HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 06 October 2016

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 and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**Minutes – 18th September 2016 and Action Log**	**5 - 18**
3	**Petitions**	

DECISIONS

4	**Service committee review of draft revenue business planning proposals for 2017-18 to 2021-22**	**19 - 58**
5	**Finance and Performance Report – August 2016**	**59 - 104**

SCRUTINY ITEMS

6	**Immunisation Task and Finish Group update report**	**105 - 110**
7	**Report from the CCG Urgent and Emergency Care Review Task Force**	**111 - 114**
8	**Appointments to internal Advisory Groups and panels, and Partnership Liaison and Advisory Groups** oral	
9	**Health Committee Agenda Plan**	**115 - 120**

The Health Committee comprises the following members:

Councillor David Jenkins (Chairman) Councillor Tony Orgee (Vice-Chairman)

Councillor Paul Clapp Councillor Adrian Dent Councillor Lorna Dupre Councillor Lynda Harford Councillor John Hipkin Councillor Peter Hudson Councillor Mervyn Loynes Councillor Paul Sales Councillor Mandy Smith Councillor Peter Topping and Councillor Susan Van de Ven

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

Clerk Name: Ruth Yule

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public. It also welcomes the use of social networking and micro-blogging websites (such as Twitter and Facebook) to communicate with people about what is happening, as it happens. These arrangements operate in accordance with a protocol agreed by the Chairman of the Council and political Group Leaders which can be accessed via the following link or made available on request: http://tinyurl.com/ccc-film-record.

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HEALTH COMMITTEE: MINUTES

Date: Thursday 8th September 2016

Time: 2.00pm to 4.20pm

Present: Councillors Sir Peter Brown (substituting for Councillor Loynes), P Clapp, L Harford, P Hudson, D Jenkins (Chairman), R Mandley (substituting for Councillor Dent), L Nethsingha, T Orgee (Vice-Chairman), P Sales, M Smith, P Topping and S van de Ven

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

Apologies: County Councillors Dent, Hipkin and Loynes
District Councillor Cornwell

243. DECLARATIONS OF INTEREST

There were no declarations of interest.

244. MINUTES – 14 JULY 2016 AND ACTION LOG:

The minutes of the meeting held on 14th July 2016 were agreed as a correct record, subject to recording Councillor van de Ven, spelled correctly, as sending apologies rather than attending. The minutes were signed by the Chairman.

It was suggested that the word 'savings' in minute 234 should be replaced by 'cuts' as closer to the meaning of what had been happening, but it was pointed out that 'savings' was the conventional usage, reflected in the minutes.

The Action Log was noted. The Chairman reminded members that the system-wide review of health outcomes, minute 234, had been added to the agenda plan in order to enable the Committee to track action to reduce health inequalities in Fenland.

245. PETITIONS

There were no petitions.

246. FINANCE AND PERFORMANCE REPORT – JULY 2016

The July 2016 Finance and Performance report was presented to the Committee. Members noted that there had been some planned use of reserves, and that there were no exceptions reported in Public Health at the end of July.

Discussing the report, members

- described the report as presenting an excellent summary of public health activities
- pointed out that agricultural workers had a reduced life expectancy as a result of agricultural injuries and exposure to chemicals, and that many eastern European workers seemed to be heavy smokers. There had once been an anomaly in the death rate in the Peterborough area, which had appeared related to packers being

exposed to chemicals; it would be interesting to pursue this. The Director of Public Health (DPH) pointed out that manual workers in general had a lower life expectancy, and that their rates of smoking, especially in Fenland, were higher too. She was involved in work with Peterborough, Norfolk and Suffolk on smoking rates among eastern Europeans, which would feed eventually into smoking cessation work. The DPH undertook to look at occupational health data and follow up the query on agricultural workers' life expectancy **Action required**

- expressed concern that the position on overweight children in Fenland was not improving. Members noted that the target to reduce the proportion of Reception children with excess weight in Fenland was a stretch target, and that the aim of reducing health inequalities was not to be achieved by reducing the health of the rest of the population

- asked whether the question had been investigated of whether there was any relationship between those children who had not received a 2-2.5 year review and those overweight on entering Reception, and whether there had been a missed opportunity to influence their diet. The DPH confirmed that one of the roles of health visitors was to convey health messages to families, and said that it was not possible to tell whether the children who did not receive the earlier review were the same children as those overweight at age 4-5

- queried whether all 38 schools and sixth-form colleges had been offered funded mental health training and consultancy support around mental and emotional wellbeing of young people, pointing out that the lack of schools' mental health training was putting pupils at risk. The DPH undertook to check whether all schools had been offered the training **Action required**

- commented that the UnitingCare working group had pursued the question of delayed transfers of care (DTOC) quite intensively, and asked whether the Committee should still be doing this in the absence of UnitingCare. The DPH advised that the Adults Committee received a more detailed update on DTOC, and suggested that the Adults Committee update be circulated to the Committee. **Action required**

- said that Cambridgeshire should aim to be better than the national average, and that it was necessary to top up reserves as soon as possible, because once they had been used, they were no longer available.

It was resolved unanimously to note the report.

247. MENTAL HEALTH VANGUARD UPDATE (Plus Appendix on PRISM; new primary care service for Mental Health)

The Committee received a report introducing the work of the Mental Health Vanguard Project Team and the PRISM project team, undertaken as part of the local Urgent and Emergency Care Vanguard programme. In attendance to present the report and respond to Members' questions were

- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
    - Dr Caroline Meiser-Stedman, consultant psychiatrist, clinical lead for the project
    - Dr Nimalee Kanakkahewa, consultant psychiatrist, leading PRISM (the name for the new enhanced primary care mental health service)

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) Tracy Dowling, Chief Operating Officer (COO)

Dr Meiser-Stedman explained that the Vanguard project had been developed in response to rising pressure on A&E, which had been experiencing an increase in people attending for non-medical mental health problems. Patients reported that A&E was a difficult place for them to come to. They often left attendance until a last resort, and it was a difficult place for clinicians to assess people in mental health crisis; the Vanguard provided the opportunity to do things differently. A limited part of the new service had already been started, and the full service would be introduced from 19 September. From that date, a telephone self-referral service would be available via 111, where callers would be put straight through to a mental health triage team, with clinical staff supporting the team at all times, and staff available 24/7 to go out to assess callers face to face where necessary.

In answer to their questions, members learned that

- capacity was a concern. Data on arrivals at A&E had been analysed to identify the times when patients were currently presenting, but there was a degree of uncertainty because of the element of self-referral. Other teams from the mental health pathway could step in to help if necessary. It was hoped that self-referral would lead to earlier referral, so that help could be given sooner and more effectively, and that patients attending the Sanctuaries could be helped to link in to other non-statutory services

- agreement had been reached that if the first response service thought a person needed home support or inpatient care, this would follow without the need to undergo further assessment

- the national triage scale for providing a very urgent mental health response was four hours, and the Cambridgeshire service would be aiming and measuring for one hour, despite the large geographical area to be covered. Staff would be based in the north and south of the county in the night; it would be necessary to triage carefully and quickly

- it was hoped that having information about people through clinical support would help reduce the use of detention by Police under Section 136 of the Mental Health Act, and ensure that it was only used appropriately

- various voluntary organisations were working together on the Sanctuary; Dr Meiser-Stedman did not know specifically whether Samaritans was one of these, but would check, as it was important that the Samaritans did know about the service

Action required

- there was to be a major advertising campaign in the week of the service launch

- the service would take referrals from family members and carers

- it was hoped that the new service would lead to savings in A&E. The COO said that the CCG spent over £4m a year on mental health admissions at Addenbrooke's, usually for a short period while assessments were carried out. The CCG would prefer to spend money on a proactive service than on hospital admissions for people who did not need to be there; the CCG would struggle to continue to fund these if

the service did not produce savings, though the COO could see that there were also benefits in terms the quality of service user experience.

Introducing PRISM, Dr Kanakkahewa said that it was intended to bridge the gap between what primary care and the secondary care mental health services could provide. A pilot had started on 9 August as proof of concept, covering five GP surgeries. The hope was to reach people before they needed secondary care, and to be able to provide rapid access if they did need secondary care. It was intended for planned, rather than crisis, work, to be carried out as early as possible.

The Chairman thanked the CCG and CPFT officers for attending, saying that the Committee was enthusiastic about the initiatives that were taking place and looked forward to hearing more about them in six months' time. He suggested that a range of measures of performance, outcome measures, be tracked, beyond the effect on A&E, as it might help to secure funding, and offered congratulations to CPFT and the CCG for this excellent piece of work.

It was resolved unanimously

a) to note the recent updates on Mental Health services for the Cambridgeshire and Peterborough health system
b) to welcome the work being undertaken by the CPFT and CCG, and
c) to receive a further update in six months' time.

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248. OUTPATIENT SERVICES AT COMMUNITY HOSPITALS

The Committee received a report from the Clinical Commissioning Group giving an update on the East Cambridgeshire and Fenland review of some of the health care services delivered from the community hospitals. Attending to introduce the report and respond to members' questions and comments were the CCG's Chief Operating Officer (COO), Tracy Dowling, and the Director of Corporate Affairs, Jessica Bawden.

A member of the public, Jean Simpson of Cambridge, asked a question (set out in full at Appendix A), in which she asked the Committee to ask the CCG four questions about the review of health care services delivered from community hospitals:

1) who was taking the decisions on which options were supported, and on what information would it be based
2) had all GPS been consulted on the viability of the options
3) had the CCG fully taken into account the effect of the closure of Minor Injury Units (MIUs), out patient departments and interim care beds
4) could the CCG explain how the public meetings and consultations would have any influence on the Sustainability and Transformation Plan (STP) proposals for community services, as there was to be no public consultation on the STP.

The Chairman thanked Ms Simpson for her questions, and said that the Committee would seek answers to any of them that were not covered in the course of the meeting.

Introducing discussion of the report, the Chairman pointed out that it went beyond outpatient services, and was strongly linked to the following agenda item.

The COO advised members that

- the review of services in East Cambridgeshire and Fenland was being conducted in the context of the Sustainability and Transformation Plan, which was a five-year plan being developed in the context of the growth anticipated in Cambridgeshire across the period

- doing nothing would leave a £150m gap over next five years between the cost of providing services as they were now and the income available to fund them
- as well the provision of services in communities, the use of the NHS estate was being looked at; this would require capital investment, and while the investment funds available were small, the development of hubs in the community formed part of the longer-term STP vision
- the MIUs had been reviewed against the standards set out in the Keogh urgent and emergency care review; because of the Urgent and Emergency Care Vanguard, Cambridgeshire had been one of the first areas nationally to do this
- services were required to comply with the Keogh standards within the next three years
- levels of activity in the MIUs had been found to vary widely through the day
- no decisions had yet been taken; it was necessary to ensure the provision of a minor injuries service even if the present MIUs were to be closed
- the reason public engagement meetings were being held across the County before the options had been developed was that an early internal document had been leaked and had given rise to great public anxiety; it was proving very helpful to receive feedback from people at these engagement meetings
- the intention was to provide services that were safe and clinically viable, to make best use of the funding available, and to meet people's needs.

Discussing the report, members

- commented that people attending one of the meetings had thought they were losing the MIUs and were anxious because they did not understand what was being proposed instead

- noted that GP federations could involve bringing practices together in one location, giving them a larger income with which they could employ a wider workforce

- said that it would have been helpful if the CCG could have had some clear proposals available, set out on a map, before embarking on the series of public meetings. It was explained that this had been the intention until the leak had occurred

- pointed out that there were still two empty wards and unused operating theatres in Wisbech

- commented that there were similar problems of access in the south of the county, and similar questions about the use of community hospitals, and their future role

- in answer to a question about how the CCG viewed the future of community hospitals, the COO said that the community hospitals had changed significantly over the years, but the estate had not. There were now higher levels of home-based care and rehabilitation, and the level of surgery undertaken had changed, both in that some surgery now only required day care, and some was now much more specialised, with limited scope for care in a community hospital. A future role for the community hospital could be as a hub in a community, with a degree of flexibility so that it could be used for a wide range of staff, services and clinics, including minor surgery, and providing support for quite ill people being cared for in the community to check that they were not deteriorating. The number of GP practices in the county was decreasing; it would be necessary to work with local GPs in developing plans.

Once the plan had been developed and approved, the CCG would publish the plan and bring it to Committee; if service changes were proposed, the CCG would go to public consultation, but this would not be until November. Work was continuing on what the estate and capital investment would be, and a plea was being made for some double running costs, because the changed service would have to come into effect before the previous service could be removed. The STP did not include cutting out large areas of service; the growth and aging of the Cambridgeshire population meant that existing capacity could not be removed, but it was necessary to use it far more efficiently

- drew attention to complaints of lack of GP capacity in some new developments, noting that the Committee would be looking at GP capacity at its November meeting. The COO said that there were vacancies in a number of GP practices, and it was important to support GPs in a way in which it had not done until now; NHS England commissioned GP services, but practices needed support to enable them to deliver services, and stronger GP practices were an important element in delivering improved services

- drew attention to difficulties that people might experience in for example travelling to get dressings changed daily if local services were removed; it might take all day to get to and from Cambridge or Peterborough. Members noted that the CCG was looking at the question of how many people would attend A&E instead if MIUs were to close, and how many would call an ambulance to get there

- sought further information on the temporary pause on admissions to the extra care unit at Doddington Court. The COO replied that the Keogh standards did not apply to Doddington Court. The issue there was that there were nine flats as extra care places for people to live in while receiving extra support. The flats had carers but not nursing support, and people who needed only carer support were increasingly receiving that in their own homes. Since Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) had taken over services at Doddington Court, they had identified that people needing overnight nursing care would be at risk if they went there. Work was therefore being undertaken to see how the capacity could be used safely, perhaps for patients in acute hospitals who were waiting for care packages to be arranged before discharge, or for people who needed more support than they could receive at home; staying at Doddington Court could perhaps act as early intervention, removing the need for hospital care. If no safe use could be found, it would be necessary to reduce the capacity rather than having it empty

- noted recent development in the three outpatient units, and that the CCG's preference would be to have providers within the local NHS, as there would be less fragmentation of governance and greater continuity for staff. However, if there was insufficient local interest in running the units, or providing radiology services, the CCG would be going to tender in a week's time in order to seek a provider before current arrangements expired.

Summing up, the Chairman asked for illustrations to explain what integrated care services were, and pointed out that care started at the patient's front door, not at the hospital front door. He also thanked CCG officers for their attendance, and asked the COO to supply him with answers to Ms Simpson's questions. **Action required**

It was resolved unanimously

to note the update on the East Cambridgeshire and Fenland review of some of the health care services delivered from the community hospitals and GPs.

249. CCG URGENT AND EMERGENCY CARE REVIEW

The Committee considered the following motion, proposed by the Chairman and set out in the Committee report:

Committee notes that:

- The CCG is conducting a review of its delivery of urgent and emergency services;
- There is considerable public concern that this review will result the closure of facilities including Minor Injury Units (MIUs) at the community hospitals in Wisbech, Doddington and Ely;
- Some people are also concerned that this review will lead to the closure of community hospitals themselves although this has not been suggested by the CCG; and
- The loss of such local minor injury services would specifically impact parts of Cambridgeshire which have higher levels of deprivation and be at odds with other programs targeted at addressing them.

It is concerned that the CCG:

- Has not taken sufficient account of the needs of communities which will be affected by the possible closures. It believes that a broad view should be taken of their full range of needs and that it should not be limited to just urgent and emergency services;
- Has not demonstrated how changes to the MIUs in the proposed options would impact on other NHS services such as primary care and A&E; and
- Has not done a good job of communicating what is needed and what the various options which it is considering might deliver. It recognises that the options have not yet been fully developed.

It therefore recommends that a task force be established to scrutinise with some urgency:

- The terms or reference of the CCG's current review;
- The process whereby it is carrying it out;
- The extent to which local needs are being factored into it;
- The objective criteria which it is using in order to identify the preferred options; and

- The way in which it has and will engage, consult and communicate with the communities which will be affected.

Introducing the motion, Cllr Jenkins said that it was necessary to rebuild public trust in the process of reviewing community hospitals and MIUs. He had been at a well-attended public meeting, at which the feeling among members of the public had been that a deal had already been done, and the MIUs and the community hospitals were to be closed. He was therefore proposing that the Committee establish a task force to examine the review process.

One member suggested that, because of the widespread concern that the review was only being carried out in order to save money, the review should explicitly identify the financial implications of the proposals.

Cllr Clapp seconded the motion, and on being put to the vote, it was agreed unanimously.

Discussing next steps, members commented that it was necessary to proceed quickly, and suggested that it could be helpful to involve local members. CCG officers advised that the proposals were being reviewed by the Clinical Senate (a regional board of clinicians and others) on 27 and 28 September to examine whether what was being proposed was safe and sensible.

It was resolved unanimously to

a) Support the motion as presented in section 2 of the report before Committee

b) Establish a task force to scrutinise with some urgency
   i) The terms of reference of the CCG's current review;
   ii) The process whereby it is carrying it out;
   iii) The extent to which local needs are being factored into it;
   iv) The objective criteria which it is using in order to identify the preferred options; and
   v) The way in which it has and will engage, consult and communicate with the communities which will be affected.

c) Appoint Councillors Clapp, Orgee and Sales (plus a Labour substitute) as members of the task force, with Local Members to be invited to attend; and

Agree that the task force conclude its work by, and report to, the Committee's next meeting on 6 October

250. PROPOSAL TO FORM A JOINT COMMITTEE TO SCRUTINISE THE PROPOSED MERGER OF PSHFT WITH HHCT

The Committee received a report asking it to decide whether to support the establishment of a joint scrutiny committee with Peterborough City Council to scrutinise proposals for the merger of Hinchingbrooke Health Care NHS Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT). Members noted that Peterborough's Scrutiny Commission for Health Issues would be considering the same question at its meeting on 15 September, and that it was proposed that Cambridgeshire be the lead authority on the joint committee, and take the chair.

Discussing the report, members

- noted that, under the draft terms of reference, it would be possible for the Joint Committee to scrutinise any matters relevant to the merger, even if not covered in the Full Business Case

- commented that any membership below five from each council would not allow for a Cambridgeshire Labour representative on the Joint Committee.

It was resolved unanimously to

a) to support the establishment of a joint scrutiny committee with Peterborough City Council to scrutinise proposals for the merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust

b) that the Health Committee's preferred size for the Joint Committee was five members each from Cambridgeshire County Council and from Peterborough City Council

c) to appoint Councillors P Brown, Clapp, Jenkins, Orgee and Sales to serve as members of the Joint Committee, with Councillor P Hudson as Conservative substitute, and Labour, Liberal Democrat and UKIP substitutes to be identified and their names notified to the Democratic Services Officer

d) to authorise the joint committee to respond on behalf of the Health Committee to the public engagement / consultation proposals

e) subject to the agreement of Peterborough City Council's Scrutiny Commission for Health Issues, to require that the joint committee scrutinise the implementation and governance arrangements, should the proposed merger be agreed by the two NHS Trust Boards

f) endorse the draft terms of reference.

251. 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. Members noted that these were informal meetings, so the formal report covered only the attendance and the themes of the meetings.

As a correction to the report, it was noted that the date of the next meeting with Cambridge University Hospitals NHS Foundation Trust (CUHFT) was planned for 23rd September, not 26rd.

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.

252. COSTED PROPOSAL TO IMPLEMENT A PILOT HARM REDUCTION PROJECT FOR STOPPING SMOKING

The Committee received a report setting out the proposed approach and costs of an evidence based harm reduction pilot project to enable smokers who have not been successful in quitting using the existing quit smoking model. Members noted that the costs of the proposed project would be met from the existing smoking cessation budget.

Discussing the report, members

- suggested that the costs of the project were high in relation to the number of quits sought, given that the aim was a 60% - 70% quit rate from a cohort of 163
- stressed the importance of encouraging smokers to quit
- noted that the aims of the project included gathering understanding on why some people found it so hard to quit smoking; even cutting down would help improve smokers' health and reduce the cost burden on health services in future
- pointed out that the report was misnumbered in the agenda pack; it was agenda item 10, not 11
- enquired when it might be possible to review the results of the pilot. Officers advised that initial findings were expected at the end of the current financial year, and members commented that it would be for next year's Committee to consider.

It was resolved unanimously to approve

a) the approach and costs of the pilot

b) implementation of the model in this financial year.

253. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan. The Chairman reported success in getting a motion on public health passed at the Local Government Association Conference that envisaged grant funding to enable reduction in health inequalities at no additional cost thereafter.

It was resolved unanimously

a) to note the training plan
b) to combine the October session on the New Communities JSNA with a session on health inequalities.
c) to hold the session on the CCG's Sustainability and Transformation Plan (STP) in December, following publication of the STP in November

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

It was resolved unanimously:

a) to note that there were currently no outstanding appointments to be made.

255. HEALTH COMMITTEE AGENDA PLAN

The Committee considered its agenda plan, including matters idendtified in the course of the meeting. In answer to a question about when to review bed-based care and minor injuries, CCG officers advised that if there were to be a public consultation, it would not start until December, so it would be possible to bring a report on plans to Committee in November. It was agreed to move the report on liver metastasis to December and the report on GP capacity to November, in order to help to spread out the business. The item on flu vaccination would not be required in November as it was due to be covered in October. **Action required**

It was suggested that the December meeting should be definite, rather than provisional, and the agenda kept fairly short, with the remainder of the afternoon being used for training.

Members noted that, following the recent rating by the Care Quality Commission (CQC) of the East of England Ambulance Service NHS Trust (EEAST) as 'requires improvement', the Vice-Chairman would be attending a meeting of the Chairs and Vice-Chairs of the region's health scrutiny committees with the Chief Executive of EEAST. This meeting was being held because potentially all the Overview and Scrutiny Committees in the region might wish to summon EEAST for scrutiny, which could place an unreasonable burden on senior EEAST officers. However, following this regional meeting, it would still be possible for the Health Committee to consider whether it wished to summon EEAST for scrutiny by the Committee locally, as EEAST had recently been awarded the contract for the Non-Emergency Patient Transport Service (NEPTS) by the CCG.

It was resolved unanimously:

a) to note the agenda plan

b) to add an update on the Mental Health Vanguard and PRISM to the agenda for 16 March 2017

c) to add an update on the pilot harm reduction project for stopping smoking to the agenda for 8 June 2017 **Action required**

Chairman

Appendix A

Outpatient Services at Community Hospitals.

There have been a number of crowded meetings, with more planned in September by the Peterborough and Cambridge Clinical Commissioning Group (CCG), to canvas the views of the public before going to full public consultation on the recommendations on changes to health care services delivered from community hospitals. The report says that continued work is taking place as part of the Sustainability and Transformation Plan (STP) and "*If any options are supported, then a public consultation could take place from November/December 2016 until February 2017*".

Could the Scrutiny Committee ask the CCCG

1. Who is taking the decision on which options are supported, and on what information will it be based?

2. Have all GPs (not just those on the Board of the CCG) been consulted on the viability of the options, since many of them depend on a transfer of service to primary care, which may not have the capacity and capability to deliver the planned services?

3. Have the CCG fully taken into account the effect of the closure of MIUs, possible closure of Out Patient departments and the likely closure of Interim Care beds at the community units and the effect this will have on access to services for a rural population?

For example, in the minutes of the meeting on 14th July of this Committee concerning the planned collaboration between Hinchingbrooke Health care NHS Trust and Peterborough and Stamford NHS Foundation Trust it was "*Confirmed that Stamford Hospital was approximately 15 miles north of Peterborough and explained that services were provided at other hospitals across the county including Doddington and Ely.* This may no longer be the case.

4. The CCG has reviewed these services "*in the context of the wider STP"* and the draft plan has already been submitted to NHS England. Since there will be no public consultation on the STP, can the CCG explain how the public meetings and consultations, will have any influence on the outcome of the plans for Community services?

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on 8 September 2016 and updates members on the progress on compliance in delivering the necessary actions.

This is the updated action log as at 28 September 2016 .

Minutes of 8 September 2016

Minute No.	Item	Action to be taken by	Action	Comments	Completed
233.	**Finance and Performance Report – July 2016**	L Robin	The Director of Public Health (DPH) to look at occupational health data and follow up the query on agricultural workers' life expectancy		
		L Robin	The DPH to check whether all schools had been offered the funded mental health training and consultancy support around mental and emotional wellbeing of young people		
		R Yule	The DPH advised that the Adults Committee received a more detailed update on DTOC, and suggested that the Adults Committee update be circulated to the Committee.	Finance and Performance Report to Adults Committee on 15 September 2016 circulated to members for information	Yes
247.	**Mental Health Vanguard Update**	Dr Meiser-Stedman/ R Yule	Dr Meiser-Stedman to check whether the Samaritans knew about the Sanctuary.		

Minute No.	Item	Action to be taken by	Action	Comments	Completed
248.	**Outpatient services at community hospitals**	T Dowling	Chief Operating Officer to supply the Chairman with answers to Ms Simpson's questions		
255.	**Health Committee agenda plan**	R Yule	Change agenda plan by • moving the report on liver metastasis to December and the report on GP capacity to November • deleting the item on flu vaccination from November • adding an update on the Mental Health Vanguard and PRISM to March 2017 • adding an update on the pilot harm reduction project for stopping smoking to June 2017	Changes reflected in current agenda plan (agenda item 9)	Yes

Agenda Item No: 4

SERVICE COMMITTEE REVIEW OF DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2017/18 TO 2021/22

To:	**Health Committee**
Meeting Date:	**6 October 2016**
From:	**Dr Liz Robin, Director of Public Health** **Chris Malyon, Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**This report provides the Committee with an overview of the draft Business Plan Revenue Proposals for the Public Health Service that are within the remit of the Health Committee.**
Recommendation:	**a) It is requested that the Committee note the overview and context provided for the 2017/18 to 2021/22 Business Plan revenue proposals for the Service.** **b) It is requested that the Committee comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2017/18 to 2021/22.**

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1. OVERVIEW

1.1 The Council's Business Plan sets out how we will spend our money to achieve our vision and priorities for Cambridgeshire. Like all Councils across the country, we are facing a major challenge. Our funding is reducing at a time when our costs continue to rise significantly due to inflationary and demographic pressures, which are greater than others due to being the fastest growing county in the country.

1.2 The Council has now experienced a number of years of seeking to protect frontline services in response to reducing Government funding. Looking back, we have saved £68m in the last two years and are on course to save a further £41m this year (2016/17). As a result, we have had to make tough decisions over service levels during this time. Over the coming five years those decisions become even more challenging. That is why this year the Council has adopted a new approach to meeting these financial challenges, which builds upon the outcome-led approach that was developed last year.

1.3 The Council last year established the strategic outcomes it will be guided by throughout the Business Planning process, which are outlined on the right. Early in the process this year, a number of Transformation Programmes have been established to identify the specific proposals that will meet these outcomes within the resources available to the Council.

1.4 These Transformation Programmes are the lens through which this year's Business Planning Process has been approached, and will feature in the material considered by Members in workshops and Committees. There are 11 Programmes, made up of "vertical" service-based Programmes, and "horizontal" cross-cutting Programmes:

1. Adult Services	2. Children's Services	3. Economy, Transport and Environment	4. Corporate and LGSS	5. Public Health
6. Finance and Budget Review				
7. Customers and Communities				
8. Assets, Estates and Facilities Management				
9. Commissioning				
10. Contracts, Commercial and Procurement				
11. Workforce Planning and Development				

1.5 In July 2016 General Purposes Committee considered and endorsed a report which summarised the role that the new approach to transformation has played so far this year. In particular, this table captured precisely how transformation – in line with the Council's strategic outcomes – will contribute towards balancing the budget:

Base Budget		Year 0
Review of Outturn		
Corporately agreed changes to	Inflation	X
	Demography	X
	Capital Financing	X
	Service Pressures	X
		Year 1
Base budget (new business plan)		
Projected Resource Envelope		A
Savings Challenge		Y1 – A = B
Transformation Programme		
"Horizontal" Cross-cutting programmes	X	
"Vertical" Service-based programmes	X	
Total Transformation Proposals		C
Revised Savings Challenge		B – C = D
Savings Challenge applied to Budgets		E

1.6 Within this new framework, the Council continues to undertake financial planning of its revenue budget over a five year timescale which creates links with its longer term financial modelling and planning for growth. This paper presents an overview of the proposals being put forward as part of the Council's draft revenue budget, which are relevant to this Committee.

1.7 Funding projections have been updated based on the latest available information to provide a current picture of the total resource available to the Council. At this stage in the year, however, projections remain fluid and will be reviewed as more accurate data becomes available.

1.8 The Committee is asked to endorse these initial proposals for consideration as part of the Council's development of the Business Plan for the next five years. Draft proposals across all Committees will continue to be developed over the next few months to ensure a robust plan and to allow as much mitigation as possible against the impact of these savings. Therefore these proposals may change as they are developed or alternatives found.

2. BUILDING THE REVENUE BUDGET

2.1 Changes to the previous year's budget are put forward as individual proposals for consideration by committees, General Purposes Committee and ultimately Full Council. Proposals are classified according to their type, as outlined in Appendix B, accounting for the forecasts of inflation, demography, and service pressures, such as new legislative requirements that have resource implications, as well as savings.

2.2 The process of building the budget begins by identifying the cost of providing a similar level of service to the previous year. The previous year's budget is adjusted for the Council's best forecasts of the cost of inflation, the cost of changes in the number and level of need of service users (demography) and proposed investments. Should services have pressures, these are expected to be managed within that service where possible, if necessary being met through the achievement of additional savings or income. If it is not possible, particularly if the pressure is caused by legislative change, pressures are funded corporately, as agreed at GPC in July. It should be noted, however, that there are no additional resources and therefore this results in an increase in the level of savings that are required to be found across all Council Services. The total expenditure level is compared to the available funding and where this insufficient to cover expenditure, the difference is the savings requirement to be met through transformation projects in order to balance the budget.

2.3 The budget proposals being put forward include revised forecasts of the expected cost of inflation following a detailed review of inflation across all services at an individual budget line level. Inflation indices have been updated using the latest available forecasts and applied to the appropriate budget lines. Inflation can be broadly split into pay, which accounts for inflationary costs applied to employee salary budgets, and non-pay, which covers a range of budgets, such as energy, waste, etc. as well as a standard level of inflation based on government Consumer Price Index (CPI) forecasts. All inflationary uplifts require robust justification and as such general inflation was assumed to be 0%. Key inflation indices applied to budgets are outlined in the following table:

Inflation Range	2017-18	2018-19	2019-20	2020-21	2021-22
Standard non-pay inflation	1.7%	2.2%	2.0%	2.0%	2.0%
Other non-pay inflation (average of multiple rates)	2.8%	1.9%	1.9%	2.1%	2.0%
Pay (admin band)	1.0%	1.0%	1.0%	1.0%	1.0%
Pay (management band)	0.0%	1.0%	1.0%	1.0%	1.0%
Employer pension contribution (average of admin and management band)	3.2%	2.8%	1.9%	2.7%	2.7%

2.4 Forecast inflation, based on the above indices, is as follows:

Service Block	2017-18	2018-19	2019-20	2020-21	2021-22
Children, Families and Adults	2,251	2,915	2,619	2,747	2,770
Economy, Transport and Environment (ETE)	795	875	840	867	832
ETE (Waste Private Finance Initiative)	856	811	881	888	903
Public Health	14	24	22	22	21
Corporate and Managed Services	398	353	383	446	482
LGSS Operational	93	282	240	274	267
Total	**4,407**	**5,260**	**4,985**	**5,244**	**5,275**

2.5 A review of demographic pressures facing the Council has been undertaken. The term demography is used to describe all anticipated demand changes arising from increased numbers (e.g. as a result of an ageing population, or due to increased road kilometres) and increased complexity (e.g. more intensive packages of care as clients age). All services are required to absorb the financial pressure of the general increase in population, estimated to be 1.4% in 2017-18. The remaining demographic pressures calculated are:

Service Block	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Children, Families and Adults	6,741	6,937	6,812	7,299	7,347
Economy, Transport and Environment (ETE)	195	200	206	211	217
Public Health	0	0	0	0	0
Corporate and Managed Services	23	24	25	25	25
Total	**6,959**	**7,161**	**7,043**	**7,535**	**7,589**

2.6 The Council is facing some cost pressures that cannot be absorbed within the base funding of services. Some of the pressures relate to costs that are associated with the introduction of new legislation and others as a direct result of contractual commitments. These costs are included within the revenue tables considered by service committees alongside other savings proposals and priorities:

Service Block / Description	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
CFA: Fair Cost of Care and Placement Costs	0	0	1,500	2,500	0
CFA: Impact of National Living Wage on Contracts	3,269	3,509	3,500	3,277	0
CFA: Local Housing Allowance limits - impact on supported accommodation	0	0	412	595	199
CFA: Children's Social Care Establishment	355	0	0	0	0
CFA: Independent Review Officers and Child Protection Chairs	261	0	0	0	0
CFA: Children Innovation and Development Service	289	50	0	0	0
CFA: Multi Systemic Therapy (MST)	368	63	0	0	0
ETE: Libraries to serve new developments	0	0	0	49	0
ETE: Reinstatement of funding for non-statutory concessionary fares	125	0	0	0	0
CS: Apprenticeship Levy	500	0	0	0	0
CS: Demography	3,405	3,389	3,469	3,535	3,589
CS: Contract mitigation	0	1,500	500	0	0
CS: Renewable energy - Soham	183	4	5	4	5
CS: Increased Revenue Costs for WAN upgrades	63	0	0	0	0
CS: Increased Revenue Costs	123	0	0	0	0

for WAN upgrades in Libraries					
CS: Corporate Office IT Assets	300	0	0	0	0
Professional and Management Pay Structure - combined	441	0	0	0	0
Impact of National Living Wage on CCC employee costs (combined)	4	18	74	174	174
Total	**9,686**	**8,533**	**9,460**	**10,134**	**3,967**

2.7 The Council recognises that effective transformation often requires up-front investment and has considered both existing and new investment proposals that we fund through additional savings during the development of this Business Plan. To this end a Transformation Fund has been created, through a revision to the calculation of the Council's minimum revenue provision (MRP). The table below outlines investments by service. Note that these figures are absolute.

Transformation Workstream	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Adults Services	146	541	245	0	0	0
Finance & budget review	0	87	0	0	0	0
Customer & communities	100	0	0	0	0	0
Assets, estates & facilities management	46	51	22	0	0	0
Commissioning	363	929	366	27	0	0
Workforce planning & development	0	536	0	0	0	0
Total	**655**	**2,144**	**633**	**27**	**0**	**0**
Cumulative	**655**	**2,799**	**3,432**	**3,459**	**3,459**	**3,459**

3. SUMMARY OF THE DRAFT REVENUE BUDGET

3.1 In order to balance the budget in light of the cost increases set out in the previous section and reduced Government funding, savings or additional income of £29.0m are required for 2017-18, and a total of £99m across the full five years of the Business Plan. The following table shows the total amount necessary for each of the next five years, separating Public Health in 2017-18 as it is ring-fenced:

Service Block	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Council	-28,374	-21,159	-17,242	-19,075	-11,997
Public Health	-606	-	-	-	-
Total	**-28,980**	**-21,159**	**-17,242**	**-19,075**	**-11,997**

3.2 There are also a number of risks which are not included in the numbers above, or accompanying tables. These will be incorporated (as required) as the Business Plan is developed. Estimates are given below where possible.

	2017-18 £'000	Risk
Vacancy Savings	1,000	Services are required to meet a target each year for staffing savings resulting through turnover of staff, for example through holding vacancies. As organisational changes are implemented, the ability/capacity to deliver this saving on an on-going basis will be reduced.
Dedicated Schools Grant funding	4,300	This potential pressure is the result of a consultation on national funding reforms.
Business rates revaluation	-	The Business Rates re-valuation is due to take effect from 1st April 2017, which could see significant rises in business rate liabilities in some areas and for some types of property.
Pension triennial review	-	The pension fund is being re-valued in 2016-17, with consultation documents due in November. Updates to assumptions following this will be incorporated during the development of the Business Plan.
Housing	-	A comprehensive 10-year pipeline of development projects has now been identified and a capital funding request has therefore been included in the Draft Business Plan. The figures are still being refined however, with the initial projections expected to be confirmed during Autumn 2016. Due to the nature of the schemes the revenue impact could be significant.
Total	**5,300**	

3.3 In some cases services have planned to increase locally generated income instead of cutting expenditure. For the purpose of balancing the budget these two approaches have the same effect and are treated in the same way.

3.4 This report forms part of the process set out in the Medium Term Financial Strategy whereby the Council updates, alters and refines its revenue proposals in line with new savings targets. New proposals are developed by services to meet any additional savings requirement and all existing schemes are reviewed and updated before being presented to service committees for further review during November and December.

3.5 Delivering the level of savings required to balance the budget becomes increasingly difficult each year. Work is still underway to explore any alternative savings that could mitigate the impact of our reducing budgets on our front line services, and Business Planning proposals are still being developed to deliver the following:

Service Block	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Council	-6,104	-3,749	-8,919	-11,785	-11,268
Public Health	-103	0	0	0	0
Total	**-6,207**	**-3,749**	**-8,919**	**-11,785**	**-11,268**

3.6 The level of savings required is based on a 2% increase in Council Tax, through levying the Adults Social Care precept in all years it is available (up to and including 2019-20), but a 0% general Council Tax increase. This assumption is built into the MTFS which was discussed by GPC in July. For each 1% more or less that Council Tax is changed, the level of savings required will change by approximately +/-£2.5m.

3.7 There is currently a limit on the increase of Council Tax of 2% and above, above which approval must be sought in a local referendum. It is estimated that the cost of holding such a referendum would be around £100k, rising to as much as £350k should the public reject the proposed tax increase (as new bills would need to be issued). The MTFS assumes that the 2% and above limit on increases will remain in place for all five years.

3.8 Following October and November service committees, GPC will review the overall programme in December, before recommending the programme in January as part of the overarching Business Plan for Full Council to consider in February.

4. OVERVIEW OF PUBLIC HEALTH SERVICE DRAFT REVENUE PROGRAMME

Transformation programme

4.1 The transformation programme for Public Health Services over the next five years focusses on the following three key themes.

- Improving engagement with communities to support behaviour changes which will improve health in the longer term.
- Strengthening the role of all three tiers of local government in providing environments and services which support health and wellbeing
- Maximising efficiency through our commissioning and procurement of services, including working in partnership with other organisations where this can improve outcomes or reduce commissioning costs.

The draft revenue proposals for 2017/18, combined with some internal changes in staff alignment and objectives, reflect the themes of the transformation programme.

Public Health Grant Allocation

4.2 The national ring-fenced public health grant allocation for Cambridgeshire reduces from £27,627k in 2016/17 to an indicative allocation of £26,946k in 2017/18, a total 'cash' reduction of £681k. The savings and efficiencies proposed for public health directorate budgets must cover the PH directorate's share of this reduction in PH grant, the costs of inflation and demography, a small reduction in income from other sources, and a small reduction in core Council funding allocated to the directorate, as part of wider corporate savings targets. The total savings requirement for the Public Health Directorate as a result of these factors is £606k.

Changes to the 2016/17 Business Plan

4.3 Proposals for savings to be made in 2017/18 were included in the 2016/17 Business Plan. There have been a number of changes since the 2016/17 Business Plan was written, both to the way in which demography and inflation figures are calculated corporately, and to the savings proposals themselves. A summary financial table of changes to the 2016/17 Business Plan is attached as Appendix A and more detail is given in the paragraphs below.

2016/17 Business Plan proposals which remain unchanged

4.4 Some savings proposals for 2017/18 were already published in the Council's 2016/17 Business Plan and remain unchanged. These include:

- Reduction in contract value for sexual health and contraceptive services £50k (ref. E/R 6.003)
- Review of exercise referral schemes £30k (ref E/R 6.006)
- Public health programmes team restructure/vacancy management 50k (ref E/R 6.019)
- Public health commissioning – explore joint commissioning with other organisations £50k (ref E/R 6.028)
- Reduction in contract value for age 0-5 public health services £90k (E/R 6.013) It should be noted that this saving has increased further as outlined in para 4.6

More details are provided in Appendix B

4.5 In addition, the 2016/17 Business Plan included the following 2017/18 savings proposals for public health grant spent by other County Council directorates.

- Reduction in contract value for drug and alcohol services (£100k) – this is covered in the Children, Families and Adults Executive Directorate 2017/18 revenue programme proposals.
- The public health grant funding for the Fenland Learning Service (£90k), which is a service commissioned by Economy, Transport and Environment Executive Directorate, will be replaced by other corporate funding.

Changes to the 2016/17 Business Plan: Unachievable savings

4.6 Some of the public health directorate savings for 2017/18 published in the 2016/17 business plan have since been identified as unachievable. These include:

- Child and adolescent mental health counselling services (£50k): This saving was proposed, in order to explore whether public health grant funding to these voluntary sector services might be replaced by NHS funding. This wasn't feasible, so this saving is no longer proposed.
- Recommissioning of age 0-19 children and young people's public health services (£250k): This savings proposal was based on a redesign of children and young people's health services across services commissioned by Cambridgeshire County Council, Peterborough City Council and the Cambridgeshire & Peterborough Clinical Commissioning

Group. The aim is to create a more 'joined up' service for children and their families, and use our combined resources more efficiently. This work is ongoing, but will not be ready for implementation in 2017/18.

Changes to the 2016/17 Business Plan: Demography, Inflation and Pressures

4.7 As noted in paras 2.3-2.5, the approach to both demography and inflation has changed for this 2017/18 business planning round. All demography as a result of general population growth has been removed from the Business Planning process, on the assumption that this will be absorbed with in Services' current budgets (demography previously estimated at £325k for Public Health for 2017-18, now zero). Inflation has been recalculated to use an expected inflation rate of 0% for general inflation (as opposed to those costs linked to specific rates of inflation e.g. in-house staff costs). As a result, the expected 2017/18 inflation for Public Health has reduced from £373k to £14k, plus a £4k pressure for changes to the management pay structure. The £660k saving described in the 2016/17 Business Plan as '(E/R.6.023) No uplift for demography/inflation/pressures for externally provided public health contracts'. has therefore been removed from the 2017/18 Public Health business planning tables.

Changes to the 2016/17 Business Plan: Additional Savings Proposals

4.8 The total savings requirement for the public health directorate as outlined in para 4.2 is £606k. Due to some 2017/18 savings identified in the 2016/17 business plan being unachievable, together with some reductions in external income, this leaves an additional £336k of savings for 2017/18 to be found.

Additional proposals identified to date are:

- Cambridgeshire Community Services have agreed to work with us to identify an additional £60k reduction in the contract value for age 0-5 public health services through a capacity review, skill mix and vacancy management (ref E/R.6.012),.
- The demand for on-line Chlamydia screening has reduced, and this is also associated with a reduction in laboratory costs for Chlamydia testing, leading to a saving of £50k (ref E/R 6.026)
- It is proposed that the current Food in Schools public health programme will be recommissioned jointly with Peterborough City Council. The saving from procuring the service jointly across Cambridgeshire and Peterborough is estimated as £25k (ref E/R 6.028)
- A three year Cambridgeshire County Council contract for a voluntary sector Homestart programme ended in September 2016. The public health grant contribution to funding this contract will no longer be required in 2017/18, creating a revenue saving of £98k (ref. E/R 6.031)

More detail is provided in Appendix B

These additional savings proposals currently amount to £233k, which leaves an ongoing gap of £103k.

Work is underway on further savings proposals to meet this £103k gap, with an initial focus on reviewing smoking cessation budgets to identify any

recurrent underspends on payments to GPs and costs of nicotine replacement therapy (ref. E/R 6.025).

Key risks

4.9 The savings requirement resulting from reductions in the national public health grant is challenging. Risks are being mitigated by our contracted services working collaboratively with public health commissioners to identify savings, while maintaining key service outcomes.

4.10 The picture for 2018/19 and beyond is less clear. Although the further percentage reductions in the national public health grant for 2018/19 and 2019/20 has been announced, there is still national debate about the future of the public health grant ring-fence, and whether in the longer term, public health services should be fully funded from business rates.

4.11 Detailed figures for revenue savings going forward in 2018/19 and beyond have not yet been proposed. Since the majority of the public health budget is spent on externally commissioned services, the main part of these savings will need to be identified through recommissioning of large external contracts as outlined in the Council's transformation plans. Work to develop the programme plan for of recommissioning of these contracts is ongoing.

Further developments

4.12 All proposals outlined are draft at this stage and subject to further development. Full Council in February 2016 is the point at which proposals become the Council's business plan.

5. NEXT STEPS

November	Service Committees will review draft proposals again, for recommendation to General Purposes Committee
December	General Purposes Committee will consider the whole draft Business Plan for the first time
January	General Purposes Committee will review the whole draft Business Plan for recommendation to Full Council
February	Full Council will consider the draft Business Plan

6. ALIGNMENT WITH CORPORATE PRIORITIES

6.1 Developing the local economy for the benefit of all

Public health services help to maintain a healthy and productive workforce in the County, which in turn supports the local economy.

6.2 Helping people live healthy and independent lives

Public health services have a key role in helping people to live a healthy lifestyle and stay healthy for longer. The savings proposals identified aim to protect, as far as possible, front line public health services which deliver this outcome.

6.3 Supporting and protecting vulnerable people

Public health services are often in contact with vulnerable people, who require additional support to maintain their health. The savings proposals identified aim to protect, as far as possible, front line public health services which have this role..

7. SIGNIFICANT IMPLICATIONS

7.1 Resource Implications

These savings proposals are focussed on providing best value for money. Resource implications are outlined within the document and accompanying tables.

7.2 Statutory, legal and risk implications

Due to continuation of the public health ring-fence until 2018/19, public health grant spend must continue to meet the grant conditions. Key risks and mitigations are outlined in paragraphs 4.9, 4.10 and 4.11.

7.3 Equality and Diversity

Equality and diversity implications are considered in the Community Impact Assessments (CIAs) provided in Appendix C. Draft CIAs are available for the majority of proposals and the remaining CIAs will be provided to the November Health Committee.

7.4 Engagement and Communications

In addition to the wider engagement and consultation on the County Council's Business Plan, ongoing engagement with service providers, stakeholder organisations, and across Council directorates is taking place during development of these proposals.

7.5 Localism and Local Member Involvement

There are no significant implications.

7.6 Public Health

The impact of each proposal on public health outcomes has been considered as part of the prioritisation process, with the aim of minimising negative impacts.

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?	Yes : 26 September 2016 Name of Legal Officer: Fiona McMillan
Are there any Equality and Diversity implications?	Yes 27th September 2016 Name of Officer: Liz Robin
Have any engagement and communication implications been	Yes : 26 September 2016 Name of Officer: Matthew Hall

cleared by Communications?	
Are there any Localism and Local Member involvement issues?	Yes 27th September 2016 Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes : 26 September 2016 Dr Liz Robin

Source Documents	**Location**
Transformation Programme	**https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/182/Committee/2/Default.aspx**
Demography Update	**https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/183/Committee/2/Default.aspx**
Cambridgeshire County Council Business Plan 2016/17	**http://www.cambridgeshire.gov.uk/info/20043/finance_and_budget/90/business_plan_2016_to_2017**

APPENDIX A

				Change since 2016-17 Business Plan					
Proposal type	Old Referenc	New Referenc	Title	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	Reason for change
DELETED PROPOSALS									
Demography	E/R.3.001	N/A	Sexual Health Services	106	92	75	74	-	Demography requirement removed as doesn't meet 1.4% threshold.
Demography	E/R.3.002	N/A	Adult Health Improvement	30	28	24	21	-	Demography requirement removed as doesn't meet 1.4% threshold.
Demography	E/R.3.003	N/A	Integrated Lifestyle Service	45	42	41	38	-	Demography requirement removed as doesn't meet 1.4% threshold.
Demography	E/R.3.004	N/A	Children's Health Improvement	144	127	151	130	-	Demography requirement removed as doesn't meet 1.4% threshold.
Saving	E/R.6.013	N/A	0-15 public health services as part of wider children's health 0-19 proposals	250	-	-	-	-	Delayed redesign of Health/CCC services for children
Saving	E/R.6.014	N/A	Review Child & Adolescent Mental Health (CAMH) voluntary sector funding as part of wider children's health 0-19 proposals	50	-	-	-	-	Alternative funding not available
Saving	E/R.6.023	N/A	No uplift for demography/inflation/pressures	660	-	-	-	-	Change to approach to demography and inflation
AMENDED PROPOSALS									
Saving	E/R.6.012	E/R.6.012	Health visiting and family nurse partnership	-60	0	0	0	0	Additional £60k reduction in contract value identified
NEW PROPOSALS									
Pressure	N/A	E/R.4.001	Professional and Management Pay Structure	4	-	-	-	-	New pressure to reflect 17-18 cost of management band pay structure
Saving	N/A	E/R.6.025	Smoking Cessation : Track 2016/17 spend on NRT and GP Payments [EI]	-	-	-	-	-	New savings proposal to meet 17-18 gap
Saving	N/A	E/R.6.026	Chlamydia Screening : Online Testing and reduction in lab costs [EI]	-50	-	-	-	-	New savings proposal to meet 17-18 gap
Saving	N/A	E/R.6.028	Food for Life : Jointly commission across Cambridgeshire and Peterborough [EI]	-25	-	-	-	-	New savings proposal to meet 17-18 gap
Saving	N/A	E/R.6.031	Contribution to CCC 0-5 voluntary sector contract no longer required [EI]	-98	-	-	-	-	New savings proposal to meet 17-18 gap
Income	N/A	E/R.7.102	Reduction in income	56	-	-	-	-	Less external income expected in 17-18 than in 16-17

APPENDIX A

				Change since 2016-17 Business Plan					
Proposal type	Old	New	Title	2017-18	2018-19	2019-20	2020-21	2021-22	Reason for change

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

Detailed Plans	Outline Plans

Ref	Title	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	Transformation Workstream	Description
1	**OPENING GROSS EXPENDITURE**	**20,948**	**20,444**	**20,468**	**20,490**	**20,512**		
E/R.1.004	One-off use of Public Health reserve funding	84	-	-	-	-		This is the removal of a Public Health grant to Economy, Transport and Environment. This funded specific work and campaigns which have now ended and so the money is no longer required.
1.999	**REVISED OPENING GROSS EXPENDITURE**	**21,032**	**20,444**	**20,468**	**20,490**	**20,512**		
2	**INFLATION**							
E/R.2.001	Inflation	14	24	22	22	21		Forecast pressure from inflation in the Public Health Directorate, excluding inflation on any costs linked to the standard rate of inflation where the inflation rate is assumed to be 0%.
2.999	**Subtotal Inflation**	**14**	**24**	**22**	**22**	**21**		
3	**DEMOGRAPHY AND DEMAND**							
3.999	**Subtotal Demography and Demand**	**-**	**-**	**-**	**-**	**-**		
4	**PRESSURES**							
E/R.4.001	Professional and Management Pay Structure	4	-	-	-	-		The revised management band pay structure was implemented in October 2016. The revised pay grades will not be inflated during 2017-18, as the inflation funding was factored into the available funding for the new pay structure. This pressure replaces inflation and funds the additional cost of the new pay structure expected to be incurred in 2017-18.
4.999	**Subtotal Pressures**	**4**	**-**	**-**	**-**	**-**		
5	**INVESTMENTS**							
5.999	**Subtotal Investments**	**-**	**-**	**-**	**-**	**-**		

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

Detailed Plans	Outline Plans

Ref	Title	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	Transformation Workstream	Description
6	**SAVINGS**							
	Health							
E/R.6.003	CCS contract for integrated contraception and sexual health services	-50	-	-	-	-	Public Health	Continued move to a more demand led model which means that although there will be a small reduction in clinic sessions the service will be even more targeted where there is most need. Specific proposals that reflect this approach are being discussed with Cambridgeshire Community Services.
E/R.6.006	Review exercise referral schemes	-30	-	-	-	-	Public Health	As part of the Public Health drive to promote and increase physical activity to benefit everyone across the County the service is reducing the investment in the the current exercise referral schemes. This current scheme sees some parts of the County and communities loosing out. Public Health will look to invest in a more equitable physical activity scheme across the whole County and Districts.
E/R.6.012	Health visiting and family nurse partnership	-150	-	-	-	-	Public Health	Reducing the cost of the contract for age 0-5 public health services with Cambridgeshire Community Services. Aim to keep current levels of service and staff through review of skill mix and ways of working which should enable some vacancies not to be filled. Existing staff will also be working in a more integrated way with other Council services, such as Children's Centres and Together for Families Programme.
E/R.6.019	Public health programmes team restructure/vacancy management	-50	-	-	-	-	Public Health	Explore the potential for closer working across smoking cessation and other healthy lifestyle services without a reduction in service.
E/R.6.021	Public health commissioning - explore joint work with other organisations	-50	-	-	-	-	Public Health	Explore the potential of creating a joint Public Health commissioning unit with Peterborough City Council. In order to drive best value across both areas.
E/R.6.025	Smoking Cessation : Track 2016/17 spend on NRT and GP Payments [EI]	-	-	-	-	-	Public Health	In 2015/16 smoking cessation targets were achieved while the budget for Nicotine Replacement Therapy and payments to GP surgeries for these services was underspent. Therefore, further work is being carried out to forecast exactly how much could be saved going forward while still meeting these targets.
E/R.6.026	Chlamydia Screening : Online Testing and reduction in lab costs [EI]	-50	-	-	-	-	Public Health	Demand for the online chlamydia screening service has declined. This is partially due to adopting a more targeted screening model. This also results in a lower spend on laboratory tests.

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

		Detailed Plans	Outline Plans					
Ref	**Title**	**2017-18 £000**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**Transformation Workstream**	**Description**
E/R.6.028	Food for Life : Jointly commission across Cambridgeshire and Peterborough [EI]	-25	-	-	-	-	Public Health	The Food for Life programme aims to promote a healthier eating lifestyle and reduce childhood obesity. Currently the Council and Peterborough City Council separately commission this programme. The proposal is to reduce costs by recommissioning jointly with Peterborough City Council the programme which will promote healthy eating and physical activity while targeting areas that are more deprived with higher levels of childhood obesity.
E/R.6.031	Contribution to CCC 0-5 voluntary sector contract no longer required [EI]	-98	-	-	-	-	Public Health	The Council's three year contract with Ormiston Trust to support Homestart services ceased in September 2016 as part of a wider refocussing of preventive services for children aged 0-5. Public Health made a contribution to the overall budget for this contract, which is no longer required.
E/R.6.999	Unidentified Savings	-	-	-	-	-		Further work being carried out to identify further savings during this years' Business Planning processes.
6.999	**Subtotal Savings**	**-503**	**-**	**-**	**-**	**-**		
	UNIDENTIFIED SAVINGS TO BALANCE BUDGET	**-103**	**-**	**-**	**-**	**-**		
	TOTAL GROSS EXPENDITURE	**20,444**	**20,468**	**20,490**	**20,512**	**20,533**		
7	**FEES, CHARGES & RING-FENCED GRANTS**							
E/R.7.001	Previous year's fees, charges & ring-fenced grants	-20,766	-20,304	-254	-254	-254		Fees and charges expected to be received for services provided and Public Health ring-fenced grant from Government.
	Changes to fees & charges							
E/R.7.101	Fess and Charges Inflation	-1	-	-	-	-	Finance & budget review	Income from teaching medical students.
E/R.7.102	Reduction in income	56	-	-	-	-		Reductions in income from Cambridgeshire and Peterborough Clinical Commissioning Group for management of joint Health Intelligence Unit. A reduction in Public Health Consultant sessions of medical student teaching.
	Changes to ring-fenced grants							
E/R.7.201	Change in Public Health Grant	407	20,050	-	-	-		Change in ring-fenced Public Health grant to reflect change in Public Health functions (FYE transfer of 0-5 public health commissioning in 2016/17),grant reductions announced in the comprehensive spending review, and removal of the ring-fence in 2018/19.
7.999	**Subtotal Fees, Charges & Ring-fenced Grants**	**-20,304**	**-254**	**-254**	**-254**	**-254**		
	TOTAL NET EXPENDITURE	**140**	**20,214**	**20,236**	**20,258**	**20,279**		

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

		Detailed Plans	Outline Plans					
Ref	**Title**	**2017-18 £000**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**	**2021-22 £000**	**Transformation Workstream**	**Description**
FUNDING SOURCES								
8	**FUNDING OF GROSS EXPENDITURE**							
E/R.8.001	Budget Allocation	-140	-20,214	-20,236	-20,258	-20,279		Net spend funded from general grants, business rates and Council Tax.
E/R.8.101	Public Health Grant	-20,050	-	-	-	-		Direct expenditure funded from Public Health grant.
E/R.8.102	Fees & Charges	-254	-254	-254	-254	-254		Income generation (various sources).
8.999	**TOTAL FUNDING OF GROSS EXPENDITURE**	**-20,444**	**-20,468**	**-20,490**	**-20,512**	**-20,533**		
MEMORANDUM: SAVINGS / INCREASED INCOME								
	Savings	-503	-	-	-	-		
	Unidentified savings to balance budget	-103	-	-	-	-		
	Changes to fees & charges	56	-	-	-	-		
TOTAL SAVINGS / INCREASED INCOME		**-550**	**-**	**-**	**-**	**-**		

APPENDIX C

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health	Name: Val Thomas.....
Service / Document / Function being assessed	Job Title: Consultant in Public Health .....
Cambridgeshire Community Services contract for Integrated Sexual Health Services	Contact details: val.thomas@cambridgshire.gov.uk .....
	Date completed: 26th September 2016 .....
Business Plan Proposal Number (if relevant) E/R.6.003	Date approved: .....

Aims and Objectives of Service / Document / Function

The Local Authority commissions an Integrated Sexual Health and Contraception Service from Cambridgeshire Community Services. Sexual health clinics offer testing, treatment and contact tracing for people at risk of sexually transmitted infections Services are 'open access' – i.e. people can refer themselves and are entitled to be seen. They are a mandated local authority public health service under the Health and Social Care Act (2012). The Integrated Service commissioned in 2014 brought together sexual health and contraception services.

It was commissioned to meet the following main objectives.

- Integrate sexual health and contraception services so that patients are able to address all their sexual health and contraception needs in one service and location.
- Address the health inequalities and inequities of service provision between the north and south of the county
- Modernise the service to ensure that it is efficient and cost effective.

What is changing?

There will be reduction in the contract value for 2016/17 and 2017/18.
CCS has been asked to find efficiencies. Initial discussions indicate that these will focus upon the following areas.

- Reviewing and identification of clinics where uptake is low and there are other services locally which are accessible.
- Reviewing of clinic opening times to identify if the out of hours services are fully utilized. Out of hours clinics cost more to operate due to increased staff costs.

There have been changes in the demand for some of the Sexual Health and Contraception clinics across Cambridgeshire.
A review of some of the service locations has resulted in limited changes to some clinics in terms of number and opening hours in 2016/17 to accommodate cost savings.
Further review of the demand for clinics in different locations will inform any changes in 2017/18. This is currently being formulated with Cambridgeshire Community Services.

Who is involved in this impact assessment?
e.g. Council officers, partners, service users and community representatives.

This CIA was completed by Council Officers

What will the impact be?

Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

Impact	Positive	Neutral	Negative
Age		x	
Disability		x	
Gender reassignment		x	
Marriage and civil partnership		x	
Pregnancy and maternity		x	
Race		x	

Impact	Positive	Neutral	Negative
Religion or belief		x	
Sex		x	
Sexual orientation		x	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation		x	
Deprivation		x	

For each of the above characteristics where there is an expected positive, negative and / or neutral impact, please provide details, including evidence for this view. Consider whether the impact could be disproportionate on any particular protected characteristic. Describe the actions that will be taken to mitigate any negative impacts and how the actions are to be recorded and monitored. Describe any issues that may need to be addressed or opportunities that may arise.

Positive Impact
None
Negative Impact
None
Neutral Impact
The aim will be to ensure that services will meet current demand and that any service efficiencies will be based on an assessment of service demand and what is known about local needs. Priority will be given to realising savings from services in the less deprived areas where residents are more likely to be able to access services in other areas.
Issues or Opportunities that may need to be addressed
If intelligence indicates that sexual health needs are not being met in the more deprived areas then alternative savings would be required. The potential for co-locating services in the new Wisbech Clinic could be considered. Drug and Alcohol Services could be s possible option to co-locate with Sexual Health Services.

Community Cohesion

If it is relevant to your area you should also consider the impact on community cohesion.

N/A

Version Control

Version no.	Date	Updates / amendments	Author(s)
2	26/09/16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	Officer undertaking the assessment
Public Health	Name: Val Thomas.....
Service / Document / Function being assessed	Job Title: Consultant in Public Health .....
Review exercise referral schemes and potential to joint fund with the NHS	Contact details: val.thomas@cambridgeshire.gov.uk 01223 703264
Business Plan Proposal Number (if relevant) E/R.6.006	Date completed: 26 September 2016 .....
	Date approved: .....

Aims and Objectives of Service / Document / Function

Exercise referral schemes seek to increase someone's physical activity levels on the basis that physical activity has a range of positive health benefits. Currently Public Health provides a grant to Huntingdonshire and to South Cambridgeshire District Councils that contribute to the exercise referral schemes that they provide through their Leisure Services. Patients are assessed by their local GP and if they do not meet the guidelines for levels of physical activity and have a long term health condition they are able to be referred to their local scheme. There a personal assessment by a physical activity specialist determines what programme of physical activity would best suit their needs.

This approach reflects current evidence found in NICE Guidance for Exercise Referral Schemes.
http://www.nice.org.uk/guidance/ph54/
This Guidance states that referrals should only be made for people who are sedentary or inactive and have existing health conditions (Long Tern Conditions) that put them at risk of ill health. They are should not be adopted as a public health promotion intervention to increase levels of physical activity in the general population

What is changing?

The potential to co-fund existing schemes with the local NHS was explored but currently future funding from the NHS has not been confirmed.

In line with the rules of the Public Health Grant all services funded by it are free at the point of delivery but it should be noted that exercise referral is provided by all District Authorities but there is a fee to clients.

However Huntingdonshire District Council provides a free service to all those referred by GPs with around 25% of referrals being funded by Public Health.

During 2016/17 work will be undertaken to identify how a more equitable physical activity scheme could be undertaken that would improve access across the whole of the county.

Who is involved in this impact assessment?
e.g. Council officers, partners, service users and community representatives.

This CIA was compiled by Council officers

What will the impact be?

Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

Impact	Positive	Neutral	Negative
Age			x
Disability			x

Gender reassignment		x	
Marriage and civil partnership		x	
Pregnancy and		x	

maternity			
Race		x	

Sexual orientation		x	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation			x
Deprivation			x

Impact	**Positive**	**Neutral**	**Negative**
Religion or belief		x	
Sex		x	

For each of the above characteristics where there is an expected positive, negative and / or neutral impact, please provide details, including evidence for this view. Consider whether the impact could be disproportionate on any particular protected characteristic. Describe the actions that will be taken to mitigate any negative impacts and how the actions are to be recorded and monitored. Describe any issues that may need to be addressed or opportunities that may arise.

Positive Impact
None. There are no positive impacts in terms of the exercise referral schemes, however there is the opportunity to develop countywide schemes for physical activity that will improve access and reduce inequity of provision.
Negative Impact
Exercise referral schemes will continue but district councils will charge a fee, which will impact most upon the deprived, those who are more rurally isolated who already have higher travel costs, and the young ,old age groups and those with disabilities who are more likely to be impoverished.
Neutral Impact
All those accessing a free service will be affected but it will not affect gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation in terms equity.
Issues or Opportunities that may need to be addressed
NHS funding of exercise referral schemes would increase the focus upon people with long term conditions who would benefit from increased physical activity. This would include those who have a disease related disability and could increase the number of referrals for those with a disability. The NHS has a current concerted focus upon long term conditions which is embedded into the Sustainable Transformation Plan and opportunities for NHS funding will continue to be sought.

Community Cohesion

If it is relevant to your area you should also consider the impact on community cohesion.

N/A

Version Control

Version no.	**Date**	**Updates / amendments**	**Author(s)**
V.1	26/09/16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		Officer undertaking the assessment
Public Health		Name: Dr Raj Lakshman/ Janet Dullaghan..... Job Title: Consultant in Public Health Medicine..... Contact details: raj.lakshman@cambridgeshire.gov.uk Date completed: 20th Sept 2016..... Date approved: .....
Service / Document / Function being assessed		
Health Visiting (HV) & Family Nurse Partnership (FNP)		
Business Plan Proposal Number (if relevant)	ER 6-012	

Aims and Objectives of Service / Document / Function

Health Visiting Service

- Public Health is responsible through the Children's Health Joint Commissioning Unit, for commissioning the Health Visitor service, a workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children in the first years of life, and help empower parents to make decisions that affect their family's future health and wellbeing. Health visitors lead the delivery of the 0-5 Healthy Child Programme, the evidence-based, preventive, universal-progressive service for children in the early years of life.
- The six high impact areas for the 0-5 Healthy Child Programme are
  - Transition to parenthood and the early years (0-5)
  - Maternal mental health
  - Breastfeeding (initiation and duration)
  - Healthy weight, healthy nutrition and physical activity
  - Managing minor illness and reducing hospital attendance and admission
  - Health, wellbeing and development of the child age 2 – 2.5 year old review (integrated review) and support to be 'ready for school'.

- The HV service uses a national service specification whereby specific elements of universal service provision are mandated for the first 5 years to ensure that there is universal coverage to a national standard format. The five mandated checks are:
  - Antenatal visit;
  - New baby review;
  - 6-8 week assessment;
  - 1 year assessment;
  - 2 to 21/2 year review.

- Between 2011 and 2015, in line with the 'Governments' Call to Action' the Government increased the number of Health Visitors nationally, and almost doubled the number of health visitors in Cambridgeshire. Whilst recognizing the importance of investing in 0-5 services and expanding the workforce, there may be opportunities to re-evaluate how elements of the 0-5 Healthy Child programme can be delivered.
- This will involve examining pathways of care to identify where savings can be made whilst minimizing the impact on frontline services and support to families. This might include identifying certain circumstances where other skilled and trained staff such as nursery nurses or family workers could perform certain roles or tasks instead of health visitors.

Family Nurse Partnership

- The Family Nurse Partnership (FNP) is a national preventive programme for vulnerable, young first-time mothers under 19 years of age. This service is commissioned alongside the Health Visiting Service and also transferred to Public Health in the Local Authority in October 2015.
- It offers intensive and structured home visiting, delivered by specially trained family nurses, from early pregnancy until the child is two. The team work in partnership with other health professionals, social care professionals and other agencies to ensure the best possible outcomes for young people, their children and families. The family nurse and the young parent(s) commit to

an average of 64 planned home visits over two and a half years.

- The FNP was developed in the USA and requires a license in the UK with fidelity to a specific model. This includes restrictions on when teenagers can be enrolled (before 16 weeks), how long the programme lasts and when visits are scheduled. Challenges or weaknesses of the FNP programme locally are that the license requires fidelity to the specific FNP model, with limited flexibility to assess the specific needs of the parents enrolled in the programme over time.
- The current FNP programme in Cambridgeshire funds places for less than 20% of the vulnerable teenage population and once caseloads are full there are no places for others, regardless of need. This also potentially excludes some teenage parents who are leaving care or who are looked after. These limitations mean that some vulnerable teenagers may 'miss the widow of opportunity' for help and support from this intervention.
- In 2016/17 a modelling exercise was carried out by a multiagency team to look at the impact of reducing/stopping FNP or revising the eligibility criteria to provide FNP to the most vulnerable teenagers.
- The outcome and recommendation of the group was to keep the FNP programme with the following changes.

Make it a core part of the HCP pathway for very vulnerable first-time mothers aged 16 years or under who are pregnant and meet at least one of the following 'fixed' criteria or at least four of the 'high risk' criteria

The fixed criteria are:

- Very young mothers – all first-time pregnant women aged 16 or under
- Currently in the care system as a Looked After Child (LAC), Child in Need (CIN), on Child Protection Plan (CPP) or recent care leavers.

'High-risk' criteria (any four or more of the following risk factors):

- Not living with their own mother or baby's father or partner
- No or low educational qualifications, i.e. no GCSEs or equivalent, low grade GCSEs
- Currently not in education, employment or training (NEET)
- Has mental health problems (need to clarify/define further)
- Ever 'looked after' as a child; or lived apart from parents for more than three months when under the age of 18
- Current smoker (and doesn't plan to give up during pregnancy)
- Living in disadvantaged area
- History/risk of abuse

Note: Some flexibility and judgement will be used in applying the criteria. Early graduation (before 2 yrs age) and flexibility of programme delivery are also possible.

Other recommendations

- Ensure the FNP service is integrated within the HCP service to support HV working with vulnerable teenagers who are pregnant on the partnership plus pathway so a step down to this support is seamless. Participation in the National FNP knowledge exchange will support transfer of knowledge from FNP to the wider HV workforce.
- It is essential that the notification pathway from midwifery is robust for ALL teenagers aged 16 and under who are pregnant. Each case could be assessed by a multi-disciplinary team including FNP, Midwifery, Health Visitor and Social Care to determine the level of support required. This could be FNP, universal , universal plus or partnership plus pathway for this group of vulnerable teenagers.

What is changing?

Where relevant, consider including: how the service/document/function will be implemented; what factors could contribute to or detract from this; how many people with protected characteristics are potentially impacted upon; who the main stakeholders are; and, details of any previous or planned consultation/engagement to inform the CIA.

- Saving proposals include consideration of skill-mix following a capacity review carried out in 2016/17
- Redesign of the FNP service- targeted to the most vulnerable teenagers and consideration of a single service across Cambridgeshire & Peterborough if possible.
- Working in a more integrated way with other Council Services e.g- Children's Centres and Together for Families Programme.

Who is involved in this impact assessment?
e.g. Council officers, partners, service users and community representatives.

Cambridgeshire County Council, Peterborough City Council and Cambridgeshire & Peterborough CCG through the Joint Commissioning Unit
Cambridge Community Services- current service provider

What will the impact be?

Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

Impact	Positive	Neutral	Negative
Age		X	
Disability		X	
Gender reassignment		X	
Marriage and civil partnership		X	
Pregnancy and maternity		X	
Race		X	

Impact	Positive	Neutral	Negative
Religion or belief		X	
Sex		X	
Sexual orientation		X	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation		X	
Deprivation		X	

For each of the above characteristics where there is a positive, negative and / or neutral impact, please provide details, including evidence for this view. Consider whether the impact could be disproportionate on any particular protected characteristic. Describe the actions that will be taken to mitigate any negative impacts and how the actions are to be recorded and monitored. Describe any issues that may need to be addressed or opportunities that may arise.

Positive Impact
None
Negative Impact
None
Neutral Impact
The front-line delivery of Health Visiting and FNP services will be maintained.
Issues or Opportunities that may need to be addressed
Working within the Children's Joint Commissioning Unit (Cambridgeshire County Council, Peterborough City Council, Cambridgeshire & Peterborough CCG) provides economies of scale, the ability to provide a more integrated service, redesign pathways and ensure a consistent approach.

Community Cohesion

If it is relevant to your area you should also consider the impact on community cohesion.

Providing an integrated Children, Young People and Families Health service across the Council has the potential to improve community cohesion.

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	20.09.16	First Draft	Raj Lakshman

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Val Thomas Job Title: Consultant in Public Health Contact details: val.thomas@cambridgeshire.gov.uk ... Date completed: 23 September 2016 Date approved: .....
Service / Document / Function being assessed		
Smoking Cessation		
Business Plan Proposal Number (if relevant)	E/R 6.025	

Aims and Objectives of Service / Document / Function

The County Council commissions 'level 2' smoking cessation services from GP practices and pharmacies. These services support people who wish to stop smoking and provide a combination of medication such as nicotine replacement therapy (NRT) on prescription, and evidence based one to one or group support for behaviour change. People are four times more likely to succeed in quitting when they use this service than if they try to quit without support or medication. When people succeed in stopping smoking is results in significant improvement to their health and in overall savings to the NHS due to their reduced risk of heart and circulatory disease, lung disease and cancers. It is important that smoking cessation services are easily accessible for people to use, so in Cambridgeshire we have tried to ensure that every GP practice offers a smoking cessation service – either through their own staff, for which payment is made, or through County Council CAMQUIT staff going into the GP practice to deliver clinics.

What is changing?
Where relevant, consider including: how the service/document/function will be implemented; what factors could contribute to or detract from this; how many people with protected characteristics are potentially impacted upon; who the main stakeholders are; and, details of any previous or planned consultation/engagement to inform the CIA.

The demand for smoking cessation services in GP practices and pharmacies has reduced over the past few years. There has been a fall in the overall percentage of adults who smoke in the county and increased usage of electronic cigarettes. Because GPs and pharmacies are paid per person receiving the service, the spend on these services has therefore reduced. Fewer people vising the service also means lower medication costs. Due to other pressures, an increased number of GP practices have asked CAMQUIT staff to come in and provide an on-site clinic, which means they are no longer paid. These factors mean that the predicted spend against budgets for smoking cessation services and GP practices have reduced. The saving is therefore made against a predicted reduction in demand on the smoking cessation budget, but smoking cessation services will continue to be easily accessible around the County.

Who is involved in this impact assessment?
e.g. Council officers, partners, service users and community representatives.

This CIA was complied by Council officers

What will the impact be?

Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

Impact	Positive	Neutral	Negative
Age		x	
Disability		x	
Gender reassignment		x	
Marriage and civil partnership		x	
Pregnancy and maternity		x	
Race		x	

Impact	Positive	Neutral	Negative
Religion or belief		x	
Sex		x	
Sexual orientation		x	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation		x	
Deprivation		x	

For each of the above characteristics where there is a positive, negative and / or neutral impact, please provide details, including evidence for this view. Consider whether the impact could be disproportionate on any particular protected characteristic. Describe the actions that will be taken to mitigate any negative impacts and how the actions are to be recorded and monitored. Describe any issues that may need to be addressed or opportunities that may arise.

Positive Impact
None
Negative Impact
None
Neutral Impact
Because this saving is based on observed demand being lower than allowed for, and local residents are still able to attend smoking cessation services it should not impact on equalities groups. The scale of the saving is such that funding should still be available to promote smoking cessation services in areas of higher deprivation which also have higher smoking rates, and to pilot a harm reduction model for smokers who wish to quit more gradually, in accordance with NICE guidance .
Issues or Opportunities that may need to be addressed
Because this saving relies on a forecast reduction in demand, if demand rises unexpectedly then in-year savings may need to be found from alternative sources.

Community Cohesion

If it is relevant to your area you should also consider the impact on community cohesion.

N/A

Version Control

Version no.	Date	Updates / amendments	Author(s)
V1	22 09 16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Val Thomas..... Job Title: Consultant in Public Health ..... Contact details: val.thomas@cambridgeshire.gov.uk ... Date completed: 22 09 16 ..... Date approved: .....
Service / Document / Function being assessed		
Laboratory testing for the Chlamydia Screening programme		
Business Plan Proposal Number (if relevant)	**6.027**	

Aims and Objectives of Service / Document / Function

Chlamydia Screening Programme

The Chlamydia Screening Programme is a national programme that offers opportunistic chlamydia testing for the sexually active under 25year olds. Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people at highest risk. Chlamydia often has no symptoms and can have serious health consequences.

1. Preventing and control chlamydia through early detection and treatment of infection;
2. Reduce onward transmission to sexual partners;
3. Prevent the consequences of untreated infection;
4. Ensure all sexually active under 25 year olds are informed about chlamydia, and have access to sexual health services that can reduce risk of infection or transmission;

Locally Public Health commissions chlamydia screening mainly from Cambridgeshire Community Services(CCS) through its countywide Integrated Sexual Health Service. CCS sub-contracts with the Terence Higgins Trust to provide outreach screening with high risk groups that have high prevalence of chlamydia infection.

Screening is also commissioned from GPs. These screens are sent to the Public Health England laboratories at Cambridge University Hospitals Foundation Trust for analysis.

An online screening programme is commissioned from Source Bioscience that enables young people to order a screening kit online and to return the completed screening pack to Source Bioscience for analysis.

What is changing?
Where relevant, consider including: how the service/document/function will be implemented; what factors could contribute to or detract from this; how many people with protected characteristics are potentially impacted upon; who the main stakeholders are; and, details of any previous or planned consultation/engagement to inform the CIA.

There has been a decrease in the number of screens analysed at the Public Health England (PHE) and Source Bioscience laboratories. This is a consequence of the following.

- Although it is difficult to confirm prevalence of chlamydia infection it is likely that it is low in Cambridgeshire given the overall general sexual health of the population which compares favourably to other areas. Consequently the programme has in recent years adopted the strategic approach of targeting population groups that have a high risk of testing positive. This means the actual numbers of screens have declined but the detection of positive screens has increased.

- An online Service has been commissioned the company, Source Bio-Science to send out kits to young people that have requested them online and to analyse their returned samples. There has been decline in demand for the online service over the past two years.

- GP practices are commissioned to provide chlamydia screening and have in recent years adopted a more targeted approach which has led to decrease in overall screens but an increase in the detection of positive screens. GP screens are analysed at the PHE laboratories

- Cambridgeshire Community Services (CCS) as part of the Integrated Sexual Health Service has sub-contracted with the Terence Higgins Trust to provide outreach chlamydia screening to high risk populations. This started when the new Service was launched in September 2014. The laboratory costs are absorbed into the block contract with CCS.

The decrease in predicted demand is based on the 20115/16 outturn. It is reflected in the underspend on the allocated funding to the PHE laboratories and the Source Bio Science services for 2015/16. Activity to date (September 2016) confirms that the fall in activity has been sustained.
Therefore a consultation is not proposed as the savings have been created by fall in demand.

Who is involved in this impact assessment?
e.g. Council officers, partners, service users and community representatives.

This CIA was completed by Council officers

What will the impact be?

Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

Impact	Positive	Neutral	Negative
Age	x		
Disability	x		
Gender reassignment		x	
Marriage and civil partnership		x	
Pregnancy and maternity		x	
Race		x	

Impact	Positive	Neutral	Negative
Religion or belief		x	
Sex		x	
Sexual orientation		x	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation	x		
Deprivation	x		

For each of the above characteristics where there is a positive, negative and / or neutral impact, please provide details, including evidence for this view. Consider whether the impact could be disproportionate on any particular protected characteristic. Describe the actions that will be taken to mitigate any negative impacts and how the actions are to be recorded and monitored. Describe any issues that may need to be addressed or opportunities that may arise.

Positive Impact
The positive impact of the ongoing changes to the Chlamydia Screening Programme is that it targets those groups most at risk either through age, deprivation, disability or rural isolation.
Negative Impact
None identified. The identification and treatment of chlamydia is associated with the avoidance of gynaecological complications.
Neutral Impact
The likelihood of a low chlamydia prevalence and the changes to the Chlamydia Screening programme that have already been introduced have not had any observed impact on those groups indicated above in this category.
Issues or Opportunities that may need to be addressed
There is the opportunity to further review the strategic approach of the Chlamydia Screening Programme to ensure that the most cost-effective approaches are being used and that the service reflects need.

Community Cohesion

If it is relevant to your area you should also consider the impact on community cohesion.

N/A

Version Control

Version no.	Date	Updates / amendments	Author(s)
V1	22.09/16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health	Name: Val Thomas.....
Service / Document / Function being assessed	Job Title: Consultant in Public Health .....
Joint Commission Cambridgeshire County Council(CCC) and Peterborough County Council (PCC)	Contact details: val.thomas@cambridgeshire.gov.uk ...
	Date completed: 22 09 16 .....
Business Plan Proposal Number (if relevant) 6.028	Date approved: .....

Aims and Objectives of Service / Document / Function

The aim of the Food for Life Programme is to promote a healthy eating lifestyle and contribute to reduction in childhood obesity.

Currently both CCC and PCC commission separately Food For Life to deliver a programme in schools. The Food for Life Programme is part of the Soil Association and works with schools helping them build knowledge and skills through a 'whole setting approach'. This engages children and parents, staff, patients and visitors, caterers, carers and the wider community to adopt a healthier eating lifestyle. It has been operational in Cambridgeshire for four years, focusing upon schools in more deprived areas where there are higher rates of childhood obesity. Over 1 in 4 children in Year 6 are either obese or overweight; this increases in the more deprived areas of the county.

What is changing?
Where relevant, consider including: how the service/document/function will be implemented; what factors could contribute to or detract from this; how many people with protected characteristics are potentially impacted upon; who the main stakeholders are; and, details of any previous or planned consultation/engagement to inform the CIA.

The proposal is to procure new schools based Programme that will promote healthy eating and also physical activity. This will be through a joint procurement with PCC. Any Programme commissioned will focus upon areas that are more deprived with higher levels of childhood obesity.

The Programme will be implemented across the two local authorities through the employment of one co-ordinator which will create savings through reducing duplication and facilitating the sharing of resources, for example shared events. Currently the Programme has a strong focus in Fenland and other more deprived areas. This will remain unchanged; however innovative approaches that are cost-effective and enable the Programme to be rolled out more widely will be sought through the procurement.

Who is involved in this impact assessment?
E.g. Council officers, partners, service users and community representatives.

This CIA was compiled by CCC officers.

What will the impact be?

Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

Impact	Positive	Neutral	Negative
Age	x		
Disability	x		
Gender reassignment		x	
Marriage and civil partnership		x	
Pregnancy and maternity		x	
Race		x	

Impact	Positive	Neutral	Negative
Religion or belief		x	
Sex		x	
Sexual orientation		x	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation	x		
Deprivation	x		

For each of the above characteristics where there is a positive, negative and / or neutral impact, please provide details, including evidence for this view. Consider whether the impact could be disproportionate on any particular protected characteristic. Describe the actions that will be taken to mitigate any negative impacts and how the actions are to be recorded and monitored. Describe any issues that may need to be addressed or opportunities that may arise.

Positive Impact
The programme will target schools in areas of deprivation, rurally isolated areas and where there is high level of disability amongst students.
Negative Impact
None
Neutral Impact
There would a neutral impact on a number of the groups, indicated above. As the focus on the Programme and its activities will not change in anyway that would affect the equality of any of these groups.
Issues or Opportunities that may need to be addressed
It might prove difficult for Programme to be managed effectively across CCC and PCC with one coordinator. The demand from more schools for the Programme could exceed its capacity to provide support. This could be addressed through additional funding or the development of model where schools contribute to the funding of the Programme, as is the case in other areas.

Community Cohesion

If it is relevant to your area you should also consider the impact on community cohesion.

The Programme can contribute to building closer links between families, communities and schools

Version Control

Version no.	Date	Updates / amendments	Author(s)
V1	22 09 16		Val Thomas

Agenda Item No: 5

FINANCE AND PERFORMANCE REPORT – AUGUST 2016

To:	**Health Committee**
Meeting Date:	**6 October 2016**
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 August 2016 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 August 2016.**
Recommendation:	**The Committee is asked to review and comment on the report**

	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 AUGUST 2016 FINANCE & PERFORMANCE REPORT

2.1 The August 2016 Finance and Performance report is attached at Appendix A.

2.2 A balanced budget has been set for the Public Health Directorate for 2016/17, 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. There are no financial exceptions reported in Public Health at the end of August.

2.3 The Public Health Service Performance Management Framework for July 2016 is contained within the report. Of the thirty eight Health Committee performance indicators, thirteen are red, six are amber, sixteen 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 Significant financial risk owing to the nature of demand led budgets and savings targets.

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: Martin Wade
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Suzy Edge
Are there any Equality and Diversity implications?	No Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Are there any Localism and Local Member involvement issues?	No Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer: Liz Robin

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: 9 September 2016

Public Health Directorate

Finance and Performance Report – August 2016

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
July (No. of indicators)	13	6	16	3	38

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Jul) £000	Directorate	Current Budget for 2016/17 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Aug) £000	Forecast Variance - Outturn (Aug) %
0	Health Improvement	8,459	-104	-4.0%	0	0%
0	Children Health	9,276	-81	-2.6%	0	0%
0	Adult Health & Well Being	916	-68	-30.9%	0	0%
0	Intelligence Team	13	-7	-119.7%	0	0%
0	Health Protection	6	1	23.4 %	0	0%
0	Programme Team	136	-34	-58.5%	0	0%
0	Public Health Directorate	2,175	149	16.4%	0	0%
0	**Total Expenditure**	**20,982**	**-145**	**-2.1%**	**0**	**0%**
0	Public Health Grant	-20,457	-83	0.7%	0	0%
0	Other Income	-343	179	-41.7%	0	0%
0	**Total Income**	**-20,800**	**96**	**-0.8%**	**0**	**0%**
0	**Net Total**	**182**	**-49**	**0.9%**	**0**	**0%**

The service level budgetary control report for August 2016 can be found in appendix 1.

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

2.2 Significant Issues

The savings for 2016/17 will be tracked on a monthly basis and any significant issues reported to the Health Committee.

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

The total Public Health ring-fenced grant allocation for 2016/17 is £27.6m, of which £20.457m 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)

There have been no virements made in the year to date, and this can be seen in appendix 4.

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE

4.1 Summary

4.1.1 The Public Health Service Performance Management Framework (PMF) for August 2016 can be found in appendix 6. Performance indicators for sexual health services, smoking cessation services, and integrated lifestyle and weight management services have been updated since the previous FPR. Key points are:

- All sexual health services performance indicators for both the Cambridgeshire Community Services and Dhiverse contracts remain green.
- Smoking cessation performance is at 87% of the year to date target (first two months data combined), details of improvement actions to achieve the target are outlined in appendix 6.
- Integrated lifestyle and weight management services continue to show a varied performance picture, due to ongoing transition to the new model of service and recruitment of new staff. The latest performance figure for July show 8 green performance indicators (an improvement on 7 green performance indicators in June) and 10 red indicators (a deterioration from 9 red indicators in June). The service, which is provided by Everyone Health, has now successfully recruited to all areas of the county, but staff training was not completed until the end of August.

4.1.2 The nationally produced Local Authority Health Profiles were updated in September 2016. The Health Profiles are useful to help us understand how the health of Cambridgeshire's population benchmarks nationally, but the data are not the most recent, due to the time taken to collate and benchmark information at a national level. Detailed information on the updated 2016 Health Profiles for Cambridgeshire and its districts can be found in Appendix 10 , together with an analysis of recent trends. Significant information for Cambridgeshire County includes:

- Hospital stays for self-harm (all ages) in 2014/15 in Cambridgeshire improved slightly on the previous year, but remained worse than the national average.
- The number of people killed and seriously injured on the County's roads in 2012-14 remained worse than the national average per head of population. However the figures had improved more quickly than the national trend, and the numbers of people killed and seriously injured per passenger kilometre travelled was lower than the national average.
- Both alcohol related hospital admissions and the proportion of adults with diagnosed diabetes have shown a statistically significant worsening trend over five years, although remaining better than the national average.
- The percentage of children in low income families, the long term unemployment rate, the rate of under 18 conceptions, and the rate of new sexually transmitted infections have all shown a statistically significant improving trend over four to five years.
- Modelled trends in rates of under 75 mortality due to cardiovascular disease and cancer are both consistent with a statistically significant improvement over the nine years from 2003/4 to 2012/14.

4.1.3 Detailed information on the District Health Profiles can be found in appendix 10. In the updated district level health profiles, Huntingdonshire had one public health indicator which was significantly worse than the national average, South

Cambridgeshire had two, Cambridge City and East Cambridgeshire had three, and Fenland had ten.

4.1.4 There is no new information since the previous FPR presented in September for Health Committee Priorities (Appendix 7), Health Scrutiny Indicators (Appendix 8), and Public Health Memorandum of Understanding monitoring (Appendix 9) as these are all collated on a quarterly or bi-monthly basis.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Jul) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of August £'000	Actual to end of August £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (August) £'000	Forecast Variance Outturn (August) %
	Health Improvement							
0	Sexual Health STI testing & treatment	4,074	1,295	1,188	-107	-8.24%	0	0.00%
0	Sexual Health Contraception	1,170	268	243	-25	-9.27%	0	0.00%
0	National Child Measurement Programme	0	0	0	0	0.00%	0	0.00%
0	Sexual Health Services Advice Prevention and Promotion	152	64	71	7	10.88%	0	0.00%
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Obesity Children	82	35	21	-14	-39.51%	0	0.00%
0	Physical Activity Adults	84	35	63	28	78.40%	0	0.00%
0	Healthy Lifestyles	1,605	696	698	2	0.25%	0	0.00%
0	Physical Activity Children	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking Service & Intervention	907	-56	-80	-24	42.81%	0	0.00%
0	Wider Tobacco Control	31	13	-13	-26	-200.02%	0	0.00%
0	General Prevention Activities	272	216	280	64	29.39%	0	0.00%
0	Falls Prevention	80	34	26	-8	-23.12%	0	0.00%
0	Dental Health	2	1	0	-1	-100.00%	0	0.00%
0	**Health Improvement Total**	**8,459**	**2,601**	**2,497**	**-104**	**-4.01%**	**0**	**0.00%**
	Children Health							
0	Children 0-5 PH Programme	7,531	2,500	2,499	-1	-0.03%	0	0.00%
0	Children 5-19 PH Programme	1,745	608	527	-81	-13.28%	0	0.00%
0	**Children Health Total**	**9,276**	**3,108**	**3,026**	**-81**	**-2.62%**	**0**	**0.00%**
	Adult Health & Wellbeing							
0	NHS Health Checks Programme	716	135	137	2	1.49%	0	0.00%
0	Public Mental Health	164	69	15	-54	-78.54%	0	0.00%
0	Comm Safety, Violence Prevention	37	16	0	-16	-100.00%	0	0.00%
0	**Adult Health & Wellbeing Total**	**916**	**220**	**152**	**-68**	**-30.93%**	**0**	**0.00%**
	Intelligence Team							
0	Public Health Advice	13	6	-1	-7	-119.70%	0	0.00%
0	Info & Intelligence Misc	0	0	0	0	0.00%	0	0.00%
0	**Intelligence Team Total**	**13**	**6**	**-1**	**-7**	**-119.70%**	**0**	**0.00%**
	Health Protection							
0	LA Role in Health Protection	0	0	3	3	0.00%	0	0.00%
0	Health Protection Emergency Planning	6	2	0	-2	-100.00%	0	0.00%
0	**Health Protection Total**	**6**	**2**	**3**	**1**	**23.44%**	**0**	**0.00%**

Forecast Variance Outturn (Jul) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of August £'000	Actual to end of August £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (August) *£'000*	Forecast Variance Outturn (August)
	Programme Team							
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking no pay staff costs	31	13	3	-11	-80.58%	0	0.00%
0	General Prev, Traveller, Lifestyle	105	45	21	-23	-52.04%	0	0.00%
0	**Programme Team Total**	**136**	**58**	**24**	**-34**	**-58.54%**	**0**	**0.00%**
	Public Health Directorate							
0	Health Improvement	531	221	312	91	41.02%	0	0.00%
0	Public Health Advice	710	296	296	0	0.06%	0	0.00%
0	Health Protection	151	63	95	32	50.99%	0	0.00%
0	Programme Team	613	255	252	-3	-1.34%	0	0.00%
0	Childrens Health	67	28	35	7	25.37%	0	0.00%
0	Comm Safety, Violence Prevention	50	21	44	23	111.20%	0	0.00%
0	Public Mental Health	53	22	22	-0	-0.38%	0	0.00%
0	**Public Health Directorate total**	**2,175**	**907**	**1,056**	**149**	**16.44%**	**0**	**0.00%**
0	**Total Expenditure before Carry forward**	**20,982**	**6,901**	**6,757**	**-145**	**-2.10%**	**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	-20,457	-11,961	-12,044	-83	0.69%	**0**	0.00%
0	S75 Agreement NHSE - HIV	-144	0	144	144	0.00%	**0**	0.00%
0	Other Income	-199	-84	-49	35	-41.67%	**0**	0.00%
0	**Income Total**	**-20,800**	**-12,045**	**-11,949**	**96**	**-0.80%**	**0**	**0.00%**
0	**Net Total**	**182**	**-5,144**	**-5,192**	**-49**	**0.94%**	**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 2016/17 £'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	Outturn Expenditure £'000	Expected / Actual Transfer to PH Reserves	Notes
Public Health Grant as per Business Plan	**27,627**				Ringfenced grant
Grant allocated as follows;					
Public Health Directorate	20,457		20,457	0	Including full year effect increase due to the Children 0-5 transfer into the LA, the 16/17 confirmed decrease and consolidation of the 15/16 in-year decrease.
CFA Directorate	6,422		6,422	0	
ETE Directorate	327		327	0	
CS&T Directorate	201		201	0	
LGSS Cambridge Office	220		220	0	
Total	**27,627**		**27,627**	**0**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	20,948	
Virements		
Non-material virements (+/- £160k)	0	
Budget Reconciliation		
Current Budget 2015/16	**20,948**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2016	2016/17		Forecast Balance at 31 March 2017	Notes
		Movements in 2016/17	Balance at 31 Aug 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,138**	0	1,138	**638**	**Estimated use of reserves to fund part year 16-17 savings not made, redundancy costs and one off funding agreed for previously MOU funded activity. (Estimated £500k pending review of commitments)**
subtotal	**1,138**	**0**	**1,138**	**638**	
Equipment Reserves					
Equipment Replacement Reserve	0	0	0	0	
subtotal	**0**	**0**	**0**	**0**	
Other Earmarked Funds					
Healthy Fenland Fund	500	0	500	400	**Anticipated spend over 5 years**
Falls Prevention Fund	400	0	400	200	**Anticipated spend over 2 years**
NHS Healthchecks programme	270	0	270	170	
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	675	
Other Reserves (<£50k)	0	0	0	0	
subtotal	**2,020**	**0**	**2,020**	**1.445**	
TOTAL	**3,158**	**0**	**3,158**	**2,083**	

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

Fund Description	Balance at 31 March 2016	2016/17		Forecast Balance at 31 March 2017	Notes
		Movements in 2016/17	Balance at 31 Aug 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	158	-47	111	111	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**158**	**-24**	**144**	**144**	

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 July 2016 can be seen within the tables below:

Measures										
Measure	Y/E Target 2016/17	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%	100%	100%	G	99%	98%	100%	↑	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	89%	89%	G	93%	80%	89%	↓	
Dhiverse : % of people newly diagnosed offered and accepted appointments	100%	100%	100%	100%	G	100%	100%	100%	↔	
Access to contraception and family planning (CCS)	7200	2400	3355	140%	G	147%	600	140%	↑	
Number of Health Checks completed	18,000	4,500	3686	82%	R	n/a	n/a	n/a	↔	• The comprehensive Improvement Programme is continuing this year. Intelligence from the commissioned social marketing work clearly indicates a lack of awareness in the population of Health Checks. Actual health check numbers compare reasonably well to other areas but the issue is the conversion rate which is attributed to the poor public understanding of the Programme. • The introduction of new software into practices has been delayed due to the extensive work that needs to be undertaken to introduce it into the 77 practices. This involves close working with the Clinical Commissioning Group, Information Governance and LGSS. Its purpose is to support the invitation system and to ensure that the data collection system is comprehensive. • Other activities include staff training from a commissioned Coronary Heart Disease specialist nurse. The Lifestyle Service is commissioned to provide outreach health checks for hard to reach groups in the community and in workplaces. This commenced in February and has started gaining momentum. A promotional campaign has been launched and 30 champions and local "advocates" have been recruited and are working in communities.
Percentage of people who received a health check of those offered	45%	45%	37%	37%	A	n/a	n/a	n/a	↔	

Number of outreach health checks carried out	2,633	890	359	40%	R	74%	223	75%	↑	Due to recruitment / staff changes Health Checks were not completed in Huntingdonshire Hub in July. Recruitment has now improved and can expect local improvements.
Smoking Cessation - four week quitters	2249	452	392	87%	R	n/a	157	83%	↔	• 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 is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit the core Stop Smoking service is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. During 2014/15 social marketing research was undertaken which is informing activities to promote Stop Smoking Services. Other activities introduced recently include a mobile workplace service, a migrant worker Health Trainer post that will target these communities where smoking rates are high and ongoing targeted promotion
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	56%	N/A	A	57%	58%	56%	↓	The current month actual represents the Q1 position for 2016/17 and compares with the Q4 actual (2105/16). This is a slight reduction since the last quarter. However, PHE are now collecting pilot information based on the health visiting data. 56% is one of the highest proportion of breastfeeding mothers in the Eastern region, when looking at the latest published date (Q4 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	44%	61%	47%	↑	This has increased between Q4 (2015/16) and Q1 (2016/17). This was a new service for 2014-2015 and had stretch targets to improve coverage. It has remained fairly constant in each quarter between 44-49%. The target of 50% remains in place for 2016/17.

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%	96%	↔	• Of note, all of the health visiting data is reported quarterly. The data presented here for July 2016 is data for Q1 (Apr-Jun) 2016-2017 and is compared to Q4 2015-2016 data for trend. • A stretch target for the percentage of infants being breastfed was set at 58%, - above the national average for England. This target was almost met with 56% of infants recorded as breastfed (fully or partially) at 6 weeks for Q1 and the figure is one of the highest statistics in the Eastern region in the recently published Public Health England data (Q4 2015/16). • 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%. This is being discussed with the provider. • The target of 90% for percentage of children who received a 2-2.5 year review has not been reported as met. However, if 'not wanted and not attended' figures are included, Q1 figure rises to 88% which falls within a range of 10% tolerance. • 96% of mothers received a face to face visit with 14 days of birth and 94% received a review at 6-8 weeks, well above the 90% targets. • The number of antenatal contacts increased for Q1 compared to Q4 of last year. Although below the quarterly target, this has remained fairly static in most areas and priority is given to contacting parents who are assessed as being most vulnerable.
Health visiting mandated check - Percentage of children who received a 6 - 8 week review	90%	90%	94%	N/A	G	95%	90%	94%	↓	
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	92%	N/A	A	91%	100%	92%	↑	
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	77%	N/A	A	84%	90%	77%	↓	
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	169	N/A	N/A	38	N/A	169	↑	• These new KPIs should help to gain better understanding of baseline activity and the type of work which school nurses are carrying out day to day, in order to improve health outcomes for children, young people and their families. • Two Key Performance Indicators (KPIs)—number of young people seen for behavioural interventions (smoking, sexual health advice, weight management or substance misuse) and number of young people seen for mental health & wellbeing concerns, are currently recorded and provided. These data are part of new KPIs monitoring. Data from the first year are used to benchmark the service. This quarter shows significant increase in numbers of contacts reported compared with Q4 last year although it is noted that there was a recording issue last quarter.
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	513	N/A	N/A	166	N/A	513	↑	
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	90%	91%	101%	G	82%	90%	91%	↑	15/16 year coverage target achieved. New Measurement Programme will start in 16/17 academic year
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	90%	94%	104%	G	88%	90%	94%	↑	

Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1983	688	609	89%	R	86%	170	79%	↓	The new Countywide Integrated Lifestyle Service provided by Everyone Health commenced on June 1 2015. It includes the Health Trainer and Weight Management Services. The Service has now successfully recruited to all areas The South of the county had been problematic and there was limited Health Trainer service in this area. However staff training will not be completed until the end of August. The KPIs that are not on target have an upward trend.
Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	1686	584	568	97%	A	72%	97	72%	↑	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1075	373	232	62%	R	n/a	92	85%	←→	Quarterly reporting. This intervention can take up to one year. Therefore there are cyclical
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	992	345	444	129%	G	114%	88	97%	↓	
Number of physical activity groups held **(Pre-existing GP based service)**	581	188	197	105%	G	107%	48	69%	↓	
Number of healthy eating groups held **(Pre-existing GP based service)**	290	96	52	54%	R	27%	24	58%	↑	This target has been re-evaluated and amended in line with current need.
Recruitment of volunteer health champions **(Pre-existing GP based service)**	20	6	2	33%	R	0%	2	50%	↑	
Personal Health Trainer Service - number of referrals received (Extended Service)	739	295	187	63%	R	80%	75	76%	↓	
Personal Health Trainer Service - number of initial assessments completed (Extended Service)	628	252	150	60%	R	63%	64	81%	↑	
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	400	160	14	9%	R	n/a	41	20%	←→	This intervention can take up to one year. Consequently the target KPI is being reviewed. Thsi is reported quarterly
Number of referrals from Vulnerable Groups (Extended Service)	370	149	124	83%	R	68%	38	100%	↑	

Number of physical activity groups held (Extended Service)	578	231	255	110%	G	143%	60	123%	↓	
Number of healthy eating groups held (Extended Service)	726	231	269	116%	G	209%	60	68%	↓	Due to school finishing there has been a reduction in workshops delivered by the NCMP team.
Recruitment of volunteer health champions (Extended Service)	24	8	5	63%	R	100%	2	50%	↓	
Number of behaviour change courses held	34	10	4	40%	R	0%	3	0%	↔	Courses not delivered in June or July. Five course set up to be delivered in September and October 2016.
Proportion of of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	33%	110%	G	n/a	30%	31%	↔	This is reported quarterly as the intervention takes 3 - 6 months
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	60%	60%	50%	83%	R	n/a	60%	50%	↔	No data is currently available for 16/17. Each course is 6 months.
% of children recruited who complete the weight management programe and maintain or reduce their BMI Z score by agreed amounts	80%	80%	100%	125%	G	n/a	80%	100%	↔	
Falls prevention - number of referrals	386	88	100	114%	G	91%	22	159%	↑	
Falls prevention - number of personal health plans written	279	64	89	139%	G	44%	16	200%	↑	

* All figures received in August 2016 relate to July 2016 actuals with exception of Smoking Services, which are a month behind and Health Checks, 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

Health Committee Priorities are reported bi-monthly. The next report due to be taken to committee will be in November 2016.

APPENDIX 8 – HEALTH SCRUTINY INDICATORS

Health Scrutiny indicators are reported to the Health Committee on a bi-monthly basis. The next report will be submitted in November 2016.

APPENDIX 9 - PUBLIC HEALTH MOU 2016-17 UPDATE FOR Q1

Directorate	Service	Allocated	Contact	Cost Centre Finance Contact	Q1 Update	YTD expected spend	YTD actual spend	Variance
CFA	**Chronically Excluded Adults (MEAM)**	£68k	Tom Tallon	MN92145 Stephen Howarth	During Quarter one we have started work with seven new complex needs clients. Five clients have been closed. Of those three were living more positively and safely, one had left the area and one where CEA could not provide any further assistance. The CEA approach has been recognised as bringing effective results with those that are hardest to reach and engage. It continues to disseminate good practice to partners in other areas, most recently Leicester and Bristol. Cambridge City Council have also approached CEA to start some work on engaging and supporting members of the Street Life community for which they will fund an additional post. Discussion has been had with the police, particular in respect of the change in the Police & Crime Commissioner to see what opportunities and commonalities can be found and how the CEA approach can support them to reach those hardest to engage. This dialogue is ongoing but there does seem to be some areas of practice around working with Domestic Abuse cases that may be effective. One very positive result this quarter has enabled a victim to leave her partner following 8 months of work to engage and support. She is currently reunited with family and we hope she will flourish. The CEA team contribute to support the set up work on Peterborough CEA by attending operational and strategic meetings. CEA has recently been put on the action plan for the Safer Peterborough partnership. CEA has been tasked by the Homelessness Strategic Implementation Partnership (HSIP) led by Cambridge City Council, to “Evaluate and address demand for training flats available for people accessing the county council’s Making Every Adult Matter (MEAM) service”. The City Council would like CEA to evaluate and if possible expand the ‘Housing First’ programme to enable chances to be open to a greater number of clients	£17,000	£17,000	£0

					The CEA team continued its work on the national stage contributing to the paper produced by MEAM (link below) on how back-to-work support can be improved for people experiencing multiple needs. As well as contributions from the staff team, two service users were interview by the author for their thoughts. http://meam.org.uk/wp-content/uploads/2016/07/Steps-towards-employment-FINAL.pdf CEA also contributed via interview to the MEAM coalition review published earlier this year. The establishment of a three year strategy has been delayed due to changes in staff, however this remains part of the action plan for 2016/17.			
CFA	**PSHE KickAsh**	£15k	Diane Fenner	CB40101 Adam Cook	• Primary School visits completed for academic year 2015-2016 • Recruitment of secondary schools (10) for 2016-2017 completed. • Kick Ash training for autumn term 2016 planned and organised.	£3,750	£3,750	£0
CFA	**Children's Centres**	£170k	Jo Sollars/ Sarah Ferguson	CE10001 Rob Stephens	The overall aim of Cambridgeshire Children's Centres remains ensuring a healthy start to life for children aged 0-4 and ensuring readiness for school, whilst maintaining a focus on inequalities in the early years, and targeting support which will minimise the need to access specialist services where possible. The Public Health funding is utilised as part of the total Children's Centre budget to improve health of children aged 0-5. Close alignment and joint working with community health colleagues in Health Visiting. Family Nurse Partnership and Maternity Services is established for all Children's Centres. Work continues to ensure arrangements with Health Partners are consistent and functionally effective at a community level for families as structural service change is introduced across the system.	£42,500	£42,500	£0
CFA	**Mental Health Youth Counselling**	£111k	Holly Hodge/ Emma De Zoete	CD20901 Clare Andrews	Cambridgeshire Youth Counselling Services • Youth counselling services are provided by Centre 33 and YMCA covering the whole of Cambridgeshire. • This quarter's contract monitoring meeting is upcoming, however the most recent data is shown below: Centre 33 (2015/16) [figures will change as they only include those that have completed counselling so there is a time lag] ○ 504 young people contacted the service ○ 336 had an assessment (face to face)	£27,750	£27,750	£0

					○ 251 went on to ongoing counselling£27 YMCA (2015/16) ○ 304 young people contacted the service ○ 280 had an assessment (telephone) ○ 215 went on to ongoing counselling. The waiting list for Centre 33 in the Cambridge area is a concern for both provider and commissioners, but work is ongoing to reduce this. A new delivery model is being piloted by Centre 33 which is more flexible to accommodate the variety of clients that they see. The model reflects the varied needs of clients, which may range from advice to more complex individuals that require multiple appointments.			
CFA	**CAMH Trainer**	£71k	Holly Hodge/ Emma De Zoete	CD20901 Clare Andrews	The CAMH trainer is employed by CPFT and delivers specialist mental health training for a range of roles working with children and young people. Training specifically tailored to the needs of schools is also provided and there will be a greater focus on this in the coming year. To increase uptake to training a re-design of the packages of training available to schools is underway. The service is also looking at developing a mental health literacy course that can be delivered in a train-the-trainer model with teaching staff. Most recent data (2014/15) 16 out of 38 secondary schools and sixth form colleges have accessed the training. Individuals from a further 12 schools have attended face-to-face training sessions. 9 of the schools have accessed the training in 2014/15, including 4 new schools. 21 primary schools have engaged with the training programme, plus 40 individuals have attended training from other schools. 9 primary schools have accessed the training in 2014/15 and 8 have booked training for the summer term.	£17,750	£17,750	£0
CFA	**DAAT**	£5,980 k	Susie Talbot	NB31001-NB31010 Jo D'Arcy	At the end of Qtr 1 there had not been any current spend for the allocated budget for GP Shared Care, Nalmefene, Recovery Hub Coordinator and BBV as this is work in progress. The inpatient detox beds contract is paid up to date for Qtr 1 along with the Service User Contract. We have now received Qtr 1 80% invoice from Inclusion for the Drug & Alcohol Contracts which will now show on Qtr 2 report. The predicted Q1 spend is based solely on a quarter of the overall allocated budget so the predicted and actual spend will vary during the year depending on when invoices are received however we anticipate	£1,567,250	£192,660	£1,374,590

					the budget will be fully spent by year end. The only exception to this being the Inclusion Contract where the contract is based on 80% in advance quarterly and the remainder 20% performance related which is normally paid during the next quarter following the performance meeting. This is to ensure that Inclusion have met their targets in line with the contract agreement, the 20% performance related invoices are then agreed for payment.			
CFA	**Contribution to Anti-Bullying**	£7k	Sarah Ferguson		This is a nominal amount and is part of a large budget, it is therefore difficult to pull out exactly what the £7k covers, and difficult to apportion amounts. This will be spent in total.	£1,750	£1,750	£0
					SUB TOTAL : CFA Q1	**£1,677,750**	**£303,160**	**£1,374,590**
ETE	**Active Travel (overcoming safety barriers)**	£55k	Matt Staton	HG03560 Robert Emery	Currently 73 schools are engaged in the school travel planning process through STARS. It is expected that by the end of July there will be 33 accredited to Bronze level, 1 Silver and 2 Gold. Since the beginning of April: • Walk Smart has been delivered to 115 pupils • Scoot Smart has been delivered to 1002 pupils • Pedal Smart has been delivered to 80 pupils	£13,750	£13,750	£0
ETE	**Explore additional interventions for cyclist/ pedestrian safety**	£30k	Matt Staton	HG03560 Robert Emery	A cycle safety campaign based around the strapline 'Let's look out for each other' will be launched by the Road Safety Partnership on 11 July. A further intervention(s) is being explored to be delivered in the spring. At present data and intelligence around cycle collisions is being collated to understand who the other drives involved in cycle collisions are.	£7,500	£7,500	£0
ETE	**Road Safety**	£20k	Matt Staton	HG03560 Robert Emery	Junior Travel Ambassador Scheme has continued in 9 primary schools, with 45 Junior Travel Ambassadors across the 9 schools. All 9 schools will continue the scheme into the new term and an additional 7 primary schools have already committed to join the scheme in September. Safety Zones have been delivered for approximately 1700 Year 5 pupils from schools in Huntingdon, St Ives, St Neots, Whittlesey and Wisbech. A young road user event designed to help young people make informed decisions around travel choices and learning to drive was held at Huntingdon Racecourse. Around 1,000 students from 6th forms around the County came to the event across two days. The event was	£5,000	£5,000	£0

					covered on ITC Anglia news.			
ETE	**Trading Standards KickAsh and Alcohol Advice**	£23k	Elaine Matthews	LC44590 John Steel	Prior to 1st April this funded activity was carried out by an officer in Supporting Businesses and Communities with the generic job description of Level 2 Community and Business Support Officer. Following the service restructure a dedicated post has been created to fulfil this funded Kick Ash role within Community Protection team in Community and Cultural Services. Sarah Freeman has been appointed to this post and will carry out the specified activities on behalf of Trading Standards. As we approach the end of the school year all 11 schools have received training, encouragement and support for their mentors and have delivered a number of different activities including raising awareness with their peers on No Smoking Day, Flash mob event, participating in Year 8 career or personal development days in school, lunchtime peer advice and Kick Ash Mentors carrying out business visits on behalf of Trading Standards. As well as usual administration and contact with schools and parents, specific activity during Quarter 1 of 2016_17 includes: ***April*** **Bottisham:** meetings with Mentors to discuss their personal and team progress. Training mentors to carry out the Business Visits on behalf of Trading Standards, advising businesses on the legislation for tobacco sales and why Kick Ash volunteers encourage their peers to stop smoking. Within the Community Resilience team new colleagues took part in the Safety Zone in Huntingdon – supporting the messages about underage sales and shop policies and sharing information with 9/10 year olds about E-cigarettes, the effects of those and tobacco on their health. ***May*** **Longsands**: meetings with mentors to discuss and plan their three catchment Primary School visits to talk to Year 6's about the effects of smoking and their involvement in Kick Ash. **Bottisham Village College**: Accompanied mentors who visited 6 local shops to talk to businesses about Kick Ash and their underage sales policies. **Cottenham VC:** Supported mentors involved in their school year 8 development day where they invited pupils to take part in an interactive game about smoking and choices to be made.	£5,750	£4,347	£403

					Sir Harry Smith, Whittlesey: Accompanied and advised 6 mentors who visited 10 shops over 2 days. **St Neots Fire Station** taking part in a Safety Zone over 4 days. ***June*** **St Ivo:** Accompanied six pupils who carried out 11 shop visits over 2 days. Three shops were found to have not been displaying the Statutory Tobacco notice so further advice was given and follow up visits done to ensure compliance. **Longsands and Cottenham Village College**: Evaluation focus group meetings with mentors from both schools. Establishing what they have got out of their involvement with the programme, the effectiveness of programme and mentor support and what can may be improved for future. **Bottisham VC**: Further email contact made and evaluation forms awaited.			
ETE	**Illicit Tobacco**	£15k	Aileen Andrews	JM12800 John Steel	• Following the 6 Magistrates warrants executed late March and all 6 premises yielding illicit tobacco, investigation work has continued. Pace interviews conducted and cases prepared for court. One case is proving particularly problematical as ownership of the tobacco cannot easily be proved. • Financial Investigations ongoing. • Officers trained on new labelling legislation, standardised packaging and Tobacco Products Directive. • Intelligence work on going. • One alcohol licence reviewed as a consequence of the raids, licence revoked. • Two cases have been in the courts, one of which is concluded with defendant given 100 hours unpaid work. Court hearings arranged for the cases, which are in the court system, (Hearings on 15 July and 20 July). One defendant offered a simple caution, as only a small quantity found and main business is takeaway and restaurant and unlikely to re-offend. Regional Project - Costs not within this allocation. • Preparation for proposed education, intelligence and enforcement in the Autumn and Winter 2016. Meeting being arranged to discuss week long illicit and tobacco education campaign, including illicit	£3,750	£6,041	-£2,291

					education trailer in the county.			
ETE	**Business and Communities Team**	£10k	Elaine Matthews		Update awaited			
ETE	**Fenland Learning Centres**	£90k			Contract awarded and all funds allocated.	£22,500	£22,500	£0
					SUB TOTAL : ETE Q1	**£58,250**	**£59,165**	**£915**
CS&T	**Research**	£22k	Adrian Lyne	KH50000 Maureen Wright	The majority of the funding is used to maintain/develop the Cambridgeshire Insight website, include maintaining the content for Health Joint Strategic Needs Assessment (http://www.cambridgeshireinsight.org.uk/jsna). The contribution is also used to partly support the Research Team's work on population forecasting and estimating that is used heavily by Cambridgeshire Health Services. No additional work was carried out during Q1 in addition to that listed above.	£6,250	£6,250	£0
CS&T	**H&WB Support**	£27k	Adrian Lyne	KA20000 Maureen Wright	With supervision from Director of Public Health, approximately 2.5 days per week of the Policy and Project Officer's time, who sits within the Policy and Business Support Team of Customer Service and Transformation. Support during Q1 has included: • Working with the Local Government Association to plan for a development session on 14 June. • Work with HealthWatch Cambridgeshire and HealthWatch Peterborough on planning for a stakeholder event around the learning from the termination of the Older People's and Adult Community Services contract. • Supporting the effective functioning of the Health and Wellbeing Board • Supporting the effective functioning of the Health and Wellbeing Board Support Group • Researching and preparing reports for the Health and Wellbeing Board, including on key policy/strategy changes • Presenting relevant reports at the Health and Wellbeing Board Support Group meeting, such as on the HWB Working Group and persons story items • Presenting a report to the HWB on the June development session	£6,250	£6,250	£0

					• Agenda Planning for HWB support group and (working with democratic services) the HWB meetings • Co-ordinating and preparing the quarterly stakeholder newsletter – latest newsletter issues in June 2016 This is in addition to ongoing, reactive support as required.			
CS&T	**Communications**	£25k	Adrian Lyne	KH60000 Maureen Wright	Highlights include: • Continued support for PH campaigns such as warm homes • Working closely with Val Thomas and other consultants on reactive media enquiries • Supporting PH in the development of a new website • Developing a workshop for the PH away day • Working with the media to maximise opportunities for Public Health • Supporting Health Committee	£6,250	£6,250	£0
CS&T	**Strategic Advice**	£22k	Adrian Lyne	KA20000 Maureen Wright	Continuing on from the last quarter, the focus of strategic resource has been on developing the Transformation Programme into the 16/17 Business Planning Process. This has involved supporting a number of SMT Away Days ad GPC/SMT workshops. As well as the strategic nature of the Business Planning Process referenced above, there is a wide array of practical elements to the process – which strategic colleagues have been involved in ensuring aligns with the work of the Public Health Directorate. Devolution work also continues, as a potential Cambridgeshire and Peterborough deal gets the support of local partners and awaits response from Government.	£5,500	£5,500	£0
CS&T	**Emergency Planning Support**	£5k	Adrian Lyne	KA40000 Maureen Wright	Ongoing close working with the Health Emergency Planning and Resilience Officer (HEPRO) on a number of Emergency Planning tasks: • Provision of emergency planning support when the HEPRO is not available • Provision of out of hours support for the Director of Public Health (DPH), ensuring that the DPH is kept up to date on relevant incidents that occur, or are responded to, outside normal working hours as part of the 24/7 duty provision • CCC EMT has taken over the running of the review of the 'Excess Deaths Plan' and will being the work shortly in support of the Pandemic Flu arrangements • DECC return and work on Fuel Support Shortage Planning • Initial work on Public Health Business continuity review, and	£1,250	£1,250	£0

					including of Public Health details in the new emergency contact mechanism currently being completed			
CS&T	**LGSS Managed Overheads**	£100k	Adrian Lyne	UQ10000 Maureen Wright	This continues to be supported on an ongoing basis, including: • Provision of IT equipment • Office Accommodation • Telephony • Members Allowances	£25,000	£25,000	£0
					SUB TOTAL : CS&T Q1	**£50,500**	**£50,500**	**£0**
LGSS	**Overheads associated with PH function**	£220k	Adrian Lyne	QL30000 RL65200 TA76000 Maureen Wright	This covers the Public Health contribution towards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance £20k HR £25k IT £20k The remaining £155k is a general contribution to LGSS overhead costs	**£55,000**	**£55,000**	**£0**
					SUB TOTAL : LGSS Q1	**£55,000**	**£55,000**	**£0**

SUMMARY

Directorate	YTD (Q1) expected spend	YTD (Q1) actual spend	Variance
CFA	£1,677,750	£303,160	£1,374,590
ETE	£58,250	£59,165	£915
CS&T	£50,500	£50,500	£0
LGSS	£55,000	£55,000	£0
TOTAL Q1	**£1,841,500**	**£467,825**	**£1,373,675**

APPENDIX 10 - PUBLIC HEALTH OUTCOMES FRAMEWORK UPDATE

Briefing: Local Authority Health Profiles 2016 September 2016

Introduction

Public Health England's annual Health Profiles give a snapshot of the overall health of each local authority in England. The profiles present an important set of indicators relating to the wider determinants of health and health outcomes. The local value for each indicator is compared with the national average in order to highlight potential problem areas. The profiles are produced for use by elected Councillors, Directors of Public Health, Health and Wellbeing Boards and to inform Joint Strategic Needs Assessments.

The latest Health Profiles and interactive Fingertips data tool can be found at: http://fingertips.phe.org.uk/profile/health-profiles.
The Local Health tool includes data at small area level:
www.localhealth.org.uk

This briefing highlights the indicators that are statistically significantly worse than the England average for Cambridgeshire and its districts, and where possible, looks at recent trends. The RAG (red-amber-green) charts on page 3 summarise how each indicator compares to the national average based on the 2016 Health Profiles. Key terms are defined in the glossary on page 2.

It is important to remember that indicators rating similar to or better than the national averages do not necessarily mean that they are not important public health issues as they may affect large numbers of people or disproportionately affect particular vulnerable groups or deprived areas.

The methodology for the calculation of some indicators has changed compared to those published in previous profiles and so comparisons to previous profiles should be made with caution. Many of the indicators have changed to align with the Public Health Outcomes Framework.

- Quick links to the profiles for Cambridgeshire, and a copy of this briefing, are available at www.cambridgeshireinsight.org.uk/health/profilesdata/lahealthprofiles
- Further local data at county and district level: www.cambridgeshireinsight.org.uk/health/profilesdata

Main source: Public Health England. Health Profiles 2016. © Crown Copyright 2016.

Contact: Cambridgeshire County Council Public Health Intelligence: PHI-Team@cambridgeshire.gov.uk

Glossary of Key Terms

Indicator
The term indicator is used to refer to a quantified summary measure of a particular characteristic or health outcome in a population. Indicators are well-defined, robust and valid measures which can be used to describe the current status of what is being measured, and to make comparisons between different geographical areas, population groups or time periods.

Benchmark
The term 'benchmark' refers to the value of an indicator for an agreed area, population group or time period, against which other values are compared or assessed.

National average
The national average for England, which acts as the 'benchmark' for comparison of local values in the 2016 Health Profiles, represents the combined total summary measure for the indicator for all local authorities in England.

Statistical significance
Comparisons of local values to the national average in the Health Profiles are made through an assessment of 'statistical significance'. For each local indicator value, 95% confidence intervals are calculated which provide a measure of uncertainty around the calculated value which arises due to random variation. If the confidence interval for the local value excludes the value for the benchmark, the difference between the local value and the benchmark is said to be 'statistically significant'.

RAG-rating
RAG-rating refers to the colour-coding of local indicator values according to a red-amber-green (RAG) system. Local indicator values that are significantly worse than the national benchmark are colour-coded red and local indicator values that are significantly better than the national benchmark are colour-coded green. Local indicator values that are not significantly different to the national benchmark are colour-coded amber.

Recent time trends
A number of Health Profile indicators are also included in the Public Health Outcomes Framework and include statistical assessment of recent trends over time. Statistical trends in non-PHOF indicators have been assessed locally using comparable methods where possible. It is not possible to assess trends for all indicators as there is not always enough time periods or it is not possible because of the measure.

Summary – Health Profiles 2016

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Our communities

Indicator	Period	England	Cambridgeshire	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Deprivation score (IMD 2015)	2015	21.8	13.4	13.8	12.1	25.4	11.8	8.1
Children in low income families (under 16s)	2013	18.6	12.1	14.3	9.8	20.3	11.2	8.0
Statutory homelessness	2014/15	0.9	*	0.8	*	0.1	0.1	0.2
GCSEs achieved	2014/15	57.3	58.9	64.2	55.7	48.4	55.7	69.3
Violent crime (violence offences)	2014/15	13.5	9.2	14.4	6.2	12.4	8.0	5.8
Long term unemployment	2015	4.6	1.2	1.5	1.0	2.0	0.9	0.8

Children and young people's health

Indicator	Period	England	Cambridgeshire	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Smoking status at time of delivery	2014/15	11.4*	*	*	*	*	*	*
Breastfeeding initiation	2014/15	74.3	*	*	*	68.8	80.9	*
Obese children (Year 6)	2014/15	19.1	15.0	14.6	14.4	18.8	15.5	12.6
Alcohol-specific hospital stays (under 18)	2012/13 - 14/15	36.6	32.0	26.5	22.9	44.9	42.5	21.7
Under 18 conceptions	2014	22.8	16.2	23.1	13.7	22.5	16.1	9.8

Compared with benchmark: Better | Similar | Worse | Lower | Similar | Higher | Not compared

Adults' health and lifestyle

Indicator	Period	England	Cambridgeshire	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Smoking Prevalence in adults	2015	16.9	16.4	17.7	14.4	26.4	13.9	12.8
Percentage of physically active adults	2015	57.0	58.6	69.8	53.8	47.9	57.9	59.5
Excess weight in adults	2012 - 14	64.6	63.6	48.3	68.0	73.1	67.3	63.6

Disease and poor health

Indicator	Period	England	Cambridgeshire	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Cancer diagnosed at early stage	2014	50.7	59.0	56.1	67.2	55.6	58.8	59.0
Hospital stays for self-harm	2014/15	191.4	221.5	252.7	238.5	236.2	184.0	228.4
Hospital stays for alcohol-related harm	2014/15	641	611	740	557	706	551	589
Recorded diabetes	2014/15	6.4	5.5	3.3	6.5	7.8	6.1	4.8
Incidence of TB	2012 - 14	13.5	6.4	11.0	3.1	8.6	4.5	5.0
New sexually transmitted infections (STI)	2015	815	495	772	273	376	518	397
Hip fractures in people aged 65 and over	2014/15	571	529	515	447	571	540	551

* Data quality issue - not available, suppressed or to be interpreted with caution

Compared with benchmark	Better	Similar	Worse	Lower	Similar	Higher	Not compared

Indicator	Period		England	Cambridgeshire	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire
Life expectancy and causes of death									
Life expectancy at birth (Male)	2012 - 14		79.5	81.2	79.9	82.2	79.4	81.2	82.7
Life expectancy at birth (Female)	2012 - 14		83.2	84.5	84.1	85.5	82.6	84.5	85.6
Infant mortality	2012 - 14		4.0	3.5	3.7	2.2	4.9	3.8	2.8
Killed and seriously injured on roads	2012 - 14		39.3	**48.6**	41.6	**63.3**	**48.6**	44.0	**51.3**
Suicide rate	2012 - 14		10.0	9.0	9.4	*	12.0	8.9	7.9
Deaths from drug misuse	2012 - 14		3.4	2.8	*	*	*	*	*
Smoking related deaths	2012 - 14		274.8	220.3	212.7	200.3	297.5	224.5	175.6
Under 75 mortality rate: cardiovascular	2012 - 14		75.7	58.8	75.2	46.9	78.0	56.3	46.9
Under 75 mortality rate: cancer	2012 - 14		141.5	126.5	131.0	113.7	146.3	123.9	120.6
Excess winter deaths	Aug 2011 - Jul 2014		15.6	12.0	18.7	9.0	12.1	10.2	10.8

* Data quality issue - not available, suppressed or to be interpreted with caution

CAMBRIDGESHIRE

Priorities

To address the impacts of population growth and ageing, mental health issues and health inequalities, by embedding public health improvement throughout local government and the NHS.

Inequalities in Cambridgeshire

- 4.1% of Cambridgeshire's population live in areas in the most deprived 20% of areas in England.
- In men, life expectancy in the most deprived 10% of areas in Cambridgeshire is 6.5 years shorter than in the least deprived 10%. In women, this figure is 5.2 years.
- A lower percentage of all hospital admissions in Cambridgeshire present as emergencies compared with the England average. Percentages are higher, however, in mixed, Black and other ethnic groups compared to white ethnic groups. This may be due to higher levels of urgent need or lower use of services in the community.

Indicators statistically significantly worse than the England average:

Hospital stays for self-harm (all ages)

Emergency hospital admissions for intentional self-harm decreased slightly in Cambridgeshire in 2014/15, but remain significantly above the England average. Around 1,450 admissions occurred among Cambridgeshire residents in 2014/15.

Mental health and well-being is an important aspect of public health. Self-harm is an expression of personal distress which can have a variety of causes. Those who self-harm are often repeat attenders to accident and emergency departments and are at significant and persistent risk of future suicide.

People killed and seriously injured on the roads

Cambridgeshire remained worse than the England average for this indicator in 2012-14. However, the rate has decreased in Cambridgeshire since 2009-11, faster than the slight decrease seen nationally. Just over 300 people a year are killed or seriously injured on the county's roads.

This indicator is partly influenced by the high levels of through-traffic on major roads through the county and many people killed or injured may not be Cambridgeshire residents. Casualty rates per vehicle kilometre travelled are actually lower than the national average.[1]

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups.

Recent time trends

Getting worse

The rate of **hospital admission episodes for alcohol-related conditions** has statistically significantly **increased** over the last 5 years, but remains lower than the national average.

The percentage of patients with **recorded diabetes** has statistically significantly **increased** over the last 5 years, but remains lower than the national average. This may, however, be due to better detection and recording and so not necessarily reflect 'getting worse'

Getting better

The percentage of **children in low income families** (under 16s) has statistically significantly **decreased** over the last 5 years.

The **long-term unemployment** rate has statistically significantly **decreased** over the last 4 years.

[1] Cambridgeshire and Peterborough Road Safety Partnership Handbook – Annual Statistics Summary 2015. Available at: http://www.cambridgeshire.gov.uk/info/20081/roads_and_pathways/136/road_safety

The rate of **under 18 conceptions** has statistically significantly **decreased** over the last 5 years.

The rate of **new sexually transmitted infection diagnoses** (excluding chlamydia in under 25s) has statistically significantly **decreased** in the last 4 years.

Modelled trends in rates of **under 75 mortality due to cardiovascular disease** are consistent with a statistically significant **decrease** between 2003-05 and 2012-14.

Modelled trends in rates of **under 75 mortality due to cancer** are consistent with a statistically significant **decrease** between 2003-05 and 2012-14.

Other indicators where RAG-ratings have changed in 2016

- **Alcohol-specific hospital stays (under18)** (previously **better**)
- **Smoking prevalence in adults** (previously **better**)
- **Percentage of physically active adults** (previously **better**)
- **Excess winter deaths** (previously **better**)

Other data notes for Cambridgeshire

Data for statutory homelessness (eligible homeless people not in priority need) in Cambridgeshire for the latest two periods in Health Profiles (2013/14 and 2014/15) are not published due to unavailability of data. Alternative homelessness data, however, from the Department for Communities and Local Government, on **statutory homeless acceptances**, indicate a statistically significantly higher rate per 1,000 households in Cambridgeshire compared with the England average in 2015/16, and data suggest this rate has **increased** in recent years.

No data are presented for **smoking status at time of delivery** for Cambridgeshire in 2014/15 because a large percentage of mothers have unknown smoking status. The last published data for 2013/14 indicated a statistically significantly lower percentage compared to the England average. It should be noted, however, that this refers to Cambridgeshire & Peterborough CCG.

No data are presented for **breastfeeding initiation** for Cambridgeshire for 2014/15 due to data quality issues. The last published data for 2013/14 indicated a statistically significantly higher percentage compared to the England average.

CAMBRIDGE

Priorities

Improving mental health, addressing drug and alcohol misuse, and tackling health inequalities including homelessness.

Inequalities in Cambridge

- 2.6% of Cambridge's population live in areas in the most deprived 20% of areas in England.
- In men, life expectancy in the most deprived 10% of areas in Cambridge is 8.9 years shorter than in the least deprived 10%. In women, this figure is 7.6 years. This is a greater level of inequality than seen for the county as a whole.
- A higher percentage of all hospital admissions in Cambridge present as emergencies compared with the England average. Percentages are higher in Black ethnic groups compared to white ethnic groups. This may be due to higher levels of urgent need or lower use of services in the community.

Indicators statistically significantly worse than the England average:

Violent crime (violence offences)

The rate of violent crime (recorded violence offences) increased in 2014/15 to a level statistically significantly worse than England. Around 1,800 offences were reported in the county. It should be noted however that this indicator can be affected by recording practice and a high rate may indicate good recording.

Public health services have in important role in tackling violence, through community safety promotion, violence prevention and local initiatives to tackle social exclusion.

Hospital stays for self-harm (all ages)

This indicator remained worse than the England average in Cambridge in 2014/15 but the rate did decrease. Around 380 hospital admissions occurred in Cambridge's residents in 2014/15 due to intentional self-harm. Again, this indicator is known to be affected by quality of recording.

Mental health and well-being is an important aspect of public health. Self-harm is an expression of personal distress which can have a variety of causes. Those who self-harm are often repeat attenders to accident and emergency departments and are at significant and persistent risk of future suicide.

Hospital admission episodes for alcohol-related conditions

The rate of hospital admission episodes for alcohol-related conditions or causes increased in Cambridge residents in 2014/15 and the rate is statistically higher than the England average. 789 admission episodes occurred in 2014/15. One individual may be admitted on more than one occasion or episode.

The consumption of alcohol contributes to a wide range of short and long-term health conditions, as well as accidents. Alcohol misuse has a considerable impact and cost to the NHS and society as a whole. Reducing alcohol-related harm is one of Public Health England's seven priorities for 2014-19.[2]

Recent time trends

Getting worse

Smoking prevalence has statistically significantly **increased** over the last 4 years.

Getting better

The percentage of **children in low income families** (under 16s) has statistically significantly **decreased** over the last 5 years.

The **long-term unemployment** rate has statistically significantly **decreased** over the last 4 years.

[2] Public Health England. From evidence into action: opportunities to protect and improve the nation's health. Available at: https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health

The **percentage of adults physically active** has statistically significantly **increased** over the last 4 years.

The rate of **under 18 conceptions** has statistically significantly **decreased** over the last 6 years. Having said that, rates have increased in the last two years.

Public Health England analysis of trends in **violent crime** suggest an overall significant **decrease** in the rate over the last 5 years but this the trend does not appear to be linear with increases being seen in the most recent years (see inclusion as an indicator 'getting worse' and previous section).

Other indicators where RAG-ratings have changed in 2016

- **Violent crime** (violence offences) (previously **better**)
- **Statutory homelessness** (previously **better**)
- **New sexually transmitted infections** (previously **better**)
- **Under 75 mortality rate from cardiovascular disease** (previously **better**)
- **Hip fractures in people aged 65 and over** (previously **worse**)

EAST CAMBRIDGESHIRE

Priorities

Diabetes, older people (including falls prevention and mental health), and mental health in the working age population.

Inequalities in East Cambridgeshire

- None of East Cambridgeshire's population live in areas in the most deprived 20% of areas in England.
- In men, life expectancy in the most deprived 10% of areas in East Cambridgeshire is 3.5 years shorter than in the least deprived 10%. In women, this figure is 3.9 years.
- A lower percentage of all hospital admissions in East Cambridgeshire present as emergencies compared with the England average. This may be due to lower levels of urgent need or higher use of services in the community.

Indicators statistically significantly worse than the England average:

Excess weight in adults

The percentage of people overweight or obese in East Cambridgeshire is statistically significantly worse that the national average at 68.0% compared to 64.6%.

Excess weight and obesity are known to be a major determinant of premature mortality and preventable ill health. Obesity is associated with diabetes, heart disease, hypertension and stroke, hormone-sensitive cancers, osteoarthritis and sleep apnoea, as well as having a psychosocial impact on wellbeing.

Hospital stay for self-harm (all ages)

The rate of hospital admissions for self-harm as increased in the district from a rate statistically significantly better than the national average in 2012/13 to a rate statistically significantly worse than the national average in 2014/15. Around 200 admissions occurred. This indicator is known, however, to be affected by quality of recording.

Mental health and well-being is an important aspect of public health. Self-harm is an expression of personal distress which can have a variety of causes. Those who self-harm are often repeat attenders to accident and emergency departments and are at significant and persistent risk of future suicide.

People killed and seriously injured on the roads

East Cambridgeshire remained worse than the England average for this indicator in 2012-14, but the rate did decrease slightly.

This indicator is partly influenced by the high levels of through-traffic on major roads through the county and many people killed or injured may not be Cambridgeshire residents. Casualty rates per vehicle kilometre travelled are actually lower than the national average.[3]

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups.

Recent time trends

Getting worse

The prevalence of **recorded diabetes** has statistically significantly **increased** over the last 5 years but this may be due to better detection and recording and may not necessarily reflect 'getting worse'.

Getting better

The percentage of **children in low income families** (under 16s) has statistically significantly **decreased** over the last 5 years.

The **long-term unemployment** rate has statistically significantly **decreased** over the last 4 years.

The rate of **under 18 conceptions** has statistically significantly **decreased** over the last 8 years.

[3] Cambridgeshire and Peterborough Road Safety Partnership Handbook – Annual Statistics Summary 2015. Available at: http://www.cambridgeshire.gov.uk/info/20081/roads_and_pathways/136/road_safety

The rate of **new sexually transmitted infections** has statistically significantly **decreased** over the last 4 years.

The percentage of **cancer diagnosed at early stage** (not RAG-rated but statistically significantly above the England average) has statistically significantly **increased**, but this this may be due to better recording.

Other indicators where RAG-ratings have changed in 2016

- **Hospital stays for self-harm** (all ages) (previously **similar**)
- **Alcohol-specific hospital stays (under 18)** (previously **better**) – the rate actually decreased but not as fast as the England average.
- **Obese children (Year 6)** (previously **similar**)
- **Hip fractures in people aged 65 and over** (previously **similar**)

FENLAND

Priorities

Focussing on healthy lifestyles to reduce heart disease and diabetes, meeting the needs of our ageing population, and improving partnership working.

Inequalities in Fenland

- 20.4% of Fenland's population live in areas in the most deprived 20% of areas in England; 57.6% live in the most deprived 40% of areas.
- In men, life expectancy in the most deprived 10% of areas in Fenland is 4.6 years shorter than in the least deprived 10%. In women, this figure is 1.1 years.
- The percentage of all hospital admissions in Fenland presenting as emergencies is similar to the England average. Percentages were higher in mixed ethnic groups but lower in Asian ethnic groups compared to white ethnic groups. Variation may be due to differing levels of urgent need or differing use of services in the community.

Indicators statistically significantly worse than the England average:

Children in low income families (under 16s)

The percentage of under 16s in low income families in Fenland actually continues to decrease slightly, but greater improvement in the percentage nationally has seen Fenland become worse than the England average in the last two years reported.

Growing up in poverty adversely affects children's health and wellbeing and is associated with poor health and life chances in adulthood.

GCSEs achieved

This indicator remained worse than the England average in Fenland in 2014/15 with 48.4% of children achieving 5 A*-C GSCEs including maths and English compared to 57.3% nationally.

Educational attainment is influenced by a range of factors including the quality of education children receive, their family's socio-economic circumstances and parental aspirations. Educational qualifications are a determinant of an individual's labour market position and wellbeing, which in turn influences income, housing and other material resources which can influence health and quality of life.

Breastfeeding initiation

The percentage of new mothers breastfeeding their babies in the first 48 hours after birth in Fenland in 2014/15 was 68.8%, significantly lower than the national average of 74.3%.

Breastfeeding provides ideal and cost-free nutrition for babies and protects them from gastro-intestinal and respiratory infections. There are also health benefits for the mother, such as a faster return to pre-pregnancy weight.

Smoking prevalence

Smoking prevalence in the district returned to a level statistically significantly worse than the England average in 2015 at 26.4% compared with 16.9%. This equates to nearly 21,000 smokers aged 18+.

Smoking is the single most important cause of preventable ill health and premature mortality and is a risk factor for lung cancer, COPD and heart disease, as well as cancers of many other organs. Smoking is a modifiable lifestyle factor and effective tobacco control measures can reduce smoking in populations.

Percentage of adults physically active

The percentage of adults classified as physically active according to the Chief Medical Officer's guidelines remained significantly lower in Fenland compared with the England average in 2015, at 47.9% compared to 57.0% and fell compared to the 52.1% reported for 2014.

People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. In older adults, physical activity is associated with increased functional capacities.

Excess weight in adults
In Fenland in 2012-14, 73.1% of the resident population were estimated to be overweight or obese, significantly higher than the England average of 64.6%.

Excess weight and obesity are known to be a major determinant of premature mortality and preventable ill health. Obesity is associated with diabetes, heart disease, hypertension and stroke, hormone-sensitive cancers, osteoarthritis and sleep apnoea, as well as having a psychosocial impact on wellbeing.

Hospital stays for self-harm (all ages)
The rate of hospital admissions due to intentional self-harm remained worse than the national average in Fenland in 2014/15 but the rate did decrease slightly compared with the previous year. Around 223 admissions occur each year among Fenland residents.

Mental health and well-being is an important aspect of public health. Self-harm is an expression of personal distress which can have a variety of causes. Those who self-harm are often repeat attenders to accident and emergency departments and are at significant and persistent risk of future suicide.

Hospital admission episodes for alcohol-related conditions
The rate of hospital admission episodes for alcohol-related conditions increased in Fenland in 2014/15 to a rate statistically significantly higher than the England average, having been statistically significantly lower in 2011/12. There were nearly 700 admission episodes in 2014/15. This indicator is known, however, to be affected by quality of recording.

The consumption of alcohol contributes to a wide range of short and long-term health conditions, as well as accidents. Alcohol misuse has a considerable impact and cost to the NHS and society as a whole. Reducing alcohol-related harm is one of Public Health England's seven priorities for 2014-19.[4]

Recorded diabetes
This indicator remained worse for Fenland compared with the England average in 2013/14, as it has been since 2010/11. The percentage recorded with diabetes has increased both locally and nationally. Approximately 7,080 people in Fenland were recorded as having diabetes on GP registers.

Type 2 diabetes (which accounts for around 90% of cases) is partially preventable by lifestyle changes to diet and physical activity. Complications of diabetes, such as cardiovascular, kidney, foot and eye diseases, cause considerable morbidity and impact on quality of life.

People killed and seriously injured on the roads
The rate of people killed or seriously injured on the roads during 2012-14 in Fenland was statistically significantly higher than the England average, increasingly slightly compared to 2011-13 and following 3 previous periods of decrease.

This indicator is partly influenced by the high levels of through-traffic on major roads through the county and many people killed or injured may not be Cambridgeshire residents. Casualty rates per vehicle kilometre travelled are actually lower than the national average.[5]

Recent time trends

Getting worse
The rate of **hospital admission episodes for alcohol-related conditions** has statistically significantly **increased** over the last 5 years.

The **incidence of TB** remains lower than England average but has statistically significantly **increased** since 2006-08.

[4] Public Health England. From evidence into action: opportunities to protect and improve the nation's health. Available at: https://www.gov.uk/government/publications/from-evidence-into-action-opportunities-to-protect-and-improve-the-nations-health
[5] Cambridgeshire and Peterborough Road Safety Partnership Handbook – Annual Statistics Summary 2015. Available at: http://www.cambridgeshire.gov.uk/info/20081/roads_and_pathways/136/road_safety

The prevalence of **recorded diabetes** has statistically significantly **increased** over the last 5 years but this may be due to better detection and recording and may not necessarily reflect 'getting worse'.

Getting better

The percentage of **children in low income families** (under 16s) has statistically significantly **decreased** over the last 5 years but its RAG-rating compared to the England average has worsened due to a faster rate of decrease nationally.

The rate of **under 18 conceptions** has statistically significantly **decreased** over the last 5 years.

Modelled trends in rates of **under 75 mortality due to cardiovascular disease** are consistent with a statistically significant **decrease** between 2003-05 and 2012-14.

The **long-term unemployment** rate has statistically significantly **decreased** over the last 4 years.

The rate of **new sexually transmitted infections** has statistically significantly **decreased** over the last 4 years.

Other indicators where RAG-ratings have changed in 2016

- **Smoking prevalence** (previously **similar**)

HUNTINGDONSHIRE

Priorities

Reducing excess weight in the worst affected areas, improving mental health, and supporting older people to live independently, safe and well.

Inequalities in Huntingdonshire

- 1.9% of Huntingdonshire's population live in areas in the most deprived 20% of areas in England.
- In men, life expectancy in the most deprived 10% of areas in Huntingdonshire is 6.1 years shorter than in the least deprived 10%. In women, this figure is 4.4 years.
- A lower percentage of all hospital admissions in Huntingdonshire present as emergencies compared with the England average. Percentages are higher, however, in mixed and Asian ethnic groups than in white ethnic groups. This may be due to higher levels of urgent need or lower use of services in the community.

Indicators statistically significantly worse than the England average:

Excess weight in adults

In Huntingdonshire during 2012-14, 67.3% of the resident population were estimated to be overweight or obese, significantly higher than the England average of 64.6%.

Excess weight and obesity are known to be a major determinant of premature mortality and preventable ill health. Obesity is associated with diabetes, heart disease, hypertension and stroke, hormone-sensitive cancers, osteoarthritis and sleep apnoea, as well as having a psychosocial impact on wellbeing.

Recent time trends

Getting worse

Public Health England assessments of trends indicate that the rate of **hospital admission episodes for alcohol-related conditions** has statistically significantly **increased** over the last 6 years. Having said this, the trend does not appear to be linear and the rate has reduced in the last two years.

The prevalence of **recorded diabetes** has statistically significantly **increased** over the last 5 years but this may be due better detection and recording. An increase may not necessarily indicate 'getting worse'.

Getting better

The percentage of **children in low income families** (under 16s) has statistically significantly **decreased** over the last 5 years.

The **long-term unemployment** rate has statistically significantly **decreased** over the last 4 years.

The rate of **under 18 conceptions** has statistically significantly **decreased** over the last 5 years.

The rate of **new sexually transmitted infections** has statistically significantly **decreased** over the last 4 years.

Modelled trends in rates of **under 75 mortality due to cardiovascular disease** are consistent with a statistically significant **decrease** between 2003-05 and 2012-14.

Modelled trends in rates of **under 75 mortality due to cancer** are consistent with a statistically significant **decrease** between 2003-05 and 2012-14.

Other indicators where RAG-ratings have changed in 2016

- **Percentage of adults physically active** (previously **better**)
- **Killed or seriously injured on roads** (previously **worse**)

SOUTH CAMBRIDGESHIRE

Priorities

Supporting the independence of older people, ensuring access to mental health services, and creating a healthy environment through new housing development.

Inequalities in Huntingdonshire

- None of South Cambridgeshire's population live in areas in the most deprived 20% of areas in England.
- In men, life expectancy in the most deprived 10% of areas in South Cambridgeshire is 2.1 years shorter than in the least deprived 10%. In women, this figure is 1.1 years.
- A lower percentage of all hospital admissions in South Cambridgeshire present as emergencies compared with the England average. Percentages do not vary significantly by ethnic group.

Indicators statistically significantly worse than England average:

Hospital stays for self-harm (all ages)
The rate of hospital admissions due to intentional self-harm in South Cambridgeshire remained statistically significantly worse than the England average in 2014/15. Around 340 admissions occur each year among South Cambridgeshire residents.

Mental health and well-being is an important aspect of public health. Self-harm is an expression of personal distress which can have a variety of causes. Those who self-harm are often repeat attenders to accident and emergency departments and are at significant risk of future suicide.

People killed and seriously injured on the roads
South Cambridgeshire remained worse than the England average for this indicator in 2012-14, having been worse since 2009-11. However, the rate has notably improved in the district over recent years.

This indicator is partly influenced by the high levels of through-traffic on major roads through the county and many people killed or injured may not be Cambridgeshire residents. Casualty rates per vehicle kilometre travelled are actually lower than the national average.[6]

Motor vehicle traffic accidents are a major cause of preventable deaths and morbidity, particularly in younger age groups.

Recent time trends

Getting worse
The rate of **violent crime (violence offences)** remains lower than the average but has statistically significantly **increased** in the last 5 years.

The prevalence of **recorded diabetes** has statistically significantly **increased** over the last 5 years but this may be due better detection and recording. An increase may not necessarily indicate 'getting worse'.

Getting better
The percentage of **children in low income families** (under 16s) has statistically significantly **decreased** over the last 5 years.

The **long-term unemployment** rate has statistically significantly **decreased** over the last 4 years.

The rate of **under 18 conceptions** has statistically significantly **decreased** over the last 5 years.

The rate of **new sexually transmitted infections** has statistically significantly **decreased** over the last 4 years.

Modelled trends in rates of **under 75 mortality due to cardiovascular disease** are consistent with a statistically significant **decrease** between 2003-05 and 2012-14.

[6] Cambridgeshire and Peterborough Road Safety Partnership Handbook – Annual Statistics Summary 2015. Available at: http://www.cambridgeshire.gov.uk/info/20081/roads_and_pathways/136/road_safety

Other indicators where RAG-ratings have changed in 2016:

- **Percentage of adults physically active** (previously **better**)
- **Infant mortality** (previously **better**)
- **Excess winter deaths** (previously **better**)

Agenda Item No: 6

IMMUNISATION TASK AND FINISH GROUP UPDATE REPORT

To:	Health Committee
Meeting Date:	6th October 2016
From:	East Anglia, Screening and Immunisation Team
Electoral division(s):	All
Forward Plan ref:	Not applicable
Purpose:	To provide feedback to the health committee on the activities of the Cambridgeshire Immunisation Task and Finish Group(TFG) including: a) indications from preliminary analysis of immunisation uptake data which shows no strong association between the poor uptake of childhood immunisation and index of multiple deprivation within the county b) the TFG's decision to focus on the outlier GP practices. c) that there are ongoing surveys to gain further insight as to why some parents are not bringing their children forward for immunisation. The outcome would be shared when they have been completed. d) the recommendations of the Task and Finish Group will form the basis for the establishment of a follow-up implementation group to deliver on these recommendations. e)) there is an ongoing plan to improve the call-recall Child Health Information System ensuring all babies are invited for immunisation once they are eligible and accurate records kept. This would involve a clear guideline on management of suspension lists. f) that the East Anglia Screening and Immunisation Team has a robust plan on the safe delivery of this year's seasonal flu immunisation. The plan cuts across commissioning, communication/promotion, school based programme, primary care, residential home/housebound, healthcare workers/Occupational Health, maternity, pharmacy, data reporting and monitoring, vaccine supply and a county council funded project to increase flu vaccination of pregnant women
Recommendation:	To note and comment on the information provided

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

1.1 A task and finish group was established in 2016 with terms of reference to develop a shared understanding of the uptake and delivery in Cambridgeshire of the national childhood immunisation programmes, specifically Prenatal Pertussis, MMR and preschool booster. The aim of the Task and Finish group was to identify local issues relating to the low uptake of childhood immunisations and Prenatal Pertussis; in addition, to identify potential solutions and to make recommendations to resolve barriers to uptake of immunisations.

1.2 The recommendations from this group will to be followed by an implementation group to put them into action.

2. MAIN ISSUES

2.1 The uptake of childhood immunisation continues to fall for most of the immunisations.- Appendix 1-4.1 and 4.2

2.2 “Out of the eight programmes sampled Cambridgeshire is the lowest seven with reference to childhood immunisations. Concerns were raised on how low Cambridge is in comparison to the other areas”-minutes of the inaugural TFG

2.2 The uptake of seasonal flu vaccination uptake dropped by 11.1% and 6.0% amongst pregnant women and the at risk groups (<65yrs) respectively when compared with the previous year (15/16 against 14/15).

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

The main cost implication is the cost of a proposed population based campaign required to enlighten the population and professions of the benefits of immunisation. This cost has not been fully agreed.

Additionally there is a cost associated with the project to increase flu vaccination of pregnant women that is covered by the fund made available by the health Committee to improve vaccination uptake.

3.2 Statutory, Risk and Legal Implications

1) The NHS Constitution for England, 2015 states: “You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommends that you should receive under an NHS-provided national immunisation programme”. https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

2) The risk of not achieving herd immunity means that the unimmunised continues to remain at risk of infection. Interestingly, families who have resentment to immunisation seem to cluster together posing huge risk of cross-infectivity during an outbreak.

3.3 Equality and Diversity Implications

1) No Equality Impact Assessment was done. It is envisaged that due to the nature of this project it more likely that health inequity would be address gaps in uptake across different protected groups rather than create one.
2) It hopes to address functional gaps in service delivery most especially improving accessibility.

3.4 Engagement and Consultation Implications

1) The survey mentioned in the recommendation would seek to sample the opinion of service users as well as professionals. The information gained would be fed back into addressing some of the gaps in service delivery.
2) This piece of work is in collaboration with arm's length bodies linked to the immunisation programmes in Cambridgeshire which includes, NHS England, PHE, CCG, LA, provider organisations and NGOs.

3.5 Localism and Local Member Involvement

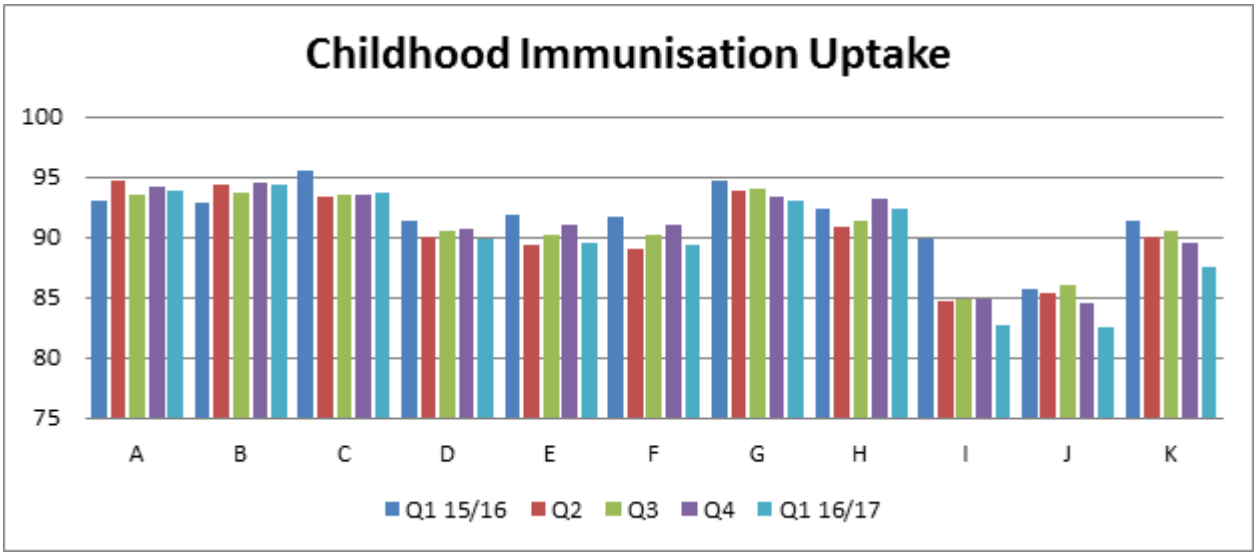
Led and directed by the Joint C&P Health Protection Steering Group which is chaired by the DPH with input from the Cambridgeshire County Council Public Health Team.

3.6 Public Health Implications

1) Achieving herd immunity is the surest way of protecting a community against outbreak of infectious diseases. As long as there are isolated communities that harbor strong negative views about vaccination, there will be outbreaks of vaccine-preventable diseases in those communities.
2) Flu vaccination of pregnant women and those who are at risk would help reduce mortality rate which is a Public Health target for all arm's length organisations.
3) Will the proposal have an impact on the health of Cambridgeshire residents? Yes
4) Will the proposal support improving the health of the worst off fastest? Yes
5) Will the proposal impact on a key health and wellbeing need identified in the Cambridgeshire Joint Strategic Needs Assessment (JSNA)? Yes

Source Documents	Location
Vaccine uptake guidance and the latest coverage data	https://www.gov.uk/government/collections/vaccine-uptake

Appendix 1: Childhood Immunisation Uptake over the past 5 quarters- Graph 4.1



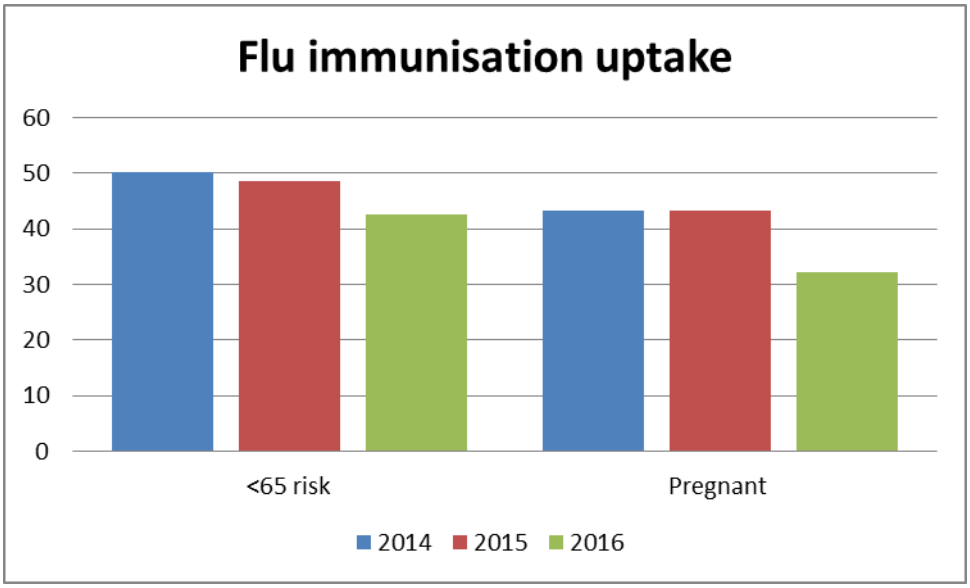
4.2 Childhood Immunisation Uptake over the past 5 quarters- Table

*	Q1 15/16	Q2	Q3	Q4	Q1 16/17 (**)
A	93.1	94.7	93.6	94.2	93.8 (25)
B	92.9	94.4	93.7	94.6	94.3(22)
C	95.6	93.3	93.6	93.5	93.7(24)
D	91.3	90	90.5	90.7	89.9 (96)
E	91.9	89.4	90.2	91	89.6 (102)
F	91.7	89.1	90.2	91	89.4 (105)
G	94.7	93.8	94.1	93.4	93.1 (37)
H	92.3	90.9	91.4	93.2	92.4(51)
I	89.8	84.7	84.8	84.9	82.7 (237)
J	85.7	85.4	86	84.5	82.6 (239)
K	91.3	90	90.6	89.5	87.6 (143)

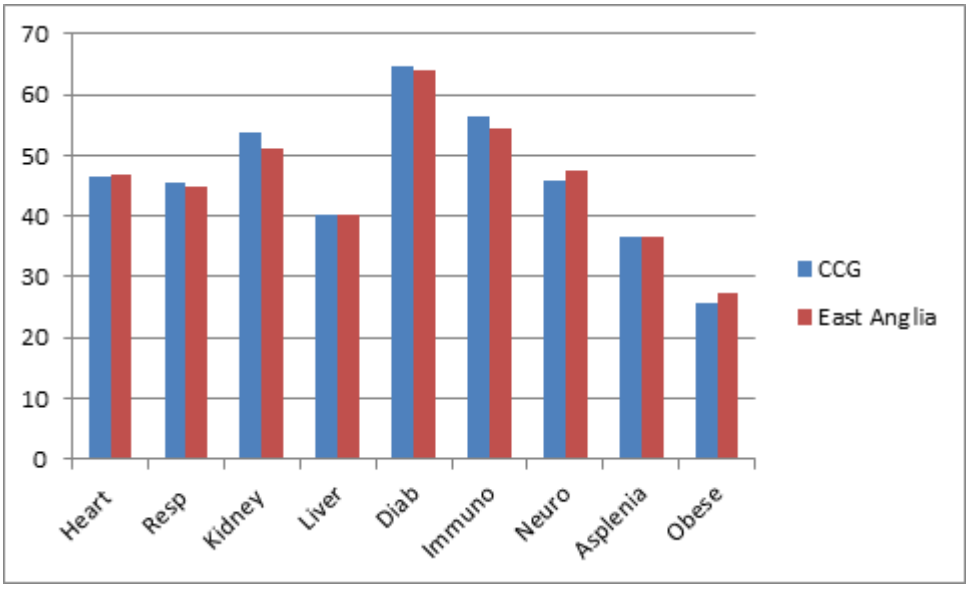
*A) 12 months DTaP/IPV/Hib [target 95%]; B) 12 months PCV [target 95%]; C) 24 months DTaP/IPV/Hib [target 95%]; D) 24 months PCV Booster [target 95%];E) 24 months Hib/Men C [target 95%];F) 24 months MMR 1 [target 95%];G) 5 years DTaP IPV Hib [target 95%];H) 5 years MMR 1 [target 95%];I) 5 years MMR 2 [target 95%];J) 5 years DTaP/IPV Booster [target 95%];K) 5 years Hib/Men C [target 95%]

** Number of children that need to be vaccinated to reach the 95% target.

4.3 Seasonal Flu vaccination uptake over the past 3 years amongst pregnant women and those <65 years categorised to be at risk.



4.4 Seasonal Flu vaccination uptake by risk factor (2015/16 data)



Agenda Item No: 7

REPORT FROM THE CCG URGENT AND EMERGENCY CARE REVIEW TASK FORCE

	Health Committee
Meeting Date:	**6 October 2016**
From:	**The Monitoring Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To note the report from the Health Committee's scrutiny task force on CCG's Urgent & Emergency Care Review.**
Recommendation:	**To approve the recommendations of the task force as set out in the report and to write to the CCG informing them of the task force findings.**

	Officer contact:		***Member contact:***
Name:	Kate Parker	Name:	Councillor David Jenkins
Post:	Head of Public Health Programmes	Chairman:	Health Committee
Email:	Kate.Parker@cambridgeshire.gov.uk	Email:	ccc@davidjenkins.org.uk
Tel:	01480 379561	Tel:	01223 699170

1. BACKGROUND

1.1 The Health Committee received a report in September providing details of the Cambridgeshire and Peterborough System as an Urgent & Emergency Care (UEC) Vanguard site. Under national guidelines, Clinical Commissioning Groups that have vanguard sites are required to carry out a re-designation of all UEC facilities including minor injury units.

1.2 The Health Committee agreed to establish a task force to scrutinise;

i) The terms of reference of the CCG's current review
ii) The process whereby it is carrying it out
iii) The extent to which local needs are being factored into it
iv) The objective criteria which it is using in order to identified the preferred options
v) The way in which it has and will engage, consult and communicate with the communities which will be affected.

1.3 The task force members were appointed at 8 September 2016 Health Committee meeting and consisted of Councillors Clapp, Orgee & Sales. This report provides details of the conclusions the task force have made.

2. MAIN ISSUES

2.1 The task force met on 15th September; in attendance were Councillors Connor, Jenkins, Orgee, Sales and Jessica Bawden (Director of Corporate Affairs-Cambridgeshire and Peterborough Clinical Commissioning Group [CCG]). Apologies were noted from Councillor Clapp.

2.2 The task force made the following conclusions:

2.2.1 <u>Need to be taking a long term view</u>

The NHS has standards which need to be followed in such reviews and these dictate their time horizons and how they consider planned developments. However it needs to recognise that Cambridgeshire is a high growth county and this must be appropriately considered

We recommend that the review recognises current and planned developments over a longer time frame so that its robustness in different circumstances can be tested.

2.2.2 <u>Can't force general practices to change their role</u>

Some options depend on a contribution from expanded GP practices. It is important that such contribution be fully qualified and not simply assumed.

We recommend that, if an option is dependent on some form of expanded GP role, the practices concerned be identified, their capability be assessed and their commitment be secured.

2.2.3 Patient behaviour and understanding is key

In order for any option to be successful, it is important that it be fully understood by patients and that they recognise the options available in regards to accessing urgent and emergency care, and how they should behave in order to get the best out of it.

We recommend that a full picture be developed of all the services which will operate in the future (primary, urgent, emergency, out-patient etc.) and how they will be accessed by different people in the community.

We further recommend that a specific and compelling communications program be developed to encourage people to use the proposed new configuration

2.2.4 Set criteria - manage expectations

It is difficult for members of the public to get their heads around the various options in the absence of specific information about what it means to them in terms of the ease with which they will access the various services.

We recommend that a set of service standards (distance, access times, availability etc.) be developed so that people can understand exactly what any new service configuration means to them and that these be set out, along with the financial considerations, when the various options are being compared.

This recommendation notwithstanding we would advise caution in the setting of these standards so that the CCG does not become hostage to unrealistic expectation.

2.2.5 Need to look at total costs including A&E

All options must operate within the context of a full range of NHS services, especially A&E, and will impact on them in one way or another.

We recommend that, when total costs of different options are being presented, these include the full costs of any expected diversions to other services especially A&E. These should be clearly identified as such.

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications
Officer time to support the final recommendations from the task force.

3.2 Statutory, Risk and Legal Implications
There are no significant implications within this category

3.3 Equality and Diversity Implications
Promoting equality and access to services is covered in section 2 of this report

3.4 Engagement and Consultation Implications
Engagement and consultation implications are covered in section 2.2.3 and 2.2.4

3.5 Localism and Local Member Involvement

Local issues were examined by the task force and local members are aware of the current CCG's review.

3.6 Public Health Implications

Potential changes to access to services are noted in this report (see section 2.2.4) and recommendations from the Transport & Health Joint Strategic Needs Assessment (JSNA) 2015 should be noted.

Source Documents	Location
CCG website contains further information on the Urgent and Emergency Care Reviews	http://www.cambridgeshireandpeterboroughccg.nhs.uk/
NHS England website contains general information about the national Urgent and Emergency Care Vanguards	https://www.england.nhs.uk/ourwork/futurenhs/new-care-models/uec/

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 1st September 2016 Updated 28th September	Cambridgeshire County Council

Agenda Item No: 9

Notes

Committee dates shown in bold are confirmed.
Committee dates shown in brackets and italics are reserve dates.

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.

* indicates items expected to be recommended for determination by full Council.

\+ indicates items expected to be confidential, which would exclude the press and public. Additional information about confidential items is given at the foot of this document.

Draft reports are due with the Democratic Services Officer by 10.00 a.m. eight clear working days before the meeting.
The agenda dispatch date is six clear working days before the meeting

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
10/11/16	Public Health Finance and performance report	Chris Malyon/ Liz Robin		20/10/16 3.30pm	28/10/16	01/11/16
	Business Planning 2017-18	Liz Robin				
	Community Led Physical Activity Proposal	Val Thomas	2016/058			
	Procurement of child and adolescent mental health counselling services'	Emma de Zoete	2016/063			
	Scrutiny Item: GP Capacity	Iain Green/ Alice Benton				
	Scrutiny Item: Older People and Adult Community Services (OPACS) – six-month update on arrangements for service delivery (CCG & CPFT)	Kate Parker				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: bed-based intermediate care and minor injuries consultation plan	Kate Parker				
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report TBC) (or December)	Kate Parker				
	Scrutiny Item: update on the development of the integrated NHS 111 and Out of Hours service	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
01/12/16	Business Planning 2017-18	Liz Robin		17/11/16 3.30pm	*18/11/16*	*22/11/16*
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report TBC) (or November)					
	Scrutiny Item: Health Committee Working Groups – Quarterly update	Kate Parker				
12/01/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		15/12/16 3.30pm	03/01/17	29/12/16
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	System Wide Review of Health outcomes In Cambridgeshire	Liz Robin				
	Public Health Risk Register (six-monthly update)	Tess Campbell				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[16/02/17] Provisional Meeting				26/01/17 3.30pm	*03/02/17*	*07/02/17*
16/03/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		23/02/17 3.30pm	03/03/17	07/03/17
	Scrutiny item: Non-Emergency Patient Transport Services performance update six months after September 2016 commencement	Kate Parker				
	Update on Mental Health Vanguard and PRISM [primary care mental health service]	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[13/04/17] Provisional Meeting				23/03/17 3.30pm	*31/03/17*	*04/04/17*
08/06/17	Co-option of District non-voting Members	Ruth Yule		20/04/17 3.30pm	25/05/17	30/05/17
	Public Health Finance and performance report	Chris Malyon/ Liz Robin		18/05/17 3.00pm		
	Update on pilot harm reduction project for stopping smoking	Val Thomas				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				

To be scheduled 0-19 Joint Commissioning of Children's Services (PCC,CCC & CCG; lead authors CCC)

Notice made under the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012 in compliance with Regulation 5(7)

Decisions to be made in private as a matter of urgency in compliance with Regulation 5(6)

1. At least 28 clear days before a private meeting of a decision-making body, public notice must be given which must include a statement of reasons for the meeting to be held in private.
2. At least 5 clear days before a private meeting of a decision-making body, further public notice must be given which must include a statement of reasons for the meeting to be held in private, details of any representations received by the decision-making body about why the meeting should be open to the public and a statement of the Council's response to such representations.
3. Where the date by which a meeting must be held makes compliance with the above requirements impracticable, the meeting may only be held in private where the decision-making body has obtained agreement from the Chairman of the Council.
4. Compliance with the requirements for the giving of public notice has been impracticable in relation to the business detailed below.

Forward plan reference	Intended date of decision	Matter in respect of which the decision is to be made	Decision maker	List of documents to be submitted to the decision maker	Reason for the meeting to be held in private
…/…	[Insert Committee date here]		[Insert Committee name here]	Report of … Director	The decision is an exempt item within the meaning of paragraph … of Schedule 12A of the Local Government Act 1972 as it refers to information ….

5. The Chairman of the Council has agreed that the Committee may hold a private meeting to consider the business referred to in paragraph 4 above because the meeting is urgent and cannot reasonably be deferred for the reasons stated below.

Date of Chairman's agreement	Matter in respect of which the decision is to be made	Reasons why meeting urgent and cannot reasonably be deferred

For further information, please contact Quentin Baker on 01223 727961 or Quentin.Baker@cambridgeshire.gov.uk