Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: TUESDAY, 22 JULY 2014 at 5.30pm

P R E S E N T :

Councillor Cooke – in the Chair

Councillor Chaplin Councillor Cutkelvin

Also in attendance

Sue Locke	Chief Operating Officer, Leicester City CCG
Rod Moore	Divisional Director, Public Health
Dr Fabdia Noushad	Community Services Specialist Clinical Director LPT
Ballu Patel	Chair Leicester Mercury Patients Panel
John Singh	Long Term Conditions Adults and Older People Manager. Leicester City CCG
Teresa Smith	Director of Adult Mental Health and Learning Disability Services LPT

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9. DECLARATIONS OF INTEREST

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

10. LEICESTER CITY CLINICAL COMMISSIONING GROUP

Sue Locke, (Chief Operating Officer) and John Singh (Long Term Conditions Adults and Older People Manager) attended the meeting to provide an overview of services commissioned, specifically relating to this topic area.

A copy of the presentation to the Commission is attached for information.

The following comments were made during the presentation in addition to the comments contained in the presentation:-

a) The CCG commissioned services at all 5 steps of the Stepped Care Model and NHS England commissioned some specialist services at Step 5 as well.

b) The programmed spend by Leicester City LPT/CCG on Core Mental Health had dropped in recent years as some funds for specialist commissioning had transferred to the NHS England.

c) The spend was, however, above the national trend for this expenditure and was on par with Derby CCG but below Nottingham CCG on weighted spend per head of population.

d) West Leicestershire CCG led on contract monitoring, finance and qualitative performance. This was monitored by the Finance and Technology and the Performance Committees. These Committees had representatives of all 3 CCGs in Leicester and Leicestershire had GPs on them.

e) The 3 CCGs spent approximately £80m on mental health services.

f) The targets for commissioned services were found in the Outcome Frameworks for NHS, Adult Social Care and Public Health and also in the contracts and KPI's for local providers.

g) Mental Health was a priority work stream within the Better Care Together strategy. The CCG was working with GPs so that services could be more responsive to changes in local communities.

h) The Liaison and Diversion Services had led the way in a national pilot initiative.

i) Although there was no specific commissioning of mental health services for young black British men, all commissioned services were available to all parts of the community and could be accessed by young black British men. More work was required to understand why this group were not accessing the services available. There was a balance to be struck between commissioning services for specific groups and commissioning universal services that were accessible by all.

Following questions from members the following comments and observations were made:-

a) The voluntary sector provided services for health, counselling and advocacy through Adult Social Care commissioning and a list of the bodies that provided these services at Steps 1-4 could be supplied after the meeting.

b) The funds transferred to NHS England filled the apparent gap in funding Core Mental Health Expenditure since the CCG was established in 2013.

c) The CCG Board receive monthly reports on attempted suicides of patients in hospital and patients 'out of stay' and the length of stay of patients. The CCG had raised some concerns with the LPT prior to the CQC initiating their inspection of the Bradgate Unit.

d) Equality Impact Assessments (EIA) were undertaken for all new service provision and these would also be undertaken for initiatives under the Better Care Together programme. EIA's were not always easily accessible from previous health bodies which were no longer in existence.

e) The CCG had used a portal in a community 'voxpop' to capture views on services and it was recognised that there was still more to do in this area.

f) The CCG worked closely with GPs in all areas of the City and listened to specific issues that may be emerging. Any proposed responses to these issues would be assessed in relation to outputs/benefits and gains to the population in order to maximise the use of limited budgets and resources.

h) National feedback on population changes was behind local information on population changes. GPs were a useful resource in identifying changes in population movements or identifying specific issues within a particular community. For example the influx of new communities such as the Somali community in recent years or different cultural approaches to lifestyle issues such as alcohol within east European communities. The CCG would also discuss with GPs the health impacts upon the system and what could be undertaken to address these.

i) Some communities showed a prevalence for only accessing services through A&E facilities because primary care services were not prevalent in their country of origin.

j) IAPS service showed that GP and locality based services were responsive to patients needs and more needed to be done.

k) CAMHS was a key stream in the Better Care Together programme.

l) Network4Change had been involved in the Crisis House consultation process which had led to the pilot scheme being introduced to see if it should be a helpline, a bed based facility, a drop in centre or an open house facility.

m) Communications on services were conducted jointly with providers through the communications engagement team.

n) The CCG used a wide variety of monitoring methods to provide feedback on issues of concern and take up of services. These

included:-

- Public Health data which could show hospital activity generated by difference communities or groups.

- GPs IT systems were also use to analyse activity by the coding of conditions.

- GPs identified clinical needs to the CCG which were then assessed to determine priorities.

- Locality meetings were held with GPs, practice nurses, practice managers and receptionists etc provided a wide range of feedback. These meetings were held monthly in each area of the city, and also included training and discussion on new initiatives. If practices did not attend the engagement team would visit the practices to ask why and to ensure that they got the information they had missed.

- There were a number of clinical leads for health issues, e.g diabetes which also helped to inform on priorities and best practice.

- The engagement team also liaised closely with community leaders.

- There were specific 'tweet' groups to keep people informed of their interest area.

- Groups with specific conditions e.g COPD had been invited to open meetings to discuss services and attendees have 'voted' on their preferences for service provision.

o) As the Mental Health Partnership developed its strategy it would consult various interest groups etc and would need to ensure that those taking part were representative of the issues involved and not just the core organisations involved in health delivery.

p) The Better Care Together Programme was currently being developed and as it went through the various stages it would be considered by the various democratic processes in all partner organisations.

Members of the Commission made the following observations:-

a) The issues facing young black British men have remained the same for the last 30 years. Numerous surveys and research have been carried out during this period, which have consistently shown that the issues still remain the same.

b) A comparison was drawn with the specific measures that were

introduced in relation to HIV and there may be a case to introduce specific targeted measures to reduce the issues for young black British men.

c) Use of social media methods should be widely utilised to engage with young people and to seek their views, comments and complaints on services, as they were less likely to use traditional methods to communicate these to statutory or formal bodies.

d) Communications should be an essential element of commissioning services if it was to be successful. Evidence suggests that including communications as part of the commissioning process, ensures that elements of communication are considered at, and embedded in, all stages of the commissioning process and, as such, both the service and the communication of it, were more successful than if communications was dealt with at the end of the process when the service had been shaped in isolation to any communication issues it might involve.

The Chair thanked Sue Locke and John Singh for their participation in the meeting.

11. LEICESTERSHIRE PARTNERSHIP TRUST

Teresa Smith (Director of Adult Mental Health and Learning Disability Services) and Dr Fabdia Noushad (Community Services Specialist Clinical Director) provided an overview of services delivered specifically relating to this review.

The following comments were presented during the overview:-

a) LPT won the tender to be a national pilot site for Liaison Diversion Services which involved working with the Police, Criminal Justice System and the Courts.

b) The Bradley Commission had made a visit on 10 July 2014

c) The Trust was working to identify local stakeholders to plan and improve services in response to the Mental Health Crisis Care Concordat issued in February 2014.

d) Some key service developments will also improve the quality of care of young black people. A briefing note on these services can be provided.

e) National data sets are being complied as part of this work which will then be broken down to local levels and although this is at an early stage and it will influence how service are provided in the future.

f) LPT pioneered the Triage Car (mental health nurse accompanying a police officer) which had now been used as a national model. The Triage Care showed a 33% reduction in people being detained under Section 136 of the Mental Health Act 1983. The Triage Car had now

been included in the Liaison Diversion Services.

g) LPT had set up the recovery college and over 500 people had gone through the college and the data was being monitored and analysed.

h) Feedback is also received for the Voluntary and Community Sector which informs the LPT on where services need to be redesigned.

i) A workshop was being held the following week to profile demographics and to see what services should be commissioned in each of the three CCG areas. Each CCG area had differing commissioning needs.

j) LPT also provides some specialised commissioned services such as health care in prisons which includes providing mental health services.

k) LPT are already rolling out the R10 system in mental health services and for older people and will shortly roll it out in the Crisis Care Team.

l) Data can be provided on the breakdown of the workforce for the services provided.

m) The 'Smoothie Project' involving music, drama and DJ skills for young black patients had produced tangible health benefits for those involved. A briefing note would be supplied after the meeting.

In response to Members questions, the following responses were received:-

a) It would take further work to look at the existing data to see if it was possible to make comparisons or show trends at national, regional and local levels for the three main mental health illnesses suffered by young black men in relation to the population as a whole.

b) LPT takes part in national data benchmarking but it does not go down to lower levels as there is no specific key performance indicator for mental health involving BME communities.

c) In some instances the Police are unaware that young black children exhibiting behavioural problems may have adopted or attachment disorder issues.

d) There are systems in place to move people quickly to hospital care if this is need, but equally there is a need for the Police to have more training on these issues in view of the number of the numbers of young black people that become engaged in the system.

e) The Liaison Diversion Services also includes a pathway for CAMHS and was felt that these pathways worked effectively.

f) The CQC identified training as an area for improvement and additional

training had now been provided for staff and staff also had access to translation service. The effectiveness of training was monitored was monitored through patient feedback and experiences, complaints received, interpreter feedback and ward monitoring and audits. There was however, more work to be done in the future on cultural competency skills for staff.

g) Patient discharge and re-admission was monitored to see if the community support was available and effective after discharge. A clinical sub-group of 3 GP lead met monthly with the commissioners to discuss these issues.

Members of the Commission made the following observations:-

a) That everyone collecting data should use the same data collection categories as those used in the national census as this would allow a consistent approach and allow more meaningful comparisons between data sets.

b) There was higher proportion of black children excluded from schools.

c) All services commissioned locally should meet the national framework set out in the Joint Commissioning Panel for Mental Health's publication 'Guidance for commissioners of mental health services for people from black and ethnic minority communities.

d) There may be a need to recall Adult Social Care officers to provide further information on the changing relationships with Akwaaba Ayeh.

e) Young black men are known to live alone and if they are leaving care robust measures need to be in place to ensure that this group receive the after car they need. Evidence may be needed from Corporate Parenting and Social Care to receive assurances that this group do not miss out on care and support provided in the community.

f) If would be useful to have data for the groups for each step level.

g) There was still a preponderance of generic commissioning of services to meet the needs of a very diverse population, parts of which had specific health issues.

The Chair thanked Teresa Smith and Dr Noushad for their attendance and participation in this review.

12. BACKGROUND PAPER FOR MEMBERS

The 'Guidance for Commissioners of Mental Health Services For People From Black And Minority Ethnic Communities' issued by the Joint Commissioning Panel for Mental Health had previously been circulated and was received as background information for the review.

13. CLOSE OF MEETING

The Chair declared the meeting closed at 7.30 pm