HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 20 July 2017

Democratic and Members' Services
Quentin Baker
LGSS Director: Lawand Governance

14:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall, Castle Hill, Cambridge, CB3 0AP

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1. Apologies for Absence

2. Declarations of interest

Guidance on declaring interests is available at
http://tinyurl.com/ccc-conduct-code

3. Minutes of the Meeting on 14 June 2017 and Action Log **5 - 16**

4. Co-Option of District Council Representatives

The Committee is invited to co-opt Councillor Mike Cornwell, Fenland District Council as a non-voting member of the Committee.

5. Petitions

DECISION

6. Finance and Performance Report May 2017 **17 - 34**

SCRUTINY ITEMS

The Health Committee comprises the following members:

Councillor Lynda Harford (Chairman) Councillor Peter Hudson (Vice-Chairman)

Councillor Chris Boden Councillor Lorna Dupre Councillor John Gowing Councillor David Jenkins Councillor Linda Jones Councillor Kevin Reynolds Councillor Tom Sanderson and Councillor Susan van de Ven

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

Clerk Name: Ruth Yule

Clerk Telephone: 01223 699184

Clerk Email: ruth.yule@cambridgeshire.gov.uk

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Agenda Item No: 3

HEALTH COMMITTEE: MINUTES

Date: Wednesday 14th June 2017

Time: 2.00pm to 4.35pm

Present: Councillors C Boden, D Connor (substituting for Cllr Reynolds), J Gowing, L Harford (Chairman), L Joseph (substituting for Cllr Hudson), D Jenkins, L Jones, L Nethsingha (substituting for Cllr Dupré) and S van de Ven

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

Apologies: County Councillors L Dupré, P Hudson, K Reynolds and T Sanderson

1. NOTIFICATION OF CHAIRMAN AND VICE-CHAIRMAN

The Committee noted that Councillor Lynda Harford and Councillor Peter Hudson had been appointed by Council on 23 May 2017 as Chairman and Vice-Chairman respectively for the municipal year 2017-18

The Chairman welcomed both new and returning Committee members, including the returning District Councillors.

2. DECLARATIONS OF INTEREST

There were no declarations of interest.

3. MINUTES – 16 MARCH 2017 AND ACTION LOG:

The minutes of the meeting held on 27th March 2017 were agreed as a correct record and signed by the Chairman.

The Director of Public Health provided an update on the Action Log, drawing attention to the need to monitor the vacancy rate in the school nursing service [minute 310], and pointing out that the 'Be Well in Cambridgeshire' section of the CCC website, which would soon be launched, would be an important resource for communicating health advice to residents [minute 310]. The action on the Sustainability and Transformation Plan (STP) communication programme [minute 296] had been covered in discussion with STP officers at the Committee development session in February, and could be marked as complete.

In relation to the Cambridge GP Out of Hours Service and Emergency Department Co-location [minute 297] Councillor Ellington reported that she and Councillor Abbott had been attending fortnightly meetings on implementation of the co-location. Some difficulties had emerged, including

- the finding of asbestos in the walls of the proposed new clinic
- the provision of on-site pharmacy services
- the availability of sufficient GPs to staff the service
- indemnity insurance for GPs streaming patients from A&E to the new service (currently covered by Addenbrooke's).

The handover date was now 31 July 2017, with the service going live on 8 August and GP screening and streaming due to start on 15 August. Lloyds Pharmacy, which provided pharmacy services at Addenbrooke's, had expressed the view that it would not be economic to have a pharmacist available overnight, so patients would therefore be required to take prescriptions to the Newmarket Road late-night pharmacy. The Committee agreed that the implementation of the co-location should be placed on the forward agenda plan.

The Action Log was noted.

4. CO-OPTION OF DISTRICT COUNCIL REPRESENTATIVES

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

- from Cambridge City Council:
  Cllr Margery Abbott
- from East Cambridgeshire District Council:
  Cllr Carol Sennitt
- from Huntingdonshire District Council:
  Cllr Jill Tavener
- from South Cambridgeshire District Council:
  Cllr Sue Ellington, substitute Cllr Andrew Fraser

5. PETITIONS

There were no petitions.

6. HEALTH COMMITTEE AGENDA PLAN AND TRAINING PLAN

The Committee reviewed the agenda plan. Although the Out of Hours relocation had been postponed to July, members decided to keep it on the July agenda because of the concerns reported; Councillor Ellington would send a list of the issues to the Chairman and the Head of Public Health Business Programmes, copied to all members of the Committee. **Action: Cllr Ellington**

In the course of discussion, members

- noted that the Risk Register update would be better taken in September rather than July because of the timing of a related meeting
- considered how to approach monitoring the East of England Ambulance Service (EEAST) following the Care Quality Commission (CQC) inspection of local delivery, and reviewing its performance in delivering Non-Emergency Patient Transport Services (NEPTS); it was suggested that the EEAST report should include the question of joint working with community transport providers on NEPTS
- asked that the STP be restored as a standing item on the agenda plan, with a general update on progress in July enabling members to identify areas on which to concentrate attention; suggestions included communications, staffing and GPs

- stressed the importance of addressing health inequalities, noting that it was one of the Committee's current priorities and that there was a workshop on committee priorities in July. Members pointed out that this should not be seen as a narrow public health issue; health inequalities should be viewed in the light of the social determinants of health, which were beyond the control of Public Health and included factors such as difficulty in securing housing at an affordable price

- drew attention to the importance of the school nursing service in preventing later health problems, and noted that a briefing on the existing action plan for the service could be circulated to members, to be followed by a more strategic item on the agenda; it would fit well with the immunisation task and finish group item in October

Action: Liz Robin

- requested an update on minor injuries units (MIUs) in East Cambridgeshire and Fenland; it was suggested that this could be raised initially at the next quarterly liaison meeting with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

The Committee also reviewed its training plan, noting that the finance training was now booked for 14 July; it would be looking at financial matters specific to the work of the Health Committee, and new members should try to attend both this and the more general finance training being offered to all new members. It was suggested that an update on the work being done by the Director of Public Health and colleagues as part of the devolution agenda would be helpful in relation to the Committee's understanding of work to address health inequalities.

It was resolved unanimously to:

a) agree the agenda plan attached at Appendix A of the report before Committee, subject to the following amendments:
    - receive the Risk Register update in September 2017, not July
    - combine the scrutiny items on the EEAST CQC inspection and the performance update on Non-Emergency Patient Transport Services into one item for July 2017
    - add an update on the Sustainability and Transformation Plan (STP) to the agenda for July 2017, and add the STP as a standing item for future agendas
    - add a scrutiny item on pressures in school nursing and health visiting to the agenda for October 2017
    - add an update on the pilot harm reduction project for stopping smoking to a future agenda

b) agree the training plan that had been developed as set out as Appendix B of the report before Committee, and note the new date of 14 July for finance training, and that there would be a session on Health Committee Priorities on 21 July

c) consider if there were any other areas of the Committee's remit where members felt they required additional training, and identify the work being done by the Director of Public Health and colleagues under the devolution agenda as an area for briefing.

7. FINANCE AND PERFORMANCE REPORT – OUTTURN 2016-17

The Committee considered the 2016/17 Outturn Finance and Performance report for Public Health. Members noted that

- the actual underspend was close to that forecast in January
- detailed information on spending under the Public Health Memorandum of Understanding (MOU) across CCC directorates was not included in this report although a summary was provided in Appendix 9
- the £182k received from the County Council (CCC) in addition to the Public Health ring-fenced grant had been returned to the CCC general reserve, and the remaining £15k of underspend had been added to the public health ring-fenced reserve.

In the course of discussion, members

- congratulated the Director of Public Health and her staff on keeping within budget

- noted that, as part of the significant recurrent savings that had been required in 2016/17, the budget for health protection had been reduced. This budget was used only in response to emergency events, so in some years it was overspent and in other years hardly needed at all. To avoid holding money unspent, the amount allocated had been reduced, recognising that in some years it would be overspent

- suggested that it would be helpful if the finance and performance reports could have a column showing the following year's budget, so that the magnitude of the budget challenge would be clearly visible; officers accepted this suggestion

- observed that merely measuring childhood obesity did not remedy the problem, and suggested that there should be a comment that this reflected activity, not outcome. Members were advised that it was necessary to monitor the contractors'' performance carrying out the measurements; performance in addressing the problem of childhood obesity was collated through a national system and published nationally

- suggested that it would be helpful for new members to see the Healthy Fenland Fund action plan. Officers advised that they had recently been examining the outcomes of the performance indicators applied against the organisation responsible for delivering the project, and offered to convey this information to members.

Action: Val Thomas

It was resolved unanimously to:

- review and comment on the report
- note the finance and performance position as at the end of 2016-17.

8. ANNUAL PUBLIC HEALTH PERFORMANCE REPORT

The Committee received a report presenting a year end update on public health performance measures, to sit alongside the year-end financial reporting for 2016/17. Members noted the improvements over the year, and the areas of continuing difficulty.

Members' comments on the report included that

- it would be helpful to see the statistics for the work of the health trainer, and evidence of change in health behaviours clearly set out; this was an area that could be measured.

The Consultant in Public Health undertook to provide performance information for the Health Trainer role, giving evidence of changes in health behaviour in easily-readable headline graphs, as requested. **Action: Val Thomas**

- the figure of 130% for four week quitters required explanation; it would be helpful to see the raw data in this area, and when looking at percentage graphs in general, as the numbers involved, for example in falls prevention, could be rather smaller than might be expected. Members noted that 130% was the percentage achievement against the calculated target number of quitters

- the number of people who had gone through the falls prevention process was disappointingly small; what were the targets for the future. It was explained that work was being done as part of the Sustainability and Transformation Plan (STP), and reserve funds were being held back until they could be co-invested under the STP. Another health trainer would be appointed with Everyone Health next year, and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) would be appointing Occupational Therapy Assistants; each recipient of strength and balance training needed about 50 hours of input. It was necessary to attract people to make use of the services available, both those of district leisure centres, at modest cost, and the free service supported through the public health budget

- the present falls prevention funding was time limited; it was important to get it incorporated in the base budget for the future

- other Policy and Service Committees bore an element of responsibility for falls prevention, and it was important that the Health Committee work with them; the reduction in spending on pavements, and their deteriorating quality, meant that falls in the street were a major cause of falls in older people

- a target of 90% for the Health Visiting mandated check required justification, given the importance of early intervention in preventing ill health. Janet Dullaghan, speaking as the lead commissioner for school nursing and health visiting, said that reasons were always sought for not meeting targets; some families failed to attend, some moved away, some missed an appointment and when eventually seen were over the timescale by a few weeks. The aspiration was to reach all children

- reaching members of the Gypsy and Traveller community was of particular concern; they formed the second largest ethnic group within South Cambridgeshire. Councillor Ellington invited officers to talk to her if there was anything the district could do to assist in this

- outreach NHS checks in Fenland were an element of the health inequality work that the Committee needed to look at; members noted that considerable efforts were being made to promote these in Fenland through for example information at bus stops and on social media, and working with employers, but the level of output was small in relation to the effort being put in to the work

- on emotional health in schools, information such as mapping of hotspots, if available, would help members raise awareness and know the local picture. The lead commissioner said that considerable resources were being put into meeting emotional health and wellbeing needs in schools; a recently-introduced helpline on self harm was receiving 40 calls a day, and the waiting time for Child and Adolescent Mental Health (CAMH) services was much reduced compared with 18 months previously. Thought was being given to joining up the efforts of all those going in to schools on health matters, such as volunteers and school nurses.

Members were advised that it was possible to map self harm admissions, which were highest in the most deprived areas. District-based information was available on harmful behaviours, but not school-based information

- the number of young people seen for mental health and wellbeing concerns had been extremely high in some months, if correctly recorded; this and subsequent peaks seemed to coincide with periods of particular stress in school, such as exams, mock exams, and the start of the school year. It was important to ensure that emotional support was available in school at times of crisis in the year. Members were advised that this graph in report paragraph 6.0 had the numbers correctly at the bottom; the scale at the side should also be actual numbers, not hundreds

- children of members' acquaintance reported finding the ChatHealth confidential text messaging service, available to all children, was a really good and helpful service

- it would be helpful to have greater granularity within the data, for example if the year-end dashboard could have some indication of the degree of variation within the county, and of any particular problem areas, so that spending decisions could be aligned with areas of need. There seemed to be no correlation between the activity in the dashboard and the outcomes; there were some unacceptably high levels of variance across the county which should not be accepted. The Director of Public Health said that she would be happy to adopt the approach in future reports of bringing exceptions to the Committee, drawing attention to areas where performance was particularly poor

- members should be supplied with links to useful internet sources of public health information to help them understand what was going on in their own areas; Lower Layer Super Output Areas (LSOAs) showed small area data. **Action: Liz Robin**

It was resolved unanimously to note and comment on the Annual Performance Report.

9. 0-19 JOINT COMMISSIONING OF CHILDREN'S HEALTH AND WELLBEING SERVICES

The Committee received a report from Janet Dullaghan, Head of Commissioning, Child Health and Wellbeing, updating it on the 0-19 Healthy Child Programme (HCP) and the work programme for this area, and the impact this was having through the Joint Commissioning Unit (JCU). Members noted that responsibility for health visiting and school nursing had been transferred to Public Health from the NHS; these services should be viewed in the context of the wider group of services for children and young people which were joined up round the needs of children.

The joint commissioning unit had been developed by Cambridgeshire County Council, Peterborough City Council and the CCG in response to children and families saying that they were having to deal with many different parts of the system rather than with a single body; they wanted to be able to tell their story once. The aim was to pool resources and develop a more integrated approach to delivering services, and give children the best possible start in life from pregnancy onwards, in contrast to the position 18 months previously, when there had been long waiting lists, now much reduced, for CAMH services, and disjointed pathways for those affected by autism and attention deficit hyperactivity disorder (ADHD). A multi-disciplinary team was now in place to ensure that people were directed to the best place to receive the services they needed.

Members noted that a business case had been made for the necessary funding, and the Children and Young People Committee had also recently received a report on this work. Although savings had had to be made, this had been done by developing different ways of working rather than by cutting services. The JCU was beginning to make a difference to children and young people's services, and was a candidate for a national award in the forthcoming MJ Achievement Awards.

Welcoming the report, the Chairman commented that the Head of Commissioning had provided more information orally than in writing; she should not hesitate to use the report to set out the successes more clearly, such as the reduction in waiting lists.

In discussion, members

- expressed their support for the work, and for prioritising spending on early help and support

- commented that it was important to include mention of the targeting necessary to those people and areas in greatest need; the Head of Commissioning said that she would ensure that the next report did so

- pointed out that increasing the health element of children's centre work could only be achieved if children's centres continued to exist; there were currently serious threats to the number, funding and management of children's centres in the county, and a resulting risk that the service would cease to be universal, and people in need of help would slip through the net

- drew attention to the findings of Professor Marmot's review into health inequalities in England, and the importance of avoiding means-testing and of meeting need in areas of deprivation.

It was resolved unanimously to:

- support the work to date
- note the interdependencies with other transformation work streams.

10. NHS QUALITY ACCOUNTS – RESPONDING TO REQUEST TO COMMENT

The Committee received a report outlining the requirement that NHS Healthcare providers produce an annual Quality Account report and send a copy of it to the Health Committee in its Overview and Scrutiny function for information or comment. The timing of these requests for comment had not fitted well with the cycle of committee meetings in recent years, and a process was being proposed for responding to the reports in 2017/18. At the stage when the Committee was sent the Quality Accounts, they were in draft, and so could not be circulated beyond the Committee.

Discussing the report, members welcomed the proposal that the Committee establish a task and finish group to comment on the draft Quality Accounts, and authorise the Head of Public Health Business Programmes to respond to them, with final responses being reported back to the Committee at the next meeting.

It was resolved unanimously to note the requirement to comment on Quality Accounts and to

a) note the responses sent to the NHS Trusts (Appendix A)

b) agree the process for responding to Quality Accounts for 2017/18 set out in report paragraphs 4.2 and 4.3, subject to changing 'approval for' to 'authority to' in paragraph 4.3.

11. HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

The Committee received a report informing it of the recent activities and progress of the Committee's working groups, and inviting it to agree membership of the Committee's various liaison groups with NHS Commissioners and Provider Trusts. It was noted that, though members had appreciated being able to attend liaison meetings when their diaries permitted, it was helpful to have a core of members for each liaison group, and to keep numbers to a manageable size for the Chief Executives hosting the meetings.

It was resolved unanimously to:

a) note and endorse the progress made on health scrutiny through the liaison groups and the schedule of liaison meetings (Appendix 1 of the report before Committee)

b) appoint members to the following Liaison Groups with NHS Commissioners and Provider Trusts:

- with Cambridgeshire & Peterborough NHS Foundation Trust (CPFT), Councillors Abbott, Ellington, Harford, Joseph and van de Ven

- with Clinical Commissioning Group and Cambridgeshire Healthwatch, Councillors Connor, Ellington, Harford and van de Ven

- with Cambridge University Hospital NHS Foundation Trust (Addenbrooke's Hospital) Councillors Ellington, Jones, Harford and van de Ven

- with North West Anglia NHS Foundation Trust (Hinchingbrooke Hospital), Councillors Connor, Ellington, Harford and Tavener.

12. APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee received a report inviting it to consider appointments to outside bodies, internal advisory groups and panels, and partnership liaison and advisory groups. Members noted that the role of those appointed to the Council of Governors of an NHS Foundation Trust was not to scrutinise the trusts, but to work within the organisational structure to contribute to making them more effective.

The Chairman thanked those who had undertaken these duties in the past, and paid tribute to the good work of her predecessor as Chairman of the Health Committee, thanking him for his commitment in the role over the years.

It was resolved unanimously to:

(i) review and agree the appointments to partnership liaison and advisory groups as detailed in Appendix A of the report before Committee, namely

a) Cambridge Local Health Partnership – Councillor L Jones
b) Cambridge University Hospitals NHS Foundation Trust Council of Governors – Councillor M Howell
c) Cambridgeshire and Peterborough NHS Foundation Trust Council of Governors – Councillor G Wilson
d) North West Anglia NHS Foundation Trust Council of Governors – Councillor J Gowing
e) Papworth Hospital NHS Foundation Trust Council of Governors – Councillor P Topping

(ii) defer the appointment of a Member Champion for Mental Health to a later meeting, to allow time for the Chairman to discuss the matter with the Chairwoman of the Adults Committee

(iii) note that the Economy and Environment Committee had appointed Councillor Tim Wotherspoon as Transport and Health Champion

Chairman

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on **14 June 2017** and updates Members on progress in delivering the necessary actions.

This is the updated action log as at 8 July 2017

Minute No.	Item	Action to be taken by	Action	Comments	Status
6.	**Health Committee agenda plan and training plan**	**Cllr Ellington**	Send a list of concerns about the implementation of the GP Out of Hours Service and Emergency Department Co-location to the Chairman and the Head of Public Health Business Programmes, copied to all members of the Committee.	Received 8 July 2017 and circulated to all members of the Committee.	**Completed**
		Liz Robin	A briefing on the existing action plan for the School Nursing Service to be circulated to members, to be followed by a more strategic item on the agenda.		
7.	**Finance and Performance Report – Outturn 2016-17**	**Val Thomas**	Circulate to members outcomes of the performance indicators applied against the organisation responsible for delivering the Healthy Fenland Fund.		

Minute No.	Item	Action to be taken by	Action	Comments	Status
8.	**Annual Public Health Performance Report**	**Val Thomas**	Provide performance information for the Health Trainer role, giving evidence of changes in health behaviour in easily-readable headline graphs		
12.	**Appointments to internal advisory groups and panels, and partnership liaison and advisory groups**	**Democratic Services/ Chairman**	Defer the appointment of a Member Champion for Mental Health to a later meeting, to allow time for the Chairman to discuss the matter with the Chairwoman of the Adults Committee		

Agenda Item No: 6

FINANCE AND PERFORMANCE REPORT – May 2017

To:	**Health Committee**
Meeting Date:	**20 July 2017**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the May 2017 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of May 2017.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of May 2017.**

	Officer contact:
Name:	Chris Malyon
Post:	Chief Finance Officer
Email:	LGSS.Finance@cambridgeshire.gov.uk
Tel:	01223 507126

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE MAY 2017 FINANCE & PERFORMANCE REPORT

2.1 The May 2017 Finance and Performance report is attached at Appendix A.

2.2 A balanced budget has been set for the Public Health Directorate for 2017/18, incorporating savings as a result of the reduction in Public Health grant.

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

The May 2017 Finance and Performance report (F&PR) is attached at Appendix A and shows the forecast outturn for the Public Health Directorate is a balanced position.

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

2.3 The Public Health Service Performance Management Framework for April 2017 is contained within the report. Of the thirty Health Committee performance indicators, three are red, ten are amber, fourteen are green and three have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Statutory, Risk and Legal Implications

4.2.1 There are no significant implications for this priority

4.3 Equality and Diversity Implications

4.3.1 There are no significant implications within this category.

4.4 Engagement and Consultation Implications

4.4.1 There are no significant implications within this category.

4.5 Localism and Local Member Involvement

4.5.1 There are no significant implications within this category.

4.6 Public Health Implications

4.6.1 There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	No
Are there any Equality and Diversity implications?	No
Have any engagement and communication implications been cleared by Communications?	No
Are there any Localism and Local Member involvement issues?	No
Have any Public Health implications been cleared by Public Health	No

Source Documents	Location
As well as presentation of the F&PR to the Committee when it meets, the report is made available online each month.	http://www.cambridgeshire.gov.uk/info/20043/finance_and_budget/147/finance_and_performance_reports

From: Martin Wade
Tel.: 01223 699733
Date: 13 June 2017

Public Health Directorate

Finance and Performance Report – May 2017

1 SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
April (No. of indicators)	3	10	14	3	30

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Apr) £000	Service	Current Budget for 2017/18 £000	Current Variance £000	Forecast Variance - Outturn (May) £000	Forecast Variance - Outturn (May) %
-	Children Health	9,200	0	0	0%
-	Drug & Alcohol Misuse	6,058	0	0	0%
-	Sexual Health & Contraception	5,297	-4	0	0%
-	Behaviour Change / Preventing Long Term Conditions	3,638	-12	0	0%
-	General Prevention Activities	56	-5	0	0%
-	Adult Mental Health & Community Safety	263	-6	0	0%
-	Public Health Directorate	2,208	-39	0	0%
-	**Total Expenditure**	**26,720**	**-67**	**0**	**0%**
-	Public Health Grant	-26,041	19	0	0%
-	s75 Agreement NHSE-HIV	-144	0	0	0%
-	Other Income	-149	0	0	0%
-	Drawdown From Reserves	0	0	0	0%
-	**Total Income**	**-26,334**	**19**	**0**	**0%**
-	**Net Total**	**386**	**-48**	**0**	**0%**

The service level budgetary control report for May 2017 can be found in appendix 1.

Further analysis of the results can be found in appendix 2.

2.2 Significant Issues

A balanced budget has been set for the financial year 2017/18. Savings totalling £606k have been budgeted for and the achievement of savings will be monitored through the monthly savings tracker, with exceptions being reported to Heath Committee and any resulting overspends reported through the monthly Finance and Performance Report.

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

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

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

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

The budget for the Drug and Alcohol treatment contracts has been vired from CFA to Public Health, due to the creation of the Public Health Joint Commissioning Unit (PHJCU), who will manage the commissioning of drug and alcohol treatment services going forward. The budget consists of £5,880k funded from the ringfenced public health grant, and £178k funded from County Council budgets (£6,058k gross budget). This budget will still be used for the same purpose but the budget management and commissioning responsibilities will transfer to the PHJCU. This will be noted by General Purposes Committee (GPC) as part of the Integrated Resources and Performance Report for May, to be presented to July GPC.

The budget for youth counselling (£111k) previously held within CFA as part of the public health grant MOU has been vired to Public Health. This budget will still be used for the same purpose but will sit within the Public Health budget rather than within CFA, and will be managed through the joint children's commissioning unit.

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

Sexual Health

- Performance of sexual heath and contraception services remains good with all indicators green.

Smoking Cessation

- End of year performance figures are not available until July 2017 due to the length of the intervention. The commentary provides details around smoking rates in routine and manual workers.

National Child Measurement Programme

- Measurements are undertaken during school term time and commenced in November 2016. Both key performance indicators are green.

NHS Health Checks

- The end of year results for 2016/17 is presented and the performance indicators remains at amber. Outreach NHS Health Checks are red, this reflects the target set for Fenland which has proved challenging particularly around engagement of workplaces in Fenland.

Lifestyle Service

- From the 17 Lifestyle Service indicators reported the overall performance shows seven green, seven amber and three red indicators. It is noted in the commentary that the provider has had two senior management vacancies in this period that may have affected performance.
- Performance around falls prevention remains good with the two key performance monthly indicators achieved.

Health Visiting and School Nursing data

- The overall performance indicators for Health Visiting and School Nursing show three amber and three green indicators, the commentary provides further details of targets not met which has been attributed to a reduction of staffing levels by 16%
- Health Visiting data is reported quarterly and at the end of Q4 performance is at amber for mandated checks.
- The number of infants recorded as breast feeding at six weeks is one of the highest in the Eastern region.

4.2 Health Committee Priorities (Appendix 7 – not attached)

Reports due bi-monthly and will be reported on next month.

4.3 Health Scrutiny Indicators (Appendix 8 – not attached)

Reports due bi-monthly and will be reported on next month.

4.4 Public Health Services provided through a Memorandum of Understanding with other Directorates (Appendix 9)

The next update to Appendix 9 will be made at the end of the first quarter of 2017/18.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Apr) £'000	Service	Current Budget for 2017/18 £'000	Expected to end of May £'000	Actual to end of May £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (May) £'000	Forecast Variance Outturn (May) %
	Children Health							
0	Children 0-5 PH Programme	7,253	0	0	0	0.00%	0	0.00%
0	Children 5-19 PH Programme - Non Prescribed	1,707	-32	-32	0	0.00%	0	0.00%
0	Children Mental Health	240	26	26	0	0.00%	0	0.00%
0	**Children Health Total**	**9,200**	**-6**	**-6**	**0**	**0.00%**	**0**	**0.00%**
	Drugs & Alcohol							
0	Drug & Alcohol Misuse	6,058	-113	-112	0	0.00%	0	0.00%
0	**Drugs & Alcohol Total**	**6,058**	**-113**	**-112**	**0**	**0.00%**	**0**	**0.00%**
	Sexual Health & Contraception							
0	SH STI testing & treatment – Prescribed	3,975	51	64	13	25.37%	0	0.00%
0	SH Contraception - Prescribed	1,170	-233	-244	-10	-4.35%	0	0.00%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	8	1	-7	-90.51%	0	0.00%
0	**Sexual Health & Contraception Total**	**5,297**	**-174**	**-178**	**-4**	**-2.32%**	**0**	**0.00%**
	Behaviour Change / Preventing Long Term Conditions							
0	Integrated Lifestyle Services	1,732	22	20	-2	-8.86%	0	0.00%
0	Other Health Improvement	281	29	17	-12	-41.40%	0	0.00%
0	Smoking Cessation GP & Pharmacy	828	-95	-106	-11	-11.72%	0	0.00%
0	Falls Prevention	80	0	0	0	0.00%	0	0.00%
0	NHS Health Checks Prog – Prescribed	716	11	24	13	114.87%	0	0.00%
0	**Behaviour Change / Preventing Long Term Conditions Total**	**3,638**	**-33**	**-45**	**-12**	**-37.65%**	**0**	**0.00%**
	General Prevention Activities							
0	General Prevention, Traveller Health	56	26	21	-5	-19.77%	0	0.00%
0	**General Prevention Activities Total**	**56**	**26**	**21**	**-5**	**-19.77%**	**0**	**0.00%**
	Adult Mental Health & Community Safety							
0	Adult Mental Health & Community Safety	263	6	0	-6	-99.99%	0	0.00%
0	**Adult Mental Health & Community Safety Total**	**263**	**6**	**0**	**-6**	**-99.99%**	**0**	**0.00%**

Forecast Variance Outturn (Apr) £'000	Service	Current Budget for 2017/18 £'000	Expected to end of May £'000	Actual to end of May £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (May) *£'000*	Forecast Variance Outturn (May)
	Public Health Directorate							
0	Public Health - Admin & Salaries							
0	Health Improvement	450	75	86	11	14.67%	0	0.00%
0	Public Health Advice	694	116	96	-20	-17.00%	0	0.00%
0	Health Protection	214	36	35	-1	-1.87%	0	0.00%
0	Childrens Health	649	108	88	-20	-18.64%	0	0.00%
0	Comm Safety, Violence Prevention	56	9	9	-0	-3.57%	0	0.00%
0	Public Mental Health	21	4	1	-3	-71.43%	0	0.00%
0	Cross Directorate Costs	124	21	14	-7	-32.26%	0	0.00%
0	**Public Health Directorate total**	**2,208**	**368**	**329**	**-39**	**-10.64%**	**0**	**0.00%**
0	**Total Expenditure before Carry forward**	**26,720**	**74**	**8**	**-67**	**-90.26%**	**0**	**0.00%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0.00%**
	Funded By							
0	Public Health Grant	-26,041	-6,755	-6,736	19	0.28%	**0**	0.00%
0	S75 Agreement NHSE – HIV	-144	216	216	0	0.00%	**0**	0.00%
0	Other Income	-149	0	0	0	0.00%	**0**	0.00%
	Drawdown From Reserves	0	0	0	0	0.00%	**0**	0.00%
0	**Income Total**	**-26,334**	**-6,539**	**-6,520**	**19**	**0.29%**	**0**	**0.00%**
0	**Net Total**	**386**	**-6,465**	**-6,512**	**-48**	**-0.75%**	**0**	**0.00%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Current Budget for 2017/18 £'000	Current Variance		Forecast Variance - Outturn	
		£'000	%	£'000	%

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

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Notes
Public Health Grant as per Business Plan	**26,946**		Ringfenced grant
Grant allocated as follows;			
Public Health Directorate	20,050	26,041	Including full year effect increase due to the transfer of the drug and alcohol treatment budget (£5,880k) from CFA to the PH Joint Commissioning Unit. Also the transfer of the MH Youth Counselling budget (£111k) from CFA to PH mental health budget.
CFA Directorate	6,322	331	£5,880k drug and alcohol treatment budget and £111k mental health youth counselling budgets transferred from CFA to PH as per above.
ETE Directorate	153	153	
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**26,946**	**26,946**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	20,560	
Virements		
Non-material virements (+/- £160k)	-8	
Budget Reconciliation		
Drug and Alcohol budget from CFA to PH	6,058	
Youth Counselling budget from CFA to PH	111	
Current Budget 2016/17	**26,721**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2017	2017/18		Forecast Closing Balance	Notes
		Movements in 2017/18	Balance at 31 May 2017		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,040**	0	1,040	**1,040**	
subtotal	**1,040**	**0**	**1,040**	**1,040**	
Other Earmarked Funds					
Healthy Fenland Fund	400	0	400	300	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	400	0	400	200	Planned for use on joint work with the NHS in 2017/18 and 2018/19.
NHS Healthchecks programme	270	0	270	170	This funding will be used to install new software into GP practices which will identify patients for inclusion in Health Checks. The installation work will commence in June 2017. Funding will also be used for a comprehensive campaign to boost participation in NHS Health Checks.
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	592	£517k Committed to the countywide 'Let's Get Moving' physical activity programme which runs for two years 2017/18 and 2018/19.
Other Reserves (<£50k)	0	0	0	0	
subtotal	**1,920**	**0**	**1,920**	**1,262**	
TOTAL	**2,960**	**0**	**2,960**	**2,302**	

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

Fund Description	Balance at 31 March 2017	2017/18		Forecast Closing Balance	Notes
		Movements in 2017/18	Balance at 31 May 2017		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	59	0	59	59	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**68**		**0**	**68**	

APPENDIX 6 PERFORMANCE

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

Below previous month actual
No movement
Above previous month actual

The Public Health Service Performance Management Framework (PMF) for April 2017 can be seen within the tables below:

Measures										
Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	98%	98%	G	98%	98%	98%	↔	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	94%	94%	G	93%	80%	94%	↑	
Number of Health Checks completed	18,000	18,000	17,452	97%	A	94%	4500	106%	↑	This is the end of year result for 2016/17 •Actual health check numbers compare reasonably well to other areasand have increased by 3000 but the issue is the conversion rate which is attributed to the poor public understanding of the Programme and ongoing data issues. • The comprehensive Improvement Programme is continuing this year with an extensive pormotional campaign in high risk areas and the introduction of the new software into practices has commenced which will increase the accuracy of the of the number of invitations that are sent for NHS Health Check. There is also ongoing training of practcie staff.
Percentage of people who received a health check of those offered	45%	45%	35%	35%	A	41%	45%	35%	↓	
Number of outreach health checks carried out	2,000	120	73	61%	R	N/A	120	61%	↔	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. Workplaces in the South of the county are performing well, however it has not been possible to secure access to the factories in Fenland where there are high risk workforces. This has affected performance. However the service being delivered outside of Fenland is on target. Engaging workplaces in Fenland however is challenging. In excess of 100 workplaces and community centres have been contacted with very little uptake.
Smoking Cessation - four week quitters	2249	2129	2008	94%	A	112%	259	81%	↓	The end of year data for the Stop Smoking Services will not be avilable until July 2017 due to the length of the intervention. • The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) suggest the prevalence of smoking in Cambridgeshire has increased slightly in the last few years, returning to a level statistically similar to the England average (16.4% v. 16.9%), although the trend is not statistically significant. Smoking rates in routine and manual workers are consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where routine and manual smoking rates have returned to a level worse than the average for England (39.8%). There has been ongoing performance improvement this year. • There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area.

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	56%	N/A	G	53%	58%	57%	↑	A stretch target for the percentage of infants being breastfed was set at 58% for 2016/17, - above the national average for England. The number of infants recorded as breastfed (fully or partially) at 6 weeks for Q4 has increased to 57%, from a position of 53% in Q3 and the figure is one of the highest statistics in the Eastern region in published Public Health England data (2015/16).
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	/	47%	N/A	A	36%	50%	33%	↓	All of the health visiting data is reported quarterly. The data presented relates to the Q4 period (Jan to March 2017) and is compared to Q3 2016-2017 data for trend. Since Q3 there has been a further fall in the antenatal contacts from 36% to 33%. Priority is being given to those parents who are assessed as being most vulnerable. Since the same period last year, staffing levels are down by 16%. There has been recruitment days, and posts have been recruited to as a result. New staff are expected to start in the next 3 months.
Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	90%	90%	96%	N/A	G	96%	90%	95%	↓	There has been a small reduction since Q3 - however, the performance is well within the target of 90%
Health visiting mandated check - Percentage of children who received a 6 - 8 week review	90%	90%	94%	N/A	G	92%	90%	95%	↑	Performance has increased since Q3, with an increase of 3% - this is well within the performance targets set
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	92%	N/A	A	92%	100%	91%	↓	The target of 100% for percentage of children who received a 12 month review by age 15 months has not been met, however if 'not wanted and not attended' figures are included, the figure rises to 96%, which is the same as the previous quarter.
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	77%	N/A	A	79%	90%	82%	↑	The target of 90% for percentage of children who received a 2-2.5 year review has not been reported as met, although the proportion has increased since the last reporting period again. However, if 'not wanted and not attended' figures are included, Q4 figure rises to 93% which does meet the performance target.
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	1388	N/A	N/A	35	N/A	59	↑	Interventions have increased since Q3, particularly in the area of emotional health and well being. An action plan has been put in place to address staffing issues and improve the school nursing service which is being closely monitored with providers
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	3521	N/A	N/A	105	N/A	305	↑	

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	58.9%	70.0%	119%	G	122%	58.9%	119%	↓	The National Child Measurement Programme is undertaken during school term times. It is not possible to formulate a trajectory as this is dependent on school timetabling. Measurements commenced in November 2016.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	58.9%	65.5%	111%	G	116%	58.9%	111.2%	↓	
Overall referrals to the service	5100	360	342	95%	A	N/A	360	95%	↔	The Countywide Integrated Lifestyle Service provided by Everyone Health has been without two senior managers during this period, although these staff were covered by interims it has had an effect on service delivery. We have been working with EH on their data returns supported by the Chief Executive Officer and reviewing the Service to ensure that measures are being put in place to address those areas where there is under achievement. However there is an overall upward trend in activity in recent months but this it is now static which reflects the staff turnover. Because of the lower referrals due to recruitment issues with frontline staff the number of plans produced remain behind target. Clients may take up to 12 months to complete their personal health plans. A new senior manager has now been appointed and improvement action has commenced.
Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	1517	108	107	99%	A	N/A	108	99%	↔	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1138	81	67	83%	R	N/A	81	83%	↔	An action plan is in place to address this which aims to promote the servove with the GP referrers and the general public
Number of physical activity groups held **(Pre-existing GP based service)**	664	30	30	100%	G	N/A	30	100%	↔	
Number of healthy eating groups held **(Pre-existing GP based service)**	450	45	51	113%	G	N/A	45	113%	↔	
Personal Health Trainer Service - number of PHPs produced (Extended Service)	723	61	58	95%	A	N/A	61	95%	↔	This reflects the recruitment issue which was resolved in November when the new staff were trained.
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	542	46	19	41%	R	N/A	46	41%	↔	This intervention can take up to one year and therefore perfomance will vary over the year. The poor performance reflects to some degree the recruitment issues in years 1 and 2 of the contract and the associated lower number of PHPs produced. And therefore the lower number of completions.
Number of physical activity groups held (Extended Service)	830	30	29	97%	A	N/A	30	97%	↔	

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of healthy eating groups held (Extended Service)	830	55	55	100%	G	N/A	55	100%	⇐⇒	
Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	N/A	133%	G	131%	30%	133%	⇑	
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	60%	60%	N/A	83%	G	167%	60%	50%	⇓	Although the 60% target was not achieved this reflects the high percentage (167%) achieved in the previous month. Patient flows vary greatly each month and after having such high % in the previous month there were fewer people completing in April
% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	80%	0%	0%	0%	N/A	n/a	80%	n/a	⇐⇒	
Falls prevention - number of referrals	386	20	20	100%	G	46%	20	100%	⇑	
Falls prevention - number of personal health plans written	279	14	14	100%	G	39%	14	100%	⇑	

* All figures received in May 2017 relate to April 2017 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

*** The assessment of RAG status for services where targets and activity are based on small numbers may be prone to month on month variation. Therefore RAG status should be interpreted with caution.

APPENDIX 7

Health Committee Priorities

Reports due bi-monthly and will be reported on next month.

APPENDIX 8

Health Scrutiny Indicators

Reports due bi-monthly and will be reported on next month.

APPENDIX 9

PUBLIC HEALTH MOU 2017-18

An update will be provided after the end of Quarter 1.

Cambridge University Hospitals NHS
NHS Foundation Trust

Roland Sinker
Chief Executive

Health Committee
20 July 2017



CUH is about its patients…

300 ED attendances per day

55% DGH income vs 45% specialist income

500 new Inpatient attendances per day (inc day cases)

1,600 Outpatient attendances per day

…and its staff

1,200 doctors

9,000 staff members

1,600 Administrative and Clerical

2,700 nurses

3

The Trust is performing well

- CQC rating now ‘Good’ and out of special measures
- Cancer and 18 Weeks Referral to Treatment on track
- A&E performance has greatly improved
- Financial target achieved for second year and on plan this year
- Staff survey improving but more to do

CQC inspection report – January 2017

Our ratings for Addenbrooke's and The Rosie

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Good	Requires improvement	Good	Good	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	☆ Outstanding	☆ Outstanding	Requires improvement	Good	Good
Maternity and gynaecology	Good	Good	Good	Requires improvement	Good	Good
Services for children and young people	Good	Good	Good	Requires improvement	Good	Good
End of life care	Good	Requires improvement	☆ Outstanding	Requires improvement	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Good	Good
Overall	Good	Good	☆ Outstanding	Requires improvement	Good	Good

Our ratings for Cambridge University Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	☆ Outstanding	Requires improvement	Good	Good

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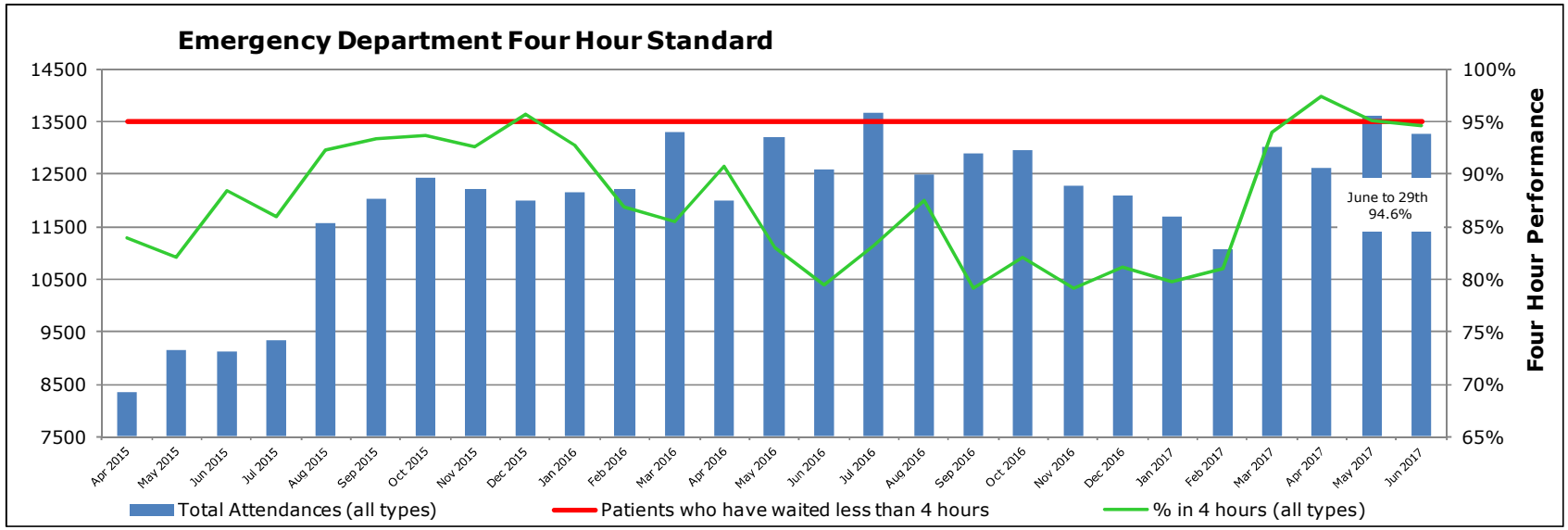
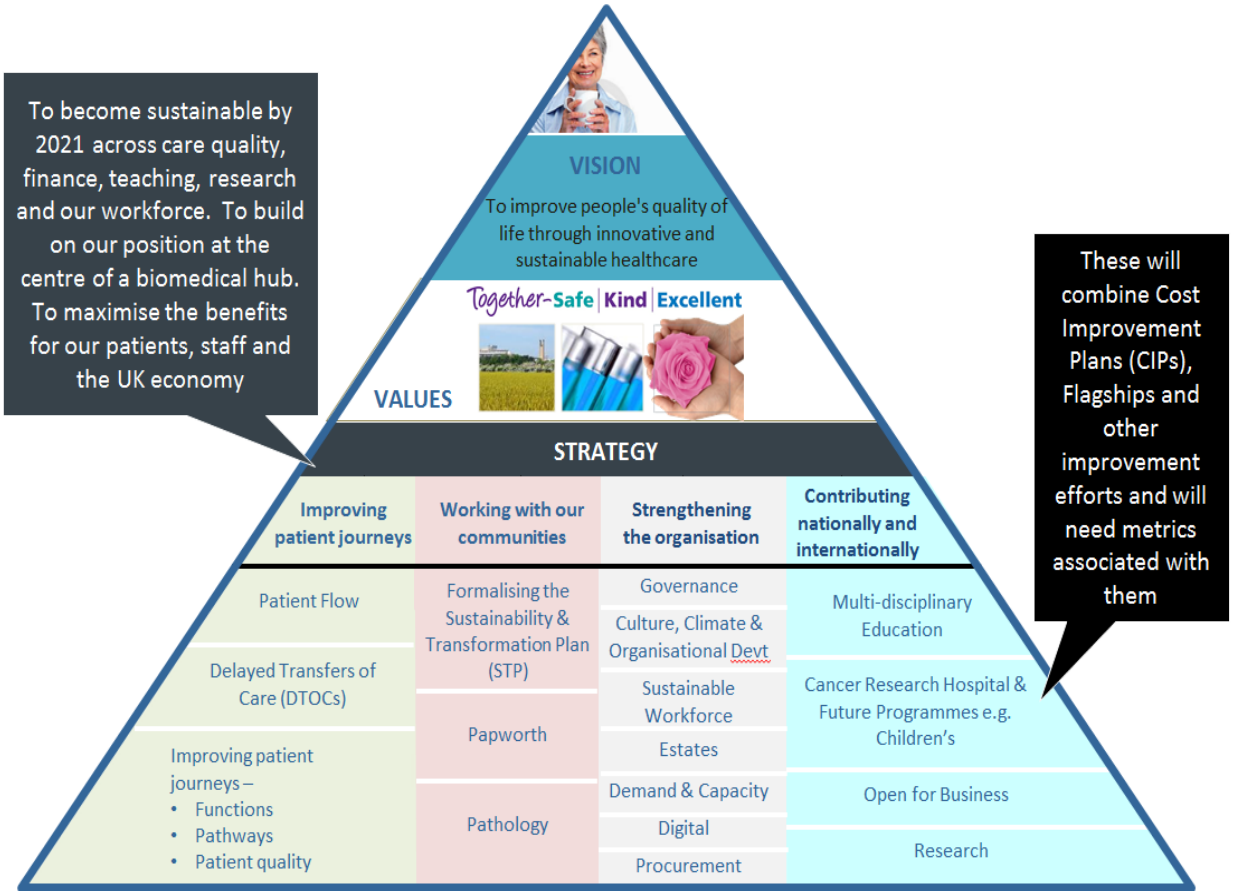
Together-Safe | Kind | Excellent

A&E performance



The Trust is aligning around a strategy for a sustainable future

To become sustainable by 2021 across care quality, finance, teaching, research and our workforce. To build on our position at the centre of a biomedical hub. To maximise the benefits for our patients, staff and the UK economy



These will combine Cost Improvement Plans (CIPs), Flagships and other improvement efforts and will need metrics associated with them

7

Together-Safe | Kind | Excellent

We are also working on culture…

- Empowering staff to make improvements
- Commitment to staff development, education and training
- A new way of working developed with staff

Some specifics…

- Out Of Hours service
- Fire safety
- Emergency preparedness
- Delayed Transfers of Care
- eHospital (EPIC) – *slides 10-12*
- Liver Metastases service – *slide 13*

eHospital update

- eHospital is the Trust's digital transformation programme
- EPIC electronic patient record system went live in October 2014
- Paper notes now practically a thing of the past - clinical staff can quickly and securely access all of a patient's record on internet-enabled devices
- MyChart portal providing patients with access to part of their record
- CUH recently recognised as one of 16 Global Digital Exemplar acute hospitals in England
- Staff survey data shows improving satisfaction in use of EPIC
- Significant benefits to patients, staff and the organisation

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eHospital update

eHospital

Fully integrated EPR
one patient, one record, one system, one place (integrated healthcare)

Barcoded wristbands
full closed loop barcoded-enabled medication administration in paediatrics.

Full closed-loop transfusion ordering, preparation, supply & administration

Same information viewed by the clinical team
vital for patient care and safety

Electronic sepsis alerts in ED
patients receiving antibiotics within 90 mins of arrival increased by 80%

Patients don't stay in hospital for longer than they need to
Discharge medication prep time has reduced from 90 mins to 45 mins

Virtual fracture clinic
Notes & X-rays reviewed virtually – appointments available in clinic for patients that need to be seen

Use of mobile devices
Real-time information recorded at the patient's bedside = staff have more quality time with patients

Technology transforming health and care

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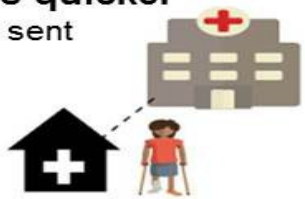
eHospital update

eHospital

Electronic prescribing
100% reduction in sedation-related prescribing errors in paediatrics = 50 intensive care beds & 100 regular beds saved / year

100% recording of the indication for antibiotic prescribing

Information sent to GPs quicker
900,000 clinical documents sent electronically / year



Virtual fracture clinic
4,500 appointments freed up for patients who need to be seen in clinic

Routine review of best practice for intensive care ventilator tidal volumes
saving 2-3 avoidable ventilator-related deaths / year

Integrated devices
All physiological monitors & ventilators in 40 theatres & 148 high-dependency areas connected to the Epic EPR

Reduction in surgery delays
Increase in main theatre usage 1,319 cases increased to 1,554 a year

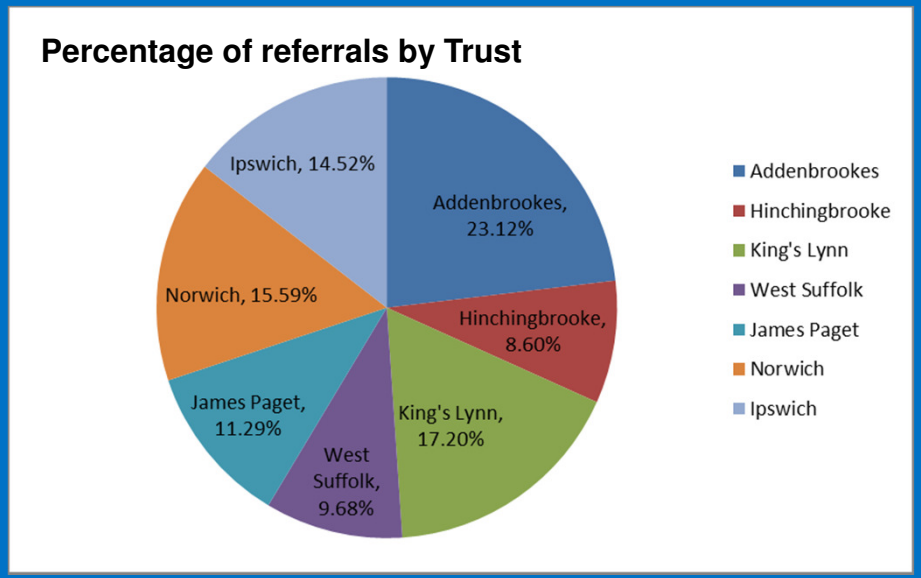
Decision support
16% of allergy-related prescribing alerts in the EPR have led to a change in prescription (2,450 bed days saved = £0.98 million)

Paperless processes
99% reduction in paper notes in inpatient & outpatient areas
= £460,000 / year staff time equivalent saving

Technology transforming health and care

Liver Metastases service

- Centralised service at CUH fully commissioned by Anglia Cancer Network from September 2015
- Year 1: 183 of all 186 (98%) patients had agreed treatment plan within two weeks of referral
- 100% of patients had a nominated key worker
- No non-clinical cancellations in the past 18 months
- 0% 30-day mortality
- Patient survey currently being undertaken – results due in autumn



Agenda Item No: 9

NON-EMERGENCY PATIENT TRANSPORT SERVICE (NEPTS) PERFORMANCE UPDATE

To:	**Health Committee**
Meeting Date:	**20 July 2017**
From:	**Kyle Cliff Assistant Director, Commissioning and Contracting, Cambridgeshire and Peterborough Clinical Commissioning Group**
Electoral division(s):	**All**
Purpose:	**To report on the performance of the Non-Emergency Patient Transport Service.**
Recommendation:	**The committee is asked to note and comment on the performance of the Non-Emergency Patient Transport Service (NEPTS).**

	Officer contact:
Name:	Kyle Cliff
Post:	Assistant Director, Commissioning & Contracting
Email:	kyle.cliff@nhs.net
Tel:	01733 847376

1. BACKGROUND

1.1 The Clinical Commissioning Group (CCG) has a responsibility to ensure access to transport for those patients that meet our Non-Emergency Patient Transport (NEPTS) eligibility criteria. The CCG's Governing Body agreed to award a new Non-emergency Patient Transport contract to the East of England Ambulance NHS Foundation Trust (EEAST) on 22 March 2016. This followed a procurement process and public consultation.

1.2 The new contract provides the CCG with a cost effective service over the 5 year life of the contract. The Governing Body was assured that the EEAST tender was fully evaluated in line with the invitation to tender (ITT) Terms and Conditions Documents.

1.3 Following the procurement the new provider undertook a 5 month mobilisation period. The new service commenced on 1 September 2016.

1.4 During mobilisation additional vehicles were bought in to supplement the existing fleet. Patients now benefit from wider and uniform geographical access and being able to book their own transport direct using EEAST's call centre.

1.5 The new contract provides equity of access across the CCG population with agreed standards of delivery for response times and journeys, the previous contracts had different standards of access to different hospital and other NHS health services.

1.6 There has been progress with the mobilisation of the new service but also a number of issues have arisen, and the CCG are working closely with EEAST and acute providers to resolve these issues.

2. MAIN ISSUES

2.1 Initial mobilisation issues have been resolved. After the first four months the provider entered a phase of reviewing the operational model benchmarked against the activity requirements and working with individual treatment units to resolve operational issues.

EEAST are failing to deliver a number of performance standards required by the CCG. A Contract Performance Notice was issued in November 2016 for EEAST's failure to meet some of these. 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 has been held and a revised RAP was agreed at the end of June 2017.

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

2.2.1 Discharges from hospital:
There are significant bed capacity pressures in the local acute hospitals and a need to get patients discharged within a timely manner.

2.2.2 Since the commencement of the contract same day requests for patient transport have exceeded the expected levels from the tender or planning process. The proportion of on the day journeys is 8-10% of journeys as opposed to 3% in planning.

The CCG and EEAST are working with the Acute Trust partners to address this issue. EEAST have asked the Acute Trusts to ensure that patients are ready for transport pick up from the wards as they report that they have had to wait long times and this has caused them further delays. Changes have been made to booking processes with the Acute Trusts. Central points of contact are in place as well as a day to day Ambulance Liaison Officer assigned to each acute.

2.2.3 Resourcing:
EEAST have a high number of vacancies, recruitment to vacant posts continues.
The operational model was on indicative activity and while overall the number of journeys is below expected levels the mix and categories' of transports is significantly different from what the initial EEAST operating model was set up to deliver.
For example we have seen 4% less routine car journeys and 7% more wheelchair journeys.
Overall there has been a greater proportion of journeys that fall into longer travel bandings, 5% less of 0 to 10 mile journeys; 3% more of 10 to 20 mile journeys.
The proportion of on the day journeys is significantly higher, 8-10% of journeys as opposed to 3% in planning.

3. Actions

3.3 EEAST have undertaken a capacity review in conjunction with the CCG using 4 months worth of data, and has planned several adjustments to skill mix, shifts, staff rotas and vehicles, some of which require staff consultation before they can be implemented.

3.4 EEAST have taken a number of actions to try and improve their performance including:

3.4.1 Use of Private Ambulance Subcontractors and Taxis to offset vacancies
3.4.2 Staff training on exception reporting and Key Performance Indicator requirements
3.4.3 The Control Centre staff ringing wards to ensure patients being discharged are ready for transportation. This means EEAST staff are not waiting longer than the agreed 10 minutes and are ready for the next patient journey
3.4.4 Deep dive investigations into specific issues highlighted by the acute hospitals

3.5 Communication: One of the biggest areas of feedback within the first couple of months was the need to increase the level of communication. To that end EEAST implemented daily regular contact with acute providers, regular face to face meetings and further clarification of the escalation process.

3.6 Daily emails are sent to EEAST with details of the bed status at each hospital. In addition the CCG are holding regular teleconferences with EEAST covering any issues and incidents related to NEPTS to ensure further problems are identified with possible solutions.

3.7 Nursing Home and Care Packages:
Some bookings had not made clear that Care Packages were time critical. Some Nursing Homes have a cut-off time when people can no longer be admitted back into the home from. In order to mitigate this, the call handling process has been amended to specifically ask this question. EEAST have also compiled a list of all Nursing Homes this includes details of the cut off time for patients to arrive back at the home, and EEAST prioritise these patients.

3.8 Patient Experience:
It should be noted that while there have been operational issues as set out above, in terms of on the day discharges from acute hospital sites, the feedback from patients in the period of transition has been positive. There has been a significant reduction in the number of complaints seen by the service. A patient experience survey was undertaken for patients with the Cambridgeshire and Peterborough CCG area who used the NEPTS during the period 1 to 8 February 2017. The objective of this survey was to establish patient satisfaction and to involve patients in the service received, whilst also monitoring the quality of the service provided.
Overall, 96.8% of patients who responded to this survey and had used the NEPTS described the service received as being either ‘satisfactory’ or ‘very satisfactory.’
96.0% of patients also answered that they would either be ‘likely’ or ‘extremely likely’ to recommend the service to a friend or a relative.

4 Conclusion

4.1 The new contract offers parity of access for patients across the area replacing inequity of service provision across a number of separate contracting arrangements.
4.2 Access for patients to the call centre and ability to book transport centrally is now in place
4.3 Patients experience survey results should be noted
4.4 There have been issues with the mobilisation of the service, predominately linked to discharges. While a number of actions have been taken the CCG and providers continue to work to address these.

Agenda Item No: 10

CAMBRIDGESHIRE & PETERBOROUGH SUSTAINABILITY & TRANSFORMATION PARTNERSHIP (STP) UPDATE REPORT

To:	**HEALTH COMMITTEE**
Meeting Date:	**20TH July 2017**
From:	**Scott Haldane, Executive Programme Director – STP**
Purpose:	**To provide the Committee with an update on progress relating to the Cambridgeshire & Peterborough STP.**
Recommendation:	**The Committee is asked to:** **a) comment upon and note this update report;** **b) consider whether future Health Committee meetings should focus on specific STP themes; and** **c) subject to b), above, identify STP themes for future Committee consideration.**

	Officer contact:
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1. BACKGROUND

1.1 The Cambridgeshire and Peterborough health system faces significant challenges due to:

- the health and care needs of our rapidly growing, increasingly elderly population;
- significant health inequalities, including the health and wellbeing challenges of diverse ethnic communities;
- workforce shortages including recruitment and retention in general practice;
- quality shortcomings and inconsistent operational performance; and
- financial challenges which exceed those of any other STP area in England on a per capita basis, such that by 2021 we expect our collective NHS deficit, if we do nothing, to be £504m.

1.2 In order to address these challenges, the NHS (including general practice) and local government came together in 2016 to develop a five-year Sustainability and Transformation Plan (STP) to improve the health and care of our local population and bring the system back into financial balance. The STP can be found at Cambridgeshire & Peterborough STP and, in essence, seeks to do the following:

- deliver a shift from reactive to proactive care, with a holistic approach to care planning, coordination, and delivery that empowers people to take as much control of their care as possible. This approach aims to manage the growth in demand for services through better prevention, self-management, re-enablement and intensive management of rising risk and high risk people;
- deliver care pathway changes, standardised care and reduced variation to maximise quality and minimise unit costs through, for example, improved clinical networks, reduced Length of Stay in hospital and staff skill mix;
- deliver knowledge sharing, breaking down organisational and setting boundaries;
- close the under-funding gap as quickly as possible and maximising income growth;
- reduce overheads within and across the health and care system by, for example, managing our Estate more effectively, maximising joint procurement across health and other public sector organisations, and integrating organisations and functions;
- use technology to improve modes of interaction/intervention; and
- mobilise collective efforts across the County's NHS and public sector bodies to leverage the 'Cambridge research' brand and the Cambridgeshire and Peterborough-wide education and business offer to attract investment and make new partnerships, in line with on-going devolution.

1.3 To enable us to deliver the best care we can, we have agreed a unifying ambition for health and care in Cambridgeshire and Peterborough. This is to develop the beneficial behaviours of an 'Accountable Care System' by acting as one system, jointly accountable for improving our population's health and wellbeing, outcomes, and experience, within a defined financial envelope.

1.4 Through discussion with our staff, patients, carers, and partners, we have articulated four priorities for change and we have also developed a 10-point plan to deliver these priorities, as set out below and illustrated at Annex 1.

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

1.5 The STP also addresses the system-wide financial challenge of £504m over the next four years. It estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge to £547m.

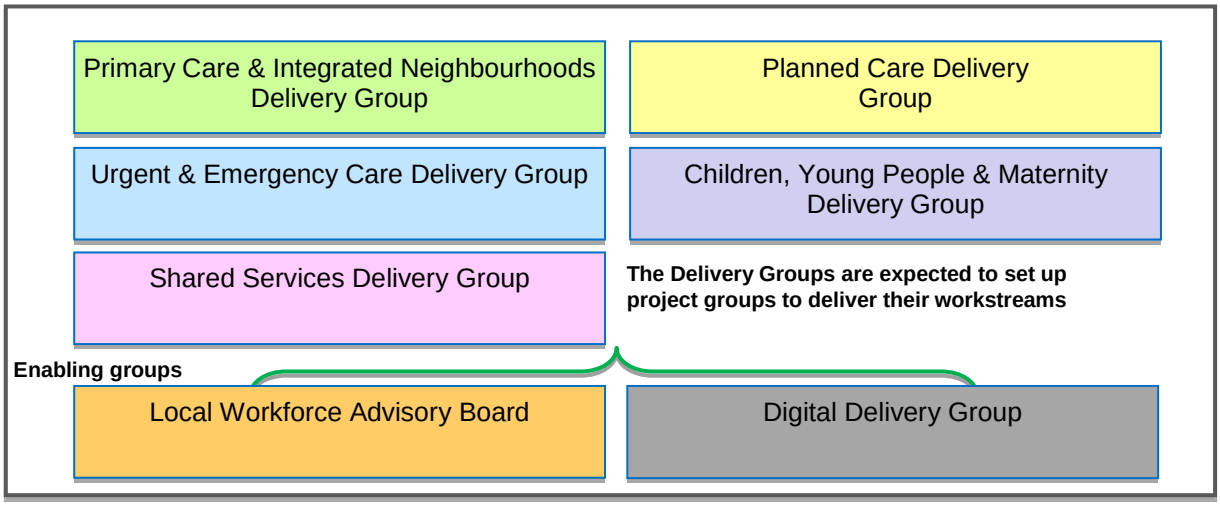
2.0 STP DELIVERY PROGRAMME

2.1 We have moved from the planning phase to the delivery phase of the STP. We have put in place *Fit for the Future* (STP) programme arrangements, with a delivery governance structure to ensure effective implementation and this is illustrated at Annex 2, with an explanation of the purpose of each Group provided at Annex 3.

2.2 The Committee is asked to note that the Programmes governance arrangements have undergone a recent review to ensure that they continue to be fit for purpose and a number of changes are being proposed but are still to be implemented, including the establishment of an STP Board.

2.3 The programme has, at its core, seven Delivery Groups, each one responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system, as set out below.

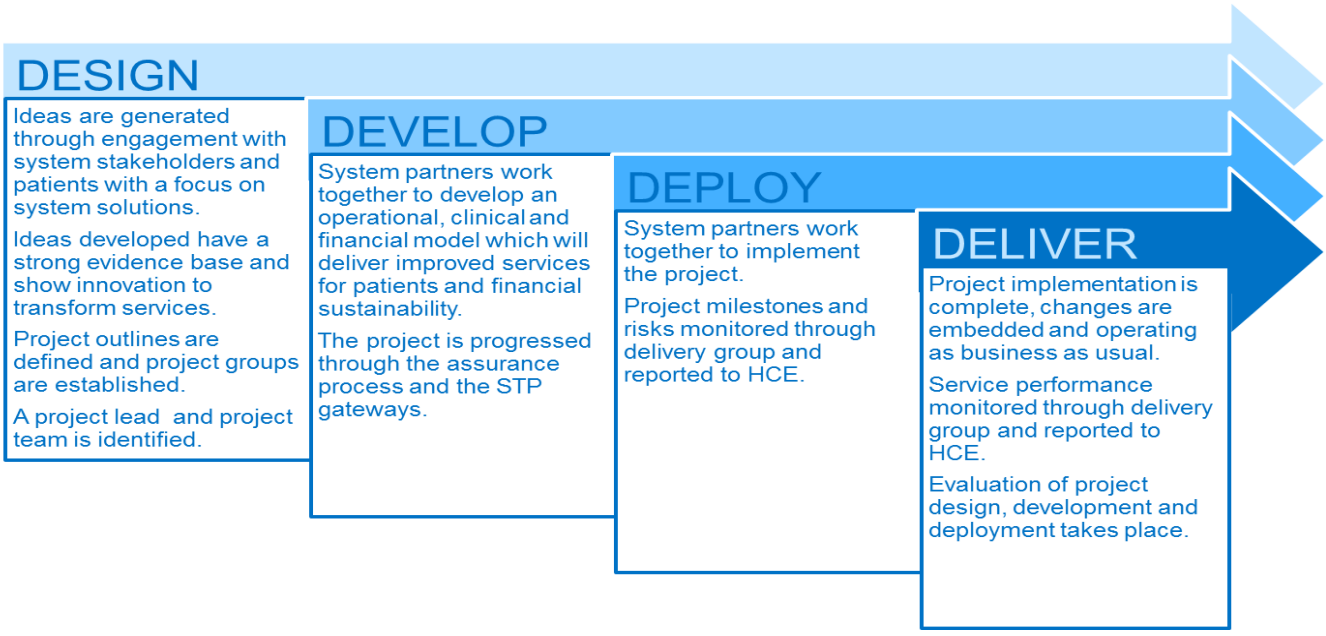
***Fit for the Future* (STP) Delivery Groups**



2.4 The Delivery Groups cover clinical services, workforce and support services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do. Membership includes clinicians from organisations across the system as well as patient and public representation.

2.5 Improvement Project Groups have been established within each Delivery Group to take forward specific aspects of work and, again, these groups include/will include clinical membership and patient and public representation.

2.6 We have established a clear and consistent structure to frame the various processes across the STP to ensure appropriate accountability across the 'lifecycle' of each STP Improvement Project, as set out below. Over 30 projects are currently 'live' across one or other of the four stages of the STP programme cycle.



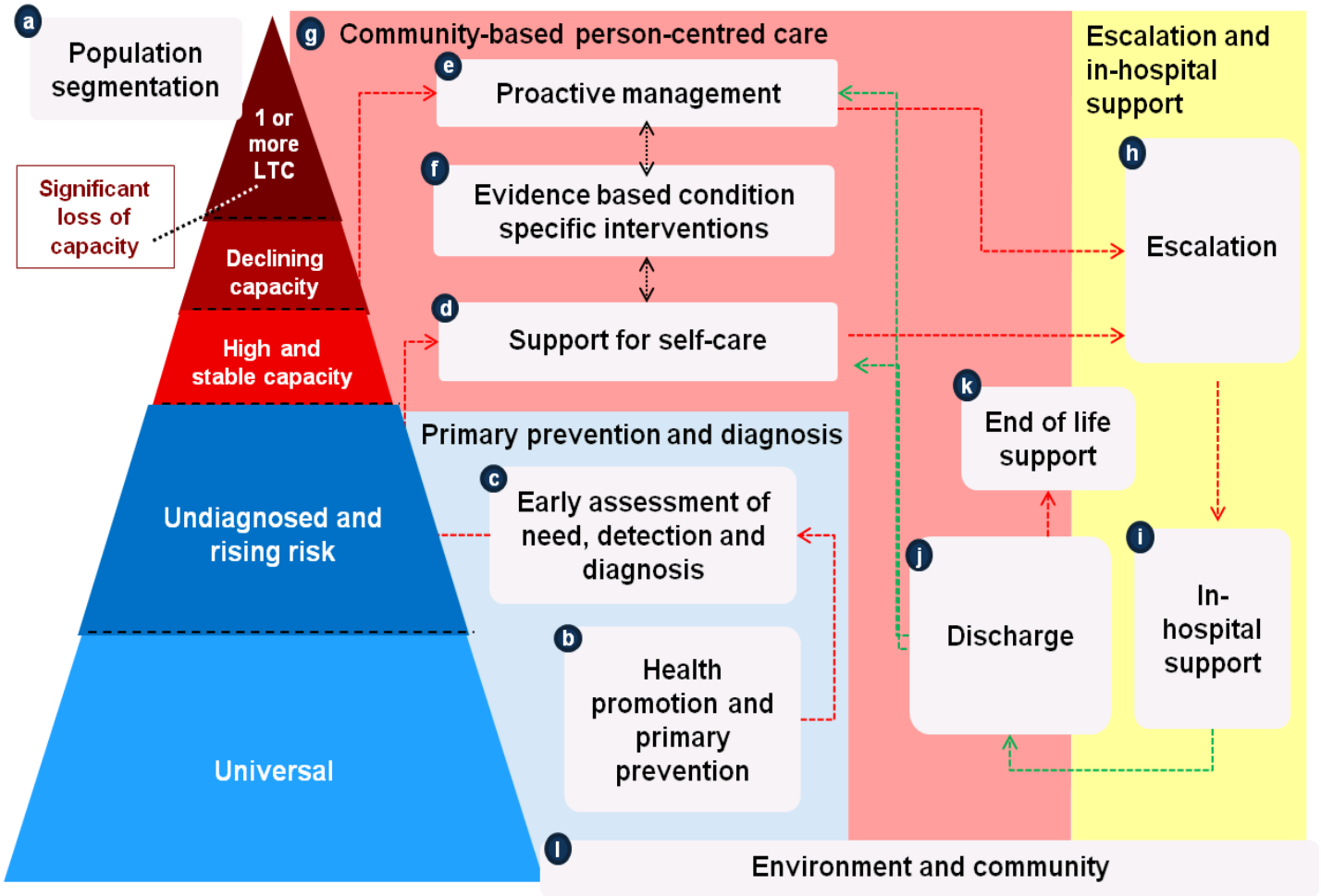
2.7 It is important to bear in mind that STP delivery will take place over several years and we are seeking to ensure a good balance of pace that will deliver real changes for people as quickly as possible but without overwhelming the health and care system's ability to process the changes.

3. MAIN ISSUES

3.1 This section summarises the current focus for implementation across the seven Delivery Groups within *Fit for the Future*.

3.2 Primary Care and Integrated Neighbourhoods

3.2.1 The purpose of this Delivery Group is to implement integrated health and care neighbourhood teams providing proactive care stratified by different levels of need, as determined by peoples medical and psychosocial conditions, and as illustrated in the diagram below. We have brought together previously disparate work on healthy ageing, long-term conditions management, and mental health for the first time in this delivery programme.



Key 2017/18 Interventions

- More specialist support for people with long term conditions such as ***diabetes, lung problems and heart disease***.
- Extra help for ***people who are at risk of falls*** by strengthening existing services. This will mean more staff in the community to help to prevent falls and help people recover if they do get injured.
- More case managers to identify patients who need the most ***support to remain at home*** and to ensure they get the help they need (this will be piloted in four neighbourhoods in the first instance and then expanded to other areas on the basis of the evidence from these pilots).
- Improving the ***prevention of stroke*** by identifying more patients with atrial fibrillation, a heart problem which is a significant risk factor, by giving them medication that will help earlier
- More support for ***people with dementia*** at all stages of the disease.
-

Key Achievements in 2017/18 to date

- £1m invested in respiratory, stroke prevention and falls prevention services
- £1.6m Diabetes funding awarded from national bid

3.3 **Urgent and Emergency Care**

3.3.1 This Delivery Group is seeking to manage demand for urgent and emergency care services which have seen significant increases over recent years resulting in clinical and financial challenges for the system. The increase in demand in Cambridgeshire & Peterborough is driven mainly by population growth and, in particular, by growth in the older frail population, as well as a lack of community based services to support vulnerable people.

Key 2017/18 Interventions

- ***Extended Joint Emergency Team (JET):*** This team intervenes to support vulnerable patients in their homes and/or the community. We will be expanding and enhancing this service to enable it to care for more patients.
- ***Stroke Early Supported Discharge (ESD):*** Establishing a service which will provide both intensive stroke discharge support and home based neuro rehabilitation.
- ***Discharge to Assess***
- Develop and deliver a ***mental health first response service*** to enable 24/7 access to mental health

Key Achievements in 2017/18 to date

- £1.9m invested in expanding the Joint Emergency Team with recruitment of additional staff and service expansion underway
- £0.5m invested in early supported discharge of Stroke patients
- £1.1m Psychiatric Liaison funding awarded from national bid for 2018/19 at Addenbrookes and Peterborough City Hospital

3.4 Planned Care

3.4.1 The focus for Planned Care is to define, design and implement shorter, faster, better and more cost-effective pathways of care for patients needing planned (or sometimes known as 'elective') care. This involves looking at every stage of the patient 'journey' from GP referral, outpatient appointment, procedure to follow up, ensuring that we are making the most effective use of clinical and financial resources.

Key 2017/18 Interventions

- Improve referral management
- Standardise high volume treatment pathways (orthopaedics, ophthalmology, ENT, cardiology)
- Reduced variation in diagnostic testing
- Improved cancer services

Key Achievements in 2017/18 to date

- Pathway reviews and re-design underway across several specialties.
- East of England Cancer Alliance awarded £9m national funding and Cambridgeshire & Peterborough awaiting confirmation of % share of this funding
- Appointed a Cancer Programme Manager for two years – by securing funding through the Cancer Alliance National Business Case. The role will be key in the overall delivery of the Cancer Priorities for 2017/18 and ensure they create sustainability for the future.

3.5 Children, Young People & Maternity Delivery Group

3.5.1 The Children, Young People and Maternity Services STP Delivery Group is leading seven projects over the next five years to improve services and outcomes for women and children.

Key Interventions

- Introducing 7-day-a-week paediatric community nursing
- Maternity developments such as implementing the national Better Births vision
- Improving the care models for children with asthma and children's continence services
- Developing an integrated children and family health and wellbeing service for 0-19 year olds
- Improving the emotional, mental health & wellbeing and specialist disabilities support for children and young people

3.6 Shared Services

3.6.1 This Delivery Group is focussed on ensuring that we optimise the use of our resources, assets and potential. This includes, for example, making best use of NHS buildings and land, sharing 'back office' functions such as Human Resources, and streamlining our procurement and purchasing processes.

Key 2017/18 Interventions

- Merger of Hinchingbrooke and Peterborough to enable shared service savings
- Explore back office consolidation across primary care
- Implement a single approach to procurement
- Develop a strategic estate plan - making best use of NHS buildings and land

Key Achievements in 2017/18 to date

- The merger of Hinchingbrooke Healthcare NHS Trust and Peterborough & Stamford Hospitals NHS Foundation Trust will ultimately make a significant contribution to shared service savings.

3.7 Local Workforce Advisory Board

3.7.1 In order to maximise the impact of new care models, the Local Workforce Advisory Board is working closely with clinical leads to ensure that workforce requirements can be met. Care models must take into account current workforce capacity and capability, and consider the change required to develop a workforce which is capable, competent, motivated, and supported to provide the best care for the population in future.

Key Interventions

- System-wide long-term workforce plan
- System-wide Organisational Development Plan
- Develop a system-wide Workforce Investment Plan, in which all providers commit to investment priorities in relation to Apprenticeships, Pre-Registration, Continued Professional Development (CPD) and wider workforce transformation

3.8 Digital Delivery

3.8.1 This Delivery Group is concerned with how best we can meet the opportunities and challenges of providing healthcare in a digital world where making the best use of technology is fundamental to supporting good care in areas such as tele-medicine, tele-monitoring, remote monitoring and paper free care delivery.

Key Interventions

- Deliver the Local Digital Roadmap
- Digital opportunities: tele-medicine, tele-monitoring, GS1, remote monitoring, internet of things, Paper-free care delivery

4 WORKING COLLABORATIVELY

4.1 Health, Cambridgeshire County Council and Peterborough City Council partners are working within the framework of the Memorandum of Understanding, agreed in 2016 to promote better joint accountability.

4.2 The STP Health and Care Executive and Cambridgeshire Public Services Board meets quarterly and has agreed a number of priority areas for collaborative action, including:

- Maximising the potential of **devolution**
- **Workforce** availability and development
- Better joint **procurement** practices
- Making best use of digital **technology**
- Maximising use of the public sector **estate**
- **Planning policy**

4.3 The Health and Care Executive and Cambridgeshire Public Services Board have also reviewed the role of District Council Local Health Partnership Boards and Area Executive Partnerships, leading to streamlining proposals that are currently under consideration.

5 ENSURING EFFECTIVE STAKEHOLDER INVOLVEMENT IN STP IMPLEMENTATION

5.1 We are committed to ensuring that we effectively involve local people, patients, carers and service users at every stage of STP implementation. To this end, we are taking the following steps in the short term:

- Ensuring that there is patient, service user or voluntary sector representation on every *Fit for the Future* Delivery Group and 'live' Improvement Area Group;

- Putting in place training, guidance and support tools for colleagues involved in implementation;

- Ensuring that there is a communications specialist on every *Fit for the Future* Delivery Group and 'live' Improvement Area Group to advise and support best involvement practice as well as ensure that a Communication & Engagement Plan is developed and deployed;

- Developing a clinical engagement strategy to ensure that hospital, community and primary care colleagues can contribute effectively; and

- Working with Healthwatch who can advise on effective involvement and, in particular, facilitate access to specific and seldom heard groups.

5.2 We recognise that we need to engage more widely than we have traditionally done and reach audiences that have not been heard to date. We will do this in a variety of ways, including:

- Exploiting the potential of social media to establish an on-going two-way dialogue with audiences that we would not routinely access e.g. teenagers and women aged between 30- 50;

- Use the facilitative input of organisations and groups that understand how to engage effectively with seldom heard groups e.g. Healthwatch and mental health charities;

- Promote the *Fit for the Future* website as the central point of contact with up-to-date information on activity and progress;

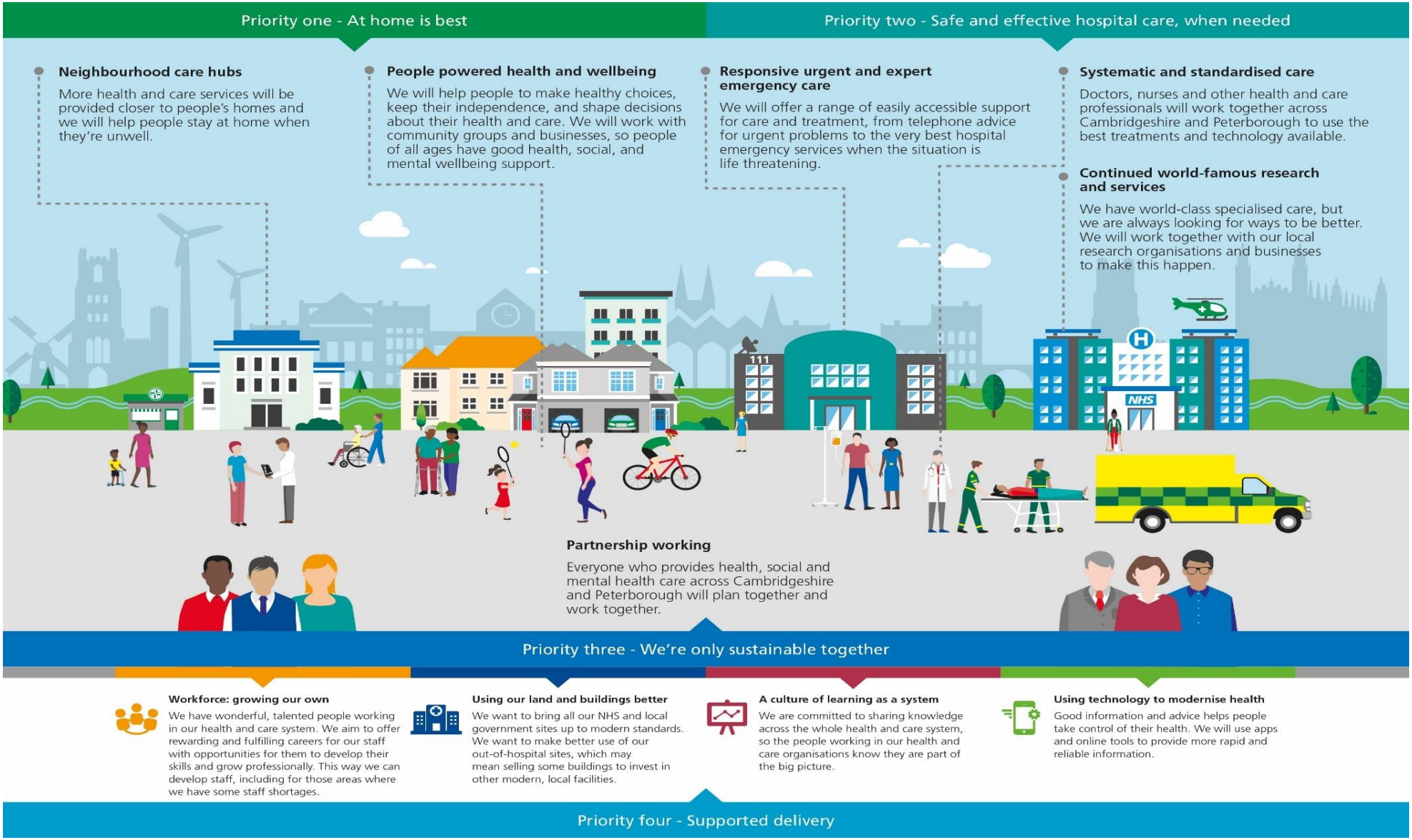
- Advertise opportunities for people to be involved; and

- Develop opportunities for individuals and groups to improve their involvement skills e.g. quality events, conference or guides.

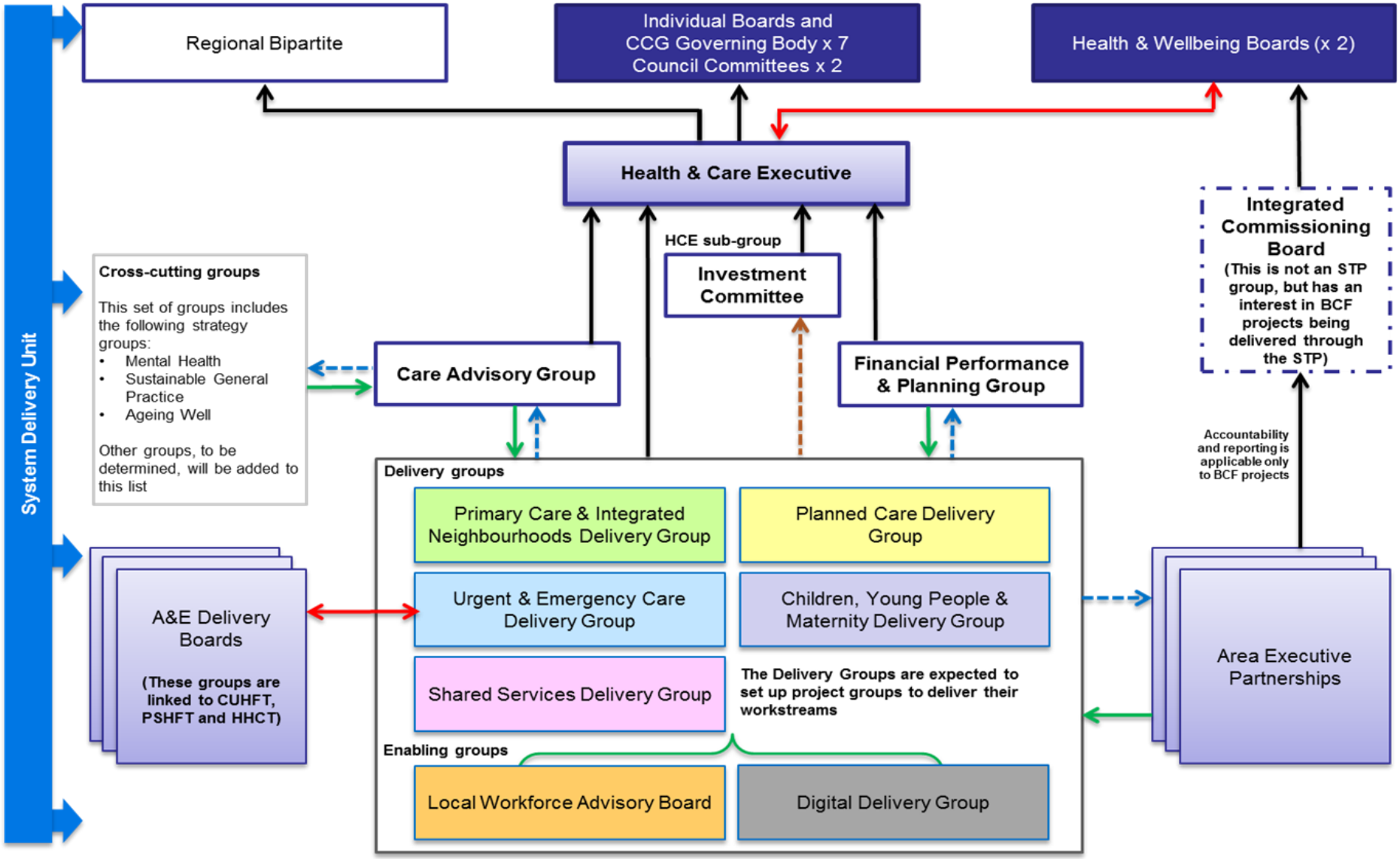
6 SOURCES

Source Documents	Location
Cambridgeshire & Peterborough STP	http://www.fitforfuture.org.uk/documents/cambridgeshire-peterborough-sustainability-transformation-plan-october-2016/
Cambridgeshire & Peterborough Local Digital Roadmap	http://www.fitforfuture.org.uk/documents/cambridgeshire-peterborough-local-digital-roadmap-january-2017/

ANNEX 1: Cambridgeshire & Peterborough *Fit for the Future* Priorities



ANNEX 2: *Fit for the Future* Delivery Governance Structure



ANNEX 3: Purpose of each Group within the *Fit for the Future* Delivery Governance structure

1. Health and Care Executive (HCE)

Organisations from across the system have agreed to work together, taking joint responsibility for improving the population's health and wellbeing within a defined financial envelope. The Health and Care Executive (HCE) exists to provide strong, visible and collective leadership to this process.

The HCE's main purpose is to commission and oversee a programme of work that will deliver the *Fit for the Future* priorities:

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

2. Care Advisory Group (CAG)

The main purpose of the Care Advisory Group (CAG) is to contribute to the overall delivery of *Fit for the Future* objectives by reviewing care model design proposals, horizon scan for innovations, ensure that there is a robust evidence base behind decisions, and making recommendations to the HCE. Expertise and opinion will be represented and sought from the public, from health and care providers and from clinical experts. The CAG will prioritise clinical issues to be considered by HCE and make recommendations for their consideration.

3. Financial Performance and Planning Group (FPPG)

The main purpose of the FPPG is to contribute to the overall delivery of *Fit for the Future* objectives by promoting financial sustainability of health and care provision within the Cambridgeshire and Peterborough footprint.

The responsibilities of the FPPG are as follows:

- To ensure that proposals are affordable, efficient, and represent value for money;
- To ensure that investments reduce health inequalities;
- To ensure that financial incentives are aligned around minimising system costs; and
- To ensure that patient benefit is maximised.

4. Investment Committee (IC)

Organisations from across the system have agreed to work together, taking joint responsibility for improving the population's health and wellbeing within a defined financial envelope. In order to deliver this aim, a number of organisations in the system have committed to the creation and funding of an investment pot to fund some of the initiatives necessary to deliver the required change. The main purpose of the Investment Committee is to assess and evaluate Business Cases submitted for funding from this investment pot and, where supported, to recommend to the HCE for approval.

5. Delivery Groups

The structure includes the following Delivery Groups:

- Primary Care & Integrated Neighbourhoods;
- Urgent and Emergency Care;
- Planned Care;
- Children, Young People & Maternity;
- Shared Services;
- Digital; and
- Local Workforce Advisory Board

The role of the Delivery Groups is to contribute to the overall delivery of *Fit for the Future* objectives by ensuring that the quality improvements and financial opportunities identified are realised. In particular, the delivery groups will be responsible for ensuring implementation (including savings realisation) of design projects, and delivery projects where implementation needs to happen consistently across the system.

6. Local Workforce Advisory Board (LWAB)

Critical to the successful delivery of *Fit for the Future* is the creation of an enabling workforce strategy for health and care. The Cambridgeshire and Peterborough Local Workforce Advisory Board (LWAB) has been established to create this strategy which will align and develop the local workforce to meet the priorities set out in *Fit for the Future*. The LWAB brings together health and care organisations and key stakeholders across a broad range of workforce issues, current and future, and its purpose is to ensure that the people elements of the 5 year service strategy can be identified and delivered.

7. Area Executive Partnerships (AEP)

Three Area Executive Partnerships have been established around the following areas: (1) Cambridge and Ely, (2) Huntingdon and Fenland and (3) Greater Peterborough. Their role is to contribute to the overall delivery of *Fit for the Future* objectives by providing strategic advice and local knowledge and expertise to the Delivery Groups within the structure. They have a key role to play in ensuring that the local context is factored into project design as well as a role to assist delivery by providing links to local groups, unblocking any issues related to the local context and helping the Delivery Groups to address local barriers to change. ***[It should be noted that the role of AEPs and how they relate to District Council Local Health Partnerships has been reviewed to ensure that work is aligned and not duplicated]***

Each Area Executive Partnership:

- works with local communities (residents, patient groups, voluntary sector) and staff (primary care, NHS and local authorities) and develops an understanding of how to build capacity for proactively keeping people independent, well, and at home;
- provides a vehicle for strong and visible front-line clinical leadership and resident/ patient involvement; and
- promotes a culture of continuous quality improvement.

8. A&E Delivery Boards

Each A&E Delivery Board's main purpose is to:

- ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds);
- provide a vehicle for strong and visible front-line clinical leadership and resident/ patient involvement; and
- promote a culture of continuous quality improvement

The A&E Delivery Boards are expected to oversee improvement projects that require locality tailoring for successful implementation. The over-arching guiding principle is that 'the same things are done differently' rather than 'different things are done' across Cambridgeshire and Peterborough.

Cambridgeshire and Peterborough Clinical Commissioning Group

Agenda Item No: 11

GP Out of Hours Base Relocation from Chesterton Medical Centre (CMC) to Addenbrooke's Clinic 9

Briefing update for Cambridgeshire Health Committee

Attachments:

A. Standard Operating Procedures (SOPs), including exclusion criteria
B. Pharmacy location in relation to Addenbrooke's

1. Background

In March 2017 the CCG consulted on this GP Out of Hours (OOH) base move with feedback and recommendations being presented back to the Health Committee on 16 March 2017.

After discussion of the feedback the Committee requested that the CCG provides the Committee with regular updates that address the issues being raised. For the July meeting, the Committee has asked for feedback on the following points:

- Position with pharmacy provision at Addenbrooke's
- 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

Two members of the Health Committee (Cllr Marjorie Abbott (East Chesterton, Cambridge City Council) and Cllr Sue Ellington (Swavesey, South Cambs District Council)) are contributing members of the weekly Project Delivery Group (PDG) and the Project Steering Group (PSG) meetings.

1.1. Project Current Status

The move to Addenbrooke's Clinic 9 has required some refurbishment works to be undertaken prior to occupation by Herts Urgent Care (HUC). In the process of carrying out these works asbestos was found within the ceiling cladding. This has caused a delay and the following dates have been agreed:

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

2. Pharmacy provision at Addenbrooke's

One of the discussed potential benefits of moving the Cambridge GP Out of Hours base to Addenbrooke's was associated with local pharmacy provision.

Addenbrooke's has a commercial Lloyds Pharmacy on site and adjacent to Clinic 9, however opening times are not in line with the OOH service and this branch of Lloyds does not offer a prescription (FP10) service.

Due to current legalities and the requirement of applying for additional licenses, following go live the GP OOH service will continue to offer FP10s as Chesterton currently does.

For example, if a prescription is required the patient will be issued with enough analgesics (pain relief) or other medication to see them through the night or the weekend by the OOH service (with the exception of antibiotics where a prescription would be issued for a full course). A prescription for the remainder of the medication required can be given by the OOH provider for the patient to fulfil at their local pharmacy of their choice the next day.

There are pharmacies located in close proximity to the Addenbrooke's site which offer extended hours. The OOH service will produce a list of these pharmacies so that patients are aware of opening times and are able to choose where they have their medication dispensed.

We are working towards finding solutions to support the 'one stop shop' concept and a pharmacy sub group has been established to ensure we can deliver this service in the future.

3. Access arrangements for patients who do not have an appointment

The GP OOH service will continue to be an appointment only service accessed by calling NHS 111; they will **not** be able to offer a walk in service. On the rare occasion a patient turns up at the OOH base without an appointment to see the GP they will be redirected to the Emergency Department, for clinical and safety reasons they will be assessment by the streaming nurse and directed appropriately to the right place.

If the patient presented to the OOH base with a life threatening or emergency condition, support will be requested from the hospital's emergency response team. This process has been put in place to ensure the any patients attending the Addenbrooke's site receive the safest and most effective pathway.

4. GP streaming service of patients from Emergency Department (ED)

The key role of the Project Delivery Group has been to agree the clinical criteria and pathway for streaming to enable patients presenting at ED with primary care related conditions to be assessed and streamed to the GP-led service without delay. The clinician will direct the patients using streaming criteria.

There is capacity to stream up to 70 patients per day, which is approximately 25% of all daily ED attends. Detailed activity analysis has been undertaken to ensure that sufficient clinical capacity is available to meet the assumed demand, standard operating procedures are in place to ensure a safe, quality service is maintained (see attachment A).

5. GP recruitment and session cover for ED and OOH

HUC has been running the Cambridgeshire and Peterborough Integrated Urgent Care (IUC) service since October 2016, including the provision of GPs to work within the streaming service at the Addenbrooke's ED.

Shift fill is monitored daily and mitigations put in place where gaps in the rota exist.

Whilst still variable shift fill at Chesterton (OOH) at 80.39% and the Addenbrooke's ED (GP streaming) is approx. 64.41% for June 2017.

Shift fill is improving slowly, however there are some significant challenges in attracting GPs to work in the OOH and GP streaming services. The move to Clinic 9 will see the amalgamation of both services onto a single site, but there is an issue of indemnity to be resolved.

Currently GPs working in OOH have to pay up to £7k per annum for indemnity cover. The issue has been raised with NHS England which is reviewing its policy.

Whilst OOH sessions are both flexible and offer attractive remuneration, the take up is variable. The CCG and HUC are looking into a number of different approaches to increase shift fill such as:

- Salaried OOH GP model
- Use of Advanced Nurse Practitioners
- Looking nationally to find resolution to secure indemnity for our GPs
- Flexible packages/incentive schemes
- Extensive engagement with local GPs

6. Summary and recommendations

In summary, the discovery of non-encapsulated asbestos at Clinic 9 has caused the launch of the service to be delayed by three months. Whilst disappointing this has allowed further planning and GP engagement to take place to ensure the best possible chance of success when the service goes live in August 2017.

Following its launch, the service will be monitored closely against a range of metrics. Joint clinical governance arrangements are in place between HUC and Addenbrooke's to ensure a safe, quality service is maintained. The steering group will continue to support and monitor the service development. We would be happy to return in a few months' time and report on the first three months of performance and patient experience data.

Produced by

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June 2017

Standard Operating Procedure for the Urgent Treatment Centre (UTC) Support to ED

Key messages

- Roles and responsibilities
- Acceptance criteria and referral process
- UTC pathway
- Management of clinical deterioration and escalation process

Summary

The Urgent Treatment Centre is a GP led service based in clinic 9 7 days per week. The service supports patients to be seen by the clinician most appropriate to their presenting condition.

The designated service operates 08:00 – 23:00 seven days per week including bank holidays.

1 Scope

The Urgent Treatment service is a co-located provision offering the Out of Hours GP service and a GP led Primary care service. This Standard Operating Procedure covers the GP led Primary care service only. The Out of Hours provision is managed by Herts Urgent care and is delivered under a separate policy.
All patients meeting the agreed acceptance criteria.
SOP applies to CUH staff and HUC teams providing the Urgent Treatment Centre service.

2 Purpose

To provide an overview of the operational functioning of the Primary care streaming delivered in the Urgent Treatment Centre

3 Definitions

UTC	Urgent Treatment Centre
OoH	Out of Hours
GP	General Practitioner
ANP	Advanced Nurse Practitioner
ED	Emergency Department

CUH	Cambridge University Hospitals
HUC	Herts Urgent Care
CCG	Clinical Commissioning Group

4 Introduction

Facilities

- The service operates from Outpatient clinic 9
- Outpatient clinic 9 has seven consulting rooms, a reception, waiting area complying with out of hours standards, a store room and a telephone triage office.
- The CUH campus also offers:
  - Childcare facilities
  - Leisure and Fitness Facilities
  - Food and Drink Facilities 24hrs a day
  - Very good bus links, with the site having a main bus station
  - Staff parking at a fixed price per 24hr period

Opening Hours

The designated service operates 08:00 – 23:00 seven days per week including bank holidays.

5 Responsibilities

UTC Clinician

- The UTC clinician is responsible for patient care from arrival via ED triage/streaming to discharge, where appropriate this will include prescribing TTO medications. They are responsible for referring patients to the respective specialty teams when clinical need arises or is indicated.

Specifically UTC clinicians will

- Work as a primary care clinician
  - Accept undifferentiated patients of all ages streamed by the Front Door Triage team based in the ED, whose condition is either primary care or does not warrant ED attendance.
  - See and independently manage the patient – should patient need to be seen by a specialty they will be referred directly as would be the case when working in a GP surgery.

  - To not order diagnostics (other than obs and urinalysis) or imaging as this moves away from premise of working as a primary care clinician.
- Ensure that all patients and attendance details are recorded onto SystmOne. Reasons for patient attendance and any discharge summaries, child safeguarding screening, should be completed on SystmOne.
- Ensure patients are seen in time order, except where clinical need indicates otherwise and operate within the four hour ED standard.

UTC receptionist (Herts Urgent Care)

- Welcome patients when they arrive at the UTC
- Monitor the GP Care trackboard of EPIC, if a patient hasn't arrived at UTC after 15 minutes of being allocated on the screen then immediately escalate to the 219 Bleep holder (1560219) to ensure that a welfare check can be made.
- Transfer patient details from EPIC and register patient onto SystmOne
- Book patient onto next available allocated streaming appointment slot
- Provide administrative support to GP/ANP if required
- When confirmed via the GP/ANP that the patient can be discharged, then to discharge the patient from EPIC within real time
- To summon security assistance either by phone (3333) or panic alarm
- To offer a parking stamp to the patient using an Addenbrookes car park.
- To contact 219 bleep holder (1560219) to escalate if any patients referred by ED are at 1.5 hours from arrival and have not been seen by a clinician.
- If patient has an onward referral to a speciality, print a copy of the consultation, allocate to speciality stream on EPIC and redirect patient back to the ED

ED 219 bleep holder (nurse in charge) (supported by Patient Flow Navigators and Senior Support)

- Maintain oversight of current waiting time in urgent treatment centre to ensure four hour standard is met, if waiting times become extended
  - to link with the UTC team to ensure ED streamed patients are being appropriately prioritised and seen within the agreed time frame of 1 hour
  - to restrict streaming levels if appropriate, taking into account ED pressures
- To respond to all 2222 emergency calls within urgent treatment centre and to arrange for patient transfer to resus if required.
- To respond to any fire calls to urgent treatment centre (clinic 9) and take on the role of nurse in charge of area and liaise with the fire response team

Streaming Nurse/Clinician (Front Door Triage Team)

- To work within their own organisations policies and procedures, and professions code of conduct

- Service provided through partnership working between ED and HUC staff
- To apply the streaming guidance developed for the UTC to identify patients suitable to be seen in the UTC (Appendix 2 Adults & Appendix 3 Paeds)
- To explain to patients that their emergency pathway means they are being streamed to the UTC based on their presenting condition and provide directions to the UTC
- To register the patient onto EPIC and provide a brief single note and to change speciality on EPIC to GP Care
- To provide guidance following a secondary triage of the patients, whereby the obs and ECGs are within normal limits and whether the individual is suitable to be streamed to the UTC
- To provide patient education regarding choosing the most appropriate source of healthcare
- Where suitable, and within competence, to direct patients to other sources of healthcare such as pharmacies or to provide self-care advice and discharge patients and document on EPIC.

Clinical Responsibility

Clinical responsibility for each patient is with CUH from presentation at the ED front door, until booking in to the UTC at clinic 9.

Clinical responsibility for each patient is with the UTC from booking in at clinic 9 and following discharge.

Clinical responsibility for patients referred back to CUH from UTC remains with UTC, until they are reassigned back into ED by the front door team.

Indemnity

Through honorary contracts CUH provides indemnity, under its NHSLA, for all clinicians working in UTC when seeing patients streamed from ED until point of discharge. Indemnity for patients booked through 111 or any other service is the responsibility of HUC or individual clinicians.

6 Acceptance Criteria and Referral Process

6.1 Patients suitable for UTC

- UTC clinicians will accept undifferentiated patients of all ages streamed by the front door triage team whose condition is either primary care or does not warrant ED attendance

- Patients presenting condition meets the agreed criteria (Appendix 2 Adults & Appendix 3 Paeds) or following a discussion with the UTC practitioner
- Following secondary triage and the observations and ECG are within normal limits, the patient is reassessed and meets the criteria
- Outside of the streaming criteria, the Streaming Clinician has used their professional judgement and feels that the most appropriate place to see the patient is within the UTC Clinic 9

Front door assessment team / streaming nurse/clinician

- Make an initial assessment if the patient is suitable for UTC referral (Appendix 2 Adults & Appendix 3 Paeds)
- Change speciality within EPIC to GP and care area allocation to minors
- Document on EPIC rational for referral to UTC

Patients not suitable for UTC

- Patients who have been referred directly by a primary care clinician to ED or a specialty team
- Patients requiring x-rays
- Patients requiring more than oral analgesia on arrival
- Specific exclusions are also noted in the criteria in appendix 2 and 3

6.2 Onward referral

Should the UTC clinician wish to refer the patient to another team this should be done directly by bleeping the relevant team.

Contact can be made with the relevant specialty by calling the GP Liaison Sisters weekdays 08.30 – 19.00: bleep 156-0449 via the GP switchboard 01223 216151.

Outside these hours bleep the specialty SpR on-call via GP switchboard

Should a team request the UTC clinician undertake tests or place orders this should be declined as this is not within the remit of the UTC clinician.

The patient is given a print out of the consultation from SystmOne, the UTC receptionists changes the speciality stream on EPIC and redirects the patient back to the ED.

The patient remains within their original 4 hour time frame

6.3 Self presenters to the UTC

For those patients who self present to the UTC without a 111 or an ED referral and are not clinically compromised they should be directed to the ED for assessment by the front door team and referred onto either the ED or into the primary care stream and redirected back to the UTC

7 UTC Patient Pathway 08:00 – 23:00

The clinical pathway is shown as a flow chart in appendix 1. For clarity the CUHFT responsibilities are in the red boxes and the UTC responsibilities are shown in the blue boxes. The purple box is an UTC responsibility on behalf of CUH.

The designated service operates 08:00 – 23:00 seven days per week including bank holidays.

- The UTC will be staffed from 08:00. At 08:00 the ED front door team will review patients who have been in the department for under an hour and currently waiting to be seen by a clinician. If patients meet the criteria, they can following discussion be streamed over to the UTC. Patients will not be held in the ED waiting room in preparation for the service to open. Streaming to the service will cease at 22:00 however following communication between the ED and the UTC, if there are no patients waiting to be seen, streaming can continue, ensuring the last patient is seen and discharged by 23:00
- Patient arrives at ED and is greeted by the front door triage team who enter the patient on the CUH IT system EPIC (this initiates the clock start time of the 4 hour performance indicator), the patient is assessed according the streaming guide (appendix 2 & 3)
- Following assessment, patients are either streamed to the Emergency Department or to the UTC. Those streamed to the UTC are allocated to GP Care on EPIC and redirected to clinic 9 where they will be met by the UTC receptionist who will allocate the patient to the next available (ring fenced ED streaming appointment) and enter the patient's details onto SystmOne.
- Through commissioning and activity modelling HUC will ensure there are sufficient ring fenced ED streaming slots to deal with the anticipated hourly flows from ED. It is expected that patients will be offered an appointment within one hour of attending the service following redirection, inline with CUH internal professional standards and the national ED indicators.
- Patients will be seen by the UTC clinician and the clinical contact and closure information will be recorded on SystmOne
- Patients seen, treated and completed within the UTC will be closed on SystmOne by the UTC clinician. The UTC receptionist will monitor ED streamed cases and once closed by the clinician will need to discharge the

patient on the CUH EPIC System in real time, this initiates the clock stop time and is measured against the national 4 hour standard

- For those patients who require an ongoing referral the UTC clinician needs to contact the relevant specialty by calling the GP Liaison Sisters weekdays 08.30 – 19.00: bleep 156-0449 via the GP switchboard 01223 216151. Outside these hours bleep the specialty SpR on-call via GP switchboard. The patient is then redirected back to the ED and remains within their 4 hour target.
- If patients have been directed into the ED stream and following secondary triage the observations and ECG are within normal limits, the patient is reassessed and meets the criteria they can be streamed to the UTC.

All patients seen in the UTC service will have their contact and treatment passed onto their registered GP by 8am following morning, the contact will be passed using ITK messaging on SystmOne.

ED notifications will need to be recorded streamed to UTC as the clinical details will be in the ITK message to the registered GP.

8 Clinical Deterioration and Escalation Process

In the event of sudden clinical deterioration or UTC clinicians are instinctively concerned:

Instruct receptionist to place 2222 call stating either Adult, Paediatric or Obstetric Cardiac Arrest (as appropriate) and giving location as "clinic 9 outpatients, level 2". The CUH cardiac arrest team will respond together with the senior nurse in charge of ED. In addition a hospital resuscitation equipment trolley will arrive to support the cardiac arrest team.

If the UTC clinician has any clinical concerns, that do not present an immediate risk of deterioration, they should first be directed to the relevant on call specialist contactable via the switchboard or rotawatch. It is likely to be safer in the first instance to make arrangements for the patient to be returned to ED and the referral made as a secondary consideration. In such instances the ED portering team will assist with the physical transfer of patients.

The Emergency Physician In Charge of ED remains contactable for support at all times (bleep 156-2226) as does the Nurse in charge of ED (bleep 156-0219)

Emergency resuscitation equipment provided in the UTC will be an AED, emergency box and portable oxygen and suction. The emergency box will have similar contents to the emergency boxes that are provided on the CUH site. HUC have responsibility for ensuring this equipment is checked and maintained in line with the appropriate standards and the equipment will be supplied and managed by HUC.

9 Pathway/Capacity escalation

As part of the development of the UTC extensive modelling was completed to model capacity requirements, the CCG has commissioned HUC to provide sufficient ring fenced slots for ED streamed patients.

It is however recognised by both HUC and CUH that extended waits to be seen in the UTC do not support a good patient experience and both HUC and CUH are committed to ensuring that the four hour standard is delivered. The following escalation steps support this

Issue	Action
Absence of streaming nurse/practitioner provided by HUC	ED front door assessment team to stream patients within their competency levels
Shortage of UTC clinicians	ED NIC and CUH operational matron to be notified, streaming volumes to be restricted to ensure operational performance standard of 1 hour to see a UTC clinician is met CUH Operational Matron to notify CUH Duty Director/oncall director. CUH director escalates to HUC senior management and CCG Director on call. *NB Inability to deliver any UTC service for streamed patients would be regarded as a service closure and an SI*

Waiting time in UTC for streamed patients (as monitored by HUC reception team) reaches 2 hours.	UTC receptionist notifies ED NIC, streaming ceased/restricted for 1 hour. UTC receptionist completes incident form.

ED NIC, ED patient flow navigators and ED consultant in charge will proactively monitor the waiting times in the UTC for streamed patients through epic as part of their normal oversight of ED.

Monitoring and escalation of non ED streamed patient's capacity and waiting times is covered by HUC normal operating procedures and not this document.

10 Staffing model

The staffing levels for the UTC are the responsibility of HUC and will be flexible to ensure capacity meets demand.

Reception cover will be from 08:00 – 23:00

A GP will be present from 08:00 – 23:00

Supported by an ANP 18:00 – 23:00 (Mon-fri)
10:00 – 18:00 (sat – sun)

A streaming HUC clinician will support the ED front door team from 10:00 – 22:00 seven days a week to meet peak levels of activity.

Outside of the times where a streaming nurse/clinician is provided by HUC the ED front door assessment team will undertake streaming to the UTC.

If there is not adequate staff to operate the service escalation via the agreed pathway needs to be followed.

11 Visitors

There are no visiting times in the clinic, it is expected most attendees will have friends or family who may accompany them to the service. Rules for numbers of families and friends will be as per wards no more than two at any time however this may be changed on a patients situation e.g. children. Monitoring of occupancy levels will be undertaken by the UTC receptionists and should it be deemed that the UTC has become crowded then those accompanying patients will be asked to wait in the main CUH concourse.

12 General

12.1 Drugs & Other Stock

The drug cupboards will be stocked via the UTC provider's pharmacist and other stock will also be supplied via the provider. CUH has no responsibility for medications of any type within the UTC. HUC has responsibility for ensuring appropriate medicines management systems are in place, this includes maintaining the security of medicines inline with all appropriate standards/requirements. HUC have responsibility for monitoring the temperature of any medication storage areas and escalating to the CUH estates (ext 2696) team if temperatures fall outside of acceptable ranges.

Stocking of equipment and consumables for the UTC is the responsibility of HUC.

During the hours of operation a hand written or printed FP10 prescription will be prepared and issued at the UTC by the Clinician. The patient or their carer / representative will be advised to take the prescription to a pharmacy to have it filled. Information on pharmacies with extended hours and opening times on bank holidays will be available.
Prescriptions cannot be faxed to pharmacists in C&P.

12.2 Cleaning

Overseen by CUH Medirest will provide cleaning and waste removal services from the UTC. Any concerns should be escalated in the first instance to the CUH helpdesk on ext 2696.

12.3 Catering

Arranged as part of the CUH campus wide contract vending machines will be in operation in the UTC waiting room. Any concerns should be escalated in the first instance to the CUH helpdesk on ext 2696.

12.4 Security

Access to clinic 9 will be restricted and HUC staff will be required to wear a Trust photo ID and access badge at all times whilst on the campus. A designated UTC security group has been created within the CUH access control system to provide UTC staff with access to the required areas.

The doors to the UTC will be open between the hours of 08:00 – 23:00, outside of these hours patients will be required to use the intercom and reception will release the doors to allow access.

If there are any concerns then entry should not be granted and security should be called for assistance.

CCTV is installed both inside and outside of the building and will be monitored by the onsite CUH security team

A panic alarm is installed in the reception area when once pressed alerts the security control room that will immediately send a response team to clinic 9 Emergency Security assistance can be summoned by

- dialling 3333
- pressing the reception panic alarm

For Non emergency security assistance dial 6606

12.5 Parking

There are 3 designated 'drop off no waiting bays' located outside of the UTC. Patients and visitors are required to park in car park 1 and will be charged the set outpatient rate. The car park ticket is required to be stamped by the UTC prior to the patient leaving the centre. Parking enforcement is in place 24/7.

Parking for HUC marked response vehicles is facilitated in car park H at the front of the campus with space outside the UTC for the vehicles when operational.

UTC staff parking is provided inline with the standard CUH Campus policies. Access is provided in line with these policies on return of the honorary contract from HUC to CUH and the issuing of a CUH ID card.

12.6 Patient Experience

Patients who have 'GP' as their treatment speciality within EPIC will be excluded from the CUH standard ED patient experience questionnaire. A joint patient experience survey will take place between CUH and HUC for patients streamed to the UTC, this will be administered by HUC will results discussed at the joint governance meetings between CUH and HUC.

13 Discharge

- Discharge will occur following completion of the patients consultation and discharged on Systmone
- E-discharge will be completed by the UTC Receptionist on EPIC
- The GP will receive one discharge summary which will be generated from Systmone only.

14 Applicable standards/KPI's

Performance Indicator	Target / Standard	Baseline position	Information Source / Evidence Base	Responsibility	Frequency of assessment
Number of occasions UTC pathway has to be ceased/reduced due to reduced capacity as a result of staffing levels being below commissioned levels NB full service closure would be regarded as an SI	Zero	Zero	Incident forms/rotas.	HUC	Monthly
Number of Patients seen by the Primary care clinician per hour as part of the UTC stream	4 per hour NB trajectory to be developed to support this	4 per hour	S1	HUC	Monthly
Number of patients returned to the ED stream following triage and initial review by Primary care Clinician	<5%	5%	S1	HUC	Monthly
Number of patients re-attending the ED following review and discharge by UTC with the same presenting condition within 7 days	<5%	<5%	EPIC data	CUH	Monthly
Time seen by the Primary care Clinician following initial Triage	<1 hour		S1	HUC	Monthly
Patient satisfaction response rate	40%		Patient survey	HUC	Monthly
Patient satisfaction – net promoter score	>75		Patient survey	HUC/CUH	Monthly
Number of complaints, incidents,	<5%	<5% of attends	HUC/CUHFT	HUC	Monthly
Number of SIs	<2%	Zero	HUC/CUH	HUC/CUH	Monthly

UTC four hourly performance (excluding those referred onto a speciality/back to ED within 2 hours of initial arrival)	100%	95%	EPIC data	HUC	Weekly
Left before being seen rate	<5%	<5%	EPIC data	HUC	Monthly

15 Clinical Goverance, Performance Monitoring and Service Development

A UTC monthly meeting will take place between CUH, HUC and the CCG. Administration support for this will be provided by the CCG. Both CUH and HUC will submit the necessary information, as outlined in the performance standards/KPIs, to the CCG 5 five days ahead of the meeting to enable collation of a joint performance report.

Membership of the monthly governance meeting will comprise

For CUH:

- ED Consultant
- ED Matron
- Operations Manager
- Deputy Operations Manager
- Divisional Quality Manager (as required)
- Pharmacist (as required)
- Paediatric ED Consultant (as required)

For HUC:

- Clinical Services Manager
- Associate Director of Quality
- IUC Service Manager
- UTC Administrator
- GP Clinical Lead

For CCG (Commissioner)

- Administration support
- GP Urgent care lead or representative
- Programme Manager

A quorum will be a minimum of three individuals, which must include one from each party with a minimum of one of the three being a registered health professional.

Monthly Governance Meeting Agenda

1. Governance/patient experience/quality
    a. Complaints/PALS
    b. Incidents/SIs
    c. Claims
    d. Risk register and risk assessments
2. Delivery / KPIs
    a. Activity levels
    b. Return to ED/referral rates
    c. 4 hour performance
    d. 1 hour to see decision maker performance
    e. Left before being seen rates
    f. Re-attendance within 24hour rate
    g. Service delivery issues including reduced shift coverage
3. Workforce
    a. Shift cover levels
    b. Turnover/vacancy levels
4. Nursing
    a. Infection control/cleaning check results
    b. Patient experience including national friends and family test results
5. Pathway development/service development opportunities

Each party will ensure that this meeting is incorporated into their own organisations governance structures and that minutes, produced by the CCG, are retained for a minimum of five years.

For any Serious incidents which occurs, following discussion between HUC and CUH operational and clinical team an investigating officer will be appointed. The incident will need to be reported to the CCG Clinical lead within the next working day and the SI guidance followed.

16 Monitoring compliance with and the effectiveness of this document

- Review of incident forms, as recorded on QSIS, for non-compliance and the results presented to the Patient Safety & Governance group and

relevant Standards Setting Group - the minutes of these meeting are retained for a minimum of 5 years.

17 References

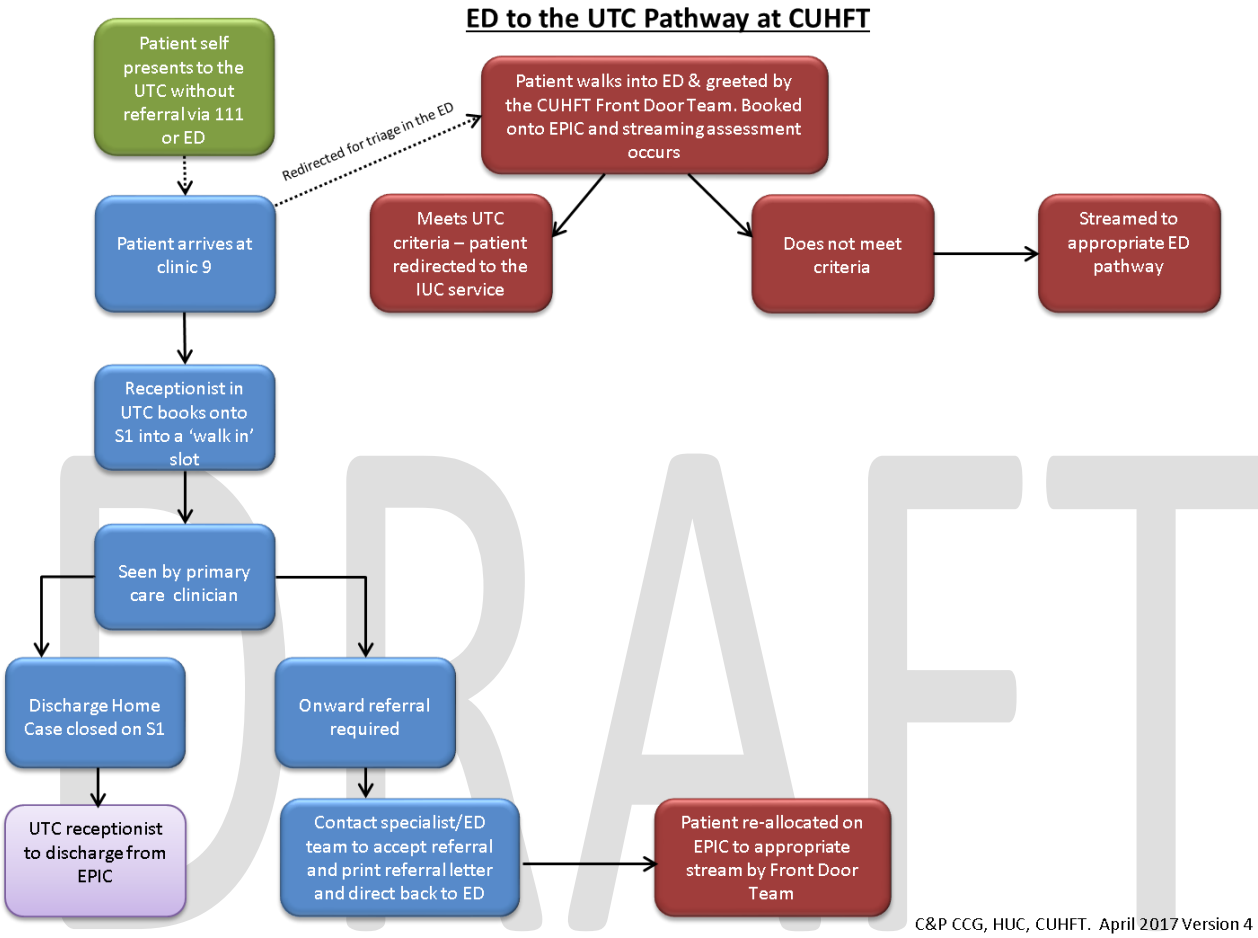
This policy has been established with references to the following national guidance

Primary Care Practice in Emergency Departments, Feb 2015, NHS ECIP
Primary care streaming: Roll out to September 2017, March 2017, NHS England
Walk-In Procedure 1, HUC

18 Contact Details

ED Nurse in Charge Bleep 1560219
ED consultant Bleep 1562226
UTC base TBC
HUC shift manager 01733 424082 / 08445605040 (2)
Security Emergency 3333
Security Non Emergency 6606
CUH Estates/Facilities Helpdesk 2696
CUH IT Helpdesk 2757
Clinical emergency 2222
CUH GP Switchboard 01223 216151
CUH Operational Matron Bleep 1560707
CUH Oncall manager via CUH Switchboard
HUC Oncall manager via IUC Shift Manager
CUH Shift Facilities Manager Bleep 1560697
ED Reception 3118/3062
ED Paediatrics 6028/6841/6842
ED Resus 3114/4635
ED Majors 3061/3896
ED Minors 3119/6843

Appendix 1 UTC Pathway 08:00 – 23:00



Appendix 2 Streaming Criteria – Adults

Criteria as agreed June 2017

Urgent Treatment Centre criteria for ED walk in patients

The Following System-based list of presentations applies to patients of all ages, but special consideration should be given to infants and young children

Type of injury	Exclusion criteria
Abdomen, chest, pelvis or genitalia	Major injuries
Bites and stings	Associated anaphylaxis (even if resolved prior to presentation) Airway involvement Human Bites
Burns	>3% body surface area Electrical or inhalational eg smoke Involving mouth, perineum, SIGNIFICANT palm or palmar aspects of digits Full circumference of a limb Requiring plastic surgery input owing to depth, site or size
Ear	Involving cartilage or eardrum Associated with foreign body
Eye	Penetration of globe and / or blood in anterior chamber Involvement of eyelid margin or tear drainage system Foreign body or suspected foreign body
Face	Uncontrolled epistaxis Any laceration with cosmetic consequences or that requires suturing
Foreign bodies	Foreign body in the airway or rectum Suspected but non-visible foreign body in a deep or penetrating wound Foreign body in a wound overlying important anatomical structures
Head	Intoxicated Confusion 2 or more episodes of vomiting On Anti-coagulants
Limbs	Suspected fracture and / or dislocation Neurovascular deficit Deformity Severe or apparently disproportionate pain or tenderness
Neck	Off-road vehicle incident, motorised or otherwise Axial direction of force
Wounds	Penetrating or deep injuries Severe crush injuries Suspected or actual tendon or nerve injuries Any wound requiring suturing Other wounds requiring surgical intervention, eg post-op dehiscence

Type of illness	Exclusion criteria
Respiratory	Severe respiratory distress and / or stridor Cyanosis Heavy haemoptysis
ENT	Uncontrolled epistaxis currently bleeding Foreign body Airway obstruction (stridor, choking)
Dental	Uncontrolled bleeding after extraction
Ophthalmological	Suspected foreign body, corneal abrasion Red eye with pain or altered vision
Cardiovascular	Chest pain with cardiac history Cardiac sounding chest pain in the >25yrs Current palpitations Suspected PE / DVT
Gastrointestinal	Haematemesis Dehydration requiring IV fluids Swallowed high risk foreign body abdominal pain in the >70yr
Genito-urinary	Priapism Sexual assault
Gynaecological	>16 weeks pregnant with bleeding Severe pelvic pain Suspected labour
Dermatological	Anaphylaxis Suspected meningococcal rash
Neurological	Sudden onset headache Suspected stroke or TIA Currently fitting or 1st fit.
Musculoskeletal	
Mental Health– follow existing ED Pathway - 111	Overdose / Significant self harm Acute Psychosis Suicide plan

General exclusions: Any patients who are intoxicated or displaying behavioural problems.
Patients with communication difficulties to the extent that streaming would be unsafe.

HUC

Appendix 3 Streaming Criteria Paediatric

Criteria as agreed June 2017

STREAMING GUIDE FOR CHILDREN (AGE 0-15 YEARS) TO THE UTC

The following children are **NOT** suitable to be streamed to the Primary care service.

All infants under 3 months with a current temp of 38C or above
Children who have been seen by a GP and referred to ED or specialty
Children with injuries where there are current safeguarding concerns
Clinical suspicion of meningitis or meningococcal septicaemia
Any child who is likely to need x ray
Limping children
Under 1's with a head injury and older children fulfilling NICE CG 176 criteria (see over)
Any child in the red zone on the NICE traffic light assessment
Children presenting with a mental health problem

NICE TRAFFIC LIGHT ASSESSMENT

	Green – low risk	Amber – intermediate risk	Red – high risk
Colour (of skin, lips or tongue)	• Normal colour	• Pallor reported by parent/carer	• Pale/mottled/ashen/blue
Activity	• Responds normally to social cues • Content/smiles • Stays awake or awakens quickly • Strong normal cry/not crying	• Not responding normally to social cues • No smile • Wakes only with prolonged stimulation • Decreased activity	• No response to social cues • Appears ill to a healthcare professional • Does not wake or if roused does not stay awake • Weak, high-pitched or continuous cry
Respiratory		• Nasal flaring • Tachypnoea: RR > 50 breaths/minute, age 6–12 months RR > 40 breaths/minute, age > 12 months • Oxygen saturation ≤ 95% in air • Crackles in the chest	• Grunting • Tachypnoea: RR > 60 breaths/minute • Moderate or severe chest indrawing
Circulation and hydration	• Normal skin and eyes • Moist mucous membranes	• Tachycardia: > 160 beats/minute, age < 1 year > 150 beats/minute, age 1–2 years > 140 beats/minute, age 2–5 years • CRT ≥ 3 seconds • Dry mucous membranes • Poor feeding in infants • Reduced urine output	• Reduced skin turgor
Other	• None of the amber or red symptoms or signs	• Age 3–6 months, temperature ≥ 39°C • Fever for ≥ 5 days • Rigors • Swelling of a limb or joint • Non-weight bearing limb/not using an extremity	• Age < 3 months, temperature ≥ 38°C • Non-blanching rash • Bulging fontanelle • Neck stiffness • Status epilepticus • Focal neurological signs • Focal seizures

Equality and diversity statement

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Issue	**Author(s)**	**Owner**	**Date**	**Circulation**	**Comments**
Draft 1	Andy Bailey	Emergency Department	24/03/17	Herts Urgent Care, CCG and CUH	Further updates required
Draft 2	Input from DM				References added
Draft 2.1	Clare Hawkins		06/04/17	Herts Urgent Care, CCG and CUH	Questions added and draft distributed to operational group for comment
Draft 2.2	Clare Hawkins		13/04/17	Herts Urgent Care, CCG and CUH	Updated with Vaz Ahmed, Alex Manning and Emma Downey's comments
Draft 2.3	Clare Hawkins		19/04/17	Herts Urgent Care, CCG and CUH	Updates following liz Robinsons review
Draft 2.4	Clare Hawkins		03/05/17	Herts Urgent Care, CCG and CUH	Updates following review from pharmacy, David Monk & security
Draft 2.5	David Monk		11/05/17	Herts Urgent Care, CCG and CUH	Updated governance, escalation and standardisation throughout document
Draft 3	David Monk		15/05/17	Herts Urgent Care, CCG and CUH	Full review with CUH and HUC
Draft 4	Clare Hawkins		24/05/17	Herts Urgent Care, CCG and CUH	Reviewed following decision on change of operational hours
Draft 5	Clare Hawkins		26/05/17	Herts Urgent Care, CCG and CUH	Revised following agreement on self presenters and 23:00 – 08:00 pathway
Draft 6	Clare Hawkins		14/06/17	Herts Urgent Care, CCG and CUH	Final Draft to be submitted for agreement

The table below will be completed by the Trust Documents Team:

Approval:			
Owning department:			
Author(s):			
File name:			
Supersedes:			
Version number:		Review date:	
Local reference:		Media ID:	

Reviewed: 12 July 2017

PHARMACY NAME	ADDRESS
Bottisham Pharmacy	8 High Street Bottisham Cambridgeshire CB25 9DQ
Asda	Beehive Centre Coldhams Lane Cambridge CB1 3ER
Bassingbourn Pharmacy	24 High Street Bassingbourn Royston Cambridgeshire SG8 5NE
Boots the Chemist Ltd	Unit 3, Cambridge Retail Park Newmarket Road Cambridge CB5 8WR
Boots the Chemist Ltd	Unit 1 39A High Street Cherry Hinton Cambridge CB1 9HX
Boots the Chemist Ltd	25 High Street Sawston Cambridgeshire CB22 3BG
Boots the Chemist Ltd	37 Woollards Lane Great Shelford Cambridgeshire CB22 5LZ
Boots The Chemists Ltd	5-6 Grafton Centre Cambridge CB1 1PS
Boots The Chemists Ltd	28 Petty Cury Cambridge CB2 3ND
Boots UK Ltd	237 Cherry Hinton Road Cambridge CB1 7DA
Boots UK Ltd	68 Chesterton Road Cambridge CB4 1EP
Ditton Pharmacy	37 Ditton Lane Cambridge CB5 8SR
Gamlingay Pharmacy Ltd	37 Church Street Gamlingay Sandy Bedfordshire SG19 3JH
GFT Davies & Co.	50 Hills Road Cambridge CB2 1LA
JT Gregory Pharmacy & Opticians	54 High Street Trumpington Cambridge CB2 9LS

Kays Chemist Ltd	39 Wulfstan Court Wulstan Way Cambridge CB1 8RE
Kumar Chemists	15 Rectory Terrace High Street Cherry Hinton Cambridge CB1 9HU
Lloyds Pharmacy	45 -47 Arbury Court Alexwood Road Cambridge CB4 2JQ
Lloyds Pharmacy	Nuffield Medical Centre Nuffield Road Cambridge CB4 1GL
Fitzwilliam Pharmacy	30 Trumpington Street Cambridge CB2 1QZ
Lloyds Pharmacy	9 High Street Great Cambourne Cambridge CB23 6JX
Milton Road Pharmacy	123 Milton Rd Cambridge CB4 1XE
N K Jank (Chemist)	32A Eltisley Avenue Newnham Cambridge CB3 9JG
Well Pharmacy	115 Station Road Impington Cambridge CB24 9NP
Well Pharmacy	71 High Street Melbourn Royston SG8 6DU
Well Pharmacy	Unity House 183 Mill Road Cambridge CB1 3AN
Well Pharmacy	1 Station Road Histon Cambridge CB24 9LQ
Well Pharmacy	222 High Street Cottenham Cambridgeshire CB24 8RZ
Well Pharmacy	York Street Health Centre 144 York Street Cambridge CB1 2PY
Well Pharmacy	17 Barnwell Road Cambridge CB5 8RG

Numark Pharmacy (100 hrs)	2 Adkins Corner Perne Road Cambridge CB1 3RU
Over Healthcare Limited	1 Drings Close Over Cambridge CB24 5NZ
Petersfield Pharmacy	56 Mill Road Cambridge CB1 2AS
Rowlands Pharmacy	189 Histon Road Cambridge CB4 3HL
Sawston Partnership Ltd (Answerphone message advising Pharmacist busy, try again later - unable to speak to anyone)	Sawston Medical Centre London Road Sawston Cambridge CB22 3HU
Superdrug Pharmacy	59 Sidney Street Cambridge CB2 3HX
Superdrug Pharmacy	38 Fitzroy Street Cambridge CB1 1ER
Lloyds Pharmacy (Sainsbury's) (100 hrs)	Brooks Road Cambridge CB1 3HP
Tesco Instore Pharmacy (100 hrs)	Tesco Superstore Yarrow Road Fulbourn Cambridgeshire CB1 9BF
Tesco Pharmacy	Tesco Extra 15- 18 Viking Way Bar Hill Cambridge CB23 8EL
Tesco Stores Ltd	In Store Pharmacy Cambridge Road Ind Est Milton Cambridge CB24 6AY
The Village Pharmacy (New Owner - Milz Pillz Ltd T/A The Village Pharmacy - from 1st May 2017)	2 High Street Fulbourn Cambridge CB21 5DH
Linton Pharmacy Ltd T/A Village Pharmacy	49 High Street Linton Cambridge CB21 4HS
Waterbeach Pharmacy	6 Chapel Street Waterbeach Cambridge CB25 9HR

Willingham Pharmacy	52 Long Lane Willingham Cambridge CB24 5LB
Prescription2you Homes Ltd T/A Prescription2you Homes (**Nothing listed on Internet - except for one in Clacton-on-Sea)**	50 Arbury Court Arbury Road Cambridge CB4 2JQ
One Click Pharmacy Ltd (**No longer Trading as of 31st January 2016 - taken from Internet, expalins why phone number no longer valid**)	53 Pembrook Avenue Denny End Industrial Estate Waterbeach Cambridge CB25 9QP
	Cannot Trace/Closed

TELEPHONE	FAX	OPENING HOURS	
01223 812321	01223 851210	Monday - Friday - 9:00am - 1.00pm & 2.00pm - 6:00pm Saturday - Closed	
01223 531610	01223 531611	Monday - Friday - 9:00am - 9:00pm Saturday - 9:00am - 9:00pm Sunday - 10:00am - 4:00pm	
01763 250660	01763 250660	Monday - 8:45am - 5:30pm Tuesday - 8:45am - 6:30pm Wednesday - Friday - 8:45am - 5:30pm Saturday - 9:00am - 12:00pm	
01223 357487	01223 319925	Monday - Friday - 9:00am - 1.00pm & 2.00pm - 12.00 Midnight Saturday - 9:00am - 1:00pm & 2.00pm - 12.00 Midnight Sunday - 10:00am - 4:00pm	**LATE TO MIDNIGHT**
01223 246535	01223 213919	Monday - Friday - 8:30am - 6:00pm Saturday - 9:00am - 5:30pm	
01223 832965	01223 832965	Monday - Friday - 8:30am - 6:00pm Saturday - 9:00am - 5:00pm	
01223 843262	01223 843262	Monday - Friday - 8:45am - 6:00pm Saturday - 9:00am - 4:00pm	
01223 302576	01223 304696	Monday - Tuesday - 8:30am - 6:00pm Wednesday - 8:30am - 8:00pm Thursday - Friday - 8:30am - 6:00pm Saturday - 8:30am - 6:00pm Sunday - 11:00am - 1.30pm & 2.00pm - 5:00pm	
01223 350213	01223 307165	Monday - Friday - 8:00am - 8:00pm Saturday - 8:00am - 8:00pm Sunday - 11:00am - 5:00pm	
01223 247567	01223 249598	Monday - Friday - 9:00am - 5:30pm Saturday - 9:00am - 4:00pm	
01223 355055	01223 355055	Monday - Friday - 9:00am - 1.00pm & 2.00pm - 6:00pm Saturday - 9:00am - 4:00pm	
01223 576384	01223 576384	Monday - Friday - 9:00am - 6:00pm (closed 1:00 - 2:00)	
01767 650334	01767 650334	Monday - Friday - 9:00am - 6:00pm Saturday - 9:00am - 1:00pm	
01223 352086	01223 352086	Monday - Friday - 9:00am - 12.00am & 2.00pm - 6:00pm Saturday - 9:00am - 1:00pm	
01223 841109	01223 841109	Monday - Friday - 9:00am - 6:00pm (closed 1:00 - 2:00) Saturday -9:00am - 1:00pm	

01223 242687	01223 242687	Monday - Tuesday - 9:00am - 6:00pm Wednesday - 9:00am - 5:30pm Thursday - Friday - 9:00am - 6:00pm Saturday - 9:00am - 1:00pm	
01223 410268	01223 517088	Monday - Friday 9:00am - 1.00pm & 2.00pm - 6:00pm Saturday - 9:00am - 5:00pm	
01223 351349	01223 305250	Monday - Friday - 9:00am - 12.00 & 2.30pm - 6:30pm Saturday - 9:00am - 5:00pm	
01223 425090	01223 425090	Monday - Friday 8:30am - 6:30pm	
01223 359449	01223 359449	Monday - Friday - 9:00am - 5.:30pm	
01954 718296	01954 718296	Monday - Thursday - 9:00am - 1.00pm & 3.00pm - 6:00pm Friday - 9:00am - 1.00pm & 2.00pm - 6:00pm Saturday - 9:00am - 1:00pm	
01223 353015	01223 307677	Monday - Friday - 9:00am - 5:30pm (closed 1:00 - 2:00) Saturday - 9:00am - 1:00pm	
01223 322473	01223 322473	Monday - Friday - 8:30 - 6:00pm Monday and Thursday closed for lunch 1:00 - 2:00 Saturday - 8:30am - 1:00pm	
01223 234754	01223 234754	Monday - Friday - 9:00am - 6:15pm (closed 1:00 - 2:00)	
01763 260221	01763 260221	Monday - Friday - 9:00am - 6:00pm Saturday - 9:00am - 1:00pm	
01223 210662	01223 210662	Monday - Firday - 9:00am - 6:00pm (closed 1:00 - 2:00) Saturday - 9:00am - 5:30pm	
01223 232672	01223 232672	Monday - Friday - 9:00am - 6:00pm (closed 1:00 - 2:00) Saturday - 9:00am - 1:00pm	
01954 250556	01954 250556	Monday - Friday - 9:00am - 6:00pm (closed 1:00 - 2:00) Saturday - 9:00am - 1:00pm	
01223 460977	01223 460977	Monday - Friday - 8:30am - 6:00pm (closed 1:00 - 2:00)	
01223 241176	01223 241176	Monday - Friday - 8:30am - 5:30pm (closed 1.00 - 2.00) Saturday - 8:30am - 6:00pm	

01223 517073	01223 517073	Monday - Friday - 7:00am - 11:00pm Saturday - 7:00am - 7:00pm Sunday - 9:00am - 5:00pm	**LATE UNTIL 11PM M-F (Kumar)**
01954 233457	01954 231573	Monday - Tuesday - 8:30am - 6:00pm (closed 1:00 - 2:00) Wednesday - 8:30am - 2:30pm Thursday - Friday - 8:30am - 6:00pm (closed 1:00 - 2:00)	
01223 354383	01223 354383	Monday - 9:00am - 8:00pm (Closed 1.00 - 2.00) Tuesday - Friday - 9:00am - 6:00pm (Closed 1.00 - 2.00)	
01223 368537	01223 300823	Monday - Friday - 9:00am - 6:00pm (closed 1:00 - 2:00) Saturday - 9:00am - 1:00pm	
01223 727555	01223 836096	Monday - 8:00am - 8:00pm (closed 1:00 - 2:00) Tuesday - Friday - 8:00am - 6:00pm (closed 1:00 - 2:00	
01223 353002	01223 353002	Monday - Friday - 8:30am - 6:00pm (closed 1.00 - 1.30 & 2.30 - 3.00) Saturday - 8:30am - 6:00pm	
01223 352917	01223 352917	Monday - Friday - 8:30am - 5:30pm (closed 1:00 - 2:00) Saturday - 9:00am - 5:30pm (closed 1.30pm - 2.00pm)	
01223 246838	01223 246838	Monday - Friday - 7:00am - 11:00pm Saturday - 7:00am - 10:00pm Sunday - 10:00am - 4:00pm	
03456 779287	01223 389607	Monday - 8:00 am - 10:30pm Tuesday - Friday - 6:30am - 10:30pm Saturday - 6:30am - 10:00pm Sunday - 10:00am - 4:00pm	
03456 779031	No Fax	Monday - Friday - 8:00am - 8:00pm Saturday - 8:00am - 8:00pm Sunday - 10:00am - 4:00pm	**LATE UNTIL 8PM M-F**
03456 779466	01223 389610	Monday - Friday - 8:00am - 8:00pm (Closed 1.00 - 2.00pm) Saturday - 8:00am - 8:00pm (Closed 1.00 - 2.00pm) Sunday - 10:00am - 4:00pm	**LATE UNTIL 8PM M-F**
01223 880744	01223 880744	Monday - Friday 9:00am - 6:00pm Saturday - 9:00am - 1:00pm	
01223 892018	01223 892018	Monday - Friday - 9:00am - 6:30pm (closed 1:00 - 2:15) Saturday - 9:00am - 1:00pm	
01223 564422	01223 564422	Monday - Friday - 9:00am - 5:30pm (closed 1:00 - 1:30) Saturday - 9:00am - 12:00pm	

01954 261787	None listed	Monday - 8:30am - 6:30pm (closed 1:00 - 2:30) Tuesday - 8:30am - 6:30pm (Closed 1:00 - 2:00) Wednesday - 8:30am - 7:00pm (Closed 1:00 - 2:00) Thursday - 8:30am - 1:00pm Friday - 8:30am - 6:30pm (Closed 1:00 - 2:00) Saturday - Closed Sunday - Closed	
01223 321234	01223 321234		
01223 862327	None listed		

Agenda Item No: 12

NORTHSTOWE HEALTHY NEW TOWN – COMMISSIONING PRIMARY CARE SERVICES

To:	**HEALTH COMMITTEE**
Meeting Date:	**20 July 2017**
From:	**Sue Watkinson, Director of Transformation and Delivery – Primary and Planned Care, Cambridgeshire and Peterborough CCG**
Forward Plan ref:	**Not applicable**
Purpose:	**In recognition of the development of the new town at Northstowe, this report to Health Committee is provided to update Members on the plans and engagement that are underway to secure primary care medical services for the emerging and anticipated population. Northstowe presents an opportunity to commission proactive and integrated services which reflect the needs of the population and the ambitions of the Healthy New Town programme.** **The report provides key background information, alignment with national programme, detail of current provision, commissioning challenges and opportunities (services and infrastructure), and key timeline information.**
Recommendation:	**The Committee is asked to note the progress to date and the key timescales to be achieved.**

	Officer contact:
Name:	Sue Watkinson
Post:	Director of Transformation and Delivery – Planned
Email:	and Primary Care
Tel:	Susan.watkinson@nhs.net
	07534 101165

1. BACKGROUND

1.1 Healthy New Towns Programme

The housing development at Northstowe was advanced for inclusion in the Healthy New Towns Programme by a partnership led by Cambridge University Hospitals NHS Foundation Trust, South Cambridgeshire District Council and the Homes and Communities Agency, the government's housing and regeneration body, as developer of Northstowe Phases 2 and 3 (7,500 homes). Phase 1, a development of 1,500 homes, where Gallagher is the master developer, is at a more advanced point in delivery and therefore outside of the Healthy New Towns programme.

From the outset the Northstowe bid identified the need for a clear understanding of the health and social care needs and preferences of our ageing population. Research into the future demand for specialist accommodation is key to understanding how new communities must respond to the changing demographic and facilitate more effective, community focused strategies for care and support, as envisaged by the CCG's Sustainability and Transformation Plan (STP).

In developing its STP, the CCG has recognised the need to exploit the benefits of new developments and has earmarked Northstowe as an opportunity to explore how to work differently to "prevent illness, build social resilience and empower people to self-care", by reinforcing active lifestyles and, potentially, introducing smart technologies.

1.2 Support from NHS England

As Northstowe is a designated Healthy New Town, local planning and commissioning from a health perspective, is supported by a programme of support provided by NHS England's national team. The programme recognises the crucial relationship between developer, planning authority and the various tiers of the health service in bringing about the sorts of improvements which can serve as a template for new development across the country. The local team, focussing on Northstowe, is able to contribute to and benefit from the experience in other areas of planning and commissioning for significant growth.

1.3 Opportunity for innovative approach

NHS England has recognised that new towns afford a valuable opportunity to both explore how best the built environment can contribute towards a shift to healthier lifestyles (through interventions which encourage active travel and positive community identity, for example) and how existing models of care may be reshaped in response to increasing demands on NHS services resulting from a population beset by lifestyle diseases and an increasingly elderly demographic, in the face of static or reducing budgets. Given the population size of Northstowe when built out (c.28,000) and the planned development of a Health Hub in the town centre within Phase 2, Northstowe presents itself as a natural candidate for considering new models of care in service design.

1.4 Northstowe – National Demonstrator Site

NHS England has sought, from among the 10 national demonstrator sites, to apply a focus on the key themes of New Models of Care, the Built Environment, Community Engagement and Evaluation. Northstowe, partnered with Darlington, has been

selected to provide insights into the development of New Models of Care (and digital deployment) and specifically to examine:

- Business cases and contracting models
- Service specifications and workforce models
- Predictive modelling for risk stratification and health needs analysis
- Digital deployments in new developments
- Design of Health Campus/Hub buildings
- Transitional arrangements when in construction phases

This detailed work is supported by investment from NHS England for specialist input over the next two years.

1.5 Implications for planning primary care provision

The focus on new models of care underpins the overall planning for primary care provision for Northstowe. This cannot be considered in isolation of the wider ambitions to deliver integrated services and to secure the objectives of the overall programme in terms of the delivery of proactive and preventive integrated services for a growing, resilient and empowered community. Achieving this will challenge existing commissioning approaches and current contractual frameworks.

2. MAIN ISSUES

2.1 Current Primary Care Provision

As the first residents start to move into the Phase 1 build at Northstowe, provision has been made at the Willingham Practice, and in particular its branch at Longstanton, to accommodate the new community. Welcome packs, which include details of where and how to register for primary care services, are distributed to new homes, and residents are informed of other points of access to NHS services. Learning from the New Housing Developments and Built Environment Joint Strategic Needs Assessment (JSNA) 2015, which has drawn on the experience of new residents in other growth sites, has prompted the commissioning of Citizens Advice Bureau (CAB) support, to be accommodated within the practice. This is in recognition of the wider needs of new residents and the previous utilisation of health services for more social or financial advice reasons. The piloting of CAB services in this way has been jointly funded by South Cambridgeshire District Council and Cambridgeshire and Peterborough CCG. If successful, it is anticipated that ongoing Citizens Advice will be built into the substantive, integrated service specification for provision to Phases 2 and 3.

A baseline dataset, in line with information governance, is being collated to help inform population profiling and service design for the integrated provision within the town centre Health Hub.

There is sufficient capacity at the Willingham/Longstanton practice to accommodate the new population associated with Phase 1 of the development, 1500 homes and up to 3000 patients.

Planning for integrated primary care services associated with Phases 2 and 3 will also take into the population in Phase 1 one, as well as patients registered at existing local practices situated around the Northstowe site, as a hub and spoke model of delivery is explored.

2.2 Commissioning Opportunities and Challenges

2.2.1 Contracting for new care models

- Using Existing Contract models – the following options are being considered:

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

  Option 2a: A primary medical services contract is put out to tender. A neighbouring practice, or group of practices bidding as one provider, is awarded the contract to run the Northstowe Care Hub alongside their existing contract. Maximum contract term is likely to be 10 years.

  Option 2b: A primary medical services contract is put out to tender and awarded to a provider not currently operating within the catchment of the hub. Maximum contract term is likely to be 10 years.

- Explore New Forms of Contract

  Community services, including mental health services, social care and voluntary sector services could be wrapped around any one of the above options, but a more profound integration of services to allow a Multispecialty Community Provider (MCP) to emerge would require the current barriers of contract forms and estate to be overcome.

  Nationally the MCP Vanguard programme is pointing to possible solutions and has proposed a new streamlined hybrid between the NHS Standard Contract and primary medical services regulations to include new requirements specific to the MCP care model (improving patient health, addressing health inequalities, integrated person-centred care, putting in place strategies for patient activation, developing shared electronic patient records). There is limited experience in utilisation and market response to these new contract forms.

2.2.2 Phasing of provision in line with growth

As it is anticipated that there is sufficient capacity in existing provision until 2021, the emphasis is on planning 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. It is recognised that the build out for this many homes will take up to 20 years to complete and services therefore need to reflect the growth projections, acknowledging the time lag for health funding to match actual population.

Space requirements within Health Hub will need to be phased to match growth patterns. New workforce models to include integrated teams and wider skill mix, along with technological solutions and commissioning services over extended opening hours (in line with NHS 7 day service ambitions) will ensure that space utilisation is maximised and flexible utilisation (in line with Health Building Note requirements) is achieved.

2.2.3 Commissioning and tenure of Health Hub premise

Detail of services and their space requirements in the new Hub will be required by the

developer in 2019.

The vision of achieving integrated service provision, located in a centrally positioned Health Hub and meeting the wider population health and social care needs will require existing barriers associated with building tenure and leasing to be challenged. Too often, ambitions for integration in the past have been hampered by unfavourable accommodation options resulting in void space and missed opportunities. Leases for sessional usage may be required as well as ways to manage shared space more effectively for flexible room usage. Traditional assumptions around consulting space may well be challenged as increased telecare and online interactions with Hub professionals will impact on required room sizes.

2.3 Key Timeline Information

The roll out of the development itself applies 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.

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

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

- Full capital and revenue consequences are yet to be determined.
- Section 106 associated with Phase 2 of £14.5m capital contribution to library/care hub and community centre
- Ongoing revenue costs associated with infrastructure to be determined. Under existing primary care contract regulations, rental costs for space to deliver primary medical services are reimbursed by the CCG. These costs may not be incurred under a new contract model but would be reflected in the service delivery costs.
- Service delivery costs under both traditional and integrated models will need to be costed to take planned growth into account.
- Integrated models requires budgetary transparency and identification of population level costs for joint commissioning across organisations.
- Workforce challenges in primary care are well documented – options to consider new models with a broad skill mix provide a level of mitigation for this risk.

3.2 Statutory, Risk and Legal Implications

- This is a high profile scheme for which reputational risks for all stakeholder organisations will need to be assessed.
- The challenging integration ambitions may well be facilitated by the Devolution priorities and opportunities.

3.3 Equality and Diversity Implications

- The five key themes of the Northstowe Healthy New Town project cover behaviour change, mental health, thriving economy, positive community identity and new care models. Equalities Impact Assessments associated with each theme will be undertaken as the project evolves.
- Any commissioning activity to secure the required services will be subject to robust equalities and diversity impact assessments being undertaken.

3.4 Engagement and Consultation Implications

- Engagement via Willingham Practice Patient Participation Group (PPG) and early contact with new residents. PPG keen to extend membership to include Northstowe representation.
- Wider engagement with network of local practices surrounding Northstowe about to commence.
- Establishment of health working group with key stakeholder representation, including Member involvement, to support through design, engagement and commissioning phases.

3.5 Localism and Local Member Involvement

- Primary Care team will meet with local members as the timelines progresses
- The CCG also liaises directly with district level planning departments

3.6 Public Health Implications

- The growth associated with the new community will impact on wider public health determinants of the local population. Public health colleagues are developing population predictive modelling in the context of anticipated disease. This will influence design of service specifications.
- Learning from Northstowe will influence health planning for other large growth sites across the county.

SOURCE DOCUMENTS GUIDANCE

It is a legal requirement for the following box to be completed by the report author.

Source Documents	Location
New Housing Developments and the Built Environment JSNA (2015/16)	http://cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/new-housing-developments-and-built-environment

Agenda Item No:13

HEALTH COMMITTEE APPOINTMENTS TO PARTNERSHIP LIAISON AND ADVISORY GROUPS

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Cambridge Local Health Partnership The Partnership has been established to identify local health and social care priorities in Cambridge and to feed these back into the network and develop local actions.	6	1	Councillor L Jones (Lab)	Yvonne O'Donnell Cambridge City Council Yvonne.ODonnell@cambridge.gov.uk
Cambridge University Hospitals NHS Foundation Trust Council of Governors The Board of Governors represents patients, public and staff. The majority of the Governors are elected by the membership. Governors provide a direct link to the local community and represent the interests of members and the wider public in the stewardship and development of the Trust.	4	1	Councillor M Howell (Con)	Martin Whelan Assistant Trust Secretary 01223 348567 martin.whelan@addenbrookes.nhs.uk
Cambridgeshire and Peterborough NHS Foundation Trust Provides mental health and specialist learning disability services across Cambridgeshire and Peterborough. Also provides some specialist services on a regional and national basis. Partners are Cambridgeshire County Council, Peterborough City Council, NHS Cambridgeshire and NHS Peterborough.	4	1	Councillor G Wilson (LD)	Louisa Bullivant Corporate Governance Manager 01223 219477 Ext 19477 louisa.bullivant@cpft.nhs.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
North West Anglia NHS Foundation Trust Council of Governors Peterborough & Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care Trust merged with effect from 1 April 2017 and from that date, the merged Trust has a reformed Council of Governors that reflects the wider catchment of both organisations and which includes representation from Cambridgeshire County Council as a statutory partner required by the Health and Social Care Act 2012 and NHS Act 2006.		1	Councillor J Gowing (Con)	Jane Pigg Company Secretary North West Anglia Foundation Trust 01733 677926 (direct dial) jane.pigg@pbh-tr.nhs.uk PA Jackie Bingley 01733 677953 (Weds) 01480 418755 (rest of week)
Papworth Hospital NHS Foundation Trust Council of Governors NHS Foundation Trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital and mental health services. The County Council is represented on the Council as a nominated Governor.	4	1	Previously Councillor P Topping (Con)	Mary MacDonald Trust Secretary Mary.macdonald9@nhs.net Liz Bush Office Manager and EA to Chief Executive and Medical Director Direct Line 01480 364585 liz.bush@nhs.net

HEALTH COMMITTEE TRAINING PLAN		**Agenda Item No: 14**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
1.	***Health Committee Induction Training***	To provide the new committee members with an overview of the Health Committee's remit. To provide members with background information on the Public Health executive function of the committee and its statutory health scrutiny function.	1	14th June	Democratic Services / Public Health	Training Seminar	For new members of Heath Committee (all members welcome)	9	**Completed** 60% of full committee
2.	***Finance Training***	To provide members with a background information around the council's finance process and familiarise new members with the specific details of the Public Health Directorate budgets	2	14th July 9.30-10.45	Public health	Training seminar	All members of Health Committee		
3.	***Sustainable Transformation Programme***	To provide new committee members with an overview of the Sustainable Transformation Programme	1	TBC	Public Health	Scrutiny Training	All members of Health Committee		

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
4.	***Health Committee Priorities 2017-18***	To develop and identify Public Health priority areas for the Health Committee to focus for 2017-18	1	21st July 2-4pm	Public Health	Development session	All members of Health Committee		

- In order to develop the annual committee training plan it is suggested that:
    - The relevant Executive/Corporate/Service Directors review training needs and develop an initial draft training plan;
    - The draft training plan be submitted to a meeting of the relevant committee spokesmen/women for them (in consultation with their Groups as appropriate) to identify further gaps/needs that should be addressed within the training plan;
    - The draft plan should be submitted to each meeting of the committee for their review and approval. Each committee could also be requested to reflect on its preferred medium for training (training seminars; more interactive workshops; e-learning etc and also to identify its preferred day/time slot for training events.)

Each attendee should be asked to complete a short evaluation sheet following each event in order to review the effectiveness of the training and to guide the development of future such events