HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Overview and Scrutiny Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford on Friday 17 February 2012 at 10.00 am

Present: **Councillor A Seldon (Chairman)**
Councillor JW Millar (Vice Chairman)

Councillors: AM Atkinson, PL Bettington, MJK Cooper, PGH Cutter, EPJ Harvey, RC Hunt, TM James, Brig P Jones CBE, JLV Kenyon, R Preece, SJ Robertson and P Rone

In attendance: **Councillor PM Morgan, Cabinet Member (Health & Wellbeing)**

Officers: C Chapman (Assistant Director Law, Governance & Resilience), Y Clowsley (Head of Programmes, Integrated Commissioning Directorate), JJones (Head of Governance) and DJ Penrose (Democratic Services)

62. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor PJ Watts.

63. NAMED SUBSTITUTES (IF ANY)

There were no named substitutes.

64. DECLARATIONS OF INTEREST

There were no declarations of interest.

65. MINUTES

The Minutes of the Meetings on the 16th and 18th January 2012 were approved.

66. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

There were no suggestions from the public.

67. QUESTIONS FROM THE PUBLIC

There were no questions from the public.

68. MENTAL HEALTH SERVICES FOR HEREFORDSHIRE - 2GETHER NHS TRUST (Pages 1 - 8)

The Committee received a presentation from the Shaun Clee, Chief Executive, 2gether NHS Trust, on the work of the Trust over the previous year. The presentation is appended to the Minutes at Appendix 1.

In his presentation, Mr Clee highlighted the following areas:

- That the number of agency staff being used was being reduced in order to improve the patient experience, as many often didn't know the staff who were looking after them.
- That the number of beds within the service had been reduced from 29 to 16, allowing for a greater focus on care within the community.

- That reductions had also been made in readmissions and waiting times.

- That added value had been provided thorough psychiatric liaison. For those over 65, a quarter of patients did not go home after admission to the acute hospital in an unplanned way. Of the 80% of those in this age range, 40% were suffering from undiagnosed dementia. A bid had been made to the NHS West Mercia PCT Cluster for acute and community liaison services in order to try and ensure that patients were not admitted in this manner

- That joint working between providers and commissioners within the Quality, Innovation, Productivity and Prevention (QIPP) Delivery Board was proving beneficial.

- That GP's were actively working with 2gether though the GP Parliament, and there was a willing process of engagement.

- That more patients were being seen faster than the number seen in the year to date in 2011.

In the ensuing conversation, the following points were raised:

- That there were signs and symptoms that GP's were aware of which would result in a referral of mental health patients though the Improving Access to Psychological Therapies (IAPT) care pathway. There were referrals to the County's mental health team from twenty four care clusters across twenty one spectrum mental health areas. It had been ensured that GP's were sighted on what the areas were, and all Practices had access to the Clinical Director. There were variations in rates of referral between practices, but it was not possible to quantify why this was as there was no electronic record system. The GP mental health leads were very proactive, and understood that such variations were important and should be considered by their colleagues.

- In reply to a question, Mr Clee said that the spend on Agency nursing staff had been reduced by approximately 5%. It was the intention that no agency nurses would be used at all, and staff would be taken from an in-house bank of nurses.

- In reply to a further question, he said that it was difficult to ensure that mental health patients received the optimal care in the Wye Valley Trust A&E Department, which was why a bid had been made to the PCT Cluster for acute and community liaison services to help provide additional resources.

- That there was a clear link between economic wellbeing and suicide rates, which had increased nationally as unemployment had risen. A 1% rise in unemployment figures could be matched by an increase of 7% in suicide rates. The suicide rate rise across Europe was closer to 25%. There was insufficient data to show a trend in Herefordshire as there had only been one suicide of a patient known to 2gether since 2gether had taken over the service in April 2011.

- That a patient journey through the admissions system would be presented to the next meeting attended by 2gether NHS Trust.

- Mr Clee replied to a further question by saying that the Out of County adult placement liaison was going well, and patients were being brought back into the County where appropriate. This was both helpful to the patients and provided a cost benefit to the County. Panels were in place to look at wrap around care issues for patients.

- In reply to a question, Mr Clee said that one of the weaknesses of the system was the lack of joined up thinking between the agencies working in the field. There was also a lack of supported housing in the County, and work was underway with the social housing providers to address the matter. The strength of the present system lay in monthly meetings with GP's to drive up awareness of the available care pathways.

- A Member suggested that, as part of the change management process when 2gether first took over, it would have been useful to have audited the number of people who had approached the service, but who had not returned for treatment. Mr Clee concurred, and said that the service had been managed as closely as possible, and that there had been no reduction in staff or beds and no diminution in service.

- In reply to a further question, Mr Clee said that there was a national requirement to see patients within 7 days of referral; this was also a contractual obligation placed on 2gether NHS Trust. The evidence base indicated that the first 48 hours were crucial, and whilst it would not be possible to reach that target, the emphasis had been to ensure patients were seen within 5 days. Since October, all patients had been seen within this timescale.

- That 2gether staff had links with Job Centre Plus, and all staff were trained to be mindful of the employment status of patients. As employers, 2gether NHS Trust employed people with mental health issues.

RESOLVED: That Cabinet be recommended that it should investigate how Herefordshire Council might undertake the process of becoming part of the Mindful Employer Initiative, and should prioritise the necessary resources to enable the process to take place, and inform the Committee of its decision.

69. THE MIDLANDS & EAST SPECIALISED COMMISSIONING GROUP (Pages 9 - 14)

The Committee received a presentation from Stephen Washbourne, Director of Operations, Midlands & East Specialised Commissioning Group (MESCG). The presentation is appended to the Minutes at Appendix 2.

During his presentation, Mr Washbourne highlighted the following areas:

- That specialised commissioning groups would be clustered along the same footprint as the Strategic Health Authorities (SHAs). This was part of the transition into a single nationwide function following the publication of the Shared Operating Model for PCTs.

- That specialised services, which were required for rare and complex cases that were high cost, needing specialist interventions with expensive equipment, would be provided in relatively few specialist centres to a population of more than one million people.

- That services would be commissioned by the NHS Commissioning Board (NHSCB) rather than individual Clinical Commissioning Groups. The budget and service portfolio for the Board would be determined nationally. One of the challenges going forward would be to mitigate risk to patients during the transition period.

In the ensuing discussion, the following points were made:

- In reply to a question, Mr Washbourne said that there was no question that Herefordshire would be marginalised within the new structure. Across the West Midlands area there was a budget of £925m, of which Herefordshire had an allocation of £24m. This should be seen in the context of the allocation for Birmingham, which was £90m. The Chair of NHS Herefordshire, the West Midlands NHS West Mercia PCT Cluster and the Midlands & East Specialised Commissioning Group (MESCG) was Joanna Newton. She was always looked to rural issues, and ensured that the populations under the aegis of the Midlands & East Specialised Commissioning Group were treated equitably.

- That one of the main challenges for the new structure was effective communications with elected Members. This had been an issue in the past, and was one of the roles of that would be taken on by the Health & Wellbeing Board.

- Mr Washbourne added that there was a need to ensure the correct access to cardiac, neurosurgery and dialysis, and how patients should be integrated back into the community from acute beds. There was often a focus by commissioners on commissioning numbers, rather than identifying outcomes. NHS Herefordshire was the body accountable for ensuring the delivery of the portfolio of services from the MESCG.

- The Vice Chairman pointed out that the Health and Social Care Bill was still under discussion in Parliament and that it would be appropriate to assume that the changes laid out would take place. It was imperative that the local PCT should still have a voice in the decision making process. It was important that at least 80% of available funds for commission should be provided to the Clinical Commissioning Group, whilst the rest could be handled by the MESCG. There was a quarterly meeting of Overview and Scrutiny Committee Chairmen within the area covered by the Group, and it was important that this should continue to take place. He added that it had been suggested to this committee that a review of Trauma Care should be undertaken in light of the introduction of the trauma care network in the West Midlands.

- In reply to a question as to where power and accountability lay within the new structure, the Cabinet Member (Health & Wellbeing) agreed that there were enormous changes afoot and a lack of clarity as to how this was being managed. It had been proposed that a seminar for Members should be organised to outline what the changes would entail and asked that Members provide her with specific areas of concern.

- A Member expressed concern that appropriate service delivery models for localities were being developed within the area of adult social care. It was not important to own the services, but it was important that users should not have to travel further in the future to access them. The Cabinet Member concurred, and said that where possible specialist outreach services would be provided in the County. It would be possible for people across Herefordshire to access services in a more coherent fashion with linked appointments to specialist clinics.

- The Cabinet Member added that the role of the Health & Wellbeing Board was to hold the system that comprised the PCT Cluster, Wye Valley NHS Trust and the GP Parliament to account. As with all other Health & Wellbeing Boards, the Board was still in the process of working out how this could be effectively done. She suggested that the work of the Board might be an area that Overview & Scrutiny could consider in 18 months' time.

RESOLVED:

That

a) **the Committee expressed concern that there was a lack of clarity as to how specialised services would be delivered under the new centralised commissioning model.**

b) **It be recommended that centralised specialised services should be organised within the Midlands & East Specialised Commissioning Group in a manner that did not disadvantage the residents of Herefordshire.**

The meeting ended at 12.50 pm **CHAIRMAN**

MINUTE ITEM 68
Appendix 1

Mental & Social Healthcare

[2]gether
......................in Herefordshire

Health Overview and Scrutiny Committee

Foundation Trust
For Herefordshire

2gether
Making life better

Foundation Trust
For Herefordshire
NHS

PURPOSE:

- The focus today is to
- Remind colleagues of the scope of services contracted
- Remind the committee of the promises we made and the ways on which success would be measured
- Update colleagues on progress on delivering our promises to Herefordshire's community
- Receive feedback on the services we are providing and our approach to building and sustaining productive partnerships

Scope of Services

- **Adult Working Age Health and Social Care Services**
- **Older People's Health and Social Care Services**
- **Child & Adolescent Mental Health Services**
- **Adult Learning Disabilities Services (transfer 1/4/12)**
- **Substance Misuse Services**

To Herefordshire GP registered population c170,000

NHS contract plus S75 with Herefordshire County Council

Emphasis

- To reduce the service's dependency on Acute Inpatient beds and provide care within or as close to a patient's home as possible
- To ensure services and practitioners operate within appropriate and safe practice
- To reposition existing services as much as possible to meet the increasing demands of an ageing population
- To engage, work with and support the whole system and our service users and their carers
- To maximise patient wellbeing and to maintain their support in their home community for as long as possible
- To facilitate prevention and Early Intervention to prevent carer or family breakdown

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NHS

We planned an increase in:

- Access rates per 100,000
- % of individuals provided with appropriate alternative to admission via crisis and home treatment services
- Year on year patient satisfaction scores
- Service User and Carer, Staff and Whole Systems Partners satisfaction
- Compliance with CPA to 100%
- % of individuals discharged from inpatient care seen within 5 days face to face (not 7 days)

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For Herefordshire
NHS

We also expected to make significant reductions in the following:

- % of unplanned readmissions within 28 days and 90 days
- Waiting time for routine provision
- Year on year sickness levels
- Length of stay for those requiring admission
- Reliance on agency leading to improved productivity and quality consistency
- Reduction in delayed transfers of care
- % of individuals in contact with services who spend time as an inpatient
- Year on year harm from serious untoward incidents
- Beds within the service
- Expenditure on anxiolytics within Primary Care
- GP appointments for individuals with mild to moderate symptoms of depression, anxiety and obsessive compulsive states

We said we would increase:	***We have:***	RAG Rating
% of individuals provided with appropriate alternative to admission via crisis and home treatment services	Increased by 22% the number of individuals treated at home from189 to 231	
Year on year patient satisfaction scores	Quarter 4 survey taking place as part of CQUIN	
Service User and Carer, Staff and Whole Systems Partners satisfaction	Quarter 4 survey taking place as part of CQUIN	
Compliance with Care Programme Approach compliance to 100%	100%	

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For Gloucestershire
NHS

We also expect to see significant reductions in:	We have:	Reduced by 18% from £53,701 to £44,213
% of unplanned readmissions within 28 days	Reduced number readmitted from 56 to 34 Significant change from Sept	
Waiting time for routine provision	Significant improvements across the board	
Year on year sickness levels	Up from 4% to 4.86% Changed calculation	
Length of stay for those requiring admission	See separate table	
Reliance on agency leading to improved productivity and quality consistency	To date we have used 2545 less hours of agency nursing time than last year	
Reduction in delayed transfers of care		
Expenditure on anxiolytics within Primary Care	***We have reducedby 18% from£53,701 to £44,213***	
Beds within the service	***Reduced adult beds from 29 to 18 and will achieve 16 by May 2012***	

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For Gloucestershire NHS

We said we would reduce length of stay:	We have:	*RAG Rating*
Mortimer	Down from 44 days to 28 38% reduction	
Jenny Lind	Down from 50 days to 49 days 2% reduction	
Cantilupe	Up from 62 days to 85 days an increase of 37%	
	Length of stay on Cantilupe is significantly impacted on by 2 delayed discharges	

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For Herefordshire NHS

Progress after 10 months…

Staffing

- Management of change - ward and team manages appointed. Social Care Lead and Lead Nurse for Psychosis also appointed and in post.

Changes to Services

- Crisis Assessment & Home Treatment Team retrained
- CAMHS recruitment & Choice And Partnership Approach implementation
- Memorandum Of Understanding signed with Wye Valley Trust
- Forensic integrated with AOT

Foundation Trust
For Herefordshire NHS

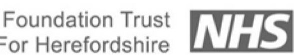
Progress cont.

- **Environment**
- Work schedule to ensure Cantilupe Ward single gender compliance completed
- Investment on Oak House to address high risk environmental issues - Direction of travel agreed with commissioners.
- integration of DASH and CAS into one Substance Misuse service.
- **Governance**
- Case note mapping and tracking
- Care Programme Approach audits to assure compliance
- Memory Service accreditation
- Integrated Mental Health Act Administration, Complaints and serious incident processes
- Policy Harmonisation has been completed
- **Transfer of Estate**
- Dialogue ongoing to establish framework necessary to achieve this successfully

NHS

Added Value

- Psychiatric Liaison
- Psychiatric Intensive Care Unit placements enacted
- Access to Learning Disability Inpatients enabled
- Access to Substance Misuse Inpatients enabledq
- Quality Innovation Productivity and Prevention (QIPP) joint working with Commissioners and partner providers
- GP Parliament
- Implementing the Fair Horizons model of care in years 2 and 3
- Implementation of Electronic Records on track



Primary Care Mental Health Service

- A new service
- To enable primary care to manage stable service users
- Will provide priority re-entry for Service Users to secondary care
- Brief intervention and assessment
- Work closely with Increasing Access Psychological Therapies
- Primarily mild to moderate needs

And Finally

- Number of people receiving Early Intervention Services up by 15% from 66 to 76
- Number of people receiving Assertive Outreach Treatment up by 7% from 68 to 73
- Waiting list for CAMHS down from 58 to 14 whilst YTD seen 526 compared to 512 full year last year. However 100% seen within 18 weeks compared to 52% in 2010/11
- Number of individuals with a review within 12 months up from 75% to 96%

Commissioning Specialised Services

Stephen Washbourne
Director of Operations
Midlands & East Specialised Commissioning Group
(West Midlands office)

Equity & Excellence

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Midlands and East
Specialised Commissioning Group

Midlands & East Specialised Commissioning Group

One of the first visible changes during the transition is the clustering of specialised commissioning groups along the same footprint as SHAs. This is part of the transition into a single nationwide function following the publication of the Shared Operating Model for PCTs (July 11)

There are now four specialised commissioning groups: North, South, Midlands and East, and London.

Midlands and East Specialised Commissioning Group is formed of East Midlands SCG, East of England SCG and West Midlands SCG.

Equity & Excellence

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Specialised Commissioning Group

What are specialised services?

- Specialised Services are typically provided in relatively few specialist centres to a population of more than one million people
- These services are mainly planned for and commissioned across more than one primary care trust's population
- Challenges include: training of specialist staff; supporting research; making best use of staff expertise *and high tech equipment*

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Specialised Commissioning Group

What are specialised services? (continued)

Regionally commissioned services can be broadly grouped into two categories:

Relatively rare / complex - services such as paediatric intensive care, burn care, cleft lip and palate an genetics.

Pathway/ long term conditions - services such as cardiac, mental health, neurosciences, HIV/AIDs and kidney care. The majority of funding and activity in specialised commissioning is in this group of services. These offer the greatest opportunity for CCG influence and involvement.

The Specialised Services National Definition Set can be found at:
www.specialisedservices.nhs.uk/info/specialised-services-national-definitions

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Health & Social Care Bill 2011

The 2011 Health & Social Care Bill will have a significant impact on the way specialised services are commissioned.

Specialised Services are to be a core responsibility of the NHS Commissioning Board (NHSCB) based on four key principles:

1. Rarity
2. Complexity
3. Scarce expertise
4. Financial risk

The Bill sets out plans to transfer specialised commissioning to the NHSCB once it is established, into a nationwide function.

Midlands and East
Specialised Commissioning Group

Changes to Specialised Commissioning

- Specialised services to be commissioned by NHS Commissioning Board (NHSCB) rather than Clinical Commissioning Groups.
- Service portfolio and budget for NHSCB to be determined (using national definition set).
- Budget for specialised commissioning to be retained by NHSCB.
- Greater focus on consistency – single national policies, standards, contracts and QIPP – move towards convergence - mainstreaming patient engagement
- Concern regarding impact of separate commissioning arrangements on provision of integrated care across patient pathways.

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Transition to new arrangements

- National Commissioning Development Transition Team – led by Dame Barbara Hakin – to ensure smooth transition
- National 'Direct Commissioning' work stream overseeing transition of specialised services into NHSCB
- In July 2011, Shared Operating Model for PCTs published - 10 SCGs to be clustered alongside new 4 SHA Clusters
  - North, Midlands & East, South of England and London
- Ultimately, 1 national specialised commissioning function under NHSCB

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Specialised Commissioning Transition

- 10 SCGs and the NSCT moving towards single national function
- National work streams established to oversee process of convergence, including patient and public engagement, quality and outcomes, and projects looking at Commissioning Integrated Care and the role of networks and Clinical Senates
- By April 2012, all SCGs to commission a common set of services to include neurosciences, burns, cystic fibrosis, mental health, renal transplantation and dialysis

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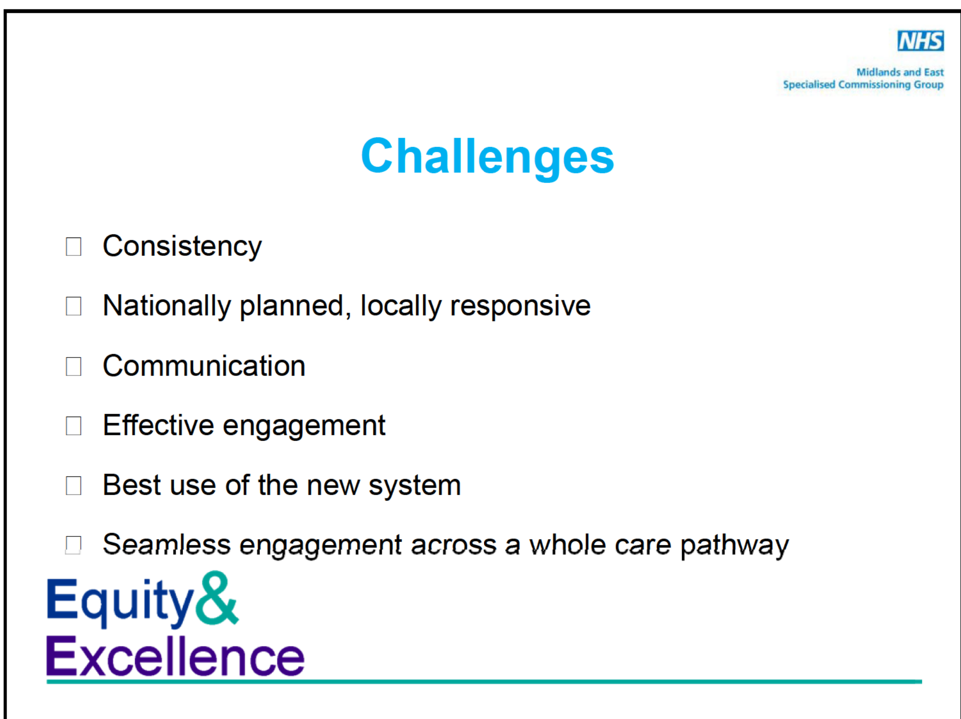
NHS
Midlands and East
Specialised Commissioning Group
Challenges
Consistency
Nationally planned, locally responsive
Communication
Effective engagement
Best use of the new system
Seamless engagement across a whole care pathway
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NHS
Midlands and East
Specialised Commissioning Group
Opportunities for Commissioning
Greater Consistency and Equity
Focus on QIPP
Improved Patient Experience
Strengthened Clinical Leadership
Reducing Variability
Outcomes Driven
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