PETERBOROUGH
CITY COUNCIL

MINUTES OF A MEETING OF THE SCRUTINY COMMISSION FOR HEALTH ISSUES HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 16 JULY 2013

Present:	Councillors B Rush (Chairman), J Peach, D McKean, K Sharp, N Shabbir and A Sylvester	
Also present	Margaret Robinson	Healthwatch
	Mary Bryce	Healthwatch
	Cambridgeshire and Peterborough Clinical Commissioning Group:	
	Dr Neil Modha	Chief Clinical Officer
	Jess Bawden	Director of Corporate Affairs
	Chris Humphris	Assistant Director for Commissioning and Contracting
	Fiona Head	Consultant in Public Health Medicine
Officers Present:	Jana Burton	Interim Director of Adult Social Care
	Paulina Ford	Senior Governance Officer
	Gurvinder Kaur	Lawyer

1. Apologies

Apologies for absence were received from Councillor Allen and Councillor Peach attended as substitute.

2. Declarations of Interest and Whipping Declarations

There were no declarations of interest or whipping declarations.

3. Call-in of any Cabinet, Cabinet Member or Key Officer Decisions

There were no requests for Call-in to consider.

4. Draft Young Peoples Sexual health and Wellbeing: Summary of Needs and Commissioning Strategy

The Chair advised the Commission that due to unforeseen personal circumstances the officer presenting item 4 on the agenda Draft Young Peoples Sexual health and Wellbeing: Summary of Needs and Commissioning Strategy had been unable to attend the meeting to present her report. The Chair asked the Commission if they would agree to defer the item until the next meeting in September. The Commission agreed in favour of this request.

5. Cambridgeshire and Peterborough Clinical Commissioning Group - Priorities

The report provided the Commission with an update on the work on the three priority areas for Cambridgeshire and Peterborough Clinical Commissioning Group.

The Chief Clinical Officer presented the report and highlighted items within the first priority; which was 'The Older People Programme. Areas highlighted included:

- Programme overview
- Stakeholder engagement
- Provider engagement
- Critical success factors
- Contract length
- Funding options
- Scope of services

Observations and questions were raised and discussed including:

- Members had noted from previous presentations to the Commission from the NHS and Adult Social Care regarding reablement and the elderly leaving the hospital and then having to go back quickly was an issue. Members asked if the CCG was aware of this and did they know why this was happening? *Members were advised that the reasons patients go in and out of hospital were varied and each case would have to be looked at individually. The CCG had been working with the hospital and the Council to identify the causes for readmission. It had been found that some were related to community provision. The services currently provided by Cambridgeshire Community Services (CCS) in the community for district nursing services and community matron services needed to be strengthened. The CCG continued to work with CCS to identify where the attention needed to be as well as community provision regarding communication aspects.*
- Members asked what flexibility was built into the programme of priorities as healthcare needed to be flexible. *Members were informed that flexibility was essential and that this was exactly what the CCG were trying to achieve and change the way care was commissioned in the city as the current method was very rigid. Members were advised that the aim was to move to a method that would enable them to look beyond yearly budgets and move to longer contracts.*
- Members also sought clarification on what was being done for End of Life Care in Peterborough. *Members were advised that there was a separate programme for End of Life Care.*
- Members noted that funding for the NHS was very restricted at the moment and asked if this meant more work would be given to the current staff or was there provision for more staff should they be required. *Members were informed that financial modelling had been built around the predicted budget that would be available. It was noted that this would be changed when they had further information as to what funds would be available.*
- Members commented that having long contracts could be better at times but it could also allow for complacency. There would need to be very clear contractual terms about outcomes and achievements. *Members were advised that a good proportion of time was spent managing the contracts that they sign with providers. Contracts would be monitored carefully and the CCG would work closely with organisations to ensure patients were getting what they signed up for.*
- Members asked about lead providers and whether the reference to lead providers under the section '*scope of services in voluntary sector'* indicated that voluntary organisations would not be lead providers, and if not who would. *Members were advised that nothing would preclude voluntary organisations from being lead providers. Lead providers could be third sector organisations but it was critical to confirm financial viability of the organisation. It was therefore more likely to be an amalgamation of organisations working together rather than a voluntary organisation being the lead.*
- Members wanted to know how the CCG would ensure there was integration between health and social care. *Members were informed that the CCG had liaised with the Council on how they could work together. People were worried about the integration regarding budgets being pulled however a consensus had been reached that what was needed was a functional integration. The avoidance of duplication was being looked at and whilst*

there was no easy way to achieve this there were definitely ways of moving towards integration within The Older People Programme. Some of the changes that had recently been announced (for example more health money going into integrated budgets) provided an opportunity to talk about what the money was going to be used for. The changes brought different teams around the table to discuss how to functionally integrate the teams.

- Members wanted to know if the new providers would be in place by April 2014. *Members were advised that the changes would not be rushed through as they wanted to ensure everything was done correctly. Members were advised that the CCS would not be gone as was previously thought as national policy had changed, therefore there was no reason to rush things through for April 2014. A Department of Health Gateway review had been commissioned to look at the programme and provide feedback as to whether this was realistic. July 2014 was now the aim to enable the CCG to achieve everything they needed to. It was therefore expected that the lead providers would be in place by July 2014.*
- Members asked how the group would ensure that service quality would not be reduced until the new arrangements were up and running. *Members were advised that the report on The Cambridgeshire Community Services Transition Programme at agenda item 6 would address this question.*

The group then presented the second priority, namely the 'End of Life Programme Board'. It was highlighted that work had started in December 2012 and the group met every two months. The group had strong representatives from all across the CCG as well as a strong representative from Peterborough. Their main goal was to improve the experience that carers and people had when dying and to ensure people had more choice about how and where they died.

- Members referred to the last paragraph on page 49 of the report regarding the draft deliverables and asked if they were available for the Commission to review and comment on. *Members were informed that the final deliverables were going to the Board on the 31 July and they could then be provided to the Commission.*
- Members asked why there was nothing in the report about liaising with providers such as Sue Ryder and whether such providers were engaged with the programme. *Members were advised that those providers were engaged with the programme and there were also patient representatives included in discussions.*
- Members commented that it must be remembered not to lose sight of End of Life Care for people who die in their own homes not just those in hospital. *The Chief Clinical Officer agreed that this was very important and advised Members that more than half of people who died in Peterborough did so in their own homes; which was greater than the national average*.
- Members noted that district nurses had day to day responsibilities as well as caring for people at their end of life, and asked whether there were sufficient resources to support people at home. Would extra capacity be needed if the aim was to reduce the number of people dying in hospital? *Members were advised that the CCG had identified a need for more community district nurses in Peterborough. The End of Life Care Board was liaising with the Older People's Programme Board to ensure that the changes would mean that community care was more flexible and more readily available to cater for this. It was confirmed that the mechanism for achieving this deliverable was available in the Older People's Programme.*
- Members asked if in light of all the publicity about the Liverpool Pathway if the End of Life Pathway was being changed. *Members were informed that of the 44 recommendations within the report many of them were issues that had already been detected and as such were being built into the delivery plan.*

The third priority, 'Coronary Heart Disease Programme Board' was presented. The main goal of this Board was to try and tackle the area of reducing the premature mortality rate resulting from heart attacks and strokes. It was highlighted that in this area there was a lot of work

already being done but the Board was looking at how to pull all of the work together to make it easy for a patient to understand and be signposted to.

- Members commented that the Scrutiny Commission for Rural Communities had received a presentation from First Responders who were struggling financially to increase the number of first responders as they were funded by charitable donations. Members asked if the CCG was looking at the First Responders as a way of catching people early and getting them to hospital quicker therefore providing better outcomes. *Members were informed that this particular Board was about trying to catch people even before this took place. Identifying the right population and performing tests to check people's hearts was an important part of the process. The Board had looked at factors that caused the diseases which could be stopped and found that smoking and obesity were big factors as well as diabetes care. There were programmes already in place to address those factors, but the group was trying to ensure those programmes were consistently delivered. At this stage they had not got down to the level of asking how people got to hospital if they had already had a heart attack. However if there was evidence that lack of response time in rural areas was a factor contributing to this problem of premature mortalities then this would be looked into further.*
- Members commented that small amounts of money put into rural areas for first responder training courses would be of great benefit.
- Members asked what three changes would be needed to reduce the high admission rates and premature mortality due to coronary heart disease. *Members were informed that the Programme Board had looked at how to reduce premature mortality rates and had found that by reducing the number of people who smoke; increasing the number of people who exercise and increasing the people who take general responsibility of their health they could reduce premature mortality rates eventually. Economic prosperity was also an important factor.*
- Members asked how long it would take to show a positive impact if these changes were made. *Members were advised that there was evidence to suggest that what happens to an individual before birth actually affects that individual's risk of coronary heart disease. Stopping smoking would decrease coronary heart disease risk over a matter of months but to make large scale population changes it would take about twenty years.*
- Members suggested that the Board may want to consider the Open Space strategy. Open spaces could be used to build more gyms or skate parks, etc. *The Chief Clinical Officer agreed with this and reiterated that this was an area where different teams needed to integrate and work together. It was hoped that the current changes within the Health and Wellbeing Board and other integrating changes taking place would address these kinds of issues. It was further noted that there was hard evidence that the provision of green space not only decreased the risk of coronary heart disease but is was also more beneficial to those who are already had coronary heart disease.*
- Members asked if the CCG should also be tackling Fast Food outlets to help decrease the premature mortality rate. *Members were advised that it was an important factor but reiterated that the Board could only tackle factors where there was evidence.*
- Members highlighted that education was important to preventing heart disease and asked how much time and money was being invested to ensure people were aware of what to do and what was available to them to reduce their risk of heart disease. *Members were informed that the responsibility for health promotion has shifted to the Public Health team in the Local Authority. This CCG had been working actively with that team to ensure they were sending out the same set of messages. It was noted that one of the deliverables of the Board was to undertake a lifestyle mapping exercise which would help towards educating the public as well.*
- Members commented that education regarding this should be delivered at an earlier stage and should be integrated into the education system. It was further noted that there were a lot of issues about poor diet as a result of the changes to the welfare system.

ACTIONS AGREED

1. The Commission noted the report and requested that the CCG provide the Commission with a copy of the Draft deliverables for the End of Life Programme Board.

2. The Commission also requested that the CCG liaise with the Coronary Heart Disease Programme Board to discuss assisting in increasing First Responders in Rural areas.

6. Update Report on the Cambridgeshire Community Services (CCS) Transition Programme

The report provided the Commission with an update on the work of the CCS Transition programme. A steering group had been formed to ensure a clear timetable and process to find alternative services due to the expectation that CCS would cease to function in April 2014. CCS provided three groups of services of which the largest in Peterborough was services for Adults and Older people.

Due to some changes in responsibilities the future of CCS was now determined by a body called The Trust Development Authority. This Trust was currently looking at the organisation and had indicated that by the end of July 2013 they would confirm either continued support for a set period of time or a date at which the CCS would dissolve.

Observations and questions were raised and discussed including:

- Members asked if CCS would still be able to procure for services as they currently do or would the organisation be completely dissolved. *Members were advised that if CCS was NOT dissolved they would still be able to bid when the procurement exercise took place and may therefore still be involved in Adult and Older People's work if they were a successful bidder. In terms of other services whilst they continued to exist they could continue to provide those services and theoretically continue as bidders for those services in the future if other procurement exercises took place.*
- Members asked about the status of the Trust Development Authority, how long they had been around and who was on the board. *Members were advised they have not been around for long as their previous function was exercised by the Strategic Health Authority under the Provider Support function. Their role as a national body was for about 120 NHS Trusts that were not yet foundation trusts and over which there was some question about the future. Their responsibility was to work with those organisations to find an appropriate future for them. The consisted of a group of senior managers within the Department of Health and their funding was national.*
- Members referred to page 67 and the term '*Shadow Running'* and asked it was in the correct time frame on the work plan. *Members were advised that one of the options was to transfer the services to another organisation. If this happened although the official date at which they might transfer was on a given date there would be a period where the services were in a transitional period (where management was transferred, but the transfer was not yet formal). 'Shadow Running' was a description of this transitional period. It was confirmed that the Shadow Running period would be in May and June and the Jan to Feb description was incorrect in the report.*
- Members asked if the CCS Transition group was confident that service quality would not reduce in the period between now and the possible end of CCS. *Members were assured that the Trust Development Authority had a responsibility to ensure that the quality of services was still provided by CCS. This was done through having a contract with CCS which described the quality required and standards that should be maintained. CCS reported daily to the TDA on these aspects. There were also monthly reports from CCS submitted to a specific quality meeting which described all their work to assure both themselves and the Transition group that they were maintaining their quality of service. Announced and unannounced visits were also conducted. It was noted that any concerns*

raised by these visits and reports were submitted to CCS and CCS were expected to produce a remedial action plan for each issue. These action plans were then monitored.

- Members asked if the uncertainty was affecting the workforce. *Members were advised that the workforce had been affected. In one way it had been positive as sickness rates had decreased and turnover had not increased. CCS was communicating well with their staff about what was happening and encouraging their own staff to be part of talking about the future. TDA were not saying they needed less district nurses and staff they were saying they needed more and had made sure that the staff members were feeling needed in order to minimise the number that wanted to leave the area. It was also added that TDA has attended some of the CCS staff briefings to talk directly to the frontline staff members and assure them they will always be needed and were seen as part of the solution not part of the problem.*

ACTIONS AGREED

The Commission noted the CCS Transition Programme Board report

7. Adult Social Care Prevention Strategy

The report provided the Commission with an update on progress made with developing an Adult Social Care Prevention Strategy. The Director of Adult Social Care introduced the report and informed Members that the development of the strategy arose from the consultation on eligibility and charging which was approved by Cabinet on 25 February 2013. The Prevention Strategy aimed to set out the Council's offer to people who were not eligible for statutory social care support but who would benefit from support to maintain their independence and wellbeing. The transformation would result in a significant improvement to the preventative offer.

Observations and questions were raised and discussed including:

- Members asked if the £165k was in addition to the current funding. *Members were informed that it was additional funding.*
- Members referred to page 90 of the report which provided a list of items that early interventions should be focused on and suggested a more holistic approach is required for this work. Transport services for example had just been cut and one of the items listed in the report was the promotion of mobility e.g. transport services. Members asked how this kind of problem could be dealt with. *The Director of Adult Social Care agreed that it was important for people to work together. A lot of the issues regarding transport were about particular specialist transport requirements such as people not able to get on a bus or in taxi. While the Council did not necessarily provide this transport they wanted to be able to provide information and guidance about what sort of transport was suitable and where it could be obtained. This was what 'promoting mobility' was about.*
- Members mentioned that Local Link buses were used by people who did not need specialised transport but were unable to walk very far. As a preventative measure the buses would be an ideal service to have before these people reached a stage where they needed specialised transport. In preventative care a certain element of independence was needed for people and by taking away the Local Link bus services the people were losing that element of independence. Members highlighted that they felt this should have been dealt with together and not as two separate issues. *The Director of Adult Social Care agreed that this was an important point but there was only so much that the Preventative Strategy could do with regards to that. Feedback about what worked and what did not would continue to be obtained. Part of the transformation would result in a new section that would look at a wider customer service. This would be a front-door service providing information and advice that would offer low-level prevention which would be accessible to as many people as possible.*
- Members asked how the team would ensure that resources for prevention were not reduced due to budget pressures. *Members were advised that one of the ways this would*

be achieved was by the Cabinet agreeing that Prevention would be essential for the future. It was noted that the team had also looked at increasing the budget rather than decreasing it and were looking across all services provided by the Council to see what the whole offer was to prevent duplication and ensure resources were effectively directed towards providing the right services.

- Members asked how much the team was spending on prevention altogether. *Members were informed that this figure would come together as the team finalised the strategy. The final strategy would be able to detail spend on prevention as well as provide more information about what was on offer.*
- Members asked if the team had a list of what was on offer for prevention. *Members were advised that the list would be presented in the final strategy.*
- Members asked how the team would measure performance when the strategy was finalised. *Members were advised that there would be no quick results but they would monitor to ensure there was no increasing demand through long-term support and look at the numbers of people and the outcomes of whether customers were satisfied with services offered.*
- Members asked how the team would reach and/or identify those people who had not yet come on to the radar. *Members were informed that prevention was one element of work in ASC. It would depend on how the Local Authority decided what its universal offer would be and what its customer service strategy was and whether this was available to everyone. Currently the team was looking at two types of customers, those who were currently using ASC and those who may approach ASC in the future. An example was those people currently in residential care who were self-funders and the first time those people appeared on ASC's radar was when their funding ran out.*

The Director of Adult Social Care requested that if there were any further comments from Members after the meeting that they could be sent to Nick Blake.

ACTIONS AGREED

The Commission noted the report and requested that the Final Adult Social Care Prevention Strategy be brought back to the Commission for recommendation when it is ready.

8. Notice of Intention to Take Key Decisions

The Commission received the latest version of the Council's Notice of Intention to Take Key Decisions, containing key decisions that the Leader of the Council anticipated the Cabinet or individual Cabinet Members would make during the course of the following four months. Members were invited to comment on the Notice of Intention to Take Key Decisions and, where appropriate, identify any relevant areas for inclusion in the Commissions work programme.

ACTION AGREED

The Commission noted the Notice of Intention to Take Key Decisions.

9. Work Programme

Members considered the Commission's Work Programme for 2013/14 and discussed possible items for inclusion.

- Members requested the presentation on Sexual Health and Wellbeing to be included in the work programme at a future meeting.

ACTION AGREED

To confirm the work programme for 2013/14 and the Senior Governance Officer to include any additional items as requested during the meeting.

10. Date of Next Meeting

Thursday, 19 September 2013

The meeting began at 7.00pm and finished at 8.30pm CHAIRMAN