Leicestershire County Council

Meeting: **Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee**

Date/Time: **Friday, 5 March 2021 at 10.00 am**

Location: **Microsoft Teams video link**

Contact: **Euan Walters (0116 3052583)**

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Membership

Dr. R. K. A. Feltham CC (Chairman)

Cllr. T. Aldred	Mr. J. Morgan CC
Mukesh Barot	Mr. J. T. Orson JP CC
Cllr. P. Chamund	Mrs. R. Page CC
Cllr. L. Fonseca	Mr T. Parton CC
Mrs. A. J. Hack CC	Cllr. D. Sangster
Mrs S Harvey	Dr Janet Underwood
Dr. S. Hill CC	Miss G. Waller
Cllr. P. Kitterick	Cllr. P. Westley
Cllr. M. March	

Please note: This meeting will not be open to the public in line with Government advice on public gatherings.

The meeting will be filmed for live or subsequent broadcast via YouTube: https://www.youtube.com/channel/UCWFpwBLs6MnUzG0WjejrQtQ.

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 23 September 2020.		(Pages 5 - 10)
2.	Minutes of the meeting held on 14 December 2020.		(Pages 11 - 40)
3.	Question Time.		

4.	Questions asked by Members.		
5.	Urgent items.		
6.	Declarations of interest.		
7.	Presentation of Petitions.		
8.	System Update: Winter Pressures Review and NHS 111 First.	Leicester, Leicestershire and Rutland Clinical Commissioning Groups, University Hospitals of Leicester NHS Trust	(Pages 41 - 56)
9.	Covid-19 Vaccination Programme.	Leicester, Leicestershire and Rutland Clinical Commissioning Groups	(Pages 57 - 64)
10.	University Hospitals of Leicester NHS Trust Audit.	University Hospitals of Leicester NHS Trust	(Pages 65 - 88)
11.	Chairman's Announcements.		

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 1

Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held via Microsoft Teams video link on Wednesday, 23 September 2020.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Mukesh Barot	Mr. J. T. Orson JP CC
Mrs. A. J. Hack CC	Mrs. R. Page CC
Mrs S Harvey	Mr T. Parton CC
Dr. S. Hill CC	Cllr. D. Sangster
Cllr. P. Kitterick	Dr Janet Underwood
Cllr. M. March	Miss G. Waller

In attendance
Caroline Trevithick, Deputy Chief Executive, LLR CCGs (minute 8 refers).
Sara Prema, Executive Director of Strategy and Planning, LLR CCGs (minute 8 refers).
Sam Leak, Director of Operational Improvement, UHL (minute 8 refers).
Eleanor Meldrum, Deputy Chief Nurse, UHL (minute 8 refers).
Tamsin Hooton, Assistant Director of Urgent and Emergency Care, LLR CCGs (minute 9) refers).

1. Chairman and Vice Chairman.

It was noted that as per the Working Arrangements and Terms of Reference of the Committee, for the 2020/21 year the Chairman Dr. R.K.A Feltham CC was nominated by Leicestershire County Council and the Vice Chairman Cllr. Patrick Kitterick was nominated by Leicester City Council.

2. Minutes of the previous meeting.

The minutes of the meeting held on 3 July 2020 were taken as read, confirmed and signed.

3. Question Time.

The Chief Executive reported that two questions had been received under Standing Order 34.

1. Question by Mrs Sally Ruane

How many JHOSC meetings will take place during the period of the forthcoming NHS consultation and will they scrutinise the proposals for acute hospital reconfiguration?

Reply by the Chairman:

Assuming the consultation runs to the planned timetable, two meetings of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee are due

to take place during the consultation period (those meetings are currently scheduled for 15 October 2020 and 14 December 2020) and it is intended that the UHL Acute and Maternity Reconfiguration consultation will be on the agenda of both those Committee meetings.

2. Question by Mrs Sally Ruane:

Will the JHOSC use its powers to collect evidence from a range of individuals and groups in the community regarding the acute hospital reconfiguration proposals?

Reply by the Chairman:

The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee is expecting senior representatives from UHL and LLR CCGs to attend Committee meetings to present and answer questions on the UHL Acute and Maternity Reconfiguration consultation. Whilst the Committee does not intend to independently call witnesses relating to the consultation nor conduct research separately to UHL and LLR CCGs, the Committee meetings are public and residents of Leicestershire, Leicester and Rutland are welcome to submit comments and questions to the Committee which the Committee will have regard to when formally responding to the consultation.

Supplementary Question

Mrs Ruane asked whether the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee would be taking advice from The Consultation Institute when scrutinising the UHL Acute and Maternity Reconfiguration consultation.

The Chairman replied as follows:

Members of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee have already provided the CCGs feedback on the UHL Acute and Maternity Reconfiguration consultation plans and Pre-Consultation Business Case at a private meeting on 20 August 2020, however the Chairman would take advice from County Council officers on whether the Committee required any further input from consultation experts.

4. Questions asked by Members.

The Chairman reported that no questions had been received from members under Standing Order 7(3) and 7(5).

5. Urgent Items.

There were no urgent items for consideration.

6. Declarations of Interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting. No declarations were made.

7. Presentation of Petitions.

The Chairman reported that no petitions had been received under Standing Order 35.

8. Covid-19 Update.

The Committee considered a joint report of the three Clinical Commissioning Groups in Leicester, Leicestershire and Rutland (CCGs), and University Hospitals of Leicester NHS Trust (UHL), which provided an update on the actions taken by the local NHS to ensure preparedness for the increased pressures caused by the Covid-19 pandemic, and actions being taken to recover and restore non-COVID services in particular those relating to cancer. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Caroline Trevithick, Deputy Chief Executive, LLR CCGs, Sara Prema, Executive Director of Strategy and Planning, LLR CCGs, Sam Leak, Director of Operational Improvement, UHL and Eleanor Meldrum, Deputy Chief Nurse, UHL.

Arising from discussions the following points were noted:

(i) Concerns were raised by a member that the cancer presentation slides included in the agenda pack were difficult for a lay person to understand. In response the CCG agreed to provide the Committee with more easy to read documentation regarding cancer performance with the technical issues explained.

(ii) The Single Access Point telephone number was available to the public to call and access mental health services throughout the Covid-19 pandemic. There were plans to invest in mental health locally and ensure the Mental Health Standards were adhered to.

(iii) Reassurance was given that NHS managers in UHL provided support to colleagues with regards to their wellbeing and mental health and a letter of thanks had been sent to all staff from the Chief Executive and Chairman. Professional development of NHS staff was being continued despite the pandemic as it was felt this was good for staff wellbeing.

(iv) NHS managers were quick to recognise where hotspots were occurring in terms of service demand and where services were being impacted due to staff shielding, and managers allocated the appropriate staffing cover.

(v) Members questioned whether patients with cardiac or mental health issues were being deterred from presenting at hospitals during the Covid-19 pandemic. It was agreed that the CCGs would provide an answer to members after the meeting.

(vi) Concerns were raised by members that the communications process for reminding patients to have their flu vaccine was confusing and as a result it was difficult for members to explain to the public how the process worked and if and when patients would be contacted. Further concerns were raised that patients that decided not to have flu vaccines in previous years may wish to have one this year but could get missed from any communications. The CCGs offered to provide members with written clarification of the communication process after the meeting.

(vii) The PPE Portal had a weekly order limit for each NHS service to prevent each service stockpiling PPE when it was needed elsewhere. Members queried what would happen should the limit be exceeded and requested further data regarding the PPE weekly order limit. Reassurance was given by the CCGs that the PPE process had worked well so far during the pandemic.

(viii) Many elderly people appreciated the reassurance of a face to face medical appointment and the NHS acknowledged that they could not entirely rely on video consultations and reassured that there were plans for some face to face appointments to still take place where it was clinically appropriate.

(ix) The Phase 3 recovery plans as set out in the letter dated 31 July 2020 from NHS Chief Executive Sir Simon Stevens had not been put on hold as a result of the recent increase in new Covid-19 cases. The recovery planning was happening at the same time as the planning for surges in demand was taking place. The recovery status was reviewed twice a week. Health services were not expected to return to exactly as they were before the pandemic began and there was no precise date for when the 'new normal' would be reached.

RESOLVED:

(a) That the update on the actions taken in the local NHS to ensure preparedness for the increased pressures caused by the Covid-19 pandemic, and the actions being taken to recover and restore non-COVID services, be noted.

(b) That officers be requested to provide a report for a future meeting of the Committee on the impact of Covid-19 on dentistry in Leicester, Leicestershire and Rutland.

9. <u>NHS 111 First.</u>

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) regarding the NHS 111 First initiative which aimed to ensure that patients attended the appropriate NHS facility for their needs and did not attend the Accident and Emergency Department when there were other more appropriate venues for them to receive healthcare. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed to the meeting for this item Tamsin Hooton, Assistant Director of Urgent and Emergency Care, LLR CCGs.

Arising from discussions the following points were noted:

(i) Members felt that the public needed greater clarity on what NHS 111 was for and when they should use it. Members emphasised the importance of clear communication to the public regarding which services they could use and when, particularly in relation to whether patients needed to make appointments before attending urgent care centres. It was suggested that flow charts could be used to demonstrate to the public how NHS 111 interlinked with the rest of the local health services.

(ii) Consideration needed to be given to how the NHS communicated with people that resided in rural areas and whether print media or leaflet drops were the best method.

(iii) Members raised concerns regarding the capacity of the NHS 111 service and whether it would be able to cope with additional demand caused by NHS 111 First publicity. In response reassurance was given that the scheme would not be promoted to the local population until the level of resilience was certain and a soft launch would take place over the coming weeks. Should the local NHS 111 service be overloaded with calls then the calls were automatically transferred to NHS call handlers elsewhere in the country.

(iv) Concerns were raised by members that the NHS 111 call handlers had no clinical training and were merely following a checklist in order to refer patients for the appropriate advice and/or treatment. In response reassurance was given that as a result of national funding that had been received additional call handlers and clinicians were being recruited for the NHS 111 service and consideration was being given to the mix that was required. There were times when it was better for the call handler to send a patient straight to the Emergency Department rather than referring them to talk to a clinician on the phone.

(v) After the initial call between a patient and the NHS 111 service had taken place, two further attempts would be made by NHS 111 to contact the patient and ensure their wellbeing. There was a risk that should the patient miss those two further calls they would lose contact with the NHS, however patients were advised to attend the Emergency Department if they were unable to access any other kind of support.

(vi) Patients that lived near County borders would be referred to the nearest Emergency Department to where they resided even if it was in a different County, they would not automatically be referred to the Emergency Department in their own County. It was agreed that further details would be provided to members after the meeting regarding how the system chose which medical facilities to refer patients to.

(vii) Members were interested to see more data on the numbers of patients attending the Emergency Department as opposed to calling NHS 111. They were also interested in seeing any data from the pilots which took place in Devon and London. The CCG agreed to find out what data could be shared with members.

(viii) Given that patients were being advised to stay away from Leicester Royal Infirmary wherever possible a member questioned whether drugs could be accessed locally out of hours and whether there could be stock piles at community hospitals. The CCGs agreed to investigate this situation and report back to members.

RESOLVED:

That the update on NHS 111 First be noted.

10. <u>Director of Public Health for Leicestershire update on Covid-19.</u>

The Director of Public Health for Leicestershire gave a verbal update on the spread of Covid-19 in Leicester, Leicestershire and Rutland and the measures being taken to prevent further spread.

Arising from the Director's update the following points were noted:

(i) Leicester City was no longer an outlier with regards to the numbers of people testing positive for Covid-19. The figures were broadly similar to the rest of the nation. There was a trend that the Districts of Leicestershire which were closer to Leicester City centre such as Blaby, and Oadby and Wigston, had higher numbers of positive Covid-19 cases than other Districts.

(ii) An announcement from the Prime Minister was expected that day which could introduce further social restrictions in England.

(iii) The Director of Public Health acknowledged concerns raised by members regarding delays in Covid-19 testing results being received. He explained that some of these delays were due to backlogs at the testing laboratories and provided some reassurance that the Lighthouse Laboratory in Loughborough would provide additional testing capacity. Testing slots and lab capacity was protected for Leicester and Leicestershire residents to ensure there was sufficient capacity for local people. Testing needed to be prioritised for those that had Covid-19 symptoms and this message appeared to be getting through to the public locally if not nationally.

(iv) Members requested an update on what level of antibody testing was taking place and the Director of Public Health agreed to provide an update after the meeting.

(v) A member raised concerns that some Leicestershire residents were deterred from taking Covid-19 tests because a positive result would affect their insurance. The Director of Public Health agreed to investigate this after the meeting.

(vi) A member requested to receive local data regarding the percentages of patients in hospital with and without Covid-19, how many Intensive Care Unit admissions there had been for patients with Covid-19, and how many hospital deaths from Covid-19 there had been. UHL agreed to establish whether this information could be made available and provide it to the Committee after the meeting.

RESOLVED:

That the update from the Director of Public Health be noted.

11. Date of next meeting.

RESOLVED:

That the next meeting of the Committee take place on 15 October 2020 at 10:00am.

10.00 am - 12.45 pm
23 September 2020

CHAIRMAN

Agenda Item 2

Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held via Microsoft Teams video conferencing on Monday, 14 December 2020.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Cllr. T. Aldred
Mukesh Barot
Cllr. P. Chamund
Cllr. L. Fonseca
Mrs. A. J. Hack CC
Mrs S Harvey
Dr. S. Hill CC
Cllr. P. Kitterick
Cllr. M. March
Mr. J. Morgan CC
Mr. J. T. Orson JP CC
Mrs. R. Page CC
Mr T. Parton CC
Cllr. D. Sangster
Dr Janet Underwood
Miss G. Waller
Cllr. P. Westley

In attendance

Andy Williams, Chief Executive, LLR CCGs (minute 28 refers).
Richard Morris, Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group (CCG) (minute 28 refers).
Sara Prema, Executive Director of Strategy and Planning, Leicester City CCG (minute 28 refers).
Rebecca Brown, Acting Chief Executive, UHL (minute 28 refers).
Mark Wightman, Director of Strategy and Communications, UHL (minute 28 refers).
Ian Scudamore, Director of Women's and Children's Services, UHL (minute 28 refers).
Justin Hammond, Head of UHL Reconfiguration PMO, UHL (minute 28 refers).
Florence Cox, Community Midwifery Matron, UHL (minute 28 refers).
Caroline Trevithick, Chief Nurse and Executive Director of Nursing, Quality and Performance, West Leicestershire Clinical Commissioning Group (minute 29 refers).

Note: The meeting was not open to the public in line with Government advice on public gatherings however the meeting was broadcast live via YouTube.

22. Minutes of the meeting held on 15 October 2020.

The minutes of the meeting held on 15 October 2020 were taken as read, confirmed and signed.

23. Question Time.

The Chief Executive reported that 13 questions had been received under Standing Order 34.

1. Question by Godfrey Jennings

In light of the Covid pandemic and limited awareness among the general public of the Better Hospitals for the Future consultation and that no community provision assurances have been given do you not think an extension of the consultation period should be considered?

Reply by the Chairman:

I have put this question to the Clinical Commissioning Groups and they have provided the following response:

"When looking at the current circumstances the world finds itself in, then in order to fulfil our duty and to continue to exercise our functions we have adapted our processes to achieve that objective. The use of technology to hold meetings, share information and promote the consultation has enabled a wider reach across communities. This activity has been combined with off-line activities to reach communities not digitally enabled. We are able to measure the majority of our activities confidently. This demonstrates that the vast majority of adults across Leicester, Leicestershire and Rutland will have had the opportunity to be aware of the proposals, often through multiple channels, and participate in the consultation process if they wish.

We are confident that our activities to date and the approach we have taken has allowed us to meet both our statutory and common law duties. Therefore we see no reason to extend the consultation period, which will close on 21 December 2020."

2. Question by Glynn Cartwright, Melton Mowbray

I, along with many others, am deeply concerned that the UHL Acute and Maternity Reconfiguration consultation process itself contravenes the Gunning Principle of those being consulted having sufficient information to respond appropriately to what is being asked of them.

Given that the proposals signify a particular loss of services to the communities of Melton Mowbray and Rutland specifically and generally
to North East Leicestershire, East Leicestershire and South Nottinghamshire areas:

a) What steps have been taken to ensure information has been adequately provided in these population groups, about which exact services are going to be lost, especially with those who are not able to access online meeting facilities or use the internet frequently?

Reply by the Chairman:

The NHS bodies involved in this decision-making process have been quite clear what acute services they intend to move, why and the impact of the change, which means the Gunning Principle referred to has been met.

NHS England and Improvement run a thorough assurance process on all service reconfiguration programmes which are undertaking public consultation and, throughout this process, the CCGs have been advised by Gerard Hanratty of Browne Jacobson, who is a solicitor specialising in public law and service reconfiguration advice for the NHS.

This ensures the CCGs have been advised on their compliance with both their statutory duties and common law obligations, including those set out in the Gunning Principles.

When looking at the current circumstances the world finds itself in, then in order to fulfil their duty and to continue to exercise their functions the CCGs had to adapt their processes to achieve that objective.

The pandemic has shown how technology can be used to involve and engage the public on a range of issues. The CCGs have adapted and adopted new ways of working including the use of technology which has enabled them to reach more communities. This is in addition to off-line communications and engagement activities in order to reach people not digitally enabled.

To reach people the CCGs have used a variety of both online and offline tools and techniques. These are set out elsewhere in the papers for this meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee and the Committee will further scrutinise the issue during the meeting.

b) Can you confirm the areas that have received a leaflet to their home addresses regarding the proposals, and explain why there has not been a leaflet provided to ALL households in LLR as promised, even at this late stage in the consultation process?

Reply by the Chairman:

The CCGs have undertaken solus door drops of an information leaflet to 440,000 residential properties across Leicester, Leicestershire and Rutland. In addition, rural communities in Rutland were sent a leaflet via Royal Mail as solus was not an option.

Whilst many people have said that they have received this leaflet, the CCGs are also aware that some believe they have not. Solus delivery is not an exact science and is dependent on many key factors. This includes the attitude of recipients to unsolicited deliveries, with some people simply disposing of leaflets immediately upon receipt. Other issues include the volume of marketing material being received by households, which can reduce the impact and recall of specific items, as well as the exposure of different people within the household to the material following delivery.

The CCGs have raised concerns from residents with their delivery partners who have provided GPS tracking information for their agents. This is in addition to feedback from telephone calls to a sample of homes within each of the postcode areas to validate delivery, which is undertaken by an organisation called DLM.

However, it is important to recognise that the door-drop is only one small part of the overall awareness activities CCGs have undertaken, details of which can be found elsewhere in the papers for this meeting and the Committee will seek further reassurances during the meeting regarding this issue.

c) Can you outline the reasons the Clinical Commissioning Group have gone ahead with a consultation of this magnitude, during the restrictions of a global pandemic, when engaging with the issues at hand is more challenging for those whom it impacts, and many are more focussed on the problems caused by Covid 19?

Reply by the Chairman:

I have put this question to the Clinical Commissioning Groups and they have provided the following answer:

"The CCGs recognise that the world has changed, for everyone, not just the NHS. One of the only *certainties* being that we will be living with increased *uncertainty* for a long time.

That being the case it is tempting for organisations to shelve plans, put off decisions and hunker down, in the hope that the future becomes more certain or that someone comes along to tell them what to do.

The CCGs think that is the wrong approach especially now when we consider all that we have learnt in planning for, and dealing with, the impact of the first wave.

So, at the heart of the clinical strategy (which drives the £450m reconfiguration plan) is the desire to focus emergency and specialist care at the Royal and the Glenfield hospitals and separate non-emergency care from emergency care so that when the hospitals are very busy those patients waiting for routine operations are not delayed or cancelled because of having to prioritise an influx of emergency patients.

More recently, the CCGs have asked 'Does this still make sense when we look at what the pandemic has taught us?' The CCGs believe the short answer is yes, and these are the reasons:

Intensive Care:

One of the biggest challenges faced preparing for the first COVID peak was to create enough adult Intensive Care Unit (ICU) capacity. In steady state UHL have 50 ICU beds, the initial pandemic modelling suggested that UHL would require closer to 300 beds. Which was a daunting ask of clinical teams. Nonetheless within a fortnight UHL had a plan to increase its capacity in line with the peak, largely as a result of converting every available space with the right oxygen supply into makeshift ICUs and by suspending children's heart surgery so that we could convert children's ICU, into adult ICU.

Thankfully, largely as a result of the success of lockdown halting the spread of the virus, the peak was not as pronounced as first expected and UHL had at the highest peak, 64 patients in intensive care.

In the reconfiguration plans it is said that UHL will create two 'Super ICUs' at the Royal and the Glenfield doubling capacity to over 100 ICU beds. Had these been in place at the time of the pandemic UHL's response would have been very different; they would have had enough ICU capacity with plenty to spare.

Children's Heart Surgery:

As mentioned above, UHL knew that COVID would require them to care for very many more adult patients on ICU. Mercifully children were less affected by the virus. With limited ICU capacity UHL therefore took the difficult decision to halt children's heart surgery in Leicester, transfer those children awaiting their operation to Birmingham Children's Hospital and convert the Paediatric Intensive Care Unit at the Glenfield into an adult ICU. On balance we took the decision based on what would save the most lives, knowing that our children would still have their surgery albeit not in Leicester and as a

consequence we could care for more of the terribly sick adults whose only hope was sedation and ventilation.

However, in our reconfiguration plans we are going to create a standalone Children's Hospital at the Royal; the first phase completes in spring 2021. Had the Children's Hospital been built we would have been able to continue with heart surgery during COVID knowing that the children were safe in a standalone hospital with a totally separate ICU.

Cancer and Elective operations:

Locally and nationally patients who had been previously listed for operations and procedures were cancelled in very large numbers as hospitals made preparations for the pandemic. This affected all services and all types of patients even some with cancer. The only surgery we were able to continue was for those emergency cases that without an operation within 24-72 hours would have been likely to die. In terms of cancer cases where patients are often immuno-compromised there was the added concern about bringing them into a hospital with positive COVID patients and the impact that this could have if, in their already poorly state they picked up the virus.

In our reconfiguration plans we are going to build a standalone treatment centre at the Glenfield Hospital; this will be a brand new hospital next to the existing hospital. It fulfils our desire to separate emergency and elective procedures. Meaning that when we are busy with high numbers of emergencies, our elective patients still receive care. Had this been in place by the time of the pandemic we would have been able to maintain significant amount of our non-emergency work and create a 'COVID clean' site.

Impact on staff:

Even before the pandemic we regularly struggled to effectively staff our services. The fact that we have three separate hospitals with the duplication and triplication of services that entails means that we often have to spread our staff too thinly in order to cover clinical rotas. During the first peak of COVID we had 20% sickness across all staff groups meaning that 1 in 5 staff were either sick or self isolating. It is a testimony to all our staff that despite this we kept going but it is unsustainable in the long term.

Once reconfigured, we will no longer have to run triplicate rotas for staff on three hospital sites. For example with two super ICUs rather than the current 3 smaller ones we would have been able to consolidate our staffing making it easier to cover absences when they occurred and perhaps even give staff the time to 'decompress' after repeat days of long and harrowing shifts.

Overall, it is clear to us that had the timing been different our hospitals would have been better able to cope with COVID 19 in their reconfigured state and our patients would have received a better, safer service."

d) Can you explain why the removal of the postnatal facility along with the trial of the LGH birth centre is not specifically mentioned in the consultation documents, using misleading language of "relocation", instead of closure, which prevents people from understanding fully the impact of the proposals being consulted on?

Reply by the Chairman:

I have sought a response from the Clinical Commissioning Group/UHL and they have stated the following

"Our proposal and the consultation documents do include the relocation of the midwifery-led unit at St Mary's Hospital to Leicester General Hospital, where it will be accessible to many more women. While we are proposing to move the midwifery-led unit, we would maintain community maternity services in Melton Mowbray. We would ensure that there is support for home births and care before and after the baby is born in the local community. If someone has a complicated pregnancy, antenatal care would be provided in an outpatient service located at Leicester Royal Infirmary or in remote/virtual clinics.

If the consultation shows support for a standalone midwifery-led unit run entirely by midwives, it would need to be located in a place that would be chosen by enough women as a preferred place of birth and ensures fair access for all women regardless of where they live in Leicester, Leicestershire and Rutland. It would also need to be sufficiently close to more medical and specialist services should the need arise.

This is important since it will provide more reassurance to women who may need to be transferred to an acute setting during or after birth. Transfer rates in labour and immediately after birth, according to the Birth Place Study, is currently 45% for first time mums and 10% for 2nd, 3rd or 4th babies.

The consultation document describes the proposed unit as running as a pilot for 12 months to test public appetite for this service with an indicative target of 500 births per year. To be clear, this is not a hard target that must be achieved in year one. Instead we are looking for evidence that a clear trajectory for 500 births in subsequent years is likely to be achieved.

If the consultation shows support for the Midwifery Led Unit at Leicester General Hospital and the proposal is implemented and the centre is open, a review body would be established comprising of midwifes, parents and other stakeholders who will co-produce the service with UHL."

Supplementary Question

Glynn Cartwright submitted that the transfer rate for first time mothers was actually 36.3% not 45% as stated by the Clinical Commissioning Groups and that for 2nd and 3rd time mothers the transfer rate was under 10%. He questioned whether the Clinical Commissioning Groups were serious about allowing St Mary's Birth Centre to succeed or whether they were trying to end the use of birth centres such as St Mary's altogether. The Chairman asked the Clinical Commissioning Groups and UHL to cover these issues as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and advised Glynn Cartwright that he would receive a written answer to his supplementary question after the meeting.

e) Bearing in mind the future of St Mary's Birth Centre has been discussed for over 20 years (ref Ian Scudamore) and more particularly in the last 8-10 years, when did the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee first scrutinise the proposals?

Reply by the Chairman:

At its meetings on 14 December 2016 and 4 September 2018 the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee touched upon issues relating to St Mary's Birth Centre and the UHL Acute and Maternity Reconfiguration plans as part of scrutiny of the Sustainability and Transformation Plan/Partnership (STP). The Committee then began looking in more detail at the reconfiguration plans including the proposal to close St Mary's Birth Centre at its meeting on 24 January 2020, and then held a further meeting on 15 October 2020 where explanations were sought regarding the proposals in relation to St Mary's Birth Centre.

f) At that time did the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee consult with any members of the public, in particular in the affected areas, for their views of the proposals?

If not why not and do you normally make decisions for the public on proposals of this magnitude without asking for their views?

Reply by the Chairman:

The consultation on the UHL Acute and Maternity Reconfiguration plans, including the plans for St Mary's Birth Centre, is being run by the Clinical Commissioning Groups. The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee is a consultee therefore it is not required to carry out consultation with the public on this particular issue. The Committee has not made any decisions regarding the UHL Acute and Maternity Reconfiguration plans. The Committee's role is to scrutinise the way the consultation process is carried out and feed its own views into the consultation. However, the public are welcome to submit comments and questions to the Committee regarding UHL's reconfiguration plans and the Committee will raise those comments and questions with the CCGs/UHL on the public's behalf.

g) What was the outcome of the scrutiny of the proposals undertaken by the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee?

Reply by the Chairman:

The Committee has submitted comments both positive and negative to the CCGs and UHL regarding the Acute and Maternity Reconfiguration proposals and raised some areas of concern. The details of the issues raised are recorded in the minutes of Committee meetings which can be found on the Leicestershire County Council website: http://politics.leics.gov.uk/ieListMeetings.aspx?CommitteeId=1182
However, this scrutiny process is still ongoing and there has been no final outcome.

h) Is the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee acquainted with the paper written recently by Dr Ruane of DMU which suggests the suggestion of closing the SMBC in favour of a new birth centre at LGH is not sustainable?

Reply by the Chairman:

The Committee is aware of the paper written by Dr Ruane and it has been included in the agenda pack for this meeting.

3. Question by Louise Wilkinson

I stayed at St Mary's from the 28th September to 1st October, during this time the staff at St Mary's literally helped me to keep my baby alive through breastfeeding. I required hourly face to face support from the staff in St Mary's and would not have been able to feed my baby had I not been receiving post-natal support on the ward. How can you claim that mothers will be able to access the same level of post-natal support through community care and watching online videos after the closure of St Mary's? In the same situation would I be able to call a mid-wife to my house every hour during the night to help me feed?

Reply by the Chairman:

I have put this question to the Clinical Commissioning Groups and they have provided the following response:

“There is the full expectation that short term postnatal stays for uncomplicated pregnancies and births will be provided in both the proposed standalone midwifery led unit and in the birth centre running alongside the proposed new Maternity Hospital at Leicester Royal Infirmary. Taking this into account, and from looking at the details of patients using the facility, it is clear that in the overwhelming majority of cases it is more appropriate for those new mums to be recovering at home, away from the risks, including from infection, of being in a communal inpatient areas. From there they will be able to access support including from family and experience the essential mother and family bonding in familiar surroundings. Access to care can either be delivered in that home setting or through community-based drop-in type services.

Of course, we recognise that some mums require additional inpatient postnatal care for clinical reasons, either maternal or neonatal and, where this is the case, it is important that they are cared for in an appropriate medical environment. Under our proposals this would be provided from the new maternity hospital at Leicester Royal Infirmary.

Sadly we do not believe that it would be possible to provide this kind of service from a community location. Most significantly this is because of the requirement for around-the-clock 24/7 medical cover.”

4. Question by Louise Wilkinson.

I live on Craven Street, please can you explain to me why I have not received a leaflet to my home explaining the planned changes and consultation process?

Reply by the Chairman:

The CCGs have undertaken a solus door drops of an A5 information leaflet to 440,000 residential properties across Leicester, Leicestershire and Rutland. In addition, rural communities in Rutland were sent a leaflet via Royal Mail as solus was not an option.

Whilst many people have said that they have received this leaflet, I am also aware that some believe they have not. Solus delivery is not an exact science and is dependent on many key factors. This includes the attitude of recipients to unsolicited deliveries, with some people simply disposing of leaflets immediately upon receipt. Other issues include the volume of marketing material being received by households, which can reduce the impact and recall of specific items, as well as the exposure of different people within the household to the material following delivery.

The CCGs have raised concerns from residents with their delivery partners who have provided GPS tracking information for their agents. This is in addition to feedback from telephone calls to a sample of homes within each of the postcode areas to validate delivery, which is undertaken by an organisation called DLM.

Industry standards dictate that feedback from these telephone calls would expect to establish a level of positive recall of between 40% - 60% to substantiate that deliveries have been completed to the standards expected. We are still receiving the community reports from this exercise, but at the moment the recall is within this range for communities across Leicester, Leicestershire and Rutland.

However, the door-drop is only one small part of the overall awareness activities the CCGs have undertaken. These are set out elsewhere in the papers for this meeting of the Joint Health Scrutiny Committee and the Committee will seek further reassurances regarding this issue during the meeting.

5. Question by Louise Wilkinson

At 22 weeks pregnant I had to travel by car to Leicester General Hospital as I was suspected of going into early labour- the journey took me over an hour. Please can you explain to me, if it's not acceptable for women in the city to travel to Melton Mowbray, why is it acceptable for women in Melton Mowbray to travel to the city, where there is increased traffic, surely this will add to the congestion?

Reply by the Chairman:

Reviews of maternity services have identified that the standalone birthing centre at St Mary's Hospital in Melton Mowbray is not accessible for the majority of women in Leicester, Leicestershire and Rutland. It is also under-used with just one birth taking place approximately every three days, despite attempts to increase this number. This means the unit is unsustainable, both clinically and financially.

The CCGs/UHL believe underutilisation of the unit may, at least in part, be due to concerns over the length of journey from Melton Mowbray to Leicester should mum or baby experience complications during the birth, as well as its relative inaccessibility to the majority.

The proposal would see the relocation of the midwifery-led unit at St Mary's Hospital to Leicester General Hospital, subject to the outcome of the consultation. While it is proposed to move the midwifery-led unit, community maternity services in Melton Mowbray would be maintained. It would be ensured that there is support for home births and care before and after the baby is born in the local community. If someone has a complicated pregnancy, antenatal care would be provided in an outpatient service located at Leicester Royal Infirmary or in remote/virtual clinics.

Access at Leicester Royal Infirmary site where it is proposed to develop the new Maternity Hospital would actually be easier in future. This is because it is proposed to provide approximately 100,000-day case procedures and 600,000 follow up appointments done each year in a different way e.g., carried out closer to home in the community which is what patients say they want. More appointments will also be done remotely, over the phone and via the internet. Others will move to the new Treatment Centre at Glenfield Hospital

UHL are also creating extra parking spaces on site at both Glenfield and the Royal Infirmary so access and parking would be easier.

6. Question by Liz Warren

Has the Clinical Commissioning Group seen or asked for any evidence to support UHL's assertion that St Mary's Birth Centre is not cost-effective? If there is evidence can the Joint Committee request the CCG/UHL to publish it?

How can UHL justify the 500 births a year requirement for the midwifery unit at the General to be considered viable?

Reply by the Chairman:

I have put these questions to the Clinical Commissioning Groups and they have provided the following response:

"The Clinical Commissioning Groups have worked closely with UHL to develop these plans and supports the Pre-consultation Business Case, which was approved by the Clinical Commissioning Group Governing Body. The plans have also been independently reviewed by NHS England, as well as clinicians locally and regionally to test their appropriateness.

When considering the financial viability and sustainability, looking at births alone is not reflective of the wider value. The model of providing 24 hour cover for 130 births as opposed to 500 is more expensive per birth. In a bigger unit midwives have more opportunity to maintain skills, and students will receive a more meaningful learning experience. There is a gap in Midwifery Led Birthing Unit's nationally between capacity (the number of births that can take place) and actual use, all of which are underutilised. If we can care for 500+ women then costs per birth with the staffing models to support this will prove cost effective and sustainable.

The consultation document describes the proposed unit as running as a pilot for 12 months to test public appetite for this service with an indicative target of 500 births per year. To be clear, this is not a hard target that must be achieved in year one. Instead they are looking for evidence that a clear trajectory for 500 births in subsequent years is likely to be achieved.

If the consultation shows support for the Midwifery Led Unit at Leicester General Hospital and the proposal is implemented and the centre is open, a review body would be established comprising of midwifes, parents and other stakeholders who will co-produce the service with UHL."

The Committee will further scrutinise this issue during the meeting.

Supplementary Question

Liz Warren asked if she could see the facts and figures which supported the assertion that St Mary's Birth Centre was not cost-effective? The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and also stated that Liz Warren would receive a written answer after the meeting.

7. Question by Kathy Reynolds

Neuro Rehabilitation services were for many years provided in Wakerley Lodge in the grounds of LGH. It was a 1980's purpose built centre with plenty of space both indoor and outdoor for therapy, wider corridors and moving space for wheelchairs, purpose designed bedrooms, bath/shower areas with hoists, a "gym", and a central communal area for social and occupational activities. By 2016 it had been allowed to fall into such a poor state of repair that the patients were moved out on a "temporary basis" into Ward 2 at Leicester General Hospital, they are still there. This is a conventional ward, cramped for space and having none of the special facilities of Wakerley Lodge. Over the last few years, therapists have performed heroics with their disabled patients in these conditions. Is the Joint HOSC satisfied that the services formerly provided to severely disabled people at Wakerley Lodge Neuro Rehab Centre have been adequately considered in the reconfiguration plans for UHL? There is little evidence in the PCBC document to suggest it has. Does it not suggest the needs of these disabled people are of little import to those leading the reconfiguration?

Reply by the Chairman

I have sought reassurances from the Clinical Commissioning Groups and they have provided the following answer:

"The Reconfiguration team has worked with the Neurological Rehab and Brain Injury services concurrently and both were in agreement that to remain on an acute site that has access to ICU support was of paramount importance. The growing dependency between the two units within recent years also led to the request that the services be co-located as interdependencies between the two patient cohorts has benefits for the patient groups.

At the time of writing the Pre-Consultation Business Case the space identified at the Leicester Royal Infirmary site would allow for both services to provide facilities which would allow for the appropriate delivery of care that is necessary for the patients. However the clinical team during the consultation have been exploring whether the Glenfield might be a better option, because of the opportunity to access more open space to support rehabilitation. The clinical services along with patient representation will be involved in the design development.

The plans are being thoroughly reviewed as part of the process to ensure the users of the service get facilities that meet their needs. The final decision, taking on board the learning from the consultation, will be presented as part of the decision making business case for consideration by the CCG at their governing body."

It is important that the assurances are followed up, so scrutiny will continue to review this service in our ongoing work programme.

Supplementary Question

Kathy Reynolds asked when would firm plans be in place for permanently relocating the Neuro Rehabilitation services following the closure of Wakerley lodge. The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals", stated that Liz Warren would receive a written answer after the meeting and re-iterated his commitment to have Neuro Rehabilitation Services as a specific agenda item at a future Committee meeting.

8. Question by Bob Waterton

(a) The methodology underpinning the Total Net Present Cost calculations appears to be missing from the appendices to the PCBC. Please could you provide the methodology which has informed the 'bottom line' (ie the Total Net Present Cost) in Table 6.12 on page 163 of the PCBC. Specifically I wish to know precisely which costs and benefits have been included, what values have been assigned to each of these costs and benefits and how you have arrived at those values. In addition, I would like a clear statement on the period over which each of the costs and benefits have been assessed.

Reply by the Chairman

The Trust has used the Comprehensive Investment Appraisal Model as mandated by the Department of Health and Social Care. This identifies a methodology which is described in and consistent with the HM Treasury Green Book appraisal and evaluation in Central Government.

In line with the Treasury Green Book, costs have been discounted by 3.5% for the first 30 years and 3% thereafter to reflect the time value of money. Therefore the Net Present Cost of an additional item of expenditure is less than the total cost if it expended over a number of years beyond the present year.

Please see the Treasury Green Book for more detail on the modelling methodology – link below.

https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-governent#

Costs and Benefits

The financial modelling in all options uses the UHL 2019/20 recurrent Forecast Outturn as the "baseline" which was submitted to the CCG in September 2019 representing activity, workforce and finance assumptions for the 2019/20 financial year.

For each of the three options, this baseline was then adjusted for the financial impact of each option. These adjustments are described in Table 6.9 on page 161 of the PCBC with further detail provided below:

1. The clinical and overhead savings identified in the first six items in table 6.9 incorporate savings identified as a direct result of Reconfiguration and changes in models of care.

a. Option 3: savings are described in detail, including the underlying assumptions, in the table in pages 4-6 of Appendix AB.

b. Options 1 and 2: same themes as Option 3 with different values calculated due to still maintaining services across three acute sites and inherent inefficiencies.

Detailed as per excel spreadsheet provided, a copy of which is filed with these minutes.

2. Estates and Facilities savings represent the savings from vacating the Leicester General.

a. Option 3: outlined in the table in page three of Appendix AB.

b. Option 2: same value as Option 3 whereby the financial impact between maintaining 2.25 and 2 sites was considered minimal.

c. Option 1: Pro-rated to represent 50% of savings could only be achieved.

3. Estates and Facilities costs represent additional costs to maintain the new build and larger area at the LRI and Glenfield. These costs are similar in nature to cost savings from vacating the Leicester General and are detailed in the excel spreadsheet.

In addition to the specific costs and benefits described above, the options within the PCBC includes Societal and non-cash releasing benefits as reflected in table 6.10

The Net Present Value of Savings and Benefits as summarised in Table 6.12 in the PCBC are detailed below:

Area	Option 1 £m	Option 2 £m	Option 3 £m
Efficiencies	441	543	729
Estates Efficiencies	102	203	203
Non Cash Releasing Benefits			
Improvements in Staff motivation as a result of better facilities and care pathway also proxy for quality of care	41	83	123
Societal Benefits			
Carbon Emissions	2	2	2
Impact of ALOS reduction on economy	21	21	21
Multiplier impact on economy	350	440	456

Appraisal period

The appraisal period for each option was over a period of 67 years reflecting construction time and a 60 year period post construction. Costs for each option have been identified in relation to Construction and Lifecycle costs for buildings and equipment.

Supplementary Question

Bob Waterton referred to table 6.10 of the Pre-Consultation Business Case which set out the proposed benefits as a result of improvements in staff motivation which the Business Case stated would remain the same for each year. He questioned whether the benefits should in fact be expected to decline over time and questioned over what period these benefits were expected to be accrued. The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and stated that Bob Waterton would receive a written answer after the meeting.

(b) Please could you tell me if, when valuing the costs and benefits of the project, the following have been included in your costs:

- the cost of not having enough beds;
- the cost of additional travel time; details included in PCBC;
- the cost of the additional care which will be required of family members and friends from models of care which entail more care given in the patient's own home;

Medical care

the cost of losing staff through the reorganisation;

- the cost of maintenance for the life of the project;
- the cost of additional congestion on the roads arising from the proposed concentration of services at the LRI;
- the cost of out of hours care for deteriorating patients at the General Hospital following interim moves;
- the cost of not having enough beds;

Reply from the Chairman

The Pre-Consultation Business Case (PCBC) includes detailed bed modelling to take into account activity, growth in demand and the reconfiguration of services. All options have been evaluated on the same number of beds with the assumption, in line with bed modelling, that the Trust will have provide sufficient beds through Reconfiguration.

<u>The cost of additional travel time</u>

There is cost breakdown of additional travel time shown in the travel impact assessment in the PCBC Appendix X

The cost of the additional care which will be required of family members and friends from models of care which entail more care given in the patient's own home

The PCBC does not assume that there are any changes to models of care that require additional care of family members and friends.

The cost of losing staff through the reorganisation

In line with Trust policy, the Trust will look for all redeployment opportunities for staff which are impacted by the reconfiguration and changes in models of care. A transitional cost of £2 million per annum has been assumed for 5 years which will be used for any reorganisation costs.

The cost of maintenance for the life of the project

Lifecycle costs have been allowed for in the option appraisal of £623 million (£188 million discounted).

The cost of additional congestion on the roads arising from the proposed concentration of services at the LRI

The reconfiguration results in service moves from the Leicester General and across the two sites at LRI and Glenfield Hospital. The net impact of the reconfigured estate results in less patient activity at LRI and is therefore likely to result in less congestion.

The cost of out of hours care for deteriorating patients at the General Hospital following interim moves.

This was factored into the interim ICU business case previously.

Supplementary Question

Bob Waterton stated that the implication of a policy of low bed numbers at the Leicester Royal Infirmary over the next decade, together with the loss of community hospitals, meant that more of a burden would be placed on the community. He submitted that the answer given by the Chairman did not take account of the costs of community care and questioned whether the cost of community care should be incorporated into the calculations? The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: “Building Better Hospitals” and stated that Bob Waterton would receive a written answer after the meeting.

(c) The Total Net Present Cost (TNPC) results in Table 6.12 of the Pre-Consultation Business Case show relatively small differences between the options (for example, it is £448,000 between Options 1 and 3). Please could you tell me, therefore, what the variances are around the TNPC for each of the options shown in Table 6.12 since significant variance is likely to eliminate the small differences between the option totals. Could you also, please, explain the level of confidence you have in the estimates for the Multiplier effects on the economy and for 'Improvement in Staff Motivation' since both of these are given the biggest number for Option 3 but both

are very difficult to measure; different assessments may, again, eliminate the small differences between the TNPC option results.

Reply by the Chairman

The difference is £448 million not £448,000 which is a significant difference between the options. The significant part of this difference is the cash releasing benefits of £389 million. This difference is caused by the need to maintain a significant element of multi-site working in Option 2, as more services would remain on the Leicester General Hospital site. These are broken down in table 6.9.

The multiplier effects relate to the level of capital investment and how that then has a consequential impact on the local economy. The higher the investment, the bigger the effect. The calculation has been based on evidence provided from other schemes and reviewed by NHSE/I and a prudent view has been taken on this. Further detailed work will take place in producing the OBC.

The staff motivation is a qualitative view quantified in relation to sickness absence and vacancies. Following the new Emergency Department at the LRI, there was a material improvement in staff turnover from approximately 15% to 6% (the Trust average is 8%) which provides confidence in the benefits within the PCBC**.**

It is important to note that the Total Net Present Cost is one consideration in the options appraisal. Other factors are taken into consideration in determining the preferred option including Value For Money and strategic fit. In terms of strategic fit, clinical sustainability underpins the PCBC to ensure safe patient care which is challenging whilst operating on three acute sites. Whilst the Treasury advises that all benefits and costs are quantified which is difficult and some elements do remain qualitative.

Supplementary Question

Bob Waterton questioned whether further detailed work on the multiplier effects could establish that the multiplier effects would significantly reduce over time due to leakages from the local economic system? The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: “Building Better Hospitals” and also stated that Bob Waterton would receive a written answer after the meeting.

9. Question by Lorraine Shilcock

The WHO have been predicting the increase in pandemics for a few years now. Due to many reasons worldwide Covid will not be the only pandemic in the next 40 years. There is a lack of pandemic preparedness in the Pre-Consultation Business Case. There are no plans for redesign of new developments in design and capacity to future proof these new buildings to cope with pandemics. Will this increase costs and by how much?

Reply by the Chairman

Whilst not explicitly spelt out, the current proposal will respond well to a future pandemic. For example, the plans include:

– a doubling of Intensive Care Unit capacity. During the peak of the Covid-19 pandemic UHL had to use some theatres, and move children’s heart intensive care to

Birmingham for a period of time. UHL needed in excess of 70 Intensive Care beds at the peak; the scheme will provide over 100 Intensive Care beds.

– In addition, the development of the new treatment centre allows UHL to split a lot of planned care from the emergency care. This means that at times of peak emergency pressure UHL can maintain their planned activity.

New buildings also have a more generous footprint. This will make it easier to separate flows of people and goods around the new buildings.

Supplementary Question

Lorraine Shilcock stated that being pandemic ready was not just about providing more intensive care/elective care capacity but also related to the design of buildings. She asked whether the proposed design of the hospital buildings would be modified to achieve pandemic readiness and requested details of what other aspects of the £450 million proposals would help the system to become pandemic ready. The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and also stated that Lorraine Shilcock would receive a written answer to her supplementary question after the meeting.

10. Question by Jean Burbridge

Can you estimate the percentage of the 440,000 households in Leicester, Leicestershire and Rutland to which a Solus leaflet drop was arranged actually received the leaflet (Building Better Hospitals)?

Please clarify the size of the leaflet - was it the A4 6 page "Summary Document? What percentage of the total delivery was checked by GPS? Who was the 'Independent Third Party who telephoned random households to "backcheck" delivery and how many households gave answers?

Reply by the Chairman

The CCGs have undertaken a solus door drops of an A5 information leaflet to 440,000 residential properties across Leicester, Leicestershire and Rutland. In addition, rural communities in Rutland were set a leaflet via Royal Mail as solus was not an option.

Whilst many people have said that they have received this leaflet, we are also aware that some believe they have not. Solus delivery is not an exact science and is dependent on many key factors.

This includes the attitude of recipients to unsolicited deliveries, with some people simply disposing of leaflets immediately upon receipt. Other issues include the volume of marketing material being received by households, which can reduce the impact and recall of specific items, as well as the exposure of different people within the household to the material following delivery.

The CCGs have raised concerns from residents with their delivery partners who have provided GPS tracking information for their agents. This is in addition to feedback from telephone calls to a sample of homes within each of the postcode areas to validate delivery, which is undertaken by an organisation called DLM.

Industry standards dictate that feedback from these telephone calls would expect to establish a level of positive recall of between 40% - 60% to substantiate that deliveries have been completed to the standards expected. We are still receiving the community reports from this exercise, but at the moment the recall is within this range for communities across Leicester, Leicestershire and Rutland.

However, the door-drop is only one small part of the overall awareness activities the CCGs have undertaken. These are set out elsewhere in the papers for this meeting of the Joint Health Scrutiny Committee and the Committee will seek further reassurances during the meeting.

Supplementary Question

Jean Burbridge questioned what was meant in the reply by "Solus delivery is not an exact science" and submitted that surely the leaflets were either delivered or not. She also asked how much the CCGs paid for the solus delivery and what compensation was sought for the leaflets not being delivered to all areas the first time? The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and also stated that Jean Burbridge would receive a written answer to her supplementary questions after the meeting.

11. Question by Sarah Seaton

Please could you tell me what your calculations are in terms of:

(a) reduction in footfall and car movements on or around the site of the LRI once the departments moving off the site have moved (eg elective care);

(b) the increase in footfall and car movements on and around the site of the LRI as departments are moved to the site (eg the larger maternity provision);

and

(c) the net position.

Reply by the Chairman

The footfall to each site has been calculated using actual activity data with the baseline of 718,289 from the year period 2019/20. The figures are overall footfall and do not distinguish the mode of transport used. The following data is provided as part of the sustainable travel solutions in the Travel Action Plan.

a. Reduction in footfall to the Leicester Royal Infirmary in year 2025/26 once departments have moved off the site is forecast as 384,084
b. Increase in footfall to the LRI in year 2025/26 once departments have moved on to the site is forecast as is 23,109 taking the numbers up to 407,193
c. The net difference in footfall is 23,109

Supplementary Question

Sarah Seaton asked for further detail on what was covered by the 23,109 increase in footfall referred to in part c of the answer and asked for further clarification on the net increase/reduction in footfall/traffic overall? The Chairman asked the Clinical

Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: “Building Better Hospitals” and also stated that Sarah Seaton would receive a written answer to her supplementary questions after the meeting.

12. Question by Ann Cowan

(a) What proportion of the £24m to be cut from Prescribing and Continuing Healthcare will be applied to cut Continuing Healthcare (CHC) from patients who by definition are eligible? Page 94 of Appendix C states "A saving of 2% per annum for CCGs focussed on Prescribing and Continuing Healthcare costs equating to £24m"

I have some personal experience of CHC funding and know only too well that without it, personal finances rapidly run out, leaving local authorities with large care bills.

(b) Can you provide a breakdown of the £48m cuts proposed by "Transformation savings relating to Community Services Redesign, Planned Care and Urgent Care Transformation of £48m”? Additionally please provide a breakdown of the "£26m of savings which are still to be identified which will be delivered through transformation in the latter years of the plan (from 2021/22 onwards)" just 4 months away. (Page 94 of the LLR 2019 plan)

Reply by the Chairman

The Clinical Commissioning Group state as follows:

“The world has changed over the last 9 months. We are now working in a different environment and therefore we need to revisit our plans from 2019, to ensure that they are still appropriate given the learning of the NHS during the pandemic. This will include reviewing services and finances. A new Operational Plan will be developed in 2021.

A central tenet of our overall clinical strategy for health and care services is and always has been about delivering as much care as we can as close to where patients live as is practically possible.

We have already started discussions in some local areas as the first step to developing plans for what local health and care services should look in communities across Leicester, Leicestershire and Rutland. These plans would include discussions relating to 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. Our focus will be on working with each local community to identify services that can and should be delivered locally through the development of new local services, potentially in partnership with other local public sector bodies, should that be deemed to be preferable or more viable. When we have developed the plans as an outcome of these conversations, we will be able to quantify the care that will be provided in the community and the cost of delivering this care.”

13. Question by Giuliana Foster

Can you quantify the extra amount of care which will be undertaken in the community by 2025 as a result of changing hospital use and new models of care and how much it will cost to deliver this care in community settings'?

Reply by the Chairman

Please see my response to question 12 above.

Supplementary Question

Giuliana Foster pointed out that the Pre-Consultation Business Case repeatedly stated that hospital plans were premised on new models of care and extra work in community settings and questioned whether this extra care had been quantified and costed. The Chairman asked the Clinical Commissioning Groups and UHL to cover this issue as part of their presentation on agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals" and also stated that Giuliana Foster would receive a written answer to her supplementary question after the meeting.

24. Questions asked by Members.

The Chief Executive reported that three questions had been received under Standing Order 7.

14. Question by Dr Terri Eynon CC:

I would like to ask about the closure of the hydrotherapy pool at LGH:

(a) How many patients currently access the hydrotherapy pool at LGH?

Reply by Chairman:

118 patients per week, both children and adults

(b) How is the hydrotherapy pool at LGH currently staffed?

Reply by Chairman:

Sessions are provided by UHL Physio Therapists and also used by LPT Therapy teams and external groups who staff independently with a lifeguard

(c) How many patients do the CCG envisage accessing hydrotherapy under the new arrangements?

Reply by Chairman:

This number is yet to be determined as the changes will not be implemented for a further 5 years, and would depend on where the pools are located.

(d) How will the new hydrotherapy sessions be staffed?

Reply by Chairman:

Please see my answer to question b above.

(e) Have the CCG already identified sites in the community?

Reply by the Chairman:

A mapping exercise identified 5 possible pools in Loughborough, Glenfield, Oakham and Stamford. The CCG is working with the One Public Estate Leisure Group to expand this offer over the next 5 years, with possible areas including Wigston and Harborough. The feedback from the consultation will also be used to understand impact on people and may also identify other options for us to consider

(f) Where are these pools likely to be?

Reply by Chairman:

Please see the answer to question (e) above.

(g) How can the CCG ensure these community pools are suitable for use as hydrotherapy pools? Will they be warm enough? Will they have hoists?

Reply by Chairman:

There is clear guidance that must be complied with. This includes:

- Temperature – The pool should be heated between 32.3c – 36.0c;
- Depth - approximately 1.0 – 1.2m at its deepest with steps down to each depth; not a sloping floor.
- The pool must also have access to a hoist.

(h) How much investment will this require?

Reply by Chairman:

The expectation is that the pools will he hired for sessions, so no capital investment will be required. There will be a cost to the services for those who want to use them and this will be calculated at the appropriate time in the future.

(i) How will hydrotherapy treatment integrate with community provision after patients are discharged from hydrotherapy?

Reply by Chairman:

This is yet to be determined as part of a wider review of community based therapies. As now patients are signposted to local hydrotherapy/self-help groups and other forms of exercise e.g. exercise referral schemes.

(j) How will this change lead to better outcomes for patients?

Reply by Chairman:

It should reduce travel time for patients, as they should be able to access pools closer to home. The evidence from the cardiac physio therapy pilot that provided patients with

physio at Aylestone Leisure Centre rather than in the hospital setting, showed that the outcomes were improved because the patient continued to access the services at the leisure centre after they were discharged by the physio team, giving long-term health benefits. Therefore the planning for the hydrotherapy service will consider this model and possible wider health benefits.

15. Question by Cllr Sam Harvey

Please confirm the following for the year 2019/2020:

(a) The number of Rutland residents who delivered at St Mary's Unit;

Reply by Chairman

14

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

Reply by Chairman:

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;

Reply by Chairman

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.

Reply by Chairman:

The Clinical Commissioning Groups have undertaken to provide an answer to this question by 23 December 2020 and I will make sure you receive it.

16. **Question by Cllr Sam Harvey**

The Clinical Commissioning Group has stated that Rutlanders formed eleven percent of respondees to the Building Better Hospitals consultation. Can you confirm the following:
(a) The total number of respondees to date;
(b) The number per unitary authority;
(c) A breakdown of respondees by age, as per the demographic question on the consultation.

Reply by the Chairman:

I have put your questions to the Clinical Commissioning Groups and they have provided the following response:

"All the consultation responses received from the consultation will be independently analysed and evaluated by Midlands and Lancashire Commissioning Support Unit (CSU).

The responses provided by the public are anonymous. However, the questionnaire does ask people to provide socio-demographic and equality data. This is optional. Where people have provided this information, the CSU will include a full breakdown of this data in their Consultation Report. The final Consultation Report of Findings will be received by the three CCG governing bodies and discussed in a public meeting in the first half of 2021. The public consultation feedback will be considered and taken into account in any decisions they make.

The papers for this meeting will be publicly available including the Consultation Report of Findings. We will promote the governing body meetings to enable people to attend and hear the discussions. All decisions will be made public after the governing board meetings and further engagement work will commence with people who use services provided by UHL. This work will include communicating the decision via local newspapers, social and broadcast media. We would also expect to present this information to the Scrutiny Committee."

25. Urgent items.

There were no urgent items for consideration.

26. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting. No declarations were made.

27. Presentation of Petitions.

The Chairman reported that two petitions had been received under Standing Order 35 but as they were both in relation to St Mary's Birth Centre in Melton they would be considered under Agenda item 7: UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals".

28. UHL Acute and Maternity Reconfiguration Consultation: "Building Better Hospitals".

The Committee considered a joint report of University Hospitals of Leicester NHS Trust (UHL) and Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) regarding the consultation on the plans to reconfigure Leicester's Hospitals known as 'Building Better Hospitals for the Future', with particular emphasis on the proposals for St Mary's Birth Centre, Melton Mowbray. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Andy Williams, Chief Executive, LLR CCGs, Richard Morris, Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group (CCG), Sara Prema, Executive Director of Strategy and Planning, Leicester City CCG, Rebecca Brown, Acting Chief Executive, UHL, Mark Wightman, Director of Strategy and Communications, UHL, Ian Scudamore, Director of Women's and Children's Services, UHL, Justin Hammond, Head of UHL Reconfiguration PMO, UHL, and Florence Cox, Community Midwifery Matron, UHL.

The Chairman reported that the following petitions had been received in relation to St Mary's Birth Centre:

Keep St Mary's Birth Centre Melton Mowbray Open

St Mary's Birth Centre Melton Mowbray should be kept open because it provides gold standard maternity care both during and after birth. The unit is the only maternity unit in the county outside the City of Leicester and provides an important choice for expectant parents both from Melton and the rest of Leicestershire. It is the only unit in the County where mothers are attended by a midwife throughout labour, which is recommended by NICE. The excellent postnatal care received at the unit helps new families become more confident and have a better transition to parenthood.

This petition had 1,470 supporters at the time of consideration by the Committee.

Save St Mary's Birthing Centre

We firmly believe that Melton needs its Birthing Unit. As a much loved, vital service, it forms an important piece of the jigsaw for women and their families requiring maternity care. The unit gives pregnant mothers a choice in the ethos of care and being local it saves the long drive when in labour. Furthermore, it provides wonderful after care, including support around breastfeeding and mothers mental health. The larger hospitals simply don't have the resources for this.
If it closed there is also the risk of more pressure on midwives as more low risk mothers might choose to have home births instead of risking the journeyy to Leicester. Each home birth requires two midwives present and the question is will there be enough to go around.
Finally, the Birthing Unit not only needs to stay open but we call on it to be properly funded going forward.
This petition has been started by The Rutland and Melton Labour Party.

This petition had 3,499 supporters at the time of consideration by the Committee.

Both Petitions were presented by Ms. Helen Cliff. In presenting the Petitions Ms. Cliff emphasised that the supporters of the Petition resided in various locations across LLR not just Melton. She also raised concerns that NHS staff were not making pregnant mothers aware that the St Mary's Birth Centre was an option or were deterring mothers from opting to give birth there.

Arising from discussions the following points were noted:

(i) Members welcomed the proposed £450 million investment in Leicester's Hospitals.

Consultation

(ii) The format of the consultation was that the CCGs and UHL set out how they were minded to proceed and the public were asked whether any issues or alternatives had not been considered and whether the proposals disproportionately impacted a particular group or area. Whilst the CCGs and UHL were not looking for a majority of the public in favour of the proposals, all responses would be taken into account and consideration would be given to whether the proposals needed to be revised. After the close of the consultation all of the responses received would be collated and analysed by an independent third party. Whilst this was not an appeal process, there were likely to be modifications to the proposals as a result of the consultation feedback.

(iii) The consultation website had been visited by over 90,000 different people which was higher than expected and there had been over 4000 responses to the consultation so far, the majority of which were either positive or neutral regarding the proposals.

(iv) The CCGs had committed to distribute leaflets regarding the consultation to every home in Leicester, Leicestershire and Rutland. This was unusual for a consultation such as this. The distribution had been carried out by way of solus delivery. Due to concerns raised that not all homes in LLR had received the leaflet the distribution company carried out a second delivery to all homes in LLR by way of compensation. GPS tracking data for the second delivery verified that all the required locations had been covered. An independent company then carried out phone calls to residents across LLR to verify that the leaflets had been received and it was found that the industry standard (40-60% of people phoned recalling that they received the leaflet) had been met. Reassurance was given by the CCGs that the geographical areas where concerns had been raised that leaflets had not been received actually had a greater response to the consultation therefore even if leaflets had not been received in those areas it had not inhibited the ability of the people in those areas to respond to the consultation.

<u>St Mary's Birth Centre</u>

(v) The midwifery-led unit at St Mary's Hospital in Melton was the only standalone birth centre left in the East Midlands. The other units had been closed in the early 1990s due to mothers choosing not to use them. A review had taken place in Leicester, Leicestershire and Rutland around 2009/10 regarding standalone birthing units which found that they were not sustainable as most mothers had a preference for birthing units which were alongside other medical facilities.

(vi) Annually 10,000 women gave birth in Leicester, Leicestershire and Rutland. There were approximately 1800 mothers living in Melton and surrounding post codes that could potentially choose to give birth at St Mary's however only a sixth of those chose to give birth at St Mary's and only a twelfth actually ended up giving birth at St Mary's. Mothers often decided that St Mary's Birth Centre was not the appropriate facility for them due to the transfer time to other medical facilities should there be complications with the birth. For example if the mother required a caesarean section, requested an epidural, or the baby required resuscitation then a transfer into Leicester was required. In addition, part of the NHS 10 year plan was to

reduce the amount of still births and babies born with brain damage which further supported the case for moving birthing facilities alongside emergency hospital facilities. In response to queries as to the accuracy of the published statistics regarding transfer rates from St Mary's for mothers in labour and immediately after birth, it was confirmed that the rate was currently 45% for first time mums and 10% for 2nd, 3rd and 4th babies.

(vii) In response to a query as to whether the new home birthing model had impacted on the numbers of mothers opting to give birth at St Mary's it was confirmed that there had been no impact as whilst the numbers of mothers that had opted for a home birth had increased, the numbers for St Mary's had remained the same.

(viii) UHL emphasised that St Mary's Birth Centre was not going to be closed. It was proposed that the midwifery-led unit would be relocated to Leicester General Hospital as a pilot for 12 months to test the public appetite for this service with an indicative target of 500 births per year. Members raised concerns that this was too short a time for a trial to take place and questioned whether UHL and the CCGs were genuinely open minded about the outcome of this trial. In response reassurance was given that UHL were not expecting to close the birthing centre at Leicester General Hospital at the end of the 12 month trial period and if there was sufficient interest in the facility at that location from mothers then it would remain open. It was desirable to offer choice for mothers as to where they gave birth but each birth unit had to be financially sustainable. A member submitted that there was a lack of facts and figures in the public domain to demonstrate that St Mary's Birth Centre was not sustainable and asked for this information to be provided. In response it was explained that the cost of a delivery at St Mary's Birth Centre was around £4000 whereas at both the Leicester General Hospital and Leicester Royal Infirmary it was around £2000.

(ix) In response to concerns raised by a member that too much emphasis was being placed on the risks of a standalone birthing unit rather than the outcomes and experience of the mother, UHL acknowledged that both the risks and benefits needed to be explained to the mother and it was important to give mothers a choice, listen to and take account of a mother's concerns about giving birth and make a plan in case problems arose.

(x) A member reported strong concerns amongst the people of Melton that facilities were continually being lost from the area and the proposed loss of the birthing unit was the latest of many.

(xi) Given the closure of many Sure Start Centres, concerns were raised regarding a lack of support for mothers with regards to breast feeding.

Neuro Rehabilitation services

(xii) Neuro Rehabilitation services had previously been provided at Wakerley Lodge in the grounds of Leicester General Hospital but were now temporarily located in Ward 2 at Leicester General Hospital. Consideration was being given to whether Neuro Rehabilitation services should be permanently located at Leicester Royal Infirmary or Glenfield Hospital. Glenfield Hospital had the advantage that there was garden

space which was important for patients that required Neuro Rehabilitation. The consultation feedback would be taken into account when making the assessment. A final decision on where the service would be permanently located would be made in 2024 and overall it was a 7 year project.

Bed numbers

(xiii) In response to concerns raised that the additional beds proposed under the reconfiguration scheme would not be ready by the time there was a demand for them, reassurance was given that taking into account the model of care and the rate the population of Leicester, Leicestershire and Rutland was rising the planned bed numbers were sufficient and the new beds would be in place in time to meet demand. Care needed to be taken that the acute sector was not bigger than needed and did not unnecessarily divert funding from other areas of healthcare. Should circumstances change from that which was predicted then there was latitude to expand bed numbers in excess of those currently planned. A member suggested that the bed modelling should be extended up until 2036.

Car parking and transport

(xiv) Under the proposals car parking at both Leicester Royal Infirmary and Glenfield Hospital was to be extended, however after the reconfiguration had taken place it was expected that footfall at LRI would reduce by 30-40% whereas at Glenfield Hospital it would increase by a similar number. A member raised concerns around pollution around Glenfield Hospital due to traffic.

(xv) Other options to improve transport to Leicester's hospitals were being considered including extending the existing Park and Ride scheme, reviewing Hospital Hopper bus routes and enabling patients to hire bikes. A member raised concerns about a lack of public transport to the hospital from rural areas such as Rutland and questioned whether there were suitable locations for Park and Ride sites on the east side of Leicester. In response reassurance was given that conversations had taken place with Rutland residents regarding solutions to their travel issues.

RESOLVED:

(a) That the contents of the report be noted;

(b) That the comments now made be fed into the consultation on Building Better Hospitals for the Future.

29. Covid-19 Vaccine in Leicester, Leicestershire and Rutland.

The Committee received an oral update from Caroline Trevithick, Chief Nurse and Executive Director of Nursing, Quality and Performance, West Leicestershire Clinical Commissioning Group regarding the Covid-19 vaccination programme in Leicester, Leicestershire and Rutland (LLR).

Arising from the presentation the following points were noted:

(i) The vaccination programme began in LLR on Saturday 12 December 2020 using Leicester General Hospital as the hospital hub. Prior to Leicester General Hospital

being chosen as the hub consideration had been give to whether Leicester Racecourse was the best venue as there was a need for the venue to be suitable for both NHS staff and the general public to visit. Although the Racecourse was was not currently being used as a vaccination venue it could still become one in the future.

(ii) The Pfizer vaccine was currently being used in LLR and initially vaccines were only being given to people over 80 years old and care home staff. However, it was important not to waste the vaccine and when all the people in those categories had been vaccinated the programme would be widened out to other people. Due to the way it was required to be stored the Pfizer vaccine was not as able to be taken out into communities as the Astra Zeneca vaccine which was still awaiting approval. It was planned that in the near future vaccinations would be able to be given more locally in places such as GP Practices. A schedule of the exact locations had not yet been published as care needed to be taken that the published information was accurate and would not be subject to change however a communications plan was in place. The public were advised not to contact their GP Practice regarding receiving the vaccine but to wait until the GP Practice contacted them. Clarification was awaited on whether it was safe for the Pfizer vaccine and the Astra Zeneca vaccine to be stored at the same venue and the answer to this question would have implications on which vaccination venues were chosen. There was a further reason for not yet publicising the venues of where the vaccine would be given and that was security concerns involving public disturbances at the venues and conversations were ongoing with the Police to ensure NHS colleagues were not put at risk.

(iii) The CCG were aware that some of the population of LLR were eager to be vaccinated whereas others were concerned about side effects and did not wish to receive the vaccine. In order that the vaccine was not wasted conversations were being had with individuals to ensure that they were willing to commit to the vaccination programme before the vaccine was allocated to them. The Pfizer vaccine involved a two stage vaccination process therefore it was important that participants were willing to take part in both stages of the process.

(iv) Once the vaccine was extended to wider categories of people the CCG intended to use local leaders and champions to encourage as many people in communities as possible to agree to be vaccinated.

(v) It would be difficult for people in receipt of domiciliary care to travel to receive the vaccine therefore it was intended that their carers would receive the Pfizer vaccine in order to give them some protection until the Astra Zeneca vaccine was approved and ready to be taken into homes.

(vi) Young people with learning disabilities were high on the priority list to receive the vaccine. Whilst categories of people such as the homeless and rough sleepers were not on the national list of priorities, conversations were taking place with local authorities and primary care partners to ensure they were included in the vaccination programme. Prisoners would also be included.

(vii) The vaccination communications plan needed to take into account adults with learning disabilities that did not have carers and those with sight and hearing problems to ensure that they were all made aware.

(viii) Nationally consideration was being given to a single telephone number for the public to be able to call to make the authorities aware of people that needed to be vaccinated but that had not yet received the vaccine.

(ix) Leicestershire Partnership NHS Trust were managing the staff recruitment process for the vaccination centres. There were a range of job descriptions for the various roles required. Volunteers were being sought and hundreds of people had applied so far but they would need to fit the specific criteria for each role.

RESOLVED:

That the contents of the update be noted.

30. Impact of Covid-19 on Dental Services in Leicestershire, Leicester and Rutland.

The Committee had been due to consider a report regarding the Impact of Covid-19 on Dental Services in Leicestershire, Leicester and Rutland, a copy of which, marked 'Agenda Item 9', is filed with these minutes. The Chairman reported that due to time constraints Thomas Bailey, Senior Commissioning Manager, NHS England and NHS Improvement – Midlands was no longer able to present this item.

RESOLVED:

That this agenda item be deferred to a future meeting of the Committee.

31. East Midlands Ambulance Service Clinical Operating Model and Specialist Practitioners.

The Committee had been due to consider a report of East Midlands Ambulance Service (EMAS) regarding their Clinical Operating Model and Specialist Practitioners. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.The Chairman reported that due to time constraints Russell Smalley, Service Delivery Manager, EMAS was no longer able to present this item.

RESOLVED:

That this agenda item be deferred to a future meeting of the Committee.

32. Date of next meeting.

It was noted that the next meeting of the Committee was scheduled for 5 March 2021 at 10:00am however a meeting needed to be arranged in the intervening period to enable the Committee to consider the analysis of the Building Better Hospitals for Leicester consultation feedback.

RESOLVED:

That officers be requested to liaise with members regarding potential dates for a meeting to consider the Building Better Hospitals for Leicester consultation feedback.

10.00 am - 1.50 pm
14 December 2020

CHAIRMAN

Agenda Item 8

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

NHS
Leicestershire Partnership
NHS Trust

NHS
East Midlands
Ambulance Service
NHS Trust

NHS
University Hospitals
of Leicester
NHS Trust
Caring at its best

LEICESTERSHIRE, LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 5 MARCH 2021

SYSTEM UPDATE: WINTER PRESSURES REVIEW AND NHS 111 FIRST

REPORT OF THE DIRECTOR OF TRANSFORMATION AND INTEGRATION

Purpose of the report

1. The purpose of this report is to inform the Committee of how the NHS system has managed COVID and winter pressures over winter 2020/2021. The report also provides an update on the development of the NHS 111 service and pathways into urgent care.

Winter Pressures Review

2. The LLR health and care system has faced unprecedented challenges over the last twelve months, not least the challenge of planning for winter pressures during the time of the COVID pandemic. In normal times, the health and care system prepares for winter with a multi-agency winter plan, which aims to enable the maintenance of key services and delivery of safe, timely care during what is traditionally the busiest period of the year in relation to unplanned care services; emergency department attendances, ambulances, medical inpatient

admissions and the need for rapid social care and community support to people in crisis so that they can remain at home.

3. Winter planning for 2020/21 brought with it added complexities and demands, due to:

    - the likelihood of further outbreaks of COVID-19, which indeed materialised in a significant third wave during December and January;
    - the anticipated COVID-19 vaccination programme adding to pressures on workforce and organisational capacity over winter;
    - an expected increase in non-elective activity pressures due to seasonal illness;
    - reduced capacity in health and care services as a result of COVID cohorting and infection prevention and control requirements, which essentially require health care settings to operate two separate areas for COVID and non-covid patients with separation of staff, as well as requiring additional time for cleaning and changing PPE; and
    - the need, as far as possible, to restore elective activity and deal with a growing back log of routine and planned care.

4. NHS England requested that systems develop a single plan for ‘phase 3’ of COVID in this period and therefore we brought together routine annual planning for winter pressures with our planning for the use of system capacity to deliver elective and cancer care, developing a single integrated winter and COVID plan for the period November 2020 to March 2021.

5. The winter pressures plan was led by the Urgent and Emergency Care Group, which has senior lead representation from all health organisations in LLR, including East Midlands Ambulance Services (EMAS) and all three local authority social care leads.

6. The key objectives of the winter plan were to:

    - Ensure the continued delivery of high quality, safe care to patients by the whole system;
    - Reduce demand for unnecessary presentation at primary care, Emergency Departments (ED) and other emergency pathways through providing alternatives including the use of NHS 111 First and self-care;
    - Enable demand to be managed within defined, existing bed capacity and other capacity, setting out available core and surge capacity, minimising the risk of cancellations of planned care;
    - Mitigate and manage situations whereby care provided in corridors occurs ensuring risk and harm is avoided/mitigated;

- Mitigate the risk that pressures within ED impact on ambulance handover, minimising lost time and avoiding unseen risk to people needing a response in the community;
- Operate clear organisational and system-wide surge and escalation management protocols, with the management of system escalation levels led by the CCG UEC team;
- Provide assurance that all services have and maintain priority actions and resilience plans including setting out how UHL's ED is prepared to meet expected demand;
- Support the primary care and community flu vaccination programme and increase health and social care staff take up;
- Build relationships across the system for providers to manage pressures effectively in collaboration;
- Ensure that patient flow is optimised to free up maximum bed capacity to cope with anticipated bed pressures;
- Describe plans for out of hospital services to increase capacity and/or manage demand to prevent admission/discharge step down;
- Describe any additional plans required in response to COVID, in relation to IPC, surge and escalation;
- Improve patient experience by removing unnecessary delays in care and delivering care with a 'right first time' approach;
- Support primary care to remain resilient and sustainable.

7. The LLR system was operating within COVID-19 pandemic resilience arrangements throughout the winter period 2020/2021. These are overseen by the Local Resilience Forum arrangements, working alongside the Health Economy Strategic Co-ordinating Group and supporting sub-groups. The LLR Urgent Care Group is one of these supporting groups and continued to meet weekly throughout the winter period to provide oversight of system pressures, manage the escalation and emergency response arrangements and agree any actions required in the system to respond to changing pressures or challenging areas of system performance.

8. The key elements of the winter plan for 2020/2021 are described below:

- A review of the surge and escalation plans for all organisations, including social care, to include specific actions in response to anticipated COVID pressures. Primary care escalation actions and weekly escalation reporting were included for the first time.
- Increasing capacity for urgent telephone and face to face contacts in urgent care services across LLR to restore the opening hours and range of service locations previously in place before COVID. During the emergency response to COVID in March and April, a number of sites

were temporarily closed in response to the dramatic reduction in face to face activity. This equated to expanding the available clinical capacity for appointments by 31%.

- Maintaining changes to access arrangements at ED and other walk in sites put in place in response to COVID with COVID screening (including via calls to NHS 111) before patients are seen face to face.
- Continuing to deliver separate 'hot' clinics for patients who have either confirmed or suspected COVID and need to be seen urgently face to face, in addition to the existing urgent care sites across LLR.
- Strengthening the service delivered through NHS 111 to make sure that patients are seen in the right place at the right time, aiming to reduce unnecessary attendance and crowding in emergency departments and other site. More information on the NHS 111 first initiative is provided in a later section in this report
- A new service providing support for care homes and East Midlands Ambulance Service crews responding to patients in care homes, with on call specialist consultant advice to agree the right approach to care and to keep patients in their place of residence wherever possible.
- Investment to increase capacity in the Home First service, to recruit additional community nurses, therapists and social care staff to work in partnership with primary care.
- Increasing bed capacity in University Hospitals of Leicester by 75 beds to care for the expected numbers of additional admissions over winter.
- Availability of 36 'surge' beds in Leicestershire Partnership Trust which could be opened in case of a significant second COVID surge, or unmanageable winter pressures.
- Work with the three Universities in LLR to communicate the right access routes to healthcare to students including access to testing, encouraging GP registration and promoting wellbeing and mental health.
- Enhanced plans for flu vaccinations as part of our Flu Plan
- A strengthened system workforce plan in response to COVID-19 which includes mutual aid between organisations and effective monitoring of the workforce situation across health and social care, including care homes.
- Changes to the referrals routes to mental health services to provide a single, direct crisis access point for users and referrers.
- Improved and increased general signposting to the public through a communications plan and social media campaign.
- A specific plan for the Christmas and New Year period including enhanced senior cover and staffing, and additional discharge support services in place.

9. Despite the COVID pandemic and the significant increase in COVID infections and hospitalisations, which began in November and continued through to January, the LLR system has managed relatively well throughout the winter period. The following sections summarise the picture in relation to the demand faced by services and how well the urgent care and wider care system managed through the winter period.

10. Presentations to Emergency Departments, both at the Leicester Royal Infirmary and by LLR patients to other sites outside the LLR footprint, have been significantly lower than in previous years. From January 2020 we saw a marked decrease in attendances at ED, as a result of people's concern about the risk to attending health care premises during the pandemic. Although attendances have increased since the early days of the pandemic and the low point in April 2020, they remain consistently at 75% or lower than pre COVID levels. This is in part attributable to the work we have done to strengthen alternatives to emergency care both pre and during COVID, including the switch to virtual consultations and navigation through 111.

Chart 1: Presentations to UHL ED Jan 20 – Jan 21

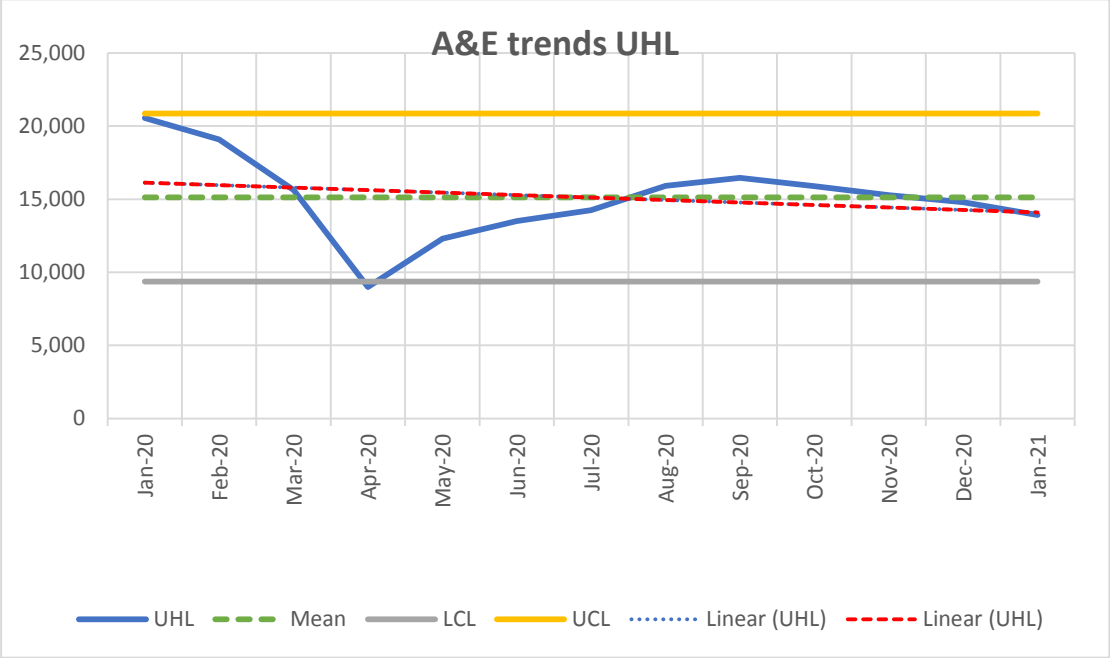
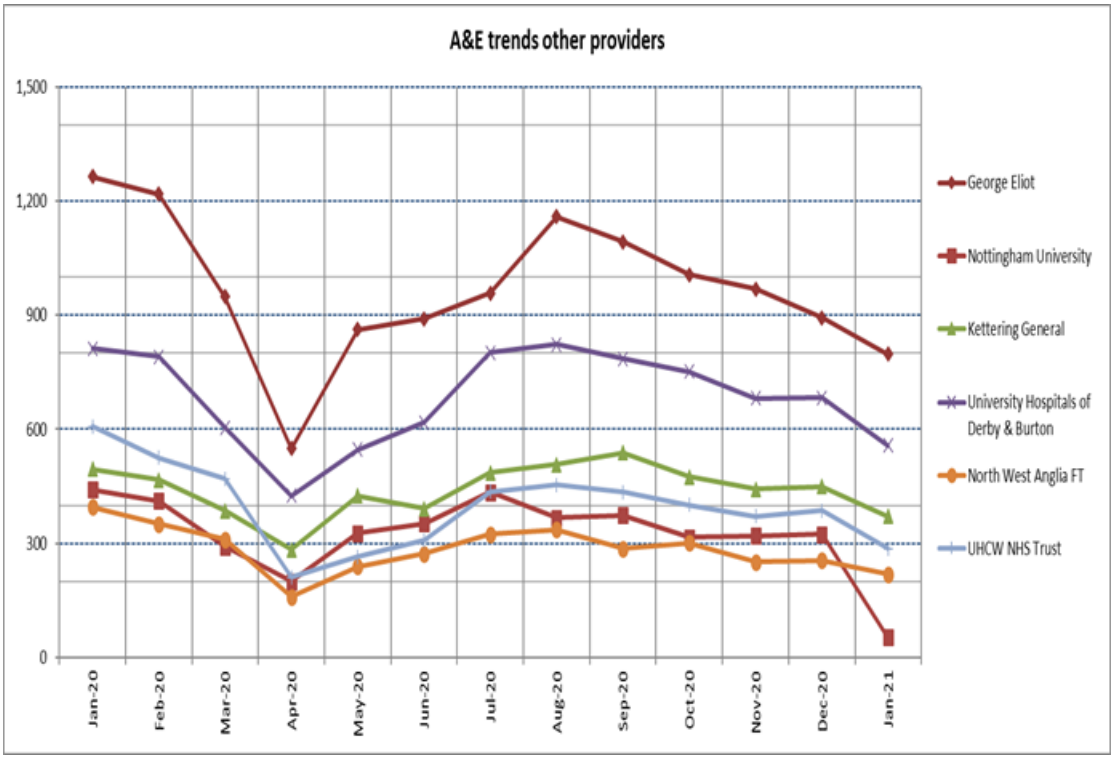
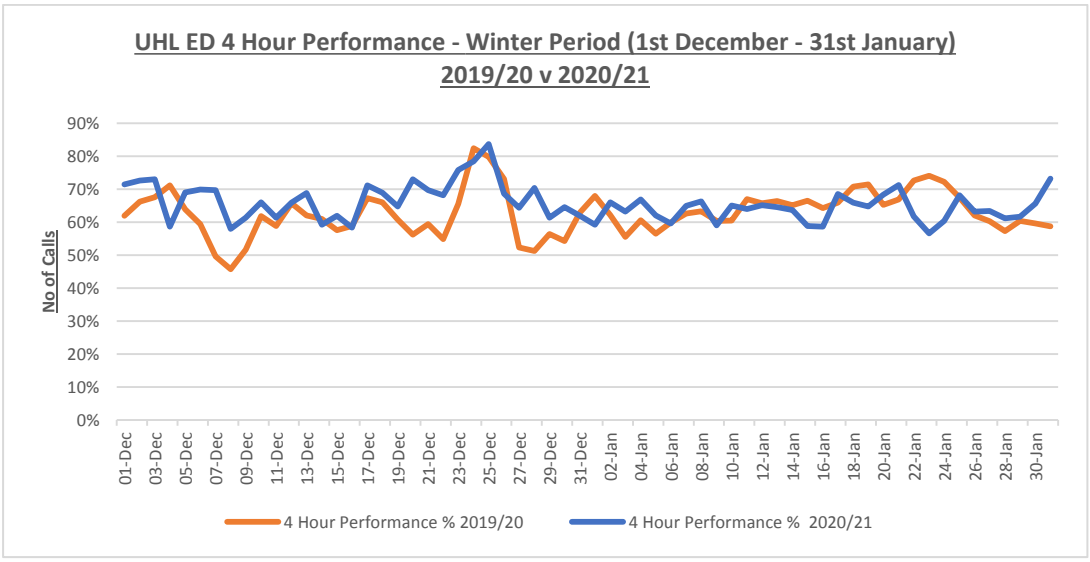


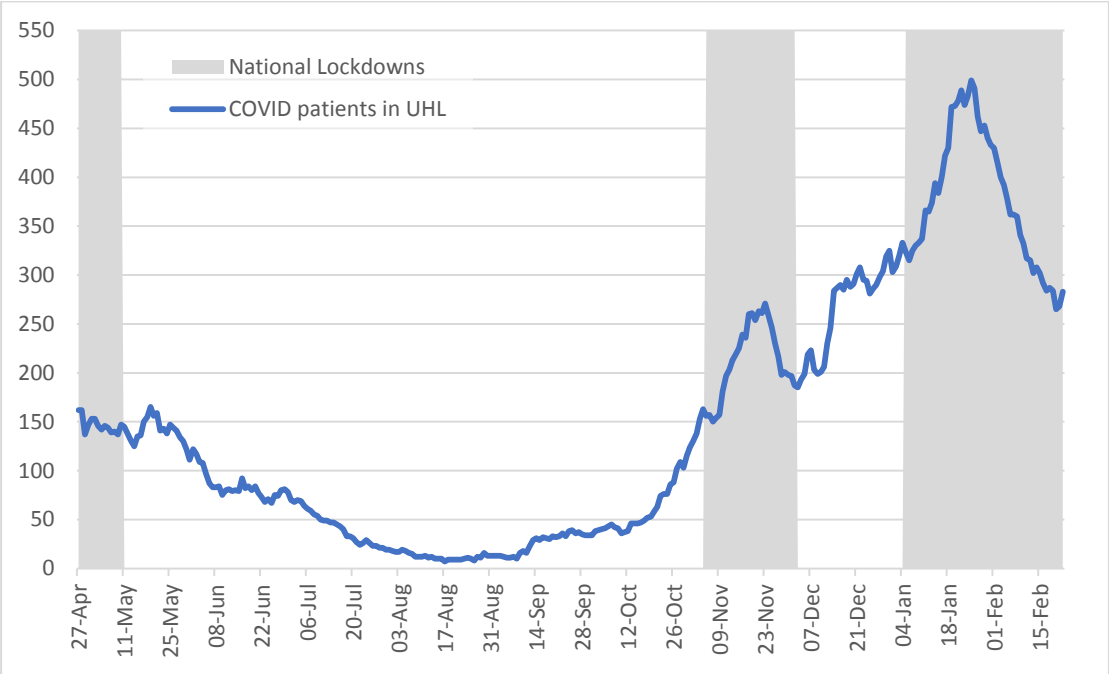
Chart 2: LLR attendances at other EDs





11. Overall waiting times in LRI ED were slightly better over December and January in 2020/2021 than 2019/2020 (66% compared to 63%) but performance has remained challenging, despite the decrease in the number of attendances. This is partly attributable to the operational impact of separating ED staffing over COVID and non COVID ED areas, as well as being a reflection of the increasing pressures on bed capacity within UHL slowing admissions within the four hour national target timeframe, for those patients who cannot be discharged home. During December and January, the number of patients with COVID requiring admission to hospital increased rapidly, as the chart below shows, regrettably coinciding with the peak winter months.

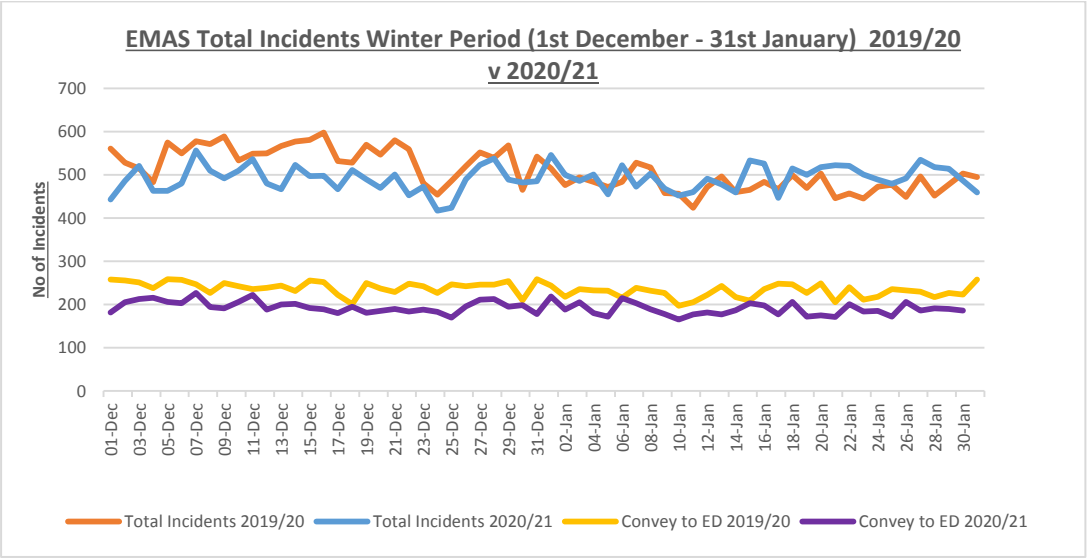
Chart 4: COVID admissions at UHL



12. From the second half of December 2020, the LLR system was operating at its highest level of COVID response, due to the significant increase in COVID infections and numbers of patients requiring hospital admission and ventilation, and this co-ordinated response has continued through to February 2021. The system response has included the full enactment of our COVID surge plans, and the need to redeploy significant clinical space and staffing away from routine and urgent planned care to manage the needs of patients with COVID. Theatre staff, theatre operating spaces and intensive care recovery beds (ITU) were all deployed to manage the response to the COVID wave during the peak winter months of December and January. Other actions taken included opening additional community hospital beds (at the highest point 67 COVID beds were created in community hospitals), and redeploying social care staff from non-urgent cases to provide crisis response both to keep people from being admitted and to enable patients to go home quickly, releasing hospital capacity to take new admissions.

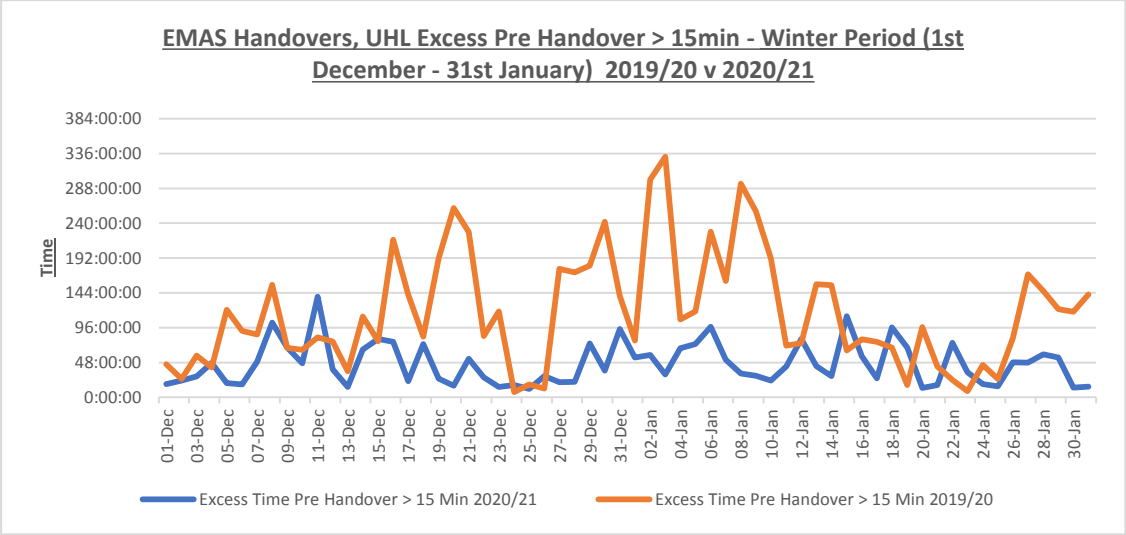
13. We have worked very effectively with EMAS and other urgent care services to reduce the proportion of calls to EMAS that result in a person needing to be taken by ambulance to the Emergency Department. LLR consistently has the lowest 'conveyance' rate of any of the East Midlands systems, as a result of the initiatives we have put in place to support EMAS to access clinical advice and alternative care pathways, so that fewer than 50% of patients seen by EMAS end up going to hospital. The chart below shows that although total EMAS demand has not decreased from last year and indeed was higher on average in January, the number of patients taken to ED has been lower.

Chart 5: EMAS activity and ED conveyance rates 19/20 and 20/21



As a result of the above, and the strong partnership working between EMAS and staff at the LRI, ambulance handover times at the LRI ED have been improved. The chart below shows that the number of ambulances waiting for more than the national target of 15 minutes to transfer a patient into the ED has been reduced compared to the previous year.

Chart 3: EMAS handover delays at LRI ED 19/20 and 20/21



14. Despite the improved handover performance in general, on some days of high pressure, particularly when there are problems with staffing capacity in ED or with medical inpatient bed capacity, ambulance handovers have built up to unacceptably high levels. These instances are much less frequent than in 2019/2020 and operational performance generally recovers much more swiftly to get waiting times down than before. This has been achieved despite the

challenges posed by in effect running two emergency departments, one for suspected or known COVID patients. As a system we now tend to 'de-escalate' and recover acceptable performance more quickly than in pre-COVID days which is a testament to operational processes and how resilient the overall system is.

15. The pressures caused by winter and the number of COVID patients in hospital has had an inevitable detrimental impact on the provision of routine and planned or 'elective' care for LLR patients. During the level 5 COVID incident during December and January, UHL hospitals were only able to complete planned surgical procedures for the highest priority (P1) urgent care and cancer patients, with the vast majority of other elective cases deferred or not booked for procedures during the incident response. This has led to an understandable but very significant number of patients who have not received care, including patients who have been on waiting lists for more than 52 weeks. Reviews to assess and avoid any patient harm are being undertaken in all clinical specialties and UHL is actively reviewing the backlog patient lists and scheduling care in order of clinical priority.

16. In summary, despite an unprecedented period of pressure as a result of the COVID pandemic, combined with expected seasonal pressures over winter, the LLR system has been remarkably resilient in maintaining service provision and performance relative to the previous year. Health and care plans and joint working arrangements across system partners stood up well to the challenge, managing to deliver the most essential services and maintain operational delivery of life saving care in a timely way for our population while coping with the third wave of COVID over winter. Staff in all our services have worked immensely hard in the face of extreme pressures and deserve all our thanks. Looking ahead, restoring pre-COVID levels of planned care and recovering from the impact of the pandemic presents a perhaps even greater challenge.

NHS 111 First Update

17. NHS 111 First is a national programme to extend the use of the NHS 111 service to support the principle of offering people the right care in the right setting at the right time and avoiding unnecessary use of emergency healthcare services. This is important so that emergency service capacity is available to meet the needs of people with serious clinical emergencies.

18. The learning from the early period of COVID demonstrated that people with urgent care needs could be offered advice, support and care in different ways without needing to attend Emergency Departments. There was a big shift

towards telephone consultations and the provision of virtual care in LLR, mirroring the national experience. These factors, combined with the desire to avoid infection and associated harm risks to patients and staff of people attending clinical settings unnecessarily, have been the driving force behind the further development of the NHS 111 model.

19. LLR has always had a strong model of clinical triage and navigation in its urgent care services, and was one of the first systems in England to introduce clinical navigation to support NHS 111 in 2017, as an Urgent Care Vanguard. In addition, LLR has a good range of urgent care services outside of hospital, with urgent care centres and extended primary care hubs in multiple locations which offer an alternative to Emergency Department care. We have continued to build on this in subsequent years, and have relatively low rates of usage of ED compared to the national average.

20. The key deliverables of the 111 First programme were to:
    - Aim for 20% of 'unheralded*' attendances at ED or urgent care centres to be re-directed elsewhere, either through calling 111 or by triage at the front door of the ED;
    - Increase the number of alternative pathways available directly through NHS 111, such as ambulatory care and 'hot' clinics at hospital;
    - Enable direct booking from 111 into timed slots in ED;
    - Develop a clear communication & engagement strategy, with local and national media;
    - Carry out a structured evaluation of outcomes, and provide data into a national reporting system;

    '* unheralded' means that people have not been referred to or advised to attend ED after contact with a clinical service.

21. LLR was asked to be one of the first systems nationally to go live with an expanded 111 offer, with a short timeframe to meet the national deliverables requiring rapid development and implementation of a project plan. We progressed to mobilisation of key changes, including booking into ED services at the end of September 2020, a mere eight weeks after project inception.

22. The key partners in this work have been Derbyshire Health United (DHU), who provide the East Midlands 111 service as well as the LLR Clinical navigation hub and run a number of LLR urgent care/treatment services; East Midlands Ambulance Service (EMAS); primary care and University Hospitals of Leicester (UHL).

23. Having successfully introduced a number of changes to the 111 First and ED service in LLR, we have undertaken an initial evaluation of the impact of the changes, which is summarised in this report.

What changes have been made?

24. By the end of September 2020, achieving our target date, 111 began to book patients who required care in an Emergency Department into booked time slots in the Leicester Royal Infirmary ED. This was enabled despite the lack of a national IT solution, building on work we had already done with UHL and DHU. The benefit to patients has been that they can attend at a specified time, were expected by the ED team and would not have to wait in communal waiting areas. This is more convenient for people as well as reducing the risk of infection from people in busy waiting areas. LLR was the first area in the East Midlands to do this, but most other EDs in the region are now also accepting direct bookings from 111 and LLR patients can be booked into a range of other hospitals as well as UHL, depending on where they live and their choice of location.

25. Building on the existing model of clinical navigation via NHS 111, we have reviewed the types of clinical problems that are mapped to different services. There has been an increase in the number of patients that go to clinical navigation for further assessment before advice is given to the patient on the most appropriate care, and this has reduced ED referrals further.

26. Changes have been made to the Directory of Services that supports 111 and enables patients to be referred into alternative pathways. This will continue to be an ongoing piece of work, adjusting for the learning and initial evaluation findings.

27. Improvements have been made to direct booking pathways, in particular to resolve IT issues that were preventing patients being booked into appointments with their own GP practice.

28. Significant changes have been made to ambulatory care pathways at UHL to enable EMAS, the clinical navigation hub and GP practices to refer and book patients directly into specialist and emergency clinical assessment pathways without patients having to go first to an Emergency Department, where they have to wait to be seen before getting to the right clinical service. This change means patients are now going straight to assessment units for medicine, surgery and gynaecology who previously were being seen first in the UHL ED.

This has improved patient experience, reduced waiting times and reduced pressures on ED.

29. The above changes have been supported by a range of communication activities. From October 2020, once the initial changes had been tested, we ran a range of communications, using social media and local radio. A large scale national TV campaign promoting the use of NHS 111 ran during November and December 2020. The key messages of our local campaign have been to stress that people can get help in identifying the most appropriate and convenient service for them by calling NHS 111.

30. Communications materials have been translated using the most frequently used languages in LLR and we have used community radio stations and multi-lingual broadcasts fronted by local GPs to help get messages across to different communities in LLR, including Hindi, Polish and Somali as well as English. 5 out of 6 community stations in Leicester City are participating and playing the messages.

31. A number of webinars, communications materials and learning events have been organised to promote the 111 First work. Some of these have targeted GPs and primary care staff, while others have been open to a wider audience.

What impact have the changes had?

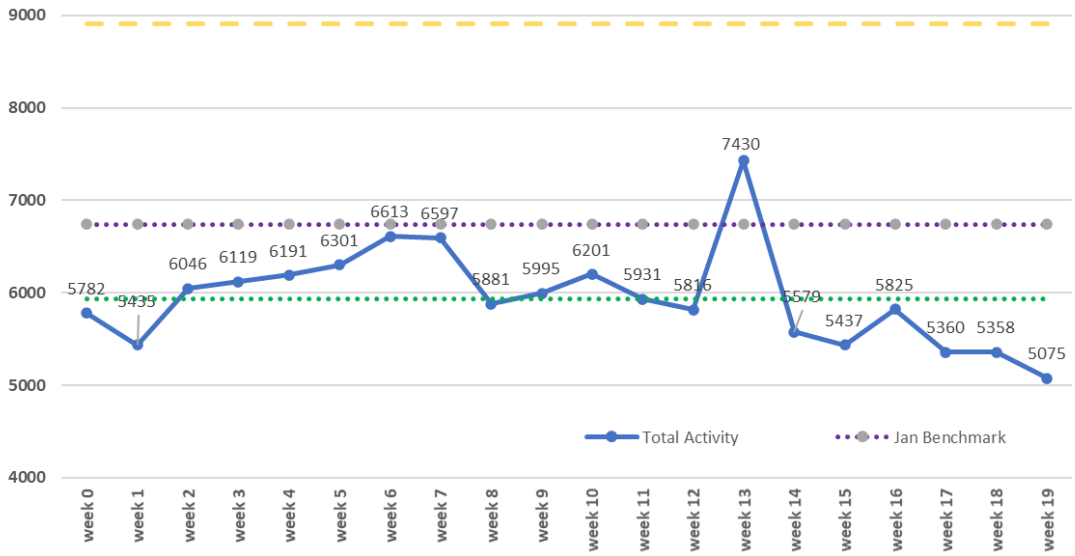
32. It has been difficult to draw definite conclusions from the initial evaluation data about the impact of 111 First for a number of reasons:

33. As well as implementing 111 First, we have made a number of changes to services and pathways through last summer, autumn and winter, which mean there is not a stable baseline or comparator and the cause of changes may not be attributable to 111.

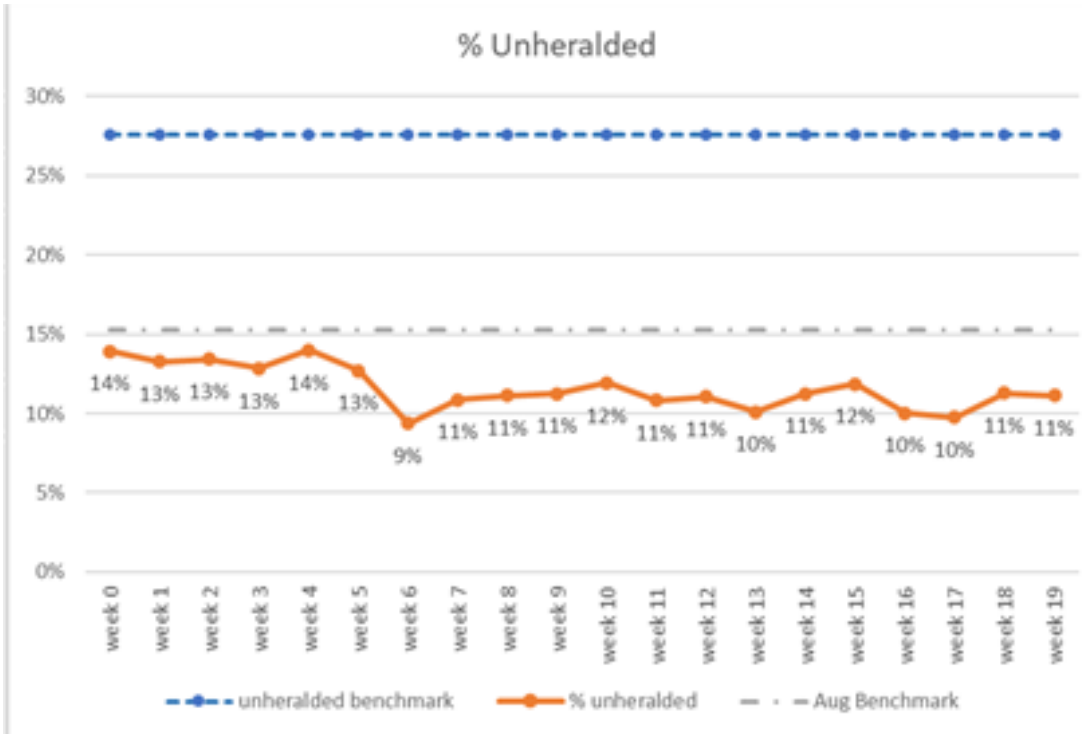
34. Since implementing 111 First, we have experienced two further COVID peaks which will have affected total demand for health care as well as the case mix. However, we can identify some clear trends from the work so far, which are summarised in the paragraphs below.

35. NHS 111 activity has gone down since the introduction of the 111 First changes, despite both local and national promotion activity. This is the reverse of the expected position, which was predicted to be a 13% increase nationally. The trend in LLR patient calls to 111 is shown below (the spike at week 13 is Christmas). The decrease locally mirrors the national trend and this is thought

to have two causes, the first is that there has been less prevalence of minor colds and injuries due to lack of social contact and activities. Secondly, suspected COVID calls are managed by the national COVID 111 CAS service and are excluded from local 111 activity.



36. There has been a decrease in the number of ‘unheralded’ patients arriving at ED who have not got a booked appointment or been referred by a health professional. We have exceeded the target reduction in un-referred walk in activity, as shown in the graph below.



37. Since implementing the direct booking from NHS111 and our Clinical Navigation Hub into ED we have seen an increase in patients being booked, from an average of 15 patients per day in week 1 to 28 patients per day in week 12. This is reflected in the reduction of unheralded activity presenting at ED.

38. Compared to the pre-mobilisation baseline week in August, the proportion of patients who have been referred to ED from 111 has dropped from 5% of calls to 2% of calls, reflecting the increase to the range of conditions that now get clinical assessment via 111 and the navigation hub.

39. Work to improve IT booking pathways has led to an increase of 38% in the number of patients getting a booked GP appointment after calling 111. (Note that most of these patients would previously have been told to simply call their practice but not given a confirmed appointment.)

40. Uptake of new direct pathways into ambulatory care has been slow so far, despite publicising this to GPs, EMAS and clinical navigation.

Further work

41. We are still undertaking further evaluation to understand the impact of the changes to date. This will feed into work to improve the NHS 111 model further as well as urgent care pathways more generally.

42. Work is underway to develop an inequalities plan, including analysing the use of NHS 111 by patient from different post codes and age groups across LLR to compare this to the demographic profile of our population. This will enable us to see any groups who are under or over represented in using NHS 111 and develop plans to target these groups with relevant information, engage with them to identify the reasons why they may not use 111 and adapt our services so that we can improve access and reduce any inequalities,

43. We are gathering patient experience information in two ways; firstly from DHU by asking patients to share their feedback on using 111, secondly by undertaking engagement with UHL ED users on their experience of 111 and urgent care pathways. The results of this work will be available later in the spring.

44. A key focus of our future work is to increase the number of ambulatory and emergency care services that can be accessed as an alternative to ED, and to increase the direct referrals and direct bookings into these via 111/EMAS/DHU/GPs.

45. To conclude, we have successfully implemented a number of improvements to the NHS 111 service and met the national expectations in respect of this. This has had some positive benefits for local people in allowing more booked appointments at ED, GP practices or other services, and reducing walk in activity at ED. However, the impact to date appears to have been fairly modest. We are continuing to refine our local pathways as well as we learn from the initial evaluation and are continuing to review the equalities impact and develop further plans for improvement.

FLU

46. Uptake has increased, and the national target was met for the over 65's.There was a 10% increase in uptake for 'at risk' groups.

47. Overall vaccination rates for key 'at risk' groups were up 8.7% on last year at 67.8%.

48. For the over 65's, flu vaccine uptake rates were 81.1% (up 10% % on last year).

49. The data below is the latest available from the monthly reports provided through the IMMFORM data.

GP Practice Flu Immunisation uptake - Week 03 202		Summary of Flu Vaccine Uptake %					
CCG Code	CCG	65 and over	Total Combined - 6 months to under 65 years: At-risk % uptake	All Pregnant Women	All Aged 2	All Aged 3	50-64
03W	NHS EAST LEICESTERSHIRE AND RUTLAND CCG	83.4%	53.0%	50.6%	67.3%	68.9%	35.5%
04C	NHS LEICESTER CITY CCG	75.9%	43.6%	34.9%	44.8%	45.1%	24.8%
04V	NHS WEST LEICESTERSHIRE CCG	83.4%	51.1%	49.7%	68.5%	68.9%	37.1%
	ENGLAND	**80.7%**	**52.1%**	**43.6%**	**55.0%**	**57.6%**	**-**

50. Support to general practice and primary care networks continues to be provided by the CCG with general and specific targeted support undertaken. However efforts and work is being undertaken on the COVID vaccination programme so it is not anticipated that the flu percentage will increase much further if at all.

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Agenda Item 9

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT OVERVIEW AND SCRUTINY COMMITTEE

5th MARCH 2021

COVID – 19 VACCINATION PROGRAMME

REPORT OF THE EXECUTIVE DIRECTOR OF NURSING, QUALITY AND PERFORMANCE

Purpose of Report

1. The purpose of this paper is to provide an update on the progress of the Covid-19 vaccination programme in Leicester, Leicestershire and Rutland (LLR).

2. Members should be aware that this is a highly dynamic programme and although the information provides an accurate description of the position of the programme at the time the report was written there will most likely be some significant changes to report at the meeting. For this reason the report is high level.

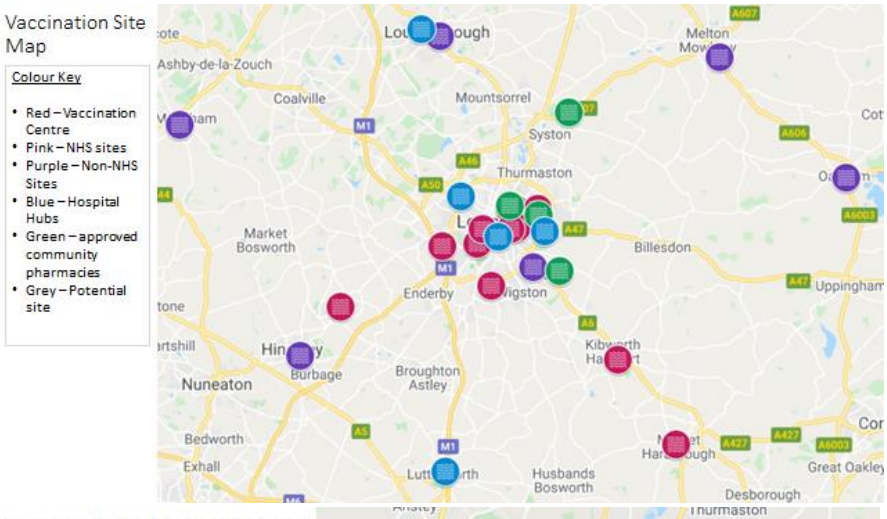
Capacity & delivery

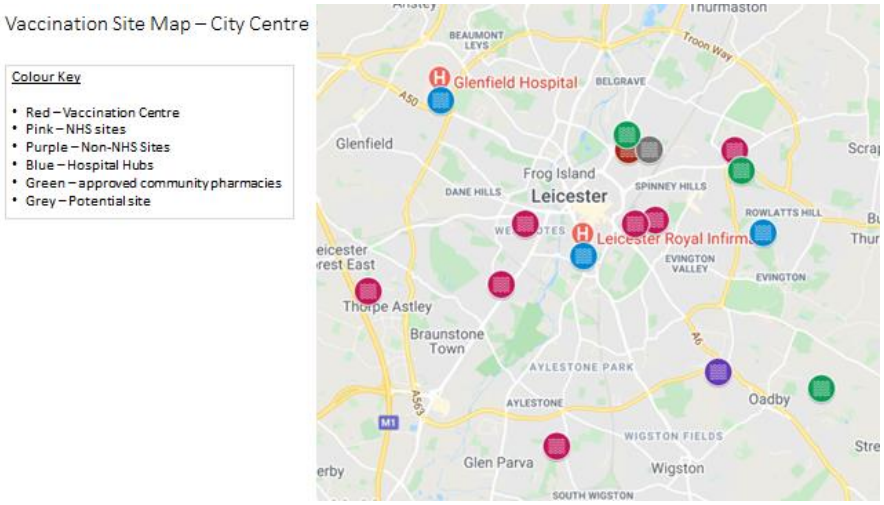
3. We are currently providing vaccinations from the following sites across LLR:
    - 19 GP led Primary Care Network (PCN) sites. These are split between 12 NHS sites (e.g. larger GP practices) and 7 non - NHS sites (e.g. The Kube Leicester Racecourse)
    - Large Vaccination Centre – The Peepul Centre
    - 5 Hospital Hubs
        - Leicester General Hospital
        - Leicester Royal Infirmary
        - Glenfield Hospital
        - Loughborough Hospitals
        - Feilding Palmer Hospital

- 3 pharmacies

4. The PCN sites, Peepul Centre and pharmacies provide vaccines to the public. The hospital hubs provide staff vaccinations. In recent weeks, however, the Leicester General Hospital, the Leicester Royal Infirmary and the Glenfield Hospital have been opened to the public to book slots. This is in response to the availability of vaccine and booking slots at these hospitals. The maps below show the location of sites.

5. A PCN site has been approved at the Prajapati Centre (Grey on the map).





Vaccination Cohorts

6. As Members will be aware, priority cohorts have been set and the vaccination programme must adhere to these, ensuring vaccinations are only given in the order set by the Joint Committee on Vaccinations and Immunisations (JCVI). The cohorts for phase 1 of the vaccination programme are:

1. Residents in a care home for older adults and their carers
2. all those 80 years of age and over and frontline health and social care workers
3. all those 75 years of age and over
4. all those 70 years of age and over and clinically extremely vulnerable individuals
5. all those 65 years of age and over
6. all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
7. all those 60 years of age and over
8. all those 55 years of age and over
9. all those 50 years of age and over

6. It is estimated that taken together, these groups represent around 99% of preventable mortality from COVID-19. Cohorts 1 – 4 were completed by 15 February in line with the Government's target. At this point we were confident that all eligible people in cohorts 1-4 had been offered a vaccine.

7. We are currently vaccinating people in cohorts 5 and 6. Cohort 6 has been expanded to include approximately 20,000 people identified following a national assessment of population risk as clinically extremely vulnerable. Adult carers are also included within these current cohorts.

Progress on vaccinations

8. The number of vaccinations is reported each week by NHSE. Figures are provided below on the number of vaccines given as at 14 February. This is the latest date for publication of the statistics at the time this report was compiled. We will provide an update at the meeting. The level of detail provided is being increased gradually. Currently the following information is available:

- Vaccinations by Region and Age;
- Vaccinations by Integrated Care System (ICS)/Sustainability and Transformation Partnership (STP) and Age;
- Vaccinations by Clinical Commissioning Group (CCG) and Age;
- Vaccinations by Ethnicity (nationally);
- Vaccinations by Ethnicity and Region;
- Vaccinations by Ethnicity and Integrated Care System (ICS)/ Sustainability and Transformation Partnership (STP);
- Vaccinations of Residents in Older Adult Care Homes;

- Vaccinations of Trust Health Care Workers;
- Vaccinations of the Clinically Extremely Vulnerable Cohort (CEV);
- Population estimates.

9. The latest set of figures will be published on Thursday 25 February and can be viewed here: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

Headline statistics on vaccinations are below:

Number of doses at STP Level at 14 February 2021

ICS/STP of Residence	1st dose				2nd dose				Cumulative Doses to Date
	Under 70	70-74	75-79	80+	Under 70	70-74	75-79	80+	
Leicester, Leicestershire and Rutland	110,262	50,637	37,364	50,073	2,027	90	785	3,704	254,942

Housebound

10. Delivering house bound vaccinations is logistically challenging: the GP practice has to plan these carefully. Once they take a vial (8-10 doses in a vial) out they need to ensure that they are able to utilise this within 6 hours whilst maintaining cold chain. So in order to minimise wastage there is careful planning that needs to take place:

- Identifying enough patients within a geographical location to vaccinate
- Ensuring that the patients are at home and are well enough
- Booking these visits in
- Cold chain management
- Ensuring PPE and consumables required to safely deliver

11. Over 70% of housebound patients have received vaccinations at home.

Vaccine Supply

12. Vaccine supply has generally increased since the programme commenced. We are using two vaccines, Pfizer and AstraZeneca/Oxford. As well as increasing levels of vaccine the AstraZeneca provides greater flexibility and has helped for example with the delivery of the housebound vaccinations.

13. We are operating on a 'push model' with supplies determined based on proposed activity regionally. Nationally the aim is to ensure the country moves through the cohorts at a similar pace so supplies are issued on a 'fair share' basis.

14. All vaccinations sites should have arrangements in place for creating reserve lists of people who can be called at short notice to avoid any vaccine being wasted if there is likely to be excess vaccine due to 'no shows' for example. We are also in discussions with NHSE about the inclusion of other workers within the cohorts.

15. As the programme has developed spare appointment slots are becoming available at the UHL hospital sites. We have therefore opened up the hospital sites to the public. We ensure the public is aware that they must be in an eligible cohort to be given a vaccine at the hospital site. Unfortunately there has been 'fake messaging' relating to this which we try and deal with as soon as possible.

Staff vaccinations

10. Across LLR we are currently at around 75% uptake for frontline staff for a cohort of around 66,400 people across 800 organisations. We are working on an action plan to improve this, in particular to understand and respond to hesitancy. Fear of the vaccine causing infertility for example has been raised as a significant reason for hesitancy. We are also aware from feedback that some staff find practical difficulties in the booking process and we are working on putting place arrangements to support staff.

11. Work is being undertaken in conjunction with the public health teams in Leicester City and Leicestershire County Council to develop an approach to conversations about vaccines and responding to often personal reasons for reluctance to have the vaccine.

Homeless

12. Homeless people have been classed as Clinically Extremely Vulnerable or Clinically Vulnerable so are within the current groups. Inclusion Health practice health team has visited hostels and ran a very successful drop – in clinic from a gazebo in a car park.

13. There are plans to offer the vaccine to more of those in hostels, rough sleepers, those in Houses of Multiple Occupancy, and asylum seekers in large scale accommodation sites such as hotels.

Inequalities & vaccine hesitancy

14. The programme is working closely with public health colleagues on the response to the Equalities Impact Assessment (EIA). A detailed report on actions taken and how the delivery model should adapt to ensure the programme meets statutory duties on equality are integrated within our programme.

15. This work will involve a detailed response on how we will ensure the programme pays due regard to the impact on each protected group.

16. The inequalities work will focus particularly on vaccine hesitancy. This will influence our approach to engagement in particular where we know particular groups may be hesitant about being vaccinated.

17. We are also considering direct calls by GPs to their patients when the vaccination hasn't been accepted.

Communications and engagement

18. There is a detailed communications and engagement plan which aims to co-ordinate a range of activities across partners in LLR, including local authorities and the voluntary and community sector.

19. In summary, our strategic approach is based around providing simple messages in a wide range of languages and formats, easily shareable where possible, that target misinformation and encourage take-up. The delivery of messages includes utilisation of trusted voices, such as local health workers and others including faith and community leaders.

20. The plan is particularly focussed on:

- Understanding the data to support targeted communications and engagement work, as well as undertaking local research to understand opinions towards the vaccine and generate insights that can be used to modify the communications approach;

- Information provided in other languages e.g. GP and other healthcare worker videos which can be shared organically through social networks such as WhatsApp;

- GPs and other clinicians taking part in community conversations and focus groups in conjunction with faith and community leaders as well as other representatives of the voluntary and community sector to tackle myths or barriers to vaccine hesitancy based on evidence and insight;

- Extensive radio advertising in a range of languages across community and cultural specific radio stations such as Sabras, Koh-i-noor, EAVA and others;

- Information video in various languages produced in partnership with the Together in Hope Near Neighbour Project;

- Social media advertising targeted at users of different backgrounds based on browsing data, with messages delivered in relevant languages;

- Development and sharing of relevant and appropriate messages in ‘toolkit’ format for use by a wide range of stakeholders that can be shared quickly and easily with communities and networks;

- Opportunities for discussion through public webinars (the first one attracted over 1000 people) and this has been followed by a Facebook Live on 28 February;

- Leaflet to be distributed with council tax information in Leicester City. Exploration taking place as to whether this can be replicated across district councils;

- In Leicester City a Covid vaccination factsheet is to be distributed by a door to door testing team as well as at testing centres and local food banks;

- Linking in with initiatives such as Covid Health Champions in the Leicestershire County Council area;

21. Through our communications and engagement we will aim to promote confidence in the vaccination and the programme. Ensuring people have the right information on vaccines and information on the programme itself is core to our approach.

Next Steps

22. It is aimed to complete cohorts 1-9 by April. The Government has stated that all doses in the first 1-9 cohorts are to be completed by 31 July.

23. We are working beginning second doses – around 660,000 doses will be needed.

24. We are also working on our plans for Phase 2 which is the next cohorts after 1-9 have been completed. There is also a third phase to cover boosters.

25. We are also in discussions about ensuring our model for delivery remains fit for purpose.

Officer to contact

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Leicestershire County Council

LEICESTERSHIRE, LEICESTER AND RUTLAND JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

5TH MARCH 2021

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST AUDIT

REPORT OF THE CHAIRMAN & CHIEF EXECUTIVE OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Purpose of the Report

1. The purpose of this report is to explain the events and background to the UHL Trust Board's decision not to agree the 2019/20 annual accounts as 'true and fair' and to set out the actions being taken to address the issue.

Background

2. The Trust's accounts for the financial year 2018/19 received an unqualified, ('clean') opinion, from the external auditors however the auditors did raise some concerns which although they were below the 'materiality' threshold (i.e. the level at which they would impact on the unqualified / clean audit opinion), nonetheless merited further investigation.

3. The then Chief Financial Officer of the Trust was therefore tasked with looking into and responding to those concerns by the then chair of the Audit Committee, he did not do that in a timely manner and subsequently left the Trust in autumn 2019.

4. The then chair of the Audit Committee raised this with the then Chief Executive and the Chairman who instructed the Interim Chief Financial Officer to look into the matters raised by the auditor.

5. This he did and in doing so found that the 2018/19 accounts had been significantly misstated to the tune of some £46m. (The Trust's annual turnover is £1.1 billion). As a consequence of this the Trust had to make a 'prior year adjustment' to the 2018/19 accounts correcting them.

6. That was during January 2020 and stakeholders including Overview and Scrutiny colleagues from Leicester, Leicestershire and Rutland received a briefing on that matter at the time.

7. That however was not the end of the issue; detailed and forensic work to accurately assess the Trust's financial position continued throughout 2020, led by the Trust's new Chief Financial Officer and with the support of a Financial Improvement Director appointed by NHS England/Improvement as part of the regulator's 'Special Measures for Finance' regime. At the same time the Trust's external auditors have conducted a rigorous audit of the 2019/20 financial statements.

8. This work subsequently identified further significant technical accounting issues in the draft 2019/20 accounts and as a consequence the Trust Board were not prepared to sign off the 2019/20 draft accounts as 'true and fair'.

9. Instead, the Trust is continuing to review the financial position and will seek to prepare a new set of accurate financial statements with a view to completing the audit later this year.

10. The Trust Board takes this very seriously and although the Auditor General in his comments on this matter refers to the 'accounting judgements and manual intervention associated with the previous senior leadership regime', the Trust is clear that the responsibility for exposing and addressing these issues sits with the Board.

11. The Board were not prepared to adopt the accounts because they did not reflect a true and fair record despite the exhaustive efforts made by our external auditor. The Trust is determined to correct what has happened previously and put in place measures to make sure it cannot happen again. Due to the scale and complexity of the task this work is still on-going but a huge amount of progress has already been made. Further work is planned to enable the Trust to file restated audited accounts for 2019/20 and audited accounts for 2020/21 by August 2021.

12. Separately there have been a number of changes to the Board in recent months such that a third of the Board and all those who had direct professional or oversight accountability for finance and audit have left the Trust; the finance team are under new and strengthened senior management; the Trust has been placed in the Financial Special Measures (FSM) regime and the Board are now part of an intensive development programme. Most importantly grip and control of 'run rate' and reporting has been re-established.

Background Papers

UHL Trust Board papers from meeting on 4 February 2021:
http://www.library.leicestershospitals.nhs.uk/pubscheme/Documents/How%20we%20make%20decisions/Board%20Papers/(2021)%20-%20Thursday%204%20February%202021/paper%20G1.pdf

Agenda and Minutes of Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee meeting on 3 July 2020 where Prior Year Adjustment to UHL Accounts was considered:
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1182&MId=6295&Ver=4

Circulation under the Local Issues Alert Procedure

6. Not applicable

Officer to Contact

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List of Appendices

Appendix 1 - Timeline
Appendix 2 - Trust Audit Committee Minutes from Public Trust Board meeting February 2021
Appendix 3 - External Auditor's Statutory Recommendations
Appendix 4 - Trust Board Development programme overview.

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Appendix 1

July 2019

- External Auditor briefs Board on 18/19 audit opinion (unqualified) and highlights concerns.

August2019 - October 2019

- Audit Committee Chair requests CFO to report back on concerns
- CFO does not comply and leaves the Trust in October 2019

November - December 2019

- Audit Committte Chair raises concerns with CEX and Chairman they ask new Interim CFO to look into matters raised by external audit
- Interim CFO joins December 2019 and commences work on concerns

January 2020

- Interim CFO initial work concludes and reports trust accounts misstated by circa £46m for 2018/19.

January - December 2020

- Chief Executive shielding and then on long term sick leave
- Acting Chief Executive starts work
- CFO / External audit teams continue forensic review of financial statements / ledgers etc to inform 2019/20 audit process
- Trust Board take decison that the 2019/20 audit cannot be signed off as 'true and fair'. External Auditor unable to give audit opinion
- New Finance Chair appointed March 2020, former Finance Chair resigns Feb 2021
- Audit Chair resigns July 2020
- Financial Special Measures Regime begins August 2020
- New Non-Executive Director appointed and takes on Chair of Audit Committee September 2020
- CEX retires Sept 2020

January-February 2021

- External Audit issue 'Statutory Recommendations'
- Auditor General commentary in DHSC consolidate provider accounts
- Trust Board accepts 'Statutory recommendations'
- Two Associate Non-Executive Directors appointed to UHL Board, both of whom have significant senior financial and governance experience.

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University Hospitals of Leicester NHS
NHS Trust

Trust Board paper G1 **Appendix 2**

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 4 February 2021

COMMITTEE: Audit Committee

CHAIR: Mr M Williams, Non-Executive Director and Audit Committee Chair

DATE OF COMMITTEE MEETING: 27 January 2021

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE PUBLIC TRUST BOARD:

- **External Audit Section 30 Referral to the Secretary of State for Health (Minute 1/21/1) –** *report appended to these Minutes*
- **Draft Statutory Recommendations (Minute 1/21/2) –** *finalised report appended to these Minutes*
- **UHL Response to Draft Statutory Recommendations (Minute 1/21/3) –** *finalised response appended to these Minutes*
- **Update on Plans/Timetable to Revise and Re-Audit the 2019/20 Accounts (Minute 1/21/5)**
- **Update on Plans/Timetable for Preparation of the 2020/21 Accounts and External Audit (Minute 1/21/6)**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR NOTING BY THE PUBLIC TRUST BOARD:

- **None**

DATE OF NEXT COMMITTEE MEETING: 5 March 2021

Mr M Williams Non-Executive Director and Audit Committee Chair

Appendix 2

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF AN AUDIT COMMITTEE MEETING HELD ON WEDNESDAY 27 JANUARY 2021 AT 1.30PM

(held virtually via Microsoft Teams)

Present:

Mr M Williams – Non-Executive Director (Chair)
Ms V Bailey – Non-Executive Director, and Chair of the Quality and Outcomes Committee
Col (Ret'd) I Crowe – Non-Executive Director, and Chair of the People, Process and Performance Committee
Mr A Johnson – Non-Executive Director, and Chair of the Finance and Investment Committee (excluding Minute 3/21/2 [part])

In Attendance:

Ms A Breadon – PwC (the Trust's Internal Auditor) (excluding Minutes 2/21, 3/21, and 13/21)
Mr M Brice - Deputy Financial Improvement Director (excluding Minute 3/21)
Mrs R Brown – Acting Chief Executive (for Minute 3/21/1)
Ms A Clarke – Local Counter-Fraud Specialist, PwC (excluding Minutes 2/21, 3/21, and 13/21)
Mr R Cooper – Financial Improvement Director (excluding Minute 3/21)
Mr S Lazarus – Chief Financial Officer (excluding Minute 3/21)
Mr S Linthwaite – Deputy Director of Finance (Financial Services) (excluding Minute 3/21) Ms E Mayne – Grant Thornton (the Trust's External Auditor) (excluding Minutes 2/21, 3/21, and 13/21)
Mr M Stocks – Grant Thornton (the Trust's External Auditor) (excluding Minutes 2/21, 3/21, and 13/21)
Ms H Stokes – Corporate and Committee Services Manager
Mr S Ward - Director of Corporate and Legal Affairs
Ms C Wood - PwC (the Trust's Internal Auditor) (excluding Minutes 2/21, 3/21, and 13/21)
Mrs H Wyton – Chief People Officer (for Minute 3/21/1)

RECOMMENDED ITEMS **ACTION**

1/21 2019/20 ANNUAL ACCOUNTS AND RELATED ISSUES

1/21/1 External Audit Section 30 Referral to the Secretary of State for Health

Paper C comprised External Audit's referral of UHL to the Secretary of State for Health under section 30 of the Local Audit and Accountability Act 2014, which had been issued to the Secretary of State for Health before Christmas 2020. The referral related to failures in the Trust's duty to break even, and in the Trust's duty to issue financial statements and an annual report 2019/20. The Audit Committee Non-Executive Director Chair noted this report, which would also be submitted to the public Trust Board on 4 February 2021.

Recommended – that the External Audit Section 30 Referral to the Secretary of State for Health be received, and appended to these Minutes for discussion at the public session of the 4 February 2021 Trust Board. **AC NED CHAIR**

1/21/2 Draft Statutory Recommendations

Mr M Stocks, External Audit, presented his Statutory Recommendations draft report at paper D, which would be finalised and issued formally on 29 January 2021. The report would be presented to the public session of the 4 February 2021 Trust Board. These Statutory Recommendations were being made under section 24 of the Local Audit and Accountability Act 2014 (Schedule 7) due to issues with regard to the Trust's financial reporting, governance, and financial sustainability. In presenting his report, Mr M Stocks External Audit noted in particular:- **AC NED CHAIR**

(1) that his concerns re: financial reporting had been discussed in detail at the 2 December 2020 Audit Committee. He considered that the Trust's response on these points (Minute 1/21/3 below refers) was appropriate, but he noted that action was needed in some areas to avoid future errors. He reported his feedback from UHL finance staff that they had felt under-pressure and under-resourced, and he noted his view that they had been aware of the concerns flagged by External Audit during the 2018/19 annual accounts audit and had been directed to continue reporting in the same way as before;
(2) that governance issues had also been discussed in detail at the 2 December 2020 Audit Committee. Mr M Stocks External Audit emphasised the crucial importance of an appropriate financial tone and leadership within the Trust, and considered that the required delivery of the Control Total had become the pre-eminent focus. He considered that change had begun to address the cultural issues at UHL and the previous lack of Trust Board/Board Committee challenge of management, but that it remained early days;
(3) his urging of UHL to engage with Commissioners and Regulators to address UHL's longterm financial position and reach financial sustainability, as detailed in the 2019/20 draft Audit Findings Report, and
(4) his view that financial accounting, governance and ethics training was required for the finance team.

In discussion on the draft Statutory Recommendations report, the Audit Committee noted:-

(a) a query from the Audit Committee Non-Executive Director Chair as to whether the Audit Committee needed to be specifically sighted to any issues arising from Mr M Stocks' interviews with UHL staff. In response, Mr M Stocks noted his wish to re-review the interviews (the final one of which would be held on 1 February 2021) and advised the Audit Committee that staff had been open and transparent with him about the perceived culture of the department and the pressure felt to continue with incorrect practices. Ms V Bailey Non-Executive Director considered that there was an important distinction between capability and capacity issues arising from overwork and those relating to innate ability; although this was echoed by Mr M Stocks External Audit, he considered that the general team skillset was appropriate, with capability issues relating primarily to direction and capacity. The Audit Committee Non-Executive Director Chair queried whether there were any in-house training issues;
(b) a query from Col (Ret'd) I Crowe Non-Executive Director as to what further action UHL could take to break even in future, in addition to the numerous actions put in place through the Financial Special Measures programme. In response, Mr M Stocks External Audit considered that this was not an objective UHL could deliver in isolation; he reminded Audit Committee members that the Trust had declared deficits each year since 2013/14 and he noted his view that UHL's underlying structural deficit could not be addressed through efficiencies alone as it required a correction of the fundamental underfunding of the Trust. It was crucial, therefore, that UHL worked with Commissioners and Regulators to agree a strategy which would return the Trust to a longterm sustainable financial position. Mr A Johnson Non-Executive Director voiced significant concern that the LLR system was being asked to deliver further savings in the next financial year thus placing the Trust under further additional pressure, and he also voiced his concern that the underlying need for more funding was not being addressed (as recommended by External Audit), and
(c) comments from the Audit Committee Non-Executive Director Chair on the expectations made clear to all NHS Trusts re: meeting their Control Totals. He considered that it was clear that meeting its Control Total had been prioritised by the Trust to the detriment of accuracy of accounting, and he noted the pressures leading to reporting in such a way as to achieve the Control Total. Although noting these points, Mr M Stocks External Audit urged the Trust not to continue to accept an undeliverable Control Total and emphasised the need for Trusts to be clear with Regulators on what was achievable.

<u>Recommended</u> – that draft Statutory Recommendations report be noted, and the finalised version recommended for consideration at the public session of the 4 February 2021 Trust Board (as appended to these Minutes). **AC NED CHAIR**

1/21/3 UHL Response to Draft Statutory Recommendations

Paper D1 from the Director of Corporate and Legal Affairs and the Chief Financial Officer comprised UHL's response to the draft Statutory Recommendations report at Minute 1/21/2 above. The Director of Corporate and Legal Affairs noted the good engagement between the Trust and Mr M Stocks External Audit on this, with the latter having amended an earlier draft of his report as a result of the Trust's comments. Subject to any Audit Committee comments, the finalised version of paper D1 would also be submitted to the public session of 4 February 2021 Trust Board, accompanying the finalised Statutory Recommendations report. Once adopted by the Trust Board, paper D1 would be translated into a formal action plan and incorporated within the overarching UHL financial governance improvement plan, resulting in a single, comprehensive action plan which would be reviewed monthly by the Trust Board and FIC, and at each Audit Committee.

Ms V Bailey Non-Executive Director particularly welcomed this assurance from the Director of Corporate and Legal Affairs on how the action plan would be aligned to appropriate governance processes, and on the fact that a single action plan would cover progress. However, Ms V Bailey Non-Executive Director advised that further clarity was still needed on how the progress of actions was described – eg to clarify the meaning of 'on track'/'pending'/ 'in progress' etc. This point was supported by the Audit Committee Non-Executive Director Chair, who also emphasised the need for more rigorous and detailed monthly challenge of the overarching financial governance improvement plan by the Trust Board and Board Committees. Col (Ret'd) I Crowe Non-Executive Director asked for assurance that any issues arising from the action plan for other Board Committees such as People, Process and Performance Committee and/or Quality and Outcomes Committee would be appropriately flagged to those Committees, as he considered that there were potential issues for those groups (eg workforce efficiency discussions at PPPC). The Director of Corporate and Legal Affairs agreed to ensure that appropriate alignment and cross-referral of items took place. Mr A Johnson Non-Executive Director also requested that detail on the monitoring of each action be included in paper D1.

DCLA/ CFO

DCLA

Mr M Stocks External Audit also considered that UHL should request Internal Audit to review whether the actions in paper D1 resulted in subsequent, tangible change. The Chief Financial Officer advised Audit Committee members that the actions in paper D1 were already underway; he confirmed that strengthened controls had been introduced re: journals before Christmas, and he noted the key appointment of Mr S Linthwaite Deputy Director of Finance (Financial Services) to the Trust's senior finance team and the very strong additional support currently being provided to UHL by NHSE/I in the form of high quality interims.

CFO

Mr A Johnson Non-Executive Director sought Mr M Stocks External Audit's view on whether the Trust's (draft) response to the (draft) Statutory Recommendations report was adequate – in response, Mr M Stocks considered that paper D1 was broadly adequate but that the response to point 9 (agreement with Commissioners and Regulators of a strategy to return UHL to a longterm sustainable financial position) required more detail from UHL. Given External Audit's comments, Mr A Johnson Non-Executive Director advised that he was unwilling to endorse paper D1 for recommendation to the Trust Board without strengthened wording being included on point 9. The Audit Committee Non-Executive Director Chair considered that the issue of only agreeing a deliverable Control Total (which UHL was committed to doing) was separate to the issue of LLR-wide and NHSE/I engagement on the Trust's fundamental underlying financial deficit position, and he noted comments from Mr M Stocks on the need for the Trust Board to take a view on accepting a deficit Control Total in future. In further discussion, the Director of Corporate and Legal Affairs outlined the commitments required of UHL as part of the Financial Special Measures programme, including development (and sharing with NHSE/I) of a longterm financial model aligned to the LLR STP longterm plan. The Financial Improvement Director emphasised the need for UHL to develop a credible route map for exiting Financial Special Measures and to be able to demonstrate a track record of financial delivery against plan. He also echoed comments on the need for any agreed Control Total to be realistic and deliverable.

Following discussion, the Audit Committee Non-Executive Director Chair advised that he would agree a strengthened form of words outside the meeting for the Trust's response to point 9 of paper D1, ahead of the February 2021 Trust Board. **

** revised form of wording subsequently agreed for inclusion as follows:-

	External Auditor Recommendation	UHL Response (updated)
9.	The Trust Board should agree with its commissioners, NHS England and Improvement, and the Department of Health a strategy that will return the Trust to a long term sustainable financial position.	The Trust is committed to eliminating the underlying financial deficit as soon as practically possible and has commenced a programme of work to identify cash and efficiency savings and to ensure the best possible value for money. If this produces a compelling case for increased funding it will work constructively with Commissioners, NHS England and Improvement and the Department of Health to secure appropriate funding levels. In the meantime it will not agree unrealistic financial targets but recognises it has an obligation to work together with partners in the local health economy to build a system that is both clinically and financially sustainable.

Recommended – that (A) subject to inclusion of the revised 'UHL response' wording above for point 9, the Trust's draft response to the draft Statutory Recommendations report be endorsed and recommended for Trust Board approval on 4 February 2021 (as appended to these Minutes); **AC NED CHAIR**

(B) with regard to the action plan resulting from paper D1 for report to FIC and Trust Board monthly and each Audit Committee, the Chief Financial Officer and the Director of Corporate and Legal Affairs be requested to:- **DCLA/ CFO**

(1) ensure that all of the actions were incorporated within the Financial Governance Improvement Plan, identifying key action owners, dates for completion and monitoring arrangements (including at Trust Board, the Finance and Investment Committee, and Audit Committee);

(2) ensure that other Board Committees were appropriately sighted to issues requiring their discussion/monitoring, and

(C) consideration be given to seeking an Internal Audit view on whether the action plan measures resulting in tangible practice and culture changes. **CFO**

1/21/4 Report from the Chief Financial Officer

Recommended – that this Minute be classed as confidential and taken in private accordingly.

1/21/4 Update on Plans/Timetable to Revise and Re-Audit the 2019/20 Accounts

Paper G from the Deputy Financial Improvement Director updated the Audit Committee on the plans to revise and reaudit the Trust's 2019/20 annual accounts, and the timetable for that work. An appropriate action plan was being developed from paper G. Following a scoping exercise which had begun before Christmas 2020, it was the Trust's ambition to restate the accounts by 31 March 2021 (unaudited position – the timescale for auditing the restated balance sheet remained to be agreed) although this was not without risk. The 2019/20 closing balance sheet would then be 'rolled forward' as the Trust's 2020/21 opening balance sheet and the basis for the construction of the 2020/21 annual accounts (for completion by 31 August 2021 as detailed in Minute 1/21/6 below).

The Deputy Director of Financial Improvement emphasised the need for significant communication and coordination between the Trust and its stakeholders throughout the process. Appropriate governance was essential in awarding the contract for the 'delivery' phase of the work to revise and reaudit the 2019/20 accounts, and the Deputy Financial Improvement Director was working closely with the Trust's procurement team and the Director of Corporate and Legal Affairs on that.

Recommended – that the proposed plan and timetable to revise and reaudit the 2019/20 accounts be endorsed and recommended for Trust Board approval. **AC NED CHAIR**

1/21/6 Update on Plans/Timetable for Preparation of the 2020/21 Accounts and External Audit

Paper H from the Deputy Director of Finance (Financial Services) updated the Audit Committee on the plans to prepare the Trust's 2020/21 annual accounts, and the timetable for that work (at both draft and audited stage). He emphasised the need to align to the national accounts timetable without any delay associated with the 2019/20 restatement, and the Chief Financial Officer noted the crucial importance therefore of meeting the 31 March 2021 timescale for restating the 2019/20 accounts (unaudited position) as detailed in Minute 1/21/5 above. Although the draft accounts deadline for NHS bodies was 27 April 2021, NHSE/I was giving those provider organisations who required more time (and met the criteria) an extended date of by 11 May 2021, with a consequent deferment of the audited accounts deadline to 29 June 2021. The Audit Committee Non-Executive Director Chair confirmed the Audit Committee's agreement to seek this extension. As detailed in paper H, however, due to the likely complexities of auditing its 2020/21 accounts UHL anticipated that its final audited accounts would not be ready for submission until 31 August 2021. The ability to submit a clean true set of accounts by that date would be a significant milestone for the Trust. In response to a query from the Audit Committee Non-Executive Director Chair seeking assurance on any repercussions from missing the 29 June 2021 submission date, the Chief Financial Officer considered that NHSE/I were aware of the need for a clean set of accounts, and he noted that the reasons for the complexity of the audit process were clear to the Regulators. It would be crucial, however, to avoid any significant slippage on that 31 August 2021 date. **CFO/ DDF(FS)**

Recommended – that (A) an application be made to NHSE/I to seek the available 2-week extension to the submission of both the unaudited and audited accounts 2020/21, and **CFO/ DDF(FS)**

(B) the proposed plan and timetable for preparation of the 2020/21 accounts be endorsed and recommended for Trust Board approval. **AC NED CHAIR**

2/21 REPORT FROM THE CHIEF FINANCIAL OFFICER

Recommended – that this Minute be classed as confidential and taken in private accordingly.

3/21 REPORT FROM THE ACTING CHIEF EXECUTIVE

Recommended – that this Minute be classed as confidential and taken in private accordingly.

RESOLVED ITEMS

4/21 APOLOGIES FOR ABSENCE AND WELCOME

Apologies for absence were received from Mr J Shuter, Director of Operational Finance. The Audit Committee Non-Executive Director Chair welcomed Mr S Linthwaite, Deputy Director of Finance (Financial Services) to the meeting.

5/21 DECLARATIONS OF INTERESTS

Mr A Johnson, Non-Executive Director, declared his interest as Non-Executive Chair of Trust Group Holdings Ltd and Fight4Rutland. Mr S Lazarus Chief Financial Officer declared his role as a Non-Executive Director of Trust Group Holdings Ltd. With the agreement of the Audit Committee, these individuals remained present.

Resolved – that the position be noted.

6/21 MINUTES

Resolved – that the Minutes of the 16 November 2020 Audit Committee (papers A1 and A2), and the Minutes of the 2 December 2020 Audit Committee (paper A3) be confirmed as a correct record.

7/21 MATTERS ARISING REPORT

Resolved – that the matters arising report be noted.

8/21 KEY ISSUES FOR DISCUSSION/DECISION

8/21/1 Actions Taken and Planned to Strengthen the UHL Finance Function and Key Financial Controls

Paper F from the Chief Financial Officer provided assurance to the Audit Committee on the actions underway to strengthen UHL's finance function, noting the very significant (and welcomed) interim support available from NHSE/I as part of the Financial Special Measures programme. Given the work required, the Chief Financial Officer considered that this high quality interim support was likely to be needed until Autumn 2021. A number of new substantive senior finance team appointments had also been made by UHL. A new finance function structure was being developed for implementation on 1 January 2022 – although recognising that this was a period of uncertainty for the existing team the Chief Financial Officer considered that this timescale was necessary to deliver the required improvements. The Audit Committee Non-Executive Director Chair emphasised the need to take as much time as required, but no more than was necessary, and requested that a more detailed update be provided to a future Audit Committee (including, eg, a proposed structure chart). The Chief Financial Officer advised that the work on key financial controls was covered in more detail elsewhere on the agenda. **CFO**

Resolved – that a detailed update on the work to strengthen the UHL financial function be provided to a future Audit Committee. **CFO**

8/21/2 Internal Audit Progress Report, Including the Updated 2020/21 Internal Audit Plan

Paper I advised Audit Committee members that work continued to progress on all elements of the Internal Audit plan, although impacted by the current pandemic pressures on the NHS. Two final repots had been issued as per Minutes 8/21/2 and 8/21/3 below, and the draft report on the NIHR Clinical Research Network had also now been finalised. Some delays had been experienced in receiving information for the payroll audit currently underway, which had been escalated to the appropriate Executive Director. In introducing the report, Ms A Breadon Internal Audit noted changes to the original Internal Audit plan (deferral of the financial reporting review, and use of the days originally planned for Governance to carry out a review of Contract Management, as requested by the Trust's Finance and Investment Committee).

Ms C Wood, Internal Audit also updated the Audit Committee on a number of changes to the overdue actions from previous Internal Audit reports, as detailed in paper I. Since paper I had been issued, 4 actions had been closed and extended action dates had been agreed to be appropriate for a further 3, resulting in a reduction in the number of overdue actions to 7 from the original 14. The Audit Committee Non-Executive Director Chair requested assurance on whether any of the overdue actions should be of specific concern for the Audit Committee – in response, Ms C Wood Internal Audit advised that only 1 of the remaining 7 overdue actions was rated as high risk – this related to private patient debts and the Deputy Director of Financial Improvement confirmed that work was in hand on this issue. Although noting this update, the Audit Committee Non-Executive Director Chair emphasised his wish for progress to have been made on this issue by the time of the next Audit Committee. With regard to the other 3 high risk rated actions in this section of paper I, 2 had been extended and Internal Audit had requested sight of specific evidence in order to close the remaining 1. In discussion, Ms V Bailey Non-Executive Director advised that the Quality and Outcomes Committee (which she chaired) was reviewing the ED safety checklist issues, and she requested therefore that these actions not be closed until QOC had sufficient assurance. **DFID/ CFO** **CW (IA)**

Resolved – that (A) the Internal Audit plan update be noted, and

(B) with regard to the overdue actions from previous Internal Audit reports:- **DFID/ CFO**
(1) appropriate progress be made on the private patient debt high risk finding by the time of the next Audit Committee (March 2021), and
(2) the need for QOC to be satisfied of the position before the ED safety checklist actions were closed, be noted. **CW (IA)**

8/21/3 Internal Audit Review of Accounts Payable – Final Report

Paper J1 detailed the final report of Internal Audit's review of Accounts Payable, which had an overall 'high' risk classification. Ms C Wood Internal Audit particularly advised the Audit Committee of the high risk finding on purchase to pay tolerances, as the 10% threshold for automatic processing was higher than would be expected, not **in** line with UHL policy, and higher than previously in place within the Trust. Variances greater than 10% were processed manually. Ms C Wood Internal Audit also highlighted medium-rated finding 2 on BPPC Reporting in respect of small and medium enterprises (SMEs) and purchase orders not being raised. Internal Audit intended to rerun this data analysis in March 2021. The Deputy Financial Improvement Director provided assurance to the Audit Committee that the issue of SMEs was part of the overarching financial governance improvement plan, and he voiced his own concern about the purchase order issues which was a whole-Trust issue – this was echoed by Ms V Bailey Non-Executive Director who also noted the need for appropriate governance to be in place. The Deputy Financial Improvement Director was working with UHL's Head of Procurement and Supplies and the Director of Corporate and Legal Affairs to review the Trust's Standing Orders and Standing Financial Instructions and reinforce the requirement for purchase orders. The Chief Financial Officer echoed these comments, and noted his own view that tolerances should not be used.

The Audit Committee Non-Executive Director Chair queried why the report did not mention the risk of duplicate payments if no purchase order was in place, and he emphasised the benefits of having a robust purchase to pay system in place. The Deputy Financial Improvement Director advised that the revised budget-holder training programme would also cover process issues, and he confirmed that compliance with the process would be monitored. The Deputy Director of Finance (Financial Services) commented on the need to make better use of appropriate technology and automated system controls, which was particularly welcomed by Mr A Johnson Non-Executive Director. Mr A Johnson Non-Executive Director also commented that the 10% tolerance threshold had originally been introduced with a view to being tightened up over time, which had clearly not occurred. The Deputy Financial Improvement Director also suggested a need to build a follow-up assurance review into the Internal Audit plan.

CFO/ CW (IA)

Resolved – that consideration be given to including a follow-up assurance review on accounts payable in the Internal Audit plan. **CFO/ CW (IA)**

8/21/4 Internal Audit Review of Waiting List Management – Final Report

Paper J2 detailed the final report on Internal Audit's review of waiting list management, which had an overall 'medium' risk classification. Ms V Bailey Non-Executive Director voiced concern at the findings of this review, particularly in respect of the lack of evidence available to demonstrate that processes were taking place at specialty-level. Ms V Bailey Non-Executive Director also voiced her concern at the lack of consistency between specialties and the risk that Covid-19 pressures were disrupting process, and suggested that this issue should be reviewed further by the People, Process and Performance Committee. Although recognising the intense pressures on specialties, Ms C Wood Internal Audit agreed that an audit trail of the process was crucial, which was not currently always in place. However, she considered that the availability of evidence might have been impacted by the timing of the report. She also advised that consistency concerns related primarily to outpatients rather than inpatients. Ms C Wood Internal Audit also advised the Audit Committee that the Trust's RTT Policy did not clearly outline what was required of specialties, and she noted the need for greater clarity on expectations. Mr A Johnson Non-Executive Director echoed the Non-Executive Director concerns expressed about process inconsistencies between specialties – given that these were stated in the report to be 'significant' he emphasised the need for appropriate follow-up on those issues.

PPPC NED CHAIR

Resolved – that the process consistency concerns highlighted in the Internal Audit review of waiting list management be referred to the People, Process and Performance Committee for discussion and follow-up. **PPPC NED CHAIR**

8/21/5 Local Counter-Fraud Specialist Report

Ms A Clarke, Local Counter-Fraud Specialist, PwC, introduced her progress report at paper K. She confirmed that the Deputy Director of Finance (Financial Services) had been identified as

UHL's Counter-Fraud Champion and nominated counter-fraud contact. Work was broadly in line with plan, although impacted by Covid-19 pandemic pressures on the Trust, and the Local Counter-Fraud Specialist noted the need for input from UHL on progressing certain reactive cases (as detailed in paper K). She also confirmed that she had supported UHL in making the required return in response to the NHS CFA Fraud Prevention Guidance Impact Assessment, on time (4 December 2020). National vaccination fraud alerts had also been shared with the Trust.

In respect of open fraud cases, the Local Counter-Fraud Specialist commented on the need to understand the differing level of HR sanctions applied, which she was discussing further with the Deputy Director of Finance (Financial Services). Ms V Bailey Non-Executive Director queried whether ethnicity data was collected as part of counter-fraud work (and was advised that it was not routinely collected, unless pertinent to the investigation), and requested therefore that the Local Counter-Fraud Specialist discuss that issue further with the Deputy Director of Finance (Financial Services). The Audit Committee Non-Executive Director Chair supported the collection of ethnicity data, and also voiced his concerns over the length of suspensions and the overall time to investigate cases, noting that he intended to discuss the detail of the open cases further with the Local Counter-Fraud Specialist. **LCFS**

AC NED CHAIR

Resolved – that (A) the issue of routine collection of ethnicity data as part of local counter-fraud investigations be discussed with the Deputy Director of Finance (Financial Services), and **LCFS**

(B) a discussion take place outside the meeting between the Audit Committee NonExecutive Director Chair and the Local Counter-Fraud Specialist, to understand the detail of the open fraud cases. **AC NED CHAIR/ LCFS**

9/21 ITEMS FOR NOTING

Resolved – that the following reports be received and noted at papers L1-O respectively:

(A) Minutes of the Quality and Outcomes Committee meetings held on 29 October 2020, 26 November 2020, and 17 December 2020;
(B) Minutes of the People, Process and Performance Committee meetings held on 29 October 2020, 26 November 2020, and 17 December 2020;
(C) Minutes of the Finance and Investment Committee meetings held on 29 October 2020, 26 November 2020, and 17 December 2020, and
(D) Minutes of the Charitable Funds Committee meeting held on 18 December 2020.

10/21 ANY OTHER BUSINESS

There were no items of any other business.

11/21 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the items recommended in Minutes 1/21-3/21 above be brought to the attention of the Trust Board.

12/21 DATE OF NEXT MEETING AND MEETING DATES 2021/22

The next Audit Committee meeting will be held on Friday 5 March 2021 from 9am – 12noon (held virtually via MS Teams).

Remaining 2021/22 meetings will be held as follows (9am to 12noon):-

- **Friday 28 May 2021;**
- **Friday 9 July 2021;**
- **Friday 10 September 2021;**
- **Friday 12 November 2021; Friday 14 January 2022, and**
- **Friday 11 March 2022.**

13/21 DISCUSSIONS IN THE ABSENCE OF EXTERNAL AUDIT AND INTERNAL AUDIT REPRESENTATIVES

13/21/1 Minutes

Resolved – that the confidential Minutes of the Audit Committee meeting held on 2 December 2020 be confirmed as a correct record.

13/21/2 Matters Arising

Resolved – that the confidential matters arising log from the Audit Committee meeting held on 2 December 2020 be noted.

The meeting closed at 5pm

Helen Stokes
Corporate and Committee Services Manager

Audit Committee Cumulative Record of Members' Attendance (2020-21 to date):

Members:

Name	Possible	Actual	%
M Williams	3	3	100
V Bailey	4	4	100
I Crowe	4	4	100
A Johnson	4	4	100
K Jenkins (Until July 2020)	1	1	100

In attendance:

Name	Possible	Actual	%
S Lazarus	4	3	75
N Sone	1	1	100
J Shuter	4	3	75
S Ward	4	4	100

Appendix 3

University Hospitals of Leicester NHS Trust

Audit of Accounts 2019/20

Statutory Recommendations

	External Auditor Recommendation	UHL Response
1.	The Trust Board should seek to create a culture that is focussed on accurate financial reporting. In particular, the Board should discourage the use of aggressive accounting policies and practices and should provide appropriate challenge of management.	The Trust Board is to undergo a programme of development, externally facilitated, with particular emphasis on the financial aspects of the Board's responsibilities. Specifically, the programme will focus on: • Reviewing the responsibilities of unitary Board members, emphasising that all are accountable in relation to the financial performance of the Trust; • The provision of specific financial analysis training, tailored to individual Board member experience and need; • A programme of support for Non Executive Directors in how to effectively scrutinise and challenge within a unitary Board environment; • The provision of training and guidance for Executives focussing on their corporate Director role for challenging financial performance and reporting.
2.	The Trust Board should finalise and publish its Annual Governance Statement at the earliest opportunity.	The annual governance statement will be finalised and published alongside the annual accounts 2019/20, once finalised.

3.	The finance and other management teams involved in finance should receive accounting, governance and ethics training to ensure that they are clear on the appropriate accounting practices and the governance standards required by the Trust Board.	The Trust will provide organisational wide budget/financial training/governance programmes for all budget holders. This will also include specific training in relation to the upcoming restated SFIs/SOs/Scheme of Delegation. All Finance staff will undergo a capability review that will identify specific training needs and training programmes will be provided; this will be monitored on an ongoing basis through the staff appraisal process and to ensure their continual professional development. All Trust staff will receive regular ethics and values training.
4.	The Trust should complete its planned review of the structure and capacity of the finance team as soon as possible. As necessary additional investment should be made in the capacity and capability of the team.	Restructure of the Finance Department will be completed and in place for 1/1/22. In the period leading up to the implementation further interim support will be put in place to support this transitional period. The current capacity of the Finance Team is also to be reviewed and benchmarked against peer level/top performing Finance Departments within the NHS.
5.	The Trust Board should undertake a review of its financial procedures and controls to ensure that they are 'fit for purpose'.	Review of the SFIs/SO's/Scheme of Delegation is currently underway. Once finalised and adopted by the Trust, a further education and training programme for all budget holders will be rolled out and for all new starters (budget holders) to support adherence to these controls. In addition the specific internal controls that operate within the Finance Department will also be reviewed and enhanced and supported by a further training programme for Finance personnel.

6.	The control of journals should be significantly enhanced. The Trust Board should ensure that the automated system recently introduced is effective and prevents the self-authorisation of journals.	New journal controls have been implemented wef December 2020. These will be further reviewed and will be subject to internal audit review by March 2021 to review compliance and to consider further control enhancements as appropriate.
7.	The Trust Board should undertake a detailed review of its accounts preparation processes and amend its procedures to allow accounts and supporting working papers of an appropriate quality to be prepared for audit.	The Trust is currently undertaking a systematic review of its accounts preparation processes and procedures Actions have been identified to review and redesign the working papers to ensure adequacy, clarity, linking to accounts and file accessibility.
8.	The Trust Board should take urgent action to complete the revision and audit of its financial statements.	The Trust has engaged with Deloitte on a scoping exercise to ultimately reconstruct the 2019/20 closing balance sheet that will allow the audit to conclude. This will then allow the Trust to build its financial statements on a recognised and robust foundation for 2020/21.
9.	The Trust Board should agree with its commissioners, NHS England and Improvement, and the Department of Health a strategy that will return the Trust to a long term sustainable financial position.	The Trust is committed to eliminating the underlying financial deficit as soon as practically possible and has commenced a programme of work to identify cash and efficiency savings and to ensure the best possible value for money. If this produces a compelling case for increased funding it will work constructively with Commissioners, NHS England and Improvement and the Department of Health to secure appropriate funding levels. In the meantime it will not agree unrealistic financial targets but recognises it has an obligation to work together with partners in the local health economy to build a system that is both clinically and financially sustainable.

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Board development programme

Appendix 4

An overview of proposed activities

Activity \ Month	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Board programme	Confirm plan and activities	1.1 Role of the unitary Board & Board Members (A1)	1.2 Board Member financial training (A3)	1.3 Business chemistry (styles and ways of working)		1.4 Board Committee and effective Board reporting		1.5 Review of progress; Board impact & the Board's role in shaping culture		1.6 Integrated system working	1.7 Feedback on progress and refining future actions
Non-executive director programme			2.1 Effective challenge & seeking assurance (A4)	2.2 Audit Committee Training (including role of the chair) (A4)	2.3 Finance and Investment Committee training (including role of the chair) (A4)		2.4 Revisit role of the NED in the unitary board			2.5 Refining Board debate	
Executive director			3.1 Reviewing the role of corporate director (A5)			3.2 Effective board reporting (A5)		3.3 Role of the ED in Board to Ward assurance			
	Board survey Board / Committee observations Desktop review		Business Chemistry survey	Board / Committee observations				Board / Committee observation		Review of progress (A2) Board / Committee observation	

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