SHOPSHIRE COUNCIL

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting held on 16 July 2018
10.00 am - 12.10 pm in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

Responsible Officer: Amanda Holyoak
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Present
Councillors Karen Calder (Chair), Madge Shineton (Vice-Chair), Roy Aldcroft, Simon Harris, Tracey Huffer, Heather Kidd, Paul Milner and Pamela Moseley

6 Apologies for Absence and Substitutions

Apologies were received from Councillors Gerald Dakin and Simon Jones.

7 Disclosure of Pecuniary Interests

8 Minutes

The minutes of the meetings held on 26 March 2018, 14 May 2018 and 17 May 2018 were all confirmed as a correct record.

The Chairman referred to the minutes of the 17 May 2018 and the concern raised by the Healthwatch representative in relation to Stroke Rehabilitation and waiting time and said these points would be further explored with a view to potentially adding them to the work programme.

9 Public Question Time

There were no public questions.

10 Member Question Time

There were no questions from Members.

11 Midwifery Led Units

Members had received a copy of a paper which had been presented to the Shrewsbury and Telford Hospital Trust (SaTH) Executive Board and provided an update on the position of Midwife Led Units (copy attached to signed minutes).

The Chairman welcomed the Head of Midwifery, SaTH to the meeting and thanked her for attending. She explained the reasons for the proposal to extend the temporary suspensions in rural Midwife Led Units. A six week period of engagement was underway and focused on addressing the immediate operational pressures on the service. It was not part of the work being undertaken by the CCGs to develop a new long-term

sustainable model of care which would be subject to formal public consultation in due course.

View of local communities were being sought through a questionnaire, targeted conversations and discussion groups for women and families currently using maternity services and representative groups. This was designed to help understand the impact of extending the temporary suspensions in the rural midwife led units and how this might be mitigated to best meet the needs of women using the services at this time. The result of the engagement would be presented to the Trust Board on 27 September 2018.

During discussion, members asked the following questions of the Head of Midwifery:

What was being done to publicise the engagement?

The engagement activity was being advertised in all Midwife Led Units, via CCGs and details had been forwarded to every GP practice in the county. Heads of midwifery in bordering counties and all key stakeholders had been contacted including Healthwatch, MPs, NHS England and NHS Improvement. The Head of Midwifery reported that she personally had forwarded the information to the lead campaigners in Ludlow, Oswestry and Bridgnorth and was trying to work with them as much as possible. Press releases and internet had also been used.

In response to a member who said that women were unaware of the engagement she said she was very surprised and very frustrated as every available forum had been utilised. However, posters could be resent to all stakeholders.

Was the reason women were opting to give birth at the Consultant Led Unit a result of inconsistency of service at Midwife Led Units?

The Head of Midwifery said she understood this comment but explained that this was not representative of figures before temporary closures had been implemented. Less than 3% of births had been in midwife led units before any suspensions had been made. In the past, ad hoc closures had not been made until a crisis point was reached and women not informed of them until the point they went into labour. Staff had also been moved in the middle of the night, and this was not safe. Since her appointment in September 2016, the Head of Midwifery had felt that there was a duty to let women know of a closure beforehand so that they could make alternative arrangements, especially in relation to transport.

What banding were the four midwives recruited to cover ongoing maternity leave, was this number enough and would they be kept on once maternity leave came to an end?

The Head of Midwifery confirmed that the four midwives were Band 6 and would be kept on permanently, on the bais that there would always be approximately 10 fte postholders on maternity leave.

What was the current recruitment situation – were there any unfilled vacancies?

The Head of Midwifery explained that a number of Band 5s were recruited every year into the preceptorship programme to maintain the workforce. Newly qualified midwives

received support and rotation throughout all areas and were practitioners in their own right but were not left on their own at night or to staff midwife led units alone. There were currently no vacancies over and above one internal Band 7 post which had just been filled.

Could the Consultant Led Unit cope if the Midwife Led Units were to close?

The number of births in the Midwife Led Units was very small and the Consultant Led Unit could cope with these. Some women who were able to have a Midwife Led birth had been moved to the Wrekin Midwife Led Unit at Princess Royal Hospital. Impacts of the recent suspension for six months had been reviewed and could be addressed.

How many women were expecting babies over this period of time? Could they be approached directly rather than relying on a wider engagement exercise; and were community midwives providing them with the engagement document?

It was estimated that there would be 7 – 10 women due to give birth at each unit over the continued suspension period. These women had not been approached directly but Community Midwives would be informing them about the engagement and directing them to the document or arranging a printed copy for them if necessary.

What was being done to tackle sickness levels and had there been a particular problem in Oswestry which appeared to have higher sickness levels?

Staff morale had increased due to a consistent plan being in place and no more last minute moves in location. Unfortunately the Maternity System consultation had been delayed by the Future Fit consultation and the long term future of Maternity systems rested in that consultation. The new model involved a move towards not giving births in midwife led units but towards delivering continuity of care from hubs. Currently £50 – £60,000 was spent a month on overtime and excess hours. It was acknowledged that Oswestry had been shut more than Ludlow and Bridnorth as staff were moved around to cover units where the most number of women were booked.

Was work planned across the Welsh border and did it take into account the hub at Welshpool?

The Head of Midwifery explained that lack of flexibility in the system meant that Shropshire patients were not currently able to use the Welshpool Hubs. However the CCG system work would look at this and there was a clear plan to dissolve borders and bring in border partners. Heads of Midwifery in other services were part of the conversation. Members highlighted the need for ambulance issues to be addressed as good ambulance cover would be necessary if something were to go wrong. Flexibility of staff across a border would also be essential. The Head of Midwifery confirmed that the Ambulance Service was involved in discussions and were involved in both the current engagement and wider system review.

The Chair observed that this item had only featured on the agenda for this meeting at the request of Members and asked how the work had been raised or discussed with the Joint Health Overview Scrutiny Committee. She observed that the Engagement Plan within the Maternity Services Update on the MLU position which had recently been received by the Trust Board (paper 13) indicated that this would be done.

The Head of Midwifery said she would look into this.

The Portfolio Holder for Health reported that he chaired the Health and Wellbeing Board Communications Group which was able to provide advice on communicating messages. He said this was a shared resource and offered the help of the Group and asked for a copy of the engagement document to be re-sent. The Head of Midwifery said this was a useful offer which she would discuss with communication leads. An external engagement company had been utilised to help with the work so far.

The Committee expressed its appreciation to the Head of Midwifery for her time in attending the meeting and answering questions.

12 Phlebotomy Services

Members had received a copy of a letter from the Chief Executive of Shrewsbury and Telford Hospital Trust written in response to a letter from the Chair regarding changes in location of phlebotomy services in Shrewsbury Town Centre. Helen Harvey, Pathology Centre Manager, Shrewsbury and Telford Hospital Trust was thanked for attending the meeting. She explained
that the phlebotomy service at Princess House in Shrewsbury Town Centre had originally been provided by SaTH at the request of two town centre GP Practices. There had been no charge for use of the accommodation initially but there had been a significant charge made for the last year's use. At the same time, an opportunity to acquire a clinic room in Elizabeth House at Royal Shrewsbury Hospital for the phlebotomy service had been identified, and this had led to the relocation. During May – July patients using the service were being asked to give views on their experiences, preferred location and reasons for this. It was now hoped to find a permanent location for the service in an alternative town centre location.

The Chair observed that there appeared to be a significant demand for a town centre location. The Pathology Centre Manager reported that alternative venues had been considered, in the Darwin Centre and Pride Hill Centre. User Groups had commented that the Pride Hill Centre proposal was not suitable as it was downstairs and dark. The Darwin Centre might be subject to reconfiguration plans which could lead to a request to vacate at short notice. Another venue had been identified in the last week and patient representatives were to be asked about the suitability of this site.

The Chair thanked the Pathology Manager for this positive news and asked her to keep the Committee appraised of any developments.

13 Mental Health Needs Assessment

Members received the findings of the Mental Health Needs Assessment (copy attached to signed minutes) and went on to discuss how these could be progressed in the design and commissioning of services.

The following participants from the Mental Health Strategy Task & Finish Group were welcomed to the meeting:

- Gordon Kochane (Consultant in Public Health)
- Collen Manhuwa (Commission and Redesign Lead, Shropshire CCG)
- Tanya Miles (Head of Adult Social Care)
- Claire Parrish (Midlands Partnership Foundation Trust)
- Deborah Curtis (Adult Mental Health Social Worker)
- Fiona Williams (Social Care Efficiency and Innovation)
- Marilyn Jones (Carer representative)

The purpose of the Mental Health Needs Assessment was to identify the changing trends and patterns in the distribution of mental ill health across Shropshire. The Needs Assessment had a specific focus on adult mental health as there had previously been data assessed to commission services recently relating to Children and Young People. In addition, as existing Strategies were in place for Alzheimer's and Dementia and Carers, these topics were excluded within the assessment but it was recommended that they be included within a Shropshire Mental Health Strategy. This document was produced under sponsorship of the Mental Health Partnership Board using national data from Public Health England Health Profiles, the ONS Adult Psychiatric Morbidity Survey and data from the Mental Health Trust alongside service user and provider qualitative feedback.

A Mental Health Strategy Group had recently formed and had agreed to hold a workshop with as wide a range of stakeholders as possible to consider what the strategy should look like.
[Note Addendum: this workshop has now been delayed and will be rescheduled for the new year with a different focus - this will allow for a draft version of a Shropshire Mental Health Strategy to be produced and for the new event (date to be confirmed) to be a combination of both consultation and consideration for specific actions from delegate feedback. Date/location to be shared once agreed.]

The Committee considered and discussed the information presented and first asked questions related to accuracy of data and whether it reflected need, particularly in cases where a service had once been available but was not any more. A member gave the example of a substance misuse service in Ludlow which was no longer available and asked if the interpretation of that might be that there was need.

The Consultant in Public Health explained that the data presented provided a good starting point to initiate discussions on what was happening on the ground. It would be essential to obtain qualitative information from the local community in addition to statistical data. One of the difficulties of substance misuse was that it was often hidden and the true figure was therefore hard to identify. The Carer Representative reported on a joint piece of work underway on diagnosis and an attempt to try and find a better way of working together along with substance misuse partner agencies. Analysis of data had so far raised more questions than those that had been answered but had provided a fair and equitable base to move forward from.

Mr Manhuwa, the Commissioning and Redesign Lead, Shropshire CCG, responded to questions about how quantitative information was weighed against qualitative data. The CCG collected mental health data from people who were presenting to the NHS but was aware that there were many others who did not present. In addition, some data sets were nationally designed but might not fit well locally, and data could be poor, dated or

inaccurate. Listening to what was said locally was just as important, and a judgement was needed when it came to quantitative and qualitative information. Public health analysis was designed to fit local need.

Members went on to ask about trends in relation to isolation, loneliness, bereavement and deprivation. Mr Manhuwa reported on the CCG's reliance on services, voluntary services and charities to provide feedback. The Adult Psychiatric Morbidity Survey did recognise that mental health was strongly associated with deprivation, both in cause and effect. There was a desire to engage with people who worked in the community both on a formal and informal basis.

Members went on to discuss the role of housing associations and the police in targeting the supply of drugs The Director of Public Health reported on national and local working to disrupt the supply of drugs and pointed out that a dual diagnosis was often the case, with people self medicating using alcohol or drugs to deal with mental health symptoms.

Discussion then covered patients living in sparsely populated parts of the county who had difficulties accessing services and might not be identified as needing help, for example in cases of postnatal depression. This could also be complicated further where Shropshire patients were registered with a Welsh GP. Mr Manhuwa explained that data was collected when a parent CCG was recharged for services provided. He suggested that a subset of the Task and Finish Group could be formed to look at issues around cross border working.

Mr Kochane explained that Shropshire was currently providing child mental health workshops in 60 schools and support services across Shropshire. He hoped that these sort of issues would be identified during the workshops.

Members asked how the Strategy would be developed with budget pressures in mind. Mr Manhuwa explained that the government had released a small amount of mental health funding nationally which would help in development of the strategy. Key work programmes had been set including early access to psychological therapies and increased access to children and young people's mental health services.

A Member reported on a meeting held in the last week by the CCG Board on the gaps in 0 – 25 mental health provision. Mr Manhuwa referred to the performance notice issued by Shropshire CCG in relation to this provision. It had been hoped that a new provider would solve issues facing the Children and Young People mental health service but there remained significant issues to address. NHS England had conducted a deep dive and a list of recommendations had been identified to help integrate pathways. Measures had also been taken to speed up access in urgent cases.

It was confirmed that the Five Year View on mental health would be shared with the Health and Wellbeing Board and the roles of different organisations would be discussed there.

The Portfolio Holder for Health and Adult Social Care referred to the need to make more connections across work for children and young people, families and adults including clustering support for vulnerable families. He wished to explore opportunities to address these in a more holistic way. The Head of Adult Social Care referred to opportunities

afforded by inviting partners to a Mental Health Strategy workshop and referred to the benefits of having one provider for adults and children's services.

It was confirmed that the Strategy was still in pre-discussion phase. There would be much opportunity to shape it and it was intended that it would not be a separate topic or outlier but link into every single service. There would, however, be a need to retain accountability somewhere and maintain links to existing programmes, eg social prescribing and healthy lives and look for potential for joint commissioning.

Members agreed that recognition was needed of the breadth and depth of what contributed to mental health wellbeing, and parity of esteem of mental health and social care with physical health. The Chair referred to work undertaken by the Communities Overview Committee on social prescribing.

Mr Kochane confirmed that details of the Strategy workshop would be provided to all members. He also referred to a suicide prevention event on 11th November 2018, details of which would also be circulated.

The Chair thanked all visitors for their time in attending the meeting and the Committee looked forward to being kept informed of progress.

14 Quality Accounts

Members discussed the Quality Accounts presented by each of the NHS provider trusts and noted the differing depth and quality of the accounts. It was agreed that presentation of the accounts to Committee members and Healthwatch representatives at the same time had been a positive development and that it was worth exploring inclusion of Telford and Wrekin Health and Adult Social Care Scrutiny Committee next year. It was also hoped to arrange dates of the presentations with more notice if possible, and to have no more than two presentations in one session.

15 Work Programme

Members considered potential items for the Committee's Work Programme and agreed the following:

That Public Health budget and service provision feature on the 24 September 2018 agenda – to include scrutiny of future funding proposals, understand current commissioning for falls reductions and other muscular-skeletal traumas and examine how local authorities use telehealth care.

That Winter Planning feature on the 24 September 2018 agenda – to scrutinise proposals to mitigate the effect of winter pressures on NHS services.

That a Task and finish Group be established on Reducing Admissions through Warmer Homes with a remit to: understand how warmer homes reduce hospital admissions and demand for social care support; scrutinise the effectiveness of Keep Shropshire Warm; Scrutinise the role of registered social landlords in keeping homes warm; understand how

warmer homes reduce delayed transfers of care; explore the links between work to reduce falls and warmer homes. Terms of Reference to be presented at a future meeting.

The Chair reported on background work regarding blood transfusion service collection points and said the Committee would be kept informed of any progress.

Signed .... (Chairman)

Date: ....