Adults and Health Committee Minutes

Date: 23 January 2025

Time: 10.00 a.m. – 4.12 p.m.

Venue: New Shire Hall, Alconbury Weald, PE28 4YA

Present: Councillors M Black, C Boden, A Bulat, C Daunton, A Hay, M Howell, R Howitt (Chair), E Murphy, K Reynolds, G Seeff, P Slatter, S Taylor and S van de Ven (Vice Chair)

From 2.00pm:
Councillors C Garvie (South Cambridgeshire District Council), K Horgan (East Cambridgeshire District Council) and C Tevlin (Huntingdonshire District Council)

295. Chair's Announcements

The Chair welcomed Sally Cartwright as the new Director of Public Health. He also announced that Kirstin Clarke, Service Director for Adult Social Care, was leaving the Council and thanked her for her service on behalf of the Committee.

The Chair updated the Committee on the upcoming Care Quality Commission (CQC) assessment. The Council received notification on 11 November 2024 from the CQC with a request to submit evidence. On 5 December 2024, the Council submitted a self-assessment for the Council's Adult Social Care service, along with an information pack. The CQC would conduct an on-site visit within the next six months.

296. Apologies for Absence and Declarations of Interest

Apologies were received from Councillor Corney, Councillor Costello and Councillor Prentice (substituted by Councillor Bulat).

There were no declarations of interest.

297. Minutes – 12 December 2024 and Minutes Action Log

The minutes of the meeting on 12 December 2024 were approved as an accurate record and signed by the Chair.

An updated action log was circulated to committee members and published on the meeting webpage on 21 January 2025. The updated action log was reviewed and individual Members:

- asked for an update on the Care Academy. The Executive Director for Adults, Health and Commissioning stated a briefing note would be circulated before the end of the municipal year **– action required.**

- thanked officers for the briefing note on Right Care, Right Person (RCRP) and requested future update reports. The Chair asked for the request to be noted in the minutes but agreed this action should be closed.

- noted Minute 267 ‘Mental Health S75 Agreement Extension’ would be discussed in a future Spokes meeting **– action required.**

  The action log was noted.

298. Petitions and Public Questions

No public questions or petitions were received.

299. Business Plan and Budget 2025-26 to 2029-30

The Committee received the proposed Business Plan and Budget 2025-26 to 2029-30 relating to the services and responsibilities within the Committee’s remit. The report also set out the Committee fees and charges schedule.

While discussing demographics, inflation and demands, Members:

- clarified that pressures were costs that could not be avoided.

- queried how preventative investments were recognised and the impact on demand forecasting. Clarity was provided the level of spend on demand management and early help services cost, as well as examples of prevention and reablement. The Executive Director for Adults, Health and Commissioning identified investments in the proposal, for example B/R.5.005d ‘Investment into review of prevention agenda’. Members learnt that Cambridgeshire County Council was in the top twenty councils for demand management.

- questioned how the future population was taken into account. Assurance was given that population and housing forecasts formed part of the budget setting assumptions. The Executive Director for Adults, Health and Commissioning stated that work would be undertaken with system partners to look at new communities and identified areas of growth.

- sought clarity on how investments in areas such as Care Together would be reflected beyond 2026. Members noted that future business planning would take on board the learning from work to date and form part of future discussions regarding place-based delivery and financial models.

- questioned how commissioning considered insourcing and the impact on the budget. The Executive Director of Adults, Health and Commissioning confirmed that the directorate considered in-sourcing when looking at contracts and tenders, but that most of the services needed were within the private sector. It was noted that B/R.5.009 ‘Contract Management and brokerage – Invest to save’ focused on efficiency and effectiveness. A paper on the review of in-house services was on the agenda plan for March.

- queried how the Council could engage with the Independent Commission into Adult Social Care. The Chair asked for a report to be brought to the committee when

there was more clarity on the scope and mechanism for engaging with the review **– action required.**

- clarified that nationally the length of stay in long-term care had fallen.

[Councillor Boden joined the meeting at 11.12 a.m.]

While discussing investments to deliver savings, Members:

- queried how confident officers were that contract investments, such as B/R.5.009 ‘Contract Management and brokerage – Invest to save’ would yield the procurement savings noted in the report. The Executive Director for Adults, Health and Commissioning advised that learning had been taken from the 2024/25 forecasts and focused contract management work had been carried out in-year to maximise efficiency. Clarity was provided regarding the work carried out on block contracts, the use of procurement frameworks, turnaround of providers and improved open book accounting.

- queried B/R.5.010 ‘Double Up Care provision – Invest to save’ regarding safeguarding and support for service users’ individual needs. Clarity was offered on the provision of two Occupational Therapists to help make people aware of the equipment available to support them.

- asked if there were any new investments in technology. Members noted the Council Data, Digital and Technology Change Programme and learnt of some initial pilots within adult social care.

- sought further clarification on B/R.5.008 ‘Social Care apprenticeships’ and the impacts on savings. Members learnt that twenty apprentices had recently started, and savings were from the pay and workforce succession modelling.

- highlighted the importance of the quality of service and the best outcomes for service users.

While discussing savings and pressures, Members:

- sought further clarification on how confident officers were regarding savings, in particular procurement. Clarity was provided on frameworks.

- sought clarity on B/R.7.006 ‘Mental Health supported accommodation’ and B/R.7.009 ‘Mental Health residential and community.’ Members learnt that a strengths-based approach meant identifying and drawing on an individual’s strengths to build on what they could do and provide support in areas where they needed some help.

While discussing capital projects, Members:

- questioned the impact of Local Government Reform on the budget proposals. The Executive Director for Finance and Resources recognised that this would inform the

thinking in-year but at this stage it was recognised to be too early to identity within the proposals.

- clarified the current stage of model design for accommodation for people with complex needs.

While discussing fees and charges, Members:

- welcomed the inclusion of fees and charges for transparency.

- learnt that ‘peace of mind charges’ related to extra care housing schemes where additional services like 24-hour support were provided. The charge applied to all tenants and it was not possible to opt out as provision of this support was one of the factors that made it an extra care facility.

[The meeting adjourned from 12.03 p.m. – 12.13 p.m.]

The Conservative Group Spokes noted the challenges in adult social care and commented on the procurement process, block contracts and spot purchases in relation to care packages, underspends in Public Health and the difficulties in demand forecasting. For these reasons they would not be supporting the report recommendations.

The Liberal Democrat Group Spokes highlighted the unique challenges to adult social care and public health. They welcomed the move towards locality-based delivery models and the strong performance on early intervention. It was noted that the Public Health grant was not confirmed until after the budget was set.

The Independent Group Spokes highlighted pressures around adult social care.

The Labour Group Spokes welcomed the work done around equality of employment, the real living wage and apprenticeships expressed concern about elderly persons’ services, although they were satisfied that the budget proposals contained no cuts to those services.

Members thanked officers for their work.

The Executive Director for Adults, Health and Commissioning summarised the debate to be reported to the Strategy, Resources and Performance Committee on 28 January 2025.

It was resolved to:

a) consider and scrutinise the proposals relevant to this Committee within the Business plan and Budget 2025-26 – 2029-30 put forward by the Strategy, Resources and Performance Committee, 17 December 2024.

b) recommend changes and /or actions for consideration by the Strategy, Resources and Performance Committee at its meeting on 28 January 2025 to enable a business plan and budget to be proposed to Full Council on 11 February 2025.

c) receive the fees and charges schedule for this Committee included at appendix 2.

300. Recommissioning Drug and Alcohol Treatment Services for Adults and Children and Young People

The Committee received a report seeking approval for the recommissioning drug and alcohol treatment services for adults and children and young people. Attention was drawn to the two services being commissioned and delivered separately, rather than an integrated 'all age' service. The separate services allowed the specific needs of the service users to be met. The Deputy Director of Public Health advised that there was uncertainty around the continuation of the additional national grant funding. A needs assessment and stakeholder consultations would inform the ongoing development of the service.

The Chair highlighted that the committee was wrongly named in the report recommendations and proposed that this should be corrected with the consent of the meeting.

While discussing the reports, individual Members:

- questioned the success rate of the services and treatments provided as their impression was that it was quite low across the country. Members learnt that drug and alcohol issues were viewed as a long-term condition which often sat alongside other complex needs. The service was monitored on activity and outcomes which were measured against regional and national figures for treatment progress, and the position against national figures was strong.

- noted that improving outcomes should be considered throughout the commissioning process.

- queried the appropriateness of the year three break clause in the contract in view of the planned Local Government Reform. The Deputy Director of Public Health offered to seek legal advice on this point. The Executive Director for Adults, Health and Commissioning stated that year three was often used for a break clause as it allowed long enough for a provider to make some impact but was short enough to end the contract if it was not working. A request was made that that officers raise the question of procurement and contract management arrangements in the run-up to local government reorganisation with the Corporate Leadership Team **– action required.**

- questioned what the standards were for providers.

- agreed with the use of market analysis, as listed in recommendation B.

- agreed that drug and alcohol services for children and young people and adults should be kept separate and asked if that aspect should be taken to the Children and Young People Committee for decision. The Deputy Director of Public Health stated that the report was brought to the Adults and Health Committee as there was uncertainty if Members would want integrated or separate services. The Executive Director for Adults, Health and Commissioning advised that the Constitution gave the Adults and Health Committee the authority to take decisions relating to

exercising management, oversight and the delivery of all the Council's public health services for the population.

- queried if reports could be referred to other committees for information only. Officers agreed to clarify this **– action required.**

- welcomed the partnership with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

- queried if future contracts would replicate the current contract or if changes would be made.

- asked about the transitioning from children and young people's services to the adult service. The Deputy Director of Public Health stated children and young people's services tended to get marginalised when integrated with adult provision. It was important to ensure that the transition from young people's services was managed sensitively, and good commissioning could ensure that. The Provider Selection Regime (PSR) Procurement Regulations reflected the stability element.

- highlighted the desire for there to be more preventative work, however acknowledged the difficulties in measuring preventative success. Members learnt that prevention work was undertaken in conjunction with partners.

It was resolved unanimously to approve:

a) a new Section 75 with the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for it to continue to provide the Children and Young People's Drug and Alcohol treatment Service for 7 years at a total value of £3,218,047, with the option of breaks at years 3 and 5.

b) undertake a market analysis to determine if a competitive or direct award is the appropriate procurement route for the adult Drug and Alcohol Treatment Service under the Provider Selection Regime regulations.

c) if the National Drug Strategy additional grant funding is not extended or only to a minimum level, undertake a review of the improvements arising from the funding to inform decisions relating to the allocation of additional funding from any uplift in the core Public Health Grant to the Drug and Alcohol Treatment services.

d) bring a report to the **Adults and Health** ~~Adults, Health and Commissioning~~ Committee with the proposed service model based on the needs assessment currently in train, any confirmed additional grant funding, and the results of the market analysis to determine the appropriate procurement option. Current base value: £33,282,466 over seven years.

e) the **Adults and Health** ~~Adults, Health, and Commissioning~~ Committee to review and approve the recommendations initially and then they will be taken to the Children and Young People's Committee for information.

f) to delegate authority for awarding and executing the Section 75 for providing the Children and Young People's Drug and Alcohol Treatment

Service and the Adult Drug and Alcohol Treatment Service contract both starting 1 April 2026, to the Executive Director Adults, Health and Commissioning in consultation with the Chair and Vice-Chair of the **Adults and Health** ~~Adults, Health and Commissioning~~ Committee for a total of 7 years with the option of breaks at the 3 and 5 years.

301. Recommissioning Behaviour Change Services

Members learnt that Behaviour Change Services were commissioned to support improvements in health outcomes and the reduction in health inequalities in Cambridgeshire. The report sought approval for recommissioning a place-based service delivery model which would strengthen the opportunity for prevention work and integration with partners.

The Chair highlighted that the committee was wrongly named in the report recommendations and proposed that this should be corrected with the consent of the meeting.

While discussing the report, individual Members:

- asked for outcome targets to be considered in the procurement process.

- requested consideration for services to be targeted in areas of greatest need and highlighted the smoking rate in Fenland was 24% in 2023, compared to 10.8% across the rest of Cambridgeshire. The Deputy Director of Public Health highlighted the success of the Ferry Project.

- received confirmation that extensive engagement had been undertaken with a wide range of partners.

- welcomed the place-based model.

It was resolved unanimously to:

a) re-commission for Cambridgeshire residents only an integrated behaviour change service through the Provider Selection Regime competitive regulations for seven years, with contract break options at 3,5 and 6 years at a total value of £12,470,397 at 2024/25 prices including Integrated Care Board funding. Inflationary uplifts will be applied as considered appropriate and in line with the Council's Business Plan across the life of the contract.

b) develop a place-based commissioning and financial model following completion of the four areas of work described in paragraph 3.11 and to bring the finalised model back to the **Adults and Health** ~~Adults, Health, and Commissioning~~ Committee in March 2025, prior to commencing the procurement.

c) delegate authority for awarding and executing the contract for providing the Behaviour Change Service starting 1st October 2025 to the Executive Director Adults, Health, and Commissioning in consultation with the Chair

and Vice-Chair of the Adults and Health Committee for a total of 7 years, with the option of breaks at Years 3, 5 and 6.

302. Adults and Health Policy and Service Committee Agenda Plan, Training Plan and Committee Appointments

It was resolved unanimously to:

a) note the committee agenda plan

b) note the committee training train

c) note that committee appointments to outside bodies and internal advisory groups remained unchanged.

[The meeting was adjourned between 1.25 p.m. to 2.00 p.m.]

[Councillors Howell and Reynolds left the meeting at 1.25 p.m.]

Health Scrutiny

303. Health Inequalities

The Committee welcomed the following to its scrutiny of health inequalities:

-	Louis Kamfer	Deputy Chief Executive, Cambridgeshire and Peterborough Integrated Care Board (ICB)
-	Jonathan Bartram	Programme Director for Health Inequalities, ICB
-	Dr Ashley Shaw	Medical Director, Cambridge University Hospitals NHS Foundation Trust (CUH)
-	Jess Slater	Chief Executive Officer, Healthwatch Cambridgeshire and Peterborough

The ICB representatives explained that the local ICB was focusing on alignment with NHS strategic priorities for tackling health inequalities and embedding the CORE20PLUS5 approach. The report contained examples of how this was being put into practice, as well as setting out improvements around coding to improve data driven analysis of health inequalities and to support a more preventative approach. Tackling health inequalities effectively required a collaborative approach both within and beyond NHS healthcare services.

Dr Shaw explained that CUH was a large teaching hospital which provided local, regional and some national patient care. Its main focus was the delivery of secondary care to patients requiring treatment rather than on preventing the need for treatment. The Trust was looking at ways of improving access to care. This included improving data collection and analysis; improving website accessibility and reviewing the language used when communicating with patients; considering models of care for those struggling to travel to hospital; and understanding how different communities accessed care differently. Work included looking at ways of reaching people not

currently accessing health screening programmes or preventative support like smoking cessation and how to design research to be more inclusive of a wider population.

The Committee's questioning focused on identifying and addressing health inequalities in Cambridgeshire, partnership working and funding. Individual committee members and co-optees raised the following issues:

1. Identifying and addressing health inequalities in Cambridgeshire

- asked how are measures to tackle health inequalities were weighted against clinical need in the allocation of the limited resources available.

- described Fenland as the most deprived area of Cambridgeshire across all key performance indicators for health and asked if it would be appropriate for further geographical initiatives to focus resources in the areas of most need. Access to health services in rural areas was a key issue, and the member suggested setting up additional GP surgeries in Whittlesey, Wisbech, March and Chatteris. Transport to medical appointments was also an issue, and they encouraged bringing services closer to residents. The ICB representatives advised that they were exploring ways of creating a different offer that took more account of patients' individual needs around accessing services. Patient transport services could also help. Dr Shaw described a paucity of travel options for patients in Fenland trying to access services at CUH, and the difficulties experienced by patients working on zero hours contracts who felt they could not afford to take time off to attend appointments. CUH was responding to this by trying to offer virtual appointments where appropriate and through the use of the community diagnostic centres in Wisbech and Ely which could provide some testing closer to home.

- noted that the figures for healthy life expectancy contained in the report had stayed quite stable over the past 10 years, and expressed concern that initiatives over this period had not had more impact. The member asked about the main problems being faced in tackling health inequalities locally and what difference the proposals set out in the report would make. The ICB representatives explained that a key difference now was having better patient data, which made it possible to assess the local population more accurately and see what risks to health could be mitigated or moderated. This allowed the identification of patient cohorts which were most at risk and who could be targeted via their GP practice or a more individualised approach. It was also possible to make information available in a wider variety of languages to reach more people.

- asked if the ICB saw scope for collaboration with the local Transport Authority and local government to develop new transport options for patients. The ICB representatives explained that it was difficult for the NHS to invest in transport provision, but there were other things that could be done to reduce the need for patients to travel to access services, like taking services closer to them or offering virtual appointments where appropriate.

- asked what was being done to encourage men to get tested for prostate cancer. The ICS representatives explained that a Public Health population approach could be taken, but that a more targeted approach could also be used based on data. Dr Shaw explained that there was no reliable and affordable screening programme for prostate cancer at present. A screening programme for lung cancer was being

rolled out nationally and would go to areas of greater deprivation first. It took a long time for innovations to be approved and rolled out.

- asked what learning was being taken from elsewhere, and what innovative practices the ICB and local providers were using to tackle health inequalities locally. ICB representatives described a meeting the previous week about a 3D heart scan which could be done at home or in a GP surgery as one of a number of innovative ideas being explored.

2. Partnership working and funding

- heard about an innovative partnership approach between the ICB and the Council aimed at supporting individuals with five or more attendances at an Emergency Department within 12 months. This had attracted praise from NHS England.

- asked about the barriers to partnership working. The Deputy Chief Executive of the ICB stated that partnership working was fundamental. There was already a significant amount of synergy between health and social care sectors and beyond, but all organisations had their own priorities and pressures which could be a limiting factor.

- heard examples of partnership working between CUH and the ICB and system partners, including multi-disciplinary team meetings with other NHS Trusts. The new Cambridge Children's Hospital would be providing physical and mental healthcare services on one site which represented an innovative approach based on collaboration

- asked what was being done to support primary care services to reduce the pressure on emergency departments. The ICB representatives acknowledged that capacity constraints at primary care level increased the number of people seeking treatment at emergency departments. A strategic plan had been presented recently to the ICB Board examining other access points to care like pharmacies to make best use of GP capacity.

- expressed concern about patients falling through gaps in treatment and on-going care, especially for vulnerable patients, and asked what was being done to ensure that people who might be experiencing health inequalities were identified and supported holistically. The ICB representatives acknowledged that there was a risk of people falling through gaps in provision. The issue was how to get better at identifying individuals at risk of this and to improve pathways for them. The importance of hearing the patient voice in the redesign of patient pathways was empathised, and Healthwatch was a valuable partner in this. Learning was also being taken through the Core20PLUS approach.

- asked if there were sufficient GP surgeries in deprived areas of the county or areas of high growth. Another member asked why more services were not delegated to local primary care networks and GPs, and more GP surgeries set up. The Chair noted that the recent Healthwatch summit on tackling inequalities has identified opening more GP surgeries as one thing the ICB could do to tackle inequalities. The ICB representatives advised that the ICB had increased GP capacity quite significantly in recent years. Increased capacity could be about new surgeries, but it could also be involve investing in existing surgeries in deprived areas. Looking

ahead, work was being done to understand where the population was growing the most and ways of bringing care closer to those communities. This included looking at integrated neighbourhood team capacity to wrap around GP practices and primary care networks (PCNs).

- the Chief Executive of Healthwatch advised of some perceived discrimination described by patients, especially in areas like language. Healthwatch believed that improving communication with patients was key. The issue of waiting times had been a growing area of concern to patients in the last six months, including for under 18s. It was important to look at engagement while people were waiting. The ICB representatives emphasised the importance of waiting well, and how improvements to general health while waiting for treatment improved surgery outcomes. There had been a big emphasis on addressing smoking rates in areas and groups of people with higher smoking rates, with work taking place in Fenland via PCNs.

- the Director of Public Health welcomed the reports under discussion, which had described lots of positive things. Tackling health inequalities was a complex issue and there was a wider collective responsibility which went beyond the NHS.

It was resolved unanimously to delegate authority to the Democratic Services Officer, in consultation with Committee Spokes, to produce a summary of the Committee's feedback and recommendations, and to send these to the relevant parties.

304. Cambridgeshire and Peterborough NHS Foundation Trust Mental Health Services

The Committee welcomed the following attendees for its scrutiny of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) mental health services:

- Steve Grange — Chief Executive, CPFT
- Holly Sutherland — Chief Operating Officer, CPFT
- Rachel Gomm — Chief Nurse, CPFT
- Dr Catherine Maxey — Interim Deputy Medical Director
- Jess Slater — Chef Executive, Healthwatch Cambridgeshire and Peterborough

The Chair stated that there had been concern about the number of deaths by suicide at CPFT for quite some time. The Committee had refrained from scrutinising this issue when an independent enquiry was planned, but as that had been stood down the committee owed it to the public to ask that question now.

The Committee's questioning focused on safety and performance, workforce, and leadership and finances. Individual committee members and co-optees raised the following issues:

1. Safety and performance

- paragraph 2.11 of the report stated that CPFT had seen its waiting list for assessment grow considerably during the period from December 2021 to December 2024, but paragraph 2.12 stated that the Trust had a below average

number of patients waiting for mental health assessment and a below average number of long-waiters. That felt contradictory, and it was unclear with whom CPFT's performance was being compared. The Chief Operating Officer CPFT explained that CPFT was experiencing the same rise in demand for mental health services that was being seen nationally. The comparison related to CPFT's performance within the Cambridgeshire and Peterborough Integrated Care System (ICS) in comparison to other ICS's of which it was part, and it was below average on that basis

- paragraph 2.2 stated that 'CPFT mainly applies a "by exception" basis of reporting, which seemed a reactive approach. CPFT was asked at what point it anticipated taking a proactive approach, and what would be the right balance between a reactive and proactive approach. The Chief Executive CPFT stated that as an organisation the Trust must not rely solely on data, but also on what its staff was seeing and what patients were telling them. The Trust should be constantly checking where things stood, not assuming things were ok until told otherwise. The Chief Nurse advised that any performance metrics were validated at team and service level, so it was only the exceptional issues that were raised at Board level.

- noted that the number of deaths by suicide had been an issue at CPFT for a long time, and asked about the zero suicide task force alliance which had been established in light of previous concerns. The Interim Deputy Medical Director stated that CPFT was absolutely committed to the prevision of deaths by suicide. The zero suicide task force had been superseded a newly reinvigorated system-wide learning from deaths group.

- asked who was responsible for overseeing the care of patients following discharge, including medication reviews, and what support was in place for vulnerable people who might not have someone to advocate for them. The Interim Deputy Medical Director CPFT explained that this depended on the patient's needs, and that there were clear governance procedures in place for all services. The Trust recognised that it worked with some vulnerable people and it offered advocacy and protection where appropriate. Where things went wrong there were Trust-wide learning forums to share learning from incidents.

- asked if there was a clear pathway for autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) assessment and diagnosis in Cambridgeshire, to make sure that people were on the right pathway. The Chief Operating Officer confirmed that there were pathways for both children and for adults, and that these areas had seen biggest increase in referrals and were the Trust's most challenged waiting lists. CPFT was looking to move towards a need-led pathway for children, rather than focusing on diagnoses. It was looking at various options for adults, including from other providers where that would be most appropriate. A strengthened primary care mental health service triage would also help get patients to the right service the first time and support waiting well.

- asked for an example of where something was working well, and where a service had broken down and what was being done to address this. The Chief Executive CPFT stated that since joining the Trust in October 2024 he had spent as much time as possible with service users and their carers to find out what they thought, and speaking to the Trust's workforce. This had identified things that CPFT was getting right as well as some that needed to improve. Sometimes thing went wrong

when the organisation did not connect with its partners, or when processes got in the way. The local Integrated Care Board was good at bringing partners together and the arrival of the Council's new Director of Public Health provided an opportunity to fix some inter-organisational issues. He extended an invitation to committee members to carry out a follow-up visit to CPFT.

2. Workforce

- noted that there was a 24 hour telephone support line for people experiencing a mental health crisis, but that ambulances were often called in these cases and their crews were not trained to deal with this. Norfolk and Waveney was piloting a mental health response vehicle which had led to 90% of hospital admittances being avoided via community based support. The member asked if CPFT had considered this approach. The Chief Operating Officer CPFT advised that the Trust was constantly looking at areas of best practice. It had previously had a mental health joint response vehicle with the East of England Ambulance Service Trust NHS Trust (EEAST). This had been paused as EEAST had been unable to provide staffing, but conversations were continuing. A joint response vehicle existed with the police, and links also existed with voluntary sector partners. It was understood that an emergency department was not the best place for most people experiencing a mental health crisis, and EEAST staff could call the CPFT advice team to get advice on how best to support individuals. A resource hub had been set up by the ICB as part of its winter planning and consideration was being given to how this might be expanded to cover mental as well as physical health.

3. Leadership and Finance

- asked how CPFT's new leadership team would balance running two major hospitals alongside a wide range of community services across multiple sites, as this was an unusual model. The Chief Executive CPFT stated that the leadership team was committed to managing the day to day delivery of services to some of the most complex and challenged people in society. He had been tasked with setting a clear five year strategy for the organisation, and would be happy to submit a report on that in the future if the committee wished. A member suggested that this might include looking at specific groups at risk of suicide, like young people or those with eating disorders.

- asked about the longer term strategy in relation to staffing, culture and finance. The Chief Executive CPFT highlighted the Trust's duty to manage within the finances available in partnership with other agencies, and the important role played by the voluntary and charitable sector. He could not comment on previous administrations, but his would be transparent and learn from lived experienced. The financial position for month 8 was not great, but month 9 was more positive and was moving towards a break even position. The duty to make best use of the public purse was recognised, but the prime narrative was about looking after people and nothing must dilute that.

- noted the seminars and mental health awareness training courses listed on the CPFT website and asked if there was anything the Council could do to help if this came under Public Health (PH). The Chief Executive CPFT stated that the Trust would welcome the opportunity to work with PH on delivering training if the opportunity arose.

- highlighted epidemiology of mental health needs in rural and urban areas and asked if there would be different strategies for different areas. The Chief Executive CPFT acknowledged the complexity of this issue, and the need to check that interventions were effective through a co-production lens and listening to communities and patients. The Trust would continue to work with the Public Health team and Adult Social Care to develop a strategy around health inequity.

The Chair asked what CPFT could learn from its record on deaths by suicide. There had been two critical coroner's reports and the previous chief executive had stepped down saying that the Trust had got things badly wrong. He would have liked to see more candour around this, and expressed some disappointment. The Interim Deputy Medical Director stated that the leadership team was committed to preventing suicide at CPFT. The previous criticisms had been heard and there were numerous things that CPFT could do as part of a system-wide suicide prevention strategy. The Trust continued to advocate for the treatments its patients needed to get well. The learning from deaths processes now were very different. An offer to meet had been made to all affected families and it had been invaluable to hear their stories, and be able to explain the changes being made in the Trust.

The Chair acknowledged that the report contained a lot of technical detail, but felt that from a public perspective there was insufficient reflection more widely of the scale of the mental health crisis being seen in Cambridgeshire and nationally. The Chief Executive CPFT stated that the Trust was fully cognisant of the difficulties it faced every day, and of the need to work with partners in the NHS and social care. CPFT must be unrelenting in getting the fundamentals of care right to deliver the Secretary of State's vision for health with its partners.

It was resolved unanimously to delegate authority to the Democratic Services Officer, in consultation with Committee Spokes, to produce a summary of the Committee's feedback and recommendations, and to send these to the relevant parties.

305. Health Scrutiny Work Programme

The health scrutiny work programme for 2025/26 would be discussed informally at the next health scrutiny pre-meet and a report brought to the meeting in March.

The 2024/25 health scrutiny was noted.

306. Health Scrutiny Recommendations Tracker – January 2025

The Health Scrutiny Recommendations Tracker was noted.

[Chair]