BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE 23 FEBRUARY 2016

MINUTES OF A MEETING OF THE HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE HELD ON TUESDAY 23 FEBRUARY 2016 AT 1000 HOURS IN COMMITTEE ROOMS 3 AND 4 COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Majid Mahmood in the Chair; Councillors Mohammed Aikhlaq, Sue Anderson, Maureen Cornish, Andrew Hardie, Mohammed Idrees, Karen McCarthy, Eva Phillips, Robert Pocock and Sharon Thompson.

IN ATTENDANCE:-

Les Williams, Director of Performance and Delivery, Birmingham CrossCity Clinical Commissioning Group

Desmond Jaddoo (Birmingham Empowerment Forum) and Ian Hamilton (who worked with him on prostate cancer in the local community); Roger Wheelwright (Prostate Cancer Nurse Specialist) and Gerard Scandrett (Programme Manager), John Taylor Hospice

Maria Gavin, Assistant Director of Commissioning Centre of Excellence, BCC

John Denley (Assistant Director - Commissioning) and Max Vaughan (Commissioning Manager), BCC; Dr Keith Radcliffe (Clinical Lead) and Andrea Gordon (Assistant Director), Umbrella (UHB); Kymm Skidmore (Project Manager), Umbrella

Candy Perry, Interim Chief Executive, Healthwatch Birmingham

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

300 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

301 Apologies were submitted on behalf of Councillors Sir Albert Bore and Margaret Waddington.

At this juncture, the Chair also welcomed Councillor Eva Phillips to her first meeting since having been re-appointed to serve on the Committee.

MINUTES

302 The Minutes of the meeting held on 19 January, 2016 were confirmed and signed by the Chairperson.

DECLARATIONS OF INTERESTS

303 Councillor Andrew Hardie declared that he worked as a GP at surgeries in Birmingham; Councillor Karen McCarthy that she served as a city stakeholder governor on the Birmingham Women's Hospital; and Councillor Mohammed Aikhlaq that he was a governor on the board of the Heart of England NHS Foundation Trust.

(This report was brought forward on the agenda)

BIRMINGHAM CROSSCITY CLINICAL COMMISSIONING GROUP (CCG) DRAFT OPERATIONAL PLAN 2016/17

304 Les Williams, Director of Performance and Delivery, Birmingham CrossCity CCG presented the following PowerPoint slides:-

(See document No. 1)

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

a) Members were advised that Aspiring to Clinical Excellence (ACE) was concerned with giving General Practices the opportunity and the funding to work together and develop services in their surgeries and community settings to reduce the need for patients to be referred to hospital or for consultant out-patient appointments. It was highlighted that ACE was especially being looked to as a way through which to reduce the number of premature deaths by addressing conditions that shortened life expectancy.
b) The Director of Performance and Delivery acknowledged that the overlap of the Sandwell and West Birmingham CCG into the west of Birmingham did give rise to some problems in terms of looking at Birmingham as a whole. Consequently, this was why they were pursuing Associate status for that CCG and the Sandwell and West Birmingham NHS Foundation Trust in respect of the Sustainability and Transformation Plan (STP). It was reported that all the local CCGs did share their Operational Plans and that there would be a meeting in the next few weeks to identify which areas should be aligned and where a greater impact would be achieved by pursuing the issues through the STP.
c) The Committee was informed that at a meeting the previous day there had been consensus that across the Birmingham and Solihull STP footprint the first priorities that they should work on were maternity and children services and developing with the Local Authorities and other agencies a much broader based offer around prevention.

d) In relation to earlier diagnosis of cancer, the Director of Performance and Delivery considered that General Practices working together at scale was part of the answer; mentioned ensuring that GPs were made aware of the latest evidence; and referred to looking at making diagnostics more accessible through 24/7 Urgent Care Centres, for example.

e) It was reported that an Urgent Care strategy was currently being developed which included looking at how the NHS 111 service would be procured and how Birmingham CrossCity CCG out-of-hours services would be configured alongside Urgent Care Centres / existing Walk-in Centres. The Director of Performance and Delivery informed Members that at this stage he could not confirm how many Urgent Care Centres there would be and highlighted that a range of options were being investigated aimed at persuading service users that they were a viable alternative to going to Accident and Emergency. He indicated that the types of services that they were looking to provide at the locations were diagnostics, a GP and Advanced Nurse Practitioner presence on a 24/7 basis; minor procedures etc. Once the options had been developed a full public consultation process would be embarked upon. He also gave an assurance that they would not be looking to close any existing facilities until it had been established what might replace them.

f) The Director of Performance and Delivery considered that the approach being taken nationally was that personal health budgets were an area to expand as they promoted choice but acknowledged that they made the potential for funding to flow through to existing services more uncertain. He highlighted that he had only heard earlier in the day about the proposals to have personal health budgets for maternity services and was not therefore in a position to report in detail on the issue. However, he felt that this was an issue that would be debated through the STP given pressures on maternity services in and around Birmingham and Solihull.

g) In relation to engagement with patients and the public, the Director of Performance and Delivery informed Members that the CCG now had a Patients' Health Panel involving around 3,000 members and highlighted that as part of the work on formulating the Urgent Care strategy an online survey had been carried out. In referring to a debate that existed on whether Urgent Care Centres should be co-located with hospitals or not he highlighted that accessibility and car parking had been raised as major issues in the feedback. He also reported that it was planned to hold an engagement event on their draft Operational Plan within the next month and that he was aware that with regard to the STP discussions had taken place around establishing a workstream to address the issue of engaging with patients.

h) The Director of Performance and Delivery indicated that the CCG would welcome working with the Local Authority on wider determinants of health problems (e.g. poor quality housing, air pollution) which had been omitted from the plan on a page and undertook to pursue this issue.

i) Members were advised by the Director of Performance and Delivery that quality measures (that included patient reported outcome measures) concerning providers were monitored on a monthly basis and that a Quality Surveillance Group met on a monthly basis which included representatives of the Local Authority, CCG and providers. In relation to building-in a systematic way of listening for the unintended consequences of change he indicated that he would welcome discussing this further outside the meeting.

j) The Director of Performance and Delivery highlighted that tackling diabetes was amongst next year's priorities; undertook to give consideration to the findings in a report that had been submitted to the Licensing and Public

Protection Committee on air pollution in and outside shisha bars; and, in relation to prostrate cancer, indicated that his understanding was that the general medical view was that there was not the firm evidence to justify a national screening programme. However, he undertook to look further into the issue of local communities and especially the Afro-Caribbean population in Birmingham being at greater risk.

The Chair thanked the Director of Performance and Delivery for reporting to the meeting.

PROSTATE CANCER – IMPLICATIONS FOR THE BIRMINGHAM POPULATION

The following report was received:-

(See document No. 2)

Desmond Jaddoo (Birmingham Empowerment Forum) and Ian Hamilton (who worked with him on prostate cancer in the local community) together with Roger Wheelwright (Prostate Cancer Nurse Specialist) and Gerard Scandrett (Programme Manager), John Taylor Hospice were in attendance. The Chair advised the meeting that Dr Richard Viney, Consultant Urological Surgeon and Senior Lecturer in Urology, UHB was unable to attend because he had been called into theatre.

The following were amongst comments made by Roger Wheelwright and Desmond Jaddoo in the course of introducing the agenda item:-

a) Members were advised that prostate cancer was a slow growing cancer but there was now a prevalence of younger men coming through (that had not been seen before) who were presenting with the disease in an advanced stage. However, if detected early it was very treatable through surgery or radio-therapy.
b) The Prostate Cancer Nurse Specialist reported that their work with partners was aimed at raising awareness with the Afro-Caribbean population where the risk of a men developing prostate cancer at some point in their lives was 1:4, as against 1:7 nationally. However, if there was a family history of prostate cancer / female relatives who'd had breast cancer the risk doubled. He considered that there was therefore a case for raising awareness and proactively screening in respect of the Afro-Caribbean group and highlighted that Birmingham had the largest population outside of Kingston, Jamaica.
c) Desmond Jaddoo referred to the Hear Me Now programme and two reports that had been presented to Parliament highlighting the inequality in tackling prostate cancer, particularly in respect of Afro-Caribbean men. He reported that in 2013 the Hear Me Now report had been launched in Birmingham as there was no awareness programme or local screening programme. The initial aim of the work had been to develop a local action plan.
d) The Committee was advised that one of the biggest issues found in Birmingham was that Afro-Caribbean men around 50 years of age seeking screening were being turned away by their GPs. Data was currently being collected in this regard.

e) Desmond Jaddoo indicated that the following were amongst their recommendations / aims: developing Community Champions to raise awareness of prostate cancer locally; educating the wider community, such as faith leaders; the Health and Wellbeing Board recognising the importance of the issue; increasing knowledge of how to access funding for community initiatives; facilitating partnerships with the NHS and Urology Teams (Desmond Jaddoo highlighted that his organisation was now partnered with Cancer UK); and increasing knowledge about prostate cancer within families. In referring to socio-economic issues, he pointed out that a white person would normally die with prostate cancer where as an Afro-Caribbean person died because of prostate cancer.
f) Members were advised that a service that they were looking to provide was drop-in screening centres. Furthermore, it was reported that they were canvassing for prostate cancer to be covered by 'Health MOTs' with the issue being on the same agenda as diabetes, blood pressure, heart disease etc.
g) Desmond Jaddoo reported that men of Asian origin had a 1:6 risk of developing prostate cancer and considered that due to integration their prostate cancer concerns was not a niche issue. He underlined that lives could be saved if the disease was caught early. In pointing out that there was no national screening programme, he nevertheless advised the Committee that they were looking for a screening programme to be developed locally through the Clinical Commissioning Groups (CCGs).

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

a) Desmond Jaddoo advised Members that the risk of a Caucasian developing prostate cancer was 1:8 and reported that the Hear Me Now was a national initiative and operated in Bristol, Leeds, London and Nottingham.
b) A Member highlighted that the PSA test though useful was not an actual screening test for prostate cancer. However, he considered that a debate about how screening was carried out in the health service might be a good idea e.g. could it be done in a better way that helped General Practice.
c) Desmond Jaddoo informed the Committee that Hear Me Now in Nottingham had launched a drop-in clinic and carried out PSA tests and digital rectal examinations.
d) The Chair asked that Desmond Jaddoo provide data on the issue of men seeking screening who had been turned away by their GPs with a view to the Council or Healthwatch Birmingham potentially taking-up the issue with the GP services.
e) In response to a question from a Member concerning the information in the penultimate paragraph on page 2 of the report it was highlighted that there were potential side effects of prostate cancer treatment. Consequently, for those at low risk, there was a need to carefully balance these side effects with the consequences of not screening.
f) Desmond Jaddoo advised the Committee that his main recommendations to the Local Authority and partners would be for a city-wide awareness programme to be developed alongside some form of local screening programme and a 'Health MOT' at 40 years of age, particularly for Afro-Caribbean men.
g) Members were advised that work carried out in raising awareness of prostate cancer had resulted in individuals going to their GP and had saved lives; however there were many citizens who did not know what a prostate

was and therefore still a tremendous amount of work to do. It was highlighted that educating mothers, wives and partners (creating messengers) was an approach that was beginning to work in terms of encouraging more Afro-Caribbean men to visit their GPs. Mention was also made of work that they were looking to do around creating health activists in community groups and the health sector and in respect of spreading the message across the city: a model that could then be replicated in other cities.

h) The Prostate Cancer Nurse Specialist informed that Committee that he was working with some of the universities with a view to increasing young people's awareness of the risk for men of prostate cancer when they became older. In relation to the PSA test, he acknowledged that this on its own was not enough to predict prostate cancer and therefore he would also advise that a digital rectal examination be carried out and a patient's family medical history considered. He re-iterated that Afro-Caribbean men were a higher risk group and that the type of prostate cancer that they faced, at a younger age than typically seen in Caucasians, was a more aggressive strain.

i) In referring to previous work that had taken place, Desmond Jaddoo highlighted that there had been changes at the CCGs and that he was seeking to convene a meeting with them to take the agenda forward and bring all the partners together. In relation to Public Health, he indicated that the service did not at present seem keen on prioritising the issue of raising the awareness of the risk of prostate cancer.

j) Desmond Jaddoo reported that he had recently taken up a position at a church in Lozells and that they were looking to hold monthly health and wellbeing sessions covering a whole range of health issues (e.g. diabetes, blood pressure, heart disease, breast cancer) and placing prostate cancer on the same agenda. The intention was to take the model, as a complete roadshow, out to multicultural events.

In relation to individuals being turned away by their GPs, the Chair asked that the representatives liaise with Healthwatch Birmingham in terms of examining what data was available and whether there was a case for the Council taking this matter up with GP surgeries.

The Chair also proposed that arrangements be made for letters to be sent along the following lines and this was agreed by Members:-

1) To the Chair of the Health and Wellbeing Board to see if there was a possibility of including prostate cancer in 'Health MOTs' and setting-up drop-in clinics.

2) To the Head of Events asking that the representatives be included on the circulation list in respect of events scheduled to take place in the City to give them the opportunity of raising awareness of prostate cancer.

The Chair thanked the representatives for reporting to the meeting.

305 **RESOLVED**:-

That letters be sent to the Chair of the Health and Wellbeing Board and Head of Events, as outlined above.

TRANSFORMING CARE IN BIRMINGHAM FOR PEOPLE WITH LEARNING DISABILITIES WITH OR WITHOUT AUTISM WHO DISPLAY BEHAVIOUR THAT CHALLENGES

306 The following report was received:-

(See document No. 3)

Maria Gavin, Assistant Director of Commissioning Centre of Excellence, BCC introduced the information contained in the report.

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

a) The Assistant Director reported that a stakeholder day had been held at the end of January and that the commissioners were currently linking-in with the Autism Partnership Board; the Learning Disabilities Partnership Board; Experts by Experience Patient Panels; Children's Forums and also utilising the engagement functions across the City Council and health service aimed at having as wide a dialogue as possible. Mention was also made of a suggestion that had been made by a carer of having more focused discussions with families who had experienced care and treatment reviews and commented that this was at the heart of what was planned.

b) Members were advised that since the closure of assessment and treatment units it had become apparent that there were a very small number of providers with the right level of skill to support individuals with challenging behaviour in the community. The Assistant Director indicated that addressing this was a strong strand within their plans and that one of the workstreams related to learning and development for professionals and families / carers who supported people in their own homes. It was reported that notwithstanding the relatively low number of service users, mainly owing to the complexity of their care, there was a large shortfall at present particularly on the adult side in respect of the availability of services and therefore a need to expand provision.

c) The Committee was informed that there was £30m capital funding available to the 150+ Clinical Commissioning Groups (CCGs) across the country and that Birmingham had put in a bid of £1.2m for 2016/17 to develop wrap-around service provision (e.g. acquire accommodation, carry out adaptation works, fund trial service arrangements) and that, as the City's work was further ahead than some other areas, the bid might be more likely to succeed. It was reported that NHS England had not confirmed the size of the main transition fund (figures having varied between £50m -£70m) but that Birmingham had put in a bid of nearly £900,000 to support the development of services for next year; £1.3m the following year; and a further £1.3m the year after that: around £3.6m in total. It was highlighted that at present there were 21 people in CCG and 57 in NHS England assessment and treatment units at a cost £14.7m; however most of that money would not follow the patient when stepped-down with a lot of the cost falling on the Local Authority and CCGs to fund.

d) Members were informed by the Assistant Director that as joint commissioners they influenced the purchase all the specialist disability healthcare services. However, in relation Primary Care / GP services and the hospitals in general, though improvements had been made, there was

still a need to work to improve the care that individuals with learning disabilities and autism received.

e) The Assistant Director advised the meeting that there were robust safeguarding arrangements in place that linked-in with step-down activity and that where concerns were raised these were acted upon quickly. Furthermore, it was reported that the care and social work teams who worked with clients were very well sighted in respect of what would trigger an alert and how to process it.

f) In relation to listening for any unintended consequences of changes taking place, the Assistant Director reported that a range of views (e.g. those of the Clinical Advisory Panel, Partnership Boards) were listened to on an ongoing basis and fed into their plans as appropriate. In addition, she reiterated that one of the discoveries of removing funding from a hospital setting and using it to fund community services had been the skills and training development gap mentioned earlier. It was therefore now recognised that there had to be more focus on ensuring that the care provided in the community was effective and sustainable and that re-admissions were avoided. Mention was made, for example, of the need for good behavioural support programmes written by psychologists who could analyse behaviour and home-in on what triggered someone's behaviour to escalate.

The Chair thanked the Assistant Director for reporting to the Committee and asked that she keep Members informed of developments on the transformation programme and capital funding position.

(At this juncture, the meeting briefly adjourned for a comfort break)

BIRMINGHAM SEXUAL HEALTH SERVICES, UMBRELLA (UHB) – 6 MONTHS INTO NEW CONTRACT

307 The following report was received:-

(See document No. 4)

John Denley (Assistant Director - Commissioning) and Max Vaughan (Commissioning Manager), BCC; Dr Keith Radcliffe (Clinical Lead) and Andrea Gordon (Assistant Director), Umbrella (UHB); and Kymm Skidmore (Project Manager), Umbrella were in attendance.

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

a) The Assistant Director indicated that he considered that the delivery and community partners identified in the report showed the success that a systems-wide approach had been in creating stability for the Third Sector partners and helping to achieve outcomes.

b) Members were assured by the Assistant Director that there had been no disruption in respect of any of the GP services since the commencement of the contract and underlined that those services were part of work taking place aimed at setting-up longer term arrangements that addressed the 10 key sexual health outcomes.

c) The Committee was informed that the online ordering and return of sexually transmitted infection (STI) testing kits which had not been available before

was a major part of the new model and improving access to services. It was also highlighted that, in addition to GP surgeries, community pharmacies were a considerable part of the service and that there was also a network of clinics across Birmingham and Solihull that were open now for longer hours. In terms of overall access to services the meeting was informed that this was greater than it had been in the past.

d) Reference was made to feedback from partners being positive and it was highlighted that to get everyone 'on the same page' there had been focus on outcomes not on the need for any particular organisation or service.

e) Members were advised that it would be a while before the Umbrella service would be in a position to report on progress against the set outcomes. However, in testimony to the availability of online STI testing kits, it was commented that initial indicators were showing improvements in both the overall and the positive identification testing rates for chlamydia.

f) In relation to reaching hard to reach groups and covering the diverse population in Birmingham the meeting was informed that it was believed that the Umbrella service had linked-in to a number of communities; however the partners were continually asked who else they worked with and whether there were any other further avenues that the Umbrella service should explore.

g) Further to comments made by Members concerning the student populations around Edgbaston / Selly Oak, the Chair asked if the representatives could look at providing a mobile clinic in the area. The Assistant Director referred to needs based analysis work that they carried out and confirmed that this was something that they could consider and report back upon.

h) A Member indicated that he considered that when the Umbrella service next reported to the Committee it would also be helpful to hear from some of the delivery and community partners and look at the effectiveness and efficiency of the processes being used to achieve the outcomes.

i) Further to h) above, the meeting was advised that the Umbrella service structured its work around their Partnership Board where they focused on such matters as the available evidence, Key Performance Indicators (KPIs) and the actions required to achieve the set outcomes. The Assistant Director advised Members that he felt that if a contract monitoring as opposed to outcome based approach was pursued it would impact adversely on partnership working.

j) In referring to the great number of contracts each with their own KPIs that had been in place in the past, the Assistant Director indicated that he considered that the adoption of 130 indicators as part of a systems-wide approach based on 10 key sexual health outcomes was about right and not too many.

k) Members were advised that the delivery partners had been commissioned to provide posts / carry out pieces of work whereas the community partners though not paid were offered training as part of their links to the Umbrella service. The arrangements would be monitored over the course of the contract and if any gaps were identified these would be investigated.

l) The Committee was informed that though there was not a delivery partner specifically focused on the homeless the Umbrella service's work with homeless charities including the YMCA and St Basils was developing well. The identification of a delivery partner for the homeless was something moving forward that they could consider. Reference was also made to wider work that was brought to the table through the Partnership Board e.g. connections with the Council and contracts in place with organisations such as Sifa Fireside. Mention was made for example of activity that had started

in the evenings around the provision of food and work taking place to ensure that there was advice on sexual health as well. The approach being taken was that every contract counts which given budget pressures was probably the best way of making the most of the limited resources available.

The Chair thanked the representatives for responding to questions and advised them that they would be invited back to provide a further update in 6-9 months' time.

2015/16 WORK PROGRAMME

The following Work Programme was submitted:-

(See document No. 5)

308 **RESOLVED**:-

That the Work Programme be noted.

AUTHORITY TO CHAIR AND OFFICERS

309 **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 1250 hours.

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CHAIRPERSON