Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 30 JUNE 2016 at 5:30 pm

P R E S E N T :

Councillor Dempster (Chair)
Councillor Fonseca (Vice-Chair)

Councillor Cassidy	Councillor Cleaver
Councillor Chaplin	Councillor Unsworth

In Attendance:

Councillor Osman	Assistant City Mayor, Public Health
Karen Chouhan	Chair Healthwatch Leicester
Richard Morris	Director of Corporate Affairs Leicester City Clinical Commissioning Group

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15. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Sangster and Councillor Palmer.

16. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda. No such declarations were made.

17. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 25 May 2016 be approved as a correct record subject to “The impact on looked after children of the reduced budget be assessed” be added to Minute No 9 in paragraph a) of the members comments and observations.

18. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

19. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations and statements of case had been submitted in accordance with the Council's procedures.

The Chair commented that she had received a full response from the Monitoring Officer in relation to the issue of the requirement for questions from the public to be received 5 clear days before the meeting. This provision was intended to allow members of the public the opportunity to raise health issues of concern to them but was not intended to specifically receive questions on the published agenda. To allow this to happen would require a change to the Council's Constitution.

20. CQC INSPECTION OF EMERGENCY DEPARTMENT AT THE LEICESTER ROYAL INFIRMARY

Members received the Care Quality Commission's (CQC) report, issued in April 2016, of their unannounced inspection of the Emergency Department at the Leicester Royal Infirmary on the evening of 30 November 2016. Following the inspection an urgent Notice of Decision was issued to the Trust on 4 December 2015.

Mark Wightman, Director of Marketing and Communications, University of Hospitals Leicester NHS Trust (UHL) gave a presentation on UHL's response to the Notice of Decision.

During the presentation it was noted that:-

a) The CQC report had highlighted 3 areas where conditions were imposed on the Trust's registration as a service provider. These were
   - Patient Assessment
   - Emergency Department Staffing
   - Sepsis Management

b) The Trust had been aware of these issues prior to the inspection. It was well known that the A&E department was the busiest single A&E site in the country and had originally been built to accommodate 100,000 attendances per year but the attendances between November 2014 and October 2015 were 217,832. The large attendances at A&E in recent years had prompted the building of new Emergency Department to

improve the operation and efficiency of the A&E unit.

c) The Trust had taken the following actions in response to the CQC's Notice of Decision:-

Patient Assessment

Additional staff resources were taken from hospital wards to work in the assessment area in the A&E unit to improve the performance of patients being assessed within 15 minutes of arriving in the Emergency Department. At the time of the inspection the actual performance was 55%-60% against the standard of 90%. Following the inspection, performance was significantly improved and performance during the last 6 months had fluctuated between 85%-95%. A graph showing the performance was circulated with the agenda.

Emergency Department Staffing

A graph showing the performance was circulated with the agenda and indicated the improvement in performance that had been achieved in staffing levels. The CQC had been concerned with the number of staff and the skills mix of staff dealing with the poorliest patients. Additional senior nurses had been moved into these areas and more consistent levels of performance were now being achieved.

Sepsis Management

Sepsis was a life threatening condition that can occur when the whole body reacts to an infection. The symptoms of sepsis are similar to the symptoms for a number of ailments and if not spotted quickly, the patient can deteriorate very quickly. The performance was improved but was not yet consistent. The national standard was for 90% of patients who presented with sepsis to receive their medication within 1 hour of arriving at the Emergency Department. Patients with symptoms of sepsis may not always present themselves within the A&E, major injuries or resuscitation units and additional education and training was being rolled out across all staff to assist them in identifying patients with sepsis.

Following comments and questions from Members the following responses were noted:-

a) The peaks and troughs in patient assessment performance were mainly related to the varying numbers of patients attending the emergency department.

b) One of the troughs in the sepsis performance was related to an East Midland wide flu outbreak which had affected both patient numbers and staff absences.

c) The Trust employed over 13,000 staff and always had a large number of vacancies within its workforce; these were currently in excess of 400. Moving senior nurses within the hospital had little impact upon finances. By putting more staff resources into the assessment, resuscitation and majors units did mean, however, that patients waited longer for treatment in minor ailment units.

d) Ambulance crew personnel were also trained in identifying sepsis and any suspected cases would be notified to UHL staff on arrival at the hospital.

e) The incident relating to the breech of procedures for administering medicines on page 10 of the CQC report had been the result of human fallibility. This had been addressed through training and encouraging all staff to act in self-regulation and challenge instances where they observed staff not adhering to established policies and practices.

f) There had been a campaign last winter to encourage people who did not feel well to see a GP or a pharmacist in an attempt to reduce the numbers attending the emergency department. Although the campaign was felt to be the best that had been delivered in recent years, the numbers attending the emergency department had increased. This increase had also been experienced nationally.

g) The numbers of people attending the Emergency Department was now becoming relatively constant throughout the year, although the types of admissions did change with the seasons.

h) Staff absences also fluctuated throughout the year and were higher in the winter when attendances at the Emergency Department also increased through winter illnesses.

i) The report of the recent inspection was not expected for some months. Initial comments from the inspectors had mentioned that they had not seen any examples of poor, inconsiderate or uncompassionate care and for an organisation employing 13,000 staff this was considered unusual. It was expected that the report would identify poor performance in the emergency department waiting times, ophthalmology department for waiting times and general quality of the building it operates from and the appearance of public areas of the hospital. These issues were already known within the hospital. The facilities management had been brought in-house because whilst the previous contractor had performed well in relation to the cleanliness of the wards, they had performed less so in relation to the corridors and public areas. The in-house service was gradually improving the appearance of the public areas.

Members made additional comments as follows:-

a) It would be helpful for Members and community groups to be given simple information on sepsis and meningitis to raise awareness and

enable them to identify symptoms.

b) It would also be useful to have simple information on other pathways to receive medical advice and treatment to help reduce the number of people attending the emergency department. This could include promoting the services of local pharmacies, GPs and home safety advice to reduce accidents in the home. For example, a simple information card could be devised and distributed to the elderly and vulnerable people to give 5 simple and clear messages.

c) It was recognised that health services staff were working in difficult circumstances and the improvements that had been made were welcomed.

d) Whilst welcoming the improvement in increasing the numbers of patients seen within 15 minutes from 55% to approximately 90% within 3 weeks, this raised the question of why it had initially fallen to 55%.

The Healthwatch representative stated that Healthwatch had made 2 unannounced visits to the emergency department and 2 notified visits to the Merlyn Vaz Centre and the Walk in Centre. Visits had also taken place on a number of wards at the Royal Infirmary and Glenfield Hospitals. Healthwatch had also launched an open day with UHL. UHL had also helped Healthwatch to involve patient panels in their work. Reports on visits were available on the Healthwatch website.

AGREED:

1. That the Director of Marketing and Communications be thanked for the presentation and his frank and informative responses to Members questions.

2. That a further report be received in December to enable the Commission to be satisfied that the improvements made in response to the CQC report are being sustained.

ACTION:

That UHL submit a further report to the December meeting of the Commission on the performance of the issues identified in the CQC report.

21. SUSTAINABILITY AND TRANSFORMATION PLAN

The Commission received a presentation from Sarah Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group (LCCCG) providing an overview of the Sustainability and Transformation Plan (STP), the next steps and the expected milestones.

It was noted that the STP was a place based plan to accelerate the implementation of the Five Year Forward View required in the NHS Planning Guidance 2016/17 – 2020/21. The STP covered all areas of CCG and NHS England commissioned services including specialised services and primary medical care. The plan also covered the better integration with local authority services. Toby Sanders, Chief Officer, NHS West Leicestershire CCG was the lead officer for STP.

The Better Care Together programme would form an integral part of the STP and Leicester, Leicestershire and Rutland were ahead of many areas of the country in developing the BCT programme.

In developing the STP each area has to show how they are going to ensure sustainability in the following areas:-

- Health and Wellbeing
- Improving care and quality
- Ensuring financial sustainability (improving productivity and closing the financial gap)

The feedback from NHS England on the initial submission in April had been positive and further work had been undertaken to develop where LLR could go further on the three areas listed above. A detailed submission has to be submitted to NHS England by 30 June 2016 and this was based upon both the BCT Programme and the STP emerging priorities.

The emerging priorities for the STP were:-

- BCT Phase 1 service reconfiguration.
- Public sector efficiency.
- Prevention.
- Urgent and emergency care.
- Mental Health.
- Integrated place based community teams.
- Primary medical care.
- Digital technology.
- Public sector estate.
- Health and care workforce.
- LLR place based system approach.

These priorities would be developed by the 6 STP work-streams of:-

- Improving health outcomes and independence.
- Delivering care in the right place.
- Making better use of resources.
- Integrated place based teams.
- Resilience in primary care.
- System leadership.

It was expected the STP would not be finally approved until late autumn. As part of this process the pre-consultation business case for the BCT was being refreshed. As a consequence, public consultation on BCT could not start until this business case had been approved.

Members made the following comments:-

a) Place based planning could be a topic for the planned Primary Care Health Summit.

b) The requirement to prepare the STP was frustrating as it appeared to be yet another strategic plan on top of the BCT which had still not progressed to public consultation after two years of development.

c) Further details of the financial gap outlined on page 3 of the presentation and the proposals to address this should be made available to the Commission.

d) Documents made available to the public should be written in a clear non-technical style that was easily understood by non-health professionals.

e) There were concerns that insufficient resources would be spent on twin tracking of services ant his may not be in the best interests of people living in the city.

In response to other further comments made by Members, it was noted that:-

a) Implementation was considered a key element of delivering the plan and its outcomes, which was reflected in it being a key work-stream of STP.

b) Placed based teams were at an initial stage but the CCG shared Members' view that STP was not just a health plan but a system wide plan to deliver best health outcomes to people living in the city. Preventative measures were equally important to delivering health care and reducing demand upon the system as a whole.

c) The initial draft of the STP would not be available until further guidance had been received.

d) Consultation would start on the BCT when the STP had been formally signed off. The CCG were equally frustrated by the delay on the consultation process but expected to be able to proceed soon after receiving approval of the STP as the BCT was further advance than other parts of the country.

The Chair commented that redesigned services should be fully embedded and sustainable before any reduction in the number of hospital beds was implemented. She stated that there should be concrete evidence as to the

reasoning behind the plans and how they will deliver better outcomes for people in the city. She also recognised that staff were working in difficult situations to deliver improvements to services whilst at the same time making savings within unrealistic circumstances at times.

AGREED:

1) That the update on the STP be noted.

2) That the Commission receive a report at its next meeting giving costs of producing the BCT and STP and listing actual examples of what has been implemented and what will be implemented to provide assurance that good quality services are embedded before any bed reduction programme is implemented.

ACTION:-

The CCG to submit a report to the next Commission meeting outlining the costs of producing the BCT and STP and providing the examples requested on how the BCT and STP have and will improve health outcomes for people living in the city.

22. MEDICINES AND SELF CARE

Members considered a report from the Leicester City Clinical Commissioning Group (LCCCG) informing members of the proposals regarding the promotion and education of self-care for Leicester city patients to maximise the benefits of existing resources. The report included low priority prescribing in particular: gluten free foods and paracetamol and other items for self-limiting illness.

Sara Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group (LCCCG) and Lesley Gant, Head of Prescribing LCCCG presented the report to the Commission.

The proposals in the report were to:-

- either partially or fully cease to prescribe gluten free products for patient with coeliac disease; and
- support GPs in not prescribing paracetamol and other products for self-limiting illnesses, such as viral infections.

The CCG had a responsibility to provide a reasonable level of care for all patients but was also required to work within the financial resources allocated to them. The two proposals had been identified as the products involved were now widely available in shops and pharmacies etc at cheaper costs than through prescriptions. In relation to patients with coeliac disease more than 50% of patients managed their condition without prescribed gluten free products.

The Commission's views were being sought as part of the pre-engagement process and any views would be taken into account before any formal public consultation was carried out on the proposals. Each of the three CCGs in the Leicester, Leicestershire and Rutland would engage with Patient Participation Groups and work with GPs to contact patients with coeliac disease to make them aware of the consultation process. A stakeholder event with specialist charity representatives (Coeliac UK) dieticians and coeliac patients had already taken place and a further stakeholder event would be held in relation to paracetamol and other products for self-limiting illnesses.

Commission Members made the following comments and observations:-

a) There were concerns that the proposals would adversely affect poorer families and the homeless community and their views may be missed in the consultation process.

b) There should be joint working with children and families teams to see how advice can be disseminated to families in relation to dealing with minor ailments.

c) The CCG could have used their resources to provide additional training and support to GPs to reduce overprescribing paracetamol for self-limiting illnesses.

d) There were concerns that other products may be added to the list of products to be removed from being routinely available on prescription.

In response to Members' comments and questions it was stated that:-

a) The CCG's had links with hard to reach communities and these would be used to ensure that the views of the homeless and homeless services were fed into the consultation process.

b) Whilst West Leicestershire CCG was taking the lead for the review, Leicester City CCG was still required to approve that the engagement was 'fit for purpose' for the City area.

c) Paracetamol would still be available through prescription for patients that required it for their illness, e.g patients who suffered with arthritis etc.

d) The consultation process would end on 31 July 2016 and each of the three CCGs would make a decision in relation to their own area of responsibility.

AGREED:

That a further report be submitted to the next meeting of the Commission on the outcomes of the consultation in relation to the gluten free products and paracetamol.

That the Commission receive a report should other products be added to the list of products not to routinely available on prescription in the future.

ACTION:

The CCG to submit a report to the next meeting of the Commission on the outcome of the consultation and if other products are to be added to the list of products not to be routinely available on prescription.

23. ANCHOR RECOVERY HUB

The Director of Public Health reported that the final options for the location of the Anchor Recovery Hub were expected to be completed the following week. The current service providers, Inclusion Healthcare, had been included in the discussions during the development of the options. It was intended to provide a briefing for the Chair and Ward Members on the preferred option before the next meeting of the Commission.

Members of the Commission also asked to be provided with details of the preferred option.

AGREED:

That the update on the Anchor Recovery Hub be noted.

ACTION:

That the Chair and Members of the Commission be advised of the preferred option for the location of the Anchor Recovery Hub.

24. LEICESTERSHIRE PARTNERSHIP NHS TRUST - SCRUTINY REVIEW

The Commission received the draft report of the Commission' review of the Leicestershire Partnership NHS Trust – Quality monitoring following the Care Quality Commission Inspection. Members were asked to comment upon the draft report and endorse it to be submitted to the relevant bodies involved.

The Chair thanked Councillor Sangster for leading this review which had made a number of important recommendations that would be taken forward in in other areas of work.

AGREED:

That draft report be received and approved for final issue and that the relevant bodies and organisations mentioning in the report be asked for their comments on the recommendations.

ACTION

1. The Scrutiny Policy Officer to arrange for the report to be issued in its final form to all those taking part in the review and to those bodies and organisations requested to take action in the report.

2. That the bodies and organisations requested to take action in the report also be requested to submit a formal response to the recommendations.

25. CAMHS REVIEW - DRAFT SCOPING DOCUMENT

Members received the draft scoping report for a proposed scrutiny review on the 'Child and Adolescent Mental Health' and were asked to comment on the draft and approve the terms for the review.

Members commented that they welcomed the inclusion in the review of what happens to those children and adolescents that don't get accepted on the waiting list and whether there is any follow up procedures for those who get an appointment and then don't attend.

It was noted that there were specific procedures in place for 'Looked After Children' and these were considered to be of a good standard.

AGREED:

That the terms of references in the scoping report be agreed and that they be submitted to the Overview Select Committee for endorsement.

ACTION

The Scrutiny Policy Officer to submit the Scoping document to the Overview Select Committee for endorsement.

26. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2014/15.

Councillor Chaplin requested that the Health Messaging Scrutiny Review Scoping Document be reconsidered at the next meeting.

AGREED:

That the Work Programme be noted subject to the addition of the Health Messaging Scrutiny Review.

ACTION:

The Scrutiny Policy Officer add the Health Messaging Scrutiny Review to the Work Programme and submit the Scoping Document to the next meeting.

27. CLOSE OF MEETING

The meeting closed at 8.05 pm.