Minutes of a meeting of the Health and Social Care Overview and Scrutiny Committee held on Thursday, 9 February 2017 in Committee Room 1 - City Hall, Bradford

Commenced 4.35 pm
Concluded 7.10 pm

Present – Councillors

CONSERVATIVE	LABOUR	LIBERAL DEMOCRAT
Gibbons Poulsen	Greenwood A Ahmed Duffy Mullaney Sharp	N Pollard

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer
Jenny Scott	Older People's Partnership

Observers: Councillor Richard Dunbar (Executive Assistant (Education, Employment and Skills)) and Councillor Val Slater (Portfolio Holder (Health and Wellbeing))

Apologies: Councillor Lisa Carmody

Councillor Greenwood in the Chair

65. DISCLOSURES OF INTEREST

(i) Councillor A Ahmed disclosed, in the interest of transparency, that she was employed by the Yorkshire Ambulance Service NHS Trust.

(ii) Councillor Sharp disclosed, in the interest of transparency, that she was employed by an organisation that received funding from Clinical Commissioning Groups in Bradford.

(iii) Councillor Mullaney disclosed, in the interest of transparency, that she was employed by an organisation that received funding from Clinical Commissioning Groups in Bradford.

(iv) Susan Crowe disclosed, in the interest of transparency, that she was commissioned by the Bradford Districts Clinical Commissioning Group and the Council's Health and Wellbeing department to deliver services.

(v) Councillor Gibbons disclosed, in the interest of transparency, that he was a member of the NHS Foundation Trust Board and a Patient Participation Group.

(vi) Councillor Greenwood and Sam Samociuk disclosed, in the interest of transparency, that they were members of Patient Participation Groups.

ACTION: City Solicitor

66. MINUTES

Recommended –

That the minutes of the meeting held on 17 November 2016 be signed as a correct record.

67. INSPECTION OF REPORTS AND BACKGROUND PAPERS

There were no appeals submitted by the public to review decisions to restrict documents.

68. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

There were no referrals made to the Committee.

69. DAISY HILL INTENSIVE THERAPY UNIT

The Deputy Director, Specialist Inpatient Services, presented **Document "Y"** which outlined the closure of Daisy Hill Intensive Therapy Centre at Lynfield Mount Hospital. It was explained that the main reason behind the closure had been that the forecast demand had not met the actual demand. Members noted that it was an internal venture and austerity measures along with the fact that people had not been referred, as the service was not locally commissioned, had affected the demand. The service had made a loss and the Trust had thoroughly considered the decision to close. The Deputy Director, Specialist Inpatient Services, reported that a total of eight patients, two local, had been treated at the Centre whilst it had been open and there had been an impact on those patients

that had accessed the service when it had closed. It was confirmed that the Trust had undertaken to support those affected. With regard to staff, Members noted that the Trust had managed to retain a high number of those that had been employed in the Centre.

Members then raised the following points:

- When Trusts closed facilities, people used the voluntary sector services more but no additional funds were provided.
- Why had the demand not met that forecast?
- Was there a need for the provision in Bradford? Were people not willing to pay?
- Had marketing been undertaken?
- It was a difficult area to fund and the Centre had only been open for 18 months. How had the error of judgement been made? Why had a great deal of money been invested and then the Centre closed?
- Would the local patients be able to access the same care in the District now?
- What about new patients?
- How many people had been diagnosed in the District?
- It was regrettable that the Centre had closed as the service was required and people would attend hospitals or a doctor's surgery instead, which would create further costs.

The Deputy Director confirmed that:

- The closure only had a limited impact as only two of the patients were local and the Trust had agreed to continue its support, however, it was acknowledged that the demand on the voluntary sector could increase.
- The Centre had provided 12 beds with an optimum length of stay of six months and 24 patients had been required per annum for it to be viable. Only eight had been admitted and not all had stayed for six months, therefore, the forecasted income had been well below the costs incurred.
- There was a need for the provision and the Trust would not have opened the Centre if they had not believed so. The financial challenges faced by Trusts were also being faced by commissioners. Marketing had been undertaken and service users were positive about the Centre but had limited funds. Despite there being patients that required the service, there were no funds available.
- An error of judgement had not been made and there would always be an element of risk when opening a service. The private sector had more funds and could afford to run at a loss for longer. Private providers had been asked how long it would be before they believed that the market would improve and they had indicated that it could be at least two years. The landscape had also changed in that the preferred policy was to keep people at home. It would have been an error of judgement to keep the service open and community services support was available. There was still a need for services like Daisy Hill, however, the Trust would not have been able to sustain the loss.

- The local patients had responded well to the programme and would only require out patient support for the next two years.
- The Trust was trying to mirror some of the elements of expertise in community settings and develop community pathways. The potential re-use of the Centre for this service had been identified. It was hoped that the Centre would not be empty for long, though it was a shame that it had closed early.
- The figures could be provided after the meeting.
- It was deeply regrettable that the Centre had closed and the Trust would try to work with commissioners where it could and forge links with others.

Resolved –

That the report be noted.

Action: Deputy Director, Specialist Inpatient Services, Bradford District Care NHS Foundation Trust

70. HILLSIDE BRIDGE HEALTH CENTRE

The Deputy Director, Primary Care, presented **Document "Z"** which provided information on the future of primary care service provision from Hillside Bridge Health Centre. Members were informed that the Alternative Provider Medical Services (APMS) contract was due to expire on 31 March and negotiations were ongoing for a further extension of this contract. Hillside Bridge Medical Centre had opened in 2008 and contained two practices and an enhanced primary care centre. In 2008 the enhanced primary care (EPC) service had been open between 8am and 8pm. A consultation had taken place and the operating hours had changed to 2pm to 8pm for patients outside Bradford and from 6pm to 8pm if they were registered in Bradford. Only 20 appointments were available per day. The Deputy Director, Primary Care, reported that in 2013 the Committee had been involved in discussions regarding the future of the Centre. It was noted that when the service had originally been commissioned it had been aimed at different services and the two medical centres were the main users of the EPC service. Further work had been undertaken and an emergency care strategy had been developed. Part of the APMS contract related to the GP service and this would be re-tendered. The Deputy Director, Primary Care explained that the EPC would be commissioned differently and from Spring 2017 the service would operate from 12 noon to midnight. The next step would be the procurement of the GP services contract then the provision of the EPC service element.

Members made the following comments:

- Would the process start in June 2017?
- Why had a survey not been undertaken to find out why the service was not being used?
- Why had the information gathered not been used to turn the service around?

- It was confusing and complicated for patients to have three services together.
- Would the GP services open until 8pm instead?
- Hillside Bridge Health Centre provided a very helpful and good service.
- Had there been a drop in the service? Why did people queue and why were only 20 seen?
- Were there any plans to educate or help patients?
- How was the change being promoted?

In response Members were informed that:

- A three month process would have to be undertaken and the timelines would be subject to Local Care Direct.
- A consultation had been undertaken and people had not had a positive experience.
- Bevan Healthcare provided an excellent service for hard to reach people.
- After 6pm patients could ring the Extended Primary Care Access, though this was not overly advertised or ideal and was only meeting a small minority of needs.
- There would be a GP service open until 8pm but it would not be located at GP Centres.
- There were only a small number of people using the service and an equitable service was not being provided for the people of Bradford.
- It was not a 'walk in' service, it was appointment based and people would be seen anytime of day.
- The NHS needed to improve its communication strategy and was working with patient groups.
- Discussions with service users and the wider Bradford population were being undertaken.

Resolved –

That a report on the delivery of 'enhanced primary care' that includes details of the consultation process undertaken with service users be submitted to the Committee in 12 months.

Action: Head of Service Improvement, Bradford Districts and Bradford City Clinical Commissioning Group (CCG)

71. ACCESS TO PRIMARY MEDICAL (GP) SERVICES IN AIREDALE, WHARFEDALE AND CRAVEN

The Chief Operating Officer, Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG), presented **Document "AA"** which provided an update on the position relating to primary medical services. Members were informed that there was a workforce crisis in relation to GPs and the Council's budget cuts had a massive impact on primary care. The CCG wanted to work with the Council in order to devise new ways of working and look at current

practice. It was noted that 85% of patients had a positive experience of GP practices, however, there was a great deal of pressure on these services and other options would need to be explored as GPs would not be available. The Chief Operating Officer stated that a number of new approaches, such as Complex Care and Enhanced Primary Care, were being progressed. Complex Care was a proactive service and every patient would be allocated navigational support. The next tier down was Enhanced Primary Care followed by self care and prevention, which would provide people with individual support and empower them to look after themselves.

The Chair queried why local GPs were moving to Australia and New Zealand and was informed that it was due to the better lifestyle.

A representative of the local Medical Committee stated that low morale was a major problem within the GP service along with the huge pressures put upon them. He expressed concerns in relation to the alternative models and new ways of working that were being proposed and explained that patients wanted to be seen by a GP and unless their mind set was changed then the demand would not be met.

Members then raised the following issues:

- What was an extensivist GP?
- Was it an internal scheme?
- Would the personal support navigator function take over personal prescribing?
- What was the CCG's opinion of GPs being trained in the UK and then leaving? How could the situation be turned around?
- Was there anything that could be done to retain GPs?
- It had been stated 2 years ago that there was a massive crisis in GP practices. Doctors could not be made to go into General Practice. If the issue had been known, what had been done about it?
- How were GPs being persuaded to enter into practices within the area?
- What were the differences between GPs and physician associates?
- Were physician associates trained in medical school?
- There was an oversubscription of students in medical schools.
- What was the percentage of graduates that went into General Practice?
- The retention of Pharmacy First was welcomed.

In response Members were informed that:

- An extensivist was a GP that had undertaken additional training and would be responsible for where a patient was directed to and the proactive treatment of a cohort of patients. It was a pilot scheme.
- It was a new service.
- The role would be an enhancement of personal prescribing.
- The CCG was trying to make General Practice more attractive, however, funding was being reduced.
- The CCG was trying to create more capacity within the GP service,

however, an understanding of the patients and population was required.

- The CCG had physician associates.
- Patients were triaged by GPs and seen by an appropriate person.
- Yes, physician associates trained for 2 years and enabled patients to be seen quickly.
- The problem was getting students to move into General Practice.
- It used to be 50%, but was probably less now.
- Many patients asked about medication that could be bought and they were directed to Pharmacy First. Over 2000 appointment slots had been saved and the service would be continued, with evaluations undertaken every 6 months.

The representative of the local Medical Committee stated that he was a great believer in the local GP service, however, people could not be blamed for leaving when they saw what was on offer elsewhere. There was more work that could be done, GPs needed to be trained and primary care funding should be increased.

Resolved –

That a further report be submitted to the Committee in 12 months, with the proviso that any major issues that arise prior to then be reported as and when necessary.

Action: Chief Operating Officer, Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG)

72. ACCESS TO PRIMARY MEDICAL SERVICES IN BRADFORD

The Head of Primary Care, Bradford Districts Clinical Commissioning Group (CCG), presented a report (**Document "AB"**) that described the initiatives being undertaken to improve access to primary care. It was reported that both CCGs had the same workforce pressures as Airedale, Wharfedale and Craven and a five year strategy had been developed. There were 67 GP practices in Bradford, 19 of which were within 1 square mile of another. In relation to Primary Medical Services (PMS) funding, a Plan had to be in place to ensure that within 5 years everyone would be on the same contract value. It was noted that new roles were being piloted and the role of the pharmacist was key. GP practices were being encouraged to work together or merge contracts and it needed to be ensured that the vision was sustained for patients. The Head of Primary Care explained that Bradford's National survey results were lower and different to those for Airedale, Wharfedale and Craven. Members were informed that positive development had been achieved with Practice Participation Groups (PPGs) and an event would take place in May. The CCGs were trying to support GP Practices in any way and were submitting bids for National funds wherever possible. The cost of locums was huge and the CCGs were trying through resilience money to assist. GP Practices were being pushed to integrate, as back office work could be done together and Practices were going to be asked to undertake more work.

Members then posed the following questions:

- Was social prescribing limited to City practices or spread across the District ?
- Why was social prescribing required?
- The navigation of the systems was an issue. What could be done to 'signpost' people?
- It was common sense for people to work together to ensure that the correct pathways were identified.
- A telephone line could be established to help people in association with '111'.
- What evidence was there to substantiate that the new procedures would work in Bradford?
- It was disappointing that Pharmacy First was not being retained. What would the impact be?
- Pharmacy First had not allowed repeat prescriptions.
- Many disabled people were concerned that they would have to go back to see their doctor.
- Would the Pharmacy First service be retained for children?

In response it was explained that:

- Social prescribing was spread across the District.
- It had been a competitive process and the need for social prescribing had been identified in the bids submitted and 26 practices had been funded.
- Work could be undertaken with PPGs and experiential learning could be used in order for services to be right the first time, which would enable people to change their practice.
- A number of Practices were trialling models from Vanguard areas.
- The numbers using the service had reduced and the decision had been made to not support Practices by allowing patients to obtain over the counter medications, as it was against protocol and policy. It was also costly to the Practice as NHS prescription charges had to be paid on top.
- The issue was in relation to repeat ordering. Some pharmacies over ordered and needed to be stopped.
- There were exceptions to the rule and vulnerable patients were one of them. This information could be made available.
- No, the service would not be retained as it was contrary to the stopping of over counter prescribing, however, GPs would have some discretion.

Resolved –

That a further report be submitted to the Committee in 12 months.

Action: Head of Primary Care, Bradford City and Bradford Districts Clinical Commissioning Group (CCG)

73. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2016/17

Members were informed of amendments made to the Work Programme 2016/17.

Resolved –

That the Work Programme 2016/17 be noted.

Action: Overview and Scrutiny Lead

Chair

Note: These minutes are subject to approval as a correct record at the next meeting of the Health and Social Care Overview and Scrutiny Committee.

THESE MINUTES HAVE BEEN PRODUCED, WHEREVER POSSIBLE, ON RECYCLED PAPER