HEALTH COMMITTEE: MINUTES:

Date: Thursday 20th November 2014

Time: 2.00 p.m. to 5.00 p.m.

Present: Councillors K Bourke (Chairman), P Ashcroft, P Brown, P Clapp, A Dent, S Frost, P Lagoda, M Leeke (substituting for Cllr Jenkins), L Nethsingha, T Orgee, P Sales, J Schumann, J Scutt, M Smith, P Topping and J Wisson

District Councillors R Carter (Huntingdonshire), M Cornwell (Fenland), S Ellington (South Cambridgeshire), T Moore (Cambridge City, substituting for Cllr Roberts and H Williams (East Cambridgeshire)

Apologies: Councillor D Jenkins; District Councillor P Roberts

65. DECLARATIONS OF INTEREST

Councillor Ellington declared an interest as a trustee of the Care Network.

66. MINUTES: 16th OCTOBER 2014

The minutes of the meeting held on 16th October 2014 were agreed as a correct record and signed by the Chairman.

67. PETITIONS

No petitions were received.

68. INTEGRATED LIFESTYLES AND WEIGHT MANAGEMENT PROCUREMENT: AWARD OF CONTRACT

The Committee received a report setting out proposed arrangements to award the contract for the Integrated Countywide Lifestyle Services, which was reaching the final stages of a competitive procurement process. Members noted that the section on resource implications (paragraph 4.1) should read, 'All costs of the contract are covered within the various lifestyle services budgets. No additional resources will be required.'

It was resolved:

a) to note and endorse the progress made to date in undertaking the procurement of an Integrated Lifestyles Service;

b) to 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; and

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

69. PUBLIC HEALTH FINANCE AND PERFORMANCE REPORT

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of September 2014. Members noted the proposal to use over-accruals on smoking cessation and sexual health from 2013/14, and a non-recurrent underspend in 2014/15 from the delay in implementing the Health Trainer investment, to pump-prime a fund to address health inequalities in Fenland.

Commenting on the report, members

- asked whether the underspends indicated that work had not been carried out. Officers advised that, following the transition of Public Health to the Local Authority in 2013, there had been some uncertainty around financial forecasting for 2013/14. There had been a genuine reduction in the use of smoking cessation services (and now some evidence of a fall in the prevalence of smoking), and it was still planned to implement the Health Trainer investment, but this had been delayed due to the inclusion of this service in the wider integrated lifestyles procurement

- noted that because Public Health funding was ring-fenced, there was a requirement to carry forward the amount underspent

- enquired about success criteria for the pump-priming expenditure in Fenland. It was explained that the intention was to place this money with an external, non-County Council vehicle, which could then attract other funding. The aim was to improve long-term public health outcomes for smoking, diabetes and obesity using a community engagement approach

- noted that the expenditure of the Public Health grant described in Appendix 3 as 'Changing Behaviours of Staff in CCC' related to paying the backfill costs of training staff in directorates other than Public Health; this training included brief intervention training (i.e. motivational interviewing) and Mental Health First Aid

- asked whether the red indicator for the number of referrals to the health trainer service was expected to improve. Officers advised that the health trainers were based in GP practices. There had been a fall in the number of referrals in some practices, and a fall in staff in some practices. A similar target had been set for the future, but with a greater element of self-referral

- requested the inclusion of key figures and performance indicator at the start of each section of the written commentary. Officers undertook to include them in the next report. **Action required.**

It was resolved to note the report.

70. SERVICE COMMITTEE REVIEW OF THE FINAL DRAFT 2015-20 REVENUE PROPOSALS

The Committee received a report setting out an overview of the final draft Business Plan Revenue Proposals for Public Health. Members noted that the main proposals were unchanged from those presented at the Committee's meeting in October, and that

the final amount of the ring-fenced public health grant after 2015/16 was still not known. The introductory sentence to report paragraph 5.12 should refer to indicators for 2015/16, not 2014/15. The Director of Public Health reported that, following concerns expressed at the last meeting about the community impact assessment on community providers, providers had been invited in writing to comment. To date, no negative feedback had been received.

The Chairman reported on the General Purposes Committee business planning workshop, at which the chairmen/women and vice-chairmen/women of the service committees had outlined the financial situation for their committee's area of responsibility. The possibility had been raised of using Public Health funding for falls prevention work being undertaken by Children, Families and Adults (CFA), thus relieving some pressure on the Adults Committee budget area. Other members who had attended the workshop confirmed his account. They commented that falls prevention was clearly a health issue for the Council, but recalled that the investment in question had been for training for care-givers to prevent falls, which fell within the Adults area of work.

The Director of Public Health commented that falls prevention was a key Public Health aim, with the potential to save money for both the health and the social care systems; the new Older People's Service provider would be focussing on falls prevention. The Director of Public Health outlined the interventions which were evidenced to prevent falling, which included strength and balance training, home visits to identify and correct falls hazards, sight tests, and medication review. Training care staff formed only part of this package. She offered to investigate options for supporting falls prevention work, for example by using the previous year's carry forward on a non-recurrent basis.

It was proposed by the Chairman and seconded by Councillor Nethsingha that a fourth recommendation be added to the report before Committee:

d) The Committee request the Director of Public Health to investigate falls prevention as discussed by Committee, and to bring back information and implications to Committee.

On being put to the vote, the amendment was carried unanimously.

Discussing other aspects of the proposals, members

- drew attention to the importance of public transport as supporting an active lifestyle for older people, for whom public transport was active travel. Members noted that there was evidence that the use of public transport did promote active travel, and that work on the transport and health Joint Strategic Needs Assessment (JSNA) was due to be reported to the Committee in April 2015

- expressed regret that the proposals failed to mention gypsies and travellers, who lived all over the county and were in general not well served by existing provision. Members were reminded that Public Health already included a dedicated Travellers' Health Team.

It was resolved:

a) to note the overview and context provided for the 2015-20 Revenue Proposals for Public Health

b) to endorse the final draft proposals for Public Health's 2015-20 revenue budgets

c) to note progress against the shared public health priorities programme, which would lead to revision of the current Memorandum of Understanding for use of ring-fenced public health grant funding across County Council directorates

d) to request the Director of Public Health to investigate falls prevention as discussed by Committee, and to bring back information and implications to Committee.

71. PROPOSAL TO RE-PROCURE CAMBRIDGESHIRE CHILDHOOD VISION SCREENING SERVICES

The Committee received a report setting out current arrangements for childhood vision screening services in Cambridgeshire, including inequities in service provision across the county, and describing proposals to re-procure childhood vision screening services to provide a consistent county-wide service for children in Cambridgeshire. Members noted that the aim of the screening was to identify children with amblyopia, a problem with the way visual pathways develop in the brain, usually resulting from a problem with the eyes, in order to treat the underlying condition and improve future vision.

Commenting on the report, members

- observed that the successful bidder often only started to recruit staff to perform the work committed to once the tender had been accepted, and urged that, to avoid this situation, those tendering be required to state what staff they already had available and how they would fulfil the contract

- drew attention to the possible connection between vision defects and reading difficulties, and suggested that there could be an association between poor levels of attendance for screening and low literacy levels; an eye test could be the first step in tackling a child's dyslexia.

It was resolved to:

Approve the proposal to re-procure childhood vision screening services on a county-wide basis.

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

The Committee received a report setting out the main issues for the transfer of responsibility for public health commissioning for children aged 0-5 into existing joint commissioning arrangements. Members noted that full commissioning responsibility would transfer from NHS England to local authorities in October 2015.

Discussing the report, members

- enquired whether any guarantee had been received that the budget transferred for 0-5 public health services would be adequate. Officers advised that NHS England had given assurances that the amount of funding would be adequate, and that the East of England was getting a good deal. However, concerns remained about payment of staff increments and pay rises, the numbers of health visitors, and the costs of commissioning, so the answer to the question was both yes and no

- noted that it was expected that draft local authority allocations would be announced and there would then be a period of consultation and feedback

- commented that the connection between Health Committee, Children and Young People (CYP) Committee and Children's Health Joint Commissioning Board could be less direct if the member chair of the Commissioning Board ceased to be a person who sat on both committees. The Committee was assured that the intention was that the Board would continue to have member representation from both Health and CYP Committees

- sought more information on the project management structure, including plans for feeding back information to the Committee, and suggested that, as children's joint commissioning was a complex topic, a briefing to a general member seminar would be helpful. **Action required.**

It was resolved:

a) To note the briefing on the transfer of commissioning responsibility of health visiting to Cambridgeshire County Council, including fit with the Children's Health Joint Commissioning Unit.

73. COMMITTEE WORKING GROUPS AND VISITS: REPORT BACK

The Committee received a report informing it of the activities and progress of the Committee's working groups since the last Committee meeting. Members noted the presence in the audience of Sandie Smith, Chief Executive of Healthwatch, and suggested that it might be helpful to invite a representative of Healthwatch to attend meetings of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) liaison group.

It was resolved to note the report.

74. COMMISSIONING OF OLDER PEOPLE'S HEALTHCARE WORKING GROUP: REPORT BACK

The Committee received a report on the activities undertaken by the Commissioning of Older People's Healthcare Working Group and seeking agreement on a new remit and terms of reference for the working group. Members considered whether the group should be allowed to make recommendations on the Committee's behalf, or should be required to seek the Committee's agreement before providing feedback. Because there was often the need for a rapid response, the consensus was that it would be better to delegate the power to make recommendations, without prior authorisation.

It was proposed by Councillor Scutt and seconded by the Chairman that the wording of paragraph 3 of the section on Powers be revised to read [both a) and b) adopted, but in the reverse order, additional text underlined, deleted text struck through]

The working group ~~will~~

a) is delegated by Health Committee to make recommendations to relevant parties on behalf of the Health Committee in its health scrutiny function, and

b) will report back to the ~~full Health~~ Committee ~~on activities and get agreement before proceeding with feedback to relevant parties~~

On being put to the vote, the proposal was carried unanimously. [The terms of reference as adopted are attached to these minutes as Appendix A.]

It was resolved:

a) to note the report

b) to agree a new remit for the working group and formally agree terms of reference as drafted in Appendix A, subject to amendment of the section on Powers, paragraph 3 to read

The working group

a) is delegated by Health Committee to make recommendations to relevant parties on behalf of the Health Committee in its health scrutiny function, and
b) will report back to full Health Committee on its activities.

c) to note the joint presentation from Cambridgeshire and Peterborough Clinical Commissioning Group and UnitingCare Partnership scheduled on 11th December 2014.

75. CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP OUT OF HOURS AND 111 SERVICES PROCUREMENT: ENGAGEMENT PROPOSAL

The Committee received a report from the Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group, introducing proposals for a future procurement of the GP out of hours (OOH) service and the 111 service for patients in Cambridgeshire and Peterborough, and seeking the Committee's support for a consultation period of eight weeks rather than a longer period.

In the course of discussion, members noted that

- the intention was initially to establish the out of hours service and the 111 service in time for winter 2015, and build in the flexibility in the contract later potentially to add in an element of triage by providing a face to face 111/OOH assessment desk at the front door of Accident and Emergency (A&E) departments

- work was being undertaken to explore options for pilot 111/OOH assessment schemes at Addenbrooke's and Hinchingbrooke hospitals to support them through the winter of 2014/15

- if experience of the trials at Addenbrooke's and Hinchingbrooke hospitals suggested that the assessment desk had been helpful, there would be a further consultation on any extension to the initial out of hours and 111 procurement

- patient representatives on local commissioning groups and Healthwatch were already engaged in the consultation process.

Members commented that, provided sufficient publicity was given to the consultation, the eight-week period seemed acceptable.

It was resolved:

a) To support the Clinical Commissioning Group's intention for a consultation lasting eight weeks

b) To endorse the consultation process plan (attached as Appendix A to the report before Committee).

76. RECENT PRESSURES IN THE CAMBRIDGE AND SOUTH CAMBRIDGESHIRE HEALTH SYSTEM

The Committee received a report from the Cambridgeshire and Peterborough Clinical Commissioning Group's Director of Corporate Affairs updating it on the current situation relating to recent pressures in the Cambridge and South Cambridgeshire health system. In attendance to respond to the Committee's questions and comments were:

- from the Clinical Commissioning Group
    - Dr Neil Modha, Chief Clinical Officer
    - Jessica Bawden, Director of Corporate Affairs
- from Cambridge University Hospitals NHS Foundation Trust (CUHFT, Addenbrooke's Hospital)
    - Dr Keith McNeil, Chief Executive
- from Cambridgeshire Community Services NHS Trust (CCS)
    - Matthew Winn, Chief Executive
- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
    - Stephen Legood, Director of Business and People
- from East of England Ambulance Service NHS Trust (EEAST)
    - Matthew Broad, Locality Director/Assistant Chief Ambulance Officer – Norfolk, Suffolk and Cambridgeshire (NSC).

The Chairman explained that this item had been placed on the agenda as the result of concerns expressed to the Leader of the Council about a major incident at Addenbrooke's Hospital. He and the Chairwoman of the Adults Committee had attended a meeting with the hospital examining these concerns on behalf of the Council.

At the Chairman's invitation, each senior officer spoke about the pressures in the local system from their organisation's experience.

The Chief Clinical Officer of the CCG spoke to the report from the Director of Corporate Affairs addressing technical issues, quality issues, discharges and delayed transfers of care (DTOCs) and winter pressures funding. He said that the e-hospital (EPIC) had many benefits and the rest of the country was looking to see how it would work. Many systems had however been affected by its introduction. The CCG's Quality Team had made an unannounced visit to Addenbrooke's, and had held a meeting with the hospital. The Quality Team had concluded that the introduction of the e-hospital had slowed down processes, but there had been no adverse impact on the quality of service received by patients. Nationally, there had been no summer lull in hospital activity; it had been winter all year round, and work was being undertaken at national level to see what could be done about changing how people used hospital services.

The Chief Executive of CUHFT said that the two issues were the immediate impact of the introduction of EPIC, and the system-wide struggle with demand being experienced nationally. A very high number of DTOCs had been resolved as part of planning a perfect week for the introduction of EPIC, but there were currently 74 DTOCs, and altogether 200 of the hospital's 1,000 beds were being occupied by people who were fit to be cared for elsewhere. There was currently a severe shortage of beds, which a week ago had let to the cancellation of all elective surgery for a day, including some cancer surgery, and a patient who was admitted two days later as an emergency. Addenbrooke's was not alone in having to choose who could have a bed; this was the experience of other hospitals across the country.

He went on to say that e-hospital had been introduced after five years of planning. Eventually, primary care, community care and social care would all be included, and electronic health records would be a national requirement. Patient welfare remained CUHFT's highest priority and had been the subject of heightened scrutiny in recent weeks. Conversations with CCG and Coroner had not revealed any patient welfare issues. The rising number of frail elderly (7% above the predicted worst-case level) had taken the health system by surprise. Reasons for the sudden high rise in demand were unclear; it was necessary to examine how best to care for chronic disease in the community.

The Chief Executive of CCS addressed the question of DTOCs at the Chairman's request. The Chief Executive explained that in a normal week, CCS would receive about 100 referrals from Addenbrooke's, but in the five days Thursday 30th October to Monday 3rd November, just after EPIC had been introduced, they had received only four referrals. Realising that this was unusual, CCS and CUHFT had investigated the issue and arranged for manual referral systems to be put in place until the technical issues were resolved.

The County Council's Executive Director: Children, Families and Adults Services (CFAS), in reply to a question from the Chairman, confirmed that the number of DTOCs attributable to the County Council had halved compared with two years ago. However, the Council's ability to access nursing and residential care for those with high care needs was hampered by a shortage of beds and nurses. CFAS was phoning providers on a daily basis to check their capacity and staffing levels. It was necessary to explore how to make the system work better, and to work hard to improve admission avoidance.

The Director of Business and People, CPFT said that the CPFT Liaison Psychiatry Service maintained a presence in Addenbrooke's A&E from 8am to midnight and also worked with in-patients. Preparations had been made for the introduction of e-hospital; the new system was working well, and being accessed by CPFT staff. In general, CPFT was experiencing a significant increase in demand and referrals across Older People's, Adults and Child and Adolescent Mental Health (CAMH) services, with a 13%-15% rise in demand for CAMH and about 5% rise for Adults.

The Assistant Chief Ambulance Officer – NSC, EEAST said that his service was also experiencing a rise in demand. The Ambulance Service was about 12% busier than last year, about 9% above the contracted level (a 3% rise in activity had been anticipated). He agreed that it was important to avoid unnecessary admissions. EEAST was the second highest non-conveyance ambulance service in the country, with 45% of cases assessed on-scene not being taken to hospital. At Addenbrooke's, the ambulance arrival to handover performance had been very good, but significant pressures had arisen following the introduction of EPIC, with a rapid rise in handover delays. A meeting had been held with CUHFT staff to see what could be done to reduce these delays.

The Committee went on to discuss what it had heard. One member recalled that the former Adults, Wellbeing and Health Overview and Scrutiny Committee had conducted a member-led review into delayed discharge from hospital some years ago, and had drawn attention to the need for an integrated system to address deficiencies in patient information and recording.

Members received further information and views from the senior officers in answer to their questions about various aspects of pressures in the local health system.

Supply of nurses

- Regionally, it was estimated that there was a shortage of about 2,000 to 4,000 nurses.
- A major issue was that of NHS London weighting, which stopped in the middle of Hertfordshire; Cambridgeshire employers could decide unilaterally to pay more, but were not funded to do so.
- The costs of living near Cambridge were affecting recruitment of care staff
- Addenbrooke's had recently held an overseas recruitment exercise, with the result that the vacancy rate, currently 12%-13%, was expected to drop to 5% in January 2015.
- Nurses being employed by CCS from abroad were required to take an English language test and all staff employed by CUHFT went through an accreditation process which included an English test. A member supplied anecdotal evidence of poor language skills amongst some nursing staff, particularly at night, at a hospital outside the county.
- Seepage of newly trained nurses away from the NHS was an issue throughout the country; locally, Anglia Ruskin University was training nurses who received NHS funding for their course and went on to work in the NHS.

111 Service

- Every health system that had introduced 111 had experienced an increase in attendance at A&E, thought to be largely for one of two reasons

- people asked to ring an unfamiliar number, rather than 999 or the out of hours service, were trying to avoid the unknown by going straight to A&E
- the algorithm of questions to determine the severity of a caller's symptoms was producing a result that recommended attendance at A&E. To try to avoid unnecessary visits to A&E, the CCG was introducing an additional stage in the algorithm, by getting a GP to examine whether it was really necessary for the patient to attend A&E. The aim in future was to join up the 111 service and the out of hours service.

Bed capacity

- Capacity at Hinchingbrooke and Peterborough, as well as at Addenbrooke's, was challenged; fresh thinking was needed about how to make better use of beds.
- Once people had been treated, it was desirable to get them out of hospital quickly, for reasons including the avoidance of hospital-acquired infections.
- Opportunities for step-down care were due to be discussed by the senior officers present at the conclusion of the current committee meeting.
- A campaign of public education was needed to encourage them to accept other ways of accessing healthcare.

Rise in number of frail elderly

- A rise in the numbers of frail elderly was being experienced across the country and the resulting pressure was leading to changed ways of working
- GPs were experiencing funding cuts, leading them to change how they ran their practices.
- The CCG was looking to commission an enhanced way of working from GP surgeries, incentivising them to do more, more quickly, for example visiting frail elderly patients sooner and managing long-term conditions better.
- One of the CCG's reasons for joining up community care and health care through the Older People's contract was to improve care for older people.

Alternatives to hospital or residential care

- Falls prevention work should reduce hospital admissions as a result of falls.
- CCS step-up/step-down services provided more intense support at home than a GP could provide.
- Care homes could reasonably be expected to seek medical advice and deal with almost all conditions apart from very acute emergencies.
- Work was being done to increase the number of ambulatory care pathways, whereby people would have their tests in hospital then go home the same day.
- Admission avoidance was not one thing, but a strategy encompassing hospital, primary care and community care.

Closer working between EEAST and Cambridgeshire Fire and Rescue Service (CFRS)

- The Ambulance Service was looking at a number of collaborative schemes which could be introduced for patients' benefit (in answer to a question from Councillor Brown, speaking as Chairman of the Fire Authority).
- Collaboration could give a first response facility, but the question was who could do what when they arrived at an accident scene. Firefighters could give basic first aid and perhaps defibrillation; ambulance paramedics could do more.

- The Assistant Chief Ambulance Officer was due to meet the Assistant Chief Fire Officer in the next fortnight and would include discussion about closer working on the agenda.

The CCG's Chief Operating Officer and CUHFT's Chief Executive agreed that there was no lack of will to work together within the constraints outside their control. The Older People's Programme and the Better Care Fund both involved the different elements of the health system working together for patients' benefit.

The Chairman thanked all the officers for their attendance and contributions to the meeting, and wished them well.

77. HEALTH COMMITTEE AGENDA PLAN

The Committee considered and noted its agenda plan to May 2015.

78. HEALTH COMMITTEE PRIORITIES AND APPROACH: UPDATE

The Committee received a report in tabular form updating it on progress with its priorities. Members considered how best to approach four specific topics:

- Whether the Committee should scrutinise forward plans of various health providers and whether they align. Members suggested that this was an important topic on which information could be assembled and sent out to members prior to consideration at Committee.

- Whether the Committee wished to find out more about NHS England's commissioning of 'liaison and diversion' services designed to identify health issues in people when they came into contact with police. Members noted that information had been supplied on a confidential basis to share with the Chairman about the mental health of local prisoners, and commented that the mental health of people in prison was a long-standing issue on which the Howard League was a good source of information. Prisons were also now experiencing problems caused by rising numbers of elderly prisoners, including those convicted of cyber-crime, to the extent that geriatric wings were being established in some prisons. The Chairman offered to explore, with the Director of Public Health, what could be done about making the information on prisoner mental health more widely available. It was also suggested that the 'liaison and diversion' services could be of interest to a general member seminar. The Director of Public Health offered to request and circulate a briefing paper from NHS England. **Actions required.**

- Review of implications of NHS 5-year forward view around 'radical upgrade in prevention and public health' and role of local authority in system transformation. The Chairman suggested that the Committee should give priority to this topic and place it on the agenda plan. It was agreed that this should wait until after the winter period was over.

- Follow-up on 'delayed discharge' work. It was agreed that the Committee would wait until after winter to pursue this fully. Meanwhile, the CCG's Director of Corporate Affairs agreed to supply a detailed briefing paper by email.

It was resolved to note the Health Committee priorities and approach.

79. HEALTH AND WELLBEING BOARD FORWARD AGENDA

The Committee received the Health and Wellbeing Board's forward agenda plan for information, noting that the Board would be considering whether to move to a pattern of six meetings a year rather than four from May 2015.

It was resolved to note the Health and Wellbeing Board's forward agenda.

Chairman