HEALTH COMMITTEE: MINUTES:

Date: Thursday 12th March 2015

Time: 2.05 p.m. to 4.55 p.m.

Present: Councillors K Bourke (Chairman), P Ashcroft, P Brown, P Clapp, A Dent, D Giles, G Kenney (substituting for Cllr Wisson), L Nethsingha, T Orgee, J Schumann, J Scutt, M Smith and A Walsh (substituting for Cllr Sales)

District Councillor S Ellington (South Cambridgeshire)

Apologies: Councillors D Jenkins, P Lagoda, P Sales, and J Wisson; District Councillors M Cornwell (Fenland) and H Williams (East Cambridgeshire)

101. DECLARATIONS OF INTEREST

Councillor Schumann declared an interest in agenda item 5 (minute 106) as the relative of an employee of the East of England Ambulance Service NHS Trust (EEAST).

102. MINUTES: 15th JANUARY 2015 AND ACTION LOG

The minutes of the meeting held on 15th January 2015 were agreed as a correct record and signed by the Chairman.

The Action Log was noted.

103. PETITIONS

No petitions were received.

In the absence of any representative from the Care Quality Commission to contribute to agenda item 4 (Patient care issues at Hinchingbrooke Hospital), the Committee first considered agenda item 6.

104. CCG OUT OF HOURS AND 111 SERVICES PROCUREMENT: OUTCOME OF CONSULTATION

The Committee received a report setting out the Health Committee's response to the Cambridgeshire and Peterborough Clinical Commissioning Group consultation on the 111 / Out of Hours Service procurement as background to an oral update on the consultation process. Jessica Bawden, Director of Corporate Affairs, CCG, attended to provide the oral update, and a member of the public, Jean Simpson of Cambridge, attended to ask a question of the Committee.

Ms Simpson addressed the Committee, saying that the consultation document had not given the public a chance to comment on proposals, and having attended consultation meetings, she herself had no firm idea of the model being proposed. She suggested that there was a risk that the contract could be awarded to a large outside private

provider because it was too large for a local provider. Ms Simpson also said that the consultation document had not set out the health needs of the local population, and had not taken account of recent or planned changes in the local health environment and in the opening hours of GP surgeries. In reply, the Chairman said that the Committee's response to the consultation had accepted the basic logic of seeking an integrated service and had raised other points. It was for the CCG rather than the Committee to give a definitive assessment of the commissioning process; he had passed Ms Simpson's question to the CCG for a full response.

The CCG's Director of Corporate Affairs reported that the extended consultation period had finished on 6 March, and the CCG's Governing Body had received a preliminary report on 3 March. Over 700 responses had been received; points raised had included:

- from the deaf community about accessing the service; for them to do so required the technology to be up-to-date
- the length and number of questions asked when people first call
- the length of time people have to wait for GP call backs; a shorter time would be specified in the new contract
- potential changes in primary care and GP opening times as a result of the Prime Minister's Challenge Fund
- on medical records, surprise was expressed that it was not easy to share records, and concern was expressed at the idea that records could be shared
- some respondents wanted the Out of Hours service to operate on a walk-in basis rather than requiring an appointment to be made through the 111 service.

The Director of Corporate Affairs went on to say that the CCG Governing Body had decided to introduce a short pause into the process to enable them to consider the responses received more closely, and to ask acute providers what the CCG could do to help meet acute pressures. The Governing Body was next due to meet on 12 May, and the Director of Corporate Affairs would bring a report to Committee on 21 May 2015.

Discussing the update, members reported both positive and less successful experience with the 111 service, including a failure to distinguish between types of chest pain which had led to an over-cautious approach being taken. Members noted that the CCG was looking at the chest pain algorithm in response to concerns that had been raised previously.

It was resolved unanimously to note the response and the update from the Clinical Commissioning Group.

105. PATIENT CARE ISSUES AT HINCHINGBROOKE HOSPITAL

The Committee received a report setting out background information for its scrutiny of patient care quality and safety issues in Hinchingbrooke Healthcare NHS Trust (HHCT) and also considered written presentations from the Care Quality Commission (CQC), from the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and from HHCT. A message had been received from the CQC confirming that no officer was available to attend the meeting. Other officers present to talk to their presentations and respond to members' questions and comments were:

- from the Clinical Commissioning Group
    - Jill Houghton, Director of Nursing and Quality
- from Hinchingbrooke Healthcare NHS Trust

- Dr Hisham Abdel-Rahman, Chief Executive
- Deirdre Fowler, Director of Nursing, Midwifery & Quality

Members expressed disappointment at the lack of representation from the CQC, but noted that CQC officers had attended the recent workshop for members of the Health Committee at which they had presented their findings in detail and answered members' questions and concerns, although the Committee had not been included in the CQC's initial meeting to present the findings of their inspection of HHCT. The presentations supplied by the CQC and the CCG for the present Committee meeting were virtually identical to those given at the workshop. The Chairman reminded members that the focus of the present session was on the patient care aspect of the inspection findings, the Committee's first priority. The intention was to hold a separate scrutiny session on wider financial and contract issues at a future meeting of the Committee.

The Director of Nursing and Quality talked to the CCG's written presentation. Members noted that the quality concerns that had arisen in the days of the Primary Care Trust (before the CCG came into existence) had all been resolved, and that concerns expressed by the CCG were all in the public domain and had been considered by the CCG's Governing Body. Although neither the A&E 4-hour standard nor the 62-day cancer wait standard had been met consistently over time, Hinchingbrooke's performance on both standards had been better than that of the CCG's other providers. The two mixed-sex accommodation breaches had both been resolved. In relation to actions following the CQC inspection, members noted that the Quality Oversight Group included members from the Health Committee and from the Trust Development Agency (TDA). The CCG was able to say with confidence that Hinchingbrooke was already making progress in all the areas of concern identified by the CQC.

The Chief Executive and the Director of Nursing, Midwifery & Quality talked to HHCT's written presentation. Dr Abdel-Rahman said that he had joined the hospital in 2000 and was still a practising gynaecologist. Members noted that

- problems with breast cancer and colorectal surgery had been resolved and the improvement had been sustained; many patients had had a good experience even at the time of difficulty, but there had been problems with some outcomes and standards
- HHCT was one of only three trusts in the country to achieve a level 3 (i.e. high) rating for its maternity services; the maternity unit had been a failing department in 2000 and it had taken five years to bring it up to standard
- A&E performance had been improving, but had then been affected by a 20% increase in attendance, which a more resilient team might have coped with better; however, patient survey had shown only a slight drop in standard
- the hospital standardised mortality ratio (HSMR) was below the national trend and cancer care had improved
- the hospital had already been aware of and seeking to address many of the issues identified by the CQC, including workforce and financial issues
- financial stability and the delivery of high-quality care were linked; HHCT believed it would be possible to achieve both
- HHCT was addressing every aspect of the CQC findings, and continued to take all feedback seriously
- HHCT had fed back to the CQC the need to balance their ratings and to make use of intelligence monitoring as well as of point of time monitoring
- Hinchingbrooke remained committed to being one of the ten best district general hospitals in the country.

The Director of Nursing, Midwifery & Quality said that what was most important for her was to deliver compassion in practice at all levels of the organisation. The CQC's findings had not been a reflection of the hospital she knew, with dedicated and responsible nurses and doctors. She had recently revisited the Patient Experience Strategy; it was vital that patients be at the heart of everything the hospital did.

In the course of discussion, members

- raised the question of infections as a source of poor outcomes. Members noted that there had been no cases of hospital-acquired MRSA in the current year, but it was likely that the target for Clostridium difficile infections would not be met, with 12 cases expected against a target of seven. There had been two cases of Group A Streptococcus in the maternity unit, which was by definition an outbreak, but the Trust had subsequently invested in high-calibre, highly-qualified infection control nurses and were seeking to recruit a consultant micro-biologist

- noted that 'stop the line' was a social movement concerned with keeping staff empowered to be proactive to stop something that was going wrong. Patients too could stop the line – the executive nurse of the day would then come to the patient within an hour and deal with the problem

- in relation to the leadership structure, asked what structurally had been the reason that services had been allowed to become inadequate. The Chief Executive said that the team was clinically led, by working doctors and nurses. There had been a 20%-30% increase in that group's workload in the past year. Many agency staff had been deployed, and it had proved difficult to get them to absorb the hospital culture quickly. Maternity and critical care found their own staff and used their own bank. The Director of Nursing's team now had a policy of over-recruitment, and arrangements were being put in place for agencies to deliver the hospital's induction for staff about to work there

- noted that the Trust Development Agency was being very supportive of the hospital both with the handover of management from Circle and with the programme of continuous improvement following the inspection

- commented that there was no longer any dispute between HHCT and the CQC; the Trust acknowledged that there were problems and was endeavouring to address them. The Chief Executive welcomed and agreed with this observation; he agreed that the CQC's role was to draw attention to problems and said that HHCT was supportive of that, and had already carried out many of the actions required. However, he said that he would like to see the CQC also learning from the experience and considering its; his principal objection was to the way in which the ratings were aggregated to produce an overall rating, which was not in his view representative. HHCT had never disputed the CQC's findings, only the inaccuracies within the report. It was not contesting the report, and was well into work on the subsequent action plan.

The Chairman reported that the CQC had made it very clear to committee members that not everything at the hospital was bad, and had told them that when inspectors had found a concern they had sought further information, so that its method was not based

on isolated or anecdotal evidence, but recurring patterns, and that this systematic approach was applied consistently when inspecting NHS Trusts. On behalf of the Committee, the Chairman welcomed the fact that HHCT accepted the report's findings and was not contesting them, that there was broad agreement on the areas needing improvement and that an action plan was in place and being progressed. Two members representing Huntingdonshire divisions reported high satisfaction with their experiences as patients of the hospital, and high levels of satisfaction with the hospital among local residents.

It was resolved unanimously:

to note the reports from the above organisations on Patient Care issues at Hinchingbrooke Health Care NHS Trust.

106. EAST OF ENGLAND AMBULANCE TRUST – UPDATE ON PERFORMANCE

The Committee received a report updating members on the performance of the East of England Ambulance Service NHS Trust (EEAST), following consideration of EEAST's performance and plans by the Adults, Wellbeing and Health Overview and Scrutiny Committee in February 2014. Officers attending from EEAST to present the report and respond to members' questions were:

- Glenn Young, Senior Locality Manager for North Cambridgeshire
- Steve Segasby, Senior Locality Manager for South Cambridgeshire.

The Senior Locality Managers said that EEAST December had been a time of high activity nationally and exceptionally high activity in Cambridgeshire, including delays in Accident and Emergency (A&E) handover, which had contributed to ambulance delays. EEAST had worked hard with other service providers to reduce delays, especially with Addenbrooke's and Peterborough hospitals. The Clinical Commissioning Group had increased funding to EEAST by 9%

In answer to their questions, members noted that

- within the contract with the CCG, there were 32 elements of EEAST performance that could attract fines, including £20 for a delay of over 30 minutes when handling a patient over at hospital (delay attributable to the Ambulance Service element of the handover, not to the hospital's), with a larger fine for a longer delay; EEAST had received some fairly heavy fines

- ambulances sometimes went across a county border if neighbouring ambulances were busy, as it was a regional service and it was necessary to get to patients as quickly as possible

- levels of activity were fairly constant, but the source of activity changed through the week. At weekends, activity came from the 111 service, whereas in the past there had been less activity at weekends than in the week because people would wait to see their own GP

- ambulance crews called to a patient at home tried to do everything possible to keep the patient at home, only taking them to hospital if it was absolutely essential

- conversations were already taking place with the UnitingCare Partnership about working with geriatric patients; often for ambulance paramedics it was a case of knowing what services existed, but there was neither uniform provision of services across the county nor uniform power for paramedics to make referrals to services. The new contract would be a great help to the Ambulance Service in getting to the patient at the right time and getting the patient to the right place

- over 400 student paramedics had been recruited across the region in the past 12 months, 66 of whom were now active in Cambridgeshire, making it possible to put about eight additional ambulances on the streets. In contrast to the situation in February 2014, when up to three ambulances had been non-operational because of staff shortages, four or five extra ambulances a day were now usually available

- the implementation of eHospital at Addenbrooke's had caused problems and had an impact on delays

- in a survey of EEAST patient satisfaction, 92.7% had described themselves as very satisfied, and the remainder as satisfied. One member reported favourably on the service he had himself received in a recent emergency.

As a general point, members expressed some concerns about the presentation of the report, and requested explanations of any numbers or letters on maps, and keys for all charts in future; the EEAST officers indicated that guidance on the type or report required in future would be helpful. The Chairman agreed that greater clarity on what the Committee required would have been helpful, and thanked the Senior Locality Managers for their attendance and contribution to the meeting.

It was resolved unanimously:

to note the report from the Ambulance Trust

107. NHS QUALITY ACCOUNTS – RESPONDING TO REQUEST TO COMMENT

The Committee received a report informing it of the requirement that each NHS Provider Trust produce an annual Quality Account (QA) and send it to the Committee in its Overview and Scrutiny function for comment. Members noted that some providers had requested earlier feedback than others, but it was proposed to consider all the QAs at the Committee's next meeting on 21st May, and to tell providers of this approach. The deadline for submission of final versions of QAs to the Department of Health was 30 June each year.

It was resolved unanimously:

to note the requirement to comment on Quality Accounts and endorse the proposed process for doing so.

108. HEALTH COMMITTEE WORKING GROUPS: REPORTBACK

The Committee received a report informing it of the activities and progress of its working groups since the Committee's last meeting, and inviting it to nominate members to participate in a programme of liaison meetings with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). Councillors Bourke, P Brown, Orgee, Scutt and Schumann volunteered to serve on the liaison group, and Councillor Sales's name was also put forward in his absence. The Democratic Services Officer was asked to ascertain whether Councillor Sales would be willing to serve on the liaison group. **Action required**

It was resolved unanimously:

a) to note and endorse the progress made on health scrutiny by the working groups.

b) To nominate Councillors Bourke, P Brown, Orgee, Schumann and Scutt to participate in a programme of liaison meetings with Cambridgeshire & Peterborough Foundation Trust (CPFT), and in his absence to nominate Councillor Sales to participate in these meetings subject to his agreement.

109. TRANSFER OF RESPONSIBILITY FOR COMMISSIONING HEALTH VISITING AND FAMILY NURSE PARTNERSHIP TO CAMBRIDGESHIRE COUNTY COUNCIL

The Committee received a report proposing novation as the mechanism for the transfer of the contract with Cambridgeshire Community Services for Health Visiting and Family Nurse Partnership Services from NHS England to Cambridgeshire County Council, as part of the national implementation of the transfer of commissioning responsibility for the Healthy Child Programme 0-5 from the NHS to Local Authorities.

One member drew attention to the allocation of £49,000 for Homestart in the funding for 1st October 2015 to 31 March 2016, pointing out that there were several Homestart schemes across the county. He enquired whether the scheme based in Royston, which also served some Cambridgeshire residents, was included in this funding. Officers undertook to check the position of Royston Homestart. **Action required**

It was resolved unanimously:

a) to approve the novation of the contract with Cambridgeshire Community Services for Health Visiting and Family Nurse Partnership Services from NHS England to Cambridgeshire County Council on October 1st 2015

110. CHILDHOOD VISION SCREENING PROCUREMENT: AWARD OF CONTRACT

The Committee received a report on the arrangements proposed to award the contract for the Childhood Vision Screening Service, which was going through a competitive procurement process. Members noted that delegations were being sought for formal award of the contract in order that the new provider could be commissioned in time to enable that provider to make arrangements with primary schools before the end of the school summer term 2015.

It was resolved unanimously *to*

1) Note and endorse the progress made to date in undertaking the procurement of a Childhood Vision Screening Service.

2) Authorise the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health Committee, to formally award the contract subject to compliance with all required legal processes

3) Authorise the Director of Law, Property & Governance to approve and complete the necessary contract documentation.

111. DRAFT PUBLIC MENTAL HEALTH STRATEGY

Following the Committee's discussion of a public mental health strategy at its meetings in July and October 2014, the Committee received a draft public mental health strategy for approval prior to consultation. Members noted that the consultation period would last six weeks, and that the strategy sought to highlight issues around the promotion of mental health and the prevention of mental illness.

Examining the draft strategy, members

- asked about the connections, the interrelationships between the various complementary strategies listed on page 8 of the draft strategy. Officers advised that this list was a reflection of the cross-cutting nature of much mental health work, and of efforts to take from other strategies elements that were of greatest relevance to public mental health. Members suggested that it might aid public understanding of the document if a similar explanation of how the complementary strategies fitted in to the whole public mental health strategy could be included

- drew attention to the huge variation in the numbers of children living in poverty within county and suggested that greater local detail would be helpful. Members noted that an earlier draft of the strategy had included a deprivation map, which could be re-inserted, but pointed out that the question was not only one of deprivation but also the prevalence of serious mental illness

- expressed support for the draft strategy, but commented that it contained little about engaging with district councils on such matters as housing, new communities and open space, and no links to district councils' work to promote mental health. It was noted that district councils had been involved on the steering group for the strategy and that some of these points had been included. The strategy attempted to focus specifically on interventions that were known to make a difference to mental health. Members suggested that as district councils were spending considerable sums on work to promote mental health, combining county and district resources could lead to better value and outcomes

- stressed the importance of communicating as widely as possible the message that half of all mental health problems emerge before the age of 14, including to primary school headteachers, who might not yet realise it, but were key partners in delivering the strategy. Officers reported that they had already arranged to go to the Cambridgeshire Primary Heads' Group

- enquired for whom the strategy was intended and who would be using it, and suggested that it would be better if the section on delivering the strategy started with actions rather than the development of another strategy, on anti-bullying. Officers replied that the strategy was intended for a variety of audiences, firstly for the public, and also as a clear articulation for the Council and key partners of what they were doing, including enabling council colleagues to see that what they were doing was actually mental health work. The point about reordering actions was acknowledged, though development of anti-bullying work was not just about another strategy, but about giving schools tools that they could use

- in relation to the perinatal period, commented on the importance of providing 1:1 support for mothers of young babies, and of promoting friendships among mothers; a good friendship network was an important factor as a basis for better mental health. Officers undertook to highlight this point beyond what was already in the document about early years settings and workforce training and development

- asked about opportunities for member involvement and offered assistance, noting that the strategy was due to be presented to a member seminar on 20 March

- drew attention to the possibility of working with the Fire Service on mental health promotion, and noted that Public Health and Fire Service had worked together on some topics in the past, though so far not on the public mental health strategy

- suggested that, as a point of presentation and layout, it would be helpful to break the document up by subdividing the different strategies.

It was resolved unanimously:

to agree the draft strategy for consultation.

112. HEALTH INEQUALITIES – PROGRESS REPORT

The Committee received a report updating members on progress in addressing health inequalities in Cambridgeshire, following its identification in September 2014 as a Health Committee priority for action.

In the course of discussion, members

- welcomed the establishment of the Cambridgeshire Public Health Reference Group and noted that the Group would be accountable to its constituent members and to the Health and Wellbeing Board. It would be possible for the Health Committee to request feedback from the Group for areas where the Committee had responsibility, but the Group would formally report to the Health and Wellbeing Board. The Chairman asked the Director of Public Health to work out how the Committee could best liaise with the Reference Group **Action required**

- welcomed the marked reduction in the prevalence of smoking across the county but noted that the inequality gap between the rest of the county and Fenland had almost widened

- pointed out that the inequality gap was greater than a comparison between Cambridgeshire as a whole and Fenland suggested; the comparison should be between Fenland and the other districts of Cambridgeshire

- commented that East Cambridgeshire featured quite high in several of the tables in Annex B, and that it was necessary to monitor levels of health inequality in those parts of East Cambridgeshire known to be deprived

- in relation to prisoners' health noted that inmates and offenders as a group were at higher risk of poor health; this was not a comment on the quality of health services provided in prisons

- noted that the relatively high rate of people killed or seriously injured in road traffic accidents in Cambridgeshire by comparison with national figures was an issue for the whole county as a rural area with such features as fenland ditches. Members noted that one of the Committee's shared priorities with the Environment and Economy Committee related to road traffic accidents, and suggested that it might also be helpful to work with the Fire Authority.

It was resolved unanimously:

a) To note progress with actions on the key areas of health inequality in Cambridgeshire identified as priorities for action by Health Committee in September 2014

b) To endorse the Cambridgeshire Public Health Reference Group as the appropriate partnership through which to initiate joint strategic work on health inequalities.

113. FINANCE AND PERFORMANCE REPORT – January 2015

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of January 2015, and providing further detail of the 2015/16 Public Health Memorandum of Understanding (MOU) for public health grant which was spent across Council directorates. Members noted the two areas of underspend and that the budget remained on target for a balanced position at year-end.

Commenting on the report, members

- drew attention to issues associated with eHospital at Addenbrooke's Hospital as a cause of difficulties in achieving targets both for access to sexual health services within 48 hours and for chlamydia screening. The Committee was advised that the provider had secured a new contract for laboratory services, which was expected to improve the situation

- noted that a larger number of health checks may have been undertaken during the year than the figures suggested. New software was being installed in GP practices to improve data collection and to make it possible for patients to receive the results of health checks immediately; permission had had to be sought from both the CCG and NHS England for the installation of software in GP practices

- suggested that it might be appropriate to reduce the target for use of the smoking cessation service in view of the national trend attributable at least in part to the use of e-cigarettes; members were advised that this was already planned.

It was resolved unanimously *to:*

1) Note the financial and performance information in the report.

2) Endorse the alignment of public health grant funding in other Council directorates to the activities and outcomes outlined in Appendix 7.

3) Endorse the development of the Public health MOU into a comprehensive governance framework document as outlined in Appendix 8.

114. REVIEW OF IMPLEMENTATION OF SMOKE FREE ENVIRONMENT POLICY

The Committee received a report reviewing the Council's Smoke Free Environment Policy six months after implementation and asking it to consider whether any further actions needed to be taken. Members noted the responses received from staff and neighbours and the implications for contractors; there were no outstanding issues.

The Committee did not identify any further actions which needed to be undertaken in relation to the implementation of the policy.

It was resolved unanimously:

To note the responses to the implementation of the Council's Smoke Free Policy

115. HEALTH COMMITTEE AGENDA PLAN

The Committee considered its agenda plan. In addition to the items identified for the next meeting, a request was made for an item on how the Council could work together with other authorities, including the Fire Authority.

It was resolved unanimously to note the agenda plan, subject to the following changes to the agenda for 21st May 2015:

a) the inclusion of a scrutiny item updating the Committee on the implementation of eHospital at Addenbrooke's Hospital

b) the deletion of the duplicate Smoke Free Environment Policy item

Members pointed out that the planned date of 21st May 2015 clashed with meetings both of the Fire Authority and of South Cambridgeshire District Council. The Democratic Services Officer was asked to investigate changing the Committee date.
Action required

Chairman