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

DATE: **MONDAY, 27 JUNE 2022**
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 Pantling (Chair of the Committee)
Councillor Aldred
Councillor O'Donnell
Councillor Dr Sangster
Councillor Khan
Councillor Pandya
Councillor Westley

Leicestershire County Council

Councillor Morgan (Vice-Chair of the Committee)
Councillor Ghattoraya
Councillor Hills
Councillor King
Councillor Harrison
Councillor Charlesworth
Councillor Newton

Rutland County Council

Councillor Ainsley
Councillor Waller

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

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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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 AND APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING 28 MARCH 2022 **Appendix A (Pages 1 - 18)**

The minutes of the meeting held on 28th March 2022 are attached and the Committee will be asked to confirm them as a correct record.

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

5. COMMITTEE MEMBERSHIP 2022-23

Members are asked to note the membership of the committee for 2022-23 to note as follows:

City Council representatives
Cllr Elaine Pantling (Chair)
Cllr Gary O'Donnell
Cllr Teresa Aldred

Cllr Shahid Khan
Cllr Vandeviji Pandya
Cllr Dr Deborah Sangster
Cllr Paul Westley

County Council representatives
Mr Jonathan Morgan (Vice Chair)
Mr Phil King
Mr Fula (Kamal) Ghattoraya
Mr Ross Hills
Mr Dan Harrison
Mrs Betty Newton
Mr Michael Charlesworth

Rutland County Council representatives
Cllr Gale Waller
Cllr Paul Ainsley

6. TERMS OF REFERENCE **Appendix B (Pages 19 - 26)**

Members are asked to note the Terms of Reference and working arrangements for the Committee as attached at Appendix B.

7. DATES OF MEETINGS 2022-23

Members are asked to note the dates of meetings for 2022-23 as follows:

- Monday 27th June 2022 at 5.30pm
- Wednesday 16th November 2022 at 12 noon
- Wednesday 12th April 2023 at 5.30pm

8. PETITIONS

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

9. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

10. DENTAL SERVICES UPDATE / NHS ENGLAND/IMPROVEMENT **Appendix C (Pages 27 - 64)**

Members to receive a report and presentation updating on Dental Services across Leicester, Leicestershire and Rutland to include coverage; access and recovery following the impact of Covid 19 along with data on tooth decay rates.

11. UPDATE ON UHL FINANCES AND ACCOUNTS FOR 19-20

An update will be provided to the meeting on the UHL Finances and Accounts for the financial period 2019-20 following the UHL process in approving the 19-20 accounts at their separate Board meetings recently.

12. LEICESTER LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEMS UPDATE **Appendix D (Pages 65 - 84)**

Members to receive a report providing an update following the Health and Care Act receiving Royal Assent on progress with the transition of organisational arrangements before the implementation date of 1st July 2022.

13. COVID 19 VACCINATION PROGRAMME UPDATE

Members to receive a verbal update on the status of the Covid 19 vaccination programme.

14. MATERNITY SERVICES REPORT **Appendix E (Pages 85 - 128)**

Members to receive a report providing assurance that the LLR Local Maternity and Neonatal System (LMNS) have addressed the immediate and essential actions in relation to the Interim Ockenden Report published in December 2020 (Part 1).

15. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA

None notified.

16. WORK PROGRAMME **Appendix F (Pages 129 - 132)**

Members will be asked to note the work programme and consider any future items for inclusion.

17. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

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

Held: MONDAY, 28 MARCH 2022 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 March
Councillor Fonseca
Councillor Pantling
Councillor Whittle
Councillor Poland (substitute)
Councillor Grimley
Councillor King
Councillor Hack
Councillor Smith
Councillor Powell
Councillor Waller

In Attendance
Andy Williams Chief Executive ICS
David Sissling Chair ICS
Richard Lines EMAS
David Williams Exec Director LPT
Dr Janet Underwood Healthwatch
Richard Mitchel Chief Executive UHL
Harsha Kotecha Healthwatch
Richard Morris ICS
Caroline Trevithick LLR CCG
Jo Mckenna LLR CCG

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53. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Morgan and, Ruth Lake - Director of Adult Social Care.

It was noted that Councillor Poland was in attendance as a substitute for Councillor Morgan.

54. DECLARATIONS OF INTEREST

Members were asked to declare any pecuniary or other interest they may have in the business on the agenda.

Councillor Hack declared an interest in that she worked for Advance Housing and Support in the Housing division providing accommodation and support in the Leicester, Leicestershire and Rutland area for individuals with Learning Disabilities and Mental Health Disabilities.

Councillor King declared an interest in that he was involved with the Carers Centre Leicestershire, a local charity providing help and support for unpaid carers across Leicester, Leicestershire, and Rutland.

For the purpose of discussion and any decisions being taken they retained an open mind and were not therefore required to withdraw from the meeting.

55. MINUTES OF PREVIOUS MEETING

It was noted that the minutes of the meeting held Tuesday 16th November 2021 omitted to include the presence of Councillor Waller and Councillor Pantling who were both present.

It was also noted that the minutes of the meeting held Tuesday 15th February 2022 omitted to include the presence of Councillor Pantling who was present.

AGREED:

That subject to an amendment to correct attendance of Members as referred to above, the minutes of the meetings held on Tuesday 16th November 2021 and Tuesday 15th February 2022 be confirmed as an accurate record.

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

None outstanding.

57. CHAIRS ANNOUNCMENTS

The Chair announced a change to the running order of the agenda and agreed to take the Item Re-procurement of the Non-Emergency Patient Transport Service (NEPTS) as the next substantive item of business.

58. PETITIONS

The Chair informed those present that the response to the ICS Constitution petition submitted at the last meeting would be received as part of the substantive item Integrated Care System Update.

59. RE-PROCUREMENT OF THE NON-EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS)

Members received a presentation providing details around the re-procurement of the Non-Emergency Patient Transport Service (NEPTS)

Joanne McKenna, Head of Contracts and Procurement, LLR CCG introduced the presentation noting that certain details remained commercially sensitive and drew attention to the following points:

- Non-emergency patient transport within Leicester, Leicestershire and Rutland was currently provided by Thames Ambulance Service Ltd (TASL) providing around 15000 journeys per year. The current contract was due to end in September 22 but was being extended to enable feedback from stakeholders and to fully consider improvements for the new service.
- The new procurement was aimed at bringing services together to improve both quality of service to all patients and flow of patients through the healthcare system.
- Feedback was being sought from patient and service users as well as by provider engagement using a variety of tools e.g., online surveys, patient QAs, and discussions with service referrers; that feedback would be used to support the service specifications and a complete data report would be produced in April 2022.
- Internal stakeholder engagement showed there were good and bad experiences with the current system; generally service users had good relations with the drivers however the downside included long waits for journeys, resources not matching peeks in activity; delays in collecting discharges for time critical patients, patient appointments overrunning and the knock on effect of that on other patient services.
- The new contract would seek to include real-time patient updates to address issues of waiting, journey delay and pick-ups.
- Local guidance was also being developed to improve the user experience taking account of recently reviewed national guidelines.

Members discussed how the service would change; the improvements for patients; increased flexibility and the eligibility criteria as set out in the presentation.

Members noted the transport provision needed to be reflective of patients' needs and to progress with them. It was hoped that the frictions and issues experienced previously would be reduced through the long mobilisation phase of the procurement process. In terms of service change, it was advised response transport would be wrapped into the system such as Emergency Services as well as Outpatient Services, and providers would have to have special awareness and establish their own patient participation groups to understand the proposals, delivery plans, expectations etc.

Concerns were raised about the eligibility criteria: the lack of information/data in

that regard; the uncertainty around patients who had transport initially but not later; and ensuring the eligibility criteria was broad and inclusive.

Members were informed that NHS England and NHS Improvement had established a team to review and help standardise the approach in this area and they had developed updated national eligibility criteria following the published outcome of a review into non-emergency patient transport services (NEPTS). That was consulted upon in Autumn 2021 and the criteria was subject to final stages of development before publication of a final report in Spring 2022. Indicators were that the proposed new criteria were broadly consistent with LLR local eligibility criteria. The patient criteria may change, and a personalised approach could be adopted however the final procurement pack would feature all of these details and should be available by end April 2022.

In relation to the level of journeys commissioned each year, the new contract was bidding for 15,200 journeys but there was also a building in of growth through modelling of tenure of service and it was expected that the biggest area of growth over the period of the contract would be for patients travelling to and from renal dialysis.

In terms of cross border patient journeys, it was advised that the transport provider was responsible for all LLR users no matter where they were going however, it was noted that there were not always reciprocal arrangements in place with other areas.

As regards the procurement exercise, state of market and commercial viability, the CCG couldn't go into a great level of detail at this stage due to commercial sensitivity, however, sift testing showed that four or five national providers were likely to be interested and it was accepted that recent economic changes, cost of living and fuel increases were likely to be a factor in the process.

Discussion moved on to some of the challenges of transporting patients and how that was addressed. As to the flexibility of transporting patients and being able to cope with sudden changes or patient needs the service were looking to improve booking facilities and introduce online options to provide flexibility.

Regarding the longer term provision of transport for patients and the issue around patients ongoing mobility, the draft eligibility criteria referred to receipt of certain benefits, but the CCG were trying to avoid that being fixed and were looking to build into the service provision to take account of people at the time for a more holistic approach.

Consideration was given to ensuring a patients dignity and discussion progressed into complaints processes noting that patients did come to the CCG to raise complaints e.g., if they felt they had not been treated with dignity and they were supported by the CCG to try and reach a solution. The procurement specification would also build in clinical appeals process which would improve that part of the service too.

As for complaints about service delivery, those could also be sent to the

transport provider and there would be an opportunity to raise that externally if a service user was unhappy about the service and/or response from the provider. The Transfer of Care Initiative also gave the opportunity for people to raise concerns at handoffs and through system interface.

In relation to the engagement and feedback processes it was noted that the CCG had reached out to people using online surveys and had run focus groups for anyone to attend, this included young people however, there would be more engagement activity over the next month and the CCG would take back the point to engage with young people more.

The Chair summarised the points made, thanking officers for the presentation and drew discussion to a close.

AGREED:

1. That a copy of the final procurement pack containing eligibility criteria be shared with Members of the Committee as soon as it is available;
2. That the CCG take steps to ensure they involve young people in their processes to capture their voice around service provisions;
3. That the CCG provide Members of the Committee with a flow chart of the decisions being made to help understanding;
4. That an update report providing details of progress with the procurement exercise be brought to the Committee for November 2022.

60. QUESTIONS OR REPRESENTATIONS

The Chair explained the procedure to be followed and took public questions as follows:

From Steve Score: Will the public be consulted on the draft integrated care board constitution before it is finalised?

From Sally Ruane on behalf of Kathryn Jones: I have been trying unsuccessfully to find the papers taken by the shadow Integrated Care Board meetings in the papers for the CCG governing body meetings and am concerned about the lack of transparency. Please could you tell me where they can be found?

From Sally Ruane: Will the ICS Chair guarantee that the Integrated Care Board or any other local commissioner will pay for the emergency health care, including ambulance services, required by all people in its geographical area even if some of those individuals are visiting from other parts of the country?

The Health and Care Bill makes reference to the group of people for whom each integrated Care Board has core responsibility. Will the ICS Chair pledge that the Integrated Care System in Leicester Leicestershire and Rutland will abide by the principles of comprehensive and universal health care?

From Kathy Reynolds (read by the Chair on her behalf): At a previous meeting the LLR ICS explained that councillors were explicitly banned from sitting on

integrated care boards. In the House of Lords on 9th February Health Minister Lord Kamall, announced that NHS England will revise its draft guidance to remove the proposed blanket exclusion of councillors sitting on integrated care boards. What does this mean for the membership of the LLR ICS Board?

We know that the Designate CEO and Designate Chair have been appointed, have any other Designate Members been appointed and how will the selection process for board members change to allow selection of councillors?

From Godfrey Jennings: Please could you tell me why the draft integrated care board Constitution has not been to the joint health overview and scrutiny committee as is happening in several other parts of the country where good practice is being observed. When will the draft be brought to this committee before it is finalised?

From Jean Burbridge: At the January meeting of the Leicester City Health & wellbeing Scrutiny Committee, I asked the question whether social enterprises would sit on the Integrated Care Board and/or ICS Partnership. I have since discovered that there is already a social enterprise (namely DHU Health Care) represented on the shadow integrated care board, but I was not given this information in the response to my question. Please could you let me know if there are plans to include other social enterprises or "independent organisations" on the Integrated Care Board in either shadow or full form?

Andy Williams Designate CEO, ICS responded to the public questions as follows:
The LLR ICB constitution was based upon the national model and was still being developed. The national model was available on the NHS website and the only substantive change suggested to that was to broaden membership so it could include availability for local government representatives and local partners.

From April 2022 the board meetings would take place in public. ICS was not proposing to consult beyond what they had done already as they were following the national consultation and its outcomes. In relation to the shadow ICB meetings, minutes of those were taken through the LLR CCG and were available to the public.

Regarding councillors being included in the membership, the regulations had changed to enable this, and the selection process would be up to the local authorities/partner organisations to appoint their representees and further guidance was awaited around this.

In addition to the Designate CEO and Designate Chair appointments the ICS had appointed non-executive Directors and chosen their preferred candidates for remaining executive roles. The ICS were still awaiting government legislation before making partners.

Regarding social enterprises, DHU Health Care were a partner in the original CCG and shadow ICS arrangements however, that would not formally continue

once the board was established. It was noted that whilst they would not be part of the board when it went live, organisations like DHU Health Care were an important part of the system and positive engagement with them was necessary.

In terms of who paid for emergency health care, including ambulance services, required by people in a geographical area, there was already clear guidance around that; as a general rule the ICB would pay regardless of where persons were treated, however there were some exceptions. Core comprehensive and universal health care would be bound by the Bill and the ICS would work within that.

David Sissling, Chair of ICS then addressed a couple of points and commented that interest in the ICB's constitution was understandable, but it was a work in progress and subject to national guidance, however the ICS would be happy to share the template and invite observations in due course.

As to meetings, so far, the ICS had met as a partnership not as a board and were trying to progress as much as possible in shadow form with membership, structure etc before convening as a board from April 2022. ICS were already demonstrating that the quality of work was enhanced by collaboration and relationships were strong.

The Chair invited any supplementary comments/questions which included the following:

From Steve Score: the ICS/ICB was a major change to the way the NHS is run and making details public about board meetings was not the same as a full public consultation. It was suggested that wider involvement of the public would be better from the point of transparency.

Sally Ruane on behalf of Kathryn Jones noted frustration that Leicester City Health & Wellbeing scrutiny was informed papers of the shadow ICB meetings were in public domain and noted the clarification that the public could access minutes through CCG but not papers.

Sally Ruane expressed concerns around emergency care not being covered by the Bill and other possible gaps and sought to have categoric assurance that emergency care and ambulances would be fully covered by the Bill and that the ICB would pay. There was also concern about new core responsibilities, what that meant and whether it pointed towards core services and shrinkage if some services were not defined as core.

Andy Williams responded to the supplementary points that the ICS had tried hard locally to engage with people in the description and discussion of changes taking place, however this was totally driven by the national statutory agenda over which ICS has no discretion and where there has been any discretion and the ICS were minded to exercise that they have engaged on that before making initial submission e.g., more representation on the board.

Regarding access to papers, it was confirmed the minutes of the shadow board meetings are available through the LLR CCG and from April 2022 all papers will be made available as the ICB meetings will be held in public.

In relation to emergency care the scope and remit of ICB will be determined in the final analysis of legislation. There was no reason to believe there was any intent to be unclear on budgets or funding for emergency care and there was no intention for ambiguity. The core responsibilities were a matter of drafting and for government to determine the remits of ICB, but the ICS was not aware currently of any attempt to use this to restrict access to services.

The Chair expressed concern that this committee was being taken up with question/answer sessions that should really be de facto fulfilled by the ICB and queried whether there would be facility at the ICB meetings to include a mechanism for public questions. David Sissling, Chair of ICS confirmed that intention was one of the first matters for board to facilitate public question and answers or appropriate arrangements at meetings and during the preparatory period the board would discuss that point. The Chair welcomed that transition moving forward and thanked representatives of ICS for their responses.

61. INTEGRATED CARE SYSTEM UPDATE

Members received a report providing an update on progress towards the Leicester, Leicestershire and Rutland Integrated Care Board.

The Chair invited Members comments which included the following points:

Concerns were expressed about accessibility of documents, and the impact of that, for example limiting the opportunity for disabled people to respond to consultations/engagements so losing a valuable voice. A request was also made to ensure that all future reports and documents submitted to this committee were fully accessible not just easy read.

Andy Williams Designate CEO of ICS apologised for the difficulties with accessibility of all documents and agreed to investigate this issue as the ICS was keen to avoid disenfranchising any groups.

Concerns about how the voluntary sector would be engaged considering the gap in voluntary sector emerging across LLR were noted and the ICS would reflect further as to whether there was more, they could do to strengthen that.

In relation to engagement with non-public bodies, the ethos was to move towards integrated care systems and away from tendering/market based procurement however, for a variety of reasons there was a lot of important involvement with organisations, and they tried to do that appropriately. Relations with all partners were important to deliver services, including with private sector, and there would be times when the ICS needed to work in active partnership with non-public bodies, but they wanted to be very transparent around that and it was not envisioned there would be any non-public body

involved in governance or as part of the ICB, that included any it's sub-committees. In respect of service delivery or bringing something back within public delivery that was a possibility for ICS, but it had to be what was in interest of the public, and the ICS would have greater discretion moving forward.

In terms of councillors being able to sit on ICB, the board was being formed to include local authority membership and the three local authorities (Leicester, Leicestershire, and Rutland) would determine their own nominations whether that be councillors or a specific role/officer.

Andy Williams confirmed that it was intended for the Healthwatch Chairs across LLR to be invited to ICB meetings as non-voting members.

The Chair thanked Andy Williams for the update.

AGREED:

That the contents of the report be noted.

62. COVID 19 AND VACCINATION PROGRAMME UPDATE

Caroline Trevithick of LLR CCG provided an update on the ongoing situation with Covid 19 and the vaccination programme including recent data and emerging patterns across Leicester, Leicestershire, and Rutland.

Members noted that:

- Uptake had slowed considerably and focus was on progressing vaccination uptake among those in population that haven't had any vaccination; steps taken included opening more drive through centres i.e., at County Hall and across parts of the city and districts to make vaccination process more accessible.
- Roll out of the 2nd booster (4th dose) to over 75 years had started and those clinically vulnerable who had 3rd dose were now eligible for a 4th.
- Planning for Autumn was underway as well as for roll out of boosters should that be required.
- There were still some high numbers of covid patients in hospital and people being tested positive in hospital as a secondary issue.
- Uptake among 5-11 year olds was proving difficult as there was a lower willingness for parents to allow children to be vaccinated.
- 81% of population of LLR had now received a 1st dose and care home uptake was the best in region for boosters however, there were significant differences spread across LLR and it was agreed to share data by CCG cohorts for City, County East and West.

The Chair noted that there had already been significant discussion on this topic at the recent Leicester Health & Wellbeing Scrutiny Committee and invited Members questions and comments which included the following points:

Concerns were expressed at the low uptake levels among younger age groups, the lack of information being provided to parents to help them make informed

choices about the pros and cons of the vaccination and the scarce details around immunity e.g., in younger people that had already had Covid or for those that had a vaccination some time ago.

In response it was advised as regards the 5-11 year old group there was national recognition that delivery of vaccination in schools puts lots of pressure on small immunisation teams and stops parents getting their child vaccinated when they want so there was a different model being applied. There remained a vaccination programme in secondary schools and for any 11-12 years that missed the 1st programme details were on CCG websites about catch up vaccinations. As for pros/cons of vaccinating the main message remained that vaccination helped reduce the spread and severity of the illness particularly amongst those more vulnerable.

In terms of immunity, the understanding was that for those over 75 years immunity does wain at around 6 months and so boosters were encouraged.

It was acknowledged that messages around Covid had gone quiet nationally and locally and the CCG were looking to fill the communications gap. There was a large amount of concern about anti-vaxing and the impact of that on other vaccine programmes across the country and CCG were also looking at systematic targeted approaches to address that.

The Chair thanked health partners for the update and recommended colleagues to read the recent report to the City Health & Wellbeing Scrutiny Committee by Ivan Browne.

AGREED:

That data by CCG cohorts for City, County East and West be shared with the Committee.

63. UPDATE ON GENERAL ACTIVITIES AT UNIVERSITY HOSPITALS LEICESTER

Richard Mitchell, Chief Executive Officer at university Hospitals Leicester (UHL) was introduced to the Committee as the Chief Executive in post since October 2021.

Richard Mitchell provided a verbal update around 5 themes which included the following points:

Covid

There were currently 210 patients in UHL across 10 wards, of these 85% were presenting with Covid as a secondary diagnosis. As for staff, 10% were currently off with Covid too.

Waiting Lists

Acknowledged that waiting times had deteriorated and had been worsened during the Covid situation. Some progress had been made over last 6 months

to reduce the waiting times for Elective Care although given length time of closures there were still very high volumes and Leicester was amongst worse in country and they were looking to address that.

Emergency care performance had been very challenged at Leicester; Covid was still making it more difficult, and the hospital was focusing on discharge pathways to improve the situation.

In relation to cancer care patients were waiting longer than pre-covid, however waiting times were overall within the safety marker but the hospital was keen to get back to where they were and to improve.

Senior Staffing

There had been a number of changes since October 2021 with Richard Mitchell taking up the CEO role following John Adler's retirement. Three executive director vacancies had also been recruited to and 4 non-executive directors had joined. The Board chaired by John McDonald were looking to fill other senior appointments over next 3 months.

UHL Finances

The annual accounts for the financial year 2019-202 were still not signed off, although they had now been presented to the audit board and were due to be taken to the public board next week. The annual accounts for financial year 2020-2021 were also due to be taken to the public board next week and the hospital hoped to be exiting the Recovery Support Programme (RSP) around October 2022.

UHL Reconfiguration

As part of national strategy UHL was lucky to be one of eight pathway trusts on the reconfiguration programme. Members were reminded that there were four pillars to the programme, a dedicated Children's Hospital; restructuring of the Intensive Care Units from three to two due to be completed in May 2022; reconfiguration of Maternity services to two units; and finally the separation of elective/emergency care, this was awaiting final confirmation around receipt of £37m to help facilitate that.

Members discussed the update which included the following points:

There were concerns that the concentration of services around Glenfield Hospital was problematic for residents in south Leicestershire and it was accepted that access to Glenfield could be difficult, but UHL wanted to work with people to address those issues e.g., through development of a travel plan.

It was commented that despite the reconfiguration plans and the large amount of monies involved that was not addressing the waiting list issues mentioned or the waits for other services e.g., musculoskeletal conditions and assurance was sought that was being addressed. In response it was advised that in January UHL had been able to reopen orthopaedics; 9% of the waiting lists were related to musculoskeletal conditions, in comparison to pre covid there would have been less than 10% of patients who were waiting more than 12 months to be seen, unfortunately since covid and the length of time that certain

services were restricted UHL were now a long way from getting patients waiting under 2 years. In terms of numbers on waiting lists, those were growing and continued to do so with a forecast they would grow nationally to 12+ million so waiting lists at UHL were also likely to go up but importantly for those who were waiting a long time the length of time spent waiting was now reducing.

In relation to cancer care patients, it was recognised that long waits could have detrimental impact on patients and assurance was given that the 14 day and 62 day referral/treatment rates had improved, patients were being clinically prioritised and cancer markers used and it was affirmed that Leicester, Leicestershire and Rutland were not an outlier in terms of its cancer care.

There was dissatisfaction that the hydro facility at the General Hospital had remained closed since covid and those using it to maintain conditions had nowhere to go during that time and no effort made to repair or restore that facility

Members expressed their disappointment that a range of subjects had been covered on a verbal report preventing them the opportunity of fully scrutinising points about topics, particularly as they hadn't been updated on progress with things like the reconfiguration programme for some months.

Members noted it was reported that a lot of staff were off with covid, and more details of that impact were sought as well as steps being taken to ensure staff wellbeing. Members were informed UHL staff were an important priority and there was a variable range of services in place to support them, among the basics it was crucial that staff had ability to take breaks, were supported to eat well, provided with lockers and had working equipment. However, people were tired and there was trauma arising from the effects of the pandemic as well as the ongoing transmission of the virus.

Discussion progressed onto the reconfiguration programme. Members were told that the reconfiguration programme had been approved and conversations had taken place today with the government around the business case. Leicester UHL was now 1 of 8 organisations waiting to move to the next stage. Members asked for clarity that the £450m had been approved by the Treasury and queried any current estimated shortfall or changes to the reconfiguration proposals. It was advised in terms of estimated shortfall there had been conversation with government around increased construction cost, and they were looking at ways forward to secure the money for that.

Members were not satisfied that the £450m had been formally approved by the Treasury and were uncertain as to the hospitals final reconfiguration plans or whether there would be changes to those due to increasing costs. There followed a strong discussion in which Members raised concerns they had not been advised previously about such approval and they were not assured by what was being said at this meeting.

Richard Mitchell clarified and reiterated that:

- the reconfiguration programme still had 4 pillars, namely the 3 into 2

12

intensive care; reducing maternity departments from 2 to 1; a stand-alone children's hospital and separation of elective/emergency care.
- the Treasury had committed to £450m as stated.
- UHL had not received confirmation that capital was extended beyond £450m but the wider context was that construction costs, resources and supplies etc had gone up.
- there was an ongoing discussion with government for additional funds to meet the uplift costs.

The Chair drew further discussion on the reconfiguration to a close and requested more detailed information about the status of the reconfiguration bid be provided to the Chair/Vice Chair and Rutland representative outside this meeting.

AGREED:

1. That Health Partners provide detailed information on current status of reconfiguration bid to the Chair, Vice Chair and Rutland representative as soon as possible.
2. That a briefing be convened as soon as possible for Chair, Vice Chair and Rutland representative with Andy Williams, Richard Mitchell, and Angela Hillery to ascertain position and progress with reconfiguration.
3. That future updates to the committee be by written report and to include any data in a written digest.
4. That the Committee at a future meeting have opportunity to scrutinise the £46m misstatement of accounts and to explore what the systemic failures were, and any measures put in place to avoid that happening again.

64. EMAS - NEW CLINICAL OPERATING MODEL AND SPECIALIST PRACTITIONERS

Members received a report providing an update on the EMAS Clinical Operating Model and introduction of Specialist Practitioners.

Richard Lines Divisional Director EMAS introduced the report providing insight into the background of the Clinical Operating Model review and the three areas of focus: the clinical model; clinical hub and clinical leadership.

It was noted:

- one of the outcomes of the review was the introduction of specialist practitioners to enhance delivery of clinical care; six were recruited initially in September 2020 with an additional 12 in 2021 allowing for 24/7 cover across the division (Leicester, Leicestershire, and Rutland).
- alongside clinical outcomes there had been a reduction of burden on emergency departments in Leicestershire as specialist practitioners were mainly focused on chronic patients which avoided admissions into hospital.
- as fast responders specialist practitioners also dealt with cardiac arrests, their role at cardiac arrest was to lead rather than be hands on, providing clinical leadership for ambulance/paramedic crews with the

aim of getting patients to the right care.

Members welcomed the report and the positive outcomes, and the ensuing discussion included the following points:

In relation to any concern that ambulance crews might be waiting for a specialist practitioner to arrive, it was not the case that they would be waiting for a specialist as calls were prioritised and appropriate crews responded e.g., in terms of despatch a cardiac arrest would take priority and where necessary a paramedic would be sent if that gave a quicker response time. Typically, a call in categories 3 or 4 would have a 4-6 hour waiting time.

Specialist practitioners were a specific resource providing additional roles to support the existing provision and there had not been any reduction of other ambulance provision. The number of specialist practitioners was being steadily increased and EMAS were looking at the possibility of different roles within that, i.e., specialists in an area.

Members queried whether there were any increased risks associated with carrying additional end of life drugs by the specialist practitioners. It was advised that all crews carried a range of drugs which were all logged with limited accessibility. There were very few incidents upon staff for purpose of obtaining drugs.

The Chair thanked Richard for the update.

AGREED:

That the contents of the report be noted.

65. INTERIM UPDATE ON LPT RESPONSE TO CQC INSPECTION - DORMITORY ERADICATION PROGRAMME

Members received a report providing an update around the dormitory eradication programme.

It was noted that

- In 2018 four specific wards were identified to be changed and £9.2m provided to make those changes to improve safety and ensure dignity of patients, this also helped with infection control especially during the covid pandemic
- 3 out of the 4 wards identified had been completed as highlighted by CQC in their inspection and work on the 4th had started and would be completed by next year.

Members viewed images of the improvements to the wards noting they were brighter, more attractive and provided patients privacy which also helped improve their mental health. Improvements included the wards being painted throughout, improved Wi-Fi signals, replacing staffing call points, and roll out of wrist bands for patients which was another feature captured in the CQC inspection last year.

14

It was noted that feedback had been gathered from patients and staff resulting in the latest installation of modern doors using most recent technology which could indicate if someone was looking for a ligature point and also anti-barricade.

Members expressed some concern about the impact of the programme on the number of bedspaces. It was advised that 27 bed spaces (from a total of 247) had been lost, all but two of those were in older people wards but the plan was to return to the original number of beds and a bid had been made to support that with the outcome expected in July. In terms of impact, the situation was unchanged as it was always a difficulty to get people into beds and the shortage was a national issue. To address the issue there was now more emphasis on community services in first instance and trying to prevent hospitalisation.

As far as the programme of works, scope for slippage had been built into the programmes, although there were risks within projects of this scale and size. The main concerns were around supply chain in general and long lead in times which made it difficult to switch supplier. The current economic situation and rise in inflation was adding to price. Funds for the programme were based on initial costs but that included a small contingency and at the moment the programme was on target and within budget.

Reference was made to discussion at the last meeting which talked about the wider issues arising from the CQC inspection and its findings. As regards the challenge around the Trust being given a Requires Improvement (RI) rating it was important to note the inspection related to only 3 core services out of 15 core services. It was also noted that the report at this meeting was only in relation to the dormitory programme, although acknowledged that across the wider estate the dormitory programme was a significant reason why the ratings were the way they were. Members were informed that the CQC visit was nearly a year ago and a lot of progress had been made by the Trust since, e.g., maintenance issues had been reduced 75%. The CQC had also revisited recently and were happy with the progression and improvements and would be writing to that effect soon.

It was queried how long an average stay was at the Bradgate Unit and how the programme might impact on that. It was responded that there were different ward settings across the bed base with facilities depending on a patient's condition, e.g., acute wards and long stay rehabilitation. Phasing of the dormitory eradication programme took a very clear staged approach for safety of patients.

The Chair summarised the discussion noting the committees interest in an update around work done by the Trust to address workplace culture and confirmed the committees support for the bid for additional funds to support regaining bedspaces and asked for the outcome of the bid to be informed to the committee in due course.

AGREED:

That an update on progress of all matters arising from outcomes of the CQC inspection and including the dormitory eradication programme be reported to the committee at its November meeting.

66. TRANSFORMING CARE IN LEICESTER, LEICESTERSHIRE AND RUTLAND - LEARNING DISABILITIES UPDATE

Members received a report providing an update on the partnership work across Leicester, Leicestershire and Rutland to deliver improved performance and outcomes for people living with a learning disability or autism.

David Williams Executive Director of Strategy & Partnerships, Leicestershire Partnership Trust introduced the report setting out what had been achieved so far, this included successes e.g., less people in long-term hospital now than in 2015; when working together to avoid a crisis admission was avoided 79% of the time; the culture and improvement journey so far and LPT's future vision. Attention was also drawn to opportunities over the next 12 months to further develop.

Members commented that conditions such as autism still took a long time to get a diagnosis and were often missed at schools, although the report had some positive outcome in relation to autism there was still more help needed in the community to better understand these conditions and it was queried whether support to schools was extended to further education and parents of those in further education.

Regarding early identification and support, it was advised the government was investing in mental health in schools, and there was joint funding for LPT, and education being used towards supporting identification; schools and teachers as well as a key programme with Barnados to give families support.

Concern was expressed that the report was lacking in details or data and gave no information about the level of support available during transition from child to adult or once a person with autism reached 18 years old and it was emphasised that this was a lifelong condition but as an adult there was little support especially for those who were more cognitive or able to hold a job.

Members were reminded that this was a joint report of the SRO and there were additional services and launched specialist NHS services available. As regards the points made about employment, this was a whole society issue and required working together, some conversations were taking place about how to make LA health more anchoring and there had been progression, but this was part of a wider improvement journey.

The Chair thanked health partners for the report and indicated it would be helpful to have a more detailed report to a future meeting.

AGREED:

That a further report around Transforming Care in Leicester,

16

Leicestershire and Rutland – Learning Disabilities, to include more information and supporting data be brough to a future meeting.

67. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA - IF ANY

None received.

68. WORK PROGRAMME

Members received and noted the current work programme.

69. DATES OF FUTURE MEETINGS

Future meetings of the committee for the municipal year 2022-23 were noted as follows:

- Monday 27th June 2022 at 5.30pm
- Wednesday 16th November 2022 at 12 noon
- Wednesday 12th April 2023 at 5.30pm

70. ANY OTHER URGENT BUSINESS

None notified.

There being no further business the meeting closed at 9.20pm.

17

Appendix B

Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee

Working arrangements and Terms of Reference

1. Membership

The Membership of the Committee shall be made up of 16 voting members – 7 members nominated by the City Council, 7 by the County Council and 2 by Rutland Council. In view of the size of the Committee and the range of its responsibilities, it is considered that there should be no co-opted members.

Each Healthwatch body in Leicester, Leicestershire and Rutland will be invited to send a non-voting representative to the meeting.

Members of the Committee will be appointed by each relevant Local Authority in accordance with its procedures.

2. Chair and Vice-Chair

The position of Chair will rotate between the City Council and the County Council on a two-year cycle. The Vice-Chair will be from the Authority not holding the Chair. The City Council will nominate the Chair for the period May 2021 to May 2023 and the County Council and City Council will then rotate the position of Chair and Vice-Chair in each two-year cycle afterwards.

3. Secretariat

The Secretariat will be provided by the Authority nominating the Chair. The Secretariat will liaise with all three authorities in drawing up the agenda. The Constitution/Standing Orders of the Authority providing the Secretariat will apply to the Joint Committee.

4. Policy Support

Both the City Council and the County Council will each provide an officer to assist the Health Scrutiny Process.

Both officers will liaise with and assist the Secretariat in drawing up the agenda and undertaking or commissioning research from within their respective Councils on behalf of the Joint Committee. Liaison will take place with the nominated officer(s) from Rutland Council.

5. Agenda Planning and Briefing

The Chair and Vice-Chair will be consulted on the agenda. Arrangements will be made for providing information on agenda items to Rutland at an early stage. An agenda setting meeting will be held prior to the main meeting with the Chair and Vice-Chair to which the lead Rutland member will be invited to attend. These meetings may be held virtually.

Any member of the Joint Committee will be entitled to ask for an issue to be placed on the agenda. Any such request should be in writing and accompanied by the reason for raising the item. If appropriate, the Secretariat may discuss with the member whether other means of addressing the issue have been explored and the outcome of this (e.g. has it been raised with the relevant Trust and what response was received). The Secretariat may report on such other means and outcomes to the Joint Committee.

In planning agendas, members will bear in mind the purpose of the Joint Committee, namely, to achieve a co-ordinated response from the three authorities on key issues of common interest within the health agenda and to avoid duplication whilst recognizing that authorities may wish to carry out separate scrutiny exercises in the light of the particular circumstances of their areas and priorities of their authority.

A joint briefing arrangement will be provided for the Chair and Vice-Chair with officer support. The briefing meeting will be held on the same day as the meeting, one hour before the meeting is due to start.

There will be provision to include as a general item on the agenda for Member Questions on matters that are not covered elsewhere in the same agenda.

These arrangements will be reviewed periodically.

6. Scope of the Joint Committee

i) The Joint Committee is the appropriate body to be consulted by NHS England on any proposals in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. The regulation provides that where the appropriate person (NHS England) has any proposals for a substantial development or variation of a health service in an area they must consult the local authority. Where the consultation affects more than one local authority in an area, the local authorities are required to appoint a Joint Committee to comment upon the proposal and to require a member or employee of the responsible person to attend its meeting and respond to questions in connection with the consultation.

The Regulation does not prevent constituent Councils of the Joint Committee considering the issues separately; but it is the responsibility of the Joint Committee to formally respond to the consultation process.

ii) The Regulations also provide that a Council may refer a proposal to the Secretary of State where: -

- it is not satisfied that the consultation has been adequate in relation to content or time;
- it is not satisfied with the reasons given for the change in services; or
- it is not satisfied that that the proposal would be in the interests of the health service in its area.

iii) A referral to the Secretary of State must be made by the full Council of a constituent authority unless the full Council has delegated the function to a Committee of the Council or to the Joint Health Scrutiny Committee.

iv) To scrutinize and comment on the exercise by all other NHS bodies of functions or proposals on a strategic basis which affect the areas of all three authorities.

v) To scrutinize the activities of Health Trusts with responsibility for health service functions across the area of the three authorities (i.e. UHL Trust, Leicestershire Partnership Trust, East Midlands Ambulance Service, Public Health England and the NHS England etc.).

vi) To respond to any consultations by the Health bodies referred to in (i) above, including those which involve a substantial variation in provision of such service.

vii) To respond to other consultations issued by all the NHS bodies which affect the areas of the three authorities.

7. Frequency of Meetings

Meetings of the Committee will generally take place three times a year, but extra meetings may be convened with the agreement of the Chair.

8. Quorum

The quorum of the Committee shall be at least one quarter of the whole number of the Committee. (4)

9. Voting

All decisions will be made by a majority vote of Members present at the Committee. In the event of an equality of votes, the chair will have a second and casting vote. Where a casting vote is exercised this will be recorded in the minutes.

A minority report may be prepared and submitted to the relevant NHS body (or Secretary of State) along with the majority report in the following circumstances: -

(i) when a majority of members of a particular Authority disagree with the findings; and

(ii) when at least one quarter of the members of the joint committee disagree.

10. Referrals

Referrals to the Joint Committee from individual health scrutiny committees should be carefully monitored and the reasons for the referral should be included in any report.

Referrals from Healthwatch should be considered carefully in line with the purpose of the committee to avoid overloading the
Joint Committee. The City and County Councils have protocols in place to ensure that referrals are not used as a substitute for other processes.

11. Media/Publicity Protocol

Where possible any press releases or publicity on behalf of the Committee should be undertaken after consulting all Spokespersons. Where this is not possible the Chair and Vice Chair of the Joint Committee will be authorised to issue press releases on the basis that these will be copied/e-mailed to all Group Spokespersons.

Responsibility for public and media relations on behalf of the Committee lies with the Authority responsible for the Secretariat.

12. Access to Information

The Access to Information Procedure Rules laid down by the Host Authority will apply with any necessary modifications. Link to Access to Information Procedure Rules contained in Part 4B of the Leicester City Council's Constitution

13. Interpretation of Rules of Procedure

Subject to the provisions outlined in these working arrangements the Scrutiny Procedure Rules laid down by the Host Authority will apply with any necessary modifications.

Appendix C

Leicester, Leicestershire and Rutland (LLR) Health Scrutiny Committee

27th June 2022

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1 Background and information

1.1 The LLR Health Scrutiny Committee (HSC) received a report on access to NHS Dental Services in November 2021 and requested a further briefing on:

- recovery rates
- Integrated Care Board (ICB) input on place-based plans
- identification of gaps within LLR

1.2 This report also includes oral health improvement initiatives and activities which are the statutory responsibilities of local authority Public Health teams.

1.3 For the LLR HSC to note that NHS England and NHS Improvement (NHS E/I) is currently responsible for the commissioning of all NHS dental services and that this responsibility will be delegated to the LLR Integrated Care Board (ICB) on the 1st. April 2023.

1.4 The report has been developed by:

- NHS E/I commissioning team senior managers
- NHS E/I Consultant in Dental Public Health
- Public Health colleagues in Leicester City and Leicestershire County Councils

1.5 Representatives from NHS E/I will be present at the LLR HSC meeting. In addition, the Executive Director of Strategy and Planning for the LLR ICB, Consultant in Public Health from Leicester City Council and Chair of the LLR Oral Health Promotion Partnership Board and a Consultant in Public Health from Leicestershire County Council have also been invited to attend the meeting.

2 NHS dental contract

2.1 NHS E/I is currently responsible for commissioning all NHS dental services including those available on the high street (primary care dental services), specialist dental services in primary care e.g. Intermediate Minor Oral Surgery (IMOS) and Community Dental Services (CDS) as well as from Hospital Trusts. Private dental services are not within the scope of responsibility for NHS E/I.

2.2 Although NHS E/I is responsible for commissioning all NHS general dental services, there are certain limitations of the current national contract. However, flexible commissioning can be utilised where a percentage of the existing contract value is substituted (up to 10%) to target local needs or meet local commissioning challenges. This approach requires a balance to ensure dental access is maintained.

2.3 The current NHS dental contract for primary and community dental care was introduced in 2006. Prior to that, dentists could choose to set up a dental practice anywhere in the country. They could also see and treat as many patients who attended and they claimed for each element of the dental treatment that was carried out under the old 'Items of Service' contracting arrangements; e.g. if a patient had two fillings, the dentist was paid twice the unit cost of a filling etc. However, the old dental contract did not work for various reasons, therefore, there was a reference period in 2005 which determined how many Units of Dental Activity (UDAs) each NHS dental practice that existed at that time would be allocated per annum and it was no longer possible for dentists to set themselves up as an NHS provider on an ad hoc basis. Any new NHS dental service had to be specifically commissioned by the then Primary Care Trusts (PCTs) within their capped financial envelope.

2.4 In effect, the former PCTs, and subsequently NHS England, 'inherited' those practices that were already in existence and that wished to continue to provide NHS dentistry under the new contracting arrangements. Sadly, a number of dental practices opted out of the NHS to become fully private at this time as they did not feel that the new UDA system would adequately recompense them for their work. This had a significant impact on the availability of NHS dentistry. The PCT had no control over where these 'inherited' dental practices were situated or over the number of UDAs commissioned in each geographical area. Hence, capacity did not (and in some areas continues to not) necessarily meet demand. Although there has been significant population changes in subsequent years, the number of UDAs commissioned (which is set contractually and cannot be amended without the agreement of both parties) has not always increased/decreased accordingly in order to meet the changing demand and need.

2.5 Unlike General Medical Practice (GMP), there is no system of patient registration with a dental practice and patients are free to choose to attend any dental practice, regardless of where they live. Dental practices are responsible for patients who are undergoing dental treatment under their care and once complete (apart from repairs and replacements), the practice has no ongoing responsibility. However, people often associate themselves with a specific dental practice. 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 GMP practices and patients are theoretically free to attend any dental practice that has capacity to accept them.

2.6 Prior to the pandemic, patients would often make their 'dental check-up appointments' at their 'usual or regular dental practice'. During the pandemic, contractual responsibilities changed, and practices were required to prioritise:

- urgent dental care
- vulnerable patients (including children)
- those at higher risk of oral health issues

For many practices, there has not been sufficient capacity to be able to offer routine dental check-up appointments.

3 NHS dental services across LLR

3.1 NHS General Dental and Orthodontic Services

3.1.1 There are 134 NHS dental practices across LLR as follows:

- 58 within Leicester City
- 66 within Leicestershire County
- 9 within Rutland County

3.1.2 Thirteen of the NHS dental practices above also provide NHS orthodontic services as follows:

- 7 within Leicester City
- 5 within Leicestershire County
- 1 within Rutland County

3.1.3 There are also 6 further specialist Orthodontic practices within LLR:

- 2 within Leicester City
- 4 within Leicestershire
- 0 within Rutland County

3.1.4 In addition, there are 7 Orthodontic Pathway contracts:

- 2 within Leicester City
- 4 within Leicestershire
- 1 within Rutland County

The purpose of the specialist Orthodontic Pathway is to reduce waiting times in secondary (hospital) care by ensuring that only those patients with extremely complex orthodontic needs are placed on the hospital waiting list, with all other complex cases being diverted to the pathway contracts.

3.2 Extended hours, urgent dental care and out of hours

3.2.1 Extended or out of hours cover is provided by five 8-8 NHS dental contracts:

- 2 within Leicester City
- 2 within Leicestershire County
- 1 within Rutland County

These are NHS dental services which provide access to patients from 8am to 8pm every single day of the year (365 days) and provide both routine and urgent care.

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

Table 1: Timelines in accordance to dental need

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

3.2.3 If a person has a regular dental practice and requires urgent dental care:

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

3.2.4 If a person does not have a regular dental practice and requires urgent dental care, they can contact:

- any NHS dental practice during surgery hours to seek an urgent dental appointment and this would be dependent on the capacity available at each dental practice on any given day. They can use the Find a Dentist facility on the NHS website
- NHS 111, either online or on the phone (interpreters are available). For deaf people, there is also the NHS 111 BSL Service (alternatively, they can also call 18001 111 using text relay)
- Healthwatch Leicester and Leicestershire or Healthwatch Rutland
- NHS England's Customer Contact Centre on 0300 311 2233

3.2.5 Patients with dental pain should not contact their GP or attend A&E as this could add further delays in gaining appropriate dental treatment as both GP and A&E services will be redirecting such patients to a dental service.

3.2.6 People who require urgent out-of-hours dental care can attend any service in the Midlands area and for LLR residents, the nearest sites are Leicester, Westcotes, Melton Mowbray, Oakham and Loughborough depending on the patient's address. At times of peak demand, patients may have to travel further for treatment depending on capacity across the system.

3.3 Community (Special Care) Dental Service

3.3.1 The LLR Community (Special Care) Dental Services provides dental treatment to patients whose oral care needs cannot be met through NHS primary dental care due to their complex medical, physical or behavioural needs. The service uses behavioural management techniques and follows sedation and general anaesthesia (GA) pathways. Dentists and/or health care professionals can refer into the service. There is 1 dental provider (CDS-CIC) treating children and adults from 5 clinics across LLR:

- 2 clinics within Leicester City: Westcotes and Merlyn Vaz,
- 3 clinics within Leicestershire County: Hinckley, Loughborough and Melton
- There are no clinics within Rutland County

3.3.2 The GA pathway for children and special care adults is managed between CDS-CIC and the University Hospitals of Leicester (UHL) which is commissioned on a system area footprint.

3.3.3 CDS-CIC are also commissioned to provide NHS dental care and treatment for those who are unable to leave their own home or care home. Some limited dental care can be provided in a person's own setting such as a basic check-up or simple extraction, but patients may still need to travel into a dental surgery (as this is the safest place) to receive more complex dental treatment. If such patients require a dental appointment, they or their relative/carer can contact the local domiciliary provider via NHS 111.

3.4 Intermediate Minor Oral Surgery (IMOS) Service

3.4.1 The IMOS service is a specialist referral service providing complex dental extractions for LLR patients over the age of 16 years who meet the clinical criteria. There are 10 providers across LLR:

- 6 within Leicester City
- 4 within Leicestershire County
- There are no providers within Rutland County

3.4.2 A map of the location of local dental practices or clinics (including orthodontic and community sites) across LLR is in Appendix 1. In some cases, there are practices in close proximity and the numbers on the map reflect this as the scale does not permit them to be displayed individually. The maps are also shaded to demonstrate accessibility of dental services and travel times by public transport or car within 30 minutes and also walking times of 15 minutes for residents of Leicester City.

3.5 Hospital dental care

3.5.1 Secondary care dental services e.g. Orthodontics, Oral Surgery, Oral Medicine, Maxillofacial are commissioned from UHL to deliver complex dental (often multi-disciplinary) treatment to patients who meet the clinical criteria in line with the NHS E/I Commissioning Guides. Activity and contract values are agreed annually with acute trusts.

4 LLR ICB

4.1 NHS E/I will be delegating full commissioning responsibility for NHS dental services to the ICB as of 1st April 2023.

4.2 In preparation for this, as of the 1st April 2022 for effective date 1st July 2022, joint commissioning arrangements were set up between NHS E/I and the ICB in advance of the full delegation next year. This is where there are opportunities within the integration agenda to deliver place-based commissioning that is specific to the system rather than on a wider footprint. This does not mean that working on a wider footprint is not beneficial as there are times when it provides the opportunity to streamline services to provide best value for money (public funds) whilst ensuring best patient outcomes.

4.3 There is a vision for one plan for the LLR ICB. The principles and priorities for the system strategy have been agreed and the full strategy is still being developed. This is a statutory requirement of the ICP (LLR Health and Wellbeing Partnership) and therefore a draft will be written in 2022/23.

4.4 In addition and in order to understand the full impact of the pandemic to the oral health of local populations down to a lower level which will highlight inequalities and gaps, Public Health colleagues at Leicester City Council are updating the Leicester Oral Health Joint Strategic Needs Assessment (JSNA). Leicestershire County Council Public Health colleagues are also committed to refreshing the Leicestershire Oral Health Needs Assessment (OHNA) as well as undertaking a Rutland OHNA but work on these have been delayed due to current capacity issues. It is anticipated that both pieces of work for LCR will be completed by April 2023.

5 NHS Dental Charges

5.1 Dentistry is one of the few NHS services where patients pay a contribution towards the cost of NHS care. Any treatment that a dentist believes is clinically necessary to achieve and maintain good oral health should be available on the NHS. The current charges are:

- **Emergency dental treatment – £23.80** This covers emergency dental care such as pain relief or a temporary filling.
- **Band 1 course of treatment – £23.80** This covers an examination, diagnosis (including X-rays), advice on how to prevent future problems, a scale and polish if clinically needed and preventative care such as the application of fluoride varnish or fissure sealant if appropriate.

- **Band 2 course of treatment – £65.20** This covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or removal of teeth but not more complex items covered by Band 3.
- **Band 3 course of treatment – £282.80** This covers everything listed in Bands 1 and 2 above, plus crowns, dentures, bridges and other laboratory work.

More information is available here. All NHS dental practices have access to posters and leaflets that should be displayed prominently.

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

6 Impact of the pandemic

6.1 The ongoing COVID-19 pandemic has had a considerable impact on dental services and the availability of NHS dental care; the long-term impact on oral health is as yet unknown but it is a cause for concern. All routine dental services in England were required to cease operating when the UK went into lockdown on 23 March 2020. A network of Urgent Dental Care Centres (UDCCs) was immediately established across the Midlands in early April 2020 to allow those requiring urgent dental treatment to be seen. These UDCCs are currently still operational however referrals are of a very low volume as routine dental practices have now reopened. The UDCCs remain on standby in case of future uncontrolled issues that may affect delivery of NHS dental services (such as staff shortages due to sickness – for example as a consequence of a COVID-19 outbreak).

6.2 From 8 June 2020, dental practices were allowed to re-open however additional infection prevention and control measures were required (including social distancing) for patients and staff. A particular constraint was the introduction of the so-called 'fallow time' – a period of time for which the surgery must be left empty following any aerosol-generating procedure (AGP). An AGP is one that involves the use of high-speed drills or instrument which would include dental fillings or root canal treatment. This has had a marked impact on the throughput of patients and the number of appointments that could be offered. For a large part of 2020, many practices were only able to provide about 20% of the usual number of face-to-face appointments and relied instead on providing remote triage of assessment, advice and antibiotics (where indicated). The situation improved in early 2021, with reductions in fallow time requirements and since then practices have been required to deliver increasing levels of dental activity.

6.3 NHS dental practices are currently required to offer dental services to patients throughout their contracted normal surgery hours (some practices are offering extended opening hours to better utilise their staff and surgery capacity). They are also required to have reasonable staffing levels for NHS dental services to be in place. Increases in capacity have been gained in line with subsequent changes to national protocols for infection prevention and control such as reducing social distancing requirements and the introduction of risk assessments for patients who may have respiratory infections.

6.4 All NHS dental practices are required to maximise capacity and also to prioritise urgent dental care for:

- their regular patients
- patients without a regular dental practice referred via NHS 111
- all vulnerable patients

6.5 Infection prevention and control measures have been regularly reviewed and the following minimum requirement for the recovery of dental activity has been imposed on NHS dental contracts:

- Q3 2021/22: 65% of contracted activity for general dentistry and 80% of contracted activity for orthodontics
- Q4 2021/22: 75% of contracted activity for general dentistry and 90% of contracted activity for orthodontics
- Q1 2022/23: 95% of contracted activity for general dentistry and 100% of contracted activity for orthodontics
- Q2 2022/23: 100% of contracted activity for general dentistry and orthodontics

6.6 Figure 1 shows the level of NHS dental activity delivered across LLR during the pandemic against the minimum threshold activity set by the national team and against the Midlands total. It can be seen that there have been some surges of higher levels of activity for LLR as a whole against the minimum threshold requirements. Unfortunately this data is only available at an ICB level and therefore cannot be reported separately for Leicester City or Leicestershire and Rutland Counties. Appendix 2 shows the average pattern of delivery of NHS dental activity over the course of the pandemic across the Midlands.

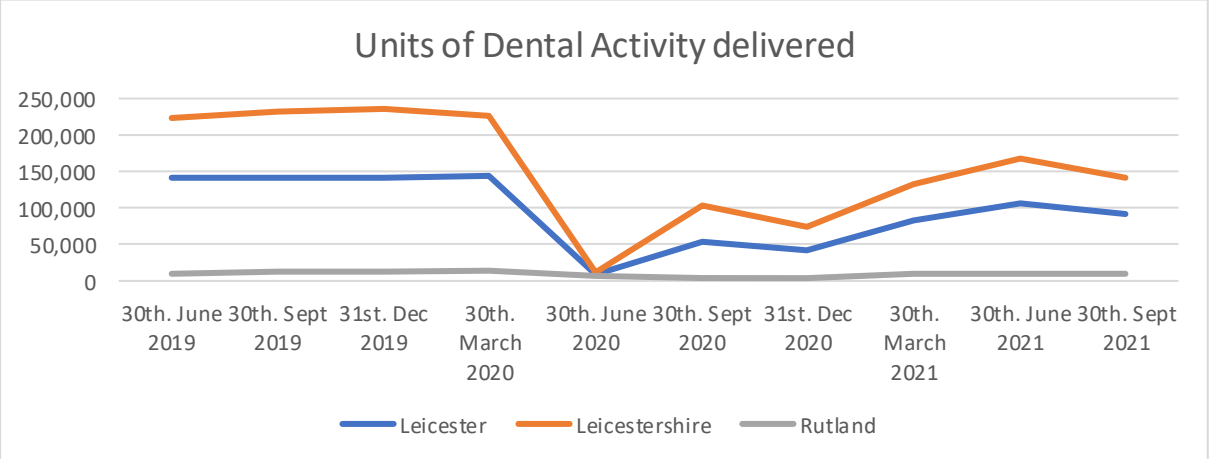
Fig 1: LLR Primary Care Dental Activity vs Minimum Thresholds

- - - - - - - Midlands Total
_____ Leicester, Leicestershire and Rutland
…….. Minimum Thresholds

6.7 Figure 2 shows the NHS Units of Dental Activity delivered by upper tier local authority during the pandemic (although NHS dental practices are not contractually associated to them). By September 2021, NHS dental practices in:

- Leicester City had recovered 64% of pre-pandemic dental activity
- Leicestershire County had recovered 63% of pre-pandemic dental activity
- Rutland County had recovered 87% of pre-pandemic dental activity

Figure 2: Units of Dental Activity delivered by local authority during the pandemic



6.8 The national minimum requirement for all NHS dental contracts was set at 65% for Q3 2021/22. Tables 2 and 3 show that NHS dental practices within LLR ICB achieved 65.5%, with 79 out of 135 (58.5%) of NHS dental practices meeting or exceeding this requirement (compared to 60.8% in the Midlands region).

6.9 The national minimum requirement for all NHS dental contracts was set at 75% for Q4 2021/22. Tables 2 and 3 show that NHS dental practices within LLR ICB achieved 77%, with 60 out of 135 (44.4%) of NHS dental practices meeting or exceeding this requirement (compared to 38.3% in the Midlands region).

Table 2: Proportion of Units of Dental Activity delivered in Q3 and Q4 of 2021/22 by NHS General Dental Practices across LLR
(this information is not available at a lower level)

	Period	Threshold	LLR System performance
LLR	Q3	65%	65.5%
LLR	Q4	75%	77.0%
Midlands	Q3	65%	66.2%
Midlands	Q4	75%	76.9%

Table 3: Number of NHS dental contracts meeting / exceeding national minimum requirements during Q3 and Q4 of 2021/22 across LLR
(this information is not available at a lower level)

	Period	Outcome – number meeting or exceeding thresholds
LLR	Q3	79 out of 135 (58.5%)
LLR	Q4	60 out of 135 (44.4%)
Midlands	Q3	718 out of 1,181 (60.8%)
Midlands	Q4	452 out of 1,181 (38.3%)

7 NHS Dental access

7.1 Figure 3 shows the percentage of children (0-17 years) accessing NHS dentistry during the pandemic. The proportion of children living in the East Midlands accessing NHS dentistry both before and during the pandemic has been higher than the national average. It can also be seen that pre-pandemic, the proportions of children resident across all LLR local authority areas accessing NHS dentistry were higher than both the national and regional averages, with the exception of Leicester being close to the regional average but higher than the national average. Although the proportion of children accessing NHS dentistry fell below both the national and regional averages between July to December 2020 for Leicester, Blaby and Hinckley and Bosworth, the recovery for all local authority areas throughout 2021 have exceeded the national and regional averages.

7.2 The National Institute of Health and Care Excellence (NICE) does not support routine 6-monthly dental check-ups universally for all patients. It recommends that dentists should take a risk-based approach to setting the frequency of dental check-ups and that the longest gap between dental check-up appointments for every child (younger than 18 years) should be 12 months. Figure 4 demonstrates that the proportion of children residing across LLR accessing NHS dentistry within 12 months (as per NICE recommendations) have constantly been above national average, both prior and during the pandemic.

7.3 Figure 4 also shows the impact of the pandemic lockdown of March 2020 on access which can be observed 12 months later (March 2021). It can also be seen that as NHS dental services have gradually been recovered and restored,

the proportions of children accessing NHS dentistry are increasing again. As of 31st. December 2021, the proportion of children accessing NHS dentistry within 12 months in England was at 75% of that reported for 31st December 2019 (pre- pandemic). Recovery of access for children across LLR has been higher than England at 77% for Leicester, 76% for Leicestershire and 92% for Rutland.

7.4 Figure 5 shows the percentage of adults accessing NHS dentistry during the pandemic. The impact of the national lockdown can be seen by the drastic reduction in access in 2020. The proportion of adults living in the East Midlands accessing NHS dentistry both before and during the pandemic has been higher than the national average. It can be seen that the proportions of adults living in Hinkley and Bosworth, Oadby and Wigston, Blaby and Harborough have constantly been above the regional and national averages, before and during the pandemic. For those living in North West Leicestershire, access was above regional and national averages pre-pandemic and similar to the regional average during the pandemic (still higher than the national average). For those living in Charnwood, access was above the national average but below the regional average pre-pandemic and similar to the national average during the pandemic (lower than the regional average). For those living in Leicester, Melton and Rutland, accessing NHS dentistry has constantly been below the national and regional averages, before and during the pandemic.

Fig 3: Proportion of children (0-17 years) accessing NHS dentistry during the pandemic

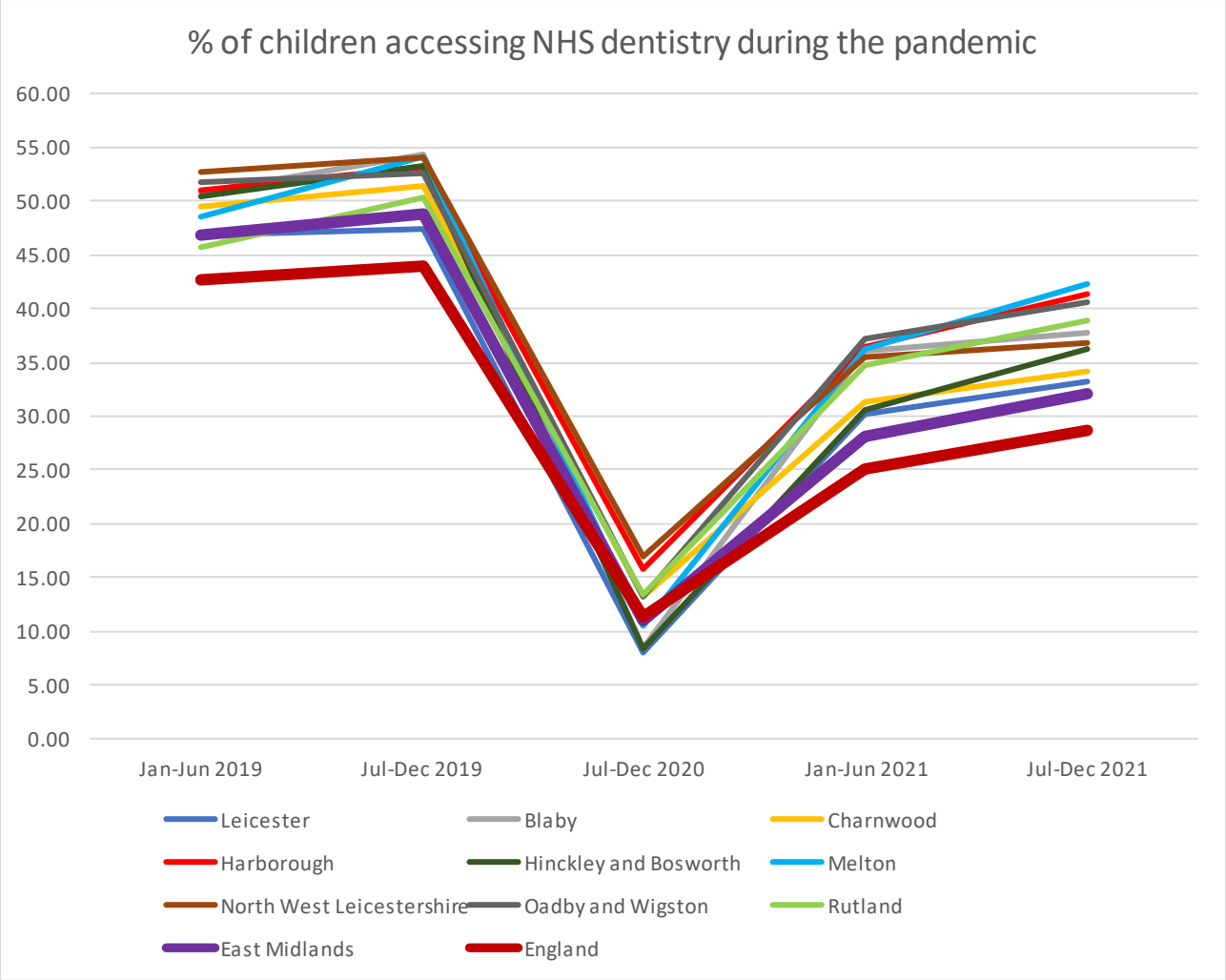


Figure 4: Proportion of children resident across LLR accessing NHS dentistry within 12 months

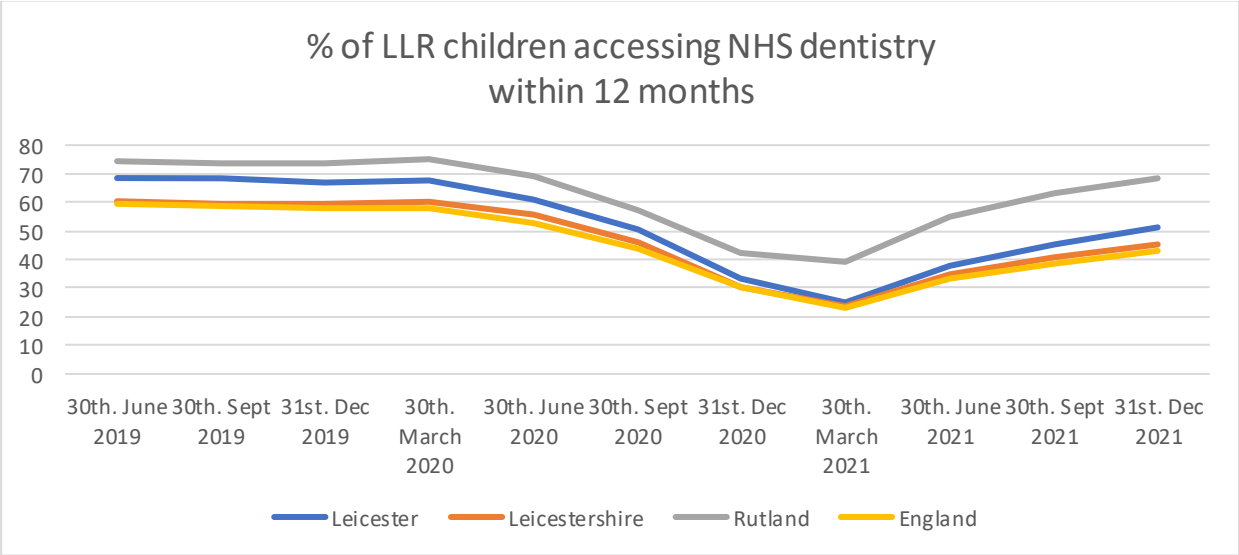


Fig 5: Proportion of adults accessing NHS dentistry during the pandemic

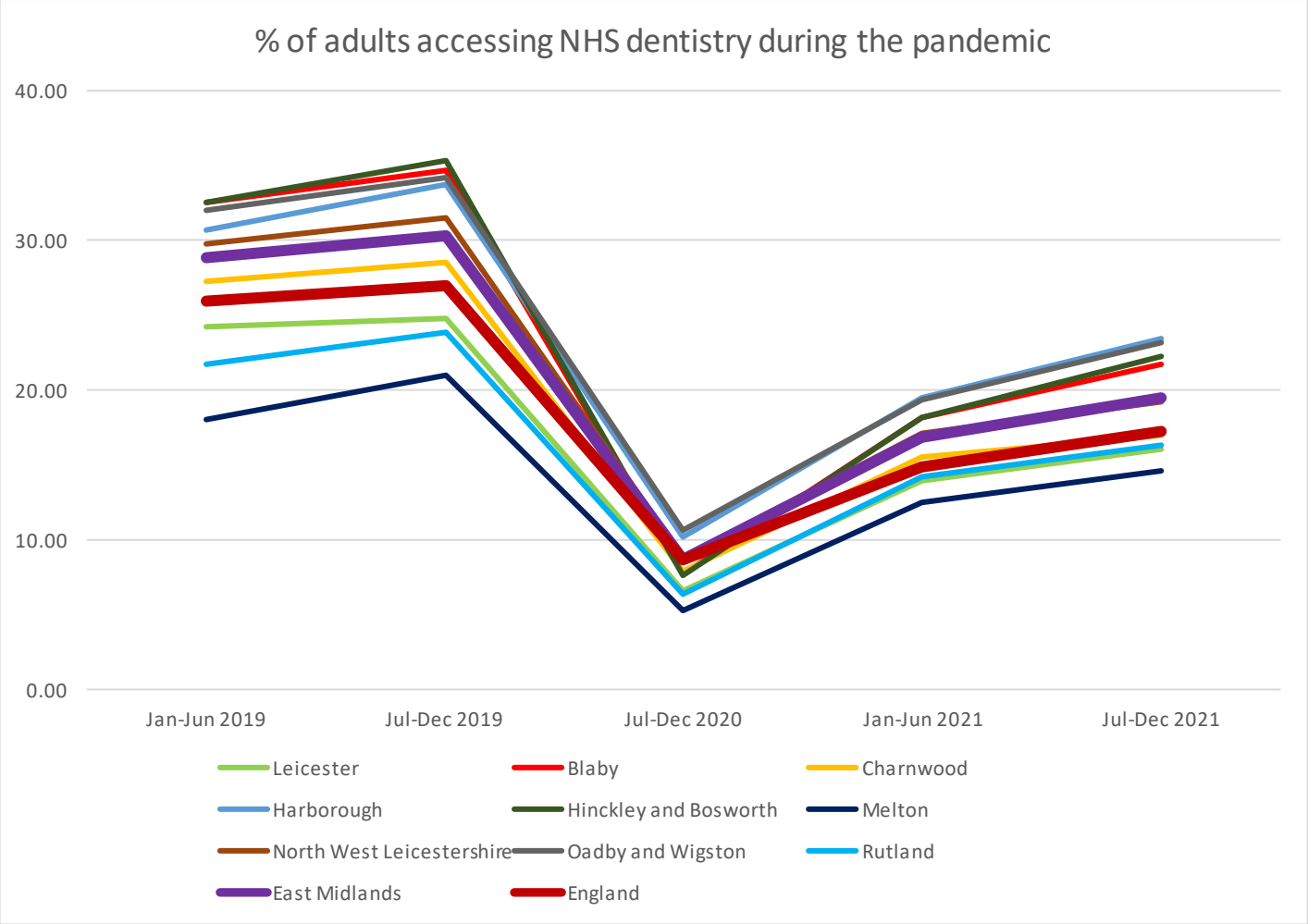
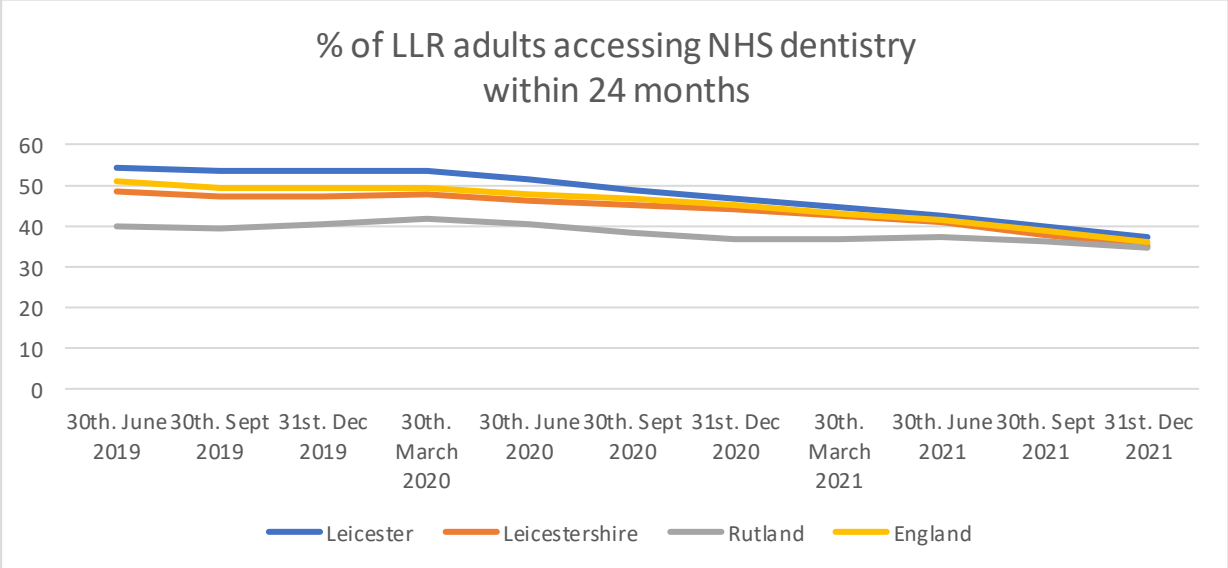


Figure 6: Proportion of adults resident across LLR accessing NHS dentistry within 24 months



7.5 As mentioned earlier, NICE does not support routine 6-monthly dental check-ups universally for all patients. It recommends that dentists should take a risk-based approach to setting the frequency of dental check-ups and that the longest gap between dental check-up appointments for every adult (over 18 years) should be 24 months. Figure 6 demonstrates that the proportion of adults resident in Leicester accessing NHS dentistry within 24 months (as per NICE recommendations) has typically been higher than the national average, both prior and during the pandemic. In contrast, the proportion of adults resident in Leicestershire is very close and similar to the national average with Rutland constantly being lower than the national average. However, when making comparison of proportionate loss between December 2019 and December 2021, Rutland suffered the least loss at 12%, compared to 28% for Leicestershire, 31% for Leicester and 29% for England.

7.6 It is estimated that across the Country there has now been the equivalent of a year's worth of appointments lost in primary care dentistry since the start of the pandemic. The effects have been similar in community and hospital care due to restricted capacity from staff absences or re-deployment to support COVID-19 activities.

7.7 Furthermore, since the start of the COVID-19 pandemic, two dental contracts have been handed back to NHS E/I within LLR (Leicestershire County). The dental activity from the terminated contracts have not been lost and NHS E/I have recommissioned them by dispersal to surrounding local dental practices in the area.

7.8 As part of the dental activity dispersal process, the NHS dental practice that is handing back their NHS activity must agree a communication letter for their patients with NHS E/I. This letter is to notify patients that the NHS dental practice will no longer be providing NHS dental care with appropriate sign posting provided on how to continue gaining access to NHS dental care from elsewhere. This provides assurance to NHS E/I that there is no inappropriate/forced signup to private dental services and enables informed patient choice.

7.9 It should be noted that many dental practices operate a mixed private/NHS model of care and although NHS contract payments have been maintained by NHS E/I, the private element of their business may have been adversely affected by the pandemic. The Chief Dental Officer for England set up a time limited working group that undertook an investigation into the resilience of mixed economy practices. They concluded that whilst there would have been an interruption of income, the risk of a large number of dental practices facing insolvency over the next 12 to 18 months was low.

8 Restoration of NHS Dental Services

8.1 The NHS E/I commissioning team is working with the local dental profession to restore NHS dental services and deal with the inevitable backlog of patients that has built up since the COVID-19 pandemic. In line with national guidance issued, all NHS dental practices in England are currently working towards

providing routine dental care in the same way as they were prior to the pandemic, with the expectation of full (100%) delivery of contracted dental activity from July 2022.

8.2 It is important to note that patients should expect to be contacted and asked to undergo an assessment (undertaken remotely in most instances) prior to receiving an appointment. The latest guidance is that patients will be directed to the most appropriate service depending on whether they:

- have any respiratory symptoms
- need urgent dental care

This pathway will not change due to the removal of free COVID-19 tests and patients will also not be required to purchase these tests in order to gain access to NHS dental services.

8.3 Reduced access to NHS dental care over the course of the pandemic will have resulted in compromised outcomes for some patients. Due to the duration of the lockdown and the length of time during which routine face to face activity ceased, a number of patients who ordinarily would have had a clinical intervention may have struggled to gain access to NHS dental care. Some who were part way through dental treatment will undoubtedly have suffered and may have lost teeth they would not have otherwise - temporary fillings placed pre-lockdown, for example, and only intended as temporary measures, may have come out causing deterioration in outcome.

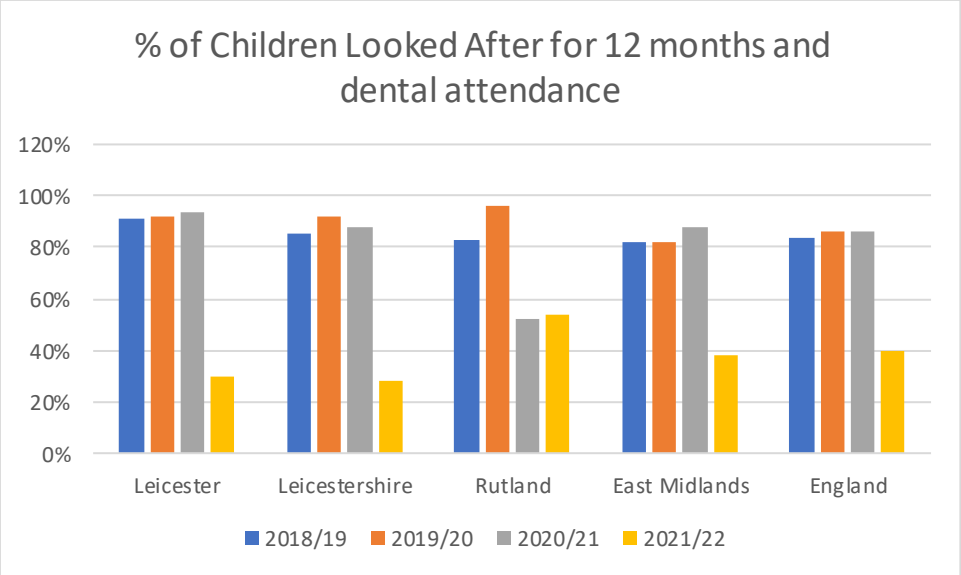
8.4 Orthodontic patients who are routinely seen for regular reviews will have missed appointments, although harm reviews and remote consultations undertaken should have helped identify any urgent issues. The ongoing backlog and ever-increasing waiting lists do however mean that there is still a risk of those recall intervals being extended in order to free up capacity to see new patients. Patient compliance with the required oral hygiene measures may decrease over time and consequently there is an increased risk of dental decay developing around the orthodontic appliances if treatment is prolonged in this way.

8.5 Aside from the effects of reduced dental access, it is possible that the pandemic will have other long-term impacts on oral and general health due to changes in nutritional intake – for example, increased consumption of foods with a longer shelf life (often higher in salt or sugar) coupled with possible increased intake of high-calorie snacks, takeaway foods and alcohol. Increases in sugar and alcohol intake could have a detrimental effect on an individual's oral health. Those impacted to the greatest extent by this are likely to be vulnerable population groups and those living in the more deprived areas, thus further exacerbating existing health inequalities.

8.6 It is important to note that some of the most vulnerable in the population, whose oral health may have been affected by the pandemic as described above, could also be at greater risk of contracting COVID-19 and of experiencing worse outcomes due to risk factors linked to other long term health conditions.

8.7 Figure 7 below demonstrates that access for Children Looked After across LLR has significantly deteriorated since the pandemic.

Figure 7: Percentage of Children Looked After for 12 months and dental attendance



8.8 In recognition of the access difficulties for children in care, NHS E/I, the Local Dental Network Chairs in the East Midlands with support from the Orthodontic and Paediatric MCN Chairs, Public Health, Local Authorities and clinical colleagues have worked with safeguarding colleagues to support dental access for children taken into care. To assist with the process, an oral health assessment support sheet was developed for those undertaking general examination and, in acknowledgement of the difficulties in accessing NHS dental care, a pathway was also developed to enable children identified with acute dental problems at the Initial Health Assessment to be directed straight to CDS-CIC (the local community special care dental service) for a comprehensive dental examination. NHS E/I wrote to all Directors of Children's Services in the East Midlands to clarify the position regarding access to dentistry and the Looked After Children pathway that was developed. This has meant that no child being taken into care with urgent dental need was disadvantaged as a result of the challenges related to the pandemic. The pathway was completed in April 2021.

8.9 Additional dental capacity was also commissioned to support Afghan refugees repatriated to the UK and housed in local hotels. This was provided by way of dedicated domiciliary support to quarantine hotels and ongoing additional capacity at 2 local practices within Leicester City (to ensure the additional workload did not negatively impact on wider patient access).

9 NHS Dental Services recovery initiatives

9.1 A large financial investment has been made to facilitate initiatives designed to increase access across primary, community and hospital dental care, as follows:

- Weekend Sessions – For LLR, 8 practices were contracted to provide 63 additional sessions at a cost of £41,202.00. Out of the 8 practices, 5 practices were within Leicester City providing 41 additional weekend sessions: with the remaining 3 practices within Leicestershire County providing 22 additional weekend sessions. No uptake was received from Rutland County. Additional national funding was allocated as part of a national scheme and further applications were reviewed on an on-going basis until the scheme ended on 31 March 2022.

- Weekday Sessions – For LLR, 3 practices were contracted to provided 55 additional sessions at a cost of £35,970.00. All 3 practices were within Leicester City providing 55 additional weekday sessions. No uptake was received from practices in Leicestershire or Rutland Counties. Additional national funding was allocated as part of a national scheme and further applications were reviewed on an on-going basis until the scheme ended on 31 March 2022.

- NHS E/I approached the 5 dental providers across LLR who are contracted to open from 8am to 8pm with the view to commissioning additional funded sessions. Unfortunately, none of the providers felt that they had any capacity to provide any further sessions.

- Additional Orthodontic Case Starts – For LLR, 4 practices are contracted to provide additional capacity equating to 415 case starts to address the orthodontic waiting lists. One practice is in Leicester City offering an additional 40 case starts and 3 practices are within Leicestershire County offering 375 additional case starts. There was no interest received from Rutland County.

- Dedicated In Hours Urgent Care Slots (voluntary service from NHS general dental practices) – additional capacity for NHS 111 to signpost patients without a regular dental practice who require urgent dental care during surgery hours. Five practices in LLR are taking part and providing extra appointments. One of the five practices is in Leicester City offering 3 additional urgent care appointments per week with four out of the five practices within Leicestershire Country offering 54 additional urgent care appointments per week. There was no interest received from practices in Rutland County.

- Additional funding has also been provided to local authorities:
    - £150,000 recurrent for 2 years to support oral health improvement initiatives and activities
    - £40,000 non recurrent to support purchase and distribution of toothbrushing packs to food banks and other venues

- £10,000 non recurrent to enable each local authority's oral health promotion service to expand and improve their resources
- £5,000 non recurrent to support each local authority's oral health promotion services' training resources
- £10,000 non recurrent to provide each child with a toothbrushing pack as part of the dental epidemiology survey

All the above funding was allocated jointly to Leicester City, Leicestershire and Rutland County Councils. Funding was transacted to Leicester City Council to be distributed between the three local authority areas via the LLR Oral Health Promotion Partnership Board. Agreement on the spending of all the additional funding will be discussed and agreed at the LLR Oral Health Promotion Partnership Board to ensure alignment with oral health needs of the area.

- Non recurrent investment to support IMOS providers in reducing waiting times for patients to be seen within 6 weeks of referral into the specialist service. At March 2022, there were 3,526 accepted patients onto the IMOS pathway for LLR and 2,197 (62%) had been waiting over 6 weeks to be treated. This has been reduced from 2,928 as at June 2021 when the waiting list initiative was launched.

- Non recurrent investment of £62,048 to support waiting list initiatives for LLR Community (Special Care) Dental Service (CDS-CIC) during 2021/22. The waiting list initiatives ran additional sessions for new referrals, first and follow up appointments for patients with open courses of treatment. Additional dental hand pieces were also purchased to support improving efficiency of dental clinics resulting in reduced fallow time between patients. Commitment has also been secured for 2022/23 to support reducing GA waiting list (subject to securing additional sessions at the hospital trust).

- Trusts are monitored on referral to treatment within 18 weeks, 52 week waits and in addition, due to the impact of the pandemic, monitoring 104 week waits. All Trusts are required to clear any 104 week waits by July 2022. As at March 22, there were 60 LLR patients waiting over 104 week waits for Oral and Maxillofacial Surgery and UHL has plans in place to clear this within the target deadline. Please see Appendix 3 for Midlands Oral Surgery Referral to Treat Trends and Appendix 4 for referrals into secondary care which have started to recover, however, these remain lower than previous levels due to the reduction in routine appointments in primary dental care. Additional non recurrent investment of £35,791 has been secured to support secondary care dental waiting list initiatives for UHL. The waiting list initiatives are to address 104 and 52 week waits in the secondary care dental speciality Oral and Maxillofacial surgery. Further commitment of £463,224 has been secured to support waiting list initiatives in 2022/23.

10 Oral Health and Inequalities

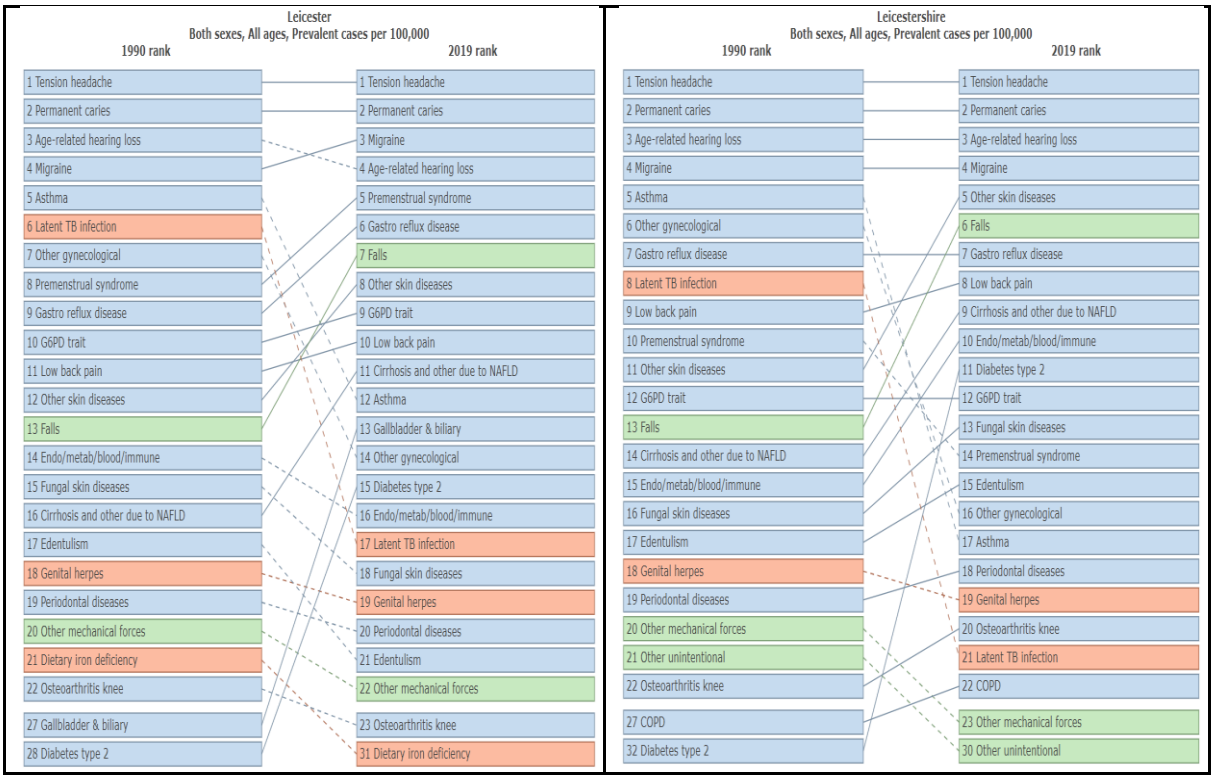
10.1 Whilst NHS E/I is responsible for commissioning NHS dental services, the responsibility for public health, including oral health improvement, is with local authorities who have the statutory role in assessing local oral health needs and commissioning or providing evidence based oral health improvement programmes appropriate to those needs. In addition, the Local Authority is also responsible for oral health surveys to facilitate the planning and evaluation of the arrangements for provision of dental services as part of the health service and NHS E/I are working with Public Health local authority colleagues on this.

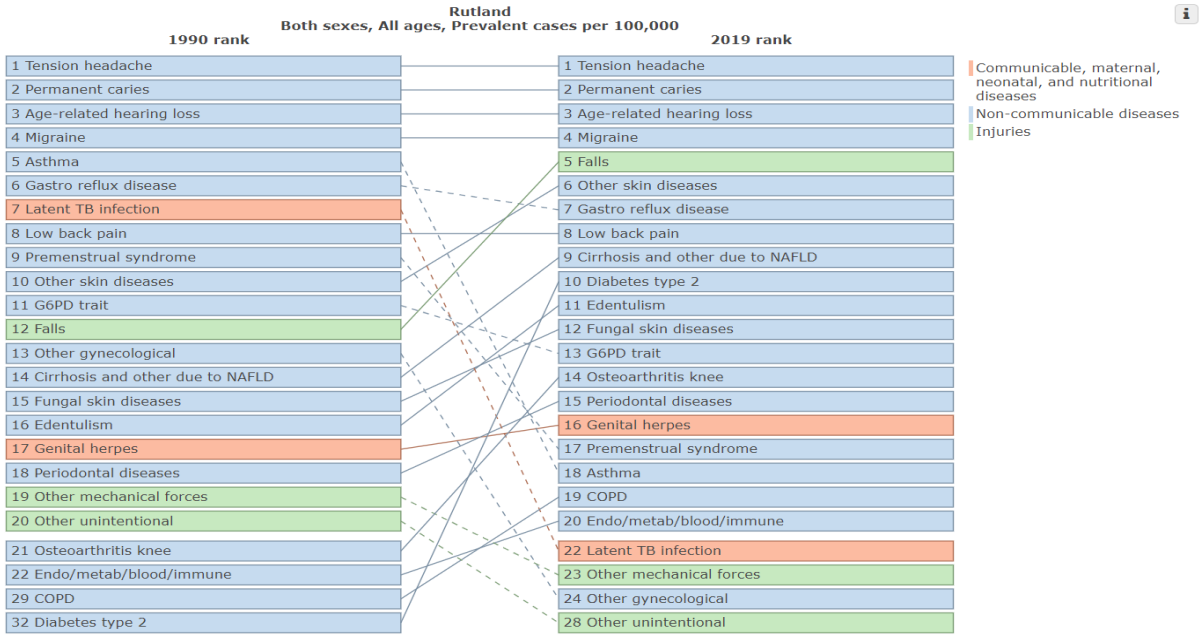
10.2 Oral diseases continue to be a leading public health problem with significant inequalities. Those living in more deprived areas and vulnerable individuals are more at risk, both of and from, oral diseases. Whilst there has been an overall improvement in oral health in recent decades, further work is needed to improve oral health and reduce inequalities.

10.3 Figure 8 shows that oral health remains in the top 20 rankings of the most prevalent causes affecting the overall health and wellbeing of people living across LLR from 1990 to 2019:

- rank 2 (LLR) – dental decay (caries)
- ranks 21 (Leicester),15 (Leicestershire),11 (Rutland) – edentulism (no teeth)
- ranks 20 (Leicester), 18 (Leicestershire), 15 (Rutland) – periodontal (gum) disease)

Figure 8: Ranking of prevalent cases per 100,000 affecting overall health and wellbeing of people living across LLR (Global Burden of Disease)

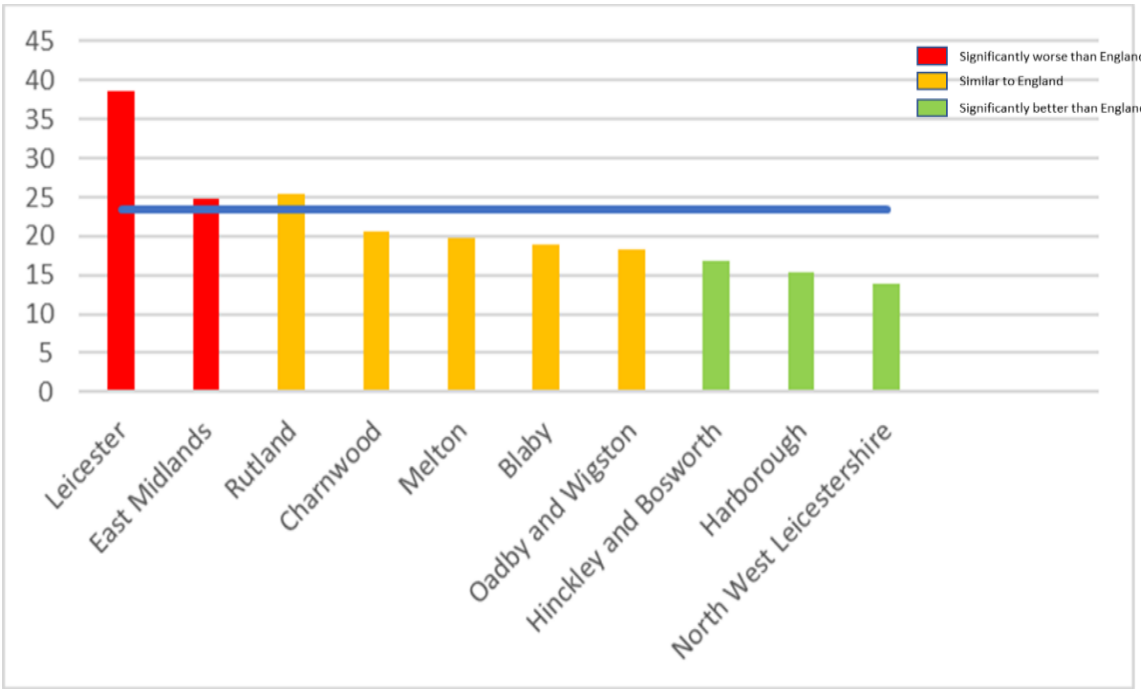




10.4 The findings of the 2017/18 survey of adults attending general dental practices in England showed that poorer oral health disproportionately affected those at the older end of the age spectrum and those living in more deprived areas.

10.5 The 2018/19 national oral health survey of 5-year-old children showed wide variation in both the prevalence and severity of dental decay among young children across LLR (Figure 9). It can be seen that 5-year-old children in Leicester have significantly worse oral health compared to those living in England, East Midlands, Leicestershire as well as Rutland.

Figure 9: Percentage of 5 year olds with visually obvious dental decay (2018/19)



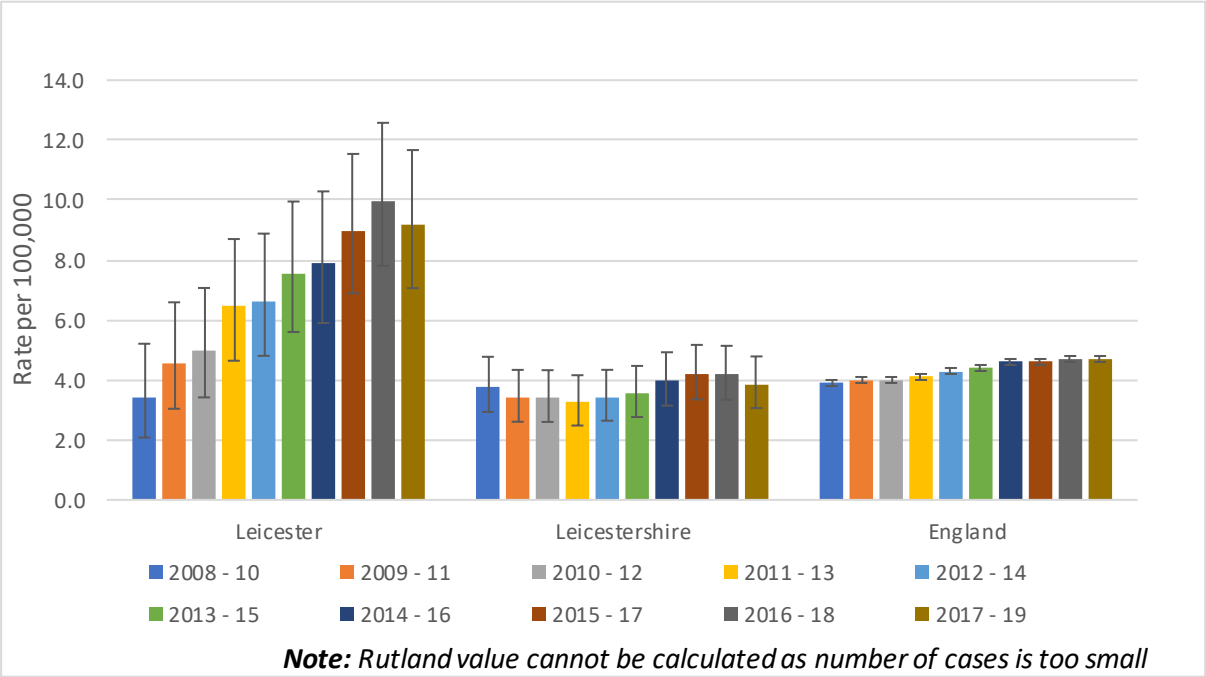
10.6 Dental health remains a significant public health concern with approximately 37,000 hospital admissions of children to extract decayed teeth in 2019/20 nationally. The estimated cost to the NHS of all tooth extractions in children is £50 million per year, most of which were due to avoidable tooth decay. Evidence supports water fluoridation as an effective public health measure that has the ability to benefit both adults and children, reduce oral health inequalities and offer a significant return on investment. Fluoridated water is currently supplied to ten percent of the population in England and unfortunately, residents across LLR do not benefit from water fluoridation.

10.7 The Health and Care Bill was granted Royal Assent on the 29th. April 2022 for healthcare recovery and reform. We are currently waiting for secondary legislation through parliament for the new Health and Care Act 2022 to come into force. The new Health and Care Act 2022 introduces measures that will level up disparities in oral health by making it simpler to add fluoride to the water in more areas across England. For the moment, the statutory responsibility with regards to decision making on water fluoridation still lies with local authorities but when the new Health and Care Act 2022 commences, it will change the decision-making responsibility on water fluoridation that has resided with local authorities since 2013 by transferring the responsibility for such decisions to be made centrally. Adding fluoride to drinking water can significantly reduce tooth extractions and cavities among children and young people. The evidence shows that children and young people in areas in England with higher fluoride concentrations were up to 63% less likely to be admitted to hospital for tooth extractions due to decay than those in areas with low fluoride concentrations. The difference was greatest in the most deprived areas as children and young people in these areas benefited the most from fluoridation.

10.8 Figure 10 shows that mortality rates from oral cancer are significantly higher than the national average and have also been increasing significantly over the years in Leicester. The most recent local authority data reports Leicester with the highest mortality rate from oral cancer in the country. Although tobacco use has been proven to increase the risk of oral cancer, people who use both alcohol and tobacco are at an especially high risk of contracting the disease. The high oral cancer mortality rate may indicate that patients could be presenting and/or being diagnosed late, as earlier diagnosis with cancer reduces the risk of mortality.

10.9 The Local Dental Network publicised Mouth Cancer Awareness month in November 2021 and distributed a set of key messages to dental practices to help them raise awareness, identify patients with symptoms, and ensure they are aware of how to refer patients quickly to the appropriate services. This is as a proactive local follow up to a dental bulletin issued by the Chief Dental Officer in May 2021 https://bit.ly/3vK70Ez.

Figure 10: Oral cancer mortality rates across LLR



***Note:** Rutland value cannot be calculated as number of cases is too small*

11 Collaborative working

11.1 The local NHS E/I dental commissioning team works collaboratively with Public Health colleagues in Leicester City as well as Leicestershire and Rutland County Councils around prevention initiatives linked to oral health improvement and in amplifying key oral health messages. Further information has been provided by each Council's public health teams on the local oral health improvement initiatives across Leicester, Leicestershire and Rutland in Appendix 5.

11.2 There have been regular meetings with the profession via the Local Dental Committee. The local dental commissioning team at NHS E/I are grateful for the co-operation received from the dental profession in mobilising Urgent Dental Care Centres and co-producing solutions to help manage the current restrictions in NHS dental services. This has included joint working between the local Community (Special Care) Dental Service and General Dental Practices.

11.3 There is a Local Dental Network (LDN) covering the LLR ICB with an LDN Chair in place. There are also a number of Managed Clinical Networks (groups of local clinicians) who have continued to meet virtually to plan care and agree good practice guidance to support practices in managing their patients. The Urgent Care Network met weekly early on in the pandemic to help plan and deliver ongoing access to urgent dental care.

11.4 The NHS E/I commissioning team have also been working with colleagues in the Communications team to draft a series of stakeholder briefings to update key partners and the public on the situation with respect to NHS dental services. These have been distributed to local authorities, Directors of Public Health and CCGs. Examples of tweets that have been shared on Twitter are given in Appendix 6.

11.5 NHS E/I have also engaged with Healthwatch Leicester & Leicestershire as well as Healthwatch Rutland and they have shared intelligence on local concerns or on difficulties people may be having accessing NHS dental services.

12 Assessment of access

12.1 A strategic review of dental access is planned for 2022/23 and NHS E/I anticipate having access shortly to a mapping tool which will help to identify local areas which may have specific issues in order to assist with a more targeted approach in tackling them.

12.2 The assessment of access below includes findings from the updated (currently in draft) Leicester City Oral Health JSNA (2022). Due to current capacity issues, Public Health colleagues have not commenced on the Oral Health HNAs for Leicestershire and Rutland but NHS E/I will work collaboratively with them when it starts.

12.3 Access is defined as the degree of fit between the user and the service; the better the fit, the better the access. Access is optimized by accounting for 6 independent yet interconnected dimensions:

- Affordability:
  - Leicester City Council Oral Health JSNA (2022) "*Leicester patients are more likely to suggest that they have found treatment too expensive*".
  - Although those on certain benefits are entitled to free NHS dental care, those on a low income may struggle to pay for NHS dental services but may not be aware of the NHS Low Income Scheme.
  - NHS E/I have received anecdotal reports that some practices are seemingly promoting private treatment instead of providing an NHS appointment. NHS E/I does not support any stances of pressuring patients into private dental care. NHS E/I will investigate any report of this nature but will need detailed information so that this can be raised with the practice for a response. Any such concerns can be raised via a complaint about any specific practice/s by contacting the NHS England Customer Contact Centre on 0300 311 22 33 or www.england.nhs.uk/contact-us/.

- Availability:
  - Leicester City Council Oral Health JSNA (2022) "*Following an audit of Leicester dental practices listed on the NHS website only 8 were accepting new adult NHS patients and a further 7 were accepting*

under 18s only. Also, according to the GP Patient Survey (Jan-Mar 2021), 71% of residents in Leicester City reported success in gaining a dental appointment, which is significantly lower than the national rate of success".

- NHS E/I are aware that information on the NHS website may not always be up to date but it is unfortunately not a contractual requirement for dental providers to do so. NHS E/I are continuously working with all local dental providers to improve the accuracy of this information.
- NHS E/I are also aware that some patients who had previously accessed dental care privately may now be seeking NHS dental care due to financial problems related to the pandemic. This is putting additional pressure on NHS services at a time when capacity is constrained.
- NHS E/I also recognise the backlog of NHS dental care which has accumulated during the period where dental services have not operated at full capacity. Many NHS dental contractors are already delivering over 100%, and it is critical for those providers who are not to make progress as quickly as possible. Unfortunately, many practices are struggling to recruit staff (both dentists and nurses) and this is having an impact on capacity. Nevertheless, NHS E/I are expecting full (100%) delivery of contracted dental activity from July 2022.

- Accessibility:
  - Leicester City Council Oral Health JSNA (2022) "*Most of Leicester City's residential areas are within 15 minutes' walk of a dental practice but there are some areas of the city where residents would need to travel further. This includes areas to the West, East, and North West. Furthermore, if only 8 dental practices are currently accepting new adult NHS patients, many people would find it difficult to access these locations if walking and public transport were there only options".*
  - NHS E/I is continuing to work with all NHS dental providers in delivering their full contracted activity and also in improving the accuracy of the information on the NHS website.
  - Appendix 1 (Maps 4 and 5) show that some residents on the northern point of Melton are not within the 10 mile radius of NHS dental practices in Leicestershire and also not within 30 minutes by car in rush hour – they may be accessing NHS dental care from Nottinghamshire and/or Lincolnshire (as commissioned by NHS E/I) but they may also be having difficulties as dental access for adults in Melton (within 24 months) is lower than the national average. The Leicestershire Oral Health Needs Assessment will help to determine this.
  - In addition, those who were advised that they are extremely clinically vulnerable or previously shielded, special arrangements have been made to ensure they are able to access care safely at their usual practice by being offered an appointment at the beginning or end of a session.

- Adequacy:
    - Leicester City Council Oral Health JSNA (2022) "*Due to the developmental of the LAC Pathway, access rates for children being taken into care requiring urgent dental treatment seem to be good but there is anecdotal evidence that access to routine dental appointments are more challenging for these vulnerable children".*
    - NHS E/I are aware that it has been very difficult during the pandemic for foster carers to find appointments for these vulnerable children. For children who were being taken into care and not identified with an urgent dental need, their foster carers have been asked to take them to a local dentist. NHS E/I are continually reminding NHS dental practices that these vulnerable children are a priority for dental access. If the foster family regularly attends the practice, the children should be considered as part of that arrangement. It is expected that NHS dental practices would manage the child within the general dental practice setting (high street dentist) as they would any other child.
    - The orthodontic treatment transfer process for children in care has also been reviewed in order to make it as seamless as possible and foster carers are informed of the process.
    - NHS E/I are aware that other vulnerable groups are also finding it harder than usual to access services. We are continuing to review pathways and treatment arrangements to ensure continued NHS dental access which is primarily facilitated through NHS 111. NHS E/I are also working with the LLR Oral Health Promotion Partnership Board to address the inequality for those experiencing Severe Multiple Disadvantage.
    - NHS E/I have commissioned a pilot collaborative approach on the delivery of special care dental services, which is intended to add capacity in assisting the management of special care dental patients in the system. Unfortunately, there was no uptake from NHS dental providers across LLR, however NHS E/I are currently trying to secure additional funding to extend the pilot into 2022/23 and hope to encourage uptake from NHS dental providers in LLR.

- Acceptability:
    - Leicester City Council Oral Health JSNA (2022) "*Leicester patients are more likely to suggest that they have not needed to attend a dentist (GP Patient Survey). Leicester City Council have also commissioned health and wellbeing surveys for both adults (2018) and children (2016/17). These surveys have asked about dentist attendance. They reveal significant differences by gender, age, ethnicity, and deprivation. Also, children and young people are more likely to say they have never been to the dentist if from the North area of the city or if they are Asian".*
    - The extent that NHS dental services are responding to the attitude of residents and patients regarding characteristics of the service and social or cultural concerns are not known. Leicester City Council has also identified some areas where there are higher rates

of urgent dental care including areas with a large Eastern European population (West End and Newfoundpool) and also more diverse areas (Belgrave, Spinney Hill and Highfields) where the 65+ population also have high rates or urgent dental activity. There are many reasons why people may not engage with routine dental care and may choose to seek dental care only when problems arise. NHS E/I will work with Leicester City Council to explore these issues further through the LLR Oral Health Promotion Partnership Board.

- It is also acknowledged that dental access for adults living in Rutland is lower than the national average. It could be that they have a preference for private dentistry instead. The Rutland Oral Health Needs Assessment will help to determine this.
- NHS E/I have been working on a new scheme to encourage local child friendly dental practices to provide support to their local Community (Special Care) Dental Service by collaborating on a shared care model, serving to free up capacity on tackling backlogs for those requiring complex dental treatment. Unfortunately, there was no uptake from NHS dental providers across LLR, however it is part of NHS E/I's investment plan to continue this scheme into 2022/23 and will continue to seek further interest and support from NHS dental practices across LLR.

- <u>Awareness:</u>
  - Leicester City Council Oral Health JSNA (2022) "*Analysis shows that males, younger adults and those from a non-White ethnicity in Leicester are finding it more challenging to successfully get a dental appointment".*
  - The extent that effective communication and information strategies currently being used are taking full consideration of context and health literacy particularly of specific population sub-groups is not known. NHS E/I will explore this with the LLR Oral Health Promotion Partnership Board to ensure that appropriate communication and information strategies are in place.
  - NHS E/I have also received anecdotal evidence that Care Home providers are not aware of the existence of the Domiciliary Dental Service, the eligibility criteria and how to contact the service. Prior to the pandemic, work was underway to look at new ways of collaborative working with primary care networks to strengthen support to care homes in accessing NHS dental services and in improving the oral health of their residents. This remains a priority and NHS E/I will continue working with the LLR Oral Health Promotion Partnership Board and Leicestershire Partnership NHS Trust on this agenda.
  - There is also ongoing concern about a reluctance amongst some people in attending dental appointments during the pandemic either because they do not want to be a burden on the health service or because they fear being infected with COVID-19. A campaign reassuring people that it is safe to attend NHS dental appointments has been launched by NHS E/I.

- NHS E/I will also work collaboratively in raising awareness of the NHS Low Income Scheme which provides financial support for those on a low income.

13 Supporting Information

- Appendix 1 - Location of dental practices and clinics across Leicester, Leicestershire and Rutland
- Appendix 2 - Activity Trends in Primary Care
- Appendix 3 – Midlands Oral Surgery Referral to Treatment (18 week and 52 week waiters)
- Appendix 4 – Midlands Secondary Care Dental Referral Trends
- Appendix 5 – Oral Health Improvement activities across Leicester, Leicestershire and Rutland led by local authority Public Health teams
- Appendix 6 - Examples of tweets shared by the NHS England Communication Team

14 Contact Points

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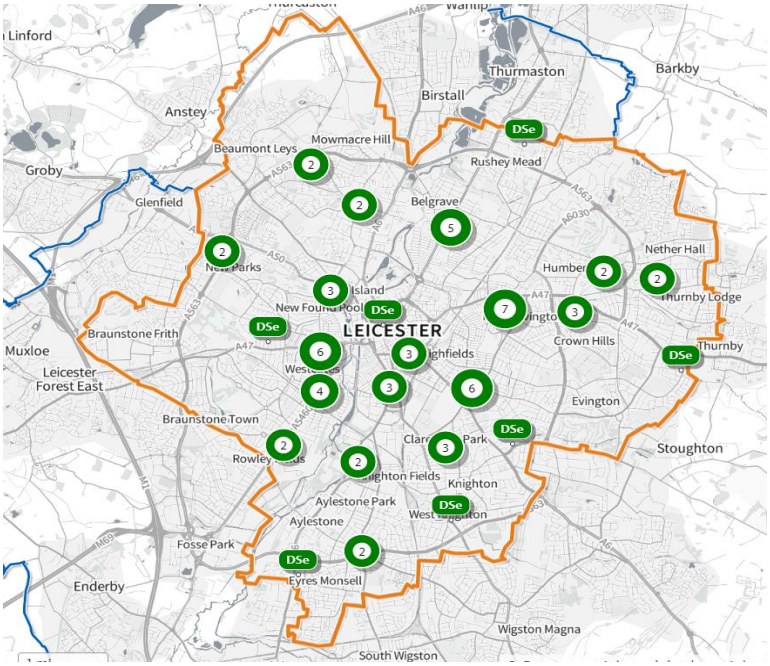
Appendix 1: Location of dental practices or clinics including orthodontic and community sites

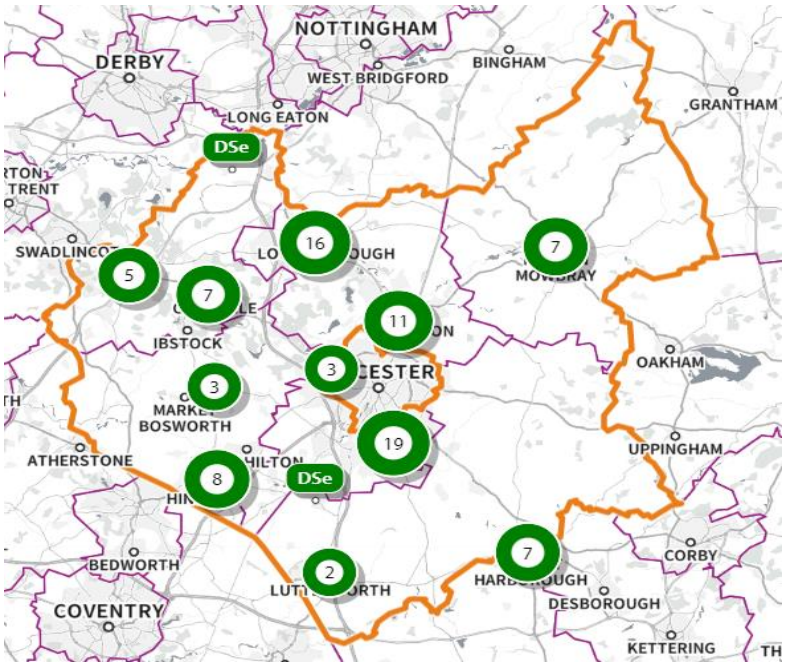
NB:

- The numbers denote the number of NHS dental practices within the location
- DSE (dental service) indicates one NHS dental practice within the location

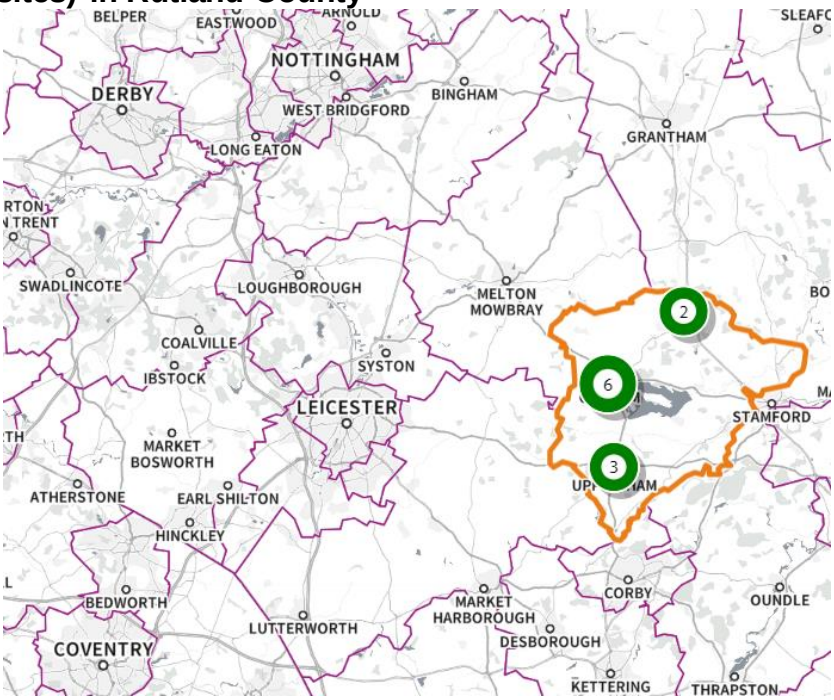
Map 1: Location of dental practices and clinics (including orthodontics and community sites) in Leicester City



Map 2: Location of dental practices and clinics (including orthodontics and community sites) across Leicestershire County

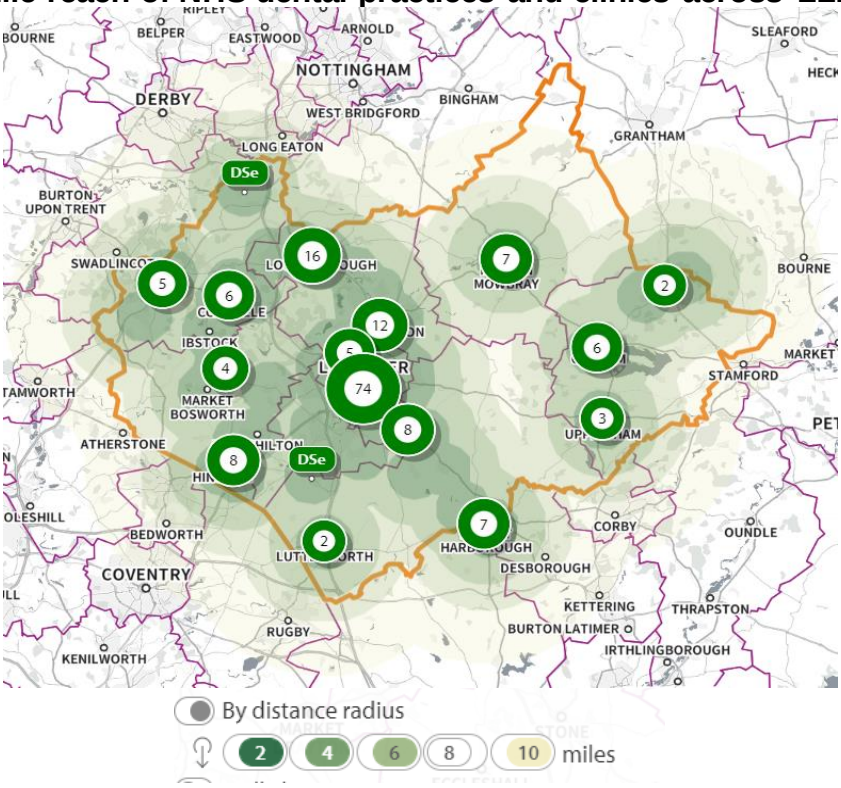


Map 3: Location of dental practices and clinics (including orthodontics and community sites) in Rutland County



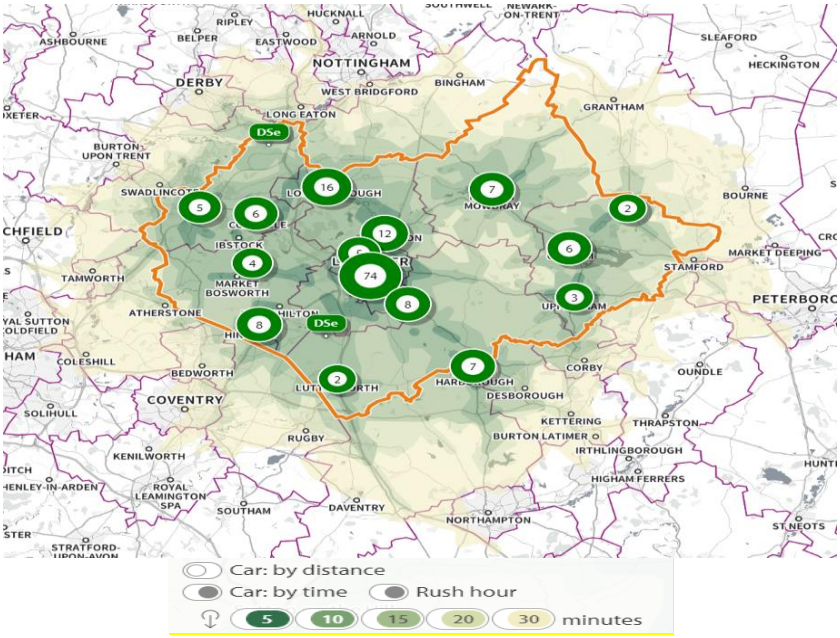
Map 4 below demonstrates that every dental practice or clinic (including orthodontic and community sites) are within a 10 mile radius of every resident living in Leicester, Leicestershire and Rutland, apart from those living in the northern point of Melton who may be accessing NHS dental care from dental practices in Nottinghamshire and/or Lincolnshire. The Leicestershire Oral Health HNA will help to determine this.

Map 4: 10 mile reach of NHS dental practices and clinics across LLR



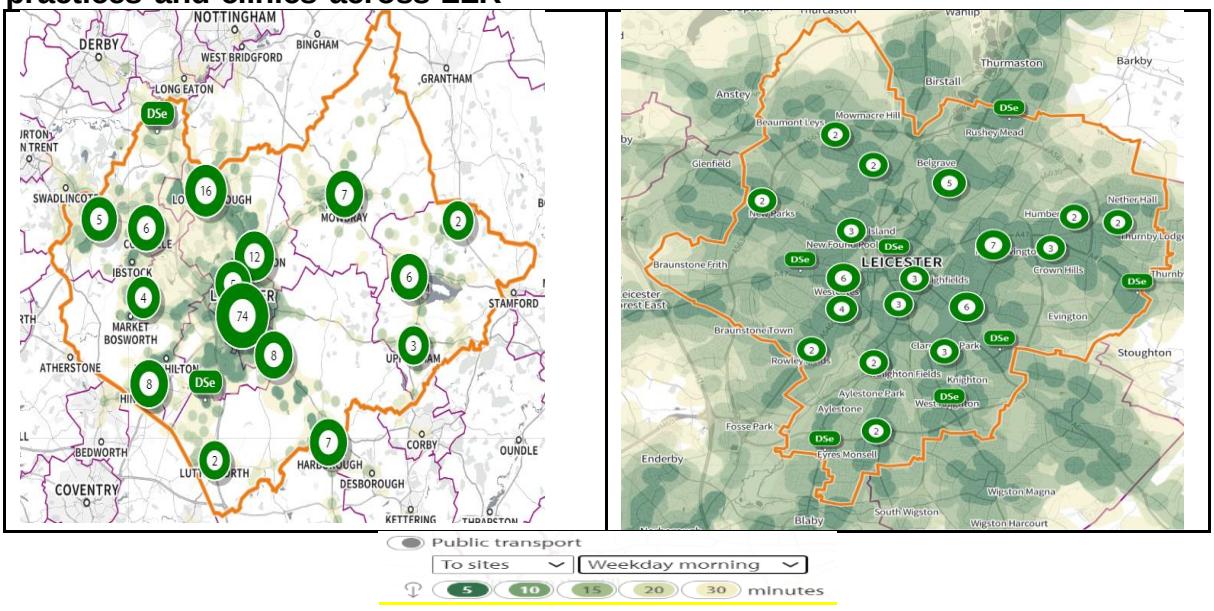
Map 5 below demostrates that every dental practice or clinic (including orthodontic and community sites are accessible by car within 30 minutes in rush hour, apart from those living in the most northern point of Melton who may be accessing NHS dental care from Nottinghamshire and/or Lincolnshire. The Leicestershire Oral Health HNA will help to determine this.

Map 5: 30 minute travel by car (rush hour) to NHS dental practices and clinics across LLR



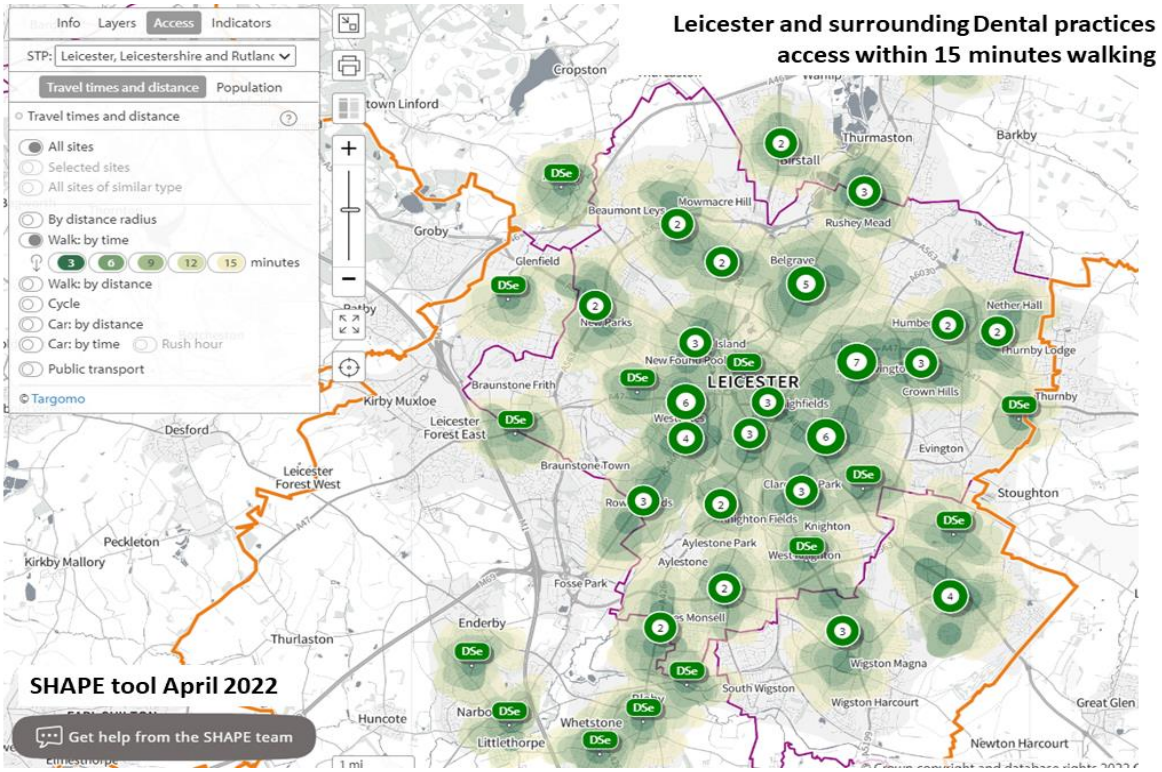
Map 6 below demostrates that not every dental practice or clinic (including orthodontic and community sites are accessible by public transport within 30 minutes on a typical weekday morning for those living in Leicestershire and Rutland Counties. However, all dental practices and clinics are accessible by public transport within 30 minutes for every resident in Leicester City.

Map 6: 30 minute travel by public transport (weekday morning) to NHS dental practices and clinics across LLR

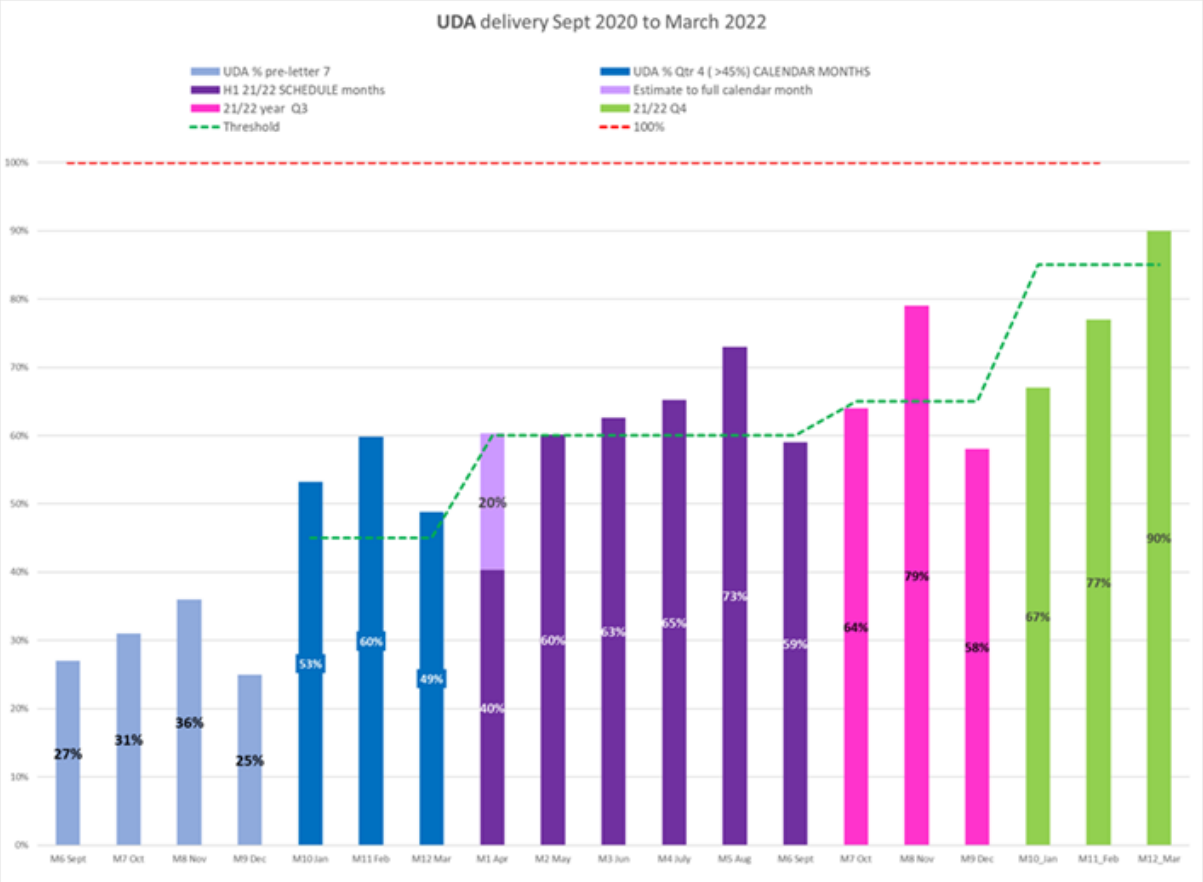


Map 7 below demonstrates that most of Leicester City's residential areas are within 15 minutes' walk of a dental practice but there are some areas of the city where residents would need to travel further. This includes areas to the West, East, and North West.

Map 7: 15 minute walk to NHS dental practices and clinics in Leicester city



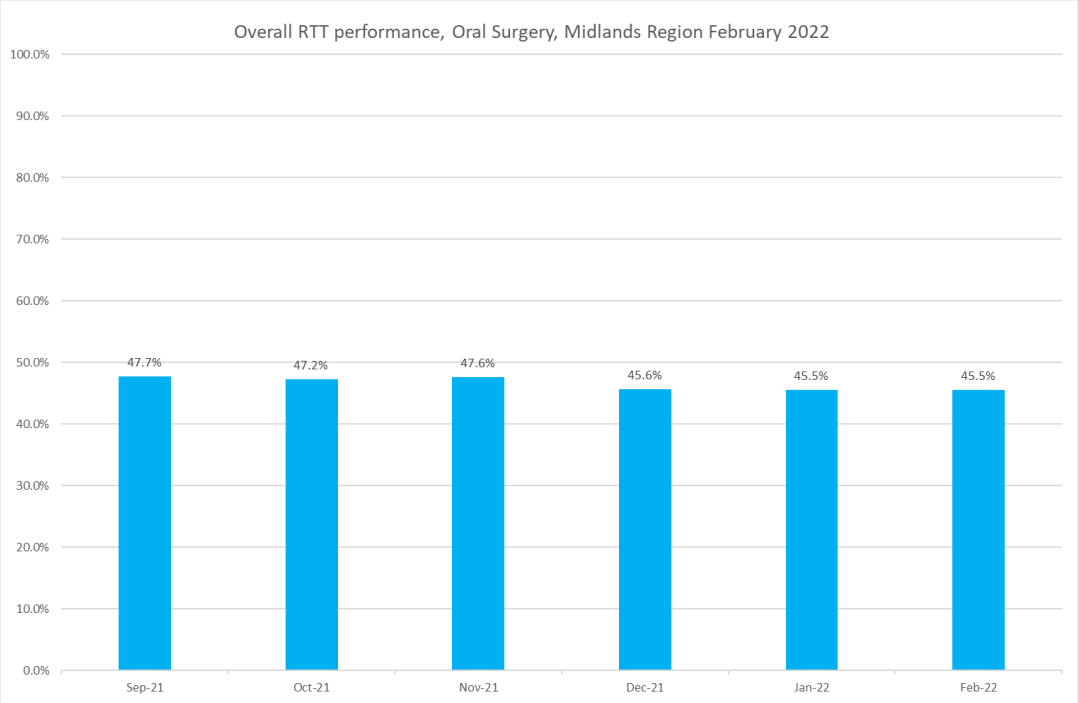
Appendix 2: Activity Trends in Primary Care for Units of Dental Activity (UDA) - Midlands

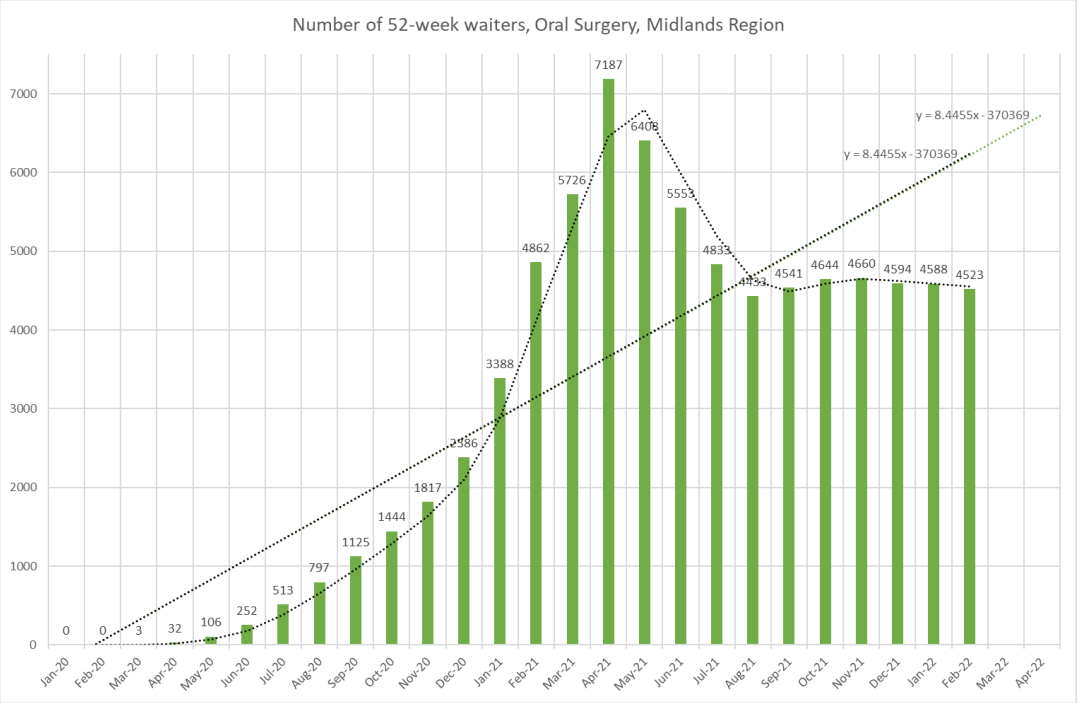


Appendix 3: Midlands Oral Surgery Referral to Treatment (18 week and 52 Week Waiters)

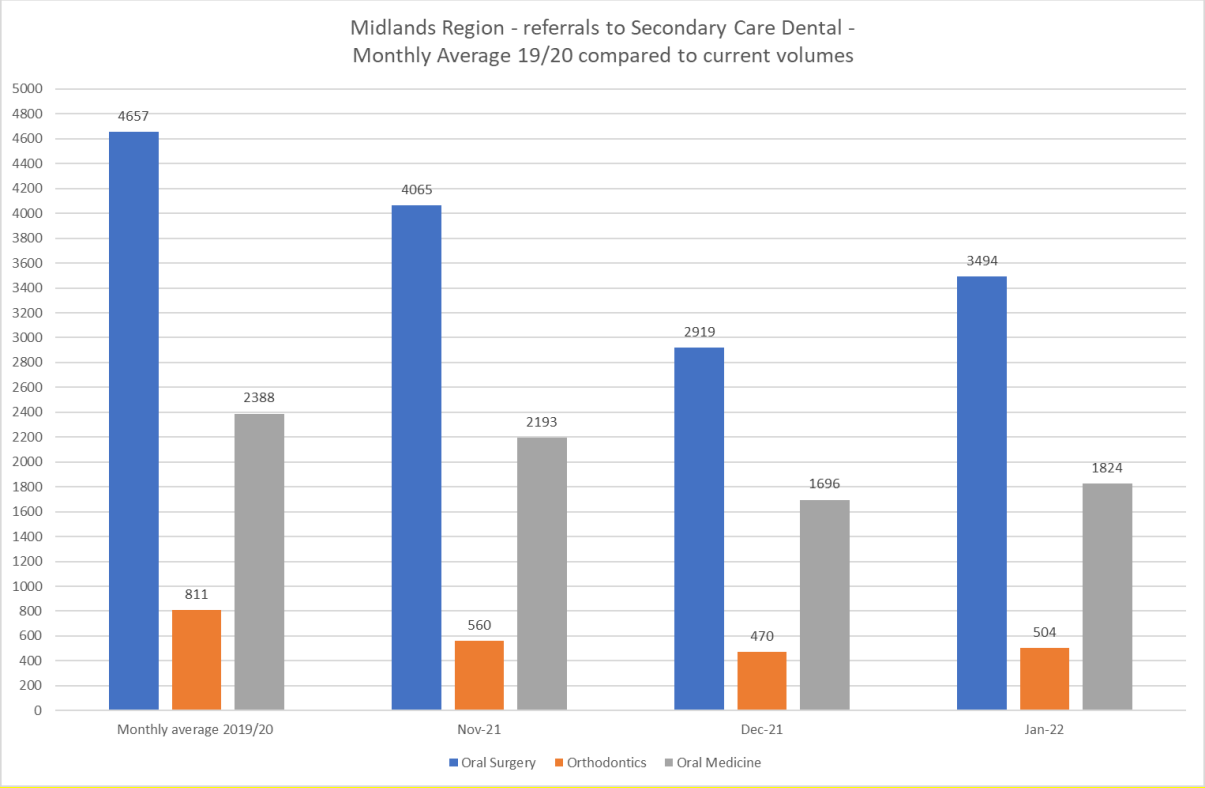
Note – the increase in 52-week waiters in April is largely due to a change in reporting process whereby maxillofacial surgery data was included for the first time. The proportion of the total waiting list that have been waiting 52 weeks or more has fallen from 19 per cent to 10 per cent between March 2021 and February 2022.

At the current time data cannot be split to report for LLR.





Appendix 4: Midlands Secondary Care Dental Referral Trends



Appendix 5: Oral Health Improvement activities across Leicester, Leicestershire and Rutland led by local authority Public Health teams

Healthy Teeth, Happy Smiles! – Leicester City Council

Leicester City Council has the overall statutory responsibility for public health, and this includes oral health. The Council is also responsible for commissioning dental epidemiology surveys and delivering oral health promotion.

Due to Leicester having the highest rates of tooth decay for 3-year olds (2013) and 5 year olds (2012), improving children's oral health was made a priority in Leicester. In September 2013, Leicester City Council established the Oral Health Promotion Partnership Board (OHPPB) to facilitate and coordinate responsibilities and activities for improving oral health across partner organisations. The OHPPB developed Leicester's early intervention programme Healthy Teeth, Happy Smiles! (HTHS!). The OHPPB has an action plan which includes the development and progression of HTHS! resources and activities aimed at adults and children.

Examples of work of the service are:

- A universal supervised toothbrushing programme for 0-5 years children in pre-school and primary school settings. Figure 54 and 55 (below) show the proportion of settings in each ward that are currently taking part in the programme. During the COVID pandemic, PHE recommended ceasing supervised toothbrushing programmes nationally. In August 2020, PHE released updated infection prevention and control guidance that would allow settings to re-start supervised toothbrushing as appropriate. The team has been supporting settings to re-start supervised toothbrushing in a risk assessed environment, offering virtual re-trainings and refreshers for staff.
- HTHS! Dental Practice Accreditation scheme, where dental practices who demonstrate a commitment to prevention are awarded with the HTHS! kitemark. As of December 2019, there were 12 practices with full HTHS! accreditation.
- The Smile Early Years Award accreditation enables early years settings to be awarded with an accreditation for completing a portfolio of work showing their commitment to oral health promotion, healthy eating and general wellbeing in the early years setting. Currently, seven settings are working towards their Bronze accreditation, six have achieved their Bronze accreditation and five of those are working towards their Silver.
- Various oral health promotion activities/campaigns including National Smile Month, Mouth Cancer Action Month and a year-round city-wide baby bottle swap scheme.
- Free multi-agency oral health training sessions for the health and care workforce
- The provision of 4 oral health packs in the first 5 years of life is embedded into the Healthy Child Programme. During the COVID pandemic when the health visiting service could not conduct face to face support, oral health packs were posted to children for the 1 year and 2-year check, including toothpaste, toothbrush and information for parents.

The service also supports work for adults' oral health including support for adults living in care homes.

Leicestershire and Rutland

Oral Health Improvement activities within Leicestershire and Rutland are currently focussed mainly on Early Years. However, with the additional funding from NHS E/I, the reach can be extended further. The LLR ICB footprint has received £150,000 for a period of 2 years to support oral health improvement initiatives and activities. At the last Oral Health Promotion Partnership Board, it was agreed the money would be spent on a number of initiatives including increasing the capacity to develop a care homes oral health education offer, support for Making Every Contact Count, developing information on oral health for people with diabetes and assessing feasibility of community fluoride varnish initiatives. The LLR ICB footprint has also received £40,000 non recurrent funding to support purchase and distribution of toothbrushing packs to food banks and other venues which the oral team promotion teams are sourcing a provider for. Described below as this encompasses oral health improvement activities.

Supervised Toothbrushing (STB)

- STB is offered to all Early Years settings within Leicestershire. This is an evidence-based intervention. Resources are also provided to these settings, as well as ongoing support and training.
- The STB programme is tied in closely with the Leicestershire Healthy Tots accreditation programme (https://www.leicestershirehealthytots.org.uk/oral-health)

Multiagency Training

- Multiagency training is provided to those working with families and young children, including health visitors and early years staff.
- Lately demand has increased, therefore an eLearning package is currently in development which will sit on the Healthy Tots website.
- Face to face training will still be available for targeted settings and areas.

Resources

- The Leicestershire Oral Health Improvement Team provide a range of resources targeted at Early Years Professionals and Parents and Carers - https://www.leicestershirehealthytots.org.uk/oral-health-resources
- Toothbrush packs are provided for all children within Leicestershire by their Health Visitor.
- An extensive resource catalogue is available for early years professionals to 'loan' resources for use within their settings. https://www.leicestershirehealthytots.org.uk/oh-resources-for-early-years-prof
- The resource catalogue is currently being digitised to give an improved service for early years professionals.

Campaigns

- Several campaigns are focussed on during the years including National Smile Month, Mouth Cancer Awareness Month and Fizz Free Feb.
- Additionally, working with foodbank volunteers to further and support them in their knowledge of key oral health messages and access to dental services (including the NHS low income scheme). MECC videos, hosted on the Healthy Conversation Skills website, will be produced to support having health conversations instead of the transfer of toothbrushes being only transactional.

Healthy Child Programme

Health visitors have an important role in providing advice and support as part of the healthy child programme. Health Visitors provide oral health advice and support and signpost to dental service If appropriate. Key touch points help identify families that need additional support for example, dental services the siblings of children who have attended hospital for dental extractions due to tooth decay or encouraging dental attendance when the first tooth erupts at 6 months of age, to enable the dental teams to give preventable messages.

Appendix 6: Examples of tweets shared by the NHS England Communication Team

Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee

27 June 2022

LLR ICS Transition Programme Update

Background

1. In April, the Health and Care Act 2022 completed the parliamentary process and received Royal Assent putting Integrated Care Systems onto a statutory footing with the establishment of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), known locally as the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership.

2. ICBs are statutory NHS organisations responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. When ICBs are legally established with effect from 1 July 2022, Clinical Commissioning Groups (CCGs) will be abolished.

3. The vision for greater integration was laid out in the Five Year Forward View and then the NHS Long Term Plan in 2019. The Bill builds on this, whilst also incorporating valuable lessons learnt from the pandemic to benefit both staff and patients.

4. A Leicester, Leicestershire and Rutland ICS Transition Programme was established in 2020 to ensure:
    - The three LLR CCGs were legally and safely closed overseeing the safe transfer of people (staff) and property (in its widest sense) to integrated care boards (ICBs); and
    - Ensure that the legal and operationally critical elements are in place ready for the establishment of the NHS LLR ICB as a statutory body on 1 July 2022.

5. The LLR ICS Transition Assurance Committee has met monthly to provide assurance to the shadow NHS LLR ICB that the programme to transition the system to statutory status on 1 July 2022 is sufficient and robust.

6. Highlight reports from the LLR ICS Transition Assurance Committee have been shared in progress updates at the monthly NHS LLR ICB and LLR CCGs Governing Bodies meetings in Common, with all members being asked to note progress.

7. This paper provides the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee (JHSC) with an update on progress towards the establishment of a statutory Integrated Care Board by 1 July 2022. The paper contains detail on:
    - System preparedness
    - Key appointments
    - Governance arrangements for the ICB and ICS

System Preparedness

8. The system has been preparing using the Readiness to Operate Statement (ROS), a high-level statement to confirm that all legally required, and operationally critical elements are in place ready for the establishment of each ICB as a statutory body on 1 July 2022.

9. The statement is underpinned by a checklist that includes reference to due diligence work required to ensure the safe and legal close of the three CCGs and assurance of the transfer activity for the newly established ICB.

10. LLR has worked closely with NHSEI to manage the ICB transition sharing evidence and progress at agreed review checkpoints, further developing progress based on feedback and system requirements.

11. There are 12 priority areas within the checklist with key supporting elements that are required and once complete LLR will receive approval to proceed. Table 1 lists the 12 areas and their status as per the June 2022 submission:

Table 1 ROS Checklist Priority Areas

Ref	Description	Final RAG Rating at June 2022
1	Integrated care partnership (ICP): **Initial ICP arrangements and principles agreed**	Completed
2	Integrated care board (ICB): **Designate appointments to the Board of the ICB made and Board quorate in line with relevant guidance**	Completed
3	System development plan, ICB constitution and governance arrangements: **System Development Plan, ICB constitution and governance arrangements in place**	Completed
4	Provider partnerships: **Provider partnership arrangements agreed**	Completed
5	People and culture: **People function ready for operation**	Completed
6	Quality, safety and Emergency Preparedness, Resilience and Response (EPRR): **Quality, safety and EPRR systems and functions ready for operation**	Completed
7	Clinical and care professional leadership: **Model / arrangements prepared**	Completed
8	Working with people and communities: **Public involvement and engagement strategy / policy**	Completed
9	NHS oversight and ways of working: **NHS oversight and ways of working between NHS England and NHS Improvement regional team and ICB**	Completed
10	Finance and planning: **Planning for 2022/23 developed in line with national requirements and finance function and systems ready for operation**	On target for delivery by 1 July
11	Data, digital and information governance: **Systems ready to operate and information governance activities on target**	On target for delivery by 1 July
12	Transition from CCGs to ICBs: **Equalities duties complied with, due diligence of people and property complete, consultation completed in line with Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) requirements / The Cabinet Office**	Completed

	Statement of Practice (COSoP guidance), staffing and property lists prepared and first day arrangements confirmed	

12. On 30 May 2022 LLR received feedback on the 20 May 2022 ROS assessment submission from NHSEI. The feedback set out the key actions and additional evidence required for the final ROS assessment on 10 June 2022. All the key points and actions were addressed and included within the 10 June 2022 submission, and wider system development feedback was noted.

13. On 1 June 2022 LLR CCGs AO provided written assurance to the ICS Chair (designate), with a copy to NHSEI's Regional Director that due diligence processes had been completed.

14. On the 10 June 2022 LLR submitted their final ROS and checklist signed by the ICB Accountable Officer (designate).

15. On the 17 June 2022 NHSEIs Regional Support Group will review and recommend ICS establishment readiness to enable the NHSEI Regional Director to sign each ICS Readiness to Operate Statement.

16. The inaugural NHS LLR ICB meeting will be held on 1 July 2022 whereby members will be requested to endorse, adopt and/or approve all new and adopted strategies, policies and governance arrangements and other necessary documentation to finalise the ICB establishment.

17. Property and Staff Transfer Schemes will transfer their assets and liabilities, with staff transferring into the NHSLLR ICB on 1 July 2022 under a legal Transfer under Protected Employment Rights (TUPE).

18. The new Constitution and Governance Handbook will set out the governance framework within which the ICB will operate.

19. Policy and strategy adoptions will ensure continuity, whilst a programme of consolidation takes place. This will ensure the strategy and policy frameworks of the legacy CCGs for those staff and registered populations to which they apply, will continue until such time as consolidation is completed, successor documents are approved, or they are no longer required.

20. The former LLR CCGs Audit Committees and Governing Bodies will close their final business in June 2022.

Key Appointments

Committee Appointments

21. The proposed NHS LLR ICB membership is as follows. Further details will be included on the ICS website on 1 July 2022.

    - David Sissling, Chair
    - Andy Williams, Chief Executive Officer

- Darren Hickman, Non-Executive Director, Audit and Risk
- Simone Jordan, Non-Executive Director, Remuneration and People
- Professor Azhar Farooqi, Non-Executive Director, Equalities and Communities
- Pauline Tagg, Non-Executive Director, Quality
- Richard Mitchell, NHS Trust Partner Member
- Angela Hillery, NHS Trust Partner Member
- Professor Mayur Lakhani, Clinical Executive Lead
- Martin Samuels, Partner Member, Leicester City Council
- Mark Andrews, Partner Member, Rutland County Council
- TBC, Partner Member, Leicestershire County Council
- TBC, Partner Member, Primary Care
- Nicci Briggs, Chief Finance Officer
- Dr Nilesh Sanganee, Chief Medical Officer
- Dr (Hon) Caroline Trevithick, Chief Nursing Officer
- Alice McGee, Chief People Officer
- Sarah Prema, Chief Strategy Officer
- Rachna Vyas, Chief Operating Officer

22. With regard to representation on the LLR ICB and Health and Wellbeing Partnership, nominations for membership of the ICB have been requested. (At the time of writing confirmation of the Leicestershire County Council Partner Members is awaited). The three Health and Wellbeing Chairs will be invited to attend the meetings of the Board and contribute to discussions. It has been proposed that a limited number of areas which the Health and Wellbeing Partnership (ICP) might focus on in its first phase of operation. These will be those which can, distinctively, be best addressed at an LLR level. This will avoid the risk of duplicating work which can and should be progressed at Place. Initially the Health and Wellbeing Partnership will be constituted with limited membership to include David Sissling, ICB Chair, three Local Authority representatives, the two Directors of Public Health and Andy Williams, ICB CEO. In the first instance, there will be a meeting of the three Health and Wellbeing Boards to discuss and approve the list of priorities. The Health and Wellbeing Boards will be asked to discuss and agree membership of the Health and Wellbeing Partnership that will meet three or four times a year with one of these being the full Health and Wellbeing Board membership.

Executive Appointments

23. The Executive management structure is in place and recruited to including designate ICB members.

24. A copy of the ICB leadership structure including details of executive portfolios can be found in Appendix 1. This includes reference to the mandatory SRO roles for board level functions of people, digital and data, emergency planning, safeguarding and special educational needs and disabilities (SEND) and for children and young people's services as well as relating to key ICB functions such as quality, performance, strategy and planning.

Governance arrangements for the ICB and ICS

25. The LLR Integrated Care System (ICS) provides an excellent opportunity to further develop collaboration and joint working in health and care. The attached Functions and Decision-Making Map provides further detail (Appendix 2).

26. The Integrated Care Board (ICB) will be the formal statutory NHS organisation and operational decision-making board for NHS resources across the system (including place and neighbourhood), whilst Cabinet/ Executive are the decision-making boards for the respective local authority resource at place.

27. There is an emerging consensus that the ICP locally should focus on the health, care and wellbeing of the LLR population overall and not be hierarchically 'above' the Health and Wellbeing Boards. Instead, the ICP should be the partnership board that operates on a system or LLR footprint. It is also the driver for the development of the system-wide Integrated Care Strategy which is due early December 2022.

28. The Health and Wellbeing Boards (HWBs) are the statutory partnership boards that operate on a place footprint and will have crucial role in bridging the collaborative work between system and place. The Health and Wellbeing Boards also have delegated authority to sign of the Better Care Funds for each place.

29. On 1 July 2022 (10.00 – 11.30am) the inaugural NHS LLR Integrated Care Board meeting will be held. NHSEI will have brought into effect the Constitution and Standing Orders through the establishment order and formal business will be transacted.

Recommendations

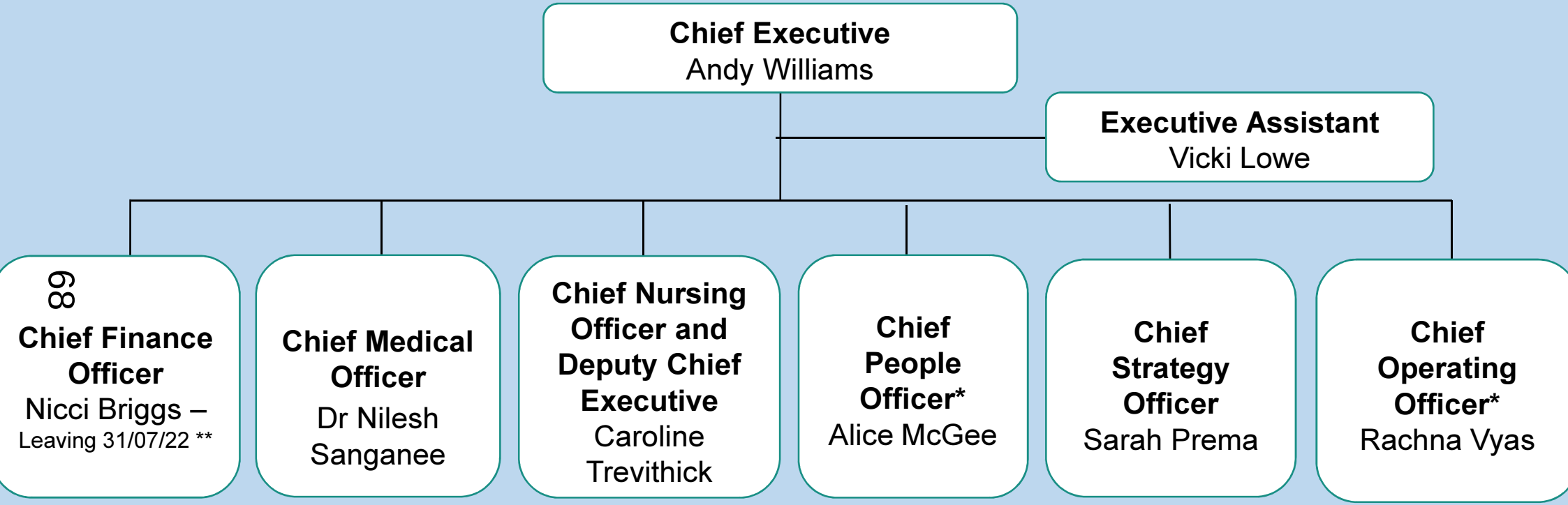
30. The Joint Health Overview Scrutiny Committee (JHOSC) is asked to:

- **NOTE** progress of the LLR ICS transition programme.

LLR Integrated Care Board Appointments

Appendix D

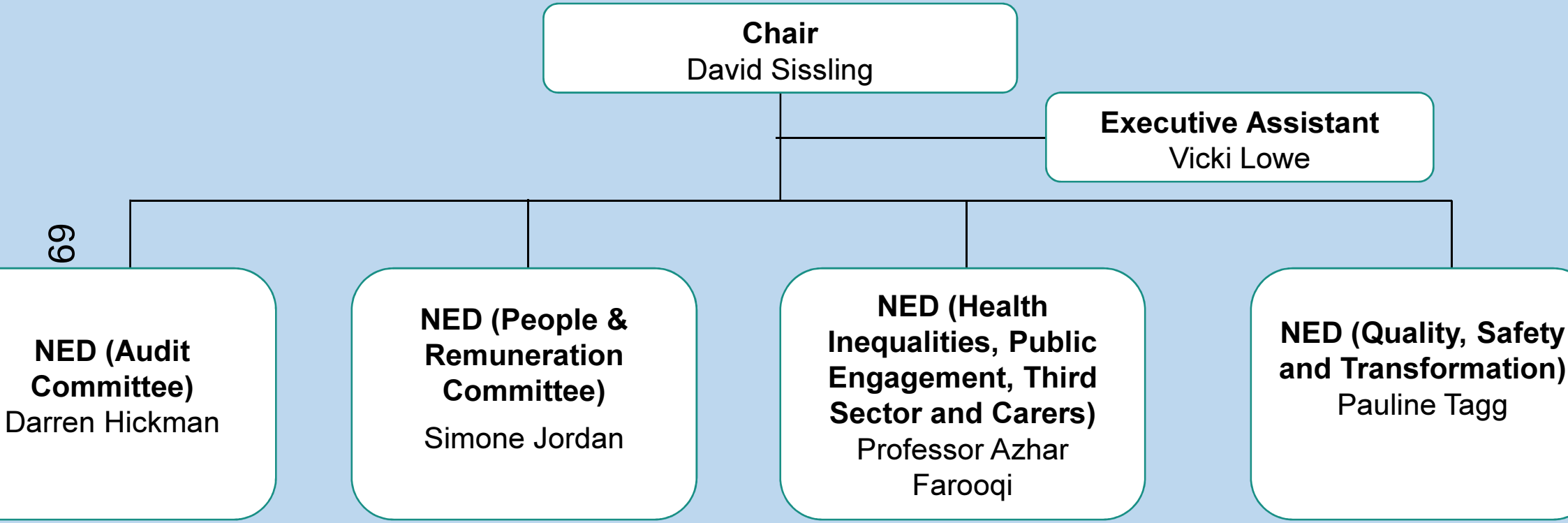
LLR Integrated Care Board Leadership Team



lon-voting member

Plans in place to recruit interim to commence ideally mid-July and permanent replacement following that

LLR Integrated Care Board Non Executive Members



Portfolios

Role	Postholder	Portfolio
Chief Finance Officer	Nicci Briggs	• Financial leadership and financial performance • Contracts and Procurement • Corporate Governance • Information Governance • SIRO
Chief Medical Officer	Dr Nilesh Sanganee	• Clinical Strategy & Leadership • Clinical and Professional Leadership Model • Research and Development
Chief Nursing Officer	Caroline Trevithick	• Deputy ICB CEO • Clinical Strategy & Leadership • Caldicott Guardian • Quality assurance / improvement • Safeguarding • Medicine's Optimisation • Performance Improvement • Personalisation • Vaccinations
Chief People Officer	Alice McGee	• Innovation • Digital Enablement including CIO • Communications and Engagement • People (HR and OD) • System People Plan • Primary Care Workforce
Chief Strategy Officer	Sarah Prema	• Strategic Plans & Policies • Business Intelligence • Joint / Delegated Commissioning • Operational Commissioning • Estates
Chief Operating Officer	Rachna Vyas	• Primary and Community Integration • Primary Care • CYP & Maternity • Long Term Plan delivery – transformation and resilience • Emergency Preparedness, Resilience and Recovery (EPRR) • Elective Care and Cancer Services • All age MH, LD, Autism and Dementia

Functions

Function	Responsible Officer
SRO (CIPD accredited or equivalent experience) to have clear leadership and accountability for the ICBs role in delivering agreed local and national people priorities	Alice McGee
SRO to have clear leadership and accountability for Data and Digital	Alice McGee
Board Level EDI representative	Alice McGee
Caldicott Guardian for the ICB	Caroline Trevithick
SIRO for the ICB	Nicci Briggs
Accountable Emergency Officer (AEO) for EPRR	Andy Williams
SRO for Adults and Children's Safeguarding	Caroline Trevithick

DRAFT

Leicester, Leicestershire and Rutland Integrated Care System (ICS): Functions and Decisions Map

(v13, 31 May 2022)

Version control: v13, 31 May 2022 / DKB (status: draft document, to be finalised by June 2022)

Requirement: To develop a functions and decisions map showing the arrangements to support good governance.

It should provide an overview of where decisions are taken across the ICS, it should outline roles of different committees / partnerships and has to be easily understood.

Content: Content is draft at present and continues to be informed by:

- Legislation, guidance and national requirements..
- Discussions taking place through the development of the ICB Constitution with ICB Chair and CEO for ICB governance arrangements.
- Arrangements at “place” reflect existing forums.

LLR Integrated Care System: planning, partnerships and delivery (key functions and roles)

Residents and local population

Statutory Body

Health and Wellbeing Boards

- Joint Strategic Needs Assessments and development of Joint Health and Wellbeing Strategies for each respective area.
- Population health management at place.
- Planning and improvement of health and care.
- Develop strong connection with place(s).
- Operates at place level, can also operate at system level.

Statutory Committee

LLR Health and Wellbeing Partnership

(i.e. the Integrated Care Partnership)

- Develop an integrated care strategy covering health and social care needs of population informed by JSNA. Does not commission services.
- Champion inclusion and transparency and demonstrate progress in reducing inequalities and improving outcomes.
- Agree collective objectives and outputs at system level.
- Influence wider determinants of health including creating healthier environments and inclusive and sustainable economies
- Bring the statutory and non-statutory interests of places together.
- Promote mobilisation of resources and assets in the community and system and across place-based partnerships.
- Support the Triple Aim (better health for everyone, better care for all and efficient use of NHS resources).

Two-way communication /interface and influence

Statutory ICS

Statutory Body

NHS LLR Integrated Care Board

- Develop plan to meet health and healthcare needs of population informed by partnership's strategy and by JSNA.
- Secure collaboration within the NHS and at the interface of health and local government.
- Responsible for NHS resource allocation to deliver the plan across the system.
- Arrange provision of health services in line with allocated resources across the ICS.
- Establish joint working arrangements with partners.
- Hold the NHS bodies within LLR to account.
- Fulfil functions delegated from NHS E/I.
- Lead system implementation of:
  - people priorities including delivery of the People Plan
  - Data and digital.
  - Estates, procurement, supply chain and commercial strategies to maximise value for money
  - Emergency Preparedness, Resilience and Response
- Population Health intelligence
- Economic development and environmental sustainability

Locally established

Collaboratives

- Partnership arrangements involving NHS providers working at scale across system and / or across multiple places with a shared purpose.
- Build broader coalitions with community partners to transform, promote health and wellbeing and reduce unwarranted variation and inequality in health outcomes, access to services and experience.

Accountability

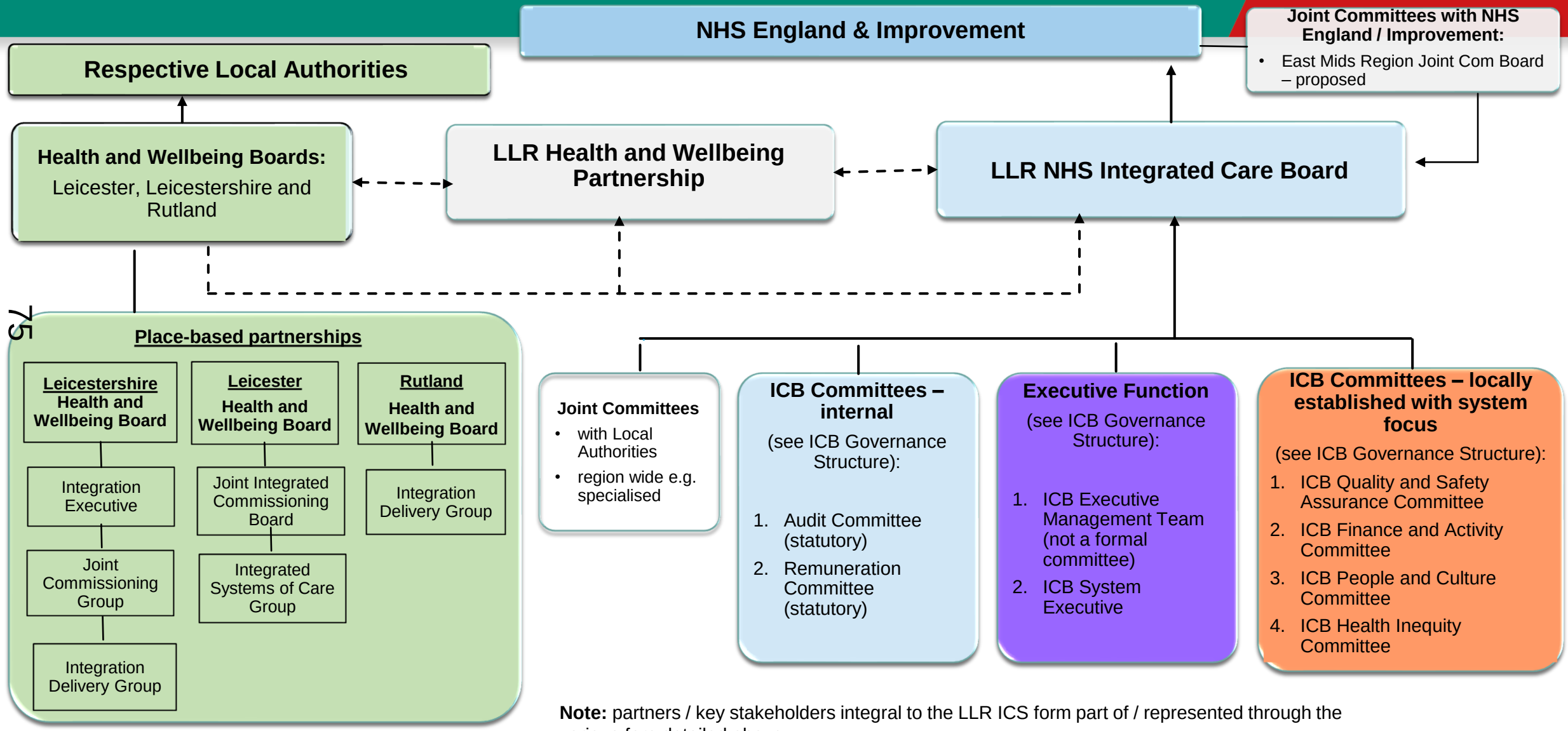
Place-based partnerships

- Delivery at place.

Accountability

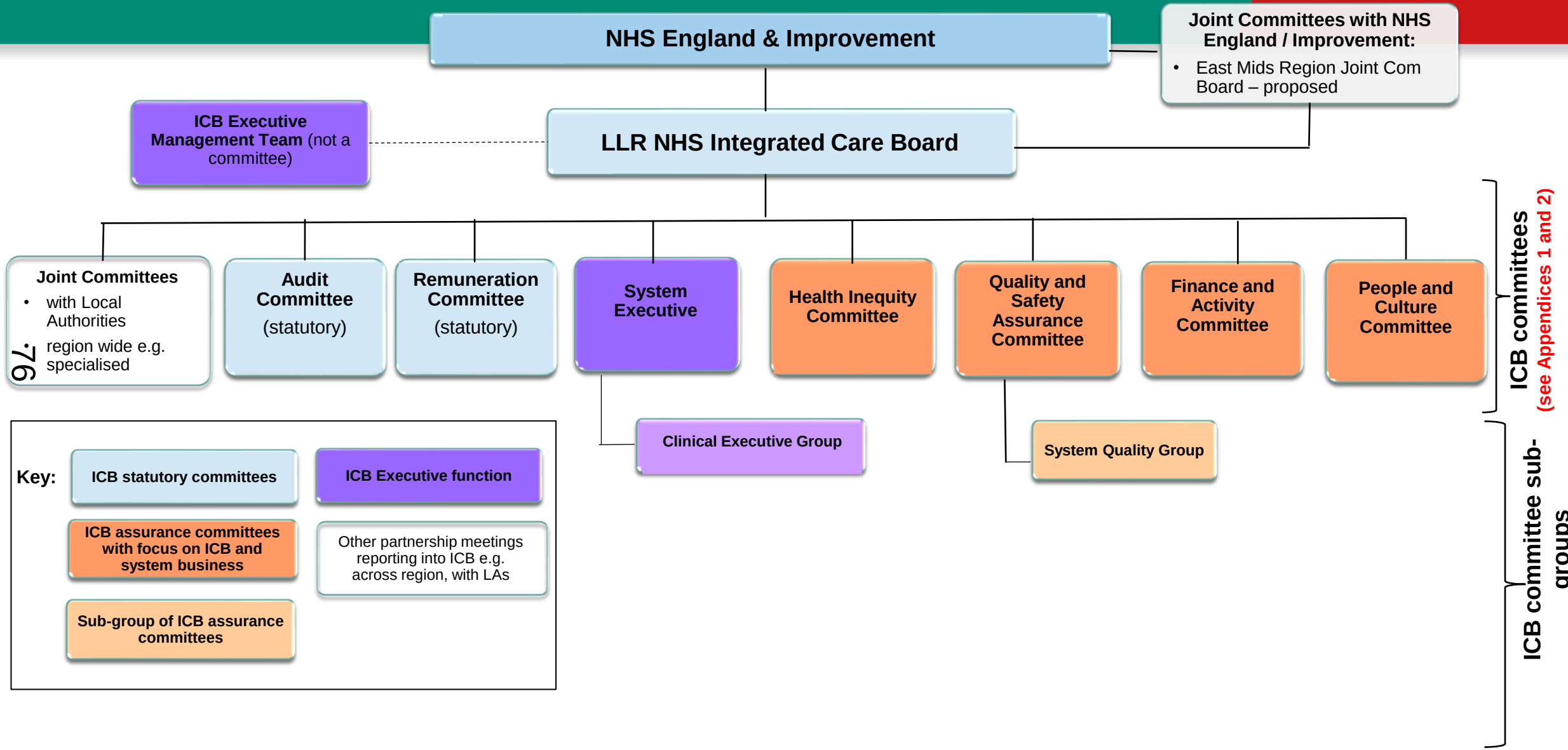
Defining need for place → Aggregating need at system level → Defining healthcare needs and responsibility for commissioning health care → Delivery

LLR Integrated Care System: interface and accountability



Note: partners / key stakeholders integral to the LLR ICS form part of / represented through the various fora detailed above.

LLR Integrated Care Board governance structure



Appendices

APPENDIX 1: SUMMARY OF STATUTORY AND INTERNAL COMMITTEES

Committee / group	Responsible for…
Integrated Care Board (Board of the statutory Body)	• Responsible for developing a plan and allocating resource to meet the health and healthcare needs of the population. Establishing joint working arrangements with partners that embed collaboration for delivery. Establishing governance arrangements to support collective accountability for whole-system delivery and performance. Arranging for the health provision of services including contracting arrangements, transformation, working with local authority and partners to put in place personalised care for people. Leading system implementation of people priorities including delivery of the People Plan and People Promise. Leading system-wide action on data and digital. • Scheme of Reservation and Delegation determined by the ICB Board, has overarching financial authority. • Delegations as from NHS England.
Audit Committee (Statutory)	• Providing ICB with independent and objective review of adequacy and effectiveness of internal control systems including financial information and compliance with laws, guidance and regulations governing the NHS. • Delegation in relation to Annual Report and Accounts and governance related policies in line with SORD.
Remuneration Committee (Statutory)	• Pay policy, terms of service and remuneration. Review remuneration for CEO, executive directors and clinical leads (outside of pay arrangements set at a national level). Oversee contractual arrangements for staff. • Approve remuneration for executive members (except Chief Executive) and clinical leads.

APPENDIX 2: SUMMARY OF COMMITTEES WITH SYSTEM FOCUS

Committee/Group	Responsible for…
System Executive Team	Executive and management responsibilities. Development of system strategy, planning and finance. Oversight of system performance and manage the day-to-day delivery of NHS services at system level with support from Collaboratives, Clinical Executive and other such groups. Financial delegation to be proposed **approx. up to £20m** for approval of healthcare procurement and contracts over term of contract following approval of the Operational and Financial Plan by the Board. Membership to include: - ICB EMT members - SROs for various collaboratives - UHL and LPT CEOs
Finance and Activity Committee	• Scrutiny of the delivery of a robust, viable and sustainable system financial strategy and plan. • Oversight of payment policy reform and oversight of reporting of placed based allocations and provider collaborations. • Provide assurance on the system's current and forecast financial position and recovery plans to address any challenges. • Oversight of system capital plans and monitoring and forecasting for onward assurance.
Quality and Safety Assurance Committee	Development of system quality, performance improvement and assurance strategy. Provide assurance on quality, safety, performance improvement, patient engagement, patient experience, patient and public involvement, and the personalisation of care. Monitor quality, safety and performance risks at and receive assurance in relation to mitigations and improvement plans. Approval of clinical pathways and clinical policies. **Sub-groups:** System Quality Group will be a key sub-group a requirement set out by the National Quality Board.
People and Culture Committee	Details to be confirmed
Health Inequity Committee	Details to be confirmed

Appendix E

Leicester, Leicestershire and Rutland Joint Health and Overview Scrutiny Committee

27th June 2022

Progress on Ockenden Immediate and Essential Actions (IEA's) following the publication of the Interim Report (December 2020)

Introduction

This report is to provide the committee assurance that the LLR Local Maternity and Neonatal System (LMNS) has addressed the immediate and essential actions in relation to the Interim Ockenden Report [1]published in December 2020 (Part 1). UHL as the maternity provider has worked closely with system partners and the regional NHSE/I team to submit substantial evidence for assessment and provide confidence in compliance.

The evidence required had to be submitted via a portal by June 2021 and assessed externally, progress was monitored through the monthly LMNS for LLR. The regional team then provided each LMNS and provider Trust with the outcome of compliance. This report will provide a summary of achievement against the immediate and essential actions and provide next steps with the Final Ockenden report [2]Published in March 2022.

Whilst continuing to work through and embed the 7 EIA's from Ockenden (Part 1), we are also preparing to assess ourselves against a further 15 IEAs published in the final Ockenden report (Part 2) on the 31st of March 2022. These actions complement and expand upon the initial IEA's published in the first report as well as new actions. Further details around our plans can be found in Appendix A.

Background

In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

This independent maternity review was to focus on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE) (grades 2 and 3) and other severe complications in mothers and new-born babies. In addition, a small number of earlier cases have emerged these are being reviewed by the independent team wherever medical records are available.

[1] Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. Our First Report following 250 Clinical Reviews (Dec 2020) www.gov.uk/official-documents.

[2] Findings, conclusions, and essential actions from **The Independent Review of Maternity services** at The Shrewsbury and Telford Hospital NHS Trust, Our Final Report (March 2022) www.gov.uk/official-documents.

The total number of families to be included in the final review and report is 1,862. The first interim report was published arising from 250 cases reviewed. The number of cases considered to that point so far included the original cohort of 23 cases.

The review panel identified important themes which must be shared across all maternity services as a matter of urgency and have formed **Local Actions for Learning** within Shrewsbury and Telford Hospitals and make early recommendations for the **wider NHS Immediate and Essential Actions** (IAE).

Findings from the report

Below is a brief summary of some of the findings from the interim report that led to the development of the essential and immediate actions for all maternity services nationally.

Review of the Trust's maternity governance processes:

- Inconsistent governance processes for the reporting, investigation, learning and implementation of maternity-wide changes.
- Inconsistent multi professional engagement with the investigations of maternity serious incidents.
- In some serious incident reports the findings and conclusions failed to identify the underlying failings in maternity care.
- Lack of objectively in Serious incident reviews and a lack of consideration of the systems, structures and processes in the reports.
- Limited evidence of feedback to staff following incident review.
- There were examples of failure to learn lessons and implement changes in practice such as in the selection of, or advice around, place of birth for mothers and management of labour overall. There was a failure to escalate concerns in care to senior levels when problems became apparent and continuing errors in the assessment of fetal heart.

It was also found that:

- Incidents not investigated in a timely manner and not investigated using a systematic and multi professional approach.
- Lack of evidence that lessons were learned and applied in practice to improve care.

Labour care and management of complex pregnancy:

- Women were not always risk assessed in a consistent manner that led to incorrect place of birth being identified
- Staff were not trained regularly and appropriately in assessment of fetal monitoring
- Risk assessments were not regularly carried out in labour
- The service did not always follow national guidance or have robust up to date local guidance in place. Where guidance was in place it was not always followed.

Multi professional training did take place however it was not consistent and often not recorded in a way that could provide evidence of completion and funding for essential training and backfill not always ring fenced or supported.

Trust Board did not always have oversight of serious incidents or concerns within the maternity service. Turnover of Executive leadership was shown to have impacted on organisational knowledge and memory.

This is a snapshot of findings from the report, the full report has been reviewed at length both within UHL and in the LMNS.

Immediate and Essential Actions to Improve Care and Safety in Maternity Services across England

1. Enhanced Safety

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g., through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

LMS must be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.

An LMS cannot function as one maternity service only.

The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda.

All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months.

2. Listening to Women

Maternity services must ensure that women and their families are listened to with their voices heard.

Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome

Each Trust Board must identify a nonexecutive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

CQC inspections must include an assessment of whether women’s voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership.

Maternity services must ensure that women and their families are listened to with their voices heard.

3. Staff training and working together

Staff who work together must train together.

Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.

Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

4. Managing Complex Pregnancy

There must be robust pathways in place for managing women with complex pregnancies through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

Women with complex pregnancies must have a named consultant lead.

Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.

The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.

This must also include regional integration of maternal mental health services.

5. Risk assessment throughout pregnancy

Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

6. Monitoring fetal wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on:

- Improving the practice of monitoring fetal wellbeing
- Consolidating existing knowledge of monitoring fetal well being

- Keeping abreast of developments in the field
- Raising the profile of fetal wellbeing monitoring
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.

The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.

They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.

The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle and subsequent national guidelines.

7. Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care.

Women's choices following a shared and informed decision-making process must be respected.

Current position in Leicester, Leicestershire and Rutland

Our self-assessment against the seven IEA's concluded that we are complaint for majority of actions and where gaps have been identified we have plans in place to address them.

Within the Seven Immediate and Essential actions there are forty-nine criteria to be met and the LMNS submitted one hundred and twenty-seven pieces of evidence to support compliance.

Some of the criteria are in progress but not embedded, these are detailed below:

IAE action 1

External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

The NHSE/I regional Midlands team has created a list of clinical experts from a number of Trusts, however with current clinical pressures in maternity services, releasing clinicians for external reviews is challenging. Currently in LLR, there external review from clinicians in the Quality team from the CCGS who join UHL perinatal risk and perinatal mortality meetings. This team also review any serious incidents declared and review draft and final reports from investigations.

Buddying arrangements are being finalised from two external LMNS's to join LLR LMNS meetings for oversight.

IAE action 2 Listening to Women

Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.

The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

The advocate role is being developed as a regional approach with NHS England oversight, devising a Job description that is consistent nationally, including training for advocates, who will be available for Trusts to engage when meeting with women and their families.

We continue to work closely with out MVP and Leicester Mamma's to ensure our pathways are co-produced in response. A recent example is the engagement of our service users in the co-production of our maternity equity and equality action plans.

IAE action 3 Staff Training and Working Together

Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.

One element of this action is particularly challenging, multidisciplinary Consultant led ward wards, night and day, seven days a week-UHL currently have not enough consultants to cover this, recruitment for obstetricians has been ongoing for some months with limited applications. Currently this is provided five days a week and once on a weekend, the evening ward round is discussed by telephone with the consultant on call.

Risks and challenges:

Risk: Staffing pressures at UHL (midwifery): Continue to remain extremely challenging.

Mitigation: Our workforce plan (Appendix A) includes retention, recruitment, and consideration of other roles to support the service acknowledging the national challenges around midwifery supply. The service is reviewing a shortened degree programme for midwifery. We are pushing ahead with our international recruitment and there is ongoing work in relation to recruitment and investment in obstetric staff to to discuss these plans further. Systems are in place within the Trust to review acuity and staffing throughout the day, to ensure safety at all times. Concerns around midwifery staffing have been raised and are on both the Trust and LMNS risk registers as high risk.

UHL maternity service with oversight from the LMNS will continue to provide the families within LLR with safe care, enhanced with listening to women's voices and caring for the staff within the service.

Summary and next steps

The LMNS in LLR had met a number of the actions prior to the interim Ockenden and has embedded and introduced further actions required, two of the three elements above are awaiting a regional response and UHL are actively trying to recruit the number of consultants required to extend delivery suite cover to enable the evening ward round to take place on weekends.

All processes introduced are monitored monthly through audit or spot checks to ensure the actions are continued and reported through the UHL clinical management group Governance board and through the LMNS.

The NHSE/I regional maternity team are visiting UHL maternity services with members from the LMNS in July to review the compliance with the Ockenden IAE actions and speak to staff and the members of the executive team.

NHSE/I have not yet issued the evidence they will require to support our assessment of the newly published 8 IEA's, however our early assessment (in anticipation of the release of Part 2) suggests we have steps in place. Following the formal publication of the final report in March this year we will reassess ourselves against the new 8 IEA's to help us understand progress and devise a plan to address any identified gaps. This will be reported to NHSE/I once they have released the criteria for assessment.

In addition to the above we understand the findings of the current inquiry led by Dr Kirk up into East Kent Maternity services are due to be published later this year. Our benchmarking exercise suggests that the service is overall compliant, with action plans in place where we have rated ourselves against actions we are progressing.

Recommendations

The Joint Health and Overview Scrutiny Committee is asked to:

RECEIVE and note contents of this report.

Maternity self-assessment tool

Leicester Maternity, March 2022

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Trust and CMG Organograms
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Triumvirate engagement – meeting papers
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		No JD for UHL Plan to appoint to DoM role
		Agenda for change banded at 8D or 9		HoM 8D
		In post		Have HoM not DoM
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		Trust organograms
		Clinical director to executive medical director		Clinical director reports directly to Medical Director
		DoM to executive director of nursing		HoM report directly to Chief Nurse
		General manager to executive chief operating officer		Head of operations reports directly to COO

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		UHL governance structure - maternity reports to TB through EQB and QOC every 3 months. Board reports are in place.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Monthly minimum data measures for TB paper
		There should be a minimum of three PAs allocated to clinical director to execute their role		Job description & work plan
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Clinical Management group structure
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		JD of HR lead Monthly board meetings Quarterly confirm and challenge meetings
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		JD of Head of Finance
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		Meeting plan
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		CMG & organisational structure
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		ToR and meeting papers

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		ToR and meeting papers
		Leadership culture reflects the principles of the '7 Features of Safety'.		
	Leadership development opportunities	Trust-wide leadership and development team in place		Evidence available from CMG education lead and UHL OD team
		In-house or externally supported clinical leadership development programme in place		
		Leadership and development programme for potential future talent (talent pipeline programme)		
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		UHL organogram
		Organisational vision and values in place and known by all staff		UHL strategy & values
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		UHL values, appraisals process and HR policies
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		Development of strategy in progress with key stakeholders
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		As above
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.		In progress

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		MVP ToR Patient experience feedback Co-production evidence (Ockenden)
		Maternity strategy aligned with trust board LMNS and MVP's strategies		As per strategy development above
		Strategy shared with wider community, LMNS and all key stakeholders		As above
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		JD for NED
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Monthly maternity safety staff meetings Bi-monthly Maternity Safety meetings with CN and NED
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		One held at each site in 2021 with MVP member and board level safety champion
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		TB papers (presented by NED)
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		Safety champion boards in clinical areas
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans		Quarterly audit day QI meetings eg IOL,CTG
		Record of attendance by professional group and individual		Attendance record

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recorded in every staff member's electronic learning and development record		Electronic training records (HELM) Appraisals
	Multi-professional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		Education lead HELM
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		TNA, Education lead
		All staff given time to undertake mandatory and job essential training as part of working hours		Staff rotas
		Full record of staff attendance for last three years		Education team data base & Helm
		Record of planned staff attendance in current year		HELM
		Clear policy for training needs analysis in place and in date for all staff groups		UHL policy
		Compliance monitored against training needs policy and recorded on roster system or equivalent		HELM Maternity Quality Board papers
		Education and training compliance a standing agenda item of divisional governance and management meetings		Agendas – internal meetings & LMNS
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		MDT training programs TNA & appraisals
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		Job Descriptions

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	professional revalidation plan for staff	Compliance with annual appraisal for every individual		Due to Covid-19, compliance with appraisals lower than trust target 100% compliance with NMC revalidation
		Professional validation of all relevant staff supported by internal system and email alerts		Emails from HR
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Formally at appraisal Ongoing support from line managers
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		Meetings are set times/days each month. E-mails/posters
	Multi-professional clinical forums	HR policies describe multi-professional inclusion in all processes where applicable and appropriate, such as multi-professional involvement in recruitment panels and focus groups		Not explicit in UHL policy however maternity practice is in line with standard
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Recruitment policy & process
		Multi-professional inclusion in clinical and HR investigations, complaint and compliment procedures		HR policies & examples from practice
		Standard operating procedure provides guidance for multi-professional debriefing sessions following clinical incidents or complaints		No SOP however debriefs occur supported by MDT & PMAs
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		Locally led by PMAs UHL TRiM support

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule of attendance from multi-professional group members available		These sessions are confidential however in practice they are multi-professional
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi-professional attendance.		MVP ToR & meeting papers
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		MVP representation at Maternity Quality Board & LMNS
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Development of strategy in progress which captures current QI workstreams
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		As above, QI programs in practice to be captured in overarching plan
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		As above (QIP)
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Achieved through LMNS, MVP, ICS QPIAC (quality board)
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Evidence available but need to ensure robust organised process in place
		Clear communication and engagement strategy for sharing with key staff groups		Governance reporting structure Monthly maternity safety newsletter & e-mails
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		As above (QIP)

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Weekly/monthly scheduled multi-professional safety incident review meetings		PRG/PMRT ToR and papers
	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		Developing Time to Train quarterly safety meetings to incorporate wider MDT & LMNS and include specific maternity focus
		Positive and constructive feedback communication in varying forms		Written, verbal and Facebook pages for shared learning
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Matrons contact lead PMA to arrange staff debriefs following incidents More work required for reporting and feeding back good outcomes
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		PMA hold debrief and RCS sessions for all staff. TRIM practitioners available in every area for clinical support. Learning shared in QUAIL and safety newsletter as well as unit meetings
		Schedule of focus for behavioural standards framework across the organisation		
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		Trust Friday Focus Trust values
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		Evidence via HR meetings that inappropriate behaviour corrected. Appropriate MhPPS is followed accordingly for consultant body

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		All policies and procedures align with the trust's board assurance framework (BAF)		UHL policy
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		Risk Management policy
		Staff across services can articulate the key principles (golden thread) of learning and safety		Exec walkabout feedback
		Staff describe a positive, supportive, safe learning culture		Freedom to speak up guardian actively utilised within the service.
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		Risk management policy
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		ToR All membership in place.
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Risk Management Policy
		Team capacity able to meet demand, eg risk register and clinical investigations completed in expected timescales		Risk assessment and actions to support capacity
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		UHL Risk Management Policy includes BAF

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		As above
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Governance structure Board reporting template ready for use by Trust Board
		Mechanism in place for trust-wide learning to improve communications		UHL learning bulletins from SI's Monthly safety bulletin
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Local examples in safety and learning bulletins
		Governance communication boards		Clinical area Hot Boards
		Publicly visible quality and safety board's outside each clinical area		Clinical area Hot Boards
		Learning shared across local maternity system and regional networks		EMCN MatNeo LLS Neonatal ODN
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Meeting ToR & papers e.g. LMNS, Midlands HoM meetings, EMCN
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Trust communication strategy being developed
		Multi-agency input evident in the development of the maternity specification		Completed jointly with CCG
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Approved at LMNS and reviewed by provider contract team
		In date and reflective of local maternity system plan		Due for review

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Full compliance with all current 10 standards submitted		Achieved CNST year 3
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Not applicable - action plan not required for year 2 and 3 as compliant
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		LMNS & EQB ToR
		Clear process for multi-professional, development, review and ratification of all clinical guidelines		Guideline meeting ToR & papers
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multi-professional meetings for a rolling 12 months programme.		Dates for monthly guideline meetings
		All guidance NICE complaint where appropriate for commissioned services		Guideline meeting ToR & papers
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		Guideline meeting ToR & papers
		All five elements implemented in line with most updated version		Guideline meeting ToR & papers
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		Monthly safety dashboard CNST actions
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		Quarterly reports to national team Sign off by Trust Board
		All four key actions in place and consistently embedded		Achieved CNST year 3
	Application of the four key action points to	Application of equity strategy recommendations and identified within local equity strategy		In progress

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	reduce inequality for BAME women and families	All actions implemented, embedded and sustainable		We have embedded all four actions set out in the COVID document
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		JD & job plans
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		1PA for training lead who oversees fetal surveillance
		Plan in place for implementation and roll out of A-EQUIP		Monthly PMA meeting minutes
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Monthly PMA meeting minutes
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		Training programs available from PMA lead
		Service provision and guidance aligned to national bereavement pathway and standards		Bereavement guideline
	Maternity bereavement services and support available	Bereavement midwife in post		JD and job plans
		Information and support available 24/7		Bereavement team rotas & labour ward numbers Information for families
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Bereavement suites
		Quality improvement leads in place		Trust QI lead
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		QI projects in line with national transformation but not formally documented

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recognised and approved quality improvement tools and frameworks widely used to support services		Available via UHL QI hub
		Established quality improvement hub, virtual or otherwise		UHL hub and team
		Listening into action or similar concept implemented across the trust		Transformation hub and QI team UHL Quality Strategy
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		MatNeoSip ToR and papers
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy) – *in place, needs updating*		Maternity safety plan
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		Quarterly CMG Board and exec board papers
		FTSU guardian in post, with time dedicated to the role		FTSU JD and job plan
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		UHL have 3 leads in post
	Human factors training available	Human factors training part of trust essential training requirements		Helm training records
		Human factors training a key component of clinical skills drills		Training programs
		Human factors a key area of focus in clinical investigations and formal complaint responses		Fishbone used for RCAs including human factors

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.		Safety huddles in place with appropriate people
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		Monthly audits for care of high risk women & consultant ward rounds
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		In place
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		Safety huddles in practice, SOP being written
		Audit of compliance against above		Spot check audits
		Annual schedule for Swartz rounds in place		Trust schedule
	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time		Evidence from UHL wellbeing team
		Broad range of specialties leading sessions		As above

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Weekly senior clinical cabinet Weekly Friday focus
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Information shared by UHL comms team, e-mails
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		Conference dates & agendas
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		Trust board minutes
		In date business plan in place		CMG business plan
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		CMG business plan
		Business plan supports and drives quality improvement and safety as key priority		CMG business plan
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		CMG business plan Workforce papers
		Consultant job plans in place and meet service needs in relation to capacity and demand		Job plans
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		Job plans
		Business plans ensures all developments and improvements meet national standards and guidance		CMG business plan
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		CMG business plan
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		Business plans Compliant in practice

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		through maternity research team, innovation in JDs
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		UHL policy
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Diversity & deprivation work plans

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18

Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Results of Phase 2 Audit			UNIVERSITY HOSPITAL LEICESTER NHS TRUST		
RAG rating from national review team					
IEA	**Question**	**Action**	**Evidence Required**	**UNIVERSITY HOSPITAL LEICESTER NHS TRUST**	**Updates & Actions**
IEA1	**Q1**	Maternity Dashboard to LMS every 3 months	Dashboard to be shared as evidence.	100%	Further safety dashboards have been developed to monitor CNST & Ockenden standards
			Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken.	100%	
			SOP required which demonstrates how the trust reports this both internally and externally through the LMS.	100%	
			Submission of minutes and organogram, that shows how this takes place.	100%	
		Maternity Dashboard to LMS every 3 months Total		**100%**	
	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Audit to demonstrate this takes place.	0%	Evidence submitted June 2021 which demonstrates external reviews for SI's and also evidence where SI has been downgraded following external review. The need for agreement on the process for external reviews which supports regional maternity centres discussed at LMNS Oct 21, joint meeting planned 22/11/21 with Birmingham & Northampton. Request for update at LMNS meeting 1/3/22. Midlands Maternity Clinical Network are currently developing a team of experienced reviewers. Audit to be completed once process for external review agreed and implemented
			Policy or SOP which is in place for involving external clinical specialists in reviews.	100%	
		External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death Total		**50%**	
	Q3	Maternity SI's to Trust Board & LMS every 3 months	Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion	100%	
			Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed	100%	

			Submit SOP	100%	
		Maternity SI's to Trust Board & LMS every 3 months Total		**100%**	
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Audit of 100% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.	100%	
			Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance.	100%	
		Using the National Perinatal Mortality Review Tool to review perinatal deaths Total		**100%**	
	Q5	Submitting data to the Maternity Services Dataset to the required standard	Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.	100%	
		Submitting data to the Maternity Services Dataset to the required standard Total		**100%**	
	Q6	Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme	Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.	100%	audits planned for eligible cases - 2020/21 being completed Feb 22 2021/22 being completed April 22 by audit midwife
		Reported 100% of qualifying cases to HSIB / NHS Resolution's Early Notification scheme Total		**100%**	
	Q7	Plan to implement the Perinatal Clinical Quality Surveillance Model	Full evidence of full implementation of the perinatal surveillance framework by June 2021.	100%	
			LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.	100%	
			Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure.	100%	
		Plan to implement the Perinatal Clinical Quality Surveillance Model Total		**100%**	
IEA1 Total				**94%**	
IEA2	**Q11**	Non-executive director who has oversight of maternity services	Evidence of how all voices are represented:	100%	

			Evidence of link in to MVP; any other mechanisms	100%	
			Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed	100%	
			Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions	100%	
			Name of NED and date of appointment	100%	
			NED JD	100%	
		Non-executive director who has oversight of maternity services Total		**100%**	
	Q13	Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services	Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	Consultant midwife supporting the development of the MVP The MVP is currently being reviewed with the support of the CCG
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	
		Demonstrate mechanism for gathering service user feedback, and work with service users through Maternity Voices Partnership to coproduce local maternity services Total		**100%**	
	Q14	Trust safety champions meeting bimonthly with Board level champions	Action log and actions taken.	100%	Embedded system for communication of actions taken from concerns raised by staff in the monthly maternity safety bulletin "you said, we did" style
			Log of attendees and core membership.	100%	
			Minutes of the meeting and minutes of the LMS meeting where this is discussed.	100%	
			SOP that includes role descriptors for all key members who attend by-monthly safety meetings.	100%	
		Trust safety champions meeting bimonthly with Board level champions Total		**100%**	

	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
		Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. Total		**100%**	
	Q16	Non-executive director support the Board maternity safety champion	Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken	100%	
			Name of ED and date of appointment	100%	
		Non-executive director support the Board maternity safety champion Total		**100%**	
IEA2 Total				**100%**	
IEA3	**Q17**	Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year.	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	Monthly monitoring of training data through Quality Board & LMNS Included in CNST year 4 workstream
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data.	100%	
			Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session.	100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	
			Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	

		Multidisciplinary training and working occurs. Evidence must be externally validated through the LMS, 3 times a year. Total		**100%**	
	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)	100%	Consultant posts recruited to in order to achieve standard Audit required
			SOP created for consultant led ward rounds.	100%	
		Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward. Total		**100%**	
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Confirmation from Directors of Finance	100%	
			Evidence from Budget statements.	100%	
			Evidence of funding received and spent.	100%	
			Evidence that additional external funding has been spent on funding including staff can attend training in work time.	100%	
			MTP spend reports to LMS	100%	
		External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only Total		**100%**	
	Q21	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			Attendance records - summarised	100%	
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place.	100%	

		90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session Total		**100%**
	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)	100%
		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week. Total		**100%**
	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%
			LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data.	100%
		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place Total		**100%**
IEA3 Total				**100%**
IEA4	**Q24**	Medicine Centre & agreement reached on the criteria for those cases to be discussed and	implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has	100%
			SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway.	100%
		Links with the tertiary level Maternal Medicine Centre & agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre Total		**100%**

	Q25	Women with complex pregnancies must have a named consultant lead	Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.	100%	included in monthly audit program and reviewed in safety dashboard
			SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnancies but who do not require referral to maternal medicine network must have a named consultant lead.	100%	
		Women with complex pregnancies must have a named consultant lead Total		**100%**	
	Q26	Complex pregnancies have early specialist involvement and management plans agreed	Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the clinical team in consultation with the woman.	100%	included in monthly audit program and reviewed in safety dashboard
			SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams.	100%	
		Complex pregnancies have early specialist involvement and management plans agreed Total		**100%**	
	Q27	Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	Audits for each element.	100%	included in monthly audit program and reviewed in safety dashboard
			Guidelines with evidence for each pathway	100%	
			SOP's	100%	
		Compliance with all five elements of the Saving Babies' Lives care bundle Version 2 Total		**100%**	
	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	SOP that states women with complex pregnancies must have a named consultant lead.	100%	
			Submission of an audit plan to regularly audit compliance	100%	
		All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place. Total		**100%**	

	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Agreed pathways	100%	confirmed Leicester will become specialist centre - work in progress to meet all criteria
			Criteria for referrals to MMC	100%	
			The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs.	100%	
		Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres Total		**100%**	
IEA4 Total				**100%**	
IEA5	**Q30**	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	How this is achieved within the organisation.	100%	included in monthly audit program and reviewed in safety dashboard
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard
			Review and discussed and documented intended place of birth at every visit.	100%	
			SOP that includes definition of antenatal risk assessment as per NICE guidance.	100%	
			What is being risk assessed.	100%	
		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional Total		**100%**	
	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Evidence of referral to birth options clinics	100%	
			Out with guidance pathway.	100%	
			Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard

			SOP that includes review of intended place of birth.	100%	
		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. Total		**100%**	
	Q33	A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance.	Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)	100%	
			How this is achieved in the organisation	100%	
			Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above.	100%	included in monthly audit program and reviewed in safety dashboard
			Review and discussed and documented intended place of birth at every visit.	100%	
			SOP to describe risk assessment being undertaken at every contact.	100%	
			What is being risk assessed.	100%	
		A risk assessment at every contact. Include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PCSP). Regular audit mechanisms are in place to assess PCSP compliance. Total		**100%**	
IEA5 Total				**100%**	
IEA6	**Q34**	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	Copies of rotas / off duties to demonstrate they are given dedicated time.	100%	
			Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs.	100%	
			Incident investigations and reviews	100%	

			Name of dedicated Lead Midwife and Lead Obstetrician	100%	
		Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring Total		**100%**	
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health	Consolidating existing knowledge of monitoring fetal wellbeing	100%	
			Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision	100%	
			Improving the practice & raising the profile of fetal wellbeing monitoring	100%	
			Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.	100%	
			Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post	100%	
			Keeping abreast of developments in the field	100%	
			Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.	100%	
			Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training.	100%	
		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on elements of fetal health Total		**100%**	
	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Audits for each element	100%	included in monthly audit program and reviewed in safety dashboard
			Guidelines with evidence for each pathway	100%	
			SOP's	100%	
		Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? Total		**100%**	

	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	A clear trajectory in place to meet and maintain compliance as articulated in the TNA.	100%	
			Attendance records - summarised	100%	
			Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements.	100%	
		Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Total		**100%**	
IEA6 Total				**100%**	
IEA7	Q39	Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery	Information on maternal choice including choice for caesarean delivery.	100%	
			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Trusts ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery Total		**100%**	
	Q41	Women must be enabled to participate equally in all decision-making processes	An audit of 1% of notes demonstrating compliance.	100%	included in monthly audit program and reviewed in safety dashboard
			CQC survey and associated action plans	100%	
			SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded.	100%	

		Women must be enabled to participate equally in all decision-making processes Total		**100%**	
	Q42	Women's choices following a shared and informed decision-making process must be respected	An audit of 5% of notes demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction.	100%	included in monthly audit program and reviewed in safety dashboard
			SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded.	100%	
		Women's choices following a shared and informed decision-making process must be		**100%**	
	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.	100%	
			Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps)	100%	
			Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP.	100%	
		Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Total		**100%**	
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Co-produced action plan to address gaps identified	100%	
			Gap analysis of website against Chelsea & Westminster conducted by the MVP	100%	Gap analysis complete - maternity website is currently being updated
			Information on maternal choice including choice for caesarean delivery.	100%	

			Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.	100%	
		Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. Total		**100%**	
IEA7 Total				**100%**	
WF	**Q45**	Demonstrate an effective system of clinical workforce planning to the required standard	Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan	100%	maternity staffing on risk register with associated mitigation & actions
			Evidence of reviews 6 monthly for all staff groups and evidence considered at board level.	100%	
			Most recent BR+ report and board minutes agreeing to fund.	100%	
		Demonstrate an effective system of clinical workforce planning to the required standard Total		**100%**	
	Q46	Demonstrate an effective system of midwifery workforce planning to the required standard?	Most recent BR+ report and board minutes agreeing to fund.	100%	
		Demonstrate an effective system of midwifery workforce planning to the required standard? Total		**100%**	
	Q47	Director/Head of Midwifery is responsible and accountable to an executive director	HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director	100%	
		Director/Head of Midwifery is responsible and accountable to an executive director Total		**100%**	
	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care:	Action plan where manifesto is not met	100%	
			Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care	100%	

		Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: Total		**100%**
	Q49	Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.	Audit to demonstrate all guidelines are in date.	100%
			Evidence of risk assessment where guidance is not implemented.	100%
			SOP in place for all guidelines with a demonstrable process for ongoing review.	100%
		Providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Total		**100%**
WF Total				**100%**

Kirkup report recommendations
Regional Update 31st December 2021

Those that are greyed out are superseded by Ockenden and do not need completing on this tab.

Kirkup Action no.	Relating to Kirkup Recommendation (see Kirkup Recommendations tab for further information)	Action	Suggested documents that may support Trust assurance.	Leicestershire UNIVERSITY HOSPITAL LEICESTER
1	R1, R13, R24	Ensure that an open and honest approach is taken to any incident	Critical friend is allocated for every level 4/ 5 incident (SI's)	
			Women and their families are kept informed of the progress of the	
			Women and their families are invited to contribute to the investigation	
			Offering an apology	
			Ensure that all nurses and midwives are aware of their responsibilities in	
2	R1, R13	Review the current processes for obtaining feedback from the public to increase the information received	Offering women and their families the opportunity to make suggestions	
			Ensuring that national/ local awareness opportunities are utilised	
			Continue to support the LSA in the feedback mechanism to staff from	
			Share patient stories	
3	R2	Review the current skills and drills programme across the directorate to ensure that a wide range of scenarios are included across all clinical settings, including bespoke skills drills for different clinical areas	Ensure a high quality training scheme is delivered	
4		Foster a culture of shared learning between clinical departments that supports effective communication and practice development	Minutes of meetings showing MDT working	
5	R2	Review the current preceptorship programme	Midwives/ Nurses are allocated a buddy in each clinical area and that this is supported by the clinical team.	Green
			The buddy midwife is allocated time to support the preceptee	Green
			Midwives are supported throughout the programme, progress is monitored and there is a clear plan developed for any midwife that is	Green
			Midwives are confident and competent to go through the gateway within the agreed timeframe	Green
6	R2	Obtain feedback from midwives and nurses who have recently completed a preceptorship programme to identify any improvements that can be made to the programme	This is now in progress and will be completed May 2022	Amber
7	R2, R3	Review the skills of Band 6 midwives to identify and address any training needs to ensure a competent and motivated workforce	Develop a robust support package for new band 6 midwives	Green
			Completion of the Mentoring module	Green
			Suturing competency	Green
			IV therapy competency	Green
			Care of women choosing epidural anaesthesia.	Green
8		Review the current induction and orientation process for midwives and nurses joining the organisation at Band 6 to ensure they are competent and confident to provide care	Practice educator reports and feedback	Green
9	R2	Review the current induction programme for locum doctors	Locum policies	Green

10		Review the current provision of education and training for locum doctors with the aim of introducing streamlined bespoke training for this group.		Green
11	**R2**	Review the provision of maternal AIMS courses and ensure that all places are allocated appropriately and staff attend the session.	Practice educator meeting notes, discussion with DoMS/HoMs	Green
12	**R2**	Review the educational opportunities available for staff working in postnatal areas to increase their understanding of the compromised neonate, including consideration of bespoke educational sessions and HEI courses e.g. Care of the compromised baby module at University of Salford	Practice educator reports and feedback	Green
13	**R2**	Improve staff knowledge, response time and escalation processes in relation to a woman's deteriorating condition	Incident review and feedback, related lessons learnt, training opportunities	Green
14	**R2**	Implement a process for cascading learning points generated from incidents or risk management in each clinical area e.g. email to staff, noticeboard, themed week / message of the week, core huddles, NICU news	The service completes most of these, there is a SOP been developed to describe what is in place, to ensure we use every possible way to share learning	Amber
15	**R3**	Review the current process for staff rotation to ensure that a competent workforce is maintained in all clinical areas.		Green
16	**R2, R3, R4**	Review and update the Education Strategy		
17	**R3**	Review the support provided when staff are allocated to a new clinical area and what supernumerary actually means in order to manage staff expectations		Green
18	**R3**	Offer opportunities to other heads of service for staff from other trusts to broaden their experience by secondment or supernumerary status		
19	**R5**	Develop a list of current MDT meetings and events and share with staff across the directorate		
20	**R8**	Develop and implement a recruitment and retention strategy specifically for the obstetric directorate	This is in progress	Amber
21		Review the current midwifery staffing establishment to ensure appropriate staffing levels in all clinical areas		
22		Ensure that all staff who leave are offered an exit interview with a senior member of staff and use the information gained from these interviews to inform changes aimed at improving retention		Green
23		Provide Staff Forum meetings where staff are encouraged to attend and discuss concerns		Green
24	**Only applicable to multi-site trusts.**	Improve working relationships between the different sites located geographically apart but under the same organization.		Green
25	**R9**	Reiterate to all staff via email and team meetings the roles and responsibilities of the consultant obstetrician carrying the hot week bleep.		
26	**R11, R12**	Ensure that staff receive education during their induction regarding the incident reporting process including the process for reporting incidents, the incidents that should be reported and the rationale for learning from incidents.		Green
27	**R11, R12**	Including a review of the processes for disseminating and learning from incidents		
28		Ensure that staff undertaking incident investigations have received appropriate education and training to undertake this effectively	All consultants to have completed RCA training	Green
			Identified midwives to have completed RCA training	Green

			Staff who have completed RCA training undertake an investigation within 1	Amber
			Develop a local record of staff who have completed RCA training and the	Amber
29	**R12**	Ensure that the details regarding staff debriefing and support are completed on the Trust incident reporting system for all level 4 and 5 incidents		
30	**R12**	Ensure that all Serious Incidents (SI's)are fedback to the staff		
31	**R12**	Identify ways of improving attendance of midwives at SI's feedback sessions		
32	**R13**	Maternity Services Liaison Committee involvement in complaints	Collation of complaints reports	
33	**R14**	Review the current obstetric clinical lead structure		
34	**R15**	Review past SI's and map common themes	Thematic reviews	
35	**R23**	Ensure that maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths are reported, reviewed and an investigation undertaken where appropriate	Maternal deaths, stillbirths and early neonatal deaths reports	
36	**R26**	Ensure that all staff are aware of how to raise concerns	Whistle blowing staff policy	Green
37	**R31**	Provide evidence of how we deal with complaints		Green
38	**R31**	Educate staff regarding the process for local resolution and support staff to undertake this process in their clinical area	Identifying situations where local resolution is required	Green
39	**R32**	Develop a plan to maintain a supervision system beyond the decommissioning of the LSAs once national recommendations have been agreed.	Implementation of the A-AQUIP model	
40	**R38**	Ensure that all perinatal deaths are recorded appropriately	Sending the completed form to the Deputy Director of Nursing/ Head of Midwifery and the Divisional Clinical Effectiveness Manager	
41	**R39**	Ensure that Confidential Enquiry reports are reviewed following publication and that an action plan is developed and monitored to ensure that high standards of care are maintained	MBRRACE action plan-there is not a specific action plan the actions for each	Green

Leicester, Leicestershire, and Rutland Joint Health Scrutiny Committee

Work Programme – 2022/23

Date	Topic	Actions arising	Progress
27 Jun 22	1. Update on Dental Services 2. UHL Finances and Accounts for 19-20 and 20-21 3. Leicester, Leicestershire, and Rutland Integrated Care Systems Update 4. Covid-19 Vaccination Programme Update 5. Maternity Services	1. Information on recovery of services post COVID19 across LLR and access to dentistry. 2. This item will be taken to the Committee this year as reports will be decoupled and approved at separate Board Meetings over the last few months. 3. Update on organisational arrangements before the implementation date of 1 July 2022. 5. Item to include information on Maternity Services and any self-assessment conducted by UHL, given the recent media interest.	
16 Nov 22	1. Mental Health Services: a. Progress on the implementation of the outcomes on the Step Up to Great Mental Health programme b. Update on the LPT CQC inspection outcomes and the dormitory eradication programme 2. Re-procurement of the Non-Emergency Patient Transport Service (NEPTS)	1. Combined update following the special meeting held on 15 February 2022 on progress with the Mental Health Programme and the CQC inspection outcomes. 2. The service will be procured and at a standstill period before this meeting.	

Date	Topic	Actions arising	Progress
12 Apr 23	1. Transforming Care – Learning Disabilities and Autism Update 2. EMAS Update – Clinical Operating Model	1. Comprehensive report requested by the Commission with a joint LLR overview. 2.	

Prospective Items

Agenda item	Organisation/Officer responsible	Notes
1. EMAS - Clinical Operating Model and Specialist Practitioners	Russell Smalley, EMAS	This item was presented in March 2022 and an update was requested in 12 months' time, once the model has been implemented further.
2. Update on Dental Services	Thomas Bailey, NHS England	This item was presented in July 2021 and September 2021, with the Committee interested in an update returning in June 2022 on the recovery of dental services following COVID and general access to dentistry across LLR.
3. Progress Updates on the UHL Acute and Maternity Reconfiguration Proposals (Building Better Hospitals Programme)	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; an update on the co-located design work for the standalone midwife-led unit, and details of the emerging strategy and patterns of activity to be developed in relation to primary care.
4. Transforming Care – Learning Disabilities and Autism progress update	County/City Council and LPT	This item was taken in March 2022, with a view for this to return to the Committee in the 2022/23 municipal year, with a joint LLR overview to this.
5. UHL Finances and Accounts for 19-20 and 20-21	UHL	On 5 March 2021 it was agreed that UHL would come back to the Committee with further updates regarding the actions taken to address

Agenda item	Organisation/Officer responsible	Notes
		the financial issues. This is planned for Summer 2022, with a Member Briefing beforehand, from UHL.
6. Maternity Services (including Black Maternal Healthcare and Mortality)	UHL	Item was initially considered in November 2021, with further interest in Maternity Services expressed prior to the start of the civic year.
7. Covid-19 Vaccination Programme Update	CCGs	This was a former standing item in the previous municipal year and relevant updates in 2022/23 may be requested, where required.
8. 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 July 2022 and the Health and Care Act has also received approval; update on this item anticipated for June 2022.
9. Outcome of LPT CQC inspection	LPT	This was taken at the special meeting in Feb 2022 with a follow up update in March 2022 regarding the dormitory accommodation. Anticipated that an update on inspection outcomes will return to the Committee this year.
10. Findings and analysis of the Step Up to Great Mental Health Consultation - Leicester, Leicestershire, and Rutland	CCGs/LPT	Consultation about proposals to invest and improve adult mental health services for people in LLR was discussed in Feb 2022 and March 2022. Anticipated that the progress on the implementation of the outcomes on the Step Up to Great Mental Health programme will return to the Committee this year.
11. Autumn/Winter Vaccination Programme Report	CCGs	A standing item in the previous municipal year, with the Committee expecting an update in Autumn 2022.
12. Re-procurement of the Non-Emergency Patient Transport Service (NEPTS)	CCGs	Item was taken in March 2022 prior to the start of the procurement exercise. Committee recommended that a further update on procured services and how to access them, will return in November 2022.