LEICESTER, LEICESTERSHIRE AND RUTLAND CLINICAL COMMISSIONING GROUPS GOVERNING BODY MEETINGS

Minutes of the LLR CCGs' Governing Body Meetings held in common on Tuesday 11 May 2021 at 9.30am, via MS Teams

Present:

Leicester, Leicestershire and Rutland CCGs:

Mr Andy Williams	Chief Executive
Ms Rachna Vyas	Executive Director of Integration and Transformation
Ms Nicci Briggs	Executive Director of Finance, Contracts and Corporate Governance
Ms Sarah Prema	Executive Director of Strategy and Planning
Ms Caroline Trevithick	Executive Director of Nursing, Quality and Performance
Ms Alice McGee	Executive Director of People and Innovation

East Leicestershire and Rutland CCG:

Dr Vivek Varakantam	Interim Clinical Chair (Chair of meeting)
Ms Fiona Barber	Deputy Chair and Independent Lay Member
Mr Warwick Kendrick	Independent Lay Member
Mr Clive Wood	Independent Lay Member
Dr Andrew Ahyow	Member Practice Representative and Clinical Vice Chair
Dr Girish Purohit	Member Practice Representative
Dr Graham Johnson	Member Practice Representative
Dr Nikhil Mahatma	Member Practice Representative

West Leicestershire CCG:

Dr Nil Sanganee	Clinical Vice Chair
Ms Gillian Adams	Independent Lay Member
Mr Steve Churton	Independent Lay Member
Ms Wendy Kerr	Independent Lay Member
Dr Geoff Hanlon	Locality Lead, North Charnwood
Dr Reema Parwaiz	Locality Lead, Hinckley and Bosworth
Dr Fahad Rizvi	Locality Lead, North Charnwood (left after item 21/79)
Dr Rowan Sil	Locality lead, North West Leicestershire
Dr Umar Abdulmajid	Locality Lead, South Charnwood

Leicester City CCG:

Prof Azhar Farooqi	Clinical Chair
Dr Avi Prasad	Assistant Clinical Chair
Mr Nick Carter	Independent Lay member
Mr Zuffar Haq	Independent Lay member
Prof Jeffrey Knight	Independent Lay member
Dr Tony Bentley	North and East Health Need Neighbourhood Chair
Dr Gopi Boora	North and West Health Need Neighbourhood Chair
Dr Sulaxni Nainani	South Health Need Neighbourhood Chair
Dr Raj Than	Left Shift / Integration Lead
Dr Matthew Trotter	Secondary Care Clinician
Dr Kath Packham	Consultant in Public Health, Leicester City Council

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In Attendance:

Mrs Harsha Kotecha	Healthwatch, Leicestershire
Mr Richard Morris	Deputy Director of People and Innovation (for items 21/78 and 21/79)
Ms Paula Vaughan	Head of All Age Mental Health, LD, Autism & Dementia, LLR CCGs (for item 21/79)
Mr John Edwards	Associate Director of Transformation, Leicestershire Partnership NHS Trust (for item 21/79)
Dr Avinash Hiremath	Medical Director, Leicestershire Partnership NHS Trust (for item 21/79)
Ms Sarah Smith	Head of Integration and Transformation City, LLR CCGs (for item 21/81)
Dr David Shepherd	CCG Analyst on Health Informatics and Population Health (for item 21/81)
Mr Mark Pierce	Head of Population Health Management (for item 21/81)
Mr Andrew Roberts	Finance Senior Manager, Primary Care (for item 21/81)
Ms Hannah Hutchinson	Assistant Director of Performance and Improvement (for item 21/82)
Mrs Daljit Bains	Head of Corporate Governance
Ms Clare Mair	Corporate Affairs Officer (minutes)

Members of the public: There were 3 members of the public in the meeting.

ITEM	DISCUSSION	LEAD RESPONSIBLE
GBs/21/69	**Welcome and Introductions** Professor Azhar Farooqi welcomed members of the Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups (CCGs) to the meeting of the Governing Bodies in common.	
GBs/21/70	**Apologies for Absences** Apologies for absence were received from: **East Leicestershire and Rutland CCG:** • Dr Nick Glover, Member Practice Representative **West Leicestershire CCG:** • Professor Mayur Lakhani, Clinical Chair • Dr Ash Kothari, Locality Lead **Leicester City CCG:** • Mr Ivan Brown, Director in Public Health, Leicester City Council The meeting was confirmed as quorate for East Leicestershire and Rutland CCG (ELR CCG), Leicester City CCG (LC CCG) and West Leicestershire CCG (WL CCG) Governing Bodies.	
GBs/21/71	**Notification of Any Other Business** Professor Farooqi reported he had not received notification of any	

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	other items of business.	
GBs/21/72	**Declarations of Interest on Agenda Topics** All GP members declared an interest in items relating to primary care where a potential conflict may arise and also where there are any items concerning the Leicester, Leicestershire and Rutland Provider Arm for instance where GP members' are minor shareholders. The conflict was noted and will be managed during the discussions as required. It was noted that each CCG maintains a conflicts of interest register available on respective CCG websites and any declarations raised at this meeting will be documented in the minutes of the meeting and action(s) will be taken to manage the conflict(s) at the meeting in line with the conflicts of interest policy. Members of the Governing Bodies were reminded of the following: • Please have your video turned on, but microphones muted when not talking (unless there are connectivity issues and you need to turn off your video). • If you wish to speak please use the 'Raise Hand' functionality and the Chair of the meeting will invite you to speak. • When speaking refer to the page number or slide so that all attending have a clear understanding of what is being discussed at all times. • If you leave the meeting temporarily, please turn off your camera and ensure your microphone remains on mute. • Please **do not** use the MS Team private chat facility for individual conversations between Members and/or Members and the Chair during remote meetings. • If you are only accessing the meeting by phone (audio only), please state your name when speaking. **Specific conflicts and actions to mitigate any risks confirmed as follows:** **Papers A to G** – no specific conflicts had been identified. **Paper H – Primary Care Funding Model** • Professor Farooqi noted the report was for approval. • All GPs (with the exception of Dr Tony Bentley) were directly conflicted in relation to this report relating to future funding models for primary care. • It was proposed and agreed that Nick Carter, LC CCG Independent Lay Member chair, take on the chair of the meeting for this item.	

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	• It was stated that GP members had been engaged and involved throughout the development of this funding model but would be excluded for the discussion and decision, at which point conflicted GP members would go into the public gallery. **Papers I – L** – no specific conflicts identified. **Paper M** - **LLR CCGs' PCCC summary report:** • Professor Farooqi noted the report was for information only. • It was agreed that if a detailed discussion took place, particularly in relation to paragraph 4 "Support for Canon Street" then Mr Nick Carter would chair this item. • It was noted that all GP members (including members from ELR CCG and WL CCG), with the exception of Dr Tony Bentley, were directly conflicted should further detailed discussion take place as General Practice Resilience funds are available to all LLR CCGs' Practices. • Given the meeting was being held in public, conflicted members would remain in the meeting and not be required to leave the meeting for the decision. **Papers N and O** – were for information and no specific conflicts had been identified. It was **RESOLVED** to: • **RECEIVE** the declarations of interest and **NOTE** the actions being taken.	
GBs/21/73	**To receive questions from the Public in relation to items on the agenda only** It was noted that no questions had been received in writing from members of the public prior to the meeting. One question was raised during the meeting. Ms Reynolds, member of the public, noted from the Accountable Officer's report on today's agenda and from information previously shared at the Governing Body meeting by Sue Venables, the findings on the UHL reconfiguration consultation had been completed and being reviewed by the CCGs. Ms Reynolds asked when this report would be made available to the public and if this cannot be done immediately, why was that the case. Much was said about involvement and transparency and so it would be nice to see it made available as soon as possible to the public. In response Mr Williams said it was the Governing Bodies' intention to consider the findings in public at a meeting to be arranged for	

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	June. The reason for considering it then would provide sufficient time to interpret the outcome of the feedback alongside what the CCGs would change or amend for the final Decision Making Business Case (DMBC). That would be done in discussion with partners and the CCG would want to bring the outcome and response at the same time in public session in June. Ms Reynolds further asked why the findings could not be made available to the public now to afford the public the same opportunity to go through the report findings and ask relevant questions at the meeting with regard to the DMBC. Ms Reynolds understood why the two documents would be considered by the Governing Bodies at the same time but did not understand why the consultation findings could not be made available in advance to the public. Mr Williams assured the consultation findings paper would be put into the public domain at the earliest opportunity, and time would be afforded at the meeting for questions from the public. It was **RESOLVED** to: • **RECEIVE** the questions from the public on agenda items.	
GBs/21/74	**Minutes of the LLR CCG's Meetings in common held on 9 March 2021 (Paper A)** The minutes of the LLR CCG meetings in common held on 9 March 2021 were accepted as an accurate record subject to correcting some typographical errors. It was **RESOLVED** to: • **APPROVE** the minutes of the LLR CCGs' Governing Body meetings in common held on 9 March 2021.	
GBs/21/75	**Matters arising and actions from the LLR CCGs' Meetings in common held on 9 March 2021 (Paper B)** The action log was received. Of the three actions, two were green and would be closed and the other action related to off payroll workers and was due to be actioned by the Audit Committee in May. It was **RESOLVED** to: • **RECEIVE** the updates provided.	

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GBs/21/76	**Report from the LLR CCGs' Chairs (Paper C)** Professor Farooqi took the report as read and invited the Chairs to add any further comments. Dr Varakantam reported the commonality of thinking for place discussions had been good. He had attended a virtual Covid Crisis in India event and noted the huge effort being made by the NHS nationally and locally. Professor Farooqi talked about the Covid response and pleasing position in that the number of new cases, admissions and deaths had rapidly reduced, in part due to the lockdown and also due to the hugely successful vaccination programme. The vaccination work continued apace and general practice remained busy and was working hard to vaccinate as many people as possible. Huge challenges were being experienced by the NHS to restore and recover services affected whilst the Covid response was prioritised. Professor Farooqi reported general practice was now busier than ever and data showed that consultations were up by 20% against pre-Covid levels. Data also showed a significant backlog for chronic disease management. Waiting times for elective surgery were now substantial and the emergency department was busier than ever. The combined factors are creating tension and putting pressure on staff and public expectation is that services should now return to normal. It is taking time and resource to manage those expectations and a communications piece from the NHS as a local system would be beneficial. In terms of the development of the Integrated Care System (ICS), some workshops had taken place with partners to clarify and outline the ICS and the work that would sit at place and neighbourhood level and system governance. It was **RESOLVED** to: • **RECEIVE** the contents of the report.	
GBs/21/77	**Accountable Officer's Corporate Report (Paper D)** Mr Williams acknowledged the professionals and volunteers for their extraordinary effort and commitment to take forward the Covid vaccination programme and expressed his gratitude and pride. Mr Williams was pleased to be able to draw on many examples of innovative approaches to provide vaccinations to groups who the CCGs had conventionally struggled to support and access.	

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	Mr Williams' report also described some of the questions that had been raised today regarding the acute reconfiguration consultation process. To accommodate the timetable of reconfiguration, it was intended to convene an extra-ordinary governing body in June with a single focus on the report of findings and Decision Making Business Case. Congratulations were expressed to Gillian Adams, Independent Lay Member who had been appointed as the LLR CCG's Wellbeing Guardian. The agile working consultation for CCG employees concludes on Friday 14 May and the comments would provide a useful insight from staff on move the move to agile working. Significant representation had been made by Independent Lay Members and GPs about their thoughts and the issues that would need to be addressed prior to making the change if the CCGs chose to go forward with the proposal. Mr Williams was pleased to report that engagement had been good and that should provide a reliable and meaningful outcome from that process. The Executive Team had reviewed the Governing Body work programme and further progress had been made on the annual reports and Board Assurance Framework (BAF). Mr Kendrick noted the work of the ICS at paragraph 14 of the report and the developing approach for provider collaboratives. He asked if that included out of county providers as well. Mr Williams responded that provider collaboration and out of county providers was an interesting point and broadly the answer was yes, they would be included. Each system was thinking through the relationship with provider collaboratives and two broad models were emerging; 1) partnership at all levels with system partners setting strategic direction, partnership at place and locality to deliver and 2) a model for areas where multiple providers made up the system, with suggestions being something akin to an internal market, with one provider commissioned to act on behalf of all as a lead contractor. LLR has not formally decided on a model but was erring to an approach of collaboration at all levels. The governance of the ICS already includes partners with wider areas of responsibility such as Derbyshire Health United and East Midlands Ambulance Service. Discussion and collaboration with partners across the East Midlands is now common place. The ICS will partner strongly with providers in the footprint and then think about the wider partners. Mr Kendrick had raised the point as a number of patients on the periphery of the county would choose to attend out of county services and therefore that needed to be	

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	addressed in the governance arrangements, appreciating this would take time to develop. Mr Kendrick queried whether the Governing Body work programme should include approval of accounts and the annual general meeting. Through the chair, Ms Bains clarified that approval of the annual report and accounts had been delegated to the Audit Committee and therefore were not on the Governing Body work programme. Professor Farooqi noted for the ICS governance process, the CCG had not specifically scheduled key dates on the work programme for the CCG response, recognising some things would be NHSE/I being mandated and others would be for local decision. Mr Williams agreed that was an important issue and Governing Bodies would need to sign off the detail of that and build that into the work programme. At some point the CCGs would need to make a decision on the ICS or proceed with the fall back plan of moving to single LLR constituted CCG. As an Audit Committee Chair, Professor Knight was pleased to note the implementation of actions following internal audit reviews which was a key element of the Head of Internal Audit opinion letter. It was **RESOLVED** to: • **RECEIVE** the Accountable Officer's report. • **APPROVE** the LLR CCG Governing Bodies' work programme	
GBs/21/78	**LLR system resilience: a)Surge Planning, b)COVID vaccination, c) COVID vaccine hesitancy survey results (Paper E)** *Mr Morris joined the meeting.* <u>Surge Planning (E1)</u> Ms Vyas spoke to the slides noting; • The position at 8 May showed a continued decrease in daily Covid case numbers for LLR. • No significant spikes had been seen on the back of the road map easing. • For the latest reported 7-day period (4 May) the city cases decreased by 35%, and similarly for Rutland, as issues identified last month were brought to control. • A single care home had a high case number and work had been done with the Primary Care Network (PCN) to ensure the home was supported and staff had been vaccinated to	

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	expected levels. • Looking at case growth by region, Leicester City was returning to normal. Leicestershire and Rutland were almost at return to normal. • Some surrounding areas are in a status of 'issues to be resolved' and a close watch was being kept due to movement across boundaries. • Surge management continues to consider the following; making access 'Fit for Purpose', implementing complex care model and long term condition management, integrated community response and management of Covid as a pathway, integration across providers. • All providers have seen an activity surge over the last 6 weeks as things open up. The public expects more to be open and that included accessing health services. Demand had been pent up for primary care access and other services. • One general practice would normally receive 500-600 calls a day and reported 3,500 calls on a single morning. • The emergency department has returned to pre-pandemic figures of 700 daily attendances. • EMAS reported a surge in calls but not all attendance has translated into conveyance. • A piece of work is being done with 111 colleagues to ensure clinical pathways are correct and patients aren't being booked into appointments they don't need. • The health economy tactical group remains in place to carry out this work. • The system is supporting each other across LLR. Mr Wood said he understood the demand for primary care and asked what was being done to address that because he assumed some calls had gone unanswered and some patients were left without. Mr Haq reported that patients were ringing their practice for a hub appointment, waiting around 30 minutes to get through, and therefore was there another way that patients could access the hubs and take the pressure away from practices. He asked if there was data on the timeliness of 111 making contact with patients because he understood waits could be 2 to 3 hours, in which time some patients would seek alternate help at the ED. Dr Prasad stated how important communication was right now as some patients were feeling desperate and had the impression of nothing being done. He felt with the right information a high proportion of patients would be able to make a decision that they didn't actually need to access primary care.	

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	Ms Vyas said the situation had been looked at on a practice by practice basis and many were reporting difficulties and had asked for a mechanism to manage demand up front. The CCGs were working with Leicestershire Health Informatics Service (LHIS) to produce something that was much better for those who were able to manage digital care and this would take pressure off the telephone lines. With regard to patients calling to query when their elective care wold be, the elective care stream was doing a piece of work to communicate that and unless a patient had experienced clinical changes, the GP could not influence the waiting list. A number of pieces were coming together to ensure the CCGs had in place an access strategy and engagement with patients so they could understand what they could expect. Ms Vyas was aware that 111 experienced peak call times between 8.00am to 10.00am and 5.00pm to 7.00pm during which the call back times were long. Generally though 111 was delivering the right level of service, recognising they were under the same pressure that practices were. Communications and engagement was a regular focus for Ms Vyas' team and they were preparing a piece on 'a day in the life of a GP' looking at pre-pandemic work and what they were doing now. All available capacity across the system was being utilised. Professor Farooqi suggested allocating a budget for this specific piece on communication because it would be critical in supporting primary care. Ms Kotecha concurred that patients were struggling to make contact with primary care and the frustration of patients was that they didn't know where they were in the phone queue and when they did get through they were told there were no appointments and to call back the next day. That compounded the problem as yesterday's patients join the call queue the next day. Ms Kotecha had been invited to join the communications task group for patients and she very much welcomed that. Dr Varakantam echoed the views shared about communicating with patients and having honest conversations to explain the need to work differently across the whole system. A joint message from UHL, LPT and the CCGs would ensure a united and consistent message. Dr Varakantam noted the current home visiting contract was ending in Jun 2021 and expressed the need to ensure on-going capacity for patients to be seen and managed in practice. Dr Abdulmajid concurred with Dr Prasad's point that some patients had to access a clinician for their healthcare and there were other patients who could access care elsewhere. Babylon Healthcare	

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	established themselves in London with a digital-first solution but patients then navigated around the system to get an in-person appointment, so if the end user felt they needed to speak to someone, they would access that somewhere in the system. Dr Abdulmajid commented how difficult it was to measure primary care demand because GPs were over-subscribed anyway and are now saturated. The 30% to 40% increase being seen will have a financial impact on practices. A central and single message was needed that every provider could give to the public, asking for self-management where appropriate, in a bid to reduce the system pressures. He felt there was an opportunity to develop practice website front pages to aid navigation and self-care as a more localised approach, rather than patients being directed to national NHS websites. Navigation training for practice staff at the 'front door' would also be helpful to put patients on the right pathway. Dr Than echoed that the home visiting and hubs service needed to be maintained. Community pharmacy was an opportunity to develop more system capacity for minor illness and self-care. As a lay member with a patient and public involvement portfolio, Ms Adams Gillian impressed the need for an honest conversation with patients who would not understand the problem and instead would start to blame the NHS which was not a position anyone would want to be in. This was a whole LLR system problem and required a whole LLR system solution. Ms Adams recognised the phenomenal number of vaccinations being delivered every day and that was an opportunity to communicate with patients we would not usually see. Mr Trotter said this issue was larger than LLR and was an NHSE/I issue. He referred to the NHSE/I website which clearly stated a patient's legal right to have their secondary care started within 18 weeks of a GP referral. He understood NHSE/I was putting pressure on secondary care providers to publically publish their waiting lists until a policy decision was made on how to manage that. Waits for individual specialties varied and that would show honesty and integrity if each patient was given a realistic timeline of when they would be seen and whilst that was uncomfortable and unpalatable it would give the patient an honest assessment and they would then be less likely to ask their GP to expedite an appointment that cannot be expedited. Dr Sanganee agreed it was difficult for primary care to demonstrate unmet need and delays in the way secondary care could through waiting lists. He added that the vaccination work is a massive demand on the administrative teams too as well as answering a high volume of calls into practice. Engagement was happening with Healthwatch and PPGs and Facebook live events	

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	could be used to explain system navigation and accessing right care in the right place at the right time. The Integration and Transformation team is looking at additionality to support present primary care volume and vaccination. Ms Vyas said the focus was on three top actions; 1) engagement with patients around models of care and the reality of what the system is facing, 2) capacity issues and focussing on additional services rather than augmenting the current services like home visiting and pharmacy, 3) being clear on the elective care position and current waiting times so patients are clear what to expect. Every point of contact over the next months will be a key opportunity to communicate. <u>Covid Vaccination - E2</u> Ms Trevithick provided the presentation slides at the meeting highlighting the following; • A range of delivery sites are in place for the vaccination programme. The hospital hub sites may be consolidated to two; one for UHL and one for LPT. • Community pharmacy as vaccination providers is starting to increase and will be targeted to identified areas of need. • At 29 April, over 766,328 vaccination doses had been administered and yesterday that had exceeded 800,000 doses. • There is a national campaign around Covid vaccination and locally the CCGs are focussing on hard to reach groups. An NHS Facebook campaign is targeting men aged 40 and over who are at risk of developing Type 2 diabetes. • Vaccination cohorts 10-12 (10: adults aged 40-49, 11: adults aged 30-39, 12: adults aged 18-29) are now being rolled out with Cohort 11 opening on 11 May 2021. • The Joint Committee on Vaccination and Immunisation (JCVI) recommendations for AstraZenica has changed for cohorts 10 to 11 and this is having an impact on confidence of uptake. A dual vaccination programme is being offered but take up of AstraZeneca for those who it's safe for is being encouraged. • Workforce recruitment continues through the workforce bureau. A workforce summit took place last week and another was due for tonight. Support to primary care is being looked at. • Inequalities work has been coproduced with public health teams, focussing on confidence, convenience and complacency issues so that vaccination can be delivered in a way that meets population and neighbourhood needs. • Practical examples of responses to the above included trying to access workplaces and factories linked to Covid positive cases, a pop-up clinic at the Islamic Centre vaccinated 69 patients between 5pm & 9pm on 24th April, a pop-up clinic in Beaumont	

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	Leys vaccinated 958 people over 3 days. • The registration teams attended the above events to register un-registered patients. • Masks and visors are an issue for the deaf community, and so the vaccination sites responded positively to suggestions made by one deaf patient in particular. • Second doses are a priority whilst the number of first doses required is increasing week by week as new cohorts come on stream. • LLR is on track to deliver its vaccination programme to all adults by the end of July which will position the system well for moving to the next phase of the programme for autumn and winter and scenario planning. <u>Vaccine hesitancy survey results – E3</u> Mr Richard Morris spoke of the good research and insight work undertaken by the patient engagement team. Whilst the work had been led by the CCGs this had been genuine system-wide collaboration with NHS and system partners and took into account qualitative responses to the survey and quantitative responses. Over 4000 people across LLR participated. The findings were treated as dynamic and emerging themes formed the communications strategy. Ms Trevithick and Ms Vyas took into account this feedback to change the vaccine delivery model and find local solutions such as pop-up clinics. Some areas of the survey validated things that were already expected and others elicited a greater knowledge and understanding. Despite the incredible work on vaccination, take up has been lower in the city than the county and in some ethnic groups. Confidence, convenience and complacency will be heightened as the roll out moves to a younger population. Those aged 34 and under have double the hesitancy of that seen in the city so far or ethnic groups and deprivation is a greater driver than ethnicity. Hesitancy was driven by concerns over the efficacy of the vaccine and the use of AstraZenica for under 40s. Younger age groups have a lower likelihood of severe illness so as society opens up it is less of an issue to these groups to get vaccinated. The motivation for these age groups to take the vaccine is different and so the types of engagement and messaging will need to shift as the programme moves forward. A number of high impact actions to improve the vaccination offer have been identified and those had been addressed as and when identified.	

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ITEM	DISCUSSION	LEAD RESPONSIBLE
	The communications need to be relevant and targeted at the motivations and aspirations of those groups. Generalised and massed communications will miss the mark and must be relevant to their circumstances. The service delivery model might look different going forward. Younger patients expressed a desire for drop-in clinics, hyper locally and delivered in major workplaces going forward. Professor Farooqi was intrigued by how the research had informed the service delivery. He opened the item up for questions. Mr Haq congratulated the team on the delivery of pop-up clinics which had received very positive feedback. He supported workplace vaccination because some people would be reluctant to take time off. Whilst evidentially severe Covid complications in the younger age groups were lower, there were cases of younger adults who'd required acute care and Mr Haq believed sharing those stories might resonate and encourage vaccine take up. He welcomed more vaccines coming on stream, such as Moderna as an alternative to AstraZenica if that reduced hesitancy. Mr Carter recognised this as a sophisticated and dynamic and therefore useful piece of work. He noted the preferred ways to receive information on Covid and many people not being interested in online communications. Mr Carter asked whether every opportunity had been taken to display general and specific posters about Covid in places regularly used by the public across LLR, such as schools, community notice boards, community centres, indeed, anywhere people gather. He recognised the scale of such a task. Professor Knight commenced by saying this was a tremendous piece of work. He asked whether an angle of approach should be asking people to consider the health of the wider community by not having the vaccine. Dr Prasad recognised all the efforts being made nationally and locally on communication but Covid is a worldwide phenomena and is being talked about by many languages and nationalities. Media has a worldwide connection and every government is supporting vaccination. Dr Prasad felt the reality was that some people did not wish to have the vaccine and that should be respected. Ms Trevithick expressed her praise of the vaccination programme which demonstrated real ICS working with everyone in the system, including the local authority and voluntary sector, coming together to deliver a system-wide programme. The teams go far and wide and some of them give up hours of their time voluntarily to this	

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	programme. The qualitative and quantative action research had been really helpful but the difficult areas were increasing and focus would need to be renewed and adapted. In regard to the question on posters, Mr Morris confirmed that alongside online activity, posters had been put into the community and the campaign included an emphasis on printed media such as local parish newsletters, posters in supermarkets, adverts and phone-ins on local radio stations. It had been assumed the under 40s would use social media as a key tool but they want to receive texts or personalised email. Consideration would be given to tailoring the programme going forward. It was **RESOLVED** to: • **RECEIVE** the updates.	
GBs/21/79	**Step up to Great Mental Health – public consultation (Paper F)** *Ms Paula Vaughan, Head of All Age Mental Health, LD, Autism & Dementia, LLR CCGs, Mr John Edwards, Associate Director of Transformation, Leicestershire Partnership NHS Trust, Dr Avinash Hiremath, Medical Director, Leicestershire Partnership NHS Trust and Mr Richard Morris, Deputy Director of People and Innovation, LLR CCGs joined the Governing Body for this item.* Approval was being sought from the governing body to commence a public consultation from 24 May 2021 for a period of 12 weeks. The governing body had previously received the Pre Consultation Business Case in confidential session in January and March 2021 and following feedback, this had been updated with the final version presented to this meeting. Work had been undertaken to systematically realign all mental health services delivered by Leicestershire Partnership Trust (LPT) to drive forward the system wide ambition for the whole spectrum of services across LLR. Co-production and design of the consultation had taken place with service users across LLR and had been written in response to the Long Term Plan for Mental Health. The LLR Clinical Senate and local authority Health and Wellbeing Boards had been engaged with. The period of consultation was now ready to be launched, to ensure that the services being realigned would meet the different population and patient needs. Mr Edwards explained the reconfiguration of mental health services focussed on two main elements; urgent care and planned treatment delivered through community teams. Other changes were happening in inpatient services and GP services and he	

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ITEM	DISCUSSION	LEAD RESPONSIBLE
	welcomed an opportunity to talk to the Governing Body about that another time. Dr Varakantam welcomed the document and the collaboration with LPT. He noted the focus was on integration but various areas had already been integrated, such as mental health facilitators and he asked how it would be ensured that as services were integrated further, they would be right and optimally deliver. Ms Vaughan said it was important to firstly get the reconfiguration right before addressing the integration. Mr Edwards recognised the long-standing variability of mental health facilitators across the areas, regardless of integration or not. A step change was needed for mental health facilitators to feel part of the primary care set up and network. Dr Johnson said that most GPs would resonate with the long waits and assessment times and he was keen to see how the proposed changes would address that. Duplication of assessment was not good for patients but also put pressure on an already stretched workforce. Integration across primary and secondary care much needed. Dr Johnson was supportive of the direction. Dr Than wanted internal escalation and triage to happen without referring back to GPs. Professor Farooqi asked if there was a specific strand of the consultation to engage with clinicians and professionals. Mr Morris advised the consultation was open equally to NHS employees and those outside of the NHS. Between 10%-15% of the total responses to consultations tended to come from inside the NHS. With that in mind Professor Farooqi noted the opportunity to proactively raise awareness of this opportunity at the Protected Learning Times and other forums. Dr Abdulmajid noted one problem was patients presenting or being navigated to the right place and at the first opportunity. A growing number of mental health presentations were being seen at varying degrees of need. GPs were often the first contact but patients are more appropriately dealt with elsewhere, so GPs signpost to IAPT, utilisation of a digital solution, self-help and therapy. To ensure access and equality of opportunity, the consultation would have different engagement approaches. As was the case with the acute reconfiguration consultation, this should be representative of LLR and a partnership approach would be used to work with the voluntary and community sectors engage with hard to reach communities.	

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ITEM	DISCUSSION	LEAD RESPONSIBLE
	It was **RESOLVED** to: • **APPROVE** this report in order to commence public consultation. *Ms Vaughan, Mr Edwards, Dr Hiremath and Mr Morris left the meeting.* *Dr Rizvi left the meeting.*	
GBs/21/80	**Final draft Equality, Diversity and Inclusion Strategy for Leicester City, East Leicestershire & Rutland & West Leicestershire (LLR) Clinical Commissioning Groups (Paper G)** Ms Alice McGee presented the new draft Equality, Diversity & Inclusion Strategy covering the period 2021-2025. The governing body received the draft in February 2021. The CCGs are required to publish a strategy in relation the Equality Delivery Scheme (EDS) of which there are 4 goals. This is a living document and will deliver enhancements and understand the work of the ICS and support addressing health inequalities. Feedback on the consultation during March included more clarity on successes and what the CCGs had done pre and post-Covid on inequalities Approval was sought from the governing body to publish the strategy on the CCGs' respective websites. Updates would be further presented as the strategy evolved and the ICS developed. In response to Dr Varakantam's question on whether the document had been developed yet or was to be developed, Ms McGee referred to the document at appendix A, which is the strategy at this point in time and would undergo further. This iteration would be made available on the websites. Dr Packham asked what was meant in this document by 'system' as sometimes it was NHS only and other times more widely referenced partners such as local authority and voluntary and community sectors. Dr Packham had not come across the Inclusive Decision-Making Framework in public health work and asked if it was used by all partners. Ms McGee responded that the energy and focus to date had been with NHS partners. The strategy was discussed at the People Board and will become a tool for wider partners, as part of wider health inequalities work, but there was some way to go before for all decision making could be demonstrated. Professor Farooqi spoke of how colleagues in formal and informal leadership roles needed to develop skills to lead inclusively, such	

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	as anti-racist, unconscious bias becoming conscious so skills were about inclusivity, moving beyond training and development and embedding into culture. It was **RESOLVED** to: • **RECEIVE & APPROVE** the final draft LLR CCGS's Equality, Diversity & Inclusion Strategy prior to publication on the LLR CCGs websites.	
GBs/21/81	**LLR Primary Care Funding Model (Paper H)** *Ms Smith, Mr Pierce, Dr Shepherd and Mr Roberts joined the meeting.* As agreed during the conflicts of interest discussion at the start of the meeting, at this point Mr Nick Carter took over the chair and GP members left the meeting, with the exception of Dr Tony Bentley who was not conflicted. Ms Nicci Briggs was joined for this item by Ms Sarah Smith, Mr Mark Pierce, Dr David Shepherd and Mr Andrew Roberts. A task and finish group had explored the inadequacies and inequalities in primary care funding that had arisen from the national funding formula and explored an LLR alternative. The review process included discussion at a governing body development day, the work of the task and finish group over a 13 week period which included members of the governing body and a further engagement process led by Ms Smith and Mr Roberts. Dr Bola Owolabi, Director Health Inequalities NHSE/I endorsed this as a great example of local initiative, collaboration and system working. The primary care funding model was 20 years old and the LLR CCGs wanted something that was more reflective and engaged with primary care and could drive up health equity and reduce health inequalities. Fundamental principles were applied; The first principle was a levelling up exercise using data and a model that was locally developed and explored extensively. Some practices would receive an increase in investment and those who were already above that threshold would receive inflation and growth. The levelling up of funding would commence 1 July 2021. The second principle addressed service harmonisation. Disparity	

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	of services offered across primary care in LLR would be removed and thereby patients could expect the same provision of service. There will be additional commissioned services through the PCNs. The basket of services was yet to be determined but should be in place by 1 October 2021. The existing GP core contract would be retained. The remaining 60% of the core contract and other funding in the model took account of need (90%) and deprivation (10%), adjusted for case mix, communication and patient turnover. Performance based payments such as QOF will be maintained. The financial impact is about £3m for the levelling up and £1.8m for the basket of services. There would be a £700k impact in H1 and that had been provided for in the primary care financial plan. The engagement process had been extensive. The task and finish group met over 13 weeks and interrogated the model and met with all practices and provided each with a bespoke report. Phase 1 would address the levelling up and then Phase 2 would deliver the harmonisation of services from 1 October 2021. The PCN clinical directors had been keen to expedite this and asked to proceed with levelling up as soon as possible. Prescribing professional fees and ELR minor injury units were not included in this funding model. The model had been adjusted for those patients who declined to have their data used outside of the practice and those practices with high turnover such as rurality and university practices. A subsequent task and finish group will meet in 6 months to review the model. Practices would have some time before 1 July to understand their payments. Dr Bentley noted the importance of this for patients and for practices as investment into primary care was so much needed. He added it had long been recognised that the national formula did not address a number of factors. Leicester City commissioners had looked at funding differentials work previously and made some headway. Better allocation of resources would support conversations with practices on quality because funding would not now be cited as a reason. He expressed his thanks to Ms Briggs and the team in progressing this, recognising there were pockets of deprivation across all of LLR.	

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ITEM	DISCUSSION	LEAD RESPONSIBLE
	Mr Churton noted some items had been removed from this funding model, such as prescribing professional fees, and asked what rational that had been based on and whether that resulted in a material change to the proposal. In response it was explained that services and payments not included in the local funding model would continue separately. The minor injuries element was specific to ELR CCG. Dr Shepherd said practice list data had been taken from the data sharing agreement so those who had opted out were not included, giving a smaller list size. The data had been adjusted for true list sizes and it had been assumed those who opted out had general health needs. Discussions had taken place with rural practices around their health needs, areas of deprivation, university practices who have high patient turnover so differences were taken into account and adjustments made. The model can be moulded to meet the population needs. Ms Prema supported equalisation of funding in primary care as the right thing to do and asked how it would be ensured that equalisation was seen on the front line and reflected the care received by patients. Ms Briggs said that part of the conversation with practices would take place to agree on the right outcomes to measure and each would start with a baseline from which movements would be seen, becoming more aligned across LLR. Ms Prema added that the work done by Dr Shepherd on population health management had been really helpful. Mr Haq spoke of the many and varied elements that influence health and coming out of Covid, many patients would be in a worsened position, such as lack of employment and these issues hadn't yet fully materialised. The joined up approach of the ICS would consider these wider issues. Ms Barber noted the positive feedback, the hard work and the two-way exchange of information. Her ELR GP colleagues had asked for reassurance on funding for the end of the quarter around ECGs, phlebotomy, dressings and the diabetes service. Ms Barber asked for assurance that primary care lists were regularly checked and cleansed and that coding was correct. Ms Barber felt it was key that the outcomes were identified appropriately because the funding linked to inequalities and unless that was correct, it would not drive the outcomes for patients and communities. Ms Briggs responded that the basket of services work continued and would take into account the matters Ms Barber had raised. The outcomes piece was also to be worked through between now and October 2021 and a wide task and finish group would be established with a number of interested parties.	

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	Dr Bentley said keeping lists up to date was on-going business and it was in the practices' interest to have these accurate as practices cannot carry out health checks on ghost patients. Qualitative coding is high on the agenda for a number of reasons. Mr Carter concluded by remarking that of all the achievements of the CCGs over the last 10 years this would be the legacy project. Mr Williams agreed the LLR CCGs had done something that virtually no other PCT or CCG had been able to do and this was a great legacy and fantastic foundation going forward. It was **RESOLVED** to: • **NOTE** the scrutiny that went into the model and primary funding proposal by the Task and Finish group • **NOTE** the extensive engagement with primary care and wider LLR system colleagues • **NOTE** the changes made to the model following feedback from practices • **NOTE** the support given from NHSI/E to move to this innovative industry leading model reflecting patient need and addressing inequities in primary care • **APPROVE** the adoption of the LLR Primary Care funding model and to level up services from 1st July 2021. *The GP members returned to the meeting.* *Ms Smith, Mr Pierce, Dr Shepherd and Mr Roberts left the meeting.*	
GBs/21/82	**CCG Performance Improvement & Quality Overview Report including Out of County Performance Dashboard (Paper I)** Ms Hannah Hutchinson presented the report, noting the performance was set against the impact of Covid and demand on ITU. The report included current national metrics for those that had been published in the last 6 months for which there was benchmarking or an SPC (statistical process control) chart. A placeholder had been put on workforce and would be picked up with system colleagues, looking at absences, vacancies and the impact that would have. Contact had been made with other areas across the country to understand what was being done for elective and cancer backlogs and work was in hand with the design groups. Those waiting lists were being broken down by postcode and ethnicity. A health inequalities officer for cancer was being recruited to using Macmillan funding. There had always been a difference in bowel	

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	cancer screening rates with take up 50% higher in the county. The dashboard showed a number of key metrics as not achieving the standard but there were a number of key metrics being achieved for LLR. Trend arrows had now been added to show where improvements had been made. The key areas currently not achieving for LLR included; • Elective care with 11,000 LLR patients waiting in real time • 12,000 patients waiting over 52 weeks for treatment which was the highest number waiting in the Midlands, but is comparable to peer group acute trusts. A lot of work was being done in the design groups and a clinical prioritisation framework was being produced. Spire and Nuffield had agreed to LLR using 25% to 30% of their capacity to September 2021 to support getting through the waiting lists. Theatre and ITU capacity had now increased as the system moved to restoration, acknowledging the risks of staff burnout. A new provider of IAPT services was recently contracted with. The access target was not currently being met. £145k had been invested into suicide and bereavement. Referrals for children and young people had increased by 200%. There was a backlog of breast cancer patients on the treatment list and levels were 260% that of pre-Covid. Some work is being done to see if there was a connection with the national screening pause. The report also included Out of County information for LLR patients who were receiving care other than by UHL or the local independent sector. Professor Farooqi commented on the number areas not achieving the target, acknowledging mostly that was due to the impact of Covid, but also that there were some encouraging signs. Professor Farooqi asked whether primary care access could be added to the future dashboards. Ms Hutchinson said that addition had already been considered and would be added to the work of the task and finish groups. Dr Varakantam really like the report and narrative providing a good level of intelligence, noting Ms Hutchinson had taken on board previous comments and requests. With regard to the elective backlog, Dr Varakantam asked if regional GIRFT (getting it right first time) was being used to get high volume, low intensity work	

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	through at pace. Mr Trotter explained patients on the list for over 52 weeks could be waiting for surgery or they could be waiting for a first appointment and would then join a surgical waiting list so the report did not provide an in-depth understanding of where patients were on the pathway. He said it would be good to categorise the waiters by specialty and understand the capacity for each specialty. In response to Dr Varakantam's question, Mr Trotter said the high volume patients would not necessarily have clinical urgency. Professor Farooqi agreed it was an important point about prioritising critical cases and asked if the dashboards could be adjusted to take account of that. Mr Trotter advised that every patient who was on a surgical waiting list should have been clinically prioritised (the prioritisation runs from P1 – P6) and that information would give a clear indication of whether the acute sector was working through their urgent and emergency work or if they had capacity to further work through their waiting list backlog. Ms Hutchinson assured that level of detail had already been worked through for cancer patients and the wider elective categorisation information could be requested by UHL. Dr Nainani reported that each patient waiting over 52 weeks had been contacted to see if they needed clinical re-categorisation and if patients had waited over 6 months they had received a letter to re-state they were on the waiting list and to advise if they had deteriorated and they would be triaged. Non-urgent cases were being moved to community hospitals and the independent sector, where appropriate. Mr Haq agreed a twin-track approach was needed to treat patients based on clinical urgency and to utilise capacity elsewhere in the system for less complex cases. He was concerned that patients would be anxious whilst waiting or their condition could worsen and they'd go via their GP, putting more pressure onto primary care. It was **RESOLVED** to: • **RECEIVE** the CCG Performance Improvement & Quality Overview Report • **DISCUSS** the format of reporting & other areas of interest for future reports • **DISCUSS** areas of concern and where further dialogue is required with system Design Groups around performance improvement	

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GBs/21/83	**Summary Report from the Audit Committee meetings in common – March 2021 (Paper J)** Professor Jeffrey Knight presented the summary of business conducted at the March 2021 Audit Committee meeting. Appended to the paper were the Terms of Reference for the LLR CCG's Audit Committees in Common, which had been revised to reflect a change in membership with ELR CCG now having all three independent lay members as committee members. This is in line with the arrangements for WL CCG and LC CCG. Professor Knight drew attention to an important change on counter fraud work and public bodies were now expected to look at fraud with a greater emphasis on risk. Professor Knight assured the CCGs were in a good position to respond to that requirement. Two final Internal Audit Assurance Reports had been issued; NHSE Primary Care Delegated Functions receiving substantial assurance and Standing Financial Instructions/Scheme of Delegation Review receiving significant assurance. He explained the different levels of assurance; the Primary Care report used an NHSE points scale, and received substantial assurance whereas the SFI/SoD report used the Internal Audit scale and received significant assurance. It was **RESOLVED** to: • **RECEIVE** the report. • **ELR CCG Governing Body APPROVED** the terms of reference as at Appendix 1, noting the change in membership for ELR CCG Audit Committee.	
GBs/21/84	**Summary Report from the Clinical Reference Group – March and April 2021 (Paper K)** Professor Azhar Farooqi took the paper as read and received no questions or queries. It was **RESOLVED** to: • **RECEIVE** the LLR CCGs Clinical Reference Group Highlight Report.	
GBs/21/85	**Summary Report from the Commissioning Committee meeting – March and April 2021 (Paper L)** Ms Gillian Adams took the paper as read and received no questions or queries.	

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ITEM	DISCUSSION	LEAD RESPONSIBLE
	It was **RESOLVED** to: • **RECEIVE** the highlight report from the Commissioning Committee.	
GBs/21/86	**Summary report from the LLR CCGs' Primary Care Commissioning Committee meetings in common – April 2021 (Paper M)** Mr Nick Carter took the paper as read and received no questions or queries. It was **RESOLVED** to: • **RECEIVE** the highlight report from the Primary Care Commissioning Committee.	
GBs/21/87	**Summary report from the Quality and Performance Committee – April 2021 (Paper N)** Mr Warwick Kendrick took the paper as read and received no questions or queries. It was **RESOLVED** to: • **RECEIVE** the highlight report from the Quality and Performance Committee.	
GBs/21/88	**Summary report from the Finance and Activity Committee (March and April 2021): (Paper O)** Ms Wendy Kerr and Mr Zuffar Haq took the paper as read and received no questions or queries. It was **RESOLVED** to: • **RECEIVE** the summary report and take assurance from the Finance and Activity Committee held on March and April.	
GBs/21/89	**Items of any other business** Professor Farooqi confirmed that there were no items of other business to discuss.	
	Date of next meeting The next meeting of the LLR CCGs' Governing Body meetings in common will be take place on **Tuesday 13 July 2021,** via MS Teams. **The meeting concluded at 12:36pm**	

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