

**HEALTH SCRUTINY PANEL**

A meeting of the Health Scrutiny Panel was held on 28 February 2017.

**PRESENT:** Councillors E Dryden (Chair), S Biswas, (Vice Chair), A Hellaoui, C Hobson and J McGee and M Walters

**ALSO IN ATTENDANCE:** Rob Morris - Service Manager Children Adolescent & Mental Health Service - CAMHS  
Mark Burdon - Commissioning Manager (Mental Health) - South Tees CCG  
Heather Corlett - Commissioning Manager - South Tees CCG  
Maria Catterick - FASD Network

**OFFICERS:** Caroline Breheny and Jane Wilson - Head of Service - Looked After Children, Placements, Children with Disabilities

**APOLOGIES FOR ABSENCE** Councillors R Brady and L McGloin.

**DECLARATIONS OF INTERESTS**

None declared.

16/20 **MINUTES - HEALTH SCRUTINY PANEL - 31 JANUARY 2017**

16/21 **FETAL ALCOHOL SYNDROME DISORDER - FURTHER EVIDENCE GATHERING**

FASD the panel had requested that the review would focus on the scale of the problem in Middlesbrough and consider the support that was/needed to be provided. A number of representatives were in attendance at the meeting to provide evidence in the form of a round table debate on the topic. The Chair invited the Commissioning Manager at South Tees CCG to give a presentation on the information requested by the panel as follows:-

What CAMHS / LD support was currently being commissioned for children and young people in Middlesbrough?

The panel was informed that South Tees CCG commissioned multi-disciplinary community teams supported children with both mental health and learning disabilities. Some staff specialised in children and young people who had a learning disability. The Team consisted of a good mix of staff including Consultant Psychiatrists, Consultant Psychologists, Occupational Therapists and Mental Health Nurses. A separate Crisis Team was also in place to support young people in any crisis situation. In such a scenario the young person would be seen within 1 to 2 hours. Whereas the multidisciplinary team responded to referrals, invited young people in for triage and undertook comprehensive assessments. The CAMHS Manager confirmed that FASD was not diagnosed or treated by CAMHS in the truest sense. However, co-morbid mental health conditions, for example, anxiety and depression were treated by CAMHS.

How much was being spent in Middlesbrough on CAMHS/LD support?

It was explained that no breakdown was available at a Middlesbrough level. However, in 2016/17 at a South Tees level, the agreed contract values were:

- £2,642,306 was spent on community CAMHS
- £16,533 on Learning Disability specific CAMHS community support\*
- £238,937 on Learning Disability respite services
- £95,086 on CAMHS eating disorder services. Figures from latest Contract Management Board papers.

It was noted that the figure of £16,533 on Learning Disability specific CAMHS community support needed to be queried, as there was a Consultant Child and Adolescent Learning Disability Psychiatrist and other specific LD clinicians for Middlesbrough.

The panel queried what proportion of support was accessed by children and young people who were looked after? It was explained that:-

- Looked after Children's (LAC) CAMHS input was commissioned by the Middlesbrough Local Authority with a separate contract and reporting structure.
- Looked after Children from other local authorities were seen within the general teams but there was no breakdown of activity available by LAC/non-LAC.
- In response to whether there were generic treatments available to children and families experiencing challenging behaviour? South Tees CCG advised that:-
- Yes, some support was given all along the pathway. Staff within the Middlesbrough Team specialised in Positive Behaviour Support and parenting support.
- Input was assessed and based on need.
- Input ranged from parent support training days, individual packages, groups, consultation to special schools.

Members were keen to understand whether individual clinical pathways were commissioned for any of the following conditions: - Autism, ADHD, Attachment Disorders, FASD, Sensory Processing Disorder, Conduct Disorders, other neurodevelopmental conditions?

It was advised that of that list, pathways were only commissioned for:

- Assessment of Autism Spectrum Disorders
- Assessment and treatment of ADHD
- Positive Behaviour Support for Behaviours that Challenge.

It was advised that where interventions were external to Tees Esk and Wear Valley (TEWV) NHS Trust no pathway was in place.

The panel queried whether there were any comparative figures on the number of children diagnosed with FASD in the last 3 years in Middlesbrough, Stockton, Darlington, Redcar & Cleveland and Hartlepool? South Tees CCG advised that:-

- The CCG does not hold this information.
- Data had been requested from Tees, Esk and Wear Valleys FT to determine numbers of children and young people who have a FASD diagnosis code in services.

Following the presentation from South Tees CCG the Head of Service for Looked After Children was invited to provide an insight into the department's experience of working with children diagnosed / suspected to have FASD

How many looked after children in Middlesbrough had been diagnosed with FASD?

The Head of Service explained that it was difficult to quantify the numbers of children affected. In the UK accurate identification of FASD was not yet as consistent as in some other countries such as the US and Canada, but it had been estimated that in Western countries as many as 9 per 1,000 live births involved children affected by Foetal Alcohol Syndrome (FAS), Partial Foetal Alcohol Syndrome (PFAS) or Alcohol Related Neurodevelopmental Disorder (ARND). Of the children concerned, 10 -15 per cent were affected by FAS, 30 to 40 per cent by PFAS and nearly half by ARND. However FASD could be misdiagnosed as ADHD, oppositional defiant disorder (ODD), conduct disorders amongst others. In Middlesbrough:-

- A major issue was that there were a limited numbers of paediatricians who were prepared to diagnose in our surrounding areas.
- There appeared to be more children coming through the system with a diagnosis of FASD who required an adoptive placement. However, they were typically from the southern regions of the country.
- There were currently 441 Children Looked After by Middlesbrough - of whom there were only 3 who had a diagnosis of FASD, which was a lot less than in other areas.
- At present the data team could not currently produce a report to reflect this information but could, if the information was in there to pull through.
- It was possible and probable that there were children who were not diagnosed –

- training and briefings had been and would continue to be rolled out for Social Workers, Foster Carers, Connected Persons Carers and adopters to raise awareness.
- Many of our looked after children were 'diagnosed' as having problems with their emotional health and some with behavioural issues - all of which were responded to as part of their health assessment and plan. In short – the presenting issues were managed whether or not their source was related to parental alcohol misuse.
  - What type of support were these children accessing and was support available to their families / foster carers?
  - A year's worth of drop in sessions had been secured by Middlesbrough Fostering Team to provide support to carers.
  - FASD was now a 'stand alone' topic on the Adoption Preparation Group
  - Children's Social Workers were being encouraged to include ANY information in the Child's Permanence Report (CPR) about alcohol consumption during pregnancy which could be vital to diagnosis in the future.
  - Maria Catterick (FASD Network) had produced a checklist for GPs and other health practitioners to assist in their 'ruling in or out' of FASD. This had been shared with prospective adopters during their preparation.
  - CAMHS Looked After Children's service were not currently working with any children/young people with FASD - though many of the children with whom they ARE working (41 currently) may have the 'wider effects' of foetal alcohol. The Local Authority was keen to see CAMHS working with more LAC children, as previously the figures had been around 70-75 and ideally the Local Authority would wish them to be higher. It was anticipated that the numbers would be higher next quarter. Psychologist support would be provided should a child's referral cite FASD as an issue.

The FASD Network representative made the point that generic support offered to families of a child suspected but not diagnosed with FASD were often inappropriate. The Triple P Positive Parenting Program for example was not appropriate and left families feeling frustrated. The point was made that children were in effect ending up in the CAMHS system but were not necessarily accessing the right support. Reference was made to work undertaken in Gateshead and the need for own pathways to be developed in Middlesbrough.

In preparation for the meeting the Head of Service explained that she had spoken with a very experienced Foster Carer about her long term support of a young person with FASD who provided the following insight:-

- Without a clear diagnosis there was very little support was available
- Doctors were reluctant to diagnose either because they did not want to label a child OR because they just didn't know enough about FASD
- There was no local 'specialist' to diagnose the young person in her care
- Training on FASD (then) meant travelling to London - this was NOT the case now
- Emphasis should be on the WIDER effects of alcohol upon the child and not solely the syndrome as that would capture many more children e.g. impulsive behaviour
- When asked what would have helped, the carer said;
- Specialist medical knowledge - locally
- Better Social Worker knowledge
- Understanding of the changing needs and 'presentation' of children who have FASD as they grow and develop.
- Specialist schools are essential

In terms of whether FASD had been raised as an issue of concern by adopters via the After Adoption Support Team no specific concerns had been raised. However, there were children who had been diagnosed post placement (with Adopters and Foster Carers) because of the skill and knowledge of the adopters - who knew what to ask and what to request.

The Chair queried whether Social Workers were regularly working with children in Middlesbrough they suspected had FASD? The following response was provided:-

- In the Children with Disabilities team there were only 5 children (and they are NOT looked after) out of 200 cases in total who were suspected of having FASD i.e. there was no diagnosis.

- The Team Manager for the Children with Disabilities team suggested the low number may be due to there being no diagnosis due to medical reluctance to label and/or reluctance of families to attend appointments. Often if a child was diagnosed with FASD the statistical prevalence of siblings also having the condition was approximately 70 per cent.
- Social Workers across the piece were working with children who have FASD - or wider symptoms of - though the workers themselves may not recognise that what the children/young people were presenting was alcohol related - hence the programme of training being rolled out.

In terms of training six Social Workers have been trained on 'Have a Word'- preventative work to establish the parent's understanding of the impact and use of alcohol upon their unborn child. The intention was that the workers then train their peers so that practice was cascaded. Specific training on FASD was scheduled for 5 April 2017 for the children with Disabilities Team which would then roll out to all Social Work practitioners. This was organised and funded by public health.

General views and observations of Adoption Team Practitioners;

- Adoption Team staff have shared the view that there was a possibility that FASD has historically not been 'seen'- that - perhaps, there were children who may have been wrongly diagnosed instead with ADHD or ASD as we were learning more about the effects of alcohol on the unborn child this may change.
- A major issue is that there were limited numbers of paediatricians who were prepared to diagnose in our surrounding areas.
- There appear to be more children coming through the system with a diagnosis of FASD who require an adoptive placement. However, they were typically from the southern regions of the country.

The Democratic Services Officer explained that an invite had been extended to the Principal Educational Psychologist, as requested by the panel but unfortunately she had been unable to attend today's meeting. However, she had provided a response to questions posed by the panel.

In response to whether working in the Educational Psychology Team had undertaken training on FASD it was advised that unfortunately Middlesbrough has had a much depleted team with regard to its Educational Psychology Service for a couple of years. Therefore, it was not possible to comment on the training and skill set of an existing team, as such. The Principal Educational Psychologist was appointed in August 2016 with the main task of re-building a Service and she was happy to announce that additional staff would be joining the team after Easter, and some further staff would be joining in September. It was advised that advice would need to be sought with the local and national training providers to get a fully accurate response as to the nature of training programme content for EPs in training. However, it was advised that many (if not most) EPs were 'aware' of FASD, if not trained. In addition, some experienced EPs had received and delivered training on this subject (for example to foster carers and specialist provision (special schools) often when this had fallen under their Specialist Senior EP roles ( e.g. specialist senior complex needs roles).

The Principal Clinical Psychologist advised that experience has yielded 2 areas the panel may wish to explore: Firstly, that it was extremely difficult to broach the subject/trace the history without 'blaming' the mother, which is why it might be that diagnosis tends only to be sought/given when children are looked after. A second reflection was that many of these effected children when older were perhaps receiving Autism Spectrum Disorder, or other, diagnoses (instead).

In terms of the support provided for children diagnosed with FASD or suspected FASD educational provision tended to be 'needs led' and not 'labels led'. In other words, support was provided following an assessment of need (either at a pre-statutory level or statutory level). This meant that provision was mapped and determined on an individual basis, rather than a one size fits all based on diagnosis alone.

In response to whether work was taking place with children with FASD in the early years it was advised that it was highly likely that staff were working with children with FASD, but whether the children had diagnoses, and whether staff were FASD aware, were separate questions. The Principal Educational Psychologist raised the following queries: - How many children have our Paediatricians / CAMHS colleagues diagnosed with FASD in the last year? Does their routine screening / assessments ask explicit questions around alcohol consumption during pregnancy? It was noted that there would be a real benefit in posing these questions to the Consultant Paediatrician who had expressed a very interest in FASD at the training event held recently at James Cook University Hospital (JCUH).

What improvements could be made to ensure children with difficult to diagnose conditions received the right support at the right time?

- Children currently seemed to go down 'pathways', one at a time often. To my knowledge there was an ASD pathway (which when staffing permits is multiagency), and an ADHD Pathway (CAMHS), but I'm not sure which service would claim that FASD is 'theirs'. I guess this could open a wider discussion about joint commissioning of approaches to assessment.
- Multi-disciplinary case discussion would be helpful (FASD as a condition of medical origin) and knowledgeable educational psychologists, through involvement with multidisciplinary case discussions, could support with the educational, social, emotional implications of FASD.
- We do have access to an EP in the region with considerable complex needs experience and FASD experience and special interest, if the group decided they wanted further support.

The FASD representative accepted that there were challenges in the diagnosis of FASD but obtaining a diagnosis and accessing post diagnostic support were important for children and families. Reference was made to work undertaken in Peterborough and Gateshead and the Chair expressed the view that we should learn from good practice. If a model was in place in Gateshead using an integrated approach we should be encouraging that same dialogue and multiagency approach in Middlesbrough. The Peterborough research had looked specifically at Looked After Children and given the demographics of the town it was suggested that a similar piece of research could be undertaken in Middlesbrough. Public Health and the South Tees Consultant Paediatrician who had expressed an interest in FASD could be approached to undertake a piece of work in this area. The view was expressed by the Chair that despite the challenges it would appear that we had some good foundations on which to build.

The Chair thanked all of the guests for their attendance and valuable contributions.

AGREED as follows:-

1. That an invitation be extended to the Consultant Paediatrician with a specific interest in FASD, a Public Health Intelligence Specialist, the Principal Educational Psychologist, the Head Teacher at Priory Woods School, the Looked After Children's Manager and FASD Network representative to provide further information on this topic at the panel's next meeting.
2. That the information received be incorporated in the panel's final report on this topic.

16/22

### **SUSTAINABLE TRANSFORMATION PLAN (STP)**

The Chief Officer at South Tees Clinical Commissioning Group (CCG) and the South Tees Integration Programme Manager were in attendance at the meeting to discuss the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby Sustainable Transformation Plan (STP) 2016 - 2021. Rather than revisit any information presented at the all Member briefing on the STP the Chair used the opportunity to have a conversation about the STP and how Members could influence its future development.

It was explained that the STP was a nationally determined planning process across broader footprints than individual CCGs. The NHS Five Year Forward Plan focussed on health outcomes, financial challenges and the need to establish a broader agenda. The Better Health

Programme was one programme whereas the STP incorporated more than simply hospitals. It was about prevention, neighbourhoods and communities and the need to think differently about health and social care.

The Chief Officer at South Tees CCG advised that the STP had already identified the need to work more collaboratively and on a bigger scale. The clinicians were driving the agenda and if services wanted to deliver the best clinical outcomes for patients they needed to work outside of organisational silos. Service provision in the NHS was starting to crumble and the clinicians were passionate about doing what was right for patients. In terms of formal governance arrangements it was advised that there was no formal sign off process. Eighteen statutory organisations made up the footprint of the STP and each had its own governance processes. The Chief Executive Officer expressed the view that there was only one single pot of money and it was about spending that money effectively to achieve the best possible outcomes.

A major factor at present was that investment was needed in our communities and neighbourhoods to take away the demand from acute services. Reference was made to the work undertaken in Hartlepool in response to past reviews and as a result Hartlepool had a much better community infrastructure compared with other areas. The most important aspect was to have the right services in the right place. At the moment we were not getting it right with the health outcomes we all wanted. There needed to be a channel shift of activity from JCUH into primary care and neighbourhoods.

During discussion the following points were made:

- It was acknowledged that from a South Tees perspective community infrastructure was our most important challenge.
- The frail and elderly accounted for a significant proportion of people in hospital and there needed to be a shift to having more therapy and active support provided in people's homes instead of hospitals.
- Hartlepool had an effective scheme in place for respiratory conditions, which although may need to be delivered differently in Middlesbrough, had proven that better results could be achieved in a more effective way outside of hospitals. Such programmes should be developed over the bigger footprint.
- The 'Care Homes Project' and 'Single Point of Access' project were providing real tangible and practical assurances of what was taking place in communities.
- The STP needed to make sense to everyone as we all want the best outcomes for our residents.
- In terms of timescales it was advised that the NHS was developing a model around community hubs. Grangetown was provided as an example and some work had been undertaken with public health to assess what support was needed in the community. The findings had shown that often the type of support most needed by people in the community were not related to health issues.
- Reference was made to the fantastic work undertaken at Marton Pharmacy and the diverse range of support available at this facility.
- Arthritis, Diabetes and Cholesterol were conditions that could be well managed in the community and by people becoming active in their own care.
- Work around prescribing was important given our deprived population and there was also a need to make people away of the costs the NHS were incurring.

The Chief Officer at South Tees CCG acknowledged that the NHS needed to get the public on board with the proposals and would welcome the opportunity to hold a mature and informed debate with Members on the STP.

The Chair put forward the suggestion that in Middlesbrough the format of the debate could take the form of a 'Council Conversation', which would be held as part of the Council meeting to ensure maximum Member involvement. It was suggested that June could be a good time for the debate, as the Council would be out of the purdah period. A Member requested that in advance of any such event taking place regular information needed to be provided to all Members around the detailed evidence on which the STP proposals were being developed.

The Chief Officer at South Tees CCG and the South Tees Integration Programme Manager

confirmed that they would provide a monthly briefing paper for Members on the STP and related developments. The Chair thanked the invitees for their attendance.

AGREED as follows:-

1. That arrangements be made for a 'Council Conversation' on the STP to take place.
2. That a monthly briefing paper on the STP and related developments be produced for Members by the Chief Officer at South Tees CCG / South Tees Integration Programme Manager in advance of holding a 'Council Conversation'.

16/23

#### **OVERVIEW AND SCRUTINY BOARD UPDATE**

The Democratic Services Officer presented a verbal update on the matters that were considered at the Overview and Scrutiny Board meeting held on 17 January 2017.