

**Bristol City Council  
Health Overview and Scrutiny Committee (HOSC)**

**7 February 2024 at 4.00 pm**



**4 Minutes of Previous Meeting**

Draft Minutes of the 7.12.23 HOSC

Meeting ended at Time Not Specified

**CHAIR** \_\_\_\_\_



**Bristol City Council**  
**Minutes of the Health Overview and Scrutiny**  
**Committee (HOSC)**



**7 December 2023 at 4.00 pm**

**Members Present:-**

**Councillors:** Steve Smith (Chair), Jos Clark (Vice-Chair), Lorraine Francis, Tom Hathway, Graham Morris and Tim Wye

**1 Welcome, Introductions, and Safety Information**

The Chair welcomed everyone to the meeting. Health and safety information was provided.

Also, in attendance were;

- Christina Gray, Director of Communities & Public Health (DoPH)
- Councillor Asher Craig, Deputy Mayor and Cabinet Member for Children's Services, Education and Equalities

**2 Apologies for Absence and Substitutions**

- Cllr Brenda Massey, Committee Member
- Cllr Amal Ali, Committee Member
- Reena Bhogal-Welsh, Director: Education & Skills
- Helen Holland, Cabinet Member for Adult Social Care and Integrated Care System
- Councillor Ellie King, Cabinet Member with responsibility for Public Health and Communities
- Becky Balloch, Head of Communications & Engagement NHS & Integrated Care Board (ICB)
- Jennifer Bond - Associate Director of Communications & Engagement, NHS & Integrated Care Board (ICB)

**3 Declarations of Interest**

No declarations were received.



#### 4 Minutes of Previous Meeting

The minutes of the previous meeting were approved as an accurate record.

#### 5 Chair's Business

Chair highlighted the recent announcement by North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust that they are to “have a Joint Chair and Joint Chief Executive who will lead both NBT and UHBW as the first and important step on a journey for our organisations to form a Hospital Group within the next two years”. It was suggested this topic could be included as and when a joint BNSSG Health Overview and Scrutiny Committee (JHOSC) or ‘meeting in common’ took place.

#### 6 Public Forum

The Public Forum received was published prior to the meeting and can be viewed here [Public Forum Doc](#)

- One statement was received from Jen Smith regarding agenda item 8. Children and Adolescent Mental Health Services (CAMHS).

**RESOLVED; That the Public Forum be noted.**

#### 7 Healthwatch Updates (Standing Item)

Vicky Marriott briefly introduced the item that focussed on information and data based on the feedback received on the most frequent themes during Quarter 2 of 2023.

This was said to be the largest feedback received and in Bristol comprised of 472 respondents. The report can be found here: [Healthwatch Slides](#).

It was reported that Healthwatch were currently producing booklets such as ‘changes in your surgery’ to help people better understand what was happening. These would be circulated to Members as soon as they were available.

A Member asked about the longitudinal nature of the data and commented that even where it showed a quarter of the comments were negative about the care they had received this was still a very negative rating. Had the figures changed much over time? It was said it was difficult to gauge this due to the changes in how the feedback had been gathered.

The Committee thanked Vicky for the useful and insightful information. The Chair commented that the data was very helpful but wondered if perhaps the data was slightly skewed as the respondents had gone to Healthwatch? A Committee Member responded that any patient feedback provided, especially in this context, was relevant.

#### 8 Children and Adolescent Mental Health Services (CAMHS)

Heather Kapeluch, Head of Operations – CAMHS, AWP and Anna Clark, Senior Performance Improvement Manager, BNSSG ICB attended to introduce the paper and respond to questions from the Committee.

Some of the highlighted included the following;



- The number of referrals had increased and so had the complexity of cases.
- Recruited to half of the posts now. Can recruit in Bristol but other areas are much more difficult. So, they were trying to make these roles more accessible and linking with other areas.
- Getting advice is hard and this can seem like a hidden service. The aim was to make this more accessible so they were setting up an advice line now.
- Some people were rejected, so the phone line advice could help signpost to other support services.
- The number of eating disorder cases had risen locally and nationally. The main focus was on prevention work to avoid people needing to go into hospital.
  - A pilot project was underway to support people early and had significantly reduced the numbers going into hospital.
- There was a clear need to help improve access for young black and minority ethnic (BAME) people. - In response, a second outreach worker had been recruited to help make services more accessible.
- 16+transition; They said to be looking at best practice in other areas and undertaking discovery work. Successes are on the published slides.
- Riverside Tier 4 Service; has opened all 12 beds now (these are day beds). This is a positive development.
- The southwest region does not have any 24-hour beds for young people with eating disorders. They are looking to provide this in the BNSSG area but there are no timescales as of yet and this could take another couple of years.
- CAMHS Crisis Team; currently refining model. This was a 24/7 service but is now only until midnight.

The following points were discussed and questions asked:

A Member asked about the 'Referrals Bristol CAMHS' slide and the shape of the graph which appeared to show there was very little consistency. Why was this? It was replied that school holidays and terms affected when referrals came in. With regards to trends, it was said there was a 70% increase in referrals relating to eating disorders but there was also a general increase, especially in Bristol. Work was being undertaken with a referrers group and schools to try and understand more about the increases.

A Member requested more data on the demographics of referrals from deprived areas and wards in Bristol.

**ACTION: It was agreed that more in-depth information would be provided on the demographics of referrals from deprived areas and wards in Bristol.**

It was discussed how the Integrated Care Partnership's (ICB) positive investment in new outreach workers in 2024 would also help to provide more data on this and that the locations they would work in were based on deprivation data provided by Public Health.

A Member highlighted that under new plans, some police forces in England will no longer respond to concerns primarily about mental health if there is no risk to life or crime being committed. The police had previously highlighted they were dealing with huge numbers of calls because there was no one else to respond after midnight. What would happen now if the 24/7 crisis services for young people was not available after midnight? It was replied there were services such as emergency ambulances services but they were also looking at other areas and what helps and working with the police to ensure a robust response process was in place. It was said there could be a tendency for young people to be admitted at night but it was very difficult to place them in the right care during the night anyway.

It was clarified that the Metropolitan Police Force have withdrawn from responding to calls related to mental health concerns but Avon and Somerset Police have not done that. There was said to be confidence at the moment



but they were working closely with partners in case there is a change in response. It was also noted that CAMHS workers can access psychiatrists 24 hours a day and 7 days a week.

A Member asked about children self-referring to CAMHS. It was said in some areas they could do that but not all. In research across different parts of the country children were asked what the best or easiest way was to do that, for example via a website or phone etc. But it was highlighted there are a number of ways to self-refer, such as via mental health teams in schools. A follow-up question was asked about how young people would know to refer to CAMHS or where to seek help, for example, do some call ChildLine and find out? It was said that some young people have complex needs, but there was early intervention provided to try and catch them to support them. It required ensuring the right information was accessible and in the right places for everyone including parents and carers, such as in schools.

Another Member said they were very pleased that things were being put in place to improve access to services at the 'front door'. He said CAMHS wasn't the answer for everyone but signposting to other services was an important part of the support. The practitioners agreed and said it was crucial to get this right so that no child got lost in the system. They had already seen a reduction in the number of complaints and some anecdotal positive feedback which was promising.

A Member said there was a perception that many young people get turned away from CAMHS. What percentage of referrals were accepted? The practitioners said that about 80% of referrals were accepted. There was a triage process in place and the number of referrals and the number of those who were accepted was recorded. They were trying to support young people much earlier now, so they did not get to the point of needing intensive specialist care. They were also working with other groups so they could gauge if the response was right.

A Members said they thought it would be useful to do a 'deep dive' on the numbers of children that get accepted on the service. They then asked how involved children and young people were in assessing the service. It was said there is a group of about 30 young people who were being supported to be involved in designing the 'front door'. They also had some participation from young people at Bernardo's. They were also invited to various events to talk and then use that feedback and information to help shape services.

**Resolved; that more in-depth information would be provided on the demographics of referrals from deprived areas and wards in Bristol.**

## **9 Hospital Education Delivered at UHBW**

The item and information were introduced by;

- Joanna Herbelot, Primary Lead, and Jacqueline Ward-Warren, Secondary Lead, Bristol Royal Hospital for Children.
- Bethany Shirt, Deputy Director of Nursing Bristol Royal Hospital for Children
- Mark Goninon, Deputy Chief Nurse UHBW

The Hospital school was said to be part of the wider Bristol Hospital Education Service provision. It had been judged by Ofsted as outstanding in the last three inspections.

Staff numbers were now equivalent to 10 full-time positions.



The Service provides a personalised curriculum for each child, based on their needs, both educational and emotional. The Serviced worked closely with schools. However, they were sick children and so it was not always straight forward.

Some teachers included some subject specialist teachers and also two SEND specialist teachers. The provision was there for all children and young people from day one where possible. The service offered all subjects and provided a rich learning experience.

It was highlighted that the service was very lucky to be supported by charities. It was also partnered with Deloitte over a 3-year period. This meant that they could offer what was over and above the core local offer.

The learning experience was said to be informal and not uniformed. There were usually about 40- 60 pupils at any one time and they were usually teaching 30 – 40 children daily as some as some are in theatre etc. But they did get around to all children in a daily basis.

Provision could be for both short stay and long stay patients. One child had currently been receiving hospital education for 18 months.

The service was provided from diagnosis to treatment and when patients leave they can be home tutored. It could also be provided to siblings if they came from other areas outside of Bristol.

The service was said to be working very well and the Ofsted rating had they had had for some time now reflected that. The feedback received and evaluation was also said to be very good.

The following points were discussed and questions asked

The Cabinet Member - Councillor Asher Craig offered her congratulations on the 'outstanding' Ofsted rating and said she had no questions.

A brief discussion was had about children who were too sick to go to school but are not in hospital and what could be provided for them. It was said it was possible to provide schooling at a base or at their home and the service communicated with schools in order to continue the curriculum as much as possible so progress is as uninterrupted as can be.

A Member asked about continuity and how they knew what was needed for example where children where in their curriculum? The practitioners said they mostly looked at the relevant websites for secondary schools as the majority of the information was there. If children look to be long-term patients, are in secondary education or have and ECHP they will communicate with the school directly. They plan individual programmes of learning with each child and school. They then send reports back to the schools on progress.

The Chair then congratulated the practitioners for stunning the Members into silence. The Committee expressed their thanks for the positive discussion.

## **10 BNSSG Neurodiversity Workstream update**

The item was introduced by;

- Jan Potts, Interim Deputy Chief Operating officer, Sirona care & health
- Penny Agent, Chief Therapy and Allied Health Professional Officer, Sirona care & health
- Kate Lavington, Head of Design, BNSSG ICB



- Laura Westaway, Head of Children – Performance and Delivery, BNSSG ICB

The report provided an overview of the work being undertaken to transform the services and support for neurodiverse children, young people and their families. Some of the key points highlighted to Members included the following:

The services were overrun with approximately 387 referrals per month. There were said to be variations within data but it was said that 86% of referrals were accepted after triage. Demand was said to be twice as high as capacity and was a significant problem. This was why work was taking place with the ICB on a transformation programme. It was understood and appreciated how frustrated families were whilst they waited for services.

The transformation programme was a key piece of work and the problems it faced were detailed in the published paper. Local practitioners were learning from others nationally and internationally. It had been agreed that the best way to look the issues were by user-co-design and so it was being led locally by the Parent Carer Forum.

An event had recently taken place that brought around 90 people together to hear and understand the work that's been done to-date and find solutions that fit people's needs. Some of the conversations were said to be difficult but it had been important to be honest with people. Another event would be organised early in 2024 to continue this developmental work.

It was said that practitioners were now starting to see children with specific needs at primary and early years now. Some situations were complex and often parents did not know the right routes to take, feeling they were being blamed. Many said they wanted a medical diagnosis in order to get the right support, which can help from an educational perspective.

Structural inequalities needed to be understood in this context. There were high levels of referrals across the region and especially in Bristol. The experience was not good for anyone but was said to be worse for some people, particularly those who do not speak English. The changes to service provision were not said to be about cutting services but rather about early intervention to help people to get the right support.

A relatively new Member of the team said they were not happy with how things currently were but they were also working with other teams such as the Intensive Support Team to find ways to make improvements.

There were backlogs of assessments, but it was questioned whether assessments were always what was needed and if they did actually help all children. Some professionals suggested they did but apparently not all. The developmental work would look at this. The Intensive Support Team were also working with other similar teams around the UK with similar issues and who were feeling same levels of anxiety. It was acknowledged this was not a one size fits all situation but more if a graduated pathway. Where the pathways started was said to be debatable but the system was now joining hands so to speak.

The following points were discussed and questions asked;

The Committee Chair highlighted that he had received an email from the Chair of Bristol Parent and Carer Forum about the very positive work that was taking place on this.



A Member then asked about the above-mentioned early interventions. They said there were many existing problems and teachers were already contending with so much. Did this not require a holistic approach and what did early Intervention look like in this context?

The practitioners said they didn't yet know. They were still undertaking the co-design work but felt confident from talking to people that upskilling teachers and equipping them with more tools could make a big difference. They said they would welcome coming back to talk to the Committee again in future on what progress was being made.

A discussion ensued about how some professionals think parents can self-diagnose their children effectively and thus not all children need to be assessed by a professional. A Member suggested that things could become very messy if that was the chosen route going forward. However, it was said there were new developments in the pipeline such as artificial intelligence (AI) that could really help in the future. The Cabinet Member said she would be interested to know which schools were being worked with on this.

The wide range of parent's experiences and understanding were then highlighted for example, some parents knew relatively nothing about the process or support that should be available to them. It was agreed that more information was needed and the consistency of information was key to enable navigation of the system or parents could go around in circles.

Members also highlighted that when families move or become of age they often get lost in the system and have to back to the beginning and start again waiting for assessments. Also, how some children were on several different waiting lists. The practitioners agreed it shouldn't be that way and said they were looking at the re-designing transitioning process, for example if someone was 17 or 18 they mustn't go to the back of the queue.

A Member said it sounded very positive that teams of different professionals were now working together. The system was broken and he was glad this was being acknowledged. He agreed that more work needed to be done with parents so that they could help their children more. He suggested all the information provided needed to be on one website where parents and schools can access all in one place.

It was said however that some parents needed their child's diagnosis so they could get the required help. Not having an assessment was a barrier to getting support. Was anything being done so that parents don't need that 'rubber stamp' to get support? It was said that to compound the issue, because there are so many children waiting for assessments it increased the risk of missing the children with severe needs. More work on clinical prioritisation was taking pace but it was assessed that only about 10-15% of the children on waiting lists need to see a doctor. Most just needed a pathway to help their needs.

Members concurred with the co-production and design principles for the pilot projects in schools. This was recognised as such a huge national problem and it was hoped this would start to put things on the right path.

The DoPH said she thought this direction of travel was right and it was good to see the ICB working across the system. With regards to the ongoing prescribing issue, it did not necessarily always need to be medical diagnosis.

The Cabinet Member said the figures were 'through the roof' and they had been trying to ascertain what was driving the numbers for some time. The schools couldn't offer extra support until there has been an assessment and diagnosis. The system was broken. Schools all had different approaches and processes and there needed to be consistency and parents needed more confidence in the system and that did not always stem from an Education, Health and Care Plan (EHCP).





A Member said the way ECHPs were being used had changed over time. They weren't meant to be about identifying extreme needs. They were meant to be for signposting and identifying a pathway of support.

Another Member said it was key that parents didn't feel they were to blame. There were situations where parents had become isolated in their efforts to help children. Often it was the shame of what parent's felt that was driving negative situations such as that.

The Cabinet Member said it was incredibly important to understand what was going on and driving the figures.

The Chair thanked the practitioners for their paper and the very useful discussion. It was suggested that an informal briefing on this might be required to keep Members updated.

## **11 Work Programme**

The Committee noted the Work Programme.

Meeting ended at Time Not Specified

**CHAIR** \_\_\_\_\_

