MEETING OF THE LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

DATE: **TUESDAY, 16 NOVEMBER 2021**
TIME: **5:30 pm**
PLACE: **Meeting Rooms G.01 and G.02, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Kitterick (Chair of the Committee)
Councillor Aldred
Councillor March
Councillor Dr Sangster
Councillor Fonseca
Councillor Pantling
Councillor Whittle

Leicestershire County Council

Councillor Morgan (Vice-Chair of the Committee)
Councillor Bray
Councillor Grimley
Councillor King
Councillor Ghattoraya
Councillor Hack
Councillor Smith

Rutland County Council

Councillor Harvey
Councillor Waller

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

For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact Anita James**, Democratic Support on (0116) 454 6358 or email anita.james2@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	**Meaning**
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
AMH	Adult Mental Health
AMHLD	Adult Mental Health and Learning Disabilities
BMHU	Bradgate Mental Health Unit
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CMHT	Community Mental Health Team
CVD	Cardiovascular Disease
CCG LCCCG ELCCG WLCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group East Leicestershire Clinical Commissioning Group West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CTO	Community Treatment Order
DTOC	Delayed Transfers of Care
ECMO	Extra Corporeal Membrane Oxygenation
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
EIRF	Electronic, Reportable Incident Forum
EMAS	East Midlands Ambulance Service
EPR	Electronic Patient Record
FBC	Full Business Case
FYPC	Families, Young People and Children
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HWLL	Healthwatch Leicester and Leicestershire
IQPR	Integrated Quality and Performance Report

JSNA	Joint Strategic Needs Assessment
NHSE	NHS England
NHSI	NHS Institute for Innovation and Improvement
NQB	National Quality Board
NRT	Nicotine Replacement Therapy
OBC	Outline Business Case
PCEG	Patient, Carer and Experience Group
PCT	Primary Care Trust
PDSA	Plan, Do, Study, Act cycle
PEEP	Personal Emergency Evacuation Plan
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
PSAU	Place of Safety Assessment Unit
QNIC	Quality Network for Inpatient CAHMS
RIO	Name of the electronic system used by the Trust
RN	Registered Nurse
RSE	Relationship and Sex Education
SOP	Standard Operating Procedure.
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

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1. CHAIRS ANNOUNCEMENTS

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

4. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 18)**

The minutes of the meeting held on 13th September 2021 are attached and the Committee is asked to confirm them as a correct record.

5. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS (NOT ELSEWHERE ON THE AGENDA)

6. PETITIONS

The Monitoring Officer to report on the receipt of any petitions submitted in accordance with the Council's procedures

7. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer to report on the receipt of any questions, petitions, or statements of case in accordance with the Council's procedures.

The following questions have been received:

From Robert Ball

1. What provider collaboratives are under development or being anticipated?
2. Can ISC leads confirm that commercial providers will be excluded from these provider collaboratives?

From Jean Burbridge

1. At the least meeting ICS leads were asked "How will the Integrated Care Board improve the current reduced accountability and transparency?" but this was not answered. Are the ICS leads now able to answer this question?
2. In the last meeting David Sissling stated that the local NHS is currently making no use of private companies to assist it in moving towards an ICS. Please could you clarify whether any companies have been used in recent years to assist in the transition to an ICS and, is so, which they were.

From Giuliana Foster

1. Has a decision been made by the Treasury or Department of Health regarding the funding of the UHL reconfiguration scheme. If so, what is the decision? If not, when is this decision expected?
2. University Hospitals of Leicester judges that a) some of the information in the templates returned to the National Hospital Programme team setting out alternative versions of the Building Better Hospitals for the Future Scheme was commercially sensitive and b) that it is not in the interest of the public to have this information. What type of information was provided in the templates returned to the National Hospital Programme team which was considered commercially sensitive?

These questions will be considered in accordance with Rule 10 of the Scrutiny Procedure rules of the Council's Constitution.

8. UPDATED REPORT ON DENTAL SERVICES IN LLR; NHS ENGLAND & NHS IMPROVEMENT RESPONSE TO HEALTHWATCH SEND REPORT

Appendix B (Pages 19 - 36)

Members to receive an updated report on the provision of NHS dental services commissioned in Leicester, Leicestershire and Rutland together with an overview of the ongoing effects of the Covid 19 pandemic and the steps being taken to restore and recover service provisions.

9. COVID 19 AND THE AUTUMN/WINTER VACCINATION PROGRAMME UPDATE **Appendix C (Pages 37 - 46)**

Members to receive an update on the Covid 19 and Autumn/Winter vaccination programmes.

10. BLACK MATERNAL HEALTHCARE AND MORTALITY **Appendix D (Pages 47 - 52)**

Members to receive a report on black maternal healthcare and mortality, including details of what the local maternity and neonatal system is doing to address health inequalities and poor outcomes for women of a black and minority ethnic background.

11. LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEM UPDATE **Appendix E (Pages 53 - 68)**

Members to receive a report providing an overview of the LLR Integrated Care System taking into account recent guidance issued by NHS England and the Health and Care Bill.

12. MEMBER QUESTIONS (ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA)

Councillor Samantha Harvey submits the following question:

Following a negative patient experience at LRI last month, and the difficulty faced trying to navigate the LRI site, can our UHL colleagues comment on the following:

- Why does the website contain incorrect information that is years out-of-date? The receptionist, at the incorrect location, explained the web site information has been incorrect for ages and the correct location was at the other end of the campus.
- Why is the website so difficult to navigate and makes it almost impossible to find any useful patient information?
- Why is the signposting to campus so very poor? Circling the site, in search of the correct entrance is not good for a calm state of mind or for patient wellbeing.
- Internal signage is poor and there was no sight of the usual cheery volunteers or porters to point or lead the way.
- Why are there no maps of the campus and car parks available on-line?

13. WORK PROGRAMME **Appendix F (Pages 69 - 74)**

Members will be asked to consider the Work Programme and make any comments and/or suggestions for inclusion as it considers necessary.

14. ANY OTHER URGENT BUSINESS

AOUB 1
UHL Finance and misstatement of accounts.

15. DATE OF NEXT MEETING

28th March 2022 at 5.30pm

Appendix A

Leicester
City Council

MINUTES OF THE MEETING OF THE
LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Held: MONDAY, 13 SEPTEMBER 2021 at 5.30pm at City Hall as a hybrid meeting enabling remote participation via Zoom

P R E S E N T :

Councillor Kitterick – Chair
Councillor Morgan – Vice Chair

Councillor Fonseca	Councillor Grimley
Councillor Hack	Councillor March
Councillor Smith	Councillor Whittle

In Attendance
Rebecca Brown Acting Chief Executive UHL
David Sissling, Independent Chair, LLR Integrated Care System
Andy Williams Chief Executive Leicester CCG
Caroline Trevithick Leicester CCG
Kay Darby Leicester CCG
Darryn Kerr, Director of Estates UHL
Nicky Topham UHL
Tom Bailey, Senior Commissioning Manager, NHS England
Dr Janet Underwood – Healthwatch
Mukesh Barot - Healthwatch

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15. CHAIRS ANNOUNCEMENTS

The Chair welcomed those present both in person and via Zoom and led introductions.

The Chair confirmed this was a hybrid meeting and explained what that meant for those present.

The Chair mentioned that he had recently met with officers from UHL Hospitals around a Building Better Hospitals update and note there are a number of questions here tonight and hopefully those responses will accord with what was said in the briefing.

The Chair indicated that future standing items to the agenda would include a regular update on Covid 19 and the Vaccination programme as well as an item for Members questions.

16. APOLOGIES FOR ABSENCE

Apologies for absence were received and noted from Councillor Aldred, Councillor Bray, Councillor King, Councillor Harvey, Councillor Dr Sangster and Councillor Waller.

17. DECLARATIONS OF INTEREST

Members were asked to declare any pecuniary or other interests they may have in the business on the agenda. There were no such declarations.

18. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 6th July 2021 be confirmed as an accurate record.

19. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS (NOT ELSEWHERE ON AGENDA)

None outstanding.

20. PETITIONS

The Monitoring Officer reported that no petitions had been received.

21. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that several questions had been submitted by members of the public as set out on the agenda.

The Chair outlined the procedure for the meeting and advised that there was a wide amount of overlap in the questions which had therefore been put into three groups to be taken together with the opportunity for each questioner to ask a supplemental question.

- Health Service Journal report

From Indira Nath : Q1: “According to the Health Service Journal (29th July 2021) the New Hospital Programme Team requested the following documents of Trusts who are “pathfinder trusts” in the government’s hospital building programme.

- An option costing no more than £400 million;
- The Trust’s preferred option, at the cost they are currently expecting; and
- A phased approach to delivery of the preferred option.

So, in relation to the Building Better Hospitals for the Future scheme, when will the documents sent to the new hospital programme team on these options be made publicly available? Are they available now? If not available, why not?

From Sally Ruane: Q1: “Following information requested by the New Hospital Programme Team, what changes were made to the Building Better Hospitals for the Future scheme in order to submit a version of the scheme which costs £400m or less? And what elements of the scheme were taken out to reach this lower maximum spend?

From Tom Barker: Q1 “The government is indicating that they may now not fully fund trusts’ preferred new hospital schemes, despite previous assurances. Both a phased approach and a cheaper, £400m scheme will impact the delivery of care significantly as both will require changes to workflow. This would especially affect people in Leicester, Leicestershire and Rutland as the UHL reconfiguration plans have limited new build (the Glenfield Treatment Centre and the LRI Maternity Hospital) and involve a lot of emptying and reconfiguration of working buildings. Dropping a project or delaying it could very easily create a situation where necessary adjacencies are lost etc. What will be the impact on patient experience of both the £400m version of the project and the phased approach?

Q2 “With regard to Building Better Hospitals for the Future, what are the revised costings as of August 2021 for the full (and preferred) scheme including local scope/national policy changes as requested by the New Hospital Programme?”

From Jennifer Foxon: “Re the hospital reconfiguration plans in LLR, how would a phased approach change the final organisation of hospital services when compared with current plans?”

Rebecca Brown, Acting Chief Executive UHL, responded that in terms of the reconfiguration, as one of the 8 national New Hospital Programme (NHP), Pathfinder schemes UHL had been asked to look at a range of approaches on how to go about building new hospitals in Leicester. Three scenarios were being considered:

– An option that fits the Trust’s initial capital allocation of £450m in 2019
– The Trust’s preferred option
– A phased approach to delivery of the preferred option

The Leicester scheme had remained almost exactly as described three years ago at the time of the initial capital allocation, however some of the parameters now expected to be met had changed significantly; for example the percentage of single rooms with the impact of Covid versus open wards, the amount of money expected to be set aside for contingency and the requirement to make the buildings “net zero carbon”. UHL had therefore submitted plans which illustrated what can be achieved within the original allocation, their preferred option and a phased approach which would deliver the preferred option albeit over a longer time scale.

It was recognised that it was a necessary part of the process for colleagues in the New Hospital Programme to challenge each of the Pathfinder schemes,

this was a proper process on behalf of the treasury for delivery and value for money.

The content of the submitted template was commercially sensitive and not in the public domain however details of the way forward would be released once it had been agreed with the New Hospital programme.

The Chair invited supplemental questions:
Indira Nath asked why papers were being withheld, and for further explanation of why they are “commercially sensitive”.

Sally Ruane asked if there was any more information on what would be taken out of the scheme in the version expected to meet the changes requested nationally/locally.

Rebecca Brown Acting Chief Executive UHL replied that in respect of commercial sensitivity, whenever the government was given information that could impact on anyone wanting to bid or pursue a tender exercise then that information could not be shared. As this scheme involved 8 Pathfinders the information was all being held centrally. Once UHL was able to share details it would do so, but they had no timescale yet on that.

In relation to elements within the plan the UHL were committed to delivering all the proposals they went out to consultation for.

Tom Barker asked with regard to the £450m being cut to £400m and potential for a large overspend, if the impact was considerable would the public be consulted again?

Rebecca Brown Acting Chief Executive UHL, clarified that the Health Service Journal letter was talking about a different scheme and UHL were asked to put in a template against their £450m scheme and were committed to deliver the full programme on that.

The Chair referred to the Building Better Hospitals item later on the agenda where further discussion could be had and confirmed that £400m was another scheme.

The Chair indicated that the Joint LLR Health Scrutiny committee would recommend that the UHL reconfiguration scheme was funded in full and support that request.

- Integrated Care System

From Indira Nath Q2: “ICS Chair David Sissling stated at the Leicester City Health and Wellbeing Scrutiny Commission that the local NHS needs to become more adept at engaging the public. What do you think have been the weaknesses in NHS engagement with the public and what will becoming more adept at public engagement involve?

Q3 Please can you also explain the relationship between the main ICS NHS

Board and the ICS Health and Care Partnership Board, and tell me what each will focus on and the balance of power between them?

From Sally Ruane Q3: “There is little in the government’s legislation about the accountability of integrated care systems to the local public and local communities. How will the integrated care board be accountable to the public? Its precursor, the System Leadership Team, has not met in public or even, apart from the minutes, made its papers available to the public. The CCGs have moved from monthly to bi- monthly governing body meetings; UHL has moved from monthly to bi-monthly boards and does not permit members of the public to be present at the board to ask questions. How will the integrated care Board provide accountability to the public and how will it improve on the current reduced accountability and transparency?”

From Tom Barker: Q3 “NHS representatives have stated that there will be no private companies on the Integrated Care Board. Can you assure me there will be no private companies on the Integrated Care Partnership, on ‘provider collaboratives’, or committees of providers, or any sub-committees of the Integrated Care Board or Integrated Care Partnership?”

Q4 “CCGs currently have a legal duty to arrange (i.e. commission or contract for) hospital services. This legal duty appears to have been removed for their successor, the Integrated Care Board. If this is indeed the case, the Integrated Care Board may have a legal power to commission hospital services but no legal duty to do so. What do you think are the implications of this for the way our local Integrated Care Board will run?

From Brenda Worrall: Q1: “Besides representation from the Integrated Care Board and three Local Authorities, which organisations will have a seat on the ‘Integrated Care Partnership’ and what will its functions be?”

Q2: “In moving towards integrated care systems, NHS England has significantly increased the role of private companies on the Health Systems Support Framework, including UK subsidiaries of McKinsey, Centene and United Health Group, major US based private health insurance organisations. Please could you tell me which private companies NHS organisations in Leicester, Leicestershire and Rutland have used or are using to help implement the local integrated care system.”

From Kathy Reynolds: “As we move towards Integrated Care Systems, I would like some clarity on Place Led Plans. About April 2021 at a Patient Participation Group meeting Sue Venables provided some information suggesting there would be 9 or 10 Places, 1 in Rutland, 3 in Leicester City and several in Leicestershire. I would like to know how many Place Led Plans are in or will be developed? What are the geographic areas covered by these Place Led Plans? Further what will be devolved to Places as the Place Led Plans become operational and how will this be funded including what will the Local Authorities responsibilities be for funding as a partner in the ICS? I’m not expecting detailed financial information at this time, but I would like to

understand the general geographic areas, approximate funding requirements and where funding streams will come from."

From Steve Score: " The government intends to reduce the use of market competition in awarding contracts. While this is generally not problematic when contracts are awarded to NHS and other public sector organisations, it is likely to be controversial to extend a contract or give a contract to a private company without safeguards against cronyism provided by market competition. Given this reduction in safeguarding public standards and given the different motivation of private companies who prioritise shareholder interests over public good, can you confirm that neither the Integrated Care Board, nor its sub-committees, will be awarding any contract to private companies, much less without competition?"

The Chair invited David Sissling to respond

David Sissling, Independent Chair, LLR Integrated Care System responded regarding engagement that the NHS in Leicester, Leicestershire, and Rutland would continually reflect on its engagement practices and strengthen these wherever possible. During the Covid-19 pandemic in particular the NHS had worked hard to re-establish links with many communities through genuine outreach and have worked to understand relevant issues and co-create solutions. Work with the voluntary and community sector, including faith and community leaders, has been central to this, as has been our partnership with Healthwatch.

These improvements will be continued and feedback from as many people as possible will be sought. The NHS would look to engage with all individuals and communities on their own terms, in places and at times that suit them, using materials in appropriate languages and formats. It was recognised too that there were often communities within communities and that these may be hidden and not typically have a voice and steps would be taken to provide the opportunities for these people and groups to be heard.

Engagement activity across NHS partners was increasingly being joined up, using common approaches, pooling resources and sharing intelligence. Work had also begun to work more closely with local authority partners on engagement where practicable.

Across the NHS partnership focus has increasingly been on actively listening to communities to understand their experiences and aspirations. This insight allows us to make enhanced decisions about the way in which services will be delivered and to flag potential issues that may require closer examination by partners. We recognise the need to do more to close the feedback loop, explaining to the public how what we have heard through our engagement has influenced our thinking and the decisions that are made.

The next step of the improvement process will be to embed genuine co-production techniques throughout the system to redesign services and tackle health inequalities in partnership with people and communities. We will also

learn from recognised good practice and build on the expertise of all ICS partners.

It was planned to develop a system-wide strategy for engaging with people and communities that sets out an approach to achieving this by April 2022, using the 10 principles for good engagement set out by NHS England as a starting point.

In terms of the relationship between the main ICS NHS Board and the ICS Health and Care Partnership Board, the ICS Partnership will operate as a forum to bring partners: local government; NHS and others, together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

The ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population. The expectation is that this should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. These plans will be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities.

The NHS Integrated Care Board will be established as a new organisation (replacing CCGs) that bind partner organisations together in a new way with common purpose. The NHS Integrated Care Board will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population.

The relationship between the ICS Partnership and the NHS Integrated care Board is non-hierarchical and based on existing and enhanced relationships with the three Health and Wellbeing Boards.

In relation to accountability once established meetings of both the ICS Partnership and the NHS Integrated Care Board will be held in public, with papers published.

Whilst final membership of both the ICS Partnership and the NHS Integrated Care Board is to be finalised, local Healthwatch organisations, are expected to continue to fulfil a key role in both of these groups. The NHS Integrated Care Board will have a minimum of two independent members, in addition to the independent chair.

Local authority health scrutiny will retain an important role in ensuring accountability. The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the development and delivery of health services and that those services are effective and safe.

Regarding private companies the Membership and terms of reference for the ICS Partnership and the NHS Integrated Care Board were still under

development, although any private companies were not expected to be members of these groups.

However, Non-NHS providers (for example, community interest companies) may be part of provider collaboratives where this would benefit patients. Collaborative work was still at a very early stage of design and NHS organisations in Leicester, Leicestershire and Rutland are not using any private companies to help develop or implement the local integrated care system.

With regard to legal duty under the proposed legislation the NHS Integrated Care Board would assume all statutory duties of the CCGs, including the responsibility to secure provision of NHS services for its area.

Andy Williams, Chief Executive Leicester CCG, responded to the question on Place Led Plans that the CCG's had worked with local government to determine place and so that was constituted differently as a local place for Place Led Planning. It was not a hierarchy or about delegating certain things to a place. Three place based plans were currently being developed, one for each of the three upper tier unitary authorities (Leicester, Leicestershire, Rutland). These plans were being developed in partnership between the local NHS and the local authorities, taking account of evidence and insights of what is important to the public and other stakeholders in those areas, and would be supported by additional local public engagement where appropriate.

The Chair asked for further details of those Place led Plans to be shared at respective scrutiny committees across Leicester, Leicestershire ad Rutland.

David Sissling, Independent Chair, LLR Integrated Care System responded to the question around market competition in awarded contracts, that whilst they were pleased by what was offered in terms of continuity and being able to form longer contracts the priority was that NHS and other public sector organisations will provide the overwhelming majority of services as they do now.

It was noted that proposals contained in the draft legislation would remove the current procurement rules which apply to NHS and public health commissioners when arranging healthcare services. The ambition was to provide more discretion over when to use procurement processes to arrange services than at present, but that where competitive processes can add value they should continue. As a result, the local NHS would have greater flexibility over when they choose to run a competitive tender.

The Chair invited supplementary questions:
Indira Nath asked whether the public would be allowed to ask questions once public meetings were held?

Steve Score sought a response to the commercial conflict example mentioned earlier.

Sally Ruane in relation to accountability asked for confirmation that meetings would be held publicly monthly and in relation to ICS Board meetings, what the

timescale for opening these up was?

Tom Barker raised concern that assurances given at other meetings were not the same as those now being given and was concerned that the discussion was of the role of private companies during the pandemic rather than referring to the funding position of NHS.

Brenda Worrall asked for more detail of funding and how the funding stream would flow?

David Sissling, Independent Chair, LLR Integrated Care System replied that the frequency of meetings for the body which prefaced the ICS Board was monthly and would continue to be monthly, however the ICS board would make its own decision about frequency and papers would be made available to the public. At this point it was still open to consideration how best to involve the public in meetings. The broader Integrated Care Partnership was currently meeting three times a year and would be subject to review.

Regarding procurement it was clarified that any decision in a possible scenario with a private company would be done entirely in an open and transparent tender process.

In relation to capacity, the priority was to grow the service to meet needs of people who have had to use private sector as an alternative.

In terms of the role of private companies it was not possible to be more definitive on private companies involvement on the Leicester Care Partnership as that doesn't exist yet, however as it became clear David Sissling would be happy to return and discuss any decision or basis for its membership.

Andy Williams Chief Executive Leicester CCG responded to the supplementary point about Place stating that initially there was a plan with budgets set for a range of services. No final decisions had been made but thought was being given to continue to plan and programme services in the same way and include those by place e.g. a City Plan, a County Plan and a Rutland Plan. The aim was to try and avoid a limited range of services and to be inclusive, it was still to be decided how to make allocations of resource.

In the absence of Jennifer Fenelon, Chair of Rutland Health & Social Care Policy Consortium, the Chair agreed to take her questions as read on the agenda and invited officers to respond.

Rebecca Brown Acting Chief Executive UHL advised this had been partially answered in the earlier responses and confirmed that the preferred option was not to have a phased approach. It was not possible to discuss that further as more information would be needed than was currently available and it would be a political decision as to when the programme would be started.

- <u>UHL Reconfiguration</u>

From Sally Ruane: Q2: "My question to the Joint Health Scrutiny meeting in

July asked about an 'Impartiality Clause' voluntary organisations were required to sign by CCGs if they wished to promote the Building Better Hospitals for the Future consultation in exchange for modest payment. Unfortunately, neither the oral nor the written responses fully addressed this question. Please can I ask again whether the Impartiality Agreement was legal, whether it is seen as good practice and what dangers were considered in deciding to proceed with these agreements; and what steps the CCGs took to ensure that organisations under contract informed their members/followers in any engagement they (the organisations) had with their members/followers that they were working under a service level agreement which contained an "impartiality clause".

Andy Williams responded that the CCGs were confident that the agreements reached with the voluntary and community sector to support participation in the recent Better Hospitals Leicester consultation was both lawful and based on examples of best practice and that remains their view and overall the CCG's believe the activity achieved this very successfully.

The Chair thanked all for their questions and responses.

AGREED:

That full written responses be appended to the final minutes.

22. DENTAL SERVICES IN LEICESTER, LEICESTERSHIRE AND RUTLAND AND THE NHS ENGLAND & NHS IMPROVEMENT RESPONSE TO HEALTHWATCH SEND REPORT

The committee received a report containing an overview of NHS dental services commissioned in Leicester, Leicestershire, and Rutland and an update on the impact of the ongoing Covid 19 pandemic on those services.

The Chair noted that Tom Bailey, Senior Commissioning Manager, NHS England had to leave the meeting early and there was no-one else at the meeting to present this report or respond to questions.

The Chair was disappointed that the report contained insufficient information about the recommencement of services across the City, County or Rutland. The Chair noted it was the responsibility of the committee to scrutinise this and therefore a fully updated report with more detail and data would be sought for the next meeting.

Mukesh Barot from Healthwatch welcomed the response noting however the concerns of the public and the issues raised about people for SEN were not fully answered. He indicated that Healthwatch were intending to do further research into dentistry issues as a special project. The Chair suggested it would be helpful to do that collaboratively and to press for data on dentistry to come to this committee.

Dr Janet Underwood from Healthwatch commented that there were mixed messages that needed clarification. Some practices were not accepting NHS patients but would if they paid privately; children were not being seen regularly

and some patients were waiting up to 3 years for orthodontal treatment.

It was suggested that the updated report should also include information about dental services for children in the care of local authorities too.

The Chair confirmed that the item would be brought as a priority to the next meeting where the debate could be extended then.

AGREED:

That a fully updated report with data and including information on dental services for children in care of local authorities be provided for the next meeting.

23. TRANSITION OF CHILDREN'S SERVICES FROM GLENFIELD HOSPITAL TO THE KENSINGTON BUILDING AT LEICESTER ROYAL INFIRMARY PROGRESS REPORT

Rebecca Brown, Acting Chief Executive gave a presentation detailing progress on the transition of children's services from the Glenfield Hospital to the Kensington building at Leicester Royal Infirmary.

Background details of the East Midlands Congenital Heart Centre and NHS Standards were given, and Members were reminded of the decision taken in September 2019 to move the paediatric congenital heart service to the Leicester Royal Infirmary in order to meet the co-location standard.

It was noted that:

- The project comprised a 12 bed intensive care unit, 17 bed cardiac ward, a cardiac theatre and catheter lab as well as an outpatient and cardiac physiology dept.
- Phase 1 had completed with the Kensington building being attractively refurbished
- The move from Glenfield to Kensington building took place from 5th – 8th August 2021 with the support of other providers during the transition to ensure that emergency services for children remained available.
- The Kensington building was fully up and running with all equipment and clinical teams in place.

Images of the new Kensington building were viewed and noted.

Rebecca Brown, Acting Chief Executive explained the next phase, Phase II envisioned the creation of East Midlands first dedicated standalone Children's Hospital to ensure all children could be cared for on one dedicated site and would see the move of all children's services into the Kensington building.

Members of the Commission welcomed the presentation, expressing positive comments about the smooth transition and commented on how good the building and unit looked. Members asked that their thanks be passed on to the staff who made this happen and that everyone involved in save Glenfield should be assured seeing everything transitioned across so well.

The ensuing discussion included the following points:

In relation to specialist children's services it was noted that UHL consultants were recognised nationally and regionally as experts. Clinical teams worked with networks across Northamptonshire, Lincolnshire to expand the region and be experts for all those areas too. National recognition for clinical outcomes showed UHL was up in top three.

Regarding space, the Kensington building was very spacious with room for growth and had been very well designed for children and adolescents with dedicated play therapists and support staff to help children with special needs.

Nicky Topham, Programme Director of Reconfiguration confirmed the new build and existing Kensington building interior had been extended too, including down into lower floors.

Phase II would be looking to move services from the Balmoral building and there would be a combined ICU. At moment it had not been prioritised when services would be moved as UHL were still waiting for maternity hospital to be completed that area in the Kensington building decanted and then consider which children services go in and where.

In terms of lessons learnt it was always good practice to review what had been done well and what could be done better and feed into new projects, this process had been started and one such lesson learnt was to give selves more time to move in between the build time.

Rebecca Brown, Acting Chief Executive confirmed there was provision for parents to stay overnight so they could be close to very sick children. There were also other provisions such as McDonalds House.

The Chair mentioned plans for space on Jarrom St and asked for any details about potential development there to be shared.

In relation to data protection and safeguarding of children it was confirmed that all relevant GDPR were complied with and there were a number of rules in place around processing data which were observed and maintained, the space within the building had also been designed so computers were in secure areas. Safeguarding was important and the safety of children paramount so there were systems ensuring doors were secure and people were only let in with appropriate identification to maintain safety of children whilst they are in hospital care. Systems were also in place around checks and training of staff to ensure safe and secure environment.

In terms of splitting adult and children's cardiac service from Glenfield e.g. staff/peer support, there had been long term planning and especially in lead up to the transition around recruitment. UHL also invested in training as part of the programme and up skilling staff at LRI side too. UHL had invested to have the right teams on both sites and to support staff moving sites and UHL was

12

confident they now had two very good stand alone services although there were still some services that are joint.

The Chair thanked officers for their responses.

AGREED:

That an update on further developments be brought to a future meeting.

24. COVID19 AND THE AUTUMN/WINTER VACCINATION PROGRAMME - UPDATE

The Chair reminded those present that since the situation around Covid was fluid written reports were not provided as the data changed daily.

Caroline Trevithick and Kay Darby of Leicester City CCG, gave a presentation and verbal update on the Covid 19 and Autumn/Winter vaccination programmes including recent data and vaccination patterns across Leicester, Leicestershire and Rutland latest plans

It was noted that:

- The City compared favourably with other similar cities in terms of vaccination uptake.
- Vaccination rates had fallen significantly so CCG partners were reviewing that and looking at what next steps could be taken to boost uptake.
- Leicester, Leicestershire and Rutland had published vaccination data that showed the lowest uptake was amongst the under 29 year old age category.
- In relation to 12-15 year olds, the vaccination programme was due to roll out across secondary schools from next week.
- A third primary dose vaccination had been approved and recommended for vulnerable people; this was not to be confused with a booster. Work was ongoing to look at which people might benefit from this vaccination.

Expanding the points around low uptake, there were some patterns which included particular areas heavily populated by students, so work was being done to deliver key messages and target people across campuses. Various pop up vaccination clinics were also planned.

In terms of younger people: 16 – 17 year olds were averaging 51.8% uptake, 12-15 year olds currently only had crude numbers however it was known there were 3,034 people in at risk cohorts within this age group waiting for vaccination.

Regarding the vaccination programme for 12-15 years olds and the issue of parental consent, it would be an opt in programme that followed tried and tested practice for other vaccination programmes. However, because it was Covid there was more contention and so there was work around that in terms of parental consent and whether children who are conscient may be able to

consent for themselves.

Regarding logistics, it was noted that children in year 7 were a mixture of ages with some not yet 12 years old however the age cut off was 12 years so only those 12 years and above would be vaccinated. Clarity on those arising 11-12 was still awaited. At the moment this was a one dose vaccine, being administered using existing programmes to deliver logistically to schools across LLR.

In terms of encouraging uptake, each school would be visited and given information, some parents/children would need more information and take longer to reach a decision on whether their child should be vaccinated so there would need to be consideration of how those not ready when teams were at school could then have it if they changed their minds.

The Covid Booster vaccination programme would commence from September.

The seasonal Flu cohort's vaccination had now started and there was also talk of the Flu programme being wrapped into a combined offer although this would be subject to supply. Additional community pharmacy capacity was also being targeted at hard to reach communities.

Slides on geographical coverage were noted (appended).

In terms of timing of the vaccination for 12-15 year olds, that was guided by the National programme but did present additional challenges as children in LLR schools had returned to school earlier than nationally but CCG's now had approval to begin and would work through any nuances.

In relation to care homes, care home staff were now required to be vaccinated by November. CCG partners were working closely with councils and care home staff to help and support them and address any reasons for not having the vaccine, however it was still personal choice. Focus was on building confidence in the vaccine and ensuring convenience for its uptake.

Regarding the vaccination of UHL staff compared to take up elsewhere it was noted that 83.1% had received a first dose and 83% had received a second dose. These figures did not include those that may have received their vaccination elsewhere but overall, our hospital vaccination rate was above average.

It was suggested some of the low uptake may be due to people moving away from the area during the period especially university students or Europeans and GP registers not being maintained and updated. In response it was explained that a data exercise was being started to undertake a major clean up of all GP lists and verify them, this would take some time and there was no short cut to that to get to underlying issues.

It was queried whether there were steps to encourage more teachers to be vaccinated especially in schools with vulnerable pupils. In reply it was

14

explained this was not a data set captured nationally, however there was awareness that the vaccination initially had been limited by process of age and there was a push by teachers for them to receive the vaccination sooner.

The Chair welcomed that GP data exercise and asked for an update on any early indicators or patterns as well as updates on initiatives and attempts to increase vaccination uptake.

AGREED:

That a further update on Covid 19 and the Autumn/Winter Vaccination Programme be brought to the next meeting.

25. UHL ACUTE AND MATERNITY RECONFIGURATION - BUILDING BETTER HOSPITALS UPDATE

Darryn Kerr, Director of Estates UHL provided an update on the UHL Acute and Maternity Reconfiguration as part of the Building Better Hospitals programme.

Referring to earlier discussion during the public questions item of the meeting he confirmed a key point that UHL were not planning to change any clinical models or pathways.

It was noted the team continued to work up the design brief as well as work on enabling the project and business case to create the space needed. They were also undertaking early works on the decontamination programme and liaising with system colleagues on concepts around sustainability.

The ensuing discussion with Members included the following points:

- Assurance was given that there would be no change to bed numbers referred to during the consultation process. The issue of single rooms for patients put pressure on space not on the number of beds.
- In terms of moving services, staff and patients, a lot of consideration was given to this from an early stage in all programmes and clinical service exercises to minimise disruption.
- Referring to a question asked at the December 2021 meeting clarity was sought on the number of women who delivered out of area and were seen by the community team and not just those that received inpatient care at St Mary's. Rebecca Brown, Acting Chief Executive UHL agreed to provide more details on that outside this meeting.
- With regard to back office functions and new ways of working, this was something UHL were considering everyday alongside optimising the best accommodation available. This was being worked through, learning lessons from outside the system. As an example, they had just opened their first agile building and that adopts policy of no-one having their own office. A lot of lessons had been learnt during Covid which were part of ongoing considerations.

AGREED:

That further detail be provided in relation to the response given

around post-partum/post-natal care numbers in the County for women who delivered out of area.

26. INTEGRATED CARE SYSTEMS UPDATE

The Chair reminded those present there had already been comprehensive questions and answers around the Integrated Care Systems and opened the item for Member discussion.

David Sissling, Independent Chair, LLR Integrated Care System briefly reintroduced himself and set out the reasons for integrated care systems and their aim to provide new models of care for physical and mental health, reduce inequity, create better workspace and provide volunteer opportunities. It was noted that emerging issues such as defining goals of ICS and addressing inequality and inequity had been identified, especially around supporting those with frailty and enabling people to have a voice.

A lot of the work was about building in continuity with CCG's and developing good relations, trust, and openness between partners.

In practical terms work was accelerating towards the formal launch of the Integrated Care Partnership (ICP) next April. Focus was on making critical appointments in key roles, as well as working with local authorities to launch the Integrated Care Partnership.

Responding to enquiries about the vision for how the Integrated Care System would work across Leicestershire, this was partly described in terms of outcomes and remaining focused on the reasons why we were doing this work. There was a lot to learn from local government and the way in which NHS was mobilising itself. One change was to recognise that the NHS was an enormous and major contributor to GDP and contributor to the City and County. In that respect the vision was broad but there is no agenda in terms of the private sector and in time that assurance will be seen.

Andy Williams, Chief Executive Leicester CCG commented that they were moving away from competition philosophy so that the standards of care and pathway should be the same across the County and City and there should be a consistent experience for people. However, there might also be a need for different targeted approaches in areas e.g. to increase uptake of vaccinations and these changes would be aimed at facilitating ability to do both these things consistently.

It was queried what element of choice there was in terms of services across borders, and it was indicated that the current situation seemed to be based on resources and they planned to look to make services more universal in terms of the population.

There was a brief discussion around what the NHS offered and the role of scrutiny to challenge process, as an example it was noted that audiological services were not always available on NHS but could be sought privately, this

16

was an interesting point that came back to statutory obligations. There was also the issue around NHS or private prescriptions and members were informed that although there was a lot of discretion to create the care system appropriate for LLR it was subject to statutory obligations.

Referring to gaps in scrutiny around procurement frameworks, David Sissling advised that the involvement of elected members was critical, and the ICS would have to learn from local government. Meetings were already being held with local health and wellbeing boards to better understand scrutiny processes.

It was queried how closely the ICS and ICP would work with pharmacies and whether there were existing communications. David Sissling replied that there was a massive opportunity to rethink what was meant by primary care and to consider that alongside pharmacy, dental, and optician services. That was a transformational area where the ICS can affect a change, and more could be done if there was work with pharmacies as a group.

The Chair thanked David Sissling for taking this opportunity to engage with the commission.

AGREED:

That there be further updates on the Integrated Care Systems at future meetings of the committee.

27. MEMBER QUESTIONS (ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA)

There were no other Members questions that had not already been covered elsewhere on the agenda.

28. WORK PROGRAMME

Work programme received and noted.

29. DATE OF NEXT MEETING

Date of next meeting to be noted on 16th November 21 at 5.30pm

30. ANY OTHER URGENT BUSINESS

None notified.

There being no other business the meeting closed at: 8.45pm .

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 16 NOVEMBER 2021

UPDATE PAPER ON NHS DENTAL SERVICES IN LEICESTER, LEICESTERSHIRE AND RUTLAND

REPORT OF: NHS ENGLAND AND IMPROVEMENT (NHSEI) – MIDLANDS

Purpose of the Report

1. The purpose of this report is to provide an update to the committee on the provision of NHS dental services commissioned in Leicester, Leicestershire and Rutland (LLR). The report will include an overview of the ongoing effects of the COVID-19 pandemic and the steps being taken to restore and recover service provision.

Background

Access to services

2. It is important to clarify that NHS dental care, including that available on the high street (primary care), through Community Dental Services or through Trusts is delivered by providers who hold contracts with NHS England and NHS Improvement. All other dental services are of a private nature and outside the scope of control of NHSEI. The requirement for NHS contracts in primary and community dental care has been in place since 2006.

3. There is no system of patient registration with a dental practice. People with open courses of treatment are practice patients during the duration of their treatment, however once complete; apart from repairs and replacements, the practice has no ongoing responsibility. People often associate themselves with dental practices. Many dental practices may refer to having a patient list or taking on new patients, however there is no registration in the same way as for GP practices and patients are theoretically free to attend any dental practice that will accept them. Dental statistics are often based on numbers of patients in touch with practices within a 24-month period and this in many cases be based on repeat attendances at a “usual dentist”.

4. General Dental Practices within Leicester, Leicestershire and Rutland offer a range of routine dental services; some of these generalist providers also provide less complex orthodontic services. In addition, there are specialist Orthodontic practices; the orthodontists in these practices are specialists and provide more complex care. Extended or out of hours

cover is provided by five 8-8 contracts, services which provide access to patients 8am – 8pm 365 days of the year for both routine and urgent care. Secondary care is provided by University Hospitals of Leicester (UHL) and Community Dental Services for special care adults and children is provided from five clinics in the area by CDS-CIC.

5. Around 50% of the population are routinely in touch with NHS high street dental services; the numbers of people attending private services is not known; but is not expected to be the remaining 50% of the population. Many people with less structured lifestyles or who are vulnerable may not engage with routine care and may instead use unscheduled/out of hours dental services. Individuals are free to approach practices to seek dental care and further information on NHS dental practices is available on the NHS website: https://www.nhs.uk/service-search/find-a-Dentist.

Timeline of National pandemic response and impacts upon dentistry

6. A timeline of the key decisions taken nationally and the impact upon dentistry is included below:

- ***March 23rd, 2020***
  Routine dental services in England were required to close. Providers continue to receive contractual payments as previously (with a 16.75% abatement to mitigate cost savings of closure).

  All staff are required to be paid as per previous arrangements and providers instructed to operate remote telephone access for any patient contacting the practice.

- ***April 2020***
  NHSEI commissions and mobilises Urgent Dental Centres (UDCs) to ensure that patients with urgent needs can continue to access treatment. Dental practices are obliged to provide remote triage and advice, the prescription (where appropriate) of analgesia and antibiotics despite being 'closed' as per an Urgent Care Standard Operating Procedure (SOP).

  UDCs are mobilised in Leicester City (Nelson street), Melton Mowbray, Loughborough and Oakham. Post analysis of patient referrals and usage, the UDC in Oakham is stood down and a further UDC site in Hinckley is mobilised in June 2020.

  The Urgent Dental Centres remain open and operational and continue to operate at the time of writing to provide urgent care access and treatment for patients across LLR.

- ***June 8th, 2020***
  NHS Dental practices are allowed to reopen, with strict Infection Prevention Control (IPC) and social distancing protocols outlined and implemented. NHSEI supports practices to reopen as swiftly as possible.

- ***June 30th, 2020***
  An additional period of "lockdown" is enforced in Leicestershire. This decision taken by government to mitigate the impact of a rise in COVID-19 cases.

  During the Leicester and Leicestershire incident and restrictions, UDCs continued to provide access to patients requiring emergency treatments.

  General dental practices are supported to undertake rigorous risk assessments to ensure that, wherever possible, practices remain open and able to provide access to patients.

  A vast majority of Leicester and Leicestershire practices in affected areas remain open and continue to provide access to patients. Those that are unable to remain open are supported to re-open as soon as possible and are mandated to provide remote triage to all patients that contact the practice (referring onwards to a UDC if necessary).

- ***July 20th, 2020***
  All dental practices are expected to reopen and recommence provision of face-to-face services. Any practice advising that they are unable to reopen are contacted to understand the barriers to reopening and to support the development of an action plan to reopen as soon as possible.

- ***January – March 2021***
  General dental providers are required to deliver a minimum threshold of 45% of their pre-COVID Units of Dental Activity (UDA) or 70% of their pre-COVID Units of Orthodontic Activity (UOA) in order to continue to receive 100% payment of their contract.

  The minimum thresholds are not designed as 'targets' and are based upon the impact of providers adherence to the IPC and social distancing guidance imposed nationally.

  Providers advised to inform NHSEI immediately as to any circumstances which may limit their achievement of these minimum thresholds so that arrangements can be put into place to support service recovery.

  Failure to achieve the minimum threshold of activity to result in a clawback of funding paid to providers upon reconciliation and review of activity.

- ***April 2021 – September 2021***
  Required minimum thresholds for contract delivery are increased to a minimum of 60% of UDAs for general dental providers and 80% of UOAs for orthodontic providers, in order for providers to continue to receive 100% payment of their contract.

  The thresholds are to remain constant for Quarters 1 & 2 of 2021/22 to provide stability to providers as they continue to recover services.

Failure to achieve the minimum threshold of activity results in a clawback of funding paid to providers upon reconciliation and review of activity.

- ***October 2021 – December 2021***
  Required minimum thresholds for contract delivery are increased to a minimum of 65% of UDAs for general dental providers and 85% of UOAs for orthodontic providers in order to continue to receive 100% payment of their contract.

  Minimum thresholds are increased owing to some flexibility in IPC guidance which allows practices to treat patients with less 'downtime' between appointments.

  IPC guidance and contractual minimum thresholds are to be revisited and reassessed in the coming weeks, with the minimum thresholds for January 2022 – March 2022 communicated in due course.

Ongoing impact and effects of the COVID-19 Pandemic.

7. The ongoing COVID-19 pandemic has had a considerable impact on dental services and the availability of dental care. The long-term impact on oral health is as yet unknown but forms a key component of recovery and restoration work being undertaken by NHSEI.

8. A significant constraint, that has limited practices in their ability to offer increased patient access and treatment, has been the introduction of 'downtime' – a period of time for which the surgery must be left empty following any aerosol-generating procedure (AGP). An AGP is a procedure that involves the use of high-speed drills or instruments and would include fillings, root canal treatment or surgical extractions. This has had a marked impact on the throughput of patients.

9. The constraints on the amount of activity that practices are able to safely deliver has dictated that NHS dental care remains prioritised towards those in greatest need. Primarily, during the pandemic, this has referred to patients with an urgent need for dental assessment and treatment.

10. NHSEI has worked closely with providers and other stakeholders to develop an Outbreak Standard Operating Procedure for practices to report any staff members that are self-isolating or have received positive COVID-19 tests. NHSEI is committed to supporting practices where incidents occur but can confirm that service delivery impacts have been minimal and are being well managed by practices across LLR.

Urgent Dental Centres (UDCs) and the Urgent Care pathway

11. Urgent and emergency oral and dental conditions are those likely to cause deterioration in oral or general health and where timely intervention for relief of oral pain and infection is important to prevent worsening of ill health and reduce complications (SDCEP, 2013). Urgent dental care problems have been defined previously into three categories (SDCEP,

2007). The table below shows current national information about the 3 elements of dental need and best practice timelines for patients to receive self-help or face to face care.

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

12. UDCs and Out of Hours services have been set up to operate to provide care in line with the standards described above. Practices also apply the same criteria but routine dental problems (those not associated with significant pain or swelling) are unlikely to be deliverable currently within 7 days due to the need to prioritise those in pain.

13. The availability of routine check-ups remains likely to be limited to those who are vulnerable or who have ongoing dental issues, however the number of providers 'recalling' patients for routine check-ups and treatments continues to increase across the Midlands.

14. Many patients with generally good oral health would not be expected to require 6 monthly check ups under normal circumstances and these remain safe to be deferred at this time. Treatment options may be more limited than usual. This is due to the need for AGP (aerosol generating procedures) for restorative dentistry (e.g. fillings and root canals) which are limited due to the extended 'downtime' necessary between patients.

15. At the outset of the pandemic response, the dental team engaged with stakeholders (including the Local Dental Committee (LDC), Local Dental Network (LDN) and PHE colleagues) to agree suitable sites for urgent dental care centres.

16. Across Leicester, Leicestershire and Rutland (LLR) initial sites were mobilised in Leicester City (Nelson Street), Loughborough, Melton Mowbray and Oakham. These sites were all established 8-8 practices, which offered the optimum combination of geographical coverage, contracted hours of opening and staffing.

17. Post analysis of patient access and geographical location of patients accessing the UDCs, the decision was taken to stand down the service at Oakham in order to mobilise an additional site in Hinckley, thus providing better access for patients in the west of the county. Hinckley remains an operating UDC along with sites in Leicester City, Loughborough and Melton Mowbray.

18. In addition, sites were mobilised to provide care for those vulnerable patients that were "shielding" and for symptomatic patients. The local Community Dental Service was mobilised to provide these services, with

enhanced infection prevention control measures in place for patients attending the symptomatic site.

19. The local Community Dental service continues to provide care for those with special care needs including some children.

20. The UDCs remain operational and continue to support other local practices in providing care to local patients – in particular those who do not have a "usual" dentist or are new to NHS dental care.

21. There remains no direct access into the UDCs; they are required to follow distancing and appointment only face to face contacts. Referral to a UDC is via a general dental practice or via 111.

22. The optimum pathway for accessing dental services (whether urgent or routine) remains for patients to contact a local dental practice (when attempting to access care during working hours) or to contact NHS 111 outside of working hours.

Vulnerable patients

23. NHSEI, the Office of the Chief Dental Officer (OCDO), the Department of Health and Social Care (DHSC) and Public Health England have all written to providers to try and ensure that patients from vulnerable groups are not detrimentally impacted by the continued reduced levels of dental service provision.

24. Practices are expected to prioritise vulnerable patients (including children and those most 'at-risk' of dental disease and oral health problems) when recommencing routine care and recalls for check-up appointments.

LLR dental service performance

25. Across LLR during the first six months of the financial year 2021/22, 64.4% (vs. a minimum threshold of 60%) of pre-COVID contracted UDAs was delivered.

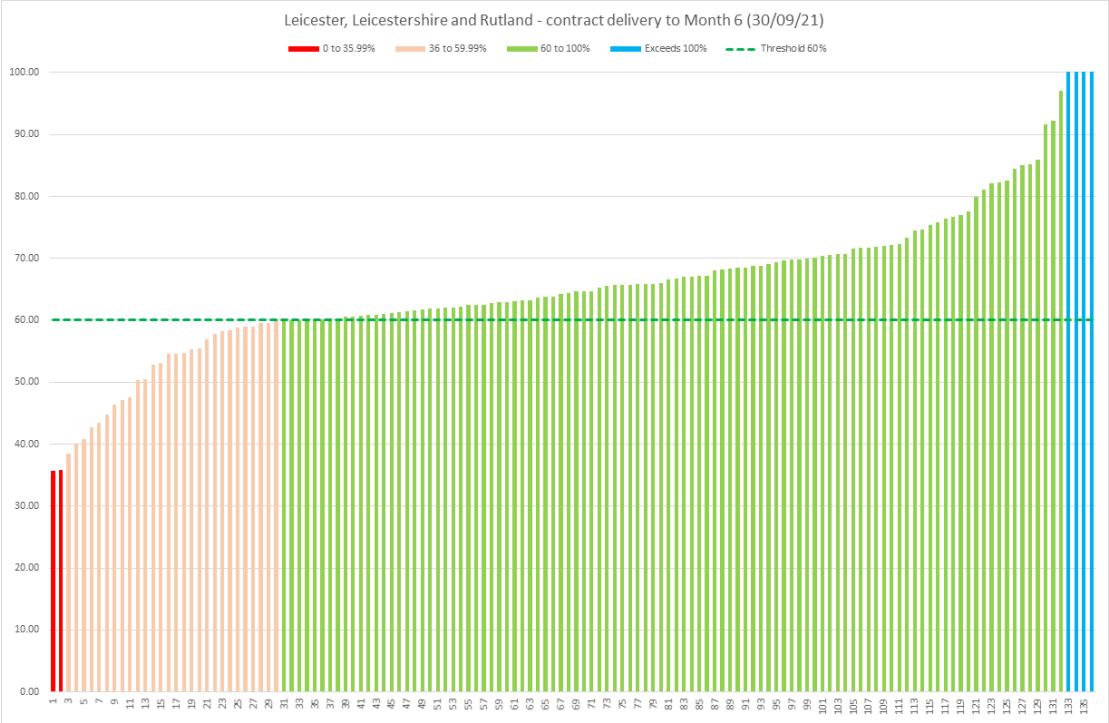
26. This represents a 'loss' of over 300,000 Units of Dental Activity (UDAs) during this period against the levels of pre-COVID activity commissioned by NHSEI and illustrates the level of service impact that the pandemic continues to have upon dental services.

    However it is also important to note that one UDA does not equate to one appointment of course of treatment as different treatments attract different levels of UDAs (i.e. the more complex a course of treatment, the more units the course of treatment attracts to ensure that providers are compensated for the increased amount of time and resource required for that treatment).

27. During April-September 2021 (Q1 & Q2) providers were required to deliver a minimum of 60% of their pre-COVID contractual activity, in order to

continue to receive 100% payment. Figure 1 (below) illustrates this achievement for all LLR providers during this time period.

Figure 1: LLR provider delivery Apr-Sep 2021



28. Of the 136 contracts in LLR providing general dental services:

- 2 contracts (red) delivered less than 36%
- 28 contracts delivered between 36% - 60%
- 102 contracts delivered between 60% - 100%
- 4 contracts delivered greater than 100% (i.e. greater than the level of activity commissioned by NHSEI)

29. For Orthodontic providers the minimum threshold is higher (owing to less complex IPC guidance and less frequent use of AGPs) at 80%. During Q1 and Q2 across LLR providers delivered 86.9% of contracted orthodontic activity.

30. All providers delivering less than 60%/80% of activity are subject to contractual action by NHSEI. NHSEI will reclaim the appropriate proportion of monies paid to under-performing providers and reinvest these monies in schemes designed to support service recovery.

Recovery and Restoration of services

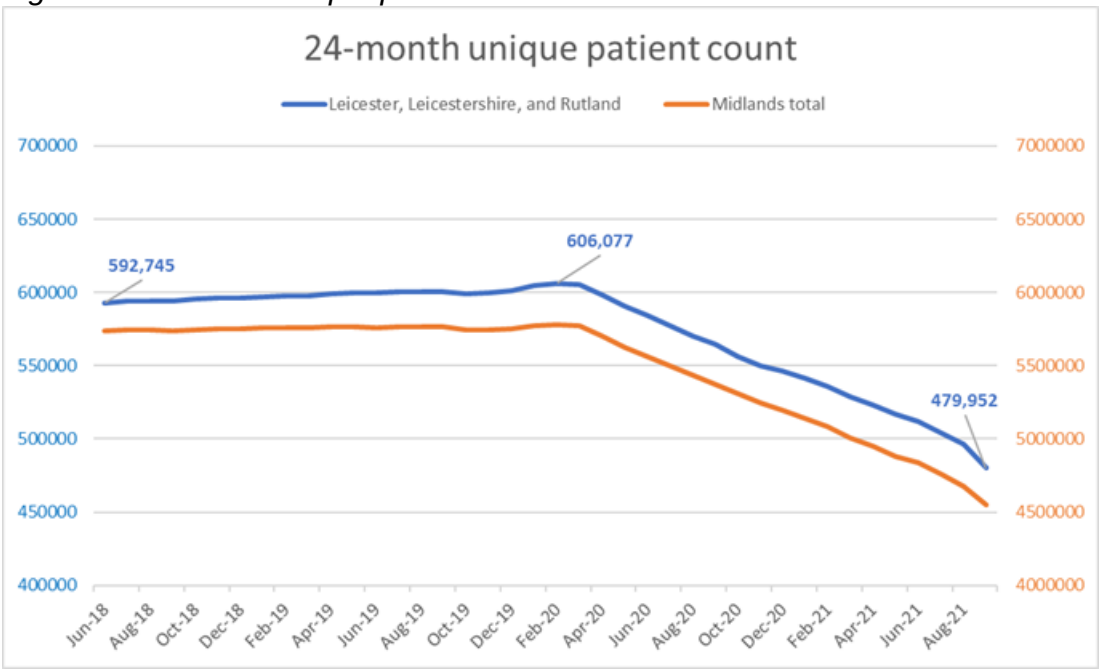
31. Outlining a timeframe for full service recovery remains difficult, owing to the continued requirement for enhanced IPC measures and the impacts upon providers and their staff of the pandemic thus far.

32. The most appropriate objective measure to illustrate the 'loss' of activity is in the shape of 24-month unique patient access figures. These figures show the number of patients accessing NHS dental services over a two-

year period. While this measure is not perfect (as some patients may be more likely to visit a dentist in this timeframe and others may not ordinarily visit at all) it does provide a proxy measure for 'lost appointments' and demonstrates the scale of the service backlog that exists.

33. Figure 2 (below) shows the impact of the COVID-19 pandemic on the 24-month unique patient count for both LLR and the Midlands region:

Figure 2: LLR 24m unique patient count



34. Broadly speaking, the above chart illustrates that, across LLR, there are approximately 126,125 patients that would ordinarily visit a dentist that have been unable to do so during the last eighteen months or so. Before dentistry can be fully 'restored' to pre-pandemic levels, this backlog will need to be addressed.

NHS England and Improvement initiatives

35. To support the recovery and restoration of dental services, NHSEI has commissioned additional initiatives across the Midlands to attempt to mitigate the detrimental impact upon dental access and the limitations upon providers in delivering maximum numbers of appointments.

Weekend Access scheme

36. NHSEI opened an expression of interest to all dental providers across the region to provide additional sessions of activity outside of contractual hours at weekends. This initiative was designed to encourage providers to open for additional sessions and appointments and increase patient provision.

37. Criteria were developed to ensure that activity commissioned was additional and that providers were only eligible if they were able to deliver their contracts in line with national minimum thresholds. Providers were also required to pass clinical checks to ensure that activity commissioned was of a high and safe standard for patients.

38. The initiative was initially offered to providers during January – March 2021; 152 additional sessions were commissioned from 4 providers across LLR. This represents an additional 1500 UDAs.

39. Following the success of the scheme it was repeated with providers able to deliver sessions during the period July 2021 – March 2022. 14 providers across LLR submitted applications which met the criteria and an additional 460 sessions have been commissioned. This represents approximately an additional 5520 UDAs.

Ventilation schemes

40. A key input towards the restoration and recovery phase of NHS Dental services is the ability to increase patient access and treatment by reducing post AGP 'downtime' by supporting NHS dental practices to understand their air changes per hour (ACH) and 'downtime' whilst meeting the Workplace (Health, Safety and Welfare) Regulation.

41. To assist providers in operating as efficiently as possible NHSEI commissioned support via a contribution to practices to undertake a basic ventilation and filtration survey. This helped providers to understand their current building ventilation and filtration and how this can be enhanced to maximise throughput.

42. Across LLR seven providers have received funding to improve the ventilation in their practice and to reduce the required 'downtime' between AGP appointments.

Dedicated 111 slots

43. NHSEI recognises the impact of the pandemic on dental access and particularly the accessing of care by vulnerable groups. Many vulnerable groups access services infrequently and only when their needs are of an urgent nature.

44. To support this cohort of patients, NHSEI engaged with providers and NHS 111 to secure an additional 56 appointments per week across LLR, to be accessed and booked via NHS 111, for patients that do not regularly attend a dental practice.

45. Providers are required to reserve these appointments and to ensure that they are utilised only for the patients in this cohort, who access the dental pathway via 111 and meet the criteria for urgent treatment.

46. Review of the initiative is ongoing but all parties have reported a good level of usage and treatment of patients that fit the vulnerable criteria, with no slot wastage as any unused slots are offered for patients who contact the practice directly should a slot not be booked by 111.

47. It is hoped that this ongoing initiative will ensure access to services for those patients that do not ordinarily engage with dental services, via a direct and expedited route.

New appointments

48. To ensure that NHS Dental services are at the forefront of the new Integrated Care Systems NHSEI has newly appointed Steve Claydon as the Local Dental Network (LDN) Chair for LLR. Steve's role will be ICS-facing and provide a direct senior clinical link between NHSEI and the ICS and other stakeholders, including the JHOSC meeting.

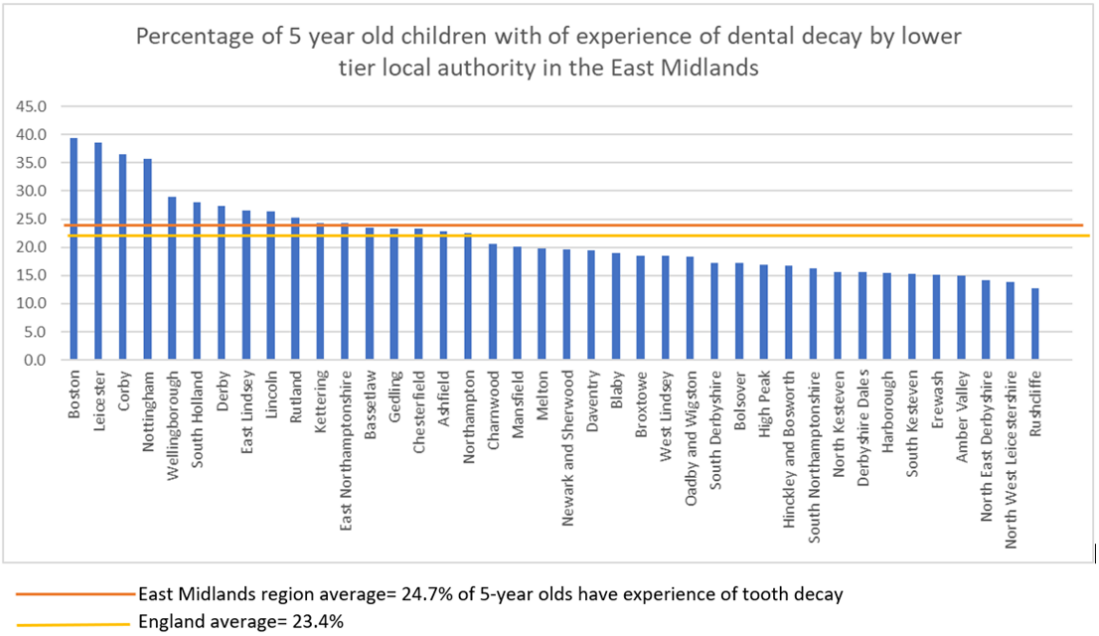
49. In addition, Adam Morby has been appointed as the Midlands Regional Chief Dental Officer, to provide senior clinical leadership for dentistry across the region and a greater link to the chief dental officer for England and the DHSC.

Oral health in Leicester, Leicestershire and Rutland

Child oral health

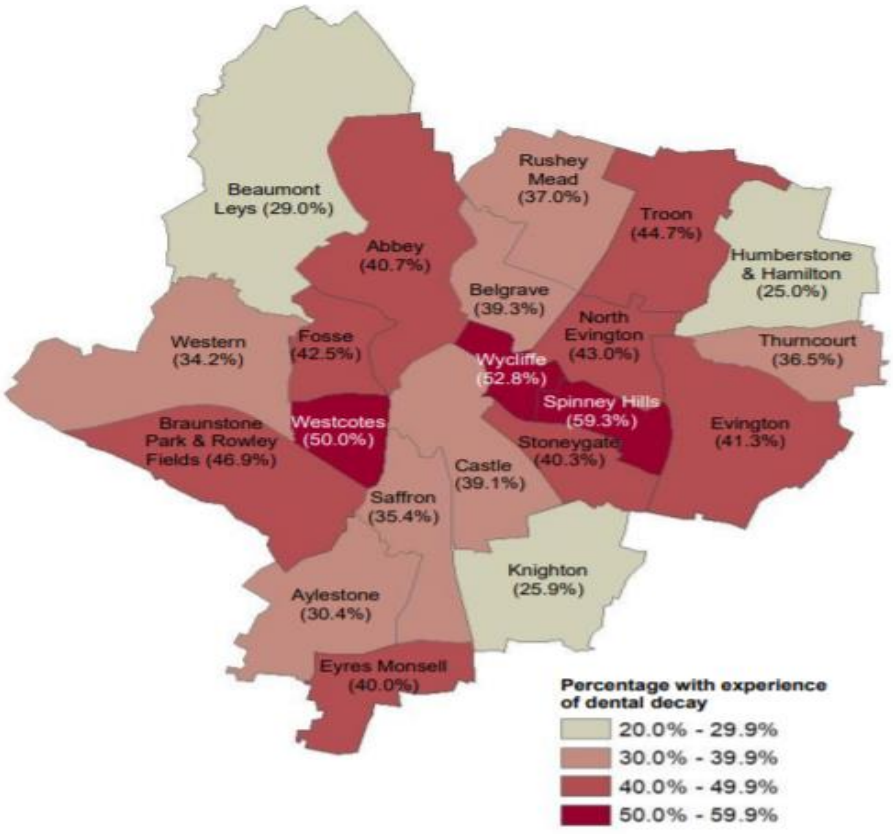
50. The national child dental epidemiology programme conducts a survey of the dental health of 5-year-old state school pupils every two years. The most recent survey published at the start of 2021 shows that:

- in Leicester city, childhood tooth decay levels are the second highest in the region.
- Within Rutland, child decay is slightly higher than the regional and national average.
- In Leicestershire, Charnwood district has the highest tooth decay rates in the county.



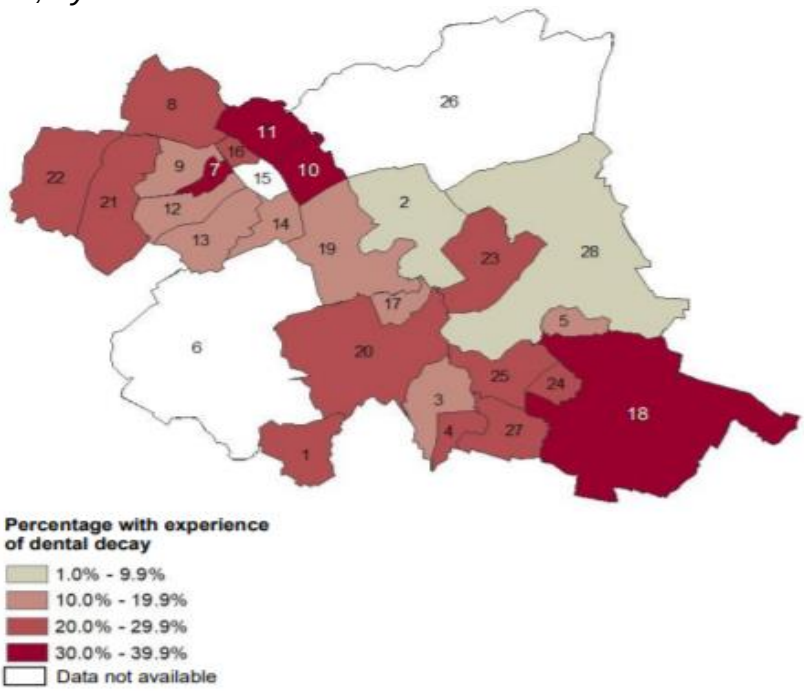
51. In Leicester average levels of dental decay are higher than the average for England. Within Leicester there are areas where there are higher than average levels of experience of dental decay. At ward level, children living in Westcotes, Wycliffe and Spinney Hills have the highest levels of experience of dental decay. Within the school health profile areas, the highest levels of experience of dental decay are clustered around Central, West and North

Figure 3: Prevalence of experience of dental decay in 5-year-olds in Leicester, by ward



52. In Leicestershire average levels of dental decay are lower than the average for England. However, within Leicestershire there are areas where there are higher than average levels of experience of dental decay. At lower-tier local authority level, children living in Charnwood have the highest levels of experience of dental decay. Within Charnwood, the highest levels of experience of dental decay are clustered around the wards of Loughborough Ashby, Loughborough Hastings, Loughborough Lemyngton and Queniborough.

Figure 4: Prevalence of experience of dental decay in 5-year-olds in Charnwood, by ward

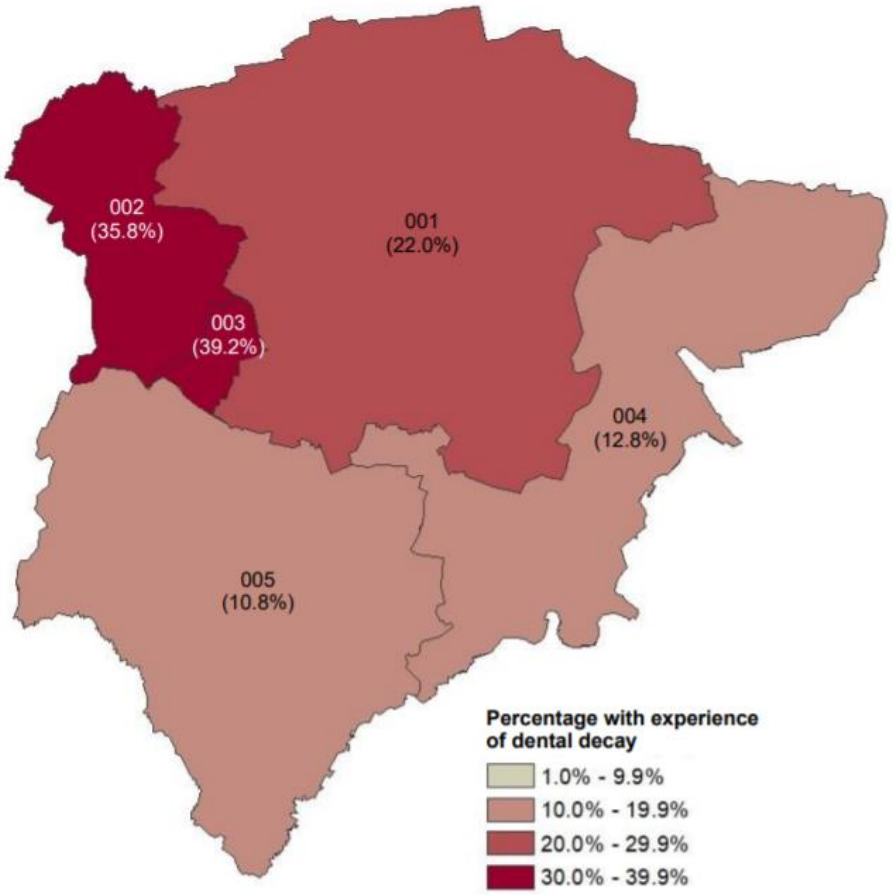


Key	Label
1	Anstey (24.0%)
2	Barrow and Sileby West (4.5%)
3	Birstall Wanlip (15.7%)
4	Birstall Watermead (24.1%)
5	East Goscote (11.1%)
6	Forest Bradgate
7	Loughborough Ashby (33.3%)
8	Loughborough Dishley and Hathern (27.0%)
9	Loughborough Garendon (16.7%)
10	Loughborough Hastings (33.3%)
11	Loughborough Lemyngton (38.2%)
12	Loughborough Nanpantan (16.7%)
13	Loughborough Outwoods (19.0%)
14	Loughborough Shelthorpe (15.4%)

Key	Label
15	Loughborough Southfields
16	Loughborough Storer (26.3%)
17	Mountsorrel (14.8%)
18	Queniborough (33.3%)
19	Quorn and Mountsorrel Castle (19.0%)
20	Rothley and Thurcaston (22.9%)
21	Shepshed East (28.0%)
22	Shepshed West (27.5%)
23	Sileby (20.6%)
24	Syston East (27.3%)
25	Syston West (22.6%)
26	The Wolds
27	Thurmaston (26.7%)
28	Wreake Villages (6.3%)

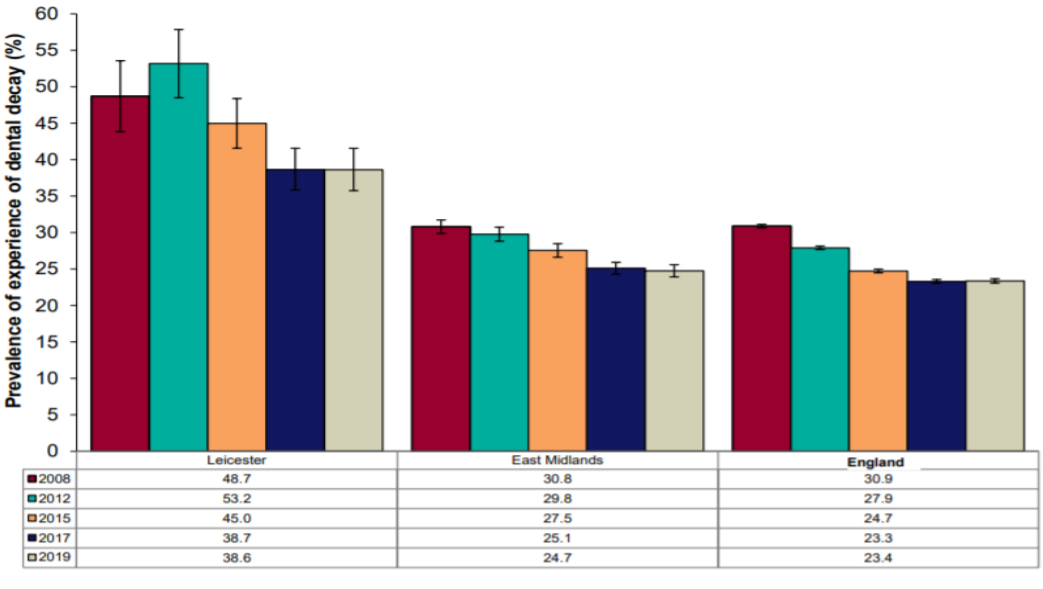
53. In Rutland average levels of dental decay are higher than the average for England. Within Rutland there are areas where there are higher than average levels of experience of dental decay. At a Middle Super Output Area (MSOA) level, children living in MSOA 002 and MSOA 003 have the highest levels of experience of dental decay.

Figure 5: Prevalence of experience of dental decay in 5-year-olds in Rutland, , by middle layer super output area (MSOA)



54. Despite these higher than average levels of child dental decay in Leicester city, rates have fallen considerably over the past decade in both city and county, reflecting national and local oral health improvement efforts.

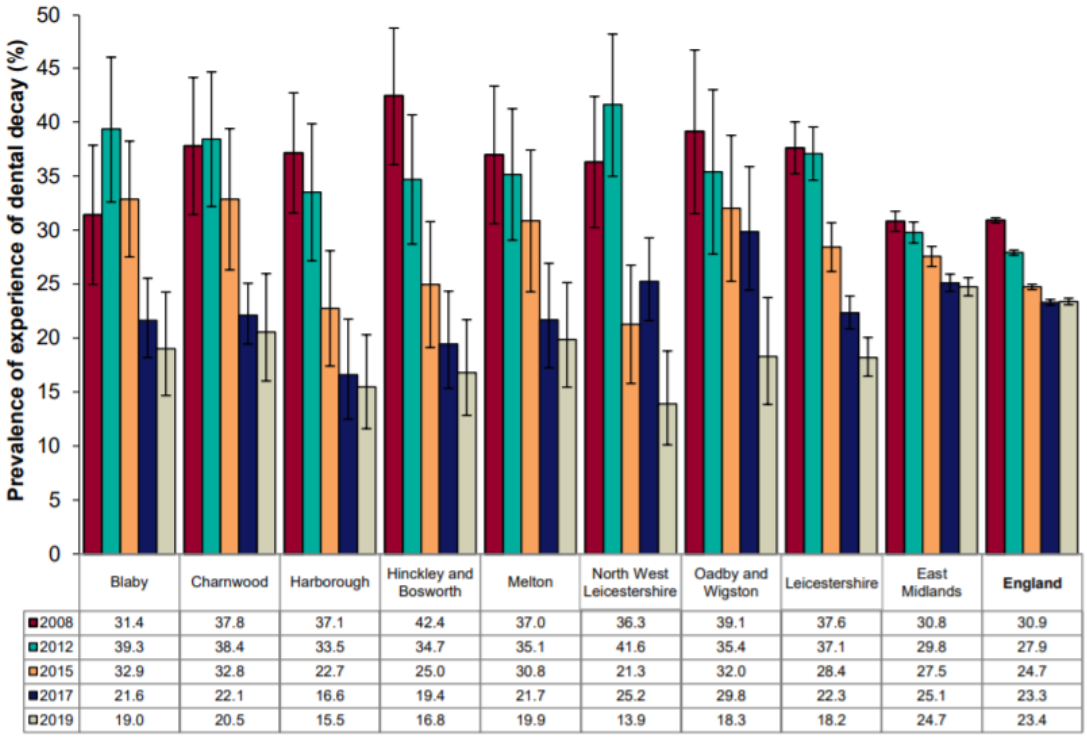
Figure 6: Prevalence of experience of dental decay (%)



	Leicester	East Midlands	England
2008	48.7	30.8	30.9
2012	53.2	29.8	27.9
2015	45.0	27.5	24.7
2017	38.7	25.1	23.3
2019	38.6	24.7	23.4

Error bars represent 95% confidence limits

Figure 7: Prevalence of experience of dental decay (%)



	Blaby	Charnwood	Harborough	Hinckley and Bosworth	Melton	North West Leicestershire	Oadby and Wigston	Leicestershire	East Midlands	England
2008	31.4	37.8	37.1	42.4	37.0	36.3	39.1	37.6	30.8	30.9
2012	39.3	38.4	33.5	34.7	35.1	41.6	35.4	37.1	29.8	27.9
2015	32.9	32.8	22.7	25.0	30.8	21.3	32.0	28.4	27.5	24.7
2017	21.6	22.1	16.6	19.4	21.7	25.2	29.8	22.3	25.1	23.3
2019	19.0	20.5	15.5	16.8	19.9	13.9	18.3	18.2	24.7	23.4

Error bars represent 95% confidence limits

Prevention of child dental disease in LLR

55. LLR has a well-established and very active Oral Health Strategy Group, jointly led by the local authorities and consisting of system-wide partners across health and social care, with the input of specialist dental public health advice through the former Public Health England (recently transitioned into NHS England). This multiagency partnership group develop strategic plans around oral health improvement for all LLR residents across the lifecourse, informed by undertaking a joint oral health needs assessment of the population, which is regularly updated as new data becomes available. The local authorities commission dedicated oral health promotion services who engage with and visit schools across LLR to deliver oral health promotion and prevention.

56. Priorities and actions for the group in tackling child dental decay include:

- Increasing access to supervised toothbrushing in nursery and school settings, and increasing access to fluoride across the region (via toothpaste distribution and topical varnish applications), particularly targeted to those areas that do not enjoy the benefits of water fluoridation

- Working with health visitors and community workers to better identify children and their families who are at high risk of tooth decay and poor oral health so that preventative advice, support and signposting to available services can be actioned, thus contributing to a reduction in the number, and associated financial, social and personal burden, of

children having to attend hospital for tooth extractions under general anaesthetic.

- Working with NHSEI dental commissioners to improve access to child dental services, both at primary and community dental care levels across the county, targeted at areas of highest need wherever possible, and engaging with general dental practices to upscale and enhance their delivery of evidence-based prevention activities

57. NHSEI dental commissioning, public health and the local authority co-design and fund a range of evidence-based prevention interventions and initiatives to improve child and adult oral health and mitigate against the recognised risks to oral health with further funding being made available to mitigate against the effects of the pandemic on dental services.

    With the recent government White Paper of healthcare reform plans to take central government control in relation to the future expansion of community water fluoridation schemes, to help remove some of existing barriers to this, we would recommend wider political advocacy and support at a local level for the introduction of water fluoridation across LLR, as this would be a significant positive and highly cost-effective intervention in reducing the inequalities in child dental health.

Adult oral health and prevention in LLR

58. In 2017/18 the National Dental Epidemiology Programme undertook an oral health survey of adults attending general dental practices in England. It provided data to inform joint strategic needs assessments and oral health needs assessments to plan and commission oral health improvement interventions and services for adults.

    Adults attending general dental practices for any reason, aged 16 years and over, were recruited to take part in the survey. The survey consisted of a questionnaire on the impact of oral problems on individuals, use of dental services and barriers to receipt of care and a brief clinical examination conducted by trained local epidemiology teams under standardised conditions.

59. Summary of adults' oral health for LLR

- the oral health of adults has improved significantly over the last 40 years with more of the population retaining their natural teeth throughout life

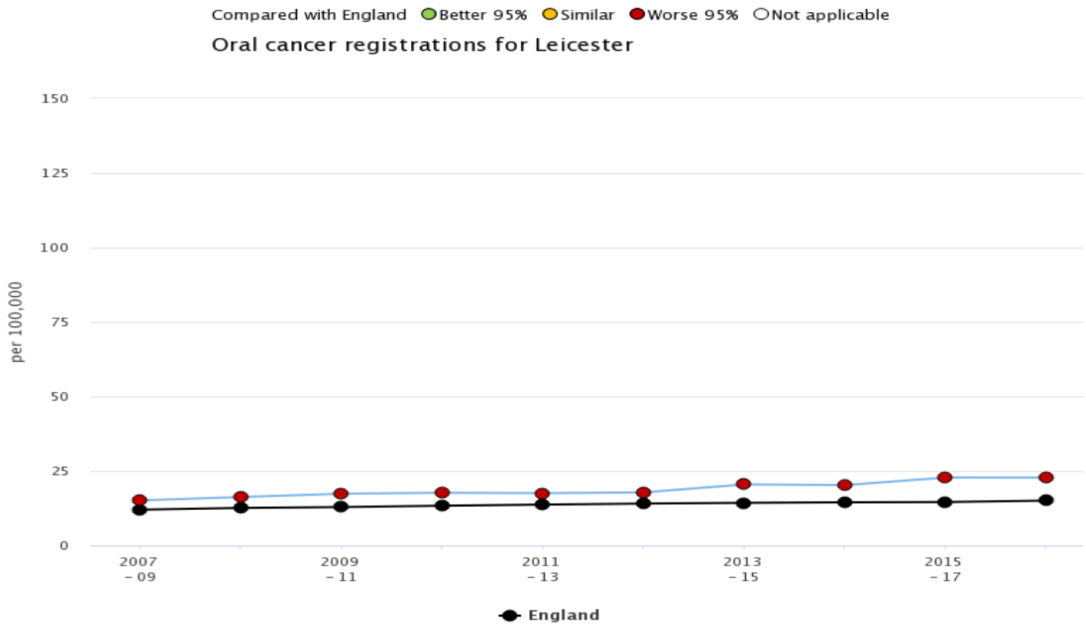
- in Leicester 36.4% of adults had tooth decay, compared with 28% nationally, and 2% had severe gum disease. 84% of adults in the city had an identified dental treatment need-compared to around 70% nationally, with around 2% classed as urgent need. Around 11% of adults in Leicester had not seen a dentist within the last 2 years, compared with a national figure of 8% of adults. Corresponding levels for Leicestershire and Rutland were lower than the national averages across all these indicators

- men from materially deprived backgrounds were more likely to experience higher levels of tooth decay and gum disease but least likely to visit a dentist.

Oral cancer in Leicester

60. Oral cancer diagnosis and death rates in Leicester are consistently and significantly higher than the national average. The latest data shows national oral cancer new registration rates at 15 per 100,000 populations, whereas in Leicester, this was around 23 per 100,000

Figure 8: Oral cancer registations



61. The main risk factors for oral cancer are age, current or previous tobacco and alcohol use, with risk increasing greatly with increasing levels of exposure to these, and poor diet. Many oral cancers are diagnosed at a late stage and where there is a poor survival rate.

    Leicester has the second worst death rates from oral cancer in the country (mortality rate of 9.2 per 100,000, almost double that seen nationally), which indicates that too many oral cancers are being diagnosed too late. Dentists are the main diagnostic route to referral with many cases picked up at routine check-up appointments, as well as GPs, so there is a risk that the impact of the pandemic on access to dental services will have led to cancers not being detected with subsequent poorer patient outcomes.

62. Delivery of effective lifestyle advice and Making Every Contact Count (MECC) initiatives to help people quit tobacco use and reduce alcohol consumption is a key prevention tool in tackling rising rates of oral cancer, along with training for all healthcare professionals and the public on the importance of early identification and diagnosis. Over the past number of years, the public health team has had a programme of education and training activities working with the local authority, the NHS and cancer

charities within Leicester and wider to raise awareness and upskill the workforce around MECC and oral cancer.

Epidemiology of oral diseases in vulnerable groups

63. Vulnerable groups are those people whose economic, social, environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services. This includes people who are old and frail, have physical or mental disabilities, homeless, children who are, or who have been in care.

    These groups often require special treatment or treatment in a special setting to accommodate their needs. The 2015/16 Oral Health Survey of Older People presented the results of a questionnaire and standardised dental examination of older people (aged 65 years and older) with mild dependency who live in "extra care" housing establishments. This is the first oral health survey of this population group and the method was implemented as a pilot. There is therefore no directly comparable data to use which could help to show trends.

64. Summary of vulnerable groups' oral health:

- 35% of those older vulnerable adults surveyed in Leicester reported having not visited a dentist in the last two years-similar to the national figure. Rutland was slightly higher at 37% and Leicestershire at 26%.

- A higher number of vulnerable adults require domiciliary dental care in Leicester than nationally (8% versus 5%)

- children with learning disabilities are more likely to have teeth extracted than filled and have poorer gum health

- adults with learning disabilities are more likely to have poorer oral health than the general population

- adults with learning disabilities living in the community are more likely to have poorer oral health than their counterparts living in care

- homeless people are more likely to have greater need for oral healthcare than the general population

65. The LLR Oral Health Oversight and Steering Group has had a particular focus on improving oral health and dental access for vulnerable adults including homeless persons and, more recently, been actively engaged with the inclusion oral health agenda with refugees and asylum seekers' oral health improvement and access in the city and beyond. Additionally, oral health and dental services are an integral part of the Enhancing Health in Care Homes agenda within LLR with a range of initiatives underway to improve oral health in care homes and for vulnerable older people in the community.

Background Papers *(excluding exempt items)*

66. *None*

Circulation under the Local Issues Alert Procedure

67. *None*

Officer to Contact

68. Tom Bailey (Senior Commissioning Manager, NHS England and Improvement – Midlands)
t.bailey1@nhs.net

List of Appendices

69. *N/A*

Equalities and Hunan Rights Implications *mandatory*

70. Acknowledgement of impact upon access to dental services for population of Leicestershire, particularly vulnerable patient groups, and the mitigating actions taken

Leicestershire, Leicester & Rutland Joint Health Overview & Scrutiny Committee

16November 2021

Covid–19 Vaccination Programme

Report of the Executive Director of Nursing, Quality & Performance

Purpose of Report

1. The purpose of this paper is to provide an update on the progress of the Covid-19 vaccination programme in Leicester, Leicestershire & Rutland (LLR).
2. Members should be aware that this is a highly dynamic programme and although the information provides an accurate description of the position of the programme at the time the report was written there will most likely be some significant changes to report at the meeting; for this reason, the report is high level.

Programme Developments & Key Milestones

- Phase 3: Adult Booster Programme for cohorts 1-9 commenced on 20th September
- Care home booster vaccination is being delivered as a priority: continued plans to visit all care homes around restrictions on outbreaks
- Care home booster vaccination is being delivered as a priority: continued plans to visit all care homes around restrictions on outbreaks
- Joint Committee on Vaccinations and Immunisations (JCVI) announce a third primary dose for immunocompromised people with an additional booster dose to be administered
- Vaccination of 16 & 17 year-olds continues
- 12 to 15 year-olds: COVID-19 immunisation programme commenced on 22nd September and due to complete by 30th November.
- Evergreen offer for first and second doses is ongoing
- Changes to the national booking system imminent to improve access with people able to book further in advance

- Pfizer and Moderna vaccines are the recommended vaccines for boosters, irrespective of which vaccine was administered for primary course.

Capacity & Delivery

PCNs: delivering from 16 sites. Melton Syston & Vale & Rutland have recently re-joined the programme to deliver the housebound programme

Community Pharmacy: 34 sites approved for Phase 3.

Hospital Hubs: five hospital hubs; Leicester Royal Infirmary, Leicester General Hospital, Glenfield Hospital, Loughborough Hospital, Fielding Palmer Hospital with one satellite Hospital Hub at Melton Sports Village.

School Aged Immunisation Service: delivering in school vaccination programme for 12 to 17 year-olds and supporting additional clinics off school premises.

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Vaccination Cohorts

Priorities for the programme are set nationally by JCVI and the programme must adhere to these. Changes to the programme are announced by JCVI based on their review of the clinical evidence and benefits analysis. Announcements are then operationalised via the national programme.

Progress on vaccinations

The number of vaccinations is reported each week by NHSE. Figures are provided below on the number of vaccines given as of 31st October, the latest data at the time of submitting this report. We will provide an update at the meeting. This information is taken from the official published statistics available at https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

Vaccinations: Leicester, Leicestershire and Rutland by age

1st dose														
12-15	16-17	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
9,771	15,630	80,093	53,952	59,114	62,173	62,294	63,857	72,289	70,076	62,556	53,757	53,396	39,876	50,983

2nd dose													
Under 18	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
3,036	69,089	47,835	53,679	58,068	59,360	61,560	70,458	67,951	61,179	53,040	52,925	39,516	50,253

Vaccinations by Clinical Commissioning Group (CCG) & age:

CCG	1st dose[5,6]														
	12-15	16-17	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
NHS East Leicestershire and Rutland	3,668	5,554	19,685	14,931	17,191	17,952	18,993	20,197	24,048	24,549	21,698	18,792	19,925	15,601	20,482
Leicester City	1,953	4,324	30,086	20,222	20,665	22,134	21,463	20,197	20,240	18,249	16,619	13,534	11,060	7,259	10,384
West Leicestershire	4,150	5,752	30,322	18,799	21,258	22,087	21,838	23,463	28,001	27,278	24,239	21,431	22,411	17,016	20,117

	2nd dose[5,6,7]													
CCG	Under 18	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Leicestershire	1,209	17,344	13,484	15,893	17,008	18,284	19,643	23,640	23,921	21,301	18,614	19,810	15,501	20,266
Leicester	762	25,016	17,363	18,232	20,098	20,028	19,088	19,355	17,451	16,100	13,204	10,828	7,094	10,013
Rutland	1,065	26,729	16,988	19,554	20,962	21,048	22,829	27,463	26,579	23,778	21,222	22,287	16,921	19,974

Vaccinations by ethnicity: LLR Level

1st dose[5]																
A: White - British	B: White - Irish	C: White - any other White background	D: Mixed - White and Black Caribbean	E: Mixed - White and Black African	F: Mixed - White and Asian	G: Mixed - any other Mixed background	H: Asian or Asian British - Indian	J: Asian or Asian British - Pakistani	K: Asian or Asian British - Bangladeshi	L: Asian or Asian British - any other Asian background	M: Black or Black British - Caribbean	N: Black or Black British - African	P: Black or Black British - any other Black background	R: Other ethnic groups - Chinese	S: Other ethnic groups - any other ethnic group	Not stated/unknown
511,409	2,913	33,956	1,942	1,235	2,367	3,457	109,748	7,984	4,496	16,812	2,757	9,139	3,117	3,403	12,732	82,539

2nd dose[5]																
A: White - British	B: White - Irish	C: White - any other White background	D: Mixed - White and Black Caribbean	E: Mixed - White and Black African	F: Mixed - White and Asian	G: Mixed - any other Mixed background	H: Asian or Asian British - Indian	J: Asian or Asian British - Pakistani	K: Asian or Asian British - Bangladeshi	L: Asian or Asian British - any other Asian background	M: Black or Black British - Caribbean	N: Black or Black British - African	P: Black or Black British - any other Black background	R: Other ethnic groups - Chinese	S: Other ethnic groups - any other ethnic group	Not stated/unknown
480,513	2,770	31,448	1,645	1,059	2,025	2,867	101,794	7,009	3,956	15,258	2,516	7,612	2,600	3,101	11,097	70,679

Vaccinations of Residents in Older Adult Care Homes

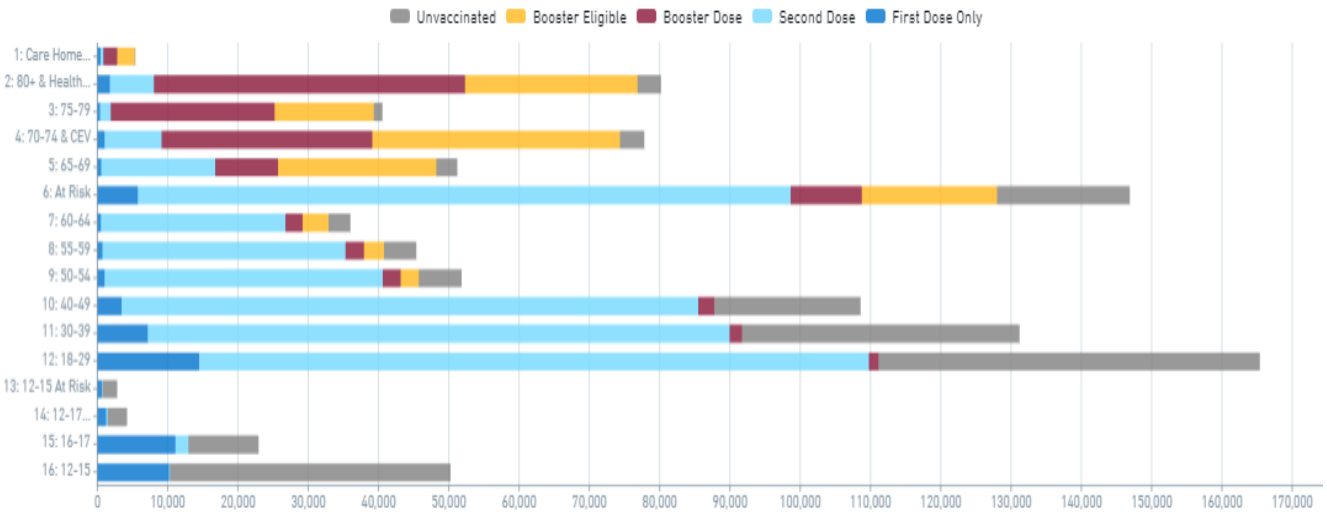
	Residents[5]				
UTLA Name	Total number of residents[7]	Number of residents reported to be vaccinated with at least one dose[7]	% of residents reported to be vaccinated with at least one dose[8]	Number of residents reported to be vaccinated with a 2nd dose[9]	% of residents reported to be vaccinated with a 2nd dose[8,10]
Leicester	1,936	1,838	94.9%	1,816	93.8%
Leicestershire	3,525	3,415	96.9%	3,360	95.3%
Rutland	304	301	99.0%	301	99.0%

Vaccinations of care home staff

	Staff[6]				
	Total number of staff[7]	Number of staff reported to be vaccinated with at least one dose[7]	% of staff reported to be vaccinated with at least one dose[8]	Number of staff reported to be vaccinated with a 2nd dose[9]	% of staff reported to be vaccinated with a 2nd dose[8,10]
Leicester	2,874	2,627	91.4%	2,462	85.7%
Leicestershire	4,981	4,658	93.5%	4,320	86.7%
Rutland	433	424	97.9%	414	95.6%

Headline Vaccination Statistics at STP Level at 5th November 2021

- Population size (cohorts 1-16): 1,021,552
- Received a vaccine dose: 79.1%
- First dose: 808,430
- Second dose: 746,894
- Booster eligible population: 253,482
- Boosters received: 131,641 (51.9%)



Housebound

Delivering house bound vaccinations is logistically challenging: the GP practice must plan these carefully. Once they take a vial out (8-10 doses in a vial) they need to ensure that they can utilise this within six hours whilst maintaining the cold chain. To minimise wastage, careful planning needs to take place, in terms of:

- Identifying enough patients within a geographical location to vaccinate
- Ensuring that the patients are at home and are well enough
- Booking these visits in
- Cold chain management
- Ensuring PPE and consumables required to safely deliver
- Continuing vaccinations for housebound patients (to date vaccination uptake for this population group is detailed below:

Performance	Doses administered	% Uptake
1st Doses	7,611	95.8%
2nd Doses	7,464	93.9%
Boosters	1,892	23.8%

Staff Vaccinations

Across LLR we are currently at around 94.57% for frontline staff for a cohort of around 66,400 people across 800 organisations. We are working on an action plan to improve this; to understand and respond to hesitancy. Fear of the vaccine causing infertility for example has been raised as a significant reason for hesitancy. We are also aware from feedback that some staff find practical difficulties in the booking process and we are working on putting place arrangements to support staff.

Work is being undertaken in conjunction with the public health teams in Leicester City and Leicestershire County Council to develop an approach to conversations about vaccines and responding to often personal reasons for reluctance to have the vaccine.

Inequalities & Vaccine Hesitancy

The programme is working closely with public health colleagues on the response to the Equalities Impact Assessment (EIA). A detailed report on actions taken and how the delivery model should adapt to ensure the programme meets statutory duties on equality are integrated within our programme.

This work will involve a detailed response on how we will ensure the programme pays due regard to the impact on each protected group. The inequalities work focus's particularly on vaccine hesitancy. This will influence our approach to engagement where we know groups may be hesitant about being vaccinated.

LLR has secured national funding to support the equalities programme and a detailed plan is in development to support a mobile vaccination unit to make vaccination more accessible to underserved communities and initiatives to address vaccine hesitancy.

LLR has been following a systematic review of the MSOAs with the highest numbers of unvaccinated population to assess the needs of that community based on the aspects of Convenience, Confidence and Complacency. Information from Local Authorities and Public Health on areas of concern have also been factored in. Some key activities that are being developed as a result to address the needs include:

- Engagement and opportunities for vaccination at the Diwali celebrations at Cossington Recreation Ground on 4th November and the Firework display in Abbey Park on 6th November
- Pop up at King Power Stadium over 12-14th November
- Potential for:
    - a McDonalds pop up for vaccinations in Loughborough and City Centre,
    - extended hours / walk-ins at vaccination sites that do not currently offer this
    - a store front in the city centre
    - engagement in the city centre, particularly tied to Christmas light switch on and other events.

Communications & Engagement

We have a refreshed communications and engagement strategy for phase 3 of the vaccination programme. The strategy reflects learning to date, building on excellent infrastructure created during phases 1 and 2 and is 'follows the data' in terms of targeting. This is supported by a detailed communications and engagement plan which aims to coordinate a range of activities across partners in LLR.

The strategy recognises the highly dynamic nature of the vaccination programme and the need for a rapid response to changes in policy, service delivery and insights as they emerge. Current priorities are:

- 12–15-year-olds
- Booster vaccine: cohorts 1-9
- Pregnant women
- Third dose

- 16 – 17 year olds:
- 12-15 year olds immunosuppressed/living with someone immunosuppressed
- Evergreen offer: latest data shows c165k still not vaccinated in cohorts 1-12
- Low uptake communities/areas e.g., support for ‘pop ups’
- Low uptake in specific ethnic groups
- Second doses
- Mandatory vaccines for people working in care homes

Current work is also focussed on MSOAs with low uptake of vaccinations as highlighted in the previous section. Within these areas we will undertake a higher profile campaign to promote and encourage vaccinations with target groups, including working with established community networks to reach specific groups more effectively. In addition to this there is more intense communications and promotion of services include pop-ups and community pharmacist provision.

Through our communications and engagement, we will aim to promote confidence in the vaccination and the programme and ensure people have the right information on vaccines and availability.

Next Steps

- Continued analysis of MSOA data and focus initiatives to improve uptake across all cohorts
- Scenario planning for further extensions of the programme.

Officer to contact
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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST,
Local Maternity and Neonatal System (LMNS)
LLR Integrated Care system (ICS)

REPORT TO: **Joint Health and Overview Scrutiny Committee**

DATE: **15th October 2021**

REPORT BY: **Elaine Broughton, Head of Midwifery**

SUBJECT: **Black maternal healthcare and mortality**

Introduction

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), is a collaboration appointed by the Healthcare Quality Improvement Partnership to run the national Maternal, Newborn and Infant clinical Outcome Review Programme. The Infant Mortality and Morbidity studies for MBRRACE are led by the University of Leicester by two local Professors. MBRRACE carries out a national programme of work conducting surveillance and investigating the causes of maternal, stillbirths and neonatal deaths. A confidential enquiry is a systematic process of multi-disciplinary, anonymous review of all or a sample of defined cases occurring in a defined geographical area during a defined period of time, all demographics should remain anonymous to avoid identification of person or place.

What the MBRRACE reports continue to highlight are multiple and complex problems that affect women who die in pregnancy, these can be a combination of Social, physical and mental or just one of these factors alone. The women who live in deprived areas continue to be at greater risk of dying during or after pregnancy. MBRRACE also have highlighted before the disparities in outcomes for women from different ethnic minority groups. The coronavirus pandemic has brought this disparity even more starkly to the fore, and we must not lose sight of the actions that are required to address systemic biases that impact on the care we provide for ethnic minority women.

MBRRACE-UK - Saving Lives, Improving Mothers' Care 2020[1], which reviewed maternal deaths from 2016-2018, has shown little difference in outcomes of mortality rates for women of a black ethnic background since the previous report from 2013-2015. There remains a more than four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to white women, emphasising the need for a continued focus on action to address these disparities.

A petition presented to the house of Commons in April 2021 was part of a debate on healthcare disparities and black Women's experiences in maternity care, followed by a programme on Channel 4 dispatches, called the 'Black Maternity Scandal' has all raised the profile of the experience of maternity care in Britain today and although we recognise there are greater risks in this population of pregnant women, listening to the women and how they felt and the description of personal experiences is sad and disheartening.

[1] MBRRACE-UK: Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18. National Perinatal Epidemiology Unit, 2020

Background

The cause of poorer outcomes for women and babies from Black and ethnic communities are multi-factorial and more research is needed to better understand the contributory factors. Common issues which can exacerbate problems for this population include:

- low socio-economic status or social support
- lack of proficiency in English
- Multiple vulnerabilities such as FGM or recent migrant status
- Policy of charging undocumented migrants for maternity care
- A 'one size fits all' approach to maternity care which does not consider differences in women's abilities to understand or access care, or serve the most vulnerable appropriately, can result inequalities in healthcare provision, contributing to structural racism
- Cultural barriers combined with insufficient training of healthcare professionals in cultural sensitivity and knowledge

The National Requirement

The NHS Long Term Plan' (NHS England 2019)[2] set out that by 2024, 75% from Black and minority ethnic communities would receive continuity of care from the same midwife during pregnancy, birth and in the postnatal period. The benefits of this pathway of care are well researched and set out in Better Births (2016)[3]. It also documents the requirement to reduce health inequalities experienced by women of a Black and Minority ethnic background across England. Better Births (2016) set out a recommendation for personalised care for all women, which would address the contributory factor mentioned above 'the one size fits all approach' to maternity care. More recently the Ockenden report (2020)[4]

During the Covid Pandemic, MBRRACE published a rapid report, 'Learning from SARS-CoV-2-related and associated maternal deaths in the UK'[5] It reviewed maternal deaths over a 3 month period from 1st March 2020 to 31st May 2020 and reported a number of key messages, it is reported 10 women died in this period, the majority were from a minority ethnic background. This report identified existing guidance and some recommendations that had already been published that required improvement in implementation. These recommendations were for all pregnant women but highlighted in particular women of black or minority ethnic background (and women with other high risk health conditions) should be advised that they are at greater risk to seek help and advice as soon as possible if they have concerns about their health, either with a Covid Diagnosis or with symptoms

Following the report, the Local Maternity & Neonatal System (LMNS) received a letter advising all systems to ensure specific actions were taken in relation to the Black and minority ethnic women, during the ongoing pandemic, the response from the system is discussed below.

[2] NHS Longterm Plan, NHS England, 2019
[3] Better Births. Improving outcomes of maternity services in England. A Five Year Forward View for maternity care. National Maternity Review, 2016
[4] Ockenden Report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust. Dec 2020
[5] MBRRACE-UK. Saving Lives, Improving Mothers' Care Rapid Report 2021: Learning from SARS-CoV-2-related and associated maternal deaths in the UK June 2020-March 2021. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2021

Public Health England made a number of recommendations in a report published in December 2020[6], they highlighted Maternity is a high impact area in achieving a universal approach to improving outcomes for mothers, babies and children and ensuring the best start in life. The report specifies six key topics that will impact outcomes based on research evidence, one of which is based on reducing the inequality of outcomes for women from a Black and minority ethnic background. All are based on improving outcomes for all women, there are large areas in England where there is social deprivation and these women are equally disadvantaged in terms of access to health care and achieving good outcomes.

In 2018 NICE[7] published guidance around Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups, this was not specific to pregnancy and childbirth but in particular the statement in relation to equality and diversity considerations is well evidenced in maternity specific publications. Due to language and communication difficulties and poor past experiences of racism and perhaps prejudice, some people from black, Asian and other minority ethnic groups may not engage with services and increase their risk of poor health outcomes, health professionals in maternity services must recognise and promote this when planning services, using a system wide approach.

There are specific recommendations published in September 2021 following the NHS 2021/22 Priorities and operational planning guidance produced in March 2021, called Equity and Equality: Guidance for local Maternity systems[8]. This document describes six interventions for the LMNS to take action on and shows which ethnic group will benefit most from the intervention, this also covers vulnerable groups and socially deprived groups of women. Plus the four pledges made by the NHS to improve equity for mothers and babies and race equality for NHS staff[9] in which they make four pledges. On the back of this each LMNS is required to complete and submit an equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan by 30th September 2021, and then Co-produce an Equity Action Plan by 31st December 2021

Current position in Leicester, Leicestershire and Rutland

This report is to describe what the local maternity & neonatal system is doing in relation to all the national evidence and guidance for health inequalities and poor outcomes for women of a black and minority ethnic background.

Below is a snapshot of the local population by ethnic group, the information describes by ethnic group the percentage of the population who fall in that group up to the age of 24 years. It is very reflective of the population of Leicester as a whole. The national statistics in terms of maternal deaths and ethnicity and the local data that UHL has collected in relation to maternal deaths up to 42 days of birth, all mothers were black Asian or mixed race.

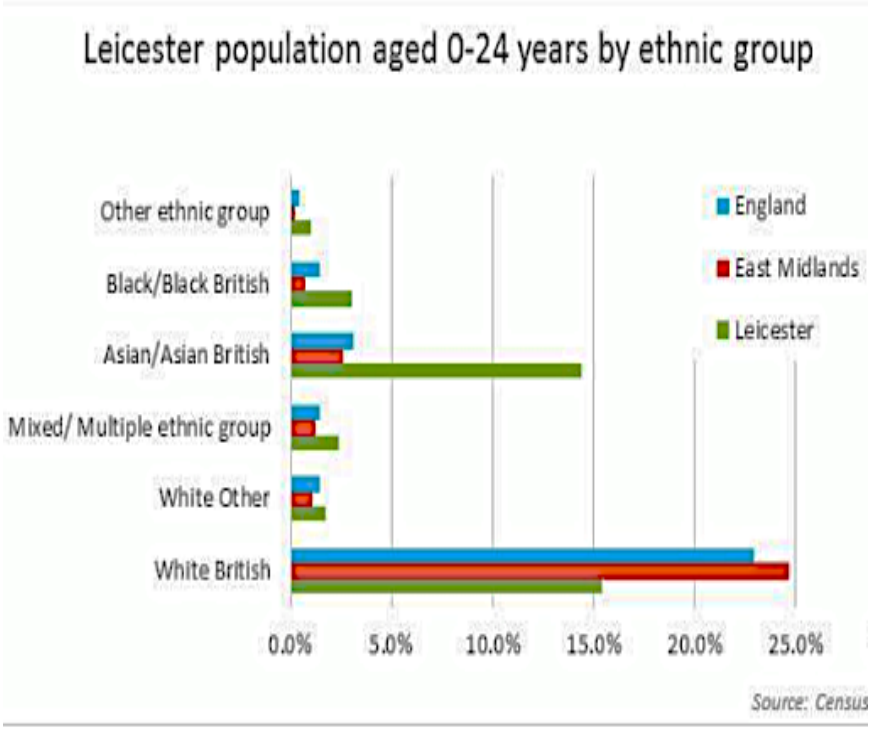
[6] Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies, 2020

[7] Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups. NICE(2018)

[8] NHS, Equity and Equality: Guidance for local Maternity Systems, 2021

[9] NHS pledges to improve equity for mothers and babies and race equality for staff , September 2021, NHS

What is clear when reviewing ethnicity that compared to the rest of the East Midlands and England, there is a significant difference to the national average, of Asian and Asian British group and also larger black and black British group. This suggests that LLR Local maternity system have the opportunity to make a difference in the lives of the women who receive maternity care with the UHL maternity service either in the provider Trust sites or in community. This is not just the responsibility of midwives and obstetricians but the system as a whole, to ensure robust implementation of guidance to improve outcomes.



National Statistics

	Ethnic group				Quintiles of deprivation	
	Black	Asian	Mixed	White	Most deprived	Least deprived
Maternal mortality rate per 100,000 maternities[4]	34.27	14.65	25.14	7.87	15.27	5.70
Number of maternal deaths 2016–18	28	28	8	117	74	15
Relative risk of maternal death	x4	x2	x3	Reference	x3	Reference

Local Data for the past 5 years of maternal Deaths (pregnancy-42 days)

Year	No of deaths	Ethnic group			
		Black	Asian	Mixed	White
2016	2	1	1		
2017	1			1	
2018	1		1		
2019	0	-	-	-	-
2020	1	1			
2021	2	1	1		

Over the past eighteen months these are the actions the maternity system has taken in response to the pandemic and national guidance, in relation to Black women's healthcare equity.

- Launched a continuity of carer team based at a city GP practices, the majority of women in this area are from an Asian or Indian background.
- Produced an informatics poster aimed at women whose first language is not English to encourage them to attend a health professional as soon as possible with any symptoms of Covid, working with members of the Maternity Voice Partnership (MVP)
- Produced a UHL Standard operating procedure to incorporate all the recommendations from the MBRRACE rapid report findings.
- A webinar to raising awareness and discussing health concerns and offering advice in relation to COVID-19 and other health concerns, encouraging women to attend for health and maternity care as soon as possible, this was run by a consultant obstetrician ,matron for community and midwives from the continuity team and discussed in 3 different languages
- Development of a Black and Minority dashboard. In conjunction with mental Health services' Public Health and Neonates, this group was started to identify and understand issues by analysing the local population, understanding the root cause of any disparity and then use the information and learning to design/target interventions accordingly. We believe LLR is the first in the region to undertake this work.
- Raised awareness of the use of interpreters throughout the service, reviewed many different ways of aiding communication with women whose first language is not English. There is now a midwife who is completing a chief nurse fellows programme, the project she is working on is improved communication and interpreting in maternity care
- The LMNS are completing the Equity and Equality analysis following the publication of the four pledges the NHS made to improve equity for mothers and babies and race equality for NHS staff in September 2021. This is to cover health outcomes, community assets and staff experience and set out how we will work in partnership with women and their families to draw up the plans to be completed by the end of November 202. Then submit an Equity and Equality action plan by February 2022
- Following the Channel 4 programme 'Despatches-Black Maternity Scandal' The community midwifery matron and An MVP member were interviewed on the radio to try and assure the local population of the maternity care in LLR and encourage them to seek maternity care early, discuss their concerns and seek interpreting help if needed.

- The Community midwifery matron recorded a video on the benefits of the Covid-19 vaccine with LPT which is on social media (U-Tube)
- The UHL maternity website is in the process of been upgraded, however the current one can be converted into other languages. The upgrade will ensure it is more accessible to all women
- As a system we are committed to delivering the governments ambition 'The Best Start in Life: The First 1001 Critical Days'-The importance of the conception to age two period' and plan to hold our first stakeholder event on the 10th November 2021.

Summary and next steps

A maternal death is a catastrophic event for the family, children are left without a mother and it has long reaching effects on families and also on health professionals, it is a rare event, the mortality rate been around 82 mortalities per 100,000 maternities. In a period of three years, 181 deaths occurred nationally. From the table above in that same 3 year period, there were 4 maternal deaths attributed to the LLR maternities. There is no indication LLR is an outlier for maternal death rates, given the local population.

It is not possible to pin point exactly why maternal mortality rates are higher in women from black and minority groups, there is no one factor that increases the risk. As shown above it is a complex combination of factors, social, physical and psychological. Women must have confidence in maternity services to access care earlier and maintain attendance, they must be facilitated to access health information and encouraged to seek advice.

How the Maternity system do this above and beyond what has been achieved so far, will be led by the results of the Equity and Equality analysis, we will work together to complete a comprehensive action plan and work as a system to implement the actions. When comparable data becomes meaningful from the ethnic Minority Dashboard we can incorporate findings and new indicators and measure results and review if LLR Maternity System is making a difference to the mortality and morbidity of Black and ethnic communities and to the lives and maternity care of vulnerable and socially disadvantaged women. The overall aim is to eliminate maternal deaths, improve the experience of Black and minority ethnic women in maternity services and continue to monitor and embed evidence based research in relation to this population of women

Appendix E

OVERVIEW OF INTEGRATED CARE SYSTEMS

JOINT LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMISSION

16 NOVEMBER 2021

Background

1. The purpose of this report is to provide members with an overview of the Leicester, Leicestershire and Rutland Integrated Care System taking into account recent guidance issued by NHS England and the Health and Care Bill. The paper also sets out what this will mean for Leicester, Leicestershire and Rutland. These changes are still subject to final legislation being put in place.

2. The development of Integrated Care System has been set out in the following documents:

- *Integrating care: next steps to building strong and effective integrated care systems* which was published by NHS England in November 2020. *https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-andeffective-integrated-care-systems-across-england/*
- *Integration and innovation: working together to improve health and social care for* all which was published by the Department of Health and Social Care in February 2021. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-allweb-version.pdf*
- *NHS Operational and Planning Guidance* which was published by NHS England in March 2021 *https://www.england.nhs.uk/publication/2021-22-priorities-and-operational-planning-guidance/*
- *Integrated Care Systems: design framework which was published by NHS England in June 2021. https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf*
- *Health and Care Bill published July 2021* *https://publications.parliament.uk/pa/bills/cbill/58-02/0140/210140.pdf*
- *Thriving Places published September 2021* *https://www.england.nhs.uk/publication/integrated-care-systems-guidance/*

The changes are subject to the Health and Care Bill being approved by Parliament.

What does this mean for Leicester, Leicestershire and Ruland?

3. Integrated Care Systems are focused on three levels, System, Place and Neighbourhood and how health, care and wider partners can work together to improve outcomes and reduce inequalities. Working at Place and Neighbourhood is key to achieving this and the slide deck attached as Appendix One sets out what we have achieved in Leicester and the next steps.

Officer to Contact

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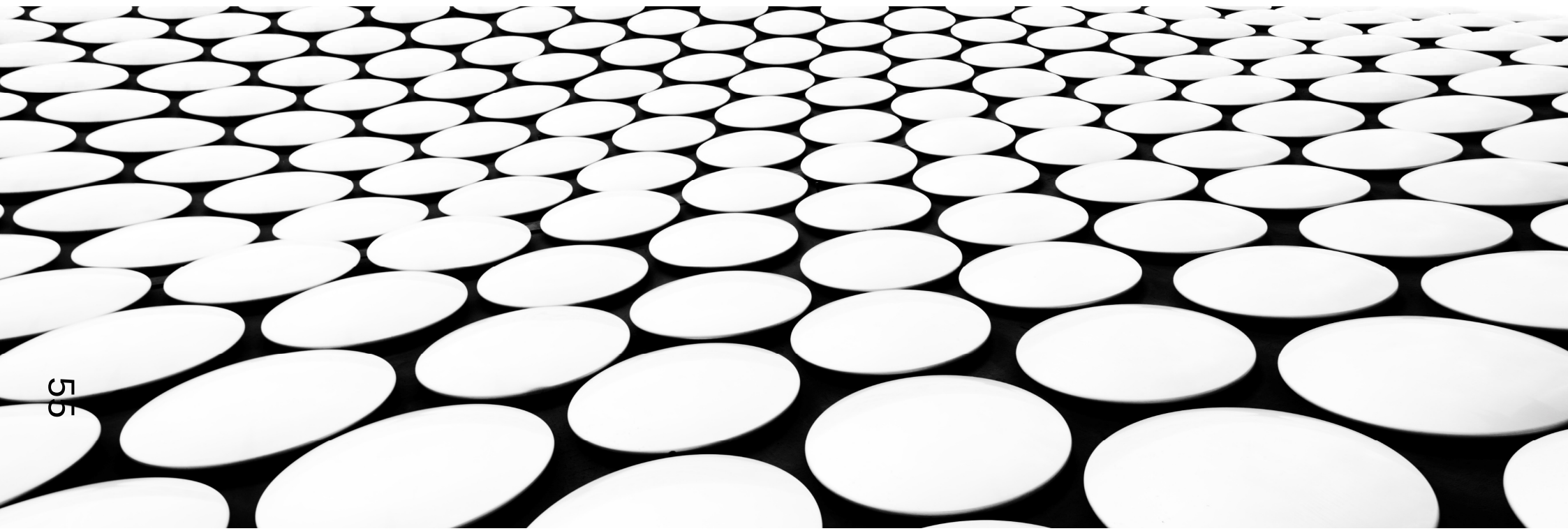
0116 2951519 – sarah.prema@nhs.net



Appendix D

DEVELOPING THE LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEM

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 16TH NOVEMBER 2021

TEGRATED CARE SYSTEMS – WHAT ARE THEY?

bling transformation of health and care:

- Joining up and co-ordination of health and care
- Proactive and preventative in focus
- Responsive to the needs of local populations

unded in the following:

- Planning for populations and population health outcomes and reducing inequalities and unwarranted variation
- Building on system and place based partnerships
- Subsidiarity and local flexibility
- Collaboration

grated Care Systems will:

- Improve outcomes in the population
- Tackle inequalities in outcomes, experience and access
- Support partners input into the broader social and economic development of the area through an anchor approach
- Enhance productivity and value for money

WHAT WILL BE THE DIFFERENCE WITH INTEGRATED CARE SYSTEMS?

- **Removing barriers:** enabling organisations to work collaboratively by removing barriers to better co-ordinate transform and deliver services resulting in improved outcomes and or experience.
- **Easier to provide seamless care:** to a growing older and multi-morbidity population. The ICS will allow us to remove barriers and better co-ordinate the work of general practices, community services, social services and hospitals to meet people's needs.
- **Improves our ability to tackle health inequalities and implement preventative care:** enabling the NHS and local authorities and other partners to work together to better address social, economic, and environmental determinants of health.
- **Better use of resources:** we can more easily pool and share staff, knowledge, technology, data, expertise and financial resources.
- **Reduce duplication:** the better use of resources should also reduce duplication, thereby makes the most efficient use of the limited resources available.
- **Greater flexibility:** funding will be allocated at system level bringing greater flexibility on how this is used to support transformation and delivery of services.

OUR SYSTEM

Integrated Care System: Leicester, Leicestershire and Rutland

Place

58

- Leicester
- Leicestershire
- Rutland

Neighbourhoods

Place	Local Integration Hubs
Leicester	Central; South; North West; North East
Leicestershire	North West Leicestershire; Hinckley; Blaby & Lutterworth; Charnwood; Melton & Rutland; Harborough, Oadby & Wigston
Rutland	Rutland

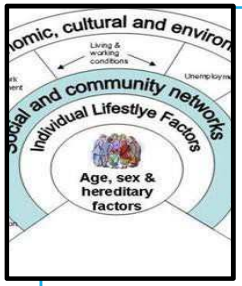
WHAT DOES THIS MEAN FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

This is not a new approach – it is a continuation of what we have been doing:

Understanding and working with communities – using JSNA, other information and public insights to drive improvements in health and wellbeing

Population health management approach – to support improvement in outcomes, enable better joined up care and impact on health inequalities and wider determinants of health

Joining up and coordinating services – developing an integrated plan for each place which improves outcomes – both at place and neighbourhood



Addressing social and economic determinants of health and wellbeing and reducing health inequalities – how we can use the assets of the local public sector to improve outcomes and reduce inequalities

EXAMPLES OF WHAT WE HAVE BEEN DOING IN LEICESTER, LEICESTERSHIRE AND RUTLAND TO INTEGRATE SERVICES

Home First: an integrated service to respond to people who are risk at being admitted to hospital

Mental Health: integrated teams working alongside GP practices focused on patients with Long Term Conditions

Discharge: integrated work between social care and acute services to reduce discharge delays

Co-location: social Care and community services co-located improving patients care through better co-ordination

Care Navigation: neighbourhood-based team working to support people in a range of areas – health; social care and wider services

Voluntary Sector: joint work with a number of voluntary sector organisation to provide support to particular groups

PRIORITIES FOR INTEGRATION AND TRANSFORMATION IN LEICESTER, LEICESTERSHIRE AND RUTLAND

Neighbourhood Teams: develop further the integrated team offer – primary care; social care; community care; voluntary sector

Health Inequalities: implement the local health inequalities investment fund

Joined Up Data: improve the sharing and quality of data across health and social care

Communities: build on the joint community based work undertaken during COVID to support health and wellbeing

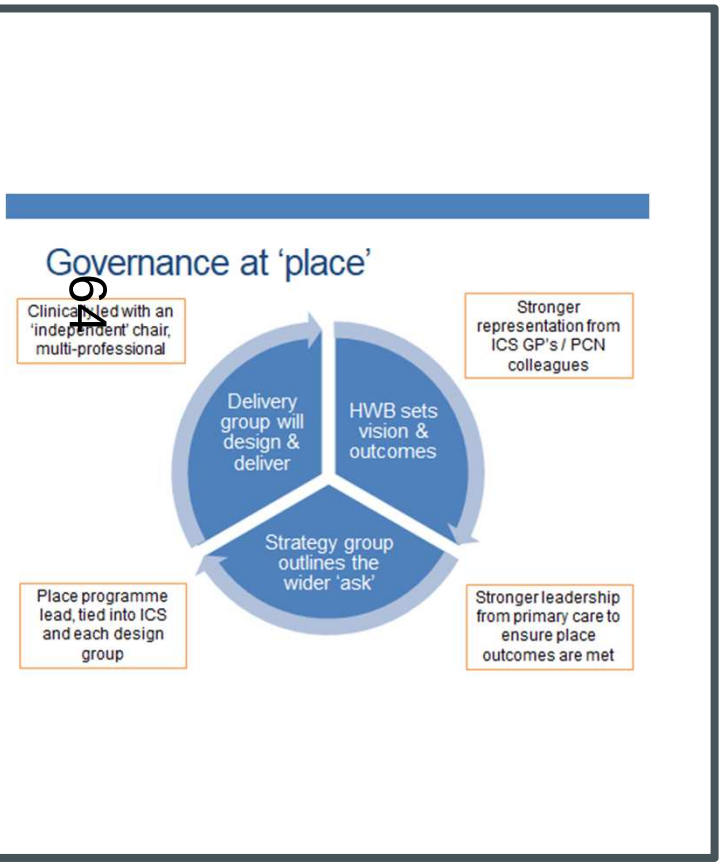
Mental Health: embed mental health services at a local level

Health and Wellbeing: refresh the Health and Wellbeing Strategies

OVERVIEW OF ICS INFRASTRUCTURE

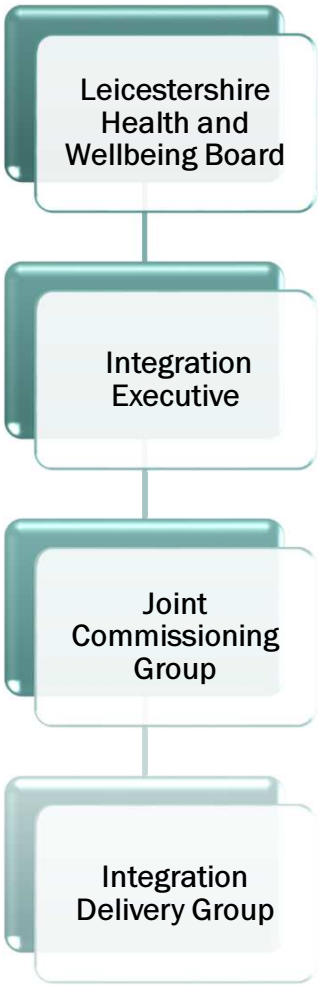
PLACE

HIGH LEVEL RESPONSIBILITIES OF EACH PLACE GROUP

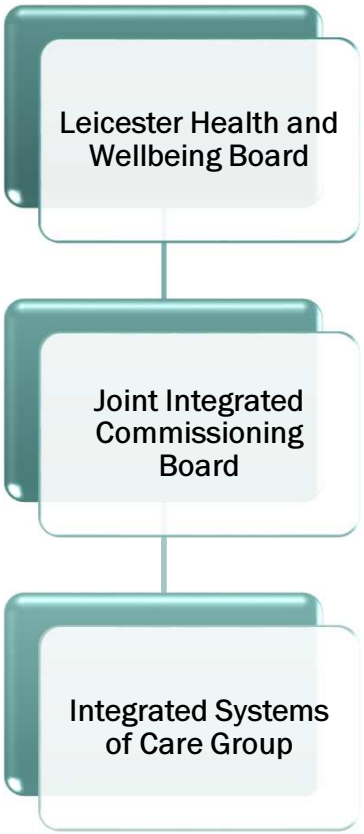


- Our **Health and Wellbeing Boards** will develop strategic plans for the improvements in population health and wellbeing at Place level.
- **Strategic Partnership Groups** will develop operational plans to enact the strategy.
- Delivery will be led by each of the **delivery groups**, with accountability to the place-led Strategic Partnership Groups. The delivery group will also be responsible for any neighbourhood and sub-neighbourhood modifications, based on local intelligence and need.

DRAFT PLACE BASED GOVERNANCE



Leicestershire



Leicester

Rutland

SYSTEM INFRASTRUCUTRE

SYSTEM INFRASTRUCTURE

Integrated Care System

working together for everyone in Leicester, Leicestershire and Rutland to have healthy, fulfilling lives

LLR ICS NHS Board

(takes on CCG statutory responsibilities)

- Day to day running of the ICS including strategic planning, allocation decisions and performance
- Develop a plan to address the health needs of the population
- Set strategic direction for the system
- Develop and deliver revenue and capital ensuring value for money and enhancing productivity
- Secure the provision of health services

Integrated Care Partnership

- Equal partnership across health and local government
- Facilitate joint action to improve health and care services and to influence the wider determinants of health and support broader social and economic development.
- Develop an integrated care strategy covering relevant health and care aspects, addressing inequalities and tackling the wider determinant of health and wellbeing. This will align with the strategic plans of the Health and Wellbeing Boards.

PROGRESS AND NEXT STEPS

Progress	Next Steps
✓ Designate Chair in place ✓ Discussions in relation to Integrated Care Partnership role and membership have taken place – proposals being finalised ✓ Place arrangements discussed ✓ Draft governance for Integrated Care Board ✓ Development of governance documents underway ✓ Resources and plan in place to manage the transition from CCGs to ICB ✓ ICS Purpose, Principles and Priorities agreed ✓ Clinical leadership proposals being developed	❑ Complete Executive recruitment ❑ Complete Non-Executive Director appointments ❑ Finalise and approve ICB governance and related documents ❑ Finalise and approved ICP governance ❑ Finalise and approve place arrangements ❑ Continue with due diligence work ❑ Progress detailed plan to close down the CCGs and establish the ICB ❑ Finalise clinical leadership within the ICS ❑ Continue to develop our approach to collaborative working

Leicester, Leicestershire, and Rutland Joint Health Scrutiny Committee

Work Programme – 2021/22

Date	Topic	Actions arising	Progress
6th Jul 21	1. Analysis of UHL Acute and Maternity Reconfiguration consultation results 2. Covid-19 Vaccination Programme Update	1. The consultation findings were published on 8th June 2021. 2. Update requested at Mar 2021 meeting	Completed
13th Sep 21	1. Progress Report on the Transition of Children's Services from Glenfield to Kensington 2. Dental Services in Leicester, Leicestershire, and Rutland; NHS England & NHS Improvement Response to Healthwatch SEND Report. 3. COVID19 & Autumn/Winter Vaccination Programme 4. Verbal Update on UHL Reconfiguration 5. ICS Board - Verbal Update	3. Standing item as of August 2021 and a brief update on the A/W Vaccinations Report	Completed
16th Nov 21	1. COVID19 and the Autumn/Winter Vaccination Programme (standing item) 2. Updated Report on Dental Services in LLR; NHS England & NHS Improvement Response to Healthwatch SEND Report 3. Black Maternal Healthcare and Mortality 4. Leicester, Leicestershire, and Rutland Integrated Care System AOUB or Chair's Announcements: UHL finances and misstatement of accounts – Members Briefing for Dec 21		

Appendix F

Date	Topic	Actions arising	Progress
28th Mar 22	1. COVID19 & Vaccinations update (standing item) 2. Report on UHL Finances and Accounts for 19-20 and 20-21 3. Findings and analysis of Step Up to Great Mental Health Consultation - Leicester, Leicestershire, and Rutland 4. EMAS - New Clinical Operating Model and Specialist Practitioners 5. UHL: report on responding to waiting times and backlog 6. Transforming Care in Leicester, Leicestershire, and Rutland - Learning Disabilities Update	Item 2 will be discussed following a Members Briefing planned for December 2021 once audit reports are released. Item 3 has been deferred to March 2022 provisionally, until a suitable alternative date is found. Item 4 was due to be discussed in December 2020 but had to be deferred due to insufficient time. Item 5 was a request from Cllr Hack following the last update at October 2020.	

Prospective Items

Agenda item	Organisation/Officer responsible	Notes
1. EMAS - New Clinical Operating Model and Specialist Practitioners	Russell Smalley, EMAS	This item was on the agenda for the meeting on 14 December 2020 but Russell was unable to present the report so the Chairman suggested the item could come back to a future meeting.
2. Update on dental services and response to Healthwatch report on children with SEND.	Thomas Bailey, NHS England	This item was on the agenda for the meeting on 14 December 2020 but Thomas was unable to present the report so the Chairman suggested the item could come back to a future meeting.
3. Community Services/Place based plans overview	Tamsin Hooton, CCGs	It was intended that the high-level strategy would come to the Joint HOSC and the detail on individual areas such as Hinckley/Lutterworth would come to individual HOSCs.
4. Progress Updates on the UHL Acute and Maternity Reconfiguration Proposals	CCGs/UHL	Analysis of the UHL Acute and Maternity Reconfiguration Consultation results was taken at the July 2021. Progress updates are expected at future meetings for: - - The transition of Children's Services from Glenfield to Kensington - Update on the co-located design work for the standalone midwife let unit - Details of the emerging strategy and patterns of activity to be developed in relation to primary care
5. Neuro – Rehabilitation services	CCGs/UHL	Kathy Reynolds asked a question at the JHOSC meeting on 14 December 2020 about Neuro – Rehabilitation services and the Chairman promised to have it on the agenda of a future meeting.
6. LLR NHS System Workforce Group/ Recruitment and Retention/NHS People	Louise Young, CCGs	The County members wanted an agenda item on NHS workforce to cover recruitment and wellbeing of staff going forward. We thought this was a good item to have at Joint HOSC.

Agenda item	Organisation/Officer responsible	Notes
Plan/Mental Health of workforce		
7. Transforming Care – Learning Disabilities and Autism progress update	County/City Council and LPT	This issue came to the meeting on 15 October 2020 and members requested a progress update at a future meeting.
8. UHL finances and misstatement of accounts	UHL	At the meeting on 5 March 2021 it was agreed that UHL would come back to the JHOSC with further updates regarding the actions taken to address the financial issues. This is planned for March 2022, with a Members Briefing beforehand in Dec 2021.
9. Black maternal healthcare and mortality	UHL or CCGs – to be confirmed.	Email discussion regarding the national interest in this issue (MPs debated a petition relating to this on 19 April 2021) and both City and County interest in looking at this issue locally and how mortality rates can be improved.
10. Covid-19 Vaccination Programme Update	CCGs	March 2021 - LLR CCGs be requested to provide a further update to the Committee regarding the areas of Leicester, Leicestershire, and Rutland where vaccination uptake had been comparatively low and reasons behind this.
11. Leicester, Leicestershire, and Rutland Integrated Care System	CCGs	LLR CCGs successfully applied to become one single CCG by 31st March 2021 ready for organisational change on 1st April 2022. This update is planned for November 2021, with an initial verbal update given in September 2021.
12. Findings and analysis of the Step Up to Great Mental Health Consultation - Leicester, Leicestershire, and Rutland	CCGs	Consultation (ends 15 August 2021) about proposals to invest and improve adult mental health services for people in Leicester, Leicestershire, and Rutland when their need is urgent, or they need planned care and treatment. Agreed that an item on this while the consultation is live, is not required for this Commission as sufficient engagement is being conducted with Members individually for this.

Agenda item	Organisation/Officer responsible	Notes
13. UHL: report on responding to waiting times and backlog	UHL	A report to be circulated to Commission Members by the end of the summer. This will determine which meeting this should go to.
14. Autumn/Winter Vaccination Programme Report	CCGs	Referenced in the July 2021 minutes as a report for the next meeting and is now a standing item for this municipal year.
15. Progress Report on the Transition of Children's Services from Glenfield to Kensington	UHL	Specifically referenced in the July 2021 minutes as a report for the next meeting. Completed as of September 2021.