City of BRADFORD METROPOLITAN DISTRICT COUNCIL

# Minutes of a meeting of the Health and Social Care Overview and Scrutiny Committee held on Thursday, 21 October 2021 in Council Chamber - City Hall, Bradford

Commenced 4.40 pm
Concluded 8.40 pm

**Present – Councillors**

| LABOUR | CONSERVATIVE | LIBERAL DEMOCRAT |
|---|---|---|
| **Berry**<br>**Greenwood**<br>**Godwin**<br>**Berry**<br>**Iqbal** | **Glentworth**<br>**Majkowski** | **Griffiths** |

NON VOTING CO-OPTED MEMBERS

| | |
|---|---|
| Susan Crowe | Bradford District Assembly Health and Wellbeing Forum |
| Trevor Ramsay | i2i patient involvement Network, Bradford District NHS Foundation Care Trust |
| Helen Rushworth | Healthwatch Bradford and District |

Apologies: Councillor Julie Humphreys

**Councillor Greenwood in the Chair**

## 19. DISCLOSURES OF INTEREST

During the meeting and In the interests of transparency, Councillor Berry declared that his current employer provided advocacy in the area of safeguarding (Minute 22). The interest was not prejudicial and he remained in the meeting during discussion and voting on that item.

**ACTION: City Solicitor**

## 20. INSPECTION OF REPORTS AND BACKGROUND PAPERS

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

## 21. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

There were no referrals made to the Committee.

## 22. UPDATE ON CYGNET

The report of the of the Bradford District and Craven Clinical Commissioning Group and Bradford Metropolitan District Council (**Document "H"**) provided a joint update on the local arrangements in place for responding to safeguarding concerns from Cygnet Hospitals Health Care, Bradford.

The Strategic Director of Health and Wellbeing for Bradford Council was in attendance, accompanied by the Strategic Director of Quality and Nursing for Bradford District and Craven Clinical Commissioning Group, Deputy Director of Nursing, NHS England and Improvement, Director of Nursing and Patient Experience, Cygnet Healthcare and the Managing Director, Cygnet Healthcare North.

With the request of the Chair, the Strategic Director of Quality and Nursing for Bradford District and Craven Clinical Commissioning Group gave a detailed synopsis of the report to the committee.

Following an introduction of the report, a question and answer session ensued:

- As there was no mention in the report, clarification was sought in regards to whether there was an independent advocacy support network in place for people with learning disabilities and, a general insight on the independent advocacy services for all users was requested
    - Yes. An independent advocacy support network was in place for vulnerable adults who were unable to fully take part in their own planning process as it was the responsibility of the Council to offer this service;
    - Viable contracts were in place with external advocacy organisations through immense work in the development of strong relations over the last six months.
    - A co-production steering group was in place and chaired by an expert through experience. The group was about working in partnership with patients and service users to make sure that the agenda was not proven only by professionals, but in partnership with patients and service users. This was an important feature as it brought together all of the leads for the advocacy organisation, for the purpose of reporting on current themes and trends. This process also gave an opportunity to challenge needs.
    - Every clinical area had contact information, the advocacy service visited the clinical areas regularly, at least weekly depending on the size of the hospital sites and the medical board once a week. Contact numbers for service users were also available, if users wished to contact the advocates from outside;
- Further to a report by the Transforming Care and Commissioning Steering Group, chaired by Sir Stephen Bubb – 2014 in relation to Winterbourne View Hospital scandal; concerns expressed by this committee's constituents; the public's concerns of the treatment of people with learning

disabilities, it has always been favoured for more intermediate level of psychiatric provision and care closer to home. Therefore, could assurances be given that everything was being done to ensure the correct safeguarding processes were in place?
    - There were plans to reopen Woodside hospital as a care in the community facility in November 2021 but had been pushed later in January 2022. The reopening of the hospital was to make a significant difference to the services provided. The services would provide specialist services for people with a primary diagnoses of mental health problems in addition to a secondary diagnosis of autistic spectrum disorder. The facility would be providing specialist services for complex needs;
- In terms of a general overview, what were the services being provided?
    - There were three wards. Each delivering specialist care services, (1) specialist services for patients with a primary diagnosis of mental health problems and secondary diagnosis of autistic spectrum disorder; (2) a psychiatric intensive care unit; and, (3) services for patients diagnosed with acute or mental health cases;
- Following the Care Quality Commission's (CQC) announced inspection of Woodside Hospital following allegations of abuse which at the time was subject to an ongoing police investigation, what reassurances could be relayed to the committee in terms of the lessons learned and whether there would be a cultural change within the facility towards patients?
    - There would be a safeguarding lead in position, trained to an enhanced level of recognising how to provide the correct specialist care provision. The facility would also include corporate support for the site, additional supervision, additional training for all staff, specialist advice, and to include a dedicated role in corporate safeguarding. Therefore, the whole supervision and support for the site has been enhanced to meet the needs of vulnerable adults. In addition, the site would entail additional roles to support corporate mechanisms by having access to more specialists than previously. In terms of advocacy support for the site, there would be continual monitoring on a corporate level to ensure that patients, service users obtained as much advocacy as required. If it came to light that additional services were required, then contracts were in place to ensure that resources would be made available.
    - Woodside Hospital would be visited regularly and reasons for visits would be to ensure that people were not at any point at any form risk. However, if something contentious was to come to light then an investigation would be initiated in order to establish the correct the mechanisms be put in place for patients and officers delivering the specialist care;
- Further to an extract contained in the report: "*Local Authority with a monthly average of 6.6 safeguarding concerns from Cygnet Hospital Bierley. From Cygnet Hospital Wyke, during the same time period, the Local Authority received an average of 7.6 safeguarding concerns each month. The average s42 conversion rate for Cygnet Hospital Bierley was 30% and for Cygnet Hospital Wyke it was 41%".* Therefore, explanation was sought to the information of there being high profile cases and people being denied access to services. In such circumstances, concerns or complaints being submitted as well as the public looking for reassurance,

which being in response to the earlier statement of support for advocacy was very firm including a welcoming culture for staff to raise concerns?
    - The process set in place was a culture based freedom to speak up within a service area. A dedicated role had been implemented for staff members to approach a designated staff member on a confidential basis, anonymously, or not anonymously if the staff member felt comfortable in coming forward to address concerns. This was an independent role that reported directly to the board.
    - Outside of Cygnet, an external service was also provided as well as a whistleblowing helpline.
    - Each service area was now working towards having an ambassador and this process was being profiled locally to make sure that all staff were aware of the freedom of speech culture.
    - In the coming year, there would be additional resources available that would give additional information and insight to other support for staff.
    - Experienced experts were positioned to lead for the organisation and these roles reported directly to the board;
- The report touched on Host Commissioner (HC) arrangements that provided an opportunity to share intelligence between stakeholders, including commissioners and strengthen the link with the Local Authority safeguarding team and Safeguarding Adults Board to triangulate any issues that are identified. Could a simplified explanation for HC arrangements be provided to the committee?
    - In response, the key role of the HC in CCG, in respect of inpatient care commissioned for people with a learning disability, autism or both, was to:
        - be the point of contact for commissioners and for the CQC for issues relating to quality and safety for units where inpatient care is delivered;
        - ensure that placing commissioners are aware of the key contact in the host CCG should they become aware of issues of concern
        - establish a mechanism for sharing intelligence between commissioners who are placing individuals (or considering placing individuals) with a learning disability, autism or both within the service;
        - ensuring interface with the council's adult social care safeguarding service, and also with the local safeguarding adult board (SAB) and with local partners so that any identified actual or potential safeguarding concerns are raised with the host local authority and dealt with as appropriate;
        - to work in consultation with colleagues in contracting and quality teams and be the key point of contact with the provider for issues relating to quality and safety, including those that impact multiple commissioners;
        - to work with providers and with colleagues in contracting and quality teams to develop actions that would deliver required quality improvements, and seek assurance that necessary improvements have been made; and,
        - to work in conjunction with local, regional and national quality

surveillance group (QSG) arrangements, taking a lead role in co-ordinating the response required if there are serious and/or multiple concerns identified. Ensure the QSG has strong and formal links with the local SAB, so that concerns discussed at QSG can also be discussed with SAB chairs.

- A recent BBC Panorama programme that featured undercover filming from inside a Norfolk Hospital for vulnerable adults and reveals patients being mocked, taunted and intimidated by abusive staff had also been an influential factor towards the new policy guidance in regards to the HC;
- Cygnet was currently predicting important factors to consider which had come about through conversations with the police;
- With HC, other areas of services would be accessible for patients who may have had new problems that required treatment on an immediate basis. HC were specialists that had access to various other services; and,
- HC role was to ensure that the place based role in Cygnet as the service provider had undertaken the correct checks and balances in order to provide the right care.

During the discussion, the committee and officers made the following comments:

- For the West Yorkshire region, a group was set up that played an important role for a significant programme in undertaking a review of provisions throughout the region to ensure that the system of keeping people as close to home as possible was effective and efficient for patients;
- Cygnet tried its best in its overall goal which was to always ensure that patients were placed close to home as possible. However, occasionally specialist services were not available within a locality to enable them to be placed as preferred. If this was the case, then provisions would be implemented to ensure regular contact with families and carers through the means of iPads to FaceTime was made available. It being paramount that from a provider perspective that it was essentially critical to ensure the users of Cygnet services had everything in order to enhance the recovery stage; and,
- This joint report from Bradford Metropolitan District Council (BMDC) and Bradford District and Craven Clinical Commissioning Group (CCG) had a responsibility to understand the ranges of basic responsibilities that set out the arrangements in place of how the System works together to safeguard service users in Cygnet, identifying roles, responsibilities and mechanisms in place to support patients and staff.

The Chair concluded the discussion by stating that it was easy to say that immense work was being invested into the system of delivering specialist care and equally for the committee to praise the efforts of Cygnet due to the implementation of new processes however, it was important to note that unforeseen challenges were yet to be met. The system itself was for the provider to meet the ever increasing challenges and even more paramount to note that no matter what the circumstances, that no one slipped through the net, therefore:

**Resolved:-**

**(1) That a report on the implementation of the new 'Host Commissioner' arrangements be added to the Committee's 2022/3 programme of work;**

**(2) That the assurance against the safeguarding actions taken in relation to Cygnet be welcomed.**

***Action: Overview and Scrutiny Lead***

## 23. UPDATE ON THE RESTORATION AND RECOVERY OF GENERAL PRACTICE PRIMARY CARE AND COVID -19

Covid -19 continued to have a significant impact on General Practice. General practices continued to support the Covid-19 pandemic in delivering the vaccination programme as well the new Covid-19 booster programme. Practices continued to take mitigating actions in line with national guidance to ensure both staff and patient are kept safe, and practices could continue to deliver, high quality care for their registered population.

The report of the NHS Bradford District and Craven CCG **(Document "I")** provided an overview on the Restoration and Recovery of General Practice aligned to national guidance.

Even with the success of the vaccination programme, Covid-19 remained prevalent and presented an ongoing risk to the health and wellbeing of communities. It was acknowledged the tremendous efforts of General Practice and system partners were making to retain ongoing safe delivery of primary care services.

The Associate Director, Keeping Well, Bradford District and Craven Clinical Commissioning Group (BDCCG) was in attendance, accompanied by the Strategic Director, Keeping Well at Home, BDCCG and the General Practitioner - Strategic Clinical Director, BDCCG.

At the request of the of the Chair, the Associate Director gave a synopsis of the report followed with a PowerPoint presentation of breakdown of data on the General Practice – Access Update 2021. The data related to the following areas of working practices:

- General Practice
    - Bradford District and Craven – Primary Care Networks (PCN)
    - PCN current delivery service specifications
    - Key Priorities for PCNs
- GP Workforce
    - GP to Patient Ratio – overview
    - GP to Patient Ratio – in order of PCN deprivation;
    - Face to face GP appointments
- NHS England and NHS Improvement (NHSEI) Plan for Improving Access for Patients and Supporting General Practice
    - Winter Access Funding Guidance
    - NHSEI Winter Access Funding
    - NHSEI Plan Highlights

    - ICS Level
- Next Steps
- Time Line
- Risk Issues
- Risk Issues – Local and National

As an overview summary, the focus was to continue with online consultations as remote triage was part of the national agenda within PCNs. However face to face appointments were still available for those people who were clinically vulnerable. It was not about seeing a GP, but more so, the most appropriate way forward for people in accordance with their medical condition. In terms of industry requirements for key areas, there was ongoing complicated work development including the increase of workforce to deliver the new functions in addition to resuming back to business operations in terms of reducing the backlog of appointments including for chronic disease management and routine vaccinations and immunisations. In general Practices, high number of staff had been infected with COVID. There were challenges in trying to backfill positions. There was an increasing number of an abusive incidents . However, to deal with such behaviour, patients were made aware that they could be excluded from primary care. There were some signs of direction from government to tackle some of the long term effects of the pandemic but guidance was expected. There were four practices which were currently closed of which three could not be opened currently due to the sizes of the facilities and the small number of staff within them. In terms of the national Restoration and Recovery of primary care, general practices for 2021/22 had 3 key areas for delivery: expanding primary care capacity to improve access, local health outcomes and address health inequalities. NHS Digital has made available an assessment of GP appointments by CCG area. The snapshot for Bradford District and Craven taken from July 2019 to August 2021 showed that, aggregated CCG level data suggested appointments are showing signs of returning to pre pandemic levels e.g., July 2019: 350,000 appointments total, July 2021 (latest data): 344,000 appointments total. There was a national contractual requirement for general practices to offer a GP Online Consultation service and NHS England have suggested that this be available 24/7 but there was no legal contractual requirement for this to be made available outside of core practice hours of 08.00am to 18.30pm Monday to Friday. Despite the switch of practices struggling with online enquiries, aggregated data to August 2021 demonstrated Bradford District and Craven Practices deliver over 21,000 eConsultations consistently each month at a rate of 33.28 per 1,000 patients currently. There were two national extended access schemes, one was a national Directed Enhanced Services (DES) called Extended Hours which was delivered by practices, but since last year PCNs were responsible for the delivery of this scheme. PCNs were required under this scheme to ensure that a 100% of their population could access primary care services Monday to Friday outside of core primary care hours i.e., before 8.00am and after 6.30pm. The second scheme known as the Extended Access was commissioned by the CCG and is nationally funded to deliver a 7 day a week primary care provision. This included cover over the national holidays including Christmas. There were also Mental Health Practitioner roles which were funded jointly between primary care centres and the Mental Health Trust. These roles were very much focused on our primary care networks at home and focused on addressing health inequalities around mental health.

A question and answer session ensued:

- Explanation was sought on the telephone based triage system?
    - Appointments had increased significantly as established in the Total Triage approach to managing Primary Care patients during the pandemic. Patients called in, in response, the GP or a health care professional would ask the patient to attend the practice and this would count as two appointments. In some practices it would be counted as one appointment. This triage approach system was a standardised national requirement;
- Was there further improvement to specialist provision services provided for people with complex diagnoses?
    - The service was equally managing and improving health provision tailored for individual complexities. In context, there was continuous engagement within the provision of providing further capacity. In a perfect world, the commencement of this work should have begun a decade ago. In current status, improvement was being made to what there was capacity for access;
- During the pandemic, what progress had been made towards learning opportunities?
    - Whilst during the first phase of Covid -19 as per national directive, all but essential services in general practice were paused to deal with the pandemic, therefore many learning opportunities through patient satisfaction surveys had been interrupted. This brought challenges of clearing the back log of work accumulated during the pandemic as well as dealing with unprecedented demand for general practice access against workforce shortages;
- The report touched lightly on social prescribing and further explanation was sought?
    - There were six pilot areas in Bradford that were using social prescribers within GP practices, especially around health checks. This was successful at present for people with learning disabilities and people with Autism were responding really well to this approach. If this remained successful, then there were plans to roll it out across West Yorkshire and in to other neighbouring areas;
- A more detailed summary was requested on the LD/Autism health checks?
    - There was national set target of 75% for uptake of LD/Autism health checks for 2021/22 an increase on the target of a minimum of 67% for 2020/2021. Last year the service achieved 81.1%, which was well above the target of 67%.
    - In addition to the report, the 81.1% of health checks, a large percentage of which was work undertaken to the standard, as many people had checks as part of their respective Health Care Plans;
- How were people with learning disabilities being advised on their annual health checks?
    - There was a full time Patient Education Officer a few years ago that went out to visit patients within the community and there was a consideration in progressing further into this area;
- The report stated that the digital transformation within GP services, occurred much more rapidly than planned?
    - The digital transformation had been under discussion for a number of years and yes, due to the pandemic, the technical changes implemented were undertaken swiftly for the sake of continuing vital

services to patients. However, necessary assessments had not been made to date on whether the transformation was worthwhile. This was an area yet to be rigorously assessed;

- In relation to the overall objective towards the impending change and intentions for helping to create a more supportive stable NHS for reducing carbon emissions generated by everyday Asthma inhalers and other general prescribed drugs. What was the consensus between senior professionals on whether the aim for reduction was possible or if this objective lacked ambition?
    - It was the aspiration of the NHS to significantly reduce emissions and this could influence structured medication reviews and medicines optimisation; and,
- How were health inequalities being addressed?
    - Funding was spent as part of a national formula or per capita and was higher in more deprived areas. There was a programme called Reducing Health Inequalities in our communities. This programme entailed the investing of additional funds into the most deprived areas in order to tackle health inequalities.

During the discussion, the following comments were made by the committee and officers:

- There was an additional role within the structure that included a GP Nurse Practitioner. This role worked in surgeries as part of the Primary Healthcare Team, which included GPs, pharmacists and dietitians. In larger practices, there could possibly be one of several practice nurses sharing duties and responsibilities, however on rare occasions, working on their own and taking on various roles;
    - In response to comment, the Committee stated that despite the additional role, patients attending surgeries located in affluent areas would expect to be seen by the most senior role within the practice and this was an issue which required addressing.
- In terms of primary care, there is now a suite of options for people to access which differentiates access to response, for example, securing an appointment with a GP or general communication as a whole through online digital based format. This form of digital based communication has been accelerated by the Covid pandemic. This digital system has been tailored to fit in with current systems and directly matched with a new and advanced skilled workforce. Unfortunately, there had been a lack of clarity and not effectively publicised and had been driven without any public messaging. Therefore, in current status, the service is to address certain points from the beginning and make use of social media to bring the messaging to the general public up to speed;
    - In response to comment, the committee echoed the sentiments of the officer's outline and followed by adding that members as community representatives were in contact with their constituents in regards to lack of communication and therefore it was paramount that a great deal of work was yet to be undertaken in sending out clear and simplified messages to the public that was easily understandable to communities rather than information that was going out in a complex nature by policyholders and unable to be interpreted by the general public. In current circumstances of improvement and changes due to the pandemic, it was the most

appropriate opportunity to seize the moment to make aggressive change in favour of meeting the needs of the general public.

- The introduction of the Care Navigation (CN) model was introduced a few years ago that improved the access to primary care services for patients and reduced GP pressures all in one. This model entailed social prescribing to the extent that receptionists and admin staff who had been given specialist training to help them direct patients to the right health professional during initial contact. In current circumstances, it seemed that this was a missed opportunity owing to the fact that all the skills and experience within GP practices were not promoted effectively, hence resulting of the approach of the CN not meeting the needs of the large demographic area of West Yorkshire. Of course, the West Yorkshire and Harrogate Care Partnership (HCP) had a role within this model and that there should have been better advertising to the general public and community representatives of the changes made, showcasing better services of provision could be obtained by not going to directly to the GP but being referred somewhere to avoid arduous obstacles and directed to the provision required;
    - *Reference: HCP covered 2.6 million people. It was made up of around 50 local health and care networks, eight local authority areas, seven local care partnerships and six place plans (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield).*
- Effective communication was essential in providing good healthcare and pivotal to ensuring patients received safe and quality care. Good communication was also the key to promoting all GP services and would reduce the likelihood of patient complaints;
- As stated in the report, there were plans for improved patient access to primary care services – through the implementation of a PCN-based approach to extended access provision, and rewarding PCNs who improved the experience of their patients, the avoidance of long waits for routine appointments and tackling the backlog of care resulting from the Covid-19pandemic; and,
- Infection prevention accompanied with the number of single use items that were used across the NHS were completely inappropriate it was paramount that attempts to address this area in favour of the climate and, making the NHS more sustainable in the current and future climate..

**Resolved:-**

**(1) That the contents of Document "I" as assurance of the continuation of the safe delivery of care by GP practices during the Covid-19 pandemic and the steps towards Restoration and Recovery of primary care in line with the NHS 2021/22 priorities and operational planning guidance for October 2021 to March 2022 published 30 September 2021 be noted;**

**(2) That a further report be provided in 12 months' time.**

***ACTION: Overview and Scrutiny Lead***

## 24. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME 2021/22

The Committee received a report (**Document "J"**) of the work programme 2021/22.

**No resolution was passed on this item**

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.**