Shropshire Council

Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 4 February 2015

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Thursday, 12 February 2015**
Time: **2.00 pm**
Venue: **Wilfred Owen Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Joint Health Overview and Scrutiny Committee

Gerald Dakin (Co-Chair)
Derek White (Co-Chair)
Tracey Huffer
Simon Jones
Veronica Fletcher
John Minor
David Beechey (Co-Optee)
Ian Hulme (Co-Optee)
Mandy Thorn (Co-Optee)
Martin Witnall (Co-Optee)
Dilys Davis (Co-Optee)

Your Committee Officer is:

Amanda Holyoak Scrutiny Committee Officer
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AGENDA

1 **Apologies for Absence**

2 **Disclosable Pecuniary Interests**

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 **Minutes** (Pages 1 - 8)

The minutes of the meeting held on 29 September 2014 are attached for confirmation.

4 **Future Fit** (Pages 9 - 16)

An update on the progress of the Future Fit Programme will be provided by the Senior Responsible Officers.

The Committee will then consider the responses to the questions submitted to NHS and Local Authority Representatives regarding the Programme (attached)

Papers which support answers to some questions will follow when they become available after a Future Fit Programme Board meeting on 4 February 2015.

TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on at 4.00pm in Training Room 5/6, AFC Telford Learning Centre, Haybridge Road, Wellington, Telford TF1 2TU

PRESENT – Councillor D White (TWC Health Scrutiny Chair) (Chairman), Councillor G Dakin (SC Health Scrutiny Chair), Ms D Davis (TWC Health Scrutiny Co-optee), Cllr S Jones (SC), Mr R Shaw (TWC Health Scrutiny Co-optee) and (from 4.20pm) Mrs M Thorn (SC Health Scrutiny Co-optee).

Also Present –

Fran Beck (Executive Lead Commission T&W CCG)
James Briscoe (Consultant Psychiatrist, Shropshire & South Staffordshire Healthcare Foundation Trust)
Wendy Brook
Paul Cooper (Commissioning and Service Redesign Lead - Mental Health and Learning Disabilities – Shropshire CCG)
Dr Julie Davies (Director of Strategy and Service Redesign – Shropshire CCG)
Yvette Jones – Social Worker (SSSFT)
Gary Joy- Senior Mental Health Nurse (SSSFT)
Emma Thompson-Carse – Social Worker (SSSFT)
Zena Young (T&W CCG)
Andrew Hughes - Project Director (SSSFT)
Lesley Crawford (Director of Mental health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust)
Paul Taylor (Interim Director: Health, Care & Wellbeing, TWC)
Cllr A R H England (Cabinet Member: Adult Social Care, TWC)
Cllr L Chapman (Portfolio Holder: Adult Services, SC)
Mrs F Bottrill (Scrutiny Group Specialist, TWC)
Miss D Moseley (Democratic Services Support Officer, TWC)
Ms A Holyoak (Committee Officer, SC)
Steph Wain (Commissioning Specialist, SC)

JHOSC-6 MINUTES

RESOLVED – that the minutes of meeting of the Joint Health Overview and Scrutiny Committee held on 19 June 2014 be confirmed and signed by the Chairman.

JHOSC-7 APOLOGIES FOR ABSENCE

Mr D Beechey (SC Health Scrutiny Co-optee), Cllr T Huffer (SC), Cllr J Minor (TWC) and Mr M Withnall (TWC Health Scrutiny Co-optee)

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JHOSC-8 DECLARATIONS OF INTEREST

None

JHOSC-9 REVIEW OF THE MODERNISATION OF MENTAL HEALTH SERVICES IN SHROPSHIRE AND TELFORD &WREKIN

Following the introduction of representatives from the South Staffordshire and Shropshire Healthcare Trust, Telford and Wrekin Clinical Commissioning Group and Shropshire Clinical Commissioning Group, the Commissioning and Service Redesign Lead introduced the report on the findings of the review of the Business Case for the modernisation of Mental Health Services in Shropshire and Telford and Wrekin which was approved in 2011. He gave some background to service provision in the area, stating that there had been an ambition to provide a new patient facility to replace the old Victorian asylum, known as Shelton Hospital, since 1956. The project was completed ahead of schedule, with the new hospital being only one element of a wider strategic approach to modernising mental health services, which also included a new model of care and review of community services, including dementia services and crisis prevention.

James Briscoe, Consultant Psychiatrist at Redwoods, set out the achievements of the review:-

- Success of Commissioning Provision with more people supported in their own home. This had been achieved through the provision of additional dedicated staff in the Community Mental Health Team and a different model of care including an increased level of community activity.
- Length of stay had appropriately reduced within the revised commissioning model.
- Piloting a 7 day service for people who suffer from Dementia, which had resulted in reduced admissions due to the support and care received in the community.
- Adoption of Purposeful Inpatient Admission Process (PIPA) demonstrated a further reduction in length of stay.
- The design of facilities at The Redwoods Centre provided a building fit for purpose.

Mr Briscoe continued by explaining identified challenges and next steps following the review which focussed upon:-

- A need to understand and improve options around increased Psychiatric Intensive Care Use (PICU) in Telford and Wrekin.
- Looking to explain the difference between community services in Shropshire and Telford & Wrekin, which was related to data on occupied beds.
- Consult on the future use of Castle Lodge.
- Further examine how to reduce length of stay and occupancy levels.

Gary Joy, Senior Mental Health Nurse, explained his experience of the service and significant changes which had taken place over the last three

years, noting a reduction in staff and changing model of care away from the recovery model. He noted that there had been in a rise in referrals and it was important to focus on patient needs, rather than what they want which presented a challenge to changing culture and expectations. This theme was expanded by Emma Thompson-Carse, Social Worker,who identified that a significant number of patients had been service users for 10-15 years and this required delicate management of expectations, whereas with new patients, it was easier to implement the recovery model with in-patient care being a last resort. Ms Thompson-Carse also commented upon the pilot of 7 day dementia service provision, noting that carers had reacted positively to this responsive service from experienced staff.

The long journey towards modernisation and the more focussed approach required was noted by Yvette Jones, Social Worker, and the different issues identified by both CCG Boards was noted: for Telford and Wrekin, benchmarking data was sought especially regarding caseloads and readmission rates with a rise in dependency noted, whereas Shropshire identified issues regarding quality measures and the family and friends test, exploring the difference between the community teams and recruitment difficulties.

The Chairman noted that some improvement in service could be identified, for instance around dementia care, but registered concern that there were still some major problems and he sought views from the Cabinet Members, particularly around consultation engagement. Paul Taylor (Interim Director: Health, Care & Wellbeing, TWC) supported the underpinning direction of travel for the service but believed that the reports flagged up issues to improve joint working arrangements and he felt communication between the parties was a key issue. He identified potential issues regarding out of area care which would affect Approved Mental Health Professionals in terms of recovery and support for dementia care outside hospital placing an increased cost responsibility on Councils particularly in light of increasing placement costs. Cllr A R H England (Cabinet Member: Adult Social Care, TWC) picked up the communication issue, noting the perception that there was a lack of involvement at service user level, which was brought home by the closure of Castle Lodge which carers, who bore the brunt of work in the community, saw as a respite facility. He also felt that a joint approach would be most beneficial expressing a wish for the NHS to work more closely with the Local Authorities in developing their reasoning behind changes and addressing issues. Cllr L Chapman (Portfolio Holder: Adult Services, SC) echoed the views of Cllr England, also citing a lack of adequate engagement but noted encouraging signs of new ways of working, particularly in Shropshire where there was evidence of more joined up working with the voluntary sector.

Continuing the theme of communication and lack of engagement, the Chairman noted that volunteers and community groups were not represented at the meeting and that methods of engagement needed to be identified so that their concerns and needs could be acknowledged and their role could be better recognised. He felt that service users were more confident in speaking to non-experts in this regard.

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A Member also identified issues regarding engagement highlighting the exclusion of the provider sector from consultation events and concern regarding lack of support in care homes in terms of circumstances where acute needs were identified which fed into concerns regarding commissioning for beds. Concerns regarding continued reliance upon out-of-county placements were raised together with support for carers. It was noted that GPs were still not picking up on signs of stress in carers and that carer breakdown too often resulted in patient admission.

Opportunities for the redesignation of beds at The Redwoods Centre, which would support a pilot for mental health rehabilitation involving a third sector partner were noted and further information sought. Members were advised that the pilot would be county-wide and would look to identify which carers were at risk by March 2015 and create a register of carers to receive home support. The aim was early intervention and would involve joint working with private carers and the voluntary sector. Results would be known in Summer 2015.

Discussion took place regarding the variation in levels of occupied bed days and use of the PICU in Stafford between the two local commissioners. With regard to increased PICU use in Telford and Wrekin, NHS representatives indicated that this was a pattern not previously seen and some work was required to analyse and understand the upward trend. The Chairman and Cabinet Member: Adult Social Care, TWC both commented upon social deprivation and social demography of the new town, noting the stresses of living conditions in smaller units and the likelihood that extended families would live in close proximity. A Member also expressed concern regarding out-of-area placements, noting the stress on patients, carers and families, and with regard to bed use questioned whether Castle Lodge could be brought into use primarily for older people with dementia and whether it was still the case that Shropshire utilised under-used placements commissioned for Telford and Wrekin. NHS Representatives agreed that the disparity in PICU use was somewhat concerning but more work was required to understand the reasons for this. A collective approach between providers and commissioners would be required. Fran Beck (Executive Lead Commission T&W CCG) concurred that more engagement on this issue was required and offered assurance that CCGs would be looking to rapidly drive these issues forward to solution.

The Chairman expressed concerns regarding support for dual-diagnosis patients and the need for a qualified expert in the autism spectrum. The Consultant Psychiatrist, Shropshire & South Staffordshire Healthcare Foundation Trust explained the clinical difficulties in providing support for dual-diagnosis patients, noting the vicious circle around being unable to provide mental health counselling for an intoxicated person who also needed to work with substance misuse teams. The Interim Director: Health, Care & Wellbeing (TWC) indicated that this issue had been recognised by the Local Authorities and Drug and Alcohol Service and that discussions had taken place regarding a more joined up approach. The Executive Lead

Commissioner T&W CCG also noted the difficulties providing solutions in complex situations but felt that too much significance was placed on diagnosis on the spectrum when the real issue was the solutions that could be provided.

A Member offered to share the points he had noted when discussing mental health care with both staff and service users which he felt would add context in terms of the report presented.
From staff:-

- Lack of whistle-blowing culture, staff were afraid to speak up
- High level of absenteeism due to stress and low morale
- No time to do a proper job with support being handed to the voluntary sector
- Patients placed out of county due to a lack of beds
- Discharge occurring too eagerly
- Care at the Redwoods facility was exceptional

From service users:-

- Lack of staff continuity
- No in-county secure beds
- Nowhere for potentially violent dementia patients. A particular incident with an Alzheimer's patient was cited where the GP had failed to spot the potential for violence and the resulting fear caused to the patient's partner.
- Inadequate children's services

In response, NHS Representatives offered their perspective on staff issues raised. Ms Thompson-Carse, Social Worker, noted that the team in which she worked was close-knit with a low absence rate and just a couple of staff with long-term sickness issues, staff had a level of autonomy and were respected as practitioners with regular meetings taking place and care provision followed through until it was inappropriate to do so (for instance, in the case of over-dependency); training was always supported and an open relationship with managers existed. Similarly it was noted that any staff issues raised were always voiced and acted upon. The Director of Mental health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust stated that monthly absence modelling took place and concerns were identified; individuals were encouraged to raise issues without fear of reprisal. Assurance was offered on the role of the commissioners addressing incidences of training and sickness, review by external bodies (eg peer review and CQC assessment) and the occurrence of regular serious incident meetings which allowed lessons learnt to be translated into practice. The Cabinet Member: Adult Social Care, TWC commented upon the perception he had of an open, honest and caring Trust.

The Chairman considered that it was imperative that a dialogue take place between all the parties, with the Local Authority as a key partner, and with community groups supporting users as they had knowledge on the ground.

The Chairman sought reassurance that the Service would be NICE compliant and, due to the various NICE guidelines in existence the Scrutiny Officer agreed to send further details to the Commissioners.

Debate turned to consultation on the future of Castle Lodge. The Director of Mental Health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust advised that a report was due in October which would set out consultation details and the Cabinet Member: Adult Social Care (TWC) urged that events should take place in the locality.

The Chairman asked how Mental Health Services worked with SaTH regarding treatment options. The Director of Mental Health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust advised that there was a good working relationship with liaison at A&E and significant investment in the Rapid Access Interface and Discharge (RAID) scheme had placed more staff within the Accident and Emergency setting and who were also available to help patients in an acute setting. The report did not include evaluation of the RAID Service. The Commissioning and Service Redesign Lead - Mental Health and Learning Disabilities – Shropshire CCG explained that the RAID initiative offered support to patients with co-morbidities, noting that 2/3 of patients admitted to hospital were over 65 and 2/3 of that number suffered from undetected dementia. Commissioning of the RAID service aimed to meet two main service standards: that every referral in A&E be seen within one hour and all other referrals seen within 24 hours – a target which had been met. The degree of collaboration, treatment and assessment or prevention was pleasing. A Member shared an experience with the Committee wherein a gentleman had been admitted to hospital in otherwise good mental health but the pain medication administered had resulted in dementia-like symptoms and a number of detrimental assumptions about his care, the gentleman was having to undergo significant rehabilitation to regain his former good health. NHS Representatives asked the Member to encourage the patient or his carer to make a formal report so that a clinical review could take place. Another case was raised where a GP had failed to recognise a mental health issue resulting in patient death. The Executive Lead Commissioner (T&W CCG) said that it was an important part of the process to study how the Trust could learn about such cases earlier and provide a proper conduit for information.

The Project Director (SSSFT) recognised that there were a wide range of issues identified by the Committee, but he explained that these were outside of the scope of the review that had been undertaken which focussed on the performance of the inpatient service at the Redwood Centre.

In the circumstances, the Chairman agreed to receive comments from two members of the public attending the meeting who raised issues regarding the poor response to mental health among the homeless, changing model of commissioning, the failures of the friends and family test, the best way to consult with service users to assess perception of services and how to support carers and maintain support.

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The Committee was advised that a separate report on partner engagement was available which could be circulated.

Turning to the aspect of the report dealing with the Next Steps, the Co-Chairman (SC) indicated his concern regarding those project objectives which remained unconfirmed or not achieved. The Chairman stated he had difficulties agreeing with the conclusions of the report and felt it was important to continue to work together with community groups to improve the service.

The Cabinet Member: Adult Social Care, TWC noted future action points included support to the key aims of Future Fit and co-location and it was advised that the inference was that RAID services co-located with the A&E Department wherever that may be.

A Member sought clarification of the ward designations at The Redwoods Centre and The Director of Mental Health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust advised that Oak was a dementia ward for younger and older people and Holly was a functional ward. The ward designations were working well and each patient had their own bedroom and en-suite.

To conclude the debate, the Chairman indicated that he believed the mood of the meeting was that although there had been a long journey to this point and tremendous strides forward had been taken, the conclusions of the report could not be endorsed. NHS Representatives indicated that the conclusions were based on the Full Business Case and felt that the issues raised in the meeting were much wider than that remit.

In response to questioning, The Executive Lead Commissioner (T&W CCG) indicated that the future action identified in Table 9 would be undertaken by small teams, but broader representation and wider steering groups would agree the work.

The Chairman proposed that a formal response from the Co-Chairmen be sent to the appropriate organisations based on the Committee's discussions and identifying areas of concern for further work and reporting to be undertaken. He also felt that it was important for the Committee to talk to service users and appropriate community groups. The proposal was seconded and unanimously agreed.

RESOLVED – that the Co-Chairmen write to appropriate organisations to set out the Committee's concerns and identify areas which require further reporting and that the Committee engage with service users and appropriate community groups to invite them to share their experiences of Mental Health Services.

The Chairman thanked everyone for attending and concluded the meeting at 5.44pm.

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Chairman……………..………………………

Date……….…………………………………

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QUESTIONS FROM JOINT HOSC REGARDING FUTURE FIT

ACUTE SECTOR AND WMAS

Question from Joint HOSC	Name of person who will provide answer	Please indicate below if question will be provided via: • A written response (needed by 2nd Feb) • Verbal response at meeting • Be answered at a future date – (please state when if known)
1. How are organisations working together to address the challenged services at the acute Trust e.g. A&E and ensure they are safe until changes are made.	Caron Morton David Evans	verbal
2. How will you work together to resolve the wider capacity issues and reduce the number of patients fit for discharge at SaTH? How will you work together to identify the extent of this problem and the underlying issues?	Caron Morton David Evans	verbal
3. If there is a problem to address and ICS is not the answer, does the Acute Trust have any other suggestions? What are the other pressure points in freeing up beds?	Caron Morton David Evans Peter Herring	verbal

4. How will SaTH's financial position affect the viability of the Future Fit Programme?	Peter Herring	verbal
5. How many Urgent Care Centres / Local planned care facilities/ Community units /Health hubs and Diagnostic and Treatment Centres will there be as part of the Future Fit programme and where will they be located?	Mike Sharon	Shortlisting paper (after Board on 4th Feb)
6. How affordable is the Future Fit Programme? How is the programme taking into account utilising existing buildings, facilities and equipment and including the costs of the maintenance backlog at RSH? (We understand that only co-location with paediatrics is a must.)	Mike Sharon	Verbal *N.B. The assumptions in the Feasibility Study align with College of Emergency Medicine Guidance about the 'seven key specialties': Critical Care, Acute Medicine, Imaging, Laboratories, Paediatrics, Orthopaedics & General Surgery.*
7. What is the outcome of the CQC inspection? Does this affect the Future Fit programme?	Peter Herring	Inspection Report now published on CQC website. Overall rating is 'requires improvement' with 'good' for caring services. See http://www.sath.nhs.uk/cqc/
8. What is the clinical view on the co-location of A&E with Women's and Children's Services?	Mike Innes Bill Gowans	An 'Acute services template' completed by SaTH clinicians was provided to the Evaluation Panel and can be provided after Board on 4th Feb. It summarises the clinical quality and safety advantages and disadvantages of collocating consultant-led obstetrics/neonatal care with EC. Other obstetric services are not considered, and paediatric inpatient services are an essential colocation with EC (see 6 above).
9. How will you work together to reach a realistic consensus on the number of beds needed in the acute sector? How does this	Mike Sharon Mike Innes Bill Gowans	Verbal

affect the affordability of the Future Fit programme and what are the long term consequences for the sustainability of services?		
10. How are you ensuring that the current services are delivered with care, compassion, competence, communication, courage and commitment while planning and delivering the Future Fit Programme?	Peter Herring	verbal
11. How are transfers between hospitals being managed? What are the performance measures for the current contract and how is the provider performing?	Caron Morton	verbal
12. What arrangements have been put in place to build on the success of the GP service at the A&E at PRH?	Caron Morton	verbal
13. How well is the Welsh Ambulance Service engaging in the Future Fit Programme and working to resolve the cross border pressures on the WMAS?	Mike Sharon	Verbal
14. How well has Future Fit communicated the current provision of services at PRH and RSH? e.g. that patients with some acute illnesses / injuries are currently treated out of county?	Adrian Osborne	verbal

PRIMARY AND COMMUNITY CARE

15. How are you working together to develop the capacity and model of care in Primary and Community Services (Future Fit 2)?	Caron Morton	Board paper (after 4th Feb)

How will you ensure that this work takes place alongside the current Future Fit Programme? What is the timetable for Future Fit 2 and do you have the capacity to deliver on this in time? What is the risk that resources will be directed towards increasing capacity at SaTH at the expense of primary and community services?		
16. What are the local plans for 7 day working in primary care? How can this be used to encourage integration of primary and community health services and are doctors and the GP Federation engaged?	Mike Innes Bill Gowans Ian Winstanley	verbal
17. How many Urgent Care Centres / Local planned care facilities/ Community units /Health hubs and Diagnostic and Treatment Centres will there be as part of the Future Fit programme and where will they be located?	*See 5 above*	
18. How will GPs be supported to work together / federate? How will this be managed particularly in rural areas? What is the role of the Community Health Trust to support this?	Caron Morton Jan Ditheridge	verbal
19. How will you ensure that GPs are fully engaged in Future Fit? It is recognised that there are several channels to do this through the CCG, GP Federation and Shrop DoC. How will this work be co-ordinated to	Mike Sharon	Board paper (after 4th Feb) as for 15 above.

recognise the role of GPs as commissioners and providers? How will you enable GPs to develop a clear vision for how their sector relates to the wider NHS and care services?		
20. Is there an enhanced role of the GP Federation to work with GPs to develop new services and business models? How robust is the current model of primary care and how is the shortage of GPs being addressed?	Caron Morton	verbal
21. How will you ensure that the Future Fit Programme and the Better Care Fund work is co-ordinated?	David Evans	verbal
22. What is the future of the Community Health Trust?	Jan Ditheridge	verbal
23. How are you ensuring that the current services are delivered with compassion, competence, communication, courage and commitment while managing change?	Jan Ditheridge	Verbal
24. What are the financial implications of the installation and running costs of diagnostic equipment in primary and community care locations?	Mike Sharon	Verbal
25. What is meant by the term 'prevention' - is this preventing people getting ill or preventing ill people going to hospital or both?	Mike Innes Bill Gowans	verbal

HEALTH AND SOCIAL CARE SYSTEM

26. How will the health economy deal with the underlying deficit? How will you deliver financial sustainability for the next 3-4 years?	David Evans	verbal
27. How can the different health and social care systems and regulators be aligned to deliver the Future Fit Programme?	David Evans Stephen Chandler Paul Taylor	verbal
28. How far is integration between health and social are a joint programme? What capacity is there within the local authorities to jointly lead this work?	Stephen Chandler Paul Taylor	verbal
29. How can you jointly manage and share the risk of the perverse incentives that the payment by result system creates?	David Evans Stephen Chandler Paul Taylor	verbal
30. How well are Welsh commissioners and providers of health and social care engaging in the Future Fit Programme? If the Welsh commissioning arrangements change so Welsh patients are treated at Welsh hospitals what are the implications for the Future Fit programme?	Caron Morton	verbal
31. How will the change to co-commissioning affect the decisions about the Future Fit programme?	David Evans Caron Morton	verbal

PUBLIC EXPECTATIONS

32. How are patient and political expectations being managed?	David Evans Caron Morton	Verbal
33. How can people be helped to understand	Mike Innes	Verbal

that when seeking primary care you do not always have to see a GP often primary care clinician would be sufficient?	Bill Gowans	
34. How can patients be supported to understand that they do not always need continuity of care from the same GP?	Mike Innes Bill Gowans	Verbal
35. How can patients be supported to manage their own health more effectively? *ie Smoking and obesity – are these measureable and being tracked?*	Mike Innes Bill Gowans Rod Thomson Liz Noakes?	Verbal

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