Leicester
City Council

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

Held: FRIDAY, 27 APRIL 2018 at 10.00am

P R E S E N T:

Councillor Cutkelvin – Chair of the Committee
Mr L Breckon CC – Vice Chair of the Committee

Leicester City Council

Councillor Chaplin	Councillor Corrall
Councillor Osman	Councillor Sangster

Leicestershire County Council

Mr P Bedford CC	Mrs A.J. Hack CC
Mr T Parton CC	Mrs D Taylor CC

Rutland County Council

Councillor Dr L Stephenson Councillor Miss G Waller

In attendance

Mr Simon Fogell – Healthwatch

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46. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and asked those present to introduce themselves.

The Chair thanked Members for their contributions towards the agenda; items for consideration included suggestions from both the Leicestershire and the Rutland County Councils. Officers were also thanked for their collaboration in compiling the agenda.

The Chair reminded everyone that the primary purpose of the meeting was to consider items that were relevant across all three authorities to prevent duplication and to come to a shared position on particular items.

47. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Councillor Fonseca	Leicester City Council
Mrs Fryer C.C.	Leicestershire County Council
Dr Hill C.C.	Leicestershire County Council
Councillor Waddington	Leicester City Council

48. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda.

Councillor Chaplin declared that she was a patient of the Leicestershire Partnership Trust in the Mental Health Services.

49. MINUTES OF PREVIOUS MEETING

AGREED:

that the minutes of the meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee held 27 June 2017, be confirmed as a correct record.

50. PETITIONS

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

51. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

52. REVISED WORKING ARRANGEMENTS AND TERMS OF REFERENCE

Members were asked to agree the revised working arrangements and Terms of Reference for the Committee. Members heard that the main change related to the plan to rotate the Chair every two years. The City Council would nominate the Chair for the period May 2018 to May 2019 and the County Council and the City Council would then rotate the position of Chair and Vice Chair in each two year cycle afterwards.

RESOLVED:

that the Revised Working Arrangements and Terms of Reference

for the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee be agreed.

53. UPDATE ON LEICESTERSHIRE PARTNERSHIP (NHS) TRUST IMPROVEMENT PLAN FOLLOWING THE CARE QUALITY COMMISSION INSPECTION

The Chair introduced the item and explained that a report of the Leicestershire Partnership NHS Trust (LPT) on the Care Quality Commission (CQC) Inspection 2017 had been considered by Leicester City Council's Health and Wellbeing Scrutiny Commission on 7 March 2018. That report was attached at appendix B4 of the agenda. At the meeting, Members had requested further information on the inspection and also for the Clinical Commissioning Group (CCG) to provide an update from their perspective on the inspection and the LPTs response. The Chair added that she was pleased that areas inspected had moved from an 'inadequate' rating to 'requiring improvement'.

Dr Peter Miller, Chief Executive of the Leicestershire Partnership (NHS) Trust presented a report that outlined a summary of the CQC's latest key findings as well as details of the Trust's processes for delivering assurance against the CQC inspection action plan. Members heard that Dr Miller was pleased with the improvement in the five services that had been inspected. While he wanted the services to be 'Good', the CQC's findings demonstrated that the trust was on a positive trajectory.

Members were asked to note that the CQC inspection had taken place at a specific point in time and it did not reflect the pressures that the Trust were under; including pressures in Children and Adolescents' Mental Health Service (CAMHS) and Adult Mental Health Services.

Dr Anne Scott, Acting Chief Nurse, East Leicestershire and Rutland Clinical Commissioning Group presented a briefing paper, as previously circulated, which provided an update on the commissioners' processes for monitoring the progress against the action plan.

During the ensuing discussion, a number of questions were raised. Those questions and their responses included the following:

- Dr Miller was asked if the outcome of the inspection would have been different if there had been a full complement of staff. The theme in the inspection report was that the Trust was under-resourced. Dr Miller responded that staffing and the workforce was the biggest risk on their risk register but there were monthly safer staffing reports and he was confident that there was adequate staffing at all times on all of the wards to maintain safe levels; however there were at times significant numbers of bank and agency staff to maintain those levels. Dr Miller did state though that bank staff are often existing staff members and that they knew the service well. Across the Trust there should be about 1600 band 5 and 6 qualified nurses but there were currently about 220 vacancies. There should be 150 registered nurses on the Bradgate Unit, but there were regularly vacancies

of 40-50 nurses so the challenges were to deliver consistency of care. Bank staff were subject to the Trust's training and support which resulted in greater compliance to the Trust's policies. Agency staff may be new to the ward and there was less likelihood of compliance. Dr Miller did therefore believe that a full complement of staff would have led to a better inspection outcome.

- Concerns about fridge temperatures and lack of monitoring were raised by Members. Dr Miller explained that there were procedures in place to monitor fridge temperatures and it was extremely frustrating that the inspection had identified that fridge temperatures were not being monitored correctly. There had been improvements and there was an automatic system to monitor fridge temperatures on some wards; this needed to be rolled out across all wards. Dr Miller added that this was something he was determined to get right. The Chair expressed concerns that the failure to monitor fridge temperatures had been a recurring problem. Dr Scott responded that while the CCG recognised that there was still work to be done, the CCG had been reassured that it was an isolated incident.

- Members asked why staff preferred to be part of the Trust's bank staff as opposed to having fixed hours contracts. The meeting heard that some people preferred the flexibility; they might have caring responsibilities or may not want to work at nights or weekends. The Trust tried to ensure that bank staff were as much a part of the organisation as the substantive work force.

- A Member questioned whether the culture within the Trust was such that staff were confident about approaching management with concerns. Dr Miller commented that there was a significant number of staff who felt they could raise issues with management but he acknowledged that staff surveys suggested staff in some areas might be reluctant to do so.

- Dr Miller was asked about training provision in areas such as communication and stressed the importance of people skills. Dr Miller responded that communication skills were a core part of training and there was also mandatory training in about 15 different subject areas.

- In response to a question, the meeting heard that there were women psychiatrists and the Trust tried to respect requests for referral to them where possible.

- A question was raised around the process for GPs and Locums to feed in their concerns and report complaints. Concerns were expressed that there may be barriers in particular for Locums to do so. Dr Scott said that the CCG received complaints from GPs and Locums, though not necessarily in relation to the LPT. She did not believe it was difficult for Locums to report a concern or submit a complaint as such concerns were submitted by email. After some discussion, Dr Scott said that she would feed the concern back to the Patient Safety Team and the Chair asked for this to be fed into a future scrutiny report, possibly on staffing issues.

- In response to a question relating to compliments, Dr Miller responded that they received more compliments than complaints and the Trust tried to feed them back to the individuals concerned. Both compliments and complaints were reported to the Board.

- A member referred to the action plan and asked Dr Miller how confident the Trust was that the plan would result in prompt improvements to achieve an overall rating of 'good'. Dr Miller responded that there had been improvements but some challenges remained, such as the estates, in particular the Bradgate Unit, and staffing. These were likely to remain an issue when the CQC returned in November.

- In respect of the Bradgate Unit, a capital bid was being compiled to fund either a re-build or a revamp. This would give patients privacy and dignity and make the provision CQC compliant. It would take some considerable time to put together the bid but it was anticipated that a strategic outline case would be ready in July 2018.

- Dr Scott was asked whether the CCG had the appropriate skilled and trained staff to carry out effective performance management and audits on contracts. Dr Scott confirmed that the team who managed contract monitoring were senior staff who were skilled and trained in that specialism.

- In response to a question, Dr Miller said that issues around cleanliness had been found on one ward. Cleaning was carried out by contractors provided by the UHL and the LPT had increased their scrutiny in relation to their performance. He was confident that there were sufficient resources to ensure that cleaning was carried out to the expected standard, but he had concerns as to whether there were sufficient resources in relation to maintenance and repair.

- Dr Miller was asked whether there were targets for the discharge of those patients receiving treatment from the mental health service. Members heard that while no individual patients had a target, they were looking forward to try to discharge patients as soon as possible to alleviate pressure on beds.

The Chair drew the discussion to a close with the following comments:

- It was pleasing to note that all the 'inadequate' ratings had been removed, some improvements were being made and it was important to remember that until fairly recently, the 'requires improvement' rating equated to satisfactory.

- Staff in the LPT were praised and the Chair requested that the thanks of the committee be passed onto them as they were essential in any improvement journey.

- The problems with the estate were noted; the committee would like to see the plans for the re-building of the Bradgate Unit at a future meeting.

- It had been helpful to see the action plan in more detail but assurances were sought as to the monitoring of issues once they were removed from the plan.

- The CCG were thanked for attending the meeting and the Chair felt assured that they and the Quality Assurance Committee were monitoring progress.

- There were concerns however relating to the 19 'must do' actions and whether they would relate to an improved future inspection.

- The Chair expressed concern that the committee had not been fully assured that actions around medicine management, fridge temperatures, cleanliness and blind spots in waiting rooms had been completed and could be taken off the action plan.

- It was acknowledged that the LPT were currently going through the Transformation Programme and it was anticipated that this would result in some further improvements. The Chair asked that any outcomes from that strategic piece of work should be shared with the individual authorities after which a decision could be made as to whether to consider that further as a joint committee.

The Chair moved that the Committee supported the action plan but wanted to see prompt improvements in the fundamental issues such as cleanliness, medicine management, fridge temperatures and blind spots in waiting rooms. This was agreed by the members of the committee, with the exception of Councillor Sangster who abstained.

The Chair also requested that an update on the action plan be brought to the Committee in one year's time.

AGREED:

1) that the Committee support the action plan but want to see prompt improvements in the fundamental issues as detailed above; and

2) that a further update be brought back to the committee in one year's time.

54. UPDATE ON CHD SERVICES IN EAST MIDLANDS AND THE NHS ENGLAND REVIEW INTO PICU AND ECMO SERVICES NATIONALLY

Dr Frances Bu'Lock, Honorary Associate Professor in Congenital and Paediatric Cardiology presented a briefing paper that provided the committee with an update on the Congenital Heart Disease (CHD) services in the East Midlands and progress of the national reviews on Paediatric Intensive Care (PICU) and Extra Corporeal Membrane Oxygenation (ECMO) services in England.

The Chair stated that the committee was very pleased that the NHS England

National Board had agreed to continue to commission the UHL NHS Trust to provide Level 1 CHD services, and that a fair and achievable target had been set. She thanked members of the committee and officers for capturing the intricacies of discussions in such detail, and while many people had been involved in the campaign, she felt that the contribution of the committee could not be underestimated. Dr Bu'Lock also expressed her appreciation for the rigour with which the committee had challenged NHS England.

Dr Bu'Lock explained that many of the targets were similar to those in the other centres, with the main exception being that they had to move the paediatric part of the service to co-locate with the children's services. The Chair stated that if the capital funds were available, the paediatric service would move into the Kensington building, but if capital was not made available, the service would locate in the Balmoral building and she questioned how long the service could wait for a decision regarding funding before opting for the Balmoral. Members heard that there was some flexibility in awaiting the decision. Dr Bu'Lock commented that that the NHS did not have the funding so this was dependent on the outcome of discussions with NHS Improvement and the funding for the Sustainability Transformation Plan.

Members heard that while no adult surgical cases were completed for three to four weeks because of winter pressures and the demand for respiratory beds; the Trust put in measures to prioritise paediatric cases where beds in the High Dependency Unit were sufficient as opposed to beds in Intensive Care. The overall target for surgical procedures was met but issues around winter pressures could impact on future targets.

The Chair stated that she and the Vice Chair had received a letter from Nottingham City Council seeking assurances that the committee would continue to monitor performance against targets set by NHS England. The Chair said that they would write to Nottingham to give them those assurances. Dr Bu'Lock expressed concerns that the University Hospitals of Nottingham were carrying out congenital cardiac intervention procedures on patients, although they were no longer supposed to be doing this. Concerns were expressed that this was placing patients at risk. It was also noted that this impacted on the numbers of patients undergoing surgical procedures in Leicester. Dr Bu'Lock added that it would be very helpful if the committee would write to Nottingham City Council to encourage them to ask the University Hospitals of Nottingham to refer all of their congenital heart work to the UHL. It was agreed that this would be included in the recommendations.

The Chair concluded the discussion and stated that it appeared that there were no further updates on PICU and ECMO services at the moment but asked for any relevant updates to be brought to the committee at the appropriate time.

AGREED:

1) that the committee agree to continue to monitor performance against the targets set by NHS England and an update be brought to the committee in one year's time, particularly to include targets, issues around winter pressures and the numbers

of referrals;

2) that a letter be sent to Nottingham City Council providing assurance about the monitoring of targets and to request that they encourage the University Hospitals of Nottingham to refer their congenital heart patients to UHL; and

3) that the minutes of this and future meetings of the committee where Congenital Heart Disease is discussed, to be shared with Nottingham City Council.

55. REPORT OF THE UNIVERSITY HOSPITALS OF LEICESTER (NHS) TRUST - CARE QUALITY COMMISSION INSPECTION

Sharron Hotson, Director of Clinical Quality, University Hospitals of Leicester (NHS) Trust (UHL) submitted a report that provided the committee with an overview of the outcome of the Care Quality Commission's (CQC) inspection of the UHL that took place in November and December 2017 and their Well Led review which took place in January 2018.

The Chair noted that within the inspection report, there was praise in some areas including the care of patients with sepsis. Some areas required improvement and Improvement Notices had been served in relation to insulin management.

Sharron Hotson presented the report and explained that the inspection report had been published in March and the action plan had been very recently submitted to the Quality Outcome Committee. There was also a separate action plan which related to insulin management and was subject to weekly monitoring and monthly reporting to the Board. Ms Hotson commented that it would take time to embed the new practices for insulin management; as every patient on every ward was affected.

Ms Hotson referred Members to the ratings table contained within the report and explained that some of the ratings related to a previous inspection. Those ratings could not be changed until the CQC re-inspected those areas. Members heard that there were no inadequate ratings from the most recent inspection.

A Member expressed concern that targets for some areas of staff training and appraisals were not being met. The value of the staff was emphasised and Ms Hotson was asked what the UHL were doing to address those concerns. Ms Hotson responded that there had been a problem with delivering training with the pressures during the winter months but Members were also asked to note that the data had not portrayed the correct information. The system had now been improved and targets were being monitored.

It was noted that St Mary's Birth Centre had received a 'good' rating on all aspects and in response to a question, Ms Hotson confirmed that the centre was one that Sustainability Transformation Plan was proposing to close.

A Member asked about the 'Red to Green' process for the discharge of patients. Ms Hotson explained that this was a tool that was used to ensure there was a timely discharge. If there were delays, there was need to understand what those delays were and what action could be taken. The Red to Green had added transparency to the process. Ms Hotson was asked whether some discharges took place too soon resulting in the patient being readmitted. Members heard that discussions about discharging the patient and the situation at home often occurred prior to operations taking place but it could be very difficult to manage expectations. The Chair stated that there needed to be a culture shift; Members at the Leicester City Council Health and Wellbeing Scrutiny Commission meeting had heard that patients, through patient choice, opted to remain in hospital longer rather than going into a community hospital.

A Member referred to leadership and questioned whether improvements in leadership would result in an overall improved rating. Ms Hotson explained that just two ratings of 'requiring improvement resulted in an overall rating at that level. There was a confidence in leadership at Trust level but this needed to be across the board at every level so it was a challenge to get that right. A concern was raised that the inspection report referred to inefficient performance management and Ms Hotson responded that the action plan included work around capacity and the capabilities of the clinical management team, who were the next level down from the Executive Team.

A Member questioned whether all the appraisals were being entered onto an electronic system and it was confirmed that there was an electronic system for recording appraisals, details of which were sent to managers. Questions would then be asked if appraisals were not taking place as it was very important for staff to have individual time with their manager.

The Chair concluded the discussion and made the following points:

1) The report had recognised some outstanding areas of work including the St Mary's extended post- natal care which was particularly beneficial to women with complex needs and physical disabilities. The Chair suggested that this could be considered at a future meeting alongside discussions around the STP.

2) The Chair was very pleased with the work that had taken place with the Emergency Department and sepsis team and that the experience gained was being used in relation to insulin management.

3) The new purpose built Emergency Department was excellent and had increased capacity to manage pressure surges, such as admissions from the East Midlands Ambulance Service.

The committee agreed that it would like to receive future CQC inspection reports relating to the UHL and Councillor Waller asked that the future reports be brought to the committee at a time when the action plan was also ready.

AGREED:

that further CQC inspection reports of the University Hospitals of Leicester (NHS) Trust, along with the resulting action plans, be brought to future meetings of the committee.

56. UPDATE ON THE EAST MIDLANDS AMBULANCE SERVICE QUALITY IMPROVEMENT PLAN

Richard Lyne, General Manager of the East Midlands Ambulance Service (EMAS) submitted a report that provided an update on the Quality Improvement Plan that arose following their CQC inspection.

The Chair introduced the item and explained that the Leicester City Council's Health and Wellbeing Scrutiny Commission had considered EMAS and the hand-over time at the Leicester Royal Infirmary at their meeting on 4 October 2017. The Committee had been given assurances that the new Emergency Department (ED) would increase capacity and the ability to deal with pressure surges from EMAS. However there had been winter pressures since and reports of ambulances stacking up and delays in transferring patients into the ED; all of which impacted on the rest of the county. The Chair had also heard that EMAS had requested an additional £10m funding over the next two years and then £20m which represented a 12% increase in their annual budget. This was requested in order to meet the national target which included a seven minute response time (this was currently at 9%).

Mr Lyne presented the report and explained that since the last meeting they were now in a position to address some of the 'could do' actions arising from the inspection as the key actions had been addressed. Points made included the following:

1) Leicester was now the second county in the East Midlands region to adopt the pre-hospital treatment antibiotic therapy. The therapy had been rolled out earlier that month and was a very important development in managing life threatening sepsis.

2) A leadership development programme had been put in place across all of EMAS' leaders regardless of their level of management.

3) Duty of Candour was now fully embedded which ensured that an acknowledgement and appropriate response was given when the service fell below the standard that was expected.

4) A training needs analysis was now in place for all of the paramedics. Paramedics had been upgraded from a Band 5 to a Band 6 and a requirement of that upgrade was for all paramedics to have a training needs analysis.

5) There had been a capacity and demand review which had identified a gap between demand and in what EMAS could provide, hence the request for investment to fund more front line clinicians and ambulances. In respect of this; negotiations with the CCG were currently taking place.

6) There had been a very challenging winter with activity 6% higher than anticipated between December 2017 and March 2018. There had also been an increase in acuity with approximately 12 % of the calls involving life threatening conditions. Given the increase in calls, the delays at the Leicester Royal Infirmary were significantly lower than the previous year. The average handover time during that winter period was approximately 26-27 minutes compared to 31 minutes the year before.

A Member commented that she was pleased to hear about the improvements and questioned what determined the response target; whether it was the condition or the individual concerned. The meeting heard that a lady in her 90s had fallen onto cold concrete floor outside when it was snowing but the call-handler did not consider the incident was urgent. The lady waited for 10 hours before the ambulance came and her son had been told not to move her. Mr Lyne explained that the clinician's assessment had been that the need was not urgent; but the clinician would have been in contact with the patient or their representative during that time and would have re-categorised the patient if the situation became more urgent. It was very unfortunate as it was very difficult to balance priorities.

Mr Lyne was asked whether the campaign to persuade people to visit pharmacies etc. before seeking medical treatment from a doctor might have resulted in higher incidences of acuity. Mr Lyne explained that he believed that the very cold weather and the numbers of people suffering from respiratory disorders had led to the higher incidences of acuity, but he would take these observations back for further considerations. He did not however believe that people were leaving it later before they called for an ambulance.

A Member questioned whether co-locating vehicles along with the Police and Fire and Rescue Service, had resulted in improved response times. Mr Lyne did not believe that it had improved response times because the vehicles were just garaged together and once they went out to respond to a call, they stayed out rather than return back for stand-by. The system had however resulted in better team working with partners and the economies made enabled investment in the front line.

A member asked whether someone on calling 999, might be advised of the waiting time for an ambulance and told that if they could be moved, they might prefer to find their own way to hospital. If that was the case, it was questioned whether an option might be to use taxis or similar to transport people. Mr Lyne responded that the clinicians would give the expected response time and where feasible talk to the patient or the patient's representative about finding an alternative way of going to hospital. They were looking a new ways of delivering the service to meet increased demand. There was also a new urgent care service which was dedicated to GP and health care professional referrals and this separated out those referrals from accident and emergency calls. This was a very new system but was already showing promising results.

A Member commented that many residents in Rutland went to EDs in

Grantham, Kettering or Peterborough and questioned whether there were similar problems with ambulance transfer times there. Mr Lyne responded that the Leicester Royal Infirmary had one of the busiest EDs in Europe and so the problems experienced there were not usually experienced in those other hospitals.

A member asked whether the 15 minute turnaround target was achievable and Mr Lyne responded that if the resources and pathways were there, the target was achievable but given the pressures that existed across the whole system, especially within Adult Social Care, the target was something that needed to be worked on and would continue to present challenges.

The Chair asked how the additional requested investment would drive through the necessary improvements. Mr Lyne explained that much would be predicated on handover times and while they needed more clinicians and ambulances, they also needed to work with their acute partners to improve those handover delays and find different models of care and new pathways.

The Chair concluded the discussion and congratulated EMAS for the improvements that were being made.

AGREED:

that the report be noted and a further update be brought back to the committee in one year's time.

57. CLOSE OF MEETING

The meeting closed at 12.30 pm.