# Minutes of the Health Scrutiny Committee

## Thursday 26th March, 2015 at 6.00 p.m.
## in Committee Room 2 at the Council House, Dudley

**Present**:-

Councillor C Hale (Chair)
Councillor N Barlow (Vice-Chair)
Councillors M Hanif, D Hemingsley, S Henley, I Kettle, K Turner, K Shakespeare, E Taylor and D Tyler and Ms P Bradbury

**Officers**

S Griffiths (Democratic Services Manager (Acting Lead Officer to the Committee)), K Jackson (Deputy Director of Public Health), B Kaur (Consultant in Public Health) and M Johal (Democratic Services Officer – Directorate of Resources and Transformation).

**Also in Attendance**

Ms Jacky O'Sullivan – Dudley Walsall Mental Health Partnership Trust
Mr Mark Axcell – Dudley Walsall Mental Health Partnership Trust
Dr David Hegarty – Dudley Clinical Commissioning Group
Dr Mona Mahfouz – Dudley Clinical Commissioning Group
Mr P Maubach – Chief Accountable Officer (Dudley Clinical Commissioning Group)
Ms Liz Abbis – Dudley Group NHS Foundation Trust

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51 **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of Councillors C Elcock, K Jordan and M Roberts.

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52 **Appointment of Substitute Members**

It was reported that Councillors I Kettle and D Tyler had been appointed to serve in place of Councillors C Elcock and K Jordan for the meeting of this Committee only.

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53 **Declarations of Interest**

In accordance with the Members' Code of Conduct, a non-pecuniary interest was declared by Councillor S Henley in respect of Agenda Item No 6 (Mental Health Quality and Performance Review) in view of the fact that his wife works for the Black Country Partnership National Health Service (NHS) Trust.

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54 **Minutes**

A Member referred to Minute No 38 relating to phlebotomy and stated that the service based at Russells Hall had been moved to near the maternity part of the hospital. Complaints were being made by residents as they were not aware that the service had moved and were being redirected. The new base for the phlebotomy service was located in the opposite direction to the outpatient clinics and was a long walk which was particularly tiring for the elderly. Mr Maubach (Chief Accountable Officer (Dudley Clinical Commissioning Group) undertook to relay comments back to the Trust.

**Resolved**

That the minutes of the meetings of the Health Scrutiny Committees held on 22nd January and 16th February, 2015 be approved as correct records.

55 **Public Forum**

No issues were raised under this agenda item.

56 **Mental Health Quality and Performance Review**

A report of the Head of Commissioning – Dudley Clinical Commissioning Group (CCG) was submitted on the arrangements in place for the commissioning of mental health services.

Arising from the presentation of the report the following queries and comments were made by Members and responses were given as indicated:-

- There were a number of mechanisms in place to monitor quality and safety such as holding the monthly contractual and clinical review meetings where minutiae was discussed and information checked with a view to ensuring compliance and continuous improvements being made. Surveys of service users were also undertaken to ascertain their views on issues.

- In referring to Tier 4 – specialist day and inpatient units it was queried whether there was a similar facility in the Dudley area, and if not, whether there were any plans in the foreseeable future.

  Dr Mahfouz stated that the number of children requiring admission was extremely low which made it economically unviable. However, the Black Country Partnerships NHS Trust were considering the development and commissioning of a joint unit but it was pointed out that beds in the unit had to be opened nationally and that they could not be reserved just for local patients.

- Reference was made to a policy paper associated with the mental health services and on achieving better access and it was queried how this related to the Child and Adolescent Mental Health Services (CAMHS) particularly on the tier process.

  The information as contained in the report detailed the current provision and the CCG were in the process of addressing the Department of Health's document with a view to updating the service to be open and more accessible for 0-25 year olds. However, it was reported that Tier 3 was commissioned by the Dudley Walsall Mental Health Partnership Trust (DWMHPT) and that this provision would not change because of its specialist nature as it specifically catered for young persons with acute conditions.

  An assurance was given that a system without tiers would still be robust and that joint triaging and assessment of an individual would be undertaken when being referred to the general hub or to CAMHS. The redesign of the mental health service would include several audits and evaluations taking place with a view to ensuring that every young person was assessed and appropriately referred.

- The redesign and delivery of the mental health service would be based on the "new hub and spoke" model which meant that a range of services would be provided from a central point over a defined geographical area to people within the surrounding community.

- The need for CAMHS to react and attend scheduled meetings relating to an individual child as complaints had been received from certain primary school Head Teachers that they experienced delays and often representatives did not attend these meetings. There was also insufficient input from General Practitioners (GP's) at case meetings.

  In responding it was stated that GP's were increasingly being approached by parents with a view to providing a sick note for their child to substantiate absences, however GP's were not informed about any meetings or discussions that were taking place. Further, GP's did not receive minutes of any case that was discussed by the school and if parents notified their GP's about any issues, they were advised to contact the school direct to request that they submit a report to the GP for consideration and action.

- It was considered that given extensive joint and partnership working the methods of communication needed to be improved and that a simple accessible structure should be in place within the various organisations to ensure that problems could easily be resolved to enable services to be appropriately delivered.

- The assessment process for delivering the service was explained. It would commence in the next few weeks and representatives of various organisations would assess the best service for individual young people. The GP would remain as the co-ordinator and the Hub would assume an overarching role and therefore proper communication was vital. It was further stated that Health Advisers, schools, parents and young people could access the hub at anytime.

- Reference was made to young people placed outside of the Borough, particularly those placed a considerable distance away from their home and it was commented that parents were not able to visit their children regularly because of affordability issues and other factors. It was queried whether a local unit could be provided for young people in the Black Country and capacity issues were also questioned.

  It was reported that should a collaborated unit be provided in the Black Country the Trust would still be under an obligation to prioritise places on a national basis and that beds could not be ring fenced to local young people. Prior to NHS England taking over the service there had been sufficient local provision, however beds were now filled to their capacity and taken up by national patients which has had an adverse impact on local services. Representations were continuing to be made to NHS England by the CCG and the Trust with a view to action being taken.

  The costs associated with out of Borough placements was explained in that the local CCG's were responsible for funding and costs were reciprocal. Young children that were placed out of the Borough were of all ages and placements were allocated according to the nature of their needs.

- In referring to paragraph 14 of the report it was stated that the national standard waiting times for treatment for Tier 3 services was eighteen weeks. National standards applied to waiting times for treatment and also to quality of care and some of the contractual and quality key performance indicators were contained in the appendix to the report.

- The reasons for not meeting some of the targets as highlighted in the Appendix to the report were explained in that this was largely due to staff vacancies and sickness. Also some targets were measured on a yearly basis as these would always show a dip in certain months each year due to holiday periods which resulted in there being fewer clinics.

**Resolved**

That the information contained in the report, and Appendix to the report, submitted on the position in relation to the quality and performance of mental health services, be noted.

57 **Update on Transfer of the 0-5 years Public Health Commissioning to Local Authorities**

A report of the Office of Public Health was submitted on the Local Authorities' new commissioning responsibilities for 0-5 year olds. In presenting the report the Consultant in Public Health reported that the planning and commissioning of public health services for 0-5 year olds would be transferring from the NHS to Local Authorities in October 2015.

Arising from the presentation of the report the following queries and comments were made by Members and responses were given as indicated:-

- In response to a query about the contract value it was reported that the figure of £4,757,599 for 2015/16 was the total package to fund the seventy two health visitors and additional support needed, which also included an element of Family Nurse Partnership (FNP). There was additional funding available for employing an extra two FNP nurses. It was considered that the current funding package was sufficient to deliver the service, however it was unlikely that the same amount would be received in future years. The allocation to Local Authorities was based on a national formula calculated by the Department of Health and it was essential that funding and resources were distributed efficiently to maximise its effectiveness. Consideration was being given to the possibility of integrating with Children's Centres to maintain delivery.

  In relation to how health visitors were to be allocated and resourced across the Borough it was stated that from October 2015 the service would be in line with resident based boundaries. Although there was no set number of health visitors to be allocated to each Ward, all parents with new born children would have access to a health visitor and depending on their individual needs a variance of support would be available.

  There was a national shortage of health visitors and the current service provider used "bank staff" when required. However upon transferring to the Council this would be discouraged due to the costs involved and also because it was important to have a committed, dedicated and consistent workforce.

- With regard to training it was commented that there was a commitment to provide continual professional development and an assurance was given that all staff would be fully capable of performing their duties.

- Questions were asked about the composition and diversity of the workforce and it was queried whether health visitors would focus on meeting the local community needs and whether they had bilingual skills to cater for the needs of the Borough.

  The Consultant in Public Health indicated that there were varying levels of grading amongst the staff and efforts would be made to empower them to undertake their duties based on a community led role. It was not known whether staff were bilingual and the Consultant in Public Health undertook to respond to Members in writing.

- Reference was made to integrating services with Children's Centres and it was queried how those children that did not attend these centres would be reached.

  It was stated that Children's Centres had extensive contact with young children and their associated families, particularly those that had new born babies. Recently, GP clinics had moved to Children's Centres and attendance at these centres had since increased. Also the mandatory elements of the Healthy Child Programme applied and a health visitor would be required to make contact with every parent through ante natal and the six to eight week assessments.

- The number of children born in Dudley during the previous year and the time slots that were allocated for health worker visits was queried.

  Time slots varied and were based on the level of the service allocation which was dependent upon the needs of the family. The number of children that were born in Dudley during the previous year was not known and the Deputy Director of Public Health undertook to respond to Members in writing with an approximate figure.

- It was queried whether the service operated out of hours and whether training would be provided to health visitors with a view to managing and reducing minor illnesses. There was the need to ensure continuity and good communication and it was queried how this would be conducted with relevant GP's, particularly when administering inoculations and its recording.

  Clarification was given in that the health visiting service contract would transfer to the Local Authority but the workforce would remain in the control of the Black Country Partnership Trust. Therefore the full details of the operation of the service were not known. With regard to managing minor illness and in reducing illnesses it was pointed out that treatment of illnesses

was a specialist area and the role of the health visitor would be to direct people to appropriate pathways and in line with prevention rather than curing. The health visitor would be the main contact person with a view to offering support, advice and guidance to address health concerns, particularly to those patients discharged from hospital. There was an element of related training in the delivery of the core safeguarding programme which provided staff with competency and appropriate skills that were required.

Concerns regarding nurses being given autonomy to undertake a prescribing role were noted and it was stated that these issues would be considered when developing the service and model. Public Health were in the midst of finalising the contract and were currently involved in the process to procure staff.

- It was noted that the need for a robust procedure to be in place was vital to ensure that mental illness was detected early. It was also crucial that visits were undertaken at people's homes to gauge a true picture of the circumstances surrounding the case. There were various Departments, structures and policies in place surrounding health and concerns were raised about the potential of someone 'slipping through the net', particularly during transfers and handover.

  The Consultant in Public Health referred to the emotional well being agenda and stated that service specifications contained detailed information and work undertaken in conjunction with their partners was crucial to ensure a smooth transition. Work was ongoing with a view to improvements being made and they were currently in the process of recruiting an additional three posts.

  A response in writing would be submitted to Members relating to the current procedure in place surrounding home visits and on how they were conducted particularly if being refused access and entry.

- In referring to paragraph 2 of the report detailing the benefits from research conducted in the United States of America and the United Kingdom and in referring to the fifth bullet point it was stated that it should read "improved school attendance".

- Although it would be useful for various agencies to have access to a central database containing all information relating to a young person this was not possible because of data protection issues. However, there was certain information available on the child's medical history but there were limitations on sharing this data.

Arising from further discussion the Chair requested that a report to include specific information relating to queries as raised above be submitted to a future meeting. It was also suggested that a health visitor and a representative from the service provider be requested to attend that meeting to enable the Committee to gain an understanding and perspective of issues that were encountered in delivering the service.

**Resolved**

That the information contained in the report on the Local Authorities' new commissioning responsibilities for 0-5 year olds, be noted.

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58 **Responses to Questions Arising from Previous Meetings**

A report of the Lead Officer to the Committee was submitted on updates and responses arising from the previous meeting.

**Resolved**

That the information contained in the report, and Appendix to the report, submitted on updates and responses from previous meetings, be noted.

The meeting ended at 8.25 p.m.

CHAIR