Buckinghamshire County Council

Select Committee

Health and Adult Social Care

Minutes

HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE

Minutes from the meeting held on Tuesday 30 January 2018, in Mezzanine Room 1, County Hall, Aylesbury, commencing at 10.06 am and concluding at 12.19 pm.

This meeting was webcast. To review the detailed discussions that took place, please see the webcast which can be found at http://www.buckscc.public-i.tv/
The webcasts are retained on this website for 6 months. Recordings of any previous meetings beyond this can be requested (contact: democracy@buckscc.gov.uk)

MEMBERS PRESENT

Buckinghamshire County Council

Mr B Roberts (In the Chair)
Mr R Bagge, Mrs B Gibbs, Mr M Hussain and Mr D Martin

District Councils

Ms T Jervis	Healthwatch Bucks
Mr A Green	Wycombe District Council
Ms S Jenkins	Aylesbury Vale District Council
Mrs M Aston	

Members in Attendance

Mr N Brown
Lin Hazell

Others in Attendance

Mrs E Wheaton, Committee and Governance Advisor
Dr J O'Grady, Director of Public Health
Ms J Bowie, Director of Joint Commissioning
Ms M Foster, Commissioning Manager, CCG
Ms S Taylor, Committee Assistant

1 APOLOGIES FOR ABSENCE / CHANGES IN MEMBERSHIP

Apologies had been received from:

- Mr B Bendyshe-Brown
- Ms L Clarke OBE
- Mr C Etholen
- Mr S Lambert
- Julia Wassell
- Ms J Cook
- Dr W Matthews

2 DECLARATIONS OF INTEREST

Ms M Aston declared an interest as she was Chairman of the Executive Committee of Abbeyfield Residential Home in Haddenham.

3 MINUTES

The minutes of the meeting held on 28 November 2017 were agreed as an accurate record and signed by the Chairman.

4 PUBLIC QUESTIONS

There were no public questions.
The Chairman referred to the response the Select Committee had received from the CCGs regarding the question raised by District Councillor Robin Stuchbury on the proposed changes to GP provision in Buckingham at the last meeting. The Members had received a copy of the letter by email and a copy of the response would be attached to the minutes of this meeting. Ms L Patten would provide an update in May.

5 CABINET MEMBER QUESTION TIME

Lin Hazell, Cabinet Member for Health and Wellbeing, reported that the budget was under constant focus. In December, £2.8 million had been released from the contingency fund reducing the year end overspend forecast to £1.3 million. Since then the department had found £700,000 of efficiencies resulting in a projected overspend of approximately £700,000. The Cabinet Member acknowledged that demand fluctuated and the budget situation was volatile. More controls would be put in place and a more robust transformation programme had been devised which would be closely monitored through weekly meetings.

The following questions/points were raised:

- In response to a question on how well the service had coped under the recent winter pressures, L Hazell informed the Committee that the number of Delayed Transfers of Care (DToC) had been good. However, some of the Hospitals outside of the county, with patients from Buckinghamshire, were struggling. The Buckinghamshire County Council (BCC) Adult Social Care service had also been doing well, particularly the Re-ablement service, which provided packages to enable people to live independently in their homes after leaving hospital. L Hazell offered to provide an update report if required. The Chairman added that Buckinghamshire Healthcare Trust (BHT) had planned well and coped better than some other areas. A lot of A & E staff had been off sick which had increased the pressure but the situation was improving.

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- A member of the Committee asked what was being done to help people in their 60's become more resilient as the care packages provided now were not sustainable in

the future. L Hazell explained that the Adult Social Care Service was working with Public Health and was confident that changes would be seen.

It was asked whether L Hazell could provide assurance that domiciliary care providers would not undertake the practice of “clipping”, i.e. reducing the time spent with the client. L Hazell had not heard of the term and had not received any feedback that this was happening and agreed to find out.

Ms J Bowie, Director of Joint Commissioning, had provided the following update after the meeting.

Post Meeting Note

Locally, BCC referred to a practice called “call cramming” and work had been taking place with our providers to stop this occurring. BCC commissioned domiciliary care with our main providers on a time and task basis with allocated hours for this work. The actual hours of care delivered were reconciled with the commissioned hours over 4 week periods. Any complaints received that visits had been significantly shorter than planned were investigated. Care workers were generally paid for the hours of care they delivered so there was no personal incentive to shorten the visit times.

- L Hazell did not know how many older people were readmitted to hospital and agreed to report back. Ms Bowie had provided the following update after the meeting.

Post meeting note:

Readmissions to hospital after 30 days stopped being routinely monitored nearly 5 years ago so there were no current national comparisons of rates. However local Buckinghamshire system figures showed a slight upward trend.

Financial Year	*Re-admissions*
2014/15	*1,551*
2015/16	*1,589*
2016/17	*2,229*
2017/18 YTD	*1,821*

The number of readmissions for 2017-18 was for year end to date but if the number reported in Q4 of this year was consistent with Q4 averages from previous years the full year outturn for 2017/18 would be slightly higher than 2016/17

- It was confirmed that partnership work with the Clinical Commissioning Groups (CCGs) was integral to cope with the extra demand due to the forecasted increase in the population.

- Work was continuing on the provision of respite care.

- L Hazell agreed that care homes were closing in some cases due to lack of funding and that it was a national issue. Prices had been checked and found to be competitive with other authorities. People were placed in care homes outside of the county on occasion if need be. Families were always consulted in order to deliver their needs wherever possible.

6 CHAIRMAN'S UPDATE

The Chairman updated that following the last meeting, he had assigned a RAG status to the recommendations made in the Adults with learning disabilities inquiry and met with the officers to raise some of the concerns about some of the recommendations. An update had

been attached under the information item.

Following discussions at the last meeting, the Chairman advised he had also assigned a RAG status to the recommendations in the Hospital Discharge Inquiry and this had also been attached under the information item.

Forthcoming events:

- There would be a BHT Board meeting in Aylesbury on 31 January 2018. Mr N Dardis, Chief Executive of BHT, would be leaving on 16 March due to a move to Frimley Park Hospital and Mr N Macdonald would be taking over as interim Chief Executive.
- Evidence gathering for the Child Obesity Inquiry would start on 6 February 2018. A private briefing was taking place after the HASC meeting today with the Inquiry Group and members of the Public Health team.

7 COMMITTEE UPDATE

Committee members provided the following updates:

- Mr M Hussain had recently visited the dementia tour bus in High Wycombe. The process was two hours in total and he had spent five minutes on the bus wearing headphones, glasses and special shoes to enable him to experience how someone with dementia felt; Mr Hussain said he found it extremely enlightening.

- Ms T Jervis, Healthwatch Bucks, updated that Healthwatch Bucks would be attending all the BHT engagement events on community hubs. The Chairman asked that the information be circulated to the Committee Members.

Action: Ms Wheaton

8 PUBLIC HEALTH

The Chairman welcomed Mr N Brown, Cabinet Member for Community Engagement and Public Health and Dr J O'Grady, Director of Public Health.

Mr Brown declared an interest as his daughter was a nurse at Frimley Park Hospital and confirmed the nurses were working extra shifts to cope with the winter pressures.

Mr Brown reported that the Public Health team was leading the work stream on the social care transformation plan. Mr Brown stressed the importance of engaging with older people before their situation became a crisis. The Public Health team were very involved in prevention and the prevention at scale pilot to try to keep people healthy for longer.

Dr O'Grady provided a brief overview of the presentation in the agenda pack and made the following points:

- A core value for Public Health was to improve the wellbeing of the population and narrow the gap in healthy life expectancy between different residents in the community.

- 25% of health was due to health care received, the rest was due to wider determinants of health.

- What happens before you were born affected your life as a child and an adult. It affected education prospects, health and chances of success. Public Health worked across the life course and looked for opportunities everywhere to improve people's health and wellbeing.

The following comments were made in response to questions from the Committee.

- In response to a query on how people were helped to maintain their wellbeing and resilience, Dr O'Grady replied that the main drivers for health were the environment, personal resilience, good mental wellbeing and physical health. The critical group was the 40-65 year olds. If someone was healthy in mid-life there was an increased chance of ageing without frailty and dementia. Dr O'Grady advised that NHS Health checks were available for everyone eligible in that age range (a person was eligible if they did not already have a condition such as high blood pressure or diabetes as they would already be being looked after). The rate of take up for the NHS Health checks was approximately 45-48% which was similar to other counties. The GP surgeries called people in on a five year rolling basis and Health checks were also available in outreach services. There was also the lifestyle service which provided a range of services such as smoking cessation and weight management.

- Public Health was one of 15 local authorities taking part in a national pilot called "Prevention at Scale". The aim was to get the message out to people in the community.

- Dr O'Grady agreed it was important to maintain the activity groups and make them sustainable as they were often in areas where they were most needed.

- Teaching school children about healthy eating and ensuring healthy options were available at food outlets would help prevent childhood obesity. Mr Brown added that the High Wycombe foodbank wanted to include fresh food but realised they would have to teach cooking and that was now in place.

- Public Health England was responsible for working with the government to lobby food manufacturers to produce healthier food.

- Some local authorities had managed to limit the density and proximity of fast food outlets but it tended to be a voluntary code.

- Dr O'Grady was asked to explain about the work Public Health was undertaking with the district councils and other health partners.
  - There was a Healthy Communities Partnership (HCP) which consisted of members from each of the district councils, the NHS and Public Health. The HCP sat under the Health and Wellbeing Board (HWB) which had a wide representation of organisations.
  - A lot of work had taken place with the District Councils on the physical activity strategy.
  - A themed workshop on health and wellbeing had taken place with Public Health, the Clinical Commissioning Groups, District Councils and Youth Services.
  - The District Councils were also on the steering group of the community organising project in High Wycombe.
  - The next Director of Public Health Annual Report would be on how we build health and wellbeing into the built and natural environments.
  - Dr O'Grady offered to take representatives from HASC to visit the Bicester healthy new town along with the district council representatives on the HWB. The Chairman said it was essential that HASC was represented.

    Action: Dr O'Grady

- The key challenges facing Public Health were:
  - To help communities to be healthy.
  - There would be less money available for an ageing population who was not

ageing healthily.
    - Mental health and wellbeing in a very changing world; national campaigns would be needed.

- In response to a question about how to measure the success in changing lifestyle, Dr O'Grady made the following points:
    - A risk factor in low birth weight babies was smoking in pregnancy which could be easily monitored. A prematurity clinic had been set up to prevent early births and children were measured in early years to check their development.
    - There were national surveys on physical activity with 2,000 people in Buckinghamshire included in the sample.
    - Admissions to hospital relating to self-harm and alcohol related conditions were being studied.
    - Smoking cessation was a non-mandatory service but was cheap to run and there had been very good quit rates.
    - The weight management service was another non-mandatory service but was very effective.
    - The lifestyle services had been halved in order to protect mandatory services such as substance misuse and sexual health services.
    - 80% of the Public Health budget was spent on mandatory services and 20% on other non-mandatory services such as domestic violence and children's services.

- Marketing had to be smart.

The Chairman thanked Mr Brown and Dr O'Grady for attending.

9 DEMENTIA SERVICES

The Chairman welcomed L Hazell, Cabinet Member for Health and Wellbeing and Jane Bowie, Director of Joint Commissioning, Adult Social Care and Maxine Foster, Commissioning Manager, CCG.

L Hazell advised that due to increased numbers of people diagnosed with dementia, working together with the CCGs and Public Health was essential.

Ms J Bowie reiterated that there had been joint working between the CCGs and public health and social care. There was a three year dementia strategy with five key themes:

- Improved Diagnostic Pathway and Diagnostic Rate
- Dementia Awareness
- Personalised Support and Independent Living
- Pre –Crisis Support
- Young Onset Dementia

There was a joint dementia board overseeing the implementation of the strategy and looking at an all aged mental health strategy to build on the work on dementia services.

The following points were made in response to questions from the Committee:

- Ms Bowie was asked what was meant by one of the challenges being around "Changing prioritisation of the importance of an early diagnosis". Ms Bowie said there were two aspects:
    - The residual view of what was the value if there was no cure. However, it was important to be diagnosed in order for interventions to be put in place and for family and friends to be able to make adjustments.
    - Focussing on the GP practices to improve and maintain their diagnosis rate. Work had also taken place with Oxford Health Trust to provide capacity.

- One of the barriers to early diagnosis was identifying onset of dementia in young people. For people in their 40's the condition affected a different part of their brain and it was difficult for clinicians to formally diagnose dementia. It could take up to five years for someone to receive a diagnosis of young onset dementia.
- For older people there was the stigma attached to the fear of having dementia diagnosed which could result in the loss of their driving licence and higher travel insurance costs.
- Ms Bowie confirmed the aim was for people to tell their story once but said that it was not always everyone's experience. Feedback was that professionals were not joined up in every case or shared best practice. Ms Bowie agreed this needed to be addressed and improved. There were some blockers on sharing information but there were mechanisms which could be used to overcome the blockers.
- Ms Bowie said she was happy that the adult social care assessment dovetailed with the mental health trust and a structured and legally compliant process was followed to determine when a person should have their liberty denied due to dementia.
- Ms Foster provided an explanation on why all the GP practices in Chiltern CCG were dementia friendly but not all of Aylesbury Vale CCG was dementia friendly. The difference was because there was a Quality Improvement Scheme in Chiltern CCG in 2016 to promote dementia and early diagnosis. There were currently six practices working towards becoming dementia friendly within the Aylesbury Vale CCG.
- Ms Bowie confirmed that there was an overarching strategy board with officers from adult social care and the CCGs and that data sets were routinely used to develop the work.
- Ms Bowie offered to find out the percentage of BCC staff who had received the dementia awareness training.

Action: Ms Bowie.

- In response to whether it would be beneficial to make a whole system presentation to the Local Area Forums (LAFs) to gain greater community involvement due to the end of the funding of the BCC project officer for Dementia Friendly Communities; Ms Bowie replied that they had looked at capacity within the Prevention Matters team and were working with the LAFs and Community Links Officers to see how support could be provided to individual areas.
- Ms Foster said there were a number of reasons for the stigmatisation of dementia:
    - There was not a word for dementia in some languages.
    - The cultural aspect was different within black, ethnic minority (BME) groups; however, those born in the UK, who were now supporting elderly parents, had a better understanding of dementia.
    - In some cultures people thought of their relative with dementia as "possessed".
    - There was a wide belief that having dementia meant you would go mad which was not the case.
- Ms Bowie added that there were dementia champions in the communities who were good examples of people with dementia living independently.
- Some memory clinics were delivered by the Alzheimer's Society and they did outreach work in the community.
- Ms Foster explained that there were two different types of memory clinic:
    - A memory support service which was county-wide and did a lot of outreach work.
    - Memory clinics which were delivered by Oxford Health.
    - The majority of dementia diagnosis' were provided by a memory clinic.
- Investment had been made for five memory clinics in GP practices across the county and these had been very successful in de-stigmatising the situation.
- L Hazell suggested inviting the Dementia Support Service to a Member briefing to help promote the dementia services.
- A tool called "DiADem" had been developed for more complex cases and was being used to diagnose patients in care homes.

- Ms Bowie said the team had projections on future numbers of dementia sufferers across the age ranges and that there were a number of strategies within Public Health to improve people's health and wellbeing and enable people to live well in the community. Public Health was working with housing to help people stay in their own homes and the Quality in Care team was making sure providers were aware of people's needs.
- In response to being asked where the budget would come from to provide for the rise in the number of dementia sufferers, Ms Bowie advised that a Green Paper was due in summer 2018 on social care. Review of resources for the health service was under consideration and any opportunities for consultation would be taken up.
- Ms Bowie agreed that some aspects of dementia could be offset if actions such as learning a new skill or keeping active were taken.
- L Hazell added that the strategies would be in place to keep the numbers down. The level of understanding and the number of people with dementia had changed dramatically over the last few years.
- The Care Quality Commission (CQC) regulated the care homes and provided the designation of whether the home was a residential, dementia or nursing home. The CQC carried out inspections to ensure care homes had performed to meet the registration standards.
- The BCC Quality in Care team provided dementia workshops to provide training to care home providers.
- BCC monitored the contracts with the providers.
- The electronic app DiADem was launched two years ago and was available for GPs to download.
- Work was taking place to overcome problems in sharing information with partners.
- The Quality in Care team monitors use of the DiADem app in care homes.
- The memory support service had carried out 140 screenings in care homes.
- Approximately 62-64% of GP practices were using the DiADem app. However, GP practices had different operating systems within a practice which made it very difficult to actually collate data from the different sources.
- Ms Bowie agreed to keep the HASC informed of the Mental Health Joint Commissioning Strategy consultation and for one of the members of HASC to be involved in the consultation.
- The POPPI database was a national database which was established about five years ago. A complex algorithm was used to produce the data which changed dependent on national research. The algorithm was brought in line with the NHS algorithm in 2016.
- Ms Bowie confirmed that respite care and support was offered to carers of people with dementia.

The Chairman thanked L Hazell, Ms Bowie and Ms Foster and for their attendance.

10 COMMITTEE WORK PROGRAMME

The Chairman asked the Members to note the following items on the work programme for the meeting in March:-

- Mental Health
- Direct payments – to be confirmed

The Chairman asked for any other suggestions to be fedback to Ms Wheaton.

11 INFORMATION ITEMS

The Chairman advised on the following items for information:

- **BOBW STP** – The Chairman and Ms Wheaton would be attending a meeting in Reading in March to gain an update.
- **Adults with Learning Disabilities –** update from the Service following the 12 month recommendation monitoring exercise

Hospital Discharge – table showing the 6 month RAG status assigned following the last meeting.

12 DATE AND TIME OF NEXT MEETING

Tuesday 20 March 2018 at 10.00 am.

CHAIRMAN