Minutes of the meeting of the Health Overview Policy and Scrutiny Committee, held in Committee Room 1 County Hall, Chelmsford, CM1 1QH on Wednesday, 13 September 2017

Present:

County Councillors present:

J Reeves (Chairman)	M McEwen
J Beavis	R Moore
A Brown	S Robinson
J Chandler	C Sargeant
B Egan	C Weston
D Harris	A Wood

Borough/District Councillors present:
Neil Pudney (Maldon District Councillor)
Vic Ranger (Uttlesford District Councillor)

Also in attendance:
Hannah Fletcher, Healthwatch
The following Officers were present in support throughout the meeting:

Christine Sharland, Scrutiny Officer
Matthew Waldie, Committee Officer

1 Apologies and Substitution Notices
Cllr Tony Durcan gave his apologies.

2 Declarations of Interest
There were no previously undisclosed declarations of interest.

3 Minutes
The minutes of the meeting of the Health Overview and Scrutiny Committee held on 12 July 2017 were approved as a correct record and signed by the Chairman.

4 Questions from the Public
There were no questions from the public.

5 Childrens Mental Health Services - update
The Committee received report HOSC/24/17 and the Chairman welcomed Clare Hardy, Head of Commissioning, Essex County Council, Jessica Thorn, Assistant Director, CAMHS Commissioning, West Essex CCG, and

Gill Burns, Deputy Integrated Care Director, NELFT.

Members noted that the Children's Mental Health Services had undergone a transformation over the past two years. Starting in autumn 2015, seven CCGs and three local authorities in Essex, led by West Essex CCG had integrated their services. Their first year involved much transition and staff repositioning; their second year, from November 2016, has seen the new practices bedding down, with improvements seen in KPIs, in spite of increased demand.

Members received a PowerPoint presentation on the service transformation, which had been circulated before the meeting; some specific aspects were noted:

- the merging of Tiers 2 & 3 (targeted support and community mental health) and the possible integration of Tier 4 (specialised support) in the future
- an overall integration of the elements of the service, and a more flexible approach, including digital innovation
- greater engagement with schools
- moving away from measuring in terms of simple KPIs toward outcomes.

The size and scale of the transfer was significant and challenges remained in several areas. There had been a large cultural shift - moving from a clinical to a more outreach and community based approach. And expectations had to be managed over the expected 5-year period of transformation.

The new arrangements brought together the staff from three separate providers into one unit of 180 individuals, in November 2015; and it had taken 18 months to bring them together into a team. In November 2015 there were 3,000 cases; by March 2016, this number had risen to 7,000, with the same staff levels. This indicated that there had been a substantial number of people untouched by the previous arrangements.

The NELFT model is based on a single point of entry for the whole of the County, with triage followed by allocation to one of the seven locality teams (ie the CCGs), and then onto an appropriate care pathway. The referral criteria benefit from a much broader brush approach than before - but one troublesome area is that there is no standard pathway for children with ASD and ADHD. It was suggested that a 'whole approach' would be more beneficial.

The number of referrals is high - over 13,000 between April 2016 and June 2017; an unexpected shift is that many families see the combination of NHS and social services as providing the treatment for any domestic issues they may have.

There have been 3 recruitment campaigns and the current vacancy level is

at 23-27%, which is quite low compared to NHS rates.

Considerable efforts have been directed to targeting teenagers with high use of social media and to providing award-winning digital support.

With specific reference to the nine recommendations set out in the scrutiny report on 'Mental Health Services for Children and Young People in Essex', a copy of the formal response to each recommendations is attached at the Appendix to these Minutes.

Members received responses to issues they raised, including reference to the recommendations listed in the meeting papers:

- the task has been a greater one than anticipated, but the work is progressing well. Main priorities over the next few years are the schools involvement and digital development, with the quality improvement agenda most important. Underlying this are the countywide approach and application; there is one front door, one one provider and one team - this is a very positive step forward
- a much more open approach is now the norm, with staff working in locations such as family centres and GPs surgeries
- there has been a marked increase in pressure on young people through social media; and many of the problems relate to systemic family issues
- it is hard to judge the actual extent of the problem: the historical figures suggest 30,000 children in Essex with mental health issues; but another study has put it at 60,000, and the Childline research estimates it at 90,000
- the need to work within the existing financial envelope means that it was unlikely that the waiting time of 18 weeks would reduce over the next year or so; but substantial numbers were seen within 6-12 weeks
- Essex tries to work with organisations in the voluntary sector wherever possible, which also have their capacity problems; and the intention is to refresh the relationship with them
- a lot of work has been done to raise the profile of mental health issues, including the publication of *Let's talk about mental health,* and this will continue to be explored
- a countywide perinatal service should be launched within the next few months
- there are several threads of work toward increasing the workforce, both on a national and County level
- there are also several workstreams in place to improve awareness and skills in schools.

The Chairman thanked the Service's representatives for reporting on the progress being made and suggested the Committee be provided with another update in six months' time. She also agreed that it would be useful for Members to be presented with some vignettes of anonymised cases, to provide a clearer picture of the work of the service.

Cllr Sargeant left the meeting at this point.

6 **Proposed new clinical model for Mental Health Services**

The Committee received report HOSC/25/17 and the Chairman welcomed Dr Milland Karale, Medical Director for Essex Partnership University NHS Foundation Trust (EPUT), and Andy Brogan, Executive Director of Mental Health, EPUT.

Member noted the progress being made on the progress of proposals for a new clinical model for local mental health model services, and pre-consultation including the following points:

- the two Essex mental health trusts merged earlier in the year, primarily with the aim of improving services
- the basis was the five year view published by NHS England in February 2016 - although it will take longer than 5 years to fully implement; this also informs the strategic needs of Essex, Southend and Thurrock
- two particular areas needing to be addressed are 1, that providers are not responsive and did not act quickly enough, and 2, that the service provided was not appropriate to the 21st century
- two reactions to this are that 1, more should be don at the primary care level, using the patient knowledge and facilities of GPs for instance, and 2, responses should be made at a more localised level (a problem here being that each area has its own way of operating).

Consequently, several workstreams are in place, in the following services (as set out in the paper):

- reconfigure community mental health services to "wrap around " primary care
- re-model the services to in line wth the national pathway for people with dementia
- transform how services are provided for people with personality disorders
- improve emergency and in-patient care services
- extend perinatal services.

The commissioning environment is a complicated, with separate providers in the north and south of the County plus Southend and Thurrock.

The past year has seen a 19% increase in presentations in mental health, which has not been matched by staff increases. The Government's Mental Health Workplace Plan aims to find 21,000 extra full-time staff to work in mental health - of which Essex would expect about 500. The EPUT vacancy rate is 14%, about the national average.

Members received the following information in response to their questions

and points raised:

- each area has its own way of working but there is an overall strategy; and there has been a change in attitude, toward partnership working. This stretches beyond the purely medical, as mental health issues impact on both physical and social elements of an individual's life. Some approaches are practical, eg asking individuals onto certain bodies to assist develop models; and the trust has been working with the three local authorities
- several initiatives are in place to make sure that patients do not stay in hospital longer than they need to, eg in early planning, to ensure that appropriate housing, etc would be in place. Although there are a number of delayed discharges at any time, it is a much smaller problem than in the acute sector
- Regarding consultation, the trust wants to be as open as possible as it moves forward and will take a view on each course of action, to assess the level of consultation it requires
- recreational drug and alcohol abuse constitute major issues for the trust, in some cases are major precipitants for mental illness
- at present, beds in the north are always full, but not so in the south. The creation of an assessment unit in the north would be a great benefit, as it would have a consultant doing rounds seven days a week; as opposed to another unit, which would not benefit from this at weekends.

There being no further questions, the Chairman thanked Mr Brogan and Dr Karale for their contribution. She asked that they return to the Committee in about six months' time to provide an update on progress.

7 Date of Next Meeting

The Committee noted that the next activity day would take place at 9.30am on Wednesday 11 October 2017, in Committee Room 1, County Hall.

The focus of the next meeting would be the Strategic and Transformation Partnerships (STP). A public notice on the Mid and South Essex STP 'Our Future NHS – update on current progress towards consultation' had been circulated to the Committee beforehand, and the Chairman confirmed that its consultation proposals would feature in the October agenda.

There being no further business the meeting closed at 3.37pm.

Chairman

Appendix to Minute 5: Response to Scrutiny Report recommendations

Recommendation	Update
Recommendation 1: A strong pan-Essex all-age brand for holistic mental health services that pulls together all agencies should be developed.	• 'Let's Talk' about mental health is a new brand developed for the Southend, Essex and Thurrock Mental Health strategy. • We are using the brand for our self-harm toolkit for schools and leaflets and will work with Adults commissioners around developing the brand.

Recommendation 2:
There should be a clear aspiration for a defined, acceptable 'Essex waiting time' for access to the NELFT service that is considerably less than the current national and contractual standard.
 	
&
 	
Recommendation 4:
(a) To develop and demonstrate a clear strategy to further reduce waiting times for assessment and first treatment; and (b) indicate the extent of any potential for collaborative working with other agencies to assist this.
	• We have a strategy around improving waiting times and significant progress has been made. Referral to treatment is the key national indicator, performance has improved with NELFT achieving 2.83% above the standard (94.83% against the 92% waiting time standard as @ end of Mar 17) in challenging environment of increasing demand.
	• Nationally there are significant challenges around waiting times, in 2016 the national average waiting time for referral to treatment was 17 weeks.
	• We all support an ambition to see young people as quickly as possible, however to formally change the contract around waiting times would require further investment which is difficult in relation to funding and workforce availability as noted by the HOSC. We also want to ensure the focus is on outcomes.
	• We are continuing to enable CYP to be seen as quickly as possible:
	  • EWMHS contract distinguishes between referral to assessment and referral to treatment.
	  • Monitor volumes seen within 6 weeks, 6-12 weeks, 12-18 weeks and 18+ weeks. Mar 16 over 3,100 of the 6,900 CYP were seen within 6 weeks.
	  • CYP are triaged with highest needs prioritised. Lower levels of need may benefit from alternative solutions e.g. community resources - need to ensure we appropriate community capacity.
	  • Developing a range of digital solutions e.g. NELFTs MyMind , Big White Wall, Kooth online counselling pilot.

Recommendation 3: That opportunities within the voluntary sector for further early intervention initiatives to build community resilience should be explored. & Recommendation 6: There should be a strategy and plan for closer collaborative working with the voluntary sector, including linkages for re-signposting and cross referrals that can be located in community settings (including schools).	• Building community resilience is a key priority within our 5 year transformation plan; 'Open up, Reach up'. • As we refresh the plan we are continue to explore how we can develop community resilience across a number of partners including voluntary sector and education. The next refresh is in October 2017. • NELFT has been working at a local level with a number of voluntary sector partners. • Single Point of Access does link and signpost to a wide range of community provision 'catch and carry' model. • A key focus in the first 2 years of the plan has been around Schools – see section 9 for details.
Recommendation 5: (a) That regular performance reporting should be expanded to include: (i) A breakdown of the concentration of referrals from different sources (particularly highlighting differences between schools); (ii) How long those clients who do have to wait beyond the NICE guideline of 18 weeks actually do wait for first treatment; (iii) The numbers exceeding the 'acceptable Essex waiting time'; and (iv) An illustration of the patient focussed benefits achieved from early intervention; (b) That key performance data be publicly available; (c) That the Essex HOSC should receive performance reports twice yearly (or as otherwise directed).	• Historically performance reporting around Children's Mental Health has been poor, significant improvements have been made within continuing developments. Developing outcomes reporting. • With over 700 schools and 100s GPs breaking down referrals to this level would be challenging, however local level reporting to spot trends takes place. • Exception reporting on those waiting over 18 weeks takes place. • As mentioned above reporting is broken down by 6, 6-12, 12-18, 18+ weeks • Mental Health is everyone's business and early intervention solutions are imbedded in range of services to look at early intervention we need to focus on outcomes across the system. • Annual performance reports are produced and shared with partners, these are available in request but not published at present, we will need to take this to the Commissioning Collaborative for agreement. • The annual performance report has shared in the papers for todays' HOSC and we are happy to return as the HOSC requires.

Recommendation 7: There should be clearer communication of service thresholds and provision not only with service users but also with partnership organisations.	• We have moved away from set threshold and relaxed the referral criteria to enable more CYP who need support to be seen. Mar 2017 90% of referrals to the SPA were accepted. • A wide range of factors are taken into account and it would be challenge to publish set thresholds. However over recent months we have developed a more proactive approach to communications; developed campaigns with exam stress and results periods. A key element is communicating with young people through social media and with schools. • We have resurrected the Children's Mental Health Stakeholder Forum and using the forum to communicate with a range of partners. • Commissioners held a crisis conference in June and second systems event was cancelled due to poor attendance.
Recommendation 8: The continued shortage in Essex of specialist mental health clinicians should be highlighted to the Essex Employment and Skills Board and included in the wider Essex strategy addressing skills shortages across the county.	• Conversations have commenced with the Employability and Skills Team, the health workforce is one of their priorities. Health Education England has the national lead on workforce and the government has announced plans to expand the workforce by 2020/21. • The MH Strategy has a focus on workforce and the Employability & Skills team are going to attend a Strategy Group Meeting so we can explore this from an all age approach.

Recommendation 9:
(a) All Essex Schools should understand and develop the best practice established by some schools who use early intervention, access to pastoral help, peer mentoring, liaison with outside agencies, whole school training and have a supportive ethos;
(b) A summit or more locality based mini-summits on mental health should be arranged for all Essex Schools to share learning and best practice; and
(c) A school mental health network be established for school mental health champions to share information and experience on a regular basis.
	• MH Education work stream which is overseeing 4 elements of work:
	  • NELFT offer inc consultation, group supervision, training
	  • Developing digital resources for schools inc best practice, toolkits
	  • Developed schools self-harm toolkit
	  • Refreshing schools suicide guidance.
	• Schools MH event is being held end November; launch a number of the resources above and include best practice and elements of training.
	• Exploring through the Education work stream and the conference the appetite for a network, working with Education commissioners who are developing SEND clusters.