Leicestershire County Council

Meeting: **Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee**

Date/Time: **Monday, 14 December 2020 at 10.00 am**

Location: **Microsoft Teams video conferencing.**

Contact: **Euan Walters (0116 3052583)**

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Membership

Dr. R. K. A. Feltham CC (Chairman)

Cllr. T. Aldred	Mr. J. Morgan CC
Mukesh Barot	Mr. J. T. Orson JP CC
Cllr. P. Chamund	Mrs. R. Page CC
Cllr. L. Fonseca	Mr T. Parton CC
Mrs. A. J. Hack CC	Cllr. D. Sangster
Mrs S Harvey	Dr Janet Underwood
Dr. S. Hill CC	Miss G. Waller
Cllr. P. Kitterick	Cllr. P. Westley
Cllr. M. March	

Please note: The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee meeting on Monday 14 December 2020 at 10:00am will not be open to the public in line with Government advice on public gatherings.

This meeting will be filmed for live or subsequent broadcast via YouTube: https://www.youtube.com/channel/UCWFpwBLs6MnUzG0WjejrQtQ.

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 15 October 2020.		(Pages 5 - 16)
2.	Question Time. *A number of questions have been submitted by the public and the questions and answers will be published on the day of the meeting.*		
3.	Questions asked by Members.		

4. Urgent items.

5. Declarations of interest.

6. Presentation of Petitions.

   Two petitions have been received in relation to St Mary's Birthing Centre in Melton and these will be considered under Agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals".

7.	UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals".	East Leicestershire and Rutland, Leicester City and West Leicestershire CCGs and the University Hospitals of Leicester NHS Trust	(Pages 17 - 66)
8.	Covid-19 Vaccine in Leicester, Leicestershire and Rutland. *A verbal update will be provided by Caroline Trevithick, Chief Nurse and Executive Director of Nursing, Quality and Performance, West Leicestershire Clinical Commissioning Group.*		
9.	Impact of Covid-19 on Dental Services in Leicestershire, Leicester and Rutland.	NHS England	(Pages 67 - 80)
10.	East Midlands Ambulance Service Clinical Operating Model and Specialist Practitioners.	East Midlands Ambulance Service NHS Trust	(Pages 81 - 84)

11. Date of next meeting.

    The next meeting of the Committee is scheduled to take place on Friday 5 March 2021 at 10:00am.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 1

Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held via Microsoft Teams video link on Thursday, 15 October 2020.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Mrs. A. J. Hack CC	Mr. J. T. Orson JP CC
Mrs S Harvey	Mrs. R. Page CC
Dr. S. Hill CC	Mr T. Parton CC
Cllr. P. Kitterick	Cllr. D. Sangster
Harsha Kotecha	Dr Janet Underwood
Cllr. M. March	Miss G. Waller

In attendance

Gordon King, Director of Adult Mental Health, Leicestershire Partnership NHS Trust (minutes 17 and 18 refer).
John Edwards, Associate Director for Transformation, Leicestershire Partnership NHS Trust (minutes 17 and 18 refer).
Paula Vaughan, Head of Commissioning, Leicester, Leicestershire and Rutland Clinical Commissioning Groups (minutes 17 and 18 refer).
David Williams, Director of Strategy and Business Development, Leicestershire Partnership NHS Trust (minute 19 refers).
Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Groups (minute 20 refers).
Rebecca Brown, Acting Chief Executive, University Hospitals of Leicester NHS Trust (minute 20 refers).
Mark Wightman, Director of Strategy and Communications, University Hospitals of Leicester NHS Trust (minute 20 refers).
Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG (minute 20 refers).

Note: The meeting was not open to the public in line with Government advice on public gatherings however the meeting was broadcast live via YouTube.

12. Question Time.

The Chief Executive reported that five questions had been received under Standing Order 34.

1. Question by Sally Ruane

The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee were told in January that there will be another 139 beds in the local acute hospitals under the current proposal for reorganisation and the Pre-Consultation Business Case also states there will be 139 more beds. However, the bed bridge data and accompanying narrative make it difficult to see how more than 41 new beds will be guaranteed since 28 appear to

be a changed use of existing beds and the remaining 70 beds are described as contingent, they are not covered by the £450m investment and it is not clear where they will go – ie what space they will occupy. Are the CCGs able to confirm that all of these 139 beds will actually exist by 2024 and clarify this confusion?

Reply by the Chairman:

With regards to the 28 beds that are currently being used for the Hampton suite, University Hospitals of Leicester will repatriate these for acute activity. The 41 and 70 beds = 111 beds, which will be provided as additional beds plus the 28 repatriated beds, giving a total of 139 beds by 2024.

Supplementary Question

Sally Ruane asked for further explanation as to why the 28 beds currently being used for the Hampton Suite were going to be counted as additional beds and where the 70 additional new build beds would be located and whether they would be funded by the additional £450m investment.

At the invitation of the Chairman, Mark Wightman Director of Strategy and Communications, UHL explained that the Hampton Suite was currently a step-down non-acute ward which did not admit acute medical patients. Under the reconfiguration proposals those beds would become acute beds. Mark Wightman also stated that the 70 additional beds would be located at the LRI and Glenfield Hospital but the precise allocation for each had not been decided yet.

2. Question by Giuliana Foster:

I understand the consultation process on the proposal for re-organising hospital services will include focus groups and telephone interviews. If this is correct, are the questions being used in these focus groups and telephone interviews in the public domain? Can we find out what these questions are?

Reply by the Chairman:

The questions outlined in both the online and printed consultation questionnaire will be used in the focus groups. We would expect that, in these sessions, participants will concentrate on the open questions and discuss and exchange views. The discussion will be captured and contribute to the consultation in exactly the same way as the completed online and hard copy questionnaire responses. Anyone arranging a telephone interview will also be taken through the same questionnaire.

3. Question by Giuliana Foster:

I understand the Midlands and Lancashire Commissioning Support Unit is being used to analyse consultation responses. Given that the CCG's already work with the Midlands and Lancashire Commissioning Support Unit in many ways, would contracting this work out to university-based academics not have been a better way to achieve real independence in the analysis of responses?

Reply by the Chairman:

The Clinical Commissioning Groups in Leicester, Leicestershire and Rutland undertook a competitive tendering process at the beginning of 2020 in order to procure a suitable supplier to undertake the evaluation, analysis and reporting of the consultation. A key requirement was prior experience of having previously evaluated consultations on a similar scale to the proposals to invest £450m in Leicester's hospitals. The process attracted a number of suppliers, from both the public and private sectors. Responses to the specification by each potential provider were assessed against set criteria, leading to the appointment of Midlands and Lancashire Commissioning Support Unit (CSU) based on their ability to meet the full requirements of the specification.

Supplementary Question

Giuliana Foster stated that Midlands and Lancashire CSU were a paid contractor of the NHS and questioned how they were independent from the Clinical Commissioning Groups?

At the invitation of the Chairman, Andy Williams, Chief Executive, LLR CCGs explained that Midlands and Lancashire CSU were independent to a large extent because they were not accountable to LLR CCGs and were subject to a completely separate governance system.

4. Question by Penny Campling.

What is the plan for specialist therapies for people with complex and emotional difficulties beginning in childhood, including sexual abuse, who need longer individual therapy and don't fit into other pathways?

Reply by the Chairman:

The current services in Leicester, Leicestershire and Rutland have provided various psychological interventions that have been used to support people with complex and emotional difficulties rooted in childhood trauma. However, LPT have identified that there is a need for better co-ordination and coherence of the psychological therapy provision for individuals with such presenting need. Presently, due to the organisation of services, the offer of therapy to individuals is determined by referrals into specific services rather than based on a holistic view of their need. Due to current structures people are waiting, in some instances for very long periods of time for that therapy and many individuals with such needs are not getting access to therapy across our system. This is something LPT wants to change given the crucial importance of supporting people with trauma.

LPT's plans are to integrate and join up services better in the community to organise and support the offer of therapy and care based on service user need not service configuration. LPT wants to increase access to those that need therapy and give LPT the opportunity to offer that without the existing long waits. LPT clinicians are currently developing a complex trauma pathway based on the evidence. This is being designed alongside the other therapy related pathways so that it is as coherent as possible recognising that people's needs are often complex. Whilst the absolute detail will obviously be developed as part of the engagement with staff and service users the

expected outcomes and overarching design will be ready for the consultation of the model.

5. Question by Penny Campling

Given national pressures on waiting lists and that some people have been waiting for psychotherapy for over a year, how does the trust intend to ensure that these who have been assessed, told which particular type of therapy is most appropriate for them but have been waiting a long time for that therapy to begin will have this agreement between the patient and the service honoured?

Reply by the Chairman:

The national pressures on waiting lists for therapy are seen to an even greater degree within the Leicester, Leicestershire and Rutland region with some people waiting up to 3 years. This has been the situation for some time. There are many people waiting a long time for specific therapeutic interventions. LPT continue to implement a rolling review of service users facing long waits and will discuss and jointly agree the best option for them including whether to continue to wait for the original therapy offer or to pursue alternative therapy options.

Supplementary Question

I am aware that patients that have been through a detailed psychotherapy assessment have received letters discharging them back to the GP. Can you explain this?

At the invitation from the Chairman, John Edwards, Director of Transformation, Leicestershire Partnership NHS Trust responded to say that he was not aware of such discharge letters being sent and he would conduct a review and make sure it was not happening.

13. Questions asked by Members.

The Chairman reported that no questions had been received from members under Standing Order 7(3) and 7(5).

14. Urgent items.

There were no urgent items for consideration.

15. Declarations of Interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

Mr. T. Parton CC declared a personal interest in agenda item 6: Step up to Great Mental Health, and agenda item 7: Liaison Mental Health Services as he had previously been a psychiatric patient in Leicestershire.

Mrs. A. Hack CC declared a personal interest in agenda item 8: Transforming Care: Learning Disabilities and Autism as she worked for an organisation that provided housing for people with learning disabilities.

16. Presentation of Petitions.

The Chairman reported that no petitions had been received under Standing Order 35.

17. Step up to Great Mental Health.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on progress with the Step up to Great Mental Health improvement programme. A copy of the report, marked 'Agenda Item 6', is filed with these minutes.

The Committee welcomed to the meeting for this item Gordon King, Director of Adult Mental Health, LPT, John Edwards, Associate Director for Transformation, LPT, and Paula Vaughan, Head of Commissioning, Leicester, Leicestershire and Rutland Clinical Commissioning Groups.

Arising from discussions the following points were noted:

(i) A Clinical Senate had undertaken a review of the Step up to Great Mental Health transformation proposals and whilst formal feedback was awaited, the informal feedback had been positive with the increased partnership working being particularly welcomed. As part of this partnership working multi-disciplinary teams would be created using staff from health and local authority social care teams.

(ii) In response to concerns raised by a member that removing dormitory accommodation at the Bradgate Unit would reduce the overall number of beds at the unit, reassurance was given that the process would be managed in a phased way and there would be no sudden drop off in bed numbers. Members requested that they be provided with the precise figures for the numbers of beds currently in the Bradgate Unit and the proposed numbers of beds after the dormitories were removed.

(iii) Concerns were raised that some patients could fall into a gap between addiction services and mental health services. In response reassurance was given that conversations were taking place with the Turning Point substance misuse service and the drug and alcohol service at University Hospitals of Leicester NHS Trust to ensure patients were not moved from service to service unnecessarily and a 'no wrong front door' policy was in place which meant that a patient would never be turned away and told to present elsewhere. Signposting would not direct patients away from the 'door' but should make clear to patients how to access the services they needed. The Central Access Point played a crucial role in ensuring that patients were directed to the correct service straightaway without having to be referred through several different departments. A campaign had taken place using social media such as Facebook to publicise the Central Access Point phone number but further work was needed to take place in this regard to increase awareness. The NHS 111 telephone number redirected callers to the Central Access Point without the caller having to redial.

(iv) In response to a suggestion from a member it was agreed that a flow chart would be produced to show to a lay person how the LPT services all fitted together.

(v) Performance and outcomes would be measured at neighbourhood level and the detail on this would be brought to future meetings of the Committee in iterations.

(vi) A member asked for more statistics around the services referred to in the report particularly in relation to the number of patients using the Central Access Point to give an idea of the changes in demand that were taking place. Members also asked for service user data to be broken down into geographical areas showing where there was unmet need and requested information on how LPT was tackling mental health issues in ethnic minorities and particularly those patients of African heritage. In response it was explained that there was no clear way of understanding the numbers of people that did not make it into the services they needed. Work was currently taking place to understand the demographics of current service users. It was agreed that all the requested information would be provided to the Committee at a later date and would definitely be available by the next time the Committee considered the topic.

(vii) It was important that mental health voluntary services were supported and financed. The Mental Health Investment Standard covered the voluntary sector

(viii) LPT were confident that there would be equal access across LLR to good standard of service but were not complacent in this regard and recognised that there would be challenges.

(ix) In response to concerns that families and carers of patients were not always kept updated on where a patient was receiving treatment reassurance was given that this was not typical and close working took place with patients' carers. If specific cases were known where the communication with carers or families had been poor then these could be investigated outside of the meeting.

RESOLVED:

(a) That the Step up to Great Mental Health improvement programme be welcomed and supported;

(b) That Leicestershire Partnership NHS Trust be requested to provide a further update to the Committee in early 2021.

18. Liaison Mental Health Services.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on proposed changes to Liaison Mental Health Services. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Gordon King, Director of Adult Mental Health, LPT, John Edwards, Associate Director for Transformation, LPT, and Paula Vaughan, Head of Commissioning, LLR CCGs.

Arising from discussions the following points were noted:

(i) The Liaison services provided mental health support for any patient attending the Emergency Department and general wards at University Hospitals of Leicester with any complex diagnosis. This included patients with conditions such as M.E/Chronic

Fatigue Syndrome. The services were available 24 hours a day 7 days a week. Members raised concerns that Leicestershire residents that lived in places such as Hinckley and Harborough often accessed Health services out of Leicestershire because they were closer and therefore they would not benefit from the mental health services provided to UHL patients. Concerns were also raised around the handover process for these patients as they were transferred from an out of county hospital to LPT. In response LPT agreed to give further consideration to the handover process and reassurance was given that there were strong links between LPT and health services in Northamptonshire and work was ongoing to ensure Liaison services were in place for Northamptonshire hospitals. It was confirmed that the IAPT service was for all LLR patients wherever they went for their inpatient care. Inpatient to IAPT was a self-referral portal which would make the handover process easier.

(ii) Many patients from other counties such as Lincolnshire came to UHL to receive complex treatment such as renal care and it was questioned how those patients' mental health needs would be managed once they were discharged from UHL. LPT agreed to give this issue further consideration and discuss with renal specialists if necessary.

(iii) The Liaison service would be integrated with community based mental health services which would include face to face therapy in towns and also online services. To supplement this, as of April 2021 Primary Care Networks would receive funding specifically for mental health practitioners.

(iv) The end of life team carried out a large amount of work with patients and families whilst the patient was still alive but there needed to be a better link up between the end of life team and bereavement services once the patient was deceased to ensure families continued to receive support.

(v) In response to a question regarding how the changes to Liaison Mental Health Services would affect throughput of patients it was explained that there was expected to be a reduction in Emergency Department attendance but overall throughput would not be affected because although the different services had been brought together they were responsive and would still treat the same number of patients.

RESOLVED:

That the proposed changes to Liaison Mental Health Services be supported but that LPT be requested to give consideration to how the mental health of patients crossing county boundaries for treatment would be managed.

19. <u>Transforming Care – Learning Disabilities and Autism.</u>

The Committee received a joint presentation from Leicestershire County Council (LCC) and Leicestershire Partnership NHS Trust (LPT) regarding the Transforming Care Programme which aimed to support people with Learning Disabilities and Autism through

the healthcare system. A copy of the presentation slides, marked ‘Agenda Item 8’, is filed with these minutes.

The Committee welcomed to the meeting for this item Peter Davis, Assistant Director, Adults and Communities Department, LCC and David Williams, Director of Strategy and Business Development, LPT.

Arising from discussions the following points were noted:

(i) The Learning Disabilities Mortality Review (LEDER) pilot took place in Leicestershire and the key themes which were identified in Leicestershire were very similar to those which arose nationally. Links to the national and Leicestershire LEDER documents would be circulated to members after the meeting so they could look at this in more detail. The issue of people with learning disabilities being disadvantaged whilst receiving healthcare was one which had only begun to be explored recently therefore little data was available regarding trends over time. In response to a request from a member for the figures on life expectancy for people with Learning Disabilities and Autism it was agreed that the link to the LEDER Annual report would also be circulated to Members after the meeting.

(ii) A member raised concerns regarding the lack of progress regarding patients with learning disabilities given that the abuse taking place at the Winterbourne View care home in Bristol had been exposed in 2011 and David Cameron had highlighted the issues whilst he was Prime Minister. In response it was acknowledged that not enough progress had been made which was why the issue needed greater publicity and more people talking about it.

(iii) There was a variance across Leicester, Leicestershire and Rutland (LLR) with regards to the amount of people that received annual health checks and the aim was that the national indicator of 67% would be achieved across the whole of LLR, though ideally a figure higher than 67% would be reached. Currently for LLR the figure was 19% (year to date) and improvement was required across the whole of LLR not just in particular geographical areas. The Covid-19 pandemic had not greatly affected the figures for health checks carried out therefore there was scope for improving the figures regardless of Covid-19. When trying to understand why some patients were not having health checks it should be noted that every service was busy but also patient choice was a factor and it was important to emphasise to patients the importance of having an Annual Health check. A project was being undertaken which focused on people that had not had their annual health check for over 2 years and explored the reasons why.

(iv) The system was working in a more integrated way and partnership working took place to ensure best practice was incorporated across LLR. Governance arrangements such as the Learning Disability Board and the Autism Board were in place to provide oversight. Senior managers from all three local authorities worked together and case managers would review cases to see if any learning could be gained.

(v) Concerns were raised that there had been a lack of support for carers during the Covid-19 pandemic and that support groups were no longer meeting. This was of particular concern in Rutland. In response it was explained that Leicestershire

County Council had been leading on work to support carers and conversations would now take place with Rutland County Council colleagues to ensure support was provided in that locality. The Autism Board was launching a website which would provide information, and the timing of Board meetings was being changed to enable carers to take part.

(vi) Reassurance was given that decisions made were always in the service users' best interest. Patients would not be placed in the community unless the appropriate care packages were in place.

(vii) LPT recognised that there were challenges in identifying Black and Minority Ethnic (BME) patients with Learning Disabilities and Autism and providing them with the necessary support and further work was required to be carried out in this regard.

(viii) Work was taking place in Kegworth to make the community more autism friendly and it was hoped to expand this to the rest of LLR.

RESOLVED:

(a) That the Transforming Care Programme and work aimed at getting better outcomes for people with Learning Disabilities and Autism through the healthcare system be supported;

(b) That officers be requested to provide a progress report on Transforming Care – Learning Disabilities and Autism for a future meeting of the Committee.

20. Building Better Hospitals for the Future.

The Committee considered a joint report and presentation of University Hospitals of Leicester NHS Trust (UHL) and Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) which enabled consultation on the plans to reconfigure Leicester's Hospitals known as Building Better Hospitals for the Future. Copies of the report and presentation slides, marked 'Agenda Item 9', are filed with these minutes.

The Board was also in receipt of a representation signed by 20 members of the public which submitted that there had been omissions from the consultation document and asked for the Committee to consider the issues which had been omitted. This representation is also filed with the minutes.

The Committee welcomed to the meeting for this item Andy Williams, Chief Executive, LLR CCGs, Rebecca Brown, Acting Chief Executive, UHL, Mark Wightman, Director of Strategy and Communications, UHL, and Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG.

Arising from discussions the following points were noted:

(i) Plans for reconfiguring Leicester's hospitals had originally been proposed in 2007 however those plans had not been carried out due to a lack of finance. The 2007 plans were focused on investing in the acute sector whereas the current plans were

more focused towards primary care. Care had been taken that the proposed developments at Leicester's hospitals were not larger than was necessary and the current reconfiguration plans were significantly less costly than the 2007 plans.

(ii) A leaflet publicising the consultation was being distributed to all homes in Leicester, Leicestershire and Rutland so that those residents that did not have access to the internet and social media could still be made aware and take part in the consultation. However, members reported that many houses had not received the leaflet even though the consultation had been ongoing for a few weeks. In response it was confirmed that delivery of the leaflet was still ongoing and distribution companies were being relied upon to carry out the delivery. It was known which postcodes had not yet received the leaflet and assurances were given that those residents would receive notification. Social media responses indicated that many properties had received the leaflet. Local radio stations were also being used to publicise the consultation. The Council of Faiths was being used to communicate with Faith organisations however Rutland was not part of the Council of Faiths therefore a different method was needed to communicate with churches in Rutland.

(iii) In response to a question as to why individual consultation events were not being held for specific localities such as Rutland, it was explained that as the events were being held virtually due to Covid-19 the place where the participants resided had become less relevant.

(iv) Moving services from the General Hospital to Leicester Royal Infirmary (LRI) as proposed in the consultation documents could increase congestion at the LRI site however in turn some services would be moved from the LRI to Glenfield Hospital which would reduce congestion at the LRI site. There would be some investment in carparking at LRI and the Glenfield Hospital which would alleviate some of the problems. Members raised concerns that patients that resided on the outskirts of Leicestershire and Rutland would have difficulties travelling to the LRI and Glenfield sites particularly using public transport and this would result in very long journeys. It was submitted that there were parking restrictions in the Glenfield area. It was suggested by a member that the car parks be constructed before the hospital buildings were completed to ensure that the car parks were ready when they needed to be used.

(v) In response to concerns that the digital triage process would give patients less access to clinicians it was clarified that the digital triage was designed so that there were less steps in the process and patients received a clinical consultation earlier rather than later in the process. It had been found that putting a senior clinical decision maker at the front of the process gave a clearer sense of what the appropriate service was for a patient so that they could be referred into that service earlier.

(vi) A positive aspect of moving midwifery services to the LRI was that specialist care services were available on site should mothers experience complications with the birth. Members therefore questioned why some midwifery services were remaining at the General Hospital where specialist services would not be available and patients would still have to be moved to the LRI for complex treatment. In response

it was explained that these proposals were about giving mothers choice of where they gave birth. There were many positive aspects of the St Mary's Birth Centre in Melton Mowbray but due to its location it was not suitable for many mothers across LLR therefore moving midwifery services to the General Hospital made it accessible to more people in LLR whilst retaining the positive aspects of the St Mary's Centre. The CCGs and UHL were open to reconsidering these proposals depending on the consultation feedback, and during the consultation period focused discussions were taking place regarding the maternity proposals.

(vii) In response to concerns that wider community services which the reconfiguration plans relied upon were not ready to deliver what was expected, the CCG acknowledged that not everything was in place and more work was to be done, but it was not realistic to wait until the community services changes had taken place.

(viii) The monies received as a result of the proposed sale of land at the General Hospital, valued at £20 million, would be in addition to the £450 million allocated by the Government.

(ix) UHL had calculated that there would be a need for another 139 acute beds by 2023-24 and the reconfiguration plans intended to provide those additional beds. Members were concerned that 139 additional beds would be insufficient and asked for clarification on how the figure had been reached. It was confirmed that projected housing and population growth in LLR had been taken into account in the calculations. It was agreed that after the meeting a briefing would be arranged to fully explain the calculations to members.

(x) When the reconfiguration plans had been put together consideration had been given to developments which could take place in the future such as robotic surgery and artificial intelligence but events such as the Covid-19 pandemic were very difficult to predict and plan for. The design of the new buildings did incorporate some features to protect against diseases such as Covid-19 for example using motion sensitive light switches rather than those that required touching.

RESOLVED:

That the £450 million investment in Leicester's hospitals be welcomed and the reconfiguration plans be supported subject to the comments now made.

21. Date of Next Meeting.

RESOLVED:

That the next meeting of the Committee take place on 14 December 2020 at 10:00am.

10.05 am - 1.55 pm
15 October 2020

CHAIRMAN

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Agenda Item 7

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – MONDAY 14 DECEMBER 2020

BUILDING BETTER HOSPITALS FOR THE FUTURE

REPORT OF THE CHIEF EXECUTIVE OFFICER OF THE CLINICAL COMMISSIONING GROUPS IN LEICESTER, LEICESTERSHIRE AND RUTLAND AND THE ACTING CHIEF EXECUTIVE OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Purpose of the Report

1. The purpose of this report is to consult, as required by law, with the Joint Health Overview and Scrutiny Committee on the plans to reconfigure Leicester's hospitals in order to build better hospitals for the future for the population of Leicester, Leicestershire and Rutland (LLR).

2. This is the second report to the Joint Health Overview and Scrutiny Committee during the period of the public consultation as well as a separate meeting to discuss planned bed growth for our hospitals.

3. We have been asked by members that this report particularly focuses on plans for improving maternity services as well as outline activities undertaken throughout the public consultation, which ends on 21 December 2020.

Policy Framework and Previous Decisions

4. The draft LLR Clinical Commissioning Groups' (CCGs) plan for Building Better Hospitals for the Future has been discussed with Health Overview and Scrutiny Committees, as well as other stakeholders, many times over recent years. The Committee was consulted on the proposals at their meeting on Thursday 15 October 2020. A separate discussion on bed numbers proposed as part of the plan took place on 28th October.

5. The formal 12 week public consultation for the Acute and Maternity Reconfiguration commenced on 28th September and will run until 21st December 2020.

6. The CCGs have a legal duty to involve and consult the public on the reconfiguration of Leicester's hospitals, as set out in the National Health Service Act 2006, and are leading the process in partnership with University Hospitals of Leicester NHS trust and NHS England Specialised Commissioning.

Consultation process

Background

7. The public consultation commenced on 28th September 2020. Full details on the consultation are available on the website www.betterhospitalsleicester.nhs.uk. The consultation is in line with the Cabinet Office principles for public consultation (updated January 2016) and NHS England guidance 'Planning, assuring and delivering service change for patients' (published in November 2015).

8. The public consultation provides a wide range of opportunities for interested persons to participate, including both online and offline. The purpose of the public consultation is to:

   - Give people a voice and opportunity to influence final decisions;
   - Inform people how the proposal has been developed;
   - Describe and explain the proposal;
   - Seek people's views and understand the impact of the proposal on them;
   - Ensure that a range of voices are heard which reflect the diverse communities involved in the public consultation;
   - Understand the responses made in reply to proposals and contentiously take them into account in decision-making.

CCG duty (s14Z2)

9. In undertaking a public consultation the clinical commissioning groups are fulfilling a duty to involve the public. In looking specifically at the duty which statute has placed on clinical commissioning groups, s.14Z2 of the NHS Act 2006 (as amended) states:

   Public involvement and consultation by clinical commissioning groups:

   (1)This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements")
   2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

   (a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

Equalities and Human Rights Implications

11. The consultation takes account of the range of legal matters, including legislation and common law principles that relate to CCG decision making including:

- Equality Act 2010
- Public Sector Equality Duty Section 149 of the Equality Act 2010
- Brown and Gunning Principles
- Human Rights Act 1998
- NHS Act 2006
- NHS Constitution
- Health and Social Care Act 2012

Background Papers

12. The full Pre-Consultation Business Case is available to view at the consultation website: www.betterhospitalsleicester.nhs.uk.

13. The direct link to the full consultation document is available here: https://www.bettercareleicester.nhs.uk/EasysiteWeb/getresource.axd?AssetID=80320&type=full&servicetype=Inline

Consulting in a pandemic

14. We have been asked by some members of the public whether it is appropriate for the CCGs to consult on our proposals for Leicester's hospitals during the current pandemic. The answer, we believe, is an unequivocal 'yes'.

15. This is because every single day of delay is another of spreading our staff too thinly, and patients being denied changes which will improve their experiences and outcomes of care. It is also another day of not addressing the lessons learned from dealing with this pandemic to ensure we are in the best possible place to respond to another in the future.

16. It is clear that public bodies need to exercise their functions for the benefit of those they serve and that the NHS needs to adapt and move forward even as it responds to the pandemic. The mechanisms we have put in place for the public consultation are allowing us to engage a more diverse

range of people than may have happened in the past through a town hall meeting approach. In so doing we have used the technology the majority uses on a day-to-day basis to reach a wider range of people. In fact, it is apparent that using these routes to involve and consult the public allows us to operate more effectively, efficiently and economically. It also means that we are not making temporary decisions or delaying decisions which has been complained about in some parts of the country. Instead, we are making decisions which will have a positive impact on patient outcomes and accessibility to an improved range of services. Equally as important, we are publicly consulting on our proposals in a safe and responsible manner, so we can improve the health services our communities receive now and not wait until some unknown date in the future when services have further deteriorated.

17. Taking this into account we have developed a consultation plan that allows us to deliver what is required of us legally, but more importantly it has enabled us to consult meaningfully with as many people as possible from right across Leicester, Leicestershire and Rutland.

18. Technology has played an important role in this, particularly in overcoming the limitations placed on meetings in public due to ongoing coronavirus restrictions.

Consultation Activities

19. The pandemic has shown us how technology can be used to involve and engage the public on a range of issues, including how the pandemic is tackled. In the context of health service reconfiguration, we adapted and adopted new ways of working to exercise our statutory functions.

20. The use of technology to hold meetings, share information and recordings of meetings, and enable a wider reach across communities has provided additional methods and opportunities to consult or provide information to individuals to whom the services are being or may be provided.

21. This is in addition to off-line communications and engagement activities in order to reach people who may not be digitally enabled or active.

22. The only restricting factor experienced during the consultation has been the inability to undertake public face-to face events and public outreach. However, the public face-to-face events have been replaced by many more virtual online events than would have been practically possible using off-line mechanisms.

23. In order to support people who may not be digitally enabled or active to take part the majority of meetings have included the functionality for people to dial-in via telephone should they so wish. This has been important from an accessibility perspective.

24. Several thousand people have, at the time of writing, provided their views as part of the consultation to date. Whilst many of these have opted to do so online the option has been retained for people to request consultation materials by post and to either also complete the survey by this method or by telephone.

25. As the consultation approaches the closing date we are continuing to use a variety of both online and offline tools and techniques to communicate with the people of Leicester, Leicestershire and Rutland. These include, but are not limited to, the following activities:

- Commissioning 18 voluntary and community organisations to reach out to seldom heard and often overlooked communities to encourage and support them to participate (with a focus on protected characteristics of age, race, disability, pregnancy/maternity, sexual orientation);

- Proactive partnership with the Council of Faiths to disseminate messages across the area's many diverse communities through respected faith leaders. This builds upon activity undertaken during the summer's extended local lockdown in response to Covid-19, and specific learning about the way in which some of these communities receive and interact with 'official' messaging;

- Extensive media coverage in county-wide and locality specific media including the Leicester Mercury, BBC Radio Leicester and BBC East Midlands Today as well as local weekly newspapers;

- Three full page advertorials across local newspapers with a combined readership of 173,148 people, including:
    - Leicester Mercury
    - Loughborough Echo
    - Hinckley Times
    - Coalville Times
    - Rutland Times
    - Harborough Mail
    - Melton Times.

- Full page advertorials in a number of community magazines and newsletters across Leicester, Leicestershire and Rutland with a circulation of circa 100,000 people. These include:
    - Swift Flash
    - Hinckley Roundabout
    - Groby Spotlight
    - Ashby, Coalville and Swadlincote Times
    - The Herald
    - MaHa Magazine
    - Age UK magazine.

- Commissioning of extensive six-week radio advertising across cultural and community specific radio stations with a combined listenership of

approximately 210,000 people. Adverts supported by numerous in-depth feature discussions on the proposals, lasting up to one hour. Stations include:
    - Sabras Sound
    - EAVA
    - Kohinoor
    - Sanskar
    - Seer.

- Commissioning of extensive four-week radio advertising across local commercial and community radio stations with a combined listenership of 290,900 people. These include:
    - Capital FM
    - Fosseway
    - 103 The Eye
    - Hermitage FM
    - HFM
    - GHR Stamford and Rutland
    - Three Counties Radio.

- Targeted TV advertising, using smart technology, of residents aged 55 and above and those less likely to be digitally enabled or regular users of social media. This activity has reached an anticipated 79,000 households across Leicester, Leicestershire and Rutland;

- Widespread utilisation of social media, including local NHS-owned platforms and paid for advertising to target Facebook, Instagram, Snapchat and Twitter users in Leicester, Leicestershire and Rutland. Activity and reach across main social media platforms for both paid and organic content, and other online advertising, is at least 500,000 users;

- Placement of content on approaching 100 local community websites covering areas, towns and villages across the city and two counties with a combined reach of 348,657 people;

- 26 online events have been held including public workshops and Question and Answers Panels, as well as events for specific communities/organisations including Parish Councils, Patient Participation Groups, GPs and users of mental health services;

- Facebook Live event with over 500 real-time participants, whilst 20,000 more watched it back post event. More of these events are planned before the end of the consultation process;

- Sharing of key messages with residents by local authorities via their own email lists e.g., Your Leicester with a reach of circa 83,000 people;

- Briefing and/or letter to all MPs and councillors (city, county, district and parish) providing information about the proposals, the consultation, and asking for any support in dissemination within their community;

- Email marketing to voluntary and community sector groups, schools and key business across in Leicester, Leicestershire and Rutland;

- Staff briefings and written communications shared with staff across LLR – including CCGs, UHL and LPT reaching circa 25,000 staff;

- Posters and information provided to approximately 200 supermarkets, local shops and community venues throughout Leicester, Leicestershire and Rutland;

26. In addition, a solus door drop of an information leaflet to 440,000 residential properties across Leicester, Leicestershire and Rutland was undertaken in October, with a secondary delivery in November. This activity has taken place in partnership with a specialist nationwide leaflet delivery company with many years' experience in this field. Some rural communities in Rutland received the leaflet via Royal Mail as solus was not an option due to geography.

27. It is important to recognise that the leaflet distribution is only one part of our overall activity to raise awareness of the consultation and encourage people to take part should they wish, as set out above.

28. This is important because solus delivery of leaflets is often an inexact science with many factors that impact their effectiveness.

29. This includes the attitude of recipients to unsolicited deliveries, with some people simply disposing of leaflets immediately upon receipt. Other issues include the volume of marketing material being received by households, which can reduce the impact and recall of specific items, as well as the exposure of different people within the household to the material following delivery.

30. Whilst many people have told us that they have received this leaflet, we are also aware that others believe they have not.

31. We have raised this with our delivery partners who have provided GPS tracking data for their agents to provide evidence of the routes they have taken. An independent third party organisation have also been used to 'back check' delivery. This involves a number of telephone calls to randomly selected properties within each delivery zone to ascertain if they can recall receiving the item.

32. Industry standards suggest that a recall rate of 40-60% indicates a successful delivery within any given postcode. Data provided to us so far suggests a recall rate for the majority of postcodes well within this range, with the majority at the higher end.

33. Overall we are confident that our activities to date and the approach we have taken has allowed us to meet both our statutory and common law duties.

34. After the close of consultation all of the responses received will be collated and analysed by an independent third party. A report of the evaluation and analysis will be produced and submitted to the Governing Bodies of the three CCGs in public to support a final decision to be reached. This decision will be shared widely, including with the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee.

Maternity Services

35. The proposals we are making to improve maternity services represent the culmination of extensive work over a number of years across many national, regional and local stakeholders. We believe they represent the most sustainable configuration of maternity service for the entire population of Leicester, Leicestershire and Rutland (LLR) - delivering both equity of service and access.

36. Our priority for women and families across Leicester, Leicestershire and Rutland is to provide maximum choice of 'place of birth'. This includes options such as a home birth as well as shared care arrangements between an obstetric-led unit (co-located with neonatal services) alongside a midwifery-led unit at the Leicester Royal Infirmary. In addition, the option of a birth in a standalone midwifery-led unit is also proposed.

37. Our proposals include creating a new dedicated maternity hospital to be located at the Leicester Royal Infirmary. It would provide a safe and sustainable environment for maternity and neonatal services with more personalised care provided by a named midwife. This would allow obstetric-led births (specialist care of women during pregnancy, labour and after birth) and a co-located midwife-led unit to be with neonatal services (care for premature or ill babies) all in the same building. This means that women could choose a less 'medical' delivery, but be close to the staff and equipment that can support them if circumstances make this necessary. It also means that skilled staff and expensive equipment are in one place resulting in a less fragile service when demand is high.

38. The clinical complexity of maternity care is influenced by a range of clinical factors noted in various parts of Leicester, Leicestershire and Rutland. These include:

- Complex health needs across the Local Maternity System, with pockets of high level of need focused in the city;
- High rates of low birth weight babies;
- High rates of infant mortality which may be linked to the population profile;
- High rates of teenage pregnancy;
- Projected increase in number of complex births;

- Leicester City being one of the 20% most deprived areas in England;
- High proportion of the population from BME groups and mothers whose first language is not English.

40. These complexities influence outcomes across maternity care, often negatively. This was noted in NHS RightCare data for Leicester, Leicestershire and Rutland. Although outcomes in our early years pathway are promising, the trends for maternity show that there is considerable room for improvement.

41. One of the key drivers of reconfiguration of the maternity model of care is to enable these clinical factors to be managed in the most effective way possible. For example, increasing the presence of consultant obstetricians in delivery suites has been shown to reduce caesarean section rates and complications of deliveries. Unfortunately UHL struggle to deliver this on the current multiple site model but would be able to if it was to move to the proposed reconfigured state.

42. With continuous oversight and scrutiny from our LLR Local Maternity and Neonatal System, the current Maternity Transformation Programme (Better Births) has seen significant work undertaken locally in relation to improving and maintaining quality to ensure a safe and sustainable maternity service. This has resulted in investment in midwifery, neonatal and obstetric services. However, services still face demographic challenges, especially in Leicester City, in relation to the capacity of services to cope with increasing complexity. The current split-site working has caused difficulties for both neonatal and obstetric services and we know that this is unsustainable.

43. In addition, clinical safety issues potentially could arise as a consequence of multiple site provision as seen in various neonatal services where service reviews over time have highlighted that there remains a significant risk that a baby will come to harm should consultant presence be required simultaneously on both units. This risk is compounded by significant rota gaps in junior doctor rotas, highlighted by both the East Midlands Operational Delivery Neonatal Network and the Care Quality Commission (CQC).

44. Inefficiencies are also reported in specialities such as Gynaecology as a consequence of split site working. Geography adds further to these clinical challenges. Currently there is an inefficient configuration of Gynaecology services e.g. day case activity is undertaken in main theatres, geographically separated from the ward base. There is also a conflict between Gynaecology emergency theatre use and the elective Obstetric pathway.

45. The maternity facilities in UHL were designed to cater for approximately 8,500 deliveries per year but deliveries now total approximately 9,895 (revised 2019). The local health community agreed as far back as 2010, through the Next Stage Review, that the solution would be to have a single

site maternity and neonatal service based at the LRI site, with the option of community birthing facilities. However, due to financial constraints at that time, an interim solution was adopted. The interim solution has been successful at maintaining the current provision, but progression to the single site option is imperative to sustain the safety of maternity services.

39. Reviews of maternity services have identified that the standalone birthing centre at St Mary's Hospital in Melton Mowbray is not accessible for the majority of women in Leicester, Leicestershire and Rutland. It is also under-used with just one birth taking place approximately every three days, despite attempts to increase this number. This means the unit is unsustainable, both clinically and financially.

40. We believe underutilisation of the unit may, at least in part, be due to concerns over the length of journey from Melton Mowbray to Leicester should mum or baby experience complications during the birth, as well as its relative inaccessibility to the majority.

46. Our proposal would see the relocation of the midwifery-led unit at St Mary's Hospital to Leicester General Hospital, subject to the outcome of the consultation. While we are proposing to move the midwifery-led unit, we would maintain community maternity services in Melton Mowbray. We would ensure that there is support for home births and care before and after the baby is born in the local community. If someone has a complicated pregnancy, antenatal care would be provided in an outpatient service located at Leicester Royal Infirmary or in remote/virtual clinics.

47. If the consultation shows support for a standalone midwifery-led unit run entirely by midwives, it would need to be located in a place that would be chosen by enough women as a preferred place of birth and ensures fair access for all women regardless of where they live in Leicester, Leicestershire and Rutland. It would also need to be sufficiently close to more medical and specialist services should the need arise. This is important since it will provide more reassurance to women who may need to be transferred to an acute setting during or after birth. Transfer rates in labour and immediately after birth, according to the Birth Place Study, is currently 45% for first time mums and 10% for 2nd, 3rd or 4th babies.

41. The consultation document describes the proposed unit as running as a pilot for 12 months to test public appetite for this service with an indicative target of 500 births per year. To be clear, this is not a hard target that must be achieved in year one. Instead we are looking for evidence that a clear trajectory for 500 births in subsequent years has been achieved.

42. The proposals also aim to improve community based services with antenatal, postnatal and breastfeeding support all made available closer to home.

43. In developing these proposals clinical quality, safety, configuration and choice of place of birth were all key criteria. This is combined with ensuring

equality of access for all women to a range of birthing options, as well as the efficient and effective use of resources. In addition the quality of a patient environment that maximises the provision of high quality services along with the maintenance and enhancement of education, training and research, along with the long-term viability of services from a financial perspective, were all considered as part of a three stage options appraisal.

44. At the final stages of this systematic process the proposal outlined in the consultation were reached for the following reasons:

- Single site LRI solution scored highest in the qualitative options appraisal process and is therefore the preferred clinical option on the grounds of quality, safety, configuration and choice; efficiency and service effectiveness flexibility.

- Single site LRI solution is the least expensive, recognising further work required to reduce costs to within budget.

- Single site LRI solution is likely to achieve the greatest revenue savings with efficiencies relating to consolidation of services.

Clinical support of the plans

45. In addition to conversations with the public, extensive work has been undertaken with clinicians, such as doctors, midwives, nurses and other health and care professionals, to gain clinical assurance of the proposal.

48. Our local system Clinical Leadership Group and the regional East Midlands Clinical Senate have both scrutinised the plans. These groups, comprising of clinical professionals and subject specialists, have advised on the quality and appropriateness of the plans.

49. The East Midlands Clinical Senate confirmed their support for the fact that services needed to change in line with the proposal to ensure that they are sustainable and equitable across Leicester, Leicestershire and Rutland. The panel were absolutely in support of the proposed reconfiguration and recommended that the health system proceed. They felt that our proposal hiighlights the strength of argument for the change, particularly from a workforce and sustainability perspective.

Recommendation

46. The Committee is asked discuss and provide feedback on the plans to reconfigure Leicester's hospitals in order to build better hospitals for the future for the population in Leicester, Leicestershire and Rutland.

Officers to Contact

Andy Williams,
Chief Executive, LLR CCGs
Email: andy.williams12@nhs.net

Richard Morris
Director of Operations and Corporate Affairs, Leicester City CCG
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Keep St Mary's Birth Centre Melton Mowbray Open

This petition had 1,470 supporters

St Mary's Birth Centre Melton Mowbray should be kept open because it provides gold standard maternity care both during and after birth. The unit is the only maternity unit in the county outside the City of Leicester and provides an important choice for expectant parents both from Melton and the rest of Leicestershire. It is the only unit in the County where mothers are attended by a midwife throughout labour, which is recommended by NICE. The excellent postnatal care received at the unit helps new families become more confident and have a better transition to parenthood.

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Save St Mary's Birthing Centre

3,499 have signed. Let’s get to 5,000!

We firmly believe that Melton needs its Birthing Unit. As a much loved, vital service, it forms an important piece of the jigsaw for women and their families requiring maternity care. The unit gives pregnant mothers a choice in the ethos of care and being local it saves the long drive when in labour. Furthermore, it provides wonderful after care, including support around breastfeeding and mothers mental health. The larger hospitals simply don't have the resources for this.

If it closed there is also the risk of more pressure on midwives as more low risk mothers might choose to have home births instead of risking the journeyy to Leicester. Each home birth requires two midwives present and the question is will there be enough to go around.

Finally, the Birthing Unit not only needs to stay open but we call on it to be properly funded going forward.

This petition has been started by The Rutland and Melton Labour Party.

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Representations from campaign groups regarding St Mary's Birthing Centre

The campaign groups: "Save St. Mary's Birth Centre, Melton Mowbray", "Save Our Services – St Mary's Birth Centre" and "Speak Up For St. Mary's Birth Centre", would like to draw the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee's attention to the following areas of concern and related questions regarding the proposed closure of St Mary's Birth Centre, as part of the Building Better Hospitals proposals:

1. One of the expressed aims of current proposals, is giving mums-to-be increased choice in how they give birth. Whilst clinically, a home birth offers the same risk assessment as a stand-alone midwife led unit, the environment and experience for the labouring mother is entirely different – where there might not be room for a birthing pool, there is no privacy from other family members (such as children present in the home), and it might not be suitable for those in hostels, B&Bs or shared accommodation etc, disproportionately impacting the choice of the poorest and most vulnerable. Therefore: How does the removal of the option to give birth anywhere but the city of Leicester, unless at home, increase choice of birth experience for the women across the counties of Leicestershire and Rutland?

2. The claim is that there aren't enough women giving birth at St. Mary's to make it financially viable long-term. However, we have women telling us that they are not being offered it as a choice. We also hear regularly that it is a struggle for women to find good quality information about it. If you Google St Mary's Birth Centre Melton Mowbray for example, you are presented with an outdated webpage, including a link to a Which? Guide that doesn't even exist anymore when clicked. So:

a) What evidence is there to suggest location specifically, is the only reason women aren't choosing St. Mary's birth centre, rather than under-promotion of this type of birth option – or indeed any other reason – which will then be solved by locating it elsewhere?

b) What are the plans to increase birth numbers at the new birth centre at the LGH, ensuring it is more sustainable and therefore remains a choice for women to give birth in (as per the Better Births guidelines), rather than just a trial destined to fail?

c) Can you highlight the cost analysis of giving birth in a stand-alone midwife led unit vs an alongside midwife led unit in a larger hospital with more medical resources available, confirming how you calculate the costs involved?

Prepared and Submitted by Helen Cliff, Save St Mary's Birth Centre.

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Representation from Rachel Beck

The proposals state that a stand-alone midwife led birth centre, “needs to be located in a place that ensures fair access for all women regardless of where they live in Leicester, Leicestershire and Rutland.”

According to my research, the change in location from Melton Mowbray to the LGH gives women in labour coming from Hinkley or Lutterworth (in non-peak times) a 10 minute decrease in journey time. At peak travel times this decrease in journey time narrows to 6 minutes from Hinkley to LGH and 7 minutes for women traveling from Lutterworth to LGH. At peak times especially, that saving in journey times from Hinkley and Lutterworth could potentially disappear in city centre traffic jams and by having to locate a parking space on arrival. Most labouring women do not wish to be dropped at a “drop off point” by their partners or for their partners to need to leave them during labour to move their car.

A change in location for the MLU from Melton Mowbray to LGH is also negligible for women in areas such as Coalville or Uppingham, where the travel time in peak hours to Melton Mowbray and LGH is a difference of between one and two minutes.

However, according to my research, that change in location from Melton Mowbray to LGH would add 13 minutes of journey time for women coming from Oakham, and at least 30 minutes for those in Melton Mowbray (who would currently access St. Marys.)

For the 17 locations used in my research there is a net saving of 14 minutes when travelling to Melton Mowbray. These figures show that changing the location of a MLU to LGH is not significant for some women and at a great cost to others.

1. In what ways have proposals to centralise services taken into consideration journey times in city centre traffic, and the length of time it then takes to park once at a larger hospital, when concluding the location of a stand-alone midwife led unit should be the LGH rather than St. Mary’s in Melton Mowbray?
2. Why does it appear that the women in the counties of Leicestershire and Rutland are in fact not being given equity of access to a stand-alone midwife led unit, compared with women in Leicester city, signifying a LEVELLING DOWN for these areas?
3. What support will be offered to women outside of Leicester City who do not have access to their own transport? (in case of labour or an emergency involving their pregnancy or new-born?)
4. Can you explain why, if fair access is the goal, there can’t be two stand-alone midwife led birth centres - St Mary’s in Melton Mowbray and one at the LGH as proposed?

I have attached the graphs I created when looking into travel times.

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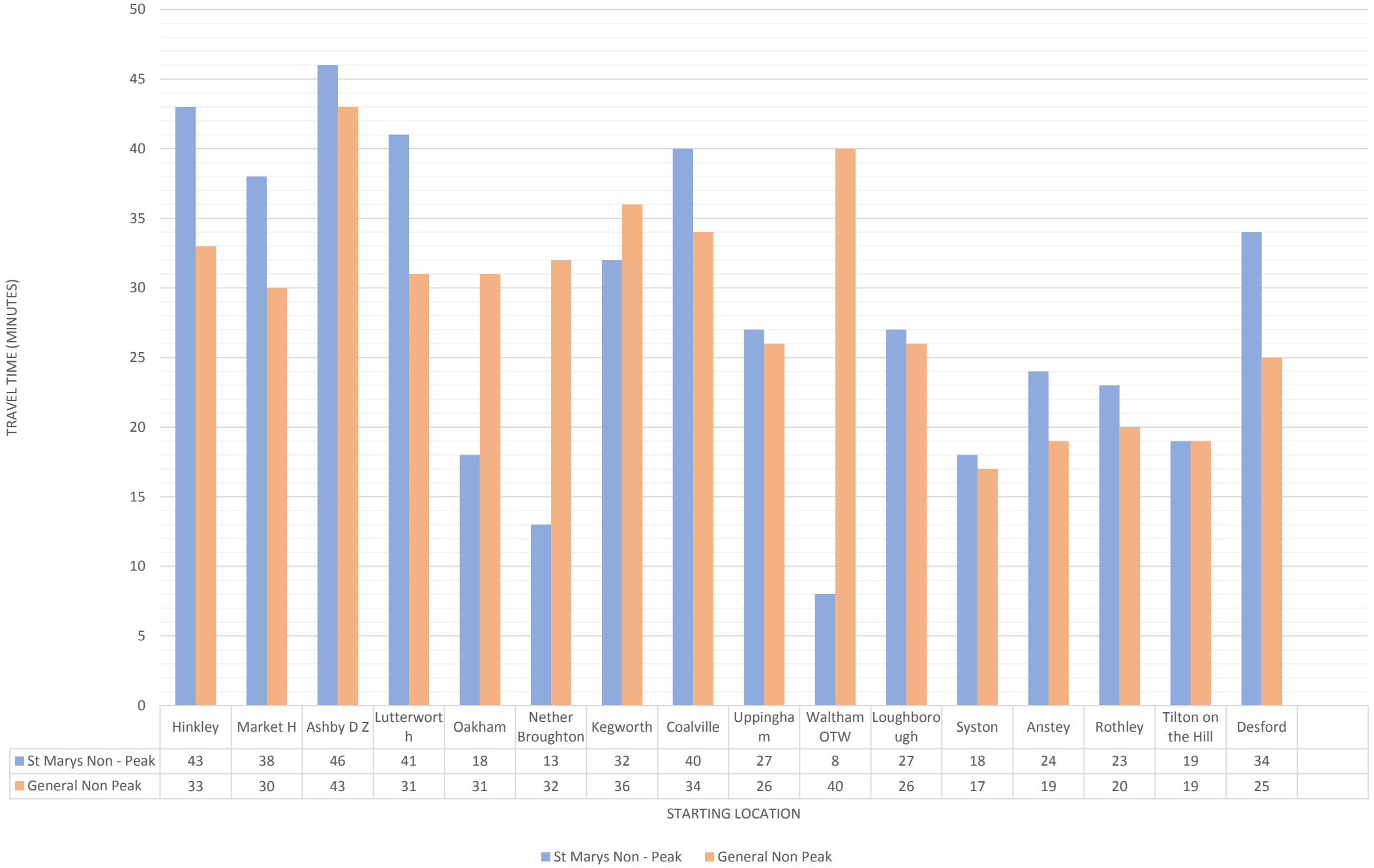
Travel at non-peak time - 7:15pm (Google Maps)



	Hinkley	Market H	Ashby D Z	Lutterworth	Oakham	Nether Broughton	Kegworth	Coalville	Uppingham	Waltham OTW	Loughborough	Syston	Anstey	Rothley	Tilton on the Hill	Desford
St Marys Non - Peak	43	38	46	41	18	13	32	40	27	8	27	18	24	23	19	34
General Non Peak	33	30	43	31	31	32	36	34	26	40	26	17	19	20	19	25

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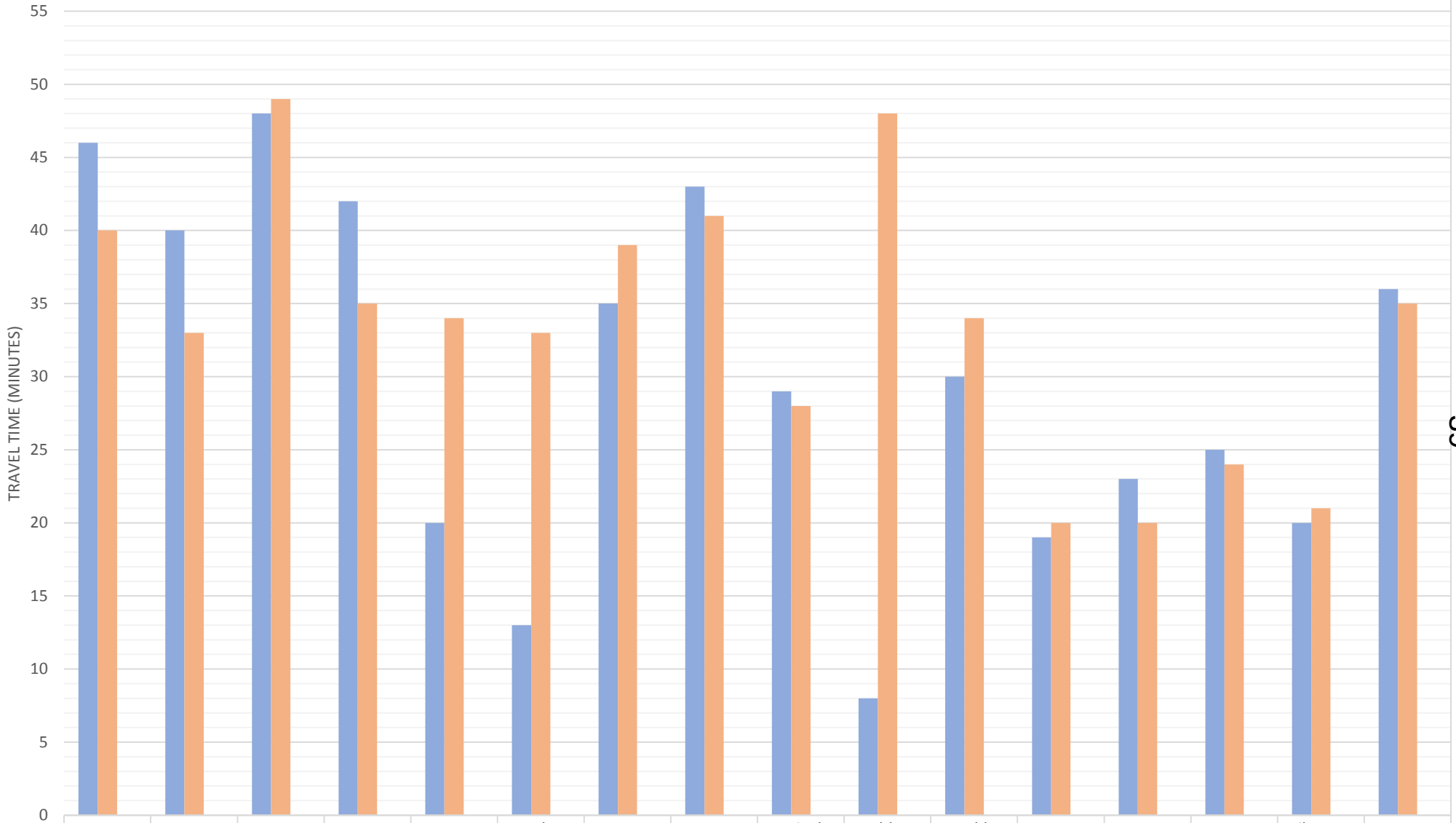
Travel at peak time - 8:15am (Google Maps)



	Hinkley	Market H	Ashby D Z	Lutterworth	Oakham	Nether Broughton	Kegworth	Coalville	Uppingham	Waltham OTW	Loughborough	Syston	Anstey	Rothley	Tilton on the Hill	Desford
St Marys - Peak	46	40	48	42	20	13	35	43	29	8	30	19	23	25	20	36
General - Peak	40	33	49	35	34	33	39	41	28	48	34	20	20	24	21	35

St Marys - Peak General - Peak

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Representation from Kerry Motta

I live in Waltham on the Wolds Leicestershire. I am very concerned about the proposed removal of St. Mary's birth centre from Melton Mowbray and the impact that would have on families not only from Melton but throughout Leicestershire and Rutland.

Page 475 of Appendix O in the Pre-Consultation Business Case documents details the impact on women currently using St. Marys. It states,

"the negative impact, in the case of midwifery services, is related to giving birth only."

However, the removal of the option of inpatient care on a postnatal ward is actually a significant reduction in postnatal care choice for all women across Leicester, Leicestershire and Rutland, many of whom currently transfer to St Mary's specifically for its postnatal services, regardless of where they have delivered their baby. The CQC in its inspection of St. Mary's singled out its postnatal care as particularly beneficial for mothers with complex conditions such as mental illness and physical disabilities.

The current proposals go beyond simply relocating the stand-alone birth centre, signalling an end for mothers being able to receive on-ward, intensive, 24-hour support for breastfeeding and post-partum recovery, alongside other mums going through the same. We may be offered breastfeeding in the community support and 'hubs' but that does not help a struggling Mum between for example 2am and 6am in the morning or build bonds with other mothers that may be of great help to you and your baby long term. Many mums credit their stays at St Mary's as being instrumental in their breastfeeding success and ongoing positive mental health. Both these areas have well-documented long-term outcomes for baby and mother.

So my questions would be:

a) Why remove such a highly valued and successful postnatal care option from the women of Leicester, Leicestershire and Rutland, when these changes are aimed at INCREASING choice?

b) Why is there no mention of this in the consultation document to inform people of the proposed changes in delivery of postnatal care?

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Representations from Liz Warren

I am strongly opposed to the proposal to close the St Mary's Birth Centre for a number of reasons.

Recent research has demonstrated that births in a midwife-led centre are actually cheaper than in an obstetric unit, taking all costs into consideration, including medical costs.

In addition I would question whether the apparent aim to concentrate all maternity facilities for the area in one huge hospital is consistent with their stated overall aim to move health facilities out of hospitals and into the community.

In their documentation, UHL talks simply of proposing to relocate the standalone midwifery unit at St Mary's to the General Hospital site in Leicester. It is not made clear that the unit at the General would not provide the additional post-natal care and support which is offered by St Mary's. The summary document and the questionnaire are both giving a misleading impression about this. The full document, itself, is not clear either. It is unacceptable to give such a misleading impression.

The documentation makes clear that 500 births are required each year for the midwifery unit at the General to be considered viable and that the unit would close if that is not achieved within a trial period. The length of the trial period has not been stated in the documentation, as far as I can ascertain, but one year has been mentioned and, at recent public meetings Andrew Furlong and Mark Wightman have indicated that it might possibly be longer. Uncertainty about this will discourage women from using the unit, as I imagine it discourages women in Melton from using St Mary's at the moment (and has probably done so in the past). I understand that women are asked at the beginning of their pregnancy to choose where they would like their baby to be born. Very few will choose a unit which may well not exist by the time they are giving birth. UHL should be required to demonstrate their commitment to this type of birth setting by trumpeting the success of St Mary's, pledging to keep it and support it long into the future - AND by setting up a similar Centre (offering the same support) IN ADDITION - Not instead - in the centre of Leicester. Bearing in mind that research has shown that births in such centres are actually cheaper than in hospitals, this would benefit the tax-payer as well as mothers-to-be.

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Dear Sir

I should like to express enormous gratitude to Tom Barker and the Save Our NHS Leicestershire campaign group for all their efforts in challenging the Leicester Hospitals revamp plans. In his recent letter to Mailbox Tom urged everyone to get involved in two on-line public meetings which they will be holding on the 9th and the 21st of November. I shall certainly try but, like many elderly people, I find the thought of trying to be involved on-line very daunting.

In the meantime, may I, through Mailbox, make public my main concern about the planned revamp.

Above all, I am extremely worried about the proposed changes to maternity provision in Leicestershire. As I understand it, the intention is to build a new maternity hospital on the LRI site, close the stand-alone midwife-led unit in Melton and set up a stand-alone midwife-led unit at the General Hospital on a trial basis of one year only.

I should like the UHL management to explain what the benefits of this arrangement would be and whether they have considered both the financial costs and the costs in terms of the welfare of mothers-to-be and their babies. Recent research in this area shows that a totally different arrangement would be infinitely preferable. I would urge the UHL management to look at that research. They would find that the best people-centred approach has actually been shown to be the most cost-effective.

If the plan to build the new maternity hospital on the LRI site goes ahead, Dr Denis Walsh, Associate Professor in Midwifery, University of Nottingham (now retired), estimates that there will be upwards of 11,000 births per year, making it one of the largest hospitals in the UK. “This results in an assembly-line model of birth that loses the personal touch and leads to a higher level of complaints from women. It also leads to higher levels of interventions – so expect caesarean rates to go up. In addition, mega units like this are more expensive to run,” he maintains. His comments are based on research conducted by Dr Walsh with several colleagues and published in 2017 under the title “Mapping midwifery and obstetric units in England”.

In their report, Dr Walsh and his colleagues point to earlier research which showed that “outcomes for low risk women were better and care was less costly if births were planned in midwifery units rather than obstetric units, without compromising the safety of babies. In particular, having a baby in a midwifery unit reduced caesarean section rates by two thirds. There was also a reduced risk of instrumental delivery or of receiving medical interventions, and significantly greater likelihood of having a normal birth. The linked economic study also

found that cost per woman was less than traditional labour wards and care more cost effective."

Dr Walsh supports the idea of a stand-alone midwifery unit on the General Hospital site but he adds "it will be set up to fail if they trial it for one year and expect 500 births to happen there over that time. It should not be a trial. They should promote it as necessary provision to meet NHS's own policy on choice of place of birth for women. Then they should aggressively market it to women who, by and large, are unfamiliar with the model. The Trust should performance-manage themselves on achieving a target of 500 births over a 3 year-period by investing staff, training, facilities and promotion, making it a flagship service. This is the only way it will succeed and there are excellent examples of this approach in other places in England."

Clearly, a stand-alone midwifery unit would only succeed if it had the full support, understanding, encouragement and commitment of the UHL NHS managers. Sadly, it would appear that that essential understanding and commitment is currently lacking.

It is abundantly clear that the UHL NHS managers need to invest more thought into providing the best possible maternity provision in Leicestershire for the benefit of future generations. Taking all the evidence into consideration, it seems obvious to me that, at the very least, they should be planning to establish a scaled-down new maternity hospital plus two fully supported and well-equipped stand-alone midwife-led units across three sites – Melton, the General Hospital and the LRI.

I sincerely hope that the UCL management will be prepared to give due consideration to the evidence about how to achieve the best possible outcomes for mothers-to-be and their babies both now and in the future

Yours,

Elizabeth Warren

Evington,

Leicester.

REPORT ON THE PROPOSALS FOR MATERNITY SERVICES IN THE BUILDING BETTER HOSPITALS FOR THE FUTURE PUBLIC CONSULTATION

Context and summary of proposals for inpatient maternity care

NHS leaders have been wanting for some years to move acute hospital services, including maternity services, off the site of the Leicester General Hospital (LGH) and to transfer them to the sites of the Leicester Royal Infirmary (LRI) and Glenfield Hospitals (GH). NHS leaders have now been assured that, subject to public consultation, they will receive from government capital funding of £450m to implement this reorganisation of hospital services, resulting in some new build and some refurbishment on the sites of the Royal Infirmary and Glenfield Hospital, the closure of the Leicester General Hospital as an acute hospital and the sale of much of the hospital buildings and land at the Leicester General Hospital. Formal public consultation entitled '*Building Better Hospitals For the Future*' began on 28th September 2020 and will close on 21st December 2020.

At present University Hospitals of Leicester (UHL) offers an Obstetric Unit (OU) and an Alongside Midwife Led Unit (AMU) at both Leicester Royal Infirmary and Leicester General Hospital. Additionally there is a Free-standing Midwife Led Unit (FMU) at St. Mary's Birth Centre, Melton Mowbray. An alongside midwife led unit is situated next to a Consultant led obstetric unit where more interventionist care is available if required. A free-standing or standalone midwife led unit is situated with no obstetric unit alongside. The units at LRI deliver 5,400 births, LGH 4,500 births and St Mary's 145 births according to the public event led by UHL /Clinical Commissioning Groups on 15 October 2020[1]. The units were built to deliver around 8,500 births but are now required to deliver approximately 10,000 births per year. Each year, about 1.5% of the births delivered by UHL staff take place at home[2]. In 2016/17, more than 5,000 birth

[1] A figure of 170 births at St Mary's was given in a UHL press release on 12th November 2020
[2] *LLR Transformational Plan for Maternity Services,* Appendix P to the Pre-Consultation Business Case, Dated 2018. Figures are for 2015/16.

deliveries were commissioned from providers outside Leicester, Leicestershire and Rutland for LLR expectant mothers[3].

The proposal is to close down the obstetric unit and the alongside midwife led unit at the General Hospital and to move all or most inpatient maternity services to a new Maternity Hospital at LRI, capable of delivering 11,000 births per annum and offering the most up to date facilities. The new Maternity Hospital will have both an alongside midwifery unit and obstetric provision. The free-standing midwife led unit at St Mary's, which has two birthing rooms, 8 postnatal beds and is staffed 24 hours a day, will close. There is the possibility, depending on the outcome of consultation, of a 12 month trial of a free-standing midwife led unit on the site of the Leicester General. The Pre-Consultation Business Case[4] makes it clear that if a midwife led unit at the General Hospital is trialled but does not demonstrate that it can achieve 500 births per annum, it will close without further consultation.

The Pre-Consultation Business Case (PCBC) justifies its proposals on the grounds that:

- There has been a decision to move other acute services away from the site of the Leicester General Hospital and this must apply to maternity services as well. This helps free up many of the buildings and much of the land on the site of the Leicester General Hospital for sale.

- Maternity facilities need to be able to cater for rising demand, and for more complex demand, for their services in ways which keep services safe.

- Staff shortages, particularly in medicine, create difficulties in staffing safely the neonatal units at both the LGH and the LRI. Relocation of all inpatient maternity services to LRI means that just one neonatal unit is required.

[3] *LLR Transformational Plan for Maternity Services*, Appendix P to the Pre-Consultation Business Case, Dated 2018.
[4] *Reconfiguration of acute and maternity services at University Hospitals of Leicester NHS Trust Pre-Consultation Business Case*, September 2020, p526; referred to here as Pre-Consultation Business Case or PCBC.

- Staff shortages, particularly medical shortages, create difficulties in staffing safely obstetric services on both the LRI and LGH sites.
- Services must be modernised to improve the experiences of expectant mothers.
- There will still be midwife led birthing and obstetric birthing on offer, alongside each other on the site of the LRI.
- Relatively few expectant mothers choose to have their babies at St Mary's. The Trust believes this is partly because expectant mothers prefer midwife led care which is close to acute and emergency back-up and partly because St Mary's is harder to access than a city location. Because of under-utilisation, S Mary's is considered unviable.

Women's Concerns

A new grassroots campaign to save St Mary's Birth Centre, a petition, which has so far attracted several thousand signatures, and views expressed at an NHS public engagement event on the reorganisation of hospital services in 2018 all suggest there are concerns among the women and other residents in the Melton Mowbray, East Leicestershire and Rutland area that the very highly regarded midwife led unit at St Mary's is closing. This is not the first time it has faced closure. Discussion about the closure of St Mary's Birth Centre extends back to 2005 at least and women have reported temporary closures over the years. Women and midwives also reported at the Melton Mowbray November 2018 NHS engagement event that, contrary to the claims of the NHS, the option of using St Mary's was not widely understood amongst midwives working elsewhere in the Trust and was not adequately publicised to expectant mothers.

Policy context and choice

A national review of maternity services entitled *Better Births, Improving Outcomes of Maternity Services in England*[5] was published in 2016. It made a number of recommendations as to how services should be redeveloped to meet the changing needs of women and babies. *Better Births* emphasises the importance of women's choice over their care in the care model to be developed through the Maternity Transformation Plan[6]. Women should be offered a choice at all stages and in all aspects of their pregnancy. This includes: choice of provider for antenatal, intrapartum and postnatal care; choice of birth setting; choice of pain management during the birth; choice regarding the involvement of their birth partner; and choice as to how to feed their baby.

NICE's guideline on intrapartum care (care during labour) for healthy women and babies[7] sets out the evidence for the safety of different birth settings and recommends that women should be given the choice of where to give birth. The guideline lists 4 birth settings which should be offered to women who are at low risk of complications: home, free-standing midwifery unit, alongside midwifery unit and obstetric unit.

The follow-up progress report on *Better Births*, entitled *Better Births Four Years On*[8], reiterates the importance of choice of place of birth and asks Local Maternity Systems to improve access to birth in midwifery settings (at home or in midwifery units) for those who want it.

The PCBC states that, as women will be able to choose a midwife led unit at the LRI, an obstetric unit at the LRI or home birth, the proposals meet national requirements for patient choice.

However, the Building Better Hospitals For the Future proposals significantly reduce choice for expectant mothers. There are two options. One of these retains more choice for mothers than the other. The first option moves most maternity services into a new Maternity Hospital on the site of the Royal

[5] *Better Births, Improving Outcomes of Maternity Services in England, The National Maternity Review*, 2016
[6] NHS England, Maternity Transformation Programme
[7] National Institute for Health and Care Excellence (NICE) *Intrapartum care for healthy women and babies: Clinical guideline* [CG190] Published 2014 Updated: 2017
[8] NHS England and NHS Improvement (2020) *Better Births Four Years On: A review of progress* March

Infirmary but establishes a midwife led unit at the General Hospital. Under these arrangements, the reduction in choice is as follows:

Table 1: Option 1 - Reduction of choice in the event a free-standing midwife led unit is created and retained on the site of the General Hospital

Current choice	Choice after reconfiguration
Midwife led unit (free-standing) – St Mary's	Midwife led unit (free-standing) General Hospital
Midwife led unit (alongside) – Leicester Royal Infirmary	Midwife led unit (alongside) – Leicester Royal Infirmary
Midwife led unit (alongside) – Leicester General Hospital)	Obstetric unit – Leicester Royal Infirmary
Obstetric unit (Royal Infirmary)	Home birth
Obstetric unit (General Hospital)	
Home birth	

Thus, in the Building Better Hospitals consultation, the public are being consulted on this option of a free-standing midwifery led unit on the site of the Leicester General Hospital. However, should this midwife led unit be trialled, it may well fail to meet the 500 births per annum criterion as, according to the Pre-Consultation Business Case, it is just a 12 month trial[9]. Within a few months of the start of the trial, many women are likely to choose the only alternative site, the Leicester Royal Infirmary, as they will be fearful that the unit will have closed by the time they give birth. Moreover, it takes time for word-of-mouth information about women's experiences in the unit to begin to circulate and for a new unit to become an established part of the spectrum of women's considered options. We assume that if the trial goes ahead, the midwife led unit will be housed in the premises of the existing maternity unit at the General Hospital but it is not clear if the £450m government investment includes any

[9] Pre-Consultation Business Case p181

capital expenditure required for the trial, or for the unit should it be retained after the trial. It has reportedly been confirmed during the consultation period that a trialled free-standing midwife led unit at LGH will not include postnatal beds as St Mary's currently does, itself a significant reduction in provision[10].

It is our belief that if the trial takes place on only a 12 month basis, the trial will probably fail. This outcome will be more likely if it is not actively championed by someone in a position of power or influence[11]. It is also possible that local NHS leaders, following consultation, will decide not even to trial a midwife led unit. In both instances, the outcome will be no maternity services provided on the site of the General Hospital. In this event, the reduction in choice presented to expectant mothers in the Building Better Hospitals proposals is this:

Table 2: Option 2 - Reduction in choice in the event there is no free-standing midwife led unit at the General Hospital

Current choice	**Choice after reconfiguration**
Midwife led unit (free-standing) – St Mary's	Midwife led unit (alongside) – Leicester Royal Infirmary
Midwife led unit (alongside) – Leicester Royal Infirmary	Obstetric unit – Leicester Royal Infirmary
Midwife led unit (alongside) – Leicester General Hospital)	Home birth
Obstetric unit (Royal Infirmary)	
Obstetric unit (General Hospital)	
Home birth	

[10] The Pre-Consultation Business Case (p6) states that St Mary's is unusual as a midwife led unit in including beds.
[11] M Kirkham et al (2012) Why births centres fail, *AIMS Journal*, 24, 2

Thus, as only a very small proportion of births take place at home, the vast majority of women face delivery at LRI without choice of alternative in Leicester, Leicestershire and Rutland should St Mary's be closed and the free-standing midwife led unit at the General Hospital not be established or be trialled but then closed down.

Research[12] has also highlighted difficulties for women across England in getting admitted to AMUs, which are sometimes temporarily closed to plug staffing gaps in the adjacent obstetric units, and having to receive care in obstetric units instead where greater medical intervention is likely. The Pre-Consultation Business Case does not say whether this is a problem for mothers giving birth in Leicester. The Pre-consultation Business Case does not state how many beds there will be in (a) the obstetric unit and (b) the midwifery led unit in the new Maternity Hospital at the Royal Infirmary. Partly because of this, we are unable to assess whether mothers in labour will find their choice *further* reduced in the coming years by being unable to get access to the midwife led unit at the Royal Infirmary for the birth of their babies.

Risks of placing all births in one building

Concern also exists about concentrating all births (except for the very small proportion of home births) onto one site.

The proposed maternity hospital is expected to cater for around 11,000 births each year. This would be an enormous maternity unit, reputedly not only the largest in the UK but also the largest in Europe[13]. Recent research suggests that the centralisation of care in obstetric units limits the time available for labouring and for professional care to support a physiological labour and birth (i.e. a 'watch and wait' approach while the mother is in labour. There is a tendency to earlier recourse to interventions which speed up the process to keep 'institutional time' rather than individual mother-in-labour time[14]. Other research

[12] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ* Open 2020

[13] The Rotunda Hospital in Dublin is sometimes described as the busiest maternity hospital in Europe; 8,409 babies were born there in 2017. *Rotunda Annual Report*, 2017.

[14] F Darling et al (2021) Facilitators and barriers to the implementation of a physiological approach during labour and birth: A systematic review and thematic synthesis, *Midwifery*, 92, 10286, 1

also points to the greater likelihood of medicalisation of childbirth in alongside midwifery units when compared with free-standing midwifery units. One of the reasons for this may be the experience of de-skilling as well as reduced confidence to make decisions autonmously which some midwives report after working in obstetric environments[15]. This may be more likely to happen where midwives have limited opportunity to work in midwife led units or where midwives are regularly switched between alongside midwifery and obstetric units[16].

If the use of the new maternity hospital is compromised through a fire, an infection outbreak or some other event, it is difficult to see how units in neighbouring cities such as Coventry and Nottingham can accommodate around 30 additional babies a day. What is more, the risks to the safety of mother and baby, where diversion to a maternity unit in a different city many miles away is required, must not be overlooked. Events which compromise the use of a building are very rare but their impact can be significant. However, the risk of "putting all our eggs in one basket" should the Royal Infirmary become the only site for births in Leicester, Leicestershire and Rutland is not included in the Building Better Hospitals risk register.

Additionally, access to the Leicester Royal Infirmary is regularly delayed by the high volume of traffic since the LRI is situated on one of the main routes into the city centre. Traffic build-up, roadworks or traffic incidents all contribute to a gridlocked road system.

It is in this congested part of the city, with higher traffic-related pollution than either of the other two acute hospital sites, that Building Better Hospitals envisages all babies will be born and all neonates will be cared for.

The value of free-standing midwife led units and care closer to home

There is little reference in the Building Better Hospitals for the Future documentation to the research evidence underpinning free-standing midwifery

[15] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895
[16] Kirkham, M. (2020) Sop, Starve, Shut: the modern birth centre process, *Midwifery Matters* 164, 6-8

units such as St Mary's Birth Centre and to the strengths and importance of such units in an overall spectrum of provision.

Good outcomes and high quality experience of mothers in free-standing midwife led units

There are significant obstacles to midwife led units reaching their full potential, especially free-standing midwife led units (FMUs), despite national guidelines recommending midwife led units for women at low obstetric risk, and a substantial evidence base for their use. Fourteen free-standing midwifery units were closed in England between 2008 and 2015[17]. Recently published research suggests that managers, midwives and clinicians in provider settings harbour considerable ambivalence about the safety of midwife units[18]. Free-standing midwife led units were especially vulnerable to negative beliefs about their efficacy even though they pre-date alongside midwife led units by decades, often under the title of maternity homes or general practitioner units. Further, this research found that, despite arguments put forward by service managers in relation to lack of demand, the majority of women in the focus groups reported lack of awareness of these services and lack of information provision about their options[19]. This is echoed in the experiences of some mothers in relation to St Mary's. In addition to this, discussions about preferred place of birth are often framed through a language of risk (but only certain kinds of risk) and the opportunity to use free-standing midwifery units to realise their full potential is rarely seized[20].

[17] J Rayment et al (2019) Barriers to women's access to alongside midwifery units in England, *Midwifery*, 77, 78-85

[18] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895

[19] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, 0:e033895. See also J Rayment et al (2018) An analysis of media reporting on the closure of free-standing midwifery units in England, *Women and Birth*; and K Coxon et al (2017) What influences birth place preferences, choices and decision-making amongst healthy women with straightforward pregnancies in the UK? A qualitative evidence synthesis using a 'best fit' framework approach, *BMC Pregnancy and Childbirth*, 17:13

[20] M Kirkham (2020) Sop, starve, shut: the modern birth centre process, *Midwifery Matters*, 164, 6-8. Kirkham also identifies other practices which undermine free-standing midwifery units including restricting hours, paring back staffing or moving staff around, and cutting back or eliminating antenatal and postnatal care.

Despite the greater hostility to free-standing midwife led units, research[21] finds that, with low risk mothers and adjusting for confounders, there is no significant difference in adverse perinatal outcomes between planned alongside midwifery and free-standing midwifery births or between midwife led units and obstetric units.

> "Overall, there were no significant differences in the odds of [adverse perinatal] outcome for births planned in any of the non-obstetric unit settings compared with planned births in obstetric units.[22]"

Further, the researchers found that the chances of having an instrumental delivery (such as forceps or ventouse suction cap) were reduced in free-standing midwife led units and the chances of having a 'straightforward vaginal birth' were higher in free-standing midwife led units than in alongside midwife led units. The authors conclude:

> "The odds of receiving individual interventions (augmentation, epidural or spinal analgesia, general anaesthesia, ventouse or forceps delivery, intrapartum caesarean section, episiotomy, active management of the third stage) were lower in all three non-obstetric unit settings, with the greatest reductions seen for planned home and freestanding midwifery unit births []. The proportion of women with a "normal birth" (birth without induction of labour, epidural or spinal analgesia, general anaesthesia, forceps or ventouse delivery, caesarean section, or episiotomy) varied from 58% for planned obstetric unit births to 76% in alongside midwifery units, 83% in freestanding midwifery units, and 88% for planned home births; the adjusted odds of having a "normal birth" were significantly higher in all three non-obstetric unit settings []. For other maternal

[21] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343,* p.d7400; J Hollowell et al. (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk 'births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

[22] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343,* p.d7400

> outcomes (third or fourth degree perineal trauma, maternal blood transfusion, and maternal admission to higher level care), there was no consistent relation with planned place of birth, although these adverse outcomes were generally lowest for planned births in freestanding midwifery units.[23]"

> "Our analysis confirms that 'low risk' women who planned birth in a [free-standing midwife led unit] had lower rates of instrumental delivery and higher rates of straightforward vaginal birth compared with women who planned birth in an [alongside midwife led unit]; and that outcomes for babies did not appear to differ between births planned in free-standing midwife led units] and [alongside midwife led units]. In general, women who planned birth in a [free-standing midwife led unit] tended to experience lower intervention rates than women who planned birth in an [alongside midwife led unit].[24]"

Free-standing midwifery led units have the additional advantage of being a more local provision for some women, particularly where these are located in a different town from that where the larger obstetric units are located, and therefore meeting the wider health service principle of moving care closer to home. This is the case with St Mary's which, located in Melton Mowbray, is the only Leicester, Leicestershire and Rutland birth unit for women outside the city of Leicester. Moreover, Melton Mowbray is located in the east of Leicestershire County and it is the residents of East Leicestershire and neighbouring Rutland who are most affected, in terms of travel time, by the closure of the Leicester General Hospital and concentration of services on the other two hospital sites.

Further, the highly valued inpatient postnatal care, in particular breastfeeding support, provided at St Mary's is taken up by far wider group of mothers than those who choose to give birth there. As the Care Quality Commission inspection of UHL maternity care noted, St Mary's postnatal care has particular

[23] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343*, p.d7400

[24] J Hollowell et al. (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk 'births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

benefits for mothers with complex needs such as women with physical disabilities or mental health conditions[25]. Too little importance is placed on this.

A recent England-wide research project[26] on midwifery-led units recommended that both alongside midwifery units and free-standing midwifery units be embedded as standard care options for birthing women in addition to obstetric units, not only to address women's choice of place of birth but because they reduce the rate of caesarean section[27] and are cheaper. In addition, the research concluded that the provision of new free-standing midwifery units, a model unfamiliar to most women, must be implemented as a permanent service provision on the back of extensive promotion by providers.

Economic viability of free-standing midwife led units

Building Better Hospitals For the Future states that each midwife led unit has running costs of £1.405m (a figure which we are told is based on St Mary's Birth Centre the running costs which are less than half this each year[28]) and that with these running costs, a midwife led unit must deliver 500 births to be viable. The impression is given that St Mary's is too expensive for the number of births which take place there each year and that the annual costs of running a midwife led unit can be justified only with that number of deliveries. However, the Birthplace in England Programme found that free-standing midwifery units provided the most cost-effective birthplace for women at low risk of complications. Researchers[29] point out:

> "Trusts also need to value their [free-standing midwife led unit(s)] as central to the broader maternity service provision and an important choice

[25] CQC (2018) University Hospitals of Leicester NHS Trust: Inspection Report, Care Quality Commission
[26] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895
[27] P Brocklehurst et al. (2011) Perinatal and maternal outcomes by planned place of birth for healthy women with low risk pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal (BMJ), 343*, p.d7400
[28] A Freedom of Information response states St Mary's cost £636,951 to run in 2019/20 https://www.whatdotheyknow.com/request/st_marys_birthing_centre_melton?nocache=incoming-1668357#incoming-1668357
[29] D Walsh et al (2020) Factors influencing the utilisation of free-standing and alongside midwifery units in England: a qualitative research study, *BMJ Open* 10:e033895

> for low risk women. In particular, the common perception that [free-standing midwife led units] are a financial burden unless operating at maximum capacity needs to be challenged as the available evidence suggests that they are cheaper than supporting the same women to birth in an [obstetric unit], even when the [midwife unit] is operating at around 30% capacity. This is because health economists factored in the savings they generate in reduced intervention and maternal morbidity[30],[31]."

Free-standing midwife led unit facilities could also be used more extensively for other outpatient services and could arguably operate as part of a community hub as envisioned by the Implementing Better Births[32] policy document.

Care closer to home

Better Births points to the value of Community Hubs which provide coordinated care services[33] built around the needs of a specific local population, which may include prevention pathways, such as smoking cessation services, and other services working in partnership with local authorities. In some areas this has helped improve access to care. In Lincolnshire, for example, hubs have been opened in children's centres in towns like Skegness and Mablethorpe, from which women have previously had to travel to the nearest hospital for all maternity care. A small number of community hubs are trialling open on demand birthing rooms to increase availability of midwifery birth settings.

An alternative which local NHS leaders could consider is to expand the St Mary's Birth Centre model by establishing Community hubs to provide coordinated care services built around the needs of a specific local population.

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[30] Schroeder E, Petrou S, Patel N, et al. (2012) Cost effectiveness of alternative planned places of birth in woman at low risk of complications: evidence from the birthplace in England national prospective cohort study. *BMJ*;344:e2292. These researchers found that analysing low risk women without complicating conditions at the start of care in labour revealed these cost differences between planned places of birth: total mean costs per birth were £1511 for an obstetric unit, £1426 for an alongside midwifery unit, £1405 for a free standing midwifery unit, Cost differences were driven largely by differences in overheads and staffing costs.

[31] Schroeder L, Patel N, Keeler M, et al. The economic costs of intrapartum care in tower Hamlets: a comparison between the cost of birth in a free-standing midwifery unit and hospital for women at low risk of obstetric complications. *Midwifery* 2017;45:28–35.

[32] NHS England (2017) *Implementing better births: a resource pack for local maternity systems*. Publications gateway Ref No. 06648. England: NHS.

[33] *Better Births Four Years On: A review of progress* March 2020

The advantage of a planned birth in a free-standing midwife led unit is lost should no such unit be retained. As mentioned above, less intervention among low risk women, when compared with planned birth in an alongside midwife led unit, provides a better experience for women and offers cost benefits to organisations[34].

As with other aspects of health care, little is said in Building Better Hospitals For the Future about services to be provided in the community settings making a full assessment of the adequacy of what is planned for maternity care difficult.

Options for pandemic preparedness

Covid-19 has shown the advantage of networked sites where Covid-19 and non Covid-19 cases can easily be separated. Apart from infection risks, there is a risk for healthcare resources. As indicated above, the evidence shows the planned delivery in FMUs require fewer caesarean sections, fewer instrumental births, far lower use of epidurals, significantly lower admission of mothers to higher level care or need for blood transfusion[35]. All these interventions require medical staff, particularly anaesthetists, who arguably hospitals may want to prioritise for ICU work in the context of a pandemic. Indeed some birth facilities at LRI and LGH had to be closed for a time during the spring 2020 Covid-19 pandemic but the remote site at St Mary's stayed open and offered its service to a wider geographical area. The number of babies born at St Mary's Birth centre increased from 76 in March-August 2019 to 92 in March-August 2020[36], an increase of over 20%, with double the number of babies being born at St Mary's in May 2020 in comparison with May 2019.

[34] J Hollowell et al. P (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk ' births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

[35] J Hollowell et al. P (2017) A comparison of intrapartum interventions and adverse outcome by parity in planned free-standing midwifery units and alongside midwifery unit births: secondary analysis of 'low risk ' births in the Birthplace in England cohort. *BMC Pregnancy and Childbirth* 17:95

[36] Freedom of Information request DP/FOI/44286

Travel

At public meetings since at least 2015 concern[37] has also been expressed that getting to the Royal Infirmary from East Leicestershire and Rutland is difficult and time consuming. Some of the travel calculations contained in the proposals under-estimate the travel time required to come into Leicester City's centre from the furthest parts of LLR. Time from Rutland to the General Hospital is usually approximately 40 minutes by car irrespective of the time of day whereas it can take 1h15m or even 1h30m with parking to get to departments within the Royal Infirmary. One concern is that the number of inductions will increase and the number of births in transit will increase.

The concentration of maternity services on one site (LRI, with the tentative possibility of a FMU at The General Hospital) makes access more difficult for many women. Women must make decisions as to when to go to their chosen or allocated maternity unit once labour has started. Women are sometimes sent home from maternity units if midwives or doctors judge they have gone in too early. The advice from midwives in early labour is sometimes shaped by workload considerations, the availability of beds or rooms and the maternity unit's protocols[38]. Research[39] suggests the prospect of being sent home is a cause of significant anxiety to some women and that the transfer of women between place of birth and home and back again can give rise to distress and fatigue when women feel unsupported. This becomes more problematic in cases where women have to travel some distance since they may need to make the same lengthy journey three times in the same day[40]. The problem is exacerbated where the mother lives in a rural area and does not have access to a car.

There is also some concern that women sent home in early labour are at higher risk of giving birth outside a facility, without midwife attendance, and also at

[37] Healthwatch Rutland run event for Rutland women, Pre Consultation Business Case page 426
[38] S Beake et al (2018) Experiences of early labour management from perspectives of women, labour companions and health professionals: A systematic review of qualitative evidence, *Midwifery*, 57, 69-84
[39] J Rayment et al (2019) Barriers to women's access to alongside midwifery units in England, *Midwifery*, 77, 78-85; D Bick et al (2011) A case study evaluation of implementation of a care pathway to support normal birth in one English birth centre: anticipated benefits and unintended consequences. *BMC Pregnancy and Childbirth* 9-47, (Oct 5).
[40] S Beake et al (2018) Experiences of early labour management from perspectives of women, labour companions and health professionals: A systematic review of qualitative evidence, *Midwifery*, 57, 69-84

greater risk of trauma[41]. Births which take place unintentionally before the mother gets to the maternity unit are called 'births before arrival'. However, there does not appear to be a systematic collection of birth before arrival statistics at hospital trust level and what figures there are appear not be collated nationally[42]. It is difficult therefore to know how many of these births occur annually and whether these numbers are rising as maternity services become increasingly centralised. Many women interviewed for research studies have expressed real fear and anxiety about being at home without a midwife present and about getting back to the facility in time.[43] This problem is frequently overlooked by decision makers[44].

The staffing drivers of maternity reorganisation

Increasingly, the restructuring of health services is driven by workforce shortages. A key factor in the choice of a single building to accommodate all inpatient maternity services is a reported shortage in certain categories of staff, a shortage which is connected by local NHS leaders with a threat to the safety of mother and baby. This concerns not only the maternity services but also neonatal care. Staff shortages are exacerbated by the need to create separate staff rotas for different sites.

At present, a staffing rota for obstetric and midwife led units is required for the General Hospital and another staffing rota for each is required for the Royal Infirmary. Each hospital hosts a neonatal unit, with special care (level 1), high dependency (level 2) and the highest level of intensive care (level 3) at the

[41] H Shallow (2016) *Are you listening to me? An exploration of the interaction between mothers and midwives when labour begins,* PhD Thesis, University of the West of Scotland. The charity Birthrights has also expressed concern about women being turned away from their chosen place of birth when thought to be in early labour.
[42] In Scotland, a baby born before the mother reaches the hospital, for example in an ambulance, in the hospital car park or in a lift at a domestic address, is recorded as a hospital birth but with a maternity admissions code which signals baby born before arrival. It is not clear if this distinguishes between planned home births and unplanned births outside hospital. https://www.ndc.scot.nhs.uk/Dictionary-A-Z/Definitions/index.asp?Search=S&ID=998&Title=SMR02%20-%20Summary%20of%20Rules/
[43] J Rayment et al (2019) Barriers to women's access to alongside midwifery units in England, *Midwifery*, 77, 78-85; D Bick et al (2011) A case study evaluation of implementation of a care pathway to support normal birth in one English birth centre: anticipated benefits and unintended consequences. *BMC Pregnancy and Childbirth* 9-47, (Oct 5).
[44] We have been in touch with several UK midwives who have expressed concern about the anxiety women feel at the prospect of being sent home in early labour, exacerbated by fear of travelling longer journeys in the context of service centralisation.

Royal Infirmary and special care only at the General Hospital. These two units must also be staffed. With the concentration of all maternity inpatient services into a new maternity building at the Royal Infirmary, neonatal care will also be centralised into one unit at the LRI.

Data underpinning this justification is scant in the documentation. The Pre-Consultation Business Case emphasises the shortage of medical staff. With regard to neonatal care, the two-site location of the service creates difficulties: several reviews have warned that insufficient consultant presence poses a risk to baby safety since a consultant can be present on only one neonatal unit at a time. In addition to this, we are told there are significant rota gaps arising from a shortage of junior doctors in neonatal care. There is a reference to a 'growing issue'[45] with neonatal nursing but no further detail is provided.

There is currently insufficient cot capacity in neonatal services and some babies are sent many miles away to other cities for care. The PCBC states the consolidation of neonatal services at LRI will entail increased capacity but no numbers are provided. By concentrating all neonatal services onto one site, no further consultant shortage is envisaged (there will be a consultant presence 24/7) and the impact of junior doctor shortages will be reduced. It is not clear what the extent of junior doctor shortage is in neonatal care. The Workforce Strategy and Plan (p39) states that, at any point in time, there are 50-100 vacancies in junior doctor posts across the Trust in all specialties.

Where maternity care is concerned, we are told there are local and national shortages of obstetricians and that women and children's services have the largest number of vacancies for junior doctors. Current recommendations state that a 60 hours per week consultant presence should be in place on maternity units delivering more than 6,000 births and that UHL struggles to maintain this standard. Neither the LRI nor LGH deliver this many babies annually but the numbers being born at the LRI are close to this figure.

Medical staffing gaps in the rota are expensive to fill and the PCBC states that these staffing problems are expected to worsen, endangering patient safety. Bringing all maternity services into one unit and all neonatal services into one

[45] Pre-Consultation Business Case p137

unit is seen as safeguarding the clinical sustainability and safety of the service in years to come.

Less is said in the Pre-Consultation Plan about midwives. The impression is gained from this that a shortage of midwives is a less significant problem and the Maternity Transformation Plan[46] states recruitment is positive. However, the PCBC also refers to a local and national shortage of midwives and the Workforce Plan appears to suggest 15 more midwives are required[47]. This may be to do with the number of births expected or partly because of the greater complexity of the work being undertaken as more women present with complex conditions and partly because additional midwives are required to meet continuity of carer requirements[48]. It isn't clear if the goal of achieving continuity of carer by delivering ante-natal and post-natal care through teams of 7-10 is in tension with a single site staffing strategy which seeks flexibility in staff deployment and easier management of rotas. In the Nursing and Midwifery workforce Plan[49], figures for vacancy rates and turnover rates do not distinguish between the nursing and midwifery workforces.

It is not clear how any shortages of midwives are alleviated in the event of all births in a single unit. Research[50] on the retention of midwives consistently demonstrates higher job satisfaction where greater autonomy is possible and higher rates of burnout where it is not. There is no discussion as to whether the closure of St Mary's will lead to the loss of midwives, as occurred with the centralisation of maternity services in Sheffield, or whether some midwives on the site of the General Hospital might not wish to move to an alongside midwife led unit on the site of the Royal Infirmary. Without more information, it is not possible to say whether the reconfiguration of maternity services might exacerbate rather than alleviate midwifery workforce problems

[46] *LLR Transformation in Maternity Services,* Appendix P to the Pre-Consultation Business Case
[47] *UHL Workforce Strategy and Plan 2018-2023* - Appendix I to the Pre-Consultation Business Case. The wording is rather cryptic: under a heading of "Demand", we have "15 Midwives agreed for investment in year with phased increases over subsequent years"
[48] *LLR Transformation in Maternity Services,* Appendix P to the Pre-Consultation Business Case
[49] *UHL People Strategy,* Appendix H to the Pre-Consultation Business Case.
[50] M Kirkham et al (2006) Why do midwives stay? Women's informed childbearing and health research group. *University of Sheffield, Sheffield*

It is not clear what the current and future employment, if any, of maternity support workers is (individuals who are under the supervision of midwives and can carry out some procedures - such as checking blood pressure or taking blood samples - but who have significantly less training than midwives and are not on a professional register). However, there may be an increase in the employment of such support workers as this would be consistent with the overall UHL workforce strategy in the coming years.

Better Births, the 2016 Cochrane Review and the *NHS Long Term Plan* (2019) all support continuity of carer. The LLR Transformation in Maternity Services document states most ante-natal and post-natal care will be provided by teams of 7-10 midwives working from a range of community venues so that expectant and newly delivered mothers receive all their midwifery care from a relatively small number of midwives. As mentioned above, it isn't clear if this is in tension with UHL's focus of single-site hospital based care for greater flexibility of staffing and easier management of rotas since these priorities may make continuity of carer less likely.

Conclusions and recommendations

The maternity reconfiguration proposals significantly reduce patient choice, an irony given the importance afforded to choice in maternity reviews and policy guidance.

The closure of the Leicester General Hospital results in much longer travel journeys for patients in East Leicestershire and Rutland when they need to access acute care in hospital. Removing St Mary's Birth Centre in Melton Mowbray exacerbates this problem.

Research shows that free-standing midwifery units offer high quality care for women at low risk of complications and are less interventionist than other institutional birth settings.

The literature suggests that free-standing midwifery units must be championed in order to succeed. This does not appear to have happened with St Mary's Birth Centre despite its reputation for highly valued care. It has not been enabled to realise its full potential as a free-standing midwifery unit able to

provide high quality birthing experience with reduced intervention for a larger number of low risk mothers.

We are concerned that the current plans provide no guarantee that a free-standing midwife led birth centre will be available, despite NICE guidelines that is should be offered and recommendations by researchers that both free-standing and alongside midwifery units be embedded into local systems of maternity care. Indeed, on the contrary, the fact that a trial only for such a unit is offered, and then that the trial is just a 12 month trial, points, we believe, to a lack of serious intent on the part of local NHS leaders.

We believe it is essential that a free-standing midwifery led birth centre is provided as part of the spectrum of care available to expectant mothers in Leicester, Leicestershire and Rutland.

We believe the research evidence on quality of care, consideration of pandemic preparedness, concerns about accessibility for residents on the eastern side of our geographical area and the significance of postnatal support, provide a strong case for the retention of St Mary's Birth Centre.

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December 2020

Leicestershire County Council

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 14 DECEMBER 2020

IMPACT OF COVID-19 ON DENTAL SERVICES

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

Purpose of the Report

1. The purpose of this report is to provide an overview of the impact upon NHS dental services commissioned in Leicester, Leicestershire and Rutland (LLR) as a result of the ongoing COVID-19 pandemic.

Background

Access to services

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

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

4. General Dental Practices within Leicester, Leicestershire and Rutland offer a range of routine dental services; some of these generalist

providers also provide less complex orthodontic services. In addition, there are specialist Orthodontic practices; the orthodontists in these practices are specialists and provide more complex care. Extended or out of hours cover is provided by five 8-8 contracts, services which provide access to patients 8am – 8pm 365 days of the year. Secondary care is provided by University Hospitals of Leicester (UHL) and Community Dental Services for special care adults and children is provided from five clinics in the area by CDS-CIC.

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

Impact of COVID-19 Pandemic

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

7. Routine dental services in England were required to cease operating when the UK went into lockdown on 23rd March 2020. A network of Urgent Dental Centres (UDCs) was established across the Midlands during early April to allow those requiring urgent treatment to be seen. There are now over 90 UDCs and these remain operational.

8. In LLR, UDCs were mobilised in Oakham, Melton Mowbray, Loughborough and Leicester city (Nelson Street). Post analysis of patient referral numbers and assessment of geographical locations of patients accessing the UDC services, Oakham was stood down and another location in Hinckley was mobilised. At present, all of the UDCs remain operational and able to provide a full range of general dental services.

9. From 8th June, practices were allowed to re-open, however practices have had to implement additional infection prevention control measures and ensure appropriate social distancing of patients and staff.

10. Unfortunately, across parts of Leicester and Leicestershire, an additional period of “lockdown” was enforced at the end of June. This decision was taken by government to mitigate the impact of a rise in COVID-19 cases. During this local lockdown, NHSEI worked closely with Public Health colleagues, including the Directors of Public Health for both Leicester

City and Leicestershire to ensure a robust response, but also to ensure that patient access was maintained as much as possible.

11. During the Leicester and Leicestershire incident and restrictions, UDCs continued to provide access to patients requiring emergency treatments. General dental practices were supported to undertake rigorous risk assessments to ensure that, wherever possible, practices remained open and able to provide access to patients. A vast majority of Leicester and Leicestershire practices in the affected areas remained open and continued to provide access to patients. Those that were unable to remain open were supported to re-open as soon as possible and were mandated to provide remote triage to all patients that contacted the practice (referring onwards to a UDC if necessary).

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

13. Aside from the effects of reduced dental access, it is possible that the pandemic will have other long-term effects on oral and general health due to the impact on nutritional intake – for example, increased consumption of foods with a longer shelf life (often higher in salt or sugar), coupled with possible increased intake of high-calorie snacks, takeaway foods and alcohol. Increases in sugar intake and alcohol intake could have a detrimental effect on an individual's oral health.

14. Those impacted to the greatest extent by this are likely to be the vulnerable and most deprived cohorts of the population, thus further exacerbating existing health inequalities. It is important to note that some of the most vulnerable in the population, whose oral health may have been affected by the pandemic as described above, are also those individuals who are at greater risk of contracting COVID-19 and of experiencing worse outcomes due to risk factors linked to other long term health conditions.

15. NHSEI is working closely with public health colleagues to mitigate the impact of COVID-19 on these vulnerable groups and the Midlands Regional team has identified this aspect of work as one of the highest priorities as our response to the pandemic continues.

16. NHSEI continues to work with providers to ensure that they operate safely and within national guidelines and have shared national guidance and Standard Operating Procedures that give guidance on how care can safely be provided.

17. The Dental Team have engaged and surveyed dental practices on a number of issues, in order to gain assurance that practices have received and implemented the guidance that has been sent out. This includes:
    - a statement of preparedness return (gauging practices ability to restart patient care, and to what level, post lockdown restrictions);
    - information on air exchanges to support appropriate use of surgeries and 'downtime' between procedures and to maximise patient access, in a safe manner;
    - information on risk assessment of staff to ensure that staff are supported and aware of additional resources available to them to address occupational health issues.

18. As of 20th November 2020, all practices in Leicester, Leicestershire and Rutland are now re-opened and seeing patients. NHSEI has developed an Outbreak Standard Operating Procedure for practices to report any staff members that are self-isolating or have received positive COVID-19 tests. NHSEI is committed to supporting practices where incidents occur but can confirm that service delivery impacts have been minimal and are being well managed by practices across the county.

19. As a result of the pandemic, dental practices have undertaken risk assessments of their premises and many have made changes to the way that they provide dental care. This is to ensure the safety of both patients and staff.

20. These additional safety precautions dictate that practices are able to see fewer patients than previously due to the required measures to ensure social distancing and prevent any risk of spreading of infection between patients. Surgeries require 'downtime' between patients to allow for air changes, droplets to settle and for cleaning.

21. As a result, not all practices or clinics are able to offer the full range of dental treatment. Patients may be referred on, particularly if the referral to another service will offer treatment in a safer setting for the patient. This may involve travelling further than would usually be the case.

22. It is important to note that no practices are providing walk in services and patients should expect to be contacted and asked to undergo an assessment prior to receiving an appointment. Patients need to be honest about their COVID-19 status and whether or not they are experiencing symptoms or have been asked to isolate. Patients will then be directed to the most appropriate service. This is to ensure patient safety and the safety of staff and other patients.

23. The dental team are aware that some vulnerable groups are finding it harder than usual to access services – particularly as no walk-in options are available. We have been reviewing pathways and treatment arrangements for these patients to ensure that they can continue to

access urgent care. Primarily this is through NHS 111 or local dental helplines.

24. Many practices are operating with reduced capacity and will therefore be restricted in the care that they can offer to new patients. Arrangements are being put in place to ensure that telephone advice and triage is available and the Urgent Dental Centres (UDCs) remain open across the Midlands to ensure access to urgent dental care where practices are unable to provide this to all patients.

25. Some patients that have previously accessed care privately may now be seeking NHS care due to financial problems related to the pandemic or due to the additional PPE charges that may be levied by some private dental practices. This is placing additional pressure on services at a time when capacity is constrained. These patients are eligible for NHS care; and are advised to contact local practices or NHS 111 to ensure access to care.

26. It should be noted that many dental practices operate a mixed private/NHS model of care and although NHS contract payments have been maintained by NHSEI, the private element of their business may have been adversely affected by the pandemic.

27. A working group convened by the Chief Dental Officer of England carried out an investigation into the resilience of mixed practices. It was concluded that whilst there would have been an interruption of income, the risk of a large number of practices facing insolvency over the next 12 to 18 months was low.

28. There were however significant concerns raised about the viability of the dental laboratory sector that manufacture dentures. These businesses are wholly private and will have suffered a major interruption to income during the first lockdown and a significant reduction to their business subsequently due to the reduced numbers of patients being seen and treated. The group made a number of recommendations for actions to support the wider dental industry.

Urgent Dental Centres (UDCs)

29. Urgent and emergency oral and dental conditions are those likely to cause deterioration in oral or general health and where timely intervention for relief of oral pain and infection is important to prevent worsening of ill health and reduce complications (SDCEP, 2013). Urgent dental care problems have been defined previously into three categories (SDCEP, 2007). The table below shows current national information about the 3 elements of dental need and best practice timelines for patients to receive self-help or face to face care.

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

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

31. The availability of routine check-ups is likely to be limited to those who are vulnerable or who have ongoing dental issues.

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

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

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

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

36. In addition, sites were mobilised to provide care for those vulnerable patients that were "shielding" and for symptomatic patients. The local Community Dental Service was mobilised to provide these services, with enhanced infection prevention control measures in place for patients attending the symptomatic site.

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

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

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

40. The site that a patient is referred to will depend upon an individual’s COVID-19 status and it is important for people to be honest about whether they are symptomatic or isolating to ensure that they are directed to the correct service. Minimising the risk to themselves and other patients, and the dental staff.

Personal Protective Equipment (PPE) and Fit Testing

41. One of the initial barriers to practices being able to re-open and then to provide a full range of treatments and services was access to appropriate levels of Personal Protective Equipment (PPE).

42. NHSEI supported UDCs throughout the initial period of lockdown (March-June) to ensure that UDCs had access to all the necessary PPE – particularly early on when supplies were limited.

43. Post lockdown NHSE introduced a PPE Portal, which enables all dental practices to order and access to PPE through an online ordering system. This portal ensures ongoing supply to practices and is managed nationally, to mitigate future case increases or periods of additional restrictions such as the one presently enforced.

44. All equipment available to order via the PPE portal is tested prior to release to ensure that it is safe and effective for practices to use.

45. An initial barrier to practices being able to deliver a full range of treatments and service was the need to “Fit test” all staff to ensure that they were able to safely use certain protective masks and equipment. This test must be conducted every time a new model of tight-fitting mask is selected; and is to be conducted by a suitably qualified professional. It is important that the masks fit and provide an adequate seal to protect from airborne transmission of the virus. The ‘fit-test’ is a requirement of the Control of Substances Hazardous to Heath (COSHH).

46. NHSEI worked closely with Public Health England (PHE) staff during the initial lockdown to fit test UDC staff to ensure that services were available for patients requiring emergency treatment.

47. Subsequently, work has been ongoing, supported by PHE and Health Education England (HEE) to train ninety dental staff from across the Midlands region to undertake fit testing. These trained members of staff have been traversing the region to provide support to practices to ensure that their staff are appropriately fit tested and able to use sufficient and appropriate PPE.

48. Where staff are unable to use standard masks, possibly due to difficulties ensuring an acceptable fit, wearing beards or for cultural reasons, staff are able to use specialised hoods instead. As the response to the pandemic has continued, an increasing number of practices have been utilising reusable, rather than disposable masks, to lessen the environmental and economic impact of PPE usage.

Dentures

49. If a person breaks their dentures then they will need to contact their local dental practice. If they do not have a regular dentist, then they should contact NHS 111.

50. During the ongoing pandemic response, dental practices are prioritising urgent care and unfortunately broken dentures do not classify as urgent care. Broken dentures can sometimes be fixed without a patient needing to see a dentist for an appointment – the dentist will assess the denture and if possible, send to the dental laboratory for the denture to be repaired.

51. Some instances of broken dentures and all lost dentures will require new dentures to be made. This takes on average 5 appointments over a number of weeks with at least a week between appointments. This type of service is likely to be restricted at present due to the impact of the pandemic.

Recovery and restoration of services

52. Dental teams and commissioning teams across the country are working to restore services and to manage the inevitable backlog of patients that has built up during the pandemic response.

53. There is significant potential for the reduction in access to services to have disproportionately affected certain population groups and therefore to have further widened existing inequalities. Those with poorer oral health and/or additional vulnerabilities are likely to have suffered more from being unable to access dental care than those with a well-maintained dentition

54. There is ongoing concern regarding a perceived reluctance amongst some people to present for care because of the pandemic, either because they do not want to be a burden on the health service or because they fear getting coronavirus. A campaign reassuring people that it is safe to attend appointments has recently been launched. It is acknowledged that this delay in seeking care is likely to have affected some of the more vulnerable population cohorts disproportionately more than the general population thus further exacerbating the health inequalities.

55 Reduced access to dental care over the course of the pandemic will have resulted in compromised outcomes for some patients. Due to the duration of the lockdown and the length of time during which routine face to face activity ceased, a number of patients who ordinarily would have had a clinical intervention, will have instead received antibiotics; possibly repeated courses

56. Some patients that were part way through treatment will undoubtedly have suffered and patient compliance with the required oral hygiene measures may wane over time. These risks are acknowledged, and work is ongoing to mitigate the impact as much as possible.

57. NHSEI is committed to addressing instances such as those above and has identified doing so as a priority work stream as the recovery and restoration of services continues.

Secondary and Community Dental Care

58. Infection control measures in place to protect patients and staff also mean that there is reduced capacity in clinics and hospitals for certain procedures, particularly those requiring a general anaesthetic or sedation. As a result, the wider NHS system is prioritising theatre capacity and treating the most urgent cases – for instance those with cancer. This means that some specialist services will only be available at a more limited number of centres. There may also be additional requirements for prospective patients relating to swabbing or isolating at home prior to treatment. This is to ensure the safety of patients undergoing surgery and those already in the hospital.

59. University Hospitals of Leicester are restoring access to secondary care dental services. Infection prevention and control measures has reduced capacity with regard to restoring Oral Surgery/Maxillo-Facial and Restorative Services due to the required ‘downtime’ between patients. In addition, the Trust have had two Consultants leave by the end of November 2020 and are securing locums to provide short term cover. This has resulted in isolated incidents of patients waiting over 52 weeks to access Oral Surgery treatment.

60. Access for children requiring dental treatment under general anaesthesia has been limited (as is the case across the country), however, this has improved as regular lists have now been reinstated for the children

general anaesthesia pathway. Access to theatres in hospitals is being monitored, however, with rising number of COVID 19 cases, this may impact on access to the regular sessions.

61. Regular meetings are being held between providers and NHSEI to monitor restoration of services. To support restoration of services, NHSEI have invited Trusts and Community Dental Services providers to submit business cases for 2020-21 non-recurrent funding to support managing patients waiting for treatment. These will be considered in early December 2020.

Staffing issues

62. The Midlands region as a whole is highly diverse, and Leicester and Leicestershire has a particularly diverse population. This is reflected in the staffing for local practices. In order to ensure that staff are not at risk, all dental contractors have undertaken COVID-19 risk assessments with their staff.

63. Working arrangements have been altered to keep people safe where necessary and staff that may have been unable to see patients face to face have been involved with telephone triage or have been redeployed to help in other services such as NHS 111.

Communication with dental practices and stakeholders

64. There have been regular meetings with Local Dental Committees (LDCs) since April, initially on a weekly basis, latterly fortnightly, and the dental team is grateful for the co-operation received from the profession in mobilising UDCs and seeking solutions to help manage the current restrictions in services.

65. LDCs have continued to update their members regularly and to share information as guidance is updated. Managed Clinical Networks (MCNs) (a network of local Clinicians from primary and secondary care developing a consistent and equitable service to patients through care pathways) have continued to meet virtually to plan care and agree guidance to help practices to manage their patients. The Local Dental Network and PHE colleagues have been integral in supporting these meetings, and the wider efforts of the dental team with regard to the pandemic response.

66. Every year the dental team engages with practices to gain assurance about practice opening over holiday periods in order to ensure that services will be in place for patients. Information is currently being gathered for this year to ensure that services are in place over the Christmas period.

67. The Dental Commissioning team have been working with colleagues in the NHSEI Regional Communications team to draft a series of

stakeholder briefings to update key partners and the public on the situation with respect to dental services. These have been distributed to local authorities, Directors of Public Health and CCGs.

68. We continue to engage with local Healthwatch organisations to encourage the sharing of intelligence relating to local concerns or regarding difficulties people may be having in accessing services.

COVID-19 and outbreaks in dental settings

69. Dental practices are well equipped to manage risk relating to COVID-19 as all staff are trained in infection prevention and control as part of their role in delivering dental services.

70. A dental Standard Operating Procedure for outbreak management has been circulated via all contract holders and also to the Local Dental Committees to support practices manage any positive cases in their practices, whether visitors or staff.

71. As with all primary care settings, the risk is staff to staff transmission when they are outside their immediate clinical setting such as in shared reception areas or staff rooms or through community contacts outside work (such as with family or friends). NHSEI is planning a webinar to raise awareness of good practice in IPC and to share learning to prevent outbreaks in dental settings.

72. Nationally all of the latest guidance for dental practices can be found here: https://www.england.nhs.uk/coronavirus/primary-care/dental-practice/

73. IPC guidance for dental practices can be found here: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

74. Support is being provided to practices that have staff who are symptomatic or have been asked to isolate through Test and Trace. This is to ensure that practices take the relevant and appropriate actions through their business continuity plans, to continue to operate safely and provide care to their patients.

75. If a practice is unable to remain open then patients may be redirected to an alternate local practice or to a UDC.

Opportunities for Innovation including Digital

76. There have been some positive impacts observed during the pandemic response, including ways in which local services and clinicians have worked together collaboratively to maintain and recover services.

77. There has also been opportunities relating to the widespread acceptance and adoption of innovative ways of providing care remotely by using digital methodologies such as video consultations. This has been widely used by Secondary and Community services, and by Orthodontic practices, to provide support and advice to patients already in treatment.

78. 125 dental practices across the Midlands have signed up to a six-month pilot to make use of video technology. This is part of a wider initiative covering Pharmacies and Optometrists. Further details are available at this link: https://www.youtube.com/watch?v=rXtykDGljjk

79. The dental team is committed to working with stakeholders to ensure that any opportunities are evaluated and supported, but that fundamental aspects of patient care and assessment are maintained.

Background Papers *(excluding exempt items)*

80. *None*

Circulation under the Local Issues Alert Procedure

81. *None*

Officer to Contact

82. Tom Bailey (Senior Commissioning Manager, NHS England and Improvement – Midlands)
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List of Appendices

83. *N/A*

Equalities and Hunan Rights Implications *mandatory*

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

NHS ENGLAND & NHS IMPROVEMENT RESPONSE TO HEALTHWATCH LEICESTER AND LEICESTERSHIRE REPORT ON THE EXPERIENCE OF PATIENTS WITH A SPECIAL EDUCATIONAL NEED OR DISABILITY USING DENTAL SERVICES IN LEICESTER AND LEICESTERSHIRE.

The Healthwatch Leicester and Leicestershire report can be accessed via the following link: https://healthwatchll.com/wp-content/uploads/2020/09/FINAL-REPORT-SEND.pdf

The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee asked NHS England & NHS Improvement (NHSEI) to respond to the issues raised in the Healthwatch report. NHS England have provided the following statement.

"NHSEI Midlands would like to thank Healthwatch for sharing the Using Dental Services with Special Educational Needs and Disabilities (SEND) Report for Leicester, Leicestershire and Rutland. We will undertake a thorough and robust review of this report to fully understand its content and inform commissioning decisions across the wider primary care dental and community dental services. We will liaise and engage with the Special Care Managed Clinical Network, Local Dental Committee and the Community Dental Services Provider regarding the recommendations and managing access for patients with special educational needs and disabilities."

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East Midlands Ambulance Service NHS Trust

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 14TH DECEMBER 2020

REPORT OF EAST MIDLANDS AMBULANCE SERVICE

EMAS CLINICAL OPERATING MODEL AND SPECIALIST PRACTITIONER INTRODUCTION

Purpose of the Report

1. The purpose of this report is to provide an update on the Clinical Operating Model of East Midlands Ambulance Service (EMAS), and subsequent introduction of Specialist Practitioners across Leicestershire.

Policy Framework and Previous Decisions

2. This paper is set in the context of national NHS policy and in line with the governance framework hereto. No previous decisions have been made on this subject through the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee. The Committee last received an update from EMAS at its meeting on 10 September 2019.

Background

3. As an integral part of the healthcare system EMAS aim to continually develop its clinical services to support and treat patients in and out of hospital environment. In September 2018 EMAS commenced a review of its Clinical Operating Model, to ensure a clear direction of travel which was fit for purpose, fit for the future and fit for our patients. The review focused on three key areas, the clinical model, clinical hub and clinical leadership inclusive of clinical supervision.

4. One of the outcomes of the review and development of the Clinical Operating Model was the introduction of specialist practitioners, supporting the delivery of senior clinical assessment and intervention to patients seen by EMAS. Leicestershire is one of two divisions where the specialist practitioner role has been successfully launched.

Specialist Practitioners

3. To enhance the delivery of clinical care, six specialist practitioners have been introduced across Leicestershire (September 2020), providing 24/7 cover, with further recruits planned for early 2021 resulting in 12 specialist practitioners across the division.

4. There are a number of intended aims and outcomes to the specialist practitioner role. Firstly, the role will further enhance the clinical skill mix of emergency pre-hospital care in order to ensure patients receive the most appropriate care, in the most appropriate setting. The role also intends to maximise the effectiveness of existing ambulance resources in order to focus on those with the most critical needs.

5. It is intended that there will be a reduction of burden on the emergency department and ensuring those that require time critical emergency care are able to be seen and receive definitive care in a timely way. This will also have a secondary impact of contributing to and supporting the reduction of hospital handover delays.

Scope of practice:

6. The scope of practice of the specialist practitioners is as follows:

    - Can supply medication to leave with the patient, not just administer, so can better manage patients in the community avoiding the need for treatment at hospital or waiting for another community provider to support.

    - Carry a range of medications for supply to treat minor ailments including infections, asthma, COPD and pain avoiding the requirement for referral to another agency and expedite treatment.

    - Carries additional end of life drugs to better support patients in their last few days of life, allowing care if their preferred place.

    - Wound closure skills - able to close wounds in the community that would previously have been transported to hospital.

    - Development and access to alternative pathways. Supported to communicate with the wider healthcare system to try and arrange individual care plans for patients to aide in managing their condition in the community where possible.

7. This scope of practice will grow as the role develops to further enhance patient treatment, experience and support reduction in emergency department conveyance.

8. In addition to the skills specialist practitioners can provide directly to patients on scene, they also rotate through the EMAS emergency operations centre. This function allows the specialist paramedics to identify appropriate calls for divisional based colleagues to attend, enhancing the dispatch and utilisation.

Clinical Leadership

9. The plans for Clinical Leadership are as follows:

- Provide a senior clinician that ambulance crews can call to discuss patient care - with the potential for the specialist practitioner to attend immediately or later in the shift dependant on the presenting complaint and complexity of the patient.

- Provide clinical leadership at difficult, complex and challenging calls of high and low acuity, helping to facilitate timely and appropriate care for the patient.

- Have clinical discussions and support other staff to help develop the clinical community of the division alongside station level leaders.

- Supported to communicate with primary care networks and patient's own specialists to discuss patient's situation today and arrange bespoke care plans.

10. The small amount of data collected so far shows that the specialist practitioners are managing nearly twice as many patients in the community as they were 12 months ago as paramedics. The rate of non-conveyance by specialist practitioners is significantly above that of normal paramedics so far through both enhanced treatment options, but also the use of alternative care pathways and individual care plans.

Future development

11. The specialist practitioner role provides a clinical career development option for paramedics, with the aim to keep these experienced clinicians in EMAS, and in the local community. Further high acuity skills to bring additional care to patients when they need it most. Including enhanced cardiac arrest care (technical and non-technical skills), post cardiac arrest care, management of acute mental health crisis, enhanced maternity care and some critical care skills.

Background Papers

12. None

Circulation under the Local Issues Alert Procedure

13. Not applicable.

List of Appendices

14. No appendices.

Equalities and Hunan Rights Implications

15. The Clinical Operating Model and subsequent specialist practitioner introduction has been developed in line with the principals of the Public Sector Equality Duty and has had a Quality Impact Assessment and Equality Impact Assessment completed following production.

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