ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Cambridgeshire County Council

19 July 2012

Action

71. DECLARATIONS OF INTEREST

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

- Councillor V McGuire by reason of working for caring agencies as a professional carer.
- Councillor F Whelan as a member of the Mental Health Trust and as a member of the committee of the National Autistic Society for Cambridgeshire.
- Councillor S Brown as a member of the Mental Health Trust.
- Councillors: G Heathcock, P Read, R West and G Kenney as members of Cambridgeshire Older People's Enterprise (COPE).

72. MINUTES OF THE LAST MEETING – 29 MAY 2012

The minutes of the meeting held on 29 May 2012 were confirmed as a correct record and signed by the Chairman.

73. CO-OPTION OF DISTRICT AND CITY COUNCIL MEMBERS

The following District Council representatives were co-opted:

Member	Substitute
T Cornell, East Cambridgeshire	S Willows, East Cambridgeshire

74. MENTAL HEALTH SERVICES FOR YOUNG PEOPLE

The following Officers attended for this item:

Eva Alexandratou, Head of Children's Joint Commissioning, CYPS/NHS Cambridgeshire
Janet Gandolfi, Assistant Director, Children's Divisions, Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)
Stephen Legood, Head of Client Management (CPFT)
Dr Helen Geall, Head of Children, Young PeopleMaternity & Child & Adolescent Mental Health (CAMH) Commissioning,
Claire Bailey, Operational Service Manager, Transitions - Adults Services (CCC)

The following points were made in introduction by the Head of Children's Joint Commissioning, CYPS/NHS Cambridgeshire:

- Mental Health Services for young people had improved recently especially for those in transition.

- Improvement in access had resulted from increased inter-agency working and a whole system approach.
- Contractual arrangements would be clearly defined in future in order that providers were clear about expectations.
- The Operational Service Manager's job focused specifically on supporting transitions.

The following points were raised in discussion:

- This item had been requested to enable the Committee to consider whether gaps between Children's and Adults' Mental Health Services were being addressed. The Chairman asked the panel what the main barriers were to prompt access for young people.

- The Assistant Director replied that the age a client accessed the service could be a barrier, particularly if they started receiving treatment at 16 or 17 years of age, as this could be disrupted when the client transferred to Adult Services. There might not be an adult version of the therapy the client was receiving, and even if there was, the threshold for intervention was higher.

- The Assistant Director estimated that there were approximately 250 clients in transition between CAMH and Adult Services last year, not including those with learning difficulties or those with complex needs. The Head of Children's Joint Commissioning clarified that 250 was not the total cohort of young people receiving Mental Health Services, but referred only to those in transition.

- CYPS Scrutiny Committee had conducted a Member Led Review on Transitions a few years ago and Members had been assured that gaps in provision had been addressed. Members asked what confidence the Committee could have that the situation had improved. The Assistant Director replied that this was a systems-wide issue, for both commissioners and providers. CPFT had restructured *life course pathways* to be flexible and accommodate clients' movement between CYPS and Adults Services.

- Members requested figures on levels of need and were concerned that the panel was unable to supply any. The Assistant Director replied that they dealt with clients on a case by case basis. The Head of Children's Joint Commissioning commented that monthly and quarterly data was now used to hold providers to account.

- The Operational Service Manager reported that the Executive Director (CYPS) Adrian Loades, was sponsoring transitions projects, which involved primary prevention work upstream. It was noted that demand was growing.

- The Head of Children emphasised the importance of preventative work in helping people deal with low levels of anxiety, but this was distinct from clinical need. More information was available to agencies now and they had a new IT system to help manage data.

- One Member queried whether the service was truly patient focused. 14-20 year olds were a vulnerable group and likely to fall through gaps in the system. He queried how clients accessed the service. The Head of Children directed Members to paragraph 2.4.5 of the report, which described how any agency could make a referral through the Multi-Agency Referral Unit (MARU), this included the courts and the

Youth Offending Service (YOS). YOS provided dedicated mental health support.

- The Members recognised that the panel understood there was a problem, but were concerned that they did not yet have adequate solutions in place. The Head of Children's Joint Commissioning stated that services were linking well together, although she recognised that there was a commissioning gap. Early intervention was needed, which might be in the form of community services, rather than from a clinical model.

- One Member related her own experience of accessing services for children with autism, which had been very difficult. Many schools did not use the Common Assessment Framework (CAF), and she was concerned that if access to services depended on use of the CAF, then the process was flawed. The Operational Manager replied that the Special Educational Needs (SEN) Review recommended additional support to schools. The same Member replied that not all children with autism had a statement and a SEN did not necessarily equate with mental health problems. Mental health difficulties could became magnified with the onset of adolescence.

- The MARU gathered all information and pulled it together. There was a gap in capacity with autism in what was commissioned and as a result services were overloaded.

- Members were dissatisfied that the report did not provide detail or map out the direction of travel for Mental Health Services for young people over the next 3-5 years. There was not enough resource or investment into the service and little progress had been made in terms of facilitating transition. Members wanted to know the specific actions taken, explained in layman's terms.

- Members asked whether Members of the Committee might have a role on a working group considering the future direction of the service. One Member feared that when the GP Commissioners took over in April 2013, they just would not have the time to devote to mental health. **The Head of Children's Joint Commissioning replied that the panel would be working on a detailed plan for the next three years, including roles and responsibilities.**

- The Assistant Director commented that GPs had been involved in the strategy to date, and that they too wanted to see better access to mental health services. One Member stated that whilst some GPs might be engaged with the issues, many were not.

- One Member felt that the report should have started by defining transitions and avoided the use of unexplained acronyms. A lower level of knowledge should be assumed and the report structured more simply. The same Member asked who were the 22 specialist clinicians referred to in paragraph 2.4.7 of the report. The Assistant Director replied that they were Systemic Clinicians that worked alongside Children's Social Care staff and were from a variety of health backgrounds e.g. mental health, psychology, social work etc

- **The Assistant Director offered to send the Committee simple publicity materials, which provided a flavour of the services offered.**

- One Member asked whether there was any flexibility for a young person moving from

Children's to Adult Services to continue treatment if they fell just below the Adult Service's threshold. The Assistant Director replied that there was some flexibility if the client was already in the service and that there was now the discretion to waive the threshold.

- One Member stated that those that did not meet the threshold for qualified help might still have a real problem and need support. The Member asked for details of the Privacy and Dignity Standards in acute facilities. Whilst schools should pick up mental health issues these were not always passed on to health professionals. It was very difficult to ensure that a child had a statement, due to the additional costs.

- The Assistant Director agreed that access and identification were problematic and if the point at which clients entered the service was 16 this only exacerbated the problem. Working together more effectively would help, but it did not produce more resource.

- One Member noted the expense of talking therapies which might require an extended time period to take effect. He queried whether the basic problem was simply a lack of resource. The Head of Children stated that whilst extra resource would be good, they were working to do the best they could with the resources that they had, accepting that there might be some gaps.

- One Member asked whether there had been consultation with the people in the system. The Head of Children replied that consultation had been conducted with parents, Pinpoint, Young Lives, Young Minds and trained staff. Clients were also asked at the beginning of their sessions and during treatment for their comments. Specialist support for young offenders was also being commissioned in order that mental health problems could be detected early.

- With reference to paragraph 2.4.3 one Member asked how much support was given from the Cambridgeshire and Peterborough Intensive Support Team (IST). The Assistant Director replied that they were recruiting staff for the IST and the team would consist of a senior nurse and four mental health nurses and support recovery nurses with experience of working with families. This team worked with community teams and aimed to prevent ward admission by providing support at home in a family setting.

- One Member asked for more detail regarding the particular support given to young people in adolescence and the specific clinical support needed for this group. The Assistant Director replied that there was a clear differentiation between child and adult psychiatry. However dialogue between child and adolescent clinicians took place as appropriate.

- One Member contended that more information was needed as regards where the referrals were coming from, how to make referrals and access to services from outside the system.

The Chairman concluded the discussion with the following list of the Committee's concerns:

- The need for a clear definition of *transition.*
- The definition of *systemic clinicians.*
- More detail was requested on the NHS Privacy & Dignity Standards.

- More information was needed on the provenance of referrals.
- The Panel's lack of knowledge of the number of those in the system and requiring clinical support.
- Disappointment that lessons had not been learnt and disseminated since the previous review on Transitions, other than the establishment of a protocol.
- The gap in provision for those with autism, given the high levels of need in Cambridgeshire.
- Insufficient resource for Mental Health Services generally, given the growing demand from wide sectors of the population.
- The role of Committee Members in the development of the strategy and establishing priorities needed to be clarified.
- If informed and capable parents found the system so difficult to access, how would the less able manage?

The Committee accepted that there was good engagement with existing clients, but invited the Panel to return in the near future to cover the concerns outlined above, and provide a Plan covering the next three years. **JB**

75. THE HEALTH & WELLBEING STRATEGY 2012-17

The Cabinet Member for Health & Wellbeing, Councillor Tierney and Dr Kirsteen Macleod, Public Health Registrar (representing the Director of Public Health, Dr Liz Robin) attended for this item. The following points were made in introduction:

- The Shadow Health & Wellbeing Board's vision involved identifying priorities which they could influence.
- The Joint Strategic Needs Assessment (JSNA) incorporated community views and involved consultation with local people; this had also been supplemented by a stakeholder event.
- There was a 13 week consultation on the Strategy between 18 June and 17 September 2012. It was possible to comment online; engagement had been good so far. Following the consultation the Strategy would be finalised and thereafter revised annually. The Strategy built on existing work and included current strategies and plans.
- One key message was to find new ways of working together. The first principle of the Strategy was to tackle inequalities and improve the health of the worst off fastest.
- The key cross-cutting principles of the Strategy were that it was: equitable, evidence-based, cost-effective, preventative, empowering and sustainable.
- The Cabinet Member urged people to respond to the consultation and for Members to encourage other Members, citizens and organisations to respond. The Committee's feedback would be welcomed.

The following points were made in discussion:

- One Member queried the role of the Health & Wellbeing Board, whether it was decision making and whether it could deliver the Strategy. The Cabinet Member replied that at present it was a shadow board and whether it had the power to deliver was still to be determined. The fact that there were lead players from every agency on the Board was significant in itself and he believed that it would have some enforcement power.

- Another Member felt that the report was disappointing in that it said what Members already knew and lacked focus. How the Strategy could be achieved with a reduced

budget was unclear. The Strategy had not included tackling delayed discharges from hospital, which was a key inefficiency. Some of the bullet points in the Strategy were vague and anodyne and lacked impact. The Strategy contained few new ideas, and the emphasis on partnership working should already be happening.

Paragraph 3.3 of the Strategy stated that 10% of the NHS budget (£83.5m) was spent on mental health, which was low considering the extent of the problem. Greater input of resources would also act as prevention.

District Councils could play a key role in prevention, but this was not detailed in the Strategy. Nor was it explained how collaboration with the District Councils and the voluntary sector would work.

The Strategy's first priority of *Ensuring a positive start to life for children* did not square with the Council reducing its budget in youth services and moving from universal to targeted provision.

The Member did not agree that *Supporting older people to be safe, independent and well* should be a priority. Older people's needs were increasing, but maximum resource invested in the young would yield benefit for the future.

The Member felt that priority 4: *Create a safe environment and helping to build strong communities, wellbeing and mental health* was so anodyne as to be almost meaningless.

The Member felt that Mental Health should be a more prominent priority in the Strategy.

The Member regarded primary prevention as key, and although older people would benefit from a more active life, the Strategy did not establish how this would be encouraged.

- The Cabinet Member responded to all these points by stating that the Strategy purposefully avoided detail as it was not a policy document. It was setting out the Strategy from which policies would flow. Provision for mental health was integrated throughout the document. 10% was not the total budget for mental health as prevention was encouraged across the board. He did not agree that resources should be weighted in favour of younger people, as the Council had a duty to all its citizens.

  The Public Health Registrar replied that the exact way the money was to be spent was still to be indentified. Delayed discharge was covered in Section 2 of the Strategy, as was reducing time in hospital. Section 3 focused on preventative intervention, targeted at young people.

- Another Member asked why prevention was not the first priority. He also highlighted that the aspiration to reduce homelessness was one which the voluntary sector and district councils needed to be involved in addressing. He was concerned that this might prove an unobtainable goal for the Health & Wellbeing Board. The Cabinet Member replied that prevention was their aim over the long term. Homelessness could not be ignored and the Council would be working with other agencies to tackle it.

- One Member observed that the fundamental demographic problem was that more and more money was being spent on fewer people. He raised the issue of prison population and mental health, as it was estimated that 60-75% of prisoners had mental health problems and for a proportion of them their offences might have been linked to their mental health problems.

- The Cabinet Member replied that the mental health of prisoners was a national challenge. The issue of crime and offenders would feed into the consultation, in particular how to help offenders back into society. More detail on the Crime Commissioner's role was awaited.

- One Member felt strongly that the Strategy dealt with the symptoms of poor health rather than its causation. With reference to the diagram on determinants of health and wellbeing on page 9 of the Strategy, he stated that if people had jobs, access to transport links and stable families, then it was likely that their health would be good. He queried whether the Strategy was addressing the right questions and considering the structures and contexts that facilitated good health.

- The same Member noted that universal youth provision had been beneficial in integrating those that needed targeted support back into mainstream society.

- The Cabinet Member replied that many of these points related to policy rather than strategy. Tackling employment was too wide a remit to fall within the Strategy and other Groups within the Council were considering the economic context. He queried whether not having a job really did cause poor health. The Council could support people to be robust enough to deal with temporary problems.

- It was confirmed by the Deputy Leader & Cabinet Member for Community Engagement, Councillor Mac McGuire and the Cabinet Member for Health & Wellbeing that reablement had resulted in savings for Adult Social Care and was included in the Strategy**.**

It was agreed that:

- **the Committee's Health Reform Working Group would respond to the consultation on the strategy on behalf of the Committee**

- the Committee would review the Strategy again and Members advised that it should include greater level of analysis and an action plan next time. **JB**

76. UPDATE ON THE DEVELOPMENT OF CLINICAL COMMISSIONING IN CAMBRIDGESHIRE & PETERBOROUGH

The following Officers attended for this item:
Andy Vowles, Chief Operating Officer
Jessica Bawden, Director of Communications and Engagement, NHS Cambridgeshire
David Roberts, GP Huntingdonshire

The Committee noted the following from their update:

- PCTs would be abolished in April 2013. The Clinical Commissioning Group (CCG) would be based around GP practices and local health care groups. The exact configuration was still being discussed, although a shadow organisation had already

been set up with a sub committee. The CCG was currently in the second wave of the authorisation process and a survey of stakeholders had taken place. There would be a site visit in September/October and a decision in November regarding authorisation. The CCG would cover Cambridgeshire, Peterborough and parts of Northamptonshire and Hertfordshire near the Cambridgeshire borders.

- The CCG would link to Local Commissioning Groups (LCGs) and aimed to be as close to local citizens as possible.

- The CCG would have eight GP members, plus the Director of Public Health. Dr Neil Modha would be the GP Accountable Officer and would be meeting the shadow CCG shortly. The CCG's governing body would be elected from its membership.

- The shadow governing body was working on the vision and values of the CCG in order to set some early priorities. These priorities would include care for frail older people, improving the end of life by helping more people die in an environment of their choosing and tackling health inequalities, especially with regard to coronary heart disease.

The panel members stated that they could be available to provide the Committee with regular updates over the next 6-9 months.

The following points were raised in response:

- One Member asked whether the Officers were working with Patient Groups with regard to commissioning priorities. The Chief Operating Officer replied that they had informed them of both interim and long term commissioning priorities. LCGs had lay members on their boards, and the Patients' Reference Group chaired by lay members fed into the CCG.

- Doctors' practices should publicise their patient representative on their notice boards and via their websites.

- The Chief Operating Officer predicted that small bodies and the umbrella CCG would produce more efficiencies that the PCTs. Under the new model care and commissioning could be devolved to the most appropriate local level.

The Committee requested regular updates as plans took shape.

JB

77. ADULT SOCIAL CARE: REVIEWING PROGRESS AGAINST THE INTEGRATED PLAN

The following people attended for this item:
Councillor Martin Curtis, Cabinet Member for Adult Services
Adrian Loades, Executive Director CYPS
Claire Bruin, Service Director: Adult Social Care

The Cabinet Member for Adult Services reviewed progress made over the last year, as follows:

- The £2.3m overspend of 2011/12 should be seen in the context of £22m of savings made in Adult Social Care. In 2012/13 the aim was to find £3m of savings.

- Arrangements with Cambridgeshire Community Services (CCS) could be made more robust and CCS needed to prove itself capable of meeting growing needs.

- The census predictions for the next 10 years showed demographic pressure increasing as the proportion of the population over 65 would become nearly one third and the number living to over 90 would increase. The Cabinet Member observed that society had been reacting to changing demography for the last 100 years.

- The Leader of the Council, Councillor Nick Clarke had given a speech at the Local Government Association (LGA) challenging the Government to tackle the growing demands on adult social care. Cambridgeshire County Council aimed to be at the forefront of change and was prepared to forge ahead, rather than wait for national legislation.

- The Council would be making reablement a first option for a client's care, thereby simultaneously making savings and improving lives. Through social work, individuals' environments and long term care could be improved. The Executive Director led a team that was convinced of the need for change.

- The Older People's budget was overspent by £3.5m at present.

- The Cabinet Member believed that, all things being equal, they could balance the budget this year.

The following points were made in response:

One Member asked what would be the implications for the Council's pension obligations if staff who had been TUPEd to the NHS were received back. The Executive Director agreed to check this point. **AL**

One Member was concerned that the Council might be relying too heavily on reablement to reduce costs. He asked whether Personal Budgets had been widely taken up. The Cabinet Member believed that the message of Personal Budgets was being disseminated successfully.

One Member asked where unidentified savings would come from in future years. The Executive Director replied that this was work in progress, but there were a number of options that could yield savings: through the use of the independent sector, reviewing contracts, driving down the cost of the residential market, prevention, social work, identifying risk earlier through GPs and considering the health system as a whole. The Cabinet Member added that it was also important to use money to support carers in order that there were less carer breakdowns.

One Member asked whether the Council's plans were innovative enough and suggested that family based community caring be considered as it could improve quality and reduce costs. The Cabinet Member replied that it was one of their aims to build capacity in families and they would look at the issue of voluntary carers.

One Member asked about the quality of services supplied by the agency Crossroads and whether it was doing what other agencies could not do. The Cabinet Member replied that the contract had been won by Crossroads and they had a good national reputation. Crossroads specifically supported family carers.

The same Member asked whether clawback meant that a client might receive a bill they were not prepared for. Clawback related to direct payments and was only taken when not all the money received as a direct payment had been used. The Council would review spend with the client and write to them if they had an under spend. The client provided the information so they should be aware of the situation.

One Member queried how there had been a surplus in the Supporting People budget. The Executive Director replied that the surplus had accumulated, partly from when the service had been grant funded, but that an over spend was expected in 2012/13.

There was now a statutory requirement for Adult Social Care to work with housing authorities to meet needs appropriately.

One Member noted that over £20m savings had been made last year and that this was a huge achievement for a needs led service. However he questioned whether the service was overspending because it was not being realistic regarding the resources required in the first place. The Cabinet Member replied that predictive modelling had been applied, but there was no more money. However he believed that more could be done to reduce costs, even though demographic pressures were working against them. The Council would be working with Addenbrookes and the CCG to make the whole sector work more efficiently.

The Member asked whether the first priority was to meet needs or balance the budget. The Cabinet Member replied that it was to meet needs; however preventative work would be better for people and for the public purse.

78. MEMBER WORKING GROUPS & LIAISON ARRANGEMENTS

The Chairman asked the Committee Members if they wanted to make any changes to the Member Working Groups and liaison arrangements listed in the report. It was noted that the Committee would be involved with the CCG in its transitional stage and its implementation. Some Members of the Committee would be meeting Dr Modha shortly to discuss the working relationship. The following points were made:

Councillor Batchelor agreed to join the CCS/NHS Trust liaison group.

The Committee noted that some liaison arrangements with NHS organisations might need reactivating. It was up to the liaison member to attend their board meetings if they wished to do so.

- Councillor Cornwell offered to assist Councillor Hoy as a liaison member to the Queen Elizabeth Hospital, King's Lynn.

- The Health Reform Working Group was meeting on 31 July to respond to the Health & Wellbeing Strategy and Government draft regulations on scrutiny powers. Draft responses would be circulated for comment.

79. FORWARD WORK PROGRAMME

a) Committee Priorities and Work Programme

The Committee agreed to add the following to their work programme:

- Mental health and offenders including those in local prisons (it was noted that the Howard Leagues and the Prison Reform Trust were good sources for information).
- Young people and mental health
- The role of voluntary carers (It was noted that Anglia Ruskin University students were conducting an investigation regarding why carers did not engage with the Council – the response was awaited).

b) **Cabinet Agenda Plan**

The Committee noted that the Joint Health & Wellbeing Strategy for Cambridgeshire was on the Cabinet agenda for 23 October 2012.

80. CALLED IN DECISIONS – THERE WERE NONE

81. DATE OF NEXT MEETING

The next meeting on 12 September 2012 would be **held at the earlier time of 10am with a 9.30am pre-meet.**

Members of the Committee in attendance: County Councillors K Reynolds (Chairman), J Batchelor, N Guyatt, G Heathcock (substituting for Cllr Austen) G Kenney (Vice-chairman), V McGuire, P Read (substituting for Cllr Hutton), P Reeve, P Sales, S Sedgwick-Jell, F Whelan; District Councillors S Brown (Cambridge City), M Cornwell (Fenland), R Hall (South Cambridgeshire) and R West (Huntingdonshire)

Apologies: County Councillors: S Austen, C Hutton
Also in attendance: County Councillors M Curtis, S Tierney

Time:10.30h – 13.25h
Place: Shire Hall, Cambridge

Chairman