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 Pantling
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 GP's 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 patients 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.