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

DATE: **MONDAY, 28 MARCH 2022**
TIME: **5:30 pm**
PLACE: **Meeting Room G.01, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Leicester City Council

Councillor Kitterick (Chair of the Committee)
Councillor Aldred
Councillor March
Councillor Dr Sangster
Councillor Fonseca
Councillor Pantling
Councillor Whittle

Leicestershire County Council

Councillor Morgan (Vice-Chair of the Committee)
Councillor Bray
Councillor Grimley
Councillor King
Councillor Ghattoraya
Councillor Hack
Councillor Smith

Rutland County Council

Councillor Harvey
Councillor Waller

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:
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Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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Further information

If you have any queries about any of the above or the business to be discussed, please contact Anita James**, Democratic Support on (0116) 454 6358 or email anita.james2@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

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USEFUL ACRONYMS RELATING TO
LEICESTERSHIRE LEICESTER AND RUTLAND JOINT HEALTH SCRUTINY COMMITTEE

Acronym	**Meaning**
ACO	Accountable Care Organisation
AEDB	Accident and Emergency Delivery Board
AMH	Adult Mental Health
AMHLD	Adult Mental Health and Learning Disabilities
BMHU	Bradgate Mental Health Unit
CAMHS	Children and Adolescents Mental Health Service
CHD	Coronary Heart Disease
CMHT	Community Mental Health Team
CVD	Cardiovascular Disease
CCG LCCCG ELCCG WLCCG	Clinical Commissioning Group Leicester City Clinical Commissioning Group East Leicestershire Clinical Commissioning Group West Leicestershire Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CTO	Community Treatment Order
DTOC	Delayed Transfers of Care
ECMO	Extra Corporeal Membrane Oxygenation
ECS	Engaging Staffordshire Communities (who were awarded the HWLL contract)
ED	Emergency Department
EHC	Emergency Hormonal Contraception
EIRF	Electronic, Reportable Incident Forum
EMAS	East Midlands Ambulance Service
EPR	Electronic Patient Record
FBC	Full Business Case
FYPC	Families, Young People and Children
GPAU	General Practitioner Assessment Unit
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HWLL	Healthwatch Leicester and Leicestershire
IQPR	Integrated Quality and Performance Report

JSNA	Joint Strategic Needs Assessment
NHSE	NHS England
NHSI	NHS Institute for Innovation and Improvement
NQB	National Quality Board
NRT	Nicotine Replacement Therapy
OBC	Outline Business Case
PCEG	Patient, Carer and Experience Group
PCT	Primary Care Trust
PDSA	Plan, Do, Study, Act cycle
PEEP	Personal Emergency Evacuation Plan
PICU	Paediatric Intensive Care Unit
PHOF	Public Health Outcomes Framework
PSAU	Place of Safety Assessment Unit
QNIC	Quality Network for Inpatient CAHMS
RIO	Name of the electronic system used by the Trust
RN	Registered Nurse
RSE	Relationship and Sex Education
SOP	Standard Operating Procedure.
STP	Sustainability Transformation Partnership
TASL	Thames Ambulance Service Ltd
UHL	University Hospitals of Leicester
UEC	Urgent and Emergency Care

PUBLIC SESSION

AGENDA

NOTE:

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1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda.

3. MINUTES OF PREVIOUS MEETING **Appendix A (Pages 1 - 26)**

The minutes of the meeting held on 16th November 2021 and the special meeting held on 15th February 2022 are attached and the Committee will be asked to confirm them as a correct record.

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

5. CHAIRS ANNOUNCMENTS

6. PETITIONS

The Monitoring Officer to report on the progress of any petitions submitted in accordance with the Council's procedures.

Response to ICS Constitution petition to be received.

7. QUESTIONS OR REPRESENTATIONS

The Monitoring Officer to report on the receipt of any questions, or representations in accordance with the Council's procedures.

The following questions have been received:

From Steve Score
Q1 Will the public be consulted on the draft Integrated Care Board constitution before it is finalised?

From Kathryn Jones
Q1 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 Kathy Reynolds
Q1 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?

Q2 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 Jean Burbridge:
Q1 At the January meeting of the Leicester City Health Overview and 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?

From Sally Ruane
Q1 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?

Q2 The Health and Care Bill makes reference to "the **group of people** for whom each [Integrated Care Board] has **core** responsibility" (emphasis added). 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 Godfrey Jennings
Q1 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?

8. INTEGRATED CARE SYSTEM UPDATE **Appendix B (Pages 27 - 30)**

Members to receive a report that provides an update on progress towards the establishment of the Leicester, Leicestershire, and Rutland Integrated Care Board.

9. COVID 19 AND VACCINATION PROGRAMME UPDATE

Members to receive a verbal update on the current position around Covid 19 and the ongoing vaccination programmes.

10. UPDATE ON GENERAL ACTIVITIES AT UNIVERSITY HOSPITALS LEICESTER

Members to receive a verbal update on general activities regarding University Hospitals Leicester (UHL).

11. EMAS - NEW CLINICAL OPERATING MODEL AND SPECIALIST PRACTITIONERS **Appendix C (Pages 31 - 34)**

Members to receive a report providing an update on the East Midlands Ambulance Service (EMAS) Clinical Operating Model and introduction of Specialist Practitioners.

12. RE-PROCUREMENT OF THE NON-EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS) **Appendix D (Pages 35 - 48)**

Members to receive a presentation that provides details around the re-procurement of the Non-Emergency Patient Transport Service (NEPTS).

13. INTERIM UPDATE ON LPT RESPONSE TO CQC INSPECTION - DORMITORY ERADICATION PROGRAMME **Appendix E (Pages 49 - 60)**

Members to receive a report that provides details of the dormitory eradication programme together with a brief update on the LPT response to CQC inspection.

14. TRANSFORMING CARE IN LEICESTER, LEICESTERSHIRE AND RUTLAND - LEARNING DISABILITIES UPDATE **Appendix F (Pages 61 - 68)**

Members to receive a report that provides details of the Transforming Care programme in Leicester, Leicestershire and Rutland - Learning Disabilities update.

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

None received.

16. WORK PROGRAMME **Appendix G (Pages 69 - 74)**

Members will be asked to note the work programme and consider any future items for inclusion.

17. DATES OF FUTURE MEETINGS

Members will be asked to note the dates of future meetings as follows:

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

All meetings to take place at City Hall unless otherwise notified.

18. ANY OTHER URGENT BUSINESS

Appendix A

Leicester
City Council

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

Held: TUESDAY, 16 NOVEMBER 2021 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 Morgan – Vice-Chair
Councillor Fonseca
Councillor Grimley
Councillor Hack
Councillor March
Councillor Smith
Councillor Whittle

In Attendance:
Andy Williams – Chief Executive, ICS
Caroline Trevithick Leicester CCG
Kay Darby Leicester CCG
Ruth Lake – Director of Adult Social Care & Safeguarding
Rose Marie Lynch – NHS England and NHS Improvement
Elaine Broughton – Head of Midwifery
Allan Reid – NHS England
Sarah Prema – Leicester CCG
Richard Mitchell – UHL
Floretta Cox – Midwifery service
Dr Janet Underwood – Healthwatch Rutland
Mukesh Barot – Healthwatch Leicester

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31. CHAIRS ANNOUNCEMENTS

The Chair welcomed those present and led introductions.

The Chair mentioned the following matters:

- a separate Member briefing on the UHL statement of accounts was to be arranged by virtual means and communicated to Members as soon as possible.
- the recent report from the Care Quality Commission was to be brought

to both City and County scrutiny committees; Members suggested it would be better to come just to this joint committee. Chair agreed to look at arrangement of dates outside this meeting.

32. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Bray, Councillor Whittle and Councillor Smith.

It was noted that Councillor Poland was present as a substitute for Councillor Smith.

33. DECLARATIONS OF INTEREST

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

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

Councillor Waller declared that she was a Trustee at the Carlton Hayes Mental Health Charity.

Both gave assurance that they retained an open mind for the purpose of discussion and any decisions being taken and were not therefore required to withdraw from the meeting.

34. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 13th September 2021 be confirmed as an accurate record.

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

It was noted that health partners had offered a meeting outside this committee to explain responses to Councillor Harveys previous questions on post-partum figures in more detail.

36. PETITIONS

The Monitoring Officer reported that no petitions had been received.

The Chair agreed to a change in the running order of the agenda to take the item on Dental Services in LLR; NHS England & NHS Improvement Response next.

37. UPDATED REPORT ON DENTAL SERVICES IN LLR; NHS ENGLAND & NHS IMPROVEMENT RESPONSE TO HEALTHWATCH SEND REPORT

5.50pm The Chair agreed to a short adjournment to resolve technical and audio issues with participants joining the meeting via Zoom for this item.

5.58pm Meeting resumed.

The committee received an updated report in relation to dental services commissioned across Leicester, Leicestershire and Rutland and an overview of the ongoing Covid 19 pandemic effects on those services as well as the steps being taken to restore and recover service provision.

Rose Marie Lynch, Allan Reid, and Catriona Peterson from NHS England were present to provide responses to any points raised.

Rose Marie Lynch, NHS England and NHS Improvement briefly introduced the report summarising key points which included:

- An overview of the background and clarification as to how NHS dental care was provided;
- Details of dental contracts in place across Leicester, Leicestershire, and Rutland as wells as extended or out of hours cover and secondary care;
- NHS dental care access was routinely at around 50% of the population, and dental practices had a duty to see people who needed treatment, however the number of people attending private services is not known;
- The timeline for impact upon dentistry of the pandemic was referred to as set out in the report together with the ongoing impact and effects;
- Significant impacts were largely due to measures introduced around infection prevention control and the national guidance that dental practitioners had to adhere to, e.g., introduction of “downtime” a period where the surgery must be left empty following any aerosol-generating procedure (AGP) i.e., fillings, root canal treatment or surgical extraction.
- Information about the Urgent Dental Centres (UDC’s) provision and Urgent Care pathway was noted. Four urgent dental care centres (UDC’s) established during pandemic remained in place across Leicester, Leicestershire, and Rutland; their openings offered optimum coverage with a pathway to access through general dental practices or the 111 service.
- Since the pandemic schemes had been commissioned with purpose of increasing patient provision and to enable additional activity at weekends, this had led to availability of 152 additional sessions for dental treatment. Providers had also been engaged to provide dedicated slots to the 111 service generating an additional 56 appointments each week across LLR for urgent treatment.
- NHS England were now looking at commissioning a child access team as it was recognised children’s oral health and routine dental care had been impacted by the pandemic.
- Steps were also being taken to invest in adult oral health and to address oral health inequalities.

Allan Reid, NHS England provided further details regarding oral health in Leicester, Leicestershire, and Rutland during which it was noted that:

- Based upon the last national survey of 5 year old state school pupils (2021) Leicester City had the 2nd highest childhood tooth decay levels in the region. Within Rutland, child decay was slightly higher than the regional and national average and in Leicestershire, Charnwood district had the highest tooth decay rates in the county.
- Charts within the report set out the prevalence of dental decay in 5 year olds by ward areas and included profile areas where action was to be targeted.
- Priorities and actions to tackle children's dental decay included school initiatives such as increasing access to supervised toothbrushing in nursery and school settings and upscaling of prevention measures.
- Regarding adult oral health, the focus was on oral cancer, Leicester was seen as a hotspot with diagnosis and death rates consistently higher than the national average, that was felt to be related to tobacco use and areas of deprivation. National oral cancer registration rates showed Leicester at 23/100,000 population compared to national rate of 15/100,000 and that also caused concern for impact on dental services in terms of early care.

Members discussed the report and there was some surprise at the differentiation in the rates of dental decay especially in areas where the demographics might be considered the same and/or where there was less deprivation than in the city e.g., Queniborough compared to Quorn. It was also noted that in the city the Beaumont Leys ward had comparatively good figures compared to Spinney Hills ward, yet both had lower socio-economic levels in terms of deprivation, and it was queried whether any research had been done into why areas with the same demographics or socio-economic backgrounds were so different and whether this related to access to services and if so, the steps being taken to address that.

It was advised that geographically the survey could be dealing with very small numbers, with cohorts as low as 15 in some areas and that could account for some of the differential between areas, especially those of a similar demographic. Sampling was done using a detailed sampling framework, however, there was also the issue of consent and sometimes the consent rate level was lower, therefore the minimum number being sampled in an area could be 15 but in practice it was usually up to 30 children sampled.

Members questioned the age of the data and its reliability and queried when more recent data would be available. It was explained that in terms of timeliness the survey was carried out every 2 years, the age of the children sampled was varied every 2 years and it was noted the last survey conducted was of 3 year olds and the next would be young people aged 12 years. Conducting the survey involved a massive collation of data and school access for sampling. It was noted that the survey due to take place last year had been postponed due to the Covid 19 pandemic.

Members discussed the level of access to dental services and expressed

concerns that people in some areas were not able to access urgent dental treatment and that there was ongoing delay in returning to routine dental care. It was queried whether there was any over mapping of where services were available and where people were accessing services. It was also questioned why the Oakham UDC had been closed.

In response it was noted that UDC's were part of the covid urgent dental care systems set up when it was known that general dental practices were closed. Specific practices were chosen on contracted open hours and their geographical spread. Existing dental practices were now reopening for urgent treatment but with measures in place to comply with government guidance. With regards to South Leicestershire there was not currently a contract in place that met the needs of the urgent care practices set up for covid but there were other dental practices there.

In relation to Oakham, the general dental practice was still practicing and the nearest UDC was in Hinckley. A UDC was initially mobilised in Oakham but analysis of patient referrals and usage showed there was little uptake in the area, so it was relocated to Hinckley where more need was identified.

Regarding the commissioning and provision of dental practices, this was targeted at areas of highest need wherever possible, and surveys were used to determine if there were gaps in areas. The Oral Health surveys pre pandemic had not highlighted any gaps in provision. It was accepted there was an issue accessing dentists at the moment, and it was about managing the expectations of the public and restoring those services. The availability of routine check-ups remained likely to be limited only to vulnerable people and those with ongoing dental issues but the number of providers recalling patients for routine check-ups continued to increase.

Members were concerned that the situation regarding child dental decay did not appear to be improving and with the impact of the pandemic, dentists closed for routine appointments and people unregistered for dental care the situation looking forward would deteriorate further. Members also noted that the data around trends did not include Rutland.

Allan Reid, NHS England apologised for the omission of data relating to Rutland and undertook to provide this outside the meeting. It was advised that the data used to look at trends went back to 2008 and this did show an improvement across all of Leicestershire, and it was expected that would be replicated across all areas. Data from the most recent survey of 3 year olds would be available in Summer 2022 and would be analysed for any trends.

Members considered the information around LLR dental service performance and challenged the statement that 50% of people were accessing NHS dentists while dental practices were being charged with dealing with 60% of Units of Dental Activity (UDA's) suggesting that equated to just 30% of people across LLR being able to access dental services.

Members expressed their dissatisfaction that dental service performance

showed dental practitioners were not delivering 60% UDAs, but they continued to receive 100% monies towards cost of operating services. There was also disappointment at the lack of clarity to address the backlog of patients who had missed out on routine appointments and non-urgent treatment, and it was noted that there was no time indicator yet of when there would be 100% restoration of services.

The issue of people accessing private dental care provisions through lack of choice and because of necessity was raised and it was queried why private practice were able to continue providing routine appointments and treatment if they had to comply with the same government guidance.

Members were informed that private practices allowed more time for their patient appointments and that was a key factor. NHS practices worked at a higher rate, and it was more difficult for them to see volumes of patients under the current guidelines.

In relation to LLR provider delivery of contractual activity and the figures in the chart it was clarified that the chart did not show how big a contract was, e.g., a small practice might only see a few patients a day, and other reasons such as single handed practitioners and having to keep appointments to an hour. There was also the knock on effect of areas with higher levels of decay requiring treatment which required higher downtime between appointments.

In relation to vulnerable groups and especially those with learning disability it was advised there was SEND work locally within local health steering groups around improving access. Data was recorded regarding dental access, and it was recognised that needed to be better and NHS England had been explicit on the need to prioritise vulnerable groups. In terms of any statutory entitlement, it was noted that although it was a priority and there was an annual health check requirement there was no statutory entitlement.

It was noted that the Healthwatch report was focused on aspects around the SEND pathway and a detailed response to the recommendations within that report was requested. The Healthwatch report had been shared with health partners and the recommendations were being considered along with steps that could be taken to form an action plan.

Discussion progressed onto Adult Oral Health, and it was queried whether some of the checks around oral mouth cancers could be conducted by other health practitioners if people were not seeing dentists.

Allan Reid, NHS England explained that regular oral checks might pick up issues such as a non-healing ulcer and that could be picked up by care home staff for example, they could then notify a GP to look at that or make a referral to dentist. However, whilst such issues could be identified and noted a confirmed diagnosis had to come from the centre i.e., dentist. It was suggested that further consideration should be given to oral checks being conducted by someone other than a dentist as GP practices may be aware of patient lifestyles and perhaps could factor in surface level checks for people at risk

especially those not accessing dental practices.

Drawing discussion to a conclusion the Chair identified that the mapping of need for dentistry services did not. The Chair commented that although this was a vastly improved report to that received previously it did expose issues and there was concern that it could not be described where gaps in provision were across Leicester, Leicestershire and Rutland. The Chair expressed interest in seeing where this would fit into place based plans of the Integrated Care System in future.

AGREED:

1. That the missing data in the report regarding Rutland statistics be shared with members as soon as possible outside this meeting;
2. That a detailed response on SEND pathway access be shared with members outside this meeting as soon as possible;
3. That a written update be provided to Healthwatch in relation to the recommendations within their report and a copy of that provided to the Chair and Vice Chair of this Committee;
4. That an update report on Dental Services in LLR be brought to a meeting of the Committee in 6 months, to include input from ICS on place based plans and further detail on recovery rates and progression since the last update.
5. That consideration be given to mapping the needs in dentistry services to identify the gaps in provision across LLR.

38. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Chair explained the procedure to be followed for taking questions from the public and indicated that questions relating to the Integrated Care System could be taken under that item on the agenda.

The Chair took public questions as follows:

From Giuliana Foster

1. Has a decision been made by the Treasury or Dept of Health regarding the funding of the UHL reconfiguration scheme. If so, what is the decision? If not, when is this decision expected?
2. University Hospitals of Leicester judges that a) some of the information in the templates returned to the National Hospital Programme team setting out alternative versions of the Building Better Hospitals for the Future Scheme was commercially sensitive and b) that it is not in the interest of the public to have this information. What type of information was provided in the templates retuned to the National Hospital Programme team which was considered commercially sensitive?

It was noted that a representative of UHL was not present who could provide a response to these questions.

The Chair expressed dissatisfaction that a response wasn't available for the meeting and asked for written responses to be provided before the next

meeting.

Responses provided post meeting:
Q1 Answer – The plans are currently at the pre-outline business case stage and what we have submitted is being reviewed nationally. Details of the way forward, and timeframes, will be released once this has been agreed with the New Hospital Programme.

Q2 Answer – We have submitted plans which illustrate what can be achieved within the original funding allocation, our preferred option and a phased approach which would deliver the preferred option, albeit over a longer time scale. The Trust considers that this information is exempt from disclosure on the grounds of commercial interests and has applied the Public Interest Test as required.

From Jean Burbridge:

1. At the last meeting ICS leads were asked "How will the Integrated Care Board improve the current reduced accountability and transparency?" but this was not answered. Are the ICS leads now able to answer this question?
2. In the last meeting David Sissling stated that the local NHS is currently making no use of private companies to assist it in moving towards an ICS. Please could you clarify whether any companies have been used in recent years to assist in th transition to an ICS and, if so, which they were?

Andy Williams, Chief Executive ICS responded that:
Q1. The Integrated Care Board (ICB) will hold meetings in public between 6 to 10 times per year, the exact configuration of those meetings was still to be determined by the board. There would typically be an annual meeting held in public. The ICS was still subject to the Act of Parliament being finalised and that would establish the board. The ICB would expect to undertake extensive engagement and it was envisaged that would be transparent.

Q2. This query related to the previous system when the STP linked with big companies. It was clarified that ICS would not be doing that locally and work was being taken forward with an in-house team. There was no private sector partner or big consultancy working with them on that.

39. COVID 19 AND THE AUTUMN/WINTER VACCINATION PROGRAMME UPDATE

Caroline Trevithick, and Kay Darby, both of Leicester, Leicestershire and Rutland CCGs provided a presentation update on the ongoing situation with Covid 19 and the Autumn/Winter Vaccination programme including recent data and vaccination patterns across Leicester, Leicestershire, and Rutland.

Members noted that:

- The vaccination programmes changed weekly and had now moved into the under 50 year old category, this meant the number of eligible people

changed too.

- There continued to be several ways to access vaccinations and details were updated regularly online.
- Although there was data around vaccination take up the situation remained fluid and data changed regularly.

Members raised various concerns about the 3rd dose and booster doses and the confusion amongst people around that. It was advised that the 3rd dose and the booster were different. The 3rd dose was for very vulnerable people, and they would still be called to have a booster. It was acknowledged there was confusion around those 2 terms and further clarity was needed especially when booking through GP surgeries to avoid people who were eligible being turned away. The CCGs were taking steps to ensure that the right messages were sent out in relation to 3rd doses and boosters.

It was noted that there were instances of people having 2 vaccinations and still catching covid and queried how the booster worked to promote immunisation and whether people had a natural immunity if they had covid. It was advised that where people had been vaccinated and then caught covid they were not usually as poorly as they might have been, but it was also important to note that immunity receded over time. It was likely anyone who had covid did have more immunity, but the levels of immunity were not known as there weren't the resources to investigate that yet.

There was unease at the level of take up among young people, those of school age and children in care and it was queried how the vaccination programme had been developed since the last meeting to increase uptake in these groups and also among those living and working in care homes.

In relation to mandatory care home vaccination the CCGs had worked closely with local authorities to mitigate the risk of there not being enough staff to care for people. There were 3 homes in the city and 3 homes in the County with concerns and plans in place to work with them to ensure proper staffing. It was noted that the mandatory vaccination of clinical staff was most likely to affect unregistered staff nationally and CCGs were looking at steps to encourage and increase uptake of the vaccination amongst those. Campaigns were focused on convenience, confidence and addressing complacency and there was work with staff to support them in their choices.

Responding further on the comments regarding vaccination uptake Members were informed that:

- The care homes team had now visited 90% of care homes and there was a 64% uptake of vaccinations across the residents; 18 care homes were still to be visited and CCGs were on target to achieve 100% offer in terms of the visits but there would need to be a follow up to catch those missed because they were too poorly etc at the initial visit.
- Uptake of the 3rd dose and boosters was currently within national uptake range.
- 3rd primary doses were being recorded as boosters, but CCGs/GPs should be able to identify and pull them out of data sets for their 4th vaccination

which would be a booster. Letters would be issued to those eligible and there were processes to run searches and follow up booking people in for recall. It was recognised very vulnerable groups need reassurance and that CCGs needed to communicate to assure those receiving 3rd dose that they would get boosters too.

- In relation to eligibility to a 3rd dose for those who access specialist care out of area, they would be checked to ensure they were being picked up.
- Regarding concerns of people being turned away, the CCGs were driving PCNs to look again at those eligible for 3rd dose or booster but there was a broad agreement to be more inclusive than exclusive.
- In relation to vaccination of school children, the CCGs undertook to visit all schools by end November but were seeing lower vaccination uptake rates across LLR with just 20% in the city vaccinated. City uptake leaned more towards the national programme and walk ins and CCGs were working to drive uptake up. There was lower uptake in some categories and they were seeing rising differential for reasons such as it was likely children would not have the vaccination if their parents hadn't. In terms of take up by children in care no issue had been identified in this category.

Members felt there were issues with communications from the CCGs and referred to conflicting communications with Rutland. Issues were also flagged about the online booking systems.

Members queried the covid infection rate amongst young people suggesting there was no slow down and whether being given half dose vaccinations was sufficient. In response it was informed that clinical opinion was that vaccinating 12-15 year olds was the right thing to do but the roll out of that vaccination programme was still ongoing and the impact was yet to be assessed.

Members also expressed concerns about accessing the right type of vaccination in circumstances where a person was unable through medical reasons to have Pfizer or Moderna. In response it was advised there was an allergy pathway set up to direct people for the Astra Zeneca if they were unable to have Pfizer or Moderna however there was some supply restricted to a small number of sites accessed through GP pathway. Members challenged the accessibility of the GP/allergy pathway to the Astra Zeneca vaccine noting that it had been a real difficulty for people to get that vaccine and people were being misdirected to vaccination centres then on arrival being told it was not available.

There was a general discussion around lines of communication with health colleagues and suggested it would be helpful to provide a line of communication that enables elected members to raise constituents concerns/case work directly with health colleagues.

The Chair thanked health partners for the update.

AGREED:

1. That the contents of the presentation and verbal update be noted,
2. That CCG partners investigate the communications issues

referred to during discussion and escalate the concerns about the working difficulties with 119/online bookings.

3. That CCG partners explore whether frequently asked questions/constituent concerns could be communicated to a single point of contact and to provide that contact.

40. BLACK MATERNAL HEALTHCARE AND MORTALITY

The Committee received a report on black maternal healthcare and mortality, including details of what the local maternity and neonatal system was doing to address health inequalities and poor outcomes for women of a black or minority ethnic background.

Elaine Broughton, Head of Midwifery introduced the report and drew attention to the following points:

This report followed on from the work of MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) which continued to highlight multiple and complex problems that affect women who die in pregnancy, these could be a combination of social, physical and mental or just one of these factors alone. The Covid pandemic had also highlighted even more disparity.

During the Covid pandemic MBRRACE published a rapid report following a review over a 3 month period from 1st March 2020 to 31st May 2020 which included several key messages. During that period 10 women died, the majority being from black/ethnic minority backgrounds and the report went on to identify existing guidance that needed improvement and recommendations that needed implementation.

Following that report the NHS had developed a long term plan and recommendations to be implemented as part of their Equity and Equality: Guidance for Local Maternity Systems and on the back of this a piece of work was being done by LLR health colleagues around equality analysis. That would be used to inform an action plan and would be reported to the committee in due course.

Members discussed the report which included the following comments:

The in depth summary was welcomed and it was acknowledged this was a very difficult subject.

In terms of lessons learnt, all deaths were investigated by an external H&S branch set up by the government, that involved extensive investigation and a comprehensive report of findings, and this had been in place locally for over 2 years so there was confidence that the service was addressing lessons to be learnt.

It was noted that one of the issues raised concerned black and ethnic minority women’s voices not being heard and it was asked how the service were taking

that forward. Floretta Cox, Midwifery Matron advised that they were developing a dashboard with key performance indicators to look at issues such as this. There was a joint healthcare review of the issues that black and ethnic women had and an action plan would be drawn from that. Leicester, Leicestershire and Rutland were the only area in UK doing that as the demographics and diversity of the area were well recognised. As an example of the steps being taken, the Covid action plan was shared with Sharma and other women's groups and feedback from them informed that plan was pitched right. In another example antenatal services during Covid were moved online with peer supporters and steps taken to get the same ethnic mix/language among peers.

It was queried whether the ethnicity of midwives working across LLR reflected the demographics of the area as a whole and any steps being taken to reach out to communities and allay fears about systems. Regarding the midwifery population it was noted there were not as many midwives from black or ethnic minority backgrounds in terms of percentages as the population of LLR and in Leicester there was an overall shortage of midwives. Recruitment was therefore broad to address the shortage and encourage diversity.

In terms of language barriers, language was an issue and there were processes in place for completion of questionnaires from GPs to identify if English was not the first language and to ensure interpreters were available at every appointment. Health colleagues tried not to use family members for interpreting as they were conscious, they might only say what they think the woman wanted to hear.

It was also found that a lot of women who did not speak English as their first language also lacked literacy skills in their own language and so leaflets were not always interpreted, however there was a facility online to translate voice over of information.

Members noted there was a distinction between the issues around medical care and the issues around systems i.e., communication and understanding practices.

Referring to medical issues it was noted that women of black and ethnic backgrounds tended to have more other risk factors such as diabetes and co-morbidities. Members noted that during the covid pandemic health colleagues were advised to change the way diabetes was tested during pregnancy and so clinics were set up at children centres and GP surgeries, so no-one was missed.

Regarding systems, health colleagues tried to treat people as individuals and there were groups that met where the midwife attended monthly to engage e.g., the midwifery service had regular access with the Sharma women's group before covid and now restrictions were being lifted the midwifery service would be re-engaging.

In terms of cultural concerns around maternal mental health there were services for women to get extra support and access psychologists and women

12

that went through traumatic birth were contacted. The service also tried to ensure continuity of care with one midwife throughout the pregnancy.

Members were reassured that LLR was not an outlier in terms of mortality however Members would have liked to see more data to support that with national/regional comparators as well as data that included the ages of women as that was a known risk factor.

It was confirmed that other data sets were available, and reports could be provided to that. Data on national comparators relating to mortality and older women would be shared if available outside the meeting.

Members expressed some dissatisfaction that the only data provided in the report related to Leicester rather than the wider area of Leicester, Leicestershire and Rutland, especially since this was a joint committee. The Chair agreed that data should be provided for the whole of LLR however taking the data provided it was still quite stark.

Members queried whether there was data or evidence revealing any links with infant mortality. It was advised that as this report remit was around maternal mortality other data sets were not included to avoid confusion. The Chair also expressed an interest in seeing any reflection in full term infant deaths.

The Chair commented in relation to the investigative processes following a death or traumatic birth and suggested consideration be given to seeking views of a non-medical advocate for the woman to gain another perspective. The Chair asked that issues of advocacy and that role should be explored further.

The Chair thanked health partners for the comprehensive report and in summary commented that the maternity partnership was appreciated however the committee would be interested in a broader sense of how that works and if it could be better.

AGREED:

1. That a report providing full details of maternity partnership arrangements be provided to a future meeting.
2. That data on national comparators relating to mortality and older women to be shared if available outside meeting.
3. That comparative data to that in the report for Leicester be provided for the wider area of Leicestershire and Rutland.

41. LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE SYSTEM UPDATE

The Chair invited Robert Ball to put his questions.

From Robert Ball:
Q1: What provider collaboratives are under development or being anticipated?

Q2: Can ISC leads confirm that commercial providers will be excluded from

these provider collaboratives?

Andy Williams, Chief Executive ICS responded that they were looking at collaboratives based on care areas. The focus would be on care areas such as elective care, learning, disabilities, children services etc. ICS were keen to progress the first two care areas then set up other collaboratives over the next 12 to 18 months

In relation to the second question, the government had not placed any commercial providers in governance although it was unavoidable there would be some involvement in the collaboratives as it was an integral part of service delivery.

Leadership would therefore be through the ICB, and collaboratives would be through public sector but would involve the independent sector in collaboration work.

The Chair invited Andy Williams to continue that discussion with Robert Ball outside this meeting.

Sarah Prema, Executive Director of Strategy and Planning briefly reminded members of the situation around ICS which had already been discussed in detail at independent Health Scrutiny Commissions of local authorities across LLR.

Members noted that the process to develop ICS was 2 fold; the legal process to close existing CCG's and importantly improving experience and outcomes. The statutory footing of ICB and ICS provided the facility to remove barriers and enable faster co-ordination of care across pathways and increase improvement of outcomes for patients.

Sarah Prema presented details of the approach for LLR, examples of what was being done to integrate services, the priorities for integration and transformation in LLR, the overview of the ICS infrastructure, the high level responsibilities of each place group and draft place based governance.

Members noted the progress and next steps which included:

- A designated Chair (David Sissling) in place and appointment of Andy Williams as Chief Executive.
- Recruitment processes and ICP governance arrangements to be finalised.
- Due diligence to complete in closing CCG's establishing the Board.
- Finalising leadership arrangements.

Members discussed the presentation which included the following comments:

- It was clarified that Andy Williams had been appointed by the Chair as designate CEO and through NHS England. In due course the ICB would become the statutory board and that would be the legal employer. ICB would be the board whereas the ICP would be the partnership body in between.

14

- In relation to governance arrangements, equal partnership and involvement of local government, it was clarified that both upper and lower tiers would be engaged however it would be for the Health and Wellbeing Board to determine that involvement. The board (ICB) would advocate 3 places around the table from local government and that could include officers. The board would be subject to scrutiny at all levels and there was no attempt to differentiate between place and system scrutiny.
- With regards to maintaining patient care during the transition arrangements there was a long history of re-organisation and with support of CCGs they had already effectively re-organised into a shadow ICS form, there would not be a need to further re-organise, and they were ready to make the change which would mostly be a change of name.
- It was recognised that communication with the public was ongoing but driven by availability of policy within NHS and this communication had largely been with specific interest groups. It was noted that in terms of statutory consultation as this was a national policy there was no public consultation but locally, they were trying to be open about the process.

Chair thanked health partners for the update.

AGREED:

That the contents of the presentation update be noted.

42. MEMBER QUESTIONS (ON MATTERS NOT COVERED ELSEWHERE ON THE AGENDA)

Councillor Samantha Harvey submitted the following questions:

Following a negative patient experience at LRI last month, and the difficulty faced trying to navigate the LRI site, can our UHL colleagues' comment on the following:

- Why does the website contain incorrect information that is years out of date? The receptionist, at the incorrect location, explained the web site information has been incorrect for ages and the correct location was at the other end of the campus.
- Why is the website so difficult to navigate and makes it almost impossible to find any useful patient information?
- Why is the signposting to campus so very poor? Circling the site, in search of the correct entrance is not good for a calm state of mind or patient wellbeing.
- Internal signage is poor and there was no sight of the usual cheery volunteers or porters to point or lead the way.
- Why are there no maps of the campus and car parks available online?

Response received post meeting:
Maria O'Brien, Head of Communications replied that:
"Our website is tabled for improvements next year. Given the scale of the project, it has not been possible to update the site until this time.

We are aware of search issues and whilst we provide as much via homepage links as possible, we know this can be improved and will be a critical part of our website development plan.
Whilst there are maps of the sites, we know these are out of fate. We are currently in the middle of an improvement project looking at all of these in light of continued development work at all of our sites."

Answers to the remaining questions will be sent as soon as possible.

43. WORK PROGRAMME

The contents of the work programme were noted and additional items mentioned during Chairs announcements to be updated.

44. ANY OTHER URGENT BUSINESS

None.

45. DATE OF NEXT MEETING

The next scheduled meeting to take place on: 28th March 2022 at 5pm

Any special or extraordinary meetings before then will be notified separately.

There being no further business the meeting closed at 9.10pm.

16

Leicester
City Council

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

Held: TUESDAY, 15 FEBRUARY 2022 at 12 noon at City Hall as a hybrid meeting enabling remote participation via Zoom

P R E S E N T :
Councillor Kitterick – Chair
Councillor Morgan – Vice-Chair
Councillor Grimley
Councillor Hack
Councillor King
Councillor Powell
Councillor Smith
Councillor Whittle

In Attendance:
Andy Williams – Chief Executive, ICS
Angela Hillery – Chief Executive LPT
Dr Avinesh Hiremeth – Executive Medical Director LPT
Anne Scott – Director of Nursing LPT
Sarah Prema – Leicester CCG
Mark Wightman - UHL
Dr Janet Underwood – Healthwatch Rutland
Mukesh Barot – Healthwatch Leicester

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46. APOLOGIES FOR ABSENCE

The Chair welcomed those present and led introductions.

Apologies for absence were received from Councillor March, Councillor Fonseca, Councillor Aldred and Ruth Lake

Apologies for absence were also received from Councillor Waller who it was noted was participating remotely at the discretion of the Chair. The Chair clarified rules around attendance in person and restrictions on members attending remotely in terms of voting.

47. DECLARATIONS OF INTEREST

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

Councillor Morgan declared that his wife was the patron of a wellbeing café in Loughborough and ran a Crisis café.

Councillor Hack declared that she worked with Advanced Housing in the County providing long distance accommodation.

Councillor Waller declared that she was the Rutland County Council nominated Trustee to the Carlton Hayes Mental Health Charity.

Councillor King declared that he was involved with the Carers Centre Leicestershire.

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

48. FINDINGS AND ANALYSIS OF THE STEP UP TO GREAT MENTAL HEALTH CONSULTATION - LEICESTER, LEICESTERSHIRE AND RUTLAND CCGS AND LPT

Members of the Committee received a report and presentation providing details of the Step Up to Great Mental Health programme to improve and transform mental health services, which included the findings and analysis to the Step Up to Great Mental Health Consultation and an overview of the final proposals in the decision-making business case.

Andy Williams, Chief Executive Officer LLR Integrated Care introduced the report and gave a presentation with focus into the formal public consultation, figures around response levels, and the outcomes from the consultation including how the findings of the consultation were considered and the final proposals in the decision-making business case.

It was noted that the Step Up to Great Mental Health programme was jointly led by CCGs and Leicestershire Partnership NHS Trust (LPT) working with a broad range of partners and part of its purpose was to improve pathways to urgent and emergency mental health care and to strengthen the integration of community mental health services.

The Chair invited members to discuss the report and presentation. The ensuing discussion included the following comments and responses to Members questions.

Members welcomed the depth of consultation however there was some concern around the level of change being represented in the action plan and how that would be implemented. Assurance was given that there was a strong

overarching commitment to rebalance mental and physical health and in broad terms resources were already in place. Funding this was not an issue and where necessary funds would be ringfenced. The action plan was about ensuring the programme was co-produced with partners and communities/voluntary sector organisations and that there was a mandate to act so CCG's and LPT could work with stakeholders to achieve and deliver the best quality care in LLR.

Members were advised that some of the work around co-production was already happening, e.g., tenders were being issued and there was grant funding for more Crisis Cafes and improving learning in the local voluntary sector which was important too. There was continued engagement to bring services closer to local populations and all aspects were being done in partnership including with local authorities as delivery partners.

It was clarified that the term Crisis Café originally came about as the idea of a physical location where people could drop in when they felt unable to cope and needed some support. Crisis Cafes were linked with other services and helped to try to stabilise people and provided a local offer closer and more accessible to neighbourhoods with links to wider community assets too. At the moment Crisis Cafes were not including children as they would need a different environment, however LPT had tried out "Chill out Zones" this year which was a similar idea to a Crisis Café targeted to older children. In relation to plans to expand the number of "Crisis Cafes" grants were usually received in March and expected implementation could take up to 3 months thereafter. Marketing and publicising Crisis Cafes was still to be developed and would be wide ranging.

It was noted that the needs of people in rural/remote areas were very different to people in urban areas and Members expressed concern about how specific services would be in real neighbourhoods, as there was no definition of a neighbourhood in the report.

Members were informed that several discussions had taken place in rural parts and they were very different conversations, "neighbourhood" was not defined exactly in the report for the very reason that in the city it may be just a street whereas in rural areas it could be a whole village, and this was being explored further to establish what worked best in each area. It was noted that although the consultation was broad it revealed interest in other things too such as prevention, children services, older adult social care so there was a lot still to explore further. It was confirmed that the CCGs and LPT were every bit as focused on trying to meet the needs of people in rural areas as they were those in the city and towns.

In terms of partnership work and opportunity closer working with the police it was noted there were already close working arrangements in place, e.g., Leicestershire Police and LPT had been leading on street triage pilots and a Triage Car project since 2013, this brought together officers and health professionals in order to respond to people with mental health problems in public places and had reduced the number of people detained by the police and taken instead to a place of safety for mental health assessment.

Members referred to their experiences of Crisis Cafes noting feedback was positive and they provided comfortable surroundings for those attending. In terms of prevention, it was suggested that the Crisis Cafes could be used as an opportunity to work with community safety partnerships and other agencies in each area too, including Police and Fire services.

In relation to memory and dementia services it was suggested that rural areas often had an aging population and lower diagnosis rates for dementia. It was advised there were dedicated memory services across LLR, and the aim was to have seamless pathways as it was understood how important it was for individuals to get the right diagnosis. CCG's/LPT were continuing to work towards that however there was insufficient research data around low diagnosis rates and one of the difficulties was identifying the issue which was often led by family/service users referring people for memory loss then coming into primary care where there was a bottle neck getting through the system.

In terms of the Crisis Cafes and Memory Cafes being facilitated by volunteer organisations there was concern that they were doing a lot of the work against a backdrop of reduced funding for the voluntary sector. Members were informed that the funding for Crisis and Memory cafes was joint, and their governance was intentionally integrated. The cafes were quite advanced in terms of their journey regarding mental health services as they linked to health and wellbeing priorities across LLR. Investment monies had been used for a range of things such as social care partnerships and dementia and this area of partnership working would continue to evolve over time.

In response to concerns around the involvement of volunteers in Crisis/Memory Cafes, their training and career progression opportunities and the issue of the lack of professional people in mental health services it was acknowledged that workforce in mental health services was a challenge nationally. In terms of voluntary sector workforce and retention that was still work in progress as different voluntary sectors may have different recruitment steps, but LPT would be looking to define roles and participants would be included in that strategy. Crisis Cafes were successful by operating with the voluntary community sector and part of this programme was sustaining those sectors too and giving them contracts and ability to channel success for their workforce whilst ensuring there was still access to professional and specialist skills when needed. It was noted that the Crisis Cafes were there to support but they were not in position to escalate access to professionals/services. The Chair indicated this was an area that needed careful monitoring to avoid deflection in future.

Responding further to concerns around funding, assurance was given that the financial resources were recurrent and there year on year with the intention that once those funds were committed, they remain so. The top steer was to ensure there was as much growth available for mental health services as for other acute services. This initiative builds on that and going forward that helps build a workforce too. It was noted that monies were linked to measures of success and outcomes would have to be demonstrable.

Concerns were raised that the consultation work on the programme was being done in isolation and queried how that would fit with GP and other services. In response health partners advised they were conscious they were consulting on a specific set of propositions, initially the thought was LPT would be main service provider however this was something that needed more consideration and health partners were willing to return to elaborate on how it would dovetail to other services at a future meeting.

Members were told that people conceptualise mental health and wellbeing differently and advised that the work being done in partnership was also focused on addressing and tackling areas of inequity. The proposals as they stand would contribute to greater equity of service. Some services had already been taken into direct access away from the route of GPs to address difficulties accessing mental health services quickly.

There was some debate around whether the first point of call for someone in crisis would be to their GP and it was suggested that the extent to which people thought of their GP first varied substantially with some people remarkably well informed about other services available. Members noted that there was no "wrong door" in terms of access to mental health services and there was a desire by CCG's/LPT to ensure the right support was in place no matter the route taken. Health partners recognised the onus was not on the patient to navigate through services, that had been clearly heard from feedback during the consultation and LPT were keen to address.
There was a brief discussion around the potential for a mental health hotline that could signpost individuals to mental health services. It was noted LPT was trying to decongest GP services and give people simpler ways of access to mental health (and other) services especially when in crisis.

It was queried whether 6500 responses to the consultation were enough considering the population of Leicester, Leicestershire, and Rutland. In reply it was stated that although that number seemed small it was significant as it produced a wide ranging view and perspective, and it was important to note that every time a consultation was run there was a massive silent majority which was taken as them not having a particular view or concern on the proposals. 6500 responses were huge compared to other consultation response rates and online viewing figures of the proposals in addition to the actual responses showed large numbers had viewed the consultation material and the responses received were balanced demographically and geographically.

In relation to the wider issues of a person's first encounter of mental health services being with the police and any learning points in relation to community safety it was advised there was a firm relationship with the police and other agencies, with established structures in place which included a process for case reviews. Assurance was given that there was a genuine determination to work on issues around community safety by all partners and Health partners were willing to examine their relationships with other agencies and service providers, and the process for case reviews to see if there was an issue and whether it could be improved.

The Chair indicated he would be interested in further discussion around Mental Health and police involvement at a future meeting. The Chair agreed to revisit the topic at the Autumn meeting of the committee and to receive progress on the implementation of the outcomes to the Step Up to Great Mental Health consultation

The Chair suggested it would be helpful outside this meeting to explore how key performance indicators (KPI's) and dashboard monitoring would be taken forward.

AGREED:

1. That the contents of the report be noted;
2. That there be further discussion around Mental Health to include the involvement of the Leicestershire Police at the Autumn meeting;
3. That this topic be revisited at the Autumn meeting and to receive progress on the implementation of the outcomes on the Step Up to Great Mental Health programme;
4. That Health Partners in consultation with the Chair, Vice-Chair and Councillor Waller explore how key performance indicators (KPI's) and dashboard monitoring shall be taken forward.

49. OUTCOME OF THE LPT CQC INSPECTION

Members received a report providing details of the Care Quality Commission (CQC) Inspection of Leicestershire Partnership NHS Trust(LPT).

Angela Hillery, Chief Executive, LPT gave a presentation providing details of the CQC Inspection, the three core services inspected, the CQC assessment of LPT and findings together with an overview of the improvements required and steps being taken to progress that.

It was noted that mental health dormitory accommodation continued to be a significant priority area to improve, and it was national policy to move the programme on and eliminate shared sleeping arrangements. LPT had a robust 3 year plan in place to eliminate shared sleeping arrangements, taking account of bed numbers and access to capital funding. Phase 1 had completed; Phase II was now underway, and Phase III would see the programme brought to completion.

Other key areas identified for improvements in the inspection included:

- Issues of timeliness for repairs; storage and cleanliness – steps had been taken to act upon points raised and improve facilities management provided by UHL.
- Call alarms and accessibility – this had been risk assessed in line with new national guidance since the inspection.
- Personalised care plans - focus was on embedding this in practice.
- Learning across teams - there was focus on learning lessons and embedding that across services too.

- Mandatory training – prior to Covid LPT were compliant but since they had to redeploy staff and stop face to face which impacted on ability to complete mandatory training. Staff were being supported to attend mandatory training as a priority now covid restrictions had eased.
- Patient risk – a Quality Improvement programme was in place to address the findings and to monitor the embedding of these actions.
- Access to psychologist roles/services – recruiting continues to these key roles.

Members noted that the service had continued to make improvements throughout the Covid-19 pandemic and the inspection report recognised that.

Members discussed the report which included the following comments:

In relation to the improvements outlined, most were covered off during January/February 2022 and the action plan showed some steps to complete by March. It was queried whether this meant there was confidence that by April 2022 the standard reached would therefore be good or still requiring improvement should there be an inspection? It was advised the CQC retained a relationship with LPT and met regularly to feedback on the findings and implementation of improvements. In terms of the action plan there was a series of actions up to end of April 2022, however the aim to complete mandatory training by end January was impacted by the rise in Omicron variant cases so the timetable was revised, however LPT had been very transparent with CQC over that.

Members were informed there was a shift in mindset, with regular governance and reporting twice a month on the CQC action plan. The action plan focused on quality transformation and any areas going off track were reported to the executive board on a regular basis. The action plan as at today had just six outstanding actions, these were around mandatory training and all due to complete by end February/beginning March 2022, there was confidence that would be achieved despite the impact covid has had over past 2 years.

Members welcomed the improvements being taken forward noting that medicine management had also been improved. It was queried why the third core service inspected “wards for people with a learning disability or autism” remained static at Requires Improvement. Members were advised this was in part due to the mandatory training not being achieved and partly due to the challenge of algorithms used in the assessment, however this did not mean that the CQC did not find some improvement.

Members acknowledged the impact that the Covid-19 pandemic had and thanked staff for their work during the pandemic however, considering the damning report in 2018, Members expressed their concerns at the slowness and level of progress e.g., the dormitory accommodation programme, and it was suggested that the action plan and activities to be done before April 2022 seemed to be a tick box exercise rather than a culture change. Members queried the strategic approaches being taken to address the inspection findings and commented that it was not appropriate to accept drift.

In response it was asserted there had been some clear progress during the pandemic but accepted it was slow however following the report in 2018 it was indicated that the LPT were on a 3-5 year journey to make and embed changes. There was now a clear position and programme in place to deal with the dormitory accommodation with an implementation plan which was on track to deliver. The action plan following the latest inspection was there to satisfy the CQC on the evidence that they required, and it was difficult to demonstrate a focus on culture, but LPT were committed to deliver what it says is firmly there.

In terms of seeking a peer review to provide more assurance that LPT were improving, Members were informed that part of the work had been to seek an outside view from Northampton Trust as part of the process. There was also membership to accreditation schemes and Royal College networks that were used to check/inspect as part of the LPT journey of improvement. Assurance was given that the Board were committed to overseeing the changes and embedding improvements/culture change necessary and that was emphasised by the presence of Board members at this meeting.

A point was raised about regular checks and spot checks to ensure consistent and effective management of contraband items and how that was balanced with patient dignity. It was clarified that in terms of process, those searches were focused on storage of clothing and how to enter a patient's space, with clearer processes for entering and leaving rather than searches of the person.

In relation to the findings around personal patient call alarms it was explained that there were alarms in place on all wards and there was no instance where a call alarm was not available for incidents. The issue was around those patients that declined wrist alarms however, the CQC would like to see more availability and usage of wrist alarms and LPT had reflected upon that in their guidance.

The Chair thanked LPT health partners for the report.

AGREED:

1. That a report providing more detail of the Mental Health Dormitory Accommodation programme be provided to the 28th March 2022 meeting of the committee together with a brief update on progress with the Action Plan.

2. That a further update on the LPT CQC inspection outcomes and a digest of peer review work be brought to the Autumn meeting in conjunction with the update on Step Up to Great Mental Health.

50. ANY OTHER URGENT BUSINESS

The Chair agreed to take an item of urgent business to allow the submission of a petition which would be received and dealt with in accordance with the Councils procedures, on basis that expediency was necessary to ensure

transparency of process and public scrutiny before the finalisation of the ICB governance and constitutional arrangements.

The petition was received as follows:
"We, the undersigned, request that joint scrutiny scrutinise the draft constitution of the Leicester, Leicestershire and Rutland Integrated Care System while there is time to build insights of scrutiny into the final version.

The Integrated Care Board Constitution will establish the governance arrangements for Leicester, Leicestershire, and Rutland. This will include membership of the Integrated Care Board; arrangements for delegating Integrated Care Board powers to sub-committees which may not be required to meet in public or publish their papers and may include commercial or independent sector providers with interests other than the public good; and arrangements for managing conflicts of interest.

These arrangements will affect the operation of the NHS in our area, and we insist on our right to be consulted over these plans.

In several other parts of the country, not only have shadow Integrated Care System leaders published their draft constitution, but they have also established formal public consultations to gather public views. By contrast, at the last meeting of the Leicester City Council Health and Wellbeing Scrutiny Commission a request by a member of the committee for a copy of the draft Integrated Care Board constitution was denied and a copy of the national "model" was offered instead. However, while the "model" constitution gives broad structure to assist in the drawing up of the constitution locally, it permits significant local variation. The constitution proposed locally should therefore be formally scrutinised and subjected to a formal public consultation before it is finalised.

In sum, we are requesting that the Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee scrutinise the draft Integrated Care Board constitution and recommend that a formal public consultation exercise is arranged on the amended draft constitution."

RESOLVED:

That the Petition be received and dealt with in accordance with the Council's procedures and health partners be put on notice to provide a response to the next meeting.

51. MEMBERS QUESTIONS NOT ELSEWHERE ON THE AGENDA

Prior to the meeting the Chair asked the following questions regarding mental health services, in his own right and received written responses from health colleagues as follows:

Q1 What proportion of outpatient appointments with doctors are taking place remotely and do you have a target for the proportion of outpatient appointments

with doctors you would like to take place remotely?

Virtual (video) consultations and telephone consultations were adopted across LPT's outpatients as a way of ensuring that services were not discontinued across the various lockdown and other restrictive measures across the last two years. The proportion of contacts (in LPT's mental health services) that were made using virtual or telephone moved from 2% prior to the pandemic to currently over 80% of contacts. LPT's current position, reinforced by the feedback from the public consultation, is not to set a target or fix an expectation on contacts being undertaken virtually but instead be providing a choice to our service users. LPT have listened to feedback with a mixture of very positive experiences using virtual consultations such as reduced travel, easier and more comfortable experience for the service user as well as some people preferring to physically see a clinician or do not like using telephone or video calling.

Q2 As you have experienced a growing need for mental health services during the course of the Covid19 pandemic, have you been able to increase your inpatient provision?

LPT put in various temporary measures during the pandemic to better support that need such as direct free phone number, through central access point, and the mental health urgent care hub to help assess and support people presenting with urgent needs. LPT have also focused on various ways to strengthen community services including the introduction of an community rehabilitation services. All of these measures were included in the consultation to sustain them going forward. The cumulation of these measures has meant that over the course of the last two years there has been a lowering of demand for inpatient services and also reduced length of stay in those services. This has allowed LPT upgrade the inpatient environments to remove dormitory accommodation and replace with single room accommodation. LPT has been able to do this without needing to increase the inpatient bed numbers and also avoiding inappropriately sending people of Leicester, Leicestershire and Rutland for acute mental health beds.

52. DATE OF NEXT MEETING

To note the next meeting date on Monday 28th March 2022 at 5.30pm at City Hall.

There being no further business the meeting closed at 2:04pm.

Appendix B

Leicester, Leicestershire and Rutland Joint Health Scrutiny Commission

28th March 2022

Update on Transition to an Integrated Care System

Purpose

1. This paper provides an update on progress towards the establishment of the Leicester, Leicestershire and Rutland Integrated Care Board.

Delay to timeline

2. To allow sufficient time for the remaining parliamentary stages of the Health and Care Bill, a revised date of 1 July 2022 has been agreed for the new arrangements to take effect and Integrated Care Boards (ICBs) to be legally and operationally established. This replaces the previous date of 1 April 2022.

3. The new date will provide some extra flexibility as ICSs prepare for the new statutory arrangements and manage the immediate priorities in relation to the pandemic response, while maintaining momentum towards more effective system working.

4. The establishment of statutory ICSs, and timing of this of course, remains subject to the passage of the Bill through Parliament.

5. National and local plans for ICS implementation have been adjusted to reflect this timescale, with an extended preparatory phase from 1 April 2022 up to the point of commencement of the new statutory arrangements. It is not envisaged that the delay will impact on the programme significantly. Plans are well developed, and we will continue to move forward with the actions necessary to close the existing three Clinical Commissioning Groups and establish the Integrated Care Board.

Role of Clinical Commissioning Groups April to June 2022

6. As statutory organisations the three Clinical Commissioning Groups will now continue as statutory organisations, with all their existing duties and responsibilities, until the end of June 2022. Existing governance arrangements will remain in place to enable them to discharge their duties during this period.

Integrated Care Board Meetings

7. From April 2022 the LLR Integrated Care Board will start to hold its Board meetings in public. Each meeting will be advertised and agendas and papers made available on the LLR CCGs websites together with information on how the public can join the meeting.

Appointments

8. The Leicester, Leicestershire and Rutland Integrated Care Board has David Sissling as its Designate Chair and Andy Williams as its Designate Chief Executive Officer.

9. Following a recruitment process the following are the preferred candidates for the Designate Director roles for the LLR Integrated Care Board.

Role	**Appointed**
Director Finance	Nicci Briggs
Director Nursing	Caroline Trevithick
Director People	Alice McGee
Director Transformation	Rachna Vyas
Director Strategy	Sarah Prema
Director Medicine	Dr Nil Sanganee

10. Four Non-Executive Director appointments have also been made to the LLR Integrated Care Board. These roles will be designate to the end of June 2022 with roles formally commencing on 1st July 2022.

Role	**Appointed**
Audit Committee Chair	Darryn Hickman
People and Remuneration	Simone Jordan
Health Inequalities, Public Engagement, Third Sector and Carers	Professor Azhar Farooqi
Quality, Safety and Transformation	Pauline Tagg

Woking with people and communities

11. The LLR ICS has developed a draft strategy which explains at a high-level the approach to working with people and communities about how healthcare is designed and delivered. The strategy responds to the views and experiences from local people and stakeholders over the last two years.

12. The strategy is currently out for engagement and can be found via the following link https://www.leicestercityccg.nhs.uk/get-involved/the-nhs-in-

leicester-leicestershire-and-rutland-how-we-will-work-with-people-and-communities/

Integrated Care Board Governance

13. The Constitution for LLR Integrated Care Board is currently in draft form; this is based on a national template. It sets out how the Integrated Care Board will be governed including composition of the Board; the appointment process to the Board; process and procedures that the Board will use; and meeting arrangements. The national template will be revised in line with the final legislation with a view of final Constitutions being submitted to NHSEI in the middle of May 2022.

14. The Constitution is underpinned by a range of documents that support the governance of the Board and the organisation including Standing Orders; Standing Financial Instructions; Conflicts of Interest Policy; and Governance Handbook. All the supporting documents are in the process of being developed.

15. Current draft membership of the Integrated Care Board includes the Chair and Chief Executive of the ICB; four Non-Executive Directors; four ICB Executive Directors; and six Partner Members (one from Community/Mental Health Sector; one from Acute Sector; one representative from each local authority with social care responsibility in the ICB area; one Clinical Executive Lead). The Constitution sets out the nomination and selection process for the Partner Members which will be underpinned by secondary legislation setting out who can nominate each Partner Member.

16. Once the Constitution has been finalised and the secondary legislation issued that supports Partner Member nomination onto the Integrated Care Board the process of appointment for Partner Members will commence.

Health and Wellbeing Partnership Development

17. Work has been undertaken, by a partnership group, to define the priorities for the Health and Wellbeing Partnership and its membership. The current proposals are due to be considered by the Health and Wellbeing Partnership at its 31st March 2022 meeting.

Assurance on progress

18. As part of the process for the disestablishment of the three Clinical Commissioning Groups and the establishment of the Integrated Care Board an assurance process has been established and dedicated resources are in place to support this.

19. At a local level there is a programme plan setting out all the necessary actions and timelines. This is regularly reviewed by the programme team to ensure that actions are on track and any necessary actions taken. Progress is also reviewed at a weekly Transition meeting.

20. The shadow Integrated Care Board has established a system Transition Committee which receives regular reports on progress to enable it to be assured that progress is being made and any necessary issues are dealt with. Monthly reports from the Committee are provided to the shadow Integrated Care Board and the CCGs Governing Bodies.

21. At a regional level the ICS is required to provide regular updates, via a Readiness to Operate Statement, to NHSEI together with regular discussion and feedback on progress. The latest submission is due for submission at the end of March 2022. These submissions will continue until the establishment of the ICB.

Recommendations

The LLR Joint Health Scrutiny Commission asked to:

NOTE to progress being made in relation to the transition to the Integrated Care Board.

Appendix C

EMAS – New Clinical Operating Model and Specialist Practitioners.

Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee

Monday 28th March 2022 at 5.30pm

Lead officer: Russell Smalley, Head of Operations (West)
East Midlands Ambulance Service

Useful information

- Area(s) affected: Leicester, Leicestershire and Rutland
- Report author: Charlotte Walker
- Author contact details: charlotte.walker@emas.nhs.uk
- Report version number: 1

Summary
Report to provide an update on the EMAS Clinical Operating Model and introduction of Specialist Practitioners

Detailed report

Background

As an integral part of the healthcare system EMAS aim to continually develop its clinical services to support and available opportunities to support and treat patients in and out of hospital environment. In September 2018 EMAS commenced a review of its Clinical Operating Model, to ensure a clear direction of travel which was fit for purpose, fit for the future and fit for our patients. The review focused on three key areas, the clinical model, clinical hub and clinical leadership inclusive of clinical supervision.

Once of the outcomes of the review and development of the Clinical Operating Model was the introduction of specialist practitioners, supporting the delivery of senior clinical assessment and intervention to patients seen by EMAS. Leicestershire was one of the initial divisions to commence specialist practitioners, with the role now being successfully extended across the remainder of the Trust.

Specialist Practitioners

To enhance the delivery of clinical care, six specialist practitioners were introduced across Leicestershire in September 2020, with an addition 12 being recruited in 2021. This recruitment has allowed for 24/7 cover across division across two teams.

The specialist practitioner role comes with a number of intended aims and outcomes. Firstly, the role enhances the clinical skill mix of emergency pre-hospital care in order to ensure patients receive the most appropriate care, in the most appropriate setting. The role also maximises the effectiveness of existing ambulance resources in order to focus on those with the most critical needs.

Alongside clinical outcomes there has also been a reduction of burden on the emergency department in Leicestershire through non-conveyance, ultimately ensuring those that require time critical emergency care are able to be seen and receive definitive care in a timely way. This also has a secondary impact of contributing to and supporting the reduction of hospital handover delays.

Scope of practice:

- Can supply medication to leave with the patient, not just administer, so can better manage patients in the community avoiding the need for treatment at hospital or waiting for another community provider to support.
- Carry a range of medications for supply to treat minor ailments including infections, asthma, COPD and pain avoiding the requirement for referral to another agency and expedite treatment.

- Carries additional end of life drugs to better support patients in their last few days of life, allowing care if their preferred place.
- Wound closure skills - able to close wounds in the community that would previously have been transported to hospital.
- Development and access to alternative pathways. Supported to communicate with the wider healthcare system to try and arrange individual care plans for patients to aide in managing their condition in the community where possible.

Clinical Leadership

- Provide a senior clinician that ambulance crews can call to discuss patient care - with the potential for the specialist practitioner to attend immediately or later in the shift dependant on the presenting complaint and complexity of the patient.
- Provide clinical leadership at difficult, complex and challenging calls of high and low acuity, helping to facilitate timely and appropriate care for the patient.
- Have clinical discussions and support other staff to help develop the clinical community of the division alongside station level leaders.
- Supported to communicate with primary care networks and patient's own specialists to discuss patient's situation today and arrange bespoke care plans.

In addition to the skills specialist practitioners can provide directly to patients on scene, they also rotate through the EMAS emergency operations centre. This function allows the specialist paramedics to identify appropriate calls for divisional based colleagues to attend, enhancing the dispatch and utilisation.

Within the last 12 months there have been the following outcomes by appropriate utilisation of specialist practitioners within Leicestershire:

- A total of 3424 patient attended, with 2128 specialist practitioner scope drugs administered.
- An ED conveyance rate of 32.77% in comparison to other frontline clinician (Paramedic/Technician) conveyance of 42.95%.
- Attended 268 cardiac arrests in the role of Cardiac Arrest Leader; providing senior clinical leadership.

Future development

The specialist practitioner role provides a clinical career development option for paramedics, with the aim to keep these experienced clinicians in EMAS, and in the local community. Further high acuity skills to bring additional care to patients when they need it most. The scope of practice will grow as the role develops to further enhance patient treatment, experience and support reduction in emergency department conveyance, within plans to extend skills including enhanced cardiac arrest care (technical and non-technical skills), post cardiac arrest care, management of acute mental health crisis, enhanced maternity care and some critical care skills.

Appendix E

Leicester, Leicestershire and Rutland

Joint Health Overview and Scrutiny Committee

Monday 28th March 2022, 5.30pm

Report title: **Eliminating Mental Health Dormitory Accommodation at Leicestershire Partnership NHS Trust**

Report presented by: Paul Sheldon, Chief Finance Officer, Leicestershire Partnership NHS Trust (LPT)

Samantha Wood, Head of Strategy, Leicestershire Partnership NHS Trust (LPT)

Executive summary:

1. The Government has pledged to eradicate dormitory accommodation in mental health settings with additional investment for organisations to do this. In LPT we are replacing the dormitories with single rooms, improving the safety, privacy and dignity of patients suffering with mental illness. LPT's programme has been funded with £9.25 million from the government to achieve this.

2. The eradication of dormitories will improve the individual care that can be given to patients, allowing them to reduce the length of their stay in our services. It will also have benefits for patient safety, including better infection control and a reduction in the risk of incidents involving patients or staff.

3. LPT received approval from NHS England & Improvement to proceed with a large-scale programme of works to eradicate dormitories from 4 adult acute wards at the Bradgate Unit, 2 older adult wards at the Evington Centre and 2 older adult wards at the Bennion Centre and one eating disorders ward at the Bennion Centre. The scope of works included the upgrade of a ward for a local decant (and to avoid use of out of area beds).

4. Works commenced in earnest in early 2020 and were split into 4 phases;

    a. Phase 1 (completed)
        i. Bosworth ward – Bradgate unit
        ii. Thornton ward – Bradgate unit

    b. Phase 2
        i. Ashby ward – Bradgate unit (completed)
        ii. Aston ward – Bradgate unit (07/03/22 – 29/07/22)

    c. Phase 3 (21/03/22 – 03/03/23)
        i. Coleman/Wakerley ward – Evington Centre
        ii. Gwendolen ward – Evington Centre

d. Phase 4 (15/08/22 – 02/10/23)
    i. Kirby ward – Bennion Centre
    ii. Welford ward – Bennion Centre
    iii. Langley ward – Bennion Centre

Building on CQC Feedback:

5. In the previous Joint HOSC report provided by Angela Hillery (LPT's Chief Executive) it was explained how the CQC had visited last year and assessed how safe, effective, caring, responsive, and well-led services are. They selected three of our 15 core services for inspection: All 3 were mental health services.

6. The outcome from the CQC inspection included:
    - Improved core service ratings as the Trust no longer have any core service rated Inadequate overall.
    - A focus on areas where we must do more to ensure our fundamental standards are being met.

7. The CQC asked that we must make further estates improvements in:
    - Eliminating our dormitory accommodation/ensuring our ward environments do not compromise privacy and dignity
    - Ensuring all patients in our adult mental health wards have access to personal alarms should they need assistance
    - The timeliness of repairs in our wards and storage of patient's personal possessions

8. The CQC recognised that we have improved in a number of our mental health areas. and reported that there has been "an improved safety culture" at LPT. Areas of particular improvement are:

    - We have eliminated completely the number of adults requiring care in acute Mental Health beds in hospitals outside of Leicester ('Out of area placements'). We have sustained this position throughout the pandemic in recognition that receiving care closers helps families and service users to stay connected and leave hospital quicker

    - Improved seclusion environments, where a mental health patient is observed separately in a quiet space

    - Eliminated mixed sex accommodation, which ensures men and women aren't sharing facilities and therefore have better privacy and dignity

Building on Patient and Staff Feedback:

9. The work has been programmed in a phased way to ensure that feedback and learning from each ward development is captured and used to inform the design of the next ward.

10. Patients have reported that the wards have a much brighter feel, more room and that they feel safer.

11. Staff have reported; “I have found the approach to be a really positive experience and the quality of the work, communication and approachable style of everyone involved has been wonderful. It has been a rewarding experience to see the faces of some of the front-line clinical staff & patients when they walk back into their new environments and the feedback from patients has been so positive.”

    The works has included:

    - The creation of single en-suite bedrooms
    - New modern social areas in our wards
    - State of the art safety doors
    - Anti-ligature radiator covers
    - Re-positioning of fire detector heads in patient rooms
    - New furniture inc. profiling beds
    - New wet rooms
    - Fresh paint all through
    - Improved accommodation within our staff rest room
    - New larger vision panels into patient lounge areas
    - Additional Wi-Fi provision
    - Patient and staff call points with access to personal alarms should they need assistance

Summary:

12. Eliminating dormitory accommodation is a key element of our Step Up to Great Strategy, we are making good progress and improvements, committed to continuing at pace with the proceeding phases.

13. We would like to recognise the programme partnership approach; how our front line service staff have been working tirelessly throughout this Covid pandemic to ensure the progress of the work, the estates team, architects, construction partners and most importantly, our patients who have been really helpful in sharing their experiences with us and managing the transition so well between wards when moves are required for the works.

Leicestershire Partnership NHS Trust

Mental Health Dormitory Eradication Programme

March 2022

Paul Sheldon – Chief Finance Officer

WeAreLPT
compassion respect
integrity trust

Appendix E

www.leicspart.nhs.uk

Presentation Contents

1) Background introduction

2) Programme overview

3) Building on the learning

4) Questions

Background Introduction

- Government pledge – 2020

- Targeted funding to replace the dormitories – our share £9.25m

- Create single rooms - improving the safety, privacy and dignity of patients suffering with mental illness

- Benefits for patient quality and safety;

✓ including better infection control

✓ reduction in the risk of incidents involving patients or staff

- Scope
- Engagement approach

Programme Overview

WeAreLPT
compassion respect
integrity trust

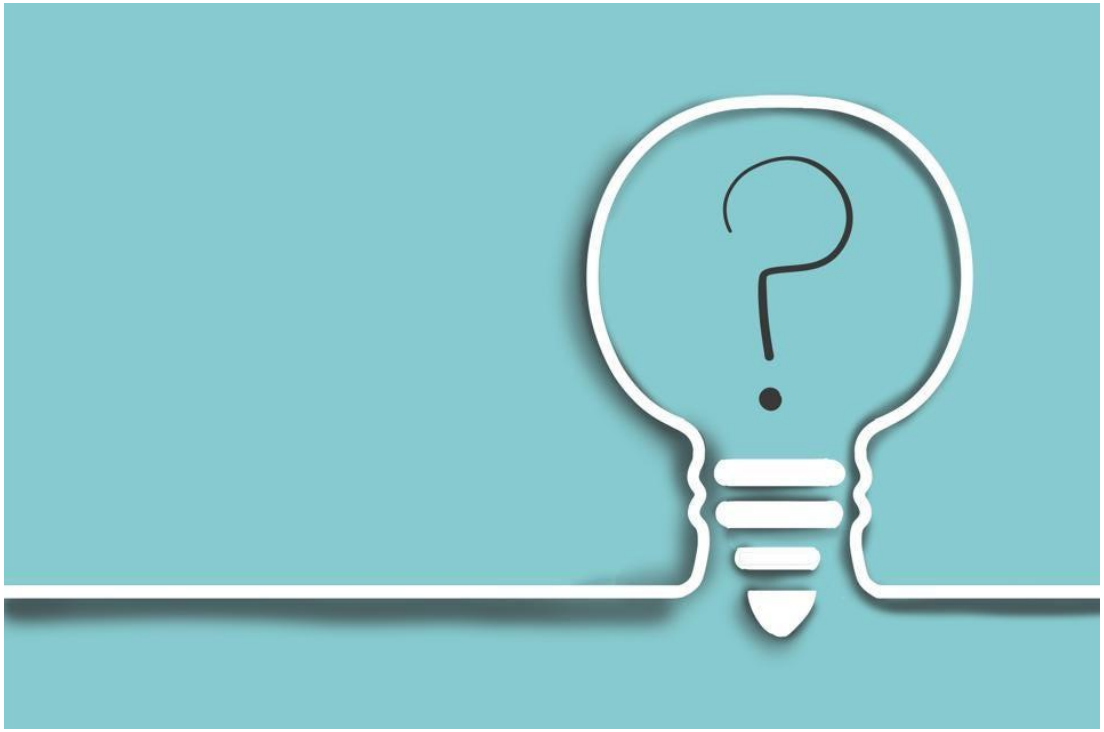
The change…

The change…

Building on the learning

- State of the art safety doors
- Anti-ligature radiator covers
- Re-positioning of fire detector heads in patient rooms
- New furniture inc. profiling beds
- New wet rooms
- Fresh paint all through
- Improved accommodation for staff room
- New larger vision panels into patient lounge areas
- Wi-fi additonality
- Patient and staff call points

Questions



Appendix F

Leicester, Leicestershire and Rutland

Joint Health Overview and Scrutiny Committee

Monday 28th March 2022 at 5.30pm

Report title: **Transforming Care in Leicester, Leicestershire and Rutland – Learning Disabilities update**

Report presented by: David Williams, Executive Director of Strategy & Partnerships in Leicestershire Partnership Trust.

Joint SRO for the programme with Heather Pick, Leicestershire County Council. Tracie Rees, Leicester City Council and Kim Sorsky from Rutland County Council are fully engaged in our joint work.

Executive summary:

1. Across LLR partners have worked together to deliver improved performance and outcomes for our people who live in LLR with a learning disability or autism.
2. Over the past 12 months in LLR we now have less people in long-term hospital now, than in 2015, we are meeting national targets for annual health checks and when we work together to avoid a crisis, we avoid admission 79% of the time.
3. We have opportunities over the next 12 months to develop:
    a. Greater collaborative working between the NHS, Social Care, Children's Services, Voluntary and Community Groups, families and service users.
    b. Collective caseload referral and management
    c. Data analysis of need, inequalities and variation to enable personalisation of care
    d. Develop seamless joint care pathways e.g.aftercare and support for children and young people
    e. Oversight of spend and effective commissioning
    f. Develop better quality social housing provision
4. Our call to action across LLR is that we continue knowing
    a. We can all make a difference for our people
    b. Everyone with a learning disability, autism or neuro-developmental need should be able to access all of our health and care services
    c. Championing and celebrating organisations working together makes a big difference and helps everyone with great care

cestershire Partnership
NHS Trust

Leicester City Clinical Commissioning G
West Leicestershire Clinical Commissioning G
East Leicestershire and Rutland Clinical Commissioning G

Transforming Care in Leicester, Leicestershire and Rutland

Our next chapters – March 2022

Leicester City Council

Leicestershire County Council

Rutland County Counc

Appendix H

LLR TCP Vision

“All people with a learning disability and/or autism will have the fundamental right to live good fulfilling lives, within their communities with access to the right support from the right people at the right time”.

LLR TCP – our culture and improvement journey so far

Collective dissatisfaction with current support to people living with learning disability/autism

A shared commitment, vision and purpose

Working together for people, as one joint operational team

"We feel like we've got Alfie back." https://youtu.be/LbxkpFKyV5M

Our successes……

- **Less people in long-term hospital now, than in 2015**
- **Meeting national targets for annual health checks**
- **When we work together to avoid a crisis we avoid admission 79% of the time**
- **Our care is joined up and connected, families have told us:**
  - **“This doesn’t feel like a tick box exercise anymore.”**
  - **“You are really listening to what we are saying.”**
  - **“This is really encouraging and exciting.”**

n 2022/23 in LLR – we can achieve even nore….

- Greater collaborative working between the NHS, Social Care, Children's Services, Voluntary and Community Groups, families and service users.
- Collective caseload referral and management
- Data analysis of need, inequalities and variation to enable personalisation of care
- Develop seamless joint care pathways e.g. S117 aftercare and support for children and young people
- Oversight of spend and effective commissioning
- Develop better quality social housing provision

Our Call to action

- We can all make a difference for our people
- Everyone with a learning disability, autism or neuro-developmental need should be able to access all of our health and care services
- Championing and celebrating organisations working together makes a big difference and helps everyone with great care

Thank you so much for today. K never smiles like that and I'm so proud of her. When you left, she said to me; 'that is the first person ever, that has done what they said they would'.

Leicester, Leicestershire, and Rutland Joint Health Scrutiny Committee

Work Programme – 2021/22

Date	Topic	Actions arising	Progress
6th Jul 21	1. Analysis of UHL Acute and Maternity Reconfiguration consultation results 2. Covid-19 Vaccination Programme Update	1. The consultation findings were published on 8th June 2021. 2. Update requested at Mar 2021 meeting	Completed
13th Sep 21	1. Progress Report on the Transition of Children's Services from Glenfield to Kensington 2. Dental Services in Leicester, Leicestershire, and Rutland; NHS England & NHS Improvement Response to Healthwatch SEND Report. 3. COVID19 & Autumn/Winter Vaccination Programme 4. Verbal Update on UHL Reconfiguration 5. ICS Board - Verbal Update	3. Standing item as of August 2021 and a brief update on the A/W Vaccinations Report	Completed
16th Nov 21	1. COVID19 and the Autumn/Winter Vaccination Programme (standing item) 2. Updated Report on Dental Services in LLR; NHS England & NHS Improvement Response to Healthwatch SEND Report 3. Black Maternal Healthcare and Mortality 4. Leicester, Leicestershire, and Rutland Integrated Care System	2. Further information to be circulated on Rutland and the SEND report response.	In Progress
15th Feb 2022	1. Findings and Analysis of the Step Up to Great Mental Health Consultation – Leicester, Leicestershire, and Rutland 2. Outcome of the LPT CQC Inspection	2. A pre-Member briefing is being arranged for this.	

Date	Topic	Actions arising	Progress
28th Mar 22	1. ICS Update 2. COVID19 & Vaccinations update (standing item) 3. UHL: verbal update on general activities 4. EMAS - New Clinical Operating Model and Specialist Practitioners 5. Re-procurement of the Non-Emergency Patient Transport Service (NEPTS) 6. Interim update on LPT response to CQC inspection & Step Up to Great Mental Health consultation 7. Transforming Care in Leicester, Leicestershire, and Rutland - Learning Disabilities Update **Note**: a response from Health Partners to the petition submitted at the last meeting, will be taken before the main items **Item Update**: The 'UHL Finances and Accounts for 19-20 and 20-21' item will be taken to the Committee in the new municipal year as reports will be decoupled and approved at separate Board Meetings over the next few months.	Item 4 was due to be discussed in December 2020 but had to be deferred due to insufficient time. Item 7 was a request from Cllr Hack following the last update in October 2020.	

Prospective Items

Agenda item	Organisation/Officer responsible	Notes
1. EMAS - New Clinical Operating Model and Specialist Practitioners	Russell Smalley, EMAS	This item was on the agenda for the meeting on 14 December 2020 but Russell was unable to present the report so the Chairman suggested the item could come back to a future meeting. TBC: March 2022
2. Update on dental services and response to Healthwatch report on children with SEND.	Thomas Bailey, NHS England	This item was on the agenda for the meeting on 14 December 2020 but Thomas was unable to present the report so the Chairman suggested the item could come back to a future meeting. Completed September 2021 and will return in July 2022.
3. Community Services/Place based plans overview	Tamsin Hooton, CCGs	It was intended that the high-level strategy would come to the Joint HOSC and the detail on individual areas such as Hinckley/Lutterworth would come to individual HOSCs. Historical item from when the Committee was administered by County in 2020.
4. Progress Updates on the UHL Acute and Maternity Reconfiguration Proposals	CCGs/UHL	Analysis of the UHL Acute and Maternity Reconfiguration Consultation results was taken at the July 2021. Progress updates are expected at future meetings for: - - The transition of Children's Services from Glenfield to Kensington - Update on the co-located design work for the standalone midwife let unit - Details of the emerging strategy and patterns of activity to be developed in relation to primary care Updates will be given where appropriate

Agenda item	Organisation/Officer responsible	Notes
5. Neuro – Rehabilitation services	CCGs/UHL	A public question received at a JHOSC meeting on 14 December 2020 about Neuro – Rehabilitation services; Chairman at the time considered having it on the agenda of a future meeting.
6. LLR NHS System Workforce Group/ Recruitment and Retention/NHS People Plan/Mental Health of workforce	Louise Young, CCGs	The County members wanted an agenda item on NHS workforce to cover recruitment and wellbeing of staff going forward. Historical item from when the Committee was administered by County in 2020.
7. Transforming Care – Learning Disabilities and Autism progress update	County/City Council and LPT	This issue came to the meeting on 15 October 2020 and members requested a progress update at a future meeting. TBC: March 2022
8. UHL Finances and Accounts for 19-20 and 20-21	UHL	On 5 March 2021 it was agreed that UHL would come back to the JHOSC with further updates regarding the actions taken to address the financial issues. This is planned for Summer 2022, with a Member Briefing beforehand.
9. Black maternal healthcare and mortality	UHL or CCGs – to be confirmed.	Email discussion regarding the national interest in this issue (MPs debated a petition relating to this on 19 April 2021) and both City and County interest in looking at this issue locally and how mortality rates can be improved. Completed in November 2021 with an update requested in one year.
10. Covid-19 Vaccination Programme Update	CCGs	March 2021 - LLR CCGs were requested to provide a further update to the Committee regarding the areas of Leicester, Leicestershire, and Rutland where vaccination uptake had been comparatively low and reasons behind this. This was a standing item until March 2022.
11. Leicester, Leicestershire, and Rutland Integrated Care System	CCGs	LLR CCGs successfully applied to become one single CCG by 31st March 2021 ready for organisational change on 1st July 2022. This is a standing item as an when there are updates available; next update is scheduled in March 2022.

Agenda item	Organisation/Officer responsible	Notes
12. Outcome of LPT CQC inspection	LPT	This was taken at the special meeting in Feb 2022 with a follow up update expected in March 2022 regarding the dormitory accommodation.
13. Findings and analysis of the Step Up to Great Mental Health Consultation - Leicester, Leicestershire, and Rutland	CCGs/LPT	Consultation (ends 15 August 2021) about proposals to invest and improve adult mental health services for people in Leicester, Leicestershire, and Rutland when their need is urgent, or they need planned care and treatment. This was discussed in Feb 2022 and a follow up update is expected in March 2022
14. UHL: update on general activities	UHL	A report to be circulated to Commission Members by the end of the summer. This will determine which meeting this should go to.
15. Autumn/Winter Vaccination Programme Report	CCGs	Referenced in the July 2021 minutes as a report for the next meeting was a standing item up to December 2021.
16. Progress Report on the Transition of Children's Services from Glenfield to Kensington	UHL	Specifically referenced in the July 2021 minutes as a report for the next meeting. Completed as of September 2021.