HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 08 February 2018

Democratic and Members' Services
Quentin Baker
LGSS Director: Lawand Governance

15:00hr

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 and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
2	**Minutes and Action Log - 16th January 2018**	**3 - 16**
3	**Petitions**	

SCRUTINY

4	**Non Emergency Transport (NEPT) Service Performance 6 Month Update**	**17 - 20**
5	**East of England Ambulance Service Trust (EEAST)**	**21 - 44**
6	**Health Committee Forward Agenda Plan**	**45 - 50**

The Health Committee comprises the following members:

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

Councillor Lorna Dupre Councillor Lynda Harford Councillor David Jenkins Councillor Linda Jones Councillor Kevin Reynolds Councillor Tom Sanderson Councillor Peter Topping 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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Agenda Item No: 2

HEALTH COMMITTEE: MINUTES

Date: Tuesday 16th January 2018

Time: 1:30pm to 4:40pm

Present: Councillors D Connor (substituting for Councillor Harford), L Dupre, P Hudson (Chairman), D Jenkins, L Jones, L Nethsingha (substituting for Councillor van de Ven), T Sanderson and M Smith (substituting for Councillor Topping)

District Councillors M Abbott (Cambridge City), M Cornwell (Fenland), S Ellington (South Cambridgeshire) and C Sennitt (East Cambridgeshire).

Apologies: County Councillors C Boden, L Harford, K Reynolds P Topping and S van de Ven.

77. DECLARATIONS OF INTEREST

The Chairman declared a non-statutory interest in item 6, Northstowe Healthy New Town – Clinical Commissioning Group (CCG) Update as he was the Local Member for Northstowe.

78. MINUTES – 14TH DECEMBER 2017 AND ACTION LOG:

The minutes of the meeting held on 14th December 2017 were agreed as a correct record and signed by the Chairman subject to the alteration of the 10th bullet point of minute 72 to read – sought assurance that the range of stock of medicines at the site were sufficient to meet demand".

The action log was noted including the following updates relating to on-going actions:

Minute 17 – This was scheduled for discussion at a meeting of Cambridgeshire Community Services (CCS) taking place in January 2018.

Minute 32 – A meeting was scheduled to take place on 29th January 2018 with the Wisbech 2020 Steering Group.

Minute 63 - Confirmation had been received that a development session had been scheduled for February 2018

79. PETITIONS

No petitions were received.

80. PUBLIC QUESTION

The Chairman invited Mr Nic Hart, father of Averil Hart whose care was the subject of an Ombudsman report regarding the Eating Disorder Service provided by Cambridgeshire and Peterborough Foundation Trust (CPFT). The Chairman exercised

his discretion and waived the three minute time limit set out in Committee procedure rules regarding public questions.

Mr Hart began by providing the background to the care his daughter received, emphasising that it was an avoidable tragedy, highlighting the poor transitional care she received. The care co-ordinator was new in post and inexperienced with regard to anorexia. Mr Hart's daughter therefore lost weight continuously and weekly weight checks were not carried out by GPs. When help was requested a review was scheduled rather than the request being responded to as an emergency by which time she had died.

The case highlighted the lack of experience of treating eating disorders at Norwich and Norfolk University Hospital, from which Mr Harts daughter was transferred to Addenbrooke's Hospital where she waited for 5 hours for treatment.

Mr Hart requested that no further patients were cared for by an unsupervised trainee who had no experience of anorexia and that the CPFT's specialist units were no longer under-staffed and under-resourced which placed patients at risk. That professionals employed at CPFT would be open and transparent particularly by adhering to their Duty of Candour and questioned, given the maladministration identified by the Ombudsman, how CPFT would learn from patient deaths throughout the Trust's services if large amounts of public money was spent on legal defence rather than investigating matters thoroughly and learning from service failures.

The Chairman thanked Mr Hart for the question, emphasising the scrutiny role of the Committee and explained that a written reply would be provided within 10 working days of the meeting

81. EATING DISORDER SERVICE – OMBUDSMAN REPORT

The Chief Executive of CPFT, Tracy Dowling and Chess Denman, Medical Director of CPFT addressed the Committee and thanked Mr Hart for his testimony and questions. The Chief Executive began by issuing a full public apology for what happened and the failings in the care provided. The Chief Executive also apologised for the difficulty in obtaining answers. Attention was drawn to the duty of all NHS organisations since 2014 regarding candour. The Chief Executive expressed a keen desire to continue to work with Mr Hart and that lessons be learnt from the in order that the service was safe and that the staff who provide the services were properly supported and supervised and that supervision was well document in order that culture of learning was developed.

Members noted that other organisations were involved in the care of Mr Harts daughter who was discharged as an inpatient on the S3 Eating Disorders Unit run by CPFT on 2nd August 2012 and was referred for follow up by the Norfolk Community Eating Disorders Service (NCEDS), also run by CPFT as she was due to begin a course at the University of East Anglia in September 2012.

Attention was drawn to the actions that had been taken in response to the service failings identified by the serious incident review and the Ombudsman's report, that focussed on policies and protocols and ensuring that they were followed and reviewed.

The Chief Executive informed Members that she was relatively new in post having commenced her role as Chief Executive in August 2017 and wanted assurance as Chief Executive that policies and procedures were systematically applied, especially for patients who transitioned between services, age groups and locations.

Anorexia was a very serious but treatable condition and it was vital that care and treatment was multi-disciplinary and that performance management of the implementation of the care took place. Weekly monitoring should take place if it was deemed necessary and the multi-disciplinary team would undertake that monitoring.

The Chief Executive expressed her intention to work closely with the service in order to ensure that the policies and procedures were being adhered to and that the prioritisation of work was safe and protected the most vulnerable.

During discussion of the report Members:

- Emphasised the dangers posed by anorexia as a condition and the need to publicise the seriousness of the condition.

- Noted the performance management of the weekly weighing sessions but drew attention to the critical issue of the inexperienced Lead Practitioner in the case and sought assurance that such an event could not happen again. The Chief Executive emphasised the vital role of performance management, the weekly monitoring was contained within National Institute of Clinical Excellence guidance and was undertaken by GPs, it was vital that there was effective communication between professionals. There was a need to ensure that monitoring took place and was discussed across a multi-disciplinary team. Inexperienced staff would be supported from within a multi-disciplinary team that utilised shared experience. There was clear learning regarding clinical supervision and it was essential that the supervisor also saw the patient and provided care. Although the causes of anorexia unknown, there was some clinical evidence that sufferers improved when something became more important to them than controlling their weight. It was hoped that in this particular case, entering University would provide a focus other than controlling weight.

- Drew attention to the lack of timescales included within the Ombudsman report, emphasising their urgency and requested that a clear time frame needed to be provided.

- Confirmed that the NCEDS service was run and managed by CPFT and highlighted the issues with communication during the transfer of care. The Chief Executive informed Members that the Norfolk service had suffered from staff shortages and highlighted the learning that was reflected in the revised policies and procedures.

- Expressed concern that closer working with universities in order to identify potential issues with students was not contained within the report. The Chief Executive

confirmed that a policy was in place and offered to attend a future meeting of the Committee to discuss further.

- Questioned how the monitoring of weekly weigh-ins would be managed. Members were informed that a monthly report would be provided to the Chief Executive that provided assurance that weekly monitoring meetings were taking place. The reporting would also identify issues such as staffing levels and surges in demand. Monthly management meetings also took place and it was intended that a member of staff would be assigned to the Eating Disorder Service to work with the service regarding compliance with policies. Assurance that services were robust enough to mitigate risk to the patient was a priority for the Chief Executive which included ensuring that there was clear documentation of decisions taken and more effective engagement with friends and family of patients and how the service responds when they raise concerns.

- Noted the policy of CPFT regarding the retention of patient records was in accordance with national policy. The policy regarding the retention of emails at the time was 12 months and the Information Commissioner found that emails had been retained in accordance with the policy. The Chief Executive informed Members that she was investigating whether any of the emails should have been included as part of the patient record and that emails relating to serious incidents were retained until the incidents had been closed. Emails relating to patients were now retained within the health record system and the Trust was now using an electronic patient record system that provided a much enhanced audit trail which allowed interrogation of activity on a particular record.

- Questioned why the anonymised case study had been withdrawn from the Marsipan Guidelines. The Chief Executive informed Members that she would be investigating why the case study had been withdrawn and whether there were sound clinical reasons why. The importance of sharing learning was emphasised to Members, especially as it would assist doctors in the acute sectors.

- Noted that the Chief Executive intended for the action plan to be concluded within 3 months, in order to be able to identify risks and where and how they were being mitigated.

The Chairman invited Mr Hart to address the Committee again having heard the comments of the Chief Executive. Mr Hart drew attention to the lack of experience of staff that had resulted in the miscalculation in the Body Mass Index (BMI) of his daughter. Several requests for records and emails had been submitted to CPFT and not provided. Mr Hart informed Members that the Information Commissioner was unable to rule on the health records of a deceased patient.

Members resumed their questions of the Chief Executive. During discussion Members:

- Noted that the Chief Executive had met with Mr Hart and was determined to answer his questions in full by providing detail and explanations if it was not available.

- Questioned and expressed concern regarding the culture of the organisation.

- Expressed concern that there was a waiting list for treatment of an illness that had such a high mortality rate. The Chief Executive explained that at times demand was higher than the capacity of the service. Waiting lists were actively managed in order to ensure that the prioritisation of cases was effective and allowed for higher risk patients to be seen more quickly. Liaison with GPs was undertaken regarding patients who were on the waiting lists regarding the management of patients.

- Questioned whether since the inclusion of community services within the remit of CPFT in 2012 there was a loss of focus on mental health. The Chief Executive explained that the addition of community services allowed for a holistic approach to patient care and gained focus on physical health.

- Noted that there were approximately 40 patients currently placed on the waiting list which was actively managed with GPs.

- Noted that when a case is handed over a care plan approach meeting was established to which the teams responsible for the care of the patient invited carers and care co-ordinators in order for a face to face handover to take place.

- Questioned whether there was a method for staff to alert managers that they and the service was struggling to cope. It was explained that there was process in place called “Stop the Line” which would result in an immediate response from senior staff. There was also a standing agenda item at the weekly management meeting that would review such incidents. Staff were encouraged to use it and a culture where staff were applauded for using it was being created.

- Expressed disappointment that no timetable had been included with the action plan, and expressed concern that waiting lists were subject to financial pressures.

- The Chairman proposed with the unanimous agreement of the Committee that the Chief Executive of CPFT be invited to return to the Committee to provide an update regarding progress made against the action plan and recommendations made by the Ombudsman in 6 months’ time.

It was resolved to:

a) Review and comment on the report and to note the actions being undertaken by CPFT to address the recommendations cited in the Ombudsman report.

b) Request that the Chief Executive of CPFT provide an update to the Committee regarding the progress made against the action plan and recommendations made by the Ombudsman in 6 months’ time.

Councillor Nethsingha left the meeting at 3pm.

82. LOCAL URGENT CARE SERVICE HUBS PILOT PROJECT (EAST CAMBRIDGESHIRE AND FENLAND).

Members were presented an update regarding the Local Urgent Care Service Hubs (LUCS) Pilot in East Cambridgeshire and Fenland.

Members were informed that the first site in Ely had been operating Monday to Friday since May 2017 and the results had been encouraging with evidence demonstrating that the percentage of patients being referred back to their GP or sent on to an Accident and Emergency centre was reducing over time.

The Clinical Commissioning Group was continuing to work on the development of the Wisbech LUCS Hub and officers were optimistic that the pilot would still go ahead.

During the course of discussion Members:

- Congratulated officers on setting up the pilot scheme and questioned whether there were alternative models that could be used in order to progress the proposed pilot in the Fenland area. Officers explained that one of the elements that the Hubs required was a constant presence on site of GPs. It was now no longer expected g for GPs to be present on site all the time. This therefore provided an opportunity for a variety of flexible options such as telephone support and on-call support.

- Questioned what action had been taken to encourage GPs to work in south Fenland. Officers explained that there was a raft of initiatives, however it would take time to correct a historical issue that had built up over several years.

- Noted the Time to Care initiative that included a new system for managing correspondence that had been implemented at several locations and allowed for staff other than GPs to manage correspondence, following a set of rules on the GPs behalf and therefore saving time.

- Clarified the difference between an Urgent Treatment Centre and a GP access centre. Officers explained that the opening hours of a GP access centre could be less and fewer services offered.

- Noted that national guidelines set 27 criteria for designation of UTC's and currently 5 criteria were not achieved. UTCs would need to be fully compliant with the national criteria by 2019.

- Noted that if UTC designation was not achieved then it was possible to apply for exceptions such as rurality or designate the service as a GP Access Centre.

- Were informed that the Ely LUCS Hub had been easier to establish because of the larger GP practices in the area that were able to support the development of the LUCS Hubs. Members drew attention to rapidly expanding practices in the Fenland area and questioned whether other areas of the country were experiencing similar issues in establishing them. Officers explained that GP engagement was challenging, however the UTC criteria had changed, no longer requiring GPs to be on site all the time which provided an opportunity operate differently.

- Suggested that another pilot be set up that would deliver the LUCS in a slightly different way.

It was resolved to note the report.

83. NORTHSTOWE HEALTHY NEW TOWN – CLINICAL COMMISSIONING GROUP (CCG) UPDATE

Members were presented an update regarding the planning and engagement that was taking place to secure primary care medical services for the emerging and anticipated population for Northstowe.

In discussion Members:

- Commented that it was not clear what the new care model would be. Officers explained that the new care model had not yet been defined and a meeting was scheduled to take place on 23rd January 2018 with GPs that would begin to develop the model.

- Emphasised that care included prevention also and the importance of an integrated process when developing a model. Officers acknowledged the scope of services and the integrated approach required.

- Questioned the provision for dentistry and a pharmacy at the site. Officers explained that those services were commissioned by NHS England and there would be opportunity for those services, however they were population dependent.

- Expressed concern that there would not be dedicated health provision until 1,500 houses had been constructed and emphasised the vital importance of securing S106 money as quickly as possible.

- Noted that 600 Full Time Equivalent GP positions were required and there was a requirement to review the workforce and understand how GPs could be encouraged not to retire early. There was also need to focus on trainee GPs because although the number of trainee places had increased, the number of applicants had not.

- Noted that Longstanton and Willingham GP surgeries had capacity that would cater for the residents that moved to Northstowe during phase 1 of the development. Members commented that residents in Longstanton had reported that appointments were more difficult to arrange.

- Highlighted the importance of the S106 funding and the need to ensure that it was collected.

- Expressed concern that facilities would not be in place within the necessary timescales given the pace of development at Northstowe and drew attention to previous Health Committee scrutiny of past S106 agreements. Officers confirmed that the Health Committee was able to scrutinise the S106 arrangements as they pertained to the health of residents, however any recommendations made by the Committee would not be within the same legal framework as recommendations made to the NHS.

  The Chairman expressed concern that a new town was being built with a population of approximately 30,000 and there was no provision for a dentist or pharmacy. Therefore the Chairman, with the agreement of the Committee proposed that NHS England be invited to attend a future meeting of the Health Committee to talk about

dental needs of Cambridgeshire, taking into account new developments such as Northstowe.

It was resolved to:

a) Note the progress to date

b) Requested that NHS England attend a future meeting of the Health Committee to speak about the dental needs of Cambridgeshire, taking into account new developments such as Northstowe

84. EMERGING ISSUES IN THE NHS

Following a query regarding Delayed Transfers of Care (DTOCS), officers explained that the confidential data provided to Members between meetings was NHS Management information that had not yet been validated.

Members expressed concern regarding the scheduling of operations that were then later cancelled due to increased demand and suggested that it was an area the Committee may wish to scrutinise in the future.

85. FINANCE AND PERFORMANCE REPORT – NOVEMBER 2017

Members received the November 2017 iteration of the Finance and Performance Report. Members noted that that there was an increase in the forecast underspend to £159k due to vacancies within the Drugs and Alcohol and Behaviour Change areas of work.

Performance was generally improving regarding Performance Indicators Attention was drawn to the additional appendices to the report which included the Public Health Risk Register that contained no red risks.

During discussion of the report:

- Members noted that the number of outreach health checks carried out had increased following a more diversified approach in Fenland that included pop up sites within the community.

- Attention was drawn by Members to childhood immunisations as a key issue and questioned whether they should be tracked monthly. Officers explained that the data was compiled quarterly and would be included in future iterations of the report. **ACTION.**

- Clarification was sought regarding the risk register diagrams included in the report. Officers explained that the data had been extracted from a relatively new system and that further clarification would be provided to the Committee. **ACTION**

It was resolved to review and comment on the report and to note the finance and performance position as at the end of November 2017.

86. HEALTH COMMITTEE WORKING GROUPS UPDATE

The Committee received an update that related to Health Committee Working Groups that had been established following the 14th December 2017 Health Committee meeting.

It was resolved to note and endorse the progress made on the Health Committee Task and Finish Groups.

87. HEALTH COMMITTEE TRAINING PLAN

Members noted that a development session had been arranged to take place on 8th February regarding the Sustainability Transformation Partnership (STP). Members also noted that a date regarding item 7 on the training plan had not yet been set due to Fenland District Council having applied to take part in the Prevention at Scale Initiative. Once discussions with the Local Government Organisation and Fenland District Council had taken place a date would be sought.

It was resolved to note the training plan

88. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES

Members received the Health Committee agenda plan and noted the following update provided at the meeting.

15th March 2018 – Added
- Child and adolescent mental health services
- Procurement of Drug and Alcohol Services.
- Integrated children's commissioning
- NHS Quality Accounts Delegated Authority

12th July 2018 – Added
- Eating Disorder Service Update

The Committee were requested to appoint a Member Champion for Mental Health. The Chairman proposed with the agreement of the Committee that Councillor Lena Joseph be appointed to the role as she had been working closely with the Chairman of the Adults Committee on the issue and was a member of the Communities and Partnerships Committee.

It was resolved to:

a) Note the agenda plan and the update provided at the meeting

b) To appoint Councillor Lena Joseph as Mental Health Champion for the Health Committee

Chairman

Agenda Item No: 2a

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on **16th January 2018** and updates Members on progress in delivering the necessary actions.

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
17.	**Public Health Finance and Performance Report** **a) Health visiting mandated checks whether geographical / social reasons for lack of take-up**	**L Robin**	Health visiting mandated checks - the percentage of children who received 12 month review by 15 months – with reference to the decline in performance, a question was raised regarding whether there was a geographical / social pattern to them not being wanted or not attended?	Meeting scheduled with CCS for Jan 2018 update will be provided at the February Health Committee	**On-going – Jan 2018**
32.	**Finance & Performance Report – July 2017**	**V Thomas**	Information would be provided to Members regarding engagement with outreach health checks following a meeting with Fenland District Council's senior management team.	A meeting had been scheduled with the Wisbech 2020 Steering Group. An update will be provided to the February meeting of the Health Committee.	**On-going - Jan 2018**

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
37.	**Suicide Prevention Strategy Update**	**K Hartley**	Members requested that the report focussed more on the positive results of the strategy and that they be circulated to Members and the public.	Strategy will be presented to Health Scrutiny Committee in Peterborough and the Health and Wellbeing Boards before it is finalised and ready for circulation. The item is on the agenda for the February meeting of the Cambridgeshire HWB om 1st February 2018.	**On-going February 2018**
48.	**Finance & Performance Report**	**L Robin / K Parker**	Members requested that an in depth analysis be undertaken and presented to the Committee of all the initiatives taking place in the Fenland area and whether they were successful in achieving their goals.	Has been placed on training plan and will commence following work undertaken between FDC and the LGA	**On-going April 2018**
71.	**Integrated Commissioning of Children's Health and Wellbeing Services**		Officers agreed to share work streams with Members and address specific concerns regarding accessibility with the Implementation Board.		**On-going**
72.	**Health Committee Update Regarding the Cambridge GP Out of Hours Base Move from Chesterton to Addenbrooke's Including the Co-location of GP Streaming**		Members requested that the development of the re-tendering process for the pharmacy and the results of the travel survey be reported to the Committee.		**Ongoing** **February 2018**
85.	**Finance and Performance Report November 2017**	**L Robin**	Data regarding childhood immunisations be included within future reports.	This data is available quarterly and will be included in the report when released.	**Completed**

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
85.	**Finance and Performance Report November 2017**	**L Robin**	Clarification of the tables within the risk register sought.	A briefing note to Members is being prepared.	**Ongoing** **March 2018**

Agenda Item No: 4

NON-EMERGENCY PATIENT TRANSPORT (NEPT) SERVICE PERFORMANCE – SIX MONTH UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	
From:	**Chief Executive or Executive/Corporate Director**
Electoral division(s):	***ALL***
Forward Plan ref:	**Not applicable**
Purpose:	**The Committee is being asked to note performance of the Non Emergency Patient Transport Service**
Recommendation:	**To note the contents of the report**

	Officer contact:		***Member contact:***
Name:	Kyle Cliff	Name:	Councillor Peter Hudson
Post:	Associate Director, Commissioning & Contracting	Chairman:	Health Committee
Email:	kyle.cliff@nhs.net	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01733 847376	Tel:	01223 706398

1. BACKGROUND

1.1 The CCG has a responsibility to provide access to transport for treatment of health conditions for patients who meet our Non Emergency Patient Transport (NEPTS) eligibility criteria.

1.2 The CCG is responsible for commissioning a service that covers the whole of the CCG population. Eligibility is based on need and covers healthcare patients who are unable to use public or other transport due to their medical condition.

1.3 The CCG awarded a new Non Emergency Patient Transport contract to the East of England Ambulance NHS Trust (EEAST) on 22 March 2016 with the service commencing on the 1st of September.

1.4 As a provider, East of England Ambulance NHS Trust (EEAST) provides 24 hour, 365 days a year accident and emergency services to those in need of emergency medical treatment and transport in - Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire. As well as the Emergency service EEAST provides non-emergency patient transport services in Cambridgeshire, Great Yarmouth and Waveney, north, south and west Essex and Suffolk.

1.5 To put the scale of the organisation in context EEAST received 1,140,394 emergency calls and handled 531,614 non-emergency patient journeys in 2016/17. They have a large infrastructure and footprint covering:

- 324 front line ambulances
- 202 marked response cars
- 175 non-emergency ambulances (PTS and HCRTs vehicles)
- 46 HART/major incident/resilience vehicles
- more than 130 sites
- three emergency operations centres (EOCs) (Bedford, Chelmsford and Norwich)
- more than 4,000 staff and more than 1,500 volunteers.

1.6 This infrastructure and experience makes EEAST well placed to deliver the NEPTS service for our population. As a core NHS provider EEAST are a key member of the local health system promoting joint collaboration across all partners to develop the service model over the 5-year life of the contract.

1.7 The Cambridge and Peterborough NEPTS service is there to provide a high quality service for patients which is safe, effective and flexible and gives people fair access to vital health services. The core aims of the service is to provide patients with:

- a timely, comfortable service, suitable for their needs
- professional care, delivered with dignity and empathy
- travel in well equipped vehicles benefiting from the latest technology
- a journey that is no longer than necessary
- information about their booking including reminders and updates
- a listening and responsive service
- assistance to their clinic
- return transport to their own home.

1.8 The Committee received a report in July 2017 on progress with mobilisation of the service and was asked to note performance against the contract, emerging issues and planned actions.

2. MAIN ISSUES

2.1 The table below show the performance against key standards April to October which is representative of how the service has performed before the agreement of an action plan with EEAST. A number of actions went live from November and while there is still a lot more to do the changes in the first month's data is encouraging.

2.2 EEAST have agreed with the CCG and acute providers an action plan to deliver further improvements against the performance measurements in the contract and ultimately to improve the timeliness and experience of the service for patients. The trajectory builds on the performance in November to achievement of the full standards by May 2018.

		Target	YTD April - Oct 17	Nov 17 following changes	Percentage change/
KPI 102	Patients will arrive no later than their appointment time. Patients can arrive earlier than their appointment time.	90%	66%	70%	4%
KPI 103	Where patients are late for their appointment, no patients will arrive later than 30 minutes after their appointment time.	90%	60%	62%	2%
KPI 107	Outpatients shall be collected within 60 minutes of requested transport zone/time	90%	59%	73%	14%
KPI 108	Outpatients shall be collected within 90 minutes of requested transport zone/time	100%	83%	86%	3%
KPI 109	Booked Discharges shall be collected within 90 minutes of booked collection time	90%	39%	78%	39%
KPI 110	Booked Discharges shall be collected within 105 minutes of booked collection time	90%	66%	82%	16%
KPI 111	On the Day Discharges shall be collected within 90 minutes of requested transport zone/time	90%	70%	77%	7%
KPI 112	On the Day Discharges shall be collected within 105 minutes of requested transport zone/time	100%	79%	84%	5%

2.3 EEAST has worked with the CCG and acute hospital providers to agree actions to improve the NEPTS service. While the CCG commissions the service the interdependencies between EEAST and each hospital site is such that it is key for all parties to agree those actions as a system. Main areas of focus are:

2.3.1 Matching Capacity to resource. EEAST have worked with staff to match staff rotas to the pattern of demand for each hospital site. In flexing the times and which vehicles and crews are available at different times and sites, the service is flexing to demand and improving the drop off and pick up times for patients. While a lot of new rotas have now been put in place there is still further work to do with a number of staff consultations still in progress. This is due to be completed by the end of February 2018.

2.3.2 Improving discharge processes and handovers. EEAST have worked with each hospital site to reduce the number of aborted journeys. Developing and training staff so that the call centre has as much information available as possible about collections and discharges so that both hospital and transport teams don't cancel journeys due to the patient not being ready to be discharged or the wrong resource or vehicle being dispatched. This has released additional capacity in terms of better utilisation of vehicles and crews.

2.3.3 Removing perverse incentives from the contract. Working with EEAST the CCG and acute providers agreed that the reward and penalties associated with some of the Key Performance Indicators in the contract did not help deliver the improvements all parties were striving for. The KPI's have been jointly reviewed and agreed as a system so there is a common expectation of performance standards and how these relate to patients.

2.3.4 Resourcing and filling vacancies. Recruitment is a national issue and has a significant impact on the services performance. EEAST have continued to run a large scale recruitment campaign and training programme. Progress continues to be made with more drivers and call centre staff and there will now be a permanent co-ordinator based at each hospital site liaising between the hospital discharge teams and the transport control centre. EEAST have also continued to develop their extensive use of voluntary car drivers and are working with accredited private ambulance providers, particularly to cover out of area or longer journeys so as to maximise their own resource locally each day. Action on training and recruitment remain ongoing.

2.4 Conclusion

2.4.1 The CCG undertook a competitive tender process in order to let a new contract which offers parity of access for patients and replaced inequity of service and governance across a number of separate providers.

2.4.2 All key partners are signed up to a joint understanding of the purpose of NEPTS to deliver a high quality service for patients which is safe, effective and flexible and gives people fair access to health services.

2.4.3 EEAST are a key NHS provider with infrastructure and expertise to deliver the service. They are continuing to work with the CCG and acute providers to improve the timeliness of the service and an action plan and improvement trajectory has been agreed by the system. Early changes have shown an improvement in the key performance indicators for November and the agreed trajectory is to bring performance back in line with targets by May 2018.

Agenda Item No: 5

EAST OF ENGLAND AMBULANCE SERVICE

To:	**Health Committee**
Meeting Date:	**8 February 2018**
From:	**Kevin Brown, Director of Service Delivery & Paul Marshall, Interim Sector Head**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with an overview of the Service, the demand it is facing, its performance in Cambridgeshire and the issues affecting performance.**
Recommendation:	**The Committee is asked to review and comment on the report.**

	Officer contact:		***Member contacts:***
Name:	Daniel Snowdon	Names:	Councillor Peter Hudson
Post:	Democratic Services Officer	Post:	Chairman
Email:	Kate.Parker@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01480 379561	Tel:	01223 706398

1.0 INTRODUCTION

1.1 Members of the Health Committee agreed to invite representatives from East of England Ambulance Service Trust (EEAST) to attend the January meeting to scrutinise the organisations performance.

1.2 An overview of the current service provided by EEAST will be presented. The presentation will also focus on the demand the service is facing and the issues that are affecting the service's performance.

1.3 The presentation slides that will be shown at the Committee are attached at appendix A to this covering report.

Source Documents	Location
None	N/A

Cambridgeshire Health Overview and Scrutiny Committee

Kevin Brown – Director of Service Delivery
Paul Marshall – Int Sector Head

Introduction

- Who are we?
- What is our demand?
- Our performance in Cambridgeshire
- Issues affecting our performance
- How EEAST is caring for our sickest Patients
- ARP – single biggest change to the Ambulance service for decades
- Innovation

Who are we?

We're the East of England Ambulance Service NHS Trust (EEAST). We're one of ten ambulance trusts within England and have a clear and simple mission: "*To provide a safe and effective healthcare service to all of our communities in the east of England*"

Our role

We provide a wide range of emergency, urgent and non-emergency services spanning six counties and around six million people. From towns and cities to rural and coastal communities, we deliver safe and high-quality care wherever it is needed, from in-the-home support to journeys to hospital.

We're at the heart of the region's health and social care services. We work together with many partners - from healthcare commissioners to local authorities, patients and patient groups, national regulators to other 'blue light' services - to deliver safe and seamless support for patients.

Our vision

Our patients are paramount and the safety and quality of care will always be our focus. Our resources remain stretched. Pressure on wider health and social care support in our communities continues to increase.

We need to find new ways of delivering our services and help ease the strain across the health care system. Our staff are developing innovative services and ways of working to deliver the right care to patients, first time, every time.

Increasingly, this means helping to join up healthcare for patients. Making on-the-phone assessments and sign-posting callers to alternative sources of care (e.g. GPs) where appropriate. Delivering care in the home where this is best for patients. Making journeys to hospital only where this is required.

Our people

At the centre of all these efforts are our skilled, committed and compassionate staff and volunteers. They are the beating heart of our service. From admin roles to paramedics, transport planners to call handlers, every one of them helps us deliver the right care to patients.

We are united by a set of common values that guide the way we work with each other, partners and patients: care, teamwork, quality, respect, honesty.

Our future

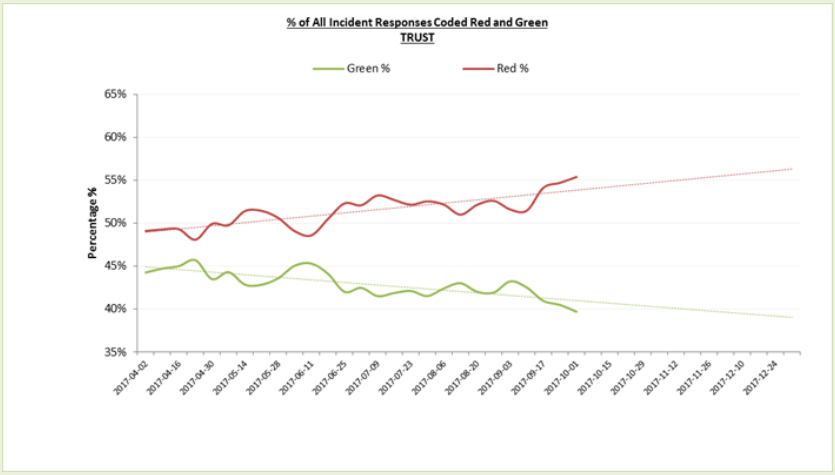
We see many opportunities for enhancing health and social care across this region. We're committed to playing our part in a changing NHS.

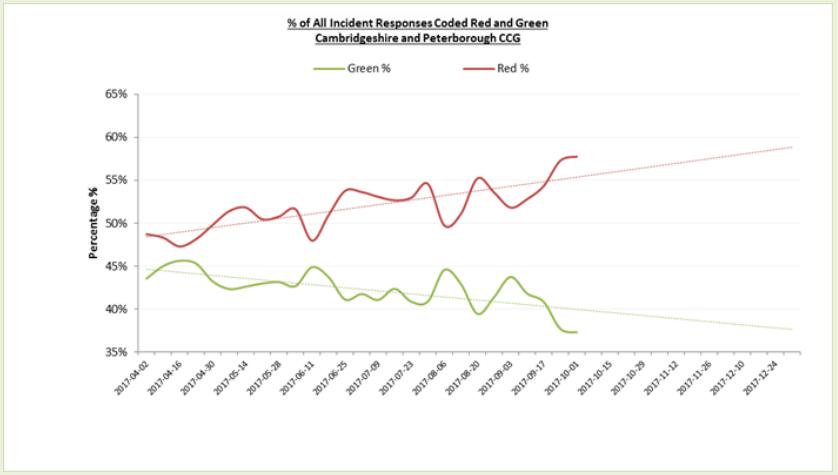
Demand

Activity

Demand on the ambulance services is increasing around 3.4% per year. Within this figure is a disproportionate rise in higher acuity callers meaning the services are required to respond to more patients in the shortest possible time.

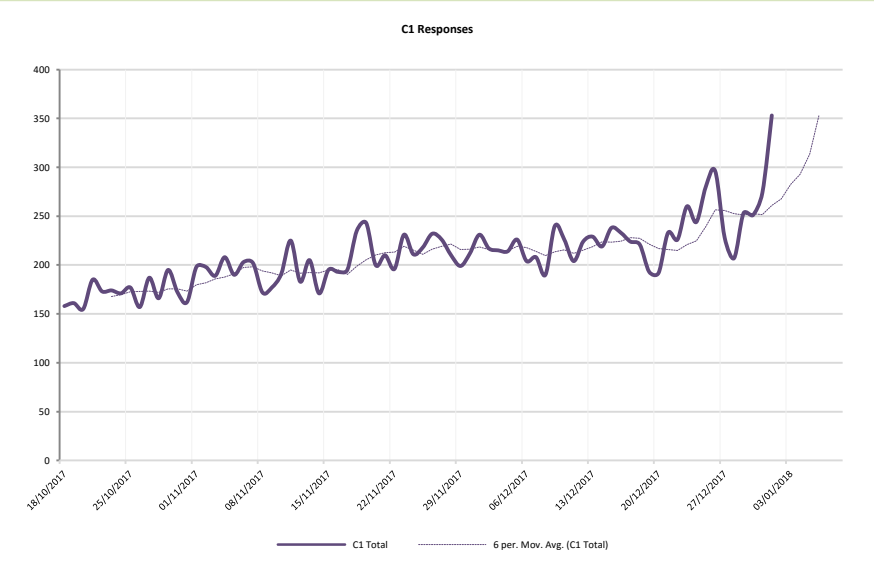
Prior to the change to the ARP standards higher acuity calls represented over 50% of all the 999 responses made. These call are usually more complex and take longer to assist patients.





Activity

Since the implementation of ARP, EEAST is already seeing an increase in Category1 calls – the most serious of calls. The proportion of these calls represents around 10% of all of our work, increased from the initial 8%.



Demand

Cambridgeshire activity We have experienced an increase in call volume every month except July when compared to 2016/17

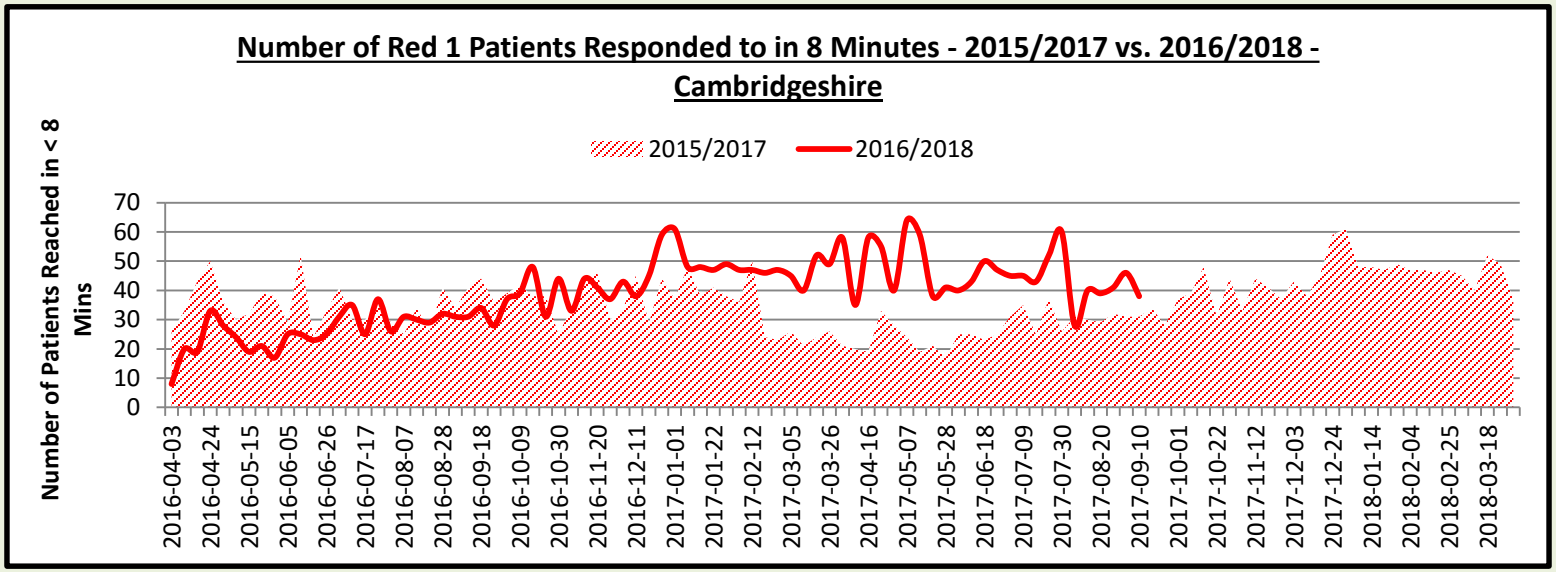
		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
Calls	2016	11,547	12,273	12,437	14,061	12,395	12,408	13,474	12,872	14,260	115,727
	2017	11,768	12,895	13,781	13,725	12,905	12,922	13,972	14,042	14,922	120,932
Conveyed	2016	5,736	6,214	6,128	6,428	5,962	6,155	6,395	6,203	6,651	55,872
	2017	5,968	6,188	6,007	5,999	5,814	5,734	6,204	6,093	6,443	54,450

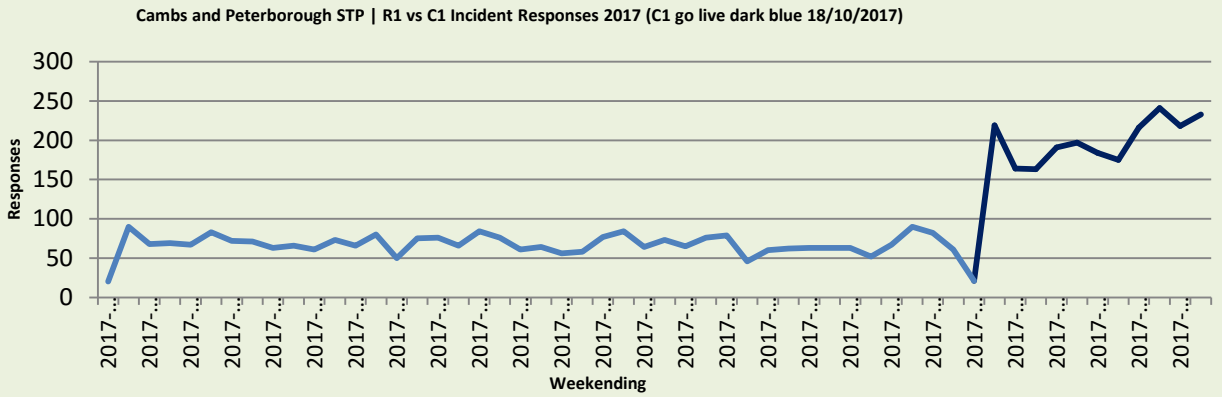
Yet are conveying less patients every month (since May) when compared to 2016/17

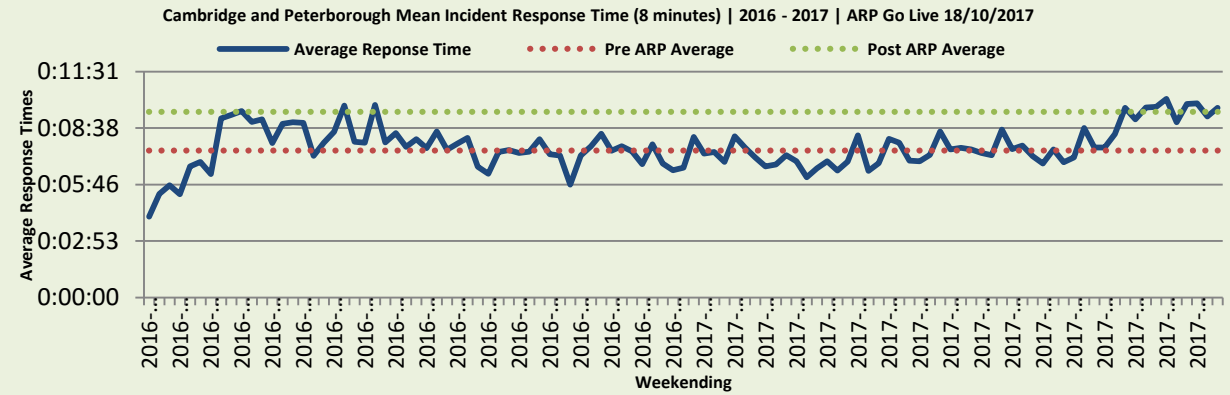
Top 5 codes Our top 5 codes has remained the same type of issue, with an increase in most.

Year	Breathing problems	Chest Pain	Falls	Sick Person	HCP admission
2016/17	7%	8%	13%	5%	7%
2017/18	10%	11%	15%	4%	10%

Although our ytd performance before ARP for our sickest patients was at 67%, we successfully responded to around 30% more patients within 8 minutes.




Cambs and Peterborough STP | R1 vs C1 Incident Responses 2017 (C1 go live dark blue 18/10/2017)
Responses
300
250
200
150
100
50
0
2017-...
Weekending

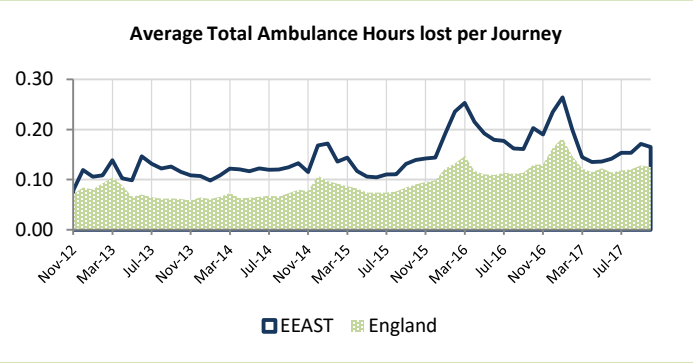

Cambridge and Peterborough Mean Incident Response Time (8 minutes) | 2016 - 2017 | ARP Go Live 18/10/2017
Average Reponse Time
Pre ARP Average
Post ARP Average
Average Response Times
0:11:31
0:08:38
0:05:46
0:02:53
0:00:00
2016-...
2017-...
Weekending

Issues affecting performance

East of England Ambulance Service NHS Trust

Handover Delays

As of November 2017 EEAST continues has the highest number of lost ambulance hours from hospital handover delays in England. This means that we are forced to 'stack' 999 callers who we are waiting to send ambulances to because they are waiting to offload their patients at hospitals. EEAST levels exceed every other service in England and have been higher than the national average for 5 years.



Capacity Gap

We have been working with Commissioners and Regulators on the assertion that EEAST has a significant capacity gap compared to the demand on the service and pressures such as hospital delays.

An independent service review (ISR) was commissioned by NHS England to independently recommend whether further funding to EEAST is required.

This report is due for release shortly but is expected to confirm that EEAST requires additional funding for several hundred more staffing positions in order to accommodate the growing pressure on the service.

Ambulance to Hospital Handover data

East of England Ambulance Service NHS Trust

Handover Delays

Cambridgeshire Hospitals compared to Trust wide (December 2017)

Hospital	Patient Journeys	No of Patient Handover Times	No. > 15min	% > 15min	No. > 30min	% > 30min	No. > 60min	% > 60min	No. > 75min	% > 75min
Addenbrookes Hospital	2878	2717	1208	44	184	7	31	1	8	0
Barnet General Hospital	589	464	294	63	120	26	35	8	27	6
Basildon & Thurrock Hospital	2710	2385	1621	68	476	20	134	6	83	3
Bedford Hospital South Wing	1660	1406	582	41	169	12	40	3	22	2
Broomfield Hospital	2724	2291	1885	82	790	34	245	11	156	7
Colchester General Hospital	2993	2634	2238	85	753	29	222	8	139	5
Hinchingbrooke Hospital	1047	910	691	76	268	29	95	10	55	6
Ipswich Hospital	2565	2346	1760	75	550	23	117	5	62	3
James Paget Hospital	2055	2005	895	45	178	9	81	4	65	3
Lister Hospital	2687	2074	1221	59	340	16	70	3	43	2
Luton And Dunstable Hospital	2669	1875	964	51	240	13	34	2	17	1
Norfolk & Norwich University Hospital	4335	3600	2843	79	1645	46	736	20	549	15
Peterborough City Hospital	2115	1603	1251	78	693	43	307	19	212	13
Princess Alexandra Hospital	1911	1668	1284	77	510	31	60	4	26	2
Queen Elizabeth Hospital	1905	1669	1382	83	654	39	311	19	229	14
Southend University Hospital	2822	2256	1496	66	700	31	271	12	188	8
Watford General Hospital	2460	1920	1575	82	578	30	176	9	115	6
West Suffolk Hospital	1930	1730	1334	77	470	27	92	5	52	3

Ambulance to Hospital handover data

East of England Ambulance Service NHS Trust

Handover Delays

Cambridgeshire Hospitals compared to Trust wide (2 week festive period)

Hospital	Patient Journeys	No of Patient Handover Times	No. > 15min	% > 15min	No. > 30min	% > 30min	No. > 60min	% > 60min	No. > 75min	% > 75min
Addenbrookes Hospital	1339	1263	666	53	138	11	34	3	12	1
Barnet General Hospital	254	206	136	66	68	33	24	12	21	10
Basildon & Thurrock Hospital	1201	963	623	65	196	20	78	8	59	6
Bedford Hospital South Wing	748	603	250	41	84	14	23	4	13	2
Broomfield Hospital	1196	900	757	84	391	43	177	20	130	14
Colchester General Hospital	1337	1095	943	86	399	36	149	14	106	10
Hinchingbrooke Hospital	481	427	343	80	152	36	62	15	37	9
Ipswich Hospital	1171	1048	797	76	295	28	106	10	68	6
James Paget Hospital	975	934	495	53	152	16	80	9	67	7
Lister Hospital	1241	940	665	71	251	27	71	8	41	4
Luton And Dunstable Hospital	1246	829	484	58	162	20	39	5	26	3
Norfolk & Norwich University Hospital	1892	1207	1088	90	724	60	358	30	287	24
Peterborough City Hospital	934	658	526	80	305	46	148	22	113	17
Princess Alexandra Hospital	856	775	597	77	229	30	33	4	12	2
Queen Elizabeth Hospital	873	721	608	84	334	46	170	24	134	19
Southend University Hospital	1265	904	640	71	353	39	153	17	109	12
Watford General Hospital	1096	822	685	83	278	34	113	14	85	10
West Suffolk Hospital	900	769	599	78	234	30	56	7	26	3

1 Return of Spontaneous Circulation (ROSC) Following a cardiac arrest, the Return of Spontaneous Circulation (ROSC) (for example, signs of breathing, coughing, or movement and a palpable pulse or a measurable blood pressure) is a main objective for all out-of-hospital cardiac arrests, and can be achieved through immediate and effective treatment at the scene.

all

national average 31%

35%

ulstein

53%

71%

The return of spontaneous circulation is calculated for two patient groups. The overall rate measures the overall effectiveness of the urgent and emergency care system in managing care for all out-of-hospital cardiac arrests. The rate for the 'Utstein comparator group' provides a more comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival. For example, 999 calls where the arrest was not witnessed, and the patient may have gone into arrest several hours before the 999 call are included in the figures for all patients, but are excluded from the Utstein comparator group figure.

NHS England AQI – Clinical outcomes (published Dec 2017)

Patient care

2 Survival to Discharge following cardiac arrest Number of patients who had resuscitation commenced/continued by ambulance service following an out-of-hospital cardiac arrest, who were discharged from hospital alive

all

national average 10%

13%

Ulstein

29%

45%

NHS England AQI – Clinical outcomes (published Dec 2017)

3 Outcome from acute ST-elevation myocardial infarction Heart attack or ST segment elevation myocardial infarction, (STEMI) is caused by a prolonged period of blocked blood supply. It is therefore vital that blood flow is quickly restored through clinical interventions such as thrombolytic ("clot-busting") treatment or primary percutaneous coronary intervention.

within 150 minutes

national average 82%

87%

received appropriate care bundle

76%

91%

NHS England AQI – Clinical outcomes (published Dec 2017)

4 Outcome from Stroke As set out in the NICE national quality standard, the health outcomes of patients can be improved by recognising the symptoms of a stroke or transient ischaemic attack (TIA), making a diagnosis quickly, and early transport of a patient to a stroke centre capable of conducting further definitive care including brain scans and thrombolysis.

within 60 minutes

national average 55%

50%

received appropriate care bundle

97%

100%

NHS England AQI – Clinical outcomes (published Dec 2017)

Following the largest clinical ambulance trials in the world, NHS England implemented new ambulance standards across the country known as the *Ambulance Response Program (ARP)*.

In a letter to Jeremy Hunt, Secretary of State for Health, Sir Bruce Keogh outlined why the results from the trial demonstrate that changes should be adopted nationally. The new system updated a decades old system that addresses the issue that most aspects of UK ambulance services have changed beyond recognition:

- a large number of responses now focus on the frail elderly rather than traditional medical emergencies,
- half of all calls are now resolved by paramedics without the need to take patients to hospital,
- for specialist care the focus of the ambulance service is increasingly on getting patients to the *right* hospital rather than simply the nearest.

Over the last four decades, however, ambulance services have had to remain organised around an eight minute response time target.

In its 18 month trial phase, the ARP covered over 14 million calls, testing a new operating model and new set of targets. In summary this new system would:

1. Change the **dispatch model** of the ambulance service, giving staff slightly more time to identify patients' needs and allowing quicker identification of urgent conditions.
2. Introduce new target **response times** which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile, so every response is counted.
3. Change the **rules around what "stops the clock"**, so targets can only be met by doing the right thing for the patient.

ARP is in 2 phases; phase 1 below relates to EOC process and phase 2 involves changes to the categories (code sets) that ambulance service triage 999 callers into.

In October 2016, EEAST joined a national pilot for phase 1 that aims to give patients a more clinically appropriate response to people who call 999 for help, implementing the following:

- **Dispatch on Disposition** (DOD): Where a maximum clock start of 240 seconds for all calls except predicted or confirmed Red 1s (where we continue to dispatch as soon as possible). The additional time to triage 999 calls (compared to the previous 60 seconds) means they can be more appropriately resourced "first time" as it gives more time to find out the clinical need of the patient. New deployment guidelines were also introduced in line with this change to clock start for Red 2 and Green calls.

- **Changes to the opening call taking process for 999** calls to "predict" Red 1 calls before full coding:
  - New "pre-triage questions" (PTQ) opening the call to assist with immediate identification of patients that are not breathing or have a potential airway problem.
  - Introduction of the **Nature of Call (NoC)** which allow selection of "key words" (for example "choking") based on the initial description of the problem by the caller. These key words cover the most likely conditions to result in a Red 1 and Red 2 coded call.

Phase 2 saw ambulance services move from having 6 triage codes (Red1,2 Green 1-4) to 4 that are outlined on the next slide:

Cat 1: Immediately Life Threatening

Response Time Standard:
Mean response time ≤ 7 Minutes
90th percentile ≤ 15 Minutes
Clock start Triggers the earliest of:

- The call is coded
- The first resource is assigned
- 30 seconds from call connect

Clock stop by:

- Trust resource arriving on scene including PAS/VAS deployed by Trust
- CFR, Co Responder
- HCP with a defib next to the patient

Cat 2: Emergency

Response Time Standard:
Mean response time ≤ 18 Minutes
90th percentile ≤ 40Minutes
Clock start Triggers the earliest of:

- The call is coded
- The first resource is assigned
- 240 seconds from call connect

Clock stop by:
If a patient is transported by an emergency vehicle, only the arrival of the
transporting vehicle counts. If the patient does not need transport the first response arrives at the scene of the incident.

Cat 3: Urgent

Response Time Standard:
90th percentile ≤ 120 minutes
Clock start Triggers the earliest of:

- The call is coded
- The first resource is assigned
- 240 seconds from call connect

Clock stop by:
If a patient is transported by an emergency vehicle, only the arrival of the *transporting vehicle* counts. If the patient does not need transport the first
response arrives at the scene of the incident.

Cat 4: Less Urgent

Response Time Standard:
90th percentile ≤ 180 minutes
Clock start Triggers the earliest of:

- The call is coded
- The first resource is assigned
- 240 seconds from call connect

Clock stop by:
If a patient is transported by an emergency vehicle, only the arrival of the *transporting vehicle* counts.

Innovation and the wider system

We continually look to improve patient care and patient outcomes, often through innovative schemes or pathways.

Currently in Cambridgeshire:

- We are providing Hospital Ambulance Liaison Officers at both Addenbrookes and Peterborough City Hospital
- We have introduced a Patient Safety Intervention Team to work closely with the Hospitals to keep patient safety as the highest priority whilst working to release our queuing Ambulances to respond to those patients in the community who are at risk
- We are providing an Urgent Vehicle; a dedicated response for the increased HCP demand
- We are in talks with commissioners to provide an Early Intervention Vehicle (EIV) to respond to the many elderly fallers in a collaborative and integrated way.
- We are discussing with Cambridgeshire Fire and Rescue Service to provide a joint response to the elderly non-injury fallers in the community, where EEAST will provide a clinical oversight and CFRS will provide a community Fire safety check.
- We are exploring a possible collaboration with First Response Service to provide a joint emergency Mental Health response service. (slide 19)

Mental Health Response Vehicle (MHRV) – TRIAL

Through combining the expertise of the Mental Health Practitioner and the Paramedic the MHRV will provide a bio-psycho-social assessment allowing the identification and differential diagnosis of mental health presentations and needs, and/or physical health presentations and needs, with the provision of immediate medical intervention at the scene. Rapid treatment and intervention will be provided to reduce risks and vulnerabilities which may have contributed to the need for an emergency response. Via triage and partnership working on scene, the Mental Health Response Vehicle will contribute to more effective use of acute services (ED, MHA Assessment, Crisis and Home Treatment Team). Through signposting and referral into follow-up care pathways patients will be directed to appropriate interventions in the right setting for longer-term support.

The MHRV will be managed by EEAST and requests will come directly from a 999 call, from either EOC or First Response Service (CPFT). As the model develops, the team will also respond to calls from existing Mental Health Services, GPs and other front line emergency services already on scene with patients.

System engagement

EEAST continually work with system partners through external groups and meetings such as:

- Health & Care Exec
- System Delivery Board
- Clinical Advisory Group
- Joint Strategic Operability Board
- Cambridgeshire & Peterborough Local Resilience Forum
- Urgent & Emergency Care Delivery group
- A&E Delivery Boards
- JET steering group

To provide a collaborative approach to delivering the best possible health and care to the communities of Cambridgeshire and Peterborough

Our biggest challenges

- Historical under funding and investment with more demand and unmatched funding
- Loss of ambulance capacity with delayed handover at hospitals locally and regionally. This displaces resources, introduces long distance travelling and longer waiting times
- Demand increases on 999

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Revised 16th January 2018	Cambridgeshire County Council

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. Additional information about confidential items is given at the foot of this document.

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
15/03/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	02/03/18	06/03/18
	Procurement of Drug & Alcohol Services	Val Thomas	2018/009		
	Child and Adolescent Mental Health Services		Not applicable		
	Integrated Children's Commissioning		Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update (GP Provision – follow up from development session?)	Catherine Pollard	Not applicable		
	Scrutiny Item: NHS England Dentistry		Not applicable		
	Scrutiny Item: NHS Quality Accounts delegated authority	Kate Parker	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[19/04/18] Provisional meeting				*06/04/18*	*10/04/18*
17/05/18	Notification of Chairman/woman and Vice-Chairman/woman	Daniel Snowdon	Not applicable	04/05/18	08/05/18
	Co-option of District non-voting Members	Daniel Snowdon	Not applicable		
	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: NHS Quality Accounts (Final Report)	Kate Parker	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Catherine Pollard	Not applicable		
	Scrutiny Item: CCG Financial Position 2018-19		Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[14/06/18] Provisional meeting					
12/07/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: Eating Disorder Service Update.	Tracy Dowling.	Not applicable.		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[09/08/18] Provisional meeting					
	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
13/09/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
11/10/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
08/11/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
06/12/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
17/01/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[07/02/19] Provisional meeting					

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
14/03/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[11/04/19] Provisional meeting					
23/05/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		

Notice made under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 in compliance with Regulation 5(7)

Decisions to be made in private as a matter of urgency in compliance with Regulation 5(6)

1. At least 28 clear days before a private meeting of a decision-making body, public notice must be given which must include a statement of reasons for the meeting to be held in private.
2. At least 5 clear days before a private meeting of a decision-making body, further public notice must be given which must include a statement of reasons for the meeting to be held in private, details of any representations received by the decision-making body about why the meeting should be open to the public and a statement of the Council's response to such representations.
3. Where the date by which a meeting must be held makes compliance with the above requirements impracticable, the meeting may only be held in private where the decision-making body has obtained agreement from the Chairman of the Council.
4. Compliance with the requirements for the giving of public notice has been impracticable in relation to the business detailed below.

Forward plan reference	Intended date of decision	Matter in respect of which the decision is to be made	Decision maker	List of documents to be submitted to the decision maker	Reason for the meeting to be held in private
…/…	[Insert Committee date here]		[Insert Committee name here]	Report of … Director	The decision is an exempt item within the meaning of paragraph … of Schedule 12A of the Local Government Act 1972 as it refers to information ….

5. The Chairman of the Council has agreed that the Committee may hold a private meeting to consider the business referred to in paragraph 4 above because the meeting is urgent and cannot reasonably be deferred for the reasons stated below.

Date of Chairman's agreement	Matter in respect of which the decision is to be made	Reasons why meeting urgent and cannot reasonably be deferred

For further information, please contact Quentin Baker on 01223 727961 or Quentin.Baker@cambridgeshire.gov.uk