MINUTES OF A MEETING OF THE HEALTH SCRUTINY COMMITTEE
HELD AT 7.00PM ON
MONDAY 17 SEPTEMBER 2018
IN THE BOURGES / VIERSEN ROOMS, TOWN HALL, PETERBOROUGH

Committee Members Present:	Councillors J Stokes (Chairman), K Aitken, S Barkham, R Ferris, S Hemraj, D Jones, D Over, B Rush (Vice Chairman), B Saltmarsh, N Simons, S Warren Co-opted Members - Parish Councillor Barry Warne and Dr Steve Watson	
Also present	Jane Pigg	Company Secretary, North West Anglia NHS Foundation Trust
	Jessica Bawden	Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group
	Dr G Howsam	Clinical Chair - Cambridgeshire and Peterborough Clinical Commissioning Group
	Marek Zamborsky	Head of Adult Mental Health, Learning Disability Commissioning and Contracting, Cambridgeshire and Peterborough CCG
	Mubarak Darbar	Head of Commissioning for Cambridgeshire County Council and Peterborough City Council
	Nik Patten	Healthwatch, Cambridgeshire
Officers Present:	Dr Liz Robin	Director of Public Health
	Paulina Ford	Senior Democratic Services Officer
	David Beauchamp	Democratic Services Officer

11. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Sandford and Councillor Jamil. Councillor Saltmarsh was in attendance as a substitute for Councillor Sandford and Councillor Ferris was in attendance as substitute for Councillor Jamil. Apologies were also received from Co-opted member Parish Councillor Henry Clark and Parish Councillor Barry Warne was in attendance as substitute.

12. DECLARATIONS OF INTEREST AND WHIPPING DECLARATIONS

Councillor Hemraj declared an interest in that she was an employee of the North West Anglia NHS Foundation Trust.

13. MINUTES OF THE HEALTH SCRUTINY COMMITTEE HELD ON 2 JULY 2018

The minutes of the meetings held on 2 July 2018 were agreed as a true and accurate record.

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

There were no requests for Call-in to consider.

15. STP UPDATE AND STRATEGIC DIRECTION 2018/9

The Clinical Chairman of the Cambridgeshire and Peterborough Clinical Commissioning Group introduced the report which asked the Committee to consider the strategic direction for the Sustainability and Transformation Partnership for 2018/19.

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

- Members commented that the report was difficult to understand and did not provide evidence of any real successes. Members were informed that appendix 1 attached to the report listed a number of successes where the system had worked together over the last year. Working together as one system would provide incremental changes rather than one big change.
- Members were advised that the five posts being created to support the delivery of core components in and around Peterborough were not specifically for Peterborough but would also cover East Cambridgeshire and Fenland.
- Delayed Transfers of Care (DTOC). One of the biggest problems regarding DTOC was co-ordinating who did what and understanding why those patients were being delayed. The process was complicated as there were a number of partner organisations involved and the first challenge was to identify exactly who did what.
- Members sought clarification with regard to patients who were deemed medically fit for discharge and why it took so long to put their care plans in place. Members were advised that there were a number of reasons why a patients discharge might be delayed which included social care packages, social care and health packages and sometimes it was family choice. It was important not to wait until the patient was fit to make those decisions, some areas within the hospital and also outside of the hospital could be speeded up. There was also an issue with workforce i.e. domiciliary care in particular. There was a team in place across Cambridgeshire and Peterborough that met every day and discussed the patients and their care packages and if these needed to be changed and also where the patients needed to go i.e. a residential home or if their family could support them. One of the issues has been around who pays for the care and the focus needed to be about the patient not who paid for the care.
- There were staff shortages across the system from carers in the community to practice nurses and consultants. This was one of the most worrying issues.
- Members sought clarification as to how many beds were available in Peterborough in both residential homes and nursing homes for Continuing Health Care (CHC) patients. Members were advised that the numbers varied daily and the information could be provided to the Committee after the meeting.
- Members enquired as to whether it was realistic to resolve the areas of persistent system challenges under Operational Performance as listed under paragraph 4.3.1. on page 14 of the report within the target of the next nine months. Members were informed that all of the challenges had to be met and this area of operational performance had to be right.
- It was noted that there was a forecast of a collective system deficit of £500m by 2021 and that only one other system in the country had a higher deficit in proportion of total income. Members were informed that the government were being lobbied as it was believed that the funding formula for Cambridgeshire was insufficient.
- The Primary Care Mental Health Service (PRISM) was set up to provide specialist mental health support to cover the gap between the specialist mental health services from the acute sector and those that could be dealt with in primary care. The service covered all spectrums of mental health including personality disorder and schizophrenia. The Head of Adult Mental Health also in attendance provided the Committee with a detailed explanation of the service provided by PRISM.
- Since the introduction of the PRISM service there had been a 25% reduction in people attending Accident and Emergency with mental health issues. The 111 option 2 first

response service had made the biggest difference as this allowed people to ring in at the point of crisis to speak to a trained mental health worker. This had meant that people were signposted to the correct service to deal with their needs at the point of crisis. Self-harm presentations at Accident and Emergency had significantly reduced since the introduction of the 111 service.

- Members sought clarification on whether the STP plan was on target to save the expected £500m. Members were informed that it was a big challenge as the rate of spend had not decreased and was therefore adding to the deficit.
- The Electronic Patent Record System (EPIC) was a bespoke computer system used by Addenbrookes. The aim was to roll out a similar system at Hinchingbrooke and Peterborough. It would be a platform that integrated data from different systems as the cost of changing to one system would be massive.
- Members noted that a new Interim Accountable Officer for the Cambridgeshire and Peterborough STP had been appointed for a period of six to nine months and questioned why is was a short term appointment. Members were informed that there was a high level of turnover in senior leadership roles which has proved to be challenging. The new Accountable Officer would bring some stability and allow the STP to move to the next stage.
- Members were concerned that the STP was a complex programme and it was difficult to see what the main objectives were, who was responsible for each element and what the vision was. Members were informed that there was a huge number of work streams in place each of which were programme managed with a timeframe in place for each and a risk register. There was an overall vision which was published in the STP plan eighteen months ago but in the health and social environment this was always subject to change. A new consultation had just been launched about the Five Year Plan for the NHS and how it should be structured for the current population which finished at the end of September. The outcome of this may affect the STP in the future.
- There was one pot of money to provide health and social care for the population. Guaranteed income contracts allowed the commissioners to know how much money would be spent across each of the providers. It also let the providers know how much money they will have to work with.
- If a patient is not at the point of discharge then they would not be classed as a delayed transfer of care because they had not been pronounced medically fit for discharge.
- Members were provided with a detailed explanation of Integrated Neighbourhoods.
- Members requested that future STP updates be more relevant and detailed towards Peterborough. Members were informed that one of the challenges was that the STP was not a statutory body but a collection of organisations working in partnership. A lot of the STP was high level strategic planning however there was some detail that could be provided from the Northern Alliance Patch work which was relevant to Peterborough.
- The Healthwatch representative sought clarification with regard to the work being undertaken around Outpatients. Members were informed that the current way of dealing with outpatients in hospitals was challenging and costly. The specialist knowledge required for outpatients did not necessarily have to be delivered in a hospital setting. The use of technology for follow up appointments could be over skype or a telephone conversation. This was one area that could be reimagined.

AGREED ACTIONS:

The Health Scrutiny Committee considered the report and **RESOLVED** to discuss and comment on the STP strategic direction and review.

The Health Scrutiny Committee also requested that the Director of Corporate Affairs provide the Committee with the following information:

1. The number of beds that were available in Peterborough in both residential homes and nursing homes for Continuing Health Care (CHC) patients.

2. The name of the other system in the country that had a higher deficit in proportion of total income to that of Cambridgeshire.
3. Provide a further update report in six months on the progress of the STP priorities to include Northern Alliance Patch work which is relevant to Peterborough and Road Map for System working.

16. NHS CONSTITUTION INCLUDING TARGETS AND PERFORMANCE

The report was introduced by the Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group. The report examined what people could expect from the NHS constitution and how the situation currently compared in Peterborough.

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

- The Healthwatch representative sought further information with regard to GP practice visits. Members were informed that the visits were not about going into a GP practice and asking why they were doing something in a particular way. The visit was about presenting them with the data on their practice referrals and then trying to understand why the referrals were being made. A high referrer was not necessarily doing something wrong. There was a variation in the number of referrals from each practice and this was often dependent on the demographics of the area or the different skills of the GP's. It had been noted that there had been an increase in referrals from the practices under the most pressure. Where there was a high level of patient turnover there was often a higher number of patient referrals. Patient expectations of the outcome of the treatment was also changing. Thresholds for referrals were being much more tightly applied in some practices and the outcome was a drop in referrals.
- Members noted that a patient's right to access services in A&E was to wait a maximum of four hours from arrival to admission, transfer or discharge. A&E attendances were 3.5% below plan. Members were informed that there were many reasons a patient attended A&E which included patients waiting for a bed and people who were not A&E patients. Primary Care teams had now been put in place within A&E to filter out people who were not A&E patients and this would take some of the strain. Additional improvements could be made to those people waiting in A&E for a bed to move them more quickly out of A&E. To improve things further it would need a culture change.
- Improvement and Assessment Framework clinical priority ratings table, page 29. It was noted that in the July 2018 column of the table there were several clinical priorities that were listed as "not yet assessed". Members sought clarification as to why. It was also noted that the C & P CCG Overall Rating was Inadequate as at July 2018. Members were informed that NHS England assessed all areas and to date they had only assessed the Cancer indicators which had been rated as "Outstanding" and Maternity Indicators which had been rated as "Requires Improvement". Diabetes, Mental Health, Learning Disability and Dementia had still to be assessed. The final ratings should be provided by September.
- Diagnosis of diabetes was difficult in that many people did not understand the severity of diabetes and therefore often did not go to the doctors to be diagnosed. Those people that did understand often did not want to receive the diagnosis. Structured education courses on diabetes were available at weekends and evenings.
- Members sought clarification with regard to the implementation of the system-wide Stranded Patients Taskforce at Peterborough City Hospital and at Hinchingbrooke. Members were informed that the term "stranded" did not only refer to elderly patients. The term stranded referred to patients who were in hospital for up to 7 days. The term "super stranded" referred to patients who were in hospital for over 21 days. Some people were in hospital waiting for a care package to be put in place or for a health intervention. On average if a patient stayed in hospital for 7 days or more every day after the 7 days the patient deteriorated and therefore it was very important that the patient did not stay in hospital any longer than they needed to.

AGREED ACTIONS:

The Health Scrutiny Committee considered the report and **RESOLVED** to note the NHS Constitution, as well as the current performance of local health services benchmarked against the pledges made within the Constitution

17. CAMBRIDGESHIRE AND PETERBOROUGH CCG COMMISSIONING PLANS AND RESPONSE TO PWC REVIEW

The Clinical Chairman of the Cambridgeshire and Peterborough Clinical Commissioning Group introduced the report which provided the Committee with the CCG's Commissioning plans following the capacity and capability review by PriceWaterhouse Coopers (PWC).

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

- The Improvement and Delivery Plan would be a fixed item on the Governing Board agenda going forward to ensure continuous monitoring of actions and timelines. NHS England would also be monitoring the plan very closely. Additionally an external body would be asked to review the work being done at six months to provide an assurance check and this could be shared with the Committee.
- The CCG were working consistently to clear the backlog of Continuing Healthcare cases and was on target to clear this by the end of the financial year. One of the main issues was the assessment and then working out the payment for the care, each case was complex and related to an individual with multiple needs and lifelong conditions. The backlog was approximately 900 when started and was now down to approximately 300 cases with the more complex cases now remaining.
- Members noted that PWC had identified that there was an *"ineffectiveness of the Governing Body to ensure the CCG met its statutory duties*" and queried whether the Governing Body had the right skill set to ensure the CCG did not find themselves in the same position in the future. Members were informed that the Governing Body was made up of a broad spectrum of clinicians and four lay members from independent backgrounds bringing a diversity of skills. There was a statutory requirement to have a clinical majority on the Governing Body.
- Members noted that PWC had found "*a history which demonstrates a lack of grip, action, financial forecasting, financial control and delivery".* The Clinical Chairman acknowledged and agreed with the findings.
- Members sought clarification as to whether there was anything in the areas identified for improvement by PWC that would be difficult to achieve. The Clinical Chairman advised that it was a very challenging environment to work in. There was now a substantive Senior Leadership Team in place and an Accountable Officer and Chief Finance Officer had now been appointed. In previous years the regulators had requested a forecast for a certain level of deficit to break even and the confidence in doing this had been difficult. This year there had been much tougher negotiations with the regulators and if the CCG achieved the controlled target of £35.1m the CCG would receive £35.1m sustainability funding which would in effect write off the debt.

AGREED ACTIONS:

The Health Scrutiny Committee **RESOLVED** to note the CCG's plans to address financial and operational challenges, for 2018/19 and beyond and requested that the Clinical Chairman report back to the Committee with the six month assurance check when available.

18. TRANSFORMING CARE - 'BUILDING THE RIGHT SUPPORT' (BRS) - INPATIENT BED CONFIGURATION. PREFERRED OPTION CONSULTATION

The Head of Adult Mental Health, Learning Disability Commissioning and Contracting, Cambridgeshire and Peterborough CCG accompanied by the Head of Commissioning for Cambridgeshire County Council and Peterborough City Council introduced the report. The report set out the CCG proposal to consult on the closure of inpatient beds, in order to invest in alternatives to hospital and community based services for patients with learning disabilities and autism in Cambridgeshire and Peterborough, in line with the recommendations of the Department of Health review of care at the Winterbourne Hospital.

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

- Spot purchasing for speciality needs would be for a small number of individuals who required specialist services for whom trying to provide a sustained local service would prove to be uneconomically viable and therefore would go to regional tertiary centres. This was known as active treatment placements. An example of this would be the National Autistic Inpatient Unit in London. It was not a question of money it was about providing the best treatment for the patient and reducing their time in hospital.
- The money saved from reducing the beds would be reinvested in to community services such as a 'Crash Pad and forensic services such as psychologists.
- Members were concerned about the impact on families of patients who may be placed outside of the area and how they might be supported financially to assist them with the extra costs involved in visiting their family member. Members were advised that there was guidance within the NHS Commissioning advice which suggested that based on the individual's situation the Commissioner should consider supporting a relative visiting a patient who has been placed out of area. It would be based on individual circumstances on how affordable the contact was. The support of a patient's family was integral to their recovery.
- The Building the Right Support – inpatient bed configuration was a cost neutral exercise. The aim of the exercise was to prevent people with learning disabilities going into hospital when there was no need and enhancing the community provision to support them outside of a hospital environment.
- The Committee were provided with an explanation of what the Crisis Pad was used for. It was a place of safety for people to go in a time of crisis rather than being admitted to hospital. The idea came from the analysis for reasons for hospital admissions. The Crash Pad would be Social Worker led with full clinical access as required.
- Plenty of job opportunities would arise for people through the enhanced community provision.

AGREED ACTIONS:

The Health Scrutiny Committee **RESOLVED** to:

- Note the report and
- Support a nine-week formal consultation, on the reconfiguration of the Learning Disabilities bed base and development of Community Services.

19. MONITORING SCRUTINY 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.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to consider the response from Cabinet Members and Officers to the recommendations made at previous meetings, as attached in Appendix 1 of the report and noted that:

- The recommendations made for the Peterborough Annual Public Health report on 4 September 2017 and the Update on the Successes and Failures of Integrated Urgent Care report on 12 March 2018 were still on-going.

20. FORWARD PLAN OF EXECUTIVE DECISIONS

The Senior Democratic Services Officer introduced the report. 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.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to note the report and considered the current Forward Plan of Executive Decisions.

21. WORK PROGRAMME 2018/2019

Members considered the Committee's Work Programme for 2018/19 and discussed possible items for inclusion.

AGREED ACTIONS

The Health Scrutiny Committee **RESOLVED** to note the work programme for 2018/19 and requested that the new Chief Executive of the North West Anglia NHS Foundation Trust attend the 5 November meeting when the Winter Plans report is presented.

22. DATE OF NEXT MEETING

Monday 5 November 2018

CHAIRMAN
7.00pm – 8.45pm