Agenda Item 1

Minutes of a meeting of the Health Overview and Scrutiny Committee held via Microsoft Teams video link on Wednesday, 9 September 2020.

PRESENT

Mr. D. C. Bill MBE CC
Mr. J. G. Coxon CC
Dr. R. K. A. Feltham CC
Mrs. A. J. Hack CC
Dr. S. Hill CC
Mr. J. Morgan CC
Mr. J. T. Orson JP CC
Mrs. R. Page CC
Mr T. Parton CC

In attendance
Mr. L. Breckon CC, Cabinet Lead Member for Health and Wellbeing.
Mukesh Barot, Deputy Manager, Healthwatch Leicestershire.
Hazel Buchanan, Associate Director of Strategic Programmes, Nottingham and Nottinghamshire CCG (minute 10 refers).
Miriam Duffy, Programme Director, National Rehabilitation Centre (minute 10 refers).
Tamsin Hooton, Assistant Director of Urgent and Emergency Care, LLR CCGs (minutes 11 and 13 refer)
Tim Sacks, Head of Estates Planning, LLR CCGs (minutes 11 and 12 refer).

1. Appointment of Chairman.

RESOLVED:

That Dr. R. K. A. Feltham CC be appointed Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2021.

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

2. Election of Deputy Chairman.

RESOLVED:

That Mr. T. Parton CC be elected Deputy Chairman of the Health Overview and Scrutiny Committee for the period ending with the date of the Annual Meeting of the County Council in 2021.

3. Minutes of the previous meeting.

The minutes of the meeting held on held on 3 June 2020 were taken as read, confirmed and signed.

4. Question Time.

The Chief Executive reported that no questions had been received under Standing Order 34.

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

The Chief Executive reported a question had been received from Mr. M. Hunt CC under Standing Order 7.

Mr Max Hunt CC asked the following question of the Chairman:

Since the covid-19 pandemic arrived, to what extent are more consultations with patients, with life threatening conditions, being conducted by telephone, rather than face to face? If so, why and what measures are in place to correct this?

To what extent are patients allowed to be accompanied by family members for such life critical consultations? If family members are not permitted to accompany patients to face to face appointments what measures are being put in place to correct this?

How do these matters affect Oncology, in particular?

The Chairman replied as follows:

Prior to the onset of the COVID-19 pandemic, the NHS Long Term Plan (released in January 2019) required NHS organisations to expand the usage of digital & telephone technologies within outpatients (to meet the year 33% target of reducing face to face outpatient appointments). The COVID-19 pandemic has acted as a catalyst for this programme and technology has been a key tool in ensuring vital outpatient appointments are not lost because of either national/local lock downs and/or population shielding.

The use of technologies such as virtual & the telephone have grown from approximately 20% of all appointments to between 50-60% and have supported the reduction in waiting times for outpatient new/follow up appointments to lower than before the onset of COVID-19 (approximately 2,500 patients are now no longer waiting for an appointment as opposed to the same time in January 2020).

Face to Face outpatients (where medically required), were not stopped (in their entirety) throughout the pandemic and technology was utilised on a patient by patient basis (based on clinical need) as part of a varied landscape of appointments types.
A standard Operating Procedure (SOP) is in place for the delivery of virtual outpatients, which ensures the nature of the conversation and attendance by family members is assessed before the appointment takes place.

There have been no known instances of telephone/virtual technologies being used inappropriately and feedback from patient surveys has demonstrated 88% satisfaction with the use of technologies such as telephone/virtual.

Patients are able to request the support of family members/carers during a non-face to face appointment (telephone and virtual) and clinician's will also ensure this is the case (where required).

At the current time UHL continues to have more restricted visiting and attendance for face to face appointments than usual to try and provide the required level of protection for all and to decrease the possibility of spread. UHL are continuously reviewing their policy triangulating with national guidance, specialty guidance and the local prevalence of infection rates. They do however aim to assess each case on an individual basis at the

discretion of the clinician and the nature of that particular consultation (breaking bad news for example). Throughout the pandemic UHL has tried to always assess the needs of its patients and their families and react with a compassionate manner whilst maintaining everyone's safety. UHL has just recently updated its visiting policy in line with the national restoration and recovery phase. Specific paragraphs from the revised guidance are set out below and UHL are in the process of developing a patient and family leaflet to further explain.

> *In specific circumstances it is beneficial for carers or family members to be invited into the clinical areas to support adult patients, such as patients with learning disabilities or who are cognitively impaired. There are also specific circumstances where the individual needs of a patient warrant the presence of a family member or carer, such as patients with communication difficulties.*
> *If a patient is to receive bad news in relation to their healthcare prognosis or general well-being, it may be in their best interests to invite a relative / carer or significant other to provide support during or after receiving this news.*
>
> *The current visiting restrictions also apply to Outpatients Facilities, and each clinic should undertake an assessment to ascertain the feasibility of implementing the relevant exceptions for a patient attending an outpatient clinic accompanied by their relative. The physical layout of the clinic; the risk to the patients attending and the number of clinic attenders will need to be considered. It is anticipated that only a small number of patients will fall into the exception criteria and if the physical environment means that the clinic is unable to accommodate relatives attending then the clinic should consider other support mechanisms, such as (where appropriate) involving a clinical nurse specialist or using a virtual clinic format so the relatives can be present and offer support.*
>
> *<u>Maternity Specific</u>*
> *Scan Facilities - Partner may attend scan ensuring social distancing is maintained.*
> *Antenatal Facilities – restricted visiting however each clinic will undertake individual assessments, and if social distancing can be maintained then partners may attend. Will be communicated on an individual clinic basis.*

The use of virtual and telephone technologies have been vital in ensuring that patients within UHL oncology (and wider cancer services) did not have their care negatively impacted during the first phase of the pandemic (especially for those shielding). Medical oncology are currently delivering 50-60% of appointments virtually and this has risen from approximately 10% pre COVID-19. Each patient's needs were assessed prior to making the decision on whether or not to proceed with a virtual outpatient and this includes the appropriateness of the conversation in terms of the non-face to face context and the attendance of family members. Appointments will not take place virtually if the clinical teams assess the needs as not meeting the requirements within the Standard Operating Procedures.

The meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee on 23 September 2020 will have an agenda item relating to the response of the health service to the covid-19 pandemic and the report will make specific reference to cancer treatment performance. I will ensure that the Democratic Services Officer forwards a copy of the report to Mr Hunt CC.

6. Urgent items.

There were no urgent items for consideration.

7. 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.

8. Declarations of the Party Whip.

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

9. Presentation of Petitions under Standing Order 35.

The Chief Executive reported that no petitions had been received under Standing Order 35.

10. NHS Rehabilitation Centre.

The Committee received a presentation from NHS Nottingham and Nottinghamshire Clinical Commissioning Group regarding a consultation they were holding on proposals for a NHS Rehabilitation Centre on the Stanford Hall Rehabilitation Estate near Loughborough. The Committee was also in receipt of written comments from Leicester, Leicestershire and Rutland CCGs regarding the proposals. Copies of the presentation slides, the consultation documents and the comments from Leicester, Leicestershire and Rutland CCGs are filed with these minutes.

The Committee welcomed to the meeting for this item Hazel Buchanan, Associate Director of Strategic Programmes, Nottingham and Nottinghamshire CCG, and Miriam Duffy, Programme Director, National Rehabilitation Centre.

Arising from discussions the following points were noted:

(i) The NHS Rehabilitation facility would be located alongside the military rehabilitation facility on the Stanford Hall estate. There would also be a National Research and Innovation Hub and a Training and Education Centre on the site. The NHS patients would be treated by NHS staff not military staff entirely separately from the military patients however the NHS patients would be able to use the military facilities. The NHS staff would have access to the whole site including the military area and would be able to take patients onto the military part of the site to use the facilities there. The distance between the NHS part of the site and the military part was approximately 400 metres so it was not far for the patients to travel. It was not intended that equipment would be moved around the different parts of the site.

(ii) Some of the equipment at the Rehabilitation Estate was genuinely state of the art such as the the Gait Laboratory, and the Computer Assisted Rehabilitation Environment (CAREN) which was one of only six in the world, and. Other equipment on the site, such as the hydrotherapy pool, was not state of the art but had not been available for NHS patients in the East Midlands to use before.

(iii) In response to concerns raised by members and LLR CCGs that there would be insufficient demand for the facilities provided by the NHS Rehabilitation Centre it was explained that the Centre was proposed to be a level 2b rehabilitation facility and whilst in Leicestershire there were level 1 and level 2a facilities, currently there were no 2b facilities. The nearest 2b facility was in Nottinghamshire. The East Midlands region was short of inpatient rehabilitation capacity and was only able to provide 33% of that recommended in the British Rehabilitation Standards. There were currently long waiting lists therefore the NHS Rehabilitation Centre would fulfil a pressing need.

(iv) With regard to the comments from LLR CCGs regarding favouring a Home First model, Nottingham and Nottinghamshire Clinical Commissioning Group clarified that they strongly supported the Home First model, and the NHS Rehabilitation Centre facility was designed to complement the Home First services not replace them.

(v) Concerns were raised by a member that should the military no longer be involved in combat operations and as a consequence lose their funding for the rehabilitation centre, the NHS patients would no longer be able to use the military rehabilitation facilities. In response reassurance was given that 85% of the military patients that used the rehabilitation centre required treatment as a result of day to day military activities, not combat operations therefore there would continue to be a military need for the rehabilitation centre whether the military was involved in combat operations or not. The military had also committed to using the site to conduct research with the NHS.

RESOLVED:

(a) That the contents of the presentation be noted;

(b) That the comments now made by the Committee be forwarded to NHS Nottingham and Nottinghamshire Clinical Commissioning Group to form part of the consultation.

11. Community Services in Ashby de la Zouch.

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) which provided an update on progress in developing the community services redesign work, particularly in relation to Ashby de la Zouch. A copy of the report, marked ‘Agenda Item 11’, is filed with these minutes.

The Committee welcomed to the meeting for this item Tamsin Hooton, Assistant Director of Urgent and Emergency Care, LLR CCGs, and Tim Sacks, Head of Estates Planning, LLR CCGs.

Arising from discussions the following points were noted:

(i) The six Community Hubs were based in Coalville, Melton, Hinckley, Loughborough, Market Harborough and one based on Warren Park Way, in Enderby, Blaby District. Ashby de la Zouch was served by the Coalville Hub and Ashby residents could also access services provided by the District Nursing Clinic. A map showing the boundaries of the Hubs would be circulated to members after the meeting along with a briefing note which set out what services each of the Hubs were providing.

(ii) The model of care proposed under the Community Services Redesign work applied to the Lutterworth area and in particular Feilding Palmer hospital.

(iii) In response to a question regarding the £720,000 funding received under Section 106 of the Town and Country Planning Act 1990 and invested in the privately owned Ascebi House premises, it was explained that funding received under Section 106 was treated as a capital grant by the NHS and used for the development of premises. Notional rent payments were made by the NHS for premises delivering General Practice services and the use of Section 106 to fund the capital required to develop the premises meant that the rent could be abated for 15 years, either entirely or reduced by 66%. The Section 106 developer contributions were passed to the CCG and then used to fund the premises developments. The ownership of the premises remained with the person, practice or organisation named on the title deeds including the additional value added by the contribution. Were the building to be sold it would still have to be used for providing healthcare.

(iv) By spending the funding on NHS buildings this benefited new and existing patients in that new or improved facilities could be provided to deliver health care services from. With the Community Services Review the investment in capital would result in more revenue and an expansion in the primary care workforce.

RESOLVED:

That the update on progress in developing the community services redesign work be noted.

12. Primary Care Estate Strategy.

The Committee considered a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) which provided an update on progress towards developing a Primary Care Estate Strategy. A copy of the report, marked ‘Agenda Item 12’, is filed with these minutes.

The Committee welcomed to the meeting for this item Tim Sacks, Head of Estates Planning, LLR CCGs.

Arising from discussions the following points were noted:

(i) The previous Estates Strategy was completed in the period 2008-2010 therefore it was now out of date and the new version would be significantly different as circumstances had changed greatly since then. NHS England had funded the latest baseline survey regarding Estates. The CCG was confident that the target to have Phase 3 of the process completed by the end of December 2020 would be met. Members were reassured that the new Primary Care Estates Strategy would be a living document which would be regularly revised and if the planning guidance changed as a result of the August 2020 Government White Paper on Planning then the Estates Strategy could be updated to reflect the new guidance.

(ii) Members emphasised the need for health infrastructure to match housing and population growth. Members asked to be more involved in the process for deciding where health facilities were to be located and how many patients the services could accommodate, in order that members could give reassurance to local people that

there would be enough provision. In response to a request from a member that Local Authorities be able to feed into the draft version of the Primary Care Estates Strategy it was explained that the CCG was not at the stage of producing a draft yet and timescales for publication of the document had not yet been agreed but partners would be involved at the appropriate time. The CCGs acknowledged that improvements did need to made in the way the process under Section 106 of the Town and Country Planning Act 1990 was communicated to Councils and Councillors and reassurance was given that in future members would be involved when their division was impacted. It was intended that in future the Planning process would give greater clarity to what the CCGs' intentions were with using the Section 106 monies; whether a new facility would be built or existing facilities be improved. As part of the process the CCGs would give consideration to whether public sector premises could be used to provide health services from. Members were pleased to see that there would be more joint working between health partners and local authorities in regard to planning health infrastructure and identifying need.

(iii) Members asked that when the CCGs were considering need they took into account the demographics of the population living in a particular area and the amount of specialist housing being built. In response it was acknowledged that housing was not generic and the demographics of the population were taken into account when assessing what infrastructure was needed, and more work would be carried out in relation to this in future Estates planning.

(iv) A member asked that the Primary Care Estates Strategy did not just focus on need created by population growth and new housing but also considered the needs of existing communities. It was acknowledged that in most geographical areas the health facilities were not underutilised, they were often overstretched therefore Estates Planning needed to give due consideration to existing communities.

(v) It was important that Section 106 monies were received early in the process rather than once houses had already been built and inhabited so that existing health premises were not overrun. In response to a query from a member as to whether rent abatements were the best way to spend Section 106 monies and whether it should be spent on new equipment instead, it was explained that the Section 106 contributions were used to fund the capital expenditure necessary to improve, extend or build health premises. The CCGs did not have capital allocations therefore they could not give capital funding to GP Practices. This is why the Section 106 contributions were so important. When the contributions were used, the CCGs were able to abate the rent paid to the practice, for fifteen years, which reduced the additional pressure on revenue budgets.

(vi) New premises did not always lead to new staff, and recruitment was a problem however it was more difficult to recruit staff for premises that were in need of maintenance therefore it was important to focus on the quality of the premises first. Where there was a population increase for a particular area, that was likely to result in an increase in the list size for a GP Practice and consequently an increase in revenue. GP Practices were required to provide services for the patients in their area and although CCGs could not instruct GP Practices to spend the money in a specific way on additional staffing, it was likely that as list sizes grew there would be increased spending by GP Practices on staffing and recruitment would take place. The CCG could only intervene where the quality of services the GP Practices were providing was below the standard expected, and numbers of staff would form part of any review process.

(vii) A member suggested that the hub and spoke model was better for GP Practices as patients had to travel less far and it was more environmentally friendly. In response it was explained that Hubs/branch surgeries were hard to staff and there were economies of scale with bigger surgeries and more services and appointments could be provided.

(viii) In response to concerns that due to Covid-19 patients would be asked to wait outside GP Practices during the winter, it was clarified that patients were being asked to attend on time and not arrive early which would avoid the need for waiting outside, and if patients did need to sit in the waiting area they would be required to wear face masks.

RESOLVED:

(a) That the update on progress towards developing a Primary Care Estates Strategy be noted and the proposals for how the system should work in future be welcomed.

(b) That officers be requested to provide a report to the Committee on the Primary Care Estates Strategy when the document is completed.

13. Independent Review of East Leicestershire and Rutland Minor Injury Units.

The Committee considered a report of East Leicestershire and Rutland CCG which provided an update on progress made with regards to the external review of daytime provision of minor injury services in the East Leicestershire & Rutland CCG (ELR CCG) area. A copy of the report, marked 'Agenda item 13', is filed with these minutes.

The Committee welcomed back to the meeting for this item Tamsin Hooton, Assistant Director of Urgent and Emergency Care, LLR CCGs.

It was noted that the review only related to the Minor Injury Units at Market Harborough, Melton and Oakham. The Oadby Urgent Care Centre was under a different contract. There was a report produced as a result of the review, but it was more discursive in nature and there were no clear recommended outcomes. In any case the findings of the review now had to be looked at in the wider context of the Community Services work and the Covid-19 recovery.

RESOLVED:

That the update regarding the external review of minor injury services in East Leicestershire and Rutland be noted.

14. Director of Public Health Update on Covid-19.

The Committee received a presentation from the Director of Public Health which provided an update on the spread of Covid-19 in Leicestershire and the actions taken to tackle the problem. A copy of the presentation slides, marked 'Agenda Item 14', is filed with these minutes.

Arising from the presentation the following points were noted:

(i) The Covid-19 outbreak which occurred in Oadby and Wigston over the summer covered the whole District whereas the recent outbreak in Melton was more localised so different strategies were required for each outbreak. When outbreaks such as these occurred Incident Management Teams were set up involving the Director of Public Health, colleagues from the County Council Communications Team, and from the relevant District Councils. Messages and leaflets were disseminated to the public. A strategy was in place to ensure testing was taking place where it was most needed and the post code data which was now available helped target this work.

(ii) The spread of Covid-19 had escalated rapidly over the previous few days not just in Leicestershire but nationally. Of most concern was the rise in cases in people under 40 and particularly in the 20-29 age group. Work had been taking place to instil good behaviours amongst the population of Leicestershire but further work was required and a strategy needed to be put in place urgently. The Cabinet Lead Member for Health and Wellbeing emphasised the need for messages to be disseminated to all age groups regarding social distancing.

(iii) Concerns were raised by members about testing capacity, the distance people were being required to travel to be tested, and the availability of online tests. In response the Director of Public Health explained that the issues with testing capacity related more to laboratory capacity rather than not having enough appointments available at testing centres. The Director was concerned about the number of people attending test centres without symptoms and messages needed to be sent to the public about not getting tested unless they had Covid-19 symptoms. The Director of Public Health was of the view that targeted testing was more appropriate than mass testing because mass testing could result in more false positives.

(iv) The testing data which was now going into the public domain was more up to date than previously and related to an average over the previous 7 days. The Director did have sight of even more up to date data which enabled him to have a better idea of trends. This particular data had heavily influenced the approach that was being taken nationally to halt the spread of Covid-19 as well as the current approach the Director was taking in places such as Harborough and Wigston.

(v) It was acknowledged that there was a risk relating to the number of students returning to Loughborough University but it was not considered to be appropriate to close the University down. The greatest concern related not to when students were in the teaching environment which would be more regulated in terms of social distancing, but related to informal gatherings when students were mingling in their own free time. Work had taken place with Charnwood Borough Council colleagues to deliver messages to students regarding social distancing. The business case had been approved for a local testing centre in Loughborough which was approximately one mile away from the University campus.

(vi) There were no plans to move the Blaby testing centre away from County Hall, Glenfield. Discussions had taken place with Blaby District council colleagues and this was the best site available.

RESOLVED:

That the update regarding the spread of Covid-19 in Leicestershire and actions being taken to prevent further spread be noted.

15. Healthwatch Leicestershire Annual Report 2019/20.

The Committee considered a report of Healthwatch Leicestershire which presented their Annual Report 2019-20. A copy of the report, marked 'Agenda Item 15', is filed with these minutes.

The Committee welcomed to the meeting for this item Mukesh Barot, Deputy Manager, Healthwatch Leicestershire.

Arising from discussions the following points were noted:

(i) Members welcomed the format of the report and the clear and simple way in which it was presented. However, members stated that given that Healthwatch was funded equally by Leicester City Council and Leicestershire County Council the report should give equal weighting to matters relating to both the City and the County. Over the previous few months Healthwatch had experienced staffing capacity issues in relation to the Leicestershire part of the organisation however the Deputy Manager would now be focusing on Leicestershire for the next two quarters to ensure Leicestershire received the appropriate level of coverage.

(ii) Over the year Healthwatch had helped 351 people get the advice and information they needed, and members asked Healthwatch to consider how the number of people engaged with could be increased

(iii) Members were of the view that the Annual Report did not reflect the full breadth of the valuable work carried out by Healthwatch and should contain a full list of the projects Healthwatch were involved in.

(iv) Since the Covid-19 pandemic had begun Healthwatch had continued to carry out its work and had been taking part in meetings remotely. Unfortunately, Healthwatch was no longer able to carry out its Enter and View work, however, UHL had now provided patients with tablets/IPads and it was hoped these could be used to enable patients to give feedback to Healthwatch. Consideration was also being given to using hospital radio to enable patients and carers to call in and give their views on the health services being provided.

(v) Healthwatch had become aware that many patients were being told by GP Practices that they were out of area and registered with the wrong GP Practice. Healthwatch had also received a large amount of feedback relating to patients struggling to access appointments at GP practices and long waiting times. A member raised concerns that whilst appointments could be booked online not all patients were able to use the internet. The lack of access to the internet meant that some patients missed out on more general messaging which was conducted online and therefore other methods of engaging with patients were required such as leaflets.

(vi) Healthwatch were aware that some patients of Black and Minority Ethnic (BME) origin could not read or write in their own language and so Healthwatch were carrying out work to establish the extent of this problem and establish what could be done to disseminate messages to these people. Members emphasised that BME patients resided in rural areas as well as inner city areas and therefore the work needed to be targeted at the whole of Leicester and Leicestershire.

(vii) Healthwatch had been involved in a research project relating to mental health and urgent care. Healthwatch were hoping to raise awareness of the symptoms of not just major mental health conditions but of mild mental health issues which arose particularly in the context of the Covid-19 lockdown, and let people know where to go for help. A member welcomed this focus on mental health from Healthwatch but raised concerns that in tackling both minor and serious mental health conditions Healthwatch would be spreading their resources too thinly and needed to make sure that those with serious mental health conditions were the primary focus.

(viii) Other priority areas for Healthwatch Leicestershire were patients with disabilities and those receiving domiciliary care. Healthwatch were interested in members' views on how to engage with these types of patients. Members made Healthwatch aware of the County Council disability network.

RESOLVED:

That the Healthwatch Leicester and Leicestershire Annual Report 2019/20 be noted.

16. Date of next meeting.

RESOLVED:

It was noted that the next meeting of the Committee would be held on 11 November 2020 at 2:00pm.

2.00 - 4.45 pm
09 September 2020

CHAIRMAN

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