Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 3 APRIL 2014 at 11.30am

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council
Dr Tony Bentley	–	Leicester City Clinical Commissioning Group – attending for Professor Azhar Farooqi
Dr Simon Freeman	–	Managing Director Leicester City Clinical Commissioning Group
Chief Superintendent Rob Nixon	–	Leicester City Basic Command Unit Commander, Leicestershire Police
Councillor Rita Patel	–	Assistant City Mayor, Adult Social Care
Philip Parkinson	–	Healthwatch Leicester – attending for Karen Chouhan Chair of Healthwatch Leicester
Tracie Rees	–	Director of Care Services and Commissioning, Adult Social Care, Leicester City Council
Councillor Manjula Sood	–	Assistant City Mayor (Community Involvement), Leicester City Council
Trish Thompson	–	Director of Operations and Delivery, Leicestershire and Lincolnshire Area, NHS England
Deb Watson	–	Strategic Director Adult Social Care and Health Leicester City Council

Invited attendees

John Adler	–	Chief Executive, University Hospitals of Leicester NHS Trust
Rachel Bilsborough	–	Divisional Director, Community Health, Leicestershire Partnership NHS Trust
Ruth Lake	–	Director Adult Social Care and Safeguarding, Adult Social Care, Leicester City Council.
Dr Peter Miller	–	Chief Executive, Leicestershire Partnership NHS Trust
Carmel O'Brien	–	Chief Nursing and Quality Officer, East Leicestershire Clinical Commissioning Group
Paul St Clair	–	Assistant Director Operations, East Midlands Ambulance Service NHS Trust
Jane Taylor	–	Emergency Care Director, Leicester, Leicestershire and Rutland, University Hospitals of Leicester NHS Trust
Mr E White CC	–	Chairman, Leicestershire County Council Health and Wellbeing Board
Mark Wightman	–	Director of Marketing and Communications,

University Hospitals of Leicester NHS Trust

In attendance

Graham Carey	–	Democratic Services, Leicester City Council
Sue Cavill	–	Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit

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74. APOLOGIES FOR ABSENCE

Apologies for absence were received from Karen Chouhan, Chair Healthwatch Leicester, Professor Azhar Farooqi, Co-Chair Leicester City Clinical Commissioning Group, Elaine McHale, Interim Strategic Director, Children's Services, Leicester City Council and David Sharp, Director, (Leicestershire and Lincolnshire Area) NHS England.

75. INTRODUCTIONS AND WELCOME

The Chair welcomed everyone to the meeting. He welcomed Mr E White CC, Chair of Leicestershire County Council's Health and Wellbeing Board.

The Chair reminded everyone that the last meeting held on 6 March 2014 had been held to understand the issues of A&E and Urgent Care and to explore the effectiveness of various interventions that had been taken. It had been agreed to meet again the review the implementation plan and to seek assurances that the plan would be effective as it needed to be.

76. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business to be discussed at the meeting. No such declarations were made.

77. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting of the Board held on 6 March 2014 be confirmed as a correct record, subject to the start time being amended to 2.00 pm.

78. URGENT CARE/A&E AT UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Jane Taylor, Emergency Care Director, Leicester, Leicestershire and Rutland, gave an overview of the actions taken over the last 6 months. During the overview the following points were made:-

- The production of the improvement plan was a continually

evolving process involving a constant review process by all partners to examine what had worked and what had not.

- Everyone involved was clear on the key themes of the improvement plan, the level of engagement and the complexity of the actions taken over recent months.

- There had been an on-going tracking of a set of indicators on a weekly basis over the last 4 weeks.

- National Standards for Accident and Emergency/Urgent Care systems had recently been published which set out 5 key areas and standards of performance for the following areas:-

    - Demand Management
    - Flows of patients within A&E
    - Hospital Flows
    - Delayed Transfer of Care
    - Wider Governance Issues

- The review and planning process had taken place to consider current arrangements against these national standards to see how the services were currently performing and what was needed to be done to achieve each of the national standards in the five key areas. The Plan was also being aligned to the Better Care Together programme and NHS organisations operational plans.

- The first draft of the Action Plan, which was being considered at the Trust Board that evening, would give a framework to build upon for what needed to be done. The detail behind the action plan would evolve over coming months.

Following questions by Members of the Board it was noted that:-

- The CCG were supporting UHL in a number of initiatives to help patients to be treated in more appropriate and alternative places than being admitted to acute services at UHL. These involved:-

    - Proactive case management of patients. E.g the named GP for every patient over 75 years old.

    - Nursing home and housebound patients' interventions to prevent unnecessary hospital admissions.

    - Management of responses to calls to the ambulance service.

    - Consultant triage process of patients from GP referrals. This was working well, although it was not an easy task to have a named GP for each patient over 75 years old

and to be available at all times for case discussions with the consultant, nor was it easily fundable.

- There was evolving evidence that public information campaigns for the winter months were more successful when targeted at specific health conditions or communities compared to general campaigns

- The previous National Campaign based around 'Choosing Better' was being revised locally to encourage patients to seek alternative medical intervention at an early stage rather than leave their condition untreated until it required a hospital admission. Often patients did not seek early intervention as they did not want to be 'burden on the system'. The publicity sought to emphasise that it was not being a burden to seek alternative interventions and reinforced the message that it was better to seek treatment early than leave it until the condition reached a point of crisis. It was hoped that this might make a difference to hospital admissions.

- These publicity campaigns were funded through CCG and local authority budgets.

- If GPs were able to maintain regular contact with patients in nursing and care homes it should be easier to provide earlier care interventions before a patient's condition deteriorated and required a hospital admission.

A representative of the Older People's Forum reminded Board Members that a large number of elderly people did not have access to PCs and could not book appointments online or access health websites and this needed to be borne in mind in any publicity campaigns.

The Chair asked that whilst it was recognised that the plan would be reviewed and that some services will continue to perform as 'Red'; what was likely to change, when would performances move from 'Red' to 'Green' and were there sufficient resources to deliver the outcomes required and, if not, where would the resources come from to ensure the plan was deliverable?

In response it was stated that:-

- The Plan was a product of all agencies involved in health and social care who had met 3 times since 6 March to evaluate and monitor the current situation against established best practice.

- The Plan contained a mixture of immediate actions and some complex issues which needed more time to be developed.

- The Plan would continue to be monitored by senior and middle managers of each agency involved to oversee its development and

ensure that it was delivered.

- Some of the elements in the Plan did not have any costs attached to them, whilst others had either recurrent investment costs or would require some transformational funding to enable services to progress from where they were now to where they needed to be in order to achieve long term savings and efficiencies. Those elements which required recurrent investments would need to be prioritised within existing budgets and there were some issues about whether there was sufficient transformational funding available. Creating the headroom to achieve this was always difficult.

- Although significant funds had been made available in previous years for winter care, the Trust Development Agency and NHS England had informed health trusts not to expect such additional winter care funding in 2014/15. Approximately £9m had been received in 2013/14.

In response, the Director of Operations and Delivery, Leicestershire and Lincolnshire Area, NHS England, stated that whilst trusts had been informed not to expect any additional winter care funding, should any additional funds be available these would be known at the end of June 2014, so those that required it could plan in advance on how to use it most effectively. It was therefore important to cost such plans in advance, so that if funds became available, NHS Trusts would be in a better position to bid for the funds if they had a prepared a deliverable plan. Leicester had received the additional winter care funds in 2013/14 as it was a failing health economy in delivering health targets. That situation had not changed, so Leicester could be looked upon in a favourable light should additional funds become available. The Urgent Care Working Group had already been asked to provide evidence of where services were in comparison to the national standards. The aim was to provide the information to the NHS England Midlands and East colleagues by the end of April so that any decisions on potential additional funding could be made by the end of June as part of the national process.

Following questions on the progress with the emergency floor proposals at the Leicester Royal it was noted that:-

- The emergency floor scheme required capital funding which was outside the financial issues discussed earlier. This was still part of the UHL Financial Recovery Plan which had been submitted to the Trust Development Authority for approval and a decision was expected in June.

- Approval of the financial recovery plan was not holding up the emergency floor scheme since preparatory works for the scheme were already being carried out as they had merits in their own right.

- There were two main reasons for the Emergency Floor Scheme being put forward. The first was a need to increase the physical size of the

A&E Department to enable it to cope with surges in attendance and avoid the consequent log-jams this caused. Secondly it enabled the co-location of Assessment Units and the Emergency Department so that both could work closely together to streamline the process.

- If the capital investment was not secured there was no other feasible alternative to address the issues as the refurbishment of existing facilities would cost more than the proposed emergency floor scheme.

- It was recognised that the current level of activity was not sustainable in the long term in relation to either quality of patient care or in financial terms, hence the initiatives and programmes being undertaken following the Better Care Together strategy. Longer term, these initiatives needed to reduce the flow of patients into emergency care facilities in order to achieve a sustainable health economy.

In response to Members' comments on the consequences of not securing sufficient funding to implement the improvements, it was stated that part of the work being undertaken by Ernst and Young was to demonstrate the extent of the problem and the amount of investment needed to solve the problem. This would then result in a fully costed plan that was supported by an independent third party (i.e. Ernst and Young) introduced into the process as a result of external intervention by the Trust Development Agency and NHS England. The Managing Directors of the 3 CCG's and the two Chief Executives of the NHS Provider Health Trusts were working with Ernst and Young to produce a viable plan that would make an irrefutable case to the Trust Development Authority and NHS England.

Healthwatch Leicester stated that contrary to statements in recent letters in the press, it was important to reassure the public that all interested parties had been working together for some time to address the issues of A&E and Emergency Care which were complex in nature. Whilst it would be misleading to imply that the issues could be easily remedied, it was equally important to emphasise the improvements that were being made. Healthwatch would continue to voice the concerns of patients and explain what measures had been taken and what could be changed immediately and what would take longer to achieve in order to manage people's expectations.

Board Members referred to the continued need to work together to secure adequate funding and ensure that discussions took place with those involved in the system to ensure that funding was secured.

Reference was made to Action Note 3.3 concerning target of achieving 70% of discharges before 1.00 pm each day. In response, the Chief Executive, UHL stated that whilst discussions were taking place with other trusts about achieving these targets, it was a very ambitious target. Work was also being undertaken to determine if early discharges had a detrimental effect on re-admission rates. A number of initiatives were being taken to increase the speed of discharges and these included:-

- Tackling transportation delays.
- Improving the speed of medications for patients to take home from the hospital pharmacy for patients being discharged.
- Learning from other trusts who achieve high performance levels to examine how this was achieved and if further changes could be made locally to improve performance.
- Avoiding patients having long waiting times to be discharged and avoiding patient transfers late at night wherever possible.

In closing the meeting the Chair thanked everyone for being candid in moving this issue forward. He wished to place on record that:-

- The continued effort of everyone in addressing the issues was fully acknowledged.

- It was fully acknowledged that this was a complex problem which presented huge challenges which were taking monumental efforts to put right.

- The resource implications were noted and it was important to impress on everyone taking decisions in this process that there were likely to be severe consequences in terms of performance of the urgent care system if the correct decisions were not made.

- Better Care Together was important in building an overarching framework and narrative that would link all the aspects of work being undertaken. This was intended to provide a vision that could be communicated to the public with authority, indicating that that there would be some fundamental changes in health care provision whilst reassuring the public that these were intended to provide better levels of sustainable patient care.

79. CLOSE OF MEETING

The Chair declared the meeting closed at 12.44 pm.