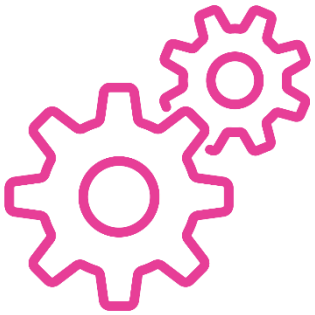
How we carry out our functions



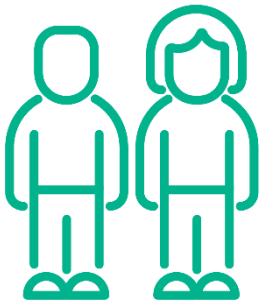
- Enter and View Programme
- Information and signposting
- Community outreach events at local services
- Public engagement and Community Partnerships
- Referrals to Independent NHS Complaints Advocacy
- Research projects on local priorities
- Have a seat on the local Health and Wellbeing board to influence commissioning decisions by representing the views of local stakeholders

Local challenges

Primary Care Access



Mental Health Services



Ageing Population

Emergency Services

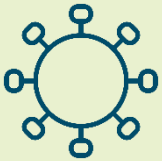
Cost of living

Language Barriers

How we're making care better

Our impact in Leicester and Leicestershire

Last year, we supported more than 30000 people to access advice, information and to have their say on care.



With the COVID-19 pandemic disproportionately impacting Bangladeshi and Pakistani communities and vaccination uptake remaining consistently low, we reached out to these communities to hear their stories.

Over the years, we have been raising the issue of access to dentistry. We have advocated for clear advice for patients and details of local NHS provision. We continued to work with HWE to voice public concerns that improvements to NHS dentistry are too slow, leaving thousands of people in pain.

On World Mental Health Day we visited three train stations to share information about local services and engaged directly with 600 people.

Our Chair went on local radio to highlight the concerns around 'delays in emergency care at A&E'. We then visited the Adults Emergency Department at Leicester Royal Infirmary in September 2022 and heard from 139 people. We revisited the department in September 2023 to see what improvements had been made.

Our impact in Leicester and Leicestershire

Last year, we supported more than 30000 people to access advice, information and to have their say on care.

Over 200 young people have shared with us their views on mental health services. We have raised concerns with the service provider about young people's services.

We spoke to over 350 people about local Dementia Services and the impact that COVID-19 has had on local service provision.

We worked with a local Lipoedema support group to help raise awareness of the condition amongst the medical profession and other women who may have the condition misdiagnosed or undiagnosed.

We have reached different communities by: Engaging with Polish communities at their local centre, talking to Somali women about how they access primary care services and meeting with the Deaf community to understand how they navigate the care system.

Partnering for Change

Partnering for change

World Mental Health Day – 'RU OK?' campaign

In October, twenty organisations in locations across Leicester, Leicestershire and Rutland hosted events to mark World Mental Health Day.

We re-launched the 'RU OK?' campaign with the aim for people to have conversations with family, friends and colleagues on the day and ask them how they are feeling.

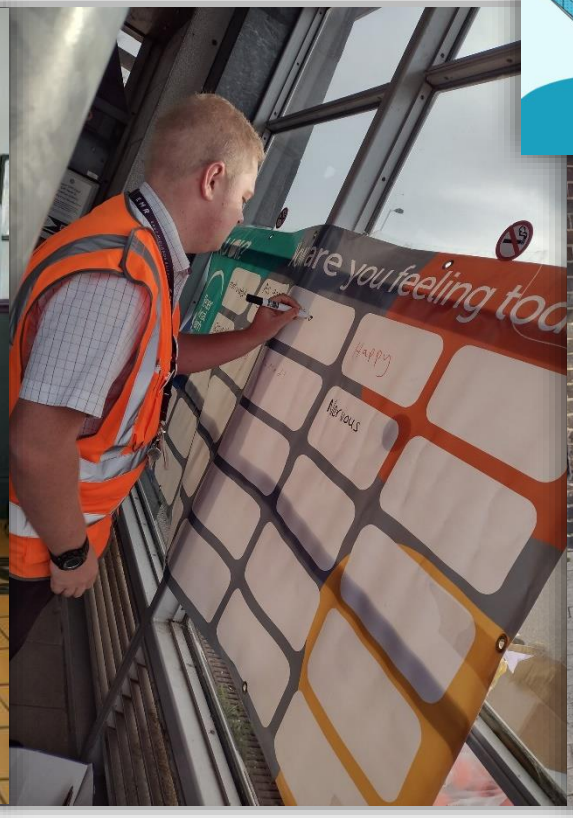
Healthwatch spent the day listening to commuters at Loughborough, Leicester and Market Harborough train stations.

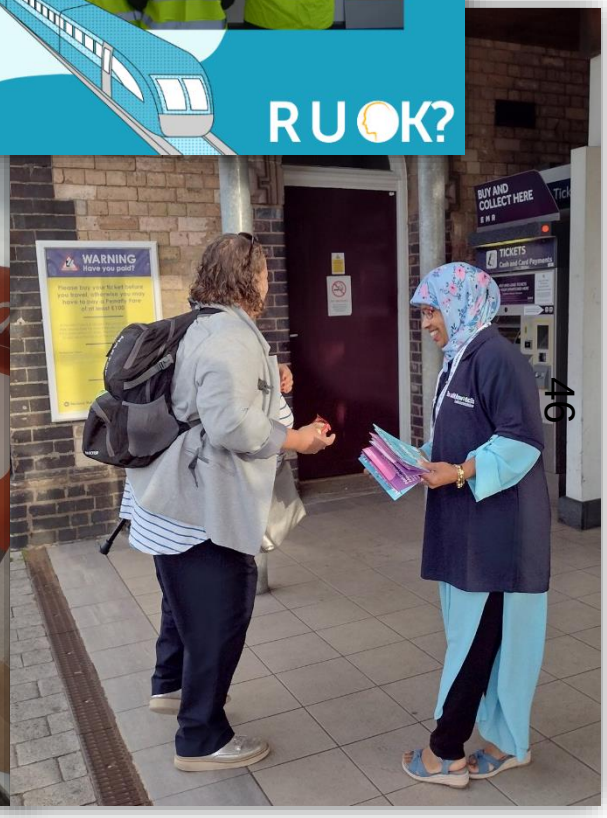
We were joined by Leicestershire Partnership NHS Trust (LPT) and Voluntary Action LeicesterShire (VAL) staff throughout the day.

We had some great conversations with people about their mental health and local services. We documented the day across our social media channels and we distributed over 600 biscuits and 1000 leaflets to commuters.

Partnering for change

World Mental Health Day – 'RU OK?' campaign





www.healthwatchll.com
TAKE TIME for your SELF
healthwatch Leicester healthwatch Leicestershire

NHS Dentistry

- Dentistry access was one of the top issues reported by the public to Healthwatch.
- Thousands of people have spoken up about their struggles accessing an NHS dentist over the last few years.
- Dentistry continues to be the key issue for a lot of patients across Leicester and Leicestershire as they are still not able to access NHS Dental Services.
- People are telling us that they are unable to access an NHS Dentist in Leicester or Leicestershire.
- People are concerned about where this is all moving to and the cost implications. People are finding private dentistry but there are considerable costs attached which some people are unable to afford.

NHS Dentistry - actions

- Regular East Midlands Healthwatch & commissioner update meetings.
- Locally, we have joined the Oral Health JSNA task group to work through the recommendations and action planning.
- We have shared our data and findings with the wider Healthwatch network.
- Healthwatch has repeatedly called for fully resourced dental contract reform to tackle these deep-seated problems. The NHS Dental recovery plan was published in February 2024.

Healthwatch position: *"The dentistry recovery plan is a good start in addressing these serious problems. To widen access to NHS dentistry to those experiencing the greatest health inequalities, it's vital dentists take up the new premium payments, promote availability of appointments to new patients and prioritise slots to people most in need... However, in the long run more radical solutions are needed to get NHS dentistry back on track. We welcome the Government's to commitment to consulting with the profession on the contract and urge this to happen as soon as possible."*

Partnering for change

Asylum seekers engagement

- Our focus for this engagement was to engage with asylum seekers who have been accommodated in hotels in Leicester and Leicestershire.
- We aimed to listen to people's experiences of accessing primary care services, mental health support and their awareness and access to health services. The aim of the visits was not intended to provide an in-depth analysis of the situation, but rather to gain insight from people into the pressing issues and common themes.
- The visit teams consisted of staff from Healthwatch, Voluntary Action LeicesterShire (VAL) and the Neighbourhood Mental Health Leads from Leicestershire Partnership NHS Trust (LPT).
- In July and August 2023, we visited five hotels in Leicestershire and spoke to 85 people.

Partnering for change

Asylum seekers engagement

Key findings

Barriers to Access: The reports identify barriers that hinder asylum seekers' access to essential health and care services. These barriers include language barriers, lack of cultural competency among healthcare providers and insufficient awareness of available services.

Mental Health Challenges: Asylum seekers often face heightened mental health stress due to the uncertainties surrounding their status. The report highlights the importance of tailored mental health support within local healthcare systems.

Recommendations for Improvement: To address the identified challenges, the reports offer a set of practical recommendations for local health and care services. These recommendations emphasise the need for language support and increased collaboration between service providers and community organisations.

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Our plans for 2023-24

Access and communication

We will explore if people's needs of health and care services are being met in Leicester and Leicestershire. We have identified groups and we will seek to listen and outline what the specific issues are for those communities.

Supported Living

We want to engage with people who are in receipt of supported living to hear their experiences of the services provided.

Enter and View

Enter and observe health and social care services as they are being delivered. We have a programme of visits to GP Practices, care homes, Community Diagnostic Centres and Mental Health units.

Community engagement

Diversity and inclusion networking sessions and winter tour.

Get involved

Volunteer
Join the community network
sign up to our newsletter

For more information

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Leicester
LE1 5SN

www.healthwatchll.com

t: 0116 257 4999

e: enquiries@healthwatchll.com

@HealthwatchLeic

Facebook.com/HealthwatchLL

healthwatch

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APPENDIX B

healthwatch

Local Healthwatch funding 2022–23

February 2023

Contents

Executive summary

Listening to the public and involving them in health and care decisions is vital to building public trust because it enables the government, commissioners and providers to be responsive to the needs of communities and be held accountable for delivering improved care[1].

The government recognise this right to participate in decisions about health care in the NHS constitution[2]:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services"

One way the government aims to promote this right is by commissioning a statutory local Healthwatch in every area, which finds out what people want from health and care and shares these views with the people commissioning or running services to help improve them.

The Department of Health and Social Care (DHSC) funds the commissioning of local Healthwatch both via the Department for Levelling Up, Housing and Communities (DLUHC) and directly to local councils.

To enable DHSC to track what is happening to its investment, each year, we're asked to analyse the funding received by local Healthwatch. This report sets out the findings for 2022-2023.

Despite a slowing down in the extent to which Local Authorities are cutting funding for local Healthwatch, rising inflation means that in real terms, overall **funding has fallen by £3.7 million this year**.

We are now in a position where Healthwatch only receives the equivalent of **49% of the funding allocated when Healthwatch began in 2013**.

We know from research carried out by Kings College that Healthwatch funding levels directly correlate with the extent to which Healthwatch can gather people's feedback on health and care services. For example, one of their conclusions was: [3]

[1] Fredriksson, M., & Tritter, J. Q. (2017). Disentangling patient and public involvement in healthcare decisions: why the difference matters. Sociology of Health & Illness, 39(1), 95–111. https://doi.org/10.1111/1467-9566.12483

[2] The NHS Constitution for England - GOV.UK (www.gov.uk)

[3] Zoccatelli G, Desai A, Robert G, Martin G & Brearley S. Exploring the work and organisation of local Healthwatch in England: a mixed-methods ethnographic study. *Health Soc Care Deliv Res* 2022;10(32). https://doi.org/10.3310/YUTI9128

"The greater the number of FTE staff, the larger the number of types of local impact"

Based on the information provided by local Healthwatch, if a local authority provides funding of £100,000 or less, they can expect 30% fewer people to be engaged by their local Healthwatch compared to services with over £100,000. Diminished funding for a service reduces staff, volunteers, and the extent to which local people are engaged to share their experience of health and care services.

In some areas, funding has fallen to such a small amount (e.g. with a staff team of only two) that local Healthwatch can't deliver the statutory functions that safeguard against poor health and care services originally envisaged by DHSC.

Commissioners are increasingly allocating only year-on-year funding rather than multi-year contracts, compounding limited resourcing with staffing uncertainty as they divert the finite resources of Healthwatch providers into annual contract negotiations or procurement processes.

In the face of a changing health and care landscape and the establishment of Integrated Care Systems (ICSs), the Healthwatch network continues to be valued by system actors for their insight into local people's concerns and their expertise in engagement. For example, 45% of Integrated Care Boards (ICBs) have a participant seat for local Healthwatch, requiring their involvement in strategic discussions.

Whilst some ICBs provide funding for the role their Healthwatch play in supporting public voice and accountability, this funding is often short-term and does not cover the additional costs incurred by local Healthwatch for carrying out these functions.

As demand for local Healthwatch insight and expertise grows, the funding for the function is in decline.

This year Local Authorities faced uncertainty about the DHSC LRCV grant allocation for Healthwatch and have been required to contract for almost a whole financial year without confirmation of the amount available.[4]

This delay, a transformed health and care system and diminished resourcing indicate that the decade-old funding model for Healthwatch is no longer fit for purpose. This requires action to address the challenges of:

- The complexity of dual funding streams for Local Authorities
- The lack of ring-fenced funding, which is leading to Local Authorities under pressure to divert funds meant for local Healthwatch
- The requirement to undergo competitive tendering processes, which drives down limited funding even further

[4] DHSC usually writes to Local Authorities to inform them of their allocated grant. AThe announcement was not made until 16th February, meaning Local Authorities have proceeded to fund at 'risk' for 11 of the 12 months of this financial year.

- Short-term contracting by local authorities, which leads to high provider and staff turnover limiting the impact
- Limited action to hold local authorities to account who do not pass on designated funds.

Inaction on the funding model means the capacity of Healthwatch and, indeed, the power of citizens' voices is becoming increasingly diluted.

Next steps

- Local Authorities should commission Healthwatch based on multi-year contracts and following expectations that DHSC set out when deciding on funding levels.
- We have discussed with DHSC creating a process for formally referring funding concerns over individual Healthwatch contracts to Ministers. This would happen when we identify Local Authorities providing worryingly low levels of funding for local Healthwatch or where principles of good commissioning are not being followed. We request that the DHSC embeds such a process.
- DHSC should complete the current review of guidance given to systems and Local Authorities on the funding of local Healthwatch to deliver the additional responsibilities brought about by the system transformation.
- We request that DHSC systematically review the current funding and commissioning model for local Healthwatch. The model needs to be modernised to reflect the current health and care system and enable local Healthwatch to carry out their statutory function fully.

Introduction

Healthwatch is the independent champion for people who use health and social care. Across England, there are 152 local Healthwatch services (153 from April 2023).

Their statutory role is to find out what people want from health and care and share these views with the people commissioning or running services to help improve them. Local Healthwatch also provides people with information and advice about local services.

In 2021-22, we supported over 2,000,000 people with information and to have their say on care.

Nationally

- 414,000 people used our service for clear information and advice.
- 9,600 people shared their experiences of care.

Locally

- 1,400,000 people used our service for clear information and advice.
- 407,400 people shared their experiences of care[5].
- 71% of stakeholders report valuing the contribution Healthwatch makes[6]

The Department of Health and Social Care (DHSC) funds local Healthwatch by making money available to local councils to commission an effective local Healthwatch. To enable DHSC to track what is happening to its investment, each year, we're asked to analyse the funding received by local Healthwatch.

A Local Authority is required by legislation to commission local Healthwatch for their area to:

"exercise its functions under this Part so as to secure that the arrangements— (a)operate effectively, and (b)represent value for money."[7]

[5] Local Healthwatch data return 2022-23

[6] Healthwatch England stakeholder perceptions survey 2022

[7] Local Government and Public Involvement in Health Act 2007 (legislation.gov.uk)

Funding

Historical changes

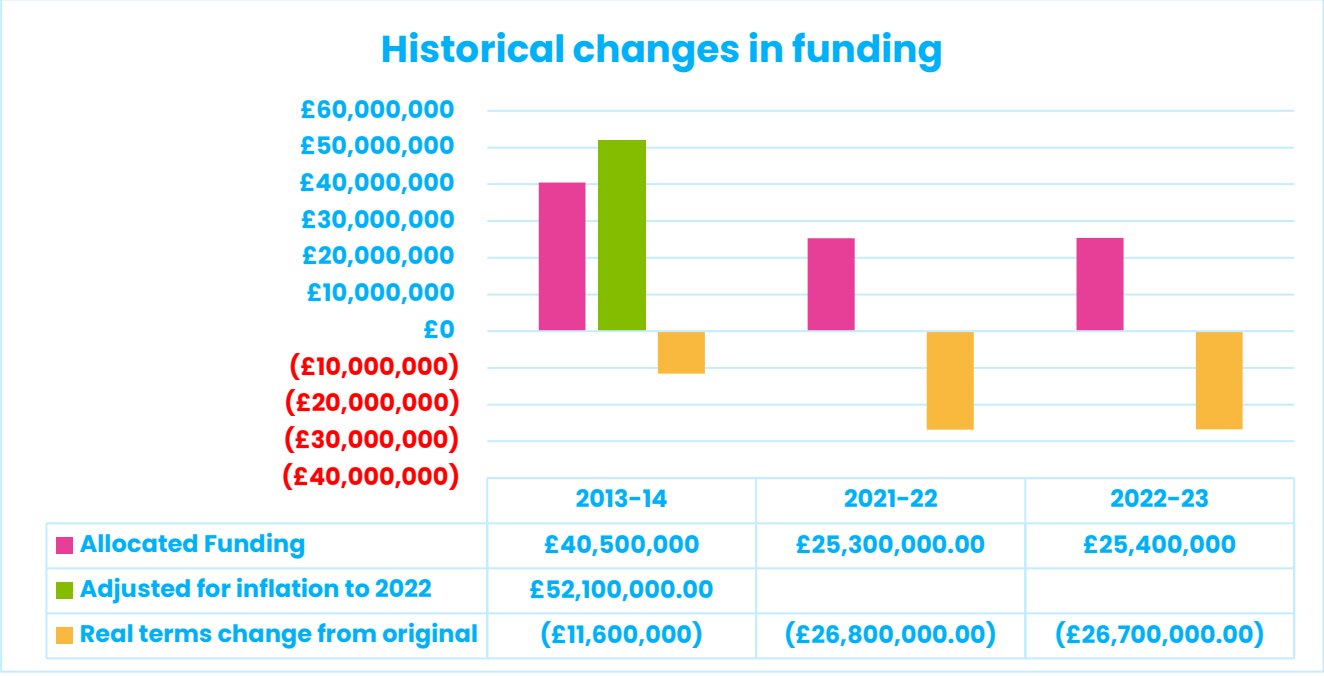
Since Healthwatch began in 2013, there has been a significant downward trend in funding for local Healthwatch provided by Local Authorities.

Commissioners and policymakers must also view the reduction in real terms from the perspective of inflationary rises. Real terms figures give a clearer indication of available resources and their impact on Healthwatch's ability to fulfil their statutory functions effectively.

The following table shows what the original funding for local Healthwatch in 2013 would be in the present day if inflation was taken into account.

Cost in 2013	Cost in 2022 accounting for inflation[8]
£40,500,000	£52,081,573

When adjusted for inflation **the real term funding for local Healthwatch is now only 49% of what was originally allocated** when Healthwatch was established.



[8] Calculated using the Bank of England inflation calculator in November 2022. The inflation rate is 14%.

Latest funding

We gather self-reported data from Healthwatch providers annually about the funding received from Local Authorities.

Appendix one shows the funding provided by 152 Local Authorities.[9]

Our analysis of the latest figures reported by local Healthwatch indicate that very few local authorities are increasing funding in line with inflation.

	Funding increase	Funding reduction
Headlines	7 local authorities increased core funding in line with inflation	16 local authorities reduced core funding
Impact of inflation	29 local authority funding increases were not in line with or above the 2022-23 inflation rate.	143 local Healthwatch received an in-year real terms funding reduction when accounting for inflation.
Average	+£11,430	-£15,116
Range	+£9 to £42,000	-£400 to -56,103
Median	+£8,082	-£12,229

This downward trajectory of local authority funding for local Healthwatch and investment in an independent service designed to listen to people and communities to shape health and care locally will have broader implications for systems and nationally.

Alignment with DHSC funding expectations

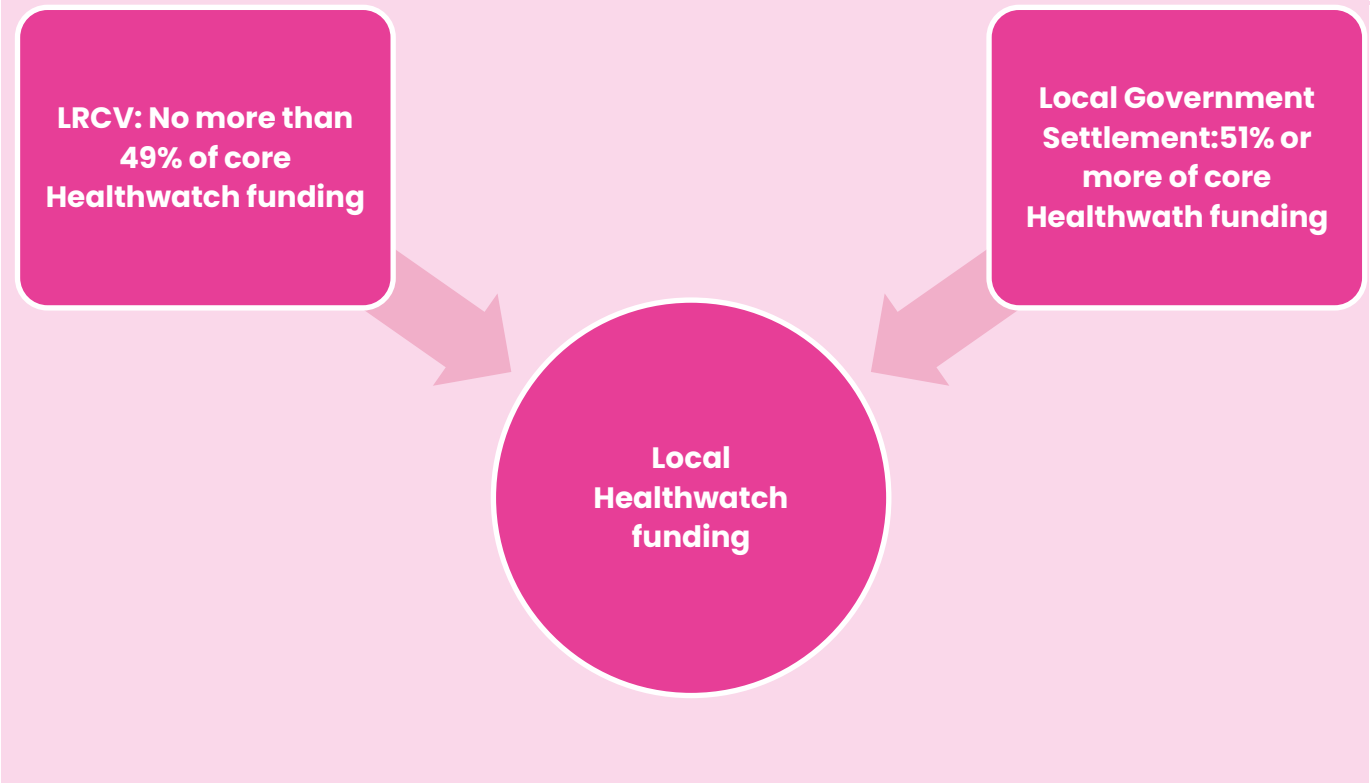
"The Local Reform and Community Voices grant provides one element of the non-ringfenced funding provided for local Healthwatch, with the larger proportion having been rolled into the local government settlement".[10]

Local Healthwatch funding is made up of two pots of DHSC funding. The first and largest is rolled into the Local Government Settlement. The smaller part comes from the Local Reform and Community Voices Grant (LRCV), the allocation of

[9] This funding does not include funding provided by the Local Authority or other state actors for projects outside of the statutory activity or on a one-off basis (e.g. for COVID support activity). As this information is self-reported, we acknowledge that there may be some inaccuracies.

[10] Local authority social services letter 2022 - GOV.UK (www.gov.uk)

which should be announced annually by DHSC before the end of the calendar year.



Each year DHSC sends the Local Authorities a letter confirming the LRCV grant funding available to Local Authorities for commissioning Healthwatch.[11] This letter has been known as the local authority social services letter (LASSL).

The letter setting out LRCV allocations for the 2022-23 financial year was not released by DHSC until 16th February 2023. This is a significant issue meaning a eleven-month delay in disbursement to Local Authorities. Commissioners have been contacting Healthwatch England to request information about the LRCV allocation and to raise concerns about the knock-on impact of the delay in announcing their funding decisions. One local authority commissioner said:

"Not having this figure (which after all is backward looking for the year we are in and not a projection for 2023/24), makes it difficult for commissioners to understand the overall trend (reduced/standstill/increased) for this particular funding stream. This in turn means we are estimating budgets for the future based on imperfect information".

[11] Local authority social services letter 2022 - GOV.UK (www.gov.uk)

Delays to announcement of the LRCV grant allocations may inadvertently force further decline in funding available for Healthwatch to deliver their statutory functions.

The expectation from DHSC is that the LRCV constitutes the smaller part of the overall funding allocated to local Healthwatch. As a minimum, local authorities should be spending at least twice the amount provided through the LRCV.

To assess compliance, we have analysed the contractual amounts given to Local Authorities against the expectations stipulated by DHSC in the previous financial year.

Local authority numbers	Compliance with DHSC expectations
77	Funding is in line with expectations
66	Funding local Healthwatch using mostly LRCV grant
6	Funding local Healthwatch only using LRCV grant
3	Funding local Healthwatch at less than the LRCV grant

In summary, 77 Local Authorities are funding their Healthwatch in alignment with DHSC expectation (of LRCV plus majority funding from Local Government settlement).

While, 75 Local Authorities are not passing on the totality of funding they receive from DHSC to local Healthwatch by an average of £72,434 (median £43,427). The largest divergence of Local Authority funding is £326,000 less than expectations.

Of these 75, six local authorities do not utilise any of the funds which were rolled into the local government settlement to fund Healthwatch. They rely solely on the LRCV grant allocations.

While three local authorities fail to pass on the full LRCV grant, with a median shortfall of £16,637.

The lack of compliance by Local Authorities with the DHSC-outlined funding levels will impede the ability of the health and care systems to consider the views of people and communities in improving care.

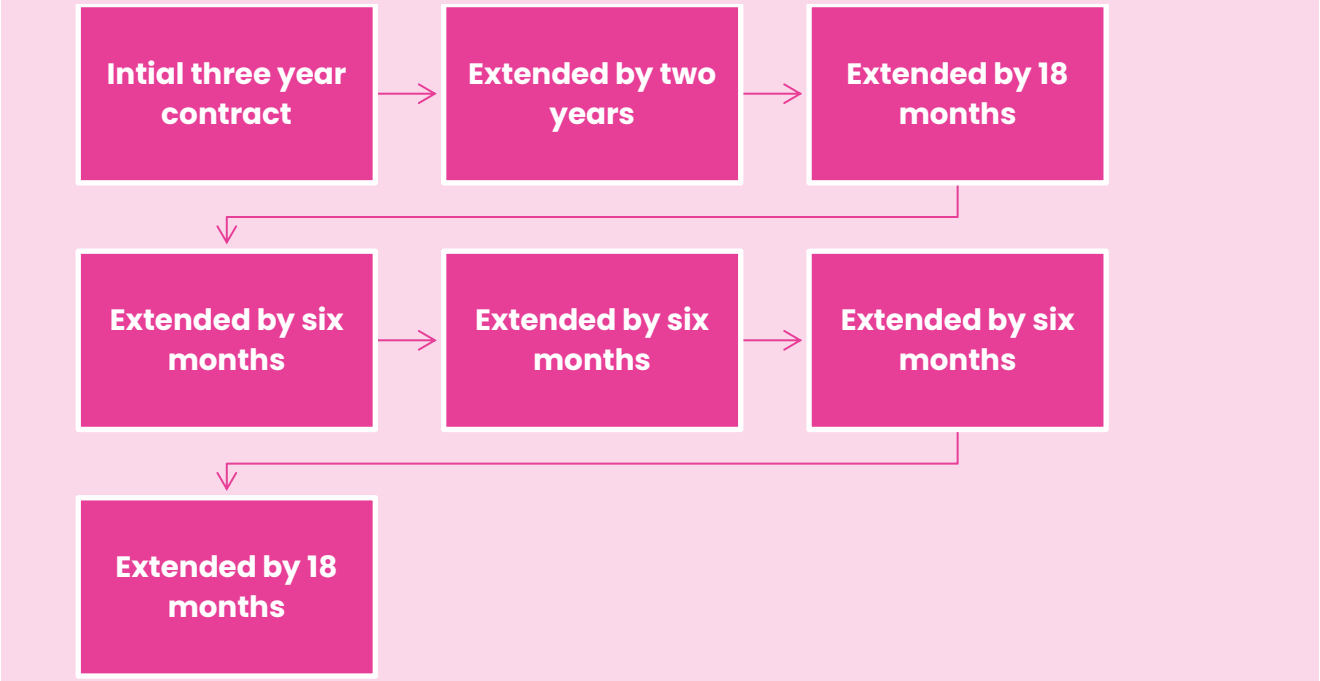
Compliance with principles of good commissioning

The National Audit Office Principles of Good Commissioning include "Ensuring long-term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness."

We have analysed the local authority contract terms against these principles and their impact on the effectiveness of Healthwatch. We found that:

73 local authorities have awarded a contract extension for 12 months or less during the last financial year.

The example below demonstrates the contract length that a local Healthwatch provider has been given since the contract began. Whilst the local authority demonstrated it was committed to multi-year contracts initially, it has since made multiple awards of less than a year. In this scenario, it is possible that the provider staff would have been issued with redundancy notices six times over nine years.



When local Healthwatch contracts are renewed every 12 months or less, this impacts their effectiveness, including the ability to forward plan work, procure essential services with good value (e.g. office lets, insurance), and retain staff.

In just under half of Local Authorities, there is a risk of non-compliance with the duty to commission effective local Healthwatch due to a failure to contract based on multi-year funding.

With this funding model, 76 Local Authority contracts with local Healthwatch providers are due to end in the coming financial year. This means that commissioners and providers across half of England will have to invest human resources in contract negotiations and procurement processes, diverting limited resources away from local Government and local Healthwatch activities.

The impact of funding on statutory functions

The statutory functions of local Healthwatch are broad, reaching across the whole population and a wide spectrum of health and care services. Yet the funding to carry out this work is limited and unevenly distributed.

To illustrate the extent to which this funding varies across local authorities, the table below categorises the contracts into income banding.

Income	Local authority numbers
£100,000 or less	27
£100,000 - £250,000	105
£250,000 - £500,000	17
£500,000 - £1,000,000	2

This demonstrates that:

- The majority of Healthwatch are funded between £100,000- £250,000.
- 18% are funded less than £100,000 and 8 contracts are below £60,000.
- Only 19 local Healthwatch receive £250,000 and over.

Research by Kings College[12] into the effectiveness of local Healthwatch states that:

"larger contract value enables such Healthwatch organisations to hire greater numbers of staff specialised in a greater range of disciplines and skills, and therefore to offer additional (and qualitatively different) services".

This year's funding figures and activity reporting affirm their findings that the extent to which local Healthwatch has the necessary human resources (including paid staff and volunteers) to deliver on its statutory functions is directly linked to its income levels. Any reduction in funding will significantly impact its ability to engage members of the public.

As demonstrated by the graph below, the smaller the income of a Healthwatch, the fewer staff and volunteers they will have to engage with the public and to help them have a say in health and care services.

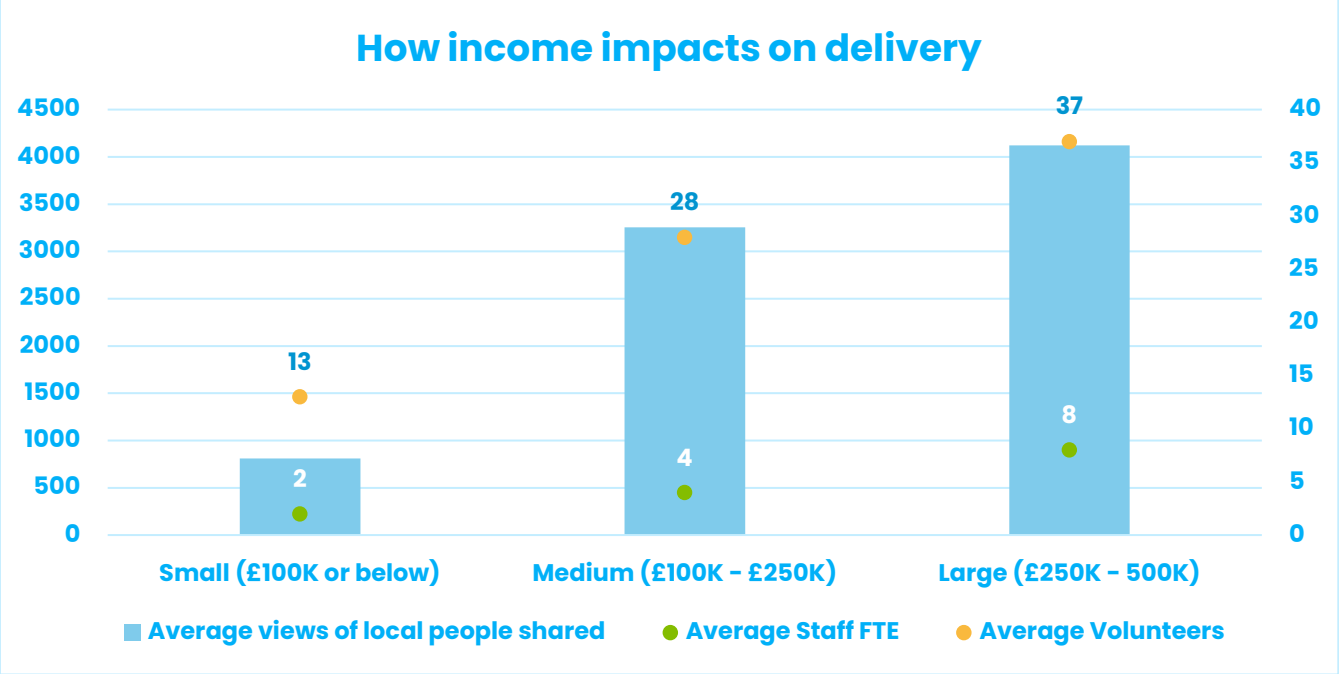
The return on investment for a local Healthwatch significantly reduces in the lowest income band. For example, a Healthwatch in the £100,000-£250,000

[12] Exploring the work and organisation of local Healthwatch in England: a mixed-methods ethnographic study Crossref DOI link: https://doi.org/10.3310/YUTI9128

income band reports on average four times the engagement levels of Healthwatch that gets under £100,000 of funding.

This is because all Healthwatch (regardless of size) have similar fixed operating costs (e.g. rent, insurance IT support, admin and finance costs). Therefore, for the Healthwatch who get under £100,000 in funding, the remaining capacity for carrying out engagement activity is disproportionately low.

Local authorities investing less than £100,000 are arguably not investing at a level where the provider can be expected to meaningfully deliver the statutory functions of a local Healthwatch.



A definition of a small Charity is one which has an income of £1,000,000 or less.[13]

45% of Healthwatch are stand-alone organisations, and a considerable proportion of the network are 'small charities' and face the challenge of balancing the requirement to operate a legally compliant organisation on small incomes for their statutory functions.

[13] www.smallcharitiesdata.org

Funding work with Integrated Care Systems

Changes brought about by the Health and Care Act 2022 require locally funded Healthwatch to collaborate with counterparts in other areas to ensure that their statutory functions are delivered effectively across integrated care systems.

Although additional burdens set out in the Act and accompanying guidance are not a change to the statutory functions of Healthwatch, there is an expectation that Healthwatch will respond to, and play an active part in, the new health and care landscape. These new responsibilities draw on the already much-reduced resources of local Healthwatch.

New responsibilities placed on the Healthwatch network include:

- Requirement for Integrated Care Partnerships to involve local Healthwatch and local people in the development of the integrated care strategy and partnership meetings.
- Local Healthwatch sharing system-wide relevant reports and recommendations, including annual reports, with the Integrated Care Boards (in addition to sharing this insight with any 'place' forums and care providers).
- Requirement to work with neighbouring Healthwatch to develop and deliver a system-wide strategy for engaging with people and communities.

However, the lack of government direction on funding local Healthwatch participation at the system level means local Healthwatch are not adequately funded for the role they are expected to play.

There is also a considerable disparity in the funding available to local Healthwatch in different ICS areas. For example, in North East and North Cumbria ICS the **average local Healthwatch funding is 47% less than the average** for a local Healthwatch in the West Yorkshire and Harrogate ICS.

Currently, 22 Integrated Care Systems still need to fund local Healthwatch for the additional work of collaborating with their ICS despite 45% of Integrated Care Boards involving local Healthwatch in their governance.

While 15 ICSs have invested a reported total of £993,449 to fund the work of 30 local Healthwatch.[14] The reported funding received by local Healthwatch ranges from £1,000 to £204,712.

Most of this funding is for the delivery of engagement activity in line with ICS priorities or to fund a coordinator who works across the local Healthwatch in an ICS area. Other funding is set out in the table below. Funding is provided for the following functions and activities:

Activity	Number of ICSs funding local Healthwatch
Engagement of the population within an ICS	10

[14] Please note that not all Healthwatch reporting that their ICS has resourced them have shared the funding figure.

Funding of a coordinator or Director at ICS level	6
Funding for ICS Healthwatch coordination	4
Dedicated Engagement Worker for ICS work	1
Collating insight across the ICS	2
Development work to get ready for ICS	2
Coordination of VCSE relationship	1

Next steps

Healthwatch England calls on the Department of Health and Social Care and local authorities to take the following action

- Local Authorities should commission Healthwatch based on multi-year contracts and following expectations that DHSC set out when deciding on funding levels.
- We have discussed with DHSC creating a process for formally referring funding concerns over individual Healthwatch contracts to Ministers. This would happen when we identify Local Authorities providing worryingly low levels of funding for local Healthwatch or where principles of good commissioning are not being followed. We request that the DHSC embeds such a process.
- DHSC should complete the current review of guidance given to systems and Local Authorities on the funding of local Healthwatch to deliver the additional responsibilities brought about by the system transformation.
- We request that DHSC systematically review the current funding and commissioning model for local Healthwatch. The model needs to be modernised to reflect the current health and care system and enable local Healthwatch to carry out their statutory function fully.

Appendices

1 - Local Healthwatch funding by local authority

Below are the funding figures provided to Healthwatch England by local Healthwatch. These figures are self-reported and, as such, may be subject to inaccuracy. If your reported figure needs to be corrected, please contact: enquiries@healthwatch.co.uk.

Local Authority	Funding provided in 2021-2022	Funding provided in 2022-2023
Barking and Dagenham	£115,677	£115,088
Barnet*	£123,845	£121,478
Barnsley	£150,000	£150,000
Bath and North East Somerset*	£83,622	£83,622
Bedford Borough	£94,760	£95,840
Bexley	£100,000	£100,000
Birmingham	£407,207	£407,207
Blackburn with Darwen	£133,650	£133,650
Blackpool	£58,000	£61,550
Bolton	£125,000	£153,000
Bracknell Forest	£64,439	£64,439
Bradford and District	£180,000	£180,000
Brent	£135,000	£127,861
Brighton & Hove	£178,600	£178,600
Bristol*	£119,155	£119,155
Bromley	£74,000	£74,000
Buckinghamshire	£175,317	£184,320
Bury	£122,000	£122,000

Calderdale	£112,000	£152,000
Cambridgeshire	£287,602	£287,602
Camden	£187,000	£187,000
Central Bedfordshire	£151,410	£161,252
Cheshire East	£151,051	£151,126
Cheshire West	£150,449	£151,126
City of London, City of	£66,722	£92,722
Cornwall	300,000	300,000
County Durham	£180,600	£180,600
Coventry	£201,000	£201,000
Croydon*	£154,000	£152,000
Cumbria	£267,174	£267,174
Darlington	£74,950	£76,709
Derby	£235,000	£235,000
Derbyshire	£321,114	£321,114
Devon	£350,000	£350,000
Doncaster	£176,360	£176,360
Dorset* (BCP and Dorset are reported combined)	£201,928	£200,532
Dudley	£206,000	£206,000
Ealing	£140,000	£120,000
East Riding of Yorkshire	£202,697	£172,697
East Sussex	£376,000	£376,000
Enfield*	£120,822	£144,973
Essex	£420,000	£420,000
Gateshead	£140,250	£84,147
Gloucestershire	£209,908	£212,252
Greenwich	£135,000	£140,000

Hackney	£150,000	£150,000
Halton	£121,715	£121,715
Hammersmith & Fulham	£122,000	£122,000
Hampshire	£249,518	£249,518
Haringey	£152,000	£152,000
Harrow	£65,000	£65,000
Hartlepool	£116,150	£116,150
Havering	£117,359	£117,359
Herefordshire	£140,000	£140,000
Hertfordshire	£384,125	£401,603
Hillingdon	£158,000	£158,000
Hounslow	£81,000	£84,667
Isle of Wight	£153,000	£153,000
Isles of Scilly	£44,600	£45,480
Islington	£156,100	£156,100
Kensington & Chelsea	£150,000	£153,685
Kent	£511,000	£511,000
Kingston Upon Hull	£135,817	£135,817
Kingston upon Thames	£122,000	£122,000
Kirklees	£185,000	£185,000
Knowsley	£171,000	£171,000
Lambeth	£225,115	£242,115
Lancashire*	£324,995	£322,000
Leeds	£374,000	£374,000
Leicester	£142,705	£142,705
Leicestershire	£157,285	£157,285
Lewisham	£105,000	£105,000

Lincolnshire	£299,600	£299,600
Liverpool	£553,825	£553,825
Luton	£119,325	£122,000
Manchester	£140,000	£140,000
Medway	£121,550	£121,550
Merton	£125,000	£125,000
Middlesbrough	£92,500	£92,500
Milton Keynes	£158,644	£158,644
Newcastle*	£209,008	£209,179
Newham	£125,000	£124,000
Norfolk	£348,140	£355,300
North East Lincolnshire	£112,340	£112,340
North Lincolnshire	£115,640	£115,640
North Northamptonshire North	£97,500	£97,500
North Somerset*	£54,284	£54,284
North Tyneside	£141,259	£151,970
North Yorkshire	£167,460	£167,460
Northumberland	£200,000	£200,000
Nottingham	£108,000	£108,000
Nottinghamshire	£198,000	£198,000
Oldham	£135,000	£135,000
Oxfordshire	252,866	290,833
Peterborough	£187,500	£187,500
Plymouth	£114,200	£114,200
Portsmouth	£106,032	£116,432
Reading	£100,000	£100,000
Redbridge	£116,309	£116,309

Redcar & Cleveland	£92,500	£92,500
Richmond upon Thames	£146,000	£146,000
Rochdale	£136,066	£136,066
Rotherham	£90,000	£90,000
Rutland	£72,600	£72,600
Salford	£166,520	£166,520
Sandwell	£180,250	£180,250
Sefton	£143,281	£143,281
Sheffield	£209,952	£209,952
Shropshire	£144,198	£144,198
Slough	£64,439	£64,439
Solihull	£155,322	£155,322
Somerset	£190,000	£191,912
South Gloucestershire*	£54,936	£54,936
South Tyneside	£103,409	£114,995
Southampton	£133,251	£133,260
Southend	£88,000	£119,995
Southwark	£140,000	£155,000
St Helens	£145,427	£145,427
Staffordshire	£205,338	£215,000
Stockport	£108,000	£150,000
Stockton-on-Tees	£130,000	£130,000
Stoke-on-Trent	£153,508	£128,000
Suffolk	£436,500	£436,500
Sunderland	£155,250	£155,250
Surrey	£470,060	£477,143
Sutton	£109,962	£89,962

Swindon	£107,400	£107,000
Tameside	£115,600	£115,600
Telford & Wrekin	£100,000	£100,000
Thurrock	£125,186	£125,186
Torbay	£95,800	£95,800
Tower Hamlets	£179,716	£149,965
Trafford	£124,500	£124,500
Wakefield	£211,295	£211,295
Walsall	£190,450	£190,450
Waltham Forest	£101,000	£111,690
Wandsworth	£185,810	£185,810
Warrington	£146,000	£146,000
Warwickshire	£217,000	£227,427
West Berkshire	£98,000	£98,000
West Northamptonshire West	£97,500	£97,500
West Sussex	£230,899	£230,899
Westminster	£150,000	£153,685
Wigan and Leigh	£200,000	£200,000
Wiltshire	£179,619	£179,619
Windsor, Ascot & Maidenhead	£64,439	£64,439
Wirral	£170,000	£170,000
Wokingham	£103,982	£108,141
Wolverhampton	£194,289	£169,000
Worcestershire	£265,000	£265,000
York	£122,898	£105,580

* Local Authority funding figures for 2021-2022 adjusted to correct errors reported to Healthwatch England in last year's funding report.

2 -Compliance with DHSC expectations

Three local authorities who are funding less than the LRCV Grant amount:

Hampshire

Manchester

Nottinghamshire

Six local authorities using only LRCV Grant to fund their local Healthwatch

Bristol

Dorset (Bournemouth, Christchurch and Poole and Dorset combined)

Lancashire

North Somerset

South Gloucestershire

Local authorities who use some local government settlement funding but not in line with expectations

Barnet

Bath and North East Somerset

Bexley

Birmingham

Blackpool

Bolton

Bradford and District

Brent

Bromley

Buckinghamshire

Cheshire East

Cheshire West

Cornwall

County Durham

Croydon

Cumbria

Derbyshire

Devon

Doncaster

Ealing

Enfield

Essex

Gateshead

Gloucestershire

Greenwich

Hackney

Harrow

Havering

Hertfordshire

Hounslow

Kent

Kingston upon Hull

Kirklees

Leeds

Leicester

Leicestershire

Lewisham

Lincolnshire

Newham

Norfolk

North Yorkshire

North Northamptonshire

West Northamptonshire

Nottingham

Plymouth

Redbridge

Rotherham

Sandwell

Sefton

Sheffield

Shropshire

Somerset

Southwark

Staffordshire

Stockport

Stoke-on-Trent

Sunderland

Tameside

Torbay

Tower Hamlets

Waltham Forest

Warwickshire

West Sussex

Wiltshire

Wirral

Worcestershire

Local Authorities that fund within the expectations of DHSC

Barking and Dagenham
Barnsley
Bedford Borough
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Bracknell Forest
Brighton & Hove
Bury
Calderdale

Cambridgeshire
Camden
Central Bedfordshire

Coventry
Darlington
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Dudley
East Riding of Yorkshire
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Knowsley
Lambeth
Liverpool
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Luton
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Milton Keynes
Newcastle
North East Lincolnshire
North Lincolnshire
North Tyneside
Northumberland
Oldham
Oxfordshire
Peterborough
Portsmouth

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Leicestershire County Council

HEALTH OVERVIEW AND SCRUTINY COMMITTEE: 6 MARCH 2024

REPORT OF THE CHIEF EXECUTIVE AND ICS PERFORMANCE SERVICE

HEALTH PERFORMANCE UPDATE

Purpose of Report

1. The purpose of the report is to provide the Committee with an update on public health and health system performance in Leicestershire and Rutland based on the available data in February 2024.

2. The report also outlines the position on Leicester, Leicestershire and Rutland (LLR) Health System Governance, Structure and Design Collaboratives.

3. An update is provided on the NHS System Oversight Framework and local performance reporting. The report contains the latest available data for Leicestershire and Rutland on a number of key performance metrics (as available on 20 February 2024) and provides the Committee with local actions in place.

Background

4. The Committee has, as of recent years, received a joint report on health performance from the County Council's Chief Executive's Department and the ICS Commissioning Support Unit Performance Service. The report aims to provide an overview of performance issues on which the Committee might wish to seek further reports and information, inform discussions and check against other reports coming forward.

Changes to Performance Reporting Framework

5. A number of changes have been made to the way performance is reported to the Committee in recent times to reflect comments at previous meetings, including inclusion of a wider range of cancer metrics and Never Events and Serious incidents related to UHL. The overall framework will continue to evolve to take account of system developments, as well as any particular areas that the Committee might wish to see included. Some extra comparative information has

been included this time, in response to comments at the last meeting, and views are welcomed on the usefulness of the new contents.

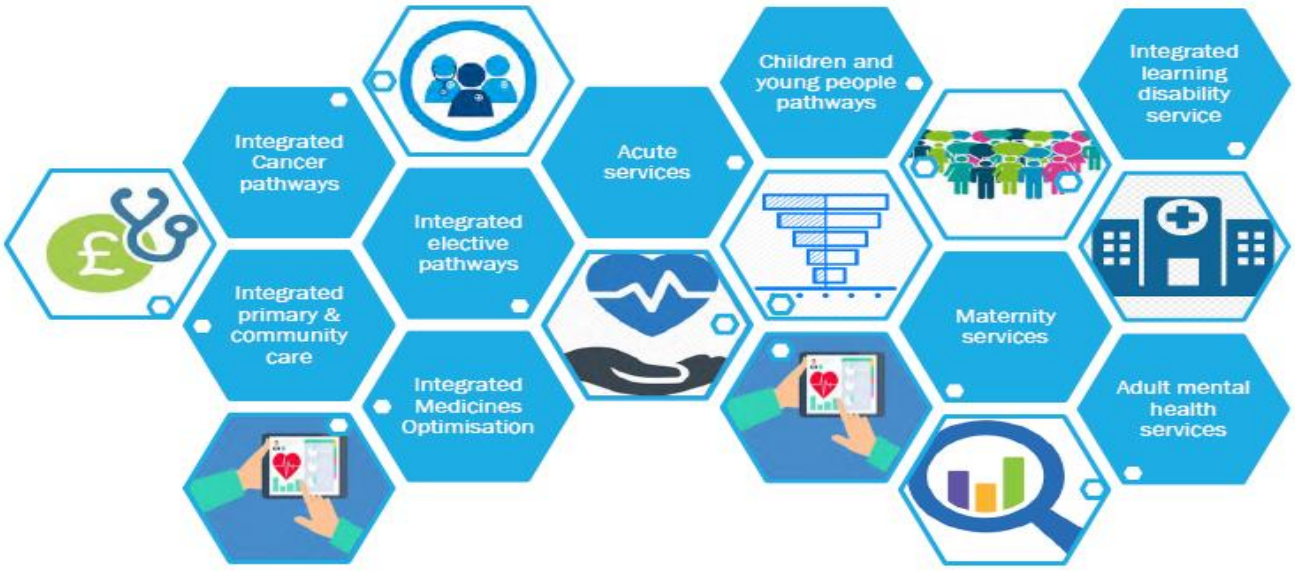
6. The following 4 areas therefore form the main basis of reporting to this Committee:
    a. ICB/ICS Performance
    b. Quality - UHL Never Events/Serious incidents
    c. Leicestershire Public Health Strategy outcome metrics and performance
    d. Performance against metrics/targets set out in the Better Care Fund plan.

LLR Health System Governance, Structure and Design Collaboratives

7. The Integrated Care Board (ICB) was formally established on 1st July 2022. This is the health element of the Integrated Care System (ICS), which works with providers and partners to take decisions about how health and social care services are coordinated.

8. In line with the National Quality Board requirements the LLR ICB has reviewed the governance structures in place. Since July 2022 there has been a System Quality Group who meet and report into the Quality and Safety Committee around quality issues and topics. Performance is reported into the System Executive Group and escalated into the Integrated Care Board.

9. Also, as a system, there is a drive towards offering quality and performance improvement support to nine system-wide Design Collaboratives. These are system groups; planning, designing and transforming services. They take a whole pathway approach and work collectively together to deliver the change required. The nine groups are outlined below.



NHS System Oversight Framework

10. The ICB Performance section of this report provides an update on Leicestershire and Rutland operational performance against key national standards.

11. An update is provided relating to the NHS System Oversight Framework and local performance reporting. The report contains the latest available data for Leicestershire and Rutland on a number of key performance metrics (as available in February 2024) and provides the Committee with local actions in place.

12. Leicestershire cannot currently be identified separately to Rutland for many performance metrics, as national reporting is only publicly available at sub-ICB boundaries (the former CCG boundaries of West Leicestershire and East Leicestershire & Rutland) or at ICB (Leicester, Leicestershire & Rutland) level. Though work is continuing to be able to provide disaggregated figures in the future.

13. A monthly performance report is presented to the LLR ICS System Executive Committee (SEC) Delivery Partnership and Governing Body. It is based on National NHS Objectives. In addition, the LLR position within the NHS Oversight framework is also reported. This benchmarks the Integrated Care Board (ICB) against over 60 KPIs and includes the best and worst 25% rank positions against ICBs in England. This was last presented on 22 February to the LLR Delivery Partnership.

14. Further details on the NHS System Oversight Framework can be found on https://www.england.nhs.uk/nhs-oversight-framework/

15. Performance reporting is also a key element of the Collaboratives and Design Groups, and many of these groups have Quality and Performance subgroups, which receive performance reports throughout the year. The following table provides an explanation of the key performance indicators, the latest performance for Leicestershire and Rutland (as available in February 2024) and details of some local actions in place.

NHS Constitution metric and explanation of metric	Latest 2023/24 Performance	Local actions in place / supporting information
A&E admission, transfer, discharge within 4 hours The standard relates to patients being admitted, transferred or discharged within 4 hours of their arrival	**National Target >95%** **January 24** **LLR Urgent Care Centres only**	Root Causes - • Overcrowding in the Emergency Department (ED) due to lack of flow resulting in long waits to see a doctor. • High inflow of walk-in patients impacting on ambulance arrivals and poor outflow across the emergency pathway • Inability to create early capacity across the emergency care pathway due to lack of

at an A&E department. This measure aims to encourage providers to improve health outcomes and patient experience of A&E.	99% (14,255 pts seen / treated in Jan 24) **UHL A&E only** 57% (22,611 pts seen / treated in Jan 24) **University Hospitals of Derby and Burton** 70% **George Eliot** 72% **University Hospital Coventry and Warwickshire** 70% **North West Anglia NHS Foundation Trust** 59%	early discharges/using the discharge lounge overnight. Actions: - • Improvements to the LLR Directory of Services profiles to direct patients to wider hospital services without ED being the conduit to wider hospital services access. • Improving Same day emergency care (SDEC) pathways - Glenfield Chest Pain Service opened October 23. Meeting with NHSE Feb 2024 to discuss the need to increase Surgical SDEC to 12hrs/day Monday-Sunday. 80% of LLR residents use Leicester Royal Infirmary for their A&E service. The remaining 20% access A&E hospital services outside of Leicestershire (Coventry & Warwick, Derby & Burton, etc). The data shown is for ALL patients attending and cannot be split for LLR patients only.
18 Week Referral to Treatment (RTT) The NHS Constitution sets out that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions if they want this and it is clinically appropriate.	**National Target >92%** **Leicestershire & Rutland patients at all Providers** 55% in Dec 23 **Total Number of Leicestershire & Rutland patients waiting at all Providers** 86,898 at the end of Dec 23 **Number of Leicestershire & Rutland patients waiting:** **Over 52weeks** 3,634 at the end of Dec 23 (2,632 at UHL) **Over 65weeks**	The overall picture for Elective Care remains challenged, however the Trust continue to progress in the reduction of those patients waiting longest for definitive treatment. Root Causes: - • Pressures due to emergency and cancer demand impacting upon elective activity. • Workforce challenges in theatres and anaesthetics reducing theatre capacity. • Workforce challenges in sub-speciality workforce teams e.g. urogynaecology (Gynaecology) and balance testing (ENT) • Impact of any future Industrial action Actions: - • The UHL long waiter position is monitored daily, including actively monitoring the 65 weeks wait March 24 cohort and working closely with the specialties who have the biggest challenge. • Use of Independent Sector and Insourcing Providers • Use of Elective Recovery Fund (ERF) funds to support additional activity.

	888 at the end of Dec 23 (595 at UHL) **Over 78weeks** 77 at the end of Dec 23 (46 at UHL) **Over 104weeks** 0 at the end of Dec 23	Focus on all patients from 65-week cohort to have first OPA as soon as possible to support overall zero 65ww by March 24 ambition.
Dementia Diagnosis rate for people aged 65 and over, with a diagnosis of dementia recorded in primary care, expressed as a percentage of the estimated prevalence based on GP registered populations	**National Target >66.7%** Jan 24 **East Leicestershire and Rutland Sub-ICB** 61.2% **West Leicestershire Sub-ICB** 63.4%	• Use of DIADEM (Diagnosing Advanced Dementia Mandate) diagnostic tool by GP and care homes to reduce unnecessary referrals to Memory Assessment Service (MAS). • Ongoing recruitment and promotion of vacant MAS staff roles. • MAS Contacting patients to remind them of appointments. Recruiting community volunteers to improve patient engagement and attendance for assessments. • MAS are looking into current demand against service capacity with aims to update workforce plan.
Cancer 62 days of referral to treatment (combined) The indicator is a core delivery indicator that spans the **whole pathway** from referral to first treatment. Shorter waiting times can help to ease patient anxiety and, at best, can lead to earlier diagnosis, quicker treatment, a lower risk of complications, an enhanced patient experience and improved cancer outcomes.	**National Target >85%** **Leicestershire & Rutland patients** December 23 60.46%	62-day backlog was ahead of trajectory prior to further industrial action. Backlog has since increased as expected over the Christmas period. Recovery plans focus on time to first seen, FDS and 62-day backlog reductions. Whilst focus on backlog continues 62-day performance will be constrained. Nationally cancer waiting times are now reporting 28 Day Faster Diagnosis Standard (FDS), 62 Day Combined (to include Upgrades and Screening) and 31 Day Combined. Root Causes: - • Impact of future Industrial action • Capacity Constraints specifically outpatient, diagnostic and clinical administrative time, in addition to workforce to deliver additional capacity. • High backlog levels being treated and prioritised having a direct impact on performance. • Oncology/Radiotherapy capacity • Winter pressures Actions: -

		• Continue to clinically prioritise all cancer patients. • Clinical review of Urology and Colorectal waiting list • Additional capacity in Skin and Urology • Backlog tool in daily use, reviewed weekly for next steps. • Targeted support for backlog reduction and next steps • Review national timed pathways and identify possible areas for improvement. • Continued validation of Patient Tracking List (PTLs) and cancer data • Recruitment for Oncology/Radiotherapy/H&N/Dermatology in progress • Focus on Faster Diagnosis Standard (FDS), reducing backlog and utilisation of capacity maximising capacity wherever possible.

Covid Vaccination Uptake

16. The below shows data on the uptake of Covid-19 vaccinations for Leicestershire residents. It shows the latest number of people aged 65 and over who have received a 2023 autumn Covid-19 vaccination. As of 14th December 2023, 75% of residents aged 65 and over had received their autumn Covid-19 vaccination. This compares favourably to the Leicester City position of 49% of residents, over 65yrs old, receiving their autumn vaccination.

Cancer Metrics

Cancer metrics included within the NHS Oversight Framework:

	NHS System Oversight Framework reference	Metric	Threshold		Dec-23
CANCER	S011a	Cancer 62 day waits - Total patients waiting longer than 62 days to begin Cancer treatment (UHL)- **Backlog**	N/A	w/e 26/11/23- 339 31/12/23- 372 28/01/24- 351	w/e 11/02/24-339
	S012a	Proportion of patients (%) meeting faster diagnosis standard (All)	>75%	**Dec-21 -61.3%** **Dec 22- 71.4%**	Dec- 23 80.2%

	NHS System Oversight Framework reference	Metric	Threshold	2023-24 Q1	2023-24 Q2
SCREENING, VACCINATION AND IMMUNINISATION	S048a	Bowel screening coverage, aged 60–74, screened in last 30 mths	Efficiency = 55%; Optimal = 60%	**Dec 2020** Leicester- 52.9% Leicestershire -67.7% **Dec 2021** Leicester- 57.8% Leicestershire -73.8%	**Dec 2022** Leicester -57.9% Leicestershire-74.7%
	S049a	Breast screening coverage, females aged 53–70, screened in last 36 months	Efficiency = 70%; Optimal = 80%	**Mar 2021** Leicester- 44.3% Leicestershire- 65% **Mar 2022** Leicester -50.3% Leicestershire- 69.8%	**Mar 2023** Leicester -52% Leicestershire- 70.5%
	S050a	Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 year coverage)	Efficiency = 75%; Optimal = 80%	2023-24 Q1 69.7%	2023-24 Q2 69.2%

<u>Note:</u> From October 2023, there has been a change in submission and publication of the national cancer data.

17. The commissioner-based statistics only include those patients who can be traced back to a commissioner using their NHS Number. Due to these changes, we are unable to provide an out of County breakdown of LLR ICB Patients seen at other Providers. Further details can be found on: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

Never Events at UHL

18. The table below shows the number of Never Events at UHL over the past 4 years.

Year	Number of Never Events
2022/23	8
2021/22	9
2020/21	7
2019/20	2

19. The extra table below shows the number of Never Events at UHL in the last 3 months of 2023.

Key Performance Indicator	Target	Oct-23	Nov-23	Dec-23	YTD
Never events	0	0	0	0	3

20. The Trust has had 3 never events reported YTD. All appropriate actions have been undertaken and immediate learning has taken place alongside duty of candour and support for colleagues involved. In previous years UHL reported:

June 23	Retained product post procedure (retained guidewire)
August 23	Wrong site surgery (Biopsy taken from the wrong side)
	Surgical/Invasive procedure (Anaesthetic nerve block performed on the wrong side)

Areas of Improvement

21. Since the last performance report there have also been notable improvements in the following areas:

- The overall increase in the number of General Practice appointments across Leicestershire & Rutland. In November 23 there were a total of 667,939 appointments, this was more than in November 2022.
- The number of patients waiting over 104 weeks for elective treatment now stands at 0 for December 2023.
- Bowel cancer screening rates increased in Leicester and Leicestershire from Dec 2021 to Dec 2022.
- Breast screening rates increased in Leicester and Leicestershire from March 2022 to March 2023.

Public Health Outcomes Performance – Appendix 2

22. Appendix 2 sets out current performance against a range of outcomes set in the performance framework for public health. The Framework contains 37 indicators related to public health priorities and delivery. The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A rag rating of 'green' shows those that are performing better than the England value or benchmark and 'red' indicates worse than the England value or benchmark.

23. Analysis shows that of the comparable indicators, 17 are green and 17 amber with no red indicators. There are 3 indicators that are not suitable for comparison or have no national data.

24. Of the seventeen green indicators, the following indicators: reception prevalence of overweight (including obesity) and cancer screening coverage - bowel cancer, have shown significant improvement over the last 5 time periods. Breast cancer screening coverage, cervical cancer screening coverage (females, 25-49 years old) and cervical cancer screening coverage (50-64 years old) have shown a significant declining (worsening) performance over the last five time periods. Inequality in life expectancy at birth for both Males and Females in Leicestershire falls within the best quintile of the country. However, healthy life expectancy at birth places Leicestershire 12 out of 15 nearest neighbours for both females and males. Latest PHOF data shows that life expectancy at birth for Leicestershire males has increased from 79.7 years in 2021 to 80.4 years in 2022. Life expectancy at birth for females has increased from 83.6 years in 2021 to 83.7 years in 2022. PHOF data also shows that national site loss certificates issued continues to be worse than the national average.

25. There are currently no indicators where Leicestershire performs significantly worse than England or the benchmark. However more detailed benchmarking looking at just County Council's performance for end year data 2022/23 highlights 7 areas with lower bottom quartile performance: air pollution – fine particulate matter; fraction of mortality attributable to particulate air pollution; excess under 75 mortality rate for those with a serious mental illness and % of physically active adults. Also, low birth weight of term babies, foundation stage

children achieving a good level of development (free school meals) and children achieving a good level of development at 2-2.5.

26. Leicestershire and Rutland have combined values for the following two indicators - successful completion of drug treatment (opiate users) and successful completion of drug treatment (non-opiate users).

Better Care Fund and Adult Care Health/Integration Performance

27. The BCF Policy Framework sets national metrics that must be included in BCF plans in 2023-25. The County Council and the ICB have established ambitions associated with each metric and set how they will be achieved. The framework retains two Adult Social Care Outcomes Framework metrics from previous years:

- Effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)
- The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population

28. In addition, local systems have agreed targets associated with three further metrics to improve outcomes across the Health and Wellbeing Board area for the following measures:

- Improving the proportion of people discharged home using data on discharge to their usual place of residence.
- Reducing unplanned admissions for chronic, ambulatory, care-sensitive conditions.
- Reducing the number of emergency hospital admissions due to falls in people over 65.

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

Metric	Target Q2	Actual Q2	Commentary
Indirectly standardised rate (ISR) of admissions per 100,000 population	163.5	189	This metric is currently off target. Intermediate care initiatives, particularly for pathway 1 improvements are moving to step-up modelling to increase avoided admissions.
Percentage of people, resident in the HWB, who are	92.6%	92.2%	The target was almost met during

discharged from acute hospital to their normal place of residence			Q2. A difference of 0.4% is noted.
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	1628.1.	471.5	Currently this metric is 10% off track to meet target. The falls sub-group are looking at proactive models of support in the community for falls reduction pathways.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	515	ASCOF 22/23 552.8	Forecast for the full year, based on the position at the end of Q3 is 522.7 admissions per 100,000 population. The new integrated model of locality support between therapy and reablement teams has helped to ensure people remain in their own home.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90%	ASCOF 22/23 89.2%	Data in the metric isn't cumulative but represents a different three months of discharges (final year figures being discharges Oct-Dec). Latest performance is 87% but has been >90% at points through 2023/24 to date.

List of Appendices

Appendix 1 – Performance on LLR ISC NHS 31 Outcome Priorities
Appendix 2 – Public Health Outcomes – Key Metrics Update

Background papers

University Hospitals Leicester Trust Board meetings can be found at the following link:
http://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/

LLR Integrated Care Board meetings can be found at the link below

https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

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APPENDIX 1 - LLR ICS 31 Priorities Summary

(as of 14th Feb 2024)

Area	NATIONAL NHS OBJECTIVES 2023/24	Month	Plan	Actual	RAG
Urgent and emergency care	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 (UHL target based on performance data for Types 1& 2)	Dec-23	76%	58%	
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25. EMAS performance for LLR ICB.	Dec-23	00:30:00	01:01:48	
	Reduce adult general and acute (G&A) bed occupancy - Reported at ICB level. Local Trajectories (National =<92%)	Dec-23	94%	92.9%	
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard *In the Ops plan template commitment to achieve on numbers*	TBC			
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	TBC			
Primary care	Percentage of patients where time from booking to appointment was two weeks or less	Nov-23	Lower 85% Upper 90%	83.6%	
	Continue on trajectory to deliver more GP appointments in general practice by the end of March 2024	Nov-23	744,970	667,939	
	Continue to recruit 26,000 (Nationally) Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	TBC			
	Recover dental activity. Improving units of dental activity (UDAs) towards pre-pandemic 2020 levels	Dec-23	1,867,483	1,157,842	
Elective care	Eliminate waits of over 65 weeks for elective care by Mar 24 (except where patients choose to wait longer or in specific specialties)	Dec-23	1,178	1,222	
	Deliver the system - specific activity target (agreed through the operational planning process) Total elective and day case spells (Ops Plan E.M.10) Tolerance 5%	Dec-23	10,776	10,809	
	Follow up outpatient attendances without procedure (Ops Plan E.M.38) Tolerance 5%	Dec-23	45,348	39,093	

Area	NATIONAL NHS OBJECTIVES 2023/24	Month	Plan	Actual	RAG
Cancer	Continue to reduce the number of patients waiting over 62 days (UHL Data Only)	Jan-24	391	351	
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	Dec-23	76%	80.2%	
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	UHL reviewing staging data - TBC			
Diagnostics	Patients that receive a diagnostic test over 6 weeks waiting - as per the Operational Plan 23/24	Dec-23	26%	26%	
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Dec-23	28,353	30,946	
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	CSU reviewing maternity data set - TBC			
	Increase fill rates against funded establishment for maternity staff	TBC			
Use of resources	Deliver a balanced net system financial position for 2023/24 - System delivery of planned surplus	M9	(23,269)	(66,594)	
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	TBC			
Mental health	Improve access to mental health support for children and young people aged 0-25 accessing NHS funded services (compared to 2019) 12 mth rolling position reported for each month	Nov-23 Q3 Plan	14,228	15,095	
	Increase the number of adults and older adults accessing Talking Therapies (3 months rolling position)	Nov-23 Q3 Plan	8,101	5,665	
	Increase in the number of adults and older adults supported by community MH services with Severe Mental Illness (SMI) Number of people who receive two or more contacts from NHS or NHS commissioned community MH service	Nov-23	6,456	12,855	
	Work towards eliminating inappropriate adult acute out of area placements (Quarterly Rolling Bed Days data)	Oct-23	0	0	
	Recover the dementia diagnosis rate	Dec-23 Q3 Plan	65.8%	65.8%	
	Improve access to perinatal mental health services	Nov-23 Q3 Plan	940	690	

Area	NATIONAL NHS OBJECTIVES 2023/24	Month	Plan	Actual	RAG
People with a learning disability and/or autism	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 (Target 4284)	Nov -23 Q3 Plan	1109	808	
	Number of adults with LD/Autsim in inpatient care	Nov -23 Q3 Plan	26	26	
	Number of children with LD/Autsim in inpatient care	Nov -23 Q3 Plan	4	4	
Prevention and health inequalities	CVDP002HYP: Percentage of patients aged 18 to 79 years with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is equal to 140/90 mmHg or less	Q2 23/24 Sept-23	77.0%	65.8%	
	CVDP003HYP: Percentage of patients aged 80 years or over with GP recorded hypertension, in whom the last blood pressure reading within the preceding 12 months is 150/90 mmHg or less	Q2 23/24 Sept-23	77.0%	75.8%	
	CVDP007HYP - Percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is below the age appropriate treatment threshold	Q2 23/24 Sept-23	77.0%	67.8%	
	CVDP003CHOL - Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Q2 23/24 Sept-23	60.0%	61.8%	
	Continue to address health inequalities and deliver on the Core20PLUS5 approach	Part of each Partnerships – strengthened through link to Health Inequalities Support Unit			

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Public Health and Prevention Indicators in Leicestershire

Prevention	Indicator		Time Period	Polarity	Value	NN Rank	England	DoT	RAG
All	A01b - Life expectancy at birth	(F)	2020 - 22	High	83.6	8/15	82.8	—	●
		(M)	2020 - 22	High	80.0	8/15	78.9	—	●
	A01a - Healthy life expectancy at birth	(F)	2018 - 20	High	63.6	12/15	63.9	—	●
		(M)	2018 - 20	High	62.9	12/15	63.1	—	●
	A02a - Inequality in life expectancy at birth	(F)	2018 - 20	Low	4.9	3/15	7.9	—	●
		(M)	2018 - 20	Low	6.0	2/15	9.7	—	●
	C02a - Under 18s conception rate / 1,000	(F)	2021	Low	10.7	5/15	13.1	—	●
Primary	C05b - Breastfeeding prevalence at 6 to 8 weeks - current method	(P)	2022/23	High	50.0	5/8	49.2	—	●
	C06 - Smoking status at time of delivery	(F)	2022/23	Low	8.5	6/15	8.8	▶	●
	C09a - Reception prevalence of overweight (including obesity)	(P)	2022/23	Low	18.7	2/13	21.3	▼	●
	C09b - Year 6 prevalence of overweight (including obesity)	(P)	2022/23	Low	31.9	3/13	36.6	▶	●
	C16 - Percentage of adults (aged 18 plus) classified as overweight or obese	(P)	2021/22	Low	64.1	6/15	63.8	—	●
	C17a - Percentage of physically active adults	(P)	2021/22	High	66.8	15/15	67.3	—	●
	C17b - Percentage of physically inactive adults	(P)	2021/22	Low	21.4	12/15	22.3	—	●
	C18 - Smoking Prevalence in adults (18+) - current smokers (APS)	(P)	2022	Low	9.4	2/15	12.7	—	●
	C28b - Self reported wellbeing: people with a low worthwhile score	(P)	2022/23	Low	3.3	3/15	4.4	—	●
	E02 - Percentage of 5 year olds with experience of visually obvious dental decay	(P)	2021/22	Low	19.1	11/12	23.7	—	●
	C21 - Admission episodes for alcohol-related conditions (Narrow)	(P)	2021/22	Low	432.4	6/15	493.9	—	●
Primary/Secondary	E01 - Infant mortality rate	(P)	2020 - 22	Low	3.3	6/13	4.0	—	●
	E04a - Under 75 mortality rate from all circulatory diseases	(P)	2022	Low	65.5	5/13	77.8	▶	●
	E05a - Under 75 mortality rate from cancer	(P)	2022	Low	113.6	5/13	122.4	▶	●
	E06a - Under 75 mortality rate from liver disease	(P)	2022	Low	18.6	9/13	21.4	▶	●
	E07a - Under 75 mortality rate from respiratory disease	(P)	2022	Low	22.5	7/13	30.7	▶	●
	E10 - Suicide rate	(P)	2020 - 22	Low	9.2	4/15	10.3	—	●
	E14 - Winter mortality index	(P)	Aug 2021 - Jul 2022	Low	8.6	8/13	8.1	—	●
	E14 - Winter mortality index (age 85 plus)	(P)	Aug 2021 - Jul 2022	Low	9.9	5/13	11.3	—	●
	C19a - Successful completion of drug treatment: opiate users	(P)	2022	High	6.0	6/15	5.0	▶	●
	C19b - Successful completion of drug treatment: non opiate users	(P)	2022	High	32.4	8/15	31.4	▶	●
	C22 - Estimated diabetes diagnosis rate	(P)	2018	High	79.4	6/16	78.0	—	●
Secondary	C24a - Cancer screening coverage: breast cancer	(F)	2023	High	70.4	8/13	66.2	▼	●
	C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	(F)	2023	High	72.1	6/13	65.8	▼	●
	C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	(F)	2023	High	78.0	3/13	74.4	▼	●
	C24d - Cancer screening coverage: bowel cancer	(P)	2023	High	75.3	7/13	72.0	▲	●
	C26b - Cumulative percentage of the eligible population aged 40 to 74 offered an NHS ..	(P)	2018/19 - 22/23	High	47.8	5/15	42.3	—	●
	D02a - Chlamydia detection rate per 100,000 aged 15 to 24	(P)	2022	N/a	1,553.9	11/13	1,680.1	—	●
	D02b - New STI diagnoses (excluding chlamydia aged under 25) per 100,000	(P)	2022	Low	283.8	8/13	495.8	—	●
	D07 - HIV late diagnosis in people first diagnosed with HIV in the UK	(P)	2020 - 22	Low	50.0	8/13	43.3	—	●

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

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

Indicators C19a and C19b present Figures for Leicestershire and Rutland combined

Nearest Neighbour Rank: 1 is calculated as the best (or lowest when no polarity is applied)

Source: OHID, https://fingertips.phe.org.uk/ February 2024

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Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee
Work Programme – 2024

27 March 2024

Agenda item	Organisation/Officer responsible
CAMHS data and analysis	LPT
UHL Capacity and critical incident	UHL
Update on Dental Services - plans to improve access. Follow on from report that went to June 2022 meeting. ***Possible item – Jenny Goodwin to check***	ICB
Medicines availability - why these issues have arisen and when they are expected to be resolved **Possible item – Ramsay Ross to provide detail and Jenny Goodwin to check**	ICB
Gluten Free Products consultation **(Information only report. Not presented)**	ICB
Measles vaccinations – summary of info that went to individual HOSCs **(Information only report. Not presented)**	ICB/Public Health
EMAS - Clinical Operating Model and Specialist Practitioners update. Five year strategy and clinical strategy. **(Information only report. Not presented)**	EMAS

June/July 2024

Agenda item	Organisation/Officer responsible
Corporate Complaints Procedure	UHL
Elective Care particularly knee and hip	UHL

September 2024

Agenda item	Organisation/Officer responsible

UHL Future Hospitals programme to include detail on modular buildings	UHL

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. Leicester, Leicestershire, and Rutland Integrated Care System	ICS	This item was last taken in February 2023. Further updates to be scheduled accordingly.
3. 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.
4. Re-procurement of the Non-Emergency Patient Transport Service (NEPTS). Contract awarded to ERS Transition Limited in June 2023 (inform Phil King when its on the agenda)	ICS	Might be worth giving ERS Transition Ltd time to settle in before scrutinising them.

Future agenda items	Organisation/Officer responsible	Notes
5. Transfer of Haemodialysis Unit	UHL	Unit moved building in March/April 2023. A paper to be brought later in 2023
6. 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.
7. PIFU and health inequalities	UHL	Arose out of Elective Care item at 18 December 23 meeting
8. Apprenticeships	ICB	Arose out of workforce discussion at 18 December 23 meeting
9. Elective Care and Operational Plan	UHL	Further report requested at 18 December 23 meeting

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