Leicester
City Council

Minutes of the Meeting of the
JOINT MEETING OF THE ADULT SOCIAL CARE SCRUTINY COMMISSION AND THE HEALTH & WELLBEING SCRUTINY COMMISSION

Held: TUESDAY, 27 JANUARY 2015 at 5:30 pm

P R E S E N T :

Councillor Chaplin (Chair)
Councillor Cooke (Vice-Chair)

Councillor Alfonso
Councillor Bajaj
Councillor Grant
Councillor Kitterick
Councillor Riyait
Councillor Sangster
Councillor Willmott

In Attendance:

Councillor Palmer, Deputy City Mayor
Councillor R Patel, Assistant City Mayor - Adult Social Care

Also Present:

Karen Chauhan, Former Chair, Healthwatch Leicester
Michelle Hurst, Inspection Manager, Central Region, Care Quality Commission
Gwen Dowsell, Programme Manager, (Business Change) Care Services and Commissioning
Kevan Lyles, Chief Executive, Voluntary Action Leicester
Sue Lock, Managing Director Leicester City Clinical Commissioning Group
Elaine McHale, Interim Director, Adult Social Care
Yin Naing, Interim Inspection Manager, Central Region, Care Quality Commission
Philip Parkinson, Former Board Member, Healthwatch Leicester
Geoff Rowbottam, Interim Programme Director, Better cart Together Programme
Tracie Rees, Director Care Services and Commissioning, Adult Social Care
Surinder Sharma, Former Board Member, Healthwatch Leicester
Mark Wheatley, Public Health Specialist, Mental Health and Vulnerable Groups
Bev White, Lead Commissioner (Dementia) Care Services and Commissioning

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1. WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the joint meeting and all present were asked to introduce themselves.

2. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Cutkelvin, Dawood and Glover.

3. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda.

Councillor Willmott declared an Other Disclosable Interest in Minute No 8 as he had a relative in a care home in the city.

In accordance with the Council's Code of Conduct the interest was not considered so significant that it was likely to prejudice Councillor Willmott's judgement of the public interest. Councillor Willmott was not, therefore, required to withdraw from the meeting during consideration and discussion on the item.

4. PETITIONS

The Monitoring Officer reported that a petition has been received from Mr R Ball, on behalf of the Campaign Against NHS Privatisation requesting the Council's Health and Wellbeing Scrutiny Commission to scrutinize the Better Care Together Five Year Plan for Leicester, Leicestershire and Rutland.

Mr Ball has requested to present the petition to the meeting. The petition had 243 signatures and was in the following form:-

"We the undersigned, call upon Leicester City Council's Health and Wellbeing Scrutiny Commission to investigate and scrutinize effectively the Better Care Together Five Year Plan for Leicester, Leicestershire and Rutland which contains plans to cut costs by closing over 400 beds (more than one fifth of all beds) despite a current bed shortage and growing need for health care. While we welcome an expansion of community services, research suggests community services do not necessarily reduce the need for hospital beds and do not lead to a cheaper model of care."

Mr Ball had subsequently requested that Ms Sally Ruane present the petition on his behalf. Ms Ruane present the petition and requested that she be allowed to ask questions on the Better Care Together Better Care Together Five Year Plan for Leicester, Leicestershire and Rutland..

Members were advised that Scrutiny Procedure Rule 9 (a) (ii) (e) stated that if a petition was presented at the same Committee meeting at which there was a report on the agenda on the same subject, a Councillor may propose that the

petition be considered with the report. Otherwise, the petition would be accepted with debate and referred to the Monitoring Officer for consideration and action as appropriate.

RESOLVED:

That the petition be received and referred to the Monitoring Officer for consideration and action as appropriate and that the petitioner be invited to submit questions when the Better Care Together Better Care Together Five Year Plan for Leicester, Leicestershire and Rutland was discussed later in the meeting.

5. CARE QUALITY COMMISSION

Michelle Hurst, Inspection Manger Central Region and Yin Niang, Interim Inspection Manager, gave a presentation on the work off the Care Quality Commission in relation to scrutiny. A copy of the presentation had been circulated to Members prior to meeting and had been published with the agenda together with a written to response to background questions relating to the work of the CQC in relation to the following:-

- Their work with GP Practices.
- The partnership working arrangements with NHS England.
- An overview of any inspections carried out in Leicester.
  The protocols, if any, for notifying local authority scrutiny functions of planned inspections.

In addition to the information in the presentation and the response to the background questions, the following comments were made:-

a) There were three directorates responsible for Hospitals (NHS and private), Primary Medical Services and Adult Social Care (Care home and domiciliary care). Each directorate had a Chief Inspector.

b) New regulations were introduced in April which made changes to the inspections and reporting mechanisms.

c) Inspections were now carried out around five key lines of enquiries:-

   i) Safe – people protected from abuse and avoidable harm.
   ii) Effective – good outcomes achieved for care, treatment and support, good quality of life is promoted and is based upon best available evidence.
   iii) Caring – people are treated with compassion, kindness, dignity and respect.
   iv) Responsive – services meet people's needs.
   v) Well led – leadership, management and governance delivers high quality care supports learning, innovation and promotes an open and fair culture.

d) There were now four ratings for inspections – 'inadequate', 'requires improvement', 'good' and 'outstanding'. If an establishment received a rating of inadequate it was put into special measures immediately and not after six months as previously. This meant that the NHS England and the CCG were able to put in additional assistance immediately to drive up standards.

e) Inspections of all NHS Acute Trusts and NHS Hospital Trusts began in April 2014. Inspections covered the 8 core services which were outlined in the presentation. Trusts were given 2-3 months' notice of planned inspections and requested to submit preliminary information. Inspections usually took approximately a 1 week for acute services trusts. Unannounced inspections also took place in both acute and community services establishments.

f) Inspection reports were shared with the establishments for them to comment upon the accuracy of the report. A Quality Summit was the held with the establishment and the stakeholders, Trust Development Agency, Healthwatch, CCG's NHS England, after which the report was published on the CQC's website.

g) The size of the inspection team varied depending upon the type of establishment being inspected. The Team Leader for each inspection would usually be a member of the CQC Inspection Directorate. The Team could comprise around 30 people for a district general hospital and more for a multi-site trust or combined acute/community trust. The composition of the various inspection teams for hospitals, primary medical services and adult social care inspections were contained in the presentation notes.

Following questions from Members, it was noted that:-

a) All inspection report were published on the CQC's website and that ultimately the Department of Health monitored the quality of the inspections.

b) Staff in the Lincolnshire and Leicestershire area worked collaboratively to take part in the inspections across the region.

c) The public could report any issue of concern on-line and submissions were reviewed daily by inspectors to determine if the issues warranted a Focused Inspection or could wait until the next scheduled inspection. Inspections could also be triggered by the information received from CCGs. Issues could also be reported by telephone (03000 616161). Contact details should also be available in GPs surgeries.

d) The CQC were currently recruiting to the inspectorate.

e) The priority for inspections of GP surgeries were determined by regular planning meeting with Inspection Teams based upon data packs provided by the CCG and the GP practices, together with any 'soft

intelligence' that had been recorded. Quarterly inspections were carried out and whilst not every risk could be inspected, every identified high risk was inspected.

f) The CQC were developing protocols for working with local authority scrutiny committees and would welcome the opportunity to discuss these with the Council's Commissions.

g) Primary Medical Services Inspections began in April 2014 and whilst inspections were undertaken from April to October, these were undertaken in the pilot phase when the methodology was being developed and ratings could not be made public as a result. The CQC would provide a comparison of how the City CCG compared to other areas and would supply what information they could.

h) Generally, if primary medical services performed well against Regulation 10 which related to systems and processes for service provision, and assurance/governance (audits and health and safety etc), then it usually followed that other aspects also worked well. The inspection process was not confined to a single visit but was an on-going process with regular reviews and staff were given regular feedback on any identified issues or examples of good practice.

i) Anyone could apply to the CQC to be considered as an 'Expert by Experience' for the purposes of taking part in inspections across all three directorates. Age Concern and partner organisations could provide Experts by Experience' for inspections of Adult Social Care establishments, but anyone could still apply.

j) The Adult Social Care inspection was still developing and the CQC offered to provide statistics etc for the City in relation to establishments that had been inspected. The CQC were also willing to meet members and officers to discuss other soft intelligence between formal meetings of Commissions.

RESOLVED:-

That the CQC be thanked for their informative presentation and that the Chair and Vice-Chair of the Joint Commission discuss the information they would wish to see in future CQC reports to the Commissions and inform the CQC in due course.

6. HEALTHWATCH - UPDATE

Members received an update on the current arrangements for Healthwatch in the City.

Kevan Lyles, Chief Executive, Voluntary Action Leicester (VAL), presented a briefing paper from Voluntary Action Leicester which had previously been circulated with the agenda for the meeting.

In addition to the comments in the briefing paper, the following statements were noted:-

a) VAL had been contracted by the City Council to deliver a successful transition from the previous LiNK to establish an independent Healthwatch for Leicester City. VAL considered that the current Healthwatch Leicester were not as successful as the Healthwatch for Leicestershire, and the Chair of the Leicestershire Healthwatch was at the meeting if members wished to ask questions.

b) VAL did not consider that there had been a breakdown between VAL and Healthwatch Leicester. The recruitment process for new Board members was now underway, following the resignations of a number of Board members.

c) Details of the current inspections being carried out by Healthwatch Leicester in conjunction with Healthwatch Leicestershire were outlined in the briefing paper previously circulated.

d) Nationally, approximately 1/3 of Healthwatch were established on the model implemented in Leicestershire. Approximately 1/3 of Healthwatch were organised on the independent stand-alone model requested by the City Council, but the vast majority were funded by a 'grant process' and not a tender process.

e) It was envisaged to have a new Independent Healthwatch Board in place by 1 June 2015.

In response to members' questions Mr Lyles stated:-

a) The initial target of Healthwatch Leicester being established as an independent organisation from 1 April 2014 had not been achieved and VAL had assessed that the Leicestershire model was working well and should be looked at again as a model for the City. VAL had not felt able to 'novate' the contract to Healthwatch Leicester as they felt that Healthwatch Leicester were not ready to become an independent body and that this was not in the best interests of the people in Leicester. VAL took their contract responsibilities seriously and felt that patients and service users in the City required the best possible voice to represent them.

b) VAL provided back office functions and systems to Healthwatch Leicester and when Healthwatch Leicester made arrangements to transfer its operations to Age Concern's premises and for Age Concern to take over these functions, VAL were concerned that IT system would not be able to deliver the requirements for Healthwatch Leicester and that VAL had not been able to discuss issues fully with the lead on finance on the Board. Consequently VAL had requested the City Council for a delay in establishing an independent Healthwatch

Leicester under the terms of the contract. This decision had been taken on the basis of best practice nationally and locally.

c) VAL were also awarded the contract to establish an independent Healthwatch for Rutland and this had been achieved. That contract was for one year and not three, as with the City Council, and with hindsight, it may have been better for VAL to have been offered a similar contract for the City. It was also felt it would have been better to secure the type of Healthwatch required by the Council through a 'grant' rather than a contract tender process.

d) A number of lessons had been learned from the process leading to the current situation, largely through hindsight. VAL felt they had been totally focused on providing an excellent Healthwatch for Leicester and had acted accordingly. They had however, been able to reflect upon recent events following the resignation of Board members.

e) The reason for not agreeing to 'novate' the contract to Healthwatch Leicester had not been about finances but had been based upon the belief there were benefits and efficiencies to be achieved by combining the work of Healthwatch Leicester with that of Healthwatch Leicestershire in relation to their inspections of the Leicestershire Partnership NHS Trust.

f) That the original tender, issued before the regulations were published, was to deliver a Healthwatch for the City and after the regulations it was clear that the City Council wished to move to an independent Healthwatch body in accordance with established timescales.

Members commented that:-

a) They were disappointed that many people had been working hard for two years to establish an independent Healthwatch and this had not yet been achieved.

b) It was not for VAL to consider what was in the best interests of the people of Leicester; Councillors were the elected democratic representatives to make those choices and the Council had entered into a contract with VAL for them to establish an independent Healthwatch for Leicester. It was evident from VAL's briefing paper that there was no acknowledgment that the decision to change the model of delivery for Healthwatch lay with the Council.

c) It should have been patently apparent to VAL that the City Council's Health and Wellbeing Scrutiny Commission and the County Council's Health Overview and Scrutiny Committee were completely different in their operation and focused on differing health needs for their respective populations. VAL should, therefore, have realised that if both the City and County Council's felt there was a need for, and had a desire for, joint arrangements for health scrutiny the two Councils would have

established combined health scrutiny arrangements.

d) The 3 former Board members, present at the meeting, were highly respected for their work over a number of years in relation to health , and VAL were requested to issue individual apologies to them for the circumstances which had led to them resigning from the Board.

Following members comments, Mr Lyles stated:-

a) That VAL were wrong to have overridden the right to establish an independent Healthwatch for Leicester, and were consequently working to establish this by 1 June 2015. VAL however, felt that had they had acted validly under the contract. VAL now accepted that they had overreached their position and that it was not their role to determine when due diligence was in place, that was rightly the role of the Contract Commissioners and the City Council.

b) The previous Board members were at the meeting and had heard VAL's apology for overreaching its position. VAL had appointed the previous Board members and had confidence in them. VAL had not made any detrimental comments about specific Board members in their briefing paper.

The Chair thanked the Chief Executive for his contribution to the discussion.

Karen Chouhan, Philip Parkinson and Surinder Sharma presented a position statement as the former chair and members of the Healthwatch Leicester Board which had previously been circulated with the agenda for the meeting.

In addition to the comments in the briefing paper, the following statements were noted:-

a) The Board of Healthwatch had made arrangements in January 2014 for an independent Healthwatch to be accredited and set up as a separate company which had been discussed in public meetings with the Council.

b) The Board had set a deadline for Healthwatch to be completely independent by September 2014. The original target of April 2014 was known to be unrealistic and the extension to September had been agreed following discussions with the Director Care Services and Commissioning, Adult Social Care, Leicester City Council and the Chief Executive of VAL.

c) VAL had written to the City Council to inform them of VAL's concerns that the Board did not have the necessary competences for VAL to novate the contract the Board.

d) Board members had subsequently met with VAL in October as the Board had not been given a copy of VAL's letter to the Council. At the meeting the Board members were informed that there would be

commercial and public perception issues for VAL if the contract was novated, it would be better for staff to remain with VAL, patients would benefit and that the 3 year contract with VAL should remain.

e) The Board had worked for nine months to ensure that arrangements were in place for an independent Healthwatch Leicester to be established. This work had taken place in tandem with all of Healthwatch's core work.

f) When VAL decided not to novate the contract to the Board and then reiterated this view in subsequent meetings, 5 Board members felt that they had no option by to resign since Healthwatch could not operate independently of VAL if it had no control of its finances or priorities for staff support. The Board members felt there had been a breakdown of trust and could not continue to work with VAL if Healthwatch was not an independent body.

g) The three ex-Board members felt patients' interests had been set aside and that it was a sad state of affairs to be in the current position. They felt the Board had the experience and commitment to oversee an independent Healthwatch for the City, to say otherwise was misleading.

h) The Vice-Chair had agreed to stay until new arrangements were in place.

i) As a result of the decision not to novate the contract the public had been poorly served as some costs had been incurred in setting up a bank account, making arrangements for telephone lines, and securing IT arrangements. These costs had been agreed at the time with the Council and VAL and VAL had now agreed to honour these abortive costs.

j) The ex-Board members indicated that they would be prepared to carry on if the contract was novated.

Following members' comments and questions, the three ex-Board members stated:-

a) That numerous efforts had been made to remedy and salvage the situation but on each occasion VAL had reiterated that they would not novate the contract to the Board.

b) The issues had subsequently been discussed with the Council to raise the Board's concerns.

c) It was vital for an independent Healthwatch for the City to have a strong voice in speaking on behalf of patient's concerns, particularly as the health economy was undergoing considerable change in the City through the Better Care Together Programme and change in the provision of mental health services.

d) There would be a loss of impact between what the previous Board had achieved and what a new Board could achieve until they were fully assimilated with the issues and practices locally.

e) It was felt that the Board had a good working relationship with the staff and the Board could have achieved more if it had not been dealing with arrangements to ensure that the Healthwatch could operate on an independent basis. Large parts of that work would now have to be repeated to achieve the new target of independent Healthwatch by 1 June 2015.

Members commented that:-

a) Every effort should be made to preserve the energy, commitment and money already spent in establishing an independent Healthwatch for the City.

b) VAL should acknowledge the situation had been poorly handled and should reconsider their decision and novate the contract as quickly as possible to demonstrate its strong leadership role and restore public faith and confidence.

The Chair thanked the ex-Board members for their contribution to the discussion.

The Director Care Services and Commissioning, Adult Social Care, Leicester City Council presented a briefing paper which had been circulated to Members prior to meeting and had been published with the agenda.

The Deputy City Mayor stated that:-

a) A great deal of effort and energy had been spent by the Council to resolve the current situation, and it was unfortunate that it had taken the Commission's intention to discuss the issue in public to make progress. The Commission's questions had reflected his own concerns as to why the issue had taken so long to make progress.

b) The events since October had not been in the best interests of Healthwatch, the public, VAL or the Council.

c) He welcomed VAL's statement at the meeting that they would now novate the contract and were working to a new deadline of 1 June 2015. It was disappointing that the Council had to resort to seeking a formal address through the contract process to achieve that.

d) He had held various meeting meetings with VAL and other parties and had welcomed the steps that were in hand to recruit a new Board. He acknowledged the former Board members indication that they were prepared to carry on if the contract was novated, but would need to seek

further clarity now that the recruitment process for a new Board was underway.

e) He was disappointed that it taken so long for VAL to indicate their concerns when so much work had been undertaken and arrangements made to establish an independent Healthwatch.

The Assistant City Mayor, Adult Social Care echoed the Deputy City Mayor's concerns and supported efforts to bring this issue to speedy conclusion. She indicated that she had not been involved in the details of recent discussions in view of her close working relationship with all three ex-members of the Board.

The Director Care Services and Commissioning, Adult Social Care stated:-

a) The original tender was issued prior to the full guidance and regulations being received, but it had been clear in the tender documents that the development of Healthwatch would be subject to further guidance once these had been published.

b) The contract was awarded to VAL in early 2013 and VAL had subsequently agreed in May 2103 to the transition arrangements for Healthwatch to become an independent body by 1 April 2014. During the discussions on this it had been made clear that the City Council wished to have independent Healthwatch because the health needs for the City were different to that of the County.

c) The contact was originally issued for a three year period as it was not known at the outset how long it would take to make the transition from LiNK to a fully independent Healthwatch, particularly as it was not known when the detailed Regulations and guidance would be issued.

Members commented that there appeared to be goodwill on behalf of all parties to reach a position whereby the contract could be novated n a short period of time. It would be unfortunate and time consuming to incur more expenditure to re-start the work already undertaken by the Board to achieve an independent status for Healthwatch.

In response to Members comments the Chief Executive of VAL stated that Val would be willing to enter into further discussions after the meeting to resolve the issue and indicated that VAL would not object in principle to suspending the recruitment process, reinstating the previous Board members and supporting the accelerated process to achieve an independent Healthwatch for the City.

RESOLVED:

1) That everyone be thanked for their contribution to move this issue forward to get back on track to establish an independent Healthwatch for the City and not lose the continuity of experience of those that had been involved prior to the current situation.

2) That the executive continue to show leadership in getting all parties together to resolve the issues as soon as possible.

3) That all other parties be encouraged to demonstrate their leadership roles in seeking a speedy resolution to the current unsatisfactory situation in the best interest of the people they serve.

4) The VAL Chief Executive's apology in public be noted but the Commission would welcome a gesture by VAL to issue personal apologies to the ex-Board members.

Councillors Bajaj, Sangster and Palmer left the meeting at this point.

7. BETTER CARE TOGETHER

Geoff Rowbotham, Interim Programme Director, Better Care Together, and Sue Lock, Managing Director, Leicester City Clinical Commissioning Group gave a presentation on the Better Care Together Programme. A copy of the presentation had been circulated to Members prior to meeting and had been published with the agenda together with the following:-

a) An article in the Leicester Mercury dated 21 January 2015

b) A briefing note on Better Care Together issued by the Interim Head of Communications and Engagement, Better Care Together on 21 January 2015.

In addition to the statements in the presentation notes the following comments were noted:-

a) The vision and proposals for change in the Programme had been the result of considerable discussions between 8 partner organisations as the preferred way forward to address the challenges faced by health and social care services in meeting the requirements of the programme.

b) There was a potential financial gap of £400m if 5 years' time if nothing was change to the way health and social care services were delivered. This could potentially be £1.2m if the projected cumulative financial shortfalls were taken into account.

c) The programme could only be delivered through partnership working and all 8 partner organisations delivering health and social care services in Leicester, Leicestershire and Rutland.

d) The proposals for the clinical and social care case for change had been derived from a number of stakeholder events in January/February 2014 attended by approximately 200 stakeholders.

e) The left shift in delivering patient care from the secondary health sector to the primary care health sector across the 8 work-streams was aimed at increasing efficiencies and increasing the overall provision of care as a result.

f) The development of the 8 clinical pathway work-streams had been developed by a cross section of clinicians, patients and carers groups and local authority representatives to identify the intervention necessary to transform for the existing service delivery model to achieve the outcomes required in 5 years' time. The urgent care, frail older people and long term conditions work-streams had been tested against the Kings' Fund Ten components of care to frame the service transformation.

g) The programme and supporting documents were now in the public domain and had been subject to external reviews by Health and Wellbeing Boards, Clinical Senates, NHS England and the Office of Government Commerce. Although the programme was still being reviewed it was already delivering early patient experience benefits.

h) Examples of improved patient pathways were shown in the presentation. One revised pathway for patients with eye problems estimated that attendances at A&E could be reduced by 2,000 visits per year by improved training and treatment by GPs and Optometrists.

i) Service reconfiguration was progressing and De Montfort, Leicester and Loughborough universities were involved in discussions to integrate their work to support workforce development and service delivery.

j) Patient and public involvement and communication and engagement workshops had fed views back on the proposals in December and wider public consultation would start on 16 February 2015. A number of specific engagement events to consult hard to reach groups were planned and mobile units would travel through Leicester, Leicestershire and Rutland in February and March. There would be a widespread public media campaign including local radio services for BME communities etc. Full details of the consultation process were contained in the presentation.

k) Parts of the programme would require statutory consultation and this would begin after the elections in May and continue through the year.

In response to members questions it was noted that:-

a) The Better Care Together Programme's remit did not include proposals to make structural changes in the administration of the NHS such as reducing the number of CCGs for Leicester, Leicestershire or Rutland.

b) Personal Medical Services was 1 of 3 contracts that GPs could hold. There was a mismatch of funding as the core funding did not reflect the

health needs covered by an individual practice. Reductions made in payments in core contracts, stayed within the health economy and would be focused back into GP practices where the health need was greater. The CCG would work with the practice to provide additional support to help them build improvements in patient services.

c) One of the principles of the programme was to include an element of double running costs by supporting tandem services. This was estimated at £250m. Services would not be closed down in one sector until replacement services in another sector were shown to demonstrate the desire benefits in service delivery.

d) The programme had been driven by clinicians with input from the public and patients and it was felt that this would give the programme a better chance of providing the envisaged benefits.

e) The programme would be subject to continued scrutiny and the Project Board would be considering different methods of scrutiny , particularly where specialist advice was required.

With the consent of the Chair, Sally Ruane asked the following questions:-

a) Is the plan going to lead to a restructured workforce which, overall, is of a lower skill mix than is currently the case?

b) Does the expenditure of £800m to achieve a gain of £17m represent a good use of public money?

c) What dangers are posed to the public through the closure of 427 beds in the context of rising need and a chronic current bed shortage?

d) Given that the tables and figures shown in the plan and strategic outline case terminate at the end of the five or seven year period, what will the picture be, financially and in terms of beds and workforce, for the five, ten, fifteen or twenty years after the end of the plan?

e) Why has there been no serious exploration of alternative options?

f) The evidence shows that community initiatives only selectively and in a limited way lead to a reduction in unplanned hospital admissions and there is no evidence to show that they will lead to a cheaper model of care. So how feasible is it to have a plan which depends upon both of these features? And have other risks inherent in the project been adequately assessed and addressed?

It was agreed that the Interim Programme Director would provide a written response to the questions and that copies of the response would be sent to members of the Commissions at a later date.

RESOLVED:

That the presentation be received and noted and that the Interim Programme Director provide a written response to the questions submitted by a member of the public and that copies of the response be circulated to members at a later date.

8. DEMENTIA STRATEGY

Bev White, Lead Commissioner (Dementia) Care Services and Commissioning and Mark Wheatley, Public Health Specialist, Mental Health and Vulnerable Groups gave a presentation on the progress made against the Implementation Plan for the delivery of the Strategy. A copy of the presentation had been circulated to Members prior to meeting and had been published with the agenda

In addition to the information shown in the presentation the following comments and statements were noted:-

a) The national costs for dementia services of £26.3m were more that the costs for strokes and cancer services combined.

b) The achievements to date were listed in full in the presentation.

c) Much work had been undertaken to design leaflets for dementia sufferers and carers.

d) The City Council's Dementia Care Advisors are a point of contact for people living with dementia from diagnosis onwards.

e) In 2014 there was a focus during National Dementia Week on BME communities in response to previous comments made by members to raise awareness and support.

f) Work was progressing under the Frail Older People priority work-stream of the Better Care Together Programme. Data was being gathered on services in all sectors. A bid to the CCG to fund a project to explore the reasons for under representation of BME communities in dementia services had been submitted and the outcome was awaited.

g) The dementia diagnosis rate in Leicester was 67% which was one of the best in the country compared to the national average of 48%. A stretch target of 72% had been set for the end of the year.

h) The diagnosis rates of dementia by ward and by ethnicity were contained in the presentation notes previously circulated. The ward analysis identified those ward where the rates of diagnosis were significantly higher or lower rate for Leicester as a whole. There was an under representation in the diagnosis of 16.8% of the Asian/Asian British ethnic category compared with their proportion of the total population of 25.7%.

In response to members' questions, the following responses were noted:-

a) Officers were working with the CCG to understand the disparities on the rates of diagnosis by wards and ethnicity.

b) Although Rushey Mead Ward had a number of elderly persons' homes, the rates for diagnosis of dementia in the ward were close to the average for the city as a whole. It may be that a number of people in residential care may not be formally diagnosed with dementia. They may be engaged with primary care services and may have entered residential care for other reasons and developed dementia as they grew older.

c) Good practice for new build care homes is to have separate accommodation aimed at residents with similar levels of need. Advice was given to potential investors in the city on the requirements for new build care homes. This separation was not always possible in existing care homes but staff were required to have training to be able to deliver care to people with differing levels of dementia and this is monitored through the contract monitoring process (QAF).

d) A number of care homes were working towards becoming dementia specialists.

e) There are 200 types of dementia with symptoms other than memory loss. Many changes to a person's health may be subtle in nature and may not be easily recognised by the person or others close to them. It was not uncommon, therefore, to encounter people for the first time when they were at a crisis stage.

f) The waiting time between people being diagnosed and receiving treatment varied depending upon the pressures on the secondary care services. Currently the average waiting time was approximately 12 weeks. Difficulties arose because efforts had been made to increase the diagnosis of dementia and no extra funds had been invested into other services along the pathway, which created inevitable bottlenecks at times.

RESOLVED:-

That the officers be thanked for their presentation and that a further update on progress with the strategy be submitted after the forthcoming elections but before the start of National Dementia Week. The update to include comparable date with other benchmark authorities together with details of the specifications for specialist dementia care homes.

9. IMPLEMENTING THE CARE ACT 2014

Gwen Dowsell, Programme Manager, (Business Change) Care Services and

Commissioning gave a presentation that provided an overview of the key implications of the Care Act 2014 and progress so far in planning for the implementation of the changes. A briefing note for Councillors and a copy of the presentation had been circulated to Members prior to meeting and had been published with the agenda

In addition to the information contained in the presentation the following comments were noted:-

a) The provisions of the Care Act would come into force on 1 April 2015 excluding the funding reforms provisions which would come into force on 1 April 2016.

b) The main emphasis of the provisions of the Act was to shift the focus on preventing, reducing and delaying care and support needs.

c) The Act placed an obligation on local authorities to assess needs against a national eligibility threshold, and, at this stage, it was not envisaged that this would create a significant impact upon current demands.

d) There were some additional duties in respect of prisoners' rights to social care.

e) Further guidance on the funding reforms was expected but currently it was proposed to operate a cap on lifetime costs of care of £72,000 for people 65 years and over. The means test threshold would increase to £118,000.

f) Details of the proposed national and local public information campaigns were detailed in the report. 11 wards had been selected to receive door drop leaflets by the agency undertaking the work for the Department of Health. These wards had been selected by postcode areas to give the demographic profile of the target group for the leaflets. The postcodes selected were LE4–6, LE4-7, LE5-2 and LE5-5.

g) The current IT system was being updated to accommodate the requirements of the new legislation as part of the software update contract.

h) There could be an influx of people coming forward after the information campaigns, particularly carers, and arrangements were being made to be able to respond to them.

i) The suggestion by Members of using ward community meetings to publicise the changes would be incorporated into the local information campaign.

RESOLVED:-

That the officer be thanked for the presentation.

10. CLOSE OF MEETING

The Chair declared the meeting closed at 9.25 pm.