Leicester
City Council

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

Held: MONDAY, 28 MARCH 2022 at 5.30pm at City Hall as a hybrid meeting enabling remote participation via Zoom

P R E S E N T :
Councillor Kitterick (Chair)
Councillor March
Councillor Fonseca
Councillor Pantling
Councillor Whittle
Councillor Poland (substitute)
Councillor Grimley
Councillor King
Councillor Hack
Councillor Smith
Councillor Powell
Councillor Waller

In Attendance
Andy Williams Chief Executive ICS
David Sissling Chair ICS
Richard Lines EMAS
David Williams Exec Director LPT
Dr Janet Underwood Healthwatch
Richard Mitchel Chief Executive UHL
Harsha Kotecha Healthwatch
Richard Morris ICS
Caroline Trevithick LLR CCG
Jo Mckenna LLR CCG

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53. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Morgan and, Ruth Lake - Director of Adult Social Care.

It was noted that Councillor Poland was in attendance as a substitute for Councillor Morgan.

54. DECLARATIONS OF INTEREST

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

Councillor Hack declared an interest in that she worked for Advance Housing and Support in the Housing division providing accommodation and support in the Leicester, Leicestershire and Rutland area for individuals with Learning Disabilities and Mental Health Disabilities.

Councillor King declared an interest in that he was involved with the Carers Centre Leicestershire, a local charity providing help and support for unpaid carers across Leicester, Leicestershire, and Rutland.

For the purpose of discussion and any decisions being taken they retained an open mind and were not therefore required to withdraw from the meeting.

55. MINUTES OF PREVIOUS MEETING

It was noted that the minutes of the meeting held Tuesday 16th November 2021 omitted to include the presence of Councillor Waller and Councillor Pantling who were both present.

It was also noted that the minutes of the meeting held Tuesday 15th February 2022 omitted to include the presence of Councillor Pantling who was present.

AGREED:

That subject to an amendment to correct attendance of Members as referred to above, the minutes of the meetings held on Tuesday 16th November 2021 and Tuesday 15th February 2022 be confirmed as an accurate record.

56. PROGRESS AGAINST ACTIONS OF PREVIOUS MEETINGS (NOT ELSEWHERE ON THE AGENDA)

None outstanding.

57. CHAIRS ANNOUNCMENTS

The Chair announced a change to the running order of the agenda and agreed to take the Item Re-procurement of the Non-Emergency Patient Transport Service (NEPTS) as the next substantive item of business.

58. PETITIONS

The Chair informed those present that the response to the ICS Constitution petition submitted at the last meeting would be received as part of the substantive item Integrated Care System Update.

59. RE-PROCUREMENT OF THE NON-EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS)

Members received a presentation providing details around the re-procurement of the Non-Emergency Patient Transport Service (NEPTS)

Joanne McKenna, Head of Contracts and Procurement, LLR CCG introduced the presentation noting that certain details remained commercially sensitive and drew attention to the following points:

- Non-emergency patient transport within Leicester, Leicestershire and Rutland was currently provided by Thames Ambulance Service Ltd (TASL) providing around 15000 journeys per year. The current contract was due to end in September 22 but was being extended to enable feedback from stakeholders and to fully consider improvements for the new service.
- The new procurement was aimed at bringing services together to improve both quality of service to all patients and flow of patients through the healthcare system.
- Feedback was being sought from patient and service users as well as by provider engagement using a variety of tools e.g., online surveys, patient QAs, and discussions with service referrers; that feedback would be used to support the service specifications and a complete data report would be produced in April 2022.
- Internal stakeholder engagement showed there were good and bad experiences with the current system; generally service users had good relations with the drivers however the downside included long waits for journeys, resources not matching peeks in activity; delays in collecting discharges for time critical patients, patient appointments overrunning and the knock on effect of that on other patient services.
- The new contract would seek to include real-time patient updates to address issues of waiting, journey delay and pick-ups.
- Local guidance was also being developed to improve the user experience taking account of recently reviewed national guidelines.

Members discussed how the service would change; the improvements for patients; increased flexibility and the eligibility criteria as set out in the presentation.

Members noted the transport provision needed to be reflective of patients' needs and to progress with them. It was hoped that the frictions and issues experienced previously would be reduced through the long mobilisation phase of the procurement process. In terms of service change, it was advised response transport would be wrapped into the system such as Emergency Services as well as Outpatient Services, and providers would have to have special awareness and establish their own patient participation groups to understand the proposals, delivery plans, expectations etc.

Concerns were raised about the eligibility criteria: the lack of information/data in

that regard; the uncertainty around patients who had transport initially but not later; and ensuring the eligibility criteria was broad and inclusive.

Members were informed that NHS England and NHS Improvement had established a team to review and help standardise the approach in this area and they had developed updated national eligibility criteria following the published outcome of a review into non-emergency patient transport services (NEPTS). That was consulted upon in Autumn 2021 and the criteria was subject to final stages of development before publication of a final report in Spring 2022. Indicators were that the proposed new criteria were broadly consistent with LLR local eligibility criteria. The patient criteria may change, and a personalised approach could be adopted however the final procurement pack would feature all of these details and should be available by end April 2022.

In relation to the level of journeys commissioned each year, the new contract was bidding for 15,200 journeys but there was also a building in of growth through modelling of tenure of service and it was expected that the biggest area of growth over the period of the contract would be for patients travelling to and from renal dialysis.

In terms of cross border patient journeys, it was advised that the transport provider was responsible for all LLR users no matter where they were going however, it was noted that there were not always reciprocal arrangements in place with other areas.

As regards the procurement exercise, state of market and commercial viability, the CCG couldn't go into a great level of detail at this stage due to commercial sensitivity, however, sift testing showed that four or five national providers were likely to be interested and it was accepted that recent economic changes, cost of living and fuel increases were likely to be a factor in the process.

Discussion moved on to some of the challenges of transporting patients and how that was addressed. As to the flexibility of transporting patients and being able to cope with sudden changes or patient needs the service were looking to improve booking facilities and introduce online options to provide flexibility.

Regarding the longer term provision of transport for patients and the issue around patients ongoing mobility, the draft eligibility criteria referred to receipt of certain benefits, but the CCG were trying to avoid that being fixed and were looking to build into the service provision to take account of people at the time for a more holistic approach.

Consideration was given to ensuring a patients dignity and discussion progressed into complaints processes noting that patients did come to the CCG to raise complaints e.g., if they felt they had not been treated with dignity and they were supported by the CCG to try and reach a solution. The procurement specification would also build in clinical appeals process which would improve that part of the service too.

As for complaints about service delivery, those could also be sent to the

transport provider and there would be an opportunity to raise that externally if a service user was unhappy about the service and/or response from the provider. The Transfer of Care Initiative also gave the opportunity for people to raise concerns at handoffs and through system interface.

In relation to the engagement and feedback processes it was noted that the CCG had reached out to people using online surveys and had run focus groups for anyone to attend, this included young people however, there would be more engagement activity over the next month and the CCG would take back the point to engage with young people more.

The Chair summarised the points made, thanking officers for the presentation and drew discussion to a close.

AGREED:

1. That a copy of the final procurement pack containing eligibility criteria be shared with Members of the Committee as soon as it is available;
2. That the CCG take steps to ensure they involve young people in their processes to capture their voice around service provisions;
3. That the CCG provide Members of the Committee with a flow chart of the decisions being made to help understanding;
4. That an update report providing details of progress with the procurement exercise be brought to the Committee for November 2022.

60. QUESTIONS OR REPRESENTATIONS

The Chair explained the procedure to be followed and took public questions as follows:

From Steve Score: Will the public be consulted on the draft integrated care board constitution before it is finalised?

From Sally Ruane on behalf of Kathryn Jones: I have been trying unsuccessfully to find the papers taken by the shadow Integrated Care Board meetings in the papers for the CCG governing body meetings and am concerned about the lack of transparency. Please could you tell me where they can be found?

From Sally Ruane: Will the ICS Chair guarantee that the Integrated Care Board or any other local commissioner will pay for the emergency health care, including ambulance services, required by all people in its geographical area even if some of those individuals are visiting from other parts of the country?

The Health and Care Bill makes reference to the group of people for whom each integrated Care Board has core responsibility. Will the ICS Chair pledge that the Integrated Care System in Leicester Leicestershire and Rutland will abide by the principles of comprehensive and universal health care?

From Kathy Reynolds (read by the Chair on her behalf): At a previous meeting the LLR ICS explained that councillors were explicitly banned from sitting on

integrated care boards. In the House of Lords on 9th February Health Minister Lord Kamall, announced that NHS England will revise its draft guidance to remove the proposed blanket exclusion of councillors sitting on integrated care boards. What does this mean for the membership of the LLR ICS Board?

We know that the Designate CEO and Designate Chair have been appointed, have any other Designate Members been appointed and how will the selection process for board members change to allow selection of councillors?

From Godfrey Jennings: Please could you tell me why the draft integrated care board Constitution has not been to the joint health overview and scrutiny committee as is happening in several other parts of the country where good practice is being observed. When will the draft be brought to this committee before it is finalised?

From Jean Burbridge: At the January meeting of the Leicester City Health & wellbeing Scrutiny Committee, I asked the question whether social enterprises would sit on the Integrated Care Board and/or ICS Partnership. I have since discovered that there is already a social enterprise (namely DHU Health Care) represented on the shadow integrated care board, but I was not given this information in the response to my question. Please could you let me know if there are plans to include other social enterprises or "independent organisations" on the Integrated Care Board in either shadow or full form?

Andy Williams Designate CEO, ICS responded to the public questions as follows:
The LLR ICB constitution was based upon the national model and was still being developed. The national model was available on the NHS website and the only substantive change suggested to that was to broaden membership so it could include availability for local government representatives and local partners.

From April 2022 the board meetings would take place in public. ICS was not proposing to consult beyond what they had done already as they were following the national consultation and its outcomes. In relation to the shadow ICB meetings, minutes of those were taken through the LLR CCG and were available to the public.

Regarding councillors being included in the membership, the regulations had changed to enable this, and the selection process would be up to the local authorities/partner organisations to appoint their representees and further guidance was awaited around this.

In addition to the Designate CEO and Designate Chair appointments the ICS had appointed non-executive Directors and chosen their preferred candidates for remaining executive roles. The ICS were still awaiting government legislation before making partners.

Regarding social enterprises, DHU Health Care were a partner in the original CCG and shadow ICS arrangements however, that would not formally continue

once the board was established. It was noted that whilst they would not be part of the board when it went live, organisations like DHU Health Care were an important part of the system and positive engagement with them was necessary.

In terms of who paid for emergency health care, including ambulance services, required by people in a geographical area, there was already clear guidance around that; as a general rule the ICB would pay regardless of where persons were treated, however there were some exceptions. Core comprehensive and universal health care would be bound by the Bill and the ICS would work within that.

David Sissling, Chair of ICS then addressed a couple of points and commented that interest in the ICB's constitution was understandable, but it was a work in progress and subject to national guidance, however the ICS would be happy to share the template and invite observations in due course.

As to meetings, so far, the ICS had met as a partnership not as a board and were trying to progress as much as possible in shadow form with membership, structure etc before convening as a board from April 2022. ICS were already demonstrating that the quality of work was enhanced by collaboration and relationships were strong.

The Chair invited any supplementary comments/questions which included the following:

From Steve Score: the ICS/ICB was a major change to the way the NHS is run and making details public about board meetings was not the same as a full public consultation. It was suggested that wider involvement of the public would be better from the point of transparency.

Sally Ruane on behalf of Kathryn Jones noted frustration that Leicester City Health & Wellbeing scrutiny was informed papers of the shadow ICB meetings were in public domain and noted the clarification that the public could access minutes through CCG but not papers.

Sally Ruane expressed concerns around emergency care not being covered by the Bill and other possible gaps and sought to have categoric assurance that emergency care and ambulances would be fully covered by the Bill and that the ICB would pay. There was also concern about new core responsibilities, what that meant and whether it pointed towards core services and shrinkage if some services were not defined as core.

Andy Williams responded to the supplementary points that the ICS had tried hard locally to engage with people in the description and discussion of changes taking place, however this was totally driven by the national statutory agenda over which ICS has no discretion and where there has been any discretion and the ICS were minded to exercise that they have engaged on that before making initial submission e.g., more representation on the board.

Regarding access to papers, it was confirmed the minutes of the shadow board meetings are available through the LLR CCG and from April 2022 all papers will be made available as the ICB meetings will be held in public.

In relation to emergency care the scope and remit of ICB will be determined in the final analysis of legislation. There was no reason to believe there was any intent to be unclear on budgets or funding for emergency care and there was no intention for ambiguity. The core responsibilities were a matter of drafting and for government to determine the remits of ICB, but the ICS was not aware currently of any attempt to use this to restrict access to services.

The Chair expressed concern that this committee was being taken up with question/answer sessions that should really be de facto fulfilled by the ICB and queried whether there would be facility at the ICB meetings to include a mechanism for public questions. David Sissling, Chair of ICS confirmed that intention was one of the first matters for board to facilitate public question and answers or appropriate arrangements at meetings and during the preparatory period the board would discuss that point. The Chair welcomed that transition moving forward and thanked representatives of ICS for their responses.

61. INTEGRATED CARE SYSTEM UPDATE

Members received a report providing an update on progress towards the Leicester, Leicestershire and Rutland Integrated Care Board.

The Chair invited Members comments which included the following points:

Concerns were expressed about accessibility of documents, and the impact of that, for example limiting the opportunity for disabled people to respond to consultations/engagements so losing a valuable voice. A request was also made to ensure that all future reports and documents submitted to this committee were fully accessible not just easy read.

Andy Williams Designate CEO of ICS apologised for the difficulties with accessibility of all documents and agreed to investigate this issue as the ICS was keen to avoid disenfranchising any groups.

Concerns about how the voluntary sector would be engaged considering the gap in voluntary sector emerging across LLR were noted and the ICS would reflect further as to whether there was more, they could do to strengthen that.

In relation to engagement with non-public bodies, the ethos was to move towards integrated care systems and away from tendering/market based procurement however, for a variety of reasons there was a lot of important involvement with organisations, and they tried to do that appropriately. Relations with all partners were important to deliver services, including with private sector, and there would be times when the ICS needed to work in active partnership with non-public bodies, but they wanted to be very transparent around that and it was not envisioned there would be any non-public body

involved in governance or as part of the ICB, that included any it's sub-committees. In respect of service delivery or bringing something back within public delivery that was a possibility for ICS, but it had to be what was in interest of the public, and the ICS would have greater discretion moving forward.

In terms of councillors being able to sit on ICB, the board was being formed to include local authority membership and the three local authorities (Leicester, Leicestershire, and Rutland) would determine their own nominations whether that be councillors or a specific role/officer.

Andy Williams confirmed that it was intended for the Healthwatch Chairs across LLR to be invited to ICB meetings as non-voting members.

The Chair thanked Andy Williams for the update.

AGREED:

That the contents of the report be noted.

62. COVID 19 AND VACCINATION PROGRAMME UPDATE

Caroline Trevithick of LLR CCG provided an update on the ongoing situation with Covid 19 and the vaccination programme including recent data and emerging patterns across Leicester, Leicestershire, and Rutland.

Members noted that:

- Uptake had slowed considerably and focus was on progressing vaccination uptake among those in population that haven't had any vaccination; steps taken included opening more drive through centres i.e., at County Hall and across parts of the city and districts to make vaccination process more accessible.
- Roll out of the 2nd booster (4th dose) to over 75 years had started and those clinically vulnerable who had 3rd dose were now eligible for a 4th.
- Planning for Autumn was underway as well as for roll out of boosters should that be required.
- There were still some high numbers of covid patients in hospital and people being tested positive in hospital as a secondary issue.
- Uptake among 5-11 year olds was proving difficult as there was a lower willingness for parents to allow children to be vaccinated.
- 81% of population of LLR had now received a 1st dose and care home uptake was the best in region for boosters however, there were significant differences spread across LLR and it was agreed to share data by CCG cohorts for City, County East and West.

The Chair noted that there had already been significant discussion on this topic at the recent Leicester Health & Wellbeing Scrutiny Committee and invited Members questions and comments which included the following points:

Concerns were expressed at the low uptake levels among younger age groups, the lack of information being provided to parents to help them make informed

choices about the pros and cons of the vaccination and the scarce details around immunity e.g., in younger people that had already had Covid or for those that had a vaccination some time ago.

In response it was advised as regards the 5-11 year old group there was national recognition that delivery of vaccination in schools puts lots of pressure on small immunisation teams and stops parents getting their child vaccinated when they want so there was a different model being applied. There remained a vaccination programme in secondary schools and for any 11-12 years that missed the 1st programme details were on CCG websites about catch up vaccinations. As for pros/cons of vaccinating the main message remained that vaccination helped reduce the spread and severity of the illness particularly amongst those more vulnerable.

In terms of immunity, the understanding was that for those over 75 years immunity does wain at around 6 months and so boosters were encouraged.

It was acknowledged that messages around Covid had gone quiet nationally and locally and the CCG were looking to fill the communications gap. There was a large amount of concern about anti-vaxing and the impact of that on other vaccine programmes across the country and CCG were also looking at systematic targeted approaches to address that.

The Chair thanked health partners for the update and recommended colleagues to read the recent report to the City Health & Wellbeing Scrutiny Committee by Ivan Browne.

AGREED:

That data by CCG cohorts for City, County East and West be shared with the Committee.

63. UPDATE ON GENERAL ACTIVITIES AT UNIVERSITY HOSPITALS LEICESTER

Richard Mitchell, Chief Executive Officer at university Hospitals Leicester (UHL) was introduced to the Committee as the Chief Executive in post since October 2021.

Richard Mitchell provided a verbal update around 5 themes which included the following points:

Covid

There were currently 210 patients in UHL across 10 wards, of these 85% were presenting with Covid as a secondary diagnosis. As for staff, 10% were currently off with Covid too.

Waiting Lists

Acknowledged that waiting times had deteriorated and had been worsened during the Covid situation. Some progress had been made over last 6 months

to reduce the waiting times for Elective Care although given length time of closures there were still very high volumes and Leicester was amongst worse in country and they were looking to address that.

Emergency care performance had been very challenged at Leicester; Covid was still making it more difficult, and the hospital was focusing on discharge pathways to improve the situation.

In relation to cancer care patients were waiting longer than pre-covid, however waiting times were overall within the safety marker but the hospital was keen to get back to where they were and to improve.

Senior Staffing

There had been a number of changes since October 2021 with Richard Mitchell taking up the CEO role following John Adler's retirement. Three executive director vacancies had also been recruited to and 4 non-executive directors had joined. The Board chaired by John McDonald were looking to fill other senior appointments over next 3 months.

UHL Finances

The annual accounts for the financial year 2019-202 were still not signed off, although they had now been presented to the audit board and were due to be taken to the public board next week. The annual accounts for financial year 2020-2021 were also due to be taken to the public board next week and the hospital hoped to be exiting the Recovery Support Programme (RSP) around October 2022.

UHL Reconfiguration

As part of national strategy UHL was lucky to be one of eight pathway trusts on the reconfiguration programme. Members were reminded that there were four pillars to the programme, a dedicated Children's Hospital; restructuring of the Intensive Care Units from three to two due to be completed in May 2022; reconfiguration of Maternity services to two units; and finally the separation of elective/emergency care, this was awaiting final confirmation around receipt of £37m to help facilitate that.

Members discussed the update which included the following points:

There were concerns that the concentration of services around Glenfield Hospital was problematic for residents in south Leicestershire and it was accepted that access to Glenfield could be difficult, but UHL wanted to work with people to address those issues e.g., through development of a travel plan.

It was commented that despite the reconfiguration plans and the large amount of monies involved that was not addressing the waiting list issues mentioned or the waits for other services e.g., musculoskeletal conditions and assurance was sought that was being addressed. In response it was advised that in January UHL had been able to reopen orthopaedics; 9% of the waiting lists were related to musculoskeletal conditions, in comparison to pre covid there would have been less than 10% of patients who were waiting more than 12 months to be seen, unfortunately since covid and the length of time that certain

services were restricted UHL were now a long way from getting patients waiting under 2 years. In terms of numbers on waiting lists, those were growing and continued to do so with a forecast they would grow nationally to 12+ million so waiting lists at UHL were also likely to go up but importantly for those who were waiting a long time the length of time spent waiting was now reducing.

In relation to cancer care patients, it was recognised that long waits could have detrimental impact on patients and assurance was given that the 14 day and 62 day referral/treatment rates had improved, patients were being clinically prioritised and cancer markers used and it was affirmed that Leicester, Leicestershire and Rutland were not an outlier in terms of its cancer care.

There was dissatisfaction that the hydro facility at the General Hospital had remained closed since covid and those using it to maintain conditions had nowhere to go during that time and no effort made to repair or restore that facility

Members expressed their disappointment that a range of subjects had been covered on a verbal report preventing them the opportunity of fully scrutinising points about topics, particularly as they hadn't been updated on progress with things like the reconfiguration programme for some months.

Members noted it was reported that a lot of staff were off with covid, and more details of that impact were sought as well as steps being taken to ensure staff wellbeing. Members were informed UHL staff were an important priority and there was a variable range of services in place to support them, among the basics it was crucial that staff had ability to take breaks, were supported to eat well, provided with lockers and had working equipment. However, people were tired and there was trauma arising from the effects of the pandemic as well as the ongoing transmission of the virus.

Discussion progressed onto the reconfiguration programme. Members were told that the reconfiguration programme had been approved and conversations had taken place today with the government around the business case. Leicester UHL was now 1 of 8 organisations waiting to move to the next stage. Members asked for clarity that the £450m had been approved by the Treasury and queried any current estimated shortfall or changes to the reconfiguration proposals. It was advised in terms of estimated shortfall there had been conversation with government around increased construction cost, and they were looking at ways forward to secure the money for that.

Members were not satisfied that the £450m had been formally approved by the Treasury and were uncertain as to the hospitals final reconfiguration plans or whether there would be changes to those due to increasing costs. There followed a strong discussion in which Members raised concerns they had not been advised previously about such approval and they were not assured by what was being said at this meeting.

Richard Mitchell clarified and reiterated that:

- the reconfiguration programme still had 4 pillars, namely the 3 into 2

intensive care; reducing maternity departments from 2 to 1; a stand-alone children's hospital and separation of elective/emergency care.
- the Treasury had committed to £450m as stated.
- UHL had not received confirmation that capital was extended beyond £450m but the wider context was that construction costs, resources and supplies etc had gone up.
- there was an ongoing discussion with government for additional funds to meet the uplift costs.

The Chair drew further discussion on the reconfiguration to a close and requested more detailed information about the status of the reconfiguration bid be provided to the Chair/Vice Chair and Rutland representative outside this meeting.

AGREED:

1. That Health Partners provide detailed information on current status of reconfiguration bid to the Chair, Vice Chair and Rutland representative as soon as possible.
2. That a briefing be convened as soon as possible for Chair, Vice Chair and Rutland representative with Andy Williams, Richard Mitchell, and Angela Hillery to ascertain position and progress with reconfiguration.
3. That future updates to the committee be by written report and to include any data in a written digest.
4. That the Committee at a future meeting have opportunity to scrutinise the £46m misstatement of accounts and to explore what the systemic failures were, and any measures put in place to avoid that happening again.

64. EMAS - NEW CLINICAL OPERATING MODEL AND SPECIALIST PRACTITIONERS

Members received a report providing an update on the EMAS Clinical Operating Model and introduction of Specialist Practitioners.

Richard Lines Divisional Director EMAS introduced the report providing insight into the background of the Clinical Operating Model review and the three areas of focus: the clinical model; clinical hub and clinical leadership.

It was noted:

- one of the outcomes of the review was the introduction of specialist practitioners to enhance delivery of clinical care; six were recruited initially in September 2020 with an additional 12 in 2021 allowing for 24/7 cover across the division (Leicester, Leicestershire, and Rutland).
- alongside clinical outcomes there had been a reduction of burden on emergency departments in Leicestershire as specialist practitioners were mainly focused on chronic patients which avoided admissions into hospital.
- as fast responders specialist practitioners also dealt with cardiac arrests, their role at cardiac arrest was to lead rather than be hands on, providing clinical leadership for ambulance/paramedic crews with the

aim of getting patients to the right care.

Members welcomed the report and the positive outcomes, and the ensuing discussion included the following points:

In relation to any concern that ambulance crews might be waiting for a specialist practitioner to arrive, it was not the case that they would be waiting for a specialist as calls were prioritised and appropriate crews responded e.g., in terms of despatch a cardiac arrest would take priority and where necessary a paramedic would be sent if that gave a quicker response time. Typically, a call in categories 3 or 4 would have a 4-6 hour waiting time.

Specialist practitioners were a specific resource providing additional roles to support the existing provision and there had not been any reduction of other ambulance provision. The number of specialist practitioners was being steadily increased and EMAS were looking at the possibility of different roles within that, i.e., specialists in an area.

Members queried whether there were any increased risks associated with carrying additional end of life drugs by the specialist practitioners. It was advised that all crews carried a range of drugs which were all logged with limited accessibility. There were very few incidents upon staff for purpose of obtaining drugs.

The Chair thanked Richard for the update.

AGREED:

That the contents of the report be noted.

65. INTERIM UPDATE ON LPT RESPONSE TO CQC INSPECTION - DORMITORY ERADICATION PROGRAMME

Members received a report providing an update around the dormitory eradication programme.

It was noted that

- In 2018 four specific wards were identified to be changed and £9.2m provided to make those changes to improve safety and ensure dignity of patients, this also helped with infection control especially during the covid pandemic
- 3 out of the 4 wards identified had been completed as highlighted by CQC in their inspection and work on the 4th had started and would be completed by next year.

Members viewed images of the improvements to the wards noting they were brighter, more attractive and provided patients privacy which also helped improve their mental health. Improvements included the wards being painted throughout, improved Wi-Fi signals, replacing staffing call points, and roll out of wrist bands for patients which was another feature captured in the CQC inspection last year.

It was noted that feedback had been gathered from patients and staff resulting in the latest installation of modern doors using most recent technology which could indicate if someone was looking for a ligature point and also anti-barricade.

Members expressed some concern about the impact of the programme on the number of bedspaces. It was advised that 27 bed spaces (from a total of 247) had been lost, all but two of those were in older people wards but the plan was to return to the original number of beds and a bid had been made to support that with the outcome expected in July. In terms of impact, the situation was unchanged as it was always a difficulty to get people into beds and the shortage was a national issue. To address the issue there was now more emphasis on community services in first instance and trying to prevent hospitalisation.

As far as the programme of works, scope for slippage had been built into the programmes, although there were risks within projects of this scale and size. The main concerns were around supply chain in general and long lead in times which made it difficult to switch supplier. The current economic situation and rise in inflation was adding to price. Funds for the programme were based on initial costs but that included a small contingency and at the moment the programme was on target and within budget.

Reference was made to discussion at the last meeting which talked about the wider issues arising from the CQC inspection and its findings. As regards the challenge around the Trust being given a Requires Improvement (RI) rating it was important to note the inspection related to only 3 core services out of 15 core services. It was also noted that the report at this meeting was only in relation to the dormitory programme, although acknowledged that across the wider estate the dormitory programme was a significant reason why the ratings were the way they were. Members were informed that the CQC visit was nearly a year ago and a lot of progress had been made by the Trust since, e.g., maintenance issues had been reduced 75%. The CQC had also revisited recently and were happy with the progression and improvements and would be writing to that effect soon.

It was queried how long an average stay was at the Bradgate Unit and how the programme might impact on that. It was responded that there were different ward settings across the bed base with facilities depending on a patient's condition, e.g., acute wards and long stay rehabilitation. Phasing of the dormitory eradication programme took a very clear staged approach for safety of patients.

The Chair summarised the discussion noting the committees interest in an update around work done by the Trust to address workplace culture and confirmed the committees support for the bid for additional funds to support regaining bedspaces and asked for the outcome of the bid to be informed to the committee in due course.

AGREED:

That an update on progress of all matters arising from outcomes of the CQC inspection and including the dormitory eradication programme be reported to the committee at its November meeting.

66. TRANSFORMING CARE IN LEICESTER, LEICESTERSHIRE AND RUTLAND - LEARNING DISABILITIES UPDATE

Members received a report providing an update on the partnership work across Leicester, Leicestershire and Rutland to deliver improved performance and outcomes for people living with a learning disability or autism.

David Williams Executive Director of Strategy & Partnerships, Leicestershire Partnership Trust introduced the report setting out what had been achieved so far, this included successes e.g., less people in long-term hospital now than in 2015; when working together to avoid a crisis admission was avoided 79% of the time; the culture and improvement journey so far and LPT's future vision. Attention was also drawn to opportunities over the next 12 months to further develop.

Members commented that conditions such as autism still took a long time to get a diagnosis and were often missed at schools, although the report had some positive outcome in relation to autism there was still more help needed in the community to better understand these conditions and it was queried whether support to schools was extended to further education and parents of those in further education.

Regarding early identification and support, it was advised the government was investing in mental health in schools, and there was joint funding for LPT, and education being used towards supporting identification; schools and teachers as well as a key programme with Barnados to give families support.

Concern was expressed that the report was lacking in details or data and gave no information about the level of support available during transition from child to adult or once a person with autism reached 18 years old and it was emphasised that this was a lifelong condition but as an adult there was little support especially for those who were more cognitive or able to hold a job.

Members were reminded that this was a joint report of the SRO and there were additional services and launched specialist NHS services available. As regards the points made about employment, this was a whole society issue and required working together, some conversations were taking place about how to make LA health more anchoring and there had been progression, but this was part of a wider improvement journey.

The Chair thanked health partners for the report and indicated it would be helpful to have a more detailed report to a future meeting.

AGREED:

That a further report around Transforming Care in Leicester,

Leicestershire and Rutland – Learning Disabilities, to include more information and supporting data be brough to a future meeting.

67. MEMBERS QUESTIONS ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA - IF ANY

None received.

68. WORK PROGRAMME

Members received and noted the current work programme.

69. DATES OF FUTURE MEETINGS

Future meetings of the committee for the municipal year 2022-23 were noted as follows:

- Monday 27th June 2022 at 5.30pm
- Wednesday 16th November 2022 at 12 noon
- Wednesday 12th April 2023 at 5.30pm

70. ANY OTHER URGENT BUSINESS

None notified.

There being no further business the meeting closed at 9.20pm.