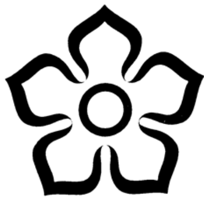

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 2 MARCH 2017 at 5:30 pm

PRESENT:

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

Councillor Cleaver Councillor Sangster
Councillor Unsworth

In Attendance:
Councillor Palmer, Deputy City Mayor

Also Present:

John Adler	Chief Executive, University Hospitals of Leicester NHS Trust
Sue Lock	Chief Executive, Leicester City Clinical Commission Group
Dr Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust
Ian Scudamore	Clinical Director for Women's & Children's Services, University Hospitals of Leicester NHS Trust
Julie Smith	Chief Nurse, University Hospitals of Leicester NHS Trust
Mel Thwaites	Associate Director, Children and Young People Services, East Leicestershire & Rutland Clinical Commissioning Group
Mark Wightman	Director of Communications, University Hospital of Leicester NHS

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61. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Cassidy and Chaplin.

Members of the Adults Scrutiny Commission and Children Young People and Schools Scrutiny Commission had been invited to attend and apologies for absence had been received from Councillors Aldred, Cole, Hunter, Riyait, Moore, Senior and Willmott.

62. DECLARATIONS OF INTEREST

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

63. CHAIR'S INTRODUCTION

The Chair stated that there would be further meetings of the Commission to consider various aspects of the STP and a further meeting of the Commission would take place on 29 April 2017 to hear the views of public, patient groups and other interested community organisations on the draft STP prior to the formal consultation process. There would also be a further meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee to submit a formal response on behalf of the three local authorities within the LLR.

64. CQC COMPREHENSIVE INSPECTION OF LEICESTERSHIRE PARTNERSHIP NHS TRUST

The Commission received the Care Quality Commission's (CQC) Quality Report of the inspection of the Leicestershire Partnership NHS Trust (LPT) in November 2016. The report was published on 8 February 2017. The Chief Executive of LPT also submitted a report that summarised the CQC's key findings and the Trust's initial response ahead of the production of a full action plan.

The Chief Executive LPT introduced the report and stated that:-

a) The Trust had received a 'Requires Improvement' rating following the initial inspection in March 2015. The follow up inspection in November 2016, involving 86 inspectors across 15 core service lines, had also resulted in an overall rating of 'Requires Improvement'; although the Safe Services rating had improved from 'Inadequate' to 'Requires Improvement'. The individual ratings for Effective, Caring and Well Led Services were still rated as 'Requires Improvement'; although it had been acknowledged that many improvements had been made since the initial inspection. The rating for a Caring Service remained unchanged as 'Good'. CAMHS Inpatient ward had received a 'Good' rating and progress had been made in adult mental health services.

b) Although disappointing, the overall CQC rating was considered a fair assessment of the improvement journey since the initial inspection and the Trust remained confident that they were moving in the right direction.

c) There was still work to be done to improve the physical environment within the estate. The Trust was in the process of changing 180 doors within the initial budget of £3m for improvements. The Trust had been planning to re-build the place of safety unit for some time following the publication of the Mental Health Crisis Care Concordat which meant that it was no longer adequate for the new requirements in the concordat. The Trust had consequently programmed the rebuilding of the unit but

this could not be achieved between the initial and follow up inspections. Rebuilding the unit was currently underway and it would reopen as all age facility, with separate entrances, in early June 2017.

d) Two central themes in the review were around staffing and the use of agency staff and the out of county pathway.

e) CAMHS had been rated 'Inadequate' overall in relation to safety and being responsive in the initial inspection. The focus since then had been to improve the waiting times for young people improving the initial triage service and introducing a new access model and additional resources for the team. As a result no one was now waiting longer than 13 weeks for an initial assessment. However, 640 young people were currently waiting for treatment and initiatives were being introduced to reduce this. The Trust, as part of the Future in Mind initiative was working with the CCG to provide a programme of measures to improve eating disorders, and provide crisis intervention. £1m of funding had been provided from 1 April 2017 for dealing with instances of unscheduled crisis. There had been a 20% increase in demand in the previous year on top of the 10% increase in the previous year. Staff were working with schools to reduce the growth in demands for service as current level of activity of 5,000 referral a year was not sustainable.

Following discussion and questions from Members, the following responses were received:-

a) The work with schools involved educational phycologists and school nurses. Schools were being asked to identify any additional support they required to enable them to pick up potential issues at an early stage and to provide early intervention and help. The work involved identifying skills staff may need and simplifying pathways to speed up the referrals process. This process would be reviewed as journeys progressed along the new pathways and public health colleagues would be involved in the process.

b) The training for staff development needed to be consistent and gradual; as it was not intended to put too much pressure on school staff and to keep their workload at manageable levels. The process would be constantly reviewed and adjustments made as the process developed.

c) Approximately £2m existing and new funding had been identified to support the commissioning process. Phase 1 of the commissioning of Worth-It Projects, an innovative social enterprise dedicated to supporting children and young people to develop and improve their resilience and emotional wellbeing, had been completed. They created bespoke evidence-based positive psychology coaching services which support children and young people to flourish. The second phase of commissioning would begin soon. Worth-It were identifying what the skills gap was and identifying measures that would ensure it could be closed.

d) The place of safety unit had originally been established for adults, but the consequence of the Mental Health Crisis Care Concordat, had meant that it then needed to provide for young people as well. When the unit was originally established it had met the requirements that were in place at the time, but the recent Concordat had introduced additional requirements which would not be met until the rebuilding of the unit was completed.

e) The CQC had felt that the Trust was not managing the list of 640 young people waiting for treatment pro-actively enough. The Trust had now addressed this issue and the process had been changed so that those waiting for treatment were contacted regularly to review their state of wellbeing.

f) Reducing the number of young people waiting for treatment would clearly be an indication of improvements being made and also maintaining or reducing the current performance on undertaking an initial assessment within 13 weeks of referral. This information on performance was now available.

g) The Trust aspired to be at 'Good' if not 'Outstanding' and significant progress had been made since the first quality summit following the initial inspection. Informal feedback suggested that improvements made in many areas were nearer to 'Good' than 'Requires Improvement'.

h) The Trust was meeting the CQC on 16 March 2017 to agree the Action Plan for Improvement and this would be monitored at regular intervals to assess the progress made. The monitoring report could be shared with the commission.

i) The Trust accepted that it was disappointing that there had been some isolated incidents in the follow up inspection that had also been mentioned in the original inspection; such as reducing ligature points, missing equipment and fridge temperatures not being monitored adequately. The Trust were trying to ensure that all staff undertake these tasks at all times across all 150 sites in the Trust's estate, but the use of agency staff can contribute to this non-compliance. The Trust was in a similar position to 5 other mental health providers in the East Midlands in the use of agency staff, and staff recruitment and retention was a national issue. Acute and specialist services vacancies were currently running at 20%; hence the reliance on agency staff. The CQC did not feel that the use of agency staff had impacted upon patient safety but it did consider it had an effect on staff morale. The September intake for new nursing entrants was down 25% and this was of concern.

j) The Trust were active in training permanent bank staff and encouraged agency staff to join their permanent and bank staff. However, some people like the freedom agency work provided in choosing when to

work, even though they lost out pensions and sick pay etc. Agency staff generally received higher payments and even though a payment cap was being introduced. The Trust was still confined by national conditions of service and payments in trying to encourage agency staff to become permanent staff. The Trust had a recruitment and retention strategy, part of which involved working with schools to offer 300 clinical apprenticeships along with UHL. Maintaining staffing levels was a challenge and remained one of the biggest risks facing the Trust.

k) In comparison to the national picture, 60% of NHS Trusts were rated as 'Requiring Improvement', 35% were 'Good' and 5% were 'Outstanding'. The Trust had invited Northumberland, Tyne and Wear NHS Foundation Trust (rated by the CQC as Outstanding) to visit them and share their experiences. Their average length of stay in hospital for mental health patients was 25 days, which was below the national average.

The Chair thanked the representatives for responding candidly to Members' comments and questions and, whilst it was clear there has been progress since the initial inspection, Members still had some concerns. It was recognised by all that staff were working in difficult circumstances to provide good care for patients. This was not made easier when the thresholds and classifications in inspection regimes changed. Until recently, 'Requires Improvement' would have been classified as 'Satisfactory' or 'Adequate' which raised less emotive reactions than 'Requiring Improvement'.

AGREED:

1) That the report be received and the representatives of LPT and the CCG be thanked for their contribution to the meeting.

2) That a further report be submitted to the Commission on the services already being provided for CAMHS, what extra services are being commissioned, any additional services that may be desirable and what outcomes will be achieved. The report to include the joint working arrangements between staff in schools, Worth-IT and other organisation involved in the process.

3) That the Action Plan and the matrix around the delivery of improvements in relation to the CQC Inspection report be submitted to the Commission in the autumn.

65. ADJOURNMENT OF MEETING

At 6.30 pm the Chair adjourned the meeting for 10 minutes to allow those Councillors, officers and members of the public who had attended for the previous item to leave the meeting.

At 6.40 pm the meeting reconvened with Councillors Dempster, Fonseca, Cleaver, Sangster and Unsworth present.

66. SUSTAINABILITY AND TRANSFORMATION PLAN - MATERNITY SERVICES

Members received a report from UHL on their intention within the STP to consolidate maternity care onto the Leicester Royal Infirmary site, with the potential for a midwifery led birthing centre at the Leicester General Hospital, subject to formal public consultation.

The Chair stated that there would be a further meeting of the Commission on 29 March 2017 to hear submissions from the public and interested organisations on their views of the proposals in the draft STP. There would also be a further meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee to consider the STP once the formal consultation process had started.

Mark Wightman, Director of Communications, University Hospital of Leicester NHS Trust (UHL), Ms Melanie Thwaites, Associate Director, Children and Young People Services, East Leicestershire & Rutland Clinical Commissioning Group, and Ian Scudamore, Clinical Director for Women's & Children's Services attended the meeting to present the report and answer Members' questions.

The details of the proposals were:-

- Women's services currently located on the LGH site would be consolidated to the LRI; where a new Women's Hospital would be developed. The Women's Hospital would include:

    - Maternity (the proposed Standalone Birth Centre at the LGH would remain when other maternity services are re-located)
    - Neonates – new-born babies needing care
    - Gynaecology
    - Clinical Genetics

- Antenatal and postnatal services will continue to be provided in the community, as they always have been

- Where clinically appropriate, women will still be able to choose from the following four birth options:
    - Home births
    - Standalone Birth Centre at the LGH (if this is the outcome from consultation)
    - Alongside Birth Centre at the LRI
    - Combined Care Unit at the LRI

The proposals had arisen from the Trust experiencing capacity issues in fully staffing all the existing units over recent years and having to temporality close some units for short periods. Providing all the maternity services on one site was considered to be safer, more efficient and would provide a sustainable

service for women and families; as well as offering a choice of services.

Members, in discussing the proposals, received the following responses to their questions and comments:-

a) The recent CQC inspection report on Maternity Services would be submitted to the Commission in due course.

b) The number of births at Melton had been reducing in recent years and now averaged 1 birth every two and half days, which made the unit expensive to run as it was fully staffed by midwives. There were no specialist obstetricians at Melton in the event of difficulties and many expectant mothers chose to use the existing midwife lead facilities at the General and the Royal Infirmary as a result. If the midwife lead services were moved to the General Hospital this should increase the choice to use midwife led services as specialist services would be available in the event of difficulties.

c) The number of home births was declining because more expectant mothers wanted a midwife led service in a safe hospital setting where specialist services were available in case of difficulties. The option of home births would still be available under the proposals.

d) There was more choice in Leicester than in the East Midlands for midwifery led services. UHL had the highest number of access to midwifery services and this was currently 24% of births.

e) A number of staff were coming up to retirement and part of the workforce plan involved developing new staff and encouraging retired ones to come back. UHL were confident that they would have the appropriate number of staff to birth ratios for the future.

f) The proposals to close the Melton unit had been discussed with Melton Borough Council recently and whilst they recognised the loss of the service they recognised the overall benefit to local people by having more community beds and other diagnostic services as a result of the proposals.

g) Most ante-natal care would still be provided by GPs in the Melton area and Melton Hospital would still provide ante and post natal services. Expectant mothers would only need to travel to Leicester for their scan and to give birth.

h) The critical mass for a birth unit was 500 births a year and the existing midwife led service at the Royal Infirmary already exceeded this. The proposal to put maternity service at the Royal Infirmary would have the capacity and staff to cope with the expected demand in the future. The Kingfisher building would be re-developed to accommodate the new unit.

AGREED:-

That the proposals be noted but the Commission has some concerns about the planned building work and how this will be funded.

67. SUSTAINABILITY AND TRANSFORMATION PLAN - ACUTE HOSPITAL SITES

Members received a report from UHL on their intention within the STP to consolidate acute care onto two acute hospital sites, subject to formal public consultation.

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust (UHL) attended the meeting to introduce the report and respond to Members questions and comments.

It was noted that:-

a) The proposal to reduce the number of acute sites from three to two sites was dependent upon the proposals in the wider STP because the reconfiguration of the acute service provision could only happen if other reconfigurations in the STP were in place.

b) The direction of travel for the acute services provision was first announced in the summer of 2014 and there was some frustration that it had taken so long to progress the plans which had previously been discussed with the Commission and the County Council's Health Scrutiny Committee. Nothing had materially changed in recent months within the overall plan to concentrate acute services at the Royal Infirmary and the Glenfield Hospital sites.

c) The projected numbers of acute bed numbers in the STP, whilst only being one part of equation, was nevertheless an important component; especially in the eyes of the public. The reduction of the number of acute beds in the STP from 1,940 to 1,647 was still 'work in progress'. The Trust was learning from the good practices of the vanguard Trusts around the country. It was envisaged that the next update would include a revised figure for acute beds. This reflected a modification of the scale of change that was feasible.

d) The proposals would also be dependent upon capital funding within the national capital programme available in the NHS. Part of the capital provision would come from the NHS and other parts from PF2 initiatives. PF2 had retained the better elements of the previous PFI and eliminated those elements that did not work in the interests of the NHS. The NHS felt this was a pragmatic approach to provide a combination of funding of £114m of public funding by the NHS and the remainder through PF2 funding streams. UHL's request for its capital funding programme was known to be towards the top of the regional programme within the

Midlands and East; which was one of the four national areas along with the north, the south and London. The outcomes of the national funding awards were expected to be announced in the next few months. Any public consultation on proposals within the STP would be delayed until it was known that capital funding was available to deliver the proposals. If the UHL were successful in receiving a capital allocation from the NHS prioritisation process, it would then begin the process of going through the pre-consultation preparation process.

Members commented that:-

a) It was difficult to comment effectively on proposals that were dependent upon other elements of change and was reliant upon capital allocations that may or may not be available.

b) The proposals for the acute provision are also heavily dependent upon community and GP services and many elements of these do not work effectively at the moment. The STP proposes to put more reliance on community and primary care provision. If the new focus on care work and prevention worked it may not be necessary to provide the current number of acute beds. It would be better to allow investment in community and primary care in the next three years in order to get existing services working better before considering whether to burden it with extra work and responsibilities. Until these elements were working well, it was felt it was premature to consider the implications of proposals such as this.

c) There were also variances in GPs services, as not all GP were prepared to accept Shared Care Agreements, whereby care can be transferred from a consultant to a GP to provide some elements of the patient's care. If these were not working already, it would again seem premature to direct more care towards the community care and primary care sector.

In response to comments made by Members and in response to further questions, the following responses were received:-

a) Calculating the projected number of acute bed provision was not a precise science but the vanguard programme and the observations of overseas experiences were adding valuable input to the process. It was felt that it was better to be adaptive on the basis of what works locally and elsewhere. It was accepted that there were elements that do not work well at present and which could be made better with appropriate investment in services. It was difficult, with the limited resources now available, to provide for double running; which did provide a tension within the system to build up alternative services elsewhere while still trying to provide the existing services. However constrained this process may be, the direction of travel was considered to be correct since the current situation was not sustainable in the long term.

b) There was a general acceptance throughout the whole health sector that not all parts of it were working well and the STP provided an opportunity to change this. For example, by creating the integrated health teams. The SCA was considered to be a good arrangement where it worked; but it was accepted that this was not universal across the system.

c) UHL would not reduce the number of acute beds until viable beds were available and effective in the community setting. UHL had the highest number of acute beds open in recent years arising from increased demands. The numbers were now levelling out from emergency care and it was felt that this was the result, in part, of the initiatives introduced such as the assessment unit at the emergency department, which had prevented admissions whilst providing high quality care.

d) The transformation monies had now reduced and this placed constraints on double running while trying to develop new services to reduce acute beds. However the cost of supporting new services will eventually reduce acute costs.

e) UHL were introducing a number of initiatives to use existing financial resources more efficiently. One such initiative was the 'Red to Green' implemented on the 14 medical wards. In-Patient processes were being monitored to reduce the number of 'red' days where a patient was in hospital and nothing happening to the patient in clinical terms, which was unproductive time and could be considerable. The 'green' days represented a key clinical process happening with the patient; such as seeing a consultant, having a scan, physiotherapy or being discharged and waiting for medications to go home. Medical teams were being encouraged to become more focused to reduce the 'red' days so that patients stayed in hospital for less time which made the use of beds more efficient.

f) There was emerging evidence elsewhere in the country and abroad that different models of care could work better and produce better outcomes for patients. For example, keeping frail and elderly people in hospital longer than was needed was not good for their long term health as it increased their dependency on support once they left hospital to go home; which, in itself, used community, primary care and social care resources. The aim was to reduce delays in system and to make sure there was adequate support available when patients are discharged. It was difficult to translate how much this intervention would reduce the number of acute beds required in the future, but providing a better fall prevention service had been proven to reduce elderly persons' admissions elsewhere in the country.

g) GPs shared the frustration of only being able to spend 8-10 minutes per patient when sometimes a patient needed 20-25 minutes for more complex health care. GPs currently spent too long with patients who didn't need their level of expertise and input for their health conditions. Work was progressing with GPs to identify groups of high risk patients

and how services could be wrapped around them to allow GPs to deliver preventative medicines to 20% of their patients. The Kings Fund and Nuffield Foundation had produced evidence that these initiatives had worked. GPs were being offered support from specialist colleagues to expand their expertise and also export their knowledge into the community. The vanguard initiative was also a good process for testing different models of care without introducing them on a large scale until they had been proven to work.

h) The STP plans were developed on the best available evidence and the proposals were adjusted in view of changing evidence.

i) 30,000 bed places had been taken out of the NHS system in recent years; which would have seemed impossible 20 years ago. Advancements in medical procedures such as key-hole surgery, mothers having caesarean sections being discharged after a short stay instead of the traditional 10 day hospital stay and GPs carrying out minor surgical procedures had all contributed to reducing the need for hospital beds.

j) There are insufficient capital funds nationally to fund all the capital projects in the 44 STP areas in the country, without the additional use of the capital funds through the PF2 initiative. PF2 was designed to have the benefits of the previous PFI initiative in providing access to other funding sources through banks and financial institutions. The less attractive elements of PFI, such as the high costs of finances and refinancing options have been taken out of the process. PF2 funding was separated from the construction process as constructors quoted for building costs and then the financiers bid for opportunity to provide funding, with the Government taking a stake in the funding circle. A new hospital build for Sandwell was a pioneer for PF2 and the finance costs were much less than had been projected. PF2 was considered a better delivery vehicle for capital projects and it was designed to avoid Trusts becoming overstretched, as they did under PFI, and ending up in long term financial difficulty.

k) The STP workforce plans were in the public domain and the system would spend more on people in different places and in different roles than at present. Eventually there would be less spent in the acute sector and more in the community, primary care and social care sectors.

AGREED:-

1) That the report be received and the officers be thanked for their responses.

2) That Commission cannot offer its views on the proposals until it has heard the views of public, patient groups and other interested community organisations at the meeting on 29 March 2017.

3) That the Commission consider that transitional funds should be made available to improve, enhance and expand existing community services so they are operating at the levels required to cope with the current demands before considering further re-configurations of acute hospital services.

3) That the Commission receive a briefing paper on the PF2 initiative and implications for funding capital project by this method, once UHL have been informed of whether their capital bids to NHS England have been successful.

5) That copies of the workforce and financial plans be submitted to the Commission.

68. CLOSE OF MEETING

The meeting closed at 8.35 pm.