Leicester
City Council

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

Held: TUESDAY, 4 SEPTEMBER 2018 at 10.00am

P R E S E N T :

Councillor Cutkelvin – Chair of the Committee
Dr R.K.A.Feltham CC – Vice Chair of the Committee

Leicester City Council

Councillor Chaplin
Councillor Dr Moore

Councillor Pantling

Leicestershire County Council

Mr T Barkley CC
Mr D Harrison
Mrs J Richards CC
Mrs A Hack CC
Dr S Hill CC
Mrs M Wright CC

Rutland County Council

Councillor Conde
Councillor Miss G Waller

In attendance

Micheal Smith – Manager of Healthwatch Leicester and Leicestershire
Dr Janet Underwood – Healthwatch Rutland
Harsha Kotecha – Chair of Healthwatch Leicester and Leicestershire

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Cleaver, Fonseca and Dr Sangster.

2. DECLARATIONS OF INTEREST

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

Dr Feltham, C.C. declared that he worked for the NHS in Northamptonshire.

Dr Janet Underwood declared that she had made a representation to Councillors, that was independent to her position in Healthwatch Rutland. The representation related to the consolidation of the Level 3 Intensive Care Units. It was agreed that this did not constitute a declaration of interest that meant she could not continue with the upcoming debate.

3. MINUTES OF PREVIOUS MEETING

The Chair stated that there were some minor typographical errors in the minutes but she believed that they did not affect their accuracy.

RESOLVED:

that the minutes of the meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee held 27 April 2018, be confirmed as a correct record.

4. PROGRESS ON MATTERS CONSIDERED AT A PREVIOUS MEETING

Minute item 54 Update on Congenital Heart Disease Services

The Chair stated that it had been agreed to write to Nottingham City Council to provide assurance about the monitoring of targets and to request that they encourage the University Hospitals of Nottingham (UHN) to refer their congenital heart patients to the University Hospitals of Leicester. It had also been agreed for the minutes of the meeting to be sent to Nottingham City Council. The Chair confirmed that the letter and the minutes had been sent as agreed and they had replied giving assurances that UHN are doing this.

5. PETITIONS

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

6. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Chair stated that questions had been received relating to an item that she had agreed to take as Any Other Urgent Business and therefore the questions would be received during that item.

7. ANY OTHER URGENT BUSINESS

The Chair agreed to take the following item of Any Other Urgent Business in accordance with the Scrutiny Procedure Rules Rule 14 (Part 4E) of the Council's Constitution.

The Consolidation of Level 3 Intensive Care

The Chair agreed to take the report as urgent on the grounds that it needed to be considered before the next meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee.

8. THE CONSOLIDATION OF LEVEL 3 INTENSIVE CARE

The Chair invited the following members of the public to read out their questions which had all been received in accordance with the Scrutiny Procedure Rules Rule 10 (Part 4E) of the constitution.

Ms Jean Burbridge

"The law requires commissioners and providers to involve the public when making changes to the provision of NHS healthcare. NHS bodies discharge this duty by carrying out consultations. There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services, usually involving a change to the range of services available and/or the geographical location from which services are delivered. Not only is a change in service location being proposed in UHL's full business case, but it is a change in the location of a **core** service, that is, one on which numerous other service depend and one where change has significant ramifications for the rest of the hospital. **Why did UHL consider it possible to proceed without a full public consultation and will the committee ensure that this omission is rectified and recommend that full public consultation takes place?"**

Giuliana Foster

"Why has UHL been planning to close level 3 intensive care at the Leicester General Hospital since at least 2015 and yet still not consulted the public?"

Ms E Brenda Worrall

"Given the recent ruling by The High Court (HHJ Jarman QC sitting as a High Court Judge) in quashing a decision by the Corby Clinical Commissioning Group over failure to undertake public consultation, is there a danger that the local NHS could find itself on the wrong side of the law if it proceeds to remove services as important as level 3 intensive care from Leicester General Hospital without full public consultation? A legal challenge will be costly in time, money and reputation. I therefore urge you to recommend full public consultation".

Ms Warrington

"Why is the NHS undertaking to consult the public on ‘our plans for acute reconfiguration’ (Next Steps to Better Care in Leicester, Leicestershire and Rutland, August 2018 p40) but is not consulting the public on the reconfiguration of intensive care and other services such as kidney services now?"

Mr A Ross

“Although the scrutiny committee does not have the right to impose its views on the local NHS, will it state its desire to see a full public consultation take place in relation to the closure of level 3 intensive care and the consequent downgrading of the Leicester General Hospital?”

The Chair also referred Members to the questions relating to this issue, that had been brought to the meeting of the Leicester City Council Health and Wellbeing Scrutiny Commission on 23 August 2018. These were circulated for reference. The Chair thanked the members of the public for their questions and invited representatives of University Hospital Leicester (UHL) to respond to the issues raised.

Mark Wightman, Director of Strategy and Communications UHL, explained that with regards to the consultation, their response and the clinical risk remained the same as it did in 2015.

The Chair explained that following the article in the Mercury in March 2018, members of the public had understandably interpreted the move of the ICU as closure of the Leicester General Hospital by stealth. Whilst she did not believe that this was the intention of UHL, she sympathised with the public’s concern of this as the conversation had not been held in the public domain since 2015 and time had moved on since then. There was now the question of whether an argument of urgency can still be applied three and a half years later. Given this, there needs to be a conversation about what the current situation is and if the legal position would require UHL to go out to consult.

Andrew Furlong, Medical Director, UHL explained that there were three Intensive Care Units in Leicester providing level 3 and level 2 services and the pressures were such that 2014 it was considered that it was no longer possible to sustain safe level 3 services at the LGH. The training status of the unit had been downgraded at LGH because it wasn’t seeing the complexity of work going through and trainees could not get the training they required to become intensive care clinicians. A number of consultants were due to retire and multiple efforts to recruit were unsuccessful because of the loss of training status and because it was a very poor environment to work in due to the facilities. There were also considerable problems in maintaining ICU nursing levels. These pressures meant that it was not safe to keep the services at LGH open long term. Numerous reviews had been carried out to say that the services were not sustainable.

The move of the level 3 ICU from LGH would affect some services such as renal transplant surgery but there would still be a level 2 ICU and High Dependency Unit, and number of other services such as orthopaedics would remain at the LGH. The move of the ICU did not mean that all services would move from the LGH as a formality.

John Adler, Chief Executive, UHL stated that they would have liked to have proceeded quicker but were prevented by a lack of capital funding. There was also a need to move the Congenital Heart Unit from the Glenfield to the LRI by 2020 and they had to ensure there was sufficient capital for that work. Members heard that the money for the ICU had been allocated in 2017. The outline business case had been recently approved and the final business case was due to be approved soon. The Chief Executive stated that if the UHL went out to consultation, the delay could impact on the funding as it had not yet been received. He added that the UHL had been open about the strategy and the ultimate plan to move acute services from LGH, which was part of 'Better Care Together' and that would be out for consultation when the funding position was clear.

Rakesh Vaja, consultant in ICU added that the critical care services in Leicester had been chronically underfunded, but he believed that the UHL were as close as they had ever been to getting that investment. The services were isolated across the three sites and it was not possible to access the expertise immediately when the patient needed it when clinicians were on different sites.

The Chair stated that she had met with senior management at the NHS. She believed they felt they had fulfilled their duty to consult by going to the various scrutiny meetings, including scrutiny at Leicester City and Leicestershire County Council in 2015 and more recently at Rutland County Council in April 2018. The Chair agreed that the plans for the consolidation of Level 3 ICUs had been in the public domain and that now the funding was available there was a strong argument for wanting to make that investment. However, she expressed disappointment that the report did not address the matter of urgency as fully as she had hoped.

The Chair stated that despite the urgency of the move, the UHL had managed to mitigate the situation with the ICU at the LGH for the last three years and although far from ideal, a public consultation would only require them to continue to manage the situation for a further three months.

The Chair expressed some disappointment that when the UHL took the issue to the Adults and Health Scrutiny Panel at Rutland County Council in April, they misrepresented the views of the Leicester City Council (LCC) Health and Wellbeing Scrutiny Commission where the issue was considered in March 2015. Rutland County Council had been informed that the Leicester City Commission had agreed that for safety and welfare reasons, the consultation was unwarranted, where in fact they had simply noted the position. This concern was also reiterated by other Members, including Members from Rutland.

Dr Feltham CC stated that his view had not changed since 2015 and now that it was known that the funding would be received, the same level of urgency still applied. The UHL had managed extremely well in keeping the Level 3 ICU operational across the three sites. Dr Feltham added that it was only Level 3 that would be moving from the LGH and he referred to the logistical problems in getting all the clinical specialists together across the three sites. He was willing to listen to the arguments, but he was of the view that the reasons for urgency still applied.

Members raised concerns about the process and the lack of consultation and clarification of the legal position was sought. Views were expressed that this was not so much about clinical need, but the process and that people had the right to have their say on the issue. Concerns were also expressed that there was a lack of transparency regarding Better Care Together and the future of the LGH. Comments were also made that there appeared to be a breakdown of trust and that the public were being denied their say in the way the NHS was run.

Concerns were expressed about the impact the removal of the Level 3 ICU would have on the LGH, and a comment was made that it was disingenuous to argue that it would not affect the future of that hospital.

The Director of Strategy and Communications explained that when the issue was discussed in April at Rutland, the UHL had explained that they had been told they could not hold a consultation until the capital investment was confirmed. In relation to urgency, they had been working extremely hard to keep the ICU open, and the level of risk had not diminished. In relation to the consultation, a basic premise was that consultations took place where there were options, but on this issue, it was considered that there were no options. The Chair responded that the City Council ran a large number of consultations with limited options, the point being to allow people to express their opinions and concerns.

In response to a question about the cost of holding a consultation, the Director responded that he did not know but he believed that the cost should not be a factor in whether a consultation took place.

The Chair asked Members, in view of the time factor, with some Members yet to speak and with four items of business on the agenda, another meeting should be arranged to continue the discussion. The Chair recommended that the Committee note the report and note that the UHL had put forward a clinical case, but they were not in a position to make any suggestions as to whether or not the UHL should consult; and that a further meeting would be reconvened to continue the debate. Upon being put to the vote, this was agreed.

The Healthwatch Rutland representative wished it to be noted that she had not had the opportunity to speak during the debate and the Chair assured her that she would have the opportunity at the reconvened meeting.

AGREED:

1) that the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee note the report and note that the University Hospitals Leicester had put forward a clinical case, but they are not in a position to make any suggestions as to whether or not the UHL should consult; and

2) that the further meeting be reconvened to continue the debate.

9. EAST MIDLANDS AMBULANCE SERVICE (EMAS) 'SHAPING OUR VISION'

Mr Richard Lyne, General Manager, East Midlands Ambulance Service (EMAS) gave a powerpoint presentation to the committee. The presentation entitled 'Shaping our Vision' was included in the agenda pack. Members were asked to consider three questions as follows:

1) Did Members feel that the parties listed in the presentation were the right stakeholders for EMAS to engage with on this particular strategic piece of work?

2) What would Members of the LLR Joint Health Scrutiny Committee like to see within EMAS' vision for the future?

3) What feedback did the committee have on the emerging vision?

Members considered the presentation and raised comments and queries which included the following:

- A Member asked whether all staff were sufficiently trained on mental health issues and Mr Lyne said that there was a plan to roll our mental health training to all staff.

- A Member referred to the co-location of blue light services and Mr Lyne commented that this was a high priority in terms of their vision as there were numerous benefits. It could be seen to be operating well in Market Harborough.

- A concern was raised that there was a 'mismatch' between public expectation and what could be delivered. A Member asked how this gap between expectation and delivery could be addressed; how EMAS could convey to people what the ambulance service was about and what alternatives there were. It was also noted that there was an aim to treat more people at home and a Member asked for more information as to how this could work.

  Mr Lyne responded that health care was very different now than it had been a few years ago and the public's expectations of the ambulance service were also very different. Very often people who called 999 did not need to go to hospital. To address this a working group was being established across the LLR with all partners with the aim to reduce conveyance by looking at new pathways, using existing pathways better and managing public

expectation better. This might involve transporting the patient to an urgent care centre instead of a hospital but if the hospital was considerably closer, they would aim to go there instead. The service would try to balance the clinical need and keep people in their local area where possible.

- Dr Underwood, Healthwatch Rutland referred to the queues of ambulances outside the Emergency Department during the winter of 2017/18 as they waited to deliver their patients. Mr Lyne explained that EMAS were working with the hospital to reduce handover delays, in order that ambulances could be released sooner. One of the high priorities in Leicester was to look at what could be done to reduce those delays.

In summary, the vision document was generally well received but a Member said he would like to have seen information about what had been achieved so far. The Chair commented that the Leicester City Council Health and Wellbeing Scrutiny Commission received regular reports, but she would also like to receive information on the use of legal highs and how EMAS, local authorities and the Police were dealing with that issue.

AGREED:

1) that the EMAS presentation on 'Shaping our Vision' be noted in the light of comments made; and

2) that a further report be brought back to the committee.

10. THAMES AMBULANCE SERVICES LTD (TASL) - UPDATE ON THE PROVISION OF SERVICES

Mike Ryan, Director of Urgent and Emergency Care, West Leicester Clinical Commissioning Group (WLCCG) presented a report that provided an update on the provision of services by Thames Ambulance Services Ltd (TASL). Members heard that TASL had been awarded the LLR Non- Emergency Patient Transport Services contract in June 2017 and began providing the services on 1 October 2017. During the first year, TASL had under-performed against expectations in terms of both performance and quality. Whilst performance had slowly improved, there were still concerns in relation to quality and this was being monitored. There were also concerns as to TASL's long-term financial sustainability as the organisation were operating at a deficit. An independent review was being carried out to ascertain their overarching long-term viability and the report of that independent review was due out shortly.

Members considered the report and raised comments and queries, which included the following:

- In relation to the procurement exercise, a Member commented that it appeared that the CCG had been aware that TASL had shortcomings but had procured their service anyway. Mr Ryan responded that non-emergency patient transport services were very difficult to procure; they had

been aware that there were some shortcomings, but these were considered to be manageable. They had not anticipated that there would be concerns relating to the financial viability of the organisation. The CCG were working closely with TASL and NHS England to ensure appropriate action was being taken to mitigate any risks associated with their financial pressures and have also established contingency plans with other providers.

- Comments were raised that reports on TASL had been brought to the Leicestershire County Council Health Overview and Scrutiny Committee twice, though a representative from TASL had not been present. Concerns relating to TASL's financial stability had also been raised earlier in the year, and Members were given assurances that the financial issues would be sorted out, but the concerns over financial viability were still there.

- In response to a question, Members heard that the current CQC rating for TASL was that the organisation required improvement.

- Micheal Smith, Healthwatch asked the committee to consider the wider impacts arising from delays with handovers at hospitals and he added that Healthwatch had been working with TASL.

- A Member commented that the concerns relating to performance and quality were not particular to Leicester, Leicestershire and Rutland alone, and she would be interested to hear how the NHS was working with other counties in relation to TASL's performance, as some patients crossed boundaries to receive services. A question was asked as to how the NHS was managing those patients. The Chair asked for this question to be noted and to be brought back and addressed in a future meeting.

- Concerns were raised at the cost incurred in monitoring TASL and Mr Ryan responded that as it was a new contact, it was expected that they would put in more time in monitoring. He believed that it was value for money. Mr Ryan was also asked as to how the financial concerns affected the contract going forward, as it had been awarded for a five-year term. In relation to those concerns, the committee heard that the TASL were backed by a group of Spanish investors and venture capitalists; they were the premier passenger transport service in Spain and they had tried to get into the UK market for the past few years. The financial backers were concerned that their investment had not reached the break-even stage. However a cost improvement plan had been drawn up which had inspired more confidence and the investors were now talking in the long term rather than the short term.

The Chair drew the discussion to a close and Members agreed the following:

AGREED:

1) that the report be noted, and a further report be brought back in six month's time and that a representative from TASL comes to the meeting; and

2) that the committee request that the report includes performance data, and information relating to contractual obligations and conditions.

11. PLANNED CARE POLICIES

Ket Chudasama, Director of Performance and Corporate Affairs, West Leicester Clinical Commissioning Group (WLCCG) submitted a report on Planned Care Policies. Mr Chudasama presented the report and explained that the Planned Care Policies enabled the CCGs to prioritise their resources using the best evidence about what is clinically effective and to provide the greatest proven health gain. Following the review, it was agreed that 49 of the existing 51 policies would not be changed, 2 of the existing policies would be changed (Hip and Knee Replacement and Male Circumcision) and 50 new policies would be introduced. The committee heard that a small number of patients who would have received treatment a year ago, would now not receive a procedure, where it was deemed it was not right for them to have it.

The Chair stated that due to time pressures, she would send in some questions after the meeting. Dr Feltham CC also said that he had a detailed question which he would submit by email. The Chair explained that responses to questions would be sent out with the minutes of the meeting and would therefore be in the public domain.

The Chair referred to engagement events and expressed concerns that the one she had attended had been held in a back room and she did not consider such engagement events to be meaningful.

During the ensuing discussion, questions and comments were raised which included the following:

- Councillor Waller asked what coverage there had been in the press as she had not seen anything in her local newspapers in Rutland. The Director said that he would check with his CCG colleagues to make sure this was happening in the county and Rutland.

- It was questioned whether there was still a matter of choice; if so, people would be able to go outside of the area for certain treatments. The Director said that they intended to work with all providers to make it clear what the referral guidelines and thresholds were. There were some clinical reasons why the treatments for certain patients, based on the threshold, had little benefit.

- The committee heard that strong concerns had been expressed that Ear Wax Removal was listed as one of the new policies being introduced. People who required a hearing aid, needed to have ear wax removed prior to the aid being fitted. Dr Tim Daniel, Public Health Consultant responded that the situation would need to be managed for those people who required a hearing aid.

- A request was made that the wording of the Gynaecology Policy be changed as the reference to the 'female parts of the body used to make babies' was patronising. Mr Chudasama apologised for the wording used and said that this would be looked at.

- A Member commented that the policy was over complex; there were too many policies and it would be preferable for it to be in smaller more manageable sections. A request was also made for consultations on the policies to take place in those clinics where people attended for their appointments.

  Mr Chudasama responded that half of the policies were already in existence and they had considered implementing the other polices in smaller sections, but the view of the clinicians was that it would be easier to implement this way. They were trying to introduce the policies as straightforwardly as possible, but they also had to ensure that they were workable and clear as to when someone did or did not meet the threshold.

- Members asked to see the Equality Impact Assessment (EIA) particularly in relation to women, older people and the LGBT community. There was also a concern that a withdrawal of some of these services could have a psychological impact on the patient. Mr Chudasama noted the request for the EIA to be brought back to the committee.

- A question was raised relating to the training of GPs, including locums. Mr Chudasama explained that they were engaging with local clinicians and there were monthly meetings with GP groups, but in relation to secondary care, they did need to make the reasons clear why a patient was being referred back to primary care if that patient did not meet the threshold.

- A Member asked how much consultation had taken place with East Leicestershire and said that there were three major areas in Rutland where people needed to know what was happening. Mr Chudasama explained that they had presented at a GP Reference Group; one of their colleagues was from Rutland and had been involved in the process, along with other GPs. Their governing bodies had been supportive.

- A comment was made that the system was inequitable as some people who were now denied treatment under the NHS would go privately; but others could not afford to pay. A request was made for this to be addressed. The Chair commented that she hoped this would be drawn out in the Equality Impact Assessment.

The Chair drew the discussion to a close and asked Members to submit any further questions, which would be forwarded on for a response.

AGREED:

1) that the committee have concerns about some of the wording in the Gynaecology Policy and seek assurances as to how that will be rectified;

2) that the committee note that the Planned Care Policies document is complex with numerous different policies and express a hope that engagement can be broken down to make it more meaningful for service users. The committee however also recognise that there was a reason why it was considered easier to implement all the policies in one go;

3) that the committee express concerns relating to the continuity of care and the application of policies across different postcodes;

4) that the committee want to see a full Equality Impact Assessment to include impacts on mental health. The committee are of the view that a procedure might not be needed medically but any impact on a person's mental health should allow for some discretion in the way the policy is applied;

5) that the CCG ensure that GPs and locums are fully trained and where treatments cannot be provided in the settings where they are, that primary care provide the treatment, particularly in relation to patients who require ear wax removal prior to having a hearing aid fitted; and

6) that Members of the committee be given the opportunity to submit further questions with responses to be sent out and included in the minutes.

12. BETTER CARE TOGETHER (BCT) - UPDATE ON THE SUSTAINABILITY AND TRANSFORMATION PROGRAMME

The Committee received a report that provided an update on Better Care Together (BCT); the Sustainability and Transformation Partnership (STP) for Leicester, Leicestershire and Rutland (LLR). The Chair provided a background in relation to the scrutiny that had taken place relating to the BCT (formerly known as the STP). The meeting heard that the draft STP came out in 2016 and was brought to the LLR in December 2016. A refreshed STP was expected but never came and during the last few months, it became known that there would be a BCT Next Steps document instead. This document had just been published.

The Chair said that scrutiny needed to be clear as to what it wanted to focus on. She was aware that some dissatisfaction had been expressed relating to the way both scrutiny and NHS bosses had approached public consultation and reports to scrutiny. However, her research showed that scrutiny had carried out a lot of work on the STP; this just needed to be consolidated and a clear way forward agreed.

Toby Sanders, Managing Director of West Leicester CCG and STP lead for LLR, Richard Morris, Director of Operations, Leicester City CCG and Sarah Prema, Director of Strategy and Planning (Leicester City CCG) introduced

themselves to the committee. Mr Sanders presented the report and explained that BCT was a partnership that came together across all health care organisations. The Next Steps document set out the important things that had been done and would be done for local people.

The Chair stated that the committee needed a clear idea as to what would be presented to Members in the future and she suggested that it would be useful to discuss this in an informal meeting. The Chair expressed a view that rather than looking at issues they would have little power to influence, it would be most useful for the committee to focus on what service improvements there would be for patients, and public engagement and consultation.

During the ensuing discussion, comments and queries were raised which included the following:

- A Member commented that she thought from the earlier debate in the meeting, officers from the NHS would understand the importance the public placed on consultation. Comments had previously been made that the NHS could not consult without the confirmation of funding, but she said it was still possible to communicate with the public. The Member said that they wanted to avoid the situation that had occurred in relation to the consolidation of the ICU. The Chair added that formal consultation could be about detailed proposals and consultation and engagement exercises on principles rather than details, could still be carried out.

- Further concerns were raised about the lack of information about the STP during the course of the process. Comments were made that the STP was linked to the consolidation of the ICU and the public had not had the opportunity to engage with the process. A Member said that local authorities had a duty to consult on the local plan, but much engagement took place before the consultation, which then informed the proposals, and she did not understand why the NHS could not do the same.

- Concerns were expressed that local authorities no longer had sufficient funding for adult social care and people would not be taken into hospital in the same way. There would be more reliance on voluntary care, but local volunteer groups were having their funding cut as well.

- It was questioned whether the digital team would be able to deliver what was required. A request was made for a written response to this question.

- A member commented that there were issues and inaccuracies relating to geographical boundaries in the report; for example, people in Market Harborough might go to Northampton hospitals and this needed to be taken into account.

- A comment was made that the document referred to hubs and urgent care centres but people did not know what hubs were and where hubs and urgent care centres were located. Concerns were also expressed that people in Hinckley had said that they were not kept informed.

- A Member referred to sickness levels and stated that it appeared that action was being taken to reduce sickness, but absences were still high. She questioned what action was being taken and asked whether those absences were long term.

- A concern was expressed that the Next Steps document looked like a stealthy back door STP with hidden information. An example was given that it did not mention the close of the Melton Maternity Unit which had been included in the original STP. The Member asked how much the process had cost as it had been going back and forth for some time.

- A Member asked how much it had cost to produce the Next Steps document. She referred to a diagram on page 38 which illustrated how the various organisational parts of the current health system came together and said that each organisation had different aims and she had concerns as to whether it was workable.

Mr Sanders and Mr Morris responded to the questions raised and made the following points:

- In relation to the cost, Mr Sanders explained that this was the mainstream work of the NHS and local partner organisations, and the diagram on page 38 was the reality of the NHS and partners. They endeavoured to work better across the CCGs, providers and partners and he believed that this was being achieved.

- Mr Sanders said that in relation to financial information and the sharing of such information, the efficiency savings as detailed in the document, were the savings across the partnership. Those savings had already been identified by the partners and made public so the financial details in the Next Steps was information that was already in the public domain.

- Further to the question about geographical borders, Mr Sanders said that whilst the document focussed on the LLR, they worked with colleagues in other counties, but that information was not as visible in the document as it could be. In relation to Hinckley, two applications for funding to support community services had been submitted but turned down. A team was working on a further funding bid and an update would be given on this when more information became available.

- In response to the comments about consultation, Mr Morris stated that he had been working on the BCT / STP for about ten years and a considerable amount of time and effort had been spent on going out and talking to people about the principles as discussed. Several thousand patients in the LLR had engaged in that process and thousands of comments had been received. He accepted that there had been 'radio silence' during the last 6 – 12 months but part of this Next Steps document being discussed now was to create the framework in order that those informal conversations about the proposals could continue. There could not be a legal consultation until the guarantee

of funding had been received, but they would continue to go out to have those conversations in the meantime.

- Dr Underwood, Healthwatch Rutland said that she was interested in the development of the STP. She expressed concerns that a number of people in Rutland had sent in letters but had not received a reply. Dr Underwood expressed further concerns that the Next Steps document had been overlooked in Rutland.

  Mr Sanders responded that he was aware of the letters and after they had been received, he and Richard Morris had attended a meeting involving Healthwatch in Rutland, where they had given a general response to the letters. Part of that feedback had been included in the Next Steps. He apologised if people felt they had not been responded to.

  Mr Sanders acknowledged that the document did not answer everything however. The Rutland Memorial, Oakham and other community sites were included in the STP but not in the Next Steps document because some areas were still a work in progress. He understood that this was frustrating and created anxiety but as a partnership, it was thought it was preferable to include information on those areas where it was clear about what was happening. Dr Underwood responded that she was not convinced and said that people in Rutland needed to know what was happening.

- Councillor Conde commented that he thought there were too many people coming from different angles which made it difficult to get proper answers. However, he looked forward to working with Healthwatch Rutland in the future.

The Chair drew the discussion to a close and asked for responses in writing to the questions about hubs and urgent care centres and staff sickness levels.

AGREED:

1) that Members be invited to submit further questions; these to be consolidated and emailed round before sending to officers for responses;

2) for the Chair to agree a timeline for questions and responses; and

3) that it be noted that Toby Sanders is leaving, and the committee thank him for his work on the STP over the past few years.

13. CLOSE OF MEETING

The meeting closed at 1.16 pm.