Agenda Item 1

Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held via Microsoft Teams video link on Thursday, 15 October 2020.

PRESENT

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

Mrs. A. J. Hack CC	Mr. J. T. Orson JP CC
Mrs S Harvey	Mrs. R. Page CC
Dr. S. Hill CC	Mr T. Parton CC
Cllr. P. Kitterick	Cllr. D. Sangster
Harsha Kotecha	Dr Janet Underwood
Cllr. M. March	Miss G. Waller

In attendance

Gordon King, Director of Adult Mental Health, Leicestershire Partnership NHS Trust (minutes 17 and 18 refer).
John Edwards, Associate Director for Transformation, Leicestershire Partnership NHS Trust (minutes 17 and 18 refer).
Paula Vaughan, Head of Commissioning, Leicester, Leicestershire and Rutland Clinical Commissioning Groups (minutes 17 and 18 refer).
David Williams, Director of Strategy and Business Development, Leicestershire Partnership NHS Trust (minute 19 refers).
Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Groups (minute 20 refers).
Rebecca Brown, Acting Chief Executive, University Hospitals of Leicester NHS Trust (minute 20 refers).
Mark Wightman, Director of Strategy and Communications, University Hospitals of Leicester NHS Trust (minute 20 refers).
Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG (minute 20 refers).

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.

12. Question Time.

The Chief Executive reported that five questions had been received under Standing Order 34.

1. Question by Sally Ruane

The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee were told in January that there will be another 139 beds in the local acute hospitals under the current proposal for reorganisation and the Pre-Consultation Business Case also states there will be 139 more beds. However, the bed bridge data and accompanying narrative make it difficult to see how more than 41 new beds will be guaranteed since 28 appear to

be a changed use of existing beds and the remaining 70 beds are described as contingent, they are not covered by the £450m investment and it is not clear where they will go – ie what space they will occupy. Are the CCGs able to confirm that all of these 139 beds will actually exist by 2024 and clarify this confusion?

Reply by the Chairman:

With regards to the 28 beds that are currently being used for the Hampton suite, University Hospitals of Leicester will repatriate these for acute activity. The 41 and 70 beds = 111 beds, which will be provided as additional beds plus the 28 repatriated beds, giving a total of 139 beds by 2024.

Supplementary Question

Sally Ruane asked for further explanation as to why the 28 beds currently being used for the Hampton Suite were going to be counted as additional beds and where the 70 additional new build beds would be located and whether they would be funded by the additional £450m investment.

At the invitation of the Chairman, Mark Wightman Director of Strategy and Communications, UHL explained that the Hampton Suite was currently a step-down non-acute ward which did not admit acute medical patients. Under the reconfiguration proposals those beds would become acute beds. Mark Wightman also stated that the 70 additional beds would be located at the LRI and Glenfield Hospital but the precise allocation for each had not been decided yet.

2. Question by Giuliana Foster:

I understand the consultation process on the proposal for re-organising hospital services will include focus groups and telephone interviews. If this is correct, are the questions being used in these focus groups and telephone interviews in the public domain? Can we find out what these questions are?

Reply by the Chairman:

The questions outlined in both the online and printed consultation questionnaire will be used in the focus groups. We would expect that, in these sessions, participants will concentrate on the open questions and discuss and exchange views. The discussion will be captured and contribute to the consultation in exactly the same way as the completed online and hard copy questionnaire responses. Anyone arranging a telephone interview will also be taken through the same questionnaire.

3. Question by Giuliana Foster:

I understand the Midlands and Lancashire Commissioning Support Unit is being used to analyse consultation responses. Given that the CCG's already work with the Midlands and Lancashire Commissioning Support Unit in many ways, would contracting this work out to university-based academics not have been a better way to achieve real independence in the analysis of responses?

Reply by the Chairman:

The Clinical Commissioning Groups in Leicester, Leicestershire and Rutland undertook a competitive tendering process at the beginning of 2020 in order to procure a suitable supplier to undertake the evaluation, analysis and reporting of the consultation. A key requirement was prior experience of having previously evaluated consultations on a similar scale to the proposals to invest £450m in Leicester's hospitals. The process attracted a number of suppliers, from both the public and private sectors. Responses to the specification by each potential provider were assessed against set criteria, leading to the appointment of Midlands and Lancashire Commissioning Support Unit (CSU) based on their ability to meet the full requirements of the specification.

Supplementary Question

Giuliana Foster stated that Midlands and Lancashire CSU were a paid contractor of the NHS and questioned how they were independent from the Clinical Commissioning Groups?

At the invitation of the Chairman, Andy Williams, Chief Executive, LLR CCGs explained that Midlands and Lancashire CSU were independent to a large extent because they were not accountable to LLR CCGs and were subject to a completely separate governance system.

4. Question by Penny Campling.

What is the plan for specialist therapies for people with complex and emotional difficulties beginning in childhood, including sexual abuse, who need longer individual therapy and don't fit into other pathways?

Reply by the Chairman:

The current services in Leicester, Leicestershire and Rutland have provided various psychological interventions that have been used to support people with complex and emotional difficulties rooted in childhood trauma. However, LPT have identified that there is a need for better co-ordination and coherence of the psychological therapy provision for individuals with such presenting need. Presently, due to the organisation of services, the offer of therapy to individuals is determined by referrals into specific services rather than based on a holistic view of their need. Due to current structures people are waiting, in some instances for very long periods of time for that therapy and many individuals with such needs are not getting access to therapy across our system. This is something LPT wants to change given the crucial importance of supporting people with trauma.

LPT's plans are to integrate and join up services better in the community to organise and support the offer of therapy and care based on service user need not service configuration. LPT wants to increase access to those that need therapy and give LPT the opportunity to offer that without the existing long waits. LPT clinicians are currently developing a complex trauma pathway based on the evidence. This is being designed alongside the other therapy related pathways so that it is as coherent as possible recognising that people's needs are often complex. Whilst the absolute detail will obviously be developed as part of the engagement with staff and service users the

expected outcomes and overarching design will be ready for the consultation of the model.

5. Question by Penny Campling

Given national pressures on waiting lists and that some people have been waiting for psychotherapy for over a year, how does the trust intend to ensure that these who have been assessed, told which particular type of therapy is most appropriate for them but have been waiting a long time for that therapy to begin will have this agreement between the patient and the service honoured?

Reply by the Chairman:

The national pressures on waiting lists for therapy are seen to an even greater degree within the Leicester, Leicestershire and Rutland region with some people waiting up to 3 years. This has been the situation for some time. There are many people waiting a long time for specific therapeutic interventions. LPT continue to implement a rolling review of service users facing long waits and will discuss and jointly agree the best option for them including whether to continue to wait for the original therapy offer or to pursue alternative therapy options.

Supplementary Question

I am aware that patients that have been through a detailed psychotherapy assessment have received letters discharging them back to the GP. Can you explain this?

At the invitation from the Chairman, John Edwards, Director of Transformation, Leicestershire Partnership NHS Trust responded to say that he was not aware of such discharge letters being sent and he would conduct a review and make sure it was not happening.

13. Questions asked by Members.

The Chairman reported that no questions had been received from members under Standing Order 7(3) and 7(5).

14. Urgent items.

There were no urgent items for consideration.

15. 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.

Mr. T. Parton CC declared a personal interest in agenda item 6: Step up to Great Mental Health, and agenda item 7: Liaison Mental Health Services as he had previously been a psychiatric patient in Leicestershire.

Mrs. A. Hack CC declared a personal interest in agenda item 8: Transforming Care: Learning Disabilities and Autism as she worked for an organisation that provided housing for people with learning disabilities.

16. Presentation of Petitions.

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

17. Step up to Great Mental Health.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on progress with the Step up to Great Mental Health improvement programme. A copy of the report, marked 'Agenda Item 6', is filed with these minutes.

The Committee welcomed to the meeting for this item Gordon King, Director of Adult Mental Health, LPT, John Edwards, Associate Director for Transformation, LPT, and Paula Vaughan, Head of Commissioning, Leicester, Leicestershire and Rutland Clinical Commissioning Groups.

Arising from discussions the following points were noted:

(i) A Clinical Senate had undertaken a review of the Step up to Great Mental Health transformation proposals and whilst formal feedback was awaited, the informal feedback had been positive with the increased partnership working being particularly welcomed. As part of this partnership working multi-disciplinary teams would be created using staff from health and local authority social care teams.

(ii) In response to concerns raised by a member that removing dormitory accommodation at the Bradgate Unit would reduce the overall number of beds at the unit, reassurance was given that the process would be managed in a phased way and there would be no sudden drop off in bed numbers. Members requested that they be provided with the precise figures for the numbers of beds currently in the Bradgate Unit and the proposed numbers of beds after the dormitories were removed.

(iii) Concerns were raised that some patients could fall into a gap between addiction services and mental health services. In response reassurance was given that conversations were taking place with the Turning Point substance misuse service and the drug and alcohol service at University Hospitals of Leicester NHS Trust to ensure patients were not moved from service to service unnecessarily and a 'no wrong front door' policy was in place which meant that a patient would never be turned away and told to present elsewhere. Signposting would not direct patients away from the 'door' but should make clear to patients how to access the services they needed. The Central Access Point played a crucial role in ensuring that patients were directed to the correct service straightaway without having to be referred through several different departments. A campaign had taken place using social media such as Facebook to publicise the Central Access Point phone number but further work was needed to take place in this regard to increase awareness. The NHS 111 telephone number redirected callers to the Central Access Point without the caller having to redial.

(iv) In response to a suggestion from a member it was agreed that a flow chart would be produced to show to a lay person how the LPT services all fitted together.

(v) Performance and outcomes would be measured at neighbourhood level and the detail on this would be brought to future meetings of the Committee in iterations.

(vi) A member asked for more statistics around the services referred to in the report particularly in relation to the number of patients using the Central Access Point to give an idea of the changes in demand that were taking place. Members also asked for service user data to be broken down into geographical areas showing where there was unmet need and requested information on how LPT was tackling mental health issues in ethnic minorities and particularly those patients of African heritage. In response it was explained that there was no clear way of understanding the numbers of people that did not make it into the services they needed. Work was currently taking place to understand the demographics of current service users. It was agreed that all the requested information would be provided to the Committee at a later date and would definitely be available by the next time the Committee considered the topic.

(vii) It was important that mental health voluntary services were supported and financed. The Mental Health Investment Standard covered the voluntary sector

(viii) LPT were confident that there would be equal access across LLR to good standard of service but were not complacent in this regard and recognised that there would be challenges.

(ix) In response to concerns that families and carers of patients were not always kept updated on where a patient was receiving treatment reassurance was given that this was not typical and close working took place with patients' carers. If specific cases were known where the communication with carers or families had been poor then these could be investigated outside of the meeting.

RESOLVED:

(a) That the Step up to Great Mental Health improvement programme be welcomed and supported;

(b) That Leicestershire Partnership NHS Trust be requested to provide a further update to the Committee in early 2021.

18. Liaison Mental Health Services.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on proposed changes to Liaison Mental Health Services. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Gordon King, Director of Adult Mental Health, LPT, John Edwards, Associate Director for Transformation, LPT, and Paula Vaughan, Head of Commissioning, LLR CCGs.

Arising from discussions the following points were noted:

(i) The Liaison services provided mental health support for any patient attending the Emergency Department and general wards at University Hospitals of Leicester with any complex diagnosis. This included patients with conditions such as M.E/Chronic

Fatigue Syndrome. The services were available 24 hours a day 7 days a week. Members raised concerns that Leicestershire residents that lived in places such as Hinckley and Harborough often accessed Health services out of Leicestershire because they were closer and therefore they would not benefit from the mental health services provided to UHL patients. Concerns were also raised around the handover process for these patients as they were transferred from an out of county hospital to LPT. In response LPT agreed to give further consideration to the handover process and reassurance was given that there were strong links between LPT and health services in Northamptonshire and work was ongoing to ensure Liaison services were in place for Northamptonshire hospitals. It was confirmed that the IAPT service was for all LLR patients wherever they went for their inpatient care. Inpatient to IAPT was a self-referral portal which would make the handover process easier.

(ii) Many patients from other counties such as Lincolnshire came to UHL to receive complex treatment such as renal care and it was questioned how those patients' mental health needs would be managed once they were discharged from UHL. LPT agreed to give this issue further consideration and discuss with renal specialists if necessary.

(iii) The Liaison service would be integrated with community based mental health services which would include face to face therapy in towns and also online services. To supplement this, as of April 2021 Primary Care Networks would receive funding specifically for mental health practitioners.

(iv) The end of life team carried out a large amount of work with patients and families whilst the patient was still alive but there needed to be a better link up between the end of life team and bereavement services once the patient was deceased to ensure families continued to receive support.

(v) In response to a question regarding how the changes to Liaison Mental Health Services would affect throughput of patients it was explained that there was expected to be a reduction in Emergency Department attendance but overall throughput would not be affected because although the different services had been brought together they were responsive and would still treat the same number of patients.

RESOLVED:

That the proposed changes to Liaison Mental Health Services be supported but that LPT be requested to give consideration to how the mental health of patients crossing county boundaries for treatment would be managed.

19. <u>Transforming Care – Learning Disabilities and Autism.</u>

The Committee received a joint presentation from Leicestershire County Council (LCC) and Leicestershire Partnership NHS Trust (LPT) regarding the Transforming Care Programme which aimed to support people with Learning Disabilities and Autism through

the healthcare system. A copy of the presentation slides, marked ‘Agenda Item 8’, is filed with these minutes.

The Committee welcomed to the meeting for this item Peter Davis, Assistant Director, Adults and Communities Department, LCC and David Williams, Director of Strategy and Business Development, LPT.

Arising from discussions the following points were noted:

(i) The Learning Disabilities Mortality Review (LEDER) pilot took place in Leicestershire and the key themes which were identified in Leicestershire were very similar to those which arose nationally. Links to the national and Leicestershire LEDER documents would be circulated to members after the meeting so they could look at this in more detail. The issue of people with learning disabilities being disadvantaged whilst receiving healthcare was one which had only begun to be explored recently therefore little data was available regarding trends over time. In response to a request from a member for the figures on life expectancy for people with Learning Disabilities and Autism it was agreed that the link to the LEDER Annual report would also be circulated to Members after the meeting.

(ii) A member raised concerns regarding the lack of progress regarding patients with learning disabilities given that the abuse taking place at the Winterbourne View care home in Bristol had been exposed in 2011 and David Cameron had highlighted the issues whilst he was Prime Minister. In response it was acknowledged that not enough progress had been made which was why the issue needed greater publicity and more people talking about it.

(iii) There was a variance across Leicester, Leicestershire and Rutland (LLR) with regards to the amount of people that received annual health checks and the aim was that the national indicator of 67% would be achieved across the whole of LLR, though ideally a figure higher than 67% would be reached. Currently for LLR the figure was 19% (year to date) and improvement was required across the whole of LLR not just in particular geographical areas. The Covid-19 pandemic had not greatly affected the figures for health checks carried out therefore there was scope for improving the figures regardless of Covid-19. When trying to understand why some patients were not having health checks it should be noted that every service was busy but also patient choice was a factor and it was important to emphasise to patients the importance of having an Annual Health check. A project was being undertaken which focused on people that had not had their annual health check for over 2 years and explored the reasons why.

(iv) The system was working in a more integrated way and partnership working took place to ensure best practice was incorporated across LLR. Governance arrangements such as the Learning Disability Board and the Autism Board were in place to provide oversight. Senior managers from all three local authorities worked together and case managers would review cases to see if any learning could be gained.

(v) Concerns were raised that there had been a lack of support for carers during the Covid-19 pandemic and that support groups were no longer meeting. This was of particular concern in Rutland. In response it was explained that Leicestershire

County Council had been leading on work to support carers and conversations would now take place with Rutland County Council colleagues to ensure support was provided in that locality. The Autism Board was launching a website which would provide information, and the timing of Board meetings was being changed to enable carers to take part.

(vi) Reassurance was given that decisions made were always in the service users' best interest. Patients would not be placed in the community unless the appropriate care packages were in place.

(vii) LPT recognised that there were challenges in identifying Black and Minority Ethnic (BME) patients with Learning Disabilities and Autism and providing them with the necessary support and further work was required to be carried out in this regard.

(viii) Work was taking place in Kegworth to make the community more autism friendly and it was hoped to expand this to the rest of LLR.

RESOLVED:

(a) That the Transforming Care Programme and work aimed at getting better outcomes for people with Learning Disabilities and Autism through the healthcare system be supported;

(b) That officers be requested to provide a progress report on Transforming Care – Learning Disabilities and Autism for a future meeting of the Committee.

20. Building Better Hospitals for the Future.

The Committee considered a joint report and presentation of University Hospitals of Leicester NHS Trust (UHL) and Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) which enabled consultation on the plans to reconfigure Leicester's Hospitals known as Building Better Hospitals for the Future. Copies of the report and presentation slides, marked 'Agenda Item 9', are filed with these minutes.

The Board was also in receipt of a representation signed by 20 members of the public which submitted that there had been omissions from the consultation document and asked for the Committee to consider the issues which had been omitted. This representation is also filed with the minutes.

The Committee welcomed to the meeting for this item Andy Williams, Chief Executive, LLR CCGs, Rebecca Brown, Acting Chief Executive, UHL, Mark Wightman, Director of Strategy and Communications, UHL, and Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG.

Arising from discussions the following points were noted:

(i) Plans for reconfiguring Leicester's hospitals had originally been proposed in 2007 however those plans had not been carried out due to a lack of finance. The 2007 plans were focused on investing in the acute sector whereas the current plans were

more focused towards primary care. Care had been taken that the proposed developments at Leicester's hospitals were not larger than was necessary and the current reconfiguration plans were significantly less costly than the 2007 plans.

(ii) A leaflet publicising the consultation was being distributed to all homes in Leicester, Leicestershire and Rutland so that those residents that did not have access to the internet and social media could still be made aware and take part in the consultation. However, members reported that many houses had not received the leaflet even though the consultation had been ongoing for a few weeks. In response it was confirmed that delivery of the leaflet was still ongoing and distribution companies were being relied upon to carry out the delivery. It was known which postcodes had not yet received the leaflet and assurances were given that those residents would receive notification. Social media responses indicated that many properties had received the leaflet. Local radio stations were also being used to publicise the consultation. The Council of Faiths was being used to communicate with Faith organisations however Rutland was not part of the Council of Faiths therefore a different method was needed to communicate with churches in Rutland.

(iii) In response to a question as to why individual consultation events were not being held for specific localities such as Rutland, it was explained that as the events were being held virtually due to Covid-19 the place where the participants resided had become less relevant.

(iv) Moving services from the General Hospital to Leicester Royal Infirmary (LRI) as proposed in the consultation documents could increase congestion at the LRI site however in turn some services would be moved from the LRI to Glenfield Hospital which would reduce congestion at the LRI site. There would be some investment in carparking at LRI and the Glenfield Hospital which would alleviate some of the problems. Members raised concerns that patients that resided on the outskirts of Leicestershire and Rutland would have difficulties travelling to the LRI and Glenfield sites particularly using public transport and this would result in very long journeys. It was submitted that there were parking restrictions in the Glenfield area. It was suggested by a member that the car parks be constructed before the hospital buildings were completed to ensure that the car parks were ready when they needed to be used.

(v) In response to concerns that the digital triage process would give patients less access to clinicians it was clarified that the digital triage was designed so that there were less steps in the process and patients received a clinical consultation earlier rather than later in the process. It had been found that putting a senior clinical decision maker at the front of the process gave a clearer sense of what the appropriate service was for a patient so that they could be referred into that service earlier.

(vi) A positive aspect of moving midwifery services to the LRI was that specialist care services were available on site should mothers experience complications with the birth. Members therefore questioned why some midwifery services were remaining at the General Hospital where specialist services would not be available and patients would still have to be moved to the LRI for complex treatment. In response

it was explained that these proposals were about giving mothers choice of where they gave birth. There were many positive aspects of the St Mary's Birth Centre in Melton Mowbray but due to its location it was not suitable for many mothers across LLR therefore moving midwifery services to the General Hospital made it accessible to more people in LLR whilst retaining the positive aspects of the St Mary's Centre. The CCGs and UHL were open to reconsidering these proposals depending on the consultation feedback, and during the consultation period focused discussions were taking place regarding the maternity proposals.

(vii) In response to concerns that wider community services which the reconfiguration plans relied upon were not ready to deliver what was expected, the CCG acknowledged that not everything was in place and more work was to be done, but it was not realistic to wait until the community services changes had taken place.

(viii) The monies received as a result of the proposed sale of land at the General Hospital, valued at £20 million, would be in addition to the £450 million allocated by the Government.

(ix) UHL had calculated that there would be a need for another 139 acute beds by 2023-24 and the reconfiguration plans intended to provide those additional beds. Members were concerned that 139 additional beds would be insufficient and asked for clarification on how the figure had been reached. It was confirmed that projected housing and population growth in LLR had been taken into account in the calculations. It was agreed that after the meeting a briefing would be arranged to fully explain the calculations to members.

(x) When the reconfiguration plans had been put together consideration had been given to developments which could take place in the future such as robotic surgery and artificial intelligence but events such as the Covid-19 pandemic were very difficult to predict and plan for. The design of the new buildings did incorporate some features to protect against diseases such as Covid-19 for example using motion sensitive light switches rather than those that required touching.

RESOLVED:

That the £450 million investment in Leicester's hospitals be welcomed and the reconfiguration plans be supported subject to the comments now made.

21. Date of Next Meeting.

RESOLVED:

That the next meeting of the Committee take place on 14 December 2020 at 10:00am.

10.05 am - 1.55 pm
15 October 2020

CHAIRMAN

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