Leicestershire County Council

Meeting: **Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee**

Date/Time: **Wednesday, 17 July 2024 at 10.00 am**

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

Contact: **Euan Walters (0116 3056016)**

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Membership

Mr. J. Morgan CC (Chairman)

Cllr. S. Bonham	Cllr. R. Payne
Mr. M. H. Charlesworth CC	Mr. T. J. Pendleton CC
Cllr. A. Clarke	Cllr. K. Pickering
Cllr. Zuffar Haq	Cllr R. Ross
Mr. D. Harrison CC	Cllr. L. Sahu
Mr. R. Hills CC	Mrs B. Seaton CC
Cllr. A. Joel	Cllr. P. Westley
Ms. Betty Newton CC	

Please note: this meeting will be filmed for live or subsequent broadcast via You Tube at https://www.youtube.com/playlist?list=PLrlN4_PKzPXhBilOPZvqU4lDm7DiSlntJ

AGENDA

Item		Report by
1.	Minutes of the meeting held on 27 March 2024.	(Pages 5 - 10)
2.	Question Time.	
3.	Questions asked by Members.	
4.	Urgent items.	
5.	Declarations of interest.	
6.	Declarations of the party whip.	

7.	Presentation of Petitions.		
8.	Update on GP Practice service improvements.	Integrated Care Board	(Pages 11 - 28)
9.	Access to Dental Services for Leicester, Leicestershire and Rutland.	Integrated Care Board	(Pages 29 - 44)
10.	Learning Disability and Autism Collaborative.	Leicestershire Partnership NHS Trust	(Pages 45 - 66)

11. Dates of future meetings.

Future meetings of the Committee are scheduled to take place on the following dates:

Wednesday 27 November 2024 at 10.00am;
Monday 17 March 2025 at 2.00pm.

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

Leicestershire County Council

Minutes of a meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee held at County Hall, Glenfield on Wednesday, 27 March 2024.

PRESENT

Mr. J. Morgan CC (in the Chair)

Cllr. S. Bonham	Ms. Betty Newton CC
Mr. M. H. Charlesworth CC	Mr. T. J. Pendleton CC
Mr. D. Harrison CC	Cllr R. Ross
Mr. R. Hills CC	Mrs B. Seaton CC
Cllr. M. March	Cllr. G. Whittle

In attendance

Harsha Kotecha, Healthwatch Leicester and Leicestershire.
Janet Underwood, Healthwatch Rutland.
Jon Melbourne, Chief Operating Officer, UHL (item 30 refers).
Rachna Vyas, Chief Operating Officer, NHS Leicester, Leicestershire & Rutland (item 30 refers).
Justin Hammond, Associate Director of Mental Health & Learning Disability, Integrated Care Board (item 31 refers).
Victoria Evans, Family Service Manager, Leicestershire Partnership NHS Trust (Item 31 refers).

24. Minutes of the previous meeting.

The minutes of the meeting held on 18 December 2023 were taken as read, confirmed and signed, subject to the amendment that Harsha Kotecha, Healthwatch Leicester and Leicestershire, and Janet Underwood, Healthwatch Rutland, be added to the attendance list.

25. Question Time.

The Chairman reported that no questions had been received in accordance with Standing Order 34.

26. Questions asked by Members.

The Chairman reported that no questions had been received under Standing Order 7.

27. Urgent items.

There were no urgent items for consideration.

28. 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 substantive agenda items as they had close relatives that worked for the NHS.

29. Presentation of Petitions.

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

30. UHL - Operational Improvements 2023.

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) on the performance of UHL's planned and urgent and emergency care activities during 2023 as well as future plans to continue the improvements achieved to date. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Jon Melbourne, Chief Operating Officer, UHL and Rachna Vyas, Chief Operating Officer, NHS Leicester, Leicestershire & Rutland.

Arising from discussions the following points were noted:

(i) UHL had improved its operational performance in 2023 from a position at the start of the year of being in Tier 1 of the National Support Programme for Urgent and Emergency Care (UEC), cancer and planned care, to being exited from tier 1 support for all three areas in 2023 (moving to tier 2 for cancer and planned care and out of tiering for UEC). A hospital trust could be placed in a support tier for any area of care but UHL had not been on a support programme for any areas apart from UEC, cancer and planned care. UHL acknowledged that further improvements still needed to be made. Committee members welcomed the improvement in UHL's operational performance particularly the 77% reduction in the number of people across LLR waiting more than a year for elective care, the biggest reduction of any system in England.

(ii) On 23 January 2024 UHL had declared a critical incident and the Trust had remained in critical incident mode for 52 hours and 3 minutes. Members queried how come the critical incident needed to be declared given the operational improvements that had taken place during 2023, and that the 2023/24 winter had not been particularly severe in terms of the weather. In response it was explained that significant operational pressures had been building up for some months particularly in emergency flow pathways. Whilst UHL held data about why the individual patients had attended the hospital, the University of Leicester had been tasked with carrying out a wider investigation into why demand had been so high during the 2023/24 winter. In response to a question from a member it was clarified that the critical incident was not caused by a lack of staff, and even if UHL had a full compliment of staff, a critical incident would still have had to be declared. To put the incident in context, most of the larger hospital trusts in England had to declare a critical incident at some point over the 2023/24 winter. The previous critical incident at UHL was on 29 December 2022.

(iii) The System Health Equity Committee had been requested to conduct a 'deep dive' into longer waits at both the Emergency Department and patients waiting for ambulances to assess the impact against protected characteristics. Separate reports of the findings would be produced for the Leicester City area, the County Council area and also individual neighbourhoods. The relevant reports would be brought to Health Scrutiny Committees when available.

(iv) UHL was using a small number of Physician Associates to support clinical staff and reassurance was given that they were only being used where clinically appropriate and they were not replacing staff with more advanced clinical skills such as doctors.

(v) The graphs in the appendix to the report indicated that the diagnostic waiting list had grown towards the end of 2022, then dropped dramatically in early 2023, before reaching a plateau in mid 2023. In response to a query from a member, UHL gave reassurance that the diagnostic waiting list would continue to decrease. It was noted that the new Hinckley Community Diagnostic Centre would play a part in this.

(vi) The Getting it Right First Time (GIRFT) programme was now working with UHL as part of a programme called "Going Further Faster" to deliver clinical transformation of patient pathways and reduce waiting times for elective care. The programme involved learning best practice from other hospital trusts. In response to a question from a member it was clarified that UHL had been learning from other trusts for some time, it was just the Going Further Faster model that was new.

(vii) Another part of the GIRFT programme was mutual aid which involved using other providers in the health sector. This could include private hospitals if they provided services to the NHS. The national patient choice initiative gave a patient the right to ask for an appointment to be moved to a different provider.

(viii) There had been zero 104+ waits for elective care. There was national guidance on what constituted a wait and when the clock should be stopped.

(ix) UHL was implementing a Patient Initiated Follow-Up (PIFU) scheme where patients were able to initiate a follow-up appointment when they needed one, based on their symptoms and individual circumstances, rather than having a set timescale for follow-up appointments. Members raised concerns that some patients might not request a follow-up appointment when they actually needed one and members queried whether the scheme resulted in patients having worse medical problems later on in time. In response it was explained that the scheme was clinically led and only implemented when it was right for a particular patient. Patients on a PIFU pathway accounted for approximately 5% of UHL's follow up pathways therefore ensuring only necessary follow up appointments took place could have a significant impact on UHL's workload.

(x) There had been a reduction in length of stay for patients at UHL with hip and knee complaints from 4.5 days (22/23) to 2.8 days (Dec 23). The quicker a patient could be mobilised the better for their long-term health. UHL was now one of the best trusts in the country for mobilisation.

(xi) In response to a positive observation from a member about staffing levels in the Clinical Decisions Unit at Glenfield Hospital it was explained that staffing ratios were clinically led using evidence bases set out in national guidance.

(xii) Da Vinci robots at Leicester General Hospital and Leicester Royal Infirmary (funded by charitable donations) were being used to carry out some procedures. A full list of the procedures would be provided to members after the meeting. It was hoped that a further Da Vinci robot could be installed at Glenfield Hospital should the funding be available.

(xiii) Healthwatch reported that patients were generally satisfied with clinical appointments once they had received one, but it was the administration process prior to attending the appointment that they experienced difficulties with. In response UHL acknowledged that some services were difficult to access but provided reassurance that UHL was working on its digital programme including texts sent to patients about appointments and ensuring the correct contact numbers were publicised.

(xiv) Some GP Practices were preventing patients from booking appointments by telephone and instead requiring patients to book an appointment by completing a form. There were concerns that patients with literacy problems would be disadvantaged and also that this method was not suitable if the patient's problem was urgent. The ICB was aware of these issues and was holding conversations with GP Practices about it. However, as GP Practices were independent contractors, they had the final decision on how they ran their appointments process. The Chairman suggested to Healthwatch that they could carry out a piece of research into the issue of access to GP Practices, and Healthwatch agreed to give this consideration. Healthwatch Rutland were already planning on carrying out a piece of research into patients' communication experiences with the NHS.

(xv) A member emphasised that patients needed educating on where to go for medical treatment. The role of pharmacists needed to be better publicised. The Pharmacy First service enabled patients to be referred into a community pharmacist for a minor illness and the pharmacists could prescribe medication for 7 common conditions.

(xvi) In response to a question from a member it was confirmed that the Integrated Care System could disaggregate its funding into the different areas such as primary care, home first etc though Urgent and Emergency Care was more difficult. However, this was only a useful activity if funding was being moved from one area to another. Members welcomed that the system had more of an understanding of its finances than in previous years.

RESOLVED:

(a) That the update on UHL's planned and urgent and emergency care activities be welcomed;

(b) That officers be requested to provide reports for future meetings of the Committee regarding the digital programme and admin processes for clinical appointments.

31. LLR Children and Young People's Wellbeing and Mental Health update.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on the Well-Being & Mental Health support available for Children and Young People across Leicester, Leicestershire and Rutland (LLR). A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Justin Hammond, Associate Director of Mental Health & Learning Disability, Integrated Care Board, and Victoria Evans, Family Service Manager, LPT.

Arising from discussions the following points were noted:

(i) LPT offered a range of well-being and mental health support services designed to tackle issues early and prevent a patient needing to be referred to Child and Adolescent Mental Health Services (CAMHS). However, the age of children being referred to CAMHS was getting younger.

(ii) A large number of referrals from GP Practices to CAMHS were being rejected due to a lack of information in the referral. Members suggested that Derbyshire Health United (DHU) who assessed the referrals should request the additional information from the GP Practice rather than rejecting the referral. In response assurance was given that this issue was known about and being investigated by the Integrated Care Board (ICB). CAMHS practitioners were being placed in Primary Care Networks to help the process run more smoothly and support signposting to other mental health services. It was pointed out that it was more useful for DHU to get the information directly from the patient rather than via the GP Practice.

(iii) In response to a query as to why there had been an increase in demand for mental health services in recent years it was suggested that the Covid-19 pandemic would have had an impact but there were likely to be other factors such as social media.

(iv) Neurodiversity in patients created additional challenges and complexity when diagnosing mental health issues. LPT had seen an increase in referrals of patients with neurodiversity and this was a national issue. LPT was bidding for additional funding to manage those patients. One bid to the ICB for funding to provide a dedicated service had been successful.

(v) Support was available to the families of patients who required mental health support. The Solihull Approach to parenting was being used which was an early intervention framework. LPT also linked in with Family Hubs.

(vi) It was important to make the best use of estate space and undertake capacity planning. However, it was more cost effective to utilise buildings owned by other organisations where possible and this fitted in with the approach of imbedding services in communities. A report on estates was requested for a future meeting.

RESOLVED:

(a) That the update on the Well-Being & Mental Health support available for Children and Young People be welcomed;

(b) That officers be requested to provide a report for a future meeting of the Committee regarding NHS estates management.

32. Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee Terms of Reference.

The Committee considered a report of the Secretariat (Leicestershire County Council) which proposed changes to the Committee's Terms of Reference, required as a result of new Regulations and guidance from the Department of Health and Social Care relating to the role and powers of Health Scrutiny Committees. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Members were advised that in conjunction with the Terms of Reference changes a Memorandum of Understanding between the Committee and health system partners would be drafted and circulated.

RESOLVED:

That the amendments to the Committee's Terms of Reference as set out in the Appendix to the report be approved.

2.00 - 4.02 pm
27 March 2024

CHAIRMAN

Agenda Item 8

NHS
Leicester, Leicestershire and Rutland

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE
17 JULY 2024

UPDATE ON GP PRACTICE SERVICE IMPROVEMENTS

REPORT OF THE LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD

Purpose of the Report

1. This report provides the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee with an update on the delivery of the Leicester, Leicestershire and Rutland (LLR) 2023/24 System-level Access Improvement Plans and the NHS England Primary Care Recovery Plan for 2024/25 and the further opportunities this presents for our people and communities.

2. The report also provides the key headline findings from the local GP Practice Survey undertaken between 23 January 2024 and 10 March 2024. The survey sought to understand the experiences of people using their general practice and provide evidence of the impact on patients of improvements plans and initiatives.

Policy Framework and Previous Decisions

3. The Delivery Plan for recovering access to Primary Care – LLR System Level Access Improvement Plan (SLAIP) was last discussed and noted by the Joint Committee on 18th September 2023.

4. The NHS England "Delivery Plan for Recovering Access to Primary Care", (NHSE May 2023), had two central ambitions:

   i. To tackle the 8am rush and reduce the number of people struggling to contact their practice - patients should no longer be asked to call back another day to book an appointment.

   ii. For patients to know on the day they contact their practice how their request will be managed. This could be:
      a) "Same day assessment" if their need is clinically urgent (phone or face-to-face).
      b) If their need is not urgent, a telephone or face-to-face appointment, scheduled within two weeks.

c) Where appropriate, signposting to self-care or other local services (e.g., community pharmacy or self-
d) referral services).

5. The 2023/24 NHS Primary Care Access Recovery Plan (PCARP) aimed to support recovery by focusing on four areas:

I. Empowering patients to manage their own health including using the NHS App, self-referral pathways, and through more services offered from community pharmacy.
II. Implementing Modern General Practice Access to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day. (The 2023/24 contract required practices to assess patient requests on the day).
III. Building capacity to deliver more appointments from more staff, adding flexibility to the types of staff recruited and how they are deployed.
IV. Cutting bureaucracy and reduce the workload across the primary and secondary care interface, and the burden of medical evidence requests.

Background

6. In August 2023, an action task was issued to ICBs from the Primary Care Transformation Programme stating that following the publication of a plan for recovering access to primary care, ICBs were required to develop a SLAIP.

7. Although titled as a plan for recovering access to Primary Care, it was acknowledged that successful implementation of the Delivery Plan for Recovering Access to Primary Care would require a concerted and not insignificant response and action from nearly all Integrated Care System Partners and Integrated Care Board (ICB) Teams in LLR.

8. The approach to implementation and delivery of the SLAIP 2023/24 was based on the central aims and focus areas of the PCARP.

9. The LLR SLAIP 2023/24 was also developed reflecting several other cross-cutting plans and strategies. These include:

- LLR Primary Care Strategy;
- LLR ICS Five Year Joint Plan;
- LLR Urgent and Emergency Care Transformation;
- Development of Place Based Access and Integration Plans;
- Tackling Health Inequalities.

10. In addition, the ask and expectation of the 2023/24 PCARP is summarised below:

Domain	Ask Summary
A. Empower patients	Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.
	Ensure ICB expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.
	Support and enable the expansion of pharmacy oral contraception (OC) and blood pressure (BP) services this year.
	Support and enable the launch Pharmacy First so by the end of 2023 community pharmacies can supply prescription medicines for seven common conditions.
B. Implement Modern General Practice Access	All ICB practices on analogue lines to move to digital telephony, including call back functionality, sign-up by July 2023.
	ICB to provide all practices with the digital tools and care navigation training for modern general practice access.
	Deliver training and transformation support to all practices from May 2023 through National General Practice Improvement Programme.
C. Build capacity	Increase numbers of "Direct Patient Care Staff" (National target but no regional or ICB specific target)
	Expand GP specialty training.
D. Cut bureaucracy	Reduce time spent liaising with hospitals by improving the interface with primary care, especially the four areas highlighted by the Academy of Medical Royal Colleges report.
	Reduce unnecessary bureaucracy and administrative burdens placed upon General Practice to free up time for patients through implementing the bureaucracy busting concordat.

Activities undertaken to achieve improvement

11. Considerable work has been undertaken during 2023/24 to meet the key requirement of the PCARP. The outputs of the work towards achievement of each of the four domains is outlined below.

12. In 2022/23 practices provided 6,948,961 clinical appointments for their patients; in 2023/24 this figure rose to 7,451,092 clinical appointments, a rise of 502,131 (7.2.%) appointments. A summary of LLR's standing against national access and appointment metrics is shown below:

Appointment/Access Metric	LLR 22/23	NHSE 22/23	LLR 23/24	NHSE 23/24
Total Appts	6,948,961		7,451,092	
Appts/1000 pop	492.7	453.0	511.8	469.0
% "Same Day"	44.0	43.7	40.9	43.1
% 0 - 1 Day	51.3	51.9	48.1	50.8
% 1 - 14 Days	38.3	40.3	37.9	39.1
% 0 - 14 Days	82.3	83.9	78.8	82.2
% GP	44.9	48.3	42.9	45.9
% "F2F" (LLR = 70%*)	73.6	67.6	73.6	68.3

13. **Empowering patients – NHS App** – the table below shows the March 2024 position in LLR of enabling the NHS App functionality:

Metric/Target	Date	LLR	Midlands	England
% of practices with all 4 core NHS App functions enabled	March 24	74%	79%	-
% of practices with messaging function enabled	March 24	95%	98%	-
% of practices with prospective record access enabled	March 24	76%	83%	-
% of practices that have enabled online booking	March 24	98%	98%	-
% of practices with online repeat prescription ordering enabled	March 24	98%	99%	-

14. **Empowering patients – self-referral –** seven pathways were identified where self-referral could be a safe and effective way for patients to access services without first having to see their GP. These pathways are:

- Musculoskeletal Physiotherapy;

- Podiatry;
- Falls Services;
- Audiology;
- Weight Management Services;
- Wheelchair Services;
- Community Equipment Services.

15. It was nationally recognised that establishing self-referral routes into services, while a laudable ambition, would be a complex process that would require robust benefit analysis of 'real' workload improvement – removing the GP contact rather than moving it – against clinical risk and safety and impacts/implications for service providers, such as increased workload, increased staffing and or training required.

16. Work is underway in LLR to assess each of the initial 7 pathways/services to undertake a benefits analysis. Currently LLR has self-referral pathways for 3 of the 7 services:

    - Musculoskeletal Physiotherapy;
    - Podiatry;
    - Weight Management Services.

17. The table below, shows a snapshot of the rate of self-referrals for these services:

Service	Jan 2024 total referrals	Jan 2024 self/carer referrals	% self/carer referral
MSK	2,760	1,766	63.99
Podiatry	1,484	920	61.99
Weight Management #1	2,935	261	8.89
Weight Management # 2	22,806	2,282	10.01
Total	29,985	5,229	17.4%

18. Two ICB systems in Midlands Region have self-referral pathways for all 7 services and the ICB will reach out to those systems for learning and support. The Regional Team recognise the complexity of this ask and will continue to provide 1-2-1 meetings with systems to understand operational issues and local governance to mitigate against risk.

19. The PCARP 2024/25 ask for self-referral is to continue to expand self-referrals to appropriate services. LLR ICB is on track to meet its initial PCARP target for increasing self-referrals, but work remains ongoing to add value through self-referrals to other services/conditions, for both users, providers, and GPs.

20. Key to this work will be a robust communications and engagement plan that informs the LLR population of their referral options and supports

service providers and GPs to promote safe and timely self-referral opportunities.

21. **Empowering patients – community pharmacy development and expansion**

22. The table below details the LLR position to date for community pharmacy development and expansion:

Metric/Target	Date	LLR	Midlands	England
# of Pharmacy First/Common Conditions Service, Oral contraceptive, Blood pressure consultations delivered	April 24	13,911	-	-
% of pharmacies registered for "PF"	April 24	99%	97%	-
% of pharmacies registered for OC	April 24	69%	66%	-
% of pharmacies registered for BP	April 24	94%	92%	-

23. Community Pharmacy (CP) development and expansion encompasses:

- Minor Illness Service - (previously known as CPCS, GP referral required);
- Pharmacy First/Common Conditions Service - (CCS, 7 common conditions the public can self-referral to CP for);
- Oral Contraceptive Services - (OC, self-referral to CP for both initiation and continuation);
- Blood Pressure Service - (BP, self-referral to CP for both initiation and continuation).

24. In 2023/24, LLR was an exemplar in the development, implementation, and delivery of the Community Pharmacy Consultation Service (CPCS). This was achieved by enabling and supporting proactive engagement and collaboration between practices, Primary Care Networks, and Community Pharmacy – both providers and the Local Pharmacy Committee (LPC).

25. Early data (as previous table) indicates the ICB will continue to deliver the community pharmacy development and expansion required for PCARP 2024/2025: in January 2024, there were 3,932 pharmacy consultations reported as carried out in LLR, in March 2024 there were 5,208 consultations reported. April 2024 saw nearly 14,000 consultations reported.

26. However, there have been, and remain several risks to optimising CP development and expansion which have been recognised nationally, and indeed, require a national solution or resolution. These include:

- Delay to national IT platform/integration – local workarounds needed.

- Delayed data sets – unable to distinguish between referred and self-referred activity, difficult to target/prioritise ICB/Local Pharmaceutical Committee support interventions.
- New requirement for "multi-factorial authentication" to make referrals – issues for both GP and CP, resulting in practices stopping referrals.
- Phased introduction of GP Connect Update Record – has caused confusion and delay.

27. A key area for development through training and up-skilling is to increase the number of CPs providing initiation consultations for both the Oral Contraceptive and Blood pressure services.

28. Whilst the ICB's Community Pharmacy Clinical Lead and the Local Medical Committee will continue to work at Primary Care Network and neighbourhood level to optimise CP opportunities for patients and GPs, it is still unclear where and how contractual and quality issues should be escalated.

29. When "official" data becomes available the ICB will seek to understand the real impact of the CP offers on GP workload, including the benefit, or not, of referring for all elements, and the patient "return" rate. A national audit of Service User Experience and Satisfaction is planned by NHS England which will inform and support further local engagement and improvement. As with self-referrals, a robust and locally tailored communications and engagement plan will be key.

30. **Implementing Modern General Practice – digital transformation, cloud-based telephony (CBT) –** all LLR practices have, or on track to have, Cloud Based Telephony by July 2024.

31. PCARP 2023/24 required ICBs to provide all practices with the digital tools and care navigation training for modern general practice access. Whilst good progress has been made with the care navigation training, there has been national delays to a Digital Platforms Framework (DPF) that have impacted us locally.

32. As an ICB we are responding to this delay by maintaining and building on solutions already established in LLR that meet the criteria we know are expected for demand and capacity analysis and management.

33. **Building capacity- additional and trained staff –** we have seen a growth in all staff groups. The table below outlines the workforce growth across primary medical care in 2023/24.

ACTUAL													
PC Staff in Position (WTE)	Base	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
GPs excluding registrars	529	525	516	515	515	514	516	509	508	508	511	511	512
GP Registrars	175	191	188	185	182	218	212	206	198	213	206	198	195
Nurses	284	289	284	285	286	288	286	288	286	284	289	286	286
DPC roles (ARRS funded)	522	579	588	598	607	658	646	672	623	654	657	592	626
DPC roles (not ARRS funded)	345	349	347	342	342	346	356	356	365	360	360	361	364
Other – admin and non-clinical	1426	1448	1433	1450	1458	1456	1453	1440	1448	1437	1440	1436	1440
Total PMC	**2758**	**2802**	**2768**	**2776**	**2783**	**2823**	**2822**	**2799**	**2805**	**2802**	**2808**	**2793**	**2797**
Total ARRS	**522**	**579**	**588**	**598**	**607**	**658**	**646**	**672**	**623**	**654**	**657**	**592**	**626**
Total	**3280**	**3381**	**3355**	**3374**	**3391**	**3481**	**3468**	**3471**	**3428**	**3455**	**3464**	**3385**	**3423**
PMC Growth (cumulative)		**1.6%**	**0.4%**	**0.7%**	**0.9%**	**2.4%**	**2.3%**	**1.5%**	**1.7%**	**1.6%**	**1.8%**	**1.3%**	**1.4%**
ARRS Growth (cumulative)		**10.9%**	**12.6%**	**14.6%**	**16.3%**	**26.0%**	**23.7%**	**28.7%**	**19.3%**	**25.2%**	**25.8%**	**13.4%**	**19.9%**
Total Growth (cumulative)		**3.1%**	**2.3%**	**2.9%**	**3.4%**	**6.1%**	**5.7%**	**5.8%**	**4.5%**	**5.4%**	**5.6%**	**3.2%**	**4.4%**

34. In addition, the table below shows the number of additional direct patient care staff, GP and Care Navigators trained in LLR to date:

Metric/Target	Date	LLR
# of additional DPC staff (2019)	March 24	613
# of additional GPs (2019)	March 24	29
# of Care Navigators trained (to date)	March 24	103

35. **Cut bureaucracy – primary secondary care interface** - in LLR this work is led by a pan ICB Transferring Care Safely Group. During a recent visit to LLR by Professor Claire Fuller (NHS England Medical Director of Primary Care) and her Transformation Team, there was praise for this innovative group and the work it was progressing.

36. Each provider trust was required to submit a Primary Secondary Care Interface Self-assessment Tool for the PCARP 2023/2024. In LLR this was done in partnership with University Hospitals of Leicester (UHL).

37. The outcomes of all Midlands Region responses have been shared with all systems to ensure that all areas can share learning and good practice with other Midland ICBs.

Capacity and Access Payments

38. Integral to the PCARP are Primary Care Network Capacity and Access Payments. The Capacity and Access Support Payment or CASP is worth 70% of the available payment, and the Capacity and Access Improvement Payment (CAIP) is worth 30% of the available payment. The diagram below shows how our local Primary Care Networks have utilised the payment.

39. To attract the 2023/24 CAIP payment, Primary Care Networks were required to:

- Improve patient experience of contact their practice.
- Make access easier for patients.
- Ensure the accuracy of recording/coding in appointments books.

40. All LLR Primary Care Networks achieved their full 30% CAIP funding. Through delivery of the CAIP, they achieved the following:

    - Workforce – recruitment and retention of staff aligned to population health needs.
    - Staff training – to support the configuration for phone lines.
    - Training sessions between May and July 2024 for practice staff to support them to make changes to their websites to enable them to be usable and accessible, focusing on making it easier for patients to navigate and carry out common tasks and information quality.
    - Digital enablement – use of NHS App, online consultation, updated websites through focus groups, matrix working, alignment to NHSE website requirements, include more information on ARRS roles and benefits, etc.
    - Recruitment of staff to deliver CAIP - which included Care Coordinators, Clinical staff for review clinics, Digital Leads.
    - Improvement in patient flow through demand and capacity modelling and triangulation – using Cloud Based Telephony (CBT) and GP Appointment Data (GPAD).
    - Better alignment of capacity with need - active signposting training and direction of patients, use of Pharmacy First, CBT triangulation.
    - Improved care navigation - staff training, development of pathways, empowering patients and informing on benefits of the Additional Roles Reimbursement Scheme (ARRS) roles e.g., clinical pharmacists, Pharmacy Technicians, Care Coordinators, and use of NHS App/

Online Consultation, holding health and wellbeing events, support training in Pride, etc.

- Improved access processes and experience - telephony journeys, Call back functionality enabled, CBT dashboard reviewed, managing staffing based on demand, clinical triage, etc.
- Improved care-related processes - focused health and wellbeing sessions, group sessions to promote self-care and health and wellbeing.

41. In addition, February 2024 the ICB introduced a People Promise Manager, to lead a retention programme for general practice. Four key areas of focus have been identified to support retention:

- Flexible working – retain GP's within LLR to support work/life balance and improve workforce capacity at 8am rush.
- Workforce pipeline – apprenticeships expansion of non-clinical roles and peer support, mentors.
- Workforce intelligence – through the two surveys (quarterly and annual).
- Collaborative NHS England Midlands Retention Event in July 2024 supporting networking, retention and communications.

Understanding patient experiences and gathering evidence of the impact of improvement plans

42. A requirement of the 2023/24 CAIP, was the engagement by Primary Care Network, of their practice populations to better understand their patient's experiences and subsequently provide evidence of the impact of their CAIP initiatives and improvements plans.

43. In partnership with the ICB, a 7-week public engagement and survey was undertaken. This commenced on 23 January 2024 and ran until 10 March 2024. A total of 28,974 people participated in the survey, representing nearly 38% of the population of LLR. The full GP Patient Survey Report of Finding can be viewed at https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/. A national GP Patient Survey was also undertaken which will report in July 2024.

44. The key high-level headline experience findings from the survey are outlined below. It is important to note that the survey was undertaken when improvements had only just been enacted or were in the process of being enacted, therefore the benefits would not have been fully realised by patients.

45. **Experiences of contacting local GP practice services**

- **Getting through to GP practice on the phone**
  Overall, more than half of respondents to the survey who provided a rating (55% - 15,524 respondents) say that they found it either 'very

easy' or 'fairly easy' to get through to their GP practice on the phone the last time they contacted their GP practice. However, 45% (12,824 respondents) feel that it was either 'not very easy' or 'not at all easy' to get through.

- **Helpfulness of the receptionist at the GP practice**
  Overall, four fifths of respondents to the survey who provided a rating (80% - 22,454 respondents) say that they found the receptionist either 'very helpful' or 'fairly helpful' the last time they contacted their GP practice. However, 20% (5,768 respondents) feel that the receptionist they encountered was either 'not very helpful' or 'not at all helpful'.
- **GP practice online services used**
  Overall, two-thirds of respondents to the survey who provided an answer (66% - 19,043 respondents) say that they have used at least one of the listed general practice online services in the past twelve months. The most commonly used online service is 'ordering repeat prescriptions online' (50% - 14,480 respondents claiming to have used this service), while just over a quarter of respondents have made use of 'booking appointments online' (26% - 7,589 respondents) and 'accessing my medical records online' (26% - 7,405 respondents). However, only 10% (3,010 respondents) say that they have 'filled in an online form'. Just over a third of respondents (34% - 9,776 respondents) say that they have not used any of the listed general practice online services in the past twelve months.
- **Ease of using GP practice website to look for information or access services**
  Overall, more than two-thirds of respondents to the survey who provided a rating (68% - 13,757 respondents) say that they found it either 'very easy' or 'fairly easy' to use their GP practice's website to look for information or access services. However, just under a third (32% - 6,557 respondents) feel that it was either 'not very easy' or 'not at all easy' to use their GP practice's website to look for information or access services.
- **Satisfaction with GP practice appointment times available**
  Overall, just over half of respondents to the survey who provided a rating (51% - 13,873 respondents) say that they are either 'very satisfied' or 'fairly satisfied' with the general practice appointment times that are available to them. However, more than a third (36% - 9,679 respondents) express the feeling that they are either 'fairly dissatisfied' or 'very dissatisfied' with the appointment times available to them.

46. **Experiences of trying to make last appointment**

- **When last tried to make a GP practice appointment**
  Overall, three-quarters of respondents to the survey who provided an answer (74% - 21,364 respondents) say that they last tried to make a general practice appointment with a GP, nurse or other

healthcare professional for themselves or someone else within the past 3 months. A further 13% (3,737 respondents) last tried to make an appointment between 3-6 months ago, while 10% (3,009 respondents) last tried to make an appointment 6 months or longer ago. A small minority (1% - 309 respondents) say they haven't tried to make an appointment since being registered with their current GP, while a further 2% (485 respondents) say that they don't know/can't remember when they last tried to make an appointment.

- **Initial action taken last time contacted GP practice**
  Overall, just under three-fifths of respondents to the survey who provided an answer (58% - 15,878 respondents) say that they tried to get at least one form of information and advice from the list of services they were presented with when they last tried to get an appointment. The most common action taken was to bypass professional/official medical advice in the first instance - 25% (6,808 respondents) 'tried to treat myself/the person I was making this appointment for e.g. with medication', while 14% (3,756 respondents) 'asked for advice from a friend or family member' and (12% - 3,344 respondents) 'used a non-NHS online service or looked online for information. The most commonly-used professional sources that were sought out initially were that respondents 'spoke to a pharmacist (19% - 5,210 respondents) and 'used an online NHS service (including NHS 111 online)' (15% - 4,081 respondents). However, 42% (11,469 respondents) say that they did not try to get information or advice when they last tried to get an appointment.
- **How tried to book the appointment**
  Respondents predominantly tried to book their last appointment 'by phone, through their practice', rather than use other ways of doing so. More than four-fifths (81% - 22,588 respondents) tried to book their last appointment 'by phone, through my practice', while 16% (4,615 respondents) tried to book their last appointment 'in person'. Overall, 18% (5,078 respondents) say they tried to book their last appointment using any online/app method, with the most common channel being 'online, on my practice's website' (14% - 3,966 respondents – using this channel).
- **Whether satisfied with the appointment**
  In the main, respondents are satisfied with the appointment (or appointments) they were offered the last time they tried to make one, with more than three-fifths (62% - 17,468 respondents) saying they were satisfied with the appointments or appointments they were offered. Although a quarter (25% - 6,844 respondents) say they were not satisfied with the appointment (or appointments) they were offered, the large majority of these still took the appointment they were offered. However, 13% (3,643 respondents) say that they were not offered an appointment.
- **Rating of experience of making last GP practice appointment**
  Overall, nearly three-fifth of respondents to the survey who provided a rating (59% - 16,406 respondents) describe their experience of making their last appointment as either 'very good' or 'fairly good'.

However, 29% (8,220 respondents) describe their experience as either ‘fairly poor’ or ‘very poor’.

47. **Experience of Most Recent Appointment**

- **How long since most recent GP practice appointment**
  Nearly all respondents to the survey who provided an answer have had a general practice appointment, with only 1% (213 respondents) saying they have not had an appointment since being registered with their current GP and 2% (461) saying that they can’t remember when their last general practice appointment was. Overall, nine-tenths of respondents to the survey who provided an answer last had a general practice appointment within the last 12 months, with 69% (19,480 respondents) having had an appointment within the last 3 months.
- **Ratings of healthcare professional at last GP practice appointment – ‘giving you enough time’**
  Overall, more than four-fifths (82%) of respondents to the survey who provided an answer rate the healthcare professional they saw at their last appointment as either ‘fairly good’ or ‘very good’ in relation to ‘giving me enough time’. Less than a tenth (9%) of respondents answering rate the healthcare professional they saw at their last appointment as either ‘fairly poor’ or ‘very poor’ in this regard.
- **Ratings of healthcare professional at last GP practice appointment – ‘listening to you’**
  Overall, more than four-fifths (82%) of respondents to the survey who provided an answer rate the healthcare professional they saw at their last appointment as either ‘fairly good’ or ‘very good’ in relation to ‘listening to me’. Less than a tenth (9%) of respondents answering rate the healthcare professional they saw at their last appointment as either ‘fairly poor’ or ‘very poor’ in this regard.
- **Ratings of healthcare professional at last GP practice appointment – ‘treating you with care and concern’**
  Overall, more than four-fifths (82%) of respondents to the survey who provided an answer rate the healthcare professional they saw at their last appointment as either ‘fairly good’ or ‘very good’ in relation to ‘treating me with care and concern’. Less than a tenth (9%) of respondents answering rate the healthcare professional they saw at their last appointment as either ‘fairly poor’ or ‘very poor’ in this regard.
- **Whether felt involved as much as wanted to be in decisions about care and treatment**
  Overall, the large majority of respondents (85% - 22,942 respondents) feel that they were either fully involved or involved to some extent as much as they wanted to be in decisions about their care and treatment when they had their last appointment, with 57% (15,375 respondents) believing that they were fully involved in decisions about their care and treatment. However, just over a tenth

(11% - 2,962 respondents) did not think they were involved at all in decisions about their care and treatment.

- **Whether had confidence and trust in the healthcare professional at last appointment**
  Overall, the large majority of respondents (88% - 23,754 respondents) feel that they had either total or partial confidence and trust in the healthcare professional they saw or spoke to at their last appointment, with 63% (16,945 respondents) stating that they definitely had confidence and trust in the healthcare professional they saw or spoke to. However, just over a tenth (11% - 2,907 respondents) did not have any confidence and trust in the healthcare professional they saw or spoke to.
  Whether patient needs were met at last GP practice appointment
  Overall, the large majority of respondents (85% - 23,245 respondents) feel that their needs had been met to at least some extent at their last appointment, with 55% (14,883 respondents) stating that their needs had definitely been met. However, just over a tenth (13% - 3,598 respondents) say that their needs had not been met at all at their last appointment.

48. **Overall Experience of GP Practice**

- **Overall rating of experience of GP practice**
  Overall, two-thirds of respondents to the survey who provided a rating (66% - 19,035 respondents) describe their overall experience of their GP practice as either 'very good' or 'fairly good'. However, 22% (6,479 respondents) describe their experience as either 'fairly poor' or 'very poor'.

Continuation of improvements in 2024/25

49. While considerable work has been undertaken to improve GP practices services in 2023/24, the second year of the delivery plan for recovering access is about realising the benefits to patients and staff from the foundations built in 2023/23. The core aims remain, as do the four priority domains.

50. Our fundamental principle of providing the right care in the right place at the right time, remains central to our delivery of PCARP 2024/25.

51. The ask for the PCARP in 2024/25 is summarised in the table below:

Domain	Ask
A. Empowering patients	Increase use of NHS App and other digital channels to enable more patients to access to their prospective medical records (including test results) and manage their repeat prescriptions.
	Continue to expand Self-Referrals to appropriate services.

	Expand uptake of Pharmacy First services .
B. Implementing Modern General Practice Access	Complete implementation of better digital telephony.
	Complete implementation of highly usable and accessible online journeys for patients.
	Complete implementation of faster care navigation, assessment, and response.
	National transformation/improvement support for general practice and systems.
C. Building capacity	Continue with expansion and retention commitments in the Long-Term Workforce Plan.
D. Cutting bureaucracy	Make further progress on implementation of the four Primary Care Secondary Care Interface Arm recommendations.
	Make online registration available in all practices.

52. Further national and regional guidance and detail in respect of regarding PCARP 2024/25 is anticipated. However, there are emergent priorities and opportunities which the ICB will capitalise on:

- Maintain engagement and collaboration between LLR Primary Care Networks and practices, and LLR Community Pharmacies.
- Explore how to optimise the opportunities offered by the new Community Pharmacy Primary Care Network Engagement Lead funding and role.
- Use the self-assessment tool responses and subsequent learning to prioritise and drive the "Primary, Secondary Care Interface work through Transferring Care Safely.
- Widen the scope for self-referrals beyond the 7 services prioritised in PCARP 2023/24 – the ICB is on track to increase self-referral numbers by the 33.3% required by PCARP 2024/25, but our aim is to improve access and reduce workload, not just meet the numbers.
- Work with the Communications, Engagement and Patient Insights Team to develop and implement a robust information and communications and engagement strategy to support PCARP, and particularly self-referrals, using Community Pharmacy, and NHS App functionality and usage – building on national messaging, but also tailoring and adapting to ensure maximum local penetration.

- The 2024/25 Capacity and Access Improvement Plan payment scheme offers the opportunity to support the implementation of the Place Based Access Plans for 2025/26 on and support meaningful and impactful PCARP delivery.
- In 2023/24, 63, (50%), LLR practices accessed national Transformational Support Funding. The ICB allocated all its £809K budget. A similar budget is expected for 2024/25.
- Throughout 2024/25, the ICB, will work with Primary Care Networks aiming to ensure further recruitment and deployment of Direct Patient Care Staff is in line with the ICB's strategic and pledge goals - of population health management, to reduce access inequity, to balance provision of same day access with that of continuity of care, and to optimise patient focused and holistic care.
- PCARP 2024/25 requires ICBs to make online registration available in all practices with more than 90% of practices using the on-line registration system by 31 December 2024. Currently 68 (54%) LLR practices offer online registration; Midlands rate is 45%, NHSE is 39%.

53. Also, in 2024/25 the LLR workforce would work collaboratively with the LLR Primary Care Training Hub with the ambitions of workforce retention and provision of resources to improve the workforce experience. Initiatives including:

- **Supporting GP recruitment -** funding available to support practices and GPs (International Medical Graduates) to meet visa sponsorship costs.
- **ARRS / New to primary care induction programme -** rolling programme of a flexible, modular induction designed for anyone (clinical or non-clinical) working in primary care.
- **GPN Practice assessor programme -** upskilling nurses to provide effective supervision and support for students
- **Legacy Nurse mentoring pilot -** our legacy nurse mentors are in post and available to support nurses who are newly qualified, or new to primary care.
- **Communities of practice for roles in primary care -** networks have now been created for nursing, pharmacy, physician associates, paramedics, personalised care roles and practice managers.
- **Apprenticeships -** Student Nurse Associate programme (both direct entry and traditional route supported), Community Health and Wellbeing Worker pilot.

54. The ICB in partnership with practices and Primary Care Network is proposing to undertake another localised survey in early 2025. This will enable the local health system to understand experiences of GP practice access and services and further monitor the progress and outcome of improvements plans, ensuring that local needs are met and we are improving the health and wellbeing of our local population.

Equality Implications

55. The purpose of the improvements plans is to reduce health inequalities in access to, and experience of accessing and using GP practice services in LLR.

Human Rights Implications

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

Appendices

57. There are no appendices. There is a hyperlink to the full GP practice Patient Survey Report of Findings.
https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/

Recommendation

58. The Leicester, Leicestershire and Rutland Joint Health Scrutiny Commission is asked to discuss and note the update on GP practice service improvements.

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Agenda Item 9

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 17 July 2024

ACCESS TO DENTAL SERVICES FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

REPORT OF THE CHIEF STRATEGY OFFICER

Purpose of report

1. The purpose of this report is to provide an update on dental services and future plans to improve dental access in Leicester, Leicestershire and Rutland.

2. The Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee received an 'information only' report on dental services in March 2024. This latest report provides a further update and gives Committee members the opportunity to ask questions at the public meeting.

Policy Framework and Previous Decisions

3. The Dental Recovery Plan published on 7th February 2024 announced plans to improve access to NHS Dentistry. Nationally, the plan could see up to 2.5 million additional NHS dental appointments delivered for patients over the next 12 months, including up to 1.5 million extra treatments being delivered, referenced in sections 9 and 10.

Background

4. NHS England was responsible for commissioning of NHS dental services until the end of March 2023. Since 1 April 2023, the East Midlands Integrated Care Boards (ICBs) have taken on the responsibility for commissioning NHS dental services e.g., primary, community and secondary dental care to meet the local population needs as part of delegation arrangements.

5. A governance structure has been agreed that enables the ICB to set the annual plan and strategic direction of the dental function and make localised decisions where possible, whilst the current dental commissioning team (who are hosted by Nottingham and Nottinghamshire ICB on behalf of the five ICBs in the East Midlands) are enabled to deliver day-to-day contracting and commissioning functions. The process has been designed to ensure minimal disruption and smooth transition to support both services and patients.

6. NHS England has recently published 2024/25 priorities and operational planning guidance on 28 March 2024 which identifies dental planning objectives for the ICB (see section 8.2 National Dental Contract Reform for further details relating to the plan to recover and reform NHS dentistry): -

- To increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels.
- To implement dental checks within special residential schools during 2024/25, following engagement and market testing.
- To apply a ringfence to NHS dentistry budget for 2024/25, to establish current and planned spend against the ringfenced allocation budget and to identify opportunities to support contractors to deliver additional capacity beyond their existing contractual requirements.

7. On 7 February 2024, NHS England and the Department of Health and Social Care (DHSC) published a joint plan to recover and reform access NHS dentistry. This plan is an important next step in improving patient access to NHS dental care and supporting dental services to return to pre-pandemic levels of activity. It aims to:

- prevent poor oral health;
- boost access and activity;
- and support and develop the whole dental workforce.

Current Service Provision

8. Current service provision is as follows:

- NHS General Dental and Orthodontic Services

There are currently 133 general dental contracts across LLR. This includes 6 Specialist Orthodontic Practices, 13 GDS Practices that provide orthodontics and 7 Specialist Orthodontic Pathway Providers.

Extended hours, urgent dental care and out of hours

There are 5 contracts in LLR. The 8-8 NHS dental service provides access to patients from 8am to 8pm every single day of the year (365 days) and delivers both routine and urgent dental care.

9. Out of hours dental services only provide urgent dental care. Urgent dental care is defined into three categories as shown in Table 1 along with best practice access timelines for patients to receive self-help or face to face care.

Table 1: Triage category and associated timescale in relation to dental need

Triage Category	Timescale
Routine Dental Problems	Provide self-help advice and access to an appropriate service within 7 days, if required. Advise patient to call back if their condition deteriorates
Urgent Dental Conditions	Provide self-help advice and treat patient within 24 hours. Advise patient to call back if their condition deteriorates
Dental Emergencies	Provide contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition

10. If a person has a regular dental practice and requires urgent dental care:
- During surgery hours, they should contact their dental practice directly.

- Out of hours, they should check their dental practice's answer machine for information on how to access urgent dental care. Most people are signposted to contact NHS 111 (interpreters are available).
- For deaf people, there is also the NHS 111 BSL Service (alternatively, they can also call 18001 111 using text relay). There is also an online option for contacting NHS 111 that will often be quicker and easier than phoning.

11. If a person does not have a regular dental practice and requires urgent dental care, they can contact:
    - any NHS dental practice during surgery hours to seek an urgent dental appointment and this would be dependent on the capacity available at each dental practice on any given day. They can use the Find a Dentist facility on the NHS website.
    - NHS 111, either online or on the phone (interpreters are available). For deaf people, there is also the NHS 111 BSL Service (alternatively, they can also call 18001 111 using text relay)

12. Patients with dental pain should not contact their GP or attend A&E as this could add further delays in gaining appropriate dental treatment as both GP and A&E services will be redirecting such patients to a dental service. At times of peak demand, patients may have to travel further for treatment depending on capacity across the system.

Community (Special Care) Dental Service

13. Community Dental Services provide dental treatment to patients whose oral care needs cannot be met through NHS primary dental services due to their complex medical, physical or behavioural needs. The service uses behavioural management techniques and follows sedation and general anaesthesia (GA) pathways. Dentists and/or health care professionals can refer patients into the service. There are 5 Community Dental Service sites across LLR in: Melton Mowbray, Merlyn Vaz Leicester, Westcotes Health Centre Leicester, Hinckley and Loughborough.

Intermediate Minor Oral Surgery (IMOS) Service

14. The IMOS service is a specialist referral service in primary care providing complex dental extractions for residents in the LLR system. This service is for patients over the age of 17 years who meet the clinical criteria. There are 10 IMOS providers located across LLR. There is also 1 Acute Trust providing Orthodontics / Oral and Maxillofacial surgery.

NHS Dental Charges

15. Dentistry is one of the few NHS services where patients pay a contribution towards the cost of NHS care. The current charges are:
    - Emergency dental treatment –£26.80 which covers emergency dental care such as pain relief or a temporary filling.
    - Band 1 course of treatment – £26.80 which covers an examination, diagnosis (including X-rays), advice on how to prevent future problems, a scale and polish if clinically needed, and preventative care such as the application of fluoride varnish or fissure sealant if appropriate.

- Band 2 course of treatment – £73.50 which covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or removal of teeth but not more complex items covered by Band 3.
- Band 3 course of treatment – £319.10 which covers everything listed in Bands 1 and 2 above, plus crowns, dentures, bridges and other laboratory work.
- More information on understanding NHS dental charges is available here (enter website details). All NHS dental practices have access to posters and leaflets that should be displayed prominently.

16. Exemption from NHS charges is when patients do not have to pay these costs, for instance when receiving certain benefits. If this is the case, then proof of entitlement would need to be presented at the NHS dental practice. It is the patient's responsibility to check whether they are entitled to claim for free dental treatment or prescription. Financial support is also available for patients on a low income through the NHS Low Income Scheme.

Local Authority	Population	All Pop Accessing NHS Dentistry July - Dec 23	% All Pop Accessing NHS Dentistry July - Dec 23	Adults Accessing NHS Dentistry July - Dec 2023	% Adults Accessing NHS Dentistry July - Dec 2023	0-17 Accessing NHS Dentistry July - Dec 2023	% 0-17 Accessing NHS Dentistry July - Dec 2023
Blaby	102,933	35,411	34.40	23,917	29.41	11,501	53.30
Charnwood	183,978	50,561	27.48	33,565	22.49	17,006	48.95
Harborough	97,631	33,501	34.31	23,183	29.74	10,324	52.47
Hinckley and Bosworth	113,640	37,789	33.25	26,643	29.12	11,149	50.34
Leicester	368,569	99,430	26.98	58,282	20.71	41,200	47.29
Melton	51,751	12,841	24.81	7,670	18.34	5,174	52.14
North West Leicestershire	104,706	32,236	30.79	21,724	25.92	10,515	50.29
Oadby and Wigston	57,753	19,616	33.96	13,236	28.85	6,385	53.78
Rutland	41,050	8,166	19.89	5,166	15.52	3,052	37.72

The tables below show the latest dental access and commissioning data (July – December 2023) for LLR, further broken down by local authority.

Local Authority	IMD Decile	Ave Distance Travelled	UDAs Commissioned per head Population 23/24	UDA Performance Target 23/24	UDA Delivered 23/24	UDA % Delivered 23/24	UDAs Delivered per head Population 23/24
Blaby	9	4.3	1.33	136,712	128,927	94.31	1.25
Charnwood	8	5.4	1.70	313,356	235,850	75.27	1.28
Harborough	10	6.4	1.31	128,161	113,889	88.86	1.17
Hinckley and Bosworth	8	6.6	1.40	158,903	121,482	76.45	1.07
Leicester	2	3.6	1.70	625,644	583,010	93.19	1.58
Melton	8	9.1	0.67	34,624	29,570	85.4	0.57
North West Leicestershire	7	5.9	0.98	102,536	103,387	100.83	0.99
Oadby and Wigston	8	4.5	1.39	80,228	76,566	95.45	1.33
Rutland	10	6.9	1.13	46,464	34,390	74.01	0.84

Figure 1 - Delivery trend for LLR ICB since the pandemic (April 2021 to June 2024)

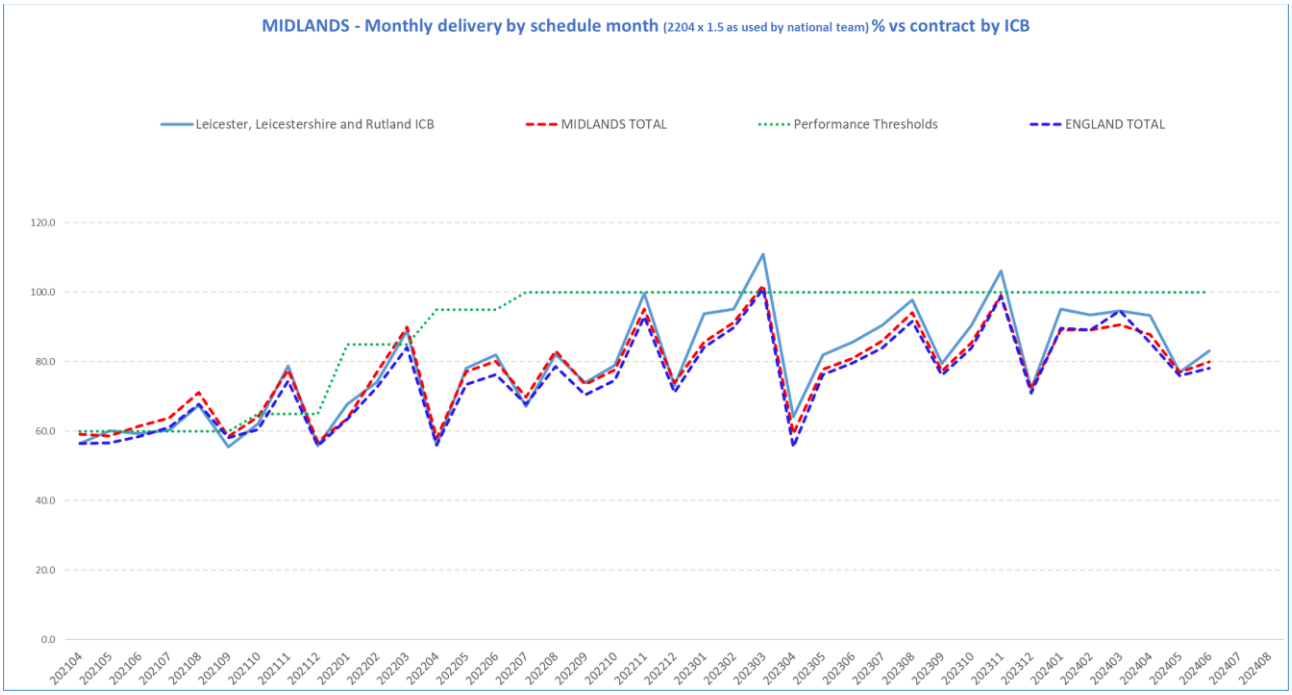

Figure 1 shows the percentage of contracted dentistry delivery per month across LLR. As shown above there has been a gradual increase in the average monthly delivery since the pandemic.

Figure 2 The Number of Unique Dental Patients Seen (March 2018 – May 2024

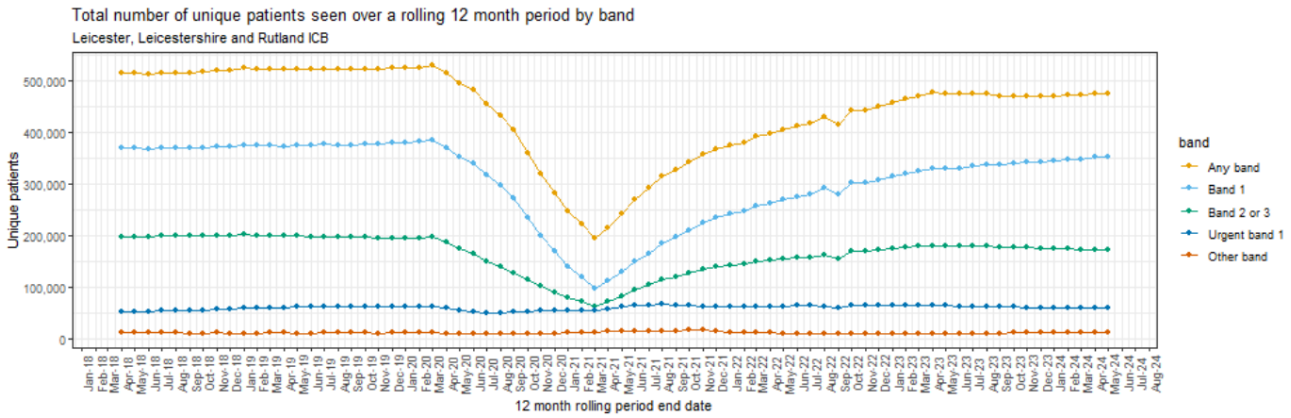

Figure 2 shows the number of unique patients seen over a 12 month rolling period which currently stands at around 92% of pre-pandemic levels. A unique patient refers to if a patient is seen more than once during the reporting period, then for purposes of measurement that patient is only counted once.

Figure 3 The Number of New Patients Seen (April 2022 – May 2024)

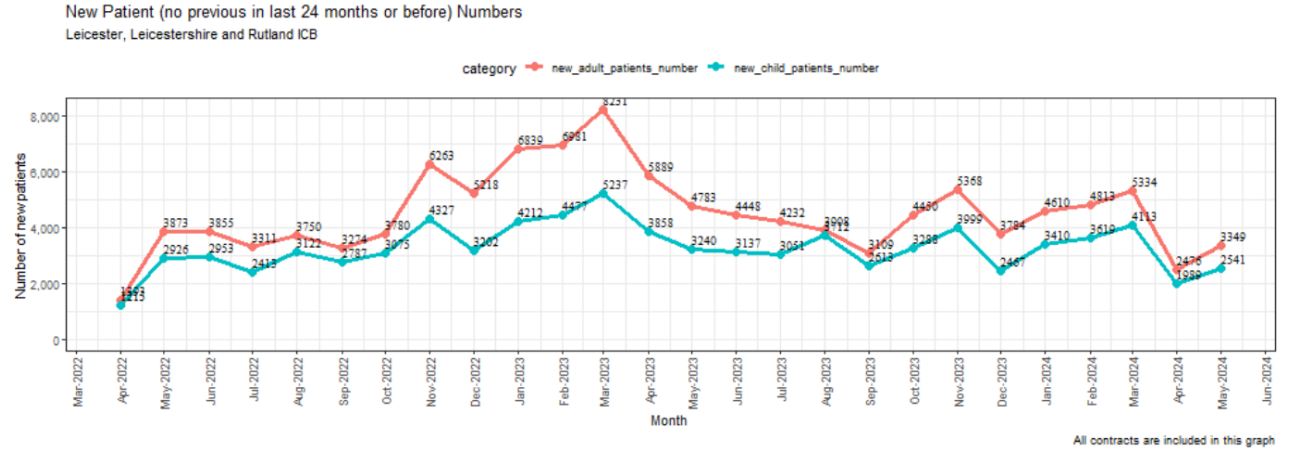

Figure 3 shows the number of new adult and child patients attending dental appointments who previously had no attendance in the last 24 months. For both adults and children, since April 2022, the number of new patients seen has increased with 3349 new adult patients and 2541 new child patients seen in May 2024.

Private Dentistry

17. Private dental services are not within the scope of responsibility for the LLR ICB. Therefore, the ICB is unable to provide any information on activity uptake within the private dentistry sector.

18. It should be noted that dental practitioners are independent contractors to the NHS and therefore many dental practices operate a mixed private/NHS model of care.

19. Some patients who have previously accessed dental care privately may now be seeking NHS dental care due to financial problems related to the cost of living crisis. This may place additional pressure on NHS services at a time when capacity remains constrained. Although these patients are eligible for NHS dental care, they may have difficulty in finding an NHS dental practice with capacity to take them on. Paragraphs 23 to 27 below highlight some of the ways we are looking to improve access to NHS dentistry.

Dental contract hand-backs

20. Since February 2021, across LLR there have been 14 contract terminations. Locations of terminated practices include Melton Mowbray, Loughborough, Oakham, Leicester, Ashby de la Zouch and Uppingham.

21. As part of the dental termination process, any NHS dental practices that are handing back their NHS activity must agree a communication letter for their patients with the commissioner. This letter notifies patients that the dental practice will no longer be providing NHS dental care and provides appropriate signposting to other nearby practices who are able to take on new patients, to continue gaining access to NHS dental care. This provides assurance to the commissioner that there is no inappropriate/forced sign-up to private dental services and enables informed patient choice.

22. Any dental activity from a terminated contract will not be lost. The ICB, East Midlands Primary Care Team and Dental Public Health colleagues continue to review the dental access data and understand the impact for patients. The normal process for terminations is to undertake a review and recommission the dental activity by dispersal to local dental practices surrounding the terminated contract or via a full procurement process. Any dental activity that has not currently been able to be dispersed will form part of a wider procurement exercise in 24/25, informed by an Oral Health Needs Assessment due to be released as detailed in section 10 below.

Future Plans to Improve Access/Oral Health

23. Work is underway nationally to transform the NHS Dental contract with the aim of ensuring patients most in need can access NHS dentistry, as set out in the Dental Recovery Plan. This plan is an important next step in improving patient access to NHS dental care and supporting dental services to return to pre-pandemic levels of activity.

24. Measures include:
    - NHS dentists will be given a ‘new patient’ payment of between £15-£50 (depending on treatment need) to treat patients who have not seen an NHS dentist in two years or more. This commenced in March 2024 and is time limited to the end of financial year 2024/2025.
    - Targeted funding to encourage dentists to work in areas which historically have been difficult to recruit to.
    - A further increase in the minimum indicative UDA value from the £23 announced in July 2022 to £28 from April 2024.
    - Improving access in underserved areas through the use of dental vans.

25. In addition to these activities, the plan announces a range of government-delivered public health initiatives to improve the oral health of children and recommits to the workforce growth and development outlined in the Long-Term Workforce Plan.

26. Further to the measures above, a water fluoridation programme will be rolled out by government, the aim of which is to reduce the number of tooth extractions due to decay in the most deprived areas of the country. Subject to consultation, the programme would enable an additional 1.6 million people to benefit from water fluoridation.

27. The East Midlands Primary Care Team, working on behalf of the five East Midlands NHS Integrated Care Boards have worked swiftly to meet national timeframes to enact the required changes to support contractors and patients through the new measures announced within the Dental Recovery Plan:

New Patient Premium

28. In accordance with the issued guidance criteria, the team identified LLR contracts and corresponded with contractors to advise them of their eligibility for the scheme between 1st March 2024 and 31st March 2024. Scheme criteria was reevaluated for 2024/25 extending the number of LLR contracts undertaking the scheme to a total of 137. The team will continue to review the impact of the scheme through monthly data monitoring.

ICB	**Number of Contracts Eligible for the Scheme (1st April 2024 - 31st March 2025)**	**Number of contracts selected by provider to be opted out of the scheme (1st April 2024-31st March 2025)**
LLR	137	1

Increase in the minimum indicative UDA value

29. National guidance to commissioners were issued to support the process required to be undertaken to introduce the minimum indicative UDA value of £28 from 1st April 2024. This can be achieved through either:

    1. A reduction to the number of a contractor's commissioned UDAs; or
    2. An increase to a contractor's Negotiated Annual Contract Value (NACV).

30. The team undertook a review of the NHSBSA data for contract eligibility to receive a change to their commissioned UDAs (option 1) or their NACV (option 2) due to an indicative UDA value of below £28. Eligibility consideration has been undertaken including historic contract delivery and any other local considerations to support the decision-making process on which option is appropriate for each contract.

31. The LLR ICB assessed the East Midlands Primary Care Team recommendations for contract eligibility and made decisions on whether to reduce activity or invest more money for all impacted contracts.

Table 1: Contracts identified to receive a change to annual commissioned UDAs

ICB	Number of contracts identified to receive change to annual commissioned UDAS (option 1)	Number of UDAS reduced per annum
LLR	8	10969

Table 2: Contracts identified to receive change to NACV

ICB	Number of contracts identified to receive change to NACV (option 2)	£ Increased investment required
LLR	38	£494,050.80

32. To enact contract changes in line with the 1 April 2024, providers were issued with appropriate contract variation notice for signature and return for counter signature by 15th March 2024. All returned CV's for East Midlands contractual changes have been actioned by NHSBSA in line with April 2024 Compass cutoff date.

Dental Recruitment Incentive Scheme 2024/25

33. The offer of incentive ('golden hello') payments has been used across different parts of the NHS to aid recruitment in areas of the country that have traditionally been hard to recruit to.

34. The aim of the Dental Recruitment Incentive Scheme (DRIS) is to offer a financial incentive to attract dentists to commit to work in parts of the country that are struggling to attract workforce through the usual recruitment routes. The scheme is designed to encourage relocation to these areas, attract new workforce to the NHS, and retain those who might otherwise have left the service.

35. The scheme is also open to the recruitment of dentists from overseas. The inclusion of overseas dentists widens the opportunity to attract dentists into areas with workforce challenge.

36. As announced on 13th May 2024, a 'golden hello' bonus payment of £20,000 will be offered per dentist for up to 240 dentists across England, 20 of which are allocated to the East Midlands. Each ICB across the East midlands will receive 4 places each.

Flexible Commissioning

37. The flexible commissioning scheme aims to make NHS dental contracts more adaptable by allowing a proportion of UDAs to be filled through locally agreed schemes. Flexible Commissioning aims to refocus a section of existing commissioned activity to increase capacity to deliver specific programmes or incentivise activity.

38. A framework was published on 9th October 2023 by NHS England on the opportunities for flexible commissioning in primary care dentistry which provided an outline to ICBs of the legal requirements of the national dental contractual framework whilst highlighting the key considerations associated with procuring additional and further services which were previously termed 'flexible commissioning'. https://www.england.nhs.uk/long-read/opportunities-for-flexible-commissioning-in-primary-care-dentistry-a-framework-for-commissioners/

39. LLR ICB is currently reviewing this framework, whilst awaiting further supplementary guidance from NHS England. The review will include working collaboratively with Dental Public Health Consultants and the East Midlands Primary Care Team to determine how best to commission additional NHS dental access within the framework guidance. This review is expected to complete by late Winter 2024.

Oral Health Needs Assessment (OHNA)

40. An Oral Health Needs Assessment (OHNA) for LLR has now been drafted, looking to identify local groups of people who are at high risk of poor oral health, and to determine their likely needs. This has been developed in conjunction with the Dental Public Health Consultant and Local Dental Network (LDN) chair.

41. The review recommendations will inform the general dental services procurement programme and commissioning requirements for LLR ICB which will need to be incorporated into a workplan for 2024/25. This will support evidence-based commissioning decisions regarding future NHS dental provision.

42. The draft OHNA is currently being peer reviewed and is to be approved formally at tier 2 dental governance, ready to be circulated widely in August 2024.

Leicester City Oral Cancer Campaign

43. An investment of £10k was made to support an oral cancer campaign. Details of the project include:

- A social marketing campaign to raise awareness of the symptoms of oral cancer.
- Messages that reach those at high risk of oral cancer
    - People living in Leicester City, especially in high incidence areas such as Belgrave, Beaumont Park and Rushey Mead;
    - Males and females, especially males aged 40-70;
    - Those who smoke or drink heavily (and especially those who do both);
    - People of all ethnic backgrounds and people who speak English as a first language and those who speak Gujarati or Punjabi as a first language.

The campaign is due to commence Autumn 2024.

Approved Commissioning Plans

44. A most suitable provider (MSP) procurement is set to commence September 2024, redistributing at least 10,000 UDA's in Rutland, as approved at dental governance in May 2024. A market engagement exercise will initially take place proceeded by going

out for an expression of interest for the providers in the Rutland area to try and capture recurrent additional activity.

45. Additionally in May 2024, funding for 84 additional general anaesthetic sessions was awarded to Community Dental Services in Leicester for 24/25, in order to reduce the current waiting list. These sessions will be a mixture of comprehensive care sessions, and exodontia sessions. Comprehensive care lists are GA sessions where children with severe learning and physical disabilities, who are unable to accept dental treatment in the dental surgery, have all the dental treatment they require (i.e. x-rays, fillings, extractions) conducted in one general anaesthetic appointment.

46. The Community Dental Support Practice (CDS) scheme also received a 12 month extension until 31st March 2025. The scheme is designed to upskill general dental practices to provide high quality care for children, within the scope of a general practitioner, thus providing dedicated additional capacity to take pressure off CDS so enabling them to reduce the waiting times for the backlog of children needing care.

Future Commissioning Plans

47. A joint East Midlands Planning Day took place on 10 May 2024 to discuss the future commissioning intentions for each ICB across the East Midlands. Based on discussions a commissioning plan on a page for LLR was drafted, informed by the draft Oral Health Needs Assessment.

48. A series of commissioning principles were also agreed to underpin any future commissioning plans. These included:

- The 2024/25 budget plans have been developed on the basis to achieve a balanced plan;
- To fully utilise the Dental budget ring fenced allocation to improve access to NHS Dental Services;
- To implement the Dental Recovery Plan initiatives in 2024-25 e.g., Unit of dental activity uplift to minimum of £28, New patient premium and Golden Hello scheme;
- To target investments to areas of greatest need and reduce inequalities within the East Midlands to improve access and reduce waiting lists as soon as possible aligned to the Oral Health Needs Assessment, within resources available;
- Commissioning investment demonstrates value for money, improves quality and patient access;
- To develop an East Midlands Quality Framework with a menu of outcome focussed options to support with implementation of flexible commissioning;
- Decision Tree to support implementation of East Midlands Quality Framework to identify the most appropriate commissioning approach;
- To focus on identified key priorities (determined by priority grouping) in 2024/25 detailed in the Dental Commissioning plan aligned to the Oral Health Needs Assessment;
- Undertake a review of fixed term resources required to support delivery of 3-year dental commissioning plan and seek governance approval.

49. The plans will be prioritised to enable LLR ICB to consider whether to support in which financial year.

Priority Group	Priorities	ICBs Determination
One	Mandatory National Directive e.g., Dental Recovery Plan or urgent need/planned recommissioning to maintain access	All to implement
Two	Aspirational if funding available or medium issue or concern, time to plan recommission in next 12-18 months e.g., 110% over performance	LLR ICB to determine at local level on need within resources available
Three	Low issues or concerns or time to plan future recommissioning in year 3	LLR ICB to determine at local level to meet need within resources available

50. To support future commissioning, a decision tree has been produced. The flow chart below offers the user several scenarios providing commissioning options depending on their contractual circumstances allowing commissioning decisions to be best placed whilst also offering local flexibility.

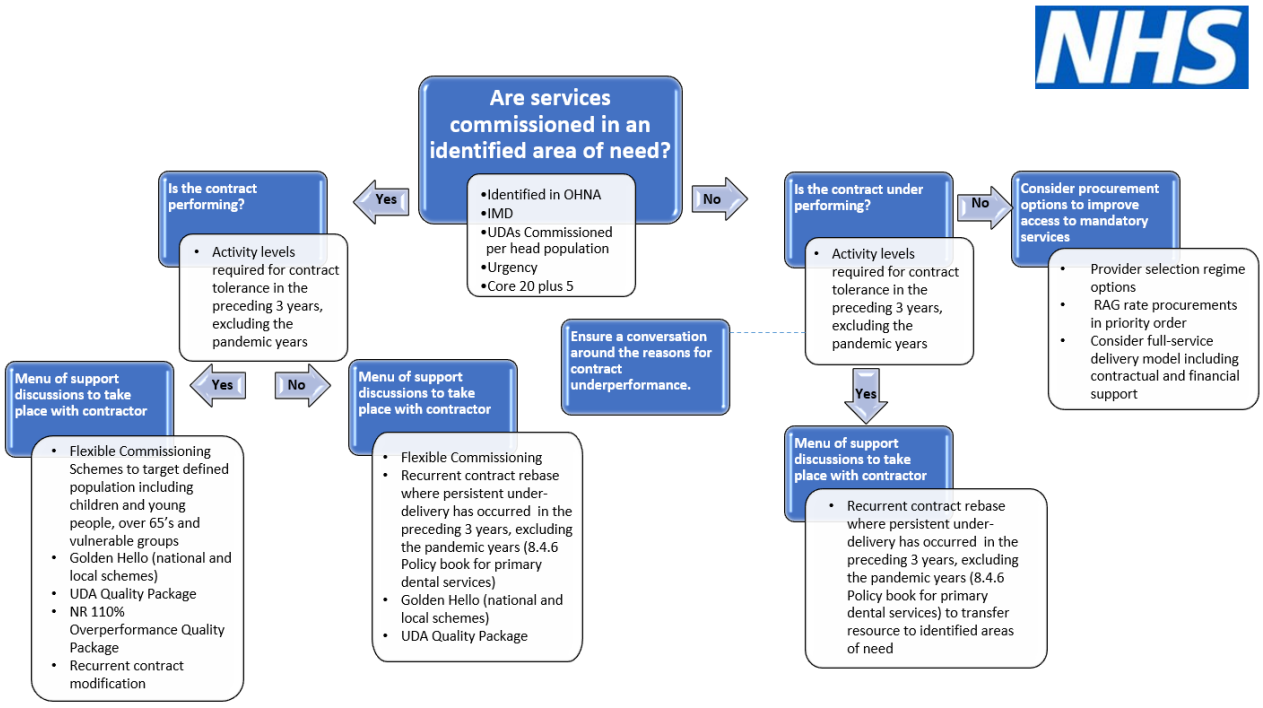

Figure 1 – Decision Tree

51. Additionally, to implement the increase in UDAs and support additional funding for Dental Practices in 2024/25, a robust methodology has been developed and will be used for all contracts where the increase in UDAs is being considered.

52. The use of the Quality Framework will enable Commissioners to apply additional quality indicators when considering an increased UDA rate. The four pillars of the framework have been developed to ensure the contractor is meeting the deliverables of their contractual obligation as well as providing additional assurances.

Figure 2 – Quality Framework

53. The Decision Tree and Quality Framework have been shared with the East Midlands Primary Care POD Quality and Risk Sharing Group to seek feedback to be incorporated into the final version.

Next Steps

Action	June	July	August	September
Oral Health Needs Assessments (OHNAs) Engagement and review of feedback				
OHNA Governance submission to seek sign off				
110% over performance review and governance paper for Julys tier 2 dental governance meeting				
Continued collaborative working to finalise the LLR ICB Dental Operational Commissioning Plans: • Review OHNAs to align and agree prioritisation. • Cost and Risk analysis • Engagement with LDN Chairs and dental profession				
ICB Dental Operational Commissioning Plans submission via ICBS internal governance process				

East Midlands Dental Operational Commissioning Plans submitted to tier 2 dental governance for formal sign off				

Non-Recurrent Investments 24/25

54. Work is currently underway to look at non-recurrent investment options for 2024/25 across LLR, following a dental contract baseline review identifying unallocated units of dental activity and non-recurrent funding available for 2024/25 from terminations. These plans include non-recurrent dental activity awards in areas of highlighted need along with recommendations to support the 110% overperformance scheme and flexible commissioning. A paper will be taken to tier 2 governance for approval in July to ratify the plans.

Procurement Regulations

55. The Provider Selection Regime (PSR) regulations came into force on 1st January 2024. This meant that NHS services were decoupled from the existing Public Sector Procurement Regulations 2015 in favour of a more flexible and pragmatic approach.

56. The PSR is intended to remove unnecessary levels of competitive tendering, removing barriers to integrating care and promote the development of stable collaborations.

Training and Education

57. As part of the NHS England Workforce, Training and Education (WTE), the School of Dentistry is currently working on different strategies to improve workforce recruitment, retention, training and development. This includes expanding training numbers within the East Midlands, increasing numbers of international dental graduates, expansion of specialist training posts and workforce development.

Future Plans Timeline Summary

- New Patient Premium – completed.
- Increase in the minimum indicative UDA value – completed.
- Flexible Commissioning – to be completed Winter 2024
- The Dental Recruitment Scheme – to be completed 24/25
- Oral Health Needs Assessment – completed.
- Commissioning Plans 24/25, 25/26 – Ongoing, sign off September 2024
- Training and Education – TBC following national guidance.

*Timelines may be subject to change

Background papers

2. Dental recovery plan: everything you need to know. - Department of Health and Social Care Media Centre (blog.gov.uk)

Equality Implications

58. Equality Health Quality Impact Assessments are completed as part of pre-procurement planning process. Due consideration has been undertaken as part of developing commissioning intentions. This will be revisited and refreshed where required prior to relaunching the procurement process.

Human Rights Implications

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

Other Relevant Impact Assessments

Health Implications

60. As part of pre-procurement planning processes an Equality Health Quality Impact Assessment is completed.

Officer(s) to Contact

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Leicestershire Partnership NHS Trust

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 17 JULY 2024

LEARNING DISABILITY AND AUTISM COLLABORATIVE

REPORT OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

Executive Summary

1. The LLR Learning Disability and Autism (LDA) Collaborative was established in October 2022 to improve services for people with a learning disability and autistic people. A Memorandum of Understanding (MOU) was in place between Leicestershire Partnership Trust (LPT) and the LLR Integrated Care Board (ICB) placing responsibility for the leadership of the Collaborative with LPT; this arrangement moved to a formal contract on 1 April 2024.

2. The Collaborative works closely with Leicester, Leicestershire and Rutland (LLR) local authorities and other stakeholders to commission, deliver and improve services for people with a learning disability and autistic people living in our area.

3. The Collaborative benefits from strong and inclusive collaborative leadership practices, the diversity of skills of the multiagency team, robust programme and project management, energetic engagement and co-production, and a vibrant health equity agenda (Appendix 1).

4. The Collaborative has significantly improved performance in the areas that it is accountable for (Appendix 2):

    - Reducing the number of people with a learning disability and autistic people being cared for in hospital;
    - Ensuring timely learning through reviews of the lives and deaths of people that die, and;
    - Ensuring people with a learning disability access their Annual Health Checks (AHCs).

LDA Collaborative Priorities 2024/25

5. During 2024/25, the LDA Collaborative is focusing on several agreed priority areas:

- **Earlier Help for Autistic Adults:** adopting a robust three pillar response (Keyworkers, Dynamic Support Pathway (DSP) and Care and Treatment Reviews (CTR)) in partnership with adult mental health services that provides improved quality of life through earlier intervention, reduced admissions to hospital and earlier discharge.

- **Stronger Community Care:** improved quality of care from community providers and improved care environments through improved contracting, benchmarking, support and training (focused on Positive Behavioural Support (PBS)). Fewer people therefore requiring hospital care.

- **Reduced Inequalities**: more inclusive measurement of progress to reduce inequalities that aligns to our Collaborative Vision (Appendix 3), supports partners plans and directs investment. Further increases in the number of people benefitting from Annual Health Checks and good quality Health Action Plans. A robust response to our LeDeR 'top ten' (Appendix 4) across health and care services e.g. improved nutrition support, more appropriate use of the Mental Capacity Act and a reduction in the medication of autistic adults.

- **Greater involvement of care providers:** a more inclusive community of practice that helps all service providers to improve the quality of care experienced by people with a learning disability and autistic adults. A broader and more inclusive community that celebrates excellent care, earlier help and a healthier and a more empowered population.

- **Better Access:** a reduction in waiting times experienced by people for Leicestershire Partnership NHS Trust LDA services that reflects the impacts of combined inequalities (intersectionality).

- **Improved employment and carer support:** aligned strategies and plans across health and care for Learning Disability, Autism and children and young people with a Special Educational Needs or Disabilities, shaped by lived experiences, more people in employment, and better access to respite care.

LDA Inpatient Performance

6. Over recent years, the number of adults, children and young people with a learning disability and autistic people in mental health hospitals has reduced substantially; ensuring many more people are able to live in a less restrictive setting and experience more fulfilling lives, closer to family and friends in their own community.

7. The most recently published national data confirmed that LLR was ranked second in the Midlands and eighth nationally in terms of our inpatient performance.

8. LLR is currently either at or below trajectory for both our adult, and children and young people inpatient performance. We are adopting a reporting mechanism by diagnosis, aligning with the national planning guidance requirement to reduce admissions of autistic people into mental health inpatient care and continue to discharge people with a learning disability with the longest lengths of stay.

Learning from the lives and deaths of people with a learning disability and autistic people - (LeDeR Reviews)

9. Learning from the lives, and deaths, of people with a learning disability and autistic people through LeDeR reviews is a key priority for the LDA Collaborative; through comprehensive LeDeR reviews we can ensure that important learning is shared, and implemented, across both health and social care with the aim of increasing the level of care provided and increasing overall life expectancy for individuals with a learning disability and autistic people.

10. LLR is currently joint second in England in relation to the number of LeDeR reviews completed within the 6 months KPI timeframe.

11. During 24/25, communication and learning from LeDeR reviews has been enhanced with the publication of the LeDeR Top 10 – this is a practical guide for staff and teams to help them set local improvement goals. Importantly, this also seeks an increase in the referral rate to LeDeR following the deaths of autistic individuals who do not have a learning disability (a new cohort included in the programme in 23/24).

12. The Collaborative is adopting a reporting mechanism focusing on the six high impact actions outlined by NHS England and continuing our focus on embedding learning into action from all LeDeR reviews.

Annual Health Checks

13. The Collaborative has been working to increase the uptake of Annual Health Checks (AHCs) for people aged over 14 years with a Learning Disability.

14. The national target is for 75% of the people included on the GP LD Register to attend an AHC and during 23/24 the LLR achieved 82.6%, making us the highest performing system in the Midlands and 5th nationally.

15. During 24/25 the Collaborative is continuing our focus on those individuals who had not attended their AHC for two years or more and increasing uptake of AHCs amongst those aged 14-20 years.

16. The Primary Care Liaison Nurses are continuing to work with the GP practices in LLR to further improve the accuracy and size of the LD Registers and focus on improving the quality of the accompanying individual Health Action Plans.

Plans for 2024/25

17. During 2024/25, the Collaborative will continue:

- Our joint working and focus on reducing the numbers of adult and young people in hospital;
- Continue to deliver the annual health checks prevention programme across primary care;
- Continue to review every death of an autistic person in LLR and those with a learning disability;
- Develop a programme of work to ensure we can apply the quality principles we have in hospitals in our commissioned community services to ensure everyone has access to high quality care.

Supporting the LDA Collaborative

18. As members of the Joint Health Scrutiny Committee, the LDA Collaborative is seeking your support in the following areas:

- Implement the LeDeR Top 10 actions identified from local learning to help prevent deaths of people with a learning disability and autistic people (aged 18 and over);
- Strengthen the response to the needs of people with a learning disability and autistic people across the system in non-specialist services;
- Press for further improvements in Annual Health Check uptake and associated Health Action Plans;
- Take every opportunity to speed up adoption of the Reasonable Adjustment Digital Flag (RADF) across the system;
- Encourage all partners to complete the Oliver McGowan Mandatory Training on Learning Disabilities and Autism;
- Seek all opportunities to embed learning disabilities and autism considerations in all pathways, strategies and plans across all system partners.

Recommendations

19. The Committee is requested to:

(a) Note the LDA Collaborative's achievements to date and our priorities for 2024/25;

(b) Support the LDA Collaborative in championing the importance of supporting people with a learning disability and autistic people across LLR.

Officers to contact

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Appendix 1

Supporting the LDA Collaborative – Health Inequalities

The LDA Health Inequalities Group has an ambitious programme of work informed by the learning from LeDeR reviews and split into 5 key areas:

- Population Health
- LD Health Checks & Access to Primary Care
- Staying Healthy and Well
- Adult Screening
- STOMP/STAMP

As members of the Joint HOSC, the LDA Collaborative is seeking your support to further increase engagement with the Health Inequalities leaders and Health Equity Champions across the system.

Health Inequalities in LLR:

- We know that there are considerable health inequalities for local people with a learning disability and autistic people across LLR.
- Our learning from deaths reports tell us that if you live in LLR with a LD, your life will be up to 25 years shorter than other people in LLR.
- We believe that there could be even greater inequalities for individuals from different communities and we have more work to do to understand and address inequalities in our services.

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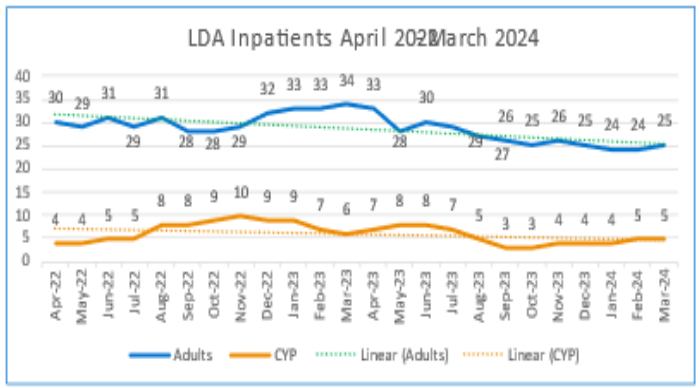
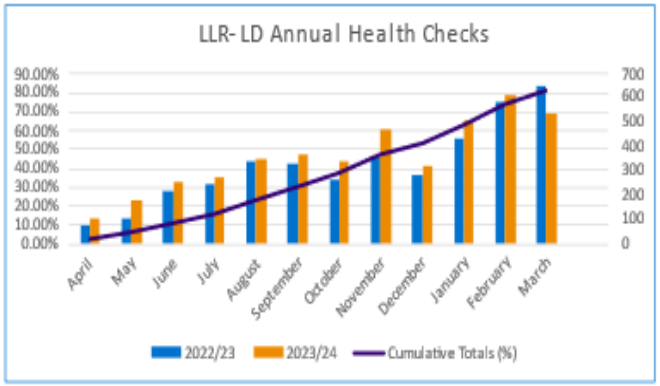
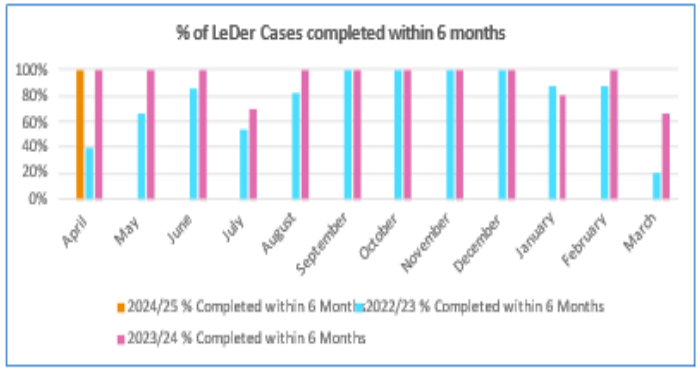
Appendix 2

LLR LDA Collaborative– Performance







LDA Inpatient numbers: LLR is ranked 2nd in the Midlands and 8th nationally

LD Annual Health Checks: LLR ranked 1st in the Midlands and 5th nationally for 23/24

LeDeR: LLR is ranked 2nd nationally for % of cases completed within 6 months

OMMT: LLR is one of the highest performing systems regionally, for both Tier 1 and Tier 2 completion rates.

Appendix 3


Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership
Learning Disability and Autism Collaborative
Our Vision
for people who live, work or study in Leicester, Leicestershire and Rutland, and their families
We want everyone to have good, happy lives.
We want everyone to be as healthy as they can be.
We want to make sure everyone has the chance to do the things that make them happy and join in.
We want to make sure everyone has the chance to do the things that make them happy close to where they live.
We want to make sure everyone has the chance to do the things that make them happy with people they want to spend time with.

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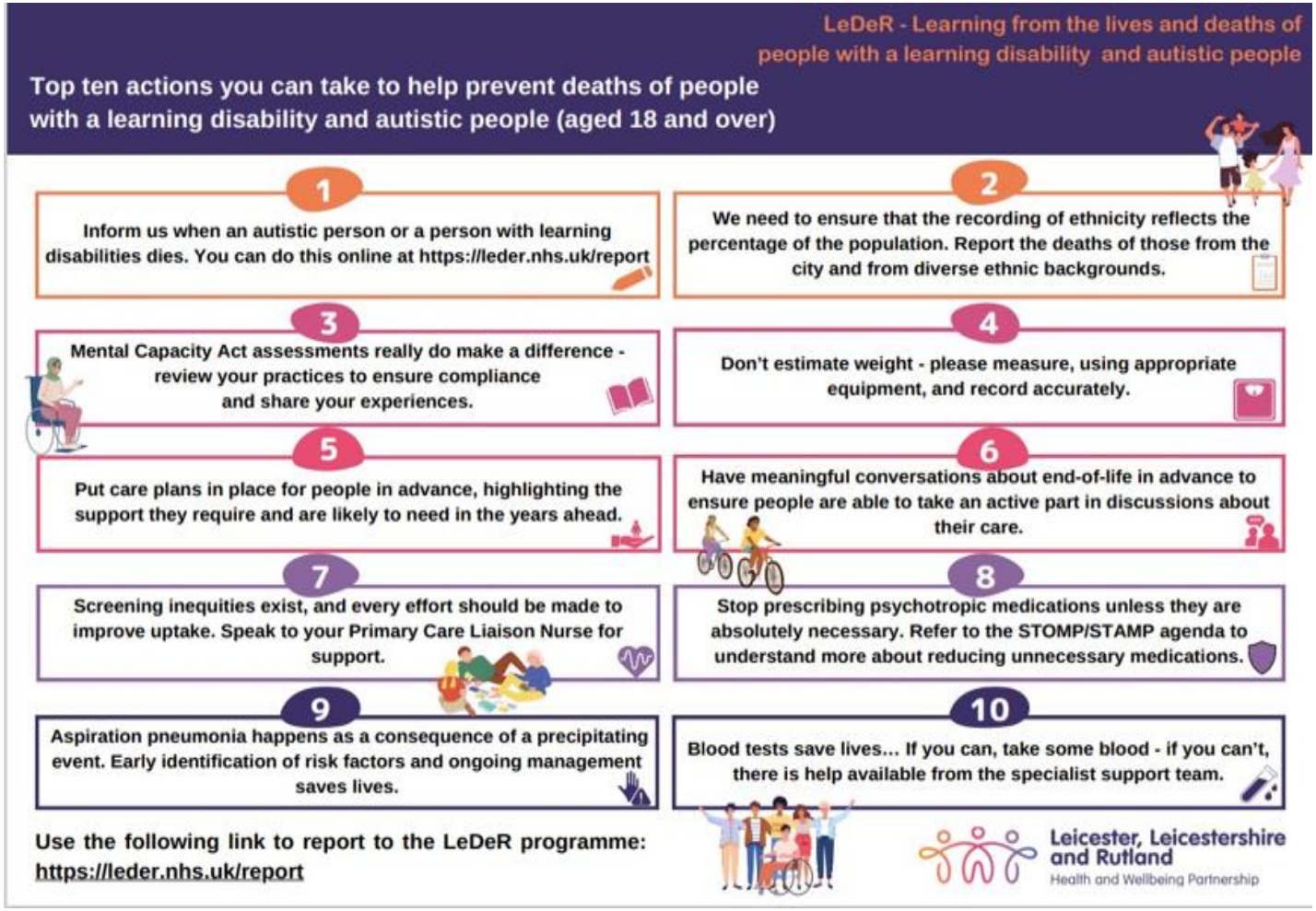
Appendix 4


LeDeR - Learning from the lives and deaths of people with a learning disability and autistic people
Top ten actions you can take to help prevent deaths of people with a learning disability and autistic people (aged 18 and over)
1
Inform us when an autistic person or a person with learning disabilities dies. You can do this online at https://leder.nhs.uk/report
2
We need to ensure that the recording of ethnicity reflects the percentage of the population. Report the deaths of those from the city and from diverse ethnic backgrounds.
3
Mental Capacity Act assessments really do make a difference - review your practices to ensure compliance and share your experiences.
4
Don't estimate weight - please measure, using appropriate equipment, and record accurately.
5
Put care plans in place for people in advance, highlighting the support they require and are likely to need in the years ahead.
6
Have meaningful conversations about end-of-life in advance to ensure people are able to take an active part in discussions about their care.
7
Screening inequities exist, and every effort should be made to improve uptake. Speak to your Primary Care Liaison Nurse for support.
8
Stop prescribing psychotropic medications unless they are absolutely necessary. Refer to the STOMP/STAMP agenda to understand more about reducing unnecessary medications.
9
Aspiration pneumonia happens as a consequence of a precipitating event. Early identification of risk factors and ongoing management saves lives.
10
Blood tests save lives... If you can, take some blood - if you can't, there is help available from the specialist support team.
Use the following link to report to the LeDeR programme:
https://leder.nhs.uk/report
Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

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Learning Disability and Autism Collaborative

Presentation to Joint Health Overview and Scrutiny Committee

17 July

2024

Mark Roberts & Laura Rodman

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Learning Disability and Autism Collaborative

Our Vision

for people who live, work or study in Leicester, Leicestershire and Rutland, and their families

We want everyone to have good, happy lives.

We want everyone to be as healthy as they can be.

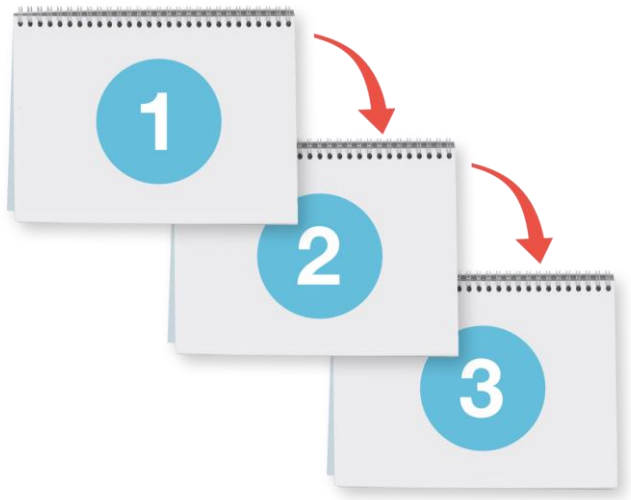
We want to make sure everyone has the chance to do the things that make them happy and join in.

We want to make sure everyone has the chance to do the things that make them happy close to where they live.

We want to make sure everyone has the chance to do the things that make them happy with people they want to spend time with.

We are working hard to make things better for people with learning disabilities and autistic people in Leicester, Leicestershire and Rutland.

We do this by working with people from the local authorities (Councils) and people with learning disabilities and autistic people.



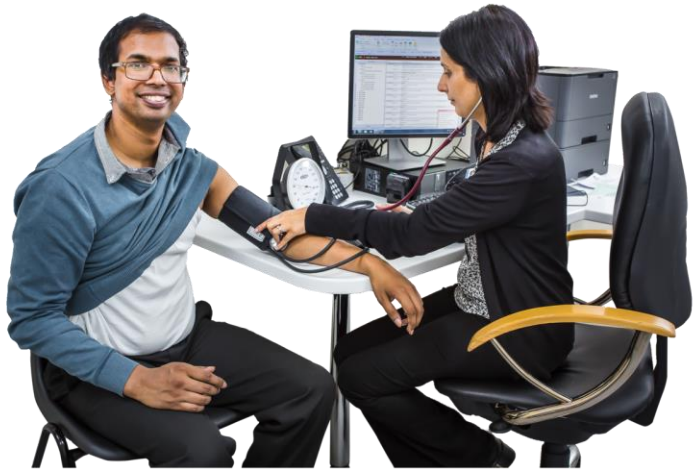
There are three things that are very important to us:

1. Reducing the number of people with a learning disability and autistic people being cared for in hospital
2. Making sure people with a learning disability have an Annual Health Check
3. Learning from the lives and deaths of people with a learning disability and autistic people.

We have seen less people with learning disabilities and autistic people being admitted to hospital than before.

This means more people are living closer to their family and friends and in their own communities.

We are working hard to make sure this continues, and people aren’t admitted to hospital when they don’t need to be.



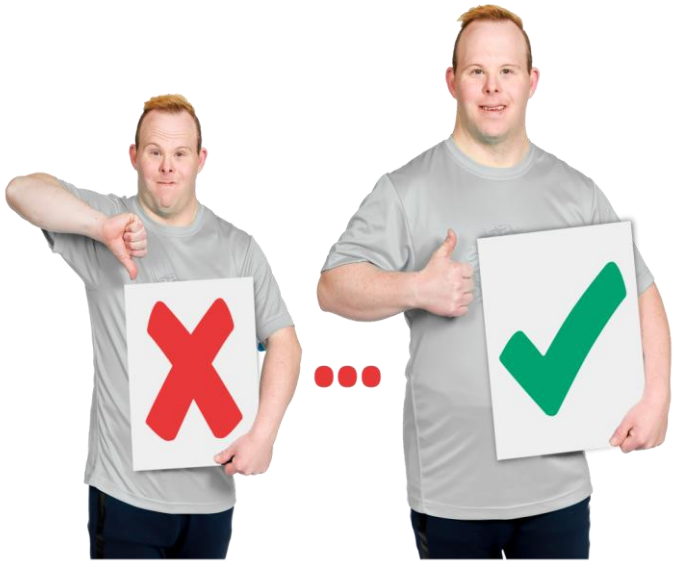
It’s important that people with a learning disability have checks to make sure they’re as healthy as possible.

Every year we try and get more people to visit their GP for these checks.

This year more people visited their GP for these checks than ever before.

We are working hard to make sure this continues every year.

We also want to find out why some people don’t have these checks and how we can help them to attend.



We want learn from things that have not worked for people and make them better next time (LeDeR)

We have put together a list of 10 actions people can take so we can learn even more about the lives and deaths of people with a learning disability and autistic people

We really want more referrals for autistic people, who do not have a learning disability.

At this meeting today, we are asking the people here to support us in our work to make things better for people with a learning disability and autistic people in Leicester, Leicestershire and Rutland.