Leicester
City Council

MEETING OF THE PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

DATE: **TUESDAY, 12 DECEMBER 2023**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Councillor Whittle (Chair)
Councillor Bonham (Vice-Chair)

Councillors Gopal, March, Modhwadia, Sahu, Singh Sangha and Zaman

Standing Invitee (Non-voting)
Representative of Healthwatch Leicester
Youth Council Representatives

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:
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Katie Jordan, Governance Support Officer
Tel: 0116 4546350, e-mail: committees@leicester.gov.uk
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USEFUL ACRONYMS RELATING TO PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

Acronym	Meaning
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DES	Directly Enhanced Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWB	Health & Wellbeing Board
HWLL	Healthwatch Leicester and Leicestershire
ICB	Integrated Care Board
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland

LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NEPTS	Non-Emergency Patient Transport Service
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
PPG	Patient Participation Group
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
UHL	University Hospitals of Leicester

PUBLIC SESSION

AGENDA

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1. WELCOME AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members will be asked to declare any interests they may have on any items to be discussed on the agenda.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A**

The Minutes of the meeting held on 7 November 2023 are attached and Members will be asked to confirm them as a correct record.

4. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer to report on any Questions, Representations or Statements of Case received.

5. PETITIONS

The Monitoring Officer to report on any Petitions received.

6. ICB 5 YEAR FORWARD PLAN - PLEDGE 4 GP ACCESS **Appendix B**

The Integrated Care Board (ICB) submits a report providing an overview of the NHSE Primary Care Recovery Plan (PCARP) and commitment to patients.

7. LEDER ANNUAL REPORT — Appendix C

The Director of Strategy and Partnerships for Leicestershire Partnership NHS Trust submits a report providing a summary to the LLR LeDeR Annual Report 2022/23 and offers key actions for learning for all partners.

8. COVID-19, FLU AND MEASLES UPDATE

The Director of Public Health to provide a verbal update on Covid-19, Flu and Measles in Leicester.

9. WORK PROGRAMME — Appendix D

The current version of the Work Programme is attached.

Members of the Commission will be asked to forward any item they wish to consider on the work programme for the Commission to the Chair or the Governance Services Officer.

10. ANY OTHER URGENT BUSINESS

Minutes of the Meeting of the
PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

Held: TUESDAY, 7 NOVEMBER 2023 at 5:30 pm

P R E S E N T :

Councillor Whittle (Chair)
Councillor Bonham (Vice Chair)

Councillor Gopal
Councillor March
Councillor Sahu
Councillor Singh Sangha

In Attendance

Deputy City Mayor, Councillor Russell – Social Care, Health and Community Safety

Cllr Batool, Chair – Children, Young People and Education Scrutiny Commission

Kash Bhayani – Healthwatch

Arshad Daud – Youth Representative
Thaneesha Hathalia – Youth Representative
Zara Jamal - – Youth Representative

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12. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were receive by Cllr Zaman and Cllr Cole.

Harsha Kotecha also gave apologies from Healthwatch.

13. DECLARATIONS OF INTEREST

The Chair asked members of the commission to declare any interests in the proceedings. Cllr Sahu declared that she co-owned a business which delivered training to the NHS.

14. MINUTES AND ACTIONS OF THE PREVIOUS MEETING

The Chair noted that the minutes of meeting held on 9 August 2023 and the joint meeting on 12 September 2023 with adult social care were included within the agenda pack and asked members to confirm that they could be agreed as an accurate account.

It was further noted that additional information requested at the last meeting had been circulated but the website and session for members on the cost of living is still being finalised and will be circulated separately.

AGREED:

- Members confirmed that the minutes for the meetings on 9 August 2023 and 12 September 2023 were a correct record.

The Chair noted items were missing from the agenda and asked whether any petitions or questions, representations and statements of case had been received.

The Monitoring Officer noted that none had been received.

15. CYP MENTAL HEALTH

The Chair highlighted the Commission have been keen to look at the issue given the growing pressures which could be argued to be a national emergency. It was also noted that the Chair of the Children's, Young People and Education Scrutiny Commission was in attendance given the importance and interests of the item.

The Head of Service for Families, Young People and Childrens at Leicestershire Partnership Trust presented the report, and it was noted that:

- NHS funded mental health support for children and young people in the city is provided by a range of services with CAMHS being one element and the most specialist.
- Investment has increased in line with the NHS long term plan for additional services for children and overall mental health. There has been a strong involvement in the development of services with collaboration with the youth advisory board in the city.
- The has been a 50% uptake in mental health support in the city – historically there has been a less than expected uptake for children and young people. The impact has been realised through the expansion of urgent mental health services including crisis support and services to support eating disorders. LPT have also improved the VCSE offer through early intervention, particularly with 'Relate'.
- An improved offer is provided in schools with a national programme to provide mental health support workers – the city

has almost 50% coverage. A pilot is underway with LCFC Community Development, and it is the intention to roll out further. Self-referrals have also been piloted in the system.

- Longer wait times is a challenge for initial appointment, particularly for CAMHS as a result of increasing referrals which spiked following the pandemic and children and young people returning to school. Significant progress is being made to address initial wait times.
- The CAMHS service also includes an offer for neurodevelopmental assessment for autism and ADHD with significant increases in referrals for such assessments for children and young people.
- Measures are in place to support children and young people whilst waiting. CAMHS now offer evening appointments, additional clinic space is available at Westcotes House and a business case has been supported to meet the capacity of increasing neurodevelopmental assessment with a neurodevelopmental transformational programme to review and streamline processes as well as supporting families with concerns.

In response to questions and comments from Members, it was noted that:

- Around 400 new referrals are being made to CAMHS per month for all services. The demand for CAMHS graph contained within the agenda pack relates specifically to outpatient referrals.
- All referrals from primary care and self-referrals for mental health support go through a triage navigation service delivered by Derbyshire Health Unit (DHU) where a mental health nurse will triage children and young people to the appropriate agency.
- Data relating to the number of children and young people referred by GPs to the DHU who are then triaged to CAMHS would be circulated along with data for referrals rejected from CAMHS back to the GP over the last 12month period.
- Information would be provided in relation to the uptake of NHSE funding available until March 2024 regarding the ACP role in Autism.
- Waiting times for an initial assessment is currently 17weeks compared to the standard 13weeks – work is underway to meet the target by December 2023. The urgent referrals standard is 4weeks and the service is fully compliant. Initial assessments provide psychoeducation, support and goal focus planning but wait times for specific treatment will vary depending on the referral.
  Further data on waiting times for services will be circulated to Members.
- Referrals for eating disorders has a target for urgent assessment and treatment of 1week and routine 4weeks which the service is fully compliant. There may be exceptions where the family may decline or not be available for the appointment.

- Crisis has a target of 2hours for an initial telephone consultation and 24hour face-to-face appointment. Compliance varies between 85-95% month on month – is not 100% as families may not be contactable so the service will also undertake visits to the home address.
- Mobilising mental health support in the community for children and young people is enabled by referral data for example age, ethnicity, disability, gender, and it was agreed this will be provided to Members.
- At the point of accepting a referral an initial assessment is made as to whether the child or young person requires urgent or routine care but families will be made aware to contact the service if there is the condition changes or deteriorating to review the referral. A telephone line is available 24hours a day, 7days a week for urgent care to speak directly with a mental health practitioner and face-to-face appointments are also available but are limited.
- The business case to support the ND diagnostic service has been submitted to the ICB for consideration of core funding from the 2024/25 budget as the government excluded neurodiversity and specifically ADHD from the mental health investment standard and service delivery fund. Concerns have been raised with NHSE about future flexibility for funding to address assessment waiting times which is a national issue. Data within the report specifically relates to secondary school age children in the city but the scale is exacerbated when primary school age and surrounding county and Rutland information is included.
- There are low numbers of inpatients at the general acute unit based at Glenfield Hospital. Children and young people admitted to the unit usually have a primary mental health diagnosis but may also have a learning disability or autism. The service will identify the most appropriate setting and support for providing care.
- 63 schools across the city currently receive mental health support, including upskilling partners on social and emotional mental health, mental health leads, inset day training on positive behaviour support, school assemblies etc. It is a rolling programme with recruitment in the New Year for the next waves. It is intended to continue to hopefully reach full coverage with analysis from public health used to identify the schools with greatest need and referrals.

The Chair invited youth representatives for comments and in response it was noted that:

- Various mental heath support services are available to children and young people waiting for initial assessments in addition to online services. Support is also provided in 63 schools and through ‘Relate’ who offer face-to-face and group support.

- The service is working to enhance support to ensure children and young people can access the right help at the right time, and as early as possible.
- There is insufficient capacity in the service to undertake ND assessments, but a business case has been submitted to seek resource to meet the demand and provide support to children, young people and their families.
- A directory of services is being produced and will be available through a QR code following consultation over the summer with children and young people who identified this as the best way to access information.

AGREED:

- The Commission noted the report.
- Members comments and concerns be noted by health partners.
- The Commission be provided with additional information requested.

16. COVID-19 AND WINTER PRESSURES UPDATE

The Director of Public Health and Chief Executive of the Integrated Care Board presented the report to update on infection prevalence and vaccination uptake. It was noted that:

- Regular testing of Covid-19 is no longer occurring as it was during the pandemic and the level of data in the community is therefore very different. Data is provided through hospital admissions and in social care settings so infection rates and trends can be tracked. ONS infection survey that was discontinued will commence again from November 2023 through to March 2024 so more sample data will be available.
- Flu positivity rates remain stable. Through primary care surveillance on individuals presenting with influenza symptoms has seen a slight increase but not of concern. Admissions into emergency departments have remained stable nationally and locally.
- Covid-19 activity has decreased over recent weeks. ICU admissions tend to lag behind, but infection has remained low and stable. There was an increase at the start of October, and there was some concern about variants but this has declined over the month and prevalence does not appear to be of concern.
- It is expected that Covid-19 and flu rates may increase throughout winter but most people have had the Covid infection at least once and been vaccinated so are reasonably well protected.
- Data illustrates that Leicester generally remains lower that other areas of the country and further information and data continues to be updated on the Council's Open Data platform.
- 91 community pharmacies are supporting the vaccination

programme and spread across the city, another 15 due to join and notification of a further 10 to join. 21 of the 26 Primary Care Networks, representing 82 practices are also delivering vaccines.

- There is joint working between the ICB and Public Health to ensure as many people as possible are offered vaccines. Particularly reference was made to delivery in care home settings, housebound patients and inequity offer – especially learning disability patients and using mobile vaccine units in areas with lower uptake.
- There have been four confirmed measles cases in city over recent weeks residents have been contacted in areas where cases have been confirmed to advise of symptoms and offer vaccines. Public health officers have been working with the ICB and UKHSA who have primary responsibility for controlling disease. Measles is very contagious, but full (2 dose) vaccination is highly effective and provides life-long immunity. 79.2% children are vaccinated by age 5 but the target is 95% to achieve herd immunity.

In response to questions and comments from Members, it was noted that:

- Barriers remain within different communities which prevents the uptake of vaccines, particularly communication, complacency, and confidence. Public Health and Health Partners continue to work with Members, Faith Councils, and other organisations to provide the right information.
  The Deputy City Mayor for social care, health and community safety commended the approach that has been developed and established in care homes to ensure the vaccine programme secures higher uptake.
- GPs are reviewing records and proactively contacting individuals that have not had the MMR vaccine and born after 1970. Those born before this date are highly likely to have been vaccinated or been exposed to the disease.
- It was agreed that further information will be provided to Members detailing where vaccines can be accessed within wards across the city.

The Chair invited youth representatives to make comments and it was noted in response that:

- Vulnerable individuals are those who have one or more of a list of identified conditions or receiving treatment that can suppress the immune system. GPs will contact individuals who are vulnerable to offer vaccines but it is the choice of the individual whether to accept. Higher uptake would be preferred amongst front-line staff in health and social care to protect vulnerable individuals.

AGREED:

- The Commission noted the report.
- The Commission be provided with additional information requested.
- The item to remain on the work programme for the Commission to be kept updated on Covid-19, flu and measles over the winter period.

17. MATERNITY CQC INSPECTION - UHL

The Chief Nurse presented the item, and it was noted that:

- The CQC have been undertaking a national thematic review of maternity services across England and visited UHL at the end of February and beginning of March. The inspection was conducted over three days to review the safe and well led domain.
- The rating for both Leicester General Hospital and Leicester Royal Infirmary reduced from good to requires improvement overall and St Mary's Birth Centre remained good overall.
- UHL take the findings of the report seriously and are committed to improving maternity services. Whilst the inspection highlighted UHL maternity services are not at the standard expected, many of the issues identified by the CQC were areas known and actions to improve underway.
- The key theme throughout the report concerns not enough staff members for safety – this is not unique to Leicester but is a national issue. Improvements are being made locally however to recruit, since April 2022, 35 neonatal nurses have been recruited as well as five midwives and another 24 due to join the service. UHL have also strengthened the leadership of maternity services.
- UHL continue to deliver improvement plans and the service is in a different place to when it was inspected. The CQC have been invited back to review the progress.

In response to questions and comments from Members, it was noted that:

- Recruitment is improving locally despite national challenges. The midwife vacancy rate does remain static - additional posts have been created to provide promotion and a senior team 24/7 to provide safety across the unit. There are 48 vacancies in midwifery services. New consultant posts have been created in the medical teams which have been fully recruited to. Nine additional junior doctor posts have been created to support the medical team with most now recruited. There are no vacancies in maternity support workers. The neonatal vacancy rate is around 8% with issues around qualifications and speciality for senior nurses but exploring how internationally trained nurse qualifications can be recognised.
- The CQC have changed the inspection regime and whilst it was a planned inspection it does not give much notice to change

ongoing issues. UHL were cited on many issues within the report and have improvement plans in place and an improved leadership team.

- Many issues highlighted as part of the warning notice have been resolved – there is a reverse RAG rating which is considered at three approval panels with the ICB also providing oversight and signing off assurance in relation to actions.
- Two identified actions remain difficult to solve and are not unique to Leicester, including staffing and induction of labour. A better oversight is in place to manage demand and capacity of inductions. A pop-up maternity assessment unit has also been created to support induction with estate options being considered but likely to be long-term plan. Assurance was provided that choice of induction is not being superseded.
- There is a national shortage of midwives and vacancies are not associated to financial savings. A rolling recruitment exercise is underway to recruit to all vacancies.
- Additional posts have been created for middle-grade doctors along with further recruitment of additional consultants. The team have been requested to undertake modelling to further increase the number of hours doctors are available on site seven days a week. UHL are also working with the University to appoint a chair of obstetrics to work on maternity safety.
- The CQC have been invited back to review progress, but this is unlikely to be until the New Year. Regular engagement meetings take place to update on the warning notice and feedback has been positive.

As part of discussions the Chair invited youth representatives to make comments and it was noted in response that:

- In order to support young mums, priority is given to those vulnerable to ensure continuity of care both anti-natal and post-natal. This ensures a woman or birthing person is able to see the same midwife or group of midwives throughout pregnancy and post-natal.
- Leicester is one of sixty maternity services that requires improvement or inadequate. UHL has been rated requires improvement with the safety domain at Leicester General and Leicester Royal Infirmary inadequate. It has been recognised that this is not good enough and being taken seriously to learn and improve.

AGREED:

- The Commission noted the report.
- Members comments and concerns be noted by health partners.
- The item to remain on the work programme for the Commission to be kept updated on progress with the improvement plan.

18. UHL RECONFIGURATION

The Deputy Chief Executive presented the report, and it was noted that:

- The programme will provide significant investment to the UHL estate. It will bring services together and provide improvements particularly for patients by addressing existing workforce instability and duplication across three hospital sites that are six miles apart. Separating pathways for those on waiting lists for planned care and emergency care should help prevent deferring planned care is emergencies arise.
- A public consultation took place in 2020 with proposals to create two critical care units, one at Leicester Royal Infirmary and one at Glenfield Hospital; co-late children's services at LRI; co-locate medical-led maternity services at LRI and midwifery unity ant Leicester General; and separate emergency and elective care where possible.
- The national new hospitals programme will enable some of the reconfiguration – a £20billion investment programme across 40 hospitals.
- Progress so far includes expanding critical care at LRI and Glenfield which has facilitated the movement of HPB - liver care, renal and transplant from the General Hospital to Glenfield and emergency surgery to LRI in line with consultation. The East Midlands Congenital Heart Centre has moved from Glenfield to LRI. All children's services have been co-located at LRI, and whilst they're currently dispersed across buildings it is intended to create a children's hospital in future.
- Investment is underway at the General Hospital with the construction of a £50m East Midlands Planned Care Centre to treat over one hundred thousand outpatient and day-patients. It will also include a £17m wing for a new endoscopy unit. It is envisaged the Centre will open at the end of 2024.
- An enabling scheme at LRI has also commenced to improve the energy infrastructure to ensure sustainability and decarbonisation of buildings. It also includes preparation for the demolition of office blocks to create space for a new hospital. It is envisaged works will be complete by 2030.

In response to questions and comments from Members, it was noted that:

- The financial envelope for delivery of the programme has increased to £640m as part of the £20bn commitment from the Department for Health and Social Care.
- The national new hospital programme is intended for off-site construction to then be collated on-site as is the approach in other countries. Clinicians are involved in the design panel and Royal Colleges are participating at a national level to influence design anticipated in Spring 2024. The programme will not save

money but will enable quicker improvements.

- The commitment to increasing bed numbers has not changed but a review and remodelling of bed demand and capacity is taking place as part of the new hospital programme. A plan is required on the gap of beds to ensure capacity for treatment, noting patients are now treated in ambulatory care which does not require a bed but will be at hospital for part of the day for tests. It was agreed that more information will be shared when the plan is developed.
- The service provided at St Mary's Birth Centre is good and on average delivers two women per week. The intention is for the service to be available to more women and relocating it at the General Hospital should improve access particularly to the east of the city. The relocation is not likely to commence until the maternity hospital at LRI is built and will be trialled to establish whether women and birthing partners identify it as a choice.
- A standalone maternity hospital will be constructed at the LRI to include neonatal services. A new ITU will also to be created at LRI, but due to space constraints of the site, this will be part of the maternity hospital building with a connection to the main hospital.
- Seven new theatre units will be created at the Glenfield Hospital.
- All aspects of the scheme previously consulted on are still proposed to be delivered with additional improvements.

The Deputy Chief Executive invited Members of the Commission for a site visit to the East Midlands Planned Care Centre at Leicester General Hospital.

The Chair invited youth representatives to make comments during the discussions and in response to questions it was noted that:

- Leicester is one of forty trusts to receive investment - £640m has been committed to be invested to improve Leicester's hospitals.

AGREED:

- The Commission noted the report.
- The item to remain on the work programme for the Commission to be kept updated.

19. RAAC IN HEALTH ESTATE - ICB

The Chair noted that the Chief Executive at the ICB provided a verbal update at the meeting on 12 September 2023 and thanked Partners for providing a detailed report.

The Chair requested that the ICB confirm with NHSE that they have no powers to compel private GP practices to undertake assessments to identify possible RAAC in buildings.

AGREED:

- The Commission noted the report.
- The Commission be provided with assurance requested.

20. SEXUAL HEALTH SERVICES RE-PROCUREMENT

The Public Health Consultant presented the report, and it was noted that:

- Public Health have commissioned sexual health services for the local population over the last ten years. This includes services such as contraception, STI testing, outreach with specific groups, sexual health education and counselling.
- The existing contract is due to expire in March 2024 and a re-procurement exercise was therefore required. This also provided an opportunity to speak to experts and conduct public engagement about the service which provided an invaluable insight.
- The model will broadly remain the same with a central hub at Haymarket and spoke centres around the city to deliver different levels of service. Work with VCSE organisations will continue on outreach initiatives.
- The new contract will ensure work with different communities recognising the demography has changed since the previous contract was procured and using data from the 2021 Census. This will ensure all communities are aware of services available and feel comfortable to access them.
- The new contract will also be procured solely by the city as opposed to previously which was jointly procured with Leicestershire County Council and Rutland County Council.

In response to questions and comments from Members, it was noted that:

- Spoke clinics vary depending on the provider for services they offer, for example there is the Sexual Health and Contraception Clinic is a spoke along with some GP practices. The consultation exercise found that an improved online offer enables individuals with the flexibility to self-manage sexual health, but spokes are needed to complement the central hub to ensure in person services also remain.
  The Deputy City Mayor for social care, health and community safety suggested Members of the Commission may wish to undertake a site visit to Haymarket Health to see the quality of the service.
- The existing provider has been successful in securing the new contract and two improvements will be implemented as soon as possible. The self-help hub online is likely to improve the quickest as the provider is looking at how this can be done but the

complicating factor is understanding the Leicestershire and Rutland position to ensure appropriate information and access. Logistics and resources are being explored to enable the single point of access to be rolled out and is likely to be in the New Year with the aim of being live before the implementation of the new contract.

AGREED:

- The Commission noted the report.

21. WORK PROGRAMME

The Chair noted that the latest work programme was included in the agenda pack and contains a number of items listed for future but that it was important to leave space for emerging issues. Members were reminded that if they have items for consideration to contact the Chair and scrutiny officer.

It was further highlighted by the Chair that the next Public Health and Health Integration Scrutiny Commission meeting will be held on 12 December.

Members were also reminded that following the joint meeting with adult social care in September, another joint meeting had been arranged for 30 November to discuss items including workforce, mental health of adults and addiction services.

22. ANY OTHER URGENT BUSINESS

A Youth Representative highlighted that the family hubs website has been working with information of activities available. The Deputy City Mayor for social care, health and community safety thanked Mo for the positive feedback and assured him that she would share this with the service.

There being no further business, the meeting closed at 19.49.

Appendix B

Primary Care Capacity Planning

Public Health and Health Integration Scrutiny Commission

Date of meeting: 12/12/2023

Lead director/officer: Mayur Patel, Head of Transformation, ICB

Useful information

■ Ward(s) affected: All

■ Report author: Mayur Patel, Head of Transformation, ICB
Nisha Patel, Head of Transformation, ICB

■ Report version number: V.1

EXECUTIVE SUMMARY:

Following the publication of the Delivery plan for recovering access to primary care in May 2023, integrated care boards (ICBs) are required to develop system-level access improvement plans for primary care.

The purpose of this report is to provide the Public Health and Health Integration Scrutiny Commission with an overview of the NHSE Primary Care Recovery Plan (PCARP) and the commitments to patients therein, and provide assurance that, through the development and implementation of LLR ICB's "System-level Access Improvement Plan", (SLAIP), during winter and beyond, we will deliver on these commitments for the people of LLR by: -

- Tackling the 8am rush - make it easier and quicker for patients to get the help they need from Primary Care
- Enabling "Continuity of Care"
- Reducing Bureaucracy

RECOMMENDATIONS:

The Public Health and Health Integration Scrutiny Commission is requested to:

- Note and comment on the report that describes the key components of the LLR System-level Access Improvement Plan and outlines how the ICB intends to deliver its key actions and priorities that supports Winter period.

Primary Care Capacity Planning over winter period

Background

1. General Practice, like many parts of the NHS, is under tremendous pressure – nationally one in five people report they did not get through or get a reply when they last attempted to contact their practice. The Fuller Stocktake stated, "there are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it". The Fuller Stocktake also provides valuable insights on the preferences of people waiting for and choosing appointments:

   People waiting for an appointment with their GP prioritise different things. Some need to be seen straightaway while others are happy to get an appointment in a week's time. Some people – often, but certainly not always, patients with more chronic long-term conditions – need or want continuity of care, while others are happy to be seen by any appropriate clinician, as long as they can be seen quickly. Equally, for some patients it is important to be seen face to face while others want faster, more convenient ways of accessing treatment and there is emerging evidence of a growing appetite (even before COVID-19) for patients to access care digitally.

2. The NHSE "Delivery Plan for Recovering Access to Primary Care" (NHSE May 2023) has two central ambitions:

   a) **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, and we will invest in general practice to enable this.

   b) **For patients to know** on the day they contact their practice how their request will be managed.

      i. If their need is clinically urgent it should be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their practice in the afternoon they may be assessed on the next day, where clinically appropriate.
      ii. If their need is not urgent, but it requires a telephone or face-to-face appointment, this should be scheduled within two weeks.
      iii. Where appropriate, patients will be signposted to self-care or other local services (e.g., community pharmacy or self-referral services).

3. The Recovery Plan seeks to support recovery by focusing on four areas:
   i. **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy.
   ii. **Implement Modern General Practice** Access to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment. The 2023/24 contract requires practices to assess patient requests on the day.
   iii. **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.
   iv. **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence

requests so practices have more time to meet the clinical needs of their patients.

Why do we need a Recovery Plan in LLR?

The "National Problem" – Pressures in Primary Care and the Problems for Patients – and what it means in LLR

4. In 2022/23:
   - LLR general practices provided **360,807** more appointments than in 2022
   - On average, 75% of LLR practices recovered to their 19/20 appts levels
   - Overall, LLR practices exceeded LLR target of 70% of available appointments being "Face to Face" – monthly average 74%
   - Overall, LLR practices exceeded LLR target of 75/1000 practice population clinical contacts – monthly average 93%

5. However, we know "access"- getting through to a practices, and then being "seen" in a "timely manner" - are major concerns for our LLR population.

6. Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. It also means that stresses appear in other parts of the health system as patients seek alternative routes to get NHS care. One key driver of growth in demand is the ageing population. Most of those over 70 live with one or more long-term condition and have five times more GP appointments on average than teenagers.

7. Nationally, overall general practice staffing is 27% higher and the number of staff delivering direct patient care is 44% higher than March 2019. However, nationally, the pandemic has changed the nature of demand. Patient contacts with general practices are estimated to have grown faster than demographic pressures, at between 20% and 40% since pre-pandemic, in part as COVID-19 backlogs have increased workload.

8. Practice surveys conducted by NHSE suggest that administrative tasks outside a consultation, measured by entries to medical records, are up 50% since 2019. Locally, and nationally, Practices report that they have never been as busy. Nationally, over the same period, NHSE reports that the growth in the number of GPs has lagged behind that of total practice staff employed.

9. Importantly, the pressure in general practice is felt strongly by these experienced GPs, who today are managing larger practices, with more patients, and supervising more doctors in GP training, more practice staff, and more clinical roles, yet remain critical to assessing the on-the-day urgent clinical need.

10. Overall growth in the LLR Primary Care workforce is at 0.9%, which is below expectation. However, separately both City and County, (including Rutland), have seen growth. County largely outgrew City in 22/23. Based on plans submitted by the LLR Primary Care Networks to NHSEI, increase in practice

staff through the “Additional Roles Reimbursement Scheme”, (ARRS), is on plan in LLR and has seen substantial growth in all staff groups.

11. Our LLR SLAIP describes the workforce strategies and initiatives – recruitment, retention, and development - through which we will optimise our most valuable workforce resource. A particular focus for Leicester City will be on the level of Social Prescriber Link Worker, (one of the ARRS roles key to enabling effective clinical navigation and sign-posting).

12. The national picture is that as demand rises, many practices are struggling to meet all the needs of their patients. Difficulties with access were also highlighted in the DHSC pulse-check survey, (December 2022), where one in five of the public said they either did not get through or get a reply when they last tried to contact their practice.

13. Good access is central to general practice being effective at meeting the reasonable needs of patients. As demand rises, the number of calls is challenging for reception staff. For those practices still on analogue lines, patients find repeated engaged tones frustrating. Retaining staff in this environment can be difficult.

14. The recently released General Practice Experience Survey, (GPES), results has allowed us to compare LLR practices performance on the Care Quality Commission (CQC) NHS GP Practice Indicators for 2023 to national performance.

15. Nationally and within the LLR ICS, performance on all indicators was lower in 2022 than in 2021. However, in 2023, average performance in LLR improved in 7 out of the 11 indicators (and 6 out of 11 nationally).

16. As in 2021 and 2022, in 2023 the worst scoring questions relate to access to GP services – GPES Q1 – *Ease of getting through to…,* LLR 2023 score down 3.29%, LLR practice score variation 11% - 97%: GPES Q2 – *How helpful was the receptionist…*, LLR 2023 score up, but LLR practice score variation 52% - 99%.

17. This is followed by *Overall experience of GP practice…*, LLR 2023 score down 0.54%, LLR practice score variation 33% - 96%.

18. Improvement initiatives will focus on addressing this variation, learning from “high” scoring practices/PCNs, and supporting “lower” scoring practices/PCNs to design, implement, and sustain improvements.

19. The results show some “positives” to learn from and build on:
    - The majority of respondents had positive perceptions of their care and felt their needs were met during their last GP appointment.
    - Confidence and trust in healthcare professionals is high (93%) among respondents.
    - 90% of respondents feel their needs were met during their last GP appointment.
    - 90% of respondents feel they are involved in decisions about their care and treatment.

20. GPES 2023 also provided useful insights into “online” usage in LLR:

- Both nationally and in LLR, respondents reported an increase in booking appointments, ordering repeat prescriptions, and accessing medical records online from 2022 – 2023.
- In 2021, 22 and 23, the most used online service was ordering repeat prescriptions (in 2023, 33% both nationally and in LLR).
- In 2023, the second most used online service, nationally and in LLR, was booking appointments online (23% of patients nationally and 18% of patients in LLR).

21. We have ranked top, middle, and bottom performing practices for each indicator to identify examples of good and poor performance and to get a deeper sense of performance across the system for each indicator.

22. Our 2023 GPES data will be, shared with practices and PCNs and data can be aggregated to PCN level to further nuance and support the implementation of the PCN Capacity and Access Improvement Payment plans - a key and integral component of our LLR SLAIP - to drive improvement in the experience of accessing general practice and general practice services.

23. Addressing variation in experience will continue through existing Access, Resilience, and Quality committees and processes.

What is in our System-Level Access Improvement Plan (SLAIP)

24. Although titled as a plan for recovering access to Primary Care, successful delivery of the **Delivery Plan for Recovering Access to Primary Care** will require concerted and not insignificant response and action from nearly all ICS Partners and ICB Teams in LLR.

25. To enable and assure this system level response, LLR ICB has developed and implemented an approach to delivery based around 3 central aims. These are: -
    - To tackle the 8 am rush - make it easier and quicker for patients to get the help they need from Primary Care
    - To enable “Continuity of Care”
    - To reduce Bureaucracy

26. These LLR aims reflect and will in turn be enabled by the four key commitments of the Primary Care Access Recovery Plan, (PCARP): -
    - Empowering Patients
    - Implementing “Modern General Practice Access”
    - Building Capacity
    - Cutting Bureaucracy

27. This relationship, and the delivery areas within our SLAIP are shown in *Figure 1 – LLR System-level Access and Improvement Plan* – below: -

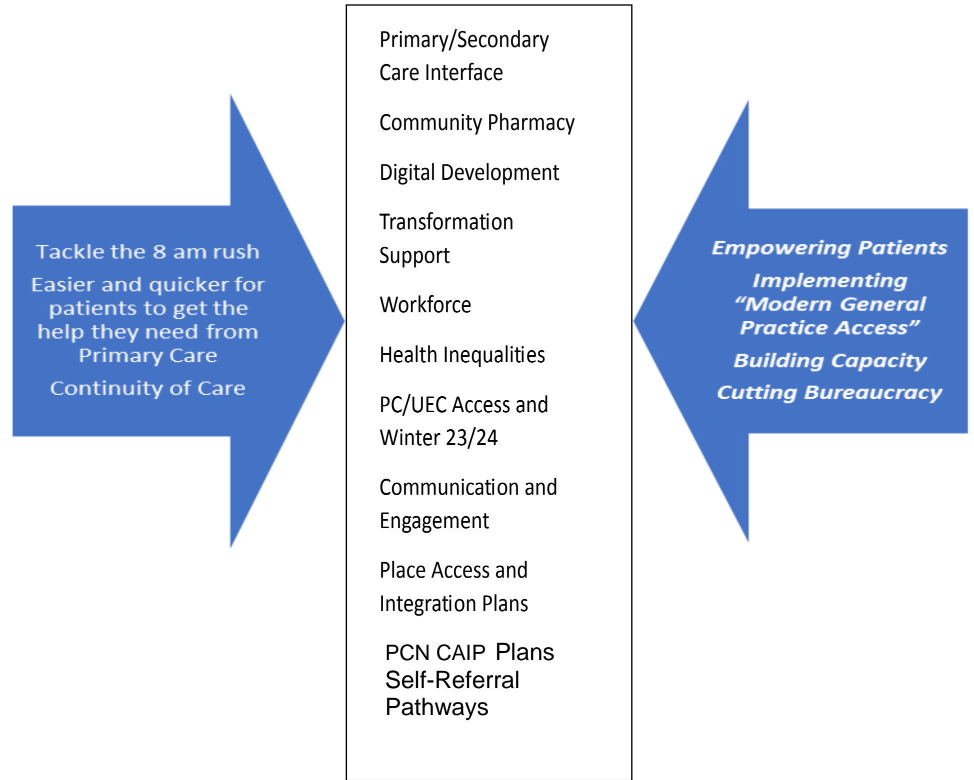


Figure 1 – LLR System-level Access Improvement Plan

Primary-secondary Care Interface

28. In the NHS, there's a growing demand amidst limited resources. To optimise patient journeys and experiences, it's crucial for healthcare professionals in primary and secondary care to collaborate effectively. However, the complex systems, varying IT systems, cultures, and priorities often hinder seamless communication and interconnection. The advent of Integrated Care Systems (ICS) represents a shared vision, where organisations partner to plan and deliver unified healthcare services for local communities. This includes delivering patient care within ICS and progressively across multiple ICS.

29. The true success lies in transitioning from 'I' to 'we.' It's not about adding to the burden on services or shifting bottlenecks within the care continuum. Instead, it's about working collectively across the primary-secondary care interface to provide the best care at the right time and place for each patient when they need it most. Patient-centred care, delivered at the right time and by the appropriate professionals, is fundamental. Effective communication is vital in interface working, as many issues stem from suboptimal communication practices. Given the pressures of workloads, waiting lists, service delays, and patient demands, healthcare professionals operate at maximum capacity. It's easy to be absorbed in one's own pressures and overlook colleagues facing their unique challenges. Improved patient outcomes and experiences are the goals. This approach not only reduces medical errors but also curtails healthcare costs and enhances overall efficiency in service delivery. It benefits patients and ensures the healthcare system's sustainability and effectiveness.

30. This approach is closely linked to the challenges outlined in our Primary Care Strategy and aligns with the themes designed to address these challenges. A significant aspect of the access challenge stems from the increasing workload, particularly for seasoned GPs, which risks overwhelming them and leaving less time available for patients. The pressure originates from the escalating number of patient contacts, which practices report to have surged by 20% to 40% since the pre-pandemic period.

Primary-secondary Care Interface -Progress so far within LLR:

31. TCS(Transferring Care Safely) established since 2016. We were one of the first nationally to set up a group to resolve ongoing interface issues.

32. C2C policy which reflects previous principles and has evolved i.e., initially consultant to consultant now clinician to clinician.

33. TCS Handbook created in 2017 with the purpose of offering comprehensive guidelines to healthcare providers regarding the best practices for effective interface collaboration.

34. **New Interface document for LLR (2023)** embedding the 10 principles to improve effective communication and behaviours. The document provides a detailed framework and principles for seamless communication, coordination, and cooperation across different levels of care. It serves as a valuable tool for healthcare professionals striving to improve the quality of care and patient outcomes by fostering better collaboration among various providers across LLR (*signed off by SE on 22/9)*

35. Pathway revisions, fit note policies, 2ww changes and various other issues as highlighted through TCS.

36. There are opportunities to reduce this workload by:
    i. improving the primary-secondary care interface
    ii. building on the “Bureaucracy Busting Concordat”

37. The existing system-level LLR Transferring Care Safely Group (TCS) is taking the lead on this and has reached a consensus on the primary areas of focus for delivery partners in the upcoming 6-9 months. These are shown in the table below:

Delivery Partner	Focus Actions
University Hospitals, Leicester	Embedding and improving the approach to providing Medical Fit Notes on discharge. Further embedding the use of Consultant Connect across the organisation. Delivery of an options appraisal for the development of a centralised contact point for those on the waiting list.
Leicestershire Partnership Trust	Provide easy access to the GP team for secondary care clinicians via non-public phone numbers and shared email mailboxes. Make 'fit note' more accessible on inpatient wards and in outpatient clinics and produce guidance for secondary care clinicians on their use. Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)
Primary Care	Prereferral work - This is mainly to look at pathways where investigations are being requested above and beyond what should be done in Primary Care (based on NICE guidance). Ensuring referrals have got all the relevant information needed. “Advice & Guidance” to get converted to referrals if deemed necessary if all the relevant information is available Build on consultant connect-currently few practices signed up, to ensure more practices sign up to allow good communication between primary and secondary care.

Community Pharmacy - Common Conditions Service and Community Pharmacy Consultation Service

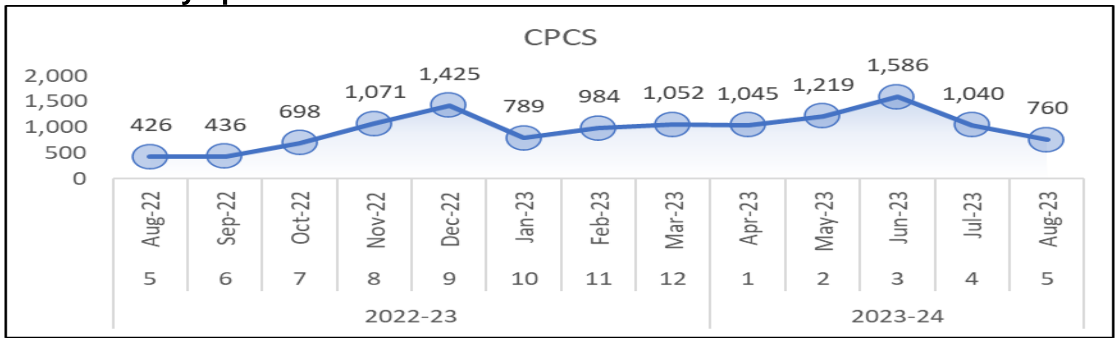
38. One of the key priorities identified within our Primary Care strategy to deliver our LLR vision is to redesign care pathways. The role Community Pharmacies have in this space is crucial.

39. As per PCARP, the ICB will support the transitioning of pharmacies participating in the regional extended care services to the proposed common conditions service where the two services overlap. We will work with our community pharmacy network and system stakeholders, including Community Pharmacy Leicestershire & Rutland to drive engagement and participation with the common conditions service, with the ambition that over 50% of the network are actively participating within 6 months of launch.

40. We will build on work already underway with regards to the Community Pharmacist Consultation Service to promote community pharmacy capacity as a viable and reliable option for patients with wider stakeholders including general practice and primary care networks.

41. Working with national colleagues we are developing an interactive map showing the services available from local pharmacies. We are still in the testing stage, but it is envisaged that this tool will help other primary care colleagues, particularly GP patient services teams and care navigators, identify pharmacies that patients can be referred to thus freeing up practice capacity and providing quicker, needs appropriate access to care in the most appropriate setting.

Leicester City specific data

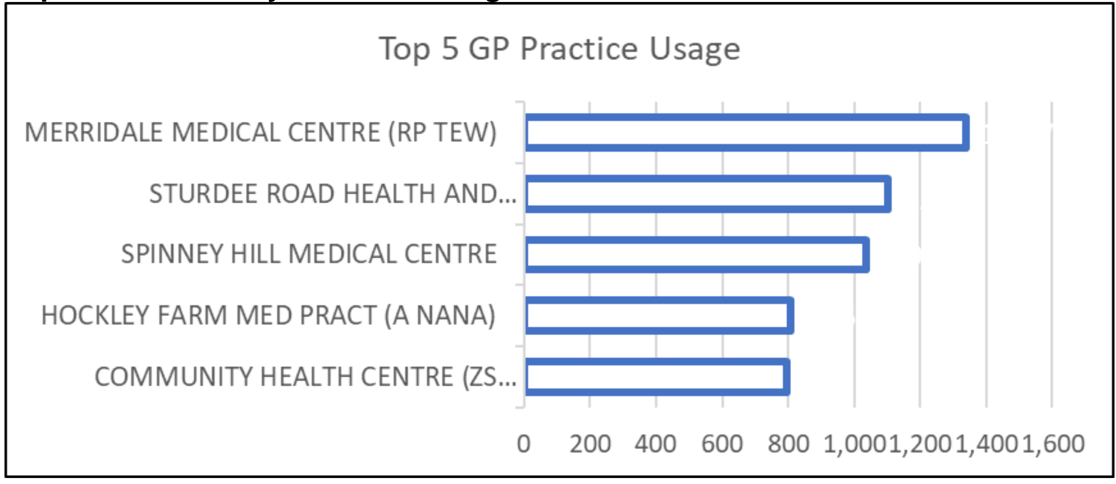


Community Pharmacy - Blood Pressure and Oral Contraceptive services

42. Targeted support has been provided to several practices and PCNs to engage with local community pharmacies to integrate the community pharmacy blood pressure checks service. We continue to see growth in referrals and pharmacy identified checks for both one off clinic checks and ambulatory blood pressure monitoring (ABPM). The LPC are working with contractors to increase confidence on the use of ABPM machines and are trialling in innovative IT platform to send data back directly into GP practices.

43. Whilst national level negotiations continue, in LLR there has been significant interest from contractors in providing the service, and several neighbourhood level meetings are planned. The latest month we have data for is June - 12 contractors have delivered a total of 63 consultations.

Top 5 Leicester City Practices Usage



	Month	Activity
2022-23	August 2022	426
	September 2022	436
	October 2022	698
	November 22	1,071
	December 2022	1,425
	January 2023	789
	February 2023	984
	March 2023	1,052
2023-24	April 2023	1,045
	May 2023	1,219
	June 2023	1,586
	July 2023	1,040
	August 2023	760
	Grand Total	**12,531**

Digital Development

44. Another of our priorities within the Primary Care Strategy is the "Digital First" approach. This includes enabling and promoting digital innovation and a "digital by default" approach to the design and delivery of care, including patient and staff education, whilst ensuring digital inclusion and avoiding un-intended digital discrimination.

45. Revised guidance for delivering the recovery plan was received from NHSE mid-September 2023, with 3 revisions specific to our digital development:

I. **Cloud-based telephony** – National support to enable 1,000 practices to transition to digital telephony by December 2023. Expectation is that all remaining analogue practices move to digital telephony by March 2024. We will be actively monitoring progress, working alongside the national procurement hub, and following further national guidance and support expected soon, we will review the quality of cloud-based telephony already in place with a view to improve this where necessary.

a. In LLR, 102 practices already have digital telephony platforms. Twenty, 20, LLR practices, supported by national funding, are in the process of migrating to a Cloud Based Telephony system. Five, 5, LLR practices are also migrating independently of national support. We will work with those practices that have not yet described their plan to migrate.

II. **NHS App** – Data shows that all our LLR practices have patients registered to use the NHS App and have patients making and cancelling appointments and ordering repeat prescriptions via the NHS App. The same data shows significant variation in relative levels between practices, and across the year within practices. We will work with practices to understand this variation and support the sharing of learning and best practice to address.

We will continue to leverage the core functions of the NHS App, to empower patients and enable them to self-serve to address appropriate. We will liaise with practices to ensure that each practice has a plan for each patient to receive prospective record access, (unless exceptions apply), from 31 October.

III. **Digital pathways framework** – Whilst national level engagement with the market continues, and the timeline for the launch of the framework is confirmed, we will work with practices to fully understand the contracting position for their online consultation, messaging and booking solutions currently in use. We expect to receive guidance and information on what to expect from the framework from our Regional Team so we can begin preparatory work.

Primary Care Transformation and Transformation Support

General Practice Improvement Programme (GPiP)

46. This national programme includes Universal, Intermediate, Intensive and Local levels of support. Programmes focuses on implementing 'modern general practice' operating models and introduces the Support Level Framework (SLF) tool.

City practices that have signed up for the different 'phases' of GPIP

Phase A

Practice Name	C Code	PCN	Offer type
Beaumont Lodge Medical Practice	C82094	Millennium	Intensive
Bowling Green Street Surgery	Y02686	Leicester Central	Intensive
Heron GP Practice	Y02469	Leicester Central	Intensive

Phase B

Practice Name	C Code	PCN	Offer type
Highfield Surgery	C82116	Leicester City PCN	Intermediate
Heron GP Practice	Y02469	Leicester Central	Intensive

Phase C

Practice Name	C Code	PCN	Offer type
East Leicester Medical Practice	c82063	Salutem PCN	Intensive
Fosse Medical Centre	C82086	Millennium	Intermediate
Willows Health	Y00137	Aegis	Intermediate

Phase D
None

Phase E
Currently available for sign-ups

Workforce

47. One of the key enablers, outlined within the Primary Care Strategy to achieve the needed transformation, is our workforce. The performance of any health and care system ultimately depends on its people.

48. We have described the LLR workforce position earlier in the report, and we are committed to addressing workforce issues through retaining our existing workforce whilst supporting, optimising new roles, and making LLR an attractive place to train and work.

49. Reflecting the NHSE "People Plan", and the expectations of PCARP, the ICB's Workforce Team has developed robust plans in place to support and build the workforce. Please see Appendix 2 – *LLR PCARP Workforce Plan Summary* – for examples of the initiatives to be actioned.

Health Inequalities

50. Improving Health Equity by identifying and addressing health inequalities is one of the ICS's key pledges within its "Five Year Joint Plan", and "tackling inequalities in outcomes, experiences, and access" is one of the plans quintuple aims.

51. This is under-pinned and enabled by our "Life Course" and "Population Health Management" approaches that run through the LLR Primary Care Strategy and all our operational and delivery plans.

52. In their CAIP Plan development and submissions, LLR PCNs have been asked how they will identify and address health inequalities in their strategies for improving patient experience and access. This will build on the work and plans our PCNs have undertaken as part of the Network DES Contract – to develop a "Tackling Health Inequalities Plan", and "Personalised Care Plans" for patients identified through risk stratification.

53. Quality and Equality Impact Assessments will be undertaken - as standard practice and process – for any service change proposals within the emerging Place Based Access and Integration Plans.

PCN Capacity and Access Improvement Payment (CAIP) Plans

54. All Leicester City PCNs submitted plans to the ICB as per the national deadline, and all 10 plans were accepted by the ICB. It is expected that these plan will be iterative and there will be opportunities, formal and informal, throughout the year to guide and support further development and implementation. Our proposed process to allocate CAIP funding to our PCNs is described later in the paper.

55. Whilst all 10 PCNs have described how they will address/achieve the core CAIP requirements, a number of themes emerged from the submitted plans. (*LLR CAIP Plan Themes* below). These have been shared with all PCNs to share ideas and spread innovation.

Leicester City Place "CAIP" Plan Themes

Ideas shared	Themes from Plans
• Addressing 8am rush • Empowering pts – Modern General Practice options (NHS App, Online Consultation, CPCS, use of ARRS, etc) • Active Signposting Training • Use of CBT triangulation data • Maintain project / delivery plan to monitor progress • Collaboration with partners and voluntary organisations to deliver the plan • Linked to the H&W / Place Plans	• Collaboration with PPGs • Promoting ARRS, CPCS services • T&D of staff; Active Signposting • Update website – online consultation / booking • Segmentation of population • Triangulation of CBT / Online consultation • Integrated working with partners / voluntary organisation • Website review and redesign / social media and use of QR codes

Winter 2023/2024 – Adult and Paediatric ARI Hubs – LLR Response

Primary Care/Urgent and Emergency Care Access and Winter 23/24

56. Although not an explicit "NHSE requirement" for our SLAIP, we are including how we intend to enhance system wide access and capacity to manage winter surge demand from Acute Respiratory Infections, (ARIs), identified as one of the "High Impact Actions" for Winter 23/24.

57. NHS England and UK Health Security Agency (UKHSA) reports from 2020-2022 show that acute respiratory infections are among the most common reasons for emergency attendance and admission. Scenarios for COVID-19, combined with those for flu, suggest that even in optimistic scenarios, high numbers of appointments and beds will be needed for respiratory patients during Winter.

58. Primary care, secondary care, and NHS111 will need to work together to prevent large numbers of children and older patients with breathing difficulties from being triaged with the outcome of an emergency ambulance, as many of these patients do not need to be admitted and can be looked after in the community.

59. In the NHSE Winter Letter published in July 2023, Acute Respiratory Infection Hubs are listed as one of the ten high-impact interventions for Winter 2023/2024. They should "support consistent roll-out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures."

LAST YEAR – WINTER 2022/2023

60. By the end of Winter 2022/23, we had 8 ARI hubs, one of which was paediatrics only, and the others were for both paeds and adults. The hubs saw an additional 4341 adults between January and the end of March. Around 1.6% were sent to ED/A&E after assessment.

61. 61% of adults were discharged home, which might indicate that the majority of these people could have been managed by pharmacy/111/CNH or over the phone instead of having a face-to-face ARI appointment.

62. This was also evident in the presenting conditions and diagnoses. However, all our data is free text (due to implementation speed), so it can't be relied upon fully. And we didn't have robust patient triage in place.

63. Additionally, many patients were seen for more chronic presentations of the allowed criteria, for example, coughs lasting longer than 4 weeks or sinus problems over several months.

64. When compared to other systems, our average price per available appointment was quite expensive: £73. And because only 72% of our appointments were utilised, the average cost per utilised appointment was £102.

CAPACITY & DEMAND

65. We cannot know the adult ARI demand over a given winter – at the moment, our primary care data doesn't allow us to know how many people will get an acute respiratory infection and want to be seen.

66. However, using the data we have, there is an undeniable surge in acute respiratory infections in LLR, as well as an increase in related emergency admissions and A&E attendances between October and February.

67. Nationally, it is understood that 73% of ED attendees are discharged on the same day of arrival. (GIRFT – Emergency Medicine) For LLR, between April 2022 and March 2023, 58% of those patients coded with a complaint of "airway/breathing" in A&E were not admitted. In many cases, it would be more appropriate for these patients to be seen in the community.

68. There are generally two types of adult patients who will require a service to manage their acute respiratory infection:
    - Patients with no known respiratory conditions who get an ARI and need low-level care, reassurance and perhaps some medicine such as over-the-counter products or antibiotics.
      Some of these patients might legitimately require urgent treatment from secondary care services, which is appropriate.
    - Patients with known respiratory conditions who are more at risk from getting an ARI and are more likely to have adverse effects, more likely leading to treatment from secondary care services and are at risk of a longer length of stay.

PROPOSAL

63 **For Cohort 1**, who don't require secondary care treatment, there are additional services/improvements in the system which have/will be set up to manage this kind of demand. They are:
- Maximising Community Pharmacy use (including CPCS) – *suitable complaints include coughs, flu symptoms, sore throat, blocked or runny nose, earache, etc.*
- Minor Injuries and Minor Illness Unit (MIaMI)
- Better access to GP services through Enhanced Access and the Capacity & Access Improvement Plans (CAIP)
- Redirecting appropriate patients from ED to Type 3 Urgent Treatment Centres such as Oadby/Merlyn Vaz.
- Increase walk-in capacity at UTCs instead of booked appointments. See ARI patients as a priority.
- Increase use of NHS App – advice and reassurance.
- Growth of 111 and Clinical Navigation Hub, including retired clinicians – As part of LLR Delivery Plan to recover UEC services, May 2023
- Targeted immunisation programmes such as flu/COVID – increasing uptake will reduce the incidence of ARI.

64 Based on our estimated data on ARI Hubs from last year, the majority of the surge in ARI demand for cohort 1 (who do not require urgent secondary care treatment) will be captured by one or more of these services.

65 All of these services are designed to meet our objective: to support the ARI demand in primary care and ED and ease system pressures.

66 There is already a tremendous amount of work happening to improve or implement these services ready for this Winter, and it is proposed that we don't add any more services to an already busy and complicated system.

67 However, all these services will be continually monitored through the UEC programme and the associated dashboard.

68 Finally, the ICB comms and engagement teams are implementing a targeted communications plan to ensure that patients know where to go and what to do over Winter. This is called “Get in the Know.”

69 **For Cohort 2**, more work is needed to help our known respiratory patients in case of ARI. There are two types of interventions:

- Proactively monitoring appropriate patients to spot signs of deterioration earlier, likely using technology. This can also be known as ‘remote monitoring.’
- Proactively optimising known respiratory patients so that in case of exacerbation or ARI, they and their clinicians are more prepared, de-escalation will be quicker, and in case of a hospital stay, length of stay may be reduced. This will also help to support flow through UHL, including pressures on the front door.

69. There is already a service in place to remotely monitor some COPD patients. Spirit Health provide the technology, and the platform is called Clinitouch Vie. It would be beneficial to expand this kind of “telehealth”; however, there isn’t currently any additional funding to do this. A review of this service is now underway to evaluate its effectiveness, and we can ensure it is maximised, even without any additional funding.

70. The Integrated Respiratory team will continue to work proactively with general practices and PCNs to optimise care for specifically for patients with respiratory conditions.

Primary Care Update

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

Areas of Focus

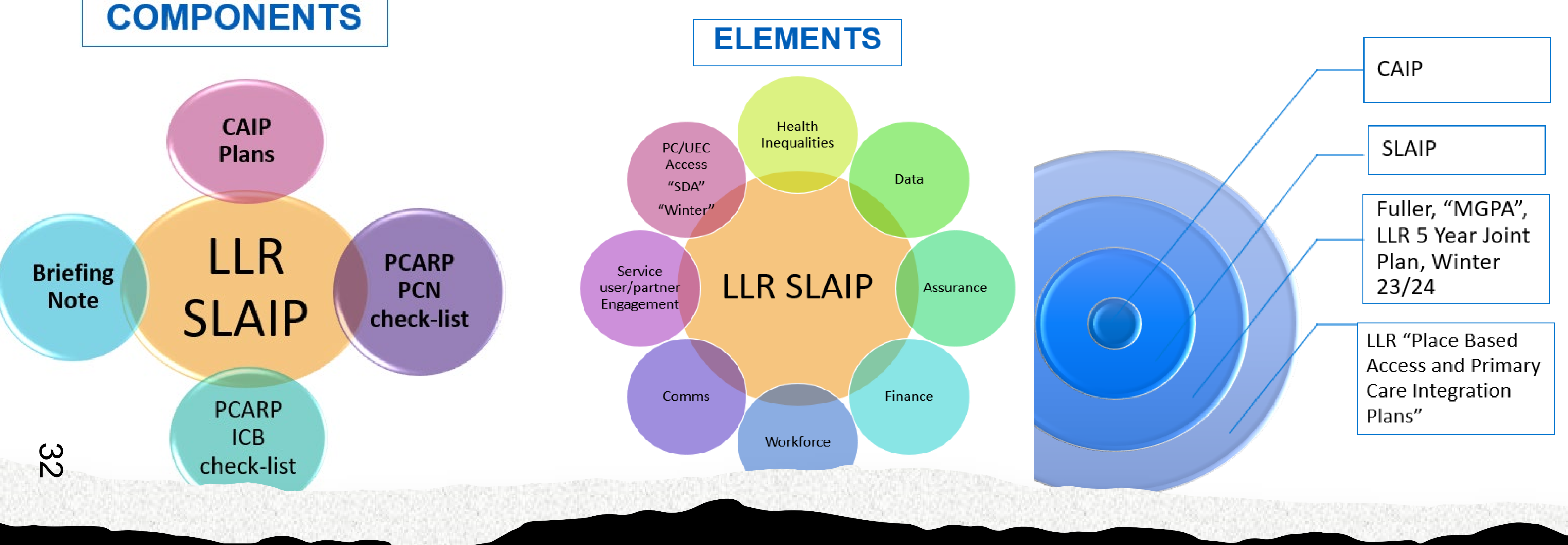
- NHSE Delivery Plan for Recovering Access in Primary Care
- Development of System Level Access Improvement Plans (SLAIP) & our approach to implementation across LLR
- Winter Planning
- Comms & Engagement Plan

NHSE Delivery Plan for Recovering Access to Primary Care

Key deliverables:

- ***Tackle the 8am rush***
- ***Easier and quicker for patients to get the help they need from Primary Care***
- ***Continuity of Care***
- ***Empowering Patients***
- ***Implementing "Modern General Practice Access"***
- ***Building Capacity***
- ***Cutting Bureaucracy***

Actions to achieve the above are underway and will support capacity challenges during Winter



"We want to build a new primary care system together, for everyone in LLR. Nurturing a safe, healthy, and caring community. Giving all our people the best start in life, supporting them to stay healthy and live longer, happier more fulfilling lives. We will use our collective capabilities and strong partnership working to provide high quality, sustainable, joined up care; ensuring greatest overall impact on health and wellbeing outcomes"

What are we going to do in LLR?

Tackle the 8 am rush

Easier and quicker for patients to get the help they need from Primary Care

Continuity of Care

- ✓ Primary/Secondary Care Interface
- ✓ Community Pharmacy
- ✓ Anti-microbial Resistance
- ✓ Digital Development
- ✓ Transformation Support
- ✓ Workforce
- ✓ Health Inequalities
- ✓ PC/UEC Access and Winter 23/24
- ✓ Communication and Engagement

Empowering Patients

Implementing "Modern General Practice Access"

Building Capacity

Cutting Bureaucracy

Primary and Secondary Care Interface

- Access challenge is a result of the rise in workload, particularly for experienced GPs, being overloaded and having less time available for patients.
- Pressure from the rising number of patient contacts, reported to have grown by 20% to 40% since pre-pandemic.
- *There are opportunities to reduce this workload by*:

1. improving the primary-secondary care interface
2. building on the Bureaucracy Busting Concordat

- The LLR Transferring Care Safely Group is taking the lead on this and has reached a consensus on the primary areas of focus for delivery partners in the upcoming 6-9 months. These are outlined in the paper.

Community Pharmacy Consultation Service (CPCS)

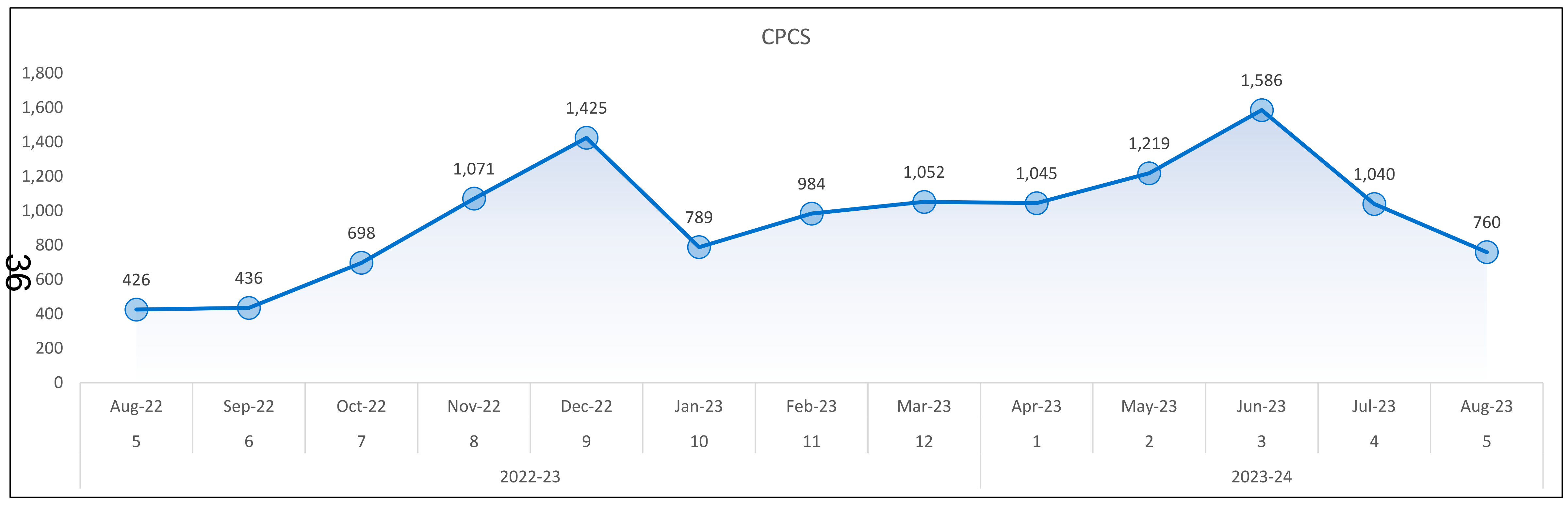
- The ICB supporting the transitioning of pharmacies participating in the regional extended care services to the proposed common conditions service where the two services overlap.
- The ICB working with community pharmacy network and system stakeholders to drive engagement and participation with the common conditions service, with the **ambition that over 50%** of the network are actively participating within 6 months of launch.
- The ICB will continue to enable referrals to community pharmacy as part of the **Community Pharmacist Consultation Service (CPCS)**

Leicester City: Total CPCS referrals from Aug 22 to August 23: **12,532**

Leicester City: Total CPCS referrals from Apr 23 – Aug 23: **5,650**

Average Leicester City CPCS referrals per month
2022: 860
2023: 1130

CPCS Referrals in Leicester City



ICB continue to work in parentship with Leicestershire Pharmacy Committee (LPC), PCNs, Community Pharmacies to promote CPCS as an opportunity to improve access across Leicester City

Utilising the Support Level Framework (SLF)

Information based on:

- Planned Quality and Contracts visits
- Sign up for national GPIP programme
- Completion of Quality Assessment Template
- 'Scores' on Quality variation dashboard

32 practices (**including 4 from City**) identified for inclusion in a local proactive Support process for 23/24 - assurance/identify improvement opportunities and challenges:

- Priority 1 – 15 Practices: concerns on variation dashboard
- Priority 2 – 17 Practices: performing 'well' but general lack of engagement/assurance

Workforce – our "People Plan"

- Continuation of GP Fellowship
- Development of a Fellowship+ and mid/wise to support GPs to diversify, retain skillset and capacity
- Introduced IMG GP Ambassador and Fellowship Ambassador
- Relationship with Leicester Medical School / ST1, 2 and 3s to promote primary care in LLR
- Funding of Next Generation GP programme
- Continuation of GP Mentoring
- Outreach programmes with HEIs, colleges / schools / access to medical education and subsequent careers in primary care

- Development of practice nursing programme
- Practice nurse preceptorship – supports integration in primary care
- Support Practice Nurse recruitment
- Support for newly qualified nurses
- Support for PCNs with ARRS roles
- Continuation of ARRS and well established primary care roles
- Group video clinics for PCN teams

- Expansion of LLRTH designed ARRS/New to Primary Care Induction programme
- Increase clinical placements
- Funding placement provision in PC
- Non-clinical training programmes - rapid upskilling
- Continuation of interprofessional education sessions
- Annual Training Needs Analysis support
- Full engagement with the METIP planning to ensure future education, training and development capacity in PC workforce

Health Inequalities

- Improving Health Equity by identifying and addressing health inequalities is one of the ICS's key pledges within it's "Five Year Joint Plan", and "tackling inequalities in outcomes, experiences, and access" is one of the plans quintuple aims.
- This is underpinned and enabled by our Leicester City Health and Wellbeing Strategy **"Life Course"** and **"Population Health Management"** approaches that run through all our operational and delivery plans.
- Quality and Equality Impact Assessments are undertaken - as standard practice and process – for any service change proposals.

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- Quality and Equality Impact Assessments are undertaken - as standard practice and process – for any service change proposals.

HEALTH INEQUALITY PLANS AND CAIP PLANS THEMES BY PCNS

HEALTH INEQUALITY PLANS

Dementia / LD / Hypertension / Diabetes

Women & menopause

At risk of financial distress & depression

Looked after children

Childhood imms uptake

CVD & HF with obesity

COPD & vaccination uptake

Mental health, low mood & anxiety

Overall health & wellbeing

PPN with unmet health needs

Social isolation

CAPACITY & ACCESS IMPROVEMENT PLANS (CAIP)

Collaboration with PPGs

Additional appointment with ARRS,

Improve the CPCS services

T&D of staff; Active Signposting

Update website – online consultation / booking

Segmentation of population

Triangulation of CBT / Online consultation

Integrated working with partners / voluntary organisation

Website review and redesign

Health Inequality Plans Summary

The plans submitted by PCNs will focus on the following areas:

- Dementia / LD / Hypertension / Diabetes
- Women & menopause
- At risk of financial distress & depression
- Looked after children
- Childhood immunisation uptake
- CVD & HF with obesity
- COPD & vaccination uptake
- Mental health, low mood & anxiety
- Overall health & wellbeing
- PPN with unmet health needs
- Social isolation

Capacity and Access Improvement Plans Summary (CAIP)

The plans submitted by PCNs will focus on the following areas:

- Collaboration with PPGs
- Additional appointments with ARRS,
- Improve usage of CPCS services
- T&D of staff; Active Signposting
- Update website – online consultation / booking
- Segmentation of population
- Integrated working with partners / voluntary organisation
- Website review and redesign

PC/UEC Access and Winter 23/24

PLACE (BASED) ACCESS AND PRIMARY CARE INTEGRATION PLANS – PROGRESSING

to design – now - and implement – by 1st April 2025 – integrated general practice/primary care systems, processes, and or services that provide and sustain levels of ***same day access*** capacity, and ***continuity of care*** capacity in general practice, as determined by and to meet the needs of the local population(s), 7 days a week

ACUTE RESPIRATORY INFECTIONS (ARI Hubs)

Children - Acute Respiratory Infection Hubs: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures

Adults - Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures

ARI service – To Commence in December

- ARI / Acute paediatric appointments will be available Monday to Friday from 4pm
- LLR will offer minimum of 10,000 additional appointments based on 15-minute consultations over a 10-week period, starting in December 2023.
- Each PCN will be required to confirm how many additional appointments will be offered each day, over and above the core contract and Enhanced Access. Each PCN will have a minimum number of appointments expected.
- For City Place, ARI service will offer a balance of appointments for children and adults that meets the needs of the population – including those with known respiratory illness and with any ARI.
- Prioritise those with respiratory illness
- Triage process implemented to signpost to other services where appropriate such as pharmacy
- Appointments accessible by 111

Communications and Engagement

- **Key** to restore trust in General Practice and for citizens to understand the changes driven by the Recovery Plan and "Modern General Practice Access"
- LLR ICB are committed to working with GP Practices, patients and the public to co-produce campaigns to ensure messaging is right to support delivery of the areas outlined and inform/educate our population.
- Our system will be guided and supported by national focus and materials and will use the learning from previous "campaigns" to ensure the message reaches all our local communities.
- National focus is on the changing Practice Team – the multi-disciplinary team and the ARRS roles – and empowering patients through the self-referral, community pharmacy, and NHS App opportunities.

Appendix C

LLR LeDeR Annual Report 2022/23

Public Health and Health Integration Scrutiny Commission

Date of meeting: 12/12/2023

Lead director/officer: David Williams,

Director of Strategy and Partnerships

Leicestershire Partnership NHS Trust

Useful information

- ■ Ward(s) affected: All LLR
- ■ Report author: Julie Gibson
- ■ Author contact details: julie.gibson27@nhs.net
- ■ Report version number: V.001

1. Summary

This report provides a summary to the LLR LeDeR Annual Report 2022/23 and offers key actions from learning for all partners.

2. **Recommendation(s) to scrutiny:**

Public Health and Health Integration Scrutiny Commission are invited to:

- Share the annual report widely.
- Promote the key learning points across all services, noting a whole LLR system response is required.
- Note the considerable disparity in life expectancy for people with a learning disability and autistic people.
- Recognise that one third of deaths were potentially preventable.

3. Detailed report

3.1: Background:

The 'Learning From Lives and Deaths of People with a Learning Disability and Autistic People' (LeDeR) Programme was launched in 2016/17. Since being established, deaths of people with a learning disability, and from January 2022 autistic people, have been reviewed with the findings presented in the LeDeR annual reports, where action from learning has been captured.

The LeDeR programme aims are to:

- ✓ improve care for people with a learning disability (LD) and autistic people;
- ✓ reduce health inequalities for people with a learning disability and autistic people; and
- ✓ prevent people with a learning disability and autistic people dying prematurely.

Within Leicestershire, Leicester and Rutland (LLR) a new team was established to solely focus on this programme.

3.2: The 2022/23 LLR LeDeR report:

The report covers the financial year 2023/23 for Leicestershire, Leicester and Rutland.

This is the first time a LeDeR report has included reviews for autistic people. Quality of care was also measured for the first time in this report. This was measured using six themes set out nationally, and further examined by sub-themes. The report also focuses on preventative healthcare; an area which the LLR LeDeR programme team have actively been involved with in supporting the learning into action part of the report.

Of note within the report:

- A total of 83 deaths were notified to the LeDeR Programme during 2022/23.
- The median age at death was 62.
- This is over 20 years younger than the general population.
- From 1 July 2023, any deaths of people under 18 years of age, reviews are no longer carried out by LeDeR, but by the Child Deaths Overview Panel only (CDOP).

The report is supplemented by top ten learning into action points. These are followed by plans for the forthcoming year, with appendices containing more detail in relation to various sections of the report.

3.3: Learning into Action:

The aforementioned top ten learning into action points recommended across the LLR system from this year include:

1. Report the deaths of those people autism (with or without a learning disability) to the LeDeR Programme.
2. Report the deaths of those from Leicester City and from diverse ethnic backgrounds to the LeDeR Programme.
3. There is an emerging theme around the widespread misuse of the Mental Capacity Act. All services should review their practices to ensure compliance with this important legislation.
4. The practice of estimating someone's weight is a significant risk for people. People should be weighed using appropriate weighing equipment and the weight should be recorded accurately.
5. Clear plans should be created for every person with behaviour that challenges highlighting the support they require and anticipating the support they are likely to need in the years ahead. This should be reflected in future commissioning considerations in LLR for provision of residential care for those with learning disabilities as physical health and nursing care needs increase particularly towards the end of their life.
6. Care providers must be competent and confident in talking about end-of-life matters and having these meaningful conversations at the right time.
7. Screening inequalities exist, and every effort should be made to improve the uptake. Barriers to non-invasive bowel screening should be rectified.
8. Better understanding of the STOMP/STAMP agenda across generic, physical, and mental health services.
9. Aspiration pneumonia happens as a consequence of a precipitating event. Identification of risk factors and ongoing management are key. The changing of pathway at discharge to LD MDT is imperative.

10. There is specialist support for people in the community who have been unable to have blood taken from standard phlebotomy, which is not always accessed appropriately. Intervention by these teams does not guarantee successful outcomes but the availability should be widely known.

A list of achievements in partner services in response to learning from LeDeR is given from page 37 in the report.

LLR LeDeR Annual Report 2023

Julie Gibson

LD and Autism Transformation Manager

Reviews of deaths in 2022/23

83 deaths of people with a LD and Autistic people were reviewed by the LLR LeDeR Programme in 2022/23

Of those

- 3 were autistic
- 6 were children with LD
- 72 were adults with LD
- 2 were out of scope

Ethnicity

- 82% were 'White'
- 12% were 'Asian or Asian British'
- 1% were 'Black, African, Caribbean or Black British'

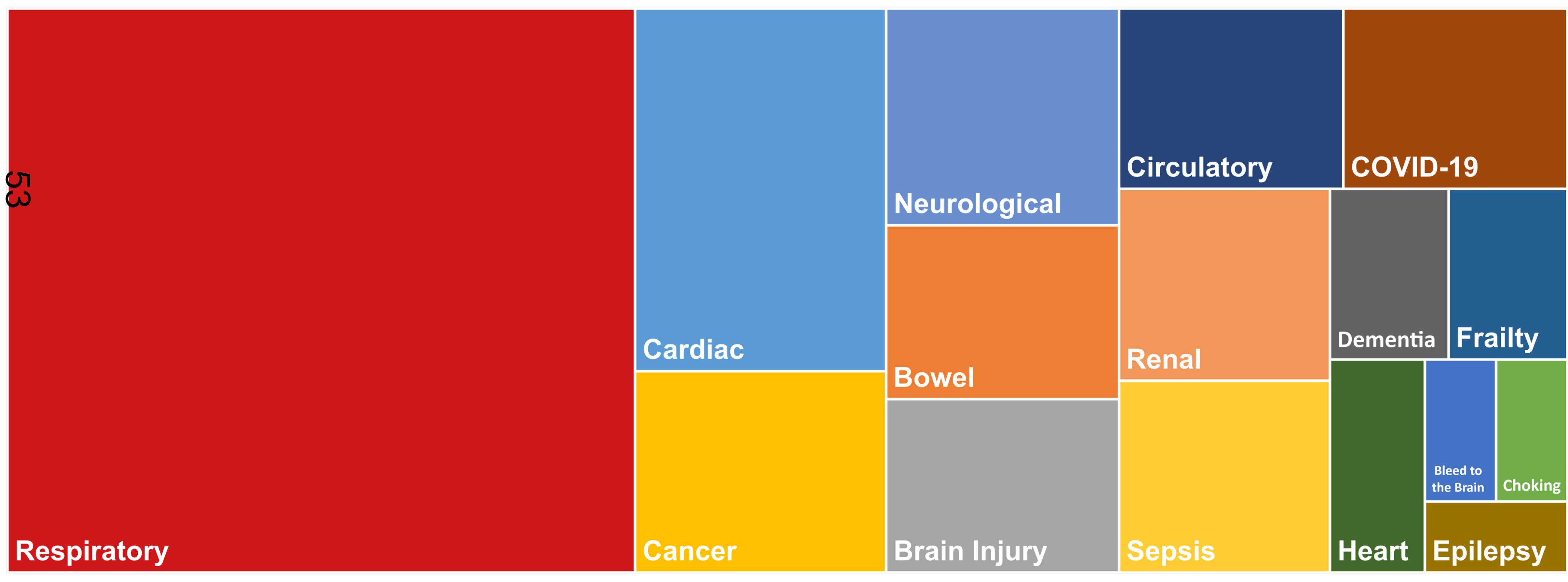
Age at death

Median age at death for those whose deaths were notified to LeDeR in 2022/23, was **62**

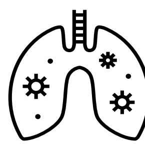
- **34% of deaths from aspiration pneumonia were avoidable**

Causes of death

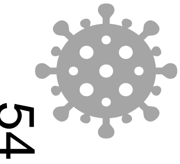
Respiratory remains the leading cause of death for those in LLR



Deeper analysis and areas of focus



Aspiration Pneumonia



Covid-19

Weight management

Mental Capacity Act assessment

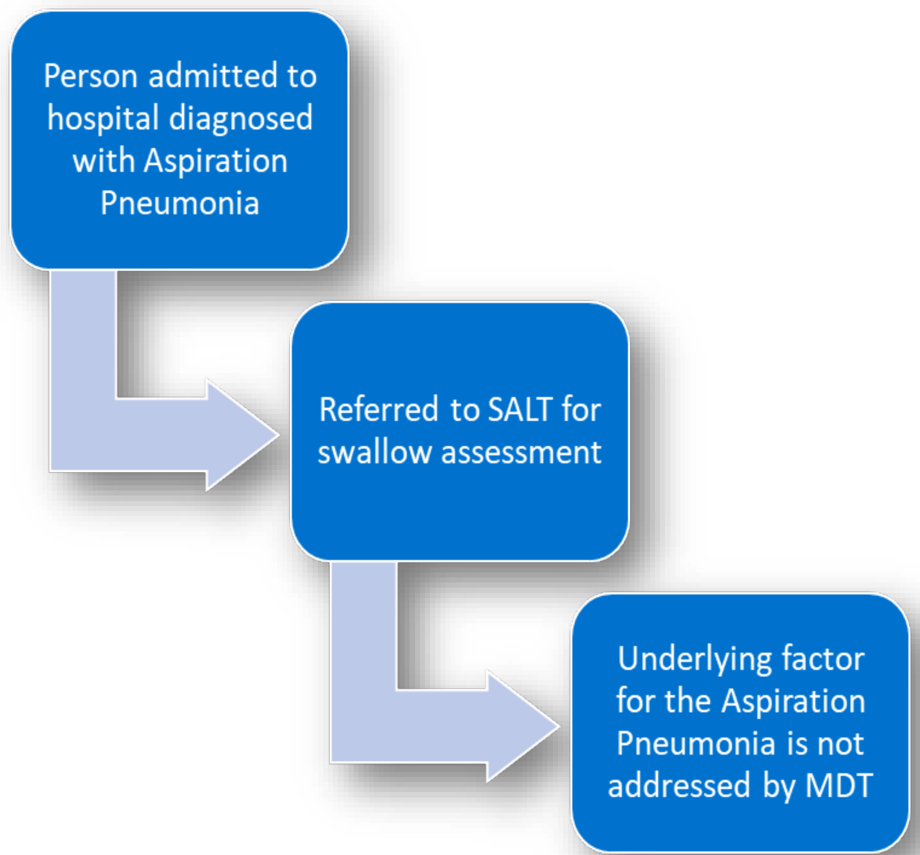
Ethnic Minorities

Venepuncture

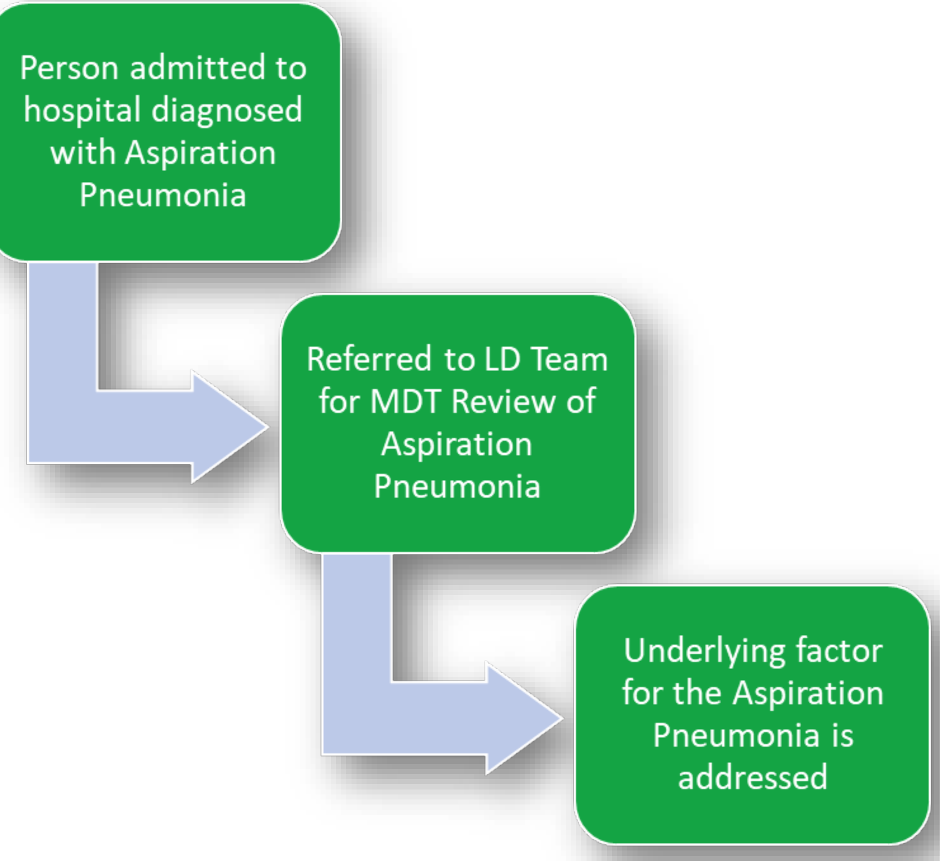
- Can be extremely challenging if a person is not compliant with the blood taking procedure and carries risks
- LLR is seeking to establish a venepuncture service appropriate for those who have received all support currently available, but require more restrictive intervention under the MCA in community care
- Successful trial with two people who had not had bloods taken for several years

Avoiding deaths from aspiration pneumonia

Current Aspiration Pneumonia pathway



Proposed Aspiration Pneumonia pathway



LeDeR 2023 TOP TEN things you can do to help

to prevent deaths of people with a learning disability and autistic people (aged 18 and over)

1. **Tell us when an autistic person dies. Deaths of autistic people are significantly under-reported.** We cannot learn from someone's life and death if we don't know they have died. Report all deaths of autistic people (with or without a learning disability) to the LeDeR Programme. This is easy to do and takes 2 minutes at https://leder.nhs.uk/report
2. **Deaths from some places and ethnic groups are under-reported. Deaths of people in Leicester City area, and of people from diverse ethnic backgrounds are not being referred to the LeDeR Programme**. This means we are unable to learn whether place of residence or ethnic background affects someone's life expectancy. Please refer all deaths to https://leder.nhs.uk/report
3. **Mental Capacity Act Assessments really do make a difference. There is widespread under-use and inappropriate use of the Mental Capacity Act across health and social care**. Please review your own practices to ensure compliance with this important legislation and share your experience with others.
4. **Weight: don't estimate, measure and record accurately. Many of those who die early have not had their weight measured accurately or managed well.** The practice of estimating someone's weight is a significant risk for people, but it is common. People **must** be weighed using appropriate weighing equipment and the weight should be recorded accurately.
5. **Plan support for people well in advance. Clear plans should be created for every person with behaviour that challenges highlighting the support they require and anticipating the support they are likely to need in the years ahead.** The needs of people with learning disabilities as physical health and nursing care increase, particularly towards the end of their life.

Top ten continued…

6. **Talk about End of Life well in advance. Care providers must be competent and confident in talking about end-of-life matters.** Have these meaningful conversations at the right time; when people are still able to take an active part in conversations about their care.
7. **Screening, screening, screening! Screening inequities exist, and every effort should be made to improve uptake**. Barriers to non-invasive bowel screening should be rectified. Speak to your Primary Care Liaison Nurse for support.
8. **Stop prescribing psychotropic medications unless they are absolutely necessary. The STOMP/STAMP agenda is well-established, but there's much to do**. Generic, physical, and mental health services all need to understand the need to reduce unnecessary medications. In the 12 months to October 2023, over 700 people with a learning disability and autistic people in LLR have had their medications reviewed and reduced as a result.
9. **30% of deaths from aspiration pneumonia are preventable. Aspiration pneumonia happens as a consequence of a precipitating event**. Early identification of risk factors and ongoing management save lives. The learning from LeDeR shows that changing of pathway at discharge to LD MDT rather than to SALT only, **will** prevent deaths.
10. **Blood tests save lives…if you can, take some blood! If you can't, there is help available.** There is specialist support for people in the community who have been unable to have blood taken from standard phlebotomy.

And finally…**spread the word!**

Contact: llr.lederadmin@nhs.net

Leicester, Leicestershire and Rutland LeDeR Annual Report 2023

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

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Foreword

This LeDeR Report would not have been possible without the dedications, commitment and passion of many people and organisations across Leicester, Leicestershire and Rutland (LLR), who have notified deaths of people with a learning disability and autistic people, conducted reviews, and coded and analysed the information. Most importantly though, we wish to acknowledge the people for whom who this report is created: people with a learning disability and autistic people, their families, their friends, their colleagues, carers, and all staff and service providers whose lives are affected by this report. Also, our LeDeR Reviewers as without their expertise, experience and passion we would not be where we are today. Whilst many people can no longer be with us today, we hope that this report honours their legacy.

We must not rest upon the contents of this report. Instead, all partners across the Leicester, Leicestershire and Rutland health and social care sector must embrace the findings of this report; everyone has a role to play. Only then will we ensure that every person with a learning disability and autistic people receive the high quality of care that they deserve. Only then will we address health inequality and inequity.

Caroline Trevithick, Chief Nurse & Executive Director, Leicester, Leicestershire and Rutland Integrated Care Board

Heather Pick, Assistant Director (Adults & Communities), Leicestershire County Council

David Williams, Director of Strategy and Business Development, Leicestershire Partnership NHS Trust

Acknowledgements

Leicester, Leicestershire and Rutland Integrated Care Partnership would like to acknowledge the support provided to the LeDeR programme by the following organisations, groups and individuals:

NHS England National Team (NHSE)

NHS England Regional Team

LLR LeDeR Team

LLR LeDeR Experts by Experience

LPT Talk and Listen Group

All family members' contributions

Leicestershire Partnership Trust

University Hospitals of Leicester

Primary Care Services

Leicester City Council

Leicestershire County Council

Rutland County Council

Leicester, Leicestershire and Rutland Child Death Overview Panel (CDOP)

LDA Collaborative

DeMontfort University

Executive Summary

The 2023 LeDeR Annual report for Leicester, Leicestershire and Rutland takes us through changes to how the LeDeR process works, including changes to the process since last year and more to come in the new working year.

The 'Reviews of Deaths' section explains how data is presented and breaks down some of the demographics by which comparisons were made. The report then looks at causes of death by demographic group, further examining the leading causes of death in LLR.

Quality of care is measured for the first time by six themes set out nationally and further examined by sub-theme.

Preventative healthcare has featured heavily in 2022/23 and LLR LeDeR has been actively involved in supporting working groups to which the programme contributes learning into action.

Thematic analysis carried out throughout the year is described, and has also been shared with national teams, notably the authors of the new 'Right Care' report.

CDOP cases and changes to policy are explained, followed by some achievements and LeDeR contributions made in the local system.

Learning into Action detail is followed by top ten learning into action, which is also highlighted below. Followed by plans for the forthcoming year, with appendices containing more detail in relation to various sections of the report.

In all, it has been a very challenging and positive year for LLR LeDeR.

Throughout the report, there are direct quotes from friends and family, shown in coloured bands across the pages. The first is shown on the next page.

Top Ten Learning into Action Points

1. Report the deaths of those people autism (with or without a learning disability) to the LeDeR Programme.

2. Report the deaths of those from Leicester City and from diverse ethnic backgrounds to the LeDeR Programme.

3. There is an emerging theme around the widespread misuse of the Mental Capacity Act. All services should review their practices to ensure compliance with this important legislation.

4. The practice of estimating someone's weight is a significant risk for people. People should be weighed using appropriate weighing equipment and the weight should be recorded accurately.

5. Clear plans should be created for every person with behaviour that challenges highlighting the support they require and anticipating the support they are likely to need in the years ahead. This should be reflected in future commissioning considerations in LLR for provision of residential care for those with learning disabilities as physical health and nursing care needs increase particularly towards the end of their life.

6. Care providers must be competent and confident in talking about end-of-life matters and having these meaningful conversations at the right time.

7. Screening inequalities exist, and every effort should be made to improve the uptake. Barriers to non-invasive bowel screening should be rectified.

8. Better understanding of the STOMP/STAMP agenda across generic, physical, and mental health services.

9. Aspiration pneumonia happens as a consequence of a precipitating event. Identification of risk factors and ongoing management are key. The changing of pathway at discharge to LD MDT is imperative.

10. There is specialist support for people in the community who have been unable to have blood taken from standard phlebotomy, which is not always accessed appropriately. Intervention by these teams does not guarantee successful outcomes but the availability should be widely known.

Having a direct payment and personal assistants ensured that every day she was well enough, she had the opportunity to go out and live her life to the max. Her car has been the only Motability car returned with 100,000 on the clock which is the maximum allowance allowed!

Introduction

The LeDeR Programme was changed from a National perspective in June 2021, when the University of Bristol's involvement came to an end and the King's College London became the new lead academic partner. The LeDeR web-based platform was launched by South Central and West Commissioning Support Unit and remains the responsibility of this team. The changes to the LeDeR web-based platform from a national level means that we continue to complete initial or focused reviews for people. This has changed the amount and type of data available at different stages of data collection. Where possible we have drawn comparisons over time but have also highlighted where, due to the transition in the system of data collection, this was not possible. For the first time since its expansion, this report will include LeDeR reviews of autistic people. As this is the first time, there is no comparable data. Notifying a death to LeDeR is not mandatory and, therefore we would not expect LeDeR to have data on all people with a learning disability and autistic people who have died in LLR. Some data contains relatively small numbers of cases, so some findings must be interpreted with a degree of caution.

National context[1]

Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR), previously known as The English Learning Disabilities Mortality Review (LeDeR) programme, was established as a pilot in 2015 and rolled out nationally in 2017. The aims are to:

1. improve care for people with a learning disability and autistic people.
2. reduce health inequalities for people with a learning disability and autistic people and
3. prevent people with a learning disability and autistic people dying prematurely.

Since being established, deaths of people with a learning disability, and from January 2022 autistic people, have been reviewed with the findings presented in the LeDeR annual reports, where the action from learning has been captured.

[1] *National LeDeR Report 2021*

Glossary of abbreviations

ALN	–	Acute Liaison Nurse
ASC	–	Adult Social Care
ASD	–	Autistic Spectrum Disorder
CDOP	–	Child Death Overview Panel
DoLS	–	Deprivation of Liberty Safeguards
DNACPR	–	Do Not Attempt Cardio-Pulmonary Resuscitation
DVT	–	Deep Vein Thrombosis
EBE	–	Expert by Experience
ECG	–	Electrocardiogram
GP	–	General Practitioner
ICS	–	Integrated Care System
IMCA	–	Independent Mental Capacity Advocate
LTC	–	Long Term Health Conditions
LeDeR	–	Learning from Lives and Deaths Review Programme
LD	–	Learning Disability
MCA	–	Mental Capacity Act
MDT	–	Multi Disciplinary Team
MHA	–	Mental Health Act
MCCD	–	Medical Certificate of Cause of Death
NHS	–	National Health Service
NICE	–	National Institute for Health and Care Excellence
ONS	–	Office for National Statistics
PBS	–	Positive Behaviour Support
PEG	–	Percutaneous Endoscopic Gastrostomy
PCLN	–	Primary Care Liaison Nurse
ReSPECT	–	Recommended Summary Plan for Emergency Care and Treatment
SJR	–	Structured Judgement Review
SMART	–	Specific Measurable Actionable Realistic Timebound
STAMP	–	Supporting Treatment and Appropriate Medication Treatment in Paediatrics
STOMP	–	Stopping the Over Medication of People with LD and Autistic People
WTE	–	Whole Time Equivalent
WHO	–	World Health Organisation

Reviews of deaths

Deaths notified to the LLR LeDeR programme

A total of 83 deaths of people with a LD and Autistic people were notified to the LLR LeDeR Programme from 1st April 2022 – 31st March 2023. Of those people:

- 3 people were autistic.
- 6 were children with a learning disability.
- 2 were out of scope for a LeDeR review.
- 72 were adults with a learning disability.

Referrals received in-year

Figure 11 below shows a total of 83 deaths referred to LLR LeDeR in 2022/23, broken down into initial and focused categories. At end of year, 22 cases remained in progress and 55 had been completed.

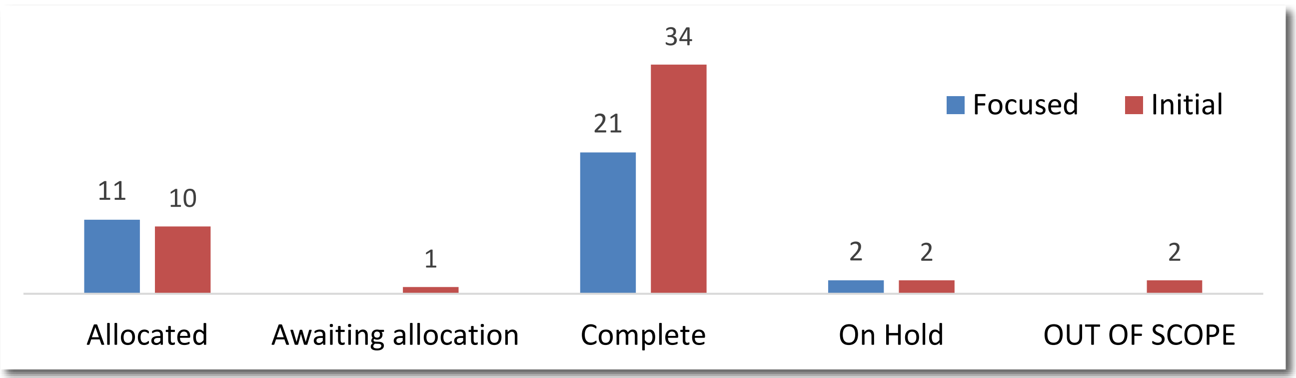


Figure 1. Referrals received by type, 2022/23

Age at death in 2022/23

Median age at death for those who passed away and their deaths notified to LeDeR in 2022/23, the median age at death was 62.

The median age at death in 2022/23, was 62.

Month of death

The 83 deaths referred to LeDeR in this time-period as shown in **Figure 2. Month of death,** with more deaths occurring in December than any other month. This is broken down in **Figure 3. Month of death by gender**

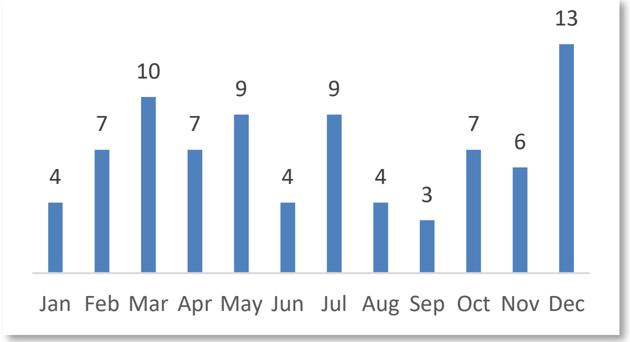


Figure 2. Month of death

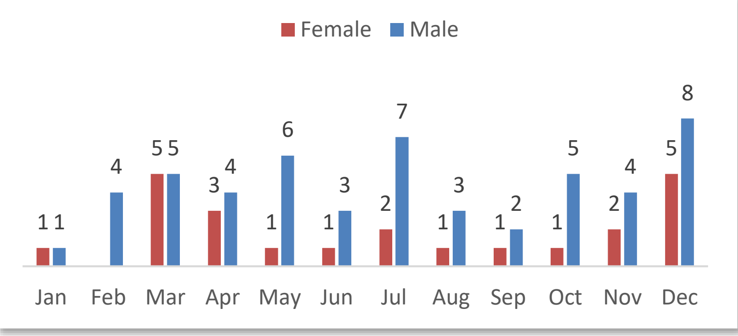


Figure 3. Month of death by gender

Reviews completed in-year

Analysis from this point covers all reviews that were completed within the 12 months from April 2022 to March 2023, rather than those received in that period.

This is because previous reports did the same, and it is possible only to report accurately on cases that were completed at the time of writing.

In 2022/23, the LLR LeDeR programme completed 94 reviews, 50 of which were initial, 44 focused (*Figure 4. Reviews completed in 2022/23*.)

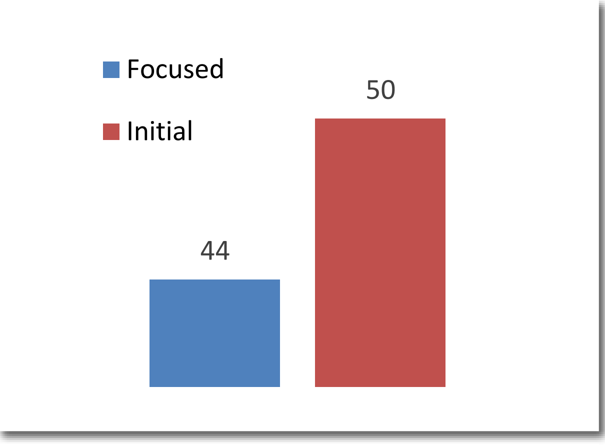


Figure 4. Reviews completed in 2022/23

It is worth noting that a number of those had been on hold for a significant period as they awaited statutory processes including Coroner's Inquests and Child Death Overview Panel (CDOP). Historically, such cases were placed 'on' hold for long periods before LeDeR was able to review them. In recent months, LLR LeDeR worked closely with LLR CDOP on 11 cases and was able finally to complete those CDOP reviews.

Equality Impact & Demographic Data

Age Group

Deaths were broken down by age group (see *Figure 5. LLR LeDeR Deaths by* age group) and is clear to see that 12% were under 18 years of age. Again, this is due to a number of referrals received pre-2022/23 that had been on hold and were completed in year, as explained in the previous

paragraph. Comparison between Figure 5 and 6 is shown for comparing deaths by age with the general population, highlighting the level of disparity. With age at death for people with a LD is 51-60yrs and for the general population this is 85-89yrs.

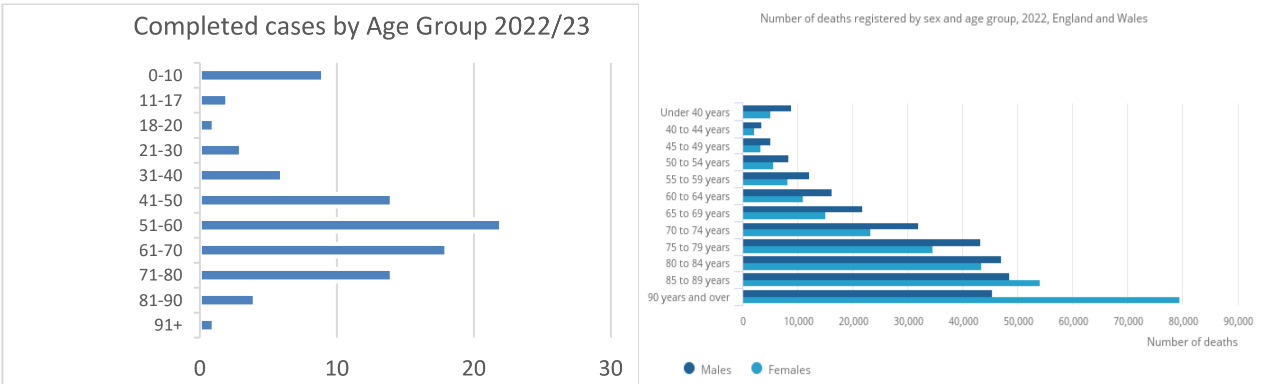


Figure 5. LLR LeDeR Deaths by age group

Figure 6. Death registration summary by age ONS

Median age at death in completed reviews

Due to the number of outstanding CDOP cases completed after being on hold (see previous paragraph), the mean age at death for reviews completed in 2022/23 is disproportionately affected. Taking all completed cases into account, median age at death in LLR was 54 years. Only one CDOP death was notified in this year and so the remaining 10 are skewing the median age at death. If the 10 CDOP cases that had been on hold are removed from pre-March 2022, the median age at death for reviews completed in 2022/23 completed reviews was therefore 58.

It is important to note that From July 2023, CDOP deaths will no longer be referred to LeDeR and so LeDeR will report only on deaths of people aged 18 or over.

Ethnicity

The vast majority of deaths were of 'White' people (82%), with 'Asian or Asian British' comprising 12% and 'Black, African, Caribbean or Black British' 1%. The remaining 5% had preferred not to state Ethnic Group. (*see*

Figure 7. Cases completed 2022/23 by Ethnic Group)

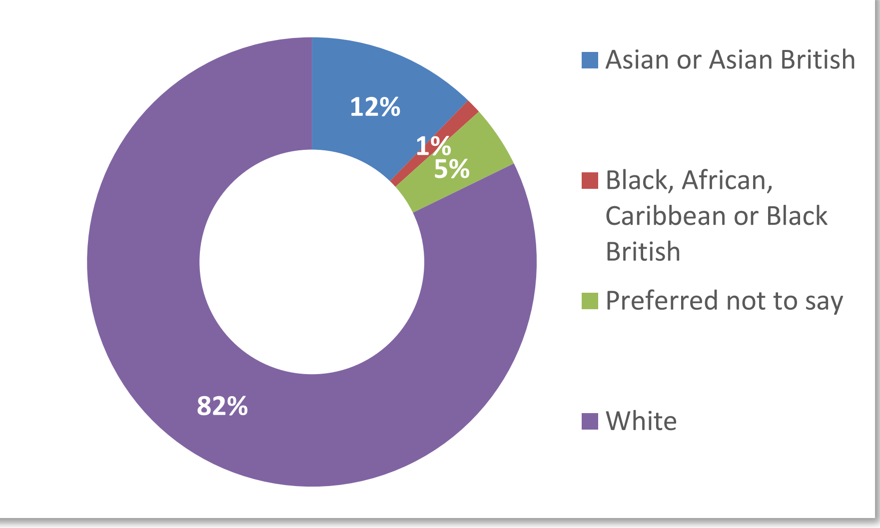


Figure 7. Cases completed 2022/23 by Ethnic Group

Breaking this down further and omitting the 'White' ethnic group allows us to see a clearer picture within different ethnicities, as shown in *Figure 8. Cases completed 2022/23 by*

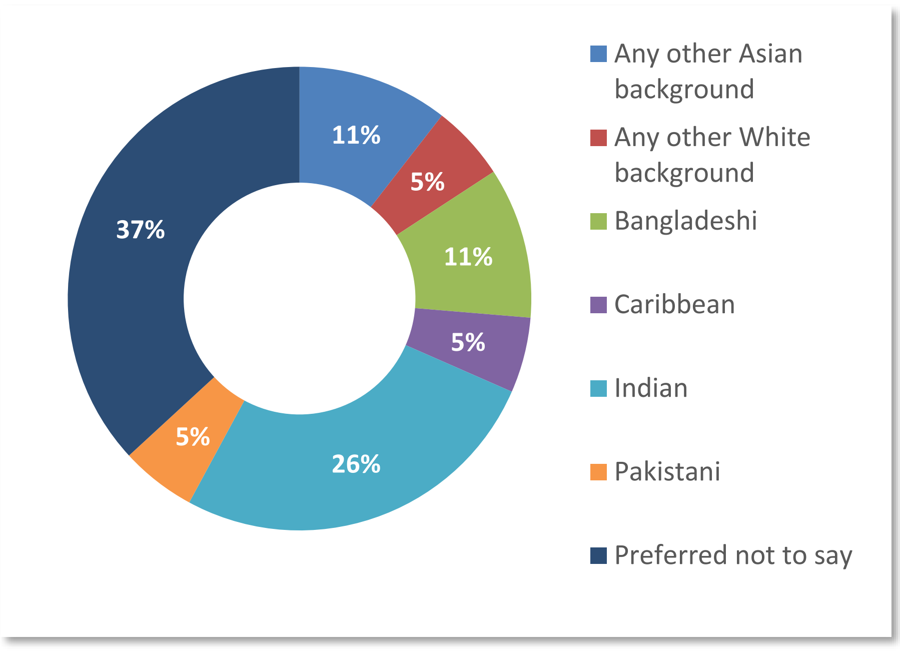


Figure 8. Cases completed 2022/23 by Ethnicity.

Gender and ICS Place

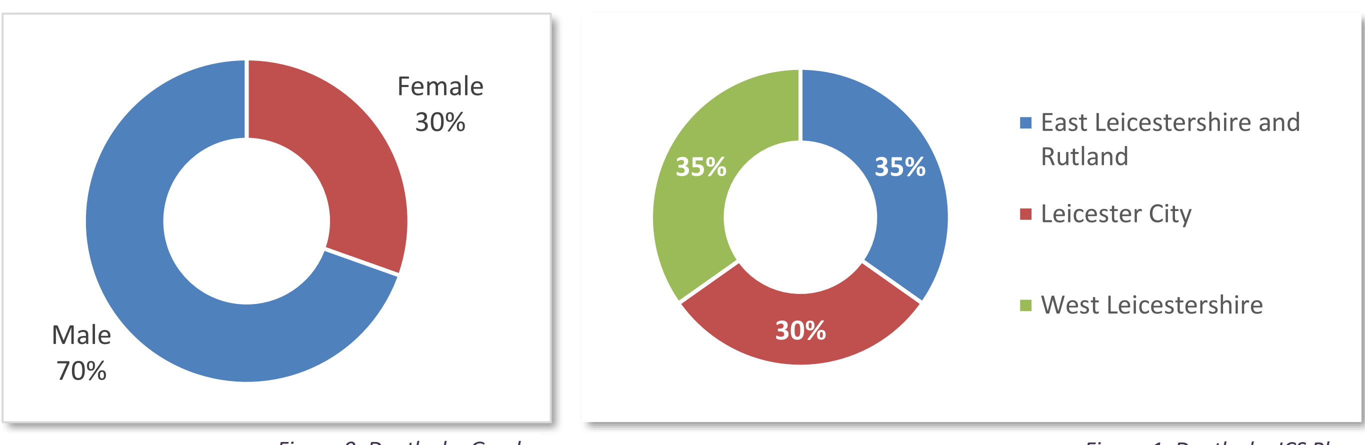


Figure 9. Deaths by Gender

Figure 1. Deaths by ICS Place

As shown in *Figure 9. Deaths by Gender*, 70% of reviews completed in 2022/234 were of males, ad 30% of females. Those people were resident across all three ICS places, almost evenly, as illustrated in *Figure 1. Deaths by ICS Place.*

Intersectionality

The LLR LeDeR team engaged in the pilot LeDeR Intersectionality train the trainer programme run by the National LeDeR Team. This was to train the remaining LeDeR workforce in culture, race and religion sufficiently to enable the reviewers to consider these factors when carrying out LeDeR reviews and make suggestions to improve services to reduce premature mortality for people with a LD and Autistic people from minority ethnic communities.

Important Statements from LeDeR

Although a lot of positive, encouraging and at times courageous work and breakthroughs have been seen in the past year for the LLR LeDeR Programme and LLR Health and Social Care System, there are two areas that require serious attention.

1. *There remains a systemic culture of acceptance with the misuse of the Mental Capacity Act (2005) for People with a Learning Disability and Autistic people. LLR LeDeR urges our local system to act now and enforce the MCA and ensure it becomes intrinsic to our everyday care and support to people with a LD and Autistic people.*

2. *Secondly, there is no doubt that some people with a Learning Disability receive inconsistent care regarding some of the basic healthcare observations. LLR LeDeR has seen the cases of a number of people who died as a consequence of malnutrition, all of whom were not weighed when they should have been. LLR LeDeR urges the seriousness of rectifying this failure.*

"The Home had two 55-inch TVs delivered and staff saw him trying to take one and put it in his room and he insisted he wanted one, so the Home contacted his Social Worker to get authorisation to get one for him. He also wanted one of the office chairs from the staff office so he helped himself to it and would sit on his swivel chair watching Family Guy and Mrs Browns Boys on his 55-inch TV to his heart's content!"

Causes and Circumstances of Death

In this section, we summarise the circumstances and most common causes of death of people with a LD and autistic people.

Cause of death by demographic group

Age Group

It is clearly shown in Figure 2. Cause of Death by Age *that the most frequent Cause of Death (CoD) was respiratory illness and that this affected most age groups, notably prominent in people aged between 41 and 70.*

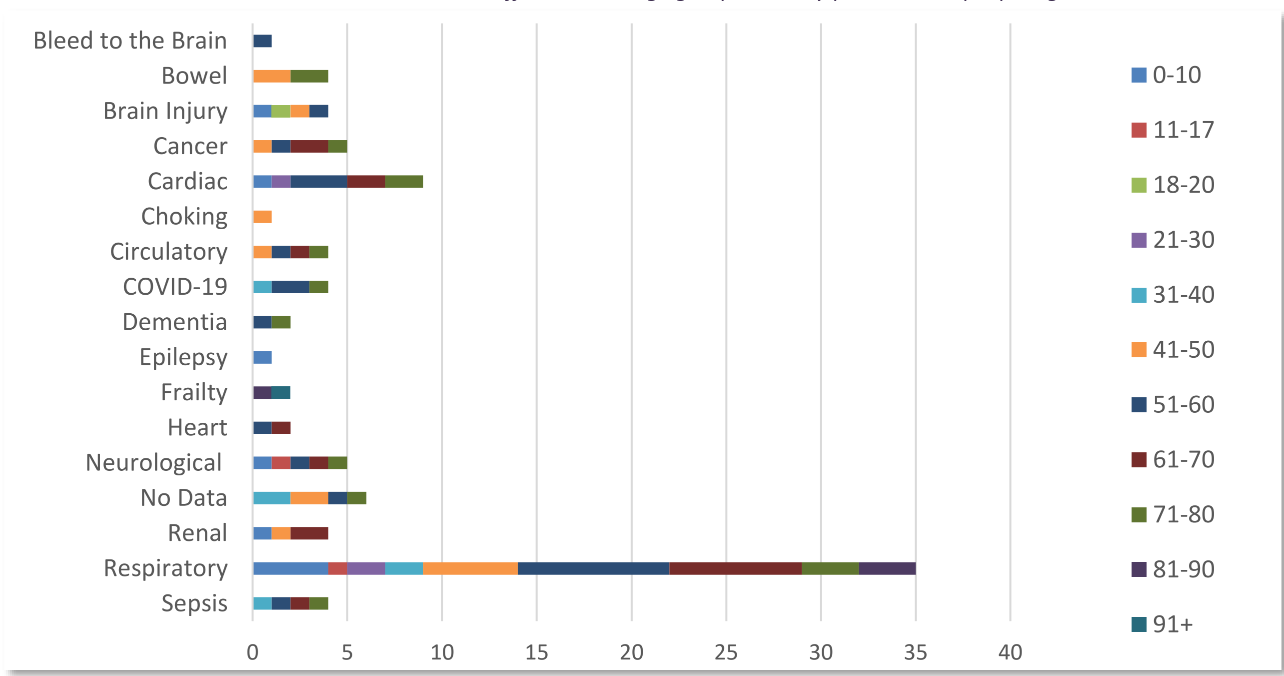


Figure 2. Cause of Death by Age

Breaking down of CoD by Ethnicity is also shown in *Figure 3. Cause of Death by Ethnicity*

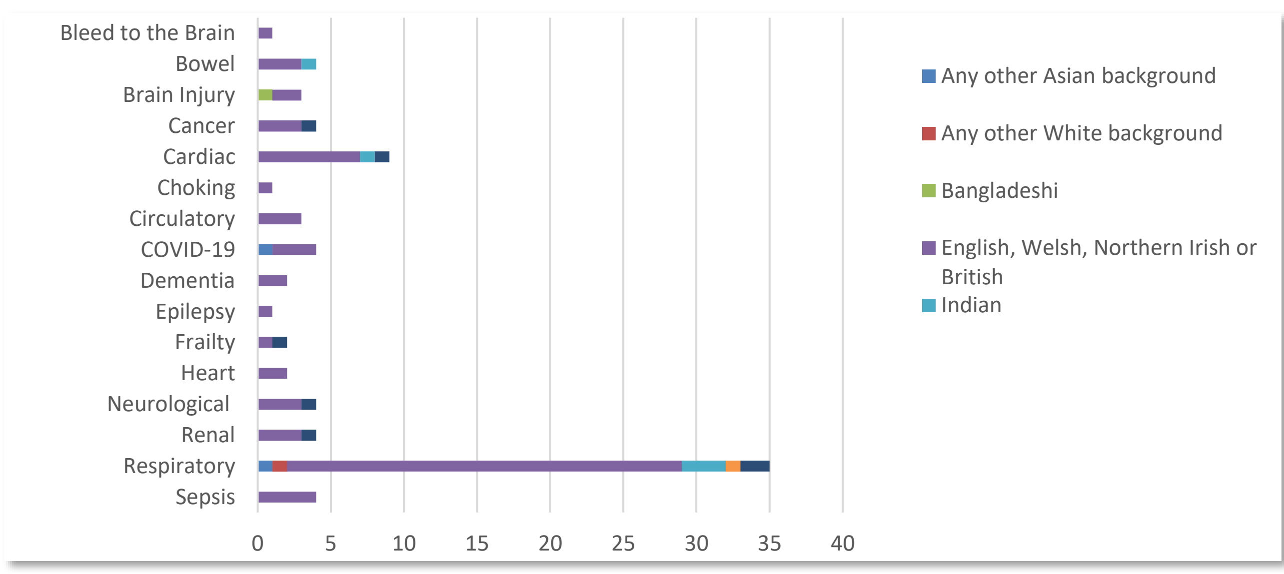


Figure 3. Cause of Death by Ethnicity

Leading Causes of Death

Causes of death in reviews competed in 2022/23 are laid out effectively in Figure 43. Causes of Death, shown below. Respiratory remains the leading cause of death, followed by Cardiac and Cancer.

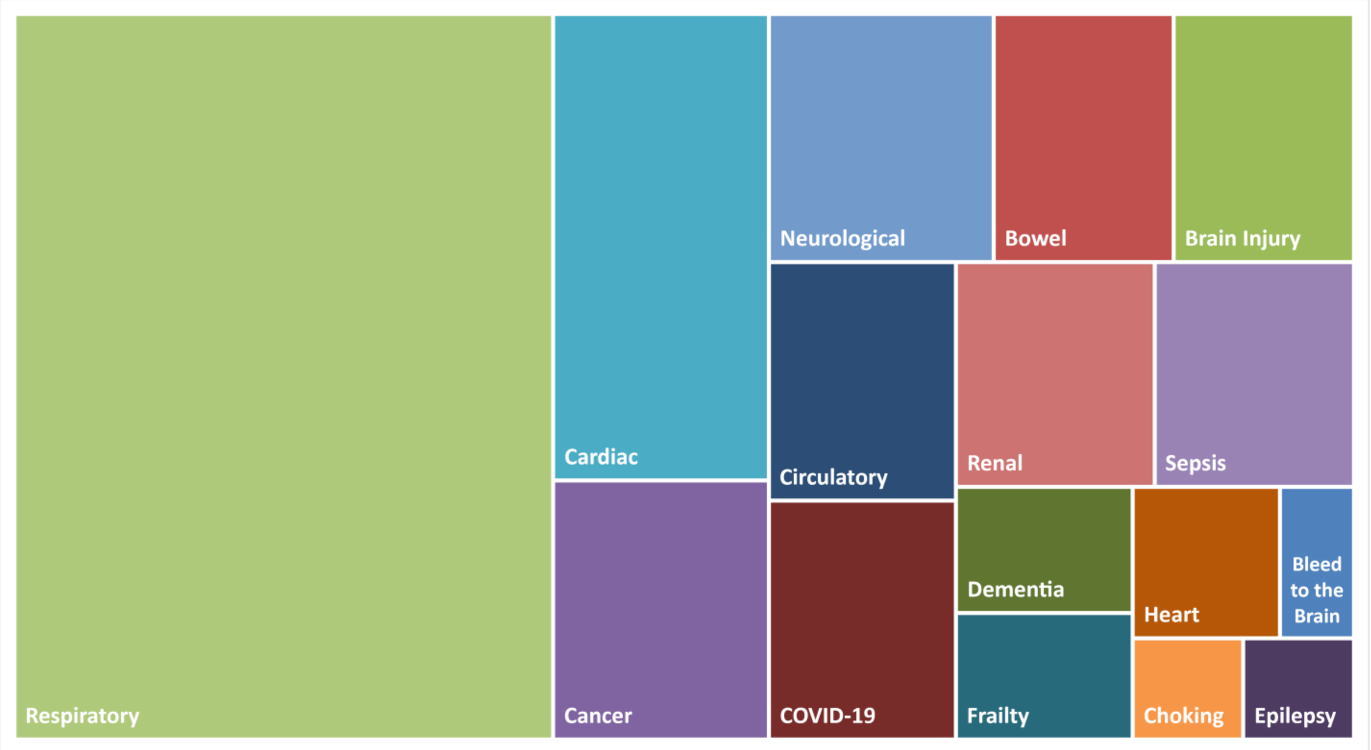


Figure 43. Causes of Death

Respiratory Deaths

Deaths from respiratory causes remains the leading cause of death for those in LLR reported to LeDeR. The Respiratory themed analysis can be found in the LeDeR 2021 – 2022 annual report. This year we were able to concentrate the Respiratory themed analysis further by analysing the deaths of those from Aspiration Pneumonia.

Cancer

Although deaths from cancer remain relatively low LLR LeDeR made the decision to revisit all the deaths from cancer reported into the LLR LeDeR Programme since 2017 up to the end of March 2023. This was to identify any inequity and offer assurance and safety in our local population. Analysis identified there were even numbers of males and females who sadly died from cancer or as a contributory factor. Since 2016, the total number of deaths from cancer is 3%, rising to 4% when including cancer listed as a contributory cause of death. There are no trends observed in the type of cancer causing the deaths of those people who have sadly died and received a LeDeR Review. Cancer screening information can be found in the section on Preventative Healthcare.

Quality of Care

High quality health and social care is of paramount importance for people with a LD and Autistic people. However, evidence has demonstrated that this is sometimes not the case and sadly, the impact on this has the potential to contribute to early or avoidable mortality. Focused LeDeR Reviews are graded in two areas, the overall quality of care the person received and the availability and effectiveness of services. The score is an overall judgement on the care the person received, it is not reflective of one service but of all the services who worked with the person as an entirety. This is the first year that grading of care has been implemented by the LLR LeDeR Programme in line with the LeDeR Policy (2021).

The breakdown of the grading can be found in *Appendix I*.

Context for grading of care 2022/23

Scoring of 1 for Quality of Care: This is related to a case that was on hold for several years following a police investigation, safeguarding enquiry and patient safety review. The actions taken from this were addressed by the relevant authorities and LLR LeDeR was satisfied by those reports and actions to redress the findings locally which reflected the grading of care at the time.

Scoring of 2 for Quality of Care: Those reviews were reflected with onward referrals and investigations to the necessary safeguarding, patient liaison and complaints boards required.

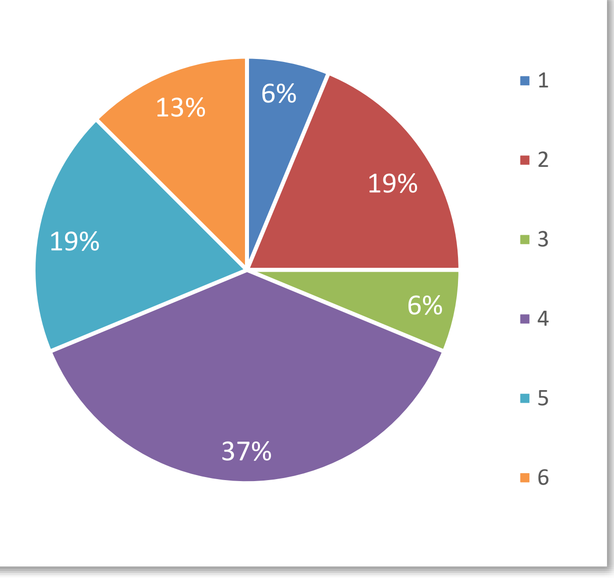


Figure 54. Grading of care

Scoring of 6 is outstanding and care we wish to celebrate and learn from; this can be demonstrated by the following: Outstanding Positive Behaviour Support and Functional Analysis assessments from the Outreach (now known as Crisis Response Intensive Support Team - CRIST) and Community LD Teams reviewed as and when required and re-referrals picked up quickly. The outcome here was that acute hospital admission was completely avoided due to the high standards of community care delivered.

Some examples of positive learning related to availability and effectiveness of services:

- Regarding the communication between the lady's carers and her GP practice there was clear evidence of good communication between the care provider and GP calls were responded to very promptly and requests for home visits were always met positively.
- The LD Annual Health Check was started via telephone call and finalised with a second appointment that was face-to-face to conduct the physical health and wellbeing checks The GP and Nurse worked together to carry out a high-quality LD Health Checks.

It is important to recognise a level of bias, as initial reviews are not graded and generally do not alert or amount to lives and deaths that have caused concern. Therefore, focused reviews are more likely to lean towards care that requires a higher level of learning into action.

Overall, the Quality of Care was favourable to higher standards, two thirds of people had satisfactory or good quality care. Although this leaves one third of people in receipt of care falling short of expected good practice.

Six Key Themes

Nationally it was requested for the first time, that all systems theme each of the learning into action into the one of six themes. As this was the first year, there is no comparable data.

In LLR, *Table 1. 6 Key Themes - learning points* shows the number of actions (learning points) related to the 6 key themes.

Theme	No. of learning points
Equality and Disability Issues including reasonable adjustments	97
All statutory duties related issues including Mental Capacity Act including end of life planning issues and DNACPR.	87
Quality of care issues in care delivery, serious incidents, and multi-agency investigations	140
Care Coordination issues including pathway issues and transition	145
Information Sharing including family involvement and documentation issues	170
Skills, knowledge and competency issues including training requirements, carers training and education.	85
Grand Total	**724**

Table 1. 6 Key Themes - learning points

The area of highest concentration is with regards to information sharing, including family involvement and documentation issues. This is broken down again in *Table 2. Sub-themes - learning points*. *(Please note only top 10 sub themes included.)*

Sub theme	No. of learning points
End of Life Care	67
Care coordination	67
Communication	59
Care Planning	57
Reasonable adjustments	53
Deteriorating Patient	47
Family Involvement	47
MCA	45
Diagnostic Overshadowing	33
Person Centred Care	28

Table 2. Sub-themes - learning points

Top areas of learning

End of Life Care, Care Co-Ordination, and Communication.

End of Life Care

Learning

"Updating of records was not completed when decisions had been made about End-of-Life Care and no hospital admissions. This prevented them from remaining in a familiar environment with familiar people supporting them. They died in hospital when they could have died at home."

"The provider felt that they had to advocate for them to receive end of life care with them at home rather than in a hospital setting."

"Conversations around end-of-life planning and respect form prior to last episode of care: Opportunities were missed to listen to them and gather their wishes as to how they wanted to be treated at EoL. They did not have a ReSPECT form completed until they were admitted into hospital at their last episode of care. Their family member stated that this is something that they would have liked to have been involved in creating."

Positive Practice

"They died a dignified death at home as planned for by those closest to them. They had an advanced care plan RESPECT form and DNACPR. All professionals involved in their life were aware their health was deteriorating and was for comfort care at home. They were actively treated wherever required and the multidisciplinary team (LD Team, family and GP) worked in co-ordination with care and compassion for them."

"It was acknowledged that they were coming to the end of their life, and they were supported to die at home. They had an advanced care plan describing their wants and wishes for the end of their life and this was explained in an easy read manner by the care home and GP. Their RESPECT form and DNACPR were all explained to them, and they were able to be in control and supported in a personalised and dignified manner with the necessary reasonable adjustments provided."

"They died surrounded by the people they loved the most."

Care Co-ordination

Learning

"They were losing weight, demonstrated in regular weight records and a referral was made to dieticians. They were eating and drinking as normal. The referral was declined, presumably due to the primary care options not being exhausted prior to the referral. Build up drinks were prescribed, the weight loss continued, and a cancer diagnosis was suspected by the GP. The GP requested a blood test due to concerns of cancer and wanting to instigate the 2-week wait pathway however there were delays in taking the bloods. During this time, they had laboured breathing and were taken to hospital where they sadly passed away. The cancer was looked at and suspected after they passed away."

Positive Practice

"The Acute Liaison Team supported them in hospital. Providing valuable information and raising best interests concerns with the ward consultant and suggesting a need for an IMCA."

"Good evidence of care co-ordination from the GP liaising with their family and carers and implementing the end-of-life care pathway in a timely and appropriate manner following their initial Alzheimer's diagnosis."

Communication

Learning

"There was no clear communication or discussion with their family or the care provider as to what was causing the urinary retention. They were discharged back to the care provider with a medical procedure in situ with no clear plan in place in relation to the presenting complaint and management of it. The care provider did not feel equipped or informed as to how to manage the rapid change in care needs."

Positive Practice

"Regarding the communication between the carers and GP practice there was clear evidence of good communication between the care provider and GP. Calls were responded to very promptly and requests for home visits were always met positively."

The decision has been made nationally to end the 6 key themes for this year only and as we enter into the new financial year 2023 – 2024, 10 key themes have been identified for LeDeR to map against instead, this will not be comparable for next year.

STOMP/STAMP

LLR LeDeR continues to see people with a LD and autistic people prescribed psychotropic medication, without the recommended STOMP or STAMP reviews.

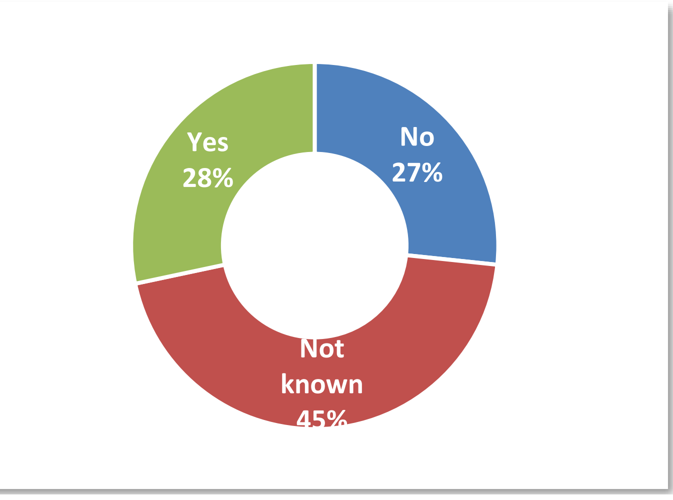


Figure 15. STOMP/STAMP review carried out for people on psychotropic medication at time of death.

Learning

- Some people were under Mental Health Psychiatry services, as opposed to LD Psychiatry, there needs to be more awareness across other directorates regarding the LDA agenda.
- Some people were prescribed Antiepileptic medication with no evidence of an epilepsy diagnosis nor prescription for behavioural management. On record analysis there were historical diagnosis of childhood epilepsy but never a review of the epilepsy or medication into adulthood. People are then living potentially unnecessarily with the side effects of antiepileptic medication.

- When a person's activities of daily living change, the impact of the psychotropic medication should be reviewed in line with STOMP. Often people with a LD communicate with their behaviour and this can be a sign of something underlying.
- Awareness in Primary Healthcare services that there are alternative options when prescribing psychotropic medication to people with a LD and a referral to Community LD Team should be considered, particularly in relation to PBS.

Positive Practice

- Some people had their medication reviewed in line with STOMP, this included clear rationale and decision making documented.
- There is evidence this year that some people had their STOMP medication with good effect, that reduced the medication they took to optimise their mental health and side effects.
- Psychiatry led MDT's when the person's presentation felt likely to be dementia avoided the need to for psychotropic medication and the care pathway implemented.
- Evidence of ongoing alternative management of behaviours that challenge for some people who experienced this their entire life and were never prescribed psychotropic medication. The stable and consistent support team were paramount in those circumstances.

An audit was conducted in 2021-22, data was collected by LPT, on local LLR prescribing practices in line with PBS guidance. Findings highlighted the need to improve physical and psychosocial health and ECG monitoring, as well improving review of medication within the 6 weeks of initiation, consent and MCA practice. Therefore, the past year has seen a benchmarking exercise against the NICE guidance NG11 (2015), and STOMP and the learning has been added to the STOMP trust wide action plan. The audit findings are comparable to what the findings are in LLR LeDeR.

For the next several years:

- LPT have delivered a new model service delivery to offer Intensive Support underpinned by PBS principles, the service is called CRIST as previously mentioned.
- The STOMP forum is led by the Clinical Director to lead improvements around polypharmacy and pharmacological interventions.
- Sponsorship of the implementation of the role of the Advanced Clinical Practitioner, in line with building the right support and STOMP. The intention is to recruit to in the next financial year.

Behaviours that Challenge

LLR LeDeR analysis highlights that more people did not have a PBS plan where behaviours that challenge were present than did. When considering this it would be anticipated that more people would have a PBS plan in place than would not. However, it should also be noted that not all behaviours that challenge presents risks and support needs that require PBS input.

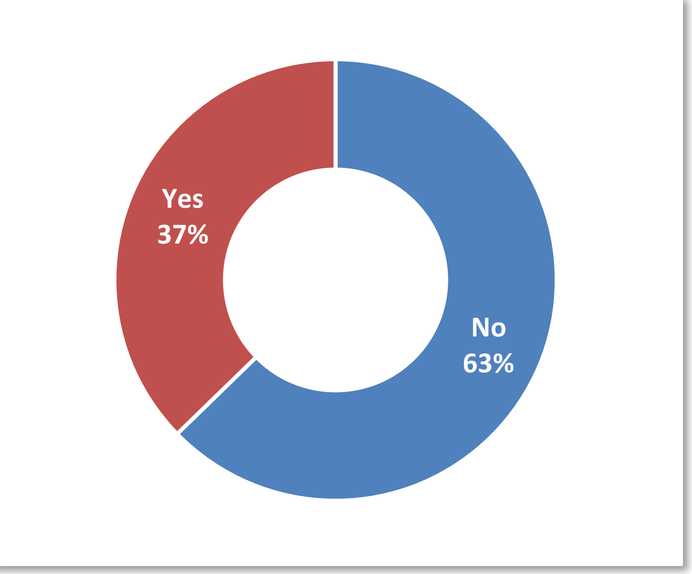


Figure 6. People with challenging behaviour who had a PBS plan in place.

Due to the ongoing evidence of Winterbourne View and Whorlton Hall enquiries and lengthy admissions to assessment and treatment hospitals for people with a LD and Autistic people with behaviours that challenge, the LLR LeDeR Programme advise that this is an area for consideration and review. The more that is understood by the behaviours that challenge and the communication needs that are being presented can only increase community care and avoidable hospital admissions.

Learning

"They received extensive support from Specialist LD and Autism services having displayed challenging behaviour for some time refusing to leave their bedroom. Although behaviours were common, they had escalated in frequency. Advice and recommendations were provided to supporting staff at their care setting; however, the care staff did not follow the suggested reasonable adjustments and the behaviour continued, he did not leave his bedroom until admission to hospital."

Positive Practice

"When their personality was understood and they were listened to and cared for in a personalised way, their challenging behaviour reduced. Community LD team particularly Outreach prevented a mental health hospital admission for them. The care from the LD team was paramount and resulted in them finally having a settled and happy life (despite years of moving from placement to placement)."

"He lived in the pursuit of happiness".

Repeated hospital admission at End of Life

It is evident to see that the EOL care of people with a LD and Autistic people in LLR is not where it needs to be yet. There are more people having repeated hospital admissions during their EOL care, than not. People with a LD and Autistic people can find hospital admissions particularly stressful and challenging, which should be avoided when it is unnecessary, in order to provide the appropriate care to the person in the community, as would be expected for all.

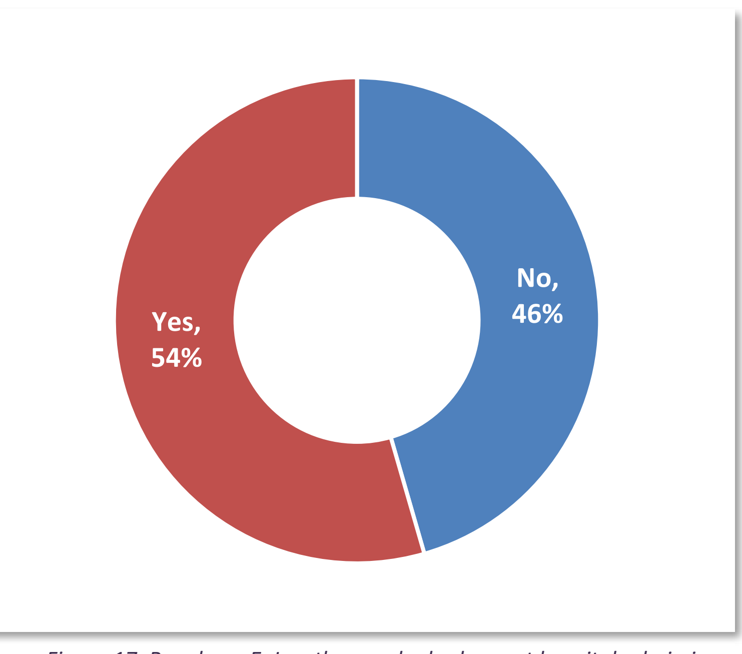


Figure 17. People on EoL pathway who had repeat hospital admissions.

It has been observed through the LeDeR governance panels that the lack of 'specialised nursing care provision for people with a LD' is showing an impact. The programme has heard the care of some people with a LD who experience behaviours that challenge and have physical healthcare needs requiring nursing care. Some people are having either their behavioural and LD needs met, or their nursing care needs met. Whereas they require both, behavioural care and management and nursing care.

Without care provision skilled in both of these areas, we will continue to see people with a LD having avoidable and repeated hospital admissions, becoming 'stuck' in hospital care having had notice handed in on their placement and frustrated care providers unable to provide the home for life and death that people with a LD and autistic people deserve.

This should be balanced with some outstanding care that has also been seen:

- Panel members describe this particular care home as brave and as a standout service. They were not a nursing care home and were not equipped to manage those needs alone (all other residents were mobile and independent). They wanted to meet the person's needs in a person-centred way, which ultimately meant they were reliant and trusting on community services supporting them all through the EOL care for them. This is not an ordinary position to take and should be commended. The person died peacefully at their care home.

LLR LeDeR is committed to a deeper understanding of the deteriorating patient and EOL care, particularly where there are concerns in those areas. This has been recognised by the LACs and LeDeR Steering Group and an agreement has been made to commit the local priority focused

review area to be "e*ither concerns around the deteriorating patient OR concerns around the EOL care the person received."*

In the past year the LDA collaborative in LLR has introduced the LDA Health Inequalities group and a subgroup focusing on learning around the deteriorating person. LeDeR has been influential and a focal point in steering these groups with the learning into action. The LeDeR themes influence the future of these working groups across the system to implement the learning into action and improvements.

An example: this year has seen successful sign off and implementation of the local accessible end of life care plan.

The LDA Collaborative focus on the deteriorating patient for this year has been:

- Weight management/nutrition and hydration.
- Improving the outcomes for people with LD and epilepsy benchmarking.
- The role out of LD specific training to care homes on recognising the deteriorating person, RESTORE2 mini and SBARD.
- Venepuncture care and provision.
- Health Equity Lead Nurse post established.

Safeguarding

LLR LeDeR continue to work closely with the LLR safeguarding teams. Where a LeDeR review and Safeguarding Adults review is being conducted at the same time, the Safeguarding Adults team lead and carry out necessary communications specifically to family members, this is also on behalf of the LeDeR Team. This enables collaborative approaches, reducing stress and inconvenience to families already under stress and upset. A memorandum of understanding is being drawn up to establish this process formally during the coming year.

"A gentle person who had a good sense of humour and someone who enjoyed being sociable."

Preventative Healthcare

Venepuncture

Venepuncture is one of easiest and the most widely used medical tests to diagnose and manage people's health. However, this can be extremely challenging if a person is not compliant with the blood taking procedure and carries risks.

Learning

"They did not have a blood test throughout their life at the GP surgery there is no evidence of a referral to the Community LD Team for desensitisation work especially after concerns were raised back in 2017 and up to the time they passed away."

"This person who had severe LDs, autism and displayed behaviours that challenge. Attempts to provide blood desensitisation support had been made over the years, but with little effect, and there were MDT discussions but there appears to have been a delayed response to best interest discussions and action around blood taking intervention. There were difficulties with the use of the Mental Capacity Act and the level of restriction that was required for successful venepuncture in the community. This person sadly died from the cancer that was in question."

"LD Team completed desensitisation work, but blood taking attempts were unsuccessful. It was decided not to do any blood tests. This was despite conventional antipsychotic medication prescribed (known to carry more side effects) most of their life. There is evidence that indicates the lack of provision available for people with a LD and behaviours that challenge with regards to blood taking when more restrictive practice under the MCA is required in community care."

"It was clearly difficult to progress through for the required blood tests and medical investigation when the person did not respond as hoped from the desensitisation."

Positive Practice

"District Nursing services would do home visits to obtain blood even though they would have been able to access the surgery. This was because it was so difficult to do a blood test and they would always have several blood vials taken to test for everything to minimise the number of times a blood test would be required. This was planned for and instigated by the GP."

"They were supported to attend all health appointments including ECG's and blood tests for metabolic monitoring."

Vaccinations

There are preventative healthcare measures that are available on rolling NHS programmes, the aim is to prevent avoidable mortality through vaccinations and screening for early detection of changes. Everyone should be given the opportunity to partake in and be aware of the available programmes. There are a number of occurrences that can affect engagement and opportunities for vaccinations for people with a LD and autistic people and therefore, reasonable adjustments are often required.

The LLR LeDeR programme, as mentioned earlier, is able to utilise only local data, manually recorded as opposed to reporting direct from the LeDeR web-based platform and the information below is reflective of this for 2022-2023.

Flu Vaccine

People with a LD, their family carers and paid supporters are entitled to a free flu vaccination. The person's choice, history and consent is important. Respiratory illness remains the leading cause of death for people with a LD in LLR. It is also known that if those around the person are vaccinated against flu, then the person themselves are less likely to contract it. Reasonable adjustments are pivotal in increasing the uptake of the flu vaccination for people, where required the nasal vaccine can be considered as an alternative with the planning and agreement of the GP practice and the person and support network. In LLR it is encouraging that 70% of people had their flu vaccine in the last year of life (*Figure 18. Flu jabs*), this should continue to be encouraged and increased. People should also be encouraged to attend their LD Annual Health Checks where further reasonable adjustments and opportunities can be discussed.

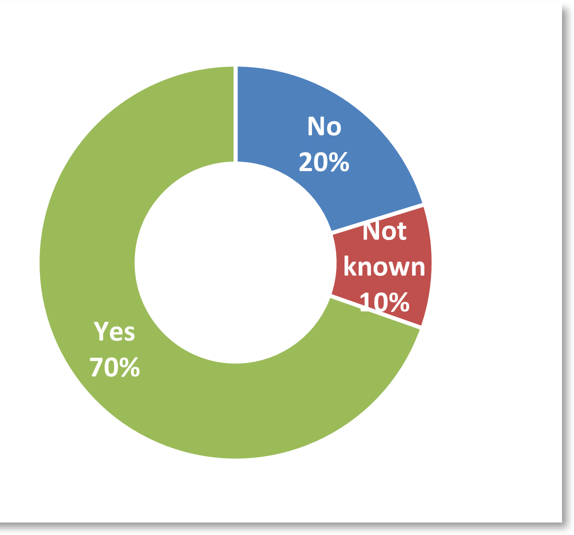
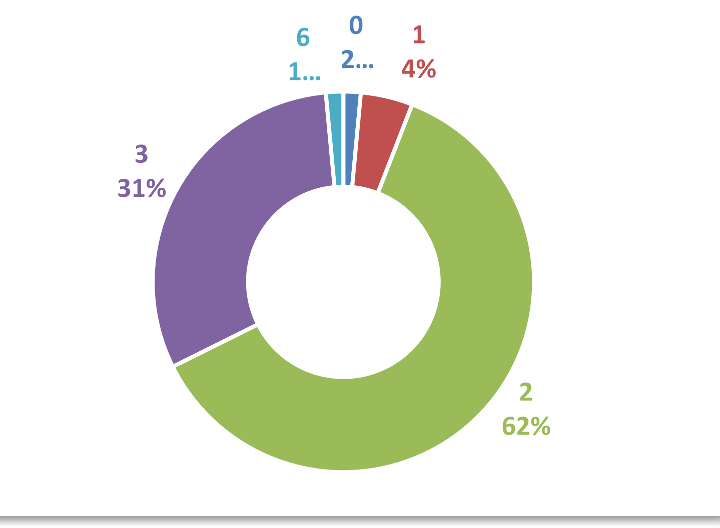


Figure 18. Flu jabs received.

Covid Vaccine

The Covid-19 pandemic struck the world in 2020 and the years that followed remained challenging for the entire population. For people with a LD and autistic people these challenges were particularly heightened and difficult; the social isolation masks, absence from families and loved ones. The change of routine and testing were demanding, tiring and for some sadly, catastrophic. The Covid vaccination programme offered some relief and protection as well as new challenges to overcome. This year has seen a decline on the number of deaths from COVID-19..



shows only 2% of people who died and not had a COVID vaccine at all. 4% had received a single vaccine, 62% had received two, 31% had received three vaccines and 1% had even received six.

In 2022 LPT was one of the lead organisations in rolling out mass Covid vaccination programmes which enabled the LD and autism leaders to influence the mobilisation of the LD and autism vaccine programme. This offer was extended until March 2023. The LD and autism vaccine programme consisted of hubs that were identified to be more accessible to the LD and autism population, that were staffed and supported by health professionals who had the skills and knowledge to overcome barriers and provide reasonable adjustments.

The teams identified a proportion of people with LD and autism who could not access the LD vaccine clinics and were able to organise a roving programme where health professionals went out to people's homes with great success.

It is important to acknowledge that there remains a portion of the population of people who did not achieve all 3 of their vaccines and some who were not successfully vaccinated. The themes for this were the complexity of restrictive practice that would have been required and would have necessitated the involvement of the Court of Protection. For some people, it was deemed not to be in their best interest by the MDT and family/carers.

There was media interest and press release which can be found in *Appendix II*.

Screening

Cancer screening is an extremely valuable and important preventative healthcare measure. However, there remain some barriers to access and even more so for people with a LD and autistic people.

Cervical Screening

In 2022-23 for those eligible for cervical screening only 19% of people attended, with 70% of people not attending. Cervical screening is known to be one of the more challenging of the screening services offered in terms of uptake, due to the intimate nature. Nevertheless, people should always be offered the appointment, never ceased from the screening register due to having a LD or autism and alternative checks can be offered such as, abdominal checks and menstrual tracking.

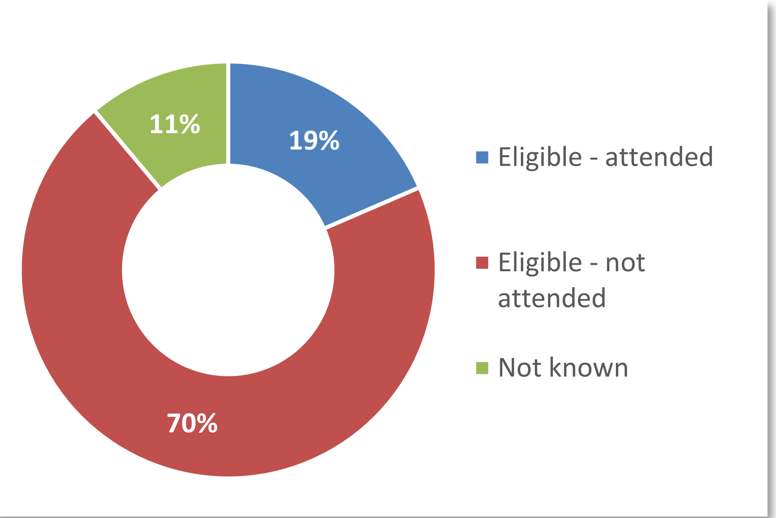


Figure 7. Cervical cancer screening attended (Where eligible)

The LD PCLN team planned and co-ordinated a specialist project on cervical screening to increase the uptake for people with a LD in LLR.

The team were successful in securing funding for the project from the LLR Cancer Screening Network. The initial project was due to run in March 2020, however due to the Covid-19 pandemic the work was suspended for two years.

The collaborative work between LPT and UHL was a complete success, yielding 100% success rate for every person on the day. The nurses have since reflected upon this session, the tilt chair was of exceptional benefit for all who attended for cervical screening, and it is hoped that this chair can be purchased and used for primary care next year. The detail of person-centred care and reasonable adjustments, including transport was found to be of most benefit.

The team are considering locations nearer to the individuals as well as plans to run regular clinics for non-attenders. The LD PCLN team have also worked collaboratively with one Primary Care Network in LLR who have put forward a proposal to run an enhanced service for LD specialist cervical screening clinics into 2023-2024. The team are considering local data analysis and impact going forward into the next financial year.

Breast Screening

In 2022-23, 33% of people eligible for breast screening attended, with 53% of people not attending. Breast screening along with breast checking are imperative for preventative healthcare and people should be adequately supported with relevant reasonable adjustments, reminders and prompts where required. The easy read video is still available to support people with LD and autism on breast screening, on the internet, that was developed by LLR and should be used and promoted.

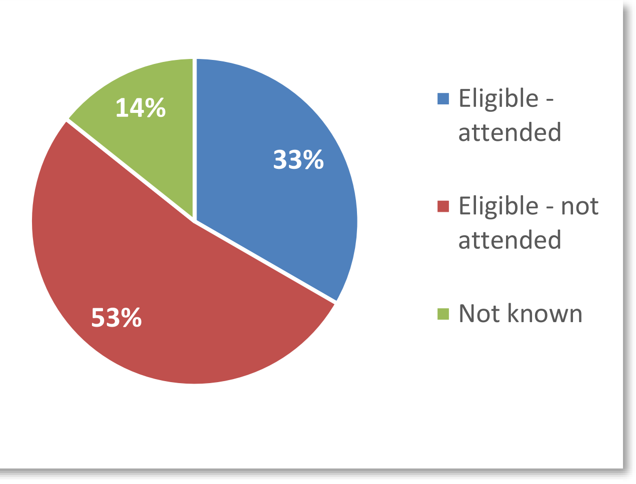


Figure 8. Breast screening attended (where eligible)

As part of the drive to increase equality for people with a LD, the LD PCLN team are working with the Breast Screening Service in LLR. The aim is to improve access by ensuring that the breast screening service are aware of individuals that have a LD and can offer them appointments at their Equality Access Clinic by using accessible letters that are more easily understood. The AHC template has also been revised and now alongside all screening questions are the links for easy read, accessible information awareness which can be printed and given during the check.

Bowel Screening

This year has seen 58% of people eligible, attend for their bowel screening appointment, leaving 32% of people not attending. Bowel screening usually yields one of the highest attendance rates due to its less invasive nature and we would be expecting this figure to rise. There has been some encouraging positive practice seen this year in LLR LeDeR with regards to supporting people with a LD to respond to the bowel screening invitation and on occasions work has been undertaken to support people in their best interests where this has been deemed necessary and appropriate. This will be continued into the next financial year.

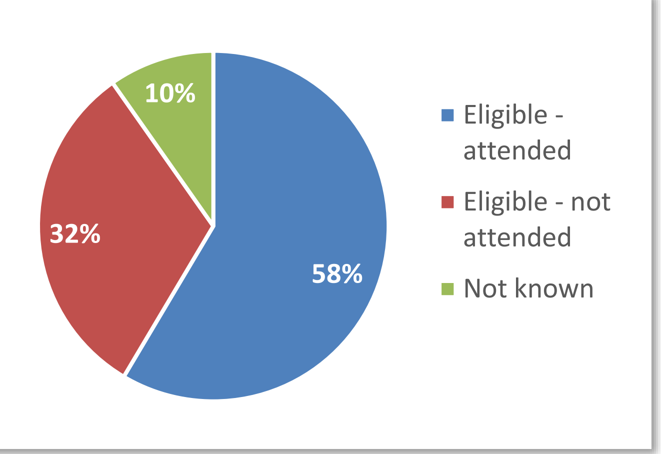


Figure 9. Bowel screening attended (where eligible)

Abdominal Aortic Aneurysm (AAA) Screening

AAA screening demonstrates that approximately half of the eligible people through the LeDeR programme are attending but half are not, further work is required to understand this better.

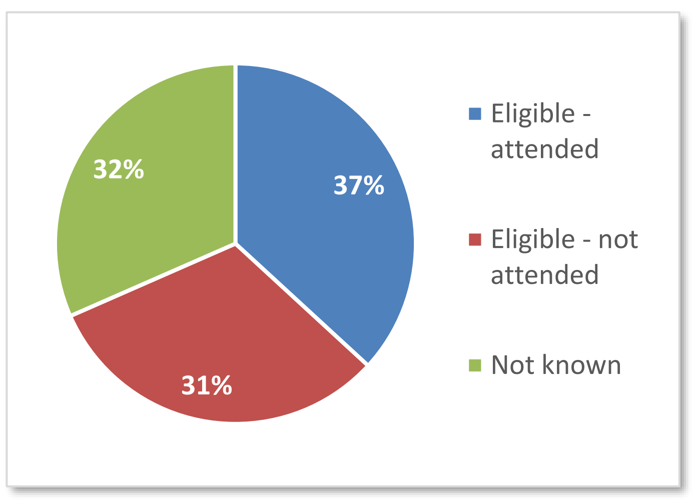


Figure 10. AAA screening attended (where eligible)

LD Annual Health Check

The past year has seen the highest achievement in LD AHCs, achieving in LLR just over 80%, which is reflected in LeDeR too. The GP practices and LD PCLN team as well as others including people with a LD and their family, friends and carers should be commended on the success in driving forward this agenda.

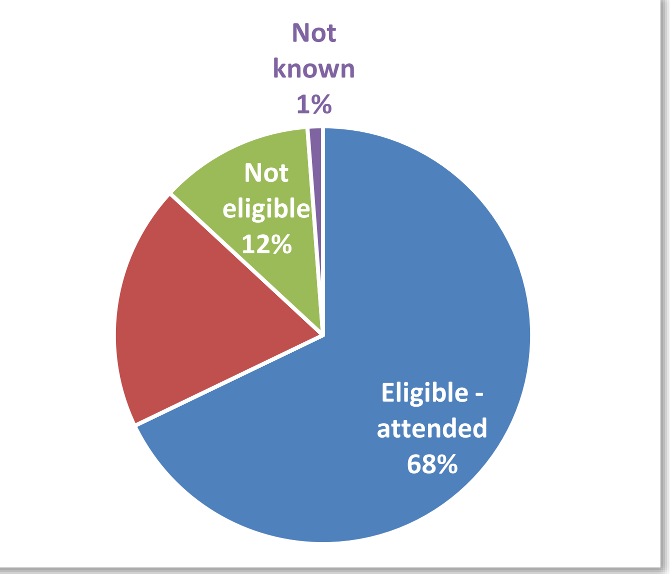


Figure 11. LD Annual Health check attendance

LLR is now second in the whole of the Midlands (and in the top ten in England) in terms of the number of annual health checks completed. Two years ago, LLR was one of the lowest performing areas in the country.

LD PCLNs, offer regular support and training on AHCs for primary care and social care partners – including GP practices – to improve access to health care and reduce health inequalities for people with a learning disability. The team are currently running a pilot project to increase the AHC uptake for those hard-to-reach communities and people who may find accessing the AHC challenging. See *Appendix III* for further information.

Thematic Analysis

Thematic analysis is a qualitative research method that can be widely used across a range of epistemologies and research questions. Lincoln and Guba's (1985) criteria for trustworthiness during each phase of thematic analysis is widely used and often viewed as the "gold standard" for qualitative research. This ensures reliability, credibility and trustworthiness in our analysis process. This framework has been adopted in LLR for the purposes of the LeDeR Learning into Action and demonstrates the systematic structure of thematic analysis undertaken for the LeDeR reviews in LLR.

There were five areas of focus for LLR LeDeR during 2022 – 2023, which were:

- Aspiration Pneumonia - *priority focused review area agreed at Steering Group.*
- Covid-19 – *Requested from Steering Group.*
- Weight - *[this was carried out but is still underway and will be explored further with completion in 2023-2024].*
- MCA - *[this work will also continue be being explored and finalised through into 2023-2024].*
- Ethnic Minority – *Mandated focused review area and agreed at Steering Group.*

Aspiration Pneumonia

Aspiration pneumonia is categorised by the Office for National Statistics (ONS86) as a preventable medical cause of death. Aspiration pneumonia results from accidental infiltration of food or other substances from the mouth or stomach into the lungs that leads to a chemical pneumonitis, lung injury, and resultant bacterial infection. **NHS website 2022**

It is diagnosed through a series of medical history, signs and symptoms along with clinical investigation. One of the challenges with aspiration pneumonia in people with a LD is that often no one actually sees the person breathe in an object or food or saliva. People are sometimes unable to communicate what and how the event occurred, putting them at greater risk.

29 LLR LeDeR reviews of people who died from aspiration pneumonia were identified for analysis, time period not restricted, this only included adults with a LD. A workstream was convened which included Consultant in Respiratory Medicine, Acute LD Liaison Nurse, Specialist Respiratory Physiotherapist and Occupational Therapist and Professional Lead for LD Speech and Language Therapy. It was found that the deaths **could not be attributed to aspiration pneumonia alone**, this is because something must have precipitated the aspiration for the incident(s) to occur. The summary can be seen below.

"He loved to watch steam trains".

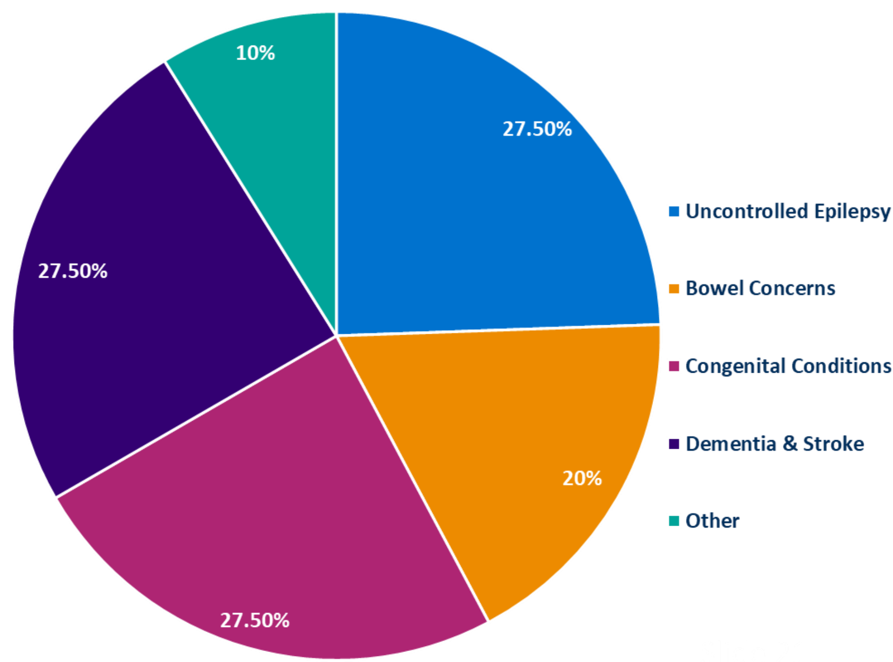


Figure 12. Percentage attributable to Aspiration Pneumonia

Sadly, 34% of the deaths were found to be potentially avoidable.

We have identified the area in the NICE Guidelines pathway that we wish to work through in LLR which is "Correct any reversible underlying problems that precipitated the aspiration". **Error! Reference source not found.**, while *Figure 27* shows the proposed pathway.

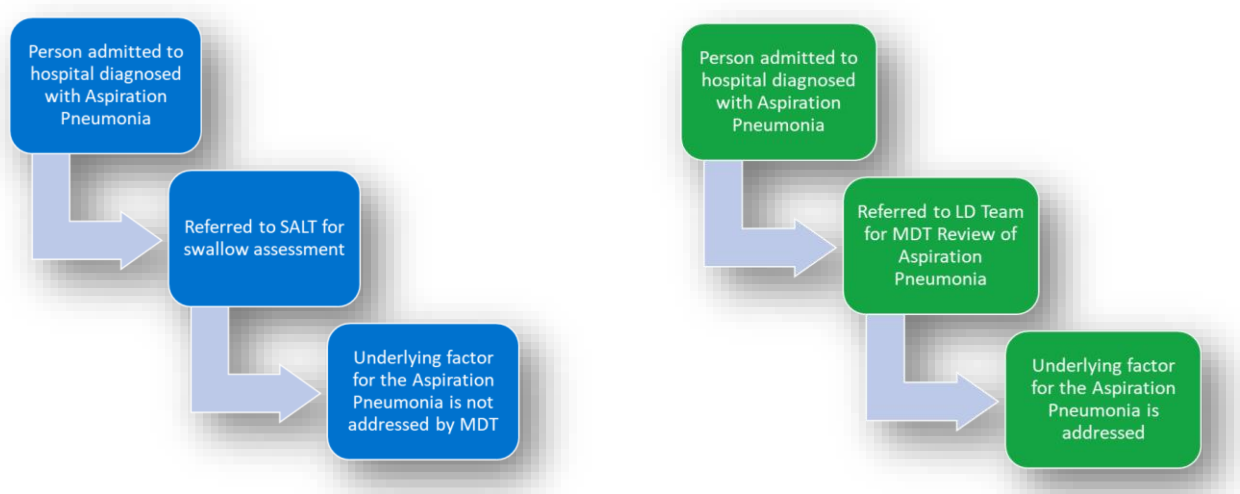


Figure 26. Current Aspiration Pneumonia pathway

Figure 27. Proposed Aspiration Pneumonia pathway

This aims to eliminate the risk of escalation by replacing referral only to SALT with referral to LD Team for MDT review of Aspiration Pneumonia.

SMART Actions

What do we want to achieve?

To reduce preventable aspiration pneumonia deaths in people with LDs in LLR.

By creating/embedding into already existing care pathways and addressing the precipitating factors linked to increased risks to aspiration pneumonia.

A comprehensive plan has been agreed based on the findings and will be implemented with the support of the LDA Collaborative partners during 2023-24. These recommendations are ambitious and require a whole system approach. The aspiration pneumonia analysis is currently being written up as a journal article piece to enable ongoing learning and research in this area.

Covid-19

A scoping exercise was completed to review further detail to inform us on the effects of the Covid-19 pandemic. This was challenging because it is often difficult to fully understand the indiscriminate nature of Covid. However, quality of care was able to be analysed with the top 3 themes highlighted and requiring improvement in the care of people with a LD and Covid:

- The implementation of the Mental Capacity Act (MCA).
- Diagnostic overshadowing and misinterpreting signs and symptoms for behaviour and communication.
- Record keeping and clearly documenting the excellent work that is often carried out, particularly in what reasonable adjustments have been provided, the MCA and how certain decisions have been reached.

Ethnic Minority

LLR LeDeR conducted a scoping exercise on all the notifications to the LeDeR Programme since 2017 of those from a diverse ethnic background.

Due to ethnicity not currently being reliably and routinely recorded on electronic patients records (SystmOne), LLR LeDeR compared the 2020 – 2021 Census data with the LeDeR notifications for the exact same time period by way of population comparative. This information and data comparison must be used with caution as it is not without its discrepancies. Special thanks to DeMontfort University in supporting this piece.

LLR LeDeR Notifications by ethnicity

White British	85.05%
Ethnic Minority	14.94%

Census data population by ethnicity

White British	87.52%
Ethnic Minority	12.48%

The charts above show on the left the LLR LeDeR Notifications received by ethnicity during specific time period of 22/03/2020 – 21/03/2021. On the right shows the Census population by ethnicity

for the same time period. This information should be used with caution, however, demonstrates the LLR LeDeR programme are receiving the expected number of notifications of those with from a diverse ethnic background.

However, when comparing specifically LLR LeDeR Notifications from Leicester City there appears to be disparity.

Comparing the census population data of those from an ethnic minority background with the LLR LeDeR notifications received of those from an ethnic minority background, in the same time period (22/03/2020 – 21/03/2021).

Census Population - Ethnic Minority background – Leicester City	**59.11%**
LeDeR Notification - Ethnic Minority background – Leicester City	**28.20%**

We would expect to be seeing more notifications to the LLR LeDeR programme of those from an ethnic minority background from Leicester City.

The scoping exercise was then undertaken, this information includes only people with a LD whose deaths were notified to the LLR LeDeR Programme.

The top 3 main causes of death were aspiration pneumonia and covid followed by pneumonia.

Diabetes in those people from an Ethnic Minority background:

- 41% of people from an ethnic minority background had **diabetes**.
- Of those people with diabetes, 71% of people had very serious health concerns. These were concerns picked up in an emergency and had been lived with for some time, but not identified or remedied prior, including ketoacidosis (life threatening condition in diabetes).
- Almost a third of those people with diabetes had morbid obesity, this increases the risks of nephropathy, heart disease and amputation, in those with diabetes.
- 86% of people lived at home with their family and no one lived in paid care environments.
- 57% of people did not attend their LD AHC and diabetic appointments.

Covid-19 in those people from an Ethnic Minority background:

- 17.5% of people from an ethnic minority background died from Covid-19.
- Of those people who died from Covid-19 85% of people had multiple co-comorbidities.
- The average age of death was 55yrs old. The average age of death from Covid-19 in the general population is 80yrs old.
- 43% of people lived in a care home and 57% of people lived at home with family.

Conditions in those people from an Ethnic Minority background:

- 14% of people from an ethnic minority background had vitamin deficiency.
- 14% of people from an ethnic minority background had anaemia.
- 60% of people did not attend age-appropriate screening and LD Health Checks.

What else have we found out through this scoping exercise?

- There is no detail at all regarding the risk level for the person with regards to their health condition and their ethnicity in clinical records/care plans, or if they are at an increased risk to a health condition. Subsequently, there is no detail on how to reduce the risk for them.

- People were more likely to live at home with their family providing care for them.
- There were higher than expected levels of obesity observed.
- Iron deficiency and vitamin D deficiency went unnoticed, especially in care homes where risks are known to be higher, but this was not accommodated.
- Culturally appropriate health and social care to support the person's life and death, was largely not documented. Where people lived with families, they were more likely to have their cultural beliefs met during life and death.
- It is not always represented in respect forms how someone's culture should be addressed at time of death.
- Assumptions are often made about someone's cultural beliefs.
- Ethnicity is not accurately and consistently recorded. Moving forward it would be more suitable to break down the ethnic groups as opposed to grouping ethnic minorities, nobody wants to be known as "other" and this should be respectfully avoided.

Autism

This year saw the LeDeR Programme open to receiving notifications of those with a clinical diagnosis of autism, and do not have a learning disability, aged 18yrs and over. The LLR LeDeR programme has received notification of very few deaths that is not representative of the local population. This is concerning and the awareness of the LeDeR programme and the notifications of deaths of autistic people must be a priority.

In total there were 3 deaths notified to LLR LeDeR of autistic people, who were all male, there have been no notifications of females. The reviews will be completed in the coming year.

"Family was very important to him, and he enjoyed going out and socialising. On a Saturday night he and his Mum would go to the local club for a drink and a dance."

LLR CDOP LeDeR themed review

Deaths of all people with learning disabilities aged 4 years and over are reviewed as part of LeDeR programme, aiming to identify learning to reduce the increased mortality and morbidity rates seen for this cohort. During 2022-23, 10 case reviews were completed for children who had died, who met the criteria for LeDeR. A review group was convened with representation from Public Health, Childrens Social Care, UHL, LPT, ICB and the LeDeR Programme to look at these cases collectively, identify themes and learning, and to generate actions.

Of the 10 cases:

- The most common category for cause of death was:
    - Chromosomal, genetic or congenital anomalies (60%)
    - Other categories included acute or chronic medical conditions, malignancy, and infection.
- Modifiable factors were identified in 2 cases.
- Positive aspects of service delivery were noted in 7 cases.
- Mean age at death was 8.3 years (4-17yrs)
- Of the two young people who were eligible for AHCs in primary care, neither were on the GP learning disability register.

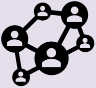
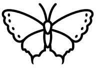
LeDeR Scope & definition: Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review.
Individuals with a learning disability are those who have:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- A significantly reduced ability to cope independently (impaired adaptive or social functioning), and
- Which is apparent before adulthood is reached and has a lasting effect on development.

"She was a lovely bubbly person and she really loved babies".

Recommendations

Key learning themes identified during the CDOP LeDeR reviews:

	Children & young people being appropriately included on the GP learning disability register at the earliest opportunity. - Ensures appropriate adjustments are made within primary care, including offer of services tailored to children and young people with a learning disability (e.g., LD vaccination clinics). - Ensures once young person is 14 years of age, they are offered an AHC. - As well as optimising overall health, can provide support with transition from child to adult services. This is also an opportunity for the GP practice to support the whole family including the needs of the parents.
	**Importance of communication with families.** - Complex care needs good coordination, families need to know who their lead professional is, effective transition to adult services for vulnerable young people is vital.
	**End of life care.** - Advanced Care Planning can be complex for children, young people and their families, whether or not they have a Learning Disability, and it is important for services to communicate and work well together to provide timely and appropriate support.

Children who have a learning disability should be on the GP Practice Learning Disability Register, to ensure that, from the age of 14 years, they are offered the opportunity for a Learning Disability Annual Health Check.

Services should ensure that:

1. At the earliest opportunity children with a learning disability are added to the GP learning disability register.

2. Inclusion in LD AHC and ensure reasonable adjustments are identified and offered at the earliest possible opportunity.

3. Individual circumstances are taken into account in terms of exceptions as it may not be appropriate for a child or young person receiving end-of-life care to be offered a LD AHC. It may be appropriate to offer a modified health check to ensure a supportive experience for the child or young person and their family.

Learning into Action

The learning into action for LLR LeDeR has a formal structured process that can be viewed in the LeDeR reporting structure at the beginning of this report. On a quarterly basis all the issues and positive practice that are highlighted from LeDeR reviews are sent to the respective service provider in order for them to develop SMART actions. The service provider then reports back to the LeDeR steering group. This is the first year it has been delivered in this way and LLR LeDeR intends to strengthen this in the coming year.

Top 3 Highlights of LLR LeDeR learning into action:

GP and Primary Care

- Improved integrated working between GP practices and LD PCLN team – enabling improved accuracy of LD registers and improved numbers of AHCs completed.
- Safeguarding, "Was Not Brought" code, is now actively in use and receiving 6 monthly updates from HIS data team, action plan will be developed from this.
- LD Primary Care Champions – seeking to establish a key person in each GP practice across LLR, including implementation of positive praise of practices demonstrating good care/positive changes for LD and Autism population.

LPT FYPC / LDA

- Accurate weight checking services for those who require alternative weighing than stand on scales. Accessible portable scales have been purchased, next step of how this will be rolled out across LLR and how wider GP networks can utilise is to be established.
- Venepuncture – seeking to establish a service appropriate for those requiring more restrictive intervention under the MCA in community care.
- Epilepsy pathway joint with UHL changes to the access to service, templates and assessments incorporating a more robust assessment of physical health and encouraging access to AHC's.

Acute Care

- Delays in access to treatment and ensuring that people with a LD are not adversely disadvantaged, there is now oversight of waiting lists by the LD ALN team.
- Limited capacity of the specialist LD ALN team to provide training and support for patients with autism and children. The capacity of the LD ALN team has been reviewed along with a business case to expand the service, which was successful and funding for an all-age LD ALN Team confirmed.
- To ensure that complex discharges are correctly identified, an audit of patients with a LD will be undertaken to confirm if they were correctly coded as a simple or complex discharge and action plan following results.

Leicestershire County Council

- Weights oversight - Care providers to understand and evidence in practice how they effectively support people with their weight management, know who they can refer to for concerns over weight management and how to make those referrals in a timely way, through training and awareness raising.
- Mental Capacity Act - Care providers to work within the Mental Capacity Act and the remit of their role. To have understanding about best interest decisions, contribute towards that decision where appropriate, working with the lead professional from health or social care, through awareness training and information.
- Reasonable adjustments - Care providers to understand reasonable adjustments and how to request this for people they support with LD and/or Autism. To make improvements through signposting care providers to LD and Autism LPT training to cover RESPECT, reasonable adjustments, hospital passports & STOMP, via Care Provider Bulletin and Provider Forums.

Leicester City Council

- Transitions care, ASC frontline staff are now discussing at point of contact with families the difference between Children's Act and Care Act. This is to ensure and support realistic support care and treatment as the child becomes an adult.
- To overcome language barriers, LD social care now have an agreement with Leicester City Council language services, that if interpreter required by phone in emergency, this can be provided. Family's preferred method of language is obtained prior to any meetings/visits and interpreter secured to enable person(s) to express views.
- ASC frontline staff are striving to secure culturally appropriate residential placements. When sourcing placements the individual's culture, language and communication needs are identified to match to the best available care provider.

"She had a wonderfully close relationship with her mother and sister and people would talk about how much her face lit up every time she saw them".

Top Ten Learning into Action

This section aims to give a final top 10 summary learning into action points from LLR LeDeR Annual Report 2022 – 2023:

1. Report the deaths of those people autism (with or without a learning disability) to the LeDeR Programme.

2. Report the deaths of those from Leicester City and from diverse ethnic backgrounds to the LeDeR Programme.

3. There is an emerging theme around the widespread misuse of the Mental Capacity Act. All services should review their practices to ensure compliance with this important legislation.

4. The practice of estimating someone's weight is a significant risk for people. People should be weighed using appropriate weighing equipment and the weight should be recorded accurately.

5. Clear plans should be created for every person with behaviour that challenges highlighting the support they require and anticipating the support they are likely to need in the years ahead. This should be reflected in future commissioning considerations in LLR for provision of residential care for those with learning disabilities as physical health and nursing care needs increase particularly towards the end of their life.

6. Care providers must be competent and confident in talking about end-of-life matters and having these meaningful conversations at the right time.

7. Screening inequalities exist and every effort should be made to improve the uptake. Barriers to non-invasive bowel screening should be rectified.

8. Better understanding of the STOMP/STAMP agenda across generic, physical, and mental health services.

9. Aspiration pneumonia happens as a consequence of a precipitating event. Identification of risk factors and ongoing management are key. The changing of pathway at discharge to LD MDT is imperative.

10. There is specialist support for people in the community who have been unable to have blood taken from standard phlebotomy, which is not always accessed appropriately. Intervention by these teams does not guarantee successful outcomes but the availability should be widely known.

Plan for 2023/24

1. LLR LeDeR projects for 2023 - 2024:
    a. LLR LeDeR – the Mental Capacity Act through story telling.
    b. Leading a safe programme – Review of deaths of those who live in care homes. Weight Management – effects of poor weight management from the perspective of LLR LeDeR.

2. Restorative Supervision:
    a. To balance the effects of compassion fatigue the LLR LeDeR Team will be engaging in 6 x restorative supervision sessions during 2023 – 2024.

3. Experts by experience:
    a. Aim to ensure all the LLR LeDeR programme, boards, panels and where possible interviews are co-chaired by an EBE. This is from a strategy and planning perspective, creating the agenda and forming the drive and commitments of the programme.

4. Intersectionality:
    a. The LLR LeDeR programme intends to embed intersectionality into each review, understanding local cultures, highlighting areas that are impactful for individuals on an individual and personable level, creating a diversity to the review, panels and discussions. This in turn will shape the steering group and LD&AAB.
    b. Accurate recording of the ethnicity of people with a LD and autistic people on electronic patient records is a priority to be addressed in LLR for next year.

5. LeDeR:
    a. To revise the membership and include more people and a wider audience i.e., registered managers of care provision for those with LDs or autistic people; mental health practitioners; Drug and Alcohol services; lay member to represent those from a diverse ethnic background etc. *[List not exhaustive].*
    b. To hold themed analysis:
        i. Ethnic Minority.
        ii. Autism only.
        iii. Local priority focused review area, which for LLR in 2023-2024 is 'concerns around end-of-life care and/or the deteriorating patient'.

6. Steering Group:
    a. To hold themed steering groups directing the focus on learning into action and bringing all providers services together:
        iv. LD AHCs.
        v. MCA.
        vi. EOL.
        vii. Weight.
    c. To receive bimonthly highlight reports from each provider service and to include positive practice. To better understand the learning into action progress more consistently.

7. Conducting High Quality LeDeR Reviews:
    a. Receive a session on the 5 Why's is scheduled for the LLR LeDeR Team in May 2023.

8. Autism:
    a. Support the introduction of the Autism register and autism AHC.
    b. To work with the Patient Safety Team and Learning from Deaths team in LPT to look to improve notifications of autistic people and improve overall governance structure of LLR LeDeR programme.
    c. Develop an autism only data collection, including additional relevant factors in autism only governance presentations.

9. The LDA Collaborative focus on the deteriorating patient workstream for next year is:
    a. Themes from the LLR LeDeR aspiration pneumonia analysis.
    b. EOL care for people with LD.
    c. Continuation of improving the outcomes for people with LD and epilepsy benchmarking - this is a 3-year plan.
    d. Continuation of the weight management and nutrition and hydration workstream.
    e. Trialling the new plans and service delivery on for venepuncture care and provision.

10. Aristotle
    a. To work with and alongside the Aristotle data system and teams utilising this database to reflect on findings from LeDeR.

11. Health Equity and LD PCLN team Qi projects:
    a. Working with people with a LD in prisons ensuring the correct people are appropriately on the LD Register and appropriate LD AHC.
    b. To re-establish the Better Health group to work collaboratively on the health equity plan which LeDeR feeds into.
    c. Implement the transition age uptake of LD AHCs project [including CDOP analysis].
    d. To implement the mobile vaccination unit for the coming year, to offer additional reasonable adjustments to access primary care; offer health promotion; screening and access to weighing and physical health checks.
    e. Quality audit for LD AHCs.

"She loved having nice clothes and she had beautiful outfits and wore these with bracelets and necklaces. She had a great collection of them and wouldn't leave the home without a necklace and a bracelet."

Appendix I

Grade	Quality of Care	Availability and effectiveness of services	Grade
6	**This was excellent care (it exceeded expected good practice).** Please identify in learning and recommendations what features of care made it excellent and consider how current practice could learn from this.	**Availability and effectiveness of services was excellent and exceeded the expected standard**	6
5	**This was good care (it met expected good practice).** Please identify in learning and recommendations what features of care that current practice could learn from	**Availability and effectiveness of services was good and met the expected standard**	5
4	**This was satisfactory care(it fell short of expected good practice in some areas, but this did not significantly impact on the person's wellbeing).** Please address these issues in your recommendations for service improvement and identify in learning and recommendations any features of care that current practice could learn from	**Availability and effectiveness fell short of the expected standard in some areas, but this did not significantly impact on the person's wellbeing.**	4
3	**Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.** Please address these issues in your recommendations for service improvement and identify any features of care that current practice could learn from.	**Availability and effectiveness fell short of the expected standard, and this did impact on the person's wellbeing but did not contribute to the cause of death.**	3
2	**Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death**. Please address these issues in your recommendations for service improvement and identify any features of care that current practice could learn from.	**Availability and effectiveness fell short of the expected standard, and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.**	2
1	**Care fell far short of expected good practice and this contributed to the cause of death**. Please address these issues in your recommendations for service improvement and identify any features of care that current practice could learn from.	**Availability and effectiveness fell far short of the expected standard, and this contributed to the cause of death.**	1

Appendix II

Covid 19 Coverage for LLR LD Vaccination Programme.

- 12 Oct: LD Vaccination Clinic promo interview on BBC Radio Leicester Breakfast Programme.
- 28 Oct: LD Vaccination Clinic, coverage on East Midlands Today lunchtime bulletin.
- 28 Oct: LD Vaccination Clinic, coverage on East Midlands Today evening bulletin.

13 Jan: https://www.leicspart.nhs.uk/news/people-with-learning-disabilities-invited-to-book-in-at-specialist-covid-19-vaccination-clinics/

06 May: https://www.leicspart.nhs.uk/news/specialist-learning-disability-and-autism-covid-19-vaccination-clinics-open-doors-to-children-and-adults-this-spring/

21 June: LD Week - https://www.leicspart.nhs.uk/news/more-specialist-covid-19-vaccination-clinics-announced-this-learning-disability-awareness-week/

21 Sept: Winter preparation - https://www.leicspart.nhs.uk/news/specialist-learning-disability-covid-19-vaccination-clinics-reopen-ahead-of-winter-season/

06 Oct: https://www.leicspart.nhs.uk/news/octobers-specialist-learning-disability-covid-19-vaccination-clinic-is-announced/

08 Nov: LD Vaccination Clinic at Highcross Shopping Centre - https://www.leicspart.nhs.uk/news/highcross-shopping-centre-to-host-the-next-learning-disability-covid-19-vaccination-clinic/

05 Dec: **LD Vaccination clinics/last of 2022 -** https://www.leicspart.nhs.uk/news/leicestershire-partnership-nhs-trust-to-host-final-covid-19-vaccination-clinic-for-people-with-a-learning-disability-of-the-year/

Appendix III

LD AHCs further information

Further information can be found here [Huge progress on annual health checks for people with learning disabilities across LLR - Leicestershire Partnership NHS Trust](https://www.leicspart.nhs.uk/news/huge-progress-on-annual-health-checks-for-people-with-learning-disabilities-across-llr/) [URL: https://www.leicspart.nhs.uk/news/huge-progress-on-annual-health-checks-for-people-with-learning-disabilities-across-llr/] (Last accessed 17/07/2023)

Appendix D

Public Health & Health Integration Scrutiny Committee

Work Programme 2023 – 2024

Meeting Date	Item	Recommendations / Actions	Progress
9 August 2023	**Introduction to health** **LCC, ICB, UHL, LPT**	Overview presentations to be circulated to all members.	Two presentations from public health and health partners distributed.
		Items to be considered for the work programme: - Public Health links to planning and development. - Access to GP Surgeries. - Strategic Priorities of ICB, UHL and LPT - UHL reconfiguration	Items added to work programme suggested list to consider.
	Leicester children's health and wellbeing survey		

Meeting Date	Item	Recommendations / Actions	Progress
12 September 2023 **Joint meeting with Adult Social Care*	**Winter Planning**	Further information requested on: - Measures taken to support bariatric patients. - Clarity on whether clinicians and other professionals (including those who are recently retired) will be supporting the 111 service - Deaths as a result of Covid-19. - Virtual wards - UHL recruitment and retention figures - Flu vaccination figures for 2022	Information shared with Members.
		Online courses relating to fuel poverty support to be circulated to all members.	Webpages are being finalised and information will be sent to Members.
		All councillors be invited to participate in the training provided on supporting those experiencing cost-of-living/fuel poverty difficulties.	Dates are being explored and invitations will be sent to Members directly.
		Further report on the health impacts of the cost-of-living crisis be brought to a future Public Health and Health Integration Scrutiny Commission meeting.	Added to the work programme.

7 November 2023	ICB 5 Year Forward Plan – Pledges 10 & 11 Mental Health (ICB / LPT)	Data to be provided to the Commission for the last 12months on referral numbers by GP's to CAMHS and numbers 'rejected' back to GP's.	Information shared with Members.
		Information to be provided on whether LPT are putting anyone through the available NHSE apprenticeship funding, available until March 24.	Information shared with Members.
		Data to be shared with the Commission on waiting times, particularly longest waiting time from contact to starting treatment and average wait times for conditions.	Information shared with Members.
		Data to be shared with the Commission on the breakdown of referrals, for example, age, ethnicity, gender, disability. It was also requested that future reports contain this level of detail in reports from the outset.	Information shared with Members.
		Members comments and concerns be noted by ICB and LPT.	
	Covid 19 & Winter Pressures Update (Public Health & ICB)	Details of vaccination centres within each ward to be shared with all members to promote to residents.	Information shared with Members.
		The item to remain on work programme for further updates on covid, flu and measles.	Verbal update to be provided at meeting on 12 December and further update on 6 February.
	Maternity Inspection Update (UHL)	Members comments and concerns be noted by UHL. The item to remain on work programme for update on improvement plan progress.	Item listed on the work programme for further update to be provided.

Meeting Date	Item	Recommendations / Actions	Progress
	UHL Reconfiguration (UHL)	Details to be shared with the Commission on increasing beds once the remodelling exercise is complete. A site visit to be arranged to the East Midlands Planned Care Centre at Leicester General Hospital. The item to remain on the work programme for the Commission to be kept updated.	Action to remain on tracker for information to be shared in 2024. Visit arranged for Members. Item listed on the work programme for further update to be provided.
	RAAC Update (ICB)	The Commission requested information be provided as to whether the ICB have confirmed with NHSE that they have no powers to compel GP practices to conduct surveys.	Clarity is being sought and will be shared with Members.
	Sexual Health Re-Procurement (Public Health)	The Commission noted the report.	

Meeting Date	Item	Recommendations / Actions	Progress
12 December 2023	Suggested items tbc: **ICB 5 Year Forward Plan – Pledge 4 GP Access (ICB)** **LeDeR Annual Report (LPT)** **Covid-19, Flu and Measles – Verbal Update (Public Health)**		

Meeting Date	Item	Recommendations / Actions	Progress
6 February 2024	Suggested items tbc: **Budget** **(Public Health)** **0-19 Contract** **(Public Health)** **ICB 5 Year Forward Plan – Pledge 8 – Elective Care** **(ICB)** **Review Report – BLM and NHS Workforce: response to recommendations** **(LPT)** **Covid-19, Flu and Measles Update** **(Public Health)**		
2 April 2024	Suggested items tbc: **Health and Wellbeing Strategy** **(Public Health)** **Oral Health Services** **(Public Health and ICB)** **ICB 5 Year Forward Plan – Pledge tbc** **(ICB)**		

Forward Plan Items (suggested)

Topic	Detail	Proposed Date
Health Inequalities Update – impact of the cost-of-living crisis **Public Health**		
Update on UHL Finances **UHL**		
ICB 5 Year Forward Plan – Pledges **ICB**		
Vaccinations **ICB**		
Mental Health **LPT, Public Health & ASC**	Commission requested at the joint meeting with Adult Social Care on 30 November that death by suicide be added to the work programme for a future meeting.	30 November 2023 Joint meeting with ASC
Drug and alcohol services **Public Health**		30 November Joint meeting with ASC
Active Leicester **Public Health**	To be discussed at Culture and Neighbourhoods Scrutiny Commission.	
Covid-19 and Winter Pressures **Public Health & ICB**	Item discussed at the Commission on 7 November. Requested item to remain on the work programme for an update on covid-19, flu and measles.	
Maternity CQC Inspection **UHL**	Item discussed at the Commission on 7 November. Requested item to remain on the work programme for further updates on the improvement plan.	

UHL Reconfiguration **UHL**	Item discussed at the Commission on 7 November. Requested item to remain on the work programme for further updates.	