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

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

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

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

There are three scenarios we have been asked to consider:

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

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

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

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

Q2: “ICS Chair David Sissling stated at the Leicester City Health and Wellbeing Scrutiny Commission that the local NHS needs to become more adept at engaging the public. What do you think have been the weaknesses in NHS engagement with the public and what will becoming more adept at public engagement involve?

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

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

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

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

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

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

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

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

Q3: "Please can you also explain the relationship between the main ICS NHS Board and the ICS Health and Care Partnership Board, and tell me what each will *focus on and the balance of power between them?*

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

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

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

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

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

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

Please see above statement from University Hospitals of Leicester NHS Trust

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

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

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

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

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

Q3: “There is little in the government’s legislation about the accountability of integrated care systems to the local public and local communities. How will the integrated care board be accountable to the public? Its precursor, the System Leadership Team, has not met in public or even, apart from the minutes, made its papers available to the public. The CCGs have moved from monthly to bi- monthly governing body meetings; UHL has moved from monthly to bi-monthly boards and does not permit members of the public to be present at the board to ask questions. How will the integrated care Board provide accountability to the public and how will it improve on the current reduced accountability and transparency?”

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

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

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

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

Please see above statement from University Hospitals of Leicester NHS Trust

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

Please see above statement from University Hospitals of Leicester NHS Trust

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

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

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

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

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

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

Please see statement above from University Hospitals of Leicester NHS Trust

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

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

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

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

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

Q2: “In moving towards integrated care systems, NHS England has significantly increased the role of private companies on the Health Systems Support Framework, including UK subsidiaries of McKinsey, Centene and United Health Group, major US based private health insurance organisations. Please could you tell me which private companies NHS organisations in Leicester, Leicestershire and Rutland have used or are using to help implement the local integrated care system.”

NHS organisations in Leicester, Leicestershire and Rutland are not using any private companies to help develop or implement the local integrated care system.

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

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

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

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

From Steve Score: “ The government intends to reduce the use of market competition in awarding contracts. While this is generally not problematic when contracts are awarded to NHS and other public sector organisations, it is likely to be controversial to extend a contract or give a contract to a private company without safeguards against cronyism provided by market competition. Given this reduction in safeguarding public standards and given the different motivation of

private companies who prioritise shareholder interests over public good, can you confirm that neither the Integrated Care Board, nor its sub- committees, will be awarding any contract to private companies, much less without competition?"

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

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

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

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

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

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

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

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

From Jennifer Fenelon, Chair Rutland Health & Social Care Policy Consortium: "At the last Joint HOSC, you kindly asked the CCGs to respond to the issues raised with them in December 2020. They came from a major conference of Rutland people which was called to consider the impact of UHL reconfiguration on Rutland. Andy Williams was present.
The resulting formal submission into the consultation process addressed how UHL reconfiguration plans to move acute services further away from Rutland could

adversely affect this isolated rural community sitting as it does at the periphery of LLR.
It put forward 15 ways in which those effects could be mitigated including practical proposals from our Primary Care Network for bringing care closer to home. We have now had a reply from the CCGs dated 17th August, but it does not offer reassurance that action has or will be taken on these points.
Mr Williams has said frequently to us that compensating services will be provided " *closer to home*" . Mr Sissling has added this week that the new ICS will be better than hitherto at engaging the public in planning modern integrated services. These words are very encouraging and reassuring.
We worry, however, that the NHS Plan to move non-urgent services closer to home has now been Government policy since 2019. Evidence shows that shifting work from acute hospitals to community services needs investment or it will fail yet planning is just starting on the Rutland Plan. That process will need to move at speed to ensure new services are in place before the UHL reconfiguration is completed. Above all it must be backed by capital and revenue.
Can we have assurance from the shadow ICS through the Joint HOSC that :-

- Where PLACE BASED PLANS contain proposals to provide alternatives closer to home, they are fast tracked to ensure they are in place *before* acute services are moved

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

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

- PLACE Based Plans will be supported by the necessary capital and revenue funding to support implementation of care closer to home especially where they will replace services that are no longer accessible.

  Development of plans section 106 funding including relevant bids

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

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

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