Minutes of a meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee held at County Hall, Glenfield on Monday, 17 March 2025.

PRESENT

Mr. J. Morgan CC (in the Chair)

Cllr. S. Bonham	Mr. T. J. Pendleton CC
Mr. N. Chapman CC	Cllr. K. Pickering
Mr. M. H. Charlesworth CC	Cllr R. Ross
Cllr. Zuffar Haq	Cllr. L. Sahu
Ms. Betty Newton CC	Mrs B. Seaton CC
Cllr. R. Payne	

In attendance

Harsha Kotecha – Healthwatch Leicester and Leicestershire
Janet Underwood – Healthwatch Rutland
Ben Teasdale, Associate Medical Director, UHL (minutes 26 and 32 refer)
Alice McGee, Chief People Officer, ICB (minute 33 refers)
Melanie Thwaites, Head of Women's, Maternity and Neonatal Transformation, Integrated Care Board (minute 34 refers).
Katie Connor - Women's Programme Manager, Integrated Care Board (minute 34 refers).
Laura French - Consultant in Public Health and Women's Programme Champion, Leicester City Council (minute 34 refers).
Hollie Hutchinson - Public Health Specialist and Women's Programme Champion, Leicestershire County Council (minute 34 refers).

25. Minutes of the previous meeting.

The minutes of the meeting held on 27 November 2024 were taken as read, confirmed and signed.

26. Question Time.

The Chairman reported that ten questions had been received under Standing Order 35.

Questions asked by Cllr Bob Waterton:

1. In relation to the UHL hospital reconfiguration scheme (Our Future Hospitals), please could you tell me how much has been spent on the scheme so far by the Trust or by the local NHS? In particular, please could you also tell me how much has been spent on enabling costs?

2. Please could you tell me whether it is now likely that the scheme will be altered as a result of the delay in starting the building work and the inevitable increases in its costs?

3. Have there been any indications that private capital is being considered for the scheme?

Reply:

1. The Leicester scheme has expended £24m to date and £4.7 is attributable to enabling works.
2. There is always the potential that the needs of the local community and the Trusts clinical strategy may result in changes as a consequence of delay. However there are no immediate plans to change the Programme scope at this point in time.
3. No not at the moment. This will be directed centrally through the New Hospitals Programme (NHP).

Supplementary Questions

2. Paragraph 7 of the report UHL submitted for the meeting under agenda item 8 refers to consolidation of sites. What is being considered regarding the consolidation of sites and is consolidation before 2032 being considered?
3. If private capital was required for the UHL Future Hospitals scheme would the New Hospitals Programme, run by the Department of Health and Social Care, be responsible for sourcing and allocating it?

Reply by Ben Teasdale, Associate Medical Director, UHL

2. UHL has constructed East Midlands Planned Care Centre and the ongoing plan is to increasingly use the Leicester General Hospital site for high volume, low complexity, care.
3. There have been no indications from the Department of Health and Social Care regarding the involvement of private capital.

Questions asked by Jean Burbridge:

1. Following the decision by the government to postpone the construction start of the planned local hospital reconfiguration scheme (now called Our Future Hospitals) has UHL made representations to the DHSC regarding the consequences of the delay for a) the state of the estate and b) the effect on the safe care of patients?
2. Will enabling works continue or are they being paused?
3. Will the design and planning teams for the local scheme be stood down / mothballed or are they able to continue their work?

Reply:

1. There has been no formal representation to DHSC at this point.
   With regards to the impact on the estate NHP have requested information regarding the impact of delay.

   With regards to the clinical impact the Trust has embarked on a piece of work to review and understand current risk mitigations and the ability to continue to manage those in the longer term.

2. All works are paused until 2028 unless New Hospital Programme inform us otherwise.

3. There will be a small team retained to deliver on-going capital works that are funded through alternative capital routes.

Questions asked by Mr Godfrey Jennings:

1. With regard to the Our Future Hospitals scheme, has UHL conducted an analysis of the possible dangers to the safe treatment of patients between now and the expected start date for construction? Is this analysis in the public domain and please could a copy be provided?

2. When was the most recent Six Facet Survey conducted on the UHL estate and is it in the public domain?

3. What are the main pressure points in the hospital estate which are likely to disrupt the safe and timely care and treatment of patients?

4. Has the Trust estimated the likely cost of addressing these pressure points to ensure care and treatment of patients can continue safely? If so, what is this cost?

Reply by the Chairman:

1. With regards to the clinical impact the Trust has embarked on a piece of work to review and understand current risk mitigations and the ability to continue to manage those in the longer term. This is not currently available for release, as it is an ongoing piece of work.

2. The most recent facet survey was undertaken in 2024 and covered three facets; Physical Condition, Statutory Requirements and Environmental Management. The most recent full six-facet survey prior to this was completed in 2017. The data is published via the Estates Return Information Collection by NHS England each year.

3. The biggest estate risks which the Trust carries are around the ageing condition of critical infrastructure. For example, site-wide electrical services and ventilation plant which are significantly beyond their service-life and don't provide adequate resilience in the event of a break-down. Beyond this, the estate is also very inefficient with limited investment available for fabric improvements to drive down the cost of operating the estate and reducing carbon emissions.

4. The cost of mitigating these risks is represented through the Trusts backlog value; which currently totals £125.7m; of which around £37m would be addressed through the Our Future Hospitals Programme. This cost is the material cost only, so actual rectification costs would be circa 300% of this value.

Supplementary Questions:

1. When will the analysis of the possible dangers to the safe treatment of patients be completed and will it be placed in the public domain at that point?

3. Would an early refurbishment of existing estate be better for patients rather than waiting for the New Hospitals Programme?

4. What is the estimated cost of additional problems with the estate which could be expected between now and 2032?

Reply by Ben Teasdale, Associate Medical Director, UHL

1. We expect the review to be completed within 3 months and it will be available to the public via Trust Board minutes.

3. That is not an easy question to answer. It would depend on the availability of capital for enabling works and the clinical review from an estates' perspective.

4. Ben Teasdale stated he was unable to answer this question personally but would consult colleagues and provide a written answer after the meeting.

27. Questions asked by Members.

The Chairman reported that seven questions had been received under Standing Order 7.

Question by Cllr. Ramsay Ross:

Staff Vaccination Policy and Absence

In early January 2025 it was reported in the media, that the take-up of the flu vaccine amongst NHS staff in England was less than 30%.

Clearly such a level of take-up will have an impact upon staff absence levels, the requirement for agency staff recruitment and potentially, the welfare of patients.

My questions are:

a) What has the current take-up been in 2024/25 within the ICB/UHL?
b) What changes, if any, have been made over the past 2 years to increase staff take-up?
c) What is the ICB / UHL policy for its employees?
d) What is the ICB/UHL policy for patient-facing agency staff

Reply by the Chairman:

I have received the following information in answer to the questions:

a) LLR ICB – Due to how the NHS Federated Data Platform (FDP) data is provided by NHS England we are unable to get specific staff flu vaccine uptake data for LLR ICB staff. We can however report that in LLR as a whole system (ICB, UHL and LPT), frontline staff (clinical and non-clinical) flu uptake based on electronic staff records (ESR) in Autumn/Winter 2024/25 is 38%.

UHL – (based on NHSE FDP data) flu vaccine uptake in A/W 2024/25 is 36.1%.

LPT – (based on NHSE FDP data) flu vaccine uptake in A/W 2024/25 is 43%

By comparison the midlands staff flu uptake level is 38.5% and national staff uptake level is 40.9%.

b) Within LLR each organisation has done a lot of work to encourage staff vaccine uptake. Each year ahead of the Autumn / Winter vaccine roll out the previous year's performance is evaluated, and staff feedback is taken into account as part of developing the upcoming staff vaccine campaign.

Staff are kept informed about vaccinations via an internal campaign that is developed and led by each organisation which includes extensive internal comms, senior and clinical leaders telling their stories and doing proactive staff engagement. There has also been the additional offer of roving clinics and promotion of the extensive range of community locations too.

The LLR ICB also supports the two trusts in LLR to share further messages out to staff including on site vaccination opportunities at County Hall which is made available via the Roving Healthcare Unit (RHU). The RHU operates as a walk-in vaccine clinic and is open to all NHS and LA staff that are either based at County Hall or that are able to attend the site.

All LLR ICB staff are also regularly informed about all locations and ways they can obtain their flu vaccine outside the workplace. It is important to note that some staff do have their flu vaccine in community settings such as at their local pharmacy which will not be recorded onto their staff record.

UHL and LPT offer vaccines through roving clinics across our sites, attending large face-to-face events and meetings, including inductions, and asking staff groups to invite us to do local vaccination clinics. LPT has an extensive peer vaccinator network and a small group of dedicated vaccination staff and UHL has delivered a communications campaign to increase uptake and has carried out roving and pop-up vaccination clinic across its sites carried out by peer vaccinators and a dedicated vaccination team.

This data is correct as of cop Wednesday 12 March 2025.

(c) All LLR ICB colleagues are offered the flu vaccine.

All frontline health care workers at LPT and UHL (permanent, bank and agency), including both clinical and non-clinical staff who have contact with patients, are

offered - and encouraged to take up the flu vaccine in line with UK government/JCVI recommendations. This offer remains open until the end of March 2025. The staff vaccination policy supports the system to ensure we have safe services with regards to infection prevention control and minimising staff sickness.

d) All LLR ICB employees are offered and encouraged to take up the flu vaccine, including all patient-facing agency staff

All frontline health care workers at LPT and UHL (permanent, bank and agency), including both clinical and non-clinical staff who have contact with patients, are offered - and encouraged to take up - the flu vaccine in line with UK government/JCVI recommendations. This offer remains open until the end of March 2025.

Supplementary Question:

Cllr. Ross noted that the UHL absence rate was 5.47% in October and 5% in the year. He asked whether there was a proper demonstration of leadership by UHL in encouraging staff to take up vaccinations.

Reply by the Chairman:

The Chairman offered to provide a written reply to Cllr. Ross after the meeting.

Question by Cllr. Ramsay Ross:

I requested, prior to this meeting, that the JCRUP (Joint Capital Resource Use Plan) for 2025/26 be included in the document pack for Committee Members, but this has not been forthcoming.

Can you please explain:

(i) The current approval status of the document.

(ii) When it is required to be submitted to Govt in its completed form.

(iii) When the document will be made public, or in the event that the document is not to be made public by the ICB, will provision be made for this Committee to have early sight of the document?

Reply by the Chairman:

(i) The current document is in draft format and is currently being reviewed.

(ii) It is due to be submitted as part of overall system operational planning over the coming weeks and due to be finalised end of April.

(iii) The document will be made public once approved through the public Board post April sign off and before the 30th June deadline.

Please see previous years ICB Joint Capital Plan which is on the website: https://leicesterleicestershireandrutland.icb.nhs.uk/publications/

28. Urgent items.

There were no urgent items for consideration.

29. 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.

Mrs. M. E. Newton CC and Mrs. B. Seaton CC both declared non-registerable interests in all substantive agenda items as they had close relatives that worked for the NHS.

Mr. R. Hills CC declared a registerable interest in all substantive agenda items as he worked for NHS England.

Cllr. L. Sahu declared a registerable interest in agenda item 9: LLR Health and Care People Plan as she was the programme lead for the Care Leavers (Universal Families) Programme.

30. Declarations of the party whip.

There were no declarations of the party whip in accordance with Overview and Scrutiny Procedure Rule 16.

31. Presentation of Petitions.

The Chairman reported that no petitions had been received under Standing Order 36.

32. UHL Our Future Hospitals.

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) which provided an update on UHL's Our Future Hospitals Programme which was part of the Department of Health and Social Care's New Hospital Programme. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Ben Teasdale, Associate Medical Director, UHL.

Arising from discussions the following points were noted:

(i) The funding from the New Hospitals Programme for hospitals in wave 2, which UHL was, had been put on a 'hard stop'.

(ii) Some positivity could be taken from UHL's position in the New Hospitals Programme compared to other hospital Trusts, in that the construction start time for UHL was ahead of all the other hospitals in Wave 2. The hospitals in Wave 1 were the hospitals built using Reinforced Autoclaved Aerated Concrete (RAAC) which

were understandably being prioritised due to the risks they posed, but UHL was next in line after those.

(iii) The New Hospital Programme and the 15-year capital funding pipeline only included the 3 hospitals in Leicester, not other hospitals in Leicestershire such as Loughborough hospital for example.

(iv) With regards to clinical risks arising from the delay in the New Hospitals Programme a series of workshops were being set up with colleagues including medical, nursing, allied health professional and operational leaders at specialty and CMG level. The sessions were clinically led, coordinated by the Our Future Hospitals Team and would include key corporate leads for digital and improvement. The review commenced in March 2025 and would continue throughout spring 2025 and be completed by the end of June 2025.

(v) Split site maternity and neonatal services had been identified as a clinical risk. Consideration would be given to how these risks could be mitigated. It was considered by UHL that were the sites to be consolidated then safer care would be able to be provided, though it was noted that there had been some public opposition to the proposed closure of St Marys Birth Centre in Melton.

(vi) In response to concerns raised about urological surgery being conducted at Leicester General Hospital without there being level 3 beds at the hospital, reassurance was given that the surgery was currently being conducted at Glenfield Hospital. Were a patient to be receiving surgery at Leicester General Hospital and something to go wrong they would be placed into the High Dependency Unit (HDU) at LGI until they had stabilised and could be transferred to another hospital.

(vii) It was not yet clear what impact the abolishing of NHS England could have on the New Hospitals Programme.

RESOLVED:

That the update on UHL's Our Future Hospitals Programme be noted with concern.

33. LLR Health and Care People Plan

The Committee considered a report of the Integrated Care Board (ICB) which provided a summary of the programmes of work, and the approach to a refreshed Leicester, Leicestershire and Rutland (LLR) People Plan. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed Alice McGee, Chief People Officer, ICB to the meeting for this item.

Arising from discussions the following points were noted:

(i) Work took place to attract young people to work in health and social care and particularly to working in LLR. There were entry experiences for young people and videos of what it was like to work in the sector. Work also took place regarding branding, minimum standards and what to expect from a job in healthcare. However, there was a lack of consistency between Trusts.

(ii) For the local authority and independent sectors for 2023/24 the turnover rate was 23.7% which was below the national average and had been decreasing over the previous 4 years. However, it was higher than the NHS turnover rate which was around 10% depending on the sector. The Department of Health and Social Care recognised the negative impact of high turnover rates and work was taking place with a national organisation called Skills for Care regarding attracting and retaining staff.

(iii) The ICB had been given a target to reduce overheads by 50% by the end of the year.

(iv) In LLR 27% of workers were on zero hours contracts. There was a national strategy around reducing zero hours contracts, however in LLR it was believed there was a place for zero hours contracts as they suited some employees.

(v) It was not yet clear what impact the abolishing of NHS England could have on the LLR People Plan.

RESOLVED:

That the update regarding the LLR People Plan be welcomed.

34. LLR Women's Health Programme

The Committee considered a report of the Integrated Care Board (ICB) which provided an update on the Women's Health Programme across Leicester, Leicestershire and Rutland. A copy of the report, marked 'Agenda Item 10', is filed with these minutes.

The Committee welcomed to the meeting for this item Melanie Thwaites, Head of Women's, Maternity and Neonatal Transformation, ICB, Katie Connor, Women's Programme Manager, ICB, Laura French, Consultant in Public Health and Women's Programme Champion, Leicester City Council and Hollie Hutchinson, Public Health Specialist and Women's Programme Champion, Leicestershire County Council.

Arising from discussions the following points were made:

(i) In response to an observation that the Women's Health Programme was focused towards younger women, it was explained that it was a 10 year programme and whilst at the moment it focused on the key elements of the national Women's Health Strategy, in future years the focus would widen to the full life course.

(ii) With regards to a comment about a lack of publicity in Rutland regarding Women's Health Hubs, it was explained that each individual Hub had been responsible for its own public communications. In response to a query as to whether a woman could refer herself directly to a Women's Health Hub it was explained that the Rutland Hub was only accessible through GP Practices currently, but an end of year review would be taking place and consideration would be given to widening out access in year 2. The Leicester City Hub had a policy of not turning women away. The benefits of women being able to self-refer into services were acknowledged by the Women's Health Programme. Currently women were able to self-refer into sexual health services and going forward it was hoped more self-referral would be able to

take place using technology such as the NHS app but the technology would take time to implement.

(iii) A member raised concerns about women living on their own and the negative impacts of loneliness. The member suggested that more needed to be done to publicise what social activities and support services were available. The Leicestershire County Council Health Overview and Scrutiny Committee had recently considered a report from the Director of Public Health regarding the work that took place regarding social isolation and loneliness in Leicestershire including the work of Local Area Co-ordinators. Reassurance was given that a number of NHS workstreams also tackled social isolation. It was also noted that the voluntary sector did a lot of work in this regard. The Women's System Partnership would be linking in more with the VCSE. It was suggested that at a future meeting the Joint Health Scrutiny Committee could consider a report regarding the work the NHS carried out with regards to isolation i.e. the social prescribing model across LLR and its effectiveness in directing patients/public to services.

(iv) Concerns were raised that perinatal mental health inpatient services were no longer being provided in LLR. In response it was explained that there were no plans to reintroduce those services but there were plans to provide an expanded community perinatal mental health service.

(v) In response to a query as to whether there was a freeze on band 5 midwives coming into the service it was agreed that this would be checked with UHL and clarification provided after the meeting.

(vi) In response to concerns raised about the adequacy of measures in place to help wheelchair bound women with cervical smear tests and a lack of knowledge and data about the scale of the problem, it was agreed to check this point with the Cancer Partnership and provide further detail after the meeting.

(vii) Concerns were raised that the number of women who died during pregnancy was the highest in 20 years and also that black women were four times more likely to die during pregnancy and childbirth. A lot of work was taking place nationally and locally to understand the causes of this. A training package had been put together for midwives regarding cultural differences and unconscious bias.

(viii) For data collection purposes a maternal death included any death during pregnancy or 6 weeks after birth.

RESOLVED:

That the update regarding the Women's Health Programme be welcomed.

2.00 - 3.35 pm CHAIRMAN
17 March 2025