Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 25 MAY 2016 at 6:30 pm

P R E S E N T :

Councillor Dempster (Chair)
Councillor Fonseca – Vice-Chair

Councillor Chaplin	Councillor Sangster
Councillor Cleaver	Councillor Unsworth

Also Present:

Mary Barber	Programme Director, Better Care Together
Professor Adrian Childs	Chief Nurse and Deputy Chief Executive, Leicestershire Primary Care NHS Trust.

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1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Cassidy, Osman and Palmer and Surinder Sharma and Karen Chauhan from Healthwatch Leicester.

2. DECLARATIONS OF INTEREST

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

3. MEMBERSHIP OF THE COMMISSION

Members noted that the membership of the Commission for the 2016/17 municipal year that was submitted to the Annual Council meeting on 19 May 2016 as follows:-

Councillor Dempster – Chair
Councillor Fonseca – Vice-Chair

Councillor Cassidy
Councillor Chaplin
Councillor Cleaver
Councillor Sangster
Councillor Unsworth

1 unallocated Non-Grouped Place.

4. TERMS OF REFERENCE

Members noted the Terms of Reference for the Commission as approved by the Council at its Annual Meeting on 19 May 2016.

5. DATES OF COMMISSION MEETINGS

Members noted that meetings of the Commission would be held on the following dates during the municipal year 2016/17:-

Wednesday 25 May 2016 – 6.30pm - G01, City Hall
Thursday 30 June 2016 – 5.30pm - G01, City Hall
Wednesday 7 September 2016 – 5.30pm - G01, City Hall
Wednesday 9 November 2016 – 5.30pm - G01, City Hall
Wednesday 4 January 2017 – 5.30pm - G01, City Hall
Wednesday 8 March 2017 – 5.30pm - G01, City Hall

6. MINUTES OF PREVIOUS MEETING

RESOLVED:

that the minutes of the meeting held on 21 April 2016 be approved as a correct record.

7. PETITIONS

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

8. 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 requested officers to consider allowing questions at meetings after the agenda had been published. Members of the public were also advised to submit any questions to the Democratic Support Officer who would arrange for them to receive a written response.

The Chair commented that it was also intended to undertake joint scrutiny with the Children Young Peoples and Schools Scrutiny Commission on CAMHS and integration of Children's 0-19 services during the next year.

There would also be joint scrutiny with Leicestershire and Rutland on the Better Care Together Programme during the consultation period to allow a joint response to be made in accordance with the Regulation 30 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

ACTION:

The Democratic Service Officer to provide advice to the Chair on the whether questions could be submitted to the Commission after the agenda had been published.

9. HEALTH PROFILE OF LEICESTER

The Director of Public Health gave a presentation providing an overview of 'A Picture of Health in Leicester City.' The presentation had previously been circulated with the agenda.

During the presentation the following comments were noted:-

a) There was now a considerable amount of data collected in the city for public health which helped to identify trends and target services. The last Health and Wellbeing survey in the city had been conducted in September 2015.

b) Child dental health had been the worst in the Country; but this had now improved by four places nationally in a short space of time due to the improvement plan introduced 2 years ago, though continued effort was needed.

c) Life expectancy for people living in city was still below the national average for both men and women; but this has shown some signs of improvement in recent years.

d) Generally people were living in good health until 58 years old and the challenge was to improve the length of time people lived in good health. Life expectancy was worse in the more deprived areas of the city compared to the more affluent areas.

e) Emergency hospital admission rates were higher in men, older ages and ethnic groups.

f) People experiencing social isolation had higher levels of poor wellbeing and mental health. Women had higher levels of poor mental health compared to men.

Following questions from members it was noted that:-

a) The City had been divided into quarters for the purposes of the survey. It was possible to use the data in the surveys to look at specific issues in greater detail, however the data could become unreliable if applied to ward level issues in some instances as the sample group in some wards may be too small for reliable statistical analysis. Public Health England also provided detailed information at ward level based upon their detailed data.

b) Teams working in Family and Children Centres had access to breast pumps, but introducing a loan system would help to improve breast feeding rate further.

c) Dentistry services were complicated to monitor as the services were commissioned by NHS England. The information on the provision of private and NHS dental services in the city would be held by NHS England.

d) Reductions in cancer and heart related diseases had already been observed in the city as a result of people benefiting from stopping smoking through the smoking cessation programme.

e) Public Health Services would need to be increasingly targeted at areas of need in the future as pressures on budgets increased. Data from the surveys would be an essential part of the decision making process.

f) The data from the health surveys was an open resource and was used widely within the local health economy to shape service provision. For example, the CCG used the data in planning GP services in the city.

g) GPs prescribed approximately 2,000 people a year for physical activities with leisure centres. It had been recognised that success rates improved for carrying on physical activity afterwards if the patient was allow to take a friend as well in the initial prescription period.

h) The Director of Public Health noted that ward health profiles for everywhere in the country were publicly available on-line and commented that ward boundaries could be an artificial area in relation to some issues affecting particular neighbourhoods/communities within the city.

Following the presentation Members made the following comments and observations:-

a) That whilst the reduction in smoking rates was welcomed, and the need

to reduce the smoking cessation budget resources as a result of the impact of e-cigarettes and self-help methods, there were reservations that budgets could be re-instated in the future should future advice change about the use of e-cigarettes.

b) The benefits to people's wellbeing through activities such as gardening should be recognised and promoted where practicable.

c) The participation in the outdoor gyms in the city could be improved if they were supported by introduction/training sessions for new users.

The Chair stated that areas of particular interest to the Commission in the future would be improving mental health, particularly as this was underfunded in many areas, reducing social isolation and reducing long term sickness level including disabilities.

It was noted that the Commission had previously looked at a number of specific issues relating to mental health and further consideration of this would be useful.

AGREED:

That the Director of Public Health be thanked for the presentation and that further work on mental health be incorporated into the work programme of the Commission.

ACTIONS:

The Director of Public Health:-

To circulate the Leicester Health and Wellbeing Survey 2015 report to all new members of the Commission.

To submit a briefing paper on measures that different services were doing to improve mental health be added to the Work Programme.

The Scrutiny Policy Officer to add Adult Dental Services and Measures to Improve Mental Health to the Work Programme.

10. BETTER CARE TOGETHER

The Programme Director, Better Care Together gave a presentation providing an overview and update of the Better Care Together Programme (BCT).

During the presentation the following comments were noted:-

a) That the timetable for consultation on Better Care Together had been delayed further due to requirement for 42 national health areas to provide Local Health System Sustainability and Transformation Plans under 'The Delivering the Forward View – NHS Planning Guidance 2016/17– 2020/21' issued in December 2015. This required placed based health providers to create an ambitious local blueprint for accelerating its implementation of the Forward View. These Sustainability and Transformation Plans (STPs) would cover the period between October 2016 and March 2021, and would be subject to formal assessment in July 2016 following submission in June 2016.

b) The Guidance had been published jointly by NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE). The guidance asked the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

c) The local health area covered Leicester, Leicestershire and Rutland and whilst the Better Care Together pre consultation Business Case had been reviewed favourably by the NHS Review Panel they had asked for further details on finance, capital and capacity.

d) NHS England had issued advice that as the BCT was a part of the STP, it would not be possible to proceed with consultation on BCT until the STP had been formally approved. This meant that the Business Case required amendment and it was therefore available for public consideration at this time.

e) A letter had been sent to NHS England expressing the need to move forward locally on the BCT and this could be shared with the Commission members.

f) The delay to the consultation, however, only delayed changes to services that required public consultation, such as the University Hospitals of Leicester NHS Trust's proposals to reduce acute care from 3 sites to 2, which involved the significant shift of services from the General Hospital Site to the LRI and Glenfield Hospital sites. It would also affect the proposals for the Maternity Services and the Women's Hospital at the LRI. These services were also subject to capital finance approvals before proceeding.

g) Some changes to services could still go ahead as these were operational changes which did not require statutory consultation. These included the Integrated Community Support Services and Review of services for people with mental health conditions and learning difficulties.

Following questions from members it was noted that:-

a) Any planned transfer of patient care from the acute sector to community hospitals and the social care sector would not occur until service plans were in place in these sectors.

b) The provision of hospital beds at home was not suitable in all cases and would only happen if this was the patient's preferred option and the patient's home was suitable to accommodate a hospital bed. Where this was not suitable an alternative offer of rehabilitation in a community hospital would be provided.

c) Where a hospital bed at home was provided, qualified nursing staff would visit the patient 4 times a day to give clinical treatment and there would also be an input from social care services.

d) The NHS were funding the twin tracking of services to allow the transfer of patients from the acute sector to the primary care and social care sector.

Following the presentation Members made the following comments and observations:-

a) Members were concerned at the delay to the BCT process as a result of the STP process. A further initiative being rolled out on top of one that had yet to be implemented gave rise to further concerns.

b) The delays to the consultation process made planning between the health and social care economy difficult especially given the current budgetary constraints and the need to target budgets at areas of need.

c) The Programme Director BCT was asked to provide a further briefing paper on the service transformations that could proceed without statutory public consultation. In response it was noted that these details may be available at the end of June.

d) Healthwatch could provide feedback on patient experiences of the new service changes.

The Chair stated that she would discuss the concern at the delay on the BCT consultation with the Deputy City Mayor and agree a response to NHS England which would be shared with members of the Commission.

The Strategic Director of Adult Social Care commented that:-

a) The Council received £14m from the Better Care Fund (BCF) to enable the transformation and integration of services with health partners. Leicester, as a local authority, was at the higher end of the proportion of BCF funds invested through adult social care services and delivery in comparison with other local authorities.

b) BCF funds had been used to improve the poor performance in the discharge of patients from hospitals back to the community/their own homes. Joint working in partnership with UHL and LPT had moved the performance from the bottom quartile to the top quartile in the last year.

c) The growing pressures on the social services budget came from increasing demand but particularly from working age adults over and above that from the increasing care and support needs of older people. There were increasing numbers of people aged 40 -65 years old who had multiple physical and mental health conditions which impacted on their own self-care

d) The national living wage had also placed additional pressures on the budget as it resulted in an additional cost of £4m per year. Whilst the government had allowed Council's to raise an extra 2% through Council Tax: this would only raise £1.8m per year. This extra cost was for existing service provision and not a service increase.

The Chair indicated that she would discuss the issues raised with the Chair of the Adult Social Care Scrutiny Commission with a view to undertaking joint scrutiny on the BCF investment and the measures being taken to address emerging issues such as the pressures being put on the budget by people of working age.

AGREED:

That the Programme Director be thanked for the presentation

ACTIONS:

The Chair to :-

Discuss the delay to the BCT consultation with the Deputy City Mayor to agree a response to NHS England.

Discuss the issue of possible joint scrutiny with the Chair of the Adult Social Care Scrutiny Commission.

The Programme Director BCT to :

Provide Members with a copy of the letter sent to NHS England.

Further details of those service changes which would proceed without public consultation and those that would be subject to the statutory public consultation process.

11. CAMHS

Professor Adrian Childs, Chief Nurse and Deputy Chief Executive of the

Leicestershire Partnership NHS Trust (LPT). Presented a report which gave a service brief and position statement on the Child and Adolescent Mental Health Services (CAMHS).

It was noted that:-

a) The data in the report related solely to the city and excluded the costs for Leicestershire and Rutland.

b) The 10 bed CAMHS Impatient Service unit was based temporarily at Coalville Community Hospital was commissioned by NHS England as it provided a regional service for not only Leicester, Leicestershire and Rutland but also Derbyshire, Lincolnshire and Nottinghamshire.

c) Planning for a permanent site for the service was being delayed until the outcomes of the 'Future in Mind' review process was known as this could have an impact upon the number of in-patient beds to be provide. Planning for a permanent site would also require capital finance approvals. When the final commissioning requirements were known, there would be consultation on the proposals.

d) Following previous concerns at the number of children and young waiting for an appointment for over 13 weeks, extra resources had been directed to address the issue. In November 2015 the waiting list was 250 and this had been reduced to the current level of 43. The remaining 43 cases had been booked appointments for assessment by the end of June.

e) Other improvements to the service included:-

- Providing a single point of access through care navigators to help families, carers and children to work through the health care system to receive help and treatment.

- There was a Focus on 'Evolving Minds' and the service was working with young people to seek their views on how they would like access the service to get information on issues that were of concern to them. Smart phone applications and the website were being developed to enable direct access for young people.

- School nurses worked closely with CAMHS so children can contact the School Nurse service through an 'app'. The response to any enquiry was provided by a qualified nurse. This had resulted in providing help issues such as bullying and eating disorders at an earlier stage, as children were more comfortable in communicating with an 'app' than talking to an adult.

Following comments from Members, the Chief Nurse and Deputy Chief Executive stated that:-

a) Whilst it was recognised that the views of the children involved with the service were important, this had to be balanced with the views of their parents and carers which was often at variance with the views expressed by the children.

b) The service recognises the importance of other services views and input they can bring to add to the service. School nurses, in particular play an important part in identifying issues by holding discussion groups in schools and seeking the views of how young people would want the service to operate.

c) The majority of schools are engaged with school nurses who will work closely with the teacher of the children and young people and their families to identify a whole package of measures to address the needs of the child or young person. The school nurses can access the services available from social workers, communication experts, and specialist with knowledge of learning difficulties, dementia and many more health conditions.

d) The service also works closely with the Police and engages in joint training. The service also has links with the Glen Parva Youth Offending Centre, the prison and probation services and many other agencies.

d) Treatment plans for children and young people involved with the service have a widespread number of initiatives and activities to improve mental wellbeing and physical activity. However, the service is not able to be involved with the child or young person to follow up and monitor provision after the discharge from the service.

f) Whilst a number of suggestions were worthy of merit: the service could only provide what it was commissioned to provide in relation to the health and wellbeing of children and young people referred to the service.

g) There was still work to be undertaken to enable primary care services to identify and refer cases to the service at an earlier stage than at present.

Members commented that it would be useful to have a Venn type diagram showing the services provided and the interaction with other agencies to depict the direction of travel for the service.

The Chair stated that:-

a) She felt the delay in providing a permanent site for the service was unacceptable and she would discuss the issue with the Deputy City Mayor.

b) There were always risks involved in transformational changes and there were concerns for children who had identified issues and could not access the service. In some instances children with mental health

issues were not referred the service when they had not been assessed by staff that were qualified to make that judgement.

c) She would also discuss with the Chair of the Children, Young People and Schools Scrutiny Commission to arrange for 2 representatives of the Youth Council to take part in a joint scrutiny of the CAMHS service.

AGREED:

That the Chief Nurse and Deputy Chief Executive of LPT be thanked for the briefing and that the Chair have discussions with the Deputy City Mayor and the Chair of the Children, Young People and Schools Scrutiny Commission to discuss the issues identified above.

ACTIONS:

The Chair to:

Discuss the delay in providing a permanent site for the service with the Deputy City Mayor.

Discuss the issue of joint scrutiny with the Chair of the Children, Young People and Schools Scrutiny Commission on the CAMHS service and other associated issues identified above.

The Chief Nurse and Deputy Chief Executive of LPT to provide further information on the relationship of the service with other agencies and the proposed direction of travel for the service.

12. ANCHOR RECOVERY HUB

The Director of Public Health gave a verbal update on the current position in relation to the Anchor Recovery Hub. It was noted that a short list of properties were currently being considered and would be considered by the Executive in due course.

AGREED:

That a further report be submitted to the Commission on the options that have been considered for the Anchor Centre.

ACTION:

The Scrutiny Policy Officer include the report on the Work Programme for the next meeting and the Director of Public Health be requested to submit a report on the options considered to the Commission at a future meeting.

13. WORK PROGRAMME

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

The Chair referred to the EMAS CQC Report and stated that EMAS had invited representatives of all local authorities in their operational area to a meeting on 6 July 2016 in Nottingham. The Chair and the Scrutiny Policy Officer would be attending the meeting and the Chair requested that a member of the Commission also attend.

AGREED:

That the Work Programme be noted.

ACTION:

Members to notify the Chair and Scrutiny Policy Officer if they are able to attend the meeting with EMAS on 6 July 2016.

The Chair to raise the Commission previous concerns and comments on the CQC Report at the meeting with EMAS.

The Scrutiny Policy Officer to provide the Chair with the Commissions previous reports and minutes on the CQC Report.

14. CLOSE OF MEETING

The meeting closed at 9.10 pm.