HEALTH COMMITTEE: MINUTES

Date: Thursday 16th March 2017

Time: 2.00pm to 5.25pm

Present: Councillors L Dupre, L Harford, P Hudson, D Jenkins (Chairman), G Kenney, R Mandley (substituting for Cllr Clapp), T Orgee (Vice-Chairman), M Smith, P Topping, A Walsh (substituting for Cllr Moghadas) and S van de Ven
District Councillors M Abbott (Cambridge City), S Ellington (South Cambridgeshire), J Tavener (Huntingdonshire)

Apologies: County Councillor P Clapp
District Councillor M Cornwell (Fenland)

Also in attendance: Councillor J Scutt

307. DECLARATIONS OF INTEREST

There were no declarations of interest.

308. MINUTES – 12 JANUARY 2017 AND ACTION LOG

The minutes of the meeting held on 12th January 2017 were agreed as a correct record and signed by the Chairman.

One member observed that the way in which the minutes were written, while giving an accurate summary of the proceedings, risked misrepresenting the detail of speakers' contributions. One contributor to the Sustainability and Transformation Plan (STP) item had been attacked on social media for his alleged remarks at the last meeting, but the minutes had not provided him with any means of refuting the allegation. She suggested that consideration should be given to filming interviews and discussions on the STP. The Chair agreed that the matter should be looked into, and possibly referred to the Constitution and Ethics Committee. **Action required**

Members noted the Action Log. Jessica Bawden, Director of Corporate Affairs at Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), apologised for the delay in providing the information requested (copies of the publicity material being used for the Cambridge GP Out of Hours Service and Emergency Department Co-location consultation, and information on how the money raised by car-parking charges was spent); she undertook to arrange for it to be supplied.

The Chairman expressed concern at the length of time that some actions had been outstanding, pointing out the importance of the issue of staff retention in neighbourhood teams and the Joint Emergency Team (JET).

The Action Log and oral updates were noted.

309. PETITIONS

The Committee was advised that one petition had been received, related to the consultation on a future model for an Integrated Out of Hours base; it would be considered at the start of that agenda item [minute 312 refers].

310. FINANCE AND PERFORMANCE REPORT – JANUARY 2017

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of January 2017. Members noted that there had been a planned drawdown from reserves, and that a forecast underspend had been identified across Public Health budgets for 2016-17.

Discussing the report, members

- were advised that the underspends were largely fortuitous; there was no indication that the Public Health directorate was failing to do that which it ought to have done

- asked about measures to engage with workplaces in Fenland to encourage them to enable workers to attend health checks. Members noted that the question was of ongoing concern and had been discussed by Health Spokes; the Director of Public Health was due to attend a meeting of the District Council's Senior Management Team. Public Health had engaged with about 100 workplaces in Fenland; the remainder of the county was largely achieving the workplace health checks target

- enquired why the status of the health visiting mandated antenatal check continued to be amber rather than red, given the decline in performance in recent months. It was confirmed that the rating related to year-to-date actual performance, and that performance in the current month was quite significantly below target

- asked why there had been such a steep drop in the number of young people seen by the school nursing service. The Director of Public Health said that she would seek an explanation; the figures came from the same source as the health visiting figures **Action required**

- commented that there was an unhelpful mixture of percentages and numbers in the information supplied in the second half of report appendix 6, on performance. Officers advised that they were very aware that the format of the table was not ideal, and discussions were being held on how to present the information in a more easily understood dashboard format.

Councillor Hudson described his own experience of making beneficial lifestyle changes following a health check, asking what could be done to bring the importance of health checks to residents' notice. He had told his local parish councils and had an article included in the parish magazine; he agreed that Public Health officers could make use of him to assist in spreading the message, for example as a champion.

The Chairman said that the Committee should start to think about how it communicated what people should be doing for their health; putting articles in district magazines and local newsletters was suggested as one method, including case studies to convey the message. The Chairman said that Spokes should be asked to consider the matter. **Action required**

Having reviewed and commented on the report, the Committee resolved to note its contents.

311. PROPOSAL TO TRANSFER THE IN HOUSE STOP SMOKING SERVICES TO AN EXTERNAL PROVIDER

The Committee received a report seeking its approval for the proposal to transfer the in house Stop Smoking Service to an external provider, Everyone Health, the integrated lifestyle service provider that was currently commissioned by the Council to provide other lifestyle services. Members noted that the existing contracts with GPs and pharmacies to deliver stop smoking support would not be affected; the commissioning of these services would stay within the Local Authority.

The Committee was advised that the January Spokes had received a briefing on performance of the current Integrated Lifestyles provider, and the contractual mechanisms to ensure best value, in line with the Committee's decision when it had last considered the matter in December 2016. The transfer would bring the behaviour change services together, making them more accessible for clients; it would also fit with the national focus on local authorities becoming robust commissioning organisations.

In response to questions, members noted that staff would be set up in the new service at the outset, but would continue to operate as a separate team in the first year so that the service could continue with its established model and retain the Camquit brand. The initial saving anticipated was £50k.

It was resolved unanimously to approve the following key elements found in the proposal

a) To contract with an external provider the in house core Stop Smoking Service that is currently part of the Public Health Directorate
b) To integrate the Stop Smoking Service into lifestyle services.
c) To support the procurement approach of transferring the Stop Smoking Service to Everyone Health, the Integrated Lifestyle Service provider currently commissioned by Cambridgeshire County Council.
d) That the Health Committee delegate authority to the Director of Public Health in consultation with the Chair and Vice Chair of the Health Committee to award the contract to Everyone Health, the Integrated Lifestyle Service provider, subject to a successful outcome of the Voluntary Transparency Notice

312. REPORT ON THE CONSULTATION ON A FUTURE MODEL FOR AN INTEGRATED OUT OF HOURS BASE AT CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (ADDENBROOKE'S)

The Committee received a report updating it on the Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG's) recent consultation on moving the current GP Out of Hours (OOH) base from Chesterton Medical Centre to the integrated Clinic 9 at Cambridge University Hospitals NHS Foundation Trust (CUHFT, Addenbrooke's).

In attendance to give a presentation and respond to questions and comments were:

- from the CCG
    - Dr Andrew Anderson, GP lead
    - Jessica Bawden, Director of Corporate Affairs
    - Tracy Dowling, Chief Officer
    - Ian Weller, Head of Transformation and Delivery, Urgent & Emergency Care
- from Addenbrooke's
    - Sandra Myers, Director of Integrated Care
    - David Monk, Operations Manager, Emergency Department

Kelley Green spoke to present a petition with 55 signatures, 'Save the Chesterton Out of Hours Urgent Care. We call on the County Council Health Committee, as a consultee for the Cambridgeshire and Peterborough Clinical Commissioning Group proposal to close the Out of Hours Urgent Care at Chesterton Medical Centre, Union Lane, to object to this proposal. Relocating the service to Addenbrooke's will seriously affect the health and access to care for people in some of the most deprived wards in Cambridge who often don't have access to affordable transport.'

Ms Green also gave CCG officers present an additional 203 signatures towards the petition already submitted to the CCG on the same subject. Points she raised in support of the petition to the Committee included:

- the way in which the health inequalities impact assessment had been completed did not conform with good practice
- residents of the CB4 area were the most frequent users of the service
- no analysis had been undertaken of the impact on people outside Cambridge
- the impact assessment's statement that the change would have no impact was not quantified
- the advantages of co-location with the Accident and Emergency (A&E) department had been over-emphasised.

In answer to members' questions, Ms Green further said that

- there were adequate GP services in the Chesterton area, but the proposal was to relocate the out of hours service; when local residents phoned 111 because they were ill at night, they were directed to Chesterton Medical Centre. The service was already in its present location because it was a poorer area, there was good parking available, and it was in pleasant surroundings. The growth of Cambridge and the opening of Cambridge North railway station were good reasons to keep the OOH service in its present location
- a petition had been presented to the Committee in addition to that presented to the CCG because, when at one of the public meetings campaigners had queried having such a short consultation period, during which there was no meeting of the Health Committee or of the Health and Wellbeing Board, they had been advised that the response from the Health Committee's March meeting would be taken into account.

Doug Whyte of Chesterton spoke to oppose the relocation, saying that

- a large proportion of residents within one and a half miles of the OOH centre were on or below the poverty line, many of whom were without their own transport
- within the same radius, there were many schools and three residential centres for the elderly, as well as many bungalows housing elderly and disabled people
- there were no buses to get the area's residents to Addenbrooke's in the early hours, whereas the present centre was within walking distance
- surveys and assessments of the centre by auditors or medical professionals had praised its efficiency and treatment of patients
- hospital A&E services were overcrowded and patients faced very long waits there; these problems would get much worse if the Chesterton centre closed
- residents of villages to the north of Cambridge would face a longer journey to the relocated OOH centre
- there would be an increase in ambulance call-outs resulting from the relocation
- the overall cost of relocation to the NHS and Addenbrooke's would be greater than that of leaving the OOH centre in Chesterton.

In answer to a member's question, Mr Whyte said that the Chesterton area was very densely populated, and the population was increasing.

Christopher Powell of Cottenham also spoke to oppose the relocation, saying that

- moving the centre to Addenbrooke's would do nothing to assist with meeting the four-hour wait target at A&E because the delays were caused by difficulty in moving patients out of A&E
- the move could increase the pressure on A&E as patients would be able to attend A&E and be referred directly to an OOH GP, bypassing the 111 service
- the Chesterton centre currently successfully treated 96% of those attending
- the CCG had quoted advice from the College of Emergency Medicine, but some of their documentation on the subject was contradictory; crowding in A&E departments was rarely caused by large numbers of patients who could be treated elsewhere
- the public consultation had lacked an equalities impact assessment, and had failed to consult the gypsy and traveller community.

Councillor Jocelynne Scutt, local member for West Chesterton, set out residents' concerns about the relocation, covering demographic issues, the consultation process, and the consultation documents. Her points included that

- residents around Woodhead Drive and Arbury Road were concerned about the lack of public transport to Addenbrooke's; express buses passed nearby but did not stop
- this part of Cambridge included its most deprived wards, with a significant proportion of social housing tenants
- relocation would further deprive the area's residents, for whom travel to Addenbrooke's would be far more expensive than to the present centre, which could be reached on foot
- some people would simply not go to the relocated OOH centre, which would cause greater problems for the NHS because patients would become more ill and require admission to hospital
- the consultation document, which used words such as 'perhaps' and 'maybe', lacked real evidence and did not supply adequate information on the proposed change
- any relocation would impact not only on north Cambridge, but also on the rest of Cambridge, and Addenbrooke's.

The Committee received a presentation [attached as Appendix 1a and 1b] from CCG officers, setting out the outcome of the consultation. Members noted that

- the biggest issue raised in the consultation had concerned access to the relocated service for people living near the Chesterton OOH base
- residents of other areas had supported the move, feeling that access would be easier for them
- the base provided a service for the whole of greater Cambridge
- as well as issues of traffic congestion and travel time, some respondents had asked whether the facilities in Clinic 9 would be as good as those at Chesterton
- the question had been raised of investing in the current service as an alternative to relocating it
- in line with issues already raised by speakers, questions had been asked about the impact assessments and consultation with the gypsy and traveller community; CCG officers advised that health impact and equality impact assessments had been drawn up in draft and were now being re-examined in the light of feedback, and updated to ensure that they were correct
- concerns were expressed about access to Addenbrooke's in the event of an outbreak of illness such as norovirus

- questions were asked as to whether the pharmacy would be open longer, and whether home visits would be available for those who could not or could not afford to get to Addenbrooke's. Members noted that the on-site pharmacy was a private business, which would need to agree to extend its hours, though the increased volume of work should strengthen the business case for doing so; no new arrangement could be entered into unless it was decided to relocate the OOH
- the maps [Appendix 1b] showed the number of face-to-face consultations at Chesterton OOH base over the course of two months, by postcode area. This base was used by about 13,000 people a year.

In the course of discussion, members

- noted that when a patient called 111, they were offered a choice between the OOH bases, of which there were five in Cambridgeshire, and one in Haverhill convenient for some people in the CB9 area; some of those choosing Chesterton would have a choice of perhaps 7 miles to one base and 10 miles to another

- commented that South Cambridgeshire was much larger than the area shown on the map; members needed the bigger picture, with context and numbers, to help them judge the situation

- noted that HUC [Herts Urgent Care] provided the OOH service for the whole of the CCG area, covering about 880,000 people

- pointed out that the online consultation had been set up in such a way that it was possible for one person to make more than one response

The Chairman identified the fundamental questions to be answered as:
  - was it a good consultation and could it have been done better
  - starting with a blank sheet of paper, would the OOH base be better located in Addenbrooke's or in Chesterton
  - although some current users would be disadvantaged if the base moved from Chesterton to Addenbrooke's, were the overall advantages sufficient to outweigh the disadvantages
  - if the move were to go ahead, what would the CCG be doing to mitigate the disadvantages.

In further discussion, members

- noted that a survey of those attending the Chesterton base between 14 February and 9 March showed that 94.1% of patients had travelled by car (72.2% driven by somebody else), 1.7% had walked, and nobody had got there by public transport

- suggested that the consultation had failed to supply sufficient information on issues such as transport; the consultation document had referred to patient postcodes, but had not provided any map, and had not given information on who was using the base at times when there was no public transport

- pointed out that the move had to meet four tests for significant service change; this was a significant change, particularly for people in Chesterton. The tests were
  - support for the proposals from the GP commissioners
  - strong public and patient engagement – the CCG had failed to demonstrate how this test had been met

    - clear clinical evidence base – this test had not been met. Some members had had a briefing at Addenbrooke's recently, but the information they received then had not been included in the consultation documents; it would have strengthened the case for the relocation if it had been included
    - consistency with the current and prospective need for patient choice – the OOH service base could have been made consistent with other services by having it close to A&E, but Addenbrooke's was a major regional resource, and not like other general hospitals

- stated that the four criteria for significant service change had not been met, and there was no proper basis on which to proceed with the relocation. The move could well represent a major improvement in the OOH service, but this had not been demonstrated, and the consultation had been presented in such a way that the service relocation appeared to be foregone conclusion

- in answer to why Addenbrooke's would be a better place for the OOH service than Chesterton, were advised by the CCG's GP lead that the Keogh Urgent and Emergency Care Review had urged that consideration be given to the co-location of services. Overcrowded A&E departments were not safe or pleasant for staff or patients; Mr Powell had been right to identify the problem of moving patients out of A&E as an issue

- noted that the present Clinic 9 GP service was quite small, but triaging work in A&E gave a basis for estimating how many patients could be diverted from A&E under the proposed new arrangements; there were not enough GPs available to staff OOH bases in two locations, and bringing them together in Clinic 9 would enable better use of GPs

- were informed that all CCGs and the chief executives of all acute hospitals had received a letter on 9 March 2017 from NHS England (NHSE) and NHS Improvement requiring every acute hospital to put front door GP streaming in place at all A&E departments, and promoting the co-location of OOH services

- asked whether the CCG accepted that many people would find it more difficult to access the relocated OOH service, and whether the advantages of the move outweighed this. The GP lead said that having GPs only on the Addenbrooke's site would avoid seriously ill people having to cross town to get to A&E; it was sometimes necessary to transfer patients, and waiting for an ambulance at Chesterton posed a clinical risk. He accepted what people said about access for those living near the Chesterton base, but nobody was using public transport to access OOH services in their present location; he asked whether the Council might be able to provide any help with public transport

- noted that a patient requiring a prescription out of hours in Chesterton had to make a car journey to the pharmacy on Newmarket Road, but there would be an on-site pharmacy open for extended hours at Addenbrooke's

- noted that it would be drop-off and disabled parking bays outside Clinic 9, that parking for outpatients at Addenbrooke's was capped at £3.50 a visit, and that the parking kiosk was staffed 24/7; in emergency, if somebody had no means of payment with them there was provision for paying later

- pointed out that the journey to Addenbrooke's would be far easier than to Chesterton for all the patients living south of the river; Melbourn residents were feeding back that this was a good move to a better location, with cheaper taxi fares to get there

- said that there were already signage and access issues at Addenbrooke's which needed to be tackled

- commented that Willingham division residents had welcomed the move, because Addenbrooke's would be easier to get to than Chesterton. Some of these residents were elderly or lacked cars or transport too, and had had to get to Chesterton for many years; they did however want the issues of parking and of pharmacy to be resolved before the move.

The CCG Chief Officer said that, should the relocation be agreed, an implementation group would be established, which would include users. She invited Councillors to be included in the group, so they could see for themselves what was being done to address the issues identified. Members noted that the degree of concern at wait times in A&E, and the national direction of co-locating GP services at A&E, meant that it would be difficult to delay taking the decision on relocating the Chesterton base; it was expected that the CCG Board would make its decision on 21 March.

In the course of further discussion, the Chairman said that he would like to see a project plan with full articulation and mitigation and a proper business case for the move. Members then went on to consider their response to the consultation document.

The Committee agreed by a majority in response to the consultation that

a) It accepted that it was best to locate the Out of Hours base alongside A&E at Addenbrooke's;

b) It noted that this would to some extent disadvantage some current users of the facility; and

c) It believed that the advantages of moving the service to Addenbrooke's outweighed these disadvantages; but

d) It was concerned that there was not a sufficient mitigation plan to address these disadvantages; and therefore

e) It called on the Clinical Commissioning Group to do more work to minimise the impact of the move on those current users who might be disadvantaged by it; and

f) It asked that the CCG develop a more comprehensive view of the impact of the proposed changes and review this and its proposed mitigation measures with the Health Committee at its June 2017 meeting

g) Furthermore the Committee, whilst noting that the CCG could have been clearer in the way that it explained the justification for the proposed change and its associated consequences, recognised the extent of the recent consultation.

313. AIR QUALITY IN CAMBRIDGESHIRE – IMPLICATIONS FOR POPULATION HEALTH

The Committee received a report setting out current concerns regarding air quality in Cambridgeshire and the opportunities locally to address poor air quality. The report gave a summary description of air quality and its effects on human health, including a snapshot of air pollution in the county, and national issues and guidance. Members noted that the Joint Strategic Needs Assessment (JSNA) was intended to provide the evidence, not an action plan. It pointed out the issues that required attention.

Linda Jones, a resident of Petersfield with an interest in public health, addressed the Committee. She welcomed the focus of the 2015 JSNA on Transport and Health, which had linked reduction of air pollution to active reducing inequalities in access to transport and a system-level approach. However, she was disappointed that the report did not seem to build on the JSNA's assessment; the report lacked evidence for some of its statements, such as for the impact of air pollution on premature mortality and for buses as the main source of air pollution from traffic. Ms Jones also said that the report did not suggest any ideas for switching to active travel, or suggest opportunities for reducing travel inequalities. She called on the County Council to build on the JSNA approach and tackle air pollution by tougher action that embedded health in all its policies.

The Chairman thanked Linda Jones for her helpful contribution to the meeting.

Discussing the report, members

- welcomed the report, pointing out that air quality was not just an urban issue but a growing problem in rural communities. For example, HGVs were travelling through villages on roads not built to accommodate them, giving rise to pollution, noise and vibration, many of the effects of which on health and sleep were not being measured

- expressed surprise that the Annual Status Report for East Cambridgeshire District Council had been signed off, in view of local problems such as a complete lack of measuring of particulates in the area, plans to build housing next to A roads with minimal screening from the road, and the expected increase in traffic on the A10 once the Ely bypass had opened.

  The Senior Public Health Manager, Environment and Planning advised that noise and vibration were outside the remit of the present report, but had been raised as a concern in East Cambridgeshire, where there had been feedback that particulate matter was not being measured. He routinely drew planners' attention to any planning application he became aware of that was near an air quality zone, and sought the advice of district air officers on such matters.

- expressed concern that the report's second recommendation (request that Director of Public Health draws this report to the attention of the Chairman/woman and Spokes for the Economy and Environment Committee and the Highways and Community Infrastructure Committee, with a recommendation that the Committees consider the potential impact on air quality as part of their decision making process) was not strong enough. Because there was no obvious financial figure attached to contributing to the number of deaths, there was a risk that air quality issues would be seen as less important than the need to build housing. Sufficient weight would not be given to the dangers to health unless the Council worked with its partners to

achieve such aims as reducing unsuitable traffic in villages, and measuring noise and pollution

- reported concern from other Policy and Service Committees that there was a lack of tools to implement the JSNA, and suggested that the present report should go to all these committees; even if they were unable to do anything, the report should be brought to their attention

- commented that there was a health-related dimension to nearly everything that local authorities did

- drew attention to the substantial reduction in miles travelled by refuse lorries following the recent reorganisation of bin rounds in Cambridge and South Cambridgeshire, and said that similarly, a better sequence of routes in parts of the county would allow social workers to travel between clients more efficiently; air quality considerations had implications for every area of the Council's work.

The Committee considered whether the second recommendation should be extended to all the Policy and Service Committees, and indeed to a wider range of bodies. With the agreement of the Committee, the Chairman proposed a revised wording to resolution b) to include all the Policy and Service Committees, and additional resolutions drawing the report to the attention of district councils, the City Deal and the Combined Authority, and requesting an update from the Director of Public Health in six months' time.

It was resolved unanimously to:

a) note and comment on the current air quality issues in Cambridgeshire, local opportunities/initiatives to improve air quality, and the NICE Draft National guidance;

b) request that Director of Public Health:
   i) draw this report to the attention of the Leader and Chief Executive of the Council and to the Chairmen/women of and Spokes for its Policy and Service Committees with a recommendation that the committees consider the potential impact on air quality as part of their decision-making process;
   ii) draw this report to the attention of the Chairmen/women and Chief Executives of the Greater Cambridge City Deal, the Cambridgeshire & Peterborough Combined Authority, Cambridgeshire's district councils and Cambridge City Council with a recommendation that they consider the potential impact on air quality as part of their decision-making process;
   iii) encourage the committees and bodies named in (i) and (ii) above to actively bring forward projects which will improve air quality; and

c) ask that the Director of Public Health report back to the Health Committee regarding the above within six months.

314. PRISM (NEW PRIMARY CARE SERVICE FOR MENTAL HEALTH) FIRST RESPONSE SERVICE (MH CRISIS SUPPORT SERVICE)

The Committee received an update report on two mental health services for the Cambridgeshire and Peterborough health system, PRISM and the First Response Service (FRS). Members noted that PRISM, accessed through GPs, was a service providing specialist mental health support for GP surgeries so that patients with mental ill health could access prompt advice and support, receive help in a community setting

and experience a more joined-up approach to care. Members of the public could access the FRS directly themselves by dialling 111 and selecting option 2 at the start of the call; they were then put straight through to the mental health team, bypassing the usual 111 triage process.

In attendance to present the report and respond to Members' questions and comments were representatives of the three bodies which were working together to deliver the projects in a joint approach:

- from Cambridgeshire County Council (CCC)
    - Fiona Davies, Interim Head of Mental Health
- from the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
    - Marek Zamborsky, CCG, Head of Commissioning and Contracting for Adult Mental Health and Learning Disabilities
- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
    - Dr Caroline Meiser-Stedman, consultant psychiatrist, clinical lead for the project
    - Manaan Kar-Ray, clinical director for the Adult and specialist directorate

Introducing the report, the clinical lead for the project said that the service, set up in September 2016, was receiving 300 calls a week from people in mental health crisis across the whole CCG area. 78% of calls were managed on the phone; the triage team had access to patients' records and if the team concluded that a caller did not need an urgent mental health assessment, it would do what it could to help them – often what was needed was somebody to listen. For patients who needed face-to-face support, an urgent psychiatric assessment could be arranged, followed by direct referral to CPFT services if required; there was also the Sanctuary, a place of refuge and support provided by MIND. Since the FRS started, there had been a reduction of 20% in attendances by patients in mental health crisis at the three hospital emergency departments across the CCG area, and a reduction in demand for ambulance and out of hours GP services. The service had funding secured for at least the next 12 months; funding was expected to continue in the longer term, but the service would need to demonstrate an ongoing reduction in mental health attendances at A&E.

The Clinical Director for the Adult and specialist directorate said that PRISM operated to support GP services during the working day. It was launched on a proof-of-concept basis in the Huntingdon and Fenland area in August 2016. The Advice and Referral Centre (ARC) had received 21,000 referrals from GPs in 2015-16, but only 5,000 of those were assessed by CPFT, and only 1,500 received active treatment; ARC was being seen by GPs as a hurdle to overcome to get help for their patients. PRISM worked directly with GP surgeries, and provided active treatment within 0 – 2 weeks instead of 8 – 12 weeks through ARC. Outcomes were so far positive, and the service would extend to cover the rest of Cambridgeshire and Peterborough over the next three months. PRISM teams were based round the older people's teams, aiming to bring physical and mental health services together; the success of the concept depended on including social care services.

The Interim Head of Mental Health said that social care staff had been transferred to CPFT under a Section 75 Partnership agreement, to ensure they were well embedded and in a good position to support PRISM and the FRS. She was responsible for seeing how the voluntary sector could be engaged to support PRISM, bringing the statutory and voluntary sectors together into one pathway. A key focus in the current year was providing employment support to help patients to access work. In her view, PRISM was

at the beginning of a really good innovative service which compared well with what was available elsewhere in the country.

In the course of discussion, members

- thanked the presenters warmly for the marvellous work being done, an example of all the services talking to each other and working together, putting the needs of the patient at the top of the list

- asked what was being done with local charities to help people work as volunteers as a step on the way to returning to employment. Members were advised that volunteering was being actively encouraged; Rachel Walsh of Cambridgeshire MIND was leading work on resilient communities, the Resilient Together project

- noted that a mental health worker was being established in the 999 incident room to provide support to the police

- in answer to a question about support for people who were homeless and had mental health problems, the clinical lead advised that the FRS team were building links with housing support workers, who could contact the team when they saw a person with deteriorating mental health. Members noted that there was also a lot of work being done on with housing support workers on mental health wards, and there were plans to review and recommission the homelessness services from April 2018

- noted that the 111 service was genuinely available on a 24/7 basis to people who were physically within the Cambridgeshire and Peterborough area, as measured by the phone signal; the PRISM service was due to cover the whole area over the next three months, and by 1 April 2018, the voluntary sector would be aligned too

- warmly welcomed the exciting work being done by all involved in both projects.

The Chairman congratulated the presenters on a good job well done, a credit to the CCG and all involved.

It was resolved to note the report.

315. CAMBRIDGESHIRE AND PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PLAN – WORKFORCE OVERVIEW

The Committee received a report from the Cambridgeshire and Peterborough Sustainability & Transformation Plan (STP) delivery programme (Fit for the Future) describing the workforce planning considerations within the STP. In attendance to present the report and respond to questions and comments were

- Lucy Dennis, Head of Workforce Partnership, Health Education England (HEE)
- Scott Haldane, Interim Programme Director, STP
- Matthew Winn, Chief Executive of Cambridgeshire Community Services NHS Trust (CCS) and Accountable Officer for the Workforce & Organisational Development STP working group.

Introducing the report, the Accountable Officer drew attention to the challenges it set out, particularly the future identification and development of nurses. With effect from September 2016, arrangements for nurses' training and their payment while training had changed, and some organisations locally had historically relied on recruiting nurses

from overseas. Each part of the county faced different pressures; housing was a major issue for staff in Cambridge and South Cambridgeshire, while in East Cambridgeshire and Fenland, access and transport to jobs were major concerns.

He went on to say that creating an integrated workforce was not easy, because people became used to working within their areas of specialism; it was necessary to persuade staff out of their siloes and into a way of working that was holistic and wrapped around the patient. For example, stroke services were being looked at differently, and were being delivered in one unit rather than four. In general, the workforce would follow once its members understood what the design of a service would be.

In discussion, members

- expressed concern that nurses were being expected to pay for their training, and asked whether anything logically could be said in favour of the new arrangements.

  The Accountable Officer's answer was yes and no. Until September 2016, because the educational element and bursaries for undergraduate nurse training had been paid for by the Government, the number of nurses being trained had been the number that could be afforded, rather than the number that was needed; this was why both the NHS and care homes looked abroad for staff to fill the shortfall. The local universities trained 350 nurses a year, and Cambridgeshire and Peterborough was doing better than some other areas; most of the children's mental health need had been supplied, though there was some concern about adult services.

  When a similar scheme to the new UK one had been introduced in Australia five years ago, there had been a dip in new trainees, followed by a substantial increase. Many local providers had been proactively marketing Cambridgeshire and Peterborough as good places to come for work and learning, and there were schemes whereby those who completed their Anglia Ruskin course satisfactorily were guaranteed employment in the area. Because trainee numbers were no longer capped, the number taking up places would not be known until the second week of September, once clearing had been completed

- noted that Addenbrooke's had a significant dependence on European Union workers from outside the UK, whereas Hinchingbrooke and Peterborough hospitals and CCS had less than 10% of non-UK employees; work was being done at Addenbrooke's to address this dependence. It was likely that providers would increasing grow their own workforce, for example by using the apprenticeship levy to train healthcare assistants, who often were already being embedded within their local communities

- on housing, noted that planning consent had been obtained to develop the Ida Darwin site, though in response to a staff survey, not very many had said that it would help them if some affordable key worker housing were provided; respondents were looking for other support in their jobs, such as training

- asked how far different health systems were co-operating with each other in developing their STPs, in the interests of not trying to reinvent solutions already devised elsewhere. The Accountable Officer said that he and the Head of Workforce Partnership had attended a session with chairs from elsewhere in the region, including for example Essex and Norfolk. Even if an idea were adopted from elsewhere, the work to implement it still had to be done locally; the different systems appeared to be working similarly because they were all facing the same pressures.

The Chairman asked that a working meeting between the STP team and the new Chairman/woman of the Committee be set up as soon as possible after the local government elections.

It was resolved to note the report.

316. CONSULTATION ON PROPOSED CHANGES TO THE FUTURE PROVISION OF SPECIALIST FERTILITY TREATMENT IN THE CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP AREA

At its meeting on 15 December 2016, he Committee had considered a report on the CCG's plans to conduct a consultation on its proposal to stop routinely commissioning any specialist fertility services other than for two specified exceptions. The Committee now received a report presenting the consultation document and inviting it to make a response to the consultation.

In attendance from the Cambridgeshire and Peterborough Clinical Commissioning Group to present the report and respond to members' questions and comments were

- Jessica Bawden, Director of Corporate Affairs
- Tracy Dowling, Chief Officer
- Dr Richard Spiers, Clinical Lead for Prescribing and Clinical Policies.

Members were reminded that the proposal had arisen as a response to the CCG's serious financial deficit; it was an area that the CCG would prefer not to have to consider, but budget requirements were such that it was necessary to examine rigorously what could and could not be funded in the CCG's present circumstances. The consultation had now started. The document had space for additional comment; attendees at the first public meeting had put forward various other ideas for savings.

Discussing the Committee's response, individual members

- acknowledged the need to set boundaries on NHS expenditure; it might be necessary to ask people to pay for IVF treatment as the price for getting the best cancer care

- suggested that, rather than the CCG picking services to cut, the approach used by the Oregon experiment should be tried, when the population had been asked what healthcare it did and did not want to fund

- expressed discomfort at cutting the service, so that only those who could afford to pay would receive any cycles of IVF

- said that IVF should not be regarded as an optional extra; there were links between infertility and mental ill health

- suggested that it might be more acceptable if there could be an element of means testing when requiring somebody to pay, and if the system could be sensitive to who could and could not handle the disappointment of not receiving the service. It was explained that neither means-testing nor co-payment were possible.

In further discussion, members noted that the CCG had not made this proposal without examining all other areas of its expenditure. IVF was a cost-effective intervention based on good data; once finances permitted, it would be one of the first interventions that had been reduced to be restored.

The Committee agreed in response to the consultation that

a) It recognised that this was an extremely difficult decision

b) It noted that specialist fertility treatment would be one of the first treatments to be restored once the CCG's financial position permitted

c) It was not in a position to make any recommendation for or against the proposed changes.

317. PROPOSED CONSULTATION ON A FUTURE MODEL FOR THE REFERRAL AND PROVISION OF NHS HEARING AIDS FOR ADULTS WITH MILD HEARING LOSS

The Committee received a report setting out the plan for conducting a consultation on proposals to stop providing NHS hearing aids for most people with mild hearing loss, and seeking members' comments on the planned consultation process and the draft consultation document. Members noted that the NHS would continue to provide testing or other non-hearing aid assistance to patients with mild hearing loss, and to provide hearing aids to patients in a number of specified groups, as well as to current patients needing replacement of NHS hearing aids they already had. The specified groups included all under 18 years old, those with dementia, and elderly patients at risk of falls, isolation and depression due to the hearing problem; these patients would continue to be provided with hearing aids even if their hearing loss was only mild.

In attendance from the Cambridgeshire and Peterborough Clinical Commissioning Group to present the report and respond to members' questions and comments were

- Jessica Bawden, Director of Corporate Affairs
- Dr Richard Spiers, Clinical Lead for Prescribing and Clinical Policies.

In response to questions, members noted that

- the cost of a hearing aid to the NHS was substantially less than the minimum cost of a private hearing aid, which was around £495; an NHS patient had no choice of hearing aid, whereas a private patient could choose the aid they preferred, though an NHS-provided aid would be no better or worse than 95% of those on the market

- hearing loss was defined on a World Health Organisation (WHO) scale based on the number of decibels lost; people with mild hearing loss experienced some difficulty hearing what was going on in a noisy environment, unless they were looking directly at the person speaking to them

- the national charity Action on Hearing Loss, and the local charity Cambridgeshire Hearing Health, had criticised proposals to restrict access to hearing aids on the grounds that the best evidence was not being used in making decisions to exclude particular groups from receiving hearing aids; Cambridgeshire and Peterborough CCG was not restricting the supply of hearing aids where there were high levels of concern on good evidence. For example, patients with dementia and mild hearing loss would continue to be eligible for NHS hearing aids, because of the importance of ease of understanding for patients and ease of communication for carers

- the CCG knew the number of people with hearing aids for mild hearing loss, but did not know how many of those people with mild loss fell into the categories eligible to continue to have NHS hearing aids

- in daily life, people with mild hearing loss but without hearing aids would not perceive any loss when in a quiet room, and would still be able to hear what was happening on stage in a theatre, but would find it difficult to hear against a background noise, for example when trying to converse with somebody at a party

- because hearing loss was principally age-related, people with a mild degree of loss were likely to go on to experience moderate loss as they got older, whether or not they had had hearing aids immediately following the diagnosis of mild loss

- examining the proposals against Action on Hearing Loss's list of points to check, the CCG had not found any major problem associated with the proposals for people with mild hearing loss

- there were no changes proposed to the provision of free hearing tests, or of assistive technologies such as amplified phones, or doorbells systems, or systems to modify TV sound

- the start date for the consultation had not yet been decided on, but was likely to be in May 2017 at the earliest

- the CCG was also looking at provision of hearing services across the whole of Cambridgeshire, and improving the contracting system to make it more efficient.

Examining the draft consultation document, members

- suggested that the layout should be tried out on ordinary people for its readability, to help get a good response to the consultation

- queried the impact that one more leaflet would have amongst the many already on display in the GP surgery. Members noted that a patient reference group was being established, and input would be sought from Cambridgeshire Hearing Health; the intention was to publicise the consultation as widely as possible, in places where people went

- urged that the layout be clearly organised, with one question to a page; long lists of bullet points and small typefaces should be avoided

- suggested that it would be helpful to explain what the alternative would be to the course of action proposed in the consultation document.

It was resolved unanimously:

> to approve the process for public consultation on a future model for the referral and provision of NHS hearing aids for adults.

As some members of the Committee were unable to stay until the end of the meeting, the Chairman proposed, and the Committee agreed, a change in the agenda running order. Agenda item 13, on NHS Quality Accounts, required the Committee to take a time-critical formal decision, so in case the meeting subsequently became inquorate, it was agreed to take item 13 before item 12, the working group update.

318. NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2016-17 REQUESTS

The Committee received a report inviting it to consider the process for responding to NHS Healthcare providers' requests for comment on their annual Quality Account reports, and to prioritise which providers' requests the Committee would respond to. Members noted the procedural difficulties posed by the timing of the requests in relation to the forthcoming local government elections and Committee meeting dates, and by the requirements of the committee system of governance and scrutiny regulations.

It was resolved unanimously:

a) to delegate approval of the responses to the Quality Accounts to the Head of Public Health Business Programmes acting in consultation with, and in accordance with the views of, members of the Committee (where a response was required before 4th May) or (for later response deadlines) such members of the present Committee as were still elected members of Council following the elections on 4th May.

b) to give priority to responding to Quality Accounts from Cambridge University Hospitals NHS Trust, Cambridgeshire and Peterborough NHS Foundation Trust, and Cambridgeshire Community Services NHS Trust

c) to request the Head of Public Health Programmes to consult the Chairman of the Peterborough City Council Health Scrutiny Committee about that Committee's plans for responding to any Quality Account from the new Northwest Anglia NHS Foundation Trust, given that Hinchingbrooke Health Care NHS Trust would cease to exist as a separate NHS Trust at the end of March 2017.

319. HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

The Committee received a report informing it of the recent activities and progress of the Committee's working groups. Members noted that it would be necessary to reconvene the Joint Health Scrutiny Committee – Collaboration of HHCT & PSHFT [Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford NHS Foundation Trust] in the new municipal year.

It was resolved unanimously to

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

2) Note the update from the Joint Health Scrutiny Committee – Collaboration of Hinchingbrooke Hospital with Peterborough & Stamford Hospital.

3) Agree to develop a programme of scrutiny of the Sustainable Transformation Programme after the local government elections in May 2017.

320. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan, noting that the reserve date of 13th April was to be used for a development session; this would look at child mental health and review the Committee's priorities for 2016-17.

It was resolved to note the training plan.

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

The Committee was advised that policy and service committees were being asked to agree a permanent delegation to allow the relevant Executive Director, in consultation with Spokes, to make appointments to outside bodies when the need arose between committee meetings to make an appointment promptly.

It was resolved unanimously

a) to delegate, on a permanent basis between meetings, the appointment of representatives to any outstanding outside bodies, groups, panels and partnership liaison and advisory groups, within the remit of the Health Committee, to the Director of Public Health in consultation with Health Spokes.

b) to note that no appointments were currently required.

322. HEALTH COMMITTEE AGENDA PLAN

The Committee considered its agenda plan and the changes to be made over forthcoming meetings, noting that it might become necessary to reduce the number of items identified for future meetings.

It was resolved unanimously

a) to note the revised agenda plan presented at the meeting

b) to authorise the Head of Public Health Programmes, in consultation with the Chairman and Vice-Chairman, to make such further revisions to the agenda plan as necessary to manage the workload for the incoming committee.

323. CONCLUDING REMARKS

The Chairman thanked members, particularly Councillor Orgee as Vice-Chairman, and officers for their work on and for the Health Committee. He said that it had been enjoyable and a privilege to have chaired the Committee for the past two years.

Chairman