Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: THURSDAY, 1 DECEMBER 2022
TIME: 5:30 pm
PLACE: Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Members of the Commission

Councillor Pantling (Chair), Councillor O'Donnell (Vice-Chair)
Councillors Aldred, Khan, Dr Sangster and Westley
(1 unallocated Labour Group place; 1 unallocated Non-Group place).

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

Standing Invitee (Non-voting)

Youth Representatives x 2
Representative of Healthwatch Leicester

Members of the Children Young People and Education Scrutiny Commission

Councillors Batool, Crewe, Dr Moore, Riyait, Thalukdar and Willmott,
Co-opted Members: Carolyn Lewis, Mohit Sharma.

Members of the Children Young People and Education Scrutiny Commission are invited to attend and participate in Item 9 School Nursing Provision as listed overleaf.

For Monitoring Officer

Officer contacts:
Anita James (Senior Democratic Support Officer):
Tel: 0116 454 6358, e-mail: anita.james2@leicester.gov.uk
Francis Connolly (Scrutiny Policy Officer):
Tel: 0116 454 6344, e-mail: Francis.Connolly@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

Acronym	**Meaning**
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
BCF	Better Care Fund
BCT	Better Care Together
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
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
CQUIN	Commissioning for Quality and Innovation
DAFNE	Diabetes Adjusted Food and Nutrition Education
DES	Directly Enhanced Service
DMIRS	Digital Minor Illness Referral Service
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
ECMO	Extra Corporeal Membrane Oxygenation
EMAS	East Midlands Ambulance Service
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GPAU	General Practitioner Assessment Unit
GPFV	General Practice Forward View

HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWLL	Healthwatch Leicester and Leicestershire
ICS	Integrated Care System
IDT	Improved discharge pathways
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LTP	Long Term Plan
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
NDPP	National Diabetes Prevention Pathway
NICE	National Institute for Health and Care Excellence
NHSE	NHS England
NQB	National Quality Board
OBC	Outline Business Case
OPEL	Operational Pressures Escalation Levels
PCN	Primary Care Network
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
TasP	Treatment as Prevention
TASL	Thames Ambulance Services Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

NOTE:
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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. CHAIRS ANNOUNCEMENTS (IF ANY)

4. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 8)**

The minutes of the meeting held on 11th August 2022 have been circulated and the Commission will be asked to confirm them as a correct record.

5. UPDATE ON PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS

To receive any update on outstanding actions of previous meetings of the Commission

6. PETITIONS

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

7. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

8. COLOUR DYERS LTD VERBAL UPDATE

The Chair will provide a brief position statement.

9. SCHOOL NURSING PROVISION — Appendix B (Pages 9 - 52)

The Director of Public Health submits a report providing an update on the Public Health Nursing, School Nursing (5-19 year's) service which delivers a universal public health and safeguarding provision.

Members of the Children, Young People and Education Scrutiny Commission are also invited to participate in discussion of this item.

Members of both the Health & Wellbeing Scrutiny Commission and the Children, Young People & Education Scrutiny Commission will be asked to note the contents of the report and make any comments.

10. TASK GROUP REPORT - "THE EXPERIENCE OF BLACK PEOPLE WORKING IN HEALTH SERVICES IN LEICESTER AND LEICESTERSHIRE" — Appendix C (Pages 53 - 94)

The Chair of the Task Group, Councillor Kitterick submits the report of the scrutiny review on the experience of black people working in health services in Leicester and Leicestershire.

Members of the Commission will be invited to support the recommendations of the Task Group.

11. MATERNITY SERVICES UPDATE — Appendix D (Pages 95 - 106)

University Hospitals Leicester (UHL) submits a report following the Ockenden review and Kirkup reports providing a consolidated overview of UHL's maternity services, learning and progress.

Members will be asked to note the contents of the report in particular the progress to date and the areas where improvement is required and the plans to address these.

12. WORK PROGRAMME **Appendix E (Pages 107 - 112)**

The Scrutiny Policy Officer submits a document that outlines the Health and Wellbeing Scrutiny Commission's Work Programme.

Members of the Commission will be asked to consider the work programme and make comments and/or amendments as it considers necessary.

13. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 11 AUGUST 2022 at 5:30 pm

P R E S E N T :
Councillor Pantling (Chair)

Councillor Aldred Councillor Khan

In Attendance:
Deputy City Mayor for Health, Councillor Dempster

Also Present:
Chris West – Deputy Chief Nursing Officer for the Integrated Care Board
Julie Hogg – Chief Nurse University Hospitals Leicester
Rachna Vyas – Chief Operating Officer for NHS Integrated Care Board
Amit Sammy – Head of Strategy and Planning at LLR integrated Care Board
Richard Morris – Deputy Director of People for the Integrated Care Board
Laura French – Consultant in Public Health
Catherine Packham – Consultant in Public Health

*** ** ***

15. APOLOGIES FOR ABSENCE

Councillor Pantling, Chair of the Health and Wellbeing Scrutiny Commission led on introductions and took the opportunity to welcome representatives of the Youth Council.

The Chair noted that apologies for absence had been received from Ruth Lake, Director of Adult Social Care and Safeguarding and from Gemma Barrow, Healthwatch Leicester.

There were no other apologies for absence.

16. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

17. MINUTES OF PREVIOUS MEETING

The Chair expressed concern that the minutes of the previous meeting did not fully reflect the meeting and all of the actions to be taken and requested that the minutes be reproduced before being submitted for approval as to accuracy.

AGREED:

that the minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 21 June 2022 be reproduced as requested by the Chair.

18. PETITIONS

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

19. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

20. COVID-19, VACCINATION PROGRAMME, AND EMERGING HEALTH ISSUES

The Director of Public Health provided the Commission with a verbal update. It was noted that:

- The summer period had been relatively quiet but strongly suggested that Covid19 had not completely gone away and Covid pressures as well as others still existed
- Over the course of the pandemic, the city had responded well and currently the infection rate was at 75 per 100,000, relatively lower than other parts of the country
- The ongoing challenges with receiving data were still existing as the granular, local data that was made available during the height of the pandemic was no longer available from the Department of Health
- Regional data from the Office for National Statistics was available and indicated that 3% of the population from the East Midlands tested positive for Covid19 in the week of the 25 July 2022
- It was suggested that there was no indication of widespread positive cases of Covid19 which was disproportionate to the rest of the country
- Covid admissions into hospitals in the UHL had increased at the beginning of summer but these had now fallen away
- Mortality cases were also low and not disproportionate of the figures nationally

- The roll out of vaccinations and the urge for the public to take the vaccines were still on and the Director of Public health was delighted to have the representatives from the Youth Council present, as there were challenges getting young people vaccinated and welcomed the support of young people
- The spring booster roll out for the over 70's, although delayed had been positive
- There had been an increase in Monkey Pox cases and local data on this would be published in the near future
- There was a case of Polio in London which was believed to be derived from a live vaccine which was not delivered in the UK
- With the recent changes in public guidance there had been some confusions as communications had changed from broadcasting messages to engaging with people

In response to questions raised by the Chair it was noted that prolonged hot temperatures could be a cause for transmission in vulnerable people, but extensive work had been carried out to ensure that vulnerable people had been protected and that the Monkey Pox vaccines had been produced by the government and that the UHL were carrying out vaccinations for those eligible with strict conditions.

AGREED:

That the Director of Public Health be requested to provide the Commission with regular updates throughout the year.

21. CQC INSPECTION OF URGENT/EMERGENCY CARE

The Chief Operating Officer for the NHS Integrated Care Board presented the report on the CQC Inspection of Urgent Care/Emergency Care and provided an overview of the report.

It was noted that the report was both a positive report and a challenging report and that the service had accepted what was in the report and understood where improvements were required, with an action plan in place to meet the required improvements.

It was noted that the 3 key areas of focus were the demand management, making sure that the right patient was in the right place at the right time, followed by the flow from one service to another and finally, capacity. The report recognised that there was not enough domiciliary care capacity out in Social Care which this Commission had discussed many times. It was noted that these key focus areas were already being actioned to ensure the service were ready for the surge in winter.

The Chief Nurse at the UHL noted that the need to improve was recognised and that things were in place to make the necessary improvements. Medical in-reach was now in place in the Emergency Department allowing patients to get their treatments quicker, cardiology was being piloted at the LRI and reablement beds were to launch tomorrow to bridge the gap between health

and social care. It was noted that the actions for the future focused around process, productivity and capacity. Making sure that there are enough beds across the system to provide care for patients that needed it.

In response to the questions and comments from the members of the Commission and the Youth Council representatives, it was noted that:

- Although patients were being triaged by consultants whilst waiting, the ambulance waiting times were not acceptable and that the ambition was to bring the waiting time down and immediate actions have been taken following the findings in the CQC report.
- Staffing rates in A&E were correct with additional post now being advertised
- Consultants staffing had now been improved with a vacancy rate of 12%
- Following the immense stress on staff over the pandemic, work was underway to understand how staff felt and what could be done to make improvements
- It was noted that the pressures were on all emergency units nationally and that the service were improving on overall planning with colleagues to improve each step and make overall improvements to the service delivery.

The Deputy Chief Nursing Officer for the Integrated Care Board noted that a patient safety risk summit would be carried out which would bring together a whole host of senior leaders, including those in attendance today, but also those people who were right on the front line who know what it feels like to be working every day in difficult situations and to see what could be done to make any difference.

The Chair took the opportunity to thank the NHS Staff for the work they do under all the pressures.

AGREED:

That the Chief Operating Officer for the NHS Integrated Care Board be requested to provide future updates on this item in 6 months.

22. LEICESTER HEALTH, CARE AND WELLBEING STRATEGY 2022-2027

The Director of Public Health introduced the item and the Consultant in Public Health for Leicester City Council delivered the report, updating the Commission on the Leicester Health, Care and Wellbeing Strategy 2022/27.

The Director for Public Health noted that this was not a council document, a public health document or even a national health document, but rather suggested it was a framework of actions and emphasised on the importance of the level of engagement. It was noted that the next step would be to deliver the plan which should voice the actions raised by the Commission.

The Assistant City Mayor for Health noted that the proposed strategy would reposition Public Health, that this piece of work over arches everything else that the Council does and that the notion of living well encompasses

everything.

The Head of Strategy and Planning at LLR an Integrated Care Board noted that in consultation with the Assistant City Mayor for Health there would be a development session at the next Health and Wellbeing board to flesh out what the delivery plan for the strategy looked like.

As part of the discussions and response to questions and comments raised by Members of the Commission and Youth Council representatives, it was noted that:

- Recognise that the delivery of plans needed to focus on engagement
- Designing strategies with the public at the core
- Recognition of the impact on primary medical services as a result of the projected growth in housing.

The Director of Health further noted that the data from the latest Census Report suggest that there would be future increases to services with the projected growth and the challenge was to promote healthy living to prevent people from needing support.

In further discussions about young people and health, it was noted that advocating young people being leaders in healthy lives was the approach with other alternative ways of delivery but prioritising what has the greatest impact and the delivery of services with the resources available. The Director of Public Health noted that the National curriculum sets out the teaching in schools but the challenge was to harness all the resources to deliver the best for the young people.

It was also noted that people within the communities across the city had the reach to spread and advocate projects to the public. Beat the Streets was given as an example of innovative ways to get people out and active, but it was suggested that it was also important to balance the priorities during tough times.

In response to the Chairs question in regard to reviewing the proposed strategy, it was noted that the delivery plan would have target dates set with ongoing monitoring and reporting on progress towards actions and a mid-term review was scheduled with the final review at the end of the 5 year term.

AGREED:

1) That the Director for Public Health be requested to consider the questions and comments raised by the Commission
2) That the Director of Public Health be requested to review the proposed strategy annually and bring it to the Commission for Scrutiny; and
3) That the Health and Wellbeing Scrutiny Commission endorses the Strategy.

23. SEXUAL HEALTH SERVICES - UPDATE

The Consultant In Public Health delivered a presentation providing the Commission with an overview of the Sexual Health Services during Covid 19.

As part of the discussions the Vice Chair of the Youth Council queried whether young people in the city knew of the service. In response it was noted that:

- This was under review as the service was relatively new and not many people were aware of the service
- There were specialist services doing the publicity work and it would also be a part of the Sexual Relationships Education programme
- The Chair noted that education and knowledge was vital in prevention

AGREED:

That the report be noted.

24. 0-19 COMMISSIONING - UPDATE

The Director of Public Health introduced the report on 0-19 commissioning and noted that the service were commissioning differently for 0-19 to allow for practical engagement with youth groups across the city.

As part of the discussions the Vice Chair of the Youth Council queried whether the Director of Public Health would consider using young people in the commissioning process and the delivery.

In response to the question raised the Director of Public Health noted that the aim was to develop services that met the needs of young people across the city and that the Director of Public Health will be using young people voices during the commissioning and delivery as Section 75 allowed for more control of the commissioning process and partnership working.

AGREED:

1) That the Director of Public Health be requested to further update the Commission again in a year
2) That the Commission support the Director of Public Health to use Section 75; and
3) That the Officers be thanked for the report.

25. UPDATE ON PROGRESS ON ACTIONS FROM PREVIOUS MEETINGS

Following the Rough Sleepers and Drug /Alcohol Programme item taken at the previous meeting, a visit had been arranged for Commission Members to visit Inclusion. Members were asked to respond to the emails for arranging the date.

26. CHAIR'S ANNOUNCEMENTS

Following a short-written update from Regulatory Services, an inspection had been carried out by the Environmental Agency. It was the intention of the Chair of the Commission to request a further update on the outcome of the inspection later in the municipal year, once this had been released by the Regulatory Services Team.

27. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2014/15.

The Chair proposed that the item on GP Services be the main focus of the Commission meeting in January 2023.

28. CLOSE OF MEETING

The meeting closed at 7.27pm.

Appendix B

Update Public Health Nursing (School Nursing) element of 0-19 Healthy Child Programme (0-19HCP)

For consideration by: Health Scrutiny Commission

Decision to be taken on/Date of meeting: 1st Dec 2022

Lead director/officer: Ivan Browne

Useful information

- Ward(s) affected: all
- Report author: Clare Mills
- Author contact details: Clare.Mills@leicester.gov.uk
- Report version number: 1

1. Summary

0-19 Healthy Child Programme (0-19HCP) is commissioned by LCC and delivered by Leicestershire Partnership NHS Trust (LPT) and it is known locally as Healthy Together. Healthy Together is an integrated offer containing a number of Public Health elements including Public Health Nursing (School Nursing) (PHN(SN)).

Public Health Nursing, School Nursing (5-19 year's)
For the last 3 years the PHN(SN) team have been delivering a model where 80% of the team focuses on universal Public Health provision and 20% focuses on Safeguarding provision. This was first piloted in Reading.

This paper provides an update on the service following on from last year's update.

2. Recommended actions/decision

Scrutiny members are asked to note the contents of the report

3. Scrutiny / stakeholder engagement

Scrutiny: This paper provides an update on the service following on from last year's report at Scrutiny Committee.

Stakeholder Engagement:

The recommissioning of 0-19 Healthy Child Programme via Section 75 is being progressed. There has been consultation with staff and service uses in 2022. Details of this engagement can be found towards the end of section 5.

As part of the recommissioning process LCC will run a joint Public Consultation with LPT from 16th January 2023 to 10th April to enable stakeholder to consider proposed changes to the 0-19 Healthy Child Programme service specification. Some details are included at the end of Section 5, and further information and updates on the Public Consultation is available.

4. Background and options with supporting evidence

This paper provides an update on the service following on from last year's report at Scrutiny Committee. Scrutiny members are asked to note the contents of the report.

5. Detailed report

Giving every child the best start in life is crucial to improving health outcomes and reducing health inequalities across the life course and is recognised as a fundamental action in helping our population live healthy, happy lives and supporting individuals to fulfil their potential. It is a key theme of the Leicester City Health and Wellbeing Strategy.

Early years have a lifelong effect on health and wellbeing, educational achievement and economic status. 0-19HCP is the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing. As part of this, Public Health Nurses (School Nurses) PHN(SN) provide a vital and unique link between school, home and the community. PHN(SN) are there from the start of primary school all the way through to secondary school and into young adulthood. Throughout these years PHN(SN) use evidence-based practice to guide and support children and help promote good physical and mental health. From being at the forefront of spotting signs of abuse to encouraging healthy eating and providing support for stress, anxiety and suicidal thoughts to sexual health provision; the range of services PHN (SN) provide is wide and far-reaching. They support children through difficult transitions, whether it is starting school, moving to secondary school, starting GCES's or leaving school. In doing so, they play a key role in reducing health inequalities, reaching out to vulnerable and marginalised young people who may otherwise fall through the gaps.

The PHN(SN)'s clinical, pastoral, and supportive role is needed now more than ever as our young people continue to recover from the impact of the pandemic and during the ongoing cost of living crisis.

In a recent review of all PH services Public Health Nursing (School Nursing) ranked 4th out of 30 assessed. It scored the highest possible marks for prevention focus; evidence of effectiveness; cost effectiveness; health and social care integration; co-dependencies with other LCC departments; and innovation.

The PHN(SN) is a clinical service offered to children 5-19 within a school setting and supported with a digital offer.

The PHN(SN) is a small team who support all children in school in Leicester, they support:

- 9 Infant Schools
- 9 Junior schools
- 67 Primary schools
- 19 secondary schools
- 1 'all age/all though' school

and provide Public Health support to 8 Special Schools. There is a PHN(SN) offer for the 2 Pupil Referral Units, NEET (Not in Education, Employment or Training) and for Home Educated Children.

The PHN(SN) offer includes:

- School Health Agreements
- Statutory National Child Measurement Programme (NCMP) in reception and year 6
- Year 7, 9 and 11 Digital Health Contact (DHC), facilitated in school to avoid digital poverty barriers
- Triage Assessments followed, as required, by Baseline Health Assessments
- Evidence-based packages of care to support early interventions for physical,

emotional, social and sexual health
- Review Health Assessments
- Chat Health (free and confidential text messaging service)
- www.healthforkids.co.uk and www.healthforteens.co.uk
- Health Promotion Fairs
- Sexual Health Clinics (for year 10 and 11)
- School Assemblies
- Parent information sessions including Healthy Bladder and Healthy Bowel, anxiety, behaviour, sleep and healthy lifestyle
- Statutory Safeguarding role.

This service uses a skill mix model and the team is made up of:
- Specialist Community Public Health Nurses (SCPHN)
- Healthy Child Programme Nurses (who are Registered Nurses) (HCPN)
- Healthy Child Programme Support Workers (HCPSW)
- Healthy Child Programme Practitioners (HCPP)

In order to best meet the needs of children the PHN(SN) workforce model was divided into two strands in October 2019 (for more information see appendix A) with staff rotating annually. The following model is based upon optimal staffing across the workforce.
- Public Health (80% of workforce)
- Safeguarding (20 % of workforce)

This model allows the workforce to deliver the public health/health promotion agenda as set out in the service specification and Standard Operating Guidance (2022), whilst also meeting the statutory safeguarding commitments as per the LSCB Guidance and Working Together to Safeguard Children (2020)

In the previous model, PHN(SN) were responsible for delivering both elements of the role concurrently. However, it became increasingly evident that the quality and consistency of the delivery of Public Health element was frequently compromised in favour of urgent Safeguarding work. The current model is able to manage the demands and commitments of statutory safeguarding responsibilities in Leicester, whilst also providing safe and effective Public Health support for young people and their families.

When the new model was established LPT created an internal Task and Finish group and followed the NHS model for improvement to support design, implement and evaluation. All 6 indicators score positive with the current position, indicating that these changes have been successful (appendix B).

Public Health Offer

There are 57,000 Children and Young People in Leicester Schools, and the PHN (SN) can be accessed by any child. However, the universal offer is aligned to targeted support and evidence-based packages of care. A typical full time equivalent caseload is 27 Universal children and 1 Universal Plus/Targeted child.

School Health Agreements

Annual School Health Agreements are completed with all schools. For the 2022/23

academic year a digital agreement has been created. This document is completed during a discussion with school staff and outlines the responsibilities of both the school and Healthy Together and the plans for delivery of care during the year. The team have currently undertaken 82 school agreements (67 Primary and 15 senior school).

National Child Measurement Programme (NCMP) in reception and year 6.
This is a mandated surveillance programme in which the height and weight of all children in Reception and year 6 are taken. This provides data on children's weight, which helps in the planning of health any weight services. In Leicester parents are sent the results of children's measurements and any child above a healthy weight is invited, along with their family, to participate in a Family Lifestyle Club (FLiC) that supports them to eat healthy and take part in physical activity (FLiC is commissioned as part of Healthy Together, more information is available)

2021 NCMP programme

This Table shows the number of schools and pupils who participated.

Local Authority	Number of Schools	Number of Reception Pupils	Number of Year 6 Pupils	Total Pupil Count
Leicester City	83	4529	5045	9,574

School involvement in NCMP is voluntary, 2 schools did not participate.

Year 7, 9 and 11 Digital Health Contact (DHC)
Schools are offered the opportunity to have children participate in a Digital Health Contact (DHC) in year 7,9,11. This is facilitated in school and is a proactive means to ask young people about their health behaviors and provides universal Public Health advice. There are key words and phrases that trigger a 'red flag', all red flags are triaged by the PHN(SN). This can lead to a Baseline Heath Assessment (face to face in school) and progress to evidence-based interventions of support, safeguarding, or referral to other services (e.g CAMHS) as required.

The schools receive information, on a school population level, about the key themes, and these can be used as a focus for School Health Fairs or public health events throughout the school year, including targeted assemblies. Engagement with the Youth Advisory Board (YAB) suggested that assemblies were viewed as a good means to relay public health messages.

The DHC was recently evaluated by Universities of Sheffield and Bristol and found to be an effective way to identify unmet health need (appendix C).

Last academic year the following schools completed the DHC.

- Year 9: Castle Mead
- Year 9: Sir Jonathan North
- Year 9: Moat Community College
- Year 9 & Year 11: Willow Bank
- Year 11: New College

This equated to 788 students completing the forms. Of this, 400 of these generated red

flag responses.

Triage and Baseline Health Assessments
All children who are referred to the service are triaged by a PHN(SN), some are provided with advice and guidance and some are invited for a Baseline Health Assessment which includes an assessment of any risks PHN(SN) use this tool to understand the holistic health needs of a child including physical, social, sexual (where age appropriate to do so) and emotional health.

This assessment is completed for all referrals requiring a package of care and for any child or young person who is to be the subject of a safeguarding meeting. It is completed by either a Public Health Nurse or Healthy Child Program Nurse.

The contact is in line with the Standard Operating Guidance and the national 0-19 Healthy Child Programme, it uses the 'Assessment Framework' upon which the following areas are assessed:

- Gillick competency of the child or young person/Consent given to complete the assessment.
- Overview and understanding around confidentiality and when sharing of information would take place.
- General health needs – including vision problems, registration at a dentist, physical appearance, known medical problems and growth measurements.
- Family and Environmental factors – who does the child or young person live with, do they get along with the household members, are they supportive, and any concerns about home.
- Education and Development – including any identified difficulties at school, neurodevelopmental concerns or receipt of any additional support in school.
- Continence
- Behaviour – concerns at school or home
- Emotional health – including a tool to scale how the child or young person feels (this allows identification to monitor the effectiveness of any strategies recommended), friendships, bullying, safe adults to talk too, is a safety plan needed and ensures that full risk assessment of emotional health has been completed (see below).
- Lifestyle – to include sleep, diet, exercise and substance use.
- Caring responsibilities.
- Gender
- Safeguarding concerns – including on-line safety
- For secondary school aged children only – sexuality and relationship explored.

Alongside the Baseline Health Assessment staff assess for emotional risk or risk-taking behaviours. This assessment was developed in partnership with CAMHS. It focuses on the emotional health and includes the following areas:

- Harm to self – including self-harming behaviours, suicidal intent/ideation or plans, self-neglect or risk-taking behaviours.
- Harm from others – sexual exploitation risk (past or present), neglect, abuse, bullying or unlawful restrictions (including physical restraint or locks on doors) Living in a home environment where there is domestic abuse (Past or present).
- Harm to others - sexual assault, violence or aggression towards others, arson, weapons or criminal activity, being a perpetrator of domestic abuse.
- Signs of risk – Including mental state, social network

- Protective factors – Emotional Resilience, motivation and engagement with service.

For each risk assessment the PHNSN/HCPN provides clinical interpretation of any risks identified which includes a record of the risk assessed (Low, raised, High, Increased Safeguarding Risk and Medical emergency).

Between September 2021-2022 745 Triage Assessments and 888 Baseline Health Assessments were completed

Evidence-based packages of care

Baseline Health Assessments often lead to additional evidence-based care packages in accordance with local care pathways and protocols. Such additional support can be provided over several weeks for identified health issues such as sexual health, emotional health and wellbeing and healthy weight. This work may result in referring to specialist services or the Early Help offer. There are also opportunities to sign post children and young people to evidence-based resources including the Health4 websites and ChatHealth text messaging service

Review Health Assessments

Upon completion of a package of care, there are a number of possible outcomes:

- The identified need is resolved, and the child/parent are discharged to Universal services with ongoing Universal support including Healthy Together's digital offer and information on how to access parent led Healthy Child clinics.
- The identified need has not been resolved and either an additional session of support is provided or the child/young person is referred to another, more specialist, service.
- The GP is informed if there are any unmet health needs that cannot be addressed by Healthy Together and the care plan is documented.

Between September 2021 – 2022 there were 723 Review Health Assessments completed.

Chat Health

ChatHealth is an award winning, free, confidential text messaging service for Young People and their parents. Either parent of a school aged child/young person or young person themselves can text at any time and they will receive a reply and support from a PHN(SN).

For a case study please see Appendix xxx

Since it was created in 2014 ChatHealth has been rolled out to 70 other NHS Organisations meaning that more than 60% of School Nursing services in England, Northern Ireland and Wales offer ChatHealth. This makes it possible for around 2.8 million young people (aged 11-19) and their parents and carers to easily send a message to get confidential help and advice about a range of health and wellbeing issues.

www.healthforkids.co.uk

Health For Kids is a fun website for primary school aged children (5-11), and their parents, to learn about their health. Its packed full of fun characters, interactive articles and exciting games to play. In the Grownups area parents and carers can get health information and advice to help keep their children healthy and happy.

Between September 2021-2022 Health For Kids saw 130,594 users (114,060 new users).

Health for Kids was pioneered by LPT and has been rolled out to11 other NHS Trust.

www.healthforteens.co.uk
Health For Teens is a website for young people aged 11-19 about everything they want to know about health. It features bite-size information on a range of physical and emotional health topics, with engaging and interactive content such as movie clips, audio snippets and quizzes.

The 'your area' section brings local information to teenagers including advice, articles, events and helps them to find the right local support services.

Health for Teens was pioneered by LPT and has been rolled out to13 other NHS Trust.

The Healthy Together digital offer, including the websites, won the overall award at the 2020 Forward Healthcare Awards. For more information on ChatHealth, Health for Kids, and Health for Teens please visit *https://impacts.dhtsnhs.uk/*

Health Promotion Fairs

PNH(SN) support schools in the delivery of Health Fairs following the 7,9,11 health and well-being questionnaires have been completed. The schools receive a report on their schools cohorts health and welling that will form the planning of the health fairs. There were 2 health fairs undertaken in the city last academic year due to the recovery phase following covid-19.

Sexual Health Clinics
The PNN(SN) team offer a sexual health service to all senior schools including some of the additional needs schools. This provision is only delivered to schools that have consented as part of the School Health Agreement meeting. PHN(SN) can provide support, advice and offer pregnancy testing and condom distribution using the C-C card initiative.

Currently 11 secondary schools have consented for PHN(SN) to deliver sexual health provision.

School Assemblies
PHN(SN) work in partnership with schools to deliver Public Health messages and support as identified in the School Health Agreements. The last academic year saw a theme of 'Emotional Support' identified. The following events were delivered as school assemblies or pop-up lunch time events.

Theme:	**Number of events:**
Healthy Eating	6
Worries – emotional health	32
Exam stress	6
Dental health	5
Chat Health and PHN(SN) promotion	12

Other events where the PNH(SN) has a presence include coffee mornings with parents, sports days and parent days.

Parent Information Sessions
Parent information sessions are offered as a blended approach alongside the digital offer. The below shows how many sessions were undertaken iSeptember 21-Septemebr 22.

Theme	Number of sessions
Healthy Bladder Healthy Bowel	138
Healthy Bladder healthy Bowel – additional needs	60
Anxiety	9
Sleep	51
Behavior	35
Continence initials	63
Continence reviews	121

In addition, PHN(SN) have developed a Healthy Growth Care pathway and a parent information session to support with healthy growth in 5-19.

Statutory Safeguarding role.
The PHN (SN) Safeguarding team are currently responsible for all telephone strategy calls and all Section 17 & 47. In August 2022 there were 8 Active Section 17's and 35 Section 47's.

Children with identified safeguarding needs require a full Baseline Health Assessment. Having a Baseline Health Assessment before the initial case conference enables all professionals in the meeting to have as full a picture of the child's health needs as possible. PHN(SN) have a unique perspective and relationship with young people and can provide essential information to contribute to safeguarding.

Between September 2021-September 2022 756 children have been supported by the School Nursing safeguarding team in Leicester City. 234 for Section 17 (Child in Need) and 522 for Section 47 (Child Protection Plan)

Commissioning in Leicestershire

From 1st September 2022 Leicestershire Partnership NHS Trust ceased to provide PHN(SN) on behalf Leicestershire County Council and Rutland County Council for children attending Leicestershire and Rutland Schools in year 7-11. The offer for Reception to year 6 remains largely unchanged. The Year 7-11 pathway in Leicestershire will now be via a new 'Teen Health' non-clinical service hosted by the County Council, and in Rutland it will be via Early help for Public Health concerns. Safeguarding concerns will be via the lead health agency such as GP's, CAMHS, Community paediatricians etc.

These changes have implications for:

- Leicester City Children attending schools in Leicestershire and Rutland (about 15% (or 3,500) City children)
- Leicestershire and Rutland Children attending Leicester City schools (about 3% (or 1000 children)

Many of these children are on a Universal pathway and are not accessing either:

- Public Health Nursing (School Nurses)
- Public Health Nursing (Safeguarding)

However a small but significant number of city children will be accessing these services, including, potentially very vulnerable children who are subject to Section 17 or Section 47. The total number of city children this affected between January 2022-September 2022 was 36.

Historically PHN(SN) have worked with children in their school, rather than by their place of residence/postcode; when LPT provided both Leicester City and Leicestershire/Rutland with the same service this was a reciprocal arrangement that worked well and it wasn't an issue. The school based model is also the most commonly used nationally. But now the Leicestershire and Rutland offer is changing significantly we need to consider the implications of children living in the Leicester City and require access to Safeguarding provision and support, as they will have Leicester City social care support and the implications for Leicestershire and Rutland children attending a Leicester City school.

This Risk has been placed on the Risk Register.

In the short term, LPT have worked hard to create the offer below, but this is just an interim solution:

Safeguarding: Leicester City Children attending a Leicestershire or Rutland school

PHN(SN)'s will be alerted about a pending safeguarding meeting through either LPT Safeguarding team (Section 47 initial child protection meetings), or directly by the social worker leading the Section 17 assessment. The City PHN(SN) will provide a written report from Healthy Together information and present this at the safeguarding meeting. In this meeting they will seek parental consent to complete a holistic Baseline Health Assessment (BHA) in partnership with education colleagues so this can be completed within the school setting regardless of locality. If a health need is identified through the BHA it is either supported through targeted interventions by Healthy Together or referred onto an appropriate specialist health service.

The PHN(SN) safeguarding team will be the health representative on strategy calls.

Safeguarding: Leicestershire and Rutland child attending a Leicester City school

PHN(SN) will be alerted about pending telephone strategy meetings or safeguarding meetings through either LPT's Safeguarding team for Section 47 initial child protection meetings & telephone strategy calls, or directly by the social worker leading the Section 17 assessment.

Strategy calls, section 47 and section 17 for Children in years 7-11 with a Leicestershire postcode that attends a Leicester city school will no longer be covered by the Leicester City 5-19 Public Health Nursing (School Nursing) team. These will be managed by Leicestershire and Rutland County Local Authority 11 plus offer.

For a case study, please see Appendix E

LPT, LCC and Leicestershire and Rutland County Councils are working together to identify what the safeguarding and Public Health offer for children will look like. Additionally, the Designated Nurse for Safeguarding, in the Integrated Care Board (ICB), is overseeing the new arrangement for a period of one year to ensure that statutory obligations for health representation in safeguarding are met.

The future:

Key Performance Indicators (KPI's):
The following KIP's will be in place from Quarter 4, 2023, which will enable detailed information about the delivery and performance of the service:

- Number of schools with children in year 7 participating in DHC's
- Number of schools with children in year 9 participating in DHC's
- Number of schools with children in year 11 participating in DHC's
- Number of children with completed Digital Health Assessments
- Number of referrals received into service
- Amber referrals: Number of children/Young people seen for a Triage/ Baseline Health Assessments within 10 working days.
- Green referrals: Number of children/Young people seen for a Triage/ Baseline Health Assessments within 20 working days.
- Number of Review Health Assessments completed
- Number of Baseline health assessments completed prior to a Child Protection (Section 47) or Child in Need (section 17)
- Number of Baseline health assessments completed within 10 working days of a Child Protection (Section 47) or Child in Need (section 17)

Use of a Section 75:
The use of a Section 75 to recommission 0-19HCP is currently being progressed.
A Section 75 is an agreement made under Section 75 of National Health Services Act 2006 between a local authority and an NHS body in England. The intention of Section 75 Agreements is to improve services for users through **either** 'pooled budgets' (where two organisations bring together resources) **and/or** 'delegated functions' (where one organisation exercises an agreed function on behalf of another) **if it could be reasonably expected that this would lead to an improvement in health as a result of the way those functions are exercised**

This is a contractual partnership, it is legally binding, for a specific length of time (but partners are able to leave/terminate early with specified notice periods), with clear outcomes that partners are accountable for achieving that are decided via collaboration and co-design.

There are an increasing number of Local Authorities considering and using Section 75 to re-commission 0-19HCP. Our closest example is Derbyshire who have provided support and guidance throughout this process.

Papers detailing the progress of the recommissioning can be provided.

Voice of Schools in the development of the Section 75 Public Health Nursing (School Nursing) provision:
The team worked with 5 schools (3 secondary, 2 Primary) between 23rd September and

13th October 2022. Feedback was:

- Transient nature of the work force meaning either currently or in the recent past they had experienced issues with the stability of the PHNSN attending their setting (all schools).
- The referrals process tends to work well, but that they don't always hear back about whether the PHNSN has taken the referral or what the outcome of the referral was. If this communication were to be improved, the schools thought it would improve partnership working (4 schools). For this to include better correspondence about which referrals were taken and which weren't, and clarity about why the PHNSN can't see certain students if they are accessing other services such as CAMHS.
- A more formal feedback including the voice of the young person (One secondary school noted they would like the voice of the child included in feedback/evaluation of the services, as currently they are unable to feedback about their experience, and any feedback received tends to be in informal moments such as results day when individuals share how contacts with the PHNSN helped them to overcome issues)
- More information about what is included in the offer being shared with students, parents, and other staff members (all schools), including informal stands during lunch times/open days for students to learn about the service
- More session availability, more help around healthy lunchboxes/healthy weight, and information about the impact of vaping (Primary Schools).
- One secondary school mentioned they would like to see more bereavement support (not counselling), low level mental health support and group sessions about topics the school has noticed may be an issue (e.g. puberty, vaping).
- PHNSN role in supporting stablishing EHCP's (to pupil and child)

This findings will feed into the service specification.

Voice of Young people in the development of the Section 75 Public Health Nursing (School Nursing) provision:

In early 2022, two listening sessions were held with young people, one with the Youth Advisory Board (YAB) and one with young people attending a group run by Centre for Fun and Families.

Some young people had directed experience of the support a PHN(SN) can offer, but most did not. Those that did praised the service highly, those that did not were unsure what the service was, what it offered, or how to access it.

All young people felt the role of the PHN(SN) could be better promoted, publicised and visible. Both groups suggested more assemblies, the more inactive or innovative the better.

Both groups wanted a variety of ways in which the PHN(SN) could be contacted and reducing stigma and maintaining confidentiality were considered very important.

This will feed into the service specification.

6. Financial, legal, equalities, climate emergency and other implications

6.1 Financial implications

6.2 Legal implications

Noted this is an update report only. Previous and ongoing legal advice is being provide in respect of the recommissioning of 0-19 Services.

Legal advice to continue to be obtained as needed.

Mannah Begum, Principal Solicitor, Commercial and Procurement Legal, Ext 1423

6.3 Equalities implications

When making decisions, the Council must comply with the Public Sector Equality Duty (PSED) (Equality Act 2010) by paying due regard, when carrying out their functions, to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not.

In doing so, the council must consider the possible impact on those who are likely to be affected by the recommendation and their protected characteristics.

Protected groups under the Equality Act 2010 are age, disability, gender re-assignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, sex and sexual orientation.

An Equality Impact Assessment (EIA) is currently underway on the 0-19 Healthy Child Programme and the school nursing provision is included within this. The EIA will need to be updated to reflect the outcomes of the LCC joint public consultation with LPT which will run from 16 January to 10 April 2023, as part of the recommissioning process. Stakeholders will have the opportunity to consider proposed changes to the 0-19 Healthy Child Programme service specification. We need to ensure the public consultation is accessible, fair and proportionate and communicated to relevant stakeholders.

Carrying out an equality impact assessment is an iterative process that should be revisited throughout the decision-making process and updated to reflect any feedback/changes due to consultation/ engagement as appropriate. The findings of the Equality Impact Assessment should be shared, throughout the process, with decision makers in order to inform their considerations and decision making.

Where any potential disproportionate negative equalities impacts are identified in relation to a protected characteristic/s, steps should be identified and taken to mitigate that impact. The EIA findings should continue to be used as a tool to aid consideration around whether we are meeting the aims of the PSED, and to further inform the work being progressed on the 0-19 Healthy Child Programme.

Sukhi Biring, Equalities Officer, 454 4175

6.4 Climate Emergency implications

6.5 Other implications (You will need to have considered other implications in preparing this report. Please indicate which ones apply?)

7. Background information and other papers:

8. Summary of appendices:

9. Is this a private report (If so, please indicate the reasons and state why it is not in the public interest to be dealt with publicly)?

10. Is this a "key decision"? If so, why?

Appendix xx: 6 change that would indicate that the change was an improvement

Indicator	**Current position**
Following Safeguarding Meetings all children and young people to be offered a baseline health assessment and completed within 10 working days	70% of children and young people are seen within10 days. Themes for the non-completion of the baseline health assessment within this timeframe are as follows: • COVID infection. • Poor school attendance. • During school holidays venues to complete the health assessments are limited. • Lack of parental engagement/consent. • Lack of COVID risk assessed rooms within schools. • Healthy Together was not invited to the initial safeguarding meeting. • Low staffing and sickness.

No cancellations or rescheduling of Public Health activities in schools due to capacity to deliver safeguarding commitments	There has been no cancellation of Public Health activities since start of model
For staff to report a manageable balance of delivering the safeguarding and public health elements of the service.	64% of staff have rotated through both safeguarding and public health – with new starters making up 23% of staff who have not yet rotated. Since the start of the model the rotation of staff has been extended from the initial 3 month rotation, then to 6 months and now is completed on a 12 month basis. This follows staff feedback that the shorter rotation periods caused disruption to planning and implementing public health interventions throughout the academic year and was difficult to manage. The 12 month rotation (which has been in place through the pandemic) is allowing staff to maintain both public health and safeguarding skills and feedback identifies this is more managable.
For staff to report increased confidence to support safeguarding cases	70% completion of baseline health assessment within 10 days of an initial safeguarding meeting is indicative of increase confidence of staff aligned to the safeguarding workforce.
Improved communication between Healthy Together, Schools and Social Care	Staff outside of our organisation have identified positive feedback from social care relating to the one cloud telephone number.
A representative from Healthy Together at all 0-19 safeguarding meetings	When staff are invited to a safeguarding meeting, Healthy Together sends representation. For the 0-5 element of the service delivery this is in the form of a PHN**(HV).** For the 5-19 element of service delivery this is either a PH(**SN)** or a HCPN.

0-19 Healthy Together:
Delivery of the 5-19 offer across Leicester City

Report overview

On October 1st 2019, a new model of delivery of the 5-19 years offer was rolled out across Leicester City. The current report will detail the journey of the development and roll out of the new offer.

Why was the change needed-

The development of the new model aims to ensure that as a workforce, Healthy Together can commit to delivering the public health/health promotion agenda as set out in our Standard Operating Guidance (2020), whilst also meeting the statutory safeguarding commitments as per the LSCB Guidance and Working Together to Safeguard Children (2018). In the previous model, each public health nurses was responsible for delivering both elements of the role. However, it was becoming increasingly evident that the quality and consistency of the delivery of public Health element of the service was becoming more frequently compromised. The service therefore, needed to develop and implement a model for the 5-19 workforce to manage the increased demands and commitments of statutory safeguarding responsibilities in Leicester City, whilst also providing a safe and effective public health service for young people and their families.

What was done-

In the new model practitioners, on a rotation basis, are assigned to either focus on safeguarding or public health related activities.

The current report will provide details of the background to the change, an overview of the new model and the impact it is having on the Service's ability to support young people.

1 Background

Safeguarding is the underpinning responsibility of all child health programmes. As the only group of health practitioners who engage with school aged children and young people at universal level, public health nurses (school nurses) are recognised for the significant impact they have on keeping children safe from harm, supporting health and wellbeing and improving outcomes for children, young people, families and communities. They have a unique perspective and relationship with young people and can provide essential information to contribute to the safeguarding of young people.

The primary commissioned role of Healthy Together is to support the school aged population in the following high

impact areas: resilience and wellbeing, keeping children and young people safe, healthy lifestyles, maximising learning and achievement and supporting complex and additional health and wellbeing needs.

Each school nurse is responsible for supporting approximately 7000 school aged young people. Over the past 12 months, approximately 470 young people were on Universal Plus, Partnership Plus and Safeguarding caseloads. To support this population, there were only 9 whole time equivalent Band 6 Specialist Community Public Health Nurses –School Nurse (SCPHN-SN) and 12 whole time equivalent Band 5 Healthy Child Programme Nurses. As such, the responsibility to deliver both the public health and safeguarding elements of their role were becoming increasingly difficult to balance.

The main areas of concern were the ability to manage strategy calls, initial child protection and children in need invitations and an increase in the volume and complexity of safeguarding cases (including an increase in the number of cases involving sexual and criminal exploitation). These increasing demands and depletion in the number of school nurses meant that team members were not always able to commit, respond and deliver public health services to their school aged populations. Safeguarding commitments across the 0-19 team were, and continue to increase across Leicester City.

It was becoming increasingly apparent that Healthy Together Safeguarding responsibilities were restricting the ability to deliver a proactive public health role, for which our service is commissioned. Therefore, to ensure our service was able to be more proactive, rather than reactive, and forward plan in relation to managing the safeguarding and public health commitments, the service needed to think differently about how to meet the service offer and support staff to provide a quality driven service with the current workforce.

As there is no proposed increase in the 5-19 workforce it was essential that the service meets these demands whilst ensuring that staff are not placed under increased stress caused by the increase of safeguarding demands.

2 Change idea

Given the background detailed in Section 1. the service aimed to design and implement a sustainable, safe and effective response to safeguarding work whilst also being able to provide a responsive and quality public health offer to young people aged 5-19 years old across Leicester City.

To design and deliver the new model, a task and finish group of practitioners including, School Nurses, Service leads and Quality leads formed and followed the NHS model for improvement to support the design, implement and evaluation of the new model. An outline can be seen below in table 1.

Table 1. NHS improvement model for change template

What are we trying to achieve?	• Reduce the use of reactive strategies by creating proactive processes to address the known needs of the population • Enable all team members to organise, plan, commit and provide a public health service that is sustainable, safe and effective • Reduce the time taken to respond to referrals from parents, education,

	partner agencies and children and young people. • Enhance safeguarding expertise and quality and consistency of delivery for families.
How will we know the change is an improvement?	• All children/young people to be offered a baseline health assessment and completed within 10 working days following the safeguarding meetings. • No cancellations or rescheduling of public health activities in schools due to capacity to deliver safeguarding commitments • For staff to report a manageable balance of delivering the safeguarding and public health elements of the service. • For staff to report increased confidence to support safeguarding cases • Improved communication between Healthy Together, schools and Social Care • A representative from Healthy Together at all 0-19 safeguarding meetings
What changes can we make that will result in an improvement	Changing the current delivery model so that there is a dedicated group of practitioners focusing specifically on safeguarding, allowing the remaining workforce to focus on delivering the public health element of the offer (for further details see section 3 below).

3 The new Leicester City School Nursing model

The new model was originally based upon the school nursing service in Reading (as outlined in The Westminster Briefing 2019 – The Future of School Nursing), where they faced similar staffing and service dilemmas. However, it is important to recognise that the population in Leicester City is larger, more diverse and the number of safeguarding cases is higher than that experienced in Reading. Therefore the model is not a direct replica, but used the principles of 'The Reading Model'.

To deliver the commissioned service offer as well as safeguarding commitments, the new model involves dividing the workforce into two strands, focusing on the two elements of the service delivery. Staff will work on a rotation basis, in the two strands (rotation time still under discussion). The strands are-

- The Public Health Practitioners (80% of our workforce)
- The Safeguarding Practitioners (20 % of our workforce).

The following sections will outline the new model.

3.1. Public Health-

Pathways to support the management of secondary school and primary school caseloads have been developed. New, clear processes have also been developed to manage referrals into the service using an evidenced based 'Traffic light process' (Public Health England, 2016).

The 'School Health Profile' has been redesigned to make it easier for the schools and staff to complete whilst outlining a clear 'school agreement' detailing what Healthy Together can provide. This Agreement also reinforces

the value of the Digital Years 7,9 & 11 Health and Wellbeing questionnaire; for which there has been an increase in uptake across the whole of Leicester City.

Our SystmOne Patient Electronic Health records have been streamlined to ensure that our assessments not only remain holistic and child/young person focused, but also allows the service to capture data to evidence contacts, outcomes and outward referrals of young people.

3.2. Safeguarding-

To support those staff working within the safeguarding team, clear pathways have been developed to reinforce the current safeguarding processes.

The safeguarding team has-

- A duty day rota – this allows safeguarding administration team to cover telephone strategy meetings in a timely manner, as the service now only has one telephone number that they need to ring instead of the previous six numbers.
- Weekly allocation meetings- to ensure that any new safeguarding cases are allocated equally amongst safeguarding staff.
- Safeguarding supervision- to ensure that staff supporting complex and often emotionally difficult cases are supported and so that the families receive the right referrals and support as needed.

Below are examples of the changes to practice.

Case 1: Managing strategy calls

Previous model

Getting cover for strategy calls could often be time consuming, leaving practitioners with insufficient time to read a child/young person's record before the call. The process of supporting a child or young person after the call was also proving inefficient.

Prior to the delivery of the new model, if a strategy call came into the safeguarding administration team they would contact the child or young person's allocated school nurse to request that they contribute to the call. However, this process was often complicated when the allocated practitioner was unable to support due to other commitments in the service. The administration team would then leave a message with the locality team to request the support of another practitioner (often the person who picked up the phone message first would be the one to cover). If the admin team received no response, they would then inform the Clinical Team Lead for that locality area, who would then find and allocate cover for the strategy call. This process could often be time consuming, reducing the amount of time a school nurse would have to read each child's SystmOne medical records and prepare for the strategy call.
Once on the call, the majority of staff would take hand written notes to then transcribe onto the child or young person's medical records and they would task the allocated school nurse to share the information with the relevant people and follow up with Social Care.

Current model

The request for support with strategy calls now comes through to one number for the safeguarding staff and staff

are allocated in a timely fashion. This allows the staff covering the call adequate time to check each child's medical records and prepare to feed into the conference call. All the safeguarding staff now use a Word Document to record the strategy meetings, which they then can copy and paste straight onto the child/young person's medical record. On average this saves approximately 20- 30 minutes record keeping per child.

Case 2: Initial Child Protection and Child In Need invitations

Previous model

The administration team would place a task into the school caseload as a notification of an invitation to a meeting. It would then be left to each practitioner to check their allocated school's caseloads and action the invitation. This often led to a disproportionate workload for some staff; as some locality areas in Leicester City have higher safeguarding cases than others. Due to this, some would not have the capacity to complete a baseline health assessment pre conference and the voice of the child would often only be reflected through the social workers report. This also impacted on their ability to deliver public health activities.

Current model

Safeguarding invitations are now placed directly into a safeguarding allocation caseload and this is checked at least three times a day by a member of the team who is on a duty day. That practitioner would then contact the parents of the child/young person and where possible, obtain consent for a baseline health assessment to be completed pre conference. They would then allocate the safeguarding meeting to a member of the team who has capacity. As consent for the baseline has been given, this allows the team to complete the baseline pre conference and share the voice of the child/young person as part of the decision making process in the safeguarding meetings. The Service has not only seen an increase in pre-conference assessments rise from below 5% to an average of 65%, but the voice of the child has changed the decision of the plan in some cases. As an example, service has seen cases where the voice of the child/young person has raised the initial perception of the risk and identified the need to protect them through a Section 47 plan (compared to the Social Care proposal which was for Early Help support or a voluntary Section 17 plan).

4 Impact

Throughout the implementation, review points were scheduled to collate feedback from staff and from the patient electronic record system, to assess the impact of the new model.

4.1. Impact on Public Health promotion

The new model has facilitated teams across Leicester City to work more cohesively as one team rather than six individual teams. As of January 2020 the impact of the new model on the public health team has been evident by the amount of contacts documented using the staff's SystmOne Ledgers. The ability to identify the activity being carried out has been facilitated by significant updates to the patient electronic record system during this period.

As an example of the activities carried out, across Leicester City North and South, there are-

- 19 mainstream secondary schools (each requiring a weekly school nurse Health Shop)
- 9 schools for children with additional needs (require a bi-weekly health shop)
- 83 primary schools (which although do not have a weekly commitment from our service does generate

individual referrals for targeted support).

During the period of the 01.10.2019 – 03.01.2020 our public health team completed 614 contacts. These ranged from Triage appointments, full baseline health assessments as well as review appointments (this period also included three weeks where the schools were closed due to school holiday breaks).
These figures do not include contacts for Healthy Bladder, Healthy Bowel or any parent workshop for Sleep, Behaviour or anxiety. Prior to the new model, a number of these contacts would be cancelled in order to prioritise safeguarding commitments; now these do not need to be cancelled.

The service has seen an increase in the completion of the 'school agreement' (previously known as the 'School Health Profile') across Leicester City and there has been an increase in the number of schools and year groups booking to complete the digital years 7,9 & 11 Health and Wellbeing questionnaire.

Planning for Public Health events is currently underway, in line with the annual public health calendar, where previously this planning was effected by safeguarding commitments.

Weekly allocation meetings are now held to look at the Leicester City 5-19 caseloads to aid the decision making processes, ensure work is equally distributed and meets the needs of the children/young people and their families. A traffic light triage system is in place to support teams during their weekly allocation meetings to ensure that children and young people who are in need are prioritised to be seen, where possible reduce the waiting time for an appointment and or redirected to a more appropriate service to support them.

A further modification to the service delivery is the opportunity to offer young people an initial 10 minute triage appointment, rather than completing a full baseline health assessment, which takes around an hour in the first instance, and is not always necessary. The triage appointment allows the practitioner to offer health and wellbeing information and assess whether a full baseline health assessment is needed. Triage templates have been developed to aid this process.

4.2. Impact on safeguarding practice

For those on the Safeguarding caseload a full baseline health assessment is needed. Prior to the implementation of the new model less than 5% of young people had a baseline health assessment prior to conference. However, as of January 2020 the number of baseline health assessments completed pre-conference rose to over 65%.

Reasons for the 35% who did have not a baseline health assessment completed pre conference were:

- Lack of parental consent – either parents refused to consent or it was not possible to get hold of them.
- Lack of notification of the meeting, as the reports have to be submitted 48 hours pre-conference the service did not have sufficient notification to complete the assessments in time.

The impact that completing a baseline health assessment can have on the outcomes for young people and their families can be seen in the case study found in Appendix 1. The skill of the Public Health Nurse (School Nurse) in reading a young person's body language identified that they and their siblings were subject to additional safeguarding issues at home, beyond the issue that had been initially presented. This could subsequently then be addressed at the Initial Child Protection Conference

Prior to the new model approximately only 25% of baseline health assessments post conference, within the 10 working day target, were completed. This has now increased to approximately 80%.

During a whole Leicester City school nurse team event on 22.01.2020 the qualified staff were asked to feedback on the impact on the new model. Due to the nature of the change and the short time that the model had been in place, the feedback largely related to the impact on the safeguarding work. The impact on safeguarding was identified as prompter responses and improved outcomes for both families and Social Care due to continuity from Healthy Together. In relation to public health, staff felt that schools were largely positive about the changes although some were adjusting to referrals being responded to by a team rather than a named nurse. It was recognised that the response to the public health work was improved by removing the unpredictable safeguarding workload.

Leicestershire Partnership NHS Trust safeguarding administration team report significant improvements for their team using this model, including a quicker response time for covering calls and clarity of responsibility within Healthy Together from the duty rota.

5 Conclusion

5.1. What is going well-

As demonstrated above, the new model is having a positive impact on the Service's ability to deliver the commissioned public health commitments and ability to deliver safeguarding duties with less impact on the public health element of the service.

5.2. Challenges and moving forward-

The service acknowledges that this is a new way of working and has been proactive in seeking out and addressing feedback. Although predominantly positive, there have been challenges to both strands of the service which the service is working through.

Schools across Leicester City are now being provided a service using a team approach; strong communication is being used in order to support schools with this change. There has been very little negative feedback regarding this change and schools continue to receive a consistent service from Healthy Together.

By creating two teams within the 5-19 team it has been recognised that staff confidence in managing safeguarding may be affected when they are not working within the safeguarding team. Staff will continue to receive regular safeguarding supervision and mandatory training and a regular rotation of staff in the teams will maintain skills.

Within the safeguarding work stream, the challenges largely relate to being able to meet the targets of completing baseline health assessment pre conference. Where the service has not been able to meet this target, this has been due to either lack of parental consent or lack of notification from social care. Timely notification of safeguarding meetings is required in order to be able to complete health assessments prior to safeguarding meetings.

It was thought on commencement of the model that staff would support work across teams. However, due to the high volume of work in the safeguarding team, particularly with strategy calls, this has not been possible.

The main challenge has been to ensure that the focus and purpose of this model is to allow the public health strand to meet the needs of the service users and not for it to solely focus on the safeguarding commitments. Working together as a whole, the Leicester City team is continually improving the quality of the delivered of the service across both public health and safeguarding. To support this, feedback continually being collated on the impact of the current Healthy Together offer to 5-19 year olds and their families across Leicester City.

Healthy Together have committed to completing a 12 month extended pilot due to the initial positive feedback of the model. At the end of this period further evaluation will take place in order to inform a decision on the future of the model.

6 Appendix

Appendix 1. Impact of the Baseline Health Assessment on inform the Initial Child Protection Conference

Impact of the Baseline Health Assessment on inform the Initial Child Protection Conference (ICPC)

Catherine Yeomanson – Lead practice teacher for school nursing in Leicester city

Case: 14 year old white British male reportedly raped younger sister

CONTACT TYPE / SETTING: Baseline health assessment – face to face in Secondary school and then an initial child protection conference (ICPC)

OTHER PROFESSIONALS INVOLVED: At ICPC: Social Services; Education; Police; Health; Parents and paternal grandfather.

REASON FOR CONTACT: Pre-conference assessment

INTERVENTION: Baseline health assessment

Child A understood why he was being seen and reported he had been accused of raping his little sister, which he then denied. He did not know who had reported him but he expressed that he was very angry towards them.

Lack of emotional connection to the allegation

At no point through the assessment did Child A's presentation change – he maintained eye contact and sat with an open frame and his tone of voice was light and did not change when talking about his emotions.
He presented with no changes to his sleep, diet, self-caring or friendships and at one point discussed that his friends knew but they didn't believe it either. He also reported no low mood, suicidal thoughts, or being scarred/anxiety. The only time he reported he got angry was linked to whom ever had reported him.
He also denied ever being sexually active and had no concerns with his sexuality or gender. He discussed no risk taking behaviours.

No safety plan in place at home

Child A was not restricted in his contacts with his younger sister whilst at home, which indicated the family either did not have a safety plan to protect the younger sister or that they were not adhering to it.

My overall assessment of his risk of harm 'very high'. This was due to the validity of the assessment, as it raised concerns about his honesty as he showed no emotional connection to the allegation made against him.

Concern over parental behaviour
Child A did not report smoking, drinking or drug taking, but **lost eye contact when discussing this (which had been unusual**). I asked if he had a friend or family member who used alcohol, smoked or took drugs. Child A was silent for a while and then started to talk about his dad.

Child A reported that his dad drinks alcohol all the time and he is scared about it – he then stopped talking as he did not want his dad to find out he had shared this as part of the assessment. We agreed that it needed to be shared if he was scarred and confirmed I would only share it in the confidential slot of the meeting (I explained what this meant). Child A then shared that **he had been hurt by his dad when he was drinking before and nothing happened to stop him** – so he doesn't bother to tell anyone now.

Child A discussed that dads mood changes when he drinks, he may start play fighting with them (Child A inferred to all his siblings) but that dad doesn't stop when they want him too and he hurts them. **They are too scared to stop him as he also gets really angry when he drinks so they let him 'play'.** Child A reported that their mum knows and she can't stop him from drinking. Child A also shared that he is **scared this drinking will mean his dad will die and he doesn't want that.** We agreed that this is something the social worker can explore with mum and dad and see if dad would want some help.

OUTCOME / REVIEW:
During the ICPC the focus was on Child A and the allegation against him and his parents' ability to protect the younger females in the family. The recommendation was that the family be subject to a child in need plan (Section 17 of the Children's Act), with support to be in place to protect the family from Child A. The other recommendation was that Child A be subject to a CUAB plan (Child undertaking abusive behaviour).
During confidential slot, the practitioner shared Child A's disclosure about dad's alcohol misuse and the alleged impact on him and his siblings. Professionals also learnt that the person whom reported the alleged rape to social care was the paternal grandmother. Whom had alleged that dad had walked in on Child A raping the youngest sibling and stopped it and allegedly told mum about it. Neither parent reported it to the police or social care.

Social Care shared previous involvement with the family linked to dad physically hurting Child A, however their assessments at this time reflected dad play fighting and it being an accident.

When the parents returned to the conference following the confidential slot – Dad's alcohol use discussed. He admitted to drinking every day at set times and mum confirmed that this stopped dad from getting angry towards them, so she didn't mind him drinking. Dad also confirmed that he had completed an intense alcohol detox programme previously, so he knows he doesn't need help now as he isn't like he was before the programme. Mum reported she has to work and leaves the children in the care of their dad; for which he then has alcoholic drinks at set times to help him cope.

Mum and dad continued to deny any concerns around Child A and the rape allegations. However, Mum then discussed how she has talked to all the children about touching each other and what they can and can't do. But they did not agreed to any safety plan and it was confirmed there was no supervision of Child A with his siblings.

OUTCOME:
The outcome of the ICPC was that all children be subject to a child protection plan under the category of 'Sexual Abuse'; which is due to the risk Child A poses towards them. **By sharing the baseline health assessment in conference, the focus was also on the parents ability to protect and parent the children due to Dad's alcohol misuse, mum colluding with dad, neither parent reporting the rape and the parents not supervising contact between Child A and his siblings**. As a consequence social care also sought legal planning to ensure the family

engaged and that Child A received the correct support to help him have positive sexual experiences in the future and not be classed as a sexual predator.

Appendix B

Appendix B: 6 change that would indicate that the change to Public Health School Nursing format was an improvement

Indicator	**Current position**
Following Safeguarding Meetings all children and young people to be offered a baseline health assessment and completed within 10 working days	70% of children and young people are seen within10 days. Themes for the non-completion of the baseline health assessment within this timeframe are as follows: • COVID infection. • Poor school attendance. • During school holidays venues to complete the health assessments are limited. • Lack of parental engagement/consent. • Lack of COVID risk assessed rooms within schools. • Healthy Together was not invited to the initial safeguarding meeting. • Low staffing and sickness.
No cancellations or rescheduling of Public Health activities in schools due to capacity to deliver safeguarding commitments	There has been no cancellation of Public Health activities since start of model
For staff to report a manageable balance of delivering the safeguarding and public health elements of the service.	64% of staff have rotated through both safeguarding and public health – with new starters making up 23% of staff who have not yet rotated. Since the start of the model the rotation of staff has been extended from the initial 3 month rotation, then to 6 months and now is completed on a 12 month basis. This follows staff feedback that the shorter rotation periods caused disruption to planning and implementing public health interventions throughout the academic year and was difficult to manage.

	The 12 month rotation (which has been in place through the pandemic) is allowing staff to maintain both public health and safeguarding skills and feedback identifies this is more managable.
For staff to report increased confidence to support safeguarding cases	70% completion of baseline health assessment within 10 days of an initial safeguarding meeting is indicative of increase confidence of staff aligned to the safeguarding workforce.
Improved communication between Healthy Together, Schools and Social Care	Staff outside of our organisation have identified positive feedback from social care relating to the one cloud telephone number.
A representative from Healthy Together at all 0-19 safeguarding meetings	When staff are invited to a safeguarding meeting, Healthy Together sends representation. For the 0-5 element of the service delivery this is in the form of a PHN**(HV).** For the 5-19 element of service delivery this is either a PH(**SN)** or a HCPN.

Appendix B

NIHR | School for Public Health Research

Exploring the potential of a school-based online health and wellbeing screening tool: An Overview

Overview Document Creator: Amy Robinson

Study Team: Patricia N Albers, Katie Breheny, Rona Campbell, Katrina d'Apice, Frank de Vocht, Hannah Fairbrother, Clare Mills, Alice Porter, Sarah Tebbett, Nicholas Woodrow.

Background

The issue

Looking after our mental and physical health should be a priority for everyone. Despite this, many young people don't ask for help or get the support they need. Health problems can have a big impact on many different areas of young people's lives including school attendance, future health, and even job opportunities.

A potential solution

To help young people get the right support, the 'Digital Health Contact' (DHC) programme was created to be used in secondary schools across Leicester, Leicestershire and Rutland. Prior to introducing the DHC, students would access the Public Health School Nurse (PHSN) either by self referral, referral from teachers, or by using the ChatHealth text service. The DHC was developed to provide a form of universal contact for secondary school children, whose last universal contact was at the age of two.

The DHC is a new intervention that links health promotion, health screening and understanding the health of the population (known as population health intelligence). Students in Year 7, Year 9, and Year 11 completed an online survey asking them a range of questions about their health and lives. The survey responses are were processed automatically. If a child 'red flags' with their answer to a question, a referral alert is sent to a PHSN. The PHSN will contact the student to take steps to help if needed, including offering evidence based advice and support and making referrals to other services. All students completing the survey are provided with general public health advice.

Our goal

We wanted to evaluate how useful and acceptable the use of the DHC in identifying and providing for unmet health needs from the perspective of a number of different people involved in the DHC. This information could then be used to inform future delivery of the DHC and give useful information for other commissioners and providers of the 0-19 Healthy Child Programme, as it is a tool that could be used in other areas of the country.

What We Did

We carried out interviews with young people who had participated in the DHC, PHSN, school leaders, providers, and commissioners involved in its delivery to explore their thoughts and experiences of the DHC.

Young people from two schools took part in the research, with one school (29 students) completing the survey at home during the COVID-19 pandemic, and the other school (22 students) completing it in the school setting. We compared the number of PHSN referrals between schools that did and did not take part in the DHC using data from 36 schools, across 3 years.

Using data for 164 pupils from one school, we looked at whether attending a PHSN appointment in Year 9 affected the number of 'red flags' after completing the DHC again in Year 11. We looked at whether pupils who red flag on certain questions are more likely to be offered an appointment.

Findings

- The DHC was seen as a useful way to identify health need and provide support for young people.
- Young people were overwhelmingly positive about the DHC.
- It was of importance young people had a clear understanding of the way the DHC worked this helped to ensure students were honest in their answers.
- Students said that doing the survey online (rather than answering questions face to face with a PHSN) helps reduce perceived embarrassment when answering questions, resulting in more detailed and honest responses.
- Doing the survey at home (rather than at school) helped young people to complete the survey honestly as they felt they had more privacy. It also felt less time restricted, meaning students could take time with their answers, and provide more detail.
- Young people describe how after completing the DHC they had a better understanding of potential support options for any health and wellbeing needs, but there was still some uncertainty about how to directly access that support.
- PHSN's found that the DHC helped them to identify and support students that might not have sought support from the service otherwise.
- PHSN's felt the DHC helped improve awareness of their role in the school with students, allowing them to assess lots of young people in a time and cost saving way.
- Both school leaders and PHSN's felt the DHC helped them better design and deliver relevant support to students, providing a better understanding of their students needs and issues.

- Some school leaders initially were reluctant to take part in the DHC due to issues around logistics. However, once they had participated in the DHC they noted these potential issues had been planned and accounted for.
- The DHC is flexible and able to adapt and be used in multiple different settings if needed.
- Students selecting items which appeared to describe negative feelings were more likely to be offered a PHSN appointment.
- The number of referrals to PHSN was slightly lower in schools taking part in the DHC than those not taking part.
- For half of pupils, the number of 'red flags' had reduced in Year 11 after attending a PHSN appointment in Year 9, however an overall reduction across all pupils who attended an appointment was not seen.
- Overall, the DHC involves a similar PHSN workload but offers a more acceptable approach to referral for pupils, PHSN's and school leaders.

Recommendations

Practice implications

- The DHC's screening and linked follow-up support approach appears to be an efficient way to target limited service recources.
- It's important for students to have a clear understanding of how the DHC works (why they are doing it, who sees their answers, what can happen after) to encourage open and honest responses.
- Continued advertising, promoting, and reinforcing of how students can directly contact PHSN for support is important.
- Increasing privacy and the time students have to complete the survey can encourage honest and detailed answers.
- Schools and PHSN need to work together effectively, to overcome perceived and actual challenges of implementing DHC in schools.

Further Information

If you would like your school to participate in the DHC, or would like further information about the programme and how it can be implemented please contact Sarah Tebbett at sarah.tebbett@nhs.net.

Young People's Views

"The survey made me aware that there are people that can help you in school if you're feeling down."
Male Student

"I do think it's a good way to do it and I definitely appreciated it because then from that I started meeting the school nurses, so I think it's a good way for students to get that first step to get help if they need it...this survey gives an opportunity to ask for help without really having to ask for help."
Female Student

"[The DHC] opened up about quite a few places within the school that I could get help from that I didn't know about before."
Female Student

"I think you could be more honest online. Sometimes if you speak to someone you might not say everything you want to say…I think some people find it like, awkward and things to speak to people about it."
Female Student

"[It's] better at home because then you don't feel like anyone's judging you around the class...I probably wouldn't have answered so honestly if I were to do it inside of school."
Male Student

"[At home] you can have a think about it and you don't have to rush through it thinking that you don't have enough time…you can just sit there at your desk or on your bed or something and you can think about questions and you can answer them truthfully and you're not limited to a time."
Male Student

Professionals' Views

"One of the things we found is about students being anxious, but they didn't know how to get information or trusted websites...since then we've also got a mental health first aider in place as well."

School Lead

"I've noticed doing the questionnaires,the teenagers were much more aware of who I was within the school. When you're walking around they know who you are, 'you're the school nurse' and things like that. So in a way it's very good to promote our service."

PHSN

"I've picked children up that have had no support in the past, not even told their parents, schools, anybody. So we are picking up young people that otherwise would have sort ofmaybe continued to self-harm and, you know, just escalated further."

PHSN

"Now that we've had it, I wouldn't want to lose it"

School Lead

"We needed a contact for those children in those age groups, we don't have enough nurses to do that face-to-face, so it was a way of having a universal contact that was offered to all the kids that fit with our staffing models really."

Provider

"It's what I would call proper Public Health work – the stuff that we're supposed to do – you know, we get to go and see the kids and give them advice and signposting and, albeit it brief, ten minutes isn't very long, but it feels like it's what we should be doing."

Provider

References

If you wish to read the full published papers for this research, they can be found using the below links:

Woodrow, N., Fairbrother, H., Breheny, K. et al. Exploring the potential of a school-based online health and wellbeing screening tool: professional stakeholders' perspectives and experiences. BMC Public Health 22, 324 (2022). https://doi.org/10.1186/s12889-022-12748-2 https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-12748-2

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Appendix D Case Study Chat Health

Case study by*: Shannon Pratt HCPN and Shelley Winterton PHN-SN*

For the basis of confidentiality, the person in the study will be named: *Fred*

GENDER: Male

AGE: 13yrs

ETHNICTY: White British

CONTACT TYPE / SETTING: Face to face in senior school setting

OTHER PROFESSIONALS INVOLVED:

Early Help – allocated family support worker until approx.. June 2022

CAMHS (since October 2022)

CHRONOLOGY:

24.05.22 Parent (mum)messaged into Chat Health (using young person number) clearly identified self as a parent. Requesting support for Fred due to concerns with Fred being anxious and this escalating that mum is very concerned about mood. School nurse (SN) provided support and information to mum via chat health and clarified if Fred would like a SN appointment face to face in school. Mum confirmed he would prefer ''to speak to a school nurse rather than just first aid.'' Referred into appropriate SN team and safety plan provided to mum in the meantime.

31.05.22 Referral received by SN team, discussed at allocations meeting and prioritised as amber due to potential self-harm risks, mood, and young male. Also referred by GP for neurodevelopmental (ND) assessment. Letter sent home to advise referral accepted, consent received from Fred and mum for assessment.

13.06.22 Face to face triage assessment completed with Fred in school. The assessment identified that Fred himself was experiencing some anxiety but also described mixture of anxiety and fear. Fred clearly found it difficult to express himself fully. Some triggers to Fred becoming angry or anxious described by Fred that included others making noises – Fred felt he had no control or warning over his responses towards others. Denies self-harm or suicidal ideation.
Due to Fred's presentation as being quiet, difficulty opening up and Fred being confused about his feelings, a full baseline health assessment was agreed. Safety plan provided and Fred consented to information being shared with parent and other professional as required.

14.06.22 HCPN telephone call to mum. Mum reports that she is worried that Fred's issues with his emotions have been ongoing since primary school but that she is concerned that Fred is deteriorating. Awaiting outcome of referral for ND assessment. Safety plan re-iterated.

27.06.22 Baseline health assessment completed face to face in school. Anonymised analysis and plan detailed below:

Fred was seen today in school for a baseline health assessment following on from his triage appointment which he consented to and mum aware. Fred appeared more relaxed and interactive during this assessment compared to his previous appointment with us. Fred was dressed in clean appropriate clothing, and he appeared well looked after. There were no concerns regarding Fred's physical health although he stated he has asthma; it appears well-controlled. Height and weight completed during baseline health assessment. Although BMI indicates that Fred is overweight, no concerns from visual assessment.

From the baseline health assessment, it has now become clear Fred struggles with anger at school and paranoia at home which he would like assistance with how to control these. He was open and honest regarding when these are happening and was able to identify how he is managing with these at home using his own coping strategies including drawing, exercise (using his punchbag) and listening to music. Fred is finding it more difficult to implement these strategies at school as he is unable to use these strategies during school hours. Fred scored high in his emotional scaling for both home and school showing positive emotional resilience for both. Risk assessment completed which was identified as low, due to no self-harm or suicidal thoughts and has good strategies and protective factors in place to support emotional health.

Fred has been given more strategies from school nurses to try during school hours including square breathing and grounded technique. Fred understands how to use these and apply them when he is feeling these emotions during school time.

Agreed a plan with Fred to implement strategies over summer holidays and to meet again following summer break for a review assessment.

Plan:

- SN contact mum to feedback from baseline health assessment within 5 working days to which Fred consented to.

- SN to review after summer holidays (allowing him to settle back into school with new strategies).

- Parents and Fred aware how to contact other professionals during summer holidays if required, safety plan including emergency numbers, chat health, and CAP remain in place and appropriate.

OUTCOME / REVIEW:

26.09.22 Fred did not attend review appointment in school. Health records that mum has contacted GP surgery same date due to Fred's mood (having more mood swings) and outburst of anger at home. GP arranged face to face 27.09.22**.** SN liaised with attendance officer at school who advised that mum has contacted to inform school that Fred will not be in due to his mental health. Further appointment arranged for Fred in school that attendance officer will inform mum to ensure he can attend.

27.09.22 health record reviewed for update re GP appointment. Fred informed GP he has thoughts to harm other people. GP referred to early intervention service for counselling. This referral was not accepted, and Fred/family signposted to local tier one services.

03.10.22 Face to face review assessment with Fred in school. Anonymised analysis and plan below:

Fred attended school nurse review appointment today. Fred presented initially as calm however as the appointment went on, he began to appear agitated with minimal eye contact.
From this assessment, Fred is at an increased emotional health risk and is a very vulnerable young person at this time. He was able to identify that he has not previously been honest with school nurses and appears to want support to change how he is feeling.

Fred did not want to give much information about the thought he has to harm others, however on exploration he was able to share enough information to indicate a raised risk to Fred and to others surrounding him, due to Fred experiencing almost constant thoughts to hurt others in violent ways. Consideration given to Fred being exploited or radicalised due to these thoughts – Fred denies any involvement from others or harm targeted towards any specific groups/persons. Whilst Fred is not acting on these thoughts at present, he could not identify that he wouldn't act on these. However did state that he feels that it is 'not the right time'. There is also an increased risk to Fred's safety from what he has disclosed today from his intent to take overdose during summer 2022. Fred has not felt able to share this with his mum or any other professional previously. Fred stated he is not actively suicidal at present, however he did not follow through with his plan in summer holidays as he was not able to find any medication at home.

Fred has been referred to early intervention for counselling however it was clear from todays appointment this risk is now high and requiring urgent assessment for his mental health and safety.

PLAN:

Immediate plan to inform school for Fred's safety, to contact mum and CAMHS crisis referral to be made immediately.

OVERALL OUTCOME:

CAMHS crisis assessment completed with Fred on 03.10.22 via telephone and deemed 'raised risk to others'. Urgent face to face assessment completed by CAMHS clinician 04.10.22. CAMHS ongoing involvement to date. It is noted that on each contact with a professional from the beginning of the referral process, Fred has shared his thoughts and feelings a little bit more openly at a time. Fred was fearful to inform professionals of having 'dark' thoughts as he felt he would be 'taken away'. Fred eventually disclosed that he has active plans to stab, shoot and strangle 'anyone who may be in the local park near my house on Halloween', these plans remain active to date.
This case highlights the importance of listening to parents' concerns, taking a full history and most crucially, building a therapeutic relationship with young people for them to feel safe enough to share their experiences and concerns. The work completed with Fred, has resulted in Fred and those around him being protected as far as possible.

Appendix E: Case study safeguarding

Safeguarding Case Study: For the basis of confidentiality, there are four siblings three 11+ years who will be named A, B and C and one 5-11 year child who will be named D

Gender: x3 Females x1 Male

Age: 5 – 15 years

Ethnicity: Other white background

Reason for involvement: An invitation was received by the Healthy together Team to attend a strategy meeting for 4 siblings, one primary school aged child (D) and three secondary (11+) young people (A, B, C). It was unknown at the time of attending the meeting which schools the children attended. The Concerns that were related to the following:

- Poor school attendance for all children.
- A, B, C &D had outstanding health needs with non-attendance to medical appointments.
- A, B &C had episodes of missing from home where they were later found out of area.
- Concerns around parenting capacity
- Parental drug and alcohol misuse
- Known possession of weapons by the children's father.

The case has escalated, and an Initial Child Protection is to be convened at a later date.

A, B, C and D having been exposed to these adverse childhood experiences, which indicate they are at risk of their own risk talking behaviours, and the unknown impact on their mental health and physical health needs.

A, B & C live within Leicestershire but attend a Leicester city school. Following the demobilisation of the 11+ school nursing service in Leicestershire County and Rutland. School nurses are not commissioned to offer a service to young people (11+). Previously Healthy Together would have supported A, B & C by completing a report to share at the initial conference, detailing any health needs or concerns known to our service. We would have attended the Initial Child Protection Conference and complete a holistic Health Assessment where any physical and Emotional health needs are further identified as well as capturing the voice of the children. Any unmet health needs identified through this assessment which required support from healthy together, would include face-to-face packages of targeted interventions in school. The long- term impact on A, B & C is not yet known, and it is essential that their current needs are identified through a holistic assessment and support is provided where necessary. It has been highlighted that A, B & C have been left feeling unsupported by Health Professionals and the Safeguarding process.

D lives with his siblings' A, B & C in the Leicestershire and attends a Leicestershire primary school. D will receive the full offer from the Healthy together School Nurse team as children under the age of 11 years have not been affected by the demobilisation process. The Healthy together School Nurse for D will attend the ICPC, a Baseline health assessment offered to D, and any identified targeted health needs addressed through targeted work or

onward referral to the appropriate services for D. A, B & C will not have a health representative from Healthy together through this process and it remains unknown at the time of writing this case study which service that will be.

Outcome:

This case study identified that for the children and young people within this family to have any support from our service depends on where they live and not due to their individual health and emotional needs. The 11+ children due to attending a city school but living in Leicestershire have no service offered at all to them under the interim process and demobilisation of the 11+ school nursing service in Leicestershire County and Rutland. This will greatly impact on the opportunity for them to achieve their best possible outcomes emotionally, physically, and socially. For sibling D however the full offer from Healthy Together is given.

For the School Nurses within the Safeguarding team this decision is currently being met with challenges. The social workers do not appear to be aware of this interim measure and have strongly challenged our staff. They are insisting that Healthy Together continues to offer the same service particularly who will be completing the Baseline Health Assessments for A, B & C. They are challenging staff as to why four siblings residing at the same address could result in only one of them getting any Healthy together support. Challenges have been met by the parents how Health within the Safeguarding process is only seeing one of their children, when all four have identified needs and require support.

It is a concern that three out of the four children within this family have no support from Healthy together to assess their health needs and offer support to enable them to have positive outcomes moving forward .

Leicester City Council
Scrutiny Review

The experience of black people working in health services in Leicester and Leicestershire'

A review of the Health and Wellbeing Scrutiny Commission

1st December 2022

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Councillor Patrick Kitterick (Chair of the Task Group)
Councillor Luis Fonseca
Councillor Elaine Pantling
Councillor Geoff Whittle
Councillor Deborah Sangster
Councillor Padmini Chamund (previous Member of the Commission 2020-21)
Councillor Paul Westley (previous Member of the Commission 2020-21)

Evidence to the Commission was given by the following organisations and officers:

Clinical Commissioning Groups (CCGs)

Richard Morris
Alice McGee
Bina Kotecha

University Hospitals of Leicester (UHL) Trust

Aloma Onyemah
Hazel Wyton
Peter Wiklo

Leicester Partnership Trust (LPT)

Haseeb Ahmad
David Bhebe
Judy Eggett

Leicester City Council

Ivan Browne
Ruth Lake

Chair's Foreword

In 2020, the growth of the Black Lives Matter movement, along with the disproportionate effect that the COVID19 pandemic had on ethnic minority groups, demonstrated the inequalities that black people face in their daily lives.

As Chair of the City Council's Health and Wellbeing Scrutiny Commission until May 2022, I was keen to lead on strands of work that could probe into the reasoning behind such inequality and to look at how it can be addressed. It was with this in mind that scrutiny commission colleagues and I felt that it was fundamental to examine the experiences of black people working within the local health sector by setting up a task group comprising local councillors and supported by a range of witnesses and stakeholders.

Over a series of several meetings, the task group gained an understanding of the workforce in the local health sector, examined the existing working practices and engaged with a number of staff groups.

I'm extremely grateful to those within the local health sector that both presented directly to the task group and facilitated the involvement of staff throughout the review. This was critical in developing our understanding of the issues that were interested in. My thanks goes to many within the local Clinical Commissioning Groups, University Hospital of Leicester, Leicester Partnership Trust and Leicester City Council. I must also thank my fellow elected members who formed part of the task group and supported me in developing this work over many months.

It's clear that there are large elements of good practice in place, and I cannot question the overall intentions of those in position of authority to enhance equality across their workforces, but from the evidence the task group gained, I'm confident that much more can be done to make progress and to address issues of disparity. The report sets out the range of information that we examined and includes eleven recommendations to local leaders and decision makers in terms of taking some steps to improve inclusion and to ensure that those from different ethnic groups, particularly from an African Caribbean background, should have the same experiences and opportunities as all staff in our health services. At the very centre of this are our recommendations, which include suggestions in terms of improving workforce monitoring systems, considering alternative delivery mechanisms for mandatory training and for organisations to consider how development opportunities are better facilitated.

I dearly hope that our work and these recommendations can help to serve as a platform for some fresh ways of working across health sector organisations and that in several years to come, we can see seem genuine improvement in experience and opportunity for black people working in our health services.

Councillor Patrick Kitterick, Chair of the Health and Wellbeing Scrutiny Commission *(until May 2022)*

Executive Summary

Introduction

In 2020, the Health and Wellbeing Scrutiny Commission initiated a review into 'The experience of black people working in health services in Leicester and Leicestershire'.

Whilst nationally, the NHS has set up the NHS Race and Health Observatory and has the Workforce Race Equality Standard (WRES), the Health and Wellbeing Scrutiny Commission wanted to explore the picture locally. This involved the analysis of employment trajectories, progression, outcomes, as well as the disciplinary practices experienced by black people while working across the health sector in Leicester and Leicestershire.

Past research conducted in 2014 study called 'The "snowy white peaks" of the NHS'[1] showed the people in the most senior positions are white and male. Analysis conducted in mid-2019 showed this was still the case, with 8% of NHS chief executives and chairs identifying as being from an ethnic minority background.

The three organisations that provided evidence to the Commission consisted of the Clinical Commissioning Groups (CCGs), University Hospitals of Leicester (UHL) Trust and Leicester Partnership Trust (LPT).

The evidence gathering sessions for this report took place virtually throughout the COVID19 pandemic, with workforce pressures due to rising infection levels impacting on the frequency of meetings. In total, the Task Group held four meetings to gather evidence from partner organisations and their employees, with substantial workforce information provided at the first and second meetings. Subsequent meetings focused on progressing particular actions, and also examined the programmes and policies in place to achieve parity in areas where staff from black or African Caribbean / Heritage groups were disproportionately affected.

[1] https://eprints.mdx.ac.uk/13201/1/The%20snowy%20white%20peaks%20of%20the%20NHS%20final%20docx%20pdf%20(3).pdf

Recommendations

At the task group meeting on Thursday 21 April 2022, Members endorsed the following set of proposed recommendations:

a. Following initial discussions on the current data systems and the limitations around tracking workforce information and progression, it was recommended that existing systems are either improved or systems that facilitate such data collection are procured to identify and monitor this. It was noted that it is difficult to change practices if they cannot be measured. There was also a wider discussion on how NHS systems should also be used to capture information/issues around inequalities and protected characteristics.

b. To compare the journeys of substantive staff against bank staff. This is because bank staff can often enter and leave the organisation in 'freer and looser' terms compared to substantive staff, which may result in the danger of contributing to unconscious bias. This recommendation was made in response to the disciplinary statistics, where it was acknowledged that there is an issue with bank staff from an ethnic minority background being subjected to a higher instance of formal disciplinary proceedings.

c. Regarding the use of mandatory training for equality, diversity, and inclusion, it was recommended that organisations look to use different channels to deliver this training that encourages interaction, rather than the use of e-learning modules.

d. A key problem for the progression of employees from an ethnic minority is the lack of development opportunities which are often arranged on an informal basis. Organisations should look at how such development opportunities are filled and facilitated. The lack of such opportunities means that when these employees arrive in interviews for promotion, they have less experiences to discuss, and less opportunity to display their abilities compared to other interviewees.

e. With regard to the use of data and monitoring in relation to progression and training, organisations should track shadowing opportunities and training, to challenge their counterparts on how they are progressing with their own initiatives.

f. The existing work and attitude on diversity and inclusion should be embedded across the organisation, to ensure there is a form of succession planning, should key staff individuals leave.

g. To consider the wider response to EU recruitment and staff from overseas, who may not be able to take leave due to management pressure and whether guidance to management can be issued to clarify leave arrangements and concerns. This is because staff from these cohorts are often from an ethnic minority background, and this may be a further adverse effect.

h. Relating to disciplinaries and reporting, the impact of bias training and bystander support should be shared with the Health Scrutiny Commission once completed, along with consideration of how widely this is being delivered across the organisations. This was following the support given from the Chair of the Task Group in facilitating contact with other organisations that have successfully implemented bystander training.

i. The Task Group reiterated the need for the experiences of bank staff and their journey through the organisation to be recorded, to ensure there are no adverse outcomes suffered. This also included the treatment of temporary bank staff, who are often from an ethnic minority background, as well as the need for the City Health and Wellbeing Scrutiny Commission to understand the implications this will have on local staffing and whether this could lead to any new ways of working.

j. In relation to the Mersey Trust – Just and Learning Culture, the Task Group recommended that local agencies should reflect on this model as an example of good practice due to the positive impact on wellbeing.

k. The Task Group commented positively on the commitment and engagement of senior health staff to racial inequality in the workforce, and how transparent they were with sharing workforce information.

Main Report

Introduction

At the Health and Well-being Scrutiny Meeting on 16th December 2020, the Scrutiny Review Scoping Document titled; “The experience of black people working in health services in Leicester and Leicestershire” was approved. This would consider the employment trajectories, outcomes as well as the disciplinary practices experienced by black people while working across the health sector in Leicester and Leicestershire.

The structure of the review was agreed as follows:

1. To track the journey of those from different ethnic groups, particularly those from an African Caribbean Heritage/background, from:

    - Arrival into the organisation
    - Probation
    - Achieving stable contract status
    - How they are encouraged to progress and grow; and
    - If so, how they leave the organisation and is this due to moving on / progression.

2. This was conducted through a blend of quantitative data via existing statistics, with an underpinning narrative provided by qualitative data in the form of stories shared by those who wished to talk about their experiences.

The Task Group gathered evidence on the following:

- A summary document shared prior to the first meeting that gathered information on the national exploration of these issues by the NHS, including what issues were identified and any programme of actions created because of this.

- Datasets on the demography of the local workforce in relation to race.

- A breakdown of the ethnic background/workforce data as far as possible for the CCGs, UHL and LPT – for different ethnic groups, particularly those from an African Caribbean/Heritage background.

- The lived experiences of black people working in the health sector locally

- The Employment/or contractual status of these staff (including agency staff and any whether any volunteering schemes have led to paid employment)

- The likelihood of the probationary period being extended for African Caribbean / Heritage groups

- The length between an individual joining the organisation, to promotion and how progression occurs
- The disciplinary histories and experiences
- Any information on practices that may act as a precursor to disciplinary proceedings and any support individuals may receive, for example, Professional Development Plans and the use of a Performance Management Framework and how this intersects with race and gender
- The use of exit survey information to understand why those from different ethnic groups, particularly those from an African Caribbean / Heritage background, leave the organisation
- Understanding how services in healthcare settings are tiered within the organisation, particularly the 'agenda for change pay bands 2-9', the number of staff in each pay band and how staff may progress through this.
- Further information on the use of the 'reverse mentoring' initiative
- Information on any headline programmes that have been developed to address what was being done to focus on progression for different ethnic groups, particularly those from an African Caribbean / Heritage background (with a focus on apprenticeships and increased training to speed up progression to senior roles)
- Further information in relation to a prediction from the organisations on how long it will take to achieve parity in this area, as well as considering any programmes currently in place to speed up this process.
- Workforce equality information provided by organisations including the number of staff in post, NHS staff survey information, WRES delivery plan information and submissions. Key sources of local workforce information that were shared by Health Partners are attached to Appendices B and C.

National Picture

Prior to the first Task Group meeting, further sources of information that were available online were shared to inform Members of the Task Group of the existing workforce monitoring requirements at a national level, and these included:

- Public Sector Equality Duty
- The Workforce Race Equality Standard (WRES)
- Equality Delivery Systems (EDS2)
- The NHS Long Term Plan
- NHS Interim People Plan
- The founding of the NHS Race and Health Observatory
- WE ARE THE NHS: People Plan 2020/21 – action for us all (August 2020)

- The People Promise

Areas such as the WRES and the NHS People Plan were regularly referred to by Health Partners throughout the subsequent Task Group meetings.

In summary, the main NHS national requirements for local organisations in relation to workforce equality are:

- Organisational WRES implementation data must be shared. The WRES reporting template must be published on the organisation's website using a unique URL.

- As a minimum, all systems should develop a local People Plan in response to 'We are the NHS: People Plan 2020/21 - action for us all'. Many organisations may also wish to complete one for their individual organisations, and this is encouraged. These should be reviewed by regional and system People Boards and be refreshed regularly in response to changes in demand or services.

- NHS England and NHS Improvement and Health Education England (HEE) will work with non-NHS employers and their representatives to agree how they support delivery of these People Plan principles in their organisations. Local systems and clinical commissioning groups (CCGs) need to do the same for services they commission.

The Impact of COVID

It was acknowledged that the continued effects of the COVID19 pandemic would affect Health Partners' abilities to engage with the review on a prompt basis. This was particularly the case during the increase of infections relating to the Omicron variant, where Task Group meetings were rescheduled to accommodate this. The use of virtual meetings for this review was particularly beneficial.

In May 2020, NHS England and NHS Confederation launched the NHS Race and Health Observatory[2]; a new expert research centre to investigate the impact of race and ethnicity on people's health. This was following significant concerns about the specific impact COVID19 had on people from ethnic minority backgrounds. The NHS Race and Health Observatory works towards reducing ethnic and racial inequalities in healthcare amongst patients, communities, and the NHS workforce. It supports, where appropriate, aspirations in these areas as outlined in national healthcare policies, including the NHS Long Term Plan.

[2] Home page - NHS - Race and Health ObservatoryNHS – Race and Health Observatory (nhsrho.org)

Local Workforce Equality Information

In preparation for the first meeting, workforce equality information was provided by the CCGs,and this included:

- LPT and UHL staff in post
- NHS staff survey information
- WRES delivery plan information and submissions across the three organisations, which included data by ethnicity and information submitted as part of the NHS Single Data Collection Service (SDCS)

The Task Group asked for further information in relation to staff pay bands and staff disciplinary data, which was provided at the subsequent meeting. This provided an insight into the disciplinary process and whether this disproportionately impacted staff from an ethnic minority background. There were several actions created following this discussion, which included contacting staff unions about their perspective on disciplinary procedures.

A further percentage breakdown into ethnicity information and workforce information was also requested, so far as possible for the organisations for different ethnic groups, particularly those from an African Caribbean / Heritage background.

The final meetings focused on linking the programmes and plans in place and included the lived experiences of staff members, as well as receiving insights from union representatives about the experiences of black people in healthcare settings which were highlighted after the first meeting.

All initial workforce information shared by the Health Partners is available in Appendix B of the report and is predominantly broken down by organisation (LPT, CCG or UHL), with additional national data in relation to benchmarking.

The Use of Data and Tools to Monitor Progression

From the initial meeting, members of the Task Group agreed that current data systems across the organisations were not suitable for tracking workforce information and more importantly, the progression of staff. There was also a need to have further breakdown for ethnicity data relating to African Caribbean / Heritage groups.

Although this information was collected though individual organisational WRES data, a holistic approach for all organisations across LLR would be beneficial to ensure the journey of an individual can be tracked, particularly how they are encouraged to progress in the organisation.

Following these discussions on the current data systems and the limitations around tracking workforce information and progression, it was recommended that existing systems are either improved or systems that facilitate such data collection, are procured to identify, and monitor this. It was noted that it is difficult to change practices if they cannot be measured. There was also a wider discussion on how

NHS systems should also be used to capture information/issues around inequalities and protected characteristics.

Health Partners explained that an inequality dashboard was being developed across LLR, which would help capture information around inequalities, but it also was acknowledged that the procurement of a single data system to track workforce information would be the ideal approach.

Benchmarking

a) **Just and Learning Culture – Mersey Trust**

The details of the Mersey Trust case study were explored by the Task Group, and Health Partners explained that it is a good example of outcome tracking in relation to metrics that matter. This is a similar approach to what is being undertaken by organisations across LLR, with the Access and Inclusion (AIM model) and NHS Toolkit being used, which will be extended to the wider work of the organisations.

Members of the Task Group reiterated the importance of looking to this model for examples of good practice, given the positive impact this had on staff well-being, levels of absence and grievances. Information on the case study is available on Appendix C.

b) **Equality, Diversity, and Inclusion Strategic Plan (Case for Change)**

In relation to the 2021 WRES data, the Chair questioned whether this was representative of the population in relation to the diversity of LLR and East Midlands. UHL explained as part of their EDI Strategic Plan (Case for Change), population comparison /benchmarking for the city will be undertaken and this can be shared.

Lived Experiences

Staff from LPT, who were part of the equality/diversity inclusion group and the reverse mentoring scheme, were invited to the third meeting to share their experiences of working in the organisation.

The following points were made by staff:

a. It was felt there was a lack of exposure and representation at recruitment level and being stuck at specific salary banding was a common feature.

b. Limited chances at attending senior meeting/shadowing opportunities and fewer chances at gaining experience were cited as examples.

c. Staff praised the work of the reverse mentoring programme and commented that this has been beneficial, particularly with the positive changes with

leadership in the organisation. This includes extensive support from senior management to members of the equality/diversity inclusion group regarding access to progression opportunities.

d. However, there needs to be a focus on speaking up and empowering people to do so to encourage change, which is in relation to the lack of pay progression for staff members beyond Band 8.

Health Partners explained how they would be addressing the points raised, including any existing actions that are in place:

a. Interview panels across the organisation will be diverse, with feedback provided. This will have a tangible impact in increasing the recruitment those from ethnic minority groups. There will also be a reporting dashboard which will be used to monitor and track progression.

b. Work will also be conducted on closing the 'experience gap', which can prevent progression and promotion opportunities for those from ethnic minority groups. This is dependent on access, networking, and correct support from senior management. Associated issues with the experience gap include hidden/attribution bias, where greater value is placed on the experiences of white colleagues compared to those from ethnic minority groups.

c. In relation to retaining staff and supporting progression, line management development would be a key area of focus, with the organisational staff survey showing where learning and development opportunities and training is being taken up. There are also national interventions such as 'freedom to speak up' champions, which the organisations are encourage staff to take up.

d. It was mentioned that leadership training for those at lower specific bands appears to have less representation for those from ethnic minority groups. It was also acknowledged that there is still some resistance from some managers in relation to allowing staff to attend ethnic minority working groups within the organisation.

When the scope of the review was decided, it was reiterated that representation of black staff in leadership positions in the health sector should also be a focus of the review as many black employees will be in either non-managerial roles or in middle management roles. Early on, Health Partners highlighted that the NHS has set each health organisation aspirational targets in this area. Even though the focus of the targets is on pay bands 8a and above, meeting the targets requires them to look more widely at the talent pipeline to establish where the 'frosted glass ceiling' is located.

Succession Planning

Based on the lived experiences shared by staff, the Task Group commended the commitment of leadership and senior management to promoting equality, diversity, and inclusion, as well as their efforts towards mitigating the barriers black and African Caribbean / Heritage staff may face.

Given this progress, there was interest in how the organisations, particularly LPT, would continue to develop the existing work and attitude towards diversity and inclusion across the organisation, to ensure succession planning should key staff leave the organisation.

Since the lived experiences shared were exclusively from LPT staff, the Task Group also queried how data and monitoring in relation to progression, shadowing opportunities and training are being tracked across the LPT and whether this could be used to challenge fellow organisations (including the CCGs and UHL) on their own initiatives.

Health Partners explained that the focus would be on talent management and leadership through partnership work with local authorities to lead the system level 'Inclusive Culture and Leadership Workstream', which will support all LLR organisations with programmes regarding equality, diversity, and inclusion. This includes embedding these systems and monitoring the strategic plans in place, to ensure that the existing work is continued even if key individuals move on.

Bank Staff

Over the course of the Task Group meetings, it was noted that there was little information recorded the experiences of bank staff who are black or from an African Caribbean / Heritage background.

Bank staff are individuals that organisations can call on as and when work becomes available, which provides them with a degree of flexibility with workforce arrangements. This is a common feature in healthcare services, where the amount of work can vary. However, this group of staff may not receive similar employment security and protection compared to contracted staff.

As a result, the Task Group reiterated the importance of organisations being able to record workforce information from start to finish for this group, with a recommendation for organisations to look at the experiences of bank staff in closer detail.

This would involve comparing the journeys of substantive staff against bank staff, as bank staff can often enter and leave the organisation in 'freer and looser' terms compared to substantive staff, which may result in the danger of contributing to unconscious bias.

This recommendation was made in response to the disciplinary statistics mentioned in section e, table 2 of the LPT data available in Appendix C, where it was acknowledged that there is an issue with bank staff from an ethnic minority background being subjected to a higher instance of formal disciplinary proceedings.

Health Partners explained that a national staff survey was conducted in February 2022, which can be shared with the Task Group once completed and will provide further insight into the experiences of bank staff. There is also a report and support tool being developed, to be used across all three organisations.

Disciplinaries, Reporting and Reasons for Leaving the Organisation

During the third meeting, a range of evidence was provided by Health Partners regarding the number of black or African Caribbean / Heritage staff who were subject to disciplinary proceedings, in relation to LPT and UHL. The data provided is available in Appendix C and contains information on why staff who have left the organisation chose to do so.

There was also discussion on the relaunched initiative of 'Cultural Ambassadors', who are independent reviewers of disciplinary or grievances cases, involving staff from an ethnic minority background. Details of this are contained in Appendix G. It was noted that a Cultural Ambassador identifies and challenges any cultural bias, unconscious bias, less favourable treatment, or discrimination and ensures that these issues were taken into consideration in the decision-making process. This programme was established due to staff from an ethnic minority background being significantly more likely to be involved in grievance/disciplinary processes than other colleagues.

The Task Group questioned the number of disciplinaries for those that led to a tribunal for those from an ethnic minority background, including further information on whether work was being completed to identify the specific numbers, the reasons for disciplinary action and how this is being reviewed.

Health Partners explained that they are required to monitor the number of disciplinaries as part of their Workforce Race Equality Standard (WRES) information. The latest WRES 2021 data showed there was no disproportionate impact on colleagues from an ethnic minority background. It was added that staff who are going through a disciplinary are also offered support from cultural ambassadors within the organisation.

It was noted that it was difficult to make interpretation on the grievance case data provided as it was a small number. However, the Task Group were concerned that despite this, the grievance data for those from an ethnic minority background was still higher than white staff, with more formal written warnings issued. It was questioned whether it was a possibility that staff from an ethnic minority background may be encouraged to accept a formal written warning to avoid further disciplinary proceedings being pursued.

Subsequently, the Task Group expressed interest in engaging with relevant staff unions, to get their perspective on the disciplinary procedures in place.

Staff Unions Perspective on Disciplinary Proceedings

Given recent organisational changes, there were problems in securing a detailed response from the UNISON Leicestershire Healthcare Branch. However, partners were able to facilitate a written summary from the staff unions, which is available under Appendix E. This particularly related to LPT, where the Task Group noted the grievance data for those from an ethnic minority background was still higher than white staff, with more formal written warnings issued.

Upon the completion of the organisational changes, further comments from UNISON are welcomed.

Initiatives that Encourage Progression

Alongside the workforce information provided, there was focus on looking at the policies and initiatives in place to mitigate the adverse experiences black or African Caribbean / Heritage staff may face, which were raised by the Task Group.

Alongside WRES Action Plan monitoring, there were also several initiatives in place, details of which can be found in Appendix F. UHL also provided information on how they were tracking progress against their Just Culture Action Plan in Appendix F, where the use of Cultural Ambassadors was explained, in relation to providing advice on disciplinary and grievance processes.

A summary of the initiatives discussed, included:

- Women in Clinical Leadership Conferences
- An Inclusive Decision-Making Framework
- The LLR Reverse Mentoring Framework (currently on its second cohort)
- Cultural Intelligence Training
- The Active Bystander Programme
- The 'Your Voice' Tool

There was interest from the Task Group in the Active Bystander Programme and what this would constitute, given many organisations were already operating a similar initiative. It was also seen as a way to benchmark if there were any initiatives or programmes that staff entering the organisation from their very first day, could be encouraged to join and whether an absence of this may restrict progression.

UHL explained that this would encourage a proactive organisational culture approach to address harmful behaviours, promote an inclusive and compassionate culture, and role model their system values. It will adopt an early intervention approach which can prevent negative behaviours from escalating and facilitate learning. At this point in time, the Programme was still in early stages of development and the Chair of the Task Group offered to facilitate contact between the Racial Equality team at his place of work, who were delivering an effective Bystander Programme on racial equality, where lessons learnt could perhaps be shared.

Regarding further information on early initiative or programmes for staff entering the organisation, UHL confirmed they are working an initiative regarding implicit bias and 'Race at Work', with all the above planned to be embedded into the organisation, alongside mandatory training.

The Task Group recommended that where mandatory training was in place for equality, diversity and inclusion, organisations should look to use different channels that deliver this training that encourages interaction, rather than the use of e-learning modules. Details of the implicit bias training and bystander support to be shared with the Task Group once this has been developed.

Contacts

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Implications; Financial, Legal, Equalities and Other Implications

Financial Implications

There are no immediate direct financial implications arising from this report, although the costs of any specific initiatives that may arise would need to be considered at the time.

Rohit Rughani, Principal Accountant

Legal Implications

There are no direct legal implications arising from the Task Group Report

Kamal Adatia, City Barrister, ext 37 1401

Equality Implications

All public bodies must comply with the Public Sector Equality Duty (PSED) (Equality Act 2010) by paying due regard, when carrying out their functions, to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. In doing so, they must consider the possible impact on those who are likely to be affected by the recommendation and their protected characteristics.

This report highlights several equalities issues particularly related to the protected characteristic of 'race' in relation to people working for health services in the city. The recommendations in the report may lead to positive outcomes for black staff and if proposals are developed, there needs to be greater consideration given to the impacts with the need to give due regard to how it will affect people who share a protected characteristic.

Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

Kalvaran Sandhu, Equalities Manager, Ext 37 6344

Climate Emergency Implications

There are no climate emergency implications directly associated with this report.

Aidan Davis, Sustainability Officer, Ext 37 2284

Scrutiny

Summary of Appendices

Appendix A – Review scoping document

Appendix B – Workforce Data (Meeting 2)

Appendix C – Disciplinary Data (Meeting 3)

Appendix D – Just Culture Mersey Case Study

Appendix E – Staff side collective views regarding the experience of Black staff members within LPT

Appendix F – UHL Report Extract: Measuring Progress against Just Culture Action Plan

Appendix G– Policies and Initiatives

Scrutiny

Leicester City Council
Scrutiny Review

The experience of black people working in health services in Leicester and Leicestershire'

A review of the Health and Wellbeing Scrutiny Commission

October 2020

Background to scrutiny reviews

Determining the right topics for scrutiny reviews is the first step in making sure scrutiny provides benefits to the Council and the community.

This scoping template will assist in planning the review by defining the purpose, methodology and resources needed. It should be completed by the Member proposing the review, in liaison with the lead Director and the Scrutiny Manager. Scrutiny Officers can provide support and assistance with this.

In order to be effective, every scrutiny review must be properly project managed to ensure it achieves its aims and delivers measurable outcomes. To achieve this, it is essential that the scope of the review is well defined at the outset. This way the review is less likely to get side-tracked or become overambitious in what it hopes to tackle. The Commission's objectives should, therefore, be as SMART (Specific, Measurable, Achievable, Realistic & Time-bound) as possible.

The scoping document is also a good tool for communicating what the review is about, who is involved and how it will be undertaken to all partners and interested stakeholders.

The form also includes a section on public and media interest in the review which should be completed in conjunction with the Council's Communications Team. This will allow the Commission to be properly prepared for any media interest and to plan the release of any press statements.

Scrutiny reviews will be supported by a Scrutiny Officer.

Evaluation

Reviewing changes that have been made as a result of a scrutiny review is the most common way of assessing the effectiveness. Any scrutiny review should consider whether an on-going monitoring role for the Commission is appropriate in relation to the topic under review.

For further information please contact the Scrutiny Team on 0116 4546340

To be completed by the Member proposing the review		
1.	**Title of the proposed scrutiny review**	The experience/ development of Black People working in health services in Leicester and Leicestershire.
2.	**Proposed by**	Councillor Patrick Kitterick Chair, Health and Wellbeing Scrutiny Commission
3.	**Rationale** Why do you want to undertake this review?	The recent Black Lives Matter movement together with the disproportionate effect COVID19 has had on ethnic minority groups, specifically people of Black heritage, has highlighted the inequalities black people face in their day to day lives. Whilst nationally the NHS has set up the NHS Race and Health Observatory and has the Workforce Race Equality Standard (WRES), the Health and Wellbeing Scrutiny Commission would like to explore the picture locally. This would consider any the employment trajectories, outcomes as well as the disciplinary practices experienced by black people while working across the health sector in Leicester and Leicestershire.
4.	**Purpose and aims of the review** What question(s) do you want to answer and what do you want to achieve? (Outcomes?)	The purpose of this review is to map and highlight the experiences of black people working in the health sector and explore practices, trajectories and outcomes for Black staff managers and directors, and how this are being mitigated going forward if they exist. The review would look to achieve the following outcomes: • Explore how this has been investigated nationally by the NHS and to what extent any national issues identified, are reflected in Leicester. • Understand the demography of the local workforce, particularly in relation to race. • Gain an understanding of the experiences outcomes and trajectories of black people working in the health sector locally • Identifying practices that may disadvantage black health workers; and • How health services and partners can work together to mitigate this (focus on policies and programmes)

5.	**Links with corporate aims / priorities** How does the review link to corporate aims and priorities?	This review links to the City Mayor's Black Lives Matter statement (June 2020) which states the Council is 'committed to working with young people to reflect their concerns and shape their future city', as well as the recent appointment of a lead member with the responsibility for developing an agenda in response to the Black Lives Matter Campaign. https://leicestercitycouncil.sharepoint.com/sites/communications-and-marketing/SitePages/Cllr-Sue-Hunter.aspx?utm_campaign=1817628_All-staff%20email%2030%20September%202020&utm_medium=email&utm_source=Leicester%20City%20Council&dm_i=36CU,12YHO,4LNECS,45GTE,1 This review also links to Sir Simon Stevens' (NHS Chief Executive) statement on Black Lives Matter and health inequalities. https://www.england.nhs.uk/2020/06/personal-message-from-sir-simon-stevens-on-black-lives-matter-and-health-inequalities/
6.	**Scope** Set out what is included in the scope of the review and what is not. For example which services it does and does not cover.	The review will look at information from the public health team, health partners in relation to; general workforce profile, employment and retention of staff by ethnicity, pay band data and HR information relating to dismissals and redundancy. It will also focus on profiles, policies, and programmes in place.
7.	**Methodology** Describe the methods you will use to undertake the review. How will you undertake the review, what evidence will need to be gathered from members, officers and key stakeholders, including partners and external organisations and experts?	This will include: • Profiles, policies, guides, and programmes of health partners; collective data and action plans available on public websites of all health partners. Existing work such as - https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/ • Relevant supporting research reports and documents • Virtual round table discussions with NHS partners • Information from health regulators such as CQC and NHS England – publicly available information including new requirement for Health Partners to provide assurance against the NHS People Plan And if available: • Workforce profile and information relating to Employment and retention of staff by ethnicity

	Witnesses Set out who you want to gather evidence from and how you will plan to do this	Potential witnesses may include: • Health Partners (CCG, UHL and LPT) • Local universities • Local Nursing Colleges • Public Health Team • Executive Leads for Public Health • Carers • Pharmacists
8.	**Timescales** How long is the review expected to take to complete?	**November 2020** Scoping document to be agreed the upcoming Health and Wellbeing Scrutiny meeting, scheduled in November 2020. **December 2020 – March 2021** • Take evidence from partners • Task Group meetings (hybrid and/or virtual) • Draft findings and conclusions to be established. **April 2021** The final review report to be agreed at an upcoming Health and Wellbeing Scrutiny meeting.
	Proposed start date	December 2020
	Proposed completion date	April 2021
9.	**Resources / staffing requirements** Scrutiny reviews are facilitated by Scrutiny Officers and it is important to estimate the amount of their time, in weeks, that will be required in order to manage the review Project Plan effectively.	The review can be conducted within the resources of the scrutiny team. Scrutiny Officers will support the review process by capturing information at the meetings, facilitating the people to give evidence and writing the initial draft of the review report based on the findings from the review.
	Do you anticipate any further resources will be required e.g. site visits or independent technical advice? If so, please provide details.	Virtual meetings instead of site visits (if any) due to COVID19 pandemic.

10.	**Review recommendations and findings** To whom will the recommendations be addressed? E.g. Executive / External Partner?	It is likely the review will offer recommendations to Health Partners such as the CCGs, UHL and LPT.
11.	**Likely publicity arising from the review -** Is this topic likely to be of high interest to the media? Please explain.	It is expected that this review will generate considerable to medium media interest but the relevant partners, the Executive lead and the council's communications team will be kept aware of any issues that may arise of public interest.
12.	**Publicising the review and its findings and recommendations** How will these be published / advertised?	There will be a review report that will be published as part of the commission's papers on the council's website.
13.	**How will this review add value to policy development or service improvement?**	This review will support health partners to mitigate any discriminatory practices identified and strengthen policies and practices in place. It will contribute to ongoing actions and approaches that are already being conducted by health partners and may help identify a number of metrics to measure progress and demonstrate and evaluate impact.
To be completed by the Executive Lead		
14.	**Executive Lead's Comments** The Executive Lead is responsible for the portfolio so it is important to seek and understand their views and ensure they are engaged in the process so that Scrutiny's recommendations can be taken on board where appropriate.	The findings from this review would be complementary to the work we are doing in the Council around Black Lives Matter and I am supportive of this review **Councillor Sue Hunter - Assistant City Mayor, Black Lives Matter response**

Comments from the relevant Director from NHS partners		
15.	**Observations and comments on the proposed review**	We welcome the review of the experiences of black people as part of the scrutiny review process. The equality, diversity and inclusion agenda is something that is particularly important for LLR health and social care partners at present and many of our actions for this agenda are collective actions across health and social care partners Considerations: • The resources required of Health partners to participate in the review, including any additional data we would be required to produce during a time where our energy and resource is focussed on action. Please note that much of our collective data and action plans are available on public websites of all health partners. Understanding of the witnesses required to attend scrutiny committee would also be helpful • Health partners are monitored and scrutinised by our health regulators – mainly CQC and NHS England but also our new requirement to provide assurance against the NHS People Plan, please consider using data already available for this scrutiny Through our learning and actions that have been particularly focussed in the last few months we would also encourage you, dependent on the considerations noted above, to consider the following areas within your scoping document. • **Attraction and recruitment** of black people into clinical and professional corporate roles at the system level and how we minimise and mitigate the impact of racial bias and stereotyping at all stages of the selection process. • **A focus on how we retain black people in our local health system** by creating a sense of belonging at the team, directorate, organisational and system level by developing interventions to promote improved rates of racial literacy and cultural intelligence within our workforce. • **Performance management and appraisal** is a key determinant of eligibility for progression and should be considered in the review, within the context of career progression of Black staff in the health sector and our local system. Research indicates that people from BAME communities, and particularly those from a Black British background, are performance appraised differently to their white peers. Kandola (2018) suggest a 'pro-white bias' in appraisal ratings because of 'attributing success bias' i.e. When a black leader is seen as successful, their success is attributed to factors other than their decision-making or leadership skills, e.g. they just have a great team working with them.

		• **Representation of Black people in leadership positions in the health sector** should also be a focus of the review as many black colleagues will be in either non-managerial roles or in middle management roles. The NHS has set each system and each health organisation aspirational targets in this area. Even though the focus of the targets is on bands 8a and above, meeting the targets requires us to look more widely at the talent pipeline to establish where the 'frosted glass ceiling' is located. Current actions: Below are some of key actions and approaches we are taking to address issues we have identified and may be of interest • **Fulfilling our aim to create a zero-tolerance approach to racial bias, prejudice, harassment and discrimination**, by addressing not only overt forms of these attitudes and behaviours, but also addressing more subtle forms e.g. micro-agressions. UHL is developing a intervention initiatives called the 'Active Bystander Programme to intervene early and /or prevent bully and harassment. • **Ensuring that Black people can bring their whole selves to work by addressing 'Code Switching Behaviours'.** Code Switching involves adjusting your style of speech, appearance, behaviour and expression in ways to fit in with the dominant culture. Many Black people will engage in this behaviour to be seen as talented and eligible for career progression by white colleagues. • **Developing a culture which is 'anti -racist' as opposed to non-racist.** An 'anti-racist' culture involves people making an active and conscious effort to work to address the multidimensional aspects of racism i.e. structural, cultural, and institutional. A non-racist culture is one where people say that they do not tolerate racism but do not take action to address incidents when they occur, it is a more passive approach. Developing allies for and sponsors of BAME colleagues is considered one of the best practice interventions which can support wellbeing and a sense of belonging. We could also highlight the LLR reverse mentoring programme as a key programme we have already initiated. • Research suggests that **leadership and stereotyping** is a significant issue as the prototype for leadership in many organisations if white and male i.e 'The Snowy White Peaks of the NHS'. Black women are often stereotyped as not good at people or thought leadership, but great for roles involving task leadership. Black men tend to be stereotyped as not good at either people, thought or task leadership. • The review could also set out the vision for **what success would look like and how we will measure our success.** Adopting a whole employee lifecycle approach and identifying a number of metrics to measure progress would be advised, so that we could demonstrate and evaluate impact.

	Name	Richard Morris
	Role	Director of Operations and Corporate Affairs for NHS Leicester City Clinical Commissioning Group (CCG)
	Date	02/12/20
To be completed by the Scrutiny Support Manager		
16.	**Will the proposed scrutiny review / timescales negatively impact on other work within the Scrutiny Team?**	It is anticipated that there will no adverse impact on the scrutiny team's work to support this review, but it must be anticipated that there may need to be some prioritising of work done during the time of this review.
	Do you have available staffing resources to facilitate this scrutiny review? If not, please provide details.	The review can be adequately support by the Scrutiny Team as per my comments above.
	Name	Kalvaran Sandhu, Scrutiny Support Manager
	Date	08/12/20

Appendix B - Workforce Data (Meeting 2)

CCGs

LLR CCGs FINAL WRES report 2019-20

WRES LLR Data by Ethnicity.xlsx

Individual CCG Workforce Data - Pay

UHL

210226 UHL Staff in Post.xlsx

UHL WRES Submission 2018-19.p

UHL WRES Delivery Plan 2020-2021.pdf

LPT

LPT WRES March-2020.pdf

210226 LPT Staff in Post.xlsx

WRES metrics 2019-20 for QAC sep

National

WRES 2019 - SDCS Information.xlsx

Appendix C – Disciplinary Data (Meeting 3)

LPT

LPT - Further Data.XLSX

UHL

UHL - Further Data.xlsx

UHL - Further Data 2.xlsx

UHL -Black heritage diversity - Dec 2020.xl

NHS Employers
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OCTOBER 2020

IMPLEMENTING A JUST AND LEARNING CULTURE

MERSEY CARE NHS FOUNDATION TRUST

Overview

In 2016, Mersey Care NHS Foundation Trust began to implement a 'just and learning culture' within their organisation. The culture fundamentally changed the way it responded to incidents, patient harm, and complaints against staff. After seeing the benefits in their own organisation, the trust partnered with Northumbria University to create a just and restorative learning training package for other organisations to follow.

Key benefits and outcomes

Mersey Care NHS Foundation Trust estimates the economic benefit of a just and learning culture in their organisation to be roughly £2.5 million. This is made up of:

1. A reduction in suspensions by 95 per cent and disciplinary investigations by 85 per cent since 2014. At the same time the trust has increased its workforce by 135 per cent.
2. An increase in reporting of adverse events.
3. An increase in staff who felt encouraged to seek support.
4. An increase in staff who felt able to raise concerns about safety and unacceptable behaviour.

What the organisation faced

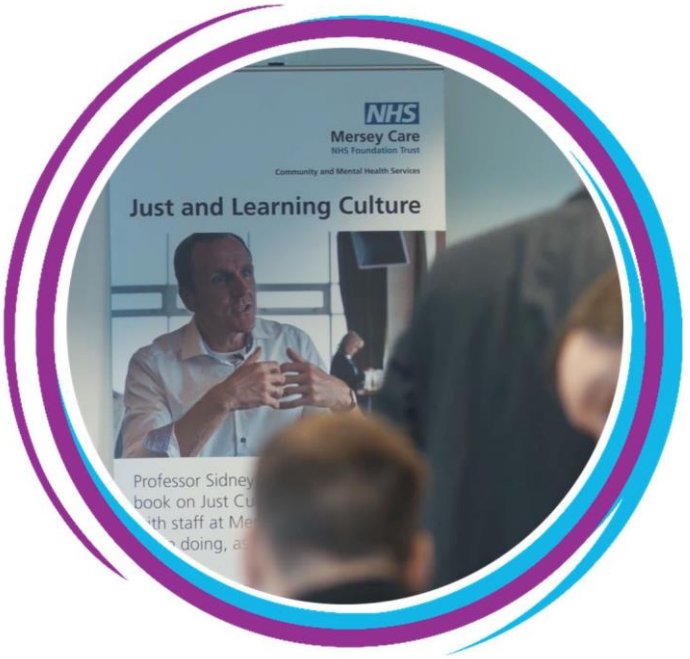
Mersey Care's reliance on HR processes and practises which focused on rules, violations, and consequences were not seen to be working for its employee relations disciplinaries.

Costs associated with suspensions were rising. So too were legal costs, agency costs for backfill absenteeism, and staff turnover.

The organisation decided on a new approach. Steps to implement a just and learning culture were taken. This type of culture involves creating an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed.

What the organisation did

So far, the trust has trained over 400 individuals at Mersey Care in the just and learning culture way. The trust intends to provide further training across the organisation during the autumn. There has also been appetite from other trusts to learn from Mersey Care and in collaboration with Northumbria University, it has developed an accredited programme to enable other organisations to take part in the training too.



Typically, training is provided face-to-face. This year, due to the COVID-19 pandemic, the trust plans to deliver the training via a blended digital learning approach. Mersey Care worked closely with Northumbria University to develop engaging training in a virtual setting to help learners to get the most out of the new way of training,

The programme is aimed at managers, patient safety leads, operations managers, staff side colleagues, OD and HR. It is requested that a board member commits to supporting those who attend the training and provides an opening comment or letter to attendees to endorse their attendance and permission to enact their learning.

The programme includes four days of facilitated teaching over three weeks. It is delivered through a variety of live speaker and group facilitated sessions, self-directed learning through workbooks and filmed role plays and presenter sessions. This blended digital learning approach aims to retain an authenticity that could have been lost via an e-learning package.

Considerations have also been given as to how to ensure that those who attend the training feel psychologically safe. This is more challenging in an online setting, so adaptions such as shorter days and less days per week of virtual training have been factored in. Training online is tiring and having no more than eight learners and a tutor is considered best practice to ensure meaningful engagement.

The course material can be completed individually or in small groups. Reflective learning is built into the programme. Upon completion of the third week, participants

take three actions back to their organisations to work on. Six weeks after that, participants complete a post-programme action learning set. This is a new step to enable the trust to evaluate and understand what is working well with the programme, and what might need to be adapted to work better for learners.

The aim of the programme work is to allow participants to implement what they have learnt into their own organisations and accelerate the transition from Mersey Care's experience.

Mersey Care's staff survey shows safety, morale and performance have all improved.

Results and benefits

Research the trust commissioned shows staff feel more engaged, open and able to speak up. There have been increases in staff morale and job satisfaction, staff engagement among senior leaders has increased and so has staff motivation. The research found there is an increased feeling from staff that they work in an 'open and accommodating work environment that facilitates honesty and learning'. This is directly linked to the just and learning culture and training the trust provides.

The trust continues to assess the economic benefit of a just and learning culture (estimated to be roughly one per cent of turnover) and look at the impact it has on women, black, Asian and minority ethic (BAME) staff and other underrepresented groups.

Mersey Care NHS Foundation Trust's vacancy rate currently stands at 3.5 per cent. They have a waiting list for district nurses in some areas and other professions. The organisation's just and learning culture is seen to be a large part of that pull.

Overcoming obstacles

Great strides have been taken at Mersey Care, but the trust admits it do not always get it right. When things do not go to plan, they take ownership and apologise for it, and they learn from it.

The goal of the culture is ultimately to restore faith, but this is not always possible. This can lead to difficult conversations.

Takeaway Tips

1. When training online, use smaller groups of up to eight or nine people (including the presenter), this way everyone's face can be seen on the software and it makes the session more interactive.
2. Get board support to show the organisation's commitment to the training.
3. It is easier to create a psychologically safe environment when everyone is in the same room, it is harder to do online, but just as important to the success of the training.
4. Giving people the chance to analyse a situation with hindsight and by asking the question 'what happened and how can we understand it?' can be powerful as they understand all of the factors and context behind a decision.

Further information

Example:
For more information about the work in this case study, contact Amanda Oates, Executive Director of Workforce, Mersey Care NHS Foundation Trust: amanda.oates@merseycare.nhs.uk or Kristina Brown, Northumbria University: kristina.brown@northumbria.ac.uk

Watch Mersey Care's Just Culture journey, as told by the staff themselves.

Further details on Mersey Care's Just and Learning culture can be found on their website, and you can register your interest in attending Northumbria University's Principles and Practises of Restorative Just Culture course on their website.

Appendix E - Staff side collective views regarding the experience of Black staff members within LPT

Staff side has a Unison Equalities Lead as part of its membership.
It was felt that there were more difficulties for staff within the Mental Health Directorate but there was no data to support this. Experience suggested that black staff felt more blamed for issues and felt that they were not listened to. It was also noted that patients could be more negative towards black staff in terms of being racist. This was felt to be particularly so from patients suffering from dementia. There were specific issues identified relating to black staff since the pandemic commenced.

Examples were given relating to Black staff with family members that had died abroad since the commencement of Covid. There were also other important family events that staff wanted to attend. Whereas people in the UK with families here could fairly easily support their families in these instances this was not the case for some black staff. Policy does not allow for the carry-over of annual leave beyond 5 days excepting in exceptional circumstances. With the effects of lockdowns, travel restrictions and increases in flight prices due to Covid it was not possible for some staff to travel home as planned or to carry over the total accrued leave in excess of five days to be used at a time when this was possible. This was felt to disadvantage them.

It was felt that black staff were less likely to be taken seriously when raising issues and that they were more likely to be “fobbed off”.

It was noted that some staff were extremely supportive when dealing with relevant management issues. Other staff had not been so supportive. This highlighted a potential training issue. One instance was identified where concerns had been raised regarding how issues were being dealt with in a very negative way. When this was pointed out staff side found that the comments were taken on board and a positive outcome was able to be achieved.

In our experience black staff generally felt committed to and enjoyed their work. They were genuine in their concern when they felt that race/ethnicity was an issue.
The staff side equalities lead has supported people with pertinent issues. She has worked with the Unison lead rep to identify where she might be able to offer support and has found this process to be very effective.

The Trust has recently welcomed overseas nurses to its workforce. We are looking forward to supporting, getting to know and to working with them. They are viewed as a positive asset.

As a staff side team, we work to support any staff member on a day-to-day basis. As part of our role, we support staff where there is injustice, inequality or unfairness in any way. We work inclusively with all staff.

Appendix F – UHL Report Extract – Measuring Progress against Just Culture Action Plan

Case work data shared with the Executive People and Culture board in August 2020.

Please note that this extract is part of a report developed to review progress against the action set out in the just culture action plan.

The data covers the period up until May 2020.

EQUALITY & DIVERSITY

Cultural Ambassadors

UHL has a group of seven 'Cultural Ambassadors' who are able to advise on disciplinary and grievance processes. They have been trained by the Royal College of Nursing (RCN) to act as an independent reviewer of cases involving BAME (Black, Asian and Ethnic Minority) colleagues. The programme was established after recognition that staff within the NHS from a BAME background were significantly more likely to be involved in grievance/disciplinary processes than other colleagues. Whilst trained by the RCN, a Cultural Ambassador is available to any member of staff or bank worker. The remit of a Cultural Ambassador is not to represent the individual, but to identify and challenge any cultural bias, unconscious bias, less favourable treatment or discrimination and ensure that these issues are taken into consideration in the decision making process, as well as share any learning amongst colleagues.

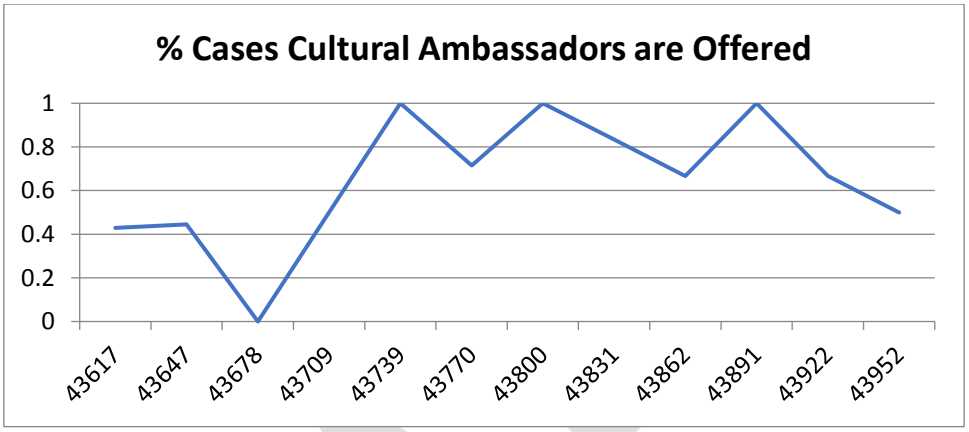
Our Cultural Ambassadors were trained in 2018 but in recognition that they are under-utilised, we have re-launched the initiative to ensure individuals are well-informed about their purpose:

- The ER team was trained again in Summer 2019 on the role and remit of CAs and how best to offer them to people from a BAME background.
- Leaflets are given to everyone who is under investigation, outlining the process in simple terms and introducing the CA initiative to them.
- CAs are offered at multiple steps in the process to maximise the chance that individuals take up the offer: in the notification letter, at the initial meeting, and prior to the hearing if applicable.
- However, it remains a voluntary programme so cases only involve a CA where the individual agrees to this.

Cases starting 1st June 2019 – 31st May 2020	Total number of cases involving staff member from BAME background*	CA offered*
Disciplinary & MHPS	51	32 (63%)
Anti-Bullying & Harassment	27	8 (30%)
Capability	10	2 (20%)
Grievance	7	1 (14%)

*For this paper, BAME includes anyone not listed as White British (and all derivations) or White Irish
**For anti-bullying & harassment cases, CAs may be offered to the complainant and/or accused as appropriate

Cases where a Cultural Ambassador has not been offered are typically those which are withdrawn before formal investigation, or more recent cases for which the ER team is still awaiting further information before progressing.
It is also likely that Cultural Ambassadors have been offered in more cases as there are prompts in our template letters and meeting crib sheets, but there is under-reporting through ER Tracker. This is being addressed with the Employee Relations team.



Disciplinaries, MHPS cases, and Anti-Bullying & Harassment cases where a Cultural Ambassador has been offered to either the accused, the complainant, or both

There has been a clear increase in the percentage of cases where individuals are being offered a Cultural Ambassador, since the importance of this programme was re-emphasised to the ER team in June and July 2019.
No cases were offered a Cultural Ambassador in August 2019. This appears to be an anomaly and is because during this month 3 cases were resolved at the preliminary stage without the need for a formal investigation.
There appears to have been a decrease in the past two months, however this is because some cases are still at early stages, before formal meetings/letters have been sent offering a Cultural Ambassador.

3 offers of Cultural Ambassadors have been accepted by staff between June 2019 and May 2020.

Feedback from some staff going through a formal process has been that they do not feel they need a Cultural Ambassador because they are satisfied with their union representation, or they feel the process is being handled fairly.

Since March 2020, we have also been offering Cultural Ambassadors to individuals involved in formal performance management and grievances to increase their reach and maximise opportunity to embed this approach in all our casework.

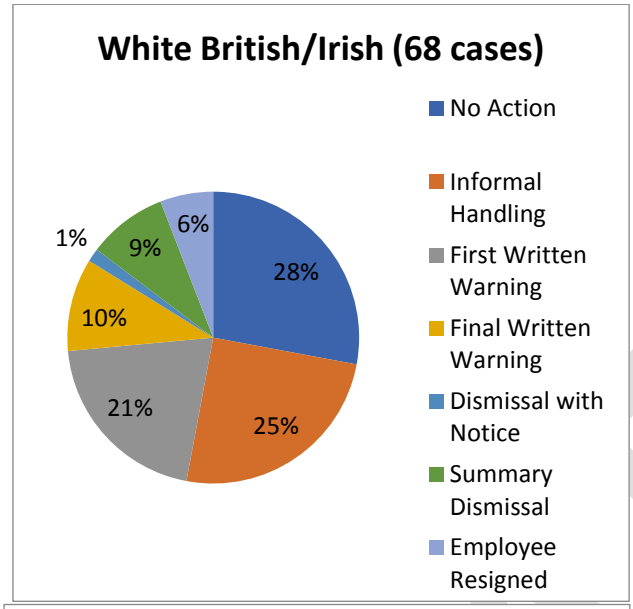
There is further work to do:

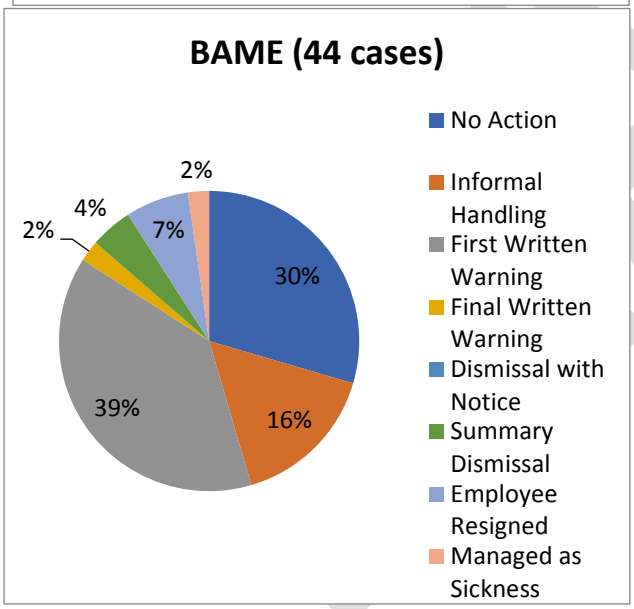
- Update HR Insite pages, including information about Cultural Ambassadors and examples where they may be useful, and communicate this to managers
- Further embed communications (leaflets at EDI events, investigation meetings) to support the HR team to explain the role and purpose of Cultural Ambassadors

Outcomes for BAME staff and White British/Irish staff

For the purposes of this report, BAME is taken to mean anyone who is not White British/English/Scottish/Welsh/Northern Irish or White Irish. Cases where ethnicity is Not Stated have been excluded from these figures.

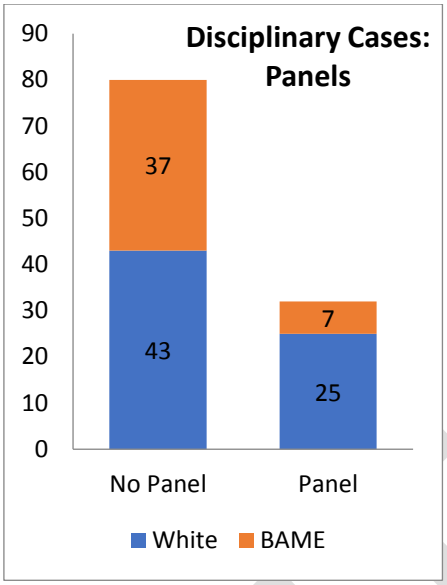
Disciplinaries & MHPS Cases





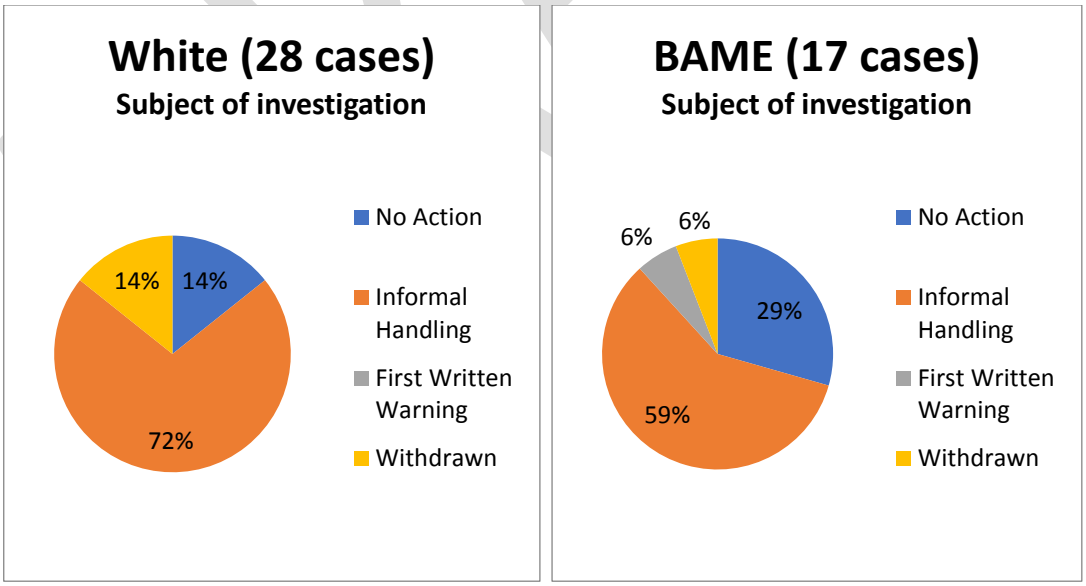
For disciplinaries/MHPS cases, the number of investigations into BAME staff are fewer than those into White British/Irish staff, but BAME staff are more likely to receive a formal warning. However, of those receiving formal warnings, BAME staff are less likely than White British/Irish staff to receive the higher levels of sanction: Final Written Warnings and dismissals.

White and BAME staff are approximately equally likely to receive an outcome of No Action.



Similarly, disciplinary cases involving BAME staff are far less likely to proceed to a panel hearing than those involving White British/Irish staff. This is concerning as one explanation may be if most cases involving BAME staff are resolved without the need for formal action, it raises questions about why a formal investigation was launched. However, considering the outcomes graph which shows over half of BAME staff do receive a formal warning, it appears BAME staff are more likely to accept Agreed Outcome Sanctions than White staff. This may be because they are more likely to accept an AOS as the facts are not in dispute, or perhaps because the allegations against them are more likely to be at a misconduct, rather than gross misconduct, level.

Anti-Bullying & Harassment

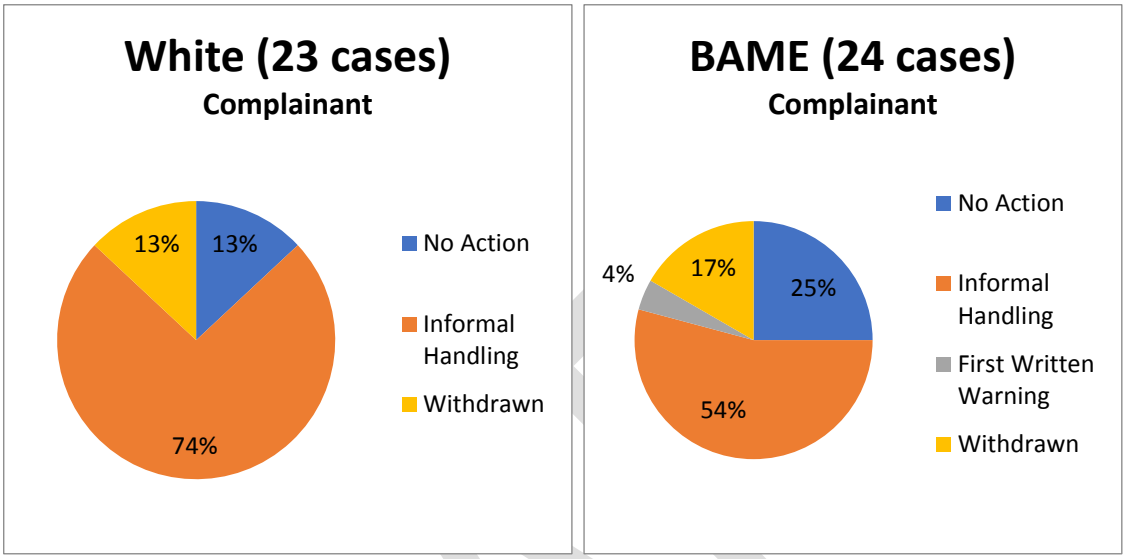


**Subject of investigation is recorded as BAME if at least one person under investigation was BAME*

BAME staff are overrepresented as subjects of bullying and harassment investigations. This may be because of certain cultural factors which should be taken into account before deciding to proceed to a formal ABH investigation, or in consultation with a Cultural Ambassador. Equally, it is a concerning possibility that BAME staff are more likely to be the

subject of such concerns because of bias and discrimination from their colleagues. This is not limited to White British/Irish colleagues are over half of concerns submitted by BAME staff are also against BAME staff.

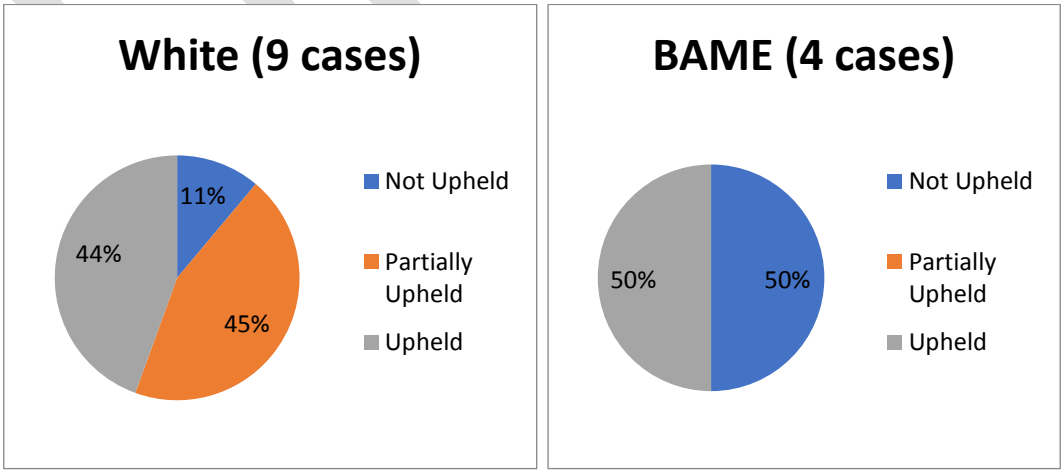
Investigations into BAME staff behaviours are more likely to result in no action than those into White British/Irish staff's behaviour. This suggests there may be other steps which need to happen, such as an independent preliminary review of the facts, before formal investigation is considered necessary.



**Complainant is recorded as BAME if at least one person raising the concern was BAME*

BAME staff raise approximately half of all ABH concerns, meaning they are overrepresented as complainants in ABH cases when compared to the ethnicity proportions in our workforce. Concerns raised by BAME staff are more likely to result in No Action than those raised by White British/Irish staff. This may reflect biases, unconscious or otherwise, of investigators and this is being explored in the Managers' Investigations training.

Grievances



White British/Irish staff are more likely to have their grievances upheld, even partially, than BAME staff. However, as numbers are so small it is difficult to draw convincing conclusions.

Appendix G – Policies and Initiatives

CLG presentation 09032021.pptx

LPT - Microaggressions &

Leicester City Health and Wellbeing Scrutiny Commission

Consolidation Report of UHL Maternity's Learning and Progress from the Ockenden and Kirkup Reports

Lead Director: Julie Hogg, Chief Nurse and Andrew Furlong, Medical Director

Author: Kerry Williams, Head of Midwifery
Liz James, Senior Project Manager

Report version: Final

Purpose of the Report

Following the maternity report to HOSC in June 2022 providing details of the Ockenden report and Leicester Maternity's position at that time, this report provides a consolidated overview of UHL's maternity services learning from the:

- Review of Maternity services in Shrewsbury & Telford (Ockenden report)
- Review of Maternity & Neonatal services in East Kent (Kirkup report)

This paper aims to provide the Committee with information about maternity services' current performance and includes reference to the Perinatal Surveillance Scorecard.

An exception summary of Leicester maternity's performance against the standards from Ockenden is provided below the main report (Appendix 1).

Executive Summary

The initial Ockenden report was published in December 2020 with compliance expected against 7 immediate and essential actions (IEA) by December 2021. The final Ockenden report (March 2022) highlighted a further 15 IEA to improve standards of care. UHL continues to implement and embed these actions with the support of the local maternity and neonatal system (LMNS) and the regional Chief Midwifery Officer.

The Kirkup report published in October 2022 is reflective of the findings from Morecombe Bay (March 2015) and the Ockenden report. Rather than adding to the list of IEAs, Kirkup draws focus to 4 areas for action and makes recommendations for the national teams to address:

- Identifying poorly performing units
- Giving care with compassion and kindness
- Team working with a common purpose
- Responding to challenge with honesty

Themes are identified between Ockenden and Kirkup reports:

- Good governance and data analysis
- Positive culture with open and honest ethos
- Multidisciplinary team working
- Hearing women's feedback
- Leadership
- Organisational behaviours

UHL Maternity Progress

Continual monitoring of Ockenden standards:

UHL maternity was able to provide evidence of compliance for each of the 7 Ockenden IEA's in December 2021 with support and scrutiny provided by the regional chief midwifery officer. The regional perinatal team completed an assurance visit in July 2022 and highlighted points for consideration to support the delivery of a safe and high quality service. We continue to implement and embed these standards and further detail is provided in Appendix 1.

Strengthening governance:

The maternity governance process from ward to Trust Board has been reviewed externally, this has identified a strong structure with some opportunities for improvement. We have also implemented a new Trust Board reporting schedule to ensure the board of directors has oversight of the maternity service. This provides assurance and the information the board is required nationally to be sighted upon. The most recent Maternity Scorecard produced monthly for Trust Board is produced in line with the Perinatal Quality Surveillance Model designed by NHSE to support sharing intelligence from floor to board and is included in Appendix 2.

Over the next quarter we will:

1. Review our performance monitoring alongside system colleagues to ensure it is meaningful, timely, analysed, discussed robustly at MDT governance forums and looks for the signals
2. Recruit 2 renumerated patient safety partners for maternity services

Leadership and Culture:

We have strengthened the midwifery and obstetric leadership team with some additional posts. Our leadership structures are now compliant with the leadership standards set by the Royal College of Midwives.

We are also working hard to understand the culture within maternity and have commissioned Ashley Brooks to lead the empowering voices programme across the service. This is almost complete for the Leicester Royal Infirmary teams. Completion of this will ensure we have a culture that support the safest possible care for women and their families at UHL.

Over the next quarter we will:

1. Welcome our new Director of Midwifery – Danni Burnett
2. Appoint to second Head of Midwifery
3. Develop our safety plan with a key focus on culture
4. Run a bespoke leadership programme for band 7 midwifery leaders funded by HEE

Multidisciplinary Team Working:

Key to the Saving Babies Lives care bundle (2019) is the need for teams to train together. Compliance with training and our ability to run simulations in the clinical setting has been affected by covid-19 restrictions. Training programs will be face to face from January 2023 with an expectation that engagement and compliance will improve.

As part of the empowering voices programme the teams are collectively agreeing a common purpose and objectives to support team working.

Over the next quarter we will:

1. Reinstate face to face training
2. Review the preceptorship programme for newly qualified midwives
3. Launch the maternity strategy
4. Roll out a programme of cultural change (to be commissioned)

Hearing Women's Feedback:

The UHL maternity team is working with LMNS partners to relaunch the Maternity Voices Partnership. We also have strong links with Leicester Mamas who have been involved in service improvements over the past year.

Workstreams are also ongoing to improve outcomes for women from ethnic minority communities and women from areas of deprivation. Action is being taken which focuses on implementing innovative ideas in practice to improve outcomes.

Over the next quarter we will:

1. Relaunch the MVP
2. Recruit 2 renumerated patient safety partners for maternity services
3. Adopt the new patient safety incident review framework to strengthen the voice of families
4. Establish a patient advice and liaison service
5. Review our approach to complaints

Recommendations

The Committee are asked to be assured by the progress to date and note the areas where improvement is required and the plans to address these.

Appendix 1

Exception Summary: Leicester Maternity Ockenden September 2022
(shared with UHL Trust Board October 2022)
Ockenden Final Report, 15 IEA's (published March 2022)

Overview	RAG	Outstanding Actions	Update (if required)
IEA 1: Workforce Planning and Sustainability			
Includes specific standards for labour ward co-ordinators, HDU care & Newly Qualified Midwives and an emphasis on funding MDT workforce & staff training		Workforce planning, recruitment & retention actions ongoing	Establishment reviews complete (Sept 22) & in line with Birth Rate plus establishment setting tool. Progress indicated as amber due to the workforce vacancies.
		2 national actions, awaiting further update re: investment in maternity & neonatal services; and review of BirthRate Plus tool	
IEA 2: Safe Staffing			
Focus on clear escalation processes and associated actions		Update Midwifery Staffing Policy to reflect escalation processes for both community & hospital based teams	Due Nov 22
			Compliant with all other actions however amber reflects reality of day to day operational pressures
IEA 3: Escalation and Accountability			
Need for clear guidance which supports all staff to escalate clinical concerns.		Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Consultant PA's increased. Focus on increasing weekend cover with recruitment & job plan reviews in progress
IEA 4: Clinical Governance – Leadership			
Reinforces need for Trust Board oversight of maternity governance. Midwifery & obstetric leadership needed through governance, guidelines & audit.			Compliant with all actions
IEA 5: Clinical Governance - Incident Investigation and Complaints			
Focus on investigations being meaningful for families and lessons being learnt in a timely manner in practice.		Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Additional resource for governance team in place, rapid reviews & associated actions implemented. Embedded compliance Dec 22
		All maternity services must involve service users (ideally via their MVP) in developing complaints response processes.	Engaged in redesign of MVP, re-launch date subject to ICB procurement process. Standards from national recommendations included in this workstream.
IEA 6: Learning from Maternal Deaths			

Standards around post-mortems, joint investigations & timely learning in practice.		1 national action, awaiting further update re: availability of expert maternity pathologists	Compliant with all actions
IEA 7: Multi-Disciplinary Training			
Continues to support MDT training in emergency skills, CTG & human factors		All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events and attendance should be monitored.	MDT training program in place however not consistently meeting 90% compliance expected of CNST – actions in place to achieve across MDT Oct 22
		Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.	
IEA 8: Complex Antenatal Care			
Focus on Maternal Medicine Networks, and care for women with multiple pregnancy, diabetes & hypertension.		Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. Supported by the NICE Guideline Twin and Triplet Pregnancies 2019.	Plan to develop specialist multifetal clinic (requires midwife recruitment).
IEA 9: Preterm Birth			
Systems & processes to support women at risk of preterm birth			Compliant with all actions
IEA 10: Labour and Birth			
Includes care outside hospital setting, IOL pathways and centralised CTG monitoring systems.		All women must have full clinical assessment including place of birth	Risk assessment completed at every contact – monthly audits show improvement but not consistently meeting 90% target
		Midwifery-led units must complete yearly operational risk assessments.	Operational plan being created with annual review date
		Women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit.	Information for women being updated, due Oct 22
		Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs	Awaiting further information from national fetal monitoring group
IEA 11: Obstetric Anaesthesia			
Includes safe staffing, documentation, information for women & follow-ups.		Review documentation in maternity patient records and take steps to improve this where necessary	HoS supporting national work around anaesthetic documentation. Local audit of documentation taking place to inform actions
		The full range of obstetric anaesthesia	Business case agreed to increase

		workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.	caesarean section capacity. Implementation process initiated.
		Participation by anaesthetists in the maternity multidisciplinary ward rounds	HoS working to ensure full MDT ward rounds twice each day, due Nov 22
IEA 12: Postnatal Care			
Safe staffing for postnatal care, timely consultant reviews for women re-admitted or unwell postnatally.		Staffing levels must be appropriate for both the activity and acuity on the postnatal ward both day and night.	Further exploration of the best way to monitor acuity on the wards taking place
IEA 13: Bereavement Care			
Focus on compassionate, individualised bereavement care available 24/7.		All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth.	Substantive bereavement team increased to 7 day service. Plan in place to increase training for MDT in bereavement care & to increase number of team trained in post mortem consent
IEA 14: Neonatal Care			
Increasing neonatal critical care cots. Clear pathways of care with advice & support throughout the network		Care that is outside the agreed pathway for neonatal care must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network.	Working with LMNS to agree process for oversight exceptions (network consistency)
		Work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Continued engagement with regional QI projects which support this
		Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit to deliver safe care 24/7.	Business cases for medical, nursing & AHP workforce with ongoing recruitment. Risk of split site working recognised by the Trust.
IEA 15: Supporting Families			
Supporting maternal mental health including specialist psychological support.			Compliant with all actions

Additional actions (not captured above) from NHSE Insight Visit July 2022
Ockenden Initial Report, 7 IEAs (published December 2020)

Overview	RAG	Outstanding Actions	Update (if required)
IEA 1: Listening to women and families			
Includes the roles of safety champions and maternity voices partnership (MVP)		Strengthen MVP role and the relationship between safety champions and service users	Engaged in redesign of MVP, re-launch date subject to ICB procurement process. Evidence of engagement with service users in QI projects
IEA 3: Staff training and working together			
Focus on the MDT's importance in patient safety		Consultant led MDT ward rounds twice each day	Plan to trial new model to increase consultant cover (involves job planning reviews) Auditing monthly
		90% compliance required for MDT training in emergency skills drills & fetal monitoring	Actions being taken to increase compliance across all MDT
IEA 7: Informed consent			
Focus on information available to women		Information available on the maternity website	Current website under review following input from MVP, new internal website launch October 22

Appendix 2

Meeting title:	Public Board of Directors
Date of the meeting:	November 2022
Title:	UHL Maternity Perinatal Quality Surveillance Scorecard
Report presented by:	
Report written by:	Kerry Williams, Head of Midwifery John Barnett, Business Intelligence Specialist

Action – this paper is for:	Decision/Approval		Assurance	x	Update	X
Where this report has been discussed previously						

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The report provides a monthly update of the maternity scorecard, presenting data against key performance indicators and exception report highlighting areas of underperformance and associated actions for improvement.

Impact assessment
N/A

Acronyms used:
Please see abbreviations commonly used in maternity reports

Purpose of the Report

The scorecard is produced in line with the Perinatal Quality Surveillance Model designed by NHSE to support sharing safety intelligence from floor to board.

Executive Summary

The scorecard includes 5 areas of focus:

- Patient Safety
- Workforce
- Training
- Friends and Family
- Outcomes

The scorecard provides monthly data with trends since March 2022. The exception report highlights actions to improve compliance against each underperforming metric.

There are 6 areas of challenge:

- Moderate incidents
- Midwife vacancies
- Staff training compliance
- Friends and family footfall
- % blood loss greater than 1500ml
- % 3rd and 4th degree tears

Recommendation

The board of directors are asked to be assured by the progress to date and note the areas where improvement is required.

Maternity Perinatal Quality Surveillance Scorecard - W&C CMG Month 6 (September) 2022-23

	National Target / Alert Level	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	2022-23 TOTAL / AVERAGE (YTD)	Variation - 12 month period / SPC
PATIENT SAFETY										
Total deliveries (LRI, LGH, SMBC, HB & BBA)	Actual	842	787	809	786	781	850	823	4836	
No. of hospital deliveries at LRI (excl HB & BBA)	Actual	473	463	440	443	431	495	455	2727	
No. of hospital deliveries at LGH (excl HB & BBA)	Actual	344	305	344	315	312	326	343	1945	
No. of hospital deliveries at SMBC Plus HB & BBA	Actual	25	19	25	28	38	29	25	164	
SIs (Obstetrics)	Actual	2	3	1	3	5	1	1	14	
SIs (Neonatology)	Actual	0	0	1	0	0	0	0	1	
Number of Still births - overall total	Actual	5	2	3	3	8	4	3	20	
Still births as %age of Total Deliveries	<0.45%	0.6%	0.3%	0.4%	0.4%	1.0%	0.5%	0.4%	0.4%	
HSIB Referrals	Actual	2	1	0	4	5	1	0	13	
Moderate Incident	Actual	9	5	5	8	5	8	6	7	
Coroner Regulation 28 Requests	Actual	0	0	0	0	0	0	0	0	
WORKFORCE										
Funded Midwife to Birth ratio (UHL complete care) - 1	>1:26.4	1:27.0	1:25.5	1:25.5	1:25.5	1:25.5	1:25.6	1:25.6	1:25.5	
Midwife Vacancies (%)	Actual				14.4%	13.6%	13.6%	15.2%	14.2%	
1 to 1 Care in Labour	Actual	100%	100%	100%	100%	100%	100%	100%	100%	
TRAINING										
% of All Staff attending Annual MDT Clinical Simulation	Actual	78%	81%	83%	86%	88%	87%	90%	86%	
% of All Staff attending NLS Training	Actual	88%	83%	76%	84%	92%	93%	92%	87%	
% of All Staff attending CEFM Training (Theory)	Actual	94%	82%	91%	93%	92%	96%	95%	92%	
% of All Staff attending CEFM Training (Assessment)	Actual	92%	81%	91%	93%	92%	96%	94%	91%	
FRIENDS AND FAMILY										
Maternity Friends & Family - Footfall	>=30% (UHL Target)	19.3%	17.4%	19.7%	15.4%	19.0%	18.3%	22.0%	18.6%	
Maternity Friends & Family - percentage of promoters	>=96% (UHL Target)	96.3%	96.6%	97.3%	95.7%	95.4%	95%	97%	96.1%	
OUTCOME										
Spontaneous Deliveries %	Alert if <51%	47.4%	48.2%	47.3%	46.4%	49.7%	50.0%	44.8%	47.7%	
Caesarean Section Rate - total	Alert if >23%	41.6%	38.5%	39.6%	38.2%	38.7%	38.2%	41.6%	39.1%	
% Blood loss greater than 1500 ml (as a % of total deliveries)	<3.6% (Local Target <=2.7%)	3.3%	2.9%	3.7%	2.9%	4.0%	2.7%	2.9%	3.2%	
% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	1.8%	3.7%	3.3%	2.7%	3.7%	3.0%	3.9%	3.4%	
% of Full term babies admitted to NNU NB:Figures from January 2019 reflect ATAIN: Term admissions to NNU as % of UHL Term births	ATAIN Target <6.0%	4.42%	4.42%	3.31%	5.86%	3.99%	3.51%	4.87%	4.36%	

Maternity Perinatal Quality Surveillance Scorecard – Exception Report
October 2022 (September data)

Metric underperformed	Driver for underperformance	Actions to address the underperformance
Patient Safety		
Moderate incident	• 6 moderate harms reported in September • 1 reviewed and downgraded	• Completed rapid review on 4 of 5 moderate incidents. 1 outstanding is 4th degree tear for consultant review • 1 case taken to perinatal risk group (PRG) no concerns identified about management of care with no recommendations • Remaining cases being discussed at PRG in October • All cases received verbal duty of candour • 1 case referred to HSIB, but was declined as MRI normal • Cluster review to be arranged for 3 Massive Obstetric Haemorrhage with hysterectomies
Workforce		
Midwife vacancies	• Midwifery vacancy 66.71 WTE • Vacancy rate impacting on staff morale, retention and service delivery	• Empowering voices programme commenced at LRI, commissioned further review for LRI and community • 27 newly qualified midwives due to start around November/December 2022 • 2 further external candidates to be interviewed • 2 international midwives to commence in November plus 2 more to interview • Matron for safe staffing post out to advert
Training		
% staff attending MDT simulation training % staff attending CEFM training	• CNST requirement >90% compliance for each staff group	• Engagement from anaesthetic staff to improve compliance • NHSR contacted to review update on compliance indicator changed in October 22
Friends and family		
Maternity Friends & Family - Footfall	• Footfall below UHL target of 30% • Poor compliance with collection in community due to national change of 36-week collection metric	• Team leads encouraging completion at meetings, this has seen slight increase for September. • Community matron to scope text process with patient experience team
Outcomes		
% Blood loss greater than 1500 ml % 3rd & 4th degree tears	• Likely to coincide with Increase in numbers of caesarean sections • National outlier for 3rd & 4th degree tear rates identified through benchmarking	• Work in progress to implement OBS Cymru programme to reduce postpartum haemorrhage • Perineal tears workstream focusing on education and prevention care bundle to improve outcomes

Health and Wellbeing Scrutiny Commission

Work Programme 2022-23

Date	Topic	Notes
21 Jun 22	1. COVID19 Vaccination Progress & Vaccination Champions Update 2. Emerging Trends & Ongoing Health Issues 3. Rough Sleepers Drug and Alcohol treatment Programme	Note: the UHL accounts will be taken as a verbal update at Joint Health on 27 June 2022 1. Information on current infection rates and the £485k Vaccinations Champions funding was requested by the Commission. 2. Suggested item to cover updates on health-related issues 3. Request for Members of Housing Scrutiny to be invited for this item.
11 Aug 22	1. Update on COVID19/Vaccination Programme & Emerging Health Issues 2. CQC Report: Urgent/Emergency Care across LLR (UHL) 3. Leicester Health, Care and Wellbeing Strategy 2022-2027 (ICS Place Led Plan) 4. Update on Sexual Health Services / Contraception and PrEP (Pre-exposure to HIV) service 5. 0-19 Commissioning Update	3. Following the approval from the HWB Board. 4. Update report expected on an annual basis. 5. Item deferred from the previous year due to COVID.
21 Sept 22	Joint meeting with CYPE and ASC on the Local Plan	

Date	Topic	Notes
6 Oct 22	1. Update on the ICS structure 2. Autumn/Winter Vaccination Update (including vaccinations in care homes) 3. Winter Planning 4. Results of 'How are you, Leicester?' 5. Safeguarding Adults Annual Report 6. Cost of Living Impact (Joint Meeting with ASC)	1. Updated structure for both Commissions 2. Joint working on this item between ICS and the Council 3. As above 4. Survey was conducted by the Council over the summer, with the consultation ending in June. 5. Partnership report: for information 6. Additional item of interest that was agreed
1 Dec 22	1. Colour Dyers Ltd – Update 2. School Nursing Provision 3. Task Group Report – BLM and NHS Workforce 4. Maternity Services Update	1. This matter was predominantly dealt with by the Neighbourhood Services commission on 15 November. A verbal position statement will be provided by the Chair. 2. Scheduled update following last year – (joint item with CYPE) 3. Findings and recommendations of the Health Scrutiny's Task Group to be presented before going to OSC for endorsement. 4. Requested by the Chair in October as a result of national news coverage and previous interest by the commission.
17 Jan 23	1. Access to GP services and Community Pharmacy Services Update 2. Oral Health Services 3. Alcohol Strategy Update 4. Draft General Fund Revenue Budget & Draft Capital Programme 2023-24 5. Winter Flu update	1. This item will be the predominant focus of the meeting, given the interest shown by the Commission in June 2022. 2. Future item to be presented on the broader issues of oral health, with a focus on the issue of NHS vs private practices. 3. Report requested previously 4. Standard item to be taken to all commissions as part of the budget-setting process.

Date	Topic	Notes
16 Mar 23	1. Health Inequalities Update – Action Plan (including the inequality impact of COVID19 on the local population) 2. Tobacco Control (Public Health) 3. The work of No.5	1. Scheduled update following last year – may be subject to change 2. Scheduled update following last year – may be subject to change 3. Item requested by Chair following the No 5 visit in September 2022.

Forward Plan Items

Topic	Detail	Proposed Date
Health & Care section of Forward Plan - **No decisions** due to be taken under this heading for the current period (on or after 1 May 2022)		
The operation of Patient Participation Groups	Requested at joint ASC/HWB scrutiny meeting on 6 October	TBC
Self-neglect	Arising from the joint scrutiny discussion on the Safeguarding Adults Panel, a report on this was requested – possibly for the next Joint Scrutiny meeting.	TBC
Engagement work by the Health Sector in response to the cost-of-living crisis	A report was requested at the joint ASC/HWB meeting on 6 October	TBC
Virtual Wards	An update on this work to be brought late 2022/early 2023	Possibly January 2023
Winter Planning	Update requested at Joint ASC/HWB meeting on 6 October – likely to go to the next joint ASC and HWB meeting - TBC	At the next joint ASC/HWB commission meeting
COVID19 Update and Vaccinations Update	Was previously a standing item on the agenda in the last civic year. Commission to request updates where appropriate.	June 2022

Topic	Detail	Proposed Date
Alcohol Strategy	Update given in December 2021, with a further update expected in a year with information on links to obesity.	December 2022
0-19 Commissioning Update	Planned for January 2021 but current contract extended by a year due to COVID	August 2022
Update on Sexual Health Services / Contraception and PrEP (Pre-exposure to HIV) service	Initial sexual health services presentation given in Sept 2021. Commission requested an annual report on both items going forward, with pre-COVID information and pregnancy data.	Completed in Sept 2021; tbc August 2022
Review Report – BLM and NHS Workforce: progress update	Anticipated that the completed report will come to the Commission this year.	December 2022
Updates on Obesity (whole systems approach)	Completed in Dec 2021, an update requested in the next cycle of meetings.	Winter 2022
Consultation Response to UHL Reconfiguration; now **Updates on Reconfiguration Proposals**	Consultation response covered at both HWB and JHOSC in July 2021. Updates expected on; birthing unit, budget changes for the reconfiguration, backlog of repairs, primary urgent care locations.	Covered in July 2021, with progress updates expected at future meetings
Health Inequalities Update – Action Plan (including the inequality impact of COVID19 on the local population)	Mentioned in the January 2021 minutes, following the LLR health inequalities item. Followed up with a LLR Framework and Action Plan Update in April 2021, with a further update in 2022 regarding; implementation, statement of intent and action plan.	March 2023
Integrated Care Services (ICS)	In January 2022, the Commission requested a diagram explaining the structure of the ICS and sharing the draft constitution, once ready.	June 2022, with further updates expected later.
Draft Revenue Budget and Draft Capital Programme	Standard report to go to all Commissions	January 2023
Air Quality Pollution	Joint item with EDTCE	TBC 2022
School Nursing Provision	Joint item with CYPE Scrutiny. Initially taken in Nov 2021	December 2022.
Community Pharmacy Service	Initial update given in Sept 2021 with follow up information in Nov 2021 and Jan 2022.	January 2023
Health and Wellbeing Strategy	Progress update since it was launched in 2019	TBC

Topic	Detail	Proposed Date
Results of the survey on the health, care, and wellbeing plan; relating to ICS Place Led Plans	Leicester health, care, and wellbeing delivery plan - to improve future health outcomes of the people of Leicester.	Summer 2022
Tobacco Control	Report from the Public Health team	March 2023
Oral Health	Following the 3-year-old oral health survey, Commission requested report on broader issues around oral health.	January 2023
Local Plan – joint meeting	Upcoming item for all Commissions to consider	October 2022
Rough Sleepers Drug and Alcohol treatment Programme	Requested to be added to the work programme, with Commission Members from Housing Scrutiny to be invited.	June 2022
Results of 'How are you, Leicester?'	Consultation conducted by City Mayor's Office in Summer 2022.	October 2022