15 November 2017

AT AN INFORMAL MEETING

of the

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

held in Committee Room 1, Bedford Borough Council, Cauldwell Street, Bedford on 15 November 2017 at 4.00pm

PRESENT:

Representing Bedford Borough Council:

Councillors Mingay and Uko

Representing Central Bedfordshire Council:

Councillors Ferguson, Goodchild and Hollick

Representing Luton Borough Council:

Councillors Lewis and Pederson

Representing Milton Keynes Council:

Councillors Coventry and Jenkins

Representing Bedford, Luton and Milton Keynes Sustainability and Transformation Partnership

Mark England, Chief of Staff, Sustainability and Transformation Partnership (STP)
Pam Garraway, Lead for the Digital work stream, STP

Maria Wogan, Lead for the Accountable Care work stream, STP

Also Present:

5 Members of the public.

Apologies for absence were received from Councillor Rider (Bedford Borough Council), Councillor Agbley (Luton Borough Council), Emma Goddard (BLMK STP) and Healthwatch Bedford.

1. ELECTION OF CHAIR

RESOLVED:

That Councillor Mingay be elected Chair for the meeting.

2. QUESTIONS

The Chair advised that this meeting was with Councillors from the four local authorities in the Sustainability Transformation Partnership (STP), who were non-executive members of their respective councils. The purpose of the meeting was to allow health scrutiny Councillors from across the STP area to question STP leaders on the progress of the partnership with its main work streams (prevention, community services, acute services, digitalisation and accountable care), and to comment on such work. Health scrutiny, like other scrutiny committees, was not a decision-making body of a local authority, and whereby its role was to hold local decision-makers to account.

Question by David Maxwell, Bedfordshire Climate Change Forum:

Under "*Priority*" you mention various diseases by name and then show a sense of cause of disease by mentioning "*SmokeFree*" then you mention "*enabling interventions by the population*" not based on medicine but supporting wider determinants of health outcomes, you called it "*Social Prescribing*". My first question is would you regard objections to an environmental permit for an incinerator in Marston Vale fits that category – or if not outright objecting feeling that the pre-cautionary principal requires researching the likely outcomes more thoroughly?

Response by the Chair:

Thank you for your attendance, however regrettably, your questions fall outside the remit of this committee. I would like to look into this for you and provide you with a written response to your question[1].

Question by Ms L Herron:

There is a lot of concern at the moment about the proposed merger of Bedford and Luton & Dunstable Hospitals. One question I have been asked to bring forward is why is the full business case not being made available to the public? At the moment we are only being told that it's a good idea, and not being shown the facts and figures that proves it's a good idea both financially and in health terms.

There is currently a lot of concern over the provision of stroke patients cared for at Bedford Hospital, because some stroke patients are still cared for at Bedford Hospital but the beds have been dispersed around the hospital, meaning there is now a lack of expertise and focused care needed by those patients. We would like to know what is happening and how the proper care of patients is being assured?

We also understand that there are very serious staff shortages in maternity and we would like to know what is being done to address that issue.

We'd also really like to know, there does seem to be some rumours going around that there may be an announcement relating to the STP in January 2018 – is this Committee aware of an impending announcement, and if so does the Committee know which form it will take?

We would like to know if the Committee really believes that the merger will guarantee the future of services – one issue we bring to your attention is that the Community and Mental Health Trust in north and south Bedfordshire were merged some years ago yet today there is not acute in-patient mental health care in Bedford, with patients having to go to Houghton Regis with friends and family having to travel, which is great difficulty if travelling by public transport. I think we are looking for some degree of reassurance, it is very easy to say we all work together and that things will get better, but what the public wants is to see that they're getting better and not hopes and good wishes.

[1] *A written response regarding Mr Maxwell's questions were provided to him on 4 December 2017.*

If you can address any of the these issues, I would be most grateful.

Response by the Chair:

We have three experts here this afternoon which I hope they will be able to answer your questions for you. You may also wish to attend the next meeting of the Adults' Services and Health Overview and Scrutiny Committee, in Committee Room 1, Borough Hall on Tuesday 12 December 2017 at 6.30pm, where we will have the Chief Executives of both Bedford and Luton & Dunstable Hospitals.

3. DISCLOSURE OF LOCAL AND/OR DISCLOSABLE PECUNIARY INTERESTS

There were no disclosures of interest.

4. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

The Chair welcomed Mark England, Chief of Staff for the Sustainability and Transformation Partnership (STP), Maria Wogan, Lead for the Accountable Care work stream (also Director for Strategy and Planning at Milton Keynes Clinical Commissioning Group) and Pam Garraway, Lead for the Digital work stream.

The Chief of Staff for the STP introduced his report which provided an update on the progress of various work programmes taking place within the Bedford Luton and Milton Keynes (BLMK) STP footprint. In terms of a general approach, the Chief of Staff advised that the BLMK STP would seek to unpick the history of the NHS, care services, divisions and silos created since 1948 which was an extremely challenging process. During the last eighteen months to two years, focus had been on the building of bridges across the system (including ambulance services, community services, social services, hospitals and GPs) and it would not be able to be solely addressed by the NHS. Therefore 16 BLMK partner organisations were working together with regulators to try and design a more integrated system. In addition, it enabled BLMK to access transformational funding to enable change at a faster pace and deliver benefits to its residents.

The Committee was referred to Page 3 of the report which showed how the STP was working overall with specific reference to hospital performance, patient focussed change and transformation which were working relatively well. It was also noted that an external assessment of the STP had provided a positive view of the STP from the outside.

The Lead for the Accountable Care work stream provided an example of an individual real life case study entitled "*Paul's Story*" which was tabled at the meeting. She reported that Milton Keynes had undertaken a significant amount of good work regarding diabetes which had been a challenge, co-ordinating and negotiating with a number of different organisations. Improvements in diabetic foot care had been made whereby a significant reduction in the number of foot amputations (from 29 to 4 per year) had been identified. Issues concerning TUPE and IT connectivity had also been experienced as the system did not currently work as one yet. The STP was therefore trying to break down the barriers and remove incentives which did not currently align, and replace them with incentives that would see systems and organisations working together for better outcomes generally.

By becoming an Accountable Care System, it enabled the STP to gain access to Transformation Funding which would be a pool of available funding to the sixteen partners for investment. The key areas to focus funding were Out of Hospital Services and General Practice needs. Deeper discussions were taking place within the four Local Authority places, whereby providers were starting to become more involved and consider where best to intervene along a pathway with a small amount of funding to re-engineer their local area.

The Lead for the Digital work stream advised that the programme was based on work which had considered a digital roadmap, which then assisted with the creation of the digital work stream. A significant strategic direction had been identified and the following were being considered as part of it moving forward: shared care records and resident facing portals which would require significant financial investment. Work regarding this matter was currently at the options appraisal stage, identifying a business case and monetary requirements prior to moving onto procurement issues and would take a number of months to complete. In the meantime, some tactical pieces of work had been undertaken to improve the current position whereby some money from the hospitals "*Estates and Technology Transformational Fund*" to secure £1.2million to assist with the STP journey had been made. Improvements concerning systems and linkages had been considered, part of which would seek to ensure that primary care records were available in urgent care settings. The strategic long term goal was a shared care record and ensuring that information governance was correct, up to date and compliant. It was noted that all the deliverables as shown on page 11 to the report were due at the end of this year.

Work continued in Milton Keynes Hospital in terms of GP access requirements, and with Luton & Dunstable and Bedford Hospitals.

The Lead for the Digital Work Stream reported that joint working with partner organisations could produce significant benefits, particularly around joint procurement, additional secure connections and money saving incentives.

In terms of digitalising care homes, the Lead of the Digital Work Stream confirmed that the STP had been successful in bidding for a number of mirror bids (submitted by Luton Borough and Central Bedfordshire Councils) which had been pooled to create Phase 1 and to consider 13 care homes could become digitally enabled. The first level of this work included the following:

- To wi-fi enable every care home for their residents and staff;
- Provide a secure connection of information between care homes and other care settings which were IG compliant; and
- Significant bids were in place to secure this work across all the BLMK care homes.

The Lead for the Accountable Care work stream, STP provided an update regarding the end model of the Accountable Care System and referred to the model being developed as shown at Figure 2 to the report. A three tier Accountable Care System model within BLMK provided opportunities to support activities "*at scale*" (Tier 3 - BLMK), borough-level "*at place*" (Tier 2) with integrated "*at locality*" (Tier 1) delivery.

Within STP governance, place based Boards had been established within different Local Authority areas and were working hard together to discuss what the "*at place*" tier of the model would look like within BLMK and was considered to be an important area of work. It was acknowledged that there was a need to understand local population needs further, and for Health and Wellbeing Boards within Local Authorities to set out the health and wellbeing outcomes for their populations. Placed based Boards would then take a lead from this work to consider what they wanted to achieve for the local people in the area, and how the services should work better locally to ensure that it happened.

In relation to Tier 1 (Locality Level), some work had been undertaken with Primary Care colleagues to consider the structure of Primary Care services in different places. This was a new way of working for GPs to work in networks, deliver services and maintain their practices.

A "*functional review of commissioning*" was currently being undertaken to consider how the STP could work better together, setting a different working environment and incentivising service providers. Some providers work was also being undertaken to encourage services to work more collaboratively, including a "*Provider Alliance*".

The Lead for the Accountable Care work stream also referred to "*System Integration*" which sought to pull systems together which could be digital in terms of information and collating data for sharing in the future.

In response to Members questions, the Chief of Staff, STP, Lead for Accountable Care and Lead for Digital work streams provided the following responses:

- The example of "*Paul's Story*" highlighted some issues related to diabetes. It was acknowledged that some diabetic patients also suffered with mental health issues and needed support to manage such conditions (including isolation and depression). It was considered to be an illustrative analogy relating to some of the issues experienced by diabetics and health services across the country. Mental Health organisations were included as some of the 16 partners of the STP and sought to provide a holistic approach to mental health matters. The STP was working closely with mental health providers to link up thinking around both the mental and physical health of the person as a whole;

- STP Chief Officers had been meeting once a week for two hours for the last eighteen months. In terms of identifying opportunities, the STP was trying to understand the demand more as some services could be reactive. When the data and population was considered, particularly for mental health services, if a patient had mental health issues, a chronic health condition and diabetes, their life expectancy was 18 years shorter which was considered to be a disturbing figure;

- In terms of the digital work stream, a number of events had been held inviting everyone to attend and explore how partners could work together on some of the issues identified. More and more people and groups were becoming involved, meeting regularly and drawing out evidence to support the developments moving forward;

- No firm conclusions regarding finances had been identified yet, however part of the working together element was still trying to work through the different work streams, consider how people were to be managed through greater social care needs and to identify how such services would be financed and evidenced. There were some good integrated service models in place in certain areas working with joint teams in a seamless way, however other parts of the system did not have such models which, with the pooling and sharing of benefits would be increased;

- In terms of finances, a group of Chief Executives and Finance Officers regularly met up to try and understand each other's' finances to overcome barriers of working together and understand a mutual appreciation of how different financial systems worked. Within the Accountable Care System, a "*Health System Control Total*" was in place which looked at financial pressures and how particular areas could manage pressures better. The end position was hoping for a shared process to manage the Accountable Care System, however additional meetings and discussions between the partners, particularly Local Authorities and Health Services, were required at this stage;

- The STP was a collaboration of 16 partner organisations and their individual democratic structures and accountabilities which limited its pace based on a level of consensus. Financial pressures would need to drive organisations to work more collaboratively together (which included the proposed merger of Bedford Hospital and Luton & Dunstable Hospital);

- Areas of focus for the STP included emergency admissions, medical specialties with ongoing chronic conditions (often multi-morbid conditions) being presented to the hospital due to gaps outside of the hospital. Each hospital had approximately 60-70 escalation beds with agency staffing for emergency admissions. Month 5 data this year was up by 15% compared to last year which was frustrating for hospitals and a challenge for service providers;

- There were approximately 6,000 care home beds and 1,500 acute hospital beds within the STP. There was well established evidence across the NHS that there were enhancements for health care in care homes which had a positive impact and maintained the settings for patients. Pharmacists had been recruited to regularly review patients' prescriptions in care homes and carers were receiving training on hydration. Rapid response services for out of hours calls in care homes would also be increased;

- NHS England chose some organisations from across the country to test certain issues, including the "*the Red Bag*" scheme which was described as when a care home resident was identified as needing hospital attention, all their medication, clothes, care plans and personal items etc. went with them in a red bag;

- The STP was helping to enable the enhanced care and design of the model but it was involving all of the Councils and Health Services within that system. It would also seek to give more enhancement to staff for training and encourage a greater involvement from them;

- Every social care system needed to provide a market shaping document and was a place based calculation and plan to be considered;

- The aim of a shared care record was to include social care needs (i.e. GPs, hospital records, community health services, mental health care provider and social care provider etc) with the right governance in place to support these records. GP records would commence with this process. Another aim was to secure one system for the whole BLMK digitalisation of its services;

- In terms of data protection, essentially individuals could opt out of sharing their care record information should they wish to do so. The STP was working to ensure that data protection and consent model changes were being complied with;

- It was understood that every STP would receive between £1–3 million, however caution was expressed in terms of when such funding would be received and other financial pressures being experienced within health and social care services;

- It was hoped that additional funding would be made available for cyber security in light of the cyber security outbreak on many public sectors including the NHS earlier this year, however local NHS providers were largely unaffected. Cyber security should continue to be raised and discussed, and work would continue with this important issue moving forward;

- STP members met with neighbouring STPs on a quarterly basis to check alignment of plans. In terms of the digital work stream, the STP was trying as best it could whilst seeking to resolve internal issues and being compliant with other STPs;

- There was also a need to focus on the patient/resident accessing services themselves. A model at Luton and Dunstable Hospital called "*Patient Knows Best*" for approximately 700-800 patients with IBS was referred to whereby they had an app on their mobile phone to help manage their condition and could invite other health professionals to access their records if required;

- A combination of approaches at scale and locally would assist with identifying savings. There was quite a lot of buy-in at scale whereby places could influence the delivery, therefore there would be more scalable deliveries to offer better value in terms of any savings;

- The STP was currently not in a position to work through the financial model and there was a need to revisit it as part of the 2018/19 discussions moving forward;

- The concept of hubs would vary between the different local authority areas with different expectations. Hubs could be a physical or virtual network provider where care was provided. There was currently no single model for the STP in terms of hubs, and that it would be for the places to determine in terms of the estates they had and how practices wished to work together;

- Hubs would not necessarily present a radical change as GP surgeries were not being proposed to merge. Hubs should focus on collaboration of services and finding better ways of working within their current GMS contracts;

- The STP was seeking to work alongside and support the approach of the "*One Public Estate*" being undertaken by Local Authorities. Access to NHS capital would be available via the STP approach which it was hoped would form part of the five year forward view of enabling hospital services moving forward;

- The biggest risk to the STP currently was its workforce as no workforce planning had been undertaken to date. Therefore as the model of care transformed it was key for a pipe line of staff to fill new roles and to be maintained throughout. Significant financial pressures had also been identified within the system; and

- Training, retention and provision of other opportunities to train staff (should they wish to) were key for the success of the STP. Workforce issues, including staff wellbeing could be considered at a future meeting if required.

In response to Ms L Herron's questions, the Chief of Staff, STP provided the following responses:

- A full business care concerning the proposed merger of Bedford Hospital and Luton & Dunstable Hospital did not currently exist, although a strategic case was available on the websites of both hospitals;

- In terms of stroke patients, staffing issues had been identified at Bedford Hospital whereby it was proposed that the bringing together of the two hospitals would help to make smaller services more sustainable and improve services in the future;

- Staff shortages concerning maternity services did not form part of the STP;

- The Chief of Staff was not aware of any announcement being made in January regarding the STP; and

- The Chief of Staff believed that the proposed merger would provide the best model possible for both hospitals, to share expertise and provide greater sustainability for key services.

RESOLVED:

i) That the following be agreed:

a) The Committee wants to see emerging evidence of an agreement regarding shared funding for an integrated health and social care system between the 16 organisations;

b) The Committee wants to see an analysis of care home places to ensure sufficient future places, taking into account financial difficulties in the care home sector, demography and moves towards better care at home and better discharges etc.;

c) The Committee would like to know that there was a Plan B if additional funding was not forthcoming with regard to the digital work stream projects above;

d) Given that there was no General Hospital in Central Bedfordshire, the Committee wished to see how the needs of Central Bedfordshire residents were to be met alongside the ambition to deliver wide ranging services in locality hubs and spokes in the Central Bedfordshire area; and

e) That a timeline/timetable for each STP priority work stream be provided.

ii) That the Chief of Staff for Sustainability and Transformation Partnership (STP), Lead for the Accountable Care work stream and Lead for the Digital work stream be thanked for their attendance.

The meeting ended at 5.45pm.