Scrutiny Committee

HINCHINGBROOKE HOSPITAL JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

2nd April 2007

Action

1. WELCOME AND APOLOGIES

Councillor Heathcock welcomed everyone to the meeting and noted the apologies received.

2. DECLARATIONS OF INTEREST

Councillor Heathcock declared a personal interest under Paragraph 8 of the Code of Conduct, as a board member of Age Concern Cambridgeshire.

3. MINUTES OF PREVIOUS MEETINGS

The minutes of the meetings held on 28th February and 16th March 2007 were confirmed as correct records and signed by the Chairman.

3a. ELECTION OF VICE-CHAIRMAN

With the agreement of the Chairman, the Committee considered a change in its vice-chairmanship as an item of urgent business.

Councillor Male resigned as Vice-chairman of the Committee because it appeared likely that Councillor Heathcock would not be available for the Committee's final meeting in July. As the consultation proposals affected Cambridgeshire most closely of all the authorities forming the Committee, members took the view that it would be appropriate to have a Cambridgeshire member in the chair for the Committee's final meeting.

The Committee therefore resolved unanimously that Councillor Kevin Reynolds be elected Vice-chairman of the Committee with immediate effect.

4. CONSIDERATION OF FURTHER EVIDENCE IN RELATION TO:

- **Finances**
- **Risks and how these are addressed**
- **Nature and impact of changes**
- **Shifting activity from the hospital to the community setting and the interface with social care services**
- **Transport and access to services**

4a. Councillor Male reported on the **sub-group meeting** held on 22nd March, when he, Councillor Downes, Dr Angela Owen-Smith and Nick Roberts, together with the County Council's Health Scrutiny Co-ordinator, Jane Belman, met representatives of Hinchingbrooke Health Care Trust (HHCT). The purpose of the meeting had been to look at the financial and risk

assessment background to the proposals, with a view to understanding the future business plan. Some of the information conveyed was confidential to HHCT because if made public it would identify particular departments or posts.

The sub-group had noted that of the projected £10 million savings

- about £3 million were associated with the reconfiguration of hospital wards
- £1.1 million were associated with savings from the proposed Trust dissolution, and
- £1 million were associated with procurement savings.

Members had not identified any obvious difficulties with these figures.

The sub-group had noted that the 25% reduction in acute services at Hinchingbrooke was made up of a 10% natural reduction because of clearing the backlog (the Strategic Health Authority (SHA) had attributed 4% to backlog issues) and a 15% reduction made by transferring care from the hospital to the primary care sector.

4b. At its last meeting on 16th March, the Committee had raised a number of questions and sought **information from the Cambridgeshire Primary Care Trust (PCT) and HHCT**. Written replies to these requests, and to requests made by the sub-group on 22nd March, had been circulated to the Committee in advance of the meeting and included in the papers for the meeting on the Cambridgeshire County Council website. Commenting on these replies, the Committee

- (answer 2) queried the apparent discrepancy between the PCT's view that the initiative to reduce waiting lists had had a greater effect on patient numbers (10%) than the SHA's 4% figure. Simon Wood (Interim Programme Director for Service Reconfiguration, SHA) said that waiting lists at Hinchingbrooke were shorter than average so he would expect the hump to be smaller. Darren Leech (Project Director, HHCT) clarified that the 4% given in the answer referred to the contracted level of activity in the coming financial year
- (answer 12) noted an apparent disparity in calculation of the numbers represented by percentages in the answer; Tom Dutton (Assistant Director – Strategic Planning, PCT) undertook to clarify the table PCT
- (answer 13) expressed concern that the £2.2 million allocated to Integrated Community Teams might be in danger of being counted more than once
- (answer 16) sought assurance that the figures quoted were as up to date as possible and were factored in to the PCT's plans. Tom Dutton explained that planned growth in St Neots, the Paxtons and Huntingdon had been taken into account over the next 2 – 3 years, while Northstowe was a separate matter – if its residents were to choose to attend Hinchingbrooke, there would be a considerable gain in business there
- (answer 16) commented that the figures indicated a significant rise in demand by 2021, roughly the same as the reductions now being proposed, and asked whether Hinchingbrooke would have the capacity to match this demand if the land to the rear of the site were to be sold as proposed. Tom Dutton said that the figures quoted were now two years old, before the present shift in the model of care to much greater use of

primary care and community-based services; over the next 5 – 10 years, more real choice would become available to patients, particularly if transport links were to improve.

4c. Members examined the **question of long-term planning** further, noting that it was impossible to know what the position would be in 2021 (the date for which forecasts had been quoted in answer 16) because of changes in technology and in how healthcare would be delivered. The example was given of hernia repair, which had required a 3-day hospital stay 10 years ago and was now performed on a day patient basis.

The Committee asked how far ahead the PCT had been looking in drawing up its proposals for Hinchingbrooke, expressing concern that further review might be required in a few years' time, and asking what was the alternative to the proposals, Plan B. Chris Banks (Chief Executive, PCT) acknowledged the doubts which the Committee had already expressed about the land sale, but pointed out that there would be considerable cost attached to retaining the land until 2021. He emphasised that there was no Plan B, and the PCT was putting its trust in the proposals outlined in Option 2, because:

- the national direction of travel was that only that work which had to be carried out in a hospital setting be carried out there
- health trusts had a statutory duty to balance their budget, savings had to be made, and it was necessary to make those savings at the hospital level, because it would be wrong to cut community and primary care
- Hinchingbrooke's staff needed to be confident that the hospital had a viable future.

Janice Steed (Director of Strategic Development and Commissioning, PCT) told the Committee that she had looked at the proposals in detail, considered them in the light of the white paper *Our health, Our care, Our say* and of changes in clinical practice, and looked at Hinchingbrooke in the context of other hospitals. She had concluded that there had been comparative under-investment in primary and community care in the Huntingdonshire area because there had been so much use made of hospital care. She said that the PCT's Plan B would in practice be one of the other three options outlined in the consultation document, in which the PCT had been looking five years ahead and beyond.

4d. Dr Dennis Cox (a local GP and Professional Executive Committee Chair, PCT) introduced a presentation on **Extending Primary Care**. This and other PowerPoint presentations are attached to the signed copy of these minutes and included with the papers for the meeting on the Cambridgeshire County Council website; copies of the slides can be obtained from the Council's Democratic Services.

Dr Cox pointed out that as a GP, he was part of Hinchingbrooke's problem and of its solution. He had initially been sceptical about the proposals, but had become more optimistic, seeing Option 2 as achievable – though challenging for GPs, hospital doctors and patients – with Hinchingbrooke moving to a form of hospital that was neither District General nor Community Hospital. Points noted by the Committee in the course of the presentation included

- (slide 3) the local GP community did not quite understand how Huntingdonshire had come to have such a high number of hospital admissions and referrals, but it was a problem other areas had encountered sooner; non-elective admissions (slide 4) were far closer to the national average level
- (slide 6) in Dr Cox's own practice, GPs were now looking at all proposed referrals against national criteria and looking for ways of resolving problems that did not involve referral to hospital
- (slide 7) Dr Cox suggested that the Hinchingbrooke campus could be seen as a centre for care provision, whether primary or secondary, with for example a GP clinic in the Treatment Centre
- (slides 8 & 9) in Cambridgeshire, identification of low-priority procedures was already well advanced, and (slide 11) much chronic disease was already being managed in the community
- (slides 13 & 14) by NHS measures, Huntingdonshire already had good infrastructure and primary care of a high standard.

Members' comments and questions to Dr Cox included

- whether, given that Huntingdonshire was an area of growth, and that there was no national surplus of GPs, there would be GP capacity to absorb additional work displaced from Hinchingbrooke. Dr Cox said that part of the capacity problem was that patients were being referred to hospital because facilities were not available in the community; GPs had now started to build up the role of other staff members within their practices (his own practice now had diabetic, cardiac and respiratory specialist nurses, for example). If GPs, in their role as diagnosticians, had access to tests such as ECGs and 24-hour heart tracing, this would assist in the development of workable care pathways for patients
- many GPs now worked part-time, and GP working hours in general were not necessarily convenient for patients. Dr Cox pointed out that hospital appointments too were during the working day; GP surgery hours were 8am to 6pm.

4e. The Committee considered the actual (as opposed to weighted) **population figures** quoted in answer 4 of the written replies from the PCT/HHCT to the Committee, commenting that on the unweighted figures, Huntingdonshire elective hospital admissions were at the national average rate. Dr Cox said that the area was funded on (and some would say penalised for) having a healthy population, but that was how the funding system worked.

Dr Christine Macleod (Head of Cambridgeshire and Peterborough Public Health Network) told members that, looking at the Huntingdonshire population on several different analyses, the picture was of high hospital admission rates. The number of emergency admissions was decreasing because of improved community care, and suggestions for the more difficult task of reducing elective admissions (high across all 23 of Hinchingbrooke's specialisms) were contained in the consultation document. These included enhanced primary care with specialist nurses and putting preventative medicine in place, including encouraging members of the public to take responsibility for their own health.

Dr Macleod explained that unified weighted population figures were used as the basis for health funding in order to make some adjustment for varying local levels of need. Huntingdonshire, like Cambridgeshire as a whole, received less per head of actual population than more deprived areas of the country, though even on unweighted figures, Huntingdonshire's admission rates were high for the age of population.

Janice Steed (PCT) suggested that a healthy population was cause for celebration. Rather than increasing acute care resources, it was better to do more in primary care, by for example

- supporting the change in the GP's role to that of diagnostician, with work formerly carried out by GPs being done by other practice staff
- getting services quickly to (often elderly) people in their own homes, when for instance a nurse could visit to deal with a problem with medication or a catheter, avoiding the need for hospital admission.

4f. Members examined the **question of GP capacity** further, in answer to their questions noting that

- in Dr Cox's practice, 25% fewer patients were being referred to Hinchingbrooke, perhaps 1 in every 30 patients, rather than 2 in 30, though in some cases, he would arrange tests himself, then decide whether or not to refer
- use of clinical assessment procedures was already preventing three referrals per day in some practices
- Dr Mark Sanderson, a Huntingdonshire GP, and Chair of the Huntingdonshire Consortium for Practice Based Commissioning (HuntsComm) said that a full analysis of GP capacity across Huntingdonshire practices had not been carried out; HuntsComm was about to visit each practice to assess capacity, but had so far been looking at work going out of a practice, rather than the effect of additional work coming in to it
- what was being sought was not a straight transfer of work from hospital to GP, but a change in the way of working
    - reduction in demand by raising the threshold for some treatments and classing some others as low-priority
    - better patient information on medication and prescriptions
    - some increase in use of community services such as district nurses
- funding for primary care in Huntingdonshire was healthy, with a good number of doctors per head of population, good infrastructure, and good IT systems for call and recall of patients
- GPs would be able to arrange for tests without going through a consultant, though the tests would not necessarily be carried out in the practice; blood test equipment was cheap, and there were no plans to put major items of equipment in primary care
- the intention was to make more use of existing centres (e.g. the Oak Tree Centre in Huntingdon), bringing services into the market towns, rather than to every GP practice
- in answer to members' concerns that referral of patients found to have

cancer might be delayed, secondary experts were working closely with GPs to ensure that when NICE guidance was issued, GPs would be aware of pathways; the new 18-week measure would also accelerate the patient pathway

- full use of websites and PPI groups was being made to encourage patient self-awareness for cancer, though there were no plans to introduce a general prostate cancer screening service.

The Committee, while not doubting the capability of GPs to perform the work, expressed concern that no full analysis of GP capacity had been undertaken, and that it was not known whether all Huntingdonshire practices would be in a position to carry out the additional work.

4g. Judi Davis (Locality Chief Operating Officer (Cambs), East of England Ambulance Service NHS Trust) gave a presentation on **Ambulance Service Considerations** in relation to the consultation proposals. She informed the Committee that Option 2 was the Ambulance Service's preferred option.

Members' comments and questions in response to the presentation included

- how the Ambulance Service would cope with increasing numbers of transfers to Addenbrooke's Hospital, particularly given reductions in target times for the Service
- what the resourcing implications of the proposals would be. Judi Davis said that discussions on finance were in progress with the PCT, with a view to developing new resource plans because of the new targets
- the Trust had long-standing inherited financial problems, and there should be no assumption that Option 2 would save it money. Janice Steed (PCT) assured members that the Trust had been involved in assessing the options, both before and during the consultation period
- noting that the number of Level 2 Special Care Baby Unit (SCBU) transfers likely to be required was still unknown, members expressed surprise that this work had not already been done, as it could result in substantial costs to the Service. Judi Davis said that she would be meeting Darren Leech (HHCT) about this and should have the figures before the Committee's meeting on 11th May
- what the likely effect of maternity patients exercising choice in West Cambridgeshire would be for the Ambulance Service. Janice Steed said that only a small proportion of maternity patients required an ambulance, and no large increase in ambulance journeys from the area was anticipated; the Ambulance Trust would need to realign its services to meet patients' choice of hospital, but this would not necessarily result in additional costs to the Trust. The PCT was working with the local population to make Hinchingbrooke a positive option for maternity care, and had agreed to subsidise Hinchingbrooke maternity services by £1.1 million because of capacity constraints elsewhere
- how the voluntary car scheme was operated and its availability to transport patients to community clinics. Judi Davis explained that the Ambulance Service on behalf of the healthcare system managed the Ambulance Car Service and paid mileage costs to the voluntary car drivers, who were an excellent resource. Reductions in journeys to outpatients would release capacity for journeys to community clinics.

4h. Councillor Mac McGuire (Cabinet Lead Member for Transport and Delivery, Cambridgeshire County Council (CCC)) and Paul Nelson (Local Passenger Transport Manager, CCC) attended the meeting to answer the Committee's questions on the implications of the consultation proposals for CCC's **provision of transport**. Councillor McGuire stated that

- CCC had a co-ordinating role for community transport in general, with 9 dial-a-ride and 51 volunteer car schemes
- under Local Strategic Partnership arrangements, there was a thematic group, the Huntingdonshire Transport and Access Group, which looked at public transport and access to many local services, and included the PCT in its membership
- there were two types of public transport, commercial services run by independent operators and CCC-subsidised services, provided by operators under contract to the County Council; the viability of subsidised services was an area of concern to CCC given current budget pressures
- CCC was carrying out a review of passenger transport services including community transport, and was attempting to co-ordinate services, including dial-a-ride, to make them more efficient
- if services were moved from Hinchingbrooke into community settings, the demand for transport was likely to be reduced, but if specialist units were to be moved to rural locations, this could give rise to access problems (e.g. reaching the dermatology clinic in Buckden), raising the question whether specialist services would be best left on the Hinchingbrooke site.

Janice Steed (PCT) explained that there was no intention to move any one specialised service wholesale to another single location; the dermatology clinic in Buckden was a pilot to see whether dermatology would be possible in a community setting. Following the pilot, clinics would be rolled out to the market towns, or placed on the Hinchingbrooke site (but at a different cost from the present hospital out-patients' clinic). Access was one of the factors to be taken into account before taking any decision on locating clinics.

In answer to their questions, members noted that

- transport strategies, including the Guided Bus, had been developed with Hinchingbrooke as a main destination, and CCC had continued to consult over the last two years on improving provision for buses, cyclists and pedestrians in the Huntingdon and St Ives area, and on linking Huntingdon to Cambridge
- moving services from Hinchingbrooke could well increase demand for transport to non-traditional locations, for which traditional public transport was unlikely to be suitable. Instead, CCC would be working closely with the Ambulance Service, and be looking at e.g. multi-use vehicles and car schemes based in villages as making better use of resources than buses
- the Highways Agency had just completed its second consultation on the route of the A14. CCC supported the proposal to remove the A14 viaduct in Huntingdon, which with other route proposals would effect a major change to the road layout around the railway station and the hospital, and should improve journey times for ambulances, though there was no starting date for this work yet

- with regard to members' concerns that the design of some buses made them difficult for less agile people to use, there was a requirement that buses on contract to CCC be fit for purpose, and in particular, buses on the guided busway would be expected to have level access
- there would be no additional money to provide additional services for travel to clinics in market towns or GP surgeries, so the aim was to make better use of what was already in place
- although a 25% reduction in patients being referred to Hinchingbrooke was being sought, it was unlikely that this would have a major impact on the viability of current public transport to the hospital, though no formal assessment had been carried out and it was not known whether the proportion of public transport users among the 25% would be typical of the general patient population. Many buses serving Hinchingbrooke did so as a stop on their route to other destinations, including the nearby housing development, and these would still require bus services.

4i. Dr Guy Watkins (Chief Executive, Cambridgeshire Local Medical Committee) attended the meeting to present a **GP perspective** on the proposals. He explained that the Local Medical Committee was the statutory representative body for GPs, and covered Cambridgeshire and Peterborough. Its role was to represent, support and advise GPs – it did not form a part of the PCT system – and he himself had been a GP until 5 years ago.

Dr Watkins assured the Committee that the PCT's plans had not been made in isolation, but in consultation with local GP practices, involving more doctors than managers in the discussions. He welcomed the shift of work into the primary sector, which was part of an ongoing process and would

- fit in with government strategy,
- bring the Huntingdonshire care pattern into line with the norm for the rest of Cambridgeshire and Peterborough,
- enable patients to be treated at their local surgery, which was cheaper and easier for them than getting to the hospital, and
- keep patients in the safe environment of primary care, rather than exposing them to the hazards of hospital life.

Looking at the questions of GPs' capability, willingness and capacity to do the work, and funding, Dr Watkins said that

- GPs would be being asked to provide services already being delivered by GPs in other parts of the county and country. GPs were subject to a complex system of governance, involving performance management and assessment, ongoing training and a regulatory system, which ensured that they had both the capability to deliver the services and the mechanism in place to demonstrate that they had the capability
- Option 2 had developed out of the groundswell of local GP opinion, and moved GPs into what was a more normal way of working. The PCT had provided good support to GPSIs (General Practitioners with Special Interests), but there had been no incentive not to use Hinchingbrooke when services there had been cheap as well as good
- capacity included buildings, people and skill mix. GPs liked seeing patients and were used to taking on new work and reorganising their working lives. They had already become better promoters of self-care,

the use of pharmacies, and the expert patient approach, and some work could be transferred to other members of the practice team, freeing GPs to see patients who needed to be seen by a doctor. A normal referral rate was 4% of the GP workload, so a 25% reduction in referrals would result in only 1 in a 100 patients not being referred, not a huge change in referral patterns and pathway working

- there would be a risk if money were to be taken out of primary care funding rather than secondary care, but that was not being proposed.

Dr Watkins summed up by saying that he was enthusiastic about Option 2, because

- the proposals had largely come from primary care,
- it was necessary to transfer care to fit national norms, and
- it was better to do this in a controlled fashion rather than suddenly if the situation at Hinchingbrooke were to deteriorate.

Members' comments and questions to Dr Watkins included

- whether the transfer of work would affect waiting times to see a GP, which were already long in some parts of East Anglia. Dr Watkins said that patient satisfaction with GP services was high in Cambridgeshire according to recent patient surveys (70 – 75% level of satisfaction with their GPs and with the arrangements for seeing a GP or a particular GP) and not many wanted a change in GP hours, if different opening hours meant that the surgery would be shut at times when it was now open
- whether Saturday morning GP surgeries would become possible again. Members noted that the GP contract discouraged this, and that there was a political unwillingness to decide if Out Of Hours working should be used for routine work or just emergencies
- how numbers of patients per GP/surgery/practice nurse elsewhere compared with numbers in Huntingdonshire. Dr Watkins said that the whole time equivalent number of GPs in Huntingdonshire was similar to that elsewhere, but the number of part-time GPs was greater than average, which increased flexibility in working. The data on practice nurse numbers was not collected nationally. Janice Steed (PCT) said that 11% more funding went into primary care than the national average
- that the views of a practising GP might differ from the Chief Executive's picture. Dr Watkins told the Committee that few local GPs had not been involved in the process of developing the proposals, and if he were to misrepresent GPs' views, they would very quickly hear of this. Although there were challenges in delivering Option 2, they were no greater than those encountered in GPs' present work.

4j. Claire Bruin (Director of Adult Support Services, CCC), Vinny Logan (Board Nurse, PCT) and Sharron Cozens (Acting Lead for Older People's and Adults' Services, PCT) gave presentations on the **implications for social care** of the proposals in Option 2.

Points noted by the Committee in the course of the presentations included

- CCC and PCT were working closely together to support people in their own homes or as close to home as possible – the planning issue was how much of what services would be needed where

- there were community hospitals elsewhere in the county, but none in Huntingdonshire
- Vinny Logan's role was to ensure that the proposals were clinically viable
- evidence was available to support the figures in the chart of the current position on care provision in Huntingdonshire (ICT Capacity referred to Intermediate Care Teams). Bed provision more or less matched demand, but community capacity did not
- the Option 2 proposals represented a huge change in ways of working and involved significant investment in community teams
- the Hinchingbrooke discharge team could currently respond to emergency calls within 24 hours, but would need to respond in 2 – 3 hours
- care on discharge from hospital needed to be arranged more quickly – at present it could take a week to arrange care for an elderly patient medically ready for discharge after 48 hours in hospital
- if care services were always available, some hospital admissions could be avoided altogether
- developing robust community teams would help hospitals to use their systems more appropriately.

On care and staffing issues arising from the presentation, the Committee commented that

- from family experience, individuals in the homecare system were marvellous, but the existing system itself had shortcomings
- a PPI Forum survey of carers in Cambridge had shown that carers all regarded their GP's surgery as a focus of access, but many GPs did not know who they were.

In reply to their questions, members noted that

- homecare would be delivered in integrated teams, and each GP practice would have a homecare link person in the surgery; teams worked very variable hours at present, and proposals were out for consultation on normalising core times
- there were now career opportunities for care staff, with appointments in homecare / health / social care, and a package with career progression could now be offered to staff
- NVQ level 2 was the basic qualification for all staff, and further training was available
- a due system was in place under clinical governance for monitoring homecare workers; district nurses monitored them in teams in Cambridge City and South Cambridgeshire, with a weekly one-to-one session and occasional accompanied visiting, and similar arrangements were being consulted on for Huntingdonshire
- training for district nurses was now conducted on a national, competency-based, modular system, which enabled nurses to mix and match modules to enhance their capability.

On provision of beds, the Committee noted in reply to its questions that

- medical beds at Hinchingbrooke had last been reduced in 2005/06, when about 30 surgical beds had been removed when the Treatment Centre had opened with 24 beds plus day-care cabins
- interim care beds were purchased within the private sector – these were used e.g. by people who were nearly ready to return home from hospital but had to wait until their supporting homecare package was in place
- demand for interim care beds was increasing
- interim care beds might typically be in a sheltered housing scheme or a nursing home – they were being purchased in the market towns (apart from Ramsey, where there was no private sector presence), and other locations were being sought, as travel times were reduced if the beds were in a wide range of locations
- use of interim care beds would assist in meeting the Section 31 and CCC targets to reduce admissions to residential care
- patients in interim care beds did not attract delayed discharge penalties
- delayed discharge in Huntingdonshire had cost £95,000 (at £100 per person per day) in the current financial year, money which would be released by improving community care
- of hospital admissions for the Huntingdonshire population
    - 46% of emergency patients were aged over 65
    - 41% of elective patients were aged over 65
    - 41% of day case patients were aged over 65
- money would be better spent supporting elderly people outside the hospital setting
- a shift away from hospital admission for the elderly was already occurring.

On financial issues arising from the presentation, the Committee

- commented that resources appeared to be unequal to the present level of demand
- pointed out that the Local Authority did not have the capacity to pick up any shortfall in provision
- asked whether the additional £2.2 million for community services would be adequate to implement an integrated team approach and meet the existing shortfall. Janice Steed (PCT) said that £2.2 million would be enough to replace the work being done in hospital; it could be built into the PCT's commissioning plans, and reducing hospital admissions would release more money for community services
- noted that work was in progress on a detailed breakdown of how the £2.2 million would be spent; it was in Janice Steed's opinion a reasonable amount, would allow the PCT and CCC to build up integrated services and manage the anticipated demand together, and was the optimum amount for the resources available
- stated that it would welcome a breakdown of how the £2.2 million was to be spent, how it related to the present level of spending, and what its implications were for the County Council's Social Services. PCT/CCC

5. UPDATE AND DISCUSSION OF CONSULTATION PROCESS

Karen Mason, Acting Director of Communications, Cambridgeshire PCT, informed the Committee that since its last meeting, the PCT had worked with the media to raise awareness of the public meetings. Three of the seven meetings had so far been held, with a small but increasing attendance rate. Those who had attended had provided constructive, beneficial feedback. Other consultation activities included

- Invitations received to meetings of various community groups
- displays in the public library on market days in Huntingdon, St Ives and St Neots
- a phone-in with Radio Cambridgeshire, scheduled for 19th April
- attendance at meetings of the Ambulance Trust, the District Council, and the Patient and Public Involvement in Health Forum.

Members noted that about 30 written responses to the consultation had been received to date, generally supporting Option 2.

6. NEXT STEPS AND REQUESTS FOR FURTHER INFORMATION

In discussion with Jane Belman, Health Scrutiny Co-ordinator for Cambridgeshire County Council, the Committee identified the following matters as still requiring clarification by email from the PCT:

- how much the additional £2.2 million to be spent on Community Care was as a percentage of the total present spend on this service
- what the correct figures were underlying the table in answer 12 of the answers supplied to Key Questions/Requests for Further Information.

Members went on to consider how best to formulate the Committee's response to the consultation proposals.

It was decided that members should clarify their thoughts over the next one to two days, then communicate them by email to other members and officers. Jane Belman would use these thoughts as the basis for a draft response. This would then be shared with the PCT in advance of the Committee's next meeting on 11th May, at which the Committee's response would be finalised. Members J Belman

The Chairman thanked all participants for their contributions to the meeting.

Members of the Committee in attendance: *Councillor S Male (Bedfordshire County Council), Councillors G Heathcock (Chairman) K Reynolds and L Wilson (Cambridgeshire County Council), Councillor J Eells (Norfolk County Council), Councillor B Rush (Peterborough City Council), Mr N Roberts (Cambridgeshire PCT PPI Forum) and Dr A Owen-Smith (Hinchingbrooke PPI Forum)*

Also in attendance: *Councillor M McGuire*

Apologies: *Councillors A Carter and J Cunningham (Bedfordshire County Council), Councillors Y Lowndes, and K Sharpe (Peterborough City Council)*

Time: *10.30am. – 3.30pm*
Place: *Pathfinder House, Huntingdon*