Leicester City Council

Minutes of the Meeting of the
HEALTH SCRUTINY COMMITTEE

Held: THURSDAY, 1 APRIL 2010 at 6.00 pm

P R E S E N T :

Councillor Bayford- Chair
Councillor Manjula Sood – Vice Chair

Councillor Gill

IN ATTENDANCE

Sarah Cooke	Associate Director (Corporate Performance), Leicester City Primary Care Trust
Zuffar Haq	Leicester City Local Involvement Network
Daryl Hines	Leicester City Local Involvement Network
Tim Rideout	Chief Executive, Leicester City Primary Care Trust
David Riley	Head of Primary Care Improvement, Leicester City Primary Care Trust
Deb Watson	Director of Public Health and Health Improvement

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Although only two members of the Committee were present at 6.00 pm, it was decided that the meeting should proceed on an informal basis.

59. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Blackmore, Cooke and Hall.

60. DECLARATIONS OF INTEREST

Members were asked to declare any interests they had in the business on the agenda and/or declare if Section 106 of the Local Government Finance Act 1992 applied to them.

Councillor Bayford declared a personal interest, in relation to the general business of the meeting, in that his wife was a salaried GP, although she was not a partner in the practice.

Councillor Manjula Sood declared personal interests, in relation to the general business of the meeting, as she was a patron of CLASP, the Chair of the

Leicester Council of Faiths and an ambassador for the East Midlands for Sporting England.

61. MINUTES OF PREVIOUS MEETING

RESOLVED:

that the minutes of the meeting of the Health Scrutiny Committee held on 4 February 2010 be confirmed as a correct record.

62. PETITIONS

The Director of Corporate Governance reported that no petitions had been received.

63. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Director of Corporate Governance reported that no questions, representations or statements of case had been received.

64. LEICESTER LOCAL INVOLVEMENT NETWORK (LINK)

The Head of Planning and Commissioning (Leicester City Council), submitted a report that advised the Committee of the purpose and remit of the Leicester City Local Involvement Network (LINk), and the host organisation that supported the work of LINk. The Committee welcomed Daryl Hines and Zuffar Haq, Co-Chairmen of Leicester City LINk, and the Head of Planning and Commissioning, to the meeting.

Members noted that Leicester City LINk currently was reviewing the outcomes of its work during 2009/10 and proposed to report these findings to this Committee, possibly in May 2010. It was hoped that the LINk's work programme for 2010/11 could be considered at the same time. The Committee noted that most LINk organisations took approximately one year to become established and this had been the case for Leicester City LINk.

The LINk was a network of interested individuals and organisations, with the Carers Federation in Leicester acting as host organisation and providing administrative support. LINks had the right to talk to any commissioners of health services and enter premises to inspect services. In this way, they held the health authorities to account for the services they provided.

Zuffar Haq explained that LINk spoke to experts on particular areas of interest and held public meetings around the City to seek views on these matters. During 2009/10 public meetings had been held on diabetes, dementia and healthy eating.

Information at these meetings was presented in a simple, straightforward style, so that the public remained engaged with the discussion. This approach appeared to have been successful. For example, a lot of advice had been provided at the meetings that was not always readily available from GPs,

sometimes due to time constraints, and issues identified at these meetings were followed up at later meetings. The Primary Care Trust (PCT) was in constant dialogue with the LINk and came to its meetings and so became aware of problems as they were identified.

Councillor Gill arrived at the meeting at 6.14 pm, at which point the meeting became quorate.

The Head of Planning and Commissioning advised the Committee that the future of the LINk was not certain. Although each area was statutorily required to have a LINk, their funding was only guaranteed until March 2011. No indication had been given by the government of whether funding would continue after that date.

There was some discussion about the uptake of health care services in some sectors of the population, particularly amongst the elderly. Zuffar Haq advised the Committee that the first public debate hosted by LINk had been on dementia and people with particular interest in that area were on the Board of LINk. Diabetes also had been discussed at one of LINk's public meetings. In addition, care for the elderly, and its provision, had been targeted in the LINk's work, (for example, criteria for patient transport services, which could be a problem for elderly people who needed help with transport).

Daryl Hines reported that Leicester City LINk had undertaken a survey, through the Leicester Mercury, which had had a high response rate. Comments made through the survey included concerns about dignity and respect, hospital hygiene and doctors' receptionists. These would be considered for Leicester City LINk's work streams for the coming year.

Some concern was expressed that the PCT had not been able to provide information on why GP visits to people's homes were not always available. It was acknowledged that the PCT usually provided information requested and it was unclear why this had not happened in this case. The Committee agreed that it would be useful for further information on this to be sought from the PCT.

The Committee noted that some people experienced delays in getting adaptations to their homes that were needed to due to medical conditions. This was partly due to insufficient resources being available to enable all required adaptations to be done. In response to concern about this, officers were working on actions to tackle the situation. Leicester also had become a trailblazer site for the Right to Control and was examining how more choice and control could be given to people who needed adaptations, supported by the Office of Disability Issues.

RESOLVED:

1) that Leicester City LINk be asked to make a report to this Committee on the results of work undertaken by Leicester City LINk in 2009/10 and Leicester City LINk's proposed work programme for 2010/11, this report to be made to the meeting on 20 May 2010 if possible; and

2) that Leicester City LINk be asked to investigate why a response has not been received from the Leicester Primary Care Trust on why visits by GPs to people's homes were not always available.

65. BALANCED SCORECARD (BSC) AND ANNUAL QUALITY REVIEW (AQR) PROGRAMME FOR GENERAL PRACTICES

David Riley, Head of Primary Care Improvement with Leicester City Primary Care Trust (PCT), submitted a paper updating the Committee on the introduction of a Balanced Scorecard and the progress made so far in the Annual Quality Review programme, together with key themes, areas of learning and the next steps in this annual cycle.

David Riley drew particular attention to the following:-

- One element of the annual cycle of quality was the production of annual quality plans for general practice. This, and the Balanced Scorecard, were benchmarking practices;

- An example of a populated Balanced Scorecard was tabled at the meeting and is attached at the end of these minutes for information. It was hoped that this would eventually be updated monthly. The possibility of automating the Scorecard was being investigated.;

- A national Patient Experience Survey had been undertaken, to which 16,000 responses had been received. These results were taken very seriously and, when put with other data, such as that from the census, gave a clearer picture of the City;

- Each GP practice was now part of the programme of annual review visits. To date, 59 had been visited and a further 4 would be visited before mid-April 2010. Each practice had specific areas that needed to be developed. When GPs had more than one practice, each was treated as a separate practice and visited accordingly;

- Leicester City PCT was very poor in terms of patient satisfaction, but the introduction of these measures meant that GPs could now see how each practice was rated;

- As well as benchmarking, a "traffic light" system of rating also was used. The PCT worked very closely with practices receiving a red rating to improve service quality. However, if improvements could not be made, contractual remedies would have to be considered, such as the issue of notices to improve;

- The information gathered through the Annual Quality Review programme was considered by a Quarterly Review Team, which comprised of high-level officers and contractor input. The results of the review were fed to the practice concerned and the Balanced Scorecards became part of the

that practice's quarterly review plans;

- The results of the review also would be made available soon to the general public, for example when looking to change GP practice. At present, discussions were being held on whether it should be included on the national promoting NHS choices website and, if so, how it should be presented; and

- The results obtained from these reviews needed to be matched to other data, for example the number of complaints received about a practice.

During discussion on this, the Committee noted that other PCTs did not appear to be publishing data on quality of GP services. David Riley explained that practices were being categorised, so that differences in quality between apparently similar practices could be seen, (for example, as shown through comparing satisfaction surveys). Tim Rideout, Chief Executive of Leicester City PCT, undertook to give further consideration to the publication of this data, as one way of helping people to choose which GP surgery to register with.

The Committee was reminded that work had been undertaken to see if there were identifiable reasons why there was poor uptake in different GP practices. However, there appeared to be no correlation between practice coverage and ethnicity or deprivation. (Minute 28, "Smear Testing and the Detection of Cervical Cancer", 22 October 2009 referred.)

The Committee questioned whether GP practices were happy with the results of the assessments undertaken and was advised that, at present, the data was still being summarised. Further discussions on the next steps in the process would be held in mid-April 2010. It was emphasised that this work was part of the PCT's quality improvement agenda and did not form part of the GP's contracts. Although the PCT had stated at the start of the process that it would use contractual sanctions if there was sufficient cause for concern, to date this had not been necessary.

Members asked if it was likely that people would want to register with GP practices already seen as good and not take in to account that other surgeries could be improving. Tim Rideout explained that this did not appear to happen. Poor GPs often were well liked by patients, as they often routinely prescribed medicines and referred patients to hospital.

Tim Rideout further explained that this work was part of a coherent strategy that included:-

- improving capacity – including the provision of new general practices for the City, at which a lot of people were registering. This movement was being encouraged, as it was easing the pressure on other practices;

- premises – a lot of work had been done to improve these, but a lot more still needed doing; and

- funding – when the PCT looked at funding, as requested by the Leicester City Council Health Scrutiny Committee, it was found that funding had no correlation to patient care. As a result, Leicester became one of the first areas in the country to redistribute funding.

This gave an unequivocal base line against which GP practices could be held to account in the long-term. The first round in the current quality review programme therefore gave "alerts" to practices about what was expected from them, but improvements would be expected in the next round, so that the City could improve what was recognised as its poor position of 140th of out 150 PCTs in terms of quality of service.

Zuffar Haq, Co-Chairman of the Leicester City Local Involvement Network, queried whether this work was being undertaken in response to a need to reduce the number of people attending hospital Accident and Emergency departments, due to cuts in funding. Tim Rideout explained that, although the numbers attending Accident and Emergency departments needed to be reduced, Leicester City PCT had provided the department with more funding than just the national settlement, in order to help it make changes.

Some concern was expressed that communication was a problem in Leicester, with some communities, especially newly arrived ones, not understanding the system. Tim Rideout explained that the large transient population in the City presented problems, but a lot of work had been done to ensure that all communities were aware of the system. This included having community-level workers to explain how best to access services and to work with GP practices in the areas of the City concerned. However, it was recognised that more could be done to explain processes.

The Committee identified some confusion over treatment that could be provided to people who had been refused permission to stay in the country. People in this situation could not register with a GP, but this could create problems if these people had communicable diseases. In reply, Tim Rideout explained that the PCT ran some practices exclusively for asylum seekers and those refused leave to remain in the country. Accident and Emergency departments never turned anyone away, so they could receive treatment there, but the patient would be billed for any on-going treatment and the hospital would seek reimbursement. An exception to this was genito-urinary care, to which there was completely open access.

Members suggested that the PCT could make more use of elected Members. For example, some communities were at greater risk of certain health problems than others, so Members could use their networks in those communities to help share information. Tim Rideout concurred with this, explaining that the PCT currently used Ward Community Meetings as one way of reaching communities. David Riley advised that, in addition, each practice was being asked to establish a patient participation group.

David Riley suggested that:-

- the Balanced Scorecard could in future contain data about whether visits by GPs to people's homes were available, (see minute 64, "Leicester Local Involvement Network (LINk)", above); and

- it would be useful if links could be made in the Balanced Scorecard with the Leicester City Local Involvement Network.

66. NEW MANAGEMENT ARRANGEMENTS FOR LEICESTER CITY PRIMARY CARE TRUST & COMMUNITY SERVICES

Tim Rideout, Chief Executive of Leicester City Primary Care Trust (PCT), tabled a report on the organisational form and direction of travel of PCT provider services, a copy of which is attached at the end of these minutes for information.

Tim Rideout explained that the government's current view was that the PCT should commission, not provide, health care. This had been embodied in guidance issued on 5 February 2010, as explained in the Summary of the report attached. As was also set out in that paper, the Leicester City PCT and the Leicestershire and Rutland PCT were working together to determine future arrangements for their community services.

Proposals for the integration of the services were set out in the report, from which it was noted that only a very small group of services would be retained by the PCT, in view of its new commissioning focus. The Committee noted that, as the proposed direction of travel had been accepted by the two PCT Boards and had been considered by the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee, the next stage was to undertake detailed testing of the proposed direction of travel. Following this, the proposals would be put out for public consultation and subsequent implementation by the end of March 2011.

In response to a question from the Committee, Tim Rideout explained that the success of these proposals would depend on the quality of commissioning of the services, including how the new providers of the services would be held to account.

Zuffar Haq, Co-Chairman of the Leicester City Local Involvement Network, asked why the services had to be provided at arms length through a separate organisation. He further stated that this appeared to be a very quick change in the way services were provided and expressed the concern that these changes would make them easy services to cut in times of financial restraint.

In reply, Tim Rideout explained that an arms-length body had been established in January 2008. The possibility of establishing a large Health and Social Care social enterprise had been considered, but the government's rules precluded this option and it was recognised that it would have had a high cost for low patient benefit. The options presented for consideration therefore were felt to

be the best way forward, although it was recognised that the situation could change depending on which political party, or parties, came to power following the forthcoming General Election.

Zuffar Haq expressed concern that the new proposals would result in people who currently could be treated in the community having to go in to hospital. This could result in people not receiving care as quickly as they did at present and could be a lot more expensive for the PCT. Tim Rideout stressed that the investment and focus on services would not be reduced, as the Boards of both PCTs and the Trusts were committed to high quality services.

RESOLVED:

1) that the recent national guidance and the implications for Primary Care Trust-provided community services be noted;

2) that the emerging direction of travel be supported as the basis for wider engagement and more detailed testing; and

3) that it be noted that a more detailed work programme and timeline for Phases 2 and 3 will follow for discussion.

67. LIFT PROJECT - UPDATE

Sarah Cooke, Associate Director (Corporate Performance) with Leicester City Primary Care Trust (PCT), gave a verbal update on the NHS Local Improvement Finance Trust (LIFT).

In addition to several practices having opened in the last year, the De Montfort University practice was relocating from its current campus site to a new building on Millstone Lane, next to the Queens building. Construction of this was scheduled to end on 11 April 2010. This practice would open in May 2010.

Construction of the Belgrave practice would start in June 2010 and currently was scheduled for completion in August 2011. It would be built in Brandon Street, on the site of a former adventure playground. Various services would be brought together at this practice, which would use a shared reception and administration service, but which would have their own treatment rooms. The design of the practice took in to account the considerable housing development work forecast for the Belgrave area, having capacity to take additional patients over the years.

Sarah Cooke advised the Committee that:-

- the PCT had invested approximately £3.5 million in its own health centre stock over the last few years;

- approximately £600,000 had been given in financial support to smaller projects, such as the development of general practices that owned their own buildings; and

- the PCT had a Fit for Purpose programme for the practices with the most challenging issues. Currently, 19 practices were on this programme, 8 of which were seeking to rebuild their practice accommodation. The most challenged of the practices on the programme received assistance first.

Zuffar Haq, Co-Chairman of the Leicester City Local Involvement Network, commented that, following the investment in smaller projects:-

- what improvement in patient care was expected?;

- the opportunity could be taken to stop GPs charging to write doctors' letters; and

- "payback" from GPs in the form of no longer using 0844 telephone numbers would be welcomed.

Sarah Cooke confirmed that a number of measures were used to promote improved services to patients, but the PCT had to be measured in the approach it took.

68. HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 2009/10

RESOLVED:

1) that the Committee's Work Programme for 2009/10 be noted;

2) that the issues of access to maternity services in Leicester and teenage pregnancy be considered as separate subjects, not as themes within the proposed Focus on Health Inequalities; and

3) that the new Cabinet Lead for Health and Community Safety be invited to provide the Committee with an overview of his role.

69. CLOSE OF MEETING

The meeting closed at 8.03 pm

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BALANCED SCORECARD - SEPTEMBER 2009

GENERAL PRACTICE PROFILE

NHS Leicester City

PRACTICE PHOTO

PRACTICE NAME / CODE			
ADDRESS DETAILS		MAIN SURGERY	BRANCH SURGERY
ADDRESS 1 ADDRESS 2 ADDRESS 3 POST CODE			N/A
LOCALITY		2	
PBC CLUSTER		NEL CLUSTER	

PRACTICE OPENING HOURS	TRIAL HOURS: MONDAY, TUESDAY 08.00-20.30, WEDNESDAY, THURSDAY, FRIDAY 08.00-18.30, SATURDAY (FOR PRE-BOOKED) 10.00-13.00, 14.00-17.00.
OPENING HRS FOR APPOINTMENTS	TRIAL HOURS: MONDAY, TUESDAY 08.00-20.30, WEDNESDAY, THURSDAY, FRIDAY 08.00-18.30, SATURDAY (FOR PRE-BOOKED) 10.00-13.00, 14.00-17.00.

CONTRACT TYPE	GMS
CONTRACT HOLDERS	
LEAD GP	
TOTAL NO OF MALE GPs (WTE)	2.66
TOTAL NO OF FEMALE GPs (WTE)	1
SALARIED GP HOURS PER WK	0
REGULAR LOCUM HOURS PER WK	0

FIRST POINT OF PRACTICE CONTACT	
CONTACT DETAILS	
NO. OF PRACTICE NURSES (WTE)	1.6
NO. OF NURSE PRACTITIONERS (WTE)	0
NO. OF NURSE CONSULTANTS (WTE)	0
NO. OF HEALTH CARE ASSISTANTS (WTE)	0.48

GPwSI'S ACCREDITATION	NO

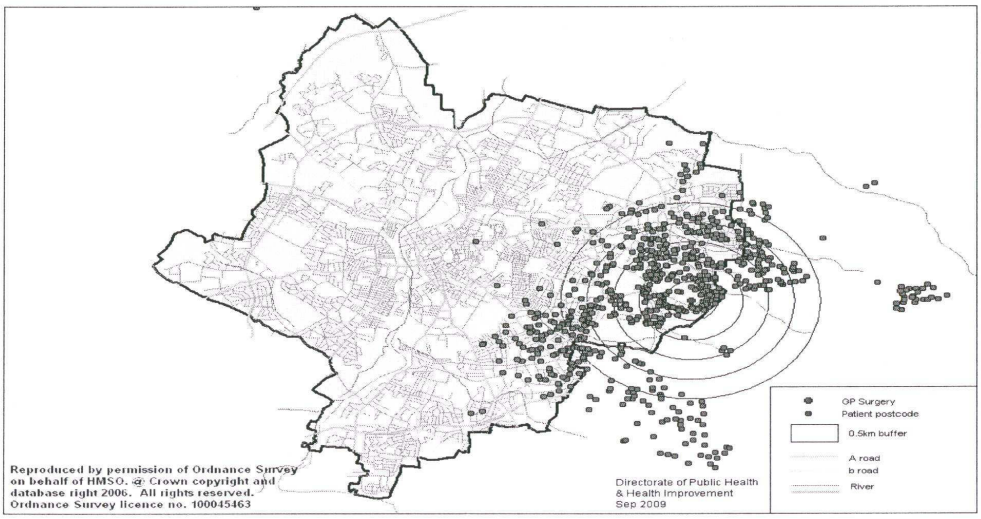
I.T. SYSTEM (VERSION)	EMIS LV
INVESTORS IN PEOPLE AWARDED	VISIT
NAMED GP FOR SAFEGUARDING CHILD	
NAMED GP FOR SAFEGUARDING ADULTS	
ADDITIONAL CONSULTATION LANG'S	HINDI, URDU, PUNJABI, MEERPURI, TAMIL, GERMAN
RESEARCH PRACTICE	VISIT

GP TRAINING PRACTICE - ACTIVE	YES
REGISTRAR	YES
MED STUDENTS	NO
OTHERS	NO

ADDITIONAL IN HOUSE SERVICES	DIABETES, ASTHMA,COIL FITTINGS, MINOR OPPS, TRAVEL ANTE-NATAL, CHILD HEALTH PROMOTION, AND VACCINATIONS, CORONARY HEART DISEASE, TEEN VACCINATIONS, WART CLINIC WEIGHT AND WELL PERSON CHECKS, DRUG COUNSELLOR, PRACTICE THERAPISTS

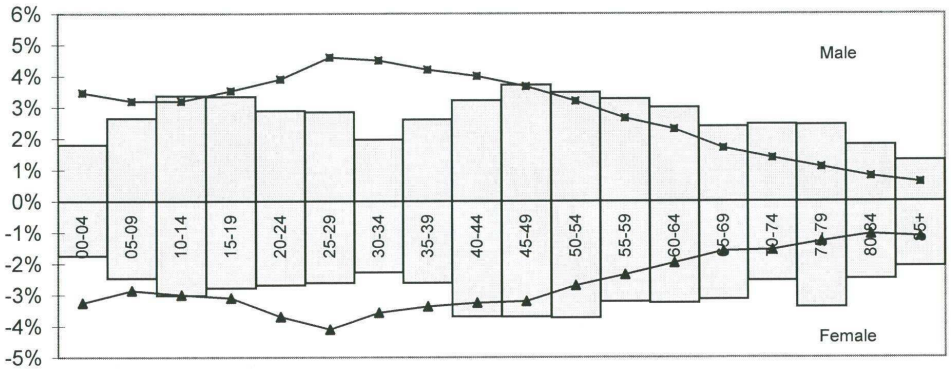
**= AWAITING PRACTICE INFO

REGISTERED PATIENTS AND THE PRACTICE BOUNDARY



PRACTICE LIST INFORMATION				
	OCT-08	JAN-09	APR-09	JUL-09
LIST SIZE	6728	6727	6724	6699
LIST CHANGE	-7	-1	-3	-25
TURNOVER (ADDITIONS/LIST SIZE)	1.56%	1.64%	2.60%	1.33%
REMOVALS	0	0	0	0
AVERAGE LIST SIZE PER GP	1838	1838	1837	1830

AGE/SEX BREAKDOWN



PUBLIC HEALTH DATA

	PRACTICE	PCT	REGIONAL	NATIONAL
DEPRIVATION (IMD: HIGHER = MORE)	15	33.2		0.37-85.46
MORTALITY (RATE PER 100,000)	463.7	645.9		594.73
NO. OF RESID & NURSING HOMES				
OLDER PEOPLE >=75 (% OF LIST SIZE)	13.51%	5.70%	7.63%	7.41%
CARERS				
ETHNIC GROUPS	33.16%	36.76%		
CHLAMYDIA SCREENING (YTD %)	1.80%	4.00%		
TEENAGE CONCEPTION	LOWER THAN AVERAGE			
ALCOHOL- BINGE DRINKING ESTIMATES (Q5 - LOW;Q1 = HIGH)	Q3			
QOF PREVALENCE				
HYPERTENSION	17.60		13.30	
CANCER	1.94	0.70	1.10	1.10
COPD	0.75		1.60	
DIABETES	4.93	4.90	4.10	3.90
CHRONIC HEART DISEASE	4.70	2.90	3.70	3.50
STROKE & TIA	2.21	1.20	1.70	1.60
MENTAL HEALTH	0.66	0.90	0.60	0.70
SMOKING	26.60			
OBESITY	6.01	6.80	8.10	7.60

FINANCE

PMS CONTRACT OR GLOBAL SUM	£436,240
CORR FACTOR OR GROWTH FUNDING	£0
QOF	£146,916
PREMISES	£42,992
ENHANCED SERVICES	£188,414
SPEND PER HEAD OF PRACTICE POP'N	£63

AREAS OF GOOD PRACTICE
VISIT
SPECIFIC PRACTICE CHARACTERISTICS
VISIT

BALANCED SCORECARD

NHS Leicester City

CRITERIA				
1. ACCESS & RESPONSIVENESS	**PRACTICE**	**PCT**	**REGIONAL**	**NATIONAL**
OVERALL PATIENT EXPERIENCE SURVEY RESULTS	91%	86%	92%	91%
48 HOUR ACCESS	92%	82%	86%	84%
ADVANCE BOOKING	71%	65%	74%	76%
TELEPHONE ACCESS	74%	65%	70%	70%
ACCESS TO A NAMED GP	71%	67%	76%	77%
HELPFULNESS OF RECEPTION STAFF	96%	89%	94%	94%
NUMBER OF DNA'S PER 1,000 POPULATION PER MONTH	11	11		
NUMBER OF FACE TO FACE GP CONSULTATIONS PER 1,000 POPULATION PER MONTH	322	263		
NUMBER OF FACE TO FACE NURSE CONSULTATIONS PER 1,000 POPULATION PER MONTH	192	113		
NUMBER OF TELEPHONE CONSULTATIONS PER 1,000 POPULATION PER MONTH	79	51		

				2008/09
COMPLIMENTS				7
CONCERNS				0
COMPLAINTS				7
INCIDENT REPORTING				0
SERIOUS UNTOWARD INCIDENTS				0

	PRACTICE
COMMITMENT TO PLEDGE - RIGHTS & EXPECTATIONS FOR PATIENTS & GP'S	VISIT
PATIENT PARTICIPATION GROUP	NO

2. PREMISES	**PRACTICE**
9 FACET SURVEY	COMPLIANT
ADOPTION OF PCT INFECTION CONTROL TOOLKIT	VISIT
CLINICAL WASTE POLICY	YES
EQUIPMENT MAINTENANCE & CALIBRATION POLICY	YES

3. PATIENT CHOICE	**PRACTICE**
USE OF CHOOSE & BOOK SYSTEM	90%
USE OF NHS CHOICES WEBSITE	LIMITED
OFFER OF CHOICE OF HOSPITAL	100%
PRACTICE SUPPORT FOR PERSONALISED CARE PLANNING AND SELF CARE SUPPORT FOR LTC'S	VISIT
PRACTICE LIST OPEN AND ACCEPTING NEW REGISTRATIONS	YES

CRITERIA				
4. QUALITY - EFFECTIVENESS	**PRACTICE**	**PCT**	**REGIONAL**	**NATIONAL**
ACHIEVEMENT IN THE CLINICAL DOMAIN OF THE QUALITY AND OUTCOMES FRAMEWORK (QOF) 2008/09	650.00	633.89	**	**
QOF EFFECTIVE EXCEPTION RATES 2007/08	2.74%	4.57%	5.34%	5.26%
PRODUCTION OF PRACTICE CORPORATE & CLINICAL GOVERNANCE REPORT INCL RISK ASSESSMENT	VISIT			
CONFORM TO NICE INTERVENTIONAL PROCEDURES GUIDANCE AND TECHNOLOGY APPRAISALS	YES			
ADOPTION OF RCGP GUIDE TO REVALIDATION OF GP'S	YES			
ADOPTION OF THE PRINCIPLES OF THE GOOD MEDICAL PRACTICE GUIDE	VISIT			
ADOPTION OF CODE OF CONDUCT FOR NHS MANAGERS	YES			
ADOPTION OF WHISTLEBLOWING IN THE NHS POLICY	YES			
MANDATORY TRAINING AND APPROPRIATE CONTINUING PROFESSIONAL DEVELOPMENT	YES			
UNDERTAKE ALL APPROPRIATE EMPLOYMENT CHECKS INCL CRB	YES			
ALL STAFF INCL GP'S ATTEND CHILD & ADULT SAFEGUARDING TRAINING	YES			
SYSTEMS IN PLACE TO ENSURE MEDICINES ARE HANDLED SAFELY	VISIT			
SYSTEMS IN PLACE TO ENSURE CONTROLLED DRUGS ARE HANDLED SAFELY	VISIT			
OVERALL PRESCRIBING INDICATOR (0 = HIGHEST; 90 = LOWEST)	13	17		
PRESCRIBING INDICATORS - EFFECTIVE STATIN USE	72.52%	78.08%		
PRESCRIBING INDICATORS - GENERIC PRESCRIPTION RATE	82.30%	80.20%		

5. DEMAND	**PRACTICE**	**PCT**
A&E ACTIVITY PER 1,000 WEIGHTED POPULATION	12.22	17.22
BETTER CARE BETTER VALUE INDICATOR ON OUT-PATIENT REFERRALS	10.92	9.21
NUMBER OF URGENT REFERRALS PER 1,000 WEIGHTED POPULATION	5.33	8.37
NUMBER OF ELECTIVE REFERRALS PER 1,000 WEIGHTED POPULATION	9.10	6.79
DIAGNOSTIC SERVICES INCLUDING IMAGING, PATHOLOGY AND PHYSIOLOGICAL MEASUREMENT SERVICES		

6. SERVICE PROVISION	**PRACTICE**	**PCT**
NUMBER OF ENHANCED SERVICES UNDERTAKEN (EXCLUDING CONTRACEPTIVE SERVICES)	14	19
CONTRACEPTIVE AND OTHER SEXUAL HEALTH SERVICES	2	3
MINOR SURGERY	YES	
CHILDHOOD VACCINATIONS & IMMUNISATIONS	YES	
6 -8 WEEK BABY CHECK. BREASTFEEDING STATUS OF WOMEN AT 6-8 WEEKS	100%	70.24
ENHANCED CARE OF LONG-TERM CONDITIONS (EG ASTHMA CLINICS, DIABETES CLINICS)	YES	
ACTIVELY ENGAGED IN PBC	YES	
PRACTICE-BASED COMMISSIONING PROPOSALS	NO	
PRACTICE-BASED COMMISSIONING APPROVALS	NO	

LEICESTER HEALTH OVERVIEW AND SCRUTINY COMMITTEE
1 APRIL 2010

REPORT FROM NHS LEICESTER CITY AND NHS LEICESTERSHIRE COUNTY AND RUTLAND

PCT PROVIDER SERVICES – ORGANISATIONAL FORM DIRECTION OF TRAVEL

Summary
National policy on future organisational form of PCT-provided community services has been clarified in the last few weeks.

Guidance published on 5 February 2010, aimed at improving care quality and enabling innovation and productivity, has made it clear that PCTs should focus on high quality commissioning and will not typically provide clinical services in the future.

NHS Leicestershire County and Rutland and NHS Leicester City have therefore begun working together to determine future arrangements for their community services.

The approach to this work has been structured around three phases:

- Phase one — development of an initial direction of travel – to be agreed in principle with the Strategic Health Authority by the end of March 2010
- Phase two — detailed testing of direction of travel prior to formal public consultation during Summer 2010
- Phase three — PCT Board decisions followed by implementation of new organisational form arrangements by the end of March 2011.

This summary report and the attached PCT Board report present the outcome of phase one.

Background
Leicester City Community Health Services (the provider part of NHS Leicester City) serves a population of around 350,000, employs around 1,600 staff, and has an annual budget of around £50 million. Services provided include the city rehabilitation centre, intermediate care services, the Leicester Urgent Care Centre, community based nursing services, health visiting and school nursing, therapies and podiatry.

Leicestershire County and Rutland Community Health Services (the provider part of NHS Leicestershire County and Rutland) serves a population of 677,900, employs around 2,500 staff, and has an annual budget of around £108 million. Services provided include ten community hospitals, a walk-in centre, community based nursing services, health visiting and school nursing, a community dental service, out of hours services, therapies, podiatry and nutrition and dietetic services.

PCTs have been working for some time to drive up quality and improve the efficiency, governance and value for money of their community services. Moving services completely out of PCTs is the next step to enable further transformation.

Various potential organisational forms, including social enterprise and community foundation trusts, have been considered over the last year.

The guidance published in February has narrowed the options for services locally. New large scale social enterprises are unlikely, and the creation of community foundation trusts is not being encouraged because it does not make sense to create new NHS organisations in a recession.

Currently the most likely option for the majority of local services is integration with an existing NHS acute or mental health provider, and it may be appropriate to put some services out to tender where there are potential alternative providers.

Integration of providers presents opportunities to provide more joined up care for patients and service users.

Development of proposals

Emerging proposals have been developed jointly between the two PCTs in discussion with community health services managers and staff representatives, local doctors, adult and children's services representatives of local authorities, and other local providers.

It is currently proposed that most services are integrated with existing NHS acute or mental health sector providers, a small number are put out to tender, and one city service is taken further forward as a social enterprise organisation as shown below. A more detailed version of this table showing financial and staffing information is included as an appendix to the attached Board paper.

Current proposed direction of travel for groups of services

Acute Sector	Mental health sector	Open Procurement (tender)	Social Enterprise	PCT retained
Intermediate care and community hospital beds **Elective care** • Dermatology • Adult MSK physiotherapy • Children's audiology • Outpatient and day case services • Genito-urinary medicine • Podiatry • Radiology • Speech and language therapy for adults • Community dental services • Dietetics (provided in acute setting) **Urgent care** • Walk-in centres and minor injury units • Primary care coordinators • Children's Rapid Assessment Follow Up Team • Diana Children's Services **Specialist long term conditions** • Sickle cell and Thalassaemia Service • Chronic Obstructive Pulmonary Disease service • Heart Failure Service • Diabetes Nursing Service • Specialist TB Nursing Service • Specialist Continence Nursing Service **Paediatric medical services**	**Adult community nursing and therapy** • Care of older people in the community (district nursing) • Generalist community matrons • End of life nursing care • Reablement (including community intermediate care teams and therapies) • Rapid response teams • Dietetics (provided in community) • Community Health Volunteer Scheme • Care home project **Children's universal** • Health visiting • Safeguarding children • School nursing • Travelling families services **Children's targeted (complex needs)** • Occupational therapy • Physiotherapy • Specialist health visiting • Speech and language therapy **Health promotion and prevention** • Choices – sexual health and contraception • HPV programme • Primary care and public health support • Chlamydia+ • Fit and active buddies • Healthy Living Centre • Stop! Smoking cessation service **GP Asylum Seeker Practice (ASSIST)**	**Urgent care** • Out of hours GP service • Out of hours call handling service • Dental Access Centre **Intermediate care** • Community equipment	**GP Homeless Practice (Dawn Centre)**	**Estates building management** • Soft and hard facilities management **Continuing care** **Interpreting and translation** • Ujala Resource Centre

When debating which option might be most suitable for each service, a major consideration has been whether services are similar or have natural alliances, or whether they are best delivered in a particular way.

For example, specialist nurses supporting patients with chronic illness in the community have close links with consultant led services in acute hospitals and so it would seem sensible that they be managed by the same organisation. Similarly, most children's services are naturally delivered in a multi agency approach in local communities and would therefore fit better with a mental health sector provider which already works in that way. Where there are alternative providers with a proven track record in service delivery it is appropriate to put some services out to tender.

It is important to note that the current proposals are a 'direction of travel' requiring much more detailed analysis and debate, and may well be subject to change.

Next steps

This report has previously been submitted to the Leicester, Leicestershire and Rutland Health Overview and Scrutiny Committee on 22 March, while the two PCT Boards considered the draft proposals at their meetings on 11 March.

The views of key stakeholders, including local authority partners, have been sought and were included in the report that they considered. At those meetings the Boards provided the go ahead for the more detailed work to take place and will receive further information about the next stages of the work at their meetings in April.

Work to date has focused on broad clinical services. Consideration of the implications for staff, and the development of a robust HR process to support them though the changes, will be a key part of the next phase of this work.

Engagement with stakeholders including scrutiny committees, local involvement networks, councils and local community representatives, will also be vital.

There is a national expectation that services will be integrated by 1 April 2011. No final decisions will be made until after staff and public consultation, which will take place after the General Election.

Recommendation

The Overview and Scrutiny Committee is asked to:

- Note the recent national guidance and the implications for PCT-provided community services
- Approve the emerging direction of travel as the basis for wider engagement and more detailed testing, and
- Note that a more detailed work programme and timeline for phases two and three will follow for discussion.

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