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

DATE: **MONDAY, 13 SEPTEMBER 2021**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Kitterick (Chair of the Committee)
Councillor Aldred
Councillor March
Councillor Dr Sangster
Councillor Fonseca
Councillor Pantling
Councillor Whittle

Leicestershire County Council

Councillor Morgan (Vice-Chair of the Committee)
Councillor Bray
Councillor Grimley
Councillor King
Councillor Ghattoraya
Councillor Hack
Councillor Smith

Rutland County Council

Councillor Harvey
Councillor Waller

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

For Monitoring Officer

Officer contacts:
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Sazeda Yasmin (Scrutiny Support Officer):
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact Anita James**, Democratic Support on (0116) 454 6358 or email anita.james2@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	Meaning
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
AMH	Adult Mental Health
AMHLD	Adult Mental Health and Learning Disabilities
BMHU	Bradgate Mental Health Unit
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CMHT	Community Mental Health Team
CVD	Cardiovascular Disease
CCG LCCCG ELCCG WLCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group East Leicestershire Clinical Commissioning Group West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CTO	Community Treatment Order
DTOC	Delayed Transfers of Care
ECMO	Extra Corporeal Membrane Oxygenation
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
EIRF	Electronic, Reportable Incident Forum
EMAS	East Midlands Ambulance Service
EPR	Electronic Patient Record
FBC	Full Business Case
FYPC	Families, Young People and Children
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers

HWLL	Healthwatch Leicester and Leicestershire
IQPR	Integrated Quality and Performance Report
JSNA	Joint Strategic Needs Assessment
NHSE	NHS England
NHSI	NHS Institute for Innovation and Improvement
NQB	National Quality Board
NRT	Nicotine Replacement Therapy
OBC	Outline Business Case
PCEG	Patient, Carer and Experience Group
PCT	Primary Care Trust
PDSA	Plan, Do, Study, Act cycle
PEEP	Personal Emergency Evacuation Plan
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
PSAU	Place of Safety Assessment Unit
QNIC	Quality Network for Inpatient CAHMS
RIO	Name of the electronic system used by the Trust
RN	Registered Nurse
RSE	Relationship and Sex Education
SOP	Standard Operating Procedure.
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

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1. CHAIRS ANNOUNCEMENTS

2. APOLOGIES FOR ABSENCE

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 - 36)**

The minutes of the meeting held on 6TH July 2021 have been circulated and the Committee is asked to confirm them as a correct record.

NOTE: appended to the minutes are written responses provided outside the meeting to questions raised at the meeting.

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

To note progress against actions of previous meetings not reported elsewhere on the agenda (if any).

6. PETITIONS

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

7. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

The following questions have been received:

From Indira Nath : Q1: "According to the Health Service Journal (29th July 2021) the New Hospital Programme Team requested the following documents of Trusts who are "pathfinder trusts" in the government's hospital building programme.

- An option costing no more than £400 million;
- The Trust's preferred option, at the cost they are currently expecting; and
- A phased approach to delivery of the preferred option.

So, in relation to the Building Better Hospitals for the Future scheme, when will the documents sent to the new hospital programme team on these options be made publicly available? Are they available now? If not available, why not?

Q2: "ICS Chair David Sissling stated at the Leicester City Health and Wellbeing Scrutiny Commission that the local NHS needs to become more adept at engaging the public. What do you think have been the weaknesses in NHS engagement with the public and what will becoming more adept at public engagement involve? Please can you also explain the relationship between the main ICS NHS Board and the ICS Health and Care Partnership Board, and tell me what each will focus on and the balance of power between them?

From Sally Ruane: Q1: "Following information requested by the New Hospital Programme Team, what changes were made to the Building Better Hospitals for the Future scheme in order to submit a version of the scheme which costs £400m or less? And what elements of the scheme were taken out to reach this lower maximum spend?

Q2: "My question to the Joint Health Scrutiny meeting in July asked about an 'Impartiality Clause' voluntary organisations were required to sign by CCGs if they wished to promote the Building Better Hospitals for the Future consultation in exchange for modest payment. Unfortunately, neither the oral nor the written responses fully addressed this question. Please can I ask again whether the Impartiality Agreement was legal, whether it is seen as good practice and what dangers were considered in deciding to proceed with these agreements; and what steps the CCGs took to ensure that organisations under contract informed their members/followers in any engagement they (the organisations) had with their members/followers that they were working under a service level agreement which contained an "impartiality clause".

Q3: "There is little in the government's legislation about the accountability of integrated care systems to the local public and local communities. How will the integrated care board be accountable to the public? Its precursor, the System

Leadership Team, has not met in public or even, apart from the minutes, made its papers available to the public. The CCGs have moved from monthly to bi-monthly governing body meetings; UHL has moved from monthly to bi-monthly boards and does not permit members of the public to be present at the board to ask questions. How will the integrated care Board provide accountability to the public and how will it improve on the current reduced accountability and transparency?"

From Tom Barker:
Q1 "The government is indicating that they may now not fully fund trusts' preferred new hospital schemes, despite previous assurances. Both a phased approach and a cheaper, £400m scheme will impact the delivery of care significantly as both will require changes to workflow. This would especially affect people in Leicester, Leicestershire and Rutland as the UHL reconfiguration plans have limited new build (the Glenfield Treatment Centre and the LRI Maternity Hospital) and involve a lot of emptying and reconfiguration of working buildings. Dropping a project or delaying it could very easily create a situation where necessary adjacencies are lost etc. What will be the impact on patient experience of both the £400m version of the project and the phased approach?

Q2 "With regard to Building Better Hospitals for the Future, what are the revised costings as of August 2021 for the full (and preferred) scheme including local scope/national policy changes as requested by the New Hospital Programme?"

Q3 "NHS representatives have stated that there will be no private companies on the Integrated Care Board. Can you assure me there will be no private companies on the Integrated Care Partnership, on 'provider collaboratives', or committees of providers, or any sub-committees of the Integrated Care Board or Integrated Care Partnership?"

Q4 "CCGs currently have a legal duty to arrange (i.e. commission or contract for) hospital services. This legal duty appears to have been removed for their successor, the Integrated Care Board. If this is indeed the case, the Integrated Care Board may have a legal power to commission hospital services but no legal duty to do so. What do you think are the implications of this for the way our local Integrated Care Board will run?

From Jennifer Foxon: "Re the hospital reconfiguration plans in LLR, how would a phased approach change the final organisation of hospital services when compared with current plans?"

From Brenda Worrall: Q1: "Besides representation from the Integrated Care Board and three Local Authorities, which organisations will have a seat on the 'Integrated Care Partnership' and what will its functions be?"

Q2: "In moving towards integrated care systems, NHS England has significantly increased the role of private companies on the Health Systems Support Framework, including UK subsidiaries of McKinsey, Centene and

United Health Group, major US based private health insurance organisations. Please could you tell me which private companies NHS organisations in Leicester, Leicestershire and Rutland have used or are using to help implement the local integrated care system."

From Kathy Reynolds: "As we move towards Integrated Care Systems, I would like some clarity on Place Led Plans. About April 2021 at a Patient Participation Group meeting Sue Venables provided some information suggesting there would be 9 or 10 Places, 1 in Rutland, 3 in Leicester City and several in Leicestershire. I would like to know how many Place Led Plans are in or will be developed? What are the geographic areas covered by these Place Led Plans? Further what will be devolved to Places as the Place Led Plans become operational and how will this be funded including what will the Local Authorities responsibilities be for funding as a partner in the ICS? I'm not expecting detailed financial information at this time, but I would like to understand the general geographic areas, approximate funding requirements and where funding streams will come from."

From Steve Score: " The government intends to reduce the use of market competition in awarding contracts. While this is generally not problematic when contracts are awarded to NHS and other public sector organisations, it is likely to be controversial to extend a contract or give a contract to a private company without safeguards against cronyism provided by market competition. Given this reduction in safeguarding public standards and given the different motivation of private companies who prioritise shareholder interests over public good, can you confirm that neither the Integrated Care Board, nor its sub-committees, will be awarding any contract to private companies, much less without competition?"

From Jennifer Fenelon, Chair Rutland Health & Social Care Policy Consortium: "At the last Joint HOSC, you kindly asked the CCGs to respond to the issues raised with them in December 2020. They came from a major conference of Rutland people which was called to consider the impact of UHL reconfiguration on Rutland. Andy Williams was present.
The resulting formal submission into the consultation process addressed how UHL reconfiguration plans to move acute services further away from Rutland could adversely affect this isolated rural community sitting as it does at the periphery of LLR.
It put forward 15 ways in which those effects could be mitigated including practical proposals from our Primary Care Network for bringing care closer to home. We have now had a reply from the CCGs dated 17th August, but it does not offer reassurance that action has or will be taken on these points.
Mr Williams has said frequently to us that compensating services will be provided " *closer to home*" . Mr Sissling has added this week that the new ICS will be better than hitherto at engaging the public in planning modern integrated services. These words are very encouraging and reassuring.
We worry, however, that the NHS Plan to move non-urgent services closer to home has now been Government policy since 2019. Evidence shows that shifting work from acute hospitals to community services needs investment or it will fail yet planning is just starting on the Rutland Plan. That process will need

to move at speed to ensure new services are in place before the UHL reconfiguration is completed. Above all it must be backed by capital and revenue.

Can we have assurance from the shadow ICS through the Joint HOSC that :-

- Where PLACE BASED PLANS contain proposals to provide alternatives closer to home, they are fast tracked to ensure they are in place ***before*** acute services are moved
- PLACE Based Plans will be supported by the necessary capital and revenue funding to support implementation of care closer to home especially where they will replace services that are no longer accessible.
- that these 15 issues (see list below) affecting this rural community will be resolved including the capital and revenue needed as above.

APPENDIX -EXECUTIVE SUMMARY FROM THE RUTLAND CONFERENCE DECEMBER 2020

Time and again the people of Rutland said that proposals to spend £450m must be properly set within a strategic context. **Shifting services from Acute to Community needs investment at both ends**. There is strong international evidence that reconfiguration of hospital buildings *without* preparing the community services to accompany them will fail.

• The 2019 LLR 5 Year plan is the nearest thing we have to a system strategy. It says LLR aims to meet the conflicting objectives of getting the finances into balance and moving services closer to home. But their proposals focus upon investment in acute only. Without pump-priming investment in community services such proposals are doomed, and doubly doomed against the back-drop of the proposed swingeing community cuts. We believe capital investment should proceed, subject to getting the investment in the right place, as follows: -.

− **Avoid built-in obsolescence** by replicating services in hospitals that should be out in the community. The Rutland Primary Care Network has led the way by listing some of those services. We ask that the CCGs also listen to the user voice and relocate services to places that would save our ageing populations from long & expensive journeys (eg urgent care, diagnostics, dialysis, chemotherapy, out-patient services, step up/step down, end of life care etc).

Address reconfiguration proposals that are not right There are services that do need to be in the new hospital reconfiguration, but are presently inadequately or wrongly specified. They need to be properly defined both for those who use them as well as for future operational efficiency. Maternity and Disability are described more fully in our report. It was difficult to establish from dearth of information provided whether other groups would be similarly affected. Please also note the recent Ockendon recommendation, following the Shrewsbury baby deaths enquiry, and listen to service users.

Use Integration to help address, not exacerbate, the financial problems. We can see that getting the financial system into balance creates a short-term challenge, but the solution proposed is unbalanced and will result in a continued downward spiral of dependency on acute care. We ask that CCGs do not make a bad situation worse by slashing

community services.

− **Complete the community strategy urgently** Please focus on getting community services ready before closures. A community strategy and its implementation are long overdue. Please recognise the fact that you state that 1/3 of UHL's beds are filled with people who do not need to be there and break that cycle by getting community services in place to allow them to fulfil their proper role.

− **Please treat Rutland as in special need**. With these proposals, the county gets the worst of all worlds. Many Rutland folk will not be able to access the shiny new services but will nevertheless have to pay the price through longer journeys and cuts to community services. Many of our residents belong to equality protected groups.

− **Mitigation help should include investment**. Andy Williams reassurance about Rutland Memorial Hospital and expanded community services was very welcome, however investment funds were neither proposed nor identified. Rather there remains the contradictory position stated in the LLR 5 Year Plan of swingeing cuts to community services that will only further undermine community provision.

We seek recognition of this current bleak outlook for our county's services. **Our plea is for a funding commitment sufficient to support existing and new community services. Only with such commitment will the** RMH complex deliver for Rutland and permit transfers closer to home under the generic heading of "joined up thinking".

- **RECOMMENDATIONS FOR IMPROVING THE PROPOSALS**

Recommendation 1 – 5 Financial tests -Do not remove excessive funds from community as described in the LLR 5-year plan. That will set back community development for years. Look for other ways of rebalancing finances without long term damage.

Recommendation 2 – Speedily pilot a discharge project for elderly people in Rutland as an exemplar for moving care closer to home. We were heartened by this thinking by the CCG for East Leicester which we believe should be applied to Rutland as well.

Recommendation 3 - Include the Rutland Primary Care network (PCN) schedule of proposed services in a Rutland Health Plan and seek early funding to establish them.

Recommendation 4 – Transport – Redo travel estimates in consultation document. Our report includes travel times based on 40 years of experience of Voluntary Action Rutland.

Recommendation 5 – Adjust time frames for capital projects from 2 years to full life.

Recommendation 6 – Provide dialysis satellite service in Oakham. Long journeys proposed for ill people that can be avoided by better location are just not right.

Recommendation 7 – Provide satellite chemotherapy in Oakham for the same reasons.

Recommendation 8 – Redo Maternity consultation in line with legal requirements incorporating a *real* choice of options & providing evidence required by Regional Senate.

Recommendation 9 -Provide a trial Midwife Led Unit at LGH for *at least* 3 years to test acceptability/ feasibility and do not build duplicate beds at

LRI implying the decision to close has already been taken. That is predetermination
Recommendation 10 – Plan reprovision of Neurological Rehabilitation unit equipped with the full range of services required for such a regional centre ie equivalent to previous range of services provided at Wakerley Lodge (NB a commercial swimming pool will not suffice as a clinical hydrotherapy pool)
Recommendation 11 – Revise reconfiguration plans to ensure all areas are pandemic proofed for the future including rehabilitation for Long Covid
Recommendation 12 –The consultation process is regarded as flawed. Extend formal consultation to enable legal and due process errors to be corrected before proceeding to final business case.
Recommendation 13 - Out of area**.** Confirmation is necessary that care of patients who have to go out of area (including to tertiary centres) because of LGH closure will have their care funded and that the new patient pathways they enter will make sense for their care.
Recommendation 14 – Provide full replies to the Freedom of Information where they are missing for bed, financial and capital information.
Recommendation 15 – Given the guarantees about retaining and expanding Rutland's community services, please exempt it from proposed cuts to community budgets because Rutland stands to lose a great deal more than any other community in Leicester, Leicestershire.

These questions will be considered in accordance with Rule 10 of the Scrutiny Procedure Rules of the Council's Constitution.

8. DENTAL SERVICES IN LEICESTER, LEICESTERSHIRE AND RUTLAND AND THE NHS ENGLAND & NHS IMPROVEMENT RESPONSE TO HEALTHWATCH SEND REPORT

Appendix B (Pages 37 - 50)

Members to receive a report providing an overview of NHS dental services commissioned in Leicester, Leicestershire and Rutland and an update on the impact of the ongoing COVID19 pandemic on those services.

9. TRANSITION OF CHILDREN'S SERVICES FROM GLENFIELD HOSPITAL TO THE KENSINGTON BUILDING AT LEICESTER ROYAL INFIRMARY PROGRESS REPORT

Members will receive a presentation detailing progress on the transition of Children's services from the Glenfield Hospital to the Kensington Building at Leicester Royal Infirmary.

10. COVID19 AND THE AUTUMN/WINTER VACCINATION PROGRAMME - UPDATE

Members will receive a verbal update on the Covid 19 and Autumn/Winter vaccination programmes including recent data and vaccination patterns across Leicester, Leicestershire and Rutland.

11. UHL ACUTE AND MATERNITY RECONFIGURATION - BUILDING BETTER HOSPITALS UPDATE

Members will receive a verbal update on the UHL Acute and Maternity Reconfiguration.

12. INTEGRATED CARE SYSTEMS UPDATE

The Independent Chair, David Sissling of the Leicester, Leicestershire and Rutland Integrated Care System will address the Commission on his vision for the Integrated Care Systems.

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

14. WORK PROGRAMME

The Committee will be asked to consider the Work Programme and make any comments and/or suggestions for inclusion as it considers necessary.

15. DATE OF NEXT MEETING

To note the next meeting will take place on Tuesday 16th November 2021 at 5.30pm.

16. ANY OTHER URGENT BUSINESS