Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 4 JULY 2019 at 5:30 pm

P R E S E N T :

Councillor Kitterick (Chair)
Councillor Fonseca (Vice-Chair)

Councillor Chamund
Councillor March
Councillor Dr Sangster
Councillor Westley

In Attendance:

Councillor Dempster, Assistant City Mayor - Health
Councillor Joshi
Councillor Khote
Councillor Solanki

Also Present:

Councillor Clair, Deputy City Mayor -
Culture, Leisure, Sport and Regulatory Services
Councillor Nangreave
Councillor Valand
Councillor Whittle

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1. APOLOGIES FOR ABSENCE

No apologies for absence were received

2. DECLARATIONS OF INTEREST

No declarations of interest were made.

3. CHAIR'S ANNOUNCEMENTS

The Chair noted that local media recently had covered proposals for future

services at Leicester hospitals and explained that these would be considered under agenda item 11, “Introduction to the NHS Long Term Plan”.

4. MINUTES OF PREVIOUS MEETING

AGREED:

that the minutes of the meeting of the Health and Wellbeing Scrutiny Commission held on 12 March 2019 be confirmed as a correct record.

5. TERMS OF REFERENCE FOR SCRUTINY COMMISSIONS

AGREED:

That the Terms of Reference for scrutiny commissions be noted

6. MEMBERSHIP OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION

AGREED:

That the membership of the Health and Wellbeing Scrutiny Commission for 2019/20 be noted.

7. DATES OF THE HEALTH AND WELLBEING SCRUTINY COMMISSION MEETINGS

AGREED:

That the dates of meetings of the Health and Wellbeing Scrutiny Commission for 2019/20 be noted.

8. PETITIONS

The Monitoring Officer reported that no petitions had been received.

9. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations, or statements of case had been received.

10. PRIMARY CARE HUB ACCESS AT THE MERLYN VAZ HEALTH AND SOCIAL CARE CENTRE

The Leicester City Clinical Commissioning Group submitted a briefing paper looking at the rationale and impact of moving from a walk-in appointment system to a combined pre-bookable and walk-in appointment system at the Merlyn Vaz Heath and Social Care Centre.

Richard Morris, Director of Corporate Affairs, Leicester City Clinical Commissioning Group, introduced the briefing paper, drawing attention to the following points:

- The Merlyn Vaz Centre received 24,000 – 26,000 patients per year.

Approximately two-thirds of these were from the city, the remainder being from the county and Rutland;

- When it was set up, it had been anticipated that operating a walk-in appointment system at the Centre would reduce demand on the hospital emergency department, but the number of people attending that department continued to increase;

- Three GP hubs had been established to improve routine access to pre-booked primary care appointments by providing an additional 1,500 additional GP and nurse appointments across the city. These were well used;

- At the time that the walk-in centre contract was due to end in 2017, government guidance indicated a move towards providing pre-booked appointments, rather than a walk-in service;

- Engagement with patients showed a desire to keep the service in the community, but also a desire for pre-bookable appointments in addition to a walk-in service. The new service therefore was commissioned as a hybrid model, with approximately 20% walk-in activity. This equated to approximately 400 bookable appointments and 100 walk-in appointments per week;

- A decreasing number of patients had been deflected from the "front door" over the last 6 – 12 months;

- Most patients regarded the service received in the hub as "good", although there was some frustration that the walk-in facility had been reduced; and

- The new hybrid system appeared to have resulted in a better dispersal of patients across the city.

At the invitation of the Chair, the Right Honourable Keith Vaz MP addressed the Commission. For clarity, he explained that the Merlyn Vaz Centre had been named after his mother and that Professor Farooqi, Co-Chair of the Leicester City Clinical Commissioning Group, was his GP.

Mr Vaz noted that, when people were unable to see their own GPs in a timely manner, the walk-in centre provided an alternative means of accessing health care. It was recognised that funding for services had been reduced, but as the walk-in centre was intended to provide an alternative means of accessing a GP to introduce an appointments system was against the purpose of the Centre. Lack of walk-in facilities also meant that patients were diverted to hospital Accident and Emergency services, so moving the problem of access to services to a different part of the system. This showed that the current balance of appointments and walk-in services at the Centre was wrong.

Mr Vaz asked the Commission to consider undertaking its own survey, to identify what people were looking for from GPs and GP hubs, and offered to

help run a local referendum, with the Ward Councillors, to identify if there was a desire for the Merlyn Vaz Centre to return to being a walk-in centre.

In response, Mr Morris explained that the survey undertaken to assess the impact of the change in services at the Merlyn Vaz Centre had largely been face-to-face with people in the building and patient participation groups. There had been 258 respondents, which was considered a normal rate of response for this type of engagement work.

Mr Vaz queried why the results had been given in percentages, rather than actual numbers and sought reassurance that the questions used in the face-to-face discussions had not been designed to provide a particular result.

Professor Farooqi, Co-Chair of the Leicester City Clinical Commissioning Group, expressed the view that both walk-in and appointment services were needed at the Centre, as the hubs provided services for GP practices, due to the city not having enough GPs. Bookable appointments resulted in a better flow of patients, with less waiting time and a levelling out of peaks and troughs in demand.

Professor Farooqi also noted that booked appointments catered for city residents, while a lot of the people using the walk-in facilities lived in the county. Ideally, both facilities would be provided, but it was recognised that resources were limited.

Mr Morris advised Members that no evidence had been found of an increase in the number of people attending hospital Accident and Emergency services as a result of reducing the walk-in service, but an audit of people attending these services was being undertaken and could provide more information. Professor Farooqi noted that some correlation was possible to people who had recently arrived in the country, as some countries had limited GP services, so people were used to using hospital services. Also, it was known that homeless people would attend hospital as they often were not registered with a GP. It also was know that people in the 0 – 30 age group used hospital services the most.

Mr Morris advised that currently no follow-up was done on people deflected from the services at the Merlyn Vaz Centre. However, the service provider had been asked to examine the data and undertake a retrospective audit over the next few months, to see if any links could be found between the number deflected and use of other services. As part of this, the advice given to those deflected needed to be noted, so that an accurate audit trail could be established.

Sarah Prema, Healthwatch, advised that Healthwatch had visited two hubs to date, to examine patient experiences of services. These experiences had been mixed, with good clinical care, but some confusion caused by a lack of awareness of the change to a hybrid access model. Healthwatch hoped to visit the other two hubs shortly, so offered to assist in assessing the impact of the change to a hybrid system.

Mr Vaz suggested that it would be helpful for the Commission to undertake an in-depth review, through which local people were asked whether or not they liked the walk-in facility at the Merlyn Vaz Centre. He also requested that community languages be used for this. Professor Farooqi suggested to the Commission that, although he did not oppose the suggested survey, some work also could be done to develop services at Leicester General Hospital, so that both systems could be used.

Members stressed that any such review needed to reflect the demography of the city and expressed some concern that the number of responses on which the decision to move to a hybrid system had been based was a very small proportion of the city's population.

Mr Vaz also expressed concern about the future use of Leicester General Hospital. He explained that he considered that the city needed three hospitals, although they did not all need to offer the same services. Reports already were being received that people had to queue to be admitted to some wards at Leicester Royal Infirmary, so Mr Vaz asked that the site of Leicester General Hospital be retained and not sold to developers.

With the permission of the Chair, Councillor Khote addressed the Commission, echoing concerns raised by the Commission that the shortage of GPs across the city was at crisis level. For example, no GP appointments were available at some practices by 9.30 am, so people were being told to attend the walk-in centre. However, at the walk-in centre they were being told to telephone the 111 service, but that service often referred people to services located in parts of the city that people could not get to. Many of these people were limited in the amount of English they could speak. They therefore often chose to use the walk-in facilities at the Merlyn Vaz Centre, as the Centre could be accessed by public transport.

She further noted that it took a along time to train doctors, but in the meantime the number of doctors coming in to the country from abroad had been affected by immigration restrictions. In addition, locum doctors were too expensive for some practices to use. The walk-in centre therefore was a very important resource, serving people from a wide area, so it either should be kept, or a better appointment system used at GP surgeries.

With the permission of the Chair, Councillor Solanki addressed the Commission. She concurred with the views expressed by Councillor Khote and suggested that GP appointments needed to be available at times more suited to people's needs, such as at night.

With the permission of the Chair, Councillor Joshi addressed the Commission, noting that the flow of patients using the walk-in service resulted in peaks and troughs of demand. Better resources therefore were needed at GP surgeries, to ensure that people could access GPs when needed. The Councillors representing the Evington Ward would welcome the suggested consultation with members of the public and were happy to assist with this as needed.

Members expressed concern at the potential exclusion of people with lower digital and/or technical skills, due to the increased use in health services of digital access. Professor Farooqi acknowledged that this was an issue, explaining that work on this was ongoing, along with ensuring that people were not excluded due to language skills.

AGREED:

1) That the Director of Corporate Affairs, Leicester City Clinical Commissioning Group be asked to provide numerical and demographic data on where people using hospital Accident and Emergency services in the city are from, if possible this information to be broken down to show attendances at times when GP practices are both open and closed;

2) That representatives of the Leicester City Clinical Commissioning Group and Healthwatch, plus the Right Honourable Keith Vaz MP, be invited to join discussions about how an analysis of patient experiences following the introduction of a hybrid system for accessing services at the Merlyn Vaz Centre can be undertaken;

3) That as much as possible of the work outlined under 1) and 2) above be undertaken in time for the outcomes to be included in the report scheduled to be considered at the next meeting of this Commission on the Primary Care Strategy; and

4) That, further to 3) above, the report scheduled to be considered at the next meeting of this Commission on the Primary Care Strategy include if possible:

   a) Consideration of the implications of the shortage of GPs in the city;

   b) Information on how the survey undertaken following the introduction of a hybrid system for accessing services at the Merlyn Vaz Centre was undertaken, including examining equality monitoring information, details of who was surveyed and how the questions were worded;

   c) How issues for people with limited digital and English language skills can be addressed;

   d) What happened to the people deflected from using the walk-in facilities at the Merlyn Vaz Centre, (for example, whether they used services located elsewhere in the city); and

   e) Consideration of how any further evidence required to enable proper consideration to be given to the issues recorded above can be obtained.

11. INTRODUCTION TO THE NHS LONG TERM PLAN

As agenda items 11, ("Introduction to the NHS Long Term Plan") and 12, ("The Development of Primary Care Networks"), were considered together, please see minute 12 for the discussion on this item.

12. THE DEVELOPMENT OF PRIMARY CARE NETWORKS

As agenda items 11, ("Introduction to the NHS Long Term Plan") and 12, ("The Development of Primary Care Networks"), were considered together, the discussion on both items is recorded in this minute.

Sarah Prema, Director of Strategy and Implementation with Leicester City Clinical Commissioning Group presented a briefing paper setting out the key requirements of the NHS Long Term Plan (LTP).

Ms Prema reminded the Commission that the LTP contained a vision for how the NHS would develop over the next 5 – 10 years and what it would deliver. Previously, a commissioner and provider model had been used, creating contractual relationships, but the new model moved towards a partnership relationship. The key to this would be to consider services from a Neighbourhood, Place and Systems perspective. For example, Place would help in the consideration of services that could not be delivered economically at a Neighbourhood level and Systems would relate to sets of outcomes based on the health needs of the population under consideration.

MS Prema then drew attention to the following points:

- As part of the LTP, it was anticipated that Integrated Care Systems would be designed and in place nationally by 2021. These would be developed from Sustainability and Transformation Partnerships;

- The first thing that needed to be done under the LTP was to establish Primary Care Networks;

- The draft People Plan had already been published, giving some direction for national initiatives on how recruitment was to be undertaken; and

- In creased use of technology, (digitally enabled care), would be embraced in all aspects of care. For example, it was anticipated that patient follow-up appointments could be reduced by one-third through the use of technology. This would release resources for use in other areas.

Richard Morris, Director of Corporate Affairs, Leicester City Clinical Commissioning Group, then discussed the development of Primary Care Networks (PCNs), showing the presentation attached at the end of these minutes and making the following points:

- PCNs were an element of the Neighbourhood part of the LTP;

- PCNs required groups of GPs to work together, so were not a new idea;

- GPs had been asked to come together in groups of registered populations of between 30,000 and 50,000. The former was a minimum number that would be acceptable, but there was a small degree of flexibility regarding the upper number;

- PCNs were formal arrangements, which they had not been previously, having contracts from Clinical Commissioning Groups to provide primary care;

- All PCNs were required to appoint a Clinical Director and would receive funding for this and other specified roles. It was understood that the Clinical Directors all would be current GPs;

- A number of service specifications would be issued at a national level in April 2020; and

- Ten PCNs had been created across the city. All GP practices were participating.

Members expressed concern that GPs already were unable to cope with the demands being made on them and queried how these changes would improve that situation. In reply, Professor Farooqi, Co-Chair of the Leicester City Clinical Commissioning Group, explained that the aim was to reduce outpatient numbers by 30%. However, these people needed to be seen somewhere else, so PCNs were being designed to have organisational structures that would enable work now being done in hospitals to be done in the community instead. Some services, such as lifestyle services, (for example, smoking cessation), could be tailored to particular areas, as they could be delivered within distinct boundaries.

It was noted that patients would no longer be able to reorder prescriptions from pharmacies, but would have to go through a GP instead, raising concern that this would in crease the burden of work on GPs. In response, Professor Farooqi explained that ordering of repeat prescriptions from pharmacies had led to great wastage of drugs, as many pharmacies reissued every drug on the prescription, irrespective of whether it was needed or not, so this change should reduce costs. When someone's medication was stable and there was no reason to change it, doctors also could consider prescribing six months' medication.

Members also suggested that it would be beneficial to have more nurses in GP surgeries, but Professor Farooqi explained that very few nurses were being trained to go in to general practice, as most remained working in hospitals. Mark Whightman, Director of Marketing and Communications at University Hospitals of Leicester NHS Trust, confirmed this, noting that there currently were 600 vacancies for nurses at the Trust. This was a safe level to work at, but there was no capacity to share nurses outside of the hospitals.

Concern also was raised that there could be a risk of creating a market between PCNs if there was not equity between them in the services provided. However, Professor Farooqi advised Members that funding for specific roles wold not be given if there was no-one in the post(s) to which that funding related. The main problem was likely to be whether there were sufficient people available to fill those roles.

The Commission enquired how much it was estimated the requirements of the LTP would cost and where this funding would come from. It also was questioned who would safeguard community resources when health services were being separated in to distinct parts.

Professor Farooqi advised Members that the NHS had set out plans for a ten-year investment programme in PCNs. As PCNs developed and services moved out of hospital settings, it was anticipated that resources would follow, so that services in the community could develop. Patient Participation Groups would be very important in holding PCNs to account.

The whole system would change, as CCGs and PCNs would work more collaboratively through Care Alliances. These would not be a way to let the private sector take over NHS work, as the emphasis would be on collaboration, rather than testing the market. As funding would be directed to achieving health outcomes, greater levels of funding could be directed to where the greatest health inequalities existed. Many of the targets being set were for 5 – 10 years, which was felt to be helpful, but it also meant that the national expectation that the targets would be met was greater.

Under the LTP, CCGs would have a more statutory role than at present, overseeing the management of the system. As a result of this, discussions were being held to determine whether it was appropriate to continue to have three CCGs for Leicester, Leicestershire and Rutland. Engagement would be undertaken to determine the most appropriate future structure for these CCGs.

Some of the funding for the LTP would be from central government, towards running services locally. It had not yet been decided what proportions of this would be passed to the PCNs and Care Alliances, but care would be taken to ensure that health inequalities were addressed.

The Commission suggested that it could be useful for health service organisations to provide officers, or work with voluntary organisations, to liaise with the community. This could be particularly beneficial in ensuring that people recently arrived in the city did not miss out on health services. Professor Farooqi agreed that this could be beneficial, including instances where staff from a PCN had particular language skills. It was hoped that PCNs would liaise with Councillors, either speaking to them direct or through PPGs. This would be facilitated by the majority of PCNs being geographically continuous.

Work had been done with PCNs with a wider geographical spread to ensure that those networks would work and that patients would not have to travel a

long way to access normal GP services during a normal working day. It was considered that if anyone had to travel it should be the GPs, not patients.

It was reported that patients already were asking how these changes would affect them and their care, especially regarding the changes scheduled to take place later. In reply, Mr Morris explained that it had not been possible to openly discuss PCNs while they were forming. The deadline for their formation had been 1 July 2019, so some restrictions had reduced and it now was possible to answer questions and provide other information.

Members noted that the summary of LTP requirements submitted with the reports were the minimum national requirements, so opportunities were available to add to it. Healthwatch had undertaken some engagement in order to inform the LTP and as this developed responses to the engagement would be incorporated in the schedule of requirements.

Some concern was expressed that dementia and older frailty were not mentioned in the summary, but it was explained that partners saw this as a key area for the city. Work on population health management was ongoing though, which included using data to understand the cohorts of patients who were intensive users of services.

In view of this, the Commission asked how it could help shape the LTP to towards local circumstances . Sue Lock, Managing Director of Leicester Clinical Commissioning Group, explained that there was a need for partners to work closely with Public Health officers to identify local health needs. This would then be reported through the Health and Wellbeing Board. However, consideration needed to be given to how wider input could be incorporated, as the draft requirements had to be ready by the end of September 2019, with the final version being completed by mid-November 2019.

AGREED:

That the Leicester City Clinical Commissioning Group be asked to submit a further report to the Commission, on a date to be agreed, on the NHS Long Term Plan, with particular focus on Primary Care Networks and Care Alliances, this report to include information on:

a) How funding for the Long Term Plan is to be calculated;

b) How Primary Care Networks will operate, (for example, how funding will be allocated and managed);

c) How the geographical spread of Primary Care Networks will be addressed to ensure that appropriate services for patients are provided;

d) How individuals and/or groups can contribute to Sustainability and Transformation Partnerships and Primary Care Networks;

e) How health inequalities will be addressed, especially through

funding;

f) How existing plans and protocols, such as the Winter Care Plan, will be embedded in new systems; and

g) If possible, a graphical representation of the structure of health services, showing what it is in place now and what they will be in the future.

13. ADJOURNMENT OF MEETING

The meeting adjourned at 7.47 pm and reconvened at 7.59 pm

14. PUBLIC HEALTH OVERVIEW AND FORTHCOMING WORK PLANS

Councillor Dempster, Assistant City Mayor for Health, reminded Members that currently there was a move towards community-based provision of public health services. As part of this, a holistic approach was being adopted, moving away from a narrow focus on health, which hopefully also would lead to greater parity between physical and mental health services. The presentation circulated with the agenda papers explained how work on this was beginning and observations from this Commission on this work were invited.

The Director of Public Health introduced the presentation that had been circulated with the agenda for this meeting. He noted that the ring fenced grant received from the NHS had been reducing and it was not know when these reductions would stop. At present, 0.9% of this grant was allocated for Public Mental Health in 2019/20 and Councillor Dempster expressed concern at this low level of expenditure. Members noted that 17.8% of this grant was allocated for "Other council services" in 2019/20. These were services such as sports, walking and cycling which added public health value but mostly fell within the remit of other scrutiny commissions.

The Director drew Members' attention to the work done by Mori, on the Council's behalf, to identify how Leicester residents rated their health. This had identified that 75% had rated their health as good in 2018. This was an improvement, but some significant challenges remained to be addressed. There were various determinants of health, some of which were lifestyle factors. However, it needed to be recognised that these factors were not always choices, as people could be driven in to situations. Consideration therefore needed to be given to how this could be addressed.

Members suggested that this provided an opportunity to work alongside primary care networks and asked how this could be achieved. The Director explained that it was hoped that the driver for future strategy would be through the Joint Integrated Commissioning Board. Although much still was unknown about the new structures proposed for primary health care delivery, the new joint health and wellbeing strategy provided an excellent opportunity to work with providers.

The Commission stressed the need for Public Health to work with services such as housing and social care services. The Director explained that this already was underway. For example, Public Health officers were in active conversation with Planning officers regarding standards for internal and external space in relation to housing. This was an example of how the delivery of some public health initiatives would be through other services.

AGREED:

1) That the Director of Public Health be asked to ensure that this Commission continues to monitor how the development of public health initiatives in relation to the development of primary care networks; and

2) That this Commission asks the Assistant City Mayor for Health and the Director of Public Health to consider giving early attention to developing a strategy for how Public Health could impact on housing space standards through the developing Local Plan, it being recognised that this will require evidence to be compiled, including the impact of these standards on mental health.

15. WORK PROGRAMME

The Commission received and considered its outline work programme for 2019/20, noting that this would be developed as the year progressed.

AGREED:

1) That the Chair of this Commission be asked to liaise with the Chair of the Children, Young People and Schools Scrutiny Commission to consider how issues such as education Health Care Plans for children, childhood obesity and children's mental health services can be scrutinised;

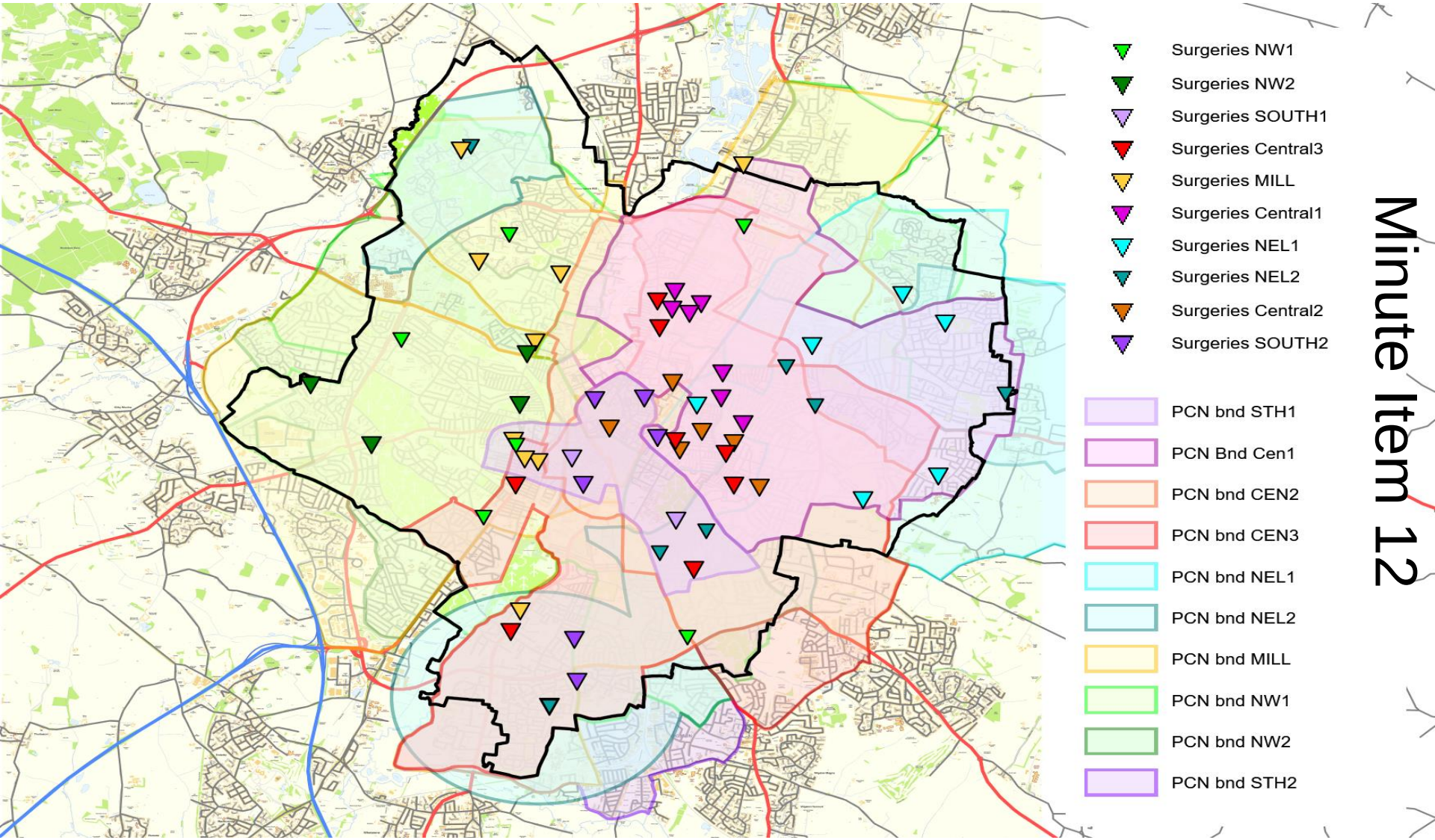
2) That scrutiny of Maternity Services be included in this Commission's work programme; and

3) That all Commission members be invited to advise the Chair, Vice-Chair or Scrutiny Policy Officer of any suggested items for inclusion in the Commission's work programme.

16. CLOSE OF MEETING

The meeting closed at 8.34 pm

Leicester City Primary Care Networks



Minute Item 12

CENTRAL PCN 1 - Belgrave & Spinney Hill PCN		
Clinical Director - Dr P Pancholi		
Practice Code	**Surgery**	**List Size**
C82037	East Park MC	10,486
C82037	East Park MC -Branch	
C82667	The Charnwood Practice	7,228
C82084	Canon St	3,197
C82024	Spinney Hill MC	20,834
C82024	Spinney Hill MC -Branch	
C82651	Broadhurst Surgery	4,029
Schedule 1	**Registration Form**	**45,774**

CENTRAL PCN 2 - Leicester Central PCN		
Clinical Director - Dr Rajiv Wadhwa		
Practice Code	**Surgery**	**List Size**
C82643	Community Health Centre	12,608
C82116	Highfields Surgery	3,744
C82642	Highfields MC	9,056
C82642	Highfields MC - Branch	
C82080	Shefa Medical Practice	4,769
C82060	Sayeed Med Centre	4,230
Y02686	Heron Practice	9,193
Y02469	Bowling Green Street	4,451
C82105	Ar-Razi	3,007
Schedule 1	**Registration Form**	**51,058**

CENTRAL PCN 3 - The Fox's PCN		
Clinical Director - Dr Vivek Sharma		
Practice Code	**Surgery**	**List Size**
C82659	Dr Kapur - St Peter's	2,684
C82119	Dr Kapur - Narborough Road	2,153
C82671	Dr Kapur - Brandon Street	5,000
C82088	Evington Medical Centre	8,953
C82088	Evington Medical Centre - Branch	
C82099	Al-Waqas	4,239
C82660	Dr D'Souza -St Peters	6,389
C82660	Dr D'Souza -Queens Rd	
C82669	Dr Sahdev - Surgery @ Aylestone	4,080
Schedule 1	**Registration Form**	**33,498**

NEL PCN 1 - SALUTEM PCN		
Clinical Director - Dr Aileen Tincello		
Practice Code	**Surgery**	**List Size**
C82031	Johnson MP	12,721
C82031	Johnson MP - Branch	
C82030	Downing Drive	6,932
C82033	Humberstone MP	10,289
C82676	St Elizabeth's	5,513
Schedule 1	**Registration Form**	**35,455**

NEL PCN 2 - Aegis Healthcare PCN		
Clinical Director - Dr M Roshan		
Practice Code	**Surgery**	**List Size**
C82029	Willowbrook	12,257
C82029	Willowbrook - Branch	
Y00137	The Willows	5,697
C82122	Clarendon Park MC	5,396
C82063	East Leicester MP	12,066
C82623	Heatherbrook Surgery	3,441
C82626	Pasley Road HC (Dr Khong)	2,247
Schedule 1	**Registration Form**	**41,104**

MILLENNIUM PCN		
Clinical Director - Dr Durairaj Jawahar		
Practice Code	**Surgery**	**List Size**
C82018	Manor Park Medical Practice	16,011
C82018	Manor Park Medical Practice - Branch	
C82094	Beaumont Lodge Medical Practice	6,906
C82094	Beaumont Lodge Medical Practice - Branch	
C82620	Briton street surgery	1,855
C82059	Westcotes Surgery 1	1,485
C82653	Westcotes Surgery 2	1,457
Y03587	Westcotes Medical Centre	6,504
C82107	Brandon Street Surgery	7,350
C82639	Westcotes Health Centre 2	5,982
C82092	Aylestone Health Centre	3,421
Schedule 1	**Registration Form**	**50,971**

City Care Alliance PCN (NW PCN 1)		
Clinical Director - Dr Umesh Roy		
Practice Code	**Surgery**	**List Size**
C82073	Merridale MC	14,938
C82610	The Parks	5,723
C82114	Fosse Family Practice	2,428
C82624	Beaumont Leys HC	6,730
C82614	Asquith Surgery	4,095
C82680	Spirit Rushy Mead	4,675
Schedule 1	**Registration Form**	**38,589**

Leicester Health Focus (NW PCN 2)		
Clinical Director - Dr Hafiz Mukadam		
Practice Code	**Surgery**	**List Size**
C82008	Oakmeadow Surgery	8,980
C82005	Groby Road MC	9,437
C82086	Fosse MC	8,931
C82053	Hockley Farm	10,846
Schedule 1	**Registration Form**	**38,194**

SOUTH PCN 1 - Leicester City & University PCN		
Clinical Director - Dr Aruna Garcea		
Practice Code	**Surgery**	**List Size**
C82020	De Montfort University	22,379
C82124	Victoria Park HC	22,855
Schedule 1	**Registration Form**	**45,234**

SOUTH PCN 2 - Leicester City South PCN		
Clinical Director - Dr Amit Rastogi		
Practice code	**Surgery**	**List Size**
C82046	Saffron Health	17,803
C82046	Saffron Health - Branch	
C82100	The Hedges MC	6,013
C82019	Pasley Road (Dr Singh)	4,844
Y00344	Assist	1,230
C82670	Inclusion Healthcare	1,014
C82662	Walnut Street MC	4,513
Schedule 1	**Registration Form**	**35,417**