Agenda Item No: 3

HEALTH COMMITTEE: MINUTES

Date: Thursday 10th March 2016

Time: 2.20pm to 4.55pm

Present: Councillors P Ashcroft, P Clapp, P Hudson, D Jenkins (Chairman), Z Moghadas, T Orgee (Vice-Chairman), P Sales, M Smith and S van de Ven

District Councillors M Cornwell (Fenland) and R Johnson (Cambridge City)

Also present: Councillor M Leeke; Peterborough City Councillor Brian Rush

Apologies: County Councillors B Chapman, M Loynes and P Topping
District Councillor S Ellington (South Cambridgeshire) and C Sennitt (East Cambridgeshire)

198. DECLARATIONS OF INTEREST

The Chairman welcomed Councillor Brian Rush, Chair of Peterborough City Council's Health Scrutiny Commission, to participate in the scrutiny of the termination of the UnitingCare contract (agenda item 4, minute 201) because the contract had been for services in Peterborough as well as Cambridgeshire. He also welcomed Councillor Leeke to the table, explaining that forthcoming changes in committee proportionality meant that the vacant Independent seat on the Health Committee would shortly be held by a different political group. Councillor Leeke would, at the Chairman's invitation, be permitted to speak but would not vote.

There were no declarations of interest.

199. MINUTES – 21 JANUARY 2016 AND ACTION LOG:

The minutes of the meeting held on 21 January 2016 were agreed as a correct record and signed by the Chairman.

The Action Log was noted.

200. PETITIONS

There were no petitions.

201. OLDER PEOPLE AND ADULT COMMUNITY SERVICES – TERMINATION OF UNITINGCARE CONTRACT

The Committee received a report setting out background information on the termination of the UnitingCare contract, including a briefing note from Monitor, and questioned senior representatives of the NHS regulatory bodies. In attendance were

- Dr Paul Watson, Regional Director (Midlands and East), NHS England (NHSE)
- David Dean, Senior Transformation and Turnaround Director, Monitor.

Also present were

- Tracy Dowling, Chief Operating Officer, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
- Aidan Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Roland Sinker, Chief Executive Officer, Cambridge University Hospitals NHS Foundation Trust (CUHFT).

A member of the public, Jean Simpson, put questions to the Committee. She said she had heard that there were seven reviews being conducted into the circumstances of the termination of the Uniting Care Partnership contract, including ones commissioned by the CCG and by NHS England. The CCG review had been published two and a half hours before the meeting, but she could find no date for the publication of the NHSE review. She asked the Committee to list the seven reviews, and sought assurance that the CCG was making use of the lessons learned for the other two procurement exercises that it was currently conducting.

In response, the Regional Director stated that the NHS England review was to be published within the next fortnight. The Chairman said that the Committee was aware of much ongoing activity, but not specifically of seven reviews; a summary of activity was being prepared for Members' information. The Regional Director advised that each organisation locally had been carrying out a review from its own organisation's perspective. He had offered to convene a meeting of all the local systems once all the reports had been published, in order to examine all the reports and the lessons to be learned from them.

The Committee noted that the ongoing procurement exercises referred to were those for the integrated NHS 111 and Out of Hours service, and for Non-Emergency Patient Transport Services.

The Committee turned to the letter from Monitor's Senior Transformation and Turnaround Director dated 2 March 2016, which had set out to explain Monitor's actions in relation to the questions raised in advance of the meeting. Concerns expressed by Members to the Director included that

- Monitor had reviewed the activities undertaken by CPFT but not by CUHFT

- the review had been conducted hurriedly against a deadline of the contract otherwise not going ahead

- conducting a limited scope risk review – which had arrived at an amber risk rating – could be seen procedurally as not very thorough.

From the letter and the Director's oral replies, the Committee noted that

- Monitor's legal role was as the regulator of foundation trusts, which had a degree of independence; Monitor only had powers to intervene when a foundation trust was at risk of breaching the conditions of its licence

- neither CPFT nor CUHFT was in breach of its licence, so Monitor had relatively limited powers to intervene

- in the case of CUHFT, because it would involve only a small part of a large overall turnover the transaction was below the threshold for classification as significant, so

Monitor was not obliged to review the licence; had it been classified as material, Monitor would have checked that CUHFT had undertaken due diligence

- CPFT had been intending to take on a large role within the contract, involving a proportion of its turnover great enough to trigger a review by Monitor of the proposed transaction's significance

- Monitor would have liked to have had more time in which to conduct its review, but in order to allow the contract to be approved by 1 April 2015, the compromise had been to conduct a limited scope, high level, risk review and keep the investigation open until it reached a satisfactory conclusion. Events had overtaken this

- there was no definition of what constituted a limited high level risk review, but it would have involved fewer meetings than normal; keeping it open made it possible to hold further meetings later

- the Director's understanding was that the source of the view on how to proceed had been the CCG; the CCG's Chief Operating Officer added that her recollection was that all parties had been key to the undertaking

- in the absence of local feeling that the contract should be completed by April 2015, Monitor would have preferred to conduct a more detailed risk analysis. As it was, the downside risk to CPFT had been estimated to be such as to allow the transaction to proceed, and Monitor had had no power to intervene in the case of CUHFT because it was not a significant transaction for CUHFT

- although according to the Internal Audit review the CCG had been refused sight of the CPFT business case, Monitor had seen the business plans

- the subsequent due diligence process involved checking, once services were being delivered under the contract, for any material changes that would affect the downside risk to CPFT; the position had appeared to be satisfactory except for the gap between the CCG and UnitingCare.

Members commented that, looking at the concept of one significant transaction and one transaction that was not significant, it was difficult to understand why the transaction had not been considered as a whole, given the scale of the contract. The Committee expressed concern that arrangements for scrutiny of a proposed contract of this magnitude had not been equal to the task.

The NHSE Regional Director outlined the roles of Monitor and of NHSE, explaining that

- clinical commissioning groups were the NHS locally, holding the majority of the budget for local healthcare and entering into contract with providers, which included both NHS Trusts and NHS Foundation Trusts

- NHSE had oversight of CCGs, Monitor of NHS Foundation Trusts, and the Trust Development Agency (TDA) of other trusts

- Monitor and the TDA were being brought together into one organisation, NHS Improvement

- NHSE had specific duties in relation to CCGs, including the carrying out of assurance reviews, including reviews of governance, financial control and prudence

- NHSE also had to approve any significant service change or configuration, such a the closure or relocation of a service

- if a CCG were to fail (e.g. loss of control of its finances), or if the CCG requested intervention, NHSE would intervene, but CCGs had freedom to enter into contracts – it was for the CCG's governing body to make the decision, not NHSE.

Asked about the role of the Strategic Projects Team (STP), the Regional Director replied that within NHSE were Commissioning Support Units (CSUs), which were semi-autonomous bodies over which he had no control. The STP had been hosted by a CSU; the review to be published in two weeks' time would cover their role.

On the question of whether there would be a clear learning process, making it impossible for a similar event to recur, the Regional Director said that it was important to undertake this learning. When the NHSE review was completed, the first task would be to prevent a recurrence, perhaps by putting in place a proactive assurance mechanism for CCGs, as already happened for service reconfigurations. Secondly, NHSE had offered to convene a session for the local NHS to share all the various reports and put their findings together into one coherent whole. A similar procurement exercise was being conducted in Staffordshire, but had been paused until the lessons from Cambridgeshire had been learned; his expectation was that the procurement would not proceed until a major assurance exercise had been completed.

Asked about the change of structure of UnitingCare to a Limited Liability Partnership (LLP), which had taken place after the Pre-qualification Questionnaire (PQQ) stage, and had not been subject to scrutiny, Monitor's Senior Transformation and Turnaround Director said that he had been unaware that UnitingCare had not always been an LLP, so could not answer immediately. NHSE's Regional Director said that NHSE did not have authority to approve corporate structures; there were benefits to the LLP structure. It was the CCG Governing Body's responsibility to ensure that any procurement was proceeding as it should, including that all necessary checks were made.

A member suggested that an overall controlling body might be required should a similar exercise be repeated, rather than having responsibility divided between several bodies. The Regional Director replied that NHSE could decide to oversee a procurement exercise more closely, but the structure of the NHS was a matter for Parliament to determine. NHSE was required to operate within the framework laid down for it; the review could well make recommendations on its future role in similar situations.

The Regional Director went on to say that one possibility might be that NHSE should proactively conduct an assurance exercise on major transactions being carried out by a CCG; only a change in procedures could prevent a repetition of what had happened in Cambridgeshire. This was why there had been a pause in the Staffordshire contract, which was the main similar exercise currently being conducted, also in the Midlands and East region. There were however advantages to CCG autonomy, which had led to many beneficial results; excessive bureaucracy of oversight could hinder this.

Members expressed concern, despite the benefits to service delivery, at the amount of time, effort and cost involved in setting up the UnitingCare contract; at the suddenness of its collapse, and at the financial loss of £20m to CPFT and CUHFT. The Monitor and NHSE representatives reminded them that much of the £20m would have had to be spent anyway, as it had been spent on employing doctors and nurses, and that the indications were that most of the service model was continuing. The OPACS contract

had triggered a move to more patient-centred care; it was not essential to have that contract in place to take forward the service benefits.

The Chairman asked whether the decision not to support the contract when it was collapsing had been made because of the regulators' legal position or because they had judged that the contract was not worth supporting. The Regional Director replied that local freedoms brought with them the freedom not only to innovate, but also to manage the consequences at the innovator's own risk. The problem in this case was a fundamental gap between what the commissioner had been prepared to pay and the costs which the provider had been incurring. NHSE did not intervene to cover contracts that became financially distressed. In this case, the view had been taken that it would be better for the contract to end, and local NHS organisations then to organise services along more traditional lines, while preserving the service benefits.

The Regional Director went on to say, in answer to further questions, that one lesson for the future was that it was necessary to be cautious about complicated contractual mechanisms where it would be possible to achieve the same result more simply. Across the NHS, commissioners and providers were increasingly looking for the simplest suitable contractual mechanism. Sources of advice were available to CCGs, but the key was to get the service change right and the contract would follow. NHSE was looking at how to help CCGs make carry out service change; the commissioning and contract process needed to be as simple as possible.

At the Chairman's invitation, the representatives of CCG, CUHFT and CPFT made brief statements.

The Chief Operating Officer of the CCG said that it was clear from what had been said at the present meeting, and from the internal audit report just published, that the CCG needed to establish a straightforward procurement process. She added that it had been a massive procurement exercise, into which a large number of people from a large number of organisations had put a great deal of personal effort. It was now necessary to step back and examine what had happened objectively.

CUHFT's Chief Executive Officer expressed his agreement with the three preceding speakers. The new models of care had been successful, and he welcomed NHSE's plan to bring together local NHS organisations to learn from the OPACS contract process. in answer to questions around the timing of the contract award, he said that it was not long from April to the winter period of intense activity; the wish had been to have the best model of care in place for winter 2015/16, and also certainty for staff as to what their employment arrangements would be.

The Chief Executive of CPFT said he supported all that had been said. There was consensus in the county and the NHS that the models of care were the right ones; the most important thing was to take these models forward. He asked the Committee to hold them to account for this. He welcomed the bringing together of the different reports, and pointed out that it was all parties together that would be working to ensure future models of care.

The Chairman thanked all the speakers for giving their time to attend and for their contributions. He also thanked the public for their interest, and invited them to submit further questions on the topic.

Discussing what they had heard, members of the Committee said that they had to examine both the CCG report published that day and the reports still to be published. It

was necessary to look at the findings and recommendations of all the various review reports for assurance that similar events would not happen again.

It was resolved unanimously:

a) to note the helpful and honest input from Monitor and NHS England's representatives

b) to note that there were clear rules in the NHS that limited the responsibility of different parties to intervene in the UnitingCare contract

c) to note that procedures for awarding such contracts were under review and that there was a national pause on similar tender processes

d) at the Committee's meeting on 12 May 2016 to review the termination of the contract again in the light of the findings of the independent reports commissioned by the Clinical Commissioning Group and by NHS England.

202. UPDATE ON ACTIONS TO ADDRESS LOW UPTAKE OF BREAST AND CERVICAL SCREENING IN CAMBRIDGESHIRE

The Committee considered a report describing the composition and work of a task and finish group set up by NHS England (NHSE) to identify issues leading to low uptake of screening in the county. The report outlined the group's main recommendations and the initial work under way to implement action to address them. Dr Shylaja Thomas, Screening and Immunisation Lead, NHSE (Midlands and East, East) was in attendance to present the report and respond to Members' questions and comments.

Members noted that the aim of the work was to increase acceptance of the offer for screening. The implementation group was taking forward the findings and was due to complete implementation in two to three months' time. Evaluation of the work would then follow, to see if uptake of screening had improved.

Examining the report, Members

- commented that reading and English language ability could be a factor in low uptake, and were advised that organisations with which NHSE was working were helping with the production of leaflets in other languages

- expressed concern at the poor rate of return to the GP practice survey, suggesting that other practices might have come up with previously unidentified issues and asking whether the findings were confident enough to be taken forward. Members were advised that the 28 practices surveyed had been chosen to represent the range of uptake; the nine which had responded had come from across that range, and the response rate was in line with expectations. It could be useful to repeat the survey with a different group of practices next year

- noted that there were trained public health staff in Cambridgeshire who could talk to more vulnerable people and encourage screening uptake; it was also necessary that GP practice nursing and administrative staff understand the importance of encouraging patients they see for other reasons to take up offers of screening.

The Chairman enquired into the timetable of activity, and was advised that data was collected and published at national level every three months, usually with a six-month time lag; a further update could usefully follow early in 2017 if required. The Chairman thanked the Screening and Immunisation Lead for her attendance and answers.

It was resolved unanimously to:

a) note the report

b) request a summary timetable of planned activity to address the low uptake of screening

c) review progress again early in 2017.

203. NHS QUALITY ACCOUNTS – RESPONDING TO REQUEST TO COMMENT

The Committee received a report informing it of the requirement, as part of its Health Scrutiny function, to comment on the Quality Accounts (QAs) drawn up by NHS Provider Trusts. Members were asked to consider how best to fulfil this requirement, given the discrepancies between the trusts' timetables and the dates of the Committee's meetings. They noted that the Committee was very dependent on the trusts getting their draft quality accounts it quickly, and that one option was not to respond to all seven Cambridgeshire requests to comment.

The deadline for getting QAs to the Secretary of State was 30th June, with Foundation Trusts being required first to submit their Quality Accounts to Monitor by 31st May. Papworth Hospital NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust had both requested responses from the Committee by 12 May, the date of its next meeting. Cambridge University Hospitals NHS Foundation Trust had not yet specified a date.

In the course of discussion, Members pointed out that, in addition to the seven trusts listed, The Queen Elizabeth Hospital King's Lynn (QEH) provided services to a considerable number of Cambridgeshire residents in the north of the county, and that it would therefore be appropriate to respond to its QA. The Head of Public Health Programmes undertook to communicate this to the hospital. The Chairman undertook to write to all the provider trusts asking them to conform to the Committee's timetable.

Action required

It was resolved unanimously:

a) to respond to as many local NHS Provider Trusts' Quality Accounts as possible in the time available, including The Queen Elizabeth Hospital King's Lynn

b) to establish a member led task and finish group comprising Councillors Leeke, Moghadas and Smith to draw up draft responses to Quality Accounts

c) to finalise draft statements at 12th May Health Committee Meeting

d) to agree an approach for Quality Accounts received after 12th May 2016 at the 12th May meeting

e) that the Chairman write to all Chief Executives of the local NHS Provider Trusts setting out the Committee's timetable and asking them to conform to it.

204. EMERGING ISSUES IN THE NHS – UPDATE ON SELF CARE AND PROPOSED PHARMACY CONSULTATION

The Committee received a report updating it on proposals for raising awareness of self care with the public, and introducing a proposed consultation on changes to pharmacy services (prescriptions for the treatment of minor ailments, for gluten-free products, and for some baby milks). Two officers from the Clinical Commissioning Group attended to present the report and respond to Members' questions, Jessica Bawden, Director of Corporate Affairs, and Sati Ubhi, Chief Pharmacist. Members noted that Cambridgeshire and Peterborough Clinical Commissioning Group's prescribing budget was probably one of the largest in the country, and that 80% of GP consultations included a prescription, of which 70% were not for medicines which could only be obtained on prescription.

In the course of discussion, Members further noted that

- the proposed policy had taken account of GPs' view that they wanted the flexibility to make exceptions to the restriction on over-the-counter products, for example allowing them to prescribe paracetamol syrup for children of low-income families

- patients who were either exempt from prescription charges or held a pre-payment certificate were currently able to obtain over-the-counter medicines on prescription, which saved them a modest sum at considerable cost to the CCG; Cambridgeshire was the only one of the neighbouring counties to do this

- a large proportion of CCGs had already stopped supplying gluten-free foods on prescription, as these were now very widely available in supermarkets

- a wide range of baby milks suitable for infants with cow's milk protein allergy or lactose intolerance was now available; the system of vouchers supplied to low-income parents to purchase milk for babies and young children would continue unaffected by this change.

It was resolved unanimously to note the report.

205. HEALTH COMMITTEE WORKING GROUPS – UPDATE

The Committee received a report informing it of the recent activities and progress of the Committee's working groups, noting that additional members were required for the Hinchingbrooke Healthcare NHS Trust liaison group. The Chairman reported on a seminar he and Councillor Ashcroft had attended at short notice at Peterborough City Hospital, on the relationship between social care services in Lincolnshire and Cambridgeshire the hospital's performance on delayed transfers of care. He undertook to write to the Chairman of the Adults Committee to convey what had been said, and Head of Public Health Programmes undertook to ensure that the presentation was circulated to Members. **Action required**

It was resolved unanimously to:

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

2) appoint County Councillors P Brown, Jenkins, Orgee and Wisson, and District Councillor Cornwell as core members of the Hinchingbrooke Liaison Group.

206. BUILDING COMMUNITY RESILIENCE

The Committee received a report introducing *Stronger Together – Cambridgeshire's Strategy for building resilient communities*, and seeking the Committee's views on the actions taking place in support of this strategy and how this could link with existing public health community resilience based work. Members noted that the strategy contained six themes, and that the focus was on a few deliverable tangible actions in these areas.

Considering the report, Members

- asked what they could do to promote the role of community pharmacists and promote the importance of people taking responsibility for their own health. Members were advised that they could work on campaigns, and also on Kick Ash and other smoking cessation initiatives

- expressed support for the strategy in general, and suggested that its aims should be communicated widely, through parish councils for example

- noted the Director of Public Health's wish to develop a website along similar lines to the Peterborough site, www.healthypeterborough.org.uk. This would be designed to provide an attractive platform for communicating health messages to a wide public, and create an environment where locally-generated ideas could flourish.

It was resolved unanimously to note the report.

207. FINANCE AND PERFORMANCE REPORT – JANUARY 2016

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of January 2016. Members noted that changes in the bottom line figures since the last report were due to the in-year reduction in the Public Health Grant. A predicted £1.5m under-recovery of income would in part be offset by a reduction of £1.1m in expenditure, and £400k would be needed from reserves, £200k less than had been expected. A smaller sum might be needed from reserves, if there were further underspends; the intention was to minimise the amount drawn from general reserves as far as possible.

Discussing the report, Members

- suggested that the 13 red indicators might be cause for concern. Members noted that there had been quite a short lead-in time to the start of the Integrated Lifestyle Service; there had been issues around data transfer, which had not provided a good benchmark to measure against; and recruitment had proved difficult in some areas. It was not easy to find people with the degree of flexibility required to work with GPs and in the community, but once the right person was found, they tended to stay

- expressed concern at the low take-up of mental health training in schools, and noted that mental health staff within the Public Health team were looking at this, and working closely with PHSE (personal, social and health education) staff in schools to encourage uptake and equip them with more tools

- reported from personal experience that one school had succeeded in providing support for a pupil who had been self-harming, once the school had been made aware of the problem

- noted that the Public Health budget had been supporting Economy, Transport and Environment (ETE) Services' work on both road safety and active travel, as part of efforts to reduce the number of physically inactive adults, and work was being undertaken with ETE on the planning of new communities to encourage activity and reduce excess weight in adults and children

- suggested that Delayed Transfers of Care (DTOC) at Peterborough City Hospital should be reported on, in addition to the information supplied on Addenbrooke's and Hinchingbrooke hospitals.

The Chairman said that it had appeared, from the recent workshop with Addenbrooke's on e-Hospital, that the Committee's earlier request for a monthly report following the Care Quality Commission's inspection of Cambridge University Hospitals NHS Foundation Trust appeared to be creating considerable work for CUHFT. He therefore suggested that the Trust be invited to develop an indicator against which the Committee could monitor their progress.

The Chairman also suggested that the presentation of performance data should be improved, to make it easier to manage the Committee's business. He undertook to discuss with Health Spokes developing a simplified, more vivid report on Public Health indicators, focussing on improving health and reducing inequalities. He suggested this should be taken at the beginning of a meeting, rather than the end. **Action required**

It was resolved unanimously to note the report.

208. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan. It was resolved unanimously to note the training plan.

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

The Committee considered its agenda plan in the light of concerns raised in the course of the meeting.

It was resolved unanimously:

a) to note the agenda plan

b) to add a scrutiny item on the termination of the UnitingCare contract to the agenda for 12 May 2016

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

Chairman