Scrutiny Committee

ADULTS, WELLBEING AND HEALTH SCRUTINY COMMITTEE

Cambridgeshire County Council

22nd March 2011

Action

56. DECLARATIONS OF INTEREST

Members declared the following personal interests under paragraph 8 of the Code of Conduct:

- Councillors Austen, Heathcock, V McGuire, Read and West as members of Cambridgeshire Older People's Enterprise (COPE)
- Councillor Austen as a family carer
- Councillor Brown as an active participant in Cambridgeshire Local Involvement Network (LINk) and a member of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Councillor Heathcock in relation to agenda item 3 (minute 58) as the relative of a person receiving services from CPFT
- Councillor V McGuire by reason of working for a caring agency
- Councillor Wilkins as an associate member of COPE.

The Chairman expressed the Committee's thanks for all her assistance to Karen Bell, who had recently stood down as Chief Executive of CPFT, and wished her well for the future. He also welcomed Councillor Guyatt to his first meeting as a member of the Committee.

57. MINUTES OF LAST MEETING

The minutes of the meeting held on 1st February 2011 were confirmed as a correct record and signed by the Chairman.

58. MENTAL HEALTH SERVICES 2011 – 14

The Committee received a presentation from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) (attached to these minutes as Appendix 1) and considered a report on emerging themes for CPFT's Business Plan 2011 – 2014. The Committee also considered a report updating it on NHS Cambridgeshire's (the Primary Care Trust, PCT) current commissioning intentions for local mental health services.

Keith Spencer, Director of People and Business Development, CPFT gave the presentation, and responded to members' questions together with Annette Newton, Director of Operations, CPFT, and Cathy Mitchell, Director of Integrated Commissioning, NHSC. In the course of the presentation, members noted that referrals to CPFT had risen by 20% over the last four years, and had also risen by 13% in the current year; CPFT was however paid on a block contract, not on the amount of activity it was undertaking, unlike acute trusts such as Addenbrooke's.

The PCT's Director of Integrated Commissioning explained that NHS Cambridgeshire and NHS Peterborough were responsible for commissioning

mental health services within the provisions of the NHS Operating Framework for 2011/12, which laid down how PCTs must apply efficiencies to providers. The Framework had set an efficiency requirement of 4% and an inflation uplift of 2.5%, resulting in a net reduction in contract baseline of 1.5%. In preparation for GP commissioning, there were GP leads for the Cambridgeshire clusters and a GP lead for Peterborough; GP leads were meeting with CPFT about commissioning intentions.

Examining the presentation and documentation, members of the Committee

- requested CPFT and PCT officers to supply the Committee with information on how Cambridgeshire's level of resourcing compared with that of the family of comparator counties, in view of Cambridgeshire's historic and ongoing low funding base for mental health services — CM, KS
- asked whether Cambridgeshire was spending less per head once a person had been referred to mental health services. The Director of Integrated Commissioning explained that how funding was spent – e.g. a high level of spending on beds - influenced the amount available for each person treated
- noted that the reduction of 36 in-patient beds would remove 10% of current beds; this would take Cambridgeshire from having slightly more beds than comparable authorities to having the fewest adult mental health beds per head of population in the East of England
- noted that the Cambridgeshire system of block grant payment to CPFT was not unusual, because of the difficulty in designing a mechanism for payment by results
- noted that the NHS had moved from a monopoly position to one where greater competition meant that the Mental Health Trust was no longer the sole source of mental health services; for example, a private health insurer could bid to provide preventative work, or an acute hospital trust could tender for work in the community, or CPFT could tender for acute care (not necessarily in the mental health area)
- sought clarification of the basis on which savings had been made. The Director of Operations advised that a detailed review had been carried out, incorporating information from the Joint Strategic Needs Assessment (JSNA). Pathways had then been designed, covering who the services were for, the timescales, the outcomes and the anticipated need for the services; the whole process of identifying savings had been evidence-led
- noted that the aim was to meet the first level of need equitably, based on good practice and on evidence
- expressed some scepticism about Key Priority No 1 (World Class Services) on the basis of a decision by the Cambridge City and South Cambridgeshire PCT some years ago that the Young People's Psychiatric Service, which had been doing world-leading work, should be closed. The Director of Operations assured members that staff aspired to deliver world class services; e.g. CAMEO, CPFT's early intervention services for people with early symptoms of psychosis, had received national and international awards for its preventative work
- queried whether being world class was an appropriate target in some areas, and suggested that it was necessary to be specific about which services were to be world class. Members were advised that it was expected that all services should be delivered to a high standard

- commenting that people were under greater pressure in the current economic climate and that referrals to CPFT had already increased substantially in the current year, asked to what extent the PCT and CPFT would be monitoring referrals both to understand what was happening, and to reflect that in changes to commissioning and adjustments in service provision. The Director of Integrated Commissioning advised that the PCT's GP mental health leads were working with the PCT on its commissioning plans and helping to ensure that there was no duplication of investment; both PCT and GPs were committed to earlier intervention to prevent more serious mental health problems arising
- asked whether there was dialogue with social care services to ensure that there were no unnecessary gaps in provision. The Director of Operations said that there was. She explained that the presentation summary slide on Key Priority No 3 (Service plans and financial stability) had omitted information on steps 2 – 4, between the low and high levels of need at steps 1 and 5. Much work was being undertaken to ensure that care was provided at the lowest level appropriate, and resources were being put in to support work in prevention and self-management at primary care level
- noted that step 1 referred to services for those with mild to moderate mental health needs, and that services in steps 4 and 5, for those with the highest levels of need, were usually the most expensive to provide
- suggested that it would be necessary to include all the steps in the consultation document, with the associated costs and savings for each element, to provide a complete picture of the Business Plan proposals
- queried how effective the proposed new online services would be, given that many mental health patients lacked motivation. Members were advised that these were intended for people with mild to moderate difficulties. Other services would still be provided, such as telephone support, and there was good research evidence for the effectiveness of online services
- in relation to the Criminal Justice Pathway, pointed out that the emerging delivery structure for Integrated Offender Management in Cambridgeshire had acknowledged the benefits of co-locating such services as mental health and police. Members noted that CPFT was already involved in the criminal justice system and would welcome more and earlier involvement
- noted that CPFT did not insist on discharged prisoners being referred to it only through GPs, though the Trust did always try to link the GP into the process; other parts of the criminal justice system, e.g. Probation, could provide a route into mental health services
- asked to what extent people in general could access mental health service without their GP's support, given that some GPs with an old-fashioned attitude to mental health were failing to refer people for mental health services, or to refer them early enough. The Director of Operations said that people could refer themselves direct to primary mental care, and that CPFT sought to identify and work with GP practices that were not referring patients
- commented that patients had in the past had little choice in mental health services and noted that efforts were being made to increase choice. There was already some choice in e.g. whom a person saw, when and where; the use of a personal budget also gave greater choice, particularly in connection with the personal care element

- enquired whether the personality disorder beds had already been established, and heard that the new unit to serve women from Cambridgeshire, Peterborough and beyond was due to open in May, but the beds for men were at the stage of exploration of the business case
- enquired how the £3m savings that the PCT still had to find for 2011/12 could be achieved. The Committee was advised that there was no guarantee this could be done through efficiencies alone; it would be necessary to look at service reductions. A further report would be made to the Committee in May 2011, when the range of proposals under consideration would be clearer. CM, KS

The Committee

- agreed that the scrutiny link members for CPFT would consider the forthcoming CPFT plans
- authorised the Scrutiny and Improvement Officer to respond to CPFT in consultation with these link members before the plans were submitted to the CPFT Board on 25th May. JB

The Chairman thanked officers for their attendance. He reminded them of the importance of providing a complete picture, with fuller evidence, in the final consultation document, so that the public could make an informed response to the proposals.

59. ADULT SUPPORT SERVICES

a) Updated Assessment of Performance Report Action Plan (2009–10) and exception report

The Committee considered a report on the progress being made to respond to the Care Quality Commission's (CQC's) Assessment of Performance Report 2009/10 for Adult Social Care (ASC) Services. As requested at the Committee's previous meeting (minute 47), this took the form of an exception report against the action plan. In attendance to present this and the following report and respond to members' questions and comments were

- Claire Bruin, Service Director: Strategy and Commissioning
- Rod Craig, Executive Director: Community and Adult Services
- Simon Willson, Head of Regulation, Performance and Business Support
- Councillor F Yeulett, Cabinet Member for Adult Social Care, Health and Wellbeing.

The Service Director advised members that three areas for improvement had amber-rated activities (five activities in total), and outlined actions being undertaken to improve performance in these activities. No area for improvement was currently rated red. Discussing the report, individual members

- suggested that the service improvement plan, prepared by the CPFT Social Care Lead to ensure that annual reviews were consistently carried out (area for improvement 10), should be shared with the Committee's mental health link members
- noted that performance in the carrying out of these annual reviews had tended to vary between teams, with even the best-performing teams not hitting the target. CPFT expected to be able to meet the target next year

- enquired how much confidence could be placed in the CQC's assessment, given that it had not commented on the recent budget-driven reform of how ASC was delivered in the county, had not picked up the issue of over-provision and unmet demand in daycare, and had not conducted any fieldwork.

  The Cabinet Member for Adult Social Care reminded members that over the past few years there had been a consistent improvement in the delivery of ASC services, as attested to by the CQC. The Service Director added that work had been carried out to transform ASC over several years, including the start of Self-directed Support in 2008, and increased links to localities and the localism agenda. She advised that in 2010 the CQC had applied a lighter touch to its assessments of all local authorities, apart from those previously judged as performing at a poor or adequate level; in this context, the CQC assessment could be regarded as robust.

  The Executive Director urged recognition for the work that had been carried out to achieve overall judgements of "well" in five of the total of seven areas and "excellent" in the remaining two; were that performance regime still in place, the aspiration would be for two more excellent. Financial constraints meant that work was more focussed than in times of plenty; the CQC had been aware that transformational changes were being planned

- urged that the paperwork demanded of residential care providers be kept as simple as possible, as local feedback suggested that Cambridgeshire's requirements were more bureaucratic than those of neighbouring counties. The Executive Director pointed out that there was a risk that if the paperwork were to be reduced, he would shortly be asked to explain why more had not been done to monitor a home; he would welcome any ideas from providers about how to reduce bureaucracy without compromising proactive monitoring

- asked whether it was part of the appraisal process in nursing homes that the carer should be aware of and involved in the appraisal. The Service Director said that best practice was that a carer should be involved during an assessment, but in individual circumstances, a person might not wish their carer to be involved; that wish should be respected. A member reported a local case where a carer had not been involved, in apparent contradiction of best practice; the Service Director said that she welcomed and needed feedback about where best practice was not being observed, so that she could pursue the matter

- noted that the work to support care home providers in providing end of life care was not intended to turn care homes into hospices, but to ensure support for GPs to give the best end of life care and avoid taking residents out of their familiar surroundings to die in hospital; this aim was supported by having clear end of life plans in place and known to all staff

- enquired how enhancing links and partnership working with neighbourhood panels could contribute to improving the quality of care. Members were advised that this was concerned with the inclusion of people in communities, and encouraging informal support networks. It was in addition to work already undertaken with Age Concern, and formed part of community capacity building. Another member commented that only knowledge of local activity enabled him to understood what was meant in this section; he urged that the wording be made clearer.

b) Reviewing progress against the Integrated Plan 2011–12

The Cabinet Member for Adult Social Care, Health and Wellbeing introduced a report setting out a proposal for how to review the implementation of the County Council's Integrated Plan 2011-12 with regard to the proposed changes for Adult Social Care (ASC). He highlighted the need to focus on delivering the Integrated Plan while mitigating the effect of changes on service users. He welcomed scrutiny engagement in this process, and drew attention to the summary of savings and efficiencies that had been agreed, the key questions to be answered in monitoring the effect of changes, and the importance of feedback and input from users.

The Head of Regulation, Performance and Business Support highlighted the work being undertaken with commissioning managers to develop their performance reports to enable them to talk to providers about performance. He explained that the diagram "Performance Review Model for ASC" showed the range of business intelligence used in the review of performance and to provide early warning of problems.

The Chairman suggested that the Committee at its next meeting might wish to consider establishing an ongoing scrutiny sub-group to work with Adult Social Care. He pointed out that scrutiny's focus would be on actual people and how they were being affected by the changes, rather than on delivering the budget; it would be important to identify where things were not going well, for whatever reason, and to act as a conduit for receiving information. The Cabinet Member welcomed this approach and its use of scrutiny members' expertise to highlight problems and provide information.

Examining the report and proposed performance targets, members

- commented that the whole approach seemed very process-oriented, and asked what the evidence-based approach (paragraph 4.8) meant in terms of knowing about people who were unable to access services.

  The Executive Director pointed out that processes were important because it was necessary to understand such questions as what the activity was, what the outcomes of services were, and what users thought of the services. One reason for engaging the local community was to extend the range of eyes and ears open to perceive problems; social workers and district nurses could not find all potential recipients of social care services.

  In reply to the observation that many city dwellers did not know their neighbours, which made reliance on local networks unreliable, the Executive Director said that it was very rare to find a person's situation deteriorating without anybody being aware of it. If any member heard about such a case, or received increased complaints or concerns about the quality of or access to services, ASC needed to be informed promptly

- noted that the target time taken to complete social care assessments was 28 days (National Indicator 132), but some took more time, some less, depending on the complexity of the individual case

- asked that monitoring of the impact of the reductions made through the Resource Allocation System (RAS) be developed in the next iteration of performance targets; members noted that this was already planned

- suggested that it would be helpful if reports to the Committee could include not only quantitative information but also qualitative information, broadly and systematically gathered. Officers advised that information on quality of outcome was already available in some areas, such as Reablement and the

Community Equipment Service, and that some qualitative information was already being collected by partner organisation; it was necessary to extend the information ASC already gathered and collate the findings from partners

- requested an explanation of the Performance Review Model diagram, suggesting that it should include a sixth point, front-line staff and care providers, as sources of qualitative information, and suggested that it would be helpful to include an explanation of what the various targets in the Performance Measures meant and/or related to.

The Chairman reminded members that the Committee might wish to pick up the suggestion of establishing a scrutiny sub-group to work with Adult Social Care at its next meeting.

60. LIAISON WITH NHS ORGANISATIONS: MEMBERSHIP

Following the discussion at its previous meeting, the Committee again considered the need for changes to the list of link members for NHS organisations used by people in Cambridgeshire.

The Committee agreed:

- that Councillors S Brown and V McGuire would join Councillors King, K Reynolds, and Walker as link members for Cambridgeshire and Peterborough NHS Foundation Trust
- that Councillor Guyatt would join Councillor Archer as a link member for Peterborough Hospitals
- to consider nominations for link councillors to the GP commissioning clusters at a future meeting.

It was suggested that the Scrutiny and Improvement Officer endeavour to establish where to find the meeting papers and other documents for those organisations to which the Committee did not appoint link members JB

61. COMMITTEE PRIORITIES AND WORK PROGRAMME 2010/11

a) Neonatal Intensive Care

The Committee noted that the East of England Specialised Commissioning Group (SCG) had proposed changes to neonatal services in Norfolk, Suffolk, Cambridgeshire and Peterborough. However, the East of England Health Scrutiny Chairs Forum had recently decided that there was no need for these proposals to be subject to scrutiny by a Joint Overview and Scrutiny Committee formed of members of the four local authorities concerned. The Committee had previously nominated Councillors Brooks-Gordon, Kenney and King as members of the joint committee, and Councillors V McGuire and Whelan as substitute members.

The Committee agreed that

- those members nominated to the neonatal joint scrutiny committee form a working group to liaise with the SCG, comment on the plans and on the public and stakeholder engagement process, and report back to the Committee
- the SCG be invited to a future Committee meeting if required to respond to areas of concern arising from the working group's deliberations.

b) Update

At the Chairman's invitation, Councillor Whelan reported on progress with the establishment of a scrutiny review of children's mental health services. She said that she would be chairing a member-led review looking at mental health and repeat offenders; many offenders had mental health difficulties, the origins of which could often be traced back to childhood, and the review would be considering the impact of mental health on criminality.

Membership of the review group would be drawn from three scrutiny committees, Children and Young People (represented by Councillor Johnstone), Safer and Stronger Communities, and Adults, Wellbeing and Health. The Committee was invited to consider which of its members might participate. Councillor Kenney expressed an interest in serving because she had worked on a previous member-led review of child offenders. Councillor S Brown also volunteered to serve. The Committee noted that the group would start its review in the new municipal year.

The Committee considered its priorities and work programme, commenting that its work programme represented recommendations to the incoming committee. It was suggested that it would be helpful if the work of the committee's sub-groups could be included in the programme, because this would make it easier to trace the links between their work and the business of the main committee. The Scrutiny and Improvement Officer undertook to produce a more detailed document for the next meeting. JB

Members asked that the Committee's thanks to the Chairman for all his hard work as chairman over the past two years be recorded.

62. CALLED IN DECISIONS

Members noted that no decisions had been called in since the despatch of the agenda.

63. DATE OF NEXT MEETING

It was noted that the next meeting of the Committee would be held on Tuesday 24th May 2011 at 2.30pm.

Members of the Committee in attendance: *County Councillors G Heathcock (Chairman), S Austen, B Farrer, N Guyatt, S Hoy, G Kenney, S King, V McGuire, K Reynolds, C Shepherd and K Wilkins; District Councillors M Archer (Fenland) S Brown (Cambridge City), R Hall (South Cambridgeshire), J Petts (East Cambridgeshire) and R West (Huntingdonshire)*

Also in attendance: *Councillors P Read, F Whelan and F Yeulett*

Apologies: *District Councillors R Hall (South Cambridgeshire), and J Petts and T Parramint (East Cambridgeshire)*

Time: *2.30pm – 5.00pm*
Place: *Shire Hall, Cambridge*

Chairman