Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: THURSDAY, 29 OCTOBER 2015 at 5:30 pm

P R E S E N T :

Councillor Chaplin (Chair)
Councillor Fonseca (Vice Chair)

Councillor Alfonso
Councillor Bhavsar
Councillor Sangster
Councillor Singh Johal

Also in attendance:

Councillor Palmer - Deputy City Mayor
Councillor Osman – Assistant City Mayor Public Health
Richard Morris – Leicester City Clinical Commissioning Group
Surinder Sharma – Healthwatch Leicester

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32. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Dr Chowdhury.

33. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda. Surinder Sharma declared and an Other Declarable Interest in Minute No 38 (Patient Handover Performance) as his wife was a Non-Executive Director of East Midlands Ambulance Service (EMAS).

34. MINUTES OF PREVIOUS MEETING

AGREED:

that the minutes of the meeting held on 28 September 2015 be approved as a correct record.

35. PETITIONS

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

36. 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.

The Chair indicated that she had allowed the following questions submitted at late notice by Mr Robert Ball (Campaign Against NHS Privatization) to be received by the Commission:-

1. In proposed reconfigurations elsewhere in England, pre-business consultations have been submitted to the health overview and scrutiny Committee for analysis and discussion as part of the NHS' statutorily required consultation with the Committee. When will the Better Care Together pre-business consultation case come before a meeting of the Leicester Health and Wellbeing Scrutiny Commission so that the BCT leads have the opportunity to respond to the advice given by the Scrutiny Commission before formal public consultation begins and so that the public have access to up-to-date information? We do not consider any further attempts on the part of Better Care Together leads to provide briefings "in private" to the Commission to be acceptable.

2. What steps are the Better Care Together team taking to avoid misleading the public about the scale of proposed bed closures by referring to care given in patients' own homes as "beds"?

3 How has the Better Care Together team built into its proposals evidence that home delivered care typically does not reduce unplanned hospital admissions and can even increase them, with additional implications for the financial case?

4 Are answers to the questions tabled in the August scrutiny meeting now available?

The following responses were then circulated to everyone present at the meeting:-

<u>QUESTION 1 - RESPONSE FROM THE PROGRAMME DIRECTOR, BETTER CARE TOGETHER</u>

The pre-consultation business case is presently being reviewed by NHS England and the governing bodies of the BCT partner organisations. Until that process is complete and the CCGs and NHS England give approval for consultation to commence the document remains "work in progress" as it may

well change. Once the programme has approval to move to consultation and the document is finalised it will be submitted to all three scrutiny committees. Briefings have already been provided to all three committees and will continue to be so. It will also be published for public information at the initiation of the consultation process. It is not possible to provide a date at this stage when this will take place as the assurance process continues.

QUESTION 2 - RESPONSE FROM THE PROGRAMME DIRECTOR, BETTER CARE TOGETHER

There is no intention to mislead and the reconfiguration of inpatients services and the shift to care in the community and home based settings will be absolutely transparent in the PCBC and the public consultation with proposed numbers throughout. The pre-consultation business case will contain a section describing changes in system capacity and will include a description of how provision of intensive community support (ICS) services in peoples own homes will over time replace the requirement for a number of beds in hospitals. The term “beds” is used to make the differentiation to general community care. The ICS ‘beds’ function much more like hospital beds; intensive support, short lengths of stay, defined small groups of patients supported by a small defined nursing and therapy team. The ICS service is already functioning and will be enhanced and as a result will provide the facilities for patients who wish to, to rehabilitate in their own homes where there is evidence they recover quicker. The system will maintain its capacity to care for patients but in a different way.

QUESTION 3 - RESPONSE FROM THE PROGRAMME DIRECTOR, BETTER CARE TOGETHER

BCT has been guided by *The Reconfiguration of Clinical Services*, an evidence based review by the Kings Fund, which looked at the drivers of reconfiguration and the underpinning evidence. It builds on a major analysis commissioned by the National Institute for Health Research (NIHR) and reviews of service reconfigurations conducted by the National Clinical Advisory Team (NCAT). The Kings Fund report concluded that there is strong patient satisfaction associated with virtual ward programmes and case management programmes. Available evidence points to a positive impact of integrated care programmes on the quality of patient care and improved health or patient satisfaction outcomes. Patients are more satisfied with hospital at home than with inpatient care because it was possible to provide a more personal style of care and staying at home was considered to be more therapeutic. The Kings Fund also found that there is mixed evidence on the capacity of community based initiatives to reduce unplanned hospital admissions and help keep people at home. As such, the expansion of the home based intensive community support service proposed by BCT will be predominantly targeted at step-down from acute hospital and not admission prevention.

QUESTION 4 – RESPONSE

A response to this question from the Chair was sent to Mr G Whittle, Campaign Against NHS Privatization on 22 September 2015. Mr Whittle had asked the

question at the August Commission meeting. Mr Ball has been provided with a copy of the response.

37. MESOTHELELIOMA

Ghislaine Boyd, Business Development Manager presented a briefing paper from the Mesothelioma UK Charitable Trust which is based at the Glenfield Hopsital. The briefing note was previously circulated with the agenda for the meeting.

In addition to the points made in the briefing note the following comments were noted:-

a) There were 2,500 cases diagnosed in the UK each year compared to 3,400 in the United States. The condition was a cancer of the lining of the lung or abdomen caused by asbestos.

b) 30 new cases were diagnosed each year in Leicester, Leicestershire and Rutland. The University Hospitals of Leicester NHS Trust dealt with 150 new referrals each year as it was centre for excellence for the condition.

c) There was currently no cure for Mesothelioma and the average the prognosis for life expectancy, once diagnosed, was 12-18 months.

d) Mesothelioma UK was launched in 2004 with the support of Macmillan Cancer Support and the Charity became independent when it was launched in 2009.

e) The Charity had 12 nurses nationally of which 2 were currently independently funded. All 12 nurses would be funded by the Charity from 2017. Nurses were funded to work 2 days per week and it was hoped to ultimately increase the number of nurses to 18.

f) The Charity would fund research projects in conjunction with the British Lung Foundation totalling £300,000 in the next two years.

g) Fundraising was currently on target to reach £500,000 for the year with 80% from donations and 20% from sponsorship.

h) The Charity's welfare officer provided advice on benefits and compensation as well as helping to complete the associated forms with family members. The hours of this post had recently been increased to reflect the increased activity in this area.

i) The Charity organises a local monthly luncheon club activity for both Mesothelioma and lung cancer patients and their carers. A specialist nurse is always available to discuss clinical issues, which has been

found to reduce pressures on GPs and hospital staff.

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

a) The majority of new cases are aged 60 years old but there was an increase in the number of patients aged 30 years old. There had also been rare instances of children and spouses being diagnosed with the condition after coming into contact with work clothes and inhaling the fibres on them.

b) There was only limited treatment available through the NHS generally, and specialist treatment was only provided by a few centres around the country. Specialist treatment for conditions involving the abdomen was only available at Basingstoke due to its extremely specialised nature.

c) Financial support could involve government and industrial disease compensation and death benefits. The process could be complex and there were numerous forms to complete. It was beneficial to start the claim for compensation, shortly after diagnosis as this increased the levels of compensation available. There was no financial support for funeral costs but support was given to relatives to help with dealing with administrative matters when the patient died. All deaths from the disease were referred to the Coroner's Office and the Charity also provided support in dealing with this process.

d) The level of diagnosis in Leicester was relatively low compared to dockland areas and heavily industrialised areas of the north east.

e) The number of new cases was predicted to rise until the mid 2020's and then decrease.

f) The Charity had worked with the Health and Safety Executive, Fire Brigades, asbestos awareness groups and the construction industry to promote education and preventative measures. A campaign involving DIY suppliers had not been well received.

g) There was no test to see who may be vulnerable to the condition and patients were normally diagnosed in the later stages of the condition and particularly through emergency admissions rather than GP referrals.

The Chair suggested that the Charity could distribute literature through the Ward Meetings and Richard Morris, Leicester City Clinical Commission Group, offered to arrange for the Charity to attend one of its bi-monthly meetings to address GPs on the condition. Representatives of EMAS also offered to discuss how they could promote the work of the Chairty.

AGREED:

1) That Ghislaine Boyd be thanked for her informative and

educational briefing.

2) That the Charity be invited to distribute information leaflets on Mesothelioma at Ward meetings.

3) That arrangements be made for Council staff to be made aware of the condition.

4) That the Commission write to representatives of the local DIY trade to encourage them to take part in publicity campaigns with the Charity.

ACTION:

The Scrutiny Policy Officer to liaise with the Charity to facilitate the Commissions' decisions above.

38. PATIENT HANDOVER PERFORMANCE

The Commission received a presentation on recent delays in patient handovers from East Midlands Ambulance Service (EMAS) to University Hospitals of Leicester NHS Trust (UHL). Dr Richard Mitchell (Deputy Chief Executive/Chief Operating Officer,UHL), Dr Bob Winter (Medical Director EMAS) and Mr Will Legge (Director of Strategy and Information, EMAS) attended the meeting to address the Commission and answer questions on the presentation.

Dr Mitchell commented that hand-over times at the Leicester Royal Infirmary (LRI) were acknowledged as a long standing issue for reasons which have been widely stated before. The A&E unit at the Leicester Royal was the busiest single site A&E unit in the Country and had large numbers conveyed to it by ambulances. The building of the new emergency care centre due to open in November 2016, would address the current limitations imposed by the physical estate constraints and restrictions. Staff were also confident that the issues currently arising from the patient processes that contributed to some parts of the delays would be addressed before the new emergency centre opened.

The following points were noted during the presentation:-

a) The recent increase in lost hours over the 15 minutes target handover time and the 1hr + delays in September had both exceeded the levels experienced in December 2014. There were 1,400 lost hours in December 2014 compared to 1,700 in recent weeks.

b) The EMAS rate of non-conveyance to hospital in Leicestershire was 48%-50% which was the highest in the EMAS area of operation. Other areas had non-conveyance rates of 15%-20%.

c) The current pressures were seen as a consequence of the unprecedented levels of demand placed upon the Emergency Department and the LRI.

d) Action taken to date to address these issues were:-

- Continued focus on community pathways and non-conveyance where it right to do so. EMAS were currently providing a Hear and Treat service to 15%-16% of 999 callers and were looking to increase this where it was safe to do so.
- Processes had been reviewed and communications streamlined between UHL and EMAS staff through implementing new technology whereby staff from both services could enter simultaneous PINs to verify patient handover details.
- EMAS Emergency Care Practitioners had also worked as part of the UHL clinical team at times of peak demand.

e) Further planned actions included combined working on greater management of GP urgent flows, assess options for future 'surge' support from EMAS and other partners, complete data alignment of new handovers screens, assess the potential for increasing non-conveyance rates by possible support from GPs through the extended evening and weekend working arrangements currently being put in place.

f) Unipart had been engaged to undertake an 8 week appraisal, analysis and re-design of process to achieve greater efficiencies, following their initial 5 day interim work on process mapping exercises and gathering data. This had the support of the Trust Development Agency and was designed to achieve rapid improvements in systems, internal capacity and skill sets to achieve sustainable working practices in the future.

Following discussions and questions from Members, it was noted:-

a) The delays impacted upon the EMAS performance for responding to 75% of RED calls in 8 minutes. The current performance was 67%.

b) During October EMAS had conveyed 4,887 patients to the LRI compared to 5,017 to the Queens Medical Centre (QMC) at Nottingham. It was noted that the number of 'walk-in patients' to the A&E unit was considerably far higher in Leicester than Nottingham.

c) The estate footprint for the A&E unit at the QMC was 30% - 40% larger than the LRI and had been purpose built to accommodate patient flows through the hospital.

d) Whilst 1,650 hours had been lost at the LRI in October, only 570 hours had been lost at the QMC. The number of delays over 2 hours during October had been 103 occurrences at the LRI compared to 2 at the QMC.

e) The design of the QMC allowed for non-acute patients to be treated on trolleys at times of high demand which was not an option at the LRI. This meant that ambulances could return to service sooner at the QMC, whilst at the LRI this resulted in non-acute patients being assessed and held in ambulances until they could be transferred over to LRI staff.

f) Ambulances were not designed as platforms for treating a patient over a long period.

g) EMAS would always prioritise responses to Red category calls. At times when ambulances were experiencing long delays in handovers at the LRI, patients within the Green 1 and Green 2 category response times were disproportionately affected, as the remaining available ambulances were responding to Red category responses.

h) Ambulance crews also experienced additional emotional pressures as communications to all ambulances were open channel broadcasts and they would be aware that there were Red category calls that they could not respond to whilst waiting to hand patients over to hospital staff.

i) EMAS were highly focused on quality patient care and the call centre operatives carried out regular welfare checks and gave reassurance to patients when delays were being experienced. Where required, the status of the call could be upgraded if a patient's condition required this. EMAS were not aware of large numbers of patients being put a risk as a result of delays, but there were a number of patients in a healthcare setting that experience longer waiting times to be transferred.

j) The LRI was not the only hospital in the EMAS area of operation that was experience the problem of delayed handover times.

k) Whilst the work being undertaken by Unipart was designed to improve efficiencies, it would not itself address the challenges faced during the winter care period if there continued to be excessively high levels of attendances with resultant delays in discharges and transfer to social care.

AGREED:

1) That the representatives of UHL and EMAS be thanked for their presentation and reassurances on the work being undertaken to address the issues of delays in patient handover times.

2) The proposed re-modelling of the procedures and systems to make them more efficient were welcomed and it was hoped that a key element of this would also focused on improving the patient experience.

3) That both organisations should provide a glossary of abbreviations in future, or state them in full when making a presentation to non-NHS staff.

4) That a further presentation be submitted to the Commission in January providing an update on the outcomes of the Unipart initiative and the measures that have been put in place to reduce the impact upon patients.

ACTION:

That the Scrutiny Policy Officer add the update on the presentation to the Work Programme.

That UHL and EMAS give an update to the January Commission meeting on the outcomes of the Unipart initiative and the measures put in place to reduce the impact upon patients.

Councillor Singh Johal left the meeting part way through this item.

39. ANCHOR CENTRE UPDATE

The Commission received an update report on the plans to relocate the 'Wet Day Centre' (Anchor Centre).

The Assistant City Mayor, Public Health reported that work had been carried out on addressing the heating, electrical, and lighting issues previously reported to the Commission. This would enable the centre to stay open at its current location in the interim period until an alternative site could be found. Works to repair the roof had not been undertaken for this reason, but would be required if alternative accommodation was not secured. Work had also been authorised to repair or replace the shower.

Officers were still investigating a number of buildings as a potential site for the centre but none had been identified at present.

The Chair commented that she was delighted to see the progress that had been made and that the comments previously made by the Commission to consult ward members about potential buildings had been implemented. It was hoped that Commission's previous comment to involve residents once a potential site had been identified would also be adopted.

AGREED:

1) That the report be received and the actions taken be welcomed.

2) That a further update be presented to the next meeting of the Commission.

ACTION:

The Scrutiny Policy Officer to add the update report to the Work Programme for the January 2016 meeting of the Commission.

40. HEALTH AND WELLBEING BOARD

The Deputy City Mayor gave a verbal update outlining the current work of the Health and Wellbeing Board.

The Deputy City Mayor stated:-

a) There remained an invitation for a representative of the Commission to attend all Board meetings.

b) The Board's focus in next few months would be to:-

i) Develop and publish the Joint Health and Wellbeing Strategy. The current Strategy expires in 2016 and needed to be updated and re-published. Although the republished strategy would set out the priorities for 2016-19, the Board also wanted to set out their vision for the health and wellbeing of the city for the next 20-25 years. The Board were working on establishing sensible milestones and priorities for themes involving healthy children, healthy lifestyles, healthy minds and aging well in Leicester.

The Board recognised that there was now a substantial evidence base on the health and wellbeing of citizens and this should be used to shape a bold and adventurous Strategy for the future. The Strategy should encompass more imaginative use of assets such as economic and social capital, green spaces and community and voluntary assets.

There would be a period of public engagement to underpin and shape the strategy towards the end of the year.

ii) Leading the development of the Live/Work Leicester Campaign The Board were taking the lead role in developing the joint campaign involving the Council, health partners and other interested parties such as the Leicester Child Improvement Board to address the shortage of skilled workers in children's services and social care, GPs, and NHS staff in primary care.

The aim was to produce a coherent approach amongst all partners to positively promote Leicester as a vibrant place in which to live and work. Leicester had a good medical school but there were currently a large number of vacancies in the East Midlands Training Programme for GPs.

The Commission's eventual outcomes on the scrutiny review of the 'Primary Care Workforce' would be welcomed by the Board.

c) The Board's role had been evolving since it was formally established in April 2013. The challenges posed by the health system were constantly changing and emerging. The Board regularly signed off Better Care Together assurance reports which had previously been carried out elsewhere.

Following questions from Member, the Deputy City Mayor commented that:-

a) The Board's role in relation to the BCT strategy was largely that of a strategic oversight and to provide one of a number of public arena where these issues could be discussed. The Board also had a role in relation to receiving assurances and to questioning the proposals, although the Board were mindful that they did not have a scrutiny role. The Better Care Together Board now met in public and this also provided a level of public scrutiny of the development of the Better Care Together proposals.

b) The Chair of the Commission and the Deputy City Mayor would discuss their respective roles in order to avoid duplication of effort in relation to the sign off of the pre-business case prior to consultation on the BCT proposals.

c) The Better Care Together Programme Director had responded positively to the comments made at the last Commission meeting and the Chair's subsequent letter in relation to encouraging partners to be more open and transparent in providing information. The Board had resisted private briefings on the programme; preferring to receive public reports and updates.

d) It was appropriate for the scrutiny commissions/committees in Leicester Leicestershire and Rutland to scrutinise the BCT proposals when the consultation process started later in the year. He supported a collaborative approach to joint scrutiny of the proposals as the programme included an interdependency of proposals for health service in both the City and the County. He considered that scrutiny's role was to look at specific parts within the programme and the consultation process to be satisfied that the programme was heading in the right general direction and was responding to the challenges being faced by the health economy.

e) The strategy would encompass proposals for addressing health inequalities within different ethnic groups based upon the wealth of evidence from various health and wellbeing surveys.

f) It was hoped to have the draft Joint Health and Wellbeing Strategy prepared by February 2016 and views of the Commission would be

welcomed.

g) The Board would have performance indicators for initiatives in the new strategy and would take ownership of 'recovery plans' for areas of concern or poor performance. These reports were considered in public at Board meetings.

Richard Morris, Leicester City Clinical Commissioning Group (CCG), commented that the BCT Programme Director had been unable to answer some of the Members' questions in full at the last meeting; as they related to specific details in the proposals which had not been approved for consultation by the CCG. The CCG had indicated that any information that would be available to the public through a Freedom of Information request should always be provided in public meetings.

The Chair thanked the Deputy City Mayor for the informative update in the Board's work.

AGREED:

1) That the Deputy City Mayor's support for joint scrutiny be welcomed.

2) That the Commission receive a further report when the Draft Joint Health and Wellbeing Strategy was available for consultation.

3) That the Chair and the Deputy City Mayor meet to discuss protocols for the respective roles of the Commission and the Board to avoid duplication in considering the Better Care Together Programme.

4) That the Commission nominate a member to attend meetings of the Health and Wellbeing Board.

5) That the Deputy City Mayor presents regular updates on the Board's work to future Commission meetings.

ACTION:

The Chair and Deputy City Mayor meet to discuss avoiding duplication of work in relation to the Better Care Together Programme.

The Director of Public Health submits a report to the Commission when the Draft Joint Health and Wellbeing Strategy is available for consultation.

The Commission nominates a representative to attend meetings of the Health and Wellbeing Board. Members who are interested in this role to contact the Chair or the Scrutiny Policy Officer.

The Scrutiny Policy Officer to update the work programme to include regular

updates on the work of the Health and Wellbeing Board to future meetings.

The Deputy City Mayor left the meeting at this point.

41. NHS 111 SERVICE

The Commission received an update from Sara Prema (Chief Strategy and Planning Officer, Leicester City Clinical Commissioning Group) on recent issues relating to capacity issues, staff shortages in relation to the operation of the NHS 111 Service, and in difficulties experienced by users of the service accessing translation services.

During the update the following was noted:-

a) The contract covering Leicester, Leicestershire and Rutland was provided by Derbyshire Health United (DHU) and West Leicestershire CCG had the lead role for the contract which was commissioned by all 3 CCGs in Leicester, Leicestershire and Rutland.

b) DHU were contracted to provide a 24/7, 365 day a year NHS non-emergency telephone advice and triage service to direct patients to the best medical care that meets their needs.

c) DHU also provided services to other CCGs in the region.

d) The issue had arisen following allegations in the media from a former DHU employee which related to the Derbyshire call-centre and not the Leicestershire call-centre. At peak times, however, both call-centres could take calls on behalf of each other if one call-centre was experiencing particularly high levels of calls. The allegations in the Derbyshire call-centre included low clinically trained staffing levels, service targets missed on answering calls, lack of clinical support to non-clinical call handlers and calls being avoided by call handlers.

e) In addition to the ongoing contract assurances process, local commissioners and regional commissioners were seeking assurances in relation to the concerns raised. The Provider was also providing assurances to concerns raised.

f) West Leicestershire CCG held monthly contract meetings with DHU where quality, finance and performance issues were reviewed and discussed. The CCG had undertaken a visit in March 2015 that highlighted that DHU provided a safe, effective, caring, responsive and well-led service.

g) Following the recent allegations, West Leicestershire CCG made an unannounced visit to the Leicestershire NHS 111 site to review staffing

levels, planned staffing levels, sickness and absence levels, recruitment processes, staff experience and safety and quality. There was no evidence from the visit, or the documentation provided, that supported the issues raised. Further assurances have been received from DHU and North Derbyshire CCG based upon their preliminary findings from their investigations. To date no escalation has been made.

h) Due to a number of CCGs commissioning services from DHU assurances on the issues raised was being managed at regional level. North Derbyshire CCG were leading an external investigation focusing on staffing levels and warm transfer of calls. The review included a review of staffing levels for a 13 week period from 29 June to 27 September 2015. A Reginal Investigation Group had also been established to support the CCG with its investigation. The final report was expected to be available at the end of November 2015.

i) DHU are also conducting their own internal investigation led by the Director of Nursing, Director of Performance and Director of Finance, which is due to be completed in December 2015.

j) Following the completion of the two investigations, the Oversight Group would review all the information and if appropriate, action plans would be developed and subsequently monitored through the contractual process.

k) In relation to the access to translation services, DHU used Language Line and they had experienced an issue where a small number of calls were delayed due to work on the Language Line telephony platform. This was expected to resolved before the end of October. However, DHU had also taken the decision to have a second source provider to increase the availability of interpreters at times of increased activity and to make the service more robust.

In response to a Member's question Sara Prema and Richard Morris confirmed that they would seek to locate the Equality Impact Assessment that was undertaken for the service. It was thought that that this was a national EIA. The Chair requested that if the national EIA was not readily available, a local EIA be prepared to take account of the technical issues which had led to the recent problems.

AGREED:

1) That the comprehensive and re-assuring update be received and that the outcomes of the two investigations by North Derbyshire CCG and DHU be submitted to a future meeting of the Commission.

2) That the national EIA be forwarded to the Commission, or failing that, a Local EIA be prepared taking into account the recent technical issues.

ACTION:

The Leicester City CCG to provide an EIA for the NHS 111 service commissioned by them.

The Leicester City CCG to provide a further report on the outcomes of the two investigations into recent events.

The Scrutiny Policy Officer to update the Work Programme accordingly.

42. PUBLIC HEALTH PERFORMANCE

The Director of Public Health submitted a report giving an overview of performance management in relation to public health in Leicester. The report focused on the delivery of national and local priorities. The local priorities were expressed in the key plans and strategies for public health in the City and wider plans and strategies to which public health makes a significant contribution. The national priorities were captured in the national performance framework for public health (the Public Health Outcomes Framework - PHOF). The report included a summary of current performance against the various plans and strategies and the PHOF.

In response to Members' questions and comments, the Deputy Director of Public Health commented that:-

a) Whilst the regular monitoring report would not be broken down into sub-groups such as age and ethnicity etc for each measurement, it would be possible to do this in instances where a measurement gave rise for concern and warranted further investigation.

b) There was data on respiratory diseases, such as diagnosis and treatment of COPD and that this could be included in future monitoring reports.

c) It would be possible to show a breakdown by gender for the performance of priorities in future reports.

d) "Health Life expectancy at birth" appeared in both the 'Indicators that are significantly worse than the national rate' and the 'Indicators showing improvements' because, although the average life expectancy in Leicester was significantly lower than the national average; the gap in that difference had reduced considerably this year.

AGREED:

1) That the report be received.

2) That a Public Health Performance Monitoring report be

submitted to the Commission quarterly on both national and local priorities, and that respiratory care (COPD) be added to future monitoring reports and also all the performance measures show the differences between gender.

3) That the Health Messaging Task Group be asked to consider smoking cessation as part of their review.

ACTION:

The Director of Public Health to submit quarterly monitoring reports to future Commission meetings, including respiratory care and gender analysis.

The Scrutiny Policy Officer to include smoking cessation in the Health Messaging Review.

The Scrutiny Policy Officer to update the Work Programme to include quarterly Public Health Performance Reports.

The Assistant City Mayor Public Health left the meeting during this item.

43. HEALTH AND WELLBEING SURVEY UPDATE - HEALTHY EATING

The Director of Public Health submitted a report providing an update on the Health and Wellbeing Survey which was the subject of a presentation to the last meeting of Commission. The report also contained additional information on the Diet and Healthy Eating aspects of the survey as requested at the last meeting of the Commission.

Members had also been provided with a copy of the final report on the findings of the survey which can be found on the Council's website at the following link:- http://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-and-information/leicester-health-and-wellbeing-survey-2015.

Members commented that:-

a) The report lacked detail on the operation of food banks and this information was still required.

b) Further work was required on the apparent correlation between Stoneygate Ward having the highest concentration of take away food outlets and one of the lowest rates of residents preparing a meal from basic ingredients and a lower rate of residents eating 5 portions of fresh, tinned, frozen or dried fruit and vegetables in a day.

c) Further information was required on the reasons for the comment that 'Muslim residents and Sikh residents in particular are more likely to mention friends/family pressures' in response to 'Barriers to healthy eating'.

d) There was confusion in what exactly constituted a portion.

e) That the feasibility of school kitchens opening at week-ends to demonstrate basic cooking skills to the local community should be explored.

Ivan Browne, Deputy Director of Public Health, commented that whilst concentrations of take away food outlets in a particular area was not a material factor that could be taken into account by the Council as the planning authority in determining planning approvals for such establishments; he felt there was also a responsibility for the Council, as the public health authority, to ask whether a concentration of such outlets in a particular area was appropriate.

AGREED:

1) That the update be received and a further update be submitted to the Commission at its January meeting.

2) That the Executive be advised of the Commission comments and they be asked to provide a response on proposals to address them.

ACTION:

The Scrutiny Policy Officer to add a further update on the item to the Work Programme and to request the Executive to respond to the Commissions comments.

The Director of Public Health submit information on the operation of food banks as previously requested.

44. HEALTH MESSAGING REVIEW

The Chair provided a verbal update on the progress in relation to the Health Messaging Review being undertaken by the Commission. She stated:-

- It was intended that the report from this work would be a constructive part of the council's aims to improve health messaging to support people in Leicester and help deliver Better Care Together.

- The first Task Group review meeting had reviewed the scoping document and members had suggested schemes/ initiatives/research that could be asked to provide evidence. Superheroes in Walsall, the men's health forum, the children dental campaign Leicester,

psychological research (British Psychological Society), the Richard III communications campaign, King's Fund, Public Health England, the professional body for public health officers, other local authorities, the hospitals, etc.

- It was agreed to focus on three priority aspects of health for the city: cardio vascular disease (including diet); mental wellbeing and smoking cessation. These areas would naturally involve broader links with council services like such as parks, events, cycleways and transport etc.

- The review would also look at core communication of a successful campaign that had resulted in a good impact, such as Richard III, to see if there were communication lessons to be learnt in terms of better reach and effect incorporating partnership working and evaluation of the outcomes.

- In addition to the key questions in the scoping document it was also proposed to evaluate communicating to minority populations, the ways clinicians (and communicators) make the most of a key situation/venue to communicate health messages and the effect of technology.

Other points that would be explored would include:-

- Establishing whether there was or should be a communications guide/toolkit across agencies in Leicester City Council.
- Whether clinicians were trained in health messaging.
- Do big health scare stories in the media help or hinder (eg processed meat, flu vaccinations).
- Health communications should be informing – influencing-motivating, evaluation of success is important.
- Evaluating whether the advertising boards in the windows of the customer service centre could be digital and would that be helpful to show people activities and events that might help with health and wellbeing.

Actions:

- October/November/December – All members of the scrutiny commission were asked to put forward further suggestions of examples of good (or poor) practice.
- November –organisations to be invited to submit written evidence.
- November – invite current communications representatives to the next meeting – Public Health, UHL, (particularly in relation to our key areas) Richard III Communications Team.
- Next meeting in early January – communications teams written and oral evidence to be considered.

AGREED:

That the update be received and that the Air Quality, 5 a day and

COPD elements of health messaging be added to the January meeting.

ACTION:

The Scrutiny Policy Officer to implement the actions outlined above.

45. PRIMARY CARE WORKFORCE - SCOPING DOCUMENT

Members received the draft scoping report for a proposed scrutiny review on the 'Primary Care Workforce' and were requested to make comments on the draft and approve the terms for the review.

AGREED:

that the terms of references in the scoping report be endorsed and that they be submitted to the Overview Select Committee for approval.

ACTION:

The Scrutiny Policy Officer to submit the Scoping document to the Overview Select Committee for approval.

46. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2014/15.

AGREED:

That the programme be received and updated by the items which were added at the last meeting and this meeting.

ACTION:

The Scrutiny Policy Officer to update the Work Programme.

47. UPDATE ON PROGRESS WITH MATTERS CONSIDERED AT A PREVIOUS MEETING

There were no updates on previous items.

48. ITEMS FOR INFORMATION / NOTING ONLY

The Commission noted the following:-

a) Reduction to Public Health Budget

A letter that was sent on behalf of the Commission to the Secretary of State for Health following the Commission's previous discussion on the Government's proposal to reduce Public Health funding by £200m in 2015/16.

49. CLOSE OF MEETING

The Chair declared the meeting closed at 8.30 pm.