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Havering
LONDON BOROUGH

HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
AGENDA

7.00 pm	Tuesday 12 January 2016	Havering Town Hall

Members 6: Quorum 3

COUNCILLORS:

Conservative Group (3)	East Havering Residents' Group (2)	Residents' Group (1)
Dilip Patel (Vice-Chair) Jason Frost Carol Smith	Gillian Ford Linda Hawthorn	Nic Dodin (Chairman)

Andrew Beesley
Committee Administration Manager

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AGENDA ITEMS

1 ANNOUNCEMENTS

Details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation will be announced.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS

(if any) – receive.

3 DISCLOSURES OF INTEREST

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any time prior to the consideration of the matter.

4 MINUTES (Pages 1 - 6)

To agree as a correct record the minutes of the meeting held on 19 November 2015 and to authorise the Chairman to sign them (attached).

5 NHS PROPERTY UPDATE

To receive updates from senior officers at NHS Property concerning the position with health facility sites within Havering.

6 BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST (BHRUT) IMPROVEMENT PLAN

The Chief Executive of BHRUT will update the Sub-Committee on progress with the Trust Improvement Plan.

7 PROVISIONAL ITEM: PARKING ISSUES AT HAROLD WOOD CLINIC

8 CORPORATE PERFORMANCE REPORT QUARTERS 1 AND 2 (Pages 7 - 16)

Report attached.

9 APPOINTMENTS CANCELLATION TOPIC GROUP

The Chairman will give an update on the position with the Appointments Cancellation topic group being run in conjunction with Healthwatch Havering.

10 URGENT BUSINESS

To consider any other items in respect of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item shall be considered as a matter of urgency.

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MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
19 November 2015 (7.00 - 8.45 pm)

Present:

Councilllors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Gillian Ford, Jason Frost, Linda Hawthorn and Carol Smith

28 **ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event that should require the evacuation of the meeting room.

29 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

There were no apologies for absence.

30 **DISCLOSURE OF INTERESTS**

There were disclosures of pecuniary or personal interests.

31 **MINUTES**

The minutes of the meetings of the Sub-Committee held on 8 September 2015 and 8 October 2015 (joint meeting with Children & Learning Overview and Scrutiny Sub-Committee) were agreed as a correct record and signed by the Chairman.

32 **PRIMARY CARE UPDATE**

The Director of Primary Care Transformation, Havering Clinical Commissioning Group (CCG) explained that there were three types of GP contact:

General Medical Services (GMS) – a national contract that could not be changed locally. This mainly covered traditional GP services along with some additional services such as influenza treatment and maternity services.

Personal Medical Services (PMS) – Local GP contracts of higher value that could be commissioned locally. It was these contracts that were currently being reviewed by the CCG. These contracts could only be held by a GP practice.

Alternative Provider of Medical Services (APMS) – Whilst still being provided by GPs, these contracts could be held by any suitable organisation.

It was noted that, in addition to whichever contract was held, the Council also commissioned some services from GPs e.g. smoking cessation services.

The review of PMS contracts locally had to be completed by March 2016 and it was possible that this could lead to changes in some GP services but officers agreed to return to update the Sub-Committee once further details were known, probably in January/February 2016.

Contracts included a number of performance indicators that providers were expected to meet in areas such as patient satisfaction. Indicators within the London Primary Care Framework also applied for areas such as on-line patient access (including to records) and the target of Saturday opening for all practices.

It was noted that CCGs were required to meet a gap in Government funding for PMS contracts and these types of contracts were therefore a cost pressure for the CCG. The CCG was therefore currently trying to complete a financial analysis of the new contract package and what services were currently being commissioned. In addition to completion of the financial modelling, discussions on the revised PMS contracts would take place with the Local Medical Committee. Discussions would also take place with the Council and with Healthwatch and a final decision on the PMS contracts would be taken by the Primary Care Committee.

A working group on PMS contracts had also been established across the Barking & Dagenham, Havering and Redbridge area, supported by NHS England and the North East London Commissioning Support Unit. The Local Medical Committee and clinical leads for Primary Care were also represented. Briefings on the new PMS contracts would be circulated, once details had been confirmed.

It was confirmed that there were a total of 15 Havering GP practices with PMS contracts although it was uncertain if there were PMS contract practices within each GP cluster. The PMS practices within Havering tended to be those that were higher performing.

It was also clarified that patients within a practice area had to be allowed to be allowed to register with a local GP, providing that practice's list was open. The target was to have 1,800 patients to each GP but there was no maximum patient number.

The issue of GPs moving to larger premises to allow them to provide e.g. minor surgery was not part of the PMS review but was covered in the CCG's programme of transformation work. A total of £1 billion of Government funding for GP premises had been announced from 2015/16 although this had not been released as yet. The funding would be managed by NHS England although it was clarified that associated revenue costs would have to be met by the CCGs. The CCG officer felt that this was deliverable but that a clear policy was needed re premises investment.

It was accepted that there were a lot of single-handed GPs in Havering as well as many GPs approaching retirement age. It was not possible to reclaim from overseas patients the cost of primary care; this was only possible with hospital treatment.

The King's Park surgery in Harold Wood was under an APMS contract, currently held by the Hurley Group. This contract was coming to an end and a procurement exercise was therefore currently under way with patient engagement and provider events planned. Contract procurement was at an early stage and a new contract would be in place by 1 August 2016.

The walk-in service formerly based at Orchard Village had moved to South Hornchurch clinic. The CCG also planned to introduce a GP practice for the Orchard Village estate although a funding route for this would be need to be agreed with NHS England. The contract for walk-in services at South Hornchurch clinic was also currently held by the Hurley Group. The walk-in service would become part of the CCG's Vanguard work and would hence be a different contract from the Orchard Village GP surgery.

The Sub-Committee **NOTED** the updates.

33 JOINT STRATEGIC NEEDS ASSESSMENT

The Interim Director or Public Health explained that the Joint Strategic Needs Assessment (JSNA) predated the establishment of Health and Wellbeing Boards and had been established by the former Primary Care Trust. Following the disbandment of Primary Care Trusts under the Health and Social Care Act 2012, the production of the JSNA was now overseen by the Health and Wellbeing Board.

A new approach had been taken to the JSNA from January 2015 and a dynamic, active work programme had now been established. The core document of the JSNA was the Key Facts and Figures document which gave a single set of health statistics, focussed on Havering. This document was updated quarterly and published on the Council website.

A high level overview of the health and social care needs of the borough was also in production and this was currently in draft. Ward health profiles would also be produced and would be available once problems with the technical platform used had been resolved.

Two 'deep dives' on specific topics would also be carried out each year although these were highly labour intensive. These exercises would aim to answer specific questions with the first review covering issues related to obesity. A local obesity strategy would be developed following the launch of the national obesity strategy early in 2016.

The JSNA summary would be updated annually and it was planned to update the ward health profiles on a six-monthly basis. Factsheets and technical briefings related to the JSNA would also be produced. It was also planned to look at aligning the Havering JSNA more closely with those for Barking & Dagenham and Redbridge.

It was accepted that the Key Facts and Figures document needed to be publicly launched, now that it was available on-line and the overall public health pages on the Council website were in the process of being changed.

The Sub-Committee welcomed the work being undertaken on the JSNA and **NOTED** the position.

34 **JOINT HEALTH AND WELLBEING STRATEGY**

The Interim Director of Public Health explained that the JSNA was also used to inform the Joint Health and Wellbeing Strategy (JHWBS). The Council's first JHWBS covered the period until 2014 and was based very much on adult social care. The priorities of the strategy had therefore recently been reviewed. Further changes had however been put on hold for the present in order to seek to align the strategy more with those covering Barking & Dagenham and Redbridge. There was not therefore an underlying action plan to the strategy although specific actions were being taken in connection with it.

It was clarified that public health did not commission most services, this was undertaken by the Clinical Commissioning Group (CCG). The public health section dealt with Havering CCG as well as with policies covering the three local CCG areas. Any commissioning that was undertaken by public health was specific for Havering residents. The CCG acted on what the JSNA decided were the services required for local residents.

It was noted that none of the organisations involved were co-terminus and that there were multiple commissioners for e.g. services provided by the North East London NHS Foundation Trust (NELFT). There had also been moves recently by central government to potentially offer more health commissioning powers to councils and it was suggested therefore that the Sub-Committee could have a role in scrutinising the work and outcomes of the Health and Wellbeing Board. Some national work had recently been

completed on evaluating the work and function of Health and Wellbeing Boards.

It was also suggested that the Health and Wellbeing Board should look at the wider determinants of public health. Community services were commissioned via the Better Care Fund in order to e.g. improve care outside of hospital. This work was overseen by the Health and Wellbeing Board. Social care outcomes were monitored by the Council and contractual monitoring of services such as district nursing was carried out by the CCG. Oversight of these areas was also kept by the Integrated Care Coalition which was chaired by the Council chief executive and by the accountable officer for the three local CCGs.

The Sub-Committee **NOTED** the position.

35 HEALTHWATCH HAVERING UPDATE

A director of Healthwatch Havering explained that the organisation had recently commenced a new campaign to encourage people to give their opinion of local health and social care services. This comprised the distribution of postage paid cards for patients and service users to complete and return to Healthwatch. The scheme would be fully launched in early 2016 but it was planned to use feedback received (both good and bad) to inform the organisation's work programme and schedule of visits planned under its powers to enter and view premises.

It was noted that Healthwatch Redbridge had recently conducted such a visit to Queen's Hospital with local people who were deaf. The report, which was available on the Healthwatch Redbridge website, had made a number of recommendations to improve accessibility of the hospital for people who were deaf or hard of hearing.

Members of the Sub-Committee were given packs of the cards to give to constituents and it was suggested that similar packs be sent by Healthwatch to all other Havering Councillors.

It was hoped to also make the comment cards available in hospitals, GP surgeries etc although it was emphasised that these did not circumvent the formal complaints systems in the NHS or social care. Respondents would be directed or signposted (where contact details were given) to the appropriate agency should they wish to make a formal complaint about their treatment etc.

Several Healthwatch listening events had been planned for 2016. It was clarified that, although it was situated in Redbridge, Healthwatch Havering could undertake an enter and view visit to King George Hospital, as Havering patients were treated there. Healthwatch Havering had not however received any complaints about King George Hospital as yet.

The Sub-Committee also considered a recent letter from the Chairman of Healthwatch Havering concerning delays to surgical and outpatient appointments at Barking, Havering and Redbridge University Hospitals' NHS Trust (BHRUT). It was emphasised that the letter did not imply any criticism of the current BHRUT chief executive or management team but there was concern about the level of backlog that had been reported.

It was therefore proposed by Healthwatch Havering that a joint topic group-style review of the delayed procedures and appointments be undertaken. This would build upon the review of appointments cancellation at BHRUT that had recently been undertaken by a topic group of the Sub-Committee. Results of recent enter and view visits conducted by Healthwatch Havering could also be fed into the review.

Officers added that it was the responsibility of Havering CCG to monitor the performance of BHRUT on referral to treatment times and the CCG should also therefore be involved in the review. This would allow Members to understand the reason for increased waiting times.

It was **AGREED** that the Clerk to the Committee and the director of Healthwatch should draft a terms of reference and outline meeting schedule for the review. Officers would also seek to meet with the scrutiny lead officer at BHRUT in order to seek to explain the purpose of the review.

36 **URGENT BUSINESS**

There was no urgent business raised.

Chairman

Havering
LONDON BOROUGH

HEALTH OVERVIEW AND SCRUTINY SUB-COMMITTEE

Subject Heading:	Corporate Performance Report: Quarters 1 & 2 (2015/16)
CMT Lead:	Isobel Cattermole, Deputy Chief Executive (Children, Adults and Housing)
Report Author and contact details:	Mayoor Sunilkumar, Public Health Intelligence Analyst (phi.havering@havering.gov.uk)
Policy context:	The report sets out Quarter 1 and Quarter 2 performance for indicators relevant to the sub-committee

SUMMARY

The Corporate Performance Report provides an overview of the Council's performance for each of the strategic goals (Clean, Safe and Proud). All of the indicators relevant to this committee contribute to the achievement of the strategic goal that the people of the borough will be safe, in their homes and in the community.

The report identifies where the Council is performing well (Green) and not so well (Amber and Red). The RAG ratings for 2015/16 are as follows:

- Red = more than the **'target tolerance'** off the quarter target and where performance has *not improved*.
- Amber = more than the **'target tolerance'** off the quarter target and where performance has *improved or been maintained*
- Green = on or within the **'target tolerance'** of the quarter target

Where performance is more than the **'target tolerance'** off the quarter target and the RAG rating is 'Red', '**Corrective Action**' is included in the report. This highlights what action the Council will take to address poor performance.

Also included in the report are Direction of Travel (DOT) columns, which compare:

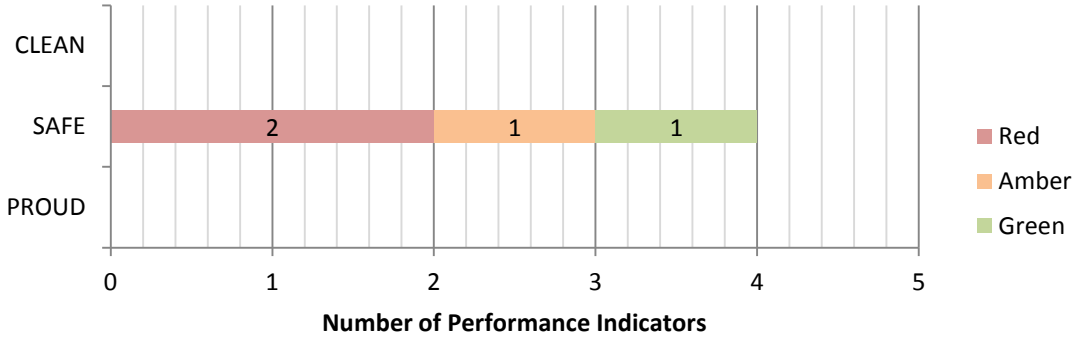
- Short-term performance – with the previous quarter
- Long-term performance – with the same quarter the previous year

A green arrow (↑) means performance is better and a red arrow (↓) means performance is worse. An amber arrow (→) means that performance is the same.

OVERVIEW OF PUBLIC HEALTH INDICATORS

4 Corporate Performance Indicators fall under the remit of the Health Overview & Scrutiny sub-committee. These all relate to the Public Health Service.

Q2 2015/16 RAG Summary for Public Health



Of the 4 indicators, all have been given a RAG status for Quarter 2. 1 is **Green,** 1 is **Amber** and 2 are **Red**.

Future performance reporting arrangements

In discussion with the Overview and Scrutiny Board and some of the Overview and Scrutiny Sub-Committees, consideration has recently been given to the current performance reporting arrangements and how they might be improved going forward.

Under the current arrangements, the quarterly and annual corporate performance reports are considered by the Cabinet first, then the Overview and Scrutiny Board and finally the various Overview and Scrutiny Sub-Committees. Depending on the meetings schedule in any given quarter, the whole cycle of reporting takes between four and seven months to complete. For Quarter 1 of this year, there is a seven-month time lag between the end of the quarter and the point at which most of the overview and scrutiny sub-committees have had the opportunity to scrutinise the data (so performance during the April to June period is being scrutinised in January).

Going forward, from the new financial year onwards, Cabinet has agreed that the quarterly and annual Corporate Performance Reports will be considered first by the individual overview and scrutiny sub-committees, then the Overview and Scrutiny Board and finally the Cabinet. This will allow the Cabinet reports to reflect any actions or comments the overview and scrutiny committees may be making to improve performance in highlighted areas as well as shortening the overall performance reporting cycle.

RECOMMENDATIONS

Members are asked to review performance set out in **Appendix 2** (for Quarter 2) and the corrective action that is being taken; and note **Appendix 1** (for Quarter 1) attached.

REPORT DETAIL

Only 1 of 4 of Public Health indicators was rated to be performing within target tolerance at the end of Quarter 2. But note highlights below for the "Percentage of women smoking at Time of Delivery" indicator**.**

Highlights:

Percentage of new patients attending sexual health services accepting offer of HIV test

- This indicator is rated green
- The Council's contract with the provider of the sexual health service ceased on 30th September 2015. As a result of this, the Council is not expecting to receive performance data until a new contract has been agreed.
- However, our local provider has agreed to share the existing performance scorecard while further negotiations are taking place.

Improvements required:

Number of schools achieving stated level of healthy schools award

- This indicator is rated amber
- The number of schools awarded Silver and Gold is one below the target for Quarter 2. In both cases, applications have been submitted to the Healthy Schools London team and were awaiting approval.
- Positive progress has since been made: the gold award has been successfully approved. Although feedback on the two silver applications required amendments to be made prior to approval, these have since been made and the applications resubmitted.
- Schools sign up to Healthy Schools London voluntarily and as such it is expected that timescales may occasionally slip.
- Thus no significant improvements are proposed at present.

Percentage of eligible patients offered an NHS Health Check

- This indicator is rated red
- Performance (8.2%) is below target (10.0%) and worse than at the same point in the previous year (10.4%). To date, 5,474 people have received an invite offer to undertake an NHS Health Check; 1,542 fewer than in 2014/15.
- Underperformance is as a result of a combination of factors:
    - Staff Resourcing: In order for the service to achieve its in year MTFS savings and grant cuts it was necessary to remove its GP supporting staff resource capacity of 0.6 FTE.
    - Reporting System Change: From April 2015 Public Health has introduced a new method of performance management against delivery to improve efficiency.
    - Incentives: It is widely recognised that local authorities can improve performance through increasing incentives to GPs. LBH's incentive offer is based upon providing value for money to the council whilst maintaining a fair return to GPs for their services.
- As a consequence of the in-year cuts to the Public Health grant there are no new initiatives planned for increasing the performance of Health Checks.
- However, this will be reviewed once the announcement for the 16/17 Public Health grant has been announced.

Percentage of women smoking at Time of Delivery

- This indicator is rated red.
- However, this should have not have been rated red because the performance (10.9%) is within the variable tolerance (±1%) of the target (10%).
- Due to the Health and Social Care Information Centre (HSCIC) publishing its data 3 months after the period to which it relates, there is a time lag of one quarter. Therefore, the performance figure (10.9%) is actually for quarter 1.
- A jointly funded BabyClear programme between Havering and Barking and Dagenham Councils is being implemented, and it is anticipated that this provision will have an impact on the data around smoking status at point of delivery. This is due to the use of CO2 monitors rather than relying on mothers to self-report.

IMPLICATIONS AND RISKS

All the information here relates to Health Checks.

Financial implications and risks:

An increased financial incentive for the health check offer was implemented during 14/15 which had a positive effect. The financial incentive has been maintained but no

further increases can be considered in light of the in-year cuts to the Public Health grant.

Human resources implications and risks

In response to the anticipated in-year cuts to the Public Health grant, the Public Health service has been reduced to meet this cost pressure and this approach will be maintained.

Legal implications and risks:
Health Checks is a local authority mandated service that continues to be provided and is funded through the Public Health grant.

Equalities implications and risks:
The Council, through the Public Health grant, is mandated to provide Health Checks and continues to do so. This service has been commissioned from Havering CCG general practices (GPs) who have access to the registered patient list. This enables the GP to identify the eligible population suitable for a Health Check and thereafter update the relevant record. As a consequence of this niche market position, we are limited in the types of alternative providers that we can successfully engage with. Additional support has been sourced from the GP federations within the current financial envelope.

BACKGROUND PAPERS

The Corporate Plan 2015/16 is available on the website at http://www.havering.gov.uk/Documents/Council-democracy-elections/Corporate-Plan-on-a-page-2015-16.pdf

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Ref.	Indicator	Value	2015/16 Annual Target	2015/16 Quarter 1 Target	Variable Tolerance	2015/16 Quarter 2 Performance	Short Term DOT against 2015/16 (Q1)		Long Term DOT against 2014/15 (Q2)		Comments	Service	O&S Sub-Committee
PH4	Percentage of new patients attending sexual health services accepting offer of HIV test	Bigger is Better	85%	85%	±5%	86.7% (GREEN)	–	NEW	–	NEW	Barking, Havering & Redbridge University Trust is commissioned to provide sexual health services in Havering. As part of the service, the Trust offers HIV testing to all patients who attend their clinics. 86.7% of patients accepted the offer in the first quarter of 2015/16, which is higher than target (85%). This is a new corporate indicator for 2015/16, so a DOT cannot be provided.	**Public Health** *Local performance indicator*	**Health**
PH5 **(C)**	Number of schools achieving stated level of healthy schools award	Bigger is Better	65 Registered 25 Bronze 8 Silver 2 Gold	52 Registered 13 Bronze 3 Silver 0 Gold	Under performance on more than 1 level of achieveme	56 Registered 23 Bronze 3 Silver 0 Gold (GREEN)	–	52 Registered 13 Bronze 1 Silver 0 Gold	↑	33 Registered 3 Bronze 0 Silver 0 Gold	Health schools awards (56 registered, 23 bronze, 3 silver and 0 gold) are higher than target (52 registered, 13 bronze, 3 silver and 0 gold) and the same period last year (33 registered, 3 bronze, 0 silver and 0 gold).	**Public Health** *Registered with Healthy Schools London*	**Health**
PH6 **(S)**	Percentage of women smoking at Time of Delivery	Smaller is Better	10%	10%	±1%	9.8% (Q4 2014/15 time lag) (GREEN)	↑	10.6% (Q3 2014/15)	↑	12.4% (Q4 2013/14)	Women smoking at time of delivery (9.8%) is lower than target (10%) and the same period last year (12.4%). The new BabyClear programme, being jointly implemented by Havering and Barking & Dagenham councils, is anticipated to have an affect on performance later in the year when CO_2 monitors provide a more accurate report on smoking.	**Public Health** *Reported to Department for Health (DH) (PHOF)*	**Health**
PH3a **(C)**	Percentage of eligible patients offered an NHS Health Check	Bigger is Better	20% (equates to 13,343)	5%	±10%	4.7% (predictive) (3,165 of 66,713) (GREEN)	–	18.7% (12,551 of 67,265)	↓	6.1% (4,080 of 67,265)	Eligible patients offered an NHS health check (4.7%) is within target tolerance (5%) but lower than the same period last year (6.1%). This is a predictive outturn. The final outturn will be available at the end August.	**Public Health** *Local performance indicator* *(The statutory return to the DH uses less accurate population data)*	**Health**

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Ref.	Indicator	Value	2015/16 Annual Target	2015/16 Quarter 2 Target	Variable Tolerance	2015/16 Quarter 2 Performance	Short Term DOT against 2015/16 (Q1)		Long Term DOT against 2014/15 (Q2)		Comments	Service	O&S Sub-Committee
PH4	Percentage of new patients attending sexual health services accepting offer of HIV test	Bigger is Better	85%	85%	±5%	84.5% (Estimated) GREEN	↓	86.7%	_	NEW	The Council's contract with the provider of the sexual health service ceased on 30th September 2015. As a result of this the Council will not receive performance data until a new contract has been agreed. It is anticipated the procurement of the new contract will take up to 6 months and therefore performance data will not be made available for the remainder of this annual reporting period. The Council is in receipt of actual data covering 5 months (April to August), thereby only able to offer an estimate for the second quarterly period (July to September).	**Public Health** *Local performance indicator*	**Health**
PH5 **(C)**	Number of schools achieving stated level of healthy schools award	Bigger is Better	65 Registered 25 Bronze 8 Silver 2 Gold	55 Registered 17 Bronze 4 Silver 1 Gold	Under performance on more than 1 level of achieveme	58 Registered 24 Bronze 3 Silver 0 Gold AMBER	↑	56 Registered 23 Bronze 3 Silver 0 Gold	↑	37 Registered 6 Bronze 0 Silver 0 Gold	The number of schools awarded Silver and Gold is one below the target for Quarter 2. In both cases, applications have been submitted to the Healthy Schools London team and are currently awaiting approval.	**Public Health** *Registered with Healthy Schools London*	**Health**
PH6 **(S)**	Percentage of women smoking at Time of Delivery	Smaller is Better	10%	10%	±1%	10.9% (Q1 2015/16 time lag) RED	↓	9.8% (Q4 2014/15 time lag)	↓	9.6% (Q1 2014/15)	Due to the Health and Social Care Information Centre (HSCIC) publishing its data 3 months after the period to which it relates, there is a time lag of one quarter. We are currently in the process of implementing the jointly funded BabyClear programme between Havering and Barking and Dagenham Councils, and it is anticipated that when this provision is in place this may have an impact on the data around smoking status at point of delivery. This is due to the use of CO2 monitors rather than relying on mothers to self-report.	**Public Health** *Reported to Department for Health (DH) (PHOF)*	**Health**
PH3a **(C)**	Percentage of eligible patients offered an NHS Health Check	Bigger is Better	20% (equates to 13,343)	10%	±10%	8.2% (5,474 of 66,713) RED	↑	4.7% (3,165 of 66,713)	↓	10.4% (7,016 of 67,265)	Performance (8.2%) is below target (10.0%) and worse than at the same point in the previous year (10.4%). To date, 5,474 people have received an invite offer to undertake an NHS Health Check; 1,542 fewer than in 2014/15. **Corrective Action:** Underperformance is as a result of a combination of factors; • Staff Resourcing: In order for the service to achieve its in year MTFS savings and grant cuts it was necessary to remove its GP supporting staff resource capacity of 0.6 FTE.	**Public Health** *Local performance indicator (The statutory return to the DH uses less accurate population data)*	**Health**

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