Agenda Item 2

Leicestershire County Council

Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held via Microsoft Teams video conferencing on Friday, 3 July 2020.

PRESENT

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

Cllr. L. Fonseca
Mr. T. Gillard CC
Mrs. A. J. Hack CC
Mrs S Harvey
Dr. S. Hill CC
Cllr. P. Kitterick
Cllr. M. March
Mr. J. Morgan CC
Cllr. D. Sangster
Mrs B. Seaton CC
Micheal Smith
Janet Underwood
Miss G. Waller
Cllr. P. Westley
Mrs. M. Wright CC

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

In attendance
Andy Williams, Chief Executive LLR Clinical Commissioning Groups (minute 28 refers).
Rebecca Brown, Acting Chief Executive, UHL (minutes 28, 29 and 30 refer).
Angela Hillary, Chief Executive of LPT (minute 28 refers).
Rachel Bilsborough, Director - Community Health Services, LPT (minute 28 refers).
John Edwards, Associate Director of Transformation, LPT (minute 28 refers).
Jonathan Shuter, Deputy Chief Financial Officer, UHL (minute 29 refers).
Mark Wightman, Director of Strategy and Communications, UHL (minute 30 refers).

22. Minutes of the previous meeting.

The minutes of the meeting held on 24 January 2020 were taken as read, confirmed and signed.

23. Question time.

The Chief Executive reported that six questions had been received under Standing Order 7(3) and 7(5).

1. Question by Mrs Jean Burbridge:

Did out breaks of Covid-19 occur in Care Homes in LLR to which patients with Covid had been discharged from UHL?

Reply by the Chairman:

The three Councils across Leicester, Leicestershire and Rutland (LLR) have worked closely with University Hospitals of Leicester NHS Trust (UHL) and Leicestershire Partnership NHS Trust (LPT) to implement Government Guidance to ensure the safe and timely discharge of patients from hospital. Where appropriate, this has included ensuring

that patients recovering from Covid can be discharged on a long or short term basis to care homes. Since March 2020 around a third of care homes in LLR have had a Covid outbreak although a lessor number in Rutland. This means that it is inevitable that some homes with outbreaks also admitted people discharged from hospital. Some of these infections are likely to be linked to these discharged patients, but others will have been as a result of community infection, often through asymptomatic care staff which has been shown through national and international research to be significant. In this respect Leicester, Leicestershire and Rutland is no different to other parts of the region and lower than the all England average

The number of new infections in care homes has declined significantly, and the number of new outbreaks has been very low in the last 2 weeks.

2. Question by Mrs Jean Burbridge:

From what date were patients tested for the Coronavirus before being discharged from Hospitals to Care Homes?

Reply by the Chairman:

I have received the following answer to the question from University Hospitals of Leicester NHS Trust:

> "National COVID-19 hospital discharge service requirements were first published on 19th March – these set out the actions to be taken immediately to enhance discharge arrangements. There was no mandate to test patients being discharged to care homes. At this time most patients were discharged to care homes with no test unless;
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> - they had been symptomatic, as the directive at this time was to test only symptomatic patients;
> - the receiving care home refused to take the patient without a test result.
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> The "Admission and Care of Residents during COVID-19 Incident in Care Home" guidelines were published on the 2nd April highlighting the need for care homes to isolate patients – this included no details regarding additional testing prior to discharge.
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> The UHL approach to the guidance was to share with care homes our view that, 'Hospitals are a high risk environment and there is a case for considering isolation in a care home on admission from secondary care. Trusted Assessors and Discharge Co-ordinators will be able to support care homes with the most up to date information on the individual patients and relevant guidance.'
> In other words our advice to care homes was to be cautious and isolate patients discharged from hospital.
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> The "Coronavirus (COVID-19): Adult Social Care Action Plan" was published on the 15th April and for the first time the need to test patients prior to discharge to a care home was recommended. With the Government stating "we can now confirm we will move to institute a policy of testing all residents prior to admission to care homes. This will begin with all those being discharged from hospital"
>
> The guidance was very clear stating that 'where a test result is still awaited, the patient will be discharged and pending the result, isolated in the same way as a COVID-positive patient will be'.

Thus from the 15th April – all care home discharges have been tested. The test is requested up to 48 hours prior to discharge, as per the guidance, and we continue to advise all care homes to isolate patients for 14 days from the date of the test."

3. **Question by Mrs Jean Burbridge:**

How many physical real extra beds in community hospitals or community buildings were prepared by Leicester Partnership Trust? A paper presented by LPT to City Council states that 222 could be expanded to 350. LPT made a video showing the preparations of 36 extra beds at the end of April for Loughborough Hospital. Were these beds used? Which other hospitals had the extra beds? What will happen to these beds?

Reply by the Chairman:

I have sought information from Leicestershire Partnership NHS Trust (LPT) on the question and received the following response from LPT:

"In April 2020, the Trust approved a plan to increase community bed capacity in order to accommodate an expected surge in the number of patients requiring in-patient rehabilitation as a consequence of catching Covid-19.

The plan to expand our beds included the conversion of 75 Independent Sector (private hospital) beds into rehabilitation beds. From mid April 2020 onwards, 33 of the 75 beds were converted and 6 were in use at any one time. These beds are no longer being used for rehabilitation purposes and have reverted back to their original use.

In our community hospitals, three wards (53 beds) were refurbished and made ready to accommodate rehabilitation patients. Two of the wards are located at Loughborough community hospital (Charnwood and Gracedieu ward) and one at Coalville community hospital (ward 4). During April, the Trust opened the wards at Loughborough community hospital to ensure additional capacity was available to respond to an expected surge of patients over the Easter period. The expected surge did not materialise and the wards were not required to accommodate any patients. On 1 May 2020 a decision was made to stand the wards down.

The refurbished wards in our community hospitals will enable the Trust to respond to any future wave of the virus, in addition to any bed pressures that the winter months may bring."

4. Question by Mrs Jean Burbridge

I am concerned that a massive reduction in hospital outpatient appointments is forecast in "Covid 19 Restoration and Recovery " (UHL Board meeting paper) and that the projected number of 'virtual' (phone/video) outpatient appointments is too high (70%). It looks as though the local NHS has already made a decision about Digital First implementation without consulting the public. The survey referred to with response from 1400 people was a set of questions on people's experiences during the pandemic and being ONLINE by its very medium will contain bias. Can the UHL Trust assure us that proper formal consultation will take place on these matters and that it will seek evidence that the proposals will not break Equality principles?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust have provided me with the following assurance:

> "The Chief Medical Officer for England has highlighted that we are likely to be living with COVID-19 and its implications for the foreseeable future. The safety of our population and patients is paramount and we are adapting all models of service provision, to ensure that our patients only need to travel to hospital for care they cannot safely receive elsewhere. Outpatients are no different, and the use of virtual technology allows us to maintain the vital services we offer to our patients, in a safe and timely manner. We are aware that virtual appointments will not be the appropriate option for all patients and therefore technology will be used in combination with appointments in our community hospitals, GP practices & traditional UHL sites. The approach to virtual technology will be flexible, meeting the needs of our patients, whilst maintaining their safety. All UHL & LLR transformation programmes are undertaken in collaboration with patient representatives and engagement/consultation will be a key pillar of the changes we make.
>
> The NHS Long Term Plan (Released in January 2019), required all NHS providers to deliver 33% of the outpatient activity virtually and follow ups to only take place when clinically necessary. More recently to reduce the risk of infection and support the safe switch on of services NHSE/I have issued guidance stating that,
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> "As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure…"
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> It should be recognised that for years we have received feedback from patients regarding their frustration with regularly attending our hospitals for 15 minute appointments only to be told they are well and to return in six months. Roughly 30% of all new outpatient activity involves patients traveling to an acute hospital site to receive no ongoing treatment, following the initial appointment. COVID-19 has therefore shown that the original aim of 33% reduction in face to face consultations is at the lower end of what is possible and so we have chosen a stretching target of 70%. Of course there cannot be a one size fits all approach, not least because there are some services where 'face to face and hands on' is essential for diagnostic reasons; equally there are patients who are unable or unwilling to access care virtually BUT the idea that we will continue to ask hundreds of thousands of patients to travel into hospital in a COVID endemic world is counter intuitive when other options exist.
>
> Finally and importantly a digital approach to outpatient activity allows the NHS to contribute to the ambitious national climate change and air quality targets, given that circa 5% of traffic on England's roads is NHS related."

The Committee ensures that it is consulted by NHS partners on all major transformation programmes and it is intended that the local response to the NHS Long Term Plan will be on the agenda for a Committee meeting later in the year.

5. Question by Mr Robert Ball

How in practice will UHL manage to 'juggle' between handling ordinary treatments and handling more Covid-19 patients if there is a resurgence of the Coronavirus?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust has stated the following:

> "The Paper on Restoration and Recovery (part of the agenda pack for this 3 July 2020 meeting and the monthly updates in public at the UHL Trust Board https://www.leicestershospitals.nhs.uk/aboutus/our-structure-and-people/board-of-directors/board-meeting-dates/), cover this off in some detail. The summary is that we have managed to turn back on the majority of our services, (whilst still anticipating a second peak). However, it is important to recognise that although services are being restored it is not back to 'business as usual'. For example, a typically efficient theatre list pre-Covid might have seen our surgeons carry put 10 procedures in a session. Now, with the added infection risk posed by COVID, surgeons are working in full PPE, which is changed between patients; the theatre is deep cleaned between each patient and the air is completely exchanged. This means that in the 'new normal' we can only treat half the numbers of patients on a list."

The Committee will discuss this issue further as part of agenda item 7 at this meeting: Covid-19 Leicester, Leicestershire and Rutland NHS Response, and also at future Committee meetings.

6. Question by Mr Robert Ball

How many non-urgent operations were cancelled by UHL to stop hospitals being overwhelmed and provide space to treat Covid-19 patients? Also, assuming no resurgence of the Coronavirus, how long will it take to clear the backlog in operations, in months and years?

Reply by the Chairman:

University Hospitals of Leicester NHS Trust have provided the following information:

> "We postponed almost all of our non-urgent surgery in anticipation of the first peak of the pandemic and given the size of the Trust and the numbers of patients we routinely see, that amounts to some 13,000 patients who did not have their procedures. The numbers who were actually 'cancelled' is much smaller (700) but this is only because we generally book patients a few weeks in advance meaning that only a relative few had dates for their operations at the time we took down lists. There were two drivers for this; the first (and lesser) of the two was to create sufficient surge capacity in our bed base. The second (and more important) was to create sufficient surge capacity for patients requiring Intensive Care and other types of ventilation. This meant that we converted operating theatres into ICUs and diverted theatre staff to support the large number of ventilated patients we were caring for. With theatres and staff 'repurposed', non-urgent activity could not take place. (Though of course we continued urgent and emergency activity throughout).
>
> As the briefing paper in the agenda pack for this 3 July 2020 meeting explains, we are now restoring / recovering services and aim to be at 75% capacity by early July. However, as the example above explains, being at 75% capacity does not equate to being able to run services at their previous levels of efficiency. All of which means that waiting times for non-urgent operations will be much longer than people have been used to. In terms of how long it will take to 'recover' to previous levels, for which we would mean waiting lists back to 'normal'… that is still a work in progress

and also depends on what levels of new referrals we receive but a conservative estimate would be 12 months."

The Committee keeps a close eye on waiting times for operations and will monitor performance going forward in particular the impact of the Covid-19 cancellations.

Mr Ball asked the following supplementary question:

What percentage of the non-emergency operations were undertaken by private providers?

The Chairman replied as follows:

The precise figure would be sought from UHL and provided to Mr Ball after the meeting.

(Note: After the meeting UHL informed Mr Ball that **23%** of their non-emergency activity was being undertaken by the private sector.)

24. Questions asked by members under Standing Order 7(3) and 7(5).

Mrs Amanda Hack CC asked the following question of the Chairman:

Please could we receive an update on the support for 2017 Student Nurses, who put their studies and lives to one side to assist the NHS with the Covid response. There had been reports of student nurses having their 6 month contracts reduced by 2 months, whilst it looks like the 6 month contracts will now be honoured, is this the correct position?

How many 2017 cohort student nurses do we have across our sites and how are our hospitals going to support these student nurses through the next 2 months.

Reply by the Chairman:

I have sought an answer to the question from University Hospitals of Leicester NHS Trust and received the following response:

"Across UHL, we have approximately 100 finalist student nurses and midwives from the 2017 cohort who volunteered to become an aspirant nurse at the beginning of the COVID-19 outbreak in England. Some of the Aspirants are from other universities across England who have chosen to complete their training in Leicester to be nearer to their families during the pandemic. All Aspirant nurses are being paid a Band 4 salary.

We also have 80 x 3rd year finalist students who chose not to be an aspirant nurse or midwife but wanted to have an extended paid placement in UHL. They are being paid a Band 3 salary. At the beginning of the COVID outbreak, Health Education England (HEE), believed that the extended paid placement initiative would be for six months and this was communicated to universities and students. However in UHL we gave all of our students (and all the NHS Bring Back Scheme volunteers) a three month fixed term employment contract in UHL that would end on July 31st 2020. This was a pragmatic decision because of the unpredictable nature of COVID. It is always easier to have a shorter contract that can be extended rather than bringing a longer contract to an end with little notice to an individual (which may be the case elsewhere in the UK). However, HEE announced on Friday 26th June that these paid placements could now continue for six months as per their original decision.

Locally, we will now extend contracts until the 31st August so as of the 1st September the students will revert back to full supernumerary status in order to complete their training. Our finalist students at DMU should complete their training on the 20th September and many have secured jobs in UHL so we will make sure they are supported to complete their programme in the best way possible.

HEE and NHSI/E agreed that students who chose to continue their placements during the pandemic should have an NHS contract and be reimbursed for their time working on wards. This is because as an NHS employee, students would benefit from the COVID legislation around statutory sick pay which would give them the same protection as existing NHS employees should they contract COVID whilst working in the NHS and as a result, become very ill (or in the worst case scenario, die as a result of COVID so, family becoming eligible to receive death in service payment). The salaries for students are being paid for by NHSI/E. Many students across the UK may have given up part-time employment thinking they would be receiving a band 4 salary for six months and this has caused distress to the students. This is not the case we believe, in LLR. However, when the contract ends on August 31st the students will no longer be an NHS employee or be remunerated for the remainder of their training (they should still receive their bursary) but they could still contract COVID but will be no longer eligible for benefits. So, we now await a decision from the Council of Deans who are working with NHSE/I, regulatory bodies, HEE and DoH to agree what needs to be in place that will support students appropriately. The final decision lies with the Department of Health and Social Care under the direction of the Secretary of State.

In relation to the point about “we have 500 vacancies in UHL” and using our students to support this position, we actually have circa 400 RN vacancies in UHL but we cannot use our students as qualified nurses and the most important thing is that we support them to complete their training.”

Mrs Hack CC will be aware that I am open to suggestions for agenda items for future Health Overview and Scrutiny Committee meetings and I am happy to discuss with her the best way to scrutinise this issue. I expect we will have several future agenda items regarding the impact of Covid-19 on the NHS in LLR, and we also have an item on the work programme regarding Recruitment and Retention at UHL and the NHS People Plan.

25. Urgent items.

There were no urgent items for consideration.

26. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

27. Presentation of Petitions.

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

28. Covid-19 - Leicester, Leicestershire and Rutland NHS Response.

The Committee considered a joint report of Leicester and Leicestershire Clinical Commissioning Groups (CCGs), University Hospitals of Leicester NHS Trust (UHL) and Leicestershire Partnership NHS Trust (LPT) which set out how the local NHS had responded to the spread of the Covid-19 virus. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Andy Williams, Chief Executive LLR Clinical Commissioning Groups, Rebecca Brown, Acting Chief Executive, UHL, Angela Hillary, Chief Executive of LPT, Rachel Bilsborough, Director - Community Health Services, LPT and John Edwards, Associate Director of Transformation, LPT.

Statement from the Director of Public Health for Leicestershire.

Prior to the presentation of the NHS report, the Chairman asked the Director of Public Health for Leicestershire to make a statement on the health protection restrictions which were in place in Leicester and parts of Leicestershire. The Director of Public Health informed that a data sharing agreement was now in place with Public Health England and post code level data on positive Covid-19 cases in LLR had now been received. The data indicated that the numbers of Covid-19 cases had stabilised in Leicester City, and in Leicestershire there were less cases of Covid-19 than in the City though the public should not be complacent. The areas of Oadby and Hinckley were higher than the rest of Leicestershire, though not as high as Leicester City. Close working was taking place between Leicester City Council and Leicestershire County Council to manage the spread of the virus and communication strategies and community engagement was in place, particularly in those areas of Leicestershire that were part of the restriction zone.

Arising from the statement the following points were discussed:

(i) Members suggested that the communications strategy should take into account the ethnic and cultural diversity of the residents of Leicester and Leicestershire and messages should be disseminated in different languages using paper leaflets as well as digital methods because not everybody had access to social media technology. The Director of Public Health supported this approach and stated that some of the money received from the Government for the extended public health restrictions locally would be used to improve communications to all communities in Leicester and Leicestershire.

(ii) The Public Health England report entitled 'Preliminary investigation into COVID-19 exceedances in Leicester (June 2020)' only covered Leicester City and not the parts of Leicestershire that had been included in the restriction zone. The Director of Public Health was not aware of any plans to produce an updated version of the report to include the parts of Leicestershire which had been included in the Leicester restriction zone. Data would be published soon regarding Leicestershire but it would not be broken down into ethnicity.

(iii) Members raised concerns regarding the Test and Trace system, particularly how difficult the home testing kit was to use and the length of time the courier took to pick the sample up. The Director of Public Health acknowledged that the home testing system was not as easy to use as the drive-through system but reassured that the Test and Trace system was improving and 91% of people tested received their results within 24 hours.

(iv) In response to a question regarding the difference between pillar 1 and pillar 2 testing and the importance of each, it was explained that pillar 1 testing was prioritised for clinical staff and gave an outline of the spread of Covid-19 in an area, whereas pillar 2 testing gave a more specific idea of the number of cases and was more likely to pick up younger people that had no symptoms and not been admitted to hospital.

NHS response to Covid-19

Arising from the NHS presentation the following points were noted:

(v) In dealing with the pandemic the different NHS organisations had worked closely together and with partners in local government. In order to increase local capacity for treating Covid-19 cases a large number of elected medical procedures had been postponed. Some elective cancer treatment had been provided by private providers and this had been funded nationally. The public had adhered to requests not to attend hospital unless it was urgent and as a result footfall had been low and the capacity of the local NHS had never been exceeded.

(vi) There had been difficulties with obtaining equipment particularly as the pandemic impacted on the supply chain elsewhere in the world but these difficulties had been overcome. Each NHS organisation had an Incident Control Centre and the availability of Personal Protective Equipment was monitored and tracked. Reassurance was given that at all times staff were provided with the required equipment and the correct safety procedures were carried out.

(vii) The biggest problem had been a lack of data regarding the spread of Covid-19 locally and it was important for any future outbreaks that more data was received so that the local NHS could prepare appropriately. A data cell had now been put in place which would hopefully improve data sharing. In response to a request from a member the CCGs agreed to give consideration to whether a service recovery dashboard could be published where data from different organisations could be made available in one place for the public to view.

(viii) The work of NHS staff had been commendable and many staff members had gone above and beyond their duties. Care was being taken to monitor the wellbeing of staff and ensure that their mental health was looked after.

(ix) With regards to the mental health of the general public, the mental health urgent care hub had been put in place which provided a direct phone number for mental health support, and the feedback regarding this service had been positive. LPT would provide an update to a future meeting of the Committee regarding the mental health transformation plans.

(x) A member from Rutland raised concerns regarding a lack of public briefings from the NHS.

(xi) A decision had just been made by local NHS management to restart the recovery process in order that non-covid related treatments could be made but care was being taken not to put staff at risk.

(xii) Planning for winter 2020/21 had already begun and was being led by the Chair of West Leicestershire CCG Professor Mayur Lakhani. As part of this planning,

consideration was being given to ensure there was sufficient capacity to provide influenza vaccinations.

RESOLVED:

(a) That the update from the Director of Public Health regarding the spread of Covid-19 in Leicester, Leicestershire and Rutland and the Health Protection Restrictions in place in Leicester be noted with concern;

(b) That the update on the Leicester, Leicestershire and Rutland NHS response to Covid-19 be noted, and that NHS staff be thanked for their work in responding to the Covid-19 pandemic.

(c) That a further report on the full impact of Covid-19 on the NHS in Leicester, Leicestershire and Rutland be brought to a future meeting of the Committee.

29. Prior Year Adjustment to UHL Trust Accounts.

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) which provided an update regarding a prior year adjustment which had to be made to UHL's accounts due to a misstatement in the previous year's final accounts. A copy of the report marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Rebecca Brown, Acting Chief Executive, UHL and Jonathan Shuter, Deputy Chief Financial Officer, UHL.

Arising from discussions the following points were noted:

(i) The misstatement in the end of year accounts was believed to be the result of an under reporting of expenditure and an over reporting of income but investigations were still ongoing to establish the full reasons for the misstatement. Grant Thornton had been the auditors of UHL for the 2019/20 financial year which was why Pricewaterhouse Coopers (PwC) had been appointed to carry out the investigations. It was not known when PwC would complete their investigations and publish their report. The investigations so far had reviewed the accounts of the previous 3 years and found that the accounts for the previous 2 years required adjusting. Indications were that once the investigations had been completed the prior year adjustment was not likely to be greater than the £46 million which it was currently set at.

(ii) UHL was not expecting to be fined as a result of the misstatement in the accounts but the Trust was likely to receive increased support and oversight from the regulators.

(iii) In the meantime measures had been taken to improve the financial governance and controls at UHL, improve the culture around finance by providing training and staff development, and focusing on financial sustainability.

(iv) In response to concerns raised by a member, reassurance was given that NHS Boards would usually have at least one non-executive member with financial expertise.

RESOLVED:

(a) That the update regarding the prior year adjustment to University Hospitals of Leicester NHS Trust accounts be noted with concern;

(b) That University Hospitals of Leicester NHS Trust be requested to provide a further update to the Committee once Pricewaterhouse Coopers have published the report of their investigation into the Trust's underlying financial position.

30. UHL Acute and Maternity Reconfiguration.

The Committee received an oral update from University Hospitals of Leicester NHS Trust (UHL) regarding the Acute and Maternity Reconfiguration plans.

The Committee welcomed to the meeting for this item Rebecca Brown, Acting Chief Executive, UHL and Mark Wightman, Director of Strategy and Communications, UHL.

Arising from discussions the following points were noted:

(i) UHL had not yet received the £450 million Government funding which they had been awarded for the reconfiguration plans but were confident that the money was forthcoming. It was hoped that the public consultation on the plans would take place in August/September 2020.

(ii) The Covid-19 pandemic had reassured UHL that its reconfiguration plans were the correct approach. At the peak of the Covid crisis 82 patients had required a ventilator and having two Intensive Therapy Units in LLR would have meant that demand could have been managed much better. At the start of the pandemic children's heart surgery had to be transferred from Glenfield Hospital to Birmingham because additional capacity for adults had been required in Leicester, Leicestershire and Rutland (LLR). Had there been a children's hospital in LLR then the children's heart surgery would not have been required to move to Birmingham.

(iii) At the previous Committee meeting a briefing document for the public which summarised all the information already in the public domain regarding the proposals had been requested by members. This document had not yet been put together but would be produced in the near future. Members now asked that the briefing document include any changes made to the reconfiguration proposals as a result of the Covid-19 pandemic.

RESOLVED:

(a) That the lack of progress regarding the University Hospitals of Leicester NHS Trust acute and maternity reconfiguration plans be noted;

(b) That University Hospitals of Leicester NHS Trust be requested to attend a future meeting of the Committee as part of the consultation process for the acute and maternity reconfiguration proposals.

10.00 am - 12.20 pm
03 July 2020

CHAIRMAN

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