Time commenced – 18.00
Time finished – 20.10

ADULTS AND HEALTH SCRUTINY REVIEW BOARD

21 March 2022

Present: Councillor Martin, (Chair)
Councillors Lonsdale (Vice Chair), Grimadell, Hussain

In Attendance: Gareth Harry, Executive Director of Derbyshire Healthcare Foundation Trust
Steve Lloyd, Executive Medical Director, Derby & Derbyshire CCG
James Lewis, Head of Joint Strategic Commissioning Learning Disabilities & Autism, Derby & Derbyshire CCG

41/21 Apologies for Absence

There were apologies from Cllrs Froggatt and Pegg, A Smith Strategic Director Peoples Services and Perveez Sadiq, Director of Adult Services

42/21 Late Items

The Chair proposed that the Vice Chair chaired this meeting whilst she (the Chair) was present so that she gains experience. This request was agreed by the Board.

43/21 Declarations of Interest

There were none.

44/21 Minutes of the Meeting on 1 February 2021

The Minutes from the meeting held on 1 February 2021 were agreed as a correct record.

45/21 Mental Health Post COVID Response

The Board received a presentation from the Executive Director of Derbyshire Healthcare Foundation Trust (DHCFT) who are the main Mental Health and Learning Disability services provider in the city.

The presentation was based on information at the peak of the Omicron Wave in the second week in January. It provided a snapshot of the position in terms of the response to the wave and what it meant to the services and the pressures they were under.

The Omicron Wave in December through to January reached a peak in the 2nd week in January, it had less impact in terms of patients being admitted to acute services than in terms of impact on general community transmission and therefore the number

of staff in the organisation and in Adult Care and the Voluntary Sector who had staff off sick and isolating.

The COVID related workforce sickness absences in DHCFT were at 134, down from 167 in the week of 3rd Jan with 267 people in total having to be away from their COVID workplace, some of staff could work from home. The Board noted that normal sickness levels are 4% to 5 % but were at 12% during this period. There was a wider impact of people not being able to be at work due to isolation or caring for family.

For a two-week period, 27th December to 14th January the acute mental health wards were incredibly busy, occupancy on the acute Mental Health DHCFT wards was 100% and had not been below 97% since the 4thJanuary. There were Covid outbreaks in care homes, supported accommodation providers and step-down facilities closed across the City and County. Because of ward staffing challenges staff were deployed from other services into the ward environment to maintain levels on the ward.

A Daily Incident Management response was started within Derbyshire Healthcare to monitor and manage responses to workforce, inpatient admissions, bed management and communications. Business Continuity Plans were reviewed across services. There were daily management and updates across all adult/older adult ward settings. A specific Multi-Agency Discharge Cell was set up (inpatient wards, social care, voluntary sector, and step down/supported accommodation) to lead work to rapidly discharge patients who were medically fit to leave inpatient care, maximising capacity in step down facilities.

The twenty-four-hour crisis helpline for Mental Health and Learning Disabilities and Autism line, which was available for all ages to call, and had been operating since June 2020 continued to see a high level of calls, there was an increase in calls in December. The data on 3 months showed in November, December and January a lot of people had their needs met by speaking to someone on the line, who gave advice guidance and support so there was no need for escalation. It avoided a lot of people being admitted, they were referred to the crisis team who met them in their homes or a place of safety such as the Safe Haven.

Additional funding over the winter period was used for several purposes including the “All Age Emotional Health & Wellbeing” support website being updated, it was available to professionals and all members of the public. The Crisis Alternatives Safe Haven operating in Derby city which accepted referrals from the city/county areas. Additional Discharge Coordinators/Social Care support workers were appointed during January to support discharge from inpatient wards. Four additional Rethink step-down beds were contracted to support additional discharge from the wards. Additional Crisis Alternatives crisis cafes (drop-in access facilities) across the county are coming on board in mid-2022. A councillor asked if the 4 extra beds were still in operation. The officer confirmed they were in place to the end of March and possibly would continue in April to May. The Service was currently reviewing the number of stepdown beds needed, as the flow was getting better.

A councillor asked the officer to comment on the level of service that it was was able to provide when services came under acute pressure due to staff absences or greater levels of referrals coming in. He suggested that the service had to concentrate on people in the most acute need and some of the people slightly lower down might have missed out on this period. He also asked for comments on whether services have returned to near normality because things now seem to be getting back on track.

The officer explained that the service has learnt though Pandemic that they need to keep all caseloads and people waiting for services under constant review in terms of their needs and potential risk. The risk was structured across caseloads in the community, when services became pressured, people were redeployed to support wards. Patients were identified from caseloads who might be able to wait a little bit longer for regular follow up appointments which enabled staff to see people who had more urgent needs. In terms of services being re-established, the impact of the Omicron wave has been worked through, the ongoing challenge will be sickness absence, the level of endemic covid in the community means more people will be off sick, isolating or caring for family members. We can see more people face to face now than over the last 2 years and are looking to bring people back to the workspace, perhaps using flexible arrangements.

A councillor welcomed the Derby and Derbyshire crisis phone line. It had been publicised in the Derby wards to promote awareness of that phone line. She suggested the Trust should consider promoting this service more. There are a series of helplines, some directed at men only, which are vital as suicide rates are high among men. Was it possible to provide occasional drop in areas in wards across Derby?

The officer stated there was an opportunity for voluntary sector and groups to host crisis facilities, perhaps a network of small ward level facilities could be considered the Trust and CCG are open to ideas. Regarding the Crisis Helpline it was set up quickly in a four-week period during the first lockdown, it was not good branding but was a practical name. The Trust welcomed branding ideas to make it more attractive. Thank you for your comments.

A councillor was surprised at the number of calls to Crisis Help Line which went up by 8% in December and asked if since 14th January, call levels have reduced, stayed the same or become worse. The officer confirmed they had stayed the same. He explained that the increased number of calls was because the level of staff had increased. It was not an increase in demand, there were more staff available at different hours. The councillor asked if staffing levels were the same now. The officer confirmed they were the same. The number of calls had increased during November to December 2021. The service was a partnership between P3 voluntary sector provider and Derbyshire's health care clinical staff.

Another councillor recognised that the service was under a great deal of pressure and asked whether staff are being looked after. The officer explained the health and wellbeing was a focus for organisation and wider Derbyshire health and care system staff. There was a Health and Wellbeing Hub with a range of services from advice and guidance to counselling and expert interventions including psychology support available to people depending on need, it was available to all health and care organisations in the city.

The officer was thanked for the excellent report.

The Board resolved to note the report

46/21 Provision for people with chronic conditions such as ME, Chronic Fatigue Syndrome (CFS), Long COVID

The Board received a presentation by the Executive Medical Director of the Derby & Derbyshire CCG which provided an update on provision for people with chronic conditions such as ME, Chronic Fatigue Syndrome (CFS) and Long COVID.

The officer explained briefly about Post-Covid Syndrome, which was completely new to humanity. The science was again new in terms outcomes of the SARS COV 2 infection. The definition for Long COVID circulated by NICE was “Enduring COVID 19 symptoms over 12 weeks”. Imperial College undertook a study in June 2021 and defined two main categories of Post COVID symptoms; a small group of mainly respiratory symptoms like an enduring cough, shortness of breath, there was a larger group with more generalised symptoms including fatigue. Other more recent studies also identified two main groups mainly respiratory symptoms along with fatigue and headache and another group which was more organ specific and had symptoms such as enduring dizziness, heart problems or palpitations.

Overall numbers from the Office of National Statistics (ONS) suggest that 3% to 12% of people who have had COVID still have enduring symptoms past 12 weeks. It was difficult to gauge the impact that the vaccination programme has had on Long COVIDs spread and occurrence. ONS data suggested that 1.3 million people in the UK have had or are experiencing Long COVID which was about one in fifty of the population. The impact was difficult to measure because of the wide and different types of presentations. A recent Leicestershire study suggested that most hospitalised patients (70%) do not recover fully even after five months. There are reports of patients suffering symptoms for over 12 months, the symptoms can even be cyclical in nature. The most common symptom post COVID and enduring beyond 12 weeks was fatigue, about 51% of patients experience fatigue, about 37% of people experienced a loss of smell. Other symptoms included shortness of breath, difficulties of concentration and brain fog. It was difficult to understand what to expect in the future from Long COVID and what level of health services would be required.

The response to Post COVID as a service was described. In October 2020 NHS England launched a directive and guidance alongside the NICE guidelines which gave definitions of Long COVID and how to respond to it. Derbyshire set up an assessment service for patients from December 2020 to accept referrals from GPs and secondary care for patients who were beginning to experience Post COVID syndrome symptoms. Further guidance was issued in June 2021 on configuring rehab services for these groups of patients. The Lead provider in Derbyshire was Derbyshire Community Health Services (DCHS), there was a specific focus on patients with chronic fatigue and shortness of breath and the enduring psychological aspects of COVID.

The level of service in place was comprehensive and was flagged up in the Midlands region as a very good service for patients. A clinical group operational group was formed between CCG and DCHS as Lead provider for assessment and rehabilitation to look at how to put in place pathways for referral for patients, management pathways and to configure them along lines of specific symptoms that needed to be tackled alongside health inequality issues.

The access route for patients was through primary and secondary care routes. GPs carried out an initial assessment against a template, they referred patients to assessment centres run by DCHS, where patients were assessed by telephone or face to face. They were then directed to rehabilitation services geared towards specific areas including psychological and mental health. If there were more significant symptoms, they were referred to a heart or respiratory specialist for specific assessment.

The Post COVID Mental Health response was highlighted, patients who are referred through Long COVID assessment service with specific mental health issues are transferred to Improved Access for Psychological Therapy Providers (IAPT) providers for city and County, patients can self-refer into that route also.

There was a Chronic Fatigue Syndrome (CFS) and ME Service in Derby which was formed in 2004 and sits within Specialist Rehabilitation at London Road Community Hospital provided by the UHDB. It provides a specialist centre for the treatment of adults (age 16 and over) with a diagnosis of mild, moderate, and severe chronic fatigue syndrome (CFS)/ME. Specialist therapy assessment and treatment are available.

The challenges of Long COVID were described, bearing in mind the impact of the Omnicom wave, the most significant challenge or risk was the extent of the waiting list, which was at 12 weeks, the national ambition was to reduce this to 6 weeks. Actions have been put in place by challenging the lead provider to put resource into the assessment and rehab to get numbers down to six weeks.

The Chair thanked the officer for the report but explained that this was not the report the Board had requested. They had been offered a report on Long COVID earlier in the year, but they had specifically stated that the Board wanted to focus on services for CFS and ME. The Board was already concerned about COVID, it had been a standing item at every meeting this year, concerns about the effects of Long COVID had also been raised. It was quite telling that the NHS had been asked to address the serious issues that people have been suffering for decades with CFS and ME, but that report was not received. However, there may have been some confusion in communication along the way. An officer suggested that checks should be undertaken with the CCG to ensure subject matter was correct. The chair felt that the system generally worked well, although there was confusion on this particular issue.

The Board are concerned about Long COVID but are aware that CFS and ME was not a new problem, people have had CFS and ME for a long time. One of the issues in the treatment of CFS was that it was a treatment of managing the symptoms rather than addressing the causes. The physio can be useful for some people, but this usually tends to ignore the fact that the NHS does not address or cure the problem itself, it was a superficial way of dealing with it. CBT was a good service, but other diseases such as cancer would not be treated in the same way. Does the NHS believe that the current approach to CFS and ME treatment was adequate, or should there be movement towards dealing with the illness itself rather than its symptoms?

The officer explained that the message received was to present on Long COVID as well as CFS so there had been a communication failure. In terms of causes of CFS, as a clinician, the treatment options that are generated through the service are best practice. The cause of ME and CFS have been controversial in the past, and it was difficult to pin down the actual cause of CFS and ME as something to be specifically treated. Caution should be used in asking whether what was in place in terms of a service offer could be expanded as NICE guidelines were being followed in terms of management of these conditions. The officer also stated he could return to the Board at a future date and expand both on the presentation of patients with those conditions, the management pathways and the NICE guidance that supported service development from 2004. A councillor stated that there was new guidance issued recently for CFS and ME and queried whether that had been actioned within the area. The officer could offer no response now but would bring information back to a future meeting if the forum required that.

Another councillor was interested in the current COVID situation and asked whether new strains of COVID could easily appear if people would have to have more vaccinations and could new strains be more dangerous than previous strains. The officer responded as both Executive Medical Director, SRO of the Vaccination Programme and explained that in terms of COVID 19 strong advice was given that over the next 2 years there would be an unstable and unpredictable picture of what

could happen with COVID 19 but there was a high probability of a new variant emerging within the next 6 to 9 months. Omicron was exceptional in terms of mildness and less severe characterisation in terms of symptoms. In the UK the comprehensive achievement of vaccination programme has mitigated the effects of Omicron. China was currently experiencing an Omicron BA2 variant, they do not have comprehensive vaccination cover, particularly for the elderly and are running into issues with high mortality rates and hospital admissions. Omicron was thought to be a mild experience, but a comprehensive level of vaccination gives good cover against it. However, another variant may well emerge in the unstable period over the next 2 years which could be more transmissible, and more severe, the vaccination programme will need to continue for the most vulnerable. The councillor asked how long the protection would last, it was explained that it will depend on the variant. The next part of the strategy will be to vaccinate the most vulnerable and over 75's and those with a weakened immune system.

A councillor returned the discussion to the issue CFS and stated that given that the exclusive focus on COVID might influence treatment for CFS and any sufferers who do struggle to get a focus on their condition. It was known that in terms of CFS it costs the economy up to 100 million per year in lost productivity, what was the recovery rate like for people who have CFS on the NHS treatment they receive? The officer explained that he was unable to give detail now but would bring a more focused item covering the service delivery for CFS and outcomes from the latest guidance to a future meeting.

The Chair noted the dissatisfaction of the Board at receiving a different report than they had requested through communication error, but felt it was a very interesting report and thanked the officer for delivering it.

The Board agreed to note the report and requested that a report be brought back the first meeting of the next municipal year on chronic ME and CFS setting out the situation with CFS and ME, the number of people suffering from it and the nature of the treatment and outcome of the treatment on the NHS. The Board would like to hear more about these subjects even though there was a crisis with other conditions currently, to ensure that aspect of the NHS was not neglected.

The Board resolved to request that a report be brought back to the first meeting of the next municipal year on chronic ME and CFS. The report should set out the situation with CFS and ME, the number of people suffering from it and the nature of the treatment and outcome of the treatment on the NHS.

47/21 Review of Services for autistic adults and adults with a learning disability.

The Board received a presentation from the Head of Joint Strategic Commissioning Learning Disabilities & Autism (Derby & Derbyshire Clinical Commissioning Group). The presentation hoped to demonstrate how the system of health and social care and community services was working to improve the lives of autistic people and those with a learning disability.

Learning Disabilities defined by Mencap was 'a reduced intellectual ability and difficulty with everyday activities which affects someone for their whole life.' There are a variety of different causes, and these can occur prenatal, perinatal, and postnatal. The most recognised was 'Down's Syndrome' & Cerebral Palsy', but there are lesser-known causes such because of infections such as meningitis or measles or sociological / environmental such as 'Foetal alcohol syndrome' or injury because of abuse. Learning disabilities should not be used interchangeably with Learning Difficulties, Learning Difficulties include Dyspraxia and Dyslexia.

In Derby there are approximately 4,700 adults with a learning disability, and about 1,500 children which represents about 2.16% and 2.5% of the adult and child population respectively.

In Derby there are approximately 1,950 autistic adults, 600 children this was based upon a prevalence rate of 1%. Autism as described by the National Autistic Society autism or autism spectrum condition was a 'lifelong developmental disability affecting how people communicate and interact with the world.' Autistic people often describe it as a different way of experiencing the world around them, and because society has not been designed around autistic people this causes challenges such as: social communication and social interaction, repetitive and restrictive behaviour, over- or under-sensitivity to light, sound, taste or touch, extreme anxiety, 'meltdowns' or "shutdowns".

There are 891 'working age adults' with a learning disability in receipt of long-term support from Derby City Council (19% of total estimated population). This included a broad range of services including home and residential care, supported living and day services. A significant majority of adults with a learning disability (around 80%) live with their families or on their own. 80% of autistic people experience mental health issues during their lifetime. The most common two health conditions present at the same time are anxiety and depression. Furthermore, autistic people are around 9 times more likely to experience ideas about suicide than most of the population. The average age of death for men with LD in Derby & Derbyshire was 60, and 62 for women it was around 20 years younger than the general population.

Autism is the most common primary need for children and young people with an Education Health Care Plan (EHCP) (37%). However, this does not capture all autistic children who may require support, evidence suggests that autism is under recognised and diagnosed in girls. Finally, only 22% of autistic adults are in any form of paid employment, compare that to a 6.3% rate of unemployment in Derby. Only 2.8% of adults with a learning disability are in receipt of long-term support compare that to a national rate of 5.1%.

The officer provided an overview on the types of health services available for autistic people and people with learning disabilities which are common across Derby and Derbyshire which included:

- Community support such as specialist Community Nursing, Occupational and Speech and Language Therapy
- Mental Health Services Scrutiny has just received an update about these types of services at this meeting.
- Intensive support team which is a specialist learning disability team co-ordinates and delivers care to prevent and address crisis.
- Forensic service which provides specialist support for people who are or have been part of the criminal justice system.
- A range of inpatient services including a learning disability assessment & treatment unit at Ash Green hospital, local mental health inpatient services and the use of out of area hospitals.
- Short Breaks - NHS provided respite services in the North of the County.
- Neurodiverse diagnostic services the two main providers being Derbyshire Healthcare Foundation Trust for autism, and Sheffield Adult Autism & Neurodevelopmental Services for autism & ADHD.
- Strategic health facilitation team which provides guidance and support to GPs in providing for example reasonable adjustments to ensure people with a learning disability can attend their Annual Health Check and other primary care

appointments.

- LD and ASD programme team which ensures that Derby & Derbyshire delivers requirements set out by NHSE/I, including co-ordinating and supporting the delivery of Care & Treatment Reviews.
- Psychology and Psychiatry including community psychiatric nursing & clinical psychiatry and psychology to support community and inpatient care.

The officer then described Adult Social Care (ASC) Social & Community Services available in Derby:

- Residential & Nursing Care services either commissioned by Derby City Council or available to self-funders. There are currently 138 people whose primary support reason is a learning disability who are open to Derby City Council Adult Social Care.
- Supported Living, which offers the opportunity for people to have their own tenancy, often living alongside others, with care and support provided by a commissioned provider.
- Shared Lives where people are 'matched' with an approved carer to share their family and community life as well as provided care and support.
- Day Services where staff and volunteers provide activities for children, young people, adults and families, for example Manor Care Farm
- Therapeutic and Wellbeing such as Inspirative Arts, which offers psychotherapy and wellbeing sessions through drama, art, music, or movement therapy.
- Learning and Education not just through 'specialist' education settings but also through universal services such as Derby Adult Learning Service.
- Advocacy which helps people to express their views and wishes alongside standing up for their rights.
- Parent and Carer Support - support in both providing their caring role and ensuring their health and wellbeing. Parent Carers Together is Derby City's Parent Carer Forum and, alongside their support role, contributes to our work to improve services through transformation.
- information, advice, and guidance on a range of topics from universal credit to where to access care and support. This is provided by organisations such as Citizen's Advice Mid Mercia and complements directories such as 'Community Directory Derbyshire' and the 'Local Offer'.

The officer described the service plans going forward and explained that in March last year all Integrated Care Systems were asked to develop a Learning Disability & Autism Road Map. The Road Map outlined how Joined Up Care Derbyshire was going to deliver the commitments of the Long-Term Plan alongside any local LD & ASC transformation priorities. Stakeholders were given the opportunity to contribute to the Road Map. This included the ambition statement *to reconfigure how care and support is delivered for people with LD/ASD and their families. JUCD aims to move away from reactive and intensive interventions to preventative and flexible support provided in local communities*. The approval of the Road Map unlocked' NHSE/I investment into JUCD funding will be distributed across the Integrated Care System to deliver the Road Map's programme plan.

The officer highlighted what the service wanted to be different by 2025:

- Fewer people with LD &/or ASC who are inpatients by investing in community-based alternatives to inpatient care.
- More people with LD to have their Annual Health Check by increasing the number of people with a learning disability registered with their local GP and ensuring the quality of 'Health Action Plans'.

- No one to have an inappropriate Do not attempt resuscitation (DNAR) order in place when they pass away
- Fewer people with LD to pass away with a recorded cause of death of ‘epilepsy’ or ‘constipation’
- Increase in the percentage of people with LD &/or ASC who are in paid employment including in the public sector
- A decrease in the number of autistic people who complete or incomplete suicide by working alongside autistic people and their families and health, social and community care professionals to understand, recognise and prevent suicide ideation.
- Communities & service are more neurodiverse friendly by increasing awareness and understanding across all sections of society
- Decrease the waiting times for new diverse assessments.

The achievements to date include creating a specialist autism team in the NHS, initial concepts approved for a new child and young person key worker role, commissioning a new voluntary community & social enterprise sector lead organisation, increased the number of people who have received their annual health check.

Future Priorities included further improvements to the neurodiverse diagnostic pathway, development of new care and support accommodation, improving accessibility and quality of mental health services.

A councillor stated that one in five people presenting with Learning Disability were in receipt of help and support. But there was no indication what percentage or number presenting with autism are in receipt of help and support from the local authority, he asked if the officer could comment on that. The officer explained that one of the issues faced with prevalence of autism, was that autism was not recorded as well as it could be whether that be in employment or who was receiving health and social care support so commenting on the number of people who are autistic receiving support was more difficult than it was for people with LD that’s why it was not presented as an infographic in the presentation.

The Councillor then asked if the officer could comment on those people who have got autism are they receiving appropriate services was there help available to them which was tailored to meeting their needs or was that still evolving or not quite there yet. The officer explained that support was really varied, there are lots of autistic people who live their whole lives without access to any services at all, there are lots of autistic people who get good support, and others who raise challenging questions about the appropriateness of the support they get and whether people recognise their autism as being the primary cause of the concerns they have. So, it was a mixed bag, primarily the service was trying to improve by the way it was working with voluntary and community sector, putting in investment into that area throughout COVID 19 has demonstrated how agile and flexible the voluntary sector can be in supporting people. It was a mixed picture but one we hope to improve over the next few years.

Another Councillor reflected on the fact that girls tend to be under diagnosed, anecdotally a lot of autistic traits tend to be attributed to masculine behaviour traits and asked if the officer could elaborate. She also asked if the officer could explain more about the Move to community care, what it means and what was the service aiming for. Finally, she stated that the number of different services and help and support networks was overwhelming, and asked if there was a single point of contact and if there was not, would one be useful.

The officer explained the diagnostic test was primarily developed through testing on boys and men which has created a legacy, the other issue was masking/chameleon like behaviours, where autistic girls especially may copy the behaviour of other people, to fit in, or life choices, sometimes girls mask their traits, so they go unrecognised. There will be a lot of work going to be done on the new diverse diagnostic process particularly in schools where children spend a lot of time interacting with others. It was hoped to invest in the process to ensure there was recognition of the all the signs symptoms and characteristics of autism earlier on. One locality in the midlands was doing a piece of work focusing on girls in schools and how the mental health and autism support available for them can be improved. The diagnostic picture was complicated across the country, and it seemed like a regional and national solution was needed.

In terms of the move to Community Based Care it was recognised that the best place for people to receive long term care and support and MH support was in the community with local networks not in mental health settings. There are challenges to deliver this, the main one was workforce. There was a level of specialist care needed to ensure people can remain in the community instead of being in a hospital. Work and investment were needed on that front for the LD population. People do not want loads of support they want some support when they need it. That solution could be best delivered most flexibly through in the local by the voluntary sector in the community. In the new VCSE work the service want to explore the idea of no discharge, so services are open to people for as long as they want even if they attend only once a year. However, that challenges the service as an ICS to hand over more responsibility to the voluntary sector.

Regarding different organisation and a Single Point of Access and knowing where people want to go. There are services that provide advice, information, and guidance to people, there was a need to make sure those services are publicised on the Crisis Helpline as you commented earlier. There was a need to improve the referral links and pathways between diagnostic services and those types of services, so when a diagnosis was received people are not handed off to information, advice and guidance but supported to access the service. It was planned to focus over the next 6 months on mapping out all the VCSE services available to ensure no gaps and everyone was aware of what was being provided.

A councillor commented that part of the difficulty was the way the new services are implemented, for example the government are under pressure from stakeholders (parents/carers) on issues such as autism, so they will make it a mandatory service for local authority to provide. However, an assessment is not undertaken to establish how many people with needs in relation to autism there would be in the country and what new finance should be put into the service to make it workable. The Government make it a statutory duty for health authorities to assess and provide but do not allocate any additional finance, through the years many services have been introduced in that way, possibly the Board should consider recommending that the issue needs to be given more thought and any new needs identified and made a statutory duty should have accompanying finance.

The councillor proposed that the Board recommend that when new services are identified then the government should more accurately estimate the additional cost to the providers such as local authorities or health partners and before the government makes it a statutory duty on health or local authorities, they should make that financial assessment and they should provide an accompanying financial package alongside the new statutory duties.

The Board unanimously agreed the recommendation.

Councillor asked about people who have missed being diagnosed as being autistic in childhood and have masked successfully, how long was the timeframe between the initial appointment and being diagnosed. The officer confirmed the waiting time for autism diagnosis for adults diagnosed with autism in adults was three years. Patients do have another option to access a different service through "right to choose", however there has been a significant rise in demand for this service it now had a waiting time of one year. There was no ready solution available, there will be a focused piece of work addressing this element on the pathway, a lot of Integrated Care Systems across the country are each doing something different, and the answer was not readily obvious, but part of the solution was to work with clinicians and autistic people as key partners to understand a good diagnostic process for them. There was a need to address adult waiting times for autism diagnosis.

The Vice Chair thanked the officer for all this report and returned the chairing of the meeting back to the Chair.

The Board resolved:

1. **to note the report and**

2. **recommended that when new services are identified then the government should more accurately estimate the additional cost to the providers such as local authorities or health partners and before the government makes it a statutory duty on health or local authorities, they should make that financial assessment and they should provide an accompanying financial package alongside the new statutory duties.**

The Chair thanked all officers again for their reports.

48/21 Work Programme and Topic Review

The Board received a report of the Strategic Director of Corporate Resources on the Work Programme and Topic Review.

The meeting on the 19th April 2022 will be focused on Dentistry.

The Chair provided an update on the Topic Review, there were still a few interviews outstanding, draft recommendations and a possibly a report would be provided for the April meeting.

The Board were reminded of the upcoming visit to the Derby West Indian Community Association (DWICA) on 31st March 2022

The Board resolved to note the report and presentation.

49/21 Item for Information – Older People Mental Health Services Consultation Update

The Board received a report from the Engagement Manager NHS Derby and Derbyshire Clinical Commissioning Group. The report provided an update on the Older People mental Health Services Consultation. The report was for information.

The Board resolved to note the report

MINUTES END