GATESHEAD METROPOLITAN BOROUGH COUNCIL

FAMILIES OVERVIEW AND SCRUTINY COMMITTEE MEETING

Thursday, 20 October 2016

PRESENT: Councillor B Oliphant (Chair)

Councillor(s): S Green, L Caffrey, B Clelland, S Craig, A Geddes, J Graham, M Hall, S Hawkins, J Kielty, L Kirton, K McCartney, E McMaster, R Mullen, S Ronchetti and C Simcox

CO-OPTED MEMBERS John Wilkinson and Jill Steer

APOLOGIES: Councillor(s): J Adams

Co-opted Member(s): Maveen Pereira and Sasha Ban

F16 MINUTES OF LAST MEETING

The minutes of the meeting held on 8 September 2016 were agreed as a correct record.

F17 REVIEW OF CHILDREN'S ORAL HEALTH IN GATESHEAD - EVIDENCE GATHERING

The Committee received a presentation from Stuart Youngman, Primary Care Contract Manager for NHS England . The presentation aimed to clarify the position in terms of commissioning and highlight the current arrangements.

It was reported that since 2012 the local authority has become responsible for oral health improvement, and NHS England is responsible for primary and secondary dental care. General dental services are commissioned by the primary care dental commissioners, the service can be accessed through NHS 111, NHS Choices, self-directed contact and professional sign-posting. That general service may not be able to meet all the needs for each individual and therefore referrals can be made to special care dental services. This special care can offer discreet community dental service where high street services cannot meet needs, for example for people with learning difficulties or bariatric patients, and can be accessed through professional sign-posting. Specialist dentistry, including orthodontics, minor oral surgery and sedation services is commissioned by the primary care dental specialist referral service. This service supports the general high street dental practices. In terms of the secondary care services this is consultant led and commissioned by secondary care commissioners. Overarching all of these services is Public Health’s oral health improvement programmes commissioned by Local Authority Commissioners.

It was noted that patient preference dictates that a number of patients will choose to access private dental care rather than NHS services. In addition a number of

patients will be unscheduled dental health seekers who will only access services when they have a specific need. It was noted that private dental care regulation is undertaken by the Care Quality Commission and the General Dental Council.

Primary Care Dental Services must operate in accordance with National Dental Regulation. This stipulates what should be provided, there is no requirement for patients to be registered, it is a demand led system and the practice has direct responsibility for patients only during the course of treatment. It was acknowledged that patients will perceive that they are registered with a particular practice, although practices only send out appointment reminders etc in order to manage their system. Secondary Care Dental Services do not fall under the same regulation and are commissioned under separate Standard NHS Contracting arrangements and funded through Payment by Result tariffs.

It was reported that the regulations set the contract currency and is measured in units of dental activity (UDA's) and 'banded' to courses of treatment. Band 1 equates to one UDA and is for a routine visit, scale and polish, Band 2 is for fillings and extractions and is 3 UDA's, Band 3 is 12 UDA's and is for laboratory work. The regulations require the collection of patient charges, which are nationally derived charges which vary year on year. It was noted that there are certain groups of people who are exempt from paying for treatment, it was acknowledged that there are gaps in terms of getting this message out to those who are exempt.

In terms of national statistics it was reported that the percentage of Gateshead residents accessing NHS dental care is very high. Within the previous 24 months 61.9% of the Gateshead population accessed a dentist, compared to the North East number of 61.1% and the national figure of 55.1%. It was acknowledged therefore that there is the capacity in Gateshead to meet demand, although it would be unlikely to ever reach 100% because some people will access private practices or are irregular attenders.

It was noted that the spread of primary dental care provision is good in Gateshead. During the period April 2015 to March 2016 over 374,000 Units of Dental Activity (UDA) were funded to support general patient access across Gateshead to 104,000 patients. Of that number 26% were children and young people aged between 0-18. 93% of practices in Gateshead could offer a routine appointment within two weeks and 7% within three weeks. It was also reported that 100% of the practices stated they would prioritise child patients in pain.

It was also noted that there is a Community Dental Service that provides services to children, young people and families with special care needs. This service is provided by the South Tyneside Foundation Trust and is located at the Queen Elizabeth Hospital, Wrekenton Health Centre and Blaydon Primary Care Centre. During the period April 2015 to March 2016 the Community Dental Service provided primary dental care to approximately 1200 patients with special care needs, of this number 41% were children and young people aged 0-18.

It was reported that the National Dental Contract Reform Programme is looking at a remuneration model. The development of National Paediatric Dentistry Pathway Guidance will be published in early 2017, this will set expectations for how paediatric

dentistry should be provided to ensure high quality care into the future.

Committee was advised that NHS England is keen to work with partners to improve oral health and connect with local communities.

The point was made that oral health is linked to other health problems, for example heart problems, tonsillitis and ear nose and throat problems. It was noted that conversations are being held with dental leads nationally around broadening the role of dentists to look at other issues in order to offer a more holistic approach. Committee agreed that this would be a positive direction of travel and should be highlighted in the recommendations within the final report of its review into child oral health.

It was queried why there is no primary dental practice in Chopwell and High Spen, it was pointed out that there is a poor population in the area and the lack of a dental practice is a local concern. It was questioned whether the demographic of poor dental health is mapped. It was confirmed that it is the job of all Commissioners to collect information about what is happening in the community. Under the reforms a local dental network has been established which covers Northumberland and Tyne and Wear, the group will look at all information including general access to determine if and where there are any gaps.

RESOLVED - That the comments of the Committee and the content of the presentation be noted.

F18 PERFORMANCE IMPROVEMENT UPDATE - CHILDREN PRESENTING AT HOSPITAL AS A RESULT OF SELF-HARM

The Committee received a report on the self-harm hospital admissions during 2014/15. National research shows that self-harm rates are higher among children and young people and are four times higher for girls than boys. It was noted that certain groups of young people are more vulnerable to self-harm, including; children and young people in residential settings, lesbian, gay, bisexual and transgender young people, Asian young women and children and young people with learning disabilities.

The Child Health Profile shows that in 2014/15 179 young people aged 10-24 years were admitted to hospital as a result of self-harm. This is a reduction from 2013/14 where the figure was 214. It was reported that Gateshead is higher than the Newcastle and the North East in terms of self-harm rates.

An analysis of data from North East Commissioning Support showed that in 2015/16 overall the admission rates for females is higher than males, however the trend for female admissions is down in this year. During 2015/16 there was an increase in the number of male admissions in the age group 10-24, however it was pointed out that within that group there were two males who had over 10 admissions each which may have skewed the data
In relation to the intentional self-harm during 2014/15 and 2015/16 the majority of female admissions were coded by the hospital as self-poisoning with medicine. There was also 37 females coded as self-harm by sharp object. In the same period

for males the majority of admissions were coded as self-poisoning by exposure to drugs used to treat epilepsy, tranquilisers or medicines that alter chemical levels in the brain. There was also six male admissions coded as self-harm by sharp object. It must be noted that the 2015/16 data from North East Commissioning support has not yet been validated so must be treated with caution at this time.

It was reported that the causes for concern forms passed from the Queen Elizabeth Hospital to children's services are low compared to the number of hospital admissions. In 2014/15 there were 77 forms passed to children's services, against a total of 179 admissions, in 2015/16 there were 83 forms passed over against a potential total of 223 admissions. It was acknowledged that there are potential issues around coding and work is ongoing to improve this for the future.

It was noted that there is a full review ongoing in the Child and Adolescent Mental Health Service and work is underway with the CCG to cross reference hospital data.

In order to address the issue of self-harm, training has been delivered to schools over three sessions and has been well attended by all secondary schools. It was pointed out that schools had previously raised the issue of how to support young people who are self-harming. It was reported that the Gateshead Self-Harm Protocol has been developed to help professionals identify and support children and young people who are self-harming. It is anticipated that this will be rolled out to GP's, School Nurses and A&E staff in the near future.

It was reported that the Schools Health and Wellbeing Survey has been developed for schools to sign up to and now includes questions around self-harm.

It was questioned whether the training around self-harm would be expanded to primary schools in the future. It was confirmed that currently the training is offered to secondary schools through designated safeguarding leads, with five or six staff from each school attending. It was noted that discussions are ongoing around the roll out of the training to other professional groups and that primary schools can be looked at as an option. It was confirmed that mindfulness work is in place for primary school pupils, this helps to promote the resilience of children and young people.
It was queried as to the age range of the children taking part in the Health and Wellbeing Survey. It was noted that currently this is for children in years four to six and years eight to 10, however this age range could be extended if requested.

It was questioned whether there are any links between the number of young people self-harming and the cuts in services, for example youth services. It was acknowledged that there is a need for better understanding as to whether there are links with other services as currently there is only reporting on hospital admissions.

A point was raised that different activities resulting in self-harm (ie. Taking pills versus cutting) could be viewed as more or less immediately harmful by degree. It was clarified that self-harm can be defined in a number of ways including "intentional self-poisoning or injury, irrespective of the purpose or act". It was also noted that better understanding is needed around the male's with repeat admissions.

It was questioned as to how many admissions were from young people who are

waiting for appointments with CAMHS. It was noted that this will be looked at.

RESOLVED - (i) That the comments of the Committee on the information provided be noted.

(ii) That the Committee agreed that further work should be undertaken by Public Health, Children's Services and North East Commissioning Support to look at the coding of admissions, the cause for concern forms that are sent to children's services to gain a fuller picture of the issues and the differences in the data.

(iii) That the Committee agreed to receive an update in 12 months in relation to:

- The implementation of the Self-Harm Protocol
- The findings of the Schools Health and Wellbeing Survey
- The new model for CAMHS and the implications and outcomes for children and young people

F19 CASE STUDY - CONSEQUENCES OF ALCOHOL CONSUMPTION IN PREGNANCY

The Committee received a report and case study on the harmful effects of alcohol in pregnancy, with a focus on the situation in Gateshead.

A detailed case study was provided to the Committee which identified the circumstances around a child in Gateshead who has been diagnosed with Foetal Alcohol Spectrum Disorder.

It was reported that 1-2% of children and young people in Gateshead are affected by alcohol consumption during pregnancy, but it was acknowledged that this could actually be as high as 2-5%. It was also noted that within the looked after children population there is a high concentration of children and young people diagnosed with foetal alcohol spectrum disorder.

It was noted that this can often be misdiagnosed as autism or attention deficit disorder. It was also suggested that often there will not be a diagnosis of foetal alcohol spectrum disorder because of the stigma attached. A study undertaken by SCOPE found that 75% of women in the UK reported drinking alcohol at some point in pregnancy.

Clinical features of children with foetal alcohol spectrum disorder can include neurodevelopmental difficulties in areas of; attention, adaptive behaviour, language, memory, motor skills, social communication and sensory integration.

It was questioned as to what evidence has been published to prove foetal alcohol spectrum disorder is a recognised disorder. It was clarified that this is recognised by the Royal College of Paediatricians and is known both nationally and internationally and is a validated condition. The British Medical Association published information in

2007 and updated in 2016 around the disorder. It was confirmed that this exists within neurodevelopmental disorder DSM5 and can be evidenced. It was noted that there is no test for it but there are diagnostic tools which are also used in other countries. It was reported that the Royal Holloway in London recently held a conference around this issue. It was acknowledged that there is an overlap between foetal alcohol spectrum disorder and other disorders, for example it is probable that 50% of children with ADHD will be due to exposure to alcohol.

The point was made that many women would not admit to drinking during pregnancy therefore how can there be a proven link if there is no certainty as to whether the mother has consumed alcohol. It was acknowledged that the disorder cannot be diagnosed with a test, however children affected all display the same characteristics. It was also noted that within foetal alcohol spectrum disorder there is widespread damage and all children can vary within that, for example ADHD is one of the features. However, by just recognising a child having ADHD ignores a wider range of issues in children with foetal alcohol spectrum disorder, such as learning difficulties and expressive language disorder. Foetal alcohol spectrum disorder was likened to autism spectrum disorder which had a huge surge in the 1990's when the diagnosis widened.

It was queried as to how many of the clinical features identified would a child need to have in order to be diagnosed with foetal alcohol spectrum disorder as some could be attributed to environmental factors. It was clarified that there is a four digit classification and strict guidance as to how many clinical features a child would need before it could be diagnosed.

It was clarified that not all mothers who drink during pregnancy would go on to have a child with foetal alcohol spectrum disorder. It was also noted that looked after children are not being labelled but due to their backgrounds there is a higher concentration of this disorder within that population. The point was made that within the looked after children population there is 83% placement stability, which is extraordinarily high, therefore regardless of the circumstances of some of these children and young people the situation is being managed well.

It was questioned as to what is being offered to these young people which is different to other young people. It was confirmed that a lot of work is being done with foster carers to help them support children in their care through different strategies, schools are also being supported and a lot of resources are being offered to teachers. It was also pointed out that there is a comprehensive directory of foster carers receiving training around behaviour management.

It was questioned what more could be done to promote no alcohol in pregnancy. It was confirmed that there is a champion group looking at preventative measures. It was also noted that Public Health continue to raise the '0 for 9 months' message across the population. The point was made that in other countries, such as Canada, a lot more education work is done in schools around this.
It was acknowledged that this is a growing problem and that the Health and Wellbeing Board looked at the issue two years ago, at which time the Chief Medical Officer was written to for better guidance.

It was questioned what proportion of the general population might be affected by foetal alcohol spectrum disorder. It was confirmed approximately 1% aged between 0-19 years, this equates to 500 children and young people in Gateshead, however this is more likely to be around 2-3% from the information identified in the Public Health Survey.

The point was made that if there is 1% of the population affected yet 75% of women drink during pregnancy is the data skewed to heavy drinkers or those with a genetic disposition. It was confirmed that there has been a case where the mother drank two bottles of wine per day during pregnancy and her child is fine, therefore there is variation on gender and parent and there is lot not yet understood around children's genetics. It was therefore suggested that by and large this disorder is due to genetic disposition and is skewed towards people who are heavy drinkers yet stigmatising all women who drink even a small amount during pregnancy. The point was made that there is a stigma in society, similarly if a pregnant woman smokes.

It was clarified that no amount of alcohol is safe during pregnancy and it is important that men support women to abstain from drinking for nine months.

It was suggested that the diagnostic rate is high for looked after children and higher than UK estimates. It was clarified that there is a high rate of the disorder in looked after children and that paediatricians will not just label children. It was noted that more Social Workers are asking for children to be looked at as it becomes more recognised.

It was queried as to the international picture and if other countries became aware of this earlier. It was confirmed that in 1966 a diagnostic tool was established, in Canada, Australia and South Africa, due to its indigenous population. It was acknowledged that Britain is very slow in comparison, although there is the biggest database in Gateshead this is not comprehensive. It was noted that Britain has not moved yet other countries have done massively more. Although Britain has recommended zero alcohol in pregnancy from January 2016, this is the only country not to have done so earlier.
It was questioned what facial characteristics a child with foetal alcohol spectrum disorder would display. It was confirmed that the child may be petite, have a flattened philtrum, widely set small eyes and lower set ears, birth defects can include hole in the heart and kidney damage.

It was acknowledged that the alcohol industry must take some blame. It was confirmed that Public Health commission Balance who lobby for minimum unit pricing.

RESOLVED - That the Committee agreed to allow more time for Public Health and other professionals to understand the study further before accepting the recommendations set out in the report.

F20 UPDATE ON HEALTHY SCHOOLS PROGRAMME AS A TRADED SERVICE

The Committee received a report on performance of the Healthy Schools Programme. It was reported that in early 2015 the decision was made to move the

Healthy Schools Programme to a traded service.

The programme was launched as a traded service on 1 September 2016 and last year was included in the brochure to schools for services that schools can choose to buy into.

The new offer will give schools access to a Health Coordinator to provide roll out of the programme in schools, including support to training for staff. There will also be a Mental Health Liaison Worker to support the promotion of social skills and resilience of pupils and also to identify and support those pupils at risk of mental health problems. The programme also provides access to an online community to allow schools to access information and resources.

It was noted that the programme is open to all schools and offers a much more comprehensive breakdown of findings in relation to their school population. The cost of the programme is £500 for Primary Schools and £700 for Secondary Schools. It was reported that 44 schools within Gateshead have bought in, 37 primaries, six special schools and one secondary school.

The next steps will be to continue to promote the programme following the publication of the Government's Child Obesity Strategy, which offers an important role for the programme.

It was questioned why not all schools have bought into the programme. It was confirmed that the schools who did not buy in were contacted for feedback and only five or six responses were received, four of these responses stated that cost was the reason for not buying in.

It was also questioned whether some schools provide the mental health element without buying into the programme. It was confirmed that some schools already offer this support and therefore do not feel the need to buy in.

RESOLVED -

(i) That the comments of the Committee and the contents of the report be noted.

(ii) That the Committee agreed to receive an update in 12 months in relation to;

- Continuing performance of schools and updates on the health priorities they will be focusing on
- Update on the number of schools agreeing to engage in the Healthy Schools Programme for 2017/18.