Questions and answers from the 2020/21 Annual General Meeting of the Leicester, Leicestershire and Rutland CCGs

1. Andy Lawrence (member of the public and Chair of the Leicestershire Home Care Alliance), in writing had asked, "How can I, as a representative of SME homecare providers carrying out ~20% of all LLR homecare work, get involved and have a say in the integration agenda?"

Mr Williams informed that there would be several ways to contribute; through the work with local authorities, through the Health and Wellbeing Board and through the planning work going forward as an integrated care system. There is also a direct opportunity to contribute through joining the citizens' panel which has been established.

2. Gemma Uddin (member of the public) asked what the annual allocated budget was for children with SEND and how this budget was being reviewed.

Ms Briggs undertook to provide a written response on the financial commitment to SEND.

3. Gemma Uddin (member of the public) noted the CCGs had a collaborative approach for EHCPs but had observed a poor standard of EHCPs and the application of their recommendations into health care planning and asked whether there were initiatives to introduce better practices so standards could be improved. This related to her own experience with regard to clinical recommendations and reports submitted to the CCG.

Due to poor audio quality, Mr Williams asked if a detailed question could be provided by Gemma Uddin in writing and a response would be provided.

Dr Caroline Trevithick acknowledged Gemma Uddin had raised a really important point for an area of improvement that the CCG currently had underway. Dr Trevithick welcomed an offline conversation and to hear of her experiences. That would include exploring Gemma's question on how the ICS would work to improve SEND.

4. Dr Hannah Robbins, Long Lane Surgery submitted a question in writing in advance of the meeting in relation to gender balance and leadership of boards which was skewed towards male representation and asked how the ICB would make sure there was greater equality of opportunity. Specifically, "what changes will the new ICB be making around recruitment to ensure that our patient population and workforce are represented at all levels of clinical leadership?

What will be done at pre-recruitment and selection to ensure inclusivity at all levels of our clinical workforce?

Alice McGee, Executive Director of People and Innovation spoke of the work being done to promote women in leadership across the ICS including a network with around 90 members and the female clinical workforce, amongst others, being provided with support to take up leadership positions. Great clinical and professional leadership includes diversity in those leadership positions. Ms McGee was acutely aware that diversity does not just happen at the selection stage, so designing roles that attracted diversity, for women and other underrepresented groups would be at the forefront of thinking as the Integrated Care Board (ICB) is established.

5. Nasim Minhas (member of public) through the chat function had asked, "what was being done to tackle health inequalities, given the greater impact of Covid19 on BAME communities?"

Professor Azhar Farooqi responded that the CCGs' work with communities had been deep and longstanding. Ensuring a very good uptake of Covid-19 vaccination was one way to reduce health inequalities and the results on BAME uptake was very encouraging. Social distancing and wearing face masks was a message relevant to all communities. LLR had invested in the identification and treatment of underlying conditions like diabetes.

6. Mr Williams referred to a written question from Dr Darren Jackson who had asked, how the CCGs were addressing the constant denigration of general practice and whether the CCGs had proactively put out some positive news as a balance.

In response, Mr Williams highlighted that the CCGs have been very active and have used a variety of media outlets to enforce the positive messages. Work is being undertaken and briefings for elected members so that we can provide them with the facts and figures showing that primary care in LLR was working at higher levels of appointments than pre-Covid. LLR has the highest level of face-to-face appointments of the eleven systems in the Midlands. Mr Williams appreciated this was a difficult time for many health professionals, including primary care and the CCGs were correctly portraying the contribution made by primary care.

7. Jean Burbridge (member of public) enquired whether the meetings of the ICS would be held in public and the minutes made available. Also decisions made to date regarding members of the ICS, ICP and subcommittees, would they involve private companies such as APMS contract holders?

Mr Williams advised that Mr David Sissling is the designate Chair of the Integrated Care Board (ICB). The ICB and Integrated Care Partnership (ICP) membership was still being developed, for which there was a minimum requirement, however David

Sissling had indicated he wanted to go beyond that minimum to strengthen the contribution from local government, local NHS providers and ensure a greater number of non-executive directors if required. Mr Williams informed that Mr David Sissling had been clear there was no expectation for private providers to be at the board table. Some sub committees had started to meet in shadow form and the exact structure was yet to be decided. Social enterprise, not for profit and private organisations would continue to have a good relationship with local health commissioners but it was not expected they would be part of the ICB membership.

8. Alison Clowes, of the Alzheimer's Society had submitted a question in writing on the benefits of early access to diagnosis and the subsequent access to other services, asking what work the CCGs had done to support early access and what might the ICS do going forward ("Is this a key area of concern for the members; what plans are in place to look into this area; and do they feel the transition to an ICS will benefit the referral process for all LLR residents?").

Mr Williams undertook to provide a detailed written response to Alison but shared Alison's view, highlighting the additional funding the CCGs had put into dementia services to address some of the variation and the development of dementia pathways. The response would cover the amounts of money, including direct funding support and grants to the voluntary services.

9. Five questions had been submitted regarding services in Rutland and how the Rutland Plan will reflect the particularities of this area from Andrew Nebel, CoChair Empingham PPG.

Mr Williams summarised the first four questions from Andrew Nebel which asked whether place-led plans would reflect and address the complex boundary around Rutland. Particularly in respect of working across other systems and areas for Rutland patients accessing services, whether there would be greater diagnostic, outpatient services and care closer to home, the provision of additional primary care to serve the growing population and investment in capital development.

Mr Williams advised the Rutland Plan would address the issues raised. There was consciousness of the boundary issues and the Plan would take that into account and strengthen relationships across those boundaries. The work with partners at this stage was formative because other systems were going through ICS changes, however contact had been made and discussions commenced.

Care closer to home was a shared programme of work through the Health and Wellbeing Boards and the CCGs would continue to develop that. The growing population was also reflected in these plans and there would be a focus on primary care in the place-based plans.

10. Andrew Nebel's fifth question related to capital investment at UHL (Leicester's Hospitals) and whether they had been asked to develop plans that would scale back the investment by £50m, thereby reducing the allocation of £450m for the development to £400m.

Mr Williams undertook to provide a detailed answer in writing but made it clear the local system had not been asked to reduce their costs for this investment. It was noted that media had reported on plans for another area and that had given the impression that the UHL reconfiguration programme would be scaled back, which is not the case. The CCGs and UHL had been asked to provide further information as part of an overall evaluation of the capital program nationally.

Locally work continued on the assumption that at least £450m would be invested in this programme of work. The CCGs and UHL had also been asked to state cost profiles that reflected the greater ratio of single rooms, the composition of inpatient spaces, and achieving carbon neutrality.

11. Cllr Phil Knowles (member of the public) expressed his thanks to all healthcare professionals for their continued support to communities and the fantastic work they had done during the pandemic. Given the green and climate impact agendas, he asked what commitment there was towards community hospitals and providing care closer to home. Areas like Market Harborough would benefit from good satellite healthcare provision by clinicians attending clinics locally and that would reduce patient travel time. The hubs in Leicester could then focus on a more local patient population whilst looking at opportunities to expand St. Luke's Hospital and other community hospitals.

Mr Williams acknowledged this was important and something the CCGs were very positive about going forward. Plans would be addressed on a community-by-community basis rather than seeing the community hospital network as a whole. The CCGs were working hard to consider the housing growth and planned infrastructure changes. The overall approach set out in the acute and community consultations, including maternity care, was predicated on the delivery of care closer to home. Work on a decentralised model of care for outpatients, diagnostics and primary care services would be done with PCNs (primary care networks) and communities, place by place. The work would cover all areas but had started in some areas particularly. There was intent for better access and more appropriate care closer to home which would improve convenience and reduce the carbon footprint. Mr Williams assured this was happening in real time and substantial progress had been made.

12. Andrew Nebel (member of the public) wanted to understand the governance of the ICB and ICP, particularly the strength of governance for

independent lay member/non-executive director positions (ILMs/NEDs) and assurance the patient voice will be part of the ICP/ICB.

Mr Williams thanked Andrew for a great question and was happy to share the current thinking around governance. The ICB minimum requirements as set out in statute included two independent lay member/non-executive director positions of which one would take responsibility for the audit process. Mr David Sissling had indicated he thought the LLR ICB would benefit from having three if not four non-executive directors which would exceed the minimum requirement. There was active debate about the composition of the ICB as a whole and to ensure inclusivity. Mr Williams advised that Mr David Sissling intended to share quite widely the proposed composition of the ICB around the beginning of October before it was finalised.

13. Andrew Nebel (member of the public) noted there was a greater number of independent lay members currently on the CCG boards and asked for those numbers.

Mr Williams responded it was typical for each CCG to have between three to five ILMs per board but the CCGs currently had a board each, so that was three boards and going forward there would be only one board. [post meeting note: to confirm there are currently nine independent lay members in total across the three CCGs].

14. Andrew Nebel (member of the public) as a resident of Rutland wanted to know if the non-executive representative on the ICB would represent a specific place.

Mr Williams advised it was Mr David Sissling's intention to achieve a balance with each place represented at the ICB. That could be achieved with nonexecutive directors or supplemented with additional roles for place. Each local authority would have a position on the ICB. As well as system-level, governance would work at place and locality level and so the involvement at ICB level would not be the only way to secure engagement.