Overview and Scrutiny Committee

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Cambridgeshire County Council

18th July 2013

Action

1. CONFIRMATION OF CHAIRMAN AND OF VICE-CHAIRMAN

The Committee noted the appointments of Councillor Kilian Bourke as Chairman and Councillor Anna Bailey as Vice-Chairman of the Committee for the municipal year 2013 – 14.

2. DECLARATIONS OF INTEREST

District Councillor Sutton declared an interest as a Mental Health Act Manager, which was an unpaid role in the National Health Service (NHS). He also declared an interest in that his wife worked for the NHS. County Councillor Smith declared an interest in agenda item 8 (minute 8) as a member of the Cambridgeshire and Peterborough Fire Authority.

3. MINUTES OF LAST MEETING

The minutes of the meeting held on 19th March 2013 were confirmed as a correct record and signed by the Chairman.

4. TERMS OF REFERENCE AND WAYS OF WORKING

The Committee received a report providing it with background information about the remit of the Committee and possible ways of working. Members noted that Council on 16th July 2013 had amended the terms of reference by updating the reference to legislation, and by agreeing to give the Committee the power of referral of health service proposals to the Secretary of State for Health. This delegation restored to the Committee the power of referral that it had had under previous legislation up to 1st April 2013.

5. CO-OPTION OF DISTRICT AND CITY COUNCIL MEMBERS

The following District and City Council representatives were co-opted:

Members	Substitutes
Simon Brierley, Cambridge City	Zoe Moghadas, Cambridge City
Mike Cornwell, Fenland	Will Sutton, Fenland
John Pethard, Huntingdonshire	Robin Carter, Huntingdonshire

Members noted that South Cambridgeshire members were due to be nominated before the Committee's next meeting on 12th September, and that because East Cambridgeshire District Council no longer had any scrutiny committee, it was now not possible to co-opt an East Cambridgeshire member onto the Committee.

6. THE FUTURE COMMISSIONING OF OLDER PEOPLE'S SERVICES

The Committee received a report updating it on developments in Older People's Services, including the Older People's Programme led by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), and arrangements for the transfer of older people's services from Cambridgeshire Community Services NHS Trust (CCS) to Cambridgeshire County Council (CCC). Councillor Fred Yeulett, Cabinet Member for Adult Services, presented the report. Also in attendance to respond to members' questions and comments were

- Claire Bruin, Service Director: Adult Social Care, CCC
- Andy Vowles, Cambridgeshire Chief Operating Officer, CCG
- Matthew Smith, Programme Lead Older People, CCG
- Matthew Winn, Chief Executive, CCS.

The Cabinet Member welcomed the report as giving an insight into the challenges surrounding the provision of Older People's Services; these included changes in demography, increased acuity of need, reduced resources, and forthcoming changes in legislation. Members noted that Cabinet had already agreed that some or all of the Older People's Services provided by CCS would be transferred to County Council management, and that CCC had had an input into the success criteria for the Older People's Programme. The Cabinet Member reported that, because reablement was one of the mainstays of service delivery, at a recent meeting with East of England Lead Members he had asked that some work on reablement benchmarking be undertaken in the region.

Responding to questions, CCG Officers said that

- Older People's Services were the highest priority area for the CCG
- the CCG was now focussing on outcomes, an approach which would be better served by a multi-year model of contracts for services than by the historic pattern of a contract with a single provider for a period of one year
- the core services for people aged over 65 were within the scope of the procurement exercise (including hospital and mental health); discussions were taking place about whether or not continuing healthcare would be included
- there was a difference between structural and functional integration of social care; a shared commitment on the part of CCC and CCG did not necessarily mean shared funding. The question was always how services could work best at each local level
- it was not yet possible to say whether there would be any break clauses in the five-year contracts, because no draft contract had yet been developed, but it was standard practice to include a requirement that performance standards be met, and unlikely that there would be no element of break clause
- the principal consideration in framing contracts would be whether desired outcomes were being met, rather than having rigid lists of what was included and excluded. The use of outcome-based contracting was uncommon in the UK, but occurred more frequently elsewhere. Members urged that contracts should include clear break clauses and traceable and accessible performance metrics
- it was likely that ways of varying contracts would be built in, because of the level of uncertainty, for both CCG and providers, about future developments, such as potential changes in legislation.

- despite there being fewer providers, ways of giving service users an element of choice could be explored. The CCC Service Director clarified that the finance for the CCG procurement exercise was separate from the Social Care funding used to support direct payments
- though it would probably not be possible to allow service users to opt out of CCG arrangements completely, it might prove possible to construct a health corollary to social care direct payments
- to avoid a scenario where providers might be reluctant to take on difficult or complex cases, the preferred approach was to proceed on a population basis, under which the provider would be contracted to provide services for all the patients in a specified area
- a team was working on the development of outcome measures, such as patient and carer satisfaction, and whole-system efficiency (e.g. avoiding unnecessary admissions, reducing length of stay, avoiding unnecessary readmissions); evaluation could include benchmarking for some measures, e.g. bed days, and improvement in e.g. patient satisfaction. The most complex area to assess was patient-reported outcomes
- in drafting success criteria for supporting people to maintain their independence, ways were being explored of incentivising contractors to find people at severe risk of sudden deterioration; outcome measures could include reducing the number of people going into long-term residential care
- the draft success criteria listed in the report were high-level descriptions; metrics would be included in contracts, and a set of success criteria was being developed and tested with clinicians. The Programme Lead offered to supply further details outside the meeting **MS**
- the CCG had not laid down how the aim of having a single point of contact for an older person using services was to be achieved, because it wanted providers to say how this would be done. The Service Director: Adult Social Care commented that this might challenge CCC's Contact Centre as the point of contact for Adult Social Care services
- the CCG had no fixed view on the size of organisation acting as Lead Provider. There were arguments for and against having one contract for the whole area, but the key consideration was how operational planning happened at the very local level; it could be appropriate to have different ways of responding, and of reaching outcomes, across the county.

The Chief Executive of CCS, in reply to members' questions, advised that

- Cambridgeshire Community Services NHS Trust would remain in existence to deliver services for as long as necessary
- children's services and ambulatory services were not included in the current procurement exercise
- CCS staff would be transferred under TUPE (the Transfer of Undertakings (Protection of Employment) Regulations) where appropriate; the present uncertainty for staff was unfortunately not uncommon in Local Authority and NHS services. The Chief Executive offered to supply a breakdown of staff affected; as well as its work in Cambridgeshire and Peterborough, CCS also provided some services in Luton and Suffolk **MW**

- despite the uncertainty, some performance metrics were improving, including sickness rates, and it was no more difficult to recruit staff than it had been previously; efforts were being made to provide appropriate support to staff through the time of transition, and to give them greater certainty
- work to mitigate the risks identified in the CCC risk register for the project was focussing on the risks identified as having the highest probability of occurrence. The Chief Executive offered to supply the detail in the risk register, which was a public document. **MW**

The Chairman thanked the presenters for their contributions; the Committee would be following up some of the areas discussed in more detail at a future meeting.

7. DELAYED DISCHARGE REVIEW – RESPONSES FROM NHS BODIES

The Committee received a report setting out the responses to the review of delayed discharge and discharge planning undertaken by members of the Committee in 2012/13. Members noted that the review's main outcomes had concerned the discharge planning process, service capacity, and admission avoidance. The responses from local NHS bodies would be considered at this meeting and the following one. Officers replying to questions on the responses from the first three organisations were

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
    - Andy Vowles, Cambridgeshire Chief Operating Officer
    - Nigel Smith, Local Chief Officer
- from Cambridgeshire Community Services NHS Trust (CCS)
    - Matthew Winn, Chief Executive
    - Jackie Galwey, Community Unit Manager – Cambridge and South Cambs
- from Cambridge University Hospitals NHS Foundation Trust (CUHFT)
    - Fran Cousins, Chief Operating Officer
    - Richard O'Driscoll, Complex Discharge Transformation Manager.

Introducing the CUHFT response, the Transformation Manager said that the Addenbrooke's programme had started 12 months ago, working with all the key partners. Three factors had made a difference in improving delayed discharges: the expansion of community rehabilitation and of reablement, and service redesign, including redesign of Addenbrooke's own internal processes. The number of assessments waiting to be carried out was much lower, though variable, and had even been zero twice recently. More remained to be done, including working together with the County Council on purchasing residential and domiciliary care, rather than each organisation purchasing care separately. A key factor was supporting people in the appropriate setting, getting them out of hospital as soon as they were fit enough and putting in place a range of out of hospital services.

Speaking for CCS, the Community Unit Manager thanked the Committee for its members' interest in the topic of delayed discharge. Their work had shown the importance of all the organisations concerned working together, and of involving patients and carers. Reablement had been successfully developed in the south of the county, with 60% more people going through reablement compared with a year ago. 70% of participants experienced some benefits; 60% had no further care needs once the period of reablement was completed, and the remainder had reduced needs. The philosophy of reablement had been extended to other settings, for example seeking opportunities to enhance the independence of patients in interim beds. It was however necessary to reduce delays in setting up reablement.

The Local Chief Officer said that the CCG had been working with senior representatives from all partners through the Urgent Care Network, the aims of which included reducing delayed transfers of care. Through the Network's System Planning Group, work was being done to develop a co-ordinated, system-wide approach to responding to delays in transfers of care; the problem was not just about the number of patients, but about the flow of patients through the health system and how the system responded to a blockage in that flow. If necessary, the Group would meet weekly or even daily during the winter. The CCG had invested transformation funding for long-term improvement, including enhanced community nursing to avoid acute admissions; a further ten intermediate beds had also been commissioned in the past year.

Commenting on the organisations' responses to the review report, members

- enquired what was being done to address the situation of there being several different IT systems in use across the health and social care systems. The Complex Discharge Transformation Manager said that there had been numerous attempts to resolve this long-standing problem. He did not expect that it would be possible to have a single fully-integrated health and social care IT system. The primary care and acute hospital systems were becoming more integrated, and work was being done around making care information available to clinicians at the point of decision-making
- noted that the IT system used by Addenbrooke's could not give the County Council the function it needed in order to manage its spend, whereas its SWIFT system did have the necessary functionality
- drew attention to the increase of 19% in the level of admissions of over 85 year olds in the past two years, and asked whether the reasons for this might be associated with Whitehall's imposition of austerity measures two years ago.

  The Local Chief Officer said that higher pressure in the system might be one of the drivers for the increase, though he was not aware of the recession as a particular factor. Much work was focussed on trying to prevent problems escalating to the point where acute services were needed, but when over 85 year olds were admitted, it was necessary to get them through hospital quickly.

  It was pointed out that the County Council's criteria for providing services had not changed, and funding for adult social care had remained at much the same level. There was no clear link between the rise in admissions of older patients and any actions of the Council
- asked what was being done about getting ownership of the report's recommendations embedded in the different organisations, and requested that reporting should be against the report's recommendations in future.

  Members were advised that, under the governance arrangements outlined in the CCG response, each organisation identified a key owner on each aspect of the system plan, which went wider than just delayed transfers of care. The CCG was in a good position to act as a conduit for information to the Committee. The Community Unit Manager added that multi-disciplinary work was being developed at GP practice level in order to increase collaboration closer to the patient, with the aim of preventing avoidable admissions to hospital.

  The Chief Operating Officer said that the issue of delayed transfers of care had a high profile at Addenbrooke's, with monthly reports to the Board. Significant changes had been made in 2013, from over 100 bed days being lost each week

because of delayed assessments in early January to only three days being lost in the current week. This demonstrated how well aligned the organisations were to each other; the joint planning was having an impact, and the will, engagement and governance processes were all in place.

The Chairman thanked the officers for their comprehensive responses, and reminded both them and the Committee that work still remained to be done on this matter. The Committee would consider the responses from Hinchingbrooke and Peterborough Hospitals and from the Cambridgeshire and Peterborough NHS Foundation Trust at its meeting in September 2013.

8. EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST – PERFORMANCE AND PLANS

The Committee received a report on the performance and plans of the East of England Ambulance Service NHS Trust (EEAST). Members also considered the findings of Dr Anthony Marsh's governance review into EEAST's service. EEAST officers in attendance to respond to members' questions and comments were

- Chris Hartley – Assistant Director of Communications
- Simon King – General Manager Cambridgeshire
- John Knott – Clinical Operations Manager.

The Chairman thanked the EEAST officers for their report and asked whether the Trust had accepted all the recommendations of the governance review. The Assistant Director explained that the Trust had published a turnaround report in April 2013, and a new Interim Chief Executive had started work in December. The governance report had covered the same issues as the turnaround report, which acted as the overarching and prime plan for the Trust. The Trust had developed an action plan incorporating actions from the turnaround plan and the governance review. The action plan had been submitted to the NHS Trust Development Authority (TDA) within the required timescale (by 5th July), but no response had yet been received from the TDA.

In reply to members' questions, officers said that

- there had been huge changes made at EEAST, with not only the new interim Chief Executive but a new interim Chair of the Board appointed in May 2013. All five non-executive directors had resigned in late June 2013, and two interim non-executive directors had been appointed on 15th July
- the vast majority of the governance report's findings were accepted by the Trust; this was not a trust in denial. The new Chair of the Board and the new Chief Executive were both fully committed to turnaround
- progress was being made with recruiting additional substantive non-executive directors. These were remunerated posts for which people applied. The appointments would be made by the TDA and were subject to the Code of Practice of the Commissioner for Public Appointments
- the work of Clinical Operations included clinical audit, work with training, and clinical investigation. Clinical Operations dealt with all frontline staff regardless of grade
- discussions had already been started with partners such as Cambridgeshire Fire and Rescue Service (CFRS) about priorities and aims for improvement in order to minimise delays to other organisations from any delay in providing ambulance services e.g. at the scene of an accident. A meeting had been held with CFRS

but no meeting had yet been arranged with the Police, because the focus so far had been on internal engagement of staff, which had been time-consuming. The General Manager accepted a member's point that engagement with partners was taking a long time

- on a day-to-day basis, there was little engagement with the other emergency services, though when they were involved with each other, the input needed to be good. Partnership arrangements were already in place with Fire and Police; if EEAST went out to a Road Traffic Accident (RTA), the EEAST Operations Manager and the Fire Officer would debrief the whole team together. There was collaboration with Police in crime reduction, e.g. sharing information on recent drug-related calls, without breaking confidentiality
- although engagement with the other emergency services was not a day-to-day occurrence for emergency crews, EEAST managers were very aware of its importance
- the turnaround plan had identified the need to recruit 351 frontline staff. £5m had been invested from the Trust's budget in the previous year for services to support the front line, and plans were now being developed to divert £20m to the front line
- although the governance review had advised against recruiting further Emergency Care Assistants, the Trust was looking to recruit 67 new ECAs because this suited the Trust's model of delivery; the aspiration was to have a paramedic on every ambulance and in every car, but – in line with national opinion – it was not a good use of staff resources to use higher-grade paramedics in GP transport. A staff progression route had now been developed for ECAs
- routine, non-emergency patient transport was now run by the Clinical Commissioning Group, which set the eligibility criteria for the service
- in relation to the governance report's view that the Trust had lost focus on the strategic objective of its core business, the Chief Executive was clear that EEAST must focus on improving its 999 response, getting to patients and putting more vehicles on the road
- back-office savings were to be made and full-time HR support had been obtained to help managers manage levels of sickness on the front line. Practical steps included manager training about e.g. speaking to staff on their first day off sick, speaking to them on the day they returned to duty, and referring to occupational health where appropriate
- it was necessary to improve staff morale and engagement; staff were being empowered to take decisions locally
- some of the fluctuations in performance could be put down to poor recording; for example, some cases were being recorded as strokes that turned out not to be strokes, but they continued to be coded as a stroke. Staff were now being challenged and educated about the accuracy of data, and the Clinical Operations Manager checked the figures each month. Another factor could be that if there was a very small number of a particular type of incident such as a cardiac arrest adverse outcomes in the few cases could have a disproportionate statistical effect. The Clinical Operations Manager undertook to supply actual numbers of cases rather than percentages, and the Assistant Director undertook to supply much stronger data in the performance tables in any future report to members **JK, CH**

- difficulties were sometimes experienced in locating patients, particularly where the person calling was not actually with the patient or the patient was away from roads, for example in woodland. Mobile data technology was very helpful. in such cases, and there was usually no difficulty in finding patients where road name and house number were given
- one more full-time ambulance had been put on the road in Cambridgeshire in the last two months; the issue was staffing for vehicles, but 70 of the 200 new staff needed had already been recruited, and rotas had been redesigned to raise the number of ambulances available
- initiatives for Cambridgeshire included
    - working on delivering services in a way tailored to the local area; it was better for patients and more motivating for staff to keep resources local
    - renewing use of community responders, which had tailed off from previous levels; in the Ely, Littleport and St Neots areas, staff were running their own volunteer training sessions
    - a national innovation awards had been achieved in Cambridgeshire for work by Phil Lumbard, an Emergency Care Practitioner, to develop a falls service. This aimed to provide a thorough response to elderly callers who had fallen, and to avoid unnecessary admission to hospital.

The Chairman thanked the officers for their attendance and their candid answers. The General Manager extended an invitation to members to come out for a day with the Ambulance Service.

9. MEMBERSHIP OF REGIONAL JOINT OVERVIEW AND SCRUTINY COMMITTEE (OSC) ON LIVER METASTASES SURGERY PROPOSALS

The Committee received a report on plans for a regional Joint Overview and Scrutiny Committee to examine proposals for specialist surgery for liver metastases in the Norfolk, Suffolk, Cambridgeshire, Peterborough and North Bedfordshire area. Members noted that each authority had been invited to nominate three members, plus substitutes; nominations should be of County Councillors and made on a politically proportionate basis. A preliminary briefing for the joint committee was likely to be held in late July 2013.

The Committee agreed that names would be sought by email and the nomination of members would be reconsidered at the next meeting, on 12th September. **JB**

10. MEMBER LIAISON ARRANGEMENTS

The Committee received a report on arrangements for members of the Committee to liaise with lead County Council officers, with NHS organisations used by people in Cambridgeshire, and with Healthwatch Cambridgeshire. The Committee was invited to nominate liaison councillors for Adult Social Care, Public Health, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), other NHS organisations, and Healthwatch Cambridgeshire.

Councillors Hickford and Scutt expressed an interest in liaising with the CCG and Councillor Downes offered to liaise with Hinchingbrooke. Members noted that any liaison groups formed would be treated as working groups, with no requirement for political proportionality to be observed.

Because several members had already left the meeting, the Committee agreed

- that the Scrutiny and Improvement Officer would email County and District members and substitutes to seek volunteers as liaison councillors **JB**
- that the Committee would reconsider the nomination of liaison councillors at its next meeting, on 12th September.

11. FORWARD WORK PROGRAMME

a) Committee priorities and work programme 2013/14

The Committee considered its priorities and work programme for the municipal year 2013/14, including topics identified at the Committee's induction seminar in June 2013. Members commented that two major agenda items would be sufficient for the next meeting. The Chairman invited members to contact him, the Vice-Chairman or the Scrutiny and Improvement Office about any further suggestions for the work programme.

b) Cabinet agenda plan

The Committee noted the Cabinet agenda plan.

12. CALLED IN DECISIONS

There were no called in decisions.

13. DATE OF NEXT MEETING

The Committee noted that its next meeting was due to be held at 2.30pm on Thursday 12th September 2013.

Members of the Committee in attendance: County Councillors K Bourke (Chairman), P Ashcroft, A Bailey, R Butcher (substituting for Cllr Loynes), P Downes, S Frost, D Giles (substituting for Cllr van de Kerkhove), R Hickford , J Scutt, M Smith, M Tew and S van de Ven; District Councillors S Brierley (Cambridge City), W Sutton (substituting for M Cornwell) (Fenland) and J Pethard (Huntingdonshire)

Apologies: County Councillors M Loynes, K Reynolds, M Tew and S van de Kerkhove; District Councillor M Cornwell

Also in attendance: County Councillor F Yeulett

Time: 2.30pm – 5.40pm
Place: Shire Hall, Cambridge

Chairman