JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview & Scrutiny Committee held on Thursday, 19 November 2020 at 12.30 pm in

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

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

Also Present: Councillors Andy B, Cabinet Member for Health & Social Care (Telford & Wrekin Council), A McClements, Chair Children & Young People Scrutiny Committee (Telford & Wrekin Council) and P Mullock, Chair of Shropshire Children's Scrutiny Committee (Shropshire Council)

In Attendance: Z Bowden, Chair of Shropshire Parent & Carer Council and West Midlands Regional Representative for Parent Carer Forums across England, K Bradshaw, Director of Children Services (Shropshire Council), J Dean, Service Manager Special Educational Needs and Disabilities (Shropshire Council), J Galkowski, Democratic Services and Scrutiny Officer (Telford & Wrekin Council), H Jones BeeU Quality and Governance Lead Emotional Health services (MPFT), Dr A Maclachlan, Consultant Clinical Psychologist and Clinical & Care Director, Shropshire and Telford & Wrekin Care Group (MPFT), Cllr K Middleton, Health & Wellbeing Specialist representing 3rd sector professional group, C Parrish, Service Manager BeeU Service & Urgent Care Adult Pathway,Shropshire and Telford & Wrekin (MPFT), E Pearce, Project Manager, Pods Parent/Carer Forum,Telford & Wrekin , C Riley, Managing Director Shropshire and Telford & Wrekin Care Group (MPFT), J Stevens, Strategic Coordinator, Pods Parent/Carer Forum, S Thomas, Participation Coordinator for Shropshire Parent Carer Council (PAC), Dr S Waheed, Consultant Child & Adult Psychiatrist and Medical Lead for BeeU Service (MPFT), D Webb, Overview & Scrutiny Officer (Shropshire Council), Stacey Worthington, Senior Democratic and Scrutiny Services Officer (Telford & Wrekin Council)

Apologies:

None

JHOSC1 Declarations of Interest

None

JHOSC2 Minutes of the Previous Meeting

To follow

JHOSC3 Children Mental Health Services

The Managing Director, Midlands Partnership Foundation Trust presented a report to the Committee on the BeeU service commissioned in 2017. A partnership between CAMHS and Partners. The service provided an Emotional Health and Wellbeing service for children and young people up to 25 years of age. The Committee heard that new referrals were taken up to the age of 18 and supported up to the age of 25 though service users could transfer to adult services earlier if they wished to do so. The report noted the I-Thrive Model & Partners, a stepped framework which started with self-support, moving to advice guidance and consultation then onto getting help and getting more help. The report also covered Poly-Pharmacy. Services had been reviewed in line with NICE guidance, with the creation of a standard operating procedure for repeat prescribing and the setup of a weekly physical health clinic. A case study was presented which highlighted the changes made in prescribing medication, offering behavioural therapies and also the psycho-educational groups for parents.

Members asked a number of questions and received responses as follows:

What services has CAMHS provided, what was the evidence for the service and what was the profile of its need?

Low level support was provided by way of a text service, specialist CAMHS access point, clinical triage, signposting for all age access to adult practitioners and CAMHS specialist professionals and online CBT (Cognitive Behavioural Therapy). A core part of the workforce for BeeU service was predominantly medical and nursing led to meet prescription demands. This had been changed over the last few years. Speech & language therapists, occupational therapists, psychological practitioners, CBT therapists and specialist trauma therapists had been employed as part of the workforce and had been linked into improvements. A wider range of therapies were offered including a number of pathways such as learning disabilities and ASD (Autism Spectrum Disorder) diagnostic pathway. These changes were commissioned by the CCG (Clinical Commissioning Groups) and added to the funding to develop the ASD pathway. The ADHD (Attention Deficit Hyperactivity Disorder) pathway previously had long waiting lists, at the time of the meeting only 29 people were waiting to be seen, a reduction from 100. Children had been seen and started on a pathway. The Committee heard that there had been difficulties nationally.

They had created two separate teams who looked at those who had waited over 12 months and also new referrals. A waiting list initiative was completed in the recommended 6 week time frame. A link with local authority and schools was introduced in Telford so that any schools that had any concerns around child mental health/developmental went to a school panel MDT (Multi-Disciplinary Team). Additionally, mental health support teams were going into schools to help early identification of those that needed help. The same

format was planned for Shropshire. Members noted that what may work in Telford may not always be appropriate for such a different area as Shropshire.

What communication was there between schools, GPs, parents and other agencies?

Where any child is seen, the information is documented and communicated by letter back to the GP. Every letter is copied back to the GP.

Could further detail of the current staff level, skills shortages and recruitment concerns be provided?

There have been a huge array of disciplines to recruit from. However, members decided that being limited on the meeting time constraints, written questions could be posed as there would be a workshop in the future where these could be addressed.

Was there uniformity in the commissioning and services provided across Shropshire and Telford and Wrekin?
There was the same service specification from the two CCGs and the Local Authority contributed to the income received but not the detail or split. It was confirmed that there was uniformity and that it had improved with the new tender.
How near were they to meeting the structure the British Psychological Society has set? How many trained mental health practitioners in post were from diverse backgrounds and were they focused on schools of high deprivation or was it a blanket service?
When the bid was placed there was specific criteria about what schools were targeted. The service worked with the Local Authority and looked at schools that had the highest level of deprivation, highest referrals into early years programmes and also the highest exclusions. At the time of the meeting there was a group going through training to qualify in December. It was a 12 month training programme. There were band five and six practitioners spread equally across Telford & Wrekin and Shropshire. In terms of diversity, there was a diverse background of various ethnic groups that work across Telford and Wrekin and Shropshire.

What factors were considered when looking at rurality and accessing Pharmacies during COVID restrictions?

The CAMHS service had defined resources. More video consultation was used which allowed the service to reach different people in different communities. This was not fit for all and in those situations they connected through telephone and face to face interactions. Working with system population health needs the service was waiting for more information to understand how resources linked to particular PCN areas. They had worked closely with PCNs and developed plans for the 18-25 age group. As the service progressed, it was hoped that there would be further working with other PCNs.

How would the service work with rural primary schools that can be quite isolated? PCNs don't quite fit the format here though school development groups could be worked with rather than just the individuals.

The Anna Freud link project were working with schools across the county, led by the local authority and schools. Mental Health teams are also working in schools across rural areas. Further information on the school development groups would be gratefully received to see how that could be taken forward.

How did the service utilise strategic pathways to support teams and the community effectively? How confident were staff that strategic opportunities with shaping the footprint in the county ensured services were properly supported?

The ASD service was not clearly commissioned from when they received initial funding and it had taken up to the meeting to be funded. It was acknowledged that this resolution came too late for many service users. However, the next development would be the parent support group 'Rollercoaster'. Parent link programmes and service users would be involved in developing feedback for transition. Feedback surveys were reviewed but it was acknowledged that there was still some way to go to involve people more and earlier on in the process.

What was the demand for the service?

The Committee were informed that the CCG would be able to provide more in depth demographic information to answer this question and it was noted that this would be looked at, at the next meeting.

How did the service engage with the groups appropriately?

Engagement with the parents was the next planned move. The CCG was working around commissioning of post diagnostic referral provision, but this was with other providers and not the BeeU service.

How did the level of funding of CCG for Shropshire and Telford & Wrekin apply to the CAMHS service? How did it compare to other areas that had commissioned services from BeeU?

IST reported benchmarking around the workforce showed to be lower than other areas when compared to CAMHS and it was noted that this service goes up to age of 25.

What was the typical wait time for assessment?

There was no waiting list for the main BeeU service. However the waiting list for newer developmental pathways was inherited and was considerable. Though it had greatly reduced (at the time of the meeting to just 20). The ADHD clinic had helped work through those on the list to get help they needed

and it was hoped those remaining would shortly be cleared. ASD still had a large waiting list which was being worked through with the funding to get to an 18 week wait plan. This would meet NICE guidance target of 3 months. It was hoped that the funding could be applied to new referrals again to meet NICE guidance.

It was requested that the criteria for referral was provided to help understand if it was still fit for purpose in the current climate. The request was recognised but it was noted that the upcoming workshop covered this.This meeting was perhaps not the most appropriate format. The workshop with users involvement could look at the needs of the service/users.

What are wait times for ASD?

For ADHD there were 29 waiting to be seen. For ASD there were 120 waiting for assessment, but since the funding had been finalised, this would be addressed.

Where were the gaps in staffing?

Recruitment of substantive CAMHS consultants had been a struggle since very few came off the development line. There were two locum doctors within the BeeU service. Speech and language/diagnostic areas were also difficult to recruit to due to being so specialised, especially in rural areas.

How were the crisis provisions locally coping?

The crisis service was available 9am to 5pm. During COVID-19 there was national requirement to create an urgent telephone line for crisis response. This had been created for adult services but had also been requested for children and young people. From the end of January this was being implemented following funding for a 24 hours a day 7 days a week service. It was deemed likely this service would see higher demand from young people due to a lack of tier 4 beds. There were only a small number of providers and these were mostly private providers. Previously when that happened, children could be stuck waiting for a tier 4 bed with only BeeU service support. For older children assessments, if it was a serious incident they could be admitted to adult Mental Health wards. Where this was deemed unsafe a health based place of safety was converted to a ward to hold those people and care for them. There was no alternative for teenagers to health based places of safety. Winter funding would add to the service. This was viewed to be a serious issue for the service.

Were these not known to the service previously?

There were a mixture of new and previously known users. It was noted that those with eating disorder referrals did not come early enough to the service though the service was able to respond well to the referrals.

With the identified shortages and areas of gaps what was being done?

There was a paper on behalf of the group taken to CCG to demonstrate the lack of tier 4 beds. The CCG still had a responsibility under Mental Health act to ensure alternative bed provision. Due to the specialist needs and specialist workforce required this was not an easy problem to address. Although tier 4 beds have been paid for, they have not been getting allocated.

If we've been exporting children to areas with lack of support and help they're already making difficult adjustments why can't we have a local solution?

Tier 4 beds are not commissioned by the CCG but by a specialised commission. The CCG try to influence that but they still have a responsibility to provide alternative arrangements to those in need where they can't get hold of them.

Who is in charge of the specialised commissioning?

NHS EI in charge of specialised commissioning.

JHOSC4 Co-Chair's Update

Time did not allow taking the agenda any further. The remaining items were suspended.

It was noted that the attendees from MPFT would hopefully return participate at the next meeting to continue from where the agenda was halted.

The meeting ended at 2.00 pm

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

Date: Tuesday, 24 November 2020