Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 10 MARCH 2016 at 5:30 pm

P R E S E N T :

Councillor Chaplin (Chair)
Councillor Fonseca (Vice Chair)

Councillor Alfonso
Councillor Bhavsar
Councillor Dr Chowdhury
Councillor Sangster
Councillor Singh Johal

Also In Attendance

Councillor Palmer	–	Deputy City Mayor
Councillor Osman	–	Assistant City Mayor Public Health
Richard Morris	-	Director of Corporate Affairs, Leicester City Clinical Commissioning Group
Surinder Sharma	–	Healthwatch Leicester

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65. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda. No such declarations were made.

66. MINUTES OF PREVIOUS MEETING

AGREED:

That the minutes of the meeting held on 14 January 2016 be approved as a correct record.

67. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

68. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations and statements of case had been submitted in accordance with the Council's procedures.

The Chair indicated that she had received the following questions submitted at late notice and would take them at the meeting:-

QUEENS ROAD MEDICAL CENTRE

Mr David Shelley asked the following questions and responses had been submitted by the Leicester City Clinical Commissioning Group prior to the meeting:-

1) There is public concern that the meeting on 14th January which decided the future of the Queens Road Medical Centre was held in private. Consequently it is difficult for the decision making process to stand up to scrutiny, and public confidence in the CCG has been damaged. Why was it necessary for this meeting to be held in private, particularly given that the CCG has said that they had no access to the financial records of the practice when making the decision?

Response from the CCG

This question was answered in the meeting with Jon Ashworth MP on 26th February. It was necessary for this item to be taken in confidential session as the papers considered by the committee contained information that was commercially confidential and information personal to individuals employed by the practice. Although the CCG did not have access to the full accounts of the practice the papers presented disclosed information relating to the full NHS income of Queens Road Medical Centre, from which it may have been possible to deduce the profit of the practice. It also contained information about the personal details of employees of the surgery. This included their annual salaries, length of service and redundancy liabilities. This information was vital in making an assessment as to the likely ongoing viability of the practice. It would not have been appropriate to make this information available publicly and to do so is likely to have been unlawful as it may well have represented a breach of data protection legislation.

The CCG tries to undertake as much business as is possible in its public meetings. However, from time-to-time this is not possible. Where an item is deemed necessary to be considered in confidential session the reasons for this must be clearly explained to the relevant committee.

2) Campaigners reported there were parties who have expressed an interest in taking over the running of the practice, who believe that the practice would be financially viable, and who have said they would be able to deliver continuity of care for patients in the available time. Why did the CCG believe that this would not be the case when taking the

decision to disperse the patient list?

Response from the CCG

This question has been answered at the public meeting on 25th February and the meeting with Jon Ashworth MP on 26th February. The CCG could not have sought to establish a partnership arrangement on behalf of Dr Lenten or the practice. Contractual partnerships between GPs are private matters between the individuals concerned and it would be wholly inappropriate for the CCG as a commissioner of services to attempt to influence arrangements of this nature. Indeed, to do so may have been considered to be anti-competitive and a breach of European procurement law.

In considering its response to Dr Lenten's resignation, the CCG was obligated to consider the reprocurement of the contract as an APMS time-limited contract, which would have most likely been re-let at a rate considerably below the current per patient income of Queens Road Medical Centre. It is national policy that all re-procurements of GP contracts must be as APMS contracts. Had Dr Lenten entered a partnership agreement with another GP it would have been possible for the current GMS contract to be maintained. This would also have secured the step down funding available to former PMS contract holders as part of the review of those contracts, making it a much more financially attractive to potential partners. It was our view that an APMS contract would not have been considered to be sufficiently attractive or viable.

3) Was adequate consideration given to the needs of patients, particularly elderly and disabled patients, in respect of transport and accessibility to alternate practices?

Response from the CCG

This question has been answered at the public meeting on 25th February and the meeting with Jon Ashworth MP on 26th February. In reaching its decision the CCG considered a range of information about the practice and its patients. The CCG has also undertaken a full Equality Impact Assessment.

Fewer than 10% of Dr Lenten's patients are aged over 75, with only 20 patients living in care homes. The largest proportion of patients at the practice is between 15 and 44 years of age. Patients tend to have fewer chronic long-term or life-limiting illnesses than patients at many other practices in the city. The CCG considered that the area is well served with 23 practices within 1.5 miles of Queens Road Medical Centre, while there is also a wide distribution of Dr Lenten's patients across the city and into the county. The four closest practices to Queens Road Medical Centre are Dr Mansingh, Willowbrook Surgery at Springfield Road, Clarendon Park Medical Centre and Victoria Park Health Centre. These practices range from 0.1 to 0.5 miles from Queens Road Medical Centre and are all in areas heavily populated by Dr Lenten's patients. Some of these have car parking facilities. As such, the CCG is of the view that suitable alternative GP facilities are available for patients within the local area. Indeed, the availability of alternative provision in this area is much greater than

in some other parts of the city.

4) Do you think given his association with the GP federation that is dominant in Clarendon Park, it was appropriate for Prof. Farooqi to play such a public role in managing the closure of the surgery, and would it not have been better for him to distance himself from the entire process?

Response from the CCG

No. The advantage of clinical commissioning groups is that they are clinically-led organisations and it is right and appropriate that the CCG's most senior clinicians are prepared to lead from the front, especially when difficult decisions need to be made. Professor Farooqi has been elected to chair the CCG by practices within Leicester. There are no benefits to either Professor Farooqi, his practice or the federation of which his practice is a member from dispersing the list of Queens Road Medical Centre.

It should be noted that while practices that CCG board members are part of may be members of a federation, it is not allowed for individual GP board members to also hold executive positions within a federation from 1st April 2016. This is a resolution that was voted on and approved by all practices in Leicester during 2015.

5) Given the concern expressed at the public meeting on 25th February, would it not be wise to consider a different structure for GP federations in Leicester, perhaps as community interest companies which would be seen as more "for the public" and less "for shareholders".

Response from the CCG

This question has been answered at the public meeting on 25th February and the meeting with Jon Ashworth MP on 26th February. GP federations are completely separate to the CCG and how they are legally established is a matter for them. It is not something over which the CCG has any control or influence. However, we are aware that the emerging federations in Leicester have at their heart the principles of developing and providing new and innovative models of care for patients as set out by the NHS' five-year Forward View.

Federations are groups of like-minded practices that have joined together to find solutions to the challenges faced in primary care. This can include sharing back office functions such as practice managers and accountants to help release money that can be invested in patient care, through to providing additional specialised clinics that can be offered to all patients of practices within the group. It is important to note that federations are no different to GP practices, which are private small businesses that naturally aim to return a profit. This has been the case since the NHS was founded in 1948.

The CCG could provide contact details of those leading the discussions on

federations of GP practices to Mr Shelley should he wish to feed patients views and concerns directly to those involved.

The Chair commented that a number of concerns had been expressed in relation to transparency issues for patients and also control/accountability issues once public funds become part of a private business such as a federation. The Deputy City Mayor stated that the concerns expressed about federations would be considered at the forthcoming summit he was arranging.

BETTER CARE TOGETHER

Mr Geoff Whittle asked:-

1. What specific plans have been put in place to scrutinise the Better Care Together (BCT) proposals for Leicester and to ascertain the views of the residents of Leicester? It was understood that some parts of BCT had already been implemented and that no timetable had been received for the public consultation.

2. How will the extent and nature of this scrutiny reflect the scale and long term significance of the BCT programme? It is now believed that savings of more than £400m are being proposed as part of BCT. The Council is does not attend the BCT Partnership Board and we question how seriously the Council is taking this programme given the scale of what is being proposed.

The Chair stated that the Commission had received briefings on the proposed BCT consultation process and the likely contents of the consultation; but these had not yet been finalised or approved for publication. The Council had not received dates for the proposed public consultation in view of the restrictions on carrying out consultations during the forthcoming elections in May for the Police Commissioner.

The Deputy City Mayor stated that many parts of the Council were involved in the BCT process through work on the Health and Wellbeing Board; and service areas and directors had been involved in the process through considering implications for adult social care services within the BCT programme. Service directors attended sub-groups within the BCT Programme which considered how services could be affected and re-shaped to meet the programme's requirements. The Deputy City Mayor also had regular meetings with BCT directors. He was firmly of the view that as the BCT Partnership body was not a decision making body it was not the most important interface for the Council's limited resources, which were directed to where the most impact could be made.

CARE AND PLACEMENT OF ASPERGER PATIENTS ON BEAUMONT WARD, BRADGATE UNIT

Mr David Bradly submitted a representation and expressed the following

concerns:-

1) The lack of adequate and appropriate facilities in Leicester to care and recover autistic (and Asperger) patients who have experienced a breakdown in residential care or at home.

2) The lack of a properly managed process to find and secure a residential placement for autistic (and Asperger) patients after such a breakdown should they need one.

On the first point, it seems that the only facility in Leicester to house such patients are the acute mental health wards at the Bradgate Unit which are not equipped to care and treat them. The persons who have suffered a breakdown cannot be cured of their autism and so need to be cared for very differently from patients who are suffering a temporary mental illness. The psychiatrists at the Bradgate Unit are trained to treat mental illness largely through medication, whereas autistic persons need a completely different care approach in order to restore them to a level at which they are able to cope with society again – something which is difficult at the best of times. The health service on its own is not the body to meet this need.

On the second point, the involvement of Social Services, Community Mental Health, Continuing Care and the ward staff are all necessary in finding a suitable placement once recovery/restoration has been achieved, but none of these are willing to take overall responsibility of the whole process. No one person is responsible for managing the process and ensure that it is completed in a timely fashion. In fact, there is no process worthy of a name.

The Chair thanked Mr Bradly for his statement and stated that a written response would be sent to him.

The Deputy City Mayor commented that there was a need to reflect and consider lessons learned from examples such as this in operational issues. These comments could be considered at the Joint Integrated Commission Board and the Mental Health Care Pathways as part of the BCT programme.

The Strategic Director of Adult Social Care commented that a new national programme had arisen out of the Winterbourne Agreement which challenged the assessment of patients diagnosed with Asperger's and Autism conditions. Care was provided by a multi-disciplinary team with funding streams divided between local authorities and the National Health Service.

The Deputy City Mayor invited Mr Bradly to meet with the Strategic Director and himself to discuss the issues further.

The Chair requested that a report on the outcome of discussions with Mr Bradly and whether the policy could be changed to improve the care of people diagnosed with Asperger's or autism.

69. PRIMARY CARE WORKFORCE TASK GROUP REVIEW

The Chair updated Members on the work of the Task Group and the Commission received evidence that had been submitted prior to the meeting. An extract of the Minute of the Health and Wellbeing Board held on 2 February 2016 relating to the issue was previously circulated for information with the agenda.

The evidence received at the meeting included a formal response from the Deputy City Mayor to the Task Group's Review, the views of Professor Harris at the University of Leicester and a briefing paper form the National Health Executive.

Prior to discussion on the Task Group's work, the Director of Corporate Affairs, Leicester City Clinical Commissioning Group reported that Danum Medical Services had advised the CCG that they would not be able to fulfil their contractual obligations to provide GP services at Asquith Surgery and Bowling Green Surgery after 11 March 2016.

The CCG had put in place temporary and urgent measures to allow patients to receive care at both practices as normal through caretaker arrangements from other local providers until a longer term solution could be found. Both practices would still be able to register new patients. This had only been possible in this instance as both premises were owned by the NHS and had list sizes that were likely to make practices clinically and financially viable going forward.

Expressions of interest were being sought from other GP practices wishing to take on this role and any bids received would be evaluated and it was hoped to make an announcement on March 14th.

Following comments from members, the Director of Corporate Affairs, Leicester City Clinical Commissioning Group stated that single handed GP Practices were more vulnerable than larger practices, particularly when the principal GP wished to retire or resign. Practices affected by the changes from PMS to GMS contracts were also potentially vulnerable, and CCG staff had been in discussions with those practices affected to determine the effects this may have. The CCG were seeking assurances from GPs moving from PMS to GMS contracts that they had plans in place to enable the practice to manage in the future. To date some practices were developing plans and others required additional support in the process.

Those GP practices that could not demonstrate they could provide the additional services required by the new national contracts would have their funding reduced over a 6 year period.

The Chair referred to the suggestion at the Health and Wellbeing Board that single GP practices be invited to enter into a voluntary agreement to give 6 months' notice rather than the 3 months required by the national contract agreement. The Director of Corporate Affairs, Leicester City Clinical Commissioning Group stated that some had already agreed to this and others

were still in discussion.

It was noted that 4 GP service hubs established by the CCG earlier in the year had provided approximately 2,000 extra patient appointments per week. The hubs were well used Monday to Friday but there was a drop in usage at weekends. It was also noted that many GPs were reporting increased workloads with up to twice as many consultations as they carried out 5 years ago.

The Healthwatch representative commented that more needed to be done with patients at an early stage when GP practices closed, particularly when large number of patients did not speak English as a first language and were less able to organise themselves and articulate their concerns.

The Director of Corporate Affairs, Leicester City Clinical Commissioning Group stated that the CCG had established a Patient Community Steering Group, which had representatives covering all 9 protected characteristics, various organisations and faiths within the city. It was accepted that the CCG had not engaged some groups as well as they could have done in the past.

The CCG was engaged with the Patient Participation Groups which meet regularly and this provided good information on current issues affecting patients. 17 large scale community events had been held between August and December aimed at groups and communities that did not normally engage with the system. The CCG had also launched a procedure whereby GPs could report patient experiences at both an individual and a community level to a dedicated team who could then take the issues forward.

The Chair stated that the Task Group had heard submissions from:-

- A GP
- 2 GPs at different stage of training
- Practice Nurses
- The Deputy City Mayor
- The CCG

The Task Group's findings were being prepared and the following issues had been considered:-

- Whilst the Universities provided good training courses for GPs, many did not stay to practice in Leicester after qualifying.
- Many preferred to remain locums as they could earn more than becoming permanent members of a practice and could gain wider experiences by moving to other medical practices. This however was considered to be to the detriment of continuity of care for patients.
- Career options were not made clear enough to trainees during the early stages of their training in sufficient time for them to consider other options in their training.
- There were concerns about the pressures that the CQC

Inspection regime had upon single GP practices and some GPs had indicated that they found the inspections too onerous and time consuming to the point where they had considered ceasing to practice. 80% of GP practices were compliant with CQC inspections and the CQC were currently reviewing their inspection process as a result of reducing funding.

- There were similar issues with training practice nurses as those for GPs in that primary care options were not offered at the early stages of nurses training. The CCG and De Montfort University were currently considering this issue.
- There were variances in the availability of staff being released for training purposes.
- Some GPs had managed pressures by recruiting health professionals including paramedics and nurses to treat some patients' conditions and illnesses.

It was intended to provide a draft of the Task Groups report to members prior to it being considered by the Overview Select Committee in March. The final report was also intended to be available to be considered at the Deputy City Mayor's health summit.

The Deputy City Mayor outlined the comments made in his submission to the Commission. He also outlined the arrangements and purpose of the health summit. The aim of the summit was to get everyone involved in health provision and social care to come together and to align their plans and achieve an understanding of the financial constraints faced by each other and the implications this had for resources to deliver integrated health care. He wished to see a succinct, pragmatic and overarching plan for primary care in Leicester that reflected the current health and primary care landscape. He was waiting for the Health Minister's to indicate his availability before setting the date for the summit as he felt it was imperative for the Health Minister to be in attendance. He felt it was important for the Minister to appreciate grass root concerns and see at first hand the impact on patient care at a local level of GP practice closures and other pressures on the health system.

The Chair welcomed the planned outcomes of the Deputy City Mayor's primary care health summit and felt that the work undertaken by Scrutiny would help to provide evidence to highlight the issues of concerns. Together with the Health and Wellbeing Board, the Commission would continue to monitor the primary workforce planning involving partners and other organisations.

AGREED:

That the update be received and comments made by the CCG and others at the meeting be noted and reflected in the Task Group's findings.

ACTION:

The Scrutiny Policy Officer to prepare the report of the Task Groups findings

to be submitted to the Overview Select Committee's meeting in March.

70. HEALTH AND WELLBEING BOARD UPDATE

The Deputy City Mayor outlined the current work of the Health and Wellbeing Board and stated that at the Board meeting in February it had:-

a) Approved the 2016/17 Better Care Fund Plan.

b) Approved the Mental Health Joint Commissioning Strategy.

c) Considered the 2016/17 - 2020/21 NHS Planning Guidance

d) Received a presentation and discussed the UHL strategic priorities.

e) Discussed the Primary Care Workforce Planning and the Board had suggested seeking a voluntary agreement to GPs giving a six month notice period rather than the 3 months in the national contract.

He had attended the public meeting organised by the CCG in relation to the Queens Road Medical Centre and had met with campaigners and was involved in ongoing discussions with the CCG and others.

He was also arranging a Primary Care Summit to discuss a Primary Care vision and strategy.

f) Other areas of the Board's current work included:-

Joint Health and Wellbeing Strategy 2016-19
Sustainability & Transformation Plan LLR
Community Pharmacy
Public Health grant
Health Education East Midlands workforce plan
Better Care Together
Strengthening links between Learning Disability Partnership Board, Mental Health Partnership Board & Health & Wellbeing Board

g) As Chair of the Board he was also involved in following activities:-

#timetotalk day & employers pledge
Health in all Policies workshops
Mental Health Summit
East Midlands Health & Wellbeing Boards Chairs network
LGA Health & Wellbeing Boards chairs summit

Following questions from Members, the Deputy City Mayor stated that there was now a wealth of data that had been accumulated from a number of health surveys over recent years and this was informing and shaping the development

of the Joint Health and Wellbeing Strategy 2016-19. He wished to develop a strategy that clearly set out a long term ambition beyond the 3 year life of the strategy.

In relation to Sustainability & Transformation Plan LLR (STP), it was intended to align this as close to the Better Care Together Programme (BCTP) as possible to avoid unnecessary duplication, whilst recognising that the STP had a wider remit that the BCTP.

The Chair thanked the Deputy City Mayor for his update.

71. ANCHOR CENTRE UPDATE

The Commission received an update report on the Anchor Centre. The Assistant City Mayor Public Health stated that:-

a) The Council had been successful with its capital bid in partnership with Inclusion Healthcare to Public Health England and had been awarded £267,861 to develop suitable accommodation for the service and to support people using the service towards recovery.

b) The proposed model for the Anchor Recovery Hub was outlined in the report and a project team had now be established to develop plans for the new service and to complete an options appraisal for possible sites for the recovery hub in an suitable and appropriate location.

c) A waiver had also been obtained to extend the current contract with Inclusion Health for one year to allow the time to get the new service model in place before the service was re-commissioned.

Following discussion and comments it was noted that:-

a) the Council had received positive feedback from Public Health England on the quality of the bid application.

b) the costings for the grant application had been based upon renovation costs and the number of clients that would use the service.

c) the centre would now be called the Anchor Recovery Hub to reflect its new role to stabilise service users' alcohol use, engage and maintain contact with treatment services and mutual aid to improve their physical and mental health and to help users learn new skills.

d) that service users and the service providers were involved in preparing the joint bid.

The Chair welcomed the developments and felt this was a good example of scrutiny helping the Executive to look at the facility in a different way. Further updates on the Recovery Hub were requested.

AGREED:

That the update report be welcomed and that further reported be submitted to future meetings.

ACTION:

The Scrutiny Policy Officer to update the work programme to receive further updates at future meetings.

72. HEALTHWATCH URGENT CARE REPORT

Healthwatch Leicester submitted a report providing an overview of a number of visits to the Urgent Care Centre at Leicester Royal Infirmary that were carried out in November 2015.

AGREED:

That that report be received and noted.

73. NHS 111- UPDATE

The Commission received an update on the NHS 111 service previously considered at the Commission's meeting on 29 October 2015. (Minute 41 refers).

The Director of Corporate Affairs, Leicester City Clinical Commissioning Group reported that the report on the investigation carried out by North Derbyshire CCG originally expected to be available in January had been delayed. It was expected that the report would be available for the Commission's next meeting on 21 April 2016.

AGREED:-

That the report on the outcomes of the investigation carried out by North Derbyshire CCG be submitted to the next meeting of the Commission.

ACTION:

The Scrutiny Policy Officer to add the report to the Work Programme for the April meeting of the Commission.

74. ARRIVA PATIENT TRANSFER SERVICE

The Director of Corporate Affairs, Leicester City Clinical Commissioning Group provided an update on the recent issues relating to the Arriva Patient Transfer Service.

It was noted that:-

a) The contract was awarded to Arriva in 2012 for a 5 year period with a value of £26m. There was a provision in the contract for it to be extended.

b) Prior to 2012, the contract had been awarded to EMAS and there had been a number of performance issues during the contract.

c) There had been a number of performance related issues during the current contract with Arriva, some of which arose from Arriva's operations and some from health service procedures.

d) Current issues experienced were unacceptable waiting times for pre-planned appointments, patients being discharged from hospital waiting more than 2 hours, and difficulties in servicing rural areas where patients had experienced too many delays in being taken to their appointments or transport failing to turn up altogether.

e) Discussions had been held with Arriva who were being responsive to the issues being faced and some improvements in performance had been observed during the previous three months.

f) The procedures for discharging a patient in the Urgent Care Planning process often meant that Arriva were not notified until the end of the process and that could cause planning issues for staff planning for Arriva. Equally there were instances where Arriva had arrived to pick up a patient and the patient had not been fully discharged. This problem was not just local but was part of a wider issue.

g) It was recognised that the health and care system was different now to when the contract was awarded in 2012, as there was more demand being placed upon Arriva than in 2012.

h) Commissioners of the service were now looking at the contract details and whether to extend it beyond 2017. Commissioners were conscious that the contract should be fit for purpose, it should meet the needs of the patients and that patients should be involved in shaping the future of the service.

The Chair thanked the Director of Chief Corporate Affairs, Leicester City Clinical Commissioning Group for the update.

AGREED:

That the update report be received and further update be presented to the next meeting of the Commission.

ACTION:

That the Scrutiny Policy Officer add the update to the Work Programme for the next meeting of the Commission.

75. HEALTH MESSAGING SCRUTINY REVIEW - UPDATE

The Commission received an update on the work of the Task Group in relation to this scrutiny review. The Chair stated that although some progress had been made with the review the review had not been completed as, available resources had been prioritised to complete the Primary Care Workforce Review.

Councillor Alfonso had arranged with the Head of Markets for a health messaging event to be held at the Leicester Outdoor Market. Councillor Alfonso outlined the programme for the event which would be attended by the City Mayor, Lord Mayor and ex Lord Mayors on 1 April 2016 at 11.30am. Members were encouraged to attend the event.

The Chair thanked Councillor Alfonso for helping to organise the event.

AGREED:

That the update report be received.

76. LPT SCRUTINY REVIEW TASK GROUP

Councillor Sangster provided an update on the work of the Task Group on 'Leicestershire Partnership NHS Trust – Quality monitoring following the Care Quality Commission Inspection'. It was hoped that the Review Report would be available in April.

The Chair encouraged Members to attend Task Group meetings.

AGREED:

That the report be received.

77. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2014/15.

The Chair referred to the current consultation taking place on the Disability Related Expenditure under the Care Act 2014 and asked for this to be added to the Work Programme. The Strategic Director of Adult Social Care briefly outlined the arrangements for the consultation and the proposed changes. This item was not currently on the Adult Social Care Scrutiny Commission's Work Programme; but the Director undertook to discuss this with the Chair of the Adult Social Care Scrutiny Commission. If it was decided to add it to their Work Programme a copy of the report would be copied to the Commission for

information.

AGREED:

That the Work Programme be noted and that the following items be added:-

a) Future Budget Items – April Meeting
b) Maternity Care Services

ACTION:

The Scrutiny Policy Officer to update the Work Programme with the additional items above.

The Strategic Director of Adult Social Care to discuss the Chair's request with the Chair of the Adult Social Care Scrutiny Commission.

78. CLOSE OF MEETING

The meeting closed at 8.05 pm.