PUBLIC

MINUTES of a meeting of the **IMPROVEMENT AND SCRUTINY COMMITTEE – HEALTH** held remotely on MS Teams on 8 March 2021

PRESENT

Councillor D Taylor (Chairman)

Councillors R Ashton, S Bambrick, S Burfoot, L Grooby and G Musson

Apologies were received from Councillors D Allen, S Blank and A Stevenson

Also in attendance were H Dillistone, D Gardner, E Prokopiuk, M Scouse and C Wright from Derby and Derbyshire Clinical Commissioning Group (CCG)

05/21 **MINUTES** **RESOLVED** that the Minutes of the meeting of the Improvement and Scrutiny Committee – Health held on 18 January 2021 be confirmed as a correct record and signed by the Chairman.

06/21 **PUBLIC QUESTIONS** There were no questions from the public.

07/21 **IMPROVING MENTAL HEALTH INPATIENT FACILITIES IN DERBYSHIRE** Claire Wright presented the report and was keen to receive the Committee's views.

In view of the increasing demand for mental health support, a number of conversations were being held around the requirements of the Five Year Forward View will would be implemented locally. The report focused on local inpatient (hospital based) mental health services and on how to improve the local facilities currently available using national funding identified to ensure services provided locally were able to meet current national requirements.

Acute mental health services in Derbyshire were provided by Derbyshire Healthcare NHS Foundation Trust through two units: the Hartington Unit in Chesterfield (based on the Chesterfield Royal Hospital site) and the Radbourne Unit in Derby (based on the Royal Derby Hospital site). Both provided care from old fashioned dormitory style facilities, with approximately four beds within a bay. The estate did not comply with current regulatory and legislative requirements for single, en-suite accommodation and due to the significant level of investment required, these changes could not be funded by the local health care system.

With support from the Clinical Commissioning Group (CCG), the Trust raised the need for national investment with NHS England and Improvement and had received a small level of investment allowing the development of business cases on how to move forward and develop services to meet the requirements. The Trust was also expecting to receive national dormitory

eradication funding to improve the services in Derbyshire. The changes would need to be made at pace to improve privacy and dignity and the overall patient experience.

Focus at national level was on the dormitory provision at both Derbyshire's units. Derby City HOSC had already been briefed and the intention to improve the facilities and would ensure the County HOSC was made aware of any changes to both units. It was understood that the funding allocated for Derbyshire was slightly lower than initially expected, however it was still substantial. Given this, the options would be reviewed to ensure the development could successfully progress within this financial envelope.

There was no Psychiatric Intensive Care Unit (PICU) facility within Derbyshire and patients have needed to travel outside of Derbyshire to access this service, which was not ideal for patients/carers and not in line with national guidance. In addition to the planned development of the two new acute units, Derbyshire Healthcare had committed to separately funding the development of a PICU on the Kingsway Hospital site in Derby.

It was expected that the central funding for the eradication of dormitory accommodation would be utilised before the end of March 2024. The Trust assured the Committee that both HOSC's were aware of possible developments and engagement with stakeholders had taken place. It was intended work alongside current and former patients, their carers and service user representatives to shape developments, making sure any new facilities met their needs and preferences. This was seen as an overwhelmingly positive development that would greatly enhance the acute mental health care currently provided in Derbyshire.

The Committee welcomed the report and were encouraged by the proposals.

RESOLVED – that the report be noted.

08/21 **GENERAL PRACTICE IN DERBYSHIRE – UPDATE** Emma Prokopiuk gave the Committee an update on the primary care response to the COVID 19 pandemic to maintain and deliver key services and then provided details on the opportunities for April 2021 and beyond.

All practices in Derbyshire were open and seeing patients face to face. Following national guidance, GPs had adopted a 'total triage' system, treating patients over the phone or online where appropriate. Appointments had risen since the same time last year and access had improved. Some surgeries temporarily closed due to difficulties ensuring COVID security or the need to rationalise staffing but all were now open and advertising this on websites, in reception and on phone messages alongside CCG and Local Medical Committee (LMC) communications advising patients that their surgeries were

open. The CCG had investigated all patient concerns raised about practices being closed, or refusing face to face appointments; none of these concerns had been upheld.

On the 25th February 2021, 5.7% absence levels were reported which was relatively low compared to other parts of the NHS and social care system and low compared to the height of the first wave (15-20%). None of the 112 Derbyshire practices were currently experiencing outbreaks. Practices had updated their business continuity plans to address this risk and the CCG was working with the GP Task Force to establish a clinical and non-clinical staff bank.

Primary Care Network Clinical Directors had worked with the CCG to establish a RAG rating system to assess pressure on General Practice. This asked practices to assess themselves as green, amber or red in terms of pressure on practice, balancing demand on services against capacity to deliver. As of the week commencing 24th November General Practice was on 'amber' alert (the definition and consequences were detailed in the report).

General Practice had focussed on a number of areas to catch up and restore services and, overall, were on track to deliver all the national targets linked to recovery and restoration. Progress was being monitored in light of the increasing pressure on services from COVID and normal winter demands.

The pandemic had forced a transformation in the way practices and patients use IT to provide virtual, telephone and online service by issuing hundreds of laptops and working away from their surgeries using online consultation tools. Practices were rapidly moving back to face to face contact however there had been some benefits in remote working in terms of improved patient choice and experience, more rapid access and more efficient use of time. It was hoped to make those improvements permanent; the CCG was surveying practices for their views.

The CCG had also been working on consolidating and developing its local commissioning approach and had already delivered the first two phases. The next phase was urgent response in the community and would look at new services to improve care, focusing on those who need support the most, including the intention to establish a service for people who are 'housebound' and cannot get to their practice but need care quickly. This would link to the Directed Enhanced Service for Care Homes started in October 2020 and the national 'Ageing Well' programme of work which focused on improving care for older people both proactively and reactively.

Access to General Practice had improved however delivering good access for patients with finite capacity and increasing demand was a big challenge for General Practice. Triage people was one of the ways to improve this and to channel them to the right service or person.

There was also evidence that showed patients could be broadly differentiated into 'hot' patients who needed on the day and 'cold' patients who needed care for more complex long term conditions. This could be developed at a network level, where 'hot hubs' be established for on the day care and freeing practices to focus on patients with more complex problems with specialist 'cold hubs'. Some places in Derbyshire were already doing a version of this.

Committee members asked questions predominantly around the security of patient data and around the 'hot' and 'cold' hubs.

RESOLVED – that the report be noted.

09/21 PROCUREMENT OF CHILDREN AND YOUNG PEOPLES MENTAL HEALTH DIGITAL SERVICE Dave Gardner presented the report which outlined improvements in mental health services across Derby and Derbyshire and engagement activity undertaken by NHS Derby and Derbyshire Clinical Commissioning Group (DDCCG) for the procurement of a Digital Mental Health offer for children and young people, parents and carers.

National prevalence data suggested that approximately 10% of children and young people would have a diagnosable mental health condition; this equated to 22,000 children in the DDCCG area. The impact of COVID-19 had seen an increase in demand with significant rises in Eating Disorders, self-harm and suicide ideation. To increase accessibility, NHS England required digitally enabled care to be used more widely and DDCCG commissioned Kooth, a universal digital mental health service for children and young people and Qwell, a universal digital mental health service for parents and carers, up to the 31/12/2021.

The report detailed the key purpose of the current Service, it showed Kooth and Qwell activity and described the processes of its surveys. Feedback from users and primary care was positive, with widespread support from partners for the continuation of a digital offer and engagement had taken place with all stakeholders.

Members were encouraged by the development of the digital mental health offer for children and young people and their parents and carers, and thanked Dave Gardner for his presentation.

RESOLVED – that the report be noted.

10/21 SOUTH YORKSHIRE AREA JOINT HEALTH SCRUTINY COMMITTEE UPDATE The Improvement and Scrutiny Officer provided the Committee with an update on the South Yorkshire Joint Health Scrutiny Committee which had held a briefing meeting on 22 February to receive information on the Government's Health and Care White paper and its impact

on the local Integrated Care System. On 11 February the Government published its White Paper – "Integration and Innovation: working together to improve health and social care for all."

Members were reminded that ICSs bring together more joined-up working arrangements between health and social care service providers and the White Paper proposes to place Integrated Care Systems (ICS) on a statutory footing and to make a range of structural and other changes at "place" and neighbourhood level. Other key elements of the White Paper included:

- The legal merger of NHS England and NHS Improvement - to be known as NHS England - which would have a single governance structure and be accountable for all aspects of NHS performance, finance and care transformation;
- The Secretary of State for Health & Social Care to direct NHS England (the merged body), and include their intervention in service reconfiguration changes at any point without need for a referral from a local authority;
- New powers for the Department of Health & Social Care to reconfigure and transfer the functions of arm's length bodies (including closing them down) without primary legislation;
- The Secretary of State would have a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary, community care and sections of the workforce shared between health and social care;
- CCGs would be dissolved and their roles in procurement and finance would become the responsibility of the ICS – with Health and Care Partnerships of NHS, LA Social Care and Public Health being established to plan services;
- Accountability systems at a local level to be reduced. Significant power and responsibility would rest at system level – the level at which ICSs would operate. In Derbyshire the ICS was coterminous with county boundaries, but it could raise border challenges, in how accountability was conducted in respect of services in Sheffield and Greater Manchester or across the East Midlands region, for example; and
- ICSs and Health & Care Partnerships would develop plans for future services. These plans would involve wide consultation and public participation and local Health Scrutiny would provide a mechanism to facilitate this participation.

The Centre for Governance and Scrutiny (CfGS) was pressing for Health Scrutiny to be given a formal role in supporting the way services were specified. Potential removal of the power and responsibility of Health Scrutiny Committees to make referrals to the Secretary of State – and giving this power to the Secretary of State direct – could weaken local knowledge and accountability. The CfGS was in active conversation about

this with colleagues at NHSE&I and DHSC and it was hoped that there would be a shift in approach between now and when the Bill was published in May. The CfGS would welcome direct feedback from councils about their views on this.

RESOLVED that (1) the report be noted and;

(2) Members submit any comments they wish to make to the Improvement and Scrutiny officer who would collate them into a formal letter to the CfGS from the Committee Chairman.