Agenda item No: 2

HEALTH COMMITTEE: MINUTES

Date: Thursday 8th September 2016

Time: 2.00pm to 4.20pm

Present: Councillors Sir Peter Brown (substituting for Councillor Loynes), P Clapp, L Harford, P Hudson, D Jenkins (Chairman), R Mandley (substituting for Councillor Dent), L Nethsingha, T Orgee (Vice-Chairman), P Sales, M Smith, P Topping and S van de Ven

District Councillors M Abbott (Cambridge City), M Cornwell (Fenland), A Dickinson (Huntingdonshire) and S Ellington (South Cambridgeshire)

Apologies: County Councillors Dent, Hipkin and Loynes
District Councillor Cornwell

243. DECLARATIONS OF INTEREST

There were no declarations of interest.

244. MINUTES – 14 JULY 2016 AND ACTION LOG:

The minutes of the meeting held on 14th July 2016 were agreed as a correct record, subject to recording Councillor van de Ven, spelled correctly, as sending apologies rather than attending. The minutes were signed by the Chairman.

It was suggested that the word 'savings' in minute 234 should be replaced by 'cuts' as closer to the meaning of what had been happening, but it was pointed out that 'savings' was the conventional usage, reflected in the minutes.

The Action Log was noted. The Chairman reminded members that the system-wide review of health outcomes, minute 234, had been added to the agenda plan in order to enable the Committee to track action to reduce health inequalities in Fenland.

245. PETITIONS

There were no petitions.

246. FINANCE AND PERFORMANCE REPORT – JULY 2016

The July 2016 Finance and Performance report was presented to the Committee. Members noted that there had been some planned use of reserves, and that there were no exceptions reported in Public Health at the end of July.

Discussing the report, members

- described the report as presenting an excellent summary of public health activities
- pointed out that agricultural workers had a reduced life expectancy as a result of agricultural injuries and exposure to chemicals, and that many eastern European workers seemed to be heavy smokers. There had once been an anomaly in the death rate in the Peterborough area, which had appeared related to packers being

exposed to chemicals; it would be interesting to pursue this. The Director of Public Health (DPH) pointed out that manual workers in general had a lower life expectancy, and that their rates of smoking, especially in Fenland, were higher too. She was involved in work with Peterborough, Norfolk and Suffolk on smoking rates among eastern Europeans, which would feed eventually into smoking cessation work. The DPH undertook to look at occupational health data and follow up the query on agricultural workers' life expectancy **Action required**

- expressed concern that the position on overweight children in Fenland was not improving. Members noted that the target to reduce the proportion of Reception children with excess weight in Fenland was a stretch target, and that the aim of reducing health inequalities was not to be achieved by reducing the health of the rest of the population

- asked whether the question had been investigated of whether there was any relationship between those children who had not received a 2-2.5 year review and those overweight on entering Reception, and whether there had been a missed opportunity to influence their diet. The DPH confirmed that one of the roles of health visitors was to convey health messages to families, and said that it was not possible to tell whether the children who did not receive the earlier review were the same children as those overweight at age 4-5

- queried whether all 38 schools and sixth-form colleges had been offered funded mental health training and consultancy support around mental and emotional wellbeing of young people, pointing out that the lack of schools' mental health training was putting pupils at risk. The DPH undertook to check whether all schools had been offered the training **Action required**

- commented that the UnitingCare working group had pursued the question of delayed transfers of care (DTOC) quite intensively, and asked whether the Committee should still be doing this in the absence of UnitingCare. The DPH advised that the Adults Committee received a more detailed update on DTOC, and suggested that the Adults Committee update be circulated to the Committee. **Action required**

- said that Cambridgeshire should aim to be better than the national average, and that it was necessary to top up reserves as soon as possible, because once they had been used, they were no longer available.

It was resolved unanimously to note the report.

247. MENTAL HEALTH VANGUARD UPDATE (Plus Appendix on PRISM; new primary care service for Mental Health)

The Committee received a report introducing the work of the Mental Health Vanguard Project Team and the PRISM project team, undertaken as part of the local Urgent and Emergency Care Vanguard programme. In attendance to present the report and respond to Members' questions were

- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
    - Dr Caroline Meiser-Stedman, consultant psychiatrist, clinical lead for the project
    - Dr Nimalee Kanakkahewa, consultant psychiatrist, leading PRISM (the name for the new enhanced primary care mental health service)

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Tracy Dowling, Chief Operating Officer (COO)

Dr Meiser-Stedman explained that the Vanguard project had been developed in response to rising pressure on A&E, which had been experiencing an increase in people attending for non-medical mental health problems. Patients reported that A&E was a difficult place for them to come to. They often left attendance until a last resort, and it was a difficult place for clinicians to assess people in mental health crisis; the Vanguard provided the opportunity to do things differently. A limited part of the new service had already been started, and the full service would be introduced from 19 September. From that date, a telephone self-referral service would be available via 111, where callers would be put straight through to a mental health triage team, with clinical staff supporting the team at all times, and staff available 24/7 to go out to assess callers face to face where necessary.

In answer to their questions, members learned that

- capacity was a concern. Data on arrivals at A&E had been analysed to identify the times when patients were currently presenting, but there was a degree of uncertainty because of the element of self-referral. Other teams from the mental health pathway could step in to help if necessary. It was hoped that self-referral would lead to earlier referral, so that help could be given sooner and more effectively, and that patients attending the Sanctuaries could be helped to link in to other non-statutory services

- agreement had been reached that if the first response service thought a person needed home support or inpatient care, this would follow without the need to undergo further assessment

- the national triage scale for providing a very urgent mental health response was four hours, and the Cambridgeshire service would be aiming and measuring for one hour, despite the large geographical area to be covered. Staff would be based in the north and south of the county in the night; it would be necessary to triage carefully and quickly

- it was hoped that having information about people through clinical support would help reduce the use of detention by Police under Section 136 of the Mental Health Act, and ensure that it was only used appropriately

- various voluntary organisations were working together on the Sanctuary; Dr Meiser-Stedman did not know specifically whether Samaritans was one of these, but would check, as it was important that the Samaritans did know about the service

Action required

- there was to be a major advertising campaign in the week of the service launch

- the service would take referrals from family members and carers

- it was hoped that the new service would lead to savings in A&E. The COO said that the CCG spent over £4m a year on mental health admissions at Addenbrooke's, usually for a short period while assessments were carried out. The CCG would prefer to spend money on a proactive service than on hospital admissions for people who did not need to be there; the CCG would struggle to continue to fund these if

the service did not produce savings, though the COO could see that there were also benefits in terms the quality of service user experience.

Introducing PRISM, Dr Kanakkahewa said that it was intended to bridge the gap between what primary care and the secondary care mental health services could provide. A pilot had started on 9 August as proof of concept, covering five GP surgeries. The hope was to reach people before they needed secondary care, and to be able to provide rapid access if they did need secondary care. It was intended for planned, rather than crisis, work, to be carried out as early as possible.

The Chairman thanked the CCG and CPFT officers for attending, saying that the Committee was enthusiastic about the initiatives that were taking place and looked forward to hearing more about them in six months' time. He suggested that a range of measures of performance, outcome measures, be tracked, beyond the effect on A&E, as it might help to secure funding, and offered congratulations to CPFT and the CCG for this excellent piece of work.

It was resolved unanimously
a) to note the recent updates on Mental Health services for the Cambridgeshire and Peterborough health system
b) to welcome the work being undertaken by the CPFT and CCG, and
c) to receive a further update in six months' time.

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248. OUTPATIENT SERVICES AT COMMUNITY HOSPITALS

The Committee received a report from the Clinical Commissioning Group giving an update on the East Cambridgeshire and Fenland review of some of the health care services delivered from the community hospitals. Attending to introduce the report and respond to members' questions and comments were the CCG's Chief Operating Officer (COO), Tracy Dowling, and the Director of Corporate Affairs, Jessica Bawden.

A member of the public, Jean Simpson of Cambridge, asked a question (set out in full at Appendix A), in which she asked the Committee to ask the CCG four questions about the review of health care services delivered from community hospitals:
1) who was taking the decisions on which options were supported, and on what information would it be based
2) had all GPS been consulted on the viability of the options
3) had the CCG fully taken into account the effect of the closure of Minor Injury Units (MIUs), out patient departments and interim care beds
4) could the CCG explain how the public meetings and consultations would have any influence on the Sustainability and Transformation Plan (STP) proposals for community services, as there was to be no public consultation on the STP.

The Chairman thanked Ms Simpson for her questions, and said that the Committee would seek answers to any of them that were not covered in the course of the meeting.

Introducing discussion of the report, the Chairman pointed out that it went beyond outpatient services, and was strongly linked to the following agenda item.

The COO advised members that
- the review of services in East Cambridgeshire and Fenland was being conducted in the context of the Sustainability and Transformation Plan, which was a five-year plan being developed in the context of the growth anticipated in Cambridgeshire across the period

- doing nothing would leave a £150m gap over next five years between the cost of providing services as they were now and the income available to fund them
- as well the provision of services in communities, the use of the NHS estate was being looked at; this would require capital investment, and while the investment funds available were small, the development of hubs in the community formed part of the longer-term STP vision
- the MIUs had been reviewed against the standards set out in the Keogh urgent and emergency care review; because of the Urgent and Emergency Care Vanguard, Cambridgeshire had been one of the first areas nationally to do this
- services were required to comply with the Keogh standards within the next three years
- levels of activity in the MIUs had been found to vary widely through the day
- no decisions had yet been taken; it was necessary to ensure the provision of a minor injuries service even if the present MIUs were to be closed
- the reason public engagement meetings were being held across the County before the options had been developed was that an early internal document had been leaked and had given rise to great public anxiety; it was proving very helpful to receive feedback from people at these engagement meetings
- the intention was to provide services that were safe and clinically viable, to make best use of the funding available, and to meet people's needs.

Discussing the report, members

- commented that people attending one of the meetings had thought they were losing the MIUs and were anxious because they did not understand what was being proposed instead

- noted that GP federations could involve bringing practices together in one location, giving them a larger income with which they could employ a wider workforce

- said that it would have been helpful if the CCG could have had some clear proposals available, set out on a map, before embarking on the series of public meetings. It was explained that this had been the intention until the leak had occurred

- pointed out that there were still two empty wards and unused operating theatres in Wisbech

- commented that there were similar problems of access in the south of the county, and similar questions about the use of community hospitals, and their future role

- in answer to a question about how the CCG viewed the future of community hospitals, the COO said that the community hospitals had changed significantly over the years, but the estate had not. There were now higher levels of home-based care and rehabilitation, and the level of surgery undertaken had changed, both in that some surgery now only required day care, and some was now much more specialised, with limited scope for care in a community hospital. A future role for the community hospital could be as a hub in a community, with a degree of flexibility so that it could be used for a wide range of staff, services and clinics, including minor surgery, and providing support for quite ill people being cared for in the community to check that they were not deteriorating. The number of GP practices in the county was decreasing; it would be necessary to work with local GPs in developing plans.

Once the plan had been developed and approved, the CCG would publish the plan and bring it to Committee; if service changes were proposed, the CCG would go to public consultation, but this would not be until November. Work was continuing on what the estate and capital investment would be, and a plea was being made for some double running costs, because the changed service would have to come into effect before the previous service could be removed. The STP did not include cutting out large areas of service; the growth and aging of the Cambridgeshire population meant that existing capacity could not be removed, but it was necessary to use it far more efficiently

- drew attention to complaints of lack of GP capacity in some new developments, noting that the Committee would be looking at GP capacity at its November meeting. The COO said that there were vacancies in a number of GP practices, and it was important to support GPs in a way in which it had not done until now; NHS England commissioned GP services, but practices needed support to enable them to deliver services, and stronger GP practices were an important element in delivering improved services

- drew attention to difficulties that people might experience in for example travelling to get dressings changed daily if local services were removed; it might take all day to get to and from Cambridge or Peterborough. Members noted that the CCG was looking at the question of how many people would attend A&E instead if MIUs were to close, and how many would call an ambulance to get there

- sought further information on the temporary pause on admissions to the extra care unit at Doddington Court. The COO replied that the Keogh standards did not apply to Doddington Court. The issue there was that there were nine flats as extra care places for people to live in while receiving extra support. The flats had carers but not nursing support, and people who needed only carer support were increasingly receiving that in their own homes. Since Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) had taken over services at Doddington Court, they had identified that people needing overnight nursing care would be at risk if they went there. Work was therefore being undertaken to see how the capacity could be used safely, perhaps for patients in acute hospitals who were waiting for care packages to be arranged before discharge, or for people who needed more support than they could receive at home; staying at Doddington Court could perhaps act as early intervention, removing the need for hospital care. If no safe use could be found, it would be necessary to reduce the capacity rather than having it empty

- noted recent development in the three outpatient units, and that the CCG's preference would be to have providers within the local NHS, as there would be less fragmentation of governance and greater continuity for staff. However, if there was insufficient local interest in running the units, or providing radiology services, the CCG would be going to tender in a week's time in order to seek a provider before current arrangements expired.

Summing up, the Chairman asked for illustrations to explain what integrated care services were, and pointed out that care started at the patient's front door, not at the hospital front door. He also thanked CCG officers for their attendance, and asked the COO to supply him with answers to Ms Simpson's questions. **Action required**

It was resolved unanimously

to note the update on the East Cambridgeshire and Fenland review of some of the health care services delivered from the community hospitals and GPs.

249. CCG URGENT AND EMERGENCY CARE REVIEW

The Committee considered the following motion, proposed by the Chairman and set out in the Committee report:

Committee notes that:

- The CCG is conducting a review of its delivery of urgent and emergency services;
- There is considerable public concern that this review will result the closure of facilities including Minor Injury Units (MIUs) at the community hospitals in Wisbech, Doddington and Ely;
- Some people are also concerned that this review will lead to the closure of community hospitals themselves although this has not been suggested by the CCG; and
- The loss of such local minor injury services would specifically impact parts of Cambridgeshire which have higher levels of deprivation and be at odds with other programs targeted at addressing them.

It is concerned that the CCG:

- Has not taken sufficient account of the needs of communities which will be affected by the possible closures. It believes that a broad view should be taken of their full range of needs and that it should not be limited to just urgent and emergency services;
- Has not demonstrated how changes to the MIUs in the proposed options would impact on other NHS services such as primary care and A&E; and
- Has not done a good job of communicating what is needed and what the various options which it is considering might deliver. It recognises that the options have not yet been fully developed.

It therefore recommends that a task force be established to scrutinise with some urgency:

- The terms or reference of the CCG’s current review;
- The process whereby it is carrying it out;
- The extent to which local needs are being factored into it;
- The objective criteria which it is using in order to identify the preferred options; and

- The way in which it has and will engage, consult and communicate with the communities which will be affected.

Introducing the motion, Cllr Jenkins said that it was necessary to rebuild public trust in the process of reviewing community hospitals and MIUs. He had been at a well-attended public meeting, at which the feeling among members of the public had been that a deal had already been done, and the MIUs and the community hospitals were to be closed. He was therefore proposing that the Committee establish a task force to examine the review process.

One member suggested that, because of the widespread concern that the review was only being carried out in order to save money, the review should explicitly identify the financial implications of the proposals.

Cllr Clapp seconded the motion, and on being put to the vote, it was agreed unanimously.

Discussing next steps, members commented that it was necessary to proceed quickly, and suggested that it could be helpful to involve local members. CCG officers advised that the proposals were being reviewed by the Clinical Senate (a regional board of clinicians and others) on 27 and 28 September to examine whether what was being proposed was safe and sensible.

It was resolved unanimously to

a) Support the motion as presented in section 2 of the report before Committee

b) Establish a task force to scrutinise with some urgency
   i) The terms of reference of the CCG's current review;
   ii) The process whereby it is carrying it out;
   iii) The extent to which local needs are being factored into it;
   iv) The objective criteria which it is using in order to identify the preferred options; and
   v) The way in which it has and will engage, consult and communicate with the communities which will be affected.

c) Appoint Councillors Clapp, Orgee and Sales (plus a Labour substitute) as members of the task force, with Local Members to be invited to attend; and

Agree that the task force conclude its work by, and report to, the Committee's next meeting on 6 October

250. PROPOSAL TO FORM A JOINT COMMITTEE TO SCRUTINISE THE PROPOSED MERGER OF PSHFT WITH HHCT

The Committee received a report asking it to decide whether to support the establishment of a joint scrutiny committee with Peterborough City Council to scrutinise proposals for the merger of Hinchingbrooke Health Care NHS Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT). Members noted that Peterborough's Scrutiny Commission for Health Issues would be considering the same question at its meeting on 15 September, and that it was proposed that Cambridgeshire be the lead authority on the joint committee, and take the chair.

Discussing the report, members

- noted that, under the draft terms of reference, it would be possible for the Joint Committee to scrutinise any matters relevant to the merger, even if not covered in the Full Business Case

- commented that any membership below five from each council would not allow for a Cambridgeshire Labour representative on the Joint Committee.

It was resolved unanimously to

a) to support the establishment of a joint scrutiny committee with Peterborough City Council to scrutinise proposals for the merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust

b) that the Health Committee's preferred size for the Joint Committee was five members each from Cambridgeshire County Council and from Peterborough City Council

c) to appoint Councillors P Brown, Clapp, Jenkins, Orgee and Sales to serve as members of the Joint Committee, with Councillor P Hudson as Conservative substitute, and Labour, Liberal Democrat and UKIP substitutes to be identified and their names notified to the Democratic Services Officer

d) to authorise the joint committee to respond on behalf of the Health Committee to the public engagement / consultation proposals

e) subject to the agreement of Peterborough City Council's Scrutiny Commission for Health Issues, to require that the joint committee scrutinise the implementation and governance arrangements, should the proposed merger be agreed by the two NHS Trust Boards

f) endorse the draft terms of reference.

251. HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

The Committee received a report informing it of the recent activities and progress of the Committee's working groups. Members noted that these were informal meetings, so the formal report covered only the attendance and the themes of the meetings.

As a correction to the report, it was noted that the date of the next meeting with Cambridge University Hospitals NHS Foundation Trust (CUHFT) was planned for 23rd September, not 26rd.

It was resolved unanimously to

a) note and endorse the progress made on health scrutiny through the liaison groups and the schedule of liaison meetings.

252. COSTED PROPOSAL TO IMPLEMENT A PILOT HARM REDUCTION PROJECT FOR STOPPING SMOKING

The Committee received a report setting out the proposed approach and costs of an evidence based harm reduction pilot project to enable smokers who have not been successful in quitting using the existing quit smoking model. Members noted that the costs of the proposed project would be met from the existing smoking cessation budget.

Discussing the report, members

- suggested that the costs of the project were high in relation to the number of quits sought, given that the aim was a 60% - 70% quit rate from a cohort of 163
- stressed the importance of encouraging smokers to quit
- noted that the aims of the project included gathering understanding on why some people found it so hard to quit smoking; even cutting down would help improve smokers' health and reduce the cost burden on health services in future
- pointed out that the report was misnumbered in the agenda pack; it was agenda item 10, not 11
- enquired when it might be possible to review the results of the pilot. Officers advised that initial findings were expected at the end of the current financial year, and members commented that it would be for next year's Committee to consider.

It was resolved unanimously to approve

a) the approach and costs of the pilot

b) implementation of the model in this financial year.

253. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan. The Chairman reported success in getting a motion on public health passed at the Local Government Association Conference that envisaged grant funding to enable reduction in health inequalities at no additional cost thereafter.

It was resolved unanimously

a) to note the training plan
b) to combine the October session on the New Communities JSNA with a session on health inequalities.
c) to hold the session on the CCG's Sustainability and Transformation Plan (STP) in December, following publication of the STP in November

254. APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

It was resolved unanimously:

a) to note that there were currently no outstanding appointments to be made.

255. HEALTH COMMITTEE AGENDA PLAN

The Committee considered its agenda plan, including matters idendtified in the course of the meeting. In answer to a question about when to review bed-based care and minor injuries, CCG officers advised that if there were to be a public consultation, it would not start until December, so it would be possible to bring a report on plans to Committee in November. It was agreed to move the report on liver metastasis to December and the report on GP capacity to November, in order to help to spread out the business. The item on flu vaccination would not be required in November as it was due to be covered in October. **Action required**

It was suggested that the December meeting should be definite, rather than provisional, and the agenda kept fairly short, with the remainder of the afternoon being used for training.

Members noted that, following the recent rating by the Care Quality Commission (CQC) of the East of England Ambulance Service NHS Trust (EEAST) as 'requires improvement', the Vice-Chairman would be attending a meeting of the Chairs and Vice-Chairs of the region's health scrutiny committees with the Chief Executive of EEAST. This meeting was being held because potentially all the Overview and Scrutiny Committees in the region might wish to summon EEAST for scrutiny, which could place an unreasonable burden on senior EEAST officers. However, following this regional meeting, it would still be possible for the Health Committee to consider whether it wished to summon EEAST for scrutiny by the Committee locally, as EEAST had recently been awarded the contract for the Non-Emergency Patient Transport Service (NEPTS) by the CCG.

It was resolved unanimously:

a) to note the agenda plan

b) to add an update on the Mental Health Vanguard and PRISM to the agenda for 16 March 2017

c) to add an update on the pilot harm reduction project for stopping smoking to the agenda for 8 June 2017 **Action required**

Chairman

Appendix A

Outpatient Services at Community Hospitals.

There have been a number of crowded meetings, with more planned in September by the Peterborough and Cambridge Clinical Commissioning Group (CCG), to canvas the views of the public before going to full public consultation on the recommendations on changes to health care services delivered from community hospitals. The report says that continued work is taking place as part of the Sustainability and Transformation Plan (STP) and "*If any options are supported, then a public consultation could take place from November/December 2016 until February 2017*".

Could the Scrutiny Committee ask the CCCG

1. Who is taking the decision on which options are supported, and on what information will it be based?

2. Have all GPs (not just those on the Board of the CCG) been consulted on the viability of the options, since many of them depend on a transfer of service to primary care, which may not have the capacity and capability to deliver the planned services?

3. Have the CCG fully taken into account the effect of the closure of MIUs, possible closure of Out Patient departments and the likely closure of Interim Care beds at the community units and the effect this will have on access to services for a rural population?

For example, in the minutes of the meeting on 14th July of this Committee concerning the planned collaboration between Hinchingbrooke Health care NHS Trust and Peterborough and Stamford NHS Foundation Trust it was "*Confirmed that Stamford Hospital was approximately 15 miles north of Peterborough and explained that services were provided at other hospitals across the county including Doddington and Ely.* This may no longer be the case.

4. The CCG has reviewed these services "*in the context of the wider STP"* and the draft plan has already been submitted to NHS England. Since there will be no public consultation on the STP, can the CCG explain how the public meetings and consultations, will have any influence on the outcome of the plans for Community services?