Leicestershire County Council

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

Date/Time: **Wednesday, 27 November 2024 at 10.00 am**

Location: **Sparkenhoe Committee Room, County Hall, Glenfield**

Contact: **Euan Walters (0116 3056016)**

Email: **Euan.Walters@leics.gov.uk**

Membership

Mr. J. Morgan CC (Chairman)

Cllr. S. Bonham	Cllr. R. Payne
Mr. M. H. Charlesworth CC	Mr. T. J. Pendleton CC
Cllr. A. Clarke	Cllr. K. Pickering
Cllr. Zuffar Haq	Cllr R. Ross
Mr. D. Harrison CC	Cllr. L. Sahu
Mr. R. Hills CC	Mrs B. Seaton CC
Cllr. A. Joel	Cllr. P. Westley
Ms. Betty Newton CC	

Please note: this meeting will be filmed for live or subsequent broadcast via You Tube at https://www.youtube.com/playlist?list=PLrlN4_PKzPXhBilOPZvqU4lDm7DiSlntJ

AGENDA

Item		Report by
1.	Minutes of the previous meeting.	(Pages 5 - 14)
2.	Question Time.	
3.	Questions asked by Members.	
4.	Urgent items.	
5.	Declarations of interest.	
6.	Declarations of the party whip.	
7.	Presentation of Petitions.	

8.	Critical Incident declared at University Hospitals of Leicester NHS Trust.	University Hospitals of Leicester NHS Trust	

https://www.leicestershospitals.nhs.uk/aboutus/our-news/press-release-centre/2024/critical-incident-declared-due-to-significant-pressures/

Dr Nil Sanganee, Chief Medical Officer, Leicester, Leicestershire and Rutland Integrated Care Board will give a verbal update.

9.	UHL Future Hospitals Programme	University Hospitals of Leicester NHS Trust	(Pages 15 - 16)
10.	East Midlands Fertility Policy - Case for Change.	Integrated Care Board	(Pages 17 - 28)
11.	Water Fluoridation in Leicester, Leicestershire and Rutland.	Director of Public Health	(Pages 29 - 34)

12. Date of next meeting.

The next meeting of the Committee is scheduled to take place on Monday 17 March 2025 at 2.00pm.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

The ability to ask good, pertinent questions lies at the heart of successful and effective scrutiny. To support members with this, a range of resources, including guides to questioning, are available via the Centre for Governance and Scrutiny website www.cfgs.org.uk. The following questions have been agreed by Scrutiny members as a good starting point for developing questions:

- Who was consulted and what were they consulted on? What is the process for and quality of the consultation?
- How have the voices of local people and frontline staff been heard?
- What does success look like?
- What is the history of the service and what will be different this time?
- What happens once the money is spent?
- If the service model is changing, has the previous service model been evaluated?
- What evaluation arrangements are in place – will there be an annual review?

Members are reminded that, to ensure questioning during meetings remains appropriately focused that:

(a) they can use the officer contact details at the bottom of each report to ask questions of clarification or raise any related patch issues which might not be best addressed through the formal meeting;

(b) they must speak only as a County Councillor and not on behalf of any other local authority when considering matters which also affect district or parish/town councils (see Articles 2.03(b) of the Council's Constitution).

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Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee held at County Hall, Glenfield on Wednesday, 17 July 2024.

PRESENT

Mr. J. Morgan CC (in the Chair)

Cllr. S. Bonham
Mr. M. H. Charlesworth CC
Cllr. Zuffar Haq
Mr. D. Harrison CC
Mr. R. Hills CC
Ms. Betty Newton CC
Cllr. R. Payne
Mr. T. J. Pendleton CC
Cllr. K. Pickering
Cllr R. Ross
Mrs B. Seaton CC

In attendance

Mayur Patel, Head of Transformation, Integrated Care Board (minute 8 refers).
Sue Venables, Project Lead - Engagement and Communications, Integrated Care Board, (minute 8 refers).
Yasmin Sidyot, Deputy Director Integration and Transformation, ICB (minute 8 refers).
Sulaxni Nainani, Deputy Chief Medical Officer, Integrated Care Board (minutes 8 and 9 refer).
Lewis Parker, Commissioning Manager – Pharmacy, Optometry and Dental East Midlands Primary Care Team (minute 9 refers).
Jenny Oliver Consultant in Dental Public Health (minute 9 refers).
Catriona Peterson, Associate Medical Director (Dental) (minute 9 refers).
Mark Roberts, LDA Collaborative Lead, Leicestershire Partnership NHS Trust (minute 10 refers).
Laura Rodman, Project and Planning Lead, LDA Collaborative, Leicestershire Partnership NHS Trust (minute 10 refers).

1. Minutes of the previous meeting.

The minutes of the meeting held on 27 March 2024 were taken as read, confirmed and signed.

2. Question Time.

The Chairman reported that no questions had been received in accordance with Standing Order 34.

3. Questions asked by Members.

The Chairman reported that the following question had been received under Standing Order 7:

Question by Cllr. Ramsay Ross:

On 19 June 2024 a BBC news article reported that there were plans to replace the Bradgate Unit at Glenfield Hospital and build a new mental health treatment unit on the

same site with more modern facilities. The article stated that a planning application had been submitted to Blaby District Council and would be considered by their planning committee on 13 June 2024. On reading this article I requested further information from Leicestershire Partnership NHS Trust (LPT) about the plans. I was informed that LPT did not currently have any capital to build the new unit with and had therefore applied for outline planning permission to demonstrate to the NHS that this was a realistic plan and once planning permission had been granted the plan was to make a case for funding and develop the next round of business cases etc. This whole process could take up to 10 years. I thank LPT for this information.

I now ask the following questions:

1) *The need for Long-term Planning and the Effective Use of Funds* - Most large businesses have plans that allow them to bring forward, at relatively short-notice based upon economic circumstances, specific capital projects. Does the ICB have a long-term, integrated Capital Expenditure Plan extending over more than 10 years?

2) *Political Support for Priorities* - Should this Committee and our residents not be concerned that the delivery of what I believe to be a relatively modest capital project, will take more than two Parliamentary terms?

Reply by the Chairman:

Information has been sought from Leicestershire Partnership NHS Trust (LPT) and the Integrated Care Board (ICB) in relation to the questions from Cllr Ross. I have been informed that the issue of capital and funding falls mainly within the remit of the ICB. I understand that capital resources available to the ICB are not confirmed by central office beyond the end of 2024/25.

Capital resources that are available to the ICB on an annual basis are for business-as-usual (BAU) capital and are extremely limited. The value of the capital BAU allocation is less than the depreciation costs of the assets – this means the ICB prioritise resources to replace/maintain the current equipment/buildings rather than considering significant strategic re-developments/new builds.

Significant capital projects such as the Bradgate Unit proposals require national funds, and support and approval by the national team for local use (e.g. new Hospital Programme).

The ICB inform that together with NHS partners they consider together how, by pooling the limited resources they are assigned by NHS England, they may be able to support schemes alongside the operational capital requirements. Work currently underway is as follows:

- A draft LLR Infrastructure Strategy will be submitted to NHS England this month and will set out the priorities and a framework that the ICB will use to continue to prioritise effectively going forwards. This strategy includes the new Bradgate Unit and it will be included in the LLR list of capital requests for future funding. The importance of the strategy is that it details the future thinking of the system – it does not guarantee funding. All systems will submit strategies and they will be collated by NHS England and form part of the discussions with Treasury for the Comprehensive Spending Review.

- A 3-year outline capital plan (which will be mainly focussed on operational capital that will include some strategic schemes funded in a phased approach over several years).

To deliver a scheme from proposal to completion does take time. The following website may help to understand the process: https://thepsc.co.uk/index.php/news-insights/entry/20-years-to-build-a-hospital-how-to-save-up-to-7.5m-by-speeding-up-design-and-approvals-for-new-hospitals-what-this-could-mean-for-the-new-hospital-programme#skip

The ICB and LPT would welcome support from elected members to make a case for why capital funding is needed in LLR, and offer to discuss the matter further with Cllr. Ross at a time of his convenience.

4. Urgent items.

There were no urgent items for consideration.

5. 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.

Mrs. M. E. Newton CC and Mrs. B. Seaton CC both declared non-registerable interests in all substantive agenda items as they had close relatives that worked for the NHS. It was also noted with regards to agenda item 8: Update on GP Practice service improvements that Mrs. Seaton CC was a member of her local Patient Participation Group.

Mr. R. Hills CC declared a non-registerable interest in agenda item 9: Access to Dental Services for Leicester, Leicestershire and Rutland as he worked as a NHS Dentist in Nottinghamshire.

6. Declarations of the party whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

7. Presentation of Petitions.

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

8. Update on GP Practice service improvements.

The Committee considered a report of the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) which provided an update on the delivery of the LLR 2023/24 System-level Access Improvement Plans and the NHS England Primary Care Recovery Plan for 2024/25. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Chairman welcomed to the meeting for this item Mayur Patel, Head of Transformation, ICB, Sue Venables, Project Lead - Engagement and Communications,

ICB, Sulaxni Nainani, Deputy Chief Medical Officer, ICB and Yasmin Sidyot, Deputy Director Integration and Transformation, ICB.

Arising from discussions the following points were made and noted:

(i) In 2022/23 GP practices provided 6,948,961 clinical appointments for their patients; in 2023/24 this figure rose to 7,451,092 clinical appointments, a rise of 502,131 (7.2.%) appointments. Members noted that whilst on the face of it this seemed a big positive, how much of an improvement it really was depended on the exact nature of the appointments. Some patients were more reassured by having an appointment with a GP rather than with another medical professional. In response it was explained that there was a broad array of different types of clinical appointments in LLR; the majority of these additional appointments were with a GP but some were with clinical pharmacists, physiotherapists, and Advanced Nurse Practitioners. There was only a very small amount of Physician Associates employed in LLR.

(ii) The Pharmacy First scheme was launched in January 2024 which involved expanding the role of community pharmacies so that they could supply prescription medicines for seven common conditions. In response to a question from a member as to whether the scheme had been sufficiently publicised, it was explained that a publicity campaign had already taken place which had included social media but more publicity could be carried out and a further campaign would take place in 2024. Given that the Pharmacy First service was relatively new, assessments were being made of how it could be improved, and pharmacies were being consulted on what further training they required. In LLR 99% of pharmacies were registered for Pharmacy First. Some pharmacies had felt they needed more training before they could deliver the whole Pharmacy First package. Once the further training had been provided the capacity of Pharmacy First could increase.

(iii) Patients were being empowered to manage their own health by using self-referral pathways for services such as musculoskeletal physiotherapy, podiatry and weight management. In response to a question from a member as to the impact of these self-referral pathways and whether waiting lists were being reduced it was agreed that this information would be provided after the meeting.

(iv) A member raised concerns about patients not attending appointments that they had booked and queried whether this was a particular issue with self-referrals. It was also questioned what measures could be put in place to discourage patients from not attending appointments. In response it was agreed that the issue of self-referrals would be looked into and data on non-attendance would be provided to the Committee when available.

(v) There was some variance between Primary Care Networks (PCNs) across LLR in relation to the service provided. Some of this variance was warranted due to local need, but some of it was unwarranted such as differences in websites, and work was taking place to address this.

(vi) A 7-week public engagement and survey was undertaken in LLR regarding GP Practices. The survey commenced on 23 January 2024 and ran until 10 March 2024 and a total of 28,974 people participated. Members welcomed the numbers of people that had taken part in the survey. However, members raised concerns that more than a third of respondents said that they were either ‘fairly dissatisfied’ or ‘very dissatisfied’ with the appointment times available to them. In response it was

suggested that the answers to this question might have reflected the perception of respondents rather than reality. Members were also reminded that further improvements had been made since the survey took place. A fresh survey would be carried out in January 2025.

(vii) A member requested that NHS professionals avoid jargon when engaging with patients and emphasised that the elderly in particular needed processes articulated to them clearly.

(viii) NHS colleagues from other parts of the country had been learning good practice from LLR. There had been praise nationally on the digital interface between primary and secondary care in LLR.

(ix) Members welcomed the improvements that had been made with regards to GP access in LLR but emphasised that performance needed to improve further.

RESOLVED:

That the update on access to GP Practices be noted.

9. Access to Dental Services for Leicester, Leicestershire and Rutland.

The Committee considered a report of the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) which provided an update on dental services and future plans to improve dental access in LLR. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Chairman welcomed to the meeting for this item Lewis Parker, Commissioning Manager – Pharmacy, Optometry and Dental East Midlands Primary Care Team, Dr Sulaxni Nainani, Deputy Chief Medical Officer, ICB, Jenny Oliver Consultant in Dental Public Health, and Catriona Peterson, Associate Medical Director (Dental).

Arising from discussions the following points were noted:

(i) There were currently 133 general dental contracts across LLR over a similar amount of practices, though a small number of practices had more than one contract. Members raised concerns about whether this was enough contracts to cover the whole of LLR.

(ii) Serious concerns were raised about the lack of access to dental services in Rutland specifically. The problem was compounded by the fact that Rutland residents would normally go to the Melton area as a second choice but Melton was also performing poorly in terms of dental access. Expressions of Interest to provide dental services in Rutland would be requested in September 2024 but the whole procurement process could take 3 months.

(iii) Since February 2021, across LLR there had been 14 contract terminations though there had been no terminations since March 2024. Most of the contracts were terminated by the provider themselves and the most common reason was that the provider did not have the workforce to carry out the NHS contract. When a contract was terminated the patients from that practice were sent a letter signposting them to other practices that were able to take on new NHS patients. A member raised

concerns that those patients were not being followed-up to ascertain whether they did in fact attend another practice. In response it was explained that this was not possible as patients did not register with dental practices like they did with GP practices.

(iv) There were 5 out of hours dental contracts in LLR providing services from 8am to 8pm every single day of the year. In response to a question as to whether this was a sufficient number, it was explained that those services were actually underutilised therefore the provision of those services needed to be re-evaluated.

(v) The provision of dental services was measured in Units of Dental Activity (UDAs). Each NHS dental provider was contracted to deliver a set number of units of dental activity (UDAs), for an agreed price, over the contractual year. Each patient's course of treatment was associated with a given number of UDAs, ranging from 1 UDA for a simple check up to 12 UDAs for a complex course of treatment, like dentures. There was some variation across LLR in terms of the % of UDAs delivered across NHS dental contracts. For example, contracts in Blaby delivered 94.31% whereas Charnwood contracts delivered 75.27%. This difference was believed to be due to differences in the way the practices managed the contracts and the availability of workforce. It was also noted that Charnwood had a high proportion of University students who tended to access dental services in the places they originally came from rather than where they were attending university.

(vi) An Oral Health Needs Assessment (OHNA) for LLR had been drafted, which identified the oral health needs of the LLR population, highlighting inequalities in health and access to dental care for local groups of people, for example those who were at high risk of poor oral health. The Needs Assessment included the results of research carried out by Healthwatch. Members raised concerns that the publication of the Needs Assessment had been delayed which had led to improvements in access to dental services being delayed. In response it was explained that the document was going through governance processes and would be considered by the ICB at their meeting in August 2024. The Needs Assessment would not resolve all the issues by itself but was the start of a process to improve access to dental services. The contents of the Needs Assessment were already being used to set out commissioning intentions.

(vii) Between July and December 2023 approximately 50% of 0-17 year olds in LLR accessed NHS Dental Services. In response to concerns raised by members that the other 50% might not be accessing dental services at all (not even private services), it was acknowledged that since the Covid-19 pandemic the amount of children accessing dental services had reduced. Some reassurance was given that the issue had been looked into as part of the Needs Assessment and when the document was published it would show the demographics of which children were and were not accessing Dental Services. Looked after children was one demographic that was not accessing dental services as well as they could and work was taking place to tackle this issue. A member requested a more detailed breakdown of the 0-17 year olds accessing dental services so as to understand exactly which ages of children were most affected by this issue. It was agreed that more detailed data would be provided after the meeting.

(viii) Some children and families were hard to reach with dental campaigns. In response to a suggestion from a member that dentists should visit schools it was explained that this had been discussed at an ICB meeting. However, there was not the

capacity of dentists available to carry out this work and there were not the facilities at schools to carry out dental procedures. In any case consent from parents would be required. Therefore, the work that did take place in schools tended to focus on encouraging children to brush their teeth properly. A member informed that some families in LLR could not afford toothpaste therefore the problem was a financial one and not just a matter of educating people.

(ix) The causes of poor oral health, such as intake of sugar, were linked in with broader issues that were within the remit of public health departments such as diet and obesity. Therefore, the strategy to tackle oral health needed to be multi-layered and could not be addressed through access to dental care alone.

(x) As an incentive to Dental Practices, a scheme had been put in place nationally where Practices would be paid for up to 110% over performance on their contract. ICBs in the East and West Midlands had originally decided not to implement the scheme. For the 2023/24 year there had been an underspend in LLR for dental services but decisions had been made nationally on how that underspend was dealt with. It was hoped that going forward the scheme would be implemented in the East Midlands, subject to the NHS dentistry budget being protected at ICB level.

(xi) None of the national initiatives that were being put in place to improve access to dental services in LLR came with any additional funding from NHS England so therefore they had to be funded from underspends locally.

(xii) Both dentists and GPs could make a referral in relation to oral cancer.

(xiii) Patients always had a choice on where they were referred to for specialist NHS dental treatment in hospital settings, though there were some complications arising from different systems being in place in different areas, for example the referral process was different in the East and West Midlands.

(xiv) Water fluoridation had been shown to reduce the likelihood of tooth decay. Some parts of the UK were covered by water fluoridation schemes but LLR and Nottinghamshire were not. The upper-tier Councils in Nottinghamshire had submitted a letter to the Department of Health and Social Care seeking to have water fluoridation in Nottinghamshire. Members questioned whether similar representations to the Secretary of State could be made on behalf of LLR. In response it was confirmed that conversations between the local authorities in LLR had already begun taking place in this regard and an update could be brought to the next meeting of the Committee.

RESOLVED:

(a) That the update on plans to improve access to dental practices in LLR be noted;

(b) That officers be requested to provide further updates to future meetings of the Committee on progress with improving dental access, and water fluoridation in LLR.

10. Learning Disability and Autism Collaborative.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on the LLR Learning Disability and Autism (LDA) Collaborative which

had been established to improve services for people with a learning disability and autism. A copy of the report, marked 'Agenda item 10', is filed with these minutes.

The Chairman welcomed to the meeting for this item Mark Roberts, LDA Collaborative Lead, and Laura Rodman, Project and Planning Lead, LDA Collaborative, both of LPT.

Arising from discussions the following points were noted:

(i) The Collaborative had been working to increase the uptake of Annual Health Checks (AHCs) for people aged over 14 years with a Learning Disability. The national target was for 75% of the people included on the GP Learning Disability Register to attend an AHC and during 23/24 the LLR achieved 82.6%, making LLR the highest performing system in the Midlands and 5th nationally. Specific work was taking place targeting those who had not had a heath check in the previous two years. Members welcomed the targeted work and the significant improvement from historical performance. It was noted that individual staff members could make a real difference to the levels of uptake with their diligent work in encouraging patients to undertake health checks.

(ii) Screening was one area where there were concerns about the numbers of people with learning disabilities and autism taking part. Approximately one third of women with learning disabilities took part in cervical screening as opposed to 75% of women overall. It was agreed that further screening data would be provided to Committee members after the meeting.

(iii) Videos had been made and were circulated to GP Practices to help them manage patients with learning disabilities and autism.

(iv) One of the aims of the LDA Collaborative was to encourage all partners to complete the Oliver McGowan Mandatory Training on Learning Disabilities and Autism. It was agreed that a link to the training would be circulated to Committee members after the meeting.

(v) Early diagnosis was important and therefore it was concerning that approximately 7000 children were waiting for a neurodevelopmental assessment.

(vi) Autism in females was believed to be under-diagnosed and females were believed to be better at masking the symptoms.

(vii) It was important to make people with learning disabilities and autism feel welcomed in communities and give them opportunities for social interaction. Social prescribing had a role to play here. It was noted that the Joy mobile phone app directed people towards social activities and support groups.

(viii) The LDA Collaborative worked with the Leicester City Council employment team to find job opportunities for people with learning disabilities and autism. However, one of the challenges was assessing the impact of this work as measurements of people with learning disabilities in employment were only taken once a year.

(ix) It was requested that when the Committee scrutinised health providers in future members ask the providers what work they were carrying out with regards to people with learning disabilities. The Committee agreed to take this on board.

RESOLVED:

(a) That the LDA Collaborative's achievements to date and priorities for 2024/25 be welcomed;

(b) That the work of the LDA Collaborative in championing the importance of supporting people with a learning disability and autistic people across LLR be supported;

(c) That the Committee recommends that future Joint and Place Based Health Scrutiny Committees in LLR ensure through their scrutiny meetings that partners embed learning disabilities and autism considerations in all pathways, strategies and plans.

11. Dates of future meetings.

RESOLVED:

That future meetings of the Committee take place on the following dates:

Wednesday 27 November 2024 at 10.00am;
Monday 17 March 2025 at 2.00pm.

10.00 am - 12.40 pm
17 July 2024

CHAIRMAN

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Agenda Item 9

NHS
University Hospitals of Leicester
NHS Trust

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 27 NOVEMBER 2024

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OUR FUTURE HOSPITALS PROGRAMME UPDATE

Purpose of report

1. The purpose of this agenda item is to provide an overview and update of University Hospitals of Leicester NHS Trust's (UHL) 'Our future hospitals programme', a multi-million pound transformation of services.

2. UHL have been requested to provide a written report for the meeting but at the time of publishing the agenda for this meeting no information from UHL had been received by the secretariat of the Committee (Leicestershire County Council Democratic Services). Should a report be received before the meeting it will be circulated and published as a supplementary document.

3. This report is to explain to members and the public what the agenda item will cover.

Background

4. At the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee meeting on 18 December 2023 UHL provided an update on the 'Our Future Hospitals Programme'. The report considered at the meeting can be found here: https://democracy.leics.gov.uk/documents/s180237/UHL%20Recon%20report%20LLR%20Joint%20HOSC%2018%20Dec.pdf

5. The report explained that the Trust cannot continue to operate in its current format as medical and nursing resources are spread thinly, many buildings are not fit for the needs of modern healthcare and have significant and expensive maintenance requirements. In September 2019, £450m funding was confirmed by the government to progress with this programme; following which a full public consultation process was undertaken in 2020.

6. At the time of the meeting in December 2023 UHL was waiting for the New Hospitals Programme (NHP) to confirm the funding envelope to progress the design of the new buildings. Funding had been received from the NHP to prepare both the Leicester Royal Infirmary and Glenfield Hospital sites for the large-scale building works.

7. UHL agreed to provide a further report on the Future Hospitals Programme for a future meeting of the Committee once there had been any significant

developments. It is intended that this update takes place at the meeting on 27 November 2024.

Recent events

8. The secretariat is aware that the new Labour Government intends to carry out a review into the New Hospital Programme to consider the options for putting the New Hospital Programme onto a "realistic, deliverable and affordable footing." The review will assess the appropriate schedule for delivery for schemes in the New Hospital Programme in the context of overall constraints to hospital building and wider health infrastructure priorities, while also looking at where improvements can be made. Out of scope will be schemes that have approved full business cases, and any associated phases that have specific commitments. https://www.gov.uk/government/publications/new-hospital-programme-review-terms-of-reference/new-hospital-programme-review-terms-of-reference

9. The UHL schemes relating to Leicester Royal Infirmary and Glenfield Hospital are in scope of the review. It is hoped that UHL will provide further information regarding this at the meeting on 27 November 2024.

Officer to contact

Euan Walters
Senior Democratic Services Officer – Leicestershire County Council
0116 3056016

Leicestershire County Council

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 27 NOVEMBER 2024

EAST MIDLANDS INTEGRATED CARE BOARDS FERTILITY POLICY: CASE FOR CHANGE

REPORT OF THE CHIEF MEDICAL OFFICER, LLR INTEGRATED CARE BOARD

Purpose of report

1. The purpose of this report is to provide the Committee with details of the East Midlands Integrated Care Boards Fertility Policy: Case for Change engagement phase.

Policy Framework and Previous Decisions

2. It was agreed that the five East Midlands Integrated Care Boards would undertake a review of existing fertility policies with a view to aligning them to improve equity of access to fertility treatments.

Background

3. Currently, there are differences across the East Midlands in the criteria for how people can access the treatments. The NHS wants to create one policy for the whole region, to make access fairer for everyone.

4. The NHS review of the policy addresses these differences in the criteria for people who can access treatment, such as age, body mass index (BMI) and the number of treatment cycles available.

Proposals/Options

5. The review has informed the Fertility Policy: Case for Change (Appendix A). The engagement phase was launched on Monday 11th November 2024 and will run until 10th January 2025.

6. The key proposals are that, as is currently the case, one cycle of IVF treatment will be offered across Leicester, Leicestershire and Rutland. However, in addition, it also considers access for single women and same sex couples.

Consultation

7. At this stage, a full public consultation is not required. This is the engagement phase for the case for change where the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB) is inviting people across Leicester, Leicestershire and Rutland to have their say on how fertility treatments are provided by the NHS in the East Midlands by completing a short questionnaire which is open to everyone: https://leicesterleicestershireandrutland.icb.nhs.uk/be-involved/fertility-review/

8. Updates on the engagement process, including how the feedback is being used, will be shared on the LLR ICB website.

9. Following the engagement phase, feedback will be evaluated with a view to draft a policy. A further engagement phase will then take place.

Resource Implications

10. There are no resource implications in the context of this paper.

Timetable for Decisions

11. As stated, the engagement phase will run until 10th January 2025, after which feedback will be evaluated that will inform the draft policy. The timetable for this is yet to be determined and is dependent on the level of change required.

Conclusions

12. This report has been provided to ensure that the Committee is sighted on activity being undertaken.

Background papers

13. The full Fertility Policy: Case for Change is attached as appendix A.

Equality Implications

14. The purpose of the fertility policy review is to improve equity of access to fertility treatments. As such, an EQIA has been produced (available on request).

Human Rights Implications

15. There are no human rights implications arising from this report.

Other Relevant Impact Assessments

16. There are no other relevant impact assessments arising from this report.

Appendices

17. Fertility Policy: Case for Change (Appendix A).

Officer(s) to Contact

Jo Grizzell, Senior Planning Manager, LLR ICB
Email: Jo.grizzell@nhs.net

APPENDIX

East Midlands Fertility Policy Review

Case for Change

Author: Mark Sheppard, Associate Director of Commissioning Acute and Community Contracts, NHS Nottingham and Nottinghamshire ICB, on behalf of all ICB's in the East Midlands Region.

Date published:

1. Glossary of Acronyms

AI – Artificial Insemination

BMI – Body Mass Index

DI - Donor sperm Insemination

ICB – Integrated Care Board

ICSI – Intracytoplasmic Sperm Injection

IVF – In Vitro Fertilisation

LB – Live Birth

NICE - National Institute for Health and Care Excellence

UCI - Intrauterine insemination

2. Executive Summary

There are currently differences between Fertility Policies in the East Midlands, in terms of access to treatment, in relation to age, BMI and number of cycles available. Moreover, there are also inequalities inherent in the policies in that they exclude or limit access to same sex couples, couples with children from former relationships and single people.

This case for change sets out proposed criteria for access to Specialist Fertility Services for the population of the East Midlands, aimed at supporting a more collaborative approach to ICB Policy that will result in one policy to address fertility treatment across the whole of the East Midlands region.

The review aims to address inequalities to improve access to fertility treatment whilst prioritising treatment for people with proven fertility issues. The proposals outlined on pages 8,9 and 10 maintain elements of existing policy, and update others, giving the rationale or evidence base for each proposal.

It is felt that this case for change proposes commissioning arrangements for fertility services in a manner that is clear, fair, and transparent, and the proposed criteria has been developed in line with clinical evidence taking in to account the success rates of fertility treatments and the impact that different factors have on this.

However, at this stage in the review the proposals put forward are recommendations only and following agreement by decision making forums within each ICB to endorse the direction of travel, a period of engagement will then follow to determine the impact of these proposals on our populations in the East Midlands and gather feedback and thoughts on the proposals to be considered and fed into the final policy.

3. Introduction

Fertility refers to the ability to conceive a child**.** On the other hand, infertility is the difficulty or inability to conceive a child naturally. Infertility is the period people have been trying to conceive without success, after which formal investigation is justified and possible medical assistance implemented.

- Over 80% of couples in the general population will conceive within 1 year if the woman is aged under 40 years and they have regular (every 2–3 days) unprotected sexual intercourse.
- Of those who do not conceive in the first year, about half will do so in the second year bringing the cumulative pregnancy rate to over 90%.

- One in seven UK couples is estimated to have difficulty conceiving (approximately 3.5 million people).

Risk factors for infertility include:

- Increasing age
- Being under or over weight
- Smoking

Common causes of infertility can include:

- Lack of regular ovulation**:** When the monthly release of an egg does not occur as expected.
- Poor quality semen: Issues related to sperm health.
- Blocked or damaged fallopian tubes**:** Hindrance to the fertilisation process.
- Endometriosis: A disorder in which the tissue similar to the inner lining of the uterus (endometrium) grows outside the uterus.

Treatment for infertility varies based on the underlying cause and may include assisted conception techniques which may involve medical treatments and/or surgical procedures such as:

- Intrauterine insemination (IUI) **-** a type of fertility treatment that involves placing sperm inside a woman's uterus close to the fallopian tubes in order to increase the chances of conceiving.
- In vitro fertilization (IVF) - During IVF, an egg is removed from the woman's ovaries and fertilised with sperm in a laboratory. The fertilised egg, called an embryo, is then returned to the woman's womb to grow and develop.

In the East Midlands there are five Integrated Care Boards (ICB's), who commission health and care services for their local population:

- NHS Derby and Derbyshire
- NHS Nottingham and Nottinghamshire
- NHS Northamptonshire
- NHS Leicester, Leicestershire and Rutland
- NHS Lincolnshire

Each ICB sets its own Fertility Policy outlining the guidelines relating to who can and cannot receive fertility treatment.

4. Reason for review of Fertility Policy

4.1. Differences between Fertility Policies in the East Midlands

There are currently differences between Fertility Policies in the East Midlands, in terms of access to treatment, in relation to age, BMI and number of cycles available. Moreover, there are also inequalities inherent in the policies in that they exclude or limit access to same sex couples, couples with children from former relationships and single people.

This review of fertility is therefore aimed at supporting a more collaborative approach to ICB Policy that will result in one policy to address fertility treatment across the whole of the East Midlands region. The review will aim to address inequalities to improve access to fertility treatment whilst prioritising treatment for people with proven fertility issues. The suggestion is to maintain elements of existing policy, and update others.

The majority of ICBs across the East Midlands have policies based on or fully reflective of the 2014 East Midlands policy written by the East Midlands Specialised Commissioning Group (no longer an entity). This policy does not account for changes in law or societal thinking and therefore needs review.

Currently the National Institute for Health and Care Excellence (NICE) has guidance in effect for fertility – Clinical Guideline CG156 'Fertility problems: assessment and treatment' 2013. This guidance is due to be reviewed and the current indication is that new guidance may be available at some point in 2025. This new guidance has been delayed a number of times and it is therefore felt that the East Midlands review cannot wait for the new guidance to be published. Once the new guidance is available a tabletop exercise can be undertaken to understand if this impacts on the East Midlands policy position.

It is also important to note that recent boundary changes initiated by the Secretary of State in 2022 have led to a misalignment of policies within the same ICB region. This is relevant to NHS Derby and Derbyshire ICB where the decision has been taken to move the area of Glossop from Greater Manchester into Derbyshire, and NHS Nottingham and Nottinghamshire where the decision has been taken to move the area of Bassetlaw from South Yorkshire into Nottingham and Nottinghamshire.

Some ICBs have also made amendments to the existing policies where locally it was appropriate to do so, hence this has made the provision across the region even more disparate.

4.2. Comparison of national and local policies

Current ICB policies differ across several policy areas:

- Closest to NICE CG156 – Fertility Problems: Assessment and Treatment - Bassetlaw and to a lesser extent Glossop are most closely aligned with NICE CG156. See scenarios 2 and 3 in Table 2. No policies currently meet the full guidance. However the former Bassetlaw CCG included funding for surrogacy which will be excluded from the East Midlands policy as NHS England clearly state that surrogacy is not available on the NHS.

- The policies for other East Midlands areas are more similar to each other but differ more significantly from NICE CG156. They do so in a number of key areas:

    - **Criteria for access to In Vitro Fertilisation (IVF) and Intracytoplasmic Sperm Injection (ICSI)**: The majority require the woman's BMI to be between 19 and 30 kg/m2 and both partners to be non-smoking whereas Bassetlaw only expects the provider to provide advice on BMI and smoking (similar to NICE guideline recommendations).
    - **IVF/ICSI pathway**: For women under the age of 40, Bassetlaw and Glossop are in line with the NICE guideline, offering up to three IVF cycles (including privately funded cycles); all other policies offer one cycle. Glossop offers IVF with donor oocytes for women aged 40 to 42 with low ovarian reserve, unlike the other policies.
    - **Criteria for access to Intrauterine Insemination (IUI) and Donor sperm Insemination (DI)** vary, but most offer IUI where vaginal intercourse is very difficult or not possible including for same-sex relationships, and Glossop includes single women. Age and BMI criteria vary.

4.3. Financial constraints in the NHS

The NHS finite and scarce financial resources and ICBs are charged with ensuring that all services provide value for money and are affordable. The review looks at the current expenditure and considers the impact of any changes to the policy.

Using NHS tariff payments, the estimated total cost of IVF/ICSI and AI/DI/IUI (excluding costs of donor sperm) for each ICB using these baseline tariffs for the four years from 2019/20 to 2022/23 is shown in Table 1 below.

Table 1 Costs of IVF/ICSI cycles and AI/DI/IUI cycles by ICB and year - 2019/20 to 2022/23)

	2019/20	2020/21	2021/22	2022/23	Total
IVF/ICSI cost*					
NHS Derby and Derbyshire ICB	£584,800	£479,600	£472,800	£542,000	£2,079,200
NHS Leicester, Leicestershire, and Rutland ICB	£417,600	£523,400	£522,800	£515,400	£1,979,200
NHS Lincolnshire ICB	£281,000	£260,400	£254,600	£251,200	£1,047,200
NHS Northamptonshire ICB	£472,000	£218,200	£352,000	£372,200	£1,414,400
NHS Nottingham and Nottinghamshire ICB	£596,800	£473,200	£571,200	£441,000	£2,082,200
TOTAL FOR 5 EAST MIDLANDS ICBs	**£2,352,200**	**£1,954,800**	**£2,173,400**	**£2,121,800**	**£8,602,200**
	2019/20	**2020/21**	**2021/22**	**2022/23**	**Total**
AI/DI/IUI cost					
NHS Derby and Derbyshire ICB	£825	£2,475	£825	£1,650	£5,775
NHS Leicester, Leicestershire, and Rutland ICB	£172,425	£94,875	£141,900	£112,200	£521,400
NHS Lincolnshire ICB	£14,025	£16,500	£14,025	£10,725	£55,275
NHS Northamptonshire ICB	£1,650	£1,650	£2,475	£825	£6,600
NHS Nottingham and Nottinghamshire ICB	£0	£0	£0	£0	£0
TOTAL FOR 5 EAST MIDLANDS ICBs	**£188,925**	**£115,500**	**£159,225**	**£125,400**	**£589,050**

* These figures do not include the costs of frozen embryo transfer, luteal support, or cancelled cycles

Further analysis of the costs of fertility treatments can be found in appendix A.

The NHS is facing unprecedented levels of demand and costs, this is due to a number of factors including an aging population, the aftermath of the Covid-19 pandemic, continuing improvement to medicines and procedures to treat patients the impact of the cost-of-living crisis and the levels of inflation.

This sets the NHS both nationally and locally the challenge to ensure that patient care is delivered within the finances available.

ICBs are charged with managing a considerable amount of public money and are required to ensure that all expenditure is value for money and achieves the best possible outcomes for patients for every pound spent. The funding of fertility services, as demonstrated above is a significant pressure on these financial resources. This paper outlines a number of criteria and parameters to ensure that access to fertility is available to those patients that require access, ensures access is fair and equitable but is also measured in that it recognises additional investment in these services is not currently affordable and therefore isn't something that can be offered.

5. Evidence-based Decisions

Solutions for Public Health (SPH), a specialist Public Health Consultancy team at Arden and GEM Commissioning Support Unit, were commissioned to review existing fertility policies across the five East Midlands ICBs, to provide information to support a collaborative approach to ICB policy making. The work included a comparison of assisted conception policies; evidence enquiries; a discussion on the ethical considerations (for policy areas where evidence is not helpful); collation and analysis of data on activity, costs and outcomes; and modelling of a range of policy scenarios. The full report can be found as appendix A.

The report presented a series of scenarios to outline the impact of changes to policy in relation to access in terms of clinical criteria, i.e. a patients BMI and/or age, and also looked at the impact in relation to changing the number of cycles of Intracytoplasmic Sperm Injection (ICSI) and In-vitro Fertilisation (IVF) and the impact this would have on the number of babies delivered and the cost of provision.

Although the review did consider the impact of inequity of access in relation to same sex couples, couples with children from former relationships and single people, it was unable to offer robust modelling on the impact of removing the inequity due to the availability of limited data.

Table 2 below provides the modelled scenarios for IVF/ICSI policy provision in terms of age and BMI of the patient and the number of IVF/ICSI cycles provided. Scenarios higher in the table provide more cycles of IVF to more people and indicates more live births. This is, however, with lower overall cost effectiveness (higher cost per live birth) and higher overall costs to ICBs.

The scenarios range from nearly full NICE guideline implementation to scenarios closer to current policies in East Midlands ICBs (bearing in mind that they do not include all policy criteria due to data constraints). Separate tables for each ICB are provided in the full report provided in appendix A.

Table 2: A selection of modelled scenarios for IVF provision for the five East Midlands ICBs combined

Scenario		Number treated	Total number of IVF cycles	Live births (LBs)	Cost	Cost per live birth (LB)	Comments
1	**Close to full NICE guideline implementation**: *BMI 18.5 to <35 kg/m^2 3 IVF cycles for women <40 1 IVF cycle for 40 to 42 year olds No other restrictions	1,680	2,962	872	£10.8 million	£12,356	• Least restrictive • Highest number treated • Most live births • Highest cost • Highest cost per Live Birth (LB)
2	**Close to current Bassetlaw policy**: *BMI 18.5 to <35 kg/m^2 3 IVF cycles for women <40 1 IVF cycle for 40 to 42 year olds Other restrictions e.g., re smoking, childlessness, etc.	972	1,712	505	£6.2 million	£12,357	• Highest cost per LB • Similar to NICE for BMI and number of IVF cycles but includes some restrictions
3	**Current Glossop policy**: BMI 18.5 to 30 kg/m^2 3 IVF cycles for women <40 1 IVF cycle for 40 to 42 year olds Other restrictions e.g., re smoking, childlessness, etc.	793	1,369	423	£5.0 million	£11,907	• Similar to NICE and Bassetlaw re number of IVF cycles, but additional BMI criteria and other restrictions

4	**Between Bassetlaw/Glossop and other East Midlands policies, closer to Glossop:** BMI 18.5 to 30 kg/m^2 3 IVF cycles for women ≤37 2 IVF cycles for 38-39 year olds 1 IVF cycle for 40 to 42 year olds Other restrictions e.g., re smoking, childlessness, etc.	793	1,342	421	£4.9 million	£11,671	• Reducing number of IVF cycles (3, 2, 1) with increasing age of woman • Little change in numbers treated, LBs or cost compared to Glossop policy
5	**Between Bassetlaw/Glossop and other East Midlands policies, closer to latter:** BMI 18.5 to 30 kg/m^2 2 IVF cycles for women <40 1 IVF cycle for 40 to 42 year olds Other restrictions e.g., re smoking, childlessness, etc.	793	1,170	382	£4.3 million	£11,289	• Same number of women treated, but 1.3x more LBs, higher cost per LB and 1.5x higher overall cost compared to most current East Midlands policies
6	**Wider BMI criteria than most current East Midlands ICB policies:** 1 IVF cycles for women ≤42 BMI 18.5 to 35 kg/m^2 Other restrictions e.g., re smoking, childlessness, etc.	972	981	335	£3.6 million	£10,698	• Less restrictive BMI criteria than most East Midlands policies except Bassetlaw • Fewer cycles for women <40 than Bassetlaw and Glossop
7*	**Close to most current East Midlands ICB policies:** 1 IVF cycles for women ≤42 BMI 18.5 to 30 kg/m^2 Other restrictions e.g., re smoking, childlessness, etc.	793	793	283	£2.9 million	£10,343	• Most current East Midlands policies except more restrictive than Bassetlaw and Glossop
8	**Most restrictive:** BMI 18.5 – 30 kg/m^2 1IVF cycle for people <38 Other restrictions e.g., re smoking, childlessness, etc.	693	693	263	£2.5 million	£9,508	• Most restrictive • Lowest number treated • Lowest live births • Lowest cost • Lowest cost per LB

The above table is an extract from the Management of Assisted Fertility: review of policies and options attached at appendix A. Page 6.

In this table, scenario 7* is the closest modelled option to existing service provision in the East Midlands.

In making the decision about which criteria to adopt for the East Midlands Fertility Policy, ICB's need to consider the potential impact of the different scenarios in terms of:

- Numbers of patients treated
- Outcomes, i.e., live births
- The cost to the ICB at a time of financial constraint
- The capacity of locally commissioned services to deliver fertility services
- The impact this might have on quality of provision
- The impact this might have on waiting lists.

Please note: The modelled options do not take into account maternal or perinatal complications, or the additional cost of drugs associated with treating patients with a higher BMI. This means that the cost per live birth may be an underestimate, particularly for obese child bearers. (See main report for model assumptions and limitations. See ethical considerations section for population groups not included).

6. Proposals for East Midlands Fertility Policy

6.1. Surrogacy Statement

In line with NHS England Policy that surrogacy is not available on the NHS the East Midlands ICBs deem that assisted conception treatments involving surrogates for any patient group are not routinely commissioned. Support and funding will not be provided for any associated treatments related to those in surrogacy arrangements. The below link relates to the NHS England web page regarding surrogacy amongst others;

Having a baby if you are LGBT+ - NHS (www.nhs.uk)

6.2. Number of cycles

Considering that:

- The increase in the number of cycles for IVF is the major contributor to the modelled cost increases outlined in Table 1
- Most current fertility policies across the East Midlands only offer one cycle of IVF, with the exception of Bassetlaw and Glossop
- The financial pressures outlined above that dictate that there is no additional funding available.

The proposal for the East Midlands Fertility Policy is to offer one cycle only across the whole of the East Midlands region.

6.3. Funding for IUI/DI and the number of cycles

It is proposed that IUI/DI will be offered for those couples / individuals where vaginal intercourse is not possible or appropriate and there are no other identified fertility issues (must have regular ovulation, patent tubes, and normal sperm count for the partner/donor). The success rate for unstimulated IUI / DI is low therefore the option of proceeding straight to IVF should be discussed with the person wishing to become pregnant. The proposed policy does not require IUI / DI prior to consideration of IVF.

The proposal for the East Midlands Fertility Policy is to offer up to three cycles of unstimulated IUI/DI for those couples / individuals where vaginal intercourse is not possible or appropriate prior to considering IVF.

Single women or trans men with no known fertility issues (must have regular ovulation, and patent tubes) will also be offered for up to three cycles of unstimulated DI where the donor has a normal sperm count.

6.4. BMI and Age

It is recommended that the new policy maintains the age ranges and BMI ranges currently within the NICE Guidance these criteria have the clinical evidence and review to support them.

For heterosexual couples the age criteria apply to the female only men with a BMI of 30 or over should be informed that they are likely to have reduced fertility.

Same sex female couples the BMI and Age would be relevant to the pregnancy carrier and egg provider if different, it should be noted that IVF is funded per couple for shared motherhood.

The proposal for the East Midlands Fertility Policy is to offer access to services around BMI and Age in line with the clinical criteria set out in the NICE guidance.

6.5. Smoking

The NHS should encourage people to quit smoking at every opportunity. Studies have shown that women who smoke are at an increased risk for a delay in becoming pregnant and for both primary and secondary infertility. Research has also shown that women who smoke during pregnancy risk complications, premature birth, low birth weight (LBW) infants, stillbirth, and infant mortality.

The proposal for the East Midlands Fertility Policy is to include the requirement for all parties involved in the treatment to be non-smoking/vaping or have quite smoking/vaping.

6.6. Living Children

Most current policies require that both partners have no living children (except Glossop), this is not addressed by the NICE guidance.

The proposal for the East Midlands Fertility Policy is to maintain the majority position in that the person wishing to become pregnant and / or their partner must not have a Living Child from their current relationship or any previous relationship.

6.7. Partners who have been sterilised

Most policies do not currently fund IVF if either partner has ever been sterilised (except Bassetlaw and Glossop) again this is not addressed by the NICE guidance. Sterilisation is offered within the NHS as an irreversible method of contraception.

The proposal for the East Midlands Fertility Policy is to go with the majority and not provide fertility treatment for couples where their infertility arises wholly or partly from sterilisation of either partners.

6.8. Same-sex female couples

For same-sex female couples the requirements for proving infertility prior to access to IVF vary between policies with the majority being silent on the issue.

The proposal for the East Midlands Fertility Policy is that same sex couples are considered to have a known fertility issue and are therefore eligible for treatment if all other criteria are met.

6.9. Single women

For single women the requirements for proving infertility prior to access to IVF vary with the majority being silent on the issue.

The proposal for the East Midlands Fertility policy is that single women and trans men are considered to have a known fertility issue and are therefore eligible for treatment if all other criteria are met.

The new policy should include access for all individuals and couples with a fertility problem, regardless of their sexual orientation, gender identity or relationship status.

6.10. Gametes Storage

For cryopreservation of gametes and embryos to preserve fertility, all policies include funding for those about to start treatment that permanently affects fertility (as does NICE) although the conditions listed, and age criteria and duration of storage vary.

The proposal for the East Midlands Fertility policy is to include access to storage of gametes if the patient is due to commence a medical or surgical treatment likely to permanently affect their fertility.

6.11. Duration of storage

The legal duration of storage is governed by statutory Human Fertilisation and Embryology Authority (HFEA) legislation and regulations.

The proposal for the East Midlands Fertility policy is to include NHS funded storage of gametes or embryos for up to 3 years.

7. Next Steps

This case for change will be presented to decision making forums within each ICB to endorse the direction of travel.

Following this a period of engagement will then follow to determine the impact of these proposals on our populations in the East Midlands and gather feedback and thoughts on the proposals to be considered and fed into the final policy.

Appendices

Solutions for Public Health (SPH), a specialist Public Health Consultancy team at Arden and GEM Commissioning Support Unit, were commissioned to review existing fertility policies across the five East Midlands ICBs, to provide information to support a collaborative approach to ICB policy making. The work included a comparison of assisted conception policies; evidence enquiries; a discussion on the ethical considerations (for policy areas where evidence is not helpful); collation and analysis of data on activity, costs and outcomes; and modelling of a range of policy scenarios.

Appendix A

East Midlands ICBs assisted conception policy review – executive summary – Final October 2023.

Appendix B

East Midlands ICBs assisted conception policy review – Final October 2023.

Agenda Item 11

LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE: 27 NOVEMBER 2024

WATER FLUORIDATION

REPORT OF THE DIRECTORS OF PUBLIC HEALTH FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

Purpose of report

1. The purpose of this report is to update the Committee on the process for requesting and implementing water fluoridation, as well as to provide an overview of the progress made to date in relation to this across Leicester, Leicestershire and Rutland (LLR).

Policy Framework and Previous Decisions

2. The Health and Care Act 2022 provides powers for the Secretary of State to introduce, vary and terminate community water fluoridation schemes. Prior to this, local authorities had the responsibility, through the Water Industry Act 1991.

3. Water fluoridation was discussed during the Joint Health Scrutiny Committee meeting on 17 July 2024, where officers were requested to provide an update at a subsequent meeting.

4. Water fluoridation has been presented at Leicester City Council's Public Health and Health Integration Scrutiny Commission on 16 April 2024, where the Commission were supportive.

5. A motion will be proposed and seconded at the Rutland Council meeting on 21 November 2024 by Liberal Democrat Councillors Abigail West and Mark Chatfield in support of water fluoridation.

Background

6. Oral health varies significantly across LLR, with substantial inequalities present.

Upper Tier LA	% of 5-year-olds with experience of tooth decay (dmft) (2021/22) *dmft= Decayed, missing due to caries, or filled teeth*

Leicester	37.8%
Rutland	15.1%
Leicestershire	19.1%
England	23.7%

7. Research has consistently shown strong associations between socioeconomic disadvantage and poorer oral health, which also includes oral cancers. Our most disadvantaged and vulnerable populations carry the greatest burden of oral diseases, and also face substantial barriers to accessing dental care.

8. Evidence supports water fluoridation as an effective public health measure that has the ability to benefit both adults and children, reduce oral health inequalities and offer a return on investment. There is also no evidence of health harms from the levels of fluoride used in English schemes, nor the slightly higher levels allowed naturally. Despite this, no new schemes have been implemented for nearly 40 years.

9. Fluoride is a naturally occurring mineral found in water and some foods. The amount of naturally occurring fluoride in water varies across the UK due to geological differences.

10. Water fluoridation schemes involve adding fluoride to community drinking water supplies in areas of low natural fluoride, increasing the level to that known to reduce tooth decay. This happens in approximately 25 countries internationally, covering an estimated 400 million people.

11. Evidence from observational and interventional studies shows that appropriate levels of fluoride can reduce the prevalence and severity of dental decay in both adults and children.

12. Fluoride in water does carry a small risk of dental fluorosis. In its mildest form, dental fluorosis appears as very fine pearly white lines or flecking on the surface of the teeth. To minimise the risk of fluorosis, fluoride in drinking water is tightly controlled and measured. Although the regulatory limit for fluoride is 1.5mg/l, in England, water companies with fluoridation schemes have a lower target dose of 1mg/l.

13. Water fluoridation is supported in the UK by many professional health organisations including dentistry associations, the UK Chief Medical Officers, the NHS, the British Medical Association and UK Faculty of Public Health. Globally water fluoridation continues being supported by the World Health Organisation (WHO), the FDI Dental Federation, and the International Association for Dental Research.

14. There is very little data on public perception of water fluoridation schemes. In England, a study published in June 2021 assessed public attitudes in five areas in the North East of England, and found that 60% of respondents were in favour of adding fluoride to the water supply to prevent dental decay, while 16% were opposed. A 2022 Scottish study also found strong support for water fluoridation, with significant numbers wrongly believing their water was already fluoridated.

15. A consultation to expand the water fluoridation scheme in the North East of England has recently closed. The results of this consultation are expected to be published by the Department of Health and Social Care in late 2024. If the results from this consultation are negative and the Secretary of State chooses not to progress, then the likelihood of fluoridation across LLR is extremely low.

16. The process for achieving water fluoridation is as follows:

    a) Although not part of the legislative process, other local authorities have aimed to demonstrate their need and interest by gaining local approval and then the creation of a comprehensive evidence pack submitted to the Secretary of State for Health and Social Care (SoS);
    b) Decision by SoS to potentially establish a new scheme, or vary an existing scheme;
    c) Water company (e.g. Severn Trent or Anglian) would be instructed to conduct a feasibility study to identify if a new/expanded scheme would be feasible and the geography that would be covered;
    d) Public consultation undertaken if a scheme is determined as feasible;
    e) After considering this, the SoS would decide whether fluoridation will be implemented in the area;
    f) Detailed engineering plans to be created and planning permission to be obtained;
    g) Drafting of legal agreements;
    h) Building of new infrastructure;
    i) Switch on of the new system.

17. No timeframe for this process is available however it is likely to be considerable, possibly 5-10 years.

18. The previous Conservative government was in favour of water fluoridation and launched the consultation on expansion of the scheme in the North East of England. The new Labour government has not yet announced a position on water fluoridation.

19. In early 2024, Nottingham City and Nottinghamshire County Council jointly submitted a letter and evidence pack to the Secretary of State to petition for water fluoridation. They are yet to receive a response, beyond an acknowledgement.

20. The evidence pack should contain all relevant documents to highlight why fluoridation would benefit the local population. It was also advised, and conducted by Nottingham(shire) colleagues, to have various signatories to their letter to the SoS, as well as showing how other key stakeholders and partners were engaged and who is supportive. It is logical to assume that if there is support across a wide range of organisations, and a larger geographical/population footprint that an approach may be looked on more favourably by the SoS.

21. Due to the high initial infrastructure costs (which central government take on), as demonstrated by the North East expansion proposals, working across a larger

footprint would likely be more favourable to the government due to the cost effectiveness. Working together across LLR is more likely to strengthen the case.

Fluoridation Across LLR

22. The majority of LLR's water is supplied by Severn Trent, with smaller areas on the East of LLR provided by Anglian Water. Very small conurbations have existing fluoridated water within North West Leicestershire and Melton. Officers have met with fluoridation specialists within both water companies to informally discuss logistics and feasibility. Although the local water supply is complex, fluoridation would be possible, but until feasibility assessments are conducted the whole impact and effect cannot be known.

23. Leicester City Council have publicly declared their intention to approach the Secretary of State, and reports have been presented to the relevant bodies and committees including the Public Health and Health Integration Scrutiny Commission.

24. A motion will be proposed at the Rutland Council meeting on the 21st of November seeking support for fluoridation.

25. Leicestershire County Council are currently undertaking internal discussions, with Public Health Officers liaising with the lead Cabinet member for Health.

26. Fluoridation has been discussed within the Integrated Care Board Clinical Executive and they are supportive of an approach to the Secretary of State. NHS England, via the regional Consultant in Dental Public Health, and the Office of Health Improvement and Disparities, via the Regional Deputy Director have also been consulted and are supportive of an LLR approach.

27. The evidence pack developed by Nottingham City and Nottinghamshire County Councils will be used as a blueprint locally in LLR to formulate a local evidence pack.

Impact Assessments/Implications

28. Water fluoridation would be of benefit to all within the community and provides an opportunity to narrow oral health inequalities across all populations and protected characteristic groups. However, to have maximum benefit, it should be provided within a suite of other interventions and preventable measures such as supervised tooth brushing and reducing high sugar diets, as well as supported by access to dentistry. Local schemes and plans are in place to address all of these.

29. An equality impact assessment has not yet been conducted. This would form part of the consultation, if taken forward by the Secretary of State.

30. Other impact assessments would also be considered at later stages and by either the secretary of state or by water companies, such as environmental impacts and risk assessments.

Consultation

31. If, after approaching the Secretary of State, the Secretary decided to look at LLR as a potential area for fluoridation, a full public consultation would be undertaken, as

described in the steps under paragraph 14 above. This would be led by the Department of Health and Social Care.

Resource Implications

32. At present, there are no resource implications. In the future, if fluoridation was considered by the Secretary of State, then all consultation, feasibility, subsequent water infrastructure changes and ongoing delivery costs would be covered by central government. If a consultation were to be carried out local bodies, including councils, would need to consider identifying resources to support local engagement and communication.

Timetable for Decisions

33. Leicester City Council have already considered fluoridation via the Public Health and Health Integration Scrutiny Commission and are working on putting together an evidence pack to submit to the Secretary of State. Rutland Council and Leicestershire County Council are still undertaking internal processes.

34. The next step is to review the outcomes of the consultation in the North East of England. If the SoS decides not to progress with fluoridation, then further local action across LLR may not be viable. However, if the response is positive, then submitting a letter and supporting evidence to the SoS for their consideration would be explored.

Conclusions

35. Overall, water fluoridation is an effective approach to improving oral health, and with the current issues affecting the dental sector, population approaches are much needed. The process for fluoridation is summarised above.

Background papers

Health and Care Bill: Water Fluoridation
https://www.gov.uk/government/publications/health-and-care-bill-factsheets/health-and-care-bill-water-fluoridation#what-the-bill-will-do

Oral Health Needs Assessments

- Leicester City https://www.leicester.gov.uk/media/ejoj3sa5/oral-health-adults-jsna-2023-update.pdf
- Leicestershire https://www.lsr-online.org/uploads/oral-health-14.pdf?v=1701700707
- Rutland https://www.lsr-online.org/uploads/oral-health.pdf?v=1678984171

Statement on water fluoridation from the UK Chief Medical Officers
https://www.gov.uk/government/publications/water-fluoridation-statement-from-the-uk-chief-medical-officers/statement-on-water-fluoridation-from-the-uk-chief-medical-officers

Circulation under the Local Issues Alert Procedure

36. None.

Equality Implications

37. An equality impact assessment is not needed at this time, as there are no equality implications arising. However, if fluoridation was to be explored further, then a full equality impact assessment would be conducted.

Human Rights Implications

38. There are no human rights implications arising from the update in this report.

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