Buckinghamshire County Council

Minutes **Overview & Scrutiny Committee for Health**

AGENDA ITEM:

MINUTES OF THE MEETING OF THE OVERVIEW AND SCRUTINY COMMITTEE FOR HEALTH HELD ON FRIDAY 20 DECEMBER 2002, IN MEZZANINE ROOM 3, COUNTY HALL, AYLESBURY, COMMENCING AT 9.50AM AND CONCLUDING AT 12.00PM

MEMBERS PRESENT

Buckinghamshire County Council

Mr M C Appleyard (Chairman)
Mrs P Bacon, Mr M Colston, Mrs P Wilkinson and Mr H Wilson

District Councils

Mrs E M Lay	Wycombe District Council
Mr G Smith	Aylesbury Vale District Council
Mrs M Hamilton	Chiltern District Council
Mrs J Woolveridge	South Bucks District Council

Others in attendance

Mrs J Hunt	Vale of Aylesbury Community Health Council

Officers

Mr R Edwards
Ms J Hall
Mrs C Capjon

APOLOGIES FOR ABSENCE/CHANGES IN MEMBERSHIP

Apologies for absence were received from Mr C Jones, Julia Wassell and Mrs J Kverndal.

DECLARATIONS OF INTEREST

1 MINUTES

The minutes of the meeting of the Overview and Scrutiny Committee for Health held on Friday 29 November 2002, copies of which had been previously circulated were confirmed subject to the adding of Mrs G Smith to the Members Present.

2 THE COMMUNTIY CARE ALLIANCE

The Committee welcomed Barbara Poole of the Community Care Alliance to the meeting.

Barbara Poole explained how the Community Care Alliance (CCA) interfaced with Health and Social Care. It was noted that membership was open to all voluntary organisations throughout Buckinghamshire with an interest in Health and Community Care. She explained that the organisations affiliated to the CCA provided much of the preventative and support work to both Health and Social Care.

Barbara explained that the CCA viewed the Overview and Scrutiny Committee for Health (OSCH) as an opportunity to develop links between Social Services and Health, to support concerns being raised regarding the focus on acute care to the detriment and underfunding of community services and ensure that social care was not lost within the Health agenda.

Barbara highlighted the lack of feedback resulting from various consultations and hoped that the OSCH would ensure that future results were fed back. A member responded that often consultation was not wide enough and did not include 'hard to reach' groups. This comment was confirmed by the CCA who felt that existing organisations could be used more effectively and the CCA could assist in sign-posting hard to reach groups as the organisation had vast experience of consultation and public patient involvement. Barbara also referred to the draft regulations pointing out that OSCH was required to ensure consultation was communicated appropriately and felt that the CCA was a service that could assist in this area. Referring to organisations with responsibilities for consulting, the committee were reminded of the Locality Forums who were jointly funded by Health and Social Care via the Partnership Development Fund (PDF).

Barbara outlined ways the organisation felt they could assist the committee in its future work programme through:

- Reaching individuals and groups
- Providing the committee with questions that needed to be asked
- Ensuring that a CCA representative attended future meetings
- That the OSH was an agenda item on each of the CCA meetings
- Setting up of an email consultation and information group

Barbara reported that the CCA experienced difficulty engaging with Health and Social Care and contributing towards specific pieces of work, particularly with planners. In response the Chairman suggested that the CCA should contact the relevant PCT who had direct access. He continued that the OSCH needed to clarify routes of communication and highlight to the County Council and District Councils the need to provide information to PCTs at an early stage. A member reported that District Councils often had representatives on Focus Groups who consulted with Planners about developments that affected access to care and this may be an area for the CCA to become involved through co-option.

During discussion members recognised that with the significant residential developments, particularly in Aylesbury Vale, District Councils needed to work closely with the PCTs to ensure that Health needs were met. It was suggested that a model, defining public services and facilities in communities, would assist partners with the process.

The committee discussed the new public and patient involvement that was required under section 11 of the Health and Social Care Act. Barbara reported that as an organisation they were aware of the requirements but raised concerns on how best to reach the public, she reported that to ensure public patient involvement was successful, it needed to be properly resourced. She highlighted that the work of the TAB had identified that resources were limited.

The Chairman thanked Barbara Poole for attending the meeting noting that a number of issues had been raised that the Committee needed to further investigate.

3. BUCKINGHAMSHIRE MENTAL HEALTH TRUST – KEITH NIELAND, CHIEF EXECUTIVE

The Committee welcomed Keith Nieland, Chief Executive, Buckinghamshire Mental Health Trust. Keith gave an overview of the Buckinghamshire Mental Health Trust outlining:

- Work of the Trust
- Achievements this year
- Strategy for the future
- Budget

The Trust offered a mental health service to most parts of the Buckinghamshire County Council area and provided forensic mental health care within prison settings.

The Committee noted that one in seven women and one in nine men suffered mental health problems. He also reported that most mental health work was carried out by GP's and the Trust provided specialist services that could not be provided by GP's. He reported that alarmingly the number of children and young adolescents suffering with mental health problems was increasing

whilst the age was decreasing; children as young as eight were on long-term medication for mental health problems

The Trust currently employed 2,500 people. As with most health care providers, it was suffering with recruitment and retention problems. He reported that recruitment and retention varied across Buckinghamshire, but the further south in the County the problem became worse.

Keith reported that over 12 months, 2,000 in-patients were seen at Tindal and Haleacre and care was provided for 61,000 patients in outpatient's settings, and made 80,000 community visits.

A number of initiatives had been set up to achieve better outcomes by:

- Providing care at a place of the patients choice
- Reducing the length of stay in hospital settings
- Improving links with education and employers

Benefits were now being seen through the Integration Agreements with health and social care staff sited together ensuring that patients were less likely to fall through the net.

It was further reported that pressures were being experienced with children and the complexity of their needs was increasing. Although not nationally recognised, clear evidence highlighted that children coming from broken homes were more likely to experience mental health problems. Work was being undertaken to teach children strategies to deal with mental health problems. Often, by the time a child was presented to the Mental Health Trust it was difficult to make any long-term improvements to health.

Work was being undertaken with the Courts in High Wycombe to direct and signpost offenders through the Court Diversion Scheme.

Finance

Keith reported that there were two overwhelming priorities in mental health

1. Access to acute general hospitals
2. The financial balance.

Keith reported that the pressures on financial balance were great and that health had always been focussed on achieving acute hospital targets.

Strategy

The model for mental health in Buckinghamshire, although designed 20 years ago, was implemented 10 years ago at which time Bucks was seen as leading edge. Buckinghamshire was the first Authority to close asylums and develop community based care through network homes, and development of day centres.

In parts of Buckinghamshire further work was needed with partners to address the lack of choice for patients. A number of initiatives had been set up including Assertive Outreach, Crisis Services providing 24 hour emergency care and Early Intervention which all need investment. The Trust was also involved in negotiations with the PCT to develop the Learning Disability Partnership and develop and implement the new strategy.

Studies had shown that providing community support in a setting of a patient's choice resulted in a much quicker recovery rate. Therefore, the Trust's aim was to invest in the community aspect and provide more community workers and settings whilst reducing mental health beds.

Keith reported that of the majority of patients treated, two thirds either got better or were maintained. It was noted that by looking at the indicators a lot of patients came from broken homes, step families or families on a low incomes. Of the increase of children with mental health problems, he reported that the wider community needed to be engaged in order to help children deal with stress to avoid greater mental health problems in later life.

During discussion a member asked for further clarity on how mental health was identified, in response, it was noted that mental health referred to lifestyles that began to alter and behaviour that indicated the individual could not cope. He reported that GP's used a number of initiatives and that generally the benchmark was when an individual's chosen lifestyle began to break down.

A member commented on identifying the real gains, as he recognised that many mental health areas were difficult to address. In reply it was noted that gains were identified by knowing that if care in the environment of the patients choice could be provided they recovered much more quickly and by ensuring the patients either returned to work or found employment, that they were less likely to relapse. Referring to the Buckinghamshire Project as evidence of this success, it was reiterated that investment in lunch clubs and day centres, provided an essential lifeline.

In response to comments regarding substance misuse it was noted that Drugs Advise Team (DAT) worked hard to address these issues and had identified funding for further work.

In response to comments on the provisions available for under 16's, it was reported that the Mental Health Trust provided therapeutic counselling services. It was suggested that the service provided by Education was not always appropriate; this comment was reiterated by the representative from the CHC who reported that through community work that had been undertaken with young people, counselling from teachers and peers was not always appropriate. It was noted that more resources were needed to empower young people to 'self help' and treat themselves.

A member commented on the more severe mental health cases, i.e paranoia, schizophrenia and the small percentage who become violent. In response it was noted that mechanisms were in place to identify patients who were potentially at risk through not taking their medication appropriately. It was

also highlighted that health care professionals continuously worked on risk assessment prior to patients leaving hospital. These included assessments for violence, self neglect (which was a bigger problem than violence). Patient's support in the community was based on continuous risk assessments and part of the skills of health care professionals was to recognise these signs. He reported that the suicide rate in Buckinghamshire was below that of the national rate and that 3 out of 5 people who self harm were not know to Mental Health.

In response to comments on early diagnosis and early preventative work it was noted that further work was needed on social inclusion. One of the benefits of the Integrated Agreement was to acquire funding from different sources for more schemes.

In response to comments on the links between Mental Health Trusts, DAT and other drug organisations it was noted that a lot of pressure was being put on resources to be moved from drug misuse into the criminal area. The Sefton Project in High Wycombe, run by Stephen Dye and the Community Health Team, provided a detox service for drug and substance misuse patients.

In response to comments on recruitment and training Community Nurses, it was noted that there was a chronic shortage of Mental Health Nurses and Health Care Professionals. Nurses generally preferred to work in community settings developing relationships with patients. The Trust had found it easy to recruit to the community posts and work was ongoing with the Development Agency who were responsible for recruitment in to health care.

Keith reported that recruitment of younger people was an added problem, and the NHS was addressing the skill shortage and unfilled vacancies by reconfiguring and combining the skills of others for specific health care posts and looking at other models to adopt. He reported that the worst outcome for mental health would be that due to a lack of staff, patients would be forced back into hospitals.

In response to comments on resources and financing mental health, Keith reported that since the late 1970's the emphasis had always been to look after the acute side of health care. In Buckinghamshire investment in Mental Health Services had been under 11%. He continued that this was the first time health had known the funding being received over the medium term (3 years) and the emphasis was for investment in mental health in years two and three. Keith continued that the new funding system enabled long term planning and was good news for health. In response to comments on the financial position of Mental Health it was noted that in order to achieve financial balance, the service would need to be reduced to its core, treating only patients under the Mental Health Act. It was noted that the Trust's aim was to increase community alternatives and look at alternative models to provide care. The representative from the CHC reported that parts of the Thames Valley Strategic Health Authority, Oxfordshire, in particular, had eaten up resources in the acute sector. It was noted that Oxfordshire as part of the TVSHA was a problem and the John Radcliffe was forecast an end of year deficit of between £14 and £20 million pounds (half of the total Thames Valley deficit). Keith

reported that the TVSHA did understand Mental Health and realised that extra resources were needed.

The Chairman and Committee thanked Keith Nieland for the interesting presentation.

4 UPDATE ON HEALTH OVERVIEW AND SCRUTINY

Roger Edwards reported that the guidance, giving powers to Local Authorities to scrutinise health, had been delayed and were expected in February 2003.

Guidance on patient and public involvement was expected later in 2003. It was reported that the setting up of Patients Forums was crucial to the Committee for the development of the work programme. Until the Patients Forums were set up, the CHC would continue. In response to comments regarding the work of the CHC being picked up by Patients Forums the representative reported that the CHC's were busier than ever due to the changes in NHS service provision. She explained that the Aylesbury Vale CHC was currently piloting a Patients Forums.

It was also reported that the Department of Health had indicated that some money might be available to provide support to Overview and Scrutiny for Health. This was still unconfirmed.

The Chairman thanked Margaret Hamilton, who, under the regulations was now unable to sit on the Committee, as she was an executive member of the District Council, for her contribution to the Committee.

5. DATE OF NEXT MEETING

Friday 31 January 2003 at 10.00am in Mezzanine Room 3.