Leicester
City Council

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

Held: MONDAY, 13 SEPTEMBER 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 Smith	Councillor Whittle

In Attendance
Rebecca Brown Acting Chief Executive UHL
David Sissling, Independent Chair, LLR Integrated Care System
Andy Williams Chief Executive Leicester CCG
Caroline Trevithick Leicester CCG
Kay Darby Leicester CCG
Darryn Kerr, Director of Estates UHL
Nicky Topham UHL
Tom Bailey, Senior Commissioning Manager, NHS England
Dr Janet Underwood – Healthwatch
Mukesh Barot - Healthwatch

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15. CHAIRS ANNOUNCEMENTS

The Chair welcomed those present both in person and via Zoom and led introductions.

The Chair confirmed this was a hybrid meeting and explained what that meant for those present.

The Chair mentioned that he had recently met with officers from UHL Hospitals around a Building Better Hospitals update and note there are a number of questions here tonight and hopefully those responses will accord with what was said in the briefing.

The Chair indicated that future standing items to the agenda would include a regular update on Covid 19 and the Vaccination programme as well as an item for Members questions.

16. APOLOGIES FOR ABSENCE

Apologies for absence were received and noted from Councillor Aldred, Councillor Bray, Councillor King, Councillor Harvey, Councillor Dr Sangster and Councillor Waller.

17. DECLARATIONS OF INTEREST

Members were asked to declare any pecuniary or other interests they may have in the business on the agenda. There were no such declarations.

18. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 6th July 2021 be confirmed as an accurate record.

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

None outstanding.

20. PETITIONS

The Monitoring Officer reported that no petitions had been received.

21. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that several questions had been submitted by members of the public as set out on the agenda.

The Chair outlined the procedure for the meeting and advised that there was a wide amount of overlap in the questions which had therefore been put into three groups to be taken together with the opportunity for each questioner to ask a supplemental question.

- Health Service Journal report

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?

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?

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?”

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?”

Rebecca Brown, Acting Chief Executive UHL, responded that in terms of the reconfiguration, as one of the 8 national New Hospital Programme (NHP), Pathfinder schemes UHL had been asked to look at a range of approaches on how to go about building new hospitals in Leicester. Three scenarios were being considered:

– An option that fits the Trust’s initial capital allocation of £450m in 2019
– The Trust’s preferred option
– A phased approach to delivery of the preferred option

The Leicester scheme had remained almost exactly as described three years ago at the time of the initial capital allocation, however some of the parameters now expected to be met had changed significantly; for example the percentage of single rooms with the impact of Covid versus open wards, the amount of money expected to be set aside for contingency and the requirement to make the buildings “net zero carbon”. UHL had therefore submitted plans which illustrated what can be achieved within the original allocation, their preferred option and a phased approach which would deliver the preferred option albeit over a longer time scale.

It was recognised that it was a necessary part of the process for colleagues in

the New Hospital Programme to challenge each of the Pathfinder schemes, this was a proper process on behalf of the treasury for delivery and value for money.

The content of the submitted template was commercially sensitive and not in the public domain however details of the way forward would be released once it had been agreed with the New Hospital programme.

The Chair invited supplemental questions:
Indira Nath asked why papers were being withheld, and for further explanation of why they are “commercially sensitive”.

Sally Ruane asked if there was any more information on what would be taken out of the scheme in the version expected to meet the changes requested nationally/locally.

Rebecca Brown Acting Chief Executive UHL replied that in respect of commercial sensitivity, whenever the government was given information that could impact on anyone wanting to bid or pursue a tender exercise then that information could not be shared. As this scheme involved 8 Pathfinders the information was all being held centrally. Once UHL was able to share details it would do so, but they had no timescale yet on that.

In relation to elements within the plan the UHL were committed to delivering all the proposals they went out to consultation for.

Tom Barker asked with regard to the £450m being cut to £400m and potential for a large overspend, if the impact was considerable would the public be consulted again?

Rebecca Brown Acting Chief Executive UHL, clarified that the Health Service Journal letter was talking about a different scheme and UHL were asked to put in a template against their £450m scheme and were committed to deliver the full programme on that.

The Chair referred to the Building Better Hospitals item later on the agenda where further discussion could be had and confirmed that £400m was another scheme.

The Chair indicated that the Joint LLR Health Scrutiny committee would recommend that the UHL reconfiguration scheme was funded in full and support that request.

- <u>Integrated Care System</u>

From Indira Nath 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?

Q3 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 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: 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 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?"

The Chair invited David Sissling to respond

David Sissling, Independent Chair, LLR Integrated Care System responded regarding engagement that the NHS in Leicester, Leicestershire, and Rutland would continually reflect on its engagement practices and strengthen these wherever possible. During the Covid-19 pandemic in particular the NHS had worked hard to re-establish links with many communities through genuine outreach and have worked to understand relevant issues and co-create solutions. Work with the voluntary and community sector, including faith and community leaders, has been central to this, as has been our partnership with Healthwatch.

These improvements will be continued and feedback from as many people as possible will be sought. The NHS would look to engage with all individuals and communities on their own terms, in places and at times that suit them, using materials in appropriate languages and formats. It was recognised too that there were often communities within communities and that these may be hidden and not typically have a voice and steps would be taken to provide the opportunities for these people and groups to be heard.

Engagement activity across NHS partners was increasingly being joined up, using common approaches, pooling resources and sharing intelligence. Work had also begun to work more closely with local authority partners on engagement where practicable.

Across the NHS partnership focus has increasingly been on actively listening to communities to understand their experiences and aspirations. This insight allows us to make enhanced decisions about the way in which services will be delivered and to flag potential issues that may require closer examination by partners. We recognise the need to do more to close the feedback loop, explaining to the public how what we have heard through our engagement has influenced our thinking and the decisions that are made.

The next step of the improvement process will be to embed genuine co-production techniques throughout the system to redesign services and tackle

health inequalities in partnership with people and communities. We will also learn from recognised good practice and build on the expertise of all ICS partners.

It was planned to develop a system-wide strategy for engaging with people and communities that sets out an approach to achieving this by April 2022, using the 10 principles for good engagement set out by NHS England as a starting point.

In terms of the relationship between the main ICS NHS Board and the ICS Health and Care Partnership Board, the ICS Partnership will operate as a forum to bring partners: local government; NHS and others, together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

The ICS Partnership will have a specific responsibility to develop an 'integrated care strategy' for its whole population. The expectation is that this should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. These plans will be focused on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities.

The NHS Integrated Care Board will be established as a new organisation (replacing CCGs) that bind partner organisations together in a new way with common purpose. The NHS Integrated Care Board will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population.

The relationship between the ICS Partnership and the NHS Integrated care Board is non-hierarchical and based on existing and enhanced relationships with the three Health and Wellbeing Boards.

In relation to accountability once established meetings of both the ICS Partnership and the NHS Integrated Care Board will be held in public, with papers published.

Whilst final membership of both the ICS Partnership and the NHS Integrated Care Board is to be finalised, local Healthwatch organisations, are expected to continue to fulfil a key role in both of these groups. The NHS Integrated Care Board will have a minimum of two independent members, in addition to the independent chair.

Local authority health scrutiny will retain an important role in ensuring accountability. The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the development and delivery of health services and that those services are effective and safe.

Regarding private companies the Membership and terms of reference for the

ICS Partnership and the NHS Integrated Care Board were still under development, although any private companies were not expected to be members of these groups.

However, Non-NHS providers (for example, community interest companies) may be part of provider collaboratives where this would benefit patients. Collaborative work was still at a very early stage of design and NHS organisations in Leicester, Leicestershire and Rutland are not using any private companies to help develop or implement the local integrated care system.

With regard to legal duty under the proposed legislation the NHS Integrated Care Board would assume all statutory duties of the CCGs, including the responsibility to secure provision of NHS services for its area.

Andy Williams, Chief Executive Leicester CCG, responded to the question on Place Led Plans that the CCG's had worked with local government to determine place and so that was constituted differently as a local place for Place Led Planning. It was not a hierarchy or about delegating certain things to a place. Three place based plans were currently being developed, one for each of the three upper tier unitary authorities (Leicester, Leicestershire, Rutland). These plans were being developed in partnership between the local NHS and the local authorities, taking account of evidence and insights of what is important to the public and other stakeholders in those areas, and would be supported by additional local public engagement where appropriate.

The Chair asked for further details of those Place led Plans to be shared at respective scrutiny committees across Leicester, Leicestershire ad Rutland.

David Sissling, Independent Chair, LLR Integrated Care System responded to the question around market competition in awarded contracts, that whilst they were pleased by what was offered in terms of continuity and being able to form longer contracts the priority was that NHS and other public sector organisations will provide the overwhelming majority of services as they do now.

It was noted that proposals contained in the draft legislation would remove the current procurement rules which apply to NHS and public health commissioners when arranging healthcare services. The ambition was to provide more discretion over when to use procurement processes to arrange services than at present, but that where competitive processes can add value they should continue. As a result, the local NHS would have greater flexibility over when they choose to run a competitive tender.

The Chair invited supplementary questions:
Indira Nath asked whether the public would be allowed to ask questions once public meetings were held?

Steve Score sought a response to the commercial conflict example mentioned earlier.

Sally Ruane in relation to accountability asked for confirmation that meetings

would be held publicly monthly and in relation to ICS Board meetings, what the timescale for opening these up was?

Tom Barker raised concern that assurances given at other meetings were not the same as those now being given and was concerned that the discussion was of the role of private companies during the pandemic rather than referring to the funding position of NHS.

Brenda Worrall asked for more detail of funding and how the funding stream would flow?

David Sissling, Independent Chair, LLR Integrated Care System replied that the frequency of meetings for the body which prefaced the ICS Board was monthly and would continue to be monthly, however the ICS board would make its own decision about frequency and papers would be made available to the public. At this point it was still open to consideration how best to involve the public in meetings. The broader Integrated Care Partnership was currently meeting three times a year and would be subject to review.

Regarding procurement it was clarified that any decision in a possible scenario with a private company would be done entirely in an open and transparent tender process.

In relation to capacity, the priority was to grow the service to meet needs of people who have had to use private sector as an alternative.

In terms of the role of private companies it was not possible to be more definitive on private companies involvement on the Leicester Care Partnership as that doesn't exist yet, however as it became clear David Sissling would be happy to return and discuss any decision or basis for its membership.

Andy Williams Chief Executive Leicester CCG responded to the supplementary point about Place stating that initially there was a plan with budgets set for a range of services. No final decisions had been made but thought was being given to continue to plan and programme services in the same way and include those by place e.g. a City Plan, a County Plan and a Rutland Plan. The aim was to try and avoid a limited range of services and to be inclusive, it was still to be decided how to make allocations of resource.

In the absence of Jennifer Fenelon, Chair of Rutland Health & Social Care Policy Consortium, the Chair agreed to take her questions as read on the agenda and invited officers to respond.

Rebecca Brown Acting Chief Executive UHL advised this had been partially answered in the earlier responses and confirmed that the preferred option was not to have a phased approach. It was not possible to discuss that further as more information would be needed than was currently available and it would be a political decision as to when the programme would be started.

- <u>UHL Reconfiguration</u>

From Sally Ruane: 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”.

Andy Williams responded that the CCGs were confident that the agreements reached with the voluntary and community sector to support participation in the recent Better Hospitals Leicester consultation was both lawful and based on examples of best practice and that remains their view and overall the CCG’s believe the activity achieved this very successfully.

The Chair thanked all for their questions and responses.

AGREED:

That full written responses be appended to the final minutes.

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

The committee received a report containing an overview of NHS dental services commissioned in Leicester, Leicestershire, and Rutland and an update on the impact of the ongoing Covid 19 pandemic on those services.

The Chair noted that Tom Bailey, Senior Commissioning Manager, NHS England had to leave the meeting early and there was no-one else at the meeting to present this report or respond to questions.

The Chair was disappointed that the report contained insufficient information about the recommencement of services across the City, County or Rutland. The Chair noted it was the responsibility of the committee to scrutinise this and therefore a fully updated report with more detail and data would be sought for the next meeting.

Mukesh Barot from Healthwatch welcomed the response noting however the concerns of the public and the issues raised about people for SEN were not fully answered. He indicated that Healthwatch were intending to do further research into dentistry issues as a special project. The Chair suggested it would be helpful to do that collaboratively and to press for data on dentistry to come to this committee.

Dr Janet Underwood from Healthwatch commented that there were mixed

messages that needed clarification. Some practices were not accepting NHS patients but would if they paid privately; children were not being seen regularly and some patients were waiting up to 3 years for orthodontal treatment.

It was suggested that the updated report should also include information about dental services for children in the care of local authorities too.

The Chair confirmed that the item would be brought as a priority to the next meeting where the debate could be extended then.

AGREED:

That a fully updated report with data and including information on dental services for children in care of local authorities be provided for the next meeting.

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

Rebecca Brown, Acting Chief Executive gave a presentation detailing progress on the transition of children's services from the Glenfield Hospital to the Kensington building at Leicester Royal Infirmary.

Background details of the East Midlands Congenital Heart Centre and NHS Standards were given, and Members were reminded of the decision taken in September 2019 to move the paediatric congenital heart service to the Leicester Royal Infirmary in order to meet the co-location standard.

It was noted that:

- The project comprised a 12 bed intensive care unit, 17 bed cardiac ward, a cardiac theatre and catheter lab as well as an outpatient and cardiac physiology dept.
- Phase 1 had completed with the Kensington building being attractively refurbished
- The move from Glenfield to Kensington building took place from 5th – 8th August 2021 with the support of other providers during the transition to ensure that emergency services for children remained available.
- The Kensington building was fully up and running with all equipment and clinical teams in place.

Images of the new Kensington building were viewed and noted.

Rebecca Brown, Acting Chief Executive explained the next phase, Phase II envisioned the creation of East Midlands first dedicated standalone Children's Hospital to ensure all children could be cared for on one dedicated site and would see the move of all children's services into the Kensington building.

Members of the Commission welcomed the presentation, expressing positive comments about the smooth transition and commented on how good the building and unit looked. Members asked that their thanks be passed on to the

staff who made this happen and that everyone involved in save Glenfield should be assured seeing everything transitioned across so well.

The ensuing discussion included the following points:

In relation to specialist children's services it was noted that UHL consultants were recognised nationally and regionally as experts. Clinical teams worked with networks across Northamptonshire, Lincolnshire to expand the region and be experts for all those areas too. National recognition for clinical outcomes showed UHL was up in top three.

Regarding space, the Kensington building was very spacious with room for growth and had been very well designed for children and adolescents with dedicated play therapists and support staff to help children with special needs.

Nicky Topham, Programme Director of Reconfiguration confirmed the new build and existing Kensington building interior had been extended too, including down into lower floors.

Phase II would be looking to move services from the Balmoral building and there would be a combined ICU. At moment it had not been prioritised when services would be moved as UHL were still waiting for maternity hospital to be completed that area in the Kensington building decanted and then consider which children services go in and where.

In terms of lessons learnt it was always good practice to review what had been done well and what could be done better and feed into new projects, this process had been started and one such lesson learnt was to give selves more time to move in between the build time.

Rebecca Brown, Acting Chief Executive confirmed there was provision for parents to stay overnight so they could be close to very sick children. There were also other provisions such as McDonalds House.

The Chair mentioned plans for space on Jarrom St and asked for any details about potential development there to be shared.

In relation to data protection and safeguarding of children it was confirmed that all relevant GDPR were complied with and there were a number of rules in place around processing data which were observed and maintained, the space within the building had also been designed so computers were in secure areas. Safeguarding was important and the safety of children paramount so there were systems ensuring doors were secure and people were only let in with appropriate identification to maintain safety of children whilst they are in hospital care. Systems were also in place around checks and training of staff to ensure safe and secure environment.

In terms of splitting adult and children's cardiac service from Glenfield e.g. staff/peer support, there had been long term planning and especially in lead up to the transition around recruitment. UHL also invested in training as part of the

programme and up skilling staff at LRI side too. UHL had invested to have the right teams on both sites and to support staff moving sites and UHL was confident they now had two very good stand alone services although there were still some services that are joint.

The Chair thanked officers for their responses.

AGREED:

That an update on further developments be brought to a future meeting.

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

The Chair reminded those present that since the situation around Covid was fluid written reports were not provided as the data changed daily.

Caroline Trevithick and Kay Darby of Leicester City CCG, gave a presentation and verbal update on the Covid 19 and Autumn/Winter vaccination programmes including recent data and vaccination patterns across Leicester, Leicestershire and Rutland latest plans

It was noted that:

- The City compared favourably with other similar cities in terms of vaccination uptake.
- Vaccination rates had fallen significantly so CCG partners were reviewing that and looking at what next steps could be taken to boost uptake.
- Leicester, Leicestershire and Rutland had published vaccination data that showed the lowest uptake was amongst the under 29 year old age category.
- In relation to 12-15 year olds, the vaccination programme was due to roll out across secondary schools from next week.
- A third primary dose vaccination had been approved and recommended for vulnerable people; this was not to be confused with a booster. Work was ongoing to look at which people might benefit from this vaccination.

Expanding the points around low uptake, there were some patterns which included particular areas heavily populated by students, so work was being done to deliver key messages and target people across campuses. Various pop up vaccination clinics were also planned.

In terms of younger people: 16 – 17 year olds were averaging 51.8% uptake, 12-15 year olds currently only had crude numbers however it was known there were 3,034 people in at risk cohorts within this age group waiting for vaccination.

Regarding the vaccination programme for 12-15 years olds and the issue of parental consent, it would be an opt in programme that followed tried and tested practice for other vaccination programmes. However, because it was

Covid there was more contention and so there was work around that in terms of parental consent and whether children who are conscient may be able to consent for themselves.

Regarding logistics, it was noted that children in year 7 were a mixture of ages with some not yet 12 years old however the age cut off was 12 years so only those 12 years and above would be vaccinated. Clarity on those arising 11-12 was still awaited. At the moment this was a one dose vaccine, being administered using existing programmes to deliver logistically to schools across LLR.

In terms of encouraging uptake, each school would be visited and given information, some parents/children would need more information and take longer to reach a decision on whether their child should be vaccinated so there would need to be consideration of how those not ready when teams were at school could then have it if they changed their minds.

The Covid Booster vaccination programme would commence from September.

The seasonal Flu cohort's vaccination had now started and there was also talk of the Flu programme being wrapped into a combined offer although this would be subject to supply. Additional community pharmacy capacity was also being targeted at hard to reach communities.

Slides on geographical coverage were noted (appended).

In terms of timing of the vaccination for 12-15 year olds, that was guided by the National programme but did present additional challenges as children in LLR schools had returned to school earlier than nationally but CCG's now had approval to begin and would work through any nuances.

In relation to care homes, care home staff were now required to be vaccinated by November. CCG partners were working closely with councils and care home staff to help and support them and address any reasons for not having the vaccine, however it was still personal choice. Focus was on building confidence in the vaccine and ensuring convenience for its uptake.

Regarding the vaccination of UHL staff compared to take up elsewhere it was noted that 83.1% had received a first dose and 83% had received a second dose. These figures did not include those that may have received their vaccination elsewhere but overall, our hospital vaccination rate was above average.

It was suggested some of the low uptake may be due to people moving away from the area during the period especially university students or Europeans and GP registers not being maintained and updated. In response it was explained that a data exercise was being started to undertake a major clean up of all GP lists and verify them, this would take some time and there was no short cut to that to get to underlying issues.

It was queried whether there were steps to encourage more teachers to be vaccinated especially in schools with vulnerable pupils. In reply it was explained this was not a data set captured nationally, however there was awareness that the vaccination initially had been limited by process of age and there was a push by teachers for them to receive the vaccination sooner.

The Chair welcomed that GP data exercise and asked for an update on any early indicators or patterns as well as updates on initiatives and attempts to increase vaccination uptake.

AGREED:

That a further update on Covid 19 and the Autumn/Winter Vaccination Programme be brought to the next meeting.

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

Darryn Kerr, Director of Estates UHL provided an update on the UHL Acute and Maternity Reconfiguration as part of the Building Better Hospitals programme.

Referring to earlier discussion during the public questions item of the meeting he confirmed a key point that UHL were not planning to change any clinical models or pathways.

It was noted the team continued to work up the design brief as well as work on enabling the project and business case to create the space needed. They were also undertaking early works on the decontamination programme and liaising with system colleagues on concepts around sustainability.

The ensuing discussion with Members included the following points:

- Assurance was given that there would be no change to bed numbers referred to during the consultation process. The issue of single rooms for patients put pressure on space not on the number of beds.
- In terms of moving services, staff and patients, a lot of consideration was given to this from an early stage in all programmes and clinical service exercises to minimise disruption.
- Referring to a question asked at the December 2021 meeting clarity was sought on the number of women who delivered out of area and were seen by the community team and not just those that received inpatient care at St Mary's. Rebecca Brown, Acting Chief Executive UHL agreed to provide more details on that outside this meeting.
- With regard to back office functions and new ways of working, this was something UHL were considering everyday alongside optimising the best accommodation available. This was being worked through, learning lessons from outside the system. As an example, they had just opened their first agile building and that adopts policy of no-one having their own office. A lot of lessons had been learnt during Covid which were part of ongoing considerations.

AGREED:

That further detail be provided in relation to the response given around post-partum/post-natal care numbers in the County for women who delivered out of area.

26. INTEGRATED CARE SYSTEMS UPDATE

The Chair reminded those present there had already been comprehensive questions and answers around the Integrated Care Systems and opened the item for Member discussion.

David Sissling, Independent Chair, LLR Integrated Care System briefly reintroduced himself and set out the reasons for integrated care systems and their aim to provide new models of care for physical and mental health, reduce inequity, create better workspace and provide volunteer opportunities. It was noted that emerging issues such as defining goals of ICS and addressing inequality and inequity had been identified, especially around supporting those with frailty and enabling people to have a voice.

A lot of the work was about building in continuity with CCG's and developing good relations, trust, and openness between partners.

In practical terms work was accelerating towards the formal launch of the Integrated Care Partnership (ICP) next April. Focus was on making critical appointments in key roles, as well as working with local authorities to launch the Integrated Care Partnership.

Responding to enquiries about the vision for how the Integrated Care System would work across Leicestershire, this was partly described in terms of outcomes and remaining focused on the reasons why we were doing this work. There was a lot to learn from local government and the way in which NHS was mobilising itself. One change was to recognise that the NHS was an enormous and major contributor to GDP and contributor to the City and County. In that respect the vision was broad but there is no agenda in terms of the private sector and in time that assurance will be seen.

Andy Williams, Chief Executive Leicester CCG commented that they were moving away from competition philosophy so that the standards of care and pathway should be the same across the County and City and there should be a consistent experience for people. However, there might also be a need for different targeted approaches in areas e.g. to increase uptake of vaccinations and these changes would be aimed at facilitating ability to do both these things consistently.

It was queried what element of choice there was in terms of services across borders, and it was indicated that the current situation seemed to be based on resources and they planned to look to make services more universal in terms of the population.

There was a brief discussion around what the NHS offered and the role of

scrutiny to challenge process, as an example it was noted that audiological services were not always available on NHS but could be sought privately, this was an interesting point that came back to statutory obligations. There was also the issue around NHS or private prescriptions and members were informed that although there was a lot of discretion to create the care system appropriate for LLR it was subject to statutory obligations.

Referring to gaps in scrutiny around procurement frameworks, David Sissling advised that the involvement of elected members was critical, and the ICS would have to learn from local government. Meetings were already being held with local health and wellbeing boards to better understand scrutiny processes.

It was queried how closely the ICS and ICP would work with pharmacies and whether there were existing communications. David Sissling replied that there was a massive opportunity to rethink what was meant by primary care and to consider that alongside pharmacy, dental, and optician services. That was a transformational area where the ICS can affect a change, and more could be done if there was work with pharmacies as a group.

The Chair thanked David Sissling for taking this opportunity to engage with the commission.

AGREED:

That there be further updates on the Integrated Care Systems at future meetings of the committee.

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

There were no other Members questions that had not already been covered elsewhere on the agenda.

28. WORK PROGRAMME

Work programme received and noted.

29. DATE OF NEXT MEETING

Date of next meeting to be noted on 16th November 21 at 5.30pm

30. ANY OTHER URGENT BUSINESS

None notified.

There being no other business the meeting closed at: 8.45pm .

Minute Item 21

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?

As one of the 8 national New Hospital Programme, (NHP), ‘Pathfinder’ schemes, we have been asked by the NHP team to look at a range of approaches to how we go about building new hospitals in Leicester.

There are three scenarios we have been asked to consider:

1. An option that fits the Trust’s initial capital allocation of £450m in 2019.
2. The Trust’s preferred option
3. A phased approach to delivery of the preferred option

The Leicester scheme has remained almost exactly as described three years ago at the time of the initial capital allocation however some of the parameters we are expected to meet when we build the new hospitals have changed significantly; for example the percentage of single rooms versus open wards, the amount of money expected to be set aside for contingency and the requirement to make the buildings ‘net zero carbon’. We have therefore submitted plans which illustrate what can be achieved within the original allocation, our preferred option and a phased approach which would deliver the preferred option albeit over a longer time scale.

We recognise that it is a necessary part of the process for colleagues in the New Hospital Programme to challenge each of the Pathfinder schemes on both deliverability and value for money.

The content of the submitted template is commercially sensitive and not in the public domain. Details of the way forward will be released once it has been agreed with the New Hospital programme.

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?

The NHS in Leicester, Leicestershire and Rutland will continually reflect on its engagement practices and strengthen these wherever possible. We are justifiably proud of much of our approach to engagement, some of which is noted as nationally leading, whilst also recognising there is always room for improvement.

During the Covid-19 pandemic in particular we have worked hard to re-establish links with many seldom heard and often overlooked communities through genuine outreach and have worked to understand relevant issues and co-create solutions.

Our work with the voluntary and community sector, including faith and community leaders, has been central to this – as has been our partnership with Healthwatch.

It is vital that these improvements are now continued and we do all we can to hear feedback from as many people as possible. As part of this it is critical that we engage with all individuals and communities on their own terms, in places and at times that suit them, using materials in appropriate languages and formats. It is also important that we continue to recognise that there often communities within communities and that these may be hidden and not typically have a voice. Our job is to provide the opportunities for these people and groups to be heard.

To achieve this we are increasingly joining-up our engagement activity across our NHS partners. This entails using common approaches, pooling resources and sharing intelligence - together with a collaborative attitude to ensure consistency, reduce duplication and avoid engagement fatigue within communities. We have also begun to work more closely with our local authority partners on engagement where practicable and will continue to do so going forward.

Across our NHS partnership our focus has increasingly been on actively listening to communities to understand their experiences and aspirations. This insight allows us to make enhanced decisions about the way in which services will be delivered and to flag potential issues that may require closer examination by partners. Whilst these developments are positive we recognise the need to do more to close the feedback loop, explaining to the public how what we have heard through our engagement has influenced our thinking and the decisions that are made.

The next step of the improvement process will be to embed genuine co-production techniques throughout the system to redesign services and tackle health inequalities in partnership with people and communities. We will also learn from recognised good practice and build on the expertise of all ICS partners.

We plan to develop a system-wide strategy for engaging with people and communities that sets out our approach to achieving this by April 2022, using the 10 principles for good engagement set out by NHS England as a starting point.

Q3: “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?*

The ICS Partnership will operate as a forum to bring partners – local government, NHS and others – together across the ICS area to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population.

*The **ICS Partnership** will have a specific responsibility to develop an ‘integrated care strategy’ for its whole population using best available evidence and data, covering health and social care (both children’s and adult’s social care), and addressing the wider determinants of health and wellbeing. The expectation is that this should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused*

on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities.

*The **NHS Integrated Care Board** will be established as a new organisation (replacing CCGs) that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population. They will ensure that dynamic joint working arrangements, as demonstrated through the response to COVID-19, become the norm. They will establish shared strategic priorities within the NHS and provide seamless connections to wider partnership arrangements at a system level to tackle population health challenges and enhance services at the interface of health and social care.*

The relationship between the ICS Partnership and the NHS Integrated care Board is non-hierarchical, and based on existing and enhanced relationships with the three Health and Wellbeing Boards.

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?

Please see above statement from University Hospitals of Leicester NHS Trust

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".

As described at the last meeting of the Joint health Scrutiny Committee, the CCGs are confident that the agreements reached with voluntary and community sector to support participation in the recent Better Hospitals Leicester consultation was both lawful and based on examples of best practice.

The CCGs considered the use of the voluntary and community sector in great detail prior to the launch of the consultation, particularly as a vehicle for reaching out into marginalised or often overlooked communities and supporting participation. Overall we believe the activity achieved this very successfully.

VCS partners were asked to be clear with their communities and/or members that their role was to inform them that the consultation was happening, provide factual

information about what was being proposed, and support people to take part in the consultation should they wish irrespective of their views.

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?”

Once established meetings of both the ICS Partnership and the NHS Integrated Care Board will be held in public, with papers published.

Whilst final membership of both the ICS Partnership and the NHS Integrated Care Board is to be finalised, local Healthwatch organisations, which have a statutory duty to obtain views of people about their needs and experience of local health and social care services, are expected to continue to fulfil a key role in both of these groups. The NHS Integrated Care Board will have a minimum of two independent members, in addition to the independent chair.

Meanwhile, local authority health scrutiny will retain an important role in ensuring accountability. The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the development and delivery of health services and that those services are effective and safe. Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working and in making recommendations about how it could be improved.

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?

Please see above statement from University Hospitals of Leicester NHS Trust

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?”

Please see above statement from University Hospitals of Leicester NHS Trust

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?”

Membership and terms of reference for the Integrated Care Partnership and the NHS Integrated care Board are still under development, although we do not expect any private companies to be members of these groups.

Non-NHS providers (for example, community interest companies) may be part of provider collaboratives where this would benefit patients and makes sense for the providers and system.

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?

Under the proposed legislation the NHS Integrated Care Board would assume all statutory duties of the CCGs, including the responsibility to secure provision of NHS services for its area.

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?”

Please see statement above from University Hospitals of Leicester NHS Trust

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?”

Members of the Integrated Care Partnership must include local authorities that are responsible for social care services in the ICS area, as well as the local NHS. Beyond this discussions are currently ongoing to determine wider membership of the Partnership, drawing on experience and expertise from across the wide range of partners working to improve health and care in our communities.

*The **ICS Partnership** will have a specific responsibility to develop an ‘integrated care strategy’ for its whole population using best available evidence and data, covering health and social care (both children’s and adult’s social care), and addressing the wider determinants of health and wellbeing. The expectation is that this should be built bottom-up from local assessments of needs and assets identified at place level, based on Joint Strategic Needs Assessments. We expect these plans to be focused*

on improving health and care outcomes, reducing inequalities and addressing the consequences of the pandemic for communities.

The ICS Partnership will be based around existing and enhanced relationships with the three Health and Wellbeing Boards.

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.”

NHS organisations in Leicester, Leicestershire and Rutland are not using any private companies to help develop or 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.”

Three place based plans are currently being developed, one for each of the three upper tier unitary authorities (Leicester, Leicestershire, Rutland). These plans are being developed in partnership between the local NHS and the local authorities, taking account of evidence and insights of what is important to the public and other stakeholders in those areas, and will be supported by additional local public engagement where appropriate.

These plans will build upon and supersede existing Health and Wellbeing Strategies in each of these areas. The Health and Wellbeing Boards in each local authority will have a key role in working with partners at this ‘place’ level to turn delivery of the plans into a reality.

Funding requirements, and funding sources, can only be identified after these plans have been developed.

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?"

Our priority is, and will continue to be, that NHS and other public sector organisations will provide the overwhelming majority of services as they do now.

Proposals contained in the draft legislation will remove the current procurement rules which apply to NHS and public health commissioners when arranging healthcare services. The ambition is to provide more discretion over when to use procurement processes to arrange services than at present, but that where competitive processes can add value they should continue. As a result the local NHS would have greater flexibility over when they choose to run a competitive tender.

The current system will be replaced by a new provider selection regime which will provide the framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services.

Locally we plan to adopt a "system first" principle, which effectively means that the needs of the local population and the stability of the local health and care system will be prioritised in decisions about services and providers.

However, it should be recognised that the independent sector has played an important role in the delivery of some NHS services for a very long time. For example, additional capacity provided by the private sector has played a key role in improving patients' access to hospital treatment, as well as increasing patient choice.

As such there may be times where local needs and market conditions mean that these considerations are best secured by non-NHS providers - for instance by private providers, the voluntary sector and social enterprises.

In assessing potential providers' appropriateness to deliver a particular service we will continue to use measures for quality and safety, value, integration and collaboration, access and choice, service sustainability, and social value.

Transparency in the award of contracts will be vital. Where contracts are being renewed or changed we will publish our intended approach in advance as well as detailing contracts awarded along with other relevant information about the contract and its contents. In making decisions about contract awards decision makers will continue to be expected to adhere to the Nolan Principles on Standards in Public Life, as well as relevant Conflicts of Interest and other governance policies.

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

The changes to acute services within Leicester's hospitals are the right ones irrespective of any localisation of services brought about through Place Based Plans and stand alone as a package to consolidate services and address issues of inter-dependencies after many years of capital underinvestment. It should also be recognised that a great deal of healthcare activity is already being delivered in Rutland, while patients are already using specialist services across all three of the existing UHL sites as well as hospitals in neighbouring counties.

In any event, and as set out during and after the consultation, the implementation of plans for Leicester's hospitals are phased over a number of years.

- 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.

  Development of plans section 106 funding including relevant bids

Funding requirements, and funding sources, can only be identified after these plans have been developed.

- that these 15 issues (see list below) affecting this rural community will be resolved including the capital and revenue needed as above.

The report by the group, and issues raised, have been shared with the multi-partner steering group leading the development of the Place Based Plan for Rutland for consideration alongside the insight and feedback from many other engagement activities with Rutlanders.

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

NHS

Building Better Hospitals

Minute Item 23

Leicester, Leicestershire and Rutland

Joint Overview and Scrutiny Committee

Overview of the Leicester, Leicestershire and Rutland CCGs Decision Making Business Case

8th July 2021

Building Better Hospitals
For the future

Summary proposals set out in the UHL Acute Reconfiguration PCBC

- Build a new maternity hospital with a doctor-led inpatient maternity service. A shared care unit with midwives and doctors and a midwifery centre provided alongside the obstetric (pregnancy) unit
- Refurbish the Kensington building to create a new children's hospital including a consolidated children's intensive care unit
- Build new premises to house a major new treatment centre for planned care, inpatient wards and theatres
- Expand the intensive care units at LRI and Glenfield
- Expand car parking facilities, for example, additional levels on the multi-storey car park and create dedicated welcome centre
- Repurpose the General Hospital to create a smaller campus that focuses on community health with some beds and more GP-led services
- Retain the diabetes centre of excellence and stroke recovery service with inpatient beds
- Potentially relocate a midwifery led unit from Melton Mowbray to Leicester General Hospital

Consultation reach

1.8*** million reached by people in Leicester, Leicestershire and Rutland through the consultation

971,657

Digital media (all online including websites, social media, email marketing, AdsMart)

853,048

Print and broadcast media (newspapers, magazines, newsletters, radio etc.)

4,960

Event promotion

1,049

Stakeholders (MPs, councillors, VSO etc.)

25,000

Staff

N.B. ***In some instances e.g. newspapers advertising, information will be read by other people in a household, therefore 1.8 million represents minimum exposure based on our ability to evidence it

Response figures

5,675

Total response to the consultation

4,682

Survey responses

70

Correspondence (email and letter)

923

Event participants across 113 events

Equality Impact Assessment

The CCGs had an independent Equality Impact Assessment undertaken on the proposals at Pre-Consultation Business Case stage and this was updated following the formal consultation. The summary of findings were:

- LLR CCG and UHL have both demonstrated significant respect and understanding in their discharge of their Equality Duty and the wider duties to reduce inequalities conferred on the CCG under the NHS Act 2006.
- The efforts since 2018 to engage with representatives of those from protected groups is significant and has generated immensely useful feedback that is already being actively used to inform continued engagement and future decision making.
- The responses are largely proportionate to the broad geographic and demographic diversity of the LLR population, indicating that a comprehensive range of views have been garnered.
- The engagement with diverse communities during the consultation has given the CCGs and UHL a great foundation on which to continue engagement work during the implementation phase and our wider work.
- Through the introduction of the systems Inclusivity Decision Making Framework, there is a commitment to embed such approaches routinely in practice.
- The value of material arising from the views of the local and diverse population of Leicester, Leicestershire and Rutland is potentially rich, and to be capitalised upon.

The Equality Impact Assessment also states the following in relation the CCGs meeting the NHS Act 2006 Section 14T and subsequently the Equality Act 2010:

“responders who chose to disclose their association with one or more of protected group were indeed proportionately representing the wider population of LLR; i.e. the public consultation captured the views from suitable representative groups of the general LLR population.”

Process for considering feedback from consultation

- The consultation findings were collated by an independent organisation who produced a report setting out the findings – this is known as the Report of Findings
- The Report of Findings has been used to consider whether the proposals set out in the Pre-Consultation Business Case should form the final proposals in the Decision Making Business Case (DMBC)
- Where the consultation responses have impacted on clinical proposals UHL have undertaken a review of their original proposal against the consultation responses to decide the final proposals within the DMBC
- The following set of slides go through the rationale for the decisions that were taken by Leicester City Clinical Commissioning Group; West Leicestershire Clinical Commissioning Group; and East Leicestershire and Rutland Clinical Commissioning Group on the proposals set out in the University Hospitals of Leicester Acute Reconfiguration Decision Making Business Case which was considered and approved at their Governing Body meetings of 8th June 2021

Moving acute services on to two of the current three hospital sites with acute services being provided at Leicester Royal Infirmary and Glenfield Hospital

Consultation outcomes

58% of respondents agreed with proposal

14% neither agreed or disagreed with proposal

28% disagreed with proposal

We also heard from staff that some services were best retained on one place

We also heard during consultation that people wanted to understand the impact of COVID on our plans and whether we would be future proofing services by releasing some of the Leicester General Hospital site

Main reasons for support is that:

- The proposals made sense
- It would increase efficiency and that it would improve access

Main reasons for disagreeing:

- The proposal would reduce accessibility for rural communities in the east and south of LLR
- LRI is not a suitable site and the lack of parking at the LRI

What we will be doing to address the concerns:

- A Travel Action Plan has been developed to support the reconfiguration which includes:
  - Improvements to the bus and hopper routes to the hospitals
  - Work with the local authorities to increase park and ride facilities including trailing the General Hospital as a site
  - Increase public parking spaces at the LRI and Glenfield hospitals by circa 300 per site
  - Improve sustainable travel options

Speciality changes in location

PCBC Proposal	DMBC Decision	Rationale
Brain Injury and Neurological Rehabilitation Units to be moved from General to Leicester Royal Infirmary	Brain Injury and Neurological Rehabilitation Units to be moved from General to Glenfield Hospital	Glenfield will provide better opportunities to provide appropriate clinical space and rehabilitation facilities including green spaces
Ear Nose and Throat: Adults Outpatient/Daycase – Glenfield; Inpatient/Emergencies - LRI	**Ear Nose and Throat**: All services to remain at LRI	**ENT**: to maintain adult; paediatric and emergency services in the same place
Ophthalmology: Outpatient/Daycase – Glenfield; Inpatient/Emergencies - LRI	**Ophthalmology**: All services to remain at LRI	**Ophthalmology:** to ensure on call to ED and the Childrens Hospital can be delivered effectively
Plastics: Outpatients/Daycase – Glenfield; Inpatient/Emergencies - LRI	**Plastics**: All services to remain at LRI	**Plastics**: provide a better service by keeping service together
Endocrinology: Outpatients/Daycase – Glenfield; Inpatient/Emergencies - LRI	**Endocrinology:** All services to remain at LRI	**Endocrinology**: to enable inpatient services at LRI to be supported

Impact of COVID on our proposals

A review was undertaken by clinicians within UHL to determine whether the proposals set out in the Pre-Consultation Business Case were still sound in the light of learning from COVID. They found that if the changes had been in place before the pandemic it would have enabled LLR to manage better for the following reasons:

ICU: the proposals will see the doubling of ICU capacity at UHL to over 100 beds. If these beds had been in place at the height of the pandemic there would have been sufficient capacity to manage acutely ill COVID patients and to undertake more urgent and complex surgery – thus reducing the number of cancelled operations that had to be made.

Children's Heart Surgery: the proposed dedicated Children's Hospital would have meant the urgent heart surgery could have continued locally rather than having to send children out of area. Paediatric ICU had to be converted into adult ITU at the height of the pandemic.

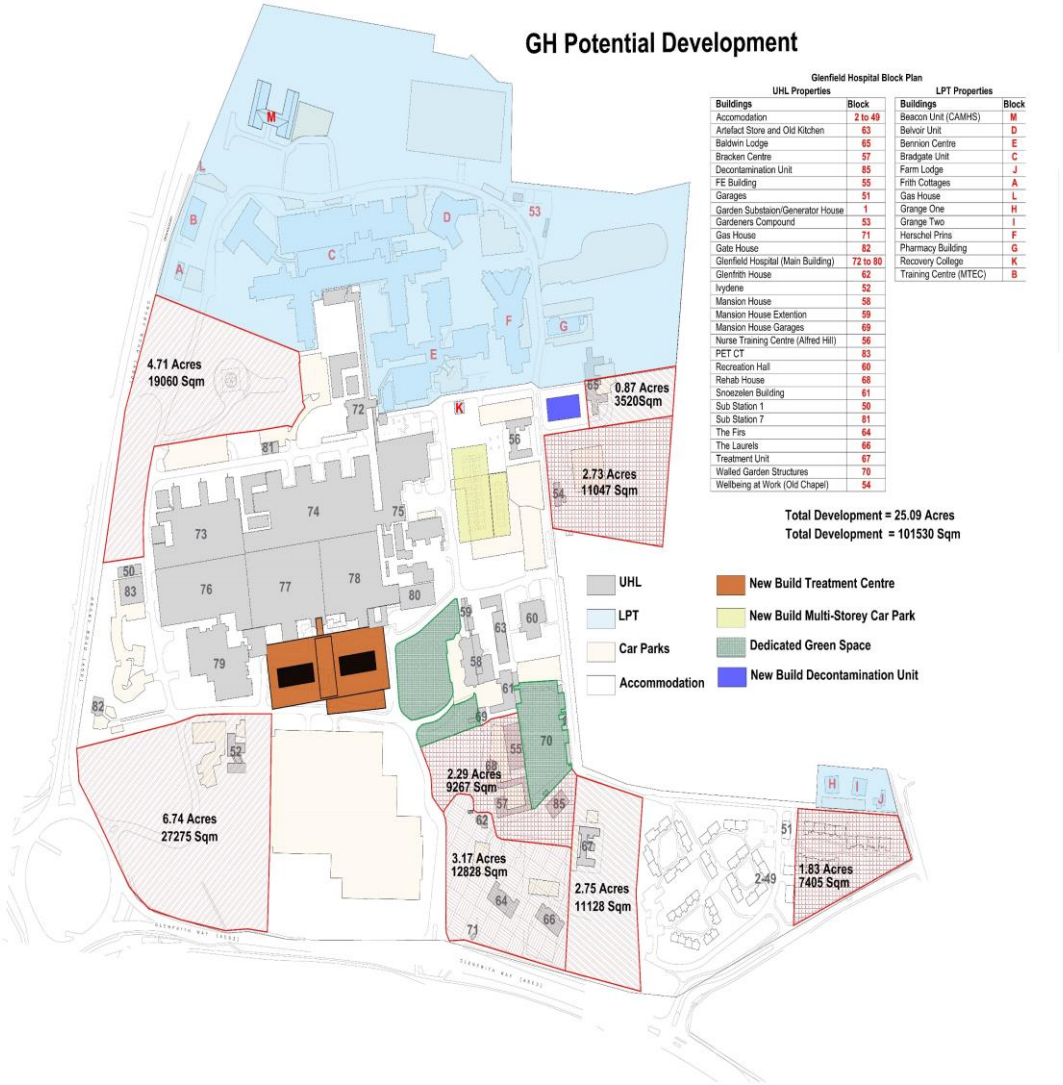
Cancer and Elective Operations: by creating a dedicated Treatment Centre and increasing ICU capacity this would have enabled more surgery to have continued during the pandemic and as a result there would have been less cancellations and a smaller backlog of cases.

Developable land post reconfiguration

One of the questions that was raised during consultation was whether by moving services from the General Hospital site and selling the land for housing would this reduce the local NHS ability to increase services in the future should the need arise.

An analysis of the available land at the Leicester Royal Infirmary and the Glenfield Hospital shows that after the full reconfiguration work has been completed there would 25 acres of developable space available at the Glenfield Hospital, the majority of which is already vacant land.

This shows that there would be considerable scope for further development should this be needed in the future.



New treatment centre – moving outpatient services from Leicester Royal Infirmary and Leicester General Hospital to a new purpose build treatment centre at Glenfield Hospital

Consultation outcomes

60% of respondents agreed with proposal

25% disagreed with proposal

In addition the clinical case set out in the Pre-Consultation Business Case and the clinical review of the proposals post COVID sets out the advantages of separating elective and emergency care

Main reasons for support is that:

- Glenfield Hospital is a more suitable location than the LRI (24%)
- There was general agreement with the proposal
- The proposal will improve access to outpatient services – i.e. all services in one place.

Main reasons for disagreeing:

- The reduction in accessibility for patients in rural communities and east and south of the city
- Glenfield is not suitable location for outpatient services (8%)
- LRI is more suitable location due to public transport links

What we will be doing to address the concerns:

- A Travel Action Plan has been developed to support the reconfiguration which includes:
  - Improvements to the bus and hopper routes to the hospitals
  - Work with the local authorities to increase park and ride facilities including trailing the General Hospital as a site
  - Increase public parking spaces at the LRI and Glenfield hospitals by circa 300 per site
  - Improve sustainable travel option

Use of new technologies – offering appointments by telephone or video call for certain aspects of pre-planned care

Consultation outcomes

64% of respondents agreed with proposal

23% disagreed with proposal

Main reasons for support is that:

- Technology improves access to services by reducing travel
- COVID has proven that technology can work

Main reasons for disagreeing:

- Some groups will require face to face appointments
- We should consider the lack of access to technology for some people
- We should consider the need for physical examination when this will aid diagnosis

What we will be doing to address the concerns:

- Where face to face appointments are needed they will be offered including were there is a need for a physical examination
- Lack of access to technology will be considered as we develop our plans further and there must always be an alternative for people that cannot or do not have access to technology

Create a primary care urgent treatment centre at Leicester General Hospital site and scope further detail on proposals for developing services at the centre based upon feedback and further engagement with the public

Consultation outcomes

67% of respondents agreed with proposal

14% disagreed with proposal

Main reasons for support is that:

- It would reduce the pressures on other services
- The Leicester General Hospital site was a suitable site for these services

Main reasons for disagreeing:

- Accessibility to the site for rural communities city residents in the west
- Concern about the removal of existing services
- The General Hospital site not being suitable

What we will be doing to address the concerns:

- This would predominately be a primary care site covering the city – the actions set out in the Travel Action Plan should support travel to the site
- Providing urgent care services away from an acute site will relieve pressure on emergency services and with diagnostics and observation facilities it will enable patients to be monitored outside of an acute environment
- With the predicated housing growth and limited current provision in the area it is anticipated that additional primary care facilities will be required in the coming years
- There is also a national drive to develop community diagnostic hubs as outlined in these proposals

New haemodialysis treatment units – providing two new haemodialysis treatment units, one at Glenfield Hospital and the second in a new unit to the south of Leicester

Consultation outcomes

69% of respondents agreed with proposal

7% disagreed with proposal

Main reasons for support is that:

- Improved access to haemodialysis services
- Glenfield is a suitable site

Main reasons for disagreeing:

- General Hospital site is a suitable site for the service
- There was no need for two sites
- The proposals would reduce accessibility

What we will be doing to address the concerns:

- A decision on the second site will be made in due course, once potential sites have been identified, via an options appraisal approach which will include considering the view of services users
- The service will continue to explore innovative ways of delivering dialysis including the option of home or community based dialysis when this is right for the patient

Hydrotherapy pools – using hydrotherapy pools already located in community settings

Consultation outcomes

71% of respondents agreed with proposal

7% disagreed with proposal

Main reasons for support is that:

- Improved access to facilities
- The impact that hydrotherapy has on a patient's outcomes

Main reasons for disagreeing:

- Quality of care
- Community pools would not have the required facilities

What we will be doing to address the concerns:

- In determining location criteria will be establish to determine the locations this will include the availability of the right equipment and pool facilities
- Appropriately trained staff, i.e. NHS Physiotherapists would deliver the service

Children's hospital – refurbishing the Kensington building at Leicester Royal Infirmary to create a new children's hospital including a consolidated children's intensive care unit, co-located with maternity services

Consultation outcomes

77% of respondents agreed with proposal

7% disagreed with proposal

Main reasons for support is that:

- An improvement in the quality of care
- It is positive to have a children's hospital

Main reasons for disagreeing:

- The LRI not being a suitable site
- Difficulty with parking and reducing access for rural communities

What we will be doing to address the concerns:

- The Travel Action Plan will support the concerns about parking and access
- The LRI was chosen as the site as it has the Children's Emergency Department and will be the home for the Children's Congenital Heart Services from 2021. Part of the requirement for the continued delivery of CHD services is the formation of a Children's Hospital and as such the LRI was proposed as the location due to the co-location with the Children's Emergency Department of the CHD Service

New maternity hospital – building a new maternity hospital on the LRI site, including a midwifery-led birth centre provided alongside the obstetric unit. Moving existing maternity services (services provided in pregnancy, childbirth and post-pregnancy) and neonatal services from Leicester General Hospital to Leicester Royal Infirmary

Consultation outcomes

50% of respondents agreed with proposal

19% neither agreed or disagreed

31% disagreed with proposal

More people disagreed from postcodes in Rutland and the south and east areas of Leicestershire compared to other areas in LLR

Main reasons for support is that:

- Increased efficiency and improved quality of care

Main reasons for disagreeing:

- The Leicester Royal Infirmary not being a suitable site
- Reduced accessibility for rural communities
- Lack of parking at the LRI

What we will be doing to address the concerns:

- The Travel Action Plan will support the concerns about parking and access

Breastfeeding services – enhancing breastfeeding services for mothers by post-natal breastfeeding drop-in sessions alongside peer support

Consultation outcomes

41% of respondents agreed with proposal

7% disagreed with proposal

Main reasons for support is that:

- Increase access to breastfeeding support
- It would benefit mothers and babies

Main reasons for disagreeing:

- Consideration should be given to the high-quality support provided at St. Marys Birthing Unit
- Leicester is not suitable for drop-in sessions

What we will be doing to address the concerns:

- Breastfeeding support will still be provided locally

New standalone maternity unit – relocating the standalone maternity unit at St Mary's in Melton Mowbray and trial a new standalone midwifery unit at Leicester General Hospital to assess its viability

Consultation outcomes

36% of respondents agreed with proposal

23% neither agreed or disagreed

41% disagreed with proposal

More people disagreed from postcodes in Rutland and the south and east areas of Leicestershire compared to other areas in LLR

Main reasons for support is that:

- It would improve access by moving the service to Leicester General Hospital site
- The quality of care would improve at the Leicester General Hospital

Main reasons for disagreeing:

- It would reduce access in some parts of LLR to the service
- People valued the quality of care at St. Marys Birth Centre

What we will be doing to address the concerns:

See next slide

Area	Agreed	Neither agreed or disagreed	Disagreed
Leicester City	45%	21%	35%
Rutland	16%	28%	56%
Leicestershire South & East	30%	19%	51%
Leicestershire North & West	39%	24%	37%

Consultation outcomes

A review panel considered the feedback from consultation and concluded that the proposal for the standalone Midwifery Led Unit to move from St. Marys in Melton Mowbray to the Leicester General site should be the one considered by the LLR CCG Governing Bodies. The rationale for this was:

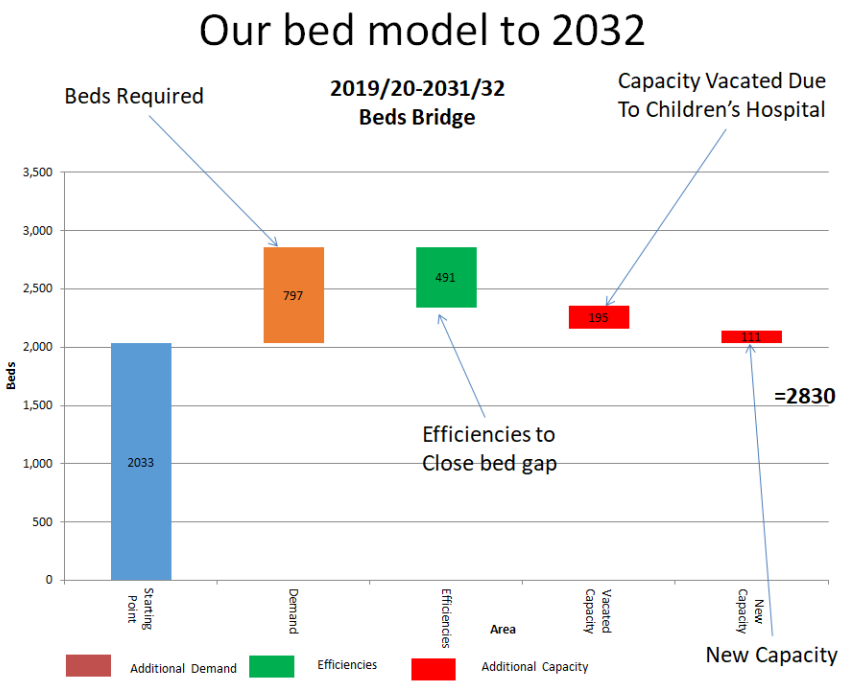
- The General Hospital site will be more accessible to more women across LLR thus providing a more equitable service to the women of LLR
- Transfer time to acute service will be significantly reduced and this will reduce clinical risk and encourage more women to choose the standalone Midwifery Led Unit
- Staff sustainability is improved by relocation to the Leicester General Hospital site due to difficult in recruiting staff in its current location
- The current service does not see enough patients for it to be viable but LLR wants to offer an standalone Midwifery Led Unit as an option for women and moving it the Leicester General Hospital will give a better chance of long term sustainability

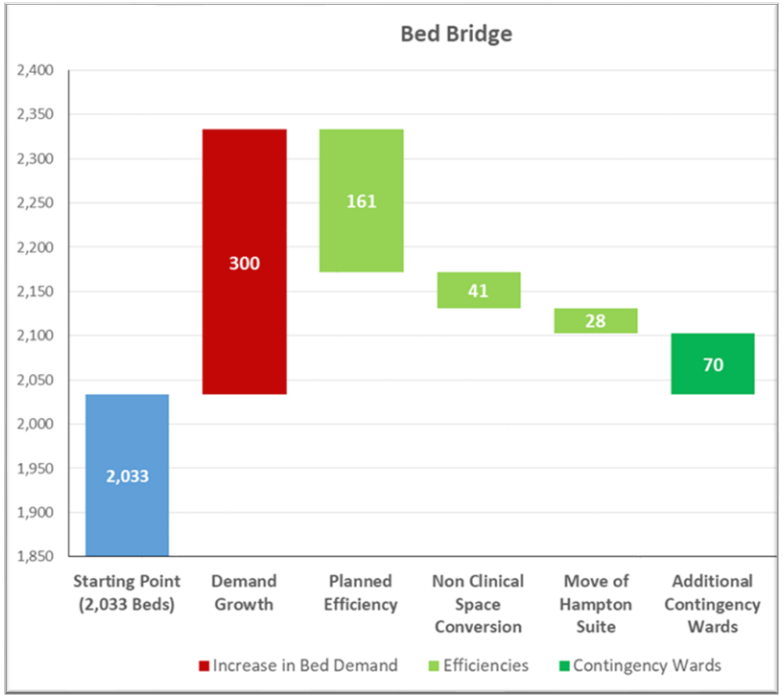
What we will be doing to address the concerns:

- Significant ongoing improvement to postnatal support services will take place including:
  - Locally based services
  - Local breastfeeding support services
  - Expanded team of midwives who will provide continuity of care
  - Support for home births
- We will use the skills and expertise of the midwives providing the service at St. Marys Birth Centre in the development to the Leicester General service
- It is acknowledged that the viability of the standalone midwifery Led Unit at the Leicester General Hospital site will not be able to be assessed within a one year period as set out in the PCBC – this will take time to grow. As such we will establish a panel made up of professionals and women to agree how and when this assessment will take place
- We will actively promote the option of the standalone Midwifery Led Unit at the Leicester General to women

Bed modelling

- During consultation we had feedback to plan our bed model over a longer period which we have now done taking the model to 2032 rather that 2024 as set out in the Pre-Consultation Business Case
- The new model will see an additional 306 beds from the starting point of 2033 which is an increase of 167 new beds on the PCBC
- Efficiencies increase from 161 to 491 over the same period





Pledges/commitments

A set of 17 principles which the NHS in Leicester, Leicestershire and Rutland will adhere to when implementing change.

1. Good access cross all sites
2. Good access onto and around all sites
3. Embrace environmental sustainability
4. Adapt high quality patient communication and interactions
5. Co-design services and provide information to all socio-demographic groups throughout implementation of change
6. Focus attention beyond clinical need
7. Develop solutions for those people living in rural locations – care closer to home, particularly if needed in an emergency
8. New technologies – adopted and adapted to meet the patient need and choice
9. Engage communities on next steps for Leicester General Hospital

Pledges/commitments

A set of 17 principles which the NHS in Leicester, Leicestershire and Rutland will adhere to when implementing change.

10. Consider variety of locations to achieve the best access to haemodialysis treatment
11. Provide quality of care in hydrotherapy services, at the right and appropriate locations with good access e.g. wheelchair users, and provide trained staff and pay attention to single sex sessions
12. New maternity hospital providing personalise high quality care
13. High quality and sustainable standalone Midwifery Led Unit
14. Provision of community breastfeeding support
15. Provision of high quality Children's Hospital for children, young people and family carers
16. Provision of adequate acute bed capacity to match need
17. Ensure that all improvements ensure better outcomes for patients improving the health and wellbeing of our local population.

LLR COVID-19 &Seasonal Flu Vaccination Programme Update

Minute Item 24

LLR HOSC

13 September 2021

MSOAs of lowest uptake

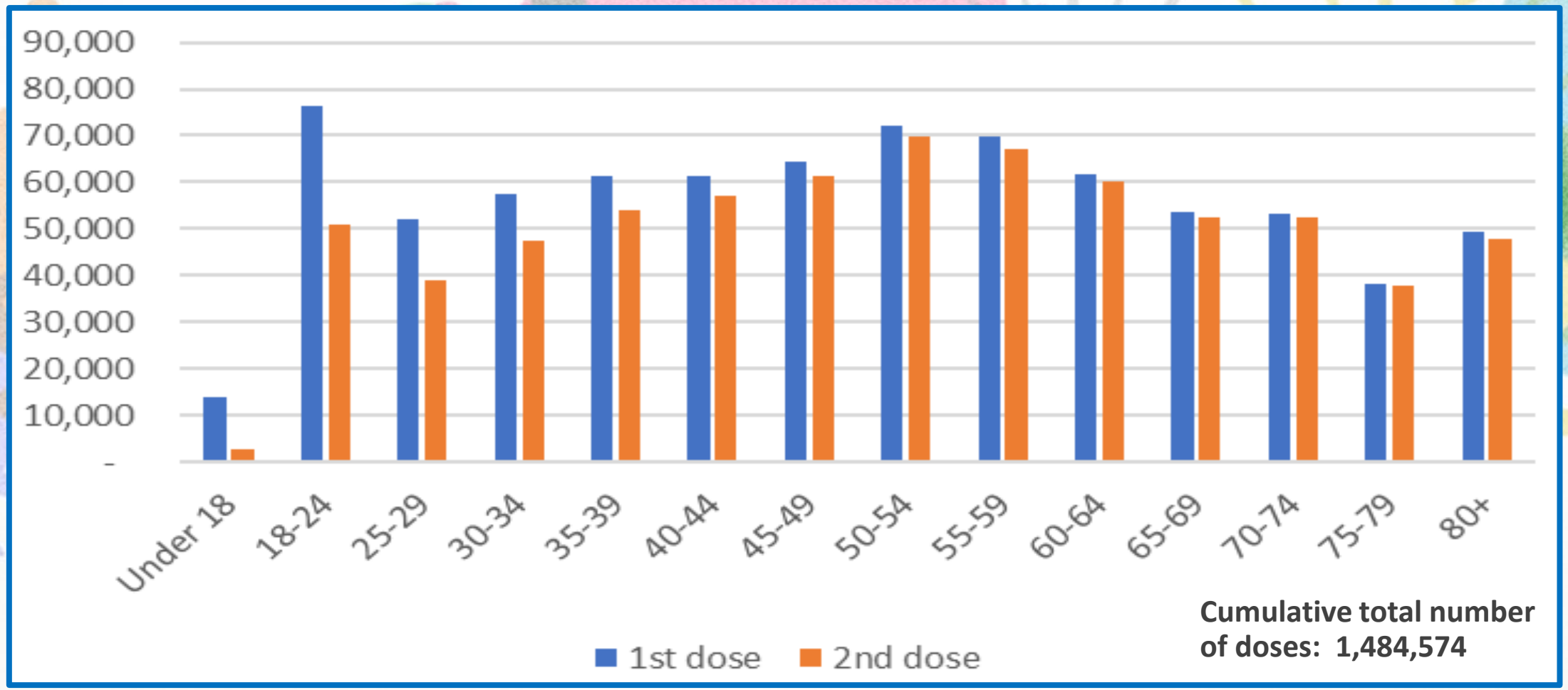
Specific initiatives have been put in place for those communities with lower uptake with temporary sites in neighbourhood localities to facilitate access e.g. Fearon Hall Loughborough, African Caribbean Centre Leicester, 'Pop up' clinics' in Belgrave but vaccination rates over recent weeks have seen a declined. This is consistent with the national picture on uptake

There are further initiatives planned through September to target the returning student populations in the City and County, with campus- based vaccination and further event at Leicester City Football Club

The programme team are working with City Public Health colleagues to refocus efforts in areas of low uptake based on a public health 'deep dive' of the city data, and behavioural insights work

LLR published vaccination data

Uptake by age from 8th Dec 2020 to 29th August 2021

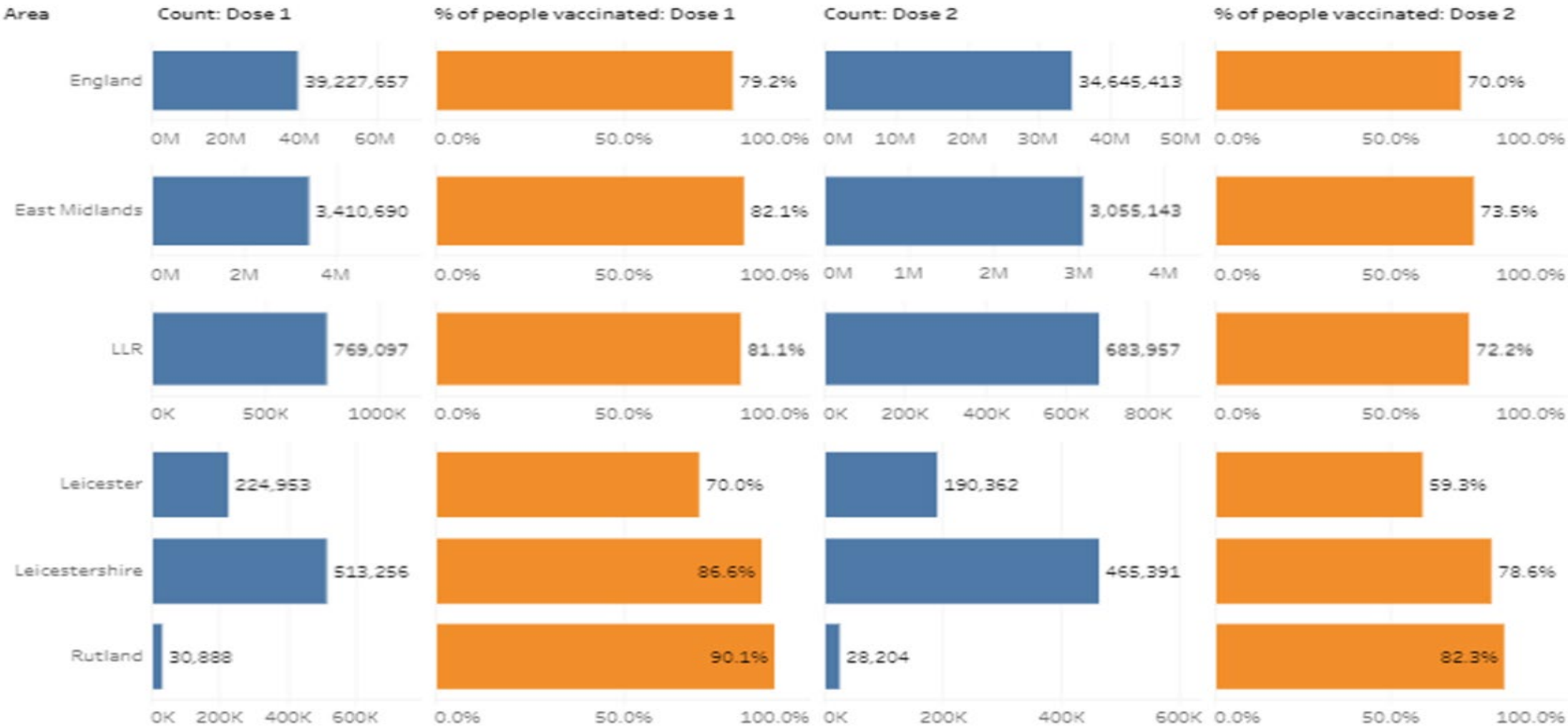


Covid-19 Vaccination Uptake up to 22/08/2021

Cohort selected: Over 18

Cohort: Over 18

Vaccination Uptake by Area



Produced by Strategic Business Intelligence, Updated 26th August 2021

JCVI recommendation: vaccinating ALL 12-15 year olds

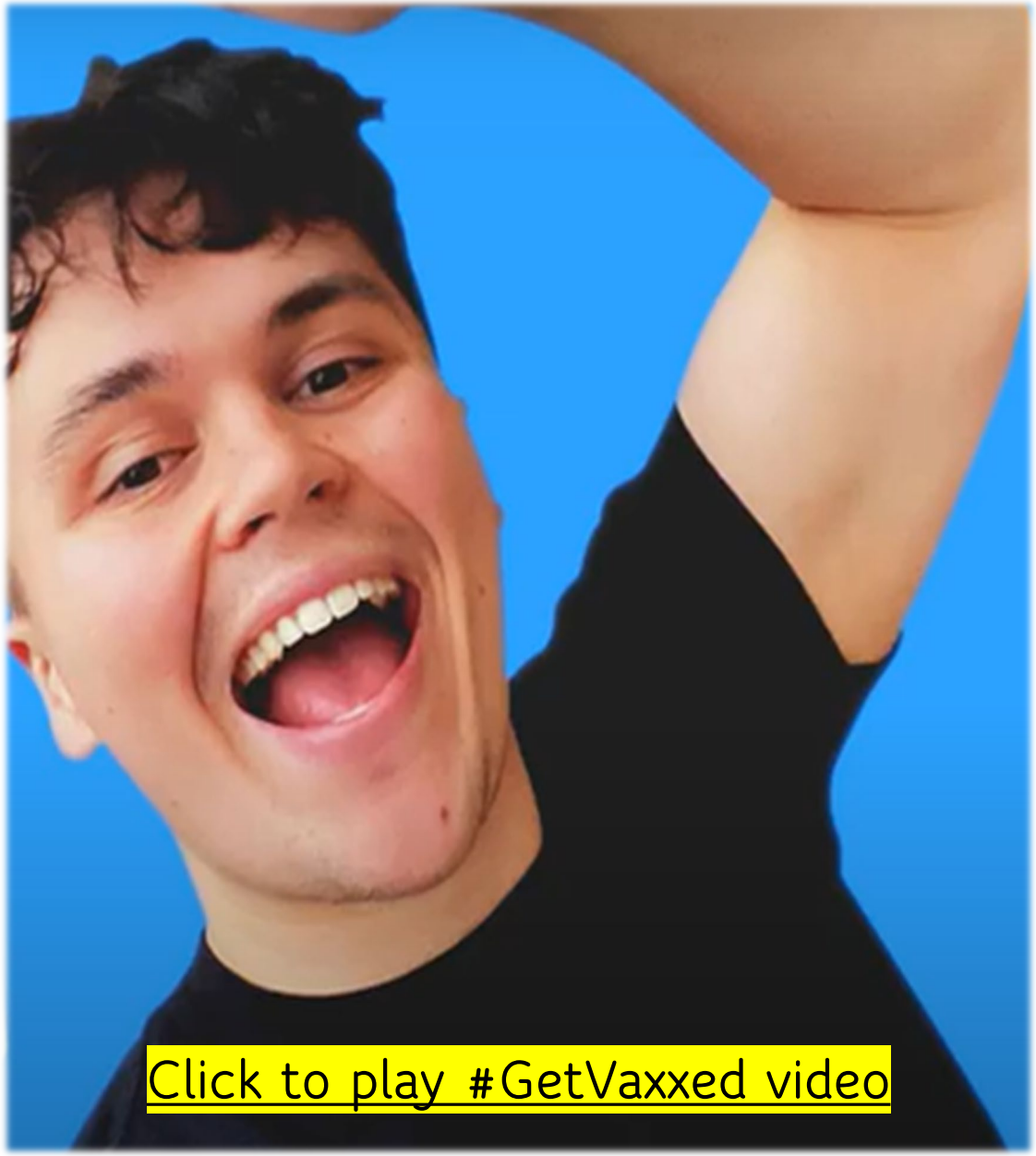
The JCVI announced on 2 September that while the health gains from vaccinating the entire age group were greater than the risks, “the margin of benefit is considered too small to support universal vaccination of healthy 12 to 15 year-olds at this time”.

The 4 CMOs have been asked to consider the position and a decision to vaccinate 12-15 year olds is expected imminently

Capacity has been planned to deliver once an announcement is made and LPT SAIS service will be the lead provider and have planned the first 3 weeks of a 10 week programme

JCVI has recommended an expansion to an existing programme of vaccinations for older children with health conditions, including heart disease, type 1 diabetes & severe asthma.

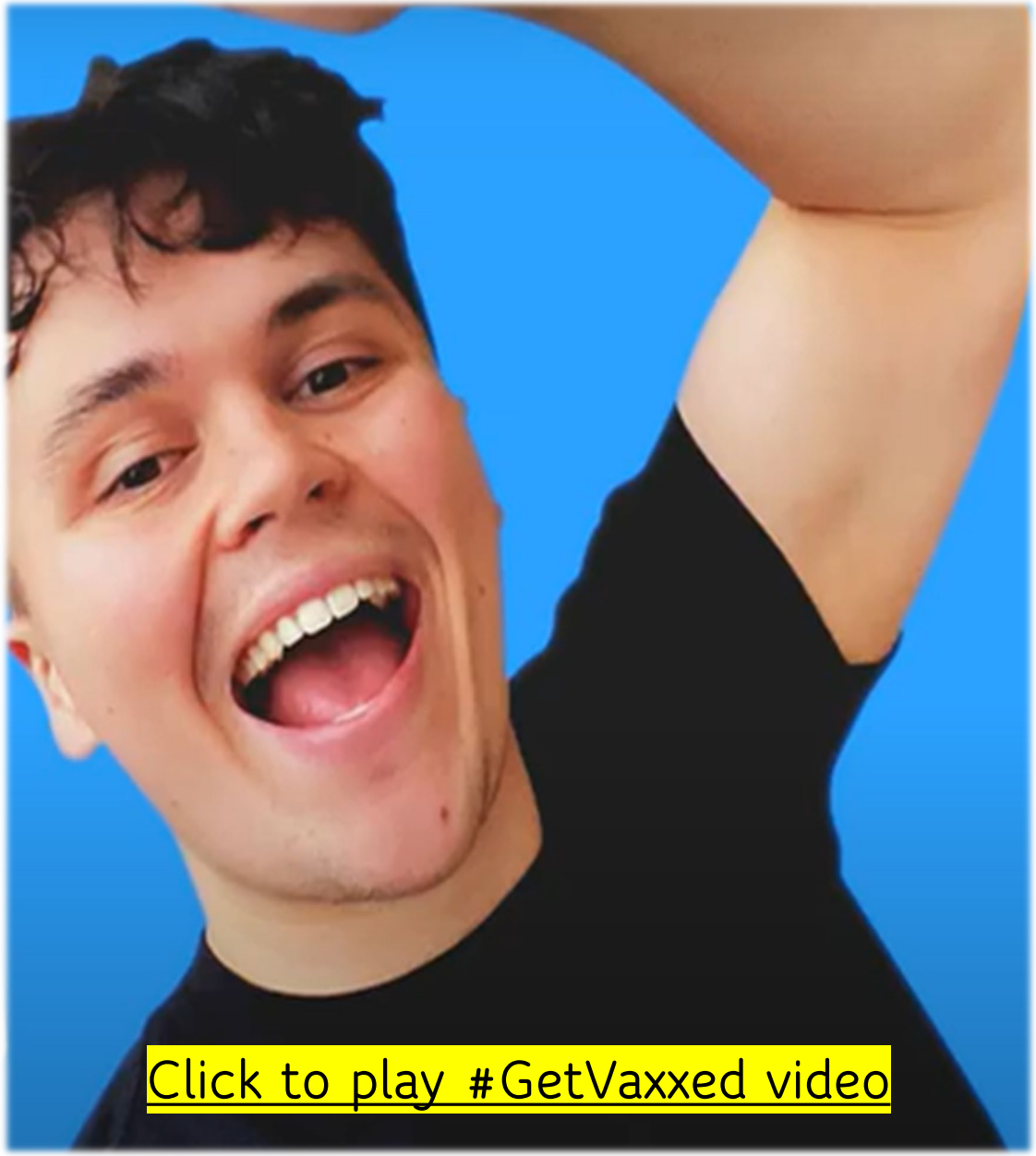
JCVI recommendation: 3rd vaccinations



On 1st September, JCVI advised that a 3rd primary dose be offered to individuals aged 12 years & over with severe immunosuppression in proximity of their 1st or 2nd vaccine doses. Severe immunosuppression at the time of vaccination includes:

1. Individuals with primary or acquired immunodeficiency
2. Individuals on immunosuppressive or immunomodulating therapy
3. Individuals with chronic immune-mediated inflammatory disease who were receiving/had received immunosuppressive therapy
4. Individuals who had received high-dose steroids for any reason in the month before vaccination.

MSOAs of lowest uptake



University ‘pop up’ clinics :
University of Leicester – 24th – 28th Sept, 9th, 10th Oct

De Montford University – 29th Sept to 3rd Oct

Loughborough University – 24th, 29th, 30th Sept and 9th,10th Oct

LLR are in talks with a number of colleges across LLR:
Loughborough College - 9th and 10th of September 2021 (11am to 5pm)
Leicester College - 16th September 2021 (10am to 2pm)

Clinics held on the 26, 27th and 28th of August 2021 at North Warwickshire and South Wigston College (covers Hinckley & Bosworth Area) and delivered 571 vaccines.
LCFC walk bookable and in appointments for young people 3,4 &5 September with Circa 1200 vaccinations

Joint meeting with Public Health to agree priorities and next steps for MSOA areas with lowest uptake to inform future approaches

CYP Vaccinations

16-17 year olds

Age	First Doses	Total Population	% uptake
16	6,253		
17	7,705		
Total	13,958	26,957	51.8%

12-15 year olds

Age	First Doses
12	133
13	155
14	172
15	2,574
Total	3,034

Delivery of vaccinations to the 16-17 year olds is continuing to progress. The target of 75% of the population is progressing with performance increasing from 46.6% to 51.5% last week.

There are additional clinics operating over the weekend with both walk in & booked facilities which are available to view on the national Grab a Jab portal, including sessions at Kings Power Stadium (3rd – 5th September). The Grab a Jab portal now has links to it from the NBS booking site due to 16-17 year olds being unable to book on NBS.

Currently the 12-15 year olds at risk cohort are open for vaccination. There have been 2,521 vaccinated to date. The majority of the vaccinations have been delivered to 15 year olds, with very few 12-14 year olds coming forward.

The total at risk population was identified to be 453. Work is continuing to identify the 12-15 year olds living in an immuno-supressed households, however, plans to vaccinate all 12-15 year olds as part of an 8 week programme continue, whilst a decision is reached nationally.

Three ways to get your Covid jab

NHS

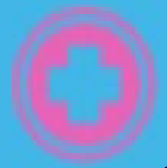
1

National Covid Vaccine Booking Service

Visit www.nhs.uk
or call 119

For appointments at:
- Peepul Centre
- Hospital Hubs
- Pharmacies
- Melton Sports Village
- Sturdee Road Health & Wellbeing Centre

2



Your GP practice

You don't need to contact your GP practice. If your practice is offering vaccines, they will be in touch when it is your turn.

3

Drop-in clinic

Details of available drop-in clinics will be published on the website below.

Boosters to commence from 20th September

#GetVaxxedLLR

Phase 3 Booster Programme

- Combined Flu and Covid programme
- 22/25 PCNs signed up
- Additional Community Pharmacy capacity targeted at hard to reach communities and to address geographical gaps
- A series of ‘Pop up’ and temporary sites will be operated, in phase 3 to provide convenient access in areas of low uptake

Seasonal Flu Cohorts

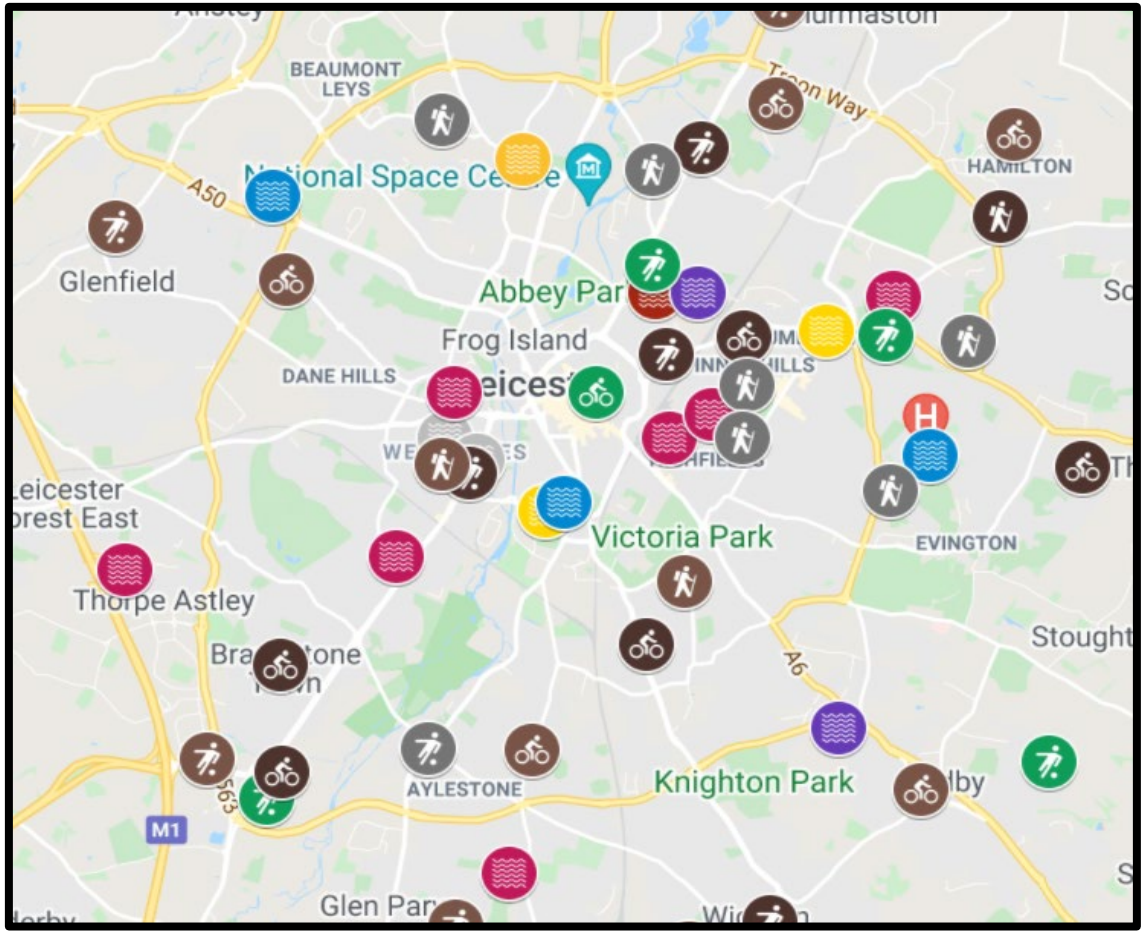
- all children aged 2 to 15 (but not 16 years or older) on 31 August 2021
- those aged 6 months to under 50 years in clinical risk groups
- pregnant women
- those aged 50 years and over
- those in long-stay residential care homes
- carers
- close contacts of immunocompromised individuals
- frontline health and social care staff employed by:
  - a registered residential care or nursing home
  - registered domiciliary care provider
  - a voluntary managed hospice provider
  - Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants.
- All frontline health and social care workers are expected to have influenza vaccination to protect those they care for.

Flu Delivery Model

- **Mixed landscape across LLR**
- **PCNs and GPs have developed Flu plans**
- **Other delivery pillars will be; Community Pharmacists , Hospital Hubs and Vaccination centre (if concomitant administration with Covid is recommended)**
- **Home Visiting via GPs practices and LPT**
- **Additional training provided: Covid Workforce are being trained to deliver Flu**
- **Last years uptake data provided and support to areas of low response and Covid 'pop up' approach will be used to target uptake**
- **Comms and engagement plan in place**

Phase 3: Leicester City

- Based on the EoIs there are potential sites in most areas with lower uptake to address issues within Phase 3.
- Dependant on the approved sites, we will work with Public Health to ensure secondary EoIs are requested from community Pharmacies within the challenged MSOAs



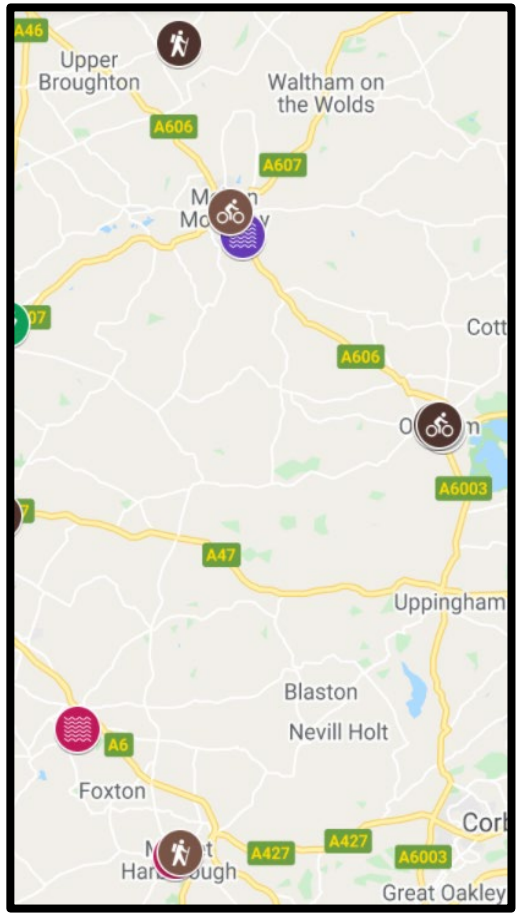
Phase 3: East Leicestershire & Rutland

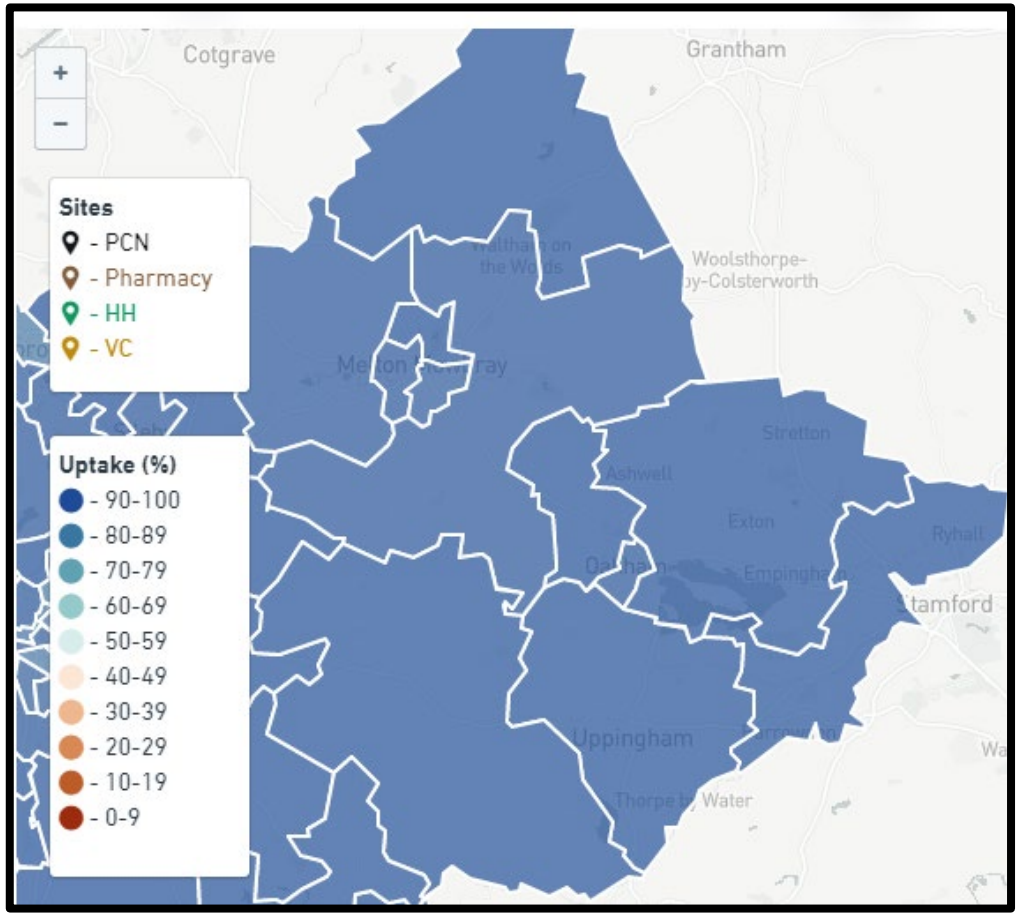
Uptake by MSOA was less challenged during Phase 1 & 2; however limited additional CP EoIs were received.

The challenges:

- **Rutland** - PCN not submitted an EoI & low uptake in Market Overton, Cottesmore & Eppingham. Two CPs have put themselves forward & a site is being identified to support delivering the larger numbers.
- **MSV** - PCN not submitted an EoI. LPT will operate from Melton Sports Village continuing provision from this site via NBS bookings. MSV PCN is in discussions around providing the Housebound covid vaccination,

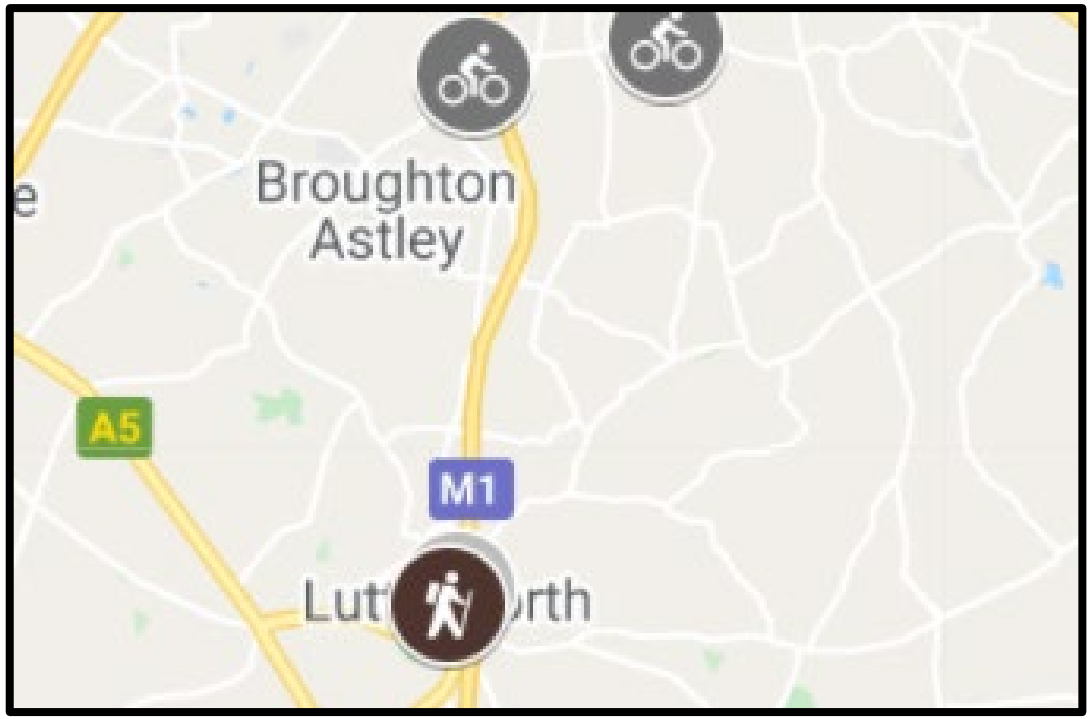
along side seasonal flu vaccination.

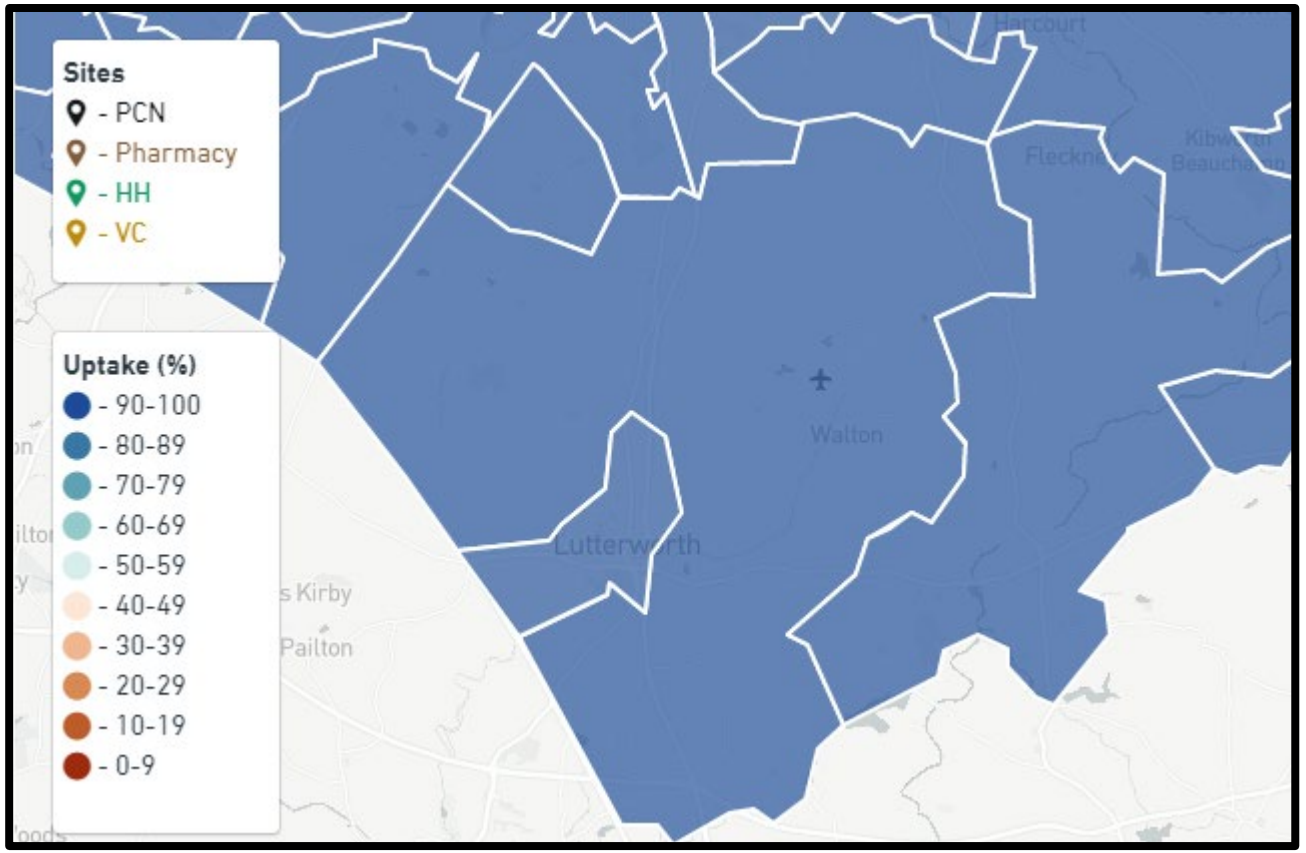




Phase 3: South Leicestershire

- Uptake by MSOA was less challenged during Phase 1 & 2.
- The challenged area is south towards Lutterworth. The PCN has not submitted an EoI. , although some practices within the PCN are joining other provision. One CP has submitted an EoI and there is potential for LPT to re-open the Hospital Hub at Feilding Palmer.





Phase 3: West Leicestershire

- Uptake by MSOA was less challenged during Phase 1 & 2. However, there are delays in some areas for second doses including Coalville, Hugglescote & Agar Nook.
- Two pharmacies have been put forward in the Coalville & Whitwick with smaller numbers, there is an existing Community Pharmacy delivering in Castle Donington & the PCN will be operating an additional site in Coalville