HEALTH COMMITTEE

Date:Thursday, 11 July 2019

13:30hr

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

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

2 Declarations of Interest

Guidance for Councillors on declaring interests is available at:

http://tinyurl.com/ccc-conduct-code

3 Minutes - 23rd May 2019 & Action Log **5 - 16**

4 Co-Option of District Members

5 Petitions and Public Questions

SCRUTINY ITEMS

The Health Committee comprises the following members:

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

Councillor David Connor Councillor Lorna Dupre Councillor Lynda Harford 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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HEALTH COMMITTEE: MINUTES

Date: Thursday, 23 May 2019

Time: 1.35p.m. – 4.07p.m.

Present: Councillors D Connor, L Dupre, J Gowing (substituting for Councillor Boden), L Harford, P Hudson (Chairman), L Jones, T Sanderson, and S van de Ven

District Councillor G Harvey.

Apologies: Councillors C Boden, P Topping and J Tavener

208. NOTIFICATION OF THE APPOINTMENT OF THE CHAIRMAN/WOMAN

The Committee noted the appointment of Councillor Hudson as Chairman of the Health Committee for the municipal year 2019/20.

209. NOTIFICATION OF THE APPOINTMENT OF VICE CHAIRMAN/WOMAN

The Committee noted the appointment of Councillor Boden as Vice-Chairman of the Health Committee for the municipal year 2019/20.

210. DECLARATIONS OF INTEREST

There were no declarations of interest.

211. MINUTES - 14TH MARCH 2019

The minutes of the meeting held on 14th March 2019 were agreed as a correct record and signed by the Chairman.

212. HEALTH COMMITTEE – ACTION LOG

The Action Log was noted.

213. CO-OPTION OF DISTRICT MEMBERS

It was resolved to co-opt, Councillor Geoff Harvey (South Cambridgeshire District Council), Councillor Nicky Massey (Cambridge City Council) and Jill Tavener (Huntingdonshire District Council) to the Committee.

214. PETITIONS

There were no petitions.

215. FINANCE AND PERFORMANCE REPORT – OUTTURN 2018/19

The Committee considered the 2018/19 Finance and Performance Outturn report. In presenting the report officers highlighted uncertainty regarding forecasts due to the implementation of ERP Gold, the Council's new enterprise resource system.

The financial year ended with a final outturn of £600k underspend which was an increase of £130k since the previous forecast underspend. The main areas of underspend were the Public Health Directorate staffing budget where vacancies due to be deleted as a saving in 2019/20 were not filled, and the Sexual Health and Contraception area.

Officers noted the disappointment of the Committee in relation to underspends however, drew attention to the further reduction in the Public Health Grant in 2019/20 and that the directorate as a result was in a good position for 2019/20 to meet those challenges.

During discussion Members:

- Noted the rationalisations that had taken place however, expressed disappointment that the directorate had recorded such a large underspend when the work of Public Health was so vital.

- Emphasised the need for a strong and determined Public Health directorate that had greater influence over the Local Authority.

- Noted the funding streams for Public Health and the implications of the reduction of £700k in the ring-fenced grant of which £500k had been implemented.

- Expressed concern regarding performance data and what was actually measured in the Key Performance Indicators (KPIs) with specific reference to childhood obesity measures. Officers explained that the KPI measured the national childhood measurement programme delivery and it provided valuable information in contract management. Annual obesity rates were provided annually which were broken down by school, however they were not included in the monthly performance monitoring report.

- With regard to the School Nursing service Members noted the information regarding the numbers accessing services and the sort of support they were receiving however, it did not answer all the questions. Officers explained that it had been identified as a key action to develop the data gathered in order for a greater understanding of where impact areas were to be achieved.

- Drew attention to staffing issues related to Health Visiting Mandated Checks that did not appear to have changed. Officers commented that staffing was a significant issue in the south of the county and was taking time to address. It was anticipated that the position would begin to improve in quarter 2.

- Queried the Health Visiting Mandated Checks and the number of reviews that were not wanted or not required. Officers explained that some reviews that were not attended could have been not offered due to capacity. Work was being undertaken to understand whether there was a difference with parents who have more than one child as they were potentially more likely to not take up the offer of a visit.

It was resolved unanimously to:

> Review and comment on the report and to note the finance and performance position as at the year end.

216. RECOMMISSIONING SEXUAL HEALTH SERVICES

Members considered a report that sought the support of the Health Committee for undertaking a competitive tender for Integrated Sexual Health Services across Cambridgeshire and Peterborough.

Members were informed that the recommissioning of the services across the two local authorities provided opportunities for synergies and ensuring that pathways were more effective and efficient across services.

During discussion Members:

- Questioned the use of the word efficiency during the officer's presentation and sought evidence that jointly commissioned contracts were more efficient. Officers explained that the jointly commissioned contract provided an opportunity to reduce the level of duplication across both local authorities and also an opportunity to review senior management structures.

- Drew attention to the differences between Peterborough City Council and Cambridgeshire County Council in terms of needs and patient profiles contained within the report and questioned whether there was a risk that quality would be sacrificed. Officers provided assurance to the Committee that teams were assessing where money was spent and where it could be spent on patient care rather than the system. Members noted that compliance with NICE guidance and targets would have to be met.

- Sought assurance that the savings would be appropriate and would not undermine the overall efficiency of the service. Officers explained that the service comprised of relatively senior staff that would not expect close supervision. There were also innovations regarding digital platforms that would improve access and work was being undertaken to ensure people were not excluded as a result.

- Expressed concern regarding the increased digitalisation of the service and questioned what work had been undertaken to assess the benefits before further digitalisation was undertaken. Members noted that increase online screening had increased take-up of services and allowed a more sensitive approach tailored to meet needs. Attention was drawn to work in Fenland where it had been found that social media was a far more effective tool for communication than traditional print media.

- Noted the break clauses within the contract in years 3 and 4.

It was resolved to support and approve:

a) The undertaking of a competitive tender for Integrated Contraception and Sexual Health Services as a shared service contracted to work across Cambridgeshire County Council and Peterborough City areas

b) The establishment of a legal agreement between Cambridgeshire County Council and Peterborough City Council that assigns Cambridgeshire County Council as the lead commissioner

c) Delegate and sign off for the agreement to the Director of Public Health in consultation with the Chair and Vice Chair of the Committee.

217. INTERIM CONTRACT FOR THE PREVENTION OF SEXUAL ILL HEALTH SERVICES

The Committee received a report that sought the support and approval of the Health Committee to award an interim contract for the delivery of the prevention of sexual ill health services to the current provider, DHIVERSE for a period of six months commencing 1 October 2019 and would terminate 31 March 2020. The report also sought approval to commission the prevention of sexual ill health service as a shared service across Cambridgeshire County Council and Peterborough City Council.

Officers explained that the services were provided by a number of smaller of voluntary sector organisations and the model would allow a collaborative bid to be placed. Efficiencies could also arise from a reduction in the duplication of work and would align the contract with the wider procurement of iCASH services.

During discussion, Members:

- Noted that DHIVERSE provided part of the services to Peterborough City Council and was first formed in the 1980's during the HIV crisis.

- Noted that following the approval of the contract set out in the report a contract would be brought forward that required voluntary organisations to collaborate with one another more effectively through a lead provider model. Recent collaboration had worked well in Peterborough.

- Drew attention to the number of late HIV diagnoses in the Cambridgeshire area and the underpinning reasons for health problems.

- Drew attention to the seeming unwillingness for employers in Fenland to encourage good practice of going to doctors for regular check-ups. The NHS would therefore have an extremely long period of looking after people because issues were not dealt with early enough. Officers explained that part of the work organisations undertook focussed on prevention which they were effective at.

It was resolved to:

a) Review the rationale for the request to award an interim contract

b) Support the interim contract being awarded to DHIVERSE for the delivery of the Prevention of Sexual Health Ill Services in Cambridgeshire

The award of an interim contract for the Prevention of Sexual Ill Health Service

a) Authorise the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health Committee, to formally award the interim contract subject to compliance with all required legal processes.

b) Authorise the Consultant in Public Health, Health Improvement, in consultation with the Executive Director of LGSS Law to approve and complete the necessary contract documentation

Recommissioning the Prevention of Sexual Ill Health Services

a) Support a competitive procurement for the re-commission of the Prevention of Sexual Ill Health Service as a shared service contracted to work across the Cambridgeshire County Council and Peterborough City Council areas

b) The establishment of a legal agreement between Cambridgeshire County Council and Peterborough City Council that assigns Cambridgeshire County Council as the lead commissioner

c) Delegate sign off for the agreement to the Director of Public Health in consultation with the Chair and Vice Chair of the Committee

d) Authorise the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health Committee, to formally award the new shared contract effective from April 2020, subject to compliance with all the required legal processes.

e) Authorise the Consultant in Public Health, Health Improvement in consultation with the Executive Director LGSS Law to approve and complete the necessary contract documentation.

218. COMMISSIONING INTEGRATED LIFESTYLES SERVICES

A report was presented that sought to secure the support of the Health Committee for undertaking a competitive tender for Integrated Lifestyle Services across Cambridgeshire County Council and Peterborough City Council as a shared services established through one contract.

Commenting on the report Members:

- Sought greater clarity regarding how a joint commissioning process would deliver greater efficiency when the needs of Cambridgeshire and Peterborough were very different. Officers explained that in terms of behavioural change the intervention methods were broadly the same. There was a standard skill set and training for staff and with regard to behavioural change staff should be able to apply skills to different populations

- Noted that in Peterborough due to the population there was a diverse workforce that could meet the needs of some of the Fenland population where the same diversity of workforce was not available in Cambridgeshire and vice versa.

- Noted that due to the small size of the service the proposal would provide greater resilience and assist in the management of sickness and annual leave.

- Sought clarity regarding funding received from the Clinical Commissioning Group (CCG) contained at paragraph 2.7 of the officer report and queried whether funding was in place for 2019/20 and as it appeared that Peterborough did not, Cambridgeshire may be disadvantaged if funding was rationalised. Officers explained that funding for Cambridgeshire was open ended and funding for Peterborough was more proscribed however, it was currently under discussion with the CCG.

- Questioned whether joint commissioning as the default position for the Council when commissioning services. Officers explained that within the Public Health directorate there were many strategic partnerships that work across Cambridgeshire and Peterborough such as criminal justice. There was a strategic direction to avoid duplication of tasks. The joint commission approach also improved pathways across agencies. It was however vital that local needs were not lost.

- Questioned whether there was an overall direction of travel for digital platforms to carry out health checks. Officers confirmed that there was an intention to provide direction to information held online and for facility to carry out a mini health check however, it would not replace the physical health check.

Councillor Connor left the meeting at 2:16

It was resolved to support and approve:

a) The undertaking of a competitive tender for Integrated Lifestyle Services as a shared service contracted to work across Cambridgeshire County Council and Peterborough City Council areas

b) The establishment of a legal agreement between Cambridgeshire County Council and Peterborough City Council that assigns Cambridgeshire County Council as the lead commissioner

c) The Delegation to sign off for the agreement to the Director of Public Health in consultation with the Chair and Vice Chair of the Health Committee.

219. LETS GET MOVING PHYSICAL ACTIVITY PROGRAMME UPDATE

Members considered a report that provided further information regarding the Let's Get Moving physical activity programme funded by the Health Committee from Public Health reserves.

Members were informed that at the core of the project was a theme of sustainability and how the various groups could be taken forward and owned by communities.

The Chairman welcomed representatives of Living Sport who were available to answer Member questions.

During the course of discussion:

- Expressed disappointment with the response from Huntingdonshire District Council (HDC). Councillor Sanderson as a HDC Member undertook to take the matter up with the Council.

- Sought clarity regarding the activity levels recorded and queried that based on the statistics contained within the report 49% of participants did not increase their activity levels. It was explained that activity levels were measured in catagories and

although a person's activity may have increased it may not have increased enough in order to move to the next category.

- Questioned whether there was a fixed minimum number of people required in order to establish a group as sheltered housing schemes had smaller numbers which could grow but would take longer to become self-sustaining. Members were informed that there was no minimum membership requirement for a group to be set up.

- Noted that 45% of the groups established have become self-sustaining and that the programme had provided the opportunity for innovation and risk taking. Officers drew attention to the success of recreational running from which the learning was being implemented into other programmes.

- Commented on nudge theory of behavior change and its potential benefit to other Committees.

- Noted the work that had been undertaken regarding the evaluation of the programmes and the changes that had been made in recognition that the people delivering the groups were not necessarily the best people to evaluate its success.

- Drew attention to the feedback questionnaire contained at Appendix C of the report which was quite complex and queried the numbers of completed questionnaires received. Members were informed that the process did appear to be intensive however, the form had been recently re-designed and the first quarter response rate was nearly 100%. A more digital first approach was being undertaken and though a local customer engagement company a more automated form would be issued.

- Highlighted the importance of longitudinal evidence and questioned whether there was a method through which longer term data could be collated as there was a risk that when groups became self-sustaining the data would be lost at the most significant point in public health terms. Officers commented that an exit strategy would be developed to capture that information.

It was resolved to:

a) Acknowledge the ongoing development and positive progress achieved by Let's Get Moving

b) Acknowledge that Let's Get Moving is contributing to the establishment of sustainable physical activity programmes in Cambridgeshire Communities.

220. ANNUAL HEALTH PROTECTION REPORT 2018

Members received the Cambridgeshire and Peterborough Annual Health Protection Report 2018 which provided information on and assurance of the local delivery of health protection functions. The 2018 report represented the first year of a joint report across Cambridgeshire and Peterborough however, where possible the data had been broken down between the two local authorities. Attention was drawn to the childhood vaccination rates which had remained stable or were increasing which was encouraging. There was focus on pre-school vaccinations which were the lowest take-up rates.

During discussion Members:

- Drew attention to paragraph 3.2 of the report that contained data related to outbreaks in residential settings and commented that it would be beneficial for trend data to be presented in the next iteration of the report

- Welcomed the section of the report related to air quality and suggested that it would be beneficial to have it statistically based. It was noted that a lot of data was averaged out across the year and this meant that areas that were hotspots at certain points of the year could be lost.

- Confirmed that with regard to screening that eligible people were proactively contacted and invited to appointments.

- Confirmed that officers were not aware of any screening programmes having ceased due to funding constraints.

It was resolved to note the information in the Annual Health Protection report (2018)

221. PUBLIC HEALTH SYSTEM LGA PEER REVIEW

The Committee considered the findings of the Local Government Association (LGA) peer review of the Cambridgeshire and Peterborough public health system, carried out earlier this year, and to endorse the associated multi-agency action plan, which had been approved by the Cambridgeshire and Peterborough Health and Wellbeing Board.

Officers drew attention to paragraph 2.3 of the report which highlighted the key messages identified by the Peer Reviewers. The Key recommendation of the review contained at section 2.4 of the report which were being monitored by the Cambridgeshire and Peterborough Joint Health and Wellbeing Boards.

Commenting on the report Members:

- Welcomed the overall helpful process however expressed concern that there had been slippage in terms of timescales with regard to the action plan.

- In drawing attention to paragraph 2.3 of the officer report relating to the key messages identified by the Peer reviewers commented that they did not appear in the action plan. The third key message regarding the need for the Public Health team to have a more expansive view of its role raised questions regarding resources and the ability of the Public Health directorate to influence other directorates. Officers explained that the action plan published as an appendix to the officer report was not the most up to date version. There was sufficient capacity within the directorate through which to deliver the action plan and priority had been given to People and Communities, Communities and Safety and Place and Economy directorates. Senior officers within Public Health were joining senior management groups within directorates. Members requested that formal reporting be aligned with the Health and Wellbeing Board. **ACTION**

- Noted and welcomed the work taking place with the People and Communities directorate and requested the work was given a higher profile in future reports.

- Noted the role of the Health and Wellbeing Board in providing a system-wide forum in which to drive forward integration and partnership working.

- Members requested a structure chart in which the links between directorates were visible. **ACTION**

It was resolved to:

a) Comment on the findings of the Cambridgeshire and Peterborough public health system peer review

b) Endorse the multi-agency action plan

222. UPDATE AND PROGRESS ON THE DEVELOPMENT OF THE MINOR INJURY UNITS IN EAST CAMBRIDGESHIRE AND FENLAND

The Chairman invited Matthew Smith, Senior Responsible Officer, Urgent and Emergency Care and Jess Bawden, Director of External Affairs and Policy, Clinical Commissioning Group (CCG) to update the Committee regarding Minor Injury Units in Fenland and East Cambridgeshire.

Attention was drawn to the Local Urgent Care Hub (LUCS) model that provided an extended local, more accessible urgent care services for the population of East Cambridgeshire and Fenland.

During discussion Members:

- Sought greater clarity regarding Minor Injury Units (MIUs) expectation to meet national standards and when that would be. Members were informed that there was a national expectation that the plan would be delivered by the end of the year however that position had softened due to the nature of rural areas and a recognition that one size did not fit all. Attention was drawn to the 'roundtable' programme that was developing a solution to meet the needs of Cambridgeshire and Peterborough which looks at a wide range of services not limited to Urgent Treatment Centres.

- Expressed concern that the 'roundtable' programme pilot might result in some options being lost and people therefore may not have access to the full plethora of services. Members noted that engagement had been undertaken with Healthwatch however it was not yet the appropriate time to communicate to wider stakeholders. Further wider engagement would be undertaken over the summer once a preferred model and pilot had been agreed.

- Sought clarity regarding the provision of telemedicine at Doddington Hospital. Members noted that facilities such as Skye or telephone consultations were being offered in order that patients did not need to attend the hospital. While the option was appropriate for some patients it was not suitable for all and would not dispense with the need for physical appointments.

It was resolved to note the contents of the report.

223. HEALTH COMMITTEE AGENDA PLAN, TRAINING PROGRAMME, AND APPOINTMENTS TO OUTSIDE BODIES AND INTERNAL ADVISORY GROUPS

The Committee examined its agenda plan and training programme. It also considered the appointments to Outside Bodies and Internal Advisory Groups. It was noted that Councillor Sanderson would replace Councillor Taylor on the Northwest Anglia Foundation Trust Liaison Group and Councillor Gowing on the Northwest Anglia Foundation Trust Council of Governors.

It was resolved to:

a) Review the agenda plan

b) Review the training plan

c) Agree the appointments to outside bodies

d) Agree the appointments to internal advisory groups and panels

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee up to the meeting on **23rd May 2019** and updates Members on progress in delivering the necessary actions.

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
Meeting of 17 January 2019					
185.	**Finance & Performance Report – November 2019**	**Liz Robin /**	Provide further information relating to the Ambulance Trust within C&CS Research	Research team has been asked for an update.	**Ongoing**
Meeting of 7th February 2019					
196.	**Re-Commissioning of the Healthy Child Programme**	**Liz Robin**	Lead Members to do discuss how the Committee oversaw large amounts of performance data.	A review of performance data was being undertaken though which the views of Lead Members would be sought	**Ongoing March 2019**
Meeting of 23rd May 2019					
221.	**Public Health System Peer Review**	**Liz Robin**	Members requested a structure chart in which the links between directorates were visible		

Agenda Item No: 6

COMMUNICATIONS AND ENGAGEMENT APPROACH TO DELIVERING THE CCG FINANCIAL PLAN

'THE BIG CONVERSATION' – USING OUR NHS RESOURCES WISELY

To:	**Health Committee**
Meeting Date:	**11 July 2019**
From:	**Director of External Affairs and Policy**
Purpose:	**For approval of the consultation process, and to give the committee the opportunity to comment on the proposed consultation**
Recommendation:	**The Committee is asked to endorse this approach to the communications and engagement and the draft Engagement Process Plan.**

	Officer contact:
Name:	Jessica Bawden
Post:	Director of External Affairs and Policy
Email:	Jessica.Bawden@nhs.net
Tel:	-

1. BACKGROUND

1.1 The CCG is facing an unprecedented financial challenge in 2019/20. To meet this challenge, we need to garner support from our key stakeholders, providers and importantly the wider public. This requires a new approach, a Big Conversation about how we use our valuable NHS resources and how we take more responsibility for our own health. The CCG has specific duties in relation to consultation and engagement, but with the support of Healthwatch and our Scrutiny Committees, we will agree a process that is open, transparent and proportionate.

2. MAIN ISSUES

2.1 **Our objectives for this approach**

- This programme of work is a catalyst for how we communicate with our public about how NHS resources are used wisely;
- To start an open conversation about commissioning priorities alongside individual responsibilities in relation to self-care and lifestyle, supported by evidence;
- To ensure that we meet our statutory duties in relation to decommissioning of services, in a proportionate and pragmatic way;
- To seek the support and understanding of key stakeholders in relation to this work and our ongoing lobbying and partnership work to bring the system into financial sustainability for the long term.

2.2 The CCG has a savings plan of £32.7 million in 2019/20. Many of these are around contractual transactions, but many propose a change in how a service is delivered or the level of service or medication that is available.

2.3 Working alongside the CCG's Programme Management Office (PMO) and the proposed QIPP (Quality, Innovation, Productivity and Prevention) schemes, engagement plans have been identified into the following main areas:

- **Specific stakeholder engagement** by workstream lead, generally with providers or local authority partners;
- **Primary care engagement** around a number of schemes and potential changes to commissioned services, supported by Governing Body members;
- **Staff engagement** to ensure that staff know what the proposals are, act as champions and also to support the identification and implementation of running cost reduction initiatives;
- **The Big Conversation**, a major communications initiative to engage people in the challenges we face and what we can all do to use NHS resources wisely;
- **Formal public consultation** alongside, this will be required for a small number of proposals such as change in the provision of hearing aids.

2.4 The major piece of work will be our Big Conversation with the public. The majority of our savings proposals are around medicines waste, clinical thresholds, service transformation etc. The key messages from this will be as follows:

- This is our NHS;
- Resources are limited;
- We all have a responsibility to use the NHS wisely;
- The NHS is working hard already to reduce inefficiency, reduce duplication and running costs;
- We all have a responsibility to look after ourselves, when we can, and the NHS will help people to do that;
- How the NHS looks after us changing – we can all use more technology to access and services and be treated;
- We need to make choices about where we focus resources to get the best outcomes.

2.5 This is being supported by information and facts around the impact of lifestyle on health and demand on health services. This will be a communications and marketing led exercise supported by engagement with interest groups and established patient groups. Healthwatch is developing a proposal to support this work alongside focus group work around prioritisation and values-based decision making.

2.6 Timescales

Throughout May and June 2019, we have worked with Healthwatch and Cambridgeshire and Peterborough Scrutiny Committees as well as our own Patient Reference Group to develop the proposed approach to engagement. We will attend public Scrutiny meetings to present the process at the beginning of July and we will also be sharing the draft document with key stakeholders before we launch. Healthwatch will also be contributing the outputs of their NHS Long-Term Plan engagement and survey responses. We will also be continuing our round of briefings for Members of Parliament (MPs).

These conversations have been invaluable in helping us build the framework for our document, which will be set out as follows:

1. The problem and context;
2. What we in the NHS are doing to address the problem, such as reducing running costs or duplication of contracts;
3. What work we have already been doing with the public, such the great strides we have made with public attitude to over the counter medicines;
4. How lifestyle behaviours impact on our own health and NHS costs and how we can help ourselves more and where the NHS can help;
5. Other areas we will be looking at in the future such as simplifying routes into Urgent Care Services, or reviewing wait times for certain procedures;
6. Specific Areas where we are proposing to stop or reduce services;
7. Survey to gather views.

We propose to launch the Big Conversation week beginning 22 July 2019, running until the end of September 2019. Timescales will be finally agreed with main Scrutiny Committees.

2.7 Key outputs will be as follows:

- Big Conversation document, infographics, Public Relations materials and survey developed with Healthwatch;

- Impacts of lifestyle facts & figures;
- Suite of materials, including leaflets, presentations, Frequently Asked Questions and social media tools;
- Public Meetings.

3. CONSULTATION

3.1 We have developed the attached draft Consultation Process Plan which is being developed with key stakeholders and will be presented to Scrutiny Committees, alongside our key messages. This is attached at Appendix One

4 ANTICIPATED OUTCOMES OR IMPACT

4.1 The Committee is asked to endorse this approach to the communications and engagement and the draft Engagement Process Plan.

5 REASON FOR THE RECOMMENDATION

5.1 The CCG and system financial challenges provides an opportunity for a change in the conversation we have with the public about how we all use the NHS and the need to take more responsibility for our own health. A wider debate, rather than a focus on traditional consultation processes will open up a new level of engagement that we can use going forward as we plan for the next 3-5 years.
This approach will step up our two-way communications with the public it is also vital to support our challenging financial plan for 2019-20.

6. SIGNIFICANT IMPLICATIONS

6.1 **Financial Implications**
Funding for healthcare across Cambridgeshire and Peterborough is under pressure. We are currently buying more than we can afford, which means we need to make some difficult decisions about the services we can afford to provide in the future.

As a CCG we need to make savings of around £65 million. This is our part of the whole system challenge.

Much of this will be through work with our providers to cut down on duplication, reduce costs of running certain services, and setting clear prices for services, known as tariffs. This will have minimum impact on patients, but around £35 million will need to be found from services that the CCG currently commission.

We are currently overspending £1 million pounds a week and need to review what we commission and focus on core NHS services that bring the most benefits for our patients.

The table below gives some detail on the areas where the CGG will be able to make these savings. This is not a final list as more detail is being added and we will share with the Committee as soon as possible.

2019/20 savings programme	£'000	Notes
NHS Continuing Healthcare case reviews and contract management	5,136	
Review of contracts and services	4,087	
Prescribing Over the counter medicines, medicines waste, switches to lower cost medicines	3,050	EG over the counter medicine £400k, Generics £350k, switches to lower cost drugs £1.8m
Learning Disability Delayed Transfers of Care Management	680	
S117 (complex case management) Case review	1,000	
Wheelchair Procurement	1,063	Already engaged with service users to develop specification
Contract management	3,759	e.g. negotiating lower uplifts £1.9m, coding audit £0.8m
Further community services review	734	
Ambulance contract	2,500	Arbitration resulted in only £500k achieved in 19/20
Line by Line budget review	3,723	
Running costs	1,043	Additional £2.5m to be found in 20/21
Review of acute capacity	3,000	
Primary Care	1,500	
Efficient management of discharge pathways	1,425	
Total	**32,700**	

The areas that we expect to be including in the Big Conversation are:

- Audiology pathways including a review of hearing aid provision for mild to moderate hearing loss
- Over the counter medicines
- Medicines waste
- Local enhanced services by GP practices
- Changes to the End of Life Pathway
- Simplifying access to Urgent Care Services
- Reviewing the waiting time for some procedures
- Vasectomy services
- Lifestyle changes
- Endoscopy services

The contents of the document are being finalised and we would like to share the draft document with the Committee and/or the Chair for feedback before we commence the process.

6.2 **Legal Implications**

The CCG has a statutory duty to consult and engage with the public and key stakeholders:
Section 14Z2 Health and Social Care Act 2012
14Z2 Public involvement and consultation by clinical commissioning groups
http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

6.3 **Equalities Implications**

All relevant workstreams will complete impact assessments before changes are considered and these will be published on the CCG website from the start of the consultation.

7 Appendices

7.1 Appendix One – Draft Consultation Process Plan

Source Documents	Location
Cambridgeshire and Peterborough Clinical Commissioning Group Refreshed Communications and Engagement Strategy July 2018	https://www.cambridgeshireandpeterboroughccg.nhs.uk/about-us/governing-body-meetings/governing-body-papers-2018-19/ Refreshed Communications & Engagement Strategy July 2018

Appendix1

Cambridgeshire and Peterborough Clinical Commissioning Group

WORKING DOCUMENT,

Consultation Process Plan

Big Conversation
Spending our NHS Money Wisely

Proposed consultation xxx July to xxx September 2019

V3

26/06/19

Jane Coulson
Jessica Bawden

Background

Funding for healthcare across Cambridgeshire and Peterborough is under pressure. We are currently buying more than we can afford, which means we need to make some difficult decisions about the services we can afford to provide in the future. As part of the decision-making process, we want to have a Big Conversation with members of our community, clinicians, providers and stakeholders, to fully understand their needs and priorities. This information will help to inform how we invest our limited funds. Putting patients at the heart of our decision making.

Why are we consulting now?

The CCG is facing an unprecedented financial pressure in 2019/20.
The whole of the NHS system in our area is facing an enormous financial challenge, this includes all of the hospitals and community providers as well as Primary Care. That challenge is a funding gap of almost £200 million.

Much of this will be through work with our providers to cut down on duplication, reduce costs of running certain services, and setting clear prices for services, known as tariffs. This will have minimum impact on patients, but around £35 million will need to be found from services that the CCG currently commission.

We are currently overspending £1million a week and need to review what and how we commission and focus on core NHS services that bring the most benefits for our patients.

The Proposal

The Big Conversation

The Big Conversation is our way of opening up the challenges we face and working together with our community, staff, stakeholders and providers to find the right solutions. We want to put patients at the heart of our decision-making processes. We will do this by launching our Big Conversation that will run from XX July to XX September. During this time, we want to have a Big Conversation with…

1. **With our Community** – about what services they need and value most, at the same time as looking at how they use NHS services, including out of hours care, over the counter medications, and medicines waste
2. **With our Clinicians** – about referrals, prescribing and service constraints and how we help people to look after themselves better
3. **With our Providers** – about how they can become more efficient and embrace innovation whilst still providing good quality healthcare

Process

Pre-consultation and engagement

Cambridgeshire and Peterborough CCG will:

- Prepare a full and comprehensive consultation document that explains the programme and the options for consultation in clear plain English.
- Prepare a summary of this consultation document for people who are not able, or do not want, to able to read the full consultation document.
- Translate the summary consultation documents into key community languages when required, explaining that more information is available if people want it.
- Prepare text rich and plain text versions of all of the consultation documents for people with sensory disabilities to download.
- Ensure that drafts of the full consultation documents and questions for consultations are shared with the following groups:
    - CCG Governing Body
    - Health Scrutiny Committees from Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire and Norfolk.
    - The CCG Patient Reference Group (PRG)
    - Healthwatch organisations from Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire and Norfolk.
- Ensure that the final consultation document reflects feedback from these groups.
- Ensure that we provide materials for different audiences and how much they want to engage, including briefings for stakeholders, leaflets and infographics and messaging for social media.
- Plan public meetings in accessible venues in the CCG area.
- Publicise these meetings within the consultation documents in good time in advance of meetings.

Consultation and engagement

Cambridgeshire and Peterborough CCG will:

- Have copies of the consultation documentation available on the website from the first day of the consultation and throughout the consultation.
- Have translations and rich text versions of the documentation on the CCG website as close to the start of the consultation as possible.
- Have photocopies of the documentation prepared for distribution on the first day of the consultation.
- Have printed copies of the full document, summary document and translations available on request as soon as possible after the start of the consultation.
- Distribute these documents to:
    - GP practices
    - Pharmacies
    - Stakeholder database
    - MPs
    - Councils for Voluntary Services (Peterborough and Cambridgeshire).
    - Local Medical Committee

  - Local Pharmaceutical Committee
  - Health Scrutiny Commissions, Cambridgeshire, Peterborough, Hertfordshire, Northamptonshire, Norfolk.
  - Health and Wellbeing Boards, Cambridgeshire, Peterborough, Hertfordshire, Northamptonshire, Norfolk.
  - District Councils across our regions
  - CCG Patient Reference Group
  - Public Service Board
  - Patient Forum Groups
  - Healthwatch organisations, Peterborough, Cambridgeshire, Northamptonshire, Hertfordshire, Norfolk.
  - Libraries
  - Cambridgeshire Community Services NHS Trust
  - Cambridgeshire and Peterborough NHS Foundation Trust
  - East of England Ambulance Service MNHS Trust
  - North West Anglia NHS Foundation Trust
  - Cambridge University Hospitals NHS Foundation Trust
  - Royal Papworth NHS Foundation Trust
  - Peterborough City Council
  - Cambridgeshire County Council
  - Queen Elizabeth Hospital NHS Trust
  - Unions
  - NHS England/Improvement Area Team
  - Cambridgeshire and Peterborough Combined Authority

- Send media release to all local media outlets at the start of the consultation and at strategic points in the consultation to ensure widespread media coverage.
- Use Facebook and Twitter, and other social media platforms, to raise awareness of the consultation, conversation phased, sent to local stakeholders to support disseminate
- Ensure that translations are made available on request in key community languages.
- Ensure that all translations are available on the CCG website when requested.
- Ensure that all responses received in other languages are translated into English and included in the response reports.
- Log all calls received with regard to the consultation.
- Collate all letters and emails received as part of the consultation.
- Ensure that all public meetings held have full meeting notes, recording comments and questions.
- Ensure that when we attend meetings we record a briefing note of the meeting and request full minutes when available.
- Collate all meeting notes, briefing notes and minutes.
- Respond to requests for attendance at meetings to discuss the consultation.

- Attend meetings with the following key stakeholder groups during consultation:
    - Health Scrutiny Commissions in Cambridgeshire, Peterborough
    - Health Scrutiny Committees in Northamptonshire, Hertfordshire and Norfolk on request.
    - Healthwatch organisations in Cambridgeshire and Peterborough. Attend in Northamptonshire, Hertfordshire and Norfolk on request.
    - CCG Patient Reference Group
    - Health and Wellbeing Boards in Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire and Norfolk (on request)
    - Relevant patient representative groups

Post Consultation

A report to be produced on the consultation responses

Cambridgeshire and Peterborough CCG Governing Body will review report and findings before making its decision.

Press release on the outcome of the consultation, emphasising the changes made following consultation feedback.

Communications to be sent via email/letter to stakeholders/and consultation respondents with link to consultation report and outcomes.

Feedback to staff via email, staff briefings and iConnect.

Feedback to members via, Members news and Members email.

Continued communication as project progresses.

Legal requirements

The consultation documents will be drawn up in accordance with following legal requirements and guidance:

Cabinet Office Consultation Principles July 2012
This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.

Policy makers should bear in mind the Civil Service Reform principles of open policy making throughout the process and not just at set points of consultation and should use real discussion with affected parties and experts as well as the expertise of civil service learning to make well informed decisions. Modern communications technologies enable policy makers to engage in such discussions more quickly and in a more targeted way than before and mean that the traditional written consultation is not always the best way of getting those who know most and care most about a particular issue to engage in fruitful dialogue.

The full consultation principles document can be accessed via the Cabinet Office website at:
https://www.gov.uk/government/publications/consultation-principles-guidance

Section 14Z2 Health and Social Care Act 2012

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2) (b) to the delivery of services is a reference to their delivery at the point when they are received by users.

For more on the Section 14Z2 Health and Social Care Act 2012 see http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

Four Criteria for Significant Service Change

In May 2010, the Secretary of State for Health, Andrew Lansley, set four new tests that must be met before there can be any major changes to NHS Services:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice

CCG Constitution Section 5.2.

5.2. General Duties - in discharging its functions the NHS C& P CCG will:

5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by:

a) ensuring that individuals to whom the services are being or may be provided are involved:

(i) in the planning of the CCG's commissioning arrangements;
(ii) in the development and consideration of the proposals by the CCG for changes in commission arrangements;
(iii) in the decisions of the CCG affecting the operation of commissioning arrangements, where the decisions would, if made, impact on the manner in which the services are delivered to the individuals or the range of health services available to them;

b) in order to understand the views of patients and the public and to disseminate relevant information to them, establishing and working closely with:

(i) a Patient Reference Group which is constituted as a subcommittee of the Governing Body in accordance with this Constitution;
(ii) Local Commissioning Groups which are constituted as subcommittees of the Governing Body in accordance with this Constitution;
(iii) the Patient Safety and Quality Committee which is constituted as a subcommittee of the Governing Body and considers patient experience, complaints and feedback;
(iv) Patient Participation Groups which will seek the views of local populations and assist with the dissemination of information, and representatives of which will sit on each Local Commissioning Group's patient forum;

c) in order to understand the views of patients and the public and to disseminate relevant information to them, ensuring regular liaison and the development of close working relationships with each of the following bodies:

(i) Patient Forums, which are intended to give individuals the opportunity to raise questions or concerns about the provision of healthcare services at the wider county level;
(ii) Healthwatch, which gathers views of local people on local health services;
(iii) Health Overview and Scrutiny Committees which review the planning, commissioning and delivery of health services;
(iv) Health and Wellbeing Boards, each of which is a group of key leaders representing health and care organisations who work together to understand what their local communities need from health and care services and to agree priorities;

d) publishing a Communications Membership and Engagement Strategy, approved by its Governing Body and regularly revised to take into account any new guidance published by NHS England, which will be designed to ensure that the CCG involves patients and the public by a range of means that are suitable to different aspects of its commissioning arrangements, those means to include as appropriate:

(i) the publication of documents to disseminate relevant information about the commissioning arrangements;
(ii) regular attendance at key meetings, forums and events for the purpose of listening to the views of patients and the public, providing information about and explaining actions being taken or considered by the CCG, and answering questions;

(iii) the dissemination of information by means of the CCG website, emails, newsletters targeted at specific groups, media campaigns, advertising, and targeted engagement events;
(iv) the provision of an opportunity for patients and the public to make their views known via the CCG website, emails and other suitable means;
(v) the publication of consultation documents in relation to certain planning and commissioning activities, and the creation of specific engagement opportunities such as the use of public surveys and feedback forms;

e) in the implementation of the arrangements described above, acting consistently with the following principles:

(i) ensuring that appropriate time is allowed for the planning of activities and commissioning arrangements;
(ii) proactively seeking engagement with the communities which experience the greatest health inequalities and poorest health outcomes;
(iii) commencing patient and public involvement as early as possible and allowing appropriate time for it;
(iv) using plain language, and sharing information as openly as is reasonably practicable;
(v) treating with equality and respect all patients and members of the public who wish to express views;
(vi) carefully listening to, considering and having due regard to all such views;
(vii) providing clear feedback on the results of patient and public involvement.

You can read more about the CCG's duties to engage and consult in section 5.2 of the CCG's Constitution
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CPCT/Corporate%20documents/CCG%20Constitution.pdf

NHS Accessible Information Standards.

The NHS Accessible Information Standards ensure clearer health and care information for disabled people and their carers.
The Accessible Information Standard aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support so they can communicate effectively with services. Examples of the types of support that might be required include large print, plain text copy on websites, braille or using a British Sign Language (BSL) interpreter.
All organisations that provide NHS care or adult social care are required to follow the new standard, including NHS Trusts and Foundation Trusts, and GP practices. As part of the accessible information standard, NHS organisations must do five things:

- Ask people if they have any information or communication needs, and find out how to meet their needs.
- Record those needs clearly and in a set way.
- Highlight or 'flag' the person's file or notes so it is clear that they have information or communication needs and how those needs should be met.
- Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.

- Take steps to ensure that people receive information which they can access and understand, and receive communication support if they need it.The Accessible Information Standard came into effect in July 2016

Agenda Item No: 7

KEY DEVELOPMENTS AT CUH FOLLOWING AN UNANNOUNCED CARE QUALITY COMMISSION INSPECTION IN OCTOBER 2018 AND WELL-LED AND USE OF RESOURCES INSPECTIONS IN NOVEMBER 2018

To:	**Health Committee**
Meeting Date:	**11 July 2019**
From:	**Cambridge University Hospitals NHS Foundation Trust (CUH)**
Purpose:	**The purpose of this report is to update the Committee with respect to the outcome of the recent Care Quality Commission inspection of CUH and ongoing actions.**
Recommendation:	**The Committee is asked to note the contents of this report, and the work being undertaken to address the findings and deliver further improvement.**

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1. BACKGROUND

1.1 The Care Quality Commission (CQC) initiated a Provider Information Request (PIR) from Cambridge University Hospitals NHS Foundation Trust on 15 August 2018 and this was submitted on 6 September 2018 to the required deadline.

1.2 Between 30 October 2018 and 1 November 2018, the Trust underwent an unannounced inspection of four core services:

- Urgent and Emergency Care
- Medical Care
- End of Life Care
- Surgery

1.3 This was followed by a Use of Resources assessment by NHS Improvement on 12 November 2018 and a CQC Well-Led Inspection between 27 and 29 November 2018.

1.4 Preliminary feedback was received from the CQC in a letter to the Chief Executive on 30 November 2018 which was copied to NHS Improvement.

1.5 The draft CQC report and evidence appendix was received by the Trust on 18 January 2019 and factual accuracy responses were returned on 30 January 2019, ahead of the required deadline. The evidence appendix has recently been introduced by the CQC and is published in parallel with the main report. It underpins the evidence gathered to support the report findings.

1.6 The final report was published on 26 February 2019.

2. CQC INSPECTION REPORT – SUMMARY OF FINDINGS

2.1 The overall rating of the Trust stayed the same as in the January 2017 inspection report. CUH Is rated as good because:

- ‘Safe’ and ‘effective’ are good, ‘caring’ and ‘well-led’ are outstanding but ‘responsive’ remains as ‘requires improvement’.
- Three of the four core services inspected are good overall and one is outstanding (end of life care).
- The CQC considered the current ratings of the four core services that were not inspected this time. While the Trust had improved, there remained a rating of requires improvement for ‘responsive’.
- Although the Trust is outstanding in the ‘caring’ and ‘well-led’ domains, the Trust was rated as good overall because the ‘responsive’ domain remained as a rating of requires improvement.
- In addition, the Use of Resources inspection resulted in a ‘Requires Improvement’ rating, which was incorporated into the overall Trust rating for the first time under the new CQC methodology.

Ratings for Addenbrooke's and the Rosie Hospitals

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2019	Good →← Feb 2019	Outstanding ↑ Feb 2019	Requires improvement ↓ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019
Medical care (including older people's care)	Good →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Surgery	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Critical care	Good Jan 2017	Outstanding Jan 2017	Outstanding Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017
Maternity	Good Jan 2017	Good Jan 2017	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017
Services for children and young people	Good Jan 2017	Good Jan 2017	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017
End of life care	Good →← Feb 2019	Good ↑ Feb 2019	Outstanding →← Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Outstanding ↑ Feb 2019
Outpatients	Good Jan 2017	Not rated	Good Jan 2017	Requires improvement Jan 2017	Good Jan 2017	Good Jan 2017
Overall*	Good →← Feb 2019	Good →← Feb 2019	Outstanding →← Feb 2019	Requires improvement →← Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019

Ratings

Overall quality rating for this trust	**Good** ●
Are services safe?	**Good** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Requires improvement** ●
Are services well-led?	**Outstanding** ☆

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RGT/reports)

Are resources used productively?	**Requires improvement** ●

Combined rating for quality and use of resources	**Good** ●

3. SUMMARY BY KEY LINE OF ENQUIRY (KLOE) DOMAIN

3.1 Are services safe? The rating of safe stayed the same.

However:

- Since the last inspection the Trust had made improvements to improve the safety of paediatric patients within the ED, but during the inspection the CQC identified that patients and relatives within the department could access the paediatric waiting and treatment area unchallenged by staff and that the area was not always supervised. Staff were not able to see the waiting areas and there was no closed-circuit television to observe the children and relatives.
- Observations were not always documented for patients with mental health conditions who required observation every 15 minutes within the emergency department.
- The Trust did not meet all the Royal College of Emergency Medicine standards, although they had action plans to improve compliance.
- Throughout the inspection of surgery, the CQC found that learning from incidents was not always shared between different divisions.

3.2 Are services effective? The rating of effective stayed the same.

However:

- The severe sepsis and septic shock audit 2016 to 2017 demonstrated that the emergency department did not meet the national standards, although, the ED had implemented actions and had shown some improvements in 2018.

3.3 Are services caring? The rating of caring stayed the same. It was outstanding because:

- The Trust had a strong, visible person-centred culture. Despite financial and staff challenges, staff were highly motivated and inspired to provide care that was kind and promoted the dignity of patients.
- Feedback from patients and relatives was overwhelmingly positive about the way staff provided care and treatment.
- Patients told the CQC that staff went that extra mile and their care and support exceeded their expectations.
- Staff of all levels introduced themselves and took time to interact in a considerate and sensitive manner. Staff spoke with patients in a respectful way.
- The CQC observed many examples of staff responding with kindness when patients required assistance or support.
- Patient's emotional and social needs were as important as their physical needs.
- Staff involved patients and those close to them in decisions about their care and treatment. The CQC observed staff involving patients and their relatives during assessments and when taking physiological observations on the wards.
- The Trust provided support to patients' relatives where appropriate by enabling open visiting where appropriate and having on-site accommodation available.

3.4 Are services responsive?

The rating of responsive stayed the same. It was rated as requires improvement because:

- The Trust did not meet all the Royal College of Emergency Medicine standards, although they had action plans to improve compliance.
- The Trust continued to experience challenges with delayed transfers of care (DTOC). Staff understood the challenges and were acting to address shortfalls, which were mainly affected by external pressures of care home availability and rehabilitation opportunities.
- Fast track discharge did not meet the NHS England recommended time of 48 hours and on some occasions, was much longer than this. The average time to discharge was eight days, which suggests that the Trust was performing worse than the last inspection, where the average time to discharge was 3.8 days for patients living in Cambridge and 4.7 days for patients living outside Cambridge.
- The service overall referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average.
- Between 2016 and 2018, the percentage of cancelled operations for elective procedures due to non-clinical reasons was higher than the England average in all quarters apart from the most recent one (April to June 2018).
- Overnight intensive recovery (OIR) was intended to only be a 22-hour stay before patients were transferred to the appropriate ward, but there were frequent delayed discharges from OIR and main recovery to wards and the intermediate dependency area.
- Although the Trust treated concerns and complaints seriously, they were not always investigated, responded to, and closed in a timely manner.

3.5 Are services well-led?

The rating of well-led improved. It was rated outstanding because:

- Well led for urgent and emergency services and end of life care was rated as outstanding.
- There was compassionate, inclusive and effective leadership at all levels. The leadership team had the right skills and abilities to run a service providing high-quality sustainable care. Leaders worked collaboratively across departments and were knowledgeable about risks and priorities for the quality and sustainability of their services.
- The Trust had a vision for what it wanted to achieve and workable plans to turn it into action. These had been developed with involvement from staff, patients and external stakeholders. All staff the CQC spoke with were aware of the Trust vision and could describe it to them. There was a systematic approach to monitoring, reviewing and tracking progress within the Trust.
- Comprehensive and successful leadership strategies were in place to ensure and sustain service delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges, and priorities in their service, and beyond.
- Managers across the Trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff reported feeling respected and valued.

- The Trust prioritised leadership development and succession planning to enable a culture that recognised the importance of having leaders with the right attitude, skills and abilities.
- Leaders consistently involved staff, considered public feedback and welcomed stakeholder challenge to further develop services. Staff were committed to seek and embed new ways of working which improved care and services for patients.
- The Trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- The Trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care could flourish. There were effective structures, processes and systems of accountability in place to support the delivery of the strategy and good quality services.
- There were systems and processes to ensure risks were monitored and mitigated wherever possible, and performance was monitored. Risks on risk registers were known to the leadership teams and matched what the CQC found on inspection.

4. Areas for improvement by core service

4.1 The CQC found 15 areas that the Trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a regulatory requirement or to improve service quality.

Urgent and Emergency care

- Ensure patients and relatives within the department cannot access the paediatric waiting room and treatment area, and staff regularly observe the paediatric waiting area.
- Ensure medical staff attendance at mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) training is improved to meet the trust target.
- Ensure that the severe sepsis and septic shock audit continues to improve to meet the national standards.
- Ensure that patients' wait from time of arrival to receiving treatment should be no more than one hour (*for minor injury or illness*).
- Ensure that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED.

Surgery

- Encourage the learning from incidents across the service and between divisions, to help mitigate the risk of potentially avoidable incidents reoccurring.
- Continue working to improve referral to treatment time, flow through the service and reduce the number of cancelled operations.
- Ensure that escalation processes are known to staff when temperatures of medicines and flammable liquids are breached.
- Assess the arrangements for patients admitted to eye surgery in the morning when their scheduled surgery is in the afternoon.
- Continue working on the experience of the overnight intensive recovery area for patients and ensure there is mitigation in place when patients are required to stay there longer than one night.
- Ensure all patients are fully involved in their care and treatment by medical staff and ensure positive communication from medical staff.

- The service should continue to work on improving performance in the National Emergency Laparotomy Audit.

End of life care
- Review medical staffing of the specialist palliative care team against national guidance.
- Continue work to improve the fast track discharge process.
- Audit the percentage of patients that achieved their preferred place of death.

5. Outstanding practice by core service

5.1 The CQC found examples of outstanding practice:

Urgent and Emergency Care
- ED staff participated in outreach work in the community.
- A healthcare assistant (HCA) who took a 'no nonsense' attitude (practical and only interested in achieving) towards protecting patients and staff in the ED -They successfully introduced a programme called 'No Nonsense November' for annual fit testing of respirators and the HCA successfully negotiated the purchase of hoods as well as identifying safe storage.
- A paediatric HCA from the ED who coordinated an appeal for new toys for the children's emergency waiting room. The social media post was seen by BBC Cambridgeshire which highlighted fund raising within the department.

Medical Care (Including older people's services)
- Innovative practices to improve patient discharge, for example the Trust had implemented a project for patients to learn to administer their own intravenous (IV) antibiotics at home to reduce the amount of time patients had to remain in hospital.

Surgery
- The Trust had a positive focus on staff engagement.
- In the main surgery recovery was a 'listening ear' on the wall in response to patient feedback.
- There were frequent opportunities for staff to develop their competencies.

End of life care
- The bereavement care follow-up service offered grief intervention and support for relatives following the death of a loved one in hospital.
- The 'tiny feet' initiative provided free hand and foot clay imprints, of babies and children who had recently died.

6. Use of resources

6.1 The use of resources was rated as requires improvement. The Trust's deficit position had worsened and performance against the productivity metrics in assessment framework was varied. For the first time the use of resources rating was used to determine the overall Trust inspection rating under the new CQC methodology.

6.2 **Use of resources - Outstanding practice**
- The Trust's use of technology in its clinical and business processes to drive operational efficiency and better patient experience.

- The Trust's pharmacy staffing model which has helped reduce hospital admissions, facilitate prompt hospital discharge, and reduce medicine dispensing errors.
- Good use of the Purchasing Price Index Benchmark tool to secure good prices and drive down cost of purchases.
- The Trust has been recognised for its excellent engagement with the GIRFT programme in improving productivity.

6.3 **Use of resources - Areas for improvement:**

- The backlog maintenance and critical infrastructure risk is high and needs to be reduced so that patient safety does not become compromised in the future.
- The Delayed Transfers of Care (DTOC) rates remain high and the Trust should continue to work towards reducing them (in collaboration with system partners).
- There is a high proportion income generation CIPs which may not be sustainable in future years. This needs to be maintained at reasonable levels in future financial plans.
- Further work is required to understand and reduce the underlying deficit.
- Continued focus is required on areas where the Trust has made improvements, but performance is still below national medians, in particular overall staff retention.
- The Trust should continue working to reduce the cost of the eHospital system.

7. Requirement Notices

7.1 There were no regulatory breaches identified by the inspectors.

8. Factual accuracy

8.1 The factual accuracy progressed swiftly and reflected the quality of the PIR, data request returns and the communication with the CQC during the Well-led inspection.

8.2 The factual accuracy returns mainly reflected grammatical, typographical or minor clarifications to discussions reported by the CQC in the evidence appendix and main report.

8.3 The most significant response to the factual accuracy request was in relation to the requires improvement rating for 'responsive' under Urgent and Emergency care and Surgery, where additional information was submitted.

8.4 The factual accuracy process did not prompt any significant changes to the original draft report during its finalisation.

9. CQC feedback

9.1 The CQC has requested feedback on the inspection and this will be collated by the Compliance Team.

10. Conclusion and next steps

10.1 All recommendations for improvement are reviewed in line with Quality Steering Group processes, and work streams developed with relevant operational leads. These will be included in the Trust's Quality Improvement Plan that will be shared publicly through NHS Choices website and will be reviewed by the Trust's commissioners and regulators.

10.3 Progress against work streams is be monitored, with any deviations from progress escalated to the Trust's Management Executive. The Management Executive will also discuss ongoing improvement priorities for the next one to three years.

10.4 As this cycle of inspection comes to a close the CQC relationship manager will reconvene regular engagement sessions with Trust staff, and hold regular meetings with the Chief Nurse, as the executive lead for compliance. Insight reporting will resume and be shared monthly with the Management Executive.

10.5 The Compliance Team reviews and plans with operational leads a series of peer reviews with those core services that have not been inspected, utilising the new CQC methodology in readiness for potential further core service inspections during 2019.

Agenda Item No: 8

CONTRACT NOVATION IN RESPECT TO THE INTEGRATED DRUG AND ALCOHOL TREATMENT SERVICE CONTRACT.

To: **Health Committee**

Meeting Date: **11th July, 2019**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: **2019/021**

Key decision: **Yes**

Purpose: **This paper seeks the support and approval of the Health Committee to novate Cambridgeshire County Council's Integrated Drug and Alcohol Treatment Service contract from the charity Change Grow Live to the wholly owned subsidiary of the charity, Change Grow Live Services Limited.**

Recommendation:

The Health Committee is requested to:

1. **Review the rationale for the request for contract novation.**
2. **Approve the contract novation of Cambridgeshire County Council's Integrated Drug and Alcohol Treatment Service contract from the charity Change Grow Live to the wholly owned subsidiary of the charity, Change Grow Live Services Limited.**

If the request is supported:

3. **Authorise the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health Committee, to novate the current contract subject to compliance with all required legal processes**
4. **Authorise the Consultant in Public Health, Health Improvement, in consultation with the Executive Director of LGSS Law to approve and complete the necessary contract documentation**

Officer Contact:		***Chair Contact:***	
Name:	Val Thomas	Name:	Councillor
Post:	Consultant in Public Health	Post:	Peter Hudson
Email:	Val.Thomas@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 703264	Tel:	01223 706398

1. BACKGROUND

1.1 Change Grow Live (CGL) was awarded the Cambridgeshire Adult Integrated Drug and Alcohol treatment contract in June, 2018. The contract commenced on the 1st October 2018 for a 3.5 years period with the option to extend for a further 2 years.

1.2 Due to financial pressures nationally across the drug and alcohol sector, CGL are approaching all commissioners, seeking to novate contracts to their wholly owned, non-charitable, trading subsidiary 'Change Grow Live Services Limited'. This will enable them to make VAT savings.

1.3 As part of their tender submission CGL included a proposal that if it was successful the organisation would seek agreement to novate the contract to their Change Grow Live Services Ltd, to enable the reclaim of VAT (£500k over contract lifetime, £80k per annum) which would be wholly reinvested in a local 'recovery grant fund' to strengthen the growth and development of the innovative Recovery Service element of the new Cambridgeshire treatment model.

2. MAIN ISSUES

2.1 As a registered charity, the majority of CGL's services are deemed exempt from VAT as they are classed as health and welfare services by HMRC. Therefore, CGL is not allowed to charge VAT on these services which also means CGL (Charity) is unable to reclaim the VAT it pays to its suppliers in the provision of those services. In order to alleviate financial pressures across its contracts, a corporate restructure has been implemented whereby CGL (Charity) contracts are novated to its wholly owned, non-charitable trading subsidiary CGL Services Limited. This restructure allows CGL Services to charge VAT on the contract. In relation to the CCC contract the Council will be able to recover the VAT. In addition as CGL is now able to charge VAT it is also able to reclaim any charged by the provider's suppliers. See Appendix 1 where the flowcharts describe these processes. This change enables the provider to focus spend on areas that improve and maximise service delivery and ensure it continues to deliver effective service outcomes.

2.2 Novation will result in the contract for Integrated Drug and Alcohol Treatment Service being between the Council and CGL Services Limited. However CGL Services Limited will sub-contract service delivery to CGL the charity. CGL Services Limited shall be legally responsible for delivering the contract and whilst the Council consents to CGL Services Limited subcontracting to CGL (Charity), this shall not relieve CGL Services Limited of its liability to the Council for the full performance of any of its obligations under the contract.

2.3 Charity Commission guidance permits charities to consider different structures to ensure funds are maximised for delivery of their charitable purposes. CGL stated that the proposal does not require HMRC approval, however it did notify HMRC of the intention to novate the Cambridgeshire CGL contract (Charity) to CGL Services Limited.

2.4 Savings will vary during the course of the existing contract due to potential changes to VAT rules and the varying VAT position of the mix of supplies into CGL. These savings will only be realisable within the duration of the existing contract. It is anticipated that the VAT

reclaim will generate an additional yearly income of approximately 80k which will be re-invested into the local service.

2.5 The additional yearly income shall be reflected within the Specification, including variation to service delivery/outcome, key performance indicators and monitoring and reporting.

2.6 A similar proposal was requested and granted by Peterborough City Council in December, 2018 in respect to the Public Health Integrated Drug and Alcohol treatment contract which is also provided by CGL (commenced April 2016).

2.7 **Potential Risks and mitigation**

2.1 Due diligence was undertaken which included the Finance and Legal teams considering the novation proposals. See Appendix 2 for a FAQ document produced by CGL that explains and addresses questions that have been raised. The following indicates their questions and the assurances that have been provided.

(i) The Council required a financial investigation/assessment on the new subsidiary CGL Services Limited. This was undertaken and CGL Services Ltd. has been deemed to be low risk.
(ii) A parent company guarantee was requested for the novated contract which has been agreed with CGL.
(iii) In order to maintain clinical quality and compliance the Deed of Novation and letter of consent to sub-contracting will contain provisions reiterating the obligations in the contract requiring that any organisation delivering regulated activities are registered and compliant with CQC Regulations as required by law and good clinical practice. CGL have accepted these as part of the terms and conditions of the contract.

2.2 The Legal and Finance Teams also requested further information with regard to the position of HMRC in relation to the novation. This was also a concern of the Health Committee and the Director of Public Health was asked to personally assess through a dialogue with CGL any risks associated with the proposal.

2.3 The central concern was whether HMRC needed to provide written official acceptance of the proposal. CGL had supplied evidence that other areas had approved and accepted the novation of its contracts with CGL (Charity) to CGL Services Ltd. Locally Peterborough City Council legal services has also approved the request as described above.

2.4 Further discussion with CGL has taken place which included its Financial Controller, an advisor from the company that advises CGL on finance/VAT issues and the Director of Public Health. This discussion clarified the HMRC position in that as the proposed novation and its associated VAT implications are in line with the VAT legislation (VAT Act 1994, Schedule 9, Group 7, Item 9) CGL does not require any formal approval for the change.

3. ALIGNMENT WITH CORPORATE PRIORITIES

Report authors should evaluate the proposal(s) in light of their alignment with the following three Corporate Priorities.

3.1 Developing the local economy for the benefit of all

Reinvesting the VAT reclaim monies into strengthening locally based recovery support will enable growth and increased resilience across communities in Cambridgeshire.

3.2 Helping people live healthy and independent lives

Increased investment in recovery based support will encourage move on and independence away from specialist services, integrate individuals in their local communities through involvements in healthy recovery based activities and peer led support.

3.3 Supporting and protecting vulnerable people

An increase in investment to the new Recovery Service model will extend the development and delivery of recovery based activities at a local level, building peer led support thereby strengthening community resilience and providing much needed support to vulnerable individuals and families struggling with substance misuse and/or mental health difficulties.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The following bullet points set out details of significant implications identified by officers:

- Contract novation will result in additional resources made available to Cambridgeshire.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The following bullet points set out details of significant implications identified by officers:

- Any implications for procurement/contractual/Council contract procedure rules will be considered with the appropriate officers from these Departments and presented to the Health Committee before proceeding.

4.3 Statutory, Legal and Risk Implications

The following bullet points set out details of significant implications identified by officers:

- Any legal or risk implications will be considered with the appropriate officers from these Departments and presented to the Health Committee before proceeding.

4.4 Equality and Diversity Implications

The following bullet points set out details of significant implications identified by officers:

- There will not be any equality and diversity changes

4.5 Engagement and Communications Implications

The following bullet points set out details of significant implications identified by officers:

- Extensive consultation was undertaken before initial contract award with the general public, service users and stakeholders. This proposed contract change will have no impact on service delivery.

4.6 Localism and Local Member Involvement

The following bullet points set out details of significant implications identified by officers:

- The new recovery service will be co-produced with service users and will involve asset based community development mapping, connecting service users to recovery based activities/services and facilitating access to mutual aid support in their local community.

4.7 Public Health Implications

The following bullet points set out details of significant implications identified by officers:

- The contract novation will contribute towards improving long term health and social outcomes for substance misusers by ensuring that long term community based support is available after discharge from specialist provision, strengthening community and personal resilience, preventing relapse and readmission to services.

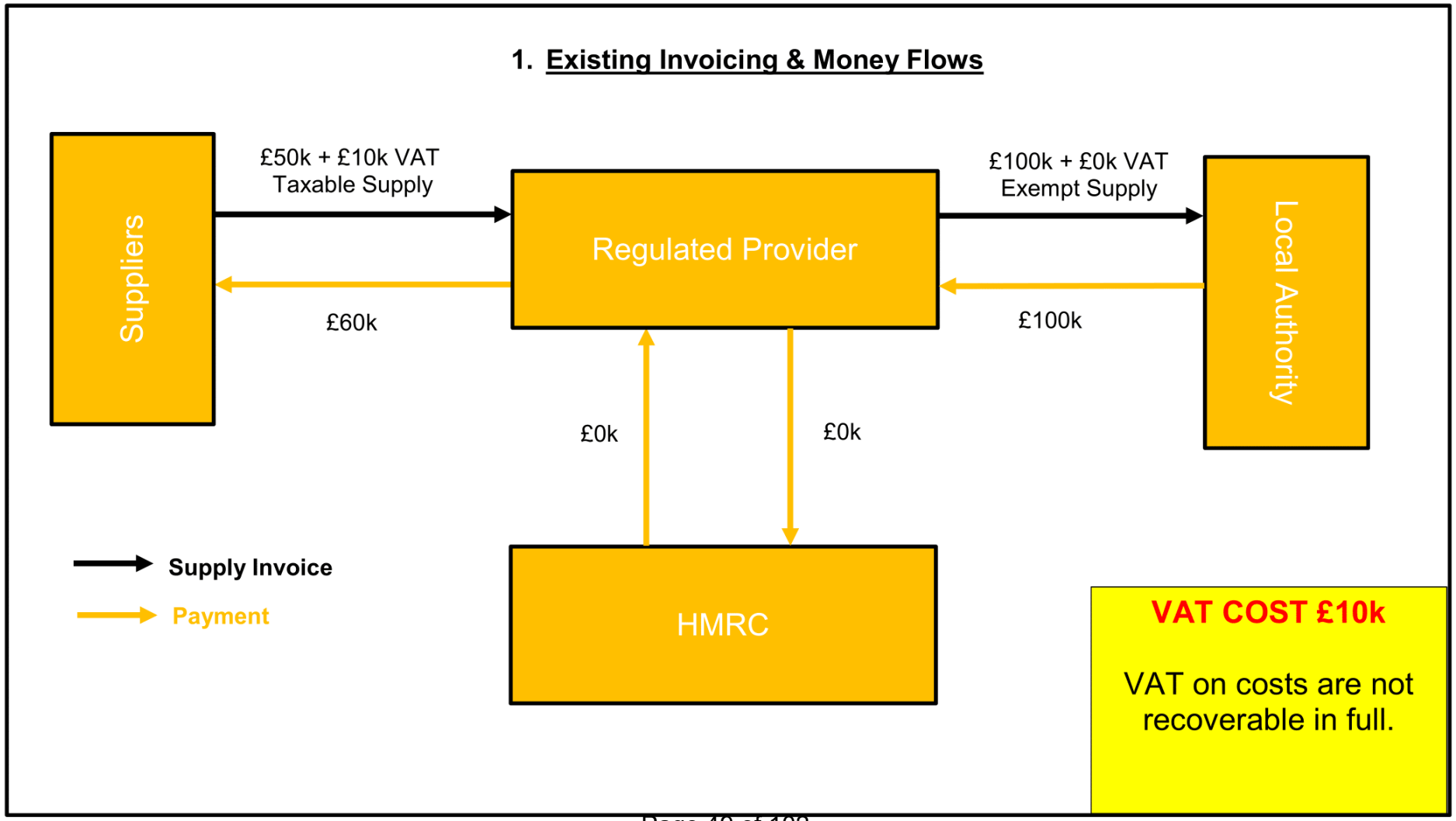
- These service developments will need to include targeted actions that will address any inequalities and improve outcomes for the most vulnerable and at risk populations.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes : 19 June 2019 Name of Officer: Gus de Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes : 20 June 2019 Name of Legal Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Liz Robin

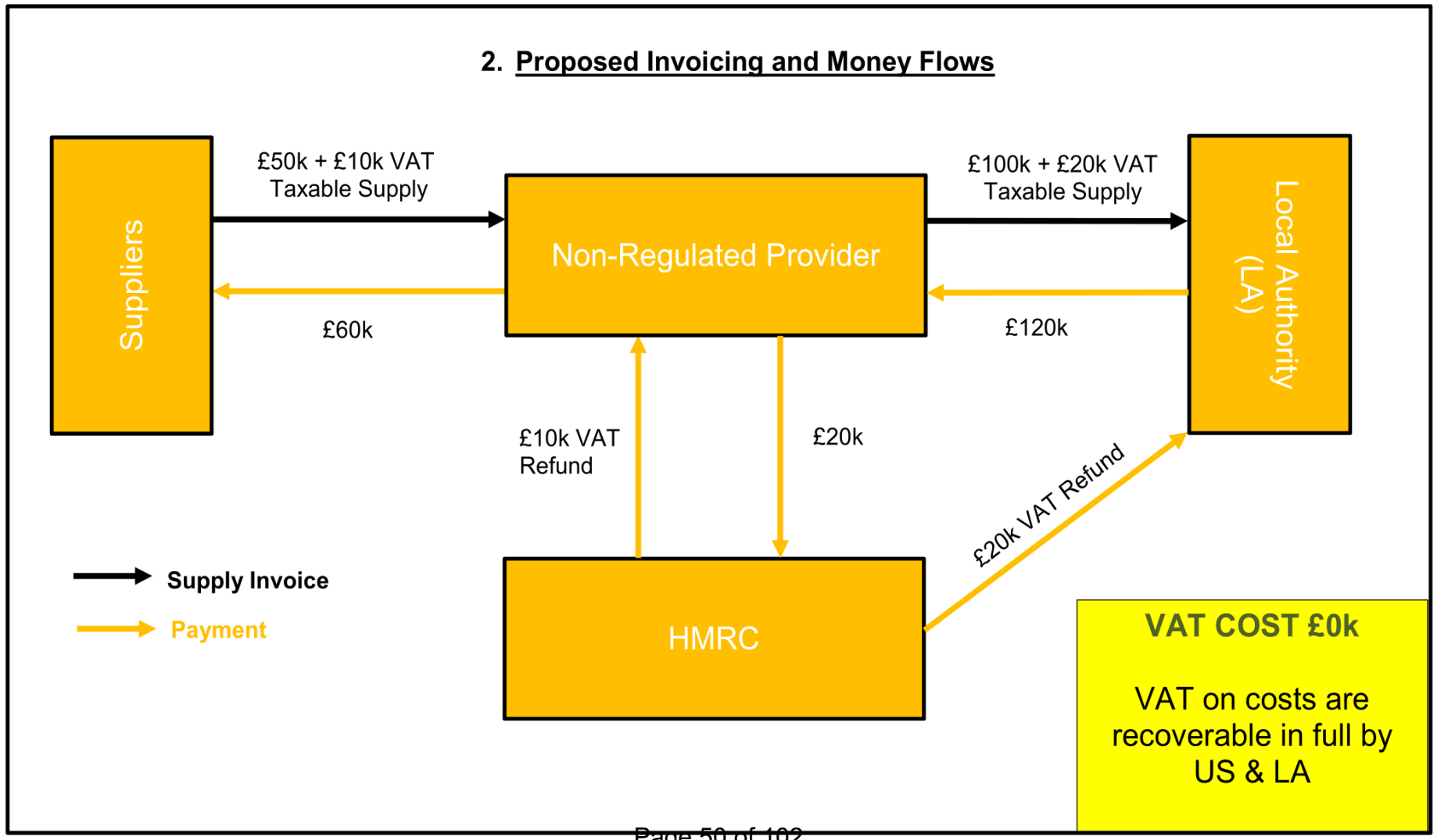
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
VAT Act 1994, Schedule 9, Group 7, Item 9	https://www.legislation.gov.uk/ukpga/1994/23/schedule/9

Existing Invoicing and Money Flows



Proposed Invoicing and Money Flows



Frequently Asked Questions

Proposed change to contracting arrangements with CGL

August 2017
Version 1.3

What is the proposal?

Change Grow Live (CGL) is a registered charity delivering health and welfare services and as such cannot recover VAT on its supplies or charges, which increases the cost of delivering our services. As a charity we believe it is incumbent upon us to maximise the use of the public funds entrusted to us on frontline delivery and as such have identified a solution to this issue.

CGL is able to contract through its wholly owned, non-charitable, trading subsidiary, CHANGE GROW LIVE SERVICES LTD (CGL Services), which means that CGL Services is then able to charge VAT on the contract, which should be recoverable by yourselves, but allows CGL to reclaim VAT charged by our suppliers, allowing us to focus our spend on areas that improve service delivery rather than paying unnecessary VAT. We are not the first organisation to take this approach.

The delivery of all services under the contract will continue to be undertaken by the charity CGL (on a subcontract basis) and CGL would maintain the appropriate regulatory status. CGL would also provide a parent company guarantee, if required, for the delivery of the services under the contract as CGL Services does not have a trading history. This means that, commercially, there will be little change for the Commissioner. Staff will continue to be employed by CGL and will not transfer to CGL Services.

Why make this change?

Several external factors have contributed to severe pressure being placed on service delivery and therefore CGL needs to be innovative in finding ways to maximise service deliver and ensure it continues to deliver effective service outcomes.

1. **Reduction in social welfare budgets.**
   The same volume and quality of social welfare provision is being demanded at a significantly reduced budget.
2. **Inflation and legislative changes.**
   Goods and services required to deliver CGL services have become increasing more costly. Staff costs, which make up the bulk of the service costs, as a result of minimum wage increases and the apprenticeship levy are particularly acute.

3. **Foreign exchange rates.**
   The pound has become significantly less valuable against other currencies. As significant IT resources are invoiced in dollars the devaluation of the pound has resulted in increases in these costs.

What is the direct benefit to service users?

Service users will benefit as the savings from VAT reduces the need to make savings on front line costs as the pressures described above become increasingly more acute. This will ensure that as service budgets become increasing challenged CGL will be able to avoid disinvesting in the service in order to meet budgetary constraints.

What is the benefit to commissioners?

In a climate of declining service budgets the scheme will ensure vital social welfare services to remain viable and the delivery of effective outcomes to continue.

What is the impact on commissioners?

The contract will be novated from CGL to CGL Services and a parent company guarantee may be entered into between the commissioner and CGL.

This would mean that the underlying commercial position for the commissioner is the same as before the novation. VAT will be charged on invoices on top of the charge for the services. Commissioners can then recover the VAT charge and so this does not represent an additional cost to the commissioner.

What is the impact on staff?

None. Staff will continue to be employed by CGL, although as noted above, recovering VAT reduces the need to maintain viability by reducing staffing levels which are our biggest area of cost.

Why is CGL unable to reclaim VAT?

As a registered charity, regulated by the CQC the majority of CGL's services are deemed exempt from VAT as they are classed as health and welfare services by HMRC. Therefore, CGL is not allowed to charge VAT on these services which then means that CGL is unable to reclaim the VAT it pays to its suppliers in the provision of those services.

What is VAT exempt?

VAT exempt means that the products or services supplied by an organisation do not carry a VAT charge. Examples of VAT exempt products and services include; education and training products, insurance and finance products along with books, newspapers and magazines.

Who will deliver the services?

There will be no change to the organisation delivering the services, this will remain CGL. There will be a management services agreement between CGL and CGL Services that requires CGL Services to subcontract all service delivery under contracts with commissioners to CGL.

How will the services be regulated?

There will be no change in the regulation. CGL, as the organisation delivering the services and whom will still remain legally responsible for the delivery of the services will maintain its current regulatory status with CQC.

All services which novate will be required to notify CQC of the change and submit an amended SOP.

Is this normal and reasonable for a charity?

The Charity Commission guidance says that charities can consider different structures to minimise paying unnecessary tax. Many charities have trading subsidiaries to minimise tax cost and ensure they maximise funds for delivery of their charitable purposes.

How is this arrangement viewed by the Charities Commission and HMRC?

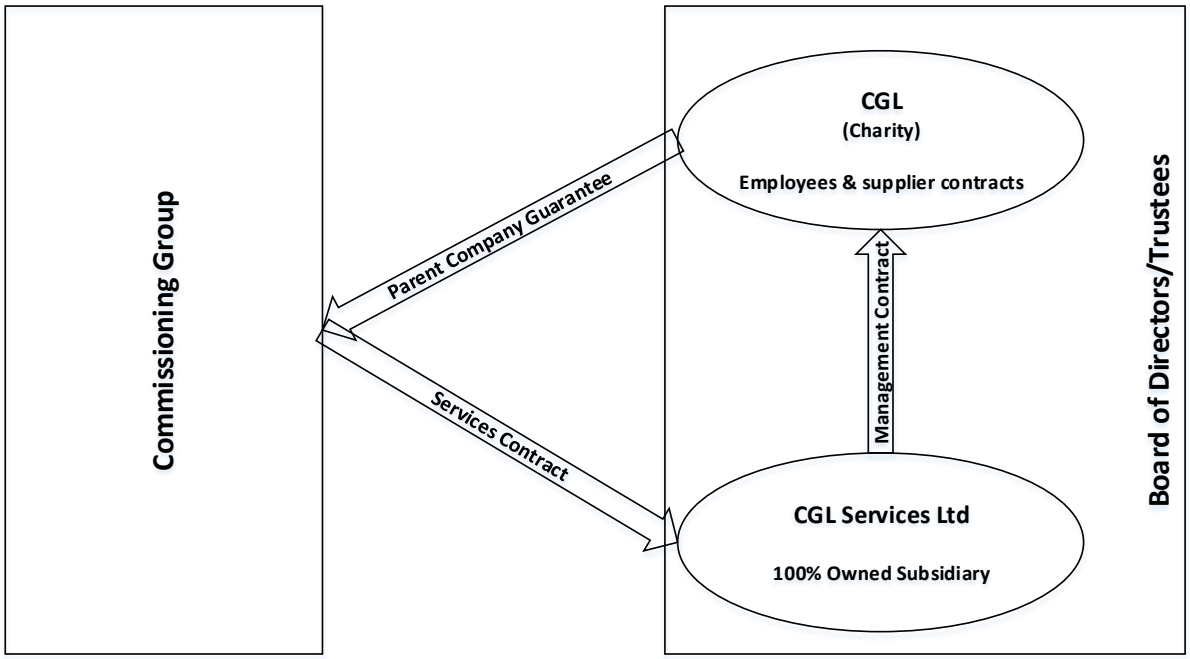
Charities Commission guidelines recognise that charities should take appropriate steps to minimise paying unnecessary tax and this structure follows that guidance.

This is not an arrangement that requires HMRC approval but we have notified them of it. We understand from our tax advisers that HMRC accept that this structure follows the rules and they have not challenged other examples of it.

What corporate governance controls will be placed over the new subsidiary?

The board of directors and company secretary of the subsidiary the same as those who are on the board of trustees of CGL the charity. CGL can also offer a company parent guarantee to ensure that the commissioner is in the same commercial position as before the novation.

The following diagram summaries this arrangement;



Where CGL is an outsourced provider operating as a subcontractor on behalf of a lead contractor how would this scheme operate?

This would depend on the VAT status of the lead contractor, if it does not charge then this approach would not generate any savings and no change will be made. If the lead contractor does charge VAT then CGL will negotiate the novation of its contract with the lead contractor not the commissioner, subject to any consents that may be required in the contract between the commissioner and the lead contractor.

How would the scheme operate in a PBR environment?

There would be no change to this. CGL and CGL Services would continue to deliver this and payment would be in accordance with the existing contract as it novates/transfers.

Perceived political risk of not contracting directly with the charity

The services will continue to be delivered by CGL the charity, although the direct contract will be with CGL Services, the wholly owned subsidiary of the charity. There may also be a parent company guarantee from the charity, further emphasising this structure and support. If the commissioner does not want this approach for political or other reasons then clearly the savings will not be delivered and other efficiency savings may need to be found to compensate.

Are these savings likely to continue indefinitely?

Savings will vary during the course of existing contracts due to potential changes to VAT rules and the varying VAT position of the mix of supplies into CGL. These savings will only be realisable within the duration of the existing contract.

However, for re-tenders or bids for a new services, budgets will be based on prices net of VAT. This will allow CGL to offer the same level and quality of service but at a more competitive price. This ensures services are able to continue to benefit from the scheme as contracts are renewed or replaced by CGL.

Agenda Item No: 9

FINANCE AND PERFORMANCE REPORT – MAY 2019

To:	**Health Committee**
Meeting Date:	**11th July 2019**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the May 2019 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of May 2019.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of May 2019.**

	Officer contact:		***Member contacts:***
Name:	Martin Wade	Names:	Councillor Peter Hudson
Post:	Strategic Finance Business Partner	Post:	Chairman Health Committee
Email:	martin.wade@cambridgeshire.gov.uk	Email:	peter.hudson@cambridgeshire.gov.uk
Tel:	01223 699733	Tel:	01223 706398

1.0 BACKGROUND

1.1 A Finance & Performance Report for the Public Health Directorate (PH) is produced monthly and the most recent available report is presented to the Committee when it meets.

1.2 The report is presented to provide the Committee with the opportunity to comment on the financial and performance position of the services for which the Committee has responsibility.

2.0 MAIN ISSUES IN THE MAY 2019 FINANCE & PERFORMANCE REPORT

2.1 The May 2019 Finance and Performance report is attached at Annex A.

2.2 A balanced budget was set for the Public Health Directorate for 2019/20, incorporating savings as a result of the reduction in Public Health grant.

Savings are tracked on a monthly basis, with any significant issues reported to the Health Committee, alongside any other projected under or overspends.

The May 2019 Finance and Performance report (F&PR) is attached at Annex A and shows the forecast outturn for the Public Health Directorate is currently a balanced position.

Further detail on the outturn position can be found in Annex A.

2.4 The Public Health Service Performance Management Framework for April 2019 is contained within the report. Of the thirty one Health Committee performance indicators, six are red, one is amber and twenty-four are green.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

4.1.1 This report sets out details of the overall financial position of the Public Health Service.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	N/A
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	N/A
Have the equality and diversity implications been cleared by your Service Contact?	N/A
Have any engagement and communication implications been cleared by Communications?	N/A
Have any localism and Local Member involvement issues been cleared by your Service Contact?	N/A
Have any Public Health implications been cleared by Public Health?	N/A

Source Documents	Location
As well as presentation of the F&PR to the Committee when it meets, the report is made available online each month.	https://www.cambridgeshire.gov.uk/council/finance-and-budget/finance-&-performance-reports/

From: Martin Wade

Tel.: 01223 699733

Date: 10th June 2019

Public Health Directorate

Finance and Performance Report – May 2019

1 SUMMARY

1.1 Finance

Previous Status	Category	Target	Current Status	Section Ref.
Green	Income and Expenditure	Balanced year end position	**Green**	2.1

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
Apr (No. of indicators)	6	1	24	0	31

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Outturn Variance (Apr) £000	Service	Budget for 2019/20 £000	Actual to end of May 19 £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
-	Children Health	8,832	-14	0	0%
-	Drug & Alcohol Misuse	5,463	64	0	0%
-	Sexual Health & Contraception	5,097	-162	0	0%
-	Behaviour Change / Preventing Long Term Conditions	3,720	-489	0	0%
-	Falls Prevention	80	-10	0	0%
-	General Prevention Activities	13	-1	0	0%
-	Adult Mental Health & Community Safety	256	-1	0	0%
-	Public Health Directorate	1,894	231	0	0%
-	**Total Expenditure**	**25,355**	**-381**	**0**	**0%**
-	Public Health Grant	-24,726	-6,390	0	0%
-	s75 Agreement NHSE-HIV	-144	-144	0	0%
-	Other Income	-38	-10	0	0%
-	Drawdown From Reserves	-57	0	0	0%
-	**Total Income**	**-24,965**	**-6,544**	**0**	**0%**
-	**Contribution to/(Drawdown from) Public Health Reserve**				
-	**Net Total**	**390**	**-6,925**	**0**	**0%**

The service level budgetary control report for 2019/20 can be found in appendix 1. Further analysis can be found in appendix 2.

2.2 Significant Issues

A balanced budget has been set for the financial year 2019/20. Savings totalling £949k have been budgeted for and the achievement of savings will be monitored through the monthly savings tracker, with exceptions being reported to Heath Committee and any resulting overspends reported through this monthly Finance and Performance Report.

2.3 Additional Income and Grant Budgeted this Period (De minimus reporting limit = £160,000)

The total Public Health ring-fenced grant allocation for 2019/20 is £25.560m, of which £24.726m is allocated directly to the Public Health Directorate.

The allocation of the full Public Health grant is set out in appendix 3.

2.4 Virements and Transfers to / from Reserves (including Operational Savings Reserve) (De minimus reporting limit = £160,000)

Details of virements made this year can be found in appendix 4.

3. BALANCE SHEET

3.1 Reserves

A schedule of the Directorate's reserves can be found in appendix 5.

4. PERFORMANCE SUMMARY

4.1 Performance overview of April 2019(Appendix 6)

Sexual Health (KP1 & 2)

- Performance of sexual health and contraception services is good.

Smoking Cessation (KPI 5)

This service is being delivered by Everyone Health as part of the wider Lifestyle Service.

- The indicators for people setting and achieving a four week quit still remain red. Everyone Health is exceeding its targets for quits for routine and manual workers but activity in primary care has been decreasing (See Appendix 6)
- Appendix 6 provides further commentary on the Public Health Outcomes Framework (released July 2018) suggesting prevalence of smoking in Cambridgeshire is statistically similar to the England figure.
- End of year date will be available at the end of June 2019.

National Child Measurement Programme (KPI 14 & 15)

- The coverage target for the programme was met in 2017/18 and data has been submitted to PHE. Updates on performance in last year's programme were provided in February 2019 performance report.
- Measurements for the 2018/19 programme are taken during the academic year and the programme commenced in November 2018.

NHS Health Checks (KPI 3 & 4)

- Indicator 3 for the number of health checks completed by GPs is reported on quarterly. Q1 is presented and reporting as green.
- The commentary provides more details on the outreach health checks provision measured in Indicator 4 which remains at red.

Lifestyles Services (KPI 5, 16-30)

- There are 16 Lifestyle Service indicators reported on, the overall performance is good with 10 green 1 amber and 5 red indicators.
- Appendix 6 provides further explanation of the red indicators for smoking cessation and the personal health trainer service. The commentary further explains performance against the proportion of Tier 3 clients completing weight loss interventions and the complexity of the client group.
- The number of clients completing their PHP for the falls prevention service has fallen and KPI 30 is at red. The drop represents increased referrals and service capacity to respond (See appendix 6)

Health Visiting and School Nurse Services (KPI 6-13)

The performance data for Q1 (April – June 2019) for the Health Visiting and School Nurse services is still pending and should be available to report on in next month's finance and performance report.

4.2 Public Health Services provided through a Memorandum of Understanding (MOU) with other Directorates

TO FOLLOW

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Previous Outturn (Apr) £'000	Service	Budget 2019/20 £'000	Actual to end of May £'000	Outturn Forecast £'000	%
	Children Health				
0	Children 0-5 PH Programme	6,907	0	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,655	-14	0	0%
0	Children Mental Health	271	0	0	0%
0	**Children Health Total**	**8,832**	**-14**	**0**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,463	64	0	0%
0	**Drugs & Alcohol Total**	**5,463**	**64**	**0**	**0%**
	Sexual Health & Contraception				
0	SH STI testing & treatment – Prescribed	3,829	9	0	0%
0	SH Contraception - Prescribed	1,116	-203	0	0%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	33	0	0%
0	**Sexual Health & Contraception Total**	**5,097**	**-162**	**0**	**0%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	1,979	-150	0	0%
0	Other Health Improvement	413	-143	0	0%
0	Smoking Cessation GP & Pharmacy	703	-206	0	0%
0	NHS Health Checks Prog – Prescribed	625	9	0	0%
0	**Behaviour Change / Preventing Long Term Conditions Total**	1,979	-150	0	0%
	Falls Prevention				
0	Falls Prevention	80	-10	0	0%
0	**Falls Prevention Total**	**80**	**-10**	**0**	**0%**
	General Prevention Activities				
0	General Prevention, Traveller Health	13	-1	0	0%
0	**General Prevention Activities Total**	**13**	**-1**	**0**	**0%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	-1	0	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**-1**	**0**	**0%**

Previous Outturn (Apr) £'000	Service	Budget 2019/20 £'000	Actual to end of May £'000	Outturn Forecast £'000	%
	Public Health Directorate				
0	Children Health	285	26	0	0%
0	Drugs & Alcohol	216	34	0	0%
0	Sexual Health & Contraception	155	13	0	0%
0	Prevention Long Term Conditions (Behaviour Change)	559	61	0	0%
0	General Prevention (Travellers)	206	32	0	0%
0	Adult Mental Health	21	4	0	0%
0	Health Protection	134	23	0	0%
0	Analysts	318	38	0	0%
0		**1,894**	**231**	**0**	**0%**
0	**Total Expenditure before Carry forward**	**25,355**	**-381**	**0**	**0%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0%**
	Funded By				
0	Public Health Grant	-24,726	-6,390	0	0%
0	S75 Agreement NHSE HIV	-144	-144	0	0%
0	Other Income	-38	-10	0	0%
	Drawdown From Reserves	-57	0	0	0%
0	**Income Total**	**-24,965**	**-6,544**	**0**	**0%**
-0	**Net Total**	**390**	**-6,925**	**0**	**0%**

APPENDIX 2 – Commentary on Expenditure Position

Number of budgets measured at service level that have an adverse/positive variance greater than 2% of annual budget or £100,000 whichever is greater.

Service	Budget 2019/20 £'000	Forecast Outturn Variance	
		£'000	%

APPENDIX 3 – Grant Income Analysis
The tables below outline the allocation of the full Public Health grant.

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Notes
Public Health Grant as per Business Plan	**25,560**	**25,560**	Ring-fenced grant
Grant allocated as follows;			
Public Health Directorate	24,726	24,726	
P&C Directorate	293	293	
P&E Directorate	120	120	
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**25,560**	**25,560**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Gross Budget as per Business Plan		
Virements		
Non-material virements (+/- £160k)		
Budget Reconciliation		
Current Budget 2019/20		

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2019	2018/19		Forecast Closing Balance	Notes
		Movements in 2019/10	Balance at end May 2019		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,683**	**0**	**1,683**	**1,683**	Usage of un-earmarked reserve to be considered by Member working group
subtotal	**1,683**	**0**	**1,683**	**1,683**	
Other Earmarked Funds					
Healthy Fenland Fund	199	0	199	99	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	271	0	271	171	Joint project with the NHS
NHS Healthchecks programme	270	0	270	270	Usage to be considered by Member working group
Implementation of Cambridgeshire Public Health Integration Strategy	463	0	463	363	'Let's Get Moving' physical activity programme has been extended.
subtotal	**1,203**	**0**	**1,203**	**903**	
TOTAL	**2,886**	**0**	**2,886**	**2,586**	

(+) positive figures should represent surplus funds.
(-) negative figures should represent deficit funds.

Fund Description	Balance at 31 March 2019	2018/19		Forecast Closing Balance	Notes
		Movements in 2019/20	Balance at end May 2019		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	128	0	128	128	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**137**		**137**	**137**	

APPENDIX 6 PERFORMANCE

More than 10% away from YTD target
Within 10% of YTD target
YTD Target met

Below previous month actual
No movement
Above previous month actual

The Public Health Service Performance Management Framework (PMF) for April 2019 can be seen within the tables below:

		Measures										
KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
1	GUM Access - offered appointments within 2 working days+D9:D12	Apr-19	98%	98%	100%	102%	G	100%	98%	100%	↔	
2	GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	Apr-19	80%	80%	87%	109%	G	90%	87%	90%	↓	
3	Number of Health Checks completed (GPs)	Q1 (Apr-Jun)	18,000	n/a	n/a	n/a	G	n/a	n/a	n/a	↔	Reporting for Health Checks is quarterly, therefore data for 19-20 will be available in the July report
4	Number of outreach health checks carried out	Apr-19	1,600	162	67	41%	R	81%	162	41%	↓	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces.The provider uses a range of innovative approaches which includes sessions in workplaces in Fenland where there are high risk workforces. Wisbech Job Centre Plus, community centres in areas that have high risk populations are ongoing, a mobile service and "pop up" shops opening.. New evenst are planned for thsi financial year. Most of the key workplaces in Fenland have received visits and the eligiable wokrforce have received their health checks. Alternative appraoches are bing adopted.
5	Smoking Cessation - four week quitters	Mar-19	2154	2154	1631	76%	R	99%	156	91%	↓	• The main issue is the core Everyone Health service is exceeding its targets for number of quitters, from routine and manual groups, pregnant smokers and carbon monoxide verification rates. • Activity and quit rates from primary care have been falling some of this is due to poor data returns but generally activity has decreased. The Provider is asked to increase its support to practices to increase their engagement in delivering stop smoking services. • The ongoing improvement represents work undertaken worth GP practices to improve their data returns by JCU staff. There is an ongoing programme to improve performance that includes targeting routine and manual workers (rates are known to be higher in these groups) and the Fenland area. • The new promotional campaign "missing moments" has secured a lot of local coverage. Any impacts upon Services will be monitored. •The most recent Public Health Outcomes Framework figures released in July 2018 with data for 2017) suggest the prevalence of smoking in Cambridgeshire is statistically similar to the England figure , 14.5% v 14.9%. All districts are now statistically similar to the England figure. Most notable has been the improvement in Fenland where it has dropped from 21.6% to 16.3%, making it lower than the Cambridge City rate of 17.0% The end of year data will not be available until the end of June and this will include data from February and March in addition to the data trawls that are undertaken in practices..

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
6	Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	Q4 Jan-Mar 2019	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	Despite being a challenging target and experiencing a 1 percentile decrease this quarter, county breastfeeding statistics remain just above the 56% target and significantly exceeding the national average of 45%. Across the year performance has fluctuated but has shown improvement over the last two quarters. Breastfeeding prevalence rates, which comprise of both exclusive breastfeeding and mixed feeding vary across the county. In February however, due to service redesign changes, the data for Huntingdonshire and Fenland have been amalgamated to form the North Locality area, whereas East Cambs has been included in the South Cambs and City data, therefore the disaggregated data cannot be comparable to previous quarters. Prevalence stands at 66% in the South Locality and 50% in the newly formed North Locality, it is expected that district level data will be available from Q1 2019/20. The Health Visiting service remains Stage 3 UNICEF Baby Friendly accredited, which demonstrates quality of care in terms of support, advice and guidance offered to parents/carers and the excellent knowledge that staff have in respect of responsive feeding.
7	Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV from 28 weeks	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	In Cambridgeshire a local target has been set for 50%, with the longer term goal of achieving a target of 90% by 2020. Service transformation, which has included use of the Benson Modelling tool to determine workforce required to deliver the service, has accounted for Health Visitors to be completing all antenatal contacts and will start to be worked against from April 2019. Quarter 4 shows an increase of 4% of antenatal contacts achieved across the service in comparison to quarter 3 and is comparable to Q2 performance. Despite these improvements, overall performance still remains significantly below target. Disaggregated into the two new Locality areas, the North team completed 38% of contacts, however the South Locality continues to face challenges, only achieving 5%. The provider reports that the South Cambs locality remains under pressure with its current staffing capacity and the staffing capacity tool has identified that for Q4 staffing reduced from 81% availability to 77%, which impacted on the mandated reviews. Staff engagement identified that the workforce do value the importance of this contact however feel processes challenges are an issue. These are being addressed and work is underway to streamline the waiting list to aid assessment and contact planning as well as improving communication with Maternity services. Monthly face to face HV/Midwifery meetings are being established to discuss identified vulnerable pregnant women and there is ongoing development to embed an electronic notification process. To mitigate the situation in the immediacy, a Business Continuity Plan has been implemented and a meeting has been scheduled to discuss next steps. Options include reviewing the frequency and delivery style of some clinics in the South Locality to include a greater skill mix, freeing up Health Visitors to complete more antenatal contacts and temporarily halting face to face contacts for universal families for the 12 month and 2-2.5 year reviews, instead offering them a letter containing an ASQ self-assessment, advising parents to get in contact if there are any concerns. It is anticipated performance will increase significantly from September, when 4 newly qualified Health Visitors come into post in the locality.
8	Health visiting mandated check - Percentage of births that receive a Face to Face New Birth Visit (NBV) within 14 days, by a health visitor	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	The 10 - 14 day new birth visit remains consistent each month and numbers are exceeding the 90% target, despite a 2 percentile decrease this quarter. If those completed after 14 days are accounted for, the quarterly average increase to 97%.
9	Health visiting mandated check - Percentage of children who received a 6 - 8 week review	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	Performance for the 6 - 8 week review has remained steady throughout the year and comparable to the previous quarter. The continuation of good performance has meant that the YTD performance has also improved, increasing from 89% to 92%, which is positive. During quarter 4, in some areas, as a temporary measure, universal pathway families have been invited to a clinic based appointment to build capacity elsewhere within the system. For universal plus/partnership plus families a home visit contact has been maintained.
10	Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	Performance has remained stable this quarter, standing at 84%; by comparison 79% of families received this visit by the time the child turned 12 months old. The inclusion of exception reporting would increase the quarterly performance to 97% of families having this review by the time the child turns 15 months, which would exceed the 95% target. Of all appointments offered this quarter, 156 were not wanted by the family and 86 were not attended. Assurances are in place to ensure vulnerable families (those on Universal Plus or Universal Partnership Plus pathways) are receiving this contact and an escalation plan is in place if these mandated visits are missed. A further 58 of contacts were 'not recorded'. The provider again cites pressures attributed to ongoing challenges in the South Locality and increased levels of short term sickness during the period.
11	Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	Despite demonstrating an upward trajectory over the course of the year, performance has declined from 76% to 73% over the duration of the quarter and continues to fall below the target threshold of 90%. The main cause of performance issues against this target was staffing and capacity challenges in the South Locality being exacerbated by short term sickness, resulting in performance reducing to 54% by this team in March, significantly impacting on overall figures. If exception reporting is accounted for, overall performance increases to 88%, a decrease of 7% from Q3. This quarter it was reported that 152 reviews were not wanted and 127 were not attended. 225 contacts were listed as 'not recorded', which has shown slippage compared to only 87 in Q3. The data indicates that non recorded contacts are predominantly an issue within the South Locality team and is being addressed with the provider through the Business Continuity Plan and options being considered in the Antenatal narrative.
12	School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management, emotional health and well being, substance misuse or domestic violence	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	The School Nursing service is actively delivering brief interventions for Healthy Weight, Mental Health, Sexual Health and Domestic Violence. There have also been 4 interventions in relation to immunisations undertaken this quarter. The numbers of brief interventions for Domestic Violence continues to be the highest recorded intervention young people are seeking support with (n=32), followed by Sexual Health (n=21) and Mental Health (n=19); there continues to be no young people seeking support for issues related to smoking or substance misuse. The provider reports that in the duration of the quarter, 573 CYP received a face-to-face intervention by the School Nursing team, however only 89 themed interventions were recorded. Work is to be conducted with the provider and their data analytics team to obtain a more rounded picture of what issues School Nurses are supporting young people with, including conducting an audit to check whether this is a recording issue.
13a	School nursing - number of calls made to the duty desk	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	The number of contacts to the Duty Desk made by telephone call, has dropped significantly this quarter, although it still higher than reported in Q2. In addition to phone contacts, this quarter there have been 2174 email contacts and 138 letter. This indicates that overwhelmingly email is the preferred method of communication into the duty desk, however further analysis is required to determine the proportion of professional contacts and those coming from young people or families. Furthermore, the provider has reported that there has been a 4.4% increase in the amount of young people requiring a 1:1 intervention this quarter.
13b	School nursing - Number of children and young people who access health advices and support through Chat Health	Q1 (Apr-Jun)	N/A	N/A	N/A	N/A	G	N/A	N/A	N/A	↔	Chat Health continues to be well embedded as the universal offer for the School Nursing service and figures are showing continual improvement. Over the duration of the quarter there have been a total of 1548 text messages received from young people, resulting in 71 conversations. Analysis of contact attributes indicates that the majority of contacts relate to seeking emotional health and health wellbeing support (54%) and signposting to other services (31%), however further development is required to increase the number of attributes allocated to conversations - this will be picked up with the provider. Additionally, it is reported that the significant difference in figures are likely due to issues/queries being resolved by a singular message rather than requiring numerous message exchanges. ChatHealth is now available nationally to 2 million young people and CCS is the health provider nationally with the most usage of licences across the 4 Healthy Child Programme services the trust delivers, evidencing that it is the right service for this cohort of people and that you can deliver this service in non traditional ways.

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
14	Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	Apr-19	>90%	70%	76%	110%	G	57.0%	90%	76%	↑	The National Child Measurement Programme (NCMP) has been completed for the 2017/18 academic year. The coverage target was met and the measurement data has been submitted to the PHE in line with the required timeline. The current programme is on track. It is difficult to develop a trajectory for this as it depends on school availability for the measuring team to visit.
15	Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	Apr-19	>90%	70%	71%	101%	G	50.0%	90%	71%	↑	
16	Overall referrals to the service	Apr-19	5300	477	676	142%	G	256%	477	142%	↓	
17	Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	Apr-19	1670	140	147	105%	G	182%	140	105%	↑	Although this indicator is still red overall there has been a general improvement in recent months . This reflects the appointment of two new Health Trainers to fill two empty posts.. Lack of capacity had compromised the ability of the Service to develop PHPs. The increased performance has not been large enough to compensate for lack of capacity earlier in the year.
18	Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	Apr-19	1252	113	63	56%	R	93%	113	56%	↓	Refrral have increased but the personal health plam completion rate remans belvo target. The manager is addressing with staff to idnetify any underlying issues.
19	Number of physical activity groups held **(Pre-existing GP based service)**	Apr-19	730	66	82	124%	G	118%	66	124%	↑	
20	Number of healthy eating groups held **(Pre-existing GP based service)**	Apr-19	495	45	43	96%	A	116%	45	96%	↓	This reflots variation between months.
21	Personal Health Trainer Service - number of PHPs produced (Extended Service)	Apr-19	800	72	81	113%	G	329%	72	113%	↓	
22	Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	Apr-19	650	59	17	29%	R	85%	59	29%	↓	This continues to be challenging and the Service Manager is addressing this with staff to determine any underlying issues.
23	Number of physical activity groups held (Extended Service)	Apr-19	830	75	78	104%	G	300%	75	104%	↓	
24	Number of healthy eating groups held (Extended Service)	Apr-19	570	48	51	106%	G	218%	48	106%	↓	
25	Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	Apr-19	30%	30%	36%	120.0%	G	17%	30%	36%	↑	

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
26	Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	Apr-19	60%	60%	45%	75%	R	75%	60%	45%	↓	There are dips in performance an this reflots the complaity of the patienst seen by this service. This has been discussed with the provider and is being carefully monitored.
27	% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	Apr-19	80%	80%	100%	125.00%	G	0%	80%	100%	↑	A new programme has commenced. A lot of work has been undertaken to increase engagement but it remains challenging. However there has been a recent improvement that reflects a more effective use of NCMP data to secure referrals.
28	Number of referrals received for multi factorial risk assessment for Falls Prevention	Apr-19	520	47	128	272%	G	671%	47	272%	↓	
29	Number of Multi Factorial Risk Assessments Completed - Falls Prevention	Apr-19	442	40	72	180%	G	181%	40	180%	↔	
30	Number clients completing their PHP - Falls Prevention	Apr-19	331	28	21	75%	R	160%	28	75%	↓	This dip represents service capacity. Ther has been in the last year a four-fold increase in refrrals which put pressure on staffing repurces

* All figures received in May 2019 relate to April 2019 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.
** Direction of travel against previous month actuals
*** The assessment of RAG status for services where targets and activity are based on small numbers may be prone to month on month variation. Therefore RAG status should be interpreted with caution.

APPENDIX 7

PUBLIC HEALTH MOU 2018-19 UPDATE FOR Q4

TO FOLLOW

Agenda Item No: 10

NHS QUALITY ACCOUNTS – HEALTH COMMITTEE FINAL RESPONSES TO QUALITY ACCOUNTS 2017/18

To:	**HEALTH COMMITTEE**
Meeting Date:	**11th July 2019**
From	**Head of Public Health Business Programmes**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To provide an update to the Committee on responses submitted to NHS Provider Trusts in regards to their Quality Accounts 2018/19. It is a requirement for NHS Provider Trusts to request comment from Health Scrutiny Committees on their Quality Accounts.**
Recommendation:	The Health Committee is asked to: a) note the statements and responses sent to the NHS Provider Trusts

	Officer contact:	***Member contact:***
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1. BACKGROUND

1.1 NHS Healthcare providers are required under the Health Act 2009 to produce an annual Quality Account report. A Quality Account is a report about the quality of services by an NHS healthcare provider.

1.2 It is a requirement for NHS Healthcare providers to send to the Health Committee in its Overview and Scrutiny function a copy of their Quality Account for information and comment. Statements received from Healthwatch and Health Overview and Scrutiny Committees must be included in the published version.

1.3 Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.

1.4 This Health Committee on 14th March 2019 delegated approval of the responses to the Quality Accounts, received from NHS Providers, to the Head of Public Health Business Programmes in consultation with the views of members of the Task and Finish Group.

2. MAIN ISSUES

2.1 Councillors, Connor, Hudson, Jones and Taylor were appointed to the Task and Finish Group on 14th March 2019. Table 1 details Quality Accounts that have been received at the time of this report was compiled.

2.2 A review of last year's responses to Quality Accounts was discussed at this meeting and it was agreed that a more interactive model should be encouraged. NWAFT were provided as an example of good practice as they hold a stakeholder workshop after receiving feedback on their quality accounts. This meeting allows technical questions to be clarified to provide a greater understanding of the quality account.

2.3 All Trusts were approached to develop a more interactive model of response and whilst no other trust offered the workshop all agreed to respond to any specific questions or clarifications raised by the task and finish group.

2.4 In the past the tight timescales for response have presented difficulties for the Health Committee, unfortunately these are based on national deadlines. Having an established process this year has resulted in a more efficient way to respond to the quality accounts.

Table 1

Organisation	Quality Account Received	Deadline to Respond	Response Made	Further feedback received
Cambridge University Foundation Trust	2nd April 2019	15th April 2019	17th April 2019	18th April 2019
North West Anglia Foundation Trust	18th April 2019	3rd May 2019	3rd April 2019	Stakeholder feedback session Scheduled for 8th May – unable to attend
Cambridgeshire & Peterborough Foundation Trust	29th April 2019	17th May 2019	17th May 2019	17th May 2019
Cambridgeshire Community Services	1st May 2019	31st May	31st May 2019	11th June 2019
Royal Papworth Trust	16th April 2019	16th May	15th May 2019	
East of England Ambulance Service Trust	14th May	13th June	Deadline for submission missed	

2.5 The Health Committees Responses to the NHS Trusts submitted are provided in Appendix 1

SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

Officer time in preparing a paper for the Committee.

3.2 Statutory, Risk and Legal Implications

These are outlined in a paper on the Health Committee powers and duties, which was considered by the Committee on 29th May 2014.

3.3 Equality and Diversity Implications

There may be equality and diversity issues to be considered in relation to the quality accounts.

3.4 Engagement and Consultation Implications

There may be engagement and consultation issues to be considered in relation to the quality accounts.

3.5 Localism and Local Member Involvement

There may be relevant local issues in relation to the quality accounts.

3.6 Public Health Implications

The quality of services at local healthcare providers will impact on public health

Source Documents	Location
NHS Choices information on Quality Accounts	http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx
Reports to and minutes of Health Committee	https://cmis.cambridgeshire.gov.uk/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/6/Default.aspx

Appendix 1

CAMBRIDGE UNIVERSITY HOSPITAL FOUNDATION TRUST

QUALITY ACCOUNT 2018/19

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has not called on representatives from Cambridge University Hospital over the last year to attend scrutiny committee meetings. However, committee members have maintained an open dialogue with senior leadership at the Trust through the valuable quarterly liaison meetings which are seen as an essential part of the scrutiny function.

The Committee has found this quality account overall an interesting report, with evidence of careful attention being paid to some key quality concerns.

At the start, attention is drawn to increased levels of activity in Outpatients, partly driven by increased referrals and the comment made that this will be challenging if it continues (p4). While the increase in the level of A & E activity was lower than anticipated, the outpatient figures indicate that pressures on CUH are not reducing. Quality monitoring continues at a high level with 58 audits across the year.

There is greater emphasis in priority setting for 2019-20 on cultural change and 'healthy and open communication' (Section 4.2.1). The Health Committee has been interested in CUH improvement strategies and notes the 'Improving Together' strategy being steered by the Improvement and Transformation directorate. This is an ambitious programme of improving staff skills, awareness and distributed leadership working with external improvement partners. Part of this is a focus on supporting individuals to raise concerns using the speaking up service for employees (FTSUG), with a longer term aim of culture change that enables staff to raise and managers to work with them to resolve issues locally. Health Committee members have recommended to CUH to consider how the responses by concerns/groups reported to the Board are being used to drive quality improvement.

We understand that DTOC challenges continue although some improvements have been made and CUH sets itself four measures for 2019-20, including a target of 20% for early discharges (p.15-16). Early discharges are defined as 'before midday' and is to be noted that this is very ambitious since performance actually declined from 15.3% to 13% between 17/18 and 18/19 (see p44). The Health Committee encourage CUH to monitor the new process that started in January 2019.

The emphasis on culture change links to the staff experience/well-led quality targets, including one related to appraisal that is a theme in the NHS National Survey. CUH should be commended that 99% of their staff received an appraisal. Whilst it noted that only 26% of CUH staff in 2018 agreed that 'my appraisal helped me to improve how I do my job' suggesting that appraisal is not currently integrated as part of a developmental process for staff. CUH's target of improving the 2018 figure by only 2% does not seem to fit with their more ambitious culture change objectives set out in Section 4.2.1. However feedback received by the Health Committee from CUH

around working to improve the quality of appraisals and the impact of staff's perception of how it helps them improve how they do their work is encouraging. In particular it was good to hear that the percentage of managers supported to receive training, learning or development has increased significantly by 6%.

The national staff survey results indicate that CUH is average or slightly better in reporting of bullying/abuse and some other measures but not on staff confidence in equal opportunities. One aspect may be addressed through the equality and diversity lead drawing on best practice elsewhere (p36). One improvement noted is CUH moving to central advertising of all acting up/secondment opportunities, an important marker for staff of fair and equal treatment.

Quality improvement in clinical practice is driven through engaging with patients and capturing 'lessons learnt'. Work on 'Learning from Death' (p30-34) includes in-depth analysis of the factors underlying sub-optimal care including training needs, staff levels, workload and cultural factors. The Health Committee has appreciated further clarification provided by CUH in regards to the 'Duty of Candour' (DOC) and new guidance published by NHSI which has impacted on the compliance position. It was good to hear that the safety team are working on establishing a revised process that prioritise the follow up of outstanding DOCs

The Committee were pleased to see the CQC inspection outcome gave CUH an overall judgement of 'Good'. Health committee members have been encouraged by the Trust's positive attitude to maintain an open dialogue and will be inviting representatives to attend a health scrutiny session around the CQC improvement plan in the near future.

NORTH WEST ANGLIA FOUNDATION TRUST

QUALITY ACCOUNT 2018/19

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has welcomed the opportunity to comment on the Quality Account for North West Anglia Foundation Trust (NWAFT).

The Committee has formally invited representatives from NWAFT to discuss the CQC Inspection report at a meeting held on January 17th 2019. Minutes of the meeting and the discussion can be found on the following link.

https://cambridgeshire.cmis.uk.com/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/882/Committee/6/Default.aspx

The Health Committee is particularly interested in the CQC inspection as it relates to Hinchingbrooke Hospital which is the only part of NWAFTs hospital provision that sits within the Health Committees scrutiny remit. Of concern is that being "safe" requires improvement for all areas of Hinchingbrooke Hospital except end of life care and outpatients. Whilst it was disappointing that the trust received a "requires improvement" rating, it was noted that the trust are acting on a range of quality improvements since the inspection and most areas that required improvement had improved.

It is clear that the priorities for 2019-20 have been informed by the CQC inspection, other audits and the Trust's own processes of learning, which is very positive. However the committee has noted that there are many priorities in the five domains and questions if this is achievable.

The Health Committee has taken a particular interest in workforce development, recruitment and retention issues across the whole health care sector and continues to scrutinise this under the Sustainable Transformation programme (expecting an update report in July 2019). The committee has welcomed the Trust's work around the "Grow with us" staff retention project and looks forward to hearing how many staff have been involved. It is encouraging to see that the Trust has been pro-active in training guardians and champions and prides itself on encouraging staff to report unsafe practice and working conditions. It is important that the Trust demonstrates how all staffing issues identified, either through the retention projects and through "Freedom to Speak out" initiatives are incorporated into clear action plans that are monitored and evaluated. This will provide the Trust with confidence that initiatives are achieving their objectives.

In recognising that the Quality Accounts are a technical document the Committee has provided some clarification comments separately. As with previous years the Committee is grateful that the Trust provides the opportunity for members to attend stakeholder meetings and responds positively to feedback received. This sense of openness from the Trust has been strengthened through the continuation of quarterly liaison meetings with the CEO and senior leadership representatives, meeting informally with committee members to discuss local concerns.

CAMBRIDGESHIRE & PETERBOROUGH FOUNDATION TRUST (CPFT)

QUALITY ACCOUNTS 2018/19

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has welcomed the opportunity to comment on the Quality Account for Cambridgeshire and Peterborough Foundation Trust (CPFT). The committee has requested attendance from the Trust at a public Health Scrutiny meeting on 12th July 2018 and further followed up with CPFT at a meeting on 17th January 2019 to specially discuss the findings of the Ombudsman report into Eating Disorders and scrutinise CPFTs response to the report. Minutes of the discussions are available from the links below:

https://cambridgeshire.cmis.uk.com/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/876/Committee/6/Default.aspx

https://cambridgeshire.cmis.uk.com/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/882/Committee/6/Default.aspx

Representatives from CPFT, as a provider of the First Response Service (for patients experiencing a mental health crises) along with commissioners were also invited on 17th January 2019 to discuss the access arrangements to this service for patients living in Wisbech. The committee were reassured by commitments from both organisations that the arrangements for accessing out of hours services did work (Minutes of this meeting available from the link below):

https://cambridgeshire.cmis.uk.com/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/876/Committee/6/Default.aspx

In reviewing the Quality Account the Health Committee notes that pressure on services continues to increase, with a 10.09% rise in referrals between 2017/18 and 2018/19. The Trust has coped with this well and the CQC inspection in June 2018 gave an overall verdict of 'Good' for its services. There were some notable areas of progress in 2018-19, for example in falls reduction, with a 5% overall reduction mainly related to community services, and this remains a priority for 2019-20. This is well related to the STP work programme priorities.

In other areas there is evidence that the Trust has not reached some of its quality priority targets set for 2018/19, which means that its overall priorities for improvement - best care, innovation, best value and good staff experience of working in the trust – are still acknowledged as work in progress.

The priority areas selected for 2018-19 focused on reducing avoidable harm, improving health outcomes and improving experience of care. Most targets were achieved but some targets relating to training, data capture and recording were missed. This may link to the data recorded locally and through the NHS England

staff survey about sickness absence, feelings of stress and motivation at work and, in the CYPF directorate about the quality of relationships between senior managers and staff (pages 13-18). Effective support and training are key components of staff wellbeing and positivity about their workplace. Page 35-37 notes that there is 'much to do to improve the health and wellbeing of our staff'.

The Health Committee has taken a particular interest in workforce development, recruitment and retention issues across the whole health care sector and continues to scrutinise this under the Sustainable Transformation programme (expecting an update report in July 2019). The Committee were encouraged to see that CPFT has focused on enhancing workforce quality and skills during 2018-19 and part of this has been working to embed a safety culture through a focus on it in staff appraisals, with acknowledged progress (pages 22 and 35). It is recognised that this work is ongoing and clarification on where this sits in the 2019-20 priorities has been requested. The ongoing work of training the trainers on the 'Understanding Quality Service and Redesign' programme is noted and Duty of Candour, Structured Judgements Reviews and Speaking Up all highlight work in progress by the Trust to drive 'a definite change in attitudes and behaviour' (pages 58-69).

The Health Committee were pleased to note that CPFT received a "Good" rating following their CQC inspection in March 2018. The 'well led' part of the CQC review highlighted some areas for management improvement including actions related to promoting equal opportunities, transparency and objectivity in recruitment and supporting diversity (page 56). The Committee would like to see further incorporation of this into the 2019-20 priorities for developing and supporting staff.

Improving experience of care for patients and the experience of carers is reported, with progress during 2018-19 on two-thirds of the priorities set. The Committee was pleased to note a fairly low and reducing level of complaints was recorded for 2018-19; interestingly, this sits alongside a 15% decrease in compliments. A priority in this area for 2019-20 is to bring in the NHS complaints satisfaction survey and focus on shared learning, improving response times and reviewing the quality of action plans (page 98-100).

At present, the Trust sits in the average group of trusts of its type across England. However, it has commendable ambitions to improve on this during 2019-20. Health Committee members look forward to discussing these improvement plans with senior representatives from the Trust at their quarterly liaison meetings. The Health Committee members have maintained an open dialogues with senior leadership at the Trust through these valuable liaison meetings which are seen as an essential part of the health scrutiny function.

CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST

QUALITY ACCOUNTS 2018/19

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL - HEALTH COMMITTEE

The Health Committee within its health scrutiny capacity has welcomed the opportunity to comment on the Quality Account for Cambridgeshire Community Services (CCS). The Health Committee has not called on representatives from CCS over the last year to attend scrutiny committee meetings.

The quality account was clearly presented and this allowed the relationship between 2018-19 progress, external and internal feedback and the priorities then set for 2019-20 to be tracked. This is commendable.

The four priority areas for 2019-20 contain some largely new quality improvement actions but also include continuation of work begun in 2018-19 (or earlier) but still in progress. We understood this to mean that rather than progress being slow actions are complex to achieve fully. For example, the Trust launched the 'Our Improvement Way' programme, and its 2018-19 comments indicate work completed but at the same time it is recognised that embedding the approach should continue. Evidence is further seen in 2019-20 Priority 4 'Learning and Continuous Improvement' in activities 4.1 and 4.4.

The Health Committee has taken a particular interest in workforce development, recruitment and retention issues across the whole health care sector and continues to scrutinise this under the Sustainable Transformation programme (expecting an update report in July 2019). The committee was pleased to see this focus replicated in the CCS quality account. Strong claims are made about the Trust's workforce: for example, that they are 'engaged and happy' and the medical director and chief nurse both focus on staff as the key to progress. This is then reflected strongly in Section 3.7 on workforce factors and in the subsequent sections on diversity and inclusion, staff excellence and service redesign. Evidence in these sections indicates that active support, development and management of staff are in place. This is reflected in the strong scores from the national staff survey, the high percentage of completed appraisals and staff belief in equal opportunities at work.

In recognising that the Quality Accounts are a technical document the Committee has provided some clarification comments separately these related to how staff experiences are translated into the priorities for 2019-20.

The committee were pleased to see how the Trust highlights the 'step change' it is engaged in – of moving from a patient engagement to a people participation approach. This work is fully reflected in 2019-20 Priority 3, which focuses on how service users, patients and local communities will help to shape future service provision. The 2018-19 findings cite the review work undertaken and the creation of

a people participation committee within the governance structure to embed this approach. The quality account discusses moving towards co-production (pg. 8) and the committee recognises that this is ambitious and not without challenge for staff and users in terms of resources and other Trust priorities, including safety. It will be interesting to see how the work is progressed during 2019-20.

ROYAL PAPWORTH NHS TRUST

QUALITY ACCOUNTS 2018/19

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has welcomed the opportunity to comment on the Royal Papworth NHS Trust Quality Account.

The Committee has received a very clear and well formulated quality account on the whole, making it easy to read and digest. In particular, it is frank and open in relation to priority areas where progress has been slower than hoped for or where there has been a slippage in performance. For example, page 6 flags concerns about ward incidents relating to deteriorating patients, where targets have not been achieved for 2018-19. This is discussed in more detail in Part 3 and it is highlighted as a continued priority for 2019-20 (page 15).

In areas where progress has been made, for example in falls reduction, it is acknowledged that further progress is possible although it is not entirely clear what the challenges are in the new hospital setting.

The challenge of moving a whole hospital to an entirely new site is dealt with through various priority targets having been set and monitored throughout the planning and moving period. Achieving a 'safe hospital move' remains a priority for 2019-20 with strong evidence of robust 'go-no go' points set down and achieved.

Two major areas are discussed in some depth: the shift in 2017 and operationalising of Lorenzo and the importance of leadership and culture. Lorenzo, with its electronic patient record system, is clearly taking quite a while to become embedded beyond the user champions and exemplar groups. The positive outcomes in terms of recording a range of data which can then be used to optimise bed management, throughput and reduced stay for example, is still a work in progress. There are also ambitions to provide better data for quality assurance, research and audit. It appears that the team understands the importance of staff training and support but still have a lot of work to do to change the approach. The comment on page 42 about sepsis is an interesting one, as it is seen as an area where there remain significant issues about documentation related to the EPRS.

The Health Committee has taken a particular interest in workforce development, recruitment and retention issues across the whole health care sector and continues to scrutinise this under the Sustainable Transformation programme (expecting an update report in July 2019). It has been helpful to see that Royal Papworth has a strong record of recruiting and retaining staff and the staff survey indicates that a high percentage of staff agree that the organization provides equal opportunities for staff to develop and get promotion, while a declining percentage report that they experience bullying and harassment; both indicators moving in the right direction.

The Quality Account features training and support for the workforce but more evidence on how the 2018-19 Priority 3 on workforce was being carried forward into 2019-20 would have been useful in the priority set for leadership and culture.

It is useful to see the preparation and progress that Papworth has made in preparing for a CQC inspection and the results of the mock inspection (page 62). There is only one ‘requires improvement’ (for diagnostics well-led category). The 2019-20 quality focus on ‘leadership and culture’ makes good sense in relation to the mock CQC outcomes, with page 22 and 23 earlier in the report flagging the work to be done on equality and diversity and on building leadership capability. It is noted that there are still targets to be added to this section.

The Health Committee looks forward to inviting representatives from the Royal Papworth NHS Trust later this year to attend committee to discuss issues relating to the relocation and to review the outcomes from the CQC inspection.

Agenda Item No: 11

HEALTH COMMITTEE WORKING GROUP Q2 UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	**11 JULY 2019**
From	**Head of Public Health Business Programmes**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To inform the Committee of the activities and progress of the Committee's working groups since the last update.**
Recommendation:	**The Health Committee is asked to:**

1) **Note the content of the quarterly liaison groups and consider recommendations that may need to be included on the forward agenda plan.**

2) **Note the discussions from the Working group on Public Health reserves**

Officer Contact:		***Chair Contact:***	
Name:	Kate Parker	Name:	Councillor Peter Hudson
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1.0 BACKGROUND

1.1 The purpose of this report is to inform the Committee of the health scrutiny activities that have been undertaken or planned since the committee last discussed this at the meeting held on 17TH January 2019

1.2 This report updates the Committee on the liaison meetings with health commissioners and providers. The report covers Quarter 4 (2018-19) liaison meetings with:

- Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) & Cambridgeshire & Peterborough Healthwatch
- Cambridgeshire & Peterborough Foundation Trust (CPFT)
- Cambridgeshire University Hospital Foundation Trust (CUH)
- North West Anglia Foundation Trust (NWAFT) – Hinchingbrooke Hospital

1.3 Liaison group meetings are precursors to formal scrutiny and/ or working groups. The purpose of a liaison group is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its scrutiny function. It also provides the organisation with forward notice of areas that Health Committee members may want further information on or areas that may become part of a formal scrutiny.

1.4 This report will also provide an update on the Health Committee working group tasked with reviewing the Public Health reserves.

2. MAIN ISSUES

2.1 Liaison Meeting with HealthWatch Cambridgeshire & Peterborough and the Clinical Commissioning Group (CCG)

A meeting was held on 6th March with Jessica Bawden (Director of Corporate Affairs, CCG), Jan Thomas (Accountable Officer CCG) Sandie Smith (CEO) and Healthwatch Cambridgeshire & Peterborough.

The liaison group members in attendance were Councillors Connor, Harford, Hudson, Jones and ven de Ven.

2.1.1 The group discussed the following items with the CCG

- Workforce recruitment and retention drives
- Brexit contingency plans for health commissioning
- Primary Care Network developments
- CCG's Financial update (18/19 position)

2.1.2 An update from Healthwatch was received on the following areas.

- Update on dental services – specific reference to the increase in childhood extractions.
- Healthwatch engagement survey on the NHS Long Term plan

2.1.3 Further meetings have been held with the liaison group members and the CCG on the 9th May to discuss the CCGs financial position for 19/20. Members were also advised of the podiatry estates relocation plans. Councillors in attendance at this meeting wanted to escalate the issues identified with the CCGs financial position with the wider Health Committee members. Due to the CCG adhering to purdah restrictions in place for the local elections and the Peterborough by election. A closed meeting was held on 5th June for all Health Committee members who were provided with a further brief on the CCGs financial plans for 19/20. It was agreed that the CCG would attend the Health Committee meeting on 11th July 2019.

The next liaison meetings for 2019/20 are currently being scheduled.

2.2 **Liaison meeting with Cambridgeshire & Peterborough Foundation Trust (CPFT)**

The scheduled liaison meeting with CPFT was cancelled due to a clash with the Trusts CQC inspection visit. The next meeting will involve a meeting to the Phoenix Unit (eating disorders unit for children & young people)

2.3 **Liaison meeting with Cambridgeshire University Hospital Foundation Trust (CUH)**

A meeting was held on 8th March 2019 with Ian Walker (Director of Corporate Affairs – CUH) The liaison group members in attendance were Councillors Harford, Hudson, Jones, van de Ven. Apologies were received from Roland Sinker (CEO-CUH)

2.3.1 The following topics were discussed at this meeting:

- Delayed Transfers of Care
- CQC Inspection feedback
- Royal Papworth Hospital joining the biomedical campus and joint working with CUH
- Regional Children's Hospital – Management structure
- Transport & Access issues to the biomedical campus
- Brexit Planning

2.3.2 It was agreed to receive a formal report from CUH on progress made since the CQC inspection. This report will be received by the Health Committee on the 11th July meeting.

2.3.3 The next meeting is currently being scheduled.

2.4 **Liaison Meeting with North West Anglia Foundation Trust (NWAFT)**

The quarter four liaison meeting was held on the 5th March with Caroline Walker (CEO –NWAFT) and Angus Maitland (Strategy Team). The liaison group members in attendance were Councillors Connor and Harford. Apologies were received from Cllr Hudson and Taylor

2.4.1 The following topics were discussed at this meeting:

- Doddington Hospital provision of outpatient services by NWAFT
- Public Consultation policy for NWAFT
- Brexit contingency plans
- Hinchingbrooke Hospital site redevelopment
- Green Travel Plans
- NHS Long term plan
- North Alliance

2.4.2 A further meeting for Quarter 1 (2019-20) was held on the 6th June with Dr. Kanchan Rege (Medical Director) and Angus Maitland (Strategy Team). The liaison group members in attendance were Councillors Sanderson and district councillor Tavener. Apologies were received from Cllr Hudson, Harford and Caroline Walker (CE)

2.4.3 The following topics were discussed at this meeting:

- Hinchingbrooke Site – redevelopment plans
- Green Travel Plans - Travel survey & hospital parking
- CQC Improvement plan
- Organisational development “Good to Outstanding” programme
- Holly Ward (transfer from CCS to NWAFT)
- Information technology and IT system upgrade across NWAFT

2.4.4 The next meeting of the quarterly liaison group is scheduled for 3rd September.

2.5 **Public Health Ear Marked Reserves – Working Group update**

A meeting of the working group to discuss the Public Health reserves was held on 31st May. The working group members in attendance were Councillors Boden, Jones and van de Ven. Cllr Harford sent apologies. A further meeting was held on 26th June with attendance from all members of the working group.

2.5.1 Public Health officers had presented a paper around potential proposals to the business planning group. Recommendations from this meeting were then presented to this working group and discussed further. It was agreed to work

up business cases alongside the proposals and review these at a further meeting in June.

2.5.2 The working group was set up to review how the public health reserve could best be used productively to improve public health outcomes, but also recognised that maintaining a reasonable level of general ring-fenced public reserve would be prudent. This consensus among the working group was that a minimum of £500k would be appropriate. Proposals reviewed by the working group included:

- Development of the falls prevention programme over a 3 year period. The total cost is estimated as over £1M and will be placed on the forward agenda of the September Health Committee as a key decisions.
- In addition the working group discussed consultancy to support the Best Start in Life (BSiL) strategy implementation, for which £45k was allocated from reserves by the Director of Public Health as an officer decision (within delegated limits), and this was supported by the working group.

2.5.3 Key areas of discussion around other proposals focused on:

- Health and Wellbeing strategy engagement and consultation which requires more work with partners to ensure the process complements other engagement work being undertaken by the CCG and STP.
- Public Health integration was discussed in the context of developing a key focus on “Health in all polices” approach. Further work was required as to precise costings but working group members agreed that there should be access to additional funds as the work develops particularly around the implementation phase.

Further proposals put forward by the working group members are being investigated and discussed at the next working group meeting.

3.0 SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

Working group activities will involve staff resources in both the Council and in the NHS organisations that are subject to scrutiny.

3.2 Statutory, Risk and Legal Implications

These are outlined in a paper on the Health Committee powers and duties, which was considered by the Committee on 29th May 2014

3.3 Equality and Diversity Implications

There are likely to be equality and diversity issues to be considered within the remit of the working groups.

3.4 Engagement and Consultation Implications

There are likely to be engagement and consultation issues to be considered within the remit of the working groups.

3.5 **Localism and Local Member Involvement**

There may be relevant issues arising from the activities of the working groups.

3.6 **Public Health Implications**

Working groups will report back on any public health implications identified.

Source Documents	**Location**
None	

HEALTH COMMITTEE TRAINING PLAN 2019/20

Updated June 2019

Agenda Item No: 12

Proposals

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
	Public Health Peer Review	Provide a feedback session on the LGA peer review and developing action plan Note item coming to Health Committee 23rd – discuss if development session necessary.	1	May 23rd	Public Health	Development Session			
	Public Health Performance reporting	To provide committee members with an increased understanding of the key performance indicators used in the F&PR To review current reporting and an opportunity to discuss what information members receive in future Performance reports.	2	Provisional 22nd July TBC	Public Health	Development session			
	Mental Health Interventions	To provide committee members with an overview of public mental health	4		Public Health	Development Session			

		focusing on local interventions and services.							
	School Nursing Service Overview	To provide a development session that specifically focusing on the provisions within the school nursing service and associated trend data around access. To agree specific objectives for the session and outline to service providers	3		Public Health	Development Session			

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published on 1st July 2019	Cambridgeshire County Council Agenda Item No:13

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.

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
[08/08/19] Provisional Meeting					
19/09/19	Finance & Performance Report	Liz Robin	Not applicable		
	Best Start in Life Strategy	Liz Robin	Not applicable		
	Quarterly Liaison Meeting Update Report	Kate Parker	Not applicable		
	Public Health Reserves	Liz Robin	2019/057		
	Scrutiny Item: STP Workforce Planning	STP	Not applicable		
	CUSPE Challenges – Healthy Fenland Fund Evaluation	Val Thomas	Not applicable		
	Scrutiny Item: STP Digital Strategy	STP	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
17/10/19	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
14/11/19	Finance & Performance Report	Liz Robin	Not applicable		
	Joint Strategic Needs Assessment and Joint Health and Wellbeing Board Strategy	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
05/12/19	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
23/01/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[06/02/20] Provisional Meeting					
19/03/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[16/04/20] Provisional Meeting					
28/05/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Daniel Snowdon	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		