Agenda Item 1

Leicestershire County Council

Minutes of a meeting of the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee held at County Hall, Glenfield on Wednesday, 27 March 2024.

PRESENT

Mr. J. Morgan CC (in the Chair)

Cllr. S. Bonham	Ms. Betty Newton CC
Mr. M. H. Charlesworth CC	Mr. T. J. Pendleton CC
Mr. D. Harrison CC	Cllr R. Ross
Mr. R. Hills CC	Mrs B. Seaton CC
Cllr. M. March	Cllr. G. Whittle

In attendance

Harsha Kotecha, Healthwatch Leicester and Leicestershire.
Janet Underwood, Healthwatch Rutland.
Jon Melbourne, Chief Operating Officer, UHL (item 30 refers).
Rachna Vyas, Chief Operating Officer, NHS Leicester, Leicestershire & Rutland (item 30 refers).
Justin Hammond, Associate Director of Mental Health & Learning Disability, Integrated Care Board (item 31 refers).
Victoria Evans, Family Service Manager, Leicestershire Partnership NHS Trust (Item 31 refers).

24. Minutes of the previous meeting.

The minutes of the meeting held on 18 December 2023 were taken as read, confirmed and signed, subject to the amendment that Harsha Kotecha, Healthwatch Leicester and Leicestershire, and Janet Underwood, Healthwatch Rutland, be added to the attendance list.

25. Question Time.

The Chairman reported that no questions had been received in accordance with Standing Order 34.

26. Questions asked by Members.

The Chairman reported that no questions had been received under Standing Order 7.

27. Urgent items.

There were no urgent items for consideration.

28. 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.

Mrs. M. E. Newton CC and Mrs. B. Seaton CC both declared non-registerable interests in all substantive agenda items as they had close relatives that worked for the NHS.

29. Presentation of Petitions.

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

30. UHL - Operational Improvements 2023.

The Committee considered a report of University Hospitals of Leicester NHS Trust (UHL) on the performance of UHL's planned and urgent and emergency care activities during 2023 as well as future plans to continue the improvements achieved to date. A copy of the report, marked 'Agenda Item 7', is filed with these minutes.

The Committee welcomed to the meeting for this item Jon Melbourne, Chief Operating Officer, UHL and Rachna Vyas, Chief Operating Officer, NHS Leicester, Leicestershire & Rutland.

Arising from discussions the following points were noted:

(i) UHL had improved its operational performance in 2023 from a position at the start of the year of being in Tier 1 of the National Support Programme for Urgent and Emergency Care (UEC), cancer and planned care, to being exited from tier 1 support for all three areas in 2023 (moving to tier 2 for cancer and planned care and out of tiering for UEC). A hospital trust could be placed in a support tier for any area of care but UHL had not been on a support programme for any areas apart from UEC, cancer and planned care. UHL acknowledged that further improvements still needed to be made. Committee members welcomed the improvement in UHL's operational performance particularly the 77% reduction in the number of people across LLR waiting more than a year for elective care, the biggest reduction of any system in England.

(ii) On 23 January 2024 UHL had declared a critical incident and the Trust had remained in critical incident mode for 52 hours and 3 minutes. Members queried how come the critical incident needed to be declared given the operational improvements that had taken place during 2023, and that the 2023/24 winter had not been particularly severe in terms of the weather. In response it was explained that significant operational pressures had been building up for some months particularly in emergency flow pathways. Whilst UHL held data about why the individual patients had attended the hospital, the University of Leicester had been tasked with carrying out a wider investigation into why demand had been so high during the 2023/24 winter. In response to a question from a member it was clarified that the critical incident was not caused by a lack of staff, and even if UHL had a full compliment of staff, a critical incident would still have had to be declared. To put the incident in context, most of the larger hospital trusts in England had to declare a critical incident at some point over the 2023/24 winter. The previous critical incident at UHL was on 29 December 2022.

(iii) The System Health Equity Committee had been requested to conduct a 'deep dive' into longer waits at both the Emergency Department and patients waiting for ambulances to assess the impact against protected characteristics. Separate reports of the findings would be produced for the Leicester City area, the County Council area and also individual neighbourhoods. The relevant reports would be brought to Health Scrutiny Committees when available.

(iv) UHL was using a small number of Physician Associates to support clinical staff and reassurance was given that they were only being used where clinically appropriate and they were not replacing staff with more advanced clinical skills such as doctors.

(v) The graphs in the appendix to the report indicated that the diagnostic waiting list had grown towards the end of 2022, then dropped dramatically in early 2023, before reaching a plateau in mid 2023. In response to a query from a member, UHL gave reassurance that the diagnostic waiting list would continue to decrease. It was noted that the new Hinckley Community Diagnostic Centre would play a part in this.

(vi) The Getting it Right First Time (GIRFT) programme was now working with UHL as part of a programme called "Going Further Faster" to deliver clinical transformation of patient pathways and reduce waiting times for elective care. The programme involved learning best practice from other hospital trusts. In response to a question from a member it was clarified that UHL had been learning from other trusts for some time, it was just the Going Further Faster model that was new.

(vii) Another part of the GIRFT programme was mutual aid which involved using other providers in the health sector. This could include private hospitals if they provided services to the NHS. The national patient choice initiative gave a patient the right to ask for an appointment to be moved to a different provider.

(viii) There had been zero 104+ waits for elective care. There was national guidance on what constituted a wait and when the clock should be stopped.

(ix) UHL was implementing a Patient Initiated Follow-Up (PIFU) scheme where patients were able to initiate a follow-up appointment when they needed one, based on their symptoms and individual circumstances, rather than having a set timescale for follow-up appointments. Members raised concerns that some patients might not request a follow-up appointment when they actually needed one and members queried whether the scheme resulted in patients having worse medical problems later on in time. In response it was explained that the scheme was clinically led and only implemented when it was right for a particular patient. Patients on a PIFU pathway accounted for approximately 5% of UHL's follow up pathways therefore ensuring only necessary follow up appointments took place could have a significant impact on UHL's workload.

(x) There had been a reduction in length of stay for patients at UHL with hip and knee complaints from 4.5 days (22/23) to 2.8 days (Dec 23). The quicker a patient could be mobilised the better for their long-term health. UHL was now one of the best trusts in the country for mobilisation.

(xi) In response to a positive observation from a member about staffing levels in the Clinical Decisions Unit at Glenfield Hospital it was explained that staffing ratios were clinically led using evidence bases set out in national guidance.

(xii) Da Vinci robots at Leicester General Hospital and Leicester Royal Infirmary (funded by charitable donations) were being used to carry out some procedures. A full list of the procedures would be provided to members after the meeting. It was hoped that a further Da Vinci robot could be installed at Glenfield Hospital should the funding be available.

(xiii) Healthwatch reported that patients were generally satisfied with clinical appointments once they had received one, but it was the administration process prior to attending the appointment that they experienced difficulties with. In response UHL acknowledged that some services were difficult to access but provided reassurance that UHL was working on its digital programme including texts sent to patients about appointments and ensuring the correct contact numbers were publicised.

(xiv) Some GP Practices were preventing patients from booking appointments by telephone and instead requiring patients to book an appointment by completing a form. There were concerns that patients with literacy problems would be disadvantaged and also that this method was not suitable if the patient's problem was urgent. The ICB was aware of these issues and was holding conversations with GP Practices about it. However, as GP Practices were independent contractors, they had the final decision on how they ran their appointments process. The Chairman suggested to Healthwatch that they could carry out a piece of research into the issue of access to GP Practices, and Healthwatch agreed to give this consideration. Healthwatch Rutland were already planning on carrying out a piece of research into patients' communication experiences with the NHS.

(xv) A member emphasised that patients needed educating on where to go for medical treatment. The role of pharmacists needed to be better publicised. The Pharmacy First service enabled patients to be referred into a community pharmacist for a minor illness and the pharmacists could prescribe medication for 7 common conditions.

(xvi) In response to a question from a member it was confirmed that the Integrated Care System could disaggregate its funding into the different areas such as primary care, home first etc though Urgent and Emergency Care was more difficult. However, this was only a useful activity if funding was being moved from one area to another. Members welcomed that the system had more of an understanding of its finances than in previous years.

RESOLVED:

(a) That the update on UHL's planned and urgent and emergency care activities be welcomed;

(b) That officers be requested to provide reports for future meetings of the Committee regarding the digital programme and admin processes for clinical appointments.

31. LLR Children and Young People's Wellbeing and Mental Health update.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on the Well-Being & Mental Health support available for Children and Young People across Leicester, Leicestershire and Rutland (LLR). A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Committee welcomed to the meeting for this item Justin Hammond, Associate Director of Mental Health & Learning Disability, Integrated Care Board, and Victoria Evans, Family Service Manager, LPT.

Arising from discussions the following points were noted:

(i) LPT offered a range of well-being and mental health support services designed to tackle issues early and prevent a patient needing to be referred to Child and Adolescent Mental Health Services (CAMHS). However, the age of children being referred to CAMHS was getting younger.

(ii) A large number of referrals from GP Practices to CAMHS were being rejected due to a lack of information in the referral. Members suggested that Derbyshire Health United (DHU) who assessed the referrals should request the additional information from the GP Practice rather than rejecting the referral. In response assurance was given that this issue was known about and being investigated by the Integrated Care Board (ICB). CAMHS practitioners were being placed in Primary Care Networks to help the process run more smoothly and support signposting to other mental health services. It was pointed out that it was more useful for DHU to get the information directly from the patient rather than via the GP Practice.

(iii) In response to a query as to why there had been an increase in demand for mental health services in recent years it was suggested that the Covid-19 pandemic would have had an impact but there were likely to be other factors such as social media.

(iv) Neurodiversity in patients created additional challenges and complexity when diagnosing mental health issues. LPT had seen an increase in referrals of patients with neurodiversity and this was a national issue. LPT was bidding for additional funding to manage those patients. One bid to the ICB for funding to provide a dedicated service had been successful.

(v) Support was available to the families of patients who required mental health support. The Solihull Approach to parenting was being used which was an early intervention framework. LPT also linked in with Family Hubs.

(vi) It was important to make the best use of estate space and undertake capacity planning. However, it was more cost effective to utilise buildings owned by other organisations where possible and this fitted in with the approach of imbedding services in communities. A report on estates was requested for a future meeting.

RESOLVED:

(a) That the update on the Well-Being & Mental Health support available for Children and Young People be welcomed;

(b) That officers be requested to provide a report for a future meeting of the Committee regarding NHS estates management.

32. Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee Terms of Reference.

The Committee considered a report of the Secretariat (Leicestershire County Council) which proposed changes to the Committee's Terms of Reference, required as a result of new Regulations and guidance from the Department of Health and Social Care relating to the role and powers of Health Scrutiny Committees. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

Members were advised that in conjunction with the Terms of Reference changes a Memorandum of Understanding between the Committee and health system partners would be drafted and circulated.

RESOLVED:

That the amendments to the Committee's Terms of Reference as set out in the Appendix to the report be approved.

2.00 - 4.02 pm
27 March 2024

CHAIRMAN