HEALTH COMMITTEE

Thursday, 19 March 2020

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

13:30

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall, Castle Hill, Cambridge, CB3 0AP

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1 Apologies for Absence

2 Declarations of Interest

Guidance for Councillors on declaring interests is available at:

http://tinyurl.com/ccc-conduct-code

2b Covid-19 Briefing

The Chairman has exercised his discretion and requested a Public Health briefing regarding the Covid 19 virus

3 Minutes

23rd January 2020

4 Health Committee Action Log **5 - 6**

5	**Petitions and Public Questions**	
	DECISIONS	
6	**Finance Monitoring Report - January 2020**	**7 - 16**
7	**Performance Report - Quarter 3 (Public Health Joint Commissioning Unit)**	**17 - 36**
8	**Joint Health & Wellbeing Strategy Consultation**	**37 - 48**
	SCRUTINY ITEMS	
9	**CCG Big Conversation Feedback Report**	**49 - 164**
10	**Urgent & Emergency Care (UEC) Collaborative Update Report**	**165 - 172**
11	**CPFT East Cambridgeshire & Fenland Consultation** *To follow*	
12	**Cambridge Children's Hospital - Engagement Plan for CAMHS Services**	**173 - 182**
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13	**Health Committee Working Group Q3 Update**	**183 - 190**
14	**NHS Quality Accounts - Establishing A Process for Responding to 2019-20 Requests**	**191 - 196**
15	**Health Committee Training Programme 2019-2020**	**197 - 200**
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The Health Committee comprises the following members:

Councillor Peter Hudson (Chairman) Councillor Chris Boden (Vice-Chairman)

Councillor David Connor Councillor Lorna Dupre Councillor Lynda Harford Councillor Linda Jones Councillor Kevin Reynolds Councillor Tom Sanderson Councillor Mandy Smith and

Councillor Susan van de Ven

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

Clerk Name: Daniel Snowdon

Clerk Telephone: 01223 699177

Clerk Email: Daniel.Snowdon@cambridgeshire.gov.uk

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Public speaking on the agenda items above is encouraged. Speakers must register their intention to speak by contacting the Democratic Services Officer no later than 12.00 noon three working days before the meeting. Full details of arrangements for public speaking are set out in Part 4, Part 4.4 of the Council's Constitution:

https://tinyurl.com/CommitteeProcedure

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HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee up to the meeting on 23 January 2020 and updates Members on progress in delivering the necessary actions.

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
Meeting of 17 October 2019 & 14 November					
259.	**Health Committee Working Group Q1 Update**	**Kate Parker**	Members requested that a liaison meeting be established with the new Papworth Hospital	Work has begun to establish a liaison group with Papworth Hospital	**Ongoing**
Meeting of 23rd January 2020					
289.	**Finance Monitoring Report – November 2019**	**Stephen Howarth / Liz Robin**	Include a small commentary to explain variances within the report	Report has been amended.	**Complete**
290.	**Public Health Risk Register**	**Liz Robin**	Requested a narrative be included that explained the difference between likelihood, consequence and the scoring of risk.	Will be included in the next Risk Register Report	**Complete**

290.	**Public Health Risk Register**	**Liz Robin**	Review the presentation of the report for future meetings including a dashboard that allowed the movement in risk scores to be tracked and, for the risks with higher scores, information regarding mitigations in place to be included in the covering paper	Will be included in the next Risk Register Report	**Complete**

Agenda Item No: 6

FINANCE MONITORING REPORT – JANUARY 2020

To:	**Health Committee**
Meeting Date:	**19th March 2020**
From:	**Chief Finance Officer** **Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the January 2020 Finance Monitoring Report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial position as at the end of January 2020.**
Recommendation:	**The Committee is asked to review and comment on the report.**

	Officer contact:
Name:	Stephen Howarth
Post:	Strategic Finance Manager
Email:	stephen.howarth@cambridgeshire.gov.uk
Tel:	01223 507126

PUBLIC HEALTH – FINANCE MONITORING REPORT – JANUARY 2020

KEY INDICATORS

Previous Status	Category	Target	Current Status	Section Ref.
Green	Revenue position by Directorate	Balanced year end position	Green	1.2

CONTENTS

1. Revenue Executive Summary

1.1 Overall Position

Public Health is forecasting an underspend of £-456k at the end of January.

1.2 Summary of Revenue

Forecast Outturn Variance (Dec) £000	Service	Budget for 2019/20 £000	Actual to end of Jan 20 £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Children Health	8,799	6,522	0	0.0%
0	Drugs & Alcohol	5,463	3,880	-25	-0.5%
-21	Sexual Health & Contraception	5,097	3,471	-60	-1.3%
-68	Behaviour Change / Preventing Long Term Conditions	3,720	2,498	-283	-7.6%
-0	Falls Prevention	190	136	-0	0.0%
-6	General Prevention Activities	13	-12	-14	-109.9%
0	Adult Mental Health & Community Safety	256	64	0	0.0%
-104	Public Health Directorate	1,744	1,556	-73	0.0%
-199	Total Expenditure	**25,283**	**18,115**	**-456**	
0	Public Health Grant	-24,726	-24,944	0	0.0%
0	Other funding sources	-167	0	0	0.0%
-199	Net Total	**390**	**-6,829**	**-456**	

The service level budgetary control report for 2019/20 can be found in appendix 1. Further analysis of variances can be found in appendix 2.

1.3 Significant Issues

At the end of January 2020, the overall Public Health forecast position is an underspend of £-456k. £390k of this is core council funding, with the remaining £65k being an expected carry-forward of the Public Health Grant.

A balanced budget has been set for the financial year 2019/20. Savings totalling £949k have been budgeted for and the achievement of savings is monitored through the savings tracker process, with exceptions being reported to Heath Committee and any resulting overspends reported through this monthly Finance Monitoring Report.

A number of small expected underspends have previously been identified following a review of activity in the first part of the year, along with a review of staffing spend over that period. In January, further analysis of activity in demand-led budgets to the end of the third quarter has resulted in an increase in the forecast underspend.

2. Savings Tracker Summary

The savings tracker is produced quarterly, and the savings tracker to the end of quarter 3 is included in appendix 4 and shows all PH savings as on track to deliver in full.

3. Technical note

A technical financial appendix is included as appendix 3. This appendix covers:

- Grants that have been received by the service, and where these have been more or less than expected
- Budget movements (virements) into or out of Public Health from other services (but not within the service), to show why the budget might be different from that agreed by Full Council
- Service reserves – funds held for specific purposes that may be drawn down in-year or carried-forward – including use of funds and forecast draw-down.
- At regular intervals, information on spend outside of the Public Health Directorate under Memorandums of Understanding,

APPENDIX 1 – Public Health Service Level Financial Information

Forecast Outturn Variance (Dec) £000's	Service	Budget 2019/20 £000's	Actual January 2020 £000's	Forecast Outturn Variance £000's	%
	Children Health				
0	Children 0-5 PH Programme	6,907	5,003	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,622	1,239	0	0%
0	Children Mental Health	271	280	0	0%
0	**Children Health Total**	**8,799**	**6,522**	**0**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,463	3,880	-25	0%
0	**Drugs & Alcohol Total**	**5,463**	**3,880**	**-25**	**0%**
	Sexual Health & Contraception				
25	SH STI testing & treatment - Prescribed	3,829	3,042	66	2%
-20	SH Contraception - Prescribed	1,116	296	-90	-8%
-26	SH Services Advice Prevention/Promotion - Non-Prescribed	152	133	-36	-24%
-21	**Sexual Health & Contraception Total**	**5,097**	**3,471**	**-60**	**-1%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	1,984	1,644	-86	-4%
-13	Other Health Improvement	408	579	-29	-7%
-55	Smoking Cessation GP & Pharmacy	703	12	-47	-7%
0	NHS Health Checks Programme - Prescribed	625	263	-120	-19%
-68	**Behaviour Change / Preventing Long Term Conditions Total**	**3,720**	**2,498**	**-283**	**-8%**
	Falls Prevention				
-0	Falls Prevention	190	136	-0	0%
-0	**Falls Prevention Total**	**190**	**136**	**-0**	**0%**
	General Prevention Activities				
-6	General Prevention, Traveller Health	13	-12	-14	-110%
-6	**General Prevention Activities Total**	**13**	**-12**	**-14**	**-110%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	64	0	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**64**	**0**	**0%**
	Public Health Directorate				
-13	Children's Health	262	223	-9	-3%
-12	Drugs & Alcohol	199	210	-8	-4%
-8	Sexual Health & Contraception	143	116	-5	-3%
-30	Prevention Long Term Conditions (Behaviour Change)	515	444	-21	-4%
-17	General Prevention (Travellers)	189	194	-12	-6%
-1	Adult Mental Health	19	22	-1	-5%
-8	Health Protection	124	129	-6	-5%
-16	Analysts	293	218	-11	-4%
-104	**Public Health Directorate Total**	**1,744**	**1,556**	**-73**	**-4%**
-199	**Total Expenditure before Carry-forward**	**25,284**	**18,115**	**-456**	**-2%**
0	**Anticipated Carry-forward of Public Health Grant**	**0**	**0**	**65**	

Forecast Outturn Variance (Dec) £000's	Service	Budget 2019/20 £000's	Actual January 2020 £000's	Forecast Outturn Variance £000's	%
	Funded By				
	Public Health Grant	-24,726	-24,944	0	0%
	Drawdown From Reserves	-167	0	0	0%
0	**Grant Funding Total**	**-24,893**	**-24,944**	**0**	**0%**
-199	**Overall Total - Core Council Funding**	**390**	**-6,829**	**-390**	

APPENDIX 2 – Service Commentaries on Forecast Outturn Position

Narrative is given below where a service area has a material variance.

Budget Line	Forecast Variance	Commentary
Drugs & Alcohol	-25k	The full budget allocation for this service is not needed to meet costs and commitments in 2019/20. The allocation will be reviewed as budgets are set for 2020/21.
Sexual Health & Contraception	-60k	There is an overspend projected against the main community sexual health contract due to activity, offset by lower than expected activity on services delivered by GPs and pharmacies after factoring expected increases for quarter 4.
Behaviour Change / Preventing Long Term Conditions	-283k	The underspend on this line is mainly due to lower than expected activity on NHS health checks and smoking cessation work - budgets were set assuming some growth but activity so far is at a similar level to 2018/19.
General Prevention Activities	-14k	There is higher activity than expected for income generating enrolments in adult learning courses where these result from targeted Public Health work.
Public Health Directorate	-73k	This budget line is mainly where staffing costs of the Public Health Directorate are incurred. It is usual for staffing budgets to experience underspends. This is mainly due to recruitment timing, not necessarily covering all posts that are absent due to parental leave or sickness, and the potential for new members of staff to cost less overall than those they replace. The Public Health service has a budget factor of £70k built-in to allow for these effects, similar to other services in the Council, but the latest projections show a likely underspend in excess of that factor reported above.

APPENDIX 3 – Technical Appendix

5.1 Public Health Grant

Grant	Originally Expected £000	Currently Expected £000
Public Health Grant as per Business Plan	**25,560**	**25,560**
Grant allocated as follows:		
Public Health Directorate	24,726	24,726
People & Communities Directorate	293	283
Place & Economy Directorate	120	130
Corporate and Customer Services Directorate	201	201
LGSS Cambridge Office	220	220
Total	**25,560**	**25,560**

5.2 Virements and Budget Reconciliation

(Virements between Public Health and other service blocks)

No such virements have been performed in-year.

5.3 Reserve Schedule

Fund Description		Balance at 1 April 2019	Balance at end Sept 2019	Forecast Closing Balance	Notes
		£'000	£'000	£'000	
General Reserve					
PH0	Public Health carry-forward	**1,683**	**879**	**944**	
	subtotal	**1,683**	**879**	**944**	
Other Earmarked Funds					
PH1	Healthy Fenland Fund	199	199	98	Anticipated spend £100k per year over 5 years.
PH2	Falls Prevention Fund	271	271	164	Joint project with the NHS
PH3	NHS Healthchecks programme	270	270	270	Usage to be considered by Member working group
PH4	Implementation of Cambridgeshire Public Health Integration Strategy	463	463	378	'Let's Get Moving' physical activity programme has been extended.
PH5	Enhanced Falls Prevention Pilot	0	804	754	Anticipated spend over three years, including evaluation
	subtotal	**1,203**	**2,007**	**1,664**	
TOTAL		**2,886**	**2,886**	**2,608**	

APPENDIX 4 – Savings Tracker

			£000	Forecast Savings 2019-20 £000							
			-949	-758	-28	-28	-137	**-949**	**0**		
Reference	**Title**	**Committee**	**Original Saving 19-20**	**Current Forecast Phasing - Q1**	**Current Forecast Phasing - Q2**	**Current Forecast Phasing - Q3**	**Current Forecast Phasing - Q4**	**Forecast Saving 19-20**	**Variance from Plan**	**% Variance**	**RAG**
E/R.6.031	NHS Health Checks - IT software contract decommissioned	Health	-41	-41	0	0	0	-41	**0**	**0.00**	Green
E/R.6.032	NHS Health Checks Funding	Health	-50	-13	-13	-13	-13	-50	**0**	**0.00**	Green
E/R.6.033	Drug & Alcohol service - funding reduction built in to new service contract	Health	-162	-162	0	0	0	-162	**0**	**0.00**	Green
E/R.6.035	Children 5-19 - Mental Health Training for Children's workforce	Health	-36	-36	0	0	0	-36	**0**	**0.00**	Green
E/R.6.036	Children's 0-19 Services - Healthy Child Programme - Proposal previously agreed in 2017/18 business planning process	Health	-238	-238	0	0	0	-238	**0**	**0.00**	Green
E/R.6.037	Children's 0-19 Services - Healthy Child Programme - Additional savings proposal for 2018/19	Health	-160	-160	0	0	0	-160	**0**	**0.00**	Green
E/R.6.038	Public Health Directorate - In house staff rationalisation	Health	-80	-80	0	0	0	-80	**0**	**0.00**	Green
E/R.6.039	Reduce Long Acting Reversible Contraception (LARCs) funding in line with audit results and completion of clinician training	Health	-60	-15	-15	-15	-15	-60	**0**	**0.00**	Green
E/R.6.040	Reduce immunisations promotion budget	Health	-13	-13	0	0	0	-13	**0**	**0.00**	Green
E/R.6.041	Expected operational savings across Public Health staffing and contracts	Health	-109	0	0	0	-109	-109	**0**	**0.00**	Green

ALIGNMENT WITH CORPORATE PRIORITIES

Developing the local economy for the benefit of all

There are no significant implications for this priority.

Helping people live healthy and independent lives

There are no significant implications for this priority

Supporting and protecting vulnerable people

There are no significant implications for this priority

Net zero carbon emissions for Cambridgeshire by 2050

There are no significant implications for this priority

Resource Implications

This report sets out details of the overall financial position of the Public Health Service.

Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications for this priority

Statutory, Legal and Risk Implications

There are no significant implications within this category.

Equality and Diversity Implications

There are no significant implications within this category.

Engagement and Communications Implications

There are no significant implications within this category.

Localism and Local Member Involvement

There are no significant implications within this category.

Public Health Implications

There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	N/A
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	N/A
Have the equality and diversity implications been cleared by your Service Contact?	N/A
Have any engagement and communication implications been cleared by Communications?	N/A
Have any localism and Local Member involvement issues been cleared by your Service Contact?	N/A
Have any Public Health implications been cleared by Public Health?	N/A

Source Documents	Location
As well as presentation of the FMR to the Committee when it meets, the report is made available online each month.	https://www.cambridgeshire.gov.uk/council/finance-and-budget/finance-&-performance-reports/

Agenda Item No: 7

PERFORMANCE REPORT – QUARTER 3 2019/20 (PUBLIC HEALTH – JOINT COMMISSIONING UNIT)

To:	**HEALTH COMMITTEE**
Meeting Date:	**19th March 2020**
From:	**Director of Public Health**
Electoral division(s):	***All***
Forward Plan ref:	*Key decision:*
Purpose:	**To provide performance monitoring information**
Recommendation:	**To note and comment on performance information and take remedial action as necessary**

	Officer contact:		***Member contacts:***
Name:	Kate Parker	Names:	Cllr Peter Hudson
Post:	Head of Public Health Business Programmes	Post:	Chair Health Committee
Email:	Kate.parker@cambridgeshire.gov.uk	Email:	Peter.hudson@cambridgeshire.gov.uk
Tel:	01480 379561	Tel:	

1 BACKGROUND

1.1 This performance report provides information on the status of performance indicators the Committee has selected to monitor in respect of the Healthy Child Programme (indicators 56-62), to understand performance of services the Committee oversees.

1.2 The report covers the period of Q3 2019/20, up to the end of December 2019.

1.3 The full report is in the appendix. It contains information on

- Current and previous performance and projected linear trend
- Current and previous targets (not all indicators have targets, this may be because they are being developed or because the indicator is being monitored for context)
- Red / Amber / Green / Blue (RAGB) status
- Direction for improvement (this shows whether an increase or decrease is good)
- Change in performance (this shows whether performance is improving (up) or deteriorating (down)
- Statistical neighbour performance (only available where a standard national definition of indicator is being used)
- Indicator description
- Commentary on the indicator

1.4 The following RAGB statuses are being used:

- Red – current performance is 10% or more from target
- Amber – current performance is off target by less than 10%
- Green – current performance is on target or better by up to 5%
- Blue – current performance is better than target by 5% or more

As agreed by General Purposes Committee, “Blue” has replaced “Very Green” as the colour grading for indicators exceeding target by 5% or more.

Red and Blue indicators will be reported to General Purposes Committee in a summary report.

1.5 Information about all performance indicators monitored by the Council Committees will be published on the internet at https://www.cambridgeshire.gov.uk/council/finance-and-budget/finance-&-performance-reports/ following the General Purposes Committee meeting in each quarterly cycle.

1.6 The appendix provides a narrative report on performance of services funded by the public health grant in other Council directorates through a memorandum of understanding.

2 CURRENT PERFORMANCE

2.1 Current performance of indicators monitored by the Committee is as follows:

Status	Number of indicators	Percentage of total indicators with target
Red	4	
Amber	2	
Green	9	
Blue	0	
No target	0	

2.2 Narrative in respect of indicators whereby RAGB status is red.

Indicator 58: Percentage of first face-to-face antenatal contact with a Health Visitor at >28 weeks.

Target	Q3 Performance	Q2 Performance	Direction of Travel	Change in performance
50%	36.4%	29%	↑	+7.4%

There is no National target and a 50% target has been set locally. Improvements are being made, evidenced by the upwards trajectory against the Q2 position and performance is being closely monitored by commissioners at monthly meetings with the provider. When exemption reporting, which includes those contacts which were offered but not attended/wanted by the service user, are included, overall quarterly performance increases to 42%.

Indicator 62: Percentage of children who received a 2 -2.5 year review

Target	Q3 Performance	Q2 Performance	Direction of Travel	Change in performance
90%	52.5%	42%	↑	+10.5%

As above, there is no National target and a 90% target has been set locally. Nationally performance against this indicator stands at 78% at the end of Q2. There had been a temporary suspension of this contact in the South Locality due to low staffing levels, however this has now been addressed and further improvements in achieving this target are expected in Q4. Of note, with exemption reporting, which includes those contacts which were offered but not attended/wanted by the service user, overall quarterly performance increases to 61.5%.

Indicator 53: Number of NHS Health Checks completed

Target	Q3 Performance	Q2 Performance	Direction of Travel	Change in performance
1,800	10,647	7,646	↑	+3001

Although the numbers of health checks has increased performance is slightly lower at 79% of the target for Q3 than for 2018/19 when it stood at 81% of the period target. In Q4 data trawls in GP practices take place which in previous years have contributed to improvement in performance. However changes in the configuration of primary care and ongoing capacity issues in GP practices makes target achievement challenging. Individuals are invited to receive their health checks though identification of eligibility from GP practice records. The majority of activity is commissioned from GP practices with some outreach work being undertaken by the Lifestyle Service which targets hard to reach high risk populations. Health Checks are a mandated Public Health programme and is an important route for engaging people in an early conversation about their health and lifestyle. It also includes the early detection of risk factors for diabetes, cardio vascular disease and an opportunity to discuss dementia awareness.

Indicator 56: Smoking cessation – four week quitters

Target	Q3 Performance	Q2 Performance	Direction of Travel	Change in performance
1,980	**1072 - Until the end of November**	**790**	↑	**+282**

This measure uses the number of individuals receiving stop smoking support via a set programme, who are confirmed as smokefree at 4/6 weeks post set quit date. This means that there is a delay of two months in reporting. Data up until the end of November was available at the time of compiling this report and is comparable to the November 2018/19 number. Stop Smoking Services activity provided by GP practices has fallen in recent years that is associated with competing pressures on GP staff. Lifestyle Service staff provide stop smoking services in some practices to ensure patients can access services. Promotional efforts including the Missing Moments campaign is focussed upon more deprived areas and certain groups where smoking rates are higher.

Source Documents	Location
None	

Indicator 49: GUM Access - offered appointments within 2 working days

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Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
98.0%	100.0%	100.0%	↑	⇔

Statistical Neighbours Mean	England Mean	RAG rating
N/A	N/A	G

Indicator Description

Key quality statement for access to Sexual health Services. Prompt access to sexual health services will promote good sexual health and reduce sexual health inequalities. Quick and easy access to support can help to reduce the likelihood of onward transmission of sexually transmitted infections (STIs).

This measure is the percentage of people who contact the service about a sexually transmitted infection who are offered an appointment within 2 working days, with a 98% target threshold.

NICE guidance suggests that people contacting a Sexual Health Service about a sexually transmitted infection should be offered an appointment within 2 working days. The outcome measure is set to reflect this.

Calculation:
(X/Y)*100

Where:
X: Number of people contacting a sexual health service offered an appointment in 2 working days in a month.

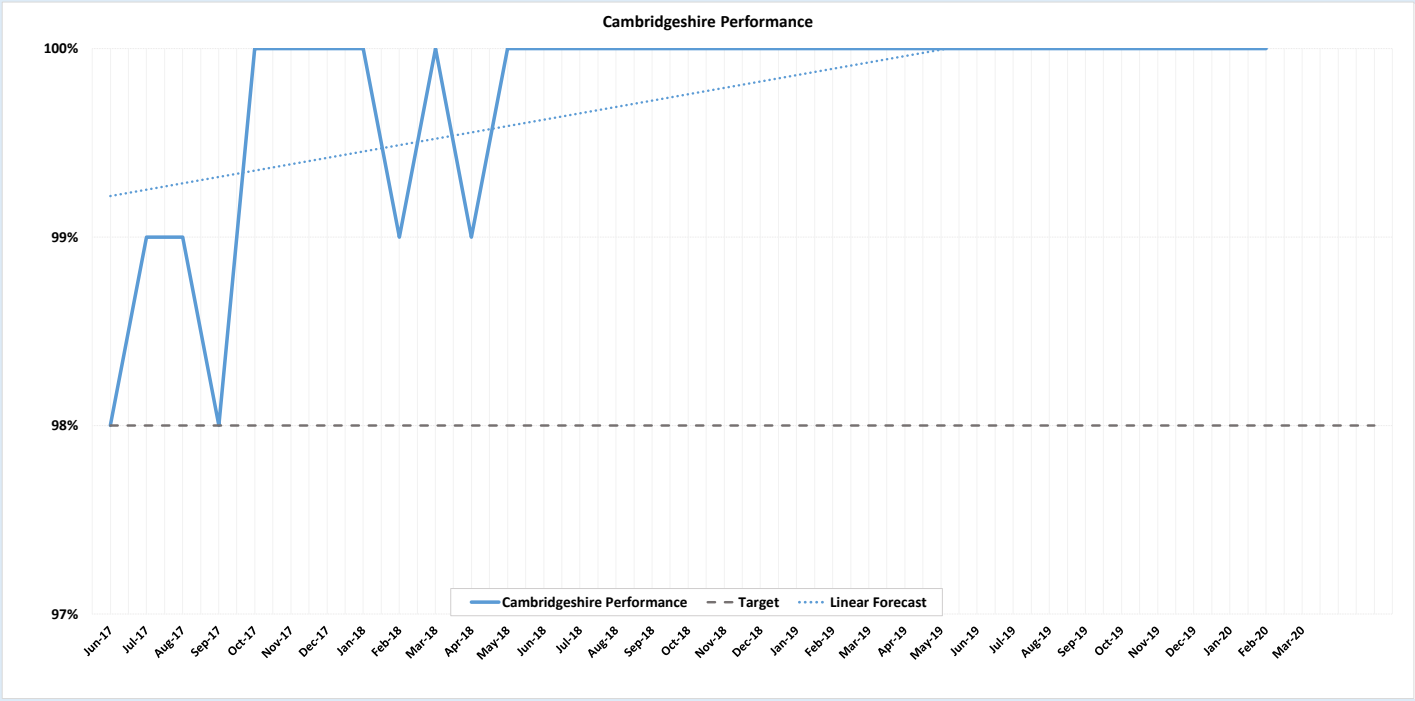
Y: Number of people contacting a sexual health service in a month.

Source: NICE

Useful Links

LG Inform:
https://lginform.local.gov.uk/

Nice Guidance Quality Statement 4
https://www.nice.org.uk/guidance/qs178/chapter/Quality-statement-4-Access-to-sexual-health-services



Commentary

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
80.0%	92.0%	93.0%	↑	↓

Statistical Neighbours Mean	England Mean	RAG rating
N/A	N/A	VG

Indicator Description

Key quality statement for access to Sexual health Services. Prompt access to sexual health services will promote good sexual health and reduce sexual health inequalities. Quick and easy access to support can help to reduce the likelihood of onward transmission of sexually transmitted infections (STIs).

This measure is the percentage of those offerd an appointment (as per above) who then go on to be seen within 48 hours of contacting the service.

This is a BASHH standard and is a recommended outcome within the Integrated Sexual Health Service National Specification template.

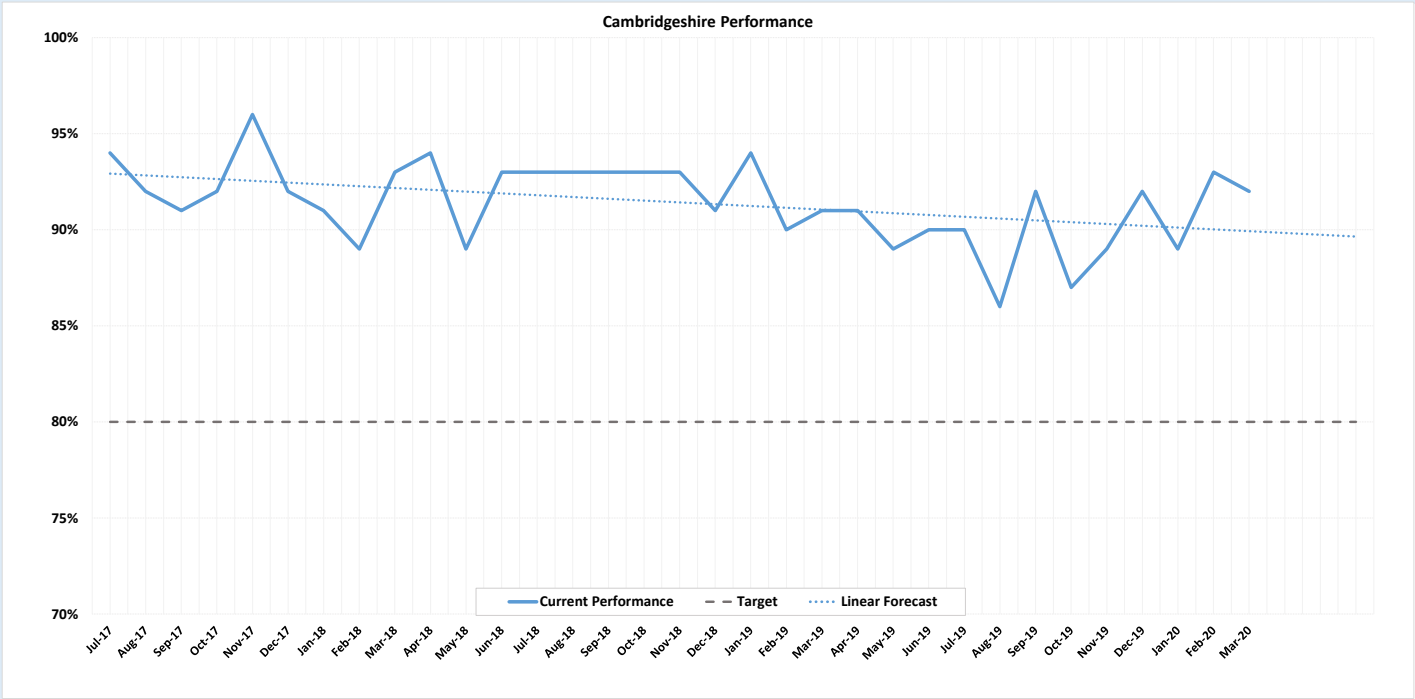
Calculation:
(X/Y)*100

Where:

Useful Links

LG Inform:
https://lginform.local.gov.uk/

Integrated Sexual Health National Specification
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731140/integrated-sexual-health-services-specification.pdf



Commentary

The target has been consistently met.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
13500	10647	7646	↑	↑

Statistical Neighbours Mean	England Mean	RAG Rating
N/A	N/A	R

Indicator Description

This measure is the number of people within the eligible population who receive an NHS health check via their GP Practice.

Targets are set based on the eligible population for an NHS health check, as outlined in the NHS Health Check programme guidance. The Local Authority's Public Health Intelligence Team support with the target setting distribution across all GP practices.

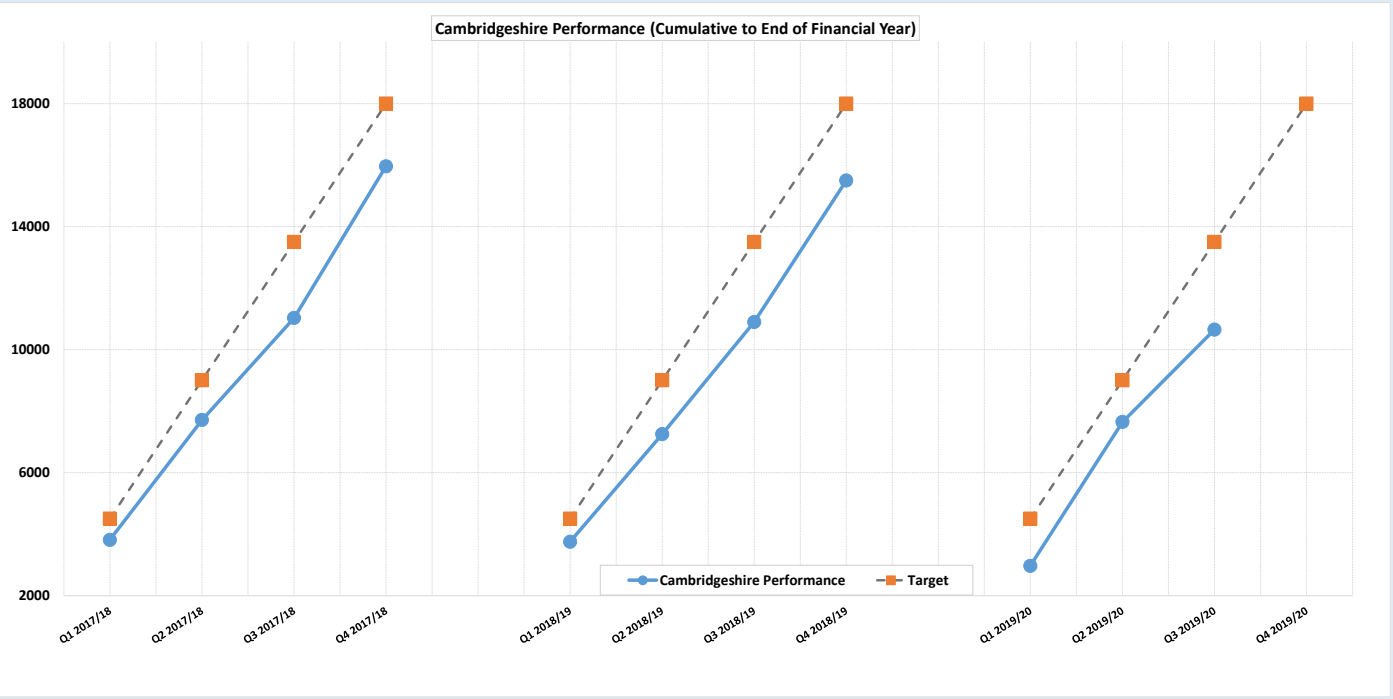
Calculation:
Number of health checks completed within a financial quarter.

Source: NHS Health Check National Guidance

Useful Links

LG Inform:
https://lginform.local.gov.uk/

NHS Health Check National Guidance
https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/



Commentary

Perfomance this quarter is slightly lower (at 79% of target for the period) than for 2018/19 (81% of the target for the period). For Quarter 4 data trawls in GP practices are undertaken which in previous years contributes to improvement in perfomance. NHS Health Checks is a core programme for Public Health as it provides a way of engaging people in an early conversation about their health, risks and lifestyle changes. It also includes potential early detection of risk factors relating to Diabetes, Hypertension, CVD and provides an opportunity to discuss Dementia Awareness. The majority of the activity is commissioned from GP practices with some outreach work being undertaken the commissioned Lifestyle Service.

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
1332	1072	912	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	R

Indicator Description

Smoking remains a Public Health Priority area, it remains the main cause of preventable illness in England.

This measure uses the number of indiviudals receiving stop smoking support via a set programme, who are confirmed as smokefree at 4 weeks post set quit date.

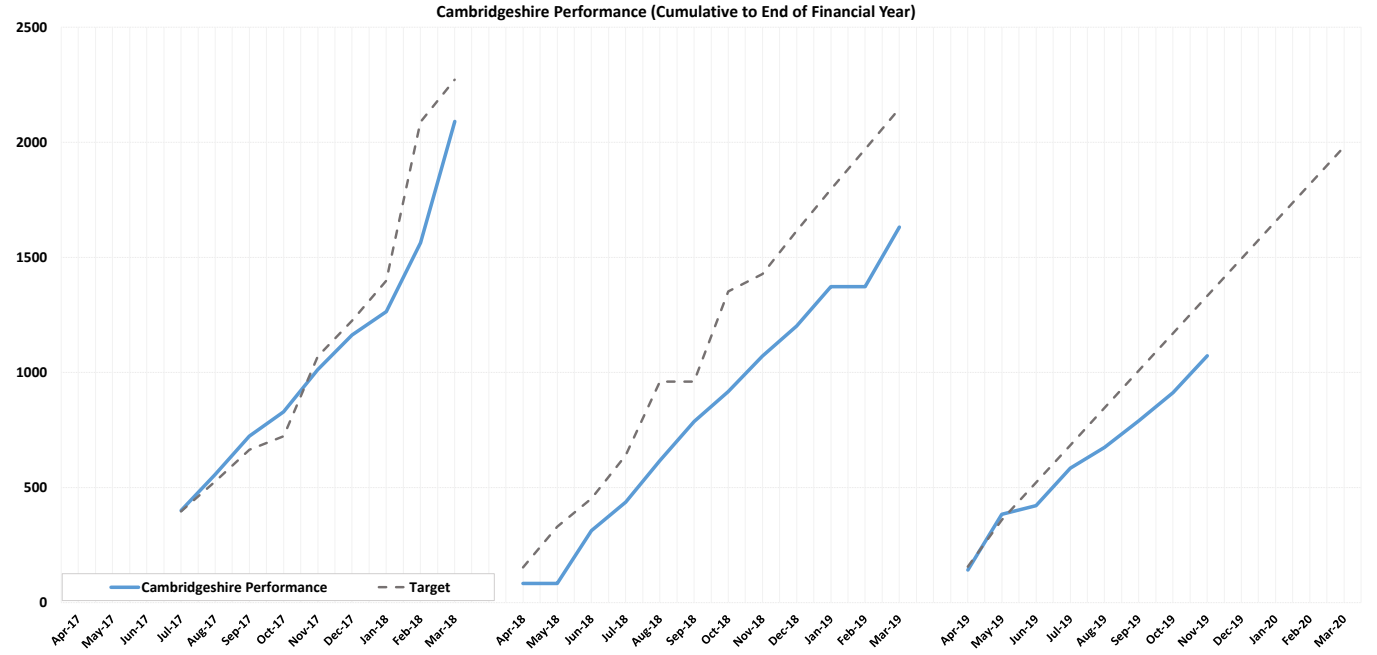
4 week quitters are counted based on the number of indiviudals accessing a stop smoking programme (via GP, Pharmacy or integrated lifestyle provider), who are confrimed as being smokefree 4 weeks after setting a quit date. Targets are calculated by the Public Health Intelligence team based on the national guidance, considering the estimated number of smokers.

Calculation:
Number of 4 week quitters.

Useful Links

LG Inform:
https://lginform.local.gov.uk/

NSCST Stop Smoking Guidance
https://www.ncsct.co.uk/usr/pub/Guidance_on_stop-smoking-interventions-and-services.pdf

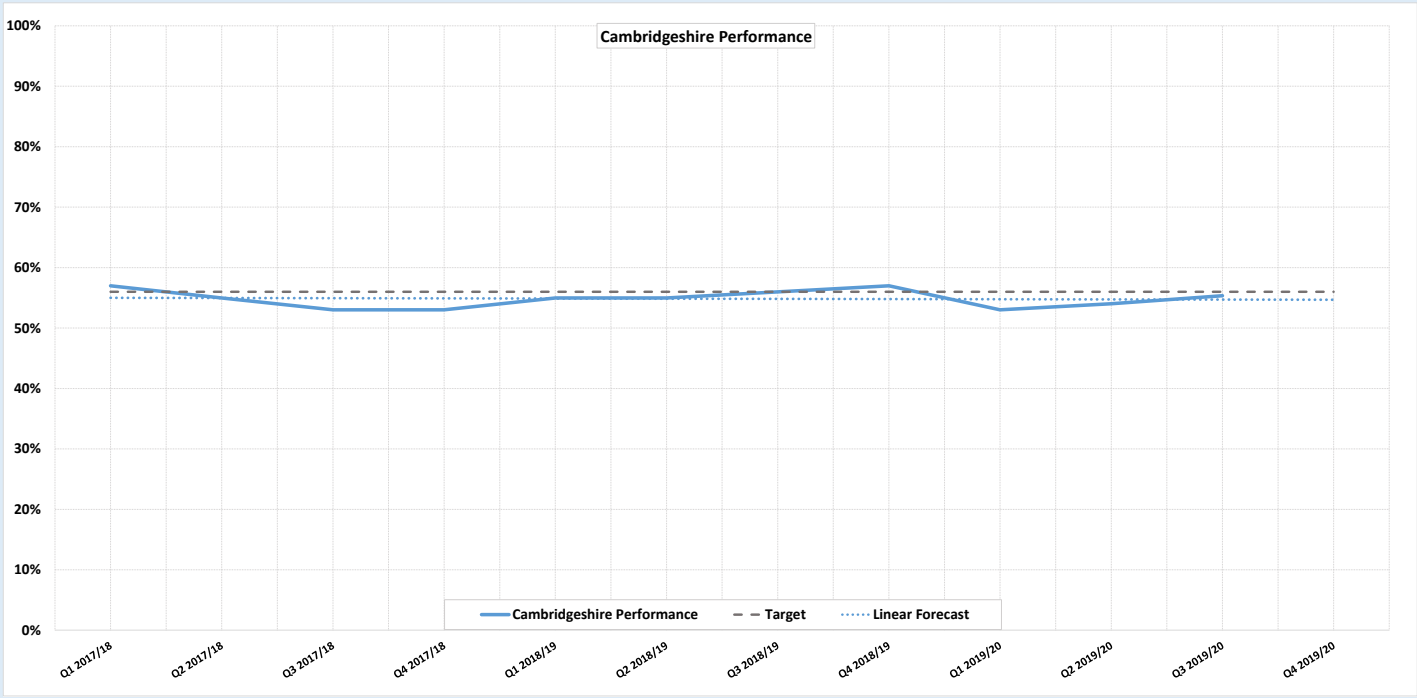


Commentary

Stop Smoking perfomance data is aways two months behind the reporting period due to the intervention taking two months in total. The latest data is for November. Performance is the same as November 2018/19 . Stop Smoking Services activity provided by GP practices has fallen in recent years that is reported as a consequence of competing pressures on GP staff. Lifestyle Service staff provide stop smoking services in some practices to ensure patients can access services. Promotional efforts including the missing moments campaign is focussed upon more deprived areas and certain groups where smoking rates are higher.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
56.0%	55.4%	54.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2018/19)	RAG Rating
49.0%	47.0%	A



Indicator Description

There has been substantial research published demonstrating the positives outcomes breastfeeding can have on mother and infant outcomes. It is recommend that mothers exclusively breastfeed. Breastmilk is associated with a number of benefits such as a reduction in the risk of infections, obesity and diabetes in the infant coupled with a reduced risk of ovarian/breast cancer in the mother. Breastfeeding is also known to have a positive impact on mother and infant attachment and enhance the quality of relationships between parents and their babies and will positively influence a child's future life chances. This indicator was calculated by: Numerator: Number of infants recorded as being totally and partially breastfed at 6-8wks Denominator: Total number of infants due 6-8wk check.

Useful Links

LG Inform:

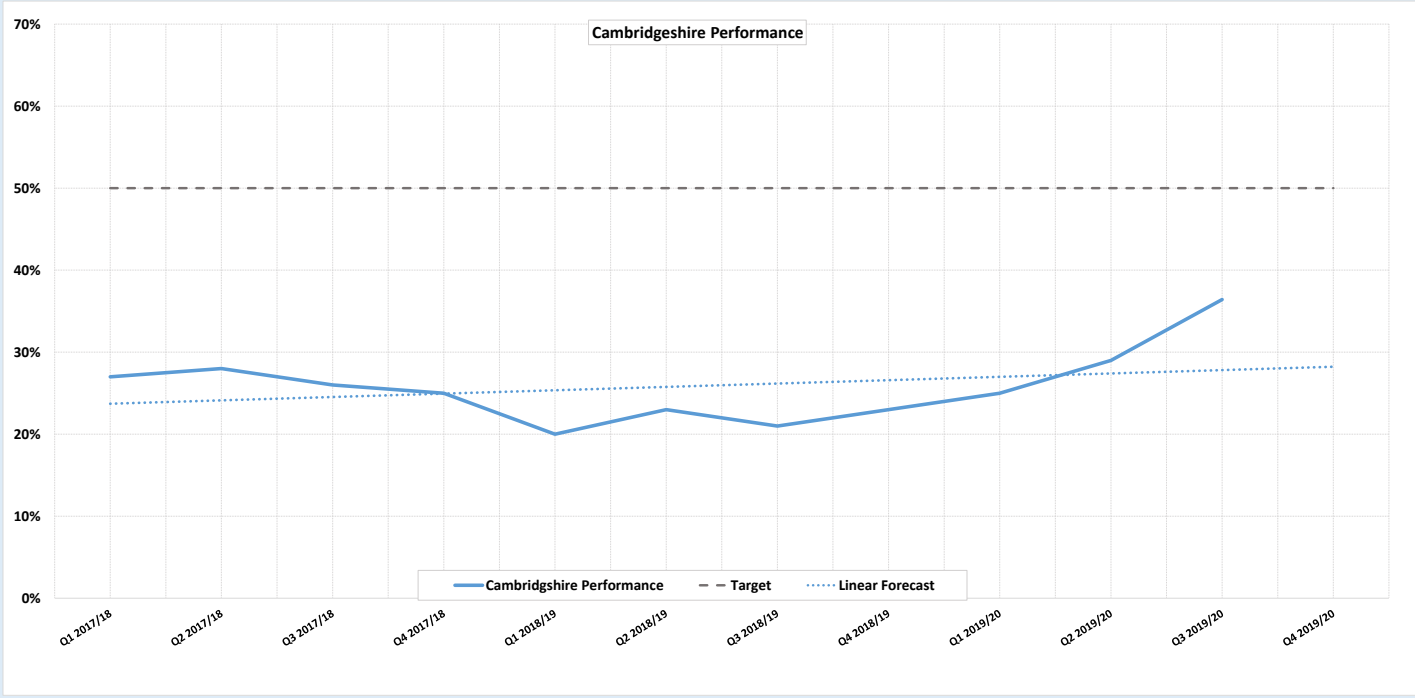
https://lginform.local.gov.uk/ ;
https://www.gov.uk/government/collections/breastfeeding-statistics

Commentary

This is a challenging target and county-wide breastfeeding statistics are presently below the 56% target by 0.6%, although performance continues to significantly exceed the national average of 47%. Breastfeeding prevalence rates, which comprise of both exclusive breastfeeding and mixed feeding vary greatly across the county. Broken down by districts, prevalence for Q3 stand at 65% in South Cambridgeshire, 73% in Cambridge City, 54% in Huntingdonshire, 53% in East Cambridgeshire, and 30% in Fenland. To address low prevalence rates in Fenland, there has been the commencement of 2 new weekly infant feeding clinics in Wisbech and March to better support families experiencing difficulties. In addition to support offered through the Health Visitors, a new community breastfeeding peer support service to improve breastfeeding initiation and duration rates has been commissioned across both Fenland and Peterborough to address inequalities against this indicator, which will come into effect from 1st April 2020. Within the new contract, the Provider (National Childbirth Trust) will conduct an extensive co-production exercise with local families and stakeholders to determine how best to support the unique needs of this community. The Health Visiting service remains Stage 3 UNICEF Baby Friendly accredited, which demonstrates quality of care in terms of support, advice and guidance offered to parents/carers and the excellent knowledge that staff have in respect of responsive feeding.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
50.0%	36.4%	29.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2018/19)	RAG Rating
N/A	41.0%	R



Indicator Description

The antenatal contact is a promotional, listening contact, offering support as directed by the parents. It enables health visitors to offer early support, introduce the services and support parents in terms of preparing for parenthood. This contact is particularly targeted towards vulnerable women and precedence is placed on ensuring vulnerable groups are identified and offered an antenatal visit by their Health Visitor. Performance data for the antenatal contacts is not available nationally because of difficulties with getting the relevant denominator (monthly birth rate are used as a denominator in this instance). Although checks are mandated, there are no national targets and these are agreed locally with the Provider. This contact is calculated by: Numerator - total number of mothers seen at 28 weeks or above. Proxy denominator based on average annual birth rate.

Useful Links

LG Inform:

https://lginform.local.gov.uk/; https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

Commentary

There is no national target set, although it continues to be a mandated visit. Across the county a local target was set for 50%, with a longer term goal of achieving 90% of all antenatal contacts by 2020. Service transformation has accounted for Health Visitors attempting to complete antenatal contacts for all families has been worked against from April 2019. Overall performance against this target remains below expectations and is proving challenging, however clear improvements are being made, highlighted by the upward trajectory. If exception reporting is accounted for, consisting of those booked but not attended, this increases to a quarterly average of 42%. Disaggregated into districts, there continues to be significant variance: Both Huntingdonshire and Fenland completed 55% of contacts therefore reaching the target and is a recognisable achievement; Cambridge City achieved 11% of contacts; East Camb achieved 22% and South Cambs managed to complete 19% of contacts. Reasoning cited for this disparity continues to be pressures in the South Locality team, which covers East Cambs, Cambs City and South Cambs. The locality moved out of Business Continuity Planning (BCP) measures in the autumn, however performance has not improved as expected. Investigation by the Programme Lead revealed that this is also down to historical localised working practices and a significant amount of disruption within the Leadership team, meaning organisational/culture change is factor impacting performance. To address the situation, an action/recovery plan is being developed, which will be submitted to commissioners to enable a close monitoring of improvements.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
90.0%	92.2%	92.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2018/19)	RAG Rating
N/A	88.0%	G

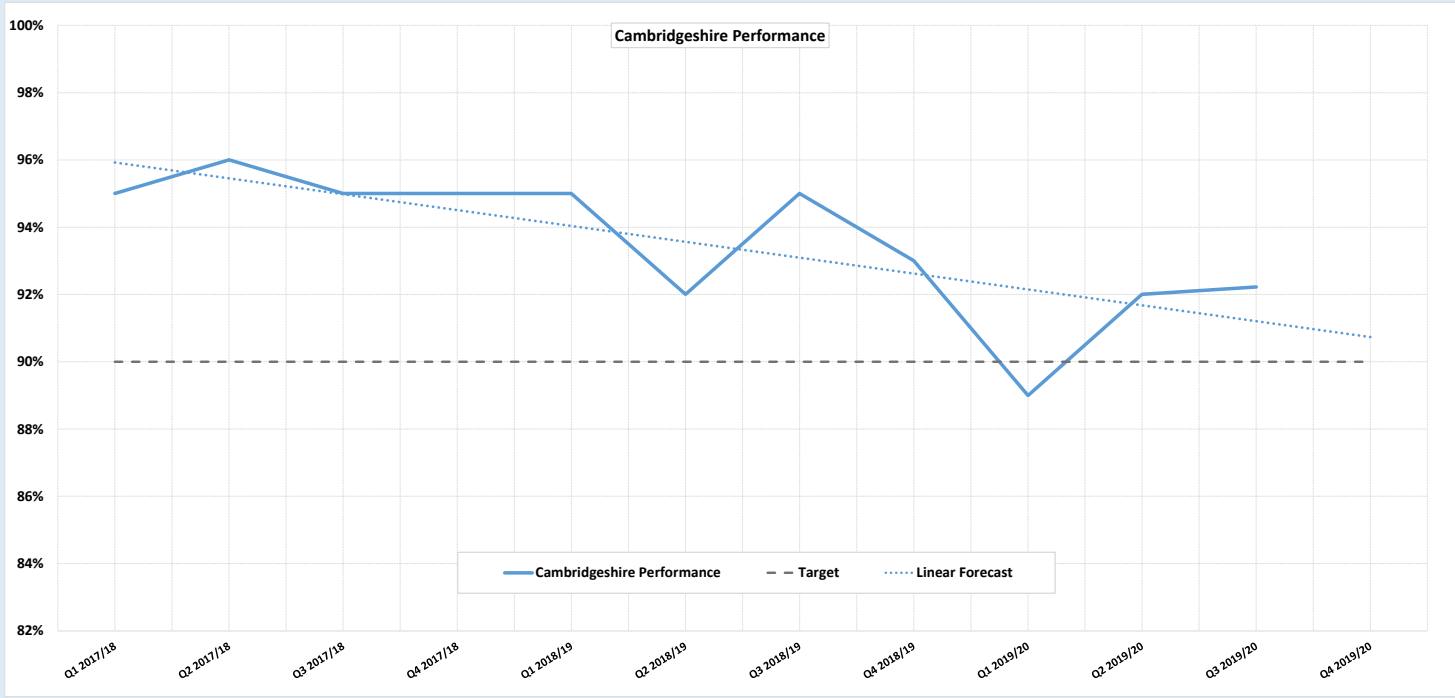
Indicator Description

The new birth visit is a face to face review and will include the provision of information on a range of subject areas including infant feeding, SIDS prevention and safe sleep, the immunisation schedule and outcomes of all screening and NIPE examination results; they will check the new born blood spot status if this was not conducted by the Midwifery team. The Health Visitor will also assess maternal mental health and the baby's growth and development. This indicator is calculated by: Numerator: Total number of infants who turned 30 days in the quarter who received a face-to-face New Birth Visits (NBV) undertaken within 14 days from birth, by a Health Visitor with mother (and ideally father) Denominator: Total number of infants who turned 30 days in the quarter.

Useful Links

LG Inform:

https://lginform.local.gov.uk/; https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

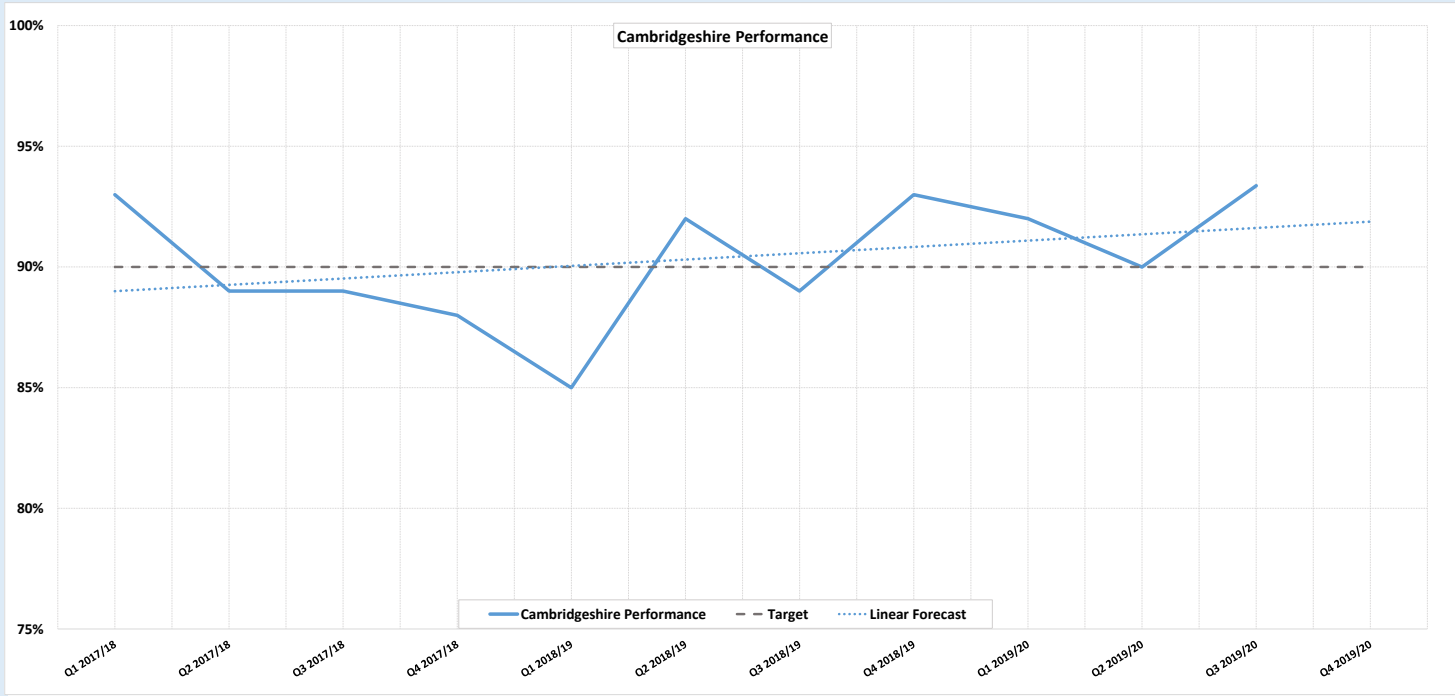


Commentary

The proportion of 10 - 14 day new birth visits completed within 14 days of birth has continued to show improvment this quarter by a further 0.2% and is continuing to exceed the target. If those completed after 14 days are accounted for, the quarterly average increases to 97%, which whilst being 1% below the overall target for completed visits (98%) indicates a majority of families are receiving this contact. The provider reports that in order to achieve continuity of care between the antenatal assessment and the new birth review, in some instances the new birth review has needed to take place outside of the 14 day target to accommodate this best practice.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
90.0%	93.4%	90.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2018/19)	RAG Rating
N/A	86.0%	G



Indicator Description

This visit is crucial for assessing the baby's growth and wellbeing alongside providing core health messages, including breastfeeding, immunisations, sensitive parenting and for supporting on specific issues such as sleep. The Health Visitor will review their general health and provide contact details for the local health clinics and children's centres, where the mother can access a range of support. The visit, in addition to the 6 - 8 week medical review, which is often completed by the GP, forms part of the Child Surveillance Programme. This indicator is calculated by: Numerator: The number of children due a 6-8 weeks review by the end of the quarter who received a 6-8 weeks review by the time they turned 8 weeks, Denomenator: Total number of infants turning 8 weeks old during reporting period.

Useful Links

LG Inform:

https://lginform.local.gov.uk/; https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

Commentary

Performance for the 6 - 8 week review has recovered from slight decease in Q2 and is moving closer to achieving the 95% target, which is positive. This target has been increased in line with national specification guidance and in order to meet the requirements of Public Health England breastfeeding status validation rules, which is predominantly captured during this visit. It is anticipated that this upward trajectory will continue throughout Q4 with the target being achieved by year end.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
95.0%	89.4%	81.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2018/19)	RAG Rating
N/A	84.0%	A

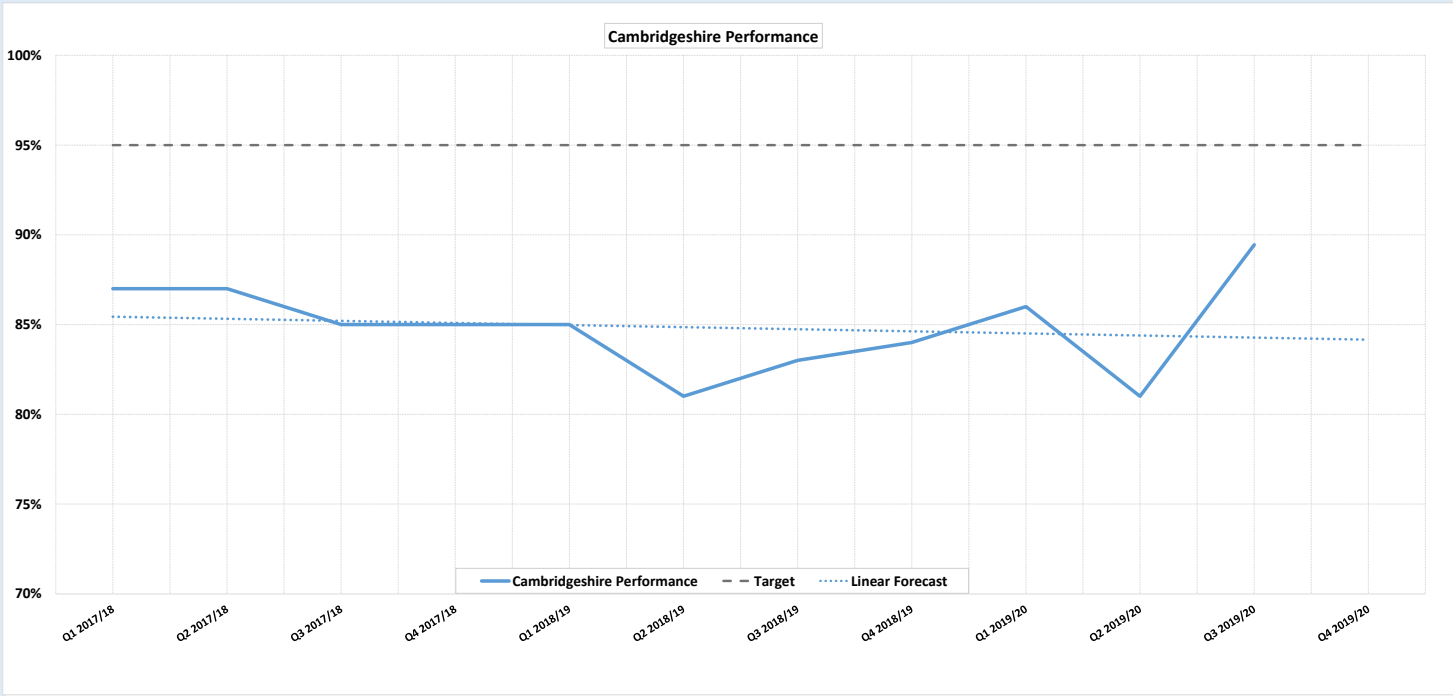
Indicator Description

The 12 month review includes an assessment of the baby's physical, emotional and social development, as well as offering support to parents and providing information on a range of topics such as attachment, development, parenting and overall health promotion (oral hygiene, healthy eating, injury and accident prevention, safety). This indicator is calculated by: Numerator: Total number of children who turned 15 months in the quarter, who received a 12 month a review by the age of 15 months. Denominator: Total number of children who turned 15 months, in the appropriate quarter.

Useful Links

LG Inform:

https://lginform.local.gov.uk/ ; https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

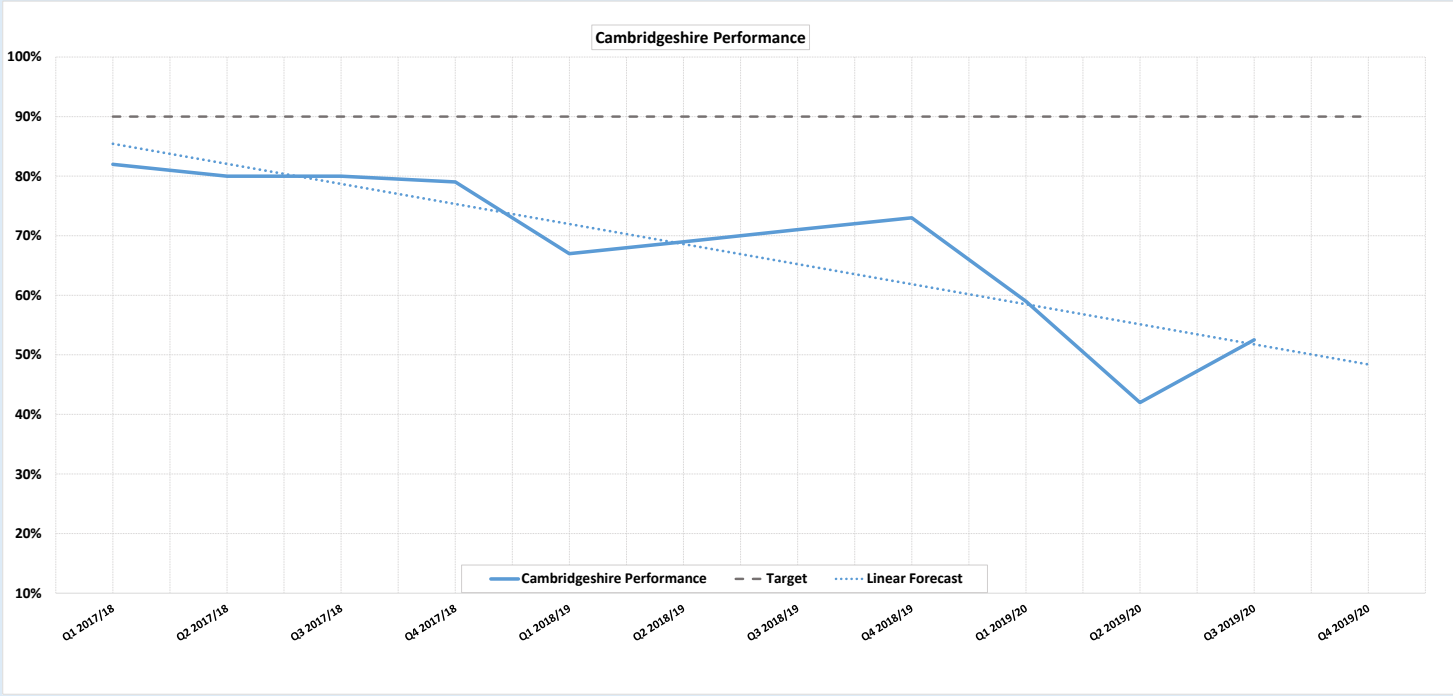


Commentary

Performance has improved by 8.4% this quarter to 89.4%, which is positive; by comparison 77% of families received this visit by the time the child turned 12 months old. The inclusion of exception reporting would increase the quarterly performance to 97% of families having this review by the time the child turns 15 months, meaning appointments are attempted for a high majority of families. Of all appointments offered this quarter, 49 were not wanted by the family and 100 were not attended. Assurances are in place to ensure vulnerable families (those on Universal Plus or Universal Partnership Plus pathways) are receiving this contact and an escalation plan is in place if these mandated visits are missed. A further 46 contacts were 'not recorded'. When district variance is considered, 95% of contacts were completed in Fenland, 86% were completed in Cambs City, 92% completed in East Cambs, 90% completed in Huntingdonshire, and 87% in South Cambridgeshire.

Target	Current Quarter	Previous Quarter	Direction for Improvement	Change in Performance
90.0%	52.5%	42.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2018/19)	RAG Rating
N/A	78.0%	R



Indicator Description

The 2 year check includes the review with parents of the child's, emotional, social, behavioural and language development using the ASQ3. The visit will respond to any concerns, offer guidance on behaviour management, promote language development, encourage the take up of early education and the two year old funded offer, as well as general health promotion (dental health, healthy eating, injury and accident prevention, toilet training). This indicator was calculated by: Numerator: Total number of children who turned 2.5 years in the quarter who received a 2-2.5 year review, by the age of 2.5 years of age. Denominator: Total number of children who turned 2.5 years, in the appropriate quarter.

Useful Links

LG Inform:

https://lginform.local.gov.uk/; https://www.gov.uk/government/statistics/health-visitor-service-delivery-metrics-2018-to-2019

Commentary

Performance has improved by 10.5% this quarter to 52.5%, which whilst commendable is significantly below target and remains concerning. The main cause of performance issues against this target is challenges in the South Locality. 2 year development checks for those who have only universal needs recorded on their records were temporarily suspended during the summer due to low staffing levels, accounting for the low performance in Q2, however this was reversed in the autumn and the team is struggling to reach expected levels of activity – this is being addressed in the recovery plan which is being developed. Disaggregated at district level, 15% of contacts were completed in Cambs City, 23% of contacts completed in South Cambs and 24% of contacts completed in East Cambs. More positively, 91% of contacts were achieved in Fenland and 80% Huntingdonshire. If exception reporting is accounted for, performance would increase to 61.5%. This quarter it was reported that 54 reviews were not wanted and 98 were not attended.

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
778	885	789	↑	↑

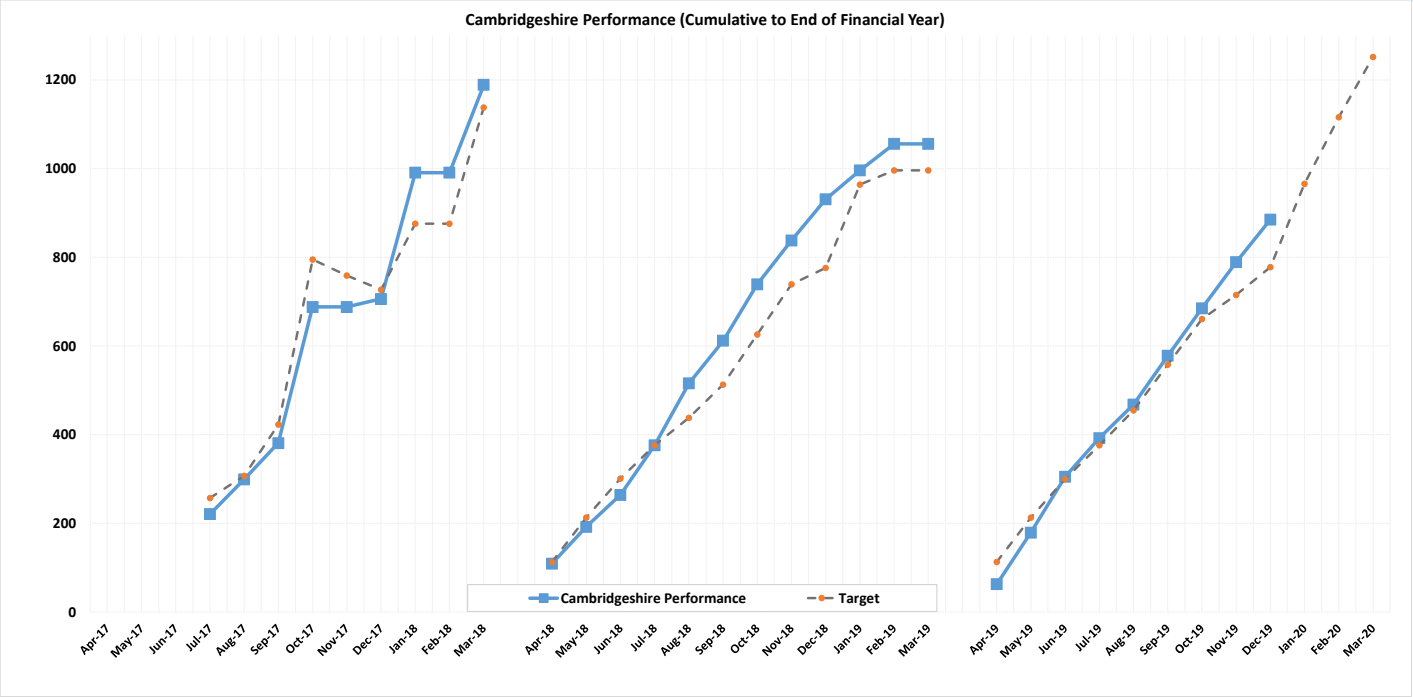
Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

Health Trainer Services provide evidence based behavioural change interventions to support individuals to make lifestyle changes over the course of up to one year. They are part of the Integrated Lifestyle Service and the these GP Service Health Trainers are located in the 20% most deprived areas in Cambridgeshire.
Those supported by Health Trainers develop a Personal Health Plan (PHP) with behavioural change goals.
This measure refers to those who complete their PHPs .

Useful Links

LG Inform:
https://lginform.local.gov.uk/



Commentary

The above target performance is being maintained.

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
484	504	434	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	G

Indicator Description

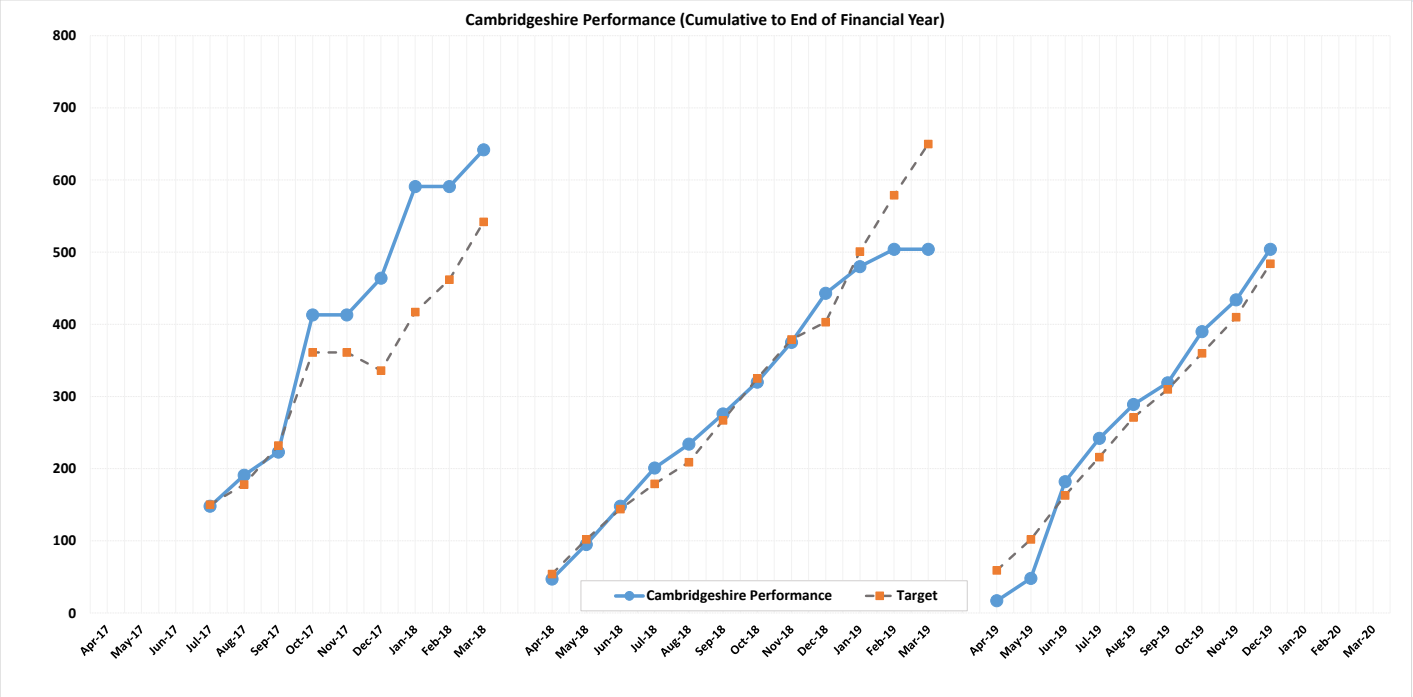
Health Trainer Services provide evidence based behavioural change interventions to support individuals to make lifestyle changes over the course of up to one year. They are part of the Integrated Lifestyle Service and the these Extended Service Health Trainers are located in the areas that are not included in the 20% more deprived areas in Cambridgeshire.

Those supported by Health Trainers develop a Personal Health Plan (PHP) with behavioural change goals.

This measure refers to those who complete their PHPs .

Useful Links

LG Inform:
https://lginform.local.gov.uk/

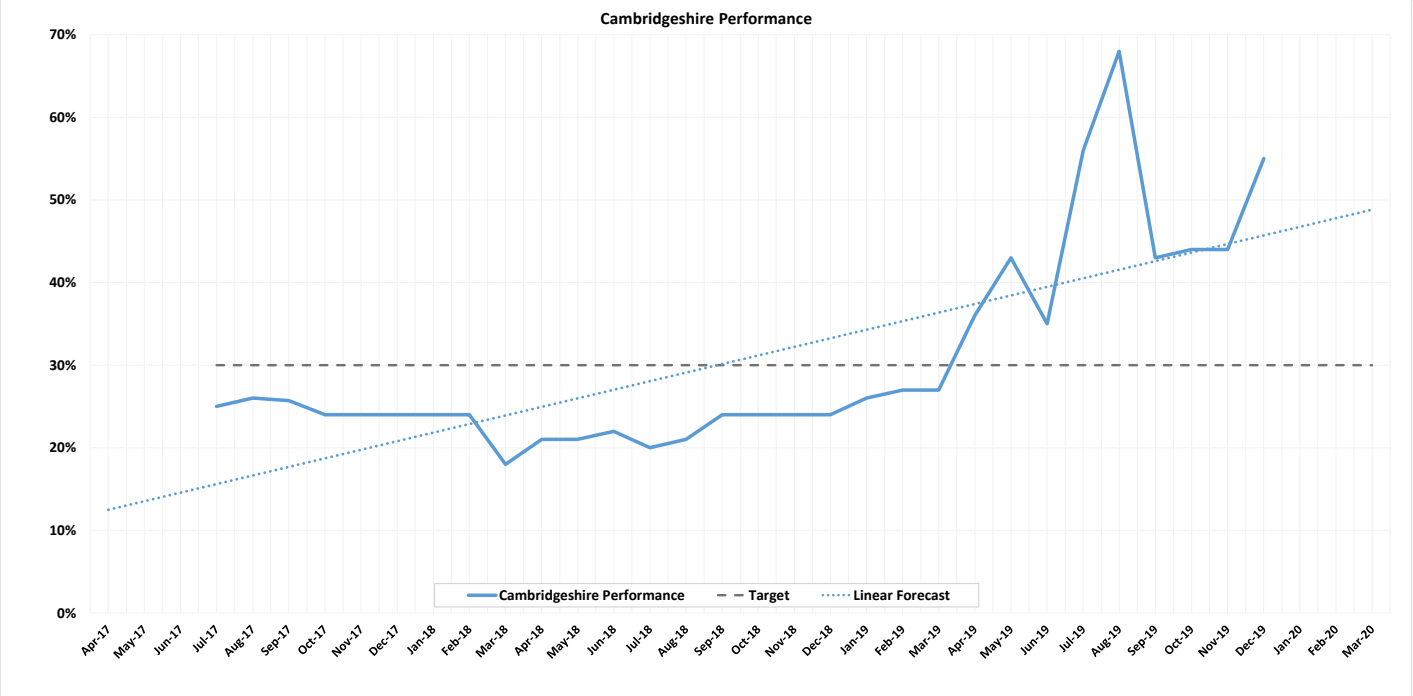


Commentary

The above target performance is being maintained and is higher when compared with the same period in 2018/19

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
30.0%	55.0%	44.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG



Indicator Description

Obesity is a chronic condition with multiple risk factors associated such as type 2 diabetes, heart disease etc. The Tier 2 weight management services offers individuals a structured programme to make continued lifestyle changes. This is a significant area of Public health Priority.

% of individuals completing a Tier 2 weight management intervention who have a weight loss of 5%.

PHE KPI recommendations for Tier 2 Adult Weight Management suggests that 30% of all participants will lose a minimum of 5% of their (baseline) initial body weight, at the end of the active intervention.

Calculation:
(X/Y)*100

Where:
X: The number of Tier 2 clients recruited who complete

Useful Links

LG Inform:
https://lginform.local.gov.uk/

Public Health Key Performance Indicators Tier 2:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/656531/adult_weight_management_key_performance_indicators.pdf

Commentary

The above target performance has been maintained for the past two quarters.

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
60.0%	64.0%	50.0%	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

Obesity is a chronic condition with multiple risk factors associated such as type 2 diabetes, heart disease etc. The Tier 3 weight management services offers individuals a structured programme to make continued lifestyle changes. This is a significant area of Public health Priority.

% of individuals completing a Tier 3 weight management intervention who have a weight loss of 10%.

PHE KPI recommendations for Tier 3 Adult Weight Management suggests that 30% of all participants will lose a minimum of 10% of their (baseline) initial body weight, at the end of the active intervention.

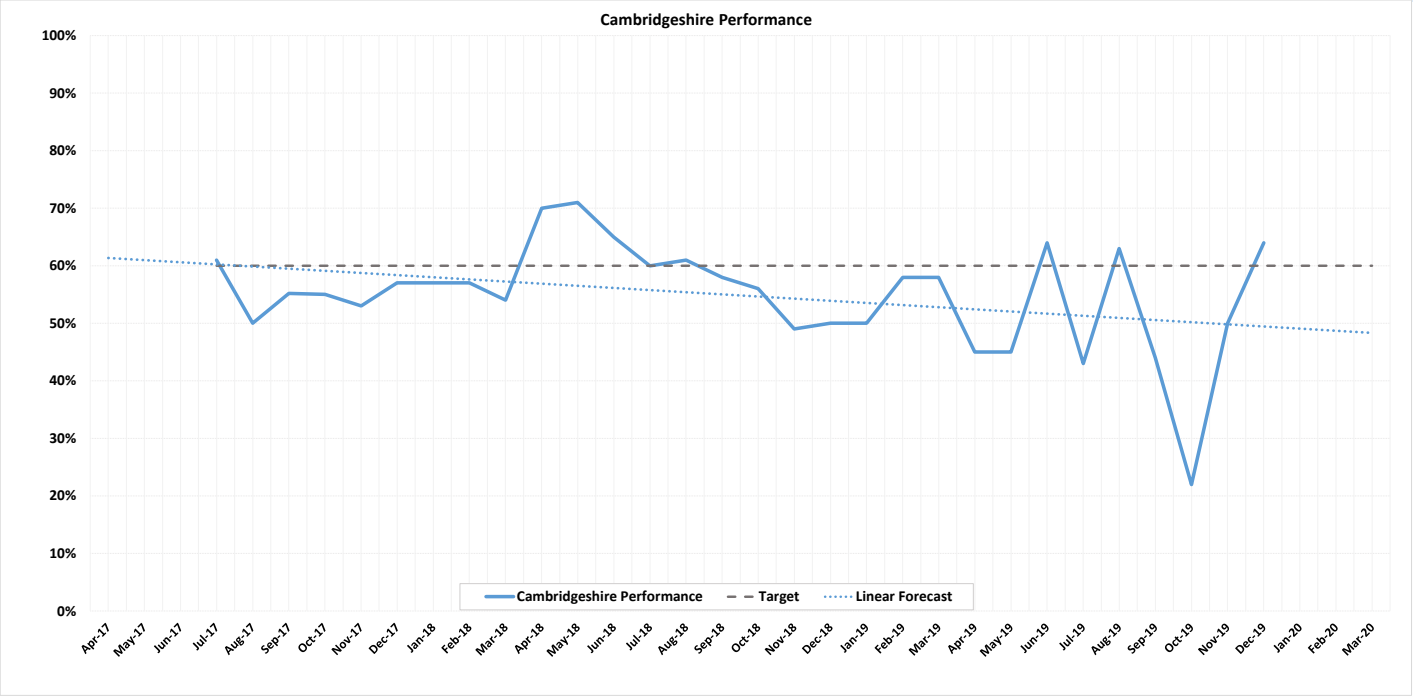
Calculation:
(X/Y)*100

Where:
X: The number of Tier 3 clients recruited who complete

Useful Links

LG Inform:
https://lginform.local.gov.uk/

Qualitative insights into user experiences of tier 2 and tier 3 weight management services:
https://www.innovationunit.org/wp-content/uploads/PHE-Report_with-discussion.pdf



Commentary

The achievement of the Tier 3 weight management service is challenging due to the complex needs of the patients. However performance has improved in Q3. Small numbers mean that a number of very challenging patients can influence achievement against targets.

Target	Current Month	Previous Month	Direction for Improvement	Change in Performance
250	271	255	↑	↑

Statistical Neighbours Mean (2017/18)	England Mean (2017/18)	RAG rating
N/A	N/A	VG

Indicator Description

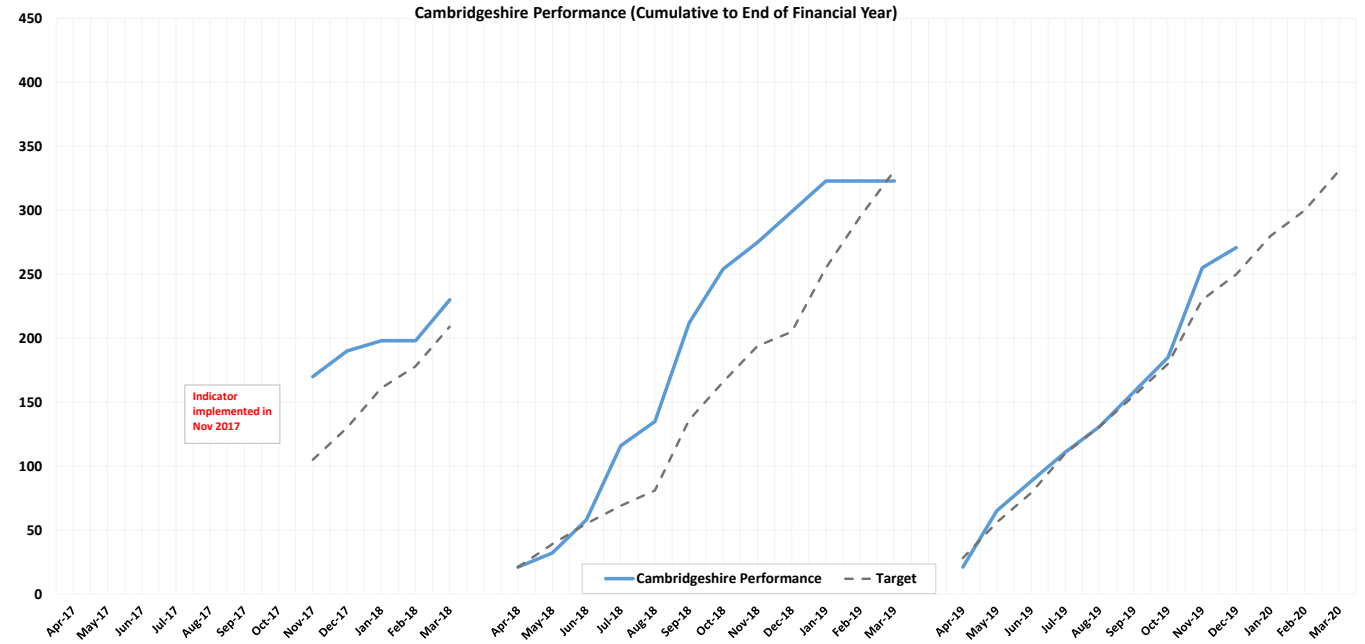
Health Trainer Services provide evidence based behavioural change interventions to support individuals to make lifestyle changes over the course of up to one year. They are part of the Integrated Lifestyle Service and the these specialist Health Trainers who provide evidence based interventions to those at risk of falling.

Those supported by Specialist Falls Prevention Health Trainers develop a Personal Health Plan (PHP) with behavioural change goals.

This measure refers to those who complete their PHPs .

Useful Links

LG Inform:
https://lginform.local.gov.uk/



Commentary

The above target performance is being consistently achieved.

Agenda Item No: 8

JOINT HEALTH AND WELLBEING STRATEGY CONSULTATION

To:	**Health Committee**
Meeting Date:	**March 19th 2020**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To present the draft Cambridgeshire and Peterborough Health and Wellbeing Strategy to Health Committee for consultation and highlight the links with a Think Communities approach**
Recommendation:	**Health Committee is asked to discuss and comment on the draft Joint Health and Wellbeing Strategy in general, on specific actions in the Strategy in which the County Council public health functions would play a role, and on the Think Communities Health Deal Agreement.**

	Officer contact:		***Member contacts:***
Name:	**Dr Liz Robin**	Names:	Cllr Peter Hudson
Post:	Director of Public Health	Post:	Chair
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Tel:	01733 207176	Tel:	01223 706398

1. BACKGROUND

1.1 Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the local health and care system could work together to improve the health and wellbeing of their local population. They became fully operational on 1 April 2013 in all 152 local authorities with adult social care and public heath responsibilities.

1.2 The Cambridgeshire Health and Wellbeing Board is chaired by the Deputy Leader Cllr Roger Hickford and the Vice-Chair is Jan Thomas, the Accountable Officer for the Cambridgeshire & Peterborough Clinical Commissioning Group (CCG).

1.3 Developing a Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in their Joint Strategic Needs Assessment (JSNA) is a statutory requirement of all Health and Wellbeing Boards.

2. MAIN ISSUES

Developing the joint Health and Wellbeing Strategy

2.1 Cambridgeshire and Peterborough Health and Wellbeing Boards have chosen to work together through a 'Whole System' Joint Sub-Committee, which includes the full membership of both Boards, to develop one Joint Health and Wellbeing Strategy across Peterborough and Cambridgeshire. This will increase the strategic impact of the JHWS on the wider health system. Cllr Holdich currently chairs this 'Whole System Joint Sub-Committee', and in the longer term the Chair will alternate between Peterborough and Cambridgeshire.

2.2 The approach to developing the new Joint Health and Wellbeing Strategy (JHWS) was to discuss the key findings of the Cambridgeshire and Peterborough Joint Strategic Needs Assessment (JSNA) with a wide range of local stakeholders. These discussions focussed on health and wellbeing outcomes where we face challenges as a system - for example the impact of population growth on infrastructure and demand for services; significant inequalities between communities; or outcomes where the system as a whole does worse than average. These discussions helped to develop the key priorities and areas of focus for the JHWS.

2.3 The four priorities identified for the JHWS are:

Priority 1: Places that support health and wellbeing
Priority 2: Helping children achieve the best start in life
Priority 3: Staying healthy throughout life
Priority 4: Quality health and social care

Further detail of the background to these priorities, the areas of focus within them, and the proposed actions for the Health and Wellbeing Board and partner agencies are described within the Strategy documents on the consultation web link and attached as Annexes A, B, C and D.

Alignment with the Think Communities Health Deal Agreement

2.4 Communities we live in are fundamental to our health, and we are taking a 'Think Communities' approach to the Joint Health and Wellbeing Strategy. Our Think Communities System Ambition is to develop a public sector workforce that listens, engages with and aligns to communities and each other, through mobilisation of citizens and communities into positive action and commits to delivering services in ways that support communities to drive lasting change.

The draft Think Communities Health Deal Agreement (Annex E) identifies how the System partners will commit to working collaboratively with the focus on place /local communities whilst aiming to empower people to take responsibility to improve their health outcomes. Supporting the health and well-being of our communities is fundamental to Local Government, and the NHS, therefore we recognise that many of the most important factors which affect our residents' health are social, economic and environmental.

The Think Communities approach is based on place and partners supporting Communities /individuals to be enabled to take back responsibility, rather than organisations working in silos .The action needed to address the Wider Determinants of Health can be challenging therefore we need to adopt a much more holistic approach to delivering solutions with Communities which contribute to the delivery of some of the Health and Well-being priorities.

The consultation process

2.5 The consultation on the draft JHWS was launched on February 7th 2020 and will close on 30th April. The consultation documents and questionnaire are available on weblink https://consultcambs.uk.engagementhq.com/health-and-wellbeing-strategy-consultation

The consultation documents include the full draft Joint Health and Wellbeing Strategy, an Executive Summary, and an Easy Read version which has been tested with HealthWatch Access Champions.

Hard copies of the consultation documents will be made available in libraries, or by request from the Public Health administrative team.

Hard copies of the Easy Read version are being sent to organisations working with people with learning disabilities.

2.6 Presentations and/or workshops on the Joint Health and Wellbeing Strategy consultation are in process of being planned for the following Committees and Boards, although at the time of writing some are still to be confirmed:

- Peterborough City Council Health Scrutiny Committee
- Cambridgeshire County Council Health Committee, and any other Committees as appropriate
- A relevant Committee, Panel or Workshop in all District and City Councils
- A relevant forum at the Cambridgeshire and Peterborough Combined Authority

- Cambridgeshire Public Service Board
- The Sustainable Transformation Partnership (STP) Board and relevant Alliances and Clinical Sub-Groups.
- The CCG Governing Body
- Cambridgeshire and Peterborough HealthWatch Board
- Patient Participation Groups and Forums
- Partnership Boards (for Older People, Mental Health, People with Disabilities)
- Voluntary Sector Chief Executives Group
- Cambridgeshire Countywide Community Safety Board
- Safer Peterborough Partnership
- Cambridgeshire & Peterborough Executive Safeguarding Board
- Think Communities Senior Officer Board
- Children's Health and Wellbeing Executive Board
- Cambridgeshire Sub-Regional Housing Board
- Planning Policy Officers Group
- Public Health Reference Group
- Cambridgeshire and Peterborough Smoke Free Alliance

2.7 A progress report on the consultation will be taken to the Cambridgeshire and Peterborough Health and Wellbeing Boards Joint Whole- System Sub-Committee meeting on March 5th 2020.

The consultation feedback report together, with the final draft of the JHWS as modified in response to the consultation, will be taken to the Joint Whole System Sub-Committee for approval on June 4th 2020.

Implementing the Strategy

2.8 The Health and Wellbeing Board doesn't hold its own budget, but works as forum to bring local organisations and leaders together, to develop a joint approach to health and wellbeing.

One outcome of the pre-consultation discussions with stakeholders, was that for most of the key issues in the JHWS we were able to identify a multi-agency board or group which was already addressing the strategic priority or focus area of concern. In some cases this group had agreed a multi-agency plan across Cambridgeshire and Peterborough to achieve this. Sometimes, other key stakeholders were not aware of this work – leading to a risk of duplication and fragmented working across the wider system.

A key proposed outcome from the JHWS is therefore to 'keep it simple' – highlighting, endorsing and signposting to existing multi-agency Boards and groups, which are addressing key health and wellbeing issues. The role of the Health and Wellbeing Boards then becomes to support these groups, prevent unnecessary duplication, regularly monitor their progress against JHWS priorities and the outcomes achieved for residents, and provide strategic challenge, support and 'unblocking' where necessary.

Implications for the work of the Health Committee

2.9 The Health Committee is the Service Committee for Cambridgeshire County Council's public health functions. The Council's Director of Public Health is the lead officer for both the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy, and public health staff in the Council have significant involvement in a number of proposed priorities and actions. The Health Committee is therefore a key partner in the JHWS, and the JWHS will help to deliver identified Health Committee priorities and key outcomes such as reducing health inequalities, children and young people's mental health, and health in new communities.

2.10 The Public Health Directorate will be involved in providing specialist input to many of the actions – either in a leadership role or in a supporting role for multi-agency groups led by organisations across the system.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The purpose of the JHWS is to improve people's health and wellbeing, which is an important aspect of quality of life. Priority 3 is 'Staying healthy throughout life' and Priority 4 is 'Quality health and social care'.

3.2 Thriving places for people to live

Priority 1 of the JHWS is 'Places that support health and wellbeing'

3.3 The best start for Cambridgeshire's children

Priority 2 of the JWHS is 'Helping children achieve the best start in life'

3.4 Net zero carbon emissions for Cambridgeshire by 2050

Climate change is a significant threat to health and wellbeing. Focus area 1.1 of the JHWS is 'Housing Developments and Transport which support residents' health and address climate change'. Under this focus area there is a proposed action 'The Health and Wellbeing Board can endorse and support member organisations' Climate Change Strategies and Action Plans as these develop'.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The draft JHWS does not have direct financial implications for the organisations involved at this point. The plans and actions outlined are expected to be delivered within existing system resources. The consultation process will require officer time, prioritised within

existing workloads as this is a statutory strategy; and there have been limited costs for design, printing (delivered in-house through Peterborough City Council design and print service) and social media.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category

4.3 Statutory, Legal and Risk Implications

The production of a Joint Health and Wellbeing Strategy to meet the needs identified in the Joint Strategic Needs Assessment is a statutory duty of Health and Wellbeing Boards.

4.4 Equality and Diversity Implications

The draft JHWS includes a focus on addressing inequalities in health and wellbeing demonstrated through the joint strategic needs assessment.

4.5 Engagement and Communications Implications

The report sets out details of significant implications in paragraphs 2.5, 2.6 and 2.7

4.6 Localism and Local Member Involvement

The focus on place through a Think Communities Health Deal Agreement is set out in paragraph 2.4

4.7 Public Health Implications

The purpose of the JHWS is to work together to improve a wide range of public health and care outcomes.

Source Documents	Location
Cambridgeshire and Peterborough Joint Strategic Needs Assessment Core Dataset (2019)	*https://cambridgeshireinsight.org.uk/jsna/published-joint-strategic-needs-assessments/*
HealthWatch 'What would you do?' Consultation Report	*http://www.healthwatchcambridgeshire.co.uk/sites/default/files/final_-_cambs_and_pboro_what_would_you_do_report_.pdf*

Joint Health and Wellbeing Strategy Consultation
Paper to Health Committee

Weblinks to Annexes A-D

Annex A: Draft Cambridgeshire and Peterborough Health and Wellbeing Strategy (2020-24)
https://consultcambs.uk.engagementhq.com/3218/documents/3920

Annex B: Executive Summary: Draft Cambridgeshire and Peterborough Joint Health and Wellbeing Strategy
https://consultcambs.uk.engagementhq.com/3218/documents/3930

Annex C: Consultation Questionnaire
https://consultcambs.uk.engagementhq.com/health-and-wellbeing-strategy-consultation

Annex D: Draft Health and Wellbeing Strategy Easy Read
https://consultcambs.uk.engagementhq.com/3218/documents/3940

Annex E

Think Communities Health Deal Agreement

Think Communities Approach

It is an approach to public services that will fundamentally evolve and change the relationship between the Public Sector and Communities.

It will transform the way the public sector delivers its services.

It will see the public sector have a much greater focus and understanding of working within place – joining up the system in innovative ways and delivering our services closer to communities to meet the needs.

It is about understanding the strengths and specific issues within specific areas and working with communities to improve lives.

Our System Ambition

A public sector workforce that listens, engages with and aligns to communities and each other, through mobilization of citizens and communities into positive action. The System commits to delivering services in ways that support communities to drive lasting change.

The Think Communities Health Deal Agreement requires the System partners to commit to working collaboratively with the focus on place /populations to aim to empower people to take responsibility to improve their health outcomes.

Why we have this ambition-

· **We need to do something fundamentally different**.

· Demand for public services is increasing at an alarming rate, often in the context of reducing budgets.

· Forecasts show that this is not likely to change anytime soon.

· Health Inequalities remain with some outcomes are not improving.

· And the system has become too complex.

Interdependencies across the System

Supporting the health and wellbeing of our communities is fundamental to Local Government, as well as to the NHS, we recognise that many of the most important factors which affect our residents' health are social, economic and environmental.

The Health and Wellbeing Board is the place where politicians, health and social care professionals and other leaders across the system work together to solve problems and lead change to benefit our residents. The Health and Well-being Boards signed Memorandum of Understanding (2018) by the Partners stating how they will work together.

The Cambridgeshire and Peterborough Sustainable Transformation Partnership (STP)has prepared their local Five-Year Plan as part of the wider NHS Long Term Plan. This will reflect national guidance from NHS England and local needs for health and care services. It is essential that the Health and Wellbeing Strategy and the STP response to the NHS Long Term Plan are aligned and complementary.

The Public Service Board has also set out its Four Grand Challenges for Cambridgeshire and Peterborough outlined below.

1. Giving people a good start in life.

2. Ensuring that people have good work.

3. Creating a place where people want to live.

4. Ensuring that people are healthy throughout their lives.

The Think Communities approach acknowledges the significant impact that housing, household income and employment, access / use of green space, and environmental issues have on a person's health .Partners know that local residents who present to health services are also the users of other public sector services, therefore the whole sector understands the importance of collective preventative activity to reduce poor health outcomes.

The Think Communities Health Deal Agreement recognises the need to focus on addressing the Wider Determinants of Health to improve health outcomes within our local communities. The Agreement outlines the transformation needed by Public Sector partners to work collaboratively with their Communities to create the conditions needed to enable Communities to take action.

The communities we live in are fundamental to our health outcomes and taking a 'Think Communities' approach based on place, rather than a silo approach based on organisations is at the core of the Strategy. The local health issues are often clear, while the actions we can take locally to address them can be more challenging therefore we need to adopt a much more holistic approach to delivering solutions with Communities.

What can the System do to deliver?

The System Partners recognises the impact on Health Outcomes caused through the Wider Determinants of health which can differ from community to community or geographical location.

Understanding the root causes maybe stemming from Housing, Employment, lack of Green Spaces, Family events / experiences, Education, Lifestyle choices etc.

The System recognises the contribution and resources that Partners can bring to help deliver change and improved outcomes.

Who are the Communities in need?

We need to be able to identify which Communities we are focusing on as System Partners these Communities maybe defined by -

Place – in that the Community belongs to a geographical area

Person – Individuals /families who are in contact with services on a frequent basis.

Community- which could be defined by people who have aspects in common such as Faith, Ethnicity, Longterm Conditions, Isolation, Falls

What are we agreeing to deliver moving forward?

Supporting a set of shared Values developed with our communities to -

Live in an area with good community spirit.

Have enjoyable activities and not be lonely.

Keep Children and young people safe and having fun.

Live in a clean, green and rubbish free area.

Be part of a Community and valued whatever their differences.

Culture change

As a System we will support cultural change through organisational development programmes designed to develop the capacity of our workforce to work across organisational boundaries. Leading to the purposeful creation of a shared culture across our workforce's where individuals can clearly see their role in supporting our communities to become resilient.

Collective delivery of Local priorities

To take some of the Priorities from the Health and Wellbeing Strategy and work at a Community Level to design and deliver improvements that address local health inequalities and improve health outcomes at an individual and Community level.

The Think Communities approach can support the delivery of some of the Health and Wellbeing Strategy priorities by utilising local data and intelligence

For example -

Promote Workplace Health Diabetes

Best start in Life Obesity/Lifestyles

Loneliness Mental wellbeing

Housing/ Homelessness Employment

What this will mean for Citizens and Communities?

Having more say on decisions that impact their lives and where they live and utilising Community Based Assets.

Understanding the community better by building clear area profiles to understand the opportunities, risks and challenges.

Building stronger local connections and community networks.

Working in partnership with the public sector and other organisations to focus on the issues most important in their area.

Focusing more on prevention than cure.

What does this mean for the System?

Letting go - people and communities do not always want and need services involved and can be empowered to take back responsibility for their lives.

Recognising that local places have different strengths and challenges and working through local System groups develop solutions with the Community.

Accepting that communities usually know best.

Working in a way that makes sense to communities, not offering one size fits all approaches and therefore build on the data and local intelligence.

Building greater collaboration with partners and local people equals better outcomes.

Developing a connection to a ‘place’ and really understanding the key issues for that area.

Training our workforce – so that they can work in new ways to support the local community.

Agenda Item No: 9

CCG BIG CONVERSATION FEEDBACK REPORT

To:	**Health Committee**
Meeting Date:	**19th March 2020**
From:	**Jessica Bawden – Director of External Affairs and Policy Cambridgeshire and Peterborough Clinical Commissioning Group**
Purpose:	**The Health Committee is asked to note and discuss the feedback given to Cambridgeshire and Peterborough Clinical Commissioning Group as part of the BIG conversation**
Recommendation:	**It is recommended that the Health Committee:**

1. **Note and comment on the findings; and**

2. **Consider how to include this feedback in future Health and Wellbeing Board planning**

	Officer contact:
Name:	**Jane Coulson**
Post:	Senior Engagement Manager
Email:	janecoulson@nhs.net
Tel:	01733 847348

1. BACKGROUND

1.1 This report is submitted to the Committee following previous reports and information from Cambridgeshire and Peterborough Clinical Commissioning Group regarding their plans and proposals for the BIG conversation engagement exercise. This report gives the Health Committee the feedback received during the BIG conversation which ran from 27 September to 20 December 2019.

1.2 Also included in this report is feedback from the BIG conversation with Primary Care that ran from January 2020 to February 2020.

2. MAIN ISSUES

2.1 The CCG is facing an unprecedented financial challenge in 2019/20 and beyond. To meet this challenge, we needed to garner support from our key stakeholders, providers and importantly the wider public. This required a new approach, so we developed the BIG conversation to talk to the wider public and our stakeholders about how we use our valuable NHS resources and how we take more responsibility for our own health.

2.2 The BIG conversation was an important engagement activity, but not a formal consultation. It was designed to support the financial recovery plan and future commissioning, decommissioning, disinvestment and investment decisions and provide an insight into what matters most to our local people.

2.3 Following on from the success of the BIG conversation with the general public we launched a BIG conversation with Primary to better understand the challenges and demands that they are facing. We launched a short survey in January 2020 and held a number of meetings across the area to engage with Primary Care staff.

3.0 Appendices

- Annex 1 - BIG conversation feedback report;
- Annex 2 – BIG conversation with Primary care feedback;
- Appendix 1 – Community Values Panel report 1;
- Appendix 2 – Community Values Panel Report 2; and
- Appendix 3 – Healthwatch Big conversation response.

Annex 1

The BIG Conversation

27 September 2019 to 20 December 2019

End of conversation report

29 January 2020

Version 7

Jane Coulson

Contents

1. Purpose of the report

This report is to inform Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG) Governing Body of the responses and feedback received during the BIG conversation from 27 September 2019 to 20 December 2019.

2. Background to the BIG Conversation

The CCG is facing an unprecedented financial challenge in 2019/20 and beyond. To meet this challenge, we needed to garner support from our key stakeholders, providers and importantly the wider public. This required a new approach, so we developed the BIG conversation to talk to the wider public and our stakeholders about how we use our valuable NHS resources and how we can take more responsibility for our own health.

The BIG conversation was launched on 27 September 2019 and ran until 20 December 2019. It was designed to help the CCG better understand what matters most to the local community, as well as asking for ideas from the community and clinicians that could help us to make savings in the future.

The BIG conversation was an important engagement activity, but not a formal consultation. It was designed to support the financial recovery plan and future commissioning, decommissioning, investment and disinvestment decisions and provide an insight into what matters most to our local people. It was also an important exercise in raising awareness of the costs of certain services, treatments and medications. We also wanted to help inform people of the options available to them when they need advice or treatment.

Before we began the BIG conversation with the public, we ran a BIG conversation with our clinicians to find out what areas they could identify as working well and working not so well. Where they could see waste and duplication. We had a good response from our clinicians to this survey.

3. Raising awareness of the BIG Conversation

Before we launched the BIG conversation, we shared an outline of our plans and the timelines for this work with Peterborough Health Scrutiny Committee, Cambridgeshire Health Committee, Cambridgeshire and Peterborough Healthwatch, CCG Patient Reference Group, and other key stakeholder groups around our area, and bordering areas. As we developed our plans and early drafts of our documents, we shared them with these groups and their feedback and views helped to shape the final versions.

We knew that we needed to be challenging with the questions and avoid giving too many choices as we really needed people to have to think hard about the difficult decisions faced by the CCG.

To signify this new approach to engagement, we wanted to develop a new brand that whilst embodying the spirit of the NHS, also looked fresh and distinct from campaigns that had run before.

We developed the branding to reinforce the fact that we were asking questions and opening a two-way dialogue. We needed to ensure the branding was eye catching as this was an awareness raising campaign as well as a BIG conversation.

The refreshed branding has received positive feedback throughout the campaign from partner organisations and others.

4. The Big Conversation 27 September to 20 December

4.1. Documents and other materials

The BIG conversation document was developed with feedback from key stakeholders, we included as much information as possible to ensure that people understood the issues faced by the CCG in making tough decisions for the future of the NHS in our area. We were very clear that this was not a consultation but was designed to gather views and understand what was important to people about their local NHS services.

Alongside this full document we produced a shorter summary version with links to the full document. We also developed posters advertising our range of public meeting dates.

On our website we created a separate page with a text only version of the full BIG conversation document to ensure that people who use text readers could access the document. We also printed larger font format versions, and on different coloured paper on request.

An Easi-read version was produced with feedback from the Healthwatch Access champions. The Easi-read version was made up of photo symbols and short easy to read text for people who have learning disabilities.

To support the BIG conversation, we created a marketing toolkit to make it as easy as possible for key partners and stakeholders to help support the engagement activity. The toolkit included wording for websites and internal newsletters, suggested social media posts and posters promoting the BIG conversation events. This was distributed to all GP practices and all local NHS trusts.

4.2. Distribution

We had a print run of 2,000 full documents and 20,000 summary documents, both included paper copies of the survey and contact information. The majority of the printed documents were for distribution to GP practices, pharmacies, local trusts and libraries, with the remainder being kept for any public meetings and local groups. We also sent the BIG conversation documents/or a link to the website via email to save on printing and distribution costs.

We distributed our documents to the following stakeholders either in hard copy or by email:

- Local MPs

- Local councillors, county, city, district and town
- Parish councils
- Patient Reference Group
- Patient Forums (Cambridge/Huntingdon/East Cambs/Greater Peterborough) - email
- All local Libraries
- Key Stakeholder database
- All GP practices
- All pharmacies
- Local trusts
    - Cambridge University Hospitals NHS Foundation Trust
    - Hinchingbrooke Health Care NHS Trust
    - North West Anglia NHS Foundation Trust (all sites)
    - Queen Elizabeth Hospital NHS Trust
    - North Cambridgeshire Hospital, Wisbech
    - Princess of Wales Hospital, Ely
    - Doddington Community Hospital
    - Peterborough Urgent Treatment Centre
    - St. Neots Walk-in Centre
    - Brookfields Hospital, Cambridge
- Healthwatch organisations for Cambridgeshire and Peterborough, Northamptonshire, Hertfordshire
- Local Medical Committee
- Local Pharmaceutical Committee
- Unions
- Local media outlets
- Local charities
- Local support groups
- Local voluntary organisations
- Local Councils for Voluntary Services
- Local businesses and large employers
- All local school sixth form departments.

4.3. Marketing

The BIG conversation was heavily reliant on a strong, integrated marketing campaign that would enable us to reach the broadest cross section of our local community as possible.

Based on low and no cost marketing activities we put in place a plan to focus on a different aspect of the BIG conversation each week to ensure fresh PR and social media content. This plan had to be amended during the pre-election period to scale back new communication.

Our main activities focused on:

- **Facebook** – promotion via our own Facebook page, including specific short polls, but more importantly via local Facebook groups. We are members of over 230 local community Facebook groups, who allow us to share information about the NHS to their members. By carefully targeting these groups with BIG conversation messages we managed to secure a significant uplift in responses.
- **Instagram** – we promoted BIG conversations messages, video and event reminders via our grid and Instagram stories.
- **LinkedIn** – to reach out to our business audience we both posted on our own LinkedIn page and encouraged members of staff at the CCG to post via their own pages as well.
- **Twitter** – we delivered a sustained Twitter campaign to promote key BIG conversation messages.
- **Hard copy distribution** – as noted above, we distributed hard copies of the survey and promotional posters to all GP practices and pharmacies within the CCG area, as well as all local libraries.
- **Advocacy** – as well as mobilising our NHS communications network (Comms Cell) and local authority colleagues, we contacted the top 100 businesses in our local area, along with a wide range of other groups including the WI, FSB, Chamber of Commerce, local charities (such as CamSight) and others to ask them to share the news of the BIG conversation with their members and followers.
- **Events** – as mentioned above, we held local events across the CCG area, as well as proactively seeking out opportunities to attend other events. This included the opportunity to speak at a Sikh Festival in Peterborough, attend Friday Prayers at Cambridge Central Mosque, talk to two dementia support groups, and meet with outpatients being cared for at Arthur Rank Hospice. As part of Self-Care Week, we also took a BIG conversation stand to each of our hospitals to encourage patients and visitors to share their views. On a hyperlocal level, members of the CCG team also shared the survey at children's football training clubs, Rainbows (young girl guides), in local pubs and more.
- **Medical students** – the Cambridge GP Soc were incredibly supportive of the BIG conversation and went out 12 times to speak to members of the public, their future potential patients, about the BIG conversation. This included visits to Cambridge train station at key commuter times and key business districts.
- **PR** – the BIG conversation was supported by a traditional PR campaign, which included the launch of lifestyle research in the last week of the campaign (once the pre-election period had passed). If we have not been in a pre-election period, we would have carried out more PR to support the campaign.
- **Internal communications** – staff were encouraged to complete the BIG conversation (if they live within Cambridgeshire and

Peterborough) and encourage their networks (family, friends, business contacts etc…) to get involved as well.

- **Toolkit and digital assets** – a digital marketing toolkit was created and shared with key system partners, plus a range of videos and social media graphics were created to raise awareness of how to get involved in the BIG conversation.

4.4. BIG Conversation meetings

Ten meetings were held in total across a number of locations in Cambridgeshire and Peterborough, over several months and at different times of the day. Two meetings were held in each of Cambridge and Peterborough, in the afternoon and evenings, to ensure that people who worked had more opportunities to attend. Overall 91 people attended and these included members of the public, Healthwatch, members of staff, local councillors and representatives from voluntary organisations. The meetings were as follows:

Public meetings		
Peterborough, The Fleet	16 October	1:30 – 3:00pm
Cambridge, The Arbury Community Centre	22 October	6:00 – 7:30pm
Huntingdon, The George Hotel	29 October	6:00 – 7:30pm
Cambridge, The Central Library	31 October	1:30 – 3:00pm
Wisbech, The Boathouse Business Centre	7 November	6:00 – 7:30pm
Cambourne, The Hub	12 November	6:00 – 7:30pm
Peterborough, The Fleet	21 November	6:00 – 7:30pm
Ely, The Cathedral Centre	26 November	6:00 – 7:30pm
St Neots, Priory Centre	28 November	6:00 – 7:30pm
March, The Community Centre	10 December	6:00 - 7:30pm

Other meetings and venues attended	
Greater Peterborough Patient Forum	7 October
Cambridgeshire Public Service Board	11 October
Cambridgeshire Area Patient Forum	17 October

Healthwatch, Peterborough Area Health and Care Community Forum	24 October
Healthwatch, Hunts Area Health and Care Community Forum	5 November
Self-care week – Moat House Surgery, Warboys	18 November
Self-care week – Peterborough City Hospital	19 November
Self-care week – Addenbrooke's Hospital	21 November
Self-care week – Hinchingbrooke Hospital	22 November
Peterborough Sikh Gurdwara, celebration event	23 November
Arthur Rank Hospice	2 December
Healthwatch, Fenland Area Health and Care Community Forum	12 December
Peterborough Dementia Network Group	13 December
Cambridge Mosque	13 December
St Ives Alzheimer's Society	17 December

The Healthwatch Community Values Panels

The CCG commissioned Healthwatch Cambridgeshire and Peterborough to run two community values panels to explore some of the issues in the BIG conversation in more detail.

Healthwatch recruited the community panels to ensure that they were fully reflective of the diverse demographic characteristics of the county. The panels were made up of 30 people and met on two separate occasions to explore in depth two issues.

Community Values panels		
Prescribing and over the counter medicines	24 October	St Ives
Urgent and emergency care.	19 November	St Ives

Healthwatch produced two independent reports that describe the work of the community panels and the outcomes of the is work. They are attached as appendix 1 and appendix 2

4.5. Media coverage

We briefed local media about the BIG conversation via a media event on 25 September 2019, supported by an embargoed press release issued on 26 September 2019 in advance of the public launch on 27 September 2019. The CCG Chair Dr Gary Howsam also gave media interviews with the BBC, the Cambridge News and the Fenland Citizen on 25 September 2019, as well as Huntingdon Community Radio on 17 December 2019.

Due to the pre-election period, which was put in place as a result of the snap election called for 12 December 2019, the CCG was not able to publicise the BIG conversation as much as it would have done outside the pre-election period. A last-minute PR push was organised for the days immediately following the election, and several more news articles were published during this final push.

Over the course of the BIG conversation campaign, it was picked up by ten local and regional media outlets including radio and print, reaching a potential audience of 2,498,299[1].

4.6. CCG website and social media

Website

The BIG conversation had a dedicated area within the CCG's website, along with a prominent banner on the homepage of the website which remained for the duration of the project. The BIG conversation also had a separate text only page which also held the easy read version of the summary document. There was also a page for the BIG conversation toolkit which contained all the assets (posters/images/videos/documents) for partner organisations to download and use on their own websites and social media. When publicising the BIG conversation, we used shortened url links (Bit.ly) to make it easier to remember.

Website visits	
Get-involved/the-big-conversation	4826
Get-involved/the-big-conversation/text-only-	64
Get-involved/the-big-conversation/big-conversation-toolkit	255
Bit.ly/NHSBigConversation	2143

Downloads		
The BIG conversation	full document.pdf	450

[1] Based on monthly visitor figures for web outlets, monthly users where this figure was the only one available, print circulation figures and monthly listeners

The BIG conversation	summary.pdf	885
The BIG conversation	Easi read.pdf	50
The BIG conversation	general video.mp4	71
The BIG conversation	toolkit poster.pdf	87

Social media

During the BIG conversation we used four social media platforms to engage with the public and staff; Facebook, Twitter, Instagram and LinkedIn. All the profile pictures and banners were changed to images with the BIG conversation branding during the engagement and regular updates were posted.

Facebook

We launched the BIG conversation with a video and link encouraging people to visit our website. This post received 163 shares and reached around 25,500 people.

In addition, we received 128 comments on our Facebook posts, 529 shares and reached 99,666 people via posts on our own page.

We didn't just post links to the survey on our Facebook page, we also:

- Ran a weekly poll asking a different question from the BIG conversation. This generated a lot of engagement, comments and shares from local residents.
- At Halloween, we took some of the stats from the BIG conversation document to highlight these 'scary stats' encouraging people to take part in the online survey – these posts alone reached 12,500 people in one day.
- We also added all our public events to our Facebook page reaching 15,450 people.

Facebook groups

Across Cambridgeshire and Peterborough, we have an active network of hyperlocal Facebook groups, where people discuss issues that matter most to their city, town or village. As part of the BIG conversation we reached out to our local community via these groups – going to the places where conversations about local issues are discussed, rather than expecting people to come to us.

In total, there are around 300 Facebook groups across Cambridgeshire and Peterborough, which connect hundreds of thousands of people.

On three separate occasions we specifically posted information about the BIG conversation into all these groups.

1. On this first post we included a link to our website, and this meant people had to look to find the link to the survey.
2. Much more successful post with a call to action to fill in a quick survey about local NHS services with a direct link to the survey. In two days, we had over 1000 responses.
3. By using a unique url we could see that over 850 people had filled in the survey as a result of this post.

Twitter

We sent messages to lots of local businesses and third sector organisations asking them for their support and to share the information about the BIG conversation to their followers to expand the reach of the campaign.

Activity	Retweets	Reach
We launched the BIG conversation with a video and link encouraging people to visit our website	21	12,400
BIG conversation tweets across the whole campaign, combination of encouraging people to take part in the survey and promoting the public events	80	47,405

Instagram

For Instagram we used a mix of promoting the events, the link to the survey and videos encouraging people to take part. These posts achieved 105 likes and reached 3,676 people, whilst our Insta Stories (of which we posted 22) were viewed 1,171 times.

LinkedIn

LinkedIn was used to reach local people, as well as our own staff. During the engagement we made nine posts, reaching 3,426 people via the CCG page, which was also supported by a range of posts by other members of the CCG team.

4.7. Response details

Activity	Responses
Survey responses	5,732
Public meeting attendance	91
Organisation responses	1
Community values panels	30
Facebook comments	128
TOTAL	5,982

4.8. Responses from other organisations

We received one response from an organisation, Healthwatch Cambridgeshire and Peterborough. The full response is attached as appendix 3

4.9. Feedback from the BIG Conversation responses

We received a huge amount of feedback during the BIG conversation, through our public meetings, responses to the online survey and through social media channels.

In the following sections you will see the responses to the questions asked during the BIG conversation as well as themes that were collated from all of the responses we received. We have not reported each individual response but have read them all and reported on the common themes and the most common responses that we received. We have also raised any particular issues of concern to the appropriate teams internally.

The responses reported below are a combination of feedback we received at meetings we attended during the BIG conversation as well feedback through social media, in person, and on the returned surveys. Forty-six percent of people who replied to the survey took the opportunity to share their views with us through the free text option.

Our survey software gave us feedback on the most common words used in the free text responses and it is important to note that the top five words given in feedback were:

1. Needs
2. Patients
3. Services
4. NHS
5. Appointments

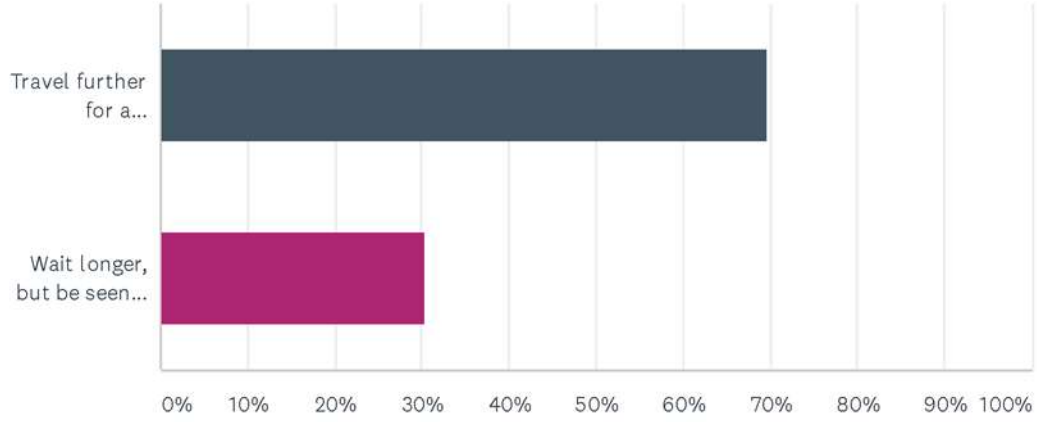
Q11 Do you have any other ideas or insights you'd like to share with us?

Fig 1. Word cloud graphic exported from SurveyMonkey

At the public meetings and in survey responses we heard that some people did not like the binary nature of the questions and found them difficult to answer as they wanted more options, or to give a nuanced response. Some people chose not to answer the questions at all and just give us their views in the free text area at the end. Others told us that the nature of the questions made them realise what difficult decisions the NHS organisations were having to make. People also appreciated being asked for their views even if they didn't like the questions.

Q1 If you needed to be seen by a healthcare professional, would you rather…

Answered: 5,619 Skipped: 113



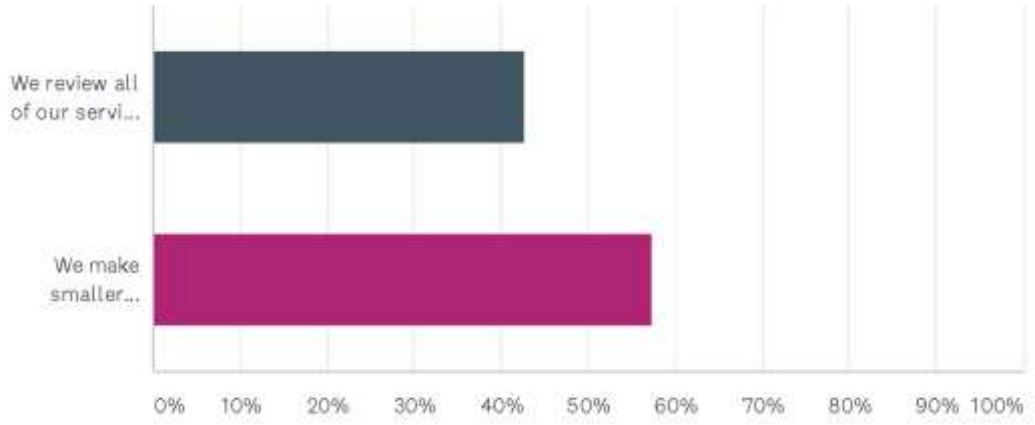
ANSWER CHOICES	RESPONSES	
Travel further for a specialist appointment, but be seen quicker	69.73%	3,918
Wait longer, but be seen locally	30.27%	1,701
TOTAL		5,619

Fig 2. Question one graph exported from SurveyMonkey

The majority of people said they would be prepared to travel further for a specialist appointment, if they could be seen quicker. However, this was of course dependent on a number of factors – such as the severity of the condition and distance they would have to travel. Some people found this a difficult question to answer as different factors could impact on the response. People wanted to see a specialist for their care, and many would be prepared to travel for that service if they had access to transport. People felt this could be difficult for older people or people who rely on public transport. Public transport and non-emergency patient transport was raised as a particular issue in our area. Public transport in our rural areas is a problem for people due to the infrequency of services.

Q2 Thinking about all of the services that we fund and the savings we need to make, would you rather…

Answered: 5,529 Skipped: 203



ANSWER CHOICES	RESPONSES	
We review all of our services and only keep the ones that have the greatest positive impact on the health of our community, while stopping others	42.65%	2,358
We make smaller reductions to most of our services	57.35%	3,171
TOTAL		5,529

Fig 3. Question two graph exported from SurveyMonkey

This question was not a popular question, people did not feel that we should be reviewing or reducing any services. This question was skipped by the highest number of people responding to the survey. People felt that we should just carry on overspending – the Government should solve the issues by giving more money to the NHS in this area. People felt that services were spread thin enough as it is, and that the Government should fund the NHS properly to provide good levels of service to everyone. Some people felt that a rise in taxes or national insurance should be considered to pay for more NHS care. People felt that our local MPs should be supporting and lobbying the government to fund the NHS better in our area. People also told us that this question really made them think and realise the tough decision that the CCG were facing.

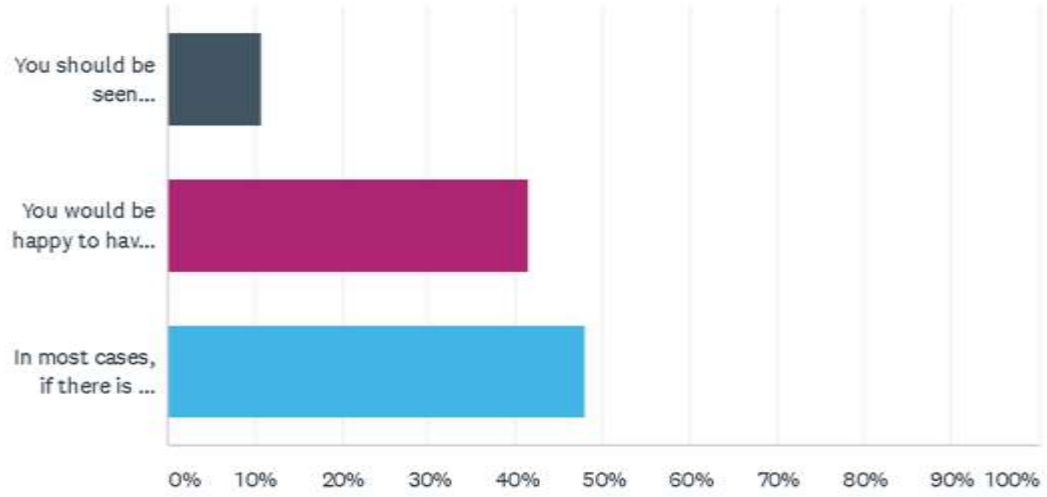
There was also feedback about which people should be entitled to free NHS care. There was a feeling that people who visit the UK for a short period of time should be charged to receive health services provided by the NHS including emergency care. People should have to prove their residency through ID and health insurance documents before they receive care.

We also received feedback that all NHS services should be delivered the same across the whole country. There shouldn't be regional differences. "Postcode lottery" of services was seen to be unfair and wrong. People mentioned this most when talking to us about IVF services. Roughly 30-40 people urged the CCG to reinstate IVF treatment for at least one cycle.

We were also told the NHS shouldn't fund any treatments or services that don't directly improve people's health or save lives – included in this were cosmetic surgery, vasectomies, gluten-free food prescribing, and IVF.

Q3 We spend millions of pounds on routine follow up appointments after a treatment or a procedure. If everything has gone well, do you think...

Answered: 5,657 Skipped: 75



ANSWER CHOICES	RESPONSES	
You should be seen face-to-face to be reassured that everything has gone well	10.62%	601
You would be happy to have a telephone call or video call (such as Skype) with a health professional to follow-up how you are doing and go in to see the Doctor if there is any concern	41.49%	2,347
In most cases, if there is no need for a follow up appointment, then you would be happy to be given a number to call if you had any concerns	47.89%	2,709
TOTAL		5,657

Fig 4. Question three graph exported from SurveyMonkey

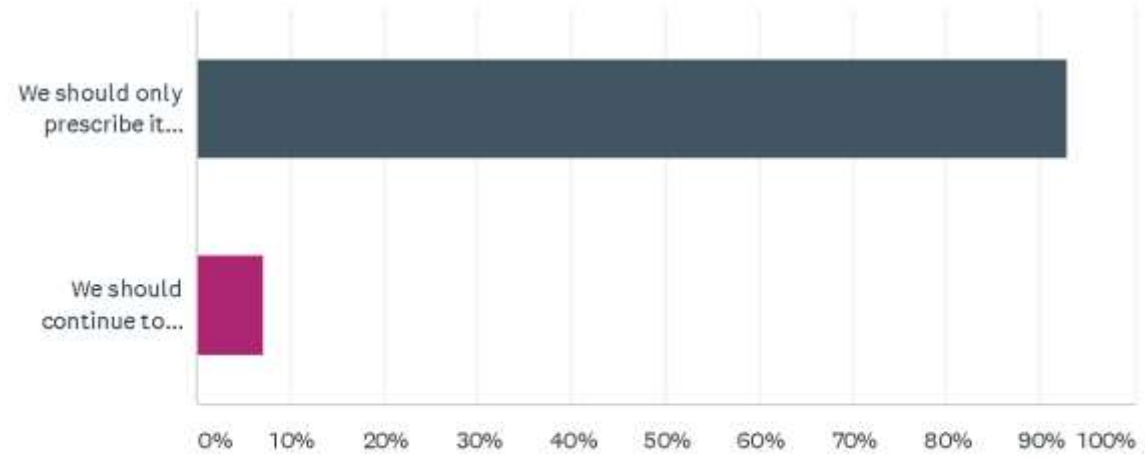
People felt that if a follow-up appointment could be easily done by phone or using technology then they would prefer not to travel to those appointments. People often felt that a follow-up appointment just to be told everything had gone well were a waste of time and expense to both themselves and our NHS staff.

People told us that travelling to our hospitals and parking there could be a real hassle and take a lot of time out of their day. They were happy to see technology used more effectively

in this area. However they did want us to be mindful that some people are excluded from use of technology whether that is computers, tablets or telephones due to age, lack of understanding on the equipment, not able to access the equipment, or due to communication issues.

Q4 We spend £5.3 million on medications each year that could be bought over the counter rather than via a prescription. Often these medicines are cheaper to buy over the counter than it is to pay for a prescription. Given the constraints on NHS finances, do you think that…

Answered: 5,639 Skipped: 93



ANSWER CHOICES	RESPONSES	
We should only prescribe items that cannot be readily purchased over the counter to enable the money to be spent on other healthcare services	92.84%	5,235
We should continue to prescribe anything people need and reduce other healthcare services	7.16%	404
TOTAL		5,639

Fig 5. Question four graph exported from SurveyMonkey

People were mostly supportive of GPs not prescribing medicines that could easily and cheaply bought over the counter in most pharmacies. However, people felt that there should be still be exceptions to this at the GP's discretion. If the GP felt that the patient would not buy the medicine and the condition or illness would deteriorate then they should still prescribe that medicine. People also told us that people on low incomes may struggle to buy those medicines so should still be able to get them on prescription if deemed necessary by their GP or prescribing clinician.

People also told us that schools and some care agencies would not administer medicines that were not prescribed, so they needed to get those medicines prescribed to ask the school or care givers to administer them.

People told us that they felt the people who receive free prescriptions should be reviewed. Some people receive free prescriptions due to having a specific long-term condition as that condition requires them to take regular medicines. The free prescriptions then apply to everything that is prescribed to treat that person, whether related to their long-term condition or not. People felt that the free entitlement should only apply to drugs related to the existing condition, not everything else. People also questioned which conditions made people eligible for free conditions. Asthma was raised as a condition which didn't make people eligible for free prescriptions but people with asthma need a lot of ongoing medical prescriptions to keep well. People asked us to review eligibility for free prescriptions, especially age. Free prescriptions from the age of 60 years was considered too young, especially now that retirement ages were higher than this.

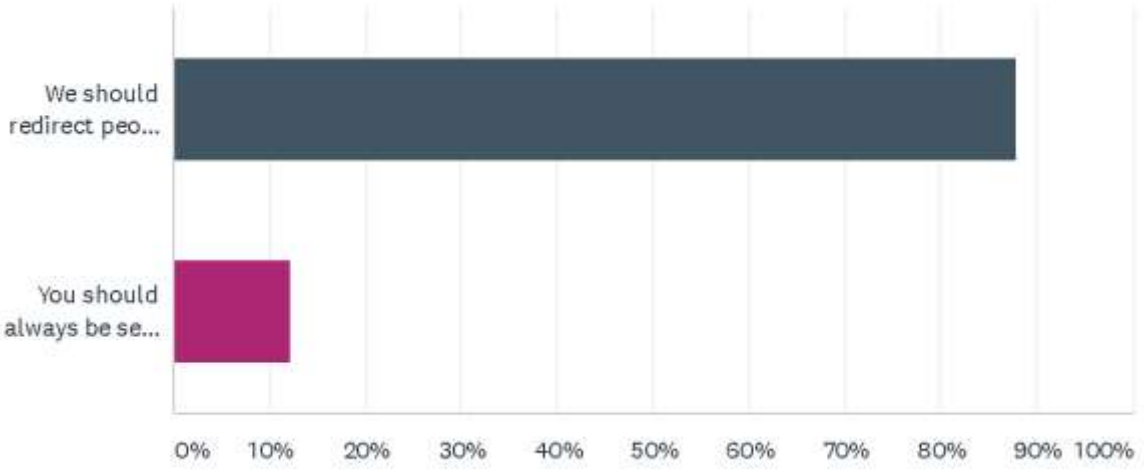
Another suggestion was that the NHS should print the costs of the drugs on the packets so people could see how much their medication was costing the NHS even if they were entitled to get it for free. People might then be more careful about what they ordered and in what quantities.

Some people felt that drugs should be prescribed in larger amounts to reduce necessity for constant re-ordering and administration cost, other felt that when medications were being changed that smaller amounts should be prescribed. Then if the patient had a bad reaction there would be much less waste.

People also thought that the NHS centrally should negotiate harder for better deals on drug prices.

Q5 Like many other areas we have busy A&E departments and sometimes we struggle to see the most urgent cases quickly. Do you think…

Answered: 5,659 Skipped: 73



ANSWER CHOICES	RESPONSES	
We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency	87.88%	4,973
You should always be seen at A&E if you go there and you shouldn't be turned away	12.12%	686
TOTAL		5,659

Fig 6. Question five graph exported from SurveyMonkey

There was generally consensus on this issue in the comments we received and at the public meetings. People told us that we should turn people away from A&E if they shouldn't be there. A&E should only see those that are urgent.

Although some people felt that could be a risk as some people presenting with what might appear to be minor ailments could actually be more urgent.

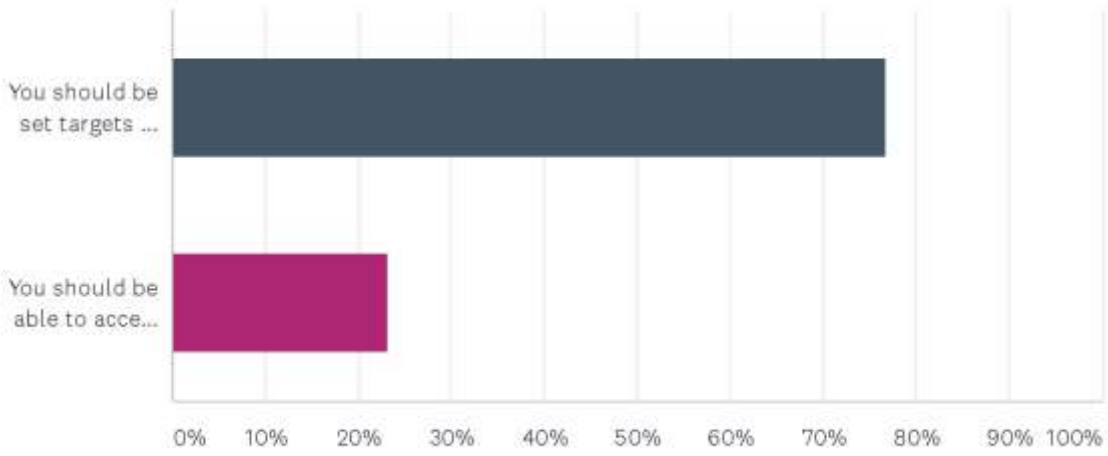
This question also raised the issue that people don't know where to go, or what needs urgent care. Some people felt you shouldn't be able to walk into A&E. You should only be able to go there if you have been directed there from a different service or delivered by ambulance. However, some people told us that it is known that if you go to hospital in an ambulance, you are given priority which doesn't encourage people to drive themselves there and could account for unnecessary ambulance call outs.

People felt that we should have a triage service that sees everyone first unless they are in an ambulance or referred there by being seen by a clinician elsewhere first.

A few responses said that people who abuse alcohol and illegal drugs should not be treated by the NHS in A&E. Or if they need to be treated, they should be billed for their treatment.

Q6 Research shows that by living a healthy lifestyle – for example not smoking, maintaining an active lifestyle and healthy weight, and not drinking too much alcohol – you can reduce your chances of suffering from a number of illnesses and diseases, such as cancer, diabetes and heart disease. Given these facts, do you believe…

Answered: 5,641 Skipped: 91



ANSWER CHOICES	RESPONSES	
You should be set targets to improve your own health, such as stopping smoking, reducing your weight or alcohol consumption, before having planned operations	76.74%	4,329
You should be able to access whatever services you need, even if you do not make lifestyle changes that would help to manage your condition better	23.26%	1,312
TOTAL		5,641

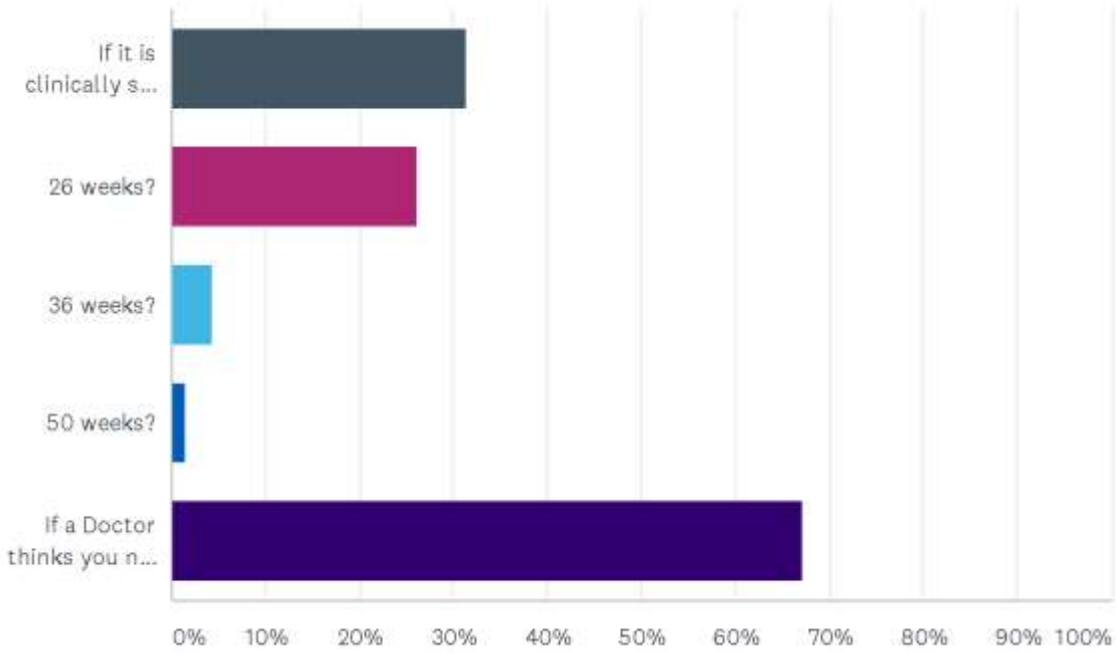
Fig 7. Question six graph exported from SurveyMonkey

The feedback we received on this issue was that people should be empowered to look after themselves, but not in a patronising way. Setting realistic goals and targets in order to improve their health is much better than imposing restrictions on services for people based on their weight or whether they smoke or not. Some people may not have access to information on healthy lifestyles so more needs to be done to educate people, especially children and young people. Changing old habits to a healthy lifestyle can be difficult so people need support.

Some people told us that the NHS should look at alternative therapies and holistic treatments, especially around healthy lifestyles and wellbeing.

Q7 Due to medical advances and people living longer and with more complex diseases we are seeing a big increase in the numbers of hospital referrals and planned operations. There are a number of reviews into how waiting lists are managed. Do you think . . .

Answered: 5,643 Skipped: 89



ANSWER CHOICES	RESPONSES	
If it is clinically safe to do so, you would be happy to wait longer than 18 weeks for a procedure or appointment so that more urgent patients can be seen first? If so, how long would you be prepared to wait...	31.28%	1,765
26 weeks?	26.10%	1,473
36 weeks?	4.39%	248
50 weeks?	1.54%	87
If a doctor thinks you need to be seen, then you should be seen as soon as possible	67.22%	3,793
TOTAL RESPONDENTS		5,643

Fig 8. Question seven graph exported from SurveyMonkey

People told us that they felt that waiting times were long enough. People have accepted that you have to wait for NHS treatment but felt that 50 weeks, or nearly a year was too long, especially if you were experiencing pain or discomfort.

People understood that priority was given to some conditions but felt that more could be done to reduce waiting times.

People felt that if all of their tests and consultations could be done on the same day in the same place then they wouldn't mind waiting a bit longer. People got frustrated with multiple visits to the same hospital for tests on one day, results on another, visit with a consultant on a different day again. People want a one stop shop for diagnosis – all tests on the same day, in the same place, followed by an appointment with someone who can understand the results. Lots of people told us about inefficiencies around repeated tests, where a GP would request a test only for this to be repeated if the patient saw a different medical professional. Test results not being shared before appointments meaning that tests needed to be repeated.

Lots of people told us that the NHS should be training many more GPs, consultants, nurses, midwives and other health professionals. People thought that If we had more clinical staff trained in the UK then we wouldn't have such long waiting times. A number of people felt that nursing training should not be through a degree. People should not have to pay university fees to training to be a nurse. This should be vocational training through apprenticeship-type training. This type of training does exist but is not widely known about. People felt there should be bursaries and training grants for people who want to work in medical professions that are bound into working in the NHS for a number of years after the training is complete. Introduce more degree-level apprenticeships for medical training so people can earn while they train.

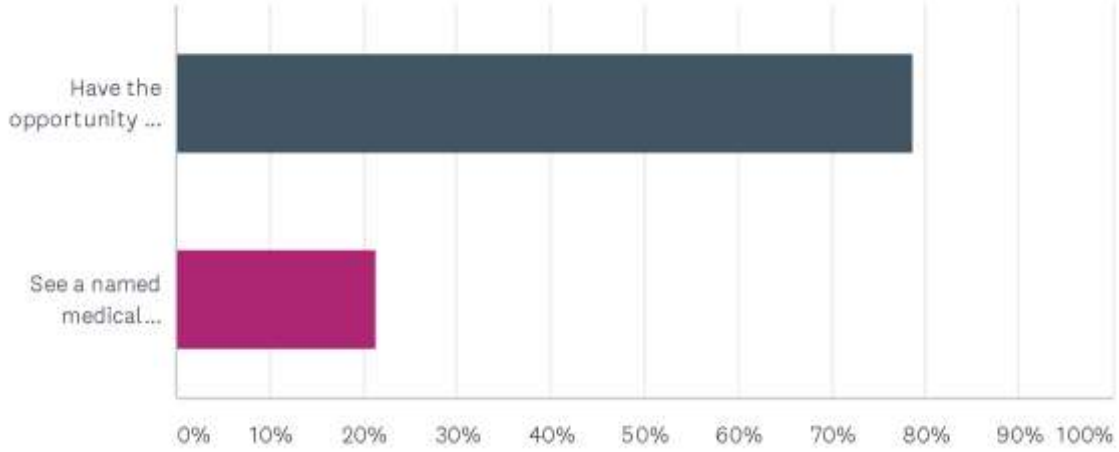
Others felt that there should be more NHS staff generally – in all areas. This would help with admin such as booking appointments and managing waiting lists etc. Others felt that all NHS managers should have to have medical training so they can fill in when needed. For example, we shouldn't have professional managers in the NHS, everyone should work on the front-line treating patients.

As well as training more staff people felt that more staff were needed in frontline service, especially nurses and healthcare assistants in hospitals. They felt that staff didn't have the proper time needed to care for people fully and that people in hospital were left on their own a lot, or if they had family, that the relatives were doing some of the care.

People also felt that there should be reduced managers and admin staff to allow for more clinical staff. Although others felt that each service should have dedicated admin and appointment team to book and manage appointments. Other felt that the NHS should be run by professional managers from business who could negotiate better deals for NHS resources.

Q8 Looking at how we use technology, would you prefer to…

Answered: 5,578 Skipped: 154



ANSWER CHOICES	RESPONSES	
Have the opportunity to access healthcare services faster via technology, for example telephone appointments with your GP or live chat with a trained healthcare professional	78.70%	4,390
See a named medical professional face to face, but have to wait longer for that appointment	21.30%	1,188
TOTAL		5,578

Fig 9. Question eight graph exported from SurveyMonkey

Lots of people agreed with increasing the use of technology in the NHS, for booking appointments, cancelling appointments, and for GP appointments. Increased use of Skype for GP appointments and follow-up appointments with consultants was also mentioned.

Also, people thought we should be exploring the use of Telemedicine for certain long-term conditions. Diabetes monitoring and blood pressure monitoring were mentioned in relation to remote monitoring.

People told us that they wanted to be sent reminders by text of hospital appointments, like some GP practices do. That text and email reminders would avoid people missing appointments.

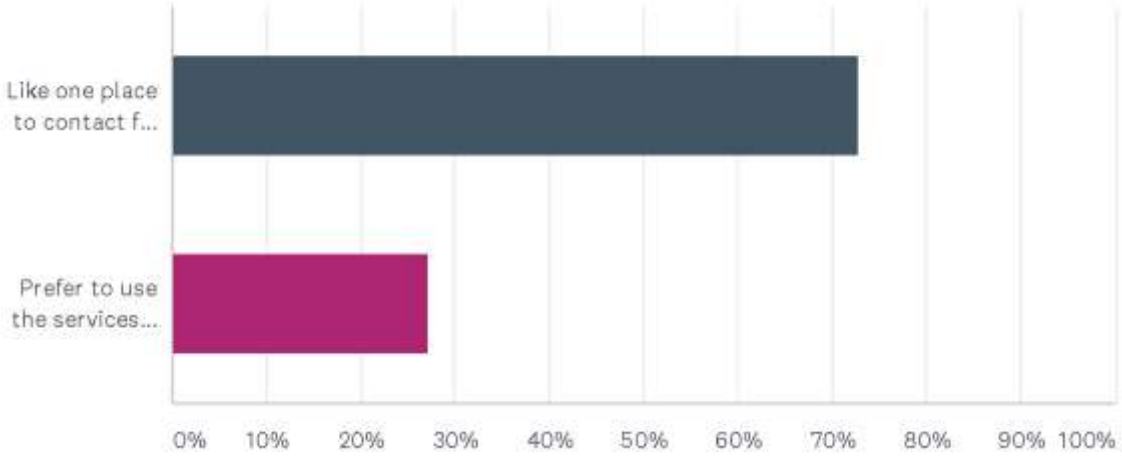
Some people did ask us to consider older people and people who found technology difficult to use in considering how to use technology more in the NHS. People shouldn't be excluded because they are not able to use technology. Some existing systems would need to remain.

When considering technology people told us they didn't understand why the NHS didn't have a single medical record system that could be accessed by health professionals from any health or care venue. People assume in our technologically advanced age that this would be something the NHS could achieve.

Some people told us that GP and NHS websites are too technical or full of jargon that makes them difficult for most people to use.

Q9 When you feel unwell, but it is not an emergency, and you need to see someone to talk about it, would you:

Answered: 5,646 Skipped: 86



ANSWER CHOICES	RESPONSES	
Like one place to contact for advice and treatment which can book you an urgent appointment with the right service, within two days or sooner if need be	72.85%	4,113
Prefer to use the services you know are available and see how quickly you can be seen, such as A&E, Minor Injury Units, Urgent Care Centres, GP out of hours or GP urgent appointments	27.15%	1,533
TOTAL		5,646

Fig 10. Question nine graph exported from SurveyMonkey

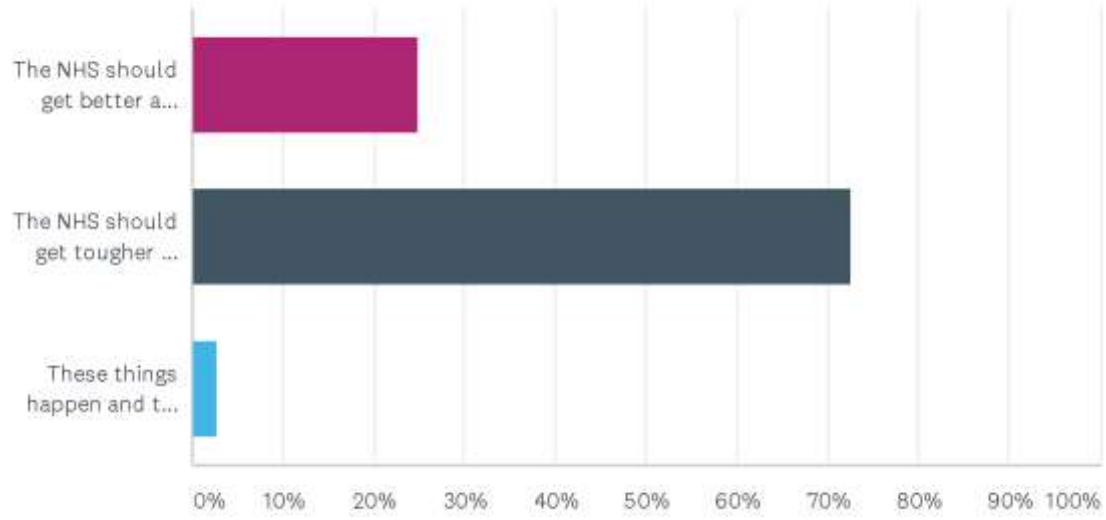
People wanted to remind us that the NHS 111 telephone service is difficult for people who have hearing disabilities or who have learning disabilities. This needs to be considered when developing this service further. Especially as more and more interface with the NHS is done over the telephone.

People told us that they are often confused by the range of services. They sometimes aren't in a position to decide what is and isn't an emergency. When a person you care about needs help or is in pain then it can feel like an emergency, and you take them to where you know they will get help.

Some people gave us good feedback about how the NHS 111 service had directed them to the right service or booked them an appointment. Others were less trusting of the service. Some told us that the questions took too long and were not personal enough.

Q10 Nearly eight million hospital appointments were missed across the country in 2017/18. Each hospital outpatient appointment costs around £120, which means almost £1 billion worth of appointments were missed - the equivalent of 257,000 hip replacements or 990,000 cataract operations. Almost 1.2 million GP hours were wasted because people did not turn up to their appointment - that's the equivalent of 600 GPs working full time for a year. Do you think...

Answered: 5,568 Skipped: 164



ANSWER CHOICES	RESPONSES	
The NHS should get better at reminding people to attend, using automatic reminder systems wherever possible	24.82%	1,382
The NHS should get tougher on people who frequently miss appointments, unless they are vulnerable or have exceptional reasons for doing so	72.52%	4,038
These things happen and the NHS should be flexible enough to manage this	2.66%	148
TOTAL		5,568

Fig 11. Question ten graph exported from SurveyMonkey

People felt strongly that the NHS should be getting tougher on people who miss their appointments without a valid reason.

This question raised lots of issues around **charging people for missed appointments.** Some people suggested that the NHS should charge a small standard fee for every appointment – suggestions between £10 - £30. This money is then refunded if you attend the appointment. People also felt there should be standard charges across the

whole system for any missed appointment that cannot be proven to have valid reason for being missed. Other suggested a three strikes system, on the third missed appointment you are charged for all previous appointments. Lots of people wanted a system introduced where you had to log a bank card or credit card with the NHS in order to receive services. Then it would be easy to charge people for missed appointments or misuse of the service.

Other people suggested the NHS develop a billing type system that lets a patient know how much their treatment would have cost if they had to pay for it. People would then start to value the service they receive from the NHS instead of taking it for granted.

People were keen to point out that there should always be exemptions for people on low incomes.

Another suggestion was that the NHS should charge people who attend A&E after taking alcohol or illegal drugs. There should also be charges for misuse of the service, or abuse of staff. If people attend A&E inappropriately, they should be told that they can be treated at A&E but they will be charged, if they want a free service then they need to go somewhere else.

Several people also thought that people should be charged for meals in hospital, this would help to improve the standard of food and be less of a drain on NHS resources.

Some people felt that if people could afford medical insurance then they should be encouraged to buy it, leaving the NHS for those who can't afford it.

Linked into this several people told us that we should introduce a deposit system for NHS equipment, so less of it went missing. For equipment such as mobility aids you should have a deposit to make it worthwhile retuning it when it is no longer needed. That equipment should always be returned so it can be used by other people. Too much disposable equipment used

The other issues that this question raised was parking at our acute sites. Parking issues should be properly planned before any new health facilities are built, or services are moved. There are not enough spaces, charges are too high. Often this can result in missing appointments as there is nowhere to park, or it takes so long to park that the appointment is missed. Another issue for parking is that there are never enough spaces for people with mobility issues near to the entrance or exit. This concern was raised as an issue at both of our large acutes, but with particular issues at Peterborough City Hospital. With only one exit and entrance to the site there can often be huge issues for people trying to leave, or ambulances gaining access at busy times.

Some people felt that staff should be given free parking at their places of work, other felt that staff should not be able to park in hospital car parks and other arrangements should be made for staff freeing up parking for patients and those attending with them. This was a particular issue for some staff as well as patients and visitors. People also felt that parking charges should go directly to the hospital trust not to private companies who manage the carparks. Public transport and cycling access were also raised as issues. Although there is public transport to our acute sites it was felt that not enough was done to promote and encourage use of sustainable transport.

Other issues raised

GP services. People had a lot to tell us about GP services. People were aware of the shortages faced by GP practices and felt that not enough was being done to train new GPs and encourage them to remain GPs. We should focus on recruitment and retention of GPs and associated practice staff. People told us of the difficulties they had making appointments at various GP practices, that they had to call at specific times of day then couldn't get through on the phone, or had to make multiple calls or stay of hold for long lengths of time. Often then to be told that all the appointments had gone, and they needed to call back at another time. People told us that they often had to wait a long time for a planned GP appointment and that getting through on the day was difficult.

Some people who had experience of the Doctor First system of call backs really liked this service as it meant that they spoke to someone on the day every time. Other people did not like this service as they felt they were being denied a face-to-face appointment.

Many people told us that there simply weren't enough GP appointments and they felt they had to struggle to be seen. Also, that GP appointments were too short, that they wanted to discuss a range of issues with the GP not just one thing in a short 10-minute appointment. Some people asked us why there couldn't be group appointments for people with the same condition such as diabetes, they could talk to each other as well as trained medical staff.

Some people told us that would prefer there to be a range of staff available at the GP practice, nurses and pharmacists so the GPs time could be used for those that need it most. Some people felt they wanted more stability and consistency in Primary Care, that they were always seen by different people which meant they were going over things from a previous appointment. People also told us that they wanted GP appointments to be available at weekends and later into the evenings. People felt that this would prevent people from turning up at A&E unnecessarily.

Sustainability and environmental issues. People told us that we were not doing enough to ensure that our sites and services were environmentally sustainable – in terms of transport facilities, waste management, and reduction of carbon footprint. They asked questions about resource use for managing our buildings as well as how we are working to reduce the carbon footprint of the NHS locally.

Mental health services. Mental health services were seen a key issue that needed addressing. People told us that we needed to increase spending in this area and give more support at an earlier stage to those who need mental health support. People found it difficult to access services and apart from calling 999 didn't know how to get help for someone in a crisis situation.

There was an emphasis from people on improved services for children and young people. People felt that not enough support was given to children and young people early enough. That people did not know where to go to find help for children and young people and more should be done in collaboration with education services. It was felt that finding the right support early enough was difficult, often leading to a mental health crisis that could have been avoided.

People felt that waiting lists – and the length of time between referral and treatment was often far too long in this area of service. People also wanted us to be aware that other services were difficult to access for people with mental health needs. More training for all staff in recognising those with mental health needs was needed.

Dementia support was a specific area that was raised, people found it difficult to access support, and assessments and more services were needed to help those with dementia and Alzheimer's, which could in part reflect our attendance at two dementia support group meetings. Older people had specific mental health needs and need different types of support.

Other specific services that were mentioned were eating disorder services. People told us that access to these services were difficult, as often the person needing help does not recognise it, or accept they need it. It is often family or friends who need help to support he person with the eating disorder, and there is a lack of provision around these types of conditions. People also mentioned the charity Petals in their responses. This was in the news as the BIG conversation started. People found this a very valuable service and wanted us to be support the service to continue.

Royston - We had a large number of responses from people in the Royston postcode area people from Royston told us that it was important to them to have a health and care hub in **Royston** using the old hospital site. The 'friends of Royston hospital' group circulated a lot of leaflets in Royston with support of the local MP Oliver Heald. Lots of response wanted us to look at using the old hospital site as a community health resource, or an intermediate care facility for older people between hospital and home.

Health and social care should work more closely together – particularly for children and older people. It was felt that services were too disjointed, and it was difficult to know where to go to get help when it was needed. People felt there was a waste of money and resources by health and social care not working closely together. There need to be more community funded roles which help people in the community. People also told us there were shortages of care assistants working to help people with their social care needs.

St George's hydrotherapy pool in Peterborough was mentioned by just a few respondents as an important facility. People it should be supported by the local NHS even if they can't fund the service. Many people benefit from this facility and pay for the service themselves.

NHS dentistry - needs improvement. People told us there are not enough dentists who take NHS patients in some areas.

Hinchingbrooke Hospital – keep service there for people of Huntingdon.

Carers – people talked to us about the difficulties faced by carers. There are thousands of carers out there who are in effect part of an unpaid workforce, it is hard for them to attend meetings, and they have little support.

Demographic information

We collected a small amount of demographic information in order to be able to ensure that we were reaching a broad range of people from across our area demographics.

In relation to age, those who chose to answer this question gave the following responses:

ANSWER CHOICES	RESPONSES	
16-29	9.19%	523
30-44	25.01%	1423
45-59	29.43%	1674
60-74	28.53%	1623
75+	7.84%	446
TOTAL		5689

The number of people between the ages of 16-24 went up after we had emailed the BIG conversation documents to all school sixth form departments in our area.

In relation to ethnic background this was a free text question in order not to be too prescriptive in how people wanted to respond.

The majority of people who answered this question gave their ethnic background as white British. Roughly 100 people described their ethnicity as European. There were some responses from people describing their ethnic background as Asian, Mixed, Black, Pakistani, African, and Indian, roughly 20 people from each group.

We also asked people for the first part of their postcode. The mix of postcodes showed that we had responses from a wide geographical area covering our whole area. Half-way through the engagement we looked at the data for where people lived to make sure we were reaching people across the area. In the postcode areas where we had the least responses, we did some targeted work on Facebook groups to encourage more people to take part, and this saw an increase in the numbers for these postcode areas.

Next steps

1. Share the feedback and responses to the BIG conversation with all of our stakeholders and the public via the CCG website.
2. Share the feedback and responses to the BIG conversation with NHS England, all other NHS providers in and around Cambridgeshire and Peterborough.
3. To ensure that the feedback from the BIG conversation is considered as part of the commissioning process for the future.
4. The BIG conversation with Primary Care – we have just stared another BIG conversation with our primary care staff and teams to ask them what they think is going well and not so well. To ask them how we can improve primary care and ensure it is sustainable for the future.

APPENDICES

Appendix 1 – Healthwatch Community Values Panel Report 1
Appendix 2 – Healthwatch Community Values Panel Report 2
Appendix 3 – Healthwatch response to BIG conversation

The first Community Values Panel

Talking about the availability of over the counter medicines on prescription.

Can our NHS afford this?

An independent panel for Cambridgeshire and Peterborough

Contents

Key Findings

30 local people from across Cambridgeshire and Peterborough joined a Community Values Panel to have a say on funding local health services.

The panel was set up by the people who plan and buy health services in our region – Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). It was supported by our Healthwatch.

The panel met twice in the autumn of 2019 to help the CCG work out what's important to local people. This report includes the outputs of the first panel meeting on 24 October in St Ives.

Panel one

Twenty-six panellists on the day helped the CCG think about whether people should still be able to get over the counter medications on prescription. They heard from experts at the CCG who told them about:

+ The tough decisions the CCG has to make to reduce their £75 million debt. And how they are having a 'Big Conversation' with local people to help them think about this.
+ How the CCG spent £117 million on prescriptions in 2018. This includes £5.3 million on medicines that people could have bought without a prescription.
+ How £4.7million worth of unused medicines were returned last year. Once returned, they must be destroyed and cannot be used for other patients.

What the panellists thought

Panellists were asked to vote on how much they agreed or disagreed with the following statements at the start and then again at the end of the day. We wanted to see how their views changed after finding out more about the issue.

1. **We should only be prescribed items that cannot be purchased over the counter to enable the money to be spent on other health services.**

   At the start of the day, over half of the panellists thought GPs should only prescribe medication that cannot be bought over the counter. A further quarter thought they should still be able to prescribe over the counter medicines in exceptional circumstances.

   At the end of the day, people's votes remained similar.

2. **We should continue to prescribe anything that people need and reduce other healthcare services.**

   At the start of the day, seven out of ten panellists thought the CCG should not reduce other healthcare services so they could continue to prescribe anything that people need. At the end of the day this increased to eight out of ten people.

Shared values

Through a series of activities, the panellists thought about what values were most important to them around access to over the counter medicines on prescription. They also talked about what was least important for the CCG to consider.

Most important

+ People taking personal responsibility – with better education and information.
+ Reducing waste.
+ There was a 'safety net' for vulnerable people.
+ Financial prudence.

Least important

+ Entitlement to 'free' medication.
+ Personal choice.

About the panel

Why the panel was formed

More people are using NHS services. But money is limited. The CCG's £1.3 billion pays for things such as doctors, hospitals, community services, some pharmacy services and mental health services.

But the CCG is operating with £75m debt and needs to make some tough decisions about what health services to buy for the region's 980,000 people.

They must save money this year and spend less in the future.

The Community Values Panel is part of the CCG's Big Conversation asking people:

+ What they value most, and
+ What changes could be made to the way people access and use health services.

Our Healthwatch suggested a Community Values Panel as a new way to help the CCG understand in some depth what's important to a representative sample of our local population. And to find out which values the panel prioritises when considering a particular part of our local health service in challenging times.

Big Conversation

Between October and December 2019, the CCG launched their 'Big Conversation' to help them understand what is most important to people in the local community.

They asked people ten questions about the choices they say need to be made about affording future services. This was done via an online survey as well as a series of public meetings and visits to local community groups.

As part of finding out what's important to people, the CCG asked Healthwatch to run a series of Community Values Panels to look independently at several topics within the Big Conversation.

The Community Values Panels are funded by Cambridgeshire and Peterborough Clinical Commissioning group.

Who the panellists are

The 30 members of the Community Values Panel are a representative sample of the population of Cambridgeshire and Peterborough.

People were recruited through a publicity campaign promoted by Healthwatch, partner organisations and the local media, as well as through Healthwatch social media and local events.

Panellists were selected to reflect the diverse demographic characteristics of the population. This was based on age, gender, and district of residence. The selection also aimed to reflect the area's disability, ethnicity, sexuality, long-term conditions and caring profile appropriately.

Not everybody was able to come to both panels. This representative selection was also used when a small number of panellists dropped out and were replaced.

Healthwatch took people's names off the application form when choosing panellists to make sure the selection was fair.

All panellists were paid £50 for each four-hour workshop and reasonable travel costs. The funding included covering the cost of taxis for panellists with sensory impairments and learning disabilities.

Details of how we reflected the CCG population in the membership of the Community Values Panel is shown in Appendix 1.

How the Community Values Panel works

The model is based on the National Institute for Health and Clinical Excellence (NICE) Citizens' Council model which was identified as best practice.

https://www.nice.org.uk/Get-Involved/Citizens-Council.

Healthwatch also learnt from work done to set up Citizens' Councils / Panels in other parts of the country for varying purposes.

Panel meetings were convened by an independent facilitator, Phil Hadridge, with extensive experience in running workshops, and our Chair Val Moore who had direct experience with NICE Citizens' Council.

Healthwatch staff facilitated the table conversations and captured the panellists' contributions throughout the day using a variety of means.

An induction for the panellists included an overview of the NHS (the King's Fund 2018 video), a basic introduction into the CCG's role in buying health services for the local population and the pressures it currently faces.

How the topics were chosen

The CCG and Healthwatch identified topics from the Big Conversation for each panel meeting to consider. Panellists didn't know what the topic was before the day, so had no opportunity to prepare.

This approach provided an opportunity to look at initial reactions and probe more deeply into how people felt and thought about the questions.

The topics for the first two panels were:

+ Prescribing and over the counter medicines
+ Urgent and emergency care.

The CCG provided background information and expert input on each of the topics to help the panellists understand the context and challenges. The panellists were encouraged to ask questions of the experts.

Meeting each other and setting the ground rules

Time was taken at the first meeting to introduce each other and develop ground rules. The panellists decided that they needed to be:

+ Open.
+ Respectful.
+ All comments valid.
+ No question is 'silly'.
+ Not sharing content of day on social media.
+ Confidential, anonymous and not attributable.
+ Photos not to be used until after session.

How the panel was structured

Each Panel meeting followed the same format with some variations in methods:

+ Topical questions described.
+ Vote on questions to test panellist divergence on the topic.
+ Experts, specialists in the topic, explaining context.
+ Structured discussion in small groups.
+ Further scenarios explored.
+ Facilitator exercise to identify community values – what matters, and how people prioritise them.
+ Repeat vote on the topic to explore changes in the Panel view and for individuals.
+ Summary, evaluation and closing business.

Feedback from the CCG representative/s and the local experts was welcomed.

The evaluation forms and the facilitator-led team debrief informed the design and practicalities for the second workshop. A summary was shared with the panellists.

Prescribing and over the counter medicines

The purpose of the first panel was to discover the values people have in mind when considering whether the NHS should prescribe free over the counter medications to people, or not.

Meeting everybody

The session started with an explanation what the Community Values Panel is.

And how the Panel members would explore and develop their thoughts by using a variety of tools and techniques to aid thinking, talking and listening

Panellists introduced themselves, explaining why they had applied to join the panel.

+ Interested, care about the NHS ('The NHS is close to my heart', 'I feel passionately about the NHS')
+ Importance of diversity – 'having all our voices heard'.
+ Equity of access – 'we should all be able to use the same range of services'.
+ Recognising difficult decisions are necessary - financial challenges in the NHS locally.
+ Concerns about the closure (and threat of closure) of local health facilities particularly in rural areas (additional rural challenges) 'things are working well in my GP surgery – I don't want it to change'.
+ Need to reduce demand on services – greater emphasis on prevention.
+ Mental health/holistic wellbeing.
+ Personal interests in local services and hospitals.

The next conversation established ground rules for the way the panellists, facilitators and experts would work together. Panellists were given the opportunity to try out their voting devices with a brief health related quiz.

Where did the panel stand on the topic of the day?

The panellists were asked to vote on two statements at the start of the day.

Statement 1: We should only be prescribed items that cannot be purchased over the counter to enable money to be spent on other health services

12 of the 23 panellists who voted agreed with the statement, and a further six said only in exceptional circumstances. Four panellists disagreed and one was unsure.

Statement 2: We should continue to prescribe anything people need and reduce other healthcare services

19 of the 25 panellists who voted disagreed with this statement, four agreed and two were unsure.

What the experts said

The panellists heard about the financial challenges the CCG are currently facing from Jane Coulson, one of their officers.

The topic of prescribing over the counter medication was introduced by Chief Pharmacist from CCG, Sati Ubi, and Dr Cathy Bennet, a GP and primary care lead for the CCG on prescribing.

Their presentation covered the size and cost of local primary care prescribing, the issue of significant waste, and explained the CCG's prioritisation of the local medicine spend of £117m (see Appendix 2).

In 2018/9

+ £4.7m spent on drugs which were prescribed but not taken.
+ £1m spent on 'low value' drugs (e.g. glucosamine).
+ £5.3m spent on over the counter medication (e.g. paracetamol, head lice treatments, emollients, gluten free products and baby milk).

Questions from the panellists

The panel was surprised to hear that more prescriptions were written for over the counter medicines in areas where people had a higher disposable income.

There was significant interest from the panellists. They asked many questions both during the presentation and in the wide-ranging conversations at their tables.

The questions they asked

+ What happens to the money when there is a difference between the actual cost of the medication and the prescription charge?
+ Can I choose which items on my script I will pay for? I'm concerned that changes will lead to further rise in prescription charges.
+ Could all GPs be encouraged to sign up to a set of principles which would encourage common practice across the area? What can be done to help GPs push back?
+ What more can be done to discourage people from stockpiling their drugs?
+ Is there any alternative to the destruction of unopened drugs? Has this always been the practise?
+ Is there any more information available about drugs destroyed that would help target campaigns?
+ How do I buy medication over the counter if I don't know what I need? I will still need to see a GP?
+ Why is medication not used?
+ Why do GPs and practices vary in terms of their repeat prescribing methods? Seems to be one month sometimes two months. Do 28 day only scripts make more work for the practice?
+ How should reviews happen? Is it appropriate for a dispenser to question the need for medications in front of people?
+ I can only buy two boxes of 16 paracetamol tablets at any one time, but I can get more if I need more on a prescription. How will I avoid lots of return trips to the supermarket?
+ Why am I having problems getting the medication I need?

What the experts told us

The experts from the CCG explained that it is was not possible to re-use medicines, even when unopened, as pharmacies had no knowledge about how medicines had been stored by patients.

They told the panellists that medicines were incinerated for many reasons. This could include clinical reasons, for example when a patient had adverse reaction to prescribed medication. Although there hadn't been any local large-scale audits, they suspected that routinely available common drugs account for a large proportion of incinerated medicines.

They explained that it was only possible to account for medicines returned to pharmacies for incineration. In many instances, patients destroy unwanted or unused medicines themselves.

Discussing changing prescribing practices, the experts explained that GPs are independent contractors and that there are limits to the pressure that can be put on them to change practise.

There is a degree of nervousness from GPs who have concerns about:

+ The amount of time they would need to spend explaining why they couldn't prescribe over the counter medicines.
+ Getting complaints from patients who felt entitled to the medicines.

Different practices can have different approaches to prescribing. This can include things like the number of weeks for a prescription, e.g. 14 or 28 days or longer in some circumstances. But all professionals supported a greater use of practices' online systems to order medication and Apps such as the NHS App.

In response to what they had heard

The panellists as a whole were shocked by what they heard about the amount of wasted medicines. This is what individuals said:

"The public needs to be better educated about this."

"If they saved money from not prescribing so many over the counter drugs – then we could have more money to spend on other things, like a health advice centre."

"If this change is made and you cannot get over the counter medicines on prescription, then I think there will be conflicting views. There will be some angry people – but they will probably be the ones who could afford to pay. And then some others will be fine."

"It is unfair that only people in Cambridgeshire and Peterborough would not be able to get over the counter medicines on prescription, but people elsewhere could. It would be fairer if it was everywhere in the UK."

"I have more disposable income now than I ever had, but because I am over 60 I can get my prescriptions free, whereas my neighbours who are both working and struggling to make ends meet, have to pay. That doesn't seem right,"

"Those of us who can pay, should pay."

"Some supermarkets charge more than others for even generic paracetamol. How can we influence market forces?"

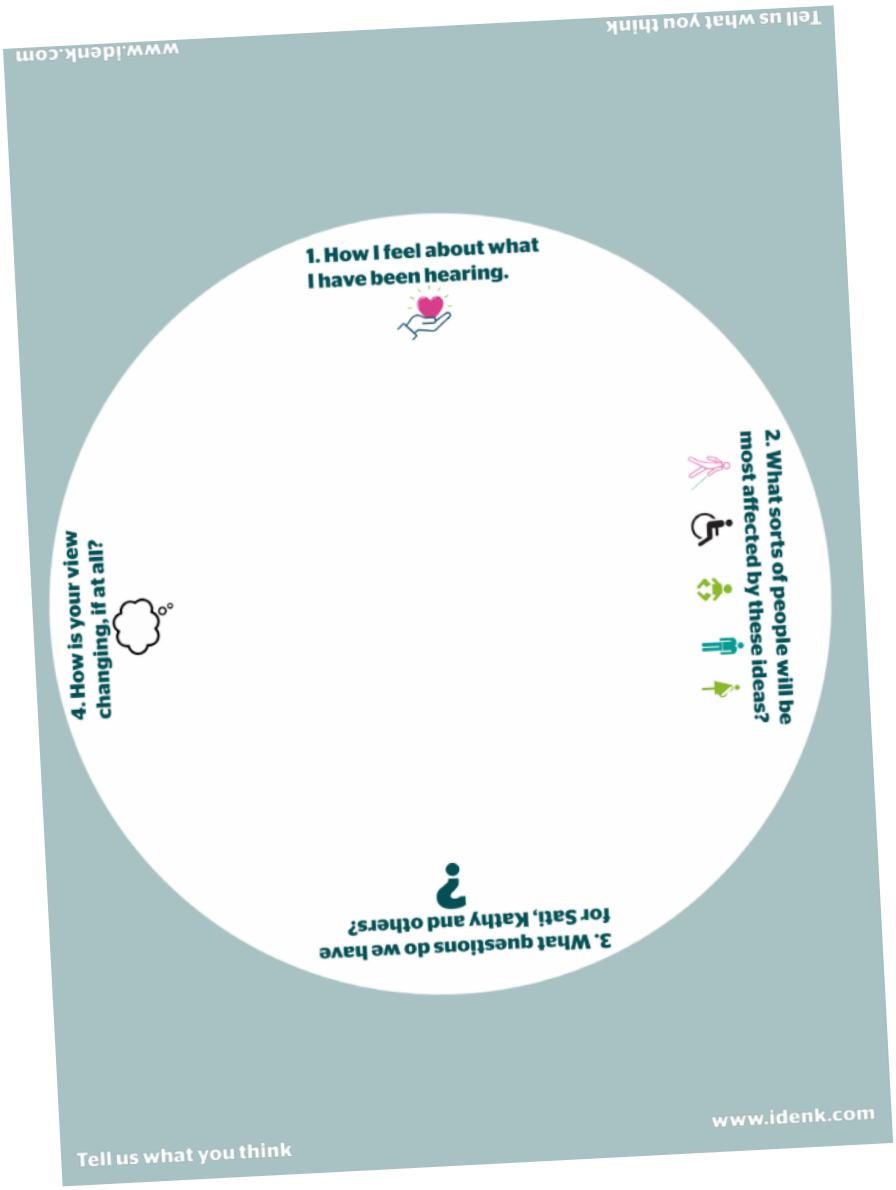
Exploring the issue in more detail

The panellists took part in five facilitated table conversations to explore the issue in more detail. The five groups each also reflected aspects of the demographic mix of the local population.

They talked about:

+ How they felt about what they'd been hearing.
+ What sorts of people would be most affected by changes in prescription practice.
+ If they had any questions for the experts.
+ If their views were changing at all.

Panellists were encouraged to record their feelings, views and questions on posters and post it notes on each of the tables.



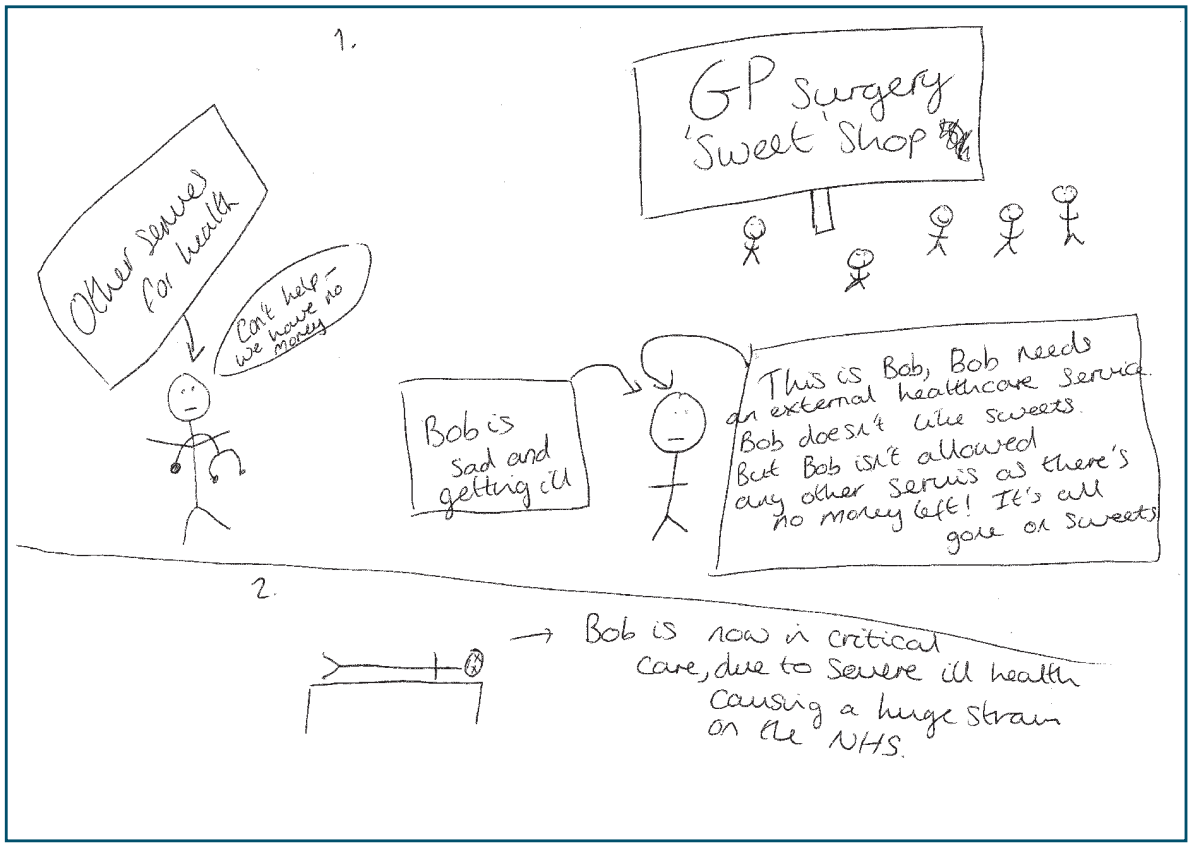
Several themes were identified from the table conversations

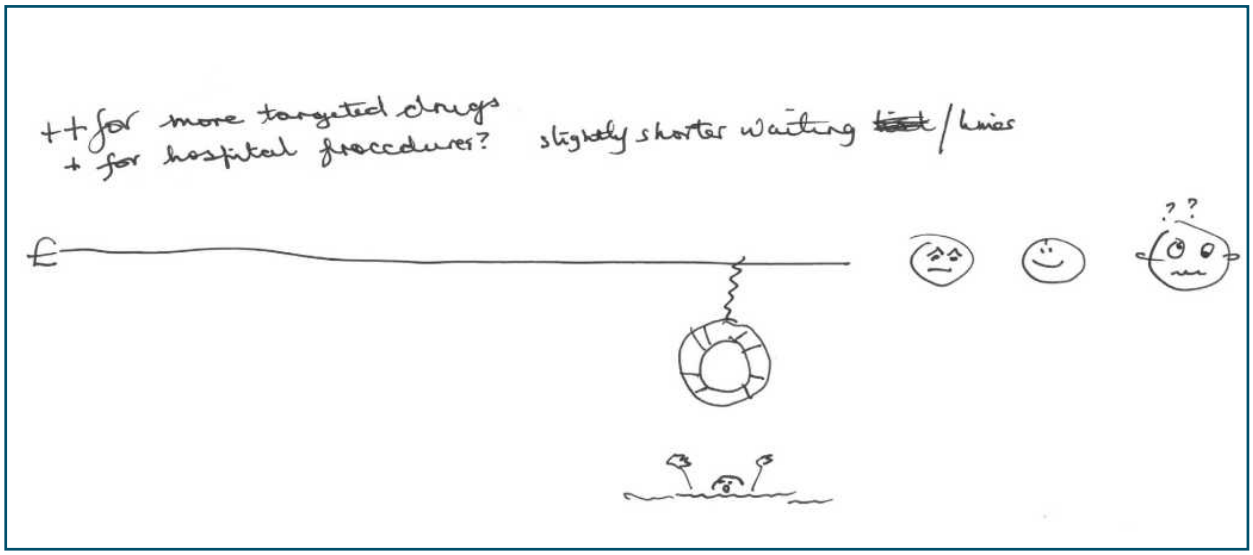
+ Support and pride in the NHS.
+ A desire to see the issue of waste tackled.
+ More, and simpler information to get key messages about waste and cost out to the local population.
+ Degree of lack of understanding that drugs will still be available to them.
+ A 'safety net' for vulnerable groups was imperative.
+ Consistency about what constitutes 'vulnerable'.
+ Support for personal responsibility.
+ Little evidence of shifting views, but people feel better informed.
+ A wish to place the issue in its wider public health context – keep people well and active 'prevention is better than cure'.
+ Implications for people who rely on other people to pick up drugs and prescriptions.
+ Support for making more and wider use of local pharmacists.
+ Wish to see all GP surgeries work to the same set of principles – at very least across the Cambridgeshire and Peterborough, but ideally nationally.

The table posters are summarised in Appendix 3.

And it felt a bit like this!

We asked our panellists to describe with drawing or words, how they felt having heard from the experts and taken part in the discussion of the topic.




++for more targeted drugs
+ for hospital procedures?
slightly shorter waiting ~~test~~ / tests
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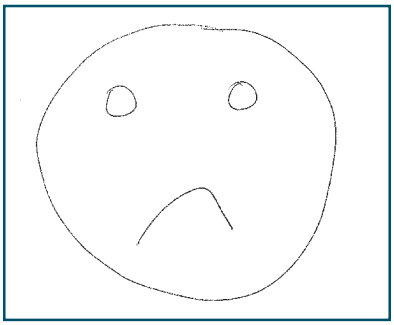
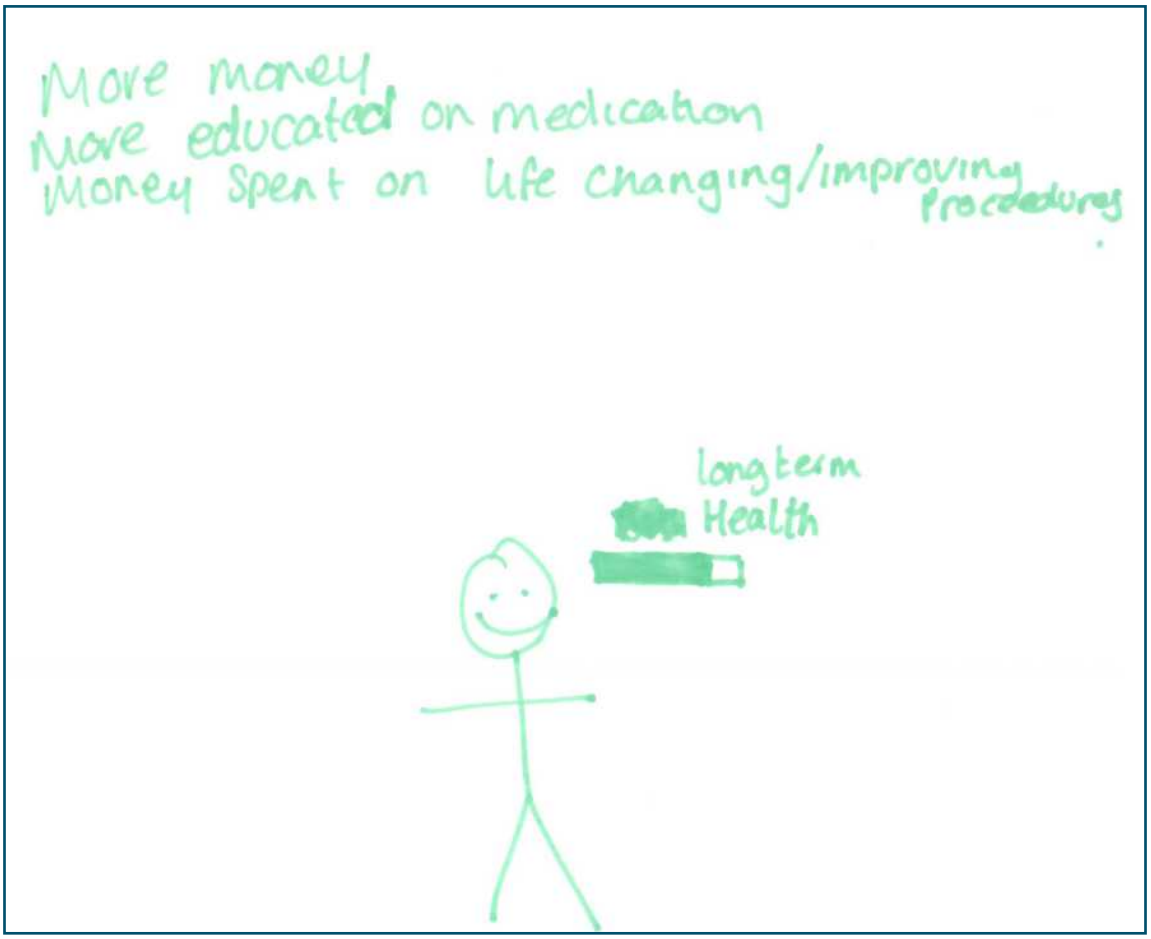
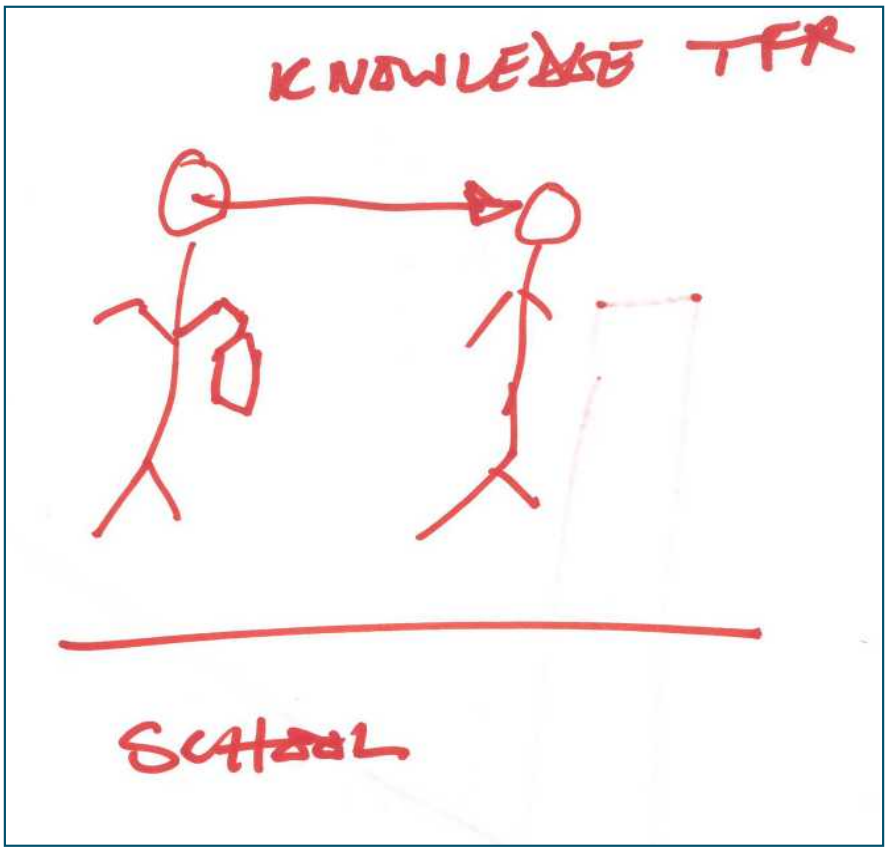
EXTRA
for
DR Surgery
Giant
Advice Centre
Education Centre
for NHS




More money
More educated on medication
Money Spent on life changing/improving procedures
long term
Health


KNOWLEDGE TFR
SCHOOL


HOSPITAL
A+E+GP+999.
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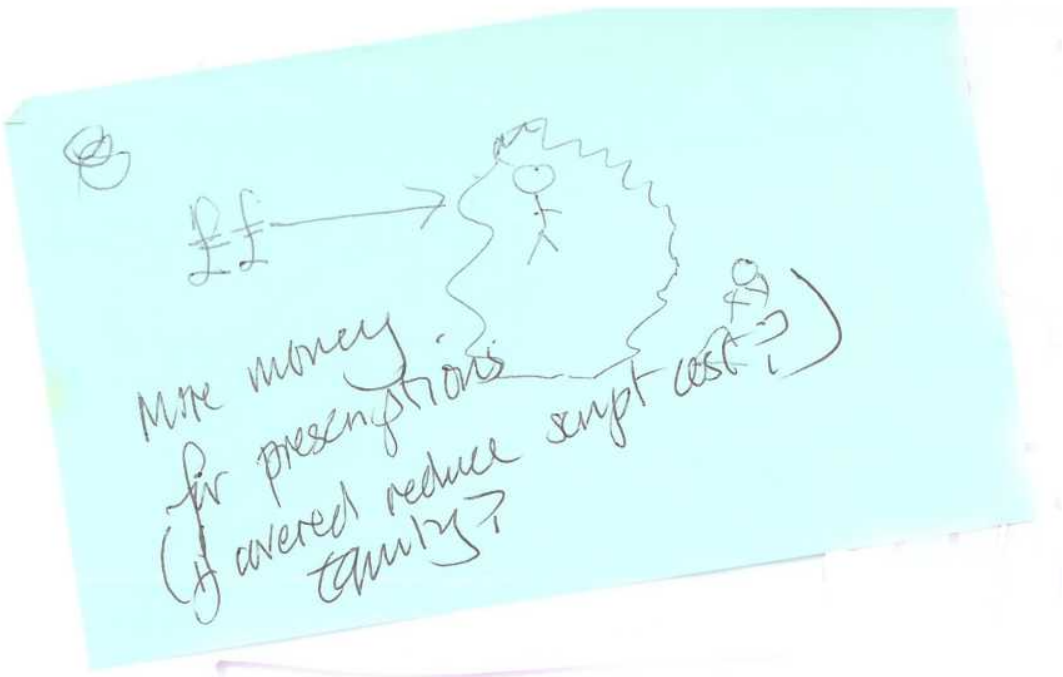
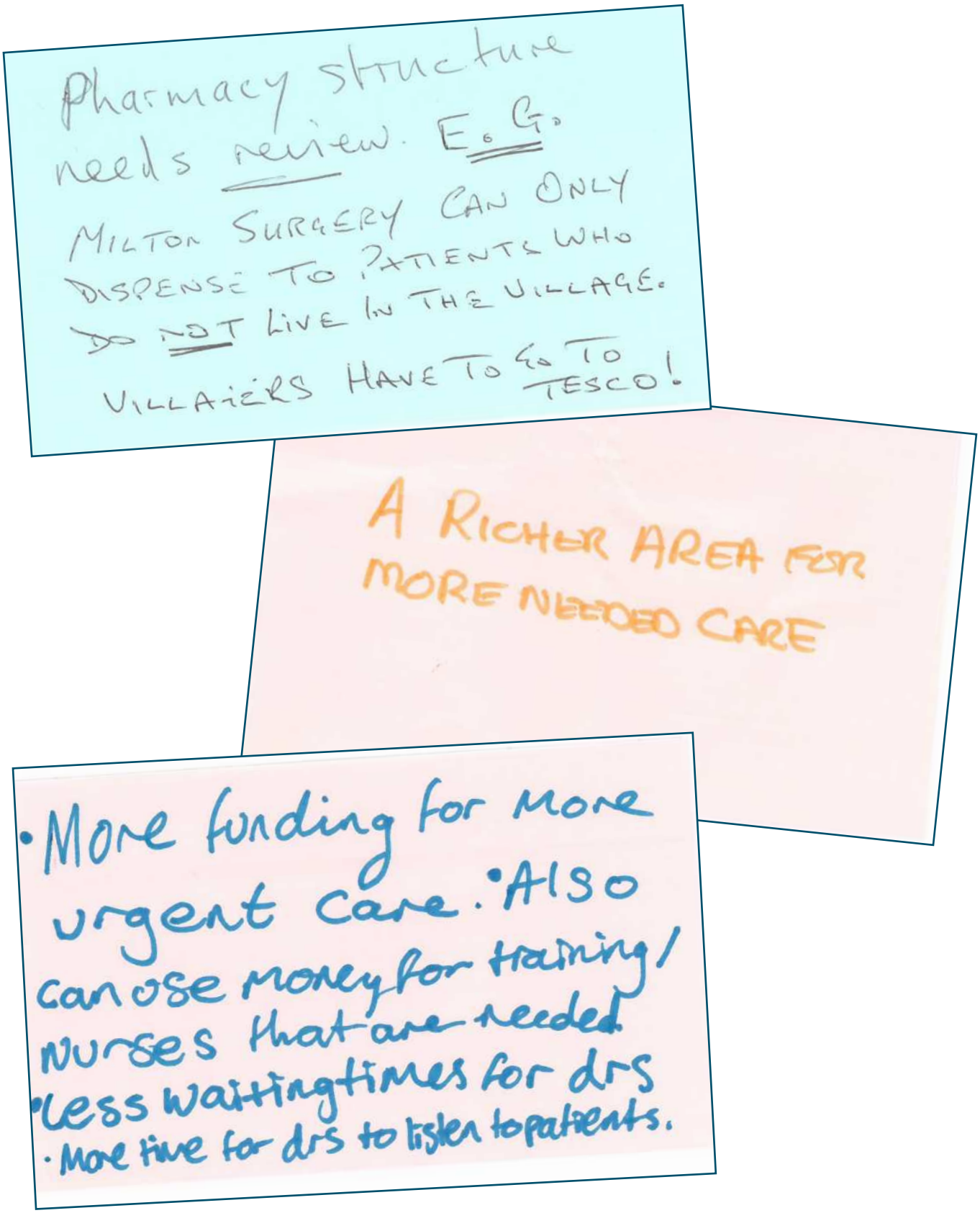
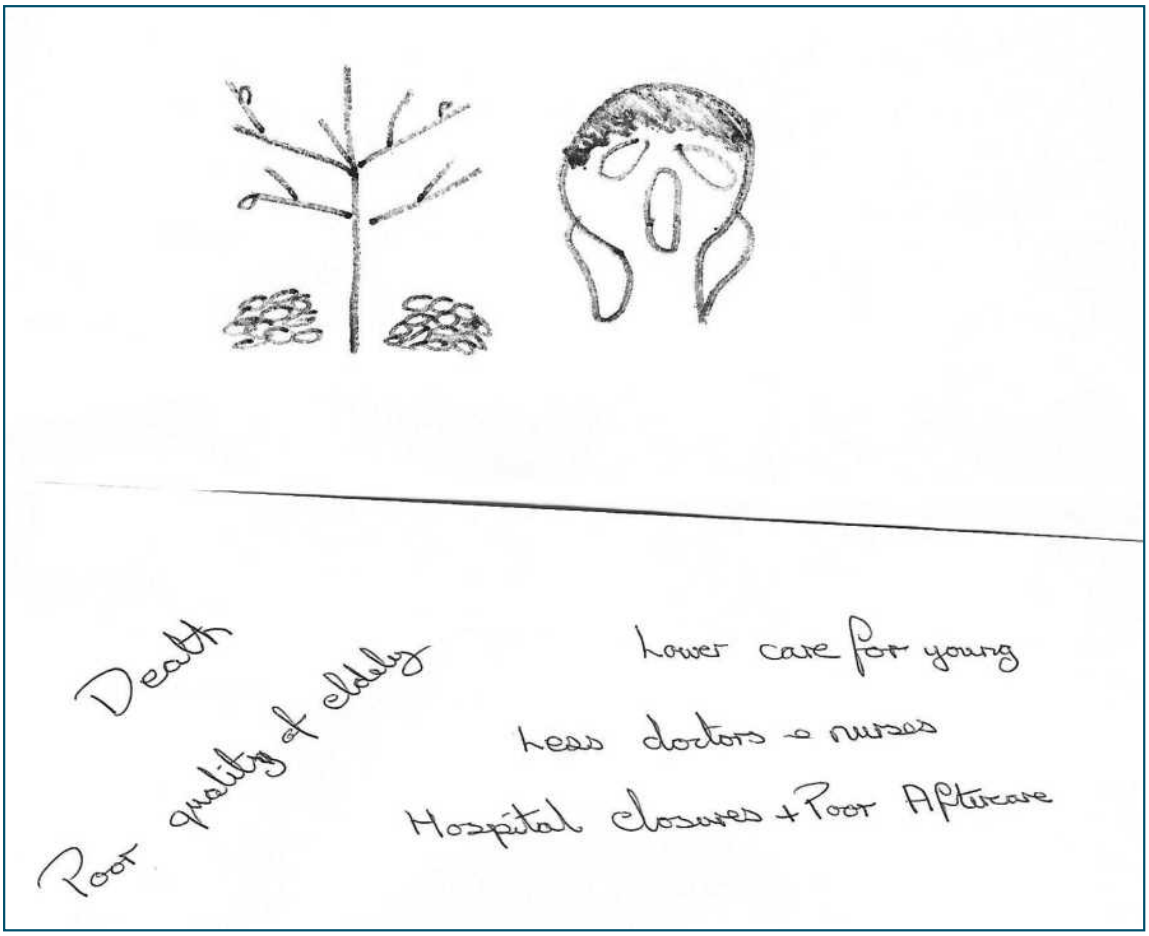
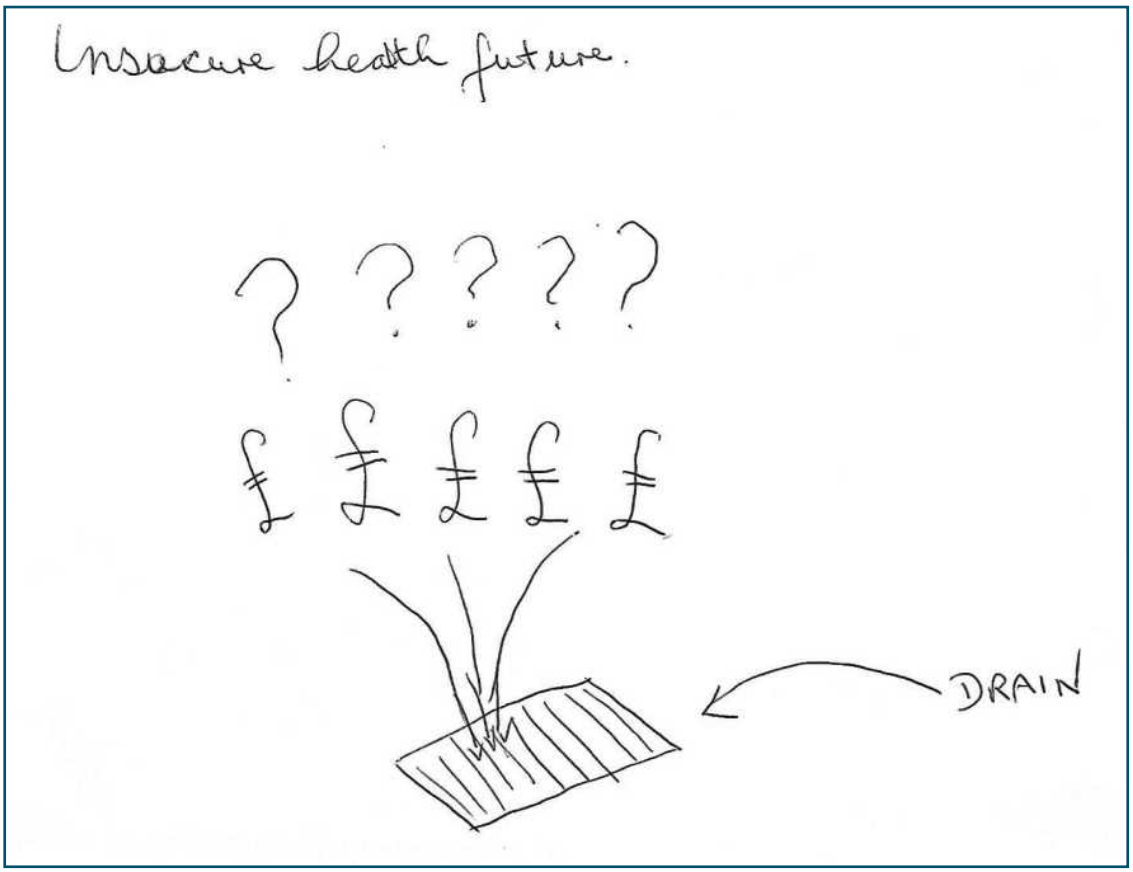

£ £
More money for prescriptions
(if covered reduce swpt cost?)
family?



See page 37 for the words.


Death
Poor quality of elderly
Lower care for young
Less doctors + nurses
Hospital closures + Poor Aftercare


Insecure health future.
? ? ? ? ?
£ £ £ £ £
DRAIN

The panellists each explained their picture (or words) to the others at their table. Again, several themes were illustrated, for example:

+ Concerns for future funding.
+ Possible threats to services.
+ Confusion about which medications may not be available.
+ Annoyed about the amount of waste.
+ Queries about how potential savings would be spent.

This conversation led on to the panellists then discussing what were the two or three things which they feel the most important.

Values and what matters most

Each group was asked to reach a consensus about the values that were most and least important to them when considering the availability of over the counter medicines on prescription. And which they felt should underpin any future decisions about changes in prescribing.

This was a demanding exercise; however, the panellists were able to agree about what was most important to them.

Which values were most important

The panel as a whole wanted people to take more personal responsibility for their health and wellbeing. And more responsibility for making choices about medicines that were thoughtful of the cost to the NHS. They believed that better education as well as easily available and understandable information was key to this.

The panellists all agreed that there had to be an adequate safety net to make sure vulnerable people were able to get all the medication they needed.

The panellists had been shocked by the amount and value of medication that was routinely destroyed and wanted this addressed.

Messages about financial prudence underlay all the conversations.

Which values were least important

Panellists found it particularly difficult to identify and agree, either individually or collectively, which values they regarded as least important. One group was unable to complete this exercise.

The panellists told us that individual personal choice should be less important. Individuals expressed concerns about people feeling that they were entitled to 'free' medication.

There was a general agreement that doctors should be less concerned or embarrassed about saying 'no' to patients. They also told us that pharmaceutical company profits should be less important but recognised that this was an issue beyond the influence of CCG.

People wanted to see the expert's voice balanced with the patient's voice so that less emphaisis is put on what the expert says and wants.

Appendix 4 shows the full details of the panellists' lists.

Repeating the Panel votes

At the end of the day, the panellists voted again on the two statements related to the day's topic.

The first vote took place before the experts introduced the topic and the second vote at the close of the session.

Statement 1: We should only be prescribed items that cannot be purchased over the counter to enable money to be spent on other health services.

12 of the 23 panellists who voted agreed with the statement, and a further six said only in exceptional circumstances. Four panellists disagreed and one was unsure.

	First vote	Second vote
Yes	12	14
Only in exceptional cases	6	6
No	4	4
I'm not sure	1	1
Total	**23**	**25**

Statement 2: We should continue to prescribe anything people need and reduce other healthcare services.

At the end of the workshop the second votes showed a small change in response to statement two.

Only one panellist answered yes – 'We should continue to prescribe anything that people need and reduce other healthcare services.

Two more people replied 'no', increasing this vote from 19 to 21, and 'I'm not sure' by one.

More people chose to vote on the second occasion. Unfortunately, there was insufficient time to explore the vote more fully to unpick whether there had been any real shift in panellists' opinions about what they described themselves as a very complex issue.

	First vote	Second vote
Yes	4	1
No	19	21
I'm not sure	2	3
Total	**25**	**25**

Rounding off the day

At the close of the meeting, panellists told us how much they had enjoyed the session. They said they welcomed the opportunity to have their voices heard. And that they had learned a lot about the topic and the challenges faced by the CCG from the opportunity to hear and ask questions of the experts.

The evaluation forms confirmed what we had been told. They also said they had valued the opportunity to meet other people and hear their opinions. They liked the tools and techniques used, for example the voting and the table facilitation.

The evaluation forms also told us about the administrative arrangements which we could improve upon, for example the length of time spent on introductions, microphone arrangements and the quality of the coffee.

Reporting on the work of the Community Values Panel

Four panellists volunteered as report checkers to help Healthwatch make sure the reports produced from each meeting accurately reflected the tone and content of the event.

The report produced from each event, along with a shared introduction, sets out:

+ The question being considered.
+ A narrative of the Panel activities.
+ The voting results/ranking at each stage.
+ The factors that influenced people's views and any conclusions.
+ Social values and deliberations about their priority relating to the topic. This is for the CCG to use as community values guidance for taking forward future policy.

Appendices

Appendix 1

Reflecting the population in the CCG area – the percentages and panel makeup.

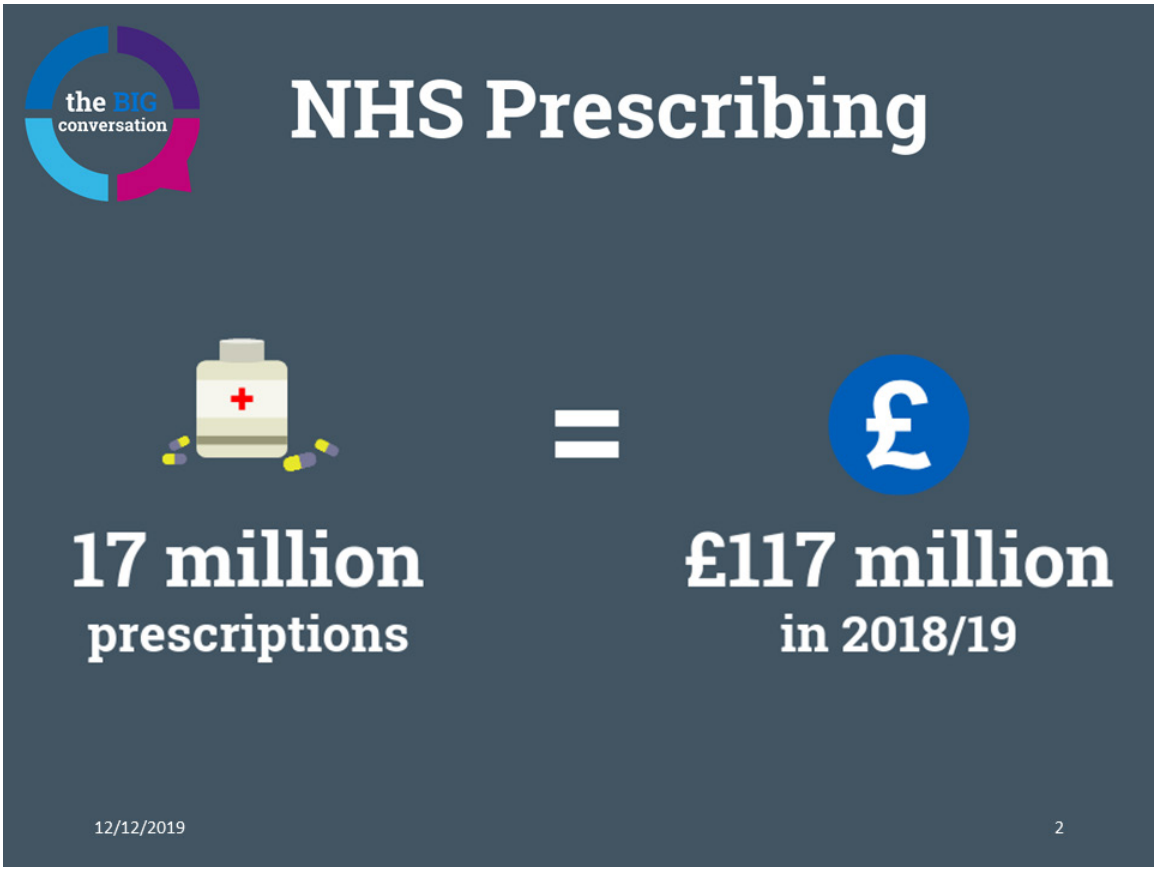
Gender	Female	Male
Percentage in local population	50%	50%
Number of panellists	15	15

Which district or city people lived in	Cambridge	East Cambs	Fenland	Hunts	South Cambs	Peterborough
Percentage in local population	15%	10%	12%	20%	19%	24%
Number of panellists	4	3	4	6	6	7

Age	15 to 24	25 to 44	45 to 64	65+
Percentage in local population	15%	33%	31%	21%
Number of panellists	5	10	9	6

Sub-categories in population	Carers	Disability or long-term condition	LGBTQ+	Minority ethnic community
Percentage in local population	12%	20%	10%	10%
Number of panellists	4	6	3	3

Appendix 2 - CCG Presentation slides



Over the Counter Medication

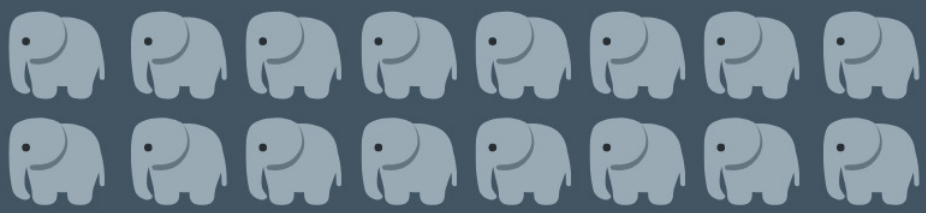
Last year we spent £5.3 million on medicines that our patients could easily have purchased without a prescription at a pharmacy or supermarket.

These include common medicines like paracetamol, emollients (skin creams/lotions), vitamins and indigestion and heartburn remedies, which are more expensive to the NHS when prescribed, compared to how much they cost to buy.

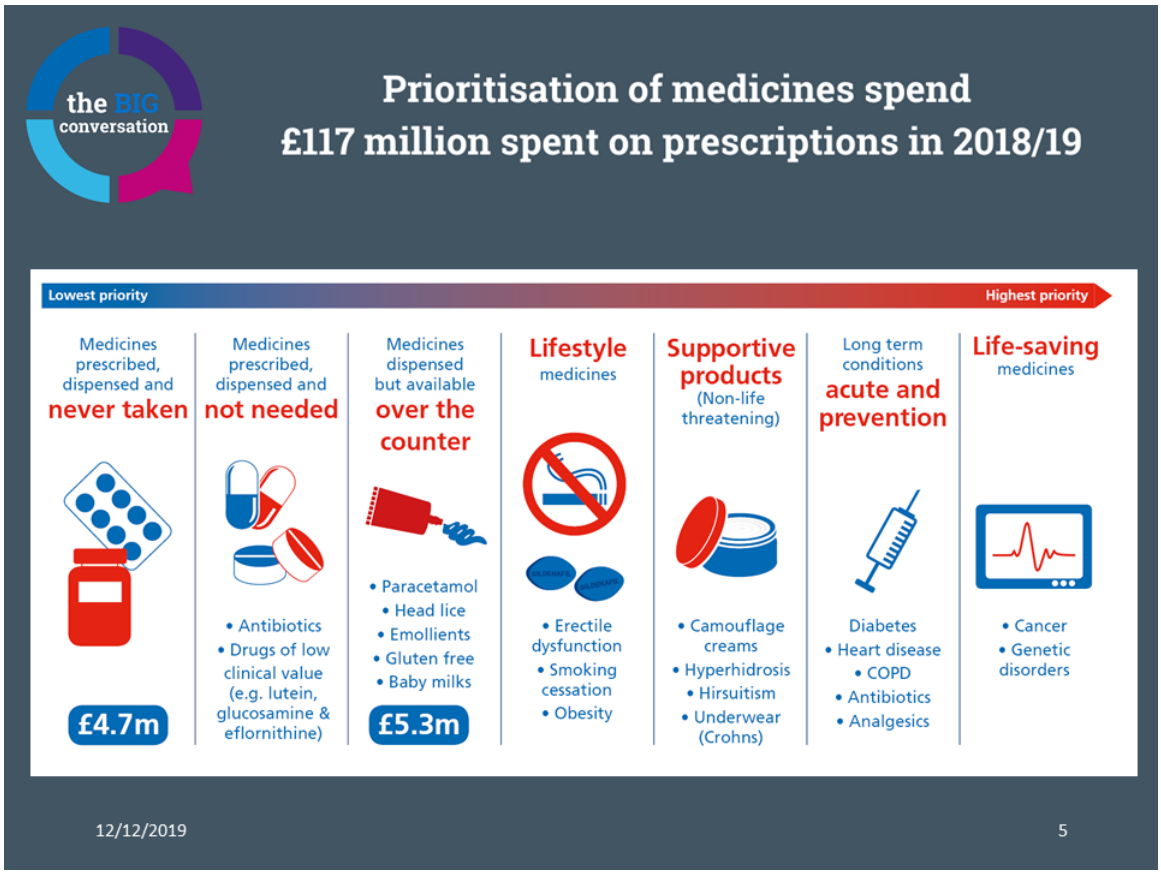
12/12/2019 3

Medicines Waste

£4.7 million of unused medicines wasted
(101 tonnes)



That's equivalent to 16 elephants


the BIG conversation
Prioritisation of medicines spend
£117 million spent on prescriptions in 2018/19
Lowest priority
Highest priority
Medicines prescribed, dispensed and never taken
£4.7m
Medicines prescribed, dispensed and not needed
• Antibiotics
• Drugs of low clinical value (e.g. lutein, glucosamine & eflornithine)
Medicines dispensed but available over the counter
• Paracetamol
• Head lice
• Emollients
• Gluten free
• Baby milks
£5.3m
Lifestyle medicines
• Erectile dysfunction
• Smoking cessation
• Obesity
Supportive products (Non-life threatening)
• Camouflage creams
• Hyperhidrosis
• Hirsuitism
• Underwear (Crohns)
Long term conditions acute and prevention
Diabetes
• Heart disease
• COPD
• Antibiotics
• Analgesics
Life-saving medicines
• Cancer
• Genetic disorders
12/12/2019
5

Appendix 3 - Summary of table posters

Question	What people said
How do I feel about what I have been learning?	Prevention better than cure. Very complicated. I feel peeved that sealed drugs are destroyed. I think the public needs to be better informed and educated about OTC drugs. People don't need medication if we do more to keep them healthy and young. We should try to reduce demand – concerned about safe disposal – people still put drugs down the loo. Time frames for support and care needs to be invested in to deliver best support to the public – saves lives and health.
What sort of people will be most affected by these ideas?	Needs to be exemptions – GP decision? Safety net essential. I suspect the elderly and disabled will be most disadvantaged so there must be a safety net regarding OTC drugs. Vulnerable groups. People who are in poverty – unaware of this, who don't have a voice/ financial/disabilities/minorities. This affects everybody. Helping people out in their local community.
What questions do we have for our experts?	Greater use of generic drugs? Should government take the lead on awareness raising – rather than local?
How is your view changing, if at all?	My views have not changed re over the counter drugs Becoming more aware of the issues. Environmental impact of medicine wastage. We need to be more aware and not in denial. Increasing population – increasing pressure. Income disparity – unfair on those who cannot afford care and medicine, need support.

Question	What people said
How do I feel about what I have been learning?	Frustrated. Are points made being listened to? See French model for basic care for everyone. NHS provides too much (e.g. cosmetic procedures), look at original purpose, NI contributions do not reflect service provision. Free prescriptions at 60 – a political issue. Need better negotiations with drug companies. Personal responsibilities?
What sort of people will be most affected by these ideas?	Rural areas/older, less mobile people who live alone/people on low incomes, especially working people with low income. Wealthy pensioners? Are they 'entitled' or should be linked to retirement age? Cost of living.
What questions do we have for our experts?	How much do drugs cost? More or less than £9? Why doesn't the NHS have their own factories to produce generic drugs cheaply (Indian model)? But concerned about conditions for workers – costs v ethics. Need more advice and recommendations from GPs. What drugs are going into 'waste'? Are they prescribed or also OTC medicine?
How is your view changing, if at all?	Offer a simple YES/NO to those people who want to or are wealthy enough to give up their right to a free prescription. Why just keep paying it to everyone regardless.
Issues/comments unable to allocate	Patients should check their drug bag before leaving the pharmacy. NHS 'Dignitas'. GP conferences funded by pharmaceutical companies.

Question	What people said
How do I feel about what I have been learning?	Good idea to have notices at pharmacies – inform £9 prescription v .45p paracetamol. Reasonable to buy privately when cheaper. People stockpiling drugs now – waste. Need local supplies. £16 taxi, return to nearest ? Confused. Difficult to get what you need. Worried about supplies. Concerned about wrong prescriptions, contra-indications with existing conditions. Need advice.
What sort of people will be most affected by these ideas?	Learning disabilities/lack of understanding. Disabled. Everyone. People with autism. Long term conditions. Low income. Financial difficulties.
What questions do we have for our experts?	How do we educate everybody? Can suppliers do 'sample packs' to see if suitable – could reduce waste? What can you do to prevent stockpiling medicine? Media doesn't help/social concerns.
How is your view changing, if at all?	Not a straightforward 'yes' or 'no'. Feel more informed. Needs simplifying. View hasn't changed due to knowledge and experience.
Issues/comments unable to allocate	

Question	What people said
How do I feel about what I have been learning?	Alarmed to hear how much is wasted. Waste – given a month's supply of tablets but only needed to take them for 10 days. GPs need to be able to say 'no'. Training – cost v benefits.
What sort of people will be most affected by these ideas?	People: With long term conditions. On benefits – already get free? On low incomes. House bound. Disabled. Volunteer shopping services – could they check for medicine cabinet drugs? Could they buy them? Risks?
What questions do we have for our experts?	Private prescriptions: are they always converted into NHS prescriptions? Personal experience. People who pay for private care. Patients recognise professional standards of pharmacist and their potential. Can pharmacists tell patients if OTC is cheaper? Delivery systems – could that be better utilised? Could the voluntary sector do more ??shopping (probably too much risk). GP - set of principles? Yes, but CCG can't insist so need to encourage a conversation.
How is your view changing, if at all?	No – but the problem is much bigger, more complex and expensive . Additional information won't make a difference.
Issues/comments unable to allocate	People being refused expensive treatments that are actually part of their necessary care. Asked GP for prescription for foot issues. Told to buy it as would be cheaper. It wasn't, foot care important for people with diabetes. NHS is free at point of use: + Health tourism (different issue) + Means testing + Private health insurance

Question	What people said
How do I feel about what I have been learning?	Need education – take ownership of own health. The NHS makes me feel alive. I pay for my prescriptions by pre-payments. Most of my medicines keep me alive, but some things I get on my prescriptions help keep me comfortable. If I don't have these things I would not feel so well and might need antibiotics. But this is on the list as something that might be taken away.
What sort of people will be most affected by these ideas?	
What questions do we have for our experts?	
How is your view changing, if at all?	
Issues/comments unable to allocate	

Appendix 4

Summarised from each table's conversations.

What is most important to you?	What is less important to you?
Education: + General public + Start young + GPs re clinical staff/trainers (Access to education and information) Reduce waste. Good availability of medicines (waste). Prudence – make best use of the money available.	
Achieving best value for the NHS and patients – over the counter, common drugs available at capped price. Informed but hard decisions need to be made due to the size of the deficit – redefine NHS. Personal responsibility to self-care first – education and information.	Except exceptional circumstances – people's right to 'free medication'. If you can, do, Just focusing on one thing in isolation – waste elsewhere, e.g. + More appointments – less frequent prescribing. + No blood test available (purchase Saturday private nurse).
Education and access to information for people. Keep it fair – need to reduce inequalities. People taking responsibility for selves with support for those who can't – a safety net.	Doctors should be less afraid of upsetting people, not embarrassed to say 'no'. Pharmaceutical company/shareholder profit. Money (but we know it really is important).
Those most able to look after themselves to be educated and encouraged to do so. Using resources wisely. Good information (self-care) on over the counter medication.	Choice.

Safeguarding our NHS. Safeguarding the most vulnerable people in our society. Personal responsibility and greater self reliance including preventing ill health.	The expert's voice, balance it with the patient's voice (I think the group were trying to say that less emphasis should be put on what the expert says and wants – it led on to the conversation about use of cutting edge IT and AI). Everything doesn't have to be 'cutting edge', 'flashy' .

Post it notes - see page 20.

1. Pharmacy structure needs reviewing, e.g. Milton surgery can only dispense to patients who do not live in the village. Villagers have to go to Tesco.
2. A richer area for more needed care
3. *More funding for more urgent care. *Also can use money for training/nurses that are needed. * Less waiting times for doctors. *More time for doctors to listen to patients

Contact us

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Healthwatch is your independent champion for health and care. Our job is to make sure that those who run local health and care services understand and act on what really matters to people.

healthwatch Cambridgeshire

healthwatch Peterborough

The second Community Values Panel

Talking about urgent and emergency care

An independent panel for Cambridgeshire and Peterborough

Contents

Key Findings

30 local people from across Cambridgeshire and Peterborough joined a Community Values Panel to have a say on funding local health services.

The panel was set up by the people who plan and buy health services in our region – Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). It was supported by our Healthwatch.

The panel met twice in the autumn of 2019 to help the CCG work out what's important to local people. This report includes the outputs of the second panel meeting on 19 November in St Ives.

Panel two

On the day, 29 panellists helped the CCG think about care in our Accident and Emergency Departments. They wanted to know if people should be redirected to other NHS services if they arrive at A&E but do not need emergency treatment.

They heard from experts at the CCG who told them about:

+ The range of NHS services that provide urgent and emergency medical treatment. And how NHS 111 helps guide people to the right service.
+ How much it costs the NHS to provide these services.
+ The increasing number of people using urgent and emergency services.

What the panellists thought

Panellists were asked to vote on how much they agreed or disagreed with the following statements at the start and then again at the end of the day. We wanted to see how their views changed after finding out more about the issue.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

At the start of the day, most of the panellists agreed with the statement. Only four panellists told us that they were either unsure or disagreed. At the end of the day all the panellists who voted agreed with this statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away.

The vote on the second statement suggested less certainty. At the start of the day, only half of the panellists agreed that people should always be seen if they went to A&E.

There was a small change in the vote at the end of the day when fewer panellists were 'unsure'. Slightly more panellists agreed with the statement and slightly more panellists disagreed. The conversation about the outcome of the vote on the second statement was particularly interesting.

Panellists talked about the significance of the different terminology used in each statement. And how they felt about people being 'turned away' - which they didn't like - as opposed to 'redirected'. This highlighted important issues about how people would be redirected, by whom, and in what circumstances.

Shared values

During the day the panellists got involved in a variety of discussions and activities. These encouraged them to consider what was important to them in relation to using emergency and urgent care services.

At the end of the event, the panellists decided their values, in order of priority, were:

+ Most in need first.
+ Access to information.
+ Access to the expert.
+ Access to a range of services.

About the panel

About the Community Panel

The Community Values Panel was set up and run by our local Healthwatch, and independently facilitated by Phil Hadridge of idenk. It is funded by Cambridgeshire and Peterborough Clinical Commissioning group. The Panel is a part of the CCG's Big Conversation asking people:

+ What they value most, and
+ What changes could be made to the way people access and use health services.

The panel workshops aim to find out which values the panel prioritises when considering a particular part of our local health service in challenging financial times.

30 panellists were selected to reflect the diverse demographic characteristics of the population in Cambridgeshire and Peterborough. This was based on age, gender, and district of residence. The selection also aimed to reflect the area's disability, ethnicity, sexuality, long-term conditions and caring profile.

More information about the role of the panel, the selection of panel members and how each panel works is included in the report of the first panel workshop - 'The first Community Values Panel - Talking about the availability of over the counter medicines on prescription', also published in January 2020.

Picture shows one of our panellists.

How the panel meeting was structured

Each panel meeting followed the same format with some variations in the methods used to capture panellists' discussions.

This was:

+ Topical questions described.
+ A vote on questions to test panellists' divergence on the topic.
+ Experts, specialists in the topic, explaining context.
+ Structured discussion in small groups.
+ Further scenarios explored.
+ Facilitator exercise to identify community values – what matters, and how people prioritise them.
+ Repeat vote on the topic to explore changes in the panellists' views.
+ Summary, evaluation and closing business.

All panellists were paid £50 for each four-hour workshop and reasonable travel costs. The funding included covering the cost of taxis for panellists with sensory impairments and learning disabilities.

Details of how we reflected the CCG population in the membership of the Community Values Panel is shown in Appendix 1.

Facilitator exercise to identify community values – what matters, and how people prioritise them.

+ Repeat vote on the topic to explore changes in the Panel view and for individuals.
+ Summary, evaluation and closing business.

Feedback from the CCG representative/s and the local experts was welcomed.

The evaluation forms and the facilitator-led team debrief informed the design and practicalities for the second workshop. A summary was shared with the panellists.

About the second panel workshop

29 panellists attended the second Community Values Panel. Most had also attended the first one. The few who couldn't come to this session were substituted with people who similarly reflected the demographic profile of the Cambridgeshire and Peterborough area.

We improved the format of the second panel based on feedback from the panellists after the first event.

They liked:

+ The input from experts.
+ Using voting buttons.
+ And the way the table discussions had been run.

We made it better by:

+ Spending less time introducing people.
+ More time in discussions.
+ And by using a smaller room so we didn't need a sound system.

Picture shows one of our panellists.

Urgent and emergency care

A&E departments in all our hospitals are very busy. A&E staff often struggle to see people with urgent needs as quickly as they would like.

The purpose of the second panel was to discover the values the panel members have in mind when they consider which urgent and emergency care service people should use.

The day started with everyone meeting the other panellists again and new panellists introduced themselves. Panellists told us they had enjoyed working with the people on their table at the first workshop and welcomed the opportunity to meet them again. And work mostly in the same groups.

The next conversation reminded everyone of the ground rules agreed at the first panel, for the way the panellists, facilitators and experts would work together.

Panellists were given the opportunity to try out their voting devices again with a brief quiz related to the day's topic.

They were asked:

+ What number would you ring if someone in your family has chest pains and breathing problems?
+ Where would you go if someone in your family has sprained or broken their ankle?
+ What number would you ring if you are feeling unwell but are not sure if it's an emergency?
+ Are you confident that you know the difference between an urgent health need and an emergency?
+ Do you know where to go for more information?

The responses to these questions immediately stimulated conversations.

Panellists were confident in their responses to the first three questions. Although a significant number of people were unsure about the most appropriate route to treatment for chest pain or a broken ankle.

Interestingly, 26 of the 28 people responding to the third question knew that they should ring 111 if feeling unwell and unsure if it is an emergency, showing that people had absorbed the messages about using NHS 111.

When asked did you know the difference between emergency and urgent care, panellists were nearly evenly split between 'yes' and 'I'm not sure'. Two people said 'no' they were not confident they knew the difference .

In response to the last question about seeking information, more than half the panellists who responded - 16 out of 27 - said they were unsure or didn't know where to go for information.

Where did the panel stand on the topic of the day?

Panellists were asked to vote on two statements at the start of the day.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

A	Strongly agree	15	56%
B	Agree	8	30%
C	I'm not sure	1	4%
D	Disagree	3	11%
E	Strongly disagree	0	0%
	Total	**27**	**100%**

Most of the panellists agreed with the statement. Only four panellists told us that they were either unsure or disagreed with this statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away.

The vote on the second statement was more ambiguous. This time only half of the panellists agreed that people should always be seen if they went to A&E. Panellists talked about how they felt about the term 'turned away' and were concerned about how this would happen in practice.

What the experts said

Jessica Bawden, from the Clinical Commissioning Group, explained the role of the CCG in contracting health services for local people. And told them about the 'Big Conversation' initiative to hear what people have to say about affording health services in difficult financial times.

She outlined in principle the different urgent and emergency services and which service people should most appropriately use when they feel unwell. She acknowledged that the range of services varied across the area and that choice of service could be complicated.

Experts Dr Andrew Anderson a local GP and the clinical lead for urgent and emergency care, and Mr Vaz Ahmed, A&E Consultant, Addenbrooke's Hospital, gave more details about the pressure on services. See Appendix 2 for the slide set used.

We heard that

+ Calls to NHS 111 have been increasing year on year.
+ Since July 2018, patients have been able to use 111 online.
+ More people are using urgent and emergency care services every year. The biggest increase is in A&E, where there's an average extra 44 people a day.
+ Roughly 15% of people attending A&E departments locally on weekdays could be treated appropriately elsewhere. This was higher at weekends.

Picture shows one of our panellists.

What we heard from our panellists

Panellists had differing levels of awareness of the range of emergency and urgent care services available.

Everyone was familiar with A&E departments. And many panellists had had direct or indirect experience of using A&E departments at the hospitals across the area and beyond.

Fewer people were aware of Minor Injury Units (MIU), Walk in Centres, and Urgent Treatment Centres (UTC).

We heard a range of comments based on panellists' direct experience of these services.

"Better than nothing" - Wisbech MIU

"Speedy", "Excellent, can't praise it enough", "It's comforting to know that it is near by" - Ely MU

"Very fast", "Excellent" - Doddington MIU

"Quite good", "Only open limited hours" - St Neots walk in centre

A lot of panellists commented on the confusion caused by:

+ Services with different names operating across the area.
+ Different opening hours.
+ And differing in what treatments are provided.

Most panellists were unaware how GP extended hours worked in their local area.

Many panellists didn't know the difference between the functions of an MIU and an UTC.

Panellists were unaware that NHS 111 was also available to the public as an online app and a web page. They were interested to know more about how these worked.

Questions from the panellists

Panellists had lots of questions for the experts.

"When there is so much pressure on A&E why was the out of hours service in Chesterton closed?"

"Why is there no other service other than what is offered on the Addenbrooke's site?"

"Does the MIU/UTCs being open affect the workload at the A&E departments?

"Why are some people sent to A&E post discharge when the minor issue could probably be dealt with by community health services?"

"How do the emergency and urgent care out of hours services handle the additional needs of people with learning disabilities?"

"Is there really not enough staff to meet the demand? There needs to be greater flexibility to attract people to stay in NHS employment, or to return "

"Addenbrooke's works like a magnet sucking people into A&E first. Couldn't there be a wider range of services spread across the city and surrounding areas?"

"A&E departments are not the best place for treating emotional and mental health problems. We need different services"

"Services need more funding. How can we lobby for a fairer funding settlement for this area?"

"What happened to GPs 24 hour duty of care?"

"What are people told now at the point of triage if staff feel they are using the service inappropriately"

"Would a more even spread of MIUs across the area help manage demand?"

What the experts said

All the experts acknowledged that there was need for greater consistency around services. This included:

+ Where they were based.
+ The opening times.
+ And the range of treatments.

They also said:

+ Locating different services together, like the out of hours' service on the Addenbrooke's Hospital site, helps make best use of limited resources. Especially staff.
+ More work was needed to make sure that some procedures could be provided in the local community.
+ There was now a wider range out of hours' support for people in mental health crisis.
+ Adjustments to funding services to reflect population growth were slow and small. And do not reflect real population growth.
+ Redirecting people to alternate services 'at the front door' of A&E departments was difficult.
+ But encouraging people to phone first, e.g. to NHS 111, would provide an opportunity to redirect people to the best service to meet their needs.
+ Providing urgent care within GP extended hours' services would reduce pressure on A&E departments.
+ However, many patients still don't know about alternatives to using A&E departments.

In response to what they heard

There was a wide range of responses from panellists to what they heard from the experts. This is what some of the panellists told us.

"Services need to be more 'hard nosed', some people are just time wasters"

"People need better information and signposting"

"People living and working in a 24-hour culture want to be seen NOW"

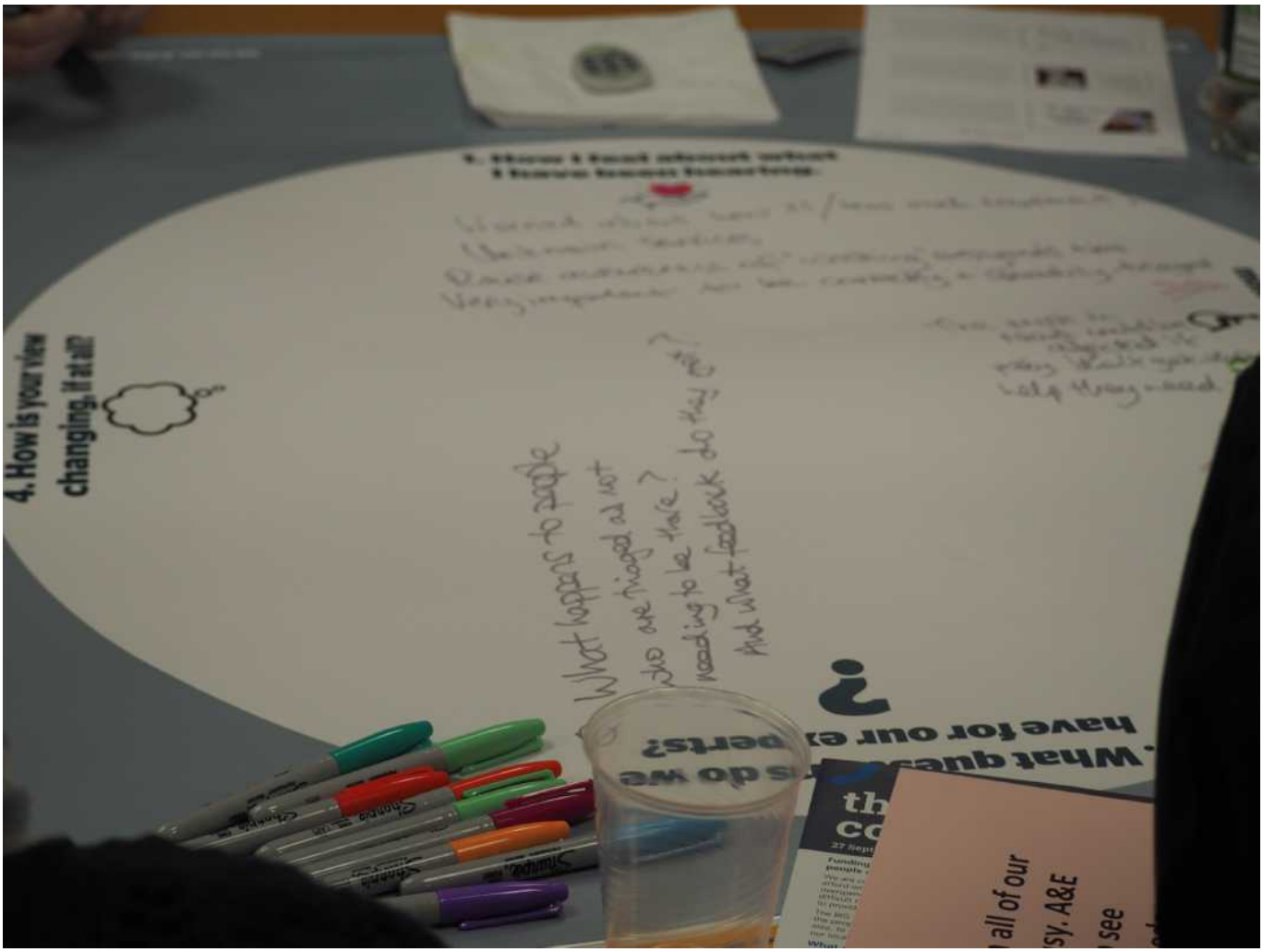
Exploring the issue in more detail

The panellists took part in facilitated conversations at four tables to explore the topic in more detail.

What they talked about:

+ How they felt about what they'd been hearing.
+ What sorts of people would be most affected by possible changes in practice.
+ If they had any questions for the experts.
+ If their views were changing at all.

Panellists were encouraged to record their feelings, views and questions on posters and sticky notes on each of the tables. Appendix 3 records these.



Picture shows notes from the panellists as they took part in this section of the day.

What they said:

+ Those that have access to wider range of services appreciate them.
+ But there were concerns about how people may be redirected, where to, and by whom. People didn't want to be 'turned away', but maybe redirected.
+ There was a lack of knowledge about what services are available and where they are.
+ Inconsistencies between different services gets in the way of people using them.
+ Limited and varying opening hours restricts how much people can use services.
+ Concerns about a growing emphasis on encouraging people to use phone and online-based services.
+ There's a need for more and better advertising to inform people of the best service for their treatment.

The panellists' experiences of using services

In our next conversation, we encouraged our panellists to think about their own decision to seek emergency and urgent care services. Drawing on their own experience, what had helped them get that service, and what was difficult.

Did they notice any information gaps? Could they suggest any improvements which may have helped? Each table talked about one of each of the services and panellists were able to move to a table they felt best suited their experience or interest if they wished.

The topic tables were:

+ A&E.
+ NHS 111.
+ MIU/Urgent care services / Walk in centres.
+ GP out of hours' services.

We reminded panellists that they should only share experiences that they felt comfortable talking about.

Themes identified and how panellists felt

Panellists liked:

+ How easily they could use NHS 111 via the phone or an app. However, some people weren't sure when they should call 999 or 111, and wondered if there were too many emergency numbers.
+ That it was easy and reassuring to use local urgent and out of hours' services, such as the MIUs.
+ Local services could help them avoid long waits at A&E.

Panellists didn't like

+ That they sometimes had a long wait for a call back from NHS 111.
+ That it was hard to decide which service they should use.

Picture shows notes from the panellists as they took part in this section of the day.

Panellists felt:

+ There should be more awareness campaigns about the range of services available to meet people's differing health needs, including out of hours' concerns and emergencies.
+ Patients should be asked routinely if they had used NHS 111 when they go directly to a service.
+ Concerned about homeless people and people from Gypsy, Roma and Traveller communities who may not be able to telephone services first.
+ There needed to be a wider skill set in the staff working in alternative urgent care services.

Appendix 4 gives more information about these conversations.

Which values are most important?

The panellists' next activity was to try to think about what was important to them when using emergency and urgent care services. Each table had a set of nine cards representing values relevant to the day's topic.

Panellists talked together to try to find agreement about how important each value was. They represented this by ordering the cards into a diamond shape. with the most important values at the top and the least important at the bottom.

The values they talked about were:

+ Access to range of facilities.
+ Prevent further harm.
+ Access to the expert.
+ Most in need first.
+ A safe place to go .
+ Convenient – good use of my time.
+ Efficient services.
+ Access to information and advice.
+ Equal opportunities.

Some panellists thought that some of the values were intrinsic in how the services should be provided. For example, all the services should be assumed to be a safe place to go. And equal opportunities was the natural outcome of most in need first.

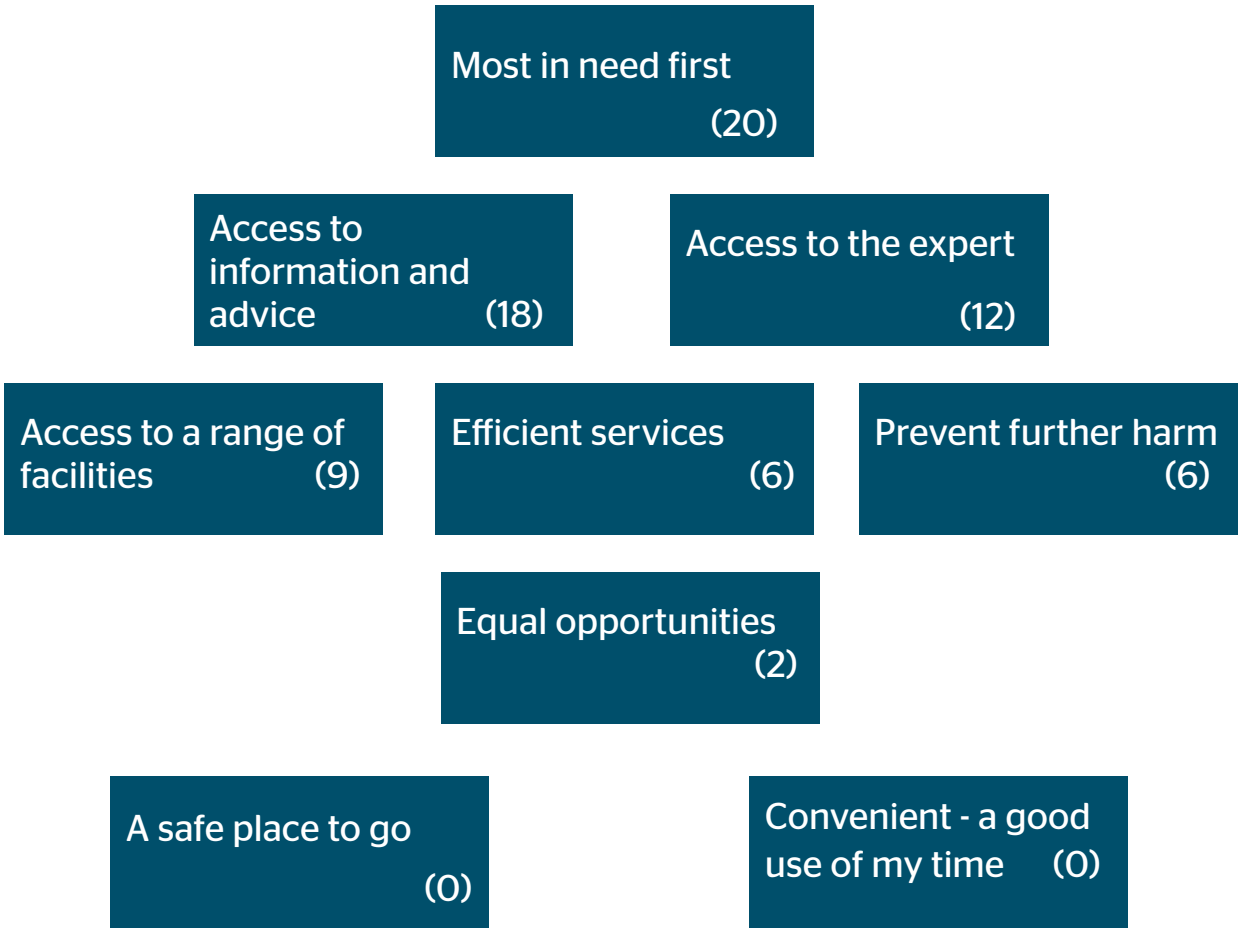
Some panellists wanted to make additions to the list. An additional two values were added by panellists:

+ Meet my health needs.
+ Quality of assessment.

The exercise generated a lot of conversation. Finding consensus was difficult. Each table shared its experience of trying to order the cards. We heard that panellists had found it easier to agree on what was less important, and to some extent on the values they would place in the 'middle' of the diamond.

In the final step in this activity, all the panellists were given three stickers to put on the final set of values, to rank their importance overall. The number on each of the boxes indicates how many stickers were put on the respective card. Two of the cards ('convenience, a good use of my time' and 'a safe place to go') had no stickers added to them.

This is how the panellists ranked the cards



Repeating the panel votes

At the end of the day, the panellists voted again on the two statements related to the day's topic.

The first vote took place before the experts introduced the topic and the second vote at the close of the session.

Statement 1: We should redirect people to other NHS services if you go to A&E and do not have a serious injury or illness that needs to be dealt with as an emergency.

		First Vote	Second vote
A	Strongly agree	15	21
B	Agree	8	6
C	I'm not sure	1	0
D	Disagree	3	0
E	Strongly disagree	0	0
	Total	**27**	**27**

The second vote showed panellists more firmly supporting the statement. Following the presentations and conversations, everyone who voted now agreed with the statement.

Statement 2: You should always be seen at A&E if you go there and you should not be turned away:

		First vote	Second vote
A	Strongly agree	10	9
B	Agree	4	6
C	I'm not sure	5	2
D	Disagree	3	5
E	Strongly disagree	6	5
	Total	**28**	**27**

The vote on the second statement showed less change. Fewer panellists were 'unsure'. Slightly more panellists agreed with the statement and slightly more panellists disagreed. The conversation again indicated the significance of the different terminology used in each statement with 'redirected' as opposed to 'turned away'.

Rounding off the day

We wanted to know how the panellists felt about the topic and conversations which they had taken part in. They were asked to pick out a photograph from a selection which they felt resonated with how they felt. Some of the panellists shared their choices with us.

They expressed the energy and enthusiasm they had felt, although one panellist said she felt 'quite disturbed' as she felt the experts 'had a different view of the world'.

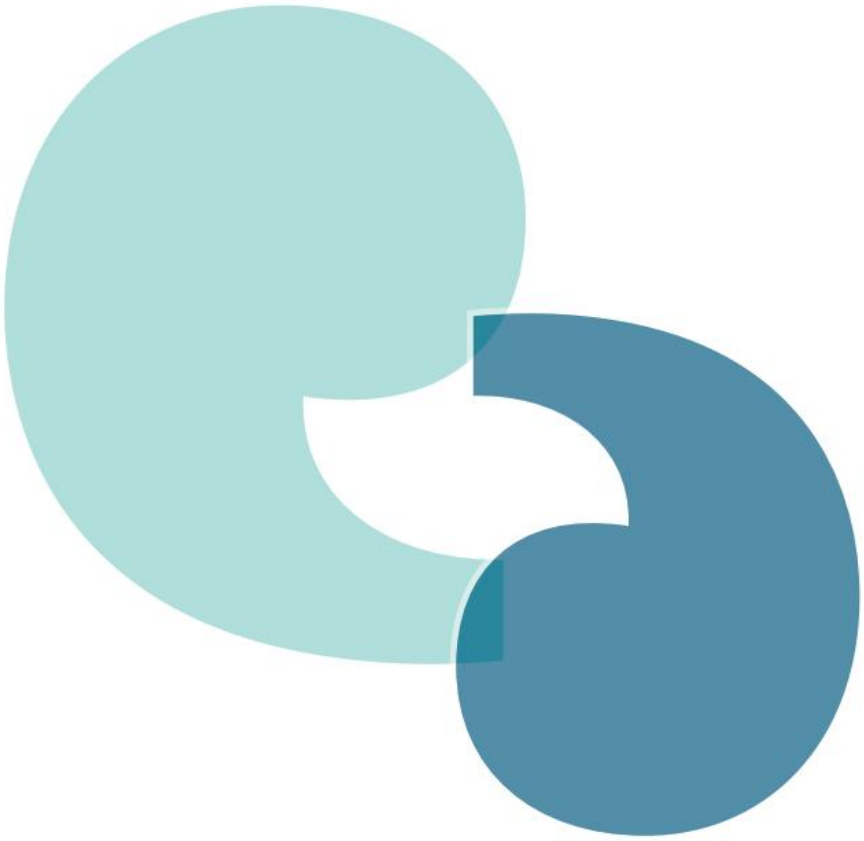
Panellists felt they had learnt a lot. They expressed how much they had enjoyed the session again and told us that they would look forward to potentially more panel meetings in 2020.

The panellists told us in their evaluation forms that they had valued the opportunity to talk with the experts who they felt were interested to hear what they had to say.

Four panellists volunteered to read the reports to check that they reflected their experience of the day.

Picture shows one of our panellists.

Appendices



Appendix 1

Reflecting the population in the CCG area – the percentages and panel makeup.

Gender	Female	Male
Percentage in local population	50%	50%
Number of panellists	15	15

Which district or city people lived in	Cambridge	East Cambs	Fenland	Hunts	South Cambs	Peterborough
Percentage in local population	15%	10%	12%	20%	19%	24%
Number of panellists	4	3	4	6	6	7

Age	15 to 24	25 to 44	45 to 64	65+
Percentage in local population	15%	33%	31%	21%
Number of panellists	5	10	9	6

Sub-categories in population	Carers	Disability or long-term condition	LGBTQ+	Minority ethnic community
Percentage in local population	12%	20%	10%	10%
Number of panellists	4	6	3	3

Appendix 2 - CCG presentation slides


the BIG conversation
NHS Urgent and emergency care
In Cambridgeshire and Peterborough we have:
Urgent treatment and Minor Injury Units
• Peterborough Urgent Treatment Centre at The City Care Centre
• Wisbech Minor Injury Unit at North Cambs Hospital
• Ely Minor Injury Unit at Princess of Wales Hospital
• Doddington Minor Injury Unit at Doddington Community Hospital
• St Neots Walk-In Centre
Accident and Emergency Departments:
• Addenbrooke's Hospital
• Hinchingbrooke Hospital
• Peterborough City Hospital


the BIG conversation
NHS Urgent and emergency care
AND we have:
• NHS 111, including GPs and clinical advisors
• GP Out of Hours services
• GPs supporting the front door of A&E
• GPs supporting our Minor Injury Units
• Extended Access to GP appointments
It's sometimes hard to know where to go.
NHS 111 is here to help.
17/01/2020
4

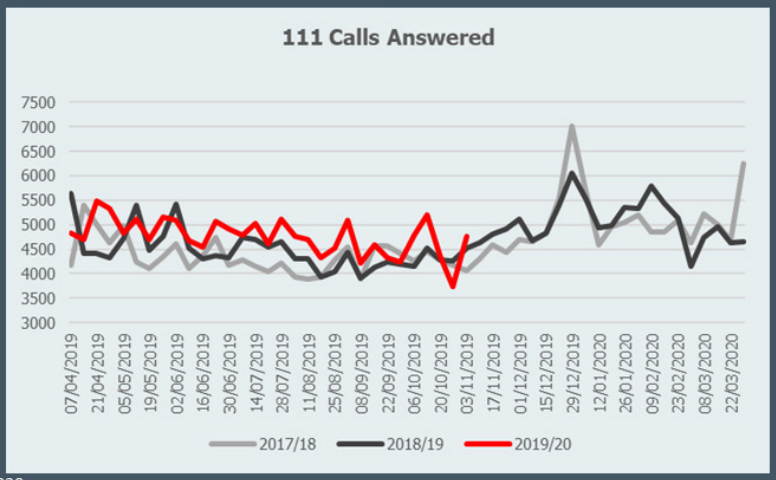
How much do urgent care services cost the NHS?

A trip to A&E	Calling out an ambulance	A visit to your local GP	A night's stay in hospital
£73	£180	£46	£1,722

17/01/2020 5

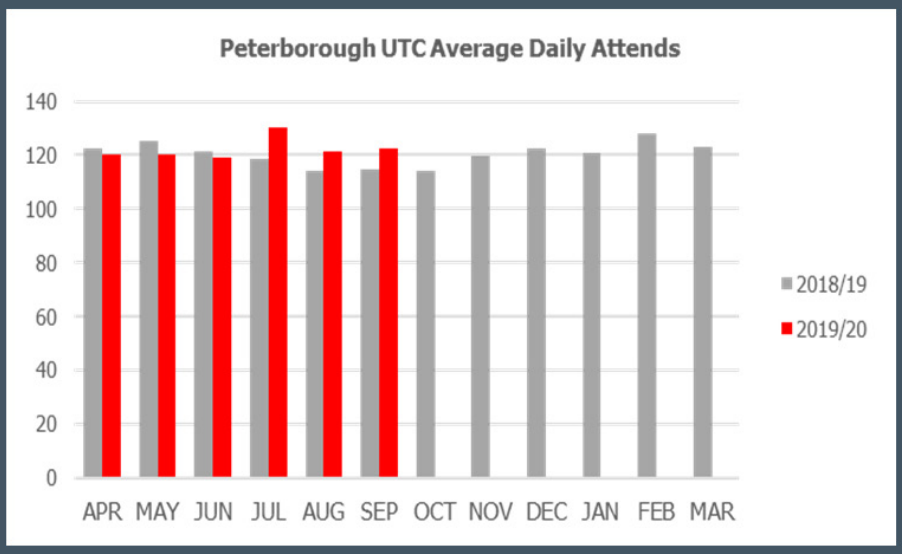
People are using these services more

Calls to NHS 111 are increasing year on year. Since July 2018 patients have also begun to use NHS online.



17/01/2020 6

People are using these services more



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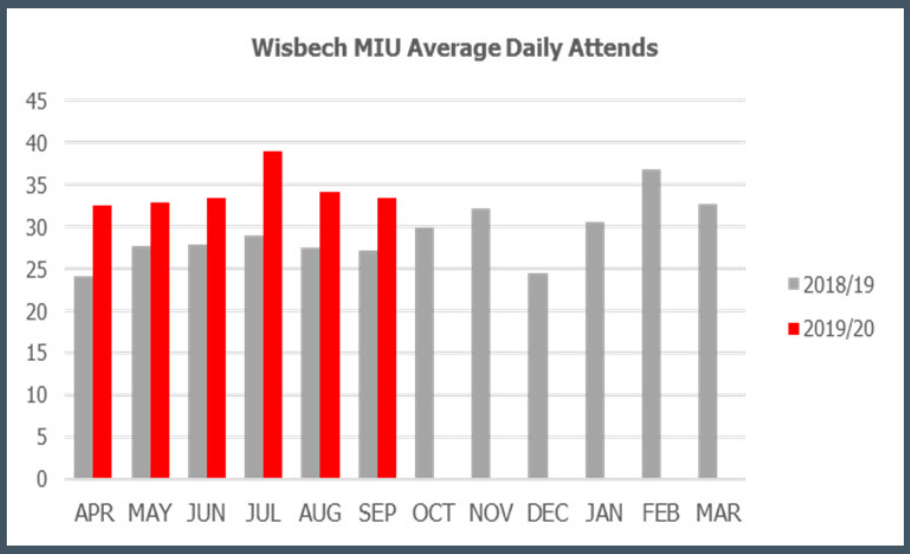
People are using these services more



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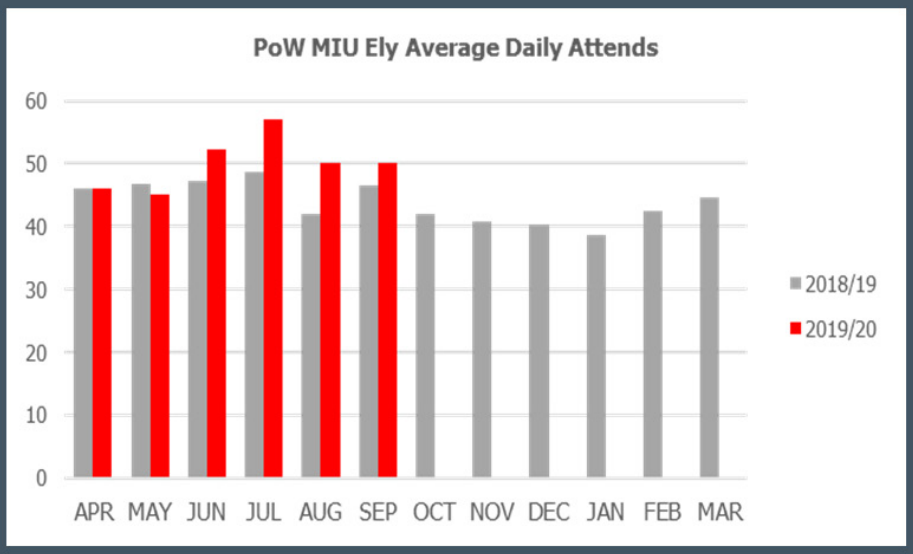

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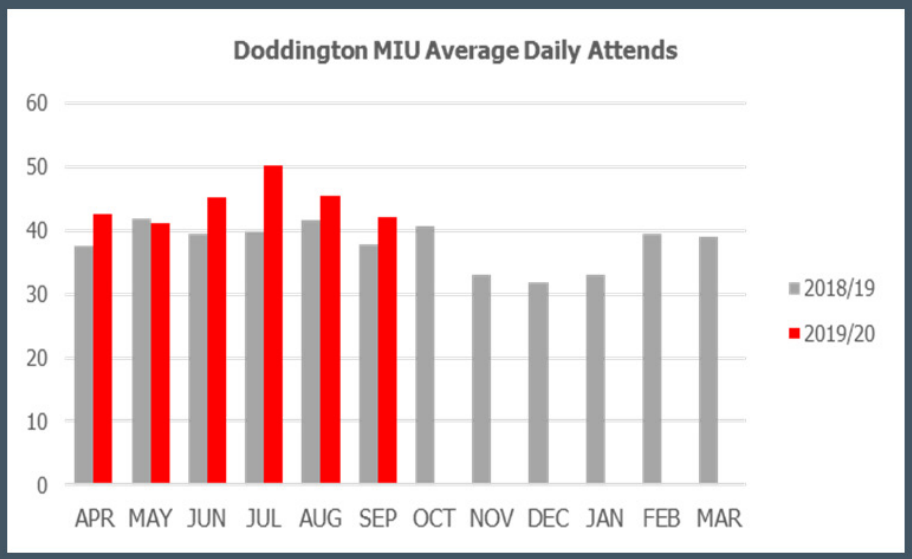
People are using these services more



17/01/2020 10

Use of Accident and Emergency Departments

A&E attendances
have increased by **4%** annually for the last five years

This means an extra **44** patients a day go to A&E

* Compared to 2014/15

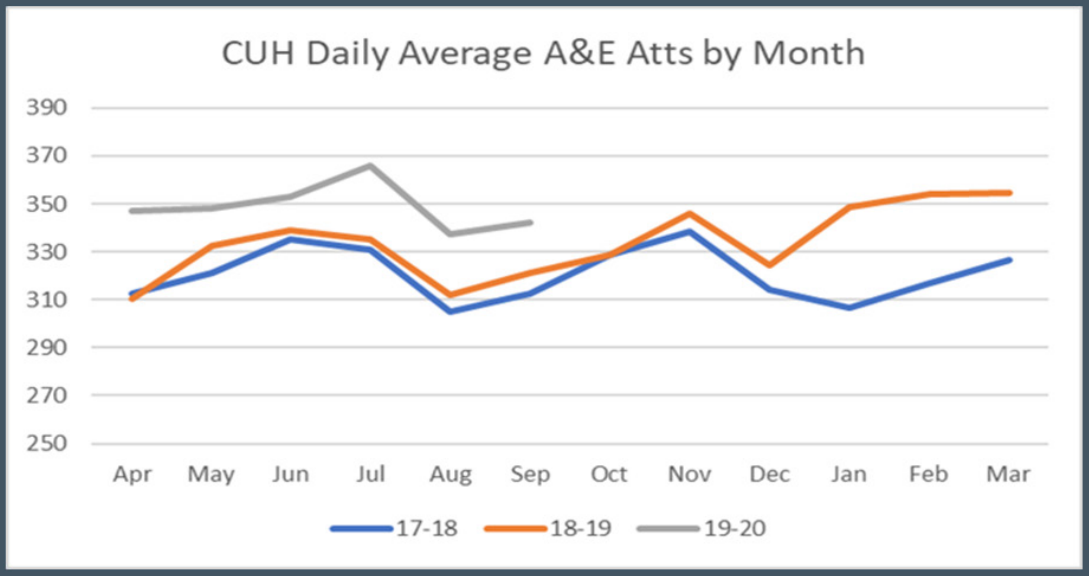
Elective care**
has increased by **2.6%**

This means an extra **42** patients are treated in hospital dailiy*

** Elective care means inpatient and day patients at hospital

17/01/2020 11

Use of Accident and Emergency Departments



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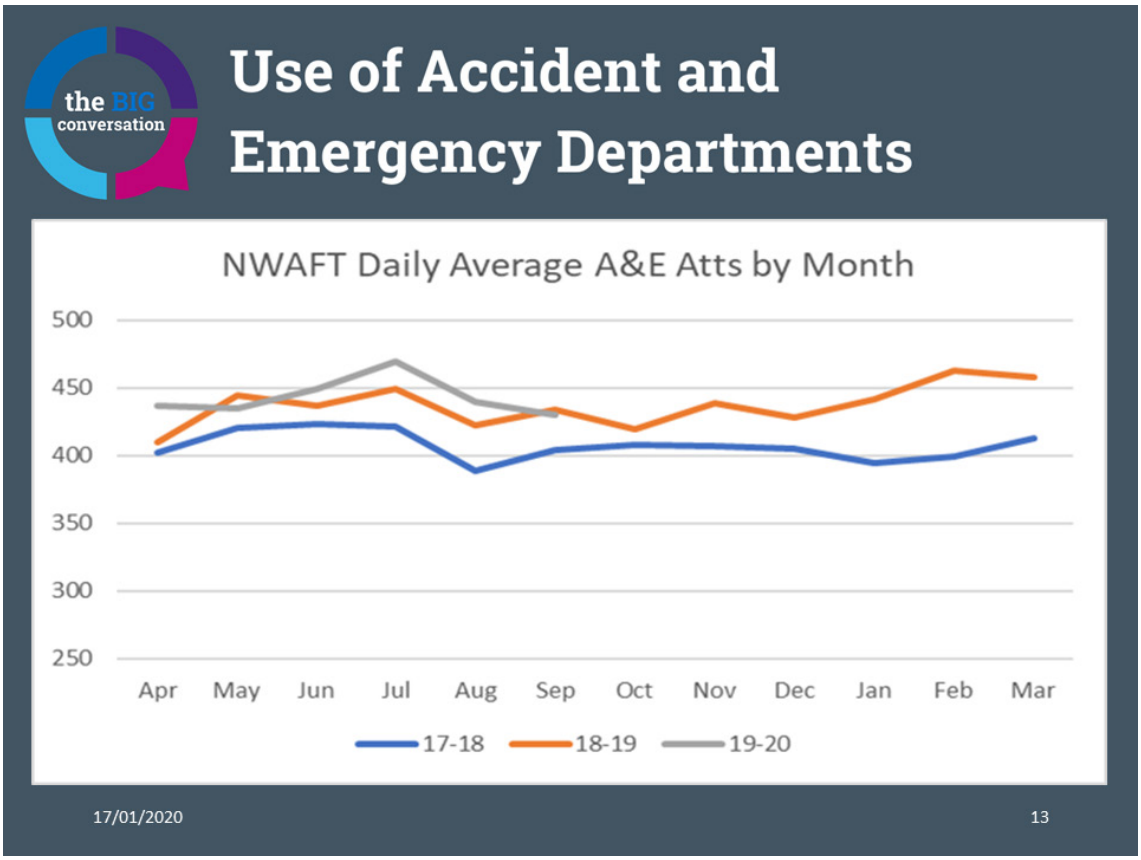


NWAFT - North West Anglia Foundation Trust. This trust runs Hinchingbrooke Hospital and Peterborough City Hospital.

CUH - Cambridge University Hospital Foundation Trust. This trust runs Addenbrooke's Hospital and the Rosie Hospital.

Appendix 3 - Summary of table posters

Question	What people said
How do I feel about what I have been learning?	+ Worried about how ill I am / how much treatment I need. + Unknown services. + Raise awareness of 'wasting everyone's time'. + Very important to be correctly and speedily triaged . + Public health info for people who have unhealthy lifestyles.
What sort of people will be most affected by these ideas?	+ The most in need could be affected if they don't get the help they need. + People who don't use IT/mobile phones might be disadvantaged. + Cambridgeshire lacks mobile signal in many places. + Worries about long ambulance waits – people abusing ambulance service (i.e. calling an ambulance when they could have called a taxi or a driver).
What questions do we have for our experts?	+ What happens to people who are triaged as not needing to be there and what feedback would they get? + Would more MIUs help? Take pressure off? Already? Is there a way they could?
How is your view changing, if at all?	+ Advertise NHS app. – could counteract 'Google effect'. + Something like the advert with the chaps in moustaches (directory services).

Question	What people said
How do I feel about what I have been learning?	+ Surgical procedure in Addenbrooke's – then other services send you back to A&E. + It's very complex. + At weekends, feel there are no options but A&E. + Worried about A&E wait. + Worried about turning away – always see at triage. Education and information needed. + Worried about ambulance estimate (cancer centre, collapse, short transfer, 8 hour).
What sort of people will be most affected by these ideas?	+ Elderly. + Low IT skills. + Vulnerable groups.
What questions do we have for our experts?	+ Support for people with learning disabilities in A&E. + Paramedics don't want to call an ambulance.
How is your view changing, if at all?	+ Good recent use of 111/A&E. improved view. + Interesting to hear about booking systems. + Better view of 111 – much improved, would use.

Question	What people said
How do I feel about what I have been learning?	+ Pleased to be living in Peterborough – localisation of services is a great idea for Cambs, don't take the services away from P'Boro'. + Education. More GP hours, NHS is a 24/7 service not just for weekdays. + I'm happy I live in Peterborough. + If they don't need to be in A&E, the correct thing is to turn them away.
What sort of people will be most affected by these ideas?	+ 111 – is ?? to the questions they ask and patients can ??? things. 999 – A&E. + People who struggle for transport -if they get a lift to A&E but then turned away, they may have to wait too long there to go to other facilities. + Elderly, don't want to call 999 so call 111 when they are actually ill. Youngsters call 999 when they don't need to – educate. + Some elderly people don't know they are acutely ill.
What questions do we have for our experts?	+ How can you and us lobby for fairer funding for this area? + Why don't GPs open 24/7? + What plan do you have to open an MIU in Cambridge?
How is your view changing, if at all?	+ Redirect, not turn away. + Where can I go? How do I find out? + People do not know about services outside of A&E. + Confused about where to go – told off for going to the wrong place.
Other comments	+ NHS 111 option 2 for mental health is failing + Broken bones – a long wait to look at x-ray by a doctor. Why not have a rapid access doctor who can discharge etc?

Question	What people said
How do I feel about what I have been learning?	+ Addenbrooke's growth + Addenbrooke's takes everyone - site is horrendous, overcrowded and poor access. Use out of centre area. + Addenbrooke's – overloaded/access/parking + Correlation between opening hours of walk in services and A&E- impact on demand. + Cost of real estate v cost of skills. + Thread of today's discussion – GP GP GP, not enough about extending NHS 111 service. Young/in work etc most use mobile apps all the time. Educate them to use 111 instead of GP.
What sort of people will be most affected by these ideas?	+ People not registered with GPs – how many? + Ability to travel/accessibility /parking. + Many people are not registered with GPs – Addenbrooke's A&E is only service for them.
What questions do we have for our experts?	+ Why have GPs at A&E when there are highly qualified nurses around?
How is your view changing, if at all?	+ More dynamic and informative advertising of the 111 service. Currently just not at a sufficient level of public comprehension. Get Saachi & Saachi type approach to up its awareness. + Flexibility for workforce – older staff returning to work/ bank staff. + Could have mobile units like breast screening units for walk in? Put a Walk in in Cambridge, for out of hours, e.g. at Trumpington P&R. + Green cross code – knew all about it as adults and children – excellent advert. Something similar to inform and educate. Was memorable and interesting.
Other comments	+ Manage the sense of expectations 'I've paid my NI'/Need to revise old cottage hospital concept based at GP. – become MIU, -empty bed blocking at Addenbrooke's, - place for low hours contract staff to return to work. + GP services, some can offer same day, - 5 min,- regular appointments still 4-6 weeks. Not available out of hours, not where I live, - referral to 111 or Addenbrooke's.

Appendix 4 - summary from table discussion

NHS 111

What helped	What was difficult
+ Ease of use – phoning. + NHS online web access. + Easy to remember phone number.	+ Lack of information. + Wait for call back was too long. + People don't know which is the right number. 999 or 111. + Some people call 111 when they need 999 and vice versa.
Any Information gaps	**Improvements?**
+ Big gaps in information. + Info for 111 app, education/info. + More advertisement on services, e.g. TV ads and leaflets. + Neighbours talking, 'Oh I used the 111 service and it was rubbish,' to someone who hasn't used it, automatically thinks it'll be bad and not call. + Too many numbers for emergency / health.	+ Gypsy communities who travel and homeless communities have no GPs or cannot always access it so use A&E. + Inaccurate / not up to date information online. + Encourage surgeries to be active on local chat mail and social media to advertise preferred contacts e.g. 111 and online. + Educate! + 111 at the door – 'Have you called 111?' + Education – advertising in roadshows in shopping centres, GPs.

Out of hours' care

What helped	What was difficult
+ Time of day/Bank Holiday. + Not sure if emergency or urgent. + Advice from out of hours' services avoided long trip to A&E – able to treat as guided over the phone. + Reassurance.	+ Questionnaire (algorithm) to access OOH very long. + Wrong prescription – too much pressure / training skills?
Any Information gaps	**Improvements?**
+ Couldn't use it if don't know it exists – thought Cambridge shut. + Access to OOH advice on phone.	+ Awareness campaign + Extend hours. + Skill set of OOH staff.

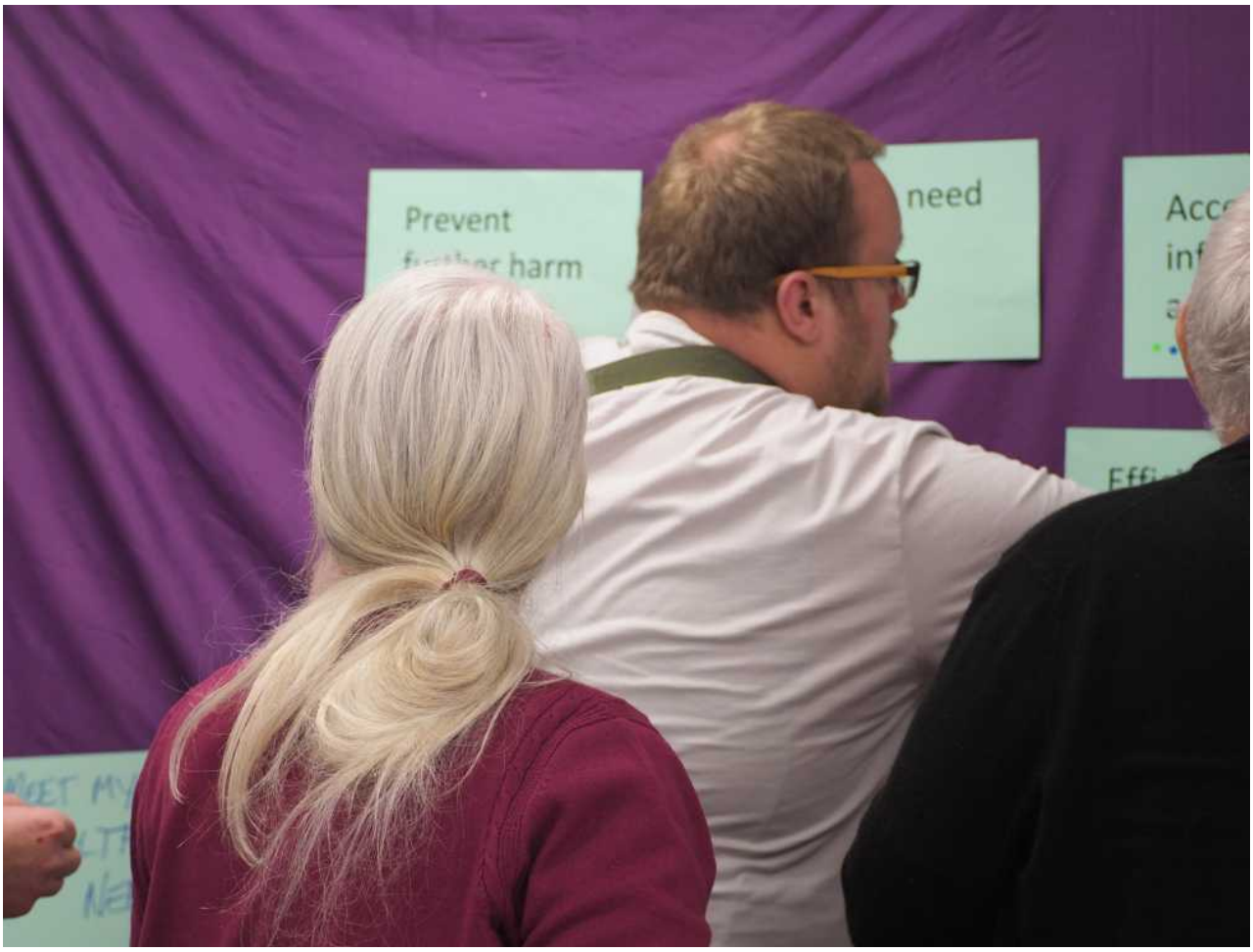
A&E

What helped	What was difficult
+ I knew I was really ill. GP no help, operation next day. + Caring attitude. + Paramedics inspired confidence.	+ If surgical procedures – 'told must go to A&E'. Knowing if it is A&E you should visit, especially out of GP hours. + No empathy shown for people with learning disabilities - lack of understanding. + Ambulance patients in same queue as walking. + Told need to go to A&E – no ambulance available –'find a lift'.
Any Information gaps	**Improvements?**
+ 111 can direct you to the more appropriate service. + Telephone number for A&E – encourage you to ring. + Lack of knowledge of local options.	+ Investment in staffing – getting staff in the right place. + Phone triage in A&E – awareness. Clear phone number. + Clear guidance – how to get communication. + Re-look at shift patterns – all emergency staff.

MIU / Walk in

What helped	What was difficult
+ Local – reassurance + Quick	+ Not one near me. + Not knowing opening hours. + Weekend closed. + Glass wall between CCG areas and hospital catchment areas on boundaries.
Any Information gaps	**Improvements?**
+ Didn't know about them and opening hours. + Awareness of who (age) and what conditions can be treated.	+ Sales pitch for MIUs. + Distribution of staff? + Get skilled people in – workforce initiative + Pop up clinics for long term conditions (like breast screening units in car parks)

Picture shows panellists talking about their experience of using services - this was the table that talked about NHS 111.



Picture shows panellists voting on what values were most important to them.

Contact us

Call: 0330 355 1285 (local call rate number)

Email: enquiries@healthwatchcambspboro.co.uk

Website: www.healthwatchcambridgeshire.co.uk

Website: www.healthwatchpeterborough.co.uk

Healthwatch is your independent champion for health and care. Our job is to make sure that those who run local health and care services understand and act on what really matters to people.

healthwatch Cambridgeshire

healthwatch Peterborough

Appendix 3

Healthwatch Cambridgeshire and Peterborough

The BIG Conversation: Our response

Context

Healthwatch Cambridgeshire and Peterborough recognise the financial pressure and growing demand being placed upon our local health and care services. We therefore welcome this public conversation and were happy to support the initial promotion. However, once the election was called, our Healthwatch took a decision to refrain from promoting and commenting on any consultations. This decision was based on advice from Healthwatch England.

We are aware that the local implementation plan for the NHS Long Term Plan will be published early in 2020. Healthwatch Cambridgeshire and Peterborough believe that this conversation being held in, what appears to be, isolation of this plan is a missed opportunity. The local Sustainability and Transformation Partnership is required by this plan to evolve into an Integrated Care System, this conversation does not refer to this shift in its text nor its questions.

This consultation response is based upon feedback received from local people and other organisations and our existing intelligence. In July 2019 we published the 'What Would You Do?'[1] (WWYD) report which compiled the views of local people on the NHS Long Term Plan. We have used its findings to assist in this response.

The Big Conversation consultation process

Regarding the process we make the following observations:

- We are pleased that the CCG has received a large number of responses to their survey. This demonstrates the very high level of interest that people have in their local health and care services.
- We are disappointed with aspects of the format of the 'Share your views' section. Questions were in 'either /or' format or gave options but included differing concepts, and sometimes covered multiple issues. In seeking to be simple the options come across as loaded and when broken down could be confusing. In Q 1 for example both options might be appropriate depending on the issue (impeding mobility) or severity (urgency). Yes or No options were implied but not used, e.g. Q7.

[1] http://www.healthwatchcambridgeshire.co.uk/news/what-would-you-do

- There were a good number of public meetings held but we are aware that there were very few members of the public at some of these.

- Alternative formats of the consultation documents were not ready until some time later in the process.

Our feedback on the Big Conversation 'Share your views' topics
Regarding the topics covered by the 10 questions we make the following comments:

- The referral of patients to secondary care is over-complicated. We hear from many people about problems they experience with this process, particularly with those specialisms in high demand. There is massive opportunity to use digital solutions to improve these processes and decrease their poor experience of longer waiting times.

- People would welcome more follow up appointments by email and telephone. Quite frankly people are bewildered why this is even a question. It is not good use of anyone's time.

- Our WWYD report clearly tells the story of transport difficulties in most areas of Cambridgeshire and Peterborough. More use of digital solutions can help with this. People also want to see more basic services in their communities and are then prepared to travel further for more specialist help. The shift of resources and expertise from hospital to community is essential in making this happen.

- Digital solutions will not be appropriate for everyone however. There needs to be an understanding that not everyone is able to engage digitally and that there are severe connectivity problems in many areas of Cambridgeshire particularly.

- We receive large numbers of stories regarding fragmented care. The system needs to find new models to overcome barriers caused by commissioning and contracts that can result in service duplication or gaps.

- It appears that are huge amounts of money to be saved through better prescribing systems. People tell us they are being given medications they do not want nor request.

- Care needs to be taken to ensure a balance between cost of branded versus generic medicines and effectiveness for individual patients. We are aware that changes of medication can result in side effects that then need further review or medication.

- We welcome action being taken by the CCG and providers of NHS services to relieve the pressures on A&E and would urge more robustness in triaging and getting people to the right place for their health need.

- People want to look after themselves better. Our WWYD report showed that people want more information about this. Information on self-care, self-management and healthy lifestyles is fragmented and often unknown.

- People want to be more involved in decisions about their care. There needs to be a shift to a culture that places the patient voice at the centre of their own care and recognises that the patient is the expert in how their condition affects them.

The findings from the first two Community Values Panels (commissioned by the CCG and delivered by Healthwatch Cambridgeshire and Peterborough) are reported directly to the CCG prior to publishing in early 2020. The topics we were asked to explore in some depth with the selected panel of 30 local individuals, who together represent the population characteristics of Cambridgeshire and Peterborough, were about prescribing and over the counter medicines, and about accessing urgent and emergency care.

The missing question?
We believe that this is a lost opportunity to seek ideas about meaningful patient and public engagement, particularly in light of the emerging Integrated Care System. We note that this conversation did not ask the public about broader engagement with health and care service changes and how to improve potential for co-production.

Healthwatch Cambridgeshire and Peterborough is keen to help shape the conversation about how complaints and compliments information can be better shared and used in the future, and how NHS and other care organisations can learn from feedback about integrated care and how to involve people in the design of new services.

Summary
Healthwatch Cambridgeshire and Peterborough understand the need for savings to be made but believe that an integrated health and care system would be cheaper and more effective for patients and provide a better experience for all.

The intentions to build on primary care, use technology better and improve opportunities for shared decision-making and self-care are supported by the feedback we get from local people.

Val Moore (Chair) Sandie Smith (CEO)
Healthwatch Cambridgeshire and Peterborough
18th December 2019

The BIG conversation with Primary Care: feedback

Annex 2

March 2020

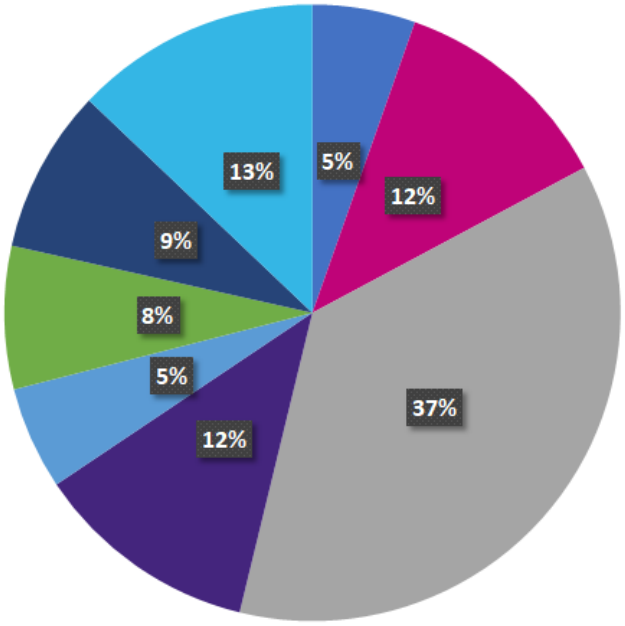
93 survey responses

37 event attendees

13 one-to-ones

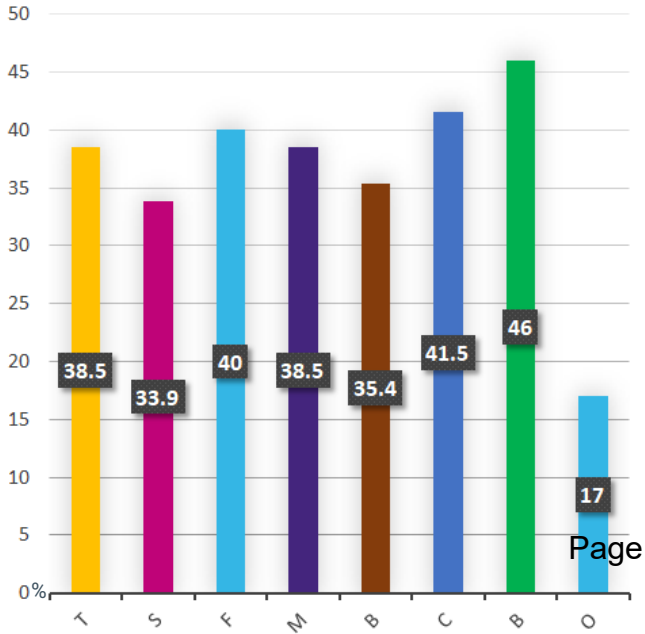
1 Primary Care Steering Group

What is the most important thing we could improve?



- Financial resources
- Being your voice
- Support in retention and recruitment
- More joined up engagement
- Better support around governance issues
- Clearer two-way communications about commissioning decisions
- Time out to think
- Other

What else can we do?



- Financial resources
- Being your voice
- Support in retention and recruitment
- More joined up engagement
- Better support around governance issues
- Clearer two-way communications about commissioning decisions
- Time out to think
- Other

Themes for improvement

Clinical governance
We should offer more protected time so that staff can get together for learning and developing, coverin the costs of locums to facilitate.

Money
Changing budgets in-year is unhelpful, and we need to be clearer about our reasoning if we do make cuts.

Mental health
There is a feeling that patients have to be very ill in order to be seen, and teen mental health support is lacking. Practices want more information on the work of the Mental Health team.

Culture
GPs feel distrusted, and there is a feeling of disconnect between the CCG and Primary Care. There were calls to stop changing policies, reducing red tape, and focusing on positives more than what is not being achieved.

Estates
A number of practices raised issues about section 106 applications, calling for more support in this process. People felt that premises are outdated and unfit.

Hospitals and emergency care
Share more hospital data to give GP practices a real insight into the situation at each acute, and address concerns that secondary care passes on too much work and unclear information.

PCNs
We should focus our energy on the PCNs that are struggling, and we should work with Clinical Directors to understand local needs. Some felt that hte next phase of PCNs is unworkable because of a lack of resources.

Border practices
there were calls for equal services and better support in Royston and other areas outside our boundaries.

What's next?

We have heard your feedback and are working on a plan for the future with the LMC, which we shared in draft form at the last Members' Event. We will share details with you all as soon as this plan is finalised. On specific area or practice issues, our team are working hard to resolve them. If you raised an issue please expect to hear more from us soon. We want to thank everyone who took the time to share their views.

Please continue to contact our Accountable Officer Jan Thomas via capccg.ao@nhs.net with any queries or concerns.

Agenda Item No: 10

URGENT AND EMERGENCY CARE (UEC) COLLABORATIVE UPDATE REPORT

To:	**Cambridgeshire Health Committee**
Meeting Date:	**19th March 2020**
From:	**Jessica Bawden, Director of Primary Care and CCG Chief Officer Lead for Urgent and Emergency Care Collaborative**
Electoral division(s):	**All**
Purpose:	**The committee is asked to note and discuss the plans for the future of Urgent and Emergency Care and the work of the UEC collaborative.**
Recommendation:	**What is the Committee being asked to do?**

a) note the formation of the UEC collaborative to improve NHS urgent and emergency care across Cambridgeshire and Peterborough; and

b) to discuss the proposals contained within this report

1. BACKGROUND

1.1 Following the initial briefing sent to committee members in February the Cambridgeshire Health Committee requested a detailed report on the work of the Urgent and Emergency Care (UEC) Collaborative and their proposals for improving NHS urgent and emergency care across the area.

2. MAIN ISSUES

2.1 The UEC collaborative is a group of 12 local providers working together to develop proposals which will deliver a new more joined up 24/7 urgent care services in 2020/21. Local providers have signed declarations of intent to work together, formed a 'board' which is meeting fortnightly to oversee the work.

2.2 **The Purpose.**

The purpose of the programme is to overcome existing challenges. Current out of hospital urgent care services are fragmented. Duplication and inconsistency produce a confusing pathway for patients. Multiple competing demands put strain on a scarce workforce and can at times lead to longer waits. The pressure on our Emergency Departments (ED) continues to increase which impacts on patients and delivery of targets. The aim is to jointly deliver improvements through providers working collaboratively to make most effective use of out of hospital urgent care resources.

The service will provide a local and simple integrated 24/7 urgent care service which delivers effective patient outcomes, reduces duplication and maximizes the workforce. It will also:

- Decrease the inappropriate use of emergency departments
- Provide timely access to appropriately qualified professionals
- Provide patients with a wider "at home" option
- Improve access to urgent appointments through scheduling previously non-scheduled care
- Improve the availability of information.

The intention is that there should be a lead provider or similar partnership arrangement with clear responsibility for delivery of integrated out of hospital urgent care service.

2.3 **The Scope**

The broad scope of the programme is all out of hospital urgent care services including NHS 111, GP out of hours, minor injuries and illness services, GP streaming in ED, and primary care extended hours. The Collaborative is developing its medium-term service proposals and how providers will work effectively together as a partnership through an agreed process with the CCG. It is important to emphasise the cultural and behavioural changes which are emerging now as the collaborative of providers work more proactively together to tackle local challenges now and in the future.

The broad scope of the programme is all out of hospital urgent care services. The main elements are below:

Service	**Provider**
NHS 111	Herts Urgent Care (HUC)
GP out of hours	HUC
Minor Injuries Units (East Cambs & Fenland)	Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) via Cambridge University Hospitals Foundation Trust (CUHFT)
Peterborough Urgent Treatment Centre	Lincs Community Services
Cambridge Urgent Treatment Centre (Primary Care Streaming Service)	CUHFT
Joint Emergency Team	CPFT
First Response Service	CPFT
Community Resolution Home Treatment	CPFT
Intermediate Care Workers	CPFT
Hospital at Home	CPFT
St Neots Walk In Centre	Malling Health
Ely Local Urgent Care Service	Mereside Medical
Wisbech Local Urgent Care Service	North Brink practice
Extended Primary Care – Peterborough**	Greater Peterborough Network
Extended Primary Care – Cambridge & Ely**	Cambridge GP Network
Extended Primary Care – Hunts**	West Cambs Federation
Urgent ambulance services under discussion with EEAST due to complexities around the contracting arrangements	East of England Ambulance Service Trust (EEAST)

** Primary Care extended access is within the service scope for re-design purposes but note that national rules will apply regarding which organisations can receive the funding and how it can be used.

2.4 **Design Workshops**

We are currently working with a wide range of stakeholders and clinicians to consider how urgent care pathway can be better delivered. We are developing a stronger 24/7 ‘front end’ service would ensure all patients were directed to the right service in a timely way. Patients would be clinically triaged by this ‘front end’ service and be given a scheduled appointment with the most appropriate service. This would result in few, if any, patients walking into ED departments without prior clinical triage. This would remove confusion for the patient on which service to use.

2.5 **Service Model Pilots**

Work is taking place currently to develop and test new urgent care pathways, booking technology and their impact on ED and patient experience.

The first model pilot started on 4 December 20219 with NHS 111 in ED at Hinchingbrooke Hospital, with strong joint working between North West Anglia Foundation Trust, (NWAFT), HUC (NHS 111 provider), the CCG and other partners to set up the new service.

Walk-in patients are now assessed by an NHS 111 Clinical Advisor in ED. Where they are appropriate for primary care, an on-the-day appointment is directly booked in their registered GP practice or GP out of hours service. The patient may, alternatively, be

advised on self-care or directed to the ED depending on their condition. The service is running from 10am to 10pm 7 days a week.

In terms of activity since the start of the pilot service, 750 patients have been successfully triaged by an NHS 111 advisor, with 47% of those being booked into an alternative service, advised to attend a pharmacy or given self-care advice and streamed offsite. This number of patients streamed away from ED equates to 11% of all patients attending the department who were eligible for assessment by the pilot service. Patients do not have to leave (as per patient choice) but will be treated as low priority if they choose to stay. So far, 0 patients have chosen to stay in ED after having been offered an alternative service or self-care advice to better suit their needs.

It is expected that the number of patients going through the reception point alternative pathway will increase as the service beds in, Clinical Advisors gain experience, and ED staff grow more accustomed to the criteria. No patients have refused their alternative dispositions so far. Patients under 5, or with mental health needs, or with a clear urgent need for ED treatment do not go through the alternative NHS 111 reception point. Monitoring is in place and we are working with Healthwatch to capture patient experience of the service.

The intention is also to test a slightly different approach at CUH which will enable ED front door streaming clinicians to use the NHS 111 call centre to rapidly secure directly booked appointments in a patient's registered GP practice or the GP out of hours service.

NWAFT and the CCG have worked together to deliver a streaming service in the main reception of ED at Peterborough City Hospital. This started on 27th January 2020 as part of the winter funding schemes.
The project is using Advanced Nurse/Clinical Practitioners to make a rapid assessment of each patient who presents to the minors' area (main reception) at ED to be seen.
The project is running for 8 hours per day across the 7-day week (1pm to 9pm)
The idea of the pilot is to educate patients on the appropriate use of the Emergency Department and to direct them to alternative NHS services (including pharmacy, UTC, GP and OOH services) if appropriate. There is also the use of self-care advice.

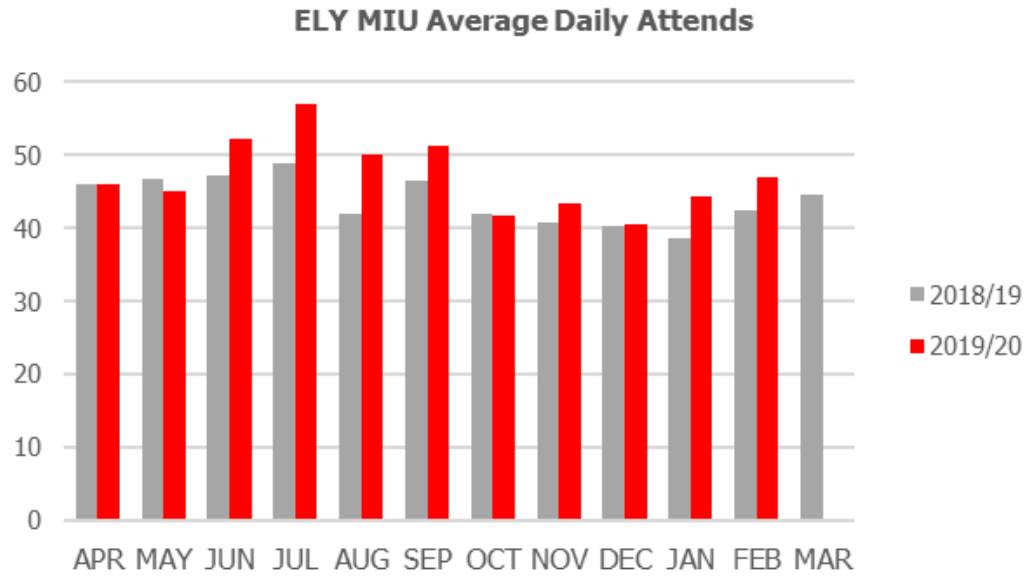
In terms of activity since the start of this pilot service at Peterborough City Hospital, 3,062 patients have been successfully streamed, with 307 of those being booked into an alternative service, advised to attend a pharmacy or given self-care advice and streamed offsite. This number of patients streamed away from ED equates to 10% of all patients attending the department eligible for assessment by the service. Patients do not have to leave (as per patient choice) but will be treated as low priority if they choose to stay. So far, 0 patients have chosen to stay in ED having been offered an alternative service or self-care advice to better suit their needs.

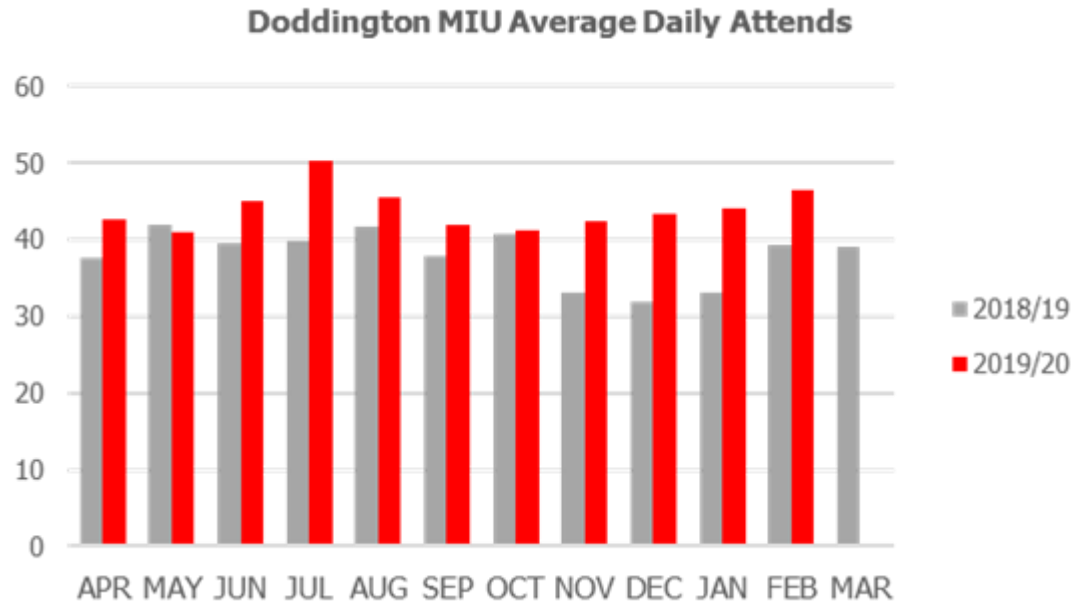
The pilots will test the pathways, booking technology, impact on ED and patient experience.

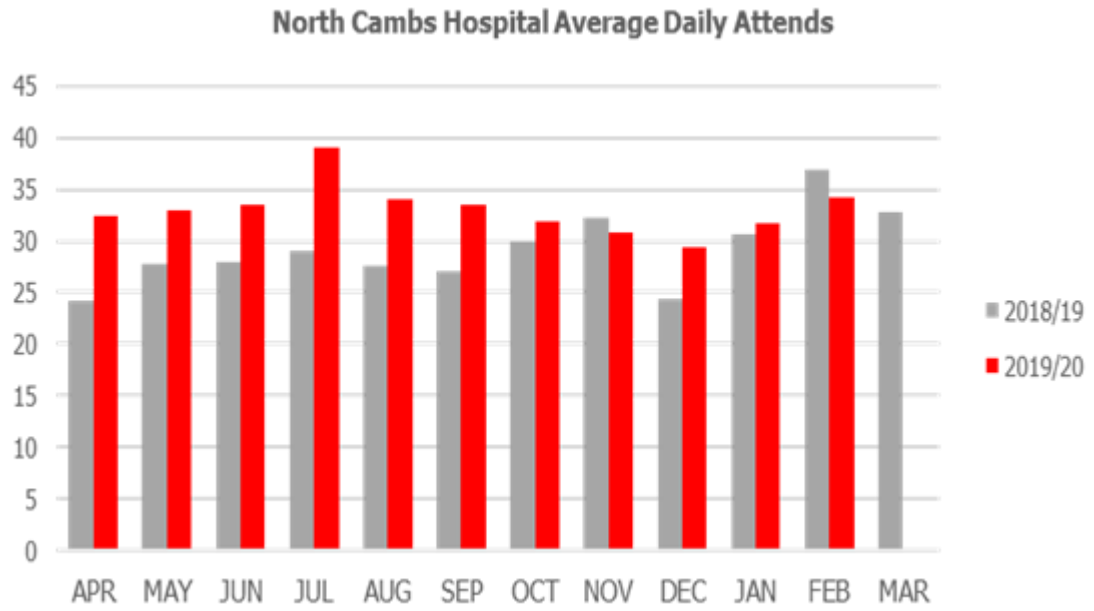
2.6 **Minor Injury Unit (MIU and Urgent Treatment Centre (UTC) activity levels**
Local hubs are seen as part of the solution to our complicated urgent care system. All of our minor injury units and the urgent treatment centre have seen an increase in activity levels compared to 20018/19.

To support and drive attendance we developed a targeted communications campaign with localised activity for each of the MIUs and the UTC. Key elements included targeted activity through Facebook groups to update local residents on the specific services available to them locally, working alongside local housing developments and parish councils to provide information for new and existing residents and localised media activity.

In addition, we developed a range of materials in different languages that provide details of the NHS local services available, when to use them and how they can be accessed. This leaflet is available in 11 different languages and has been made available to GP practices, Healthwatch, Children's Centres and key local employers.







3.0 Case studies

3.1 **Holly,** a child under 2 years old with a high temperature attends Doddington MIU at 2pm on a Saturday. The MIU is not able to see and treat Holly due to the current contract as she is too young. There is a GP on site working for the Out of Hours (OOH) service.
Holly's mum rings NHS 111 when they get home. They tell her that Holly needs to see a GP. The mum awaits a call back. The GP in Doddington rings Holly's mum 7 hours later, there were 120 calls in the call back queue. By the time the GP rings Holly's mum it is too late, she has taken Holly to ED, been seen and has gone home. Holly's mum was not satisfied with NHS 111. Is this a contracting issue or a workforce issue or both?
Each service is under pressure arguably at different times and we need to make this better for staff and patients.

3.2 **Betty** is 89, frail, lives alone, was referred to JET at 16:00 by her GP, she required assessment for her UTI symptoms but was quite well, the service was busy so was allocated a 2-4 hour priority. She was seen at 2 hours, however by the time the assessment was complete her GP surgery was closed. The JET practitioner then had to call NHS 111 for a prescription. A GP called the JET Practitioner back at 22:00 (shift ended at 8pm), GP hadn't heard of JET therefore booked the patient for a home visit from OOHs GP.
The patient ended up being seen at 2am.

3.3 **Gary.** It's a Friday morning Gary was seen by a Paramedic, his family called 999 at 8am because he was confused, not feeling well enough to get on with things and had a high temperature. A Paramedic assessed Gary and diagnosed a chest infection – they ruled out red flag sepsis – but knew he needed "urgent home treatment" to prevent deterioration.
The Paramedic called Gary's GP, who called the Paramedic back 2 hours later. The GP referred Gary to the JET service as the GP "didn't trust the Paramedic assessment" JET visited just within 2 hours (6 hours after the relative placed initial call)
By this time Gary had deteriorated – he now needed an ambulance and admission to hospital – antibiotics and steroids 5 hours earlier may or may not have helped – but Gary's

anxiety and the stress upon his family along with how much resource was used certainly was unacceptable.

4.0 The next steps

The UEC Collaborative is preparing to submit its current proposals to the CCG as part of our assurance process (March 2020). It is also currently engaging with a range of stakeholders to discuss their approach, which will inform further development of service proposals by the end of June 2020. The intention is to begin mobilising integrated services from October 2020, noting that this will be phased. If public consultation is needed for any specific development, this will be discussed with Health Committee and relevant stakeholders in the normal way.

4.1 The clinical model development continues with workshops with clinical staff.
As part of the BIG conversation He4aslthwatch ran a community panel looking at Urgent and Emergency care. The community panel was a group of people representing the demographics of the whole population. The feedback received during this community panel and the BIG conversation is invaluable to us and gives us a good flavour of public opinion on which to begin to look at how to develop services for the future.
For any specific service changes formal consultation processes will be engaged with a wide range of stakeholders and the public.

The CCG will update the Cambs Health Committee at the next meeting on the outcomes of the clinical workshops and any new proposals.

Agenda Item No: 12

CAMBRIDGE CHILDREN'S HOSPITAL: ENGAGEMENT PLAN FOR CAMHS SERVICES

To:	**Health Committee**
Meeting Date:	**19th March 2020**
From:	**Jessamy Kinghorn, Head of Partnerships and Engagement, NHS England and NHS Improvement** **Andrea Grosbois, Head of Communications and Engagement, Cambridgeshire and Peterborough NHS Foundation Trust.**
Purpose:	To consider whether the engagement and involvement plans and processes in respect of services to be transferred from the Ida Darwin site in Fulbourn to the Cambridge Biomedical Campus as part of the proposed Cambridge Children's Hospital, are appropriate, and that a formal public consultation in addition is not required. The services in question are regional and national therefore meaningful formal consultation will be challenging. The services are also very specialised, with most of the population never encountering inpatient CAMHS. We propose a targeted engagement programme, primarily aimed at those affected by the changes.
Recommendation:	To agree with the assessment at section 2.5 that a targeted and meaningful engagement programme is preferable to a formal consultation exercise.

	Officer contact:
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Tel:	

1. BACKGROUND

1.1 In December 2018, the Government announced that it would invest up to £100 million of capital over five years to build a children's hospital in Cambridge for the East of England region.

This allocation was part of a process in which Cambridgeshire and Peterborough as a system attracted over £140 million. The allocation to this health and care system was one of the highest awarded nationally.

1.2 The vision for the hospital, Cambridge Children's, is to integrate mental and physical health care so that children, young people and their families (CYPF) experience complete and seamless care according to their individual needs.

It will be co-located with research and developed and delivered through a joint proposal between the University of Cambridge (UoC), Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and Cambridge University Hospitals NHS Foundation Trust (CUH), together with staff, CYPF and the public.

Cambridge Children's aspires to be more than a hospital, seeking a visionary approach to healthcare for young people, treating the whole child, not just the illness or conditions, using all the talent available across the region and underpinned by world-leading research.

1.3 Since presenting to the committee in March 2019, work has been done to develop the plans further. As part of this CYPF and staff have been engaged to capture their ideas and better understand their needs and how they can be met.

2. MAIN ISSUES

2.1 The project is now at the point of progressing to the design and Outline Business Case.

The project team is looking at building in two phases. This is because the three children's mental health wards – Croft, Phoenix and the Darwin – currently based on the Ida Darwin hospital site, need to move by November 2023 following the sale of the site to Homes England.

CUH are also required to undertake significant remedial building works following a national directive around fire safety. As part of this, some of their paediatric services will require to be 'decanted' to allow this work to take place.

To address both of these challenges, the team is developing a plan to build the Cambridge Children's Hospital in two phases, with an early build on the Cambridge Biomedical Campus completed by the end of 2023.

The advantages of this are:

- The services don't have to move twice – for instance, first to a temporary build before moving to the fully completed children's hospital in 2025. Moving can be traumatic for young people with significant mental health illness who struggle with change.

- The exciting process of integrating mental and physical health care can begin, bringing the services under one roof for the benefit of CYPF.
- Waiting until 2025 and the full build, would incur costs of a transitional build that could compromise the affordability of Cambridge Children's.

2.2 **Engagement to date**

Meaningful collaboration, co-production and engagement with CYPF, voluntary sector, stakeholders and the general public is vital at each phase of the new hospital development.

A consultant architect was brought in to work closely with our CYPF on the mental health wards to understand what's important to them. The workshops were highly creative and generated lots of ideas about how they would want to use the space, what they currently like about their wards and what they would change. The sessions were focussed around key points in the young people's day and how their environment at each of those points can aid recovery and improve their experience, as pictured below. Further sessions are planned to develop these ideas in more detail, which will form the architectural brief.

(Images from architectural workshop on the mental health children's units)

('The art of the possible' – Imagining a new children's hospital. Inspiration for a new hospital as imagined by young people on our mental health wards together with Murphy Philipps Architects)

Other key engagement has included:

- Launch of a dedicated Cambridge Children's website, newsletter and involvement request form to start to build a database of interested parties.

- A wide range of listening events and focus groups for CYPF and local people have taken place, including a ‘family fun’ day in Peterborough supported by third sector organisation, Family Voice, to engage CYPF with additional needs from outside Cambridgeshire.
- Engagement with young people at CUH via their young supporters group called ‘ACTIVE’ which meets several times a year with support from staff to help focus on adding value to areas and services used by children and young people across CUH.
- We had a Cambridge Children’s stand at CUH’s award-winning Fab Change Day for staff and patients from children’s services to come and celebrate the work being done across the services.
- Members of the public were invited to give feedback on Cambridge Children’s plans at the NIHR PPI event, which took place at the Cancer Research Centre.
- In September 2019 we unveiled our plans for Cambridge Children’s at the annual Chariots of Fire race in Cambridge, with around 60 members of CUH staff amongst the 2,000 runners raising money for Addenbrooke’s Charitable Trust.
- Engagement with the young carers group run by the Involvement Lead at Cambridgeshire Community Services to capture feedback from CYPF in the community.
- Several engagement sessions were held with patients on our mental health wards and their families/carers to capture their views. This engagement included focus groups, questionnaires and interviews.
- A Children and Family Service Engagement Collaborative Group has been set up by CPFT to bring together professionals and involvement experts from across health, social care and the third sector to co-ordinate engagement, providing additional channels and opportunities for involvement on Cambridge Children’s.
- Number of media articles in the local and national press to help raise public awareness of the Children’s Hospital, including a special in-depth feature on BBC Look East with interviews from all three partners.
- Interviews with previous patients from CPFT and CUH to understand their journey, what worked well for them in the current hospital environment and what would have made a difference to their care and experience.
- Working closely with the Head of Patient and Parent Involvement for young people and families at CPFT to ensure that feedback they receive through their pre-existing channels of engagement such as ‘have your say groups,’ are shared and heard within the project.

(Images taken from the Family Fun Day in Peterborough)

(Chariots of Fire race participants supporting Cambridge Children's)

2.3 **Feedback from CYPF**

Feedback from CYPF from mental health services was that they had concerns about being part of a bigger hospital, stigma and privacy but could see the benefits of integrating with physical health and the University of Cambridge. This feedback has fed into the initial design conversations and we are working with CYPF and staff to ensure their ideas and suggestions are included in the design brief.

For example, the concept for the hospital is to have a 'single front door' for everyone regardless of whether they are staff, researchers, families, physical or mental health patients, to try to break some of the stigma and silos. Young people were supportive of the idea of integration and helping to reduce stigma, however, were concerned about privacy if they were distressed or agitated. So, an additional entrance to the side of the building has been included in the design brief for young people who require additional privacy.

There were other concerns raised around parking for staff and visitors, which is being looked at as part of the wider Cambridge Biomedical Campus. It was however, acknowledged that public transport links there are better than in Fulbourn.

Other key priorities identified so far by CYPF for what they would want, include:

- Safety
- Homely, non-clinical feel
- Privacy and dignity
- Peaceful, low sensory
- Green space
- Facilities for families

There has been ongoing engagement with staff and union representatives to hear their suggestions and ideas for the hospital whilst capturing any concerns to ensure they are addressed. Weekly meetings relating to the development of Cambridge Children's include staff from all three organisations – CPFT, CUH and the UoC.

To date, two half-day workshops have focussed specifically on the model of integrated care, bringing together CPFT and CUH staff to start to develop this concept and what it might look like in practice. Further events are planned. As with the building design, co-creating the clinical model with CYPF is seen as central to the project and ongoing input from CYPF will be accessed via the mechanisms outlined below under 2.4 e.g. the CYPF Network.

Some examples of broader engagement include:

- Briefings with partners across the whole Cambridge Biomedical campus from industry and academia.
- Two half-day meetings brokered by Cambridgeshire County Council with representation from various stakeholders including Cambridgeshire Community Services, Public Health England, Peterborough County Council, Cambridgeshire & Peterborough STP, Cambridgeshire & Peterborough CCG, PCN leads, etc.
- CUH have led on a number of meetings with regional stakeholders, socialising the concept of integrated physical and mental health care. CPFT are currently engaged in work with consortium partners across the region in relation to the establishment of a Provider Collaborative. For CAMHS services this is being led by Hertfordshire Partnership University NHS Foundation Trust.
- The CPFT and CUH co-chairs of the Cambridge Children's Joint Delivery Board have started a process of introductory meetings with local Councillors.
- The CPFT and CUH Council of Governors receive regular updates on the progress of the project and have been involved from the start in discussions. Further updates for CPFT Governors are scheduled for April, July, September, December 2020.
- The NHS England Head of Partnerships and Engagement met with the East of England Scrutiny Officers' Network in March 2019 to engage regional scrutiny colleagues. A further visit is planned for April 2020.
- Visits from Boris Johnson, Matt Hancock and Keir Starmer, who were briefed on Cambridge Children's. Further visits with MPs are planned

In addition to the above, the programme has started a process of identifying and learning from national and international best practice. The team has established close links with the Anna Freud Centre in London, which successfully completed a new build at Kings Cross in 2019 and have contact with centres of excellence such as Great Ormond Street, Toronto Sick Kids and Melbourne Children's Hospital. We have also established a collaboration with Copenhagen's Rigshospitalet which is being supported by the Lego Foundation to develop a new children's hospital.

2.4 **Next steps**

The existing engagement strategy is being updated in collaboration with CYPF and staff, which will set out how we meaningfully collaborate and engage on the two phases of the hospital build.

The engagement approach proposed for this project will go beyond engagement, ensuring CYPF and the public are continually involved in co-producing plans for the hospital.

There will be three key areas of focus for ensuring meaningful co-production and engagement:

1) **Establishment of a Children, Young People and Families Network**

We want to provide CYPF with a range of different ways they can formally collaborate with us. This will ensure that we hear the voices and views of those who may not be able to attend events in person. We will create a matrix of opportunities including, attending design workshops with the architect, supporting the various project workstreams, taking part in surveys, reviewing content for the website etc. We have already developed an involvement form on our Cambridge Children's website and are asking people to register their interest at events, to start to develop a database of interested parties, which will provide the foundations for our network.

The young people suggested providing an incentive for their involvement, so once they have taken part in a specific number of separate engagement activities, we will provide them with a certificate they can include on their CVs and a reward, for example an Amazon gift voucher. We will target existing and past patients from CPFT and CUH to join the network, as well as patients from other Trust's across the eastern region who may wish to be involved.

We are also looking to employ a peer support worker (an ex-service user with lived experience employed to support others with their recovery) to lead on some of the engagement with young people including developing the network. CPFT already employs a number of these 'experts by experience' to support young people's engagement in service design and development.

2) **Programme of engagement activity**

A children's collaborative forum has been set up locally together with involvement leads from the third sector, health and social care organisations, education sector and Healthwatch. This provides us with an opportunity to co-ordinate involvement across the county and engage with a wider audience via the involvement leads on the children's hospital. We will also link with existing regional forums, such as the East of England's Children and Young People's Mental Health Participation Forum, to ensure we get feedback from a broad range of perspectives.

We will run additional bespoke workshops as well as attending existing events, such as the Science Festival, to engage CYPF, key stakeholders and the public at various key milestones in the project. Various surveys will be used to capture wider views across the region for those unable to attend events.

3) **Governance**

For the engagement to be meaningful it's important that co-production is further embedded throughout the governance of the project. We want to formalise that by ensuring a named champion is on each workstream and it is a standing item on agendas. To increase the project group's understanding of how co-production works we will host a co-production workshop to provide practical guidance and ensure it's at the forefront of decision making.

These three areas of focus for engagement will be in addition to existing planned engagement activities and will complement the engagement programme with staff to co-develop the designs and clinical model.

2.5 **Commissioning view of approach to patient and public engagement**

NHS England is the lead commissioner for Cambridge Children's and has a duty under Section 13Q of the NHS Act 2006 (as amended) to 'make arrangements' to involve the public in commissioning. The Midlands and East regional Specialised Commissioning Team requires any potential service change to be made subject to an assessment against this standard to ensure that appropriate engagement takes place.

At the previous discussion with the Health Scrutiny Committee in March 2019, members were satisfied with the conclusion that a continuous cycle of engagement, rather than a formal public consultation, was a proportionate and appropriate approach to take for the development of the new Children's Hospital.

As the programme is now proposing a phased approach to the development, with the CAMHS services moving in Phase 1, the Head of Partnerships and Engagement for NHS England and NHS Improvement has reviewed the assessment.

The services in question are not 'walk-in' or 'elective' services. They are not chosen by the CYPF. CYP are referred to CAMHS services by health professionals and assessed by a consultant prior to being accepted for admission to determine if they are appropriate for the Cambridge and Peterborough services. The services are regional and national and therefore CYP can be admitted from anywhere in the country.

Whilst every effort is made to keep young people as close to home as possible, in the first eight months of 2019/20, 43% of children and young people are from outside the Cambridgeshire and Peterborough area.

In the first eight months of 2019/20, there has been an average of just under 30 patients in the affected services at any one time. The average length of stay for these patients is months, not weeks, and as such the total number of unique patients in the services in any one year is relatively low.

- Darwin ward, an acute inpatient ward, including crisis beds, has an average length of stay of 4.5 months, with some patients staying considerably longer.
- Phoenix ward, an eating disorder ward, with an average length of stay of approximately 4-6 months.
- The Croft, a specialist acute service for under 13s, with an average length of stay of 12 weeks.

It is noted that the CAMH services will have to move off the current site by 2023, and that there can be no consultation on whether to move, as there is no other option. It had previously been determined that formal consultation was not required, on the basis that the comprehensive and targeted engagement plan proposed met the duty to involve patients and the public in the planning and commissioning of services.

Given all these factors, it is felt that a formal public consultation on the earlier phasing of the move would not add value to the continuous cycle of engagement already underway,

described earlier in this report. The targeted engagement programme, primarily aimed at those affected by the changes, is considered to be a proportionate response that will achieve a more meaningful outcome.

However, it was noted that this should be tested with the Health Scrutiny Committee.

It was also recommended that a further assessment be carried out with regard to the involvement of patients and the public in the development of the new integrated healthcare models, when public consultation may be more meaningful.

The project team has committed to continue regularly consulting the Health Committee throughout the project.

As part of the Outline Business Case submission we will be asked about our engagement. We are seeking approval from the Health Scrutiny Committee with this assessment. In particular that the outlined engagement proposals above are preferable to a formal consultation exercise which would limit involvement and also be limited in the extent to which it secures inclusion from CYPF who will be using these services, given how small they are in comparison to the size of the region’s population.

Agenda Item No: 13

HEALTH COMMITTEE WORKING GROUP Q3 UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	**19th March 2020**
From	**Head of Public Health Business Programmes**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To inform the Committee of the activities and progress of the Committee's working groups since the last update.**
Recommendation:	**The Health Committee is asked to:**

1) **Note the content of the quarterly liaison groups and consider recommendations that may need to be included on the forward agenda plan; and**

2) **Note the forthcoming schedule of meetings**

Officer Contact:		***Chair Contact:***	
Name:	Kate Parker	Name:	Councillor Peter Hudson
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1.0 BACKGROUND

1.1 The purpose of this report is to inform the Committee of the health scrutiny activities that have been undertaken or planned since the committee last discussed this at the meeting held on 17th October 2019.

1.2 This report updates the Committee on the liaison meetings with health commissioners and providers. Due to purdah liaison meetings were cancelled during the end of quarter 2. The report covers Quarter 3 (2019-20) liaison meetings with:

- Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) & Cambridgeshire & Peterborough Healthwatch **(Pending at time of report)**
- Cambridgeshire & Peterborough Foundation Trust (CPFT)
- Cambridgeshire University Hospital NHS Trust (CUH)
- North West Anglia Foundation Trust (NWAFT

1.3 Liaison group meetings are precursors to formal scrutiny and/ or working groups. The purpose of a liaison group is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its scrutiny function. It also provides the organisation with forward notice of areas that Health Committee members may want further information on or areas that may become part of a formal scrutiny.

2. MAIN ISSUES

2.1 Liaison Meeting with HealthWatch Cambridgeshire & Peterborough and the Clinical Commissioning Group (CCG)

A meeting was held on 20th February with Jan Thomas (COO) and Sarah Learney (Programme Director) from the CCG, Val Moore (Chair) and Sandie Smith (CEO) from Healthwatch Cambridgeshire & Peterborough

The liaison group members in attendance were Councillors Harford, Jones & van de Ven.

2.1.1 A range of topics were raised by members and included the following:

- New GP contract
- Protocols to support people living at home
- Cross boarder provision for commissioned services i.e. patients registered with a GP from Cambridgeshire & Peterborough CCG footprint but live in another area.
- Out of Hours Services at Doddington Hospital (also see below for Urgent Care)

2.1.2 The CCG and HealthWatch raised the following topics:

- Feedback from the CCG's Big Conversation engagement exercise
- CCGs Urgent and Emergency Care Collaborative developments
- Healthwatch concerns following their report on NHS Dental provision in Cambridgeshire & Peterborough

2.1.3 Recommendations

- Feedback from the CCG's Big Conversation is to be brought to the March Health Committee meeting.
- Urgent and Emergency Care Collaborative to be discussed at the March Health Committee meeting including an update on the Minor Injury Units and Out of Hours services at Doddington Hospital.
- Health Committee to consider requesting an update from NHS England/ Improvement on progress and recommendations in Healthwatch's report.

2.1.4 The next liaison meeting is scheduled Wednesday 27th May 2020

2.2 **Liaison meeting with Cambridgeshire & Peterborough Foundation Trust (CPFT)**

A meeting was held on 31st January with Tracy Dowling (CEO) and John Martin (Interim Director of Operations)

The liaison group members in attendance were Councillors Harford and van de Ven and District Councillor Harvey. Apologies were received from Cllr Hudson.

2.2.1 A range of topics were raised by members and included the following:

- Special education needs provision project development was discussed and members flagged the potential for CPFT involvement
- Cross boarder issues were raised where patients may be Cambridgeshire residents but their GP is within Bedfordshire CCG. Tracy Dowling explained that CPFT have associate contracts in place with residents of Beds, Herts & Norfolk prior approval is required for other counties.
- Perinatal Mental Health provision was discussed.

2.2.2 CPFT raised the following areas:

- Overview of the new care models for eating disorders. NHS England are devolving responsibility of commissioning to service providers. CPFT have formed part of the East of England collaborative.
- Update on the Eating Disorders Services and the developing ambition to create a center of excellence. Outcomes from the coroner inquests were discussed.

- Community Health Exemplar Project – CPFT are in receipt of £1.8 million funding from NHS England for an innovation project that will focus on extending the PRISM service in Peterborough.
- CQC Report – inspections are now annual and CPFT received an overall rating of good.
- Children's Hospital Update was discussed along with the phased implementation

2.2.3 Recommendations

- Following a briefing requested by Cllr Hudson on perinatal mental health provision, CPFT suggested the next meeting could include a visit to the perinatal services.
- Health committee to consider receiving an update report on the developments around the CPFT services moving to the Children's Hospital

2.2.4 The next liaison meeting has been scheduled for Wednesday 15th April 2020.

2.3 **Liaison meeting with North West Anglia Foundation Trust (NWAFT)**

A meeting was held on 4th February 2020 with Caroline Walker (CEO) and Dr. Kanchan Rege (Medical Director).

The liaison group members in attendance were Cllr Connor, Harford and Sanderson and District Councilor Tavener. Apologies were received from Cllr Hudson.

2.3.1 A range of topics were raised by members and included the following:

- Update on NWAFT's improvement plan from CQC inspection on 20th December 2019. The Trust maintains an overall rating of requires improvement. For a multi-site trust it can be difficult to recover quickly as Hinchingbrooke Hospital site was only inspected on the children's services and CQC may not return to inspect this hospital until July 2020/21
- Hinchingbrooke Hospital Site Development – As previously reported on the Trust are in receipt of £25 million transitional funding. Spending on Phase 1 – focusing on the Emergency Department expansion will start in April 2020 with the intention to expand the capacity for Winter 2020/21.
- Congestion and transport issues around Hinchingbrooke Hospital site as a result of the A14 development site were discussed. Councilors agreed to discuss this further with NWAFT's Estates Director.
- Patient Admission Service – problems with delays in appointments have been reported due to the introduction of the electronic patient record. Training and procedural changes were underway to rectify the problems generated from this transition.

- Staffing Issues and Brexit – The trust has encouraged all staff to get their certificate of settlement and supporting those that are applying.

2.3.2 NWAFT raised the following issues:

- Winter Pressures – NWAFT have experienced pressure since early December 2019. They have had good infection control procedures for isolating flu and norovirus and haven not had to shut any wards.
- Clinical Strategy – Three years on from the merger of clinical teams across the hospital sites. The trust had a peer review and had positive feedback on common policies, nurse led clinics and protocols.
- Going Digital – Patient Admission service reported on above. Following NHS target to reduce outpatients face to face by a third by offering telephone conversations and piloting video conferencing.
- Alternative Clinic Appointments – Patients are being offered alternative clinic sites but the trust has found that patients are opting for their local hospital and consequently waiting longer for appointments.

2.3.3 Recommendations

- Councilors to follow up on the congestion issues associated with the A14 viaduct / re-route with Huntingdonshire District Council.

2.3.4 The next liaison meeting has been scheduled for Thursday 7th May 2020.

2.4 **Liaison meeting with Cambridgeshire University Hospital Foundation Trust (CUH)**

A meeting was held on the 13th January with Roland Sinker (CEO) and Ian Walker (Director of Corporate Affairs).

The liaison group members in attendance were Councilor Jones. Apologies were received from Councilors Harford, Hudson and van de Ven

2.4.1 A range of topics were raised by members and included the following:

- Update on Cyclists Signage – This is being addressed by the Campus wide group and cycle lanes are marked out. Plenty of locked spaces for staff. Website needs to have more information on parking for cyclists.
- Staffing issues – general staff vacancy rate is low and retention rate has increased. Specific issues on radiology were discussed and the trust recognized that June-November was a challenging time due to growth in demand for senior doctors to review images. Issues have been resolved.
- EU Recruitment Plans – the trust is relying less on overseas recruitment. Largest workforce nursing with low vacancy rates. There is some planned recruitment in the Philippians with Royal Papworth Trust for March 2020.
- Protocols for Sick Patients at Home

2.4.2 CUH raised the following issues.

- Government Infrastructure Programme

  As part of the national Hospital Infrastructure Plan (HIP) Addenbrookes Hospital was included in the second phase plan and the trust has been invited to accelerate their plans regarding the redevelopment with a rebuild around 2025. Further bid is required to central government by end of March 2020.

- Children's Hospital Development

  Stakeholder work underway with CPFT. Five year development programme but the accelerated planning for the HIP is welcomed. Plans to move children's cancer ward into the new build

2.4.3 Recommendations

- Health Committee to request an update on the Children's Hospital Development from relevant representatives from CPFT, CUH and NHS E

2.4.4 The next liaison is scheduled Tuesday 28th April 2020.

2.5 Schedule of Liaison Meetings for the Health Committee

Organisation	**Liaison meeting Date**
Clinical Commissioning Group	27th May 2020
Cambridge & Peterborough Foundation Trust	15th April 2020
North West Anglia Foundation Trust	7th May 2020
Cambridge University Hospital	28th April 2020
Royal Papworth Hospital	To be arranged

3.0 SIGNIFICANT IMPLICATIONS

3.1 **Resource Implications**

Working group activities will involve staff resources in both the Council and in the NHS organisations that are subject to scrutiny.

3.2 **Statutory, Risk and Legal Implications**

These are outlined in a paper on the Health Committee powers and duties, which was considered by the Committee on 29th May 2014

3.3 **Equality and Diversity Implications**

There are likely to be equality and diversity issues to be considered within the remit of the working groups.

3.4 **Engagement and Consultation Implications**

There are likely to be engagement and consultation issues to be considered within the remit of the working groups.

3.5 **Localism and Local Member Involvement**

There may be relevant issues arising from the activities of the working groups.

3.6 **Public Health Implications**

Working groups will report back on any public health implications identified.

Agenda Item No: 14

NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2019-20 REQUESTS

To:	**HEALTH COMMITTEE**
Meeting Date:	**19th March 2020**
From	**The Monitoring Officer**
Electoral division(s):	**All**
Forward Plan ref:	**N/A**
Purpose:	**For the Committee, as part of its Health Scrutiny function, to agree the process to respond to statements on the Quality Accounts provided by NHS Provider Trusts.**
Recommendation:	**The Health Committee is asked to note the requirement for NHS Provider Trusts to request comment from Health Scrutiny committees and**

a) To consider if the committee wishes to respond to Quality Accounts and if so prioritise which Quality Accounts the Committee will respond to;

b) To note the improvements in the process introduced for responding to Quality Accounts in 2019 and feedback from the Trusts;

c) To delegate approval of the responses to the Quality Accounts to the Head of Public Health Business Programmes acting in consultation with the views of members of the Committee appointed to the Task and Finish Group; and

d) To appoint members of the committee to the Task and Finish Group.

	Officer contact:	***Member contact:***
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1. BACKGROUND

1.1 NHS Healthcare providers are required under the Health Act 2009 to produce an annual Quality Account report. A Quality Account is a report about the quality of services by an NHS healthcare provider.

1.2 Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.

1.3 This paper outlines the proposed response to the Quality Accounts received by the Health Committee and the internal deadlines to respond to the NHS Trusts. This paper also reflects on the success of the processes introduced for responding to the Quality Accounts in 2018 and replicated in 2019.

2. MAIN ISSUES

2.1 It is a requirement for NHS Healthcare providers to send to the Health Committee in its Overview and Scrutiny function a copy of their Quality Account for information and comment. Statements received from Healthwatch and Health Overview and Scrutiny Committees must be included in the published version.

2.2 NHS Healthcare providers are required to submit their final Quality Account to the Secretary of State by 30th June each year. For foundation trusts the Quality Accounts are required to be submitted to NHS Improvement by 31st May for audit purposes. However each provider will have internal deadlines for receipt of any comments from relevant statutory consultees.

2.3 As discussed at the Health Committee meeting in previous years, the timing of the Quality Account deadlines puts the Committee in a difficult position to provide an adequate response. Often NHS Trusts are unable to send copies of their draft Quality Accounts until mid to end of April, resulting in a short timescale for the committee members to formally agree a response. There is no statutory requirement for the Health Committee to respond to the Quality Accounts.

2.4 A new process was introduced in 2018 whereby the Health Committee appointed members of the committee to a task and finish group. This group reviewed the content of the Quality Accounts that they were in receipt of and feedback was provided to the Trust. The Head of Public Health Business Programmes was responsible for submitting final statements to each Trust. It is a legal requirement for the Trusts to publish these statements as part of their complete quality account.

3. PROCESS FOR RESPONDING TO NHS QUALITY ACCOUNTS

3.1 Under the committee system of governance, it is not possible to delegate decisions to individual elected members or groups of members, but scrutiny regulations require that scrutiny be carried out by elected members and not delegated to officers.

3.2 Due to time constraints identified in section 2.2, responses before 2018 were limited to details of where the Trust has attended the Health Committee for the purposes of health scrutiny. Any recommendations made by the committee were submitted within the statement. Feedback received from the Trusts noted that they had expected more of a reflection and comment on the content of the Quality Account rather than an overview of scrutiny actions.

3.3. As a result of this feedback, in 2018 a new process was introduced whereby the committee appointed a task and finish group to review the Quality Accounts provided by trusts and provide a more detail critical analysis. Feedback from the Trusts was positive and table 1 (Section 5) indicates which Trusts responded to the feedback.

4.0 PROPOSED PROCESS FOR RESPONDING TO NHS QUALITY ACCOUNTS IN 2020

4.1 As in previous years the scheduling of the committee meeting does not allow for members to discuss the responses at the Committee meeting on 28th May 2020 as most Trusts will require a response before then. Section 4 outlines the expected deadlines from Trusts may require responses to be submitted prior to the committee meeting. In the past Trusts have refused to publish “draft” statements that have not been endorsed by the committee.

4.2 It is suggested that due to previous years success in regards to identifying an effective process to respond to Quality Accounts, the committee follows the procedures agreed last year and delegates approval of the responses to the Quality Accounts to the Head of Public Health Business Programmes, acting in consultation with, and in accordance with the views of the Committee.

Last year the committee established a task and finish working group that responded to the Quality Accounts to ensure the views of the committee were represented. However this did fall to one councillor taking on the bulk of the work. Therefore a working group with wider membership is suggested to take this on for 2020.

4.3 The committee is asked to nominate members to the task and finish working group.

The committee is asked to prioritise which Quality Accounts should be responded to.

5.0 EXPECTED DEADLINES FOR RECEIPT OF QUALITY ACCOUNTS

5.1 In order to prioritise and prepare for responding to NHS Quality Accounts, Table 1 provides details of the timescales worked on in 2019 to respond to Quality Accounts which vary for each trust and can be very tight.

Table 1: Quality Account Timeline for 2019

Organisation	Quality Account Received	Deadline to Respond	Response Made	Further feedback received
Cambridge University Foundation Trust	2nd April 2019	15th April 2019	17th April 2019	18th April 2019
North West Anglia Foundation Trust	18th April 2019	3rd May 2019	3rd April 2019	Stakeholder feedback session Scheduled for 8th May – unable to attend
Cambridgeshire & Peterborough Foundation Trust	29th April 2019	17th May 2019	17th May 2019	17th May 2019
Cambridgeshire Community Services	1st May 2019	31st May	31st May 2019	11th June 2019
Royal Papworth Trust	16th April 2019	16th May	15th May 2019	
East of England Ambulance Service Trust	14th May	13th June	Deadline for submission missed	

6.0 SIGNIFICANT IMPLICATIONS

6.1 Resource Implications

Officer time in preparing a paper for the Committee.

6.2 Statutory, Risk and Legal Implications

These are outlined in a paper on the Health Committee powers and duties, which was considered by the Committee on 29th May 2014.

6.3 Equality and Diversity Implications

There may be equality and diversity issues to be considered in relation to the quality accounts.

6.4 Engagement and Consultation Implications

There may be engagement and consultation issues to be considered in relation to the quality accounts.

6.5 Localism and Local Member Involvement

There may be relevant local issues in relation to the quality accounts.

6.6 Public Health Implications

The quality of services at local healthcare providers will impact on public health

Source Documents	Location
NHS Choices information on Quality Accounts	http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx
Reports to and minutes of Health Committee	https://cmis.cambridgeshire.gov.uk/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/6/Default.aspx

HEALTH COMMITTEE TRAINING PLAN 2019/20

Updated March 2020

Agenda Item No: 15

Proposals

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
	Public Health Performance reporting	To provide committee members with an increased understanding of the key performance indicators used in the F&PR To review current reporting and an opportunity to discuss what information members receive in future Performance reports. Business Planning updates were added to the training session	2	Sept 16th 2019	Public Health	Development session	Health Committee Members	4	40% **Completed**
	Business Planning 2020	To provide a development session on the Public Health Business Planning processes 2020	2	16th September	Public Health	Development Session		4	40% **Completed**

	STP – Long Term Plan Submission	To provide committee members with an overview of the STP's response to the Long Term Plan	2	24th October @ 9am	Public Health	Development Session	Health Committee Members (including district members)	5	50% **Completed**
	Best Start in Life Programme (BSiL)	To provide committee members with an overview of the BSiL programme	1	Provisional 23rd January (after Health Committee meeting)	Public Health	Development Session	Health Committee Members (including districts) + Children & Young People's Committee members	14 Health Committee	93% **Completed**
	Mental Health Interventions	To provide committee members with an overview of public mental health focusing on local interventions and services.	3	To be Rescheduled	Public Health	Development Session			
	School Nursing Service Overview	To provide a development session that specifically focusing on the provisions within the school nursing service and associated trend data around access. To agree specific objectives for the	2	6th Feb (using reserve date for Health Committee)	Public Health	Development Session	Health Committee Members	4	40% **Completed**

		session and outline to service providers							
	Public Health Evaluation	To discuss the wider learning from the CUSPE Evaluation of the Healthy Fenland Fund.	3	TBC	Public Health	Development Session			

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN

Published on 2nd March 2020

Cambridgeshire County Council

Agenda Item No: 16

Notes

Committee dates shown in bold are confirmed.
Committee dates shown in brackets and italics are reserve dates.

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public.

Draft reports are due with the Democratic Services Officer by 10.00 a.m. eight clear working days before the meeting.
The agenda dispatch date is six clear working days before the meeting

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
[16/04/20] Provisional Meeting					
28/05/20	Finance Monitoring Report	Stephen Howarth	Not applicable	18/05/20	20/05/20
	Breast Feeding	Liz Robin/Val Thomas	Not applicable		
	STP GP Strategy (Scrutiny Item)	STP	Not applicable		
	Active Travel	Liz Robin	Not applicable		
	Papworth Hospital (Scrutiny Item)		Not applicable		
	STP Workforce Strategy (Scrutiny Item)	STP	Not applicable.		
	Health Committee Training Plan	Daniel Snowdon	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
	Co-option of District Members	Daniel Snowdon	Not applicable		
	Notification of Chairman/woman and Vice-Chairman/woman	Daniel Snowdon	Not applicable		
[25/06/20] *Provisional Meeting*					
09/07/20	Finance Monitoring Report	Stephen Howarth	Not applicable	29/06/20	01/07/20
	Health Committee Training Plan	Kate Parker	Not applicable		
	Health Committee Risk Register	Liz Robin	Not applicable.		
	Performance Report	Liz Robin	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
[06/08/20] *Provisional Meeting*					
17/09/20	Finance Monitoring Report	Stephen Howarth	Not applicable	07/09/20	09/09/20
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
15/10/20	Finance Monitoring Report	Stephen Howarth	Not applicable	05/10/20	07/10/20
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
19/11/20	Finance Monitoring Report	Stephen Howarth	Not applicable	09/11/20	11/11/20

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
03/12/20	Performance Report	Liz Robin	Not applicable	23/11/20	25/11/20
	Health Committee Risk Register	Liz Robin	Not applicable		
	Finance Monitoring Report	Stephen Howarth	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
21/01/21	Finance Monitoring Report	Stephen Howarth	Not applicable	11/01/21	13/01/21
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
[11/02/21] *Provisional Meeting*					
11/03/21	Performance Report	Liz Robin	Not applicable	01/03/21	3/03/21
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies	Daniel Snowdon	Not applicable		
[08/04/21] *Provisional Meeting*					
10/06/21	Notification of Chairman/woman and Notification of Vice-Chairman/woman	Daniel Snowdon	Not applicable	31/05/21	02/06/21
	Co-option of District Members	Daniel Snowdon	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Finance Monitoring Report	Stephen Howarth	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and Appointments to Outside Bodies.	Daniel Snowdon	Not applicable.		