Agenda Item 1

Leicester
City Council

MINUTES OF THE MEETING OF THE
LEICESTER, LEICESTERSHIRE AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Held: MONDAY, 6 FEBRUARY 2023 at 12.30pm at City Hall

P R E S E N T :
Councillor Pantling (Chair)
Councillor Ainsley
Councillor Harrison
Councillor Hills
Councillor Khan
Councillor King
Councillor Nangreave
Councillor Newton
Councillor Waller

In Attendance
Richard Mitchell – Chief Executive Officer UHL
David Sissling – Chair Integrated Care Board
Becky Cassidy, Director of Corporate and Legal Affairs, UHL
Sarah Prema, Chief Strategy Officer Integrated Care Board
Mark Roberts, Asst. Director Leicestershire Partnership Trust (LPT)
Kate Galoppi Director Adult Social Care & Commissioning
Yasmin Sidyot LLR Clinical Commissioning Group

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32. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor O'Donnell, Councillor Morgan, David Williams- NHS and Dr Janet Underwood – Healthwatch.

33. DECLARATIONS OF INTEREST

Members were asked to declare any pecuniary or other interests they may have in the business on the agenda.

Councillor Newton declared that her son worked in the NHS and her daughter

was employed as a clinical commissioning nurse and assured that she retained an open mind for the purpose of discussion and was not therefore required to withdraw from the meeting.

34. MINUTES OF PREVIOUS MEETING HELD ON 16TH NOVEMBER 2022

It was clarified that Councillor Dan Harrison was present at the last meeting as a member of the committee and not as a substitute as mistakenly recorded.

It was noted that in terms of actions arising from the UHL financial accounts item, further detail had been provided to members immediately following the last meeting. Future reports about the UHL financial recovery had been scheduled to the work programme.

In relation to the Corporate Complaints Procedure report the Chair had requested a fuller report to a future meeting and this was reflected on the future work programme.

RESOLVED:

That subject to the correction referred to above the minutes of the meeting held on 16th November 2022 be confirmed as an accurate record.

35. PETITIONS

The Monitoring Officer reported that no petitions had been received.

36. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations, or statements of case had been received.

The Chair noted that Richard Mitchell CEO UHL and David Sissling Chair Integrated Care Board had to leave the meeting early and therefore agreed to a change in the running order of the agenda to take items on the agenda that they were talking to first.

37. UHL HOSPITAL RECONFIGURATION UPDATE

Members received a report providing an update on the reconfiguration proposals for University Hospitals Leicester.

Richard Mitchell, Chief Executive Officer, UHL introduced the report reminding members that funding was initially confirmed for the programme in September 2019 with full consultation taking place thereafter. He went on to provide a recap of the interim reconfiguration project and the delays that had arisen due to the covid pandemic which had led to changes around how prevention of infection was looked at, alongside changes in policy such as achieving carbon net zero and the greater significance of digital transformation.

Richard Mitchell advised that whilst there were some delays UHL had still made progress and went on to give an overview of the current status of the main reconfiguration programme; impact of the development of the programmatic business by the New Hospital Programme and how that affected the position in terms of the Trust being told of its final capital envelope and delivery programme.

Members were concerned about the uncertainty of the final capital figure. Assurance was given that it had been confirmed in 2019 there would be £450m capital funding and the ongoing conversation was not questioning whether plans would happen but were about how much more could be added to account for the cost increases that had occurred since.

Members referred to the current economic climate, rising costs and effect of inflation and were disappointed by the lack of clarity about what would happen if there was no subsequent funding uplift to account for rising costs.

Richard Mitchell advised that he had taken on ownership of the reconfiguration plans and collectively the UHL board were making sure that they were building for the best services. He reiterated that conversations were taking place about the increased costs/inflation and how that could be covered. UHL were also looking beyond plans for money coming only from the treasury and were exploring the feasibility of working with long term partners to generate money. It was accepted that the costs base had increased but it was hoped that UHL would receive an increase in funding in a few months. It was emphasised that UHL were committed to delivering, primarily on good health services, and if it became necessary, they would revisit plans in terms of design features to reduce costs.

Members discussed the standardised buildings approach and how that impacted on the reconfiguration. It was explained that the standardised approach was similar to what had been seen in education in that there would be an expectation of a standard approach in new buildings however not all of the reconfiguration involved new build and there would be continued flexibility locally in terms of those works.

Members suggested that modern methods of construction should be easier, faster and cheaper to build than 5 years ago, and that logic should be checked when taking forward the next design development.

In terms of steps being taken towards meeting climate/carbon emissions policies there was a greater focus on being carbon net zero and transition to digital, those plans continued to evolve, and the aim was to have a single plan for carbon net zero across the health and care system.

Members asked for a critical pathway to be provided so they could track progress and when things were projected to happen. Richard Mitchell replied that a critical pathway could be provided at a point when matters were less imprecise and there was more certainty about the volume of works and timeline.

Members wanted confidence that at any point in time if something changed the impact would be known because it had been planned through. Members were firm that they wanted to see where things were at now rather than wait another 3 months, even if they were to change in a week as a result of a government statement.

Members went on to receive a report providing an overview of the planned move of the elective Dermatology service from Leicester Royal Infirmary (LRI) to the St Peter's Health Centre.

Members noted the move was a temporary transfer of part of the service that would enable expansion of the emergency floor capacity which would help address the challenge of ambulance handover delays and the clinical risk that presented across the community.

It was also noted that:

1. all patients using the dermatology service had been written to about the proposed changes and temporary measures had been put into place to support people with transport.

2. Although car parking at St Peter's Health Centre was limited, UHL had identified some on-site parking for patients and staff and were looking to expand that as well as secure some private parking co-located with a similar cost to those around Leicester Royal Infirmary

3. St Peter's Health Centre was well served by public transport with 2 main bus routes, the centre was also fully accessible and UHL would continue to work with patients through equality impact assessments to ensure everyone can access services.

Some concerns were expressed that for most people living in Rutland or Leicestershire and reliant on public transport it would not be easy to access the centre and those patients journeys could also take some significant time. Reassurance was sought that those who were from outside the city would be guaranteed parking on site if for other reasons they could not walk from other car parks.

Members noted the difficulties accessing the LRI site with car park areas taken over with building construction sites and the very long vehicle queues to park near the hospital creating a delay of up to an hour which people were not always aware to factor in to their journey time or they faced being significantly late for an appointment.

Members commented that accessibility and getting people on and off sites quickly was important. Members suggested that the outer ring of Leicestershire market towns all had community hospitals that were not being used to their maximum extent and could be better utilised with more outpatients clinics being held in those hospitals which would ease the issue of patient journeys and traffic into LRI, as well as bring down waiting lists and go towards the carbon

net zero aspects too.

Responding to the comments made it was acknowledged that the seven community hospitals were not fully used and UHL were exploring how to increase usage.

As regards disabled patients and those less mobile UHL would ensure access to car parking on site at St Peter's Health Centre; for others in their own transport, it would be easier to access and less stressful to park in the vicinity than at LRI currently.

It was recognised that car parking at LRI had gotten worse and there was a mismatch between the volumes of people wanting to park on site. There was messaging about using co-located sites and discussion was ongoing regarding access to other car parking too.

The Chair thanked officers for the report and requested an update at the earliest opportunity about the reconfiguration figure in relation to the cost increase and how any further consultation would be carried out should any changes to the reconfiguration programme be needed.

The Chair also commented in relation to the transfer of level 3 critical care from Leicester General Hospital to other sites and requested that a report be provided to better understand how the clinical benefits of that transfer would be realised.

In relation to the temporary transfer of dermatology services the Chair asked that assurance be provided that the aims of the move had been met, how long it was envisaged the service would operate from St Peter's and what the subsequent plans would be for that service.

AGREED:

1. That the contents of the report be noted,

2. That an update report be provided at the earliest opportunity about the reconfiguration funding uplift/capital envelope and how any further consultation would be carried out should any changes to the reconfiguration programme be needed.

3. That a critical pathway for the reconfiguration programme be provided so Members can track progress and see when things are projected to happen.

4. That a detailed report on the planned changes at Leicester General Hospital be brought to a future meeting.

5. That following the temporary transfer of the Dermatology Service, assurance be provided to Members that the aims of the move have been met, particularly with regard to a reduction in

ambulance handover delays.

38. CARE QUALITY COMMISSION (CQC) WELL-LED INSPECTION OF UNIVERSITY HOSPITALS LEICESTER (UHL)

Members received a report providing details of the recent Care Quality Commission (CQC) Well-Led inspection at University Hospitals Leicester (UHL).

Becky Cassidy, Director of Corporate and Legal Affairs, UHL introduced the report explaining that the well-led inspection took place in September 2022, the outcomes of that inspection were received in December 2022 with the overall rating reduced to “requires improvement”. UHL believed the report was fair and balanced, and as a board UHL were not expecting to have a well-led inspection at that time. It was notable that there were no actions required as “must do’s” but there were eight “should do’s” which were being followed up internally.

Members considered the report and inspection outcomes which included the following comments:

It was felt this was a disappointing report although it was recognised the leadership at UHL was reasonably new. Members queried if inspectors were to come in now whether they would see any difference to September.

In response it was noted that there were a number of fundamental issues, long term that needed to be addressed, some of that related to culture which needed to strengthen and UHL were able to demonstrate some improvements, however at this point in time there was a need to embed new practices and so inspectors might not see a great deal of difference but that would change over time. The inspection report was fully accepted and there would be full reflection of where the organisation was and noting that UHL was still in financial special measures.

Richard Mitchell, CEO UHL, commented that this was an accurate report at a point in time and not necessarily disappointing. The previous CQC well-led inspection had taken place 31 months before this one, in between that time there was considerable change, and an earlier inspection may have seen more deterioration. In context with other university hospitals, the majority had done worse than “requires improvement”. It was suggested that if inspectors came back today then at a high level, not a lot would have changed, however it was hoped the CQC would come back later in the calendar year and would hopefully see improvement.

Members commented upon the level of operational leadership, accountability and lack of awareness amongst staff of the Trust’s strategy and how that aligns to their divisions and work.

Richard Mitchell responded that the report was not indicative of a deterioration in the organisation, an awful lot had occurred over the 3 year period since the

last well-led inspection visit, when the inspectors came in there was no strategy and the inspectors were told that, the UHL board had subsequently begun the process of determining the direction of travel for UHL for the next 5-10 years, and staff and stakeholders views had been sought about that with over 10k interactions received within 2 weeks. A key engager was the staff survey, as of this year 48% of the staff had engaged and completed that which was a 15% increase on the previous staff survey completion rate.

Members observed that they had not had sight of any action plan or indication of what the organisation was expected to do and by when and suggested that would be helpful for this inspection.

David Sissling, Chair of Integrated Care Board commented from an Integrated Care Partnership (ICP) perspective that the report was fair, and he did not see it as disappointing and that the Trust was taking the right steps to generate a sensible amount of improvement. David suggested that the leadership was effective, there was a culture which was open as well as receptive to challenge and there was strong focus on delivery. The focus now on strategy was necessary and the ICP very much welcomed the work put in place.

The Chair thanked Richard for bringing the report and responding to members comments.

The Chair indicated that the commission would like to gain more understanding of the process behind how the “should do” actions issued in the report were being addressed as well as the opportunity to examine the Trust’s refreshed strategy and action plan once that was available.

AGREED:

1. That the contents of the report be noted,
2. That further details be provided outside the meeting to enable the commission to gain more understanding of the process behind how the “should do” actions issued in the report were being addressed as well as the opportunity to examine the Trust’s refreshed strategy and action plan once that was available.

39. LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEMS, ORGANISATIONAL PROGRESS

David Sissling, Chair of the Integrated Care Board provided a verbal update on the organisation progress of the Leicester, Leicestershire, and Rutland Integrated Care System (ICS).

Members were reminded of the background to the introduction of the Integrated Care System and how that reflected movement in health and care towards collaboration and partnership. It was advised that collaboration and partnership were very much at the centre of the integrated care system and the aim was to bring the best out of central services, and to have broader focus to include inequity and inequality.

Members noted that over the past 8 months the foundations for the new ICS had been put in place and those were being developed at pace.

Sarah Prema, Chief Strategy Officer for the Leicester, Leicestershire & Rutland Integrated Care Board (ICB) reminded Members that the ICB was established on 1st July 2022 as part of the ICS and was the ICB that planned and co-ordinated delivery across LLR.

Members were advised there was also a Health & Wellbeing Partnership, that was co-chaired by the Health & Wellbeing Board Chairs with members drawn from Health & Wellbeing Boards across the Local Authority areas. The Health & Wellbeing Partnership had met several times looking at focused areas and were developing the integrated care strategy, the draft strategy would be presented to Health & Wellbeing Boards for consideration before going through a period of consultation. The aim was to have the integrated care strategy in place for Autumn 2023.

Members were informed that the ICB was also required to produce a delivery plan which would be called the 5 years forward view plan, this was required to be finalised by June 2023 and would set out how services will be delivered and how they would deliver on the needs of populations. The 5 years forward view plan was in process of drafting and engagement would take place within similar timescales as the integrated care strategy.

Sarah went on to inform members that there would be a change in integrated care commissioning responsibilities from April 2023, and the establishment of sets of services called pods, e.g., pharmacy, optometry and dental which would be within the remit of the ICB going forward with responsibility for delivery of services at a local level. In relation to specialist services, it was advised circa 60 (out of 169) specialist services would come within the ICB remit over the next year with ongoing dialogue about whether other specialist services would transition later in 2024.

Members appreciated the verbal update but indicated it would be more helpful in future to receive written reports so that they could absorb the content and formulate questions for a proper discussion to take place.

Members asked that a further written update report be provided from the Integrated Care Board after May 2023 to provide more understanding of what was actually taking place and how services were being commissioned rather than theoretical updates of what was planned to be done.

The Chair thanked David and Sarah for attending.

RESOLVED:

1. That the verbal update be noted,
2. That all future reports be provided in writing to give a clearer indication and enable members to fully consider and raise comments.

3. That a further written update report be provided from the Integrated Care Board to the next committee meeting after May 2023.

Richard Mitchell UHL, Becky Cassidy UHL and David Sissling ICB left the meeting.

40. TRANSFORMING CARE - LEARNING DISABILITIES AND NEURO-DEVELOPMENTAL NEED UPDATE

Members received a report giving an update on the work being done in partnership to improve the outcomes for people with a learning disability or neuro-developmental need.

Mark Roberts, Asst. Director Leicestershire Partnership Trust (LPT) introduced the report giving an overview of the aims of the programme, details of the collaborative formalised between the ICB and LPT and the close work with local authority colleagues as well as the significant improvements in the services provided and priorities moving forward.

Members were advised this work took forward the successes of the Transforming Care Programme from 2021-22 and sought to address inequalities in a fundamental way whilst also reviewing the delegated duties from NHS England to local systems too.

Attention was drawn to the key target areas namely: reducing the need for inpatient care; learning from the lives and deaths of people with a learning disability; and Annual Health Checks for people with a learning disability along with the successes, challenges and opportunities in those areas.

In summary it was noted there were fewer local adults with a learning disability or neuro-developmental need requiring care in hospital, although there had been an increase to the number of children with a learning disability or neuro-developmental need being in hospital than previously; in terms of learning this was developing well and the learning about aspiration pneumonia had gathered interest at a national level. As regards health checks it was hoped there would be more progress on completion of annual health checks for those with a learning disability.

Members welcomed the report although there was some disappointment that the number of children with a learning disability or neuro-developmental need in hospital had risen, and it was suggested there should be more emphasis on the work around children and exploring the reasons for that.

In relation to the annual health checks members enquired about the definition of a person with a learning disability or neuro-developmental need and how those that should be health checked were being captured in the data.

Responding to the points made it was advised that annual health checks were focused on those with a learning disability and the definition was a certain level

of IQ, this was relatively easy to define in the community, however neuro-developmental need such as autism was more challenging to identify, and a formal diagnosis defined whether someone was autistic.

As far as people engaging with primary care networks, it was advised that the collaborative had stimulated some improvements, such as in North West Leicestershire where a hub was being developed, however some people had more significant needs that made the annual health check more challenging to undertake. The team had commissioned some additional capacity to address the 200 people without a health check last year and who hadn't one this year either and those were being targeted through GP's to make sure they had a health check.

Members noted that other areas of the East Midlands had turned towards a more centralised process for the annual health checks, but the team were fundamentally opposed to that approach as it was a mainstream process that GPs should be engaged in with that part of community.

The Chair concluded the discussion and was pleased that changes in arrangements had led to improvements and that was as a result of strong partnership working between the NHS and local authorities across LLR.

The Chair thanked officers for the report and noted the successes and challenges of the work and commented that given the targets set for 2023-24 a further update should be brought to scrutiny in 12 months.

AGREED:

1. That the contents of the report be noted,
2. That the Committee shall champion the joint focus on people who need support to help ensure people receive timely and high-quality care enabling people to lead a fulfilling life,
3. That the Committee shall champion the importance of supporting all our people across Leicester, Leicestershire, and Rutland,
4. That a further update report should be brought to scrutiny in 12 months to provide details of progress against the targets set for 2023-24.

41. ACCESS TO PRIMARY CARE REPORT

Members received an update reporting on the current priorities and opportunities in Primary Medical Care across Leicester, Leicestershire and Rutland as well as a summary on the Primary Care Network (PCN) Enhanced Access services delivered by Primary Care Networks across Leicester, Leicestershire and Rutland.

Yasmin Sidyot, LLR Clinical Commissioning Group introduced the report and drew attention to the LLR Primary Care Plan update which concentrated on four key points:- Access, Workforce, Quality, and Delivery on key Long-Term Conditions.

It was noted that:

- In terms of Access, more appointments were now being delivered across 132 practices compared to April 2019 and there had been sustained increase in face to face appointments being given across LLR from January to October 2022.
- Enhanced access had been implemented and that came online 1st October 2022, this meant primary care networks were delivering additional appointment capacity to that stated above, this additional provision was available Mon – Fri 6.30 pm to 8.30pm and on Saturdays 9am to 5pm
- Outcomes of data showed some areas of significant improvements, such as the percentage of patients being treated on anti-coagulation treatment; hypertension patients being detected and treated earlier, although there was still some inequity across PCN's with areas of further requirement to improve such as diabetic and respiratory patients but overall seeing shift towards better service provision.
- Workforce continued to be challenging in general practice, and there was discrepancy between what workforce growth looks like across LLR. Improvements were being seen in the uptake of additional roles brought in through primary care networks such as social prescribers, pharmacists etc and there was growth in those but that was overlaid with the challenges to recruit and retain GP's, nurses, and an administrative work force too.

The Chair invited members to comment on the report which included the following:

- PCN contracts were a concern, although overall things looked to be going well underneath there were still serious issues such as around recruitment and retention of appropriate staff to general practices.
- OPEL status report was about the operating pressures and escalation level, this reporting was introduced with General Practices this year (2022-23) and is a very operational process that provides good intelligence of what GPs are facing.
- The OPEL status report showed a deterioration from November 2022 to December 2022 of the number of GP practices at Level 3, this was because of increasing winter pressures and the visible reporting enabled additional support to be put into acute respiratory services in January 2023, as well as enabling specific targeted work with practices.
- In terms of patient groups there were currently 51 active participation groups and officers were working with them to ensure consistency in how they operate and also to connect with each other and work more collaboratively around patient experiences. General Practices were also being engaged to re-establish and refresh patient groups that had stopped.

Members raised concerns about the inaccessibility of phone systems that most general practices still used and the huge variation of quality of messages within those systems. Members were informed that telephone contracts had been discussed, these were individual contracts between the GP's and phone companies, however steps had been taken to provide communication toolkits

to GP's, but this took time to implement and embed, especially with practices that had issues in terms of culture and how they operate, and where there was a rapid turnover of workforce that also brings challenges to the communications and telephony.

As far as patients being offered appointments at different hubs and having to travel to those it was acknowledged there was a challenge in terms of what could be delivered through the network hub and what had to be delivered through local general practice and they were working with the patient population to try and reflect on that better.

The data presented in Tables 4 and 5 was queried in so far as it related to Rutland. In response it was advised that officers had been working with 4 practices across Rutland who had turned to the ICB in June, there had been different reporting methods in place, and this data had been amalgamated but officers would check that data and look to extract the Rutland data and share with members outside this meeting.

It was noted that officers were actively working on issues raised about access to GP's in Rutland and there was a collaborative focus on specific elements and how to actively try to support a face led solution, it was also noted that border hopping was taking place and that mires the data too.

Members raised concern about the rise in private practice and the negative impact that brought upon the NHS for patient, and it was queried whether a 2 tier system and services were making it less attractive for GPs to work in NHS funded practices and what was being done to prevent general practice becoming an issue like dentistry. In reply it was noted that this had not been raised from the GP fraternity in LLR as a concern. Work was taking place nationally to ensure GP services and make it attractive and viable and there was local input to that.

The Chair thanked officers for the report. The Chair indicated that an update report should be provided to a future meeting and that it would also be helpful to provide an update specific to each of the local authority's scrutiny committees during the 2023/24 municipal year to enable them to delve into the data for their areas.

AGREED:

1. That the contents of the report be noted,
2. That a report detailing progress made and containing a review of data from the early months of 2023 be brought to a future meeting of the committee.

42. WORK PROGRAMME

It was noted that a formal work programme was not set as this was the last meeting of the current municipal year, outstanding items and those raised during the course of discussion today will be added to the work programme for future meetings.

43. ANY OTHER URGENT BUSINESS

None notified.

44. DATE OF NEXT MEETING

Noted that the administration of the Joint Health Scrutiny Committee will transfer to the Leicestershire County Council for the new municipal year and dates of future meetings to be confirmed in due course.

The Chair thanked committee members for their contributions to these meetings. Councillor Waller extended thanks to the Chair for chairing the meetings in a gracious manner.

There being no further business the meeting closed at 2.48pm.

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