JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview & Scrutiny Committee held on Tuesday, 24 November 2020 at 10.00 am in Remote Meeting

Present: Councillors S J Reynolds and D R W White (Co-Chair) K Calder (Chair), H Kidd and M Shineton

Co-optees: H Knight, J O'Loughlin, D Beechey and I Hulme

Also Present: Councillors A Burford (Cabinet Member for Health and Social Care,Telford and Wrekin Council), P Mullock (Chair of People Overview Committee, Shropshire Council) and E Potter (Portfolio Holder for Children's Services, Shropshire Council)

In Attendance: David Evans (Chief Officer, CCG), Zara Bowden (Shropshire Parent and Carer Council), Danial Webb (Overview and Scrutiny Officer, Shropshire Council), Josef Galkowski (Democratic Services and Scrutiny Officer, Telford and Wrekin Council) and Amanda Holyoak, (Committee Officer, Shropshire Council)

Apologies:

There were no apologies for absence

JHOSC5 Declarations of Interest

None

JHOSC6 Minutes of the Previous Meeting

The Chair reported that the minutes of the meetings held on 22 October 2021 and 19 November 2021 would be presented for approval at the next meeting.

JHOSC7 Children Mental Health Services

The Chair welcomed David Evans, Chief Officer Shropshire and Telford and Wrekin CCGs to the meeting.

Mr Evans provided the background to the transformation around the CAMHS Service three years previously and the reasons for it. The service was now predominantly delivered by MPFT and covered an age range of 0 – 25 which allowed for a good transition from children's services into adult services. The aim was to provide as good a quality service as possible that intervened early when mental health started to cause concern to prevent the risk of escalation.

Members and participants in the meeting made a number of observations and asked questions to which Mr Evans responded:

What happens to a young person if they are referred into the service at around the age of 18?

An 18 year old would normally be referred directly into adult mental health services. The idea of the BeeU 0 – 25 service was to facilitate a gentle transition from one team to another for those who were already receiving support.

Would tier 4 count as the 'getting more help' step or 'intensive help'?

Tier 4 represented intensive help – this was very specialist support commissioned by NHS England, not the CCG, there were no tier 4 beds locally.

There are currently children in hospital at the moment with mental health conditions – would two be the normal number? Do children arriving at A&E because of a mental health issue usually known to the service already?

It is unusual to have two children in hospital at the same time. Children with mental health conditions sometimes present at A&E if they reach a crisis point.

Who can refer into the system and who would progress the child onto the next step if additional support is needed?

A GP, social worker, or someone in education would normally make an initial referral. The level of support required would be determined by the BeeU service which would also determine when that level of support needed to change.

Can parents/carers refer into service?

The normal referral route was through a school or GP, but if the child was already in the service and there was parental concern about deterioration then the service could be contacted directly.

Getting help is a time limited service – was there a possibility that a young person could be returned back to the very start of a referral process once they were in it?

That would only occur if a child was discharged from the service completely, but a child was likely to be seen directly if parent/carers concerned about deterioration.

The Chair invited Zara Bowden from Shropshire Parent and Carer Council to speak. She raised a number of issues around the referral system, and the quality of the information considered at triage. Parents had described GP referrals being sent back with a request that the referral be instead made by a school. However, in order for a school to make a referral, the child needed to

be demonstrating the behaviours in the school setting and these were not always in a structured setting.

She also reported that BeeU determined the pathway on the basis of referral information that a parent had not always seen, and that a child was often discharged without the parent having the opportunity to speak to any practitioner at all. This meant that the family's whole picture was not taken into account. Children's needs, especially those related to neurodevelopment were not being met with the right support at the right time. Families were being told they could not access the neurodevelopmental system to get the support needed until they had a diagnosis but the assessment was not effective.

She referred to the CCG's Dynamic Support Register used to manage the system tier 4 and felt this could be used to commission more effective support pathways earlier on to prevent escalation.

In response, Mr Evans confirmed that the team had been working on the referral process and that he would take these comments back to them. The assessment at triage should happen appropriately and clear information provided to parents if it was decided that ongoing support was not the right course of action. He endeavoured to meet with Zara in a few weeks to ascertain whether an effective change had happened.

A Member referred to a case she was aware of where linkages were broken and referral paths became very difficult at the age of 16 when a Looked After Child progressed from school to further training. Mr Evans said this highlighted the need for a 0 – 25 service and that support for a child through such a transition period should have been maintained. Without knowing the circumstances of the particular case he could not explain why if the young person was already in the service and getting support from BEEU that this had not continued.

What evidence and information was used to support commissioning of services at lower tiers?

Mr Evans explained the process for commissioning any service but explained that the direction of CCG commissioning was changing, to focus more on outcomes for individuals. This would involve a move away from transactional commissioning with the risk of over specification and towards an alliance of providers to determine how best to deliver the outcomes needed based on the sum of money available.

When designing a service based on outcomes – is the CCG co-producing with parent carers such as PACC and PODS. Will this be from the very outcome rather than designing a service and then asking for comments?

Mr Evans referred to a recent meeting with PACC and PODS where an absolute commitment was given to co-design.

The Co-Chair referred to the large amount of direct feedback he had received related to difficulties of obtaining referrals into the service, and very long waits, even just for a telephone call. He was pleased to hear about commissioning by outcome but asked if the CCG would direct any more money into mental health services.

Mr Evans said the BeeU Service had been given a challenge to construct and deliver a new modern service. He acknowledged the current issues with commissioning and delivery and said there was a joint responsibility to get this right. He said that the difficulties of families and young people in being referred to the service would be looked at urgently.

Money was always going to be a challenge within an overall financial envelope and it would be essential to get the best service possible to achieve the right level of service at the right time. There was a commitment to spend more on mental health services and additional government money to meet the mental health standard would be used for this. However, to go further, money would have to come from elsewhere and it had not been clearly identified from where.

Why is it only now that the CCG is talking to PACC and PODS? Can you convene a meeting or open forum for those involved to share their experiences and so they can be informed of what is being planned? Early intervention in mental health will save significant amounts of money later. Are there people who can diagnose available?

Mr Evans said the CCG was very clear about the need for a service that intervened in the right way as quickly as possible to ensure children could live fulfilling lives and get the best start. The CCG could not do this in isolation and needed to work with local authority partners, education, parents and families to co-design and co-produce the right services for children. He confirmed that meetings with POD and PACC had already taken place and that he would be happy to convene another meeting including families and providers.

Zara Bowden commented that the current system did not have flexibility built into it. It needed to allow for multiple pathways to be met simultaneously to ensure needs could be met at the right time, referrals were usually made for one reason but there may be a catalogue of needs. Children required their needs to be met whilst waiting for diagnosis. The providers were not equipped to do that or commissioned adequately to do this.

She emphasised the necessity of working together with parents. Although parents had felt they had a voice during a previous commissioning process, they did not feel that it had been heard. She reiterated that co-production should be from the beginning and asked that the CCG set expectations for the provider to allow this.

Mr Evans said the service was not delivering a responsive service for children and young people and families and clarity around desired outcomes was needed. Co-production had to involve those who lived the experience as well

as providers. The overall aim and aspirations of the NHS was for preventative, self-care management with interventions at the right point to deliver the desired outcomes. It might be that more than one provider would be needed to deliver this. He also emphasised the need to be clear that the CCG wished to meet need but might not always be able to meet wants.

In response to a question about who would manage a number of providers, it would likely be through one lead provider who would hold the others to account.

Mr Evans was asked if the local authority had been fully cited and involved in developing the CAMHS Service Improvement plan and he said he check on this and report back.

A question was asked about the crisis support and home treatments in place for young people with eating disorders

Support could be sought through the normal out of hours service and BeeU were about to start a 24 hour crisis service for all young people. He believed there was support for children and parents at home but as he had not got specifics to hand agreed to report back on this outside of the meeting.

The report stated that ASD diagnosis had not been clearly commissioned – what had been the impact of that. There was no information on waiting lists available previously. The report said the expected 18 week wait would not be achieved for 18 – 24 months – what would that mean for children approaching the age of 18?

Mr Evans agreed to supply information on the waiting list outside of the meeting. It was a service requiring specialised practitioners so there was a capacity problem. He accepted that children and young people were waiting longer than we would want them to.

How is priority given to making these diagnoses?

This was made on presenting clinical need.

How are you updated as a CCG on progress?

A quarterly report was made to the CCG Board.

Zara Bowden said that no clinicians were currently involved in determination as to whether a referral would be added to the waiting list or not and parents were not involved in this decision which was made on only the advice received on the referral document.

The Chair observed that if there was an expert clinical approach from start, this would be likely to reduce turmoil for a child. Mr Evans said he was surprised to hear that there was not more clinical involvement at triage and that he would look into this.

Members discussed how as a scrutiny committee it could take this piece of work forward and obtain assurance that what the CCG was saying would happen. Mr Evans suggested that the CCG report back to the Committee after a period of 6 months.

The Chair thanked David Evans and Zara Bowden for their time in attending the meeting and Mr Evans for answering questions. The Committee would be moving on to look at transition at a future meeting.

JHOSC8 Accident and Emergency

David Evans provided an update on A&E activity as requested by the Committee. The trend overall for Shropshire and Telford and Wrekin patients was below that of 2019 activity - at PRH 25% lower and at RSH about 5% lower. During October 2020 120 patients had been admitted from A&E at PRH, in October 2019 this had been 160. At RSH 130 patients had been admitted from A&E in October 2019 but this had increased to 145 in October 2020. Arrivals at PRH by ambulance had decreased by about 10 – 15% and walk ins were much lower. At RSH ambulance attendance has increased slightly since June but walk in attendances were slightly lower.

Responding to questions on the reasons for the differences between the two sites, he said this was partly due to age profile of the population and partly related to complexity of case mix as emergency surgery was carried out at RSH. There had been increasing activity levels over the last 10 days and it was expected that this increase would continue with covid and winter pressures combined.

SATH and Shropshire Community Health Trust both currently had as many patients with Covid as they had back in April. There were however less patients in ITU although more on oxygen therapy overall.

A member drew attention to a recent long delay for an ambulance to arrive the south of the county. Mr Evans reported that the ambulance service was under a lot of pressure, particularly when large numbers of ambulances arrived at A&E at one time and there were long waits to offload patients.

Members asked if measures taken to address covid, such as social distancing and wearing of masks might help to alleviate normal winter pressures. It was hoped that this might be the case but patients did seem to be sicker and putting more strain on services, particularly at RSH.

The Committee thanked Mr Evans for the update and said they would welcome another update in approximately six months time.

JHOSC9 Co-Chair's Update

The Committee agreed that more work on children's mental health would be undertaken next year particularly to follow up on progress in addressing the issues raised at the meeting, and also around transition.

A Member felt that there were questions around covid which needed to be asked and she was encouraged to circulate her thoughts to all members for informal discussion in the first instance.

The meeting ended at 12.00 pm

Chairman: ----------

Date: Thursday, 15 April 2021