Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 23 AUGUST 2017 at 5:30 pm

P R E S E N T:

Councillor Cutkelvin – Chair
Councillor Fonseca – Vice - Chair

Councillor Chaplin Councillor Dempster
Councillor Myers

In Attendance:

Councillor Palmer	Deputy City Mayor
Richard Morris	Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group

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14. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Corrall.

15. DECLARATIONS OF INTEREST

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

16. CHANGE OF MEMBERSHIP OF THE COMMISSION

The Monitoring Officer reported that Councillor Myers had been appointed to the Commission in place of Councillor Cassidy.

17. MINUTES OF PREVIOUS MEETING

AGREED:

that the minutes of the meeting held on 21 June 2017 be approved as a correct record.

18. ACTIONS FROM PREVIOUS MEETINGS

The Chair referred to actions requested on previous Commission meetings and reported that:-

a) The Chair referred to actions requested on previous Commission meetings and reported that:-

a) The Director of Public Health had provided a written response to the questions submitted by Mr Johnson at the last meeting and the reply had been circulated to members.

b) She had attended a regional meeting which covered an update from EMAS which had been interesting and informative. There was still a specific issue in relation to the handover times at the Leicester Royal Infirmary. The Chair had, therefore, invited both EMAS and UHL to the Commission's meeting in October to discuss the issues and the steps being taken to reduce the delays.

c) The Chair expressed disappointment that the dates for the Lifestyle Services Workshops had not been provided as requested. A further workshop on 'healthy start' was planned for September. An update on the workshop outcomes had been requested for the October meeting. The Chair felt that it was important to have widespread discussions in relation to the prevention agenda.

d) An updated report on Lifestyle Services and information relating to letters issued for the Healthy Lifestyle Hubs has been sent out today.

e) The Deputy City Mayor had organised a member workshop in October for the lifestyle review. Further information relating to Infant Mortality had been received by e-mail earlier in the day and the Chair would consider whether this required further consideration at a future meeting.

f) A response had been received to the request for information on the number of elective surgery operations being cancelled and re-scheduled. There were still some issues over waiting times for elective surgery across the 3 CCG areas primarily due to bed blocking and diversion from emergency care procedures. The issue was linked to acute care at the LRI and this could be revisited when the STP was considered.

g) The issue of staff sickness raised at the last meeting had been reported at OSC and a report would be considered by the Committee at its next meeting.

h) The suggestion by the commission that FAQ's be provided for patients being offered Shared Care Agreements (FAQ) was being considered by the three CCGs. The CCGs proposed to issue general information to patients first and then develop further detailed information depending on

medicines used by the patient. The General Q&A would be issued shortly and the imminent and Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group would supply details of the timetables for which specific QAs relating to patients medicines would be taken forward first.

19. PETITIONS

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

20. CHAIR'S ANNOUNCEMENTS

The Chair reported that a workshop on Healthwatch and its future in the City had been organised by the Deputy City Mayor and a number of members had indicated they wished to attend. A Consultation had been launched on the future provision of Healthwatch in LLR had been launched. The Chair requested that all members of the Commission be sent details of the workshop when the date had been confirmed.

A response had also been received to the Chair's letter to the Secretary for State for Health in relation to members concerns at NHS England's proposal to cease commission Level 1Congenital Heart Disease Services at Glenfield Hospital. The letter had been circulated to members of the Commission.

21. 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 questions from Dr Sally Ruane, Campaign Against NHS Privatisation outside the time limits allowed by the Constitution for it to printed on the agenda but had used discretion to accept them as they raised relevant issues to the Sustainability Transformation Plan process.

The Chair had recently met CANP who had expressed their concerns and frustrations around the transparency of the STP process. A number of these concerns related to the organisational systems for developing the STP and the Chair felt it was helpful to have these issues address in public.

The questions and the responses received from officers are set out below:-

QUESTION 1

What are the channels and processes used by the City Council's representative(s) on the STP System Leadership Team (SLT) meetings for feeding back, updating and consulting councillors and officers, including but not confined to members of the scrutiny commission, regarding developments and

proposals at SLT meetings. Are any of the records / notes arising from these feedback mechanisms available to the public?

RESPONSE

The Strategic Director for Adult Social Care represents the City Council on the System Leadership Team (SLT). Minutes of the SLT meeting are shared with all members of the meeting, and these are available to other relevant officers in the City Council through the Strategic Director. Verbal feedback from the Strategic Director is undertaken with the City Mayor and Deputy City Mayor on relevant matters arising from the SLT. The Strategic Director (with the support of the Director of Public Health) discusses specific matters arising from the SLT with the Deputy City Mayor (as lead member for both Adult Social Care and Public Health) as part of ongoing management of business. The Strategic Director and Director of Public Health advise both the Chairs of Health Scrutiny and Adult Social Care Scrutiny as to any matters arising from SLT discussions that may be of interest to Scrutiny Commissions as part of the Scrutiny agenda planning process. The Council engages in the SLT as it is a senior officer forum for wide partnership and system development across the health and social care agenda, including but not only limited to matters relating to the Sustainability and Transformation Plan. The SLT supports and enables strategic planning and operational partnership working between health and social care. It supports and drives service improvement work relating to specific care pathways and needs relating to the care and health of the LLR population

QUESTION 2.

On what grounds are STP system Leadership Team meetings taking place in private? We believe these meetings are subject to the 1960 Public Bodies (Admission to Meetings) legislation and, as meetings of a joint committee of the CCGs, should be held in public.

RESPONSE - The following response from the Senior Responsible Officer for the Sustainability and Transformation Plan on behalf of the 3 CCGs was not received by the time of the meeting but has been included in these minutes for completeness.

The System Leadership Team (SLT) is primarily an operational management group with representation from the partner organisations across Leicester, Leicestershire and Rutland. Its main purpose is to keep under review the development of the proposals for the plan of the Sustainability and Transformation Partnership for consideration by each of the statutory organisations who are the decision makers. Key decisions relating to any proposed changes to local services are then made in public by the boards and governing bodies of the respective NHS organisations, including both the providers (hospitals) and CCGs (commissioners).

Going forward, to help aid greater transparency, SLT papers will be shared with the BCT patient and public involvement group - which is made up of service

users, patient champions and experts by experience. Minutes from the SLT meetings will continue to be presented to each of the CCG Governing Bodies in their public meetings, with these papers accessible through the respective CCG websites.

QUESTION 3

How does the Scrutiny Commission feedback its position on various NHS policies brought before it to the council as a whole?

RESPONSE

The scrutiny commission is part of a wider working of the council. All scrutiny commissions feed into the Overview Select Committee as the parent scrutiny committee, which comprises the Chairs of all the scrutiny commissions and the two members of the opposition. OSC and the other commissions also feed information with regards to their work into the wider Council structure. All Chairs meet regularly with members of the Executive to discuss issues and these can lead to debates at Council, as has happened previously with regards to the STP. All officers present also feed information back via channels of communication as described in the response to question 1. Minutes of all meetings are made public and are available to all Members of the Council.

QUESTION 4

What plans has the Scrutiny Commission for joint scrutiny (with other HOSCs in LLR) of the STP plans and proposals ahead of the final formulation of topics for consultation and consultation documents?

RESPONSE

As was agreed at the meeting on 14th December 2016 of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Committee, all three authorities agreed to consider elements of the STP separately based on local concerns. It was agreed that once these discussions had occurred for each authority and once information with regards to the public consultation was clear, the committee would reconvene. Prior to this meeting taking place, information on the local issues discussed by each authority would be shared with each other.

In response to Members' questions on the responses it was noted that:-

a) The date of the LLR Joint Health Scrutiny Committee would be dependent upon the timing of the 2nd draft of the STP being made public.

b) The Deputy City Mayor Rory had written to Chairs of the Health and Wellbeing Boards in Leicestershire and Rutland to urge them to press for the early publication of what currently exists for the STP including the financial re-modelling.

c) That whilst the frustration with the STP process was understood it was

preferable to have questions which supported the scrutiny process and did not appear hostile in their intent. There was provision in the constitution to request questions to be reworded if they appeared defamatory or personal.

22. SEXUAL HEALTH AND HIV PREVENTION: SERVICE REVIEW

The Director of Public Health submitted a report providing an overview of the City Council's Sexual Health services together with a summary analysis of the local need for these services.

A spending review of these services was currently underway with proposals being considered by the Executive this summer. A further report would be submitted to the Commission later in the year following public consultation on the review.

It was noted that:-

a) Leicester had a higher than average level of under 18 year old conceptions. The City had a larger proportion of under 18 year olds in the population than the average and there were also high levels of deprivation.

b) There were more health needs in the west than the east of city and services needed to reflect the needs of the population. The population in the east of the City preferred to have services provided in central clinics rather than in their own local area.

c) Leicester had the 5th highest level of HIV outside of London and there are high rates of late diagnosis of HIV. This resulted in poorer outcomes for patients. If HIV is diagnosed and treated early there are good life expectancy outcomes for patients. Ethnic minority populations are more at risk, men having sex with men and those working in the sex industry.

d) Outreach services were available for each risk area and there was an open access to sexual health services. Individuals could go anywhere in country for treatment to avoid stigma and the cost would be recharged to the patient's own area.

e) The budget for sexual health services had been reduced and the challenge was now to provide services at a suitable level to meet the needs within the available budget. Providing services digitally or on line were being investigated.

f) The current service contract ends on 31 December 2018 and the tender process for the new service start at the end of 2017 to enable the new service to be in place by 1 January 2019.

g) The use of text alerts had been used for many years to advise individuals of negative test results but these did not replace the need to

make an appointment where the test was positive and there was a need for a doctor to discuss the result the patient and to discuss their sexual behaviour and the effects if can have on their partners. It was planned to increase the use of text and e-mails in the future and also increase the use of apps to make access more accessible to young people. Use of texts and e-mails were considered to be more convenient for patients and a more efficient use of staff time.

h) It was also proposed to enable individuals to requesting testing kits for STIs and HIV on line. The test kit would then be delivered to the individual's home for them to take a self-assessment test and return the kit for analysis. The provision of vending machines to dispense test kits in Universities was also under consideration.

Following questions the following response were received:-

a) The service also provided training for a wide range of staff from school nurses to teachers and schools who needed a basic level of training to carry out Relationship and Sex Education in schools and colleges. Not all schools had taken advantage of this training and the service was currently working with 10 schools and 2 colleges. Officers have raised the issue of providing the service to all 19 schools, as the new Children's Act would make it mandatory for Relationship and Sex Education (RSE) to be provided in schools. There were also similar issue of access to schools for flu and other public health initiatives.

b) The service commissioned Long Acting Reversible Contraception (LARC) from both GPs and from centralise services. There was a mixed take up of GPs offering this service, partly due to the aging population of GPs and some of the younger GPs not been training in providing the service. Officers had visited GPs to see how the provision of this service could be increased and how the core competency of undertaking 15 procedures per year could be achieved and maintained. The dual approach to providing the service both in GP practices and in a central service was based upon preferences express by patients. There were still issues of how GPs were paid for delivering these services, access to the service and the training of staff to provide them, which were all being addressed. The possibility of a GP referring a patient to another GP in the locality that offered the service was also being considered.

c) The provision of cervical screening was the responsibility of NHS England and officers had been working for some time to have this service reinstated in St Peter's Health Centre. This had been successful and the service would recommence in the next two months. The Deputy City Mayor commented that St Peter's Health Centre was no longer the most suitable location for the service and he looking to re-locate it to a city centre location where to would be more accessible and more affordable for the future budget provision.

d) On-line services would still offer a triage system and if the person

triggered certain criterion they would be asked to make an appointment come to see a health professional.

e) The service provided 3 male sauna clinics in the city and a clinic at Trade for the LGBT community. More work would be undertaken with this community in the future and the service was available for both men and women.

f) Appropriate counselling for sexual health issues which were related to a patient's mental health were also available.

Members felt that:-

a) Given the higher use of condoms in City and the high use of Emergency Hormonal Contraception from pharmacies it would be preferable to promote the use of LARC.

b) The Commission should write to the Strategic Director of Education and Children Services to encourage schools to take up the sexual Health services offer of RSE in schools and well as the other public health initiatives. It was noted that some schools currently found it difficult to encompass Relationship and Sex Education with the curriculum, but they would need to do so in the future. It was also suggested that it would also be helpful for Public Health England to raise the issue with Ofsted.

c) The service should also allow sufficient provision for the older persons' cohort as well.

AGREED:

1. That the report be noted and that a further report be submitted to the Commission at the end of the consultation period.

2. That the Strategic Director of Education and Children's Services be informed of the Commission's concerns for the take up of training for Relationship and Sex Education in all schools and that the Commission write to Public Health England suggesting they raise the issue with Ofsted.

23. SETTINGS OF CARE POLICY

The Commission received a verbal update from the Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group on the current situation in relation to the Settings of Care Policy. It was intended to submit a report to the December meeting of the Commission.

The Settings of Car Policy which provides individual support care and provides guidance on the funding for care in that setting was first drafted in 2011. A review of the policy had been led by East Leicestershire CCG and the final

draft on the review had been considered by the Leicester City CCG in July. The City CCG had decided not to adopt the revised policy at this time as it had felt that further work was required in relation to the impact assessment of the change upon the poorest and poorliest section of community receiving the care. This was because of the proposed reduction from a 25% cap to a 10% cap.

The CCG had asked for further impact studies to be undertaken over the next 3 months. The impact upon new patients would be reviewed as if new policy was in place to see the impact it would have. These reviews would end in November and the CCG would consider the issue again by January 2018. The existing 2011 policy would remain in force for the City and West Leicestershire CCGs until the issue was considered again following the current review. Although the East Leicestershire CCG had approved the policy they had not yet decided when it would be implemented. The City CCG had taken this action because it affected patients with a severe disability such as a brain injury. Patients could live for a long time and require significant support for their care either at home or in a setting of their choice. There was a risk with the proposed changes that some vulnerable patients could be moved out of a home setting and put in an institutional setting, which could impact significantly upon both the patient and their family.

The Deputy City Mayor welcomed the CCG's decision not to proceed at this time. He had concerns that there was risk of post code lottery in relation to Care Policy within the 3 CCGs for LLR. He felt this was part of an issue around the sustainability of the working arrangements for the 3 CCGs and the need for coherence within the system.

Members commented that:-

a) This showed the fragmentation within the current system and it was questioned how the STP could be applied across the LLR footprint if there was going to be differential implementation of the policy within the geographical area of the STP.

b) The continuance of 3 separate CCGs was questioned as the current situation could lead to differential standards of patient care within the STP.

c) It was also considered that health inequalities would be amplified by the 3 CCGs working differently in affluent areas to those with high levels of deprivation

The Chair commented that there would be an opportunity to look at the issue in more detail in November. The Chair commented that the Council had already received letters asking this issue to be considered.

24. GENERAL PRACTICE FORWARD VIEW

Leicester City Clinical Commissioning Group submitted a report providing an update on the development and delivery of the Leicester City CCG Primary

Care Strategy and how it linked with the General Practice Forward View (GPFV) delivery across the Sustainability and Transformation Planning (STP) footprint of Leicester, Leicestershire and Rutland (LLR). The paper focused on reporting against delivery of key milestones for Q1 and Q2, and described some of the links between national and local approaches to supporting and sustaining primary care in Leicester City.

The Chair stated that Members had already received to briefing to better understand the process and reasons for the Five Year General Practice Forward View and the Primary Care Strategy in the context of the STP. It was likely that this issue would be re-visited as part of subsequent discussions on the STP.

The Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group stated that:-

a) The Five Year General Practice Forward View was a national directive to address the primary care challenge across the country. The review covered issues of access to GP services, workforce of GPs and other practice staff and funding of primary care. The CCGs were required to prepare a plan across the LLR footprint on the delivery of services in the next 5 years.

b) The initiative included practical and funding actions against five key areas, investment, workforce, workload, infrastructure and care re-design. A key element was the 'Releasing Time for Patients programme which included support to accelerate change either within individual practices and federations of practices. There were 10 high impact areas to support this initiative but it was not expected that all practices and federations would implement all 10 areas but it was expected that practices would develop at least 2 or 3 of them. There would be some limited funding per patient to support practices.

c) Access to GP services in Leicester had traditionally been amongst the worst performing nationally in the last 10–15 years. Leicester had regularly been in the bottom 5% percentile. The CCG had attempted to improve access by investing in hubs to give as much opportunity as possible to access GP services. The 3 hubs provided 1,300 additional appointments per week. The hubs had full access to all patients' records and were therefore able to take into account the patient's history and current medication during the consultation and treat the patient as though they were consulting their own GP. The hubs had been successful and were utilisation rate of 95%. They were busy during the day and on Saturday's but demand dropped significantly after 1.30pm on Sunday's. The CCG was in the process of procuring the hubs on a permanent basis.

d) The CCG had operated a Golden Hello scheme to attract GPs to work in the City. This had been successful in recruiting 11 GPs in the first 2 phases, with a third phase open to all practice staff currently ongoing.

The CCG was also now involved in an international recruitment exercise. The CCG were also trialling 9 pharmacists working in GP practices to review patients' repeat prescriptions and their future treatment.

e) Primary care had been underfunded historically and there were also inequalities between those GP practices funded at the highest and lowest levels. The CCG had re-invested more than £500k from existing funds to bring GP practices in Leicester up to and above the national minimum level of funding of £85 per patient. It had also recycled approximately £2m of funding from within its existing budgets to provide additional funding for primary care services in Leicester.

Members of the Commission made the following observations:-

a) There was a danger in the move to a federated model for GP services that a drift to larger contacts could lead to decisions being made at corporate levels outside of the City and the autonomy of local people could be reduced and compromised.

b) A number of low level mental health issues could be improved by patients engaging in physical and community activities such as gyms/outdoor gyms, gardening clubs, local health clubs and other community groups such as arts clubs etc. It was important that GPs had extensive knowledge of the local non-medical support that was available in the community.

c) With the advent of federations delivering health services there was a possibility that a different levels of primary care could develop over a wider area of the city if a federation decided not to provide some services, such as the 10 high impact actions.

d) The reliance on transferring more care to the social care sector was of concern given the current budgetary pressures already faced by that sector. Questions were raised at the long term sustainability of the element of the government's vision for the STP.

e) Concerns were expressed that the pubic were not being consulted on these proposals and they need to be involved and understand the reasons for the changes in order that their perceptions of access to health services changed to support the models being proposed. If, not then this could give rise to disappointed patient experiences.

h) The model should also incorporate provisions for mental health as well as physical health. Continuity of care was also important and patients should be allowed priority for subsequent appointments.

i) It would be helpful in social prescribing if IT systems could include flags to enable GPs to engage with none medical solutions to arrange adaptations to houses for patients with mobility issues.

Following discussion of the report the Director of Operations and Corporate Affairs responded to Member's questions as follows:-

a) The CCG were not proposing to issue guidance on how a federation should work or operate, but wanted to work with federations collaboratively to ensure they addressed primary care challenges in the City. There were currently 2 federations in the City that were providing a range of services. These included providing the City's GPs hubs to help practices share back office functions. There was no limit on the size of a federation and it did not appear that a single federation across Leicester City would be likely at the present time. At present just over half of the GP practices in the City were part of a federation.

b) Most GPs were of the view that that the current model was not sustainable in the long term and the present system needs to change. GPs considered that they should still be at the centre of patient care but with other professionals such as pharmacies, nurses and paramedics taking on more responsibility for appropriate patient contacts, allowing GPs to focus on patients with the greatest need such as the elderly and those with several long term health conditions. Changing to this model of health care would need a shift in the expectations of patients and it would be essential to engage patients to explain the proposals and to seek their views.

c) The CCG were considering the practicalities of one of the three hubs offering appointments for Sunday afternoons, rather than all three hubs being open and resources not being used to the best effect.

d) The CCG commissioned Inclusion Healthcare to provide medical services to homeless and asylum seekers and they carried out outreach work for the homeless, asylum seekers and other hard to reach communities. They provided good services and the CCG felt that the current model provided a robust service delivery. Inclusion Healthcare could choose if they wished work with a federation if they needed to provide services at scale. A homeless patient does not have to register in the City Centre with the Inclusion Healthcare practice as they can register with any GP practice.

e) GP services were funded through the current core contracts and if GPs failed to meet the standards of delivery required then the CCG had powers to take action under the provision of the contract. Services other than the core services, such as some sexual health services, were provided by local payments to GPs who wished to provide them. Some practices chose not to offer these services and they often don't feel they have the capacity to offer them.

f) The CCG were in the process of working with practices to provide training which would equip reception staff with knowledge for all services that are currently available in the primary care system, so that if a

particular GP practice had no available appointments they would have the ability to book the patient an appointment with one of the three hubs, direct the patient to a walk in centre or refer the patient to the NHS 111 service.

g) One reason for the apparent disparity between the population of the City and the number of patients registered with city GPs was that the number of patients registered with city GP practices tends to be 30k or 40k more than city population because of people living outside the city boundary but choosing to access city GP practices, often because they worked in the city.

h) Although these proposals were being included in the engagement arrangements for the STP it did not require statutory consultation under the STP itself.

i) There had been patient and public involvement in discussing the proposals for the Hubs and the feedback had been used to develop the way in which the hubs were provided. The provision of GPs services is determined by the primary care contracts that are issued by NHS England and the CCGs. Some practices are already working in the way described, as this is permitted by the contract. However, it was considered important to inform patients about the kind of changes they might see in their own practice and listen to their views. A programme to this was scheduled to begin in October. Some GP practices have been operating many of the current proposals for some years and some feedback from patient and public groups have questions why the changes had not already been implanted earlier.

j) The CCG were producing a public friendly facing document that would be used for public engagement purposes to clearly communicate what the proposals meant for patients. The CCG would look for opportunities to meet communities at outreach events and areas of high footfall.

The Chair commented that whilst the changes to GP services are understood many of the changes are happening already without a widespread public debate and many of the changes rely on the public taking more responsibility for their own health and health education. For example accessing cold cures at pharmacies and knowing that minor ailments such as coughs and colds can be treated through self-administration by the patient and do not always require a GP consultation. Part of the reason that more people are accessing A&E services is due to this as often patients cannot get GP appointments.

The Chair also felt it was important for the Commission to look at joint areas of interest with the Health and Wellbeing Board and for the Commission to make its views known.

AGREED:

That the report be received and that Members' comments be taken into

consideration as part of the public engagement process.

25. WORK PROGRAMME

The Chair submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2017/18.

Members requested that an update on the proposal to stop prescribing paracetamol and gluten free items be added to the work programme. The Chair stated this could be added to the item on repeat prescriptions which was being submitted to the November meeting.

26. CLOSE OF MEETING

The Chair declared the meeting closed at 8.30 pm.