PETERBOROUGH CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH SCRUTINY COMMITTEE HELD AT 7.00PM ON MONDAY 2 JULY 2018 IN THE BOURGES / VIERSEN ROOMS, TOWN HALL, PETERBOROUGH

Committee Members Present:	Councillors J Stokes (Chairman), K Aitken, S Barkham, S Hemraj, M Jamil, D Jones, D Over, Rush (Vice-chairman), B Saltmarsh, N Simons Co-opted Members - Parish Councillor Henry Clark and Dr Steve Watson	
Also present	Roxana Mojoo Jones	Commissioning Officer, NHS England, Midlands and East (East)
	David Barter	Head of Commissioning, NHS England, Midlands and East
	Stephen Graves	CEO, North West Anglia NHS Foundation Trust
	Jane Pigg	Company Secretary, North West Anglia NHS Foundation Trust
	Keith Reynolds	Assistant Director of Strategy and Planning, North West Anglia NHS Foundation Trust
	Susan Mahmoud	Healthwatch
Officers Present:	Dr Liz Robin	Director of Public Health
	Paulina Ford	Senior Democratic Services Officer
	David Beauchamp	Democratic Services Officer

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Sandford. Councillor Saltmarsh was in attendance as a substitute.

2. DECLARATIONS OF INTEREST AND WHIPPING DECLARATIONS

Item 7. North West Anglia NHS Foundation Trust – Bed Capacity

Councillor Hemraj declared an interest in item 7 in that she was an employee of the North West Anglia NHS Foundation Trust.

3. MINUTES OF THE HEALTH SCRUTINY COMMITTEE HELD ON 12 MARCH 2018

The minutes of the meetings held on 12 March 2018 were agreed as a true and accurate record.

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

There were no requests for Call-in to consider.

5. APPOINTMENT OF CO-OPTED MEMBERS

The Senior Democratic Services Officer introduced the report which recommended that the Committee appoint Parish Councillor, Henry Clark as a non-voting co-opted member to

represent the rural communities. A further recommendation included in the report was to appoint a second Parish Councillor Barry Warne as a non-voting co-opted member also to represent the rural communities or as a substitute for Henry Clark. Both nominations had been put forward from the Parish Council Liaison Committee.

The report also recommended the appointment of Dr Steve Watson as a non-voting co-opted member for his medical expertise.

Councillor Jamil proposed that Dr. Steve Watson be appointed a non-voting co-opted member and this was unanimously agreed by the Committee.

Councillor, Jamil seconded by Councillor Hemraj proposed that both Henry Clark and Barry Warne be appointed as non-voting co-opted members. The Chairman put this proposal to the vote and it was defeated (5 in favour, 6 against, 0 abstentions). It was therefore agreed that Henry Clark be appointed as a non-voting co-opted member with Barry Warne appointed as a designated substitute for Henry Clark.

AGREED ACTIONS:

The Health Scrutiny Committee considered the report and **RESOLVED** to:

1. Appoint Dr Steve Watson as a non-voting co-opted member for the municipal year 2018/2019. Appointment to be reviewed annually at the beginning of the next municipal year.
2. Appoint Parish Councillor Henry Clark as a non-voting co-opted member to represent the rural area for the municipal year 2018/2019. Appointment to be reviewed annually at the beginning of the next municipal year.
3. Appoint Barry Warne as the nominated substitute for Henry Clark should he be unable to attend.

The nominated persons were in attendance at the meeting and the Chairman invited both Dr Watson and Henry Clark to join the Committee for the remainder of the meeting.

6. DENTAL SERVICES IN PETERBOROUGH

The Commissioning Officer accompanied by the Head of Commissioning at NHS England, Midlands and East introduced the report. The report provided information in response to questions from the Committee at their meeting held on 12 March 2018 where a previous report on Dental Services had been presented.

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

- Members requested clarification on how dentists in the Peterborough area could be underperforming and not delivering their contracted levels of service when so many people found it difficult to find an NHS dentist. Members were advised that dental practices were being commissioned with a certain number of Units of Dental Activity (UDAs) but were not able to recruit sufficient dentists to fulfil those units. There was a national shortage of dentists so rural areas in particular sometimes struggled to recruit. NHS England Midlands and East Commissioning monitored practices closely and had discussions with them to adjust contracts depending on demand. Another factor was the oral health needs of the population or a lack of patient demand; many patients would only access oral health services when they experienced agony. A key priority was to get patients on a pathway to good oral health and build a good relationship with dental practices. There was an initiative to take two year-olds to the dentists to help build good relationships with their dentist.

- Members asked if patients visiting practices outside the area, in the East Midlands, Northamptonshire and Lincolnshire in particular, would skew the figures or would dentists outside the area charge the NHS in Cambridgeshire. It was clarified that patients could visit dentists anywhere they like. The FP17 form contained unique patient information and reports could be produced to establish where patients were migrating to.
- Each dental contract had an annual value with payments being received monthly. A certain number of units of dental activity would need to be delivered against each contract. A band 1 treatment was 1 unit, band 2 was 3 units and band 3 was 12 units. Underperforming meant that a provider had not delivered their quota of units and over performing meant the opposite and would result in an increase in the value of the contract being considered.
- Anyone could receive treatment from any dentists with free units and there were no registered lists, unlike GPs. The 111 number could be used to access out of hours services and these were available regardless of whether they had already registered with a dentist. Patients with dental pain, trauma etc. would be signposted via the 111 number.
- The Out of Hours contract would come to an end in April 2019 and the oral health needs of the population were being looked at to determine commissioning intentions. It was important that services were equal or better than at present. The Primary Care Dental Team were in the process of working with consultants in public health, dentists, current providers, patients, Healthwatch and other stakeholders to develop plans to recommission services from April 2019 onwards.
- Members noted the problems with the dentistry in Peterborough but stated that no solutions were mentioned in the report. Officers responded that NHS England, Midlands and East Commissioning were working with various stakeholders to identify future commissioning intentions. These included the local dental network, the managed clinical network, dental providers, and community dental services, out of hour's providers, Healthwatch, directly with patients and consultants in dental public health attached to the Commissioning team through Public Health in order to work out the needs of the area. Attempts were being made to work more closely with providers and stakeholders to ensure there was enough capacity to match the growth of the population.
- Much of the work needed to be led by current contract holders and clinicians that had a long term investment in Peterborough and could be part of future plans for the population of Peterborough to receive dentistry that benefited them and to make sure that they were on a good dental health pathway.
- Many dental practices in Peterborough did not deliver their contracts and detailed discussions were taking place to establish why that was and how they could do so in the future which may require more units of dental activity.
- Attracting good dentists was important to making dental services more sustainable in the future, in addition to the sustainability of the commissioned practices themselves, as dentists would become long-term members of the community. There were many reasons for the difficulties in attracting dentists. It was important to work closely with practices to ensure that newly qualified dentists built experience in a wide variety of fields by having 'training dental practices'. Many dentists qualified in certain teaching centres and preferred to work closer to London. There were considerably more applications per dentist positions in London and this number decreased the further north one went.
- The practices listed in appendix one of the report were a comprehensive list of those that held NHS contracts. Solely private or independent dentists were not mentioned due to the lack of a contractual relationship with them. Providers that were listed multiple times had different contracts. There may also have been different contracts for one provider aimed at different demographics of patients with different care needs.
- There would still be an out of hour's service when the consultation had ended.
- In most areas of England needs were higher than the level of provision and this was not unique to Peterborough. .
- No new practices or services had opened due to the lack of new funding. Under-delivering services with spare capacity had been recommissioned.
- Members asked if consideration had been given to mobile dentists in rural areas without permanent provision and potentially in some urban areas. It was noted that

commissioning should be based on what was appropriate for patients and this depended on transport links and the ability of patients to travel. There was a community dental service available for patients who were unable to travel to a practice and they had a referral service. GPs, other dentists and social services were able to signpost patients to this service if needed.

- The Director of Public Health explained the term 'Principles of Proportionate Universalism' found on page 28 as follows: Disadvantaged sectors of society required more services but less deprived groups also needed provision. It was a way of describing addressing health needs in accordance with their severity but across the whole population.
- The statistics in appendix two dated from December 2016 as this was the last time that a consultant in dental public health had completed a specific piece of work in Peterborough. The conclusions were that the general oral health was good but it compared unfavourably with other areas of East Anglia and the country as a whole. The data collection would be repeated in the future to see if this situation had changed.
- Members noted that Fluoride Varnishing was beneficial for children but questioned the extent to which children were being targeted for this, suggesting it may be ad hoc in nature and enquired if there was a programme to bring children in for fluoride varnishing or if this was done when children visited the dentist for other reasons. Members were advised that all General Dental Practitioners should administer fluoride varnishing where clinically appropriate and they had the funding to do so but the key was getting children into see the dentist. The checks on dentists included the recording of the information regarding fluoride varnishing on the FP17 form. It was noted that children required parental consent up to the age of 16 to receive fluoride varnishing treatment.
- Members were informed that there was an initiative in NHS England to ensure that dentists saw children at the youngest possible age, even before teeth presented so that the children and their parents or guardians get into the routine of visiting the dentist regularly.
- The more difficult problem was the number of children who were not taken to the dentist and those who miss the treatment. When they did present this was usually because of dental pain, requiring a different course of treatment.
- Mobile Dentists came under the remit of the Special Care Dentistry team who were currently investigating all special care services within East Anglia. Scoping, groundwork and discussions with stakeholders were taking place as part of an ongoing project and nothing had been decided at this stage. It had not yet been decided if mobile dentists would been used.

AGREED ACTIONS:

The Health Scrutiny Committee considered the report and **RESOLVED** to note the report for information.

7. NORTH WEST ANGLIA NHS FOUNDATION TRUST – BED CAPACITY

The Chief Executive Officer introduced the report accompanied by the Company Secretary and Assistant Director of Strategy and Planning of the North West Anglia NHS Foundation Trust. The report provided the Committee with an update on proposals and options for increasing capacity at Peterborough City Hospital and to include an update on the financial situation.

Additional information provided by the Chief Executive Officer was that the core assumption was that care was currently being delivered in the same way as when the report was written. However, there had been some changes from the Department for Health since writing the paper. An example of this was that local authorities and healthcare services were being asked to investigate long-stay patients and to reduce the number of patients staying over 21 days by 25% ahead of the winter. Those sort of policy changes would affect the bed numbers required in the report. Planning was now based on 92% bed occupancy compared with 90%

when the report was written. The report had also not looked at ways of reducing the numbers of people coming into hospital compared with the current model of discharging patients earlier although the most recent paper from the Department for Health provided many possibilities for future consideration in this area.

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

- Members asked about the likelihood of funding being made available to move offices out of the fourth Floor of Peterborough City Hospital to be converted into wards Members were informed that the NHS had to submit its five year capital plans by the middle of July 2018. This paper was therefore timely as the plan would include bed requirements in the initial stage and the four floor requirements towards 2023. It was expected that in the second half of the next five years, assuming that population and needs grow, one or two wards would be required on the fourth floor. This was the current plan and the bid process would have to be completed by the middle of July to be considered and have decisions made in the autumn.
- Plans were already in place with the money that was already available to increase bed capacity. An example would be the nine extra beds being added to the medical assessment unit this week.
- In the event of the fourth floor being used for new wards office staff would still be based on site. Although there is sometimes doubt about the usefulness of office staff taking up space in hospitals, anecdotal evidence suggested that this can actually be beneficial to medical staff.
- There was the possibility of making better use of existing office space at Peterborough City Hospital. There was a building on site that had been previously used for the storage of medical records. The plan was to convert some of this space into office space for use by support staff such as the accountancy team. Support staff would therefore still be on-site but not in the building.
- A different Clinical Commissioning Group (CCG) was responsible for Stamford Hospital. The CCG did not anticipate an increase in beds at the Stamford site. An acre of land not required for NHS use was available at the Stamford site and the correct course of action would be to use this for health and care purposes as required by the covenant. There has been some interest from nursing homes. Therefore there will be an increase in beds on the Stamford site for the people of South Lincolnshire, just not NHS beds.
- Members noted that 208 beds would be required by 2026 but the report indicated that only 186 would be provided which included the conversion of the fourth floor of Peterborough City Hospital. Given that delayed transfers of care were unlikely to drop Members sought clarification as to where this capacity would come from. It was highlighted that not all longer stay patients (over 21 days) were delayed transfer of care and not all delayed transfer of care patients were longer stay patients. The government were targeting a reduction of 25% of longer stay patients and 3.5% delayed transfer of care. If these targets were met 26 fewer beds would be required. The move from 90% to 92% bed occupancy equated to 13 beds. These factors combined would result in more beds being provided than needed.
- It was clarified that the increase from 90% to 92% bed occupancy meant that less spare beds would be needed. It was emphasised these figures were averages, with occupancy being higher in the winter for example. The number of long stay patients must be reduced over the winter. Evidence suggests that staying in a bed over a long period of time without the appropriate physiotherapy and occupational therapy caused a notable degeneration of muscles for elderly people and it was healthier for them to go home earlier once they are medically fit.
- The reduction in long-stay patients was not about discharging patients earlier than they should be.
- 12 extra beds had been provided each year for the last three years. 30+ extra physical beds would be delivered on top of those freed up by reducing the number of longer stage patients.

- Members raised anecdotal evidence about a patient being sent home too early and asked what checks and balances were in place to prevent this from happening. Members were informed that the evidence may have pointed to discharge being appropriate. A senior doctor must approve a discharge in partnership with a nurse and where relevant, occupational therapists and physiotherapists. There would be a series of checks and balances and the aim was not to discharge patients early.
- Members asked if the hospital would cope with another Flu epidemic. It was acknowledged that Peterborough City Hospital did not cope well last winter. It was difficult for staff and patients outside as well as inside the hospital as the ability to release ambulances and get to the next patient was compromised. The government's contribution was to encourage a reduction in long-stay patients and this was something that could be worked on as well as increasing physical capacity. The 12 extra beds put in last winter were not enough. Too much reliance was placed on the number of delayed transfers of care being reduced which had not happened. Capacity could be improved by enabling the right patients to leave earlier and increase physical capacity.
- Members noted that with 208 beds and a staffing ratio of 1.8 per bed an extra 400 nurses would be required by 2026. Members were informed that doctors and nurses were being trained but it would take many years to achieve seniority. Those doctors starting this autumn would complete 5 years of active clinical work and 2 years on wards before starting their more specialist and senior training. It would take 8-10 years to become a powerful decision maker and 10-15 years to become a consultant. The Government was providing additional funding and training but it would be necessary to employ staff from overseas, both inside and outside of the European Union. Immigration rules had recently been changed to meet the need to deliver doctors more quickly. A team of people were currently in the Philippines trying to recruit nurses and this was the second time officers had been there this year to recruit.
- Nurses from the Philippines were fully qualified and generally did not face problems becoming registered with the Royal College of Nurses and were not affected by the same rules that doctors were. Some groups of doctors were not affected but the majority were. The main issue with overseas nurses from inside and outside of the E.U. was the English language test which was set at a degree to masters level of English (level 7). Dispensations from the Royal College of nurses was not possible but a dispensation down to level 6.5 was possible for some groups of doctors if the Medical Director of the North West Anglia NHS Foundation Trust agreed. The biggest challenge in the U.K. was not the ability to recruit but the ability of overseas colleagues to pass the English language test.
- Members sought clarification as to whether discharge of patients was sometimes blocked because Addenbrookes or other hospitals did not have the capacity to take the patients. The CEO advised that patients may have been waiting for either Papworth Hospital or Addenbrookes. In the bed control centre, there were always patients waiting to be transferred to other hospitals as well as waiting to come to Peterborough. The flow was not necessarily dramatically in one direction but Addenbrookes was the tertiary receiving centre for everything except cardiology for a wide range of hospitals. Sometimes patients wait in Peterborough City Hospital and sometimes patients wait in Addenbrookes to be transferred back. Generally Peterborough took one patient back and delivered one patient and this was the case for much of the winter.

Members noted that the CEO of the North West Anglia Foundation Trust was retiring soon and that this might be his last scrutiny committee meeting. His career achievements in helping the NHS were acknowledged by Members as was his openness and honesty with the Health Scrutiny Committee in notifying them of future possible problems. Members thanked him for all that he had done for the committee and wished him an enjoyable retirement. The CEO responded with thanks and advised that interviews for his replacement were taking place the day after the meeting and he would stay in place until that person was in position. The date of his retirement would become public once his replacement had been recruited.

AGREED ACTIONS:

The Health Scrutiny Committee **RESOLVED** to note the current bed capacity and the impact that this was having on flow through the hospital.

8. REVIEW OF 2017/2018 AND WORK PROGRAMME FOR 2018/2019

The Senior Democratic Services Officer introduced the report which considered the 2017/18 year in review and looked at the work programme for the new municipal year 2018/19 to determine the Committees priorities and agree the proposed way forward for monitoring future recommendations.

ACTIONS AGREED:

The Health Scrutiny Committee **RESOLVED** to note the contents of the report and

1. Consider items presented to the Health Scrutiny Committee during 2017/2018 and made recommendations on the future monitoring of these items where necessary.

2. Determine its priorities, and approve the draft work programme for 2018/2019 attached at Appendix 1.

3. Note the Recommendations Monitoring Report attached at Appendix 2 and consider if further monitoring of the recommendations made during the 2017/2018 municipal year is required.

4. Note the Terms of Reference for this Committee as set out in Part 3, Section 4, Overview and Scrutiny Functions and in particular paragraph 2.1 item 3, Health Scrutiny Committee and paragraph 3.5 Health Issues as attached at Appendix 3

9. 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.

10. DATE OF NEXT MEETING

17th September 2018

CHAIRMAN
7.00pm – 8.16pm