Leicester
City Council

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

Held: MONDAY, 13 SEPTEMBER 2021 at 5.30pm at City Hall as a hybrid meeting enabling remote participation via Zoom

P R E S E N T :

Councillor Kitterick – Chair
Councillor Morgan – Vice Chair

Councillor Fonseca	Councillor Grimley
Councillor Hack	Councillor March
Councillor Smith	Councillor Whittle

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

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15. CHAIRS ANNOUNCEMENTS

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

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

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

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

16. APOLOGIES FOR ABSENCE

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

17. DECLARATIONS OF INTEREST

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

18. MINUTES OF PREVIOUS MEETING

RESOLVED:

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

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

None outstanding.

20. PETITIONS

The Monitoring Officer reported that no petitions had been received.

21. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

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

- Health Service Journal report

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

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

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

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

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

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

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

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

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

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

It was recognised that it was a necessary part of the process for colleagues in the New Hospital Programme to challenge each of the Pathfinder schemes,

this was a proper process on behalf of the treasury for delivery and value for money.

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

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

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

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

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

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

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

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

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

- Integrated Care System

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

Q3 Please can you also explain the relationship between the main ICS NHS

Board and the ICS Health and Care Partnership Board, and tell me what each will focus on and the balance of power between them?

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

From Tom Barker: Q3 “NHS representatives have stated that there will be no private companies on the Integrated Care Board. Can you assure me there will be no private companies on the Integrated Care Partnership, on ‘provider collaboratives’, or committees of providers, or any sub-committees of the Integrated Care Board or Integrated Care Partnership?”

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

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

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

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

understand the general geographic areas, approximate funding requirements and where funding streams will come from."

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

The Chair invited David Sissling to respond

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

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

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

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

The next step of the improvement process will be to embed genuine co-production techniques throughout the system to redesign services and tackle health inequalities in partnership with people and communities. We will also

learn from recognised good practice and build on the expertise of all ICS partners.

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

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

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

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

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

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

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

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

Regarding private companies the Membership and terms of reference for the ICS Partnership and the NHS Integrated Care Board were still under

development, although any private companies were not expected to be members of these groups.

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

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

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

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

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

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

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

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

Sally Ruane in relation to accountability asked for confirmation that meetings would be held publicly monthly and in relation to ICS Board meetings, what the

timescale for opening these up was?

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

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

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

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

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

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

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

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

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

- <u>UHL Reconfiguration</u>

From Sally Ruane: Q2: "My question to the Joint Health Scrutiny meeting in

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

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

The Chair thanked all for their questions and responses.

AGREED:

That full written responses be appended to the final minutes.

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

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

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

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

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

Dr Janet Underwood from Healthwatch commented that there were mixed messages that needed clarification. Some practices were not accepting NHS patients but would if they paid privately; children were not being seen regularly

and some patients were waiting up to 3 years for orthodontal treatment.

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

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

AGREED:

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

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

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

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

It was noted that:

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

Images of the new Kensington building were viewed and noted.

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

Members of the Commission welcomed the presentation, expressing positive comments about the smooth transition and commented on how good the building and unit looked. Members asked that their thanks be passed on to the staff who made this happen and that everyone involved in save Glenfield should be assured seeing everything transitioned across so well.

The ensuing discussion included the following points:

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

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

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

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

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

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

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

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

In terms of splitting adult and children's cardiac service from Glenfield e.g. staff/peer support, there had been long term planning and especially in lead up to the transition around recruitment. UHL also invested in training as part of the programme and up skilling staff at LRI side too. UHL had invested to have the right teams on both sites and to support staff moving sites and UHL was

confident they now had two very good stand alone services although there were still some services that are joint.

The Chair thanked officers for their responses.

AGREED:

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

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

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

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

It was noted that:

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

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

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

Regarding the vaccination programme for 12-15 years olds and the issue of parental consent, it would be an opt in programme that followed tried and tested practice for other vaccination programmes. However, because it was Covid there was more contention and so there was work around that in terms of parental consent and whether children who are conscient may be able to

consent for themselves.

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

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

The Covid Booster vaccination programme would commence from September.

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

Slides on geographical coverage were noted (appended).

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

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

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

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

It was queried whether there were steps to encourage more teachers to be vaccinated especially in schools with vulnerable pupils. In reply it was

explained this was not a data set captured nationally, however there was awareness that the vaccination initially had been limited by process of age and there was a push by teachers for them to receive the vaccination sooner.

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

AGREED:

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

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

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

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

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

The ensuing discussion with Members included the following points:

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

AGREED:

That further detail be provided in relation to the response given

around post-partum/post-natal care numbers in the County for women who delivered out of area.

26. INTEGRATED CARE SYSTEMS UPDATE

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

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

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

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

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

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

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

There was a brief discussion around what the NHS offered and the role of scrutiny to challenge process, as an example it was noted that audiological services were not always available on NHS but could be sought privately, this

was an interesting point that came back to statutory obligations. There was also the issue around NHS or private prescriptions and members were informed that although there was a lot of discretion to create the care system appropriate for LLR it was subject to statutory obligations.

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

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

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

AGREED:

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

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

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

28. WORK PROGRAMME

Work programme received and noted.

29. DATE OF NEXT MEETING

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

30. ANY OTHER URGENT BUSINESS

None notified.

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