ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Cambridgeshire County Council

25th October 2012

Action

88. DECLARATIONS OF INTEREST

Councillor S Brown declared a non-statutory disclosable interest as a member of the Cambridgeshire and Peterborough Mental Health Trust and as a participant in the Cambridgeshire Local Involvement Network (LINk).

89. MINUTES OF THE LAST MEETING – 12 SEPTEMBER 2012

The minutes of the meeting held on 12 September 2012 were confirmed as a correct record and signed by the Chairman.

90. EAST OF ENGLAND AMBULANCE SERVICES NHS TRUST: CHANGES TO EMERGENCY SERVICES

In response to a request by a member of the public reported at its previous meeting, the Committee considered a report from the East of England Ambulance Service NHS Trust (EEAST) on recent and planned developments in the provision of emergency ambulance services.

A letter from Hayden Newton, Chief Executive of EEAST, dated 25th September 2012, sent in reply to the Chairman's letter of 17th September, was circulated to members and is attached as Appendix 1 to these minutes.

EEAST officers present to introduce the report and respond to members' questions and comments were

- Chris Hartley, Associate Director of Communications and Engagement
- Paul Leaman, Associate Director of Urgent Care
- Phil Parr, Assistant General Manager (operations manager for the North Cambridgeshire, Peterborough and March area).

Apologies were given from Dave Fountain, the General Manager whose area included Cambridgeshire, who had been prevented by illness from attending.

Introducing the report, EEAST officers outlined the background to the recent redesign of services. Members noted that the aim was to ensure that the same level of care was delivered to patients in all parts of the region; there were challenges in Cambridgeshire arising from the mixed urban and rural nature of the county. Work was being undertaken to provide a service to callers that was more tailored to individual need, balanced against the requirement to spend and save wisely at a time of reduced income and increased activity. Until recently, calls from

Cambridgeshire had been split between two control centres, Norwich (covering most of the county) and Bedford (covering south Cambridgeshire), but all Cambridgeshire calls were now being dealt with by Bedford, on the grounds that resources could be deployed around the county more easily if one centre were responsible for the whole county.

In the course of discussion, members

- pointed out that other emergency services were under similar financial pressures and enquired whether combined emergency services control might be a solution. The Associate Director of Urgent Care said that no options would be ruled out. EEAST was in regular dialogue with Fire and Police colleagues and undertook joint training, with the Fire Service providing breathing apparatus training to some EEAST teams. Other areas, e.g. Wiltshire, shared control facilities, but the demand for ambulance services far outstripped that for fire
- sought more information on the reasons for delays in handover of patients from ambulance to hospital staff at Addenbrooke's as compared with the two district hospitals (Hinchingbrooke and Peterborough); the local member's observation was that ambulances were not obstructed on their way in and out of the site, which suggested that the delays were occurring after arrival.

  Officers acknowledged that there were handover delays as set out in the report, particularly at Addenbrooke's, though some hospitals in the region performed even less well in patient handover. Some of the issues did relate to the building works at Addenbrooke's, but there were also questions of speeding up the process by which a patient passed through Accident and Emergency. Ambulances were now also using other routes to transfer a patient, for example by taking some patients booked in by GPs to the medical assessment unit, or to the minor injuries unit, or direct to the ward.

  Members were advised that meetings were held between Addenbrooke's and EEAST at Chief Executive level to establish the principle whereby ambulance crews would be released after 15 minutes, but they were still sometimes being kept for over two hours. Efforts were also being made to reach tripartite agreement between NHS Cambridgeshire (NHSC), the Ambulance Trust and the Hospital Trust about keeping each other informed of problems at an early stage. The Ambulance Service had put a liaison officer in to Addenbrooke's to work preventatively and proactively with the hospital

  The Assistant General Manager said that significant handover problems had been experienced at Peterborough District Hospital two years ago, largely caused in his view by processes within the A&E department or by capacity – the physical number of patients in A&E at one time. Addenbrooke's had been invited to see the work done to remedy the problems in Peterborough, which was now being held up as a showcase system. Peterborough City was not immune from handover delays, however, with several ambulances waiting for over an hour recently because of the large number of people arriving at once
- noted that patients being brought to Addenbrooke's because they needed its centre of excellence facilities would not be delayed in A&E. A seriously ill trauma patient would bypass any queue, and stroke patients, for example, would be taken straight to the hyperacute unit
- expressed the wish to receive responses from all three hospitals on their experiences with patient handover, to assist members in forming a picture of what was happening across the county

- in relation to those patients who had been identified as requiring an emergency response within 8 minutes, noted that the calls were not treated as lower priority if there was no likelihood of reaching them within 8 minutes. The call remained prioritised as life-threatening; the caller would be contacted once it had become clear that the response would not arrive within 8 minutes, and the enhanced medical triage team would talk to the patient meanwhile.

  Once a 999 call had been made it could not be ignored, but it was necessary to ensure that care was delivered in the most appropriate way. Community First Responders (CFRs) were volunteer lay people within local communities trained to deliver immediate care; using these volunteers to support the Ambulance Service made it possible to deliver much better care. If a CFR could arrive more quickly than an ambulance, then one would be sent to provide care urgently

- given the nearly 20% difference between the Cambridgeshire and Peterborough areas in achieving the 8-minute response target, enquired what proportion of that 20% was affected by the delayed handover, commenting that if there was a correlation, resolving that problem would go a long way to improve response times. The Associate Director of Urgent Care confirmed that performance would be much improved if the hours lost waiting outside A&E could be recovered. He and the Associate Director of Communications and Engagement undertook to translate delays into hours lost and supply that information to the Committee **CH, PL**

- enquired whether finding a patient's exact location in a rural area ever proved a problem. Officers advised that this was not usually a major difficulty. The use of satellite navigation could be supplemented by map grid co-ordinates (eastings and northings), which were useful for the air ambulance service. There would always be a need for updates, but local crews would pick up maps from developers of local sites

- noted that the procedure when an ambulance arrived to find that a patient had died depended on whether the death was unexpected or not. If the patient had been seen by their GP within the previous fortnight and the death was expected, the ambulance crew would call the GP and depart, leaving the patient in situ; ambulance staff were able to declare life extinct, but were not empowered to sign a death certificate. If a death was unexpected or suspicious, then the Police would be called, and the crew would remain at the scene, sometimes also caring for a member of the deceased's family. A duty officer from the Operations Manager's team would sometimes be sent to take the crew's place In order to release the crew for further calls

- noted that ambulance staff were usually very resilient, but employees were able to self-refer to the occupational health service as necessary, and the employee assistance programme included psychological support

- suggested that the high level of public expectation of the ambulance service, and the fly-on-the-wall presence of the media, might at times be unhelpful, giving the impression sometimes that a major response was required even to a relatively minor injury, such as sending the air ambulance to a footballer with a sprained ankle.

  The Associate Director of Urgent Care said that the level of public expectation was huge, and the public had a right to expect a response, but 50% to 60% of cases did not require hospital treatment. There was a need to educate the public – the message was not that people should not call the ambulance

service, but that they should not expect that the response would be always to send an ambulance, or that the ambulance would always take them to hospital. A new non-emergency number, 111, was being introduced for the ambulance service from April 2013, with 101 as the police equivalent

- enquired how the 8-minute response time worked in practice in Fenland, a rural area with high levels of isolation and deprivation, whose patients went to one of four hospitals (Hinchingbrooke, Addenbrooke's, Peterborough and the Queen Elizabeth in Kings Lynn), and asked whether resources were easily available in Fenland.

  Officers advised that resources were not always easily available because they were often held elsewhere, and ambulance crews also required breaks for food and drink. In 1996, when the response time standard was new, ambulance services had recognised that targets were more easily met in urban than in rural areas. Essex Ambulance Service developed Community First Responders, and their use was adopted by EEAST; few ambulance services made use of volunteers in the way that EEAST did. In Fenland, ambulances were sited at response posts as well as in ambulance stations, which increased flexibility. For example, when a March ambulance was already on its way to Peterborough, if needed an ambulance could be sent towards March from the response post at Whittlesey Fire Station.

  Use was being made of multi-disciplinary team meetings to address the demands on the service posed by frequent callers, and efforts were being made to secure help in their own homes for frequent fallers. Efforts were also being made to manage staff sickness absence. Improved turnaround times in Peterborough made it possible for crews to return to their bases more quickly, and rotas were being redesigned to adjust cover to later in the day, when demand was higher

- noted that savings would not be sought at the expense of reducing vehicle maintenance or keeping vehicles longer – they were already worked hard. However, the deployment of a mixture of vehicles was being developed; Intermediate Tier Vehicles (ITVs) were cheaper both to buy or lease and to maintain. They would be equipped for emergency care, and might well transport patients to hospital if required, but would not be used for blue light emergency calls. No backroom staff were currently being recruited, but no savings were being made that would have an adverse effect on patients

- enquired about arrangements for liaison with Magpas. The Associate Director of Urgent Care said that he met regularly with the Magpas Chief Executive Officer, Daryl Brown, and that the Chairmen of EEAST and Magpas also met. In general working relationships with Magpas were good, though occasionally issues arose which required discussion. EEAST valued the contribution of the third sector highly.

The Committee welcomed an invitation for members to visit the Bedford control centre, where they could see calls being taken and ambulances despatched. They were also invited to spend time on a vehicle or go to hospital and talk to ambulance crews. The Chairman thanked the EEAST officers for answering the Committee's questions and said that he would be following up the invitation to Bedford.

91. CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP: GOVERNANCE, ACCOUNTABILITY AND PATIENT AND PUBLIC INVOLVEMENT

The Committee received a presentation on the development of clinical commissioning which focused on governance and accountability. Officers of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) attended to respond to members' questions and comments:

- Dr Neil Modha, Chief Clinical Officer (designate)
- Andy Vowles, Chief Operating Officer (designate)
- Jessica Bawden, Director of Communications, Membership and Engagement (designate).

The Committee noted that

- as part of the CCG authorisation process, a panel of assessors from the NHS Commissioning Board (NHSCB) was due to make a site visit on 26th October
- the CCG would be undertaking about 70% of the commissioning work formerly done by NHSC, with the remaining 30% undertaken by the NHSCB
- the CCG's structures were not dissimilar to those of the primary care trust, NHSC, but the reasons for abolishing primary care trusts had not been connected with their governance arrangements
- 106 of the 109 GP practices in the CCG area had a patient reference group
- the central CCG Engagement Team was very small, but each Local Commissioning Group (LCG) would have a person with responsibility for engagement at local level.

Responding to the presentation, members of the Committee

- commented that a focus on patient groups, which tended to be composed largely of middle-class, white, retired people, could leave some individuals feeling disenfranchised. Officers advised that the CCG was commissioning a complaints service and providing an in-house patient advice line. If it appeared that particular issues were emerging, they would be taken up with service providers or brought to the CCG Quality Committee; these arrangements would be reviewed after the first year of operation. An alternative route for a dissatisfied patient would be through their GP, who would have a role as an advocate for the patient
- looking at the CCG governance structure, suggested that it was excessively complicated, that it needed an audit and risk committee, and that being split across three groups could result in no group taking responsibility.

  The Chief Clinical Officer explained that the CCG was still in transition, with the primary care trust still as the parent body. The CCG was reluctant to cause a major upheaval in structures, but prompted by the member's suggestions, officers were re-examining arrangements. The Chief Operating Officer explained that the CCG's Audit Committee had responsibility for all financial and operation risk; it was the committee to which both Internal Audit and External Audit made their reports. There was a statutory requirement that the CCG have a separate remuneration committee
- enquired what arrangements were in place to ensure equality of clinical care across the CCG area. Officers said that for example the LCGs that made most use of Addenbrooke's (CATCH and Camhealth) tackled Addenbrooke's problems with CCG support, including strategic meetings led by the Chief

Clinical Officer. The CCG had responsibility for all LCGs, and conducted quarterly performance reviews with each LCG. An escalation regime was in place, under which the initial response to LCG problems would be to provide more support, but if necessary, the CCG had the right to withdraw some of the LCG's delegated powers

- asked whether the CCG structure corresponded to what the Government had meant by putting the health service in the hands of local GPs, and asked what the difference was between the CCG and the primary care trust, apart from a more complicated structure. The Chief Clinical Officer said that changes had been evolving in Cambridgeshire since 2009, with clinicians now leading decisions on how services were to develop; for example, the mental health service redesign had been clinician-led under delegated responsibility from NHSC. It was complicated to capture the level of local involvement, and the presentation's focus on governance arrangements made the CCG organisation appear top heavy, but the old order had been turned upside down – instead of one GP serving on the board of NHSC, local GPs were running their LCG board.

Change in running order: As the previous items had taken longer than expected, the Committee agreed to the Chairman's suggestion of taking the Health and Wellbeing Strategy next, followed by the Forward work programme.

92. CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

The Cabinet Member for Health and Wellbeing, Councillor Steve Tierney, introduced a report on the Cambridgeshire Health and Wellbeing Strategy, which had been agreed in its final form by the Cambridgeshire shadow Health and Wellbeing Board at its meeting on 11th October 2012. He thanked those members who had responded to his earlier request to seek feedback on the draft strategy from local communities; their efforts had been very helpful.

The Cabinet Member said that a whole new priority, Working Together Differently, had been added as the result of consultation, and the Overview and Scrutiny Committee's observations had also been included. The Director of Public Health, Dr Liz Robin, added that the process of action planning had already started; the first action plan would be taken to the shadow Health and Wellbeing Board in January 2013.

Commenting on the report, individual members

- looking at the reference in priority 3 to encouraging healthy lifestyles "while respecting people's personal choices", suggested that people must take responsibility for the choices they made, including in drug and alcohol consumption, which cost money and were detrimental.

  The Cabinet Member replied that it was necessary to find a balance between leaving people to make their own choices and intervening in the interests of their health. The Director of Public Health added that the background science and knowledge showed that if people were to change, it was important that they felt motivated and wanted to make that change

- pointed out that for it to be useful, a public health strategy needed to target those people who needed help, and that the language in the report was not always helpful, because some things were not always realistic choices for an individual, but were responses to life circumstances. The Cabinet Member said

that the priority was to help those in the poorest circumstances most quickly; the intention was to help people to be healthy, but without interfering in their choices. A member pointed out that when somebody was unable to buy fresh produce because it was not available locally, this was not a free choice

- suggested that the report's use of percentages was unhelpful, e.g. "most people (96%) were happy with the strategy overall", when 52 of the 234 responses had come from local groups rather than individuals. The Cabinet Member responded that the percentages had been given under the consultation findings, and that these results were all that was available to form a picture of people's views
- welcomed efforts to engage people in responding to the consultation, though the overall numbers responding had been low; it was necessary to consider how to conduct consultation more effectively. The Director of Public Health pointed out that many of the responses had been made on behalf of a larger number of people
- noting that respondents' postcodes had been obtained, asked whether it might have been helpful to ask about income or employment. It was however pointed out that asking for too much personal detail could discourage people from responding
- expressed some concern that the strategy's priorities had been influenced by the age profile and special interests of the respondents
- noted that the chart showing the age profile for unplanned hospital admissions (figure 2 of the strategy) included admissions for maternity
- welcomed the commitment to seeking evidence-based solutions, commenting that people did not always appreciate that assembling proper evidence required time, for example five years rather than one, and that evidence-based solutions could be derailed by a public view that did not take evidence seriously – there was a need for public education
- pointed out that there was a budgetary cost to running a prevention strategy, and that spending on prevention could benefit other organisations' budgets; it was necessary to move away from silo budgeting. The Cabinet Member pointed out that the Health and Wellbeing Board was a mechanism for bringing partners together to work together; one sign of its long-term success would be if budgets were to be shared between the partners
- drew attention to the fact that the element of priority 3 that dealt with promoting sexual health referred only to pregnancy-related issues, and omitted any mention of the sexual health of lesbian or gay people; it was likely that sexually transmitted disease was of greater concern than pregnancy to gay men. The Cabinet Member acknowledged the point
- suggested that it might be appropriate to develop some sort of community contract, setting out what the local authority would do and what the individual would do – this approach had been seen to work well with some groups. The Cabinet Member invited the member to give him a more detailed proposal and undertook to look into it

Several members explicitly welcomed the document, describing it as a good document, highly aspirational, and very comprehensive. The Cabinet Member said that it was largely a strategic document; the next stage would be to look at outcomes and action planning from January 2013 onwards.

93. FORWARD WORK PROGRAMME

a) Committee Priorities and Work Programme 2012/13

The Committee reviewed its work programme. The Chairman advised that the next meeting, on 13th December, would be devoted to the Business Plan (known in previous years as the Integrated Plan), unless some other urgent business were to arise which would also demand the Committee's attention.

Discussing the business plan process, members pointed out that the Committee now had an overview role, so it was particularly important that it received information early enough to enable it to influence the emerging plan. It was suggested that it was important for the chairmen of all five Overview and Scrutiny Committees to get together and try to look at priorities for savings; the Chairman advised that such meetings had taken place in previous years, but had not gone into proposals in detail. Others commented that it might be helpful if the group did not consist solely of Overview and Scrutiny chairmen.

Presenting officers were reminded that, at the meeting, it was not necessarily productive to go through material in detail which had already been supplied to members in advance.

b) Cabinet Agenda Plan

A member drew attention to the Community Right to Challenge (on the Cabinet agenda for 27th November) and the Cambridgeshire Statement of Community Involvement (18th December), and in relation to the Transport Strategy for Cambridge and South Cambridgeshire Draft Strategy (28th May 2013) pointed out the importance of transport in relation to accessing health care.

94. CALLED IN DECISIONS

There were no called in decisions.

95. DATE OF NEXT MEETING

The next meeting of the Committee would be held at 11am on Thursday 13th December, preceded by a preparatory meeting for members of the Committee at 10.00 am.

Members of the Committee in attendance: County Councillors K Reynolds (Chairman), N Guyatt, G Heathcock (substituting for Cllr Batchelor), C Hutton, G Kenney (Vice-chairman), V McGuire, P Reeve, P Sales, S Sedgwick-Jell and F Yeulett; District Councillors S Brown (Cambridge City), R Hall (South Cambridgeshire) and R West (Huntingdonshire)

Apologies: County Councillors S Austen, J Batchelor and F Whelan; District Councillor M Cornwell (Fenland)
Also in attendance: County Councillor S Tierney

Time: 10.05am – 12.35pm
Place: Kreis Viersen Room, Shire Hall, Cambridge

Chairman