Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 12 APRIL 2017 at 5:30 pm

P R E S E N T :

Councillor Dempster (Chair)

Councillor Chaplin	Councillor Sangster
Councillor Cleaver	Councillor Unsworth

In Attendance:

Councillor Dr Moore

Also Present:

Richard Morris, Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group.

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74. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Cassidy and Fonseca and Karen Chouhan, Chair, Healthwatch Leicester.

75. DECLARATIONS OF INTEREST

Councillor Dempster declared an Other Disclosable Interest in Minute No 83 (University Hospitals of Leicester Quality Accounts) as a patient of the Rheumatology Department UHL.

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

76. MINUTES OF PREVIOUS MEETINGS

RESOLVED:

that the minutes of the meetings held on 4 January 2017, 2 March 2017 and 29 March 2017 be approved as a correct record.

77. PETITIONS

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

78. CHAIR'S ANNOUNCEMENTS

The Chair announced that arrangements were being made to hold a further meeting of the Leicestershire, Leicester and Rutland Joint Health Scrutiny Meeting in late May. Members would be notified of the date when the arrangements had been finalised.

79. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions or statements of case had been submitted in accordance with the Council's procedures.

Mr David Bradley submitted the following representation:-

"Concerns were raised by myself 12 months ago about the care and treatment of autistic adults in Leicester both in terms of the lack of adequate and appropriate facilities within the NHS and a poorly managed process to return such patients back into the community.

At the time, the previous chair requested a report on the outcome of further discussions on the matter and questioned whether the policy could be changed to improve the care of people diagnosed with Asperger's or autism.

I am aware that a case study has been carried out by Mark Griffiths into particular failings in the CPA process, but I am not aware of any report or policy changes with regard to the care of adults with autism whilst held in hospital where there is a distinct lack of understanding or training in dealing with the complex issues of such cases. I note that the CQC also found deficiencies in providing necessary psychological therapies for such patients.

Similarly I would still like to question the effectiveness of the Care and Treatment Review process in achieving its aims of returning adults with learning disabilities or autism back into the community, where it is painfully obvious that there are not enough specialist residential establishments in Leicester to receive them. The result being that

patients are kept in hospital far longer than is beneficial for their health and wellbeing, or they are transferred out of the region again adding additional cost to their care and treatment.

When will this commission hold LPT to account for not providing appropriate care for autistic adults whilst in recovery and hold Social Services to account for not engaging with health services to prepare and provide appropriate care packages in the community?

I refer the Commission to the Statutory Guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy (March 2015) – page 31 – Local Authorities, NHS bodies with commissioning responsibility should JOINTLY – Develop and update local JOINT commissioning plans for services for adults with autism, based on effective JOINT strategic needs assessment, and review them annually, for example with the local Health and Wellbeing Board."

The Chair stated that the Adult Social Care Scrutiny Commission had considered several reports on Autism at its meeting in December 2016 and would receive a further update in August 2017. A number of issued raised by Mr Bradley were related to NHS issues and NHS colleagues would be asked to respond to them in writing directly to Mr Bradley with a copy to the Commission members.

The Strategic Director of Adult Social Care commented that whilst social services staff engaged in the discharge process, NHS Staff were responsible for taking the lead co-ordinating role for the patient's care whilst they remained in a hospital setting and it was identified that they continued to require clinical treatment or care. Social services could offer advice and guidance but NHS staff determined when a patient should be discharged and whether any social services were required to support the patient after discharge. It was also noted that the Council had planned to use capital monies and right to buy receipts of in the region of £7m last year to build 168 accommodation units to develop supported housing and extra care, which could support patients discharged from hospital. These plans had been put on hold following the Government's announcement that they had suspended the existing policy arrangements regarding the Local Housing Allowance and would be issuing a revised policy. The new policy had yet to be issued. The current indication was that it may be autumn 2018 before a revised policy was issued. This was frustrating to the Council in providing assistance to help people move from acute settings to a supported living setting.

Members commented that the Adult Social Care Scrutiny Commission aimed to make the City 'autistic friendly' and would be disseminating information to staff to increase their knowledge of the issues involved. It was hoped that both Commissions could work together on this topic in the future.

Mr Bradley commented that autism issues fell across many spectrums of service delivery and often fell between gaps in service as a result.

The Chair thanked Mr Bradley for raising the issue again. In addition to asking health colleagues to provide the information requested, the Chair felt that the Commission should write to the 3 City's MPs to raise the housing policy issue in parliament.

AGREED:-

1) That the representatives of the CCG be thanked for their presentation and responses to Members' questions.

2) That the Commission write to the City's MP requesting them to urge the Government to issue the revised policy on the Local Housing Allowance as soon possible.

80. CQC REVIEW OF HEALTH SERVICES FOR LOOKED AFTER CHILDREN AND SAFEGUARDING

Adrian Spanswick, Lead Nurse Adult Safeguarding, Leicester City CCG and Chris West, Director of Quality, Leicester City, CCG gave a presentation on behalf of the Leicester City Clinical Commissioning Group on the CQC review for Looked After Children and Safeguarding.

It was noted that:-

a) The Care Quality Commission (CQC) had undertaken a review of health services for Looked After Children and Safeguarding provision in Leicester City between 8th and 12th February 2016. The review covered services commissioned by both Leicester City Clinical Commissioning Group (CCG) and Leicester City Council. The CQC published its report on 5th August 2016. A copy of the report had previously been distributed to members.

b) The CQC report did not provide a rating, but had made 59 recommendations for improvements in health organisations involved in the review. The CQC had sent a separate letter for the attention of the Council's public health team where areas for improvement related to services provided by the NHS, but were commissioned by the Council,

c) A detailed action plan to address the recommendations in the CQC report had been developed and agreed with local partners involved in the review. Supplementary areas of concern brought to the attention of public health within the Council were not included in the CCG coordinated joint action plan. The action plan was submitted to the CQC on 3rd September 2016.

d) The implementation of the agreed action plan was being monitored by Leicester City CCG, Leicester Safeguarding Children Board (LSCB) with an oversight provided by NHS England. Progress against each recommendation is received from relevant organisations in accordance with a Quarterly reporting schedule.

e) The evidence for each quarter was received by the CCG Hosted Safeguarding Team and scrutinised by the Designated Nurses. Updates had been shared with the Leicester City CCG Governing Body and the Leicester City Children Improvement Board.

f) The CQC Action Plan was divided into 11 sections and attributable to the following organisations:
- Leicester City CCG
- NHS England
- Leicester City Local Authority
- Leicestershire Partnership Trust
- University Hospitals of Leicester NHS Trust
- SSAFA
- Leicester Recovery Partnership
- Staffordshire and Stoke on Trent NHS Partnership Trust

g) The 11 sections in the action plan covered the 59 recommendations highlighted by the CQC. However, there were 172 planned actions identified in the CCG plan to achieve improved outcomes following the CQC review.

h) Significant progress had been made by March 2017 against the delivery of the action plan. This included:
- 143 (of 172) planned actions had been completed.
- 28 planned actions were currently being implemented and were on track.
- 1 action, dependent on national work (Child Protection Information Sharing Project), was currently in progress but behind anticipated delivery.

i) The CCG continued to work with partner organisations to collate evidence of progress against actions relating to each recommendation. This involved detailed confirmation and challenge from the CCG Hosted Safeguarding Team on each provider's submission as part of the CCG quality monitoring process. The Quarter 4 submissions and updates were due to be received in April 2017.

In response to Members' questions the following comments were received:-

a) All evidence submitted as part of the action plan was reviewed with the provider by the quality lead for that action and the Lead Nurse for Adult Safeguarding. The evidence was also reviewed by each work stream and LPT and UHL's internal safeguarding committees and boards.

b) NHS England also had a role in overseeing the action plan and endorsing the improvements achieved against the action plan. In addition, the CQC could also make further planned and unplanned visits which focused attention on achieving the improvements required within the action plan.

c) Some of the services provided were shared with the other 2 CCGS in the LLR footprint and they had yet to be inspected.

d) Domestic Violence was a focus for the Safeguarding arrangements and a Domestic Violence Board was being created which would be chaired by the Police.

e) Each of the organisations involved in the responses to the improvements in the Action Plan had done what they said they would do. However, the CCG as the as safeguard lead, were also asking organisations to identify where further work was required to get better improvements.

f) A number of elements of children's health and wellbeing had been improved to become more resilient. For example a new GP Safeguarding Assurance Tool had been launched on 1 April and the initial feedback from GPs indicating it was working well in referring children to the access team. Phone access was available to respond to those in crisis and referrals could be made where appropriate. All children were now being assessed promptly and the service was committed to providing services to those who needed them most at the earliest possible time.

g) It was acknowledged that some areas were taking too long to achieve required standards. Often there was more than one organisation involved in working together to achieve the improvement. It was felt that the direction of travel in these instances was positive. LPT had made considerable progress in carrying out the Initial Health Assessments with the 13 week target. They were now working to reduce the time between the assessment and subsequent treatment. It should also be recognised that young people often failed to attend their appointments which caused further delays in lost appointments. Further work was needed to understand the reasons for this and to address increased access to the services.

h) Little was currently known about the demographic profiles of young people accessing the services and further work to providing information to determine, age, sex and rural/urban profiles would be helpful.

Members made comments and expressed concerns as follows:-

a) The backlog of children who had been assessed and were still awaiting treatment was still of concern.

b) Providing some support to looked after children after they became adults was considered desirable. Some looked after children still required assurance and support to access public health and GP services after losing the support of their looked after children nurses who helped them to arrange medical and dentists appointment etc. There were many

community/religious groups within communities and neighbourhoods that could provide support and help in these circumstances and it may be that those requiring the services were unaware of the pathways to access them. It was also recognised that many looked after children who had been fostered stayed in touch afterwards and it may only be a minority that felt they needed extra support when they reached adulthood.

c) Members were disappointed they had not been provided with a copy of the Action Plan. Whilst it was recognised that the Action Plan was being monitored by the Safeguarding Children's Board and the Improvement Board; reports made no reference to the involvement of the Council's scrutiny process. It was also felt that officers should involve Scrutiny Chairs (particularly the Chair of the Children, Young Peoples and Schools' Commission) in reports that were submitted to the Improvement Board.

The Strategic Director of Adult Social Care commented that the ongoing issue of providing support to individuals transitioning into adulthood who had traditionally received support from a wide network of services had always been a challenge, as there were inadequate resources to provide any support services post care where there was no ongoing statutory requirement to do so. He supported the suggestion of a community network pathway to offer community and peer support where there was no statutory requirement to provide support.

The Deputy Director of Public Health responded to the Chair's comments in relation to re-commissioning services for schools nurses and health visitors after budgets had been top sliced by a 10% reduction. He noted that this covered costs associated with locating NHS staff in children's centres which needed to be met and indicated that further updates could be submitted to a future meeting after the new Healthy Together programme goes live at the start of July. He also confirmed that the Director of Public Health was committed to ensuring that there was a continual and collective response covering both public health and safeguarding. A copy of the CQC's letter would be provided to the Commission; but it was noted that this letter had not yet been received from the CQC.
AGREED:

1) That the CCG representative be thanked for their attendance and their presentation.

2) That the Children, Young Peoples and Schools Scrutiny Commission and the Health and Wellbeing Scrutiny Commission work jointly to consider the quarterly update reports to satisfy themselves of the progress being made.

3) That a copy of the CQC's letter to the local public health team on services provided by the NHS, but commissioned by the local authority, be forwarded to the Scrutiny Policy Manager and sent

to members of the Children, Young Peoples and Schools and the Health and Wellbeing Scrutiny Commissions once this letter has been received.

81. ADJOURNMENT OF MEETING

At 18.35 pm the Chair adjourned for 10 minutes to enable those officers, councillors and members of the public who had attended for the previous item to leave the meeting.

At 18.45 pm the meeting reconvened with Councillors Dempster, Chaplin, Cleaver, Sangster and Unsworth present.

82. CQC INSPECTIONS OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST 2016

The Commission received a report from the University Hospitals of Leicester NHS Trust (UHL) providing an overview of the outcome of Care Quality Commission (CQC) comprehensive inspection of the Trust.

Julie Smith Director of Nursing UHL NHS Trust and Sharon Hotson Director of Clinical Quality, UHL NHS Trust, attended the meeting to present the report and respond to Member's questions.

It was noted that:-

a) The Inspection took place in June 2016 and the Inspection Report was published on 26 January 2017. The Inspection had been carried out at all 3 UHL sites. The Trust had received an overall rating of 'Requires Improvement'. However, a number of individual practices had been rated as outstanding; including the CHD service at Glenfield. It had also been rated as outstanding in the previous inspection in 2014 and had maintained making many improvements since then.

b) It was considered that good progress had being made in the general direction of travel since 2014 and the Trust acknowledged there was always more to do. There was a positive culture within the Trust and its leadership had made sure that staff knew about the challenges being faced and what was being done to address them.

c) The Trust had made a number of improvements since June 2016 and it had provided evidence to the CQC on these improvements. It was pleasing that the conditions previously imposed on the Trust's licence by the CQC in 2015 had been removed in November 2016.

d) The Trust had been highly praised for 'caring' by staff and there were still challenges around the emergency pathway. The Trust had been praised for its robust plans for the care of deteriorating patients. Sepsis had been an area of considerable focus and challenge and UHL had

made such considerable improvements in responding to the national performance indicators that it had been nominated for a national safety award. The Trust still had many challenges around its aging estate.

e) A Quality Summit had been held on 28 March 2017 and the initial feedback from the CQC indicated that they were satisfied with the progress being made and the Trust was making good progress to meet its aims of being rated 'Good' in future inspections.

Members made the following comments:-

a) It was not helpful when inspection regime criteria changed as this made comparisons with previous inspection reports difficult and the inspection process unsustainable.

b) The comments of 'outstanding' in relation to CHD services were extremely welcome; particularly in the context of the current national review which was seeking to close the service at Glenfield.

c) It was important to remember that the proposals to reduce acute care from 3 to 2 sites would not resolve all issues facing the Trust and the proposal still required public consultation before it could happen.

In response it was noted that:-

a) The new Emergency Department at the Royal Infirmary site was due to open on 26 April 2017 and that should allow considerable improvements to be made within the hospital. It provided a far larger space which should make the hand-over of patients from EMAS far easier and reduce the amount of waiting times of ambulances at the hospital so that they could return to active service much quicker than in recent times.

b) There should also be efficiencies for new models of care with the nearness of other services to the new emergency department. However, demand was still increasing and the department was seeing 200 more patients per day than when work started on building the new facility.

c) Improvements were also being introduce to provide hot food out of regular hours, especially when a patient had missed a meal through going to another appointment in the hospital or their bed had been moved. In some instances staff were feeling empowered to keep patients until they have eaten their meals. The hospital had taken back the provision of meals and different processes were now in place. Further work was being undertaken to see what further improvements could be made within the current financial resources.

The Chair commented that it would be relatively simple with the current inspection regime to concentrate on outliers of poor performance and lose sight of the fact that UHL is one of the largest acute Trusts in the Country facing

huge and complex issues. It was important to focus on the Trust's recognition of the challenges being faced and the steps being taken to address them. 'Requires Improvement' was a disappointing term to use in the current inspection regime when compared to the previous equivalent rating of 'adequate'; which as considered a far less emotive term. At times of rising need and lack of resources, 'adequate' could be considered to be good enough. 4 NHS Trusts had been placed in special measures during the week and the performance 'bar' was constantly moving which was not considered to be helpful.

It was felt the Trust could do more to engage with the public on the possible reduction from 3 acute sites to 2. People generally became concerned when there were proposals to 'close' facilities but if the transfer of services led to better and improved care, then this needed to be clearly explained in the communications strategy for the proposal.

AGREED:

1) That the representatives of the UHL be thanked for their report and response to Members' questions

2) That a further report providing an update on the improvement under the Action Plan be submitted in a year's time together with a commentary of any barriers that have hindered progress.

83. UNIVERSITY HOSPITALS OF LEICESTER QUALITY ACCOUNTS

The University Hospitals of Leicester NHS Trust submitted a report on the Draft Quality Account for 2016/17. The Commission was invited to review the draft Quality Account and provide feedback by Monday 1 May 2017, as part of the statutory Quality Account process.

The Chair commented that it was not an easy report to read and suggested that in future years council officers could give advice on style and format for a covering report so that it would be more meaningful for Members to make comments. It was fully recognised that the current report was written to an NHS formula.

In response it was stated that:-

a) The structure of the report was pre-scripted by a NHS toolkit. Trusts had asked for some time for it to be written in a more relaxed style because it was recognised that it was not an easy format to be readily understood by the public. The Trust was in the process of preparing a more accessible and easier to read report for the public.

b) Any response from the Council had to be included in its entirety (unedited) in the comments section of the report. The Council could comment on any item in the report or on any other issues which were of concern to the Council.

c) Comments made in previous years had been taken into account in the production of this year's report but there were still difficulties in presenting the quality matrix in an easier format.

d) The report provided an account of the Trust's performance to the public, its partners and its Board. It was intended to reflect upon the quality of services provided but it should also provide a balanced picture to include and recognise the challenges being faced, together with commentary on the improvements the Trust wished to achieve in the following year. It was particularly pleasing that the Trust performance on infection control was one of the best nationally. There were still challenges to be faced especially around capacity and the Emergency Department but there were plans to achieve improvement.

e) The final draft would be submitted to the Trust's Board in June, following the inclusion of comments received and then it would be audited by the KPMG for quality assurance against the NHS checklist and data requirements.

AGREED:

That the draft Quality Accounts be received and that the Chair of the Commission be given delegated authority in conjunction with the Scrutiny Policy Manager to prepare a response to the draft Quality Accounts and circulate it to members of the Commission for comment prior to them being submitted to UHL.

84. SHARED CARE AGREEMENTS

The Leicester City Clinical Commissioning Group submitted a report on Shared Care Agreements. Dr Danahar, GP Lead for Prescribing and Lesley Gant, Head of Medicines Optimization attended the meeting to present the report and respond to members' questions.

It was noted that:-

a) Shared Care Agreements (SCAs) aimed to facilitate the seamless transfer of an individual patient from secondary care to general practice to allow patients with complex conditions and drugs treatment regimes to be cared for closer to home. The full range of medical conditions where SCAs could be used were outlined in the report.

b) The process and monitoring requirements surrounding SCAs were robust and provided safeguards for the patient. An SCA was an agreement and, if the patient's GP agreed to take on the care in the agreement, the shared care arrangements would start and monitoring would take place between the GP and the secondary care commissioners via e-mail. Not all GP practices accepted SCA's and where this was refused by the GP, the patient's care continued to be

provided by the secondary care sector. In these instances the CCG worked with the GP to provide support aimed at enabling the GP to work towards accepting SCA's in the future. From October to December 2016 103 SCA's had been refused by GPs in the LLR area. The refusal in the City was approximately a third of the total refusals and this equated, on average, to less that I per practice per quarter. More than half of the refusals by GPs were of a temporary nature until further support or training could be provided. It was thought that the total number of refusals not accepted altogether was in the region of 40 for the quarter.

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

a) In instances where the SCA was refused by the GP, the secondary care commissioner would try to resolve the issues. The responsibility for the patient's care would remain with the specialist practitioner in the secondary care sector. Very few SCA's involved patients who were already in hospital, so this did not impact directly upon patients' length of stay in hospital. A number of SCA's involved patients with rheumatoid conditions and GP's would monitor any side effects the patient may have to the medication they received and would discuss changes to the medication with the specialist practitioner where appropriate.

b) Should a GP practice close the patient could transfer to another practice, which could then consider taking over the patient's SCA. If not then the patient's care would revert to the secondary care specialist.

c) The secondary care specialist would first discuss the possible use of an SCA with a patient before any referral was made to a GP. If a patient refused to have treatment in a safe environment then the treatment could be withdrawn. Equally if the patient did not fully comply with the monitoring arrangements with the GP then this would be flagged on the system and the patient would be called in for testing and monitoring on a quarterly basis.

d) Approximately 2,500 SCA's were agreed in a year compared to the 120 overall refusals in a year.

e) The responsibility for the patient's care rested solely with the secondary care clinician until a GP took on the responsibility for the patient's care under the SCA.

Members felt that many patients did not fully understand the process and suggested that it would be helpful if the CCG provided patients with FAQ sheet to explain the pathways involved in the process and to provide contact details in the event that there problems are encountered in the pathway.

The Head of Medicines Optimization stated that the CCG would look into specific cases where patient's felt there was an issue with SCAs and invited Members to provide details of any known cases after the meeting.

AGREED:

1) That the report be received and the CCG representatives be thanked for their presentation on the report.

2) That the CCG consider providing patients with a FAQ sheet to explain the pathways involved in the process and to provide contact details in the event that problems are encountered in the pathway.

85. ORAL HEALTH UPDATE

The Director of Public Health submitted a report providing an update in Oral Health in Leicester. Tiffany Burch, Specialty Registrar Public Health, presented the report and responded to members questions.

During the presentation of the report the following comments were noted:-

a) Since the introduction of the Oral Health Promotion Strategy 2014-17, the Council had made dramatic improvements in the oral health of 5 year olds. The intention of the strategy was to see a 10% increase in the number of 5 year olds who were decay free by 2019. At the time the strategy was launched, the Council had the worst performance in the county. Dental health survey results released by Public Health England in May 2016 showed an 8% improvement in just 2 years moving the Council from bottom to 4th worst performer in country. The scale of the improvements would normally be expected to take much longer to achieve. It was hoped that the initial target of 10% improvement would be achieved when the next survey results were released in 2017.

b) The Council had received an award from the Royal Society of Public Health for its programme of oral health improvement and the Chief Dental Officer was also looking at how the Leicester model could be fed into a national programme.

c) 18 primary schools, 84 nursery and playgroups and I special school were now participating in the Supervised Brushing programme.

d) 50,000 Oral Health Resources Packs (free toothbrushes and toothpaste) had been distributed in the last two years by schools, Health Visitors, Family Nurses Partnership and Travelling Families Team.

e) The supervised toothbrushing pilot for special schools carried out at Ellesmere College had now been completed and the Happy Teeth Happy Smiles Team were using the success of the pilot to roll out the programme to other special schools.

f) 4 dental practices have received the Happy Teeth Happy Smiles accreditation with a further practice close to accreditation.

g) Staff were working with the Leicester Pharmaceutical Committee to incorporate oral health in the Healthy Living Pharmacy Accreditation Scheme.

h) The use of social media had been found to be highly successful and would continue to be used.

Members welcomed the improvement achieved in such a relatively short space of time and made the following suggestions to continue the good progress made:-

a) The Oral Health Resource Pack could be included in the food bank distribution.

b) Consideration should be given to running Supervised Toothbrushing at Community Centres during school holiday periods so that parents can be involved with their children.

c) Consider attending a street party for children being organised in Highfields on 12 August 2017.

d) Consider contacting working men's clubs in the city as most club committees work with families and encourage them to use the clubs.

The Chair commented that she hoped there would be no budget cuts to oral health budget as it needed to be increased by inflation to keep on track. It was important to maintain funding as significant improvements had been made but there was still much more to achieve.

AGREED:

That the report be received and all staff involved be congratulated in helping to make the considerable improvements the oral health of 5 year olds in such a relatively short timescale.

86. 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 Work Programme be noted and that the suggestion of adding autism to the Work Programme and also working jointly with the Adult Social Care Scrutiny Commission on this be noted.

87. CLOSE OF MEETING

The Chair closed the meeting at 8.06 pm.