`CANP Public Meeting on Better Care Together 28 February 2015

The Campaign Against NHS Privatisation group hosted a public meeting on Better Care Together on 28 February 2015. The event was attended by John Adler, chief executive University Hospitals of Leicester NHS Trust and Dr Pete Rabey, University Hospitals of Leicester on behalf of Better Care Together. Due to time constraints a number of questions were not answered at the event. These are listed below, along with our responses.

Investment and estates

(1) We need to remind people that we are fully aware that the use of finance investment programmes of a structural nature leads to institutional indebtedness (eg structural indebtedness). Can we challenge it with better service provision?

The primary goal of the Better Care Together programme is to improve the quality of care for patients and to provide that care in the most appropriate location.

The Strategic Outline Case, which was developed through organisational financial officers alongside outside scrutiny from Ernst & Young, fully sets out the financial implications of a do nothing, a do minimum and the Better Care Together programme. The do nothing reveals a predicted deficit to the system of c£390million, the Better Care Together programme will deliver a sustainable financial model with a surplus by 2019.

(2) What is happening to NHS buildings?

There are likely to be a number of changes to NHS buildings during the life of the Better Care Together programme, for example work has already started on improving the emergency floor at Leicester Royal Infirmary. A full estates plan is presently being developed and will form part of a formal consultation process, potentially later this year.

(3) What is going to happen to the General Hospital site?

Leicester's hospitals will probably become smaller and more specialist overall, to support the drive to deliver more non-urgent care in the community. If more patients are cared for at home, less space is needed in hospitals. This does create an opportunity to do what the hospitals' clinicians have been pressing for – to consolidate all acute services onto two sites, potentially the Royal and Glenfield. However, while the direction of travel indicates that its role may change, this does NOT mean that the General Hospital site would close. It is expected to continue to provide a significant amount of healthcare, including the Diabetes Centre of

Excellence, community beds, rehabilitation, psychological therapies and outpatient clinics. In any event, this is a long term plan. There is a lot more planning, talking and listening to do before any final decisions are made.

(4) Which bits of the General are being sold off?
There are no plans to sell the General.

(5) How will the success of BCT plan be measured?
We are developing programme wide KPIs (Key Performance indicators) and the care pathways will also have their own KPIs. However the real proof of success will be a patient view of better care in the right place. There are many different kinds of metrics to evaluate integrated care, not least acute admission avoidance, which points to positive impacts.

Service design

(6) Is part of Better Care Together to create a dedicated service for the frail elderly so that the frail elderly can be diverted from A&E, medical admissions and non-dedicated wards, so that the frail elderly can be offered greater compassion and expertise?
We do have a care pathway for frail and older people. This aims to improve independence and wellbeing by having fewer older people admitted unnecessarily to hospital, discharging people promptly with agreed and managed care plans, and reducing readmissions. By having services in the community, closer to people's homes and greater community support we will be able to help them to remain independent and in their own homes for as long as possible. It is also worth noting though that in many cases frail older people could be better looked after outside hospital without a trip to A&E; from 2016, when they do come into A&E it will be to a new, UK first, 'frailty friendly' environment which is specifically designed to meet the needs of our oldest and frailest patients.

(7) Why must we accept that the literature evaluating integrated care represents an insight into what is possible?
Change has to start somewhere and with a basis of evidence. The present evidence base, both academic and anecdotal, indicates that integrated care will improve the quality of care from a patient perspective. There are many anecdotal examples that indicate integrated care could also save money for the overall health and care system if implemented efficiently. Last but not least we should recognise that where services and pathways are not integrated, patient feedback tells us that, people are frustrated and sometimes left stranded by the gaps between services… we need to listen and act.

(8) What is the telephone service that is being substituted for personal care?

We are unsure which phone service this question relates to. We think it may relate to the following recent change at Grey Friars (adult social care, Leicester City Council).

We have carried out a review of the reasons why people call into Grey Friars to speak with staff from adult social care. The review showed that most people visiting Grey Friars would be dealt with more effectively at our customer service centre. This does not in any way stop people making arrangements to see adult social care staff by appointment.

To speak to us about your care needs you can call 0116 454 1004 or visit leicester.gov.uk/asc

(9) What elements of care are likely to transfer from health service provision to social care provision?

During 2015 there will be Better Care Together planning activities that bring health and social care representatives, plus patient representatives, together to discuss how the new care pathways being developed will work in practice. This dialogue will create some options to be discussed with the public during public consultation. Until those activities have taken place we cannot say precisely what, if anything, will transfer.

(10) Planned Care workstream - *How many treatments/conditions will be moved to 'community hospital' e.g. 160 Barratts oesophagus patients. Back Pain to Melton, Hinckley, Loughborough.*

Many planned care services are already available in community settings. Over the next two years we are reviewing 18 specialisms covering 54 pathways in total. The reviews, which will involve patients and clinicians, will look at how the services can be improved in terms of patient outcomes and experience, access to appropriate diagnostic and support services, and to ensure services are in line with national standards. For some specialisms this may mean more day surgery and less in-patient surgery and that more services are available out of hospital in local communities. Patients will have opportunities to share their views on our plans and help us to design these improved services.

(11) The BCT leaflet scenario has Melton woman pleased to have her hernia operation in Melton instead of going to LRI. Where will CITY residents go for these various treatments?

Patients from Leicester city will be able to access services via at least one hospital in the city or under patient choice may choose to access any of the community based services elsewhere. We are reviewing planned care pathways and this will include looking at the places in which services are

offered. Patients will have opportunities to share their views on our plans and help us to design services. Should any major changes be proposed these would, where appropriate, from part of a public consultation.

Capacity and cuts

(12)Are people working over weekends now (X rays, physios etc) – the first thing I noticed in the video. Nurses work around in the clock.

Many health and social care services are 24/7 365 day per year services, so yes there are staff working over weekends at the present time. However it is not the case yet that the NHS nationally or locally is genuinely 24/7 i.e. the same services delivered by the same numbers of qualified staff regardless of the time of day or the day of the week. This is something which the whole NHS is working on.

(13) *When can we expect tests and scans etc to take place at weekends, thereby avoiding delays in discharges?*

A number of procedures already take place on Saturdays and Sundays at the Royal, General and Glenfield. All three will carry out emergency surgery, diagnostics and imaging, but there is also a lot of elective work that is done, predominately on a Saturday, with some cases on Sundays. For example, at the Royal we carry out orthopaedic, ENT, maxillofacial and ear, nose and throat surgery. At the General the focus us on general surgery, urology and gynaecology procedures, and at the Glenfield it tends to be cardiac procedures.

(14) What is meant by 'community beds' and rehab beds' – and where exactly are they?

Community beds and rehab beds are beds that are not in acute (eg LRI, Glenfield and General) hospitals: they are in community hospitals across the area. They are generally characterised as looking after people who are well enough to leave the acute hospitals but not necessarily well enough to return to their place of residence OR for people who might need a spell of care in hospital but are not that unwell that they need to be in an acute hospital.

(15)Could part of the problem be helped by having a bigger buffer of empty beds in wards?

That is one perspective however wards and beds are only useful if there are staff and equipment, as well as support, to run them (for example food services). In all honesty running a hospital is in part always about balancing supply and demand, so if money were no object a 'bigger buffer' of empty wards would at times be useful but given that it costs about £1m a year to

run a single ward we cannot justify having 'spare' capacity which is then unused for most of the year.

More importantly there is evidence that a person being in hospital when they do not really need to be can result in them having negative health outcomes, and in the case of the frail and elderly losing their independence. This is not high quality healthcare and the goal of Better Care Together is to ensure people are treated in the best location, which may not be in hospital. Additionally for the sake of us all as taxpayers there is a need to prevent ill health rather than creating expensive capacity to deal with it when it could be prevented.

(16) *Maternity and neonatal workstream BCT is promoting more home births. Yet 6 midwives (Band 6) and 5.4 nurse auxiliaries (Band 2) are to be cut.(Appendix 7) How can this improve the service?*

Leicester's Hospitals do not have any plans to reduce the number of midwives and support staff. Midwives have been deployed to promote and join the Community Team to support women choosing to have home births. We will still have the same number of births within Leicester, Leicestershire and Rutland, so midwives will be retained in the workforce to maintain the midwife to birth ratios.

(17) Planned Care workstream. Reduction of 6 specialties plus a further 6 specialties by 5%, then 10% (appendix 5) What are these specialties?

Our plans to improve planned care services do not include stopping or reducing any of them. Our aim is to improve patient outcomes and experience, access to appropriate diagnostic and support services, and to ensure that services are delivered in-line with national standards. For some specialisms this may mean more day surgery and less in-patient surgery and that more services are available out of hospital in local communities. This may mean less need for bed capacity at acute sites; it is this potential reduction that the text quoted refers to.

(18) This year we have seen many breaches of the 4 hour limit in A&E. Are there going to be realistic solutions which are sustainable and not just stop-gap measures?

The 4-hour target is a measure of how the entire emergency care system is coping and not just the about the performance of one department. The entire health and social care communities have been working very closely over the 2014/15 winter and we have seen sustainable improvements in performance of the 4-hour target, although there is still more to do. The focus remains on admission avoidance (ensuring that patients receive the

right care outside of hospital to prevent an emergency admission), improvements in Leicester's Hospitals internal processes, and improvements in discharge (making sure that services/packages of care are in place for a patient so that they can be discharged when they no longer need to be in an acute hospital).

The Better Care Together Urgent Care work stream (which includes all partner organisations from across the health and social care economy) has developed a plan to see a fundamental shift in how we manage patients, particularly those with long term conditions and frail older patients, so that their care is better managed at home with suitable support so that they don't end up needing an emergency admission because their health has not been managed appropriately. The new model focuses on 1- Self-care and primary care; 2- Enhanced routine care; 3- Urgent care and crisis response; and 4- Emergency acute care. Patient experience and involvement is been used to shape the future model. Last but by no means least we are planning to invest £48m into a new A&E; the current one was built to cope with 100,000 attendances a year and is seeing 160,000, the new facility combined with better management of the patients referenced above will ensure that the 4 hour target becomes routine.

(19) Why, when we are clearly talking about cuts, are we talking about service reconfiguration? Honesty is the best policy when speaking to the public. Why are we dressing up cuts as something else?

BCT is about transformation and change. This means for example £63million from Better Care Fund schemes and other capital schemes such as a new £48m emergency floor at the LRI. UHL alone expects to invest £327m in services and reconfiguration over the next 5 years… so this can hardly be characterised as a cut.

It is important to understand that providing a different service is not a "cut". Changes are being designed to ensure that the needs of local people will be met. Services will not be changed unless doctors and other professionals are satisfied that they will benefit the public and are safe.

It is a fact that the changes also need to close the big financial gap in health and social care budgets, so finding ways of working more efficiently is an important element of Better Care Together and we will have to make some difficult decisions along the way, but it is not possible at the moment to say exactly what those are.

(20) Does anyone remember what happened when most mental hospitals were closed to be replaced by 'community care'? Because of underfunding, mental

health services were drastically reduced. The result was great pressure on the remaining mental health wards and a large number of mentally ill people ending up in prison and police cells. We are in a situation where local authorities have no money for social care because of cuts in funding from central government.

It is difficult to respond as this appears to be a statement not a question. The sentiment of the statement is noted.

(21) *Why are there 10% / 70% (illegible) cuts to mental health?*

We are unsure what this question refers to? BCT does not plan to cut mental health.

(22)BCT may be better BUT mental health experience is that beds have been cut down so much that in an emergency people are sent to far-flung locations. Twenty years ago social care was given by trained and qualified staff. Now social work is about assessment and care is provided by the private sector with staff under-trained and often on the minimum wage and zero hours contracts. Why won't BCT go the same way?

We will have a full organisational development and workforce strategy to work with existing NHS staff. There is still a lot to do on workforce strategy and we will be working closely with our staff on this. The main aims are to ensure that staff are given the development opportunities they want and that people are attracted to stay in Leicester, Leicestershire and Rutland following their studies from our excellent universities. The emphasis is to raise standards of care through investment in training and development of our staff.

(23)Already we know that the level of poor mental health in young people is on the increase. We need to know that good services will be available for this important group. Can you guarantee this?

We want to ensure that good services are available to all people, including those with mental health problems. By changing the way we work we will be able to support and intervene earlier to help people and ensure that there are services closer to people's homes and in community settings. We recognise the importance of mental health and early interventions for younger people is something we would want to develop through the lifetime of the programme and beyond. We will also be investing in the crisis response service for all service users including crisis house support.

(24)What will the impact on provision, including the number of beds available to NHS patients, be of attaining mutual status?

At the present time there is no plan to attain mutual status, UHL is merely working with the Department of Health and Cabinet Office as part of a feasibility project. Moreover, 'mutual' status is about exploring different

organisational forms to improve staff and stakeholder involvement, not about the number of beds.

Staffing

(25) *How can this service possibly be delivered when there is a shortage of district nurses and only 87 are being trained nationally?*

It is true that district nurse figures are falling but we are not aware of this statistic. The Queen's Nursing Institute Report on District Nurse Education in England, Wales and Northern Ireland 2012/3 showed that there were more than 87 district nurses being trained. We recognise there is a lot of work to do to ensure we have the right staff to deliver work and that is recorded within the Better Care Together risk register which is publically available.

(26) *What is going to happen to early preventative medicine (eg with cuts to breastfeeding support, health visitors, school visits). We need these services. I frequently see cases of rickets and neglect?*

Prevention is a key part of the Better Care Together programme, as is reducing health inequalities. It is possible that the way early preventative medicine is delivered will change, for example LPT are presently trailing using digital technology to support young people and schools.

(27) *Support at home – does this mean ever more low paid, low qualified people driving unpaid all over the place?*

Ensuring a sufficiently qualified workforce is key to the delivery of the Better Care Together service improvements. So no this is not about the de-skilling of workers, it is about people with the right skills seeing patients in the community rather than the current models which defaults to hospital.

(28) *Mental Health workstream. Reduction in community service costs due to reduction in staffing …. (Appendix 10) How can this improve the service?*

The mental health service care pathway changes are an integral part of Better Care Together; the outline (and therefore not finalised or agreed) reductions mentioned are just one part of the changes of the programme: in other parts there is the need for increasing resource, not least in early intervention, crisis and prevention services.

(29) What proportion of the current health workforce are not on professional registers? What proportion do you think this will be in five years' time.

BCT does not hold this information. Each individual statutory partner holds these records. But as the answers to the questions above would indicate if,

behind this question is the inference that cheap unskilled labour will replace the current professionals, the answer is no.

(30)How is training to be addressed so that we stop spending ridiculous amounts of money on agency staff and locums?

Organisation Development and workforce development, including ensuring staff are trained in the new ways of working are key parts of the overall 5 year Better Care Together plan. The programme works closely with Health Education East Midlands to ensure that training is considered. The issue of agency staff and use of locums will however also be addressed by the proposed changes to service delivery. Additionally providers like LPT and UHL are pulling out all the stops to recruit as many nurses, midwives and HCAs as possible, including recruiting overseas (Spain / Italy / Portugal) once the local 'supply' from DMU is used up.

(31)What is happening about the shortage of GPs? There are stories of people unable to get appointments.

The shortage of GPs is an acknowledged issue across the country as well as in Leicester, Leicestershire and Rutland – there are national initiatives to address the recruitment of GPs. Workforce shortages, whether they are GPs, nurses or allied professionals is acknowledged on the publically available BCT risk register and will be monitored and addressed throughout the course of the programme.

(32)In Cuba, there is one doctor for 600 patients and doctors regularly visit their patients – would that help?

Cuba is a very different country to the UK. Different countries deal with health and social care in different ways the Better Care Together programme will work within the boundaries of the English NHS and Social Care systems.

Privatization

(33)Are Interserve going to bid for community services? In UHL, they have used zero hours contracts and unfair staff treatment and do not do all they promised in their major contract across LLR.

There are no plans to outsource to the private sector any health services.

(34)What is going to happen when hospital treatment finishes and patients go to private residential care – who will help with funding?

There are already assessment criteria in place for people who require ongoing health and/or social care. This will not change. Who funds the care depends on the needs of individuals and their own financial circumstances.

(35)Serco has an appalling record of serving the interest of those who make money form the services it provides rather than providing what is needed to the vulnerable. Essential services – our essential services – should be in our hands through public services and should stay there. How can it be cheaper with the private sector?

As mentioned above there are no plans to outsource to the private sector any health services as part of BCT.

(36)What is the legal form of the LLR Alliance as a company/organisation? Is it registered with Companies House?

This is a question that needs to be addressed to the LLR Alliance. We are unable to comment on their behalf.

(37)*When primary care is reconfigured into 'hubs', will you ensure there is no take over by private companies?*

There are no plans to outsource to the private sector any health services.

(38)Who will monitor the change if privatisation happens in the future?

There are no plans to outsource any services to the private sector.

(39)*Best practice discussions(?) are being used as an opportunity for the private sector so seek profit. The debate is confused.*

Discussion about best practice for Better Care Together at a workstream level has been exclusively made up of clinicians, managers, staff, voluntary sector and service user representatives; private sector companies have not been part of those discussions.

Various

(40)Is it true that the contracts that have been signed cannot be broken even if we repeal the 2012 Health and Social Care Act because it will enable health care companies to sue the NHS?

It is unclear how this question relates to the Better Care Together programme. There are no plans that we are aware of to repeal the 2012 Health and Social Care Act. Leicester, Leicestershire and Rutland will follow national guidelines on commissioning.

(41)Will there be transparency in commissioning where GPs on the CCG are actually commissioning their own services (ie where there is a conflict of interest)?

CCGs replaced Primary Care Trusts in 2013 and are responsible for planning and commissioning health care services in their local areas. They are independent and accountable to the Secretary of State for Health through NHS England. NHS England is responsible for ensuring that CCGs

are fit for purpose. We are not changing the way in which planning and commissioning happens.

(42)Are home births being encouraged? They are much more cost effective than hospital births.

We want to support mothers' birth choices, which include giving birth at home. We currently have a low number of home births and want to increase this when it is safe and what the mother wants.

(43)We're constantly hearing war-mongering propaganda. We can therefore expect big numbers of war casualties needing care. How is this being planned for?

We have not experienced a significant increase in service personnel needing care.

Leicester hospitals are not currently a receiving hospital for any armed forces that have received injuries during conflicts. However, some of our team are involved in the rehabilitation of service personnel.

(44)How will you know when a bed is 'superfluous' and can be closed? What are your indicators?

A proposal was taken to the Better Care Together Partnership Board in March 2015 to initiate a process of activity and capacity planning that will help the programme and its partners to understand what can be closed and when. There is also a Clinical Leadership Group in place who will provide clinical assurance to any changes and will be involved in decision making before changes such as bed closures take place.
The two important things to remember are 1) that for those who need acute care, there will be beds available. 2) We will not shut beds until other alternatives have been established and proved to work. (There are more details of the precise methods we will use to work out our 'bed base' now and in the future contained in the paper referred to above which is on the BCT public website) .

(45)*How can BCT value, build up and contribute to the local independent voluntary sector to bring models of social care and medical care together? Don't reinvent wheels.*

We value the input of the voluntary sector and a number of organisations are represented on the Patient and Public Involvement group. Throughout 2015 we will continue to work with voluntary sector partners to review plans and to get their input so that we do not reinvent the wheel.

(46)*What are your main concerns about implementing the plan and can you identify (at least) two specific weaknesses?*

Some of the major risks have already been mentioned. Workforce is one; can we ensure there are enough trained, professional and informed staff available to support the changes in services is a very key question? Also the partnership must hold together in good times and in difficult times. It is not a company or an organisation so it has none of the benefits that these have. Many of the fundamental changes to services to improve their overall quality to the public and patients can only be enacted if the partners are willing to work at times as one.

(47) *Why were staff at the General not told about this meeting and BCT?*
This meeting was called by an independent group and advertised via the letters pages in the Leicester Mercury without the knowledge of Better Care Together.
However staff in all partner organisations, including those at Leicester General Hospital, have been told about Better Care Together. Regular updates about the programme are included in organisations' usual internal communications.
As work progresses we will engage with staff, staffside representatives and others to inform them about work that might impact upon them and their work.

(48) *Does the decision by Greater Manchester to take over the running of health care signal the beginning of the break-up of the NHS and more unhelpful privatisation of services?*
The details of the Greater Manchester plans are still emerging; however our understanding is that the plan is a partnership between health and social care overseen by the Health and Wellbeing board as opposed to private companies.

Comments
We need to stop vilifying the NHS through freedom of information etc when the private sector is protected by 'commercial secrecy'.

Independent scrutiny is essential.

Demise of Leicester Healthwatch.