ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Cambridgeshire County Council

19th March 2013

Action

109. DECLARATIONS OF INTEREST

None

110. MINUTES OF THE LAST MEETING – 5th FEBRUARY 2013

The minutes of the meeting held on 5th February 2013 were confirmed as a correct record and signed by the Chairman

111. OVERVIEW AND SCRUTINY REVIEW OF DELAYED DISCHARGE AND DISCHARGE PLANNING – DRAFT REPORT AND RECOMMENDATIONS

The Committee considered the draft report and recommendations of the member-led review into delayed discharge and discharge planning. Councillor Martin Curtis, Cabinet Member for Adult Services, and Claire Bruin, Service Director: Adult Social Care, attended to respond to members' questions and comments. Also in attendance were

- Andy Vowles, Chief Operating Officer, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
- Tom Bennett, Director of Operations, Addenbrooke's Hospital
- Richard O'Driscoll, Complex Discharge Transformation Manager, Cambridge University Hospitals NHS Foundation Trust (CUHFT).

Apologies were received from Cambridgeshire Community Services NHS Trust (CCS) officers Matthew Winn, Chief Executive, and Karen Mason, Head of Communications.

Speaking as Chairman of the review group, the Vice-Chairman introduced the report. She described the group's work as interesting, time-consuming and wide-ranging, and said that their impression had been of a muddle. All the staff involved were trying hard to do the right thing about delayed discharge, but their efforts did not co-ordinate with each other very well.

The Cabinet Member acknowledged that the review report contained much of value. However, he expressed two main concerns: a number of recommendations (such as the first one, about key agencies working together), related to actions that were already being undertaken, and there was no acknowledgement of the very considerable cost implications of implementing some of the recommendations. He also said that there were two areas which had received insufficient attention, admissions avoidance and fines for delayed transfers of care (DTOC). Admissions avoidance had been a topic of discussion recently for senior County Council

members and officers, because there were huge savings to be made by not admitting people to hospital unless it was essential that they be there. Imposing fines for DTOC was unhelpful, particularly where the agencies involved were already working together, as was the case in Cambridgeshire. In some parts of the country, fines were not being charged, and there was perhaps a case for ending fines locally, though he did not wish to commit other organisations to this.

The Service Director echoed the Cabinet Member's points, stressing that it was necessary to recognise how the spending suggested by the report be managed under current cost restraints. In reply to a member's comment that the problem of DTOC had not yet been resolved, the Cabinet Member accepted the point but said that joint working at senior management and operational level was greatly improved and underlying issues were starting to be addressed.

Several members of the review group made various points, including that

- the report had been based on evidence found by the review group; at the time members had been looking into DTOC, subsequent action had not yet started to take effect
- Cambridgeshire Overview and Scrutiny members would not be the only ones to identify a need to address DTOC, as DTOC was also a national issue, and it was necessary to keep drawing attention to it as part of the national debate
- the task of the review group had been to report on what it had seen; it was for Cabinet to look at the question of resources, and for politicians in general to make the wider national point
- the cost of implementing the review's recommendations in relation to IT provision should be compared with the cost of the 600 operations cancelled last year as a result of DTOC.

Responding to these points, the Cabinet Member said that it was indeed important to highlight the issue. Addenbrooke's Hospital had said last year that DTOC had cost the hospital £12m, but the IT being suggested by the review group could not be delivered for this amount. He suggested that the report might usefully have included examples of successful implementation of IT solutions elsewhere; he wished to see a local, not a national IT solution, but it was wrong to ignore current financial constraints.

The CCG's Chief Operating Officer said that the report made useful points about DTOC and the different agencies involved. He emphasised that DTOC was a priority issue for all the CCG's partners, and as the report made clear, was a complicated area. He drew attention to two developments

- a regular workstream had recently been instigated, involving the Chief Executive of Addenbrooke's, the Accountable Officer of the CCG, and the County Council's Executive Director of Children and Adult Services
- significant additional resources were being put into addressing DTOC, and the CCG was putting resources into provision of discharge beds, including a contract with BUPA; over £200k was being put into DTOC over the winter.

He added that efforts were being concentrated on Addenbrooke's. Although it was a county-wide problem, the issues at Hinchingbrooke Hospital, though complicated, were less complex than those at Addenbrooke's. Regular discussions took place with Hinchingbrooke, but not at the most senior level.

Addenbrooke's Hospital's Director of Operations welcomed the report and thanked members for their interest in the subject. The most recent weekly count had shown that there were 50 patients in Addenbrooke's who did not need to be there, and 20 patients awaiting operations had been turned away the previous day. With the hospital full, it was necessary to resolve the problem of DTOC urgently.

CUHFT's Complex Discharge Transformation Manager explained that he was based at Addenbrooke's but employed by four organisations, including the County Council and the CCG. He drew attention to the growth in the number of over-85-year-olds admitted to hospital (about 9% a year for the last two years) and agreed that all parties needed to work together. He said that this was already happening; operational staff were in daily dialogue with each other, in addition to the regular meetings at Chief Executive level. All parties recognised the need to plan services in such a way that alternatives to hospital admission were readily available.

In reply to members' questions, the Addenbrooke's Director of Operations said that

- the fact that Addenbrooke's was a centre of excellence did have an impact on the hospital, but it planned its capacity to deal with this area of work. For example, it was a centre of excellence for trauma, so the emergency department had been extended, two new operating theatres had been built, and a mental health ward had been converted to accommodate these patients
- efforts were being made to expand the use of day treatment as an alternative to an overnight stay wherever possible, including establishing day surgery and day beds in e.g. Ely
- to speed up the discharge process, efforts were being made to ensure that patients received their discharge letter and drugs promptly on the day of discharge; the aim was to prepare draft documents the day before discharge
- delays in offloading ambulances in recent months had largely been caused by the hospital having insufficient beds available; it was necessary to address the problem of ambulance turnaround times urgently because there was only a limited number of ambulances. Measures to improve turnaround included ensuring that the only ambulances to drive past another hospital were ones with patients whom Addenbrooke's had agreed to receive, and opening up day-patient areas to inpatients overnight.

The CUHFT Complex Discharge Transformation Manager replied to members that

- members were right to draw attention to difficulties caused by incompatible IT systems. His role included improving the flow of information and patients
- as part of an attempt to improve matters, GPs, CCS and Addenbrooke's were all being encouraged to use the NHS's SystmOne, which allowed the transfer of information between its users
- joining up Social Care and Health information remained a challenge; the CCG was looking at how the number of interfaces could be reduced but had not yet reached a solution
- ideally, double funding would be available for a transition period while the essential task of shifting resources into the community was completed, but such funding was not available.

Mick Simpson, Interim Chief Operating Officer, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) said that CPFT was aware of ongoing activity in Addenbrooke's through its involvement in the Delayed Care Network, and itself

currently had eight patients whose transfer of care was delayed. Because there could be a mental health aspect to DTOC elsewhere, CPFT was establishing a liaison psychiatric service.

The Cabinet Member stressed that DTOC was not a problem that Cambridgeshire could solve on its own. The Council was working through the County Councils' Network at a national level to put pressure on the Government. Locally, it was important to avoid hospital admission wherever possible, and to increase integration between partner organisations.

Speaking at the Chairman's invitation, Alison Pegram (a member of COPE, Cambridgeshire Older People's Network, and of LINk, the Local Involvement Network) drew on her own experience of interim care following a fracture. The Addenbrooke's short term assessment and rehabilitation team (START) had made the arrangements well, but she had still found herself having to rely on neighbours for assistance. She raised doubts about transferring so much into a community setting, and pointed out that she had needed treatment rather than care or reablement. She suggested that orthopaedic and neurological recovery areas might usefully be provided.

Robert Boorman of COPE echoed these concerns, reporting that another COPE member had been provided with care on discharge after breaking a leg, but had needed additional help while bed-bound. He asked how many people requiring care were self-funded, and whether they knew where to find that care.

The Vice-Chairman thanked members and officers for their contributions. Commenting on what had been said, she acknowledged that much had improved since the review group had started its work. Hospital, social work and community staff were communicating better and the START team was clearly having an effect; a seamless system depended on people having respect for each other throughout the system. However, IT problems had still not been solved, and sufficient community support needed to be made available. She commended the report

Members thanked the Scrutiny and Improvement Officer for producing a report of such clarity despite its considerable length. The Chairman thanked the visiting health professionals for their contributions to the meeting.

The Committee agreed the report and recommendations, and resolved to submit the report in its current form to the County Council Cabinet, Cambridgeshire and Peterborough Clinical Commissioning Group, Cambridgeshire Community Services NHS Trust, Addenbrooke's, Hinchingbrooke and Peterborough Hospitals, and Cambridgeshire and Peterborough NHS Foundation Trust.

112. ACCESS TO IN-PATIENT MENTAL HEALTH CARE

The Committee considered a report from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) on the availability of urgent mental health inpatient beds for working age adults and older people, in the light of two recent instances where members had become aware that individuals had experienced difficulty in accessing a bed.

Mick Simpson, Chief Operating Officer, CPFT, introduced the report. He explained that there was a move away from larger units, and hospitalisation in psychiatric units was to be avoided as far as possible. The 3-3-3 (three days, three weeks, three months) acute care model provided a clear care pathway, with timescales

known to service users and staff at each stage. It had been introduced successfully in the north of the county, and was about to be implemented in Cambridge. An acute ward at Fulbourn Hospital had closed from 8th February to enable alterations to be made for the 3-3-3 model; small dormitory accommodation was being replaced by single rooms. The ward was due to reopen on 7th May and the 3-3-3 model would be fully implemented on 27th May.

Turning to the two specific cases referred to by members, the Chief Operating Officer said that the younger person had been given a bed with a local provider for a few days because the patient mix in the nearest CPFT unit would not have been of therapeutic benefit to that person. The older person's need for an acute bed had coincided with a period of pressure on older people's beds in both Cambridge and Peterborough (additional beds had been opened at the Edith Cavell Hospital), and when admission was required in those circumstances, a psychiatric bed would be found, but it would not necessarily be local.

The Chairman thanked him for this explanation, and recalled that when Acer ward was closed in Huntingdon, the Joint Mental Health Overview and Scrutiny Committee had been assured that there would be adequate capacity for crisis resolution and admission in the county. Asked whether this prediction had been over-optimistic, the Chief Operating Officer said that Acer had been an adult ward, not an older person's one, and that part of the redesign of services had been undertaken in acknowledgement that a small cohort of patients were being very poorly served by the unit. Some of the resources had been used to open the Springbank Unit in Cambridge for women with personality disorders. The problem with capacity in Peterborough related to older people's beds.

John Ellis, Mental Health Commissioning and Contract Lead for the CCG, said that no reduction in acute beds had been proposed at the time Acer had been closed. The closure had related to the safety of patients in an isolated unit, and the loss of Acer beds was balanced by increased capacity in Peterborough. The pressure at Fulbourn Hospital was short-term; as commissioners, the CCG believed that there was sufficient capacity.

The Commissioning and Contract Lead said that the evaluation report on the 3-3-3 system had been shared with the joint Cambridgeshire and Peterborough Overview and Scrutiny working group on mental health and could be made more widely available. He welcomed and would take up the feedback from service users and carers. Following the member-led review of dementia care, each Local Commissioning Group (LCG) was developing proposals for multi-disciplinary working on dementia.

In answer to members' questions, the Chief Operating Officer said that

- apparent delay in finding a bed could in some cases be due to the Crisis Resolution and Home Treatment team (CRHTt) working with the service user to see if it would be possible for them to stay in their own home; if a person needed admission, they would be found a bed
- in recent months, a consultation had been conducted on the redeployment of ward staff in Cambridge, and no recruitment had taken place, leading to over-reliance on bank staff. Recruitment to 30 posts was now taking place
- it was undeniable that beds had been closed; this largely reflected expectations round patients' needs, but also related to resources, as in-patient treatment was the most expensive form of care

- CPFT teams were working with other agencies, such as nursing homes and providers of supported housing, and there was probably mental health capacity to meet the demand, with a slight caveat around provision of nursing care for people with dementia
- the obligation under the Mental Health Act was on an approved mental health practitioner to find a bed, rather than on the mental health trust to provide one, unless directed to do so by a court
- it was necessary to acknowledge that the evolution of CRHTts nationally had placed additional demands on carers. Out of hours support was now in place for carers, though only up to 10pm; this would be incorporated into the 24-hour Advice and Referral Centre currently being developed
- there was considerable fluctuation in out of area use of beds; there were more people from outside the area using CPFT beds than Cambridgeshire and Peterborough residents using other areas' beds, but there was no discernible annual pattern. Part of the inward movement could be caused by Fulbourn offering more specialised skills than could be found in some other places
- periodically there was insufficient capacity for young people's psychiatric services; occasionally a young person would present with very extreme needs requiring quite secure facilities, which were not available in the area
- the need for in-patient beds for young people fluctuated. Access for young people to cognitive behavioural therapy (CBT) was being increased, though there was an issue with finding sufficient qualified staff, and a CRHTt was being developed for them. It was usually more positive for young people to resolve their issues within their own social setting than on an in-patient ward.

The Chairman thanked Mick Simpson and John Ellis for attending the meeting.

113. ADULT SOCIAL CARE: REVIEWING PROGRESS AGAINST THE INTEGRATED PLAN 2012/13

The Committee received a report providing updates on progress in meeting the savings requirements of the Integrated Plan (IP) and on business planning for 2013/14, and identifying whether the savings were having any adverse impact on service quality. The Cabinet Member for Adult Services and the Service Director: Adult Social Care attended to present the report and respond to members' questions and comments.

The Cabinet Member said that the financial position was good news, reflecting a considerable achievement by County officers and by CCS. As a result of the projected year-end underspend on Adult Social Care (ASC), it would be possible to slow down the rate of change in mental health services in 2013/14. There had been some increase in the level of complaints, but not to a significant extent in view of the changes that had been taking place. The level of complaints was not necessarily a reflection of concern about care provider issues, though one organisation had had issues drawn to its attention. The Cabinet Member expressed dissatisfaction with the proportion of adults with learning disabilities in employement, though the performance of 5.9% was in the middle of the national range; he wanted to look at what more could be done in that area, including the Council setting an example as an employer.

In the course of examining the report, members

- observed that progress in implementing savings had been patchy across ASC, and asked how the areas of poorer financial performance were being addressed. The Cabinet Member said that prevention, transformation and the reduction of unit costs were important in delivering what was a demand-led service. An underspend in one part of the budget, e.g. Learning Disabilities, was used to offset an overspend elsewhere. This would become increasingly difficult as flexibility within the budget was reduced; for example, there had been a budget line of £50k for provision of equipment for people with profound deafness, but this had been removed because in practice equipment was being supplied in response to need
- reported that they had experienced difficulty in getting information from Human Resources about how many people with a learning disability were employed by the Council. The Cabinet Member said that he would look into this. He had seen an example of a council setting up a catering service employing people with a learning disability; the Council should put pressure on itself to do more as an employer **MC**
- commented that they were frequently reassured that the adult social care database SWIFT was improving, but difficulties with invoicing continued. The Service Director explained that the system that generated invoices was the e-Business Suite. She was raising with colleagues the question of the complexity of the layout of the resulting invoices. The Cabinet Member said that he was aware of and raising the issue too
- noted that CCS had increased the number of staff it employed for reablement (Cambridge City, East Cambridgeshire and South Cambridgeshire had a full complement in place by the end of November 2012), and the Hinchingbrooke team had also increased. However, the independent home care agency sector had not increased capacity to enable it to take over the care of service users once they had reached the end of the reablement period. Two agencies had brought in staff from elsewhere in Europe; discussions were taking place about bringing people in rather than employing local staff
- welcomed the underspend and sought clarification of the Cambridgeshire Community Services NHS Trust (CCS) overspend. The Service Director explained that a savings expectation of £1.2m from Council-supplied funding had been placed on CCS for 2012/13. Half the saving would be completed in the current year, and the remainder was expected to be achieved in 2013/14. The savings expectation was not linked to the question of pensions for staff transferring to the Council; this issue was complicated by the fact that some staff had moved to the NHS pensions scheme while they worked for CCS
- noted that a number of the complaints received had been related to one issue, which had now been addressed with the organisation concerned.

The Chairman thanked the Cabinet Member and Service Director for their contributions to the work of the Committee over the past four years. They expressed appreciation for the Committee's efforts, including the valuable contribution made by the member-led reviews.

114. CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP

The Committee received an update on the progress and plans of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). Andy Vowles, the CCG's Chief Operating Officer, and Jessica Bawden, Director of Corporate Affairs, attended to present the report, and conveyed apologies for absence from Neil Modha, the Accountable Officer.

Members noted that

- the CCG was taking responsibility for the management of much of the commissioning previous undertaken by NHS Cambridgeshire, the Primary Care Trust (PCT), though it would not be commissioning primary care services (e.g. dentistry and pharmacy) or specialist care
- CCGs were unique amongst public bodies in that they were both statutory bodies and member groups. The Cambridgeshire and Peterborough CCG had a membership of 109 GP practices, and was clinically led at both CCG and LCG (Local Commissioning Group) level
- the CCG had received a very challenging financial allocation for 2013/14. If hospital admission rates continued to rise, the CCG would exceed its allocation, so was seeking to enhance admission avoidance measures and to develop a stronger set of services round GP practices.

In the course of discussion, members

- noted that the NHS National Commissioning Board (NHS CB) had based CCG allocations on PCT allocations. The issue locally was that this understated the effect of population growth, particularly as NHS CB had decided not to shift the weighting from deprivation to demography. The amount of the allocation, £854m, was on the boundary between what had been the CCG's worst-case scenario and its most likely case
- enquired about the £42m funding shortfall that would result if the CCG took no action to address it. Members were advised that the current gap was in the area of £25m and would never be a fixed sum because of the variable costs arising from the obligation to fund hospital admission work. The CCG was still aiming for an efficiency plan of £28.6m in 2013/14 to provide some headroom for subsequent initiatives
- welcomed reference to housing, pointing out that appropriate housing, including co-housing and adaptations, was an important element in reducing delayed transfers of care. Other organisations beyond the CCG needed to be looking at this too
- enquired what steps were being taken to reduce the frailty of the "frail elderly". Members were advised that there were various business cases around the use of multi-disciplinary teams, and a number of GP practices were coming together to try to identify patients at increased risk of unplanned hospital admissions and to plan measures to meet their needs proactively; the issue was being tackled at LCG level, rather than having one unified CCG approach
- developments in joint commissioning for services for older people were planned from April 2014. The County Council and the Older People's Programme Board would be involved in this work

- asked how the CCG was managing links to partnership groups that had previously been attended by the PCT, such as Local Strategic Partnerships and Local Crime and Disorder Partnerships. The Committee was advised that the CCG was working with the Director of Public Health to identify the groups that needed input from CCG, LCG or Public Health, and who should most appropriately attend each group. LCG members who attended meetings would report back to the CCG on a quarterly basis. Members were asked to tell the CCG if they became aware of anything that had been neglected in the transition phase from PCT to CCG
- drew attention to the importance of having a joined-up IT infrastructure. The Committee noted that this was an issue that required input from LCGs. A development session was being held on 19th March for the chairs of all LCGs
- noted that the national headquarters of NHS CB were in Leeds. It had four regional offices, and 27 local area teams (LATs); the Anglia LAT was based in Fulbourn and covered Cambridgeshire, Peterborough, Norfolk and Suffolk. The NHS CB could be invited to attend the Overview and Scrutiny Committee, and was a statutory member of the Health and Wellbeing Board.

The Chairman thanked both CCG officers for attending this meeting, and for the good working relationship that had been established between the Committee and the CCG / NHS Cambridgeshire over the past four years.

115. REVIEW OF COMMITTEE ACHIEVEMENTS 2012/13 AND SUGGESTIONS FOR THE NEW OVERVIEW AND SCRUTINY COMMITTEE

The Committee reviewed its activities over the past four years. For the next Overview and Scrutiny Committee, members suggested that it might wish to

- follow up previous member-led reviews to ensure that recommendations and targets were being met. Continuing problems with SWIFT highlighted the need to revisit that review
- establish a mentoring system, under which experienced members of the Committee could offer support and guidance to new members on a one-to-one basis. One member, who had originally joined the Committee part-way through its four-year term, reported that she had benefitted greatly from support she had received from another member of the Committee, who happened not to have been of the same political group
- scrutinise the performance of Local Commissioning Groups, bearing in mind the different pressures and different levels of experience across the county.

District members of the Committee expressed thanks and good wishes to County members. Members thanked the Chairman and Vice-Chairman for their work and patience, and thanked the Scrutiny and Improvement Officer and the Democratic Services Officer for providing good support to the Committee. The Chairman thanked members for the disciplined way in which they had conducted business, and commended the Committee's apolitical approach to Overview and Scrutiny to the incoming Committee.

116. CABINET AGENDA PLAN

The Committee noted the Cabinet Agenda Plan.

117. CALLED IN DECISIONS

There were no called in decisions.

Members of the Committee in attendance: County Councillors K Reynolds (Chairman), S Austen, J Batchelor, C Hutton, G Kenney (Vice-Chairman), V McGuire, P Sales, S Sedgwick-Jell, F Whelan and F Yeulett; District Councillors M Cornwell (Fenland), R Hall (South Cambridgeshire) and R West (Huntingdonshire)

Apologies: County Councillors N Guyatt and P Reeve; District Councillor S Brown (Cambridge City)

Also in attendance: County Councillor M Curtis

Time: 10.00am – 12.50pm
Place: Kreis Viersen Room, Shire Hall, Cambridge

Chairman