Leicester
City Council

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

Held: WEDNESDAY, 14 DECEMBER 2016 at 2.00pm

P R E S E N T:

Councillor V Dempster – Chair of the Committee
Dr S Hill CC - Vice Chair of the Committee

Leicester City Council

Councillor T Cassidy	Councillor V Cleaver
Councillor L Chaplin	Councillor D Sangster

Leicestershire County Council

Mrs J A Dickinson CC	Mr J Kaufman CC
Dr R K A Feltham CC	Mrs B Newton CC
Mr D Jennings CC	Mr T J Pendleton CC

Rutland County Council

Councillor G Conde	Councillor G Waller

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13. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Mrs R Camamile CC	Leicestershire County Council had nominated Mr D Jennings to attend as a substitute.

Karen Chouhan and David Henson – Healthwatch Leicester

Councillor Fonseca	Leicester City Council
Steven Forbes	Strategic Director of Adult Social Care
Councillor M Unsworth	Leicester City Council

14. DECLARATIONS OF INTEREST

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

Councillor Cassidy declared an Other Disclosable Interest as a Trustee of the Carlton Hayes Mental Health Charity.

Councillor Conde declared an Other Disclosable Interest as his daughter worked as Mental Health Nurse for Peterborough and Stamford NHS Trust.

Mrs B Newton CC declared an Other Disclosable Interest as her son and daughter worked in the local health service.

In accordance with the Members' Code of Conduct the interests were not considered so significant in relation to the strategic level of discussion that was likely to take place and it was, therefore, unlikely to prejudice Councillor Cassidy, Councillor Conde or Mrs Newton CC's judgement of the public interest. Councillor Cassidy, Councillor Conde or Mrs Newton CC's were not therefore required to withdraw from the meeting during consideration and discussion on the item.

15. MINUTES OF PREVIOUS MEETING

RESOLVED:

The minutes of the meeting held on 29 September 2016 be confirmed as a correct record.

16. PETITIONS

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

17. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

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

18. SUSTAINABILITY AND TRANSFORMATION PLAN

Toby Sanders, Senior Responsible Officer for the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP) provided an overview of the draft Sustainability and Transformation Plan that was released on 21

November 2016.

Also in attendance to answer members questions were:-

Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Tim Sacks	Chief Operating Officer, East Leicestershire and Rutland CCG
Sarah Prema,	Director of Strategy and Planning, Leicester City CCG
Mark Wightman	Director of Marketing and Communications, University Hospitals of Leicester NHS Trust
Nikki Bridge	Finance Director, Better Care Together

The Senior Responsible Officer stated that the Draft STP for Leicester, Leicestershire and Rutland (LLR) was 1 of 44 plans across the country that had been governed by national directives from NHS England and NHS Improvement, in particular. The process was designed to set out health and wellbeing outcomes for the local LLR population over the next 5 year period to address the challenges of:-

- The health and wellbeing gap in terms of health needs and outcomes over the next 5 years.
- Improving care and the quality of service provision to make sure they are of high quality and safe.
- To ensure that services are provided in a way that was affordable within the funds allocated within the NHS system.

The Plan identified the following 5 key priorities for areas which it was considered required fundamental changes over the next 5 years to address the challenges set out above:-

a) New models of care focused on prevention and moderating demand growth.
b) Service configuration to ensure clinical and financial sustainability.
c) Redesign pathways to deliver improved outcomes for patients and deliver core access and quality.
d) Operation efficiencies.
e) Getting the enablers right.

These priorities would need to be developed with local authorities, patients and patient groups, community organisations and the voluntary sector etc. The Plan addressed proposals on how to:-

- Improve services provided for particular groups of patients currently presenting challenges in the health service, including improving the home first model supporting discharges from all hospitals to ensure patients, particularly the frail and elderly, are adequately supported at home as early and safely as possible; which leads to better outcomes for patients in re-enablement and recovery.
- Improve Urgent and Emergency Care Services to enable patients in times of crisis to have rapid access to emergency care services in appropriate settings and wherever possible in primary and

community settings in order to reduce pressures and demands on emergency acute services in hospitals and the A&E Department at the Leicester Royal Infirmary.

- Developing integrated teams of community based nursing staff, therapy staff and General Practice Teams working together to support patients, particularly those with long term conditions, to remain healthy and well and manage their own conditions for as long as possible.
- Improving existing pathways and service areas to provide improved services and better patient access and a better patient journey through the system including cancer, mental health, learning disabilities and children's services.

If services were improved and changed in the way they operate to deliver better outcomes to address some of the local safety and quality issues, then that should lead to some implications and changes to the way some services are configured across both acute and community hospital sites and how much capacity is needed in different areas in terms of staff and workforce and inpatient bed facilities. This in turn would impact upon how much physical and treatment capacity and staffing levels were needed in different areas.

The operational efficiencies outlined in the Plan included a number of support services such as:-

- reducing waiting times and delays which were not only frustrating for patients but were inefficient and wasteful in terms of staff time; diagnostic procedures and the time spent by people in in-patient beds.
- workforce efficiencies and workforce skill mix;
- shared IT records and care plans between different organisations and agencies; and
- the way in which the estate buildings were used.

As the draft moved forward next year, it would be strengthened and updated in line with the feedback from the engagement process and further details would be added. There would be some elements of the STP that would require statutory consultation; such as proposals to reduce the number of acute sites from 3 to 2, changes to the community hospital settings and changes to the maternity services configurations. Consultation would start as soon as practical. The two limiting factors upon the consultation were the availability of capital nationally, so that public expectations were not raised on proposals for changes to services that could not be delivered if the capital finance was not available, and the approval of NHS England to start the consultation process.

Following the questions and comments from Members, some of which have been amalgamated below, responses were received follows:-

a) What would be the impact upon the STP if capital funds were not made available? Also, Members were concerned that the financial case for the STP had not been made public, and Members were being asked to comment on proposals in the STP without the financial details involved.

Response: The STP itself was not totally dependent upon capital resources but there were some elements which could not be built if the capital resources were not provided. However, there were still legacy issues around parts of the estate that would still needed to be addressed at some point regardless of the STP process. Support from Members would be welcomed in discussions and forums to secure additional capital resources.

b) The 'Care in the Community' initiative in the 1970's had been proposed as providing better care at hone for physically and mentally disabled people but became tagged as 'dumping in the community'. It would be essential to convince the public that the proposed services to be provided at home were as good as, or better than, the services provided in hospitals. Assurances would also be needed that a swift adequate level response would be available if a patient required it at weekends or in the early hours of the morning.

Response : Work was progressing in the 'home first model' to ensure that it was a sustainable model going forward. The prime determinant for developing the model was not based upon hospital bed numbers. People were now living longer and there were better health outcomes for individuals if they managed their conditions for longer at home with appropriate support. This would require the current system to be converted from a bed based system to an integrated community care system where teams worked closer with primary care to provide the care and support when needed. This would require a significant shift in current workforce practices. The STP workforce model planned to increase the workforce in primary care by approximately 10% and decrease the workforce in the secondary care workforce by 5% over the next 4 years and this would need to continue in future years.

The Director of Marketing and Communications, University Hospitals of Leicester NHS Trust, who was responsible for the communications issues associated with the STP, indicated that there were no intentions to 'sell' the STP to the public. It was crucial that the public would be made aware of the changes that the clinicians themselves felt needed to be changed. For example, the proposed reduction of acute hospital sites in UHL from 3 to 2 was not being proposed to make financial savings, but had been suggested by clinicians as they had recognised they would not be able to provide a safe and sustainable service in the future; because the specialised workforce needed for the service had been spread too thinly on 3 sites in recent years. The STP provided the opportunity to implement these changes. Also, UHL had said in a number of forums that they would not reduce the number of beds in the acute bed configuration until beds were available in the in community and home settings and were proven to be sustainable.

c) What plans were in place to retain staff from the European Union (EU) or replace them if there were lost as a result of Brexit?

Response: It was estimated that approximately 500 EU staff were currently employed in LLR and those involved in the workforce planning elements of the

STP we conscious of the efforts needed to protect EU workers' rights to continue to work in the NHS. In addition to those employed in the NHS, there were a number of junior researchers working with universities who also played an important part in the development and delivery of health care.

d) It was important that the public consultation should be fully accessible and provide really accessible information. It would helpful to have a document written in plain English that clearly explained what was being proposed, which services were being reconfigured and what would be the consequences. The National Guidance that had prevented early publication of the draft STP had not helped public confidence in the process. It was important that the public heard what clinicians, and not administrators, felt needed to change. It was also important that the consultation documents were not structured in such a way as to provide any pre-desired outcome in responses.

Response: Following the current engagement phase on draft plan, formal consultation would begin in early 2017 and would run for 12 weeks. Full supporting plans would be put in public domain at beginning of the consultation period. The Chief Executive of NHS England had recently written to STP local areas inviting proposals for capital investment and it was hoped that the formal announcement of the national allocations of capital for specific projects would be made soon.

It was accepted that the draft STP was technical in nature conforming to a prescribed formula and had not been produced primarily for a public audience. The public summaries produced by the communication team would be critical to the public consultation process.

e) What would be the impact of the STP on BCT for adult social care and how would it protect social care offer in County, City and Rutland?

Response: Social care was included in the STP and it was recognised that social care was a key risk factor, especially given the recent national funding issues. The STP finances were set out in high level terms and these were constantly changing. Currently the CCGs were negotiating 2 year contracts with UHL and Leicestershire Partnership Trust and the final outcomes of these contracts would also determine future finance plans. Furthermore, UHL had been asked to reduce their current deficit at faster rate than previously required which also affected the financial planning. It was anticipated that there could be a £40m movement in the financial plan since the STP was originally devised. It was for this reason that the finance plan for the STP had not yet been made public.

f) How can a 12.5% net reduction in bed numbers be proposed when bed numbers have increased over last 12months? What provision would there be to future proof in the event of more beds being needed?

Response: The issue surrounding the number of beds provided by hospitals was complex and more often than not the public perception was that the

number of beds was a form of NHS currency. The STP plan was a document written for the NHS and not public. Clinicians focused on clinical outcomes for patients and sometimes there are better outcomes for patients if they are not in a hospital bed. Over half of patients in geriatric wards were unable to be discharged because they waiting for work on their homes or for appropriate care packages to be put in place. There was clinical evidence to support the view that an 80 year old patient who stayed in hospital beyond 10 days added 10 years to 'age' as they become 'deconditioned' and effectively left hospital as a 90 year old. Those involved in the care of the elderly agreed that getting people out of hospital and supported in own home was the way forward and was better for patient outcomes; however, it must be done in a safe way. The current BCF was essentially designed to keep people out of hospital for as long as possible and also to get them home as soon as possible following a hospital admission. It was not envisaged that the BCF would cease and it was reviewed regularly to enable it to support the STP strands. There was a joint process each year involving health and social care managers to identify where BCF funds should be spent in order to provide the care needed and it was envisaged this process would not change.

g) Would the efficiencies include savings of senior managers as well? Why was there a need for 3 CCGs when the aim was to work as one health and care system?

Response: The 3 CCGs were mid-sized with 320-360,000 population. All the CCGs had worked collaboratively since their creation and would continue to so in order to achieve more savings and to allow project management capacity. Some areas of the country were considering creating a single accountable care organisation. It was also generally accepted that previous re-organisations of the NHS had rarely improved outcomes for patients to the desired effect and the effort required to implement these re-organisations had diverted staff away from other priorities.

h) Rutland reported that they had already had three public engagement meetings, supported by a public facing document which had been helpful to identify the issues affecting the local population. The meetings had been supported via Healthwatch and other local organisations. Rutland had social workers at both UHL and Peterborough Hospital as 50 % of the population access services in the east.

Response: The STP supported providing care as close to home as possible. 42,000 outpatients for East Leicestershire and Rutland received care at Leicester and Peterborough. There was a real opportunity in the STP to provide services closer to home which reduced the need to travel. There were sound financial reasons for patients in savings in time and travel and it also provided the opportunity for people to be seen early and appropriately locally.

i) Given the proposals for the changes to Rutland Memorial Hospital under the reconfiguration of community hospitals, what guarantees could be provided that the finances would be found to provide the proposed extra clinics at the hospital?

Response: It was not possible to give any guarantees at this stage for the Rutland Memorial Hospital; but given the philosophy within the STP to provide those services locally there was no reason why these would not be provided. The CCG were currently in advanced talks in relation to providing these additional services and clinics.

j) What would be the impact of the STP on CHD services at Glenfield Hospital?

Response: The impact on CHD services was capital funding at this stage. The CHD Services had to be co-located at LRI because that's where the children's hospital would be and that would be funded by UHL at an approximate cost of £4m.

k) What procedures were in place to ensure that the proposals in LLR STP linked with surrounding counties CCGs STPs proposals and to consider whether there were any consequential or conflicting impacts with other areas CCGs?

Response: The STP was national process which had focused primarily on area based plans and had not included cross area conversations or integrations with neighbouring areas. All areas of LLR have links with services provided across county boundaries. CCGs were now having more active conversations on those issues since the development of the draft plans and whilst it was occurring late in the process, it was a positive step forward.

l) The STP proposals appeared to focus on adult services and not so much on children and young people's health. This was important as young people staying well can have an effect upon services demands in the future. What work was included in the STP for preventative initiatives to keep people healthy for longer.

Prevention work was considered key to reducing the demands upon hospital services especially in relation to information provided to families who could make a considerable contribution in making a difference to the levels of desperation and loneliness experienced by family members. It was important that everyone understood the pathways to GPs and nursing services to receive treatment as a measure to prevent people going to hospital.

Response: Proposals for children and prevention plans were included in the STP but the STP was not about every service. There were other children's and prevention services that were being undertaken through existing services. There were measures being taken to strengthen these existing work services, particularly on how to scale up prevention measures to provide greater benefits in the longer term.

The Director of Public Health also commented that there were challenges in providing public health prevention initiatives when faced with the current

financial pressures. There were considerable resources for health visitors and school nurses to promote prevention measures within the LLR and there were also opportunities within the STP to explore how hospital based nurses and out-reach teams could do to support prevention measures in practical terms.

The Director of Marketing and Communications, UHL, recognised the need to work more closely with public health to make every contact with patients count and to try and impart some message that would contribute to their health and wellbeing. This was not always easy to achieve when staff were often dealing with crisis situations every day.

LPT had contact with approximately a fifth of LLR population. Collectively the NHS and local authorities employed approximately 40,000 staff and this provided an enormous potential to deliver health messages and derive subsequent health benefits.

m) Some elements of the STP needed formal consultations but who decided which elements and what were they and what opportunities existed for the for public to say we think it should be other –

Response: The elements to be consulted upon were determined by statutory guidance and regulation. Statutory consultation was required where a service ceased to be provided, where services were moved from one location to another or where the change was considered to be a significant key change as opposed to organisational management changes. Statutory consultation would be required on the proposals to reduce the number of acute sites from 3-2, the provision of in-patient beds in community wards and the future of some of those sites and the proposal for moving the maternity services to the LRI with a possible midwifery led birthing pool facility at the Leicester General Hospital.

In addition discussions with scrutiny in the engagement phase may identify other proposals to be considered to be included and also scrutiny may indicate that further clinical evidence is required for the proposals before public consultation.

n) What was PF2 and which assets would be subject to disposal?

Response: PF2 was an acronym for Private Finance 2. The original Private Finance Initiative had been tortuous process and was not liked by the public sector. PF2 was easier to access funding from private providers on a fairer footing for the NHS. It would be necessary to sell some assets to develop other parts of the estate but no buildings had yet been identified.

o) What was Vanguard and how did that affect services?

Response: Vanguard was a national programme over an 18month period in 2016/17 to fund vanguard projects which are leading the way and road testing new models of care in different parts of the country. Vanguard projects have included testing out new service models for care homes, green practices for working together, emergency care services and how telephone advice was

provided through NHS 111 to get clinicians advice sooner for patients. UHL had received Vanguard funds to test service models and provide more GPs in the out of hours period to giving advice which had reduced attendance at A&E and ambulance despatches.

'Alliance' was a delivery arrangement between UHL, Leicestershire Partnership Trust and commissioners to provide approximately £20m of elective work and diagnostic services. This included moving services out of acute services to other centre that have theatres and clinics so that some elective surgery can be carried out locally. Alliance was considered to be important vehicle to enable the delivery of operational service changes quickly without incurring additional procurement processes; since these services were already procured within existing services within the Alliance. The Alliance also provided clinical governance arrangements. It was envisaged that the STP would increase the money used through the Alliance to change services in the future. The advantages of the Alliance would allow UHL staff to provide services in LPT estate buildings without the need to recharge each other.

p) As the population rose in numbers the pressures on admissions also rises and if there were reduced bed numbers at the same time this could increase the pressure to discharge patients too early or late at night. Many patients discharged early were readmitted within 48 hours and this puts an additional strain on the service. The rationale for reducing beds was understood but if the convalescent beds were not available in the community /home settings it would not help the discharge process from the acute hospital beds.

Response: Admission rates were routinely monitored to avoid patients being readmitted within a short period of being discharged. There was no pressure put on clinicians to discharge patients early and this only added to the existing pressures within the system. It was for this reason that health and social care staff were working closely together to break the cycle and ensure that adequate support was available to the patient on returning to home and that discharges were safe.

q) What could be done to address the issue of GP recruitment and retention?

Response: Leicester University Medical School had the third highest proportion of those completing their qualifications becoming GPs. The Workforce Planning Group was looking at initiatives to address recruiting GPs to replace those retiring and also to attract other health professionals to work in the LLR area. It was recognised that many new GPs currently didn't want to go into a GP partnership and opted to become a locum or sole GP instead. There was a need to make the role of a GP more attractive to provide other work experience for them.

Members asked the STP officers to identify the significant risks to delivery that caused them the most concern if the STP was to be delivered successfully. In

response it was stated that:

- That 5 years was a phenomenally challenging period in which to deliver the massive shift of resources and services required by the STP.
- There were workforce concerns as the STP would essentially require the existing workforce to be acquire new skills and be empowered at the same to deliver new services outside of their of existing working environments and also work in an integrated way to support the cultural change
- Access to sufficient capital funding to allow the investment to achieve the efficiencies that would be required with the existing estate.
- Changing the public expectation of their use of NHS services and gaining their support for the new delivery of services.
- 75% of registered nurses would retire in the next 10 years and replacing them was a challenge.
- Managing patients with complex needs in the community would only be possible if patients that don't need that level of support do not see a GP but see a nurse or pharmacist instead. This was dependent upon the public accepting that they would not receive a worse service but would get a different service which would provide the care and treatment they required at an appropriate and safe level, and this may not always be a GP.
- The challenge of implementing significant changes alongside the existing demands of the day to day job of staff, especially for clinicians who were seeing patients daily.
- A&E was overburdened by the demands placed upon it by the frail and elderly patients due the local pathways being broken and this needed to be changed.
- Given the workforce numbers and the constrained resources there were concerns that services supporting mental health, the frail and elderly may not receive the support that was required.
- It was recognised that the STP had an ambitious plan for capital funding and investment for change.

The Chair thanked the Senior Responsible Officers and his team for attending the meeting and answering Members questions. The Chair also indicated that it was somewhat re-assuring that those leading the STP process shared the same concerns expressed by Members in delivering the proposals within the STP. The whole process was dependent upon the successful delivery of change management. Poor change management usually led to flawed implementation and staff losses. There would be a great deal of detail to unpick in the lead up to the STP implementation. The three Health and Wellbeing Boards in LLR were also looking at the STP process at the strategic level and each one was leading on different areas of the Plan to allow the breadth of changes being proposed to be discussed with the resources available to them.

The Chair suggested that the three scrutiny committees of the LLR should

mirror the approach taken by the Health and Wellbeing Boards and each scrutinise specific parts of the STP whilst recognising that this did not preclude each authority considering any part of the STP if they wished.

AGREED:

1) That the officers presenting the STP be thanked for their contribution to the meeting.

2) That whilst not precluding each authority to consider any part of the STP if they wished; each individual scrutiny committee of the LLR take the lead role to scrutinise the following areas of the STP:-

	Leicester City	Leicestershire County Council	Rutland County Council
New Models of Care	Primary Care	Integrated Teams	Community Rehabilitation
Service Reconfiguration	UHL acute hospital sites	Community Hospitals (excluding Rutland Memorial)	Rutland Memorial
Other	Mental Health Services	STP proposals of neighbouring CCGs outside the LLR area	STP proposals of neighbouring CCGs outside the LLR area

Rutland County Council representatives indicated that they were already considering the STP in the round and would continue to do so in addition to the specific areas above.

3) That each scrutiny committee of the LLR consider their lead areas in early 2017 with a view to sharing their views to a future meeting of the LLR Joint Health Scrutiny Committee.

4) That the LLR Joint Health Scrutiny Committee meet again once the formal consultation has started to prepare a formal response to the consultation process in accordance with Regulation 30 of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

19. ANY OTHER URGENT BUSINESS

There were no items of Any Other Urgent Business.

20. CLOSE OF MEETING

The Chair declared the meeting closed at 4.00pm.