Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 4 OCTOBER 2017 at 5:30 pm

P R E S E N T :

Councillor Cutkelvin (Chair)
Councillor Fonseca (Vice-Chair)

Councillor Chaplin Councillor Corrall
Councillor Sangster

In Attendance:

Councillor Clarke	Deputy City Mayor
Councillor Dempster	Assistant City Mayor
Councillor Myers	Assistant City Mayor
Richard Morris	Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group

* * * * * * * * *

27. WELCOME

The Chair welcomed Councillor Clarke to the meeting in his new role as Deputy City Mayor with responsibility for health and wellbeing.

The Chair also congratulated Councillors Dempster and Myers on their recent appointments to Assistant City Mayors. The Chair had invited them to attend the meeting to contribute to the issues previously considered by the Commission.

28. DECLARATIONS OF INTEREST

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

29. MINUTES OF PREVIOUS MEETING

AGREED:

that the minutes of the meeting held on 23 August 2017 be approved as a correct record.

30. CHAIR'S ANNOUNCEMENTS AND UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETINGS

The Commission received an update on the following items that had been considered at a previous meeting:-

a) The questions submitted by Dr Sally Ruane at the last meeting had now received a written response and were printed in the minutes of the last meeting.

b) The letter on Sexual Health to be sent to Director of Education and Children's Services had been drafted. The Chair raised the issue of Oftsed picking up these issues with schools with Councillor Russell who had confirmed that Ofsted do consider these types of issues as part of their overall inspection regime but the Council had no control over specific topics to be included in individual inspections.

c) The City CCG position on the Settings of Care Policy would be submitted to the next meeting in November

d) The comments and questions raised by Members at the last meeting in relation to the item on General Practice Forward View (Primary Care) had been forwarded to the CCG and a reply was awaited before considering the next steps on the General Practice Forward View and the STP.

e) A decision on the NHSE Congenital Heart Disease Services Review was expected to be made at NHS England's Board on 30 November 2017. The Chair had attended a meeting of the East Midlands Scrutiny Network and the Councils represented there were supportive of the stance taken by the LLR Joint Health Scrutiny Committee and the approach to collaborative working.

f) Members were invited to a Workshop set up by Councillor Palmer on the updated Health and & Wellbeing Strategy. The Director of Public Health would submit the draft Strategy to a future meeting of the Commission.

31. PETITIONS

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

32. 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.

33. SUSTAINABILITY AND TRANSFORMATION PLAN - MENTAL HEALTH

Dr Peter Miller, Chief Executive, Leicestershire Partnership Trust and Jim Bosworth, Associate Director Commissioning & Contracting, East Leicestershire & Rutland Clinical Commissioning Group presented an update on the Mental Health STP Work-stream.

The Chair referred to the briefing Members had received the previous week on the Five Year Forward View for Mental Health. This had been useful to improve Members' understanding of the issues involved and would be useful in considering mental health as part of the STP.

The Chair had attended the Healthier in Mind event in September which she felt had been a meaningful engagement event. The Chair also noted that a further update report on CAMHS would be submitted to the Commission in November and that the CQC's report following their planned re-inspection of LPT would be scheduled into the Commission's work programme.

Dr Miller and Mr Bosworth in presenting the update stated:-

a) Service integration underpinned all work-streams in the STP. The focus in the Mental Health work-stream had been on recovery, prevention and that the care pathways could support people at earlier stages, manage crisis periods effectively and avoid hospital admissions.

b) It was aimed to improve the access pathways to enable easier access to therapies especially for people with long term physical health issues that were also suffering from mild and moderate mental health disorders. The target to assess people with a new presentation of psychosis was now 2 weeks and liaison had been improved to provide rapid access wellbeing and recovery hubs if required. The need to send people out of county for treatment had been reduced from 30 people a year ago to the current level of 5. The aim was to eliminate the need to send people out of county for treatment.

c) The Trust were working closely with staff from Northumberland Tyne and Weir NHS Trust who have helped to design a new service process based upon their success of transforming the Trust from being in special measures approximately 5 years ago to a Trust currently rated as Outstanding by the CQC. The service design process, called Healthier In Mind, had started by engaging patients to provide input into designing services that were attuned to what they wanted to meet their needs. Having clear and easily understood pathways was also a prime consideration in the design process.

Members made the following comments and observations:-

a) LPT were to be congratulated on signing up to the Armed Forces Covenant as many servicemen and ex-servicemen suffered from mental health issues

b) There were references to VCS involvement in service delivery in the Plan and, as a number of VCS organisations had recently closed or had their funding reduced, had these been taken into account when preparing the Plan.

c) The Plan should include more details of the pathways for engaging with services and contain more details of the services that would be available in the hubs.

In response to Members' questions the following responses were received:-

a) The CCG were working with the provider of crisis beds to get more capacity out of them. This work involved local authority staff and a housing association that had a strong track record of working with homeless which would give extra capacity to find appropriate accommodation.

b) The plan addressed the issue of homeless people with severe mental health conditions where it would not be conducive for them to go into hospital. All partners were discussing a broad spectrum of the needs of the homeless and were also developing new relationships with housing associations to improve service delivery.

c) The 5 Year Forward View was considered to be a good starting point and it was recognised that there were wider issues to address. The current report was prepared in response to questions raised by the Commission and the formal published document would include more detailed information. The Plan was a national view and statements contained in it would be addressed in the local Plan, such as the proposals to eliminate the need for out of county treatment of patients.

d) The Plan was continually being updated to take account of changing circumstances. For example, the recent work undertaken in relation to the Healthier In Mind campaign would require various statements to be refreshed. This would also apply to the VCS provision in the Plan. The VCS were involved in launching new resilience recovery hubs with the intention of building a nucleus of what would develop to be an extensive network over time, which would not rely on the local authority to identify capacity in community, but allowed the capacity in the community to develop further. Part of the process was to stimulate engagement in the process.

e) There was a greater move to having integrated locality teams comprising GPs, nurses and other health professionals with a view to

having fewer service points in a locality so people didn't have to attend multiple locations for their care and treatment.

f) The Trust challenged a view expressed by a Member that treatment was not provided within 2 weeks for patients who were newly identified as having psychosis as the service readily accepted patients who had been tentatively diagnosed with psychosis by GPs. These patients were then fully assessed and treatment started in appropriate cases. The Trust were also reviewing the process to look at ways in which patients and families could query the pathway, or access to it, where the pathway was not working as intended.

g) The CCG, as commissioners of services, had a number of sanctions that could be taken against poor providers of contracted services. These increased in severity from discussions to address known issues arising from feedback on the services, through to financial penalties and then ultimately taking the contract away from the provider in extreme cases. NHS England and NHS Improvement also provided additional monitoring and pressures to make improvements in poor services.

h) Although the LLR bid to NHS England to extend the liaison services had not been successful, it was expected that there would be a further opportunity to bid for funds and the LLR intended to submit a another bid to fully deliver the Core 24 liaison services.

i) It was acknowledged that the acute pathways were critically important in getting access to the appropriate services. These were not right at the moment, but work was continuing to put appropriate and effective pathways in place.

j) 50% of people accessing psychological therapies were from white populations in the city and 20-30% from BME populations, of which the majority were of an Asian ethnicity. Data suggested that completion rates were similar for all people accessing the services but outcomes seemed to be poorer for BME patients. Work had started on expanding access to the service for both BME communities and people who were also under-represented in accessing the service.

i) The Trust had received the additional 2.5% funding for mental health services made available by the government, but it was still a challenge to provide services when the demand for mental health services could rise by 20%. Service efficiencies were also being re-invested back into the system to meet the costs of the rising demand for services.

j) The Trust were continually working in more collaborative and partnership arrangements through the Mental Health Partnership Board which included the Police and third sector representatives. The Trust also had representations on other partnership boards such as the Braunstone Blues initiative; which also promoted a better co-ordinated approach.

k) Partners across the LLR were re-launching the Suicide Prevention Strategy and Action Plan for 2017-2020 with the aim of reducing the number of suicides by 10% in the next 5 years.

l) Crisis response was now working better than last year and people who were identified with early psychosis were being seen promptly. There were still some issues for people who were referred to community teams experiencing delays in receiving support.

The Chair commented that the report had been written and presented to respond to specific questions which had been asked of the Trust. Further discussions would continue with the Trust to refine ways in which information could be provided in future reports that provided information that met the needs and requirements of scrutiny.

The Chair also commented that there would be an opportunity to consider a report on an update for the CAMHS service at a joint meeting with Children, Young People and Schools' Scrutiny Commission in November. The outcome of the CQC follow up visit would also be considered at the Commission's November meeting.

It was acknowledged that there were clearly weaknesses with the 5 Year Forward View and there were many areas where the Trust were working to mitigate the risks associated with recruitment, staff training, parity of funding, increasing the understanding of mental health and dealing with increased demand and socio economic pressures.

AGREED:

(1) That the Chief Executive, Leicestershire Partnership Trust and Associate Director Commissioning & Contracting, East Leicestershire & Rutland Clinical Commissioning Group be thanked for presenting the report and responding positively to Members' questions.

(2) Any further questions from Members relating to mental health provisions and the STP should be sent to the Chair and/or Scrutiny Support Manager which would then be forwarded onto the LPT and the CCG for a response, as happened previously with the Primary Care Forward View.

(3) That a further report be submitted in 6 months' time focussing on the work to address issues such as 24/7 services in acute hospitals, improved services for prevention and children having access to mental health services, improved access to perinatal mental health services and better access to physical health support.

34. EMAS AMBULANCE RESPONSE PROGRAMME AND HANOVER TO THE LRI

Will Legge, EMAS Director of Strategy and Transformation and Richard Lyne, EMAS LLR Service Delivery Manager, attended the meeting to present a briefing paper on the Ambulance Response Programme and Handovers to the Emergency Department at Leicester Royal Infirmary.

It was noted during the presentation of the report that:-

a) The presentation to the East Midlands Health Scrutiny Network, appended to the report, gave details of the improvement journey that the Trust had undertaken since CQC published its last Inspection Report in May 2016.

b) The CQC had carried out a follow-up inspection February 2017 when significant improvements had been recognised. This had resulted in the 'safe' element of the inspection process moving from the previous rating of 'inadequate' to 'requires improvement'. The CQC commented upon a number of good examples of best practice; such as the procedures for dealing with sepsis. No new areas of concern had been identified. Both staff and patients had made positive comments about changes which already been made under the Quality Improvement Plan.

c) A new Quality Improvement Plan had been produced in response to the February 2017 inspection and this was being monitored by an internal Improvement Board and the EMAS Board.

d) Handovers had improved since the new Emergency Department had opened as a result of joint work between EMAS and UHL to address the known issues. There had been some initial teething issues in the first month as the new arrangements had bedded down. Since September 2016 to September this year there had been a 77% reduction in waiting hours by EMAS crews. There had also been a bigger reduction in instances where the handover of the patient from arrival to being offloaded to the ED took more than an hour. In 2016 more than third of arrivals at the ED had waited more than an hour and now this had been reduced to 7%.

e) EMAS had worked with UHL on many aspects to see if the improvements were sustainable; especially in relation to the winter plan. EMAS felt that they had a strong relationship with UHL which enabled robust discussions to take place when needed.

f) EMAS staff had been involved in the design of the new ambulance fleet and the new fleet had made a difference to the clinical care and environment for staff. The design of the new fleet had been highlighted as an example of good ambulance design and a number of Trusts are trialing the new EMAS fleet design. The new design allowed crews to have quicker access to lifesaving and key equipment coupled with a

more accessible treatment area that allowed crews to treat a patient more effectively en-route to a hospital rather than at the scene.

g) The ambulance response targets, which had been used since 1994, were felt to be somewhat outdated as they did not reflect the huge changes in the social care system or the increased levels of demand that had occurred since then. In addition, they were based upon the relationship between time and the clinical outcomes/survival of patients. This meant that in relation to an ambulance response to an incidence involving a cardiac arrest or myocardial infarction, an ambulance could arrive on scene in less than 8 minutes and this would be regarded as a success in relation to the target even if the patient died. Alternatively, if an ambulance arrived on scene in more than 8 minutes and the patient survived, then this was regarded as a failure to meet the target.

h) In response to these target anomalies, NHS England commissioned the Ambulance Response Programme which replaced the previous Red/Green categories with new codes which aligned clinical and resource requirements. The first operator response to a 999 call was now "is patient breathing and is the patient conscious?" This enabled an immediate assessment of a life threatening conditions and whether an ambulance should be despatched immediately. It was estimated that this simple change in answering the call could save an additional 250 lives a year in the EMAS area.

i) The new response rates were now:-

- Category 1 (8% of calls) An ambulance despatched within 30 seconds of call being answered and a 7 minute mean response time and a 15 minute 90th percentile response time.

- Category 2 (48% of calls) An ambulance despatched within 240 seconds of call being answered and an 18 minute mean response time and a 40 minute 90th percentile response time.

- Category 3 (34% of calls) An ambulance despatched within 240 seconds of call being answered and a 240 minute 90th percentile response time.

- Category 4 (10% of calls) An ambulance despatched within 240 seconds of call being answered and 180 minute 90th percentile response time.

In response to Members' questions the following responses were received:-

a) It was too early to assess the public reaction to the new ARP. The vast majority of patients calling 999 for an ambulance do so for the first time so they have no expectation other than an ambulance would arrive in response to their call. There had, however, been some positive comments from patients who had expected an ambulance car to arrive and were pleasantly surprised when the ambulance arrived.

b) EMAS had bid for the Patient Transfer Service and had been disappointed not to have won the contract.

c) EMAS responded to a number of incidents involving a person who posed a possible threat to for staff safety, which require a Police presence before staff could attend to the person. Regular liaison took place with the Police in instances where an ambulance crew were waiting for the Police to arrive before entering a property. No such issues had been raised in recent months.

d) EMAS had close partnership working with LPT and UHL and had an integrated approach to addressing issues with patients with a mental health issue, who featured in a significant proportion of responses.

e) Measures had been introduced to make it easier to re-kit supplies on the ambulance between responses by having a replacement box of supplies available to replace the box used in response to the incident. The average post-turnaround was now 12-13 minutes.

f) Crew breaks were monitored by operations staff and crews would be stood down and returned to base to take breaks where appropriate.

g) There was duty of candour within EMAS and when issues needed to be raised, it was done in an open, transparent and candid manner. All NHS services had embedded this cultural change in recent years in response to a national direction. EMAS encouraged staff to report incidents and these were then reviewed and considered in formal meetings. These issues were scrutinised by both internal and external processes.

John Adler, Chief Executive UHL NHS Trust, commented that the reduction in the number of delays in the handover of patients was encouraging and had been sustained over a period of months. It was important that comparisons were made with the corresponding periods in the last year. He believed that working arrangements with EMAS should now be sustainable. In August, the clinical average for handover was 15mins. UHL were averaging a 17-18 minutes handover time where the average in the EMAS area was about 20 minutes. UHL were now performing better than average; whereas before the new Emergency Department had opened, they had consistently been one of the worst performing Trusts. The new facility was better equipped to cope with large surges of ambulance arrivals as it had more space and better links to admission wards for children and the elderly and frail.

AGREED:

(1) That the EMAS representatives be thanked for their attendance and clear presentation of the improvement that had been made to the service.

(2) That the Commission receive an update in 6 months' time on the response to the current Quality Improvement Plan.

35. EMERGENCY DEPARTMENT AT UNIVERSITY HOSPITALS OF LEICESTER

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust provided an update on the current state of play since the move to the new Emergency Department.

The Chair commented that she had attended the preview tour of the new Emergency Department and had been impressed with the facilities it provided.

In presenting the update, the following comments and statement were noted:-

a) The new emergency department had transformed privacy and dignity for patients, particularly for the frail and elderly.

b) There used to be all year round pressures but now the unit had sufficient space to accommodate big surges in attendance. There had been positive feedback on the design, quality and the build of the new facility.

c) The Trust was not consistently improving performance against the 4 hour target and as performance was still somewhat erratic. The goal was now to achieve 90% of patients being seen within the 4 hour target compared to the previous target of 95%. Overall all A&E departments in the country were performing at around 87%.

d) Approximately 35 initiatives had recently been implemented in an attempt to bring about a more consistent improvement and these were outlined in the report.

e) The Emergency Department was now one of biggest in the country seeing 600-800 patients a day. One initiative had been to provide improved access to consultants for a trial period during the night so that junior doctors could get guidance on treatment of patients with minimal delay. More porters had been provided and processes changed to allow quicker access to tests for patients. This had made improvements and a medium term plan was being developed to provide sufficient medical resources during the evening and overnight periods. Last week the Trust had been rated as the 107th performing Trust when previously they had been rated the worst.

f) The Trust has been 'buddied' with Luton and Dunstable NHS Trust which was one of the top performing trusts in the country. Although they were smaller in size, their system of operation was the key factor in providing efficiencies and long term improvements. Staff from Luton had visited Leicester to observe the relationship between specialties departments and the Emergency Department. UHL Trust were now looking to change practices and embed Luton's culture in the Emergency Department. This involved providing additional staff

resources in the Emergency Department and changing downstream working and responsibility in departments.

g) Currently UHL aimed to assess patients within an hour of arrival, devise a treatment plan within 2 hours and determine whether a patient needed to be admitted within 3 hours, and then locate a bed and move the patient to a ward within 4 hours. The Luton model assessed the patient in the Emergency Department and located a bed within the first hour. UHL were looking at an electronic bed management process to improve patient flows.

h) Phase 2 of the Emergency Floor would see the co-location of the specialised assessment units next to the new Emergency Department. This would bring together the Emergency Department and the bulk of where medical patients would need to be treated. The GP Ambulatory Unit would also move to a dedicate space within the emergency floor. This unit assessed patients who had been referred by GPs but were not considered to require an admission. These patients would now bypass the Emergency Department and go directly to the Ambulatory Unit. It was planned to open this unit in December so that it was in place for the winter 'surge' period. The remainder of Phase 2 was on target and within budget and would be fully operation in the spring of 2018.

In response to Members' comments and questions, the following responses were received:-

a) Key concerns in relation to the Winter Care Plan were having sufficient staff in the event of a flu epidemic. Staffing recruitment was now more acute than they were pre Brexit; as the number of EU nurses employed by the Trust had fallen from 400 to 200 and the Trust currently had 500 vacancies. The Trust could not open more beds as there were not enough trained staff to attend to them.

b) The Red to Green system was contributing to making improvements in patient flows as it reduced the time patients were in hospital waiting for investigations and tests.

c) The Trust would shortly be issuing a tender for a partner to provide the Trust with GPs.

d) The Trust were working with local GPs and the CCG to reduce the number of people coming to the Blue Zone (the assessment area for walk-in patients) so that inappropriate referrals could be re-directed to the hubs within the City and County. The GPs working in the Blue Zone provided a valuable primary care service to those patients that really needed it. The Trust was also looking to provide some primary care support at the Emergency Department reception to help to deflect patients to alternative care providers.

e) Patients requiring the facilities to be provided in Phase 2 would use a

separate access through the Emergency Department. There would be no walk-in access to these services.

f) There were up 200 ambulance arrivals per day at the Emergency Department and 1 in 3 patients at the Department arrived by ambulance.

g) UHL offered A&E consultants a varied work experience package which made recruitment easier and consultants trained by the Trust had a tendency to stay with the Trust longer than in other Trusts. This was important as there was a national shortage of ED consultants.

h) The 4 hour target, although a much criticised target, was a good proxy of how the whole system from arrival to discharge was working. If it all worked well there was no problem. There was a national debate in relation to the target being a blunt instrument that distracted from the sickest patients receiving timely treatment; because it related to all patients that attended an A&E department.

I) The number of patients attending the ED had plateaued for first time in some years and admissions seemed to be stabilising as well. The less unwell patients attending the ED were considered to be manageable as long as there was a process of streamlining at the front desk. There were some initial indications that the patient flows seemed to be more manageable now.

m) The Trust were looking to find a sustainable way to have senior decision makers (consultants or senior registrars) in the ED in the afternoons and nights to provide a more efficient patient throughput. Rotas were being designed for them to be in ED which would reduce admissions as they were more confident to find community services when appropriate.

AGREED:-

(1) That Mr Adler be thanked for presenting the report and for openly responding to Members' questions.

(2) That a further update be submitted in the spring of 2018 following the full implementation of Phase 2 of the Emergency Floor.

36. DE-COMMISSIONING OF NON-EVIDENCED BASED TREATMENTS FOR LOWER BACK PAIN WITH OR WITHOUT SCIATICA

Members received a report that outlined Leicester City CCG, East Leicestershire & Rutland CCG and West Leicestershire CCG's plans to de-commission a number of interventions for lower back pain, with or without sciatica, in line with National Institute for Health and Care Excellence (NICE) guidance published in November 2016. Dr Umesh Roy, Lead Planned Care, Helen Mather, Implementation Lead Planned Care and Sarah Prema, Director of Strategy and Implementation represented Leicester City CCG at the meeting to present the report and respond to Members' questions.

It was noted that:-

- The 3 CCGs were implementing the NICE guidance to streamline the management of treatment so that patients could return back to work earlier.
- Approximately 20% of the population suffered from back pain and it often led to patients developing mental health issues in the long term if the problem became chronic. Equally, many people suffering from common back pain regularly got better without any treatment and the guidance promoted self-care as key component of the treatment options for back pain. Self-care could involve weight reduction or exercise regimes.
- The proposals were intended to look holistically at how health services managed back pain.
- 360 patients were currently affected by the proposals and this number would reduce in the coming months as each individual period of 12 week treatment ended. Those already on the 12 week treatment course would have the option to continue to the end of the treatment.
- The model of treatment would reduce referrals and imaging for low/medium risk patients and focus the activities of specialist services on those at high risk of a poor outcome who would require a more intensive input.
- Patients would also be advised of other treatments available in the community if they wished to pursue them at their own expense.
- The redesign of the physio-therapy service also involved redesigning the website to assist people to access and self- refer to service they required.

AGREED:

That the proposals be noted and that the representatives of the CCG be thanked for attending the meeting and responding to Members' questions.

37. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2017/18.

AGREED:-

That the Work Programme be noted and updated to include the actions arising from the meeting.

38. CLOSE OF MEETING

The meeting closed at 8.23 pm.