CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 6 June 2019

Attendance

Members of the Health Scrutiny Panel

Cllr Obaida Ahmed
Cllr Paula Brookfield
Cllr Bhupinder Gakhal
Sheila Gill
Cllr Lynne Moran
Cllr Phil Page (Chair)
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Cllr Wendy Thompson
Dana Tooby

In Attendance
Cllr Sohail Khan

Witnesses
Dave Martin (Outgoing Chair of Suicide Prevention Stakeholder Forum)
Steven Marshall (Director for Strategy and Transformation – CCG)
Cathy Higgins (Consultant Paediatrician – Royal Wolverhampton NHS Trust)

Employees
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director for Public Health)
Dr. Ankush Mittal (Consultant in Public Health)
Neeraj Malhotra (Consultant in Public Health)
Lina Martino (Consultant in Public Health)
Parpinder Singh (Public Health Specialist)

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
An apology for absence was received from Tracey Cresswell.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Minutes of previous meeting**
The minutes of the meeting held on 21 March 2019 were confirmed as a correct record.

4 **Matters Arising**

Clarification was sought on the term “gaming,” which was used in the minutes of the previous meeting, which the Scrutiny Officer explained.

Healthwatch Chair and Panel Member, Sheila Gill referred to the section in the minutes where the Chief Executive of the Royal Wolverhampton Trust had invited Healthwatch representatives to talk to staff working in cancer treatment services about pathways and support. She stated that this had not taken place and asked if the Panel could facilitate the process. The Scrutiny Officer, with the endorsement of the Panel, gave an undertaking to help.

5 **Public Health Performance Report**

The Director for Public Health presented a performance report on Public Health for the year 2018-2019. To achieve the ambitious targets detailed in the vision, Public Health had focussed on different approaches to issues where traditional approaches had been unsuccessful in achieving change. He outlined some of the priorities in the Public Health Vision, as detailed within the report. Critical to achieving overall success was ensuring a good start to life, having a good education, obtaining skills and good employment, living in quality housing, and living within a good community. If all of these elements could be achieved for a person, the probability was that health campaigns on matters such as obesity and smoking would not be required as people would be educated and comfortable enough to make the right decisions.

The Director for Public Health remarked that NHS health checks performance had significantly improved in the last year. NHS checks were now solely provided through primary care. Through closer collaborative working with Wolverhampton Clinical Commissioning Group (CCG), Primary Care Group Managers and GP Practice Staff across the City and a complete review of the system there had been an unprecedented rise in the access and uptake of NHS health checks. Wolverhampton had gone from the bottom 8% in the country to the top quartile in the past year. This meant health problems could be identified earlier with ultimately better health outcomes achieved.

The Director for Public Health commented that they had been working more in partnership rather than the usual commissioner provider relationship, they previously had with the Royal Wolverhampton NHS Trust. They were working on getting the basics right on health visitor checks and school nursing. Performance in this area was at its best since Public Health had moved back into the Local Authority in 2013. On the matter of rough sleeping he commented there had been 33 people sleeping rough as of last May. Bucking the national trend, the number had been driven down to 16 people as of the present day. Rough sleepers would be provided accommodation if they sought help.

The Director for Public Health stated that they had achieved the best coverage in flu vaccinations in schools since Public Health had moved back to the local authority in 2013. There was also more coverage within social care settings than before and the lowest number of outbreaks of flu in social care settings had been achieved in the last year. Public Health had helped to shape the ICS (Integrated Care System), working with the CCG and NHS Trust. Partnership working was critical to addressing the health problems faced by the City. Earlier in the month they had solidified a joint intelligence unit for the City to help all partners make better decisions through the flow of information on the health of the population of the City.

The Director for Public Health remarked that they had undertaken considerable more work with the Police on Community Safety. They had obtained some pump prime funding for intervention work to help tackle the problem and perceived problem with youth violence and knife crime. They were trying to increase the number of people receiving chlamydia tests, some people who had the condition were unaware, as they were not necessarily symptomatic. Wolverhampton in the last twelve months had moved from bottom in their comparative region to second to top for chlamydia testing in the region. A congratulatory note had been sent from Public Health England for the innovative work that the Public Health team in Wolverhampton had undertaken in collaboration with the Royal Wolverhampton NHS Trust.

The Director for Public Health stated that one of the challenges they faced was the continued decrease in funding received year on year in Public Health. This emphasised the need to work better in partnership. A spending review was about to be announced, which the team awaited in anticipation.

The Chair, Vice-Chair and several Members of the Panel complimented the Director for Public Health on the refreshing approach that had been taken by the department and for their considerable achievements in the past twelve months.

A Panel Member asked for some feedback from the conference on child obesity which the Director for Public Health and a Consultant in Public Health attended on 31 May 2019. He also asked if Public Health were looking at any new innovative ways of combating childhood obesity. The Director for Public Health responded that there was a real issue with childhood obesity in the City. The evidence suggested that you could not “treat” your way out of the problem. It was therefore not about providing additional services. The conference on child obesity had been a coming together of stakeholders across the City which had been hosted by Eleanor Smith MP. There had been a concentration at the conference on service provision. He had spoken about the importance of creating a good environment for people to make better choices, which would help tackle the obesity problem. The conference had discussed some of the forthcoming NHS policies. There had been two papers recently published, “Prevention is Better than a Cure” in November and the NHS Long-Term Plan which had been published in January.

The Consultant in Public Health added that childhood obesity rates were measured by school nurses in reception year and again in year 6. There was a high prevalence of overweight and obese children in reception year and an even greater amount in year 6. In the past letters had been sent to parents informing them of a concern about a child’s weight, but these letters had not been received very well. She wanted to make sure more work was completed before the children were even measured in reception year. It was then, important to work effectively with the children who were at risk of not being a healthy weight. There was a place element to their strategy to tackle childhood obesity, if there was an attractive environment for people to be active, it was hoped obesity rates would fall. As party of the policy work stream it was clear that supermarkets had a vital role to play and it was important for the Public Health Team to work closely with the WMCA, Public Health England and the Department for Health on the issue. There was also a people’s workstream where Public Health wanted maternity services to work with pregnant women on how to have a healthy pregnancy and to advise on healthy child development. They wanted the healthy development and growth message to be consistently reinforced by health

visitors, early year settings and in primary and secondary care. A systematic partnership approach she saw as the way forward.

The Consultant in Public Health remarked that a partnership with the working title, "the Healthy Growth Partnership" was about to be launched, with their inaugural meeting in July and a second meeting planned in the Autumn. The Children and Families Together Board had asked for an update on the new partnership's work, at their meeting scheduled for December.

A Panel Member asked about the percentage of children who received a health check at 2 - 2.5 years old in Wolverhampton. The Director for Public Health responded that it had been historically poor in Wolverhampton. It had been as low as 50% in May 2018, but they had managed to improve the figure to 62% as at November 2018. More improvement was still required, which he very much wanted to achieve. The checks were ultimately aimed at ensuring that the child was ready for school, to ensure the best start to life.

A Member of the Panel asked if the GP extended opening hours in the City were making a difference. The Director of Strategy and Transformation at the CCG responded that he could provide the figures on the effect of the GP extended opening hours on A&E admissions after the meeting. He believed it was having a positive effect on reducing A&E admissions.

There was a discussion about the activities being undertaken to help combat begging in the City, this included information on the charity which had been setup called "Alternative Giving".

A Member of the Panel asked about the use of the nasal flu vaccine for children which had an ingredient derived from a pork product. She said that for some people in certain communities this was considered a prohibitive reason to give their children the flu vaccine. She asked about the alternative arrangements available and any future plans. The Consultant in Public Health confirmed that it was true the nasal flu vaccine did contain an ingredient that was derived from a pork product. Regionally NHS England were in control of how vaccines were provided across the West Midlands. It was Public Health's role to try and ensure the population had the best protection available. He had recently been in discussions with a local Imam about the matter. There was a national debate about whether there was now an equality issue, which was prohibiting certain sections of the community from accessing the vaccine. Public Health were doing various consultations with different groups. The animal-based stabiliser was better than plant-based stabilisers, with the Pork one being the best. There were two vaccines, however the jab was not commissioned by NHS England and therefore could not be offered from a Local Authority perspective. There were also many tablets which contained a pork product.

The Chair of the Panel asked what definition was used for "rough sleeper" for compiling the statistical analysis in the Public Health performance report. The Director for Public Health stated that he would circulate the current definition that was used.

The Chair asked if the good practice from the Public Health team had been shared with other Local Authorities. The Director responded that they probably hadn't celebrated and shared their good work enough, but they could do more in the future.

The Chair commented that he wanted to increase the publicity of the good work taking place.

6 **Update on Suicide Prevention**

The outgoing Chair of the Suicide Prevention Stakeholder Forum presented an update report on suicide prevention. The incoming Chair of the Forum had sent her apologies due to sustaining an injury. He had been the Chair of the Forum for three years since its initial inception. His background was working with the Local Samaritans, he also had a regional role with the Samaritans working with the twelve prisons in the West Midlands Region.

The outgoing Chair of the Suicide Prevention Stakeholder Forum remarked that nationally there had been 5821 suicides in the year 2017. This equated to 16 suicides a day. It was estimated that there were ten times as many suicides attempts as completed suicides. Nationally, approximately 75% of people who took their own life were male. The peek for men was age 45-49 and for women age 50-54. 72% of the people had not been in contact with secondary mental health services in the year prior to taking their own life. It was estimated that the direct and indirect cost to the economy of one suicide equated to £1.7 million. It was the single biggest killer of men under the age of 45 in the country. On a local level there had been 25 suicides in Wolverhampton in 2017. Broadly there had been a downward trend since 2002. Slightly more men had taken their own life than women in Wolverhampton in 2017.

The outgoing Chair of the Suicide Prevention Stakeholder Forum commented that the national strategy had two key aims, to achieve a reduction in the suicide rate in the general population of the country and to offer better support for those bereaved or effected by suicide. The national report recommended 60 areas where organisations should be placing their efforts, particularly focusing around suicide audits and suicide prevention action plans as part of a multi-agency approach. The Centre for Public Scrutiny had produced some guidance on the scrutiny of suicide prevention work. The report circulated with the agenda answered the questions that the Centre for Public Scrutiny had suggested should be asked by a Scrutiny Panel. He supported the Centre for Public Scrutiny Guidance suggestions on the ten areas that a Scrutiny Panel should seek answers.

The outgoing Chair of the Suicide Prevention Stakeholder Forum stated that in 2014-2015 a comprehensive Needs Assessment had been carried out by a Consultant in Public Health. The assessment looked at the perceived needs, the services available, where the gaps were and what could be done to rectify them. The Needs Assessment had resulted in a strategy being drawn up which was refreshed on an annual basis. The Forum's work was very much driven by the strategy. It was important to sustain momentum in suicide prevention work. He was pleased that the Forum was independently Chaired, which helped to cement the concept that a multi-agency approach was required, rather than suicide prevention being seen as solely a Local Authority function in conjunction with a limited amount of certain partners. There were now 70 people on the Suicide Prevention Forum mailing list. Every meeting of the Forum was attended by between 15-20 people. There were targets as to the most needed groups with refugees and migrants and the LGBT community

being high on the list. A considerable amount of work had gone into improving bereavement support and training agencies on suicide.

The outgoing Chair of the Suicide Prevention Stakeholder Forum commented that one of the key challenges remaining was the provision of real-time information. Up to date information was important, it was however a real struggle to obtain information from the Black Country Coroner. There was a greater push for regional activity on areas such as data sharing with the Coroner. The Suicide Prevention Strategy had to be live, meaningful and kept up to date. In 2020 there would be a fundamental review of the strategy, focussing on areas such as raising awareness of suicide, training and support to Bereavement Services and further joined up working on a national and regional basis.

Members raised a concern that the Coroner had not shared important information to help in the work of the Suicide Prevention Stakeholder Forum.

A Member of the Panel remarked that suicide prevention should be a compulsory component of health training. They commented that children should see school nurses more often and that teachers should also proactively identify bullying, loneliness, behavioural changes, self-harm and identity issues. A Panel Member added that social media had made it more difficult to obtain a full understanding of all the issues.

The outgoing Chair of the Suicide Prevention Stakeholder Forum commented that they were pro-actively working to try and introduce suicide prevention into the training for GPs. His successor as Chair was very clear about having a universal training programme that could be rolled out in the City. As a Forum it was their responsibility to engage with as many different people as possible from different organisations.

A Member of the Panel commented that the risk of suicide increased after a recent bereavement, particularly for men. The outgoing Chair of the Suicide Prevention Stakeholder Forum responded that they had been working with “Cruse Bereavement Care” on a regional level and they also worked specifically with Compton Care and other organisations. He thought men were particularly affected after a bereavement because they were less likely to talk about their emotional wellbeing and seek support. They were putting a great deal of effort into this area. A Panel Member remarked that football teams could play an important role in helping men obtain support.

There was a discussion about where the most suicides took place in the City, which seemed to be happening in the most deprived areas of the City. Members raised the importance of the role of the community in providing support to people in despair.

The Consultant in Public Health remarked that suicide prevention was much wider than the medical health system. There were various contributors as to why someone became suicidal. Identifying support to find employment and conditions in school were examples of where targeted work could help. It was therefore not just about identifying people with mental health issues and then giving them access to mental health services.

A Member of the Panel asked if there was any data on attempted suicides. The outgoing Chair of the Suicide Prevention Stakeholder Forum stated that it was difficult to obtain because self-harm incidences were not necessarily all suicide attempts. A far greater number of women self-harmed relative to men. Judging intention was very difficult and therefore accurate data on suicide attempts was hard to gather.

There was a discussion about the most common methods that men and women used to take their own life, and which were most likely to be fatal. The Senior Public Health Specialist commented that it was possible that the suicide figures for women were lower, as women tended to use less fatalistic methods. It was crucial to obtain more data from the Coroner to be able to have a full understanding of the picture in Wolverhampton and to help prevent suicides in the future.

The Chair asked if any data was captured for suicides under the age of 15. The outgoing Chair of the Suicide Prevention Stakeholder Forum stated that accurate data collation was even more difficult for under 15's. Since 2011 the figures were for confirmed suicides. There was more sensitivity and reticence in this area because of the prospect of parents and guardians blaming themselves for the suicide of their child. The Public Health Specialist commented that nationally there had been a significant increase of suicides under the age of 15, but thankfully this had not been the case in Wolverhampton, where the numbers remained small.

The Public Health Specialist stated that the figures for suicide were likely to increase. This was because since 2018 the Coroner now could judge his verdict of suicide on the balance of probabilities rather than the criminal standard of beyond reasonable doubt. The Coroner therefore had a broader scope to reach a verdict of suicide.

A Member of the Panel made reference to the report which stated that 72% of those who died by suicide were not in touch with secondary mental health services within one year prior to death. He asked if it was known how many people were in touch with primary care service and were being treated for depression, pain or anxiety and on medication such as benzodiazepines, antidepressants or opioids. He added that if it was not known, whether the data could be captured in the future. The Consultant in Public Health responded generally stating that it was not always a medical issue which was the cause for suicide. They were training GPs in suicide prevention work.

Resolved: That the Chair of the Health Scrutiny Panel write to the Black Country Coroner on the matter of improving data sharing between the Coroner and the City of Wolverhampton Council's Public Health Team.

7 **Transition from Children's to Adults' Services for Young People**

The Consultant Paediatrician at Newcross Hospital presented a report on the transition from children's' to adults' services for young people. At Newcross there were some areas where there was very good practice, such as the Diabetes Transition Service and the Epilepsy Transition Service. They were looking at introducing a Trust wide strategy for transition which was based on NICE Guidance along with some of the relevant legislation. It was being developed with support from adults' and children's services in collaboration with parents. Transition was important to achieving good outcomes. She gave a presentation, the slides of which, containing the information she relayed to the Panel, were sent out with the agenda.

As part of the changes they were piloting the concept of health passports which contained substantial information on the young person.

A Councillor relayed to the Panel his own personal experience of having a child who had been receiving treatment from the National Health Service and had transitioned from children to adult services. It had been a challenging and difficult time for the family.

The Consultant Paediatrician at Newcross Hospital raised the importance of adult services liaising with the GP of someone who had transitioned to adult services of which the health professionals had no personal knowledge. A Councillor commented that he had personal experience of GPs not being as helpful as perhaps they could have been, his experience had been mixed.

The Director for Adult Services stressed the importance of a system wide strategy as many organisations were involved in a person's life. He was cautious of the NHS Trust having their own standalone transition strategy and wanted to ensure that the processes and systems could work collectively as effectively as possible. He was keen to ensure that the Trust were supported in their work by the wider sector, citing special educational needs as an example. The Consultant Paediatrician at Newcross Hospital responded that there was a special educational needs and disability health workstream which had representation from many partners. More generally there was also the Centre Partnership Board which was looking at the work being done to prepare children for adult services. She was keen to ensure that the strategy worked in synergy with other partners.

A Panel Member asked if it was an absolute requirement that when a person reached 18 that they had to transfer to adult services. The Consultant Paediatrician responded that some people over the age of 18 were kept in children's clinics if they were still at school. The reason why a person normally transitioned to an adult ward at 18 was because at that age you were legally classed as an adult with different rights to a child.

A Member of the Panel asked how much weight was put on a person's opinion if they were under the age of 18 and in particular if their wishes were different to those of their parents. The Consultant Paediatrician responded that they did take into account the child's opinion and it was vitally important to engage them. A child had legal rights to decline consent in certain situations.

8 **Update on Child Death Overview Panel**

The Consultant in Public Health presented a report updating the Panel on the Child Death Overview Panel. The way child deaths were reviewed was a process which followed national guidance and new guidance had been released last year. They were currently in a state of transition to make sure they complied with the new guidance. She was pleased to report that Walsall, Wolverhampton, Sandwell and Dudley were working jointly together on the project. She believed that the new national guidance was a positive change. They were in the process of appointing a Black Country Child Death Overview Panel Co-ordinator. They had adopted a system known as e-CDOP which was a cost effective, secure, flexible and web-based solution which allowed the Child Death Overview Panel process to be managed efficiently, with effective and secure sharing of multi-agency information.

The Chair congratulated Public Health on working collaboratively with other Black Country Local Authorities alongside health partners on the Child Death Overview Panel.

A Panel Member asked about data capturing surrounding learning disabilities and social economic factors which may have had a bearing on the death of a child. The Director for Public Health responded that the really important question was about ensuring that the data collected and the themes arising were put to good use in the appropriate manner and directed to the right area within the system. The new system e-CDOP was a very effective data-based system and some of the data captured was of an excellent standard.

A Member of the Panel asked about how the new role of Medical Examiner had affected the processes. The Consultant in Public Health responded that the new processes were not expected to commence until 1 July 2019, so the impact of the new posts would not be felt until 6-12 months.

Resolved: That the Health Scrutiny Panel receives a report every twelve months on the Child Death Overview Panel.

9 **Health Scrutiny Work Programme**

A Member of the Panel asked for a verbal update on Brexit to be given at the next meeting of the Panel. The Panel agreed to add it to the Work Programme.

The Chair raised the matter of site visits. The Scrutiny Officer confirmed that there would be a site visit arranged to West Park Hospital at the end of September. The Chief Executive of the Royal Wolverhampton NHS Trust had also agreed that the Panel could have a site visit to Cancer Services at Newcross Hospital and A&E should they wish to do so.

The Health Scrutiny Work Programme was agreed.