Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held at County Hall, Glenfield on Tuesday, 10 September 2019.

PRESENT

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

Cllr. T. Aldred	Mr. J. Morgan CC
Cllr. L. Fonseca	Cllr. D. Sangster
Mrs. A. J. Hack CC	Mrs B. Seaton CC
Dr. S. Hill CC	Miss G. Waller
Cllr. P. Kitterick	Mrs. M. Wright CC
Cllr. M. March	

In attendance
John Adler, Chief Executive, University Hospitals of Leicester NHS Trust (minute 6 refers)
Colin Moorhouse, Head of Quality Improvement, University Hospitals of Leicester NHS Trust (minute 6 refers)
Tamsin Hooton, Director lead for Community Services Redesign, West Leicestershire Clinical Commissioning Group (minute 7 refers)
Ket Chudasama, Director of Performance and Corporate Affairs, West Leicestershire Clinical Commissioning Group (minute 8 refers)
Helen Mather, Planned Care Implementation Lead, Leicester City Clinical Commissioning Group (minute 8 refers)
Anne-Maria Newham MBE, Director of Nursing, Leicestershire Partnership NHS Trust
Russell Smalley, Ambulance Operations Manager, East Midlands Ambulance Service (minute 9 refers)

1. Chair and Vice Chair.

It was noted that as per the Terms of Reference of the Committee, in May 2019 the position of Chair rotated from the City Council to the County Council and the position of Vice Chair rotated from the County Council to the City Council.

For the 2019/20 year Dr. R.K.A Feltham CC had been nominated to be Chair and Cllr. P. Kitterick had been nominated to be Vice Chair.

2. Minutes of the previous meeting.

The minutes of the meeting held on 19 March 2019 were taken as read, confirmed and signed.

3. Declarations of interest.

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

4. Presentation of Petitions.

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

5. Urgent items.

There were no urgent items for consideration.

6. University Hospitals of Leicester 3 Year Quality Strategy and Priorities 2019-2022.

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) which presented the 3 Year Quality Strategy and Priorities 2019-2022. A copy of the report, marked 'Agenda Item 6', is filed with the minutes.

The Committee welcomed John Adler, Chief Executive, UHL and Colin Moorhouse, Head of Quality Improvement, UHL to the meeting for this item.

Arising from discussions the following points were noted:

(i) UHL would be rigorously monitoring the success of the 3 Year Quality Strategy and using data in new ways to analyse trends and variations in performance. UHL acknowledged that culture changes needed to take place within the organisation, and the leadership styles of UHL staff needed to be developed, to ensure that improvements in quality were sustained. The Quality Improvement team would measure the progress of the culture changes. Whilst lessons could be learned from private industry regarding quality improvement, it would not be practical for UHL to use the same model for improvement. It was expected that coaching of staff from the technical team at UHL would have a small impact on performance, however the significant improvements would come from staff on the wards being empowered to make changes under their own initiative. Some UHL staff would become 'Improvement Agents' to help facilitate the work on cultural leadership. There were currently 175 Improvement Agents within UHL and this number was increasing. However, care needed to be taken that quality monitoring did not prevent staff from focusing on patient care. The Improvement Agent work was intended to be a very small proportion of the Improvement Agent's duties and line managers would be liaised with to ensure that staff were able to carry out the Improvement Agent role.

(ii) In response to a question as to how the Quality Improvement philosophy would be introduced to bank staff and agency workers it was explained that there was a cap in place for how many agency staff could be employed at UHL and therefore the numbers of agency staff used was relatively low. Many of the bank shifts were staffed by permanent employees of UHL who wanted extra work therefore they would already be familiar with the cultural improvements which were taking place.

(iii) The UHL reconfiguration plans, including the proposed sale of the General Hospital, formed only a small part of the Quality Strategy and the rest of the Strategy would be implemented regardless of how quickly the reconfiguration plans progressed. With regards to reconfiguration, UHL were waiting to submit a bid for Government funding however the next bidding round had been delayed and the Government spending review would not now take place until 2020. Comprehensive Spending Reviews usually took place in the autumn but it was not known exactly when the next one would be. Discussions were taking place with the planning department at

Leicester City Council regarding earmarking the General Hospital site for housing. Staff residences at the General Hospital were being closed down and it was intended that this part of the site would be marketed for sale in 2020 however progress could not be made on the overall site until there were developments from central government. The marketing strategy for the site had not yet been determined and a decision had not yet been made whether the General Hospital land would be on open sale or whether partners would be identified to make use of the land. Consideration was being given to whether the land could be used for social housing or keyworker housing. UHL were committed to ensuring that local communities would be engaged with regarding the sale.

(iv) UHL was still relying on paper records for patients and the E-Hospital plans centred around the target for UHL to became paperless within three years and an aim to improve the interface with patients. A contract had been signed with a company called Nervecentre to provide the computer software. This was being funded from UHL's own resources though UHL would also welcome any government funding for this project.

(v) Environmental concerns around pollution and becoming carbon neutral were addressed in UHL's Sustainability Strategy though it was acknowledged by UHL that the work they were doing in this area needed to have a higher profile. Andy Williams, the new Chief Executive for Leicester City, West Leicestershire and East Leicestershire and Rutland CCGs had expressed a wish to make environmental and sustainability issues a priority for the Health and Social Care economy and UHL intended to work with the CCGs on this. UHL would give consideration to pollution issues at Leicester Royal Infirmary and whether measures could be taken to make the site more environmentally friendly.

RESOLVED:

(a) That the 3 year Quality Strategy and Priorities 2019-2022 be noted;

(b) That the approach of University Hospitals of Leicester NHS Trust towards quality improvement be welcomed;

(c) That the lack of certainty regarding the future timetable for the hospital reconfiguration plans be noted with concern.

7. Better Care Together - Community Services Redesign.

The Committee considered a report of Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups which provided an update on progress with redesigning adult community health services across LLR and set out the next phase of the work. A copy of the report, marked 'Agenda Item 7', is filed with the minutes.

The Committee welcomed Tamsin Hooton, Director lead for Community Services Redesign, West Leicestershire Clinical Commissioning Group to the meeting for this item.

Arising from discussions the following points were noted:

(i) It was expected that the real benefits of the Community Services Redesign would become apparent in future years rather than the current financial year. Whilst LPT was expected to provide additional services under the community services redesign

and the LPT community teams were to be restructured in the current financial year, no additional funding would be provided for 2019/20 and LPT were expected to provide the services using existing staff. A review would then take place of LPT capacity and how it was dealing with demand with the expectation that in the following financial year the CCGs would invest in LPT. The NHS Long Term plan was helpful in this regard as it set out how investment should take place in community services and primary care.

(ii) LPT Community staff had been consulted and engaged with regarding the redesign. Several focus meetings had been held. At a recent focus group of 20 staff members only two were unhappy with the proposals. Therapy staff had initially expressed concerns about the changes to the way they worked but now the majority of those staff were in support. No concerns had been raised by staff about the move to working seven days a week. Concerns had been raised by some staff that worked for the Intensive Community Support Service that they would lose their specialisation and skills when the service became more closely aligned with GP Practices.

(iii) A member raised concerns regarding the capacity of therapists given that they often had long travelling times between each appointment. Reassurance was given that some therapists had two patient contacts a day and it was possible to increase this to five or six even including travelling time. The therapists were organised around geographical hubs and therefore would not have to travel that far to patient's homes. Members would be provided with further details regarding team structures after the meeting. In response to a concern raised by a member regarding the potential impact on the environment of community services practitioners travelling extensively round the county by road, it was acknowledged that the amount of travel needed to be minimised. It was clarified that CCGs did not purchase vehicles for their staff to use, staff could use their own car and claim fuel costs or purchase a lease car.

(iv) Consideration had been given to whether a Locality Decision Unit should be located in Rutland however there was not felt to be the demand for one. Nevertheless, efforts were being made to ensure the best offer for Rutland and conversations were being had with colleagues in Social Care at Rutland Council.

(v) A number of patients were being discharged into reablement 'Pathway 3' beds in care home settings rather than the current community hospital inpatient beds. One of these care homes was in Leicester City and 10 were in the County area. There was less demand for reablement beds in Rutland because of the success of the Integrated Care Team.

(vi) Patients discharged from Peterborough hospitals could be dealt with by Home First, however LPT only dealt with patients referred by LLR GPs.

(vii) A member referred to reports in the media that the Intensive Community Support (ICS) service was being pressurised to take on patients that were not ready to be discharged from hospital and questioned whether the new Community Services model would resolve this. In response it was acknowledged that this was a concern which was why funding for medical cover had been prioritised and conversations were taking place with UHL and LPT regarding improving the discharge process.

(viii) An Equality Impact Assessment had been carried out in relation to the community services redesign and this would be reviewed as the redesign was implemented and any concerns raised by members would be fed into the Assessment. A further update would be provided to the Committee in the new year regarding Community Services Redesign, and the updated Equality Impact Assessment, when phase 1 and phase 2 had been completed.

RESOLVED:

(a) That the update on the redesign of adult community health services across Leicester, Leicestershire and Rutland be noted;

(b) That the reliance of the Community Services Redesign project on Leicestershire Partnership NHS Trust having the capacity and funding to carry out new services be noted with concern;

(c) That officers be requested to provide members with further information regarding the equalities impact assessment that was carried out in relation to the Community Services Redesign, and keep members updated regarding any equalities work which is carried out in future.

8. Better Care Together - Planned Care Update.

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups which provided an update on the 2019/20 Planned Care programme. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed Ket Chudasama, Director of Performance and Corporate Affairs, West Leicestershire Clinical Commissioning Group, and Helen Mather, Planned Care Implementation Lead, Leicester City Clinical Commissioning Group to the meeting for this item.

Members welcomed the proposed changes to outpatient services as they felt the current system was outdated.

Arising from discussions the following points were noted:

(i) It was intended that as a result of changes instigated by the Planned Care programme patients would be able to see a variety of clinicians at the same place and time. Some GPs had special interests in areas such as ophthalmology and dermatology and had received extra training to be able to provide these specialisms at GP practices. Planned Care would be more environmentally friendly as patients and their relatives would not have to travel to hospital as much. Nevertheless, patients would still have a large element of choice about whether they wished to travel to receive services. In response to a question about the impact of the changes on vulnerable patients, reassurance was given that although the Planned Care Programme intended to reduce the amount of appointments patients required, the needs of individual patients would be taken into account and some patients, such as those with learning difficulties, would still receive a large amount of face to face care. Patients would always have the ability to contact a professional by phone even if they did not have a face to face appointment. There were patient helplines in existence already for conditions such as Irritable Bowel Syndrome. Often patients knew their own condition very well and knew when a referral needed to be made.

Officers would give further consideration to whether the system could include a mechanism for a referral to take place when a patient insisted that they needed one.

(ii) Members asked officers to ensure that the specialism hubs were well served by public transport.

(iii) There were excellent dermatology facilities in Leicester City and efforts were being made to make them more multi-disciplinary. A member raised concerns that patients registered with GP Practices in the County were not able to attend the Dermatology clinic at Leicester Royal Infirmary; officers agreed to look into this issue as it should not be the case.

(iv) The X-ray department at Hinckley Hospital was being closed due to the equipment no longer being safe and work was being undertaken to minimise the impact on services including redistributing patients to the walk-in service at Glenfield Hospital, and looking into whether mobile X-ray equipment could be purchased. A meeting was taking place with the Director of Finance at UHL to consider the options.

RESOLVED:

That the proposals set out in the Planned Care programme be welcomed.

9. Leicestershire Partnership NHS Trust update.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on Care Quality Commission (CQC) related activity including delivery against the actions identified following the 2018/19 inspection findings and warning notice. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Committee welcomed Anne-Maria Newham MBE, Director of Nursing, LPT to the meeting for this and other items.

Arising from discussions the following points were noted:

(i) Previous CQC reports which had raised serious concerns about LPT had not led to significant improvements at LPT. For example past CQC reports had criticised LPT for its medicine administration but the issues remained. Members feared that the action plan created in response to the CQC report would not have the desired effect, though it was hoped that this time positive results would be seen. In response LPT now acknowledged that they may have erred in the past by allowing staff to regulate themselves, and whilst it was still intended to empower staff and allow autonomy, greater evidence would be required to demonstrate to management that improvements had been made and procedures were being complied with.

(ii) Concerns were raised by members that the senior management team at LPT had stopped listening and engaging with partners, however members were pleased that as a result of the new appointments at management level LPT now seemed more willing to open up a dialogue. Members particularly thanked the Director of Nursing for her contribution to the meeting. She reassured members that in her previous role as Director of Nursing at Lincolnshire Partnership NHS Foundation Trust she had instigated significant improvements and she had confidence that she could do the

same with LPT. NHS Improvement had also sent a turnaround director to work at LPT to help improve the Governance of the Trust.

(iii) Clarification was given that there were only three mental health Trusts in the United Kingdom which had been given an outstanding rating by CQC and Northamptonshire Healthcare NHS Foundation Trust (NHFT) was one of them. NHFT had made significant improvements in the quality of its services, leading to a request from NHS Improvement to work with LPT, including through buddy arrangements so learning could be shared. It was after the buddy arrangements had been put in place and no suitable applicants had come forward for the role of Chief Executive at LPT that the Chief Executive of NHFT Angela Hillary was approached to see if she would take on the role in addition to her current role and she then accepted this appointment.

(iv) The Bradgate Unit still used dormitories which were not considered good practice and CQC required LPT to have a plan in place by March 2020 for replacing them. It was intended in the short term to reduce the number of beds at the Bradgate Unit thus reducing the reliance on dormitories and improve the quality of care for the patients that were in the Unit. A Strategic Outline Case for the Bradgate Unit had been put in place and capital funding had been applied for by LPT but the bids had not been successful so far.

RESOLVED:

(a) That the update on Leicestershire Partnership NHS Trust and the Care Quality Commission Inspections be noted;

(b) That the improvements made by LPT as noted in the Care Quality Commission report published in August 2019 be welcomed but LPT be advised that the Committee has concerns whether further improvements will be made particularly in relation to the Bradgate Unit.

10. <u>East Midlands Ambulance Service Update including Care Quality Commission Report.</u>

The Committee received a presentation from East Midlands Ambulance Service (EMAS) which provided an update on the recent Care Quality Commission (CQC) inspection of EMAS, the Service's Vision and Values, and the Clinical Operating Model. A copy of the presentation slides is filed with these minutes.

The Committee welcomed Russell Smalley, EMAS Ambulance Operations Manager, to the meeting for this item.

Members congratulated EMAS for a very positive CQC report.

Arising from discussions the following points were noted:

(i) Commissioners had noted that EMAS faced a workforce challenge in order to deliver the National Strategy and therefore approximately 50 additional staff had been recruited however a further 50 were needed. A recruitment campaign had taken place in Australia which resulted in five Australian paramedics working for EMAS. In total eight paramedics had recently been recruited by EMAS and a further 15 were to be employed in the near future. EMAS recognised the need to recruit and develop local people to work for EMAS and the Emergency Services Cadets

were one way of doing this. EMAS had also developed strong links with universities. There were routes for existing EMAS staff to become paramedics via roles such as Emergency Care Assistant and Ambulance technicians.

(ii) EMAS used private ambulance providers in addition to their own ambulances to ensure that the demand was met in a timely manner. Although they costed more, the feedback regarding the service they provided was good. It was agreed that EMAS would provide members with further details regarding the costings after the meeting.

(iii) Members welcomed the dementia friendly ambulances and noted that they could also be helpful for people with autism. The music in the ambulances could be turned off depending on the wishes of the patient. EMAS used dementia champions who could help other staff recognise the emotional state of patients and whether the music would be beneficial. It was expected that by the end of October 2019 every EMAS ambulance would be dementia friendly.

RESOLVED:

(a) That the improvements identified in the Care Quality Commission report published July 2019 be welcomed.

(b) That the update on the EMAS Vision and Values, Clinical Operating Model and Advance Practice Model and future workforce planning be noted.

11. Date of next meeting.

RESOLVED:

That the next meeting of the Committee take place on 24 January 2020 at 10:00am.

10.00 am - 1.25 pm
10 September 2019

CHAIRMAN