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, 17 July 2024.

PRESENT

Mr. J. Morgan CC (in the Chair)

Cllr. S. Bonham
Mr. M. H. Charlesworth CC
Cllr. Zuffar Haq
Mr. D. Harrison CC
Mr. R. Hills CC
Ms. Betty Newton CC
Cllr. R. Payne
Mr. T. J. Pendleton CC
Cllr. K. Pickering
Cllr R. Ross
Mrs B. Seaton CC

In attendance

Mayur Patel, Head of Transformation, Integrated Care Board (minute 8 refers).
Sue Venables, Project Lead - Engagement and Communications, Integrated Care Board, (minute 8 refers).
Yasmin Sidyot, Deputy Director Integration and Transformation, ICB (minute 8 refers).
Sulaxni Nainani, Deputy Chief Medical Officer, Integrated Care Board (minutes 8 and 9 refer).
Lewis Parker, Commissioning Manager – Pharmacy, Optometry and Dental East Midlands Primary Care Team (minute 9 refers).
Jenny Oliver Consultant in Dental Public Health (minute 9 refers).
Catriona Peterson, Associate Medical Director (Dental) (minute 9 refers).
Mark Roberts, LDA Collaborative Lead, Leicestershire Partnership NHS Trust (minute 10 refers).
Laura Rodman, Project and Planning Lead, LDA Collaborative, Leicestershire Partnership NHS Trust (minute 10 refers).

1. Minutes of the previous meeting.

The minutes of the meeting held on 27 March 2024 were taken as read, confirmed and signed.

2. Question Time.

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

3. Questions asked by Members.

The Chairman reported that the following question had been received under Standing Order 7:

Question by Cllr. Ramsay Ross:

On 19 June 2024 a BBC news article reported that there were plans to replace the Bradgate Unit at Glenfield Hospital and build a new mental health treatment unit on the

same site with more modern facilities. The article stated that a planning application had been submitted to Blaby District Council and would be considered by their planning committee on 13 June 2024. On reading this article I requested further information from Leicestershire Partnership NHS Trust (LPT) about the plans. I was informed that LPT did not currently have any capital to build the new unit with and had therefore applied for outline planning permission to demonstrate to the NHS that this was a realistic plan and once planning permission had been granted the plan was to make a case for funding and develop the next round of business cases etc. This whole process could take up to 10 years. I thank LPT for this information.

I now ask the following questions:

1) *The need for Long-term Planning and the Effective Use of Funds* - Most large businesses have plans that allow them to bring forward, at relatively short-notice based upon economic circumstances, specific capital projects. Does the ICB have a long-term, integrated Capital Expenditure Plan extending over more than 10 years?

2) *Political Support for Priorities* - Should this Committee and our residents not be concerned that the delivery of what I believe to be a relatively modest capital project, will take more than two Parliamentary terms?

Reply by the Chairman:

Information has been sought from Leicestershire Partnership NHS Trust (LPT) and the Integrated Care Board (ICB) in relation to the questions from Cllr Ross. I have been informed that the issue of capital and funding falls mainly within the remit of the ICB. I understand that capital resources available to the ICB are not confirmed by central office beyond the end of 2024/25.

Capital resources that are available to the ICB on an annual basis are for business-as-usual (BAU) capital and are extremely limited. The value of the capital BAU allocation is less than the depreciation costs of the assets – this means the ICB prioritise resources to replace/maintain the current equipment/buildings rather than considering significant strategic re-developments/new builds.

Significant capital projects such as the Bradgate Unit proposals require national funds, and support and approval by the national team for local use (e.g. new Hospital Programme).

The ICB inform that together with NHS partners they consider together how, by pooling the limited resources they are assigned by NHS England, they may be able to support schemes alongside the operational capital requirements. Work currently underway is as follows:

- A draft LLR Infrastructure Strategy will be submitted to NHS England this month and will set out the priorities and a framework that the ICB will use to continue to prioritise effectively going forwards. This strategy includes the new Bradgate Unit and it will be included in the LLR list of capital requests for future funding. The importance of the strategy is that it details the future thinking of the system – it does not guarantee funding. All systems will submit strategies and they will be collated by NHS England and form part of the discussions with Treasury for the Comprehensive Spending Review.

- A 3-year outline capital plan (which will be mainly focussed on operational capital that will include some strategic schemes funded in a phased approach over several years).

To deliver a scheme from proposal to completion does take time. The following website may help to understand the process: https://thepsc.co.uk/index.php/news-insights/entry/20-years-to-build-a-hospital-how-to-save-up-to-7.5m-by-speeding-up-design-and-approvals-for-new-hospitals-what-this-could-mean-for-the-new-hospital-programme#skip

The ICB and LPT would welcome support from elected members to make a case for why capital funding is needed in LLR, and offer to discuss the matter further with Cllr. Ross at a time of his convenience.

4. Urgent items.

There were no urgent items for consideration.

5. 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. It was also noted with regards to agenda item 8: Update on GP Practice service improvements that Mrs. Seaton CC was a member of her local Patient Participation Group.

Mr. R. Hills CC declared a non-registerable interest in agenda item 9: Access to Dental Services for Leicester, Leicestershire and Rutland as he worked as a NHS Dentist in Nottinghamshire.

6. Declarations of the party whip.

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

7. Presentation of Petitions.

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

8. Update on GP Practice service improvements.

The Committee considered a report of the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) which provided an update on the delivery of the LLR 2023/24 System-level Access Improvement Plans and the NHS England Primary Care Recovery Plan for 2024/25. A copy of the report, marked 'Agenda Item 8', is filed with these minutes.

The Chairman welcomed to the meeting for this item Mayur Patel, Head of Transformation, ICB, Sue Venables, Project Lead - Engagement and Communications,

ICB, Sulaxni Nainani, Deputy Chief Medical Officer, ICB and Yasmin Sidyot, Deputy Director Integration and Transformation, ICB.

Arising from discussions the following points were made and noted:

(i) In 2022/23 GP practices provided 6,948,961 clinical appointments for their patients; in 2023/24 this figure rose to 7,451,092 clinical appointments, a rise of 502,131 (7.2.%) appointments. Members noted that whilst on the face of it this seemed a big positive, how much of an improvement it really was depended on the exact nature of the appointments. Some patients were more reassured by having an appointment with a GP rather than with another medical professional. In response it was explained that there was a broad array of different types of clinical appointments in LLR; the majority of these additional appointments were with a GP but some were with clinical pharmacists, physiotherapists, and Advanced Nurse Practitioners. There was only a very small amount of Physician Associates employed in LLR.

(ii) The Pharmacy First scheme was launched in January 2024 which involved expanding the role of community pharmacies so that they could supply prescription medicines for seven common conditions. In response to a question from a member as to whether the scheme had been sufficiently publicised, it was explained that a publicity campaign had already taken place which had included social media but more publicity could be carried out and a further campaign would take place in 2024. Given that the Pharmacy First service was relatively new, assessments were being made of how it could be improved, and pharmacies were being consulted on what further training they required. In LLR 99% of pharmacies were registered for Pharmacy First. Some pharmacies had felt they needed more training before they could deliver the whole Pharmacy First package. Once the further training had been provided the capacity of Pharmacy First could increase.

(iii) Patients were being empowered to manage their own health by using self-referral pathways for services such as musculoskeletal physiotherapy, podiatry and weight management. In response to a question from a member as to the impact of these self-referral pathways and whether waiting lists were being reduced it was agreed that this information would be provided after the meeting.

(iv) A member raised concerns about patients not attending appointments that they had booked and queried whether this was a particular issue with self-referrals. It was also questioned what measures could be put in place to discourage patients from not attending appointments. In response it was agreed that the issue of self-referrals would be looked into and data on non-attendance would be provided to the Committee when available.

(v) There was some variance between Primary Care Networks (PCNs) across LLR in relation to the service provided. Some of this variance was warranted due to local need, but some of it was unwarranted such as differences in websites, and work was taking place to address this.

(vi) A 7-week public engagement and survey was undertaken in LLR regarding GP Practices. The survey commenced on 23 January 2024 and ran until 10 March 2024 and a total of 28,974 people participated. Members welcomed the numbers of people that had taken part in the survey. However, members raised concerns that more than a third of respondents said that they were either ‘fairly dissatisfied’ or ‘very dissatisfied’ with the appointment times available to them. In response it was

suggested that the answers to this question might have reflected the perception of respondents rather than reality. Members were also reminded that further improvements had been made since the survey took place. A fresh survey would be carried out in January 2025.

(vii) A member requested that NHS professionals avoid jargon when engaging with patients and emphasised that the elderly in particular needed processes articulated to them clearly.

(viii) NHS colleagues from other parts of the country had been learning good practice from LLR. There had been praise nationally on the digital interface between primary and secondary care in LLR.

(ix) Members welcomed the improvements that had been made with regards to GP access in LLR but emphasised that performance needed to improve further.

RESOLVED:

That the update on access to GP Practices be noted.

9. Access to Dental Services for Leicester, Leicestershire and Rutland.

The Committee considered a report of the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB) which provided an update on dental services and future plans to improve dental access in LLR. A copy of the report, marked 'Agenda Item 9', is filed with these minutes.

The Chairman welcomed to the meeting for this item Lewis Parker, Commissioning Manager – Pharmacy, Optometry and Dental East Midlands Primary Care Team, Dr Sulaxni Nainani, Deputy Chief Medical Officer, ICB, Jenny Oliver Consultant in Dental Public Health, and Catriona Peterson, Associate Medical Director (Dental).

Arising from discussions the following points were noted:

(i) There were currently 133 general dental contracts across LLR over a similar amount of practices, though a small number of practices had more than one contract. Members raised concerns about whether this was enough contracts to cover the whole of LLR.

(ii) Serious concerns were raised about the lack of access to dental services in Rutland specifically. The problem was compounded by the fact that Rutland residents would normally go to the Melton area as a second choice but Melton was also performing poorly in terms of dental access. Expressions of Interest to provide dental services in Rutland would be requested in September 2024 but the whole procurement process could take 3 months.

(iii) Since February 2021, across LLR there had been 14 contract terminations though there had been no terminations since March 2024. Most of the contracts were terminated by the provider themselves and the most common reason was that the provider did not have the workforce to carry out the NHS contract. When a contract was terminated the patients from that practice were sent a letter signposting them to other practices that were able to take on new NHS patients. A member raised

concerns that those patients were not being followed-up to ascertain whether they did in fact attend another practice. In response it was explained that this was not possible as patients did not register with dental practices like they did with GP practices.

(iv) There were 5 out of hours dental contracts in LLR providing services from 8am to 8pm every single day of the year. In response to a question as to whether this was a sufficient number, it was explained that those services were actually underutilised therefore the provision of those services needed to be re-evaluated.

(v) The provision of dental services was measured in Units of Dental Activity (UDAs). Each NHS dental provider was contracted to deliver a set number of units of dental activity (UDAs), for an agreed price, over the contractual year. Each patient's course of treatment was associated with a given number of UDAs, ranging from 1 UDA for a simple check up to 12 UDAs for a complex course of treatment, like dentures. There was some variation across LLR in terms of the % of UDAs delivered across NHS dental contracts. For example, contracts in Blaby delivered 94.31% whereas Charnwood contracts delivered 75.27%. This difference was believed to be due to differences in the way the practices managed the contracts and the availability of workforce. It was also noted that Charnwood had a high proportion of University students who tended to access dental services in the places they originally came from rather than where they were attending university.

(vi) An Oral Health Needs Assessment (OHNA) for LLR had been drafted, which identified the oral health needs of the LLR population, highlighting inequalities in health and access to dental care for local groups of people, for example those who were at high risk of poor oral health. The Needs Assessment included the results of research carried out by Healthwatch. Members raised concerns that the publication of the Needs Assessment had been delayed which had led to improvements in access to dental services being delayed. In response it was explained that the document was going through governance processes and would be considered by the ICB at their meeting in August 2024. The Needs Assessment would not resolve all the issues by itself but was the start of a process to improve access to dental services. The contents of the Needs Assessment were already being used to set out commissioning intentions.

(vii) Between July and December 2023 approximately 50% of 0-17 year olds in LLR accessed NHS Dental Services. In response to concerns raised by members that the other 50% might not be accessing dental services at all (not even private services), it was acknowledged that since the Covid-19 pandemic the amount of children accessing dental services had reduced. Some reassurance was given that the issue had been looked into as part of the Needs Assessment and when the document was published it would show the demographics of which children were and were not accessing Dental Services. Looked after children was one demographic that was not accessing dental services as well as they could and work was taking place to tackle this issue. A member requested a more detailed breakdown of the 0-17 year olds accessing dental services so as to understand exactly which ages of children were most affected by this issue. It was agreed that more detailed data would be provided after the meeting.

(viii) Some children and families were hard to reach with dental campaigns. In response to a suggestion from a member that dentists should visit schools it was explained that this had been discussed at an ICB meeting. However, there was not the

capacity of dentists available to carry out this work and there were not the facilities at schools to carry out dental procedures. In any case consent from parents would be required. Therefore, the work that did take place in schools tended to focus on encouraging children to brush their teeth properly. A member informed that some families in LLR could not afford toothpaste therefore the problem was a financial one and not just a matter of educating people.

(ix) The causes of poor oral health, such as intake of sugar, were linked in with broader issues that were within the remit of public health departments such as diet and obesity. Therefore, the strategy to tackle oral health needed to be multi-layered and could not be addressed through access to dental care alone.

(x) As an incentive to Dental Practices, a scheme had been put in place nationally where Practices would be paid for up to 110% over performance on their contract. ICBs in the East and West Midlands had originally decided not to implement the scheme. For the 2023/24 year there had been an underspend in LLR for dental services but decisions had been made nationally on how that underspend was dealt with. It was hoped that going forward the scheme would be implemented in the East Midlands, subject to the NHS dentistry budget being protected at ICB level.

(xi) None of the national initiatives that were being put in place to improve access to dental services in LLR came with any additional funding from NHS England so therefore they had to be funded from underspends locally.

(xii) Both dentists and GPs could make a referral in relation to oral cancer.

(xiii) Patients always had a choice on where they were referred to for specialist NHS dental treatment in hospital settings, though there were some complications arising from different systems being in place in different areas, for example the referral process was different in the East and West Midlands.

(xiv) Water fluoridation had been shown to reduce the likelihood of tooth decay. Some parts of the UK were covered by water fluoridation schemes but LLR and Nottinghamshire were not. The upper-tier Councils in Nottinghamshire had submitted a letter to the Department of Health and Social Care seeking to have water fluoridation in Nottinghamshire. Members questioned whether similar representations to the Secretary of State could be made on behalf of LLR. In response it was confirmed that conversations between the local authorities in LLR had already begun taking place in this regard and an update could be brought to the next meeting of the Committee.

RESOLVED:

(a) That the update on plans to improve access to dental practices in LLR be noted;

(b) That officers be requested to provide further updates to future meetings of the Committee on progress with improving dental access, and water fluoridation in LLR.

10. Learning Disability and Autism Collaborative.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided an update on the LLR Learning Disability and Autism (LDA) Collaborative which

had been established to improve services for people with a learning disability and autism. A copy of the report, marked 'Agenda item 10', is filed with these minutes.

The Chairman welcomed to the meeting for this item Mark Roberts, LDA Collaborative Lead, and Laura Rodman, Project and Planning Lead, LDA Collaborative, both of LPT.

Arising from discussions the following points were noted:

(i) The Collaborative had been working to increase the uptake of Annual Health Checks (AHCs) for people aged over 14 years with a Learning Disability. The national target was for 75% of the people included on the GP Learning Disability Register to attend an AHC and during 23/24 the LLR achieved 82.6%, making LLR the highest performing system in the Midlands and 5th nationally. Specific work was taking place targeting those who had not had a heath check in the previous two years. Members welcomed the targeted work and the significant improvement from historical performance. It was noted that individual staff members could make a real difference to the levels of uptake with their diligent work in encouraging patients to undertake health checks.

(ii) Screening was one area where there were concerns about the numbers of people with learning disabilities and autism taking part. Approximately one third of women with learning disabilities took part in cervical screening as opposed to 75% of women overall. It was agreed that further screening data would be provided to Committee members after the meeting.

(iii) Videos had been made and were circulated to GP Practices to help them manage patients with learning disabilities and autism.

(iv) One of the aims of the LDA Collaborative was to encourage all partners to complete the Oliver McGowan Mandatory Training on Learning Disabilities and Autism. It was agreed that a link to the training would be circulated to Committee members after the meeting.

(v) Early diagnosis was important and therefore it was concerning that approximately 7000 children were waiting for a neurodevelopmental assessment.

(vi) Autism in females was believed to be under-diagnosed and females were believed to be better at masking the symptoms.

(vii) It was important to make people with learning disabilities and autism feel welcomed in communities and give them opportunities for social interaction. Social prescribing had a role to play here. It was noted that the Joy mobile phone app directed people towards social activities and support groups.

(viii) The LDA Collaborative worked with the Leicester City Council employment team to find job opportunities for people with learning disabilities and autism. However, one of the challenges was assessing the impact of this work as measurements of people with learning disabilities in employment were only taken once a year.

(ix) It was requested that when the Committee scrutinised health providers in future members ask the providers what work they were carrying out with regards to people with learning disabilities. The Committee agreed to take this on board.

RESOLVED:

(a) That the LDA Collaborative's achievements to date and priorities for 2024/25 be welcomed;

(b) That the work of the LDA Collaborative in championing the importance of supporting people with a learning disability and autistic people across LLR be supported;

(c) That the Committee recommends that future Joint and Place Based Health Scrutiny Committees in LLR ensure through their scrutiny meetings that partners embed learning disabilities and autism considerations in all pathways, strategies and plans.

11. Dates of future meetings.

RESOLVED:

That future meetings of the Committee take place on the following dates:

Wednesday 27 November 2024 at 10.00am;
Monday 17 March 2025 at 2.00pm.

10.00 am - 12.40 pm
17 July 2024

CHAIRMAN

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