NOTES

Health OSC Steering Group
Monday 23 February 2015– B18b
2.00pm

Present:

- CC Steve Holgate
- CC Yousuf Motala
- CC Margaret Brindle

Apologies:

- CC Fabian Craig-Wilson

Notes of last meeting

The notes of the Steering Group meeting held on 26 January were agreed as correct

Primary Care Access

Officers from East Lancashire CCG attended to discuss Primary Care Access, they were:

- Cath Randall – Senior Operating Officer
- Lisa Cunliffe - Senior Primary Care Development Manager
- Collette Booth – Communications (but works for CSU)

Lisa provided members with background to the process – Primary Care Development (PCD) was identified as a cross cutting theme

Key points of discussion were:

- Access is just one of the key priorities of PCD
- Steering Group set up to look at accessing primary care – what services were available.
- Started July 2014 – patient and population engagement – various locations, online survey, hard copies in health centres, compared data to other local and national engagement. Worked with protected groups e.g. deaf people
- Over 400 responses – used the feedback to present a co-production event (9 Oct) to identify the key themes that had emerged and from those what the priorities were.
- Created smaller co-production group based on localities – produced 3 key priority areas. Original plan was to use that information to develop service delivery models and options. Instead have developed a series of principles. Next steps is to go back out to engagement asking about the principles and use them as the basis on any service delivery.
- A representative of the Health & Wellbeing Partnership sits on the governing body of the PCD (Healthwatch also) – provides challenge
- Patient engagement – did they look at the demographics as well as geographic? – Majority of engagement so far hasn't covered a lot of young people, however specific engagement is being planned. Also need to work more with BME communities, traveller community – the people from the

protected groups are the ones who have most problems accessing primary care services.

- Asian women and specific conditions such as diabetes – issues around accessing services. CC Motala also raised his concerns around mental health problems for young people and the support they are given.
- All the existing strategies within the county need to feed into the PCD
- CC Brindle gave rural communities as an example (Cliviger – no dentist, doctor or post office and poor bus service). Housing Associations are not well represented in rural areas so they are not the best organisation to share information throughout the community. Engagement – would they consider going out to community groups in those rural areas? Could Help Direct be utilised? Aim to do as much as possible but must to work within time and financial constraints – try to reach as many as possible.
- CC Holgate stressed that as long as they ensured that there was adequate representation of different groups it wasn't expected that every single small community be engaged with directly.
- CCG keen to engage with the younger population as they will be service users of the future
- Exploit the possibility of supermarket foyers as a means of having opportunities to engage with the wider community
- Wider engagement to determine whether the principles are fit for purpose.
- Health promotion and prevention – prevention responsibilities sit with PH team in LCC. Is this a key area? GPs could be more involved in early engagement and how services can be delivered differently.
- What's the experience of the out of hours service? – how effective are they? – Many people unaware of the OOH, particularly younger people. The 111 system doesn’t fit with how people want to engage with the service (particularly young mums and BME community – based on the clunky way that information is triaged)
- The commissioning of health services is very fractured – many different partners commissioning different elements, particularly for children's health care services. Availability of information – about services, about self-care and access to medical records
- Urgent access needed much closer to home – to try and stop people attending A&E unnecessarily
- Patient experience needs to be at the forefront and not just focusing on achieving targets.
- Perfect Week – the commissioners (and GPs) spend time with the providers and follow the patients through their journey. Provides useful feedback to help influence future commissioning decisions
- How can all the different partners work together to improve the system? – better alignment.
- HW will challenge the plans of the governing body and ask questions. Maybe make better use of their 'enter and view' powers.
- Hope to present to governing body by end of June – if it results in major service redesign then it will require a full public consultation. If this is the case will approach scrutiny to discuss this further.
- A lot can be achieved regarding delivering a different service by tweaking existing contracts

- Primary care across the county – needs a consistent approach, CCG network to be more transparent and accessible – maybe use a similar model to that of BCF.
- Safeguarding needs to be at the forefront of any development of plans and future service design.
- All providers will be involved in the redesign of services
- What do patients understand what primary care is? – GPs services and other out of hospital services provided in the community
- CC Motala suggested that the team contacted local County Councillors to discuss communication and engagement options in their local areas.
- Need to also engage with District and Parish/Town councillors
- When would they be able to speak to us again to provide an update? – September. Wendy to arrange for them to attend a future SG meeting.

Calderstones

Mark Hindle (Chief Executive) attended Steering Group to update members on the action and progress since their recent CQC inspection.

Also Nick Kashew (Director of Finance) and Fran Foster attended

Key points:

- Inspected June 2014 – 60 inspectors, report produced December, followed by a Quality Summit (QS) which was attended by CC Motala and Wendy
- Lack of community based support by primary and secondary care for clients that need to move on
- Gender split of patients is 80/20 male/female
- The Trust provides low and medium secure services – high level is the likes of Rampton
- CQC report highlighted the use of restraints – used to manage people's aggressive behaviour, drugs can be used to calm them down or physical restraint.
- All these issues were discussed at the QS – and the Trust have developed a comprehensive action plan. HSC should have been identified as taking part in an improvement board – Ian Leybourne attends from LCC (need to get copies of minutes)
- Progress is generally good – real test is are the changes embedded. Invested in more cleaners, training (particularly for clinical staff), more therapists.
- £1.2 – £1.8m revenue consequences to deliver the improvements. Discussing with the commissioners regarding finding the resources to sustain the service.
- NHSE buy a certain amount of beds, (clients with exceptional needs as charged on a per client basis). It costs more to care for a female client than a male one but the funding is based on beds and not gender.
- Quite a unique service but are benchmarked against standard processes e.g. cost per bed. Difficult to demonstrate for value for money.
- The private sector don't have to abide to the agenda for change regarding terms and conditions relating to single sex provision.
- Length of treatment – 6 months to 20 years (very much depends on the individual)

- Discharge down from medium to low can proof problematic due to different commissioners for different levels. NHSE commission low/medium secure services and the CCGs commission the enhanced support packages.
- CC Motala concerned that someone discharged back to the community would have the right level of support – investment in social care, housing etc. is required to enable the provision of adequate support.
- Mental health review tribunals, DOLs are blocking discharge as many clients are resulting with a more restricted lifestyle than if they remained at Calderstones.
- Readmission rates? – very low for the Trust.
- Where is the primary care element at the very beginning to stop being getting into the system in the first place?
- Following Winterbourne it was deemed that more community provision was required – however the number of inpatients has doubled in the 2 years since.
- A lot of pressure in the system for commissioners to change the type of provision – 50 patients within Calderstones have been deemed as should be discharged but there is a lack of services to deal with these people in the community.
- The Trust have had active talks with Merseycare to discuss merged services – in advance of making a decision want the input of scrutiny. Would be a more robust organisation both financially and staffing/facilities
- How do the Trust see a financial solution for the future with increased demand? Merseycare are very financially sound and have many assets.
- There are significant savings of organisations coming together. The Trust currently use a lot of agency staff (10% sickness absence amongst staff). Recent events have made it difficult to recruit staff. Over 50% of those staffing shortages are filled with agency staff for which they pay a 25% premium. If joined with another organisation would have the use of a very large pool of 'in house' bank staff.
- Management costs could also be significantly reduced in a merged organisation. 10% could be saved through efficiencies and service delivery changes.
- However investment is still required in community based clinical services.
- Would be a rationalisation of existing estates across the two organisations but it's too early to say what the detail of this would be
- Need to be careful about people's care pathways if merged to make sure they are close to the people and services they require.
- Merseycare – flagship organisation. However concerns of CC Brindle is that Calderstones would end up with low secure dementia patients who are unlikely to be discharged back into the community. Currently not commissioned to deliver services for patients with dementia – however rationalisation of how this type of service would look in the future is needed.
- People with Learning Disabilities have never had the capacity to consider their future if affected by dementia
- CC Motala asked about governance and accountability – two organisations coming together with two Boards. Clear direction of travel, don't know yet whether this may be subject to public consultation.
- Mark asked for a steer on how the Trust continue to engage with scrutiny for the way forward. CC Holgate asked if the Trust had non-execs on the Board (yes). Demographic makeup of the organisation is largely typical of the local population. Good engagement with service users and they attend Board

meetings. Talking to staff about the future and meeting with them all over recent and coming weeks. Also dealing with the reaction of carers and relatives in light of the CQC report and conversations regarding a merger.

- Need to make sure not creating any unnecessary tension and insecurity
- Not clear when it's a relevant time to discuss next steps with HSC. The Trust just to keep us up to date – Mark to liaise with Wendy.

Dates/topics of future meetings

- 16 March – LCFT update and work planning workshop agenda
- 13 April – Healthier Lancashire programme/NWAS