Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

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

P R E S E N T :

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

Councillor Cassidy
Councillor Chaplin
Councillor Cleaver
Councillor Sangster
Councillor Unsworth

In Attendance:

Councillor Palmer – Deputy City Mayor

Also Present:

David Henson	Healthwatch Leicester
Prof Azhar Farooqi	Co-Chair, Leicester City Clinical Commissioning Group
Richard Morris	Director of Corporate Affairs, Leicester City Clinical Commissioning Group
Dr Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust

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51. DECLARATIONS OF INTEREST

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

52. MINUTES OF PREVIOUS MEETING

AGREED:

that the minutes of the meeting held on 9 November 2016 be approved as a correct record.

53. PETITIONS

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

54. 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.

55. CHAIR'S UPDATE ON ACTIONS FROM PREVIOUS MEETINGS

The Chair reported that all actions from previous meetings had been incorporated into the Work Programme.

A meeting of Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee had been arranged for 2pm at City Hall on Wednesday 1 February 2017 to discuss NHS England's consultation on the Congenital Heart Disease Review affecting Glenfield Hospital.

56. PUBLIC HEALTH BUDGET

The Commission received the draft General Revenue Budget 2017-18. The Commission was asked to consider the Public Health elements of the budget. Comments made by the Commission would be considered by the Overview Select Committee on 2nd February 2017 prior to budget being approved by the Council on 22nd February 2017.

The Deputy City Mayor introduced the report and commented that all areas of the spending within and use of Public Health Budgets were being reviewed. The Public Health Budgets were currently ring-fenced and grants had been reduced in recent years. These reductions were expected to continue in future years before the ring-fence of the budget was eventually removed altogether and the public health budget became part of the Council's overall budget framework. The Government had required savings of £2 million since May 2015 and there were a number of spending reviews underway to identify further savings in the budget which would report to the Commission in due course. The current budget details for public health were, therefore, lacking detail and this detail would appear through the spending review process. The direction of travel for the future was however clear that public health services would be delivered very differently to the current situation. The provision of public health services was far wider than those currently provided by the ring fenced public health budget. There were health implications and benefits from a wide variety of services provided by all departments and services.

The Chair welcomed the opportunity for the Commission to comment upon the spending reviews as they progressed as this would give the Commission an opportunity to help shape future service provision based upon service outputs and value for money.

Members of the Commission made the following observations and comments:-

a) The current report format did not provide sufficient detail on the breakdown the public health expenditure and the impact of other services on public health. It was therefore, difficult for the Commission to make any detailed comment on this aspect of the budget.

b) There were only 3 references to public health expenditure in the draft report and there was no reference to the impact that the Sustainability Transformation Plan (STP) would have in future service provision.

c) It would be helpful to have an analysis of health outcomes compared to budget spend and how these compared to other comparator local authorities.

d) All Council budgets impacted upon health and wellbeing and mental health wellbeing and there was insufficient information in the report to specific health issues to be able to make any meaningful comment. The report also lacked any meaningful comments in relation to equality impact assessments on protected groups (protected characteristics).

e) It would be helpful for Scrutiny Commissions to receive a short 2 page report identifying specific budget issues and implications for service delivery rather than the current general report.

In summary, the Deputy City Mayor commented on Members' observations and answered their questions as follows:-

a) Precise details of financial implications and the impact of the STP on council services were still emerging as the STP continued to develop. This, added to the uncertainly facing future local authority budgets, added to the complexity and uncertainty for planning future service delivery.

b) The Public Health Team were looking at options for assessing the wide impact of budget reductions on mental health and wellbeing, but if this was to have real value it needed to encompass services both inside and outside of the council's control.

c) The current budget process, adopted in recent years, focused on budget ceilings for each department rather than specific budget levels for each individual service within a department's area of responsibility. This reflected the budgetary pressures currently faced by local authorities and provided a greater opportunity for the scrutiny function to help shape priorities and services. The Substance Abuse Review process had been a good example of this.

d) The Equality Impact Assessment (EIA) statement in the report was

appropriate for the general nature of the draft budget report. However, when the individual service reviews were considered by the Commission, the EIA statement would be far more detailed and specific to the impact of any proposed changes on the service users.

e) The reference to a budget reduction of £0.7 million in 2017/18 (paragraph 7.26) and the saving of an estimated £1.3 million consolidating a range of children's public health services into a single contract (paragraph 7.27) did not mean that the expected budget reduction of £0.7 million had been exceeded. Whilst the overall budget was being reduced there were areas such as mental health where spending would be required to increase in the future. It was necessary, therefore, to look at all services to achieve savings so that the increases required in specific spending areas could be achieved within the overall budget reduction requirements.

AGREED:

That the draft budget report be received and the Commission's comments be reported to the Overview Select Committee.

57. CQC INSPECTION OF LEICESTERSHIRE PARTNERSHIP TRUST

The Commission received a report from the Leicestershire Partnership Trust on the progress made to date in addressing the actions required after the inspection in March 2015 and the feedback received from the CQC following the re-inspection in November 2016.

Dr Peter Miller introduced the report and commented that the original report published in July 2015 had given the Trust an overall rating of 'Requires Improvement' and was critical of 3 services. The current report showed the progress that had been made since the Action Plan had been agreed with the CQC. Currently approximately 80% of actions required had been completed with evidence and approximately a further 15% had been completed but were waiting for documented evidence. Three Actions were currently Amber, these were:-

a) Clinical Risk and Assessment and Care Planning
b) Ensuring that assessment of capacity is both undertaken and recorded within patient notes.
c) The development of a Trust-wide Mental Capacity Act assurance framework.

The CQC had re-inspected in November 2016. 86 inspectors had looked at all services again and, although the Trust had received a brief verbal feedback, they were waiting for draft report which would be issued later in the week. The final report was expected to be published in February 2017 and would be followed by 'summit' meeting to determine any further action plans.

In response to Members' questions the Chief Executive Leicestershire

Partnership Trust stated that:-

a) It would be disappointing if the report did not recognise that improvements had been made in many areas; although the CQC might be concerned that the mental health pathway still required improvement and that there were too many people being placed out of county, which the Trust did not wish to see either. The Trust was not an outlier in this respect as many other Trusts were also in this position.

b) It was hoped that the STP would make the Trust more sustainable, although the process was not about increasing capacity but about supporting more people in their own homes. Currently, 60% of patients were admitted against their will under the Mental Health Act. The Trust was in the middle 50th percentile of beds per population. However, people were in hospital longer with more delayed transfers of care within the system. The delayed transfers could be attributed to a number of reasons, such as waiting for physical adaptions to patients' homes or that no available and suitable support services were in place for them.

c) The re-inspection had looked at 15 separate service lines and each one would receive a rating. The final report would be submitted to the Commission when it was published.

d) The 3 Amber ratings were because the Trust was required to demonstrate that the 'actions' had been achieved on a consistent basis and, whilst significant progress had been made, it was expected that the CQC would still expect further work to be done.

e) The Trust had increased expenditure on services and had the evidence to support this, but there was still further work required in some areas. Parts of estate were too old and required improvement and, although the Trust had a capital programme to improve the physical environment, it was insufficient to meet the improvement required.

Members commented that it would be useful to be able to compare the original report with the final re-inspection report in order to focus on what had been done since the original report to make improvements and to identify what progress had or had not been made.

The Chair stated that in future it would be helpful to have a covering report in addition to CQC report to provide more detail about what improvements had taken place. The covering report should be in the format of a scrutiny report and that council officers could give advice on style and format. It would also be helpful to have a precis that clearly set out the issues to be addressed.

The Deputy City Mayor commented that the Health and Wellbeing Board and the Mental Health Boards had looked at the issues with service users' involvement and had worked with service providers to shape improvements. He would expect the Board to continue to be engaged in the process going forward.

The Chair thanked the Chief Executive of the Leicestershire Partnership Trust for attending and presenting the report.

AGREED:-

That the report be received and that the Commission receive the final report on the re-inspection when it is published with the covering report requested.

58. SUSTAINABILITY AND TRANSFORMATION PLAN

The Commission received the draft Leicester, Leicestershire and Rutland Sustainability and Transformation Plan which was published on 21st November 2016. The Commission was asked to comment upon the proposals during the current engagement period. These comments would then be considered to determine whether any elements of the draft Plan needed amendment prior to the formal consultation on those elements of the Plan which required it in early 2017.

At the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee on 14 December 2016, it was agreed that this Commission would take the lead on the scrutiny of the new model of care for the primary care sector and the service reconfigurations for UHL acute hospital sites and Mental Health aspects.

Members were asked to focus on the new model for primary care at this meeting, as the other two aspects would be considered at separate meetings.

Prof Azhar Farooqi, Co-Chair Leicester City Clinical Commissioning Group (CCG) and Tim Sacks Chief Operating Officer East Leicestershire and Rutland Clinical Commissioning Group.

Prof Farooqi introduced the report and stated that he would be happy to submit further progress reports in the future. Although expenditure on health care services was expected to increase in future years, the continuing rise in population, coupled with an increase demand from the ageing population on health services and fast developing technology, clearly indicated that the increased funding would not keep pace with the projected costs. If nothing was done there was a projected deficit of £350m by 2020. This represented finding savings of approximately £80m per year (approximately 4% of the budget per year). It was important, however, that changes were clinically and not financially driven. It was accepted that were some areas where improvements were needed.

Primary Care services had been subjected to 10 years of static funding; a number of practices had closed, and existing practices faced pressures from, the inadequate infrastructure of many existing buildings (which were unsuitable to deliver high quality care) increased care in the community, increased emphasis on secondary prevention to stop people with conditions developing

more complications and changes in prescribing.

Most GPs were currently employed on a national contract, although this may change in the future to allow commissioners to make the changes that may be needed to provide future health services in the primary care sector. There were, however, a number of areas where the CCG could work with GPs to deliver workforce recruitment and development. For example, many GPs had received training to deliver advanced levels of diabetes treatment over recent years. There was still a need for more GPs, advanced practitioners and pharmacists.

New models for GP working, such as federations, were being developed to deliver enhanced patient services and to meet the challenges being faced by primary care. This may mean that if patients required a specific service or specialism that was not available in their own particular practice, they may need to go to another practice within the federation that was able to deliver that service or specialism. Federations also allowed GPs to work collaboratively in order to provide sustainable out of hours service delivery.

In order to achieve a sustainable health service in the future, it would be necessary to change the public's perception of the NHS and to get them to use the NHS differently. For example, patients generally expected to see a GP for all their treatment requirements, but specialist trained nurses can provide many services and patient treatments safely and effectively; which frees time for GPs to spend with patients who have more acute and complex illnesses. The challenge of changing the public perception of what the NHS is used for should not be underestimated as currently 25% of ambulance requests were for people who didn't need one and people attended A&E Departments with minor conditions that could be treated elsewhere in the health system.

The STP envisaged the following changes and pressures on GP services in the future:-

- More care will be provided in community in next 2-5 years.
- GPs would work more in a team approach to expand services available to patients.
- GPs would be taking a more focused lead and approach on complex patient care.
- There would be more locality based care rather than hospital based care.
- There would be more hub based patient care when GPs practices were not open.
- There would be more patient diagnostic services provided in the in community.
- There would be more demands upon social care services and carers and the primary care sector would need to be more involved in prevention measures.

The national contract for GPs meant that CCG's couldn't currently commission specifically designed services for each local area. CCGs could, however,

provide information, resources and access to the workforce to enable them to provide specific patient care. A new model of GP working had been issued before Christmas based upon a multi-community provider approach which envisaged a far closer relationship between groups of practices, social care services and community services with pooled budgets to provide more joined up care for patients. Elements of the model were already being seen with GP federations. There was a clear national view for providing 7 day patient access to health services in the future and the CCG was providing support wherever possible to those affected by the changes to services that were required as a result of national guidance.

Members made the following comments during discussion:-

a) It would be helpful to have more information on the work already undertaken on workforce planning.

b) The financial details of the STP had not yet been published and details of the governance arrangements were still unknown. There were still concerns over some aspects of 'red tape' and the financial uncertainty of the STP.

c) Some of the mechanisms for getting prescriptions from pharmacies were not working and some pharmacies in the City had closed down. There was anecdotal evidence of patient hubs experiencing difficulties.

d) Any pubic engagement and consultation material should be easily understood and the public should have sufficient time in which to discuss it and put forward their views. There should be adequate publicity on the process.

The following responses were received in response to Members comments:-

a) The new models of working by GP practices would need full engagement with public as a 'one size fits all' approach would not work.

b) Health Education East Midlands were aware of the workforce 'time bomb' and newly trained staff would barely cover the number of expected retirements over next 5 years. It was also important to train staff with the skills required to delivery services in the future. CCGs were required to allocate a minimum of 10.3% of their budgets into core services and all CCGs in LLR exceeded this requirement.

c) 'Push Dr' app was an independent service that had recently been launched. Patients entered details of their symptoms ect and, for a fee of £25-£40, could get advice or a private prescription. The service could not refer patients to a secondary care service and more often than not referred the patient back to their own doctor

d) GP's have not always needed to ask for public views to make minor

changes in service provision. Healthwatch and PPGs were often consulted and provided useful feedback on proposals.

e) Any fundamental change in service provision would require public consultation. However, changes to the model of service provision would not require formal public consultation; but there would be an engagement process to discuss the proposals.

f) The CCG had produced a document which would be made public soon to engage with patients within all 59 GP practices in city. There was a huge variety of views and a number of PPGs wanted to protect the traditional forms of primary care; which reflected the view that 'one size does not fit all'. The CCG were also planning a major engagement exercise in city in February and details would be confirmed soon.

g) The concerns surrounding 'home first' were understood. It was essential as part of the process to have a robust clinical assessment of a patient to determine whether the patient's condition was suitable for home care and to ensure that, when a patient was discharged from hospital, the assessment was robust to ensure that there was no likelihood of the patient being readmitted.

h) The CCGs worked with the local universities on the appropriateness and need for specific courses. Further work was progressing on enhancing skills for the existing workforce as it was important that everyone worked at the top of their competence levels and upskilling was used to maximum effect in providing health care service to patients.

i) Consideration was being given to ways of making the role of GPs more attractive to encourage recruitment and retention. For example, giving GPs a portfolio of experience involving not only working in a GP surgery but also offering opportunities to gain experience of working in A&E and specialist clinics etc.

j) Status quo was not an option for the future as waiting 3-5 weeks to see GP was not appropriate and there was clearly a need to change the model, given the finite staff and financial resources. The STP was a mechanism for providing services that patients needed within the resources available.

k) If the overwhelming view from the engagement/consultation process indicated that patients did not want change and wanted to have a GP consultation for all their health needs, then the response would be that it could continue to be provided but the likelihood would be that it would take up to 4-5 weeks to get an appointment and other patients with more complex care needs may not have care they need.

l) There was a requirement to produce an Equality Impact Assessment for every element of STP. These were in draft form at the moment but they would be made public when they were finalised. There was also an

overarching Equality Impact Assessment for the overall STP.

In response to a Member's question concerning the 'Push Dr' app, the Deputy City Mayor commented that is was not appropriate for the Health and Wellbeing Board to look at one provider of a service, but it would be appropriate to have a broader discussion on the use of technology in patient care services. He personally would not like to see patients being charged to use tele-care services.

The Healthwatch representative stated that they were concerned at the level of public engagement and had written to the CCGs offering their help in working with the public on STP. It was also recognised that the STP required capital investment in some areas of the STP to bring about the changes required.

In response, Prof Farooqi stated that the proposals for primary care within the STP were not considered in isolation but were linked to everything else in the STP. Transformation funding was needed to bring about change but currently these were unknown and NHS finances were constantly under review. There was also a need to have resilience in primary care regardless of the STP process and the focus was to ensure that patients get the quality primary care at the right time.

The Chair commented that whilst the details currently known about the proposals in the STP sounded good in principle, there were concerns that they would not work in practice. The proposals involved a high level of cultural change for staff and patients. Also, it would not be easy to have twin tracking of services when it was being proposed to make financial savings at same time. There were also challenges in bringing about a consistent cultural change for GPs, who were self-employed.

In response, it was stated that qualified nurses currently saw and treated 1,000s of patients in a safe and effective manner. There were not enough GPs to offer patients an appointment for all health conditions. Nurses have additional training to provide advanced treatments to patients and most people with multiple conditions were not getting appropriate care at moment, through lack of GP resources.

Patient safety was paramount and health professionals would not wish to see beds taken out of UHL until replacement beds were in place within community and home settings. The City already had the lowest number of beds to population ratio. There were twin tracking elements in the overall in STP. There were currently 256 virtual beds in LLR and patients were seen 4-5 times a day by health staff.

AGREED:

1) That the Co-Chair Leicester City Clinical Commissioning Group (CCG) and the Chief Operating Officer East Leicestershire and Rutland Clinical Commissioning Group be thanked for presenting the report and answering members questions.

2) That the CCG be asked to provide the overarching Equality Impact Assessment for the overall STP and that each individual Equality Impact Assessment be provided to the Commission as they are finalised.

59. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2016/17.

AGREED:

That the Work Programme be noted and the review of maternity services be brought forward.

60. CLOSE OF MEETING

The Chair declared the meeting closed at 7.50 pm.