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).