HEALTH COMMITTEE: MINUTES

Date: Thursday 12th May 2016

Time: 2.00pm to 5.15pm

Present: Councillors P Clapp, L Harford, P Hudson, D Jenkins (Chairman), M Loynes, T Orgee (Vice-Chairman), R Mandley (substituting for Cllr Dent), P Sales, M Smith, P Topping and S van de Ven

District Councillors S Ellington (South Cambridgeshire) and C Sennitt (East Cambridgeshire)

Apologies: County Councillors A Dent, J Hipkin and Z Moghadas
District Councillor D Brown (Huntingdonshire), M Cornwell (Fenland) and R Johnson (Cambridge City)

210. NOTIFICATION OF CHAIRMAN AND VICE-CHAIRMAN

It was resolved to note that the Council had appointed Councillor David Jenkins as the Chairman and Councillor Tony Orgee as the Vice-Chairman for the municipal year 2016-17.

211. DECLARATIONS OF INTEREST

There were no declarations of interest.

212. MINUTES – 10 MARCH 2016 AND ACTION LOG:

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

The Action Log was noted. The Director of Public Health undertook to follow up the request for a summary timetable of planned activity to address the low uptake of screening (minute 202 refers). **Action required**

The Chairman reminded Members that there had been a previous action to take a motion to Full Council to ask that a motion about public health funding be submitted to the Local Government Association (LGA) conference. This had been done, and the motion had been submitted to the LGA; the outcome of the motion was not yet known.

213. CO-OPTION OF DISTRICT COUNCIL REPRESENTATIVES

It was resolved to co-opt as non-voting members of the Committee:

- from South Cambridgeshire District Council: Councillor Sue Ellington, substitute Councillor Andrew Fraser.

214. PETITIONS

There were no petitions.

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

The Committee received a report providing background information relating to the termination of the Older People and Adult Community Services contract with the UnitingCare Partnership, and including the two external reviews into events surrounding the contract collapse which had at that point been published.

In attendance to respond to members' questions and comments were

- Tracy Dowling, Chief Operating Officer, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
- Aidan Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Roland Sinker, Chief Executive Officer, Cambridge University Hospitals NHS Foundation Trust and Kate Lancaster, Director of Corporate Affairs (CUHFT)

Val Moore, Chair of Healthwatch Cambridgeshire, was also present to provide an account of the previous day's Community Learning Event.

The Chairman invited each of the guests to speak in turn, saying by way of introduction that the issue had already received a great deal of scrutiny, and it was time to start thinking about the future rather than the past. He also affirmed that the idea behind the contract had been a good idea, and deciding to do it had not been a source of regret.

The CCG's Chief Operating Officer (COO) highlighted aspects of the two reviews, as set out in the CCG's report to the Committee. She drew attention to the significant degree of agreement between the two reviews; both had identified financial reasons as a major cause of the collapse. The CCG was unreservedly adopting the review recommendations, and remained committed to the model of an integrated and outcomes-based approach to care. It continued to work constructively with CPFT and other partner organisations to implement the model of care as far as was affordable, and would be rolling out further aspects of the model as funding became available.

The Chief Executive of CPFT said that CPFT was in broad agreement with the NHS England (NHSE) report on what had happened, but had a couple of issues with the review commissioned by the CCG. CPFT had commissioned the Judge Business School to conduct a review; its findings were expected at the end of June. The Chief Executive went on to say that

- it had been very disappointing that the contract had come to an end; a great deal of work had gone into the commissioning and contracting process, and had been starting to bear fruit
- he was very proud of the staff involved, who had been through uncertainty and transfer of employing organisation as the contract had been established, and had continued to provide the service when the contract ended; no individual patient had lost services, which was a tribute to the efforts of staff in CPFT and the contracted organisations
- he welcomed both NHSE's plan to bring together a review of reviews, and the involvement of the Audit Office in looking at the issue
- CPFT had been working well with the CCG since the end of the contract and shared their commitment to the model of care; the situation could have been much more difficult, and their continued co-operation was a tribute to both sides

- the contract had collapsed because of funding, and CPFT was grateful to the CCG for the funding it had put in subsequently, but because of the financial situation it had not been possible to do some of the things planned by UnitingCare
- there was an absolute commitment to the model of care, and the common view amongst all partners was that it had been the right thing to do; in many ways they were all working more closely together now than they had before the collapse.

CUHFT's Chief Executive Officer (CEO) said that CUHFT continued to provide care going forward. He agreed with the previous speakers; they were looking forward together a how best to look after older people with long-term conditions. The UnitingCare model of care had been very innovative; it had been regarded both nationally and by patients as a ground-breaking model. He had welcomed the opportunity to contribute to both reviews, which had been well-aligned in their findings. It had not yet been possible to bring all services together, and it was necessary for all involved to think about what upfront funding could be supplied to enable a successful transition to the new version of united care. He was grateful to the CCG's COO, CPFT's Chief Executive, and the Council's Executive Director: Children, Families and Adults Services for the shared work they and he were leading to develop this.

The Chair of Healthwatch Cambridgeshire reported on the learning event, which had been attended by senior representatives from commissioners, providers, social services and voluntary and community sector (VCS) organisations, as well as by patients. Healthwatch would be producing a timeline of all the publicly-available documentation. The collapse had been painful, and uncertainty about future financial resources continued. It was necessary to address the inequalities of service across the county and to bring the various services together. Because of staff efforts to maintain services, there had been no harm to patients.

The Healthwatch Chair went on to say that at a strategic level, joining up services was easier in the absence of another tier of management, for example in an improved approach to the Better Care Fund, enabling Social Services and NHS to combine their work. There had been concern at the learning event about the ongoing involvement of the VCS, and a commitment to support the efforts and capacity of the sector. There had also been concern at the consequences of stopping the development of One View; a shared information system was key to integrating care. Those present had appreciated the opportunity to share learning locally, and were keen for integrated care to continue. It was also important that lessons be learned nationally from this local experience.

Introducing discussion of the speakers' remarks, the Chairman said that the description of how well the staff had coped with the change was, to him, typical of the NHS – they coped with change and got on with the job. He asked that the Committee's appreciation of their efforts be fed back to the staff. He also welcomed the co-operation and lack of acrimony amongst all parties as they had worked together over the months since the contract had collapsed, though it was necessary to spend time rebuilding confidence among the voluntary sector.

In the course of discussion, members

- queried the mention in one of the reviews of difficulty in identifying costs for community services. CPFT's Chief Executive explained that this did not relate to accounting systems in community services, but to the information that the CCG had available to it during the tendering process on the direct cost of community services.

When the contract had been let, there had been a mismatch between the contract value and what the organisation was spending on the services.

In one example of many, ten staff had been transferred when the CCG and CPFT had been expecting five; such information as was available had got older as negotiations went on. There had been a total of about seventy matters relating to the actual cost of the contract which had required resolution

- in answer to a question about the availability of procurement and contract advice to help ensure that difficulties were avoided, the COO said that, based on earlier experience elsewhere, there was a considerable pool of such advisers. The procurement process had been comparable to a large construction project, and it was not necessary to be an expert in NHS matters to provide such advice.

The Chairman introduced eight draft statements about the contract collapse for consideration. In the course of arriving at the conclusions set out below, most of the draft statements were agreed with little or no comment, while three were the subject of more discussion.

- Members considered whether NHS England should have taken a much more active role in assessing the robustness of the proposals. While some queried whether NHSE had the authority to do so, or would have considered it an appropriate use of resources, or preferred to leave the adult professionals involved to take their own decisions, others took the view that a person seeing a child heading for danger would intervene even if it were not their own child, and that NHSE might have wished to be involved in a contract of this ground-breaking nature.

  The NHS representatives did not disagree that an opportunity for more scrutiny had been missed; one recalled, speaking from memory, that the Regional Director at the Committee's previous meeting had expressed the hope that NHSE would learn from the experience of this contract.

- In response to the draft statement that the CCG should have conducted due diligence, the COO pointed out that the CCG had undertaken due diligence in that it had sought advice beforehand. She suggested that the statement might be worded that the CCG should have undertaken adequate due diligence

- in considering the draft statement that NHSE should not have let the contract go under for a relatively small sum, there was some suggestion from members that local MPs could have played a more active role before the contract had collapsed.

In the course of more general discussion, members recalled that the contract collapse had been as big a surprise to them as to the general public. There had for example been no clue that something was going wrong when the Committee's OPACS working party had met an officer of UnitingCare a few weeks before the collapse. The Chairman pointed out that, as a consequence of this experience, the format of such liaison meetings had been redefined and now took place with the Chief Executive of each relevant organisation, for which he thanked them.

Looking ahead, the Chairman said that collective effort was needed to support those, particularly CPFT, now working under difficult circumstances to deliver older people and adult community services. He thanked all the guests for their attendance and helpful contributions to the meeting.

It was resolved unanimously to agree the statements that:

a) this 'failure' had had an impressive amount of scrutiny

b) the UnitingCare idea had been a good one and there should be no criticism of the 'big idea'

c) NHS England should have taken a much more active role in assessing the robustness of the proposals, especially with regard to the change in corporate structure and its implications for liability for VAT

d) Monitor should not have been content with a 'high level' review

e) the contract should not have started in such a hurry with so many unanswered questions

f) the Clinical Commissioning Group should have conducted more thorough due diligence on the Cambridgeshire Community Services NHS Trust handover package before agreeing a final go-ahead

g) Cambridge University Hospitals NHS Foundation Trust should have alerted other stakeholders as soon as its deteriorating financial position had meant that it would be unlikely to be able to bail out any UnitingCare shortfalls

h) NHS England should not have let what had been going to be an invaluable pilot go under for a sum that had been small in relation to the size of the contract.

216. SIX MONTH UPDATE ON CAMBRIDGE UNIVERSITY HOSPITALS FOUNDATION TRUST PROGRESS SINCE CARE QUALITY COMMISSION INSPECTION

The Committee received an update report on the progress made by CUHFT since its inspection by the Care Quality Commission (CQC) in April 2015. The subsequent report, published on 22 September, had rated the Trust as 'inadequate', and the Trust had, on the CQC's recommendation, been placed in special measures. The Trust had been asked to produce an action plan to address the concerns raised, while at the same time reducing the amount of money spent.

Before highlighting specific aspects of the report, Roland Sinker, the Trust's Chief Executive Officer, stressed the importance of relating all this work to the fundamental question of the patient's experience of being at Addenbrooke's at the present time. He cited the example of an elderly woman he had spoken to recently whose adult children were her support network; she had been full of praise for the nursing and medical care she had received, but was lonely at home and worried about being discharged back there before she was ready.

The CEO outlined the five thematic priority areas of the CUH Improvement Plan and the considerable amount of work being done against each area. Strategy work included addressing how to return to financial stability over five years; working with the CCG and CPFT on the system transformation programme was very rewarding. Good progress was being made on quality improvement and on getting the right staff in the right place. Clinical governance included a wide range of work on such matters as ensuring that, for example, unlike his recent experience of looking in a sluice and seeing that some commodes were not marked clean, all commodes were marked as clean.

The CEO drew attention to the importance of reducing bed delays (delayed transfers of care, DTOCs), and said that the Trust still had a significant deficit of £78m on a turnover of £800m. He was grateful to NHS England for its assistance with implementing the Cost Improvement Programme; the CIP target of £50m was half-way to being met.

In answer to members' questions, the CEO went on to say that

- a number of factors were driving the Trust's deficit, including
    - public spending cuts at national level
    - by almost any metric, the hospital being less productive than it might be – the services it was providing were more expensive than average, or it was failing to make good use of taxpayers' money, or its services were wide-ranging and not to scale
    - eHospital having not yet delivered savings

- on delayed discharge, more still needed to be done within the hospital to improve how it worked with partners outside

- good progress had been made with the recruitment of permanent staff, but the cost of living locally meant that retention continued to be a concern. There was also a need to encourage staff who had trained at Addenbrooke's or the Rosie to carry on working for the Trust rather than moving elsewhere; he welcomed a member's suggestion that staff being trained be given a contract under which they stayed with the Trust for three years

- the agency spend on nursing staff was usually low, with an exception in the current week; bank staff by contrast were the Trust's own staff. There were some agency staff in corporate departments such as the estates team, where there was a need to recruit permanently

- to counter the perceived attractions of agency work for some staff, such as flexibility, good earnings and no ongoing responsibility, work was being done to engage staff in why it was exciting to work for the Trust, for example the scope for innovation and training

- a good business continuity plan meant that cyberattack was not a major concern with the continuing implementation of eHospital

- the question of whether there was a tension between meeting the CQC's requirements and making the innovation needed to make savings and deliver good quality was complex. There was a tension between spending money and reducing deficit; the hospital needed to move beyond immediate cost control to change ways of delivering care, to improve patient experience, to develop in ways identified as outstanding by the CQC, and to invest upfront in future

- the biggest risk to all areas of the recovery plan, including waiting times and use of beds, was not having capacity in hospital, so it was necessary to have the right capacity in place outside hospital to help reduce DTOCs; this was the single biggest issue, and work was being done to achieve a solution

- it was necessary to be honest with staff about what was being done well and less well, and give them a sense of how progress was being made. Those who were reluctant to participate in the programme of change should be encouraged and even challenged to see the potential benefit of change and engage in this work.

The Chairman said that the Committee was encouraged by the progress being made by what was both a world-class hospital and the local district general hospital. He noted that DTOC was the biggest single issue, thanked the Chief Executive Officer for attending the meeting, and asked him to return to Committee in November.

It was resolved unanimously to note the report.

217. CAMBRIDGESHIRE AND PETERBOROUGH REVIEW OF BED BASED INTERMEDIATE HEALTH CARE

The Committee received a report on the review of intermediate care beds currently being undertaken by the Clinical Commissioning Group and its partners through the Urgent and Emergency Care Vanguard programme. The review was at an early stage, and was being conducted with the aim of ensuring that intermediate services would be available across the county on a more equitable basis than the present mapping of provision suggested, and would be designed around the needs of patients. It included looking at the development of support services in patients' own homes, which in many cases would have better outcomes than bed-based provision, though it was necessary to maintain an appropriate balance between home-based services and beds for people who could not be reabled in their normal place of residence.

In the course of discussion, members

- suggested that the two empty wards in Wisbech hospital could be used for intermediate provision as an alternative to beds in Hinchingbrooke or Kings Lynn hospitals, but were advised in reply that staff could not be produced instantly even if the wards were suitable, and that people were often better off in their own homes

- noted that spending long lengths of time in hospital beds without mobilisation seriously harmed long-term physical function – for every ten days people aged over 80 spent in hospital, they lost ten years of function of their thigh muscles; this was a reason for exploring whether money should be used differently in order to get people home earlier safely

- some patients would never be well enough to go home, and either would need to go into a residential home, or because of complex needs would require a bed in a community hospital

- commented that intermediate beds were important to release acute beds, but noted that many patients would have better outcomes at home, so it was a question of getting the right balance of provision, and getting it equitably across the county

- stressed that it was important to have community provision in place before beds were closed

- reported, from personal experience as a day centre trustee, that outcomes were far better for patients who were able to go home

- in response to a request for clarification on timescales for the review work, were advised that the work to assess current bed provision could be completed by the end of June, and an update could be brought to the Committee in July

- sought reassurance that consultation would not be conducted over the summer holiday period; assurance was given that additional response time would be added to allow for any holiday period.

The Chairman accepted the offer of a progress report on the work in July.

It was resolved unanimously to provide support and commitment to the principles of the bed review.

218. CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP FINANCIAL REPORT

The Committee received a report updating it on the financial position of the Clinical Commissioning Group at the start of the financial year. The end of the UnitingCare contract in December 2015 had meant that the CCG was faced with greater costs than had been anticipated while the contract was in place, and instead of delivering a £4m year end surplus, it had ended the year with a deficit of £8.4m. NHS England was not requiring immediate repayment of the overspend, but it had agreed a maximum deficit of £3m, which would require the CCG to make savings in 2016/17 of £43.8m, approximately 4.4% of its total budget.

Members noted that, separately from the financial matters covered in the report, there had been concerns about the future of outpatient services at Doddington and Ely hospitals, which had been run by Cambridgeshire Community Services NHS Trust (CCS). CCS had previously declined to continue to provide these services because of their significant excess cost, and it had looked as if the services would cease at the end of the current month. However, CCS had now agreed to continue providing them until the end of March 2017, and had undertaken to work with GPs in the areas and with the CCG to make the services viable and used by GPs. Meanwhile, the CCG would be able to go out to procurement for a substantive provider from April 2017.

In response to the information supplied, members

- noted that the CCG had just received notice of the provider's intention to cease radiology services, and wished to wrap radiology services into the same procurement exercise as outpatient services so that there was one provider for both; a minor injury service needed x-ray provision, and significant areas of outpatient work could not be provided without diagnostic services

- noted that the CCG was carrying out a review of all minor injuries units against national standards; the units were now to be known as urgent care centres and it was necessary to see how they measured up against these standards

- commented that this financial situation was a consequence of the ending of the UnitingCare contract, and was of great concern to Councillors.

- drew attention to the mixed usage of percentages and cash figures in the report.

It was resolved unanimously to note the financial position of the CCG and the impact on it of the end of the UnitingCare contract.

219. CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP NON-EMERGENCY PATIENT TRANSPORT SERVICES – END OF CONSULTATION REPORT

The Committee received a report informing it of the responses to the 'Consultation on a future model for Non-Emergency Patient Transport Services' (NEPTS) and how concerns, questions, and suggestions arising from the consultation could be addressed by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

Members noted that the CCG Governing Body had been particularly careful to check such matters as VAT, form of organisation, and contract value in the light of experience with the termination of the OPACS contract with UnitingCare; contract value and cost of patient journey had also been benchmarked across the country. Much valuable feedback had been received during the consultation exercise, including from public meetings. The importance of total transport planning had been raised in consultation responses; members were assured that Total Transport had been listed as an entity in the project and the contractor was required to work with Total Transport as it developed its recommendations.

The Committee was advised that the contract had been awarded to the East of England Ambulance Service NHS Trust (EEAST). EEAST had transported some patients for the CCG in the past; this award brought all such services under one contract.

Commenting on the report, members

- thanked the CCG for conducting such a good consultation exercise and encouraged the CCG and Total Transport to continue to work together; the whole landscape of transport provision had changed by comparison with a few years ago

- noted that the CCG had identified transport need in the Isle of Ely and in Wisbech, and reported that Total Transport was starting a pilot scheme for transport to and from Princess of Wales Hospital, Ely, at about the same time as the NEPTS contract was due to start

- stressed the importance of ensuring that a person who sought NEPTS was referred to community transport services if they did not meet the NEPTS criteria. Members were advised that there would be one call centre and a centralised booking system, and that a signposting facility was built in to the service specification to ensure that such patients were given appropriate information

- expressed disappointment at the level of attendance at public meetings, and suggested that they had not been adequately publicised. Members noted that the CCG had circulated details of the consultation widely, including to town and parish councils and Healthwatch organisations, and that attendance at public meetings was in the CCG's experience usually quite limited. It had also been possible to respond to the consultation online, and through other groups and organisations, as well as through the meetings, but it was always possible to do things better, though there was also a resource issue in mounting consultation exercises

- commented that information about consultations often did not reach those people who should be responding; there was a major issue with how to communicate with people who did not use new media

- asked to be supplied with the metrics against which the new provider's performance would be measured, and asked whether there was a customer satisfaction form. Members noted that a survey requirement had been included in the new contract, though it had not been specified whether there should be an individual form for every journey, and that it would be possible to tell members in six months' time if the CCG had the evidence being sought.

It was resolved unanimously to note the report and the feedback given to this consultation

220. NHS QUALITY ACCOUNTS

The Committee received a report setting out draft response statements on the Quality Accounts provided by NHS Provider Trusts. The Chairman stated that, while he was aware that the report had not been available for public inspection five clear days before the meeting, he was prepared to exercise his discretion under Section 100B(4) of the Local Government Act 1972 to allow discussion of the report. He was doing this because information included in the report had not been available five days beforehand.

Councillor Sales said that he had not had time, in a week when Full Council had met, to read the draft statements, so he was not prepared to sign up to them. The timing of the Quality Account deadlines put members of the Committee in a difficult position. The Chairman replied that, because in his view the draft responses reflected the work carried out by members to arrive at them, he wished to continue with the item.

The Committee considered a process for responding to Quality Accounts in 2017. Members noted that not only had trusts set their deadlines earlier this year than last year, in 2017 the comparable meeting of the Committee would take place on 8th June, because Annual Council would not take place until 23rd May following County Council elections in early May and the start of a new four-year Council.

The difficulty was that under the committee system of governance, it was not possible to delegate decisions to individual elected members or groups of members, but scrutiny regulations required that scrutiny be carried out by elected members and not delegated to officers. Officers suggested that one way around this might be for the Committee, at its last meeting in the current municipal year, to delegate approval of the responses to the Quality Accounts to the Director of Public Health acting in consultation with and in accordance with the views of such members of the present Committee as were still elected members of Council following the elections on 4th May. The responses could then be reported to the incoming Committee on 8th June. It was suggested that the Constitution and Ethics Committee might wish to consider the matter meanwhile.

The Committee went on to look at each of the draft responses in turn:

- to Cambridge University Hospitals NHS Foundation Trust – draft agreed
- to Peterborough and Stamford Hospitals NHS Foundation Trust – draft agreed
- to Cambridgeshire and Peterborough NHS Foundation Trust – draft agreed, with the addition of a comment on the closure and reopening of the waiting list for Child and Adolescent Mental Health (CAMH) services
- to The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust – draft agreed; it was suggested that the hospital be invited to talk to the Committee about anecdotal reports of staffing and communication difficulties
- to Hinchingbrooke Health Care NHS Trust – draft agreed

- to Cambridgeshire Community Services NHS Trust – draft agreed; it was suggested that the Trust be invited to a meeting following the Care Quality Commission inspection planned for July 2016.

It was resolved by a majority, Councillor Sales and one other member abstaining, to

a) agree to communicate to all NHS Provider Trusts where the Committee had received a Quality Account, the difficulty in responding to their internal deadlines given the councils committee structure

b) agree the draft statements responding to the NHS Provider Trusts Quality Accounts

c) consider a process for responding to Quality Accounts in 2017 in detail at the Committee's meeting in March 2017 taking into consideration the dates of Annual Council and Health Committee in May/June 2017.

221. HEALTH COMMITTEE WORKING GROUPS – UPDATE

The Committee received a report informing it of the recent activities and progress of the Committee's working groups. Members noted that the present format of meetings was proving effective as a means of communicating with the different organisations.

It was resolved to

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

2) Defer to the next meeting a review of the membership lists for each liaison group including the use of reserve members

3) Include the possible consultation on Hinchingbrooke Healthcare Trust collaboration with Peterborough & Stamford Foundation Trust for the September forward agenda.

222. ANNUAL HEALTH PROTECTION REPORT (2015)

The Committee received a report presenting the Cambridgeshire Annual Health Protection Report. Members noted that the Director of Public Health was required to report annually on the delivery of the health protection functions of the County Council.

Members' attention was drawn to the increase in cryptosporidiosis, to the existence of some pockets of poor uptake of immunisation in Cambridgeshire, and to improvement in the uptake of breast screening. The Committee was informed that the timing of the pertussis vaccination in pregnancy had been changed very recently; it could be given at any time from 16 weeks onwards, and take-up was expected to increase as a result of arranging this immunisation to coincide with the 20-week scan.

Examining the report, members

- welcomed and commended the report as providing a great deal of valuable information about public health for a lay audience

- noted that there tended to be occasional increases in the incidence of scarlet fever; there was no obvious specific reason for the increase experienced in 2014 and 2015

- noted that the school-based approach to immunisation was helping to address the uptake of flu vaccination in years 1 and 2. It had proved impossible to obtain the information to establish a baseline for the secondary school booster, because under previous arrangements, GPs had had discretion about when to give it

- noted that the safety record of influenza immunisation in pregnancy was good; the flu epidemic of 2009 had seen higher levels of sickness among infected pregnant women, some of whom had died or lost their babies

- commented on the worldwide problem of increasing antibiotic resistance.

The Chairman requested an update on flu vaccination rates at a future meeting. He drew attention to the ongoing health protection work, and described the Annual Health Protection Report as excellent.

It was resolved unanimously to note the information in the Annual Health Protection Report (2015).

223. FINANCE AND PERFORMANCE REPORT – MARCH 2016

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of March 2016. The report provided a forecast year end position; the closedown was due to be finalised shortly and would be reported to the Committee in July.

Members noted that the Public Health Grant income had been less than originally expected because of the in-year reduction in the grant. However, savings had been made and additional income generated, and it was anticipated that an underspend could be transferred into the Public Health Grant reserves to produce a balanced year end position.

Turning to the summary of performance indicators, members noted that one area of difficulty was health checks, where there were issues of accuracy of data and of awareness in the population. The first of these was being addressed through software, and the second through an information campaign. On the Integrated Lifestyle Service, it was reported that efforts to recruit had been successful, and as of the previous week, the Service was up to complement, though some training was still required.

Discussing the report, members

- drew attention to the importance of the Council paying attention to recruitment issues such as the cost of living and housing in the area

- asked that attention be paid to the number of schools attending funded mental health training; it was noted that, while the number of academies might be a factor, officers were seeking further information about this

- noted that the county-wide work on child obesity was part of a national exercise

- expressed concern at the unclear information on school nursing numbers of young people seen for behavioural interventions and for mental health and wellbeing

concerns. It was explained that the original targets were being reformulated. The previous school nursing contract had been purely activity based, giving figures only for numbers being seen individually and numbers being seen in groups; under the new contract, information was being supplied on the reasons for which people were being seen, but there was no baseline information available

- asked why the figures for delayed bed days in Huntingdon had been going up in recent months but going down elsewhere; the Director of Public Health undertook to look into this **Action required**

Members asked that the finance and performance report be placed earlier on the agenda in future.

The Chairman congratulated the Director of Public Health and her department on the way in which they had managed the loss of mid-year funding.

It was resolved unanimously to note the report.

224. PUBLIC MENTAL HEALTH STRATEGY PRIORITY UPDATE – IMPROVING THE PHYSICAL HEALTH OF THOSE WITH SEVERE MENTAL ILLNESS

The Committee received a report setting out an overview of work to improve the physical health of those with severe mental illness (SMI). Members noted that

- following an evidence review, it had been decided to improve the support provided by existing services by for example upskilling the main lifestyle service locally
- an enhanced primary care (EPC) service was being set up to meet the needs of patients who had mental health problems of moderate to high severity and disability which could be managed within primary care but needed longer than the average 10-minute appointment
- work was also being done to explore the provision of step-up services for those whose condition deteriorated, but did not deteriorate so much that they required care in a secondary setting
- the EPC service was currently very small, but would eventually develop to have a large number of staff covering the whole of Cambridgeshire and Peterborough
- initial patient and carer feedback had been good
- the service also interfaced with the wider system such as the drug and alcohol action team, housing, and the voluntary and community sector.

Commenting on the report, members

- welcomed this work as the way ahead, given the close connection between mental and physical health, but expressed concern about its long-term future

- expressed interest in the service specification model; members noted that national examples had been sought (such work had already been done in East London), and that officers would circulate the service specification and diagram **Action required**

- suggested that, as diet and exercise and mental health were all connected, there should be exercise equipment available for all to use in every village.

It was resolved unanimously to endorse the public mental health work being undertaken.

225. ANNUAL PUBLIC HEALTH REPORT

The Committee received the Annual Public Health Report for 2015/16, prepared by the Director of Public Health in accordance with the requirements of the Health and Social Care Act (2012). The Director of Public Health thanked and congratulated all who had worked to produce this, in particular Helen Whyman and Elizabeth Wakefield.

In the course of discussion, members

- welcomed the report, describing it as an excellent, professional, informative and readable piece of work which ought to be widely read
- urged that it be widely disseminated and commended, and that the Communications team be asked to advise on how to communicate it
- noted that, as part of the distribution of the report already planned, copies were being sent to every secondary schools
- in answer to a query on the cost of producing the report, the Director of Public Health undertook to supply the figure; it had been produced at modest cost through Peterborough City Council **Action required**

It was resolved unanimously

- to note the information outlined in the Annual Public Health Report
- to endorse the approach recommended in the Report of engaging with the three tiers of local government and the voluntary/community sector, to understand how we could best work with local communities to improve health building on activities and assets which already existed at local level.

226. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan. Members noted that

- the reserve committee date of 16 June would be used for a workshop on the Sustainability and Transformation Plan being developed by the Clinical Commissioning Group; it was agreed to open this up to members of the Health and Wellbeing Board and of the Adults Committee
- the Children's Health Joint Commissioning Unit would be a brief topic at the Member Seminar in June; it was agreed to provide members with a background on the 0-5 public health commissioning responsibilities and remits of health visitors and school nurses and include this as a topic at the 16 June Health Committee
- the September Committee agenda would include a report on 0-19 Joint Commissioning of Children's Services (postponed from 14 July meeting).

It was resolved unanimously to note the training plan.

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

The Committee considered appointments to partnership liaison and advisory groups and to internal advisory groups and panels in accordance with the General Purposes Committee's delegation of appointments to Policy and Service Committees. Councillors Smith and Hickford were happy to stand down from the Council of Governors of Papworth and Addenbrooke's hospitals respectively, and Councillors Clapp and Topping were both willing to continue to serve on the Mosaic implementation group, whether as members of the Health Committee or of another nominating committee.

In the course of discussion, the query was raised as to why a nomination was being sought to the Cambridge Local Health Partnership (LHP) but not to the other LHPs in the county. Members were advised that this was because it was the only LHP which held formal meetings in public.

It was resolved unanimously to:

(i) review and agree the appointments to partnership liaison and advisory groups as detailed in Appendix A of the report before Committee, namely
   a) Cambridge Local Health Partnership – Councillor J Whitehead
   b) Cambridge University Hospitals NHS Foundation Trust Council of Governors – Councillor T Orgee
   c) Cambridgeshire and Peterborough NHS Foundation Trust Council of Governors – Councillor L Nethsingha
   d) Papworth Hospital NHS Foundation Trust Council of Governors – Councillor P Topping

(ii) review and agree appointments to internal advisory groups and panels as detailed in Appendix B of the report before Committee, namely
   a) Mosaic Implementation Members Reference Group – Councillor P Clapp or Councillor P Topping to serve for Health Committee, depending on the nominations of the Adults Committee and the Children and Young People Committee to the Group.

228. HEALTH COMMITTEE AGENDA PLAN

The Committee considered its agenda plan. The Chairman suggested that further scrutiny of Older People and Adult Community Services (OPACS) be deferred from July to November, and that retrospective scrutiny of the UnitingCare contract had concluded; the Committee would be looking at the future for OPACS.

Members noted that Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford NHS Foundation Trust might be conducting a consultation on proposals for collaboraton between the two trusts; this could be as early as July.

It was resolved unanimously:

a) to note the agenda plan

b) to move the scrutiny item on the termination of the UnitingCare contract from the agenda for 14 July to the agenda for 10 November 2016

c) to move the item on 0-19 Joint Commissioning of Children's Services from the agenda for 14 July to the agenda for 8 September 2016

d) to add a provisional item on the possible consultation on collaboration between Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford NHS Foundation Trust to the agenda for 14 July and 8 September 2016 as alternative dates.

Chairman