Leicester
City Council

MINUTES OF THE MEETING OF THE
LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Held: TUESDAY, 16 NOVEMBER 2021 at 5.30pm at City Hall as a hybrid meeting enabling remote participation via Zoom

P R E S E N T :
Councillor Kitterick – Chair
Councillor Morgan – Vice-Chair
Councillor Fonseca
Councillor Grimley
Councillor Hack
Councillor March
Councillor Pantling
Councillor Smith
Councillor Whittle

In Attendance:
Andy Williams – Chief Executive, ICS
Caroline Trevithick Leicester CCG
Kay Darby Leicester CCG
Ruth Lake – Director of Adult Social Care & Safeguarding
Rose Marie Lynch – NHS England and NHS Improvement
Elaine Broughton – Head of Midwifery
Allan Reid – NHS England
Sarah Prema – Leicester CCG
Richard Mitchell – UHL
Floretta Cox – Midwifery service
Dr Janet Underwood – Healthwatch Rutland
Mukesh Barot – Healthwatch Leicester

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31. CHAIRS ANNOUNCEMENTS

The Chair welcomed those present and led introductions.

The Chair mentioned the following matters:

- a separate Member briefing on the UHL statement of accounts was to be arranged by virtual means and communicated to Members as soon as possible.

- the recent report from the Care Quality Commission was to be brought to both City and County scrutiny committees; Members suggested it would be better to come just to this joint committee. Chair agreed to look at arrangement of dates outside this meeting.

32. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Bray, Councillor Whittle and Councillor Smith.

It was noted that Councillor Poland was present as a substitute for Councillor Smith.

33. DECLARATIONS OF INTEREST

Members were asked to declare any pecuniary or other interests they may have in the business on the agenda.

Councillor King declared that he was involved with the Carers Centre Leicestershire, a local charity providing help and support for unpaid carers across Leicester, Leicestershire and Rutland.

Councillor Waller declared that she was a Trustee at the Carlton Hayes Mental Health Charity.

Both gave assurance that they retained an open mind for the purpose of discussion and any decisions being taken and were not therefore required to withdraw from the meeting.

34. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 13th September 2021 be confirmed as an accurate record.

35. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS (NOT ELSEWHERE ON THE AGENDA)

It was noted that health partners had offered a meeting outside this committee to explain responses to Councillor Harveys previous questions on post-partum figures in more detail.

36. PETITIONS

The Monitoring Officer reported that no petitions had been received.

The Chair agreed to a change in the running order of the agenda to take the item on Dental Services in LLR; NHS England & NHS Improvement Response next.

37. UPDATED REPORT ON DENTAL SERVICES IN LLR; NHS ENGLAND & NHS IMPROVEMENT RESPONSE TO HEALTHWATCH SEND REPORT

5.50pm The Chair agreed to a short adjournment to resolve technical and audio issues with participants joining the meeting via Zoom for this item.

5.58pm Meeting resumed.

The committee received an updated report in relation to dental services commissioned across Leicester, Leicestershire and Rutland and an overview of the ongoing Covid 19 pandemic effects on those services as well as the steps being taken to restore and recover service provision.

Rose Marie Lynch, Allan Reid, and Catriona Peterson from NHS England were present to provide responses to any points raised.

Rose Marie Lynch, NHS England and NHS Improvement briefly introduced the report summarising key points which included:

- An overview of the background and clarification as to how NHS dental care was provided;
- Details of dental contracts in place across Leicester, Leicestershire, and Rutland as wells as extended or out of hours cover and secondary care;
- NHS dental care access was routinely at around 50% of the population, and dental practices had a duty to see people who needed treatment, however the number of people attending private services is not known;
- The timeline for impact upon dentistry of the pandemic was referred to as set out in the report together with the ongoing impact and effects;
- Significant impacts were largely due to measures introduced around infection prevention control and the national guidance that dental practitioners had to adhere to, e.g., introduction of “downtime” a period where the surgery must be left empty following any aerosol-generating procedure (AGP) i.e., fillings, root canal treatment or surgical extraction.
- Information about the Urgent Dental Centres (UDC’s) provision and Urgent Care pathway was noted. Four urgent dental care centres (UDC’s) established during pandemic remained in place across Leicester, Leicestershire, and Rutland; their openings offered optimum coverage with a pathway to access through general dental practices or the 111 service.
- Since the pandemic schemes had been commissioned with purpose of increasing patient provision and to enable additional activity at weekends, this had led to availability of 152 additional sessions for dental treatment. Providers had also been engaged to provide dedicated slots to the 111 service generating an additional 56 appointments each week across LLR for urgent treatment.
- NHS England were now looking at commissioning a child access team as it was recognised children’s oral health and routine dental care had been impacted by the pandemic.
- Steps were also being taken to invest in adult oral health and to address oral health inequalities.

Allan Reid, NHS England provided further details regarding oral health in Leicester, Leicestershire, and Rutland during which it was noted that:

- Based upon the last national survey of 5 year old state school pupils (2021) Leicester City had the 2nd highest childhood tooth decay levels in the region. Within Rutland, child decay was slightly higher than the regional and national average and in Leicestershire, Charnwood district had the highest tooth decay rates in the county.
- Charts within the report set out the prevalence of dental decay in 5 year olds by ward areas and included profile areas where action was to be targeted.
- Priorities and actions to tackle children's dental decay included school initiatives such as increasing access to supervised toothbrushing in nursery and school settings and upscaling of prevention measures.
- Regarding adult oral health, the focus was on oral cancer, Leicester was seen as a hotspot with diagnosis and death rates consistently higher than the national average, that was felt to be related to tobacco use and areas of deprivation. National oral cancer registration rates showed Leicester at 23/100,000 population compared to national rate of 15/100,000 and that also caused concern for impact on dental services in terms of early care.

Members discussed the report and there was some surprise at the differentiation in the rates of dental decay especially in areas where the demographics might be considered the same and/or where there was less deprivation than in the city e.g., Queniborough compared to Quorn. It was also noted that in the city the Beaumont Leys ward had comparatively good figures compared to Spinney Hills ward, yet both had lower socio-economic levels in terms of deprivation, and it was queried whether any research had been done into why areas with the same demographics or socio-economic backgrounds were so different and whether this related to access to services and if so, the steps being taken to address that.

It was advised that geographically the survey could be dealing with very small numbers, with cohorts as low as 15 in some areas and that could account for some of the differential between areas, especially those of a similar demographic. Sampling was done using a detailed sampling framework, however, there was also the issue of consent and sometimes the consent rate level was lower, therefore the minimum number being sampled in an area could be 15 but in practice it was usually up to 30 children sampled.

Members questioned the age of the data and its reliability and queried when more recent data would be available. It was explained that in terms of timeliness the survey was carried out every 2 years, the age of the children sampled was varied every 2 years and it was noted the last survey conducted was of 3 year olds and the next would be young people aged 12 years. Conducting the survey involved a massive collation of data and school access for sampling. It was noted that the survey due to take place last year had been postponed due to the Covid 19 pandemic.

Members discussed the level of access to dental services and expressed

concerns that people in some areas were not able to access urgent dental treatment and that there was ongoing delay in returning to routine dental care. It was queried whether there was any over mapping of where services were available and where people were accessing services. It was also questioned why the Oakham UDC had been closed.

In response it was noted that UDC's were part of the covid urgent dental care systems set up when it was known that general dental practices were closed. Specific practices were chosen on contracted open hours and their geographical spread. Existing dental practices were now reopening for urgent treatment but with measures in place to comply with government guidance. With regards to South Leicestershire there was not currently a contract in place that met the needs of the urgent care practices set up for covid but there were other dental practices there.

In relation to Oakham, the general dental practice was still practicing and the nearest UDC was in Hinckley. A UDC was initially mobilised in Oakham but analysis of patient referrals and usage showed there was little uptake in the area, so it was relocated to Hinckley where more need was identified.

Regarding the commissioning and provision of dental practices, this was targeted at areas of highest need wherever possible, and surveys were used to determine if there were gaps in areas. The Oral Health surveys pre pandemic had not highlighted any gaps in provision. It was accepted there was an issue accessing dentists at the moment, and it was about managing the expectations of the public and restoring those services. The availability of routine check-ups remained likely to be limited only to vulnerable people and those with ongoing dental issues but the number of providers recalling patients for routine check-ups continued to increase.

Members were concerned that the situation regarding child dental decay did not appear to be improving and with the impact of the pandemic, dentists closed for routine appointments and people unregistered for dental care the situation looking forward would deteriorate further. Members also noted that the data around trends did not include Rutland.

Allan Reid, NHS England apologised for the omission of data relating to Rutland and undertook to provide this outside the meeting. It was advised that the data used to look at trends went back to 2008 and this did show an improvement across all of Leicestershire, and it was expected that would be replicated across all areas. Data from the most recent survey of 3 year olds would be available in Summer 2022 and would be analysed for any trends.

Members considered the information around LLR dental service performance and challenged the statement that 50% of people were accessing NHS dentists while dental practices were being charged with dealing with 60% of Units of Dental Activity (UDA's) suggesting that equated to just 30% of people across LLR being able to access dental services.

Members expressed their dissatisfaction that dental service performance

showed dental practitioners were not delivering 60% UDAs, but they continued to receive 100% monies towards cost of operating services. There was also disappointment at the lack of clarity to address the backlog of patients who had missed out on routine appointments and non-urgent treatment, and it was noted that there was no time indicator yet of when there would be 100% restoration of services.

The issue of people accessing private dental care provisions through lack of choice and because of necessity was raised and it was queried why private practice were able to continue providing routine appointments and treatment if they had to comply with the same government guidance.

Members were informed that private practices allowed more time for their patient appointments and that was a key factor. NHS practices worked at a higher rate, and it was more difficult for them to see volumes of patients under the current guidelines.

In relation to LLR provider delivery of contractual activity and the figures in the chart it was clarified that the chart did not show how big a contract was, e.g., a small practice might only see a few patients a day, and other reasons such as single handed practitioners and having to keep appointments to an hour. There was also the knock on effect of areas with higher levels of decay requiring treatment which required higher downtime between appointments.

In relation to vulnerable groups and especially those with learning disability it was advised there was SEND work locally within local health steering groups around improving access. Data was recorded regarding dental access, and it was recognised that needed to be better and NHS England had been explicit on the need to prioritise vulnerable groups. In terms of any statutory entitlement, it was noted that although it was a priority and there was an annual health check requirement there was no statutory entitlement.

It was noted that the Healthwatch report was focused on aspects around the SEND pathway and a detailed response to the recommendations within that report was requested. The Healthwatch report had been shared with health partners and the recommendations were being considered along with steps that could be taken to form an action plan.

Discussion progressed onto Adult Oral Health, and it was queried whether some of the checks around oral mouth cancers could be conducted by other health practitioners if people were not seeing dentists.

Allan Reid, NHS England explained that regular oral checks might pick up issues such as a non-healing ulcer and that could be picked up by care home staff for example, they could then notify a GP to look at that or make a referral to dentist. However, whilst such issues could be identified and noted a confirmed diagnosis had to come from the centre i.e., dentist. It was suggested that further consideration should be given to oral checks being conducted by someone other than a dentist as GP practices may be aware of patient lifestyles and perhaps could factor in surface level checks for people at risk

especially those not accessing dental practices.

Drawing discussion to a conclusion the Chair identified that the mapping of need for dentistry services did not. The Chair commented that although this was a vastly improved report to that received previously it did expose issues and there was concern that it could not be described where gaps in provision were across Leicester, Leicestershire and Rutland. The Chair expressed interest in seeing where this would fit into place based plans of the Integrated Care System in future.

AGREED:

1. That the missing data in the report regarding Rutland statistics be shared with members as soon as possible outside this meeting;
2. That a detailed response on SEND pathway access be shared with members outside this meeting as soon as possible;
3. That a written update be provided to Healthwatch in relation to the recommendations within their report and a copy of that provided to the Chair and Vice Chair of this Committee;
4. That an update report on Dental Services in LLR be brought to a meeting of the Committee in 6 months, to include input from ICS on place based plans and further detail on recovery rates and progression since the last update.
5. That consideration be given to mapping the needs in dentistry services to identify the gaps in provision across LLR.

38. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Chair explained the procedure to be followed for taking questions from the public and indicated that questions relating to the Integrated Care System could be taken under that item on the agenda.

The Chair took public questions as follows:

From Giuliana Foster

1. Has a decision been made by the Treasury or Dept of Health regarding the funding of the UHL reconfiguration scheme. If so, what is the decision? If not, when is this decision expected?
2. University Hospitals of Leicester judges that a) some of the information in the templates returned to the National Hospital Programme team setting out alternative versions of the Building Better Hospitals for the Future Scheme was commercially sensitive and b) that it is not in the interest of the public to have this information. What type of information was provided in the templates retuned to the National Hospital Programme team which was considered commercially sensitive?

It was noted that a representative of UHL was not present who could provide a response to these questions.

The Chair expressed dissatisfaction that a response wasn't available for the meeting and asked for written responses to be provided before the next

meeting.

Responses provided post meeting:
Q1 Answer – The plans are currently at the pre-outline business case stage and what we have submitted is being reviewed nationally. Details of the way forward, and timeframes, will be released once this has been agreed with the New Hospital Programme.

Q2 Answer – We have submitted plans which illustrate what can be achieved within the original funding allocation, our preferred option and a phased approach which would deliver the preferred option, albeit over a longer time scale. The Trust considers that this information is exempt from disclosure on the grounds of commercial interests and has applied the Public Interest Test as required.

From Jean Burbridge:

1. At the last meeting ICS leads were asked "How will the Integrated Care Board improve the current reduced accountability and transparency?" but this was not answered. Are the ICS leads now able to answer this question?
2. In the last meeting David Sissling stated that the local NHS is currently making no use of private companies to assist it in moving towards an ICS. Please could you clarify whether any companies have been used in recent years to assist in th transition to an ICS and, if so, which they were?

Andy Williams, Chief Executive ICS responded that:
Q1. The Integrated Care Board (ICB) will hold meetings in public between 6 to 10 times per year, the exact configuration of those meetings was still to be determined by the board. There would typically be an annual meeting held in public. The ICS was still subject to the Act of Parliament being finalised and that would establish the board. The ICB would expect to undertake extensive engagement and it was envisaged that would be transparent.

Q2. This query related to the previous system when the STP linked with big companies. It was clarified that ICS would not be doing that locally and work was being taken forward with an in-house team. There was no private sector partner or big consultancy working with them on that.

39. COVID 19 AND THE AUTUMN/WINTER VACCINATION PROGRAMME UPDATE

Caroline Trevithick, and Kay Darby, both of Leicester, Leicestershire and Rutland CCGs provided a presentation update on the ongoing situation with Covid 19 and the Autumn/Winter Vaccination programme including recent data and vaccination patterns across Leicester, Leicestershire, and Rutland.

Members noted that:

- The vaccination programmes changed weekly and had now moved into the under 50 year old category, this meant the number of eligible people

changed too.

- There continued to be several ways to access vaccinations and details were updated regularly online.
- Although there was data around vaccination take up the situation remained fluid and data changed regularly.

Members raised various concerns about the 3rd dose and booster doses and the confusion amongst people around that. It was advised that the 3rd dose and the booster were different. The 3rd dose was for very vulnerable people, and they would still be called to have a booster. It was acknowledged there was confusion around those 2 terms and further clarity was needed especially when booking through GP surgeries to avoid people who were eligible being turned away. The CCGs were taking steps to ensure that the right messages were sent out in relation to 3rd doses and boosters.

It was noted that there were instances of people having 2 vaccinations and still catching covid and queried how the booster worked to promote immunisation and whether people had a natural immunity if they had covid. It was advised that where people had been vaccinated and then caught covid they were not usually as poorly as they might have been, but it was also important to note that immunity receded over time. It was likely anyone who had covid did have more immunity, but the levels of immunity were not known as there weren't the resources to investigate that yet.

There was unease at the level of take up among young people, those of school age and children in care and it was queried how the vaccination programme had been developed since the last meeting to increase uptake in these groups and also among those living and working in care homes.

In relation to mandatory care home vaccination the CCGs had worked closely with local authorities to mitigate the risk of there not being enough staff to care for people. There were 3 homes in the city and 3 homes in the County with concerns and plans in place to work with them to ensure proper staffing. It was noted that the mandatory vaccination of clinical staff was most likely to affect unregistered staff nationally and CCGs were looking at steps to encourage and increase uptake of the vaccination amongst those. Campaigns were focused on convenience, confidence and addressing complacency and there was work with staff to support them in their choices.

Responding further on the comments regarding vaccination uptake Members were informed that:

- The care homes team had now visited 90% of care homes and there was a 64% uptake of vaccinations across the residents; 18 care homes were still to be visited and CCGs were on target to achieve 100% offer in terms of the visits but there would need to be a follow up to catch those missed because they were too poorly etc at the initial visit.
- Uptake of the 3rd dose and boosters was currently within national uptake range.
- 3rd primary doses were being recorded as boosters, but CCGs/GPs should be able to identify and pull them out of data sets for their 4th vaccination

which would be a booster. Letters would be issued to those eligible and there were processes to run searches and follow up booking people in for recall. It was recognised very vulnerable groups need reassurance and that CCGs needed to communicate to assure those receiving 3rd dose that they would get boosters too.

- In relation to eligibility to a 3rd dose for those who access specialist care out of area, they would be checked to ensure they were being picked up.
- Regarding concerns of people being turned away, the CCGs were driving PCNs to look again at those eligible for 3rd dose or booster but there was a broad agreement to be more inclusive than exclusive.
- In relation to vaccination of school children, the CCGs undertook to visit all schools by end November but were seeing lower vaccination uptake rates across LLR with just 20% in the city vaccinated. City uptake leaned more towards the national programme and walk ins and CCGs were working to drive uptake up. There was lower uptake in some categories and they were seeing rising differential for reasons such as it was likely children would not have the vaccination if their parents hadn't. In terms of take up by children in care no issue had been identified in this category.

Members felt there were issues with communications from the CCGs and referred to conflicting communications with Rutland. Issues were also flagged about the online booking systems.

Members queried the covid infection rate amongst young people suggesting there was no slow down and whether being given half dose vaccinations was sufficient. In response it was informed that clinical opinion was that vaccinating 12-15 year olds was the right thing to do but the roll out of that vaccination programme was still ongoing and the impact was yet to be assessed.

Members also expressed concerns about accessing the right type of vaccination in circumstances where a person was unable through medical reasons to have Pfizer or Moderna. In response it was advised there was an allergy pathway set up to direct people for the Astra Zeneca if they were unable to have Pfizer or Moderna however there was some supply restricted to a small number of sites accessed through GP pathway. Members challenged the accessibility of the GP/allergy pathway to the Astra Zeneca vaccine noting that it had been a real difficulty for people to get that vaccine and people were being misdirected to vaccination centres then on arrival being told it was not available.

There was a general discussion around lines of communication with health colleagues and suggested it would be helpful to provide a line of communication that enables elected members to raise constituents concerns/case work directly with health colleagues.

The Chair thanked health partners for the update.

AGREED:

1. That the contents of the presentation and verbal update be noted,
2. That CCG partners investigate the communications issues

referred to during discussion and escalate the concerns about the working difficulties with 119/online bookings.

3. That CCG partners explore whether frequently asked questions/constituent concerns could be communicated to a single point of contact and to provide that contact.

40. BLACK MATERNAL HEALTHCARE AND MORTALITY

The Committee received a report on black maternal healthcare and mortality, including details of what the local maternity and neonatal system was doing to address health inequalities and poor outcomes for women of a black or minority ethnic background.

Elaine Broughton, Head of Midwifery introduced the report and drew attention to the following points:

This report followed on from the work of MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) which continued to highlight multiple and complex problems that affect women who die in pregnancy, these could be a combination of social, physical and mental or just one of these factors alone. The Covid pandemic had also highlighted even more disparity.

During the Covid pandemic MBRRACE published a rapid report following a review over a 3 month period from 1st March 2020 to 31st May 2020 which included several key messages. During that period 10 women died, the majority being from black/ethnic minority backgrounds and the report went on to identify existing guidance that needed improvement and recommendations that needed implementation.

Following that report the NHS had developed a long term plan and recommendations to be implemented as part of their Equity and Equality: Guidance for Local Maternity Systems and on the back of this a piece of work was being done by LLR health colleagues around equality analysis. That would be used to inform an action plan and would be reported to the committee in due course.

Members discussed the report which included the following comments:

The in depth summary was welcomed and it was acknowledged this was a very difficult subject.

In terms of lessons learnt, all deaths were investigated by an external H&S branch set up by the government, that involved extensive investigation and a comprehensive report of findings, and this had been in place locally for over 2 years so there was confidence that the service was addressing lessons to be learnt.

It was noted that one of the issues raised concerned black and ethnic minority women’s voices not being heard and it was asked how the service were taking

that forward. Floretta Cox, Midwifery Matron advised that they were developing a dashboard with key performance indicators to look at issues such as this. There was a joint healthcare review of the issues that black and ethnic women had and an action plan would be drawn from that. Leicester, Leicestershire and Rutland were the only area in UK doing that as the demographics and diversity of the area were well recognised. As an example of the steps being taken, the Covid action plan was shared with Sharma and other women's groups and feedback from them informed that plan was pitched right. In another example antenatal services during Covid were moved online with peer supporters and steps taken to get the same ethnic mix/language among peers.

It was queried whether the ethnicity of midwives working across LLR reflected the demographics of the area as a whole and any steps being taken to reach out to communities and allay fears about systems. Regarding the midwifery population it was noted there were not as many midwives from black or ethnic minority backgrounds in terms of percentages as the population of LLR and in Leicester there was an overall shortage of midwives. Recruitment was therefore broad to address the shortage and encourage diversity.

In terms of language barriers, language was an issue and there were processes in place for completion of questionnaires from GPs to identify if English was not the first language and to ensure interpreters were available at every appointment. Health colleagues tried not to use family members for interpreting as they were conscious, they might only say what they think the woman wanted to hear.

It was also found that a lot of women who did not speak English as their first language also lacked literacy skills in their own language and so leaflets were not always interpreted, however there was a facility online to translate voice over of information.

Members noted there was a distinction between the issues around medical care and the issues around systems i.e., communication and understanding practices.

Referring to medical issues it was noted that women of black and ethnic backgrounds tended to have more other risk factors such as diabetes and co-morbidities. Members noted that during the covid pandemic health colleagues were advised to change the way diabetes was tested during pregnancy and so clinics were set up at children centres and GP surgeries, so no-one was missed.

Regarding systems, health colleagues tried to treat people as individuals and there were groups that met where the midwife attended monthly to engage e.g., the midwifery service had regular access with the Sharma women's group before covid and now restrictions were being lifted the midwifery service would be re-engaging.

In terms of cultural concerns around maternal mental health there were services for women to get extra support and access psychologists and women

that went through traumatic birth were contacted. The service also tried to ensure continuity of care with one midwife throughout the pregnancy.

Members were reassured that LLR was not an outlier in terms of mortality however Members would have liked to see more data to support that with national/regional comparators as well as data that included the ages of women as that was a known risk factor.

It was confirmed that other data sets were available, and reports could be provided to that. Data on national comparators relating to mortality and older women would be shared if available outside the meeting.

Members expressed some dissatisfaction that the only data provided in the report related to Leicester rather than the wider area of Leicester, Leicestershire and Rutland, especially since this was a joint committee. The Chair agreed that data should be provided for the whole of LLR however taking the data provided it was still quite stark.

Members queried whether there was data or evidence revealing any links with infant mortality. It was advised that as this report remit was around maternal mortality other data sets were not included to avoid confusion. The Chair also expressed an interest in seeing any reflection in full term infant deaths.

The Chair commented in relation to the investigative processes following a death or traumatic birth and suggested consideration be given to seeking views of a non-medical advocate for the woman to gain another perspective. The Chair asked that issues of advocacy and that role should be explored further.

The Chair thanked health partners for the comprehensive report and in summary commented that the maternity partnership was appreciated however the committee would be interested in a broader sense of how that works and if it could be better.

AGREED:

1. That a report providing full details of maternity partnership arrangements be provided to a future meeting.
2. That data on national comparators relating to mortality and older women to be shared if available outside meeting.
3. That comparative data to that in the report for Leicester be provided for the wider area of Leicestershire and Rutland.

41. LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEM UPDATE

The Chair invited Robert Ball to put his questions.

From Robert Ball:
Q1: What provider collaboratives are under development or being anticipated?

Q2: Can ISC leads confirm that commercial providers will be excluded from

these provider collaboratives?

Andy Williams, Chief Executive ICS responded that they were looking at collaboratives based on care areas. The focus would be on care areas such as elective care, learning, disabilities, children services etc. ICS were keen to progress the first two care areas then set up other collaboratives over the next 12 to 18 months

In relation to the second question, the government had not placed any commercial providers in governance although it was unavoidable there would be some involvement in the collaboratives as it was an integral part of service delivery.

Leadership would therefore be through the ICB, and collaboratives would be through public sector but would involve the independent sector in collaboration work.

The Chair invited Andy Williams to continue that discussion with Robert Ball outside this meeting.

Sarah Prema, Executive Director of Strategy and Planning briefly reminded members of the situation around ICS which had already been discussed in detail at independent Health Scrutiny Commissions of local authorities across LLR.

Members noted that the process to develop ICS was 2 fold; the legal process to close existing CCG's and importantly improving experience and outcomes. The statutory footing of ICB and ICS provided the facility to remove barriers and enable faster co-ordination of care across pathways and increase improvement of outcomes for patients.

Sarah Prema presented details of the approach for LLR, examples of what was being done to integrate services, the priorities for integration and transformation in LLR, the overview of the ICS infrastructure, the high level responsibilities of each place group and draft place based governance.

Members noted the progress and next steps which included:

- A designated Chair (David Sissling) in place and appointment of Andy Williams as Chief Executive.
- Recruitment processes and ICP governance arrangements to be finalised.
- Due diligence to complete in closing CCG's establishing the Board.
- Finalising leadership arrangements.

Members discussed the presentation which included the following comments:

- It was clarified that Andy Williams had been appointed by the Chair as designate CEO and through NHS England. In due course the ICB would become the statutory board and that would be the legal employer. ICB would be the board whereas the ICP would be the partnership body in between.

- In relation to governance arrangements, equal partnership and involvement of local government, it was clarified that both upper and lower tiers would be engaged however it would be for the Health and Wellbeing Board to determine that involvement. The board (ICB) would advocate 3 places around the table from local government and that could include officers. The board would be subject to scrutiny at all levels and there was no attempt to differentiate between place and system scrutiny.
- With regards to maintaining patient care during the transition arrangements there was a long history of re-organisation and with support of CCGs they had already effectively re-organised into a shadow ICS form, there would not be a need to further re-organise, and they were ready to make the change which would mostly be a change of name.
- It was recognised that communication with the public was ongoing but driven by availability of policy within NHS and this communication had largely been with specific interest groups. It was noted that in terms of statutory consultation as this was a national policy there was no public consultation but locally, they were trying to be open about the process.

Chair thanked health partners for the update.

AGREED:

That the contents of the presentation update be noted.

42. MEMBER QUESTIONS (ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA)

Councillor Samantha Harvey submitted the following questions:

Following a negative patient experience at LRI last month, and the difficulty faced trying to navigate the LRI site, can our UHL colleagues' comment on the following:

- Why does the website contain incorrect information that is years out of date? The receptionist, at the incorrect location, explained the web site information has been incorrect for ages and the correct location was at the other end of the campus.
- Why is the website so difficult to navigate and makes it almost impossible to find any useful patient information?
- Why is the signposting to campus so very poor? Circling the site, in search of the correct entrance is not good for a calm state of mind or patient wellbeing.
- Internal signage is poor and there was no sight of the usual cheery volunteers or porters to point or lead the way.
- Why are there no maps of the campus and car parks available online?

Response received post meeting:
Maria O'Brien, Head of Communications replied that:
"Our website is tabled for improvements next year. Given the scale of the project, it has not been possible to update the site until this time.

We are aware of search issues and whilst we provide as much via homepage links as possible, we know this can be improved and will be a critical part of our website development plan.
Whilst there are maps of the sites, we know these are out of fate. We are currently in the middle of an improvement project looking at all of these in light of continued development work at all of our sites."

Answers to the remaining questions will be sent as soon as possible.

43. WORK PROGRAMME

The contents of the work programme were noted and additional items mentioned during Chairs announcements to be updated.

44. ANY OTHER URGENT BUSINESS

None.

45. DATE OF NEXT MEETING

The next scheduled meeting to take place on: 28th March 2022 at 5pm

Any special or extraordinary meetings before then will be notified separately.

There being no further business the meeting closed at 9.10pm.