MINUTES OF A MEETING OF THE SCRUTINY COMMISSION FOR HEALTH ISSUES HELD AT THE BOURGES/VIERSEN ROOM - TOWN HALL ON 13 SEPTEMBER 2010

Present: Councillors B Rush (Chairman), Y Lowndes (Vice-Chairman), Arculus, P Nash and J Stokes

Also Present: Councillor C Swift OBE, Leader of the Peterborough Independent Forum
Rita Bali, Cambridgeshire and Peterborough Local Pharmaceutical Committee
Dinah Shaw, Shaw Trust
Angela Burrows, Shaw Trust

NHS Peterborough: Dr Paul Zollinger-Read, Chief Executive
Dr Mike Caskey, Director of Clinical Change
Peter Wightman, Director of Primary and Community Care
Sue Mitchell, Associate Director of Public Health

Officers: Denise Radley, Executive Director of Adult Social Services & Performance
Marie Southgate, Lawyer
Louise Tyers, Scrutiny Manager

1. Apologies

Apologies for absence were received from Councillors Fower, Khan and Shaheed. Councillor Jamil was in attendance as substitute for Councillor Khan.

2. Declarations of Interest and Whipping Declarations

There were no declarations of interest.

3. Minutes

The minutes of the meetings held on 19 July and 3 August 2010 were approved as accurate records.

4. Call In of any Cabinet, Cabinet Member or Key Officer Decisions

There were no requests for call-in to consider.

5. Formal Consultation on NHS Peterborough's Proposals on the Future of the Alma Road Primary Care Centre

We welcomed Dr Zollinger-Read, the new Chief Executive of NHS Peterborough, to the meeting.

Dr Zollinger-Read advised that the consultation on the future of the services at the Alma Road Primary Care Centre had now been stopped. NHS Peterborough had listened to all of the comments that had been made so far and it had been agreed that the future of Alma Road needed to be considered as part of a wider review of all emergency care services across Peterborough. The services provided at Alma Road would continue to be provided as now and the wider review would take approximately two months.

Councillor Swift made a statement explaining that he had had reservations about Alma Road from the beginning as the area was already well served by GP practices and around 80% of the city did not have that type of access to a walk in centre. Rather than providing a new Centre it would have been better to have shared the money between all of the doctors in the area. It was important that a decision was made quickly on the future of Alma Road for all the residents in the City.

Questions and observations were made around the following areas:

- A lot of the other GP practices in the surrounding area were based in buildings which were in poor condition; would other practices be able to share the buildings at Alma Road? *This would be part of the wider review but it was important that decisions were made around the needs of the patients.*
- The Commission were pleased that NHS Peterborough had listened to the comments which had been made and had stopped the consultation at this time.
- Mary Cook of the Peterborough Pensioners Association stated that the plan had been to create fewer, larger surgeries in the City. *Dr Caskey confirmed that 5-6 years ago that was the initial thinking but it was important to look at what people needed.*

ACTION AGREED

(i) To note that the consultation on the future of services at the Alma Road Primary Care Centre had been stopped.
(ii) That the outcome of the review of emergency care services be brought to a future meeting when completed.

6. Changes to the NHS Estate

Peter Wightman, Director of Primary and Community Care, gave a presentation on the primary care estates.

NHS Peterborough had contracts with 29 independent contractors on a range of contracts and made contract payments to GP practices for their premises. 90% of premises were owned by GP practices and some premises were of poor quality or did not have sufficient capacity to meet future standards. There were a relatively large number of small practices whose locations had been driven by history. The City needed to bear in mind the expected future population growth in areas such as Hampton and Great Haddon.

There were a number of development principles around the estates including:

- NHS Peterborough did not support future isolated practices
- Increased out of hospital care
- Green Shoots – a public sector collaboration
- Premises should support high quality primary care
- Needed to meet future standards
- Needed to balance scale, accessibility and affordability

A number of changes had recently been made to the estate including:

- City Care Centre
- Recent investment in practices – Bretton, Nene Valley Medical Practice, Westgate Surgery moving to the Queensgate Shopping Centre
- Alma Road

NHS Peterborough was currently in Turnaround and this would have an impact on the estates by ensuring that optimum use was made of existing premises including that any premises changes must be cost neutral, premises outside of the development principles decommissioned and longer term if the financial position allowed supporting strategic premises developments.

Questions and observations were made around the following areas:

- What was meant by premises changes must be cost neutral? *Practices were given an allocation for premises within their contracts; if more money was needed NHS Peterborough could not give this extra money.*
- Would premises be closed if they did not meet the required standards? *It would be at our discretion. We took the opportunity when a practice came to the end of its natural life to review the provision.*
- Mary Cook of Peterborough Pensioners Association stated that patients were now registered with a practice and not a specific GP. *With PMS contracts patients were registered with the practice; however some practices did hold personalised lists. Larger practices gave greater flexibility to the patient compared to single handed practices.*

ACTION AGREED

To note the presentation on the primary care estates.

7. Lower Endoscopy Procurement Service

The report gave an update on the procurement process for Lower Endoscopy services.

The Community Gastroscopy Service (Upper) had been implemented in May 2009 following a successful Any Willing Provider (AWP) tendering process. The Service had demonstrated it could provide a high quality, cost efficient service in the Community and the service had been instrumental in reducing waiting times for patients who would have previously been referred to Secondary Care. The success of the Upper Endoscopy Service had led to the expansion of the service to include Lower Endoscopy. The Lower Endoscopy Service was currently being piloted at Bretton Health Centre whilst the AWP Lower Endoscopy Procurement was being undertaken.

The overall goal of the procurement was to:

- provide community based lower endoscopy services, giving patients a choice of provider
- reduce unnecessary Secondary Care attendance
- reduce commissioning service costs by 25% by carrying out lower endoscopy procedures in a community setting and not in Secondary Care

An AWP procurement model was being used as it would reduce bureaucracy and barriers to entry for potential providers and would improve patient choice, access and at the same time deliver value for money. Procurement timescales and resources would be reduced as it was a shorter process than a full procurement and it was anticipated that it would take no longer than six months to undertake. AWP did not guarantee providers with any volume of activity or payment.

Questions and observations were made around the following areas:

- Would any providers be willing to undertake the service if there was no guarantee of volume of activity or payment? *It was believed that providers would be willing as this was a positive, cost neutral way forward.*

- How many patients had taken up Lower Endoscopy services at Bretton? *It was too early to tell as it had only been in place for a few weeks.*
- Annette Beeton of the Peterborough LINk advised that lower endoscopy was more complicated than upper. Practitioners would need to perform the procedure regularly and more after care would be needed to be given to patients, had this been taken into account? *We would look at the standards in the contract but practitioners had to undertake a number of procedures to maintain their competency.*

ACTION AGREED

To note the update on the Lower Endoscopy Procurement Service.

8. Provision of Contraceptive and Sexual Health Services for Young People

The report provided an update on the provision of contraceptive and sexual health services for young people in Peterborough, following concerns over the withdrawal of some pharmacy based sexual health services (free Emergency Hormonal Contraception (EHC) and Chlamydia Screening tests).

The pharmacy based sexual health service was funded initially by the Strategic Health Authority (SHA) in 2008/9 as part of a wider successful bid to test innovative new schemes to increase access to contraceptive service for young people. The main driver behind the funding was to contribute to the Teenage Pregnancy Strategy aim of reducing under 18 conceptions. The pharmacy-based scheme offered free EHC, Chlamydia Screening and condoms to the under 25 population at a cost of approximately £30k. Funding had also been provided by the SHA in 2009/10 to continue to support the pilot programme. Over the period of just under two years 19 pharmacies had signed up to the programme and had been trained to deliver the services.

To enable the scheme to continue this year, funding would have to be identified from the PCT's baseline budget. Whilst 19 pharmacies signed up to deliver the programme only five had provided more than 20 prescriptions in the year 2009/10 and the Chlamydia Screening up-take had also been poor. The condom scheme had only registered 43 young people in 2009/10 and NHS Peterborough was of the opinion that this scheme did not offer value for money.

Whilst young people accessed pharmacies regularly, they also regularly used their GP, the Walk in Centre and also the Contraceptive and Sexual Health Service (CaSH) at Rivergate and all of those services offered free EHC, Chlamydia Screening and condoms. The National Chlamydia Screening programme continued to be an active priority and Chlamydia Screening (and free condoms) could be acquired through numerous routes including, by text, website and local services including the CaSH service, Walk in Centre, GP surgeries, schools (including drop-in clinics known as HYPAS), hospital and youth services.

The drive towards reducing unintended pregnancies was focusing much more on prevention and the use of long acting reversible contraception (LARC) as the contraceptive method young people were more likely to choose and continue with. This should reduce the need for EHC and terminations as well as promoting safe and responsible sexual behaviour.

The PCT was in financial turnaround and funding decisions had to be carefully considered. Given the performance of this service and the existing provision available to young people it was decided not to develop the pilot scheme into a mainstream service at this time (although other local pilot projects that received SHA funding had been mainstreamed - these included targeted contraceptive work with young mothers and those young women who had had a termination).

Rita Bali of the Cambridgeshire and Peterborough Local Pharmaceutical Committee spoke in support of the scheme on behalf of local pharmacists.

Observations and questions were raised around the following areas:

- How much would be saved by not continuing the programme? *In previous years £30K had been applied for. Last year the actual cost was between £10-15K.*
- Was one of the issues a perceived lack of privacy in a pharmacy? *The pharmacists who took part in the programme were trained and were required to have a private area available.*
- How was the programme promoted? *The programme was promoted in lots of outlets in the city but had been a bit more of an issue in rural areas.*
- What would be the outcome if the programme was not available, for example, the increased costs of pregnancy or termination? *To continue the scheme would cost more. It had been publicised across the city where services could be accessed. We needed to revisit how we worked with pharmacists and look to develop and deliver more effective ways in the future.*

RECOMMENDATION

That NHS Peterborough be advised that the Scrutiny Commission for Health Issues does not support the decision to withdraw funding for the pharmacy based sexual health programme and that they look again at ways for the programme to be continued.

9. Health White Paper - Equity and Excellence: Liberating the NHS

The Executive Director of Adult Social Services gave a presentation on the Health White Paper – Equality and Excellence: Liberating the NHS.

The Health White Paper had been published on 12 July 2010 and set out the Government's long-term vision for the future of the NHS. The vision built on the core values and principles of the NHS as a comprehensive service, available to all, free at the point of use, based on need and not ability to pay.

There were four core areas of the White Paper:

<u>Patients at the heart of everything</u>

- Shared decision-making: *no decision about me without me*
- Patients would have access to the information they wanted, to enable them to make choices about their care
- Patients would have increased control over their own care records
- Patients would have choice of:
  - any provider
  - consultant-led team
  - GP practice
  - treatment
  - Maternity through new maternity networks
- Patients would rate hospitals and clinical departments

<u>Health care outcomes best in world</u>

Quality would be the focus with reduced mortality and morbidity, increased safety, and improved patient experience and outcomes for all:

- NHS measured against clinically credible and evidence-based outcome measures, not process targets
- Quality standards, developed by NICE would inform the commissioning of all NHS care and payment systems
- New Cancer Drug Fund
- Provider payments linked to outcomes
- Ring-fenced public health budget
    - To reflect relative population health outcomes
    - New health premium

<u>Empowering clinicians</u>

- Devolved power and responsibility for commissioning to GP Consortia
    - Commission the great majority of NHS Services, but not dentistry, community pharmacy and primary ophthalmic services
    - Consortia would have an accountable officer
    - Every practice would be a member
    - Consortia would have a 'sufficient geographic focus'
    - Freedom to decide the commissioning activities they undertook themselves
- All NHS trusts would become or be part of a Foundation Trust (FT)
- Increased FT freedom and encouraged social enterprise model.

<u>Removing unnecessary bureaucracy</u>

- New NHS Commissioning Board with responsibilities for:
    - Achieving health outcomes
    - Allocating and accounting for resources (hold GP Consortia to account)
    - Leading on quality improvement
    - Promoting patient involvement and choice
    - Commissioning certain services
- The Public Health (Health Improvement) responsibility would transfer to Local Authorities
- PCTs and SHAs would be abolished

Questions and observations were made around the following issues:

- The proposed changes appeared to be a reinvention of what happened 50 years ago. The changes could not be undertaken by one Member in the Cabinet and it was something that everyone needed to participate in, perhaps similar to the former Public Health Committees. *The White Paper proposed that responsibility for public health would be the responsibility of councils as they had the biggest affect on the determinates of health. The proposed Health and Wellbeing Boards would comprise of Members, officers and others.*
- How would the proposed GP Consortia be financially accountable? *The White Paper stated that they would have to appoint both a Responsible Officer and a Financial Responsible Officer.*
- What would the ring-fencing of the public health budget mean in reality? *It meant that the money could only be spent on either national or local public health priorities.*
- Was this the beginning of the private provision of care? *GP commissioners would decide locally the best way of providing care to local people and would be leading the decision making. The aim would be to put patients and clinicians at the heart of decision making and to make it a more effective and better delivered service.*
- These were significant changes particularly in face of the budget cuts ahead. Was there any indication as to what the set up costs would be? *We would need to think creatively to ensure these major changes were put in place. The White Paper did not mention the set up costs.*

- Would GPs be spending some time in actually running the NHS? *GPs would but it was acknowledged that they did not have the skills to manage big budgets etc. They would be free to deliver some of the functions, such as finance, in a way that suited them, including buying in the service.*

ACTION AGREED

Any further comments on the White Paper to be forwarded to the Executive Director of Adult Social Services.

10. Presentation on the Peterborough Local Involvement Network (LINk)

We welcomed Dinah Shaw and Angela Burrows from the Shaw Trust to the meeting. Dinah and Angela gave a presentation on the role of the Peterborough Local Involvement Network (LINk).

LINks were an independent network that encouraged and supported local people to look at all the health and adult social care services in an area. They fed in views and recommendations to local service providers and ensured that groups and individuals were listened to. They had influence in a number of ways including:

- Service providers must provide LINks with the information they request through the Freedom of Information Act
- Service providers must let "authorised" members of LINks enter and view funded services
- Service commissioners must respond to a LINK report and recommendations within 20 working days and explain what action they planned to take
- LINks could refer matters to an Overview and Scrutiny Committee (OSC) for action and follow-up

The Peterborough LINk had a varied work plan, including:

- Future Direction;
  - Turnaround Plan
  - White Paper – Local HealthWatch
  - New Peterborough City Hospital
- Hydrotherapy Provision
- Cancelled Appointments/did not attends
- Complaints
- Infection Control - Hospital Hygiene
- Discharge Planning

The Health White Paper proposed to develop LINks into organisations called Local HealthWatch which would become the local consumer champion across health and social care. The Local HealthWatch would:

- retain the LINks' existing responsibilities to promote patient and public involvement, and to seek views on services which could be fed back into local commissioning
- have continued rights to enter and view provider services
- continue to be able to comment on changes to local services

The White Paper also proposed giving Local HealthWatch additional functions and funding, to provide complaints advocacy services and support to enable individuals to exercise choice. In particular, they would support people who lacked the means or capacity to make choices. Local HealthWatch would be able to report concerns about the quality of local

health and social care services to HealthWatch England, independently of their host authority, to inform the need for potential regulatory action.

Questions and observations were made around the following issues:

- It was noted that there was no hydrotherapy provision in Peterborough at the moment and this was a piece of work that the LINk had picked up. Part of the plans for the proposed PJ Care Home in Bretton included provision of a hydrotherapy pool which they hoped to look at opening up to members of the public. *The LINk believed that there was a danger if a private provider offered a service that they could withdraw public use at anytime so it was better to look for a permanent solution. The existing pool at the former St Georges School only needed superficial work doing to it and would be a way to make use of an existing facility. Transforming that facility would also be a good news story for the city.*
- Had the use of the pool at Matley School been considered? *Unfortunately that pool was not suitable as it was too shallow.*

ACTION AGREED

To note the presentation on the LINk and its future.

11. Forward Plan of Key Decisions

The latest version of the Forward Plan, showing details of the key decisions that the Leader of the Council believed the Cabinet or individual Cabinet Members would be making over the next four months, was received.

ACTION AGREED

To note the latest version of the Forward Plan.

12. Work Programme

We considered the Work Programme for 2010/11.

ACTION AGREED

That the Executive Director of Adult Social Service and the Scrutiny Manager review the work programme to ensure effective scrutiny.

13. Date of Next Meeting

Monday 8 November 2010 at 7pm

CHAIRMAN
7.00 - 9.35 pm