Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **THURSDAY, 16 MARCH 2023**
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)
vacant (Vice-Chair)

Councillors Aldred, Khan, O'Donnell, Dr Sangster and Westley

2 unallocated Labour 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)

Representative of Healthwatch Leicester

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. MINUTES OF PREVIOUS MEETING

Members of the Commission will be asked to confirm the minutes of the meeting held on 17th January 2023 as a correct record.

4. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS

5. PETITIONS

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

6. 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.

7. NHS URGENT AND EMERGENCY CARE UPDATE **Appendix A (Pages 1 - 6)**

Members of the Committee to receive a report providing an overview of the urgent and emergency care system through the peak winter months, highlighting summary actions from the LLR winter plan.

8. MATERNITY SERVICES UPDATE REPORT **Appendix B (Pages 7 - 30)**

Members of the Committee to receive a report that provides a consolidated overview of UHL's maternity services learning in respect of the following:

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

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

9. 0-19 HEALTHY CHILD PROGRAMME CONSULTATION **Appendix C (Pages 31 - 46)**

Members of the Committee to receive a report providing an update on the recommissioning of Healthy Together (0-19 Health Child Programme) and the ongoing Public Consultation together with recommendations arising from the consultation outcomes.

10. SEXUAL HEALTH SERVICES CONSULTATION **Appendix D (Pages 47 - 68)**

Members of the Committee to receive a report providing details of the Sexual Health Services public consultation, the interim results and next steps.

11. LEICESTER , LEICESTERSHIRE AND RUTLAND CHILD DEATH OVERVIEW PANEL - ANNUAL REPORT **Appendix E (Pages 69 - 106)**

Members of the Committee to receive the Annual Report of the Child Death Overview Panel for the period 2021-22.

12. WORK PROGRAMME **Appendix F (Pages 107 - 110)**

The Scrutiny Policy Officer to provide update on the Health and Wellbeing Scrutiny Commission's Work Programme.

13. ANY OTHER URGENT BUSINESS

Appendix A

Name of meeting:	**Health Overview and Scrutiny Commission**		
Date:	**March 2023**	**Paper:**	**TBC**
Report title:	**LLR health and care system – winter briefing note**		
Presented by:	Rachna Vyas, Chief Operating Officer		
Report author:	Rachel Dewar – Assistant Director of Urgent & Emergency Care		
Executive Sponsor:	Rachna Vyas, Chief Operating Officer		

To approve ☐	**For assurance** ☐	**To receive and note** ☒	**For information** ☐
Recommendation or particular course of action.	*To assure / reassure the Board that controls and assurances are in place.*	*Receive and note implications, may require discussion without formally approving anything.*	*For note, for intelligence of the Board without in-depth discussion.*

Recommendations:

The HOSC is asked to:

- **RECEIVE** the summary update
- **NOTE** implications for planning for one- and five-year plans across health and care

Purpose and summary of the report:

This paper provides an overview of the urgent and emergency care system through the peak winter months, highlighting summary actions from the LLR winter plan. The paper also outlines preparation for 23/24 and how learning is being used to inform both one-year and five-year plans across LLR

Appendices:	
Report history (date and committee / group the content has been discussed / reviewed prior to presenting to this meeting):	

LLR health and care system – Winter briefing note

March 2023

Context

1. This paper provides an overview of the LLR health and care system over Q3 22/23 and into Q4, including responses to extra ordinary events such as the ambulance service industrial action, and overall management of operational pressures across all parts of health and care.

2. As per the national directive, LLR launched its System Control Centre (SCC) on 1st December 2022, operating 08:00-20:00 365 days of the year. Recruitment for staffing is underway, with an interim rota of ICB staff. The SCC acts as a single point of contact for NHSE and the LLR system for escalation, operational support and for reporting purposes.

3. Strategic, operational and tactical leadership and coordination has been maintained across the period, with an increase across the last 6 weeks in particular due to ongoing industrial action. Regional oversight has also intensified, relying on the SCC on a live basis.

4. Whilst patient safety has been maintained as best possible, the system recognises that the patient experience of care was, at times, sub-optimal across health and care services. Staff were equally reporting high levels of moral injury, particularly those in frontline acute services within EMAS and the Emergency Department.

5. Whilst demand has stabilised through the start of Q4 23/24, all parts of the system remain busy in terms of both acuity and demand. This trend spans primary care, NHS111, Clinical Navigation Hub, home visiting, urgent care services, acute services and social care services.

Implementation of the winter plan

Primary care services

6. Primary care continued to be under pressure through this period, with all providers reporting significant gaps between capacity and demand. However, month on month increases have been noted in terms of the numbers of appointments provided and an increase in face-to-face appointments has also been recorded (c73%).

7. To support both primary care and secondary care capacity, additional capacity at our Urgent treatment centres was commissioned as part of the LLR winter plan; an additional 60 appointments daily had been planned from DHU to support primary care presentations across the system and this continues to be in place.

   In addition to this and in response to unprecedented numbers of walk-in presentations in ED, an additional 1,577 appointments were provided during the period of 20th December and 29th December. The objective of this additional activity was to minimise the

overcrowding in ED by streaming patients presenting with a specific set of conditions to an offsite primary care provider with a booked appointment. The impact of the streaming away from ED continues to be significant and has supported the ED throughout.

8. Again, in addition to planned capacity and in response to the paediatric surge, an Acute Respiratory Hub was trialled with a primary care provider, providing respiratory support to both adults and children, taking referrals from primary care and from ED itself. Six additional ARI hubs, provided by our PCN's and providing over 9,000 appointments, went live mid-January and will run until March 31st 2023.

9. The impact of both actions has supported a decrease in overcrowding at the ED and has provided an opportunity to ensure that capacity provided meets the needs of the changing way our patients want services to be available.

Pre-Hospital Services

10. The Unscheduled Care Coordination Hub has been undertaking pilots to assess the impact of extended opening hours across weekdays. It noted little impact on later working on the first trial, though is repeating the exercise. Activity continues to increase as the understanding and confidence of both the referring and receiving staff increase, meaning approximately 150 of our patients per week are supported to be in the right place at the right time with the right care, rather than in acute services.

11. The UCH demonstrates a particularly significant positive impact during the periods of ambulance service industrial action, with the numbers of patients waiting in LLR significantly lower across this period than neighbouring systems, leading to regional and national interest. The hub has been operational from 9.00-00.00 on the industrial action days, with out of hours services working together using a similar pull model between 00.00 and 06.00 the next day. This has led to a positive 'opening' position and kept services flowing through the next day through each period of industrial action.

12. The Pre-Transfer Clinical Discussion & Assessment Service (PTCDA) continues to recruit clinical staff to further strengthen its availability of face to face visiting as well as the virtual geriatrician support. PTCDA works closely with urgent community response services across health and care. Clinically validated data is evidencing between 800 and 1200 bed days saved through the scheme alone and highly positive patient and carer feedback. Clinical satisfaction rates are also high, supporting the growth of this model locally.

13. The Virtual Wards remain significantly underused in some specialties; a step-up plan has been agreed and will be ready for testing in February 2023. However, in those areas where successfully utilised, capacity has been optimal, leading to c100-120 patients being empowered to be cared for in their own home, with support as needed.

14. All health and social care Urgent community response (UCR) services remain operational and available in support of operational pressures and industrial action. The learning and evidence base from this winter period suggests that a senior clinical triage plus a single

point of contact for all UCR services would support patient flow and holistic models of care for winter 2023/24.

Acute services

15. Ambulance conveyance rates remain low, ranging from 27%-37% conveyance through this period. Whilst call numbers have been higher than previous years, conveyance has largely remained below 150-160 ambulances per day; acuity, however, has risen significantly. Since the periods of industrial action, regional demand has remained c5% below previous levels. LLR has seen little difference in terms of the number of incidents than previously; however, conveyance and diversion to other services remains high, supporting the Category 2 and call answering targets.

16. The introduction of the Elite cohorting area and cohorting pod on 20th December saw an immediate and lasting decrease in ambulance handover delays, with the average clinical handover time now within national standards, at 28 mins for February 2023. A more permanent solution was put into place in the form of 10 handover bays; since the start of Q4 however, these areas have been used less often whilst maintaining timely handovers. Whilst this is positive, it is too early yet to remove the capacity; a more permanent solution to cohorting is under construction.

17. Reducing the overcrowding has supported ED staff to focus on those requiring acute care and created a sense of community between UHL ED and partners – this is wholly significant given the pressure ED staff have and continue to experience.

Discharge

18. Pilots have been undertaken related to discharge from the Emergency Floor, in partnership with local authority and community care teams. These have shown that up to 10 patients per day can be safely treated and discharged from the Emergency floor when our health and care services are working together using a strengths-based model of care. Business cases have been submitted to ensure this remains a permanent offer within the ED.

19. An integrated discharge function (across health and care services) launches in February 2023 to support and facilitate patients being discharged both in a timely manner but also to the correct discharge destination. This will support flow and longer-term better outcomes for our patients.

20. The adult social care discharge fund was agreed and utilised across this period to strengthen domiciliary care and bedded services where appropriate. Despite additional bedded acute and non-acute capacity being opened and utilised as part of the winter plan, the numbers of medically optimised patients across the system has remained within normal variation, showing a level of efficiency and effectiveness. Whilst there is clearly further work to be done for these pathways to be optimal, this is encouraging.

Conclusions

21. Whilst this has been and continues to be a challenging period for all health and care services, the additional capacity put in across all providers as part of the Winter Plan, coupled with the pathway changes designed and implemented by our clinical teams supported the system to provide as safe a service as possible. The risk management process and oversight from the LLR Clinical Executive was felt to be a strength through this period, and relationships across the system remained strong in the face of increasing challenge.

22. Much of the learning from winter 22/23 is being used to implement sustainable change in the 23/24 operational plan. It has been widely recognised that 23/24 will be needed to stabilise and manage demand as part of plans to deliver transformational change through the LLR 5-year plan. The operational plan will include the LLR winter plan this year, with a focus on:

    a. An integrated UEC model of care, with some form of UTC access in the City
    b. Growing the respiratory capacity ahead of next winter
    c. A flexible cohort facility, able to flex as per demand
    d. A therapy-led model of additional bedded services across LPT to support flow
    e. Recurrent increase in home care staff as part of an integrated Intermediate Care offer

    Early system support of these schemes will support recruitment of substantial staffing (rather than agency staff) and support recovery of key performance indictors before winter 23/24.

Recommendations

The HOSC is asked to:

- **RECEIVE** the summary update
- **NOTE** implications for planning for one- and five-year plans across health and care

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: Danni Burnett, Director of Midwifery
Liz James, Senior Project Manager

Report version:

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 in respect of the following:

- 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.

Information is provided on the ongoing work to respond to the recommendations of the Ockenden report.

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 generate further insight into the themes around teamwork, professionalism, compassion, responding to investigations, and failures to listen. An extensive program of work has already commenced to improve the culture of the service.

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

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.

UHL Maternity Progress

Continual monitoring of Ockenden standards:

Following the initial Ockenden Report (December 2020) evidence of compliance has been collated and shared with commissioners and regulators against each of the 7 Immediate and Essential Actions (IEAs). Evidence was reviewed and feedback received from NHS England (NHSE) indicating compliance with one exception: external clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. This indicator remains partially compliant with actions taken including: HSIB cluster review; a peer review with Leeds teaching Hospital; an independent desktop review commissioned by LLR ICB) and work with our buddy maternity Trusts to establish a formal process for external review.

The NHSE Regional Perinatal team completed an assurance visit in July 2022 which generated several actions for attention. This included strengthening communication across the service on plans and actions, plus recognition of the impact on compliance due to the lack of a Maternity Voices Partnership (MVP) across the LLR system.

Below are actions which remain outstanding following the feedback from the Insight Visit:

Overview	RAG	Outstanding Actions	Update (February 2023)
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	UHL have engaged in the redesign of the MVP being led by the LLR ICB. Procurement panel conducted February 2023 with successful bidder to be awarded, timeframe for implementation awaits. In addition, there is continuous evidence of engagement with service users in Quality Improvement projects continues to be captured such as: Leicester Mammas engagement and collaboration through the development of the Equity and Equality plans, support with Unicef Baby Friendly Accreditation (BFI) and Breastfeeding Peer Support, development of Red Flags and Symptom Checkers. Plus, further work to improve our communication with women and their families such as development of an App for South Asian Women (JANAM App)
IEA 3: Staff training and working together			
Focus on staff training together and working together.		Consultant led MDT ward rounds twice each day	Insight visit highlighted need for midwife co-ordinator, anaesthetist and consultant to be present as a minimum for compliance. Targeted action based on monthly audits to increase anaesthetic representation and reduce gaps in documenting attendance.
IEA 7: Informed consent			

Focus on information available to women		Information available on the maternity website	A task and finish group has been established to review the maternity website. MVP involvement to be progressed once in place. Multiple innovative solutions to support effective communication with women in progress i.e. CardMedic pilot and the JANAM App

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 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 presented 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 1.

Over the next quarter we will:

1. Complete a stocktake review of all evidence against each of the 15 Ockenden recommendations with an active support and oversight role played by our LLR Local Maternity & Neonatal System (LMNS)
2. Be working with the LMNS and ICB to establish formal reporting (LLR Ockenden Assurance Meeting scheduled for April 2023
3. UHL will establish an executive-led Maternity Assurance Committee (MAC) which will take the lead on assurance in relation to delivery and sustainability of the Ockenden and Kirkup actions.

Whilst establishing MAC, below provides a snapshot of the ongoing work to respond to the recommendations:

Immediate and Essential Actions (IEA)	Examples of Ongoing Actions
IEA1: Workforce Planning and Sustainability	• Funded midwifery staffing in line with Birth Rate Plus • Matron for Midwifery Safe Staffing and Recruitment, Retention, and Pastoral Midwives now in post
IEA2: Safe Staffing	• Safe Staffing for nursing & midwifery policy updated (February 2023) • Refreshed Maternity & Neonatal Escalation Policy aligned to the NHSE Regional Escalation Policy • BirthRate Plus® Acuity summaries included within formal reporting
IEA3: Escalation and Accountability	• Increase in Consultant PA time, focus on weekend and job plans
IEA4: Clinical Governance (Leadership)	• Trust Board oversight in place with standing item of perinatal scorecard and annual work plan • MAC to be established
IEA5: Clinical Governance (Incident Investigation and Complaints)	• Additional resource to support the governance team • UHL involvement in the MVP procurement exercise
IEA6: Learning from Maternal Deaths	• Active Perinatal Mortality Review Group • Rapid Review process in place

	• Close working with Medical Examiners and Learning from Deaths programme
IEA7: Multi-Disciplinary Training (MDT)	• MDT training meets 90% compliance as per NHSR since November 2022 • Face to face training recommenced from January 2023
IEA8: Complex Antenatal Care	• Plans to develop specialist multifetal clinic
IEA9: Preterm Birth	• Focus on improving compliance of Saving Babies Lives Care Bundle (SBLCBv2) – reducing smoking in pregnancy and addressing the variation of antenatal steroids
IEA10: Labour and Birth	• Consultant Midwife leadership on women who choose birth outside of guidelines
IEA11: Obstetric Anaesthesia	• Head of Service national involvement with work on anaesthetic documentation, local audits in place • Business case to build capacity • Improving participation on ward rounds
IEA12: Postnatal Care	• Implementation and embedding BirthRate Plus® acuity tool in the postnatal ward areas
IEA13: Bereavement Care	• Substantive bereavement team increased to 7day service • Training embedded into mandatory training with close monitoring of staff trained in post-mortem consent
IEA14: Neonatal Care	• Business case in development for allied health professionals (AHPs) • Increasing capacity for critical care beds • Refresh of local Transitional Care plans
IEA15: Supporting Families	• Ongoing work to improve access to families requiring specialist support

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 welcomed Danni Burnett, Director of Midwifery, to the team in January 2023.

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 in progress for the Leicester Royal Infirmary, Leicester General Hospital and community 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 second Head of Midwifery – Rebekah Calladine
2. Develop our safety plan with a key focus on culture
3. 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. Compliance with the training standard of the Maternity

Incentive Scheme were achieved in November 2022 and training programs have returned to face to face in January 2023.

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. Review the preceptorship programme for newly qualified midwives
2. Launch the maternity strategy
3. 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 (MVP). Leicester Mamas were commissioned in February 2023 to deliver the MVP.

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.

Perinatal Quality Assurance Scorecard

January 2022

Appendix B

W&C CMG

Contents

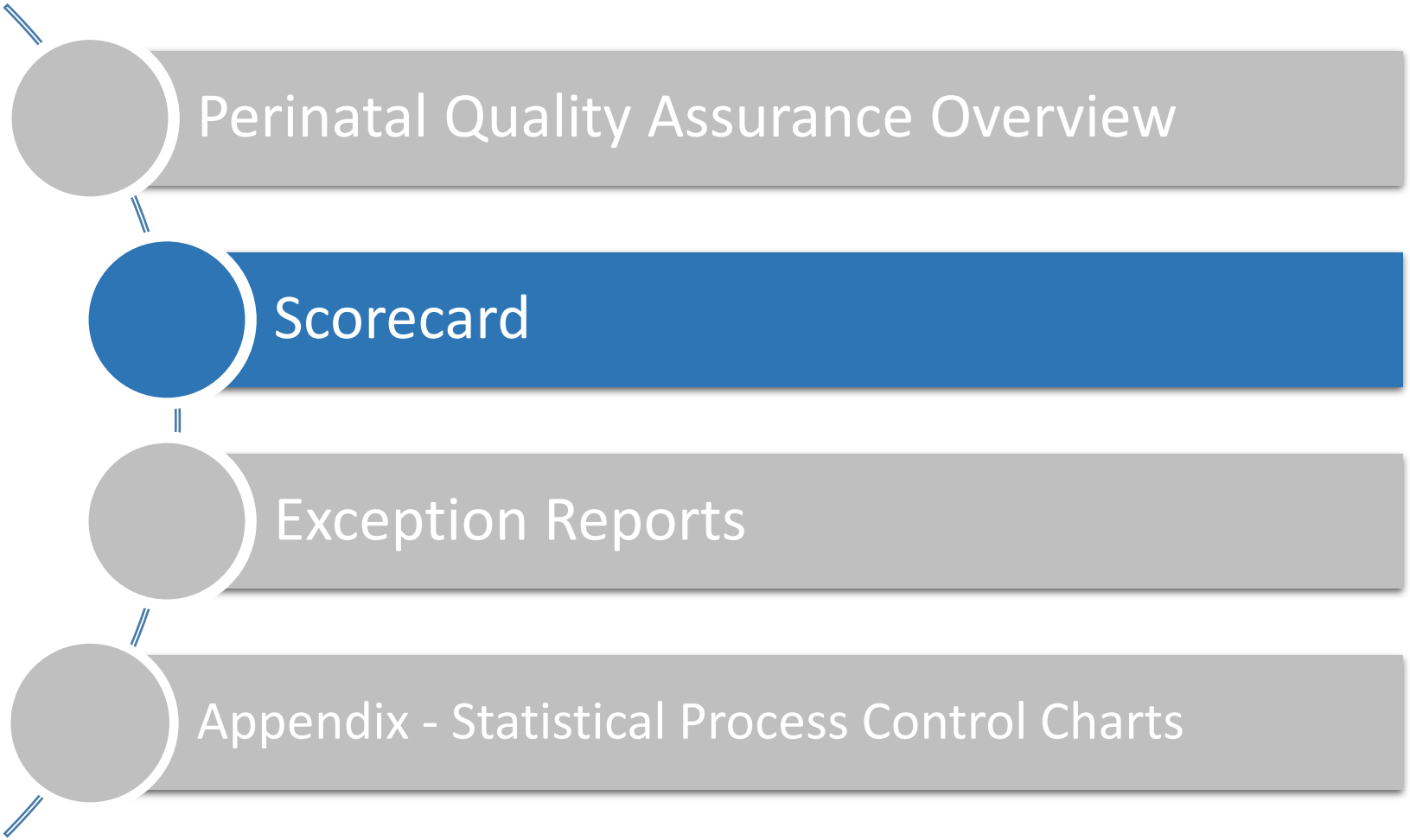

Perinatal Quality Assurance Overview
Scorecard
Exception Reports
Appendix - Statistical Process Control Charts


Perinatal Quality Assurance Overview
Scorecard
Exception Reports
Appendix - Statistical Process Control Charts

Perinatal Quality Assurance Overview (Current Month)

Domain	Overview , Risks and Actions	Lead
Overview	This is an evolving perinatal quality assurance scorecard which requires further development to support assurance of the quality and safety of maternity services. A comprehensive Maternity Improvement Programme is to be established with workstreams to include: People & Culture, Perinatal Surveillance (Safe Care), Estates & Digital, Involvement & Inclusion, Strategy & Planning. The maternity governance process will be strengthened with the establishment of a Maternity Assurance Committee (MAC) in April 23. As part of the national maternity thematic review the CQC inspection commenced on 28th February 2023 and is ongoing.	
Safe	During January 2023 there was 1 Serious Incident reported (downgrading requested following review) and 1 HSIB case. The stillbirth rate has remains below the target within month. 1-1 care in labour has been maintained at 100%.	
Workforce (exception report page 12-13)	Funded establishment is in line with Birth Rate Plus tool. Midwife vacancy for January has reduced by 1.1% with further new starters during Q4. Nursing and midwifery safe staffing policy presented at Nursing, Midwifery & AHP Committee (NMAHPC) February 2023. Maternity workforce oversight group inaugural bi-weekly meeting commenced in March 2023. Acuity data is now included showing improved performance over the last 3 months	
Training	Achieved standard required for Maternity Incentive Scheme (year 4) in November 2022 and compliance continues in January 2023. New essential to job role programme to be agreed Q4.	
Friends & Family (exception reports page 14)	FFT responses are consistently positive. The response rate has increased by 2% in January 2023 with Q4 actions in progress to improve this further.	
Outcome (exception reports pages 15-16)	Quality improvement projects in progress to achieve: • Reduction in 3rd & 4th degree tears, audit completed and action planning in progress • Reduction in blood loss (whilst below the national target of 3.6% (positive), the UHL stretch target of 2.7% was not achieved	

To note: Exception reports continue to be updated and shared for relevant elements until compliance is achieved for 3 consecutive months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Performance Overview (Safe)

Domain	Key Performance Indicator	Target	Nov-22	Dec-22	Jan-23	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	Total deliveries (LRI, LGH, SMBC, HB & BBA)	Actual	815	751	782	7976					JH
	No. of hospital deliveries at LRI (excl HB & BBA)	Actual	452	429	449	4507					JH
	No. of hospital deliveries at LGH (excl HB & BBA)	Actual	334	292	316	3200					JH
	No. of hospital deliveries at SMBC Plus HB & BBA	Actual	29	30	17	269					JH
	SIs (Obstetrics)	Actual	3	1	1	19					JH
	SIs (Neonatology)	Actual	0	0	0	1		L			JH
	Number of Still births - overall total	Actual	2	2	1	34					JH
18	Still births as %age of Total Deliveries	<0.45%	0.25%	0.27%	0.13%	0.43%	?				JH

Comments	Rating
During January, 1 (one) stillbirth was reported and this was also reported as an SI. No care concerns identified through the Perinatal risk group and rapid review. In January 1 (one) case met the HSIB criteria and a referral made. No immediate care concerns have been raised from the rapid review. 2 HSIB reports were received in January. One case with no safety recommendations however local learning identified. The second case has 2 safety recommendations in relation to neonatal resuscitation. Maternity Governance to have oversight of HSIB related action plans. These will be presented to private board in due course.	

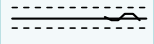
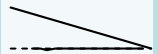
Performance Overview (Safe and FFT)

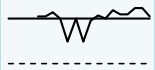
Domain	Key Performance Indicator	Target	Nov-22	Dec-22	Jan-23	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Safe	HSIB Referrals	Actual	0	0	1	12		L			JH
	Moderate Incident	Actual	14	8	18	88					JH
	Coroner Regulation 28 Requests	Actual	0	0	0	0					JH

Domain	Key Performance Indicator	Target	Nov-22	Dec-22	Jan-23	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
FFT Friends & Family	Maternity Friends & Family - % of Potential Responses Captured	30%	16.9%	16.6%	18.0%	18.3%	F				JH
	Maternity Friends & Family - percentage of promoters	96%	96%	97.8%	97%	96.2%	?				JH

Comments	Rating
Quarter 4 focused work is underway to triangulate activity and incident data to understanding contributing factors, themes and trends. 459 respondents make up 18% of the FFT feedback during January which provided a positive scoring of 97% recommending care. Initiatives continue to be implemented to increase the number of women and birthing people who provide feedback. *Please see an exception report for community friends & family response rate on slide 12*	

Performance Overview (Workforce Pt 2 & Training)

Domain	Key Performance Indicator	Target	Nov-22	Dec-22	Jan-23	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Workforce	Funded Midwife to Birth ratio (UHL complete care, 1:nn)	1:26.4	23.9	23.8	23.7	24.10	F	H			JH
	Midwife Vacancies (%)	10%	13.4%	14.2%	13.1%	14.1%	F				JH
	1 to 1 Care in Labour	100% (UHL Target)	100%	100%	100%	100%	?				JH

Domain	Key Performance Indicator	Target	Nov-22	Dec-22	Jan-23	Rolling 12 Months	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Training 02	% of All Staff attending Annual MDT Clinical Simulation	90%	96.0%	97.0%	98.0%	88.9%	?	H			JH
	% of All Staff attending NLS Training	90%	97.0%	97.0%	97%	89.8%	?	H			JH
	% of All Staff attending CEFM Training (Theory)	90%	97.0%	98.0%	93.0%	92.4%	?	H			JH
	% of All Staff attending CEFM Training (Assessment)	90%	97.0%	97.0%	93.0%	91.8%	?	H			JH

Comments	Rating
The midwifery vacancy rate continues to improve. The exception report can be found on slide 11. Ongoing work to include Birthrate Plus™ acuity insights into future reporting. Based on January 2023 there has been some improvements in the overall percentage of green rated submissions for both sites. (LRI Dec 49%, Jan 60% / LGH Dec 52%, Jan 64%). Staffing factors impacting on acuity data predominantly relate to unexpected staff absence and being unable to fill vacant shifts. Increased complexity of pregnancies results in higher acuity (reflecting national position). Training figures for individual staff groups in January are above 90% required for Maternity Incentive Scheme (MIS) compliance.	

Performance Overview (Outcome)

Domain	Key Performance Indicator	Target	Nov-22	Dec-22	Jan-23	YTD	Assurance	Variation	Trend	Data Quality Assessment	Exec Lead
Outcome 21	Spontaneous Deliveries %	Actual	47.5%	45.7%	44.9%	47.3%					JH
	Caesarean Section Rate - total	Actual	40.7%	41.4%	43.1%	40.1%					JH
	% Blood loss greater than 1500 ml (as a % of total deliveries)	<=2.7% (National Target <3.6%)	3.2%	2.7%	2.8%	3.2%					JH
	% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	2.3%	4.1%	4.7%	3.5%					JH
	% of Full term babies admitted to NNU NB:Figures from January 2019 reflect ATAIN: Term admissions to NNU as % of UHL Term births	6%	5.39%	4.50%	6.55%	4.36%					JH

Comments	Rating
Spontaneous and Caesarean section birth rates remain within normal variation and consistent with peer trusts. An audit has been completed to add understanding of 3rd and 4th degree tears with associated actions planned detailed in the exception report on page 14 Work continues to implement the Obs Cymru program to reduce postpartum blood loss, see exception report page 13	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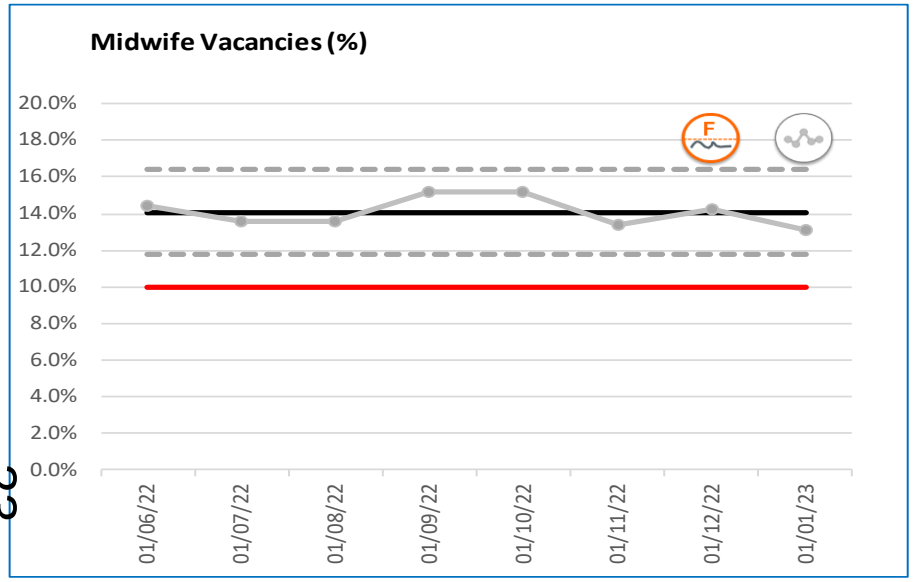
Workforce – Midwife Vacancies (%)



Current Performance			Three Month Forecast		
Jan 23	YTD	Target	Feb 23	Mar 23	Apr 23
13.1%	14.1%	10%	14%	14%	14%

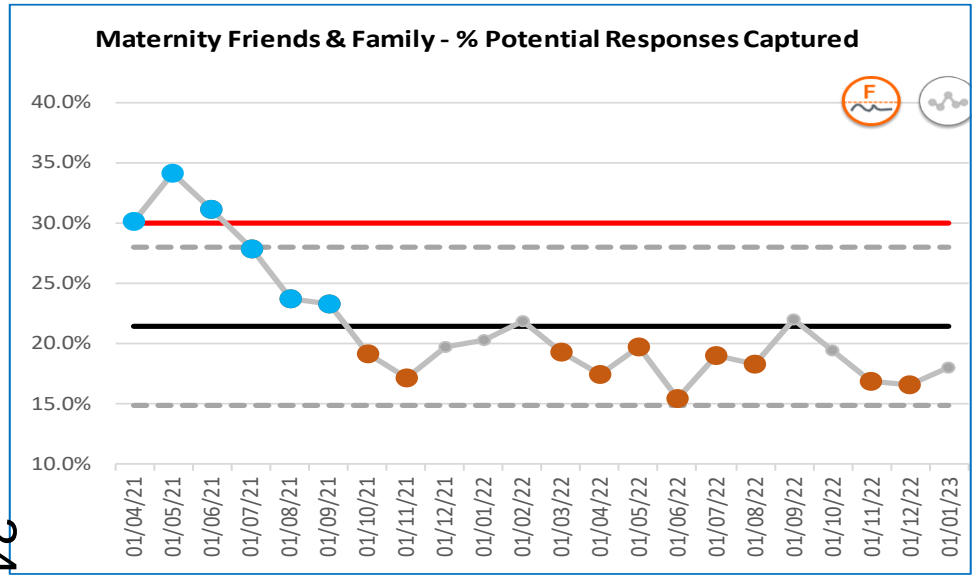
National Position & Overview

Performance anticipated to remain above target at 14% based on pipeline. Actions to address are indicated below with comprehensive workforce plan to be developed for 2023/3034

Note: Funded establishment is in line with Birth Rate Plus acuity & staffing tool

Root Cause	Actions	Impact/Timescale
Ongoing national challenges with recruitment and retention across maternity services During January there were 2 leavers, one of whom has joined the Practice Learning Team, supporting student midwives. Further analysis is underway to learn from exit interviews	• There has been a 1.1% reduction in midwifery vacancies with 53 vacancies January 2023. • Annual turnover has reduced by 1.25% • Recruitment initiatives continue with strengthened engagement with the wider organisational team • The International Midwives recruited in December have passed OSCEs and are awaiting NMC PINs with funding for a further 11 international recruits secured • Matron for Safe Staffing employed (November) and Recruitment, Retention & Pastoral leads for each site and the community • Retention plans are supported by the Empowering Voices workstream addressing issues raised by staff, led by the Women's People Partner. Recruitment, Retention & Pastoral leads are in place across LRI, LGH and community teams.	• Recruitment & retention action plan presented to NMAHPC 14 February 2023 • Focus on Culture: Empowering Voices program to complete May 2023 and inform ongoing maternity improvement plan

Friends & Family – % of Potential Responses Captured (Maternity)

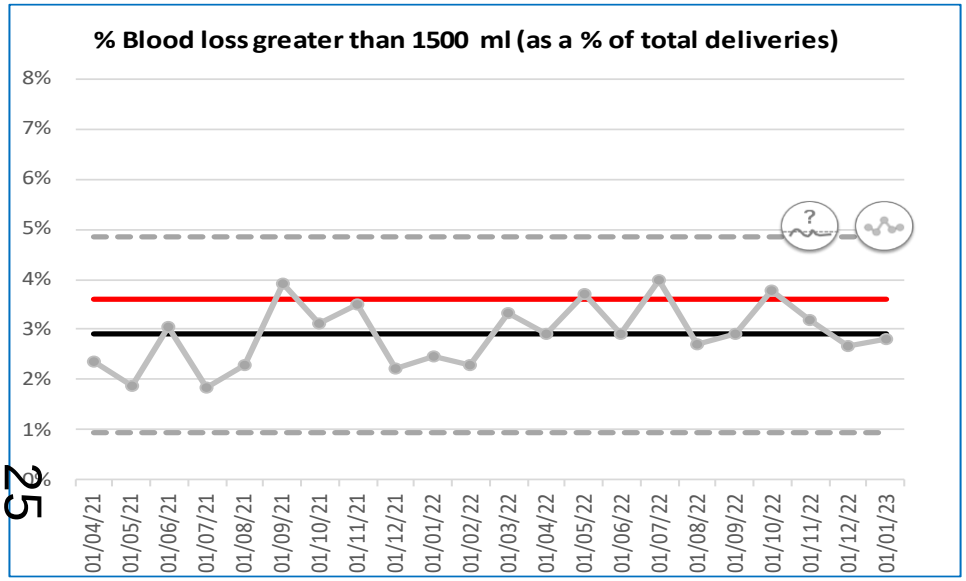


Current Performance			Three Month Forecast		
Jan 23	YTD	Target	Feb 23	Mar 23	Apr 23
18.0%	18.3%	30%	18.3%	18.3%	18.3%

National Position & Overview

Root Cause	Actions	Impact/Timescale
• Update in national reporting standards during April 2020 (implemented during Covid) which moved away from set times to collect feedback • Less face-to-face contact with women • Community identified as area for improvement – further work on data / feedback capture with the reintroduction of 36-week enquiries	Midwifery Matron leading on Patient Experience actively working with the community leads on actions through Q4. This includes • iPads for each community hub • Close working with the corporate patient experience team to initiate a texting service • Ongoing promotion through community teams • Data validation and collation: community team auditing to ensure all feedback is captured • Re-introduction of paper surveys to provide alternatives • Ensuring feedback can be captured in a variety of languages	Actions to be agreed and implemented with expected results by April 2023

Outcome - % Blood loss greater than 1500 ml (as a % of total deliveries)



Current Performance			Three Month Forecast		
Jan 23	YTD	Target	Feb 23	Mar 23	Apr 23
2.8%	3.2%	3.6%	3.2%	3.2%	3.2%

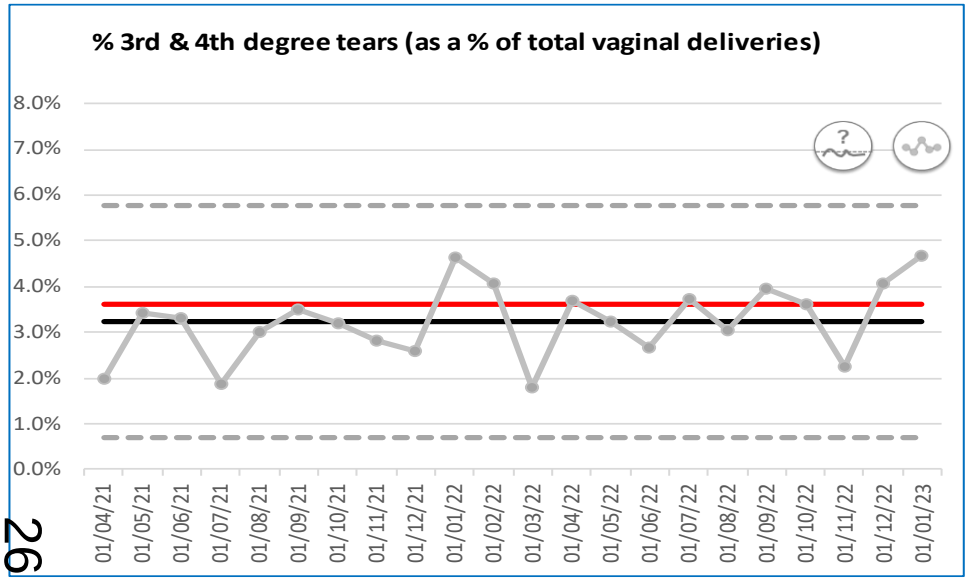
National Position & Overview

The rate of blood loss >1500mls at UHL during the current financial year (2.8%) is below the national target (3.6%, lower is better) however not achieving the internal stretch target of 2.7%

UHL (28 cases per 1000) is in the middle of the range of results for all Trusts and below both the National average (29 per 1000) and the MBRRACE Group average (31 per 1000)

Root Cause	Actions	Impact/Timescale
Investigation and review of cases indicate a variety of contributing factors: • Complexity of pregnancy & births • No. of caesarean sections • Prolonged induction of labour & prolonged labour • Low BMI (women)	Update on progress for the 2 workstreams which have been established to reduce blood loss: • Implementing Obs Cymru: draft guideline combining hospital & community management of post partum haemorrhage (PPH). Draft out for consultation with MDT • Once final standards agreed and funding identified for changes in practice (eg change in pharmacological treatments), implementation will take place	Obs Cymru adapted Guidelines expected to be ratified April 23.

Outcome - % 3rd & 4th degree tears (as a % of total vaginal deliveries)



Current Performance			Three Month Forecast		
Dec 22	YTD	Target	Jan 23	Feb 23	Mar 23
4.7%	3.5%	3.6%	3.3%	3.3%	3.3%

National Position & Overview

The average percentage rate of 3rd & 4th degree tears is below target (favourable) however close monitoring and early intervention are required to further reduce the rate or prevent it increasing.

UHL (31 cases per 1000) is in the middle of the range of results for all Trusts and above both the National average (24 per 1000) and MBRRACE Group average (23 per 1000). UHL 6 month rolling average is 36 per 1000.

Root Cause	Actions	Impact/Timescale
Audit completed for cases between November 2022 to January 2023. Findings indicated the following contributing factors: • Higher rates of 3rd degree tears associated with Asian ethnicity and where English is not the preferred language • Length 2nd stage <1hour (unassisted births) Improvements noted since 2021 audit with only 2 women birthing in Lithotomy position (unassisted births), 1 of which was clinically appropriate	Recommendations from audit include: • Continued monthly audits to inform timely actions • Update and share infographic to reflect findings of audit • Survey of clinical staff to ascertain staff perception of perineal protection & support in place for trainees • Ward walk-around planned to increase knowledge of findings and associated actions • On-going review of 3rd and 4th degree tear rates via the maternity dashboard	Roll out of actions from audit in March 2023 with continued monthly monitoring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Statistical Process Control Charts (SPC)

SPC charts look like a traditional run chart but consist of:

- **A line graph showing the data across a time series**.

The data can be in months, weeks, or days- but it is always best to ensure there are at least 15 data points in order to ensure the accurate identification of patterns, trends, anomalies and random variations.

- **A horizontal line showing the Mean.**

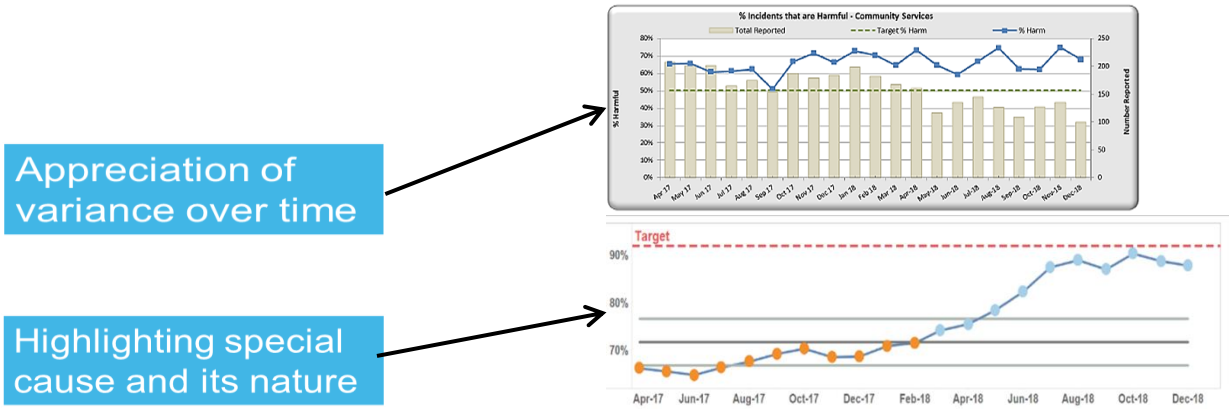
This is used in determining if there is a statistically significant trend or pattern.

- **Two horizontal lines either side of the Mean-(called the upper and lower control limits).**

Any data points on the line graph outside these limits, are 'extreme values' and is not within the expected 'normal variation'.

- **A horizontal line showing the Target**.

In order for this target to be achievable, it should sit within the control limits. Any target set that is not within the control limits will not be reached without dramatic changes to the process involved in reaching the outcomes.



Statistical Process Control Charts (SPC)

Normal variations in performance across time can occur randomly- without a direct cause, and should not be treated as a concern, or a sign of improvement, and is unlikely to require investigation unless one of the patterns defined below applies.

Within an SPC chart there are three different patterns to identify:

- **Normal variation** – (common cause) fluctuations in data points that sit between the upper and lower control limits

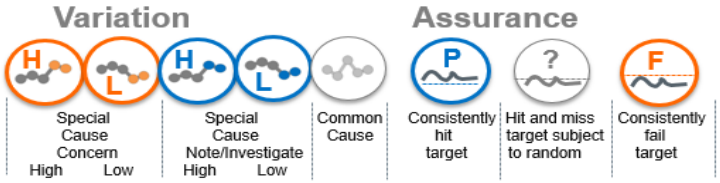
- **Extreme values** – (special cause) any value on the line graph that falls outside of the control limits. These are very unlikely to occur and where they do, it is likely a reason or handful of reasons outside the control of the process behind the extreme value

- **A trend** – may be identified where there are 7 consecutive points in either a pattern that could be; a downward trend, an upward trend, or a string of data points that are all above, or all below the mean. A trend would indicate that there has been a change in process resulting in a change in outcome

Narrative support that supports SPC theory

Summary icons and a top level summary view

	Jun-18	Target	Variation	Target Capability	Comment
Staff Sickness absence	4.4%	3.5%		F	Shift change in August 2017 showing increase in sickness - staff survey review indicated.....



Data Quality Assessment

The Data Quality Assurance Group (DQAG) panel is presented with an overview of data collection and processing for each performance indicator in order to gain assurance that it is of suitably high quality. DQAG provides scrutiny and challenge on the quality of data presented, via the attributes of:

i. Sign off and Validation
ii. Timeliness and Completeness
iii. Audit and Accuracy and
iv. Systems and Data Capture to calculate an assurance rating.

30

Assurance rates key Green = Reasonable/Substantial Assurance, Amber = Limited Assurance and Red = No Assurance.

Appendix C

Update on Service Specification and Public Consultation for the recommissioning Healthy Together (0-19 Healthy Child Programme (0-19HCP) using a Section 75 agreement

For consideration by: Health Scrutiny Commission

Date of meeting: 16th March 2023

Lead director: 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 (Leicester City Council) and delivered by Leicestershire Partnership NHS Trust (LPT), and it is known locally as Healthy Together. Healthy Together is an integrated offer containing several Public Health elements:

- 0-5 years Healthy Child Programme (0-5HCP)
- Intensive support for vulnerable pregnant women (Early Start)
- Co-ordination and distribution of Healthy Start vitamins
- Infant Feeding support
- Oral Health promotion including the co-ordination and distribution of resources
- Development and co-ordination of Eat Better, Start Better voluntary food and drink accreditation scheme
- Child Weight Management Service
- 5-19 years Healthy Child Programme(5-19HCP)
- Co-ordination and administration for the National Child Measurement Programme (NCMP)

This paper contains an update on the services specification. It identifies:

- How the £200,000 budget cut will be managed
- Changes at a national level to the High Impact Areas
- Proposed changes to the service specification
- An update on the Public Consultation
- Gaps in service provision
- The elements of the service offer that remain the same

Supporting papers:

- Equality Impact Assessment (EIA) tool
- The full draft Service Specification is available upon request

2. Recommended actions/decision

Recommendation 1:
That the proposal for managing the £200,000 budget reduction is noted.

Recommendation 2:
That the changes at a national level to the High Impact Areas is noted.

Recommendation 3:
That the following proposed changes to service specification are noted:

- Addition of a 4-month face to face, group setting, contact to initially be targeted to families identified as benefitting from additional support
- Exploration of an addition of 3-3½ (pre-school) contact via a Digital Health Contact (DHC), with 'Red Flag' results being triaged by the Public Health Nurse (Health Visitor) (PHN(HV)) or Public Health Nurse (School Nurse) (PHN(SN)), or referred to supporting agencies e.g. Family Hubs
- Intensive support for vulnerable families to change from discreet Early Start service to become part of Universal Targeted "step up, step down" support provide by the PHN(HV) team
- The Digital Health Contact (DHC) at year 7,9,11 has been evaluated as a successful way of identifying un-met health needs in young people. DHC to become part of the core offer delivered within schools.
- Changes to commissioning arrangement for Oral Health resources so they are procured by LCC rather than LPT. There is no change at point of delivery with resources being distributed by LPT therefore not included in the Public Consultation).
- Changes in the commissioning arrangements so Lunch Box Audits that are currently delivered by LNDS via a contract with Food For Life will be commissioned as part of 0-19HCP. There is no change at the point of delivery with LNDS still leading the Lunch Box Audits, therefore not included in the Public Consultation).

Recommendation 4:
It is noted that the following gaps in provision exist, and that on-going work between LCC and LPT will consider how these may be addressed via 0-19HCP:

- Inequity in provision for children aged 16-19. Children attending schools with years 12 and 13 have access to the PHN(SN) within their school setting, and to the digital offer. Children attending colleges have access to the digital offer only.
- The 0-19HCP offer is extending to 25 for children with SEND (Special Educational Needs and Disabilities). LCC and LPT need to work with partners to consider what provision of offer for children aged 19-25 with SEND will look like, it will have a focus on transition to Adulthood.

These gaps exist due to budget constraints and workforce challenges.

Recommendation 5:
That the proposal to recommission via Section 75 is noted.

Recommendation 6:
To note that consultation is ongoing until 10th April, to participate in the consultation and encourage others to do the same.
Full consultation: https://consultations.leicester.gov.uk/sec/0-19/
Young peoples consultation: https://consultations.leicester.gov.uk/sec/0-19-yp

3. Scrutiny / stakeholder engagement

Scrutiny: This paper provides an update on the service

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 recommissioning of Healthy Together via a Section 75 and the ongoing Public Consultation.

5. Detailed report

Contract details
Start date: 1st October 2023
End date: 30th September 2030 (7 years)
Contact value: £8,394,875 p/a.

- This is a £200,000 budget reduction, on top of the 20% budget reduction in 2016.
- This has a 12month notice period should there be a change to the budget.
- LPT have agreed to open book accounting with will enable LCC to see what the spend is and enable LPT and LCC to jointly deicide where best any underspend should be used.

Timeline

- **Oct – Dec 2022:** Develop draft service specification in partnership with LPT
- **7th December:** Proposed Specification to be bought to LMB
- **Jan-March 2023**: Public Consultation
- **March – June 2023:** Final specification (during Pre-election Period) and signing of contract (post-Election)
- **July-Sept 2023:** Mobilisation
- **1st October 2023:** New contract begins

Safeguarding:
Safeguarding children is at the core of all work and is embedded through 0-19HCP as Public Health Nurses (Health Visitors and School Nurses) have a vital role in keeping children safe and supporting local safeguarding arrangements. Across 0-19HCP is a relentless focus on reducing harm, protecting, and safeguarding children and young people.

Levels of support and intervention:

Across all elements of 0-19HCP the following levels of support and intervention are used: Community, Universal, Targeted (previously Universal Plus), and Specialist (previously Universal partnership Plus).

All interventions are evidence based and address an identified Public Health need. Resources are targeted towards equity of outcome, not equality of input. Resources will be targeted to those that need them most.

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The Budget Reduction (Recommendation 1)

The budget is being reduced by £200,000 this is a significant reduction and will result in a change in the workforce delivering the 0-19HCP. To manage this reduction in finance the service specification has been thoroughly reviewed and considered to ensure that essential, universal, services can be safely provided. This has been achieved by:

1) Use of a skill mix model that is supported by the updated Healthy Child Programme (PHE, 2021)
2) Planned introduction of a central Helpline (due spring 2023) that will streamline booking and administrative processes and release staff to deliver frontline services.
3) Protection of the core service offer to ensure an equitable service is maintained.

LPT's capacity and demand tool has allowed for extensive workforce modelling and LPT and LCC are confident that the content of the service specification can be delivered, where there are concerns about the impact of reduced workforce capacity this has been identified within the paper

The High Impact Areas (Recommendation 2)

High Impact Areas:

High Impact Areas define issues that need to be prioritised and ensure resources are targeted appropriately, according to health need and to maximise health outcomes. They describe the areas where the 0-19HCP workforce can and will have a significant impact on health outcomes. The following High Impact Areas have been identified for Leicester using national and local priorities and will be used to steer the work of 0-19HCP:

Previous High Impact Area	**2023-2030 High Impact Areas**
Public Health Nursing (Health Visiting)	**Public Health Nursing (Health Visiting)**
Transition to parenthood	Supporting transition to parenthood and the early weeks
Maternal mental health	Supporting maternal and infant mental health
Breastfeeding	Supporting breastfeeding (initiation and duration)

Healthy weight, healthy nutrition, and oral health	Supporting healthy weight and healthy nutrition
Managing minor illness and accident prevention	Improving health literacy; reducing accidents and minor illnesses
Health, wellbeing, and development of child aged 2	Supporting health, wellbeing, and development. Ready to learn, narrowing the 'word gap'
Support to be ready for school	
Public Health Nursing (Health Visiting)	**Public Health Nursing (School Nursing)**
Emotional health and wellbeing and building resilience, self-esteem, and confidence	Supporting resilience and wellbeing
Addressing risky behaviour	Improving health behaviours and reducing risk taking
	Supporting healthy lifestyles
Supporting vulnerable families	Supporting vulnerable young people and improving health inequalities
Maximising learning and achievement	
	Supporting complex and additional health and wellbeing needs
	Supporting self-care and improving health literacy

Proposed Service Specification
(Including Recommendation 3 – an outline for the proposed changes to the service specification, and clarification about what elements remain the same)

0-5 years Healthy Child Programme (0-5HCP),
Delivered by the skill-mix Public Health (Health Visiting) workforce

The 5 Mandated contacts remain:

- 28-36 week antenatal contact
- 10-14 day new birth contact
- 6-8 week contact
- 10-12 month contact
- 2-2 ½ year contact

More information on the contents of these contacts is available in the full draft Service Specification. These contacts result in evidence-based packages of care, which will remain the same.

The digital offer is non-mandated and will remain:

- Chat Health
- www.healthforunder5s.co.uk

Proposed Change: Additional 4-month contact

Current national guidance Healthy child programme 0 to 19: health visitor and school nurse commissioning - GOV.UK (www.gov.uk) recommends an additional (nonmandated) contact at 4 months.

Prior to COVID-19 pandemic LPT ran group sessions at 3-4 months covering key topic, including weaning onto solids, developmental milestones and safety in the home. Attendance at these groups was mixed, often with low attendance. As part of COVID-19 recovery, and in response to Listening Events with staff and service users in late 2021/early 2022 (report available), LPT refocused and established a pilot 3-4 month contact.

The service specification, and public consultation, includes a proposal that:

- SMS text message to all families directing them to the digital offer, including information on 'Next Steps' video on the Health for Under 5's website.
- Families with known vulnerabilities will be reviewed and a clinical decision will be made regarding whether a face-to-face review is required, within the home or clinic setting. This may be carried out by a SCPHN (Specialist Community Public Health Nurse) or delegated to appropriately trained and skilled staff with supervision support in place. This contact will be in line with current SOG (Standard Operating Guidance) and national 0-19HCP
- LCC and LPT will explore how a Universal face to face 3–4-month contact can be facilitated, including the further piloting of 1:1 neighbourhood clinics.

The proposed change is considered in the Equality Impact Assessment.

Proposed Change: Additional 3-3½ pre-school contact

Current national guidance Healthy child programme 0 to 19: health visitor and school nurse commissioning - GOV.UK (www.gov.uk) recommends an additional (nonmandated) pre-school contact.

LCC and LPT are committed to offering this valuable contact, which has the capacity to help with school readiness. However, there is neither the budget nor the workforce to deliver a face-to-face contact. Therefore the service specification, and public consultation, includes a proposal that:

- A pilot of a Universal Digital Health Contact (DHC) to assess a child's developmental progress. This will be completed by the parent//carer. Concerns will be assessed by a Public Health Nurse (PHN) or Healthy Child Programme Nurse (HCPN). Support will be offer by LPT and local partners.

- It will be explored how children with known vulnerabilities can receive a 3-3½ year face-to-face contact. This will be based on future workforce capacity.

As a new contact, the above will be fully evaluated including any potential or significant, impact on inequalities.

The proposed change is considered in the Equality Impact Assessment.

Intensive evidence-based support for vulnerable pregnant women:
Currently delivered by Early Start Public Health Nurses (Health Visiting)

Proposed change in delivery of support for vulnerable families from the "Early Start" team to a "step up, step down" support provide by the PHN(HV) Neighbourhood team.

It is proposed that the provision of intensive support to vulnerable families changes from its current format, provision by Early Start, to a format where these families are cared for by the Neighbourhood Public Health Nursing (Health Visiting) teams with evidence- based packages of care that provide the required amount of tailor-made support from pre-birth to 5 years.

Extensive research and modelling (papers available) has been carried out to understand which of the 2 models provide the safest and most equitable support to families with vulnerabilities. In summary the following information has been considered.

Details	Early Start Offer	Universal Targeted Offer
Is the offer evidence based?	Yes	Yes
The offer	Intensive PHN(HV) support from early pregnancy through to a child's second birthday, care handed to Universal PHN(HV) team at 2 years, who provide "step up/step down" support as need is identified until the child's 5 birthday, when care is handed to are PHN(SN).	Additional support from early pregnancy through to a child's 5 birthday, when care is handed to are PHN(SN). Support is provided in a "step up/step down" approach as need is identified. The antenatal offer would need to be strengthened; this could include referrals to Bumps to Babies
Continuity of care and professional lead	A named Public Health Nurse (Health Visiting) for each family	A named Public Health Nurse (Health Visiting) with delegation to Healthy Together team as appropriate

What is included?	Support on all aspects of parenting, including safeguarding.	Support on all aspects of parenting, including safeguarding.
Caseload, reach and equity	20-25 families per PHN(HV)	Current universal caseloads are approx. 343 children per whole time equivalent Specialist Community Public Health Nurse-Health Visitor (SCPHN-HV). Each SCPHN-HV is supported by a team of Registered Nurses and support workers. This caseload already cares for many vulnerable families. The Early Start caseload is significantly smaller, currently totalling 20-25 per worker. This creates considerable service inequality.

There are risks involved in moving from Early Start to the proportionate universalism approach provided via the Neighbourhood Public Health Nursing (Health Visiting) teams. Early Start have significantly smaller caseloads and can afford to work intensively with these families. However, many families with identified vulnerabilities are currently well supported by the Neighbourhood Public Health Nursing (Health Visiting) teams.

LCC and LPT's are committed to equity of service provision and ensuring that as many families as possible get support throughout their childhood and parenting journey. Retaining the Early Start offer, and reestabilshing its full staffing compliment, would see Universal caseloads increasing as PHN(HV)'s would most likely be recruited from within the universal cohort, creating further service inequity.

It is recommended that the hard work and commitment of the Early Start team is commended, and that this element is removed from the service specification and absorbed by the Universal Targeted offer to ensure that the service offer is equitable, safe, and sustainable.

The proposed change is considered in the Equality Impact Assessment.

Co-ordination and distribution of Healthy Start vitamins

Delivered by the skill-mix Public Health (Health Visiting) workforce. The provision of co-ordination and distribution of Healthy Start vitamins remains unchanged (see service specification for further details of provision).

Infant feeding Support

Delivered by:

- The skill-mix Public Health (Health Visiting) workforce
- The Infant Feeding Team
- (Via sub-contracting) Leicester Mamma's

The provision of infant feeding support remains unchanged (see service specification for further details of provision)

Oral health promotion including the co-ordination and distribution of resources

Delivered by the skill-mix Public Health (Health Visiting) workforce. The provision of oral health promotion remains unchanged (see service specification for further details of provision).

Proposed change in procurement of Oral Health Resources

It has been agreed that procurement of Oral Health Resources will move from LPT to LCC/ LPT and LCC are currently identifying how much this costs and this will be removed from the contract to enable LCC procurement. This will not affect the overall 0-19HCP budget.

Development and co-ordination of Eat Better, Start Better voluntary food and drink accreditation scheme

Delivered by Leicestershire Nutrition and Dietetic Service (LNDS). The provision of Eat Better Start Better remains unchanged (see service specification for further details of provision).

Proposed Change: Integration of provision of Lunch Box Audits into 0-19HCP

LNDS currently support lunch box audits in Primary Schools via a sub-contacting arrangement with food for Life. This arrangement is ending in March 2023, and LCC will explore how to ensure continuity until the s75 starts in October 2023. This amounts to £6,000 p/a. there will be no change to provision (see service specification for further details of provision).

Child Weight Management Service

Known as Family Lifestyle Club (FLiC) and delivered by Leicestershire Nutrition and Dietetic Service (LNDS). The provision of FLiC remains unchanged (see service specification for further details of provision).

5-19 years Healthy Child Programme(5-19HCP)

Delivered by the skill-mix Public Health (School Nursing) workforce

The core offer remains unchanged:
Public Health offer (80% of PHN(SN) workforce)

- School Health Agreements
- National Child Measurement Programme (NCMP) in reception and year 6 (mandated contact)
- Year 7, 9 and 11 Digital Health Contact (DHC) performed in school
- Triage Assessments followed, as required, by Baseline Health Assessments
- Evidence-based packages of care

- Review Health Assessments
- Health Promotion Fairs
- Sexual Health Clinics (year 10 and 11)
- School Assemblies
- Parent information sessions including Healthy Bladder and Healthy Bowel, anxiety, behaviour, sleep, and healthy lifestyle

Statutory Safeguarding (20% of the PNH(SN)workforce

- Telephone strategy calls
- Section 17
- Section 47
- Evidence-based packages of care
- Review Health Assessments

The digital offer is non-mandated and will remain:

- Chat Health
- https://healthforunder5s.co.uk
- www.healthforkids.co.uk
- www.healthforteens.co.uk

Proposed Change: Seeking Out Health Needs:
The Digital Health Contact (DHC) is offered to all schools with pupils in year 7,9 and 11 as a way of identifying unmet health needs and offering evidence-based support. The DHC has been evaluated (paper available) and found to be a successful way of identifying un-met health needs in young people. Currently the DHC is provided as an optional service that schools can chose to engage with. LCC and LPT are committed to promoting DHC within schools, so it becomes part of the core offer.

Co-ordination and administration for the National Child Measurement Programme (NCMP)

Delivered by the skill-mix Public Health (School Nursing) workforce. The provision of NCMP administration and co-ordinator remains unchanged (see service specification for further details of provision).

Gaps in Service Provision (Recommendation 4)

There are 2 significant gaps in service provision:

- Inequity in provision for children aged 16-19. Children attending schools with years 12 and 13 have access to the PHN(SN) within their school setting, and to the digital offer. Children attending colleges have access to the digital offer only. This is not a new inequality; it exists within the current contract.
- The 0-19HCP offer is extending to 25 for children with SEND with a focus on transition to Adulthood. This offer does not exist within the current contract. LCC and LPT need to work with partners to consider what the provision of offer for children aged 19-25 with SEND will look like.

These gaps exist due to budget constraints and workforce challenges and are included in the proposed service specification and the Equality Impact Assessment.

Recommendation 5
That the proposal to recommission via Section 75

Inn the NHS Act of 2006, the Section 75 allows for flexibilities which can enable NHS organisations and local authorities to use partnership agreements so that they can respond effectively to improve services, either by joining up existing services or developing new, co-ordinated and co-produced services.

The Section 75 Partnership Agreement intends to improve services for users through 'delegated functions' (where one organisation exercises an agreed function on behalf of another). The partnership arrangement intends to offer flexibility to support better coordination and innovative approaches in services across a range of NHS and local authority functions.

The proposed partnership agreement between LPT and LCC will allow LPT to provide the 0 to 19 HCP on LCC behalf. We believe this will enable both organisations to co-produce the best approach to improve support for children, young people and families through a more efficient service which enables LPT and ourselves to work more flexibly to continue to improve services.

Recommendation 6
Public Consultation

All of the changes proposed above are included in the Public Consultation. This consultation is running until 10th April. We are encouraging as many people as possible to participate in this consultation.

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

6.1 Financial implications

The report is seeking to commission the 0-19 Healthy Child Programme contract wef October 2023, with an annual contract value of £8,394,875 which takes into account the budget reduction of £200,000. This will be within the budget envelope.

Yogesh Patel – Accountant (ext 4011)

6.2 Legal implications

The report highlights proposed changes to the 0-19 HCP Services and reduction in budget, all of which is subject to a planned consultation exercise.

Detailed consultation advice has been provided, as a reminder any reduction in budget which will have an on the services/quality and access as well as proposed changes to the Services need to be consulted upon **prior** to a decision being taken.

The consultation process to be undertaken should be meaningful, fair and proportionate to the potential impact of the proposal. The result of the consultation should be analysed, prior

to any final decision being made, to ensure that any decision making is lawful, follows a fair process and is reasonable.

Advice should be sought from legal Services in relation to the negotiation and drafting of the S75 Agreement.

Annie Moy, Solicitor, ex 6669

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.

The report provides an update on Service Specification and Public Consultation for the recommissioning of the Healthy Together (0-19 Healthy Child Programme. Healthy Together is a universal support service for children and their families run by Leicestershire Partnership NHS Trust. The service is available to every child and their family from before the baby is born right up to the age of 19 and as such any changes may impact across a number of protected characteristics. An equality impact assessment (EIA) is currently underway and this will be revised as the service specification for recommissioning the 0-19 Healthy Child Programme (Healthy Together) using a Section 75 agreement is progressed, this should reflect findings from any consultation.

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.

Equalities Officer, Surinder Singh, ex. 37 4148

6.4 Climate Emergency implications

Following the council's declaration of a climate emergency and ambition to reach net zero carbon emissions for the council and the city, the council has a vital role to play in

addressing carbon emissions relating to the delivery of its services, and those of its partners, including through its procurement and commissioning activities.

Carbon emissions from commissioning and delivery of services should be managed through use of the council's sustainable procurement guidelines within tendering exercises, by requiring and encouraging consideration of opportunities for reducing emissions. This could include areas such as the use of low carbon and energy efficient buildings to deliver services, enabling use of sustainable travel options for staff and service users and reduced consumption and waste of equipment and materials, as relevant and appropriate to the service.

Aidan Davis, Sustainability Officer, Ext 37 2284

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 D

Sexual Health Services Public Consultation; Interim Results Report

For Consideration by Health Scrutiny Commission

Date of meeting: 16 March 2023

Lead director/officer: Ivan Browne, Public Health

Useful information

- Ward(s) affected: All
- Report author: Laura French, Consultant, Public Health
- Author contact details: laura.french@leicester.gov.uk
- Report version number: 1.0

1. Summary

The current contract for providing sexual health services to the city comes to an end in 2024 and therefore the process of re-procurement has commenced. This has involved an intensive programme of public engagement (which is still ongoing) to help gauge the opinions and views of the community on how to deliver services that work for them. The purpose of this report is to give the scrutiny commission an overview of some of the main emerging themes and important findings of the consultation process so far, as well as an appreciation of the shape of the engagement programme itself.

The online consultation survey opened on 12th January 2023 and will close on the 12th March 2023. Interim results downloaded at the 6 week point showed that 92 people had filled this in online, and a number of other people had also chosen to fill in hard copies at our face to face sessions, of which we have done several which are detailed in section 5.

Most people answering the online survey stated that they were responding as either a member of the public or someone who uses sexual health services, however there were a sizeable minority who were answering as members of voluntary or community organisations, and also as NHS or health care providers. There was a good spread of responses across the age groups, but the biggest number came from the 18-25s

The answers have reflected people's desire for flexibility in how they access services, indicating a preference for a mix of online and face to face appointments (and walk-in and bookable in advance), but also with availability of online order STI test kits and sexual health 'vending machines' across the city. Responses also indicated enthusiasm for an option for telephone advice and consultation. Some respondents indicated a preference for the GP as a provider of many of these services (often contraceptive). There also seemed to be some services of which a proportion of respondents were not aware, suggesting a need to work more on publicising these.

Next steps for commissioners are to complete the programme of engagement and compile all the results. Insights and data from the engagement process will be analysed thematically and used to inform the service specification and re-tendering process for the new service contract. It is also hoped that an open dialogue will remain between these community groups and public health, so that we can continue to work in the best way for our communities, and work together with them to achieve the best possible health outcomes for all.

2. Recommended actions/decision

This report is for information only; no actions/decisions are required.

3. Scrutiny / stakeholder engagement

Since this report describes an engagement process, please see sections 4 and 5 for details.

4. Background and options with supporting evidence

Since the Health and Social Care Act in 2013, Local Authority public health teams have had responsibility for commissioning an integrated sexual health service for their populations, which should be open access and provide both testing and treatment of sexually transmitted infections, and advice and provision of contraception/family planning services. In addition to these functions, sexual health contracts also encompass elements of community outreach work with specific groups, sex and relationship education in schools and colleges, psychosexual counselling and HIV prevention work including pre-exposure prophylaxis (PrEP). Some elements of sexual and reproductive healthcare such as termination of pregnancy, vasectomy services, gynaecology and HIV medicine have remained the commissioning responsibility of NHS colleagues and are not within the scope of the local authority contract.

The population of Leicester City is, on average, younger than other cities in England. The combination of this fact, along with the diverse nature of the communities and the high levels of deprivation in parts of the city can make responding to the sexual health needs of the population challenging. Poor sexual health outcomes are not evenly distributed throughout the population and, though these inequalities are complex and multi-factorial, an important part of tackling them is working with communities to help design and build services that work for them. A detailed programme of engagement with communities is therefore underway during the re-commissioning process for sexual health services to ensure that the views and needs of the population are kept at the centre of the service design process. This has involved both online and face-to-face consultation opportunities. The online form is available to anyone, but there has also been specific focus on key groups in whose views the team is particularly interested given their under-representation in services or poorer outcomes. The links and relationships formed through the City Council's Community Wellbeing Champions Network have been instrumental in helping to facilitate this process.

5. Detailed report

5.1 Online Consultation

The online consultation process is live until 12th March 2023 and can be accessed via the URL Sexual health services review - Leicester City Council - Citizen Space. A PDF copy is attached below.

The online survey (and its printed counterpart) asks questions on several topics, including online services, face to face appointments, telephone consultations and advice. It asks about how people would prefer to access STI test kits and condoms, and where people would prefer to see vending machines or c card stations. (Sexual health vending machines can be used to obtain equipment STI testing kits or condoms without the need for an appointment or a face-to-face contact). The survey also has questions related to

geographical areas, and which clinics people would visit if open, and whether they prefer to access services with their GP or a sexual health clinic. Finally, the survey contains information about the community wellbeing champions and their role and asks respondents if they would like to see us doing more work closely together with communities.

At the point of this review, there had been 92 responses to the survey online, from people across a range of age groups, though with the greatest number of responses in the age group 18-25. Most said they were answering as a member of the public or as someone who uses sexual health services. Of those that chose to answer the question, 50% of respondents were female and 10% male. When asked about their sexuality, there was representation across all groups (bisexual, gay, lesbian, other), but the greatest number of responses came from people identifying as heterosexual/straight. There was a spread of responses to the questions on religion and ethnicity, but the biggest number of responses came from people identifying themselves as white British or British Asian. Around 17% of respondents said either that they considered themselves to have a disability or preferred not to say.

From the responses, it was clear that the option to book appointments online is popular, with two thirds of people answering ‘definitely’ to the question ‘do you think we should increase the number of bookable online appointments?’. Interestingly though, when asked how they would prefer to access face-to-face appointments, the clear preference was for a mix of drop-in (turn up and wait) and bookable appointments.

There was enthusiasm for a greater number of vending machines to be available across the city, and an even spread of suggestions for venues, including universities, sexual health clinics and community venues.

The majority of respondents also felt that there should be the option to order STI test kits online, an option for a telephone advice service and an increase in online information available. This indicates that the shift to majority remote services over the pandemic has changed the way that people like to access services, and that they value flexibility. Having said this, many of the free text responses indicated that people also value the option to have a face-to-face appointment with a skilled professional, particularly if they have symptoms or are concerned about something.

The survey asks about previous ‘spoke’ clinics in different parts of the city and whether people had used them in the past or would use them again. These are:

- Merridale
- Beaumont Leys
- Willowbrook Practice
- Victoria Park Clinic
- Saffron Road Practice
- De Montfort University Clinic
- Groby Road Practice
- Westcotes

Interestingly, although some of these had seen a decrease in footfall in recent times, or are no longer operating, there was an even split of people answering that they either had used them before or would do again, suggesting that people value geographical flexibility in where they access these services, as well as an online/face-to-face flexibility. This will need to be taken into account when thinking about the service model.

Finally, people were asked about where they would prefer to access specific contraceptive services such as oral contraception, coils and implants. The options suggested were own GP, other GP, sexual health clinic, local pharmacy or other. Interestingly, for oral contraception options, there was no real difference in preference between these options, people seemed equally keen. For coils and implants (long acting reversible contraceptives, LARC) however, there was a clear preference for either people's own GP or the sexual health clinic. This suggests that equity of access to LARC in primary care across the city must be a priority and therefore so should training to maintain a supply of trained fitters in primary care.

5.2 Face to Face Sessions

Face to face sessions have so far been delivered with the following groups/at the following venues:

- Wesley Hall Community Centre
- Women4Change
- Afro Innovation Group
- AAG (Autism Advocacy Group)
- Autism Partnership Board
- Young Persons session (Participation Engagement Group)
- Sharma Women's Centre
- Belgrave Neighbourhood session

And there are two sessions scheduled for the coming week (at the time of writing) with the Bangladesh Action Resource Centre and the University of Leicester for a Student Engagement Event.

Sessions have been well attended and participants have provided a wealth of rich and detailed information on a wide range of topics. These will be properly combined and analysed thematically in order to best inform future practice and services, but some key themes have emerged already.

1. *Education and Training*: Groups have expressed the importance of and need for sexual health education and information for all, but that it must be given in an understandable, approachable and acceptable way for that particular community. Some felt that sexual health education should be delivered alongside other health topics to help them feel more acceptable and just part of 'health'. Groups also spoke about the importance of delivering information in partnership with communities to encourage trust in the information. This reinforces what we know from our work with the Community Champions Network; that health messaging needs to be delivered in partnership with communities. Others spoke about the importance of 'wider' sex education to include a focus on healthy relationships in general.
2. *Beliefs and Perceptions*: Participants spoke of the need to facilitate open and honest conversations around issues associated with sexual health so that any incorrect beliefs or misconceptions that people might have, for example regarding specific types of contraception, can be addressed properly. Again, the need for culturally competent support and counselling in sexual health matters was emphasised in order to make people feel confident and empowered to make decisions that work best for them.

3. *Barriers to Accessing Services:* Discussion participants offered a range of suggestions as to why people might not be accessing the services appropriate to their needs, and these ranged from practical barriers such as not knowing or understanding what services were available and where, to accessibility-related barriers with communication. Online appointment booking for appointments or test kit ordering were mentioned here as a solution for some, but others had concerns about privacy and discretion when ordering kits to arrive through the post. Outreach programmes with community-based workers were suggested as solutions too.
4. *Age-appropriate services:* There was a general feeling amongst participants that the needs of younger and older age groups, though overlapping, were different and required different considerations in everything from where sexual health services were delivered and who by, to how information is given and in what formats.
5. *Information sharing and signposting:* Feeling that the service is confidential, and that your information is secure is true of all health care, but particularly true of sexual health care where the topics discussed can be sensitive. Having said that, participants also understood the importance of safeguarding concerns in this area and the need to share info with other partners under specific circumstances. Participants also spoke of the importance of information sharing by providers within communities so that informal networks can signpost to services where needed and provide a general understanding of what is available/support members to get help when needed.

5.3 Next Steps

Next steps for commissioners are to complete the programme of engagement and compile all the results. Insights and data from the engagement process will be analysed thematically and used to inform the service specification and re-tendering process for the new service contract. It is also hoped that an open dialogue will remain between these community groups and public health, so that we can continue to work in the best way for our communities, and work together with them to achieve the best possible health outcomes for all.

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

6.1 Financial implications

There are no direct financial implications arising from this report which is for information only.

6.2 Legal implications

There are no direct legal implications arising from this report which is for information only.

6.3 Equalities implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which means that, in carrying out their functions, they have a statutory duty to pay due regard to the need to eliminate unlawful discrimination, harassment and victimisation, to advance equality of opportunity between people who share a protected characteristic and those who don't and to foster good relations between people who share a protected characteristic and those who don't.

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. There are no direct equalities implications arising from this report as it is for information only to describe the public engagement process so far. Ensuring that commissioners and providers of health and wellbeing services are aware of the views and needs of the city's diverse communities is important to help identify and overcome barriers that can result in some communities experiencing poorer health and wellbeing than others. The process of engagement with communities also provides information to inform equalities impact assessments.

6.4 Climate Emergency implications

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

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

n/a

7. Background information and other papers:

8. Summary of appendices: Sexual Health Consultation Printed Survey.

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)? No

10. Is this a "key decision"? No

Appendix D

Leicester City Council sexual health services review

Public Survey

12 January 2023 - 12 March 2023

Overview

Leicester City Council needs to procure the next sexual health services contract to begin on 1 April 2024. The current sexual health contract is jointly commissioned by Leicester City Council, Leicestershire County Council and Rutland County Council, and ends on 31 March 2024. The next contract will be commissioned solely by Leicester City Council, with Leicestershire and Rutland undertaking a separate process.

We would like to hear your views on potential changes to the services and how they are delivered, so we can ensure they meet the needs of the people who use them.

This consultation is about 'integrated sexual health services' in Leicester. This includes both contraception and prevention, testing, and treatment for sexually transmitted infections.

These services can be used by anyone, regardless of where they live. However, it should be noted that we are only referring to sexual health services that are available in the city of Leicester.

This consultation does not refer to the HIV treatment and care services that are provided by University Hospitals of Leicester.

This consultation is open to people who access sexual health services, members of the public, staff and partner organisations.

Topics covered by this consultation include:

- Online appointment bookings
- Face to face services
- Vending machines
- Sexually transmitted infection test kits
- Phone consultations / advice
- Clinics
- Contraception
- Coils and implants
- Additional services and community wellbeing champions.

Leicester City Council survey

If you prefer you can take this survey online at **consultations.leicester.gov.uk/public-health/sexual-health** or by scanning the code.

The survey closes on **12 March 2023**. Please return this survey **by 6 March** to:

Consultations / Communications & Marketing
Leicester City Council
City Hall
115 Charles Street
Leicester LE1 1FZ

Leicester City Council

Completing the survey

You can disregard any questions that are not relevant to you.

Any answers or comments that relate to Leicestershire and Rutland services will be anonymised and passed on to the respective county authorities for their attention.

If you wish to take the Leicestershire County Council survey, it is online at leicestershire.gov.uk/sexual-health-consultation or by scanning this code:

Leicestershire County Council survey

About you

Are you responding as...

Please tick only one item

- ◯ Someone who uses sexual health services
- ◯ A family member / carer of someone who uses sexual health services
- ◯ A member of the public
- ◯ A sexual health service employee
- ◯ A voluntary sector organisation or charity
- ◯ NHS / GP practice / health professional
- ◯ Other organisation representative
- ◯ A group response
- ◯ Other

If Other, please specify

What is your home / work postcode? (as appropriate)

Please note: we collect postcode data to gain a better understanding of which parts of the city / county respond to our consultations. We cannot identify individual properties or addresses from this information.

Organisation details

If you are responding as an employee of a sexual health service or from an organisation, please provide details of the service provider, voluntary organisation, charity, GP or other organisation you are responding on behalf of.

Organisation name

Type of organisation / business

Online clinic booking

The current service already offers the option of online appointment booking. However, these are often booked up very quickly.

We plan to increase the number of online booking appointments available to help reduce waiting times and allow people to book appointments when they are most convenient and needed. This will also allow the sexual health service to plan staff availability better and increase efficiency.

Where possible, the new online booking option will include appointments across all of the sexual health services available in Leicester.

Do you think we should increase the number of online booking appointments available? *Please tick only one item*

- ◯ Definitely
- ◯ Possibly
- ◯ No opinion either way
- ◯ Probably not
- ◯ Definitely not

Do you have any comments on this?

Face to face services

How would you prefer to access face to face services? *Please tick only one item*

- ◯ Turn up and wait (‘drop-in’ style service)
- ◯ Bookable fixed appointments
- ◯ A mixture of both drop-in and appointments
- ◯ No preference
- ◯ Other

Do you have any comments on this?

Vending machines

We know that many people visit sexual health service locations to pick up items that do not require them to see a doctor or nurse. We provide vending machines at some sites across the city to enable people to collect free STI self-testing kits, condoms or pregnancy tests.

The machines require some personal information to be entered to ensure that this is the right service for the individual, and also to ensure there are no health needs that mean that they need to see a doctor or nurse.

We would like to increase the number of vending machines available across the city, and also consider where they are located.

Do you think we should increase the number of vending machines across the city? *Please tick only one item*

- ◯ Definitely
- ◯ Possibly
- ◯ No opinion either way
- ◯ Probably not
- ◯ Definitely not

Do you have any comments on this?

Where do you think these vending machines should be located?
Please tick all that apply

- ☐ Children, young people and families centres
- ☐ Community centres
- ☐ Pharmacies / chemists
- ☐ Sexual health service sites
- ☐ University buildings
- ☐ Other

If Other, please specify

Do you have any comments on this?

Sexually transmitted infection test kits

New technologies have developed over the last five years, making it easier for people to test themselves for sexually transmitted infections (STIs) and to post the tests to a laboratory for analysis, with results being given back by text or a phone call.

The current service already provides this service and many people prefer this method of STI testing, particularly if they live in rural areas or have difficulty getting to a clinic.

There is potential to also order STI testing kits online. This service will be available to everyone, including those who do not have symptoms or signs of an STI at the time of ordering the kit. You will still have the option of going to a clinic if you prefer.

Do you think we should offer the option of ordering STI testing kits online?
Please tick only one item

- ◯ Definitely
- ◯ Possibly
- ◯ No opinion either way
- ◯ Probably not
- ◯ Definitely not

Do you have any comments on this?

Phone consultation / advice

We would like to provide a telephone consultation and advice service (and increase the amount of online information available) to enable people to manage their sexual health better.

Do you think we should introduce a telephone consultation / advice service?

Please tick only one item

- ◯ Definitely
- ◯ Possibly
- ◯ No opinion either way
- ◯ Probably not
- ◯ Definitely not

What subject areas should be covered?

Do you have any further comments on this?

Do you think we need to increase the amount of online information available?

Please select only one item

- ◯ Definitely
- ◯ Possibly
- ◯ No opinion either way
- ◯ Probably not
- ◯ Definitely not

What subject areas should be covered?

Do you have any further comments on this?

Clinics

There is currently one main sexual health services clinic in Leicester, located at the Haymarket. In addition to the main clinic, there are:

- Clinics (for all age groups) which are held at a number of different locations across Leicester. These clinics take place at set times every week.
- Young people specific sessions in various locations for people aged under 25 years. These are known as the CHOICES clinics.
- Other sexual health clinics located at the University of Leicester, Leicester College (Abbey Park Campus), New Parks and Beaumont Leys.

Clinics used to be available in the following locations. Please indicate if you have previously visited / would visit them if they were reinstated

	Visited in the past	Would not visit if open	Would visit if open
Beaumont Leys	☐	☐	☐
De Montfort University Clinic	☐	☐	☐
Groby Road Practice	☐	☐	☐
Merridale	☐	☐	☐
Saffron Road Practice	☐	☐	☐
Victoria Park Clinic	☐	☐	☐
Westcotes	☐	☐	☐
Willowbrook Practice	☐	☐	☐
Other clinic, not listed	☐	☐	☐

Other clinic - please give details

Do you have any comments on clinic locations?

Contraception

Most contraception is provided by an individual's own GP. However, contraception is also available from other places such as other GPs, pharmacies / chemists (for repeat oral contraception) and sexual health service locations.

How would you prefer to access oral contraception?

	Oral Contraception (initially)	Oral Contraception (repeat prescription)	Emergency Hormonal Contraception (EHC)
Not applicable	☐	☐	☐
Your own GP	☐	☐	☐
Other GP	☐	☐	☐
Local pharmacy / chemist	☐	☐	☐
Sexual health services	☐	☐	☐
Online	☐	☐	☐
Phone consultation	☐	☐	☐

Do you have any comments on this?

Where would you prefer to go for intrauterine devices and subdermal implants (coils and implants)?

	Intrauterine devices (coils)	Subdermal implants (implants)
Not applicable	☐	☐
Your own GP	☐	☐
Other GP	☐	☐
Local pharmacy / chemist	☐	☐
Sexual health services	☐	☐

Do you have any comments on this?

Intrauterine devices and subdermal implants (coils and implants)

We would like to simplify the process for people looking to have a coil or implant fitted by developing a single point of access. This would mean that women would be able to phone a number to discuss their needs with a clinician before booking a place and time for their coil or implant.

This service should mean less waiting and more choice in terms of when and where the coil or implant is fitted.

It would require the patient to give consent for other doctors and nurses to see their patient record to provide a safe service.

Do you think this 'phone first' service should be made available?

Please tick only one item

- ◯ Definitely
- ◯ Possibly
- ◯ No opinion either way
- ◯ Probably not
- ◯ Definitely not

Do you have any comments on this?

Would you use this service if it was available? *Please tick only one item*

- ◯ Yes
- ◯ No, I prefer to go to my own GP
- ◯ No, I'd prefer to go to sexual health services
- ◯ Not applicable

Additional sexual health services

Leicester City Council currently commissions additional sexual health and HIV prevention services provided to the following groups:

- Men who have sex with men
- People from Black, Asian and Minority Ethnic groups
- People new to Leicester (including new arrivals and students)
- People with HIV
- Sex workers
- Young people.

Funding of sexual health services is through a grant. This grant is reducing year on year and so we have to look at how best we can continue to provide sexual health services to these groups. These services are provided within the current sexual health service contract and may be provided by local groups who work with these communities.

We propose that sexual health promotion and HIV prevention work is provided in partnership with communities and that communities are involved in the development and design of messages and services. We will do this by requiring the sexual health services to subcontract and develop partnerships with local groups.

Community Wellbeing Champions will be drawn from communities and will work alongside them to address issues that contribute to wider health inequalities such as sexual health related services.

The Community Wellbeing Champions will work closely with the Public Health team at Leicester City Council. They will have the opportunity to engage in a range of activities, which could include:

- Health promotion events
- Community research on barriers and health needs
- Sharing knowledge and experience with local communities
- Signposting people to support and reducing social isolation
- Co-designing and shaping services.

How will working more closely with communities and community organisations impact on you, or the group on whose behalf you are responding? *Please tick only one item*

◯ It will have a positive impact
◯ It will have a negative impact
◯ It will make little or no difference
◯ I have no opinion either way
◯ Not applicable

Do you have any comments on this?

Final comments

Do you have any final comments on sexual health services in Leicester?

Equality monitoring

The information you provide in this final section of the questionnaire will be kept in accordance with terms of current Data Protection legislation and will only be used for the purpose of monitoring.

Your details will not be passed on to any other individual, organisation or group. Leicester City Council is the data controller for the information on this form for the purposes of current Data Protection legislation.

Ethnic background: *Please tick only one item*

- ◯ Asian or Asian British: Bangladeshi
- ◯ Asian or Asian British: Indian
- ◯ Asian or Asian British: Pakistani
- ◯ Asian or Asian British: Any other Asian background
- ◯ Black or Black British: African
- ◯ Black or Black British: Caribbean
- ◯ Black or Black British: Somali
- ◯ Black or Black British: Any other Black background
- ◯ Chinese
- ◯ Chinese: Any other Chinese background
- ◯ Dual/Multiple Heritage: White & Asian
- ◯ Dual/Multiple Heritage: White & Black African
- ◯ Dual/Multiple Heritage: White & Black Caribbean
- ◯ Dual/Multiple Heritage: Any other heritage background
- ◯ White: British
- ◯ White: European
- ◯ White: Irish
- ◯ White: Any other White background
- ◯ Other ethnic group: Gypsy/Romany/Irish Traveller
- ◯ Other ethnic group: Any other ethnic group
- ◯ Prefer not to say

If you said your ethnic group was one of the 'Other' categories, please tell us what this is:

Age: *Please tick only one item*

- ◯ under 18
- ◯ 18 - 25
- ◯ 26 - 35
- ◯ 36 - 45
- ◯ 46 - 55
- ◯ 56 - 65
- ◯ 66+
- ◯ Prefer not to say

Sexual orientation. Do you consider yourself to be ... *Please tick only one item*

- ◯ Bisexual
- ◯ Gay / lesbian
- ◯ Heterosexual / straight
- ◯ Prefer not to say
- ◯ Other (please specify)

Disability

The Equality Act 2010 defines a person as disabled if they have a physical or mental impairment which has a substantial and long-term effect on their ability to carry out normal day-to-day activities and has lasted or is likely to last for at least 12 months. People with HIV, cancer, multiple sclerosis (MS) and severe disfigurement are also covered by the Equality Act.

Do you consider yourself to be a disabled person? *Please tick only one item*

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

If you have answered **'Yes'** to the above, please state the type of impairment that applies to you. People may experience more than one type of impairment, in which case you may need to tick more than one box. If none of the categories apply, please tick 'Other' and state the type of impairment.

Please tick all that apply

- ☐ A long standing illness or health condition such as cancer, HIV, diabetes, chronic heart disease, or epilepsy
- ☐ A mental health difficulty, such as depression, schizophrenia or anxiety disorder
- ☐ A physical impairment or mobility issues, such as difficulty using your arms or using a wheelchair or crutches
- ☐ A social / communication impairment such as a speech and language impairment or Asperger's syndrome / other autistic spectrum disorder
- ☐ A specific learning difficulty or disability such as Down's syndrome, dyslexia, dyspraxia or AD(H)D
- ☐ Blind or have a visual impairment uncorrected by glasses
- ☐ Deaf or have a hearing impairment
- ☐ An impairment, health condition or learning difference that is not listed above (specify if you wish)
- ☐ Prefer not to say
- ☐ Other

If Other, please say

How would you define your religion or belief? *Please tick only one item*

- ◯ Atheist
- ◯ Bahai
- ◯ Buddhist
- ◯ Christian
- ◯ Hindu
- ◯ Jain
- ◯ Jewish
- ◯ Muslim
- ◯ Sikh
- ◯ No religion
- ◯ Prefer not to say
- ◯ Other

If Other, please specify

What is your sex? *Please tick only one item*

- ◯ Female
- ◯ Male
- ◯ Prefer not to say

Is your gender identity the same as your sex registered at birth?
Please tick only one item

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

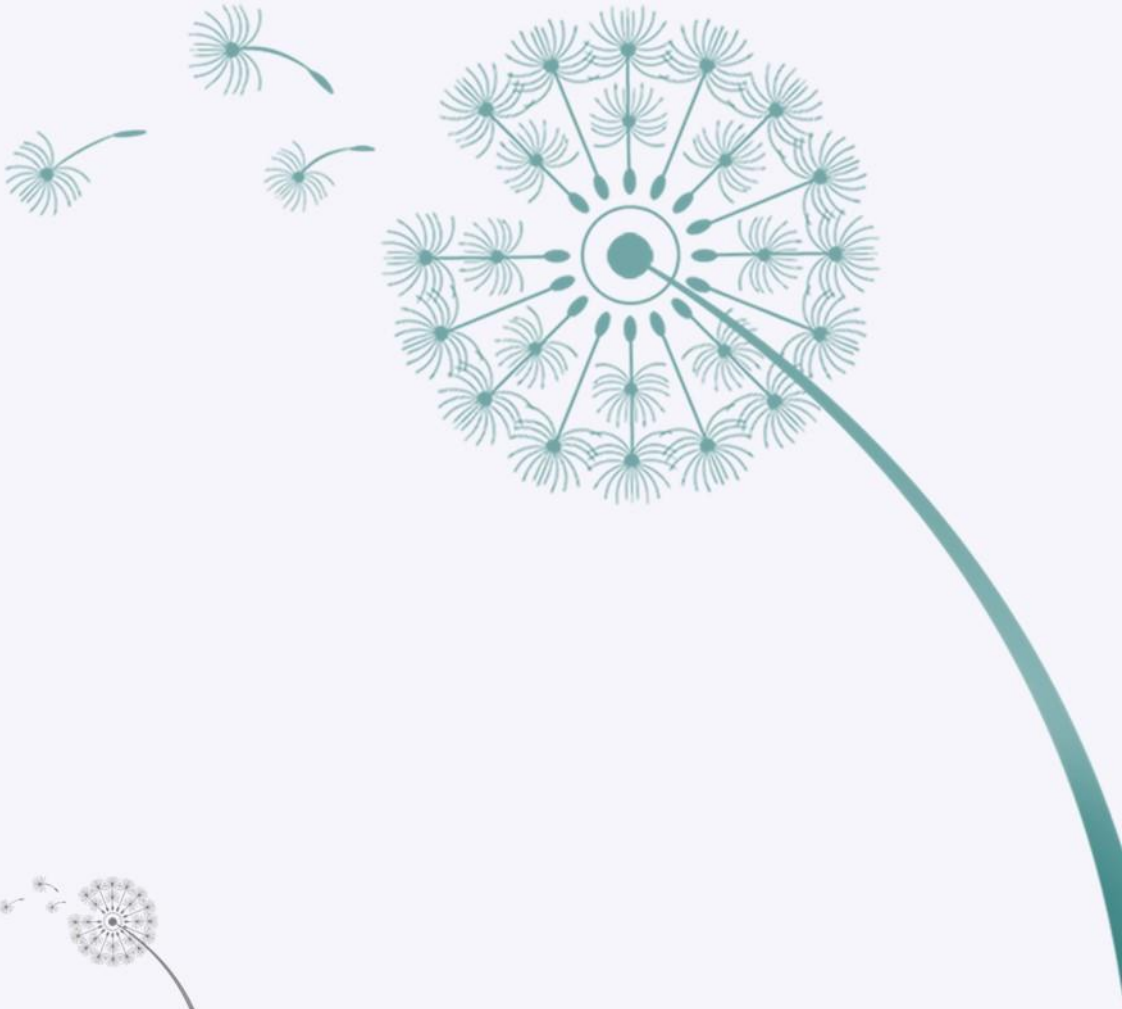
If No, what term do you use to identify your gender? (leave blank if prefer not to say)

Thank you for completing this survey.

Contact us

For further information or to request more surveys please email:
Daniel Hallam, Commissioning Manager, Public Health
daniel.hallam@leicester.gov.uk

Child Death Overview Panel (CDOP) Annual Report 2021-2022



Child Death Overview Process

Leicester, Leicestershire & Rutland

Authors

Dr Suzi Armitage, LLR Designated Doctor for Child Death
Lisa Hydes, LLR Child Death Review Manager
Rob Howard, LLR CDOP Chair, Consultant in Public Health, Leicester City Council
Helen Reeve, Senior Intelligence Manager, Public Health, Leicester City Council

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Acknowledgement to CDOP members 2021-2022:

Rob Howard, Consultant in Public Health, Leicester City Council, CDOP Chair
Claire Turnbull, Designated Nurse Safeguarding, CCG, CDOP Vice Chair

Dr Alvina Ali, CAMHS Named Doctor for Safeguarding Children, Leicestershire Partnership NHS Trust
Dr Suzi Armitage, Designated Dr for Child Death (DDCD), LLR CDR Partners
Dr Amy Atkinson, Paediatric Emergency Medicine Consultant, UHL
Teo Bott, Head of Safeguarding, Leicester City Council
DI Tom Brenton, Detective Inspector CAIU & Force Lead for Child Death, Leicestershire Police
Lee Brentnall, East Midlands Ambulance Service
Rebecca Broughton, Head of Outcomes & Effectiveness, UHL
Bernadette Caffrey, Head of Safeguarding, Rutland County Council
Liz Cudmore, Safeguarding Lead, East Midlands Ambulance Service
Rebecca Eccles, Clinical Lead for the LeDeR Programme, LPT
Kelly-Marie Evans, Consultant in Public Health, Leicestershire County Council
Louise Evans, Deputy Head of Nursing, FYPC-LD, Leicestershire Partnership NHS Trust
DCI Helen Fletcher, Detective Chief Inspector CAIU, Leicestershire Police
Kay Fletcher, Head of Safeguarding, Leicestershire County Council
Julie Gibson, Learning Disabilities Service Manager, LeDeR LAC, NHS LLR
Darrell Griffin, Service Manager, Rutland County Council
Lisa Hydes, Child Death Review Manager, LLR CDR Partners
Julia Khoosal, Service Manager, Leicester City Council
Dr Penelope McParland, Consultant Obstetrician UHL
Dr Robin Miralles, Consultant Neonatologist, UHL
Sarah Press, Lay Member
Dr Amrin Rahuf, Named GP Safeguarding Adults & Children, CCG
Dr Rachel Rowlands, Paediatric Emergency Medicine Consultant, UHL
Carmela Senogles, Acting Deputy Head of Nursing, FYPC-LD, Leicestershire Partnership NHS Trust
Dr Jeremy Tong, Consultant Paediatric Intensivist, UHL
Dr Kamini Yadav, Consultant Neonatologist, UHL

LLR Child Death Review Service
Lisa Hydes, Child Death Review Manager
Sue Stephenson, Child Death Review Practitioner
Gemma Miles, Child Death Review Practitioner
Melvinna West, Child Death Overview Process Support Officer

Contents

Glossary of abbreviations used

CAIU	Child Abuse Investigation Unit
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CDIM	Child Death Initial Meeting
CDRM	Child Death Review Meeting
CSPR	Child Safeguarding Practice Review
EMAS	East Midlands Ambulance Service
JAR	**Joint Agency Response** A coordinated multiagency response to a death occurring in any of the following circumstances: - Death due to external causes - Death occurring in suspicious circumstances - Death that is sudden (not anticipated in preceding 24 hours) and for which no medical explanation is evident – a sudden unexpected death in infancy/childhood - Death of a child or young person detained under the mental health act or in custody - A stillbirth occurring without in the absence of a registered health professional.
LeDeR	Learning Disability Mortality Review
LLR	Leicester, Leicestershire & Rutland
LPT	Leicestershire Partnership NHS Trust
LRI	Leicester Royal Infirmary
LSCP	Local Safeguarding Children Partnership
MBRRACE-UK	Mothers & Babies: Reducing Risk through Audit & Confidential Enquiries across the UK
NCMD	National Child Mortality Database
NNU	Neonatal Unit
PMRT	Perinatal Mortality Review Tool
SUDI/C	**Sudden Unexplained Death in Infancy/Childhood** Descriptive term, used at presentation - the death of an infant/child which was not reasonably expected to occur 24 hours previously, and in whom no pre-existing medical cause of death is apparent. Following detailed investigation, a cause of death may be found.
SIDS	**Sudden Infant Death Syndrome** An unexpected death of an infant occurring during normal sleep, which remains unexplained after a thorough investigation and review of the circumstances.
UHL	University Hospitals of Leicester NHS Trust

Introduction

The national process of reviewing child deaths was established in April 2008 and updated in Chapter 5 of Working Together to Safeguard Children 2018. It is the responsibility of the Child Death Review Partners to ensure that a review of every death of a child normally resident in their area is undertaken by a CDOP. Across LLR, the Child Death Review Partners are the three Local Authorities and Clinical Commissioning Groups.

The overall purpose of the LLR CDOP is to undertake a comprehensive and multi-agency review of all child deaths, to better understand how and why children across LLR die, with a view to detecting trends and/or specific areas which would benefit from further consideration. The LLR CDOP has been gathering data since 2009 and been producing annual reports which summarise the data collected in each year.

The process for reviewing child deaths commences with Notification to the Child Death Review team and culminates in final scrutiny at the Child Death Overview Panel (please see fig 1). The Child Death Review process integrates with the Perinatal Mortality Review Programme and the Learning Disability Mortality Review Programme (LeDeR). All data from LLR Child Death Reviews is submitted to the National Child Mortality Database (NCMD) for the purposes of data analysis and learning at a national level.

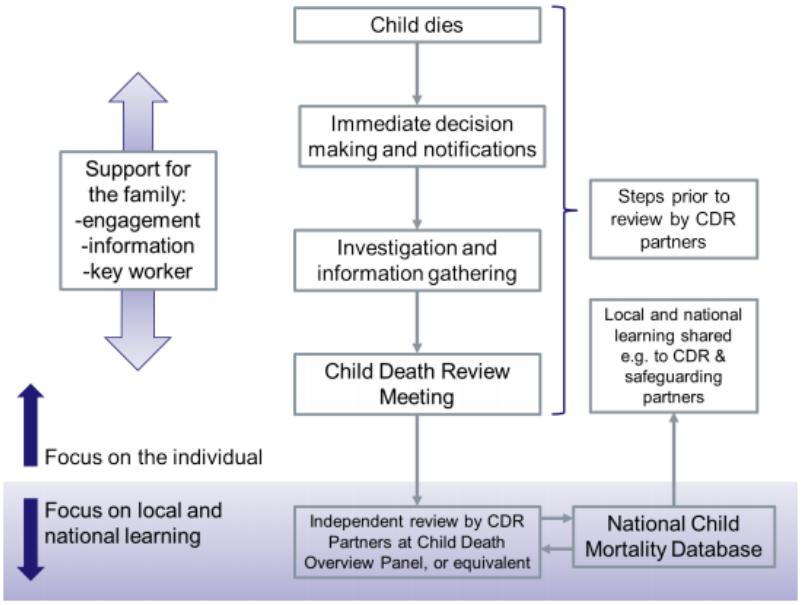


Figure 1: The Child Death Review process as set out in Working Together to Safeguard Children 2018, Chapter 5[1].

Our team: Child Death Review Practitioners

The role of supporting the families and undertaking Joint Agency Response visits with the police sits within the remit of the Child Death Review Practitioner role (CDRP). In November 2020 LLR CDOP appointed a 0.4 WTE equivalent in order to support the current 0.6 WTE post. The CDRP role is an essential aspect to the service to ensure statutory requirements are met, and families are adequately supported, through:

- Carrying out a joint home visit together with police, to gather further information around the circumstances of death. In addition, they will review the background history, identify support for the family, with signposting to specialist bereavement support where appropriate, supporting any other issues identified, preparing and submitting a report for HM Coroner (in line with guidance set out in Sudden Unexpected Death in Infancy & Childhood, 2016[2]).
- Acting as the named Key Worker for families ensuring that families are supported and engaged throughout the review process (in line with Statutory & Operational Guidance, 2018[3]), by:
    - Being a ready & accessible point of contact for the family
    - Coordinating meetings as required
    - Arranging & attending home visits with the Designated Doctor to discuss post-mortem report findings
    - Providing information to the family on the Child Death Review process
    - Liaising with Coroners Officer or Police Liaison Office
    - Representing the voice of the family at professional meetings, ensuring their questions are effectively addressed and providing feedback to family afterwards,
    - Signposting to specialist bereavement support if required.
    - Identifying any additional support needs (e.g. around housing, liaison with siblings schools, liaison with GP)

Examples of Child Death Review Practitioner work undertaken with families during 2021/22:

- Carrying out 23 Joint Agency Response home visits along with the police
- Referral to Specialist Bereavement Support
- Liaison with hospital to locate a lost item belonging to child
- Home visits with Designated Doctor to discuss post-mortem results
- Liaison with agencies to ensure equipment sensitively removed from home
- Meeting to discuss the hospital response to parents' questions with support of interpreter
- Liaison with specialist bereavement support for nursery staff
- Referral for funding towards funeral costs
- Providing telephone support to families
- Liaison with Educational Psychology for sibling support

'The team have been abundantly supportive in all aspects of our professional interactions – from the facilitation of meetings and panels to operational support and information sharing around live incidents. The team consistently strived to support joint visits in a timely and flexible way. Equally, where there have been areas for multi-agency development the team have always worked with us to find a way to make improvements in the best interests of the families and the children who sadly no longer have a voice'.

'Leicester, Leicestershire and Rutland CDOP have worked closely with [our agency] over the many years. This relationship is of course based on statutory reporting process; however it is much more than that. Frequently the bereaved families we are working with talk of the value of being able to speak to CDOP about the care of their child and the sensitivity of these interactions. As a team we have valued the advice from CDOP who have supported us around our own policy and the challenges around the death of a child. Our experience of the service is responsive, professional but importantly for our bereaved families, compassionate.'

Above: Feedback from two of our LLR multiagency partners

LLR CDOP Family Support Audit 2021-22

In order to benchmark the service offered by LLR CDOP, an audit was undertaken to review the support offered to families.

What did we learn?

- Documentation of actions required strengthening
- Stronger liaison required with key workers (who were not from CDOP) in order to ensure actions were identified and followed up

What did we do?

- Paperwork reviewed and amended to capture all information needed to demonstrate compliance with statutory guidance including a pre and post visit checklist
- CDRP pathway developed
- CDRP either keyworker or joint keyworker for all cases
- LeDeR proforma developed

Future plans: Family Feedback & enhancing family involvement in the LLR Child Death Review process

Obtaining feedback from a family is not undertaken widely by CDOPs around the Country and therefore teams need to look at alternatives to ensure they gather the voices of families. There are plans within the coming year to liaise with Rainbows, Bodie Hodges and the Diana Team to look at how we progress this with a potential to establish more regular meetings to collect feedback on a more formal basis with the aim of further developing the service and better meeting family's needs.

The team are also looking to ensure CDOP is accessible for all for families who may choose not to engage initially or have struggled to understand the role of CDOP. Options for development include:

- Plans for CDOP to have space on the BHF website where CDOP is explained using Avatars
- A local Easy read CDOP leaflet is also in development following securing funds from LLR project Launch Fund.

Notifications 2021/22

Key information

LLR CDOP received 90 notifications of deaths of LLR residents under the age of 18 years (substantially more than the previous two years). Nationally overall child mortality appeared to fall from April to December 2020 [4], which may in part explain this. Mean number of notifications per year (67.6) over the past 5 years remains similar to previous years.

30 (33%) of cases met the criteria for a Joint Agency Response. Neonatal cases continue to make up the largest proportion of notifications received to CDOP (32%).

Leicester City: 48 cases (53%)
Leicestershire & Rutland: 42 cases (47%)

82% of children died in hospital.
11% died at home.
4% died in a hospice setting.

Table 1: Death notifications by Local Authority 2017/18 to 2021/22

	2017/18	2018/19	2019/20	2020/21	2021/22
Leicester City	33	36	24	30	48
Leics & Rutland	29	35	34	27	42
Total LLR	**62**	**71**	**58**	**57**	**90**

Chart 1. Notifications by category of response 2017/18 to 2021/22

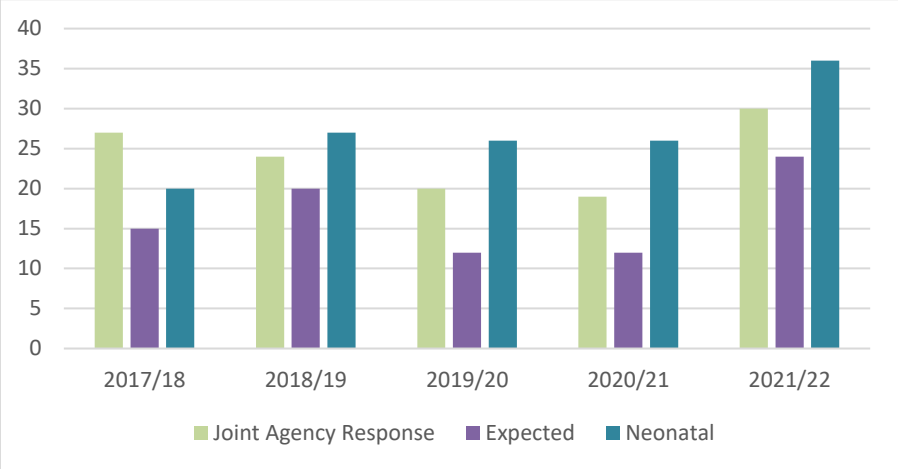


Chart 2. Notifications by place of death

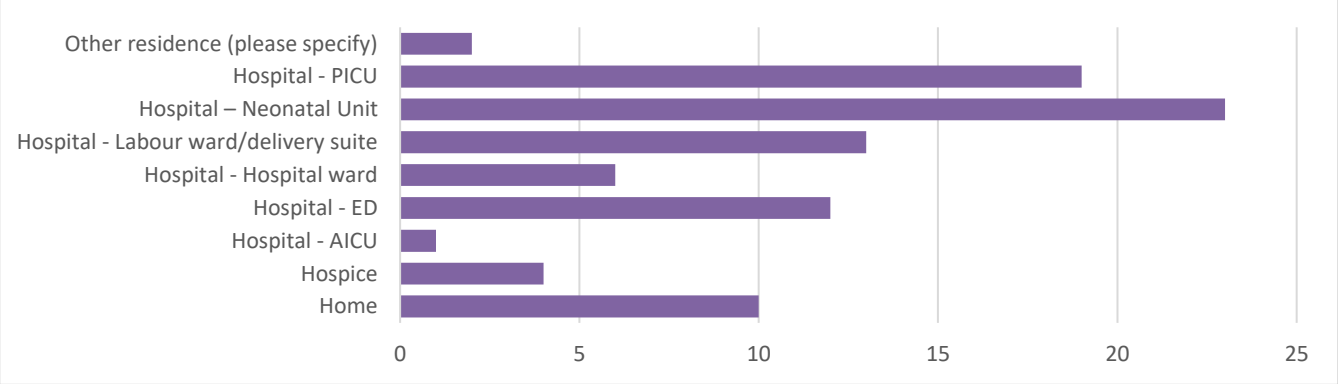


Chart 3. Notifications by age group & year

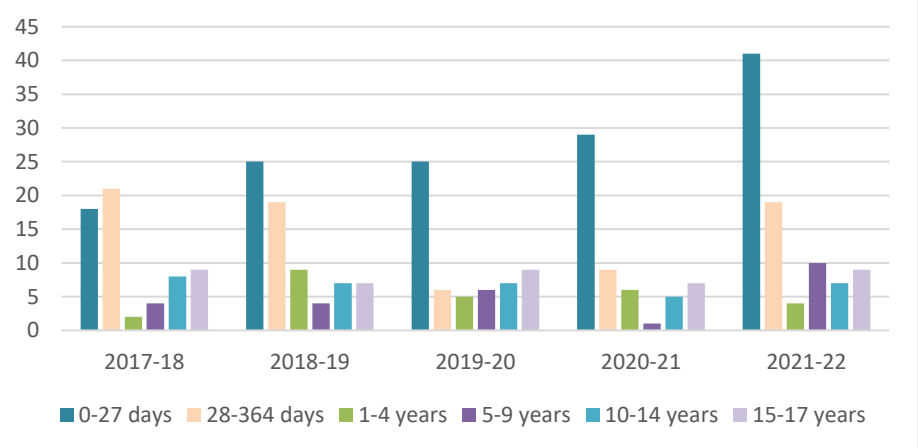


Chart 4. % of notifications by age group Inner ring LLR, Outer ring England

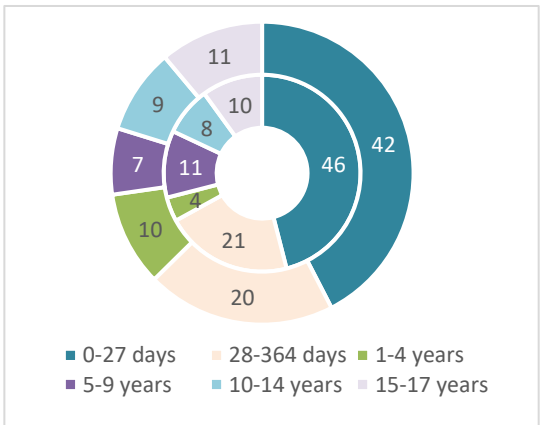


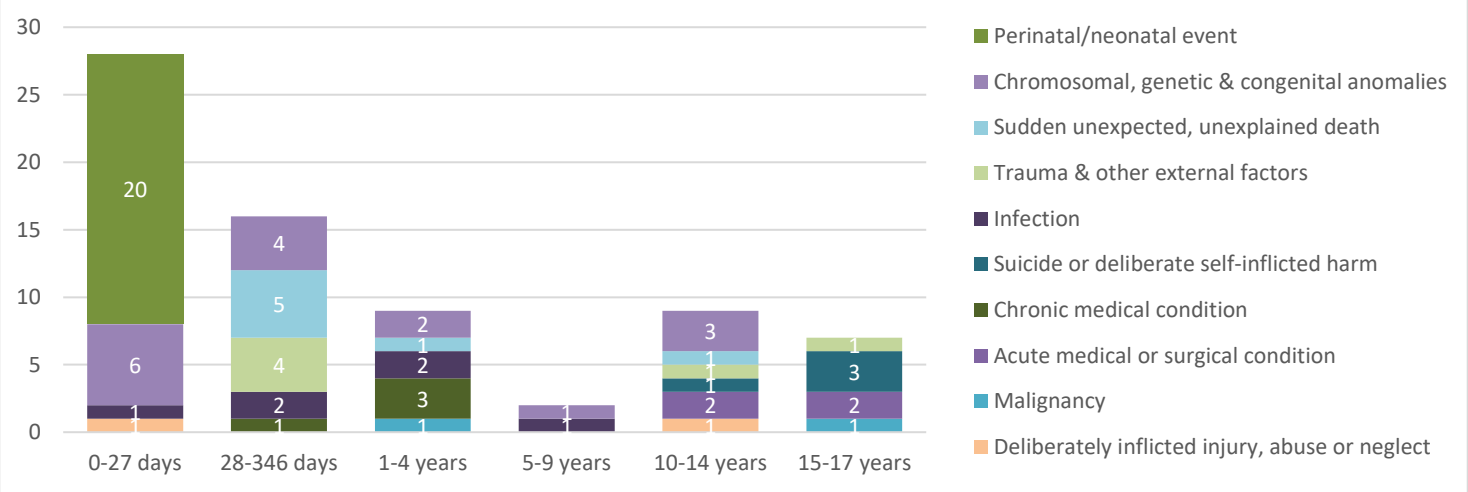
Table 2. Completed reviews by year

	2017/18	2018/29	2019/20	2020/21	2021/22
Leicester City	31	31	17	32	35
Leicestershire & Rutland	41	24	14	32	36
Total LLR	**72**	**55**	**31**	**64**	**71**

Table 3. Completed reviews by year of death 2021/22

Year of death	Cases
2017-18	2
2018-19	4
2019-20	22
2020-21	40
2021-22	3
Total	**71**

Chart 5. Completed CDOP reviews by age group & category of death 2021/22



- In 2021/22 LLR CDOP held 6 panels and reviewed 71 cases.
- Cases are only brought to panel once all other investigations (including Inquests, Police investigations, Serious Incident Investigations and Child Safeguarding Practice Reviews) are concluded and reports available to CDOP, hence there is a time lag between the year of death and completion of the review.
- The top three most frequently recorded categories of death were:
    - Deaths due to a perinatal/neonatal event (28.2%)
        - Includes perinatal asphyxia, complications of prematurity/immaturity and perinatal infection.
    - Deaths due to a chromosomal, genetic, or congenital anomaly (22.5%)
    - Sudden unexpected, unexplained deaths (10%)
        - Deaths occurring at any age, which, following a thorough investigation and post-mortem, no clear medical cause has been identified.
- Of the cases reviewed, most children (64.8%) died in hospital, with 22.5% dying at home, 4.2% in a public place, and 2.8% in a hospice setting.

Table 4. Completed reviews by ethnic group & primary category of death 2021/22

Ethnic Group	0-27 days	28-346 days	1-4 years	5-9 years	10-14 years	15-17 years	Total
White	11	14	5	2	3	6	**41**
Other	1	0	1	0	0	0	**2**
Mixed	4	1	0	0	0	1	**6**
Black or Black British	4	0	1	0	1	0	**6**
Asian or Asian British	8	1	2	0	5	0	**16**
Total	**28**	**16**	**9**	**2**	**9**	**7**	**71**

Modifiable factors 2021/22

Definition:
A modifiable factor is one which may have contributed to the death of the child, and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of further deaths.

Working Together to Safeguard Children, 2018[1]

Table 5: Cases where modifiable factors were identified by category of death 2021/22

Primary category of death (CDOP)	Completed reviews	Modifiable factors identified	Modifiable factors identified (%)
Deliberately inflicted injury, abuse or neglect	2	2	100
Sudden unexpected, unexplained death	7	6	86
Trauma and other external factors	6	4	67
Infection	6	3	50
Suicide or deliberate self-inflicted harm	4	2	50
Perinatal/neonatal event	20	6	30
Acute medical or surgical condition	4	1	25
Chromosomal, genetic or congenital anomaly	16	2	13
Chronic medical condition	4	0	0
Malignancy	2	0	0
Total	**71**	**26**	**37**

- Modifiable factors were identified in 37 % of cases (n=26).
- Across the 26 cases where modifiable factors were identified, 60 individual factors were recorded (mean 2.3, range 1-6 per case).

Table 6: Most frequently recorded modifiable factors 2021/22

No of cases	Most frequently recorded modifiable factors:
9	Parental smoking
6	Maternal obesity
6	Service provision - education
5	Unsafe sleeping practices
4	Service provision - communication
4	Service provision - local/national commissioning
2	Safeguarding
1	Public safety
1	Vehicle/transport related
1	Service provision - human factors
1	Child physical condition
1	Child mental health condition

Parental smoking

- Most common modifiable factor nationally[5].
- Babies exposed to cigarette smoke before birth are at increased risk of preterm birth, low birthweight and Sudden Infant Death Syndrome (SIDS).
- Children exposed to cigarette smoke are at higher risk of breathing problems.

Maternal obesity

- 5th most common modifiable factor nationally[5].
- Challenges with identification of fetal anomalies on antenatal scans.
- Increased risk of gestational diabetes which can lead to adverse pregnancy outcomes.

A. Infant Mortality

Infant deaths reviewed 2021/22

Infant: liveborn (of any gestation) to 12 months of age

- Infant Mortality Rates for Leicester City remain significantly higher than for England (see Appendix B)
- 44 cases reviewed, 36% with modifiable factors
- Most frequently noted modifiable factors:
  - Parental smoking
  - Maternal obesity

Table 7. Infant deaths: completed reviews by ethnic group

Ethnic Group	0-27 days	28-346 days	Total
White	11	14	25
Other	1	0	1
Mixed	4	1	5
Black/Black British	4	0	4
Asian/Asian British	8	1	9
Total	28	16	44

Table 8. Categories of death for children under 1 year – completed reviews

Category of death	No of cases	No of cases where modifiable factors identified	% of cases where modifiable factors identified
Perinatal/neonatal event	20	6	30
Chromosomal, genetic or congenital anomaly	10	1	10
Sudden unexpected, unexplained death	5	5	100
Trauma or other external factors	4	2	50
Infection	3	1	33
Deliberately inflicted injury, abuse or neglect	1	1	100
Chronic medical condition	1	0	0
Total	44	16	

Sudden unexpected unexplained deaths of infants

In the period between 1st April 2016 and 31st March 2022, CDOP reviewed the deaths of 15 children who died under 1 year of age, and whose deaths were categorised by the panel as Sudden Unexpected Unexplained Deaths.

This categorisation is based on the medical cause of death at post-mortem and review of the circumstances of death & will include all deaths due to 'SIDS' or with an 'unascertained' medical cause (where it was not possible to determine the most likely medical cause of death), but not those as a result of external causes such as overlay or mechanical airways obstruction.

Table 9. Sudden Unexpected Unexplained Deaths - Infant case characteristics – 5 year review

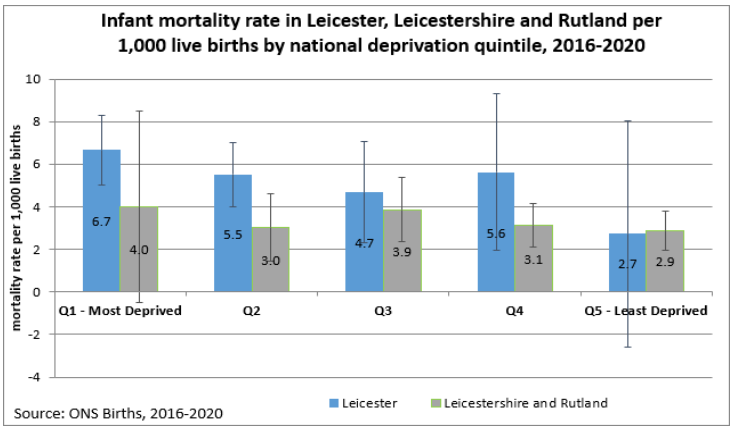
	2015/16 to 2020/21 (n=15)		2016/17 to 2021/22 (n=15)	
	N	%	N	%
Bottle fed	12	80 %	11	73 %
First born	4	27 %	6	40 %
Preterm	10	67 %	9	60 %
IMD 1&2	7	47 %	6	40 %
Birthweight <2.5kg	9	60 %	9	60 %
Mean maternal age	28.8 (20-36)		28.73 (20-36)	
Medical cause of death:				
'Unascertained'	12	80 %	11	73 %
'SIDS'	3	20 %	4	27 %
Modifiable Factors				
Unsafe sleeping	10	67 %	9	60 %
Parental smoking	9	60 %	9	60 %
One or more MF	13	87 %	13	87 %

B. Deprivation & Child Mortality

LLR CDOP submitted case data which was included in the National Child Mortality Database report into Child Mortality & Social Deprivation[6] published in May 2021, looking at the relationship between deprivation and child deaths for cases that occurred during or were reviewed by CDOPs between 1st April 2019 & 31st March 2020.

The full report is available here: https://www.ncmd.info/publications/child-mortality-social-deprivation/

Chart 6. Infant Mortality Rate in LLR by deprivation quintile 2016-2020



Key findings [6]:

1. Clear association between risk of death and deprivation across all categories except malignancy.
2. Relative 10% increase in risk of death between each decile of increasing deprivation.
3. **More than 1 in 5 deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived.**
4. Increased proportion of deaths with modifiable contributory factors with increasing deprivation.
5. 1 in 12 child deaths reviewed in 2019/20 identified 1 or more factors related to deprivation.

C. Suicide & Self-harm

In October 2021, the National Child Mortality Database published their thematic report into Suicide in Children & Young People [7], looking at deaths that occurred or were reviewed by a CDOP between 1st April 2019 & 31st March 2020.

The full report is available here: https://www.ncmd.info/publications/child-suicide-report/

Key findings [7]:

- Services should be aware that child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England including urban and rural environments, and across deprived and affluent neighbourhoods
- 62% had suffered a **significant personal loss** in their life prior to their death (including bereavement and living losses e.g. loss of friends and routine due to moving home, school or other close relationship breakdown).
- Over 1/3 had **never been in contact with mental health services**.
- 16% had a confirmed **neurodevelopmental condition** at the time of their death – this appears higher than the general population.
- Almost a quarter had experienced **bullying either face to face or cyberbullying**, the majority reporting bullying in schools.

D. Learning Disability Mortality Reviews (LeDeR)

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

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

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) Policy 2021[8]

LLR CDOP LeDeR Reviews

Deaths of all people with learning disabilities aged 4 years and over are reviewed as part of LeDeR Programme, aiming to identify learning to reduce the increased mortality and morbidity rates seen for this cohort. In addition to the standard Child Death Review process, a 'pen portrait' of the child or young person is completed with the family, and since September 2020, areas of best practice are identified, and quality of care provided is graded.

Over the past two years (2020-21 & 2021-22), 16 LeDeR case reviews were completed.

Of these 16 cases:

- The top three most common categories for causes of death were:
  - Chromosomal, genetic or congenital anomalies
  - Acute medical condition
  - Chronic medical condition
- Modifiable factors were identified in 3 cases.
- Areas of best practice were identified in 4 cases.
- LeDeR Care Grading was completed in 13 cases:
  - Good or excellent care was noted in 9 cases
  - Satisfactory care was noted in 2 cases
  - Care fell far short of expected good practice in 2 cases.

Key learning themes identified during reviews

	Communication is key - Good communication was the most frequently cited issue in good or excellent care. - Poor communication was the most frequently noted issue in terms of issues with care, including those raised by families.
	Care Coordination/transition - Complex care needs good coordination, families need to know who their lead professional is, effective transition to adult services for vulnerable young people is vital.
	Access to services at the right time - Both in terms of physical accessibility and availability, ensuring equity of access for children and young people to the services they need.

Table 10. Cases where learning identified by category of death, 2021/22

Category of death	Total no of cases	Cases where learning identified	% of cases where learning identified
Sudden unexpected, unexplained death	7	7	100
Trauma or other external factors	6	6	100
Infection	6	6	100
Deliberately inflicted injury, abuse or neglect	2	2	100
Acute medical or surgical condition	4	3	75
Suicide or deliberate self-inflicted harm	4	3	75
Chromosomal, genetic or congenital anomaly	16	10	62.5
Perinatal/neonatal event	20	10	50
Chronic medical condition	4	2	50
Malignancy	2	1	50
Total	**71**	**50**	

Key Learning Themes identified during Child Death Reviews

	Lack of integrated IT systems impacts on communication, information-sharing and recognition of vulnerability.
	Early recognition of emerging vulnerabilities is vital, to inform an appropriate response with support, advice and information to mitigate risks to the health of babies and children.
	Importance of timely communication and information-sharing within and between agencies.
	Safer Sleeping ○ Sleep positioners can be marketed as reducing risk, when they are not recommended. ○ Impact on family sleep choices when unexpectedly out-of-routine. ○ Importance of involving partners in safer sleep conversations. ○ Importance of documenting safer sleep conversations with families. ○ Baby illness as a factor in parental decision-making around co-sleeping.
	Impact of Covid 19 pandemic: ○ Reduced service capacity impacted on ability of practitioners to spend time with families and hear their voice. ○ Reduced face-to-face contact with families & visibility of the home environment was a limitation to assessments. ○ Online only services may not be acceptable or accessible to children & young people. ○ Increased social isolation compounding existing challenges faced by children, young people & families, particularly those already experiencing isolation.

Resources developed to share case learning 2021/22:

- 7 Minute Briefing: Private Fostering
- 7 Minute Briefing: Guidance when asked for informal medical advice – for health professionals
- Rapid Read: Management of blood-stained diarrhoea – for health professionals

1. **Safer Sleeping**
   To develop a multiagency approach, based on the 'prevent and protect' practice model for reducing the risk of SUDI described by the Child Safeguarding Practice Review Panel[9] in 2020. This includes the development of guidance for all practitioners around safer sleep messaging (including with partners and families) embedded within systems & processes that support effective multiagency practice across the continuum of risk.

2. **Digital solutions to improve communication**
   To prioritise the development of integrated electronic records systems to support the appropriate sharing of information & communication between practitioners working with families, particularly to support the transition of families from maternity care to community services. Well-integrated systems would allow for better sharing of information and earlier identification of emerging vulnerabilities, allowing services to offer earlier intervention and support.

3. **Infant mortality**
   For the LLR Healthy Babies Strategy Group to use this report to refresh their strategy and action plan to address the social determinants of infant mortality, including parental smoking, maternal obesity and the impact of socio-economic deprivation.

4. **Suicide & Self-harm**
   For LLR CDOP to work with stakeholders to carry out a thematic report into deaths due to suicide and self-inflicted harm in children and young people, and to share the report & recommendations to inform strategies to support mental health and emotional wellbeing of children and young people across LLR.

5. **LeDeR Reviews**
   For LLR CDOP to work collaboratively with the LLR LeDeR Programme to commence annual thematic reviews of cases, and to work together to generate clear SMART actions based on the learning themes that have been identified to support improvements in care quality, effectiveness and accessibility for children and young people with a learning disability across LLR.

CDOP Work Plan for 2022/23

- CDOP Panels every 8 weeks, with additional themed Neonatal Panels.
- Participation in the phase 1 roll-out of MBRRACE/NCMD systems integration.
- Ongoing participation in East Midlands Regional CDOP Network.
- Delivery of multiagency training sessions.
- Thematic panel and report into Suicide & Self-harm in children & young people across LLR.
- Implementation of the latest LeDeR grading system, plan for annual thematic review and report into deaths of children & young people with a learning disability across LLR.
- Ongoing development of the Key Worker role and audit of support for families.
- Ongoing work to improve the dissemination of learning from CDOP reviews.

References

1. ENGLAND. DEPARTMENT FOR EDUCATION. Working Together to Safeguard Children. London: HMSO; 2018. 116.

2. Royal College of Pathologists & Royal College of Paediatrics & Child Health. Sudden Unexpected death in infancy & childhood: Multi-agency guidelines for care and investigation. London: Royal College of Pathologists; 2016. 105.

3. ENGLAND. DEPARTMENT FOR HEALTH & SOCIAL CARE. Child Death Review Statutory & Operational Guidance (England). London: HMSO; 2018. 68.

4. Odd D, Stoinova S, Williams T, *et al*. Child mortality in England during the Covid-19 pandemic. Arch Dis Child 2021;0:1-7. Doi10.1136/archdischild-2020-320899

5. National Child Mortality Database. Second Annual Report, National Child Mortality Database Programme. Bristol: HQIP; 2021. 64.

6. National Child Mortality Database. Child Mortality and Social Deprivation, National Child Mortality Database Programme Thematic Report. Bristol: HQIP; 2021. 32.

7. National Child Mortality Database. Suicide in Children and Young People, National Child Mortality Database Programme Thematic Report. Bristol: HQIP; 2021. 37.

8. Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021. London: NHS England & NHS Improvement; 2021. 62. Available at https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf

9. The Child Safeguarding Practice Review Panel. Out of Routine: A review of sudden unexpected death in Infancy (SUDI) in families where children are considered at risk of significant harm. London: Department for Education; 2020. 56.

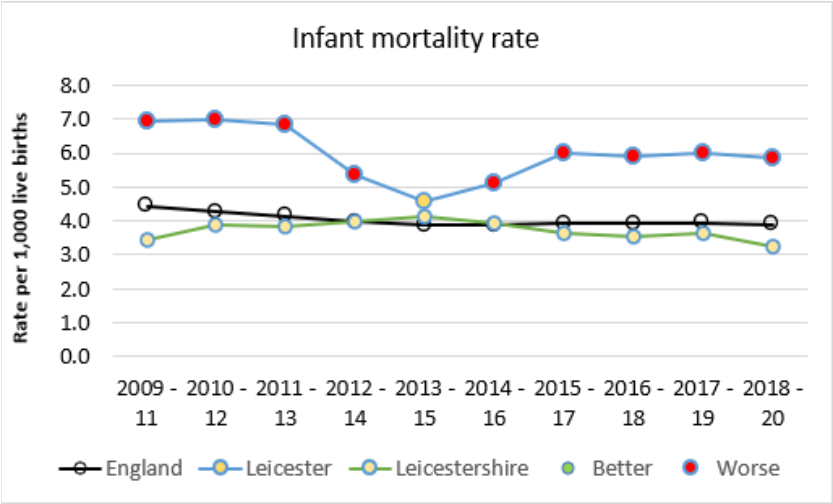
Appendix A. Cause of death categorisation

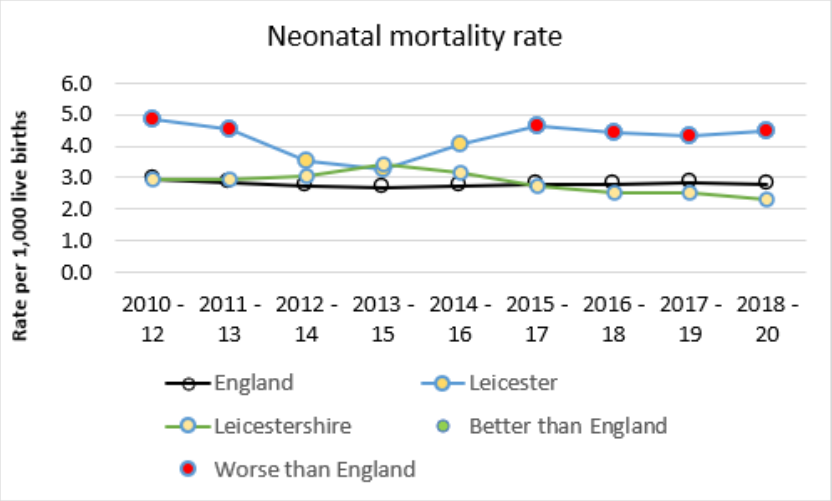
The CDOP should categorise the likely cause of death using the following schema.

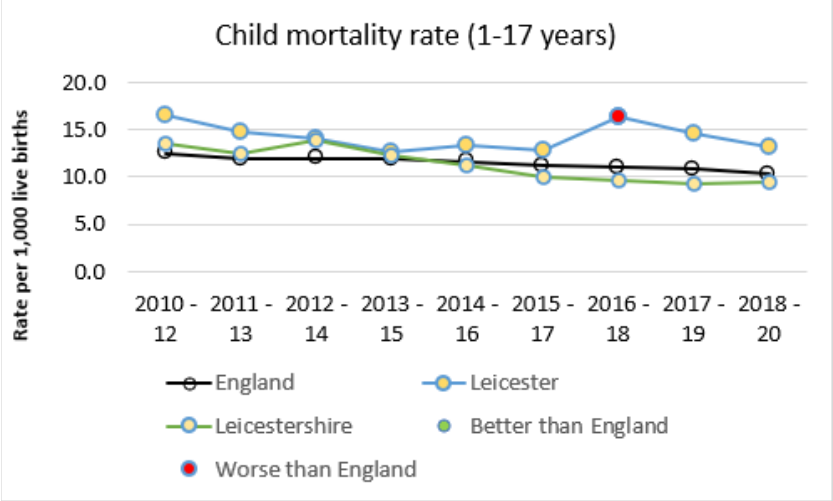
This classification is hierarchical: where more than one category could reasonably be applied, the highest up the list should be marked.

Category	Name & description of category	Tick box below
1	**Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death.	
2	**Suicide or deliberate self-inflicted harm** This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.	
3	**Trauma and other external factors** This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. **Excludes** Deliberately inflected injury, abuse or neglect (category 1).	
4	**Malignancy** Solid tumours, leukaemia's & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc.	
5	**Acute medical or surgical condition** For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy.	
6	**Chronic medical condition** For example, Crohn's disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause.	
7	**Chromosomal, genetic and congenital anomalies** Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac.	
8	**Perinatal/neonatal event** Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).	
9	**Infection** Any primary infection (i.e., not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc.	
10	**Sudden unexpected, unexplained death** Where the pathological diagnosis is either 'SIDS' or 'unascertained', at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5).	

Appendix B. LLR Summary Mortality Rate Trends 2009-2020







Appendix C. LLR CDOP Annual Report All Data 2021-22

Notifications to LLR CDOP 2021-22

Number of deaths notified: 90

Notifications by LA:

- Leicester City 48
- Leicestershire 40
- Rutland 2

Is there to be a Joint Agency Response?
- Yes 30
- No 60

Table a1: Death notifications 2017/18 to 2021/22

	2017/18	2018/19	2019/20	2020/21	2021/22
Leicester City	33	36	24	30	48
Leics & Rutland	29	35	34	27	42
Total LLR	**62**	**71**	**58**	**57**	**90**

Chart a1: Death notifications by type of response 2017/18 to 2021/22

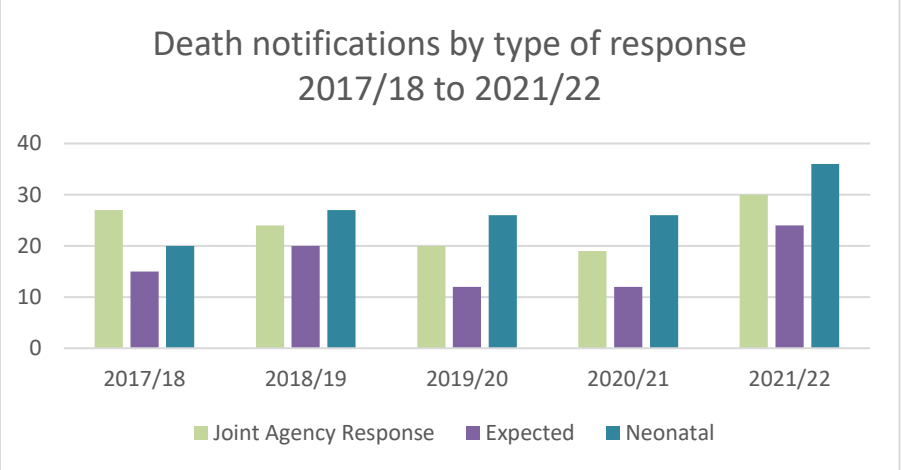


Chart a2: % of death notifications by LA and year 2017/18 to 2021/22

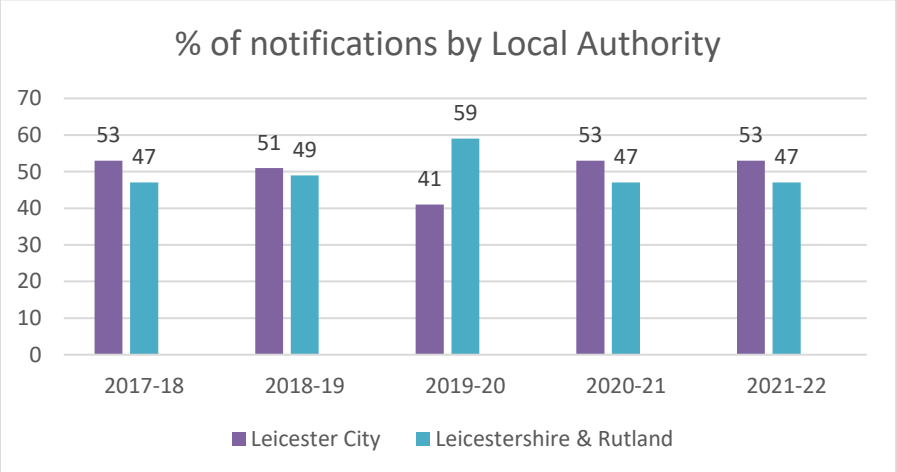


Chart a3: Death notifications by age group and year 2017/18 to 2020/21

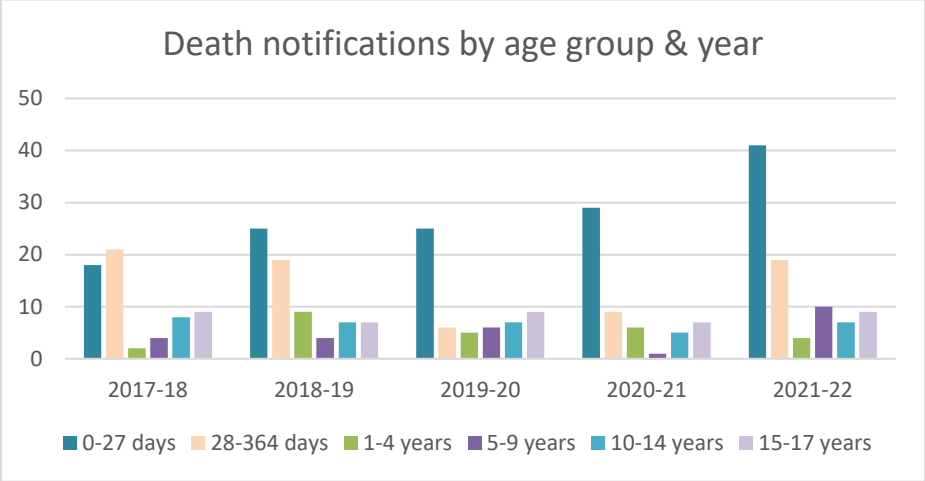


Chart a4: Death notifications by age & month of death 2021/22

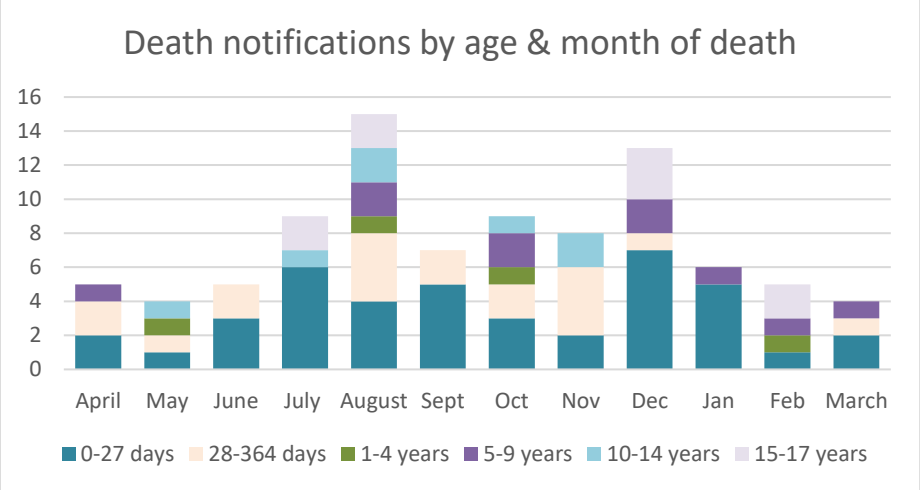


Chart a5: Death notifications by age group 2021/22

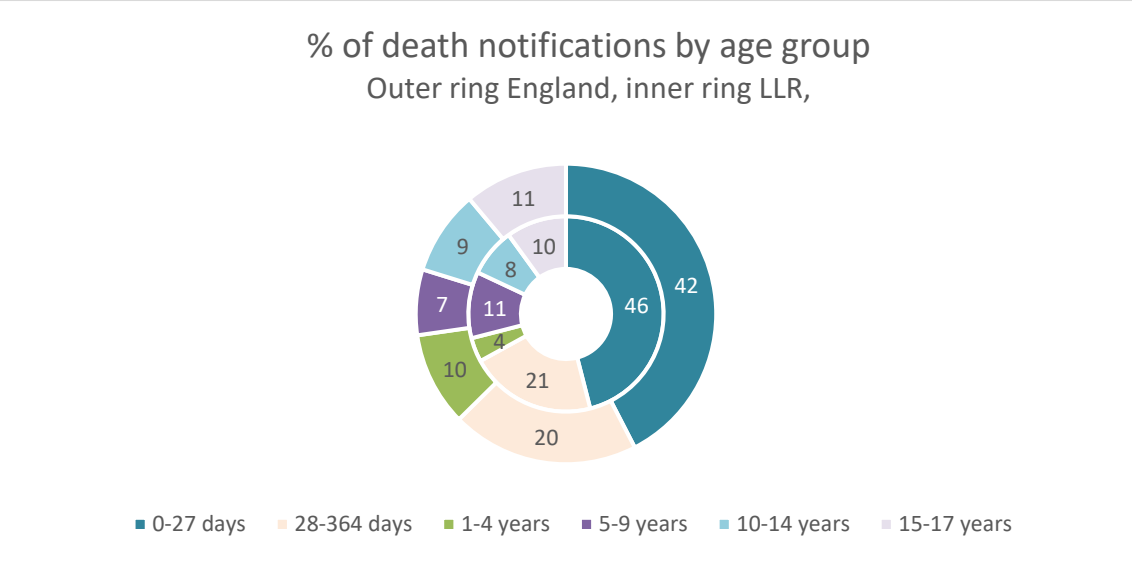
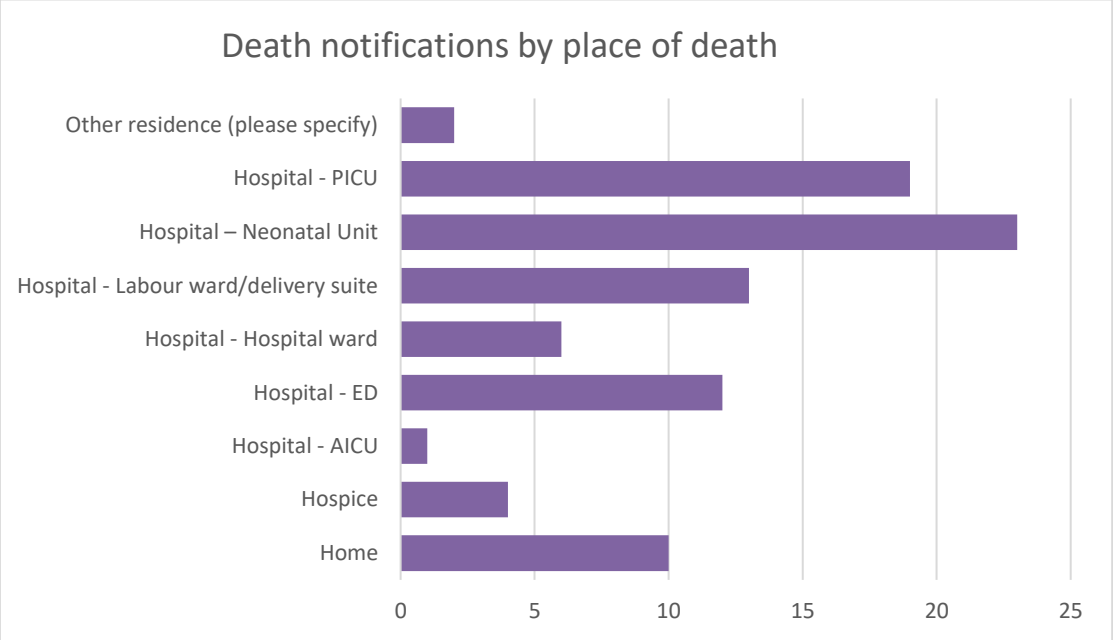


Chart a6: Death notifications by place of death 2021/22



Completed reviews 2021-2022 - Overview

Table a2: Completed CDOP reviews by year:

	2017/18	2018/29	2019/20	2020/21	2021/22
Leicester City	31	31	17	32	35
Leics & Rutland	41	24	14	32	36
Total LLR	**72**	**55**	**31**	**64**	**71**

Table a3: Completed CDOP reviews by year of death 2021/22:

Year of death	Cases
2017-18	2
2018-19	4
2019-20	22
2020-21	40
2021-22	3
Total	71

Table a4: Completed CDOP reviews by primary category of death 2021/22

NCMD Category	N	%
Perinatal/neonatal event	20	28.2
Chromosomal, genetic or congenital anomaly	16	22.5
Sudden unexpected, unexplained death	7	10
Infection	6	8.5
Trauma and other external factors	6	8.4
Acute medical or surgical condition	4	5.6
Chronic medical condition	4	5.6
Suicide or deliberate self-inflicted harm	4	5.6
Deliberately inflicted injury, abuse or neglect	2	2.8
Malignancy	2	2.8

Table a5: Completed reviews by ethnic group & age group 2021/22

Ethnic Group	0-27 days	28-346 days	1-4 years	5-9 years	10-14 years	15-17 years	Total
White	11	14	5	2	3	6	41
Unknown	0	0	0	0	0	0	0
Other	1	0	1	0	0	0	2
Mixed	4	1	0	0	0	1	6
Black or Black British	4	0	1	0	1	0	6
Asian or Asian British	8	1	2	0	5	0	16
Total	28	16	9	2	9	7	71

Chart a7: Completed CDOP reviews by age group 2021/22

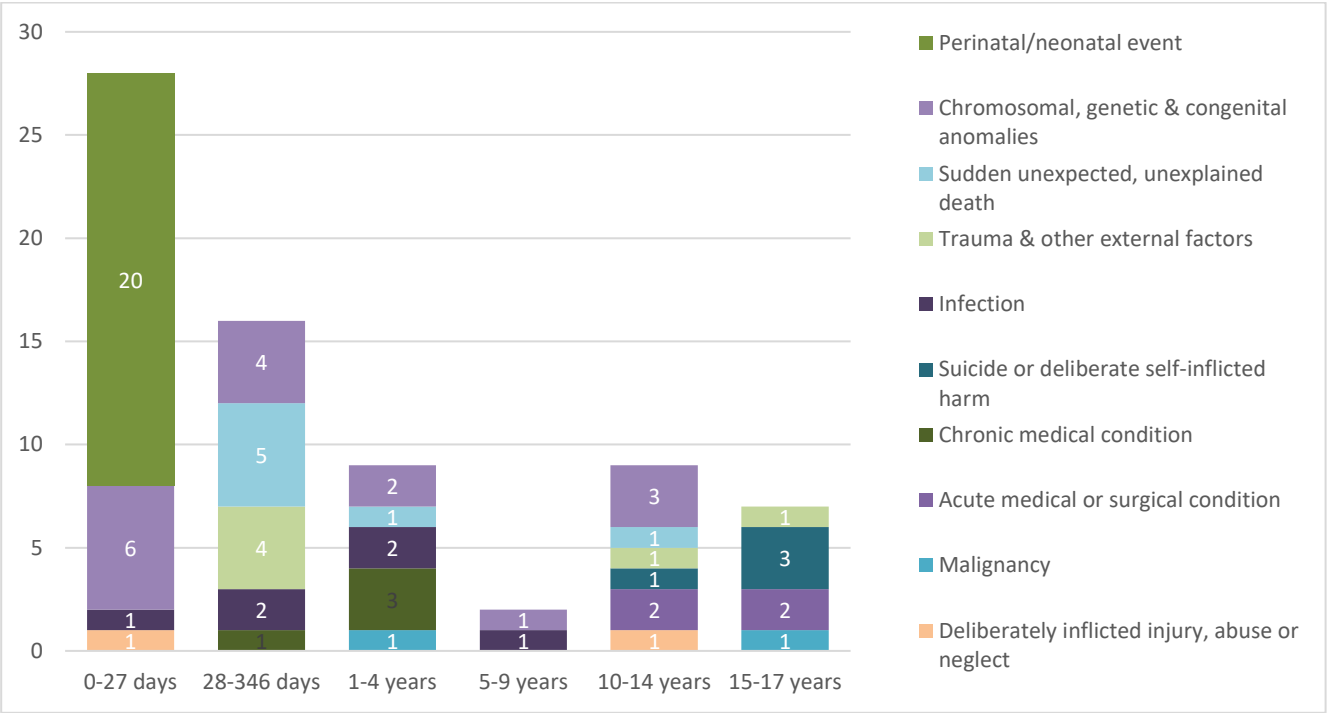


Table a6: Completed reviews by ethnic group & primary category of death 2021/22

	White	Other	Mixed	Black or Black British	Asian or Asian British	Total
Deliberately inflicted injury, abuse or neglect	2	0	0	0	0	2
Suicide or deliberate self-inflicted harm	2	0	1	0	1	4
Trauma and other external factors	5	0	0	0	1	6
Malignancy	1	0	0	1	0	2
Acute medical or surgical condition	2	0	0	1	1	4
Chronic medical condition	3	1	0	0	0	4
Chromosomal, genetic or congenital anomaly	6	0	2	1	7	16
Perinatal/neonatal event	8	1	2	3	6	20
Infection	6	0	0	0	0	0
Sudden unexpected, unexplained death	6	0	1	0	0	7
Total	**41**	**2**	**6**	**6**	**16**	**71**

Chart a8: Completed reviews by place of onset of illness/accident 2021/22

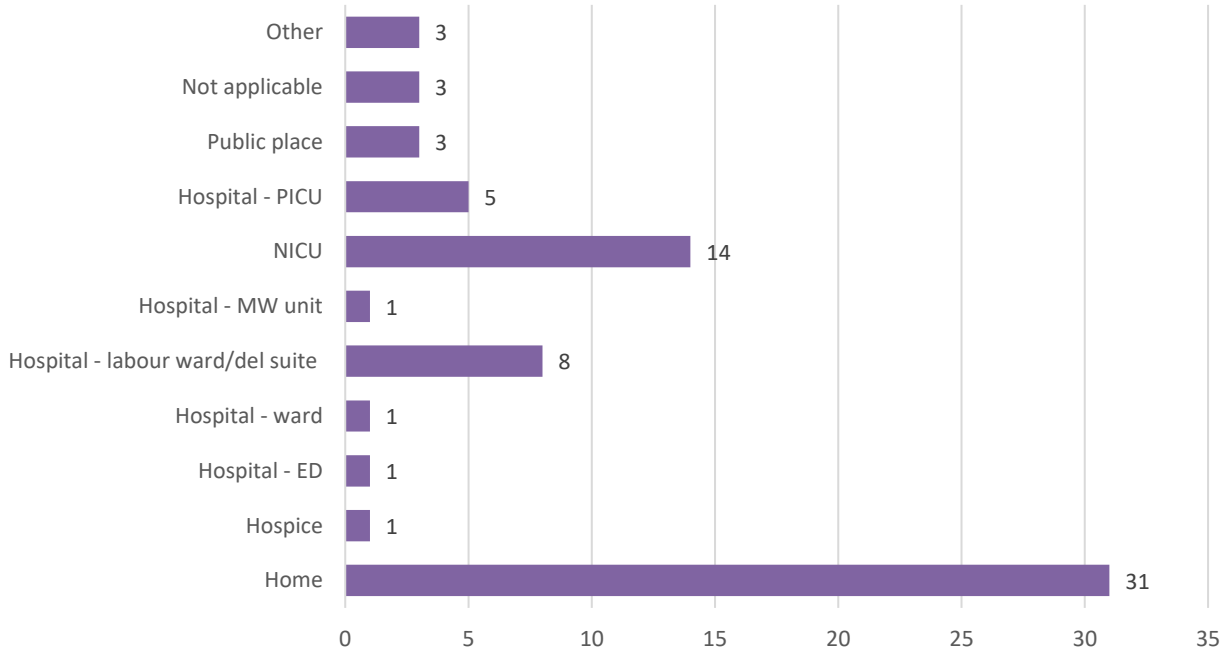
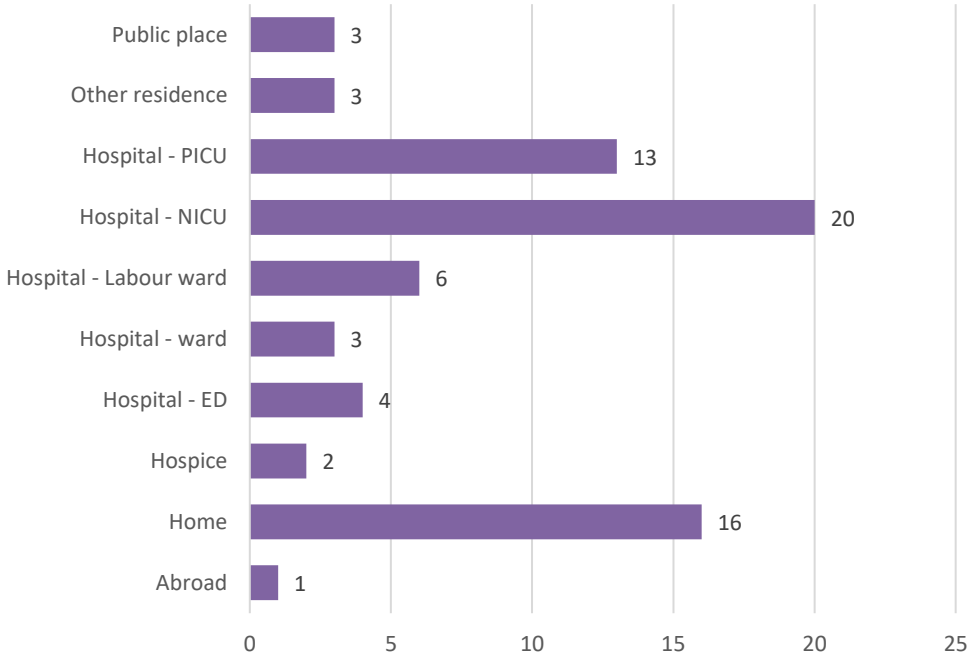


Chart a9: Completed CDOP reviews by place of death 2021/22



Completed Reviews – Modifiable Factors

% of cases with modifiable factors (CDOP): 37%
% of cases with modifiable factors (England): 37%

Table a7: Cases where modifiable factors were identified by category of death 2021/22

Primary category of death (CDOP)	Completed reviews	Modifiable factors identified	Modifiable factors identified (%)
Deliberately inflicted injury, abuse or neglect	2	2	100
Sudden unexpected, unexplained death	7	6	86
Trauma and other external factors	6	4	67
Infection	6	3	50
Suicide or deliberate self-inflicted harm	4	2	50
Perinatal/neonatal event	20	6	30
Acute medical or surgical condition	4	1	25
Chromosomal, genetic or congenital anomaly	16	2	13
Chronic medical condition	4	0	0
Malignancy	2	0	0
Total	**71**	**26**	**37**

Table a8: Cases where modifiable factors were identified by age group 2021/22

Age group	Completed reviews	Cases where modifiable factors identified	Modifiable factors identified (%)
0-27 days	28	8	29
28-364 days	16	8	50
1-4 years	9	2	22
5-9 years	2	0	0
10-14 years	9	4	44
15-17 years	7	4	57
Total	**71**	**26**	**37**

Table a9: Cases where modifiable factors were identified by ethnic group 2021/22

Ethnic Group	Completed reviews	Cases where modifiable factors identified	Modifiable factors identified %
White	41	19	46
Unknown	0	0	0
Other	2	0	0
Mixed	6	3	50
Black or Black British	6	2	33
Asian or Asian British	16	2	13
Total	**71**	**26**	**37**

Table a10: Cases where modifiable factors were identified by English Index of Multiple Deprivation (IMD) decile

IMD decile	Completed reviews	Cases where modifiable factors identified	Modifiable factors identified %
1	10	5	50
2	9	2	22
3	6	3	50
4	4	0	0
5	7	2	29
6	6	2	33
7	7	3	43
8	12	5	42
9	5	3	60
10	5	1	20
Total	**71**	**26**	**37**

Across the 26 cases where modifiable factors were identified, 6o individual factors were recorded – between 1-6 per case (mean 2.3)

Table a11: Cases with modifiable factors recorded by domain (some cases had factors identified in multiple domains) 2021/22

Domain	Cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified by LLR CDOP	% of cases where modifiable factors were identified England (2019/20)*
A: Factors intrinsic to the child	2	7	11
B: Factors relating to the family or social environment	16	62	61
C: Factors relating to the physical environment	7	27	27
D: Factors relating to service provision	11	42	35

***Data taken from NCMD 2nd Annual Report 2019/2020**

Table a12: Most frequently recorded modifiable factors 2021/22:

No of cases	Most frequently recorded modifiable factors:
9	Parental smoking
6	Maternal obesity
6	Service provision - education
5	Unsafe sleeping practices
4	Service provision - communication
4	Service provision - local/national commissioning
2	Safeguarding
1	Public safety
1	Vehicle/transport related
1	Service provision - human factors
1	Child physical condition
1	Child mental health condition

CDOP Theme: Infant Mortality

Cases reviewed 2021-22 of deaths occurring under the age of 1 year: 44

Table a13: Categories of death for children under 1 year – completed reviews

Category of death	No of cases	Cases where modifiable factors identified	% of cases where modifiable factors identified
Perinatal/neonatal event	20	6	30
Chromosomal, genetic or congenital anomaly	10	1	10
Sudden unexpected, unexplained death	5	5	100
Trauma or other external factors	4	2	50
Infection	3	1	33
Deliberately inflicted injury, abuse or neglect	1	1	100
Chronic medical condition	1	0	0
Total	44	16	

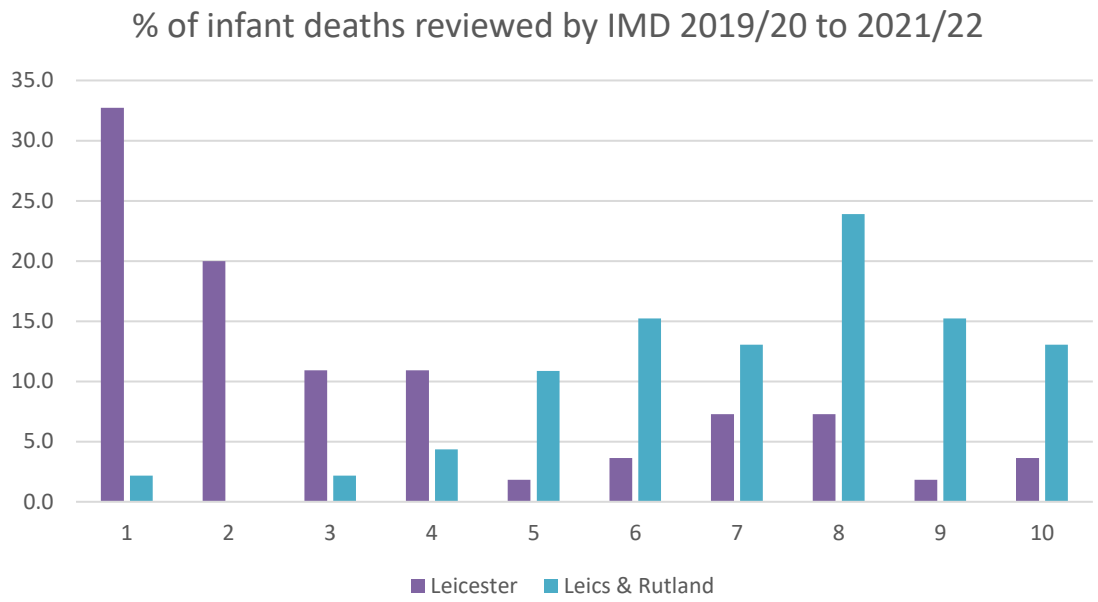
Table a14: Modifiable factors were identified in 16 cases (36%) & noted in all 5 SUUD cases. Some cases had more than one factor noted

Most frequently recorded modifiable factors:	No of cases
Parental smoking	8
Maternal obesity	6
Unsafe sleeping practices	5
Service provision issues	4
Maternal behavioural - other	2
Safeguarding-related issues	1
Maternal drug/alcohol misuse	1
Maternal health issues	1
Distance to travel to access specialist services	1

Table a15: Infant mortality & deprivation

Deprivation decile	Deaths reviewed 2019/20 to 2021/22			% of deaths		
	Leicester	Leics & Rutland	LLR	Leicester	Leics & Rutland	LLR
D1	18	1	19	**32.7%**	**2.2%**	**18.8%**
D2	11	0	11	**20.0%**	**0**	**10.9%**
D3	6	1	7	**10.9%**	**2.2%**	**6.9%**
D4	6	2	8	**10.9%**	**4.4%**	**7.9%**
D5	1	5	6	**1.8%**	**10.9%**	**5.9%**
D6	2	7	9	**3.6%**	**15.2%**	**8.9%**
D7	4	6	10	**7.3%**	**13.0%**	**9.9%**
D8	4	11	15	**7.3%**	**23.9%**	**14.9%**
D9	1	7	8	**1.8%**	**15.2%**	**7.9%**
D10	2	6	8	**3.6%**	**13.0%**	**7.9%**
Total	55	46	101	**100.0%**	**100.0%**	**100.0%**

Chart a10: % of infant deaths reviewed by Index of Multiple Deprivation 2019/20 to 2021/22



Sudden Unexpected Deaths in Infancy (SUDI)

In the period between 1st April 2016 and 31st March 2022, CDOP reviewed the deaths of 15 children who died under 1 year of age, and whose deaths were classified as Sudden Unexpected Unexplained Deaths. This will not include those children whose medical cause of death was deemed to be due to external causes associated with unsafe sleeping.

Table a16: SUUD Infant Case characteristics – 2015/16 to 2020/21 compared with 2016/17 to 2020/21

	2015/16 to 2020/21 (n=15)		2016/17 to 2021/22 (n=15)	
	N	%	N	%
Bottle fed	12	80 %	11	73 %
First born	4	27 %	6	40 %
Preterm	10	67 %	9	60 %
IMD 1&2	7	47 %	6	40 %
Birthweight <2.5kg	9	60 %	9	60 %
Mean maternal age	28.8 (20-36)		28.73 (20-36)	
Medical cause of death:				
'Unascertained'	12	80 %	11	73 %
'SIDS'	3	20 %	4	27 %
Modifiable Factors				
Unsafe sleeping	10	67 %	9	60 %
Parental smoking	9	60 %	9	60 %
One or more MF	13	87 %	13	87 %
More than one MF	10	67 %	11	73 %

CDOP Theme: LeDeR cases

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

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

Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) Policy 2021[8]

In addition to the Child Death Review process, information is gathered in the form of a 'pen portrait' of the child or young person, and since September 2020, areas of best practice are identified, and the quality of care provided is graded.

Modifiable factors were identified in 3 of the 16 LeDeR cases reviewed.

Table a17: Number of LeDeR cases reviewed by LLR CDOP

	2020-21	2021-22	Total
Number of cases reviewed	8	8	16

Table a18: Categories of death of LeDeR Cases

Category of death	No of cases
Chromosomal, genetic or congenital anomaly	7
Acute medical condition	4
Chronic medical condition	3
Deliberately inflicted injury, abuse or neglect	1
Infection	1
Total	16

Table a19: LeDeR care grading – completed in 13/16 cases:

Grade of care	No of cases
1. This was excellent care and met current best practice.	2
2. This was good care, which fell short of current best practice in only one minor area.	7
3. This was satisfactory care (it fell short of expected good practice in some areas, but this did not significantly impact on the person's wellbeing.	2
4. Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.	0
5. Care fell short of current best practice in one of more significant areas, although this is not considered to have had the potential for adverse impact on the person, some learning could result from a fuller review of the death.	0
6. Care fell far short of expected good practice and this contributed to the cause of death.	2
Total	13

Areas of best practice were identified in 4 of these 13 cases

Top 3 learning themes from the 16 cases reviewed:

1. **Communication**
   Of the 4 cases where best practice was identified, good or excellent communication between agencies was noted, including between hospital and community teams, around areas such as end of life care and complex decision making. The role of virtual platforms in enhancing this during the Covid-19 pandemic was also noted.

   Issues with poor communication, either between different teams of professionals or between professionals and families were noted the most frequently.

2. **Issues of care coordination/transition**
   Importance of good care coordination, of families being aware of who the lead professionals were, and of effective transition of care from children's to adult services were highlighted.

3. **Access to services at the right time**
   Both in terms of physical accessibility and availability, ensuring equity of access for children and young people to the services they need.

As part of the work plan for the coming year, CDOP will work collaboratively with colleagues' from LeDeR to develop SMART actions (utilising the new grading system that LeDeR has adopted). In addition, in order to support the identification of themes, CDOP will hold an annual themed panel, which will be supported by a themed analysis report.

CDOP Theme: Suicide/Self-harm

The National Child Mortality Database published their thematic report into Suicide in Children & Young People, looking at deaths that occurred or were reviewed by a CDOP between 1st April 2019 & 31st March 2020.

https://www.ncmd.info/publications/child-suicide-report/

Key findings:

- Services should be aware that child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England including urban and rural environments, and across deprived and affluent neighbourhoods
- 62% of CYP had suffered a significant personal loss in their life prior to their death (including bereavement, and living losses such as loss of friends and routine due to moving home, school or other close relationship breakdown)
- Over 1/3 of CYP had never been in contact with mental health services
- 16% of CYP had a confirmed neurodevelopmental condition at the time of their death – this appears higher than the general population
- Almost a quarter of CYP reviewed had experienced bullying either face to face or cyberbullying, the majority reporting bullying in schools.

CDOP Theme: Deprivation

The National Child Mortality Database published their thematic report into Child Mortality & Social Deprivation, looking at deaths that occurred or were reviewed by a CDOP between 1st April 2019 & 31st March 2020.

https://www.ncmd.info/publications/child-mortality-social-deprivation/

Key findings:

- Clear association between risk of death and deprivation across all categories except malignancy
- Relative 10% increase in risk of death between each decile of increasing deprivation
- >1 in 5 deaths might be avoided if children living in the most deprived areas had the same mortality risk as those living in the least deprived
- Increased proportion of deaths with modifiable contributory factors with increasing deprivation
- 1 in 12 child deaths reviewed in 2019/20 identified 1 or more factors related to deprivation

Recommendation:

Use of the data in this report to develop & monitor the impact of future strategies to reduce social deprivation and inequalities

Action by:

Policy makers, Public Health Services, service Planners and Commissioners at a local & national level.

LLR CDOP Case Learning – completed reviews 2021/22

Learning identified? Yes 50/71 cases (70.4%)
No 21/71 cases (29.6%)

Table a20. Cases where learning identified by category of death

Category of death	Total no of cases	Cases where learning identified	% of cases where learning identified
Sudden unexpected, unexplained death	7	7	100
Trauma or other external factors	6	6	100
Infection	6	6	100
Deliberately inflicted injury, abuse or neglect	2	2	100
Acute medical or surgical condition	4	3	75
Suicide or deliberate self-inflicted harm	4	3	75
Chromosomal, genetic or congenital anomaly	16	10	62.5
Perinatal/neonatal event	20	10	50
Chronic medical condition	4	2	50
Malignancy	2	1	50
Total	**71**	**50**	

Key learning themes identified:

1. Lack of integrated IT systems impacts on communication, information sharing and recognition of vulnerability factors for babies, children and young people.
2. Safer Sleeping
    - Unknown risks posed by sleep positioners – not recommended for use, but often perceived by families & professionals as enhancing safety rather than increasing risk
    - Impact on family sleep choices when unexpectedly out-of-routine,
    - Importance of involving partners in safer sleep conversations,
    - Importance of documenting safer sleep conversations with families,
    - Baby illness as a factor in parental decision-making around co-sleeping
3. Importance of early recognition of emerging vulnerabilities, to inform an appropriate response with support, advice and information to mitigate risks to the health of babies and children.
4. Importance of timely communication and information-sharing within and between agencies
5. Impact of Covid 19
    - Reduced service capacity impacted on ability of practitioners to spend time with families and hear their voice,
    - Reduced face to face contact with families & visibility of the home environment was a limitation to assessments
    - For some children, young people & families, face to face work may be more accessible and acceptable than online or virtual options
    - Increased social isolation compounding existing challenges faced by children, young people & families, particularly those already experiencing isolation.

7 Minute Briefings developed to share case learning for cases reviewed 2021/22:

- Private Fostering
- Informal Medical Advice – for health professionals

Rapid Read for health professionals on Blood-stained diarrhoea

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	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 Community Pharmacy Services Update 2. Winter Urgent/Emergency Care provision – update 3. Winter Flu update 4. Alcohol Strategy Update 5. Draft General Fund Revenue Budget 2023-24	1. This item will be the predominant focus of the meeting, given the interest shown by the Commission in June 2022. 2. Short report and verbal update outlining the latest position 3. To be presented by the ICB – with input from Public Health 4. Report requested previously 5. Standard item to be taken to all commissions as part of the budget-setting process.

Date	Topic	Notes
16 March 23	1. NHS Urgent and Emergency Care Update 2. Maternity Services Update 3. 0-19 Healthy Child Programme Consultation 4. Sexual Health Services Consultation 5. Leicester, Leicestershire and Rutland Child Death Overview Annual Report	1. An update requested at the meeting on 17 January. 2. Deferred from meeting on 1 December 3. To be presented as part of the consultation process. 4. Full paper on initial findings to follow the brief verbal update provided at 17 January meeting. 5. To be taken for information

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 2022	TBC
Health Inequalities Update – impact of the cost-of-living crisis	Likely to be a public health/NHS joint item.	Part of 2023/24 work programme.
Update on UHL Finances		Summer 2023
Self-neglect	Arising from the joint scrutiny discussion on the Safeguarding Adults Panel, a report on this was requested.	TBC
The Work of No. 5	A presentation on the work No 5 following the site visit in September 2022.	Summer 2023
Oral Health Services	A further report to be brought to the commission in 2023/24	Part of 2023/24 work programme.

Topic	Detail	Proposed Date
Virtual Wards	An update on this work to be brought in 2023	Part of 2023/24 work programme.
Review Report – BLM and NHS Workforce: response to recommendations	A response report to the task group recommendations to be provided by health partners.	TBC
Mental Health Strategy Update	Likely to be part of the next ASC/HWB joint scrutiny meeting	TBC
Updates on Obesity (whole systems approach)	Completed in Dec 2021, an update requested in the next cycle of meetings.	TBC
Leicester Children's Health and Wellbeing Survey 2021/22	The findings of the survey to come to a future meeting.	Summer 2023
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. An update was taken to JHOSC on 6 February.	TBC
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. An update was taken to JHOSC on 6 February.	June 2022, with further updates expected later.
Air Quality Pollution	Joint item with EDTCE	TBC 2022/23
Health and Wellbeing Strategy	Progress update since it was launched in 2019	Part of the 2023/24 work programme
Tobacco Control (Public Health)		TBC