HEALTH COMMITTEE: MINUTES

Date: Thursday 20th July 2017

Time: 2.00pm to 5.40 pm

Present: Councillors C Boden, L Dupré, L Harford, Cllr Hudson (Chairman), D Jenkins, L Jones, T Sanderson, M Smith (substituting for Councillor Gowing**) K Reynolds and S van de Ven

District Councillors M Abbott (Cambridge City), M Cornwell (Fenland) S Ellington (South Cambridgeshire) and J Tavener (Huntingdonshire)

Observer: Councillor Topping

Apologies: **Councillor J Gowing's apologies were received who had been replaced on the Committee by Councillor Topping on 17th July but this notification was too late for the latter to be able to take his place on the Committee for the current meeting, as five days advance notice had not been provided.

In opening the meeting and welcoming the public, Councillor Hudson, previously the Vice Chairman, explained that he had been appointed as the new Chairman by full Council on Tuesday and that Councillor Boden had been appointed as the new Vice-Chairman.

13. DECLARATIONS OF INTEREST

There were no declarations of interest.

14. MINUTES – 14th JUNE AND ACTION LOG:

The minutes of the meeting held on 14TH June 2017 were agreed as a correct record and signed by the Chairman.

The Director of Public Health provided an oral update on the Action Log, highlighting changes to the Action Log from the version included on the original agenda despatch, which had been included in a revised version published the day before on the Council web site and which was also e-mailed to the Committee with hard copies provided at the meeting.

The oral update highlighted:

Minute 6 – Health Committee agenda plan and training plan - the briefing on the existing Action Plan for the School Nursing Service had been circulated on Monday 17th July and an agenda item planned for the October meeting.

Minute 7 - Finance and Performance Report – Outturn 2016-17 – the Quarterly Performance report on the Healthy Fenland Fund along with service specifications and Key Performance Indictors (KPI's) were circulated to the Committee on 19th July. It was explained that did not capture all the outcomes from the programmes. As a result, an evaluation framework had also been circulated providing a clearer overview of outcomes.

Minute 8 - Annual Health Performance Report - In respect of the action to provide performance information for the health trainer role, giving evidence of changes in health

behaviour in easily readable headline graphs Dr Liz Robin indicated as an oral update that the intention would be to include this information as an appendix to the September Committee's Finance and Performance report.

It was resolved:

a) To note the revised Action Log.

b) To receive the Health trainers outcomes as an appendix to the September Finance and Performance Report.

15. CO-OPTION OF DISTRICT COUNCIL REPRESENTATIVES

It was resolved unanimously to appoint Councillor Mike Cornwell as the final district council non-voting co-opted member of the Committee following his recent re-confirmation nomination received from Fenland District Council.

16. PETITIONS

No petitions were received.

17. PUBLIC HEALTH FINANCE AND PERFORMANCE REPORT

The Committee received the Finance and Performance Report for the period to the end of May. There was no outturn information as the data was normally a month behind for the May report, but the expectation was that there would be a balanced budget position.

A balanced budget has been set for the financial year 2017/18 with savings totalling £606k budgeted for and their achievement to be monitored through the new monthly savings tracker.

Attention was drawn to:

- the total Public Health ring-fenced grant allocation for 2017/18 being £26.9m, of which £26.041m was allocated directly to the Public Health Directorate.

- The virement of the budget of £6,058k (£5,880k funded from the ringfenced public health grant and £178k funded from County Council budgets) for the Drug and Alcohol treatment contracts from the Children, Families and Adults (CFA) budget to Public Health, as a result of the creation of the Public Health Joint Commissioning Unit (PHJCU), who would now manage the commissioning of drug and alcohol treatment services.

- The virement of the budget for mental health youth counselling (£111k) previously held within CFA to the Public Health budget to be managed through the Joint Children's Health Commissioning Unit.

In respect of performance the following updates were provided:

- Sexual Health - Performance remained good with all indicators green.
- Smoking Cessation – as an oral update it was indicated that the annual target for 2016-17 had been achieved.
- National Child Measurement Programme - Both key performance indicators were green.

- NHS Health Checks - The end of year results for 2016/17 showed that the performance indicators remained at amber, but that there had been some improvement. Outreach NHS Health Checks was showing red, as the target set for Fenland had not been met, reflecting the lack of engagement by workplaces in Fenland.
- Lifestyle Service - the overall performance showed seven green, seven amber and three red indicators. Two senior management vacancies in the period had been a contributory factor and as the two had now been filled, there was an expectation that going forward, performance would improve. Performance around falls prevention remained good with the two key performance monthly indicators having been achieved.
- Health Visiting and School Nursing data -The overall performance indicators showed three amber and three green indicators, the commentary in the report provided further details of targets not met but which did not show a significant deterioration and were attributed to a vacancy rate of 16%. New students would be appointed in September and the position was expected to improve.
- Health Visiting data for the end of Quarter 4 performance was showing as amber for mandated checks.
- The number of infants recorded as breast feeding at six weeks was highlighted in the report as being one of the highest in the Eastern region.

In Discussion:

- In respect of Health visiting mandated checks - the percentage of children who received 12 month review by 15 months - and the decline in performance, a question was raised regarding whether there was a geographical / social pattern to them not being wanted or not attended? **Action: Dr Robin to find out and report back with more detail.**

- Another Member queried why one figure for the number of health checks completed was showing a year to date achievement of 97% checks, while the next target on who received a health check of those offered showed only a 35% achievement rate against a target of 45%. In response it was indicated that this reflected how the programme had been set up, with invitations for health checks the responsibility of the GP practice. Software was being used to help improve the service and further offers had just been sent out again, with the number of offers sent out continuing to increase. A further question from the Member asked that if the number had hit 45%, whether this would have resulted in the target year to date figure increasing from 18,000 to 23,000. In response it was explained that in theory this was correct. With regard to health checks it was explained that the outreach health checks had achieved the target apart from in Fenland. As follow up, the Vice Chairman suggested that in order to ascertain the scale of the problem future reports indicators should be split in two, to show Fenland and the rest of the County. It was confirmed that health and inequalities supplementary information had been produced in the past on a quarterly basis and this information could be added. **Action: This additional inequalities information to highlight the scale of the issue on health checks take up in Fenland to be provided on quarterly basis.**

- That as the report suggested that some of the performance problems highlighted were due to recruitment issues, a question was asked that where services had been contracted out, were there consequences for providers for not meeting the agreed level of service i.e. financial penalties? In response it was explained that

this depended on each service contract but that the standard procurement contract with officers working closely through commissioning / procurement channels would ensure that an improvement plan was put in place, and if after this it was still an issue, then financial penalties would be incurred. Penalties could not however be imposed on Section 75 or joint contracts such as Health visitors / School Nursing. **Action Liz Robin to clarify with Val Thomas what sanctions applied in these type of contracts.**

- The same Member highlighted the need to learn from previously agreed contracts when re-letting contracts, to ensure that there were consequences for poor performance. He questioned whether the officers had the capability and expertise to manage such contracts. The Director of Public health gave assurance that officers were assiduous in managing public healh contratcs.cAnother Member in response made the point that the competency of Public Health teams in letting contracts had improved in the last 10 years and made the point that penalties could result in further deterioration of service in some circumstances.

- Another Member made the point that the performance on outreach health checks had not changed for a period of time and this was not acceptable. As part of the perceived problem was the culture of employers in Fenland not allowing staff to be released to have health checks, what was required was a report with a suggested action plan on how to address and improve performance in this area. This amendment to the recommendations on being duly seconded received the support of the Committee

That having reviewed and commented on the report

It was resolved:

a) To note the finance and performance position at the end of May 2017.

b) To receive a report with an action plan aimed at improving the position on outreach health checks in Fenland, particularly around engagement of workplaces.

18. EMERGING ISSUES IN THE NHS

Fire safety at Peterborough City and Hinchingbrooke Hospitals

The Chairman highlighted that as part of the work of the Committee it will continue to seek assurances on all relevant issues affecting the delivery of health services. Further to this, following the recent tragic Grenfell House tower block fire in London and the subsequent concerns regarding the fire retardant properties of cladding used on public buildings, he had used his Chairman's discretionary powers to invite Stephen Graves the CEO of the North West Anglia NHS Foundation to address the Committee.

In his presentation Stephen Graves gave assurance that fire safety at the hospitals run by North West Anglia NHS Foundation Trust was top of their agenda. He explained that two years ago there had been fire issue concerns at Peterborough City Hospital which had involved an enforcement order being issued by the Fire Authority for remedial works. He explained, the Trust held monthly meetings with the Fire Service to closely manage the remedial works required with good progress being made. In addition, more

than 90% of staff had completed their annual mandatory fire training, which highlighted the various escape routes and the evacuation processes in an emergency situation. A full-time Fire Officer was employed to work across all three of their hospitals (Peterborough City, Hinchingbrooke and Stamford and Rutland) delivering training in fire prevention and precaution.

Since the Grenfell Tower fire, The Trust had undertaken additional actions to provide further assurance on fire management at all three hospital sites including:

- Fire risk assessments reviewed by the Trust and Fire Service.
- Visits by the Fire Service to the two acute hospitals (Peterborough City and Hinchingbrooke) to check fire management processes for which no serious issues had been identified.
- Cladding at Peterborough City and Hinchingbrooke Hospitals has been sent for testing as a precaution. With regard to this he was able to confirm that the cladding frames used were steel coated - the best material - rather than the far more flammable aluminium as used in the cladding at Grenfell House. In addition, the danger risk was far less where buildings such as the hospital were only two storeys high. In fire danger terms, height was more important and the ability to get out was a greater concern.
- The Trust would be encouraging an even greater take up of mandatory fire training among staff across all three sites.
- The Trust was working with colleagues at the Department of Health and NHS Improvement to provide regular updates on their fire management procedures.
- NHS Improvement had advised them that the fire research and testing organisation BRE Group had appointed an expert team to assess if any future tests were needed in hospital buildings and the Trust were awaiting further guidance on this.

On being invited to ask questions issues raised by Members and clarifications provided included the following:

- On having been informed earlier that there were 40,000 separate remedial works required to be carried out with PFI partners, a question was raised regarding what steps could be undertaken in the future to avoid such a massive snagging list. It was explained that there was not the same level of scrutiny in a PFI contract as could be undertaken by a private buyer and that going forward this model was clearly inappropriate and lessons would have to be learnt nationally. In terms of paying for the works, these were being undertaken by the PFI Contractor.

- A member questioned the building quality / structural integrity of the staff residences on site. In response he explained that the structural integrity of the buildings was not an issue but that there were outstanding fire alarms issues for which the Fire Service had given the Trust three months to rectify the position.

- In answer to a question raised regarding issues of ongoing maintenance and the checks in place, this was the responsibility of the owner of the building and would be dealt with by the estates team with sign off by the clerk of works. As a result of

the recent tragic experience at Grenfell Tower there would no doubt be a high level of scrutiny of any future works undertaken.

- Further to a pre-meeting enquiry on progress with the Strategic Estates Partnership to develop the site at Hinchingbrooke Hospital, it was explained that the Trust was working with a specialist partner Ryhurst Ltd who were established as the preferred partner for the Strategic Estates Partnership in the summer of 2016 and which was still the case. Ryhurst Ltd, was part of the Rydon Group, the same group that had made the cladding used in Grenfell House. He cautioned that no one currently knew what the findings of the Government sponsored review would be and it was too early to make judgements.

- In terms of the Strategic Estates Partnership goals, it was highlighted that some of the financial benefits did not appear to be as robust as first thought e.g. the sale of a staff car park for housing. The issues of receiving best value for money were still being looked at carefully along with issues on housing provision around the site.

- The need to ensure that the fire risk potential was addressed in respect of the new use of community buildings for delivering health and children's services, especially as some were of considerable age. Stephen Graves in response agreed that all public buildings would need to be further investigated for their fire risk potential while highlighting the risk increased where people were in critical care and where operating procedures were involved.

Stephen Graves was thanked for attending.

It was resolved:

To note the oral update provided in terms of the assurance provided on the fire safety of the buildings and the update provided on the Strategic Estates Partnership.

19. UPDATE FROM CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (CUHFT)

Roland Sinker the Chief Executive (CE) of Cambridge University Hospital Foundation Trust provided a presentation update on the Trust's progress (using slides already included on the agenda) since the last Care Quality Commission's (CQC) inspection in September 2016 and on behalf of the Committee, the Chairman indicated that he was delighted to hear that the Trust had been removed from special measures.

The CE highlighted / provided details that:

- The CQC had now changed its rating for the hospital to a rating of 'good'.
- For the first time since the summer of 2014 Cancer and 18 weeks referral to treatment was on track.
- Accident and emergency had greatly improved and was now at a 95% performance level.
- The financial target had been achieved for the second year with the deficit having reduced from £80m to £50m and was on target in the current year to be reduced to £40m.

- The staff survey results had improved from being the bottom rating for teaching hospitals to now having moved up to third or fourth place, while still recognising that there was further improvement to be made.
- Waiting times had improved since the CQC had last visited.
- feedback from staff highlighted issues terms of patients' journeys, the need to improve governance and take steps to empower staff to make improvements, as well as the need for far more work to be undertaken with partners regarding improved transport links and affordable housing.
- In terms of concerns on fire safety, the hospital did not have any cladding that had caused a concern.
- Regarding ehospital (EPIC) preparations - the move away from paper in the hospital went live in October 2014. Clinical staff are now able to quickly and securely access all of a patient's records on internet enabled devises. The current system was winning awards nationally.
- Regarding the Liver Metastases Service – which had been a concern to the Committee in terms of patient travel and patient choice - statistical information on slide 13 highlighted that the clinical outcomes were very strong, which had to be balanced with patient travel and their experience.

Questions / issues raised included:

- the issue of affordable transport for staff and the lack of bus transport from areas of deprivation, highlighting a local issue concerning the re-routing of the Citi 7 which was now missing most of Trumpington in order to be able to collect AstraZeneca staff. In response, it was recognised that there were issues both of getting staff and patients into hospital, particularly on wet days which would be exacerbated by Papworth moving on site and Astra2. There was commissioning work being undertaken on a new multi storey car park and there was a recognised need for enhanced park and ride facilities. The hospital was working with partners but currently did not believe that the transport solutions proposed were the right ones and supported the idea that a light railway was required.

- On issues on procurement, details were provided of what was considered to be a very strong procurement department.

- What was now being undertaken in moving towards a more systematic policy on staff training and development to help in their future career. In response, it was explained that there were targeted programmes for senior nurses with details also provided of the Kings Fund initiatives.

- Issues were raised around consultants working alongside GPs and the difficulties of moving them out. In reply it was explained that the hospital had forward looking consultants available to GPs, but that there was the need to look to establish a number of small general practice communities and to pilot EPIC in help ensure more cross working.

- Infection control had been highlighted as a concern, with a Member asking whether it was the result of people being less systematic about hand washing hygiene and standards slipping. In reply it was stated that performance in infection control was working very well, but improvements were still being sought in ensuring the organisation's staff routinely hand washed, as there was considerable concern regarding infection as a result of bugs becoming antibiotic resistant.

- Reference was made to the in the amber column on responsiveness in the CQC chart and whether this was about the fear of making mistakes, while also recognising there was a fine line to ensure staff were given the confidence to be able to ask for a second opinion. In response it was explained the amber reference related to people having to wait too long for major surgery. The CQC had come came back in respect of emergency pathways and as a result, there have been tough conversations regarding performance management. Teams were being allowed to decide what models they needed to deliver an improved service, with advice being available when required.

- A question was raised in respect of the A&E performance chart and how resilient was the hospital and whether Delayed Transfers of Care (DTOCs) was the only problem, as well as additionally asking how much of it was this Council's and other partners problem. In response it was indicated that when there were modest numbers, the hospital functioned well, but this had been in respect of the old model and not in respect of the pressures which had increased from two years ago. If DTOCS could be improved, it would be possible to sort out emergency pathways. There needed to be a lot of focus on how the people would be looked after in the community and that increased performance required a change of system. A third of the fault sat within the hospital, while two thirds sat with partners outside hospital management and was a process issue in terms of managing the caseload. Currently the performance position on DTOCS was rated as being included within the top 10 worst performers. The hospital and partners were working closely together to seek to achieve an improved performance.

- Regarding EPIC, questions were raised regarding how much it was accepted by staff and whether it was being embraced by local GPs, as well as how far was it achieving its objectives? In terms of how electronic the hospital was, it was currently at HIMs level 6 and would be aspiring to level 7 by next year which was the level of United States teaching hospitals. In real terms, it was now being used in place of paper in the hospital and the staff survey data showed high satisfaction in the use of EPIC. It was recognised that it needed to be made more accessible to GP's, and the Hospital was working on this in partnership with the Granta Practice. Not as much progress had currently been made on the financial savings side.

- In respect of a question on areas of least staff satisfaction, it was explained that all areas had improved with the exception of staff perceptions about discrimination in terms of race, sex, and the perception that there was not a level playing field for career progression. In terms of the leadership of the organisation, 40% of staff did not believe Management had a clear idea on where the organisation was going. More work was required in these areas.

- One Member highlighted that as the County Council was one of the partners, there needed to be follow up regarding the role the County Council needed to play in improving the DTOCs process **Action: The Chairman indicated that he would follow this up with the Chairman of the Adults Committee**

Having noted the presentation, the Committee resolved:

a) to recognise both the excellent improvement progress made and the hard work of the staff,

b) to express its concern regarding the current position on Delayed Transfers of Care (DTOC) and its impact with the need for partners to work together as a whole systems approach to address the issue, with the Chairman to liaise with the Chairman of Adults Committee regarding the role of the County Council.

c) To request consideration that one of the quarterly liaison meetings with CUH could be held at the Granta medical centre / practice.

20. NON EMERGENCY PATIENT TRANSPORT (NEPT) SERVICE PERFORMANCE UPDATE

This report provided details of the performance of the centralised service for Non-Emergency Patient Transport Service which had commenced on 1st September 2016 giving wider access to the service compared to the previous model with different contracts to different hospitals. Kyle Cliff, Gill Briggs and Michelle Behn were present to respond to questions.

It was highlighted there has been progress with the mobilisation of the new service but also a number of issues with the East of England Ambulance NHS Foundation Trust (EEAST) failing to deliver a number of performance standards required by the CCG and that they were working closely with EEAST and acute providers to resolve the issues.

During the first nine months the themes identified as needing to be addressed were:

- Discharges from hospital being undertaken in a timely manner.
  same day requests for patient transport exceeded the expected levels from the tender or planning process. The proportion of on the day journeys was 8-10% of journeys as opposed to 3% in planning.
- EEAST having a high number of vacancies. Recruitment to vacant posts to address this continued.
- That while overall the number of journeys had been below expected levels, the mix and categories' of transports was significantly different from what the initial EEAST operating model was set up to deliver, with a greater proportion of journeys falling into longer travel bandings.

It was explained that a Contract Performance Notice was issued in November 2016 for EEAST's failure to meet some of the performance standards. A Remedial Action Plan (RAP) was agreed in February 2017 with targets to recover by the end of April 2017. At the end of March 2017 EEAST had failed to meet trajectories of the RAP and performance had deteriorated in some areas. The CCG therefore served an Exception Notice in May 2017 requesting EEAST to propose a revised Remedial Action Plan (RAP). An Exception Notice meeting had been held and a revised RAP was agreed at the end of June 2017.

To address the issues EEAST had undertaken a capacity review in conjunction with the CCG and had planned several adjustments to skill mix, shifts, staff rotas and vehicles. Section 3 of the report set out a list of the actions EEAST had taken to improve their performance. It was highlighted that while there had been operational issues in terms of on the day discharges from acute hospital sites, the feedback from patients in the period of transition had been positive and there had been a significant reduction in the number of complaints received.

Issues raised in debate included:

- That bearing in mind the capacity issues, was there scope to work with community transport providers? It was explained that the main capacity issues were with patients with more acute needs that required ambulances and who would not be well enough to be transported in community services type transport. As a follow up, the Member asked how much activity was undertaken with community transport providers. In response it was explained that the CCG still had some contracts with providers e.g. Royston, with vehicles being sent to some hospitals and other settings. The issue found was that the levels of single car and minibus journeys had reduced, as the greater demand was for vehicles that were able to accommodate wheel chair users.

- With reference to paragraph 2.2.3 on the mix of category of transports being significantly different, a question was raised regarding whether the contract from the CCG side had been inaccurate or whether the contractor had set up the model differently from the specification or had the changes in usage occurred during the course of the contract? In reply it was explained that in setting up the contract use had been made of the data from old contracts but a lot of information was not available, with only 75% of journeys previously recorded and so from this, an estimate was made of the make-up of the additional 25% of journeys. In running the contract it became apparent that there were changes to the base line due to the nature of day to day requests.

- When will it get better as the report gave no timescales for improvement? In reply there were two main areas to be addressed. Remodelling was required as there were different types of ambulance with different availability, with the actuals different to the original model. In terms of the bidder, they could only bid on the information provided and they had been competitive in order to secure the contract. Officers had looked at the first quarter and remodelling had started in January 2017 involving change of times/ ambulance positions regarding where they were based, as well as changes to rosters, finance etc. The last stage had involved consulting with 90 staff on the proposed changes which had now been completed. The 7th August was the date set for commencement of the operational changes. Vacancy numbers had improved and work was being undertaken with job centres to fill the gaps, although there were difficulties as either there was not the interest, or the applicants were not meeting the required standards for the job.

- It was confirmed in answer to a follow up question that the remodelling was being undertaken within the same budget.

- One Member with reference to paragraph 2.1 read it to mean that the CCG were not happy with the performance provided by the Ambulance Service and were therefore telling them what to do and was uncomfortable with forcing something to happen with no additional money and with no solutions being given. Their main job was emergency patient transport. He would have liked to have seen a statement of the problem with a thread to a solution.

- Another Member expressed his concern that the quantity in the tender had been incorrect and the tenderer had responded to incorrect information and agreed a price and therefore asked that in order to address the revised quantities, would it not be the case that the CCG will have to pay more? In reply it was indicated that in fact that there was 30% less journeys than had been assumed was going to

happen. The issues were in relation to their being more out of area journeys and more wheel chair required transport rather than car journeys. There was therefore the need to look to recycle the journeys and starting some vehicles later in the day in order to meet peak demand.

- The comment was made that had the contractor been a fully commercial operator the service would have collapsed some time ago and the particular Member still had concerns that the identified imbalances could yet make the contract collapse.

- A question was raised by the Chairman that as the main use of the ambulance service was to reach people in 999 emergencies, did it have the capacity and should the service be used to undertake this additional non-emergency transport work? In response it was explained that it was a completely different sector / separate part of the business, and the service was not taking away resource from emergency provision.

Having commented on the report

a) It was resolved to note the action plans.

b) Due to the concerns raised over the original tender process, to ask for a further progress report in six months.

21. PUBLIC QUESTION:

Mrs Jean Simpson had submitted a question by the deadline and the Chairman invited her to address the Committee.

In her introduction she highlighted that “Cambridgeshire and Peterborough CCG (CPCCG) / STP had the largest deficit in the country and is now subject to the "capped expenditure process". Recent newspaper articles have leaked the proposed cuts to health service provision in other parts of the country that have less of a deficit under the capped expenditure process and include "Closing wards and theatres and reducing staffing, closing or downgrading services with some considering changes to flagship departments like emergency and maternity." (Health Service Journal, 5 June 2017). The CPCCG have declined two Freedom of Information requests to reveal both their draft delivery plan outlining proposed staff reductions and their financial template.

Question

How can Cambridgeshire County Council work together with CPCCG on delivering the STP when the scale of the cuts to our health service have not been made clear? She highlighted that the DTOC 3.5% target was now up to 6.1% and raised concerns about the need for an STP Risk Register, quality impacts, whether there were the skills and how questioned how altered waiting time targets would be achieved. She suggested that the public had not been given sufficient information on the STP, stating that it has been developed in secret and asked that the Committee should look beneath the surface of the proposals and stand up and challenge them.

No Members of the Committee had any questions of clarification but as a final point Jean Simpson asked whether the Committee had full information, including workforce details, which was being denied to the public? Liz Robin in response explained that as part of the scrutiny function of the Committee it was able to ask such questions.

It was resolved:

To provide a written response within 10 working days from the date of the meeting.

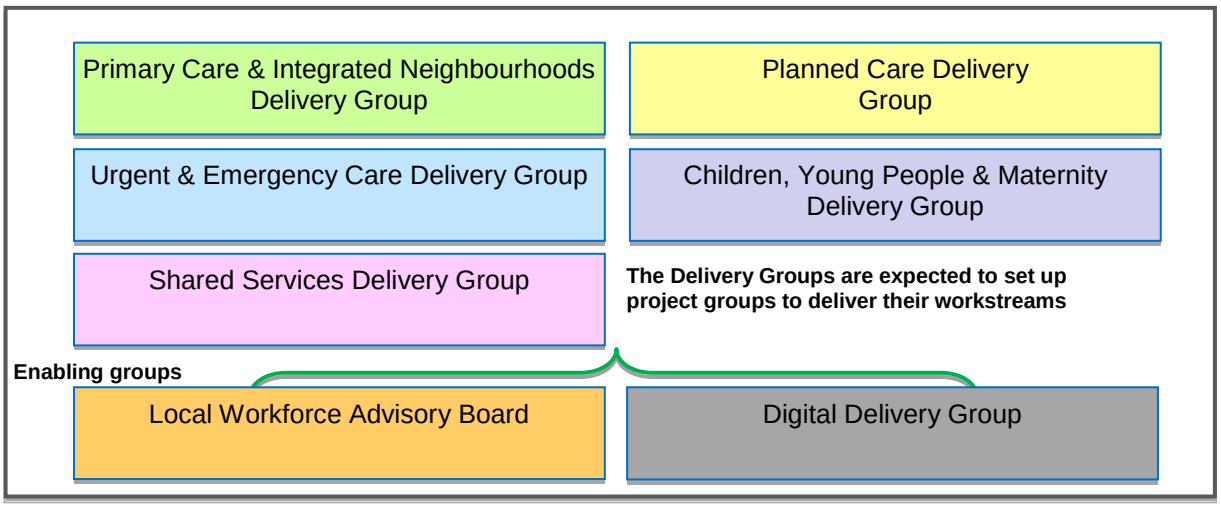
22. SUSTAINABILITY AND TRANSFORMATION PLAN (STP) UPDATE

This report provided the Committee with an update on progress relating to the five year Cambridgeshire and Peterborough Sustainability and Transformation Plan STP created to improve the health and care of the local population and to bring the system back into financial balance. The background set out the significant challenges faced with paragraph 1.2 of the report listing what it aimed to achieve.

As a result of discussions with staff, patients, carers and partners, four priorities for change had been identified together with a 10 point plan to deliver the priorities as set out below:

Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

The STP had moved from the planning phase to the delivery phase, putting in place a 'Fit for the Future programme' with the delivery governance structure provided at Annex 2 of the report and an explanation of the purpose of each group provided at annex 3 of the report. At its core were the seven delivery groups (as set out in the diagram overleaf) with section 3 of the report summarising their current focus with details of key interventions and the current key achievements to date:



Aiden Fallon and Scott Haldane were present to answer questions. They explained that the deficit of £504 million was a huge challenge. £250m of this was efficiency savings that would normally be expected from the local NHS as 'business as usual' without compromising the quality and quantity of the service.

Going forward more transparency and engagement would involve establishing an STP Board with greater involvement from elected members, along with the establishment of a stake holder forum. As a counter to the claims made earlier by the public speaker, it was explained that when developing the STP there had been a significant number of public engagement events (of which they would be happy to make available the details to the Committee). It was recognised that more engagement was required and section 5.2 of the report set out how this was to be taken forward which would include the use of social media to engage groups not routinely accessed such as teenagers and women aged between 30-50. The intention would be to engage with stakeholders in September.

It was highlighted that an Investment Forum has been set up and had invested £10m to increase the capacity in the community sector. Step change investments were being undertaken to help deliver services to enhance people being able to live in a home environment as often as possible. This included engaging with people regarding their lifestyle choices.

In terms of staffing, the biggest risk was around ensuring the right staff with the right skills set were in place in the necessary projects by October, which was why a partnership approach was required, as part of a systems wide workforce strategy.

In discussion issues raised included:

- Needing to understand the County Council's role in respect of Delayed Transfers of care (DTOC) and also issues around the future workforce and the potential impact for it of BREXIT. Workforce planning and discussions around it required to be a priority, as some Members were not sure what questions to ask. Scott indicated that they had previously undertaken a workforce briefing and would be happy to bring this back to a future meeting. DTOCS was a shared partnership issue and currently there was still a silo mentality between some partners that needed to be addressed by the STP in order to be able to achieve a one systems approach.

- that a progress report was required on plans for new models of GP practices, issues around their recruitment and how GP capacity issues would be addressed. In response, a briefing session was suggested on Primary Care, including addressing issues around future GP working.

- In future not only did GP's have to behave differently, but also patients, and how they requested appointments, which also involved communications strategies being put in place to explain the necessary change of emphasis. Due to rising demographics and the strain on existing GP services which could not keep pace with the increased numbers of patients, the current face to face appointments system with a GP was no longer sustainable and more use would need to be made of 111 services and web-based diagnostic solutions.

- In terms of the need to shift from reactive to proactive centred care, there was currently a lack of detail regarding timelines and milestones for achieving objectives. This was required in order to be able to monitor whether the STP was on target to deliver its objectives.

- There required to be more information on what new skills members of staff would be required to have and what training was to be provided to facilitate this.

- It was suggested that each of the delivery group should include a representative from the Health Committee. The report leads agreed to take this suggestion away. **Action Scott Haldane / Aidan Fallon**

It was resolved

That an STP session (s) should be scheduled, to include the following themes, (to be discussed further at the Committee's forthcoming priority setting session scheduled for 21st July):

- delayed transfers of care.
- primary care models.
- Communication with the public on ways to use the NHS.
- Risk Register.
- governance structure and key performance and key performance indicators monitoring.
- Workforce issues.

23. GP OUT OF HOURS BASE RELOCATION FROM CHESTERTON MEDICAL CENTRE (CMC) TO ADDENBROOKE'S CLINIC 9

In March 2017 the CCG consulted on the GP Out of Hours (OOH) base move with feedback and recommendations being presented back to the Health Committee on 16th March 2017. After discussion, the Committee requested that the CCG provided the Committee with regular updates and particularly feedback on the following points:

- Position with pharmacy provision at Addenbrooke's Hospital
- Access arrangements for patients who do not have an appointment
- Streaming of patients from the Emergency Department (ED)
- GP recruitment and session cover for ED and OOH

The report was introduced by Jessica Bawden, Dr Garry Howsam and a representative from the CCG Management Team in support to help answer questions. It was explained that the move to Addenbrooke's Clinic 9 had required some refurbishment works prior to occupation, during which asbestos was found within the ceiling cladding, leading to a delay and a revised timetable as follows:

- Handover of Clinic 9 to HUC 31 July 2017
- OOH 'go live' 8 August 2017
- GP streaming 'go live' 15 August 2017

One of the benefits previously argued for moving the Cambridge GP Out of Hours base to Addenbrooke's was local pharmacy provision. However it was reported as an update that the commercial Lloyds Pharmacy opening times on the site adjacent to Clinic 9, was not the same as for the OOH service and due to restrictions on its licences, it did not offer a prescription (FP10) service. As a result, the intention for a one stop service could not currently be fulfilled. To mitigate this, the GP OOH service would offer FP10s in the same way as the current service run from Chesterton, with the detail including restrictions, as set out in section 2 of the report. It was explained that there were pharmacies located in close proximity to the Addenbrooke's site which offered extended hours and the OOH service would produce a list of those pharmacies opening times for patients. A pharmacy sub group had been established to ensure the service could be delivered in the future, and this would be possible when the contract came up for renewal in March 2018.

It was highlighted that the GP OOH service would continue to be an appointment only service accessed by calling NHS 111 and that it would not be able to offer a walk in service. If a patient walked in without an agreed appointment, they would be redirected to the Emergency Department, to be assessed by the streaming nurse and re-directed to the right place. This was to ensure patients received the safest and most effective pathway.

It was explained that GP shift fill was improving slowly, but that one of the significant challenges in attracting GPs to work in the OOH and GP streaming services related to a ruling in March in respect of GP indemnity cover. GPs working in OOH had to pay around £7k-8k per annum for indemnity cover, which in some cases had doubled if the doctors were self-employed. As this was a national concern, it had been raised with NHS England who were in the process of reviewing its policy. Other different approaches to help increase shift fill were listed in section 5 of the report.

The Chairman drew attention to a submission provided from Councillor Scutt which was tabled with Members given time to read its contents. (included as Appendix 1 to these minutes)

In discussion, issues raised included:

- In answer to a question of whether doctors current general indemnity policy could be extended to out of hours service doctors it was explained that they were different contracts and each OOH doctor had to arrange their own insurance.

- With reference to Councillor Scutt's submission, one Member highlighted that as CB4 usage of the current Chesterton premises included a high percentage of older and deprived residents, it was suggested that monitoring should be undertaken regarding the percentage of CB4 residents attending the new centre

and whether it was comparable to the previous usage, as well as details regarding mode of travel used. In response, it was agreed this information could be included in an update which it was suggested to ensure that there was sufficient data to draw on, the report should come back in three months to the December Committee meeting **Action: Jessica Bawden**

- There was concern that the report did not include a comprehensive review of both the impact of the changes and the mitigation measures to be taken, which had in the previous discussion requested that GPs work longer hours to help overcome issues of accessibility. In response, it was explained that mitigations around signage and drop offs and the cost of parking would be the same as for people attending the Emergency department. In terms of extended GP opening hours in Chesterton this had not been guaranteed and was related to funding, which had not yet been made available.

- More than one Member commented on the learning points from the exercise and the questions that had not been asked regarding seeking clarification regarding the Pharmacy provision at Addenbrooke's, which if known at the time of the earlier Committee, may have made a difference to the original consultation response.

- It was also requested that the further update report should also provide information on the number of people who attempted to walk in without an appointment.

Having expressed concerns regarding the current position on GP opening hours and the proposed pharmacy provision and while noting the ongoing aspirations of the CCG to achieve these,

It was resolved:

To ask the CCG to provide a further report for the December Committee meeting having analysed the first three months monitoring data to include:

a) Information on where people are attending from (including the uptake from CB4 compared to the Chesterton usage),

b) mode of transport used,

c) details of the number of patients who try to walk in without an appointment,

d) comprehensive information on the mitigation measures to be undertaken for Chesterton residents.

24. DEVELOPMENT OF PRIMARY CARE IN NORTHSTOWE

Before asking the officers to present the report the Chairman declared a non-prejudicial, personal interest, being the local member for Longstanton, Northstowe and Over, with local knowledge of the issues included in the report.

This report to the Committee provided an update on the plans underway to secure primary care medical services for the emerging and anticipated population in Northstowe. As the first residents started to move into the Phase 1 at Northstowe (totalling 1500 homes and up to 3000 patients), provision to accommodate the new

community had been made at the Willingham Practice, and in particular, its branch at Longstanton, where it was considered there was sufficient capacity to accommodate the new population associated with Phase 1 of the development.

Using Existing Contract models – the following options were being considered:

- Option 1: One of the neighbouring GP practices relocating to Northstowe on its current contract with an extended patient list, whilst retaining branch surgeries at its previous premises.

- Option 2a: A primary medical services contract was put out to tender with a neighbouring practice, or group of practices bidding as one provider, to run the Northstowe Care Hub alongside their existing contract.

- Option 2b: A primary medical services contract was put out to tender and awarded to a provider not currently operating within the catchment of the hub.

- Exploring New Forms of Contract through integrating services – whereby Community services, including mental health services, social care and voluntary sector services were included with any of the above options, to allow a Multispecialty Community Provider (MCP) to emerge.

The report anticipated that there would be sufficient capacity in existing provision until 2021, with the emphasis being to plan health services for the population growth associated with Phases 2 and 3 (7,500 homes) within the new Health Hub planned for the town centre location. The vision of achieving integrated service provision, located in a centrally positioned Health Hub and meeting the wider population health and social care needs would require existing barriers associated with building tenure and leasing to be challenged.

The roll out of the development set out the following time critical milestones:

- the developer requires details of the services to be accommodated in the care hub by June 2019;
- the commissioning process set to commence April 2020 to secure the new primary care provider; and
- the Hub based service due to commence from June 2021 as by this point the Willingham Practice (Longstanton Branch) will have reached capacity.

In discussion the following issues / questions were raised;

- The Chairman questioned whether the provision proposed for Phase 1 would be adequate and whether the additional afternoon opening of the existing provision would be sufficient with potentially 3,000 more population.

- While it was accepted that not everyone would be moving in at the same time, there were queries regarding the timescales for reviews to ensure the delivery trajectory was aligned to projected demand. In response, it was indicated that officers would be looking to align the delivery trajectory so that when the Willingham practice had reached breaking point in terms of its capacity, the new health hub will have been built and was based on the higher density figure for a new community of 2.8 population per dwelling rather than the standard of 2.5 per dwelling with officers working alongside the developers HCA and Gallagher on

the projections. In response to this officers were advised that the assessment with the delivery trajectory needed to be lined up with individual house builders who would have a truer picture as they controlled the numbers delivered. In terms of data on plots sold, the officers did have access to this information, but in terms of occupancy, this would be data that the District Council could provide.

- The experience of other new developments, such as Cambourne, showed that there was a disproportionately larger number of children early on, which reflected the young couple age bias demographic of the people moving in to a new community.

- For the future what was required was a visionary health care document looking forward to the next 5-10 years.

- In response to a request for public health to undertake research to be able to monitor and evaluate a holistic vision of a healthy city and its sustainability and how actual provision developed, (for better or worse) it was explained that the current paper on Northstowe future primary care was one small snap shot in a wider programme of research from the Healthy Northstowe steering group which had representation from a number of bodies including CEDAR and the University. Future research proposals with partners included those relating to population, diet and mental health. Wider integration ambitions included digital workstreams and online consulting, as well as looking to challenge the current mechanisms to contract and pay for services. Officers could bring back a wider paper that could also include public health initiatives linked with cycling and walking.

- In respect of the above Member request, The Director of Public Health cautioned against the County Council resource capacity being volunteered into areas where it did not have additional support and that information requests required to be drawn down from partners.

- The Vice Chairman with reference to the wording in paragraph 2.1 expressed his surprise at the proposal to include Citizens Advice being built into the substantive, integrated service specification for provision to Phases 2 and 3. As a response it was explained that this drew on the experience of other growth sites and the recognition of the wider needs of new residents. He also challenged the wording in respect of planning for an elderly demographic and suggested that rather than planning for peak numbers in 2030-40's they should be planning for the longer term. He would rather that there were population growth estimates, including age profile estimates for the next few decades. In response it was explained that measures such as multiple morbidity age profiles would depend on the success of Public Health in terms of encouraging healthier lifestyles, including increased exercise to help tackle obesity and diabetes. As a result, it was not possible to project 30-40 years ahead.

It was resolved:

a) to Note the progress to date and the key timescales to be achieved.

B) to receive a further report in December with details of a vision for the future for the Healthy New Town for the next five to ten years and how the programme may be evaluated.

25. APPOINTMENT TO PARTNERSHIP LIAISON AND ADVISORY GROUPS – APPOINTMENT OF A MEMBER CHAMPION FOR MENTAL HEALTH

There was discussion regarding whether the Committee wished to appoint a Member Champion for Mental Health or whether this would be more appropriate for another Committee such as Adults. As there were no volunteers, it was suggested that public health officers in consultation with Democratic Services explore whether a mechanism could be devised for updates to be brought forward from other committees on mental health issues. **Action: Liz Robin / Democratic Services**

With no Mental Health Champion nominated, officers requested Committee volunteers to sit on a panel to discuss Mental Health Awareness training.

It was resolved:

a) Not to appoint a Member Champion for Mental Health, but to ask officers to explore other ways of receiving updates on Mental Health issues, including issues raised at other service committees.

b) For the purpose of representation from the Committee on discussions regarding internal training on mental health awareness to agree that either Councillor Jones or Councillor Harford (depending on whoever was available) should be the Committee's representatives.

26. COMMITTEE TRAINING PLAN

The Vice Chairman placed on record his thanks to the officers involved with the Finance Training which he had found very useful**.**

On being invited to review the training plan, there were no requests for additional training at the current time and therefore;

It was resolved:

To note the current Training Plan.

27. COMMITTEE FORWARD AGENDA PLAN

Due to an oversight, this report had been missed off the main agenda dispatch. With the Chairman's approval, it had been published circulated to the Committee in advance of the Committee on 14th July, with hard copies made available at the meeting. The Chairman used his Chairman discretionary powers to agree consider and review the Plan at the meeting which had been numbered as item 14.

There was discussion regarding the need to add a report on re-letting of the Procurement of Drug and Alcohol Service Contract report with the Director of Health seeking finance guidance on whether this key decision could be undertaken as a two stage process, with an initial non-key decision report to the September meeting to allow comments and input from stakeholders, before a final decision report was taken to a later Committee meeting (Possibly December).

In term of whether to keep the STP as a standing item on the agenda this was to be discussed at the seminar the following day.

Following discussion on other changes, including recognising the continued heavy workload of the Committee as evidenced at the current meeting with its dual function role, Democratic Services be asked to investigate the possibility of starting the Health Committee at 1.30 p.m. and to also look at the practicalities of including timings for each item on the front agenda (as previously was the case before CIMIS was used to create agendas) **Actions: Democratic Services.**

It was resolved:

a) To note the Committee Training Plan.

b) To provisionally add the Procurement of Drug and Alcohol Service Contract report for the September meeting subject to final advice being given on whether this could be undertaken as a two stage process.

c) Add relocation of Out of Hours Service to the December meeting as agreed earlier in the meeting. **Action: Democratic Sevices**

d) Add Non Emergency Transport Service Update to the January meeting as agreed earlier. **Action; Democratic Services**

e) STP standing item to be discussed at the next day's seminar. **Action: Kate Parker to inform Democratic Services of the result and any change required to the forward plan.**

f) Request to look at the practicalities of adding timings to agenda front sheets in future. **Action: Democratic Services**

g) To look into the practicalities of starting the meetings earlier at 1.30 p.m. **Action: Democratic Services.**

Chairman
7th September 2017

Appendix 1

FROM COUNCILLOR SCUTT ON ITEM 11 UPDATE ON THE RELOCATION OF OUT OF HOURS SERVICE 25TH JULY HEALTH COMMITTEE (SEE MINUTE 23)

Introduction

I regret being unable to attend the Health Committee meeting, despite having registered to speak, due to my University obligations which have arisen unexpectedly this day. I would appreciate the Committee's taking into account the matters raised below in relation to Agenda

Item No. 11.

Mitigation Measures for Nth Area Residents

When the proposal for moving the Union Lane Out of Hours service to Addenbrook's was put to and approved by the Health Committee at its March 2017 meeting, the Committee requested the CCG to outline mitigation measures that would be introduced to ensure that insofar as possible residents in the north of the City would not be disadvantaged by the move of this sole service located in the north. The CCG put forward some speculative suggestions and as I understood it undertook to return to the Committee's June 2017 meeting with a report on mitigation measures. That report did not appear.

The current report (before this the July 2017 meeting) briefly refers to mitigation however, as it appears, in passing only.

Report – Out of Hours Relocation …

The report refers solely to the £3.50 parking charge which attendees will have to pay and the can have stamped by the Receptionist at the Addenbrook's out of hours clinic for a reimbursement.

The report refers to the pharmacy situation: this – the existence of a pharmacy at Addenbrooke's – was as I recall put forward by the CCG as a benefit insofar as the move of the Union Lane Out of Hours service was concerned. Yet the report raises questions rather than substantive answers generally and insofar as benefit and mitigation are in issue. There appear to be no other references to any mitigation measures nor any attempts or even speculative measures that might be contemplated or introduced.

Mitigation Measures

<u>The mitigation measure of the £3.50 parking charge:</u> the attendee must have the money to pay this upfront. This may not seem a great deal to some – yet to those who are disadvantaged (and Arbury and Kings Hedges are recognised as being the most disadvantaged areas of Cambridge) it can be a great deal. Having to pay it, then go through the 'stamp my receipt' process, then the recovery of the money is not easy if one is ill and stressed, or has an ill child (for example) and is stressed about her/his wellbeing and health.
<u>The pharmacy issue</u>: The report acknowledges that the pharmacy at Addenbrooke's will not be open at all times, and says that a list of nearby pharmacies will be provided. First, there is no assurance that these will be open (refer to the report provided to the Health and Wellbeing Board at its most recent meeting) and secondly how will this help attendees from north Cambridge – are they to roam about streets with which they may well not be familiar, whilst ill

or with an ill child or relative, in order to locate one of these pharmacies? At minimum, a list of pharmacies in the north of the city should be provided.

Further on the pharmacy issue: The report says that attendees will be provided with medication to serve them temporarily – however, this means that they come to the out of hours at Addenbrooke's, are provided with temporary medication, then the following day must go out (ill or with an ill child or relative) to have the prescription filled. This is not satisfactory and does not appear (as with the £3.50 parking charge procedure) to recognise that ill people, or people with an ill child, relative, companion, etc are stressed, upset, ill, worried – and need support rather than being required to comply with requirements that can add to their stress and may exacerbate their problems.

Conclusion

Residents in the north of Cambridge (and indeed in the surrounding areas outside Cambridge City who will have attended the Union Lane Out of Hours service and will now be obliged to go to Addenbrook's) should be better served, and it is disappointing that the CCG now comes to the July Health Committee meeting without a clear and clearly stated programme of mitigation measures as was understood to be the plan projected at the March Health Committee meeting.

Recommendation: That the CCG be required to provide to the next meeting of the Health Committee a positive, clear and do-able list of mitigation measures that it has introduced or is in the process of introducing so that residents of Cambridge City nth area including Arbury which I represent can at least have some confidence that their position of now lacking a local service can to some extent at least be ameliorated.

Dr Jocelynne A. Scutt
County Councillor for Arbury

NOTE: City Councillor Gerri Bird and (as a candidate, now) County Councillor Elisa Meschini were involved with me and others in endeavouring to retain the Union Lane Out of Hours service in the nth of the City and I have sent a copy of this submission to them and to City Councillor Mike Sargeant who was also supportive of this endeavour.