Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 29 MARCH 2017 at 5:30 pm

P R E S E N T :

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

Councillor Cassidy	Councillor Sangster
Councillor Chaplin	Councillor Unsworth

Also Present:

Jim Bosworth	Associate Director Commissioning & Contracting, East Leicestershire & Rutland Clinical Commissioning Group
Peter Miller	Chief Executive, Leicestershire Partnership NHS Trust and

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68. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Cleaver.

69. DECLARATIONS OF INTEREST

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

70. SUSTAINABILITY AND TRANSFORMATION PLAN - MENTAL HEALTH

The Commission received an update on how mental health would be catered for within the proposals in the STP, subject to formal public consultation.

Peter Miller, Chief Executive, Leicestershire Partnership NHS Trust and Jim Bosworth, Associate Director Commissioning & Contracting, East Leicestershire & Rutland Clinical Commissioning Group attended the meeting to make a presentation and respond to Members comments. Members were also invited to make comments on the strategy and the principles of what

should be included.

During the presentation the following comments and observations were made:-

a) The draft STP had little content on mental health mainly because the guidance on preparing STPs was focused on how sustainable systems could be created in 5 years' time. The STP focused on the frail and elderly emergency care and prevention in response to the challenges of making the system more sustainable.

b) It was felt that an improved strategy with a stronger emphasis on resilience, prevention and recovery was needed in order to relieve the pressure on the acute mental pathway which was currently under pressure. The current spend of £100m on mental health services was focused on specialist inpatient type services and more needed to spent in providing support in the community setting.

c) The strategy related mainly to adults, improving resilience and recovery and supporting primary and secondary in-patient and community care to ensure it was timely and robust. CAMHS was in another work-stream as so was population based prevention. Dementia as a specialised service was also covered in another work stream.

d) Key targets in the strategy were
   - Providing a crisis response in 4 hours and 24 hours as appropriate.
   - Providing support with 2 weeks of the 1st episode of Psychosis.
   - IAPT target of 25% for support for some lower levels of anxiety and depression.
   - Liaison psychiatry – Core 24.
   - Perinatal Access.
   - Zero out of area admissions.
   - Reduction in suicides by 10%.
   - Parity of esteem.

e) The strategic direction aimed to bring about a change in philosophy, attitude and practice to put greater focus on prevention and resilience in a more structured and robust way. This would entail working with GP practices and health professionals on placed based area, whilst recognising that there would be different place based areas and different models of care within localities. Community capacity needed to be captured and built into the models with clear end to end pathways to provide efficient and high efficacy clinical care. The models would also be recovery focused.

f) Achievements to date included:-

   - The Crisis house which provided an alternative offer for treatment without the patient going into hospital by providing a respite away from the home environment. It was well used and very

successful.

- Improving the 4 hour urgent response to 71%.
- The strengthened liaison service was now at 80%.
- The all-age Mental Health Act place of safety had been rebuilt and was due to open on 5th July 2017.
- The new CAMHS crisis service would come into operation on 10th April 2017.

g) LPT were working with Northumberland, Tyne and Wear NHS Trust (rated as 'Outstanding' by the CQC) to rebuild the acute pathway to reduce the current pressure on acute beds. Northumberland had place based generic services and an open gateway to access services which had been successful in resolving problems at an early stage. The length of stay in hospital for patients was far less than the national average. If LPT could reduce the length of stay in hospital to those of Northumberland, this would increase the capacity of the hospital based service and it would then be possible to eliminate the need for out of country placements.

h) LPT were getting better at meeting patient's needs, especially in instances where they don't need to go into hospital. The NHS 111 service was linked to crisis lines and to the crisis house.

i) LPT hoped to have a female PICU facility in the near future.

j) It was important to integrate the work on mental health with other work streams in the STP and to champion parity of esteem. Mental health needs were equally important to other physical health needs and needed comparable investment.

Members made the following comments and observations:-

a) It was difficult to understand the overall picture when the Dementia and CAMHS services were in different STP streams, as it was not easy to see how all the mental health services fitted together. There was also no reference to mental health services provided to the Criminal Justice Service, and there were significant mental health issues affecting inmates in prisons and detention centres.

Response – it was envisaged that STP process would help to strengthen mental health services and make them more resilient. If the STP delivered the physical health care in the way that was envisaged it would eventually reduce the need for resources in emergency care and these resources could then be used elsewhere in the health system for services such as mental health. Mental health services for the Criminal Justice system were commissioned by NHS England as specialised services. LPT currently provided these services

in prisons. The issue of different mental health elements being in different work-streams was recognised but CAMHS was a critical part of the Children's services work-stream. The need to navigate the relationship between the different work-streams was part of the on-going work of the STP process. Integrating with schools nurses, paediatricians, social care and health visitors would help to improve access and providing assessments for children. These arrangements and pathways could be the subject of further report.

b) Parity of esteem could be a missed opportunity if it was not included in the STP, as it was felt that there was a need to join life time issues together.

Response – The STP had been produced to a prescriptive format. Producing it in a different format focused on what would be provided and the associated benefits to patients could have been helpful and more informative to the public. For example 30-50% of patients with physical long term conditions also had anxiety, depression and other mental health issues and there was strong inter-relationship between physical care and mental health care services which could impact upon both the patient's well being and the resources required from each service.

LPT's strategy for mental health had been informed and shaped by the views expressed in discussions with Healthwatch, patients, patients groups and community organisations over recent years in addition to the recent Mental Health summit held in the city. Parts of the text in the STP were being revised, at the request of NHS England, and the comments made by Members were helpful to address the issue of describing the connections between the various work-streams and their aspirations.

c) In response to a Members' comment it was noted that the IAPT service was primarily aimed at people with low levels of mental health needs. It was also available to those with long term chronic conditions in helping them to manage their conditions and reduce the patient's need for increased physical health support. Often patients with long term physical conditions also developed psychological stress. The support given helped patients manage their conditions and live better with their conditions.

d) Concerns were expressed that there were not enough trained people GPs and Police etc to identify intervention at early stage and there was a need to increase knowledge of mental issues within the community.

Response – There was an on-going need to reduce the stigma of mental health. Episodes of psychosis were often self-evident but anxiety and depression were more common and people were less likely to talk about it. 10 years ago the only access to treatment would have been through the professional mental health service, but now there were other pathways, such as IAPT, which provided treatment earlier for lower levels of mental health conditions. It was important to continue to identify and treat more moderate conditions earlier. IAPT had originally been developed for patients with anxiety

and depression but it now included people with long term physical conditions

The vast majority of patients with mental health conditions had low level needs and could be managed by GPs and social networks. The number of patients with acute mental health issues were relatively small in number but represented a high cost for treatment and high risks to themselves. The CCG were working with GPs to raise awareness of mental health issues and increase their ability to identify appropriate treatments. There were improved links between GPs and consultants to help with advice on the next steps for a patient's treatment between that offered by GPs and where an in-patient hospital treatment was not appropriate. Often developing relationships, friendships and good social interaction was an effective means of improving good health.

e) It was felt that most people would prefer and appointment with a consultant for their next level of their care and not just a phone between a GP to a consultant to advise on their further care in instances where a hospital treatment was not appropriate.

Response – This type of model was being seen more and more in providing treatment for physical health conditions and it was important to use scare resources effectively given the current challenges faced by the health service.

f) In response to a question about AHB117, it was stated that this referred to Alternative Health Placements for patients that required long term rehabilitation and specialised forms of treatment in other part of the country. If other clinically safe treatments could be provided locally, the saving in financial resources could be used in improving other mental health services.

g) Doubts were expressed that it was realistic that mental health services would achieve parity of funding?

Response - Whilst the ambition was to increase resources for mental health service both nationally and locally, this did present challenges in the current economic environment. Part of the challenge in growing the budget for mental health services locally concerned spending less on the more specialised high settings of treatment and redistributing the resources in lower level services. For example, sending patients out of county for in-patient treatment could cost approximately £500 per night; significantly more than if that treatment could be provided locally. This required sufficient beds and qualified staff to be available and there were recruitment difficulties for nurses, psychiatrists and therapists.

h) The BME community were under-represented in treatment for mental health conditions and often did not come forward for treatment through social stigma within their communities.

Response – The issues of social stigma within BME communities were understood and did present challenges, but it was important to ensure services were appropriate and responsive for this group. Part of the working being

undertaken with Northumberland and Tyne and Wear would result in building extra capacity within existing services that would be needed to cope with the rising demand for services in the future.

i) Concerns were expressed that the proposed model of care could result in some people's conditions getting worse before they were admitted to into a hospital setting. If the mental team were not available for regular contact at earlier stages then people may present to the emergency department with more severe health conditions.

Response - There was no intention of making people's conditions worse by offering alternative treatments to keep them put of hospital for longer. Patients would still be admitted at an early stage if that was the right and appropriate care for the patient.

The Chair commented that it was difficult to reach firm conclusions without having the financial information for the 5 year strategy and how the mental health strategy related to other work-streams in the STP. Whilst it was helpful to have discussions before consultation, there was further work to be done on the issues of connectivity, parity and budget implications. Although the government were allocating more resources to the NHS, this was insufficient to cope with the increased demands being placed on the NHS by the growing population and people generally living longer with complex health conditions. There were concerns that the STP process was budget driven to saving money.

AGREED:

That the officers be thanked for their presentation and for responding to Members' questions and the Commission would continue to consider and comment upon the proposals as the STP process progressed.

71. ADJOURNMENT OF MEETING

At 6.50 pm the Chair adjourned the meeting for 10 minutes to allow those officers and members of the public who had attended for the previous item to leave the meeting.

At 7.00 pm the meeting reconvened with Councillors Dempster, Fonseca, Cassidy, Chaplin, Sangster and Unsworth present.

72. SUSTAINABILITY AND TRANSFORMATION PLAN - VIEWS OF PUBLIC, PATIENTS GROUPS AND OTHER INTERESTED COMMUNITY ORGANISATIONS

The Chair stated that the Commission had previously invited members of the public, patients' groups and other interested community organisations to submit their views on the draft Sustainability and Transformation Plan (STP). A number of individuals and representatives of community organisations had registered their interest to address the Commission and had submitted written

submissions. Each person would be given 5 minutes to summarise their submission and the submission would be published with the minutes unless the person asked for this not to be done.

The primary purpose of people presenting their submission was for the Commission to hear at first hand the views being expressed and there would be no opportunity for members of the Commission to ask questions on the presentations. Representatives of the CCG were present but they would not be asked to respond to the submissions, but they would take note of the submissions for future reference.

Consideration of the draft STP was part of a long process and there would be other opportunities to for members to discuss any issues raised in the submissions.

The Chair then invited the following to address the Commission for a maximum period of 5 minutes each:-

a) Dr Rupert Earl, Honorary Lead on Care Policy, Spinal Injuries Association. A copy of the submission is attached as Appendix A to these minutes.

b) Dt Sally Ruane, Health Policy Research Unit, DeMonfort University. A copy of the submission is attached as Appendix B to these minutes.

c) Tahita Sinfield – 38 Degrees Loughborough. A copy of the submission is attached as Appendix C to these minutes.

d) Andrew Ross, Unite the Union Community Branch Leicester Area. A copy of the submission is attached as Appendix D to these minutes.

e) Jane Lane, Health Visitor, Leicestershire Unite Health Sector Branch. A copy of the submission is attached as Appendix E to these minutes.

f) Kathy Reynolds, Leicester Mercury Patients' Panel. A copy of the submission is attached as Appendix F to these minutes

g) Robert Ball, Campaign Against NHS Privatization. A copy of the submission is attached as Appendix G to these minutes

h) Margaret Pitcher, Member of the Public. Made the following comments and observations:-

- GPs are under considerable pressure now and when a misdiagnosis happens it can become costly in terms of the costs of long term treatments. Putting additional responsibilities on GPs could make the likelihood of misdiagnosis more likely.
- Patients with long term complex issues often volunteered for studies and allowed their data to be for shared medical research and training

and that was not likely to happen at a GP level. Also, medical students were often present with consultants and this element of training would be lost if care was transferred to GPs.

- Reservations that that giving GPs and primary care more complex work would not be beneficial. GPs didn't have enough time at the present and putting more pressure on them did not make sense. There was a need for more trained specialist staff.
- Who would monitor the standards in the in the primary care sector?
- Concerns expressed about proposed sales of NHS estates.

i) Michael Mccloghlan, Member of the public. Made the following comments and observations:-

- The draft STP is full of jargon and lacks details on specific proposals.
- The draft STP contains no details of existing capacity levels to give a comparison of what is sustainable, and seemed to be aspirational rather than specific planning.

The Chair re-iterated that this item was only one part of process. At the Council debate in the previous week, the Deputy City Mayor had made it clear that Members would not simply sign off the STP as there were huge concerns held by both councillors and members of the community. She felt that this was a critical moment in NHS which needed public scrutiny. Britain was 17th in Europe in terms of the percentage of GDP spent on health, and the Government were proposing to spend less for quality services. There were concerns that the STP, as a process, was bringing about change by stealth and making the more profitable elements of health care easier to be privatised; which would leave the most difficult and costly elements behind. It was important that the public made their views known to their MPs and the public.

AGREED:-

That the members of the public and the representatives of community organisations be thanked for their submissions.

73. CLOSE OF MEETING

The meeting closed at 8.10 pm.

Spinal Injuries Association Submission to:

Leicester City Health & Wellbeing Scrutiny Committee Meeting- March 29 2017

Re: Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Plan (STP) in relation to NHS Continuing Healthcare

"Individuals in receipt of ongoing or long term care through NHS Continuing Healthcare are among the most vulnerable and dependent people in our society" is how the NHS England Operating Model for NHS Continuing Healthcare (2015) describes those whose complex health care needs must be met by the NHS because their needs exceed what can be lawfully provided by a Local Authority, i.e. social care. NHS Continuing Healthcare (CHC) funding can be, and is, provided for care in individuals' own homes enabling them to continue to live in their own homes and be contributive members of their families and wider society. Those eligible for CHC funding include people with advanced degenerative neurological conditions (e.g. Parkinson's disease, motor neurone disease, multiple sclerosis), Learning Difficulties, and those paralysed as a result of a spinal cord injury.

Spinal-cord-injured (SCI) people who are in receipt of NHS CHC funding predominantly receive 'care at home' packages of care and, as a result, lead productive and socially inclusive lives. Many are young or relatively so and have, or will go on to have, families. Indeed, some SCI people in receipt of NHS CHC are in employment.

The Spinal Injuries Association (SIA) is gravely concerned by reference in the LLR draft STP of an apparent intention to implement measures to drive down local NHS Continuing Healthcare (CHC) expenditure by £29 million (STP strand 3 - Redesigned Pathways Net Savings) or ~40% from the current CHC spend of approximately £73 million per annum. There are currently approximately 1,300 of the *"…most vulnerable and dependent people…*" in LLR in receipt of NHS Continuing Healthcare funding, and these include people with paralysis as result of spinal cord injury. Matt Hampson, a high profile local figure and SIA member is one of these.

SIA also notes with concern that in LLR the CCGs plan both 'efficiency savings' and reduction in the cost of CHC 'care at home' packages in order to achieve this. This intention is clearly stated in the LLR CCGs "*Settings of Care*" policy revision, consultation on which closed on February 21, 2017: the new policy seeks to reduce the amount of money spent on providing CHC-funded care in an individual's home by comparing it to the cost of a nursing home placement, and the "*Amended Settings of Care Policy - Easy Read"* version (January 18, 2017) overtly states:

"What will change? and provides the answer *"We will spend less money on each patient*".

John Ashworth, MP for Leicester South and Shadow Minister for Health, criticised these proposals (press release February 27 2017), stating "*I am very concerned that the cost of care needed in the community setting will be more than the cap set. As a result a person could be forced to live in residential care or live at home with insufficient levels of care*". His statement went on to assert that "*this…may in fact increase financial demands on the NHS… If care packages are reduced to an unsafe level it could result in many people developing further health complications which could require hospitalisation and end up costing the NHS substantially more in the long term*".

SIA believes that to achieve the level of savings that are indicated in the draft LLR STP there would be no option but to both:

- very significantly reduce the cost of CHC 'care at home' packages,
- simultaneously attempt to reduce the numbers of patients eligible for CHC care funding.

This appears to be the intention of LLR CCGs which describe themselves as "*outliers in terms of cost and number of packages";* and describe their intention for "*robust application of guidance and scrutiny of package costs*" and "*review of high cost placements*". Both strategies would be hugely detrimental to *"…the most vulnerable and dependent people in our [LLR] society*".

SIA cautions against these measures, not least of all because there will be an inevitable 'knock-on' effect on an already beleaguered social care budget in LLR - individuals with complex care needs will still have those needs and if they cease to be found eligible for CHC funding or that funding is reduced there will be an inevitable 'budget shifting' to the social care budget and/or to other parts of the LLR NHS provision. There is furthermore considerable doubt as to the lawfulness of CHC eligibility decision making that would be required to reduce significantly the numbers of patients eligible for NHS CHC funding in LLR.

LLR CCGs assert that their expenditure on NHS continuing healthcare is *"…more than the majority of other areas across England*". SIA's own analysis demonstrates that average CHC package cost per individual is very much in line with the national average for all CCGs in England, however, and that the expenditure on CHC by LLR CCGs is a function of higher than average numbers of people deemed eligible for CHC funding of their care. In view of the fact that eligibility is only determined after an extremely rigorous assessment procedure and in accordance with a National Framework for CHC implementation, SIA considers that it is unlikely that there are

many, if any, of the "*most vulnerable and dependent people in our [LLR] society*", therefore, who have unwarranted CHC eligibility status.

Reduction in NHS CHC budgets will, without doubt, negatively impact the ability of SIA's members to achieve and/or retain eligibility for CHC and adequate 'care at home' packages. Reduced packages of care will result in regression of SCI people's rehabilitation and psychological adjustment to the traumatic acquisition of paralysis and increase their demands on a wide range of other NHS services. SIA is equally concerned regarding the fate of patients with newly-acquired paralysis due to SCI. Reducing CHC 'care at home' packages of care is completely at odds with the extensive and expensive NHS-funded rehabilitation that such patients undergo to equip them for a positive future, and is likely to result both in delayed discharge from specialist spinal cord injury centres and/or their placement in nursing home settings from which (research conducted at Loughborough University shows: *Int. J. Environ. Res. Public Health* **2015**, *12*(4), 4185-4202) return to live in their family home is very problematic and in which their health and well-being is severely damaged.

Cuts in CHC 'care at home' packages will also inevitably result in the reduction of health and care support for some of the "…*most vulnerable and dependent people*…" with other impairments in Leicestershire and Rutland. It is therefore unconscionable and potentially unsafe to reduce CHC-funded care packages for these vulnerable and dependent people - not least of all because 'cuts come with consequences', including to the wider NHS and social care economy. At a societal level and from a moral perspective, reducing SCI people's CHC 'care at home' packages, and those of other impairment groups, will inevitably have the effect of reducing their Independent Living, and threatens to undermine 30 years of hard-won progress in the area of Independent Living for disabled people. Cutting NHS CHC budgets targets the most vulnerable people, and is immoral.

Recommendation:

SIA recommends that there be a fundamental rethink of the proposals to drastically reduce NHS continuing healthcare spend by CCGs in LLR as outlined in the draft STP, and of its assumption of the adoption of the revised '*Settings of Care'* policy (viz. STP: concrete actions – "…revise, consult and implement new settings of care policy") - disturbingly before a formal decision had been taken on the latter!

SIA considers that the CCG's "Settings of Care" revised policy should not be adopted until the Sustainability and Transformation Plan for LLR is amended and consulted on.

Dr RT Earl
Hon. Lead on Care Policy
Spinal Injuries Association March 24, 2017

Appendix B

REPORT ON THE SUSTAINABILITY AND TRANSFORMATION PLAN FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

FOOTPRINT 15

Dr Sally Ruane

March 2017

HEALTH POLICY RESEARCH UNIT

DE MONTFORT UNIVERSITY

REPORT ON THE

SUSTAINABILITY AND TRANSFORMATION PLAN

FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

FOOTPRINT 15

INTRODUCTION: PURPOSE OF THIS REPORT

This report examines draws attention to some of the concerns arising from the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP). The Plan is in draft form and this report responds to the draft published on 21st November 2016. It is not a comprehensive analysis but identifies a number of areas of concern warranting further investigation.

CONTEXT

Context – Five Year Forward View

NHS England (NHSE) has divided England into 44 areas or 'footprints' and has required each to produce a Sustainability and Transformation Plan. Leicester, Leicestershire and Rutland are Footprint 15. The plans are required to demonstrate how they will bring about two principal objectives: one is the implementation of 'new models of care'; the other is achieving financial balance by 2020/21.

The focus on new models of care follows NHS England's *Five Year Forward View* (FYFV) published in October 2014 and widely understood to reflect strongly the thinking of Simon Stevens, Chief Executive of NHSE. FYFV identified three 'gaps' to be addressed throughout the health system:

- The health and wellbeing gap: focussing on illness prevention
- The care and quality gap: focussing on restructured provision
- The funding and efficiency gap: focussing on reducing unit costs

The new models of care indicated in the FYFV are:

- **Multispecialty Community Providers (MCPs)** – GP practices will be able to come together in federations, networks or single organisations. They 'could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff'. They will target 'services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients'.
- **Primary and Acute Care Systems (PACS)** – these are forms of 'vertical integration' allowing 'single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services'. This can include a mature

form of the MCP running its local district general hospital. 'At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.'

- **Urgent and emergency care networks –** Reduced reliance on A&E through greater use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country.
- **Small district general hospitals** – This allows for hospitals to be grouped into 'chains' under single management or to have some of their work (e.g. 'back office functions') managed by another organisation. Some services will no longer be provided by some DGHs though their site may be used by another, specialist provider
- **Specialist services** – This allows for greater concentration of specialist services onto fewer, larger sites.
- **Maternity services** – This allows for a reconfiguration of maternity services, for groups of midwives to set up midwife-led units and for greater sustainability of maternity services.
- **Enhanced health in care homes** – This allows for the provision of more services (such as rehabilitation and medical reviews) in care homes to try to reduce hospital admissions.

Context – Funding

The STPs are a response to the funding settlement for the NHS under the Coalition and Conservative governments. Government policy is to shrink the NHS into a smaller share of national income and STPs are seen as the mechanism for achieving this. To sustain services as they have been provided, the NHS needs a funding increase of around 4% a year after inflation and this was the historical average for NHS funding increases between 1950 and 2010. Between 2010 and 2020, the NHS is receiving on average *1% annual increases* after inflation. Sustained underfunding (relative to cost pressures) of this scale is historically unprecedented. Although efficiencies have been made, NHS finances have worsened and by March 2016 there was an underlying provider deficit of £3.7bn. STPs require each footprint to restore financial balance by 2020/21. The STP for LLR states that a £399.3m annual 'gap' between available funding and costs will open up by 2021 if its proposals for restructuring are not implemented.

There is strong political pressure to restore balance and as very limited funds are available for 'transformation', the financial driver behind STPs has come to be seen by many, including NHS Trust chairs and chief executives, as the principal driver. As the recent King's Fund report[1] notes the financial situation of the NHS and the operational pressures upon the service are now substantially more challenging than they were in 2014 when the Five Year Forward View was published. (See Appendix I for more detail.)

Billions of pounds have been stripped out of the social care budget nationally with real terms cuts in local authority budgets since 2010/11, placing local authority funded social care, and the independent sector companies and organisations which provide it, under severe pressure.

[1] C Ham et al (2017) *Delivering Sustainability and Transformation Plans*. King's Fund

Context – Joint planning and Better Care Together

The restructuring of the NHS along competitive market lines, from the 1990s onwards and most recently through the 2012 Health and Social Care Act, has led to a complex, administratively expensive and highly fragmented system. The STPs require local organisations within the health system to work together and this is broadly beneficial.

The STP builds on the reconfiguration work of 'Better Care Together', which also had a strong 'financial gap' rationale, although there are some notable differences. The STP is a reiteration of BCT plans but with a more selective focus and an even greater emphasis on eliminating the funding gap which has arisen in recent years under the post 2010 national funding settlements for the NHS and social care.

STP KEY PROPOSALS

- Increase self-care and encourage healthy living.
- Increase use of pharmacist advice (to reduce need for GP care).
- Increased prevention activity and screening for earlier detection.

- Home first – where possible look after patients in such a way they can remain at home/go back home rather than being in hospital. This involves 'integrated teams' or multi-disciplinary care in community settings, including the patient's own home, overseen by GP practice. Where possible undertake procedures outside acute hospitals and in community settings.
- Care, including 'intensive community support', will be provided to more patients in their own homes to reduce the need for hospital admission and so that their discharge from hospital can be sooner than might formerly have been the case.

- GPs will focus on patient with complex needs. Where possible, patients needing primary care will see health care workers other than GPs.
- GPs will increasingly work in networks. Some services currently provided through general practice will be provided 'at scale' so that while some services will remain at a patient's registered surgery, patients may need to travel to other surgeries for some services.

- Closure of all acute beds at Leicester General Hospital (LGH). Reconfigure services within UHL and achieve a net reduction of 243 acute beds[2].
- Close St Mary's birthing centre at Melton Mowbray and consultant led maternity services at LGH. Concentrate all inpatient maternity services (consultant led and

[2] UHL have more recently said fewer beds will be closed than the figure given in the STP but have not said how many beds will be lost.

midwife led) at LRI or establish a midwife-led service at LGH (subject to consultation).

- Close Fielding Palmer Community Hospital in Lutterworth and Rutland Memorial Community Hospital in Oakham. Provide some outpatient services on these sites (in any remaining estate).
- Almost halve the bed provision at Hinckley and Bosworth Community Hospital.
- Achieve a net reduction of 38 beds across remaining community hospitals.
- Overall bed reduction of 12.9%.

- Provide more care through ambulatory emergency care at UHL; provide greater care in community settings to prevent emergency admissions; increase referrals to alternatives to A&E.
- Further reductions in delayed transfers of care (DTOC).
- Reduce out of area placements for patient with mental illness; increase peer support and peer skills to support patients with mental illness.

- Further efficiencies within provider organisations and within CCGs.
- Save £412m (annually); requires £350m of capital expenditure.
- Workforce (WTE) reduction of 5.7%; shift towards more generic workers and associates.

AREAS OF CONCERN

Poor public patient involvement and absence of key information

The STP for LLR has been developed by a small group of individuals, largely unknown to the public, and was reportedly published only after it was leaked to the BBC. There has been an almost complete exclusion of the public from the process despite the fact that the services at stake are used by the public and paid for by the public. The use of a public and patient involvement group in the development of Better Care Together, whose members were expressly forbidden from discussing evolving proposals with other members of the public, does not offer a strong case study in good PPI practice.

The STP –which, we are told, is still in draft form - is written using a mix of technical language, jargon and acronyms. Even the briefer 'public-facing' document assumes that much terminology will be understood by the public and fails to make some of the key issues and consequences explicit. The dubious statutory basis for the STP and the role of the STP lead has resulted in hastily put together governance arrangements which are also not understood by the public.

Although the draft STP was published in November 2016, STP leads have refused to place into the public domain the appendices (or 'templates') on finance and workforce. As a result,

it is impossible to gauge what the calculations are regarding the financial underpinnings of the plan. It is likely that these documents have been withheld from the public because they are either unconvincing or politically controversial or both. That the finances are still 'fluid', to quote an STP lead, does not inspire confidence. The shrinkage of the workforce and the shift to more generic workers and (unregistered) associate physicians and nurses at a time of growing need are also causes for concern and the refusal to share the assumptions embedded in the workforce appendix prohibits the effective scrutiny of the Plan. No comprehensive needs analysis is presented and the detailed plans for the estate are also not available in the STP.

An 'unrealistic'[3] timetable has been imposed on STP leads, leading to rapidly made decisions. Drawn up in conditions of secrecy and removed from wider scrutiny, STP proposals are now being presented to local authorities across England which are being asked to sign up to complex proposals on the basis of limited information and discussion. Effective and confident scrutiny of the STP is not possible without greater detail, including the needs analysis, and financial and workforce details which are being withheld from the public.

A number of engagement events have taken place across Leicester, Leicestershire and Rutland with varying degrees of uptake by the public. The February event in Leicester City was well structured and reflected much work by STP leads but failed as an exercise in public engagement due to poor turn out, perhaps reflecting insufficient prior advertising.

Finances: Savings Targets are at the centre of the STP proposals

The STP claims that LLR are facing a shortfall of just under £400m annually by 2020/21 (taking both NHS and social care funding into account) if action is not taken. The detailed calculations and assumptions underpinning this figure are not set out in the STP and so are not available for scrutiny and independent analysis. So while broadly consistent with previous estimates, it is difficult to know, therefore, how sound the £400m figure is.

The STP identifies a number of routes by which, it is claimed, savings can be made to the tune of £413m. However, no evidence is provided to convince the reader that these figures are more than wishful thinking. For example, on p63, the STP claims that £174m can be saved through provider operational efficiencies. As providers have had to make demanding and historically unprecedented operational efficiencies since the early Coalition government period and since they have developed substantial deficits following wholly unrealistic efficiency savings targets[4], it must be asked whether it is realistic to expect provider operational efficiencies on this scale to be delivered. This is just one instance of optimism bias, a problem which runs through the STP.

Overall, the STP's claims that the large-scale savings identified can be made are unconvincing but the consequences of failing to generate them are not explored and no Plan B is offered.

It is obvious that if services are to be transformed so that more care is given in community settings, more investment is needed in both hospital and community services but this

[3] Former NHS director, reported in GPOnline

[4] Public Accounts Committee (2016) *Sustainability and Financial Performance of Acute Hospital Trusts*

investment has not so far been pledged by the government. The STP states that around £350m worth of capital investment is required. However, the Department of Health has cut its capital budget and at present it looks as if at least some of required capital funding will not be forthcoming.

Even on its own terms, the capital plan looks problematic as 'increased demand' above that already assumed is stated as a key risk. It is quite possible that £280m is invested in reconfiguring acute hospital services – services which the STP admits are already under intense strain - only to discover in a few years' time or even sooner that this has resulted in service provision which is entirely inadequate to address patient need. This would represent a substantial waste of public money as well as significantly reducing the quality of and accessibility to health care. It should be noted that, when looking beyond the local Plan at experience elsewhere in England, reconfiguration proposals have consistently failed to demonstrate businesses cases offering a convincing case.

In addition to this, the net annual saving resulting from this £280m of capital expenditure reconfiguration is just £19.2m. It will take the better part of 15 years of such savings before the accumulated savings match the initial cost. While there may be benefits in the new co-location of services, this looks an extraordinary sum to pay to achieve relatively modest savings, particularly when the danger of capacity reduction is taken into consideration. As the STP itself admits to the risk that it may have underestimated future need, these 'savings' may incur the non-financial costs of bed and capacity shortages compromising patient safety and timely access to necessary care or may trigger additional future expenditure to restore capacity. This points to the problematic character of a five year plan of this sort when a much longer time-frame is required for rational planning. Indeed, the pay back periods for some of the different capital projects do extend beyond the five year period.

Given the unpromising prospects of capital funding from public sources, UHL is considering a Private Finance Initiative (PFI) scheme. The Treasury Select Committee concluded in 2011 that the Private Finance Initiative does not provide good value for money[5] and the modified version of PFI (known as PF2) is thought to be even more expensive than PFI[6]. Nationally, £2bn of the NHS budget flows out of the NHS into PFI debt repayments each year. It is difficult to see how adding to this through a substantial PFI project in LLR will be beneficial for LLR health finances in the coming years. The STP claims the capital cost of reconfiguring acute services is around £280m. It is likely that if any of this capital is secured through the Private Finance Initiative, the initial capital expenditure (and thus long-term capital costs) will be higher than it would have been had it been funded publicly.

It should be noted that no reference is made in the STP to the costs which have so far been incurred in the development of the Better Care Together proposals since 2012, including the management consultancy costs, or to the costs incurred in preparing the STP or projected for the public engagement and consultation processes.

The STP provides effectively only a Do Nothing or Do Something choice. Treasury guidance on investment appraisal stipulates a Do Minimum option and it is unclear why this has not been developed as an alternative to the £280m sought for hospital reconfiguration.

[5] House of Commons Treasury Select Committee (2011) *Private Finance Initiative*

[6] House of Commons Treasury Select Committee (2014) *Private Finance 2;* M Hellowell (2014) *The Return of PFI: Will the NHS Pay a Higher Price for New Hospitals*. Centre for Health and the Public Interest

Weak evidence base for the overall model of moving services out of hospitals and into community settings as a means of enabling hospital bed closures

The STP does not appear to take into account a growing body of evidence challenging its core assumptions.

There are a number of good reasons to make more care available in community settings, including the patient's own home, where appropriate. Historically, the NHS has under-invested in community based services. High patient satisfaction can be found where community services are of a high quality. However, this does not necessarily mean that the overall system will be cheaper or can reduce acute bed provision. Nor, with the STP as it currently stands, can we be certain community services will be of a high quality.

The STP is premised upon a belief that expanding community based services will permit the net closure of acute hospital beds. This is almost certainly a false premise and ignores a growing body of evidence. A study[7] examining the findings of reviews which covered 18,000 different studies found that some community interventions do give rise to a reduction in unplanned hospital admissions. However, most types of community intervention either do not reduce hospital admissions or there is no convincing evidence to suggest that they do.

Research evidence on the hospital-at-home type initiative seen in intensive community support suggests it may even increase hospital admissions[8]. One report[9] found that after investigating 38 different integration schemes across 8 different countries including 13 projects in England, not one had resulted in a sustained, long term reduction in hospital admissions. The model of integrated (multidisciplinary) teams described in the STP is unproven. A Nuffield Trust report[10] noted:

> "In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision…to thorough evaluation."

The local experience reinforces the view that there is a fundamental flaw in the STP's assumption and suggests net closure is not feasible and should not be sought if patient safety is to remain paramount. The Strategic Outline Case (SOC) for Better Care Together[11], published in late 2014, pledged a net closure of 427 acute beds out of 1773 acute beds over the following five year period. This included 203 beds between April 2015 and March 2015 and 61 beds between April 2016 and end Sep 2016 (half the figure given in the SOC for April 2016 to March 2017 on p72). This would have left UHL with 1,509 beds by the end of September 2016.

However the STP (published in November 2016) says UHL has 1940 acute beds. This is a net increase of 167 beds, fully 431 more beds than had been planned in the BCT Strategic

[7] S Purdy et al (2012) *Interventions to Reduce Unplanned Hospital Admissions*. University of Bristol
[8] For example, T Georghiou and A Steventon (2014) *Effects of the British Red Cross 'Support at Home' service on Hospital Utilisation*. Nuffield Trust
[9] Serco/HSJ (2014) *A Commission on Hospital Care of Frail Older People*.
[10] T Georghiou and A Steventon (2014) *Effects of the British Red Cross 'Support at Home' service on Hospital Utilisation*. Nuffield Trust
[11] Better Care Together (2014) *Strategic Outline Case*

Outline Case despite an expansion of community based services over this period. Confusingly, the figures in the national beds database do not correspond to the figures in these local documents, raising questions about the reliability of data used by the NHS. However, when figures from the national beds database[12] are used, there were 49 more beds in September 2016 than in September 2014 (most of the addition being in day beds). This again points to the infeasibility of net reductions in beds where patient need is rising even where community services are expanding. The 'reality on the ground' means beds cannot close without the potential for dangerous harm to patients.

The importance of retaining enough acute hospital beds for safe patient care

As well as relatively low levels of investment in community services, the UK does not fare well in terms of hospital bed provision when compared with developed countries internationally. The most recent OECD figures[13] for hospital bed provision (2014) indicate an average of around 4.8 beds per 1,000 population among developed countries. The figure is 2.7 for the UK and around 2.5 for England – in other words, little more than half the average. We are amongst the lowest in bed provision in the whole of the developed world. It is unconvincing to argue that cutting hospital beds will improve patient care and points to the finance driven character of the STP.

Table 1 OECD figures for 2014 – Beds per 1,000 population

	Beds per 1,000 people
Austria	7.6
France	6.3
Germany	8.2
Norway	3.8
Switzerland	4.6
UK	2.7

In 2014 the Nuffield Trust published[14] national bed projections for 2022 and found that an extra 17,000 beds would be needed on the basis of existing trends by 2022 across England in order to cater for an extra 6.2 million bed days. The Nuffield allowed that speedier discharge and more day case treatment could mitigate this figure. However, many of these efficiencies have already been achieved and the steady fall in the number of general and acute hospital beds nationally (from 126,976 in 2006 to 101,582 in 2016) cannot be expected to continue indefinitely. Even allowing for some further efficiencies, it is unconvincing to suggest the

[12] NHS England (2017) *Bed Availability and Occupancy*. NHS England Statistical Work Areas
[13] OECD (2017) *Hospital Beds indicator* OECD
[14] P Smith et al (2014) *NHS hospitals under pressure: trends in acute activity up to 2022*. Nuffield Trust

Nuffield's projected *net increase* in required beds of about 13% can be turned locally into a *net reduction* in beds of almost 13%.

Bed occupancy figures also point to the clinical risks of bed closure. Where national bed occupancy figures are based on midnight measures, they do not reflect the day to day reality of bed use. Locally, bed occupancy is very high, often 95%-100% during the winter period when the safe level is 85%.

A 2016 analysis[15] by the Nuffield Trust has underlined the clinical risks of these dangerously high levels of occupancy. These include the greater difficulty in finding beds for emergency patients, increased 'trolley-waits', further compromises to the 4 hour wait standard in A&E, disruption to sick patients, additional workload and stress for staff, difficulties in maintaining cleanliness and the greater likelihood of infection spread. Several studies have established a link between high bed occupancy and increased rates of infection.

Despite these dangers and despite the relatively mild nature of the winter, between Nov 2015 and Feb 2016, bed occupancy rates in England fluctuated consistently around the 95% occupancy level. The recent intense pressure on beds nationally was widely covered in the media and UHL was among those hospitals having to issue the most Operational Pressures Escalation Levels alerts. Sir Mike Richards, chief inspector of hospitals at the Care Quality Commission, also recently warned[16] of the compromises to patient safety in a context of financially straitened circumstances relative to rising need where hospitals were confronted with problems often beyond their control.

According to the STP, a net reduction of 38 community hospital beds is proposed. It is difficult to see how reducing community hospital capacity simultaneously can do anything other than impede plans to close acute beds and it is noted that earlier Better Care Together plans did not entail the net reduction in community hospital beds which we find in the STP.

Reconfiguration of mental health services and bed reductions in recent years has resulted precisely in inadequate capacity and poor quality services across many parts of the UK. The reconfiguration of mental health services represented a move away from evidence-based approaches to approaches with a relatively weak evidence base[17]. It is important that these mistakes are not made again in relation to physical health. A high quality and accessible hospital with sufficient capacity is an essential part of safe community based care.

Finally, it should be remembered that social care provision in the communities into which services are being transferred is already under tremendous strain. The National Audit Office[18] notes that local authority spending on adult social care has reduced by 10% since 2009/10. During this time demographic pressures have pushed up the cost of providing care for older and disabled people. Age UK[19] reported in 2016 that around 1.2 million people do not receive the social care they need.

[15] J Appleby (2016) *Winter bed pressures*. Nuffield Trust Winter Insight Briefing 1
[16] N Triggle (2017) *NHS standing on burning platform,* inspectors warn. BBC News 2nd March
[17] H Gilburt (2015) *Mental health under pressure*. King's Fund
[18] NAO (2017) *Health and Social Care Integration*. National Audit Office
[19] Age UK (2016) *1.2m older people don't get the social care they need*. Age UK News 17th November

Weak evidence base for the assumption that the model of moving services out of hospitals and into community settings will create a cheaper (per unit) health system

There is no robust body of evidence that expanding community services and enhancing service integration will result in cash savings or cheaper care. The Commission on Hospital Care for Older People[20] described as a 'myth' the notion that providing more care for older people in the community and pooling health and social care budgets will lead to cashable financial savings in acute care and across health economies. The National Audit Office[21] concluded that:

> "There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity".

Limited research has been conducted on this and different studies have been difficult to compare. An analysis[22] of economic impacts of integrated care found 19 reviews of which 18 reported on cost-effectiveness. It found there is evidence of cost–effectiveness in selected integrated care approaches but the evidence is mixed with some studies suggesting higher costs. Overall the evidence base remains weak. The same study reported:

> "Utilization and cost were the most common economic outcomes assessed by reviews but reporting of measures was inconsistent and the quality of the evidence was often low. The majority of economic outcomes focused on hospital utilization through (re)admission rates, length of stay or admission days and emergency department visits. Findings tended to be mixed within each review, which makes it difficult to draw firm conclusions. Also, results were commonly not quantified, making an overall assessment of the size of possible effects problematic. Seventeen reviews reported cost and/or expenditure data in some form, typically reporting cost in terms of health-care cost savings resulting from the intervention, most frequently in relation to hospital costs. There was some evidence of cost reduction in a number of reviews; however, findings were frequently based on a small number of original studies only, or studies that only used a before–after design without control, or both."

A recent report by the Nuffield Trust[23] warned:

> "…in the context of long-term trends of rising demand, our analysis suggests that the falls in hospital activity projected in many STPs will be extremely difficult to realise. A significant shift in care will require additional supporting facilities in the community, appropriate workforce and strong analytical capacity. These are frequently lacking and rely heavily on additional investment, which is not available.
>
> "…NHS bodies frequently overstate the economic benefits of initiatives intended to shift the balance of care. For example, they may use prices to calculate savings rather than actual costs and can therefore wrongly assume that overhead or fixed costs can

[20] Serco/HSJ (2014) *A Commission on Hospital Care of Frail Older People*. HSJ
[21] NAO (2017) *Health and Social Care Integration*. National Audit Office
[22] E Nolte and E Pitchforth (2014) *Evidence of economic impacts of integrated care*. WHO
[23] C Imison et al (2017) *Shifting the Balance of Care: Great Expectations*. Nuffield Trust

> be fully taken out. Similarly, many underestimate the potential that community-based schemes may have for revealing unmet need and fuelling underlying demand."

The Nuffield Trust report concluded:

> "While out-of-hospital care may be better for patients, it is not likely to be cheaper for the NHS in the short to medium term – and certainly not within the tight timescales under which the STPs are expected to deliver change."

Reduction in unit cost may be driven by re-provision which is deliberately cheaper (e.g. less care given or care given by less qualified and experienced staff) as seen in social care. It is difficult to see how improved patient care is compatible with this.

Well-planned and coordinated delivery of services by cooperation across teams and agencies, hospitals and community is essential for those with complex and long-term needs. Substantial investment in developing services is required so that alternative provision can be tested before busy acute hospital beds can be safely closed.

Centralisation of services and removal of services from Rutland

The STP proposes a significant centralisation of services. The closure of Rutland Memorial Community Hospital in Oakham and the removal of acute beds from Leicester General Hospital leave a forty mile gap with no beds between Leicester and Peterborough. The Fielding Palmer Community Hospital in Lutterworth is also proposed for closure and beds at the relatively new Hinckley and Bosworth Community Hospital are to be all but halved.

Maternity services are also to be centralised on the site of the Leicester Royal Infirmary since provision is to be removed from Melton Mowbray with the proposed closure of St Mary's and consultant-led care is to be withdrawn from the Leicester General Hospital where currently around 4,400 births take place each year. Current plans are to consult on the possibility of a midwife led unit at the Leicester General Hospital.

There is no specificity regarding the services to be offered to Rutland patients at Oakham once the hospital is closed and there is no 'Plan' specifically for Rutland which is expected to give up many of its health services without knowing in detail how primary and community based care is to be strengthened.

The STP does not appear to take into account the availability of residential and nursing home care, a sector already struggling with financial and workforce difficulties, or the difficulties of securing care packages in remote rural locations.

Workforce concerns

The NHS is facing a substantial challenge with problems in both recruitment and retention of staff across the range of professions. Alongside this, insufficient numbers are being trained. Workforce planning has been poor for many years.

The East Midlands has proportionately fewer doctors, administrative and ancillary staff when compared with England as a whole. Across all professional categories, it has fewer professionals per head of population than the national average. As the East Midlands trains more than its share of some categories of professionals (adult nurses, occupational therapists and physiotherapists), there is clearly a problem of retention.

Staff, rather than receiving support through an expanded workforce and avoidance of disruptive change, are caught in a maelstrom of unrelenting reorganisation, staff shortages, rising need and chronic underfunding. Staff are being forced to undertake higher band duties on lower band pay and to undertake additional duties when there are staffing gaps. These problems are exacerbated by 'cost improvement programmes' undertaken by providers and which are highly disruptive of staff morale.

The STP admits that the development of Integrated Locality teams will require significant change in how the workforce is organised and led. On top of existing pressures, staff face the prospect of new contractual and structural arrangements. In the context of a properly funded service where a shift towards a proven model of care is well resourced and staff properly supported, these sorts of changes are easier to bear. However, the new integrated model of care is unproven and may well not work. Imposing change on staff who are already under acute pressure runs the risk of alienating and exhausting even more staff and losing them as they give up their jobs or retire. In this way, the STP could well make staffing problems worse.

To some extent, services are being reorganised around workforce shortages rather than the workforce being planned around the health services that patients need. This is putting the cart before the horse. The STP justifies the closure of the Leicester General as an acute hospital and the closure of two community hospitals on the basis that staff are too thinly spread. However, it is difficult to see how moving patients out of hospital wards and into their own homes will result in more effective use of the workforce unless they envisage care given at home being delivered by cheaper and less qualified and experienced staff.

The STP says that staff lack the skills and confidence to maintain patients in the community. However, experienced staff have been leaving the NHS partly as a result of the increasing pressure on the service and on themselves. Yet, experienced staff are needed for work in community settings because they will be undertaking more lone work and thus must work more autonomously.

Workforce data are being withheld from the public but, despite an assertion that the workforce is essential for a successful health and social care system, early indications suggest the workforce is planned to shrink and to be restructured with overall a lower skill mix, meaning that more care will be given by staff who are less qualified and less experienced. Physician Associates may have a role but it should be remembered that they have just two years of training and may facilitate de-professionalisation and tighter management control over professional decision making. There is no mandatory registration for them, raising concerns about their regulation. Similarly, nurse associates will not be registered professionals.

It is important to consider lessons which can be learnt from social care. Privatisation of social care provision as a means to manage inadequate council budgets has resulted in the

depression of wages and the casualization of carers[24] so that the turnover of carers in the social care sector is very high and private providers complain of recruitment and retention difficulties.

With regard to the STP, the proportionate increase in the number of posts needed in the coming decade is greater than the increase in the population. The danger is that an increasing amount of 'health' care is going to be given by untrained and unqualified staff as CCGs turn to outsource the provision of services transferred to the community because independent bidders offer to provide services at lower cost. It is difficult to see how quality can be restored or upheld in this scenario. Poor quality of health care given in people's own homes will be as difficult to detect as poor quality social care currently is.

The lack of adequate numbers of staff to deliver the proposed new models of service could prove to be an even more important obstacle than the lack of funding and the lack of capital, both of which could potentially be addressed simply with a change in government policy. A lack of staff to deliver the new services could prevent the effective implementation of the Plan and yet the STP provides no proposals to address this unless the proposals are precisely to downskill.

Access to GPs

The STP plans to alter the GP model of care in place since 1948. The STP offers the prospect of longer GP appointments for some patients, should sufficient numbers of GPs be in place. However, this will not apply to all patients. The STP summary document speaks of 'strengthening GP surgeries', a wise redrafting of the original version which referred instead to 'strengthening GP *services*' since it is likely to become more difficult for patients to see their GPs unless they have multiple illnesses or complex conditions. Instead, patients can more frequently expect to see a health care worker other than the GP. The implications for quality of care will depend largely on the quality of the triage process and the suitability of the substitute worker for the health care need the patient has identified. This is not made clear in the STP or public summary of the STP.

For some time, research has suggested that continuity of care leads to better outcomes for patients[25]; more recently, a Health Foundation[26] Briefing paper suggested hospital admissions could be reduced by greater continuity of care. However, it is possible that the plans to reorganise primary care could lead to greater discontinuity of care for some patients.

[24] CHPI (2013) *The future of the NHS? lessons from the market in social care in England*. Centre for Health and the Public Interest

[25] For example, J Haggerty , R Reid, G Freeman, B Starfield, C Adair and R McKendry (2003). 'Continuity of care: a multidisciplinary review.' *British Medical Journal*, vol 327, pp 1219-21.

[26] I Barker, A Steventon and S Deeny (2017) Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data. *British Medical Journal*; Health Foundation (2017) *Reducing hospital admissions by improving continuity of care in general practice*. Briefing Paper

Weak risk analysis and the experimental nature of the new models of care

As the analysis above suggests, the new models of care incorporated in the STP proposals are of a somewhat experimental nature and this was admitted at the public engagement event hosted by Leicester City CCG in February 2017. The STP represents a shift away from a tried and tested a model of care which, while not perfect and while always subject to national funding policy, was able to offer good levels of access to high quality care provided by highly skilled registered professionals. Instead, the proposals push us towards unproven models of care. Although 'vanguard' projects are piloting a range of models across England, these have not been properly evaluated and, since they are relatively new initiatives, effective evaluation may not be possible for some time.

In relation to integrated models of care, the National Audit Office[27] recently concluded:

> "The Departments [of Health and for Communities and Local Government] have not yet established a robust evidence base to show that integration leads to better outcomes for patients. The Departments have not tested integration at scale and are unable to show whether any success is both sustainable and attributable to integration. International examples of successful integration provide valuable learning but their success takes place in a context of different statutory, cultural and organisational environments".

The NAO report added

> ".. the new care models are as yet unproven and their impact is still being evaluated. NHS England plans to have evaluated the effectiveness and value for money of the new care models programme by the end of 2018. Despite this, the NHS mandate requires NHS England to roll out the new care models rapidly; achieving 20% coverage by the end of 2016-17 and 50% by 2020".

In relation to the unproven and experimental nature of the new models of care and the potential deterioration in the quality and volume of services provided, the risk analysis in the STP is weak. In addition to this must be added the paucity of funding available for 'double running', that is to say, available to run both new services in the community and existing services in hospitals for the substantial period necessary to be certain the new services adequately replace existing services.

The risks posed are exacerbated by the absence of a detailed needs analysis from the document to underpin the proposals.

Conclusions

A five year period is a poor basis for NHS planning and the short-termism of the STP jeopardises rational service planning for the longer term.

[27] NAO (2017) *Health and Social Care Integration*. National Audit Office

The STP weakens its own case by omitting a large body of relevant detailed information. The assumptions on which the financial effects of the proposals are calculated are not transparent, making effective scrutiny impossible.

The STP establishes a number of aims but does not demonstrate how these will be achieved by the proposals suggested.

As the STP provides no detailed needs analysis, it is difficult to establish that, as it stands, it is fit for purpose.

While some of the aspirations which inform the STP are worthy, there is little to convince us that the proposals can safeguard quality care through the new models of care or can deliver the scale of financial savings claimed. The risk analysis provided is weak.

Community initiatives which work are to be welcomed but assessing their impact takes time and a buffer is needed during this period through 'double running' services.

Although the Plan includes some positive ideas, including expanding services in community settings and facilitating more self-care, the key challenge is to assess whether it is likely that patient and client care as a whole will be improved – or even maintained - while stripping out £400m every year from the system. This looks highly improbable.

The UK is one of the lowest bedded health systems in the developed world and the current proposals to reduce hospital capacity lack all credibility.

The new models of care are cost-driven where change in practice should be driven by a combination of clinical need, clinical quality and reasonable patient access. Service changes should be rigorously assessed against these criteria. The new models of care have not been sufficiently evaluated and are not supported by a strong body of high quality research evidence.

The Plan seeks to address problems of recruitment and retention but may, through further reorganisation and restructuring, exacerbate these problems, particularly where staff believe the quality of services is poor.

For a range of reasons, it is unlikely that the scale of financial savings promised by the STP will materialise. If the financial case were so clear we would expect the relevant information to be made available.

STP leads should produce a Do Minimum option which could remove a substantial layer of cost associated with the STP.

It is important that high quality replacement services are established and sufficiently tested for their impact in terms of both quality and quantity before existing services are closed. The development and expansion of high quality services in the community requires substantial additional investment. It is not clear at the time of writing whether announcements made in the March 2017 budget will be sufficient to address this challenge.

Investment decisions should be based on securing improvement in the quality of services and not on attempting to cut health care costs. A five year framework is inadequate for guiding investments with long term implications for services.

It is not clear from the STP whether the investments it proposes are economic (whether they could be achieved more cheaply by other means); realistic (whether the business case and underpinning evidence base for the proposals are sound); or deliverable (whether the assumptions about the capital available and staffing (for example) are sound given the scale of the plans put forward for savings and provision.

While there may be a good case for investment in service redesign to improve services, on the available evidence capital expenditure of £280m to move from three acute sites to two cannot be considered a worthwhile expenditure to achieve savings, particularly when likely deficiencies in the resulting services are taken into consideration.

The Plan will result in less accessible and poorer quality care and will achieve neither improved health outcomes nor the financial savings it claims it will make.

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Appendix I NHS Finances

The NHS requires around 4% a year real terms increase in funding to keep pace with cost pressures arising from

- Change population size and structure
- Changing profile of morbidity
- Health service specific inflation (higher than general inflation)
- Medical technology and innovation.

A real terms annual rise of around 4% a year was the historic average between 1950 and 2010, though Labour governments tended to fund more generously than Conservative governments.

Rather than 4% a year, the Coalition and Conservative governments have created a funding settlement for the NHS which gives on average just 1% a year between 2010 and 2020. At the same time, social care funding has been dramatically cut. Now that the majority of sizeable efficiencies have been made, radical restructuring to cut the unit cost of health care is being proposed.

Around £120bn is currently being spent on the Department of Health and NHS in England. Although around the middle of the ranking of OECD nations, the UK lags behind comparable rich nations in its funding of health care. The most recent OECD statistics[28] show the following (based on new definitions of expenditure which include social care expenditure)

Table 2: % GDP spent on health and social care (using the new OECD definition) and per person purchasing parity in US dollars for selected countries, 2015

	% GDP 2015	US$ per person purchasing parity (current prices) 2015
Austria	10.4	5,016
France	11.0	4,407
Germany	11.1	5,267
The Netherlands	10.8	5,343
Norway	9.9	6,567
Sweden	11.1	5,228
Switzerland	11.5	6,935
United Kingdom	9.8	4,003

The proportion of the GDP spent on health care is falling year on year and is set to fall further before 2020. An analysis[29] of funding in Europe since 1980 found that the UK had spent around 20% less on health care than the European average over the period. An additional 20% in funding now would add around £24bn to the annual English health care budget.

[28] http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

[29] J Harding and C Pritchard (2016) UK and Twenty Comparable Countries GDP-Expenditure-on-Health 1980-2013: The Historic and Continued Low Priority of UK Health-Related Expenditure. Jnl Health Policy Management 5(9): 519–523

Appendix C

THE SUSTAINABILITY AND TRANSFORMATION PLAN FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

38 Degrees Loughborough - Submission to the Leicester City Council Scrutiny Commission

38 Degrees Loughborough wish to make the following submission detailing members concerns regarding the STP for Leicester, Leicestershire and Rutland.

Our concerns include the following:

Lack of evidence to support the STP

- No evidence base that increasing community based services is going to reduce the need for acute hospital beds.
- No financial appendices have been released to the public or to the scrutiny committee to demonstrate that the plan is realistic and deliverable.
- No workforce information has been released to the public or to the scrutiny committee. However, STP footprint 15 envisages a workforce reduction. Where is the evidence base that staff numbers can be reduced whilst safely maintaining care standards within the community?

The lack of capacity for community services to deal with increased patient care

- It's not consistent to be closing acute beds in order to move more care into the community whilst at the same time reducing the number of community hospitals and beds. There would have to be huge investment in social care to safely care for more people in the community. Community based services are already at breaking point and we have several members who have personally experienced this recently.

One member recounts his recent experience of returning home 5 days after a double heart bypass. He states, "Thanks to [my wife], I was able to cope with the first two weeks- the most difficult time. I was a prisoner in my body not being able to get out of the bed without help, not being able to pick up a glass

of water on the bedside cabinet. I was not able to turn and had to sleep on my back. I was not able to take my own medication. [My wife] had to help me in all these. If I was on my own, who will be there to help me 24 hrs? I may have had a carer in the morning and evening, but in my condition it would not have been sufficient."

Lack of capacity for friends and family in being able to provide the care necessary when patients are not admitted to hospital or discharged earlier

- The STP will undoubtedly put more pressure on friends and family to provide care at home. However, with an ageing population as well as large numbers of individuals living alone, it is unrealistic that families will have the capacity to take on this extra burden of care. Already we are experiencing the rise of elderly and young filial carers who may need care themselves. In addition, there are now very high participation rates among women in the workforce – women would previously have undertaken this caring role but no longer have the capacity to do so. It is also of particular concern given that Britain is a low pay economy where many families are 'just about managing', working full time to pay basic living costs.

Quality of care provided will deteriorate under the financial constraints imposed by the STP

- In order for the STP to make the savings required there is potential for a downskilling of the workforce. This will be particularly dangerous when caring for patients in a community setting as staff will lack the level of supervision that can be provided in a hospital setting. The staffing in a community setting will need to be more qualified and more experienced to deliver care autonomously.
- Social Services are reported to already be struggling to provide an adequate level of care. How will these services cope with increased pressure?

38 Degrees member, Peter Todd, describes the care received by a family friend suffering from Parkinsons. He states, "[My friend] is undoubtedly better at home but this is dependent on good support from social services

which has been far from satisfactory.“ He has concerns over the inconsistency in quality of care provided with some carers lacking even compassion. He cites the frequent changes and high turnover of care workers as leading to poor continuity of care. He also describes one serious incident where no carer attended leading to no food or medication being provided. Consequently, his friend became dehydrated and had to be admitted to A&E.

The STP leading to further privatisation of NHS services

- There is potential for the STP to lead to further privatisation of NHS services due to the temptation to tender out contracts to the lowest bidder in order to save money. Leicestershire has already experienced what happens when unrealistic tenders collapse after a local social care provider failed to attract and retain enough staff. This resulted in some patients being left without care for days. We now face the prospect of more health care services being privatised with a consequent reduction in quality and reduction in staff wages.

In conclusion, we believe that the STP represents a political decision to deliberately underfund our NHS. Driven by such huge cost cutting the plans are undeliverable and unrealistic. Furthermore, the STP is based on unsubstantiated assumptions that will potentially lead to poor quality care and unnecessary suffering. The focus of any NHS ‘transformation’ plans should be people not commodities.

On behalf of 38 Degrees Loughborough

Appendix D

THE SUSTAINABILITY AND TRANSFORMATION PLAN FOR LEICESTER, LEICESTERSHIRE AND RUTLAND

Unite the Union Community Branch Leicester Area - Submission to the Leicester City Council Scrutiny Commission

Unite believes that our NHS must be:

- universally available and free at the point of use
- publicly accountable, publicly funded and publicly run
- clinical driven and evidence led

This branch has serious concerns about the STP for LLR. The Plan includes many cuts to services and reflects underfunding in the health service. £22bn of cuts are being pushed through across the NHS, using STPs to force the cuts through. We oppose the STP and call on the Leicester City Council to oppose it.

In Leicester, patients will be affected by the closure of hundreds of hospital beds in University Hospitals of Leicester. It is evident that the three Leicester hospitals are already under pressure and the chief executive of the hospital has recently said that UHL actually needs more beds not less. He claimed in the Mercury that a further 113 beds are required and that beds are occupied 95% of the time which is above the safe level of 85%. UHL sees vast numbers of patients each year, reflecting the level of need in the local population and we cannot see any justification for closing beds.

The STP also says there will be the closures of community hospitals in the county and in Rutland but as well as taking services away from people living in those parts of the region it will mean placing more pressure on beds in Leicester.

We believe that these service changes are not based on clinical evidence and demand that the NHS produces the clinical evidence they have used.

One of our biggest concerns is about what will happen to NHS staff. Staff working in the community already have very heavy workloads. Even if more staff are recruited, will there be

enough staff to carry out the work, as more staff will be needed because of the amount of travelling necessary to look after patients who are scattered across a wide area in the county and Rutland? The STP says the workforce is going to get smaller but we cannot understand how this can happen if patients are getting more of their care in the community.
The STP has been developed in secret and even now there is no proper input from patients, staff, trade unions and the public. We also believe some information has also not been shared with councillors and some information is still being kept secret. It is an undemocratic plan, and so far as we can see does not even have a legal basis. The lack of legal basis for the restructuring means that there are no legal or accountability structures linking the organisations and individuals involved, while there are no procedures for determining how disagreements are to be resolved in the new informal bureaucracies.

Overall, the STP looks like little more than a cost cutting exercise. It will make our health services worse because the government is not funding the health service and social care properly. We expect the city council to defend our services and not to go along with this latest attempt to destroy our health service. The government does not support the NHS and in our view is trying to privatise it. A Labour council must play its part in opposing these privatising and cost-cutting policies. The government want the health service to become so bad that people who can afford it will go private. Everybody else will get a worse service.

Additional investment is needed in the health service – this will create jobs as well improve our health care services.

Leicester Area Community Branch
Unite the Union
19th March 2017

Appendix E

Submission on behalf of Leicestershire Unite Health Sector Branch (EM/LE32) to the Health and Wellbeing Scrutiny Committee discussion on the LLR STP - Leicester City Hall 29/3/17

This submission is informed by:

The LLR STP (Draft Nov 2016)
Presentation to LLR Union Reps (Dec 16)
Unite Health Sector Briefings
Member contributions at the Unite Health Sector Meeting (15/3/17)

We believe our members, wherever they work and in whatever capacity, do everything possible to deliver quality services to the public. We agree that the aims of the STP are admirable: to focus on illness prevention, to reduce gaps in care and quality, and to manage costs. However, we are deeply concerned that many of the proposals are not backed up by evidence, that the targets around cost savings will put patients and vulnerable members of our communities at risk and our members will be exposed to impossible workload pressures and potentially blamed when things go wrong.

Our Concerns are:

Funding

Financially, the STPs are set up to fail. It is clear and demonstrable that NHS funding is already at its lowest ever in terms of GDP and the local STP estimates a shortfall of £341.6million for healthcare and a further £57.7million for Social Care in the five years to 2021. This funding crisis has been created by central government. We know our concerns are shared by H&SC Managers and Leaders in LLR and are identified in the STP as a risk.

A recent Unite Press Release states that at least £17.6 million was spent on management consultancy advice in formulating the STPs from firms such as KPMG. McKinsey and PWC. This, when there is no money to support stretched A&E departments and when local CCGs and local authorities have had little input.
As Unions we have raised concerns about the money spent locally on these ‘consultancies’. We do not believe they deliver value for money.

We are sure councillors know, as do we, that as a result of financial constraints and legislative changes access to Social Care has been retracted. We believe this has already impacted on rising acute bed occupancy, and difficulties ensuring safe discharges (we object to patients being referred to as 'bed blockers'). Closing Acute and Community hospitals and beds will surely only add to the problem as the elderly population increases and health care becomes increasingly complex. The consequences will be an increasing wave of unmet need in our communities. We have seen the result of Mental Health 'Care in the Community' over the years as police stations, prisons, local authorities and emergency services struggle with a lack of provision for the mentally ill. We don't want to see the same happen to services for the physically ill and disabled.

In the presentation to Trade Union Reps in December 2016 the proposal that £288 million will need to come from 'operational efficiencies' was discussed. The workforce is Health and Social Care's greatest expense (and greatest asset). We are seriously concerned that the STP will be funded by large-scale pay cuts and down-banding. The impact of this will be a 'brain drain' as more experienced staff lose pay, status, job satisfaction and professional autonomy and opt for early retirement. Some of our members have already taken that decision. Commissioned services will have to be delivered to the letter, rather than to the spirit. Minimum contacts will achieve only the bare minimum of contract requirement, but not necessarily meet the needs of individuals.

Access to Services

Many of our staff are moving into 'agile' working to save money on premises and increase flexibility. There are both positive and negative views from members, depending on where they work and the local infrastructure to support them. Concerns were expressed that in some locations there is a shortage of available clinical spaces. Some members have raised IT connectivity problems and worries about confidentiality if forced to access IT in public spaces. Some members cited client difficulties accessing GP and other services, such as contraception services, due to accessibility and availability. Whilst bringing groups of GP's and Health Staff together to deliver services may manage some access issues we are concerned others may emerge. Patients in deprived inner city areas already report the impact of access difficulties, and some state they go to A&E and Urgent Care because they can't get GP appointments or an alternative surgery (run by the same group) is too far away to walk.
In some deprived inner city areas parking is an issue for practitioners. Parking Permits are restricted and, where they were available in the past, most community nurses and therapists do not have them. We pay our own fines if we get them. This is a transfer of cost to practitioners and does nothing for morale. It also contributes to the 'Inverse Care Law' where services are more accessible to those with more resources.

Agile working brings a risk of staff becoming isolated. There is concern that commitment to regular team meetings to maintain clinical supervision, shared knowledge, learning and emotional support will be lost in increasing work pressures.

It was suggested that there was something of a contradiction between integrating H&SC on one hand, and agile working on the other.

An overall reduction in the workforce of 5.7% with an increase of generic and 'associate' workers will increase the workload of all at a time when needs are known to be growing. Alongside other severe budget cuts, for example those in schools, there will be fewer opportunities for early intervention and prevention, and a greater likelihood of reactive rather than planned care, with the attendant anxiety and stress on all involved.

Quality and Patient Safety

New Models of Care, Service Reconfiguration and Redesigned Pathways of Care are the other areas targeted to deliver savings. We are concerned that there is no evidence that these can deliver the necessary savings. Service integration is complex, time consuming and requires investment in training. What works in one place does not necessarily work elsewhere. Where will the time and money come from to do this well given the lack of funds?

How do you integrate services that are means tested with those that are free at the point of delivery? How easily do you find appropriate services to meet clients needs when the constant commissioning cycle expends so much time and effort on making repeated bids and services are rarely around in one form for any significant time?

We are concerned at the increasing reliance on lower paid and lower skilled workers to reduce costs. Most patients and service users value continuity of care but breaking care down into tasks does not facilitate continuity and is not 'patient centred'.

A UHL member commented on an increase in jobs at the lowest pay bands, and increasing responsibilities in these pay bands. We are concerned this is unfair on both low paid workers and service users.
A community practitioner gave an example of a new (lower band) role which is so much more limited than the previous role it now requires two people to perform a task previously done by a lone worker. This is a false economy.
We would be happy to see apprenticeships in the NHS that allow young people to be paid whilst they learn, and that offer an opportunity to work through paid training to good professional qualifications and a rewarding career. We do not believe this opportunity exists as yet. We would like evidence of how this will be delivered and funded.

We are concerned that fully qualified staff are to be replaced by under-qualified staff. A recent BMJ article (Aiken et al in BMJ Quality and Safety 2016) concluded that '…caution should be taken in implementing policies that reduce hospital nursing skill-mix because the consequences can be life-threatening to patients'.
It is only a few short years since the Francis Report into the appalling standards at Mid Staffs Foundation Trust led to a call for a focus on quality above all other priorities. One of the concerns raised then was that of appropriate skill-mix.

Unlike Registered Nurses, Midwives and Therapists; Nursing Assistants and Associate Practitioners – a growing area - do not have a regulatory body to set and monitor standards and provide protection for the public.

A number of our members raised concerns about what 'Care in the Community' might mean for the most vulnerable and marginalised in our local communities. Has there been any kind of Equality Impact Assessment?
Is care at home a good thing if you have seriously sub-standard living conditions? If you have no transport and no money to access services? If you are homeless or socially isolated and friendless? If those around you lack resources and capacity? There was concern that the most vulnerable families will simply disappear from sight. What are the implications for children in poverty or at risk of abuse and neglect?

We have already seen 'service redesigns' that have removed or reduced a number of specialist roles in the wake of the transfer of budgets for Health Visitors and School Nurses to Local Authority Public Health Departments. The new '0-19' Services, alongside the reduction in Local Authority Children Services, will see an overall reduction in the services available to this vulnerable age group. Our members are concerned that specialist roles with Homeless Families, Asylum Seekers, SEND, DV and Teen Parents are all being reviewed and down- banded or reduced in numbers. We have seen the same happen in Therapies and, skilled as they may be, Associate Roles are new and developing and lack the autonomy and decision-making ability of fully qualified and experienced senior clinicians.

Concern was expressed for our colleagues in Community Nursing (District Nursing). When a hospital ward is full it cannot take any more patients but this is not the same for Community Practitioners. Their work is largely invisible. The RCN has recently commented on the concerns identified for this service by The Kings Fund (Understanding Financial Pressures Kings Fund March 2017). They quote that one in seven DN posts were lost between 2014 and 2016. They are essential to plans to move care into the community but the report identified premature hospital discharges and delegation of GP work to theses nurses as having a direct impact on the ability to provide end of life care at home, make full assessments of need or identify adult safeguarding concerns.

We concluded that not even staff working in Health and Social Care have heard of STP's let alone have a clear understanding of them. We feel the consultation is barely meaningful given how little people know.

Questions

- Who will be held to account if STPs fail?
- What will it mean for our communities?
- How can we work together to campaign for proper funding of Health and Social Care so that we can build capacity and the skills in both services?

Jo Lane
Unite Rep
On Behalf of UNITE Leicester Health Sector Branch EM/LE32

21/3/17

Appendix F

Submission

To

Special Meeting of Health and Wellbeing Scrutiny Commission

29th March 2017 at 17.30

Introduction

Sustainability and Transformation Plans (STPs) are the government's latest NHS reform initiative. NHS England tell us the purpose of STPs is to help ensure health and social care services in England are built around the needs of local populations. Simon Stevens, the chief executive of NHS England, says STPs are a way of delivering the reforms he set out in the NHS Five Year Forward View and the £22b of efficiency savings he promised to the government, while maintaining or improving the quality of care. The local Draft STP sets out what it proposes will be the actions needed across the health and care system in Leicester, Leicestershire and Rutland (LLR) over the next five years in order to improve health outcomes for patients and ensure services are safe and high quality while operating within the available financial resources. Across LLR there is a growing gap between income and expenditure by 2020/21and the STP states this financial gap will be £399.3m per year. The focus for the STP is to ensure the system is brought back into balance by 2020/21.

Broadly speaking, The Leicester Mercury Patients' Panel (LMPP) welcome enhanced services in the community; for example, only 7% of people say they would prefer to die in hospital with most preferring home[1]. However, we have concerns around the five Strands of Work that form the focus of the STP, including, for example, reduced capacity of acute hospital beds, the refusal to release the financial and workforce appendices (templates) and the general lack of effective public and patient involvement in the process.

Concerns

Recently concerns in relation to STPs have become visible at both national and local levels many of these centre on the ability to deliver quality services while meeting the financial targets too. The Institute for Public Policy Research[2] states "For Theresa May and (somewhat more reluctantly) Simon Stevens to suggest that this financial gap can be closed through reform alone is disingenuous to say the least". The King's Fund have noted that the post-Francis concern for quality and safety is over and that funding levels are not compatible with maintaining high quality care. The King's Fund observe: 'It is inconceivable that the NHS will be able to achieve both financial sustainability and large-scale transformation within these financial constraints[3]'. These concerns about the infeasibility of the STPs' stated intentions and the quality of care patients are able to receive are shared by the LMPP. We also share the view that the Draft STP is unlikely to produce high quality patient care and large scale reorganisation whilst at the same time cutting £400m from annual expenditure relative to what it would have been by 2020/21.

The financial details and workforce plans continue to be unavailable to the public or to elected representatives. This reflects a general weakness in the Draft STP -namely, its development 'behind closed doors' together with, little or no effective public patient involvement and limited democratic accountability.

In this submission we will highlight just two STP Proposals that will have significant effect on local services. However many of the concerns identified also apply to other proposals within the plan.

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[1] British Social Attitudes Survey published May 2013

[2]Harry Quilter-Pinner, Becca Antink, IPPR - Blog STPs Kill or Cure, 31 Jan 2017

[3] H. McKenna & P. Dunn (2016) What the Planning Guidance Means for the NHS. King's Fund

Bed Closures

The Draft STP states acute bed numbers in 2016/17 are 1,940; by 2020/21 the proposal is to reduce this to 1,697, a planned reduction of 243 acute beds or 12.5%. In addition the Draft STP also proposes a reduction in Community Hospital beds from 233 in 2016/17 to 195 in 2020/21, a reduction of 38 or 16.3%. Is there evidence locally to suggest this reduction can be achieved safely? All local evidence currently points to the need to increase acute beds to allow safe running and national evidence does not underpin the closure of beds (see Appendix A). It is implausible to argue that cutting hospital beds will improve patient care and points to the finance driven character of the Draft STP. The Draft STP has not provided the evidence base to support its planned reduction in bed numbers and does not meet Simon Stevens' patient care test, although even this offers insufficient patient protection. The LMPP believes that a significant period of 'double running' is essential so that necessary beds are not closed prematurely, jeopardizing patient safety.

Maternity Services

The rationale behind the maternity proposals in the Draft STP is unclear and the evidence base is weak. See Appendix B. The draft plan proposes that Maternity Services will be delivered by an obstetric (doctor) led inpatient unit at the Royal Infirmary; a midwifery led unit co-located with the obstetric unit at the Royal Infirmary; or a Home Birth - midwife only led home birth for low risk women. Three local maternity units (1 consultant unit and 2 midwife led units) will close. A very ambiguous proposal that there might be a stand-alone midwife led unit at LGH is described, subject to women's preferences, but is not presented in any detail.

The STP claims to follow NICE Guidelines and the Baroness Cumberledge produced recommendations in 'Better Births' in 2016. Both are clear that women should be given a full choice of place of birth. But the STP appears to restrict choice to a centralised LRI hub catering for almost 10,000 births per year or a Home Birth. As just 2.4% of all births are home births, the question must be asked as to whether the option of a home birth offers a realistic and feasible choice for the majority of expectant mothers. If not, alternative choices must be available. If the only alternative is the LRI maternity hub, this may not be adequate. The Draft STP provides neither sufficient choice nor access within a reasonable time scale for a service covering a population of more than 1m people. Women should be consulted on increasing home births to ensure this option meets their needs and to gauge demand. The option of a stand-alone midwife led unit at LGH needs to be explained in detail so that it can be fully considered during the consultation process. Travel times to LRI also need consideration; what percentage of journeys are within the accepted 30 minutes desirable travel time? Additionally demand for the Birthing Unit at St Mary's, Melton Mowbray must be investigated as there is too much anecdotal evidence that it is not offered as an option to potential users on the East side of LLR. The risks entailed in switching around 4,400 births currently taking place at the General Hospital to the LRI and reliance upon a single location for all city and county births are not set out in the STP but should be fully considered. We note that the capital funding required for service reconfiguration has not yet been secured and is a prerequisite for the proposals contained in the STP.

Concluding Comments and Recommendations

While welcoming the joint working underpinning the STP as well as its proposals to improve community services, the LMPP believe the Draft STP fails to produce a persuasive case for its proposals. This is partly because it does not produce the evidence to back up its proposals and partly because detailed information has still not been placed in the public domain. If the STP proposals are implemented in their current form, they will not succeed in improving the quality of healthcare for the people of Leicester, Leicestershire and Rutland.

The STP leads should:

- Place into the public domain the detailed information underpinning the STP which is currently unavailable
- Produce the evidence base for its proposals
- Engage honestly with the public about the implications of proposals for the quality of health care and the difficulties in monitoring delivery in peoples homes
- Present and explain the risk assessment surrounding the potential for a single (non-home) maternity hub for the whole of LLR
- Engage in meaningful and well-advertised consultations over a wider range of issues than those indicated in the Draft STP including closure of St Mary's Birthing Centre and changes in Continuing Healthcare to meet the proposed saving of £29m

No endorsement by councillors should be given to bed closures unless high quality community services of proven worth and impact have been running alongside beds for a substantial period of time (eg two years) and acute bed occupancy has dropped to consistently below 85%.

Appendix A

Local Evidence

1. The Draft STP states that service is provided to over one million people locally and that by 2020/21 those people will be supported by a bed base of 1,697 acute beds and 195 community beds (although Simon Stevens' recent intervention indicates that in practice there will be more acute beds than the STP suggests. The Draft STP is almost silent on Metal Health, Learning Disabilities and Specialist Services provided by Leicestershire Partnership Trust but there are about 400 beds available. This will provide a total of approximately 2,300 beds assuming no change in LPT bed provision outside community hospitals.
2. In 2014 Better Care Together (BCT), the reconfiguration plan which preceded the STP (the STP is an altered version of the BCT Plan), put forward its Strategic Outline Case (SOC) for change. On page 77 it tells us the acute bed base was 1773 in Nov 2014
3. The STP tells us the acute bed base in November 2016was 1,940. The CEO of University Hospitals Leicester (UHL) stated in a March 6th 2017 article in the Leicester Mercury there are currently 2,000 acute beds across 3 sites. Assuming this is a precise rather than a rounded number, acute bed numbers increased by 167 between autumn 2014 and autumn 2016 and by 227 beds between autumn 2014 and March 2017 at a time when every effort has been made to reduce beds.
4. The SOC prediction was that there should be approximately 260 fewer beds in Sep 2016 than in Sep 2014 i.e. there should be about 1500 beds rather than the 1940 the STP identifies. So in 2 years the plans are over 400 beds adrift of the BCT prediction and indeed the STP acknowledges that the BCT goal will not be met.
5. The need for growth in bed numbers is also supported by the CEO of UHL who told the Leicester Mercury they are about 113 beds short at the moment and they are occupied 95% of the time.
6. This actual increase in bed numbers has taken place at a time when 256 Intensive Community Support Service (ICS) beds have been opened. ICS delivers care in patients' own homes. This service allows patients to be discharged from hospital care in a more timely fashion, improving patient flow and freeing up hospital beds. So local experience is that ICS beds have not been effective in reducing the number of acute hospital beds required.
7. Bed occupancy figures also point to the clinical risks of bed closure. Locally, bed occupancy is very high, often 95%-100% during the winter period when the safe level is accepted to be 85%. These high levels of bed occupancy bring clinical dangers and increase pressure on A&E. In the last year Leicester, which we understand has the largest A&E in terms of attendances outside London, has had the second highest percentage of patients (33%) spending over 4 hours in A&E. (House of Commons - BRIEFING PAPER, Number 6964, 21 February 2017, Accident and Emergency Statistics: Demand, Performance and Pressure). It is not yet clear to what extent the new A&E unit will reduce this figure.

National Evidence

1. The Draft STP is based on the belief that expanding community based services will allow closure of acute hospital beds. This proposal ignores a growing body of evidence. A large scale meta analysis of several different studies found that some community interventions do give rise to a reduction in unplanned hospital admissions. However, most types of community intervention either do not reduce hospital admissions or there is no convincing evidence to suggest that they do. (S. Purdy et al. (2012) Interventions to Reduce Unplanned Hospital Admissions. University of Bristol)

2. Research evidence on the hospital-at-home type initiative as delivered by the 256 ICS beds suggests it may even increase hospital admissions.(T Georghiou and A Steventon (2014) Effects of the British Red Cross 'Support at Home' service on Hospital Utilisation. Nuffield Trust). Another report found that after investigating 38 different integration schemes across 8 different countries including 13 projects in England, not one had resulted in a sustained, long term reduction in hospital admissions. (Serco/HSJ (2014) A Commission on Hospital Care of Frail Older People)
3. The model of integrated (multidisciplinary) teams described in the STP is unproven as noted by T Georghiou and A Steventon (2014) in the Nuffield Trust report:
"In the absence of well-accepted, evidence-based solutions to reducing emergency admissions, there is a need to subject promising new interventions and models of service provision…to thorough evaluation."
4. The UK ranks low in bed provision when compared with developed countries internationally. The most recent OECD (2017) Hospital Beds Indicator figures indicate an average of around 4.8 beds per 1,000 population among developed countries in 2014 (the most recent available figures). The figure is 2.7 for the UK and is thought to be around 2.5 for England.
5. The Draft STP proposes that by 2020/21 bed numbers in LLR (acute, community & mental health) will fall to 2292 or 2.29 per 1,000 population compared with the UK average of 2.7 per 1,000 population.
6. In 2014 the Nuffield Trust published national bed projections for 2022 and found that an extra 17,000 beds would be needed on the basis of existing trends. d Even allowing for further efficiencies, the steady fall in the number of general and acute hospital beds nationally (from 126,976 in 2006 to 101,582 in 2016) cannot be expected to continue indefinitely. (P Smith et al. (2014) NHS hospitals under pressure: trends in acute activity up to 2022. Nuffield Trust)
7. A 2016 analysis by the Nuffield Trust (J. Appleby (2016) *Winter bed pressures*. Nuffield Trust Winter Insight Briefing) has underlined the clinical risks of high levels of bed occupancy.
8. Social care provision in the communities into which services are being transferred is already under tremendous strain. The National Audit Office notes that local authority spending on adult social care has reduced by 10% since 2009/10. (NAO (2017) Health and Social Care Integration. National Audit Office). Age UK reported in 2016 that around 1.2 million people do not receive the social care they need. (Age UK (Age UK News 17th November 2016).
9. NHS England Chief Executive Simon Stevens has announced that hospital bed closures arising from proposed major service reconfigurations will in future only be supported where a new test is met that ensures patients will continue to receive high quality care.
    1. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
    2. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
    3. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

Appendix B

Local

1. The reasonable travel time standard is seen as within a 30–minute drive of both an obstetric unit and a midwifery–led unit. (Maternity services in England, Report by the Comptroller and Auditor General, House of Commons, 7 November 2013 references NCT, in Location, location, location: Making choice of place of birth a reality, October 2009) Seventy-nine per cent of women nationally were within 30 minutes of both types of unit in 2013.
2. Any work undertaken on travel times for LLR is not presented in the STP. The current base travel times are required as are expected travel times post single site at LRI.

National

1. NICE Information for the Public provides the following:

1. Midwife–led units (also called birth centres) are more 'home–like' and relaxed. They can be in or next to a hospital (called 'alongside' units) or in a different place (called 'freestanding' or 'stand-alone' units). Obstetric units (also called labour wards) have more medical facilities.
2. If you have had a baby before, your midwife should advise you that planning birth at home or in a midwife–led unit is particularly suitable for you. This is because the evidence shows that:
    1. you are less likely to have interventions (such as a ventouse or forceps birth, caesarean section and episiotomy) compared with planning birth in an obstetric unit
    2. the chances of your baby having a serious medical problem (which are very low) are not affected by where you plan to give birth.

2. Baroness Cumberledge's recommendations in Better Births are:

1. There has been a longstanding expectation that women should be given a full choice of place of birth: home birth, midwifery unit and obstetric unit, and this is endorsed by NICE guidelines.
2. Providers will need to evolve the nature of the service offering, looking beyond the traditional boundary of the acute settings and into the community.
3. This report envisages more births taking place in the community, i.e. in midwifery care and at home. Commissioners will need to ensure there are services available to support this additional community-based demand.

3. Maternity services in England, Report by the Comptroller and Auditor General, House of Commons, 7 November 2013 says:

    1. The proportion of births in midwifery-led units increased from 4 per cent of births in 2006-07 to 11 per cent in 2012.
    2. Home births remain a small proportion of all births, falling from 2.8 per cent in 2007 to 2.4 per cent in 2011.
    3. The position is not uniform across the country. Only 4% of mothers in the East Midlands gave birth outside a hospital obstetric unit (that is at home or in a midwifery-led unit), compared with 11% of mothers in England.

1. The State of Maternity Services in England, Policy briefing, July 2016, Author: Giuseppe Paparella, Policy Officer Picker Institute Europe says:

1. In 2014 there were 664,543 births in England, compared to 566,735 in 2001 (National Maternity Review, 2016). According to statistical forecasts, by 2020 the number of births will increase overall by 3% to 691,038 (Office for National Statistics, 2015b).

2. Relationships: the pathway to safe, high-quality maternity care, Sheila Kitzinger symposium at Green Templeton College, Oxford: Summary report:

    1. Women at low and higher risk who received continuity of care from a midwife they know during the antenatal and intrapartum period (compared to women receiving medical-led or shared care) are 24% less likely to experience preterm birth, 19% less likely to lose their baby before 24 weeks gestation, and 16% less likely to lose their baby at any gestation. Women were also more likely to have a vaginal birth, and fewer interventions during birth (instrumental birth, amniotomy, epidural and episiotomy). These results are from a Cochrane review of continuity of midwife care provided by team and caseload midwifery of women based on 15 trials involving 17,674 women (Sandall et al 2015).

Appendix G

CAMPAIGN AGAINST NHS PRIVATIZATION SUBMISSION TO THE HEALTH AND WELLBEING SCRUTINY COMMISSION, LEICESTER CITY COUNCIL REGARDING THE SUSTAINABILITY AND TRANSFORMATION PLAN FOR LEICESTER, LEICESTERSHIRE AND RUTLAND MARCH 2017

Endangering the future of the NHS through chronic underfunding

The Sustainability and Transformation Plan poses a significant threat to the quality of health services in Leicester, Leicestershire and Rutland. The primary purpose of the STP is to restructure health services so that the unit cost of health care is reduced.

Not only have Conservative governments tended to fund the health service less generously than Labour governments historically but in addition they have taken a more ambivalent stance towards the very principle of the service. The Conservative opposition voted against the National Health Service Bill in 1946; under Margaret Thatcher, policies of privatisation were initiated and, since 2010, Conservative-led administrations have prioritised marketization and restructuring over quality health care.

Between 1950 and 2010, the average real terms annual increase in health service funding was almost 4% but since 2010, these annual increases have averaged 1% a year. Around 4% is estimated to be necessary by the Nuffield Trust to cover cost pressures arising from the growing and ageing population, increasing levels of chronic illnesses, the cost of medical innovation and health service specific inflation. NHS providers have made efficiencies but, overall, have been unable to avoid running deficits. The autumn statement of 2015 required cuts in both the public health budget and capital budget of the Department of Health and effectively money was transferred to NHS England to counter the growing deficit. (The Department of Health budget is run separately from the budget given to NHS England for providing NHS services.) Despite creative accounting, NHS providers across England, such as University Hospitals of Leicester and Leicestershire Partnership Trust locally, ended the last financial year (2015-16) with an underlying collective deficit of £3.7bn. The primary purpose of the STP is to restore financial balance by 2020/21 by reducing the gap between the amount of funding made available and the cost of continuing to provide health services on the current basis.

The financial settlement for the NHS since 2010 makes it clear that the government's vision is for a health service which fits into a smaller share of national income. While relatively high levels of funding of the NHS are associated with relatively low levels of private health insurance coverage, the danger is that reducing access to health care by restricting NHS capacity and reducing the quality of health care provided by the NHS could lead to a rise in take-up of private health insurance by those who can afford it or in out of pocket payments (fee for service), eroding the principle that health care should be available on the basis of need alone. The majority of us would be left with a poorer service.

Government policy reflects both a lower priority for health care and also a broader determination to reduce the redistributive impact of policy. Spending on benefits and public

services is our society's major vehicle for redistribution. Good quality health services are important in reducing inequalities since NHS care is available independent of the individual's ability to pay for it: health care can be equally provided to the rich person and the poor person. Moreover, good services form an important part of the 'social wage', the element of our standard of living which comes not from our own salaries or benefits but from the services we pay for collectively. Households which, during these difficult times, suffer a drop in personal income face a double whammy when public services such as the NHS are simultaneously cut back.

This cannot be seen as an unavoidable side effect of dealing with the deficit. Other comparably rich countries, which have also faced economic challenges following the financial crash of 2007/8, have continued to maintain noticeably higher levels of funding for their health services than the UK both in terms of the amount spent per person and in terms of the proportion of GDP devoted to health care. The NHS continues to have far fewer beds per head of population than most rich countries and continues to have fewer doctors and nurses per head of population compared with other rich countries.

Nor is the claim that the NHS is no longer affordable convincing. The NHS is an important part of the economy and additional spending on health care produces economic growth through the fiscal multiplier. £119bn was spent on the NHS 2016-17; 4% of this is around £5bn. The Office for Budget Responsibility produced an analysis in September 2016 which looked forward to what would be needed for NHS funding by 2030. It claimed that adequate funding for the NHS could be found by giving the NHS the proceeds of economic growth plus £1.7bn each year. From an economy of just under £2 trillion, this can be found if political decision-makers want it to be found.

We call upon the City Council to recognise that the threat posed by the STP is a direct consequence of government's policy and vision for the NHS and to oppose it.

Cuts in local health care

Given the financially-driven nature of the STP, it is not surprising that large-scale cuts are proposed. Hundreds of acute beds are threatened with closure, despite the fact that bed occupancy is running at 95% and over (that is, at any given time, 95%+ of beds are occupied), while the safe occupancy level is 85%. The clinical dangers posed by excessively high levels of occupancy have been summarised by the Nuffield Trust and include disruption in the care of sick patients, extra pressure on staff and threats to the ability of staff to contain infection and to prevent infection spread. Two community hospitals and 38 community hospital beds are also threatened with closure in the County and Rutland which is likely to lead to additional pressure on beds in Leicester. The plan to close the Leicester General Hospital as an acute hospital which also offers consultant-led maternity care is particularly startling given the relatively high proportion of acute care and maternity care provided on the site. We do not believe that closure can be undertaken while maintaining safe patient care.

The new models of care are to some extent experimental. Relying on 'emerging evidence' is not satisfactory. If new models of care are piloted, double running for a long enough period to establish the outcomes (intended and unintended) and impact of the new services is the minimum required. The closure of acute beds should not be considered until bed occupancy is consistently well below 85%. The Plan's timescale of five years is inadequate and has led to short-termist proposals likely to create more problems than they solve by 2021, particularly

by cutting services which are needed. Projections for population growth and envisaged morbidities are required and should be in the public domain.

Social care

Publicly funded health and social care services in Leicester have been particularly vulnerable over the last few years as the City Council has grappled with real terms cuts in budgets. The result has been that publicly funded care and support needed in old age are failing to meet rising demand. Leicester Council has no care homes, while the fragility of private ones, especially from a financial and staffing point of view, is a real concern. The number of private care homes in England has fallen from 18,000 in September 2010 to around 16,600 in July 2016. Social care in communities is under strain and needs proper financial investment. In our view they will only really succeed when there is taxation based funding and renationalisation of social care.

Vulnerability in communities

When the STP says services are being transferred into 'the community' we have to think what we mean by community. We already have a 'community' under severe strain. The city in a number of areas has high levels of poverty and deprivation. In part this is due to an economy built on low wages, low job security and a growth in zero hour contracts. Even some people in work struggle to feed themselves, pay the rent or mortgage and may even rely on foodbanks. Some people have to hold down several jobs to make ends meet but the STP seems to assume family members or friends will be available to look after people in their own homes. Many experience the stress of low wages and insecure work and meanwhile mental health services are also under strain. Public health funding has been cut back and support for prevention is reduced. So overall we should view the community as in many respects vulnerable and we should not assume that transferring services into the community is automatically desirable.

If there is an expansion of community services, the Plan must take account of the social care crisis and vulnerability in communities and make sure the new services are properly invested in and fully proven before hospital services are reduce. Otherwise the quality, safety and sustainability of care to Leicester residents will be at risk.

Privatisation

Setting aside the possible use of the Private Finance Initiative for hospital reconfiguration, there will be at least three factors in the STP proposals which accelerate the privatisation of health care. Community based services are more attractive to private companies, market regulation will require commissioners to undertake competitive contracting and funding shortages will create pressures on CCGs to accept low cost tenders.

Transferring services to the private sector remains a key part of government policy. We have seen how this has led to the fragmentation of services and a lowering of quality. The performance of the non emergency patient transport contract held by Arriva and the catering and cleaning contracts previously held by Interserve have proved highly unsatisfactory. Likewise there have been concerns about the performance of some companies providing home care services. Companies can just pull out either if they lose money or if they find another way of making more money. Low pay, poor training and support, lack of continuity

of care staff and impossible workloads result in high staff turnover – this is not good for the patients and their carers and reduces value for money.

Private companies generally do not want to take on acute hospitals because of the complexity and uncertainty involved and because it is hard to make any money out of it. Instead, they like to cherry pick those services where they believe they can reliably make a good profit. This leaves the NHS with less revenue but the more complex aspects of health care to provide. Privatisation inevitably results in the downskilling of the workforce and the management of professionals so that they service the company's goals rather than the needs of the individual patient. The purpose of an NHS organisation is to serve patients. The purpose of a private company is to generate income and create a surplus. We believe private companies have no role in the provision of health care.

How might the changes affect your constituents?

Councillors deal with a wide variety of casework. It is an important and valued part of the role. As the distinction between the NHS and community care becomes blurred and access to services becomes more restricted, patient dissatisfaction will grow and councillors could find an increase in their workload.
Some points to consider:

- Access to GPs. Leicester has a shortage of GPs. Patients are already finding it difficult to book appointments yet more services are to be devolved down to GPs from UHL. The new model of care sees GPs restricted to working with patients with multiple and complex needs whilst far less qualified staff such as physician assistants, nursing assistants and others will manage all other patients. Some of your constituents will find it harder to see their GPs and the quality of care may suffer.
- Access to services. We are fortunate that our three hospitals are all on bus routes. When treatments are moved out into community settings patients may have to travel to a variety of venues other than their GP surgery to receive treatment. This may present difficulties for those relying on public transport. For example, more primary care will be provided in a limited number of surgeries rather than in all surgeries. This will entail more travelling as patients find they have to obtain some primary care services at surgeries other than their own.
- Quality of care. Shorter stays in hospital and initiatives to avoid hospital admission are to be welcomed but only if there are good services available to support patients at home. Good numbers of staff, well qualified staff and continuity of care are essential. However, there is a well-known problem with recruiting and retaining NHS staff and many experienced staff have either left or are planning to retire. We are not sure where the staff are going to come from and we reject the notion that equally good care will be provided by less qualified staff. If services are privatised, a reduction in quality can be expected.
- Waiting times. Your constituents can expect longer waiting times if hospital beds are to be cut back when the pressure on beds is already there for all to see. This will be very compromising for the health and wellbeing of some residents. If beds are cut, trolley waits may also become more common which is potentially dangerous for patients admitted in an emergency.
- Regulation and safeguarding. What mechanisms will be put in place to monitor these effects and to protect both patients and staff?
- Support for staff. Many constituents work in the NHS and social care. The new model requires many staff to move out of a hospital setting where they have worked as part of a team, with expertise at hand, and into patients' own homes where they will be working alone.

This may be stressful for staff and needs careful planning. The Commission should request evidence from the representative organisations of NHS staff regarding the views and experiences of staff.

The Campaign Against NHS Privatization calls for:

- A clarification regarding the legal status of the STP
- Access by the public to full detailed financial calculations, workforce plans, demographic assumptions and so forth
- Proposals to be evidence-based
- Recognition that expanding community services may absorb some rising need for care but will not itself make possible large scale bed closures
- Recognition that expanding community services requires a much larger budget
- Double running new services in the community alongside existing hospital services for at least two years to establish their value and impact, if community services are to be piloted
- No bed closures unless bed occupancy is consistently over a year well below 85%
- Full formal consultation on major changes being proposed including changes in the way primary care is being delivered
- Assurances that care which is currently free at the point of use will not be re-categorised as social care and charged for
- Clear opposition to any investment which is intended in part to reduce hospital bed provision.