HEALTH COMMITTEE: MINUTES

Date: Thursday 28th May 2015

Time: 2.00 p.m. to 5.15 p.m.

Present: Councillors D Jenkins (Chairman), P Ashcroft, P Clapp, A Dent, S Frost, P Hudson, T Orgee, P Sales, M Smith, M Tew, P Topping, S Van de Kerkhove, S van de Ven

District Councillors S Ellington (South Cambridgeshire) and R Mathews (Huntingdonshire)

116. NOTIFICATION OF CHAIRMAN AND VICE-CHAIRMAN

It was noted that the Council had appointed Councillor David Jenkins as the Chairman and Councillor Tony Orgee as the Vice-Chairman for the municipal year 2015-16.

117. CO-OPTION OF DISTRICT COUNCIL REPRESENTATIVES

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

- from Huntingdonshire District Council: Councillor Rita Mathews, substitute Councillor Deborah Reynolds
- from South Cambridgeshire District Council: Councillor Sue Ellington, substitute Councillor Andrew Fraser.

The Committee noted that nominations from Cambridge City Council, East Cambridgeshire District Council and Fenland District Council would follow.

118. MINUTES: 12th MARCH 2015 AND ACTION LOG

The minutes of the meeting held on 12th March 2015 were agreed as a correct record and signed by the Chairman.

The Action Log was noted. The Director of Public Health reported that the Co-chair of the Public Health Reference Group (PHRG) had reservations about the attendance of an observer from the Committee at meetings of PHRG because of the large number of organisations involved in the meetings. The Democratic Services Officer was asked to send the feedback report from PHRG to the Health and Wellbeing Board out again, to include new members of the Committee. **Action required**

119. PETITIONS

No petitions were received.

120. DECLARATIONS OF INTEREST

Councillor van de Kerkhove declared an interest in Agenda Item 13, Appendix 6 (minute 128) as a trustee of DHIVERSE.

121. UPDATE ON E-HOSPITAL ISSUES AT CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

The Committee received a report updating it on issues that had arisen since the implementation of Cambridge University Hospital NHS Foundation Trust's (CUHFT's) E-Hospital Programme (EPIC). Officers present to respond to members' questions and comments were Dr Afzal Chaudhry, Chief Medical Information Officer of CUHFT and from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Debbie Oades, Local Chief Officer for the Cambridge System, and Jessica Bawden, Director of Corporate Affairs.

Members raised concerns in relation to various issues and were advised that

- Potential Harm to patients

  All providers were required to report any incident that required investigation; CUHFT was one of the highest-reporting trusts in the country, and aimed to pursue and learn from every incident. Whether an incident should be attributed to EPIC or to other factors was difficult to determine; none had been found to be solely related to EPIC, but – as with incidents prior to the introduction of EPIC – had included factors such as workflow and misunderstandings.

  With the exception of one patient who was ill for other reasons, the usual process for incidents was being followed, with patients being talked to and receiving apologies. Any consideration of compensation would follow usual procedures.

- Post-acute care communications to other services

  80% of discharge summaries were now being completed promptly, 5% were being completed but not marked as such by doctors and so not sent, and 5% of patients attending did not require a discharge summary (for example, a pregnant woman coming into the delivery unit and found not to be in labour). Work was being undertaken with every clinical team on a daily basis to improve completion of summaries, and extra training sessions were being provided for junior doctors.

  Where a patient was transferring between hospitals, an in-patient transfer report should be completed and accompany the patient to the other hospital; it was not acceptable to prepare this report in transit in the ambulance.

- Outpatient capacity and administration

  Maxillofacial, dermatology, ophthalmology, ENT (ear, nose and throat) and cardiology clinics had long been regularly overbooked. Ophthalmology had nearly 2,000 patients on its waiting list at the time EPIC had started, and now had just over 2.000, but patient care was the first priority and patients would continue to be followed up as necessary. Patients who faced long waits to be seen by CUHFT had been offered referral elsewhere, but most had elected to continue waiting.

- Pathology services including GP Direct Access

  Membership of the assurance board included GPs from the CCG. In an effort to ensure that pathology reports reached the correct owner, work had been done

before Easter to ensure that all samples sent in had a delivery route for the results. Tests were now being processed for other geographical areas, and the volume of work had increased three-fold compared with the previous year. In the past, processes had grown up in a relatively organic fashion, with not all procedures being written down, and some of them being mutually contradictory. Feedback was needed from primary care providers.

- Staff training

  It was important to train staff whenever a new system was being implemented; in the case of EPIC, over 10,000 people had received training, and additionally refresher training was being offered and other ways of delivering training, such as online, were being explored. The training requirements for clinical staff had been calculated as for example 16 to 32 hours for nurses. The anecdotal evidence cited by a Councillor of nurses receiving only four hours' training could be due to the facts that not all staff attended all the training offered, and that nursing staff numbers were nearly 200 short of the establishment level at the time of training. The intention had been that all staff, including doctors, receive a minimum of 16 hours' training, and over 95% had attended all their required training. Plans were being made to train incoming staff, including the cohort of new doctors expected at the end of July.

- Overall experience of EPIC implementation

  CUHFT was the first trust in the UK to run EPIC, which was used by a large number of hospitals in the USA, including many academic healthcare institutions. EPIC had also been installed in hospitals in Canada, Holland and Singapore. CUHFT's experience of implementation was not dissimilar to that elsewhere. Time had been spent anglicising the EPIC system, not only changing the date format to UK convention but changing nearly 18,000 medical terms to correspond to British rather than American usage.

  The E-Hospital assurance group received a wide range of reports, and the SharePoint system recorded all incidents, so further information could be provided to the Committee if required. There were no plans to institute any new submodules of EPIC for the next two years; the system was designed to be self-evolving.

The Chairman asked the CCG to send their regular EPIC update reports to the Committee for information, and the Chief Medical Information Officer offered to provide another update in future.

It was resolved unanimously to note the update on E-Hospital issues at Cambridge University Hospitals NHS Foundation Trust.

122. BRIEFING PAPER ON DELAYED TRANSFERS OF CARE FOR THE CAMBRIDGE, HUNTINGDON AND PETERBOROUGH URGENT CARE SYSTEMS

The Committee received a report updating it on the position regarding Delayed Transfers of Care (DTOC) in Cambridgeshire and Peterborough. Members noted the key causes of DTOC for each urgent care system and the remedial actions that were being taken or planned, from the perspectives of both Health and of Social Care. In attendance from the CCG were Debbie Oades, Local Chief Officer for the Cambridge System, and Jessica Bawden, Director of Corporate Affairs. County Council officers

Jackie Galwey, Head of Operations: Older People's Service and Carol Bargewell, Operational Team Manager, based in Addenbrooke's, were also present to respond to members' questions and comments. Members noted that the biggest improvement in DTOC figures had been seen at Peterborough and Stamford Hospitals NHS Foundation Trust; other hospitals were learning from their experience.

In the course of discussion, members

- sought clarification on the point at which a transfer of care was classed as delayed. Officers advised that this occurred at the point when the clinical decision had been made that a patient was ready for discharge. A multi-disciplinary team would be looking at what else a patient needed in order to go home, and a physiotherapist and occupational therapist would see them as necessary to make arrangements. A member pointed out that the time required from a decision at a 10am ward round could automatically result in one day being needed to make arrangements, but members noted that the aim was to work in anticipation of discharge, so that everything was in place in good time

- enquired whether the rise in DTOC at Addenbrooke's from October to December had been the result of the introduction of EPIC. Members noted that there had been no problems with EPIC in this context

- noted that the process of discharge planning was under continuous review. For example, efforts were being made to promote more mobile working in the hospitals, with County Council staff using mobile technology, though wifi capability was a limiting factor in two hospitals

- pointed out that discharge late in the day meant that the bed space was lost for the day; it was necessary to ensure that medications were arranged quickly so that patients could leave the hospital

- noted that half the delays in Addenbrooke's related to patients from outside the immediate area; they had come to the hospital because of complex health issues, and their discharge needs were also complex. Work was being undertaken with neighbouring authorities to improve discharge arrangements

- noted that planning for discharge started as soon as it was known that a patient was likely to be discharged; if it proved impossible to source the care required (for example, a call by two carers required four times a day), then the counting of the delayed transfer would be paused. It was known that in some areas of the county it could be difficult to find carers, in which case alternative ways of providing care would be explored with the family, such as live-in or overnight care

- noted that there was a shortage of residential care, especially for people with dementia; work was being done with partners to increase capacity, but meanwhile some patients might be placed in Cambridge or Peterborough

- asked about the availability of national comparison figures. Members noted that the local position was slightly better than the national average, and asked to be supplied with national comparator figures. **Action required**

It was resolved unanimously to note the current position.

123. HINCHINGBROOKE HOSPITAL WIDER ISSUES

The Committee received a report setting out background information relating to Hinchingbrooke NHS HealthCare Trust (HHCT) Franchise arrangements. Officers from four organisations were in attendance:

- Cambridgeshire and Peterborough Clinical Commissioning Group
  - Rob Murphy, Local Chief Officer for the Hunts System
  - Jessica Bawden, Director of Corporate Affairs
- CircleHealth
  - Michael Watson, Chief Operating Officer
- Hinchingbrooke Health Care NHS Trust
  - Christopher Davison, Board Secretary, formerly Franchise Director
- Trust Development Authority (TDA)
  - Mark Cubbon, Portfolio Director
  - Dr April Brown, Deputy Clinical Quality Director.

Each organisation in turn gave answers to the four questions sent to them in advance:

1. What is the current financial situation of Hinchingbrooke Health Care NHS Trust?
2. Why were the financial problems identified at such a late stage?
3. What monitoring was previously in place?
4. What lessons have been learnt for all the organisations involved?

The Trust Development Authority had supplied a brief presentation (distributed to members at the meeting and attached to these minutes as Appendix A), which had been prepared before the four questions above had been received. Arising from the presentation and TDA officers' answers to the four questions, members noted that

1. The TDA had good visibility of the financial situation at HHCT, and of the plans in place; the TDA would continue to apply challenge and scrutiny, and where appropriate to apply pressure and support

2. The financial problems were deemed to have been identified late in 2014. The TDA had had visibility of the plans submitted for 2014 and 2015, but the plan had changed throughout the year in response to changes in the circumstances on which assumptions had been based

3. The monitoring model in place at HHCT was similar to that in place for all the organisations that the TDA monitored. Hinchingbrooke had been deemed to be one of the lower-risk organisations in terms of quality, operational delivery and financial delivery. As with other organisations, a monthly integrated delivery meeting was held, with clinical, financial and management participation, and these meetings were supplemented by visits to the organisations

4. There had been much learning in terms of the level of intervention applied by the TDA in the considerable time spent with representatives from HHCT and Circle over the course of two years. There had been challenges that HHCT had not expected, and the depth of challenge could be seen in for example quality reports. The franchise was already in place at the time when the health architecture had been changed by the introduction of Clinical Commissioning Groups, the abolition of Strategic Health Authorities (SHAs) and the establishment of Healthwatch. If a similar situation were to arise in future, the TDA had learnt that deeper reflection would be required on the potential implications of such a change in architecture.

Replying to the four questions, the Chief Operating Officer of CircleHealth said that

1. He did not feel qualified to comment on HHCT's current financial situation.

2. From a franchiser's perspective, the year had started in a tight financial position. There was a cap of £5m on Circle's investment, of which £4.8m had already been invested in the previous year. Various factors then affected the intention of delivering a surplus by year end:
   - bigger changes to tariffs than expected, both locally and nationally
   - added pressure (the single biggest factor) arising especially from increased attendance at Accident and Emergency, and from delayed transfers of care
   - the year had started with staffing at planned levels, but contrary to the expectation that it should be possible to run the hospital with fewer beds, Hinchingbrooke, like most hospitals in the country, found it needed more staff at a time when others were also recruiting. This meant turning to agency staffing, at a cost two or three times higher than the cost of direct employment.

   Such a difficult financial situation diverted attention from plans for positive change and income generation. At the start of 2014-15, Hinchingbrooke had been an organisation with problems, and with recovery plans in place to deal with them, but the demands and pressures on the hospital did not change, and discussions had been started with the TDA on how to secure additional funding. Approaching Christmas, Circle had hoped that a solution was in sight, but despite additional support secured by the TDA, disappointingly it was not in a position to deliver without exceeding the contractual amount.

   The HHCT Board had been well aware of the situation and that Circle had been talking to the TDA. After Christmas, it had become clear that it would be impossible to recover the financial position before the end of 2014-15.

3. Monitoring had taken various forms:
   - HHCT's Chief Executive and Financial Director both sat on the Circle board and were required to account for Hinchingbrooke's performance
   - He, as Chief Operating Officer of Circle, had to account to the TDA on a monthly basis and to the Audit Committee; he had never experienced more monitoring.

4. The contract had started in 2012. In the six years between the contract being conceived in 2009 and the decision to withdraw in 2015, the way the NHS was organised had changed rapidly. One lesson learnt was the need to build flexibility into a contract to allow for change. Looking back on the move from SHA to CCG, it would have helped to have aligned incentives between the CCG and Circle (as the commissioners and the runners of the hospital).

   As a general point, more time and effort needed to be put into planning the health system as a whole, looking at primary, secondary and community care. The CCG was to be congratulated on its work looking at end-to-end planning, but it had not been achieved in time for Circle.

The HHCT former Franchise Director, now the Board Secretary, advised members that

1&2. Management functions, operational control and finance had transferred to Circle under the franchise; it had become apparent that the hospital would not achieve a surplus in 2014-15. In addition to the increases in A&E demand and the use of agency staff, HHCT had to meet cost pressures as co-owners in the Pathology Partnership. The combination of factors led to a deficit of nearly £14m in 2014-15, which meant that HHCT failed one of the three financial tests (income and expenditure) applied to NHS trusts.

3. There had been regular meetings between the HHCT Board and TDA colleagues, who had been very supportive, and fines had been applied due to non-compliance with certain CCG standards. He believed that there had been adequate monitoring, and that the financial problems had been incremental rather than sudden.

4. The contract terms had not passed the test of time. Hinchingbrooke was a small hospital in a large NHS, and in a challenged health economy in Cambridgeshire. The solution to its problems would rest inside and outside the hospital. The lessons of Hinchingbrooke were crucial for the development of any future franchise, and for how to work with NHS staff within a franchise. He would want to align incentivisation, and to see alignment across the whole health system.

The CCG's Local Chief Officer explained that the CCG held a standard NHS contract for services with HHCT, and its role was in the monitoring of that contract. The CCG applied a national framework, working closely with the Trust though monthly monitoring, but had not had insight Circle's costs. He concurred with the Chief Operating Officer's comments round closer working. The CCG was working closely with Hinchingbrooke, including on anticipating patient numbers and costs. To address how Cambridgeshire coped as a challenged health economy, the CCG had launched a system transformation programme, looking at working together across systems, in which Hinchingbrooke was very much involved.

In the course of further discussion, members

- commented that the whole franchise situation had been unviable, and earlier scrutiny of the proposed arrangements had been hampered by not being allowed to see the full contract; proper effective scrutiny of such arrangements was essential

- suggested that the intensive monitoring had been unhelpful, because of the time taken to produce monthly reports and attend frequent meetings. The Chief Operating Officer said that Circle had not perceived most of the monitoring as containing any political elements, and it had not affected the day job

- queried future financial arrangements. The Board Secretary advised that there was clearly potential for a further deficit to be reported, but the HHCT Board had agreed that a further financial plan would be produced in October. The Board was grateful for the support received from the TDA

- noted that there had been positive investment in estate and buildings at Hinchingbrooke, with NHS money being managed by Circle to ensure the best possible benefit, including plans to use some land for housing development

- were advised by the TDA officers that all their organisations in deficit were expected to set out a financial recovery plan. The HHCT Board had been asked to present a

plan for longer-term sustainability, but it was difficult to see how financial balance could be achieved in the present circumstances

- noted that there were currently no planned franchise arrangements for TDA trusts, though it was possible that there could be some in future. The Public Accounts Committee would expect all involved in any such proposed arrangement to reflect on the issues involved, as was being done at the present meeting.

The Chairman commented that members endeavoured to practise supportive scrutiny, and thanked all participants for their attendance at and contributions to the meeting.

It was resolved unanimously to note the report.

124. END OF CONSULTATION REPORT ON A FUTURE MODEL FOR NHS 111 AND GP OUT OF HOURS SERVICES FOR CAMBRIDGESHIRE AND PETERBOROUGH

The Committee received a report presenting the full report and responses to the public consultation on the Out of Hours (OOH) and 111 service, and providing an update on the outcome of the two month 'pause' to consider other related issues.

In the course of discussion, members

- noted that whether a person counted as a Royston resident was related to the GP practice with which they were registered

- pointed out that services in Royston served a number of Cambridgeshire patients and noted that currently, the OOH service for Royston was received from Stevenage.

It was resolved unanimously:

1. to take note of the feedback to this consultation and the changes that would be made to the service specification in response to the consultation.
2. to note the Royston practices request to join the procurement.
3. to note the preferred bidder of IC24 to provide integrated OOH and 111 services for Wisbech.
4. to note the additional work that has been done during the 'pause' period to ensure that all new factors are considered.
5. to support the procurement for the integrated NHS 111 and OOH to continue, which adjustment to timeline to allow for engagement with Royston patients and if they were supportive of the proposal, for the Royston practices to be included in the procurement.

The Committee requested an update on the development of the integrated NHS 111 and OOH service in six months' time, noting that the service for Wisbech was due to start in October 2015.

125. QUALITY ACCOUNTS – CAMBRIDGESHIRE NHS PROVIDERS

The Committee received a report inviting it to consider the Quality Account documents provided by NHS provider organisations in Cambridgeshire. Members noted that NHS Healthcare providers were required to send to the Health Committee in its Overview

and Scrutiny function a copy of their Quality Account for information or comment. Because of the timing of the meeting in relation to the comment deadline, it was possible that the comments would not in fact be published as part of the Quality Accounts, but lessons had been learnt for how to proceed in future years.

Discussing the draft statements, members identified one statement about which they had concerns, in view of the earlier agenda item on E-Hospital issues at CUHFT.

It was proposed by Councillor Orgee and seconded by Councillor van de Kerkhove and agreed unanimously that the words 'but there had been no adverse impact on the quality of services received by patients' from the paragraphs in Appendix A and Appendix B starting 'The Committee received a report on 20/11/14' be deleted.

With this amendment, it was resolved unanimously to

agree the draft statements of response for those Quality Accounts the Committee was in receipt of:

a) Cambridgeshire University Hospitals NHS Foundation Trust (CUHFT)
b) Cambridgeshire Community Services NHS Trust (CCS)
c) Papworth Hospital NHS Foundation Trust
d) Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

126. WORKING GROUP UPDATE AND MEMBERSHIP

The Committee received a report informing it of the activities and progress of the Committee's working groups since the last Committee meeting. Because only two of the five District Councillors had so far been co-opted, it was proposed by the Chairman and agreed by the Committee that a decision on new membership for these groups be deferred to the Committee's next meeting on 16th July 2015.

It was resolved unanimously to:

1. note and endorse the progress made on health scrutiny by the working groups.

2. note and endorse new scrutiny topics suggested by Cambridgeshire and Peterborough Foundation Trust (CPFT) Liaison working group members on Child and Adolescent Mental Health and Adult Mental Health Service pressures.

3. defer to the next meeting consideration of new membership for the liaison and working groups.

127. PUBLIC MENTAL HEALTH STRATEGY

The Committee received a report presenting an updated public mental health strategy for approval. This was a key decision because of its significance in terms of the effect of the strategy on the community living or working in Cambridgeshire. Members noted that the emphasis of the strategy was on maintaining good mental health and preventing the development of mental illness.

In the course of discussion, members

- expressed support for the principle of a strategy for public mental health and thanked officers for their good work in developing it

- in answer to a question about involvement of other organisations and avoidance of duplication, noted that there was a strand of work related to public mental health going through the Health and Wellbeing Board, and that the group putting the strategy together had included representatives from District Councils, from the CCG and from voluntary organisations such as MIND

- noted that the strategy might well involve the development of related policies, but because other organisations were involved in the strategy, it was not possible to impose a single policy on them all

- asked about work with a school which maintained that no bullying occurred. Officers advised that part of the action plan would be to provide additional consultancy support from the PHSE service; this would start by looking at the health-related behaviour survey, which included information on bullying.

- pointed out that there was already a great deal of anti-bullying material available, and cautioned against reinventing that which already existed

- welcomed the emphasis on the link between physical poor health and mental health, commenting that the link became more profound in the course of ageing.

It was resolved unanimously

> to agree the updated strategy as a final document and the proposed governance arrangements.

The Committee requested an update on the implementation of the strategy in six months' time.

128. FINANCE AND PERFORMANCE REPORT – March 2015

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of March 2015. Members were advised that the outturn report for the year 2014-15 would be brought to the Committee in July; little change was expected between the figures in that report and in the present report.

Discussing the report, members noted that all the Sexual Health services had been severely affected by the introduction of E-Hospital at Addenbrooke's in November 2014. Officers confirmed that the problems were of data, not of care standards; data provision had suffered because staff were focussing on care.

It was resolved unanimously to*:*

1) note the report.

2) endorse the transfer of non-recurrent underspend from 2014/15 to an ear-marked public health reserve for pump-priming of the Public Health Integration Strategy

129. ANNUAL PUBLIC HEALTH REPORT

The Committee received the Annual Public Health Report for 2014/15, prepared by the Director of Public Health in accordance with the requirements of the Health and Social Care Act (2012). The Director of Public Health thanked the Public Health analysts, in particular Jon Moore, for their assistance in compiling the report.

In the course of discussion, members

- welcomed the report, describing it as an excellent piece of work

- drew attention to the difference in educational achievement between pupils in Fenland and in South Cambridgeshire, commenting that it ought to be the same across the county, and noting that the Narrowing the Gap strategy was working towards this end

- commented on the importance of exercise and physical activity for good public health, and asked how the Transport and Health Joint Strategic Needs Assessment (JSNA) fed into the Council's work to provide public services, for example through the City Deal transport schemes. Members noted that JSNAs were presented to the Health and Wellbeing Board, and once endorsed by the Board, served as a background to policy making

- urged all members of the Committee to pay careful attention to the 'public health implications' paragraph at the end of reports to all the Council's Policy and Service Committees.

It was resolved unanimously:

> to consider the information and opportunities for action outlined in the Report, and the Committee's potential role in delivering against these.

129. HEALTH COMMITTEE AGENDA PLAN, AND APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

a) Agenda Plan

The Committee considered its agenda plan, noting that four suggestions had been made for further work:

1. system transformation
2. system capacity with particular reference to North Cambridgeshire hospitals and to GPs across the county
3. implications for current services Encompass Network's needs assessment looking at the experiences of the local lesbian, gay, bisexual and trans communities (LGBT)
4. costs of hospital parking and of media access in hospitals.

The Committee adopted the following approaches for the four suggestions:

1. noted that system transformation was already on the agenda for July
2. decided to place an item on system capacity on the agenda for September

3. decided to ask Spokes to look at the Encompass Network needs assessment in the first instance, with a view to its perhaps coming to Committee later
4. decided to ask the hospitals to supply a complete list of all their charges as part of an agenda item on access to health, either as part of the health system capacity item in September, or at a later meeting. **Action required**

b) appointments to be made to internal advisory groups and panels, and to partnership liaison and advisory groups

Members noted that the full list of the Committee's appointments to internal advisory groups and panels, and to partnership liaison and advisory groups, would be considered at its July meeting, but two appointments were urgently required. These were for one member each to serve on the Children's Health Joint Commissioning Board, alongside the two members of the Children and Young People (CYP) Committee already appointed, and on the Children, Families and Adults Management Information Systems Procurement Project Member Reference Group, alongside members of the Adults Committee and of the CYP Committee.

c) Health Committee priorities and approach

The Committee received an update on progress with the priorities previously identified by Committee. It was noted that the Committee's previous Member Champion for Transport and Health, Councillor Schumann, was no longer a member of the Committee, and that the only member who currently sat on both the Health Committee and the Highways and Community Infrastructure Committee was Councillor Jenkins.

It was resolved unanimously

a) to note the agenda plan, subject to the addition of an item on system capacity to the agenda for 3 September 2015

b) to appoint
   - Councillor Paul Clapp to serve on the Children's Health Joint Commissioning Board
   - Councillor Peter Topping to serve on the Children, Families and Adults Management Information Systems Procurement Project Member Reference Group

c) to note Health Committee priorities and approach

d) to appoint Councillor David Jenkins as the Committee's Transport and Health Champion

130. THANKS TO PREVIOUS CHAIRMAN

At the conclusion of the meeting, the Committee asked that its thanks to the previous chairman, former Councillor Kilian Bourke, be recorded. He had displayed a great commitment to health and a high standard of chairmanship of the Committee.

Chairman