Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: TUESDAY, 15 OCTOBER 2013 at 5.30pm

P R E S E N T :

Councillor Cooke – Chair
Councillor Sangster – Vice -Chair

Councillor Chaplin Councillor Cleaver
Councillor Singh

Councillor Palmer, Deputy City Mayor

Also in Attendance

Ms C Davenport	Director of Business Development, Leicestershire Partnership Trust
Prof. D Chiddick	Chair of the Leicestershire Partnership Trust
Ms D Chaney	Chief Executive, LAMP
Dr S Freeman	Managing Director, Leicester City Clinical Commissioning Group
Dr S Kumar	Medical Director, Leicestershire Partnership Trust
Mr T Menzies	Leicester City Clinical Commissioning Group
Mr S Sharmar	Healthwatch, Leicester

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61. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Desai.

62. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed. No such declarations were made.

63. MINUTES OF PREVIOUS MEETING

RESOLVED:

that the minutes of the meeting held on 3 September 2013 be approved as a correct record.

64. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

65. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations or statements of case had been submitted in accordance with the Council's procedures.

66. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2013/14.

The Chair reported that the Work Programme would not be fully finalised until the current external scrutiny review had been completed. However, the following items would be added to the Work Programme for the November meeting:-

a) Update on Progress on 'Closing the Gap' (Leicester's Joint Health and Wellbeing Strategy 2013-2016).
b) Bradgate Adult Mental Health Unit – review of 2nd inspection by the Care Quality Commission and progress.
c) Public Health Budgets.
d) Dental Health in the City and Dental Health Strategy and Policy.
e) Response to the Commission's Scrutiny Reviews.

67. CORPORATE PLAN OF KEY DECISIONS

The Commission received and noted the items that were relevant to its work in the Corporate of Key Decisions that will be taken after 1 October 2013.

The Chair stated that there was nothing on the current Corporate Plan that affected the Commission. There were some items that were relevant to the Adult Social Care Scrutiny Commission, which could involve Commission members if joint scrutiny was undertaken.

A Member questioned why there were no Key Decisions on the Corporate Plan

relating to health issues in the City. The Deputy City Mayor stated that the current lack of items in the Plan should not be seen as an indication that health matters were seen as being important. When the responsibility for public health transferred to the City Council in April 2013, most of the existing commissioning arrangements were extended for a year to enable the Council to review the position in relation to the budget and to enable the Council to determine its priorities for health and wellbeing provision. Once these priorities had been determined through the budget process, items would begin to appear in the Corporate Plan as changes were made to commissioning arrangements.

A Member asked that arrangements for providing training for cardiopulmonary resuscitation (CPR) in schools be considered as part of the future priorities.

68. BRADGATE ADULT MENTAL HEALTH UNIT

Professor David Chiddick, Chair of the Leicestershire Partnership Trust (LPT), Dr Satheesh Kumar, Medical Director, LPT, and Cheryl Davenport, Director of Business Development, LPT attended the meeting to provide an update on the measures taken in response to the Care Quality Commission's Notices issued in relation to the Bradgate Unit.

The Director of Business Development introduced the report which updated the Commission on the Trust's progress in responding to the Care Quality Commission's (CQC) report and also in relation to the development of the Trust's Quality Improvement Programme. (QIP) The QIP was intended to be finalised by 31 October 2013, and contained a number of themed actions beyond the immediate 30 day action plan outlined at the last meeting. The CQC had made a further visit in September 2013 to assess the progress made by the Trust in relation to the areas of concern contained in the two warning notices. The Trust believed it had made improvements but was currently awaiting the CQC report on the second visit. A draft report for factual checking was expected later in the week and the final report was expected to be published in November. The Trust also provided details of the following in their report:-

a) A summary of the NHS England Risk Summit in August.

b) Details of the roles and responsibility of the Oversight and Assurance Group, an advisory body set up by the Trust Development Authority, to collectively share intelligence and support the Trust to ensure that they become a sustainable quality organisation.

c) The Governance structure and themed work streams for the QIP.

d) A response to the Commissions' concerns raised earlier in the year in relation to Leicester LINk's Enter and View Report submitted to the Commission's meeting on 9 April 2013 (Minute 125 b) - refers). The points raised at that time were all being addressed in the QIP. A number of meetings have been held with mental health organisations

and the two acting chairs of Healthwatch to discuss the issues and make improvements for the future.

The Trust had consulted local authorities, the three CCG's, the Trust Development Authority, the Voluntary Sector, Healthwatch and patient groups on the QIP. The Trust were meeting again in two weeks to consider the feedback on the QIP and comments were welcomed on the QIP until 23 October.

The QIP demonstrated how the Trust were taking action to improve quality. The issues were not just restricted to improving quality in the Adult Mental Health Division but they also affected other health divisions within the Trust. Measures already put in place were:-

a) A situation reporting matrix;

b) A number of improvements for the crisis and home treatment service, which are shown in detail in the QIP, were being put in place;

c) Monitoring of overall bed capacity, which was not just isolated to Leicester and the use of Step Down and Crisis House facilities to reduce the pressures on beds where appropriate;

d) The appointment of the Chief Nursing Officer had already resulted in an increased quality of care;

e) An early warning system was being developed to pick up issues within the system in order to deal with them before they escalated into more difficult issues.

Dr Satheesh Kumar, Medical Director LPT, gave an overview of work of the Oversight and Assurance Group and gave examples of where this work had already contributed to the development of the QIP and to the longer terms aim of achieving sustainable improvements. The aim was to achieve a streamlined process and to take a patient pathway perspective from crisis to discharge in order to make the whole process less difficult for patients and also achieve the sustainable changes to the process.

Professor David Chiddick, Chair of the LPT, emphasised that the Trust wanted to be open and transparent with stakeholders and were keen to engage with them in developing the QIP. He felt there had already been a step change in improvements with the new team and he recognised that, whilst the Trust were currently in the spotlight, the same issues were also being faced by other Mental Health Trusts.

Members discussed the various submissions that had been made to them and asked a number of questions of the LPT representatives to clarify some points. Members made general observations that the QIP was matrix focused and, whilst it was successful in identifying the problems/issues, it did not address how these would be remedied, by whom and in what timescale.

In response, the LPT representatives stated that:-

a) The Acting Chief Executive had already overseen considerable changes in the last three months to address the issues in the CQC's notices. Staff had already been engaged in making cultural changes and some progress had been made.

b) The provision of Mental Health and Community Mental Health services was very challenging.

c) The Trust had provided an additional £1.1m funding for additional staff in the Mental Health Division against a backdrop of achieving 6% efficiency gains.

d) The CQC report on the second visit would be made public and reported to the Commission.

e) Audit tools were being used for discharge and re-admissions and a sample of care plans were also being analysed as part of this process.

f) The appointment of the two Ward Matrons that were reported at the last meeting, were beginning to deliver improvements. The Matrons had no management responsibilities and were responsible for providing professional input and support for staff. The quality of care plans had already improved.

g) Extra psychology support staff were currently being recruited to support the additional therapeutic staff already in place.

h) The Trust were changing the staff mix from a 40/60 to 60/40 mix of experienced staff to auxiliary staff. More qualified staff were joining the ward. Inpatient staff have support from the specialist Personality Disorder services for reflective practice skills. More nurses would also be delivering therapeutic measures. A RGN Champion Nurse was also working with others to offer support and improve care standards.

i) The physical health of patients was being addressed. All patients were seen by a doctor on admission, patients were reviewed every day by a registrar/consultant and they also had 1 to 1 sessions with nurses. A Therapeutic Liaison Officer was also available to offer activities. Patients nearing discharge were able to leave the ward to enjoy a full programme of activities. Access to specialist doctors was also available if required.

j) The role of the Involvement Centre was acknowledged by the CQC. The Recovery College was only 1 of 3 in the country and offered an exemplary programme of courses. Full monitoring was in progress

to assess the before and after effects and rapid progress had been observed. Discussions were also taking place with Leicester College to deliver short bite sized courses.

k) The appointment of Dr Peter Miller as Chief Executive for Trust would be beneficial in the long term as he had experience and a background in psychiatric health care and had been a leading executive in high performing trust with the same spectrum of community and mental health interests as the LPT. Dr Miller was not able to attend the meeting through a prior holiday arrangement before he joined the Trust.

l) Recruitment processes were also being revised to remove any bottlenecks in order to get new staff in place as soon as possible.

m) The Trust was continuing to work collaboratively with other agencies such as the CCG and TDA etc to secure sustainable improvements.

The Chair welcomed the measures being put in place but felt there was a need for the Trust to eventually show a correlation between increased investment and staff resources against improved outcomes for patients. He also felt that the Trust should make greater use the immense resources for mental health support that were available within the community and voluntary sector. These have been underutilised in the past, but the services they provided outside of the health service could have a considerable effect upon support and admissions. The Chair had met Dr Chiddick following the last meeting and would be writing to him to outline the Council's priorities. He would share the correspondence with Members.

Members received and noted position statements from the following bodies on their response and involvement with the Trust on the measures it has taken in response to the CQC Notices:-

Care Quality Commission
NHS England
Leicester City Clinical Commissioning Group
LAMP

Denis Chaney from LAMP gave a brief overview of their position statement and circulated an information pack to everyone present on the services that could be provided by LAMP.

During the overview it was noted:-

- LAMP provided advocacy for 1,038 clients;
- Two thirds of clients lived in the City;
- 40% of clients were from BME communities;
- Advocacy could be provided for clients on, discharge arrangements, care plans, access to services and complaints.
- LAMP were developing a peer advocacy project with people who

had personal experience of mental health issues to supplement the paid advocates.

- LAMP had experienced inconsistencies in systems at the Bradgate Unit, especially in how ward rounds were organised and timed when patients had requested an advocate to be in attendance. LAMP were keen to be part of the system to achieve improvements for patient care.

A recent article from the Leicester Mercury on 24 September 2013 was also noted.

The Chair circulated the legal advice he had received in relation to the deputation submitted by Mrs Addey at the last meeting asking the Commission to request a public inquiry into the Bradgate Unit. The advice was noted and the Chair would raise the issues with the Executive to explore a way forward.

The Chair thanked everyone for their participation in the discussions, reminded members that comments could be submitted to the Trust on the QIP and that further progress by the Trust would be reviewed at the next meeting.

RESOLVED:-

1) that the reports and submissions be received and the Trust's progress to date be welcomed and noted;

2) that the Chair discuss with the Executive the legal advice that had been received on the request for the Commission to ask the Secretary of State for a public inquiry;

3) that Mrs Addey be kept informed of the legal advice that had been received and the options available to the Commission; and

4) that a further progress report on the Trust's progress and outcome of the CQC's second visit be submitted to the next meeting.

69. NHS 111

Tony Menzies, Leicester City Clinical Commissioning Group provided an update on the roll-out of the NHS 11 service across Leicester, Leicestershire and Rutland.

The NHS 111 service provided by Derbyshire Health United went live on 9 September 2013 and anyone dialling '111' was connected direct to the service. The following day NHS Direct was made unavailable in Leicester, Leicestershire and Rutland and callers were re-directed by a voice message to call '111'. On 24 September GP practices in West Leicestershire CCG began the process of directing patients to the NHS 111 service for out of hours

service. The performance of the service between 9-22 September was monitored and 98.46% of the 2,481 calls were answered within 60 seconds.

GPs in the East Leicestershire CCG would transfer their out of hours calls to the '111' service on 23 October 2013 and the GPs in the City CCG were due to transfer out of hours call on 5 November.

Members were informed that the performance of the service was monitored daily by tele-conference, involving the three CCGs, the clinical lead, GP out of hours service and clinicians from other urgent care services. There was also weekly clinical review meeting every week with clinicians from the urgent care services for all three CCG areas.

Members questioned whether the 5 November was realistic for the City out of hours switch over, given that it was within the Diwali festivities and also Bonfire Night which traditionally led to increased volumes of calls, particularly as the switch over had been delayed by a week due to a 'minor performance issue'. Members also asked further questions of the service provision.

The Healthwatch representative reported that an impact assessment had been requested from Derbyshire United Health and a short response had been received. A full impact assessment had then been requested to indicate how the service intended to reach different patient groups in the three CCG areas, especially where English was not the first language. A response was awaited.

In response it was stated that:-

- A local equality impact assessment had been carried out locally and Mr Menzies agreed to share it with the Commission and Healthwatch;
- The service did provide a full translation service for users;
- The decision to delay the roll-out by a week had been based on a three hour period one Saturday morning when performance fell 1% short of the required standard of 95% of calls being answered in 30 seconds. This had been due to a high level of absence and an IT/Operational issue. Performance had been satisfactory since then. The decision to delay the roll-out had been based on extremely cautious approach and the service was now confident it could deal with the expected volume of calls.

RESOLVED:

1) that the update report be received and noted;

2) that the CCG submit the local equality impact assessment to the Commission's next meeting and to Healthwatch;

3) that performance and complaints data together with a further update on the implementation of the service be submitted to the January meeting of the Commission.

70. ACCESS FOR ALL

Paul Leonard Williams, Disabled Access Officer presented the report and gave a short presentation on the overall strategy and policy for Access for All and gave specific examples relating to health and wellbeing. A copy of the presentation is attached to these minutes for information.

During the presentation the following were outlined for Members information:-

- The main aim of the policy was to ensure that principles of inclusive design were achieved so that places and products could be accessed easily, safely and with dignity by everyone.
- The policy also wanted to promote getting design decisions right first time so that there was no need to 'retro-fit' in the future incurring additional expenditure;
- The 'Think Links' element of the policy was aimed at providing good information and awareness of systems and processes, to provide good access to services etc.;
- Good functional design elements also needed to be balanced with aesthetics, robustness and 'fit for purpose' functions;
- The removal of street clutter was also important to allow people to freely access health and wellbeing service and facilities, whether these were leisure or functional in nature. For example access to recreational spaces or chemists, health centres and GPs surgeries with adequate access and parking etc. There were examples of health surgeries where long queues developed through people wishing to make appointments because the telephone booking system did not cope with the volume of patients;
- There was also a need to plan bus services to integrate with health service provision;
- Street works also had an impact on health and wellbeing as a result of the cost to individuals of slips trips and falls and accidents involving cyclists etc.;
- The provision of open spaces and shade in the design of schemes was also important to health in allowing people to sit and rest in shade when this was required;

Members welcomed the presentation and felt that the importance of this work was not fully appreciated within all the Council's services. There were capacity and procedural issues arising from the report which had cross-cutting implications for cultural changes to service provision throughout the Council, and Members felt these issues should be reported back to the Overview Select Committee, which had received the original presentation and had asked all Commissions to consider the implications of the policy on their work. The principles of the policy were far reaching and Members felt that the Disabled People's Access Officer could not be consulted or involved on all planning applications, major projects or process involving access to the Council's services and facilities.

RESOLVED:

that the report and presentation be received and that the Chair report the Commission's comments back to a future Overview Select Committee to consider how the policy can be effectively be embedded into accessing Council services and also be incorporated into the planning, design and implementation of major schemes as well as ensuring that the planning process delivers the aims of the policy in each application it considers.

71. PUBLIC HEALTH COMMISSIONING AND CONTRACTING

Rod Moore, Divisional Director, Public Health presented a report on commissioning and contract management procurement arrangements for the public health responsibilities that were transferred to the City Council in April 2013.

Members noted that officers were working with the Deputy City Mayor to review the arrangements for commissioning services. Details of existing contracts were attached to the report. It was noted that whilst these were grouped under 'providers' the list could be provided to indicate contracts under specific 'health themes'. 60% of the cash value of the total contracts had been re-commissioned. Work was currently being undertaken to develop a realistic procurement plan so that all or large groups of contracts were not commissioned at the same time.

RESOLVED:-

that the report be received and that the contracts be reviewed further at a future meeting and that the contracts also be presented under the grouping of specific health themes.

72. CONGENITAL HEART DISEASE REVIEW UPDATE

Members received an update on the progress of the Congenital Heart Disease Review. The following documents were submitted to Members for their information:-

a) Letter from NHS England to Councillor Cooke

b) Response by Councillor Cooke to NHS England Letter

c) NHS England 6th Update

d) NHS England 7th Update

e) NHS England 8th Update

f) Notes of a Meeting between NHS England and the Local

Government Association and the Centre for Public Scrutiny

It was also noted that NHS England had held a New Congenital Heart Disease Review: Board Task and Finish Group meeting on 30 September 2013. The meeting had considered a 'Proposed Scope and Interdependencies' document which was also submitted for information. The document outlined what NHS England already knew about the review, as well as illustrating those areas where more work was needed before a judgement could be made.

NHS England has also notified the Council on 1 October that it planned to take questions about the scope of the review to the first meeting of the Clinical Advisory Panel on 15 October 2013 and asked for comments on the paper by 7 October 2013 so that these could be fed into the Panel's meeting. A copy of the paper was sent to Health Scrutiny Officers for Rutland County Council and Leicestershire County Council asking them to share it with their members and make any comments direct to the Congenital Heart Review Team by 7 October. The Chair had sent a response on behalf of the Commission and copy of his reply was circulated to members at the Meeting.

The Chair also reported that the meeting with NHS England referred to in the correspondence at a) and b) above had been arranged for 25 October 2013 with scrutiny members from Leicester, Leicestershire and Rutland. A separate meeting had also been arranged with the Executive members for the three authorities.

RESOLVED:-

that the update reports be received.

73. ALCOHOL AWARENESS UPDATE

Julie O'Boyle, Consultant Public Health, presented an update report on the Alcohol Awareness Campaign that was originally presented to the Commission at its meeting on 17 July 2103.

Members noted that the last of the promotional events had taken place on the previous Saturday.

The report contained a number of outcomes for the campaign. A number of events had taken place since the report was written and the results were updated as follows to take account of all the events that had been held, except for the last one:-

- 3,050 people had now seen the event;
- 800 'We Are on Tour Flyers had been handed out;
- 350 people had completed the alcohol quiz;
- Of these 200 people were drinking within safe limits and had been given 'Well Done' stickers and entered into a prize draw for recreational events;

- 15 people had scored highly and had been referred for further treatment;
- 150 people had signed up to the pledge and would receive discounts vouchers for activities in the City. These people would be reviewed over the coming months to monitor their performance of the pledge. The original aim was to have a cohort of 50 people signed up to the pledge.

Once the results of the Saturday event were known, there would be a full evaluation of campaign.

In response to Members questions on particular alcohol related problems and groups such as street drinkers in other wards not covered by this social awareness campaign, Julie O'Boyle stated that there were other measures available within public health measures to address these issues.

RESOLVED:

that the evaluation of the campaign be submitted to the January meeting of the Commission together with a report on the whole public health alcohol strategy.

74. EXTERNAL REVIEW OF HEALTH SCRUTINY UPDATE

Members received an update report on the External Review 'Fit for Purpose' Health Scrutiny by Expert Advisor (Brenda Cook) Centre for Public Scrutiny. The notes of the first development session held on 18 September 2013 were also submitted to Members for information.

The Chair reported that Brenda Cook was unable to attend the meeting but work was progressing on the review and he had received a draft questionnaire on a training needs assessment for Members and this would be shared with Members in due course.

RESOLVED:

that the update report be received.

75. REVIEW OF RESPONSES TO SCRUTINY REVIEWS

The Commission received an update on the responses received in relation to the Commissions' Scrutiny Reviews of the 'Mental Health Review for Working Age Adults in Leicester' and the 'Review of Voluntary and Community Sector Groups who raised concerns about Funding, Commissioning and Tendering issues'. These reviews were completed in June 2013 and forwarded to the Executive and interested partners.

The Chair stated that the two review reports had been issued to various interested parties but no responses had been received. However, the Executive had invited the Chair to present the reports to them on 5 November and Members of the Commission had also been invited to attend. The LPT and the CCG had also indicated that they would be submitting their responses

to the next meeting of the Commission.

The Chair also reported that he had been appointed the Council's Advocate for Mental Health. This was part of a national initiative to raise the profile of Mental Health. There were currently 11 Council Advocates for Mental Health in the country and a meeting had been convened on 2 December 2013 by the Centre for Mental Health.

RESOLVED:

that the update be received and that the responses be considered at the next meeting of the Commission.

76. PROPOSED JOINT SCRUTINY REVIEW OF WINTER CARE ARRANGEMENTS

The Chair reported on a proposed joint Scrutiny Review by the Commission and the Adult Social Care Scrutiny Commission on 'Winter Planning For Health and Social Care Provision for Elderly and Vulnerable People in Leicester.' A Draft Scoping Report was submitted for Members' consideration. The draft report had been considered at the Adult Social Care Scrutiny Commission at its meeting on 10 October 2013 and had been approved without amendment.

Members noted that Councillor Chaplin would be the Chair for the review and that meetings for the joint review had been arranged for 24 October, 14 November and 19 November at 5.30pm. Councillor Chaplin stated that a visit to the Accident and Emergency facility at the Leicester Royal Infirmary was likely to take place on 8 November.

The Scrutiny Support Officer reported that the University Hospitals Leicester (UHL) NHS Trust and the Leicester City Clinical Commissioning Group had also submitted comments to widen the scope of the winter care arrangements. Dr Freeman endorsed the view of the UHL NHS Trust that the winter care arrangements were not just about the frail and elderly or the A&E facility, but were also concerned about patient flows around all the hospital wards and patient discharge arrangements.

Councillor Chaplin confirmed that this would be form a topic of discussion at the first meeting. The issue of talking to patients and carers directly was also recognised and would also be discussed at the first review meeting.

RESOLVED:-

that the terms of the scoping document for the joint review of the Winter Care Plan for Leicester be approved.

77. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

The Chair circulated a letter received from UHL on their consultation proposals

for the emergency floor scheme and the relocation of outpatient clinics to the Leicester General Hospital, following the presentation to the last meeting of the Commission.

RESOLVED:

that contents of the letter be received for information.

78. ITEMS FOR INFORMATION / NOTING ONLY

a) Health and Wellbeing Board

The minutes of the Health and Wellbeing Board meeting held on 11 July 2013 were received for information. The attachments in the minutes were not included, but could be found at the following link:-

http://www.cabinet.leicester.gov.uk:8071/documents/g5648/Public%20minutes%20Thursday%2011-Jul-2013%2010.00%20Health%20and%20Wellbeing%20Board.pdf?T=11

Members also noted the following reports that had been considered by the Board at its meeting:-

i) Urgent Care Update
ii) Healthwatch Update
iii) Fulfilling Lives A Better Start

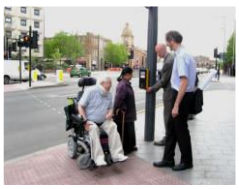
b) Being the Best

A letter issued by the East Midland Ambulance Service NHS Trust on the progress with the Being The Best Review was noted.

79. CLOSE OF MEETING

The meeting closed at 8.20 pm

Access for all (inclusive design) action programme



Paul Leonard-Williams
(Disabled People's Access Officer)

This presentation

- Action programme background
- What is inclusive design (scope, issues, approach & relevance)?
- Action programme review: findings,next steps

The action programme

2009 – Scrutiny Task Group review of access & design issues
(Cllr Russell led)

2010 – Cabinet approval:
- Scrutiny recommendations
- Commitment to inclusive design aims
- Inclusive Design Action Programme

2013 – Review by IDAP (paper to OSC)

Who's involved?

- Inclusive Design Advisory Panel (IDAP)
- Leicester Disabled People's Access Group (LDPAG)
- Other disability organisations/ partners

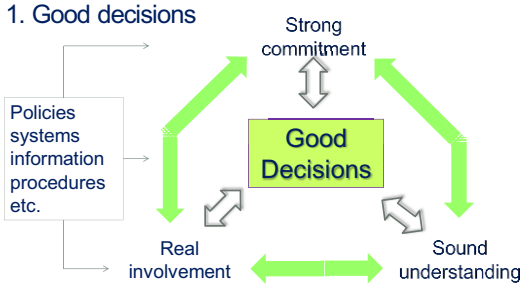
Inclusive design – what is it?

" To make places (and/ or products) which everyone can access easily, safely, and with dignity."

- Environments are often disabling ("Social Model" of disability + wider benefits)
- Legal, social & economic imperatives = strong business case
- Get it right first time - good decisions needed

How to achieve it?

1. Good decisions



2. “Think links”

Home environment

Local neighbourhood e.g. route to the bus stop

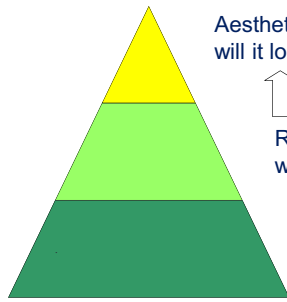
The city (& beyond?) e.g. bus to city centre

Destinations e.g. streets > shops > council offices

Return journey

Support needed: good information & awareness

3. Good functional design



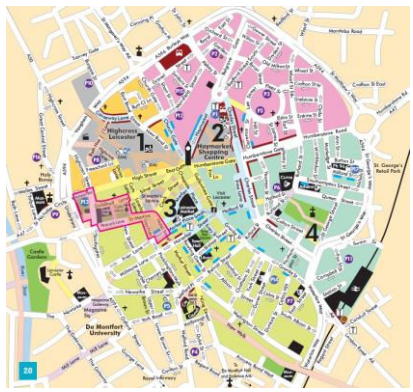
Aesthetics: will it look good?

Robustness: will it last?

Fit for purpose will it work?

Issues and examples…


walking
the way
to health



..back to the review: the verdict

- ❑ Good policy commitment
- ❑ Awareness & understanding increased
- ❑ Examples of good practice
- ❑ Variable weighting given to inclusive design – greater consistency needed

Progress & next steps

1. OSC recommendations

- ❑Scrutiny commission engagement & awareness raising
- ❑City Mayor delivery plan

2. Review schemes & issues in more detail

3. Draft "Access for all" policy & guidance

- ❑Executive commitment
- ❑Consistent standards required

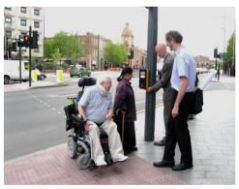
Thank you.

Any questions?

Paul Leonard-Williams
(Disabled People's Access Officer)

Leicester City Council

Inclusive design / access for all: summing up



- What it is
- Why it's relevant
- What we're doing about it

Thanks – any questions?

Paul Leonard-Williams
(Disabled People's Access Officer)

Leicester City Council

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