Leicester
City Council

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

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

P R E S E N T :

Cllr Patrick Kitterick – Chair
Cllr Jonathan Morgan – Vice Chair

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

In attendance

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

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1. CHAIRS ANNOUNCEMENTS

The Chair welcomed those present and led introductions.

2. APOLOGIES FOR ABSENCE

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

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

3. DECLARATIONS OF INTEREST

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

4. MINUTES OF PREVIOUS MEETING

RESOLVED:

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

5. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS

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

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

6. COMMITTEE MEMBERSHIP

RESOLVED:

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

7. COMMITTEE TERMS OF REFERENCE - WORKING ARRANGEMENTS

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

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

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

RESOLVED:

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

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

8. PETITIONS

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

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

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

9. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

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

10. ANALYSIS OF UHL ACUTE AND MATERNITY RECONFIGURATION CONSULTATION RESULTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

route.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Also noted:

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

releasing some of the Leicester General Hospital site.

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

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

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

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

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

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

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

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

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

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

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

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

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

During the ensuing discussion the following points were noted:

Concerns were raised about the UHL Financial arrangements, deficit budget

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CCGs how much capital and revenue has been allocated to community services has not been answered on the grounds that only UHL acute capital is being considered. We were, therefore pleased the June CCGs Extraordinary Board Meeting approved “creating a primary care urgent treatment centre at Leicester General Hospital site and scope further detail on proposals for developing services at the centre based upon feedback and further engagement with the public.” Can the CCG explain why proposals did not also included community services for residents across LLR which are needed as a consequence of reconfiguration?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The ensuing discussion with members included the following points:

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

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

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

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

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

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

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

RESOLVED:

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

11. COVID-19 VACCINATION PROGRAMME UPDATE

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

There were no questions from Members.

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

RESOLVED:

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

12. WORK PROGRAMME

RESOLVED:

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

13. ANY OTHER URGENT BUSINESS

Councillor Hack made the following submission:

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

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

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

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

RESOLVED:

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

14. DATES OF COMMITTEE MEETINGS 2021/22

Future scheduled meetings noted as follows:

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

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

There being no further business the meeting closed at 9.10pm

Minute Item 10

Questions and answers – JHOSC

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

From Jean Burbridge:

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

Response

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

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

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

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

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

   a) *LLR CCG and UHL have both demonstrated significant respect and understanding in their discharge of their Equality Duty and the wider duties to reduce inequalities conferred on the CCG under the NHS Act 2006?*
   b) *The efforts since 2018 to engage with representatives of those from protected groups is significant and has generated immensely useful feedback that is already being actively used to inform continued engagement and future decision making.*

c) *The responses are largely proportionate to the broad geographic and demographic diversity of the LLR population, indicating that a comprehensive range of views have been garnered.*
d) *Engagement with diverse communities that has now commenced, is appropriately regarded as a steppingstone, is ongoing and yet to fully reach potential.*
e) *Through the introduction of their Inclusivity Decision Making Framework, there is a commitment to embed such approaches routinely in practice.*
f) *The value of material arising from the views of the local and diverse population of Leicester, Leicestershire and Rutland is potentially rich, and to be capitalised upon. Feedback will inform decisions over many years to come. Those decisions are based upon the belief that service providers are accountable to the population they serve in promoting equality, reducing inequalities, determining resource allocation in modernised, cost effective and efficient ways.*

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

From Giuliana Foster:

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

Response

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

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

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

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

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

From Brenda Worrall:

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

Response

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

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

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

From Godfrey Jennings:

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

Response

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

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

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

From Sarah Patel:

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

Response

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

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

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

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

Response

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

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

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

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

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

Response

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

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

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

3. Any attempt to clarify with the CCGs how much capital and revenue has been allocated to community services has not been answered on the grounds that only UHL acute capital is being considered. We were, therefore pleased the June CCGs Extraordinary Board Meeting approved "creating a primary care urgent treatment centre at Leicester General Hospital site and scope further detail on proposals for developing services at the centre based upon feedback and further engagement with the public." Can the CCG explain why proposals did not also included community services for residents across LLR which are needed as a consequence of reconfiguration?

Response

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

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

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

Response

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

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

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

From Lorraine Shilcock:

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

Response

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

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

Response

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

From Sally Ruane:

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

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

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

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

1. I would like to know if this practice is legal.
2. I would like to know if this is seen as good practice and what dangers were considered in deciding to proceed with these agreements.
3. Are the CCGs able to tell us what steps they took to ensure that organisations under contract informed their members/followers in any engagement they (the organisations) had with their members/followers that they were working under a service level agreement which contained an 'impartiality clause'.
4. How many of the 5,675 responses to the consultation were as a result of these contracts?
5. What changes have been made to the Building Better Hospitals for the Future proposals following public – not clinical- feedback?

Response

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

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

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

The full clause read as follows:

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

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

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

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

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

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

From Janet Underwood:

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

<u>Response</u>

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

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

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

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

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

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

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

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

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

Response

St Marys Birth Centre	*14*

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

Response

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

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

Response

Leicester General Hospital	42
Leicester Royal Infirmary	37

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

Response

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

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

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

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

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

Response

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

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

Summary:

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

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

Main body of report

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

Question from Councillor Melissa March in relation to VCS partners

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

Response

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

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

Question from Cllr Phil King in response to Hydrotherapy

Provision and location of hydrotherapy pools in the community.

Response

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

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

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

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

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

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

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

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

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

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

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