HEALTH COMMITTEE: MINUTES

Date: Thursday 21st January 2016

Time: 1.05pm to 4.35pm

Present: Councillors P Ashcroft, P Clapp, A Dent, P Hudson, D Jenkins (Chairman), S Leeke (substituting for Cllr van de Ven), M Loynes, Z Moghadas, T Orgee (Vice-Chairman), P Sales, M Smith and P Topping

District Councillors S Ellington (South Cambridgeshire), R Johnson (Cambridge City) and C Sennitt (East Cambridgeshire)

Also present: Peterborough City Councillors Kim Aitken and Brian Rush (for agenda item 9, minute 192)

Apologies: County Councillor S van de Ven (Cllr Leeke substituting)
District Councillor M Cornwell (Fenland)

Before the start of business, the Chairman paid tribute to the late Councillor Steve van de Kerkhove, a member of the Committee who had died a few days before the meeting. He used to speak with humour, depth and knowledge, and would be greatly missed. The Committee stood in silence in his memory.

187. DECLARATIONS OF INTEREST

None.

188. MINUTES: 17th DECEMBER 2015 AND ACTION LOG

The minutes of the meeting held on 17th December 2015 were agreed as a correct record and signed by the Chairman.

The Action Log was noted. The Director of Public Health (DPH) said that Cambridge University Hospitals NHS Trust had undertaken to send the update reports in the third week of each month; the January report had been received and would be circulated to committee members electronically [minutes 167 and 175 refer]. **Action required**

189. PETITIONS

There were no petitions.

190. SERVICE COMMITTEE REVIEW OF DRAFT BUSINESS PLANNING PROPOSALS FOR 2016-17 TO 2020-21

The Committee received a report which set out an overview of the draft Business Plan Proposals for Public Health Grant (PHG) funded services that were within the Committee's remit; provided a summary of the latest available results from the budget consultation; and sought Members' endorsement for the proposed Key Performance Indicators for the Public Health Directorate.

Members noted that

- proposals for 2016-17 were given in detail, with indicative figures for the following four years
- proposals for making the considerable savings required had been prioritised on the basis of four criteria: evidence, efficiency, impact on inequalities, and the views of the Committee expressed at previous meetings
- because of the announcement in November 2015 that PHG funding would remain ring-fenced, the effect in Cambridgeshire was that further savings would have to be found from public health grant funded services, the majority of which sat within the Public Health Directorate, and correspondingly more funding would be available corporately
- additional corporate funding headroom meant that a number of savings originally planned in other directorates would no longer be required, including Children, Families and Adult (CFA) funding for older people's day services; Economy, Transport and Environment (ETE) funding for market town transport strategy; and Customer Services and Transformation (CS&T) funding for community engagement
- three proposals were being put forward for using the corporate funding headroom to partially mitigate proposed public health savings: Family Nurse Partnership and Health Visiting; public health intelligence/Joint Strategic Needs Assessment (JSNA) service; and the public health specialist nursing and immunisation function
- the Community Impact Assessments (CIAs) focussed on whether a proposal would affect some groups of people more severely than other groups; many showed as neutral because all groups were affected equally (including if all were adversely affected equally), or because mitigation measures formed part of the savings proposal.

In the course of examining the proposals, Members

- noted that, viewed from a public health perspective, older people's day centres were not an effective way of promoting physical activity, but the proposal was to use corporate headroom funding to ensure no loss of funding to day centres; General Purposes Committee would be discussing this alongside other Service Committee proposals for use of corporate headroom protection

- sought assurance that the brain injury unit at the North Cambridgeshire Hospital would still be funded. The DPH advised that this was not funded through the PHG, but offered to find out more for the Member **Action required**

- expressed concern that any reduction in the health visiting and school nursing services could have an adverse effect on the child members of gypsy and traveller families. Members noted that public health officers were working together with Cambridgeshire Community Services NHS Trust (CCS) on developing a more inclusive service than the present highly-targeted Family Nurse Partnership programme; this new service would reach a larger number of vulnerable women and children at a lower cost than the present arrangements

- expressed concern that where CIAs showed negative impact, as in the case of day care centres, immunisation programmes, and community engagement/timebanking, Fenland would be particularly affected because of the high levels of rural isolation and deprivation there. Members noted that all three areas were already included in the recommendations for corporate funding

- drew attention to the importance of preventative services as a constantly emerging theme at a recent workshop on regional working, attended by local authority chief executives and fire and police service representatives, and expressed frustration at the absurdity of being asked to make major cuts to prevention work.

The Committee went on to consider the proposed Key Performance Indicators (KPIs) for Public Health, which formed part of the Council's Strategic Framework, and which covered key services that Public Health commissioned or delivered. Discussing the KPIs, Members

- noted that the children's mental health indicator of admissions to hospital for self-harm in children and young people could act as an early indicator for more serious problems, and that it was possible to compare self-harm admissions across the country; the DPH offered to brief Members on this outside the meeting

Action required

- drew attention to the importance of long-acting reversible contraceptives (LARC), given the need to reduce the number of teenage pregnancies nationally, and of falls prevention in older people in view of the consequences of falls

- welcomed the KPIs being suggested, as reflecting each of the areas of public health expenditure.

The Chairman circulated a fifth recommendation for the Committee's consideration:

That the Committee resolve to recommend the following motion to Full Council

This Council:

- understands the impact of Public Health expenditure on health outcomes and future costs in the broader health economy in Cambridgeshire as evidenced by a comprehensive body of information including its own Prevention Strategy
- notes the Government's recent announcement to follow the 2015/16 mid-year cut in the Public Health Grant with a another cut for 2016/17 and further annual cuts in future years
- believes that these continuing cuts are ill-advised because they will result in higher long term health costs
- accepts that a broad approach to the Government through the Secretary of State for Health, its MPs and the Local Government Association is needed if these cuts are to be reversed

Resolves therefore to:

- ask the Chief Executive to write to the Secretary of State for Health and the Cambridgeshire MPs to brief them on the likely impact of the cuts, and to provide them with a copy of this County's Prevention Strategy
- ask the Chief Executive to table a motion at the LGA conference calling for the Government to rethink its approach to funding Public Health and to increase funding for public health interventions.

He explained that this had arisen from the discussion at the previous meeting about taking up the matter of public health funding with local MPs, and had been informed partly by subsequent discussion with Heidi Allen MP and Mark Lloyd, Chief Executive of the Local Government Association; he would also be meeting the MPs Lucy Fraser and Daniel Zeichner in the near future.

Some Members welcomed the motion as drafted, but others suggested that it was important to emphasise the need for preventative work across a whole range of services, including for example the Fire Service, and to point out that the prevention agenda, which Cambridgeshire had been developing for many years, was important and valuable, and that implementing it across the whole public service economy would lead to savings across the NHS and the social care budget. However, it was pointed out that the Committee's focus was on public health.

It was resolved by a majority:

a) to note the overview and context provided for the 2016/17 to 2020/21 Business Plan proposals for the Service, updated since the last report to the Committee in November

b) to endorse the draft revenue savings proposals that were within the remit of the Health Committee for 2016/17 to 2020/21 to the General Purposes Committee as part of consideration for the Council's overall Business Plan, including recommendations for corporate funding headroom outlined in paragraphs 3.6 and 3.7 of the report before Committee

c) to note the ongoing stakeholder consultation and discussions with partners and service users regarding emerging business planning proposals

d) to endorse the proposed Key Performance Indicators as part of the Strategic Framework alongside the 2016-21 Business Plan

e) to recommend the following motion to Full Council

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191. CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST – MENTAL HEALTH SERVICE PRESSURES – UPDATE

The Committee considered update reports on Mental Health Service pressures, as requested in July 2015, when it had previously considered the topic. In attendance to present the reports and respond to Members' questions were

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
  - Dr Neil Modha, Chief Clinical Officer (Accountable Officer)
  - Adele McCormack, Mental Health Commissioning & Contracts Manager
  - (for 8a) Dr Emma Tiffin, GP and Clinical Lead for Mental Health
  - (for 8b) Lee Miller, Head of Children and Maternity Commissioning & Transformation
- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
  - Aidan Thomas, Chief Executive
  - Andrea Grosbois, Communications Manager
  - (for 8b) Sarah Spall, General Manager, Children's Directorate

a) Adult Mental Health Service Pressures

The Committee first considered the report supplied by the CCG on pressures in adult mental health services. Members noted that population growth and the requirement for all NHS service providers to make efficiency savings were ongoing sources of pressure. The CPFT Chief Executive endorsed the report in its entirety. He said that for both CCG and CPFT, adults with seriously enduring mental health problems were of very great concern; they were severely affected by for example cuts in welfare benefits and cuts in social care, factors which might be partially responsible for the increase in referrals to secondary mental care services. He expressed concern if numbers were to continue increasing in future, and welcomed the acceptance of the CCG as a vanguard site for urgent and emergency care.

In the course of discussion, Members

- enquired what proportion of patients had a crisis plan in place, as an alternative to attending an Accident and Emergency department (A&E). Members were advised that the majority of patients being treated by CPFT in the community had a crisis plan, which would include risk factors which might cause a crisis, and ways for patient, family and healthcare team to manage a crisis. However, new patients, or those discharged from hospital some time ago, might not have a crisis plan

- noted that there was a smartphone crisis card app available as a source of support in a crisis, and that it was hoped to promote crisis planning through the Vanguard programme; a first response telephone service was being introduced, starting in Cambridge, with a single telephone number as a point of access

- in relation to the 12% increase in referrals to the Crisis Resolution and Home Treatment Team, asked what the baseline number was. The Chief Executive said that CPFT had about 15,000 service users at any one time across Cambridgeshire

and Peterborough, many of whom would not need to call on the crisis resolution team; he undertook to supply more detailed figures on numbers of service users

Action required

- noted that a patient presenting at one of the four local A&E departments in mental health crisis might, during working hours, and depending on which hospital it was, be seen by a psychologist in the liaison team. Out of hours, the local crisis team would be called in; crisis teams also had a range of responsibilities within the community setting

- enquired whether patients might be kept on a waiting list because of lack of resources. Members were advised that where an assessment at crisis point found that there was no urgent need, the patient would be referred on to another service, usually the locality mental health team. With some exceptions, such as Adult Attention Deficit Hyperactivity Disorder (ADHD), the patient would still be seen within NHS timescales.

It was resolved unanimously:

to note the current pressures and the measures put in place locally to mitigate these.

b) Child and Adolescent Mental Health Service Pressures

The Committee went on to consider reports from the CCG and CPFT on pressures in Child and Adolescent Mental Health Services (CAMHS). Members noted that

- because of the length of waiting time, it had been decided in about March 2015 to close the waiting lists for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals where there were no associated urgent mental health needs, and to redesign the pathways to ensure that patients received a timely service
- the CCG had invested an additional £600k recurrent and £150k non-recurrent funding in CAMHS for the current year, and a national uplift to CAMHS had also been made available to the CCG, resulting in a further £1.5m funding locally for the current and subsequent years
- some of the national funding had been targeted at, and used for, improvements in eating disorder services
- in December 2015, the waiting lists had been re-opened following pathway redesign
- the referral service for ADHD, which was a neurodevelopmental disorder, now had a pathway with less consultant engagement than previously, and closer to that seen elsewhere in the country
- the hope was that there would be no waiting list for the core CAMH pathway by the end of January 2016.

Discussing the reports, Members

- welcomed the progress made, particularly when compared with the position reported in July 2015

- enquired whether there was a gap in service for those aged 17 – 18, and noted that CPFT concentrated on children with ADHD and was working on the development of a 0 – 18 service and new commissioning process

- noted that the initial appointment for the family common assessment did not require specialist input and could be carried out by the health visitor or family support worker. CPFT, working with the CCG, sought to achieve an 18-week service, but some support services could be put in place quickly, for example behaviour support and school support; for many children, support at this lower level would be effective and sufficient

- asked whether parents and family would also receive support quickly. Members noted that the CCG was investing in parenting programmes and parent support; NICE guidance on ADHD recommended parent-training/education programmes as the first-line treatment, ahead of medication.

It was resolved unanimously:

to note the report on future plans outlined for Child and Adolescent Mental Health Services

The Chairman thanked all who had attended from the CCG and CPFT.

192. OLDER PEOPLE AND ADULT COMMUNITY SERVICES – TERMINATION OF UNITINGCARE CONTRACT

The Committee considered background information on the termination of the UnitingCare contract and questioned senior representatives of local health bodies. In attendance were

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
  - Dr Neil Modha, Chief Clinical Officer (Accountable Officer)

- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
  - Aidan Thomas, Chief Executive
  - Andrea Grosbois, Communications Manager
  - Keith Spencer, Chief Executive of UnitingCare

- from Cambridgeshire Community Services NHS Trust (CCS)
  - Matthew Winn, Chief Executive

- from Cambridge University Hospitals NHS Foundation Trust (CUHFT)
  - Roland Sinker, Chief Executive Officer.

Apologies had been received from the Finance Director and the Locality Director at NHS England, and from Monitor's Senior Regional Manager, who had sent a briefing note (attached as Appendix A and circulated to the Committee before the meeting). The Chair of Peterborough City Council's Health Scrutiny Commission, Councillor Rush, and a Member of the Commission, Councillor Aitken, participated in the scrutiny of the Older People and Adult Community Services (OPACS) contract at the Chairman's invitation because the contract had covered the provision of services in Peterborough as well as in Cambridgeshire.

The Chairman welcomed all present, and asked the lead officers from the CCG, CPFT, CUHFT, UnitingCare and CCS to make brief statements in turn, before the Committee examined the contract establishment, start-up and collapse, and the future for OPACS. First, he invited a member of the public, Jean Simpson, to put her questions to the Committee.

The questioner said that she had raised many queries with the Committee in the past about the CCG's ability to manage the competitive contract process, and that the decision to terminate the contract had had huge financial consequences on the local Health Economy, with deficits being reported by the CCG and CUHFT. She referred to the reviews being conducted by the CCG and NHS England into the factors leading to the collapse of the contract, and pointed out that the CCG was still continuing with two further important procurement exercises, for Non-Emergency Patient Transport Services (NEPTS), and for the 111 and Out of Hours Service.

Ms Simpson's two questions were:

1. Will the Committee take steps to investigate how much public money has been spent on this whole exercise so far, and how the service is going to be securely financed from now on?
2. Can the Health Committee recommend that the CCG halt the two current procurements until they have assured themselves, and the Health Committee, that lessons have been learned from this failed exercise?

The Chairman thanked the questioner for highlighting that the Committee was independent of the contract process, and said that the answer to the first question was yes, the process of investigation had already started and would continue until the Committee felt it had an adequate answer to the OPACS contract. The answer to the second question was no, because the two current procurement exercises were different in scale and complexity from the OPACS one. The 111 and Out of Hours procurement was being conducted to a national specification, and the Council's Economy and Environment Committee had been involved in responding to the NEPTS proposals, which were on a much smaller scale than OPACS.

Dr Neil Modha, Chief Clinical Officer of the CCG, stressed that the provision of good quality local care for older people and adults continued to be a priority. He was convinced that the model developed by UnitingCare was the right one, and was anxious that none of the benefits of that model be lost. All the partners had done everything they could to maintain the contract; as a CCG, it was important for them to learn from the process. He assured the Committee that the CCG would be open with all the reviews. The report to the Committee had been written from a CCG perspective. The issues that had led to the end of the contract had all been matters of finance, not quality. He wished to reiterate to the staff in the service that the plan was to continue to build on the UnitingCare model.

Keith Spencer, Chief Executive of UnitingCare, spoke on behalf of CPFT and CUHFT. He offered to supply the full text of his remarks (attached as Appendix B) as he had not had the opportunity to supply a paper to the Committee in advance. He said that he supported the Chief Clinical Officer's point that nobody had wanted the contract to terminate; UnitingCare, CCG, CPFT and CUHFT had worked tirelessly to find the necessary funding, with support from NHS England (NHSE) and Monitor. The UnitingCare service model had been co-created with service users and care staff; since its implementation it had seen reductions in hospital admissions and in length of stay. UnitingCare's role had ended, but it was necessary to ensure that key elements of the service model were preserved for the benefit of local people.

In answer to the Committee's three questions (what happened, why, and what happens next), he said that the CCG and UnitingCare had signed a contract in November 2014 which had recognised that the CCG had been unable to answer all of the 71 questions of clarification that had been outstanding when the bid had been submitted; of these, 34

questions had remained unanswered at the time of signing the contract, so the contract was based on a large number of assumptions. The contract had nevertheless been signed because of the desire to transform services without delay, and had included clauses to protect both sides from financial destabilisation; it was recognised that work remained to be done. Monitor and NHSE permitted the contract to proceed with the protection clauses in place.

The contract had ended because it became clear that costs of £9.3m were emerging that the CCG was unable to cover. At UnitingCare's request, the CCG had approached NHSE at the end of November 2015 seeking support to enable the contract to continue, but NHSE was unable to provide this. Because UnitingCare had a legal obligation to remain solvent, its Board decided to terminate the contract on 2nd December 2015. It remained the case that only by transforming services would the local health economy become viable for patients, staff and local Trusts.

Aidan Thomas, Chief Executive of CPFT, said that while there might be disagreements around the detail of the break-up of the contract, for the health economy, the partners and the CCG it was important to resolve the reasons for the collapse. For the local health economy and the local people, what was of key importance was to concentrate on how all parties could work together to implement the new model of care and follow through the work that UnitingCare had started.

Roland Sinker, Chief Executive Officer of CUHFT, said that he agreed with everything the UnitingCare and CPFT Chief Executives had said. He had spent ten years working in the NHS in London; efforts to implement exactly these models of care were being made in London, about two years behind the Cambridgeshire work. He had worked a half shift in A&E at Addenbrooke's the previous evening and visited wards; he had been pleased to see A&E calm, beds available on the wards, and patients receiving appropriate care. For the first time in 22 months, the Emergency Department had exceeded the 95% target in December 2015.

Matthew Winn, Chief Executive of CCS, explained that he had been invited to attend because it had been CCS which, prior to UnitingCare, had previously employed the community healthcare staff who had been transferred (under TUPE) largely to CPFT. Some of the cost of these services had formed around 37% of the cost of the contract.

The Committee explored questions of the contract and its collapse:

- Asked to clarify the position on outstanding issues when the contract was signed, the Chief Clinical Officer of the CCG and the Chief Executive of UnitingCare explained that there had been 34 points of clarification outstanding when the contract had been signed; it had been intended to be a fixed value contract, and had recognised that resolutions to the outstanding issues needed to be financially neutral; it had recognised the unresolved issues and had included a range of ways in which the financial issues could be dealt with. The 34 issues could have increased in number as further issues emerged.

- The Chief Clinical Officer said that none of the parties had expected what happened, but it had become clear over the year that the cost of the service was greater than the contract value, and the CCG as commissioners was unable to put additional funding into it. He confirmed that the 34 issues were not in the public domain, but it would be possible to give Members of the Committee sight of them.

Action required

One reason for the 34 unanswered questions was that the contract had been signed after the successful bidder had been announced in September 2014, part-way through the financial year, so complete information for the financial year was not available.

- The UnitingCare Chief Executive explained that if a question was unanswered at the point of submitting a bid, an assumption had to be made. One of the assumptions had been that the income transferred to UnitingCare would meet costs, but UnitingCare had discovered that the costs were greater than the amount of funding transferred. At the time of signing the contract and entering the implementation phase, it had been clear that there was further work to be done. It was known that this was the first contract of its type, but it had only become clear in late November 2015 when NHSE had been approached that there would not be a solution.

- At no point had the participants felt that they were being treated as guinea pigs for future contracts; they had all been working hard together, and the contract had been set up to focus hearts and minds on integrating services.

- The CCS Chief Executive confirmed that CCS staff had cost more in the previous year than the income received. The CCG had undertaken its own due diligence of CCS's service lines along with other bidders (conducted by one of the big four accountancy firms) and had established that staff cost exceeded income; the reason for the new way of working was that it was not possible to continue to run services in their previous form.

- Asked whether the systems integration had been sufficiently resourced, the CPFT Chief Executive said that nationally this had been one of the first contracts of its type, so it was difficult to find experience of it elsewhere. However, CUHFT and CPFT when putting the bid together had drawn on the Trusts' prior experience – some officers had been involved in the development of community services, but none had developed this sort of bid before. The CUHFT Chief Executive Officer pointed out that one of the strengths of the model had been that the partners had recognised where their areas of expertise were and where they needed bolstering, for example, CPFT had better experience of integrated working than CUHFT.

- UnitingCare as an organisation would cease to exist at the end of January 2016. The CCG had no plans to re-let the contract at present; this was a period of stabilisation during which the CCG would work with its partners, including the County Council. Looking to the future, it was important to continue with outcome-based commissioning, working out which parts of the model had worked well and should be developed, and which parts had been less successful and should be dropped.

- Asked why it had not been possible for all involved to put in extra funding to keep the transformed services going, the Chief Clinical Officer said that all parties had tried to find a solution, but as statutory organisations, they had been unable to support UnitingCare further. The contract value had been the sum of money that the CCG had available to spend on out-of-hospital care. The CCG had gone from a position of predicted financial surplus of £4m to a year-end predicted deficit of £8.4m, but the cost had gone into patient services, not legal fees.

The UnitingCare Chief Executive added that there was a wider issue for the NHS, as the future lay in providers working together in a more joined-up way. For an outlay of £9.3m, the potential return had been £170m. However, the CCG Chief Executive pointed out that the figure would have been considerably higher than £9.3m because it was a matter of recurrent funding to fund staff; the annualised figure was of the order of five to seven times greater. The basis of the model had been fundamentally correct, but because the CCG had a finite amount to spend on care delivery, it was ultimately unable to bridge the gap caused by higher costs. For the future, the intention was to develop services to be as efficient and flexible as possible, making the best use of the additional funding recently announced for the CCG and the award of Vanguard funding. The CUHFT Chief Executive Officer agreed about the importance of investing in new ways of working; the alternative would be to expand hospital services.

The CPFT Chief Executive added that they were still at the start of the journey; there had still been other elements of the model to be put in place, including working with the Council to build social capital in the neighbourhood to support local people, and developing pathways for long-term conditions. He explained that CPFT had tried to supply additional funding, but as its income came entirely from the NHS, the Trust did not have money for this. The CUHFT Chief Executive Officer said that their hands had also been tied. The Chief Clinical Officer said that what had been set up had been a two to three year intense focus on improving older people's care and joining up out-of-hospital services; the contract value had been the amount available for looking after people out of hospital, and it had been hoped that by joining up service delivery this would be sufficient. The CCG as the accountable officers took responsibility for the situation, but their focus was on the future. The Chief Executives of CPFT and CUHFT confirmed that their trusts had also lost money, in the case of CPFT, the loss was understood to be around £4m, but it was a one-off loss, not recurrent. They added that they could have reduced their losses by not looking after the smaller service providers, but both had decided that they should look after them.

- The Chairman said that he accepted that all parties had been placed in an impossible position as a consequence of rising costs and insufficient funding. It appeared that UnitingCare had been given a situation which was impossible to manage given the constraints afforded by its own structure and by the limited ability of its parent organisations and the CCG to provide additional funding.

- Asked who had been the voice of caution saying that the parties were not ready to proceed, the Chief Clinical Officer said that in the case of the CCG it had been their own Governing Body holding them to account. The CCG had set up a joint board with UnitingCare to carry out the mobilisation process; they had believed it was the right thing to do, and it had been important to make sure that there were no gaps in the process for patients in March and April 2015. The CCG would take the lessons learned from their own review and the NHSE review of the termination of the contract, and share them with colleagues.

- It was pointed out that the Monitor risk rating had been published and was accessible to all. The Chairman requested a copy. **Action required**

- Asked why the CCG did not simply tell UnitingCare that they had signed the contract and the financial situation was UnitingCare's problem, the Chief Clinical Officer said that this would not have been the right thing to do. It had been a new contract and a challenge for all involved; fundamentally there had not been enough money to fund

the service. The UnitingCare Chief Executive added that the contract had said it was a shared responsibility to work through problems together; they had resolved a many problems in the course of the contract, and had wanted to get away from a contract that placed blame.

- Asked if the total cost of the procurement exercise had been calculated, officers said that each organisation was accounting for the impact on its own finances, but nobody had worked out the total. The costs including bidding and tender costs, and the costs of paying providers off. Providers would have had to be paid to deliver services anyway. In response to a suggestion from the Chairman that it would be helpful if they could come up with defensible general figures, the Chief Clinical Officer said that they would do so. **Action required**

- Asked whether there was anything that the County Council could do to help, and whether there was any risk of the CCG being put into special measures, the Chief Clinical Officer said that their regulators had been very supportive of the approach, and from a CCG perspective there was no suggestion of special measures. Sensible conversations were being held with the regulators about how to meet the deficit and how to spend their increased funding. It was fundamental to keep hold of this model of care; there was work to be done with input from the Committee on looking at what had gone well and what had not. The CCG and the Council commissioners needed to work together on the use of the Better Care Fund, understanding that this was not new money. He would ask for the Council's leniency and grace to allow the CCG to carry on using the money for care. Nursing homes represented a large area of spend; health and social care needed to work together on improving patient care.

  The CPFT Chief Executive added that it was important that the Committee in its scrutiny role held them all to account in the delivery of the model of care.

The Chairman thanked all the participants for their attendance and participation, and asked them to return for further scrutiny of the OPACS contract in July 2016..

It was resolved unanimously:

a) to accept that the clinical model of integrated care being pursued by the UnitingCare Partnership appeared to be the correct model

b) to welcome the progress that had been made in implementing this model with positive indicators already being evident

c) to note that full and correct financial information did not seem to have been available at the time the contract was being implemented

d) to recognise that commitments have been made to maintain patient care

e) to ask that programmes of improvement continue

f) to encourage all involved to continue to talk to each other and to the Committee with a view to securing sufficient funding

g) to review the termination of the contract again at the Committee's meeting on 14 July 2016.

193. FINANCE AND PERFORMANCE REPORT – November 2015

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of November 2015. Members noted that the sum held in Public Health Grant reserves would diminish as the reserve was drawn on to partly offset the reduction in Public Health Grant.

The Chairman welcomed the inclusion of Health Committee priorities in the report, and welcomed the improvement in the Addenbrooke's Hospital delayed transfer of care figures, which were now closer to those of Hinchingbrooke Hospital. He said that it would be necessary to consider whether the indicators for transport and health were being reported in the best way possible.

It was resolved unanimously to note the report.

194. PUBLIC HEALTH RISK REGISTER UPDATE

The Committee received a report setting out details of Public Health Directorate risks. Members noted that the Public Health quality, safety and risk Group was now meeting jointly with Peterborough, in acknowledgement of the increasing amount of joint public health working undertaken by the two authorities. Because the report had been prepared in October, it did not include any of the potential risks arising from the recent cuts to public health funding.

In response to the report, Members

- sought reassurance that the needs of gypsies and travellers were being taken into account; they were a group which experienced racism and discrimination, in particular, those aged 16 – 19, who had often dropped out of secondary education then found themselves unable to get back in to education, with the result that their needs for health education – and indeed for literacy – were often overlooked. The DPH advised Members that the Council had a travellers' health team, but undertook to raise the matter with the public health risk group , and then bring a report back to Committee **Action required**

- noted that screening rates for newborn babies had improved, giving rise to the suggestion that the uptake of screening for breast and cervical cancers should be prioritised on the register instead; NHS England would be attending Committee in March 2016 for an item on this

- commented on the importance of childhood immunisation, noting that this service was commissioned by NHS England; there was a local public health task group examining the take-up of immunisation. The DPH offered to bring this report to Committee on completion. **Action required**

It was resolved unanimously:

(a) to note the position in respect of Public Health Directorate risk

(b) to endorse the amendments to the Public Health Risk Register since the previous update**.**

195. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan, noting that a seminar on the understanding of public health 0-5 services, possibly to be held jointly with members of the Children and Young People Committee, had been added following the last meeting.

It was resolved unanimously to note the training plan.

196. HOSPITAL CAR PARK CHARGES – Briefing Note

The Committee received a report setting out details of the charges for car parking at the four hospitals most commonly used by Cambridgeshire residents. Commenting on the report, Members suggested writing to the hospitals to urge them to ensure that all car park users were aware of the charges made and the concessions available. It was also pointed out that the chart was not entirely clear, giving the impression in some cases that shorter stays were free of charge when they were not; the report author undertook to update the chart. **Action required**

It was resolved unanimously to:

a) note the report and comparative charges

b) note the Healthcare Travel cost scheme (Appendix A of the report before Committee)

c) write to the four hospitals asking them to communicate their parking charges schemes visibly and actively to all users of their car parks.

Action required

197. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee considered its agenda plan, making several additions reflecting concerns raised in the course of the meeting.

It was resolved unanimously:

a) to note the agenda plan

b) to cancel the provisional meeting date of 18 February 2016

c) to add an item on the effectiveness of smoking cessation services to the agenda for 12 May 2016

d) to add a scrutiny item on the termination of the UnitingCare contract to the agenda for 14 July 2016

e) to note that there were currently no outstanding appointments to be made.

Chairman