Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee

MINUTES of the OPEN section of the Health, Adult Social Care, Communities and Citizenship Scrutiny Sub-Committee held on Tuesday 15 October 2013 at 7.00 pm at Ground Floor Meeting Room G02A - 160 Tooley Street, London SE1 2QH

PRESENT:
Councillor Rebecca Lury (Chair)
Councillor David Noakes
Councillor Denise Capstick
Councillor Dan Garfield
Councillor Jonathan Mitchell
Councillor Michael Situ
Councillor Neil Coyle

OTHER MEMBERS PRESENT:

OFFICER SUPPORT:
Dr Amr Zeineldine, Chair of the NHS Southwark Clinical Commissioning Group
Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group
Gwen Kennedy, Director of Client Group Commissioning (CCG)
Dr Roger Durston, GP Clinical Lead for Mental Health (CCG)
Harjinder Bahra, Equality and Human Rights Manager (CCG)
Juney Muhammad, SLaM
Jonna Bish, Pastor
Jacqueline Best – Vassell, Pastor
Janet Kotoka, Pastor
Cliff Bean, SLaM;
Geraldine Walters, Director of Nursing & Midwifery KCH
Jackie Green, Head of Stakeholder Relations, KCH;
Alvin Kinch, Healthwatch;
Sarah McClinton, Director of Adult Care, Southwark Council
Adrian Ward, Head of Performance, Southwark Council
Andrew Bland, Chief Officer NHS Southwark Clinical Commissioning Group
Jill Webb Deputy Head of Primary Care (South London) NHS England

Julie Timbrell, Scrutiny project manager

1. APOLOGIES

1.1 Apologies for absence were received from Councillor Davis; Councillor Coyle attended as a substitute. Councillor Mitchell gave apologies for lateness.

2. NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

2.1 There were none.

3. DISCLOSURE OF INTERESTS AND DISPENSATIONS

3.1 Councillor Coyle declared that he had been invited to join Cooltan Arts management committee, and he intended to take up a position.

4. MINUTES

4.1 The scrutiny project manager, Julie Timbrell, reported that a committee member had questioned the minuting of item 6 and the reference to the number of European users of Guy's and St Thomas' A & E and Urgent Care Centre, and that it might not be accurate to state that there were 'many' patients. It was agreed that this will be checked out with the emergency staff that attended the meeting. The minutes were agreed as an accurate record, subject to this clarification and any amendments necessary.

5. MENTAL HEALTH STRATEGY - SOUTHWARK CLINICAL COMMISSIONING GROUP

5.1 The chair announced that this agenda item and the next two items would be taken together and invited everybody to introduce themselves: Gwen Kennedy, Director of Client Group Commissioning (CCG); Dr Roger Durston, GP Clinical Lead for Mental Health CCG; Harjinder Bahra, Equality and Human Rights Manager CCG; Juney Muhammad, SLaM and local Pastors Jonna Bish, Jacqueline Best – Vassell and Janet Kotoka.

5.2 The chair invited Gwen Kennedy to do a short presentation. She reported that data showed that people with psychosis from BME communities tend to be admitted later, often in crisis and with more complex needs; moreover there is a higher frequency of people being admitted through a Section or via the judicial system. The CCG draft strategy highlighted that better data is needed and will be gathered. She said that one issue is the stigma of mental health and that there is a need to look at the range of risk

factors, as well as models for recovery and early intervention. She reported that the CCG are on a trajectory to agreeing a joint strategy for Mental Health. She added that there are significant financial factors driving the need to make better use of resources, including a growing and older population. She ended by commenting that the BME church pilot is very encouraged.

5.3 Harjinder Bahra explained that he is working nationally to reduce stigma around Mental Health, particularly with Sikh and Muslim communities. He explained that the pilot Black Majority Churches programme is a cutting edge project in London and that Juney Mohammad and delegates from the churches will speak about how participating in the course has increased their awareness and made a difference .

5.4 Juney Muhammad commented they the Black Community is often referred to as hard to reach, however often people find services inaccessible. She added that people's experiences are often difficult and challenging. She referred to Black History Month and the stories of people escaping from slavery and its impact in mental health. She said it is important to acknowledge the traumatic consequences this legacy held for many.

5.5 Juney Mohammad explained that in some communities medicine is seen as oppressive. She emphasized that people from BME communities with psychosis are much more likely to enter the system through coercive means. She referred to deaths in custody and reported that there are high levels of fear. She went on to explain that the programme facilitates difficult conversations about stigma, engagement and people's experience of duress – for example the course explores concerns around 'Sectioning.' Participants are also taught how to recognise signs of distress and there is an emphasis on mental health literacy. She reported that there is under-detection of mental health problems and events to reduce stigma can help. Once completed the participants are clearer where they can help people to access help, for example referral to GPs. She said that some of the course outcomes are about safeguarding. The Victoria Climbe case highlighted that certain beliefs can cause a great deal of harm, for example cultural views about possession.

5.6 She reported that some of the conversations are to do with why people see things differently. The course involves people from a range of religions, including Buddhist and Rastafarian, and that participants are engaged around spirituality, rather than religion. The centrality of faith also allows the people to go beyond prayer - and move to pastoral care.

5.7 The Black Majority Church delegates, local Pastors Jonna Bish, Jacqueline Best – Vassell and Janet Kotoka, then gave evidence.

5.8 .The first delegate commented that she works for SLaM but coming from a faith perspective and participating in the course as a pastor was completely different. She explained that the course allows church leaders to offer and promote primary care as the training enables pastors to improve their ability to support and signpost people. She said that people are now much more open and reported that a new Ministry was born of this training. A member asked if this was just to the congregation and the delegate emphasized that the Ministry had an outward focus and goes out to the community and includes a Food Bank. She said that this is reflected in the name; the

Ministry is called ‘Reach’.

5.9 Members enquired why they thought there was a need for more training and delegates said that one reason was the cultural norm around not airing dirty laundry in public – the ethos can be ‘don't talk, just pray’. They reported that the course allows participants to talk about the issues. A member asked if the emphasis was now on praying and talking and if there had been any assessment of the impact. A delegate responded that the course has been an eye opener and agreed that there is a culture where people are very reluctant to disclose sensitive issues, and confidentially is highly maintained. She explained one of the outcomes has been having an on -call minister; who will contact people who have withdrawn, to establish contact. She added that people are now encouraged to see GPs and refer on appropriately. She emphasized the importance of addressing spiritual sides before anything else.

5.10 Juney Muhammad commented that this is a ten week course, done on a volunteer basis, and then the learning is taken out into the church and community, rather than a professional course with high levels of capacity to measure the impact. Another delegate agreed and said that it increases the ability to recognise the signs and symptoms, to deal with services and effectively sign-post.

5.11 A member asked about the physical health needs of people with mental health problems, and if these were also addressed and commented that it has been reported that one police officer on every shift is needed to deal with people in mental health crisis. Gwen Kennedy reported that when anybody comes to a GP with a mental health problem the CCG is encouraging doctors to undertake an assessment of physical health, so that body, mind and general wellbeing are considered together. She added that the course looks at the whole person. Harjinder Bahra commented that the course promotes early intervention, signposting and looking at underlying issues - going to a doctor can help address all health issues.

5.12 Dr Roger Durston explained that records are kept of all people with mental health needs and there is targeted promotion of the health test with at risk populations. He pointed out that there is a drop in life expectancy of ten years from Dulwich to Camberwell and a drop of another ten years for people with mental health problems.

5.13 A member returned to the question about police time and asked if an investment in this course would lead to less police time being spent on people in mental health crisis. Juney Muhammad responded that police have introduced new processes whereby they record the how much time they are spending on different types of incidences and she thought that this question around the value of preventative work is very pertinent. Gwen Kennedy said that she thought the plan for early intervention would ensure that there are less people ending up in a very disturbed state and at A & E.

5.14 A member commented that he thought it was very exciting to see this soft approach and asked the delegates if this programme could reach more people. The delegates responded positively and explained that they will be working with families to enable people in distress to be better supported and that churches are also making contacts with the police.

5.15 A member asked if officers thought it was better to have separate services or if one

size fits all. Gwen Kennedy responded that the CCG aim to ensure that services are as integrated as possible and that the mainstream health services are accessible as possible. However, she added, sometimes there is also a need for specialist services - whilst progress is being made on making mainstream services more accessible. She ended by saying that given there are more constrained resources there are more limitations on the ability to provide tailored services but the CCG are commissioning for what works, and this will include targeted programmes.

5.16 The chair and committee thanked the officers and pastors for their time and a very worthwhile presentation.

6. MENTAL HEALTH , FAITH AND BME COMMUNITIES

6.1 This item was merged with item 5.

7. REVIEW: PREVALENCE OF PSYCHOSIS AND ACCESS TO MENTAL HEALTH SERVICES FOR THE BME COMMUNITY IN SOUTHWARK

7.1 This item was merged with item 5.

8. FRANCIS INQUIRY REPORT

8.1 The chair welcomed the health commissioners and providers :Cliff Bean, SLaM; Geraldine Walters, Director of Nursing & Midwifery and Jackie Green, Head of Stakeholder Relations, KCH; Alvin Kinch, Healthwatch; Sarah McClinton, Director of Adult Care, Southwark Council and Adrian Ward, Head of Performance, Southwark Council; Jill Webb Deputy Head of Primary Care (South London) NHS England and Andrew Bland and Tamsin Hooton, Director of Service Redesign, NHS Southwark Clinical Commissioning Group (CCG Primary and Community Care strategy). The scrutiny project manager conveyed apologies from Eileen Sills, Chief Nurse and Director of Patient Experience, Guys and St Thomas. The chair invited representatives to provide a short presentation based on the papers circulated.

8.2 A member referred to the reference made to Winterbourne by Sarah McClinton and asked all providers what they did to identify risks in the system, for example staff turnover and levels of staffing. Geraldine Walters, KCH, explained that there are difficulties in assessing appropriate levels of staffing as it depends on the acuity of patients and is complex; she agreed that staff turnover could be useful. The member responded that baseline figures might be needed to assess staff levels.

8.3 A member noted that the representatives from hospitals on the safeguarding board are relatively junior and referred to previous concerns raised by the committee that there were no safeguarding complaints raised by hospitals last year, as reported in the annual safeguarding report. He added that detailed information about complaints would be helpful. Geraldine Walters, KCH, responded that the

representatives from KCH on the safeguarding board are not at her level but they do know the detail and indicated that she would look into the concerns raised about the lack of safeguarding complaints.

8.4 Hospitals representatives' reported that they do send reports on complaints to the CCG and these could be shared. Cliff Bean, SLaM, said the complaints detail is available; however there are issues around confidentiality.

8.5 A member asked about avenues for staff to raise concerns. Staff surveys were referred to. Members commented that there appears to be a bit of a gap between raising concerns and whistle-blowing.

8.6 Members asked Alvin Kinch from Healthwatch if they received complaints. She responded that people don't tend to give Healthwatch complaints - but that might be to do with how Healthwatch pose questions. She commented that Healthwatch work with 'Voiceability', and they provide complaints advocacy.

8.7 Tamsin Hooton referred to the integrated performance report. The chair commented that the committee does currently get a performance report but additional information would be helpful.

8.8 A member asked about monitoring of care home quality and officers commented that the council commissioned rather than delivered care home the day to day work was not as in depth. A member referred to the evidence in the Francis Inquiry that people were sitting on evidence, rather than sharing concerns.

RESOLVED

NHS Foundation Trust Hospitals will be asked for their protocols outlining how staff can raise concerns.

The sub-committee will finalise the report on the Francis Inquiry and circulate.

9. PRIMARY CARE AND GENERAL PRACTICE

9.1 The chair welcomed the health commissioners to the meeting and Jill Webb Deputy Head of Primary Care (South London) NHS England and Tamsin Hooton, Director of Service Redesign, NHS Southwark Clinical Commissioning Group (CCG Primary and Community Care strategy) introduced themselves. They both did a short verbal presentation based on the papers circulated and the project manager promised to forward a slide presentation.

9.2 A member commented on the evidence that people are presenting later in the day

and at A & E. He asked if doctors will be providing services later in the day to meet some of this need. Tamsin Hooton commented that the Call for Action may provide more of an indication that expectations are changing, however she cautioned that places with later access might not have patient records or offer continuity of care. Jill Webb agreed and noted that provision risks being too expensive and also risks duplication. 8am to 8pm opening will be considered in 2014.

9.3 Andrew Bland, Chief Officer, CCG, commented that the focus is on changes that will make the most difference to patients and the biggest issue is still acuity in A & E. Dr Amr Zeineldine, Chair of the CCG, added that the quality, appropriateness and value of the services are also important, and concerns about continuity and patient records particularly apply to walk-in centers. A & E offer excellent diagnostic services but GPs and community care are better placed to manage long term conditions effectively.

9.4 A member referred to constituency concerns and his own experience. He reported that he had to wait between 7-9 days or even 2 -3 weeks for an appointment. He said long waits mean that people use the walk - in centre and commented that he did not think patients should have to wait longer than 5 days. Members added that it is very difficult to get an appointment after 4pm or on Saturday, when there is the biggest demand. Jill Webb commented that some practices are offering extended hours - but this is a quite marginal, rather than uniform, offer. She added that Southwark is comparable for access to other inner city areas.

9.5 There was a discussion on advance -booking and immediate access. It was reported that the former targets that used to monitor 48 hour urgent access and two weeks for a scheduled appointment have been abolished. .Members commented that nowadays people want different types of access and there is more of an orientation towards walk-in. Dr Amr Zeineldine commented that some practices are better at moving resources to meet demand - but this is often a crude process as there are not many resources. He explained that there is an emphasis on managing immediate access for acuity. Jill Webb commented when the evidence for long waits is unpicked there are often other issues which make accessing a doctor harder, for example some patients want to see a preferred doctor within two weeks, rather than the doctor at the practice who is first available.

9.6 A member asked about future planning for surgery buildings and referred to the regeneration of Heygate. He asked if there is a process to get developers and planners to work together. Andrew Bland reported that there is a strategy to get more practices to work together and that the CCG do try to ensure good use of section 106 money. The member asked if there was a plan to make best use in the coming years of the regeneration opportunities and Andrew Bland responded that sometimes the approach has been rather piecemeal, partly because it has been difficult to make forward plans because of uncertainty around phasing. The member assured Andrew Bland that these problems have now been resolved and encouraged the development of a homogeneous plan. Jill Webb commented that given the price of renting property section 106 money is very important for GP practices and Andrew Bland concurred, and agreed to pick up on this.

10. LOCAL ACCOUNT OF ADULT SOCIAL CARE

10.1 This was deferred until the following meeting.

11. REVIEW : ACCESS TO HEALTH SERVICES IN SOUTHWARK

11.1 The updated Terms of Reference was noted.

12. WORK-PLAN

12.1 The work-plan was noted.

13. PAPERS FOR INFORMATION

13.1 The papers were noted.