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

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

Members of the Committee

Leicester City Council

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

Leicestershire County Council

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

Rutland County Council

Councillor Harvey
Councillor Waller

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

For Monitoring Officer

Officer contacts:
Anita James (Senior Democratic Support Officer):
Tel: 0116 454 6358, e-mail: anita.james2@leicester.gov.uk
Sazeda Yasmin (Scrutiny Support Officer):
Tel: 0116 454 0696, e-mail: Sazeda.yasmin@leicester.gov.uk)
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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

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

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

PUBLIC SESSION

AGENDA

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1. CHAIRS ANNOUNCEMENTS

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 36)**

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

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

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

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

6. PETITIONS

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

7. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

The following questions have been received:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX -EXECUTIVE SUMMARY FROM THE RUTLAND CONFERENCE DECEMBER 2020

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

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

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

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

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

community services.

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

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

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

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

- **RECOMMENDATIONS FOR IMPROVING THE PROPOSALS**

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

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

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

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

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

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

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

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

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

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

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

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

Appendix B (Pages 37 - 50)

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

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

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

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

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

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

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

12. INTEGRATED CARE SYSTEMS UPDATE

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

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

14. WORK PROGRAMME

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

15. DATE OF NEXT MEETING

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

16. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

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

Held: TUESDAY, 6 JULY 2021 at 5.30pm at City Hall

P R E S E N T :

Cllr Patrick Kitterick – Chair
Cllr Jonathan Morgan – Vice Chair

Cllr S Harvey	Cllr M March
Cllr Dr D Sangster	Cllr G Whittle
Cllr Bray	Cllr L Phillimore
Cllr Grimley	Cllr Hack
Cllr King	Cllr D Smith

In attendance

Andy Williams, Chief Executive CCG LLR – via Zoom
Ian Scudamore Director Women's/Children's Services UHL – via Zoom
Nicky Topham UHL – via Zoom
John Jameson UHL – via Zoom
Floretta Fox Community Midwife Matron UHL – via Zoom
Mark Wightman, Director of Strategy & Communications UHL
Sara Prema Leicester City CCG
Richard Morris Leicester City CCG
Mukesh Barot Healthwatch

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1. CHAIRS ANNOUNCEMENTS

The Chair welcomed those present and led introductions.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Aldred, Councillor Fonseca, Councillor Ghattoraya, Councillor Waller, Councillor Pantling, Ivan Browne, Ruth Lake, Mike Sandys, Dr Janet Underwood and Russell Smalley.

Noted that Councillor Les Phillimore was present as a substitute for Councillor Ghattoraya.

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 5th March 2021 be confirmed as an accurate record.

5. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS

Item 42 University Hospitals of Leicester NHS Trust Audit
Members noted that more details had been requested of the UHL accounts and a response had been circulated in June. The Chair suggested that response needed to be further considered and informed Members that he would be pursuing that outside this meeting.

Referring to the meeting held on 14 December 2020 Councillor Harvey reminded that she had still not received the information around births, post-natal/partum care as requested in the supplementary questions.
ACTION: Richard Morris to pursue that response from the Clinical Commissioning Groups.

6. COMMITTEE MEMBERSHIP

RESOLVED:

That the membership of the LLR Joint Health Scrutiny Committee for 2021-22 be noted.

7. COMMITTEE TERMS OF REFERENCE - WORKING ARRANGEMENTS

Councillor Hack mentioned that when the meeting was hosted by the County Council there was provision for a general Member Questions item on the agenda.

The Chair was advised that there was no provision within the City Council's constitution for general Member Questions however it could be worked into the Committees Terms of Reference and Working Arrangements if Members were agreed.

The Chair commented that he encouraged questions and participation and would be happy to institute a regular Question from Members as an item on the agenda. Members were in agreement with this course.

RESOLVED:

That the Working Arrangements and Terms of Reference for the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee be agreed subject to inclusion of a provision of a

general item for Member Questions on the agenda of future meetings.

8. PETITIONS

The Monitoring Officer reported that a petition had been received which asked the Committee to:

"arrange a meeting, as indicated in its minutes of December 2020,as a matter of urgency to scrutinise the Report of Findings, produced by Midlands and Lancashire Commissioning Support Unit following the public consultation, Building Better Hospitals for the Future, in the autumn. This report was completed in March but has only just been shared with the public. We call upon the Scrutiny Committee to request the three local Clinical Commissioning Groups, which are responsible for the Building Better Hospitals proposals, delay finalising their decision-making until they are able to incorporate the insights of scrutiny into their Decision-Making Business Case, and not to proceed with their meeting planned for 8th June, if this is to approve the Decision-Making Business Case.

The Chair indicated that the points raised in the petition would be considered within the discussion on Item 10 of the agenda "Analysis of UHL Acute and Maternity Reconfiguration Consultation Results."

9. 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 these questions would be taken and responded to within the main item 10 on the agenda "Analysis of UHL Acute and Maternity Reconfiguration Consultation Results." Where a full response was not available at the meeting a written response would be provided outside the meeting and appended to the minutes.

10. ANALYSIS OF UHL ACUTE AND MATERNITY RECONFIGURATION CONSULTATION RESULTS

The Chair explained that a presentation would be received and taken in four subject areas with questions from the public to be taken under the relevant subject area followed by any questions from committee members.

Sara Prema, Leicester City CCG, presented the first subject area and outlined the consultation process and how that was undertaken, this included details of the range of media used such as social media: Instagram, snapchat, twitter as well as live events and the information gathered. Details were also given of the "reach" of the consultation using digital, print and broadcast methods and the work undertaken to engage people of all demographics across Leicester, Leicestershire and Rutland (LLR).

The Chair interposed questions from members of the public and invited officers to provide responses:

The Chair on behalf of Jean Burbridge asked: Following the Building Better Hospitals for the Future consultation, who are the patient representatives who were involved in reviewing the public feedback? In what ways are they representative?

Richard Morris, Leicester City CCG responded that the feedback received through the consultation was independently analysed and evaluated by Midlands and Lancashire Commissioning Support Unit, who produced the Consultation Report of Findings. The Report of Findings was then reviewed by the Public and Patient Involvement Assurance Group for Leicester, Leicestershire, and Rutland. It was not their role to approve the proposals that were being consulted upon. ACTION: Officers agreed to provide a full written answer in due course.

Sally Ruane on behalf of Sarah Patel asked: How does the profile of respondents in terms of a) ethnicity and b) deprivation match that of the population as a whole, taking Leicester, Leicestershire and Rutland each in turn?

Richard Morris replied that all details regarding profile were set out in detail in the report of findings which showed the people who participated in the consultation were statistically representative of the LLR population and endorsed through the Equality Impact Assessment.

Sally Ruane clarified that the question was about how the profile of respondents matched or did not match the profile of the area in terms of the broader population of Leicester, Leicestershire, and Rutland.

Richard Morris explained how the level of responses were reflective of LLR and the findings showed that of the responses received 46% were from Leicestershire, 26% were from Leicester city, and 6% were from Rutland, 28% of responders provided no post code or asked not to be profiled. There were various category breakdowns as an example there was a breakdown by age, this showed typically higher levels of engagement with people over 45 years old but there was another piece of work carried out with voluntary groups to engage with younger people between 25-34 years, this category represented 11.8% of the population, in terms of responses 16.4% of Leicester city replies were within this age category showing a fair representation of that age group. In relation to male/female by and large this was 50/50 across LLR, in terms of consultation responses it was found more women participated with 72% of responses being from women. Regarding ethnicity for example 78.4% of the population of LLR was white and 81.1% of respondents identified as white so again reflective of the population, the same was also found with other demographic profiles. ACTION: Officers agreed to provide that data in a written response with the benchmarks.

Sally Ruane asked: What changes have been made to the Building Better

Hospitals for the Future proposals following public, not clinical feedback?

Richard Morris replied that it was important to note they were trying to achieve a statutory duty and to have a broad demographic view and to meet equality requirements a view was taken with certain voluntary organisations. The CCG looked at several areas across the country who used similar models successfully and decided to use the same model.

Sally Ruane out her next questions about the use of an "impartiality clause" used by the CCGs during the consultation process which would have had the effect of stifling the expression of points of view at odds with those of the CCGs. Via a Service level agreement with an impartiality clause, the CCGs commissioned and remunerated organisations to undertake engagement with people as “supporters” of the consultation exercise. However, the impartiality clause obstructed the ability of these organisations to inform their members (or those they engaged with) of any concerns they had about the proposals and it obstructed the ability of these organisations to draw on independent sources or their own body of knowledge in responding to members’/followers’ questions. The Impartiality clause stated, “Organisations are not expected to express views or opinions on the consultation when engaging with their communities …and all queries and questions should be signposted to official literature or NHS leads”.
It appears, therefore, that these organisations far from being impartial, could be said to be the voice of the CCGs, able only to point people to the official literature so providing them with a single, very particular narrative.
1. I would like to know if this practice is legal.
2. I would like to know if this is seen as good practice and what dangers were considered in deciding to proceed with these agreements.
3. Are the CCGs able to tell us what steps they 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’.
4. How many of the 5,675 responses to the consultation were as a result of these contracts?

Richard Morris indicated the purpose of the clause was to protect the voluntary and community organisations that were agreeing to promote the consultation to their communities. The clause ensured that they could freely state the organisations views on the proposals and gave them impartiality to be neutral.
ACTION: Officers agreed to provide a full written response that would cite the impartiality clause in full.

Sally Ruane in supplementary response suggested the impartiality clause prevented those organisations from expressing any concerns they may have and expressed concern that this practice was unlawful.

Richard Morris assured that none of those participating was barred from making their own or an organisational response to the consultation and of the total responses received to the consultation approx. 600 came through this

route.

Jennifer Fenelon on behalf of Rutland Health & Social Care Policy Consortium (RHSCPC) asked: We are told approximately £260,000 was spent on consultation by LLR CCGs. The people of Rutland submitted many comments and proposals to mitigate the impact of moving acute services from East to West and consequent increased complexity of journeys and increased travel times making access to services more difficult. The summary of decisions published on 26th June offers no clarity on how services will be delivered closer to home to mitigate these problems. Can the CCG explain why there are none?

Sara Prema responded that the CCG were working to improve place led services and developing that in several ways, with the Health & Wellbeing Board, through Rutland partners and other stakeholders. Many community services were already delivered and that was being built upon and would be refined.

Jennifer Fenelon in supplementary commented that the CCG had an obligation to look at communities and groups. The Rutland Health & Social Care Policy Consortium had submitted a large document that included 26 points made and that had not been responded to.

Sara Prema replied that some of those points had been picked up as pledges within the business case. ACTION: Officers to provide response to the 26 points suggested.

The Chair invited comments from members and the ensuing discussion included the following points:

- Regarding any potential conflict of interest with the impartiality clause it was clarified that all activity undertaken was designed to meet the equality duty. CCG were keen not to rely on just one tool and to give people the chance to take part in the consultation. The total cost of the consultation was £260,000 and a significant portion of that was spent on the analysis and findings of Midlands and Lancashire Commissioning Support Unit. Typically, £2-3k was given to 18 organisations. ACTION: Officers agreed to provide breakdown of cost to each organisation.

- None of the voluntary organisations engaged in the consultation were coerced in any way to take part, there was no preferential treatment and those organisations were just as challenging in public meetings as they should be.

- In terms of how far they had exercised their duty to assess the impact on various communities and identify negative impacts it was explained that Equality Impact Assessments (EIA) were undertaken and are included within the business case, these were held up as an example of very good equality impact assessments. A post EIA on the consultation was also undertaken which is included in the appendices of the business case.

- Concerns were expressed that despite taking part in consultation events answers to questions raised there had still not been provided and there was delay in providing responses. ACTION: Officers to provide response to the questions raised by Councillor King at recent public meetings.

- In relation to concerns that the consultation was undertaken during the pandemic it was found that more people were taking part than would normally engage, the reasons for that were tested that out and many said it was because they had more time on their hands. As to whether their responses outside of a pandemic would have been any different, it was always a challenge and can't answer definitively if those responses would have been different but there was monitoring and content with responses and qualitative responses being received.

- Overall responses from Rutland compared to the population of the City and County seemed low and concern was raised that this was such a small response. In answer it was stated that overall population of Rutland was 4% of the City/County yet 6% of responses were from people that declared themselves to be from Rutland, so it was felt to be fairly representative. In terms of overall response rates, it was uncertain what a definition of a good response rate is as every consultation is different. However, nationally 1-2% was good but more emotive subjects achieved higher response rates. The Chair expressed interest in seeing figures of overall responses. ACTION: Officers to provide various breakdowns of overall responses outside this meeting.

- In relation to general digital exclusion, from the outset the CCG were aware of the risk of digital exclusion and determined not just to consult online, a lot of work was done through radio and publicity materials and in other languages too. Materials were handed out in villages/local areas and shops. All virtual meetings were set up to have access to dial in by phone if someone was unable to link in and there was also put in place a dedicated phone line to help people complete the consultation survey that way.

- There were in region of 90,000 visiting the website and there were a lot of views as to why there were only maximum 5-6k responses. It was felt that this has been a dialogue going on over a decade, a lot of people looked at the proposals on the website and where they were generally in agreement with proposals, they didn't feel need to complete the survey. It was suggested that there was a tendency to find those that do respond have a particular view on proposals.

Sara Prema then moved to the second subject area and outlined the process for considering feedback from the consultation and the consultation outcomes noting that 58% of respondents agreed with the proposals.

Also noted:

- During the consultation people wanted to understand the impact of Covid on plans and whether services would be future proofed by

releasing some of the Leicester General Hospital site.

- A Travel Action Plan had been developed to support the reconfiguration in conjunction with the Local Authority's this would include improvements to the bus and hopper routes, increasing park and ride facilities, increasing parking at LRI and Glenfield and improving sustainable travel options.
- The rationale behind the speciality changes in location proposals and the DMBC decision.
- A review was undertaken by clinicians into the impact of Covid which found that if the changes had been in place before the pandemic, they would have managed the pandemic better.
- An analysis of developable land post reconfiguration showed there would be 25 acres of developable space so there would be scope for further development should this be needed in future although it was difficult to say what may happen in terms of medical advancements in 10-15 years' time.
- In relation to the new treatment centre, 60% of respondents agreed with the proposal. The clinical case set out in the pre-consultation business case and the review of proposals post Covid set out the advantages of separating elective and emergency care.
- The outcomes in relation to the proposals including use of new technologies; new haemodialysis treatment units; hydrotherapy pools and a children's hospital that would include a consolidated children's intensive care unit, co-located with maternity service.
- Leicester was one of a few areas without a dedicated children's hospital although it provided one of the biggest services for children across the East Midlands.
- The LRI was chosen as the site for a dedicated children's hospital as it had the children's emergency department and from 2021 it would be the home of children's congenital heart services (CHD). Part of the requirement for continued delivery of CHD services was the formation of a children's hospital.

Public questions on this subject area were then taken as follows:

Sally Ruane on behalf of Godfrey Jennings asked: If adequate additional Public Dividend Capital (PDC) is not forthcoming, which elements of the scheme are you likely to alter? (p25 of the DMBC "Whilst the original funding of £450m PDC has been identified, in the event that further PDC funding is not made available to fund the additional national policy changes such as the requirement for New Zero Carbon and Digital, then the scope of the scheme will be reviewed again in order to fit the budget available.")

The Chair on behalf of Lorraine Shilcock asked: 1. What is the meaning of the following statement on p25 of the Decision- Making Business Case? "However, work is ongoing with the New Hospital Programme to agree the scope of inclusion in the programme, and the potential sources of capital."
2. Which proposals/services do you plan to cut if the necessary finances are not forthcoming?

Mark Wightman, UHL Leicester, replied in respect of patients accessing services that of 100% of people 30% would have a slightly longer journey time because of the reconfiguration.

Nicky Topham, UHL Leicester responded to the questions as a whole and outlined the survey findings, noting that when the process started the CCG/UHL were clear that £450m would deliver the scope of services in the business case but what had changed was that any policy changes such as around carbon emissions or digital requirements would have to be factored too.

The Chair questioned the difference between scope and services, and queried, if ambitious environmental efficiency targets were set then what would give in terms of scope or services?

Nicky Topham clarified that the £450m would provide for the move of the clinical services across the three sites and enable delivery of a high quality building. It was the net zero carbon in terms of the scope of the building being discussed, not about clinical services included in the programme.

Mark Wightman explained that the reconfiguration was covered by the £450m but there had to be consideration if the expectation of the modern building requirement changed, this was part of a series of steps in the process. The overall scheme was a solution with a series of interconnected components.

The Chair commented that concerns were not allayed by the response and expressed concern that there was not sufficient reassurance.

Mark Wightman acknowledged these were valid questions and that concerns could not be fully allayed other than to say there was still a way to go in the process to reach a full business case and full business case approval. The project was however based on a thorough understanding of clinical strategy and parts of that could not be dismantled.

Andy Williams, CCG Leicester, Leicestershire and Rutland, confirmed the reconfiguration proposals had been agreed as a package in their entirety but in approval terms each scheme would have to be planned and implemented individually.

Jennifer Fenelon on behalf of RHSCPC put that: The CCGs have refused to say how alternative services will be funded where patients are unable to access the new facilities (They estimated this to be about 30% of patients in the PCBC). The consequences of this will result in more patients accessing services outside Leicester, Leicestershire and Rutland. As the CCGs will have to meet these costs can they supply the cash flow estimates for this work which will relocate elsewhere as a result of Reconfiguration? ACTION: Officers to provide figures in writing outside the meeting to this question.

During the ensuing discussion the following points were noted:

Concerns were raised about the UHL Financial arrangements, deficit budget

and whether that would impact on service delivery. It was advised that the £450m was capital funding which was a separate allocation of funding although the revenue consequences of that had to be managed locally. The rationale was that efficiencies come from managing the estate more effectively and so reducing estate was another way of achieving that. Regarding the deficit position, LRI was currently spending more than allocated. Recovering the deficit required achieving certain levels of efficiency. The second issue to address was the imbalance as a system, to readdress that and optimise by moving secondary care business into primary services. It was expected over time growth will gradually close the gap. Assurance was given that there was no decreasing budget and there was no loan of money, the UHL were authorised to pull down a certain amount of budget each year. The financial recovery plan was to close the gap between the agreed budget total the treasury would like the hospital to live within.

The Chair drew discussion back to the agenda and advised that a separate discussion on the UHL financial arrangements and deficit would be arranged outside this meeting.

Andy Williams agreed to provide a level of detail in terms of the emerging strategy and patterns of activity and how that would develop over next few years in relation to primary care for a future discussion.

Discussion progressed onto the Travel Action Plan, concerns about accessibility to service/hospitals from rural communities and included queries about carbon emissions and environmental impacts.

Councillor Harvey on behalf of Dr Janet Underwood, Healthwatch put: The UHL reconfiguration plans were discussed and agreed at the CCG governing body meeting on 8th June 2021. However, the Chair of the CCG governing body noted the increased inequalities in accessing health care for those living in rural communities; especially in the east of the city.

The UHL Travel Plan creates improved and environmentally sustainable travel around and within the city but no mention of improved travel facilities or better accommodation of the needs of those who live in rural areas.

Healthwatch Rutland asks what plans, other than a trial park and ride for just 80 cars at Leicester General Hospital, UHL, working with partners in the Integrated Care System, they have to mitigate these inequalities?

Responding the points made about taking into account any potential increase in carbon emissions caused by more people travelling from rural areas it was recognised that the LRI was in a central position and the plan was to take up to 35% of activity off the LRI site to Glenfield so that would improve the impact of pollution around LRI. Officers agreed to share details of the BREEAM sustainability assessment.

Despite the Travel Action Plan, it was suggested that some would face difficult journeys, congested roads and junctions, and lengthy bus journeys so people

would not be discouraged from using their cars if they have one. Public transport was not always a viable option particularly in more rural areas and it was noted that the Travel Action Plan did not go beyond the city borders although considerable engagement had taken place with groups to inform the travel plan, this included with patients, partners, local authorities, bus and train operators and did include Healthwatch too.

Responding to concerns about the number of car parking spaces in the proposals it was clarified that this was not a total of 300 spaces but 300 additional spaces to the Glenfield and LRI sites.

The CCG acknowledged that travel was a difficult issue to address as it went to wider infrastructure issues outside of UHL/CCG control. The CCG had tried to set proposals that disadvantaged as few people as possible. It was asserted that the reconfiguration proposals overall, either make no or little difference, or would be better for the vast majority of people across LLR. Everyone would get qualitative benefits and the CCG were trying to mitigate the downside of centralising services and continuing to develop other services such as the community hospital. The wider issue relating to rural infrastructure was a bigger question than the UHL/CCG could address but with the reconfiguration proposals for the hospitals the UHL/CCG were trying to get the best result they could.

In relation to the speciality changes around ophthalmology and any effect of moving their location it was confirmed that lower acuity eye problems were dealt with at Rutland and other ophthalmology issues at LRI and that would not change.

Regarding paediatric outpatients' services, most children's outpatient services would continue at LRI although there would be some services exported into the community.

The dedicated children's hospital would be developed through the refurbishment of the Kensington Building, this was considered an elegant solution given that the CCG were not able to say, "money is no object". In August 2021 the first stage to move children's services from Glenfield to Kensington would begin and progress on that transition could be shared with members.

The Chair moved the meeting on to the next subject area and Sara Prema presented details of the proposal to create a primary care urgent treatment centre at Leicester General Hospital site and the consultation outcomes around that.

The Chair referred to questions received from the public and on behalf of Giuliana Foster asked: What are the estimated costs of the primary care urgent treatment centre and other community services planned for the site of the Leicester General Hospital and where will these funds come from?

Jennifer Fenelon on behalf of RHSCPC put that: Any attempt to clarify with the

CCGs how much capital and revenue has been allocated to community services has not been answered on the grounds that only UHL acute capital is being considered. We were, therefore pleased the June CCGs Extraordinary Board Meeting approved “creating 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.” Can the CCG explain why proposals did not also included community services for residents across LLR which are needed as a consequence of reconfiguration?

Responding to both questions’ it was advised that the consultation dealt with the proposals outlined in the Pre Consultation Business Case, which included the future of the Leicester General Hospital campus.

The ongoing work to improve community services for residents across Leicester, Leicestershire and Rutland to provide more care closer to home was part of separate and ongoing work around a number of key programmes. This included the Better Care Fund (a programme that supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers), Ageing Well (an NHS programme to support people to Age Well) and Place-Led Plans. Improvement work would be funded through a mixture of funds available to the NHS e.g. baseline commissioning budgets and through the Ageing Well programme.

The Chair commented that there had been some concern about the publicity used for the General Hospital site proposals, in particular the image portraying what the centre may look like.

Sara Prema answered that there was public support for the primary care urgent treatment centre and the CCG were keen to do it as it would relieve pressure on services elsewhere and was in line with National policy. There were no circumstances envisaged in which the primary care urgent treatment centre would not be delivered as it was part of the overall package although the CCG cannot say it would look exactly as the artist impression used but there was a firm intention to have a primary care facility at that site.

With regard to land at the General being sold off because there was land available at Glenfield for expansion in future, and the suggestion that the General Hospital could be used post pandemic to address backlogs and waiting times, members were reminded that during the 1st phase of the pandemic Nightingale hospitals were set up but not put into use as they couldn’t be staffed. This situation was similar, although currently the General Hospital could be used, longer term there would be the issue of spreading staff too thinly across the sites and the reconfiguration was about getting the most out of the facilities in the future and the staff resources too. In terms of backlogs, UHL/CCG were hopeful those would not take too long to address, whereas this reconfiguration programme was not due to complete until 2027.

The CCG said they were committed to continuing an ongoing dialogue with

communities on the further scope of primary care and what the end process would look like. The next step was to take that conversation out of the consultation process and move to informal discussions with communities.

In relation to the hydrotherapy proposal to move to community facilities it was explained that when scoping this proposal, the CCG did a piece of work to look at existing facilities and created a list of those. The list would need to be reviewed to ensure facilities would remain available into the future and each facility would be assessed to strict criteria including looking at issues of safeguarding and accessibility to determine which could be used. In due course that list of hydrotherapy services could be shared with members.

It was noted that there was a general perception and fear within some communities that services could be lost, and the CCG sought to assure that they were doing their best to do what was needed for all patients.

There was further discussion regarding developable land, its commercial value and whether there was a link between the Community Infrastructure Levy (CIL) and Section 106 funding to this for the primary care unit. It was noted that the Hospital Close site had been acquired by the City Council and the reference within the presentation to £16m was for the main General site. The CCG advised that in relation to any large housing development the CCG would put in an application for developer contributions if there was any impact on primary care, no differently to if there were large developments in other parts of the county.

Discussion then moved on to the final subject area and Sara Prema presented the proposals and outcomes in relation to the new maternity hospital, breastfeeding services and the standalone midwifery led unit.

It was noted that the decision regarding maternity services sat within the ongoing strategic improvement work across maternity care. It had also been established that the standalone midwifery led unit could not be assessed in one year and that would take longer with a commitment to assess over 3 years.

The Chair referred to questions submitted by members of the public and read Giuliana Foster's question: "You set out the estimated capital costs of the various parts of the proposals on pages 23 and 113 of the DMBC but these do not include the estimated capital costs for the freestanding midwife led unit on the site of Leicester General Hospital. What are the estimated costs for both the trial and the ongoing existence of the unit and where will these funds come from?

Sara Prema replied that the capital figure of £450m for the reconfiguration project included the cost of the standalone midwifery led unit which would cost in estimate circa £1m.

Sally Ruane on behalf of Brenda Worrall asked: Why has a target of births of 500 been set when this is larger than all other Free Standing Midwife led units (FMUs) in the country. Is the FMU being set up to fail?

Ian Scudamore, Director of Women's & Children's Services UHL, responded that the target was based on the point of viability and explained how it was recognised by organisations providing obstetric and maternity services that for a standalone unit to be sustainable long term and financially viable there needed to be around 500 births a year and it was therefore appropriate to have a target of 500.

The Chair enquired whether there was a need to have 500 births to deliver a quality clinical service? Ian Scudamore replied that the standalone unit would be a midwife led service and would not provide any different clinical service from a home birth service or an alongside birth service. In practical terms there would be the same services across all four settings and in those terms more resource. Financial viability however was achieved at 500 births.

Sally Ruane in a supplementary comment expressed concern that there was the perception that there was no real commitment to the standalone unit.

Ian Scudamore confirmed there was an absolute guarantee that UHL and the local health care community were committed to providing maternity health care options across LLR and to provide the four NICE options for maternity care but there needed to be the numbers to make it sustainable and so it needed to be located in a place where more people could use it.

Floretta Cox, Community Midwifery Matron UHL, commented that Leicester was the first to create the home alone service however the birth rate at St Mary's was not as high as they would like it to be and that was because of its location. There was a dedicated home birth team already in place and they supported St Mary's at night. It was expected that the St Marys staff would be used at the new standalone unit and the unit could also be used for pre-natal services too which was something that women wanted.

Andy Williams commented that the CCG motivation was to ensure a positive future for this birthing option across LLR, trying to locate it and support it to ensure its future as part of the maternity services landscape but there was a need to balance the resource that's committed and provide a genuine option for women.

The ensuing discussion with members included the following points:

- In relation to community services and breastfeeding levels in the community and the funding around that, Sure Start centres were dependent upon local authority funding, current services provided included liaison in homes, peer support and the CGG were looking to employ more community support workers.

- The standalone midwife led unit would be co-located with LRI, this would provide bigger and better facilities including a pool in every delivery room which more women preferred as an option for analgesia. Community midwives would stay in the community, so for example Melton midwives would continue to be based in local communities and

at GP surgeries. The plan was that staff at St Mary's would be relocated to the new unit although those staff would all be given options.

- Returning to the issue of viability it was confirmed there was a commitment to develop a framework to assess the financial viability of the standalone midwife led unit and that would be done with those who had a vested interest in maternity services and meeting maternity care needs.

- In terms of current and projected birth rates across LLR and the percentage needed at the unit it was advised that often women choose a maternity service based on experience or word of mouth. There were currently 10,000 women delivering in UHL, 2000 chose to deliver outside LLR and of those 2,500 were at co-located birth centres. A target of 500 therefore equated to about 5% of the current level of births needed to migrate to the unit.

- It was noted that the co-located design work could begin at any time, but the changes would not be enacted immediately. The process of talking to groups would be started and a piece of work undertaken to see what the co-located design may look like and the time frames, this could then be brought to a future meeting. The difference at the General will be that it is totally midwife led but if there was an emergency they would be transferred to the LRI and that journey would be a lot shorter and thereby quicker than from St Mary's so more women may choose it.

The Chair thanked officers for their responses and commitments given during the meeting and asked to be kept informed of progress.

RESOLVED:

1. That CCG/UHL officers provide full written responses/information to the actions set out in the body of the minutes of the meeting, as soon as possible.
2. That CCG officers provide a level of detail in terms of the emerging strategy and patterns of activity and how that would develop over the next few years in relation to primary care for a future discussion.
3. That a progress report on the first stage to move children's services from Glenfield to Kensington and transition be provided for the next meeting.
4. That a list of hydrotherapy services be shared with members in due course.

11. COVID-19 VACCINATION PROGRAMME UPDATE

The Chair commented that given the late hour of the meeting he would move straight to taking any questions from Members on the Covid-19 vaccination programme.

There were no questions from Members.

Andy Williams, CCG Leicester, Leicestershire and Rutland confirmed there were no exceptional issues around the vaccination programme to raise at this time and a report on the work for the Autumn/Winter vaccination programme would be provided in due course.

RESOLVED:

That a report on the work for the Autumn/Winter vaccination programme be provided in due course.

12. WORK PROGRAMME

RESOLVED:

That the item on Integrated Care Systems be rescheduled to an earlier date than March 2022.

13. ANY OTHER URGENT BUSINESS

Councillor Hack made the following submission:

In recent weeks there has been a raising of the profile of the medical procedure surrounding the fitting of Intrauterine devices,

The NHS website states:
'Having an IUD fitted can be uncomfortable and some people might find it painful, but you can have a local anaesthetic to help.'…'you can ask to stop at any time.'

1) Do we have the information on the % of IUD procedures that are performed with a Local Anaesthetic?
    a. Dr Louise Massey of the Faculty of Sexual and Reproductive Health Care of the Royal College of Obstetricians and Gynaecologists said on the BBC last week
    'the procedure can always be stopped if there is too much pain, discomfort or distress. It is always an option to abandon it; it can even be done under General anaesthetic if necessary and appropriate'
    Do we offer and what % of IUD are fitted with a General anaesthetic across the Trust?
2) What % of procedures are unsuccessful and are stopped from completion in Leicester, Leicestershire and Rutland?
3) What % of IUD's need removing due to complications post procedure?
4) If the data is not collected routinely is there any expected change in policy in light of the spotlight that has been placed on the procedure?
5) The anecdotal evidence that has been collected and published so far, has indicated that the procedure is far from routine for some. I note that the guidance on the procedure was recently updated on the national NHS website, but has there been any recent policy updates provided for those that fit IUD's in LLR? Particularly on pain management or device fitting triggering past trauma. If not, when will this be provided?

The CCG confirmed they had received these questions and gave a commitment to provide a response in writing outside this meeting.

RESOLVED:

That the relevant officers of the CCG provide a written response to these questions as soon as possible which will be read into the minutes of the next meeting.

14. DATES OF COMMITTEE MEETINGS 2021/22

Future scheduled meetings noted as follows:

- Tuesday 16th November 2021 at 5.30pm
- Monday 28th March 2022 at 5.30pm

The Chair noted there had been comments about the timings of meetings and confirmed they would start at 5.30pm with an aim not to go beyond 9pm.

There being no further business the meeting closed at 9.10pm

Questions and answers – JHOSC

FORMAL RESPONSES TO QUESTIONS ASKED BY THE PUBLIC IN ADVANCE OF THE MEETING

From Jean Burbridge:

- Following the Building Better Hospitals for the Future consultation, who are the patient representatives who were involved in reviewing the public feedback? In what ways are they representative?

Response

The feedback received through the consultation was independently analysed and evaluated by Midlands and Lancashire Commissioning Support Unit, who produced the Consultation Report of Finding.

The Report of Findings was then reviewed in a number of ways:

1. *By the Public and Patient Involvement Assurance Group (PPIAG) for Leicester, Leicestershire and Rutland (LLR). This group, which reports to the LLR System-wide Partnership Group, brings together people passionate about health and social care. They provide creative, fresh and independent thinking to public engagement and provide judgement on whether health and social care commissioners and providers have engaged and understood local people and that their insights are influencing the way we design local health and care. The group was independently recruited to in December 2019. The PPIAG role, in relation to the consultation, was to form an overall view as to whether the consultation process was appropriate and proportionate in terms of its attempts to reach the population, and to seek assurances that the views put forward by people in the consultation had been considered. It was not their role to 'approve' the proposals that were being consulted upon. This was the role of the CCG Governing Bodies.*

   For further information relating to the group visit: https://www.leicestercityccg.nhs.uk/get-involved/. No small group can claim that is it fully representative of a population and the socio-demographics of an area. However, the PPIAG includes a range of people from different ethnic groupings and backgrounds. It should be noted that the Report of Findings was statistically representative of the LLR population, which was endorsed through our Equality Impact Assessment.

2. *By North of England Commissioning Support (NECS), who reviewed the Report of Findings to produce a post-consultation Equality Impact Assessment which can be viewed at https://www.leicestercityccg.nhs.uk/about-us/future-governing-body-meetings/2021-governing-body-meetings/llr-ccgs-governing-bodies-meeting-june-2021/. The conclusions were:*

   a) *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?*
   b) *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.*

c) *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.*
d) *Engagement with diverse communities that has now commenced, is appropriately regarded as a steppingstone, is ongoing and yet to fully reach potential.*
e) *Through the introduction of their Inclusivity Decision Making Framework, there is a commitment to embed such approaches routinely in practice.*
f) *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. Feedback will inform decisions over many years to come. Those decisions are based upon the belief that service providers are accountable to the population they serve in promoting equality, reducing inequalities, determining resource allocation in modernised, cost effective and efficient ways.*

3. *By the Governing Bodies of the three CCGs, which comprises of local GPs and Independent Lay Member representation. The role of the lay members is to bring specific expertise and experience to the work of the Governing Body. Their focus is strategic and impartial, providing an external view that is removed from the day-to-day running of the organisation.*

From Giuliana Foster:

1) You set out the estimated capital costs of the various parts of the proposals on pages 23 and 113 of the DMBC but these do not include the estimated capital costs for the freestanding midwife led unit on the site of Leicester General Hospital. What are the estimated costs for both the trial and the ongoing existence of the unit and where will these funds come from?

Response

The capital investment required to convert the Coleman Centre at the Leicester General Hospital into the freestanding Midwifery Led unit is estimated to be £1 million. This money will come from within the overall capital allocation of £450 million. The ongoing costs of running the service will come from the revenue budget, currently allocated to run the St Mary's Birthing Centre.

The model we intend using in the new birth centre will be based on Midwifery Continuity of Carer (MCoC) principles, promoted and supported by the Royal College of Midwives. This outlines that the provision of care by a known midwife throughout the pregnancy, labour, birth and postnatal period is associated with improved health outcomes for the mother and baby, and also greater satisfaction levels. It is mandated by NHS England and NHS Improvement as an improved way of providing maternity care to improve outcomes.

2) What are the estimated costs of the primary care urgent treatment centre and other community services planned for the site of the Leicester General Hospital and where will these funds come from?

Now that the Decision Making Business Case has been agreed by the Governing Body of the Clinical Commissioning Groups we can take the next steps in developing detailed plans for the primary care led services at the Leicester General Hospital campus. This will include detailed financial planning.

As part of this process we are committed to considering the suggestions made by the public regarding the services that they wished us to consider at the Centre. Our principles for implementation also include ensuring that further engagement with the public is undertaken as plans take shape. As opportunities arise we will submit bids for external funding including additional system capital allocations, which will help us realise this project.

From Brenda Worrall:

- Why has a target of births of 500 been set when this is larger than all other Free Standing Midwife led units (FMUs) in the country. Is the FMU being set up to fail?

Response

One of the key elements of the consultation was testing public appetite for a standalone midwife led unit. We were delighted with the response to the consultation and, based on this, both the CCG and UHL are anticipating that the standalone unit at the site of Leicester General Hospital will succeed. By locating it in a more central location we believe more people will use it – including women from a more diverse range of backgrounds.

UHL are proud advocates of midwifery-led care and this will continue to be the case both now and in the future. We believe the underutilisation currently of the unit at St Mary's is due to concerns regarding proximity to emergency care and acute support as well as accessibility for a greater catchment of women in LLR. The new maternity hospital, and the midwifery-led unit on the site of Leicester General Hospital, will allow for women to be closer to support services should they be needed. We believe that this will be a key step in ensuring that the unit is a success going forward, supported by word of mouth from mum's based on their own local.

Work will be undertaken to define how the long-term viability of the unit is assessed. The CCgs and UHL recognise the fact that the new unit is unlikely to attract 500 births in its first year and viability will, therefore, be based on a phased approach over three years. Work will also be undertaken to develop promotional plans for the unit. Both aspects of this work will involve staff, stakeholders and patients/patient representatives.

From Godfrey Jennings:

- If adequate additional Public Dividend Capital (PDC) is not forthcoming, which elements of the scheme are you likely to alter? (p25 of the DMBC "Whilst the original funding of £450m PDC has been identified, in the event that further PDC funding is not made available to fund the additional national policy changes such as the requirement for New Zero Caron and Digital, then the scope of the scheme will be reviewed again in order to fit the budget available.")

Response

The original PCBC described a clinical model which is deliverable for £450m. Since the publication of the PCBC, a 'New Hospitals Programme' has been established by NHS England and NHS Improvement to deliver the national programme of 40 new hospitals. This programme is in the middle of a process which will define the outputs required within these new policy requirements, and the extent to which we, as one of the front running 8 new projects, will be required to deliver this policy change.

We have been clear that the clinical model we consulted upon, which delivers future clinical sustainability, is our priority. Any additional policy requirements since the announcement of the £450m will need to attract additional funding from the centre. Without this, the additional

policy requirements will not be possible to deliver since we do not plan to remove clinical scope from our programme.

From Sarah Patel:

- How does the profile of respondents in terms of a) ethnicity and b) deprivation match that of the population as a whole, taking Leicester, Leicestershire and Rutland each in turn?

Response

Report of Findings shows that the people who participated in the consultation was statistically representative of the LLR population, which was endorsed through our Equality Impact Assessment. This is accessible at https://www.leicestercityccg.nhs.uk/about-us/future-governing-body-meetings/2021-governing-body-meetings/llr-ccgs-governing-bodies-meeting-june-2021/

Attached is a summary document that sets out the overall representation of respondents at an LLR level.

From Kathy Reynolds on behalf of Rutland Health & Social Care Policy Consortium:

1. We are told approximately £260,000 was spent on consultation by LLR CCGs. The people of Rutland submitted many comments and proposals to mitigate the impact of moving acute services from East to West and consequent increased complexity of journeys and increased travel times making access to services more difficult. The summary of decisions published on 26th June offers no clarity on how services will be delivered closer to home to mitigate these problems. Can the CCG explain why there are none?

Response

Discussions are already well underway in Rutland to develop Place Led Plans for what local health and care services should look like in the community These Place-led Plans, developed through the Health and Wellbeing Board for Rutland in partnership with the local authority, Healthwatch and a range of other stakeholders, include GP provision and the usage of local infrastructure, such as the community hospital, to deliver a greater range of services locally. We are committed to continuing these conversations over the coming months.

As part of these discussions it is important that we understand the current position in relation to the delivery of healthcare within Rutland. The below figures are approximate but set out the large amount of healthcare already delivered within the county.

- *c69% of patients accessing same day minor illness and injury NHS services are seen and treated in sites in Rutland*
- *89% of patients accessing an NHS community inpatient service are seen and treated at Rutland Memorial with a small proportion of these at Stamford*
- *100% of patients registered with Rutland practices can access joint NHS and County council in-home services following discharge via the Home First model of care*
- *50% of emergency low acuity NHS eye care is provided within Rutland and this will increase as we launch the new local service through 2 practices with 5 optometrists within Rutland*
- *40% of all NHS outpatient appointments accessed by patients registered with a Rutland practice are seen and treated either virtually or within Rutland*

- *100% of patients registered with Rutland practices have access to virtual IAPT services*
- *100% of patients registered with Rutland practices have access to clinical navigation services and 11 services from their own homes*

2. The CCGs have refused to say how alternative services will be funded where patients are unable to access the new facilities (They estimated this to be about 30% of patients in the PCBC). The consequences of this will result in more patients accessing services outside Leicester, Leicestershire and Rutland. As the CCGs will have to meet these costs can they supply the cash flow estimates for this work which will relocate elsewhere as a result of Reconfiguration?

Response

It is important to stress that the PCBC does not suggest that 30% of patients will be unable to access the new facilities. It says that whilst journeys will become shorter for around 70% of patients journey times are likely to increase for the remaining 30%.

In the event that a patient decides to take up treatment outside of LLR the current financial regime would mean that the CCG would still pay for that treatment. This is because CCGs are given a population based allocation.

The revenue impact of any capital case will be included in future revenue planning assumptions but, at present, the NHS works on annual budgets. As we move towards the development of an Integrated Care System for Leicester, Leicestershire and Rutland the NHS financial regime will allow for greater revenue and capital freedoms so that systems can determine the movement of funds to be based on the most effective pathway for patients, thereby enabling more community based services.

3. Any attempt to clarify with the CCGs how much capital and revenue has been allocated to community services has not been answered on the grounds that only UHL acute capital is being considered. We were, therefore pleased the June CCGs Extraordinary Board Meeting approved "creating 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." Can the CCG explain why proposals did not also included community services for residents across LLR which are needed as a consequence of reconfiguration?

Response

The consultation dealt with the proposals outlined in the Pre Consultation Business Case, which included the future of the Leicester General Hospital campus.

The ongoing work to improve community services for residents across Leicester, Leicestershire and Rutland to provide more care closer to home is part of separate and ongoing work around a number of key programmes. They include the Better Care Fund (a programme that supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers), Ageing Well (an NHS programme to support people to Age Well) and Place-Led Plans. Improvement work will be funded through a mixture of funds available to the NHS e.g. baseline commissioning budgets and through the Ageing Well programme.

4. The introduction to the Report of Findings tells us "Long gone are the days when any one of the hospitals would cater exclusively for the needs of patients in their own distinct geographic area. Instead, patients are already used to visiting any one of the three city hospitals depending on the required specialism, clinical staff and bed availability." Do the CCGs have patient flows to back up this statement? Do Rutland & East Leicestershire patients (as a percentage of population) use proportionally more of the specialities delivered from the General Hospital site compared with the other sites?

Response

Outlined below are figures for Leicester Royal Infirmary (LRI), Leicester General Hospital (LGH) and Glenfield Hospital (GH):

LRI – Out of 480,011 patients, 21,078 were from Rutland and East Leicestershire which is 31.29% of the overall Rutland and East Leicestershire population.
LGH – Out of 238,694 patients, 11,780 were from Rutland and East Leicestershire which is 17.49% of the overall Rutland and East Leicestershire population.
GH – Out of 158,894 patients, 8,038 were from Rutland and East Leicestershire which is 11.93% of the overall Rutland and East Leicestershire population.

All the above are based on 20/21 data. Please note in defining Rutland and East Leicestershire, the data is based on the following postcodes LE13, LE14 and LE15.

From Lorraine Shilcock:

1. What is the meaning of the following statement on p25 of the Decision-Making Business Case? "However, work is ongoing with the New Hospital Programme to agree the scope of inclusion in the programme, and the potential sources of capital."

Response

Since the publication of the PCBC and the consultation, a 'New Hospitals Programme' has been established by NHS England and NHS Improvement to deliver the national programme of 40 new hospitals. This programme is in the middle of a process which will define the out-puts required within these new policy requirements, and the extent to which UHL, as one of the front running 8 new projects, will be required to deliver this policy change.

2. Which proposals/services do you plan to cut if the necessary finances are not forthcoming?

Response

We have been clear that the clinical model we consulted upon, which delivers future clinical sustainability, is our priority. Any additional policy requirements since the announcement of the £450m will need to attract additional funding from the centre. Without this, the additional policy requirements will not be possible to deliver since we do not plan to remove clinical scope from our programme.

From Sally Ruane:

"I wish to raise concerns about the use of an "impartiality clause" used by the CCGs during the consultation process which would have had the effect of stifling the expression of points of view at odds with those of the CCGs.

Via a Service level agreement with an impartiality clause, the CCGs commissioned and remunerated organisations to undertake engagement with people as "supporters" of the consultation exercise. However, the impartiality clause obstructed the ability of these organisations to inform their members (or those they engaged with) of any concerns they had about the proposals and it obstructed the ability of these organisations to draw on independent sources or their own body of knowledge in responding to members'/followers' questions.

The Impartiality clause (attached) stated "Organisations are not expected to express views or opinions on the consultation when engaging with their communities … and all queries and questions should be signposted to official literature or NHS leads".

It appears, therefore, that these organisations far from being impartial, could be said to be the voice of the CCGs, able only to point people to the official literature so providing them with a single, very particular narrative.

1. I would like to know if this practice is legal.
2. I would like to know if this is seen as good practice and what dangers were considered in deciding to proceed with these agreements.
3. Are the CCGs able to tell us what steps they 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'.
4. How many of the 5,675 responses to the consultation were as a result of these contracts?
5. What changes have been made to the Building Better Hospitals for the Future proposals following public – not clinical- feedback?

Response

The impartiality clause included in the Service Level Agreement with voluntary and community organisations related to the promotion of the consultation only, and clearly stated that organisations were not being asked to encourage or promote support of the proposals or to support the proposals as organisations themselves.

The purpose of the clause was to protect the voluntary and community organisations that were agreeing to promote the consultation to their communities. The clause ensured that they could freely state the organisation's views on the proposals.

We also asked them as part of the clause to not edit or change the published consultation documents, thereby inadvertently misrepresenting what the proposals were to their communities.

The full clause read as follows:

"*We are asking local voluntary and community organisations to act as supporters for our consultation by promoting to targeted groups and communities.*

"Organisations will not be expected to promote support for the proposal itself, but rather support the consultation process by encouraging as many people as possible to give their feedback and have their say.

"In acting in the role of promoting the consultation to groups and communities it is important that supporters remain impartial. Organisations are not expected to express views or opinions on the consultation when engaging with their communities, should they be positive or negative, and all queries and questions should be signposted to official literature or NHS leads. However, we do appreciate that organisations in their own right, as registered charities or other entities, may wish to contribute to the consultation and express their views using the range of feedback mechanism open to them."

The Report of Findings includes the event feedback as both a separate and integrated section. We anticipate that around 600 responses to the consultation were made as a direct result of this partnership activity with the VCS.

The Decision Making Business Case includes a set of principles. The principles have been developed to address the key themes identified through the consultation, based on what matters most to people. They are commitments to the public in Leicester, Leicestershire and Rutland and will be used to support the implementation of the proposals.

In addition, one of the biggest changes based on feedback from the public has been the removal of the one-year trial period for the standalone midwifery led unit at Leicester General Hospital. The assessment of the viability of the standalone midwife led unit at the Leicester General Hospital campus will now take place over three years.

From Janet Underwood:

> The UHL reconfiguration plans were discussed and agreed at the CCG governing body meeting on 8th June 2021. However, the Chair of the CCG governing body noted the increased inequalities in accessing health care for those living in rural communities; especially in the east of the city.
>
> The UHL Travel Plan creates improved and environmentally sustainable travel around and within the city but no mention of improved travel facilities or better accommodation of the needs of those who live in rural areas.
>
> Healthwatch Rutland asks what plans, other than a trial park and ride for just 80 cars at Leicester General Hospital, UHL, working with partners in the Integrated Care System, have to mitigate these inequalities?

<u>Response</u>

Discussions are already well underway in Rutland to develop Place-Led Plans for what local health and care services should look like in the community These Place-led Plans, developed through the Health and Wellbeing Board for Rutland in partnership with the local authority, Healthwatch and a range of other stakeholders, include GP provision and the usage of local infrastructure, such as the community hospital, to deliver a greater range of services locally. We are committed to continuing these conversations over the coming months.

Progress is being made to improve travel to the UHL sites. In summary:

- *The introduction of the PlusBus ticket option on the Hospital Hopper in February 2021 providing seamless ticketing between train and bus.*
- *Plans are being progressed for a new Park & Ride facility at Leicester General Hospital in partnership with Leicester City Council, making it easier to travel to Leicester Royal Infirmary and Glenfield Hospital on the Hospital Hopper.*

- *UHL partnership with the authority with oversight for bus service provision in Rutland (Rutland County Council) to help improve the public awareness of existing travel options and consider opportunities to improve connectivity. The new National Bus Strategy will assist this partnership working.*
- *Introduction of ANPR (Automatic Number Plate Recognition) technology on the main patient car parks at the Leicester Royal Infirmary and Glenfield Hospital to assist with access issues at the Infirmary and remove the need for patients to estimate length of stay at the Glenfield Hospital.*

As part of these discussions it is important that we understand the current position in relation to the delivery of healthcare within Rutland. The below figures are approximate but set out the large amount of healthcare already delivered within the county.

- *c69% of patients accessing same day minor illness and injury NHS services are seen and treated in sites in Rutland*
- *89% of patients accessing an NHS community inpatient service are seen and treated at Rutland Memorial with a small proportion of these at Stamford*
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- *100% of patients registered with Rutland practices have access to clinical navigation services and 11 services from their own homes*

RESPONSES TO SUPPLEMENTARY QUESTIONS OR REQUESTS FROM SCRUTINY MEMBERS FOR WHICH ADDITIONAL INFORMATION OR ANSWERS WERE REQUIRED

Questions from Cllr Sam Harvey in relation to Rutlanders use of St Mary's Birthing Unit

Please confirm the following for the year 2019/2020:
(a)The number of Rutland residents who delivered at St Mary's Unit;

Response

St Marys Birth Centre	*14*

(b) The number of Rutland residents who received post partum inpatient care in the ward at St Mary's;

Response

No Rutland residents received post-partum inpatient care in the ward in St. Mary's.

(c) The number of Rutland Residents who delivered at either LGH or LRI;

Response

Leicester General Hospital	42
Leicester Royal Infirmary	37

(d) The number of Rutland residents who received post partum/ post natal care in Rutland, who delivered out of county, i.e. Peterborough, Kettering etc.

Response

For women having a first baby, there is a fairly high probability of transferring to an obstetric unit during labour or immediately after the birth

- *For nulliparous women, the peri-partum transfer rate was 45% for planned home births, 36% for planned FMU births and 40% for planned AMU births*

The figures for St. Mary's Birth Centre are below:

	2018/19			
	Women Booked for Delivery	**150**	of which:-	
Less:	Intrapartum Transfers	13	First time mothers	12
			Multiple pregnancies	1
	Women Recorded as Delivered	**137**		
Less:	Post Natal Transfers	9	First time mothers	5
			Multiple pregnancies	4
	Women Receiving Post Natal Care at St. Marys	**128**		
	Total Transfers	**22**	**Total Transfers of First Tme Mothers**	**11.3%**
	Total Transfers %	**14.7%**	**Total Transfers of Mothers Delivered Before**	**3.3%**
	2019/20			
	Women Booked for Delivery	**181**	of which:-	
Less:	Intrapartum Transfers	29	First time mothers	24
			Multiple pregnancies	5
	Women Recorded as Delivered	**152**		
Less:	Post Natal Transfers	19	First time mothers	10
			Multiple pregnancies	9
	Women Receiving Post Natal Care at St. Marys	**133**		
	Total Transfers	**48**	**Total Transfers of First Tme Mothers**	**18.8%**
	Total Transfers %	**26.5%**	**Total Transfers of Mothers Delivered Before**	**7.7%**

Where are qualitative comments from Rutland captured in the DMBC or Report of Findings?

Response

Healthwatch Rutland issued their own report before the consultation ended. That report was analysed as part of the overall consultation – but the numbers not included in the final count, as we felt that this may be double counting.

Specific mention of Rutland is included throughout the main report of findings. Specific areas include:

Summary:

- *Table 30, Page 87 Rutland demographics*
- *4.3.4.1 Page 28 reference to Rutland Report*

- *4.4.4.1 page 141 new technology*
- *4.6.4.1. page 194 stand alone birthing unit*

Main body of report

- *2.1.1.1 page 269 children's hospital*
- *2.1.1.2 page 279 access and transport*
- *2.1.1.3 page 294 other comments*

Question from Councillor Melissa March in relation to VCS partners

Officers agreed to provide breakdown VCS organisations and of cost to each organisation.

Response

During the acute consultation the CCGs strategically partnered with 17 VCS organisations to help reach out to and engage with traditionally overlooked or seldom heard communities. This includes representation across the protected characteristics as set out in the Equality Act. The amount of funding provided to each organisation depended on the size of the target audience and the plans set out by each organisation to reach these communities. The average level of funding was £1,566 per organisation. The full list of VCS partners is as follows:

- Adhar / South Asian Health Association
- Age UK
- Ashiedu Joel (target black heritage communities)
- Pamela Campbell Morris (targeting black heritage communities)
- Carer's Centre
- CommsPlus
- Council of Faiths
- Hashim Duale (targeting Somali community)
- Somali Development Services
- Healthwatch Rutland
- British Deaf Association
- LGBT Centre
- Project Polska
- Rutland Community Ventures
- Shama Women's Centre
- Voluntary Action LeicesterShire
- Vista

Question from Cllr Phil King in response to Hydrotherapy

Provision and location of hydrotherapy pools in the community.

Response

The Building Better Hospitals for the Future consultation undertaken at the end of 2020 included a proposal for the provision of hydrotherapy pools. The proposal outlined the use of hydrotherapy pools already located in community settings, enabling UHL to provide care closer to home. We asked people to tell us the extent to which they agreed or disagreed with this proposal and to explain the impact of the proposal on them, their family or groups they represented. This proposal received significant support.

The Report of Findings and the Decision Making Business Case for Building Better Hospitals for the Future was discussed in a meeting in public of the Clinical Commissioning Groups in Leicester, Leicestershire and Rutland and a decision made to go ahead with the planned £450 million transformation plans to improve Leicester's hospitals' acute hospital and maternity services. This decision includes the proposal for hydrotherapy pools. As a result, further work can now go ahead to identify appropriate pools that will implement this change in approximately 5 years. A mapping exercise has already identified the following hydrotherapy pools as possible locations:

Westgate School, Leicester
Stanford Hall, Loughborough
Inspire2tri Endless Pool Barn, Oakham

We are working with the Leisure Sub-group of the One Public Estate Leicester Group to continue to expand this offer over the next five years. We are keen to maximise the number of pools that we have available so we broaden the community offer for people across Leicester, Leicestershire and Rutland.

In moving to community based pools further assessments of suitability is being undertaken against clear criteria including temperature, it should be heated between 32.3C – 36.0C, and a depth of approximately 1.0 – 1.2m at its deepest, with steps down to each depth not a sloping floor. Venues will need to include the appropriate equipment such as a hoists and sessions will be led by appropriately trained staff from UHL.

This question was also raised by Cllr Terri Eynon, during the consultation, and was answered at a meeting of the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee on 14th December 2020. The response is published at http://politics.leics.gov.uk/mgAi.aspx?ID=66436.

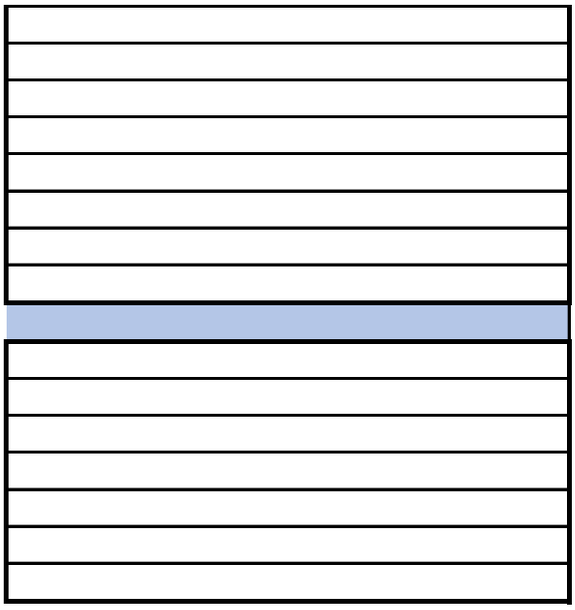
	Population statistics				
	Total	Leicestershire	Leicester	Rutland	To
Population / consultation participants	1100306	706155	354224	39927	47
	100%	64%	32%	4%	10
Population/consultation participants not including those not providing a postcode or profile					
0-14	17.9%	16.8%	20.3%	15.5%	-
15-24	13.8%	11.9%	18.0%	9.9%	247
25-34	13.2%	11.8%	16.4%	10.4%	762
35-44	12.0%	12.1%	12.5%	11.1%	804
45-54	13.2%	14.4%	10.9%	14.1%	762
55-64	11.9%	12.9%	9.7%	13.6%	916
65+	18.0%	20.5%	12.2%	25.5%	1060
Prefer not to say	-	-	-	-	98
Base	-	-	-	-	*46*
Male	49.7%	49.4%	50.2%	50.9%	1331
Female	50.3%	50.6%	49.8%	49.1%	3101
Non-binary	-	-	-	-	8
Intersex	-	-	-	-	4
Other	-	-	-	-	4
Prefer not to say	-	-	-	-	166
Base	-	-	-	-	*46*
Day-to-day not limited	83.5%	83.8%	82.7%	84.5%	3354
Day-to-day limited	16.5%	16.2%	17.3%	15.5%	1226
Registered learning disability with a GP	-	0.4%	-	-	-
Base	-	-	-	-	*45*
White	78.4%	91.4%	50.5%	97.1%	3666
Asian/Asian British	16.1%	6.3%	37.1%	1.0%	590
Black/African/Caribbean/Black British	2.4%	0.6%	6.2%	0.7%	110
Mixed/Multiple Ethnic group	2.3%	1.7%	3.5%	1.0%	70
Other ethnic group	0.8%	-	2.6%	0.2%	84
Base	-	-	-	-	*45*
Christian	51.6%	60.3%	32.4%	68.2%	2232
No religion	25.6%	27.1%	22.8%	23.4%	1521

Muslim	**6.9%**	1.4%	18.6%	0.4%	**327**
Hindu	**6.7%**	2.8%	15.2%	0.2%	**214**
Sikh	**2.2%**	1.2%	4.4%	0.1%	**50**
Buddhist	**0.3%**	0.2%	0.4%	0.3%	**20**
Jewish	**0.1%**	0.1%	0.1%	0.1%	**11**
Other religion	**0.5%**	0.4%	0.6%	0.4%	**137**
Not stated	**6.2%**	6.5%	5.6%	7.0%	**-**
Base	**-**	-	-	-	***45***
Heterosexual	**-**	-	89%	-	**3924**
Bisexual	**-**	-	3%	-	**87**
Gay	**-**	-	1%	-	**67**
Lesbian	**-**	-	-	-	**40**
Other	**-**	-	-	-	**33**
Prefer not to say	**-**	-	-	-	**401**
Base	**-**	-	-	-	***45***

Consultation participants								
tal	Leicestershire		Leicester		Rutland		Other / postcode not provided or profiled	
22	2168		943		292		1319	
0%	46%		20%		6%		28%	
	63%		**29%**		**8%**			
Age								
-	-	-	-	-	-	-	-	-
5.3%	89	4.1%	83	8.9%	3	1.0%	72	5.6%
16.4%	382	17.8%	159	17.0%	33	11.5%	188	14.7%
17.3%	388	18.0%	164	17.6%	27	9.4%	225	17.6%
16.4%	350	16.3%	195	20.9%	26	9.1%	191	15.0%
19.7%	427	19.9%	180	19.3%	50	17.4%	259	20.3%
22.8%	490	22.8%	122	13.1%	141	49.1%	307	24.0%
2.1%	25	1.2%	31	3.3%	7	2.4%	35	2.7%
49	*2151*		*934*		*287*		*1277*	
Gender								
28.8%	535	24.9%	297	31.9%	81	28.1%	418	33.4%
67.2%	1549	72.2%	592	63.7%	200	69.4%	760	60.8%
0.2%		0.0%	4	0.4%		0.0%	4	0.3%
0.1%	2	0.1%		0.0%		0.0%	2	0.2%
0.1%	2	0.1%		0.0%		0.0%	2	0.2%
3.6%	58	2.7%	37	4.0%	7	2.4%	64	5.1%
14	*2146*		*930*		*288*		*1250*	
Disability								
73.2%	1613	75.8%	643	69.8%	199	70.3%	899	72.1%
26.8%	516	24.2%	278	30.2%	84	29.7%	348	27.9%
-	-	-	-	-	-	-	-	-
80	*2129*		*921*		*283*		*1247*	
Ethnicity								
81.1%	1956	92.4%	503	55.1%	280	98.6%	927	76.9%
13.1%	99	4.7%	327	35.8%	1	0.4%	163	13.5%
2.4%	11	0.5%	41	4.5%	-	-	58	4.8%
1.5%	25	1.2%	23	2.5%	2	0.7%	20	1.7%
1.9%	27	1.3%	19	2.1%	1	0.4%	37	3.1%
20	*2118*		*913*		*284*		*1205*	
Religion								
49.5%	1177	55.8%	296	32.5%	183	66.1%	576	47.4%
33.7%	782	37.1%	253	27.7%	90	32.5%	396	32.6%

7.2%	21	1.0%	186	20.4%		0.0%	120	9.9%
4.7%	50	2.4%	113	12.4%		0.0%	51	4.2%
1.1%	16	0.8%	20	2.2%		0.0%	14	1.2%
0.4%	8	0.4%	4	0.4%		0.0%	8	0.7%
0.2%	7	0.3%	1	0.1%		0.0%	3	0.2%
3.0%	48	2.3%	39	4.3%	4	1.4%	46	3.8%
-	-	-	-	-	-	-	-	-
12	*2109*		*912*		*277*		*1214*	
	Sexual Orientation							
86.2%	1877	88.7%	742	80.5%	258	90.2%	1047	85.2%
1.9%	31	1.5%	34	3.7%	3	1.0%	19	1.5%
1.5%	25	1.2%	22	2.4%	1	0.3%	19	1.5%
0.9%	17	0.8%	7	0.8%	1	0.3%	15	1.2%
0.7%	12	0.6%	11	1.2%	3	1.0%	7	0.6%
8.8%	153	7.2%	106	11.5%	20	7.0%	122	9.9%
52	*2115*		*922*		*286*		*1229*	

Analysis notes
Option not included in consultation survey
Consultation survey: age groups were 16-19, 20-24
Consultation survey: This is a combination of those stating day-to-day activities 'limited a little' and 'limited a lot'
Not captured in the consultation survey



LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE – 13 SEPTEMBER 2021

DENTAL SERVICES

REPORT OF: NHS ENGLAND AND IMPROVEMENT (NHSEI) – MIDLANDS

Purpose of the Report

1. The purpose of this report is to provide an overview of the impact upon NHS dental services commissioned in Leicester, Leicestershire and Rutland (LLR) as a result of the ongoing COVID-19 pandemic.

Background

Access to services

2. It is important to clarify that NHS dental care, including that available on the high street (primary care), through Community Dental Services or through Trusts is delivered by providers who hold contracts with NHS England and NHS Improvement. All other dental services are of a private nature and outside the scope of control of NHSEI. The requirement for NHS contracts in primary and community dental care has been in place since 2006.

3. There is no system of patient registration with a dental practice. People with open courses of treatment are practice patients during the duration of their treatment, however once complete; apart from repairs and replacements, the practice has no ongoing responsibility. People often associate themselves with dental practices. Many dental practices may refer to having a patient list or taking on new patients, however there is no registration in the same way as for GP practices and patients are theoretically free to attend any dentist who will accept them. Dental statistics are often based on numbers of patients in touch with practices within a 24-month period and this in many cases be based on repeat attendances at a “usual dentist”.

4. General Dental Practices within Leicester, Leicestershire and Rutland offer a range of routine dental services; some of these generalist

providers also provide less complex orthodontic services. In addition, there are specialist Orthodontic practices; the orthodontists in these practices are specialists and provide more complex care. Extended or out of hours cover is provided by five 8-8 contracts, services which provide access to patients 8am – 8pm 365 days of the year. Secondary care is provided by University Hospitals of Leicester (UHL) and Community Dental Services for special care adults and children is provided from five clinics in the area by CDS-CIC.

5. Around 50% of the population are routinely in touch with NHS high street dental services; the numbers of people attending private services is not known; but is not expected to be the remaining 50% of the population. Many people with less structured lifestyles or who are vulnerable may not engage with routine care and may instead use out of hours dental services. Individuals are free to approach practices to seek dental care and further information on NHS dental practices is available on the NHS website: https://www.nhs.uk/service-search/find-a-Dentist although information provided by local dentists may not always be fully up to date.

Impact of COVID-19 Pandemic

6. The ongoing COVID-19 pandemic has had a considerable impact on dental services and the availability of dental care. The long-term impact on oral health is as yet unknown but forms a key component of recovery and restoration work being undertaken by NHSEI.

7. Routine dental services in England were required to cease operating when the UK went into lockdown on 23rd March 2020. A network of Urgent Dental Centres (UDCs) was established across the Midlands during early April to allow those requiring urgent treatment to be seen. There are now over 90 UDCs and these remain operational.

8. In LLR, UDCs were mobilised in Oakham, Melton Mowbray, Loughborough and Leicester city (Nelson Street). Post analysis of patient referral numbers and assessment of geographical locations of patients accessing the UDC services, Oakham was stood down and another location in Hinckley was mobilised. At present, all of the UDCs remain operational and able to provide a full range of general dental services.

9. From 8th June, practices were allowed to re-open, however practices have had to implement additional infection prevention control measures and ensure appropriate social distancing of patients and staff.

10. Unfortunately, across parts of Leicester and Leicestershire, an additional period of “lockdown” was enforced at the end of June. This decision was taken by government to mitigate the impact of a rise in COVID-19 cases. During this local lockdown, NHSEI worked closely with Public Health colleagues, including the Directors of Public Health for both Leicester

City and Leicestershire to ensure a robust response, but also to ensure that patient access was maintained as much as possible.

11. During the Leicester and Leicestershire incident and restrictions, UDCs continued to provide access to patients requiring emergency treatments. General dental practices were supported to undertake rigorous risk assessments to ensure that, wherever possible, practices remained open and able to provide access to patients. A vast majority of Leicester and Leicestershire practices in the affected areas remained open and continued to provide access to patients. Those that were unable to remain open were supported to re-open as soon as possible and were mandated to provide remote triage to all patients that contacted the practice (referring onwards to a UDC if necessary).

12. A significant constraint, that has limited practices in their ability to offer increased patient access and treatment, has been the introduction of 'downtime' – a period of time for which the surgery must be left empty following any aerosol-generating procedure (AGP). An AGP is a procedure that involves the use of high-speed drills or instruments and would include fillings, root canal treatment or surgical extractions. This has had a marked impact on the throughput of patients.

13. Aside from the effects of reduced dental access, it is possible that the pandemic will have other long-term effects on oral and general health due to the impact on nutritional intake – for example, increased consumption of foods with a longer shelf life (often higher in salt or sugar), coupled with possible increased intake of high-calorie snacks, takeaway foods and alcohol. Increases in sugar intake and alcohol intake could have a detrimental effect on an individual's oral health.

14. Those impacted to the greatest extent by this are likely to be the vulnerable and most deprived cohorts of the population, thus further exacerbating existing health inequalities. It is important to note that some of the most vulnerable in the population, whose oral health may have been affected by the pandemic as described above, are also those individuals who are at greater risk of contracting COVID-19 and of experiencing worse outcomes due to risk factors linked to other long term health conditions.

15. NHSEI is working closely with public health colleagues to mitigate the impact of COVID-19 on these vulnerable groups and the Midlands Regional team has identified this aspect of work as one of the highest priorities as our response to the pandemic continues.

16. NHSEI continues to work with providers to ensure that they operate safely and within national guidelines and have shared national guidance and Standard Operating Procedures that give guidance on how care can safely be provided.

17. The Dental Team have engaged and surveyed dental practices on a number of issues, in order to gain assurance that practices have received and implemented the guidance that has been sent out. This includes:
    - a statement of preparedness return (gauging practices ability to restart patient care, and to what level, post lockdown restrictions);
    - information on air exchanges to support appropriate use of surgeries and 'downtime' between procedures and to maximise patient access, in a safe manner;
    - information on risk assessment of staff to ensure that staff are supported and aware of additional resources available to them to address occupational health issues.

18. As of 20th November 2020, all practices in Leicester, Leicestershire and Rutland are now re-opened and seeing patients. NHSEI has developed an Outbreak Standard Operating Procedure for practices to report any staff members that are self-isolating or have received positive COVID-19 tests. NHSEI is committed to supporting practices where incidents occur but can confirm that service delivery impacts have been minimal and are being well managed by practices across the county.

19. As a result of the pandemic, dental practices have undertaken risk assessments of their premises and many have made changes to the way that they provide dental care. This is to ensure the safety of both patients and staff.

20. These additional safety precautions dictate that practices are able to see fewer patients than previously due to the required measures to ensure social distancing and prevent any risk of spreading of infection between patients. Surgeries require 'downtime' between patients to allow for air changes, droplets to settle and for cleaning.

21. As a result, not all practices or clinics are able to offer the full range of dental treatment. Patients may be referred on, particularly if the referral to another service will offer treatment in a safer setting for the patient. This may involve travelling further than would usually be the case.

22. It is important to note that no practices are providing walk in services and patients should expect to be contacted and asked to undergo an assessment prior to receiving an appointment. Patients need to be honest about their COVID-19 status and whether or not they are experiencing symptoms or have been asked to isolate. Patients will then be directed to the most appropriate service. This is to ensure patient safety and the safety of staff and other patients.

23. The dental team are aware that some vulnerable groups are finding it harder than usual to access services – particularly as no walk-in options are available. We have been reviewing pathways and treatment arrangements for these patients to ensure that they can continue to

access urgent care. Primarily this is through NHS 111 or local dental helplines.

24. Many practices are operating with reduced capacity and will therefore be restricted in the care that they can offer to new patients. Arrangements are being put in place to ensure that telephone advice and triage is available and the Urgent Dental Centres (UDCs) remain open across the Midlands to ensure access to urgent dental care where practices are unable to provide this to all patients.

25. Some patients that have previously accessed care privately may now be seeking NHS care due to financial problems related to the pandemic or due to the additional PPE charges that may be levied by some private dental practices. This is placing additional pressure on services at a time when capacity is constrained. These patients are eligible for NHS care; and are advised to contact local practices or NHS 111 to ensure access to care.

26. It should be noted that many dental practices operate a mixed private/NHS model of care and although NHS contract payments have been maintained by NHSEI, the private element of their business may have been adversely affected by the pandemic.

27. A working group convened by the Chief Dental Officer of England carried out an investigation into the resilience of mixed practices. It was concluded that whilst there would have been an interruption of income, the risk of a large number of practices facing insolvency over the next 12 to 18 months was low.

28. There were however significant concerns raised about the viability of the dental laboratory sector that manufacture dentures. These businesses are wholly private and will have suffered a major interruption to income during the first lockdown and a significant reduction to their business subsequently due to the reduced numbers of patients being seen and treated. The group made a number of recommendations for actions to support the wider dental industry.

Urgent Dental Centres (UDCs)

29. Urgent and emergency oral and dental conditions are those likely to cause deterioration in oral or general health and where timely intervention for relief of oral pain and infection is important to prevent worsening of ill health and reduce complications (SDCEP, 2013). Urgent dental care problems have been defined previously into three categories (SDCEP, 2007). The table below shows current national information about the 3 elements of dental need and best practice timelines for patients to receive self-help or face to face care.

Triage Category	Time Scale
Routine Dental Problems	Provide self-help advice. Provide access to an appropriate service within 7 days if required. Advise patient to call back if their condition deteriorates
Urgent Dental Conditions	Provide self-help advice and treat patient within 24 hours. Advise patient to call back if their condition deteriorates
Dental Emergencies	Contact with a clinician within 60 minutes and subsequent treatment within a timescale that is appropriate to the severity of the condition

30. UDCs and Out of Hours services have been set up to operate to provide care in line with the standards described above. Practices also apply the same criteria but routine dental problems (those not associated with significant pain or swelling) are unlikely to be deliverable currently within 7 days due to the need to prioritise those in pain.

31. The availability of routine check-ups is likely to be limited to those who are vulnerable or who have ongoing dental issues.

32. Many patients with generally good oral health would not be expected to require 6 monthly check ups under normal circumstances and these can safely be deferred at this time. Treatment options may be more limited than usual. This is due to the need for AGP (aerosol generating procedures) for restorative dentistry (e.g. fillings and root canals) which are limited due to the extended 'downtime' necessary between patients.

33. At the outset of the pandemic response, the dental team engaged with stakeholders (including the Local Dental Committee (LDC), Local Dental Network (LDN) and PHE colleagues) to agree suitable sites for urgent dental care centres.

34. Across Leicester, Leicestershire and Rutland (LLR) initial sites were mobilised in Leicester City (Nelson Street), Loughborough, Melton Mowbray and Oakham. These sites were all established 8-8 practices, which offered the optimum combination of geographical coverage, contracted hours of opening and staffing.

35. Post analysis of patient access and geographical location of patients accessing the UDCs, the decision was taken to stand down the service at Oakham in order to mobilise an additional site in Hinckley, thus providing better access for patients in the west of the county. Hinckley remains an operating UDC along with sites in Leicester City, Loughborough and Melton Mowbray.

36. In addition, sites were mobilised to provide care for those vulnerable patients that were "shielding" and for symptomatic patients. The local Community Dental Service was mobilised to provide these services, with enhanced infection prevention control measures in place for patients attending the symptomatic site.

37. The local Community Dental service continues to provide care for those with special care needs including some children.

38. The UDCs remain operational and continue to support other local practices in providing care to local patients – in particular those who do not have a “usual” dentist or are new to NHS dental care.

39. There is currently no direct access into the UDCs; they are required to follow distancing and appointment only face to face contacts. Referral to a UDC is via a general dental practice.

40. The site that a patient is referred to will depend upon an individual’s COVID-19 status and it is important for people to be honest about whether they are symptomatic or isolating to ensure that they are directed to the correct service. Minimising the risk to themselves and other patients, and the dental staff.

Personal Protective Equipment (PPE) and Fit Testing

41. One of the initial barriers to practices being able to re-open and then to provide a full range of treatments and services was access to appropriate levels of Personal Protective Equipment (PPE).

42. NHSEI supported UDCs throughout the initial period of lockdown (March-June) to ensure that UDCs had access to all the necessary PPE – particularly early on when supplies were limited.

43. Post lockdown NHSE introduced a PPE Portal, which enables all dental practices to order and access to PPE through an online ordering system. This portal ensures ongoing supply to practices and is managed nationally, to mitigate future case increases or periods of additional restrictions such as the one presently enforced.

44. All equipment available to order via the PPE portal is tested prior to release to ensure that it is safe and effective for practices to use.

45. An initial barrier to practices being able to deliver a full range of treatments and service was the need to “Fit test” all staff to ensure that they were able to safely use certain protective masks and equipment. This test must be conducted every time a new model of tight-fitting mask is selected; and is to be conducted by a suitably qualified professional. It is important that the masks fit and provide an adequate seal to protect from airborne transmission of the virus. The ‘fit-test’ is a requirement of the Control of Substances Hazardous to Heath (COSHH).

46. NHSEI worked closely with Public Health England (PHE) staff during the initial lockdown to fit test UDC staff to ensure that services were available for patients requiring emergency treatment.

47. Subsequently, work has been ongoing, supported by PHE and Health Education England (HEE) to train ninety dental staff from across the Midlands region to undertake fit testing. These trained members of staff have been traversing the region to provide support to practices to ensure that their staff are appropriately fit tested and able to use sufficient and appropriate PPE.

48. Where staff are unable to use standard masks, possibly due to difficulties ensuring an acceptable fit, wearing beards or for cultural reasons, staff are able to use specialised hoods instead. As the response to the pandemic has continued, an increasing number of practices have been utilising reusable, rather than disposable masks, to lessen the environmental and economic impact of PPE usage.

Dentures

49. If a person breaks their dentures then they will need to contact their local dental practice. If they do not have a regular dentist, then they should contact NHS 111.

50. During the ongoing pandemic response, dental practices are prioritising urgent care and unfortunately broken dentures do not classify as urgent care. Broken dentures can sometimes be fixed without a patient needing to see a dentist for an appointment – the dentist will assess the denture and if possible, send to the dental laboratory for the denture to be repaired.

51. Some instances of broken dentures and all lost dentures will require new dentures to be made. This takes on average 5 appointments over a number of weeks with at least a week between appointments. This type of service is likely to be restricted at present due to the impact of the pandemic.

Recovery and restoration of services

52. Dental teams and commissioning teams across the country are working to restore services and to manage the inevitable backlog of patients that has built up during the pandemic response.

53. There is significant potential for the reduction in access to services to have disproportionately affected certain population groups and therefore to have further widened existing inequalities. Those with poorer oral health and/or additional vulnerabilities are likely to have suffered more from being unable to access dental care than those with a well-maintained dentition

54. There is ongoing concern regarding a perceived reluctance amongst some people to present for care because of the pandemic, either because they do not want to be a burden on the health service or because they fear getting coronavirus. A campaign reassuring people that it is safe to attend appointments has recently been launched. It is acknowledged that this delay in seeking care is likely to have affected some of the more vulnerable population cohorts disproportionately more than the general population thus further exacerbating the health inequalities.

55 Reduced access to dental care over the course of the pandemic will have resulted in compromised outcomes for some patients. Due to the duration of the lockdown and the length of time during which routine face to face activity ceased, a number of patients who ordinarily would have had a clinical intervention, will have instead received antibiotics; possibly repeated courses

56. Some patients that were part way through treatment will undoubtedly have suffered and patient compliance with the required oral hygiene measures may wane over time. These risks are acknowledged, and work is ongoing to mitigate the impact as much as possible.

57. NHSEI is committed to addressing instances such as those above and has identified doing so as a priority work stream as the recovery and restoration of services continues.

Secondary and Community Dental Care

58. Infection control measures in place to protect patients and staff also mean that there is reduced capacity in clinics and hospitals for certain procedures, particularly those requiring a general anaesthetic or sedation. As a result, the wider NHS system is prioritising theatre capacity and treating the most urgent cases – for instance those with cancer. This means that some specialist services will only be available at a more limited number of centres. There may also be additional requirements for prospective patients relating to swabbing or isolating at home prior to treatment. This is to ensure the safety of patients undergoing surgery and those already in the hospital.

59. University Hospitals of Leicester are restoring access to secondary care dental services. Infection prevention and control measures has reduced capacity with regard to restoring Oral Surgery/Maxillo-Facial and Restorative Services due to the required ‘downtime’ between patients. In addition, the Trust have had two Consultants leave by the end of November 2020 and are securing locums to provide short term cover. This has resulted in isolated incidents of patients waiting over 52 weeks to access Oral Surgery treatment.

60. Access for children requiring dental treatment under general anaesthesia has been limited (as is the case across the country), however, this has improved as regular lists have now been reinstated for the children

general anaesthesia pathway. Access to theatres in hospitals is being monitored, however, with rising number of COVID 19 cases, this may impact on access to the regular sessions.

61. Regular meetings are being held between providers and NHSEI to monitor restoration of services. To support restoration of services, NHSEI have invited Trusts and Community Dental Services providers to submit business cases for 2020-21 non-recurrent funding to support managing patients waiting for treatment. These will be considered in early December 2020.

Staffing issues

62. The Midlands region as a whole is highly diverse, and Leicester and Leicestershire has a particularly diverse population. This is reflected in the staffing for local practices. In order to ensure that staff are not at risk, all dental contractors have undertaken COVID-19 risk assessments with their staff.

63. Working arrangements have been altered to keep people safe where necessary and staff that may have been unable to see patients face to face have been involved with telephone triage or have been redeployed to help in other services such as NHS 111.

Communication with dental practices and stakeholders

64. There have been regular meetings with Local Dental Committees (LDCs) since April, initially on a weekly basis, latterly fortnightly, and the dental team is grateful for the co-operation received from the profession in mobilising UDCs and seeking solutions to help manage the current restrictions in services.

65. LDCs have continued to update their members regularly and to share information as guidance is updated. Managed Clinical Networks (MCNs) (a network of local Clinicians from primary and secondary care developing a consistent and equitable service to patients through care pathways) have continued to meet virtually to plan care and agree guidance to help practices to manage their patients. The Local Dental Network and PHE colleagues have been integral in supporting these meetings, and the wider efforts of the dental team with regard to the pandemic response.

66. Every year the dental team engages with practices to gain assurance about practice opening over holiday periods in order to ensure that services will be in place for patients. Information is currently being gathered for this year to ensure that services are in place over the Christmas period.

67. The Dental Commissioning team have been working with colleagues in the NHSEI Regional Communications team to draft a series of

stakeholder briefings to update key partners and the public on the situation with respect to dental services. These have been distributed to local authorities, Directors of Public Health and CCGs.

68. We continue to engage with local Healthwatch organisations to encourage the sharing of intelligence relating to local concerns or regarding difficulties people may be having in accessing services.

COVID-19 and outbreaks in dental settings

69. Dental practices are well equipped to manage risk relating to COVID-19 as all staff are trained in infection prevention and control as part of their role in delivering dental services.

70. A dental Standard Operating Procedure for outbreak management has been circulated via all contract holders and also to the Local Dental Committees to support practices manage any positive cases in their practices, whether visitors or staff.

71. As with all primary care settings, the risk is staff to staff transmission when they are outside their immediate clinical setting such as in shared reception areas or staff rooms or through community contacts outside work (such as with family or friends). NHSEI is planning a webinar to raise awareness of good practice in IPC and to share learning to prevent outbreaks in dental settings.

72. Nationally all of the latest guidance for dental practices can be found here: https://www.england.nhs.uk/coronavirus/primary-care/dental-practice/

73. IPC guidance for dental practices can be found here: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

74. Support is being provided to practices that have staff who are symptomatic or have been asked to isolate through Test and Trace. This is to ensure that practices take the relevant and appropriate actions through their business continuity plans, to continue to operate safely and provide care to their patients.

75. If a practice is unable to remain open then patients may be redirected to an alternate local practice or to a UDC.

Opportunities for Innovation including Digital

76. There have been some positive impacts observed during the pandemic response, including ways in which local services and clinicians have worked together collaboratively to maintain and recover services.

77. There has also been opportunities relating to the widespread acceptance and adoption of innovative ways of providing care remotely by using digital methodologies such as video consultations. This has been widely used by Secondary and Community services, and by Orthodontic practices, to provide support and advice to patients already in treatment.

78. 125 dental practices across the Midlands have signed up to a six-month pilot to make use of video technology. This is part of a wider initiative covering Pharmacies and Optometrists. Further details are available at this link: https://www.youtube.com/watch?v=rXtykDGljjk

79. The dental team is committed to working with stakeholders to ensure that any opportunities are evaluated and supported, but that fundamental aspects of patient care and assessment are maintained.

Background Papers *(excluding exempt items)*

80. *None*

Circulation under the Local Issues Alert Procedure

81. *None*

Officer to Contact

82. Tom Bailey (Senior Commissioning Manager, NHS England and Improvement – Midlands)
t.bailey1@nhs.net

List of Appendices

83. *N/A*

Equalities and Human Rights Implications *mandatory*

84. Acknowledgement of impact upon access to dental services for population of Leicestershire, particularly vulnerable patient groups, and the mitigating actions taken

Appendix B

NHS ENGLAND & NHS IMPROVEMENT RESPONSE TO HEALTHWATCH LEICESTER AND LEICESTERSHIRE REPORT ON THE EXPERIENCE OF PATIENTS WITH A SPECIAL EDUCATIONAL NEED OR DISABILITY USING DENTAL SERVICES IN LEICESTER AND LEICESTERSHIRE.

The Healthwatch Leicester and Leicestershire report can be accessed via the following link: https://healthwatchll.com/wp-content/uploads/2020/09/FINAL-REPORT-SEND.pdf

The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee asked NHS England & NHS Improvement (NHSEI) to respond to the issues raised in the Healthwatch report. NHS England have provided the following statement.

"NHSEI Midlands would like to thank Healthwatch for sharing the Using Dental Services with Special Educational Needs and Disabilities (SEND) Report for Leicester, Leicestershire and Rutland. We will undertake a thorough and robust review of this report to fully understand its content and inform commissioning decisions across the wider primary care dental and community dental services. We will liaise and engage with the Special Care Managed Clinical Network, Local Dental Committee and the Community Dental Services Provider regarding the recommendations and managing access for patients with special educational needs and disabilities."

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Leicester, Leicestershire, and Rutland Joint Health Scrutiny Committee

Work Programme – 2021/22

Date	Topic	Actions arising	Progress
6th Jul 21	1. Analysis of UHL Acute and Maternity Reconfiguration consultation results 2. Covid-19 Vaccination Programme Update	1. The consultation findings were published on 8th June 2021. 2. Update requested at Mar 2021 meeting	Completed
13th Sep 21	1. Progress Report on the Transition of Children's Services from Glenfield to Kensington 2. Dental Services in Leicester, Leicestershire, and Rutland; NHS England & NHS Improvement Response to Healthwatch SEND Report. 3. COVID19 & Autumn/Winter Vaccination Programme 4. Verbal Update on UHL Reconfiguration 5. ICS Board - Verbal Update	3. Standing item as of August 2021 and a brief update on the A/W Vaccinations Report	
16th Nov 21	1. Black Maternal Healthcare and Mortality 2. Findings and analysis of Step Up to Great Mental Health Consultation - Leicester, Leicestershire, and Rutland 3. COVID19 and the Autumn/Winter Vaccination Programme 4. Black maternal healthcare and mortality 5. Leicester, Leicestershire, and Rutland Integrated Care System AOUB or Chair's Announcements: UHL finances and misstatement of accounts – Members Briefing for Dec 21	2. Deferred to November meeting due to time needed for results to be collated.	

Date	Topic	Actions arising	Progress
28th Mar 22	1. COVID19 & Vaccinations update (standing item) 2. Report on UHL Finances and Accounts for 19-20 and 20-21 3. EMAS - New Clinical Operating Model and Specialist Practitioners 4. UHL: report on responding to waiting times and backlog	Item 1 will be discussed following a Members Briefing planned for December 2021 once audit reports are released. Item 2 was due to be discussed in December 2020 but had to be deferred due to insufficient time. Item 3 may be taken at this meeting or in November, depending on the progress update to be given at the November agenda planning meeting.	

Prospective Items

Agenda item	Organisation/Officer responsible	Notes
1. EMAS - New Clinical Operating Model and Specialist Practitioners	Russell Smalley, EMAS	This item was on the agenda for the meeting on 14 December 2020 but Russell was unable to present the report so the Chairman suggested the item could come back to a future meeting.
2. Update on dental services and response to Healthwatch report on SEND children.	Thomas Bailey, NHS England	This item was on the agenda for the meeting on 14 December 2020 but Thomas was unable to present the report so the Chairman suggested the item could come back to a future meeting.

3. Community Services/Place based plans overview	Tamsin Hooton, CCGs	It was intended that the high-level strategy would come to the Joint HOSC and the detail on individual areas such as Hinckley/Lutterworth would come to individual HOSCs.
4. Progress Updates on the UHL Acute and Maternity Reconfiguration Proposals	CCGs/UHL	Analysis of the UHL Acute and Maternity Reconfiguration Consultation results was taken at the July 2021. Progress updates are expected at future meetings for: - - The transition of Children's Services from Glenfield to Kensington - Update on the co-located design work for the standalone midwife let unit - Details of the emerging strategy and patterns of activity to be developed in relation to primary care
5. Neuro – Rehabilitation services	CCGs/UHL	Kathy Reynolds asked a question at the JHOSC meeting on 14 December 2020 about Neuro – Rehabilitation services and the Chairman promised to have it on the agenda of a future meeting.
6. LLR NHS System Workforce Group/ Recruitment and Retention/NHS People Plan/Mental Health of workforce	Louise Young, CCGs	The County members wanted an agenda item on NHS workforce to cover recruitment and wellbeing of staff going forward. We thought this was a good item to have at Joint HOSC.
7. Transforming Care – Learning Disabilities and Autism progress update	County/City Council and LPT	This issue came to the meeting on 15 October 2020 and members requested a progress update at a future meeting.
8. UHL finances and misstatement of accounts	UHL	At the meeting on 5 March 2021 it was agreed that UHL would come back to the JHOSC with further updates regarding the actions taken to address the financial issues. This is planned for March 2022, with a Members Briefing beforehand in Dec 2021.
9. Black maternal healthcare and mortality	UHL or CCGs – to be confirmed.	Email discussion regarding the national interest in this issue (MPs debated a petition relating to this on 19 April 2021) and both City and County interest in looking at this issue locally and how mortality rates can be improved.

10. Covid-19 Vaccination Programme Update	CCGs	March 2021 - LLR CCGs be requested to provide a further update to the Committee regarding the areas of Leicester, Leicestershire, and Rutland where vaccination uptake had been comparatively low and reasons behind this.
11. Leicester, Leicestershire, and Rutland Integrated Care System	CCGs	LLR CCGs successfully applied to become one single CCG by 31st March 2021 ready for organisational change on 1st April 2022. This update is planned for November 2021.
12. Findings and analysis of the Step Up to Great Mental Health Consultation - Leicester, Leicestershire, and Rutland	CCGs	Consultation (ends 15 August 2021) about proposals to invest and improve adult mental health services for people in Leicester, Leicestershire, and Rutland when their need is urgent, or they need planned care and treatment. Agreed that an item on this while the consultation is live, is not required for this Commission as sufficient engagement is being conducted with Members individually for this.
13. UHL: report on responding to waiting times and backlog	UHL	A report to be circulated to Commission Members by the end of July. This will determine which meeting this should go to.
14. Autumn/Winter Vaccination Programme Report	CCGs	Referenced in the July 2021 minutes as a report for the next meeting.
15. Progress Report on the Transition of Children's Services from Glenfield to Kensington	UHL	Specifically referenced in the July 2021 minutes as a report for the next meeting.