Leicester
City Council

MEETING OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

DATE: **WEDNESDAY, 16 DECEMBER 2020**

TIME: **5:30 pm**

PLACE: **Zoom Meeting**

Members of the Commission

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

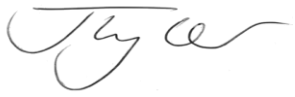
Councillors Aldred, Chamund, March, Dr Sangster and Westley

1 unallocated Non-Group place.

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

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester



For Monitoring Officer

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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

Information for members of the public

PLEASE NOTE *that any member of the press and public may listen in to this 'virtual' meeting on Zoom through YouTube at the following link:*

https://www.youtube.com/channel/UCddTWo00_gs0cp-301XDbXA

Members of the press and public may tweet, blog etc. during the live broadcast as they would be able to during a regular Commission meeting at City Hall.

It is important, however, that Councillors can discuss and take decisions without disruption, so the only participants in this virtual meeting will be the Councillors concerned, the officers advising the Commission and any external partners invited to do so.

Attending meetings and access to information

You have the right to attend/observe formal meetings such as full Council, committee meetings & Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

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Making meetings accessible to all

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Further information

If you have any queries about any of the above or the business to be discussed, please contact: Jason Tyler**,** Democratic Support Officer on (0116) 454 6359 or email jason.tyler@leicester.gov.uk

For Press Enquiries - please phone the **Communications Unit on 0116 454 4151**

USEFUL ACRONYMS RELATING TO
HEALTH AND WELLBEING SCRUTINY COMMISSION

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

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

PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. CHAIR'S ANNOUNCEMENTS

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 6)**

The minutes of the meeting held on 6 October 2020 are attached and the Commission is asked to confirm them as a correct record.

5. PETITIONS

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

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

Eight Questions have been received in respect of the reconfiguration consultation and are listed at that item later on the Agenda.

The following Questions have also been received from Mr Ambrose Musiyiwa:

Question 1

In the Health and Wellbeing Scrutiny Commission of Thursday, 30/01/2020, Cllr Melissa March reported that in 2017 she was asked to produce a passport or another form of ID before she could be allowed to access maternity care. (See item 7 here):

www.cabinet.leicester.gov.uk:8071/ieListDocuments.aspx?CId=737&MId=9470&Ver=4)

The response from the UHL NHS Trust was that they did this because they were trialling overseas visitors' policies in different settings. The Trust also indicated the trials have been taking place as recently as the 18 months leading up to January 2020.

Can the UHL NHS Trust produce the ethics, risk and impact assessments that were done before and after the passport and ID checks?

How long did/has the UHL NHS Trust been conducting these checks? How many of these checks have been conducted? Who has been conducting them, when, where and how?

What effect have the checks had on GP surgeries, hospitals and on patients and people who use the NHS?

Are the checks still going on? What does the UHL NHS Trust do with the information they collect(ed) through these checks? What effect do/have these actions had on the patients and people affected?

It is important that the hospital answer these questions and produce the ethics, risk and impact assessments because passport and ID checks are associated with borders and border control. Depending on what passport they hold or do not hold, some people can breeze through borders while others experience borders as places of extreme and sometimes lethal violence.

Question 2

Information on the Leicester City Council website says, in 2012/14, rates of stillbirth and perinatal and infant deaths in Leicester were higher than the national average

https://www.leicester.gov.uk/your-council/policies-plans-and-strategies/public-health/data-reports-information/jsna/cyp-jsna/pre-birth-to-antenatal/

Similarly, the Leicester, Leicestershire and Rutland Child Death Reviews (2011/12 to 2016/17) reports that child deaths in Leicester are higher than the national average

https://lrsb.org.uk/uploads/llr-child-death-review-analysis.pdf

Appendix B (especially pages 10 and 11) of the minutes of the Health and Wellbeing Scrutiny Commission of 30/01/2020 hints at these issues when it emphasises initiatives and measures that have been put in place to reduce child mortality - but, at the same time, does not say how many stillbirths and perinatal and infant deaths have been or are occurring Leicester or explain why these deaths are happening.

In the Health and Wellbeing Scrutiny Commission meeting of 30/01/2020, the chair asked the UHL NHS Trust for statistics and reports on the deaths.

Did the Trust provide the reports?

7. UHL RECONFIGURATION CONSULTATION — Appendices B&C (Pages 7 - 26)

The Chief Executive Officer of the Clinical Commissioning Groups in Leicester, Leicestershire And Rutland submits a report at Appendix B titled:

'Building Better Hospitals for The Future'

The report responds to questions previously raised by the Commission 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.

Eight questions have been received in relation to this item as attached at Appendix C.

Responses to those questions will be provided by the UHL/CCGs prior to the meeting.

8. COVID19 UPDATE

The Director of Public Health and NHS partners will provide a verbal update regarding Covid-19, including the vaccination programme.

A further update will be provided on the progress of the flu vaccination programme.

9. SCOPING DOCUMENT FOR SCRUTINY REVIEW - BLM AND NHS WORKFORCE — Appendix D (Pages 27 - 36)

A Scrutiny Review Document is attached titled:

'The experience of Black People Working in Health Services in Leicester and Leicestershire'.

The Commission is recommended to adopt the Review following discussion of its rationale and purpose.

10. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: TUESDAY, 6 OCTOBER 2020 at 5:30 pm

P R E S E N T:

Councillor Kitterick (Chair)

Councillor Aldred Councillor Chamund
Councillor March Councillor Sangster

In Attendance:

Councillor Dempster, Assistant City Mayor - Health

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Fonseca (Vice-Chair) and from Councillor Westley.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES OF PREVIOUS MEETING

AGREED:

That the Minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 23 June 2020 be confirmed as a correct record.

4. PETITIONS

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

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no representations or statements of case had been submitted. The following Questions had been received in accordance with the Council's procedures and were included on the Agenda pages:

A. From: Brenda Worrall

Have local NHS leads published the document which brings together or offers a guide to reconfiguration proposals and which was promised in January at the Joint Scrutiny Committee meeting?

B. From: Sally Ruane

1. Will the Health and Wellbeing Scrutiny Commission be requiring the acute reconfiguration Pre-Consultation Business Case and the details of the proposed consultation process in advance of the start of the consultation itself?

2. On 31st July Simon Stevens & Amanda Pritchard wrote to all NHS trusts and health providers outlining priorities for the rest of the year. The focus is on plans to restore cancer and GP services, expand and improve mental health services and make preparations for winter whilst also preparing for localised or national Covid outbreaks. Additionally, it sets targets to recover the elective activity. My understanding is that local systems must return a draft summary plan by 1 September using templates issued by NHSE and covering the key actions set out in the letter, with final plans due by 21 September. How were the public involved in the development of these plans and when will these plans be put in the public domain?

C. From: Robert Ball

On what date does (or did) the national committee meet to consider final approval of the Pre-Consultation Business Case for the acute hospital reconfiguration proposals in Leicester? If the committee has already met, what is the outcome? Will the public be consulted on the establishment of an Integrated Care System in Leicester, Leicestershire and Rutland?

The Chair invited each questioner present in the virtual meeting to read their question. He advised that responses to all questions could be considered concurrently and the following responses were noted:

Andy Williams (Leicester, Leicestershire and Rutland CCGs) commented on the pre-consultation business case for the reconfiguration proposals, which had been published and he encouraged the public to engage in the formal process. He acknowledged that the documentation was large and added that there were many forums involved to ensure that the plans were widely accessible.

The role of the Commission to ensure proper and full scrutiny of the proposals was recognised. The Chair added that there would be regular updates and that specific questions from members and the public would be invited to future meetings.

It was confirmed that previous concerns raised had been recorded and noted as part of the public engagement process throughout the consultation period.

The intention and work of the CCGs to ensure public engagement and transparency in the process was welcomed.

In terms of the questions concerning consultation on the role of GPs, including cancer support, and mental health practices during Covid-19, it was accepted that further information was required on the specific patient participation, as it was considered that other than the engagement through Healthwatch, there had been little public participation.

In conclusion, it was noted that as proposals developed and the consultation period continued, any further issues and matters of concern could be referred to the Commission in due course.

The Chair and Health partners highlighted the role of the Commission in the process and reminded the public of the value of their participation as part of the Scrutiny Procedure Rules.

6. PRE-CONSULTATION STAGE OF THE UHL RECONFIGURATION PROPOSAL FOR LEICESTER'S HOSPITALS – UPDATE

Further to the comments made in respect of the previous item ‘Questions’, the Chair asked Mark Wightman (UHL) to address the Commission.

It was noted that in terms of the pre-consultation business case, options had been affected by the ongoing situation with Covid-19. The outline business case and full business case would be revised, and the design of the reconfiguration proposals would be submitted to the Commission and the Joint Health Scrutiny meetings in due course.

Andy Williams (Leicester, Leicestershire and Rutland CCGs) referred to the detail and importance of presenting the proposals as an opportunity to bring forward changes.

The Chair welcomed the update and thanked health partners for their positive engagement and asked the public to use the participation options through the Commission’s Procedure Rules to raise any concerns.

It was accepted that at this stage that responses to the consultation were being collated and a more detailed report would be submitted at a later date.

The position was noted.

7. FLU PROGRAMME UPDATE

The Chair asked Caroline Trevithick (West Leicestershire CCG) to address the Commission.

The report submitted provided a briefing on work being undertaken in relation to the flu vaccination programme 2020/21 and it was noted that it was important to maintain high vaccination coverage. The flu vaccine remained one of the best defences available against flu, however the delivery of this year's programme was more challenging because of the impact of Covid-19.

It was reported that flu vaccinations were taking longer because of the need to observe social distancing rules and the need for clinicians to change personal protective equipment (PPE). The expansion of the programme to an increased number of eligible groups such as people over 50 years, despite the plans for phased approach, created practical challenges around vaccine supply and storage.

A 'Flu Board' had been established and its Terms of Reference had been agreed to ensure support and address any issues at the earliest opportunity.

A number of areas of focus had been identified and named leads were allocated to specific areas.

In terms of the Flu Vaccination programme, details were provided relating to delivery, communications, and the impact of possible future Covid-19 vaccinations.

In conclusion it was reported that although the situation was challenging, the establishment of the Flu Board would help with the coordination and support being provided would be instrumental in achieving the ambitions.

The update was noted.

8. COVID19 - UPDATE

Ivan Browne (Director of Public Health) submitted a report, which referred to the 18 June 2020 decision where the Council had established an Incident Management Team (IMT) to investigate and control the increase in coronavirus (Covid-19) following the publication of pillar 2 (community) test results for Leicester City.

It was reported that on 29 June 2020, the secretary of State for Health and Social Care announced local restrictions to the city of Leicester and to parts of the bordering Leicestershire County. At that time, the incidence of coronavirus cases in Leicester per 100,000 population for the previous 7-day period was 135/100,000. The IMT established a governance structure to investigate and control the outbreak.

It was further reported that the first laboratory confirmed case of Covid-19 in Leicester was on 11 March 2020 and that there had been 7440 confirmed cases in the city to 2 October 2020.

Ivan Browne (Director of Public Health) then gave a presentation to provide up to date information, since the publication of the report in the agenda pack.

It was confirmed that the majority of recent positive results were amongst working age people, however positive tests in children and older people had also been recognised. The pattern of cases had changed from certain 'hotspots' in areas to the north and east of the city centre to a more widespread distribution.

There had been 119,969 tests carried out on Leicester residents up to the 30 September 2020 and the percentage positive was related to the testing strategy and numbers tested.

The presentation also included details of Leicester resident UHL hospital admissions, the length of stay for admissions and deaths in Leicester, with 2096 deaths being recorded. Based on average mortality data this figure revealed an excess of 244 deaths during 2020.

The Chair invited Councillor Dempster (Assistant City Mayor - Health) to comment. She asked that thanks to all Public Health staff be recorded on behalf of the Executive and all members across the City Council in terms of the hard work undertaken in response to increased cases and the lockdown period.

In conclusion, the Commission noted the ongoing situation and also expressed their appreciation to the Public Health Team. It was clarified that further updates would be submitted to the Commission and other meetings in due course.

9. ADVENTURE PLAYGROUNDS AND FARESHARE

Simone Connolly (Leicester PlayFair and Fareshare) gave a presentation on their holiday hunger programme at adventure playgrounds in line with the stated aims of Public Health.

It was noted that Fareshare continued to lead programmes on improving access to food during the school holidays. Their aim was to reach more children and to continue to improve access to good, healthy food, ensuring that no child would go hungry.

It was noted that alongside health benefits, supported children did better at school and the work continued to provide and develop a holistic approach to addressing child hunger. This was supported by the Strategic Director (Social Care and Education) who also provided an update on the Council's link to the programme.

In terms of investment and evaluation it had been recognised that the effect of Covid-19 would continue to impact the programme's aims.

The aims of the programme were noted as follows:

"Food security is split into food access and poverty created by wealth. Neither FareShare or Feeding Leicester is trying to be the solution to poverty but instead seek to influence underlying causes and aim to ensure that communities have access to nutritious, healthy food that can help to prevent poor health and inequality.

Understanding where and why poverty occurs is vital to allow us to put in place interventions as important as the summer holiday food programme"

The Chair thanked Fairshare for their presentation and invited comments.

It was noted with regret that the statistics submitted outlined that up to 40,000 children in the city were affected by child hunger, which related to 41% of the population.

In conclusion Commission Members confirmed their continuing support to Fareshare and Leicester Playfair.

10. CLOSE OF MEETING

The meeting closed at 8.50 pm.

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

NHS

LEICESTER CITY HEALTH AND WELLBEING SCRUTINY COMMISSION – WEDNESDAY 16 DECEMBER 2020

BUILDING BETTER HOSPITALS FOR THE FUTURE

REPORT OF THE CHIEF EXECUTIVE OFFICER OF THE CLINICAL COMMISSIONING GROUPS IN LEICESTER, LEICESTERSHIRE AND RUTLAND.

Purpose of the Report

1. This report responds to questions raised by Leicester City Health and Wellbeing Scrutiny Commission 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.

   This is the second report to the Leicester City Scrutiny Commission during the period of public consultation, which ends on 21 December 2020. In addition there has been two more formal meetings with the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee and a further briefing on bed assumptions and planning.

Policy Framework and Previous Decisions

2. The draft LLR CCGs' plan for Building Better Hospitals for the Future has been discussed with Leicester City Scrutiny, as well as other stakeholders, a number of times over recent years.

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

3. 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 and NHS England Specialised Commissioning.

Background

4. The public consultation commenced on 28th September 2020. Full details on the public 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).

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

6. CCG duty (s14Z2)

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

10. The public consultation takes account of the range of legislation that relates 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

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

Consulting in a pandemic

8. 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'.

9. 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 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.

10. 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 use 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 have 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.

11. 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.

12. 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

13. 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.

14. 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.

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

16. 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.

17. 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.

18. 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.

19. 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;

20. 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.

21. 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.

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

23. 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.

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

25. 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.

26. 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.

27. 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.

28. 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 Joint Overview and Scrutiny Committee for Leicester, Leicestershire and Rutland.

Maternity Services

29. 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 - delivering both equity of service and access.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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.

35. 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.

36. 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.

37. 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.

38. 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).

39. 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.

40. 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.

41. 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.

42. 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.

43. 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.

44. 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.

45. 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.

46. 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.

47. If the consultation shows support for the Midwifery Led Unit at Leicester General Hospital and the proposal is implemented and the centre is open, a review body would be established comprising of midwifes, parents and other stakeholders who will co-produce the service with UHL.

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

49. 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.

50. 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.

<u>Clinical support of the plans</u>

51. 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.

52. 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.

53. 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 highlights the strength of argument for the change, particularly from a workforce and sustainability perspective.

Bed numbers

54. Our plans for investing £450 million in modernising and improving Leicester's hospitals is about much more than simply creating additional beds. Had it not have been it is unlikely our bid for Government funding would have been successful.

Instead our proposals are about correcting decades of capital under-investment in our hospitals. They address some of the clinical adjacency and co-location issues that all too often hinder our ability to deliver the kind of care and experiences we want for our patients.

Simply put services are currently organised in a way that is a legacy of history rather than design, often in buildings and facilities that are outdated and not fit for the delivery of modern healthcare.

This often means that clinical services which should be operating side by side aren't, creating confusion and multiple journeys for patients. Other times, by providing the same services from multiple sites, our staff and resources are spread too thinly - stretching them to breaking point.

It's on this basis that we believe these changes are absolutely essential in order for us to improve clinical quality, make the most of a workforce that is already depleted due to national shortages, as well as improving the experiences and outcomes of our patients.

However, we understand the importance of getting our bed numbers right. We are continually reviewing bed numbers and our current assumption is that, if we do nothing, we will need 300 more acute hospital beds by 2024 in order to meet rising health need and population growth.

To help address this shortfall there are a number of things we are already doing and will continue to do going forward. This includes reducing length of stay beyond what is necessary. This is important because evidence is clear that staying in hospital longer than is needed leads to poorer outcomes. It is essential that people are discharged when they are medically fit in a timely many and not sent home before they are ready. We are also improving our internal processes to make sure that every minute of a patient's stay counts and that we minimise any delays for tests or treatment.

Based on improvements already made our conservative assessment is that 161 of the beds can be achieved in this way – simply by making better use of what we already have. We think the number could be higher than this, but have taken the decision to be cautious.

We are also planning to create 139 new acute hospital beds.

The pre-consultation business case described that 69 of these beds would be created up front, with 28 coming from the conversion of an existing non-acute rehab ward so that it is able to accept patients with a greater level of need. The other 70 were described as 'contingency' beds, which would be created in later years should they be necessary. In light of our experiences of responding to the Coronavirus pandemic our thinking has updated slightly. As a result, and as set out in our consultation document, we now plan to create all 139 new acute beds up front in order to provide additional flexibility and capacity should we need it. These will be funded from the £450 million government funding and the Trust's own capital allocation.

Whilst we believe that these additional beds will stand us in good stead beyond 2024 we will keep our bed planning under constant review. If absolutely necessary we maintain the flexibility to increase bed numbers within our planned estate.

Long term planning if future developments are needed

55. As set out above, this development is about much more than beds.. However, if further capital developments are needed to meet growth in population or health need, then we do have flexibility in our existing estate. We retain 33 acres of developable land – the equivalent to approximately 22 football pitches. This is located at the Glenfield Hospital. More than 25 acres of this land is already empty space.

    If future developments are needed they would likely be funded from the Trust's own capital budgets and, working with local NHS and local government partners, through access to section 106 funding and community infrastructure levy to support services when housing growth puts pressure on them.

    We will also continue to maximise space at the Leicester Royal Infirmary, with appropriate planning consent if necessary. We appreciate that it is essential to consider travel, access and car park when considering what services are provided on this site.

Community hub

56. Under our proposals Leicester General Hospital would no longer be an acute hospital. Instead we are proposing to create a community campus on the site which would serve people living in the east side of the city and county and beyond and would include:

    - Leicester diabetes centre of excellence – a dedicated building where it currently resides. This facility has been developed over recent years and provides dedicated services from newly refurbished estate
    - Dedicated GP access imaging hub – the current imaging facilities would be retained and reconfigured to provide an independent facility.

This would ease the increased footfall on the two acute sites, release space on the two acute sites for additional development and separate urgent inpatient imaging from GP imaging
- Stroke rehabilitation – stroke rehabilitation services with in-patient beds would continue to be provided from this site
- Midwifery-led unit – dependant on the outcome of public consultation, this would be provided within the existing Coleman Centre.

In addition, we have been exploring through this consultation the potential development of other services at this site. People have so far been very receptive in their feedback on a number of areas including:

- Primary care urgent treatment centre which would be GP-led, open at least 12 hours a day, every day, offering appointments that could be booked through NHS 111, a GP practice or referred from the ambulance service. There would also be a walk-in access option. It would be staffed by GPs, nurses and other clinicians and equipped to diagnose and deal with many of the most common ailments people attend the emergency department for. We believe that the centre would ease pressure on the emergency department and improve convenience as patients would no longer need to travel to Leicester Royal Infirmary in the city centre
- Observation facility located alongside the primary care urgent treatment centre for patients where admission is not necessary, but where they need to be cared for and monitored for up to eight hours by suitably trained staff. The patient would then be assessed and a decision made on whether an admission is necessary, or whether a safe discharge or referral to another service is more appropriate
- Community outpatients service providing additional care for people referred for treatment in the community. People would be treated as an outpatient or a day case for a range of conditions both physical and mental, avoiding the need to go to an acute hospital. The service would also offer follow-up appointments
- Additional primary care capacity to provide family health care to people living in the east of the city, which would help to meet the expected increase in residents over the next decade.

We are also keen to continue to hear the views of the public on other community-based services that could be provided from this location.

As the acute services move from Leicester General Hospital to the other two hospitals, the NHS buildings they are currently housed in would be vacated.

These buildings and the land they stand on would be freed up and sold for affordable housing developments which we would hope key workers would be attracted to. The money from the sale of the land and buildings would be reinvested into the hospitals.

Recommendation

57. The Health Scrutiny Commission 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.

Appendix C

Public questions received on the UHL Reconfiguration item

For the 16th December 2020: City Health & Wellbeing Scrutiny Commission

1. Robert Ball

With regards to the UHL Reconfiguration Plan. The questions following are for the Leicester City Health and Wellbeing Scrutiny Commission ahead of its meeting on 16th December.

a) **Why are the risks of placing all 11,000 births in one maternity building not on the risk register? What do you think these risks are and how will you address them?**

At the UHL Board Trust meeting, 2pm 3rd September 2020, Paper B states:

"Sustainability is clearly going to be mandated. The expected brief has been shared with us, which includes the need to ensure new buildings are carbon neutral. Since our design assumptions are at a high level, we need to employ expert advisors to work with us to determine how this can be delivered, and at what cost. It is recognised that this requirement will impact on capital, so further discussions are required on the extent of delivery."

In addition, the Preconsultation Business Case states: "...the highest level of BREEAM performance rating and stars as **practicable**."

b) **Will UHL please confirm the new buildings will be designed and built to the highest of the five BREEAM ratings available to the 'Outstanding' rating Star 5 and the capital funding is available to achieve this?**

2. Brenda Worrall

Your proposals dramatically reduce choice for expectant mothers. Why won't you commit to the provision of a free-standing midwifery unit for low risk mothers? Offering one is part of NICE's quality statement but you are offering only a possible 12 month trial of a free-standing midwifery unit on the site of the General Hospital, with no associated capital investment. Requiring 300-500 births (the numbers keep changing) in a 12 month period, the trial looks as if it is set up to fail.

3. Jean Burbridge

Some risks of cost overruns are present in the risk register but some of them are not. Recent tenders have come in at higher than expected cost. Also, the proposals were costed before the pandemic so altering hospital design to allow for the greater space and flexibility needed in pandemic planning may also push costs up. Why is the possibility of cost overruns because of higher than expected construction and project management costs not reflected in your risk register?

Will the Department of Health cover additional costs for pandemic planning and how will you address cost overruns from higher than planned construction costs?

4. Jill Friedman

In response to public questions NHS leads have spoken about the removal of services from the Royal Infirmary to Glenfield as an example of how traffic on the LRI site will reduce. However, it has not spoken about how the new services on the LRI site, including a Maternity Hospital supporting 11,000 births, will affect traffic within the site and parking. Can it be more specific? Also it has ignored the issue of the congested nature of the roads around LRI and the impact that will have on access to LRI. Are there plans to improve traffic flow in the area?

5. Indira Nath

What happens after 2024? A £450m capital expenditure on hospital services is a long-term investment, so what is the long-term plan for hospital expansion after 2024? I appreciate that bed modelling is difficult, but population increases are a certainty, so a plan for expansion is unavoidable. 2025 is not far off and at the least, we should see a plan till 2036, including where the funding for that plan is going to come from.

6. Elizabeth Moles

How can the public be expected to give an informed assessment of the proposals without details of the community services which, we are told, will be picking up more health care through new patient pathways? The interdependence of community and hospital services is well established in whole systems thinking but community services have been bracketed off from this consultation.

7. Tom Barker

You state in the PCBC and in your response to an October 2020 JHOSC representation that the consultation does not include proposals for community services. You then make proposals for community services on the site of the Leicester General Hospital and consult the public on these, despite the fact that, as you admit, they are not funded in the £450m scheme. Do you agree that consulting the public on these possible, one-day-in-the-future 'potential' services alongside services you are committed to retaining on the site of the General Hospital is likely to confuse the public? I note that one of the prominent images on the website, in the brochures and in videos circulated on Twitter is an image of 'The Leicester General Hospital Community Hub' – which is unfunded - sometimes alongside the planned Treatment Centre and the planned Maternity Hospital - both of which are funded.

8. Sally Ruane

In the light of:

- the absence of details on community services making an informed assessment of the adequacy of the proposed hospital changes virtually impossible,
- the confusion surrounding the inclusion of unfunded 'potential' community services on the site of the Leicester General Hospital in the consultation,
- the failure of the consultation to reach what appears to be thousands of people in Leicester, Leicestershire and Rutland,
- the restrictions imposed by the pandemic, including full lockdown,
- the requirement to engage online in order to find out what is happening and to ask questions about it,

How likely do you think it is that the Building Better Hospitals consultation will fulfil the requirements of a lawful public consultation?

Questions from Member

9. Councillor Patrick Kitterick

Issues around consultation

a) There is reference to Independent Legal Analysis of the validity of the PCBC consultation - is that available in complete or redacted form?

b) A door to door leaflet drop was promised what percentage was delivered and how was this verified (lots of reports of no leaflet having been received) what was the cost of this exercise?

c) Can we have a breakdown of consultation responses with where the response originated from, when will this breakdown be supplied?

Actual Number of Beds

d) Can a detail description of how the change of 28 Hampton Suite beds to other uses will be handled?

e) 70 Capital Resource Limit funding has been discussed (if needed) what is the current official position on this?

Loss of Leicester General Hospital

f) How does the loss of Leicester General Hospital impact the city and counties resilience in terms of "Clean Sites" during the current or future pandemics.

g) Could the General Hospital be used to address the backlog of operations created by COVID19?

h) BCT Page 138-141 – Financial Pages – Are these affected by £46 million financial adjustment currently under investigation by auditors

i) BCT Page 156 What land is due to be sold at the Glenfield Hospital site and can a full map of the land left at both the Glenfield and LRI site?

j) BCT Page 327 Financials, is a sale of land required to fund the PCBC?

k) BCT Page 328 & 329 What roles does the £46 million financial adjustment play in these figures?

DELIVERY BY PRIMARY CARE

l) BCT Page 121 – Talks about delivery by Primary Care, is there a plan that we can see that describes how this formerly delivered hospital care will be delivered by primary care. This is especially important considering the difficulties in Primary Care provision in the city.

MATERNITY SERVICES

m) BCT Page 127 – Offer to look at Midwife Led Unit – Offer of 500 births to take place in a short time or total close. What is the thinking behind 500 births and the time scale? Is there any flexibility on this?

n) BCT Page 180 & 181 Reference to drop off at LRI being key to moving births, how confident are UHL about traffic management around the LRI site?

ANY OTHER QUESTIONS

o) Can we have an update on BREEAM rating of new construction and a wider narrative about the environmental targets of the PCBC project?

Scrutiny

Leicester City Council

Scrutiny Review

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

A review of the Health and Wellbeing Scrutiny Commission

October 2020

Background to scrutiny reviews

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

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

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

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

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

Scrutiny reviews will be supported by a Scrutiny Officer.

Evaluation

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

For further information please contact the Scrutiny Team on 0116 4546340

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

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

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

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

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

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

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