BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE 22 MARCH 2016

MINUTES OF A MEETING OF THE HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE HELD ON TUESDAY 22 MARCH 2016 AT 1000 HOURS IN COMMITTEE ROOM 6, COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Majid Mahmood in the Chair; Councillors Mohammed Aikhlaq, Sue Anderson, Sir Albert Bore, Maureen Cornish, Andrew Hardie, Eva Phillips, Robert Pocock, Sharon Thompson and Margaret Waddington.

IN ATTENDANCE:-

Angie Wallace (Acting Chief Operating Officer), Marie Ward (Director - Specialist Services Division), Kate Cullotty (Service Lead - Unscheduled Care) and Mike Murphy (Consultant Oral Surgeon and Head of Service), Birmingham Community Healthcare NHS Trust

Karen Helliwell (Director of Primary Care and Integration) and Ravy Gabrria-Nivas (Senior Primary Care Quality Manager), Birmingham CrossCity Clinical Commissioning Group (CCG)

Dr Andrew Coward (Chair), Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central CCG

Rose Kiely (Group Overview and Scrutiny Manager), Gail Sadler (Research and Policy Officer) and Paul Holden (Committee Manager), BCC

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NOTICE OF RECORDING

310 It was noted that the meeting was being webcast for live or subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs. The meeting would be filmed except where there were confidential or exempt items.

APOLOGIES

311 Apologies were submitted on behalf of Councillors Mohammed Idrees and Karen McCarthy for their inability to attend the meeting.

The Chair also welcomed Councillor Sir Albert Bore to his first meeting of the Committee.

MINUTES

312 The Minutes of the meeting held on 23 February, 2016 were, subject to the amendment of the third word of the second line on the fourth page to read "prostate", confirmed and signed by the Chairperson.

DECLARATIONS OF INTERESTS

313 Councillor Andrew Hardie declared that he worked as a GP at surgeries in Birmingham and Councillor Mohammed Aikhlaq that he was a governor on the board of the Heart of England NHS Foundation Trust.

BIRMINGHAM DENTAL HOSPITAL – UNSCHEDULED CARE

314 Angie Wallace (Acting Chief Operating Officer), Marie Ward (Director - Specialist Services Division), Kate Cullotty (Service Lead, Unscheduled Care) and Mike Murphy (Consultant Oral Surgeon and Head of Service), Birmingham Community Healthcare NHS Trust were in attendance.

The following PowerPoint slides were presented to the Committee:-

(See document No. 1)

During the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) The Service Lead, Unscheduled Care informed the meeting that virtually every if not all the patients booked in through NHS 111 had turned-up for their appointment.
b) Members were informed that on-site triage assistance was provided in circumstances where for example patients had a large facial swelling, bleeding or there was a child in pain. It was highlighted that there was a small leaflet listing the relevant conditions available to patients who turned-up at the Birmingham Dental Hospital.
c) The Service Lead, Unscheduled Care reported that a person presenting at the hospital with a neck swelling would definitely be seen. However, she would need to check how NHS 111 processed such cases.
d) A Member referred to the need for more detailed demographic data to be provided and the Acting Chief Operating Officer reported that it was recognised that a piece of work needed to take place in this regard.
e) The Chair pointed out that English was not the first language at home in respect of 73 per cent of the children who attended Hodge Hill Primary School (where he served as a school governor) and he enquired what work was taking place in terms of engaging with hard to reach groups. In highlighting that they were a commissioned service, the Service Lead, Unscheduled Care indicated that she considered that this was a matter that needed to be pursued jointly involving the community dental services across Birmingham and the Black Country.
f) A Member considered that the profile of people using services needed to be compared against the characteristics of the catchment area / profile of expected demand. The Consultant Oral Surgeon and Head of Service informed the Committee that this would be a matter for the Commissioners /

Public Health England to take on board and that the Birmingham Community Healthcare NHS Trust would be happy to work with them to increase take-up by hard to reach / vulnerable groups. At this juncture, the Chair also referred to involving Healthwatch Birmingham in respect of this issue and indicated that the Trust would be contacted in this regard.

g) The Service Lead, Unscheduled Care reported that they were connected to services for the homeless through the community dental services and that work was ongoing in this regard.

The Chair thanked the representatives for attending and informed them that they might be invited back to provide a further update in 12-18 months' time.

BIRMINGHAM CROSSCITY PRIMARY CARE STRATEGY 2016/20

The following paper was submitted:-

(See document No. 2)

Karen Helliwell (Director of Primary Care and Integration) and Ravy Gabrria-Nivas (Senior Primary Care Quality Manager), Birmingham CrossCity Clinical Commissioning Group (CCG) were in attendance. The paper was presented to the Committee.

During the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) In responding to concerns expressed regarding the poor quality accommodation used by many GP Practices, the Director of Primary Care and Integration informed Members that the CCG had an Estates Strategy that involved reviewing their existing buildings and which had to work hand in hand with the Primary Care Strategy. Furthermore, it was reported that an Estates Manager had been appointed and that work would start in April 2016 around prioritising and investing in premises using the National Transformation fund.

b) The Committee was informed that there were a number of ways in which GP Practices were supported including the following: Aspiring to Clinical Excellence (ACE) foundation level that sought to achieve a universal standard across all GP Practices and where there had been particular focus last year on people with learning disabilities; ACE Excellence that looked to improve the quality of services and where groups of GP Practices worked together to meet needs in their area; a GP Peer Support Programme that offered support in terms of sharing best practice; and Care Quality Commission (CQC) inspections of GP Practices (9 were currently in special measures and 3 required improvement). Furthermore, it was highlighted that a provider had been commissioned to work with the CCG on a General Practice Improvement Programme.

c) Members were advised that after 6 months if a poor performing GP Practice failed to improve there would be a follow-up CQC inspection and the Practice would be put into slow closure. A decision would also be taken on whether to re-allocate the patients to other GP Practices or re-tender the service. However, the approach being taken as part of the Strategy was to be proactive and intervene early so that the stage was not reached where a GP Practice had to be closed.

d) The Senior Primary Care Quality Manager informed the meeting that all the CCG's GP Practices were signed-up to the ACE scheme.
e) A Member voiced concern that the document did not address the important issues of identifying the areas where improvements needed to be made; what the CCG would do to make sure that there were improvements in those areas; and how it would be demonstrated that this had been achieved.
f) Further to e) above, the Director of Primary Care and Integration highlighted that she had wished to provide Members with a high-level overview and indicated that the detail would be available by May, 2016 when she could report further to the Committee.
g) A Member referred to the massive increase in the amount and intensity of work within General Practice and had real concerns for the health of people delivering the services.
h) The Director of Primary Care and Integration underlined that providing services for vulnerable groups and people with learning disabilities was a key theme of their Governing Body's work.
i) Further to g) above, the Director of Primary Care and Integration stressed that the CCG did not underestimate the challenge faced by GPs and recognised how important it was to support the workforce. It was highlighted that in addition to the General Practice Improvement Programme and the GP Peer Support Programme there was a Clinical Lead that supported the CCG on workforce issues. Furthermore, the Senior Primary Care Quality Manager referred to the importance of Information Technology (IT) (e.g. Skype, texts) as an enabler in terms of developing new ways of working.
j) The Director of Primary Care and Integration also cited working in different ways with pharmacists and across community services as a means to overcome challenges faced due to workforce capacity issues. In addition, mention was made of a workforce stream due to start in April 2016, as part of the General Practice Improvement Programme, where GP Practices would be reviewed on a bespoke basis to see how the workforce might be used differently and to identify any areas for change. The Senior Primary Care Quality Manager made reference to the resilience that came from GP Practices working together at scale.
k) Members were advised that a Health Federation had been established in the east of Birmingham and that details would be available in the CCG's Implementation Plan when the representatives next reported to the Committee.
l) The CCG had not yet undertaken any specific work associated with the new 'sugar tax' that was scheduled to come into effect. However, it did work closely with the Local Authority and Public Health on the prevention agenda which was a key theme of the organisation's work.
m) A Member referred to work the Sutton Coldfield District Committee was doing around falls prevention, dementia and child obesity and stressed the need to reduce the workload on GP Practices. He also voiced concern that owing to IT and data protection issues Healthchecks could only be carried out in GP Practices. The Director of Primary Care and Integration undertook to pursue this matter with the Member outside the meeting.
n) In responding to comments made by a Member, the Director of Primary Care and Integration undertook to follow-up the issue of the need for easy to read / picture leaflets to be available for people with learning disabilities and others who might have difficulty reading, such as individuals whom English was a second language.

o) A Member informed the representatives that the document now before Members was not a strategy but a vision statement / aspiration. The Committee therefore needed to receive information on what the position was at present in addition to the CCG's Operational Plan to assess how the CCG proposed to move from the current situation to the delivery of the vision statement. The Director of Primary Care and Integration undertook to take on board the comments made and respond in detail at a future meeting.
p) In response to a question from the Chair, the Director of Primary Care and Integration undertook to arrange for Members to be provided with details in respect of the take-up of personal health budgets.

The Chair proposed that the representatives report back to the Committee in July 2016 with the CCG's Strategy / information requested and this was agreed. He also thanked the representatives for attending the meeting.

315 **RESOLVED**:-

That the CCG's Strategy / information requested as referred to in o) above be reported to the Committee in July 2016.

DIABETES PREVENTION

316 Dr Andrew Coward, Chair of the Birmingham South Central Clinical Commissioning Group (CCG) introduced the item of business and also presented the following PowerPoint slides to the Committee:-

(See document No. 3)

Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central CCG also attended the meeting during consideration of this agenda item.

In the course of the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) The Clinical Head of Commissioning indicated that he believed that there were both genetic and lifestyle elements to why people of South Asian origin had a higher incidence of diabetes than Caucasians with the genetic aspect being the greater of the two factors.
b) Members were advised that overall there had been an approximately one in five take-up from amongst the at risk patients who were contacted by mail and that importantly there had been a good retention rate in respect of both the appointed lifestyle intervention providers - Health Exchange and Gateway Family Services.
c) In relation to Gateway Family Services it was reported that around 400 at risk patients were on courses and that the retention rate was about 92 per cent. It was highlighted that the length of time someone had to wait for a course with a provider depended on how many people there were available to attend - if there was a good sized group at a GP Practice a course could be put on straightaway.

d) The Clinical Head of Commissioning highlighted that he had been advised that a 20 per cent response was good and also considered that the commissioners of the initiative had liked the mailshot approach the Birmingham South Central CCG had taken. The CCG considered that the fact that the letters had been sent to patients by GPs had made a difference in terms of eliciting a good response.

e) It was pointed out that the CCG was a first wave implementer in respect of the 2016/17 national roll out and that the footprint included the Birmingham, Sandwell and Solihull CCGs / Local Authorities.

f) Options were still being explored in terms of how best to follow-up on those people who had not responded to the mailshot. Reference was also made to discussions taking place with the South Asian Health Foundation concerning a bespoke promotion.

g) The Senior Commissioning Manager explained that the first wave implementer would be carried out through the Healthcheck (40+ years of age) route and should produce about 900 patients a year. However, the Birmingham South Central CCG was in discussions with NHS England and Public Health England concerning the GP-led case finding route given that it was considered that the method had merit and worked. Nonetheless, at present, this approach did not form part of the first wave implementer. It was pointed out that though there was greater risk of diabetes when 40+ years of age this threshold was lower amongst people of South Asian origin.

h) The Chair highlighted that a letter could be sent to Community Events asking that the representatives be included on the circulation list of events scheduled to take place in the City.

i) At this juncture, the Chair of the Trust also drew attention to work in the United States where it had been discovered that a number of women who'd dropped out of weight loss clinics had been sexually abused and he commented on the issue of how people's Adverse Childhood Experiences (ACEs) predicated their lifetime risk of both mental and physical problems. He also referred to evidence of a decline in the number of suspensions and exclusions of children from school as a result of routinely enquiring about ACEs.

j) Further to i) above, a Member suggested looking at holding a scrutiny inquiry on the issue of ACEs. The Chair proposed that Councillor Paulette Hamilton, Chair of the Health and Wellbeing Board, be invited to bring a discussion paper to the Committee on the issue in the near future and Members indicated that they supported this approach.

k) A Member referred to the common bond between the Local Authority and NHS in terms of having to find ways of dealing with reducing budgets which in respect of adult care and tackling diabetes was largely about prevention. He considered that it therefore needed to be conveyed to the public that the only way that the City Council and NHS was going to be able to provide services into the future was if success was made of preventative measures. In highlighting the need for cost / benefit data, he referred to the need to charge someone maybe initially through the Health and Wellbeing Board or Cabinet Member for Health and Social Care with bringing matters into the public domain in a way that generated publicity - and which would have the effect of driving more people into the Diabetes Prevention programme.

l) The Chair underlined that if an increase in the prevalence of diabetes was not prevented it would be a massive problem in years to come and highlighted that this was the reason why the Committee had agreed to look into the issue. Furthermore, in referring to the tendency nowadays of a number of people of South Asian origin to use takeaways a number of times

a week he considered that in the future the adverse impact on people's health would become apparent if nothing was done. He pointed out that at weddings he'd attended there had been individuals who'd had amputations because of diabetes. He considered that the risks of not making efforts to prevent diabetes developing should be publicised and conveyed to those patients who had not responded to the mailshot.

m) In referring to a Diabetes Prevention Board, the Clinical Head of Commissioning indicated that the member who led on promoting physical activity had concerns that people currently receiving support and reducing their risk of developing diabetes might not continue to maintain the lifestyle changes in a year's time for example. Nonetheless, the Clinical Head of Commissioning also highlighted that the CCG had been informed that activities arranged as part of the diabetes prevention work taking place needed to be a group activity. He referred to the greater likelihood of individuals continuing to exercise if they were part of a close network that involved other people in similar circumstances.

n) Further to k) above, the Senior Commissioning Manager reported that the School of Health and Research at Sheffield University had been appointed to provide a cost / benefits model covering what investment would deliver on a longer term basis - the idea being to provide a tool that Local Authorities and CCGs could use.

o) The Chair of the Trust indicated that he viewed increasing levels of obesity as a modern day crisis and considered that today's generation would be judged in the future on how they had tackled the issue and encouraged people to become more active and healthier. He highlighted the need for a similar level of skills, conviction and political courage etc. to that which had been evident in this country in the past when faced with different challenges.

p) A Member who suffered with Type 2 diabetes stressed the need to convey to individuals, especially those in the South Asian community, the risks of diabetes developing. In referring to the Healthcheck at 40+ years of age he highlighted for example that people could become borderline diabetic in their teenage years. The Member also cited a link between diabetes and cholesterol and considered that people needed to be made aware of this.

q) The Chair of the Trust advised Members that in respect of diabetes the three critical indicators to a good outcome were good control of your blood pressure, cholesterol and the diabetes itself. In relation to people of South Asian origin being more predisposed to develop diabetes especially at an earlier age he acknowledged the need for a more nuanced and sophisticated approach in terms of tackling the issue.

r) Further to p) above, the Clinical Head of Commissioning informed the Committee that a number of CCGs in the West Midlands had grouped together to do case-finding work around very high cholesterol within families. In relation to diabetes, he indicated that he would welcome local leadership from Councillors on the issue and highlighted that he and colleagues could come to meetings to talk to citizens about the programme.

s) The Chair considered that it would be helpful if people knew about individuals who already had diabetes so that they were aware of how prevalent the condition was and the risks that there were of the condition developing. At this juncture he also highlighted that, as raised at previous meetings, people were discouraged from walking / exercising in the City's parks due to a lack of toilet facilities. He pointed out that this issue would be looked at during the diabetes scrutiny inquiry.

t) A Member considered that there was a need to identify how best to motivate people to exercise and also referred to the need for work to take place with schools, vulnerable groups etc. He felt that the reason why people in the country had become obese was largely because of a reduction in levels of exercise, rather than a change in calorific intake. Therefore, although diet was important, exercise was really significant and there was a need to look at how it was promoted and progress made on the issue.

u) The Chair of the Trust concurred that exercise was vitally important and in highlighting that many British people worked some of the longest hours in Europe referred to the need to look at how exercise could be built into citizens' daily lives. Members were advised that the Department of Health recommended engaging in 30 minutes of exercise 5 times a week to raise your heart rate.

The Chair advised the meeting that the Council would be liaising with the representatives concerning the forthcoming diabetes scrutiny inquiry. In addition, further to the comments in j) above, he highlighted that Councillor Paulette Hamilton would be invited to report to a future Committee meeting on the issue of ACEs with a view to that matter also forming the subject of a scrutiny inquiry in due course.

ENHANCED ACCESS TO GPs

317 Dr Andrew Coward (Chair), Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central CCG were in attendance.

The Chair of the CCG provided an initial introduction during which he referred to both the increased activity and insufficient investment that there'd been in the NHS, particularly General Practice, over many years and the lower share of the overall NHS budget going into GP services. The Clinical Head of Commissioning presented the following PowerPoint slides to the Committee:-

(See document No. 4)

In the course of the discussion that ensued the following were amongst the comments made and responses further to questions:-

a) The Chair of the CCG reported that Birmingham South Central had 55 GP Practices in total and therefore that just under 50 per cent (i.e. 23 GP Practices) were part of the MyHealthcare wave 2 pilot. He considered that the Government had envisaged there would be a reduction in avoidable hospital admissions but this had not been the experience across the country. He therefore was of the view that the Civil Servants' advice to Ministers was that for improved GP access and 7 day services to be provided, funds would need to be made available.

b) Members were advised that the CCG had been waiting for two months for an announcement on how the MyHealthcare arrangements currently in place would be funded going forward. Furthermore, the Chair of the CCG informed the meeting that they absolutely would wish to widen the initiative to cover all their GP Practices if recurrent funding was provided. He highlighted that potentially the arrangements could be put in place city-wide.

c) A Member indicated that his experience of the CCG's MyHealthcare arrangements was that they were fairly seamless and worked really well.
d) The Clinical Head of Commissioning highlighted that the Government might provide funding for the 23 GP Practices to continue with their current arrangements and indicated that he believed that those Practices within the CCG that had joined the pilot were glad that they had done so.
e) The Chair of the CCG considered that GP Practices working at scale was a reaction to an increasing demand for GP services and the financial challenges. In highlighting that the traditional model that had been in place for many years was under threat, he nevertheless considered that the MyHealthcare arrangements had the potential to provide the best of both worlds: continuity of care and working at scale - and that, by accepting compromises around the edges, there was scope to protect the heart of the service going forward.
f) Members were advised that appointments needed to be booked to access the general medical services provided under the MyHealthcare arrangements which were available from 8am to 8 pm seven days a week - though a more limited service operated on Sundays as there was less demand. The service did not compete against the urgent care system.
g) The initial language used in respect of the MyHealthcare initiative had been that of a pilot. However, the Clinical Head of Commissioning indicated that conversations were now more about a way of GPs working together at scale. In reinforcing earlier comments made, he reiterated that at the beginning it had been considered that the initiative should pay for itself through reduced Accident and Emergency / hospital admissions. However, this had not been the experience and furthermore a review of the first wave had shown an increase locally and nationally in service users presenting with primary care type health problems - reflecting perhaps previously suppressed demand. The discussions now therefore were more about the issue of there being extra cost if 7 day GP services were to be provided. Nonetheless, as also indicated earlier, MyHealthcare was viewed to be a model that worked and that the CCG would therefore like to roll out the arrangements to cover the other GP Practices in its area.
h) The Clinical Head of Commissioning advised Members that he had not interpreted that the provision of enhanced GP access / 7 day services meant that people would specifically be able to see their own GP. Furthermore, in indicating that there were alternative models to MyHealthcare, he nevertheless considered that the hub and spoke arrangements put in place by the CCG had proved their worth.

The Chair thanked the representatives for reporting and indicated that they would be invited back to a future meeting to provide an update if there was a further roll out of the CCG's MyHealthcare arrangements.

2015/16 WORK PROGRAMME

The following Work Programme was submitted:-

(See document No. 5)

Further to discussion earlier in the meeting, the Chair highlighted that the issue of Adverse Childhood Experiences / related health outcomes needed to be added to the Work Programme. He also referred to convening a scrutiny inquiry session on diabetes within the next few months and advised Members that they would be contacted in this regard.

318 **RESOLVED**:-

That the Work Programme be noted.

AUTHORITY TO CHAIR AND OFFICERS

319 **RESOLVED**:-

That in an urgent situation between meetings, the Chair jointly with the relevant Chief Officer has authority to act on behalf of the Committee.

The meeting ended at 1252 hours.

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CHAIRPERSON