PAPER C

Sustainability & Transformational Plan Meeting, Hosted by Healthwatch Rutland, 8th December 2016 at Oakham Castle

Summary

The meeting was hosted by Healthwatch Rutland. Its purpose was twofold – first to give a private briefing to key public influencers in Rutland on the Leicester, Leicestershire and Rutland (LLR) draft Sustainability and Transformational Plan (STP) and second a discussion of the plan and issues.

The briefing was given by Tim Sacks, Chief Operating Officer of the East Leicestershire and Rutland CCG(ELRCCG) , accompanied by Dr A Ker, Vice Chair, ELRCCG and Rachel Bilsborough, Chief Operating Officer of Leicester Partnership Trust.

In 2014 a Strategic Outline Case had described the intention to reduce 3 hospitals in Leicester to 2 by transferring the care of those who no longer needed acute hospital treatment either into patients' own homes across Leicester, Leicestershire and Rutland or closer to home.

It is proposed that this "Home First" approach be achieved by using new ways of working. On discharge the objective would be to go to "Home First" supported, if necessary, by integrated health and social care teams. If there was a clinical reason that patients could not be supported at home, the route would be via either a Sub-acute, Rehabilitation or Stroke Rehabilitation bed locally or to long term care in a care home.

The STP represents the next step and puts forward proposals to turn these objectives into reality - driven on by the need to find £400m of savings by 2020.

Areas discussed were:-

1. New models of care
2. Acute care - Proposed closure of Leicester General Hospital and its reconfiguration as a community hospital for Leicester

3. Maternity Care - Proposed closure of all Maternity Units at Leicester General and Melton Hospital and centralisation at LRI.
4. Community Hospitals - Proposed overall closure of all beds at Rutland Memorial & Lutterworth hospitals Hospital and creation of a health and social care hub.
5. General Considerations

Discussion focussed upon the impact of the STP plan on Rutland which in all would lose access to 430 beds at its nearest hospital (LGH) , its maternity services with 4000 births at LGH and at Melton and at its community hospital Rutland Memorial (16 beds).

Questioners therefore sought further information on the substance of the STP Plan and it was agreed that the plan was much more likely to secure people's commitment if the answers to these questions were available in advance of engagement or consultation. Due to time constraints at the meeting some questions were unanswered .This paper gathers those questions and subsequent ones together for submission to the CCG.

PROPOSED CHANGES TO ACUTE & MATERNITY CARE

(Capital Cost £251.231m at LRI & Glenfield)

Tim Sacks described the proposal to reduce acute care beds by taking out all acute and Maternity beds at Leicester General Hospital (approx. 430 beds) made possible by introducing new models of care which it is believed will reduce demand for beds equivalent to 453 beds in the following table. The plan proposes the following reductions largely at Leicester General by:-

• By reducing Elective Care length of stay	Minus 44 beds;
• By reducing non elective length of stay	Minus 90;
• By creating '*beds at home'* (called ICS beds)	Minus 65;
• By reconfiguring planned care	Minus 22;
• By reducing Stroke beds at LGH (used by Rutland)	Minus 15;
• By introducing Integrated Teams between health & social care	Minus 128;
• By introducing new Ambulatory Care models	Minus 12 ;
• By reconfiguring clinical work streams	Minus 77

Total proposed *reduction* in adult beds by closing LGH = 453 .

The plan proposes offsetting acute bed reductions at LGH beds with increases mainly at Glenfield as follows :-

- For Elective Care + 25
- For non elective care + 159

Total proposed *increase* in adult acute beds 184 (plus 19 day beds)

Overall net loss of Acute and Maternity beds would be 269 plus a reduction of 38 Community Beds

It is also proposed to transfer all Maternity & Gynae In Patient , Out Patient and ante natal from LGH to LRI and Paediatrics from Glenfield to LRI. This would remove the LGH facility which undertakes 4000 births per annum and the Melton Birthing Unit. It is not proposed to offer women the choice of a midwife led unit on the LGH as requested by Healthwatch.

Savings would be generated by the following measures :-

• New Models of Care	£54.4m
• Service reconfiguration	£19.2m
• Redesigned pathways	£33m
• Operational Efficiencies	£288m
• Enabling schemes	£17.6m
• **TOTAL GROSS SAVINGS PROPOSED**	**£412.2m**

The presentation focussed largely upon savings to be made from new models of care (estimate £54.4m), service configuration (estimate £19.2m) and redesigned pathways (£33m) with a combined total of £106.6m out of the total estimated savings of £412.2m

The remaining savings from operational efficiencies (£288m) and enabling schemes (£17.6m) were largely not discussed but for the reader's information are made up of :-

• Reducing Agency Staff	£ 6.0m
• Provider Process Efficiencies	£174.2m
• Local Authority Savings	£ 57.8m
• Specialised Services	£ 27.3m
• Pharmacy & Prescribing	£ 24.8m
• Small schemes/minor services	£ 15.0m
• **TOTAL OPERATIONAL EFFICIENCIES**	**£288.0 m**
• Other Estates	£6.3m
• Collaborative Working	£9.5m
• Back Office	£1.9m
• **TOTAL ENABLERS**	**£17.6 m**
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QUESTIONS ABOUT ACUTE CARE

1. **Evidence Base**
   - Before going out to consultation could we see all the evidence upon which new models of care are based especially the evidence that they will reduce acute bed

demand by the 453 stated ? This needs to include the cost benefit analysis of moving to new models . Without evidence, there is great vulnerability.

An undertaking to supply the evidence was given

- Will the STP state in writing that bed closures will only be undertaken when it is proved that other models such as the “Home First” model are up and running and reducing the requirement for beds? How will you be able to evidence this before bed closures?

This undertaking was given by Tim Sacks

2. Proposed bed configuration

- **Bed allocations** How can the STP evidence the proposed reduction of 12.5% in acute beds when the number has, according to the STP, grown by 9.4% over the last 2 years despite the introduction of ICS beds. It is not therefore clear that ICS beds are effective in reducing the number of acute beds required.

Response.

- **Site bed profiles** Can you please show clearly **by site** how bed numbers have changed between September 2014 and September 2016 and how they will change over the 5 years of the STP, with the evidence that was used to reach decisions on reductions.

Response.

- **Bed specialty reconfiguration profile** . Will you undertake to supply a profile of the proposed acute beds by specialty (including day beds) compared with current provision ?

Response.

- Mr Sacks states that there are 42,000 Out Patient attendances per annum from Rutland (16k LGH;16k Peterborough and 10k elsewhere) of which 12k will be relocated to RMH plus all necessary diagnostics. Has the impact been measured on those Rutland residents have to travel to Glenfield or LRI especially upon those relying on public transport and the elderly ?

Response.

3. “Home First” and impact of ICS beds

- Can this be explained properly? We are left to guess this, but my interpretation is, broadly a hospital bed at home with supporting service equivalent to a community hospital. This means a multi disciplinary package of available GP support, CNS/ SRN style support, HCA style support, domestic support, as well as Physio, OT, other specialist therapies as needed, disability and equipment assessments access to diagnostic testing etc. Clearly if or when a patient “improves”, these needs gradually drop away.

- Stemming from the above, can all this support be guaranteed to say 25 patients at any one time located across Rutland quickly and more economically than if they are in one location, i.e. a community hospital? Mention has been made of a case in Barrowden where it has proved impossible to put together a care package. To develop Home First, there is a valid argument to go the other way and EXPAND community hospital beds
- Regarding more care at home, with integrated social care and health teams. Does that now mean that instead of being cared for in an NHS funded bed, that people will be means tested for care at home, so that some people will now have to pay for their care?

Response

- Have you formally costed and evaluated use of ICS beds to date and their effectiveness in reducing bed blockage at UHL ? (We are concerned because " Beds at Home" in Peterborough and elsewhere were almost invariably terminated because they were too expensive.)

Response

- Have you assessed the numbers of additional primary care , community and social care staff needed and will they be funded? (excluding Better Care Funding which is temporary)

Response

- How soon will you be recruiting extra people for Home First?
  - Dr Ker responded that they were looking at numbers.
  - Rachel Bilsborough responded that there is no problem recruiting into these roles in health.
  - Tim Sacks responded that bed closures can't happen until the community support is in place.
  - Tim O'Neil , Director of People ,Rutland County Council reported that the County Council did not yet know how much money it would receive

- Continuing Health Care HC. To support Home First, should this not be jacked up for those going home with long term conditions – not cut back by £29m as is suggested? They are undermining their own proposals.

Response

- **Providing care at home in rural locations**

  Have the practicalities of applying these new models to rural areas been properly considered? An example was quoted where 30 domiciliary care agencies were approached to deliver a care package in Barrowden but all refused because they were unable to recruit the care staff required. This illustrated the difficulty of recruiting to and delivering care packages in rural areas.

Response

- **Integrated Care**

The briefing gave us proposals on how health care might be provided but as we heard no detailed proposals from RCC on how the social care may be provided, then we simply cannot judge how realistic or practical the health proposals can be – even if the CCG take on board all our suggestions.

I am no rocket scientist in stating such an obvious point, and the social care funding problems nationally have of course been all over the news. Locally we really should have a combined CCG/RCC presentation of all health/social care proposals work and interlock together.

Response

- **Transition arrangements .**

  Can we have in the STP that goes to consultation a written agreement that beds will not close until there is no requirement for them due to new working models – and that there will be a sufficient period of 'double running' to ensure this?

  See undertaking above

- **Urgent Care**

  This seems understated re being provided at RMH 24/7.It is not at all clear which services will be provided where and at each time of day . Please could the proposed service be set out clearly ?

  Response

- **Chemotherapy & Dialysis** With the 'closer to home' policy and aspirations to have more outpatient procedures available at RMH – could both chemotherapy and dialysis be provided at RMH? This is being introduced into the Stamford Hospital campus.

  Tim Sacks said this was being considered – it would depend on the numbers of people requiring this service at RMH as to whether it was financially viable.

- **Diagnostics**

  Can we have an assurance that the full range of diagnostics for 12,000 Out Patients and their associated services will be re provided ?

  Response

- **Specific site and specialty proposals** can we have an assurance that, after three years of planning , the feasibility studies indicated above will be completed *before* formal consultation so that specific site and speciality proposals can be considered - not just aspirations?

  Response

- **Linking STP proposals across boundaries** What work is being done to ensure that STPs across other areas are being considered by the LLR STP? Can we have an assurance that the capacity required at Peterborough and other hospitals has been estimated and that guarantees will be given before consultation that demand can be met?

Richard Clifton, Chair of the Health and Wellbeing Board, spoke to say that the Peterborough and Cambridge STP would be presented at the next Rutland Health and

Wellbeing Board in January and that the LA is already working with Peterborough. Other bordering STPs would also be considered.

Response

- Please could you give clarification on where Rutland people will go for palliative IP care, stroke and general rehab and sub acute care when they need a bed? The STP says that stroke beds at LGH will be for Leicester only and the rehab beds in Market Harborough will be for Market Harborough people. Sub acute for Rutland would presumably require travelling to Melton. A questioner described that for a 90 year old 1 hour on the bus from Oakham to Melton can be very harrowing.

Response

- **General Practice**

  We all know how stretched these are. This will increase their workload but there is no mention of more resource.

Response

QUESTIONS ABOUT MATERNITY CARE

1. You propose to close the midwife led unit at Leicester General and whether the choice of a new midwife led unit will be offered is left very vague and is lacking enthusiasm . NICE Guidance supports midwife led units and its retention would avoid about 1000 women having to travel on to LRI for ante natal care and delivery.Are you going to give women the choice of going to midwife led unit if they prefer it?

Response

2. Will you measure both the added travel and the family stress of these increased journeys?

Response

3. If women chose to go to Peterborough instead do you know there will be capacity there for them?

Response

4. Why are Rutland women currently being told they are not eligible to use the Melton Birthing Unit? Are you deliberately trying to keep the numbers down?

Response

PROPOSED CHANGES TO COMMUNITY HOSPITALS

It is proposed to close 38 community beds overall with complete removal of all beds from Rutland Memorial & Lutterworth community hospitals. Safety is given as the reason for closure because they have stand alone wards . Beds at Rutland Memorial would close in 2020/21.An increase of 4 beds at the one ward at Melton from 17 beds to 21 is proposed as alternative provision for Rutland.

Proposals for RMH are in two parts but the report itself says it requires further work :-

Extract Page 39

What does this mean for Rutland Memorial Hospital: The proposal is subject to formal consultation and will see the Hospital becoming a hub for health and adult and children social care services. This will include increased planned care outpatient, therapy services, diagnostics and well-being services which will integrate with a GP led evening and weekend urgent care service for the people of Rutland. A feasibility study, designed to ensure the provision of health and social care services for the expanding population of Rutland and exploring options for further health and social care integration, underpins the vision for the hospital. The inpatient beds will close and provision will be available for local patients within a patients' own home using the Home First model, the ICS service or where necessary in other local community hospitals.

Capital Proposals are :-

Extract Page 68

Oakham (£1.0 million) – Conversion of the old ward space at the hospital into ambulatory clinic rooms and team base so that health and social care services elsewhere in the town can be co- located on the site as part of a place-based initiative to have a single health and social care campus in the town. Discussions are currently taking place with Rutland Local Authority regarding purchase of the Oakham site.

QUESTIONS ABOUT PROPOSED CHANGES TO COMMUNITY HOSPITALS

- **Current Demand v Use of beds at RMH**

  It is not helpful to imply that beds are not wanted or needed because only 1/3 are occupied by Rutland people. Perhaps beds in RMH are being used badly given that we hear of people waiting ages to transfer from Peterborough or being sent to other hospitals like Coalville.

Response

- **Need for beds by Rutland Residents .**

  Could we have clarification and an account of how the decision was made that Rutland could not have increased beds to make it safe but that can be done at Melton which also has one ward ? The transport issues, discharge delays, and population increases of which a very significant proportion are elderly makes the case for an increase in beds in Rutland rather than their abolition. Just recently an extra stroke ward was added recently to the offer for Leicester residents on the LGH site together with £7.5 m capital for conversion and the revenue to run it. The case for changes to community hospitals has not been made?

  Response

- **Range of services** Could you tell us what exactly is proposed for the RMH site? Page 39 indicates it could have new services but page 68 explains that this is not new services but the relocation of existing services. The Stamford community is very happy with the new services on its site which include chemotherapy. Leicester is developing an attractive range of services at the Evington Centre at a total cost of £11.5m . We would like to see the same vision to keep people closer to home in Rutland .

  Tim Sacks explained that 12,000 OP from LGH and Peterborough would be relocated at RMH together with a full range of diagnostic services. (The remaining 10k approx. currently at LGH would transfer largely to Glenfield). He also added that increased primary care capacity and improved urgent care were planned.

  Response

- **Diagnostic services**.T o be viable, 12k Out Patient attendances will require a range of diagnostic and support services depending on the different needs of Orthopaedics. ENT, Dermatology, General Medicine and General Surgery as well as remote technology to transmit results /undertake Skype check ups etc. Are these being assessed and workforce /capital being costed?

  Response

- **Palliative Care** is extremely important for a population with a high proportion of elderly. The people of Rutland raised £200k to establish the Karen Ball Suite.What is being done about end of life care for Rutland with the closure of RMH beds?

  Dr Ker said the unit is not used well that services for End of Life were being worked on, services needed to be more integrated and more people supported to die at home if that is what they chose. He also mentioned using Care Homes in Rutland for End of Life if it was not suitable for people to remain at home.

  NB Cllr Joyce Lucas, as Chair of the Karen Ball Fund, has asked for details of the numbers and postcodes of patients admitted to the suite over the past 5 years.

  Response

- **Care Homes**

  There seems to be an assumption that care home beds will also be available, but given the economics of running these and a number closing across the country, these cannot be a guaranteed source of beds.

Response

- **Community Nursing Service**.

  I know how stretched this is across Rutland and the surrounding area. There is no mention of how this will cope with increased demands.

Response

GENERAL QUESTIONS

- **Synchronisation of neighbouring STPs**

  Neither the LLR STP nor Peterborough and Cambs STP discuss the almost inevitable change in patient flows from Rutland to Peterborough /Stamford for acute and maternity care that will happen .Can we have an assurance first that STPs will be synchronised to ensure that pathways and plans from other " footprints" are joined up and second that the capacity required at Peterborough and elsewhere has been estimated and that guarantees will be given before consultation that demand can be met and funded?

Response

- **Transport**

  - Transport is, without doubt, the biggest single challenge for Rutland. Please give us an assurance that proper regard will be paid to the cost, availability and ease of transport including its proposed reduction?
  - What is being done about carrying out an accurate impact assessment of the travel implications of these proposals on Rutland residents? Can we have your assurance that the results will be available as part of the consultation process? (The previous transport impact assessment was flawed.)
  - Can specific work be done to assess the impact of travel for pregnant women who will be expected to travel to LRI and also the impact of travel to Glenfield and LRI by the elderly who use the service most. They will shortly constitute over 33% of the population of Rutland having increased by 70%. The example was given of over 300 people over 80 years in Uppingham alone and the bus service to Leicester is about to be cancelled.
  - A lot more Rutland people will have to travel much further to Glenfield and LRI .
  - I have been a frequent customer of all three Leicester hospitals and still attend clinics at the Infirmary and Glenfield . I am able to either drive or use the train but I feel that transport is such an issue for many. I know this is not just a problem in Rutland . A cousin in Oxford had to make his own way to Barts for Gamma Knife treatment recently. I feel that it must be more cost effective to have patients attend clinics in Leicester and Peterborough if only there was an efficient car service that people are aware of .

Tim Sacks said that their initial transport impact assessment needed review – and this was being undertaken.

- **Cash profile and other financial information**

  There is no financial analysis or profiling . This is essential and must include the option appraisals undertaken to reach conclusions. Can we be assured that this will be available for consideration? It will also need to include Local Authority funding and details of the £57m

  Response

- **Capital investment**
  - We have been very heartened by community campuses being developed across the country to keep people out of acute hospitals. We would urge you not to leave Rutland as the only community without services . Can we urge you to also look at other means of financing capital?
  - Can we please have a proposed site plan for all the sites affected by this STP ?

  Response

- **Population Growth**

  Could you please supply the evidence to show that the proposals for each community are based upon its projected population growth and changes in demography/ health need ? (There is only mention of an overall 3% population growth which bears no relation to the changes in population size and age in Rutland.)

  Response

- **Choice**

  Here is no mention of " Choice" which is mandatory. Will each issue offer a choice of *real* alternative solutions?

  Response

- **Workforce**

1. Does the STP have a sustainable workforce plan?

   Response .

2. Has the retraining of staff been planned to shift from acute to community care posts?

   Response

3. How will the problems of recruiting care staff to work in rural villages be addressed ?

   Response

- **Continuing Health Care**

  The STP aims to reduce Continuing Health Care by £29m . Will this reduction not hinder the move to care in the community and out of hospital?

  Response

- **Health Equality impact assessment**

  Has this been done?

Response

- **Operational Efficiencies – Community Pharmacy and Medicine optimisation**

  Page 50 of the STP discusses medicine optimisation. The Local Pharmaceutical Committee has commented that proposals exclude the very substantial role that can be played by community pharmacists. They ask:-

  Whilst many primary care health care professionals are referred in the STP, plans to involve community pharmacist workforce plans are not explicit. There is a large focus on GP practice based pharmacists and Prescribing Management but the STP plans seem to largely disregard the community pharmacist workforce.

  227 pharmacies supply LLR residents all their medication of whom 30-50% of patients are not taking their medicines correctly with the increasing pressures on GP and urgent care that that entails.

  What are the STP plans to integrate and ensure pathway integration of Community Pharmacy so that we are part of the STP plans with a specific work streams that we can deliver to support delivery of the FYFW and reduce the £22 billion deficiency?

Response

- **Wastage**

  Who is looking at saving money by sorting out buying and wastage in the NHS?

Tim Sacks said this is being looked at and constantly reviewed.

- **Management costs.**

  Who is looking at reducing management level/structures to save money?

Tim Sacks said that this was constantly being looked at and that the amount spent on management in the NHS was currently at 2%.

- **Public Education**

  Public engagement is a good thing. Has the education of the public been considered as part of engagement?

- This document has been published for public consumption but is full of acronyms and technical jargon. These either need to be explained or changed.

Response

Sustainability & Transformational Plan Engagement Meeting held ,at the Falcon Uppingham on Thursday 26th January 2017

(Notes prepared for Barrowden Parish Council by Susan Pickwoad)

NHS Proposals LLR (Leicester, Leicestershire & Rutland) Sustainability & Transformation Plan (STP) Notes on Engagement Events by East Leicestershire & Rutland CCG (Clinical Commissioning Group)

Tim Sacks East Leicestershire & Rutland Clinical Commissioning Group (CCG)

Cathy Ellis Chair Leicestershire Partnership Trust

Dr Andrew Ker Oakham Medical Practice & Vice Chair East Leicestershire & Rutland CCG

Rachel Dewar Head of Community Health Services, Leicestershire Partnership Trust (LPT)

Mark Andrews RCC Deputy Director Adult Social Care

The CCG held it's first two public events on 24th & 26th January in Oakham & Uppingham respectively. A summary was presented of the STP proposals for health & social care in LLR over the next 5 years and opened for discussion with the audience. Without action by 2020 our CCG will face a deficit of between £350m to £400m. Nationally our population is growing & aging, more people are living longer with complex health needs and there are more demands on the NHS, e.g. demand for GP services has risen by 48% since 1998. The CCG has to find services to meet patient needs, but there is not enough money. For the last 2 years work has been done in LLR on 'Better Care Together'. Main areas under review are health & well being (including prevention); quality of care & services, & finance & efficiencies. The CCG assured the audiences views of the public will be listened to carefully before formal consultation begins, probably in the summer as the STP is currently only at draft stage. The plans rely on a bid for £300m capital requirement being signed off by Government, that may not be for a further 3 months. Without this money the plans cannot be implemented. Consideration is also being given to the pooling of health & social care budgets.

Home First Community hospital beds to be replaced where possible by Home First, patients remain at home with support from a multi disciplinary community team, family & friends & the voluntary sector. GPs would be allowed more time with complex patients, coordinate patient services & decide a named professional for patients with care needs.

Acute & Community Hospital Beds Acute beds across LLR cut by 243. Leicester General Hospital beds close & move to LRI (Leicester Royal Infirmary) & Glenfield Hospital. The General would retain some services but have no theatres or intensive care beds. Oakham Hospital's 16 sub-acute/rehabilitation beds to close and 10 beds at Lutterworth, but there would be 4 additional beds at Melton Hospital.

Maternity Leicester General Hospital & Melton Mowbray Hospital maternity beds close. Dependent on capital investment a women's & children's hospital would be built at LRI to centralize all maternity services.

Out Patients (OP) Services Out of a total of 42,000 OP appointments for Rutland, only 5,000 a year take place in Oakham Hospital, that would rise to 12,000 with Oakham as the hub for Rutland. With some minor investment this would make better use of Oakham Hospital, where currently 1 ward is closed and the 2 theatres are being used for storage. Clinics would expand to include Trauma & Orthopaedics, General Medicine & Surgery, Ophthalmology & Urology with consultants attending from both Leicester & Peterborough hospitals. Glaucoma was cited as an example of local OP appointments working well, it has changed the patient pathway & increased capacity. Next step to put in a local Optometrist.

Urgent & Emergency Care The aim is for urgent health care to be available 7 days a week 24 hours a day with more local diagnostic facilities (e.g. X-ray & scans). Currently funding follows patients across county boundaries if you are seen outside Rutland (e.g. Corby), this should continue. The key is the 111 service, which needs to improve. At present only 13% of callers speak to a clinician, this needs to increase to 60%. 111 can be very useful reducing pressure on 999 calls & they can book patients appointments at an Urgent Care Centre, but the service is not consistent or well understood by the public.

Summary of Audience Comments/Concerns

Both meetings were well attended & discussions were lively at both events.

Home First The theory of Home first was felt to be good as most people would like to stay in their own home, but in practical terms it was felt unlikely to work in the way described. Members of the public with experience of care, including a retired local GP, felt the cost of keeping community hospital beds open would be no more expensive than care at home & safer for patients. As Oakham Hospital building would remain in use as a hub for community services & out patient clinics, & current community services in Rutland are stretched to the limit, it did not seem logical to close the beds. Requests for a detailed breakdown of costs of care at home versus hospital were made. A strong case for keeping Oakham Hospital beds open was also made by a Consultant Geriatrician who currently attends the hospital & uses the beds. Also the national shortage of GPs was a concern, as GPs would coordinate this service. Providing enough care in rural areas with patients scattered over a wide area would require a massive investment in staff. The audience felt Home First would not have the funds needed & struggle to have enough care staff. The lack of end of life beds in Rutland if plans go ahead was also raised.

Acute Beds Cutting the overall number of acute beds was questioned, especially as nationally the NHS is short of beds. If the STP is adopted it was felt many more Rutland residents will opt for treatment in Peterborough as it is a lot closer for many than LRI or Glenfield. Concern was raised as to whether Peterborough could cope with additional demand. The hospital Trust is in debt due to the build of the City Hospital, a Privately Funded Initiative (PFI) & is often on 'black alert' due to shortage of beds.

Maternity Services Moving all maternity beds to LRI was not a good idea & could put mothers & babies at risk. LRI is not easy to get to, especially in rush hour, & parking is difficult.

Out Patient Services More out patients appointments locally was welcomed but again the practicalities of providing this with enough consultants & diagnostic services (x-ray, scans etc.) was questioned. Parking at Oakham Hospital is also an issue.

Urgent & Emergency Care Providing 7 days a week 24 hour urgent care a good idea, but a lot needs to be done to improve the 111 service & increase local facilities . Public education would be needed so people know who to ring, where to go & when services are open.

Transport for patients without cars or anyone available to take them to hospital is already an issue. More transport services would need to be available.

See Appendix attached for lists of the main questions raised & in some cases the responses.

Susan Pickwoad

PPG (Patient Participation Group) Rep. for Barrowden Surgery

Barrowden Parish Councillor

Appendix - Audience Reaction/Comments re East Leicestershire & Rutland Proposed STP

A) Home First & Hospital Beds

1) The NHS is already short of beds & the population (& demand) is growing. Reducing capacity with current demand is not right.

2) Cross border care (outside Leicestershire & Rutland) needs to be planned for.

3) Many more people in Rutland will opt for treatment at Peterborough as much closer than LRI or Glenfield. Can Peterborough cope with this increased demand?

4) LRI is not easy to access especially in rush hour, parking is a problem & Glenfield is a long way to go.

5) More transport services needed for patients who don't drive or have someone to take them to hospital.

6) Need better use of technology for care at home e.g. modern communications. Audience advised there will be growth in assisted technology e.g. video conferencing, equipment for memory loss patients etc.

7) There are not enough care beds in Rutland so badly need the community beds in Oakham Hospital.

8) More step down beds from acute hospital (like the Van Geest unit in Stamford) are needed for safe rehabilitation with doctors on hand, not less beds.

9) Hospital discharges already a problem even with community beds, as no support (social care) at home. LPT (Leicestershire Partnership Trust) advised on admission a social worker & nurse go in to hospital to plan patient's discharge.

10) Oakham Hospital is greatly valued, good treatment, homely atmosphere & not far for most people to travel. High standards of care are met e.g. very good infection control, and patients are safe. The hospital is underused with a closed second 8 bed ward that could easily reopen. A request was made for GGC & LPT to spent a day on Oakham's ward to see the work being done & the quality of care given.

11) Oakham Hospital sometimes hold beds for patients from Leicester who do not arrive for 2 or 3 days, so beds are left empty suggesting lower occupancy/lack of demand, which is not the case.

12) Why increase Melton Hospital community beds as only has 1 ward? Healthwatch Rutland asked to see the information producing the decision to close beds in Oakham rather than Melton.

13) Oakham proposed as the Rutland Hub for community services & OP appointments, so the building will remain open with associated running costs so why close beds?

14) A consultant geriatrician with 34 years of experience gave a powerful plea for Oakham beds to remain open. To close them would be "pure insanity". The beds are of great value to his elderly, confused patients who would not respond well to care in large city hospitals & are difficult for friends & relatives to visit.

15) Suggestion that Oakham Hospital building is not fit for purpose (for community beds) disputed.

16) Family & neighbourhood support the plan anticipates being available for Home First not there in reality.

17) Request for evidence, to run trials, to see how care at home works versus a community hospital bed & provide detailed costings for both. Not convinced care at home any cheaper (patients may need 2 carers 3 or 4 times a day & a night service, home help, physio, district nurse etc.). Audience told LPT (Leicestershire Partnership Trust) have done some pilot studies on home care. Currently have 250 community beds worth of nurses, physios, occupational therapists etc. doing 4 to 5 visits a day + social care for up to 10 days, like a hospital community bed service. As this grows less community hospital beds would be needed.

18) A retired local GP said currently community services are stretched to the limit & can't meet patient needs, especially in rural areas. Massive investment in staff is needed, can't do this with the budget available.

19) Equipment an issue in hospital, as often delays providing it, how will that work at home?

20) No provision for end of life care in Rutland. 30 deaths took place in Oakham Hospital last year. Also the loss of the Karen Ball suite, money for which was raised in Rutland.

21) Concerns over funding for GPs, community care & urgent & emergency care. Already a national shortage of GPs so hard to get appointments.

22) Problems with current GP services include the telephone triage system, can lead to inappropriate advice if patient not seen by their normal GP. Proper reviews & advice following blood tests etc. very important but GPs already under pressure. Drugs & repeat prescriptions not always ready on time so return visit to GP practice needed (hard for elderly & those without a car). These problems could worsen with Home First.

23) Where does the 'buck stop' with the Home First model? This would be the GP.

24) Who contacts the team if patient is unwell & how easy would this be out of hours (evenings or overnight)? What is response time of home care especially in the middle of the night? Ideally the service needs to be planned for the next day or a 2 days later service, but can react in 2 hours.

25) Conflict of interest as GP practices run as a business. Audience assured GPs would be the coordinators of Home First service not employers of the community staff.

26) Healthwatch Rutland asked for assurance (as stated at a previous closed meeting) written into the STP plan that the CCG would test their plans to close acute & maternity beds before making changes. Audience view, not logical to cut beds before an alternative is available. Healthwatch Rutland said the message is mixed, can't close beds until the new system's in place so how will this be done? There will be a national system, a Transformational Fund for double running.

27) How will money transfer from acute & community beds to the community? Better Care Together fund of £2.3m of health money to go into a health & social care fund. Savings made with STP e.g. Leicester General Hospital estimated current running costs £35m p.a.

28) Money/funding is the problem & local MPs need to be involved.

29) Healthwatch Rutland asked how will the Home First model work for mental health? Community services already exist but don't link in together. Audience advised stronger links would be formed between physical & mental health. The Crisis team currently works at LLR

level & the integrated service would include a community mental health team linked into community services.

B) Urgent & Emergency Services

1) Public education needed to get 111 used more.

2) To be trusted 111 needs to be less confused. Reduce repetition as patients are asked the same questions by the initial call handler, a nurse then a doctor. Need more clinicians taking calls not someone non-medical asking questions off a protocol (tick list). Call handlers need local knowledge to direct patients to the closest most appropriate place, including cross county.

3) More out of hours local diagnostic services (x ray etc.) are required.

4) Need more doctor led facilities for patients to be directed to.

5) Better technology so patient information is not fragmented & notes follow patients.

6) The current walk in nurse service at Oakham Hospital with a GP on call does not work well.

C) Maternity Services

1) To have to get to LRI to give birth not practical in busy rush hour traffic.

2) Longer distance to maternity services could put Mums & babies at risk.

3) Parking at LRI already difficult & more so for the maternity building.

D) Out Patient Services

1) Would local OP appointments include chemotherapy or dialysis?

2) Need consultants to attend from cross borders e.g. Peterborough.

3) Patients may opt for OP appointments in Oakham but want scans etc. elsewhere e.g. Peterborough.

4) Local OP appointments don't always mean actual treatment close to home, example quoted of cataract operations, if seen as an OP in Melton Mowbray have to go to Loughborough for surgery (may be addressed if more day case surgery done at Melton).

5) More local OP appointments good in theory but not sure of the practicalities.

6) How will shortage of consultants for local OP (Out Patient) appointments be addressed?

7) How will local OP appointments reduce pressure on the NHS if consultants have less time in city hospitals?

8) STP plan allocates money for office modification at Oakham Hospital but not to improve diagnostics facilities.