Agenda Item No: 2

HEALTH COMMITTEE: MINUTES

Date: Thursday 15th December 2016

Time: 2.00pm to 5.25pm

Present: Councillors P Clapp, D Connor (substituting for Cllr Kenney), L Dupre, L Harford, P Hudson, D Jenkins (Chairman), T Orgee (Vice-Chairman), M Smith, P Topping, A Walsh (substituting for Cllr Moghadas) and S van de Ven

District Councillor M Abbott (Cambridge City)

Apologies: County Councillors G Kenney, M Loynes, Z Moghadas, P Sales
District Councillors M Cornwell (Fenland), A Dickinson (Huntingdonshire) and S Ellington (South Cambridgeshire)

277. DECLARATIONS OF INTEREST

There were no declarations of interest.

278. MINUTES – 10 NOVEMBER 2016 AND ACTION LOG:

The minutes of the meeting held on 10th November 2016 were agreed as a correct record and signed by the Chairman.

Updating the Committee on the Action Log, the Director of Public Health reported that

- Minute 271: it would be possible to trial the inclusion of information on financial savings relating to smoking cessation in the Annual Performance Report
- Minute 274: a small working group, feeding back to Spokes, was considering the timing of scrutiny of the Sustainability and Transformation Programme (STP)
- Minute 259: paragraph 4.7 of the Review of Draft Revenue Business Planning Proposals had been redrafted into three paragraphs to make it more accessible
- Minute 261: the Immunisation Task and Finish Group update report was still awaited; the Director of Public Health would pursue this.

The Action Log and oral updates were noted.

279. PETITIONS

There were no petitions.

280. FINANCE AND PERFORMANCE REPORT – OCTOBER 2016

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of October 2016. Members noted that, apart from a planned drawdown from reserves, the expectation was that a balanced budget would be achieved for 2016-17.

In answer to questions, members further noted that

- the drop in numbers of people accessing GP services for smoking cessation had been ascribed to an increase in the use of e-cigarettes

- the lack of performance data for the school nursing service was because baseline data was still being collected; in other cases, key performance indicators were not reported because they were collected on a quarterly, rather than a monthly basis, or because the intervention was of only six months' duration and outcomes were not yet available

- in order to increase public understanding of the importance of healthchecks, efforts were being made to recruit community champions, and to support GP practices to get across the message of the benefits of healthchecks; anything members could do to support this would be much appreciated

- workplaces were also being targeted as places where healthchecks could be conducted. However, it was proving difficult to get the message across in Fenland, where it was difficult for people working on the land or in factories to attend a confidential session. In some factories it had been possible to conduct a large number of healthchecks, but others had not reacted to attempts to reach them either by cold-calling or through district council officers

- Cambridgeshire's performance on health visiting mandated checks was high by national measures, though there was an issue with cases where checks were 'not wanted and not attended'; it was a programme that parents could choose to access or not, but there would always be follow-up of any families where there was cause for concern

- the falls prevention work being monitored was that delivered by Everyone Health, so only a small part of the whole falls prevention work; it was also possible to monitor falls admissions and fractures through the national Public Health outcomes framework data collection.

Councillor David Connor, speaking as also a member of Fenland District Council, offered to give what assistance he could with contacting employers in Fenland, including visiting firms.

Having commented on the report, the Committee resolved to note its contents.

281. HEALTH COMMITTEE REVIEW OF DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2017-18 TO 2021-22

The Committee received a report setting out an overview of the draft Business Plan revenue and capital proposals for Public Health within the Health Committee's remit. A revised version of the report was distributed in which duplicate paragraph numbering had been removed and the associated cross-references amended; officers apologised for failing to make these corrections before initial publication. A table summarising the Public Health Directorate savings for 2017/18 was also circulated as report Annex D.

Members noted that

- the Public Health grant continued to be ring-fenced for the coming year
- the overall savings requirement for the Directorate was £680k less than had been anticipated in the 2016/17 Business Plan, due to changes in the treatment of pressures from inflation in external contracts and from population growth, which were now expected to be absorbed within existing budgets; a saving of £606k was to be made within the Public Health Directorate in 2017/18
- over 85% of the Public Health budget was spent on commissioned services, and the directorate was working with providers in a transformational way
- savings were also being sought through joint commissioning and working with Peterborough
- there were a number of earmarked reserves, including a five-year one for the Healthy Fenland Fund
- work was being undertaken with District Councils to develop joint working on public health issues.

In discussion, members

- welcomed the documentation provided, including the summary as very clear and helpful
- welcomed the restoration of previous savings in Child and Adolescent Mental Health services
- enquired whether there was an assurance commentary about the deliverability of savings. The Director of Public Health said that some savings were agreed with external contractors, and it was then up to the provider to find the savings. Staffing costs, on the other hand, were within the Directorate's direct control. The biggest risk to deliverability was a change in demand, for example for smoking cessation or chlamydia services.

The Chairman commended the good work of Public Health in staying within budget, adding that if it became necessary to overspend, more should be spent.

It was resolved unanimously:

a) to note the overview and context provided for the 2017/18 to 2021/22 Business Plan revenue proposals for the Service, updated since the last report to the Committee in October.

b) to comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2017/18 to 2021/22, and endorse them to the General Purposes Committee as part of consideration for the Council's overall Business Plan.

282. PROPOSAL TO TRANSFER THE IN HOUSE STOP SMOKING SERVICES TO AN EXTERNAL PROVIDER

The Committee received a report seeking its approval and support for the proposal to transfer the in house Stop Smoking Service to an external provider, Everyone Health, the integrated lifestyle service provider that was currently commissioned by the Council to provide other lifestyle services. Members noted that the existing contracts with GPs and pharmacies to deliver stop smoking support would not be affected; the commissioning of these services would stay within the Local Authority.

In the course of discussion, members

- welcomed the general trend and direction of travel

- from local experience, expressed concern at relying on community-based organisations, because of the vulnerability of some community services and premises. Members were advised that discussions had been held with providers about possible premises, which would include GP practices and other community premises; the underlying principle of providing behavioural change support was already well established, and Everyone Health was used to working with GP practices, and had worked well with the Stop Smoking Service for some years

- noted that the Everyone Health contract had been awarded in June 2015 and was for a period of five years; if the stop smoking contract were to be awarded to Everyone Health, it would also be retendered in 2020. Any savings sought during that period would be discussed with the provider, as part of the regular annual work with the providers of commissioned services

- asked about the availability of performance information on Everyone Health, and whether any of the red KPIs were applicable to this provider. Members were advised that it was commissioned to provide outreach health checks. Some of Everyone Health's outcomes were good, such as personal health plans, others were less good. There were some issues associated with establishing a service and filling posts, with experienced health trainers transferring to a new service as a career progression move. There had been some difficulties with recruitment, but Everyone Health had been performing well in terms of interventions similar to the Stop Smoking Service

- commented that it would be necessary to consider the performance of Everyone Health in other areas when the key decision on the award of the contract came to Committee

- said that it made sense to integrate the Stop Smoking Service with other lifestyle services, but cautioned that a decision to award the contract to a provider that did not perform well could be open to challenge

- enquired about scope for controlling spending in the newly-commissioned service. Members noted that part of the skill of commissioning was to ensure that value for money was obtained, and that there were mechanisms in place to deal with any lack of value for money. The Director of Public Health offered to supply further detail on how the contract was laid out when the matter next came before Committee; Public Health worked collaboratively with its providers, and they understood the constraints on the Public Health budget **Action required**

- suggested that, when they met in January, Spokes be asked to look at the performance record of Everyone Health, and contractual mechanisms to secure best value for money, and to convey to the Committee any concerns they identified.

Action required

It was resolved unanimously:

subject to

- further analysis of the performance of Everyone Health, the current Integrated Lifestyles provider
- a further briefing on performance of the current Integrated Lifestyles provider, and the contractual mechanisms to ensure best value, being discussed at the January Health Committee spokes meeting
- spokes referring to Health Committee any concerns arising from this briefing and discussion

to support and approve as a direction of travel the following key elements found in the proposal:

- to contract with an external provider the in house core Stop Smoking Service that is currently part of the Public Health Directorate
- to integrate the Stop Smoking Services into lifestyle services
- to support the procurement approach of transferring the Stop Smoking Services to Everyone Health, the integrated lifestyle service provider currently commissioned by Cambridgeshire County Council.

283. SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE

The Committee received a report from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) introducing the Sustainability and Transformation Plan (STP), which had been published on 21 November 2016. Attending to present the STP and respond to members' questions and comments were:

- David Astley, Independent Clinical Chair for Cambridgeshire and Peterborough Sustainability and Transformation Programme
- Jessica Bawden, Director of Corporate Affairs, CCG
- Scott Haldane, Interim Programme Director for STP

Two members of the public asked questions of the Committee [advance text and subsequent written response to both questions attached as Appendix A].

Jane Howell, a member of Keep Our NHS Public, expressed concern at lack of public consultation and partnership on the STP. She asked the Committee to ensure democratic and transparent behaviour in relation to the STP, and enquired about changes to the Constitution and the Members' Code of Conduct to ensure this. The Chairman thanked her for her question; the brief answer to her three points was yes, no and no, but she would be sent a fuller, written answer after the meeting. He said that the Committee intended to examine the STP in as much detail as possible; he was not aware of any seal of secrecy surrounding it.

Jean Simpson asked the Committee whether it was confident that it had enough information to evaluate the impact of the STP cuts locally, and whether it was looking at external sources of evidence to evaluate the new models of care. She also expressed concern that the Committee had already agreed to the Council signing the STP. In reply, the Chairman thanked Ms Simpson for her question, and said that she would receive a formal response in writing after the meeting. Briefly, the Committee had not

yet got sufficient information to evaluate the local impact of the STP and it would be looking at external evidence. However, she had misunderstood the position on signature – at its last meeting, the Committee had approved the Memorandum of Understanding (MOU), not the STP itself.

Ms Simpson asked whether there was a deadline for signing off the STP, and was advised that it would take as long as was needed. The Chairman said that the information it had was all publicly available; Ms Simpson could let the Committee know if she felt there was anything further needed.

Invited to introduce themselves, David Astley said that he was Independent chair of the STP process. He had had 41 years in various health executive roles, including a post at Addenbrooke's Hospital, four years in Qatar, and three posts as Chief Executive. Scott Haldane said that he had been on secondment to the STP from his substantive NHS post since October 2016, and Jessica Bawden explained that she was part of the STP communications team.

Introducing the STP, Mr Astley said that it was the result of work with health leaders and local government officers in the Cambridgeshire and Peterborough area. The plan was clinically driven, designed to help manage a challenging situation of rising demand, demography and a difficult financial climate, and to enable health services to be maintained. He stressed that joint working was essential in developing health and social services; the STP set out a direction of travel and programme of work, and would be subject to detailed scrutiny.

Members of the Committee asked questions and expressed concerns [see bullet points below] about various aspects of the STP and of health services in Cambridgeshire.

Documentation setting out the STP

- Several documents had been produced in different lengths and formats, all apparently describing or updating the STP; it would help to standardise on which document the Committee was to scrutinise. [The various publications, including the summary brochure of July 2016, the updated brochure included in the agenda pack, and the 65-page full document are available online at http://www.fitforfuture.org.uk/what-were-doing/publications/.]

  The Director of Corporate Affairs explained that NHS England (NHSE) had prescribed the format for the Plan; this was the 65-page document, setting out the Plan in full, which the CCG had published on 21 November 2016. In response to requests for a summary and an easy-read version, the other documents had been produced, based on the full Plan.

  The Independent Chair offered to make staff available for a seminar taking members through the Plan.

  Asked what areas were of particular concern to the Committee, a member listed deliverability, the financial aspects, and how the risks had been set out and considered; the risks did not feature in the brochure supplied.

Risks

- The table of risks (full Plan pages 47-48) was divided into financial, workforce and political risks, and showed a RAG (red, amber, green) rating and comments on mitigation for each risk, but had the likelihood and severity of impact been assessed in each case.

  The Programme Director said that the STP document was static, but the programme of work was fluid. Each delivery group covered areas of improvement, and each had a risk management dimension. Risks and mitigation went to the Health and Care Executive; at its meeting in early December, the Executive had agreed that it needed to make the process more timely, and as engaging and transparent as possible, making it clear what the risks were believed to be and what was being done to mitigate them. The STP was a plan, bringing together the different elements of what should be being done in the health system; the aim was to achieve an integrated system across Cambridgeshire and Peterborough.

  The Director of Corporate Affairs offered to share the risk register work that was being done with Fenland on a workstream by workstream basis.

- Given how recently the NHS had been in surplus, was it prudent to have a target of £1.3m surplus.

  The Programme Director said that the plan was to return the system to financial stability, not to a surplus position. The surplus figure quoted was the result of rounding at the present stage.

- The biggest risk was whether the approach proposed was capable of achieving financial balance by 2020/21; it was essential to invest the planned £43m for service improvement.

  The Independent Chair stressed the importance of leading change, and of making a combined effort to achieve it.

Community hospitals and minor injury units

- Comment was sought on how plans for minor injuries units (MIUs) in East Cambridgeshire and Fenland were proceeding, after the sudden revelation of draft proposals earlier in 2016, and on the reconfiguration of the Princess of Wales Hospital, Ely. The STP seemed to present mixed messages on the future of MIUs.

  The Director of Corporate Affairs recalled that the CCG had not planned to close the MIUs, but had been compelled by circumstances to speed up their work on the future of the units. Currently, the CCG was looking at running pilots on each of the three MIU sites, starting work in January 2017; an update report on this would be brought to Committee

  The Programme Director declared an interest in the reconfiguration of the Princess of Wales Hospital, because in a previous post he had been Director of Finance at Cambridgeshire Community Services NHS Trust (CCS), which owned the Princess of Wales site, and had the right to do as it saw fit with its land. CCS also owned Doddington, North Cambridgeshire Hospital, Wisbech and Brookfields, Cambridge.

The Programme Director went on to say that as part of the STP, the need in the East Cambridgeshire and Fenland area would be looked at, and consideration given to how to make best use of the estate. One STP workstream was looking at the estate across Cambridgeshire and Peterborough, with a view to optimising its use.

Deliverability

- What was the Independent Chair's confidence on the deliverability of the Plan, and whom would he tell if he felt that the Plan was not deliverable.

  The Independent Chair replied that deliverability was on curve. These activities were taking place in other parts of the country too, such as changes in the stroke pathway leading to shorter hospital stays and improved recovery. All the STP plans were evidence-based and comprehensive, examining both clinical pathways and estate; all involved were doing everything possible to ensure that the Plan did deliver, though one risk was whether the staff were available to deliver the Plan.

  The Independent Chair went on to say that both NHS and local authority services were subject to change, and had little option but to work together to meet the future challenges; his role was to ensure that people did work together. Each organisation was subject to its own regulator, and obliged to provide a service. He was not prepared to put his name to a plan that would not work; it was his job as Independent Chair to tell the Committee and others if he felt the STP was not deliverable.

  The Chairman asked Mr Astley to provide a job description for the Independent Chair role. **Action required**

Responding to demographic change and population movement

- What health services were planned for the substantial housing development proposed for Wisbech.

  The Programme Director said that services would be provided proportionate to the growth in and needs of the population. The Joint Strategic Needs Assessment (JSNA) was being used to inform planning, with forecasts from the Director of Public Health and the County Council; the item on planning for GP services [minute 286 below refers] was relevant here. The GP strategy was concerned both with ensuring an adequate number of GPs, and with challenging existing models of delivering healthcare.

- It seemed rather short-sighted to be planning only for the next five years, when in Fenland, for example, the District Council was looking 20 years ahead.

  The Programme Director said that the requirement laid down was to have a five-year plan, which currently was underpinned by annual contracts. NHSE only planned five years ahead, and the local health system had neither the opportunity nor the political desire to create a longer-term plan. He agreed with the member observation that this did not show joined-up thinking; they were trying to look as far ahead as they could.

  The Independent Chair added that it was possible to make long-term population forecasts, but it was hard to predict healthcare needs, which were determined by a range of factors. The Chairman suggested that the STP could be customised to

reflect what was known to be the case locally by providing a Cambridgeshire and Peterborough appendix, while conforming to the prescribed format for the main plan.

- It was necessary to have flexibility in planning for services, to respond to such situations as for example that in South Cambridgeshire, where the district was being asked to accommodate much more development than had been expected. One of the objections often received from residents when new development was proposed was that NHS services were unable to cope; could reassurance be given that there would be flexibility in the system to review changes.

  The Programme Director said that planning started with what was known. Changes would be planned, the plan would be tested to a point, then it would move to implementation, based on the information available up to that date. The Independent Chair acknowledged the point about flexibility, saying that it was necessary to manage the financial situation so that it was possible to manage change; when in debt, the system was constrained by its financial difficulties.

Workforce

- The current political situation meant that it was difficult to plan the workforce, given the unknown impact of the possible loss of freedom of movement. Was this seen as a risk, and was it being taken into account in planning.

  Members were advised that discussions about Brexit had already started; Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) had a large number of staff who would be affected. The chairs of each local NHS trust had asked their HR directors for an impact assessment, a survey of local providers was being undertaken, and the NHS nationally was examining the issue. The local authority was also looking at domiciliary care provision. However, until it was known how services would be delivered in future, with pathways changing from the health sector to the community, it was difficult to anticipate future workforce requirements.

- Responding to the point that bursaries for student nurses were due to end later in 2017, which was likely to have an adverse effect on recruitment, the Programme Director said that the workforce stream was looking at using the national apprenticeship levy imaginatively to attract the right workforce.

- In reply to the comment that STPs in general did not initially have enough front-loaded investment, the Programme Director said that it was a question of seeing what level of investment it was necessary to make, including national Department of Health (DoH) initiatives, and how to get access to DoH funding. The £43m referred to in the STP was for recurrent investments across the whole system.

Procurement

- Asked about procurement arrangements to ensure that best value for money was obtained, the Programme Director said that information was being gathered on who was buying what from where. The intention was to use these findings to enable smarter procurement; the STP was aiming to save £30m through improved procurement. The Independent Chair added that if the public sector worked collectively, the money saved could be used for patient care. The questioner urged that use be made of the available people who had business experience.

In conclusion

The Chairman thanked those who had attended for this item, and assured them that the Committee's intention was to scrutinise thoroughly but constructively and without hostility. Further scrutiny would be necessary in the coming months. The Independent Chair replied that they wished to work together with the Committee, and invited members to come and meet the Sustainability and Transformation Programme team.

The Committee having made its comments, it was resolved to note the Sustainability and Transformation Plan update.

284. UPDATE FROM CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (CUHFT)

The Committee received an oral update from Roland Sinker, Chief Executive Officer (CEO) of Cambridge University Hospitals NHS Foundation Trust (CUHFT) on progress following the 2015 Care Quality Commission (CQC) inspection of the Trust. He thanked the Committee for its invitation to attend, and said that the CQC inspection in Spring 2015 had looked at five domains and rated the hospital as inadequate overall, the lowest possible rating. Care had been assessed as outstanding, but almost everything else had been rated inadequate. This judgement, combined with a substantial financial deficit, had led to CUHFT being placed in special measures.

Since that inspection, the Trust, with its partners, had developed an action plan. The actions in the plan were divided into 'must-do' and 'should-do', and included for example must risk-assess patients who had been waiting too long for an outpatient appointment, and should ensure that sufficient estates staff were available to respond to maintenance requests. Improving the Trust's governance was a longer-term piece of work. It was also important to establish a culture of recognising and celebrating where something was going well, and knowing when something was not.

The CQC had returned in February 2016 and looked at the clinical areas that had previously been judged inadequate (including maternity, emergency services and diagnostics), finding them to have improved to 'requires improvement'. The inspectors had seemed to feel that the Trust was moving towards being more aware of when things were going wrong and dealing with them.

A full re-inspection had been conducted by a team of 50 inspectors in autumn 2016, who had spent a week in the hospital looking at all five domains. They had given very positive verbal feedback, and a draft report of the re-inspection was expected shortly before Christmas. CUHFT would then have 10 days in which to respond to the draft, and expected the full report to become public in January or February 2017. A clinical summit would then be held to share the inspection report's findings. NHS Improvement would then consider whether CUHFT could come out of special measures.

The CEO expressed his gratitude for all the support that the Trust had received, and offered to supply the Committee with further information as required.

Responding to his update, members

- asked the CEO what his biggest concern was. He replied that in the short term, he was concerned about the performance of the emergency pathway in and out of hospital. This was a system and a hospital issue which was damaging both to patients waiting for planned care, and to patients waiting in the emergency

department. In the longer term, there was the question of how to re-provision the estate, both of the hospital and of partner organisations such as GPs. Much of the estate was not up to standard by comparison with the rest of the country. He was also concerned about the culture and the people in the hospital, which had a staff of over 9,000, who needed to be re-empowered to work with patients; these were matters of finance, capacity, time and governance processes

- welcomed the CEO's acknowledgement of the importance of opening up channels of communication on what they know should be addressed; it was the people at the coalface who knew what was happening. He replied that the culture needed to encourage people to say what could be changed, and to track when something went wrong; there was a duty of candour with patients and it was necessary to restore power to the people at the coalface

- asked whether there were things that local government could and should be doing to assist in the running of the hospital. The CEO replied that he was pleased to see the level of partnership working across the system, as many partners came together to develop the Sustainability and Transformation Plan. A key issue for Addenbrooke's was to reduce the delayed transfers of care. The hospital had spent £2m on reablement, but success in reducing delayed transfers depended on having social care in place; the hospital was in dialogue with the local authority about working together to reduce delayed transfers.

The Chairman thanked Mr Sinker for attending and contributing to the meeting.

It was resolved to note the oral update given by the CUHFT Chief Executive.

285. PROPOSED CONSULTATION ON PROPOSED CHANGES TO THE FUTURE PROVISION OF SPECIALIST FERTILITY TREATMENT IN THE CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP AREA

The Committee received a report setting out the plan for conducting a consultation on proposals to stop routinely commissioning any specialist fertility services other than for two specified exceptions. Members noted that 'specialist fertility services' were what was more commonly referred to as IVF (in vitro fertilisation).

In attendance from the Cambridgeshire and Peterborough Clinical Commissioning Group to present the report and respond to members' questions and comments were

- Jessica Bawden, Director of Corporate Affairs
- Dr Richard Spiers, Clinical Lead for Prescribing and Clinical Polices

The Committee was advised that the Cambridgeshire and Peterborough Clinical Commissioning Group proposed to start the consultation on 19 January 2017, and meanwhile was talking to local scrutiny committees (in Northamptonshire, Peterborough and Hertfordshire) and to Healthwatch. Since drawing up the draft consultation document (report appendix 2), the CCG had thought that the list of what £1m could buy was perhaps somewhat misleading, as it seemed to imply that the CCG would receive more money by stopping the provision of IVF. IVF was the only aspect of fertility services to be affected by the proposal; the CCG would continue to commission other infertility services, and there would be a process for considering requests for funding in exceptional circumstances. The CCG believed that the NHS should deliver as many services as possible, and would keep the provision of IVF under review.

In discussion, members

- objected that the proposal would discriminate between those with resources and those without; for a childless couple wanting a baby, infertility was a life sentence

- sought clarification on the costs quoted for treatment; £1,108m for 131 cycles suggested nearly £8,500 per cycle, whereas others quoted far lower costs. Dr Spiers said that the cost of each cycle varied, depending on the providers and what exactly was required, such as the retrieval of sperm, or using a donated egg. It was also usual practice to create a second embryo at the same time, thus saving the cost of creating another embryo later; the cost of creating, storing and implanting the second embryo was included in that of the initial cycle. The vast majority of patients were treated locally, and success rates were high

- suggested that, as information suggesting much lower costs per cycle was readily available in public, the CCG should address the question of differing costs in its consultation document. The Director of Corporate Affairs acknowledged the point, and said that it would be necessary to word the information in a way that would not be too confusing for the reader

- commented that the public was likely to assume that the decision had already been made. Members were assured that no decision had been made. From past engagement exercises, the CCG had learnt things it had not known, for example about the presentation of documents, and the point about the impact of the proposal on childless couples was important. There had also been suggestions from others of different services that they thought should be cut, such as obesity services

- enquired what provision for IVF was made by neighbouring CCGs. Members were advised that North and West Essex CCGs had completed consultations and provided no service; other CCGs were in the process of consultation. It was an area of provision where many CCGs were considering a change in service on cost grounds, but the financial situation of Cambridgeshire and Peterborough CCG was particularly serious. IVF was an effective procedure, and the CCG would reconsider the question soon, but in its present financial position, the CCG could not afford to provide specialist fertility services.

The Director of Corporate Affairs asked that members of the Committee should let her know by January if they had any further comments on the documentation, beyond removal of the list of what £1m could buy, and the addition of information about the differing costs of IVF treatment cycles. The Chairman thanked her and Dr Spiers for their contribution to the meeting.

The Committee having commented on the draft consultation document as set out in Appendix 2 of the report before Committee, it was resolved to

a) approve the process for public consultation on future provision of specialist fertility treatments as set out in Appendix 1 of the report before Committee.

286. GENERAL PRACTICE FORWARD VIEW – FOCUS ON GP RECRUITMENT AND RETENTION IN CAMBRIDGESHIRE

The Committee received a report on the General Practice Forward View (GPFV), with a focus on GP recruitment and retention in Cambridgeshire. This had been compiled to give context to the development of the emerging Cambridgeshire and Peterborough primary care workforce strategy. Members noted that the report presented data for Cambridgeshire and Peterborough as a whole; the workforce was not growing at the rate that was needed, though the position on GP provision was more optimistic in Cambridgeshire that in Peterborough. In attendance to present the report and respond to members' questions and comments were

- Alice Benton, Head of Primary Care, Cambridgeshire and Peterborough CCG
- Emma Wakelin, Strategic Development Manager, Health Education East of England

In the course of discussion, members

- enquired how GP retention and return was being encouraged, and with what results. Members were advised that there was a national induction and return programme led by Health Education England (HEE), and 54 GP training places in Cambridgeshire and Peterborough. Support was provided to GPs who had not practised for some time, and to those who had received their training abroad, to ensure that they were equipped to work in a UK environment. About 20 GPs were going through that process across the East of England region. One consideration was making Cambridge more attractive as a place to live. High indemnity costs were also a problem, for example for a retired GP wanting to do a few sessions a week; work was being done to support this

- asked what the stumbling blocks to federation were, for those GP practices that were not federating. Members noted that, although not federated, practices in the Isle of Ely were working closely together, as were practices in Wisbech. The Cambridge GP federation covered 282,000 people, and the Huntingdon federation covered 20 practices. However, federation was not the only way for practices to come together; other contractual forms of co-operation were being developed

- sought assurance that the new housing development in Wisbech would include provision for a GP surgery, given that all the GP practices in Wisbech were already full. The Head of Primary Care said that the CCG worked together with developers, though it could cause problems when it was simply assumed that GP services would be there. It was necessary to know that there would be a sustainable number of people to support a GP practice. Creating new capacity was a challenge, because the supply of providers was not large, so it was a question of creating capacity from the available workforce, and using a wider range of skills than just GPs. It was already a struggle to fill vacancies, so adding new practices was not a simple matter

- asked how GPs, who ran their own businesses, could be brought into the process of planning for health services. Members noted that, under current contract arrangements, GP practices could decide which of various enhanced services they would provide, such as secondary care work and out of hours access. It was necessary to create capacity and stability in primary care services, and have sustainability going forward

- observed that the cost of housing was a major obstacle to attracting nurses and healthcare ancillary workers to the area. There was a will amongst the district councils to help with that – the CCG and HEE were urged to engage with the districts on the provision of housing for key workers. The Strategic Development Manager welcomed this assurance, especially in the light of the average age of the nursing workforce, which was 54, and the fact that a student coming out of training was unlikely to be able to afford housing in central Cambridge.

The Head of Primary Care stressed the importance of the Sustainability and Transformation Programme in GP recruitment and retention. The Chairman thanked both officers for their attendance.

The Committee having commented, it was resolved to note the report.

287. HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

The Committee received a report informing it of the recent activities and progress of the Committee's working groups. Members noted that the year's trial of the current method of working through liaison meetings was complete; providers had found the meetings useful. The Committee was also asked to authorise the continuation of the Joint Health Scrutiny Committee; officers undertook to provide information for members on the work of the Joint Committee. **Action required**

It was resolved unanimously to

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

2) note the update from the Joint Health Scrutiny Committee – Collaboration of Hinchingbrooke Hospital with Peterborough & Stamford Hospital.

3) authorise the Joint Committee to comment on behalf of the Health Committee on the mobilisation and implementation phases of any merger plans that the Trust Boards approve.

288. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan. Members noted that

- the reserve Committee date of 15 February would be used for a training session on the STP; the STP task group set up by Spokes would be looking at the focus for the training day
- there would be a session on health inequalities at 1pm on 12 January, immediately prior to the 2pm meeting of the Committee
- a session on Children and Young People's Mental Health was scheduled for the reserve Committee date of 3 April 2017.

The training plan and additional events above were noted.

289. APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee noted that it had been asked to appoint a representative to the Council of Governors of the merged Hinchingbrooke Health Care NHS Trust and the Peterborough and Stamford Hospitals NHS Foundation Trust, and that Councillor Sir Peter Brown, the member for Huntingdon and local member for Hinchingbrooke Hospital, would be willing to serve.

It was resolved unanimously:

a) to appoint Councillor Sir Peter Brown as the Council's representative on the Council of Governors of the merged Hinchingbrooke Health Care NHS Trust and the Peterborough and Stamford Hospitals NHS Foundation Trust.

290. HEALTH COMMITTEE AGENDA PLAN

The Committee considered its agenda plan and the changes to be made over forthcoming meetings.

It was resolved unanimously to note the agenda plan, subject to the following changes:

a) the additions made under the Training Plan item

b) removing the NHS England liver Metastasis Services report from the agenda for 12 January, because NHS England was unable to send a representative to speak to their report, and asking Health Committee spokes to review the report and consider whether commissioners and/or providers should be required to attend Committee on 16 March 2017

c) moving the Fertility Treatment Services consultation from 12 January 2017 to 16 March 2017

d) the provisional addition of 0-19 Joint Commissioning of Children's Services to the agenda for 16 February 2017.

Chairman

Appendix A

Questions for the Health Committee Cambridgeshire County Council
15th December 2016 at Shire Hall 2.0pm

Submitted by: Jane Howell

Background
The agreement by the County Council with NHS England to impose a seal of secrecy on the development of the STP has shaken public confidence in the Local Authority. As it is, the 'final' published STP document leaves many unanswered questions. Now that the County Council has decided to sign the STP document off without any public consultation and in partnership, support the CCG's plans as they evolve; public trust needs to be restored. Continuing to operate behind closed doors is totally unacceptable.

The agreed Memorandum of Understanding Appendix 1 - under Democratic Requirements originally said "Councillors have a unique responsibility of advocacy with respect to their constituents; Nothing in this memorandum should undermine this". The final version has been abbreviated and watered down to: "The role of all Councillors is to represent the views of their local constituents and speak up on their behalf is recognised". Whichever version you choose to follow, the fact is for the last year councillors have not been communicating with their constituents and therefore not representing them.

Response:
In regards to the points made above the final wording of the Local Authority Appendix to the Memorandum of Understanding as agreed by the Health Committee and Cambs Health & Wellbeing Board is "*The role of all Councillors to represent the views of their local constituents and speak up on their behalf is recognised. Councillors have a unique responsibility of advocacy with respect to their constituents. Nothing in this memorandum should undermine that.*"

Q.1 Will you ensure that the County Council and its various related health and social care committees behave in a democratic way regarding the STP, and that all actions/decisions are clearly, speedily and transparently communicated to all the residents of the Cambridgeshire & Peterborough Footprint 21 ?

Both the Adults Committee and the Health Committee meet in public, with agendas published a week beforehand. Anybody is welcome to attend these meetings. Usually, a decision summary is published two working days after the meeting, and the minutes are published within twelve working days.

Q.2 Would you please outline what measures and changes to the Constitution have been implemented to ensure that the CC when considering the STP, ensures that 'patient outcomes' will not suffer in any way due to aspirational 'efficiency savings'.

No changes to the Council's Constitution have been implemented. Article 2 of the Constitution, Members of the Council, already lists, as key roles of all Councillors that all Councillors will

(i) Collectively be the ultimate policy-makers and carry out a number of strategic and corporate management functions.
(ii) Contribute to the good governance of the area and ***actively encourage community participation and citizen involvement in decision making****.*

(iii) ***Effectively represent the interests of their electoral division and of individual constituents***.
(iv) ***Respond to constituents' enquiries and representations, fairly and impartially***.
(v) *Participate in the governance and management of the Council.*
(vi) *Be available to represent the Council on other bodies.*
(vii) *Maintain the highest standards of conduct and ethics.*

Q.3 Under this difficult situation where the Local Authority and NHSE are trying to integrate their services. Would a new Code of Conduct providing advice and guidance for committee members be a constructive way forward?
Where does Localism and public consultation slot into all this?

The existing Members' Code of Conduct at Part 5.1 of the Constitution is underpinned by the principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership. Councillors are already required to act solely in terms of the public interest (selflessness), and are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office (accountability).

There is already an annual training day for Chairs, Vice-Chairs and Health Committee Spokes with a focus on their roles and remits individually and collectively. Under the Protocol on Member/Officer Relations (Constitution Part 5.3) all members are expected to undertake appropriate training, and officers are expected to support them in this. Every meeting of a service committee will usually consider that committee's training plan (item 12 on 15 December's agenda), and the Health Committee has already undertaken training on the STP.

Under the Constitution (Part 3b, Section 5), the Health Committee has authority to exercise the powers conferred by Section 21 of the Local Government Act 2000 and Section 7 of the Health and Social Care Act 2001 as amended by the Health and Social Care Act 2012, and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013/218) to review and scrutinise any matter relating to the planning provision and operation of the health service in its area. The 2013 regulations emphasise the role of patients and the public in shaping services, and the Committee is well aware of the importance of this role.

Questions for the Health Committee Cambridgeshire County Council

Submitted by Margaret Ridley, on behalf of Jean Simpson

The Cambridgeshire and Peterborough Sustainability and Transformation Plan (STP) was published on the 21st November 2016 and is required to cut the health service budget by £500 million by 2021 .There has already been a great deal of disquiet from the public, both locally and nationally , about whether the STP plans are achievable. For instance, only 16% of NHS Finance directors think that they are financially achievable (NHSE survey).Questions:

1. Is the Health Committee confident that it has enough information to evaluate the impact of the STP cuts on the local health services. Does the information include the financial and workforce appendices that were not published in the public document? Aidan Thomas, CEO of CPFT said that there needs to be additional investment to ensure the success of the existing OPACS model. Is there any likelihood that this will be forthcoming in view of the savings that the STP is required to make?

The Health Committee is not yet confident that it has enough information to evaluate the impact of the STP and has requested full access to financial documents. The scrutiny of the STP will be a continual process building on a series of questions that were submitted to the CCG.

2. Is the Health Committee looking at external sources of evidence to evaluate whether the new models of care described in the STP will deliver the required savings?

The Health Committee will consider any external sources of evidence that are available to evaluate the STP. A working group was established and these members have met with representatives for Healthwatch Cambridgeshire in regards to the STP. Representatives from the Health Committee will also be participating in an Eastern Region scrutiny skills session on the STP delivered by the Centre for Public Scrutiny in February.

3. I understand that the Health Committee has already agreed to the Council signing the STP (D.Jenkins. Monthly report to parish and community Councils, November 2016). Can you tell me the date of that decision? When I questioned the Health Committee at their last meeting on 10 November, the feeling of the members was that they needed a lot more information and training in evaluation to come to a reasoned decision on the STP. Does the Health Committee feel that it has had sufficient time to make this important recommendation?

Cllr Jenkins provided a point of clarification at the Health Committee meeting on 15th December. His monthly report to parish and community councils was referring to signing off, in the capacity of Chair of the Health Committee, the Memorandum of Understanding (MOU) around the local health and social care system partners working together. This was not a sign off to the STP but rather a document about collaborative working.