HEALTH COMMITTEE: MINUTES

Date: Thursday 5th November 2015

Time: 2.00pm to 4.50pm

Present: Councillors P Ashcroft, B Chapman (substituting for Cllr van de Kerkhove), P Clapp, D Jenkins (Chairman), M Loynes, Z Moghadas, , T Orgee (Vice-Chairman), P Sales, M Smith, P Topping, S van de Ven and J Wisson (substituting for Cllr Hudson)

District Councillors S Ellington (South Cambridgeshire), R Johnson (Cambridge City) and C Sennitt (East Cambridgeshire)

Apologies: County Councillors Dent, Hudson (Cllr Wisson substituting) and van de Kerkhove (Cllr Chapman substituting); District Councillor R Mathews (Huntingdonshire)

164. DECLARATIONS OF INTEREST

In relation to agenda item 4 (minute 167), Councillor Sales pointed out that almost all Members present either were or had been patients of Addenbrooke's Hospital. In the course item 4, Councillor Wisson declared that she and Ann-Marie Ingle of CUHFT knew each other socially.

165. MINUTES: 1st OCTOBER 2015 AND ACTION LOG

The minutes of the meeting held on 1st October 2015 were agreed as a correct record and signed by the Chairman.

The Action Log was noted. The Director of Public Health (DPH) reported that

- (item 160) she had attended a constructive meeting of the Cambridgeshire and Peterborough Health Protection Steering Group, which included NHS England, on working together with the County Council. However, information governance rules meant that it would not be possible to access data on screening uptake at GP practice level, though the CCG was willing to share uptake information on a more general basis. There had been a very poor response to the GP survey

- (item 162) the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) was establishing a post to support the physical health of people with severe mental health problems; and the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)was also looking at this in terms of GP input. It would be helpful to the Local Authority's clients with severe mental health problems to ensure that they were in touch with other organisations. The DPH agreed to a Member's request that the Committee reassure itself in six months' time that this support was indeed being provided.

166. PETITIONS

There were no petitions.

167. CARE QUALITY COMMISSION INSPECTION REPORTS – CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (CUHFT)

The Committee considered the recent Care Quality Commission inspection of Cambridge University Hospitals NHS Foundation Trust. Three of the five CQC inspection areas had been rated as inadequate (Safe; Responsive; Well-led), resulting in an overall rating of the Trust as inadequate. Of the other two CQC inspection areas, Effective had been rated as requires improvement, and Caring had been rated as Outstanding. On the basis of these findings, the Chief Inspector of Hospitals had recommended that the Trust be placed into special measures.

In attendance to present information and respond to Members' questions were:

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
    - Dr Cathy Bennett, Chair of CATCH Local Commissioning Group and GP Vice Chair to the Governing Body
    - Tracy Dowling, Chief Operating Officer
    - Jill Houghton, Director of Quality / Nurse Member

- from the Care Quality Commission (CQC)
    - Fiona Allinson, Head of Hospital Inspection for East Anglia and Essex
    - Mark Heath, Inspection Manager
    - Lorraine Bess, Inspection Manager

- from Cambridge University Hospitals NHS Foundation Trust (CUHFT)
    - Dr Jag Ahluwalia, Medical Director
    - Zafar Chaudry, Chief Information Officer (CIO)
    - Ann-Marie Ingle, Chief Nurse
    - Kate Lancaster, Director of Corporate Affairs
    - Mike More, Vice-Chair
    - David Wherrett, acting Chief Executive Officer (CEO)

- from Monitor
    - Joel Harrison, Senior Regional Manager

The Chairman welcomed all who were attending for this item, explaining that the Committee intended to conduct its scrutiny in a spirit of reaching an understanding of what had happened and what was needed to ensure that special measures would no longer apply. From talking to people, he had gained an impression of a tremendous pride in Addenbrooke's and the Rosie in the county and elsewhere, and of intense disappointment at what had happened. He invited the representatives of each organisation to make a short presentation responding to the questions sent in advance of the meeting [attached to these minutes as Appendix A] and to other issues.

The Head of Hospital Inspection for East Anglia and Essex said that she had led the inspection in April 2015. The inspection had been planned because the CQC had become aware of an increasing number of issues of concern within the Trust and within the local community, such as issues around the implementation of the EPIC IT system and consequent delays in issuing letters, and concerns within the Trust about pressures on nursing staff. Teams of four to five had looked at each of eight core services; in total, about 45 people went in to inspect CUHFT over a period of three days.

The inspection had found

- issues in critical care, where there were defined staffing levels which had not always been met, and management had not been aware of failure to meet these levels
- issues with the numbers of midwives available, and with the levels of nitrous oxide in labour units
- in the outpatient service, EPIC had resulted in a backlog of patients waiting for outpatient appointments; some had waited a considerable time, without any risk assessment being carried out on them
- the hospital had been struggling with capacity, opening extra wards to try to increase capacity and staffing them by pulling staff from other wards, which had left a shortage of cover and experience elsewhere
- the estate had not been as well maintained as it should have been
- a lack of robust governance processes in place to ensure that information filtered up to the top of organisation.

Inspectors had spoken to the Trust immediately about the critical care situation because it had felt unsafe, and had imposed a condition on the Trust's registration that appropriate staffing levels be applied. This condition had been lifted in six weeks because the Trust had met it well.

The Head of Hospital Inspection went on to explain that the CQC did not place Trusts in special measures lightly, but the inspection chair had felt that special measures were required. There was now a process of monitoring what was happening at the Trust, with frequent meetings with the Trust. The CQC would review its finding of inadequate at the appropriate time, and later would also conduct a follow-up inspection.

The CQC Director of Quality apologised that Dr Neil Modha, the CCG Chief Clinical Officer, was unable to attend the meeting. She went through the presentation supplied as part of the papers for meeting. In the course of this, Members noted that

- 'escalation' described the process whereby issues of concern were discussed through the NHS England Quality Surveillance Group and participants pooled their intelligence; a 'a risk summit' meant all parties coming together to talk about the risks because of the level of their concern
- there was now an increasing use of internal bank staff rather than agency staff
- outcomes in maternity did not seem to have been compromised by staffing levels. Following an internal establishment review, maternity was now staffed to the national level with use of bank staff when needed and possible; if full staffing was not possible, maternity closed to new cases

The Vice-Chair of CUHFT thanked the Committee for its invitation and said that a very senior team had attended because they were being held to account by the Committee for the discharge of their responsibilities and of their response to the CQC rating. He welcomed the Chairman's introductory words, saying that the hospital recognised the trust that patients had in the hospital; it was CUHFT's responsibility to show that the hospital deserved this trust. The issues identified needed correction; clinical outcomes continued to be high, but some assurance issues were not as strong as they should be.

The acting CEO went through the presentation on how CUHFT was responding to the inspection findings, saying that he was proud to be a local resident and a patient and member of staff of Addenbrooke's. He assured the Committee that the hospital was not arrogant but very much listening. The Trust had conducted a self-assessment prior to the inspection and had rated itself as requiring improvement; the CQC's rating of it as

inadequate had been a disappointment. He pointed out that the inadequate ratings for 'safe' related to systems and processes, not to survival rates. In response to the report's criticisms, management was now sitting down and talking with staff and patients far more than it had been. There were 23 elements to the Trust's Improvement Plan, which was a publicly available document. He stressed that the Trust had heard the CQC's report very clearly and was working hard to remove the label of inadequate.

The Senior Regional Manager of Monitor explained that, as the sector regulator, Monitor had accepted the CQC's recommendation and had placed the Trust in special measures in September. It was now up to the Trust to deliver improvement. Monitor's role was to hold the Trust to account on delivery, and support it on the way to delivery. This support could include a buddy trust arrangement, and putting an improvement director in place if that would be helpful.

Monitor had held an improvement meeting on 2nd November involving a wide range of participants, including the Chairman of the Health Committee, and had also met the Trust in private, because some of the financial information might be commercially sensitive, and had met governors. Monitor had also met stakeholder colleagues at the engagement group. The Trust was recognising and facing its challenges and had submitted a good improvement plan to time and with granular detail on each area.

Members put questions and comments to the representatives of the CCG, CQC, CUHFT and Monitor concerning various aspects of the information provided, including:

Question: Was it realistic to seek improvement in as many as 23 areas?
Answer: Monitor's representative confirmed that 23 high-level actions had been identified; the improvement plan acted as a single overarching plan addressing all the concerns. The Trust's Vice-Chair said that the Board had seen the need to have an overall plan and one person in charge of its delivery; fewer than 23 action points would not have covered the amount that had to be done.

Comment: One Member reported that what she had heard and experienced in terms of care was excellent, with the recent exception of the virtual fracture clinic, when she and other patients had come in for an outpatient appointment, only to be told they were to be telephoned at home.
Response: The virtual fracture clinic was a means by which staff could use eHospital to assess a patient's initial X-ray and potentially save them a journey to outpatients if there turned out to be no fracture. The Medical Director offered to respond to the particular case raised outside the meeting.

Question: How was staff recruitment proceeding; were there any local factors making it more difficult?
Answer: The acting CEO said that he was usually Workforce Director, and as such he recognised the vital importance of having the right staff in the right place; he had been working to improve staffing over about the last two years. Since the CQC inspection, there had been a 10% increase in nursing staff; there were now no agency nurses in Addenbrooke's. Other CUHFT representatives advised Members that

- it was not always possible to recruit to areas such as intensive care; nationally, there was extensive reliance on overseas nurses
- each month, the Chief Nurse brought a report on filled shift numbers to the Board

- the CQC inspection had taken place mid-way through an existing process to increase staffing; the Board was clear that safety was the first priority, though it was a difficult task to balance safety and financial challenge
- only relatively recently had it been understood how many nurses and midwives were required given the complexity of the patients cared for. NICE had quite recently developed and supplied guidelines, which CUHFT now worked to; in consequence, organisations across the country were simultaneously all trying to recruit from the same pool for nurses
- there was a Cambridge problem. Demographic growth in Cambridgeshire was significant and not matched by an increase in funding, and the high cost of housing presented a problem for staff. Difficulties with the quality of residential care in the county affected the flow of patients and there was a significant growth in the number of over-85s; cancellations of elective procedures tended to occur because beds were being used by those with chronic problems
- the cost of living in Cambridge did not seem to impact significantly on the level of vacancies and the numbers applying, though it might affect how long staff stayed as their families grew
- there were particular pockets of national shortages in some specialities such as intensive care. A&E was fully staffed in Cambridge; other places were not so fortunate.

Question: Why was the effectiveness of outpatients and diagnostic imaging not rated?
Answer: The Head of Hospital Inspection explained that effectiveness was in relation to outcomes for patients. There were a number of national audits that could be used to measure medical services for example, but outpatients tended to be either discharged or referred elsewhere in the hospital, so it was not possible to measure effectiveness in the same way. The CQC was however looking into the possibility of rating the effectiveness of radiology.

Question: The CQC's findings had come as a surprise; had something gone wrong with CCG monitoring before the inspection?
Answer: The Director of Quality said that the CCG had been talking to the CQC and Monitor before the inspection and had set up a surveillance group as they were all aware of problems at CUHFT. The GP Vice-Chair added that local GPs had been aware of concerns as they had heard about them daily from their patients. They had welcomed the CQC, but had already brought other commissioners together to share concerns and start making progress. They had been disappointed but not surprised by the CQC report

Question: Systems and processes kept patients safe; what assurance did Members have that people were making the systems and processes work?
Answer: The Senior Regional Manager responded that it was Monitor's role to hold the Trust to account. The Trust was being asked what actions it had taken in relation to patient access and flow, and how improvements were being measured. Monitor would continue to challenge, and would be asking colleagues round the table to support Monitor and the Trust in this. The Trust Vice-Chair added that systems and processes were not add-ons, but were what ensured that clinical outcomes were as they should be. The Trust had strengthened the role of its Quality Committee and was clarifying accountability within the hospital. The Quality Committee was now much more data-led; EPIC would assist with this by providing richer data. The CQC report was being used as a wake-up call.

Question: Special measures had implications for resources; where were the resources coming from to report frequently to all the various bodies?
Answer: CUHFT representatives said that there was a resource requirement of ensuring that people's minds were focussed on this, though the biggest priority was to ensure that services were safe and effective. It would not be possible to solve all problems simultaneously, so the CQC had been told that the response would be phased. It would be a challenge to find the resources to address those issues raised in the report that were capital intensive. There were also questions round capacity at senior board level to be met, including hiring consultants to develop the financial plan.

The CCG Chief Operating Officer added that the different organisations were working together wherever possible, to avoid overburdening CUHFT. For example, the improvement plans for the CQC and Monitor were the same for the CCG, to avoid expecting the Trust to work to different outcomes for different bodies.

Comment: The number of intensive care (ICU) beds was presumably related to the numbers needing intensive care; if beds were closed, patients would go to other beds where they needed the same level of care.
Response: The Chief Nurse confirmed that the hospital had had to smarten up processes round all beds, in ICU and in ward areas; sometimes patients remained in ICU because there was no bed on a ward. If recruitment permitted, they would open another ICU bed. The Monitor representative added that the ICU provided an example of everything being talked about – staffing, patient flow, financial challenge – which could be magnified across 8,700 staff.

Question: What impact has the report had on doctors and nurses on the ground, and what support has been put in place for them?
Answer: CUHFT representatives said that there were some angry confused people, but generally there was a resolve to use the opportunity to put matters right. Support was in place for each area affected, including sitting with people and providing drop-in sessions for staff. The report had impacted on every level.

Question: How did closure of maternity work from the patient's point of view?
Answer: The Chief Nurse explained that she had looked at staffing with the CCG and with the head of midwifery 18 months ago. There was a recommended national midwife to birth ratio which the Trust did not meet (1:32 against a recommended 1:28), so nine midwifery posts and a new ward were created; the CQC inspection occurred part way through this process. At the establishment review in May, the head of midwifery had requested nine more midwives and six maternity support workers, which would bring the ratio to around 1:30. If bank midwives were not available to supplement the staff on duty, it was necessary to close – but mothers still arrived even when the unit was closed. A discussion to be had with the CCG was whether maternity services could be capped, but this was a complex matter because of patient choice and what was available at The Rosie.

The CCG Medical Director added that maternity staffing was a key issue in closure. This also applied to the neo-natal ICU, as it was necessary to close the maternity unit when they were unable to look after the babies.

The Vice-Chair of CUHFT offered to supply the action plan to officers for circulation to the Committee.

Question: What had been the cost of the implementation of the paperless hospital, and should there have been a back-up plan when it was installed?
Answer: eHospital followed 20 years of almost no investment in IT systems; CUHFT had now invested about the average amount nationally and globally for IT. The cost of £200m had not all been paid at once but was spread over a period of years; of that sum, about a fifth had been spent on software and 10% on implementation costs. A very full procurement process had been undertaken, including scrutiny on best value for money. The Trust wanted to share its learning with the rest of the NHS, as the Secretary of State had said that all hospitals should be paperless by 2018.

EPIC had gone live on 26th October 2014 and had changed considerably since then, which meant that there was a constant requirement for refresher training, in addition to the need to train incoming staff. Because Addenbrooke's was the only hospital in the country to use EPIC, staff did not arrive pre-trained. The previous IT hardware had been so old that it was not being supported, and the software licence was due to run out early in 2015, so the position could have been rather worse if EPIC had not been implemented. Work was being done round a speciality review to see if the considerable issues in Outpatients could be addressed.

In independent inspection, on a scale of 1 to 7 (where 7 was paperless) the Trust had been given stage 6. It could undertake positive patient identification at the bedside – data was flowing, but there had been issues of data quality and the training programme had been revised. The running cost of £27m per annum was around the average spend. EPIC had been a factor in the hospital's difficulties, but not the only cause; its introduction had coincided with enormous pressure on the acute sector across the country.

The Chairman suggested that it would be helpful to hold a workshop on EPIC for Members. The Medical Director said that the Trust would be happy to support this.

Question: how useful was the post-treatment letter of enquiry?
Answer: no trust used the friends and family test as it sole mechanism to receive patient feedback. Other means included an annual postcode survey and a maternity survey, as well as valuable input from Healthwatch and the fact that the GPs on the CCG saw patients and heard their experiences every day.

It was resolved unanimously to:

1. note the progress made in addressing the issues raised by the Care Quality Commission's (CQC's) report on its inspection of Cambridge University Hospitals NHS Trust (CUHFT)

2. express support for the co-operative approach shown by all parties to this progress

3. recognise the action plan

4. ask that the root causes identified by the CQC (e-Hospital, staff shortages, governance issues) be not forgotten in the enthusiasm to carry out the action plan

5. request CUHFT to supply a brief monthly report to the Committee on each of the root causes

6. review progress made at the Committee's meeting in six months' time.

The Chairman thanked all participants for their helpful input to the meeting, and expressed the Committee's best wishes to CUHFT going forward.

168. HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

The Committee received a report informing it of the health scrutiny activities undertaken and planned since 16th July 2015. The meeting of the UnitingCare Partnership liaison group that had taken place on the morning of 5th November would be reported on at the Committee's meeting in December 2015.

Members were asked to consider what working groups and liaison meetings should be continued or established in future, who should serve on those groups, and whether there should be further visits to healthcare providers along the lines of previous visits to hospitals in Peterborough and Kings Lynn. Those who had attended the UnitingCare meeting expressed the view that this liaison group should continue to meet.

It was resolved unanimously to:

1) Note and endorse the recommendations made on health scrutiny by the liaison groups.

2) Continue the liaison meetings with Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire and Peterborough NHS Foundation Trust, and UnitingCare Partnership

3) Retain the current membership of the liaison groups as a core, with other members of the Committee attending if available and interested.

169. SERVICE COMMITTEE REVIEW OF DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2016/17 TO 2020/21

The Committee received a report setting out an overview of the draft Business Plan Revenue Proposals for Public Health Services that were within the Committee's remit. Members noted that this work followed on from discussion of in-year savings at the Committee's October meeting, when Members had reviewed Community Impact Assessments; the proposals for next year had been developed in the light of the discussion in October. The savings sought from Public Health for 2016/17, £511k, were slightly less than the in-year savings for 2015/16 that had already been identified.

Looking at the proposals in detail, points noted by Members included that

- the Council had been commissioning health visiting from October 2015, so 2016/17 was the first full year in which funding had been received for this
- it had been assumed that the public health ring fence would be removed from the main budget for 2016/17, though it was known that the funding for the healthy child programme for 0-5 year olds (which included health visiting) would continue to be ring-fenced

- working closely with Peterborough City Council was going well; much partnership working between the two areas had already been taking place, such as work with the Cambridgeshire and Peterborough CCG.

In the course of discussion, Members expressed appreciation for the clearly set out summary table of public health savings at Annex B, and pointed out that the new operating model would be coming into effect within the next five years. It could be argued that every pound spent on public health would lead to savings elsewhere in the health and social care system.

It was resolved unanimously to

a) note the overview and context provided for the 2016/17 to 2020/21 Business Plan revenue proposals for the Service.

b) note the draft revenue savings proposals that were within the remit of the Health Committee for 2016/17 to 2020/21, and endorse them to the General Purposes Committee as part of consideration for the Council's overall Business Plan

c) note the proposed approach to demography and inflation for those Public Health services that were within the remit of the Health Committee for 2016/17 and endorse the recommendations.

170. FINANCE AND PERFORMANCE REPORT – SEPTEMBER 2015

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of September 2015. Members noted that the report took account of the in-year savings, and that for the first time it included performance information on the Health Committee's priorities (mental health, transport, and health inequalities). In relation to Child and Adolescent Mental Health Services (CAMH), it was hoped to reopen the Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) waiting lists in November 2015.

In the course of examining the report, Members

- enquired whether other authorities had developed any indicators for mental health that could be utilised, as a time-saving measure. Members noted that the proposed indicators were very local to Cambridgeshire and reflected what was being funded through the Public Mental Health Strategy; there were no indicators already in place because the Strategy was in the early stages of implementation. The Public Health Outcome Framework provided a national indicator

- commented on the difficulty of knowing and evaluating what academies were doing in relation to mental health training and taking up offers of consultancy support, but noted that Public Health had been working closely with the Council's Children, Families and Adults Services to support this work. An update on the Public Mental Health Strategy was on the Committee's agenda plan for its next meeting

- pointed out that even within Cambridge, some public transport journey times to Addenbrooke's were lengthy, and factors such as reductions in subsidies to bus operators were likely to make matters worse. The proportion of the population with

public transport journey times of under an hour should be monitored closely; lack of good access to public transport put at risk people's ability to receive good treatment

- noted that the apparent lack of spending on adult obesity was due to the transfer of weight management staff to the new provider for Healthy Lifestyle; this area of work had been expanded but did not show as adult obesity spending.

It was resolved unanimously to note the report.

171. PUBLIC HEALTH GRANT PROPOSED TARGET ALLOCATION FORMULA FOR 2016/17 – RESPONSE TO CONSULTATION

The Committee received a report seeking its approval of the draft response from Cambridgeshire County Council to the national consultation on the Public Health Grant: proposed target allocation formula for 2016/17.

Members were advised that the Department of Health (DH) on 4th November 2015 had formally announced an in-year cut in the Public Health grant; all local authorities were being asked to make a saving of 6.2%. In response to the consultation on in-year savings, the preferred option put forward by the DPH on behalf of the Council had been to focus on areas which received more than their target funding level (Cambridgeshire was 5% below target and Peterborough 20% below target); the DH had however taken the view that, because the targets were about to be changed, it was not appropriate to align funding to outdated targets.

In relation to the consultation on 2016/17 funding, Members noted that the impact of the proposed new formula would be neutral or slightly positive for Cambridgeshire compared to the old formula.

It was resolved unanimously to

> Approve the Cambridgeshire County Council response to the national consultation on the Public Health Grant: proposed target allocation formula for 2016/17.

172. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan, and agreed that is should no longer be regarded as a draft.

It was resolved unanimously

a) to accept the training plan

b) to add a workshop on eHospital to the workshop already planned for the reserve date of 18th February 2016

c) to explore the possibility of moving the date of the February workshop to avoid the school half term holiday

173. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee considered its agenda plan. The Director of Public Health indicated that she would be seeking the Committee's authorisation for her to exercise a vote on the Health Executive which was being formed under the health system Transformation Board. The Board, which met every two months, had a wide membership including social care senior officers and NHS chief executives. The Health Executive would involve the chief executives of health providers, the Chief Operating Officer of the CCG, and the Director of Public Health. It was developing a prevention strategy which would go to all Health and Wellbeing Boards in the area. The DPH would bring a report and the Terms of Reference of the Health Executive to the Committee's next meeting.

It was resolved unanimously:

a) to note the agenda plan
b) to note that there were currently no outstanding appointments to be made.

Chairman