West Leicestershire Clinical Commissioning Group
Minutes of the Planning and Delivery Sub Group meeting
Held on Tuesday 28 July 2015, 14.00 – 16.00
Board Room, Woodgate, Loughborough

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Present:

Professor Mayur Lakhani, Chairman (Chair)
Mr Toby Sanders, Managing Director
Dr Chris Trzcinski, Deputy Chairman
Dr YB Shah, GP Clinical Lead
Dr Liz Hepplewhite, GP Clinical Lead
Dr Geoff Hanlon, GP Clinical Lead
Dr Peter Cannon, GP Clinical Lead
Dr Chris Barlow, GP Clinical Lead
Dr Nick Willmott, GP Clinical Lead
Dr Nick Pulman, GP Clinical Lead
Mr Evan Rees, Lay Member
Mrs Angela Bright, Chief Operating Officer/Deputy Managing Director
Mrs Caron Williams, Assistant Director Strategy and Planning
Mrs Gill Killbery, Head of Financial Management (deputising for Mr Spencer Gay)
Mr Ian Potter, Head of GP Delivery (deputising for Mrs Angela Bright)
Mrs Cheryl Davenport, Director of Health and Care Integration

In Attendance:

Mrs Sam Kirton, Planning Manager
Mrs Michele Morton, Senior Committee clerk (minutes)
Mr Sandeep Chohan, PMO Project Support Officer

Action

PDSG/15/79 Welcome and Apologies for Absence

Apologies for absence were received from Mr Chudasama, Mrs Caroline Trevithick, Dr Mike McHugh, Mr Spencer Gay, Mr Adrian Ashe and Mrs Laura Rodman.

PDSG/15/80 Declarations of Interest on Agenda Items

All GPs present declared an interest in **PDSG/15/84 Out of Hospital Care Strategy.**

PDSG/15/81 Minutes of the Meeting held on 23 June 2015

The minutes of the meeting held on 23 June 2015 were approved and accepted as an accurate record.

PDSG/15/82 Actions arising from the Meeting held on 23 June 2015

Voluntary Sector Contract – Home Start Charnwood Contract – Mr Adam Billson provided a factual update. However this did not fully clarify the situation. It was therefore agreed to request a full position statement (to include future plans for the service) from Mel Thwaites for the August meeting.

Members noted that all other actions were completed and an updated action sheet would be appended to the minutes.

PDSG/15/83 Updating the Settings of Care Policy for Continuing Health Care, Personal Health Budgets and Packages of Care

Mrs Williams presented paper C which provided the P&D with the current status of the Leicester, Leicestershire and Rutland Settings of Care Policy and set out a process for updating this. Key points to note:

- The current Settings of Care Policy for the commissioning of services for people who had been assessed as eligible for Continuing Health Care was adopted by the Leicester, Leicestershire and Rutland CCG's at their formation
- The policy required updating and the paper set out a process for this which was aligned with the Better Care Together consultation timelines
- In updating the policy consideration needed to be given to any threshold levels that should be applied.
- The paper sets out a process for the updating of the policy which would run from August 2015 to April 2016.

A number of clinical workshops would be held to agree the clinical principles and legal advice would be sought on changes to the policy. Settings of care arrangements would also be included in the BCT consultation. The policy would be LLR-wide and out of county regulations would be taken into account.

It was RESOLVED:

- To **APPROVE** the process for updating the Continuing Health Care Settings of Care Policy

PDSG/15/84 Out of Hospital Care Strategy

Mrs Williams gave a presentation on the None Acute Community Services Strategy which included:

- Geographical Allocations and a regional sharing of beds available in the system on an equal basis, with each organisation receiving the same amount of support (no analysis of healthcare need or where services were currently placed had taken place).
- A map depicting areas where the highest and lowest concentrations of over 75's resided. This showed in Leicestershire and Rutland there were almost 60,000 people aged 75 and above, representing 9% of the population.
- A set of principles for local service configurations to meet the 'need profile'
- Where current services were based
- A Locality offer which would include:
  - Beds in the system to reflect local specialities
  - GP's retained the case management and locus of control
  - Each Footprint would have a core offer and a Speciality offer unique to the local needs.
  - The speciality offer would make each Locality sustainable and meet patient need whilst reducing conflict between providers.
  - Each system would retain beds since community facilities deteriorated without them.

A draft discussion document produced after the July Board Development Session entitled Non Acute Care and the Locality Community Services Offer articulating some of the future need and things that had already been undertaken, was tabled which provided:

- a profile on the changing care levels of an ageing population
- the principles for local service configurations to meet the need profile

- The journey so far
- Meeting the scheduled care needs of a younger population
- Paediatric needs

Mrs Williams felt the proposal was logical and supported BCT. It also gave an opportunity to articulate what was wanted in a coherent and structured way. It would be important to consider people's level of need. As people aged their under-lying strength reduced and so there was a need when rehabilitated following illness, for specific innovations to keep patients in their own homes, for example therapy services, possibly working from community hospitals.

It would also be important to look at people with step-up needs, often difficult for older adults presenting at the LRI site who became drawn into acute settings but could be treated in an alternative way. Ambulatory care patients could be kept for short periods of time for assessment in community hospitals, and if necessary be transferred to acute trusts with care plans already in place. Patients should either be taken home or have under-lying issues identified for acute intervention, though this would be an area that required testing fully.

Dr Hepplewhite added it would be important to consider step-down care where patients often improved from the time of discharge and might not necessarily require the same level of support. Mrs Williams replied that some proposals were in place surrounding step-down which could resolve some of the issues. Planning the correct infra-structure within each community hospital would provide sufficient time to stabilise people before a decision on their next stage of care. Dr Pulman added different people coped with conditions in different ways, some better than others, and this was where he found the use of the traditional GP beds helpful.

Mrs Williams reported a further major area to consider was meeting palliative care needs efficiently in the community, for example at present NWL found it problematic to access LOROS and MacMillan services. Palliative care would be for standard patient needs and not specialised requirements.

In terms of services generally Mrs Williams pointed out it would not be possible to have everything everywhere and both community hospitals and Federations must remain viable. Honesty and clarity would be vital components in service development.

Mrs Williams outlined the locality offer and Mrs Bright added it was now important to be more specific about the delivery of services in the community from a geographical perspective. A small group had started to look at the community hospitals, wider out of hospital services, and where services were currently sited, and consideration had begun on what a core offer might look like in specific geographical areas. Mrs Bright tabled a template of a Non Acute Community Services Vision which listed Services which might be sited in a Core Offer (All HUBs), an Enhanced Officer (Specific HUBs) and Community.

Whilst acknowledging there were four Localities and four Federations in the CCG, the areas for service configuration and delivery purposes had been established as Charnwood (North and South combined), NWL and H&B. An in depth discussion took place on where services might be appropriately sited. Discussion points included:

- Consideration should be given to the 0-5 year olds and the adult population in addition to the ageing population. As an example it was well known services were under-utilised for families and young children, particularly at Loughborough UCC.
- It would be important that the changes accommodated left shift and not just the

creation of more services for people.

- Enhanced GP services (not part of this exercise) would be defined at a forthcoming PCCC meeting and linked to the PMS review.
- Some services may be delivered by Federations to improve coverage and efficiency.
- Members should give some thought on where services could be provided in community hospitals, or as a practice facility if available (one practice might serve a locality). If records were stored at practice level secondary care staff would need to be able to view reports/results. Members noted the importance of having relevant clinicians available for some tests/clinics and also the opportunity to use certain mobile equipment.
- It would be important to communicate where a service should be located – following reconfiguration of community hospitals and following analysis of scale of activity, availability, opening times and dependency.
- Agreed on the need for two wards on each community hospital site for the purposes of safety.
- In terms of palliative care, the expertise could be located in fewer sites allowing more patients to be treated. A clear vision needed to be developed on standard/specialised palliative care beds, with a tight specification on what beds could be used for (with close monitoring of out of area patients in such as George Eliot). This would very much depend on the medical infra-structure, nursing, the quality of care and CQC requirements.
- If some services were provided in only one area, patients would have the opportunity to visit other out of area sites for tests and treatment and to ensure equity.
- Outpatient areas must be organised in such a way that clinicians could positively deliver clinics to groups of patients rather than on a random basis.
- All areas should have contraception, family planning and community paediatrics.
- Consideration should be given to upskilling GPs where appropriate if new services were being provided.
- Mental Health was not currently in the mix and would be considered as a separate area.
- It would be important when planning to emphasise and reflect the importance of integration and the establishment of multi-disciplinary teams which would encompass specialisms and providers.

Mr Sanders, Dr Willmott and Mrs Davenport left the meeting.

Mrs Bright took account of the service proposals and she said the details would be worked up to the next stage by the task group. The narrative document should have a similar style and format to the CCGs Operational Plan and PCMP, and would include volume and activity levels. Plans would then be shared at the August Locality Development meetings and a further update would be given at the August P&D meeting. **AB**

It was RESOLVED:

- To **RECEIVE** the content of the presentation.
- To **DISCUSS** options for the Non Acute Community Care Vision.

PDSG/15/85 Any Other Business

There was no other business to report.

PDSG/15/86 **Date and Time of next meeting**

Tuesday 25 August 2015, 14.00 – 16.00, Boardroom 1 & 2, Woodgate, Loughborough