Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: TUESDAY, 26 NOVEMBER 2013 at 5.30pm

P R E S E N T :

Councillor Cooke – Vice Chair
Councillor Sangster – Vice Chair

Councillor Chaplin	Councillor Desai
Councillor Cleaver	Councillor Singh

Also in attendance

Mr J Adler	Chief Executive, University Hospitals of Leicester NHS Trust
Mr A Archer	Partnerships Planning & Performance Lead Officer, Adults, Health and Housing, Leicester City Council
Ms J Atkinson	Consultant in Public Health, Leicester City Council
Professor D Chiddick	Chair of Leicestershire Partnership NHS Trust
Mr A Childs	Chief Nurse/Director of Quality, Leicestershire Partnership NHS Trust
Mr D Gifford	Public Health Commissioning Manager, NHS England
Mr P Miller	Chief Operating Officer, Leicestershire Partnership NHS Trust
Dr P Miller	Chief Executive, Leicestershire Partnership NHS Trust
Mr R Morris	Leicester City Clinical Commissioning Group
Dr J Murphy	Consultant in Public Health, Leicester City Council
Mr S Sharma	Healthwatch Leicester
Mr M Wightman	Director of Marketing and Communications, University Hospitals of Leicester NHS Trust

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80. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Grant, Palmer and Westley.

81. DECLARATIONS OF INTEREST

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

82. MINUTES OF PREVIOUS MEETING

RESOLVED:

that the minutes of the meeting held on 15 October 2013 be approved as a correct record.

83. PETITIONS

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

84. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations and statements of case had been submitted in accordance with the Council's procedures.

85. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Scrutiny Commission's Work Programme for 2013/14.

The Chair stated that the External Scrutiny Review being carried out by the Centre for Public Scrutiny would be completed in December and this would shape the Commission's Work Programme and future function of the Commission.

When the Scrutiny Review outcomes were finalised they would be presented to health trusts and the CCG together with Commission's function, as modified by the review, to promote a better understanding of the Commission's role.

The Work Programme was noted.

86. CORPORATE PLAN OF KEY DECISIONS

The Commission noted the items that were relevant to its work in the Corporate Plan of Key Decisions that would be taken after 1 December 2013.

87. CQC INSPECTION OF UHL NHS TRUST

John Adler, Chief Executive University Hospitals of Leicester NHS Trust (UHL) and Mark Wightman, Director of Marketing and Communications, UHL,

attended the meeting to update Members on the CQC's recent announcement to inspect 8 aspects of the Trust's work as part of the CQC's second phase inspections. 19 acute trusts were being inspected and would be given a rating of performance.

The Commission received the following reports for information-

a) A report to the UHL Board meeting on 31 October on the proposed CQC inspection.

b) The CQC's Intelligent Monitoring Report dated 21 October 20113.

c) Letter to the UHL Chief Executive from the CQC on the inspection.

d) A press statement issued by the CQC on the inspection process.

Mr Adler commented that the CQC's inspections were welcomed as the new process for the inspections was more engaging and involved peer reviews. The inspections were more comprehensive than before and this too was welcomed. UHL had been identified as Risk 1 category as the Trust had 10 elevated risks out of 150 indicators, as shown in Intelligent Monitoring Report mentioned at b) above. UHL had already carried out a review of these elevated risks and some of these were know anomalies, such as some outsourcing of services that has skewed staff turnover rates.

In response to Members questions on the inspection Mr Adler and Mr Wightman stated:-

a) In relation to the deaths in low risk diagnosis groups, the cohort of 81 patients' notes had been reviewed. If a patient was initially admitted with a bladder infection, this would be classed as a 'low risk'. However on subsequent investigation and treatment, patients may be found to have more serious conditions such as liver failure due to alcoholism, but the initial low risk diagnosis would still be used for monitoring purposes.

b) The Trust had made improvements in the quality of training and were continuing to do so.

c) The Trust carried out more high risk operations and this provided a bias against the Trust when compared to other trusts that did not undertake such operations.

d) It was not felt that the deaths arising from low risk admissions was correlated to excess winter deaths.

The Chair referred to the recent information circulated to Members on the latest proposals for the A&E department and the change of direction of the proposals was noted. Members asked that consideration be given to designated emergency parking arrangements for relatives who needed to gain access in instances where they were given short notifications of an expected

bereavement. The pressure of trying to park in these circumstances was an added strain. In response to a question about the level of car parking charges in the new proposed car park, Mr Adler commented that it was too early at this stage to have any details.

RESOLVED:

1) That the report and supporting information be received and noted;

2) That the CQC report on the proposed inspection be submitted to a future meeting of the Commission; and

3) That the Trust consider using the 'dashboard monitoring process' being used by LPT to triangulate various performance indicators to see if there was any correlation between them.

88. BRADGATE ADULT MENTAL HEALTH UNIT

Leicestershire Partnership NHS Trust (LPT) submitted an update report on the progress made with outcomes in the Quality Improvement Programme (QIP) since the last meeting.

Dr Peter Miller, Chief Executive, LPT, Professor David Chiddick, Chair of the LPT Board, Mr Adrian Childs, Chief Nurse/Director of Quality, LPT, and Mr Paul Miller, Chief Operating Officer, LPT, attended the meeting to outline the progress made and to answer Members' questions.

It was noted that the Second Report of the Care Quality Commission (CQC) on their return inspection of the Bradgate Unit was not yet available. The Trust had received the draft report and had sent comments to the CQC. The final report was expected to be received later that week. However, initial feedback from the CQC indicated that significant improvements had been observed, but this could not be formally confirmed until the final report was received. The CQC would continue to make regular inspections until they were satisfied that the period between inspections could be lengthened to that of the normal inspection regime. The Trust would have a period of time in which to produce the Action Plan to the CQC report and then the CQC would carry out a further inspection based upon the Action Plan.

The Trust were using a 'dashboard' method to monitor progress and be alerted to any potential operational issues. A number of indicators were being used to see how the Unit was performing. Some were existing performance indicators as well as key indicators such as staff vacancies, staff sickness and levels of complaints etc were triangulated with other operational indicators to form a wider operational tool to identify any emerging trends or concerns.

Following questions from Members the LPT representatives stated that:-

a) The CQC report should show the progress made on issues raised at previous Commission meetings;

b) Indicators 35 and 36 would be measured by the documentation indicating that patients' needs had been considered. Previously, patients had been asked about their care plan but it had not always been documented.

c) The quality of interaction between staff and patients would be measured in a number of ways. For example, all named nurses were clinically supervised, the quality of the documentation would be reviewed, patients would be asked about the interaction with staff and whether they had confidence with their carers. Patients could keep their own records of interaction with staff but this would be dependent upon the patient's level of illness.

d) The QIP was not a capacity plan designed to cope with pressures under the Winter Care Plan, but if performance was improved then the quality of care would be improved. There were already capacity issues with bed occupancy rates. If this was at 100% occupancy then it made the quality of the service harder to provide. The Trust had the ability to refer patients out of county and there were currently a number of these arrangements.

e) In relation to providing continuity of service arising from organisational disruptions, it was noted that addressing the CQC's concerns about documentation being up to date would allow the service to the patient to continue in the event of high levels of staff absences. If the risk assessments and the individual's needs were included in the care plan then another member of staff could carry on with the patient's care.

Members thanked the representatives of LPT for their report and comments and stated that they would wish to see evidence in the future of the impact that the proposed changes had made to improvements in service.

RESOLVED:

1) that the progress being made by the LPT through the QIP be noted;

2) that the additional information circulated to Members by the Chief Operating Officer LPT be noted;

3) that a further update report be submitted the Commission's next meeting together with a report on the CQC's report of their second inspection visit to the Bradgate Unit.

89. ORAL HEALTH IN THE CITY

Dr Jasmine Murphy, Consultant in Public Health, submitted a report on improving oral health in the City. The report outlined the oral health needs of children in the City, NHS reforms and dentistry and the development of the Oral

Health Promotion Strategy for pre-school children. The Draft Oral Health Strategy and the Draft Action Plan were also submitted for information. Dr Murphy also gave a presentation on the report and a copy of the presentation had previously been circulated with the agenda for the meeting.

During the presentation and consideration of the report Members noted:-

a) The level of 5 years olds experiencing tooth decay was twice the national average due mainly to unhealthy diets of food and drink that that were high in sugar content.

b) City residents could access NHS dental practices anywhere they chose due to the open access nature of NHS dentistry.

c) The lowest rates of people aged 0-9 years old accessing NHS dental services were in the Westcotes and Castle wards. Members noted that these wards had the highest concentration of dental practices. It was also noted that these wards had the highest levels of transient and student populations.

d) The draft strategy was presented to the Oral Health Promotion Partnership Board in September which was being led by the Council and included representatives from NHS England, Local Dental Network, CCG, Public Health England, Health Education England and Children's Services.

e) The Board was aiming to finalise and endorse the Strategy to the next meeting in December in order for mobilisation to commence in the New Year.

f) The local dental profession were engaged in support and keen to work with the Council on improving oral health for children in the City.

g) A pilot initiative had commenced with the distribution of toothbrushes, toothpastes and leaflets to children in the City. 3,000 packs would be distributed by Health Visitors over a six month period during the universal 4 months developmental checks – this would commence in the New Year. . 4,300 packs had also started to be distributed to every child in reception classes in City Council maintained schools, with a further 4,000 packs distributed to every child in year 3 in City Council maintained schools – this distribution should be completed before Christmas 2013.

h) The dental health results for 5 year old children in the City were based upon a sample survey and it would preferable, if funding was available to undertake a census survey of every 5 year old child in order to break the figures down into ethnicity, gender and wards which would allow a more focused approach to be taken.

i) Birmingham and Coventry had fluoridated public water supplies and still

had above national average dental decay rates, albeit at a much lower rate than the rate for Leicester.

j) A social marketing exercise was being considered for the future in order to target appropriate oral health promotion messages to specific groups in the City.

k) It was also intended to include a reference to donating toothbrushes, toothpastes and leaflets to food bank donations.

Members also made a number of comments upon the draft strategy including the following:-

a) Whilst noting that there were limited supplies of the toothbrush/paste packs and that not all children would receive them, it was nevertheless important to get the message of improving oral health to all parents;

b) Walsall had undertaken a successful initiative to increase the take up of vegetables and fruit in schools through innovative and exciting characters and this could be used a model of good practice;

c) The percentage of primary school age children from BME origins was greater than the population at large and therefore the messages should be relevant to both children and parents;

RESOLVED:-

1) That the report and draft strategy be received and that members commented be incorporated into the strategy; and

2) That the Health and Wellbeing Board be asked to revisit the issue of whether local water supplies should be fluoridated as a measure to improve oral health and reduce oral health inequalities.

90. CLOSING THE GAP

The Commission received the first bi-annual monitoring report on progress in delivering the Joint Health and Wellbeing Strategy 'Closing the Gap'. The report was submitted to the Health and Wellbeing Board at its meeting on 8 October 2013. The report sought to provide assurances that actions identified in the strategy were being delivered and to flag up any potential risks to delivery. It also reported on the performance indicators set out in the strategy.

It was noted that, as this was the first monitoring report, it was too early to draw conclusions on the effects of the strategy on the intended outcomes, particularly as some of the indicators were only collected annually. At this stage, however, there were no 'red' indicators where there a serious risk of actions not being developed. 10 indicators were 'green' where good progress was being made and 6 were 'amber' where there was some risk that actions may not be delivered but the risk was being managed.

Members noted that the Strategy was based upon the Joint Strategic Needs Assessment, which identifies the main priorities and pressures which need to be addressed. The Assessment was reviewed each year.

The Chair referred to the indicators for the 'carer-reported quality of life' and the proportion of carers who reported that they had been included or consulted in discussions about the person they cared for' and expressed concerns that the performance was declining as this created a poor reflection on the service. He requested that a report be submitted to the next meeting on why these particular indicators were declining and what steps were being taken to improve them.

Members also referred to the indicator for reducing obesity in children under 11 years old and commented that health implications were not included in the implications in budget strategy reports, for example when considering playground closures etc.

RESOLVED:

1) That the report be received and the progress to date be noted;

2) That health implications should be included in reports suggesting revisions to budget strategies so that a full and informed assessment can be made of future proposals; and

3) That it would be beneficial if these monitoring reports could be presented to the Commission prior to the Health and Wellbeing Board so that the Commission's comments can be considered as part of the monitoring process; and

4) that a report be submitted to the next meeting on why the indicators relating to 'carer-reported quality of life' and the proportion of carers who reported that they had been included or consulted in discussions about the person they cared for' were declining and what steps were being taken to improve them

91. HEALTH VISITORS

A joint briefing report from Leicester City Council and NHS England on the commissioning of health-visiting services and Family Nurse Partnership in Leicester was presented to the Commission. David Giffard, Public Health Commissioning Manager NHS England attended the meeting to present the report.

It was noted that NHS England was charged with increasing health visitor numbers to 228.5 in Leicester, Leicestershire and Rutland by 2015. This required another 80 health visitors to be appointed, with the majority working in the City and good progress was being made to make the appointments. The Commissioning of health visitors and the Family Nurse Partnership would

transfer to local authorities in April 2015 and joint commissioning of the new appointments was being undertaken in preparation for the transfer of commissioning arrangements.

RESOLVED:

that the report be received and the progress be noted.

92. UPDATE ON MATTERS CONSIDERED AT A PREVIOUS MEETING

The Commission received updates on the following matters that had considered at previous meetings of the Commission:-

1. Winter Care Plan

Councillor Chaplin provided an update on the Joint Scrutiny Review meetings held on 24 October, 14 November and 19 November in relation to the Winter Care Plan. The draft report of the review would be considered at a joint meeting of the Health and Wellbeing and the Adult Social Care Scrutiny Commissions on 5 December 2103 prior to a meeting of the Adult Social Care Scrutiny Commission afterwards.

2. Francis Report

The Leicestershire Partnership NHS Trust (LPT) and the Clinical Commissioning Group (CCG) submitted update reports on progress made in relation to the recommendations in the Francis Report

The Chair referred to the openness of the LPT response and felt that this was a welcomed response to the review.

It was also noted that the Government had recently published its response to the Francis Report and had accepted 280 of the 290 recommendations. The response had also been influence by the Clwyd-Hart Report into how the NHS dealt with complaints and also the Berwick Report into NHS patient safety. Trusts needed to develop an open culture for learning and improvement from complaints etc and remove the 'culture of blame' around that learning.

Dr Miller stated that he was determined to have a culture of improvement leadership and he was keen to demonstrate that patients and staff view were be listened to and acted upon. He wished to create a self-regulating authority so that a situation similar to the CQC's action on the Bradgate Unit would be prevented in future by pro-active alerting and internal corrective measures.

Professor Chiddick confirmed that the Board were equally keen to create confidence in an open and transparent culture by demonstrating this though strong leadership and encouraging the creation and empowerment of leaders throughout the organisation. It would take time

to change the traditional barriers within the NHS to achieve this.

Following comments and questions from members, it was noted that:-

a) The Trust were actively working and engaging with voluntary sector groups to reach marginalised groups and were looking to develop different ways of partnership working at all levels of service delivery. The Trust fully recognised that, if this engagement did not take place and they did not utilise the health care services provided by the voluntary sector, there could be a 'knock-back' effect with more demands being made for acute services provision.

b) The Trust recognised that placing staff under too much pressure could also lead to less compassion in delivering services, and they wished to avoid this wherever possible.

c) There was a legal responsibility to have a 'whistle blowing policy' although the term was not liked by the Francis Report as it created a negative image of the process; whereas it was important to have a positive culture in which improvements could be derived from concerns expressed about services.

d) There was a formal procedure for dealing with issues recorded as being raised through the 'whistle blowing policy' but there were also other ways in which concerns could be raised at all levels in the Trust and those raising concerns were asked how they wished to take their concerns forward. The triangulation of concerns raised with other available information would be key to identifying and avoiding poor service delivery.

Richard Morris stated the CCG were making good progress around the four 4 priority areas identified in the previous update report.

The Chair commented that he was concerned that there was no reference in the Government's response to the Francis Report to the local government scrutiny role in the process.

3. **Unannounced Visits to UHL**

Richard Morris provided a verbal update report on two further unannounced visits from the CCG to UHL. It was pleasing that the areas identified for improvement had been addressed by the UHL Trust.

4. **Public Health Budgets**

The Chair stated that he would circulate the notes of the recent briefings in relation to Public Health Budgets to Members of the Commission.

5. **Response to the Commissions Scrutiny Review Reports.**

The Chair reported upon the presentation of the two scrutiny review reports below to the Council's Executive on 5 November 2013.

a) Revisiting the Review of Mental Health Working Age Adults in Leicester

b) Review of Voluntary and Community Sector Groups who have raised concerns about Funding, Commissioning and Tendering issues.

Both reports had been well received and had resulted in the Chair being appointed as the Council's Advocate for Mental Health. It had also been proposed to have a motion submitted to the Council meeting in January on the Council's role in promoting Mental Health issues in the City.

A joint response from Adult Social Care Services and the CCG to the Voluntary and Community Sector Review was submitted to the Commission for information. The Chair commented that the Commission's report had been a major driver during consideration of last year's budgets funding reductions.

There were some procedural issues outstanding around feedback from the Executive and the Chair intended to raise these at the next Overview Select Committee.

6. **Impact Assessment for NHS 111**

The CCG gave a presentation on the continuing implementation of the NHS 111 service. A copy of the presentation is attached to these minutes for information.

7. **Congenital Heart Disease Review**

Members received the following update reports and information in relation to the Congenital Heart Disease Review:-

a) The Scoping Document for the Review

b) 9th NHS England Bulletin

c) 10th NHS England Bulletin

d) Note of Meeting with John Holden, Lead for NHS England Review Team

8. **East Midland Regional Health Scrutiny Network**

Members received a briefing note on feedback from the East Midlands Regional Health Scrutiny Network meeting on 21 October 2013. The

Chair had also offered Leicester as a venue for the next meeting on 9 January 2014. The Centre for Public Scrutiny were using these events to engage with local authorities on a number of topics. The Chair also stated that the meetings could also be useful mechanism for the Congenital Heart Disease Review team to engage with local authorities on a regional basis.

9. **External Scrutiny Review by CfPE**

The Chair provided an update on the progress with the review and reminded Members to complete the training needs questionnaire as soon as possible.

93. CLOSE OF MEETING

The Chair declared the meeting closed at 8.55 pm

SUMMARY OF 111

- It is a 24 hour, 365 days a year telephone service for people with emergencies that are urgent but not life threatening
- It does not replace 999 which should always be the number to ring for serious or life threatening emergencies
- From November 2013 people should know three numbers – their GP surgery, 111 and 999
- Rolled out progressively across LLR to enable detailed provider and performance management against increasing call volumes
- Patient safety is paramount
- Due regard is a key priority for us

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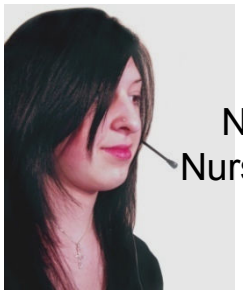
Minute Item 92

Caller dials 111

Caller dials their own GP out of hours

Warm transfer

Health Information



NHS 111 Nurse Advisor

NHS Pathways Assessment

Auto-electronic transfer to EMAS dispatch queue

999

Solution

Self care advice

Electronic Directory of Services (DoS)

Crisis Response | Midwife | GP | ED | GP OOH | WiC | MIU | Nurse | Intermediate care

WILL COVER…..

- Nationally mandated service
- Most criteria set nationally
- Public Sector Equality Duty

And….

- Significant research nationally, through pilots and local engagement
- Nine protected characteristics – patients can be in multiple groups
- Baseline assessment by protected characteristic
- Our local engagement across nine protected characteristics - examples
- Current position at launch
- Re engagement post launch to understand patient experience
- What are we doing next and questions?

CALL 111
When it's less urgent than 999

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PROTECTED CHARACTERISITICS - FINDINGS

- Age
- Disability
- Race
- Religion or belief
- Sex
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Carers

CALL 111
When it's less urgent than 999

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IMMEDIATE PRIORITIES

- **Examples of engagement, re engagement and education:**
  - **old –stakeholders, networks, target care and nursing homes**
  - **Young (inc students) – partners, social media, presentations**
  - **disability – networks, presentations, promote facilities**
  - **BME – stakeholders, networks, presentations**
  - **religion and belief – stakeholders, networks, multi dialects**
  - **gender reassignment – stakeholders, networks**
  - **pregnancy and maternity – networks, link to BME support**
  - **migrants – focus on new migrant communities, network groups**
  - **rural – reassurance re understanding of geography and**
    ographics

CALL 111
When it's less urgent than 999

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GENERAL AWARENSESS RAISING

- Leaflets and posters in GP surgeries and pharmacies
- SMS text and emails from GP practices
- Updates on prescriptions
- Other campaigns to help position NHS 111 re Choose Better
- Stakeholders circulating messages to public and patients
- Media coverage
- Stakeholders
- Many other routes

CALL 111
When it's less urgent than 999

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THANK YOU

QUESTIONS?

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