PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH SCRUTINY COMMITTEE HELD AT 7.00PM ON MONDAY 6 NOVEMBER 2017 IN THE BOURGES / VIERSEN ROOMS, TOWN HALL, PETERBOROUGH

Committee Members Present:	Councillors M Cereste (Chairman), B Rush (Vice Chairman) K Aitken, J Bull, D Fower, H Fuller, M Jamil, N Khan, S Lane, and Parish Councillor – Co-opted Member Henry Clark,	
Also present	Susan Mahmoud	Healthwatch
	Jessica Bawden	Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group
	Mustafa Malik	Greater Peterborough Network
	Katherine Hartley	Consultant in Public Health
	Aidan Fallon	Head of Communication & Engagement, Cambridgeshire & Peterborough STP
	Joel Harrison	Finance, Analytics & Evaluation Director, Cambridgeshire & Peterborough STP
	Stephen Graves	Chief Executive Officer, North West Anglia NHS Foundation Trust
	Jane Pigg	Company Secretary, North West Anglia NHS Foundation Trust
	Caroline Walker	Deputy CEO/Finance Director
Officers Present:	Dr Liz Robin	Director of Public Health
	Paulina Ford	Senior Democratic Services Officer

22. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Barkham and Councillor Nawaz. Councillor Bull was in attendance as substitute for Councillor Nawaz. Apologies were also received from Dr Steve Watson, Co-opted Member.

23. DECLARATIONS OF INTEREST AND WHIPPING DECLARATIONS

No declarations of interest or whipping declarations were received.

24. MINUTES OF THE HEALTH SCRUTINY COMMITTEE HELD ON 4 SEPTEMBER 2017

The minutes of the meetings held on 4 September 2017 were agreed as a true and accurate record.

25. CALL-IN OF ANY CABINET, CABINET MEMBER OR KEY OFFICER DECISIONS

There were no requests for Call-in to consider.

The Chairman announced that there had been a request from Officers to change the order of the agenda and asked the Committee if they would agree to the changes. The Committee unanimously agreed to change the order of the agenda as follows:

Item 6 – Sustainable Transformation Partnerships to move to item 5, item 5 – Draft Suicide Prevention Strategy 2017-2018 to move to item 6.

26. SUSTAINABLE TRANSFORMATION PARTNERSHIPS

The report was introduced by the Head of Communication and Engagement, Cambridgeshire & Peterborough STP. The purpose of the report was to provide an update on the Sustainability and Transformation Partnership (STP) implementation progress.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- What started out as the sustainable transformation plan had evolved over the year into a sustainable transformation partnership.
- The Peterborough and Cambridgeshire area had one of the fastest growing and elderly populations in the country and faced increasing challenges to improve the care and health of its residents in light reduced funding and workforce shortages.
- The Plan was attempting to shift from re-active, 'downstream' care to a more pro-active and 'upstream' approach alongside delivering pathway changes, closing the funding gap, reducing overheads and addressing quality issues.
- As with any major change programme it was being done on a delivery group basis across all the NHS partnerships and social services from both Cambridgeshire and Peterborough local authorities.
- The Plan was a long term, multi-year plan and although everything could not be done at once and had to be scheduled, the Partnership was intending to introduce things at a pace in order to alleviate some of the pressures.
- As a result of the acute care pressures on the front door of hospitals, one of the main focusses and key work streams of the Plan involved supporting the emergency care team by extending JET (Joint Emergency Team) and supporting earlier discharge from hospital.
- An STP Board had been established in order to improve accountability.
- The scheme that was currently being trialled by Southend Council which involved the renting out of spare bedrooms in private homes to relieve bed blocking, was not something that Cambridgeshire and Peterborough were considering using. Resource had instead being allocated to the Discharge to Assess scheme which looked to move discharge out of hospital earlier in the pathway planning.
- The disparity between the bed blocking figures for Peterborough and those for Cambridgeshire was due to a greater focus on the issue in Peterborough and a possible disparity on how the numbers were being counted. The numbers for Peterborough was generally very low compared to other areas.
- The STP were considering how to better integrate primary care services and extend GP hours to increase access to their services.
- Bed shortages were acute as more people were staying in hospital for longer than had ever been seen historically, partly because of social care capacity. The solution to the bed shortage did not lie in building more beds as the area could not afford them and the area had the beds that it could afford, instead the STP wished to keep people out of hospital wherever possible by increasing primary care and community services.
- The preference was to be able to keep people at home where they were able to do so and where it was safe to do so by introducing initiatives such as the Falls Prevention Service.

- Councillors felt that the report was a snapshot and did not provide enough information for them to get an accurate picture of what was happening and whether the STP was achieving its objectives, specifically with regards to Peterborough.
- The Officers presenting offered to provide a much more detailed deep dive presentation and/ or a monthly update on the situation specifically in Peterborough.
- The risks outlined in annex 2 of the report were mostly red. It was a bleak picture because there were real risks around the availability of money and workforce.
- There were plans to extend JET further and increase its utilisation rate from 71% on weekdays and 63% at weekends. The JET service had been particularly successful in the Peterborough area because of GP's increased confidence in the service.
- Staffing shortage was one of the biggest problems in the programme and the partnership were trying to find innovative ways to address the issue.
- It was felt by officers that it would have been overwhelming to have put a lot of detail into the report for the meeting as the sustainable transformation programme was so large and had so many different strands to it. A workshop was suggested as a forum for further discussion.
- There was community representation not only within the delivery groups but also within the projects and groups that fed into them.

RECOMMENDATION

The Health Scrutiny Committee noted the report and **RECOMMENDED** that the Head of Communication & Engagement, Cambridgeshire & Peterborough STP:

1. Develops an action plan that would fully address current and future workforce shortages.

2. Produce future reports in clear and plain English making them easier to read by the general public.

AGREED ACTION

The Health Scrutiny Committee requested that the Director of Public Health liaise with the Head of Communication & Engagement, Cambridgeshire & Peterborough STP to set up a workshop that would report on the work of the STP in greater depth and how it impacted on Peterborough specifically. The workshop to include workforce development with a focus on Peterborough.

27. DRAFT SUICIDE PREVENTION STRATEGY 2017-2020

The report was introduced by the Consultant in Public Health. The purpose of the report was to ask the Committee to comment on the refreshed draft of the Suicide Prevention Strategy as part of the consultation process and ahead of its approval by the Health and Wellbeing Board.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- There had been a Suicide Prevention Strategy in place for the last three years from 2014 to 2017. The draft strategy was a refresh and would ensure continuation of work until 2020.
- The Strategy was accompanied by a working action plan which covered multiple agencies including the Police, the Coroner's Office, Mental Health Trust and Charitable organisations.
- There had been a reduction in suicide rates in the Peterborough area recently and statistically it was now in line with the England average.

- The Peterborough Suicide Implementation Group in conjunction with the Coroner's office had lobbied to enclose the car parks with barriers. This had now been done and it was felt that this had impacted on the suicide rates.
- Peterborough City Council and Cambridgeshire County Council supported the Stop Suicide campaign which included such measures as a bespoke stop suicide training course for front line staff who came into contact with people who were contemplating suicide.
- People who were suffering a mental health crisis could use the first response service which was a 111 number which put them through to a mental health specialist who could triage and manage their crisis. This service was unique to Peterborough and Cambridgeshire.
- If necessary, individuals who used the first response service could be signposted to or physically taken to a 'sanctuary' which was a place of safety. There were three sanctuaries in the area at Cambridge, Huntingdon and Peterborough. The use of sanctuaries was proven to reduce the numbers of patients in mental health crisis presenting at A&E.
- There was a Kooth online counselling service available for young people as well as community based face to face youth counselling sessions.
- Funding had been received from the Sustainable Transformation Programme (STP) to provide specialised training for GPs and to set up a new bereavement support service to also include people who had suffered a bereavement due to suicide.
- There was a national target to reduce suicide rates by 10% but locally there was an initiative to bring all partners together so that suicide prevention was a priority for all and support would be given to the zero suicide campaign.
- Concerns were raised about the restricted times available for the Kooth online counselling service. It was suggested that when it was unavailable that alternative numbers and websites should be displayed so that young people could always contact services and access information to help them at their time of need.
- A detailed mental health strategic needs assessment had been undertaken in 2016 and it supported the development of the strategy that was being presented to the Committee.
- Men from the Eastern European migrant population were emerging as a high risk group for suicide. Efforts to target this group included a translation of the advertising video for the 111 service into Polish and Lithuanian, but it was recognised that there was still more work to be done in reaching this group.
- The mental health website keepyourhead.com which was targeted at young people had been advertised on social media. MIND ran the STOP suicide website and received sponsorship from private companies to do so. One of these companies was a technical/IT company which was looking to do much more work on social media marketing of the service.
- The first response service still had more work to be done in promoting itself and advice from Councillors and the Council's Communications team would be welcome. Members suggested that social media, when used effectively, enabled much more to be done with less money when compared to the use of traditional websites.
- It was acknowledged that more had to be done to reach out to students particularly in light of the new university being developed in the City and the projected increase in the number of students.
- The partnership had decided to focus on younger people for the next year because of the current pressures in that area but an approach for the older generation and middle aged men who had been highlighted as at risk groups would also be considered.
- It was highlighted that Peterborough had higher risk factors for mental health problems than Cambridge and therefore it was expected that higher rates of suicides would be seen in Peterborough.
- The Strategy covered both Peterborough and Cambridge together and so was in some instances, at a generic level. The specific risks faced just by Peterborough however would be highlighted in the new GP training and the Mental Health Crisis Care Concordat

Working Group was targeting the migrant population, a high risk group specifically in Peterborough.

- The highest risk of suicide was within the first few days of discharge from a mental health unit. To address this issue the local mental health trust was developing their own suicide strategy that would tie in with this strategy. In particular it would look at personal safety plans, follow up care and adopting a learning culture, especially around assessing risk and making sure the assessments were watertight.
- The zero suicide initiative would not be performance measured but rather it was an ambition to highlight the fact that suicide was preventable.
- The Public Health Consultant considered that three of the most important areas in the newly refreshed strategy which would make a real difference when compared to the old strategy were the bereavement support service, the work being done with young people around self-harm and the grant from the STP which would cover the cost of specialised GP training.

ACTIONS AGREED:

1. The Health Scrutiny Committee considered the report and **RESOLVED** that the draft Suicide Prevention Strategy and the action plan attached at appendices 1 and 2, be noted.

2. The Committee requested that the on line services keepyourhead.com and the Kooth online counselling service provide out of hours contact numbers to ensure young people and adults using the service were signposted to alternative support out of office hours.

28. PRIMARY CARE UPDATE PETERBOROUGH

The report was introduced by the Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group and provided the Committee with an update on primary care, specifically general practice. The report also provided further information on the local implementation plans of the national General Practice Forward View Strategy (GPFV).

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- The CCG Director of Corporate Affairs, in acknowledgement of comments that had been made about the previous reports presented to the Committee, noted that the report was very technical and therefore not particularly public friendly.
- The Committee had heard in January about the draft GP Forward Strategy around primary care which had now been signed off; this would be refreshed each year.
- The CCG had taken on delegated commissioning which meant that it was now responsible for contracting with primary care.
- Two key areas that the report addressed were around access to GP's and around the retention and recruitment of the primary care workforce.
- In recognition of a constantly changing landscape, neither of the two original care models; MCP (Multi-Speciality Community Providers) and Primary Active Care Systems were now considered fit for purpose.
- An inclusive model of healthcare which worked with the whole of the NHS, Local Authorities and voluntary sector partners was what was needed.
- One of the lessons learnt was that the approach taken by some other Councils who had procured large long term contracts which offered a plethora of services, did not work for Peterborough.
- The CCG wanted to take a disease specific pathway approach and take time to consider how integrated care could be best delivered as opposed to going very quickly to market to procure contracts.

- The CCG would rather work with existing providers in the system rather than procure long term contracts that may have associated workforce risks.
- There had been an initial workshop with colleagues from the community and the hospital which looked at how they could bring the specialist service to the community. For particular pathways such as respiratory and cardiology, instead of having patients moving along an escalator to access services, it would be preferable to have the patient static with the services moving around them. New pathways would be circular with the patient in the centre.
- There was a seven day access to primary care across Peterborough with local clinics that were open until 8pm on weekdays and which were also open at the weekend.
- The City now had an additional 2500 primary care appointments every month.
- In order to make best use of the available primary care resources, the patients who rang for an appointment would be properly assessed so that for example older patients would be given longer daytime appointments at their own practices and working residents for whom convenience was a priority could be given a clinic appointment outside of normal working hours.
- There had been leaflet drops, billboard messages and facebook campaigns to advertise the fact that there were alternatives to going to Accident and Emergency.
- Members expressed concern that the Muslim population in the City often found it very difficult to get a death certificate promptly from a GP if a relative passed away at the weekend or during out of hours.
- Although there was a GP on call in the extended service, because of the 7 day a week opening and the staffing rotas this required it was more difficult to see a GP that had seen the patient within the last 14 days; a requirement for issuing a death certificate. The problem was exacerbated by other practical issues such as the GP being on call elsewhere, working part-time, being out of the country or not being prepared to put their number on the end of life register.
- The CCG was aware that the issuing of death certificates was a particular problem for the Muslim community because their religion required that burial should take place soon after death.
- It was suggested that part of the problem with the high levels of presentation at A & E was because patients were not willing to wait for a doctor or nurse to call them back when they rang for an appointment, and wanted a face to face service instead.
- There were figures available which showed the call drop-off figures ie. the numbers of patients who did not wait for a call back.
- GP morale was low because of how they were being asked to work and were unhappy with the service they were giving and patients were receiving. The GP retirement rate was faster than the replenishment rate and so there were efforts being made to recruit from further afield and also to widen the skill mix and see what other services advanced nurse practitioners could deliver.
- There were NICE guidelines in place which determined what the first level of treatment was for patients. A GP could for example, refer to a physiotherapist in the first instance which may result in the patient not needing to be seen by a specialist consultant. GP's could contact consultants for advice and guidance on when to refer patients. Clinical threshholds were worked up on the basis of evidence and were widely consulted on.
- Members felt that although younger people could be diverted to other professionals to reduce the referral rate to consultants this was often not a suitable route for an older patient who, for example, obviously needed a hip replacement. Instead, this process simply extended the waiting time for the operation whilst the patient remained in considerable pain.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to note the report and requested that the CCG provide the Committee with the rates of call drop off which was the number of people calling the surgery and failing to wait for a return call from either a doctor or nurse.

RECOMMENDATION

The Health Scrutiny Committee **RECOMMENDED** that the CCG investigate how other areas of the Country address the problem of issuing death certificates promptly during out of hours service to those within the Muslim community.

29. UPDATE ON THE HINCHINGBROOKE HEALTH CARE NHS TRUST AND PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST MERGER

The Chief Executive Officer of the North West Anglia NHS Foundation Trust introduced the report which provided the Health Scrutiny Committee with an update on the merger and identified the key issues in the approved business case for the merger in terms of services and supporting requirements. The report also briefed the Committee on the current key operational issues.

The Health Scrutiny Committee debated the report and in summary, key points raised and responses to questions included:

- The Trust had taken over outpatients services from the Ely and Doddington Community Hospital and also radiology services for Ely, Doddington and North Cambridgeshire from their site at Wisbech.
- The management structure of the clinical service was being reorganised so that instead of having two clinical divisions in the Hinchingbrooke Trust, and four divisions in the Peterborough and Stamford Trust, there would now be three divisions overall.
- Leadership of the clinical teams was already in place and the Trust were now recruiting at the next tier down.
- The culture of each organisation was slightly different and so efforts were being made to foster an agreed vision and value set across the new structure and its 6000 staff. It had been a difficult challenge to embed a new culture in Hinchingbrooke as the majority of the senior team had come from Peterborough, mainly because they were permanent staff, which meant that Hinchingbrooke felt that a culture was being imposed on them rather than it being a natural evolution.
- Members expressed concern that patients would have to travel to even further to access cardiology services at the new Papworth site.
- The Trust was in a catch 22 situation with regard to cardiology services. The original Papworth business case which was made almost ten years ago, assumed that all patients in the area would transfer to Papworth and required that Peterborough be included in it. However because of advances in cardiac treatment and services, many of the services Papworth offered were no longer seen as specialist and would expect to see them being offered in a reasonably sized hospital such as Peterborough. Patients from the Bedford, Northampton and Kettering areas all had these services provided in their local district general hospital. Additionally, the STP future plan was to have two locations where there was a 24/7 consultant led cardiology service. Cardiologists at Peterborough were part of the general 24/7 on call service and were not an independent service. In order to justify this, Peterborough would need to have enough work and make it interesting enough for the seven cardiologists that would be required.
- The benefits of the merger hinged on the back office change that were being undertaken. The Trust was on target to make savings of £9 million from restructuring departments and having administration economies of scale benefits. To date £4.5 million of savings had been made and redundancies had been less than expected. Although 80 posts had been lost in the restructure there had only been 16 redundancies so far as many staff had found new positions elsewhere.
- The Trust had the added complication of dealing with both Lincolnshire and Peterborough & Cambridgeshire STPs. As the Trust was physically based in the geography of the

Peterborough and Cambridgeshire STP it was more involved with them and attended most of their meetings. In order to forge closer links with Lincolnshire STP regular meetings had been set up with their Chief Executive who also held the position of Chief Executive of the South Lincolnshire CCG which was part of the Trust's local geography.

- Both STPs shared many common goals, the primary one being to reduce the amount of activity and resource going into secondary care.
- In Stamford GP practices had joined together under the Lakeside consortium. They were now looking to physically come together at the Stamford Hospital site as it was felt that by bringing all of the services onto one site the need to refer people into hospital could be reduced.
- The biggest issues facing the Lincolnshire STP were in South Lincolnshire concerning the futures of Grantham hospital and the Pilgrim hospital in Boston. There were fears that because of their size they would not be able to recruit and keep enough of their senior clinical staff to keep the services they provided at present.
- It was stressed that no consultation or even pre-consultation had begun on the Grantham and Boston hospital issue but it was relevant to the merger because depending on what they decided to do, there would be a material effect on Peterborough. An example of which was if the consultant led obstetrics department was closed the 1800 plus babies born in Boston hospital would instead be delivered at Peterborough which was the next nearest hospital.
- The expected population growth over the next 20 years was a significant issue for the area. In Peterborough alone it was expected that there would be 24,000 extra homes which would mean an increase of 60 to 70,000 residents. In the whole of the Cambridgeshire area this figure was 280,000 which would be the population for a medium sized hospital under the terms of how care was currently delivered.
- There had been an expectation that some of the Hinchingbrooke site would be sold for housing and a substantial profit could be made. However consultants advised that the cost of providing a replacement car park would rule out any profit that could be made. The Trust had now come to the view that it would be better to pause and consult with everyone rather than rush ahead with former plans.
- In terms of the IT integration plan, the Trust was on target with its 3-5 year plan. New IT and associated clinical systems were needed across all three sites so that clinicians could access patient information wherever they were. A new data line had been put in place to support the transfer of information and in particular the migration of patients' records.

AGREED ACTIONS

The Health Scrutiny Committee considered the report and **RESOLVED** to note the progress made with the formation of North West Anglia NHS Foundation Trust

30. MONITORING SCUTINY RECOMMENDATIONS

The Senior Democratic Services Officer introduced the report which provided the Committee with a record of recommendations made at the previous meeting and the outcome of those recommendations to consider if further monitoring was required.

ACTIONS AGREED

The Health Scrutiny Committee **RESOLVED** to consider the response from Cabinet Members and Officers to the recommendations made at the previous meeting, as attached in Appendix 1 of the report and agreed that no further monitoring of the recommendations was required.

31. FORWARD PLAN OF EXECUTIVE DECISIONS

The Committee received the latest version of the Council's Forward Plan of Executive Decisions containing key decisions that the Leader of the Council, the Cabinet or individual Cabinet Members would make during the course of the forthcoming month. Members were invited to comment on the Plan and where appropriate, identify any relevant areas for inclusion in the Committee's Work Programme.

ACTION AGREED

The Health Scrutiny Committee **RESOLVED** to note the Forward Plan of Executive Decisions.

32. WORK PROGRAMME 2017/2018

Members considered the Committee's Work Programme for 2016/17 and discussed possible items for inclusion.

ACTION AGREED
The Health Scrutiny Committee** RESOLVED **to note the work programme for 2017/18.

33. DATE OF NEXT MEETING:

- 29 November 2017 – Joint Scrutiny of the Budget
- 8 January 2018 – Health Scrutiny Committee

The meeting began at 7.00pm and finished at 9.43pm. CHAIRMAN