NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held in the Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 17 December 2015 from 13.30 - 15.45

Membership

Present	Absent
Councillor Ginny Klein (Chair)	Councillor Corall Jenkins
Councillor Anne Peach (Vice Chair)	Councillor Chris Tansley (until 3pm)
Councillor Ilyas Aziz	
Councillor Neghat Nawaz Khan	
Councillor Dave Liversidge	
Councillor Jim Armstrong	
Councillor Merlita Bryan	

Colleagues, partners and others in attendance:

Tom Dening	-	Professor of Dementia and Research, University of Nottingham
Ciara Stuart	-	Nottingham City Clinical Commissioning Group (CCG)
Veronica Smith	-	Nottinghamshire Healthcare Trust
Andrea Ward	-	Nottinghamshire Healthcare Trust
Uzmah Bhatti	-	Nottingham City Council
Helene Denness	-	Nottingham City Council
Kim Pocock	-	Nottingham City Council (Governance Manager)
Linda Sellars	-	Nottingham City Council
Zena West	-	Nottingham City Council (Governance Officer)
Pippa Foster	-	Alzheimer's Society
Scott Smith	-	Alzheimer's Society
Martin Gawith	-	Healthwatch Nottingham
Barbara Venes	-	Citizen

44 APOLOGIES FOR ABSENCE

Councillor Chris Tansley - other Council business until 3.00pm (Item 48)

45 DECLARATIONS OF INTEREST

None.

46 MINUTES

The Committee confirmed the minutes of the meeting held on 19 November 2015 as a correct record and they were signed by the Chair.

47 DEMENTIA SERVICES IN THE CITY

Helene Denness, Consultant in Public Health, Nottingham City Council presented her report and gave a presentation on Dementia Services in Nottingham city. She was accompanied by Linda Sellars and Uzmah Bhatti, Nottingham City Council, Ciara Stuart, Nottingham City CCG, Andrea Ward and Veronica Smith, Nottinghamshire Healthcare Trust, Professor Tom Dening, the University of Nottingham and Pippa Foster and Scott Smith, the Alzheimer's Society. Helene highlighted the following points:

(a) Dementia care involves the support of a variety of agencies to ensure that citizen's needs are met;

(b) Dementia is a disease which includes a range of conditions, affecting a person's ability to operate on a day-to-day basis, including memory loss, ability to reason and communicate and a reduction in the ability to be independent;

(c) There are approximately 700,000 people in the UK with dementia and this figure is set to double in next 30 years to 1.4 million. This is primarily the result of an aging population. There may be less vascular dementia in the future, as more people choose not to smoke;

(d) Approximately 2,915 Nottingham citizens aged 65+ are estimated to suffer from dementia. Of these there are currently 2,471 with a diagnosis. The number of sufferers under the age of 65 is increasing and supporting people to stay at work is amongst the range of different types of services needed;

(e) Alzheimer's disease and vascular dementia are the most common types of dementia. Preventative activity includes stopping smoking, maintaining healthy weight, being active, avoiding excessive alcohol consumption, keeping brain healthy and active keeping stress in check and sleeping well;

(f) Dementia care is costly. Unpaid carers save the economy significant money;

(g) 7 out of 10 people with dementia will have a range of other physical long-term conditions, such as diabetes or heart disease, as well and keeping a dementia patient physically well can be challenging. Good care requires close working between services;

(h) There is stigma around dementia in some BME communities, which means people may not access services or are not aware of services available, and there is a perception by some that services will not be culturally competent;

(i) Dementia is a national priority with policy driven at the local level by national standards. Services in Nottingham aim to support individuals, families and carers

at every stage of process from prevention, through diagnosis and support following diagnosis;

(j) There is a wide range of services available in Nottingham from the point of dementia diagnosis delivered in the community (including in care homes) and in hospital, including crisis support and care, as well as providing support to carers;

(k) Nottingham is one of 6 areas chosen for the national Care Homes Vanguard, promoting a model of provision which offers older people better, joined up health, care and rehabilitation services.

(l) Next steps in service development will include increasing awareness of the needs of people with dementia; increasing awareness of services; alignment of mental and physical health support; improving the quality of acute hospital care and improving the quality of support in care homes (through Vanguard);

(m) The work of the dementia outreach team (captured in a short film shown to the Committee) demonstrates the success of providing dementia care to people in care home settings via a team of multi-disciplinary.

During discussions the following further information was provided:

(n) In response to concerns about the stigma around mental health issues in some BME communities and the need for cultural competence and training to pick up the onset of dementia at an early stage, contributors noted the following:
    (i) the CCG has commissioned a mental health and wellbeing hub which supports people to access services. The specification with the service provider makes it clear that the service must respond to the specific cultural needs of BME groups in the city;
    (ii) a specific equality and diversity staff member is now working closely with a range of communities (including Traveller, Polish and eastern European as well) and all staff are trained in equality and diversity issues and use a range of language tools, culturally neutral assessment processes and therapy.
    (iii) services can only be provided for those who have been referred, however, so there is work to do to encourage families and communities to seek help;
    (iv) the Alzheimer's Society's Dementia Friends initiative includes culturally sensitive information. The initiative focuses on increasing awareness in communities by enabling dementia champions within their own communities to engage with people and signpost them;
    (v) There have been some high profile media campaigns, nationally and locally. All media should also reflect the community and be available in different languages;

(o) In response to concerns that dementia care homes in other European countries seem to have higher quality facilities, such as outdoor space, well laid out rooms and toilet facilities etc than in the UK contributors noted the following:
    (i) The Vanguard models are an exciting opportunity for partners to look together at how the care home model can be delivered differently to support people better. Sign up from lots of key partners;

(ii) Being able to spend time outside is as valuable as treatment for both physical health and mood. Care home residents who wander can be seen as a problem, but often they're just walking. While things have improved significantly in the last 20 years, there does need to be improvement. In the Netherlands, the care home community model constructs a recognisable community environment, with old style shops, post offices etc with space for people to move around outside freely.

(p) Awareness and outreach training has been provided in community centres and other local venues with the aim of work with community leaders so that they can champion awareness raising in their communities. Training can be arranged at any local venue by contacting Helene Denness, Consultant in Public Health at the City Council;

(q) GPs can refer directly to specialist services which will feed back to the patient, their support network and the GP;

(r) Where there is social isolation there is the risk of dementia not being diagnosed early and/ or maintaining the individual's independence. There are a number of initiatives to tackle loneliness and isolation eg the Bulwell care navigators pilot which promotes and supports self-care and Click Nottingham which looks for creative solutions that help people find friendships and reconnect with their local community; and a new community-based service to target people who live alone where things are starting to go wrong (eg wandering at night, getting lost) and the Jackdaw homecare team;

(s) Working age dementia is now recognised in a way that it hasn't been in the past. There remain complexities in diagnosis but it is now quicker with specialist services available. There is a broader challenge in trying to support employers to keep people in work. Needs can be specific to the individual. Dementia can present at a range of ages and has a range of different. Employers will increasingly have issues, both with working age, and older workforces and they will have to be better prepared to support employees sympathetically.

RESOLVED to

(1) thank all contributors for the report, presentation and information provided during the meeting; and

(2) recommend that Helene Denness, Consultant in Public Health liaises with Locality Managers and Neighbourhood Development Officers to arrange reports on engaging communities in dementia awareness to all Area Committees.

48 FEMALE GENITAL MUTILATION (FGM)

Lynne McNiven, Consultant in Public Health, Nottingham City Council presented her report on Female Genital Mutilation (FGM) highlighting the following points:

(a) FGM is a severe form of child abuse which is illegal in the UK. It is also illegal to take a child abroad to carry out FGM;

(b) FGM is usually carried out at any time from infancy to puberty and the physical, psychological, and social effects often remain with girl/woman throughout her life;

(c) Support the FGM board to carry out aim, to deliver robust strategy to prevent procedure, and to support those affected:

(d) Nottingham University Hospitals (NUH) has had an FGM service (primarily for pregnant women) for 15 years. It sees approximately 150 women every year (not all new cases) and has recently offered services to women who are not pregnant;

(e) Currently work is ongoing locally looking at prevalence within those communities known to practice FGM. Few women seek out support from health services and it is difficult to collect accurate data.

(f) This year the government has introduced a requirement for data collection from health organisations on those who have had FGM or are at risk of FGM. However, the national collection system introduced has some gaps and one particularly issue is that details cannot be anonymised on the system;

(g) The Nottingham City and Nottinghamshire County Female Genital Mutilation Board was set up in January 2015 to look at how to tackle FGM in partnership. The FGM Community Steering group, led by survivors, is a member of the Board;

(h) Involving and raising awareness in communities in a sensitive way is essential. The Community Steering Group provides emotional support and signposts to relevant health services;

(i) Training in all health and social care agencies is essential and the Board is developing an accredited training package. Mainly health focused to start with, moving to social care as it develops.

During discussions the following further information was provided:

(j) The aim is to focus both on the illegality (and consequent possible prosecution) of FGM procedures and to raise awareness in local communities to stop it continuing;

(k) It is not possible to estimate prevalence in Nottingham because what data is available may not be accurate. 150-170 women access services each year but there is no data yet on younger girls not of child-bearing age and women who haven't had children. It is now mandatory for GPs to collate data on women of all ages so hopefully this will lead to a better picture;

(l) Prevention through education of young people (in schools) and of parents is key. FGM is rarely a malicious act, even though it is cruel. Targeting cultural leaders and educating boys and men is an essential part of this;

(m) Unlikely to happen in the UK, aware to ask if people have been abroad, have infections etc.

(n) There is a legal onus on professionals to report suspicions or knowledge of FGM. When it is known that a child is going abroad and there is legitimate concern about risk, parents can be informed that there will be a medical examination on their return;

(o) Understanding a child, their family, and their background helps to ascertain risk. Teachers, staff in early years' settings, GPs, health visitors etc need to be aware of signs that indicate risk, eg extended absences during menstruation, inability to sit on the floor etc;

(p) FGM usually takes place up to puberty, most commonly at age 8 or 9, and is usually instigated by the girl's mother. FGM can involve removing the whole clitoris and sometimes removal of the labia minora and majora;

(q) Those who suffer FGM are also at increased risk of suffering sexual abuse. Sometimes men do not want to marry a woman with FGM, or seek sexual relationships elsewhere due a wife's FGM;

(r) While Public Health colleagues are driving this at the moment there is flexibility for considering whether it would be more appropriate for Safeguarding services to take work forward.

RESOLVED to thank Lynne McNiven for her report, presentation and information provided during the meeting.

49 WORK PROGRAMME 2015/16

Kim Pocock, Governance Manager, presented a report on the work programme for the Health Scrutiny Committee for 2015/16.

(a) The draft report on Palliative/ End of Life Care will be presented to the January meeting for discussion and to agree recommendations;

(b) Kim will contact councillors to see if they would like to participate in a meeting with 2 carers who have experience of caring for people in need of end of life care once this has been arranged by colleagues at Nottingham CityCare.

RESOLVED to note the work programme for the Health Scrutiny Committee for 2015/16