Minutes

HEALTH AND SOCIAL CARE SELECT COMMITTEE

21 March 2023

Meeting held at Committee Room 5 - Civic Centre

	Committee Members Present: Councillors Nick Denys (Chairman), Philip Corthorne (Vice-Chairman), Tony Burles, Reeta Chamdal, Darran Davies (In place of Alan Chapman), June Nelson (Opposition Lead) and Barry Nelson-West **Also Present**: Clare Byrne, Divisional Nurse for Acute Medicine and Governance in Unplanned Care, The Hillingdon Hospitals NHS Foundation Trust (THH) Evelyn Cecil, Head of Adult Mental Health Services, Hillingdon Mind Amanda Erasmus, SENCO, Uxbridge High School Alison Foster, Deputy Head and Deputy Designated Safeguarding Lead, Vyners School Therese Glynn, Director of Services, Centre for ADHD & Autism Eamonn Katter, Deputy Chief Operating Officer, The Hillingdon Hospitals NHS Foundation Trust (THH) Councillor Jane Palmer, Cabinet Member for Health & Social Care Lisa Taylor, Managing Director, Healthwatch Hillingdon Sandra Taylor, Executive Director of Adult Services and Health, London Borough of Hillingdon Katrina Warkcup, Emergency Department Matron, The Hillingdon Hospitals NHS Foundation Trust (THH) Summer Wessels, Deputy Designated Safeguarding Lead and Senior Mental Health Lead, Douay Martyrs School **LBH Officers Present**: Nikki O'Halloran (Democratic Services Manager)
70.	**APOLOGIES FOR ABSENCE** *(Agenda Item 1)* Apologies for absence had been received from Councillor Alan Chapman (Councillor Darran Davies was present as his substitute).
71.	**DECLARATIONS OF INTEREST IN MATTERS COMING BEFORE THIS MEETING** *(Agenda Item 2)* There were no declarations of interest in matters coming before this meeting.
72.	**MINUTES OF THE MEETING HELD ON 21 FEBRUARY 2023** *(Agenda Item 3)* **RESOLVED: That the minutes of the meeting held on 21 February 2023 be agreed as a correct record.**

73.	**EXCLUSION OF PRESS AND PUBLIC** *(Agenda Item 4)* **RESOLVED: That all items of business be considered in public.**
74.	**CAMHS REFERRAL PATHWAY - SECOND WITNESS SESSION** *(Agenda Item 5)* The Chairman welcomed those present to the meeting. Ms Amanda Erasmus, Special Educational Needs Coordinator (SENCO) at Uxbridge High School (UHS), noted that 5.9% of children at UHS were on the special educational needs register and that most of these were in relation to mental health issues. She advised that the school had started to refer children to Child and Adolescent Mental Health Services (CAMHS) during the Covid pandemic and that, over time, good relations had been built with the staff and therapists there. UHS had referred 28 children to CAMHS over the last two years, five of which had been accepted. Where the children were not accepted, the school had received a letter detailing possible alternative pathways, such as SEND Advisory Service which had been helpful but which was not always that straight forward. The letter would be quite brief in terms of the availability of alternative support and schools would often not know the full range of services that were available to help young people so would just use the ones that they did know about. Schools provided the support that they could to young people but they were not mental health specialists. Members were advised that exclusion was avoided where possible and measures were put in place in schools to support the child. Mental ill health would not lead to an exclusion but would instead prompt interventions such as a personalised timetable. For ADHD, UHS worked with Screening, Assessment and Support Services (SASS) and the Behaviour Support Team to support the child so that the situation rarely ever resulted in exclusion. Ms Erasmus stated that, when the school contacted CAMHS, they did receive a response and that UHS attended meetings with the child, their parent and the psychotherapist. She also noted that the school had been chosen as one of two pilots in the Borough to work with the Mental Health Support Team whereby three mental health support workers came to the school for two days each week to work with 50 young people on issues of worry, low mood, anxiety, etc. Supporting this low level mental health need through early intervention meant that it was much easier to manage. Ms Summer Wessels, Deputy Designated Safeguarding Lead and Senior Mental Health Lead at Douay Martyrs School (DMS), advised that the school had had a positive experience with CAMHS but that, as an educational establishment, it did not expect to have to make referrals to CAMHS. Where a mental health issue had been suspected, the school had asked the parents to take the young person to see their GP who would then be able to make a referral to CAMHS. If the GP refused to make a referral to CAMHS and school believed that there was enough evidence, the school would make the referral itself (DMS had made five referrals to CAMHS in the last two years and all of them had been accepted). Where the referrals made by the GP were refused by CAMHS, DMS might ask the GP for sight of the information that had been provided to CAMHS as part of the referral. These referrals did not always include all of the information that CAMHS needed to be able to make the best assessment which was why the young person might not have been accepted.

Ms Wessels noted that the staff at CAMHS were hard working, always attended meetings and usually responded to emails within a day but the service appeared to be stretched. The wait for therapies could be long so DMS had set up its own Place To Be scheme and employed a counsellor for one day each week and would advise CAMHS when these interventions were in place so that they could be phased out when the CAMHS therapy started. The school also had a pastoral support team in place and mental health first aiders as support still needed to be in place for these young people even before they had had a CAMHS diagnosis as they were still having to go to lessons every day.

It was noted that students at DMS had said that they did not want to use Kooth as they were required to sign up for the service and they were put off by the fact that they could be identified (some young people might not want anyone, including their parents, to know that they were experiencing mental health issues). The school had not had any contact from Kooth for over two years until recently. Preventative services seemed limited or were not well advertised and no literature or posters had previously been shared with DMS to help promote Kooth to the students.

Members were advised that CAMHS provided a Single Point of Access. However, young people at DMS had complained that their calls were not always being picked up and had been left unanswered, and sometimes the calls went through to adult services. This facility did not seem to be as accessible or available as parents and young people needed. Ms Wessel also noted that the performance of the Mental Health Support Teams had been disappointing as they did not reply to emails and did not answer the telephone. It had been suggested that, as DMS already had interventions in place, the school was not likely to get any more support even though the school had had to use its education budget to provide this support for its students.

Ms Alison Foster, Deputy Head and Deputy Designated Safeguarding Lead at Vyners School (VS), advised that the thresholds could be quite confusing as there were times when the Multi Agency Safeguarding Hub (MASH) advised the school to make a referral to CAMHS and it was rejected. There had also been times when the school had made a referral to CAMHS, not necessarily expecting it to be accepted, and it was accepted. The school nurse at VS would often bridge any gaps and chase up CAMHS for a response when needed. It would be useful for the schools to receive feedback on why a referral was not accepted and to be provided with clinical signposting elsewhere.

Ms Foster noted that referrals from GPs were often unsuccessful but that there was a lot of free help available to parents and young people. Parents often wanted to know if there was something clinical going on with their child which was why they would request a referral to CAMHS (to rule out ADHD and autism spectrum disorder (ASD)). However, it was recognised that children needed to be taught coping mechanisms to deal with regular things like the stress associated with exams rather than just labelling those feelings as mental health issues. The approach was currently a little piecemeal so better signposting for self-help was needed.

Ms Therese Glynn, Director for Services at Centre for ADHD and Autistic Support (CAAS), advised that CAAS saw itself as a preventative service. CAAS had received feedback from parents about the services provided and their experience of their GP making a referral which was then rejected without providing the reasons as to why the referral had not been accepted. Signposting parents to other services would be helpful whilst they waited for an assessment or when a referral was rejected.

It was noted that, if there was a possible diagnosis of mild to moderate ADHD, parents were encouraged to follow NICE guidelines and undertake a training course (which included psychoeducation) before their child was diagnosed (CAAS did provide such courses but the places were limited). Alternatively, if the ADHD diagnosis was likely to be moderate to severe, parents were encouraged to attend a course covering behaviour management before the child was prescribed medication. However, there were times where the parents were unable to get on an appropriate training course in a timely fashion (or there were other complications such as transitioning to secondary school) which could mean that they were waiting up to two years which caused additional anxiety for the children and the parents. Rather than just following NICE guidelines, Ms Glynn suggested that the system needed to be looked at on a case-by-case basis.

Ms Glynn noted that the age of referral to CAMHS appeared to be increasing – a child used to be able to be referred at five years old but this had increased to seven years old. When a parent received their first contact letter with an appointment date, they were often under the impression that this would be for the child's assessment whereas it was usually to triage the child. There also appeared to be some frustration when children and young people were passed between the Child Development Centre (CDC) and CAMHS so it would be good to get some clarification on how this was supposed to work.

Ms Glynn advised that, whilst it was difficult for English speaking parents and children to navigate the system, it was particularly challenging for those who had English as a second language to understand the processes so they needed additional support. She noted that, once the child had been seen by CAMHS, they were usually very happy with the service. The parents understood that the process could take time and they were happy to wait but they needed to be given information on what services they could access in the interim.

Members were advised that there were many families that did not know about the services provided by CAAS but who would benefit from them to prevent their child's mental health from deteriorating during their wait for CAMHS. The organisation supported mental wellbeing rather than providing mental health services and was not equipped to deal with things self-harm. CAAS had built good relations with schools in Hillingdon.

Ms Evelyn Cecil, Head of Adult Mental Health Services at Hillingdon Mind, advised that the organisation had recently started the Hillingdon Young Adult Project (HYAP) to provide support to 25 young people aged 16 to 25 with mild to moderate mental health needs. There had been a lot of concern expressed regarding the long wait that young people had been faced with whilst waiting for CAMHS with little support whilst they waited. Concern had also been expressed about the lack of support that had been available for young people transitioning to adult mental health services and the possibility that their mental health could deteriorate further in the interim. Clear signposting to support was needed for these young people to address the confusion that existed about what was actually available.

Ms Cecil advised that HYAP provided a range of support including 121 work and holistic social worker assessments, as well as signposting and referring to other services. A directory of support had been put together for young people up to the age of 18 which included arts therapy. When they reached 18 years old, adult services such as counselling and therapeutic support would also become available to them.

Hillingdon Mind helped these young people to navigate their way to the most appropriate support services.

Mr Eamonn Katter, Deputy Chief Operating Officer at The Hillingdon Hospitals NHS Foundation Trust (THH), advised that CAMHS patients arrived at Hillingdon Hospital's Accident and Emergency (A&E) department in the same way as any other patient (ambulance, walk in or escorted by the police). When the young person had been identified as being under 18 with a mental health condition, CAMHS was contacted. During the day, a member of the CAMHS team would arrive within an hour to undertake an assessment in parallel with a physical health assessment (there would be a slower response time at night as there were fewer CAMHS staff working and they covered other NWL boroughs). The patient would then exit through a planned CAMHS pathway and could be discharged from CAMHS once a diagnosis had been made.

Ms Katrina Warkcup, Matron of the Emergency Department (ED) at THH, advised that a young person presenting at A&E might have taken an overdose so CAMHS would need to wait until they had been medically cleared before they could undertake a mental health assessment. Once the assessment had been undertaken, the child might not be admitted but might need to have a cooling off period, which could be challenging for the hospital. Those aged under 16 could be taken to paediatric A&E (where it was relatively quiet and calm), usually accompanied by a parent, and those aged over 16 would have to stay in A&E (where it could be noisy and busy and not at all calming) to cool off before CAMHS would come back. If the young person left the hospital before they were discharged, the hospital would contact the police and social care to get a welfare check completed.

If the child needed to be admitted, the CAMHS team would make a decision as to what type of bed was needed. If there were no specialist Tier 3 or 4 beds available, those aged under 16 could be taken to the children's ward at Hillingdon Hospital (as long as they were not a risk to the other children on the ward) where staff such as a play specialist would be available to offer suggestions and ideas for support. Ms Clare Byrne, Divisional Nurse for Acute Medicine and Governance in Unplanned Care at THH, advised that those aged 16-18 would be taken to an adult ward at the hospital where they would be put in a side room with a mental health nurse. A meeting would be convened to agree a plan for where the young person needed to go next.

Ms Byrne noted that Central and North West London NHS Foundation Trust (CNWL) and CAMHS were very responsive but the issue of young people who had a social care need but no physical or mental health need, had to be addressed. Ms Warkcup advised that parents of children with mental health issues often turned up at A&E as they were at the stage where they didn't know what else to do and needed the hospital to make an emergency CAMHS referral.

Although additional mental health beds would address the issue of not enough beds, it was not in every child's best interest to be admitted. Mr Katter suggested that a new separate mental health crisis centre was required to meet young people's mental health needs rather than presenting at A&E. Alternatively, adequate resourcing was needed to include a crisis space for young people in the new hospital development so that it was co-located with the ability to address any physical health needs.

Ms Lisa Taylor, Managing Director at Healthwatch Hillingdon (HH), advised that HH had received feedback from parents and children who were not happy about the lack of communication from CAMHS regarding the triage process and that they had not been

	given any information to manage their expectations. Parents needed to know what would happen next, how long the waiting times would be and what other support was available in the interim (especially if they were going to have to wait up to two years). Ms Taylor advised that parents had complained to CAMHS about the lack of communication and still not received a response. Parents had also requested that they receive feedback about why their child had not met the threshold for CAMHS as it was thought that this would be helpful. One young person had been referred to CAMHS when they were 15 - they were now 17 and had still not been seen. During the intervening period, the young person's ability to socialise had reduced as their mental health had worsened. Young people had reported to HH that they had used CAMHS but felt that they were not being listened to and that their needs were not being met by the service. As such, they then turned to social media and YouTube to look for alternative support. Ms Taylor had been working with Ms Jane Hainstock, Head of Joint Commissioning at North West London Integrated Care Board (NWL ICB) – Hillingdon, to identify what support services were available in Hillingdon and to identify challenges and solutions. It had become apparent that, with regard to children's mental health services, there was a perception that CAMHS was the only service available. As such, GPs would often just refer children to CAMHS whereas, for adults, there was a greater awareness of a range of services provided by organisations such Hillingdon Mind. Members believed that, when a child was in distress, they needed help so the idea of a young person being turned away because they did not meet a threshold seemed wrong. The Chairman advised that the Committee would be looking to come up with realistic recommendations as part of its review and would likely seek views on these from those present at this meeting before the summer. **RESOLVED: That the discussion be noted.**
75.	**CABINET MEMBER FOR HEALTH AND SOCIAL CARE UPDATE** *(Agenda Item 6)* Councillor Jane Palmer, Cabinet Member for Health and Social Care, advised that early intervention to deal with social care issues that arose in childhood reduced the impact on their lives into adulthood. Councillor Palmer praised the social workers who had worked tirelessly during the pandemic to support residents during a very difficult period. There had been a range of initiatives delivered and work undertaken over the last year included: Hillingdon Shared Lives Scheme, reablement and hospital discharge. In addition, the Hillingdon Suicide Strategy had been developed with links to health, British Transport and Hayes station. There had been no strategy in place to prevent to suicide in the Borough when Councillor Palmer had taken on her Cabinet portfolio so she was very proud of the partnership working that had resulted in this accomplishment. It was recognised that social care took up approximately 60% of the Council's entire budget and that this supported a relatively small number of residents. However, it was also noted that social care was a statutory service that had never been sufficiently funded to enable preventative work to be undertaken which would ultimately reduce the overall costs of the service provision. To ensure that the quality of service was

maintained, proper procurement and monitoring measures had been put in place to ensure that poor performance in contracts was addressed and to ensure value for money. However, inflation had meant that everything was now more expensive than it had been previously (including the workforce) but the Council continued to maintain its sound financial management.

Ms Sandra Taylor, the Council's Executive Director of Adult Services and Health, advised that social care would always be a high spend area of the local authority and would therefore always be a talking point. However, Hillingdon had demonstrated a good and effective use of resources based on early intervention. A strong hospital discharge process had been put in place resulting in 70% of people coming out of the reablement process with no ongoing care needs. It was important not to create dependencies and to keep people living in their own homes for as long as possible.

Further work was needed to create resilience in young people and, to this end, Ms Taylor would be speaking to the Interim Director of Public Health to see what action could be taken to further develop good general health. There were gaps that had emerged and it would be important to fill these with voluntary sector providers.

Councillor Palmer noted that social care in Hillingdon was a good place to work, with dedicated staff. The Council promoted social care apprenticeships to enable the authority to develop its own staff and allowed them to move between departments. Supportive working relationships were in place with proper supervision and support for social workers and caseloads were well managed.

Ms Taylor stated that staff retention in social care in Hillingdon was very good and that the leadership team had a breadth of experience to support the service area. Social workers were well equipped and had a balanced caseload and the right support. A range of workforce development schemes had also been put in place.

Members were advised that the CQC had today published its new inspection framework but that Adult Social Care had been preparing for an overarching inspection for some time. Ms Taylor noted that the CQC would be undertaking five inspections between April and October 2023, one of which would be in London. Operationally, she had attended meetings to learn how local authorities could best present their evidence to the CQC and effort had been made to gain an understanding of difference and how residents were helped to live independently. It was anticipated that Hillingdon would be inspected in 2023/24. Insofar as local care provision was concerned, a new approach of having face-to-face meetings had been introduced (where appropriate) as well as a review of complaints and the remote monitoring of services.

With regards to being dynamic in new ways of working, Councillor Palmer advised that she had initiated a review of the Hillingdon Health and Wellbeing Board when she became Cabinet Member for Health and Social Care. The Board, which she now co-chaired with the Managing Director of Hillingdon Health and Care Partners (HHCP), was no longer a talking shop and had enabled frank and honest discussions to be held with all health and care partners. In addition, Councillor Palmer raised issues such as health inequalities at meetings with her counterparts from the other seven North West London (NWL) boroughs (Brent, Ealing, Hammersmith & Fulham, Harrow, Hounslow, Kensington & Chelsea and Westminster).

Councillor Palmer advised that she had recently been appointed as a representative on the NWL Integrated Care Board (ICB) for the eight NWL boroughs and had attended a

meeting earlier in the day where there had been some discussion about the proposal to change the provision of orthopaedic services in NWL. Concerns had previously been raised at the Health and Social Care Select Committee about transport in relation to these proposals and Councillor Palmer confirmed that she would be on a Transport Working Group to look at this issue.

With regard to succession planning, Ms Taylor advised that there were three Registered Managers in Adult Services who had worked for the Borough for many years. These managers were all very supportive of their teams in terms of personal development and providing training opportunities including registered manager training. Experience and knowledge could also be shared through the Provider Forum and Registered Manager Forum.

In the past there had been a disproportionate number of out-of-town placements which had been more costly than in-Borough placements. Ms Taylor advised that extra care housing had been developed to try to meet this need and tip the balance back to being able to live in the community in supported living. There were now more supported living places in Hillingdon than there were residential care places (there were 44 registered care homes in the Borough). However, there were still some residents with niche needs that could not be met locally which would need to be reviewed and monitored. In the future, the focus would need to continue to be on early intervention rather than care homes, as people had realised that the best care could be provided at home and that the least restrictive options needed to be implemented.

Feedback in relation to the digitisation of social care applications had been positive. However, it was recognised that some people would not be able to navigate their way through the technology and, in these circumstances, there would always need to be a human available to talk to. The online assessment facility had been available for some time and an online referral system would soon also be available to try to reduce the waiting time for residents. The online facility reduced the number of steps in the process which made dealing with safeguarding issues, etc, much more efficient. More feedback on the system would need to be collected.

The work of the Hillingdon Dementia Alliance had grown and the team were commended on their efforts. Tovertafel sensory tables had been made available in libraries across the Borough. Councillor Palmer noted that the dementia team had been phenomenal, providing a good service, developing good networks and resulting in good engagement with services. Ms Taylor noted that engagement with residents had increased but that she would need to establish how much it had grown and report this information back to the Committee.

The dementia work in Hillingdon had been aligned to the third sector work to help keep residents at home for longer. Admiral nurses had provided a first-class service to support those with dementia and their carers at home and Dementia Friends had been trained inhouse.

It was anticipated that the fair cost of care would cost around £4m but that Hillingdon would only be receiving £2.4m funding towards this in 2023/24. All councils had been asked to undertake a fair cost of care assessment with providers in 2022 and Hillingdon had submitted its findings in October 2022. It was actually estimated that the costs would be £4.5m to bring them to the right level so, as the Government funding was on an incremental level, it was hoped that the 2024/2025 settlement would be £2.1m. However, inflation had risen which had put even more pressure on the

	Council in terms of the fair cost of care. The Chairman asked that Ms Taylor advise the Democratic Services Manager when the 2024/25 settlement had been announced. It was noted that there had been a drop in formal safeguarding enquiries from 2,497 cases in the previous year to 1,694 cases this year. In addition, there had been an increase in overall referrals from 8,848 in 2019/20 to 13,938 so far during 2022/23 (an increase of 58%). Ms Taylor advised that, during the pandemic, fewer referrals had been made which meant that there had been an increase in the number of people experiencing mental ill health and more mental health referrals coming through. However, consideration needed to be given to what it was that converted an enquiry into a s42 investigation. The Council wanted people to raise safeguarding referrals and, if the conversion rate to s42 was low, this would be positive. The Cabinet Member thanked the Committee for inviting her to attend the meeting and advised that she would continue to work with partners to achieve good outcomes for Hillingdon's residents. She would be happy to come back again on an annual basis to provide the Committee with an update. **RESOLVED: That the discussion be noted.**
76.	**CABINET FORWARD PLAN MONTHLY MONITORING** *(Agenda Item 7)* Consideration was given to the Cabinet Forward Plan. **RESOLVED: That the Cabinet Forward Plan be noted.**
77.	**WORK PROGRAMME** *(Agenda Item 8)* Consideration was given to the Committee's Work Programme. It was noted that the Committee's next meeting on Wednesday 26 April 2023 would receive updates from health partners. Members requested that each of the health partners be asked to provide, in advance of the meeting and to be included on the published agenda, a written account of the work that they had undertaken over the last year and to provide an indication of their performance against targets during that period. **RESOLVED: That the Work Programme be noted.**
	The meeting, which commenced at 6.30 pm, closed at 8.39 pm.

These are the minutes of the above meeting. For more information on any of the resolutions please contact Nikki O'Halloran on nohalloran@hillingdon.gov.uk. Circulation of these minutes is to Councillors, officers, the press and members of the public.