HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 10 November 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 of the Meeting on 6 October 2016**	**5 - 14**
3	**Petitions**	

KEY DECISIONS

4	**Proposal for a Locality Delivery Model to Increase Physical Activity Levels Across Cambridgeshire**	**15 - 32**
5	**Re-Commissioning Counselling Contracts for Children and Young People**	**33 - 40**

DECISIONS

6	**Health and Care System Sustainability and Transformation Programme Memorandum of Understanding**	**41 - 60**
7	**Finance and Performance Report**	**61 - 100**

SCRUTINY ITEMS

8	**Older People and Adult Community Services Update** To receive a presentation by Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust.	**101 - 106**
9	**Emerging Issues in the NHS**	

DECISIONS

10	**Health Committee Agenda Plan and Appointments to Internal Advisory Groups and Panels and Partnership Liaison and Advisory Groups** The Committee is invited to: i. Review the Health Committee Agenda Plan; ii. Note that no appointments are currently required to Internal Advisory Groups and Panels or to Partnership Liaison and Advisory Groups.	**107 - 112**
11	**Health Committee Training Plan**	**113 - 114**

12 Date of Next Meeting

To note the change of date for the next meeting. The Health Committee will now meet next on Thursday 15 December 2016 at 2.00pm in the Kreis Viersen Room, Shire Hall, Cambridge.

The Health Committee comprises the following members:

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

Councillor Paul Clapp Councillor Lorna Dupre Councillor Lynda Harford Councillor Peter Hudson Councillor Gail Kenney Councillor Mervyn Loynes Councillor Zoe Moghadas 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

Clerk Telephone: 01223 699184

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

The County Council is committed to open government and members of the public are welcome to attend Committee meetings. It supports the principle of transparency and encourages filming, recording and taking photographs at meetings that are open to the 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.

Public speaking on the agenda items above is encouraged. Speakers must register their intention to speak by contacting the Democratic Services Officer no later than 12.00 noon three working days before the meeting. Full details of arrangements for public speaking are set out in Part 4, Part 4.4 of the Council's Constitution http://tinyurl.com/cambs-constitution.

The Council does not guarantee the provision of car parking on the Shire Hall site and you will need to use nearby public car parks http://tinyurl.com/ccc-carpark or public transport

HEALTH COMMITTEE: MINUTES

Date: Thursday 6 October 2016

Time: 2.00pm to 4.00pm

Present: County Councillors Sir P Brown (substituting for Councillor M Loynes), P Clapp, L Dupre, L Harford, P Hudson, T Orgee (Vice-Chairman), P Sales, M Smith, P Topping and S van de Ven

District Councillors M Cornwell (Fenland), S Ellington (South Cambridgeshire) and C Sennitt (East Cambridgeshire)

Apologies: County Councillors D Jenkins (Chairman) and M Loynes
District Councillor A Dickinson (Huntingdonshire)

256. DECLARATIONS OF INTEREST

There were no declarations of interest.

257. MINUTES – 8 SEPTEMBER 2016 AND ACTION LOG:

The minutes of the meeting held on 8 September 2016 were agreed as a correct record and signed by the Vice Chairman.

The following updates to the published Action log were reported:

- The Director of Public Health had followed up a query on agricultural workers' life expectancy and provided the information to Councillor Sales;
- An offer of mental health consultancy support had been made to all secondary schools and training had been offered to all schools and colleges;
- The Chief Operating Officer had supplied answers to the questions raised at the previous meeting by Ms Jean Simpson and Ms Simpson was provided with a written copy of these after the meeting closed.

258. PETITIONS

There were no petitions.

DECISIONS

259. SERVICE COMMITTEE REVIEW OF DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2017-18 TO 2021-22

The Vice-Chairman noted that Sections1-3 of the report provided an overview of business planning across the County Council and would be presented to all Policy and Service Committees whilst Section 4 dealt specifically with business planning relating to public health.

The Group Accountant introduced Sections 1-3 of the report by noting that in the current financial year and in 2017/18 public health would be funded through a ring-fenced grant. From 2018/19 public health expenditure would be treated in the same

way as that of all other directorates for business planning purposes. This reflected a move away from a cash-limited approach for individual directorates towards looking more holistically across the County Council's total expenditure in relation to delivering its strategic goals.

A number of members questioned the use of the term 'savings' in the report rather than 'cuts' and highlighted the difference between savings proposals which related to efficiencies and those relating to service reductions. It was agreed that it was important to be accurate in the use of terms going forward.
(Action: The Group Accountant)

The Director of Public Health introduced Section 4 of the report which dealt specifically with the public health draft revenue programme. She explained that there was a focus on the transformation rather than the reduction of services including by working in partnership with others to reduce the duplication of costs and actions. The ring-fenced public health grant allocation for Cambridgeshire was showing an indicative cash reduction of £681k in 2017-18 compared to the current financial year with a total savings requirement for the Public Health Directorate of £606k. The Group Accountant explained that although the presentation of figures for inflation and demography had changed, the net effect would not be much different to the previous year. Work was continuing to develop additional savings proposals, for example in relation to the smoking cessation services delivered by GPs, and these would be brought to the Committee's November meeting for consideration.

The following points were raised in discussion:

- Members felt that paragraph 4.7 of the report which described a change in the approach to demography and inflation in the 2017-18 business planning round was unclear and would do little to inform members of the public. Members emphasised the importance of clarity in public documents and it was agreed that this paragraph would be re-drafted in the November paper;
  (Action: The Group Accountant)
- The need to be transparent about the impact of changes in demography and inflation on the funds available to finance services which were not a statutory requirement;
- The £4k pressure arising from changes to the management pay structure in the Public Health Directorate was part of a wider change in management pay structures which were cost neutral across the County Council as a whole;
- Some Members expressed concern about placing a reliance on community resilience at a time when many voluntary organisations and services were also facing cuts to their funding. A more holistic approach to funding was advocated which would recognise the pressures created on other organisations and partners by changes in levels of County Council funding. The Director of Public Health said that work was already being undertaken with voluntary sector representatives including the Hunts Forum with a view to developing a more holistic approach, but she undertook to look into a specific case raised by Councillor Harford;
  (Action: Director of Public Health)
- The Director of Public Health confirmed that officers worked closely with the procurement department to ensure that appropriate safeguards were in place;
- The Director of Public Health acknowledged the value of mapping provision across the full range of local authority, health service and voluntary and community sector providers to avoid duplication, but said that due to the scale

and complexity of the task this was usually targeted at specific areas, such as the examination of Integrated Lifestyle Services which the Committee had conducted previously. However, significant effort was being directed into delivering a strategic commissioning approach which would help address this issue going forward;

- Members felt that it would be helpful to see proposed savings or cuts shown as a percentage of overall budgets to give perspective to the scale of the reductions being proposed. Members also commented that previous reports had included details of the impact of proposed changes to front-line services and had explored alternative ways of delivering services. The possibility of including some information on the innovative work being done within the Public Health context in areas such as influencing behaviour change was also discussed. The Director of Public Health agreed to consider how best these comments could be reflected in the business planning papers submitted to the Committee in November.
  (Action: Director of Public Health)

It was resolved to:

i. Note the overview and context provided for the 2017-18 to 2021-22 Business Plan revenue for the Public Health Service;
ii. Comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2017-18 to 2021-22.

260. FINANCE AND PERFORMANCE REPORT – AUGUST 2016

The Committee received a report by the Director of Public Health and the Chief Finance Officer setting out the financial position and performance for Public Health as at the end of August 2016.

The Group Accountant said that the report was based on the figures to the end of August which represented the most recent complete month's figures available. The Public Health Service was currently reporting a balanced year-end position with no over or under spends, although she cautioned that this was based on first quarter figures only.

The Director of Health highlighted the inclusion at Section 4 of a performance summary supported by more detailed appendices which had been requested by the Committee.

The following points were raised in discussion:

- The figures relating to hospital stays for self-harm (paragraph 4.1.2) had been queried at Spokes and the Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) had been asked to report back to that group;
- Members debated the value of including case studies in the report and the Director of Public Health agreed to reflect on whether and how this might be done;
  (Action: Director of Public Health)
- A member questioned whether the figures in the final two columns on page 81 had been transposed and asked that this be checked;
  (Clerk's Note: The figures had not been transposed. The reason for the variance in the Drug and Alcohol Team (DAAT) figures was that the Quarter 1 invoice had not yet been received or paid by the DAAT)

- Councillor Clapp asked whether the Thomas Clarkson Academy had accessed the specialist mental health training described on page 81 of the report. The Director of Public Health undertook to report back to him direct on this. **(Action: The Director of Public Health)**

It was resolved to:

i. Review and comment on the report.

SCRUTINY ITEMS

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261. IMMUNISATION TASK AND FINISH GROUP UPDATE REPORT

The Vice-Chairman welcomed Dr Colin Uju, East Anglia Screening and Immunisation Manager, to the meeting and invited him to introduce his report. Dr Linda Sheridan, Consultant in Public Health, was also invited to contribute to this item.

Dr Uju said that the Task and Finish (T&F) Group had been established to develop a shared understanding of the delivery and uptake of national childhood immunisation programmes in Cambridgeshire, and in particular prenatal pertussis, MMR and the pre-school booster. The group had met four times since December 2015, but its final report had been delayed due to the illness of one of its members. It was anticipated that the Group would conclude its work in the next month after which it was proposed that an implementation group would be set up to deliver its recommendations. The Health Committee would be advised of the precise timings in due course and the Implementation Plan would be circulated to the Committee when it was ready. **(Action: Dr Uju)**

Dr Uju said that detailed work had begun on analysing the data obtained. In many areas of the country there was a clear link between deprivation and reduced levels of the uptake of immunisation, but this was not the case in Cambridgeshire. Five GP practices had been identified where the take-up levels of childhood immunisations were particularly low, but the reasons for this were not yet clear.

During its work the T&F Group had noted that when a parent had been offered two invitations to immunise their child and had not responded that no further invitations would be sent. This practice had been suspended and parents would now continue to receive invitations regardless of whether they attended. The Group had also identified a poor take-up rate of flu vaccinations amongst pregnant women in 2015/16, reflecting a national trend during this period. This might have been influenced by some negative press relating to the flu vaccine at the time, but a survey conducted by the T&F Group had also identified that neither GPs or midwives in Cambridgeshire saw this as an issue on which they were the lead professional. The education programme to both GPs and midwives on this topic was being revised to address this issue. Work was also in hand to set up an alert on a child's medical records to show if they had missed a vaccination so that this could be discussed with parents or the vaccination offered if the child attended a medical appointment for another reason.

The following points were raised in discussion:

- Members felt that it would be more clear for the text at the bottom of table 4.2 to be incorporated into the left hand column of the table;

- It would be helpful to have an update in 12 months' time to see if the drop in vaccination uptake rates amongst pregnant women was a single year anomaly or whether it was repeated in the figures for the following year;
- Whether it would be possible to look at the figures for vaccination uptake by district or whether this would raise information governance issues. The Director of Health agreed to investigate this question and report back; **(Action: Director of Public Health)**
- The variety of reasons why parents might not have their children vaccinated, or why child vaccination records might be incomplete;
- The variation in practice between different GP surgeries in the way in which members of the population aged 65 and over were offered flu vaccinations;
- The school vaccination programme had been extended during the past 12 months and the uptake of childhood vaccinations had been significantly increased where these were delivered in school. It was confirmed that parental consent was obtained in advance for vaccinations being carried out in school;

The Chairman thanked Dr Uju for his report and noted that it showed the impact which a change in process could have.

It was resolved to:

i. Note and comment on the information provided.

262. REPORT BY THE CLINICAL COMMISSIONING GROUP (CCG) URGENT AND EMERGENCY CARE REVIEW TASK FORCE

The Committee considered a report by its task force on the Clinical Commissioning Group (CCG)'s Urgent and Emergency Care Review. Jessica Bawden, Director of Corporate Affairs for the Cambridgeshire and Peterborough CCG, was invited to join the discussion.

The Vice-Chairman said that it was not the role of the Committee to tell the CCG its job, but to ensure that the consultation process was carried out. The focus was therefore on the process rather than on the outcome. Following a meeting on 15 September 2016 the task force had made the following recommendations:

1. That the review recognised current and planned developments over a longer time frame so that its robustness in different circumstances could be tested;
2. That, if an option was dependent on some form of expanded GP role, the practices concerned should be identified, their capability be assessed and their commitment be secured;
3. That a full picture be developed of all the services which would operate in the future (primary, urgent, emergency, out-patient etc) and how they would be accessed by different people in the community;
4. That a specific and compelling communications programme be developed to encourage people to use the proposed new configuration;
5. That a set of service standards (distance, access times, availability etc) be developed so that people could understand exactly what any new service configuration would mean to them and that these be set out, along with the financial considerations, when the various options were being compared. This recommendation notwithstanding, the task force advised caution in the setting of

these standards so that the CCG did not become hostage to unrealistic expectations;

6. That, when the total costs of different options were being presented, these include the full costs of any expected diversions to other services, especially Accident and Emergency (A&E). These should clearly be identified as such.

It was resolved:

i. 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's findings. **(Action: Head of Public Health Programmes: To draft a letter to the CCG setting out the task force's findings)**

DECISIONS

263. APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS AND TO PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee noted that no appointments were currently required.

264. HEALTH COMMITTEE AGENDA PLAN

It was resolved to:

a) note the Agenda Plan;

b) add a request for a follow-up report by the Immunisation Task and Finish Group in 12 months' time. The report should also cover whether the drop in take up of flu immunisations by pregnant women was a single year anomaly or whether it was repeated in the figures for the following year.
(Action: Democratic Services Officer)

Chairman

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on 6 October and 8 September 2016 and updates members on progress in delivering the necessary actions.

This is the updated action log as at 2 November 2016.

Minutes of 6 October 2016

Minute No.	Item	Action to be taken by	Action	Comments	Completed
259.	**Service Committee Review of Draft Revenue Business Planning Proposals 2017/18 to 2021/22**	C Andrews	To ensure accurate and consistent use of terms relating to funding reductions in future reports.	Confirmed.	**Completed**
		C Andrews	To re-draft paragraph 4.7 to make it more accessible.	In hand.	**On-going**
		L Robin	To deal direct with Cllr Harford on the reduction in funding to a specific voluntary sector organisation.	Cllr Harford provided with information by the relevant CCC officer.	**Completed**
		L Robin	To consider how best to reflect Members' comments in the business planning papers submitted in November.	Confirmed.	**Completed**

260.	**Finance and Performance Report – August 2016**	L Robin	To reflect on whether and how case studies might be included in future reports.	This is still under consideration.	**On-going**
		C Andrews	To check whether the figures in the final two columns on page 81 had been transposed.	The figures had not been transposed. The reason for the variance in the Drug and Alcohol Team (DAAT) figures was that the Quarter 1 invoice had not yet been received or paid by the DAAT.	**Completed**
		Liz Robin	To advise Cllr Clapp about whether the Thomas Clarkson Academy had accessed the specialist mental health training described on page 81 of the report.	This information has been provided to Cllr Clapp.	**Completed**
261.	**Immunisation Task & Finish Group Update Report**	Dr C Uju	To advise on precise timings for setting up the proposed implementation group and to provide a copy of the Implementation Plan for circulation to the Committee when available.	Awaited.	**On-going**
		L Robin	To consider whether it would be possible to look at the figures for vaccination uptake by district or whether this would raise information governance issues.	This has been progressed, with information on vaccinations supplied by NHS England, now being reviewed by public health analysts.	**Completed**
262.	**Report by the CCG Urgent and Emergency Care Review Task Force**	K Parker	To draft a letter to the CCG setting out the Task Force's findings.	Work in progress.	**On-going**
264.	**Agenda Plan**	R Yule	To add a request for a follow-up report by the Immunisation T&F Group in 12 months' time. This should also cover whether the drop in take up of flu immunisations by pregnant women was a single year anomaly or whether it was repeated in the figures for the following year.	Added to the Agenda Plan.	**Completed**

Minutes of 8 September 2016

Minute No.	Item	Action to be taken by	Action	Comments	Completed
247.	**Mental Health Vanguard Update**	Dr Meiser-Stedman/ R Yule	Dr Meiser-Stedman to check whether the Samaritans knew about the Sanctuary.	**12.10.16:** Dr Meiser-Steadman has been in touch with the Samaritans' lead officer in Cambridge and provided posters and leaflets to their office. These will be circulated within the Samaritans' team.	**Completed**

Agenda Item No: 4

PROPOSAL FOR A LOCALITY DELIVERY MODEL TO INCREASE PHYSICAL ACTIVITY LEVELS ACROSS CAMBRIDGESHIRE

To:	**Health Committee**
Meeting Date:	**8 September 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**2016/058** *Key decision:* **Yes**
Purpose:	**The purpose of this paper is to present and secure Health Committee support for funding the proposal for a collaborative countywide physical activity Programme.**
Recommendation:	**That the Health Committee approves the following.**

- **Approve and support the implementation of the collaborative countywide physical activity programme "Cambridgeshire Lets Get Moving".**
- **The use of Public Health reserves to fund the Programme at a total cost of £513,000 for an initial two years, with a view to identifying ongoing sources of funding after the initial two years, if positive evaluation outcomes are achieved.**

Officer contact:	
Name:	Val Thomas/Jayne Wisely
Post:	
Email:	Val.thomas@cambridgeshire.gov.uk
Tel:	01223 703264

1. BACKGROUND

1.1 This proposal and the request for funding have been developed through the Cambridgeshire Public Health Reference Group (PHRG). The PHRG provides whole system leadership and multi-agency co-ordination for public health initiatives in Cambridgeshire. It also provides governance for Priority 3 of the Health and Wellbeing Strategy, "Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices". It has a wide membership that includes CCC, the district councils, Cambridgeshire and Peterborough CCG, the voluntary sector and academics from Cambridge University.

1.2 Following its inception the PHRG reviewed the need and evidence for promoting and establishing improved public health outcomes. A healthy diet and physical activity, as determinants of a healthy weight, along with community engagement, were identified as the areas that the PHRG would in the first instance prioritise. Two Task and Finish Groups were established to take forward the work

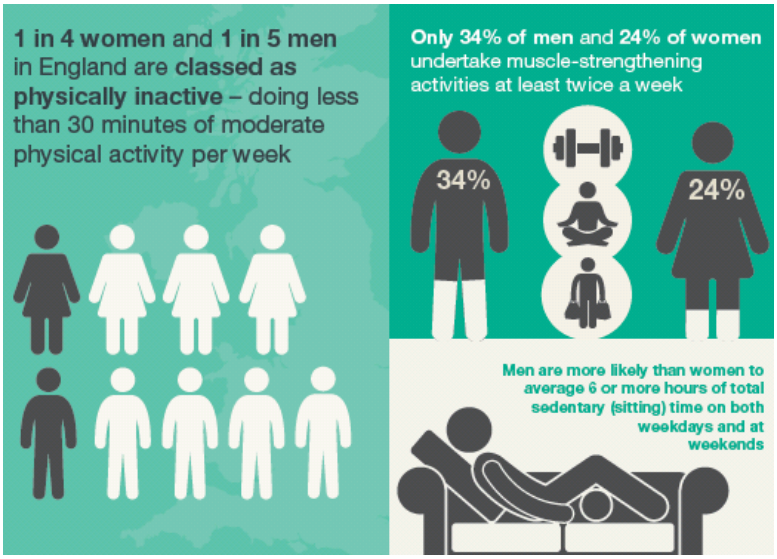
1.3 The first Task and Finish Group focused upon implementing a number of pilot diet and physical activity projects. This led to the generation of the proposal under consideration in this paper, for a collaborative initiative between the District Councils and their partners to provide a countywide physical activity programme that would involve targeting areas and groups with high need. The proposal has been reviewed by the PHRG, which approves and supports it. .

1.4 The second Task and Finish Group has overseen the development of the "Healthy Weight Strategy" which secured the support of the Health Committee (July 2016 meeting) to proceed to further engagement and consultation with stakeholders and the public, and will be launched later this month. . The main aim of the Strategy is to increase the proportion of healthy weight children and adults in Cambridgeshire through improving the levels of healthy eating physical activity. The central theme of the Strategy is that it will require collaboration across the system to achieve its aim and objectives.

2. MAIN ISSUES

2.1 Inactivity or sedentary behaviour is associated with poor health at all ages. Being physically active is good for overall health and also contributes towards addressing obesity and maintaining a healthy weight. However there is a substantial number of people in England who have a low level of physical activity. The population is around 20% less active than in 1961. If current trends continue, it will be 35% less active by 2030. Half of women and one third of men are not active enough to stay healthy. Only 21% of boys and 16% of girls aged 5 to 15 in England take the amount of physical activity they need for good development. Physical inactivity is associated with health inequalities as people living in the least prosperous areas are twice as likely to be physically inactive as those living in more prosperous areas.

Figure 2: Physical activity in England



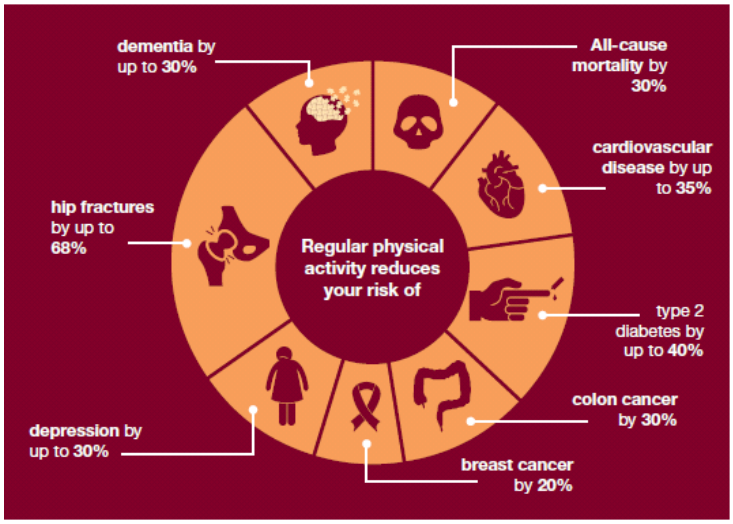
Source: Public Health England. Health Matters 2016

In Cambridgeshire 58% of adults are estimated to be active and 25% inactive. In Fenland the figure for those being active is 48% and for inactivity it is 37%. In terms of obesity, 64% of adults and 27% of 11 year olds are estimated to have an unhealthy weight.

2.2 The benefits of physical activity are extensive It is associated with the prevention of a range of physical and mental health conditions. Physical activity has been found to be key in the prevention and management of 20 long term conditions which includes coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems, and musculoskeletal conditions. 1 in 3 of the working age population have at least 1 long term condition and 1 in 7 have more than one.

Figure 2 identifies some of the most common conditions influenced by physical activity and level of risk that can be reduced by being active.

Figure 2: Physical activity and reduction of risk.



Source: Public Health England. Health Matters 2016

2.3 Physical inactivity is associated with a range of negative effects on health outcomes

- There is three year difference in life expectancy between those who are inactive and those who are minimally active
- Low physical activity is one of the top 10 causes of disease and disability in England
- It has been estimated that around 1% of cancers in the UK (around 3,400 cases every year) are linked to people doing less than the recommended 150 minutes of physical activity each week.
- The link between physical activity and mental health is well established. For example it has been found that people who are inactive have 3 times the rate of moderate to severe depression of active people.

2.4 The impact of physical inactivity upon health creates costs for the whole system.

- Physical inactivity was estimated to cost the UK £7.4 billion annually of which annual NHS costs were estimated at £0.9 billion .
- Public Health England calculated in 2016, using the most recent cost data collected at the CCG level, that physical inactivity costs the NHS in England more than £450m a year in relation to only five health issues.
- It is estimated that physical inactivity creates a further £2.5 billion cost in terms of its contribution to obesity. There are social costs are associated with increased frailty in older people and associated and health and social care services.
- Physical inactivity is associated with employment costs. In England, the costs of lost productivity from sickness absence and premature death have been estimated at £6.5 billion per year. Programmes at work designed to decrease levels of physical inactivity have been found to reduce absenteeism by up to 20%: physically active workers take 27% fewer sick days.
- Poor air quality, congestion and collisions in urban areas of England each costs society around £10 billion a year. Reducing physical in activity by increasing walking or cycling, instead of using motorised transport, can help reduce these associated costs.

2.5 It is evident that Cambridgeshire is experiencing substantial costs because of physical inactivity. These are difficult to calculate exactly as the impacts are complex and reverberate throughout the system but the national figures are indicative of their scale.

2.6 There is evidence for interventions that increase levels of physical activity in the wider population and amongst those with a high risk of poor health outcomes. The evidence indicates that physical activity is a challenging behaviour to change which reflects socio-economic factors including affordable opportunities and the built environment alongside entrenched cultural attitudes. Consequently in Cambridgeshire there is a range of initiatives led by different organisations that aim to tackle physical inactivity. These include local planning policies that increase opportunities for walking and cycling, a travel to work

programme, community led walking programmes, school and workplace based projects and the more targeted exercise referral schemes. There is also economic evidence for many of these interventions. For example a work-based physical activity programme costing £18,900 for a company with 100 employees could lead to an overall net saving of £10,941.

2.7 The proposal for the Collaborative District Physical Activity proposal as found in Appendix 1 is part of the system wide approach to increasing the numbers of people who are physically active. This is the first example of this kind in Cambridgeshire, of a consistent collaborative programme for health improvement between all the district authorities and their partner Living Sport. This proposal aims to deliver a consistent and comprehensive pilot physical activity programme across the county. It acknowledges that there has been a varied approach amongst the district councils to delivering their health and leisure activities. The programme reflects the system wide approach that evidence indicates is necessary to increase levels of physical activity. It will include evidence based interventions at a population level and also for higher risk inactive individuals in a range of settings.

2.8 The Programme is branded as “Lets Get Moving Cambridgeshire”. Each district will implement the programme and will have a district co-ordinator who will be employed and managed by the district authorities. This will ensure that all local authority health and leisure services are integrated into the Programme. A countywide coordinator will ensure consistency and quality across all the district projects along with co-ordinating elements of the Programme that are countywide.

2.9 The governance will be through the usual contractual processes. A Section 75 agreement will be used to contract with the individual district authorities. , the option of a procurement exemption for the contract with Living Sport to provide overall co-ordination of the programme will be explored. Regular reports will be submitted to the PHRG which will review progress and provide support if possible to mitigate any barriers to Programme delivery. The Programme will be part of the regular reporting of Public Health activity to the Health Committee.

2.10 The Programme will make significant contribution to the achievement of the aim and objectives found in the Healthy Weight Strategy. It supports the key theme of system wide collaboration to support healthy behavioural change and communities taking responsibility for their health and wellbeing. Key performance indicators have been developed and the programme will be evaluated for changes in levels of physical activity.

2.11 The Health Committee has previously agreed the allocation of an earmarked Public Health Reserve to be used for the development and implementation of the Public Health Integration Strategy; led by the multi-agency Public Health Reference Group. It is proposed that £513,000 of this funding be used to implement this programme over 2 years. The programme will be fully evaluated and if this demonstrates positive outcomes alternative funding sources would need to be identified to sustain the initiative. However a key objective is to engage local communities in the use of the district council facilities involved in the Programme. If successful, this would be income generating and enable the programme to become partly self-sustainable after two years.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

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

- Physical inactivity is linked to obesity and a range of health conditions that create high level costs for health and social care services as detailed in the Healthy Weight Strategy

3.2 Helping people live healthy and independent lives

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

- Physical inactivity is a major public health issue due to its substantial impact of health
- Increasing levels of physical activity in the population requires a wide range of interventions that address the varying needs of different communities These will need to include targeted actions that will address the inequalities associated with unhealthy weight and are indicated in the Strategy

3.3 Supporting and protecting vulnerable people

- The report above sets out the implications for this priority in **1.3**

4. SIGNIFICANT IMPLICATIONS 4.6

4.1 Resource Implications

The immediate resource implications of this programme for Cambridgeshire County Council and partner agencies are laid out in para 2.11. The wider resource implications of physical inactivity are described in paras 2.4-2.6

4.2 Statutory legal and risk implications

The level of funding required for this programme (£513k of earmarked reserve) is such that this is a key decision for the Health Committee. The governance and contractual mechanisms are laid out in para 2.9: A section 75 will be used for the contractual relationship with individual district authorities. A procurement exemption will be explored which would enable Living Sport, as County Sports Partnership, to provide overall co-ordination for the programme.

4.3 Equality and Diversity

A Community Impact Assessment is attached at Appendix 2.

4.4 Engagement and communications

The programme will be expected to engage with local residents to promote physical activity within communities.

4.5 Localism and local Member engagement

There are no immediate implications for localism and local Member engagement.

4.6 Public Health

The purpose of this programme is to improve population physical activity levels in Cambridgeshire, which in turn will lead to improvements in health outcomes.

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 Name of Legal Officer: Virginia Moggridge
Are there any Equality and Diversity implications?	Community Impact Assessment completed 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 Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Liz Robin

SOURCE DOCUMENTS GUIDANCE

Source Documents	Location
Cambridgeshire Healthy Weight Strategy	..\..\Health Improvement\Obesity\PHRG Obesity Strategy from 2016\DRAFT Healthy Weight Strategy 28 July 2016.docx
UK Active Report Lets Get Moving 2013	http://www.ukactive.com/partnerships/working-with-ukactive/let-s-get-moving

Department of Health Lets Get Moving 2010	http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/PhysicalActivity/DH_099438
Public Health England: Health Matters 2016	https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day
Public Health England Physical inactivity: economic costs to NHS clinical commissioning groups 2016	https://www.gov.uk/government/publications/physical-inactivity-economic-costs-to-nhs-clinical-commissioning-groups
Public Health Outcomes Framework	http://www.phoutcomes.info/
Public Health England: Health matters: getting every adult active every day 2016	https://www.gov.uk/government/publications/health-matters-getting-every-adult-active-every-day/health-matters-getting-every-adult-active-every-day
Health England: Everybody active, every day. The case for taking action	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366522/141022_EAED_MP_toolkit.pdf
NICE Physical activity, Local government briefing [LGB3]	https://www.nice.org.uk/advice/lgb3/chapter/Costs-and-savings

PROPOSAL FOR A LOCALITY DELIVERY MODEL TO INCREASE PHYSICAL ACTIVITY LEVELS ACROSS CAMBRIDGESHIRE

APPENDIX to Health Committee Paper September 8th 2016

1. Proposal

The proposal is for a countywide physical activity programme that will be implemented across all five districts and borough authorities along with Living Sport. Living Sport is the Cambridgeshire Sports Partnership. It is a charity that aims to improve the health and well being of population in Cambridgeshire and Peterborough through participation in sport.

It Programme's overall aim is to increase levels of physical activity and it has the following objectives.

- Provide organised physical activities within the different localities that will support people to increase their physical activity.
- Contribute to the maintenance of healthy behaviour change through the provision of ongoing opportunities for those leaving weight management and other behavioural change services.
- Engage and strengthen communities to enable them develop and deliver activities within their communities.
- Promote and signpost individuals and communities to existing activities.

2. The Evidence

Being physically active is good for overall health but it also contributes towards maintaining a healthy weight. In Cambridgeshire 58% of adults are estimated to be active and 25% inactive. In Fenland the figure for those being active is 48% and for inactivity it is 37%. In terms of obesity, 64% of adults and 27% of 11 year olds are estimated to have an unhealthy weight.[1]

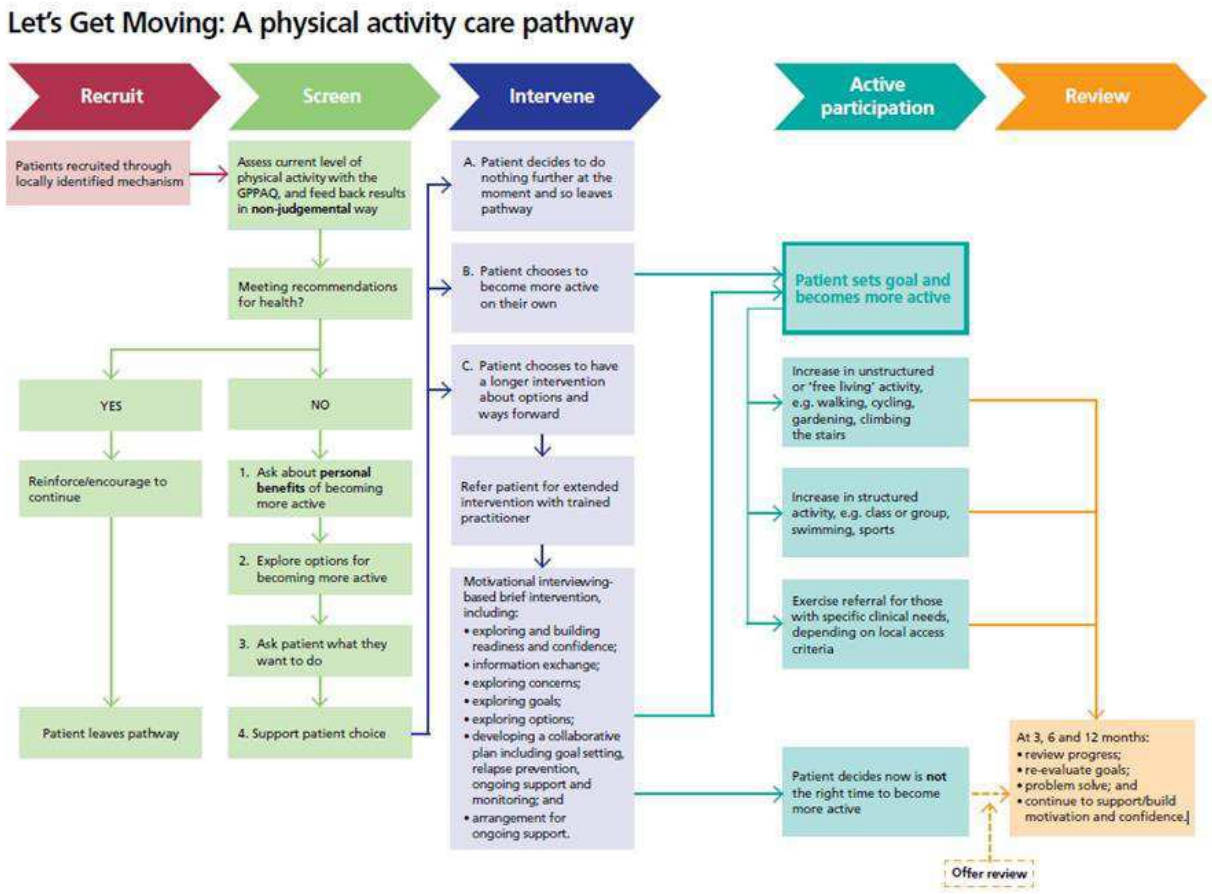
The programme that is proposed is based upon the Let's Get Moving - Physical Activity Pathway [2] [3] model. This is an evidence based model that was developed by the Department of Health that brings together a range of evidence based interventions. The model includes both universal (population

[1] Public Health Outcomes Framework http://www.phoutcomes.info/
[2] Department of Health Leys Get Moving (2010) http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/PhysicalActivity/DH_099438 2010
[3] UK Active Lets Get Moving Report http://www.ukactive.com/partnerships/working-with-ukactive/let-s-get-moving 2013

wide) and targeted approaches and will also provide the brand. It will provide consistency across the county that will ensure quality and also enable a more robust evaluation.

The evidence that underpins the model reflects behavioural change theory and includes the use of brief interventions and motivational interviewing to engage people in programmes that will increase their levels of physical activity. At a population level there will be promotional activities and an increase in opportunities to engage in physical activities. At a more targeted level communities identified as having low levels of physical activity will be targeted to stimulate community engagement in developing and owning physical activity opportunities along with providing motivating interventions for individuals. Individuals who have been through a behavioural change programme or weight management programme will be signposted to the local programmes to help them maintain any behavioural changes.

Figure1: Let's Get Moving Physical Activity Pathway ***(please note the diagram refers to patients not clients as the model was developed by the NHS)***



3. Delivery Model

3.1 Programme delivery will be through a team of coordinators and will include one in each district supported by countywide coordinator.

3.2 The district co-ordinators will be responsible for co-ordinating the local delivery of the programme. They will develop, identify and promote local structured and unstructured activities for the identification and referral of individuals and communities with low levels of physical activity. A significant part of their roles will be around engaging communities in the development and ownership of sustainable activities. They will also be responsible for local monitoring and reporting of the programme outcomes to the countywide Programme Coordinator. These posts will be employed and managed by the local authority line management structures.

3.3 The countywide Programme Co-ordinator - will be responsible and accountable for the overall delivery of the programme, ensuring the aims and objectives are met along with ensuring consistent and quality standards of any of the interventions. In addition the post will have responsibility for the co-ordinated marketing and promotion of the programme, ensuring the brand is widely recognised. A key element of the role will be to monitor the programme and ensure that the district coordinators are delivering the key outputs and that the key performance indicators are met. The coordinator will also have responsibility for ensuring that the Programme is evaluated. Furthermore the programme co-ordinator will seek external and partnership funding to support the ongoing delivery and sustainability of the programme.

3.4 The inclusion of the countywide coordinator is fundamental to the successful delivery of the programme. It will ensure that the programme is consistent across the county, that there is shared learning to inform Programme development, that it is monitored and steps are taken if it is underperforming, a countywide consistent approach to campaigns and that there is a robust evaluation. This post will be hosted and managed by Living Sport – Cambridgeshire County Sports Partnership.

4. Key Elements of the Programme

4.1 **Targeted** interventions – for those identified through for example the Health Trainer Service or through GP practices who have low levels of physical activity or communities where evidence suggests there is a greater need. The aim is to motivate these high risk individuals and communities to increase their physical activity levels.

Individuals

<u>Identification and referral</u>
The Health Trainer services and professionals in other organisations will identify and refer individuals to physical activities. In support of this the district coordinators will facilitate behavioural change training for professionals in

organisations (brief interventions) to enable them to make a motivating intervention and refer individuals who are more likely to engage in the activities.

Maintenance of behaviour change

Individuals who have been involved in structured behaviour change programme will be referred to the local activities. This is particularly relevant for individuals who have been through weight management services where maintenance of weight loss can be challenging.

Communities and other settings

The local coordinators will identify communities and other settings such as schools or workplaces with low levels of physical activity for an intervention. Across Cambridgeshire there are a number of programmes that are working to engage and strengthen communities. The coordinators will work with these programmes to encourage and support communities to develop and participate in physical activity opportunities.

4.2 **Universal interventions** are activities that are designed to encourage behavioural change and a resultant increase in physical activity in the general population. This will include the following activities.

Development of physical activity programmes

The district coordinators supported by the county coordinator will build upon the existing offers within the districts and support the development of new initiatives which could include those listed below. The role of the Programme staff will be to work with the existing programmes to identify how uptake could be improved, develop new programmes, signposting and engagement of communities in structured and unstructured programmes across a wide range of settings such as schools, workplaces, community halls and leisure centres.

Examples of structured activities - delivered in Community settings and other leisure facilities.

- Swimming
- Fitness / Exercise Classes

Examples of *unstructured activities*

- Walking for health
- Mile a Day
- Go Run For Fun
- Kids Run Free
- Park Runs (version of for families / non-competitive versions to stop them being a barrier to participation
- Park Tennis
- Outdoor exercise - outdoor gyms

Promotion and campaigns

The County Coordinator will be responsible for the development and implementation of an ongoing physical activity promotion campaign that will complement other initiatives to increase levels of physical activity in the wider population. It will involve working with other organisations to develop joint campaigns and consistent messages. District coordinators will reflect this activity in their local areas.

4.3 Integration with other services will be essential to ensure that services are complementary. This will require clear referral pathways, joint planning to avoid duplication and to ensure that consistent messages are given to the public. As indicted above working with community engagement programmes and on promotional activities will be important but also lifestyle services such the Integrated Lifestyle Service provided by Everyone Health and the Healthy Workplace programme.

5. Implementation Costs

5.1 The proposal is for the Programme to be initially implemented over a two year period. To support the delivery of this Programme it is essential that it is consistently resourced across all districts. The required funding is detailed below in Table 1.

Table 1: Annual Implementation costs for Cambridgeshire Lets Get Moving Programme

	Cost	Living Sport Contribution		Actual Funding required
		Cash	In-kind	
Programme Co-ordinator	£39,000*	£10,000		£29,000
Locality Co-ordinators x 5 @ £32.5K	£162,500**			£162,500
Training, Development and Mentoring	£5,000			£5,000
Operational Budget	£50,000			£50,000
Promotion and Marketing	£10,000		£2,500	£7,500
Evaluation	£10,000		£7,500	£2,500
Total	**£276,500**	**£10,000**	**£10,000**	**£256,500**

* Approximate salary including 'on costs'. This post will be hosted and managed by Living Sport
** Contribution to District Council's to either employ a member of staff to undertake this role, or contribute to funding existing member of staff(s) to undertake this role.

6 Monitoring and Evaluation

6.1 Due to the investment into the programme, monitoring and evaluation will be fundamental for demonstrating the impact of the programme, future investment / funding and return on investment. Where the activity permits, the following will be measured and monitored for all participants in the programme.

- Attendance / Participation
- Physical Activity levels before and after programme / intervention. (e.g. International Physical Activity Questionnaire IPAQ)
- Weight
- Heart Rate / BMI / or waist circumference (where possible)
- Self-efficacy measurement before / after intervention
- Behaviour change – adherence to increased physical activity levels, 6 & 12 month check

An initial evaluation report will be completed at the end of the first year and will influence delivery in year 2.

6.2 Key Performance Indicators have been developed which will be monitored through the contractual process.

- Baselines will be established in the first 6 months of the Service to establish ongoing targets.
- There will be thresholds for each target.
- Reporting will be at district level and will be quarterly unless there is performance issues. This will be captured in the formal agreement
- Providers will take part in audits

7. Governance

7.1 It is proposed that there will be a formal contractual agreement with each local authority through a Section 75 agreement. The option of a procurement exemption for the contract with Living Sport is being explored. Each contract will be monitored individually.

7.2 The countywide Programme Co-ordinator will be responsible for reporting through the usual contractual processes. The PHRG will regularly review progress and provide support if possible to mitigate any barriers to Programme delivery. The Programme will be part of the regular reporting of Public Health activity to the Health Committee.

Jane Wisely
Huntingdonshire District Council

Val Thomas
Consultant in Public Health

COMMUNITY IMPACT ASSESSMENT **Item 4: Appendix 2**

Directorate / Service Area	Officer undertaking the assessment
Public Health	Name: Shaun Birdsall.....
Service / Document / Function being assessed	Job Title: Health improvement specialist .....
Proposal for a locality delivery model to increase physical activity levels across Cambridgeshire	Contact details: shaun.birdsall@cambridgeshire.gov.uk 01223 703259
	Date completed: 31 October 2016 .....
Business Plan Proposal Number (if relevant)	Date approved: 31 October .....

Aims and Objectives of Service / Document / Function

The proposal is for a countywide physical activity programme that will be implemented across all five districts and borough authorities along with Living Sport. Living Sport is the Cambridgeshire Sports Partnership. It is a charity that aims to improve the health and wellbeing of the population in Cambridgeshire and Peterborough through participation in sport, exercise and physical activity.

It's overall aim is to increase levels of physical activity and has the following objectives;

- Provide organised physical activities within the different localities that will support people to increase their physical activity
- Contribute to the maintenance of healthy behaviour change through the provision of ongoing opportunities for those leaving weight management and other behavioural change services
- Engage and strengthen communities to enable them develop and deliver activities within their communities
- Promote and signpost individuals and communities to existing activities.

The programme that is proposed is based upon the Let's Get Moving - Physical Activity 2016Pathway [1] [2] model. This is an evidence based model that was developed by the Department of Health that brings together a range of evidence based interventions. The model includes both universal (population wide) and targeted approaches and will also provide the brand. It will provide consistency across the county that will ensure quality and also enable a more robust evaluation.

What is changing?

In previous funding years, Public Health has funded a variety of physical activity interventions in Districts on an individual basis, usually at small scale. This proposal aims to make investment more transparent and consistent across the County. This proposal will build upon the existing physical activity offers within the Districts and support the development of new initiatives. The role of the Programme staff will be to work with the existing programmes to identify how uptake could be improved, develop new programmes, signposting and engagement of communities in structured and unstructured programmes across a wide range of settings such as schools, workplaces, community halls and leisure centre's.

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

This CIA was compiled by Council officers

[1] Public Health Outcomes Framework http://www.phoutcomes.info/

2 Department of Health Leys Get Moving (2010) http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/PhysicalActivity/DH_099438 2010

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
Some elements of this investment would be target residents who are physically inactive. These groups include women and girls, ethnic minority groups, as well as older people and the disabled. Physical inactivity is also positively linked to areas to deprivation.
Negative Impact
None identified
Neutral Impact
Whilst there should not be any impact upon equalities as there is no proposed change in the service delivery (other than those highlighted), elements of this investment are universal, so there is potential to impact positively on all residents.
Issues or Opportunities that may need to be addressed
The impact of this investment will require monitoring to ensure that the inactive groups are being accessed and engaged. There is the potential for further positive impact due to ongoing evaluation which will provide intelligence for future work and related services, for example workplace and schools programmes.

Community Cohesion

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

The local coordinators in this proposal will identify communities and other settings such as schools or workplaces with low levels of physical activity for an intervention. Across Cambridgeshire there are a number of programmes that are working to engage and strengthen communities. The coordinators will work with these programmes to encourage and support communities to develop and participate in physical activity opportunities.

Version Control

Version no.	Date	Updates / amendments	Author(s)
V.1	31/10/16		Shaun Birdsall

Agenda Item No: 5

RE-COMMISSIONING COUNSELLING CONTRACTS FOR CHILDREN AND YOUNG PEOPLE

To:	**HEALTH COMMITTEE**
Meeting Date:	**10 November 2016**
From:	**Liz Robin**
Electoral division(s):	**All**
Forward Plan ref:	**2016/063** *Key decision:* **Yes**
Purpose:	**What is the Committee being asked to consider?** The planned re-commissioning of children's counselling services for Cambridgeshire.
Recommendation:	**What is the Committee being asked to agree?** **Key Decision:** To agree to the tender of counselling services jointly with Peterborough City Council and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) through the Joint Commissioning Unit. To agree to delegating authority to the Director of Public Health, in consultation with the Chair and Vice-chair of the Health Committee, to commit funding at the time of the award of the contract.

Officer contact:	
Name:	Emma de Zoete
Post:	Consultant in Public Health
Email:	Emma.DeZoete@cambridgeshire.gov.uk
Tel:	01223 699117

1. BACKGROUND

1.1 Around 50% of lifetime mental illness starts before the age of 14 and continues to have a detrimental effect on an individual and their family for many years. Potentially, half of these problems are preventable.

1.2 Some children are more vulnerable to mental health problems than others with a number of particular risk factors increasing vulnerability.[1] For example, those from low-income households; families where parents are unemployed or have low educational attainment; being looked-after by the local authority; having a disability (including learning disabilities); originating in gypsy and traveller communities; within the criminal justice system; with substances misusers; and having a parent with a mental health problem.

1.3 Many children experience more than one risk factor, and four or five adverse childhood experiences (child abuse, parental depression, domestic abuse, substance abuse or offending) increases the risk of developing mental health problems throughout life.[2]

1.4 Nationally, there is drive to improve mental health services for children and young people as set out in 'Future in Mind', and in particular to improve access to evidence based interventions. This work is one element of a wider service redesign using the 'ithrive' model.

NHS England has recently announced that by 2020/21, there will be a significant expansion in access to high-quality mental health care for children and young people, with at least 70,000 additional children and young people each year receiving evidence-based treatment – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions. We are working with colleagues in the CCG to understand what this estimate means locally.

1.5 Counselling services for children and young people are an evidence based treatment and should be part of a range of mental health services for children and young people. We estimate that there are approximately 12,827 children and young people aged 5-17 years with a diagnosable mental health condition in Cambridgeshire.

2. MAIN ISSUES

By jointly commissioning counselling services for children and young people across Cambridgeshire and Peterborough we can bring together funding from CCC, PCC and potentially the CCG, to be combined in one contract. This will mean we have a much larger scale contract which will have more impact and crucially increase access for children and young people across Cambridgeshire to support for their mental health. It is estimated nationally that only 25% of children and young people with a diagnosable mental health condition access mental health services and the government aim is to increase this to 35%.

Current position

2.2 Public Health currently fund the following counselling contracts for Cambridgeshire totalling approximately £240k a year. Additional funding of £80k a year was agreed in 2014/15 to

[1] ChiMat (2011).
[2] New Horizons Confident Communities, Brighter Futures: A framework for developing wellbeing. HM Government March (2010)

extend services in Fenland and Huntingdon.

2015/16			
Area	**Provider**	**Current Contract**	**Total**
Huntingdon and Fenland	YMCA	£52,659.16	£52,659
Cambridgeshire	Centre 33	£137,333	£137,333
Cambridgeshire bereavement services	STARS	£50,660	£50,660
Total			**£240,652**

2.3 These contracts were awarded for three years and expired in March 2016. It was agreed that they should be extended for a further year whilst the system wide redesign of children's mental health was undertaken.

2.4 Overall these contracts see at least 1,300 young people a year, with at least 800 of these receiving counselling. However, it has become increasingly clear through feedback from children and young people that they want to have a more flexible service offer, and standard counselling is not suitable for all. For this reason, Centre 33, have agreed new targets which reflect a wider service offer, including drop in sessions, just an initial assessment and goal setting session, further support for those with complex needs beyond 6-8 sessions, and improved access to advice.

3. What is proposed?

The process

3.1 Fortuitously, all the existing counselling contracts in Cambridgeshire and Peterborough have reached the end of their contract period and require recommissioning. For the reasons outlined below we are currently working on jointly commissioning counselling services for children and young people through the Joint Commissioning Unit across Cambridgeshire and Peterborough. This will allow funding from CCC, PCC and the CCG, to be combined in one contract.

3.2 This would bring together Cambridgeshire investment of £240k and Peterborough investment of approximately £119k a year. The CCG have agreed to an in-year investment for 2016/17 of £110k (£90k counselling services and £20k on mental health awareness sessions with schools) to widen the Centre 33 service offer in Cambridgeshire. The CCG are considering further investment for 2017/18 and beyond in these services and have planned for this.

3.3 Existing funding from each local authority would remain focused on that local authority population, and any additional CCG funding will be split according to weighted need. Peterborough City Council would lead the tender process on behalf of the Joint Commissioning Unit.

3.4 As the re-commissioning is likely to seek a contract of three years in length the CCC contribution to the contract will be in excess of £500,000 and therefore we are asking Health Committee to delegate authority to the Director of Public Health to award funding to Peterborough City Council who will be contracting on behalf of CCC and the CCG in this instance, when the award of contract is made.

Services

3.4 Recommissioning these services offers the opportunity to re-design services in line with the ithrive model in which support is based on a young person's needs. A broader support offer, ranging from advice and signposting to counselling and more intensive support for those with more complex needs will be delivered across the county; this is currently not the case. The service will build on existing models and any additional investment will enable more young people to access services.

3.5 Support will be delivered through structured sessions, but also drop-ins to cater for the variable needs of individuals and communities. The service will also make greater use of technology to cater for young people.

3.6 Currently counselling provision is for 12-25 year olds in Cambridgeshire, in the new contract this will be extended to 11-25 year olds in recognition of the level of need within the younger age groups. We are also considering potentially expanding the service to children of primary school age, depending on funding and feasibility.

3.7 Bereavement support services are provided across the county at present and this will continue to be the case in the new service, recognising the specialist support that these young people require.

3.8 Other key advantage of recommissioning services in this way include ensuring consistency of counselling services across Cambridgeshire. Currently we have two counselling providers in Fenland and Huntingdonshire (YMCA & Centre 33), and although we are assured that this does not effect on the ground provision to young people it is not an ideal situation.

3.9 We have gaps in service provision, particularly for some at risk children and young people, and in treatment provision for children of primary school age. A larger contract would mean that we may be able to address some of these gaps. It also provides an opportunity to potentially bring together small contracts, such as work providing training and PHSE support to schools, to a scale where they can potentially have greater impact.

3.10 Historically there have been issues with recruiting counsellors in some parts of the county and providers working across a wider geography are more likely to generate solutions to this.

Implications for existing service providers

3.11 The scale of the contract is likely to be best met by a range of organisations working together, possibly in a consortia arrangement. This will ensure that organisations work closely together on children's mental health, and should combine organisational strengths.

3.12 Existing services are in some part provided by volunteers and are in part funded through other grants and charitable fundraising. They are good value for money and therefore we do not anticipate additional efficiencies from the contracts. There is however an efficiency in commissioning manpower in undertaking this retender across both local authorities and the CCG through the Joint Commissioning Unit.

3.13 Children's mental health services form part of the 0-19 children's programme and any contract would include the need to work with any future lead provider for 0-19 children's services. Given that the timescales for the 0-19 are well beyond April 2017, we are proposing taking this work forward now.

3.14 There are potential implications for the voluntary sector organisations that are currently commissioned to provide youth counselling services. In particular CCC funding accounts for the majority of Centre 33's and STARs existing funding. Removal of this funding could potentially have a significant effect on these organisations. However, this would remain a risk in any recommissioning of these services and the current contracts expired in March 2016.

3.15 We do not anticipate that smaller projects such as the 'HeadsUp!' project run by Ormiston or the Allyance counselling in schools provision will be included in this tender.

4. Procurement Timelines

4.1 A draft specification for the tender is being developed with an aim to soft-market test in November with a tender process beginning shortly after.

4.2 The procurement timeline means that a longer lead in time is necessary to ensure there is sufficient time to complete the process and enable any new service to be set up. Therefore an extension of the current service provider contracts for nine months has been provisionally agreed until December 2017. The aim would be to have the new service in place for November/December 2017.

5. ALIGNMENT WITH CORPORATE PRIORITIES

5.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

5.2 Helping people live healthy and independent lives

Section 1 details how this work supports young people to live healthy lives.

5.3 Supporting and protecting vulnerable people

Section 1 details how this paper addresses supporting and protecting vulnerable young people.

6. SIGNIFICANT IMPLICATIONS

6.1 *Resource Implications*

The report above sets out significant implications in paragraphs 3.1-3.4, 3.12 and 4.2.

Statutory, Legal and Risk

The procurement process will follow the legal statutory requirements and an exemption to contracts has been agreed to allow for this. The report sets out the implications in paragraphs 3.1-3.4, 3.13 and 4.1-4.2.

Equality and Diversity

The re-commissioning of these services should ensure further improvements in equity of access for children and young people. A community impact assessment has been completed (annex A).

Engagement and Communications

Children, young people, and parents have been involved in the redesign of children's mental health services. They will be involved in the procurement process and there will be engagement and wider communication as appropriate.

Localism and Local Member Involvement

There are no significant implications within this category.

Public Health

This report has been compiled by public health and all public health significant implications are addressed in the report.

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 Name of Legal Officer: Virginia Moggridge
Are there any Equality and Diversity implications?	Community impact assessment completed (see annex A) Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Simon Cobby
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 Name of Officer: Emma de Zoete

Source Documents	Location
Confident Communities, Brighter Futures: A framework for developing wellbeing. HM Government March (2010)	http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_114774
Future in Mind	https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people
Implementing the five year forward view	https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf
ithrive	http://www.annafreud.org/media/2552/thrive-booklet_march-15.pdf

HEALTH AND CARE SYSTEM SUSTAINABILITY AND TRANSFORMATION PROGRAMME MEMORANDUM OF UNDERSTANDING: LOCAL AUTHORITY APPENDIX

To:	**Health Committee**
Meeting Date:	**10 November 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** ***Key decision:*** **No**
Purpose:	**To present the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding to the Health Committee. To ask for the Health Committee's approval of Appendix A: Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan.**
Recommendation:	**The Committee is asked:**

- **to note the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding for NHS organisations in Cambridgeshire and Peterborough**
- **to approve Appendix A: 'Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan' prior to sign off by the Health and Wellbeing Board.**

Officer contact:	
Name:	Dr Liz Robin
Post:	Director of Public Health
Email:	Liz.robin@cambridgeshire.gov.uk
Tel:	01223 703259

1. BACKGROUND

1.1 All NHS organisations in the Cambridgeshire and Peterborough Health System have been asked to participate in the preparation of a five year strategic plan – the Sustainability and Transformation Plan (STP). Because local authority adult social care and public health services are interdependent with NHS services, Cambridgeshire County Council and Peterborough City Council have also been asked to plan jointly with the NHS and align our services with STP where appropriate.

1.2 Development of the STP has been led by the Health and Care Executive (HCE) which is made up of the Chief Executives and Accountable Officers of NHS organisations including the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), local NHS Hospitals, NHS Mental Health Services and NHS Community Services. The Director of Children, Families and Adults and the Director of Public Health from Cambridgeshire County Council and Peterborough City Council attend as non-voting members of the HCE.

1.3 A draft Cambridgeshire and Peterborough STP has been submitted to NHS England in accordance with national deadlines, and the CCG expects to publish the final STP in late November/early December. The STP includes reference to the Joint Strategic Needs Assessments (JSNAs) and Health and Wellbeing Strategies overseen by local Health and Wellbeing Boards. More information about STP planning is available on http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP/

2. MAIN ISSUES

2.1 As part of the work on the STP, local NHS organisations are being asked to sign up to a Memorandum of Understanding (MOU), attached as Annex A. This MOU requires significant changes to ways of working across NHS organisations – essentially asking NHS Chief Executives to function as a single leadership team with mutual understanding, aligned incentives and co-ordinated action.

2.2 It is not feasible for Local Authorities to sign up to the full MOU due to decision making processes which are democratically accountable, and different financial and governance structures to the NHS. Because of this, a separate Appendix to the MOU has been developed for agreement by Local Authorities. This will require sign off by the Local Authority Chief Executive, and by Chair of the Health and Wellbeing Board (HWB), in line with the statutory HWB role to promote integrated working across local authorities and the NHS.

2.3 The MOU Appendix: 'Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan' has four sections:

Introduction
The introduction briefly describes the context of the local health and care economy and the Sustainability and Transformation Plan, and the role of local authorities within this.

Key behaviours
This section describes the behaviours required from the Health and Care Executive and Health and Wellbeing Board members in order to build trust and relationships across the system, to deliver the STP.

Key principles
This section describes the key principles of how organisations will work together to deliver the STP.

Democratic requirements and local authority governance
This section outlines how senior officers and Health and Wellbeing Boards will work with NHS organisations to deliver the STP, while making clear that that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.

2.4 While the final sign off of the Local Authority STP MOU Appendix will be by the Local Authority Chief Executive and the Chair of the Health and Wellbeing Board, the Appendix is also being taken to the Adults Committee and the Health Committee for approval, due to the importance of both the adult social care and public health functions of the Council to effective transformation of the local health and care system.

2.5 In July 2016, the Adults Committee and Health Committee endorsed a previous version of a Health and Care Executive Governance Framework. The new STP Memorandum of Understanding and Local Authority STP MOU Appendix replace the HCE Governance Framework endorsed in July.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

A well functioning health and care system will be a factor in attracting and retaining workforce in Cambridgeshire.

3.2 Helping people live healthy and independent lives

A key purpose of the Sustainability and Transformation Plan is to ensure that the right, sustainable, services are in place to support people to live healthy and independent lives.

3.3 Supporting and protecting vulnerable people

A key purpose of the Sustainability and Transformation Plan is to ensure that the right, sustainable, services are in place to support and protect people who are vulnerable due to health conditions.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

- Resources invested in social care services are relevant to the STP, due to the importance of close joint working with NHS services at local level. The Local

Authority STP MOU Appendix makes a statement of intent to highlight and avoid 'cost shunting' to other partners, and to adopt an 'invest to save' approach. It also states clearly that 'local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.' There are no direct financial commitments within the document.

4.2 Statutory, Risk and Legal Implications

The Local Authority STP MOU Appendix has been reviewed by local authority lawyers in both Cambridgeshire and Peterborough, who are satisfied that the MOU outlines the principles of joint working and does not have adverse legal implications or significant risks to the authorities.

4.3 Equality and Diversity Implications

There are no immediate implications. Organisations are subject to equalities legislation when planning services.

4.4 Engagement and Consultation Implications

The work of the Health and Care Executive will include an ongoing programme of stakeholder and public engagement. Any significant service changes would be subject to public consultation in line with the relevant legislation.

4.5 Localism and Local Member Involvement

There are no significant implications at this point. Local Members may wish to become involved in future public consultations on STP transformation plans, if these are relevant to their divisions.

4.6 Public Health Implications

A well functioning and sustainable health and care system is important for the overall health of the local population.

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: Quentin Baker
Are there any Equality and Diversity implications?	Yes Name of Officer: Val Thomas
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?	Yes Name of Officer: Val Thomas
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Val Thomas

Source Documents	Location
Sustainability and Transformation Plan information	http://www.cambridgeshireandpeterboroughccg.nhs.uk/STP/
Paper to Health Committee (July 2016) on the Health and Care Executive Governance Framework	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/189/Committee/6/Default.aspx

CAMBRIDGESHIRE AND PETERBOROUGH
SUSTAINABILITY AND TRANSFORMATION PROGRAMME

MEMORANDUM OF UNDERSTANDING

CAMBRIDGESHIRE & PETERBOROUGH HEALTH AND CARE SYSTEM

Version Control

Version no	Date	Source of Edits	Author
1	31/07		CP
2	02/08	Tracy Dowling	AG
3	03/08	Lance McCarthy	AG
4	07/08	Stephen Graves & Caroline Walker	CP
5	09/08	Stephen Graves	LG
6	11/08	Catherine Boaden	LG
7	12/08	Claire Tripp, Matthew Winn, NHS Providers	CP
8	16/08	Wendi-Ogle Welbourn & Will Patten, Andrew Pike	CP
9	19/08	Aidan Thomas	AG
10	19/08	Dr Liz Robin, Adrian Loades	AG
11	19/08	Roland Sinker	AG
12	28/08	CUH comments – legal & finance	CP
13	04/09	HCE Away comments	CP
14	05/09	Further CUH comments – Bill Boa & Ed Smith	CP
15	07/09	Ros Nerio/ Andrew Rawston (NHSI)	RN
16	07/09	Further CUH Comments – Bill Boa & Ed Smith	CP
17	09/09	NHSI legal changes	RN
18	12/09	CCG comments – finance section;	CP
19	18/09	Final changes for public review by Boards	CP
20	19/09	Further changes to reflect AEB	LG

Final sign off will be secured in public by statutory bodies (NHS Trust or Foundation Trust Boards, Governing Bodies). This will become a public document

Memorandum of Understanding: Cambridgeshire & Peterborough Health and Care System – a Partnership for implementing the Sustainability & Transformation Plan

Date effective: 1 October 2016 Signatories 'The partners', the CEOs/Accountable Officers & Chairs of:

1. Cambridgeshire & Peterborough CCG
2. Cambridge University Hospitals Foundation Trust
3. Peterborough & Stamford Hospitals Foundation Trust
4. Cambridgeshire & Peterborough Foundation Trust
5. Cambridgeshire Community Services NHS Trust
6. Hinchingbrooke Hospitals NHS Trust
7. Papworth Foundation Trust
8. NHS England Specialised Commissioning – tbc
9. Peterborough City Council: (CEO & HWB Chair) – Annex 1 only
10. Cambridgeshire County Council (CEO & HWB Chair) – Annex 1 only

In future others may wish to join or become more formally affiliated with the partnership embodied in this MOU, including East of England Ambulance Trust, CUHP, GP Federations, practices or third sector organisations.

Introduction

Purpose: The local health economy within Cambridgeshire & Peterborough CCG has agreed a single Sustainability and Transformation Plan (STP) for 2016 – 2021, which has been approved by NHSE and NHSI. The STP has been developed with front-line staff and patients, building from an evidence for change that had widespread public and patient involvement. The plan envisages widespread changes to how care is delivered to local people, with far greater emphasis on care being delivered in or close to home, and standardisation of necessary in-hospital care in line with best and most efficient practice. In the small number of instances where changes to the location of services are proposed, there will be formal consultation with the public, following close informal engagement.

In order to deliver this plan and return the system to financial balance, we must manage risk (financial, operational, quality and reputational) through a number of jointly agreed commitments (outlined below) to which the Partners have agreed. The most important of which relate to a new set of behaviours from the System Partners, in order to build long-standing trusting relationships that replicate those of an accountable care system.

Scope: Each of the respective partner organisations have clearly defined accountabilities and responsibilities in line with statute. This MOU describes principles of behaviour and action which pertain to the implementation of the Sustainability and Transformation Plan. Therefore, this MOU pertains only to those areas of work which have been agreed, by each individual partner organisation, as System improvement areas. The MOU does not relate to individual partners decisions but to any possible interactions those may have with other partner organisations. Active engagement between Partners will be the norm, with individual major decisions raised to the HCE's attention, to check for impact on others.

How this document relates to local authorities, their executive officers and members is described further in Appendix 1

Longevity: The term of the MOU is linked to the anticipated time required to implement the STP, therefore it is expected to expire on 31st March 2021, unless a decision is taken to extend it beyond this. If, during the intervening period, as confidence builds, System decisions are delegated to the HCE, this MOU and the associated Terms of Reference for all relevant System groups will be amended (current versions are appended). While, at no stage, can the powers of the HCE supersede those of statutory bodies, this MOU nevertheless reflects the minimum level of partnership required to implement the STP.

Commitment 1: One ambition: the STP sets out a five plus year plan to return C&P to financial, clinical and operational sustainability by developing the beneficial behaviours of an accountable care system, and thereby addressing the underlying drivers of the current system deficit. This means acting as a single executive leadership team, and operating under an aligned set of incentives to coordinate System improvements for the benefits of local residents and healthcare users by:

- Supporting local people to take an active and full role in their own health
- Preventing health deterioration and promoting independence
- Using the best, evidence-based, means to deliver on outcomes that matter
- Focussing on what adds value (and stopping what doesn't)

Such organisational altruism is fully congruent with Partners' duties to the public and is necessary to return each organisation individually to financial balance.

The Partners accept collective responsibility for delivering the plan in its totality. Together, we own the opening risk and agree that the plan, whilst challenging, is deliverable. However, in practice, the Partners recognise external influences and pressures each is subject to. We commit to honest, transparent, and mutual support of each other's position in circumstances where we may be able to help others and influence the view of regulators or external assurance bodies regarding the primacy of System sustainability entailed in this plan and the joint commitment to it.

Our immediate priorities will be agreed collectively and reflect local Health & Wellbeing strategies, together with addressing clinical and operational pressures. However given resources are scarce, priority will be accorded to projects with the greatest expected return on investment and/or fixing what is most broken – for example high levels of non-elective beddays per capita and high proportions of beds being occupied by patients whose discharge is delayed. The highest impact projects will be properly resourced with the Partners' best people. We will not try to do too many things at once, even though there are many aspects of our health and care system which need improving.

Commitment 2: One set of behaviours:

The Partners recognise the scale of change implied by this MOU and the STP. The partners agree that cultural change applies from HCE and Board level to front-line staff. By signing this MOU, all Partners agree explicitly to exhibit the beneficial behaviours of an accountable care system. In particular, Partner organisations collectively agree to:

- People first: solutions that best meet the needs of today and tomorrow's local residents and healthcare users must be the guiding principle on which decisions are made. This principle must over-ride individual or organisational self-interest. Embedding the voice and views of service users in service improvement will be key to ensuring this principle is not forgotten.

- Collective decision-making: Chairs, CEOs, SROs and clinical leads have dedicated time *face-to-face* to build trusting relationships, improve mutual understanding and to take shared strategic decisions together. As system leaders, Partners will work together with integrity and the highest standards of professionalism, for example by:
    - Not undermining each other
    - Speaking well of and respecting each other
    - Behaving well, especially when things go wrong
    - Keeping our promises – small and large
    - Speaking with candour and courage
    - Delivering on promises made
    - Seeing success as collective
    - Sticking to decisions once made.

- Common messaging: there is a consistent set of messages we tell our patients and our staff about why we need to work together, what benefits it will bring and how we are doing it, although how the story is told will be tailored to the audience. Each partner organisation will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials.
- Open book: finance (cost and spend), activity and staffing data are shared between all parties transparently and in a timely manner. This data is held independently by the System Delivery Unit. On a monthly basis actual financial positions of each organisation will be shared with the HCE (and bi-partite, as required), with explicit transparency about performance against expected cost saving and demand management trajectories. The purpose of this sharing is to support collaborative problem-solving.

Commitment 3: One long-run plan: The Partners are committed to implementation at pace. By end of 2018/19, the Partners will have achieved the following:

- *Home is best:* fully staffed integrated Neighbourhood Teams will be operational across C&P, providing a proactive and seamless service. General practices will have received support from Partners to be sustainable. Social care will be functionally integrated. The first phase of the prevention strategy will have been implemented.
- *Safe & Effective hospital care*: hospital flow will be improved, with a reduction in annual growth rates in non-elective admissions, a fall in bed occupancy and Delayed Transfers of Care. Common pathway designs will be in place across all 3 general acute sites for frailty, stroke, ophthalmology, orthopaedics, ENT and cardiology. All acute services (including fragile ones such as emergency medicine, acute paediatrics, stroke, and others) will be clinically sustainable 7 days a week. People will receive consistent urgent and emergency care in the right place, as quickly as possible. More routine urgent and planned care will be managed, with support, within community and primary care, for example by being able to access consultants' opinions without referral.
- *Sustainable together:* We will exploit our collective buying power to get reduced prices, through a common approach to Procurement. The west Pathology Hub will be operational. The merger of PSHFT-HHC (subject to FBC) will be fully embedded, and the start of consideration of other organisational consolidation will have commenced. Papworth will have successfully moved onto the Cambridge Biomedical Campus.
- *Enablers:* There will be single 10 year plan for estates and workforce, a five year plan for the digital roadmap, and a quality improvement (learning) culture. Local

community estates are being modernised. Our workforce recruitment, retention and reported staff satisfaction will be improved. The first new roles will be in the training pipeline. Patient records securely accessible by any clinician anywhere, where appropriate and relevant to patient care, and a person level linked data set will form the foundation for population health improvement analytics. Staff will have been trained in a common C&P improvement methodology and will have been involved in a system wide improvement project.

Taken together, the Partners believe that these actions give the system the best possible chance of returning to financial balance by 2021. However, capturing the savings opportunities identified will require certain assumptions to be true – for example achieving sustainable DTOC levels consistently below 2.5%. Addressing structural system deficits by securing additional system income by, for example, MFF recalculations and specific structural deficit funding (PFI support, CCG allocation increases, etc.) will also be key to system financial balance.

In many cases bringing about the changes envisaged by the STP can only be achieved with the support of local people and staff, including on occasion, through formal consultation. Therefore the exact shape of the solutions may change to reflect the feedback and views of local people and staff, the STP is a starting point not fixed destination.

Commitment 4: One programme of work: all System projects will be agreed by the HCE, and under the supervision of a CEO sponsored Delivery Group. HCE will agree what needs to be done to what end, by who, by when – be they projects done independently or as a System.

- The agreed Delivery Plan identifies the following work streams to be done as a System:
    i. Primary Care & Integrated Neighbourhoods: translating the proactive & preventative care schematic into operational practice, supporting sustainable general practice
    ii. Urgent & Emergency Care: achieving best practice non-elective bed-days per capita
    iii. Elective Care: standardising referral and treatment protocols in line with best practice
    iv. Women & Children: holistic, family-centred care, in line with iThrive, the maternity taskforce and peri-natal mental health
    v. Shared services (including estates): minimising the costs of over-heads
    vi. Digital: implementing the local Digital Roadmap, sharing data and information in a manner consistent with local and national policies and consent
    vii. Workforce & Culture: [leadership], [planning], [skills development], [recruitment & retention]
    viii. System Delivery: [system strategy], [system behaviour change / improvement culture], [supporting delivery to stay on track], [spread what works (locally & elsewhere)]
- The proposed split of work between System and organisational business will be agreed by the HCE, with new work not starting without HCE ratification.
- The proposed split of System work between what is undertaken once across Cambridgeshire & Peterborough, and what is undertaken on an area basis will be according to:
    - Phase of project life cycle: design projects must be done once across C&P
    - Locus of relationships: delivery projects should be local where vertical relationships dominate, and C&P wide where horizontal (across acutes) relationships dominate

    - Subsidiarity: change happens bottom up, and neighbourhoods across C&P differ significantly
- Each System project will have a CEO Sponsor and a named SRO (Exec level).
- Each System project will have a delivery objective – a savings, activity shift or quality improvement target (or a combination) and delivery date. Some System projects will have an agreed investment plan.
- The collective impact of System projects will be measured against an agreed definition of success (see Appendix II)

Commitment 5: One budget: in line with developing the positive behaviours of an accountable care system, and in recognition of the fact that one organisation's decisions about the level of service may impact another's costs, the Partners agree they will collectively focus on activities that take cost out, make agreed investments in order to save elsewhere, and move deficits to where they should most appropriately fall. System costs may be reduced by activity reductions and by unit cost reductions, and we recognise that all System Partners can influence both. Acting in this way requires:

- Financial incentive design: two year contracts for 2017/18 and 18/19 contracts will neutralise perverse financial incentives and aim to return the C&P System to financial balance. The Partners agree that the key aim of any incentives will be to focus on addressing the drivers of the system deficit. Financial incentive design options ***may***, therefore, include a combination of:
    - the inclusion of multilateral loss / gain sharing arrangements, for some aspects of C&P CCG commissioned activity;
    - a single System control total which has been negotiated with regulators;
    - alignment of all quality based payments to delivering System priorities (including CQUINs and following agreement with primary care, changes to local enhanced services and/or a local substitute for the QOF);
    - a suspension of non-value adding adjustments to basic cost & volume arrangements such as fines, marginal rates and 30 day readmissions rule (noting that some of these funds currently cover the costs of some community services, which would need alternative funding to be agreed if the services are to continue);
    - a cost plus based approach to local prices for service developments (eg ambulatory care)

  Within this framework and in recognition of the importance of gathering timely and accurate cost data, providers will be paid for the activity they under-take, against an agreed activity trajectory, and commissioners will be responsible for taking decisions about what services can be provided affordably, in line with their legal duties. Due to the lack of incentive to do more activity, even where this would be desirable as it would reduce overall system costs, block contracts should be avoided for all services.
- For the remainder of 2016/17, parties will exhibit win-win-win behaviours (for patients, providers and commissioners) – the financial recovery plan is a *System* financial recovery plan.
- Contract mechanics for 2017/18 and 18/19: the least required effort will be dedicated to contract negotiations, with early collective CEO engagement to agree key investment priorities and risk sharing parameters at the outset (rather than at the end). Contract management meetings will be replaced with place or care programme based financial assurance, performance and planning meetings.

- Commissioning intentions will be based on a clinically led, evidence-based and person-focussed appraisal of how best to meet local people's need. Once developed, Partners will discuss openly within HCE any new service developments, closures or relocations prior to public and staff engagement and consultation as required. The HCE and the System Delivery Groups will be the fora for agreeing commissioning intentions, including those of the Joint Commissioning Unit.
- Financial and operational plans will be aligned across health and social care: the Partners agree to plan finances and operational capacity together, neutralising any inclination to cost shift or not invest in one part of the system to save elsewhere. This will involve working from common assumptions, producing plans for regulators that are not works of fiction and doing our best to ensure there are no in-year surprises. Where appropriate, this will also include greater use of pooled budgets between NHS and council commissioners, which will be determined on a case by case basis.
- Savings: Savings will be calculated on the basis of resource utilisation across the entire patient pathway, including all points of care and Partner organisations – thereby capturing direct and indirect savings. Delivery Groups will track savings against pre-determined trajectories in a robust and timely manner, with the Programme Director's guidance and SDU support. A named AO Sponsor for each project is responsible for making sure savings trajectories are met and / or securing recovery proposals where implementation is not on track.
- Investment: an agreed 'pot' for System wide investments will be agreed up front. In 2017/18 it is likely that this will require a System bid to NHS England, due to cash constraints. Decisions on how to spend this System wide investment and re-investment pot will be taken collectively. Analysis will be under-taken first to ensure existing resources cannot be safely redeployed /or productively improved before investment can be made. The investment pot will come from any STF funds, recycled savings and the CCGs 1% hold-back. Before funding is agreed, everyone will be completely clear on recurrent vs non-recurrent investment requirements.

Commitment 6: One set of governance arrangements: the HCE and the groups reporting to it (Area Executive Boards, the Care Advisory Group (and strategic sub-committees), the FD Forum and the eight Delivery Groups), will be the vehicle through which System business is conducted. All existing arrangements will either be dissolved (eg SRGs) or aligned. The Area Executive Boards will offer the two Health & Wellbeing Boards a delivery vehicle for local health and well-being strategies.

As much business as possible that pertains to the system will be conducted via the system governance described in Appendices 3-7. However it is recognised and accepted that some decisions will need to be referred back to Partners' Boards / Governing Bodies for ratification. Given this may add time before implementation can commence, the limits to the HCE's powers must be anticipated, and accommodated in planning.

Commitment 7: One delivery team: resources are in place to deliver the STP. This means:

- System Delivery Unit: A new SDU led by an Independent Chair and Programme Director will be created from October 2016. The Independent Chair and Programme Director will be invited to attend Partners' Boards regularly to provide updates on the STP. The SDU will have a budget agreed by HCE to employ staff, funded jointly by NHS Partners (see Appendix). The SDU will be responsible for:
    - Finance, Evaluation & Analytics

- System Strategy, Planning and Development

The System Delivery Unit is primarily envisaged as adding much needed analytics, project management, quality improvement and problem solving capacity to the system. However, it will be responsible for giving assurance to the HCE that the STP plan and its future modifications is being appropriately delivered, on budget and to planned timelines.

- Alignment of resources: We recognise the scale of change required to deliver the STP, and all Partners commit to align our staff and, by prior HCE agreement, funds to deliver these changes. This may include prioritising the availability of staff for STP planning and implementation, the voluntary secondment/loan of staff and other such pragmatic arrangements – in recognition that delivering the STP is essential to each organisation's individual sustainability strategy. Through the delivery planning process, each prioritised project will be allocated staff, from across Partners. These, 'aligned' staff will be expected to dedicate the bulk of their time to the system work – with up front negotiations about what may need to be stopped as a result. SROs and if necessary CEO sponsors will be expected to escalate to the employer if they feel staff are not being released as agreed. The employing Partner will be expected to rectify the situation within [2 weeks]. The SDU will make transparent the relevant wte contributions (clinical and managerial) from each Partner organisation, to ensure the burden of effort is fairly shared.
- Assets: in addition to Partners' employees we agree there are other assets which can help deliver the STP, including local communities and Health and Wellbeing Boards. Partners will explore how existing relationships with the Universities, Charitable trusts, local business, informal carers and other public services (like the Fire Service) can be exploited for the benefit of the System. All Partners will highlight opportunities for leveraging these assets for the benefit of the System and will represent the System's interests as well as their own.
- Skills development: where our staff don't have the required skills and expertise to deliver the scale and nature of the change required, we will recognise and address this. It's important that our people are in the right roles.

Commitment 8: One assurance and risk management framework.

- Crucial to strengthening trust and creating a sense of shared accountability, will be evolving the HCE from a forum for making strategic decisions, to one where Partners can be assured of the delivery of System wide improvements. The System Delivery Unit is responsible for monitoring implementation of the STP plan and giving such assurance to the HCE about delivery of the plan. The SDU will provide timely, and regular reporting to the Delivery Groups, Area Executive Boards, the CAG, the FD Forum and the HCE to give mutual assurance that the Delivery plan is on track. A small number of new monitoring dashboards will be developed by the SDU for this purpose, subject to the agreement of the HCE and/or relevant CEO sponsor. In exceptional circumstances new data items may be collected, but the default presumption is that existing data items will be used (even if these are not normally shared beyond organisations). Once the data collection is agreed, accurate data will be supplied on time.
- Inevitably, things will not go as planned, and there are already many risks that planned impacts will not be realised. Some of these risks will be best managed individually, but many can only be effectively managed by the Partners together. The Partners therefore agree that mitigations will be more effective if they are done together. Transparency around risk / risk mitigation is non-negotiable. Whilst it is difficult to specify in advance the actions that may be required to address risks to delivering the STP, we agree about the process:

    - A HCE Risk Register maintains emerging risks to both the agreed delivery plan and agreed mitigations;
    - System Delivery Groups, Area Executive Boards, the CAG and the FD Forum may raise with the Programme Director an emerging risk and a written Requirement for Risk Mitigation by the HCE. This requirement will reflect a perceived risk that the Sponsor CEO considers he/she are unable to mitigate within the Group.
    - Project SROs are expected to deliver all actions to the pre-agreed time-table of milestones – repeated risks and issues regarding process delays due to poor project management and oversight, which are within the control of the SRO will be escalated by the Programme Director to the employing CEO.
- For the purposes of this agreement, risk is not narrowly defined; examples include reputational, clinical, governance, performance against targets and financial risks.
- Select risks will be reviewed by Boards each month, as determined by the Programme Director and Independent Chair.

Annexes

I. Local Authorities and the C&P Sustainability & Transformation Plan.
II. Delivery plan October 2016 – March 2019
III. STP Measures (One year health check, Quarterly performance tracking)
IV. ToR for HCE, including
    a. Delegation of decision-making – for example relating to contract design, (dis) investments, STP implementation risks & mitigations, activity assumptions, service developments/ reductions/ significant changes
    b. Relationship to Partners' Boards – including which decisions rest with Boards, which must have Board support pre-HCE agreement and which Boards can be informed about after the event
    c. How decisions are made – for example, voting, whether decisions are binding, limits of deputies, withholding of consent, etc
    d. Stakeholder engagement approach
    e. Bipartite reporting
V. ToR for Delivery Groups, including:
    a. Chairing: a CEO
    b. Membership: a clinical lead, an FD, an HRD + SROs
    c. Meeting frequency
    d. Escalation either to PD, another CEO or the HCE
VI. ToR for Area Executive Boards, which will also encompass the national responsibilities for A&E Delivery, for:
    a. Greater Cambridge & Ely (Papworth to be included)
    b. Huntington & Fens (Papworth to be included)
    c. Greater Peterborough
VII. ToR for Care Advisory Group, and Strategic sub-committees for:
    a. Frailty/ Ageing / BCF
    b. Mental Health
    c. Sustainable General Practice
VIII. ToR for Financial Performance & Planning Group (formerly the FD Forum)
IX. SDU Financing: Funding split (%); Initial budget for the SDU; legally binding arrangements for sharing SDU costs (expected and unexpected)

CAMBRIDGESHIRE AND PETERBOROUGH
SUSTAINABILITY AND TRANSFORMATION PROGRAMME
MEMORANDUM OF UNDERSTANDING

Appendix 1: Local Authorities and the C&P Sustainability and Transformation Plan

Introduction

- The local health economy within the Cambridgeshire & Peterborough Clinical Commissioning Group area has agreed a single Sustainability and Transformation Plan (STP) for 2016 – 2021, which has been approved by NHS England and NHS Improvement.

- All partners share an ambition to return the health and care system in Cambridgeshire and Peterborough to financial, clinical and operational sustainability, coordinating System improvements for the benefits of local residents and healthcare users by:
  - Supporting local people to take an active and full role in their own health
  - Promoting health, preventing health deterioration and promoting independence
  - Using the best, evidence-based, means to deliver on outcomes that matter
  - Focussing on what adds value (and stopping what doesn't)

  Cambridgeshire County Council (CCC) and Peterborough City Council (PCC) are key stakeholders in the development and delivery of the STP and will act as partners in the STP by aligning their public health and social care services to support its delivery. However the Councils will only be able to this in line with their statutory responsibilities, democratic and constitutional duties in the local authorities' governance arrangements

- The Cambridgeshire District and City Councils, which are members of the Cambridgeshire Health and Wellbeing Board, exercise a number of relevant functions including housing, land use planning, leisure services etc, which may also align to the wider STP Programme, and which are subject to their own democratic and constitutional arrangements.

- All partners across local authorities and the NHS are expected to support local Health and Wellbeing Strategies and Better Care Fund Plans. NHS partners will ensure that STP delivery is aligned with these wider partnership strategies and plans.

- An agreed set of behaviours and principles has been developed in order for CCC, PCC and the wider local authority membership of the HWB Board to support (and be supported) in the contribution to and delivery of the STP.

- These behaviours and principles outline how CCC, PCC and the wider local authority HWB Board membership will work together with the Health system, whilst adhering to their statutory duties and democratic and constitutional duties in the local authorities' governance arrangements

Key Behaviours:

CCC, PCC and the wider local authority Health and Wellbeing Board membership recognise the scale of change required to deliver the STP and that cultural change applies from leadership level to front line staff.

CCC, PCC and the wider local authority Health and Wellbeing Board membership will continue to build and promote trusting relationships, mutual understanding and where feasible take decisions together with the health system.

CCC and PCC representatives on the Health and Care Executive (HCE) will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials. The HCE will ensure that relevant system messages and materials are shared with the wider HWB Board membership.

All members of the Health Care Executive and the Health and Wellbeing Boards will support and promote system behaviours for the benefit of local residents and healthcare users including:

- Working together and not undermining each other
- Behaving well, especially when things go wrong
- Engaging in honest and open discussion
- Keeping our promises – small and large
- Seeing success as collective
- Sticking to decisions once made

Key Principles:

The key principles of local authorities working with partners to deliver the STP plan are:

- Commitment to implementation at pace
- Use collective commissioning and buying opportunities to improve delivery outcomes and/or system savings
- Where appropriate, HCE representatives and other senior local authority officers to act as if part of a single executive leadership team, to coordinate system improvements for the benefits of local residents in line with the STP.
- Influence the view of regulators and external assurance bodies regarding the primacy of System sustainability enshrined in the STP and the joint commitment to it.
- Highlight and work to prevent cost shunting to other partners
- Adopt an invest to save approach
- Share information on new major service developments, savings, closures or relocations, and more generally share information in a timely manner when needed to support development of partnership business cases and savings

plans. This should comply with existing information sharing agreements and protocols.

- Align human, financial, estate and digital resources to deliver these changes where this adds value, delivers people-centred outcomes and saves money.

Democratic requirements and local authority governance

- CCC and PCC will participate in the Health and Care Executive (HCE) arrangements through their senior officer representatives acting as non-voting members of the HCE. This arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.

- CCC, PCC and Cambridgeshire District and City Councils will also participate in and support the STP through their local Health and Wellbeing Boards and shared programme management arrangements. Again, this arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, which are led by elected Councillors.

- Local authorities support the commitment to longer-term planning, but the Partners recognise that local authorities are subject to democratic governance. Therefore the LAs must reserve the right to change their priorities in accordance with the priorities of their elected Councils

- CCC, PCC and wider local authority HWB Board membership cannot commit to sharing the opening financial risk in the STP, given that local authorities have a statutory requirement to balance their budgets and cannot operate at a deficit. Likewise, NHS partners are not expected to commit to meeting the financial risk of meeting statutory social care requirements.

- CCC and PCC also have a particular statutory requirement to scrutinise proposals for NHS service changes as elected representatives of their communities, and must ensure the independence and integrity of those arrangements.

Agenda Item No: 7

FINANCE AND PERFORMANCE REPORT – SEPTEMBER 2016

To:	**Health Committee**
Meeting Date:	**10 November 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 September 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 September 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 SEPTEMBER 2016 FINANCE & PERFORMANCE REPORT

2.1 The September 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 September.

2.3 The Public Health Service Performance Management Framework for August 2016 is contained within the report. Of the thirty five Health Committee performance indicators, nine are red, six are amber, fourteen are green and six 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:
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:
Have any Public Health implications been cleared by Public Health	Yes or No Name of Officer:

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 **Item 7: Appendix A**

Tel.: 01223 699733

Date: 13 October 2016

Public Health Directorate

Finance and Performance Report – September 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
August (No. of indicators)	9	6	14	6	35

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Aug) £000	Directorate	Current Budget for 2016/17 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Sep) £000	Forecast Variance - Outturn (Sep) %
0	Health Improvement	8,459	-317	-9.4%	0	0%
0	Children Health	9,276	-82	-2.0%	0	0%
0	Adult Health & Well Being	916	-83	-34.0%	0	0%
0	Intelligence Team	13	-8	-116.6%	0	0%
0	Health Protection	6	1	26.8 %	0	0%
0	Programme Team	136	-38	-56.0%	0	0%
0	Public Health Directorate	2,175	57	5.2%	0	0%
0	**Total Expenditure**	**20,982**	**-471**	**-5.4%**	**0**	**0%**
0	Public Health Grant	-20,457	-43	-0.4%	0	0%
0	Other Income	-343	182	43.7%	0	0%
0	**Total Income**	**-20,800**	**139**	**1.4%**	**0**	**0%**
0	**Net Total**	**182**	**-332**	**-21.4%**	**0**	**0%**

The service level budgetary control report for September 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 SUMMARY

4.1 Performance overview (Appendix 6)

- Performance of contract sexual health and contraception service remains good with all monthly key performance indicators achieved.
- Smoking cessation performance worsened with 70% of the smoking quitter target achieved, compared with 82% the previous month.
- Performance of the Integrated Lifestyles and Weight Management contract remained mixed, with 8 green KPIs and 11 red KPIs, following initial difficulties in recruiting staff in the South of the County. However a number of the red KPIs are on an upward trend.
- Health checks, health visiting and school nursing KPIs are monitored quarterly and childhood obesity annually, so there are no changes to these indicators.

4.2 Health Committee Priorities (Appendix 7)

- Smoking cessation performance in the most deprived 20% of areas in Cambridgeshire stands at 72% of target. This is better than the remainder of the county where performance is 65% of target.
- The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% least deprived was 2.6 years for both 2012-2014 and 2013-2015. For the latest 3-year period available, covering 2013 Q3 to 2016 Q2, the absolute gap was 3 years (80.3 years in the most deprived 20% of wards v. 83.3 years in the least deprived 80%). Although this appears to be an increase in the gap, this should be interpreted with caution as the figures for ward populations have not been updated since 2014 and this may affect the results.
- The number of schools attending funded mental health training has been presented in a new way, providing figures on a district level for the percentage of schools which have attended this training between 2012 and 2016. The percentage ranges from 19% in South Cambridgeshire to 39% in East Cambridgeshire, averaging 25% across the County.

4.3 Health Scrutiny Indicators (Appendix 8)

- Both CUHFT and Hinchingbrooke showed some improvement in delayed bed days in August 2016 compared with the previous months.

4.4 Public health Services provided through a Memorandum of Understanding with Other Directorates (Appendix 9)

Several Q2 reports for Public Health MOU services are now complete and included in Appendix 9. Spend is in line with expectations and no significant end of year variances are currently predicted. Of note are the range of PHMOU services offered to schools, including mental health training, road safety/active travel interventions, and ‘Kick-Ash’ peer-led work, encouraging young people to become smoke free. ETE Business and Communities Directorate are carrying out community projects targeted within Fenland, and working with Public Health to address illicit tobacco. The CFA Chronically Excluded Adults Team model is now being piloted in Peterborough and showing savings to the criminal justice system, similar to findings in Cambridgeshire.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Aug) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of Sept £'000	Actual to end of Sept £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Sept) £'000	Forecast Variance Outturn (Sept) %
	Health Improvement							
0	Sexual Health STI testing & treatment	4,074	1,732	1,560	-172	-9.94%	0	0.00%
0	Sexual Health Contraception	1,170	316	290	-26	-8.32%	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	76	71	-5	-6.20%	0	0.00%
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Obesity Children	82	41	41	-0	-0.66%	0	0.00%
0	Physical Activity Adults	84	42	63	21	50.92%	0	0.00%
0	Healthy Lifestyles	1,605	827	698	-129	-15.58%	0	0.00%
0	Physical Activity Children	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking Service & Intervention	907	-29	-56	-26	89.37%	0	0.00%
0	Wider Tobacco Control	31	16	17	1	8.55%	0	0.00%
0	General Prevention Activities	272	320	354	34	10.60%	0	0.00%
0	Falls Prevention	80	40	26	-14	-34.96%	0	0.00%
0	Dental Health	2	1	0	-1	-100.00%	0	0.00%
0	**Health Improvement Total**	**8,459**	**3,380**	**3,064**	**-317**	**-9.37%**	**0**	**0.00%**
	Children Health							
0	Children 0-5 PH Programme	7,531	3,117	3,116	-1	-0.02%	0	0.00%
0	Children 5-19 PH Programme	1,745	872	791	-81	-9.33%	0	0.00%
0	**Children Health Total**	**9,276**	**3,989**	**3,907**	**-82**	**-2.06%**	**0**	**0.00%**
	Adult Health & Wellbeing							
0	NHS Health Checks Programme	716	144	146	2	1.43%	0	0.00%
0	Public Mental Health	164	82	15	-67	-81.85%	0	0.00%
0	Comm Safety, Violence Prevention	37	18	0	-18	-100.00%	0	0.00%
0	**Adult Health & Wellbeing Total**	**916**	**245**	**161**	**-83**	**-34.06%**	**0**	**0.00%**
	Intelligence Team							
0	Public Health Advice	13	7	-1	-8	-116.66%	0	0.00%
0	Info & Intelligence Misc	0	0	0	0	0.00%	0	0.00%
0	**Intelligence Team Total**	**13**	**7**	**-1**	**-8**	**-116.66%**	**0**	**0.00%**
	Health Protection							
0	LA Role in Health Protection	0	0	4	4	0.00%	0	0.00%
0	Health Protection Emergency Planning	6	3	0	-3	-100.00%	0	0.00%
0	**Health Protection Total**	**6**	**3**	**4**	**1**	**26.81%**	**0**	**0.00%**

Forecast Variance Outturn (Aug) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of Sept £'000	Actual to end of Sept £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Sept) *£'000*	Forecast Variance Outturn (Sept)
	Programme Team							
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking no pay staff costs	31	16	6	-9	-59.02%	0	0.00%
0	General Prev, Traveller, Lifestyle	105	52	24	-29	-55.12%	0	0.00%
0	**Programme Team Total**	**136**	**68**	**30**	**-38**	**-56.02%**	**0**	**0.00%**
	Public Health Directorate							
0	Health Improvement	531	261	325	65	24.76%	0	0.00%
0	Public Health Advice	710	350	321	-29	-8.29%	0	0.00%
0	Health Protection	151	76	101	26	33.77%	0	0.00%
0	Programme Team	613	302	276	-26	-8.46%	0	0.00%
0	Childrens Health	67	34	37	4	10.45%	0	0.00%
0	Comm Safety, Violence Prevention	50	25	44	19	76.00%	0	0.00%
0	Public Mental Health	53	27	25	-2	-5.66%	0	0.00%
0	**Public Health Directorate total**	**2,175**	**1,072**	**1,129**	**57**	**5.27%**	**0**	**0.00%**
0	**Total Expenditure before Carry forward**	**20,982**	**8,764**	**8,293**	**-471**	**-5.37%**	**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	-10,228	-10,271	-43	-0.42%	**0**	0.00%
0	S75 Agreement NHSE - HIV	-144	0	144	144	0.00%	**0**	0.00%
0	Other Income	-199	-87	-49	38	43.68%	**0**	0.00%
0	**Income Total**	**-20,800**	**-10,315**	**-10,176**	**139**	**1.35%**	**0**	**0.00%**
0	**Net Total**	**182**	**-1,551**	**-1,883**	**-332**	**-21.40%**	**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 30 Sep 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,138**	155	983	**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**	**983**	**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**	**3,003**	**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 30 Sep 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 August 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%	99%	99%	G	100%	98%	99%	↓	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	95%	95%	G	89%	80%	95%	↑	
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	3000	4459	149%	G	152%	600	149%	↓	
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. 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	1113	475	43%	R	75%	223	52%	↓	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 started gaining momentum.However due to recruitment delays/changes the number completed has remained low Recruitment has now improved and improvements can be expected.
Smoking Cessation - four week quitters	2249	635	520	82%	R	83%	183	70%	↓	• 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. Other activities introduced recently include a , a migrant worker Health Trainer who targets the communities where smoking rates are high . It shoudl be noted that quitters are always reduced during the summer holidays. The smoking figures are for July as they are reported two months behind the reporting period.

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
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	56%	N/A	A	57%	58%	56%	↓	
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	↑	

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)	
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	0%	0%	0%	N/A	0%	0%	0%	← →	The National Child Measurement Programme is undertaken during school term times.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	0%	0%	0%	N/A	0%	0%	0%	← →	
Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1983	838	783	93%	A	79%	150	116%	↑	The 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 recruitment was not completed until the end of August. The KPIs that are not on target generally have an upward trend.
Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	1686	712	728	102%	G	97%	128	125%	↑	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1075	455	291	64%	R	85%	82	71%	↓	Quarterly reporting. This intervention can take up to one year. Therefore there are cyclical changes and reporting quarterly.
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	992	420	557	133%	G	97%	75	151%	↑	
Number of physical activity groups held **(Pre-existing GP based service)**	581	238	241	101%	G	69%	50	88%	↑	
Number of healthy eating groups held **(Pre-existing GP based service)**	290	116	67	58%	R	58%	25	60%	↑	

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
Personal Health Trainer Service - number of referrals received (Extended Service)	739	370	248	67%	R	76%	75	81%	↑	
Personal Health Trainer Service - number of initial assessments completed (Extended Service)	628	316	219	69%	R	81%	64	106%	↑	
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	400	210	21	10%	R	20%	41	17%	↓	This intervention can take up to one year. Consequently the target KPI s are being reviewed. This is reported quarterly.
Number of physical activity groups held (Extended Service)	578	291	331	114%	G	123%	60	127%	↑	
Number of healthy eating groups held (Extended Service)	726	291	289	99%	G	68%	60	33%	↓	Due to school holidays there has been a reduction in workshops delivered.
Number of behaviour change courses held	34	13	4	31%	R	0%	3	0%	← →	Courses not delivered in June, July and August. Five courses 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%	31%	104%	G	31%	30%	71%	↑	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%	n/a	n/a	N/A	n/a	n/a	n/a	↑	No data is currently available for 16/17. Each course is a minimum of 6 months

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)	
% of children recruited who complete the weight management programe and maintain or reduce their BMI Z score by agreed amounts	80%	80%	N/A	N/A	**N/A**	100%	80%	n/a		No programmes completing in August hence no completers
Falls prevention - number of referrals	386	110	146	133%	**G**	159%	22	209%		
Falls prevention - number of personal health plans written	279	80	118	148%	**G**	200%	16	181%		

* All figures received in September 2016 relate to August 2016 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elemenst of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

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

APPENDIX 7 – HEALTH COMMITTEE PRIORITIES

Health Inequalities

Smoking Cessation

The following describes the progress against the ambition to reduce the gap in smoking rates between patients of the most socio-economically deprived 20% of GP practices and the remaining 80% of GP practices in Cambridgeshire (monitored monthly). The GP practices in the 20% most deprived areas of Cambridgeshire are given more challenging smoking cessation targets and more support than other practices, to help reduce this gap.

Monthly update:

- The percentage of the smoking quit target achieved in July remains the same among the least deprived 80% practices in Cambridgeshire compared to the previous month. The most deprived 20% of practices in Cambridgeshire has improved the smoking quit target achieved compared with the previous month.
- In the least deprived 80%, 76 four-week quits were achieved, 66% of the monthly target of 116; in the most deprived 20% of practices, 52 four-week quits were achieved, 72% of the monthly target of 72.
- Looking at performance data for the year to date, the percentage of the quit target achieved in the least deprived 80% of practices stands at 65% and in the most deprived 20%, at 72%.

Year-to-date:

- The RAG status for year to date smoking quit target is red indicating that the target for both the least deprived 80% and most deprived 20% remains more than 10% away from the year to date target.
- The gap in performance in quits achieved between the two groups increased in July compared to the gap seen in June due to an increase in quits achieved in the 20% most deprived practices.

There are targeted efforts in the more deprived areas to promote smoking cessation which include community events such as promotional sessions in supermarkets, a workplace health programme and campaigns informed by social marketing intelligence.

Percentage of smoking quit target achieved by deprivation category of general practices in Cambridgeshire, July 2016/17

Practice deprivation category	Year end target	Year-to-date					June			*Previous month	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	1,388	463	303	65%	35%		116	76	66%	66%	↔
Most deprived 20%	861	287	207	72%	28%		72	52	72%	69%	↑
All practices	2,249	750	510	68%	32%		187	128	68%	68%	↔

* Due to delays in reporting smoking quits for months April and May have been combined

RAG status:
- More than 10% away from year-to-date target
- Within 10% of year-to-date target
- Year-to-date target met

Direction of travel:
- ↑ Better than previous month
- ↓ Worse than previous month
- ↔ Same as previous month

Percentage point gap between the percentage of the target reached in the most deprived 20% compared with the least deprived 80%

	Year-to-date	July	Previous month	Direction of travel
Percentage point gap	7%	7%	3%	↓

Direction of travel:
- ↑ Better than previous month
- ↓ Worse than previous month
- ↔ Same as previous month

Sources:
General practice returns to Cambridgeshire County Council Smoking Cessation Service
Public Health England 2015 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2015
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 18/10/16

NHS Health Checks

Data remain the same – quarterly update not yet available

The following describes the progress against the NHS Health Checks ambition to reduce the gap in rates of heart disease between patients of the 20% most socio-economically deprived GP practices and the remaining 80% of practices in GP Cambridgeshire (monitored quarterly). The most deprived 20% of GP practices are given more challenging health check targets to support this aim.

- The percentage of the health check target achieved in Quarter 1 was higher in the least deprived 80% of practices than in the most deprived 20%
- In the least deprived 80%, 3099 health checks were delivered, 98% of the quarterly target of 3173; in the most deprived 20% of practices, 780 health checks were delivered, 59% of the quarterly target of 1327.
- The gap in performance in health checks delivery between the two groups was 39 percentage points in Quarter 1.
- The percentage of the health check target achieved in quarter 1 is more than 10% away from the target in the most deprived 20% of practices but within 10% of the target in the least deprived 20%.
- Performance in the 20% most deprived practices is 39 percentage points behind the least deprived 80% of practices..

There is an intensive programme of support given to GP practices that deliver the majority of NHS Health Checks. However practices in these areas have

Percentage of health check target achieved by deprivation category of general practices in Cambridgeshire, 2016/17 Quarter 1

Practice deprivation category	Year end target	Year-to-date					Quarter 1			Previous quarter	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	12,691	3,173	3,099	98%	2%		3,173	3,099	98%	n/a	n/a
Most deprived 20%	5,309	1,327	780	59%	41%		1,327	780	59%	n/a	n/a
All practices	18,000	4,500	3,879	86%	14%		4,500	3,879	86%	n/a	n/a

RAG status:
- More than 10% away from year-to-date target
- Within 10% of year-to-date target
- Year-to-date target met

Direction of travel:
- ↑ Better than previous quarter
- ↓ Worse than previous quarter
- ↔ Same as previous quarter

Percentage point gap between the percentage of the target reached in the most deprived 20% compared with the least deprived 80%

	Year-to-date	Quarter 1	Previous quarter	Direction of travel
Percentage point gap	-39%	-39%	n/a	n/a

Direction of travel:
- ↑ Better than previous quarter
- ↓ Worse than previous quarter
- ↔ Same as previous quarter

Sources:
Practice returns to Cambridgeshire County Council Public Health Team
Practice level index of multiple deprivation (IMD) Public Health England/Kings College London, 2015
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 19/08/2016

experienced staff losses that affect their capacity. Outreach NHS Health Checks provided by the Integrated Lifestyle Service Everyone Health have now commenced that focus upon the deprived areas working in community settings including workplaces.

Life expectancy and healthy life expectancy

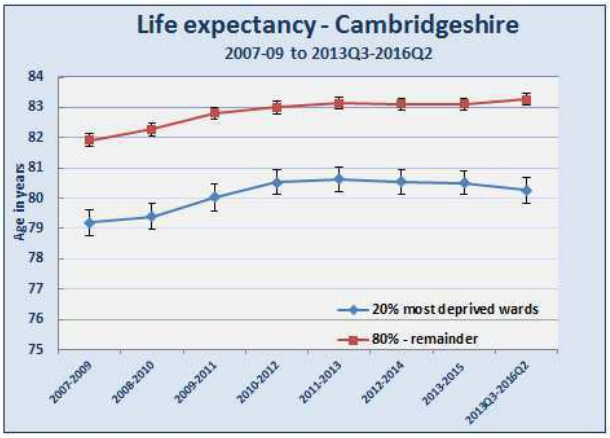
Life expectancy data have been updated using the latest mortality figures available. Healthy life expectancy data remain the same as this is currently a national, annually-released indicator.

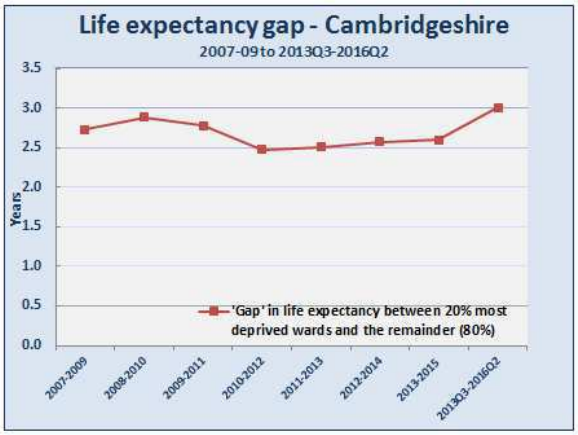
Inequalities in life expectancy: aiming to reduce the gap in years of life expectancy between residents of the 20% most deprived and the 80% least deprived electoral wards in Cambridgeshire.

- The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% least deprived was 2.6 years for both 2012-2014 and 2013-2015.
- For the latest 3-year period available, covering 2013 Q3 to 2016 Q2, the absolute gap was 3 years (80.3 years in the most deprived 20% of wards v. 83.3 years in the least deprived 80%). Although this appears to be an increase in the gap, this should be interpreted with caution. Ward level population estimates are not currently available for 2015 or 2016 and so 2014 population estimates have been used for the calculations for these periods. This may adversely affect the calculated life expectancies as increases in numbers of deaths may reflect increases in population size that have not been taken into account. Updated small area population estimates are due to be released by the Office of National Statistics in late October 2016.
- There are significant inequalities nationally and locally in life expectancy at birth by socio-economic group. Certain sub-groups, such as people with mental health problems and people who are homeless, also have lower life expectancy than the general population. Key interventions to reduce this gap are in tackling lifestyle factors and ensuring early intervention and prevention of key diseases.

Calendar years	Average Life Expectancy (95% confidence interval)				Gap (in years)	Relative gap (%)
	20% most deprived wards		80% remainder of wards			
2007-2009	79.2	(78.8 - 79.6)	81.9	(81.7 - 82.1)	-2.7	3.3%
2008-2010	79.4	(79.0 - 79.8)	82.3	(82.1 - 82.5)	-2.9	3.5%
2009-2011	80.0	(79.6 - 80.4)	82.8	(82.6 - 83.0)	-2.8	3.4%
2010-2012	80.5	(80.1 - 80.9)	83.0	(82.8 - 83.2)	-2.5	3.0%
2011-2013	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.5	3.0%
2012-2014	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.6	3.1%
2013-2015*	80.1	(80.1 - 80.9)	83.1	(82.9 - 83.3)	-2.6	3.1%
2013Q3-2016Q2*	80.3	(79.8 - 80.7)	83.3	(83.0 - 83.5)	-3.0	3.6%

Life expectancy at birth and the gap in life expectancy at birth between the 20% most deprived of Cambridgeshire's population and the remaining 80% (based on electoral wards)





* Ward level population estimates are not currently available for 2015 or 2016 and so 2014 population estimates have been used for these periods. A mismatch between the source years of population estimates and deaths may adversely affect the calculated life expectancies as increases in numbers of deaths may reflect increases in population size that have not been taken into account. Results should therefore be interpreted with caution.

Sources: NHS Digital Primary Care Mortality Database (Office for National Statistics Death Registration data), Office for National Statistics ward-level population estimates, Communities and Local Government Index of Multiple Deprivation 2010

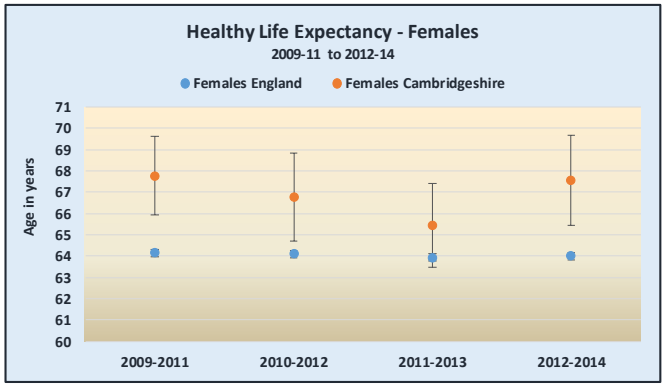
Healthy life expectancy.

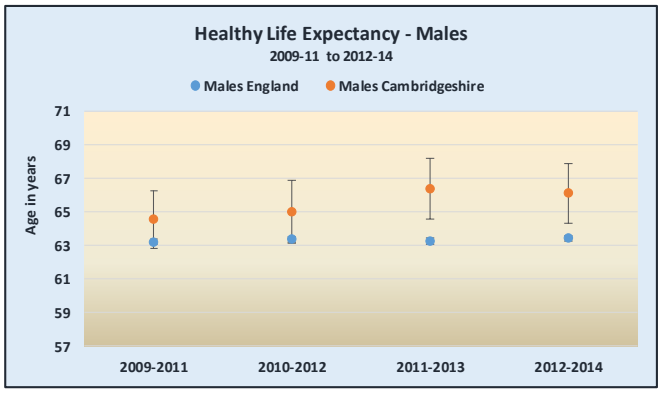
- Healthy life expectancy for men for the period 2012-2014 in Cambridgeshire was 66.1 years. For females the figure was 67.6 years. The 'actual' figure for men (66.1 years) is lower than for females (67.6 years). No target has been set for this indicator. The local value reported is to be assessed in comparison with the England figure at year end. For the period 2012-2014 in England HLE for men was 63.4 years and for women 64.0 years. The Cambridgeshire figure is higher than that of England in both men and women.
- These figures represent some change in both male and female figures on the previous year and in comparison with the England figure. For male HLE the general trend is slightly upward although the annual change is 0.3 of a year less and this difference is not important statistically. For female HLE there has been an increase of +2.3 years although this is not statistically significant. Both male and female HLE in Cambridgeshire remain higher than that of England in both men and women. Note that data fluctuates annually for a variety of reasons but is impacted by seasonal patterns of mortality which vary year by year.
- Healthy Life Expectancy (HLE) measures what proportion of years of life men and women spend in 'good health' or without 'limiting illness'. This information is obtained from national surveys and is self-reported (General Lifestyle Survey for example). Nationally the figures suggest that men spend 80% of their life in 'good health' with women spending a slightly lower proportion. Women experience a greater proportion of their lives lived at older ages and with a higher prevalence of disabling conditions. So although women live longer, they spend more time with disability. The fact that this information is "self-reported" may influence these figures as well. In many countries with lower life expectancies this difference between male and females is not so apparent.

Calendar years	Cambridgeshire				England			
	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'
Males								
2009-2011	80.6	64.5	(62.8 - 62.3)	80.1	78.9	63.2	(63.1 - 63.4)	80.1
2010-2012	81.0	65.0	(63.2 - 66.8)	80.2	79.2	63.4	(63.2 - 63.5)	80.0
2011-2013	81.2	66.4	(64.7 - 68.0)	81.7	79.4	63.3	(63.1 - 63.4)	79.7
2012-2014	81.2	66.1	(64.4 - 67.8)	81.4	79.5	63.4	(63.3 - 63.6)	79.7
Females								
2009-2011	84.5	67.8	(66.1 - 69.5)	80.2	82.9	64.2	(64.0 - 64.3)	77.4
2010-2012	84.6	66.8	(64.9 - 68.7)	79.0	83.0	64.1	(63.9 - 64.3)	77.2
2011-2013	84.6	65.5	(63.6 - 67.3)	77.4	83.1	63.9	(63.8 - 64.1)	76.9
2012-2014	84.5	67.6	(65.8 - 69.4)	80.0	83.2	64.0	(63.8 - 64.2)	76.9

Life expectancy and Healthy Life expectancy at birth in males and females in Cambridgeshire and England and the proportion of life spent in good health.

NB: chart axes do not start at zero.

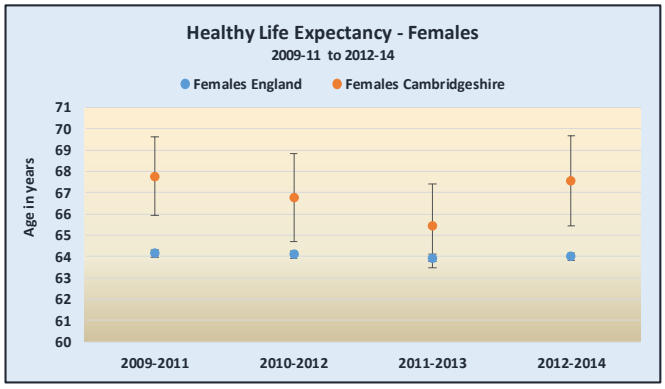


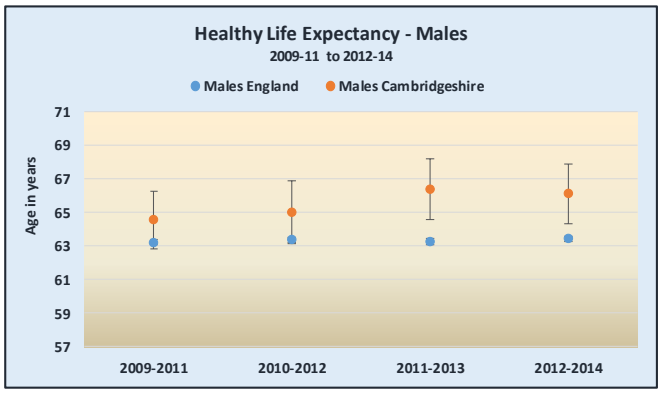


Calendar years	Cambridgeshire				England			
	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'
Males								
2009-2011	80.6	64.5	(62.8 - 62.3)	80.1	78.9	63.2	(63.1 - 63.4)	80.1
2010-2012	81.0	65.0	(63.2 - 66.8)	80.2	79.2	63.4	(63.2 - 63.5)	80.0
2011-2013	81.2	66.4	(64.7 - 68.0)	81.7	79.4	63.3	(63.1 - 63.4)	79.7
2012-2014	81.2	66.1	(64.4 - 67.8)	81.4	79.5	63.4	(63.3 - 63.6)	79.7
Females								
2009-2011	84.5	67.8	(66.1 - 69.5)	80.2	82.9	64.2	(64.0 - 64.3)	77.4
2010-2012	84.6	66.8	(64.9 - 68.7)	79.0	83.0	64.1	(63.9 - 64.3)	77.2
2011-2013	84.6	65.5	(63.6 - 67.3)	77.4	83.1	63.9	(63.8 - 64.1)	76.9
2012-2014	84.5	67.6	(65.8 - 69.4)	80.0	83.2	64.0	(63.8 - 64.2)	76.9

Life expectancy and Healthy Life expectancy at birth in males and females in Cambridgeshire and England and the proportion of life spent in good health.

NB: chart axes do not start at zero.





Child obesity

The following section describes the progress against the child excess weight and obesity targets in both Fenland and the 20% most deprived areas compared to the rest of Cambridgeshire.

Children aged 4-5 years classified as overweight or obese

The target for Reception children in Fenland is to reduce the proportion of children with excess weight (overweight and obese) by 1% a year, whilst at the same time reducing the proportion for Cambridgeshire by 0.5%. In 2014/15 Fenland did not meet this target (22.1% actual against 21.4% target), but there was a reduction from the previous year (22.4%). There was a noticeable decrease in Cambridgeshire, which meant the target was met (19.4% actual, 20.4% target) but that the gap between Fenland and Cambridgeshire had widened.

Target : Improve Fenland by 1% and CCC by 0.5% a year

Area		Actual			2014/15		2015/16	
		2011/12	2012/13	2013/14	Actual	Target	Actual	Target
Fenland	Number	261	249	232	230	-		-
	%	26.7%	24.9%	22.4%	22.1%	21.4%		20.4%
Cambridgeshire	Number	1,394	1,327	1,399	1,317	-		-
	%	22.4%	20.2%	20.9%	19.4%	20.4%		19.9%
Gap		4.3%	4.7%	1.5%	2.7%	1.0%		0.5%

Source: NCMP, HSCIC

Children aged 4-5 years classified as obese

There was a noticeable decrease in the recorded obesity prevalence in Reception children in Cambridgeshire between 2013/14 and 2014/15 (8.0% to 7.3%). The target (described below) to reduce the recorded child obesity prevalence in Reception children in the 20% most deprived areas in Cambridgeshire was met in 2014/15 (9.6% actual, 10.1% target). The target for the remaining 80% of areas was also met (6.6% actual, 7.1% target).

Target : Improve 20% of most deprived areas by 0.5% a year and in the remaining 80% of areas by 0.2% a year

Area		Actual			2014/15		2015/16	
		2011/12	2012/13	2013/14	Actual	Target	Actual	Target
20 most deprived	Number	148	156	157	146			
	Total	1,310	1,444	1,477	1,521			
	%	11.3%	10.8%	10.6%	9.6%	10.1%		9.6%
80 least deprived	Number	344	327	372	344			
	Total	4,819	4,997	5,108	5,177			
	%	7.1%	6.5%	7.3%	6.6%	7.1%		6.9%
Total (CCC only)	Number	492	483	529	490			
	Total	6,129	6,441	6,585	6,698			
	%	8.0%	7.5%	8.0%	7.3%			

Source: NCMP cleaned dataset, HSCIC

Children aged 10-11 years classified as obese

There was a noticeable decrease in the recorded obesity prevalence in Year 6 pupils in Cambridgeshire between 2013/14 and 2014/15 (16.2% to 15.0%). The target to reduce recorded child obesity prevalence in Year 6 children in the 20% most deprived areas in Cambridgeshire was off target in 2014/15 (19.6% actual, 19.4% target), but there had been a decrease from the previous year (19.9%). The target for the remaining 80% of areas was met (13.7% actual, 15.0% target).

Target : Improve 20% of most deprived areas by 0.5% a year and in the remaining 80% of areas by 0.2% a year

Area		Actual			2014/15		2015/16	
		2011/12	2012/13	2013/14	Actual	Target	Actual	Target
20 most depri	Number	245	217	226	232			
	Total	1,107	1,117	1,136	1,182			
	%	22.1%	19.4%	19.9%	19.6%	19.4%		18.9%
80 least depri	Number	613	623	671	596			
	Total	4,174	4,207	4,411	4,345			
	%	14.7%	14.8%	15.2%	13.7%	15.0%		14.8%
Total (CCC or	Number	858	840	897	828			
	Total	5,281	5,324	5,547	5,527			
	%	16.2%	15.8%	16.2%	15.0%			

Source: NCMP cleaned dataset, HSCIC

Excess weight in adults

The current target for excess weight in adults needs to be revised as the national data reporting for this indicator has recently changed to three years combined data rather than annual data. The Fenland and Cambridgeshire targets are currently based on annual data.

Physically active and inactive adults

Physically inactive adults

Target: Improve Fenland by a further 0.5% and then improve Fenland by 1% a year and Cambridgeshire by 0.5%.

Area	Actual			Target		Gap					Change 2014-2016
	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016	
Fenland	50.5%	51.1%	52.1%	53.1%	54.1%	-9.8%	-9.1%	-12.4%	-11.9%	-11.4%	2.0%
Cambridgeshire	60.3%	60.2%	64.5%	65.0%	65.5%						1.0%

Note: Number of respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 "equivalent" minutes of at least moderate intensity physical activity per week in bouts of 10 minutes or more in the previous 28 days

Actions

There is a range of programmes and services that address both childhood and adult obesity which include prevention and treatment though weight management programmes. Examples for promoting healthy eating include the commissioning of the Food for Life Partnership to work in schools to set policy, provide information and skills about healthy eating and growing healthy food, similar approaches are being used in children's centres and with community groups. The Workplace Health programme is another avenue for promoting health eating workplace policy.

There is a range of physical activity programmes provided in different settings across the county targeting all ages that are provided by CCC and district councils along with the voluntary and community sector.

CCC commissions an integrated lifestyle service which includes a Health Trainer Service which supports individuals to make healthy lifestyle changes, children and adult weight management service and community based programmes that focus up on engaging groups and communities in healthy lifestyle activities.

Mental health

Proposed indicators:

- **Number of schools attending funded mental health training:**
  - In total, 63 schools and colleges have been engaged in the training programme.
  - 15 schools have had a whole school briefing since start of April 2016.
  - Training by district has been as follows:

2012-16

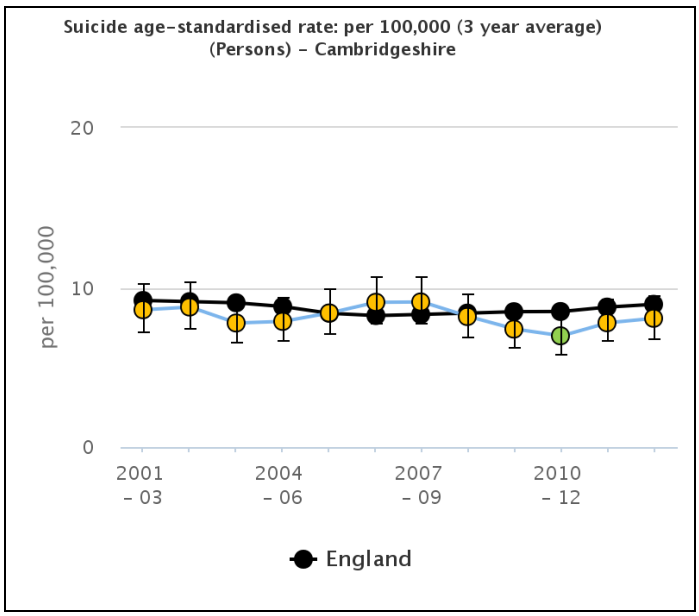
District	No. Schools	%
Cambridge City	8	22
East Cambridgeshire	14	39
Fenland	9	23
Huntingdonshire	18	26
South Cambridgeshire	14	19
Grand Total	**63**	**25**

- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – To date (June 2016), 21 out of 30 secondary schools have taken up the offer of a consultancy visit.
  This piece of work was funded for the 2015/16 academic year only.

- **Number of front line staff that have taken part in MHFA and MHFA Lite commissioned training** (quarterly):
  - Mental Health First Aid and Mental Health First Aid Lite are offered free of charge to front line staff within Cambridgeshire County Council and partner organisations:
  - MHFA (2 day course) attendance: 308 (up to 13.5.16)
  - MHFA Lite (1/2 day) attendance: 133 (up to 13.5.16)

  The contract was for a two year period and finished in September 2016. The annual target was to train 255 front line staff in full Mental Health First Aid and 126 staff from other groups in Mental Health First Aid Lite and the provider were on course to deliver this. Final data will be presented at the next update.

- **PHOF Indicator: Mortality rate from suicide and injury of undetermined intent** (annual):
  - In Cambridgeshire, the rate of suicide and injury of undetermined intent is 8.1 per 100,000 (3 year average, 2012-14), this is not significantly different to the England rate or the East of England rate. The chart below shows the trend in recent years; the rate has remained fairly stable in Cambridgeshire.



Source: Public Health Outcomes Framework

  - **Emergency hospital admissions for intentional self-harm** (annual):
    In 2014/15 the Cambridgeshire rate for emergency hospital admissions for intentional self-harm was 221.5 per 100,000 population (in 2013/14 it was 243.9 per 100,000). This was significantly higher than the England and East of England rate. Within Cambridgeshire, the following districts have significantly higher rates of emergency hospital admissions than England: Cambridge, Fenland, South Cambridgeshire and East Cambridgeshire (see chart below).

Emergency Hospital Admissions for Intentional Self-Harm: Directly age-sex standardised rate per 100,000 2014/15

Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	105,765	191.4	190.3	192.6
East of England region	10,367	173.8	170.5	177.2
Norwich	537	374.2	341.7	408.8
Peterborough	583	300.7	276.5	326.4
Tendring	326	273.3	243.8	305.4
Cambridge	379	252.7	225.8	281.8
King's Lynn and West Norf...	334	240.1	214.7	267.6
East Cambridgeshire	201	238.5	206.5	274.1
Fenland	223	236.2	206.1	269.5
Colchester	427	229.8	208.4	252.9
Ipswich	317	229.0	204.2	255.9
South Cambridgeshire	339	228.4	204.5	254.3
Southend-on-Sea	381	216.5	195.2	239.4
Harlow	182	209.1	179.6	242.0
Stevenage	184	208.6	179.4	241.2
Breckland	252	206.4	181.5	233.8
North Norfolk	170	198.3	168.7	231.5
Broadland	219	184.8	160.7	211.4
Huntingdonshire	312	184.0	164.0	205.7
St. Edmundsbury	191	180.0	155.3	207.6

Source: Public Health Outcomes Framework

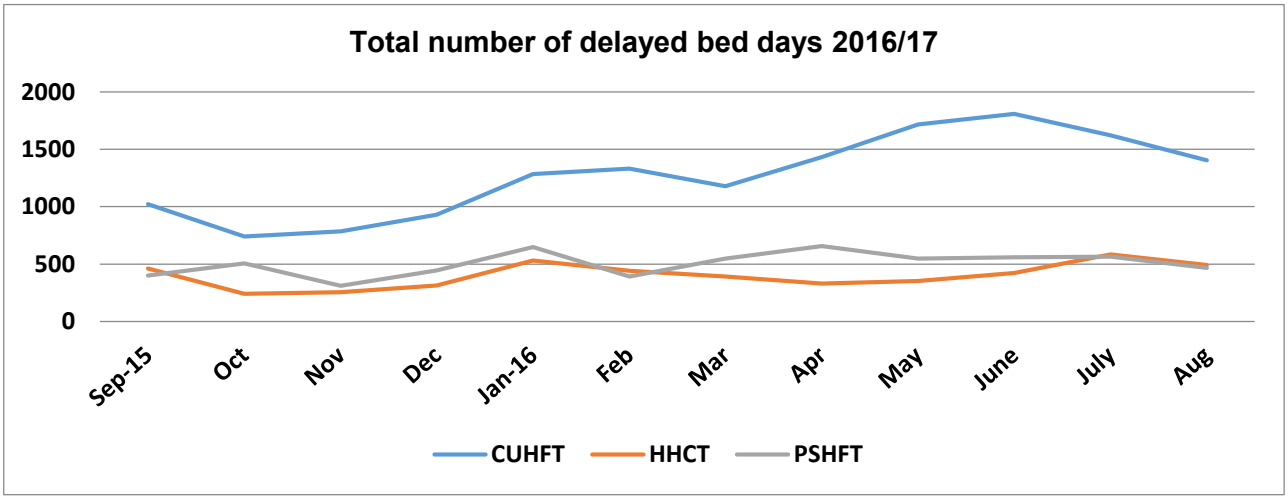
Transport and Health

At the January meeting of the Health Committee, it was request that these indicators be reviewed. The Committee is advised that this review is now under way.

APPENDIX 8 – HEALTH SCRUTINY INDICATORS

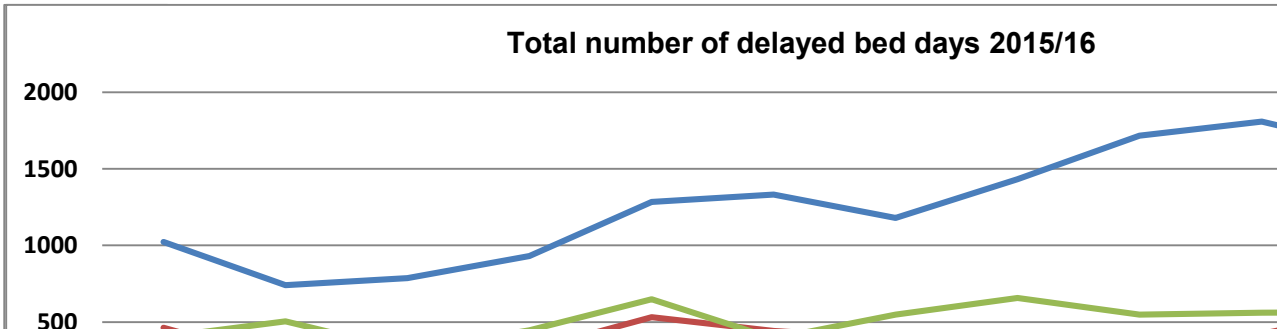
Updates on key indicators for NHS issues which have been scrutinised by the Health Committee are as follows:

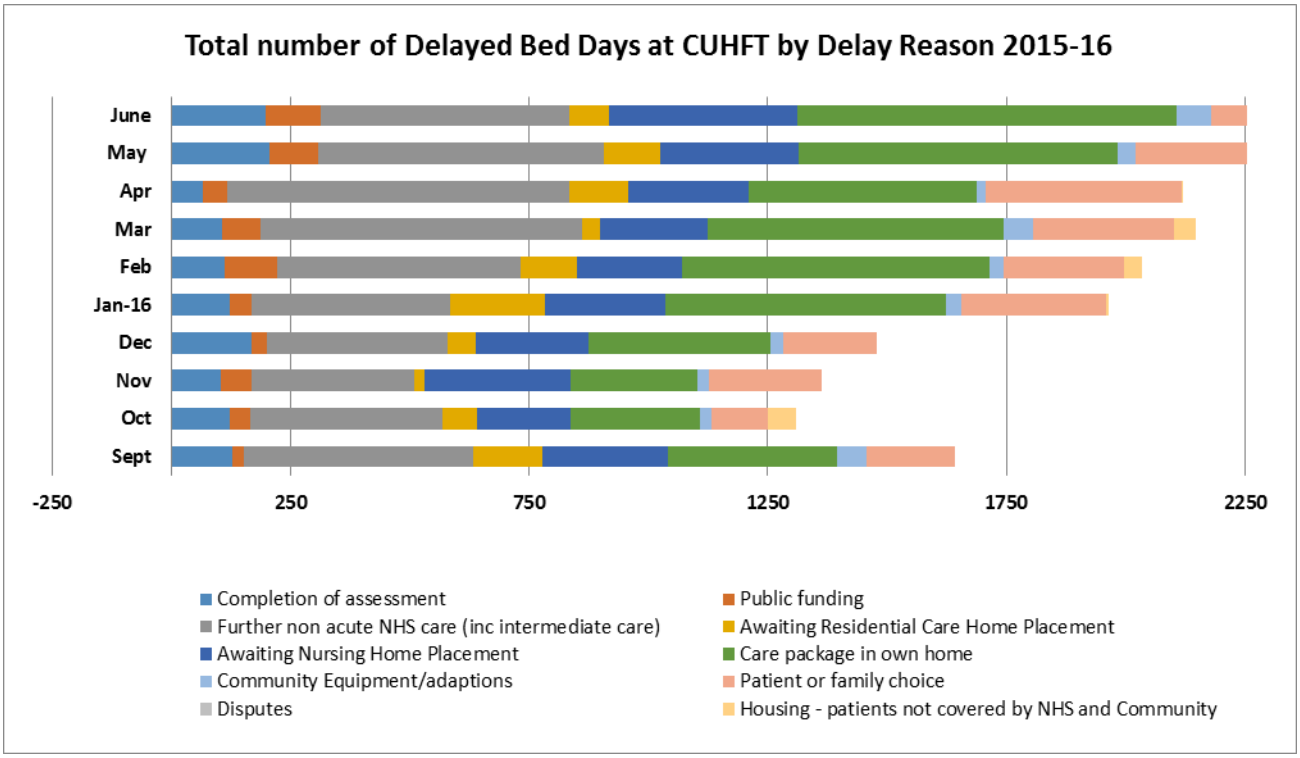
- **Delayed Transfer of Care (DTOC)**

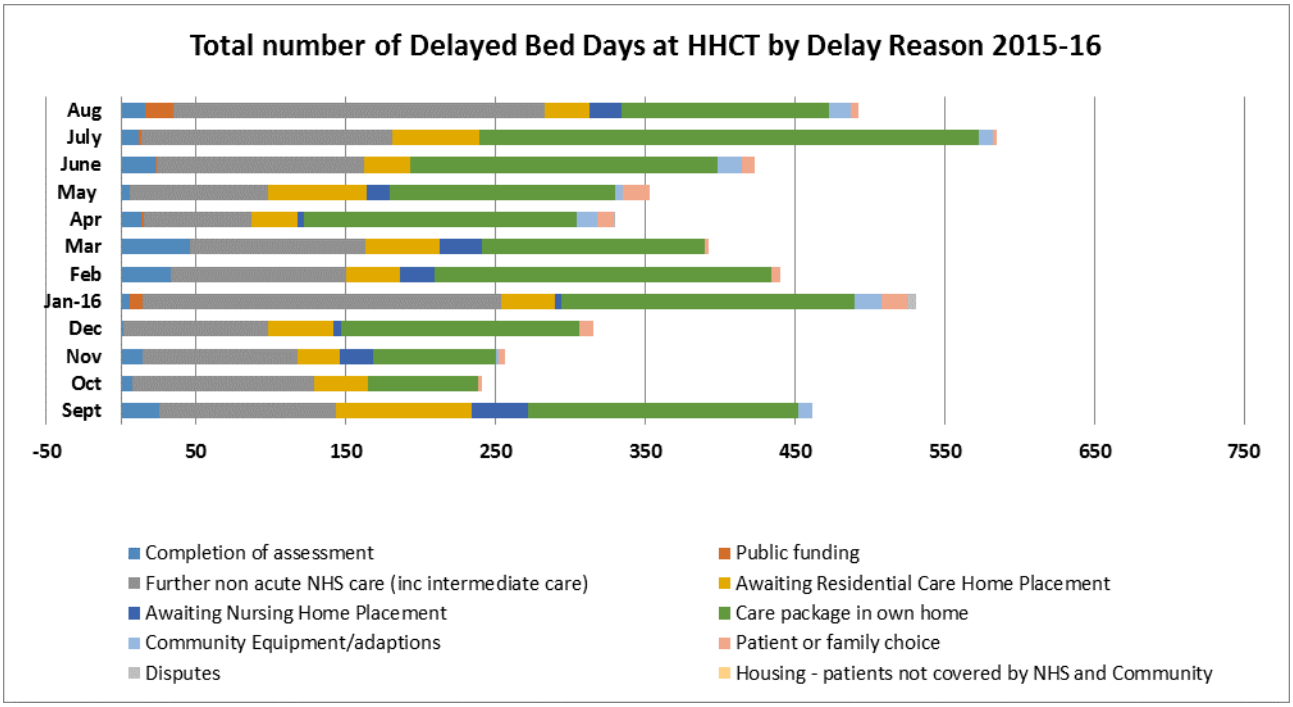


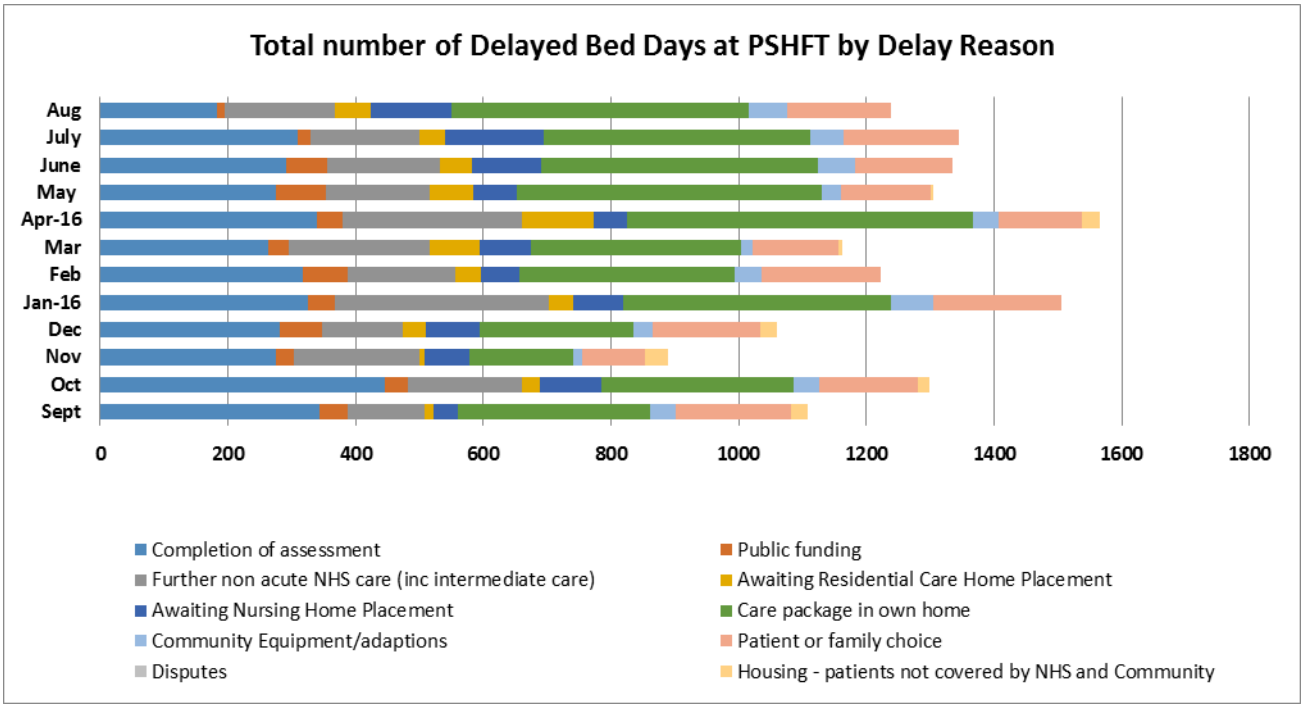
Total number of delayed bed days

	Sep-15	Oct	Nov	Dec	Jan-16	Feb	Mar
CUHFT	1023	741	786	931	1283	1333	1179
HHCT	462	241	256	315	531	441	392
PSHFT	401	505	311	446	649	391	548




Total number of Delayed Bed Days at CUHFT by Delay Reason 2015-16
June
May
Apr
Mar
Feb
Jan-16
Dec
Nov
Oct
Sept
-250
250
750
1250
1750
2250
Completion of assessment
Public funding
Further non acute NHS care (inc intermediate care)
Awaiting Residential Care Home Placement
Awaiting Nursing Home Placement
Care package in own home
Community Equipment/adaptions
Patient or family choice
Disputes
Housing - patients not covered by NHS and Community


Total number of Delayed Bed Days at HHCT by Delay Reason 2015-16
Aug
July
June
May
Apr
Mar
Feb
Jan-16
Dec
Nov
Oct
Sept
-50
50
150
250
350
450
550
650
750
Completion of assessment
Public funding
Further non acute NHS care (inc intermediate care)
Awaiting Residential Care Home Placement
Awaiting Nursing Home Placement
Care package in own home
Community Equipment/adaptions
Patient or family choice
Disputes
Housing - patients not covered by NHS and Community



The data provided for August 2016 for DTOC for Hinchingbrooke HealthCare Trust indicates an improvement in the number of delayed transfers of care.

An improved situation for CUHFT was also evident in the August data.

APPENDIX 9 - PUBLIC HEALTH MOU 2016-17 UPDATE FOR Q2

Directorate	Service	Allocated	Contact	Cost Centre Finance Contact	Q2 Update	YTD expected spend	YTD actual spend	Variance
CFA	**Chronically Excluded Adults (MEAM)**	£68k	Tom Tallon	MN92145 Stephen Howarth	During quarter two we have started work with four new complex needs clients. Five clients have been closed. Of those three were living more positively and safely and were accommodated, one had left the area and one where CEA could not provide any further assistance. One closed client was now doing some voluntary work. CEA have had information sharing sessions were our approach was discussed with Oxford. We have also had a practice session with Bristol on the theme of engaging with the most marginalised clients. We have recruited and appointed, Heather Yeadon, formerly senior project worker at Wintercomfort to the new post working with the street based community. Heather is due to start at the end of October. A review of our referral process has led to a change in practice with one person, Ben Harwin, now triaging all referrals and allocating after acceptance by the Case Group. Preliminary results from the Peterborough project indicate that savings have been made to the criminal justice system as mirrored with the Cambridgeshire work. CEA have assembled a small working group to look at expansion of the training flat model. We have been asked to present at a Homelesslink event on this work. The first social work student that was placed with the CEA team finished his placement and successfully passed. Following discussions between Making Every Adult Matter (MEAM) and CEA, MEAM have asked FTI consultancy to produce a 5 year evaluation of the CEA work. We are currently pulling together the data for this.	£34,000	£34,000	0
CFA	**PSHE KickAsh**	£15k	Diane Fenner	CB40101 Jenny	• Ten secondary schools in the programme • Kick Ash training for secondary school has commenced • Primary visits planned for spring term 2-017	£7,500	£7,500	0

<table>
<tr><td></td><td></td><td></td><td></td><td>Simmons</td><td></td><td></td><td></td><td></td></tr>
<tr><td>CFA</td><td>Children's Centres</td><td>£170k</td><td>Jo Sollars/ Sarah Ferguson</td><td>CE10001

Rob Stephens</td><td>INFORMATION AWAITED. CONTACT ON HOLIDAY.</td><td></td><td></td><td></td></tr>
<tr><td>CFA</td><td>Mental Health Youth Counselling</td><td>£111k</td><td>Holly Hodge/ Emma De Zoete</td><td>CD20901

Clare Andrews</td><td>Cambridgeshire Youth Counselling Services:

Youth counselling services are provided by Centre 33 and YMCA covering the whole of Cambridgeshire for 12-25 year olds. This quarter's contract monitoring meeting is upcoming.

There continues to be a high number of young people accessing these counselling services and responding positively to the interventions offered.

As part of a wider re-design of child and adolescent mental health services this service is likely to be re-tendered in 2017. The existing contracts are currently going through the exemption process to be extended for an additional 6-9months. The service will be re-commissioned across Cambridgeshire and Peterborough with additional funding from Peterborough City Council and Cambridgeshire and Peterborough Clinical Commissioning Group.</td><td>£55,500</td><td>£55,500</td><td>0</td></tr>
<tr><td>CFA</td><td>CAMH Trainer</td><td>£71k</td><td>Holly Hodge/ Emma De Zoete</td><td>CD20901

Clare Andrews</td><td>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 with a new 1 day mental health course for the 2016/17 academic year.

Most recent data (July 1016) shows 63 schools and colleges have been engaged in the training programme as shown below:
2012-16
<table>
<tr><th>District</th><th>No. Schools</th><th>%</th></tr>
<tr><td>Cambridge City</td><td>8</td><td>22</td></tr>
<tr><td>East Cambridgeshire</td><td>14</td><td>39</td></tr>
<tr><td>Fenland</td><td>9</td><td>23</td></tr>
<tr><td>Huntingdonshire</td><td>18</td><td>26</td></tr>
<tr><td>South Cambridgeshire</td><td>14</td><td>19</td></tr>
<tr><td>Grand Total</td><td>63</td><td>25</td></tr>
</table></td><td>£35,500</td><td>£35,500</td><td>0</td></tr>
</table>

					A range of other courses are run for professionals working with children and young people and attendees have included school nurses, family workers, social workers, young people's workers and health visitors among other roles. A broad range of topics are included within this training for example, understanding and responding to self-harm.			
CFA	**DAAT**	£5,980 k	Susie Talbot	NB31001-NB31010 Jo D'Arcy	At the end of Qtr 2 there had not been any current spend for the allocated budget for GP Shared Care & Nalmefene, this information is passed through for recharge by PH and to date no information has been received. The inpatient detox beds contract is paid up to end August, Septembers invoice has also now been paid but does not show on the grid, all payments are up to date to the end of Qtr 2. The Service User Contract is also paid to end Qtr 2. Qtr 1 & Qtr 2 80% invoices from Inclusion for the Drug & Alcohol Contracts have been received and paid. We are currently awaiting invoices for the Qtr 1 20% performance element of the contract. Qtr 2 of the young people's contract has now been paid and this will show in Qtr 3's report. The predicted Q2 spend is based solely on half 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 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.	£2,990,000	2,564,890	
CFA	**Contribution to Anti-Bullying**	£7k	Sarah Ferguson					
					SUB TOTAL : CFA Q2			
ETE	**Active Travel (overcoming safety barriers)**	£55k	Matt Staton	HG03560 Jonathan Trayer	Currently 66 schools are actively engaged in the school travel planning process through STARS. 32 accredited to Bronze level and 2 Gold. Since the beginning of April:	£27,500	£27,500	0

					Walk Smart has been delivered to 132 pupils Scoot Smart has been delivered to 1018 pupils Pedal Smart has been delivered to 120 pupils			
ETE	**Explore additional interventions for cyclist/ pedestrian safety**	£30k	Matt Staton	HG03560 Jonathan Trayer	Partnership campaign 'Let's look out for each other' ran in July Planning is underway for a 'Be Bright Be Seen' promotion after the clocks change in October and into November. Data and intelligence continues to be interrogated to produce a profile for collisions involving cyclists. Discussions have been held with Anglia Ruskin University to see whether any of their research projects looking at eye-tracking and road user behaviour are relevant to cycle safety or if they could be extended to include potential cycle safety elements, particularly in relation to driver search patterns and eye-contact between road users.	£15,000	£15,000	0
ETE	**Road Safety**	£20k	Matt Staton	HG03560 Jonathan Trayer	17 schools are now signed up to the Junior Travel Ambassador Scheme, including 9 schools who were engaged last academic year. The 8 new schools are appointing JTAs during September/October with the total number expected to reach 80-85 JTAs.	£10,000	£10,000	0
ETE	**Trading Standards KickAsh and Alcohol Advice**	£23k	Elaine Matthews/ Jill Terrell	LC44590 John Steel	*A dedicated post has been created to fulfil this funded KickAsh role within Community Protection Team in Community and Cultural Services. This post holder (employed term time only) fulfils the specified activities on behalf of Trading Standards and supports the wider KickAsh team to deliver improved outcomes.* **July:** Certificates for the 2015/16 mentors. Collating feedback and gathering information for evaluation. Administrative work completing year end reports and setting up systems for school year 2016/17 ahead. Preparation for recruitment of new Year 10 mentors for September. Attended the Safety Zone in Parkside, Cambridge – delivery messages about underage sales and shop policies and sharing information with approximately 450 9-10 year olds about E-cigarettes, the effects of those and tobacco with their health. **August:** School holidays, no work carried out during this month **September:** Launched straight in to the delivery of training to the first	£11,500	£10,752	-748

					pupils recruited to be mentors and take part in the delivery of KickAsh for 2016/17. **Swavesey Village College:** • Met 44 very keen year 10's to deliver the messages of being proud to be smoke free. • Enhanced the delivery to include more information on Nicotine Inhaling Products that are becoming more popular with young people and those who are nicotine dependent. **Bottisham Village College:** • A group of very able and enthusiastic year 10'2 gathered to receive the training. Bottisham VC is one of the link schools that will receive 5 half termly visits to support them to stay on track to deliver messages and events throughout the year. **St Peter's College, Huntindon:** • Facilitated a group of 14/15 year olds gathered to discuss the issues affecting them and their peers, and to increase their awareness of the effects of smoking in young people. • They took part in visits to local shops selling tobacco and nicotine inhaling products, advising shopkeepers of the dangers smoking has on their peers, checking Challenge 25 ID and completing the mentor's questionnaire devised for this purpose. • Three members visited three shops to complete the questionnaire and to take part in the Trading Standards Illicit tobacco Awareness roadshow, helping to deliver the messages about plain packaging, illicit tobacco etc. **Sir Harry Smith, Whittlesey:** • Met with 45+ Year 10's to talk about the KickAsh programme and to deliver the messages about plain packaging, illicit tobacco etc. **Other work:** • Continued work to support and improve the communication between the school leads and mentors. Developing an individual programme of KickAsh events and expectations for three schools (Cottenham Village College, Longsands Academy, Bottisham Village College), which fall within wider responsibilities for the duration of the year.			
ETE	**Illicit Tobacco**	£15k	Aileen	JM12800	• Following the 6 Magistrates warrants executed late March and	£7,500	£12,974	£5474

			Andrews	John Steel	all 6 premises yielding illicit tobacco, investigation work was concluded and cases prepared for court with cases in court. • Financial Investigations ongoing. • The one week illicit tobacco roadshow was during September (not calculated in to the actual spend as part of a regional project). • Intelligence work on going and intelligence received about sellers within county during roadshow week.12,974 • One premises raided in Wisbech. Hand rolling tobacco seized which was concealed in roof behind a light fitting. • The simple caution was signed by takeaway owner (mentioned as being offered in quarter one document.) • 5 cases have been through the courts, results – 1. Defendant fine reduced to £1500 and victim surcharge £120 after sentencing appeal hearing. 2. Defendant fined £250 and victim surcharge £25. 3. Defendant fined £465 4. Two defendants (directors of one shop) sentenced to 120 hours unpaid work each. 5. One defendant still going through court (hearings in this qtr.) as proceeds of crime hearings taking place. Regional Project - Costs not within this allocation. Most of the work going forward will be against the regional tobacco project funding.			
ETE	**Business and Communities Team**	£10k	Elaine Matthews		*ETE Shared Priority: Engaging with communities in Fenland* **Prioritised work completed by Community Resilience Development Team (CRD) focusing on improving lives in Fenland.** <u>Libraries and Older People project – March town</u> Bringing together a range of internal and external partners and volunteers who work on front line with older people in March to maximise use of resources, resulting in improved knowledge and intelligence of the service users, increasing knowledge and information for sharing by front line workers for residents on available services and social/local support groups. Development of a shared 'Older peoples promise', using evaluation of Fenland projects to roll out in 2 new areas. <u>Community Green Spaces: Rings End Nature Reserve</u>. CRD engagement with a large national locally based employer resulted in 120 hours of volunteer time by their employees at Rings End Nature reserve in September. These capable volunteers were joined by learning disability service users and people from the local community and led by our Green Spaces Manager, working together to create new	£7,300	£7,372	£72

					pathways, cleared a large pond, removed overgrown shrubs and trees and built new deadwood fencing which has opened up the nature reserve to far more visitors from the community and schools, learning disability groups and Forest Schools. The company has donated or pledged useful equipment and supplies for the nature reserves, further man power and loan of heavy duty equipment. Winter Warmth Packs, inputting to the development of the packs, the distribution and promotion. Mental Health support for young people in Fenland 'Shelf Help' Part of the Reading Well Books on Prescription scheme, which provides 13-18 year-olds with high-quality information, support and advice on a wide-range of mental health issues such as anxiety, depression, eating disorders and self-harm, and difficult life pressures, like bullying and exams. Dementia Awareness and local support: delivery of sessions and support to Dementia Friends and Dementia Alliance. Increased available information and book collections in all Fenland libraries, running dementia friends sessions across Fenland as part of health & wellbeing training for front line workers and several DF sessions across the district with more planned up to Christmas *Note: Costs in Q3 and Q4 anticipated to be lower due to planning carried out in Q1 and Q2. Annual spend on target in line with allocation*			
ETE	**Fenland Learning Centres**	£90k			Contract awarded and all funds allocated.	£45,000	£45,000	0
					SUB TOTAL : ETE Q2	**£123,800**	**£128,598**	**£4798**
CS&T	**Research**	£22k		KH50000 Maureen Wright		£11,000	£11,000	0
CS&T	**H&WB Support**	£27k		KA20000 Maureen Wright		£13,500	£13,500	0
CS&T	**Communications**	£25k		KH60000		£12,500	£12,500	0

				Maureen Wright				
CS&T	**Strategic Advice**	£22k		KA20000 Maureen Wright		£11,000	£11,000	0
CS&T	**Emergency Planning Support**	£5k		KA40000 Maureen Wright		£2,500	£2,500	0
CS&T	**LGSS Managed Overheads**	£100k		UQ10000 Maureen Wright		£50,000	£50,000	0
					SUB TOTAL : CS&T Q2	**£100,500**	**£100,500**	**0**
LGSS	**Overheads associated with PH function**	£220k		QL30000 RL65200 TA76000 Maureen Wright		**£110,000**	**£110,000**	**0**
					SUB TOTAL : LGSS Q2	**£110,000**	**£110,000**	**0**

SUMMARY

Directorate	**YTD (Q2) expected spend**	**YTD (Q2) actual spend**	**Variance**
CFA			
ETE	£123,800	£128,598	£4,798
CS&T	£100,500	£100,500	0
LGSS	£110,000	£110,000	0
TOTAL Q2			

Update on implementation of UnitingCare Model November 2016

Aidan Thomas

Overview on progress

- Commitment from commissioners and providers to implement model
- No patients care affected by closedown of UC
- Funding difficulties leading to slower and reduced implementation
- As a result of reduced implementation impact on A&E and community services integration significantly reduced in short term.

What has been delivered

- New integrated neighbourhood teams (including mental health) including mobile working have improved productivity – 4 of 16 now in new co-located team bases – others currently virtual
- 4 Joint Emergency Teams in place and running
- Case-management methodology largely agreed
- Some Long Term Conditions pathways developed
- Commitment to social prescribing and third sector engagement
- Strong joint committment to working together

What has not yet been delivered

- Social Care support to JET (limited support through integrated care Worker pilots)
- Integrated information viewer to enable joint working
- 80% of planned case management capacity
- Voluntary sector integrated support in neighbourhoods
- New End of Life care pathway
- Long Term conditions pathways

What is planned

- The STP includes £40m investment in community and primary Care over the next 5 years including;
  - Case Management
  - Long Term conditions Support
  - End of Life Care
- Joint Commitment Social Care and Health to adopt neighbourhood focus
- Pilots to more closely link Neighbourhoods and general practices and federations, and work to link JET with ambulance services and A+E
- Review of Intermediate Care (community beds and hospital at home)

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 1 November 2016	Cambridgeshire County Council

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
	Community Led Physical Activity Proposal	Val Thomas	2016/058			
	Procurement of Child and Adolescent Mental Health Counselling Services	Emma de Zoete	2016/063			
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme: Memorandum of Understanding	Liz Robin				
	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: 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				
15/12/16	Business Planning 2017-18	Liz Robin		01/12/16 3.30pm	*02/12/16*	*06/12/16*
	Public Health Finance and Performance Report	Chris Malyon/ Liz Robin				
	Development of Cambridgeshire Stop Smoking Services	Val Thomas				
	Scrutiny Item: Primary Care Capacity	Iain Green/ Alice Benton				
	Scrutiny Item: Emerging Issues: Fertility Treatment Services	Dr Richard Spiers				
	Scrutiny Item: Health Committee Working Groups – Quarterly update	Kate Parker				
	Agenda plan and appointments to outside bodies	Ruth Yule				
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: bed-based intermediate care and minor injuries consultation plan	Kate Parker				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report)					
	Scrutiny Item: Sustainable Transformation Plan Overview	CCG				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: East England Ambulance Trust (EEAST) Care Quality Commission Inspection Local Delivery					
	System Wide Review of Health outcomes In Cambridgeshire	Liz Robin				
	Public Health Risk Register (six-monthly update)	Tess Campbell				
	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				
	Scrutiny Item: 111 Out of Hours Service – Review of First Five Months Delivery	Kate Parker				
	Scrutiny Item: Update from Cambridge University Hospitals NHS Foundation Trust (CUHFT) on EPIC IT Service	CUHFT				

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				
[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				
	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:
1. 0-19 Joint Commissioning of Children's Services (PCC, CCC & CCG; lead authors CCC)
2. A follow-up report by the Immunisation Task and Finish Group in October 2017, 12 months on from the initial report. The report should also cover whether the drop in take up of flu immunisations by pregnant women was a single year anomaly or whether it was repeated in the figures for the following year.

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

Agenda Item No: 11

HEALTH COMMITTEE TRAINING PLAN	November 2016	

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
8.	Health Scrutiny Skills Part 1 (to be rescheduled)	To understand the roles and responsibilities of members conducting health scrutiny and to provide members with scrutiny skills and techniques	3	tba	Public Health	Training Seminar	Health Committee members & Subs		
15.	Sustainability and Transformation Plan	To improve the understanding of the Public Health elements of the STP.	1	tba	Public Health	Training Seminar	Health Committee members & Subs		
16.	JSNA New Communities	To provide an overview to members in regards to the recommendations from the JSNA to inform further scrutiny around primary care capacity	1	tba	Public Health	Training Seminar	Health Committee members & Subs		

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

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