PETERBOROUGH CITY COUNCIL

MINUTES OF THE ADULTS AND HEALTH SCRUTINY COMMITTEE MEETING HELD AT 7.00PM, ON MONDAY, 18 JULY 2022 BOURGES/VIERSEN ROOM, TOWN HALL, PETERBOROUGH

Committee Members Present: S Barkham (Chair), Ansar Ali (Vice-Chair), N Bi, G Elsey, S Farooq, C Fenner, B Rush, B Tyler, S Qayyum, Co-opted Member Parish Councillor June Bull

Officers Present:
Jyoti Atri, Director of Public Health
Debbie McQuade, Assistant Director Adults and Safeguarding
Kate Hopcraft, Director of Planned Care NHS Cambridgeshire and Peterborough
Janine Nethercliffe, Deputy Medical Director for North West Anglia NHS Foundation Trust
Charlotte Cameron, Democratic Services Officer
Paulina Ford, Senior Democratic Services Officer

Also Present:
Eva Woods, Youth Council Representative and Youth MP for Peterborough
Cllr Howard, Cabinet Member for Adult Social Care, Health and Public Health

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Burbage and Councillor Harper. Councillor Fenner was in attendance as substitute for Councillor Burbage.

2. DECLARATIONS OF INTEREST AND WHIPPING DECLARATIONS

No declarations of interest were received.

3. MINUTES OF THE ADULTS AND HEALTH SCRUTINY COMMITTEE MEETING HELD ON 15 MARCH 2022

The minutes of the meeting held on 15 March 2022 were agreed as a true and accurate record.

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

There were no Call-Ins received at this meeting

5. APPOINTMENT OF CO-OPTED MEMBERS 2022/23

The Adults and Health Scrutiny Committee received a report in relation to the appointment of Co-opted Members in accordance with the Council's Constitution Part 3, Section 4 – Overview and Scrutiny Functions.

The purpose of the report was to seek approval from the committee to appoint Parish Councillor June Bull as a non-voting Co-opted Member to represent the rural communities for the municipal year 2022/2023 and to appoint Parish Councillor Neil Boyce as a substitute for Parish Councillor June Bull should she not be able to attend a meeting.

The Senior Democratic Services Officer introduced the report and explained that the nominations for Parish Council Co-opted Members had been put forward by the Parish Council Liaison Working Group and that the appointments would be reviewed annually.

The Committee unanimously agreed to the appointments of Parish Councillor June Bull as a non-voting Co-opted Member for the municipal year 2022/23, and the appointment of Parish Councillor Neil Boyce as her substitute.

The Chair welcomed Parish Councillor June Bull who was in attendance and invited her to join the committee for the rest of the meeting.

AGREED ACTIONS

The Adults and Health Scrutiny Committee **RESOLVED** to agree to:

1. Appoint Parish Councillor June Bull as an Independent Co-opted Member with no voting rights to represent the rural area for the municipal year 2022/2023. Appointment to be reviewed annually at the beginning of the next municipal year.
2. Appoint Parish Councillor Neil Boyce as the nominated substitute for Parish Councillor June Bull. Appointment to be reviewed annually at the beginning of the next municipal year

6. ELECTIVE WAITS AND RECOVERY

The report was introduced by the Director of Planned Care NHS Cambridgeshire and Peterborough accompanied by the Deputy Medical Director for North West Anglia NHS Foundation Trust. The report provided the committee with an update on current elective waiting lists, encompassing both surgical and outpatient pathways, and the strategy for recovery following the increasing waiting times for patients post the COVID-19 pandemic. The report included background information; highlighting the key issues, current position, particularly for the North West Anglia NHS Foundation Trust (NWAFT), as well as actions taken to date and future plans to support recovery across the Integrated Care System (ICS).

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

- One Member who worked in Primary Care had noted that since Covid there had been an increase in GPs having to chase up on appointments and hospital investigations on behalf of their patients. The concern was that their patients' conditions had worsened due to the waiting times for appointments. Members were also concerned about the shortage of beds. Members were informed there had been some issues internally with the appointment booking system and this was being resolved and therefore would improve. The hospital had now published waiting times on the website. The GP liaison service was now being looked at to see what improvements could be made and the patient liaison service was also being improved so that once a patient had been

referred, they could access the hospital directly to check on their appointment without having to go through their GP. The issues were known and the hospital was working hard to rectify them.

- Members were informed that there had always been a challenge over the winter for surgical beds. There was a need to ensure better patient flow which often occurred due to blocks on discharging patients. It was a system wide problem which the Integrated Care System would help with. Other solutions like virtual wards were being looked at and ways of keeping patients out of acute Trusts when they did not need to be there and delivering their care closer to home.
- Members asked several questions on the NHS England and NHS Improvement: Equality and Health Inequalities Assessment including the following.
- Members wanted to know how many of the patients had been waiting to be seen for 52 weeks and 104 weeks who had opted out and cancelled their treatment or had gone privately. Members also sought clarification on how many patients had changed their status from elective surgery to either semi elective or urgent. The Officer advised Members that there were some patients who had chosen to go privately, and this was of course their choice, but everything was being done to assist patients to avoid them having to refer to the private sector. When re-triaging patients there had been a significant number of patients who had been changed from the routine waiting list to urgent. Examples of this were patients with bladder stones which continued to bleed, patients with long term catheters that needed to have a prostrate operation, patients with stents. Normally these conditions could have waited six months but after that time it became more urgent as waiting could cause long term risks. The waiting list was reviewed regularly to ensure those patients were treated appropriately at the right time. Everything possible was being done to minimise the waiting lists but there was still a possibility of a patient on the waiting list presenting at A&E.
- Members referred to page 27 of the report, Elective Recovery and noted that one ambition was to eliminate 104+ week waits by July 2022 and maintain performance. Members sought clarification on if this had been achieved. The Officer responded that currently there were a small number of patients waiting for treatment in the North Patch over 104 weeks. Those patients were waiting mainly due to clinical reasons or patient choice to delay the treatment due to personal circumstances. Currently across the whole of Cambridgeshire and Peterborough there were just two patients that were waiting due to capacity, but work was being done with the relevant providers to ensure that those patients received their treatment within the next few weeks.
- Members also noted that the report stated that it wanted to reduce the total system waiting list to September 2021 levels and sought clarification on whether this had been achieved and what the September 2021 levels looked like compared to the 104 week wait. Members were informed that the September 2021 ambition was more about the overall size of the waiting list which was not being achieved at the moment as the waiting list was currently growing. In terms of long waits the next step was to get to 78 weeks wait by the end of March 2023.
- Members sought clarification as to how the Trust could ensure equitability and address inequalities in waiting times in elective surgery backlogs covering every speciality. Members were advised that waiting lists were completed in terms of clinical priority. Monitoring also took place with regard to the demographics of people on waiting lists to identify any groups of patients that were waiting longer than others so that these cases could be investigated to understand what needed to be done. There was also a work stream around health inequalities for the planned care work which was being undertaken across the system to make sure everything was being done to reach all potential patients and different groups across all of the systems. It was work in progress.

- The Youth MP referred to page 34 where it mentioned work being done to assist people or families on lower incomes to ensure that alternatives to digital solutions remained in place for people who may not have access to the technology. Clarification was sought as to what this meant. Officers advised that different ways were being looked at to make sure people could access the virtual clinics even if they did not have the technology at home. There were places that people could go to access the technology to attend virtual appointments, an example of which was at Doddington Hospital.
- The issue of people with poor literacy or health Literacy was also raised and Members were informed that work was being done to ensure that alternatives to digital solutions remained in place for people who may not have access to the technology. Alternative methods of communicating new services were also being considered that were clear, graphical and accessible. Not all patients benefited from virtual appointments and treatment for each patient would be tailored to suit their needs and clinical decisions that were best for that patient.
- Members referred to page 33 of the report and groups who faced health inequalities and in particular carers of patients: unpaid family members. It was noted that the overall impact was likely to be positive, stating that some population may benefit from not having to access services on site with reduced travel time and wait times. Members noted however that there was no main recommendation against this. Officers advised that the health inequalities assessment was quite difficult to do for the overarching programme of works as each element were very different types of projects. Recommendations would be forthcoming as each project had a health inequality assessment completed.
- Members referred to page 19 MSK Services noting that the benefits expected from the redesign would reduce referrals into secondary care with patients being seen in community services closer to home. Members sought clarification as to what the community services would be. Officers advised community services already in existence were such services as physio and pain management and the idea was to make these much more accessible locally so that patients did not have to come into the hospital. The services were provided by different GP practices and through Cambridgeshire Community Services.
- Members referred to page 32 and the table which summarised the main potential positive or adverse impacts for people who experienced health inequalities. Members noted that the main recommendation for most of the proposals to reduce any key identified adverse impact or to increase the identified positive impact was stated as *"To work with wider system groups and North/South place to ensure that alternatives to digital solutions remain in place for people who may not have access to the technology".* Members felt that the recommendation was very broad, and clarification was sought as to what the wider system groups mentioned were. Officers acknowledged that the recommendation seemed very broad within that impact assessment around the areas stated. Each of the schemes were very different in how they would be delivered, and more detailed information was required, it was work in progress and each scheme would be looked at in detail as it was developed.
- Members referred to page 28, Perioperative Pathway transformation. Clarification was sought as to when the wait time started, was it from when the operation date was set or when the Perioperative Pathway started. Members were informed that the 18 week wait time started when the patient was first referred into the hospital not when the decision was taken for the patient to have surgery. Patients were waiting longer for treatment post-pandemic which could mean that their condition could deteriorate and could impact on wider aspects of their health or life. Additional support was being given to them whilst waiting by providing holistic support. For example, weight management, smoking cessation, diabetes or accessing community or voluntary sector groups/services or social prescribing to improve their overall wellbeing.

- Members sought clarification on how effective the community clinics had been and if they had been instrumental in reducing the waiting lists. Officers advised that there was more that could be done with community services especially with speciality services such as Ear, Nose and Throat and cataract surgery. Work was already being undertaken for these areas in community clinics, but work was being done to see how this could be maximised.
- Members were pleased to hear that positive steps were being taken to address waiting lists. Members commented that they often heard people's frustrations about how long they were having to wait for appointments and wanted to know if officers were aware of people being forced to go privately due to the length of waiting time before they were treated. Officers advised that no one was forced to go privately, and it was of course their own choice. Patients' expectation was that as soon as Covid was over the waiting lists would revert back to 18 weeks, assuring patients and educating them on a realistic waiting time was important. However, some patients may still choose to go privately if they have insurance and could do so. Every effort was being made to clear the backlog of waiting lists.
- Members commented that health inequalities in the city were a continuing issue and asked if data was being kept ensuring that those who needed to be looked after were being identified. Members were informed that at a system level there was a weekly patient tracking list which provided high level data that sat behind the waiting lists. The tracking list provided the demographics of each patient. The biggest issue was not knowing who was not coming on to the waiting lists and more work was being done to try and identify those patients and how this could be improved.
- Members referred to page 21 and the Non Admitted Pathways waiting list and wanted to know how this was monitored. Members were advised that the Non Admitted Pathways were monitored very closely within the Acute Trust and there was also an overview across the whole system so that peaks and troughs and high numbers of patients waiting could be identified. Patient experience and outcomes were monitored by the clinicians seeing those patients. Every long waiting outpatient has a mandatory harm review to see if the patient had suffered any harm as a result of being on the waiting list.
- Members wanted to know how people on the waiting list were being supported so that they were fit and ready to receive their treatment e.g., smoking cessation, dietary advice. Members were informed that if a patient was recognised at clinically obese or smoking this would be broached with them at their first appointment and suggest ways of assisting them like attending smoking cessation clinics or signposting them to see a dietician. There was more work that could be done but it was recognised that outcomes for patients would be better if they were fit and ready for their treatment.
- Members sought clarification as to what percentage of patients waiting for surgery were declined treatment because they were not fit and ready and had not taken advice to get themselves fit for surgery. Members were informed that surgery would not be delayed unless the risk of surgery was dangerous.
- Members referred to page 28, Theatre Utilisation and noted that there were opportunities for all providers to improve processes and pathways within theatre departments to improve efficiencies and gain productivity opportunities. The key benefits from this would be an increase in procedures within current resources and a reduction in procedure cancellations; ultimately reducing the overall waiting list. Members were informed that theatre utilisation had been looked at and it had been identified that there was capacity in theatres. Underutilisation was due to several factors and each theatre and consultant job times were being looked at including high volume less complex cases to try and maximise theatre usage.

- Officers advised Members that if a theatre case overran its time, the first thing that would be done would be to see if the list could be extended. Everything would be done to try and get all patients listed for the day completed. Should a patient's surgery have to be cancelled on the day everything would be done to get that patient seen again as soon as possible.

AGREED ACTIONS

The Adults and Health Scrutiny Committee **RESOLVED** to note and consider the information contained within the report relating to current elective waits and recovery plans.

7. HEALTH AND WELLBEING OVERARCHING STRATEGIC APPROACH

The report was introduced by the Director of Public Health accompanied by the Cabinet Member for Adult Social Care, Health and Public Health. The purpose of the report was to obtain views on the developing Cambridgeshire and Peterborough Overarching Health and Wellbeing Strategy.

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

- Members referred to page 53, paragraph 2.16 *How we will achieve these ambitions.* Members were particularly interested in the health inequalities and commented on the vast difference in life expectancy across the county due to the inequalities in social determinants across Cambridgeshire, particularly between areas of Peterborough and Cambridge. Members sought clarification on how the levelling up of health inequalities would be achieved. The Director for Public Health stated that it was very much an inequalities agenda and a wider determinants agenda as stated in the report and priorities were chosen to address poverty through employment and housing which was integral to the delivery of the strategy. The Director of Public Health felt that the Levelling Up White Paper had not offered anything to assist Peterborough in addressing local health inequalities but would have another look as Members felt that there were some 'hooks' around housing, health care access and education which could provide funding.
- Members referred to Section 2.14 and the anticipated outcomes for the Joint Cambridgeshire & Peterborough Heath & Wellbeing strategy and wanted to know how these would be achieved. Members were informed that the four priorities identified would assist in delivering the three anticipated outcomes but the detail behind these were yet to be developed. Members sought clarification as to whether the anticipated outcomes could realistically be achieved. The Director for Public Health said they were ambitious priorities, but they had to be realistically deliverable and had confidence that most would be achieved.
- The Youth MP referred to page 54 and conversations about better employment opportunities and how this linked into poverty and deprivation within the city. Clarification was sought as to whether those conversations and been linked to whether Peterborough could become a 'living wage' city. The Director for Public Health advised that when the priorities were originally written the concern was around the impact of Covid and the loss of employment or young people not being able to access employment. Whilst this was still an issue the emerging issue now was the cost of living and inflationary pressures and the fact that people who were in work were also experiencing poverty, and this was where the living wage agenda would be relevant. The priorities and outcomes would therefore be kept under review as the world around

changed. The living wage would be agreed to in principle, but it did pose challenges in terms of delivery and particularly in the care sector.

- The Youth MP also referred to the section in the report which referred to ensuring children were ready to enter education and exit and preparing them for the next phase of their lives. How would this be measured as a quantitate comparison how young people outside the academic sphere had become more prepared to enter the adult world as a result of the strategy. The Director of Public Health advised that the measures for those priorities had not yet been defined and it would be the responsibility of the lead officer for each priority area to put the measure in place. One common measure that was already in place was to measure those young people who were Not in Education, Employment or Training (NEET) but other measures were available.
- Members referred to pages 62 and 63 of the report and noted that targets had been set to increase healthy life expectancy by at least two years in Cambridgeshire and Peterborough, and to reduce the gaps between men and women in those areas and to reduce inequalities in preventable deaths before the age of 75 years by 20%. Clarification was sought on how the targets were set and if they were realistically achievable. The Director for Public Health acknowledged that they were stretched targets, but the aim was to be ambitious, however the targets were achievable. The targets were not based on any scientific calculation.
- Members noted that the aim of the strategy was to create an environment to give people the opportunity to be as healthy as they could be, but also noted that it had appeared in some areas of the city that the council were creating an environment for people to become as unhealthy as possible. This was seen by overcrowding and densely populated areas which often caused unhealthy environments. Members commented that these areas of Peterborough needed to be looked at more closely. The Director for Public Health advised that planning measures were used and would be continued to be used to support living in a healthy environment including such measures as exclusion zones for fast food outlets around schools. One of the challenges was that there was a lot of exposure to fast food outlets and unhealthy foods, additionally high density of pubs and drinking places and accessibility to cheap alcohol through supermarkets. There would need to be prioritisation on children and childhood obesity and working with schools to reduce this and improve on the lunch time and tuck shop provision.
- Members noted that the council had already identified its top ten areas of deprivation and wanted to know why those areas were not being prioritised for health inequalities. The Director for Public Health advised that she was writing a paper on health inequalities which included information on why it was appropriate or not to target certain areas. Many of the most effective Public Health measures had been universal measures. Examples of these were the Covid lockdown measures which were really effective at reducing inequalities and exposure to Covid mortality. Another example was fluoridation in water which was one of the most effective measures in reducing inequalities in dental care. This information would be explored in more detail in the annual Public Health report which would be presented to the committee at a future meeting.
- Members commented that Peterborough was a multi-cultural city and sought clarification as to whether the strategy would follow a multi-cultural approach. The Director for Public Health advised that she was a firm believer in the application of behavioural science, and that involved understanding populations where you wanted to change behaviour, understanding the motivational factors and the barriers to adopting healthy behaviours and then using marketing techniques to address them. Budget had been put aside to support this.
- Members referred to the section regarding ensuring children were ready to enter education and wanted to know if this linked into the Best Start in Life Programme.

Members were informed that the Best Start in Life Programme was still in place, this strategy would be about delivering even better outcomes. The Best Start in Life Programme had been impacted by Covid as Health Visitors had not been able to have face to face visits and one of the priorities of the strategy was to get the face-to-face visits back in place. Face to face visits would enable developmental base line checks to recommence and universal measures could then be put in place and targets for child development.

The Chair thanked the Director for Public Health for an informative and comprehensive report and invited the Director back to a future meeting to report on how the strategy was progressing.

The Chair also welcomed Cllr Howard to his first meeting as the new Cabinet Member for Adult Social Care, Health and Public Health.

AGREED ACTIONS

The Adults and Health Scrutiny Committee **RESOLVED** to note and comment on the proposals for engagement and consultation around the Overarching Cambridgeshire and Peterborough Health & Wellbeing Strategy.

The Adults and Health Scrutiny Committee requested that the Director of Public Health include in her next Service Director report the Health and Wellbeing Strategy, outlining actions that will be taken to achieve the strategies priorities.

8. REVIEW OF 2021/2022 AND WORK PROGRAMME FOR 2022/2023

The Senior Democratic Services Officer presented the report which considered the 2021/2022 year in review and looked at the work programme for the new municipal year 2022/23 to determine the Committees priorities. Members also noted the Terms of Reference for the Committee.

Members asked if information on what staffing levels were like during Covid throughout hospitals, GP surgeries and intermediate care teams and how staff were affected when operating with a lesser workforce that normal, and if this could be incorporated into a future report. The Senior Democratic Services Officer suggested that this be discussed at the next Group Representatives/Agenda Planning meeting to see if it could be incorporated into a future report.

AGREE ACTIONS

The Adults and Health Scrutiny Committee noted the report and **RESOLVED** to

1. Consider items presented to the Adults and Health Scrutiny Committee during 2021/2022 and make recommendations on the future monitoring of these items where necessary.

2. Determine its priorities and approve the draft work programme for 2022/2023 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 2021/2022 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, Adults

and 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 which included the latest version of the Council's Forward Plan of Executive Decisions containing decisions that the Leader of the Council, the Cabinet or individual Cabinet Members would make during 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.

A Member requested further information on the following decisions:

- Variations to the Integrated Drug and Alcohol Treatment System Contract - KEY/25APR2022/03
- Investment of additional funding from the Office of Health Improvement and Disparities (OHID) to improve Drug and Alcohol Treatment Services – KEY/23MAY22/01

The Director of Public Health advised that the above decisions related to work that had been carried out by Dame Carol Black that had identified deficiencies in the drug treatment pathway. There had been more money made available to increase the reach to the people that could be offered treatment to and to strengthen the pathway such as offering more family support. This was a variation to the current contract to allow for the additional investment. Further information could be provided via a briefing note.

AGREED ACTIONS

The Adults and Health Scrutiny Committee **RESOLVED** to note the report and requested that the Director of Public Health provide the committee with a briefing note on Forward Plan Item 9 Variations to the Integrated Drug and Alcohol Treatment System Contract KEY/25APR2022/03.

10. DATE OF NEXT MEETING

13 September 2022 – Joint Meeting of the Scrutiny Committees
27 September 2022 – Adults and Health Scrutiny Committee

CHAIR

7.00 - 8.23pm

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