Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 25 MARCH 2015 at 5:30 pm

P R E S E N T :

Councillor Cooke (Chair)
Councillor Cutkelvin (Vice Chair)

Councillor Chaplin Councillor Sangster

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103. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Bajaj, Glover and Singh.

104. DECLARATIONS OF INTEREST

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

105. PETITIONS

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

The Chair commented that a response to the petition submitted by Mr Ball in relation to the scrutiny of the Better Care Together Programme was being prepared in accordance with the Council's Petition Scheme.

106. 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.

107. CONGENITAL HEART DISEASE REVIEW

Michael Wilson, New Congenital Heart Disease (CHD) Review Programme Director and Jon Gulliver, Local Service Specialist, Specialised Commissioning

- East Midlands attended the meeting to provide an update on the Congenital Heart Disease Review and answer members' questions. A copy of their presentation was previously circulated to Members with the agenda.

In addition to the comments set out in the presentation notes, Mr Wilson, made the following observations:-

a) External consultants, Dialogue by Design, had been commissioned by the NHS England to receive the responses to the consultation, analyse the response and produce a report, which had been published on 2 March 2015.

b) There had been 373 responses, from both organisations and individuals. The responses were mixed with approximately a third disagreeing with the proposals, a third agreeing and a third either not knowing or neutral to the proposals. Differing views were expressed by organisations to those expressed by individuals. The responses were currently being analysed to see if these differences in responses could be explained.

c) Although the presentation was giving a high level overview; the questions in the consultation had been aimed at testing whether the proposals were appropriate and, if not, what could be done to improve them.

d) NHS England had not yet formally considered its own view on the outcome of the consultation.

e) Approximately half of the responses were from patients or families of patients and approximately 20% of responses were from 18 year olds or under.

f) There were growing numbers of adults with a CHD and these numbers would continue to grow because of the success of the service. The service would, therefore, need to develop to keep pace with the increase in future demand and the likelihood of more patients requiring complicated forms of treatment as they grew older.

g) Most of the comments relating to teams of 4 surgeons undertaking 125 operations a year expressed views rather than indicating whether they were for or against the proposed standard.

h) Concerns about access to other services were also expressed as CHD patients often had other health conditions which required treatment.

i) In relation to the proposals for co-location, it was understood that it may take time to relocate services and this was reflected in the proposed standards.

j) After the responses had been analysed, the Clinical Advisory Group would be asked to determine if the standards were appropriate or

needed to be revised, whether any new evidence required the standards to be amended and whether any of the comments that didn't specifically relate to the proposed standards raised any issues which needed to be considered further.

k) Recommendations would then be made to the NHS England Task and Finish CHD Group and, following this, the proposal would go through an internal assurance process with the aim of the submitting the final proposals to the NHS England Board meeting in July. If this was not possible, it would be considered at the September Board meeting.

l) Commissioning models would then be designed for the standards specifications with the aim of commissioning services from October 2015 to March 2016 and services being in place from April 2016 onwards.

m) Work on the review in public has been paused during the pre-election period and it is intended to use this time for internal preparatory work and for the existing centres to work on their responses to the issues now asked of them by NHS England.

During the presentation Members made the following comments:-

a) The Commission's original submission to the IRP had also highlighted regional variations in demand which had resulted from catchment areas being ill-defined. This resulted in patients in Northamptonshire travelling to centres in the south, rather than to Leicester.

b) It was felt that the flows from catchment areas were determined more by consultants referring patients to other centres rather than the NHS determining that all patients in a catchment area should be referred initially to the local centre.

c) The consultation process had not been considered to be fully representative, as the consultation had followed a conventional approach. There had not been any specific targeted consultation with specific communities or hard to reach groups.

d) The Chair had raised similar issues at the meeting in Birmingham and had commented that, whilst local government was used to engaging in widespread consultation methods to reach all parts of the community, the NHS were more used to undertaking conventional consultation methods. It was suggested that the NHS should engage with the Local Government Association in future major consultation exercises to address these shortfalls.

e) There was a responsibility for public bodies under equal opportunities legislation to consult all groups in the community and, as half of the population of Leicester were from BME groups, it was surprising that targeted or pro-active sampling of these communities was not

considered.

In response to questions made by Members of the Commission during the presentation, Mr Wilson commented that:-

a) The issue of defined catchment areas had been recognised as an issue in the consultation documents, and differing views had been received, which required further consideration. It was recognised that the rules on competition were at variance with those on collaboration and centres were expected to undertake both. Views had also been submitted that there was sufficient case work for all surgeons in all the centres to achieve 125 operations per year if the NHS determined catchment areas for each centre. Trusts had also been asked to see how proposals to establish regional networks rather than a network based upon a single hospital could be achieved.

b) There were current variations in number of operations per year carried out by each surgeon. These varied from 70 - 200. There was a view expressed in the consultation that different complexities of operations should be weighted differently and not equally as at present. The Clinical Advisory Panel had been asked to look at this aspect again. Originally it was considered that there did not need to be a different weighting for each operation as there would be a natural mix of complexities undertaken by each surgeon. However, as this issue had been raised frequently during the consultation, it was felt appropriate to reconsider the original viewpoint.

d) It was recognised that the older and more experienced surgeons were carrying out more operations than less experienced surgeons, and, whilst there was no pressure being expressed to reduce these numbers; it had been suggested that mentoring of younger and less experienced surgeons by the more experienced ones should be considered.

e) It was recognised that not all providers of Congenital Heart Services would meet all the standards as currently proposed. The standards were seen as being aspirational and all services would be improved when the standards were eventually met. Currently, communications with patients and better management of end of life care could be improved.

f) The issues of not receiving care closest to the place where the patient lived were well understood. However, this issue was likely to remain whichever model was chosen.

g) The responses from BME communities to the consultation were not as high as it was expected to have been. Material in various languages was made available during the consultation process. Members' comments were noted and would be referred back to the group responsible for engagement.

h) An Equality Impact Assessment had been carried out and was available to the public on the website.

Kate Shields stated that the Review had made Leicester look at the provision of children's services on one site and whilst the de-minimus limits were good; a network solution would be needed to achieve the best service outcomes in Leicester.

RESOLVED:

That the presentation be received and Mr Wilson be thanked for his responses to Members questions.

108. IMPROVEMENTS TO INTENSIVE CARE PROVISION

Kate Shields, Director of Strategy University Hospitals of Leicester NHS Trust (UHL) attended the meeting to discuss the issue of the future provision of Intensive Care Units (ICUs) at UHL. A background briefing paper was circulated at the meeting and a copy is attached to these minutes.

Before considering the briefing paper, the Chair circulated and extract from the 'Guidance to support Local Authorities and their partners to deliver effective health scrutiny, published in June 2014'. This is reproduced below:-

Local Authority Health Scrutiny - Extract from page 24 & 25

4.5 When consultation is not required

4.5.1 The Regulations set out certain proposals on which consultation with health scrutiny is not required.

These are:

a) Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.

b) Where there is a proposal to establish or dissolve or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.

c) Where proposals are part of a trusts special administrator's report or draft report (i.e. when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) – these are required to be the subject of a separate 30-day community-wide consultation.

Following consideration of the guidance, the Chair commented that the Commission's role was not to approve the proposals, but to understand them and to fulfil their obligations under the guidance, particularly those relating to paragraph a) above.

The briefing paper outlined the proposal to reduce the current three ICUs at each of the three hospital sites into two 'super' ICUs at the Royal Infirmary and Glenfield Hospital. There was not enough capacity at the Royal Infirmary and Glenfield Hospital to provide level 3 care, whilst there was over capacity at the General Hospital. Difficulties in recruiting staff for level 3 care had been difficult as the trust was no longer able to provide training and the volume and mix of cases at each site was not attractive to potential staff. In addition, 3 consultants had given notice to retire in the near future. The details of the proposal were being subjected to external review to validate that the proposal was safe and sustainable. It was intended to have the two level 3 care units in place by December 2015. The General Hospital would become a High Dependency Unit providing a higher level of care than a ward but not as specialised as a level 3 care ward (ICU).

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

a) Transport arrangements would be put in place to ensure that any patient requiring level 3 support on the three hospital sites would have access to them.

b) A plan would be required to ensure that the level 2 care facility at the General Hospital could be maintained in the future.

c) It was estimated that there would be 150 bed activity at the Royal Infirmary and Glenfield Hospital and this was currently undergoing a "confirm and challenge" process.

d) Plans were also being currently developed to free up surgical beds through efficiency measures. This included day case patients not being admitted before operations and being discharged earlier. Discussions were also taking place with Leicestershire Partnership Trust as part of the process of freeing up surgical bed availability.

e) The proposal was not associated with delivering the Better Care Together Programme, but was concerned with continuing to provide a service. A level 3 care ward was necessary to support multiple organ support and ventilation and, if this level of ICU was not available, then surgical operations involving renal care, kidney transplants, gall bladder and liver conditions would need to cease shortly after December 2015. Whilst the current proposal may not be ideal, it was nevertheless considered safe and sustainable for the foreseeable future.

f) There would be 2 units of 6 beds close to each other at the Royal

Infirmary.

RESOLVED:

1) That it be noted that the University Hospitals of Leicester NHS Trust (UHL) had determined that it was necessary to proceed with the proposal without engaging in a full public consultation exercise, as they felt this was in the best interests of patients in order to provide ICU facilities after December 2015.

2) That UHL continue to present periodic updates on the progress with the proposal and the consequence of the changes.

109. EMAS - DEVELOPING KEY STRATEGIES

East Midlands Ambulance NHS Trust attended the meeting to discuss a number of key strategies to help them to achieve their long term plans, allowing them to give people the right care, with the right resources, in the right place, at the right time.

The strategies were being developed together and in line with the strategic objectives contained in their Better Patient Care and draft five year plans, so that the full set will support what they wish to do.

The strategies were:

- Clinical and Quality Strategy
- Workforce Strategy
- Fleet Strategy
- Information Management and Technology (IM&T) Strategy
- Estates Strategy

The final strategies would then be presented to the EMAS Executive Board and they would then wish to come back at a later date to discuss future developments.

A copy of a report, a briefing and a presentation had previously been circulated to Members with the agenda.

RESOLVED:

That EMAS be thanked for their presentation and it was pleasing to see that the new management structure was providing improvements and allowing the service to move forward in

responding to the current challenges.

110. PHARMACEUTICAL NEEDS ASSESSMENT

The Commission received a report on the outcomes of the consultation carried out on the Pharmaceutical Needs Assessment (PNA) which was carried out from 29 September 2014 to 12 December 2014. The Report was also being submitted to the Health and Wellbeing Board at its meeting on 26 March 2015 requesting approval of the final PNA Assessment. The final PNA Assessment for approval had previously been circulated to Members.

The Commissions views on the report and the final PNA are requested.

In response to questions, it was noted that:-

a) The final PNA was a based on a prescribed format to comply with legislative requirements.

b) Although there were adequate pharmacies for the needs of the total population, not all areas of the city received the same level of service.

c) The PNA would be available for Commissioners to use when services were commissioned.

d) NHS England commissioned pharmacy services and the Council would request additional services be provided by pharmacies in different areas of the city that reflect each area's health needs.

e) The number of pharmacies in a ward did not necessarily mean better health outcomes in the ward. Commissioning different services from pharmacies according to local health needs could potentially have an effect on health outcomes. Pharmacies were also required to report on the usage of various services through the commissioning arrangements.

RESOLVED:

That the Commission supports the Recommendations to the Health and Wellbeing Board to:-

a) Approve the final PNA for publication.

b) Note the need to update the PNA by March 2018, as set out in the Pharmaceutical Regulations.

c) Note and approve the ongoing responsibilities with respect to the publication of an up-to-date map of all pharmacy provision and the arrangements that have been proposed to ensure that this takes place.

111. HIGHFIELDS MEDICAL CENTRE - SCRUTINY REVIEW REPORT OF FINDINGS

The Commission received a 2nd Draft final report for approval. The first draft was originally considered at the Commission's meeting on 10 March 2015.

The Chair reported that a response had been received from NHS England to the report's recommendations and these were incorporated under paragraph 4.3.

RESOLVED:

1) That the 2nd draft report be received and approved for final issue including the response made by NHS England.

ACTION

1. The Scrutiny policy Officer to arrange for the report to be issued in its final form to all those taking part in the review and to those organisations and individuals requested to take action in the report.

2. That the organisations and individuals requested to take action in the report also be requested to submit a formal response to the recommendations.

112. REVIEW OF MENTAL HEALTH SERVICES FOR YOUNG BLACK BRITISH MEN

The Commission received a 2nd Draft final report for approval. The first draft was originally considered at the Commission's meeting on 10 March 2015. Comments received since the meeting had been incorporated into the 2nd draft report.

A representative of LAMP attending the meeting and submitted the following comments based upon her experiences:-

a) Young black British Men could start to face isolation and mental health issues in earlier school life, through unintentional institutional racism, through a mixture of lack of resources and training for professionals who were not aware of the isolation and social issues faced by different cultures.

b) Children from mixed race marriages could face social isolation as they could feel that they were not fully accepted or felt able to fully integrated into either of their mixed races. This could make them vulnerable to mental health issues in their later life.

c) Often young black British pupils were underachieving as a result of their isolation issues, but there were no specific initiatives to address this. Often, pupils were more likely to be seen as obstructive and troublesome and, as a result, they were more likely to be excluded either form lessons or from school, which further increased their isolation. Exclusion from lessons did not count towards the formal figures for 'excluded pupils' but often had the same effects of isolation for the individuals concerned.

d) There was an under representation of African-Caribbean teachers in the workforce.

e) There was a need for a young peoples' specialist advocacy service in Leicester for mental health for all young people and not just for one specific community.

The Chair commented that, whilst a number of the comments were outside the specific narrow terms of the review, he recognised that the impact of the issues raised could have a later impact upon the group that were the subject of the review. He also recognised that interventions at an early stage may have had an effect upon the current picture.

It was noted that the Royal College of Paediatrics and Child Health had an on-line educational resource called 'MindEd' which provides practical e-learning sessions when and wherever they're needed, quickly building knowledge and confidence to identify an issue, act swiftly and improve outcomes for children and young people. The resource can be found at the following link:-

http://www.rcpch.ac.uk/minded

The project were working with schools to give them have the resources and tools to recognise mental health issues at an early stage. A similar resource for parents was also being developed.

The importance of having a service such as CAMHS was also recognised.

RESOLVED:

1) That the 2nd draft report be received and that the comments made at the meeting be noted.

2) That the Chair revisits the recommendations in the report to make them more robust and 'active' clearly indicating individuals or organisation which should take action to address them. The revised recommendations be sent to the Commission Members for comment before the final report is issued in mid-April.

ACTION

1. A copy of the report and an extract of the minutes be forwarded to the Children and Young Persons Scrutiny Commission, to allow then to feed issues into their work programme.

2. That the Chair revisits the recommendations with the report author and sends the revised recommendations to the Commission members for comment before the final report is issued.

113. SUGGESTED ITEMS FOR FUTURE HEALTH SCRUTINY

The Scrutiny Support Officer submitted a document that listed suggestions for future health scrutiny.

The Chair commented that Members could suggest further items by e-mailing the Scrutiny Support Officer if they wished.

RESOLVED:

That the list of suggested items for future health scrutiny be received and Members be invited to e-mail any further suggestions to the Scrutiny Policy Officer.

ACTION

Members inform the Scrutiny Policy Officer of any other additional items for future health scrutiny.

114. PRIMARY MEDICAL SERVICES

The Acting Director of Public Health provided an update on the proposed funding changes to GPs Primary Medical Services contracts and the implications this might have for health care in the City.

It was noted that:-

a) There were currently 17 GP practices in the City with a Primary Medical Services contact. This represented approximately 26% of GP practices in the City on this type of contract compared to 40% of GP practices nationally. A growing number of GP practices in the City were converting to General Medical Services Contracts.

b) The average financial loss to GPs with a Primary Medical Services contract as a result of the funding changes is estimated at approximately £10,000 per annum per practice. The money saved by these changes

would be retained within the health economy and it was intended to redistribute them to GPs practices that needed additional resources. These payments had been made previously to all Primary Medical Services GP practices, some of which would have been in more affluent areas and would not have needed the extra support.

c) The Minimum Practice Income Guarantee, which was used to top up practices core funding, had also been removed. This could have a further impact upon some City GP practices.

d) NHS England would be expected to redistribute the monies through the new co-commissioning arrangements with the CCG.

RESOLVED:

That the report be noted and the Acting Director of Public Health undertake further work to determine the impact upon each GP practice in the City affected by these proposals and report back to a future meeting.

ACTION

The Acting Director of Public Health undertake further work to determine from NHS England the impact upon GP practices in the City affected by these proposals and report back to a future meeting.

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

The Commission received an update on the following items that had been considered at a previous meeting:-

It was noted that:-

a) Healthwatch Leicester were still on target to be established as an independent body.

b) No formal individual apology had yet been issued to the Directors of Healthwatch who had previously resigned, following VAL's refusal to novate the contract to Healthwatch Leicester.

116. ITEMS FOR INFORMATION / NOTING ONLY

A Healthier Future for the East Midlands

A copy of a report issued by the East Midlands Councils which examined a number of issues of importance when reviewing health outcomes and practice

in the East Midlands Region. Four priority areas were highlighted as set out below:-

Inequalities ii Health outcomes.

Inequalities in funding for health care.

Recruitment and retention of the health workforce.

The need for collective leadership.

The report made a number of recommendations to support further work between councils and MPs, the NHS, Public Health England and wider health partners.

RESOLVED:

That the report be noted.

117. CLOSE OF MEETING

The Chair declared the meeting closed at 8.05 pm.