Agenda Item No: 2

HEALTH COMMITTEE: MINUTES

Date: Tuesday 16th January 2018

Time: 1:30pm to 4:40pm

Present: Councillors D Connor (substituting for Councillor Harford), L Dupre, P Hudson (Chairman), D Jenkins, L Jones, L Nethsingha (substituting for Councillor van de Ven), T Sanderson and M Smith (substituting for Councillor Topping)

District Councillors M Abbott (Cambridge City), M Cornwell (Fenland), S Ellington (South Cambridgeshire) and C Sennitt (East Cambridgeshire).

Apologies: County Councillors C Boden, L Harford, K Reynolds P Topping and S van de Ven.

77. DECLARATIONS OF INTEREST

The Chairman declared a non-statutory interest in item 6, Northstowe Healthy New Town – Clinical Commissioning Group (CCG) Update as he was the Local Member for Northstowe.

78. MINUTES – 14TH DECEMBER 2017 AND ACTION LOG:

The minutes of the meeting held on 14th December 2017 were agreed as a correct record and signed by the Chairman subject to the alteration of the 10th bullet point of minute 72 to read – sought assurance that the range of stock of medicines at the site were sufficient to meet demand".

The action log was noted including the following updates relating to on-going actions:

Minute 17 – This was scheduled for discussion at a meeting of Cambridgeshire Community Services (CCS) taking place in January 2018.

Minute 32 – A meeting was scheduled to take place on 29th January 2018 with the Wisbech 2020 Steering Group.

Minute 63 - Confirmation had been received that a development session had been scheduled for February 2018

79. PETITIONS

No petitions were received.

80. PUBLIC QUESTION

The Chairman invited Mr Nic Hart, father of Averil Hart whose care was the subject of an Ombudsman report regarding the Eating Disorder Service provided by Cambridgeshire and Peterborough Foundation Trust (CPFT). The Chairman exercised

his discretion and waived the three minute time limit set out in Committee procedure rules regarding public questions.

Mr Hart began by providing the background to the care his daughter received, emphasising that it was an avoidable tragedy, highlighting the poor transitional care she received. The care co-ordinator was new in post and inexperienced with regard to anorexia. Mr Hart's daughter therefore lost weight continuously and weekly weight checks were not carried out by GPs. When help was requested a review was scheduled rather than the request being responded to as an emergency by which time she had died.

The case highlighted the lack of experience of treating eating disorders at Norwich and Norfolk University Hospital, from which Mr Harts daughter was transferred to Addenbrooke's Hospital where she waited for 5 hours for treatment.

Mr Hart requested that no further patients were cared for by an unsupervised trainee who had no experience of anorexia and that the CPFT's specialist units were no longer under-staffed and under-resourced which placed patients at risk. That professionals employed at CPFT would be open and transparent particularly by adhering to their Duty of Candour and questioned, given the maladministration identified by the Ombudsman, how CPFT would learn from patient deaths throughout the Trust's services if large amounts of public money was spent on legal defence rather than investigating matters thoroughly and learning from service failures.

The Chairman thanked Mr Hart for the question, emphasising the scrutiny role of the Committee and explained that a written reply would be provided within 10 working days of the meeting

81. EATING DISORDER SERVICE – OMBUDSMAN REPORT

The Chief Executive of CPFT, Tracy Dowling and Chess Denman, Medical Director of CPFT addressed the Committee and thanked Mr Hart for his testimony and questions. The Chief Executive began by issuing a full public apology for what happened and the failings in the care provided. The Chief Executive also apologised for the difficulty in obtaining answers. Attention was drawn to the duty of all NHS organisations since 2014 regarding candour. The Chief Executive expressed a keen desire to continue to work with Mr Hart and that lessons be learnt from the in order that the service was safe and that the staff who provide the services were properly supported and supervised and that supervision was well document in order that culture of learning was developed.

Members noted that other organisations were involved in the care of Mr Harts daughter who was discharged as an inpatient on the S3 Eating Disorders Unit run by CPFT on 2nd August 2012 and was referred for follow up by the Norfolk Community Eating Disorders Service (NCEDS), also run by CPFT as she was due to begin a course at the University of East Anglia in September 2012.

Attention was drawn to the actions that had been taken in response to the service failings identified by the serious incident review and the Ombudsman's report, that focussed on policies and protocols and ensuring that they were followed and reviewed.

The Chief Executive informed Members that she was relatively new in post having commenced her role as Chief Executive in August 2017 and wanted assurance as Chief Executive that policies and procedures were systematically applied, especially for patients who transitioned between services, age groups and locations.

Anorexia was a very serious but treatable condition and it was vital that care and treatment was multi-disciplinary and that performance management of the implementation of the care took place. Weekly monitoring should take place if it was deemed necessary and the multi-disciplinary team would undertake that monitoring.

The Chief Executive expressed her intention to work closely with the service in order to ensure that the policies and procedures were being adhered to and that the prioritisation of work was safe and protected the most vulnerable.

During discussion of the report Members:

- Emphasised the dangers posed by anorexia as a condition and the need to publicise the seriousness of the condition.

- Noted the performance management of the weekly weighing sessions but drew attention to the critical issue of the inexperienced Lead Practitioner in the case and sought assurance that such an event could not happen again. The Chief Executive emphasised the vital role of performance management, the weekly monitoring was contained within National Institute of Clinical Excellence guidance and was undertaken by GPs, it was vital that there was effective communication between professionals. There was a need to ensure that monitoring took place and was discussed across a multi-disciplinary team. Inexperienced staff would be supported from within a multi-disciplinary team that utilised shared experience. There was clear learning regarding clinical supervision and it was essential that the supervisor also saw the patient and provided care. Although the causes of anorexia unknown, there was some clinical evidence that sufferers improved when something became more important to them than controlling their weight. It was hoped that in this particular case, entering University would provide a focus other than controlling weight.

- Drew attention to the lack of timescales included within the Ombudsman report, emphasising their urgency and requested that a clear time frame needed to be provided.

- Confirmed that the NCEDS service was run and managed by CPFT and highlighted the issues with communication during the transfer of care. The Chief Executive informed Members that the Norfolk service had suffered from staff shortages and highlighted the learning that was reflected in the revised policies and procedures.

- Expressed concern that closer working with universities in order to identify potential issues with students was not contained within the report. The Chief Executive

confirmed that a policy was in place and offered to attend a future meeting of the Committee to discuss further.

- Questioned how the monitoring of weekly weigh-ins would be managed. Members were informed that a monthly report would be provided to the Chief Executive that provided assurance that weekly monitoring meetings were taking place. The reporting would also identify issues such as staffing levels and surges in demand. Monthly management meetings also took place and it was intended that a member of staff would be assigned to the Eating Disorder Service to work with the service regarding compliance with policies. Assurance that services were robust enough to mitigate risk to the patient was a priority for the Chief Executive which included ensuring that there was clear documentation of decisions taken and more effective engagement with friends and family of patients and how the service responds when they raise concerns.

- Noted the policy of CPFT regarding the retention of patient records was in accordance with national policy. The policy regarding the retention of emails at the time was 12 months and the Information Commissioner found that emails had been retained in accordance with the policy. The Chief Executive informed Members that she was investigating whether any of the emails should have been included as part of the patient record and that emails relating to serious incidents were retained until the incidents had been closed. Emails relating to patients were now retained within the health record system and the Trust was now using an electronic patient record system that provided a much enhanced audit trail which allowed interrogation of activity on a particular record.

- Questioned why the anonymised case study had been withdrawn from the Marsipan Guidelines. The Chief Executive informed Members that she would be investigating why the case study had been withdrawn and whether there were sound clinical reasons why. The importance of sharing learning was emphasised to Members, especially as it would assist doctors in the acute sectors.

- Noted that the Chief Executive intended for the action plan to be concluded within 3 months, in order to be able to identify risks and where and how they were being mitigated.

The Chairman invited Mr Hart to address the Committee again having heard the comments of the Chief Executive. Mr Hart drew attention to the lack of experience of staff that had resulted in the miscalculation in the Body Mass Index (BMI) of his daughter. Several requests for records and emails had been submitted to CPFT and not provided. Mr Hart informed Members that the Information Commissioner was unable to rule on the health records of a deceased patient.

Members resumed their questions of the Chief Executive. During discussion Members:

- Noted that the Chief Executive had met with Mr Hart and was determined to answer his questions in full by providing detail and explanations if it was not available.

- Questioned and expressed concern regarding the culture of the organisation.

- Expressed concern that there was a waiting list for treatment of an illness that had such a high mortality rate. The Chief Executive explained that at times demand was higher than the capacity of the service. Waiting lists were actively managed in order to ensure that the prioritisation of cases was effective and allowed for higher risk patients to be seen more quickly. Liaison with GPs was undertaken regarding patients who were on the waiting lists regarding the management of patients.

- Questioned whether since the inclusion of community services within the remit of CPFT in 2012 there was a loss of focus on mental health. The Chief Executive explained that the addition of community services allowed for a holistic approach to patient care and gained focus on physical health.

- Noted that there were approximately 40 patients currently placed on the waiting list which was actively managed with GPs.

- Noted that when a case is handed over a care plan approach meeting was established to which the teams responsible for the care of the patient invited carers and care co-ordinators in order for a face to face handover to take place.

- Questioned whether there was a method for staff to alert managers that they and the service was struggling to cope. It was explained that there was process in place called “Stop the Line” which would result in an immediate response from senior staff. There was also a standing agenda item at the weekly management meeting that would review such incidents. Staff were encouraged to use it and a culture where staff were applauded for using it was being created.

- Expressed disappointment that no timetable had been included with the action plan, and expressed concern that waiting lists were subject to financial pressures.

- The Chairman proposed with the unanimous agreement of the Committee that the Chief Executive of CPFT be invited to return to the Committee to provide an update regarding progress made against the action plan and recommendations made by the Ombudsman in 6 months’ time.

It was resolved to:

a) Review and comment on the report and to note the actions being undertaken by CPFT to address the recommendations cited in the Ombudsman report.

b) Request that the Chief Executive of CPFT provide an update to the Committee regarding the progress made against the action plan and recommendations made by the Ombudsman in 6 months’ time.

Councillor Nethsingha left the meeting at 3pm.

82. LOCAL URGENT CARE SERVICE HUBS PILOT PROJECT (EAST CAMBRIDGESHIRE AND FENLAND).

Members were presented an update regarding the Local Urgent Care Service Hubs (LUCS) Pilot in East Cambridgeshire and Fenland.

Members were informed that the first site in Ely had been operating Monday to Friday since May 2017 and the results had been encouraging with evidence demonstrating that the percentage of patients being referred back to their GP or sent on to an Accident and Emergency centre was reducing over time.

The Clinical Commissioning Group was continuing to work on the development of the Wisbech LUCS Hub and officers were optimistic that the pilot would still go ahead.

During the course of discussion Members:

- Congratulated officers on setting up the pilot scheme and questioned whether there were alternative models that could be used in order to progress the proposed pilot in the Fenland area. Officers explained that one of the elements that the Hubs required was a constant presence on site of GPs. It was now no longer expected g for GPs to be present on site all the time. This therefore provided an opportunity for a variety of flexible options such as telephone support and on-call support.

- Questioned what action had been taken to encourage GPs to work in south Fenland. Officers explained that there was a raft of initiatives, however it would take time to correct a historical issue that had built up over several years.

- Noted the Time to Care initiative that included a new system for managing correspondence that had been implemented at several locations and allowed for staff other than GPs to manage correspondence, following a set of rules on the GPs behalf and therefore saving time.

- Clarified the difference between an Urgent Treatment Centre and a GP access centre. Officers explained that the opening hours of a GP access centre could be less and fewer services offered.

- Noted that national guidelines set 27 criteria for designation of UTC's and currently 5 criteria were not achieved. UTCs would need to be fully compliant with the national criteria by 2019.

- Noted that if UTC designation was not achieved then it was possible to apply for exceptions such as rurality or designate the service as a GP Access Centre.

- Were informed that the Ely LUCS Hub had been easier to establish because of the larger GP practices in the area that were able to support the development of the LUCS Hubs. Members drew attention to rapidly expanding practices in the Fenland area and questioned whether other areas of the country were experiencing similar issues in establishing them. Officers explained that GP engagement was challenging, however the UTC criteria had changed, no longer requiring GPs to be on site all the time which provided an opportunity operate differently.

- Suggested that another pilot be set up that would deliver the LUCS in a slightly different way.

It was resolved to note the report.

83. NORTHSTOWE HEALTHY NEW TOWN – CLINICAL COMMISSIONING GROUP (CCG) UPDATE

Members were presented an update regarding the planning and engagement that was taking place to secure primary care medical services for the emerging and anticipated population for Northstowe.

In discussion Members:

- Commented that it was not clear what the new care model would be. Officers explained that the new care model had not yet been defined and a meeting was scheduled to take place on 23rd January 2018 with GPs that would begin to develop the model.

- Emphasised that care included prevention also and the importance of an integrated process when developing a model. Officers acknowledged the scope of services and the integrated approach required.

- Questioned the provision for dentistry and a pharmacy at the site. Officers explained that those services were commissioned by NHS England and there would be opportunity for those services, however they were population dependent.

- Expressed concern that there would not be dedicated health provision until 1,500 houses had been constructed and emphasised the vital importance of securing S106 money as quickly as possible.

- Noted that 600 Full Time Equivalent GP positions were required and there was a requirement to review the workforce and understand how GPs could be encouraged not to retire early. There was also need to focus on trainee GPs because although the number of trainee places had increased, the number of applicants had not.

- Noted that Longstanton and Willingham GP surgeries had capacity that would cater for the residents that moved to Northstowe during phase 1 of the development. Members commented that residents in Longstanton had reported that appointments were more difficult to arrange.

- Highlighted the importance of the S106 funding and the need to ensure that it was collected.

- Expressed concern that facilities would not be in place within the necessary timescales given the pace of development at Northstowe and drew attention to previous Health Committee scrutiny of past S106 agreements. Officers confirmed that the Health Committee was able to scrutinise the S106 arrangements as they pertained to the health of residents, however any recommendations made by the Committee would not be within the same legal framework as recommendations made to the NHS.

  The Chairman expressed concern that a new town was being built with a population of approximately 30,000 and there was no provision for a dentist or pharmacy. Therefore the Chairman, with the agreement of the Committee proposed that NHS England be invited to attend a future meeting of the Health Committee to talk about

dental needs of Cambridgeshire, taking into account new developments such as Northstowe.

It was resolved to:

a) Note the progress to date

b) Requested that NHS England attend a future meeting of the Health Committee to speak about the dental needs of Cambridgeshire, taking into account new developments such as Northstowe

84. EMERGING ISSUES IN THE NHS

Following a query regarding Delayed Transfers of Care (DTOCS), officers explained that the confidential data provided to Members between meetings was NHS Management information that had not yet been validated.

Members expressed concern regarding the scheduling of operations that were then later cancelled due to increased demand and suggested that it was an area the Committee may wish to scrutinise in the future.

85. FINANCE AND PERFORMANCE REPORT – NOVEMBER 2017

Members received the November 2017 iteration of the Finance and Performance Report. Members noted that that there was an increase in the forecast underspend to £159k due to vacancies within the Drugs and Alcohol and Behaviour Change areas of work.

Performance was generally improving regarding Performance Indicators Attention was drawn to the additional appendices to the report which included the Public Health Risk Register that contained no red risks.

During discussion of the report:

- Members noted that the number of outreach health checks carried out had increased following a more diversified approach in Fenland that included pop up sites within the community.

- Attention was drawn by Members to childhood immunisations as a key issue and questioned whether they should be tracked monthly. Officers explained that the data was compiled quarterly and would be included in future iterations of the report. **ACTION.**

- Clarification was sought regarding the risk register diagrams included in the report. Officers explained that the data had been extracted from a relatively new system and that further clarification would be provided to the Committee. **ACTION**

It was resolved to review and comment on the report and to note the finance and performance position as at the end of November 2017.

86. HEALTH COMMITTEE WORKING GROUPS UPDATE

The Committee received an update that related to Health Committee Working Groups that had been established following the 14th December 2017 Health Committee meeting.

It was resolved to note and endorse the progress made on the Health Committee Task and Finish Groups.

87. HEALTH COMMITTEE TRAINING PLAN

Members noted that a development session had been arranged to take place on 8th February regarding the Sustainability Transformation Partnership (STP). Members also noted that a date regarding item 7 on the training plan had not yet been set due to Fenland District Council having applied to take part in the Prevention at Scale Initiative. Once discussions with the Local Government Organisation and Fenland District Council had taken place a date would be sought.

It was resolved to note the training plan

88. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES

Members received the Health Committee agenda plan and noted the following update provided at the meeting.

15th March 2018 – Added
- Child and adolescent mental health services
- Procurement of Drug and Alcohol Services.
- Integrated children's commissioning
- NHS Quality Accounts Delegated Authority

12th July 2018 – Added
- Eating Disorder Service Update

The Committee were requested to appoint a Member Champion for Mental Health. The Chairman proposed with the agreement of the Committee that Councillor Lena Joseph be appointed to the role as she had been working closely with the Chairman of the Adults Committee on the issue and was a member of the Communities and Partnerships Committee.

It was resolved to:

a) Note the agenda plan and the update provided at the meeting

b) To appoint Councillor Lena Joseph as Mental Health Champion for the Health Committee

Chairman