NHS
Eastern Cheshire
Clinical Commissioning Group

GOVERNING BODY MEETING in Public

23 May 2018 **Agenda Item 6.2**

Report Title	Eastern Cheshire HealthVoice

Appendix A
Unconfirmed minutes of the meeting held on 10 April 2018

UNCONFIRMED

Minutes of the meeting 39

Tuesday 10 April 2018, 18:15 – 20:15
Capesthorne Room, Macclesfield Town Hall, Market Place, Macclesfield

Attendee's Name:		
Patrick Heywood (Chair)	PH	Toft Road PPG
Barrie Towse	BT	
Cyril Towse	CT	
Charlotte Peters-Rock	CPR	KafKa
Colin Sibley	CS	McIlvride PPG
David Rutley	DR	MP
Denise Greaves	DG	East Cheshire NHS Trust
Diane Walton	DW	Lawton House PPG
Geoff Gray	GGR	Broken Cross PPG
Gill Griffies	GG	Chelford PPG
Hilary Newton	HN	
Jacquie Grinham		Annandale PPG
Jean Bonnett	JB	
John Adams	JA	Action for Sick Children
Laura Jeuda	LJ	
Maureen Sibley	MS	McIlvride PPG
May Barnsley	MB	Park Green PPG
Mike Heale	MH	East Cheshire Mental Health Forum
Pat Simmons	PS	38°
Tom Kinnerha	TK	
In Attendance :		
Neil Evans	NE	Director of Commissioning ECCCG
Dean Grice	DG	Primary Care Manager ECCCG
Charles Malkin	CM	Communications Manager ECCCG
Julia Hulland-Vernon	JHu	Engagement & Involvement Officer ECCCG
Jacki Wilkes	JW	Associate Director of Commissioning ECCCG
Dr Anushta Sivananthan	AS	Medical Director, C&W NHS Partnership Trust
Dr Sadia Ahmed	SA	Consultant Psychiatrist
Dr Sabu Oomman	SU	Consultant Psychiatrist
Apologies:		
Paul Bowen		Clinical Chair ECCCG
Jerry Hawker		Chief Officer ECCCG
Alex Mitchell		Chief Finance Officer ECCCG
Jane Stephens		ECCCG Lay Member Patient & Public Involvement
Mabel Taylor		KAFKA
Gerry Biggs		Chelford PPG

All papers/presentations are available on the HealthVoice website: www.echealthvoice.info

		Action By
1	**Welcome and Apologies** The Chair welcomed the group. Apologies were received as noted above.	

		Action By
2	**Minutes of the last meeting & Matters Arising** The minutes of the meeting held on 14 February 2018 were agreed and accepted as an accurate record subject to amendment on Page 2, 4.4 point 5, Macclesfield Road to be changed to Manchester Road.	**DW**
3	**Redesign of adult and older peoples Specialist mental health services**	
3.1	Jacki Wilkes (JW), Associate Director of Commissioning introduced colleagues from Cheshire and Wirral Partnership Trust (CWPT) and confirmed that the CCG was entering into public consultation regarding the redesign of Adult and Older People's Specialist Mental Health Services in partnership with CWPT and South Cheshire and Vale Royal CCGs.	
3.2	The Consultation started on 6 March 2018 and will end on 29 May 2018. JW explained the aims and objectives of the consultation and the reasons behind the need for change outlining the proposals and options the public were being asked to consider. http://www.echealthvoice.info/Downloads/Your-Views/HealthVoice/MH%20Consultation%20Presentation.pdf	
4	**East Cheshire Mental Health Forum**	
4.1	Mike Heale (MH), representing East Cheshire Mental Health Forum, addressed the group and put questions raised at a recent meeting of the Forum to the health representatives present who were involved in the redesign consultation: • There is still a demand for acute care beds; this has not decreased and some service users need asylum. Why is there such a rapid reduction in inpatient beds? • Why was the recent CWPT claim for capital expenditure funding from the Department of Health rejected when there is need for acute care provision in the locality? • What is being provided in Eastern Cheshire to assist patients and carers with the increased cost and time of travelling to Chester to attend or visit Bowmere? • Comparing the 3 options within the consultation document there appears to be a 'Hobsons Choice' between options 2 and 3. Is there an opportunity for an option 2½ - a local facility which includes additional inpatient beds?	
5	**Questions and Comments**	
5.1	Geoff Gray (GG) requested further information on the cost and location of the Crisis Cafes referred to in the consultation and also no reference has been made in the document to a local Primary Intensive Care Unit only one in Chester.	
5.2	David Rutley (DR) articulated public concern about the reduction of adult inpatient beds in the local area and questioned whether a smaller unit to the current one at Millbrook could be an option for consideration.	
5.3	MH advised that the extra staffing for Community Mental Health teams would be welcomed but questioned how the new members of staff would be trained and how they would operate to help carers keep people at home?	
5.4	John Adams (JA) stated that CWPT were under increasing financial pressure,	

		Action By
	notably to avoid criticism from NHS Improvement in regard to their financial management as they are at break even. The proposal is in line with NHS policy of the creation of Crisis and Resolution Teams across England to reduce residential costs. Studies of those already operating have received criticism from various sources (King's Fund, MIND charity, Mental Health Today; Manchester University) which often include: – Inability to man the multidisciplinary teams – not enough qualified staff – Continuity- unlikelihood of the patient seeing the same clinician twice – Increase in suicides in the CRHT setting as against residential Poor management If the Community option is taken up it is vital to bring in 40 more staff. JW confirmed that the CCG and its partners would make the best use of the funding available. AS advised that the national suicide rate was falling and that more people commit suicide in community teams that as inpatients but it has been documented in the 5 year Forward View for Mental Health that people preferred to have home treatment wherever possible. There has been a lack of skill mix in community teams but this is being addressed and, if improvements are made within the teams, quality of care will improve. CWPT is looking to increase the number of psychologists and occupational therapists within the teams not just nursing staff.	
5.5	JA questioned whether a failure to recruit the relevant people would result in the CCG having to monitor a substandard service against contract. In the NHS no one is deemed accountable. If CWPT fails to recruit the 40 people necessary they will just advise the CCG's and a reduced service will be in place. Only the patient suffers. JW advised that stringent processes will be put in place to monitor outcomes for patients but the CCG has worked very closely with CWPT and a commitment has been made that acute provision will not be reduced until the Community Services are in place.	
5.6	Charlotte Peters-Rock (CPR) commented that it was important that mentally ill people were treated in their local area and there were many empty NHS buildings that could be reutilized to provide care. CPR also questioned whether there were plans to screen and potentially diagnose family members of patients with mental health difficulties. JW clarified that a very detailed needs analysis had been done to determine where the care needs were and the skill mix of staff required to deal with these patients. AS confirmed that, at present, there was only one service in the region able to provide family support which is clearly not enough – providing the right clinical support and psychological care to families helps both the carers and patients. CWPT is working with CCGs, GPs, local councils, schools and voluntary services to provide support and help build resilience to mental health problems.	
5.7	Diane Walton (DW) commented that there are currently long waiting lists for Cognitive Behavioural Therapy (CBT) and counselling and questioned whether, despite a financial input, there will be enough trained staff available to fill the new posts? CWPT confirmed that Health Education England has already introduced training programmes to upskill staff in children and young peoples' psychological therapies. The training programme has expanded and people are being released to attend courses.	

		Action By
5.8	May Barnsley (MB) queried why Option 2 is the preferred option and not 3 as young people need help for longer and need to know when they go home that help and support is available locally. JW explained that, when the options were scored, 2 and 3 were very closely matched and that, although option 2 is the preferred option it is not necessarily the one that will eventually be chosen – that will be decided by public choice. AS confirmed that the length of stay for people under 65 is shorter – younger people metabolize medication more quickly and do not usually have the same side effects as older people. It is recognized that, in the case of self-harming, this can become worse in a hospital situation because people may not have access to their usual coping strategies and some conditions get worse by being in hospital.	
5.9	A question was asked regarding how to monitor whether the chosen option is working; what are performance indicators? JW confirmed that it would be essential to develop a detailed transition plan and there will be a process to identify what the risk factors are and how they are monitored. A risk monitoring plan, including the effects of increased travelling on patients and carers/families, will be drawn up should options 2 or 3 be taken forward.	
5.10	A comment was made that a patient who had experienced stays at Clatterbridge, Chester and Macclesfield argued that, whilst facilities were better at both Clatterbridge and Chester, they would choose to go to Macclesfield because of the opportunity to build upon the relationships made whilst an inpatient and take them back into their home environment.	
5.11	CPR stated that it was vital to ensure that carers and families can reach distant patients and also that the community teams/drop-in centres need to be based on the high street for people to access facilities before a crisis occurs. CWPT agreed that mental health and physical health are not separate and integration between the community and general practice was essential.	
5.12	DR questioned whether any analysis had been done to scope out the possibility of locating a smaller local inpatient unit in Macclesfield. Also the consultation document did not detail any support being made available regarding the travel element and there was no detail regarding the Crisis care centres, how many there would be and whether any would be located in Macclesfield.	
5.13	JW concluded that there is a definite appetite to integrate services within communities but no development of a solution can take place until the decision on which option has been made. Nothing has been finalized regarding where the bed based services will be located but one unit will be located within the Eastern Cheshire footprint.	
5.14	AS advised that it would cost considerably more to build a new unit which would take funds out of clinical services. There were clear bidding rules regarding use of capital expenditure funding which is coordinated through the Sustainability and Transformation Partnerships (STP).	
5.15	PH thanked JW for coordinating and CWPT for taking the time to attend the meeting.	
6	**Referral Assistance Service (Referral Management Service)**	
6.1	Neil Evans (NE) gave the members a brief overview of the Referral Assistance Service, advising that previously there has been inconsistency in the rates of GP	

		Action By
	referrals so the new service has been designed to try to increase the consistency of GPs making referrals into specialisms.	
6.2	Initially the service will support six specialist areas: • Orthopaedics (will go live first) • Gastroenterology • General Surgery • Cardiology • Paediatrics • Ophthalmology	
6.3	A dedicated web page will be set up on the CCG website which will consist of information such as FAQs, RAS Pathway, Patient Information Leaflet as well as other supporting information. Hard copies of the patient information leaflet will be delivered to each practice by Friday 27 April.	
6.4	The service aims to provide the opportunity for GPs to be able to seek advice directly from specialists using national NHS software to support the process. This in turn should free up more GP time and reduce wasted hospital appointments as evidence from other areas has demonstrated. It will also support patient choice through direct access to a booking service which will provide the patient with a full choice discussion of clinics available or provide assistance around electronic booking should the patient choose to book their appointment online. The new service will not affect the 2 week wait pathway for urgent referrals.	
6.5	Cyril Towse (CT) asked whether there were any financial benefits to the GP when referring a patient for tests. NE advised that there are no financial benefits to GPs but they are all acutely aware of using NHS resources wisely.	
6.6	Following a question regarding why the name had been changed, NE stated that a project group which included a GP representative, had come up with a range of options which were shared with members of the public and the most popular was Referral Assistance Service.	
6.7	A question was raised regarding the recruitment of triage personnel. NE confirmed that there was a large pool of clinicians to recruit from. In the example of orthopaedics, which is the first area to be targeted with RAS, governance issues dictated that it would be more effective to use a Community Interest Company to host the service rather than directly recruit clinicians into the service. The second area to be targeted will be the paediatric service and NE confirmed that the triage process will not be launched in any service area until there are suitable clinicians to operate it. Regarding the possibility of higher costs to the CCG, NE responded that the contract would be monitored closely and if savings were not achieved it would need to be reassessed but it was considered a short term initiative to enable GPs to upskill and improve their knowledge.	
6.8	Laura Jeuda (LJ) asked whether there would be additional time allowed for GP appointments or would this be an opportunity to mask waiting times? NE advised that all the GP practices currently use the same EMIS templates to capture all aspects of a referral so the time would be the same as at present. The new system should help with the 18 week delivery target as if other	

		Action By
6.9	interventions are successful this will improve consultant capacity. CPR requested assurance that GPs would be given the time to receive training. NE confirmed that clinicians do receive time out to undertake training and are keen to be upskilled as they have to be reaccredited every three years.	
6.10	MB noted the necessity to reduce the level of inappropriate referrals but questioned whether GPs would be resistant to using the system in case their referral was deemed inappropriate and patients would therefore be disadvantaged. NE assured the group that the GP skill base would quickly develop and GPs would welcome constructive comments back from the triage personnel.	
7	**Patient Representatives**	
7.1	Pat Symonds PS confirmed that the consultation with young people has commenced with about 30 returns being made so far. Most responses indicated they were 'very satisfied ' or 'partly satisfied' with their treatment. Service priorities were mental health, pain management and sexual health. Just Drop-In has designed some posters to raise awareness that young people can influence health discussions. Next steps will be to engage with Head Teachers and Department Heads in schools and colleges.	
7.2	Diane Walton DW advised that she has received a written response from the CCG's Chief Officer which would be posted on the website for information.	
7.3	John Adams JA apologised for the lack of a written report due to illness. Over the last three months the trend of A&E Attendances had increased from about 120 day to 135, Emergency Admissions had also increased from 30/day to 33. Delayed Transfers of Car had varied but controlled quite well. The result of the pressure experienced resulted in 13 days in the period where 12 hour trolley waits were experienced. Seven of those days were high attendance days and nine experienced high emergency admissions. JA visited the department on two days when trolleys were in use. The A&E staff were handling the situation well but there is no doubt about the stress they were experiencing. There is a need to increase bed capacity in the Eastern Cheshire Health Economy to improve patient experience and care and improve the working arrangements for staff. The Royal College for Emergency estimate that NHS England needs an increase of 5,000 beds. The Operational Resilience Group is now planning for next winter. The broad plan has to be ready by end April.	
8	**Outgoing Chair** The members were advised that this would be PH's last meeting as Chair of HealthVoice. CM thanked Patrick for his hard work and dedication notably implementing a more effective approach to the promotion of Healthvoice and introducing the alignment of the HealthVoice agenda to the CCG's priorities.	

		Action By
9	**Election of new chair** Julia Hulland-Vernon advised the group that there will be an election for a new Chair and Deputy Chair. There is an agreed process which is available on the HealthVoice website. http://www.echealthvoice.info/Downloads/Your-Views/HealthVoice/HealthVoice%20Election%20June%202018%20info.pdf Expressions of Interest should be advised to Julia by 11 May. Everyone on the distribution list will be sent voting information.	
10	**AOB** None. The meeting closed at 20:16	
Dates of future meetings: **Monday 11 June 09:30-12:00, Congleton Town Hall** **Wednesday 12 September 13:30-16:00, Poynton Town Hall**		