HEALTH COMMITTEE: MINUTES

Date: Thursday 17 May 2018

Time: 1.35pm to 4.55pm

Present: Councillors C Boden, D Connor, L Harford, P Hudson (Chairman), A Bradnam (substituting for Cllr D Jenkins), L Jones, P Topping and S van de Ven.

Apologies: County Councillors D Jenkins and S Taylor
District Councillor Cornwell

106. NOTIFICATION OF CHAIRMAN AND VICE-CHAIRMAN

The Committee noted the appointment of Councillors Hudson and Boden as the Chairman and Vice Chairman of the Health Committee for the municipal year 2018/19.

107. DECLARATIONS OF INTEREST

There were no declarations of interest.

108. MINUTES AND ACTION LOG: 15th MARCH 2018

The minutes of the meeting held on 15th March 2018 were agreed as a correct record and signed by the Chairman, subject to correction of the spelling of Councillor van de Ven's name in the record of attendance.

The Action Log was noted. The following oral updates were provided:

- Minute 17 – a report on the performance of Cambridgeshire Community Services NHS Trust (CCS) had been circulated to committee members, and there had been an opportunity for Lead Members, the Chairman and Vice-Chairman to meet with the Chief Executive of CCS; this meeting had taken place earlier in 2018

- Minute 32 – an update on outreach health checks in Fenland had been included in the Finance and Performance Report (item 6 on the current agenda)

- Minute 48 – a date of 2 July had been identified for the deep dive session on the initiatives taking place in the Fenland area.

  Several members reported that this date would be impossible for them, and officers were asked to identify a fresh date or dates in September 2018. **ACTION**

- Minute 72 – in relation to the relocation of the Cambridge GP Out of Hours base from Chesterton to Addenbrooke's Hospital, a briefing note on the development of the re-tendering process for the pharmacy and the results of the travel survey would be circulated to committee members in June and if necessary could be discussed at the July Health Committee **ACTION**

- Minute 85 – officers had been unable to identify any obvious problem with the tables within the Risk Register, and would endeavour to provide a clearer explanation of the Risk Register next time it was presented to Committee

- Minute 99 – the Deputy Monitoring Officer had advised that the treatment of underspends was more of an audit issue than a legal one, so officers had asked Internal Audit to consider the matter. The Section 151 Officer and the Director of Public Health were confident that the treatment had been correct.

109. CO-OPTION OF DISTRICT MEMBERS

In the absence both of District Council members and of nominations from the District Councils, it was resolved to defer the co-option of District Members to the next meeting.

110. PETITIONS

There were no petitions.

111. FINANCE & PERFORMANCE REPORT - OUTTURN 2017-18

The Committee considered the 2017-18 Outturn Finance and Performance report for Public Health. Members noted that the financial position at outturn was little changed from that forecast in the March report to Committee. In relation to the issue recorded in the Action Log, because Public Health had received £386k from corporate funds on top of the ring-fenced grant from Public Health England (PHE), the underspend of £336k would be transferred to the County Council's general reserve, as the total underspend was less than the amount of core funding allocated to Public Health.

Discussing the report, members

- commented that the Cambridgeshire and Peterborough Public Health directorate seemed to be lean and effective by comparison with some of the others around the country, and stressed the importance of ensuring that staff were not being overworked in the quest for efficiency. The Director of Public Health acknowledged members' concern and said that some feedback on pressures was starting to be received from staff; the national Public Health grant was being reduced so it was necessary to take action in response to this, but there was a risk of reducing expenditure so much that staff would be overloaded. It was important to care for employees' health and wellbeing and to be mindful of workforce pressures

- queried the low level of spending on falls prevention. Officers advised that a joint programme had been developed as part of the Sustainability and Transformation Programme (STP), funded by Public Health, the STP, and the Better Care Fund (BCF). Because arranging it had proved complex, the programme had started in October and staff had been appointed to it gradually. The programme's manager was on secondment from another post within the Public Health directorate, but because it had not been possible to appoint fixed term cover for the staff member's original post, their salary costs had not been transferred to the falls prevention programme

- noted that improvement in the notification process between Midwifery and the Healthy Child Programme, and in meeting targets for health visiting mandated checks, required negotiation with CCS and the health visiting service. The Director of Public Health undertook to bring information on this back to members. **ACTION**

- sought clarification of the underspend in percentage terms. Officers advised that it was 1.5% of total expenditure, but the 'net total' figure of 87% referred only to the underspend of the funding allocated to Public Health by the County Council

- expressed disappointment that some of the underspend was not being used to boost general prevention activities, but noted that there was a clear programme of reductions in public health grant funding which would make it difficult to maintain new investments recurrently, and that elements of the underspend, such as not recruiting to two maternity leave cover posts, would not necessarily be repeated in another year.

It was resolved unanimously to:

> Review and comment on the report and to note the finance and performance position as at the end of 2017/18.

112. ANNUAL HEALTH PROTECTION REPORT 2017

The Committee considered the Annual Health Protection Report, providing information on and assurance of the delivery of health protection functions in Cambridgeshire. The report author was thanked for her hard work in compiling the report.

Discussing the report, members

- commented that the percentage of those not being immunised was important, and asked whether there was any explanation for Cambridgeshire showing improved performance over the past eight quarters in five of the six graphs on immunisation rates, while the rate for England seemed to be declining.

  It was pointed out that Cambridgeshire had established a local task and finish group around immunisation, but there was no obvious factor to account for the difference in performance. The Consultant in Public Health undertook to ask NHS England (NHSE) whether it was able to explain the difference. **ACTION**

- drawing attention to the small number of cases involved and the length of time required to process the data, asked whether it would be possible to spot an rise in TB cases in time to prevent an increase developing into an epidemic, and also asked whether there were significant numbers of UK-born citizens being diagnosed as suffering from TB. The Consultant in Public Health undertook to check with NHSE whether more recent data was available. **ACTION**

- noted that the failure to call some women for their final breast screening had been nation-wide rather than local; a national team was co-ordinating the response to this, and the Director of Public Health would be supplied with local information

- expressed concern at the low number of people coming forward for bowel cancer screening, and asked whether the recent publicity campaign had had any effect on numbers. They advised that the Cambridgeshire performance was in line with that of other authorities nationally; numbers presenting for screening for diseases tended to be sensitive to nationally-publicised occurrences such as celebrity illness

- asked whether data on cervical screening uptake could be provided at a more local level. The Consultant in Public Health undertook to check whether cervical screening data could be broken down by small area in Cambridgeshire. **ACTION**

- expressed appreciation of the report as a whole, as being full of interesting information

- asked why the uptake of the front line healthcare worker flu vaccine varied so widely between trusts, and whether there was any correlation between levels of vaccination and of staff sickness. It was suggested that it could be easier for hospital-based staff to get vaccinated than for those working in the community. Councillor Jones said she would look out for and perhaps comment on the issue when examining the remaining Quality Accounts. The Consultant in Public Health undertook to find out more about healthcare worker vaccination uptake. **ACTION**

- drew attention to the lack of statistics in the section on Environmental Health, and requested more information in future reports on such matters as food inspection and links with trading standards. The Consultant in Public Health said that the District Council environmental health officers reported regularly to the Health Protection Steering Group, and undertook to note the need for more information in the next year's report. **ACTION**

It was resolved unanimously to:

Note the information in the Annual Health Protection Report 2017.

113. CAMBRIDGESHIRE YOUNG PEOPLE'S DRUG & ALCOHOL SERVICES PROCUREMENT

The Committee received a report describing the rationale and benefits of procuring Cambridgeshire Young People's Drug and Alcohol Treatment Service through a competitive tender. Members were advised, however, that the original recommendation – seeking approval to take forward a competitive tender process – had been modified in the light of discussions at the Cambridgeshire and Peterborough Joint Commissioning Board (JCB). The recommendation to Committee was now to instigate a review and benchmarking, with a report back to members in August before any decision on proceeding to tender was taken.

Part of the proposed tender process had been to look at synergies with commissioning for 0-19 services, and the JCB had recommended that it would be better to explore Section 75 options before proceeding to tender, as Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), who delivered the current services, had been performing well. It was however important to benchmark CPFT against drug and alcohol services in other geographical areas.

Discussing the report and revised recommendation, members

- expressed support for a more integrated approach and the revised recommendation, and suggested that it should be possible to be clearer about outcomes and have sharper Key Performance Indicators (KPIs) through this revised approach

- noted that, from a local survey, the number of young people abusing alcohol was declining, but the severity of abuse by those fewer people was increasing. In relation to drug abuse, cannabis was favoured by young people, but use of Xanax and of other, new drugs was causing concern, with internet sales facilitating and exacerbating their use

- expressed disappointment that tobacco had not been mentioned in the report, as it was also a drug. Officers replied that tobacco was treated differently because its use was legal, and did not involve the dysfunctionality sometimes associated with

the use of illegal drugs. There was an emerging evidence base on intervention with young people using tobacco, but this was a complex area

- commented that there was quite a strong link between use of tobacco and of cannabis; work on tobacco cessation was likely to have an impact on cannabis use

- noted, in response to one member's example of a group of teenagers taken to hospital as a result of drug use, that local teams were assiduous in picking up incidents in their area. CPFT clinicians went into schools, particularly when there had been an issue

- expressed concern at a perceived reduction in community policing and knowledge of drug dealing in local communities despite obvious drug activity in villages.

The Chairman pointed out that the Committee was not due to meet in August, the month when the revised recommendation envisaged a report back to Committee, so it was agreed that the report would be submitted in September. Members noted that permission might perhaps be sought to extend the existing contract, if no meaningful conclusions could be drawn in September from the work to review and benchmark.

It was resolved unanimously to approve the following actions:

- A review of the commissioning opportunities afforded by the 0-19 commissioning agenda.

- Benchmark the current service against other services in terms of outcomes and cost.

- Review the evidence for alternative models for service delivery to identify opportunities for improving outcomes and increasing cost-effectiveness.

- To report the findings of this work to the Health Committee in September to inform any decision regarding the commissioning of this service.

114. CONTROLLED DRINKERS SERVICE PROCUREMENT

The Committee received a report informing it about the procurement of a six-bed Controlled Drinkers Accommodation Service. This was a small service costing £80k a year, which provided a home for homeless long-term drinkers with the aim of getting people to a point where they could live independently.

The original recommendation to Committee had been to proceed to competitive tender, but as with the preceding report, the matter had been considered by the JCB, who recommended that more intensive research was needed, based on the work of the Supported Housing Review. The implications of the review for the Controlled Drinkers Accommodation Service should be taken into account before making any decision about its future.

In response to points raised in discussion, members noted that

- more information was held about outcomes for homeless drinkers who had been part of this programme, but no figures were published because the numbers involved were so small that individuals could be identified

- there was no limit to the length of stay in the accommodation, but in practice people remained for one to two years; the aim was within a year to get them to the point where they could live independently, having received treatment, linked in to other support and recovery networks, found out about entitlement to benefits and how to access them, and learned how to obtain help after leaving the accommodation

- it would be possible to build monitoring in to any new specification, to measure the long-term outcome of staying in the accommodation and whether there was any subsequent relapse into long-term drinking.

It was resolved unanimously to approve the following actions:

- To review the findings of the Supported Housing Review and identify any potential commissioning opportunities that could enhance outcomes and improve cost-effectiveness.

- To report the findings of this work to the Health Committee to inform any decision regarding the future commissioning of this Service.

115. PUBLIC HEALTH ENGLAND SEXUAL HEALTH SERVICES COMMISSIONING PILOT

The Committee received a report seeking its support for an invitation from Public Health England to Cambridgeshire County Council and Peterborough City Council to work with other local commissioners of sexual health and reproductive health services to develop a local collaborative commissioning model for these services.

Members noted that locally, recommissioning of integrated sexual health and contraceptive services had been about to start; the invitation to take part in one of two national pilots would provide an opportunity to look at efficiencies in commissioning. Discussions had been held with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHSE, and a report was being taken to the CCG's Clinical Executive Committee in June. Subject to confirmation from all the organisations involved, the pilot was expected to be completed by December 2018.

Discussing the report, members welcomed PHE's support for integrated commissioning of sexual health services, but asked what system-wide improvements could be expected in future, and how the services would be monitored, particularly once the pilot had been completed. The question of how much room there was to make further efficiency savings was raised, members noting that there was still considerable scope for improvements, such as in the maternity services pathways for commissioning of contraception following a birth in hospital.

It was resolved unanimously:

a) To discuss the Public Health England invitation to take part in the Sexual Health and Reproductive Services Commissioning Feasibility Study

b) To support Public Health Commissioners working with colleagues from the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England (NHSE) to develop a more efficient and cost-effective system wide approach to the commissioning of sexual health and reproductive services.

116. CHILDREN'S HEALTH JOINT COMMISSIONING UNIT INTEGRATION UPDATE

The Committee received a report updating it on progress made by the Children's Health Joint Commissioning Unit (CHJCU) in developing an Integrated Children Young People and Families (CYPF) service, and presenting the plan to include the Public Health grant funded Healthy Child Programme (HCP 0-19) within the CYPF service. Members were reminded that the proposed savings to the HCP 0-19 had been deferred in order to allow time to fully develop the integration work being taken through the CHJCU. The work was being led by the Executive Director: People and Communities in close collaboration with CCS and CPFT, and its focus was on bringing services together around the child and the family to give one point of contact and ensure consistency and continuity of services, particularly in the areas on the border between Cambridgeshire and Peterborough.

Discussing the paper, members

- suggested that it would be helpful to see KPIs for the CYPF service

- reported on a recent visit to the Peacock Centre in Cambridge. Despite efforts to make this feel like a children's centre, it still seemed to be very much an NHS facility, where a lot of specialist staff and services were gathered; the Centre was trying to develop measures to see what the health and wellbeing impact of its work was, but it was necessary to measure not only whether the treatment had worked, but also whether it had succeeded in giving the family the feeling that they were receiving support. Such measures were needed for similar facilities across the area

- expressed disquiet at the phrasing of paragraph 2.1; the reference to 'cultural dependency on public services' did not fit well with the overarching vision of the service, 'that all children and families in Cambridgeshire and Peterborough have the right to be kept safe and healthy etc'; families were entitled to these services.

- asked what the experience of working in the service was like for individual members of staff, and whether any staff survey on this had been conducted. Members were advised that CCS was in communication with staff; recruitment and retention were a challenge in Cambridgeshire, and staff might find themselves having to carry out a wide range of roles within an organisation, a situation which might be eased when several organisations worked together

- welcomed greater integration, but pointed out that the problem of health inequality across Cambridgeshire needed to be addressed, including the issue of consistency of availability of treatment and interventions across Cambridgeshire as a whole

- commented that there was in general a lack of information on the evolution of health-related services in children's centres, and on how the delivery of services was to be tackled in rural areas

- pointed out that this expenditure of Public Health funding represented good value for money for children's health, a point which should be reported by to the Children and Young People Committee.

The Director of Public Health undertook to take back the points raised above by members, including the need for indicators as well as looking at outcomes, the removal of the reference to cultural dependency on public services, the need to address the

issues of health inequalities more explicitly, though they had been implicitly considered throughout the development of the CYPF service, and the need for more information on health services in children's centres. **ACTION**

The Committee considered the question of a further update and whether the Executive Director: People and Communities should be invited on that occasion. Members were advised that the officer leading the work, Janet Dullaghan, Head of Commissioning Child Health and Wellbeing, had been invited to attend the present meeting but had been unable to do so; the Executive Director could be invited for the next update.

It was resolved unanimously

a) To note the work done to date and what the Children's Health Joint Commissioning Unit was trying to achieve.

b) To note the plans for inclusion of the Healthy Child Programme (HCP 0-19) in an integrated Children and Young People's Service.

117. CAMBRIDGESHIRE & PETERBOROUGH'S GENERAL PRACTICE FORWARD VIEW STRATEGY 2017-2020 - DELIVERY PLAN & ASSOCIATED CHALLENGES

The Committee received a report updating it on the current general practice landscape, future development, and associated challenges, following the presentation made to members of the Committee at a workshop in February 2018. Attending from the CCG to present the report and respond to members' questions and comments were Rob Murphy, Associate Director of Planned Care, and Dr Gary Howsam, Clinical Chair and Chief Clinical Officer. Introducing the report, they advised members that

- the forward view strategy had been developed with input from multiple stakeholders, and was a local response to the pressure being felt by GP services nationally
- although Cambridgeshire and Peterborough, as elsewhere in the UK, had a growing and ageing population, the demography varied across the area, so the strategy needed to be tailored to the different areas within the STP footprint
- the national direction for general practice was to serve a population of a minimum of 30,000 to 50,000 people per practice
- the age profile of GPs varied across the footprint, and work was being done on how to retain GPs already working in the area, and how to incentivise trainee GPs to stay within the local system once their training was complete
- NHSE had brought forward the date by which the CCG was required to commission for 100% population coverage from October 2018 to September 2018
- the intention was to achieve 100% compliance with NHSE access requirements, which were to provide access to primary care from 8am to 8pm
- some progress had been made to date, 18 months in to a five-year programme.

Discussing the report, members

- reported that one GP group in Peterborough served over 200,000 individuals, and seemed to be working well. It was explained that there was not an extensive evidence base behind the 30-50,000 practice size, but such a size meant that the

group of staff was small enough to form a community rather than being part of a commercial entity; the large Peterborough confederation had smaller hubs, and had been developed partly for reasons of business resilience rather than clinical delivery

- observed that primary care delivered such good value for money that, with such a restricted budget, resources should be shifted from hospital care to primary care. The Clinical Chair said that primary care undertook 90% of health contacts with less than 9% of the budget, and there was indeed a move to encourage more investment into primary care; there were new ways of contracting to ensure that the shift of care was accompanies by a shift of resource

- enquired what progress was being seen in the five-year period, which was not very long for the size of task involved. The Clinical Chair said that the business model for general practice would take more than five years to complete; it had initially been concerned with stabilising the crisis of practices shutting nationally for lack of funding or of staff. There was now work being done round new ways of meeting health needs, because it was not always necessary to see a GP to achieve improvements in health.

  The traditional model of GP practice was that partners carried unlimited personal liability, but young GPs now carried substantial debts after training, plus a burden of housing costs. Bringing practices together had the effect of spreading the financial risk for GPs. Cambridgeshire and Peterborough currently had 102 practices, having had 106 practices 18 months previously. It was expected that the number of GP businesses would shrink to 60 over the next few years, but this did not mean that there would be fewer outlets where GP services could be accessed; administrative staff would be shared across outlets rather than being employed by each small practice separately

- in relation to staff retention, noted that it was possible for people to work 'whole time equivalent' hours of 37 a week in two-and-a-half days rather than five. Efforts were being made to recruit internationally; Cambridgeshire already had a significant number of GPs who had been trained outside the UK. There were also issues of pension changes, and mental health problems and burn-out amongst health professionals, as general practice was a complex and pressured area in which to work. In short, more GPs were needed

- commented that it was harder to deliver large practices in rural areas where the population was more widely dispersed, and important to maintain access to GP services. In some areas, GPs rented premises at a peppercorn rent from parish councils, but that meant that the GPs could not take a profit when they left the practice. Members were advised that the only saleable asset when a GP left a practice was the bricks and mortar; unlike for example dental practices, there was no goodwill associated with the list of registered patients. On the other hand, GPs coming into practices in buildings own by the NHS or third parties did not have to bring a large sum of money into the partnership

- raised the question of some GP practices being unwilling to expand to meet demand. The Associate Director of Planned Care said that part of the role of the Primary Care Commissioning Committee was to ensure adequate GP coverage; options for doing this included local practices coming together, or going out to tender to cover gaps in the service.

It was resolved unanimously to:

Note the current general practice landscape, future development, and associated challenges

118. CAMBRIDGESHIRE & PETERBOROUGH CLINICAL COMMISSIONING GROUP 2017-18 FINANCIAL POSITION & PLANNING FOR 2018-19

At the Chairman's invitation, Jane Howell asked a question seeking further information in plain English about Guaranteed Income Contracts (GICs), including the risks and advantages of such arrangements. The Chairman thanked Ms Howell for her question, and undertook to supply an answer in writing within ten working days (text of question and Chairman's written answer attached to these minutes as Appendix A).

The Committee considered a report on the CCG's financial position in 2017/18 and its financial plan for 2018/19. The report set out the main reasons driving the deterioration in CCG finances, which had reported a deficit of £42.1m in 2017/18 against the £15.5m control deficit agreed with NHSE before the start of the year. Attending from the CCG to present the report and respond to members' questions and comments were Jan Thomas, Acting Interim Accountable Officer, and Dr Gary Howsam, Clinical Chair and Chief Clinical Officer. Introducing the report, they advised members that

- a greater demand for acute care than had been planned for, an increase in prescribing cost, and a rise in the number of NHS Continuing Healthcare patients had all contributed to the deficit

- the savings planned under QIPP (Quality, Innovation, Productivity and Prevention) had not been delivered as intended

- the final version of the Financial Plan was based on having GICs with three NHS provider trusts; these had been negotiated on the basis of the likely activity for the year less the realistic level of QIPP. On the old contract system, the CCG paid on a unit basis, the hospital had to increase its activity to increase its income, and the CCG had to fund less activity in order to stay in budget.

  Through GICs, the CCG wanted to take a more commercial and practical approach and find ways of doing things more effectively. The three trusts had agreed to ways of working differently, but there would be no drop in standards or expectations. A lot of time and effort had gone into setting up the old-style contracts, only to find that something would not be done if it was not covered in the contract; the new way of working aimed to take different approach, with clinicians and patients at its heart. The Clinical Chair said that, in his experience of the introduction of GICs in Suffolk, they had been well-received by clinicians and had received good feedback from patients

- PricewaterhouseCoopers (PWC) was carrying out a capacity and capability review, and the CCG was working with its auditors; a full report of their findings would be presented to the CCG Governing Body

- it was necessary to devise a realistic and achievable plan for 2018/19; the NHSE regulators had been both supportive and challenging in this endeavour.

Examining the report, members

- sought clarification of the arithmetic in the report, saying that there appeared to be a gap of £21m in the calculations, and enquired whether NHSE had agreed that the deficit could be carried forward from 2017/18 to 2018/19.

  The Acting Accountable Officer said that the CCG had an obligation to deliver a balance budget, but had been clear that this would not be possible in the current year, though written confirmation that the regulators would accept the £35m deficit had not yet been received. The use of GICs and different ways of working would lock some of the savings in, the focus on the QIPP target had increased, and time and effort had been invested into ensuring that the financial plan was achievable. There had been some movement of non-recurrent funding to recurrent funding, when what had started as non-recurrent had proved to be recurrent funding. The Acting Accountable Officer undertook to provide an explanation of the perceived £21m gap in the calculations. **ACTION**

- pointed out that there had been several accountable officers recently and asked where responsibility would lie if there were to be a repetition of the previous year's poor financial performance. The Interim Acting Accountable Officer said that it was necessary to provide stability; there was a structured improvement plan in place, and the process of recruiting a substantive accountable officer was under way

- with reference to a recent weekend closure of the Minor Injuries Unit (MIU) at Ely recently, sought assurance that the MIUs were not at risk. Members were advised that there had been some long-term sickness amongst MIU staff, which when combined with short-term sickness had meant it would not have been safe to keep the Ely unit open that weekend; the CPFT Chief Executive was looking at how to improve staff planning, and would be talking to the Committee's liaison group in due course

- in response to a question about proportion of the CCG spend which would take place through guaranteed income contracts, noted that the CCG had two-year contracts with providers for 2017-19 so the GICs were effectively an agreed contract variation. The reality was that the local system as a whole had to look at efficiencies throughout the system; the CCG was committed to locality delivery models, and greater delegation of delivery could mean that the CCG needed to maintain only a thin strategic layer, ideally integrated for provision of health and social care.

It was resolved unanimously to:

a) Note the update on the Clinical Commissioning Group's financial performance and the challenging yet achievable plan for 2018/19

b) Request the Clinical Commissioning Group to supply written clarification of the apparent discrepancy of £21m in figures quoted in the 2018/19 Financial Plan

c) Request the Clinical Commissioning Group to attend Committee in six months' time to provide an update, particularly on the budget and improvement plan.

119. NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2017-18 REQUESTS

The Committee received a report and oral update on Quality Accounts received from and responses submitted to NHS Provider Trusts. Members were advised that after the report had been written, Quality Accounts had been received from CPFT on 14 May, with a revised response date of 22 May, and from the East of England Ambulance Service NHS Trust (EEAST) with a response date of 13 June. As they were not foundation trusts, EEAST and CCS were not obliged to submit their Quality Accounts to NHS Improvement by the end of May, so were able to set a later comment deadline.

Members noted that North West Anglia NHS Foundation Trust (NWAFT) had clearly taken notice of the comments on their Quality Account. A meeting for stakeholders had been held at which the Trust had gone through the responses from the Committee and from Healthwatch and explained what it would be doing to address the points raised.

The Chairman and members thanked Councillor Jones for her hard work and valuable comments on the draft Quality Accounts. The point was made that, although they were obliged to include comments from Overview and Scrutiny Committees in their Quality Accounts, many trusts had not allowed sufficient time for the Committee to comment; NHS England should be made aware of this and a better system be found for securing Overview and Scrutiny comments in future years. Members noted that an update report would be brought to the next meeting.

It was resolved unanimously to

a) Note the statements and responses sent to the NHS Provider Trusts

b) Note any Quality Accounts that were outstanding.

120. HEALTH COMMITTEE TRAINING PROGRAMME

The Committee considered its training plan, asking that a date for the Health in Fenland deep dive be found in September rather than July, and noting that a further workshop regarding Public Health prioritisation would now take place in June. The Head of Public Health Business Programmes undertook to re-notify members of the date. **ACTION**

The question of best practice in IT was raised. Members were advised that intercommunication between health bodies formed part of an STP Workstream; there was a proposed project on much better data linkage. As this topic was of great interest to the Health and Wellbeing Board (HWB), it was suggested that any development session on it might be thrown open to HWB members.

It was resolved unanimously to:

agree the Training Plan, subject to changing the date for the Health in Fenland event from May 2018 to September 2018.

121. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES

On behalf of the Committee, the Chairman thanked Ruth Yule, Democratic Services Officer, for her work supporting the Health Committee, both at the present meeting and for many years until recently; he wished her well for her retirement.

The Committee examined its agenda plan, taking into account various additions identified at the meeting, and also considered the appointments to partnership and liaison groups which the General Purposes Committee had asked it to make.

It was resolved unanimously to:

(i) note the Forward Agenda Plan, subject to the following changes made in the course of the meeting:

c) 12 July 2018
- add Health Committee Working Group Update and Membership
- add an update on NHS Quality Accounts received and responded to
- combine the entries for Health Care Public Advice Service and Healthcare Public Health Memorandum of Understanding into one item

d) 8 November 2018
- add an update from the Clinical Commissioning Group on its financial position and improvement plan

(ii) agree the following appointments to partnership liaison and advisory groups as detailed in Appendix 3 of the report before Committee:

a) Cambridge University Hospitals NHS Foundation Trust Council of Governors – Councillor M Howell
b) Cambridgeshire and Peterborough NHS Foundation Trust Council of Governors – Councillor G Wilson
c) North West Anglia NHS Foundation Trust Council of Governors – Councillor J Gowing

(iii) not to appoint to the Cambridge Local Health Partnership, as it had been replaced by a Living Well Partnership, to which no member appointment was required

(iv) defer appointment to the Huntingdon Local Health Partnership pending confirmation that it had been replaced by a Living Well Partnership **ACTION**

(v) defer appointment to the Papworth Hospital NHS Foundation Trust Council of Governors until the District Council members of the Committee had been co-opted.

(vi) defer appointment to the Committee's four liaison groups until the next meeting, when the Committee would receive a report on the work and membership of these groups.

Chairman

Appendix A

Questions for the Health Committee 17 May 2018

Ref: Agenda item No.13 Cambridgeshire and Peterborough CCG 2017/18 Financial Position and Planning for 2018/19

Regarding 2018/19 Financial Plans, Guaranteed Income Contracts are being introduced as a new management tool. From the limited information provided in the document it is impossible to assess the purpose of these contracts and what they are intended to achieve without a specific briefing on the subject.

Point 2.13 states: A core advantage of Guaranteed Income Contracts is the change in system behaviours they facilitate as well as removing a key element of risk from the CCG's position. This allows both the CCG and providers to work collaboratively to reduce as far as possible the levels of activity seen within the Trust's, ensuring that patients are treated in the most appropriate settings and removing the potentially adversarial elements of contract enforcement present under payment by results.

Q.1 In plain English what does this mean? For example what impact will the contract have on the providers, the CCG and the patients?

Q.2 What are the advantages to utilising this contract and what risks have been taken into account? What is the main risk?

Q.3 The name of the agreement is "Guaranteed Income Contracts". What is it that's guaranteed? From the point of view of the CCG, and the point of view of the providers?

Q.4 Have these Guaranteed Income Contracts got a good track record and been successfully used in this way by other CCG's? and would they work being used in the procurement of other healthcare services?

Jane Howell

Response from Councillor Hudson

Dear Ms Howell

Thank for bringing an interesting question to the Health Committee on May 17th in relation to Guaranteed Income contracts in the local NHS.

The Health Committee scrutinises the NHS, but does not itself have a high level of technical expertise in NHS Finance or the details of NHS contractual mechanisms.

I hope that the verbal explanations of Guaranteed Income Contracts provided by Cambridgeshire and Peterborough Clinical Commissioning Group representatives at the Health Committee meeting which you attended, were helpful to you. Specifically in relation to your 4th question, we have noted in the draft minutes that Guaranteed Income Contracts had been used in Suffolk and thought to be successful there.

However, given that the technical expertise to provide the full answer to your questions sits with the C&PCCG rather than with the Health Committee, I would recommend that you raise your questions directly with C&PCCG at their Governing Body meeting in public. Their next meeting is on the afternoon of July 3rd.

Yours with very best wishes

Cllr Peter Hudson

Chair: Cambridgeshire County Council Health Committee