HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 12 May 2016

Democratic and Members' Services
Quentin Baker
LGSS Director: Law, Procurementand 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 Notification of Chairman/woman and Vice-Chairman/Woman

2 Apologies and Declarations of Interest

Guidance for Councillors on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests

3 Minutes – 10 March 2016 and Action Log **5 - 14**

4 Co-option of District Council representatives

The Committee is invited to co-opt the following District Councillors as non-voting members of the Committee:

- *from South Cambridgeshire District Council: Cllr Sue Ellington, substitute Cllr Andrew Fraser*

5 Petitions

SCRUTINY ITEMS

6	**Older People and Adult Community Services – termination of UnitingCare contract**	**15 - 76**
7	**Six month update on Cambridge University Hospitals Foundation Trust progress since Care Quality Commission Inspection**	**77 - 86**
8	**Cambridgeshire and Peterborough review of bed based intermediate health care**	**87 - 92**
9	**Cambridgeshire and Peterborough Clinical Commissioning Group Financial Report**	**93 - 96**
10	**Cambridgeshire and Peterborough Clinical Commissioning Group Non-emergency Patient Transport Services – end of consultation report**	**97 - 162**
11	**NHS Quality Accounts** to follow	
12	**Health Committee Working Groups – Update**	**163 - 172**

DECISIONS

13	**Finance and Performance Report – March 2016**	**173 - 214**
14	**Public Mental Health Strategy Priority Update – Improving the Physical Health of those with Severe Mental Illness**	**215 - 222**
15	**Annual Public Health Report**	**223 - 250**
16	**Annual Health Protection Report (2015)**	**251 - 284**
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18	**Appointments to internal Advisory Groups and panels, and Partnership Liaison and Advisory Groups** to follow	

19 Health Committee Agenda Plan **289 - 294**

The Health Committee comprises the following members:

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

Councillor Peter Ashcroft Councillor Barry Chapman Councillor Paul Clapp Councillor Adrian Dent Councillor Peter Hudson 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

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HEALTH COMMITTEE: MINUTES

Date: Thursday 10th March 2016

Time: 2.20pm to 4.55pm

Present: Councillors P Ashcroft, P Clapp, P Hudson, D Jenkins (Chairman), Z Moghadas, T Orgee (Vice-Chairman), P Sales, M Smith and S van de Ven

District Councillors M Cornwell (Fenland) and R Johnson (Cambridge City)

Also present: Councillor M Leeke; Peterborough City Councillor Brian Rush

Apologies: County Councillors B Chapman, M Loynes and P Topping
District Councillor S Ellington (South Cambridgeshire) and C Sennitt (East Cambridgeshire)

198. DECLARATIONS OF INTEREST

The Chairman welcomed Councillor Brian Rush, Chair of Peterborough City Council's Health Scrutiny Commission, to participate in the scrutiny of the termination of the UnitingCare contract (agenda item 4, minute 201) because the contract had been for services in Peterborough as well as Cambridgeshire. He also welcomed Councillor Leeke to the table, explaining that forthcoming changes in committee proportionality meant that the vacant Independent seat on the Health Committee would shortly be held by a different political group. Councillor Leeke would, at the Chairman's invitation, be permitted to speak but would not vote.

There were no declarations of interest.

199. MINUTES – 21 JANUARY 2016 AND ACTION LOG:

The minutes of the meeting held on 21 January 2016 were agreed as a correct record and signed by the Chairman.

The Action Log was noted.

200. PETITIONS

There were no petitions.

201. OLDER PEOPLE AND ADULT COMMUNITY SERVICES – TERMINATION OF UNITINGCARE CONTRACT

The Committee received a report setting out background information on the termination of the UnitingCare contract, including a briefing note from Monitor, and questioned senior representatives of the NHS regulatory bodies. In attendance were

- Dr Paul Watson, Regional Director (Midlands and East), NHS England (NHSE)
- David Dean, Senior Transformation and Turnaround Director, Monitor.

Also present were

- Tracy Dowling, Chief Operating Officer, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
- Aidan Thomas, Chief Executive, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- Roland Sinker, Chief Executive Officer, Cambridge University Hospitals NHS Foundation Trust (CUHFT).

A member of the public, Jean Simpson, put questions to the Committee. She said she had heard that there were seven reviews being conducted into the circumstances of the termination of the Uniting Care Partnership contract, including ones commissioned by the CCG and by NHS England. The CCG review had been published two and a half hours before the meeting, but she could find no date for the publication of the NHSE review. She asked the Committee to list the seven reviews, and sought assurance that the CCG was making use of the lessons learned for the other two procurement exercises that it was currently conducting.

In response, the Regional Director stated that the NHS England review was to be published within the next fortnight. The Chairman said that the Committee was aware of much ongoing activity, but not specifically of seven reviews; a summary of activity was being prepared for Members' information. The Regional Director advised that each organisation locally had been carrying out a review from its own organisation's perspective. He had offered to convene a meeting of all the local systems once all the reports had been published, in order to examine all the reports and the lessons to be learned from them.

The Committee noted that the ongoing procurement exercises referred to were those for the integrated NHS 111 and Out of Hours service, and for Non-Emergency Patient Transport Services.

The Committee turned to the letter from Monitor's Senior Transformation and Turnaround Director dated 2 March 2016, which had set out to explain Monitor's actions in relation to the questions raised in advance of the meeting. Concerns expressed by Members to the Director included that

- Monitor had reviewed the activities undertaken by CPFT but not by CUHFT
- the review had been conducted hurriedly against a deadline of the contract otherwise not going ahead
- conducting a limited scope risk review – which had arrived at an amber risk rating – could be seen procedurally as not very thorough.

From the letter and the Director's oral replies, the Committee noted that

- Monitor's legal role was as the regulator of foundation trusts, which had a degree of independence; Monitor only had powers to intervene when a foundation trust was at risk of breaching the conditions of its licence
- neither CPFT nor CUHFT was in breach of its licence, so Monitor had relatively limited powers to intervene
- in the case of CUHFT, because it would involve only a small part of a large overall turnover the transaction was below the threshold for classification as significant, so

Monitor was not obliged to review the licence; had it been classified as material, Monitor would have checked that CUHFT had undertaken due diligence

- CPFT had been intending to take on a large role within the contract, involving a proportion of its turnover great enough to trigger a review by Monitor of the proposed transaction's significance

- Monitor would have liked to have had more time in which to conduct its review, but in order to allow the contract to be approved by 1 April 2015, the compromise had been to conduct a limited scope, high level, risk review and keep the investigation open until it reached a satisfactory conclusion. Events had overtaken this

- there was no definition of what constituted a limited high level risk review, but it would have involved fewer meetings than normal; keeping it open made it possible to hold further meetings later

- the Director's understanding was that the source of the view on how to proceed had been the CCG; the CCG's Chief Operating Officer added that her recollection was that all parties had been key to the undertaking

- in the absence of local feeling that the contract should be completed by April 2015, Monitor would have preferred to conduct a more detailed risk analysis. As it was, the downside risk to CPFT had been estimated to be such as to allow the transaction to proceed, and Monitor had had no power to intervene in the case of CUHFT because it was not a significant transaction for CUHFT

- although according to the Internal Audit review the CCG had been refused sight of the CPFT business case, Monitor had seen the business plans

- the subsequent due diligence process involved checking, once services were being delivered under the contract, for any material changes that would affect the downside risk to CPFT; the position had appeared to be satisfactory except for the gap between the CCG and UnitingCare.

Members commented that, looking at the concept of one significant transaction and one transaction that was not significant, it was difficult to understand why the transaction had not been considered as a whole, given the scale of the contract. The Committee expressed concern that arrangements for scrutiny of a proposed contract of this magnitude had not been equal to the task.

The NHSE Regional Director outlined the roles of Monitor and of NHSE, explaining that

- clinical commissioning groups were the NHS locally, holding the majority of the budget for local healthcare and entering into contract with providers, which included both NHS Trusts and NHS Foundation Trusts

- NHSE had oversight of CCGs, Monitor of NHS Foundation Trusts, and the Trust Development Agency (TDA) of other trusts

- Monitor and the TDA were being brought together into one organisation, NHS Improvement

- NHSE had specific duties in relation to CCGs, including the carrying out of assurance reviews, including reviews of governance, financial control and prudence

- NHSE also had to approve any significant service change or configuration, such a the closure or relocation of a service

- if a CCG were to fail (e.g. loss of control of its finances), or if the CCG requested intervention, NHSE would intervene, but CCGs had freedom to enter into contracts – it was for the CCG's governing body to make the decision, not NHSE.

Asked about the role of the Strategic Projects Team (STP), the Regional Director replied that within NHSE were Commissioning Support Units (CSUs), which were semi-autonomous bodies over which he had no control. The STP had been hosted by a CSU; the review to be published in two weeks' time would cover their role.

On the question of whether there would be a clear learning process, making it impossible for a similar event to recur, the Regional Director said that it was important to undertake this learning. When the NHSE review was completed, the first task would be to prevent a recurrence, perhaps by putting in place a proactive assurance mechanism for CCGs, as already happened for service reconfigurations. Secondly, NHSE had offered to convene a session for the local NHS to share all the various reports and put their findings together into one coherent whole. A similar procurement exercise was being conducted in Staffordshire, but had been paused until the lessons from Cambridgeshire had been learned; his expectation was that the procurement would not proceed until a major assurance exercise had been completed.

Asked about the change of structure of UnitingCare to a Limited Liability Partnership (LLP), which had taken place after the Pre-qualification Questionnaire (PQQ) stage, and had not been subject to scrutiny, Monitor's Senior Transformation and Turnaround Director said that he had been unaware that UnitingCare had not always been an LLP, so could not answer immediately. NHSE's Regional Director said that NHSE did not have authority to approve corporate structures; there were benefits to the LLP structure. It was the CCG Governing Body's responsibility to ensure that any procurement was proceeding as it should, including that all necessary checks were made.

A member suggested that an overall controlling body might be required should a similar exercise be repeated, rather than having responsibility divided between several bodies. The Regional Director replied that NHSE could decide to oversee a procurement exercise more closely, but the structure of the NHS was a matter for Parliament to determine. NHSE was required to operate within the framework laid down for it; the review could well make recommendations on its future role in similar situations.

The Regional Director went on to say that one possibility might be that NHSE should proactively conduct an assurance exercise on major transactions being carried out by a CCG; only a change in procedures could prevent a repetition of what had happened in Cambridgeshire. This was why there had been a pause in the Staffordshire contract, which was the main similar exercise currently being conducted, also in the Midlands and East region. There were however advantages to CCG autonomy, which had led to many beneficial results; excessive bureaucracy of oversight could hinder this.

Members expressed concern, despite the benefits to service delivery, at the amount of time, effort and cost involved in setting up the UnitingCare contract; at the suddenness of its collapse, and at the financial loss of £20m to CPFT and CUHFT. The Monitor and NHSE representatives reminded them that much of the £20m would have had to be spent anyway, as it had been spent on employing doctors and nurses, and that the indications were that most of the service model was continuing. The OPACS contract

had triggered a move to more patient-centred care; it was not essential to have that contract in place to take forward the service benefits.

The Chairman asked whether the decision not to support the contract when it was collapsing had been made because of the regulators' legal position or because they had judged that the contract was not worth supporting. The Regional Director replied that local freedoms brought with them the freedom not only to innovate, but also to manage the consequences at the innovator's own risk. The problem in this case was a fundamental gap between what the commissioner had been prepared to pay and the costs which the provider had been incurring. NHSE did not intervene to cover contracts that became financially distressed. In this case, the view had been taken that it would be better for the contract to end, and local NHS organisations then to organise services along more traditional lines, while preserving the service benefits.

The Regional Director went on to say, in answer to further questions, that one lesson for the future was that it was necessary to be cautious about complicated contractual mechanisms where it would be possible to achieve the same result more simply. Across the NHS, commissioners and providers were increasingly looking for the simplest suitable contractual mechanism. Sources of advice were available to CCGs, but the key was to get the service change right and the contract would follow. NHSE was looking at how to help CCGs make carry out service change; the commissioning and contract process needed to be as simple as possible.

At the Chairman's invitation, the representatives of CCG, CUHFT and CPFT made brief statements.

The Chief Operating Officer of the CCG said that it was clear from what had been said at the present meeting, and from the internal audit report just published, that the CCG needed to establish a straightforward procurement process. She added that it had been a massive procurement exercise, into which a large number of people from a large number of organisations had put a great deal of personal effort. It was now necessary to step back and examine what had happened objectively.

CUHFT's Chief Executive Officer expressed his agreement with the three preceding speakers. The new models of care had been successful, and he welcomed NHSE's plan to bring together local NHS organisations to learn from the OPACS contract process. in answer to questions around the timing of the contract award, he said that it was not long from April to the winter period of intense activity; the wish had been to have the best model of care in place for winter 2015/16, and also certainty for staff as to what their employment arrangements would be.

The Chief Executive of CPFT said he supported all that had been said. There was consensus in the county and the NHS that the models of care were the right ones; the most important thing was to take these models forward. He asked the Committee to hold them to account for this. He welcomed the bringing together of the different reports, and pointed out that it was all parties together that would be working to ensure future models of care.

The Chairman thanked all the speakers for giving their time to attend and for their contributions. He also thanked the public for their interest, and invited them to submit further questions on the topic.

Discussing what they had heard, members of the Committee said that they had to examine both the CCG report published that day and the reports still to be published. It

was necessary to look at the findings and recommendations of all the various review reports for assurance that similar events would not happen again.

It was resolved unanimously:

a) to note the helpful and honest input from Monitor and NHS England's representatives

b) to note that there were clear rules in the NHS that limited the responsibility of different parties to intervene in the UnitingCare contract

c) to note that procedures for awarding such contracts were under review and that there was a national pause on similar tender processes

d) at the Committee's meeting on 12 May 2016 to review the termination of the contract again in the light of the findings of the independent reports commissioned by the Clinical Commissioning Group and by NHS England.

202. UPDATE ON ACTIONS TO ADDRESS LOW UPTAKE OF BREAST AND CERVICAL SCREENING IN CAMBRIDGESHIRE

The Committee considered a report describing the composition and work of a task and finish group set up by NHS England (NHSE) to identify issues leading to low uptake of screening in the county. The report outlined the group's main recommendations and the initial work under way to implement action to address them. Dr Shylaja Thomas, Screening and Immunisation Lead, NHSE (Midlands and East, East) was in attendance to present the report and respond to Members' questions and comments.

Members noted that the aim of the work was to increase acceptance of the offer for screening. The implementation group was taking forward the findings and was due to complete implementation in two to three months' time. Evaluation of the work would then follow, to see if uptake of screening had improved.

Examining the report, Members

- commented that reading and English language ability could be a factor in low uptake, and were advised that organisations with which NHSE was working were helping with the production of leaflets in other languages

- expressed concern at the poor rate of return to the GP practice survey, suggesting that other practices might have come up with previously unidentified issues and asking whether the findings were confident enough to be taken forward. Members were advised that the 28 practices surveyed had been chosen to represent the range of uptake; the nine which had responded had come from across that range, and the response rate was in line with expectations. It could be useful to repeat the survey with a different group of practices next year

- noted that there were trained public health staff in Cambridgeshire who could talk to more vulnerable people and encourage screening uptake; it was also necessary that GP practice nursing and administrative staff understand the importance of encouraging patients they see for other reasons to take up offers of screening.

The Chairman enquired into the timetable of activity, and was advised that data was collected and published at national level every three months, usually with a six-month time lag; a further update could usefully follow early in 2017 if required. The Chairman thanked the Screening and Immunisation Lead for her attendance and answers.

It was resolved unanimously to:

a) note the report

b) request a summary timetable of planned activity to address the low uptake of screening

c) review progress again early in 2017.

203. NHS QUALITY ACCOUNTS – RESPONDING TO REQUEST TO COMMENT

The Committee received a report informing it of the requirement, as part of its Health Scrutiny function, to comment on the Quality Accounts (QAs) drawn up by NHS Provider Trusts. Members were asked to consider how best to fulfil this requirement, given the discrepancies between the trusts' timetables and the dates of the Committee's meetings. They noted that the Committee was very dependent on the trusts getting their draft quality accounts it quickly, and that one option was not to respond to all seven Cambridgeshire requests to comment.

The deadline for getting QAs to the Secretary of State was 30th June, with Foundation Trusts being required first to submit their Quality Accounts to Monitor by 31st May. Papworth Hospital NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust had both requested responses from the Committee by 12 May, the date of its next meeting. Cambridge University Hospitals NHS Foundation Trust had not yet specified a date.

In the course of discussion, Members pointed out that, in addition to the seven trusts listed, The Queen Elizabeth Hospital King's Lynn (QEH) provided services to a considerable number of Cambridgeshire residents in the north of the county, and that it would therefore be appropriate to respond to its QA. The Head of Public Health Programmes undertook to communicate this to the hospital. The Chairman undertook to write to all the provider trusts asking them to conform to the Committee's timetable.

Action required

It was resolved unanimously:

a) to respond to as many local NHS Provider Trusts' Quality Accounts as possible in the time available, including The Queen Elizabeth Hospital King's Lynn

b) to establish a member led task and finish group comprising Councillors Leeke, Moghadas and Smith to draw up draft responses to Quality Accounts

c) to finalise draft statements at 12th May Health Committee Meeting

d) to agree an approach for Quality Accounts received after 12th May 2016 at the 12th May meeting

e) that the Chairman write to all Chief Executives of the local NHS Provider Trusts setting out the Committee's timetable and asking them to conform to it.

204. EMERGING ISSUES IN THE NHS – UPDATE ON SELF CARE AND PROPOSED PHARMACY CONSULTATION

The Committee received a report updating it on proposals for raising awareness of self care with the public, and introducing a proposed consultation on changes to pharmacy services (prescriptions for the treatment of minor ailments, for gluten-free products, and for some baby milks). Two officers from the Clinical Commissioning Group attended to present the report and respond to Members' questions, Jessica Bawden, Director of Corporate Affairs, and Sati Ubhi, Chief Pharmacist. Members noted that Cambridgeshire and Peterborough Clinical Commissioning Group's prescribing budget was probably one of the largest in the country, and that 80% of GP consultations included a prescription, of which 70% were not for medicines which could only be obtained on prescription.

In the course of discussion, Members further noted that

- the proposed policy had taken account of GPs' view that they wanted the flexibility to make exceptions to the restriction on over-the-counter products, for example allowing them to prescribe paracetamol syrup for children of low-income families

- patients who were either exempt from prescription charges or held a pre-payment certificate were currently able to obtain over-the-counter medicines on prescription, which saved them a modest sum at considerable cost to the CCG; Cambridgeshire was the only one of the neighbouring counties to do this

- a large proportion of CCGs had already stopped supplying gluten-free foods on prescription, as these were now very widely available in supermarkets

- a wide range of baby milks suitable for infants with cow's milk protein allergy or lactose intolerance was now available; the system of vouchers supplied to low-income parents to purchase milk for babies and young children would continue unaffected by this change.

It was resolved unanimously to note the report.

205. HEALTH COMMITTEE WORKING GROUPS – UPDATE

The Committee received a report informing it of the recent activities and progress of the Committee's working groups, noting that additional members were required for the Hinchingbrooke Healthcare NHS Trust liaison group. The Chairman reported on a seminar he and Councillor Ashcroft had attended at short notice at Peterborough City Hospital, on the relationship between social care services in Lincolnshire and Cambridgeshire the hospital's performance on delayed transfers of care. He undertook to write to the Chairman of the Adults Committee to convey what had been said, and Head of Public Health Programmes undertook to ensure that the presentation was circulated to Members. **Action required**

It was resolved unanimously to:

1) note and endorse the progress made on health scrutiny through the liaison groups and the schedule of liaison meetings

2) appoint County Councillors P Brown, Jenkins, Orgee and Wisson, and District Councillor Cornwell as core members of the Hinchingbrooke Liaison Group.

206. BUILDING COMMUNITY RESILIENCE

The Committee received a report introducing *Stronger Together – Cambridgeshire's Strategy for building resilient communities*, and seeking the Committee's views on the actions taking place in support of this strategy and how this could link with existing public health community resilience based work. Members noted that the strategy contained six themes, and that the focus was on a few deliverable tangible actions in these areas.

Considering the report, Members

- asked what they could do to promote the role of community pharmacists and promote the importance of people taking responsibility for their own health. Members were advised that they could work on campaigns, and also on Kick Ash and other smoking cessation initiatives

- expressed support for the strategy in general, and suggested that its aims should be communicated widely, through parish councils for example

- noted the Director of Public Health's wish to develop a website along similar lines to the Peterborough site, www.healthypeterborough.org.uk. This would be designed to provide an attractive platform for communicating health messages to a wide public, and create an environment where locally-generated ideas could flourish.

It was resolved unanimously to note the report.

207. FINANCE AND PERFORMANCE REPORT – JANUARY 2016

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of January 2016. Members noted that changes in the bottom line figures since the last report were due to the in-year reduction in the Public Health Grant. A predicted £1.5m under-recovery of income would in part be offset by a reduction of £1.1m in expenditure, and £400k would be needed from reserves, £200k less than had been expected. A smaller sum might be needed from reserves, if there were further underspends; the intention was to minimise the amount drawn from general reserves as far as possible.

Discussing the report, Members

- suggested that the 13 red indicators might be cause for concern. Members noted that there had been quite a short lead-in time to the start of the Integrated Lifestyle Service; there had been issues around data transfer, which had not provided a good benchmark to measure against; and recruitment had proved difficult in some areas. It was not easy to find people with the degree of flexibility required to work with GPs and in the community, but once the right person was found, they tended to stay

- expressed concern at the low take-up of mental health training in schools, and noted that mental health staff within the Public Health team were looking at this, and working closely with PHSE (personal, social and health education) staff in schools to encourage uptake and equip them with more tools

- reported from personal experience that one school had succeeded in providing support for a pupil who had been self-harming, once the school had been made aware of the problem

- noted that the Public Health budget had been supporting Economy, Transport and Environment (ETE) Services' work on both road safety and active travel, as part of efforts to reduce the number of physically inactive adults, and work was being undertaken with ETE on the planning of new communities to encourage activity and reduce excess weight in adults and children

- suggested that Delayed Transfers of Care (DTOC) at Peterborough City Hospital should be reported on, in addition to the information supplied on Addenbrooke's and Hinchingbrooke hospitals.

The Chairman said that it had appeared, from the recent workshop with Addenbrooke's on e-Hospital, that the Committee's earlier request for a monthly report following the Care Quality Commission's inspection of Cambridge University Hospitals NHS Foundation Trust appeared to be creating considerable work for CUHFT. He therefore suggested that the Trust be invited to develop an indicator against which the Committee could monitor their progress.

The Chairman also suggested that the presentation of performance data should be improved, to make it easier to manage the Committee's business. He undertook to discuss with Health Spokes developing a simplified, more vivid report on Public Health indicators, focussing on improving health and reducing inequalities. He suggested this should be taken at the beginning of a meeting, rather than the end. **Action required**

It was resolved unanimously to note the report.

208. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan. It was resolved unanimously to note the training plan.

209. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS, AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee considered its agenda plan in the light of concerns raised in the course of the meeting.

It was resolved unanimously:

a) to note the agenda plan

b) to add a scrutiny item on the termination of the UnitingCare contract to the agenda for 12 May 2016

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

Chairman

Agenda Item No: 6

OLDER PEOPLE AND ADULT COMMUNITY SERVICES – TERMINATION OF UNITINGCARE CONTRACT

To:	**HEALTH COMMITTEE**
Meeting Date:	**12 May 2016**
From:	**The Monitoring Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To provide the Committee with background information relating to the termination of the Older People and Adult Community Services contract with the UnitingCare Partnership**
Recommendation:	**That the Committee considers the information provided in advance and at the meeting, including the verbal report on the Community Learning Event of 11 May 2016.**

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

1. BACKGROUND

1.1 On 3 December 2015 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and UnitingCare LLP announced that they were ending their contractual arrangement to deliver urgent care for the over 65s and adult community services.

1.2 On 17 December 2015 the Health Committee considered events in the two weeks since the announcement of the end of the contract, and looked at what arrangements had been put in place to ensure that no service user had been disadvantaged. The Committee's intention then was to consider broader issues surrounding the termination of the contract at its next meeting.

1.3 On 21 January 2016, the Health Committee considered questions around events when the contract was being established and when it was terminated. Representatives of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Cambridgeshire Community Services NHS Trust (CCS) and Cambridge University Hospitals NHS Foundation Trust (CUHFT) were all questioned about events from their perspective.

1.4 On 10 March 2016, the Health Committee questioned senior representatives of the NHS regulatory bodies, NHS England and Monitor (which is now part of NHS Improvement), about their roles in events surrounding the development and the termination of the contract.

2. RECENT EVENTS

2.1 Several external reviews into events surrounding the contract collapse have been commissioned, two of which (those commissioned by the CCG and by NHS England) have already published their findings.

2.2 The CCG has supplied a report to the present meeting (attached as Annex A), updating the Committee on the CCG and NHS England reviews and the actions taken by the CCG to stabilise services for patients. The two published external reviews are attached as appendices 1 and 2 to the CCG's report.

2.3 Healthwatch Cambridgeshire has supplied a report to the present meeting (attached as Annex B), setting out the background to the Community Learning Event being held by Healthwatch Cambridgeshire and Healthwatch Peterborough on 11 May 2016. A timeline of key events surrounding the contract is attached as Appendix 1 to Healthwatch's report.

2.4 The Chair of Healthwatch Cambridgeshire, Val Moore, will give a verbal report to the Committee on the Community Learning Event.

Source Documents	Location
Reports to and minutes of the Health Committee 17 December 2015, 21 January 2016, and 10 March 2016	http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Committee.aspx?committeeID=76

Annex A

OLDER PEOPLE'S AND ADULT COMMUNITY SERVICES CONTRACT MANAGEMENT TRANSFERS TO CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP

To:	**HEALTH COMMITTEE**
Meeting Date:	**12 May, 2016**
From:	**Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**The Committee is asked to comment on and note the report**
Recommendation:	**That the Committee notes the report**

Director contact:		***Member contact:***	
Name:	Jessica Bawden	Name:	Councillor David Jenkins
Post:	Director of Corporate Affairs, CCG	Chairman:	Health Committee
Email:	jessica.bawden@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	01223 725400	Tel:	01223 699170

1. BACKGROUND

1.1 On 3 December 2015 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and UnitingCare LLP announced that they were ending their contractual arrangement to deliver urgent care for the over 65s and adult community services.

1.2 The CCG then took on responsibility for contracting services to deliver urgent care for the over 65s and adult community services were transferred to the CCG. The CCG and UnitingCare worked together to ensure a smooth transition and to reassure patients.

1.3 This report updates the Committee on the CCG and NHS England Reviews and the actions taken by the CCG to stabilise services for patients.

2. CCG INTERNAL AUDIT REPORT

2.1 On 10 March 2016 Cambridgeshire and Peterborough Clinical Commissioning Group published the independent internal investigation on the termination of the Older People's and Adult Community Services (OPACS) contract held between the CCG and UnitingCare LLP. The Review was commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group. It was conducted by West Midlands Ambulance Service (the CCG's internal auditors).

2.2 The CCG asked West Midland Ambulance Service to review the circumstances that led to the termination of the Older Peoples and Adult Community Services (OPACS) contract. The objective of the review was to document and evaluate CCG systems, processes and controls deployed in the procurement and management of the subsequent contract in order to identify any systemic weaknesses that may have contributed to termination of the contract and importantly identify learning points for future procurements. The CCG asked the Review to identify learning points for the CCG and for the wider NHS. The Terms of Reference for the Review are available on the CCG's website http://www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm.

2.3 The Review found that the main reason for the early termination of the contract was a mismatch in the expectations of the CCG and UnitingCare over the cost/value of the contract. The Review recognised that significant efforts were made during 2015 to bridge the financial gap, but these were ultimately unsuccessful. The Review assessed the financial evaluation process employed as part of the tender process and found that the CCG did have in place controls designed to ensure bids were within the estimated annual contract values and the values over the expected five years of the contract.

2.4 The Review identified a number of contributory factors to the eventual early termination of the contract which provide opportunities for learning and application to future procurements. These are:

- The timing of regulatory approval of bidders Business case and associated conditions prior to approval (Section 3.3.2)
- Rigorous application of controls within the procurement including re-assessment of all bidders where the nature of the bidders had changed during the process (Section 3.1.6);
- No re-assessment of the particular risks proposed by the change in legal entity of the successful bidder to a Limited Liability Partnership (LLP) and not being aware of the details of the ownership agreement between the partners; Cambridge and

Peterborough NHS Foundation Trust (CPFT) and Cambridge University Hospital NHS Foundation Trust (CUH Section 3.1.5);

- The failure to obtain Parent Company Guarantees from CPFT and CUH prior to the signing of the contract despite the engagement of external procurement and legal advisers (Section 3.1.10)
- The design of the evaluation process leading to a lack of knowledge of the of the legal entity and nature of the bidder at the time of evaluation by some of the work streams (Section 3.1.9);
- The CCG was not able to triangulate the bid with income assumptions contained within the business plan submitted by the Foundation Trusts to the regulator (Monitor) (Section 3.2.4);
- Need to identify flags of concern in particular lack of access to the bidders business case, the inconsistency of the first invoice with the contract sum (Section 3.2.3) ;
- Ensuring early flagging of the seriousness of concerns with NHS England (Section 3.3.7)
- Enhancements to the reporting to the Governing Body (Section 3.4.1)

3. NHS ENGLAND REVIEW

3.1 On 1 April 2016 NHS England published an independent review into the circumstances leading up to the termination of the contract between Cambridgeshire and Peterborough Clinical Commissioning Group and UnitingCare LLP.

3.2 The review was conducted from a commissioning perspective. The scope of the work included a review of relevant documentation and discussion with key staff members to identify the root causes and contributory factors that led to the termination of the contract. The review has also been informed by contributions to a mailbox through the NHS England website.

3.3 The report identified specific and wider lessons to be learned and makes recommendations for further action, for NHS England as well as Clinical Commissioning Groups. The full independent review can be found here: https://www.england.nhs.uk/mids-east/our-work/uniting-care/

3.4 The Report finds that the contract collapsed for financial reasons. In summary;

- There were too many information gaps around community services,
- The financial envelope of the CCG for these services could not be reconciled to current expenditure levels,
- There was an additional VAT cost,
- The mobilisation period was not sufficient to make the planned financial savings that were required in the first year,
- The contract value was not absolutely agreed at the date the contract commenced.
- The contract should not have commenced on 1 April 2015. It should have been delayed until these issues were resolved.

3.5 The Report makes 6 recommendations for NHS England and 10 recommendations for Clinical Commissioning Groups.

3.6 Recommendations for NHS England:

1) Follow up this Part 1 review with Part 2 in the form of follow up investigations.
2) Specifically on the role of external advisors to the procurement, the effectiveness of the Gateway review process, and the role of the CCG executive leadership,

Governing Body and related audit functions throughout the procurement and contract period.

3) Consider which is the most appropriate process to achieve an integrated system wide solution consistent with EU law. There are advantages to formal procurement including transparency and focus. However, this requires capacity and capability to carry out the procurement, robust costing and other information to inform the contract and financial flexibility of bidder organisations to manage risk.
4) The current approach of complete delegation to CCGs to enter into large complex novel contracts without the need to provide any assurance to NHS England should be reviewed. The consequences of failed contracts can impact on patients, staff, commissioners and providers and undermine working relationships for the future. Consider establishing an assurance process for novel contracts carried out by appropriately skilled individuals.
5) If NHS England put in place an assurance process around these major novel contracts then this could assist Monitor in the triangulation of business case assumptions as Monitor could confer with NHS England to triangulate key assumptions.
6) Consider commissioning work to determine a model around the disaggregation of acute and community costs for the over 65s so that this can assist CCGs in developing different contracting models.
7) Review all current and planned CCG and NHS England contracts of this sort as a matter of urgency, prior to entering into any new commitments
8) Consider how the innovative work in Cambridgeshire and Peterborough can be retained and developed for the benefit of not only this area but elsewhere in the country.

3.7 Recommendations for Clinical Commissioning Groups:

1) Consider the proposed level of 'risk transfer' carefully. Allocate risk proportionate to the organisation's ability to manage it.
2) Ensure that all bidders are assessed for capacity, capability, economic and financial standing and that they are re-assessed if the structure of their bid or their corporate form changes during the procurement process.
3) Ensure that future contracts with Limited Liability Partnerships or Special purpose Vehicles have parent guarantees.
4) Ensure that sufficient time is spent at the front end of the process to disaggregate costs from the existing service provision model. This is particularly relevant for community services. It is important that an accurate financial envelope for the new service procurement model is established before the procurement commences. If this is not done then existing providers can be conflicted when they are bidding in their own right whist at the same time providing information to their competitors.
5) Be open with bidders around the calculation of the financial envelope so that they can become comfortable that the envelope does reconcile back to current expenditure levels even if the CCG requires additional efficiency savings.
6) Ensure that NHS providers have included the additional cost of VAT in their bid submissions if they are utilising a relevant model, such as Limited Liability Partnership.
7) Avoid a situation where the new contract is still not agreed or ready to commence but notice has been given to providers to terminate existing contracts and TUPE notices have been issued to staff. If a CCG reaches this situation and does not have a viable alternative option then the strength of its negotiating position on the new contract is weakened and there can be a risk to the continuity of services and relationship with staff.

8) Ensure that the contract value is absolutely clear before the contract commences and is not a provisional figure based on historical or estimated data which needs to be updated for the previous year's expenditure levels and other issues.
9) Ensure that there is a way of coping with the risk of inadvertently omitting key service delivery needs from the service specification. This may be achieved by not spending all of the agreed contract savings until the contract has bedded down later in the year.
10) Escalate disputes to NHS England at an early stage and keep them informed.

3.8 Following the recommendations as set out in the report, NHS England will be commissioning a further review to investigate specific areas, such as the role of external advisors, the effectiveness of the Gateway review process and the role of the CCG executive leadership and Governing Body through the procurement and contract period.

4. NEXT STEPS

4.1 The CCG has accepted the findings of both the internal Review and the NHS England Review. The CCG is also awaiting the NHS England Part 2 review and wishes to consider those as well. In the meantime the recommendations have been shared widely and have been discussed by the CCG Governing Body. Amendments will be made to the CCG Procurement Strategy to incorporate the learning and any additional learning will be made as necessary, subject to the outcome of the Part 2 review. The CCG has also ensured that learning has been incorporated into decisions made in relation to procurements of the Non Emergency Patient Transport Services and the Integrated Urgent Care (out of hours and 111) service.

4.2 Since December 2015 the CCG has been working with its partners on how to deliver the benefits of the model within the resources available. The CCG has been working with partners (including Local Authorities, Healthwatch, providers and other stakeholders) to review all the workstreams that UnitingCare had established, including those in development.

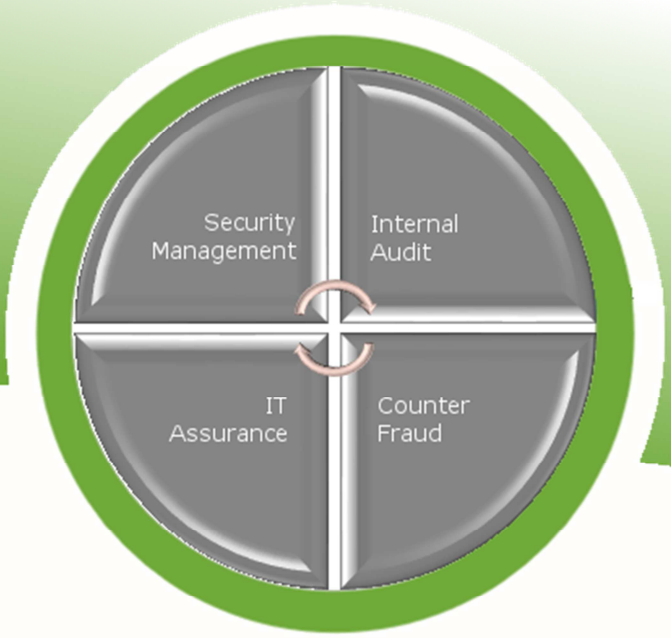
4.3 On 24 February 2016 the CCG held a workshop for organisations involved in delivering older people's and adult community services. The workshop showed strong support for the model that had been developed by UnitingCare, as well as providing feedback on what is working well and what could be improved. We are also attending a Healthwatch community learning event on 11 May.

4.4 The CCG is committed to the model of an integrated and outcomes-based approach as we believe this delivers benefits for patients and the health system. There are new pieces of work which need to be taken into account before making decisions about the range and scope of services to replace the UnitingCare contract. (For example, the new Sustainability and Transformation Programme, the Urgent & Emergency Care Vanguard and the Better Care Fund.) We are continuing discussions with partners to review the workstreams and further updates will be discussed at the Governing Body on 10 May and we will be able to verbally update the Committee on the outcome of that discussion. Our priority is to ensure that we have a good quality, sustainable model of care moving forward.

Appendix 1: Cambridgeshire and Peterborough Clinical Commissioning Group independent internal investigation

Appendix 2: NHS England independent review (part 1)

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group



Review of Procurement, Operation and Termination of the Older People & Adult Community Services Contract (OPACS)

Internal Audit Final Report: CPCCG15/23

Internal Audit Service

West Midlands Ambulance Service provides Internal Audit services to Cambridgeshire and Peterborough CCG. This report has been prepared following a request from the CCG for an independent internal investigation into the circumstances that led up to the termination of the OPACS contract in December 2015 with the aim of identifying learning points for any future procurement process. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose.

Consultation & Distribution

Exit Meeting Held	n/a
Draft Issued	5th February 2016
Final Report Pending CCG Response Issued	12th February 2016
CCG Response Received	19th February Clarifications CCG GB review 22 Feb & 8 March 2015, Audit Committee Review 2 March
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Executive Summary

Aim and Headline Context

As the Internal Audit provider to Cambridgeshire and Peterborough CCG we have been asked to undertake an independent internal review of the circumstances that ultimately led to the termination of the Older Peoples and Adult Community Services (OPACS) contract. Internal Audit is an independent, objective assurance and consulting function and as such is well placed to provide an objective assessment to the CCG of processes deployed in the procurement of the contract and subsequent contract management.

The objective of the review is to document and evaluate CCGs systems, processes and controls deployed in the procurement and management of the subsequent contract in order to identify any systemic weaknesses that may have contributed to termination of the contract and importantly identify learning points for future procurements. The review focussed on the processes and mechanisms deployed by the CCG and the review of evidence was restricted to that held by the CCG or available in the public domain and interviews with Senior Executives Lay Chair and Lay Members of the Governing Body. It did not encompass review of any further evidence held by any of the contract bidders or other parties such as NHS England or Monitor.

The OPACS procurement was a significant undertaking for the CCG incorporating:

- extensive consultation with stakeholders,
- the design of a new clinical outcomes framework,
- the undertaking of a competitive procurement exercise, to design a new service model to deliver the outcomes, and the subsequent letting of a contract to new Lead Provider of Services.

This procurement was designed to achieve better clinical outcomes, services designed to meet patient needs in a sustainable manner.

Much of the work undertaken was ground breaking and as such carried inherent risk but the termination of the contract soon after its inception is an indication that there were mismatched expectations of the financial investment required to deliver the service delivery model.

Summary of Issues and Lessons to be Learned

Fundamentally the main reason for the early termination of the contract was a mismatch in the expectations of the CCG and the Lead Provider over the cost/value of the contract. Although significant efforts were made during 2015 to bridge this gap these were ultimately unsuccessful. Internal Audit has assessed the financial evaluation process employed as part of the ISFS evaluation and found that the CCG did have in place controls designed to ensure bids were within the estimated annual contract values and the values over the expected five years of the contract however other aspects of the process have been identified as contributory factors to the eventual early termination of the contract.

In considering contributory factors there are a number of issues arising from our review which provide opportunities for learning and application to future procurements. These are:

- The timing of regulatory approval of bidders Business case and associated conditions prior to approval (Section 3.3.2)

- Rigorous application of controls within the procurement including re-assessment of all bidders where the nature of the bidders had changed during the process (Section 3.1.6);
- No re-assessment of the particular risks proposed by the change in legal entity of the successful bidder to a Limited Liability Partnership (LLP) and not being aware of the details of the ownership agreement between the partners; Cambridge and Peterborough NHS Foundation Trust (CPFT) and Cambridge University Hospital NHS Foundation Trust (CUH Section 3.1.5);
- The failure to obtain Parent Company Guarantees from CPFT and CUH prior to the signing of the contract despite the engagement of external procurement and legal advisers (Section 3.1.10)
- The design of the evaluation process leading to a lack of knowledge of the of the legal entity and nature of the bidder at the time of evaluation by some of the work streams (Section 3.1.9);
- The CCG was not able to triangulate the bid with income assumptions contained within the business plan submitted by the Foundation trusts to the regulator (Monitor) (Section 3.2.4);
- Need to identify flags of concern in particular lack of access to the bidders business case, the inconsistency of the first invoice with the contract sum (Section 3.2.3) ;
- Ensuring early flagging of the seriousness of concerns with NHS England (Section 3.3.7)
- Enhancements to the reporting to the Governing Body (Section 3.4.1)

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1. Objective & Scope

1.1. Internal Audit has been asked to undertake an independent internal review of the circumstances that ultimately led to the termination of the Older Peoples and Adult Community Services (OPACS) contract. The objective of the review was to document and evaluate the CCG's systems, processes and controls deployed in the procurement and management of the subsequent contract in order to identify any systemic weaknesses that may have contributed to termination of the contract and importantly identify learning points for future procurements. The review focussed on the processes and mechanisms deployed by the CCG and the review of evidence was restricted to that held by the CCG or available in the public domain. It did not encompass review of any further evidence held by any of the contract bidders or other parties such as NHS England or Monitor.

1.2. As part of the review a series of interviews was undertaken with representatives of the CCG Executive team and Chair as well as a selection of lay members of the CCG Governing Body. Internal Audit also contacted Healthwatch Cambridgeshire representatives to obtain their perspective of the process.

2. Significance

2.1. The OPACS procurement was a significant undertaking for the CCG incorporating:

- Extensive consultation with stakeholders;
- The design of a new clinical outcomes framework;
- The design of a new service model to deliver the outcomes, via a competitive procurement exercise;
- The involvement and use of external technical advisers (Strategic Projects Team, Financial advisers Deloitte LLP and Legal advisers Wragge, Lawrence Graham &Co); and
- The subsequent letting of a contract to a new Lead Provider of Services.

2.2. This procurement was designed to achieve better clinical outcomes, services designed to meet patient needs in a sustainable manner. Much of the work undertaken was ground breaking and as such carried inherent risk but the termination of the contract soon after its inception is an indication that there were mismatched expectations of the financial investment required to deliver the service delivery model.

2.3. A competitive dialogue procurement process ran from July 2013; OJEU advert and Pre-qualification Questionnaire (PQQ) submission through to contract award to Uniting Healthcare LLP in November 2014 and contract commencement 1 April 2015. The contract was terminated in December 2015.

3. Our Findings

3.1. Project Control Framework and Procurement Process

3.1.1. The Project Control Framework established by the CCG was commensurate with the complexity and extent of the procurement. Key features included:

- The use of a two stage competitive dialogue procurement process (external advisers were the Strategic Project Team (SPT);
- A Governance framework designed to provide information and assurances to enable the Governing Body to reach informed decisions;
- A Programme Management Board responsible for operational oversight of the project including the maintenance of risk registers and action logs
- Technical Groups and Local Project Groups responsible for the delivery of individual tasks and projects and reporting to the Programme Management Board
- Use of external procurement, legal and financial advisers throughout the procurement process and particularly in evaluating outline and final business solutions from bidders.
- Use of Dept. of Health and NHS England Gateway reviews at key stages of the Older people programme, procurement and development of the Outcomes framework.

3.1.2. At an early stage of our investigations it was clear that the principal reasons for the termination of the contract were financial rather that service quality related, for this reason this report concentrates on the procurement process, and subsequent contract management rather than the development of the outcomes framework and service model.

3.1.3. The financial principles underlying the procurement and contract aims were:

- aligning improved patient outcomes with financial incentives;
- delivering recurrent financial balance in a sustainable way;
- sharing financial risk across the commissioner – provider system; and
- creating the conditions for investment and delivering a return on investment.

3.1.4. To assist in the delivery of these aims the contract period was to be for a minimum of five years with an option to extend for a further 2 (much longer than a traditional NHS healthcare services contract, financial reward was to be linked to outcomes and the bidders were asked to tender within a

budget envelop established by the CCG (which took into account cost improvement expectations).

3.1.5. The competitive procurement process commenced on 3rd July 2013 with the publication of a Contract Notice on the Official Journal of the European Union (OJEU) and Supply2Health. The notice invited expressions of interest from parties wishing to submit a Pre-Qualification Questionnaire (PQQ) to deliver integrated care pathways for older people and a range of community services for adults. The PQQ sought responses from those parties who expressed an interest testing their capacity, capability, economic and financial standing and eligibility to take part in the procurement process. Twelve completed PQQs were received and evaluated.

The assessment of capacity, capability, economic and financial standing and eligibility was applied at PQQ stage; the ultimately successful bidder was a different legal entity to that which completed the PQQ and these checks were not applied to that entity.

3.1.6. The evaluation of the submitted PQQs included assessment against Financial, Legal, Clinical Service and Workforce criteria described in the PQQ, Bidders were ranked and the seven highest ranking Bidders for each Lot were selected to proceed to the next stage of the process, the Invitation to Submit Outline Solutions (ISOS) which ran until the deadline of 6th January 2014. These were subjected to further evaluation. As part of the ISOS submission suppliers were required to re-submit their PQQs where there had been a change. The eventual winner did not re-submit their PQQ despite the delivery vehicle now being described as a Limited Liability Partnership within their ISOS submission. It is understood that this is because the bidder considered that this did not represent a change as this had been previously reported to the CCG. The legal evaluation at this stage does however consider that the legal entity had changed from that which submitted the PQQ. The LLP was not registered/formed until 31 October 2014 after preferred bidder status had been announced.

It is unclear why the eventual winning bidder was not asked to re-submit their PQQ given the legal evaluation at ISOS stage, the implementation of such a step may have triggered a more formal risk assessment of the proposal and risks associated with contracting with a LLP.

3.1.7. After evaluation of the ISOS submissions four suppliers were asked to prepare and submit the final solutions (ISFS stage) with a closing date of 28th July 2014. One bidder withdrew. The three submitted bids were then subjected to further extensive evaluation. The evaluation process was

complex and designed to achieve an objective evaluation of each of the bids. Features included:

- The breaking down of the evaluation into specialist work streams including Corporate Governance, Workforce, Estates, Finance etc;
- The use of moderators to ensure consistency of evaluation; and
- The Use of external specialist support for key technical areas including procurement, financial and legal evaluation.

3.1.8. The evaluation process was designed to ensure objectivity and fairness to all bidders. Many managers interviewed as part of our investigation expressed the opinion that one of the key drivers in the design of the procurement process generally and the evaluation process in particular was to ensure even handedness and because of the high profile nature of the procurement to avoid the possibility of challenge and potential judicial review. Indeed the final Dept. of Health "Gateway" review and report (November 2014) issued post identification of preferred bidder, commented that the "*procurement process, so far, has clearly been undertaken professionally. It is a mark of success for such a high profile, high value procurement that it has reached this stage, maintaining competitive tension, whilst also receiving no challenges to the process"*.

3.1.9. The outcomes of the work stream evaluations were consolidated in a work stream evaluation report, prepared by the Strategic Projects Team, detailing outcomes of evaluation against each of the three ISFS bidders with indications of their respective strengths and weaknesses. From discussions with CCG Executive members involved in various evaluation work streams it is understood that not all were aware of the nature of the proposed LLP delivery vehicle. This is reflected in our review of the work stream evaluation reports which included: for example, the workforce evaluation report which comments "*was thoughtful and reflected well on the potential challenges facing the new provider. ….identity and culture was already visible for the evaluator, together with a clear picture of what they are going to provide to support the incoming workforce."*

The Corporate governance evaluation includes *"There was very strong narrative around risk management processes, and clear structure in place. This was demonstrated by assurance and, transparency and ownership at Board level, and at every level of the organisation".*

Both of these observations read as if Uniting Care to be the employer of the incoming workforce and had many levels within the organisation whereas in reality Uniting Care employed directly 20 to 30 staff (none of which were engaged in direct healthcare provision).

The different legal entity was not noted by the Strategic Projects Team in the main narrative of their contract evaluation report see paragraph 3.1.10.

Internal Audit therefore concludes there is a need to ensure clarity over the structure and nature of the bidders to better inform the evaluation and any change in the legal entity of the bidder needs to be fully reflected in the evaluation.

3.1.10 The legal evaluation was undertaken by the CCG's legal advisers and their report on the successful bidder identified the different legal entity of the bidder (compared to PQQ submission) and also identified the need for "performance guarantees to be in place from member organisations. The report goes on to record that this was raised with the bidder and accepted by them. Finally the legal evaluation records…" that this would need to be a condition attached to any decision to award them preferred bidder status ….." The legal evaluation report was included in the Strategic Projects Team "Invitation to Submit Final Solutions Evaluation report as Annex E submitted to the Governing Body in September 2014. The recommendations to proceed to appoint the preferred and reserve bidders contained in that report are not caveated with the need to obtain performance guarantees. The preferred bidder letters (drafted by the Strategic Projects Team) did not include any reference to the need for a Parent Company or Performance Guarantees nor was there any mention included in the "Preferred bidder contract issues log". It is of note that the Strategic Projects Team was appointed as procurement advisers for the ISOS and ISFS stages of the procurement following a competitive tendering exercise. The specification relating to that contract clearly states (page 22) that one of the responsibilities of the procurement adviser is to "Draft the 'provisional' recommended and reserve bidder letters that protects the C&PCCG's interests and commits the bidder to the commercial agreement." It may be argued that the absence of any reference to the need for Parent/Performance Company Guarantees did not fully protect the interests of C&PCCG.

The CCG assumed that because of the legal adviser's evaluation and agreement with the bidders, as well as the fact that the drafting of the contract was their responsibility that they would undertake the drafting of the Parent/Performance Company Guarantee.

Internal Audit understands that the CCG has sought independent legal advice to determine the circumstances surrounding the failure to draft and agree a "Parent Company Guarantee".

The failure to capture the need for performance guarantees from the partners of the preferred bidder is a weakness in the process and whilst it may not have prevented the termination of the contract it did increase the CCG risk profile in the event of contract failure.

The evaluation process failed to ensure that any issues requiring attention were resolved prior to awarding of preferred bidder status and this was exacerbated by the format of the evaluation report.

The preferred bidder letter did not require Parent/Performance Company Guarantees to be in place.

3.2. Contract Values and Payments

3.2.1. The fundamental reason for the termination of the contract in December 2015 was an inability to reconcile the CCG and Provider position in relation to contract value despite attempts to bridge the gap between the two positions. The value of the signed contract was clear £725 million over the five year period (£152 million in year one 2015/16) The CCG did acknowledge within the procurement process that the contract value would require adjustment for 2014/15 outturn (up or down) this was communicated to the preferred bidder in January 2015. From subsequent correspondence it is clear that the Provider believed there was opportunity to negotiate on other aspects of the contract value, post award.

3.2.2. At the outset of the process the CCG approach to the financial value of the contract was to seek solutions within a cost envelop that had been derived from examination of current cost of delivery but also included expectations of cost improvements to be achieved over the contract term. Bids were received from a variety of organisational types including consortia of NHS Organisations partnered with private sector organisations to straight private sector bids and from the eventual winner initially a consortia of two NHS Foundation Trusts but ultimately a Limited Liability Partnership owned (members) by the two Foundation Trusts.

3.2.3. As part of the Foundation Trust regulatory framework organisations need to seek approval of the regulator via the submission of a business case for any “significant transactions”. This applied to one of the partners of the Uniting Care Partners LLP. There was no requirement within the evaluation process for bidders to confirm whether there are any regulatory requirements to be satisfied prior to the signing of contracts. This would have highlighted to the CCG any preconditions required to be satisfied by any bidding organisation. Internal Audit understands that the CCG requested sight of the CPFT business case at a later stage but that this was declined. Whilst commercial sensitivities are understandable, at the very least the business case income assumptions should have been triangulated with the bid price. No further attempts were made to triangulate the bid value with the levels of income expected in the business plan

despite there being contact between the CCG and Regulator late in 2014/15. There was a further flag indicating a mismatch in financial assumptions on the receipt of the first quarterly invoice (April 2015) which was in excess of the CCGs expectations.

3.2.4. The final Dept. Health Gateway report (November 2014) included discussion of feedback from stakeholders concerning the risks associated with the delivery of the service. It states *"Several stakeholders expressed concern about the overall financial viability of the programme within the financial envelope. The Review Team understands that this will be addressed by a business case that is currently being prepared. Although the procurement has not required a formal business case, the two partners (CUHFT and CPFT) who form the UCP are required by Monitor to submit a Full Business Case and Long Term Financial Plans."*

No recommendations were made in this report around the need to ensure the business case was fully in line with the accepted bid.

The evaluation process would be enhanced if at PQQ stage bidding organisations were asked to confirm any regulatory pre-requisites and the timescale for satisfying them.

In order to enhance assurance, use of triangulation opportunities to ensure the bidder income expectations are in line with the accepted bid should be made.

3.2.5. The financial evaluation formed 25% of the overall evaluation of the ISFS bids. It fell into three parts: the first to pass the "Financial Hurdle", the second was qualitative based on answers provided to 7 questions; the third was quantitative and based on the bid value in comparison to the CCG expected contract value. The two assessments were then combined to arrive at an overall assessment. Internal Audit notes that there was no minimum value threshold applied to the quantitative assessment but also that there was no competitive advantage of submitting a price more than 3.5% below the CCG estimated contract value. It is of note that the successful bidder scored the maximum number of points for the quantitative element of the financial evaluation but lowest in comparison to the other bids in the qualitative assessment of the financial evaluation. The combined effect was to place them highest in the overall financial assessment.

The financial hurdle consisted of three elements these were that the bids must:

- Have an expected annual contract value (EACV) which in each year is not greater than the CCG's budget plus transformational funding (as defined in the ISFS);

- Have a Net Present Value (NPV) over the 5 year contractual period which is not greater than the NPV of the CCG's budget plus the transformational funding; and

- Not assume any additional funding from the CCG over and above the budget plus the transformational funding.

All three bidders were assessed as having passed the financial hurdle.

3.2.6. In an effort to ensure the financial evaluation was able to compare bids on a like for like basis clarification questions were raised with bidders where bids appeared to caveating the bid value e.g." *Please confirm that they would deliver their solutions within the submitted EACV (and the transformational funding of £5m in the first two years) without assuming the receipt of any additional funding (whether from the CCG, for example but not limited to exceptional funding, EDS, LES/DES, readmissions or MRET or otherwise e.g. the Better Care Fund."* The successful bidder responded "Yes" to this clarification question.

3.2.7. The contract payment schedule recognized the need to provide the successful bidder with some degree of working capital support including the payment of the first two quarters payments of 2015/16 quarterly in advance plus the payment of £5 million transformation monies for each of the first two years of the contract. The original contract start date of 1 January 2015 was put back to 1 April 2015 (agreed in response to public consultation, July 2014). The CCG made payments in 2014/15 (in advance of the commencement date) of some £4.3 million in recognition of the bidder's need to mobilize. The OPACS Contract provided for repayment of the £4.3m Support Monies by reducing the Annual Contract Value by the £4.3m under a repayment profile and timescale to be agreed between the Parties. The value of the bid excluding any additional sums (£5m transformation funds et al.) was £726 million over the five year period with the contract value for 2015/16 some £152 million. This contract was signed in November 2014. There was recognition by both sides that the contract sum would need to be amended to take account of the activity outturn for 2014/15 once the value of this rebasing could be quantified (June 2015).

3.2.8. The final Dept. of Health Gateway report (received post preferred bidder letters November 2014) commented on the professionalism of the procurement process undertaken and was particularly complimentary concerning the process delivery in terms of maintaining competitive tension and avoiding any challenge to the process.

There is good evidence that the procurement process and in particular the financial evaluation at ISFS stage was designed and implemented In terms of ensuring financial bids were evaluated consistently and designed to ensure service delivery would be accomplished within the CCG budget.

3.3. Post Contract Negotiations

3.3.1 The mismatch between CCG and Uniting Care over contract value and the expected contract income are at the heart of the reason for the contract termination. Although the signed contract value is not in dispute (£726 million over the 5 year contract term), there is evidence of disagreement over the extent to which the contract value might be varied post award, this despite the clarifications given and the financial hurdle test contained in the ISFS evaluation process. In an effort to determine how this mismatch arose and to identify the efforts made to resolve the differences Internal Audit has reviewed:

- The bid documentation and associated bid clarification questions and answers made at the time of the ISFS submissions ;
- Correspondence between the CCG and UCP during the period between the signing of the contract in November 2014 and the eventual commencement on 1 April 2015 including agreement to a local variation of the contract
- Correspondence between the two parties in the period from the commencement of the contract and the termination in December 2015
- Evidence of the operation of the escalation and mediation process involving both NHS England and Monitor.

3.3.2 As has been discussed in section 3.2.3 one of the owners/members of Uniting Care LLP was required to obtain Monitor approval of its business case submission and consideration of this took place post signing of the contract but prior to commencement (November 2014 to end of March 2015). Whilst the CCG did not have access to the detail of the Business Case it was in discussion with Monitor on certain aspects including specific questions on contract wording. Internal audit understands that, as represented by UCP, a condition of approving the business case agreement of a local variation between the contract parties was required. In terms of impact on the subsequent negotiations around contract value Internal Audit highlights the following attributes of this local variation:

- Recognition of the need for re-basing of the contract value as a result of outturn in 2014/15 and other funding changes

- Acknowledgement that in respect of any items that UCP have not been able to accurately quantify due to shortfalls in information from the UCP due diligence process, and which may arise for a period of up to 6 months post service commencement, the parties may agree a contract variation.

This local variation was agreed by the CCG. Internal Audit has reviewed correspondence between Senior Executives and Lay Chair of the CCG that preceded agreement and it is clear that the risks associated with agreement were well rehearsed at that time. The decision to accept (although never formally ratified) was considered on balance to be the best course of action. This urgent decision was communicated to the Governing Body at development session in April 2015. The CCG Lay Chair believes it is important to note that the wording of the variation set out the process by which the contract "**may"** have been amended (rather than "**shall"** have been amended). It did not commit the CCG to agreement.

The acceptance of the local variation wording did satisfy the Monitor condition and incorporated the CCG acknowledgement that the contract would require amendment as a result of rebasing but also opened the possibility of further negotiations around contract value if raised within 6 months of the contract commencement. Although Internal Audit acknowledges that this variation was never formally ratified and that the variation committed the CCG to agreement of variation is disputed.

It should also be noted that the timing of the request for this change put additional pressure on the CCG to accept to ensure the ultimate success of the contract.

3.3.3 In May 2015 (one month after contract commencement) Uniting Care Partnership (UCP) presented to the CCG as part of general contract discussion, a request for additional funding totaling £34.3 million as summarised below:

Acuity	£6 million
Delays resulting in lost savings (Acute and CPFT)	£9.4 million
VAT	£4.9 million
2014/15 Outturn adjustments MRET	£6.6 million
Other activity adjustments	£5.3 million
Technical adjustments	£2.1 million

This triggered a series of meetings between the two parties where the CCG disputed the relevance of some of the claimed monies (Acuity, VAT and

lost savings primarily) and on the 5th August the CCG wrote formally to Uniting Care offering an uplift in the contract value (£9.3 million) to reflect the 2014/15 outturn but linked explicitly to the original bid price. Other non-recurrent sums were also offered (£3.4 million e.g. System Resilience Funds for specified projects) and in addition the CCG offered additional cash support including; delay in repayment of the 2014/15 previously advanced (£4.3 million), payment in 2015/16 of the 2016/17 transformation monies (£5 million).

3.3.4 This offer was rejected by Uniting Care on 21 August based on their position that UCP faced a £34.5 million financial challenge in 2015/16. Of which it was acknowledged that £10.9 million might not be incurred or was subject to other mitigation**.** Of the remaining £23.6m: £8.4m was non-recurrent after 2015/16 (as it related to delays in savings); leaving £15.2m as recurrent with up to £9.9m of this relating to information shortfalls and to be resolved in a system wide financially neutral way.

3.3.5 UCP issued a proposed contract variation to the CCG dated 20th August which re-iterated the UCPs position re. Acuity, VAT, delays resulting in loss of savings, their calculations relating to the 2014/15 outturn and additionally £9.9 million in connection with information shortfalls in the UCP due diligence process. This variation was rejected by the CCG on the basis that it was not necessary as the contract provided for resolution of such matters already.

3.3.6 Further meetings of CCG and UCP Senior Management were held in order to resolve the issues, and agreement reached on an open book exercise which took place in September 2015. The starting position for this used the offer from the CCG of 5th August and compared this to the amounts requested in the draft contract variation (20th August); this showed a gap of £23.4 million. Meetings by this point included Chairs of the CCG CPFT and UCP (the Chair of UCP is also Deputy Chair of CUH) - which became a local oversight Group for a recovery plan process. The recovery plan resulted in reduction of the gap to c10m for 2015/16, but it should be noted that there were financial risks associated with delivery of recovery measures for all parties.

3.3.7 As part of the on-going dialogue with NHS England the CCG included within its assessment of achievability of financial surplus for 2015/16 an analysis of risks. Internal Audit notes that in the assurance report relating to Q4 2014/15, presented in June 2015, that the size of the risk identified as a result of “final settlement with UCP” as £3 million. There is no mention of the larger sum claimed by UCP as the size of their financial challenge in 2015/16.

The CCG flagged the risks associated with the situation to NHS England with a formal briefing provided on the 14th October 2015. The Local Oversight Group agreed on 17th November 2015 that most of the Recovery Plan had been completed and that the residual gap needed to be escalated

to NHS England and Monitor. A meeting of all parties took place with NHS England Regional Director and Monitor Director on 23rd November. No additional bridging funding mechanisms were identified and the parties were advised to prepare for withdrawal from the contractual arrangements ensuring as little disruption to the health system as possible. The contract was terminated on 3rd December 2015.

From the information reviewed Internal Audit recommends that earlier formal notification and briefing of the issues to NHS England should have been made. Whilst this may not have altered the eventual outcome it would have signalled the seriousness of the situation and acknowledge the wider reputational damage that would have resulted from the failure of the contract.

3.4 Reporting and Escalation to the Governing Body

3.4.1 In order to determine the adequacy of reporting and escalation processes Internal Audit undertook a review of both Public and Private Governing body papers, agendas and minutes. Our examination confirms extensive reporting and discussion at Governing Body and Clinical Management Executive Team (CMET). There is good evidence of the raising of concerns regarding financial risk associated with the contract throughout 2015 and there is also evidence of requests for decisions regarding continued financial support and assistance with cash flow September and October 2015. There are some aspects of the procurement and contract management that we would have expected to be evidenced in Governing Body papers including:

- The change in role of the contractor from a Lead Provider to an integrator role and the CCG being in a position of co-commissioning (although this was flagged in a report to CMET 29 October 2014);
- Discussion of risks associated with the establishment of the LLP as the delivery vehicle from the preferred bidder; and
- Anything summarizing the issues or actions stemming from the contract evaluation report prepared by the SPT (particularly the need for performance guarantees which were within an annex of that report.);
- Specific reporting and agreement of the levels of cash support particularly the payment of sums to the contractor in 2014/15.

Whilst the Governing body papers clearly show engagement with the process there are gaps in the detail of reporting which may have impacted the Governing body's full understanding of the issues and risks as noted above.

4. Acknowledgements

Internal Audit would like to acknowledge the support given by Senior Officers and Lay Members of the CCG throughout the conduct of this review.

5. CCG Governing Body Response

The CCG welcomes the internal investigation undertaken by WMAS internal audit services and would like to thank the auditors for their thorough, balanced and considered approach, informed by and based upon the CCG's information and documentation and other evidence that is publicly available.

The CCG Governing Body has reviewed the report and carefully considered the lessons and recommendations set out in the report, which it accepts. There are clearly lessons to be learned and in light of this the CCG will in particular be reviewing how it conducts complex, high value procurements in the future, and our related procurement policy. The CCG will reflect on this report and the NHS England review that is due to be published shortly.

The ground-breaking, challenging and innovative nature of the integrated Older People's and Adult Community Services ('OPACS') procurement meant that the CCG relied heavily on external specialist advice, including legal and procurement advice. The CCG notes that the report suggests that further investigation may be required as to the advice and support that the CCG received from its external advisers in order to better understand the extent to which this may have contributed to the early termination of the OPACS Contract, lessons to be learned from this and consequently how best to mitigate the risks of such issues arising in the future. This applies particularly to how the fundamental change to the legal entity in the form of the UnitingCare Partnership, a Limited Liability Partnership, during the procurement, and to the Parent Company Guarantees that should have been in place as a condition precedent to the signing of contracts in consequence of that fundamental change.

The CCG is pleased to note that there is good evidence the procurement process and financial evaluation was designed to ensure that bids were evaluated to ensure service delivery within the CCG's budget. While the signed contract value was not disputed, the continued negotiations running in parallel with the mobilisation of new services and staff transfer clearly resulted in greater

risk than would have occurred had the negotiations been concluded prior to commencement.

In addition, as the Audit Report observes, the fact that the CCG did not see the CPFT (UC) business case approved by Monitor meant that the CCG did not know that there was a fundamental mismatch between the financial assumptions that were in excess of the CCG's expectations and the UnitingCare bid. The CCG's evaluation process did not highlight the need for the regulatory requirements to be shared. That is an important learning point for the CCG and for the wider NHS conducting similar procurements. The delay in regulatory approval for the business case until the end of March 2015 also put additional pressures on the mobilisation of services and the contract variation negotiations.

The CCG hopes that this report alongside the NHS England review, due to be published shortly, will help other commissioners undertaking large scale and complex procurements.

The CCG remains committed to delivering an integrated, outcomes based service for older people and adults being cared for in the community. We welcome the support we have had from stakeholders to this model and we continue to work with partners, stakeholders and staff to ensure we are able to deliver a good quality service to our patients within the resources available to us.

NHS ENGLAND REVIEW OF UNITING CARE CONTRACT

The key facts and root causes behind the termination of the Uniting Care Partnership contract

NHS England Publications Gateway Ref 05072

A review by
David Stout OBE CPFA

April 2016

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Introduction and acknowledgements

This review was commissioned by NHS England in January 2016. The overall objective of this work is to establish, from a commissioner perspective, the key facts and root causes behind the collapse of the Cambridgeshire and Peterborough CCG contract with Uniting Care Partnership in December 2015 and to advise on next steps. It is particularly important to identify the lessons for any future contracts of this sort.

The work has involved a review of the events leading up to the collapse of the contract in order to draw out the lessons to be learned for other novel contracting forms in the context of the implementation of the New Models of Care strategy and more broadly.

The review has not examined the appropriateness of the governance arrangements, bid costing and tendering responses from a provider perspective, which are matters for the individual Foundation Trusts and Monitor.

The scope of the work has included a review of relevant documentation and discussion with key staff members to identify the root causes and contributory factors that led to the termination of the contract. The review has identified specific and wider lessons to be learned and makes recommendations for further action.

The full terms of reference can be found in Appendix A

The review was completed in February 2016 following a review of documentation and discussions with key individuals from the following organisations:-

- Cambridgeshire and Peterborough Clinical Commissioning Group
- Uniting Care
- Cambridge University Hospitals NHS Foundation Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- Virgin Care
- Care UK
- NHS Partners Network
- Cambridgeshire Community Services NHS Trust
- The Strategic Projects Team-a business unit of Arden and GEM Commissioning Support Unit
- NHS England-Midlands and East
- Healthwatch Cambridgeshire

In addition, I received comments and had discussions with a number of people who had an interest in this contract and wished to make a contribution.

I would like to thank all of the people I met and those who contacted me and provided information to assist this review. Without exception, everyone was helpful, open and keen to learn the lessons from this failed contract.

Executive Summary

Cambridgeshire and Peterborough Clinical Commissioning Group entered into a contract with Uniting Care, which was a limited liability partnership, in November 2014. The contract was a 5 year contract with an option to extend for a further 2 years. The contract was for the provision of all community care for over 18 year olds, acute emergency care for the over 65s together with older peoples mental health services. The contract value over the 5 year period was £725m.

This was a major novel contract for the NHS in so far as it required integrated services for the elderly and a significant proportion of the payment would be based on outcomes.

Contract procurement commenced in July 2013 and negotiations continued up to the day before the contract commenced on 1 April 2015 and then continued until the contract was terminated by Uniting Care, with regard to financial issues, in December 2015.

All parties to the final negotiations agree that the approach to contract in an integrated way for the over 65s was the right approach.

All parties to the final negotiations, the Clinical Commissioning Group, Uniting Care, Virgin Care and Care UK, agree that the approach to contract in an integrated way for the over 65s was the right approach. There was a great deal of enthusiasm within the CCG and Uniting Care and this enthusiasm was shared by many clinicians within the service.

The contract should not have commenced on 1 April 2015

The contract collapsed for financial reasons. It is clear, from reviewing the documentation and talking to the organisations involved, that this was the result of a number of factors and these are set out in the 'Findings' section of this report. In summary;

- There were too many information gaps around community services,
- The financial envelope of the CCG for these services could not be reconciled to current expenditure levels,
- There was an additional VAT cost,
- The mobilisation period was not sufficient to make the planned financial savings that were required in the first year,
- The contract value was not absolutely agreed at the date the contract commenced.
- The contract should not have commenced on 1 April 2015. It should have been delayed until these issues were resolved.

I have set out my recommendations and I have also identified a number of specific areas that require urgent follow up investigation.

Background

The contract was a major novel contract covering an initial period of 5 years

This contract was a major novel contract covering a period of 5 years with an option to extend by a further 2 years. The contract negotiations spanned a period from July 2013 up to the day before the contract commenced on 1st April 2015 and then continued during 2015 until Uniting Care terminated the contract in December 2015.

The contract was for all community care for over 18 year olds, acute emergency care for over 65s along with Older Peoples Mental Health services. The contract value was £725m over 5 years.

The Clinical Commissioning Group used the competitive dialogue process. It was an explicit requirement of the procurement that the preferred bidder established a prime vendor that was capable of holding the contract with the Clinical Commissioning Group. The Clinical commissioning Group went through the Department of Health Gateway Process and was assisted by The Strategic Projects Team [an internal business unit of Arden and GEM Commissioning Support Unit], Wragge & Co [solicitors] and Deloitte [who acted as financial advisers.]

A brief timeline of the procurement and contract termination was as follows;

- 60 expressions of interest were received and 10 consortia were successful at PQQ stage of the procurement process in September 2013.
- There was a 2 stage competitive dialogue process with multiple parallel dialogue processes.
- Outline solutions were submitted in January 2014.
- Three bidders were shortlisted -Uniting Care Partnership, Virgin Care and Care UK.
- Full and final submissions were submitted at the end of July 2014.
- The 'Go live' date was delayed twice during the process. Firstly, from 1 July 2014 to 1 January 2015 and then to 1 April 2015
- Uniting Care was appointed the preferred bidder on 1 October 2014 and the contract was signed on 11 November 2014 with a commencement date of 1 April 2015.
- The contract was terminated by Uniting Care due to financial issues on 3 December 2015.

60 expressions of interest were received and 10 consortia were successful at PQQ stage

Findings & Conclusions

Integration of Services

All of the parties to the final negotiations [the CCG, Uniting Care, Virgin Care and Care UK] agree that the approach to contract in an integrated way for the over 65s is the right approach. However, despite these intentions, the contract collapsed. The health economy will now need to find another way of continuing with the integration of older people services.

There should have been a reassessment of the bidder . . . but there was not

The work in preparing for this contract has delivered a number of benefits for the future including an Outcomes Framework, a service re-design process and service solutions. The CCG is committed to continuing the outcomes based approach and service model where it is cost effective to do so.

The Procurement Process

The procurement process was handled by the CCG with support from the Strategic Projects Team. This was a major procurement and a considerable logistical task.

In the early stage of the procurement process it was not apparent to the CCG that Uniting Care would be a Limited Liability Partnership[LLP]. It only became apparent later in the process. At the point that this became apparent there should have been a re-assessment of the bidder for capacity, capability, economic and financial standing but this was not carried out. However, It was identified at that stage that parent guarantees would be required from the two Foundation Trusts who constituted the LLP.

There was extensive reporting and discussion at the CCG Governing Body and Executive Management Team throughout the procurement process. However, there were some gaps in the detail of the reporting which may have impacted

upon the Governing Body's full understanding of the issues and risks. For example, there is no evidence of a discussion at the Governing Body around the risks associated with an LLP as a delivery vehicle. Also, there is no evidence of a discussion around a summary of the issues and actions stemming from the contract evaluation report.

Under the current arrangements, there is no requirement for NHS England to implement an 'assurance process' with CCGs on the detailed procurement arrangements.

Despite the flaws which subsequently became apparent, the final Department of Health Gateway Review on this procurement commented that ''the procurement process, so far, has clearly been undertaken professionally. It is a mark of success for such a high profile, high value procurement that it has reached this stage, maintaining competitive tension, whilst also receiving no challenges to the process" As a follow up to this review, NHS England should investigate specifically the current Gateway review process for detailed lessons learned.

There was not a satisfactory outcome with regard to risk

The Transfer of Risk

The view of all three final bidders was that there was not a satisfactory outcome with regard to the major issue of 'risk'.

The CCG's pay mechanism provided for adjustment up or down for population growth, it built in an uplift for acuity growth, it allowed the provider to spread risk over 5 years and it provided £10m additional transformation funds to manage double running in the first two years. It also provided access if non recurrent funds became available [e.g. system resilience funds]. All other risks would be passed to the provider and the provider would determine how services would be delivered in the 5 year period in order to deliver the required outcomes within the agreed financial envelope. The CCG resisted proposals for a 'risk share' / 'gain share' arrangement.

The contract was big, novel, with many information gaps and it was difficult for organisations to accept the proposed level of risk. All three final bidders seriously considered at some point walking away from the negotiations. Uniting Care did sign a contract in November 2014 but was only prepared to commence the contract in April 2015 after last minute changes were made to the contract in March 2015.

Parent guarantees should have been put in place

These contract changes provided a process to update the contract value for a] 2014/15 expenditure levels, b] additional funding for community costs if, following a 6 month due diligence process, it was established that these had been understated due to information gaps and c] any other issue that arose during the period of the contract which threatened the financial stability of either party. If agreement could not be reached on these items then either party could terminate the contract.

Parent Guarantees

Despite having identified the need for parent guarantees, the signed contract between the CCG and Uniting Care did not ensure that these were put in place. As a consequence, when the contract folded, the LLP was significantly at risk of becoming insolvent. In order to manage this situation and with the advice of NHS England and Monitor the debt and other termination costs were split between the CCG and the two Foundation Trusts.

Parent guarantees should have been put in place by the Foundation Trusts and the CCG should have required them.

It is assumed that Foundation Trusts have the legal power to enter into parent guarantees. If they do not have such power then the appropriateness of the Limited Liability Partnership model will need to be considered.

Value Added Tax

VAT was an issue

VAT was an issue for Uniting Care during the process. The rules around VAT allow organisations within the NHS VAT group to reclaim some of their VAT from HMRC. As Uniting Care was outside the NHS VAT group, sums that would have been recoverable in the past were no longer recoverable under this structure. This had the impact of increasing costs to the two Foundation Trusts which they passed on to Uniting Care. This was not included in the Uniting Care bid, and the CCG and Uniting Care agreed to explore with HMRC and financial advisers ways of avoiding this cost. However, this issue was never resolved up to the point of termination. The sum involved amounted to £5m per annum. Conversely, the two private sector providers were well aware of the VAT issue and factored this cost into their bid. In any future contract the current VAT rules should be applied consistently and factored into the bid.

The Financial Envelope

The CCG financial envelope was extremely difficult to calculate with a level of precision

The financial envelope for this contract was extremely difficult for the CCG to calculate with a level of precision. This contract covers acute services to the over 65s, adult community services and older peoples mental health. The CCG used 2013/14 SUS data to calculate the acute activity element plus contract sums for smaller sub contracts. The most challenging area was community services costs. The CCG worked with Cambridgeshire Community Services to establish the 2013/14 costs and then updated them. The CCG also retained financial advisers to carry out a Due Diligence report on community services costs. However, despite these two approaches the CCG could not be confident that this element of cost was correctly captured in its financial envelope. As a consequence the CCG was not able to demonstrate to the bidders that the envelope was reconcilable to current expenditure levels. In fact, Cambridgeshire Community Services, the provider of community services at that time maintains that they were spending in excess of the sum included in the contract with the CCG for adult services and was 'cross subsidising' from other CCG commissioned funds and service lines.

The bidders expressed the view that the Due Diligence report on community services costs did not provide the information/assurance they required. This issue ought to be investigated further as part of the next steps following this review.

There was, therefore, ongoing debate around the level and robustness of information on existing community services. There was a view from providers that the CCG could have done more around this issue. However, Cambridgeshire Community Services was a bidder itself as part of a number of consortia. The Trust was therefore potentially conflicted in being asked to provide information to its competitors. As a consequence, Uniting Care and other bidders had to make their own assumptions for inclusion in their bids. After the service had transferred on 1 April 2015, Uniting Care was of the opinion that the transferred cost was materially in excess of its assumptions[circa £9m] which had been based on the information available to it. This was a major element in the 'financial gap' between Uniting Care and the CCG and the eventual collapse of the contract.

There was on-going debate around the level and robustness of information on existing community services.

Uniting Care has said, that at the point of being awarded preferred bidder status, it had 71 outstanding clarification questions and 34 of these were still outstanding at contract signature on 11 November 2014. The CCG disputes this and says that these numbers include many duplicates, errors and closed queries.

The lesson to be learned is to obtain this information, in a robust and accurate way, early in the process before existing providers become conflicted.

Contract Commencement on 1 April 2015

Towards the end of March 2015 Monitor had not signed off the Cambridgeshire and Peterborough Foundation Trust business case for the major transaction. There was no requirement for Monitor to agree a business case for Cambridge University Hospitals Foundation Trust as this was not deemed to be a major transaction due to the size of that Trust.

To give financial certainty on the agreed contract price the contract should have been delayed

At that point the Chairs of the CCG, Cambridge University Hospitals FT and Cambridgeshire and Peterborough FT contacted Monitor to explain the likely effect on patient safety if staff did not transfer on 1 April as well as the cost to the health economy if existing contracts had to be rolled forward. Monitor gave an interim assessment on 31 March 2015 and services transferred the following day.

On 1 April 2015 when the contract commenced there should have been a finally agreed value of the contract for the first year. The contract clearly had the bid price included within it. However, this price needed to be updated to reflect actual expenditure levels on older people in the previous year, 2014/15, together with any adjustment in respect of transferred community costs if this was justified following the 6 month due diligence process.

The value of the 2014/15 expenditure adjustment, when it was calculated several months later, was £9m which is a material figure. The problem with commencing this contract on 1 April 2015 was that it was not possible to calculate this sum before the contract commenced.

The CCG did have the option of delaying the commencement date from 1 April 2015 to a later date, but it argued this could have had a destabilising impact upon staff who were scheduled to transfer under TUPE on 1 April 2015 and would have required a short term contract to be put in place with Cambridgeshire Community Services who were the current provider.

On balance, the CCG decided to commence the new contract with Uniting Care on 1 April 2015.

However, to give financial certainty on the agreed contract price the contract should have been delayed to a later date.

The Mobilisation Period- November 2014 To March 2015

The mobilisation period was originally set at 3 months but this was increased to 6 months following the public consultation on the contract. As, subsequently, a great deal of this period was taken up with preparing and discussing a business case for Monitor as well as preparing for a CQC inspection, this left little time to mobilise and commence transformation. Financially, this was a major problem for Uniting Care as they had planned to make savings in the first year and these planned savings were subsequently delayed resulting in a financial cost pressure of £9m. It is now apparent that the mobilisation period was far too short for such a complicated contract and contract commencement should have been delayed.

The mobilisation period was too short

The Dispute and Contract Termination

In May 2015, Uniting Care informed the CCG that, in line with the agreed contract variation clause, it required an additional £34m in 2015/16 to continue providing the service. Discussions took place and the CCG eventually offered, in August 2015, £9m of recurrent additional funding to reflect 2014/15 outturn together with some non recurrent funding. Uniting Care then submitted a formal contract variation for the £34m and this was escalated locally. However, a local resolution could not be agreed.

The matter was considered by NHS England in discussion with Monitor but there was no obvious national solution to the local dispute. Subsequently, Uniting care terminated the contract using the termination clause inserted into the contract in March 2015.

The CCG accepts that, with the benefit of hindsight, it should have done more to brief NHS England earlier in the dispute and request intervention.

Additional Cost to the CCG of Entering into this Contract

The additional cost to the CCG of procuring and entering into this contract, compared to a 'do nothing' position, was £6m. In addition, the two Foundation Trusts will have incurred costs. However, there were some benefits arising from the contract which include the production of an 'outcomes Framework' and 'service redesign models' which will be helpful to the CCG in the future.

External Advisers

The Strategic Projects Team and the legal and financial advisers were retained to assist the CCG in carrying out the procurement. Their function was to assist the CCG in ensuring success with the process and the logistics of a large procurement that needed to comply with European Law.

This report identifies a number of flaws in the process, which led to the contract being terminated seven months into the five year term. It is clear that there were a number of serious financial issues with this contract, primarily relating to VAT and information gaps around transferred community services. In addition, there clearly was not sufficient time during mobilisation for Uniting Care to put in place the transformation they needed in order to deliver their required savings for 2015/16. Also, there were no parent guarantees put in place.

There should be a thorough review . . . of each of the advisors

As part of the next steps following this review, there should be a thorough review of the role, function and effectiveness of each of the advisors in order to determine any specific issues with their contributions and to identify lessons to be learned for future projects of this sort.

Financial Flexibility of the CCG and Uniting Care

Some participants to the review have said that the 'financial gap' which they understood to be in the range of £6m to £9m per annum was a small price to pay for the major service benefits that could accrue in the future from the revised service models. In looking at the figures I do not believe that the gap was as low as £6m to £9m. In getting down to a gap of that size the CCG and Uniting Care agreed to work together in trying to avoid the additional VAT cost. However, whilst agreeing to look at this area there was no guarantee that this would avoid further costs. I believe the financial gap, including the VAT issue, was £14m and the reality is that neither the CCG nor Uniting Care had the financial flexibility to cope with deficits of this order even if this could be justified by savings in the future.

The reality is that neither the CCG nor Uniting Care had the financial flexibility to cope with deficits of this order

Commissioner and Provider Optimism Based on Different Financial Scenarios

At the point the contract commenced on 1 April 2015, both the CCG and Uniting Care were very optimistic that the contract could be delivered. However, each party's optimism was based on a different financial scenario.

An amendment to the contract, which was agreed in March 2015, established a process whereby financial revisions to the contract could be agreed for a period of six months after the commencement date. If the revisions were not agreed then the contract could be terminated.

The CCG view was that this clause would be used to update the contract in respect of 2014/15 expenditure levels and could also be used to transfer any additional funds into the contract from Cambridgeshire Community Services, if it could be proven that these costs had been understated due to gaps in the information made available to Uniting Care. However, the Uniting Care view was that the process would be used for these two areas but, in line with the agreed

contract variation, would also be used to cover other financial issues[e.g. additional VAT] which threatened their financial performance.

The insertion of the contract variation clause into the contract in March 2015 was a pragmatic solution to enable the contract to commence whilst resolving a number of financial issues at a later date. However, the consequence of the clause was to bring financial uncertainty.

At the point the contract commenced on 1 April 2015 both the CCG and Uniting Care were very optimistic . . . Each party's optimism was based on a different financial scenario.

All of the financial issues should have been resolved prior to contract commencement.

Recommendations

For NHS England

1. Follow up this Part 1 review with Part 2 in the form of follow up investigations specifically on the role of external advisors to the procurement, the effectiveness of the Gateway review process, and the role of the CCG executive leadership, Governing Body and related audit functions throughout the procurement and contract period.

2. Consider which is the most appropriate process to achieve an integrated system wide solution consistent with EU law. There are advantages to formal procurement including transparency and focus. However, this requires capacity and capability to carry out the procurement, robust costing and other information to inform the contract and financial flexibility of bidder organisations to manage risk.

3. The current approach of complete delegation to CCGs to enter into large complex novel contracts without the need to provide any assurance to NHS England should be reviewed. The consequences of failed contracts can impact on patients, staff, commissioners and providers and undermine working relationships for the future. Consider establishing an assurance process for novel contracts carried out by appropriately skilled individuals.

   If NHS England put in place an assurance process around these major novel contracts then this could assist Monitor in the triangulation of business case assumptions as Monitor could confer with NHS England to triangulate key assumptions.

4. Consider commissioning work to determine a model around the disaggregation of acute and community costs for the over 65s so that this can assist CCGs in developing different contracting models.

5. Review all current and planned CCG and NHS England contracts of this sort as a matter of urgency, prior to entering into any new commitments

6. Consider how the innovative work in Cambridgeshire and Peterborough can be retained and developed for the benefit of not only this area but elsewhere in the country.

Recommendations

For Clinical Commissioning Groups

1. Consider the proposed level of 'risk transfer' carefully. Allocate risk proportionate to the organisation's ability to manage it.

2. Ensure that all bidders are assessed for capacity, capability, economic and financial standing and that they are re-assessed if the structure of their bid or their corporate form changes during the procurement process.

3. Ensure that future contracts with Limited Liability Partnerships or Special purpose Vehicles have parent guarantees.

4. Ensure that sufficient time is spent at the front end of the process to disaggregate costs from the existing service provision model. This is particularly relevant for community services. It is important that an accurate financial envelope for the new service procurement model is established before the procurement commences. If this is not done then existing providers can be conflicted when they are bidding in their own right whist at the same time providing information to their competitors.

5. Be open with bidders around the calculation of the financial envelope so that they can become comfortable that the envelope does reconcile back to current expenditure levels even if the CCG requires additional efficiency savings.

6. Ensure that NHS providers have included the additional cost of VAT in their bid submissions if they are utilising a relevant model, such as Limited Liability Partnership.

7. Avoid a situation where the new contract is still not agreed or ready to commence but notice has been given to providers to terminate existing contracts and TUPE notices have been issued to staff. If a CCG reaches this situation and does not have a viable alternative option then the strength of its negotiating position on the new contract is weakened and there can be a risk to the continuity of services and relationship with staff.

8. Ensure that the contract value is absolutely clear before the contract commences and is not a provisional figure based on historical or estimated data which needs to be updated for the previous year's expenditure levels and other issues.

9. Ensure that there is a way of coping with the risk of inadvertently omitting key service delivery needs from the service specification. This may be achieved by not spending all of the agreed contract savings until the contract has bedded down later in the year.

10. Escalate disputes to NHS England at an early stage and keep them informed.

Appendix A - Terms of Reference

Background

Cambridgeshire and Peterborough CCG (CPCCG) entered into a contract with Uniting Care Partnership (UCP - a LLP formed by two Foundation Trusts) in November 2014 for the provision of Older Peoples Services. The service commenced on 1st April 2015, with transition and mobilisation activities taking place between November 2014 and 1st April 2015.

The contract was terminated in December 2015.

Overall Objective

The overall objective of this work is to establish, from a commissioner perspective, the key facts and root causes behind the collapse of the CPCCG contract with UCP in December 2015, and to advise on next steps.

This will involve a review of the events leading up to the collapse of the UCP contract in order to draw out the lessons to be learnt for other novel contracting forms in the context of implementation of the New Models of Care strategy, and more broadly.

This review will not examine the governance arrangements ,costing and tendering processes from a provider perspective. This is a matter for the individual Foundation Trusts and Monitor.

Scope

The scope of this work will include a review of relevant documentation and discussion with key staff members to identify the root causes and contributory

factors that led to the termination of the contract, specific or wider lessons to be learned, recommendations and any further action to be taken across the following areas:

- The conduct of CPCCG in the negotiation and subsequent management of the UCP contract (this will include the process and conclusion of any gateway reviews of the programme, and any immediate steps to be taken by CPCCG management following the collapse of the UCP contract)
- The role of the NHS England regional and local teams in carrying out structured assurance of these contracts for both CCGs and its own directly commissioned services
- The role of the Strategic Projects Team in the procurement, as well as any other parts of NHS England or CSUs who are relevant to the process
- The views of the two Foundation Trusts who made up the UCP Board and senior leadership
- The wider approach to negotiation and management of service integrator contracts by NHS commissioners, particularly with reference to the risk management of such contracts
- The wider approach to novel contracting forms more broadly, particularly in the context of New Models of Care.

Approach

The following procedures will form the approach to this work:

- Review of key documentation relating to the negotiation, management and assurance of the UCP contract, including correspondence relating to legal

advice and programme documentation

- Introductory discussion with NHS England Midlands and East Regional Director
- Discussions with appropriate NHS England colleagues in the regional, national and local offices
- Discussions with key contacts in the CPCCG leadership and management, as well as directors and leadership of UCP and the Foundation Trusts, as advised and arranged by NHS England
- Review of relevant contract management procedures and processes by NHS commissioners
- Review of relevant assurance and procurement procedures and processes as carried out by NHS England and CSUs
- Review discussion with NHS England Midland and East Regional Director and NHS England Chief Financial Officer on draft findings before the issuing of the final report
- Review of submissions and comments by any other parties through the designated contact mailbox on the NHS England website at ENGLAND.ucreview@nhs.net.

Deliverable

Following completion of the steps listed in the approach section above a report will be produced for the NHS England Chief Financial Officer and Regional Director of Midlands and East. This report will include the scope and approach to the work and cover any relevant observations, identified root causes and contributory factors to the issue, lessons to be learned, and recommendations where further action should be taken. The report will be published following the completion of the review.

Annex B

HEALTHWATCH COMMUNITY LEARNING EVENT

To:	**HEALTH COMMITTEE**
Meeting Date:	**12th May 2016**
From:	**Healthwatch Cambridgeshire Chair**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**The Chair of Healthwatch Cambridgeshire will give a verbal report on the Community Learning Event, held on 11th May 2016. The event gave an opportunity for all stakeholders to discuss the various reviews of the Older People's and Adult Community Services contract collapse and identify learning points to take forward.**
Recommendation:	**The Committee is asked to consider and comment on the verbal report.**

	Officer contact:		***Member contact:***
Name:	Sandie Smith	Name:	Councillor David Jenkins
Post:	CEO Healthwatch Cambridgeshire	Chairman:	Health Committee
Email:	sandie.smith@healthwatchcambridgeshire.co.uk	Email:	ccc@davidjenkins.org.uk
Tel:	01480 420628	Tel:	01223 699170

1. BACKGROUND

1.1 Local Healthwatch organisations were established under the Health and Social Care Act 2012 to be a champion for people using health and social care services. This function is performed locally by Healthwatch Cambridgeshire, an independent Community Interest Company.

1.2 Healthwatch Cambridgeshire collect people's experiences and feed these back to the Commissioners, Providers and Regulators of health and social care services, seeking improvement when necessary and maximising opportunities for local people to influence decision-making.

1.3 The Cambridgeshire and Peterborough CCG area of operation includes the Unitary area of Peterborough, as well as parts of Hertfordshire and Northamptonshire. Therefore four local Healthwatch are involved, with Healthwatch Cambridgeshire taking the lead.

2. MAIN ISSUES

2.1 In 2014 Healthwatch Cambridgeshire closely followed the CCG tender of the Older People's and Adult Community Services contract. In June 2014 a fact finding meeting held with the four Healthwatch affected identified some key risks. These were set out in a letter to the CCG:

- The imperative for strategic coherence with the Better Care Fund and CCG Transformation
- The omission of social care from the contract
- A lack of clarity regarding the scope of services being tendered
- The challenged funding environment between Trusts and the CCG
- An unrealistic timetable to transfer staff
- Whether the CCG have the expertise and capacity to effectively manage such a complex contract

2.2 The contract was awarded to UnitingCare in October 2014.

2.3 The staff transferred to Cambridgeshire and Peterborough NHS Foundation Trust on 1st April 2015.

2.4 On 3rd December 2015 the CCG announced that the UnitingCare contract had collapsed. The contract was handed back to the CCG. On 13th December Healthwatch Cambridgeshire, supported by the other three Healthwatch, wrote to the CCG calling for an Independent Review to address key questions about what happened. Since this a number of reviews have been announced by different organisations. Healthwatch Cambridgeshire is now concerned that all possible learning is identified and that there is a constructive way forward to deliver these services.

2.5 To assist with this, Healthwatch Cambridgeshire and Healthwatch Peterborough, working with the other two Healthwatch involved, held a Community Learning Event on 11th May 2016. All stakeholders were invited to this event, the purpose of which was to discuss perspectives and share learning to inform future development of integrated services in Cambridgeshire. A full report of the event will be published in due course.

2.5 The CCG published its review on 10th March 2016.

2.6 In April 2016 the NHS England review was published. This review identified several of the issues highlighted by the CCG Review and that there are further areas to be explored. A second review is being carried out.

2.7 A timeline is attached as Appendix 1.

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

There are no significant implications within this category.

3.2 Statutory, Risk and Legal Implications

There are no direct legal implications arising from this report.

3.3 Equality and Diversity Implications

There are no significant implications within this category.

3.4 Engagement and Consultation Implications

There are no significant implications within this category.

3.5 Localism and Local Member Involvement

There are no significant implications within this category.

3.6 Public Health Implications

There are no significant implications within this category.

Source Documents	Location
Healthwatch Cambridgeshire letter to Cambridgeshire & Peterborough CCG regarding the collapse of the Older People's Contract	http://www.healthwatchcambridgeshire.co.uk/sites/default/files/15_12_11_dr_neil_modha_-_opacs_contract_questions_final_vm.pdf
Cambridgeshire & Peterborough CCG's response to Healthwatch Cambridgeshire	http://www.healthwatchcambridgeshire.co.uk/sites/default/files/20160113_1215-014_healthwatch_response_re_opacs_contract.pdf
Healthwatch Cambridgeshire Chair's Report to Board January 2016	http://www.healthwatchcambridgeshire.co.uk/sites/default/files/05_chairs_report_0.pdf
Reports to and minutes of the Health Committee 17 December 2015, 21 January and 10 March 2016	http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Committee.aspx?committeeID=76

The Procurement- 2014

Cambridgeshire and Peterborough Clinical Commissioning Group tender Older People and Adults Community Services (OPACS), a large (£725 million) contract, tendered in an innovative fashion, based on an outcomes framework.

June- the four Healthwatch (Cambridgeshire, Peterborough, Hertfordshire and Northamptonshire) asked the CCG to attend a fact finding meeting, to explain in more detail the tendering process and intentions.
http://www.healthwatchcambridgeshire.co.uk/news/older-peoples-and-adult-community-contract

October- Uniting Care Partnership (UCP) was named Lead Provider

Contract Commencement- 2015

April- the Contract commenced

May- Contract negotiations continued

October- NHS England Monitor informed of contract dispute

December- The contract collapsed

Reviews, Learning, and Moving Forward 2015-2016

December 2015

11/12- The 4 Healthwatch wrote a public letter to the CCG, asking questions about the contract and its collapse:
http://www.healthwatchcambridgeshire.co.uk/news/older-peoples-and-adult-community-contract

17/12- Cambridgeshire County Health Committee scrutiny focus on OPACS arrangement for patient care following termination of the Uniting Care contract. (CPCCG invited)
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Meeting.aspx?meetingID=1079

January 2016

13/01- Response from the CCG to the Healthwatch letter:
http://www.healthwatchcambridgeshire.co.uk/sites/default/files/20160113_1215-014_healthwatch_response_re_opacs_contract.pdf

20/01- OPACS discussed at the Healthwatch Cambridgeshire Board Meeting. CCG provided an update on their position:
http://www.healthwatchcambridgeshire.co.uk/sites/default/files/03_minutes_20_01_16_draft_v_vm_0.pdf

21/01- Cambridgeshire County Health Committee scrutiny focus on OPACS termination of the Uniting Care contract (the following organisations in attendance CPCCG, UCP, CPFT, CUHFT):
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12696

February

12/02- Deadline for responses from stakeholders for the NHS England Review

02/24- CCG OPACS workshop:
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Priority%20Older%20Peoples%20Programme/Older%20Peoples%20Programme%20Update%209_final.pdf

March

02/03 Letter from Monitor to the Cambridgeshire Health Committee (Appendix A):
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12977

09/03 CCG Internal Audit released:
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Priority%20Older%20Peoples%20Programme/Internal-Audit-OPACS-Report-10-March-2016.pdf

10/03 Cambridgeshire County Health Committee scrutiny focus of regulators role in termination of Uniting Care Contract (NHS England & Monitor). Councillor Brian Rush (Chair of Peterborough City Council's Health Scrutiny Commission) was invited to participate.
http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/AgendaItem.aspx?agendaItemID=12977

April

NHS England release initial review, calling for further review. (No timeline has been released for follow up.)
https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2016/04/uniting-care-mar16.pdf

May

11/05- Healthwatch Community Learning Event

12/05- Cambridgeshire County Health Committee scrutiny focus of OPACS follow up from Healthwatch Event, confirmation of how integration model will be maintained along with patient care

June

CPFT due to release review conducted by the Judge Business School

July

National Audit Office review to be released before Parliament Summer Recess

14/07- Cambridgeshire County Health Committee scrutiny focus six months follow up OPACS, if deemed necessary.

Reviews planned or in process, information to be confirmed:

NHS England review follow up from the initial review

Anglia Ruskin University review

Cambridge University Hospitals NHS
NHS Foundation Trust

Agenda Item No: 7

SIX MONTH UPDATE ON CAMBRIDGE UNIVERSITY HOSPITALS FOUNDATION TRUST PROGRESS SINCE CARE QUALITY COMMISSION INSPECTION

To:	**HEALTH COMMITTEE**
Meeting Date:	**12th May 2016**
From:	**Roland Sinker – Chief Executive Officer – Cambridge University Hospitals Foundation Trust**
Electoral division(s):	**All**
Purpose:	**Cambridge University Hospital Foundation Trust to update the progress since Care Quality Commission Inspection**
Recommendation:	**To note and comment**

	Officer contact:		***Member contact:***
Name:	Kate Lancaster	Name:	Councillor David Jenkins
Post:	Director of Corporate Affairs for CUHFT	Chairman:	Health Committee
Email:	kate.lancaster@addenbrookes@nhs.uk	Email:	ccc@davidjenkins.org.uk
Tel:	01223 216188	Tel:	01223 699170

1. BACKGROUND

The Care Quality Commission (CQC) inspected the Trust between 21 and 24 April 2015. The subsequent report was published on 22 September 2015 and rated the Trust 'inadequate' overall.

The CQC also recommended that the Trust be placed into special measures. Monitor agreed with this recommendation and, as a result, imposed two restrictions on our licence to improve our operational performance and governance undertakings.

The Trust was asked to produce an action plan to set out how and by when we would address the concerns raised, whilst at the same time reducing the amount of money we collectively spend each week. The CUH Improvement Plan is a detailed action plan that was submitted to our regulators on 14 October 2015. It is available on our website at http://www.cuh.org.uk/news/corporate-services-finance/trust-improvement-plan-published

2. THE CUH IMPROVEMENT PLAN

2.1 The CUH Improvement Plan is a single document bringing together the multiple plans to address every concern, alongside additional areas of improvement we have identified for ourselves. It supports a very robust process developed to identify actions and monitor achievements, and is updated on a regular basis to reflect progress and ensure it remains fit for purpose and reflects the Trust's priorities.

The plan sets out our thematic priority areas for improvement:

- Leadership and Accountability
- Strategy
- Quality Improvement
- Operational Capacity
- Financial Recovery

eHospital has been pulled out specifically as a key enabler in support of each of these themes.

We are working with our regulators (CQC and NHS Improvement) to ensure all the required actions are completed as quickly as possible and Stakeholder Assurance Meetings to discuss the Improvement Plan take place on a monthly basis.

Attendees include:

- NHS Improvement (formerly Monitor)
- CQC
- Cambridgeshire and Peterborough CCG (Clinical Commissioning Group)
- Bedfordshire CCG
- West Suffolk CCG
- Cambridgeshire County Council
- Peterborough City Council
- Health Education England
- NHS England – East

- NHS England Specialised Commissioning – M&E
- Healthwatch
- Anglia Ruskin University
- University of Cambridge
- Cambridgeshire Association to Commission Health (CATCH)

2.2 Stakeholder Assurance Meetings

At each meeting, the Trust summarises operational performance and progress and achievements to date against the actions in the Improvement Plan - see Appendix 1 for example slides detailing progress as of April 2016. Plans are only reported green when they are very near completion and subsequently blue when they are both completed and embedded.

3. PROGRESS

3.1 Since September 2015 we have worked hard to address many of the issues rightly identified by the CQC in their report, and have made significant progress. Whilst there are hundreds of examples, particular examples include:

- **We have recruited more midwives to improve the patient to staff ratio** – our target is 1:32 and in March it was 1:34;
- **The installation of the Anaesthetic Gas Scavenging System (AGSS) has now been completed.** The works involved installing this new system in the Midwife-Led Birthing Unit on level 1 and Rosie Delivery Unit on level 3. All of these rooms now have the system fully in operation and in use by staff;
- We have worked hard to **reduce outpatient waiting times** and improve operational grip to maximise capacity. Additional technology is also being used to help with patient flow and clinic utilisation;
- **Medicines management** systems and processes to ensure all medicines are in date and stored at appropriate temperatures are embedded, and a Controlled Drugs Steering Group has been introduced to oversee governance and ensure fit for purpose medicines storage and security;
- **Mandatory Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) training** is being rolled out for all clinical staff;
- **Regular checks for medical devices** have been embedded into local practice;
- The Trust declared its **compliance with the Health & Safety (Sharp Instruments in Healthcare) Regulations** 2013 to the HSE on 16 February 2016.

The CQC returned to the Trust on 09 and 10 February 2016 for a re-inspection of the core areas that were rated as 'inadequate' in September 2015:

- Outpatients and diagnostic imaging
- Maternity and gynaecology
- Responsiveness of surgery

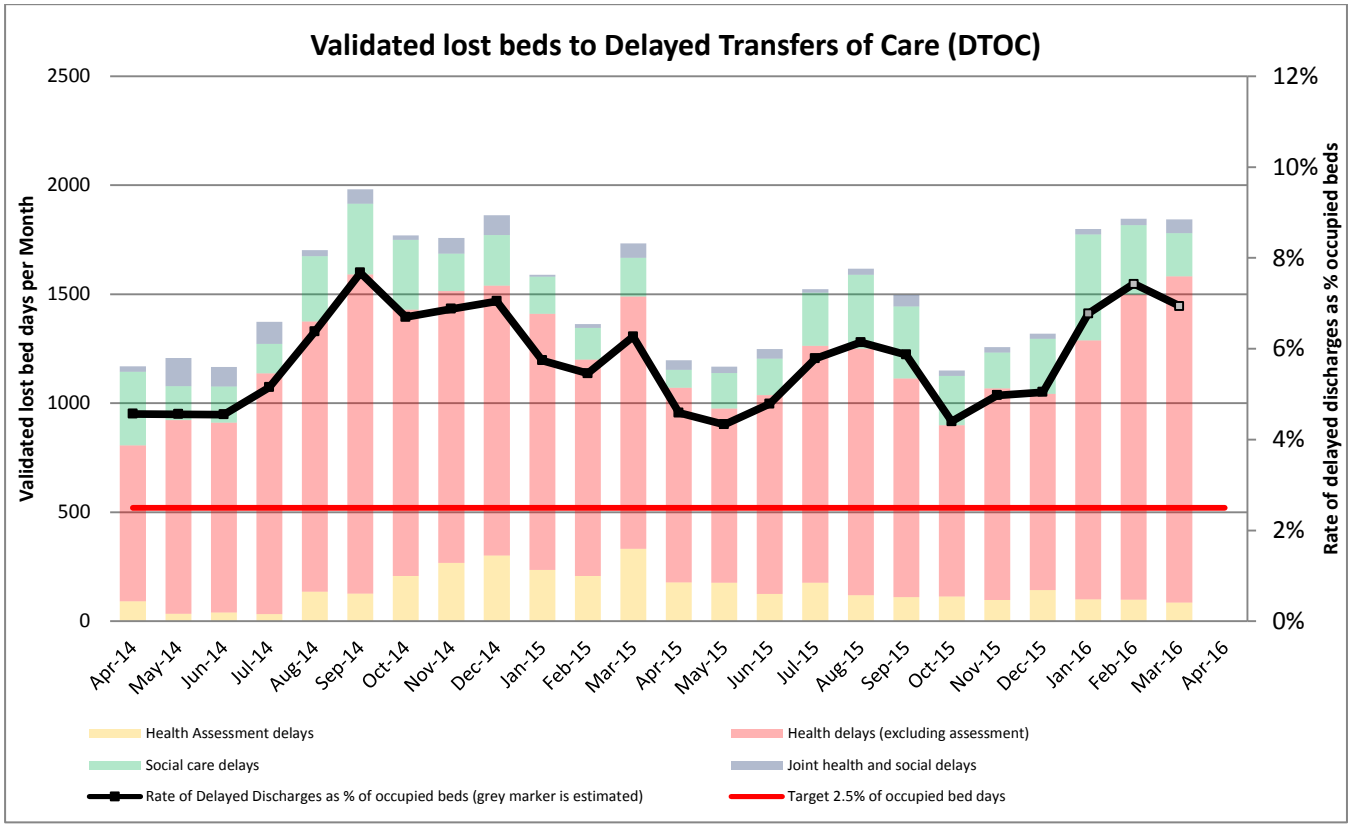
The inspectors carried out a thorough assessment of these areas and we await the inspection report. It is likely that a full re-inspection by the CQC will take place in the autumn.

4. DELAYED TRANSFERS OF CARE (DTOC)

A Delayed Transfer of Care (DTOC) is defined as occurring when a patient is ready for transfer from a general hospital bed, but is still occupying such a bed. They occur because the safe provision of the next stage of care is not ready. This will either be care in the patient's own home, care in a community hospital or placement in a nursing or residential home.

The Trust has a discharge planning team of specialist nurses who work alongside the clinicians caring directly for the patient to establish in collaboration with social care the requirements once the patient leaves hospital. Depending on the requirements the need will either be funded by the CCG, the County Council or the patient themselves (self-funding). The CCG and CCC are responsible for the majority of funding and also sourcing of care once the assessment has been completed. CCC deliver the reablement service in patients' homes.

In the last quarter the Trust has seen a significant increase in delayed transfers of care shown as follows:



The majority of delays are due to the inability to place patients within suitable nursing and residential care or to start domiciliary care at home.

The following table shows the reasons for delay in March 2016 by validated lost Bed Days according to national definitions. Of the delays 1334 bed days (72%) are due to awaiting placement either at home, in a residential or nursing home, or community hospital.

	Validated bed days lost March 2016			
Reason for delay	Attriibutable to NHS	Attributable to Social Care	Attributable to Both	**total**
Completion of Assessment	85	0	14	**99**
Public Funding	80	0	0	**80**
Other non acute NHS care (including intermediate care, rehabilitation etc.)	520			**520**
Residential Home	0	38		**38**
Nursing Home	170	48	0	**218**
Care package in own home	445	113	0	**558**
Community Equipment/adaptions	0	0	49	**49**
Patient or family choice	257	0		**257**
Disputes	0	0		**0**
Housing - patients not covered by NHS and Community Care Act	25			**25**

The Cambridge and Peterborough Health System through the Urgent and Emergency Care Vanguard is planning to achieve the target of 2.5% of occupied bed days lost to delayed transfers of care. This involves the creation of an intermediate care service, length of stay efficiencies within community services and provision of new home packages of care. Within CUH there has been a continued focussed on timely completion of assessments on the wards led by the senior nurses.

5. eHOSPITAL

After a challenging start, we continue to move forward and the system is now starting to become embedded and business as usual. Our focus now is on ensuring that change requests are completed in a timely manner.
82 per cent of the total eHospital Improvement Plan milestones have now been completed.

Given that the NHS is working towards being paperless by 2020, we receive a number of visitors including Professor Robert Wachter, who visited at the beginning of April as part of his review of computer systems across the NHS, commissioned by the Department of Health. CUH was selected as one of the hospitals to host an onsite visit and the team looked at ED, ICU and a number of ward areas. They also met with the eHospital team and a number of clinicians from various areas in the Trust.

Earlier this month, the Trust was also awarded with an international accolade for digital maturity – Stage 6 of the international Electronic Medical Record Adoption Model (EMRAM). CUH is the first Trust in the UK to receive EMRAM Stage 6 status from the Healthcare Information Management Systems Society within a year of go live, for the effective use of technology in providing high quality patient care.

This puts us among an elite group of leading hospitals and medical centres in both the US and Europe that use EPR systems as a tool to help clinicians provide high quality patient care.

The latest module of Epic implementation was launched on 26 April – the patient portal, MyChart. MyChart enables patients to be more informed and involved in their care, and access certain parts of their medical information held in Epic. Patients will also be able to view upcoming appointments, cancel appointments if necessary and complete pre-visit questionnaires.

6. LEADERSHIP AND GOVERNANCE

Roland Sinker has been in post as substantive Chief Executive Officer (CEO) at the Trust since November 2015. In addition the Trust appointed an interim Finance Director and a Board advisor.

The Trust regulators requested that the Executive team is strengthened and following a competitive process, the Trust has engaged a recruitment consultant to undertake a search and assist with the recruitment of a substantive Chief Finance Officer and a substantive Chief Operating Officer.

A need was also identified around commercial activity and a Commercial Director will also be recruited, as well as a Director of Estates and Facilities.

The Trust has worked hard to connect leadership with rest of the organisation since it was highlighted as a criticism in the CQC report. As part of the Improvement Plan, the Trust outlined a commitment to ‘Improve communication between front line staff and senior management, including board visibility’ and a range of activities have been introduced to address this:

- A review of internal corporate communications mechanisms;

- Immediate additional mechanisms to improve Board to Ward communications – a weekly Chief Executive's brief, 'The 08.27;'

- Weekly drop-in sessions for all staff to speak directly with the executive team;

- Ongoing departmental visits by executive directors and non-executive directors to operational areas of the hospital;

- A dedicated email account: **yourviews@addenbrookes.nhs.uk** for comments from staff to inform corporate decision making.

Source Documents	Location
Care Quality Commission Inspection Report of Cambridge University Hospitals NHS Foundation Trust	http://www.cqc.org.uk/provider/RGT
CUH Improvement Plan	www.cuh.org.uk/news/corporate-services-finance/trust-improvement-plan-published

Quality Improvement: delivery status (1 of 2)

eHospital

Q2.1 eHospital
All outstanding actions are in plans, but if pace of work requires accelerating there may be additional costs. 82% of the total milestones have been completed to date.

Well-led

Q3.1 Quality Governance Review Scoping review started in Jan 16 with Executive Director of Assurance from Oxford University Hospitals NHS FT; outcome awaited. Quality Committee revised work plan being reviewed. External review preparation underway.

Q3.2 Culture & Climate
A 3-5 year programme is being developed which will include learning from others and the identification of the necessary resources.

Safe

Q4.3 Mandatory Training New Learning & Management System live Jan 2016. Mandatory training content has been reviewed by the subject matter experts to ensure it is fit for purpose.

Q4.4.1 Environment (short-term) Nitrous Oxide works complete; final testing underway. Recruitment approved for Estates Operations / Maintenance. Plan nearing completion with a small number of actions delayed due to contractor availability.

Q4.4.2 Environment (longer term) Statutory and Mandatory Compliance framework in use and site wide risk assessments have been completed. Plan being scoped.

Q4.5 Equipment
Equipment maintenance data regularly presented at Divisional board. Resuscitation equipment checks continues to be monitored via Nursing Metrics.

Q4.6 Medicines storage, security & handling Nursing dashboard for completion of daily checks embedded. Improved audit results quarter on quarter, April audit outcome awaited. All actions complete, awaiting internal review.

Q4.7 Nursing Staffing Implementation of software to improve oversight of staff moves and staffing levels in relation to patient acuity and dependency – roll out of software in Apr 16 and expected to be fully implemented by end Dec 16.

Q4.8 Health & Safety An action plan has been developed for the implementation of a health and safety management system. Recruitment to H&S team underway.

Q4.9 Maternity CTG Monitoring: funding approved to install centralised monitoring for 47 beds. Action plan in place to ensure compliance with Neonatal Early Warning Scores (NEWS); this is audited weekly in all clinical areas and results presented at the monthly Divisional Quality Committee.

Caring

Q6.1 Staff Engagement Focus in Quarter 4 has been on, through a variety of interventions, improving the visibility of Executive Directors and the opportunity for staff to raise concerns and ask them questions. This continues in the new financial year.

Together-Safe | Kind | Excellent

Quality Improvement: delivery status (2 of 2)

Effective

Q5.1 Evidence-based care An analysis of serious incidents and associated guidelines is planned to ensure these guidelines are embedded in practice.

Q5.2 National Audit Data All Healthcare Quality Improvement Partnership (HQIP) audits are monitored by the Clinical Audit Committee and risks escalated to Quality Committee. 9 of 49 audits at risk - currently being reviewed and action plans in place.

Q5.3 Length of Stay Flow has continued to deteriorate; surge in emergency activity, increase in DTOCs, and a rise in delayed acute hospital repatriations. Support from Emergency Care Improvement Programme continues.

Q5.4 The Mental Capacity Act
91.63% of staff had completed the online training at the end of March 16 since Nov 15 roll-out (target = 90%). Audit of staff knowledge to be conducted.

Responsive

Q7.1 Outpatients Risk stratification of patients on referral pathways undertaken at speciality level. Plans underway to reduce waiting times. Operational grip work with PwC nearing completion. Netcall project plan developed.

Q7.2 Separation of Children & Adults
Bid for WellChild Nurse funding unsuccessful. Meeting held with NHSE and CCG on 01/04/16 to discuss significant paediatric capacity constraints.

Q7.3 Delayed Transfers of Care (DTOC) Pilot of home for assessment scheme has been highly utilised, however there is now significant pressure on the limited number of packages available; this has been raised with the CCG.

Q7.4 End of life care –Mortuary Following repair of existing facilities , capacity increased from 87 to 108 spaces. Discussions in progress with Papworth Hospital and workstreams set up to plan for future of service.

Q7.5 End of life care –UFTO/DNACPR Case for 7/7 specialist palliative care team submitted to CCG Sept 15. Review of all handover sheets in progress. Long-term plan being discussed.

Q7.6 Pharmacy 7 days
Recruitment process completed. Weekend service to Critical Care commenced 2nd April 2016

Q7.7 Physio 7 days Physiotherapy service within critical care areas already provided 7 days per week between 8:30 hours and 16:30, with on call out-of-hours. CQC content, subject to confirmation by inspection.

Q7.8 Termination of pregnancies
Works completed. Multi-disciplinary review of current guideline for the ToP policy for foetal abnormality & admission criteria signed-off. Awaiting CCG assurance.

Q7.9 Pain assessment process Pain assessment scores are now available in Epic but some modifications needed. Action plan developed to address issues.

Q7.10 Histopathology Daily escalation process in place for cases that will breach turnaround time KPIs. Scoping of off site offices to provide additional reporting space for consultants, admin and juniors is underway.

Q7.11 Critical Care ICNARC data submitted & monitored. All night time discharges from Critical Care reported as an incident. 3x daily reviews of patient acuity & staffing levels embedded.

Agenda Item No: 8

CAMBRIDGESHIRE AND PETERBOROUGH REVIEW OF BED BASED INTERMEDIATE HEALTH CARE

To:	**HEALTH COMMITTEE**
Meeting Date:	**12th May 2016**
From:	**Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To receive a report on the review of intermediate care beds currently being undertaken through the Urgent and Emergency Care Vanguard programme.**
Recommendation:	**To provide support and commitment to the principles of the bed review.**

	Officer contact:		***Director contact:***
Name:	Sa*ra Rodriguez-Jimenez*	Name:	Jessica Bawden
Post:	*Assistant Local Chief Officer, Urgent Care, Cambridgeshire and Peterborough CCG*	Post:	Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning group
Email:	Sara.rodriguez-jimenez@nhs.net	Email:	jessica.bawden@nhs.net
Tel:	Tel: 01223 725485 / 01223 725408	Tel:	01223 725400

1. BACKGROUND

1.1 The purpose of this paper is to make members of the Committee aware at an early stage of an important review on Intermediate Care beds, which the CCG and its partners are undertaking as part of the Urgent and Emergency Care Vanguard programme.

1.2 'Intermediate care' is the term used to describe healthcare which is designed to support a patient's transition from hospital to home or another long term residence; a care home for example. This intermediate care is usually provided in the community, and often takes the form of supporting the patient at home with nursing, therapy, or care. Where patients' health needs are more complex, they may be admitted to a community bed, commissioned to provide rehabilitative care.

1.3 At present, intermediate care beds are provided by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), with some additional provision by the independent sector in nursing homes. There is currently no centralised strategy for the commissioning of these services across the Cambridgeshire and Peterborough system, which has previously led to differing care models being offered across the patch (see Main issues, 2.1).

However, the current Urgent and Emergency Care Vanguard programme holds the service redesign of the provision of Intermediate Care as one of its key principles. The aim is to provide care to people 'closer to home' in new and innovative ways:

> 'Investment in community hospitals should not be at the expense of domiciliary community health and social care services, which should be the preferred pattern of service provision. An appropriate balance should be struck, with beds being provided for the minority of cases that cannot be reabled in their normal place of residence'.
>
> *From 'Transforming Urgent and Emergency care Services in England: a guide for local health and social care communities'*

Therefore, this review aims to ensure our local intermediate care services are designed around the needs of our patients, taking account of the national evidence cited above. It is anticipated that the review will result in a shift from bed based services to home based models of care, with bed based intermediate care provision remaining available for those patients with the most complex needs.

1.4 This review is being carried out alongside work within the Vanguard programme, to develop a resilient intermediate care tier that will provide home based services and intensive rehabilitation services in patients' own homes.

There is joint commitment from the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) along with Cambridgeshire County Council and Peterborough City Council, and all of our health providers, to redesign local services with the aim of enabling people to remain in their own homes for as long as possible; and ensuring that admissions to hospital are appropriate and as short as possible.

2. MAIN ISSUES

2.1 There are several key reasons why our intermediate care bed provision needs to be reviewed:

- There is a wealth of national evidence that demonstrates better patient outcomes for patients discharged from a hospital setting to their own home to receive intermediate care and therapy to complete their process of healing and rehabilitation.

- Bed based services should only be used for those patients whose clinical complexity makes it unsafe to be cared for in their own home, and who require specialised or intensive support that is can only be provided from a hospital setting.

- The current way of commissioning intermediate care beds is not always done holistically across the CCG's total area, and therefore there is a risk that the care provided is not equitable across the full CCG geography.

- At present several intermediate care beds are funded in an unsustainable way, by money that is provided on a 'one-off' basis rather than by money that is provided year-on-year.

- There are ongoing challenges regarding the recruitment and retention of staff such as nurses, carers and therapy staff. As a system, we need to develop new and clever ways to value, develop and support our existing staff capacity. This may mean shifting to innovative care models that are better for patients, but also facilitate more flexible and attractive use of resources including our health workforce.

3. SCOPE OF INTERMEDIATE CARE BED REVIEW

3.1 Inclusions

The review includes all bed-based community provision:

- Brookfields Hospital in Cambridge
- Princess of Wales Hospital in Ely
- Doddington Hospital
- North Cambridgeshire Hospital in Wisbech
- A number of beds commissioned in the independent sector (nursing and residential homes) across Cambridgeshire and Peterborough (some commissioned by health and some commissioned by the Local Authority)

3.2 Exclusions

The review does include continuing healthcare complex cases or mental health beds.

3.3. Process

The review is taking place in phases from April 2016 until March 2017. The main stages are:

- Identify and map the full stock of health bed based provision across Cambridgeshire and Peterborough

- Agree the medium and long term strategy and commitments across the system for the provision of bed based services matching available services to the needs of patients.

- Development of recommendations and a clear plan for transformation including a transition plan from the current model to the agreed model for intermediate care beds.

- Commencement of any changed services from March 2017.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

Beds: Possible outcomes of the bed review may result in some community hospital beds no longer being used for intermediate care provision. Depending on the development of other community based service models, the local system with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) may decide to deliver other clinical services such as day cases in the community beds.

Staff: In order to support the development of new models of care, staff interventions will need to follow patients into patients' own homes. This may mean staff working in a more agile way, working across both community hospital and home settings.

4.2 Equality and Diversity Implications

The review feeds into / takes account of other key pieces of work in particular:

Programme / Project	**Lead Organisation**
Older People's Accommodate Programme	Cambridgeshire County Council
In Hospital Work Strand Urgent Care Vanguard	Cambridgeshire and Peterborough CCG
Sustainability and Transformation Programme (STP)	Via CAG and Health Executive

At this stage of the review, there are no specific recommendations.

As the project moves forward, the joint steering group with representatives from primary care, both local authorities, each of the local CCGs, Addenbrooke's Hospital, Hinchingbrooke Hospital, Peterborough City Hospital and CPFT will develop a series of recommendations on a new model of care for bedded and home based intermediate care provision.

4.3 Engagement and Consultation Implications

The CCG have ensured engagement with the following organisations has been considered, or will be undertaken (dates TBC where not stated):

- CCG patient reference group on 5th May
- CCG governing body on 7th June and on 5th July
- Cambridgeshire Healthwatch
- Peterborough Healthwatch
- Cambridge Health Committee
- Peterborough Scrutiny Commission for Health Issues

Cambridge and Peterborough Local Authorities will have ensured appropriate internal consultation and with relevant stakeholders as determined by each LA.

Cambridgeshire and Peterborough Clinical Commissioning group will produce a full engagement and communication strategy to support any proposals for change that come out of this review.

Source Documents	**Location**
Cambridgeshire and Peterborough Urgent and Emergency Care Vanguard Value Proposition mark 2 – February 2016	Ian Weller, C&P CCG
Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care. A guide for local health and social care communities. August 2015	https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

Agenda Item No: 9

CAMBRIDGESHIRE AND PETERBOROUGH CLINCIAL COMMISSIONING GROUP FINANCIAL REPORT

To:	**HEALTH COMMITTEE**
Meeting Date:	**12 May 2016**
From:	**Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To update the Committee on the financial position of Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)**
Recommendation:	**To note the financial position of the CCG**

	Director contact:		***Member contact:***
Name:	Jessica Bawden	Name:	Councillor David Jenkins
Post:	Director of Corporate Affairs, CCG	Chairman:	Health Committee
Email:	jessica.bawden@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	01223 725400	Tel:	01223 699170

1. BACKGROUND

1.1 All NHS organisations have a statutory responsibility to balance their budget, and to 'break even' at the close of the financial year.

1.2 In 2015/16 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) ended the year with a deficit of £8.4 million. The CCG had originally planned to deliver a year end surplus of £4m, which the organisation had been on target to deliver until the termination of the UnitingCare contract on 2 December 2015. The revised £8.4m control total was agreed with NHS England.

1.3 NHS England (NHSE) is not requesting that the CCG repay its 2015/16 overspend, but do require the CCG to progress towards achieving in year financial balance. In 2016/17 this will require improving to a deficit position of £3m. The total savings the CCG thus needs to deliver, to achieve this net improvement, equates to £43.8m, which is 4.4% of our resource. An acknowledgement of the high level of savings required is reflected in NHSE agreeing the deficit control total. It should be noted that this control total will be stretching for the CCG to realise and will not be achieved without taking challenging decisions.

2. MAIN ISSUES

2.1 Cambridgeshire and Peterborough Clinical Commissioning Group has been reviewing all areas of spend in order to meet its financial commitments. The CCG's financial plan must be robust, realistic and achievable if it is to deliver the required savings.

2.2 The CCG has received an uplift of 4.7% to its overall programme budget for 2016/17. However, due to the requirement to address underlying deficits, the national requirement to make efficiency savings, the effect of the NHS tariff inflator[1], and growth pressures, the CCG is left with a significant net financial pressure.

2.3 The total savings the CCG needs to make in 2016/17 is £43.8 million. This figure is approximately 4.4% of the CCG's budget.

2.4 The NHS nationally is subject to financial pressures. The NHS Planning Guidance for 2016/17 – 2020/21 states that "deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment." (NHS England, December 2015).

2.5 This is also in the context of a financially challenged local health system. Cambridgeshire and Peterborough has been designated as one of the eleven most financially challenged areas in the country. There are also demographic challenges with a growing, but aging, population as well as pressures on our hospitals and rising numbers of people attending A&E.

2.6 In order to deliver savings the CCG will need to make tough decisions on the services it commissions. These decisions need to be balanced against the need to provide high quality services for patients.

[1] Changes to the national prices for NHS services, the "NHS tariff", are set out in 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21' (NHS England, December 2015).

2.7 The CCG is reviewing all areas of spend, including service provision and pathways, thresholds for certain services, tightening and ensuring adherence to clinical policies, reducing waste (e.g. wasted medicines) and ensuring appropriate referrals to services. The CCG will also be reviewing its own running costs (including estate usage and staffing costs).

2.8 The CCG has been working to agree its financial plans for 2016/17. An update will be given to the CCG Governing Body at its meeting in public on 10 May 2016.

2.9 The CCG is committed to engaging with the public and their representatives over any significant changes that it may need to make in the future and will keep the Committee updated over coming months about proposals and engagement plans.

Source Documents	**Location**
Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services. *December 2015*	***https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf***

CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP NON-EMERGENCY PATIENT TRANSPORT SERVICES – END OF CONSULTATION REPORT

To:	**HEALTH COMMITTEE**
Meeting Date:	**12 May 2016**
From:	**Director of Corporate Affairs, Jessica Bawden, Cambridgeshire and Peterborough Clinical Commissioning Group (CAPCCG)**
Forward Plan ref:	**Not applicable**
Purpose:	**The end of consultation report is being submitted to Committee to enable members to ensure that the feedback given to the consultation was reflected in the end of consultation report and will be reflected in the future model for this service.**
Recommendation:	**The committee is asked to note the report and the feedback given to this consultation.**

	Officer contact:		***Member contact:***
Name:	Jessica Bawden	Name:	Councillor David Jenkins
Post:	Director of Corporate Affairs (CAPCGG)	Chairman:	Health Committee
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Tel:	01223725584	Tel:	01223 699170

1. BACKGROUND

1.1 This report is to inform Cambridgeshire Health Committee of the responses to the 'Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) and how concerns, questions, and suggestions can be addressed by Cambridgeshire and Peterborough Clinical Commissioning Group.

1.2 The report was prepared for the Health Committee in January ahead of being submitted to the delegated authority from the Cambridgeshire and Peterborough Clinical Commissioning Group Governing Body. However, pressure of other business resulted in the report not forming part of the January committee agenda. The Governing Body delegated authority approved the start of the procurement for this service following this submission. That procurement process is now complete. The preferred bidder will be announced by the CCG following the current pre-election period.

1.3 This report has been resubmitted in May 2016 to ensure that all members can ensure that the feedback given to the consultation was reflected in the end of consultation report and will be reflected in the future model for this service.

2. MAIN ISSUES

2.1 The report details the feedback received during the consultation which ran from 27 August 2015 to 19 November 2015.

The full report with details on the responses grouped by themes, including how CAPCCG has responded is enclosed as Appendix 1.

The main changes that the CCG has implemented as a result of the consultation are detailed below:

• The new provider of this service will operate increased hours of operation, and days of the week to ensure that patients get to the appointments that are being offered to them. The service will also need to respond flexibility to any changes in hours of operation, or days of the week for NHS services.
• When a journey is booked the new provider will contact the patient before the journey is due. The patient and provider can then confirm that all the patients needs are covered, this will also allow the patient to cancel the journey if they are unwell or the appointment has changed.
• A single point of contact for booking transport will allow patients to book their own journeys if they want to, and are able. Having a variety of methods of booking transport will allow greater access and flexibility for booking journeys.
• Trained call handlers will be able to assess eligibility fairly and equitably across the whole area. They will also be trained to book the correct form of transport to meet the needs of patients.

3. Resource Implications

None

Appendices

Appendix 1 – Full end of consultation report as submitted to CAPCCG Governing Body

Appendix A – NePTS online survey responses (data only).
The free text responses are not included in the survey report. They have been used to compile the themes responses listed above. Many of the responses included personal patient identifiable information.

Appendix B – Responses from Organisations

Source Documents	Location
Chief Operating Officer's report to CCG Governing Body 22 March 2016	Agenda item 01.8 for 22 March 2016 at http://www.cambridgeshireandpeterboroughccg.nhs.uk/governing-body-meetings-2015-16.htm
Report appendices	Attached

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) for Cambridgeshire and Peterborough

27 August – 19 November 2015

End of consultation report

9 December 2015

1. Purpose of this report

This report is to inform Cambridgeshire and Peterborough Clinical Commissioning Group's (CCG) Governing Body of the responses to the 'Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) and how concerns, questions, and suggestions can be addressed

2. Background to the consultation

Patients are usually responsible for getting themselves to and from non-emergency NHS appointments e.g. attending an outpatient appointment or a visit to a minor injuries unit. In certain situations, where patients have specific medical needs and have no other way of getting to and from hospital, the NHS will provide Patient Transport Services. Cambridgeshire and Peterborough CCG has a responsibility to ensure access to NEPTS for patients who meet the eligibility criteria.

What are the issues that need to be addressed?

NEPTS services in Cambridgeshire and Peterborough are currently delivered by many providers, on different contracts, and with different service specifications.

These arrangements have been in place since before the CCG came into being, which has led to inconsistency as each contract delivers a different standard of service. This means that we cannot offer our patients equal access to NEPTS under the current arrangements. We are looking at re-commissioning the service under a single contract as we cannot continue to provide the service in the way it is being provided at the moment.

Work is taking place to look at what the new service could look like. The aim is that the procurement - the process of 'buying' a service - will be offered as 'one service' which includes patient transport and a call centre service to take the bookings.

The current contracts for NEPTS are coming to an end. This is a good opportunity for us to think about the future of these services and to improve the access to, and equity of, services for patients across the CCG's area.

Although these services are currently being run by different providers the aim is that in the future NEPTS will be one service which is managed by one provider.

We are looking for a single provider for NEPTS.

One point of call

Currently NEPTS can be booked by in a number of ways, such as your doctor's surgery and some hospitals and community clinics. In some areas of the CCG it is the patient that books the transport directly with the transport provider.

We are proposing that NEPTS should be accessed by one point of contact that patients, carers, or healthcare professionals can access.

The eligibility criteria is set nationally and will not change, however we do expect that by having a single provider the criteria will be applied equally and fairly across the whole CCG area.

3. Raising awareness of the consultation

A project team was formed in May 2015 to take this work forward. In June 2015 the project team started to raise awareness of the options for consultation. A briefing note, outlining the options under consideration, and a consultation process plan were shared with key stakeholders and patients via:

- Cambridgeshire Health Committee
- Peterborough Scrutiny Commission for Health Issues
- Northamptonshire Health Scrutiny Committee
- Hertfordshire Health Scrutiny
- CCG Patient Reference Group
- Healthwatch Cambridgeshire
- Healthwatch Peterborough
- Healthwatch Northamptonshire
- Healthwatch Hertfordshire

The consultation document was drawn up in accordance with the following requirements and guidance:

- Cabinet Office Consultation Principles July 2012
- Section 14Z2 National Health Service Act 2006
- Lansley Criteria for Significant Service Change
- Cambridgeshire and Peterborough Clinical Commissioning Group's Constitution and Communications and Engagement Strategy

4. Consultation

The consultation ran from 27 August 2015 to 19 November 2015.

4.1 Consultation documents and other consultation material

The following documents were made available in hard copy and/or on the CCG website during the consultation:

- Full consultation booklet with tear-out survey
- Summary consultation document
- Easi-read consultation document and questionnaire
- Translation of summary consultation document in:
    - Polish
    - Portuguese
    - Urdu
- Poster with public meeting dates
- Consultation process plan
- SurveyMonkey web-based survey
- Public meeting dates poster

4.2 Consultation meetings

Public consultation meetings				
	Date	Meeting	Venue	CCG attendance
1	Wednesday 16 September 10.30am-11.30am	Public consultation meeting	March Library City Road March Cambridgeshire PE15 9LT	Kyle Cliff MaryAnn Watson Jane Coulson Alex Frisby
2	Monday 21 September 2pm-3pm	Public consultation meeting	Huntingdon Library Prince's Street Huntingdon Cambridgeshire PE29 3PA	Sarah Shuttlewood Helen McPherson Jane Coulson
3	Thursday 24 September 3.30pm-4.30pm	Public consultation meeting	Peterborough Central Library Broadway Peterborough PE1 1RX	Kyle Cliff Amie Johnson Adam Miller
4	Tuesday 29 September 1pm-2pm	Public consultation meeting	Wisbech Library Ely Place Wisbech Cambridgeshire PE13 1EU	Sarah Shuttlewood Hazel Thomson Sarah Prentice
5	Wednesday 30 September 1.30pm-2.30pm	Public consultation meeting	Ely Library 6 The Cloisters Ely CB7 4ZH	Kyle Cliff Hazel Thomson Sarah Prentice
6	Tuesday 6 October 11am-12pm	Public consultation meeting	Old Bull Inn 56 High Street Royston Hertfordshire SG8 9AW	Kyle Cliff Jo Hobson Julia Walsh
7	Wednesday 7 October 2pm-3pm	Public consultation meeting	Central Library 7 Lion Yard Grand Arcade Cambridge CB2 3QD	Kyle Cliff Helen McPherson Steve Nash
8	Monday 12	Public consultation meeting	Priory Centre	Kyle Cliff

	October 10am-11am		Priory Lane St Neots PE19 2BH	Sue Last Steve Nash
9	Wednesday 14 October 11am-12pm	Public consultation meeting	Chatteris Library 2 Furrowfields Road Chatteris Cambridgeshire PE16 6DY	Janet Brooks MaryAnn Watson Jane Coulson Alex Frisby
10	Monday 19 October 1pm-2pm		New Queen Street Surgery Syers Lane Whittlesey PE7 1AT	Sarah Shuttlewood Jane Coulson
11	Tuesday 10 November 3pm-4pm		Little Shelford Memorial Hall Church Street Little Shelford CB22 5HG	Sarah Shuttlewood Jo Hobson Sarah Prentice

Meetings with organisations				
	Date	Meeting	Venue	CCG attendance
10	Wednesday 14 October 1pm-2pm	Headway hub group	Block 10 Ida Darwin Fulbourn CB21 5EE	Kyle Cliff
11	Friday 16 October 12.30pm- 1pm	Punjabi Cultural Society	Arbury Community Centre The Centre Campkin Road Cambridge CB4 2LD	Sarah Shuttlewood Julia Walsh
12	Thursday 22 October 5.30pm-7pm	Mepal Parish Council	Mepal	Sarah Shuttlewood Sue Last
13	Tuesday 3 November 10am-11am	Locksley Sheltered Housing Scheme	David's Lane Werrington PE4 5BW	Kyle Cliff
14	Tuesday 10 November 1pm-2pm	Netherton Friendship Club	Church Hall at St Andrew's United Reformed Church Ledbury Road Peterborough	Kyle Cliff

			PE3 9RF	
15	Thursday 12 November 3pm-3.30pm	Isle of Ely Patients' Forum	Doddington Community Hospital Benwick Rd Doddington March Cambridgeshire PE15 0UG	Kyle Cliff

4.3 Distribution

Email:

- GPs
- Stakeholder database – email contacts
- CCG Patient Reference Group
- Bordering CCGs – communications contacts
- Bordering CCGs – Chief Operating Officers
- MPs
- Local Authority Chief Executives
- Local Authority Leaders, Deputy Leaders, Chairs, and Vice Chairs
- Patient Participation Group contacts
- Provider Chairs and Chief Executives
- Provider communications contacts
- Health and Wellbeing Board officers
- Health Scrutiny/Health Committee officers
- Healthwatch organisations
- Local Health Partnership officers
- Council of Voluntary Service Chief Executives
- Community Safety Partnership officers

Hard copies:

- GP practices – x 2 mailouts
- Dentists
- Pharmacies – x 2 mailouts
- Sheltered housing schemes
- Nursing and residential homes
- Stakeholder database – postal contacts
- Councils for Voluntary Service
- Libraries – x 2 mailouts
- Cambridgeshire Community Services NHS Trust
- Cambridge University Hospitals NHS Foundation Trust
- Cambridgeshire and Peterborough NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Hinchingbrooke Health Care NHS Trust
- Peterborough and Stamford Hospitals NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Urgent Care Cambridgeshire

- Herts Urgent Care
- Lincolnshire Community Health Services NHS Trust/Peterborough Minor Illness and Injury Unit
- North Cambridgeshire Hospital, Wisbech
- Princess of Wales Hospital, Ely
- Doddington Community Hospital
- St Neots Walk-in Centre
- Brookfields
- County Councils
- District Councils
- Parish and Town Councils
- Health Scrutiny/Health Committee Councillors
- Health and Wellbeing Board Councillors
- Healthwatch organisations
- Voluntary and community sector/charities
- Health Education East of England
- Cambridgeshire Constabulary
- Cambridgeshire Fire and Rescue Service
- SUN Mental Health Network
- NHS England Area Team

4.4 Media Coverage

Articles on the consultation have appeared in the following newspapers:

- Ely Standard
- Wisbech Standard
- Peterborough Telegraph
- Cambridge News

Advertisements were placed in the following publications to advertise the public meeting dates:

- Cambridge News & Crier
- Royston Crow
- Cambridge News
- Peterborough Telegraph
- Hunts Post
- Wisbech Standard
- Cambs Times
- Ely Standard
- Ely News
- Fenland Citizen

4.5 CCG website and social media channels

A page dedicated to the consultation was created in the 'Have Your Say' section of the CCG's website. The page could also be accessed from a link on the homepage.

Documents relating to the consultation were made available on this page in .pdf format as follows:

- the full consultation document
- community language translations of the summary – Polish, Portuguese, and Urdu
- Easi-read version of the consultation document and survey.

A link to the consultation page on the website was publicised via the CCG's Facebook page and Twitter feed. We Tweeted and posted to our Facebook page to remind people of the consultation.

Data shows that the page was visited 2247 times during the consultation and the documents downloaded as shown in the table below:

Document	August 2015	September 2015	October 2015	November 2015	Total
NEPTS consultation document	129	145	87	88	449
Easi-read Patient Transport.pdf		30	31	45	106
Summary Non-emergency patient transport services consultation and survey - Polish.pdf		11	16	24	51
Summary Non-emergency patient transport services consultation and survey - Portuguese.pdf		9	17	28	54
Summary Non-emergency patient transport services consultation and survey Urdu.pdf		6	32	36	74

4.6 Response details

Attendees at public meetings	
Number of people attending	**66**
Enquiries received	
Email	31
Phone	16
Total	**47**
Consultation responses received	

Formal responses (statutory bodies)	8
Completed online surveys	418
Easi-read responses received	5
Total	**431**
Overall total	**544**

4.7 Responses from organisations

We received a number of responses from organisations, groups, and individuals. They are all included at Appendix C. The questions and comments raised are included in Section 4.8 below.

We received responses from the following groups and organisations:

- Cambridgeshire County Council – Economy and Environment Committee
- Cambridgeshire Health Committee
- East Cambridgeshire District Council
- Fenland District Council
- Fenland Transport and Access Group
- Peterborough Scrutiny Commission for Health Issues
- Peterborough System Resilience Group
- South Cambridgeshire District Council

4.8 Themes emerging from the consultation responses

The following describes the feedback we have received from the public meetings, additional meetings, comments sections on the surveys, emails, and formal responses from organisations. We have grouped the responses into themes that have emerged from all of this feedback; they are in no particular order.

The formal responses from organisations are attached at appendix C. The issues they raise are included in the themes summarised below.

Co-ordinated transport planning

Most of the responses from organisations asked Cambridgeshire and Peterborough CCG to ensure that we continued to be involved in looking at whole transport planning involving district, county, and city councils. Whole transport planning, to include community transport and public transport planning, will ensure a co-ordinated approach that avoids repetition and makes best use of the funding available. The organisations raised the issue of community transport being able to step in to provide transport for patients who may not be eligible for NEPTS. Total transport planning and funding was important to most of the organisations that responded.

In order to effect this co-ordinated approach, many of the organisations requested that Cambridgeshire and Peterborough CCG builds flexibility into the new contract so that when the Total Transport planning process is complete the NEPTS contractor could align with it.

Response: We continue to work closely with our council colleagues to ensure the best service for all people living in our area. We are dedicated to partnership working to ensure that good value and sustainable services, that meet the needs of our population, are provided. The service specification includes a section on interdependencies, with a requirement to work collaboratively with providers and commissioners on the wider scope and development of services. The new provider is to engage with voluntary and third sector organisations and support the further development of community and voluntary driver organisations to integrate with the NEPTS model. In particular the provider will be expected to engage in the 'Total Transport' project with Cambridgeshire County Council and to incorporate innovation and learning from the two-year pilot into the service delivery model and subsequent Quality Outcome Indicators.

Suitability of vehicles/vehicles that meet all needs.

People have told us that this is a very important issue for the NEPTS. Often people have to travel long distances when they are not feeling well and the suitability of the vehicle can make a real difference to that journey. We heard from people who, due to mobility issues getting in and out of vehicles, need to travel in specific vehicles. Low cars can be difficult for some, while others would prefer a journey by car as it is more comfortable for them. We heard from people who use wheelchairs and mobility aids - these particular needs must be taken into consideration in the type of vehicle that is used for the service. We heard feedback from people who have been transported in smaller cars that they shared with several others on a journey. This made the cars crowded and made for a longer journey while everyone was dropped off and collected. Vehicles also need to be suitable to transport guide dogs if necessary.

Response: The new provider would be expected to provide a range of vehicles. The service specification states that a range of vehicles to suit differing mobility and disability requirements will need to be available. Vehicles will also be available to accommodate assistance dogs. The one point of contact booking system should ensure efficient communication between the patient and the service.

The patient making the booking needs to ensure that all of their needs are clearly communicated at the point of booking, whether they do that themselves or through a clinic or GP practice. These needs can then be accommodated.

The provider will ensure that the appropriate vehicle is dispatched to the patient in accordance with the mobility categories as defined in the table below:

Patient Mobility Types

Patients are considered in the following mobility categories:

C	Car Transport	Patient is able to travel with minimal assistance; it is likely the patient will travel with a car driver in a saloon type car. The driver is able to offer some minimal help such as a stabilising arm as the patient walks to and from the car but will not involve any lifting or manual handling requirements *

C1	One crew car or ambulance	Suitable for patients who can manage their own mobility needs and require no lifting or moving or who need minimal assistance, but can walk up two or three steps. * C and C1 categories could be completed via volunteer drivers
C2	Two crew Ambulance	This is suitable for patients who need to be carried up or downstairs or may live in, or need to be taken to a difficult location. Also includes patients who may need assistance to walk.
WC1	Travels in a wheelchair with a single person ambulance crew	Access and egress at the patient's home does not require manual handling. Any manual handling requirements may indicate a WC2 category.
WC2	Travels in a wheelchair with a two person ambulance crew	All patients who for medical reasons are required to travel in their own wheelchair during the journey, are wheeled to and from the ambulance. Vehicles must have approved securing / tracking systems to secure chairs.
STR	Stretcher	All stretcher patients require two ambulance staff and the facility to lie down on the journey.
BAR	Bariatric vehicle, equipment and crew	Any patient who is clinically assessed to be 25 stone (350 pounds/ 159 kilos) or over. Or a patient that has difficult access to/from their home address and requires specialised moving and handling equipment.
HDU	High Dependency Unit	A patient (who may have a drip in situ), who needs to travel in a fully equipped vehicle, e.g. with piped oxygen, defibrillator, spinal board, scoop stretcher, suction etc. While there , on occasion, be a qualified nurse or medical escort, the crew should be fully trained in the use of specialised equipment.
ESC	Escort	Patients who are eligible for either a relative or medical escort. Escorts must not require assistance from the crew.

Eligibility Criteria.

The eligibility criteria is set nationally and cannot be changed by this consultation, however people did give us feedback and comments on this. Many people asked how the criteria would be assessed. Would this be done by medically trained personnel? There were

suggestions that the patient's GP should do the assessment and this should be recorded in SystmOne as a special patient note for the call centre operators to access. Many people wanted to find out, before they needed the transport, whether or not they would be eligible. They wanted to be sent a letter or email to inform them that they were or were not eligible. There were many questions about who could or couldn't travel with the patient in NEPTS. If the patient is eligible for NEPTS do they automatically have the right to have a carer or escort with them? All of this information needs to be communicated to the patient before the need for transport arises. The organisations that responded to the consultation welcomed consistently-applied criteria but had concerns that there may be more people who would no longer be eligible. Concerns were also raised about how people who were not eligible for NEPTS would find out about alternative transport.

Response: Eligibility can change as a patient's condition changes. A patient could be assessed as eligible at a certain point in their treatment but as they improve they may no longer be eligible for NEPTS. Each time the patient calls to book NEPTS the call handler will assess their eligibility using a set algorithm. The call handlers will be fully trained on how to assess a patient's eligibility. This will ensure that the eligibility criteria is applied fairly and equally for all bookings made to the service. If a patient has a long-term condition that ensures their eligibility then they could request that to be added to their patient record as a special patient note. The service specification states that a patient who is receiving an extended course of treatment over a specific time frame, for example chemotherapy, need only be assessed for eligibility once. The transport for this whole course of treatment can then be booked for up to three months ahead. The eligibility only applies to the patient. Their need for a carer or escort to travel with them is assessed separately. It is not automatically assumed that a carer or escort is needed. The single point of access call handlers will also be able to signpost people to alternative methods of transport.

What does the service cover?

On a similar theme people were not clear what type of journeys were covered by this service. Was it only for hospital appointments? Or could they also book transport to go to the GP, pharmacy, community clinics, walk-in entre, minor injury and illness unit etc.?

Response: The service specification covers the following journeys:

- acute and community day care inpatients services, discharges from acute inpatients services including A&E departments
- NHS funded beds in residential and nursing homes
- transport to and from outpatient clinics and appointments in both acute and community settings
- inter-hospital and inter-facility transfers
- hospices, end of life
- NHS funded intermediate beds
- community/satellite clinics
- renal haemodialysis
- bariatric patient journeys

Service Eligibility Exclusions:

- patients that do not meet the eligibility criteria
- patients requiring treatment for injury at the scene of a road accident or other accident
- patients requiring emergency transport
- patients attending appointments with their GP, dentist or to A&E, Out of Hours base, urgent care centre, minor injury unit
- intensive Care transfers
- acute Neo-natal transfer services (ANTS) and Children's Acute transfer services (CATS) patients
- patients with challenging behaviour as defined below

  In no circumstances should patients who are identified within this category and have been referred to as 'violent patients' be transported using NEPTS. These patients have a history of challenging behaviour and are patients who are known to pose a threat with GP practices and as a result of the inability to resolve this pattern of behaviour are excluded from the surgery list.

  Under national policy patients who have had their right to their local NHS care removed are only entitled to services if denial of treatment would cause lasting harm or put their lives at risk. There is no obligation to provide transport services or attend the home of patients identified as posing a risk, where there is no immediate clinical need.

  Commissioner will be responsible for ensuring that the Patient Transport Clinical Assessment and Advice Service is advised of any such patients as soon as they are placed on their local scheme.
- transport for mental health patients to a place of safety, admission under the Mental Health Act or for any patients who have been placed on Section unless a risk assessment has been undertaken
- patients in receipt of transport benefits e.g. adapted vehicles unless any medical condition then prevents them from using the adapted vehicle.

GP appointments are not covered, however if a podiatry or other clinic is being run in a GP practice those journeys would be included.

Waiting times/time keeping

This was a big issue for many people. People are told to be ready for their transport two hours before the transport is due to arrive. People felt this was a long time to wait. Often when they were collected the transport then went on to collect other people, often further away, making their journey time even longer. People described transport coming to collect them very late so they missed their appointment time. On return journeys people described to us that they had long waits at the clinic or hospital to be collected to go home. Again the transport then had to drop off other patients, extending the time they had been away from home for what could have been a very short appointment. Waits for transport home was a big issue for elderly patients, especially those who may become anxious when away from

familiar surroundings. Clinic staff describe having to care for personal needs of elderly vulnerable patients while they are waiting for transport home, which then makes the clinic run late as staff are performing other caring roles.

Response: In the service specification it states that the provider will advise the patient of an estimated pick up time, and that the patient should be ready for collection no more than 30 minutes before that pick up time. In order to maximise the potential for each vehicle there will still be an element of waiting for all the patients included in that vehicle to be ready to go home. We hope that by having one provider the journey planning can be more efficient than it is currently so that long waits can be avoided. There are key performance indicators in the contract so that the new provider can be held to account for this element of the contract.

Consultation survey and document

We received feedback that people felt that the survey was only geared to those who had used the service. This was because the first question asked people if they had used the service. We received some feedback that the document wasn't widely available but people went on to tell us that they had seen it in a range of locations, and seen the public meeting adverts in the local press. Peterborough Scrutiny Commission for Health Issues asked why all of the public meetings were being held in the daytime, and Cambridgeshire Health Committee expressed concern that an hour for each meeting was not sufficient. Cambridgeshire and Peterborough CCG was contacted by the MP for South Cambridgeshire to ask why there was no public meeting in this area. A Patient Participation Group (PPG) from Whittlesey also contacted us to ask us to arrange a meeting in their area.

Response: It was important to us to understand whether the feedback was coming from people who had already had experience of the current service. We wanted to hear what was important to people who use NEPTS and what could be improved so that any new specification for the service retains the things that people find important and improves on the elements that are not working so well. However, we understand how this could be viewed and for our next consultation we will design the survey to be clearer. That said we received a lot of feedback from people in the comments section who had not used the service but wanted to give us their feedback.

Cambridgeshire and Peterborough CCG agreed to review the length of the consultation meetings. If experience of the first two sessions suggested it would be appropriate, the timing of subsequent sessions could be extended. The length of meetings was found to be sufficient to address all issues that were raised and for all of those attending to have their say.

Members were advised that historically attendance at evening meetings was very low. Invitations were sent to voluntary organisations and housing associations to see if they would like us to attend any of their meetings. The organisations that contacted us to arrange these meetings are detailed in section 4.2. These were in addition to the public meetings.

An additional public meeting was arranged at Little Shelford inSouth Cambridgeshire and it was advertised locally. A meeting in Whittlesey was arranged and hosted by the PPG at New Queen Street surgery and advertised through all of the Whittlesey practices.

One point of contact

There was a lot of positive feedback for this idea. People felt it would make it easier to book transport and that this would improve communication between the people who book the transport and those who provide it. People raised concerns about whether hospital and GP staff would still be able to book transport for those who needed it and were not able to do so themselves. People also raised concerns about online booking as there are still many people who do not use computers or who do not have access to the internet. Concerns were raised about the number of call handlers that would be needed to ensure that it was an efficient service that did not leave people waiting for calls to be answered. Suggestions were made that 111 could handle these calls, as then it would truly be one point of access.

Response: The one point of contact will ensure that the eligibility criteria is applied equally and fairly to all patients. There will be a range of methods of booking journeys, by telephone and potentially a web-based booking system. We do not insist that the patient books their own transport; clinic and GP practice staff can still do this on behalf of the patients. However, we understand for this feedback that many people will welcome being able to book their own journeys and discuss their needs directly with the service provider. The new provider will be held to account for answering calls within a set timeframe. The provider will need to ensure there is sufficient capacity to meet the needs of this element of the service.

Communication between booking and transport

This is linked to the theme above but is more detailed on how this should work. People wanted to be able to cancel their own transport if their appointment was changed at short notice or they felt unwell on the day or night before. At the moment it is difficult to cancel bookings as they would need to get back to the people who booked the transport for them; if this is a GP practice or hospital clinic then they are not always available. We were given feedback that the communication between the booking and the transport provider isn't always efficient at the moment. We were given an example of a person who used a wheelchair who was sent a vehicle that was not appropriate. Also when a carer needs to travel with the patient this isn't always communicated properly so the vehicle may already be full, or booked for other patients, leaving the carer to travel separately. People asked us if their bookings could be confirmed to them. Some wanted this in writing by letter, and some asked for a text confirmation to be sent.

Response: Having one point of contact will enable people to cancel their journeys themselves if necessary. The service specification details that the provider will contact the patient prior to the journey to confirm the booking and to ensure that the patient has everything they need. This will include discussing further requirements such as carers and escorts, mobility aids, and assistance dogs. The patient can then cancel the journey at this stage if necessary

Expectations of the service and driver

Some of the feedback received was based around differing expectations of this service and what the driver should or shouldn't do. People made comments about drivers playing music

in the car that they didn't like and about drivers not opening car doors and assisting people from the vehicle. Some people asked why drivers couldn't drop them at different entrances at the hospitals, or why drivers didn't accompany them into the hospital to make sure they reached the right place. Equally for return journeys, some people felt that the driver should collect them from the appropriate clinic rather than near an entrance or exit.

Response: When the new contractor begins to operate this service, information for patients should be clear on what they can expect from the various different forms of transport that will be provided. The service specification sets out what is expected in terms of the class/type of vehicle, equipment for each category as a minimum and workforce requirements in terms of training and competencies. In addition it sets out expectations of the roles and responsibilities of staff. For example it states that the driver should leave the patient in a safe and secure manner, whether this is at the health venue or their own home.

The new service provider should also be clear where and how people will be dropped off and collected. The service specification states 'The Provider will transport the patient to a designated waiting area or ward/clinic at the healthcare setting. Where no such waiting area exists the Provider will transport the patient to the correct clinic or ward, and ensure the patient is handed over to the receiving unit. Under no circumstances should patients be left before the department or premises are open.'

Use of volunteer driver schemes

Most of the feedback we received about volunteer driver schemes was very positive. People felt these were a real asset and that they had good relationships with their drivers, as the same driver collected them each time and they understood their needs. This was of particular importance to people living in rural areas where the volunteer driver schemes were used not only for health appointments but for other social needs. Many people at the public meetings were concerned that these schemes would not continue under the new contract and they would lose a service that they valued highly.

Response: We will include in the contract the stipulation that the provider engages with volunteer sector organisations in order to develop the use of these services. The service specification includes a section on interdependencies, with a requirement to work collaboratively with providers and commissioners on the wider scope and development of services. The new provider is to engage with voluntary and third sector organisations and support the further development of community and voluntary driver organisations to integrate with the NEPTS model.

In addition the existing contracts with volunteer services for transport have been ring fenced and removed from this procurement. The CCG has committed to work with the councils across the area in order to develop the community and voluntary transport market over the next two years through projects like Total Transport in Cambridgeshire.

Poor public transport

People at the public meetings, and in the written feedback, told us that the NEPTS service was very important to them because of the poor public transport links across the area. We received this feedback from most areas, but mainly in our more rural areas. Bus and train services were described as better if you lived in some of our larger market towns or cities, but the smaller rural towns were not well serviced by public transport. People had to undertake long complicated journeys, or pay for expensive taxis, to reach our main hospitals. In these areas people asked us if they were not eligible for NEPTS could they pay to use the service? This would still be cheaper and more convenient than other forms of transport to get to the hospital or clinic. Our rural Fenland areas, Wisbech, and Royston were particularly mentioned in relation to poor transport links and distances to travel to access services.

Response: The NEPTS project team is working closely with colleagues at the district, county and city councils to look at transport as a whole, including community transport which could provide affordable alternatives for our more rural areas where public transport can be an issue. The eligibility criteria does not cover where a patient lives, although we do understand this can be an issue for some people who do not live in areas where there is consistent public transport. We are working with the county and district councils to look at how transport to key community infrastructure can be improved.

The service specification includes a requirement to signpost and direct people who are not eligible for NEPTS to other alternative transport options.

Service standards and local knowledge

People told us that the service varied a lot in standards. Often different vehicles and drivers would be sent. The criteria for getting transport did not seem to be equally applied even within the same area. People told us that a service with local knowledge was really important to them. In some rural areas it would be important to know which areas flood in winter when planning journeys to collect patients; satellite navigation is not always reliable for this type of information. It was felt that people with local knowledge would be able to plan journeys to collect and drop off a number of patients more efficiently.

Response: Eligibility criteria will be applied equally and fairly. The service specification states that the new provider will need to know and understand the local area. All provider vehicles, including cars, must be equipped with satellite navigation and two-way radios. Hands-free equipment must be installed in all vehicles.

Hours of operation

People told us that the current hours of operation are very limited. More people are getting early morning and late afternoon appointments and the current service is not set up for this. The hours of operation need to be extended to meet the opening times of hospitals and clinics. The Peterborough System Resilience Group supported increased hours for this service as it would support patient flow through the hospitals. Other organisations supported increased hours, as at present they felt there were concerns about transport being provided

for discharges. Some patients had delayed discharges because the current NEPTS service was not available at particular times.

Response: The new provider will operate increased hours and days of the week to ensure that patients get to the appointments being offered to them. This service will need to respond to any changes in operating hours and days of operation within the NHS. The hours of operation for this service must support the times that patients need to get to their healthcare setting, both earlier in the day and later into the evening.

Awareness of the service

People told us that not all GPs and health staff were aware of the service and more needs to be done to ensure that staff are aware of the service and understand the eligibility criteria. We also received feedback that more publicity for the service was needed to the general public. People felt that not enough people knew the service existed, how to access it, or how to find out if they were eligible. The organisations that responded raised the issue that staff across many areas of healthcare need to understand how to book and arrange NEPTS especially to avoid delayed discharges from hospital.

Response: The new provider will be asked to ensure that all staff are made aware of the service, the eligibility criteria, and how to book transport. Publicity will be part of the contract with the new provider, however if we advertise too widely this could be raising expectations as not everyone is eligible for this service. This will need to be handled carefully and sensitively.

Podiatry and Ear Nose and Throat (ENT) clinics

We had several responses from people who work in these clinics who felt the current system was not very effective for their patients. People who attend some podiatry and ENT clinics and are eligible for patient transport are often elderly vulnerable patents. The clinic staff felt that these patients should not be left to wait in the clinic for long periods before they are taken home. The suggestion was that some specific services and clinics should have dedicated drivers for those vulnerable patients who need to attend the clinic.

Response: Unfortunately we cannot provide specific transport for individual services. However, as mentioned above, in the service specification it states that the provider will advise the patient of an estimated pick up time, and that the patient should be ready for collection no more than 30 minutes before that pick up time. In order to maximise the potential for each vehicle there will still be an element of waiting for all the patients included in that vehicle to be ready to go home. The service specification states that patients should be collected within 45 minutes of their appointment, and no-one should wait longer than 90 minutes. There will be key performance indicators in the contract so that the new provider can be held to account for this element of the contract.

NHS organisations

Some people told us that they thought that the successful bidder should be an NHS organisation. They would not be happy if the successful bidder was a private company.

Response: All services commissioned by the CCG are subject to the standards set out in the NHS Standard Contract for the delivery of NHS funded clinical services. This ensures that all services commissioned by CCGs are delivered according to rigorous national standards and locally determined specifications. All providers, be they in the NHS, the voluntary or independent sectors must deliver services to the standards set out in the contract. Failure to deliver to the contractual standards are subject to penalties and ultimately termination of the contract, should a service be deemed to be unacceptable.
All NHS commissioned services remain free at the point of use and contracts are let for time limited periods, usually between three-five years. The intention of all CCGs is to ensure the best quality of care and value for money for the local population. The procurement process ensures that contracts are let in a fair, open and transparent manner while subjecting potential providers to rigorous and thorough appraisal of their proposals to deliver NHS commissioned services. Following the 2012 Health and Social Care Act, further regulation in 2013 required CCGs to apply a number of tests in determining whether services should be subject to a procurement process. The CCG has followed this regulation and determined that NEPTS should be subject to a procurement process in order to ensure the following:

(a) securing the needs of the people who use the services

(b) improving the quality of the services

(c) improving efficiency in the provision of the services.

5. Key changes as result of this consultation

- The new provider of this service will operate increased hours of operation, and days of the week to ensure that patients get to the appointments that are being offered to them. The service will also need to respond flexibility to any changes in hours of operation, or days of the week for NHS services.
- When a journey is booked the new provider will contact the patient before the journey is due. The patient and provider can then confirm that all the patients needs are covered, this will also allow the patient to cancel the journey if they are unwell or the appointment has changed.
- A single point of contact for booking transport will allow patients to book their own journeys if they want to, and are able. Having a variety of methods of booking transport will allow greater access and flexibility for booking journeys.
- Trained call handlers will be able to assess eligibility fairly and equitably across the whole area. They will also be trained to book the correct form of transport to meet the needs of patients.

6. Next steps

Key Milestones	**Expected Timelines**
Invitation to Tender	December 2015
Evaluation and Selection	February 2016
Contract Finalisation	March 2016
Service Commencement	September 2016

7. Appendices

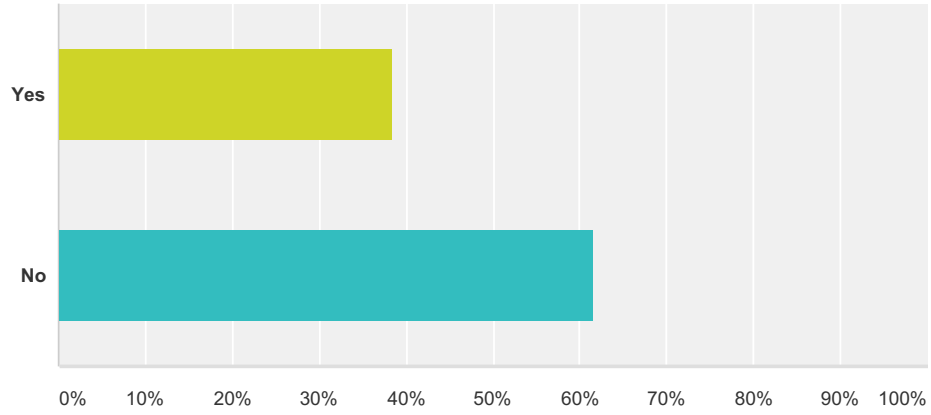
Appendix A – NePTS online survey responses (data only).

The free text responses are not included in the survey report. They have been used to compile the themes responses listed above. Many of the responses included personal patient identifiable information.

Appendix B – Responses from Organisations.

Q1 Have you used NEPTS in the last 12 months?

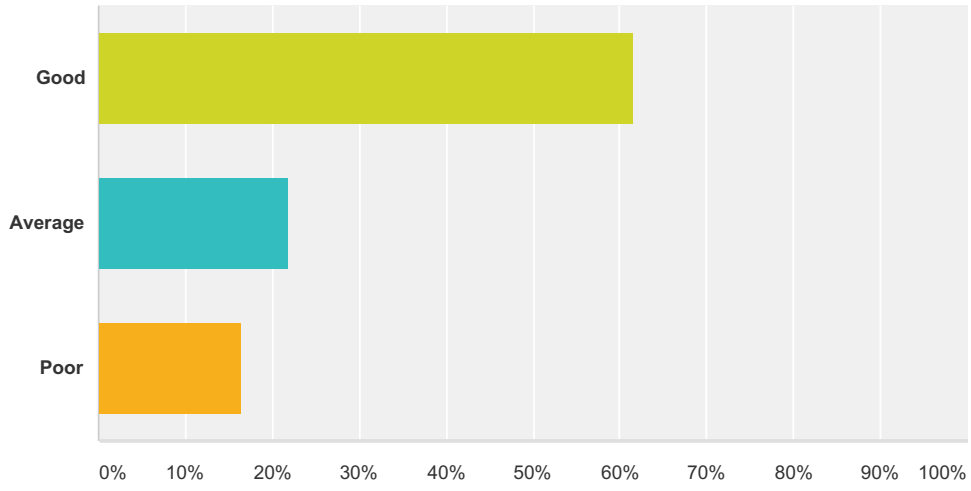
Answered: 361 Skipped: 57



Answer Choices	Responses	
Yes	**38.50%**	139
No	**61.50%**	222
Total		**361**

Q2 If you answered yes to Q1, how was your experience of this service?

Answered: 146 Skipped: 272



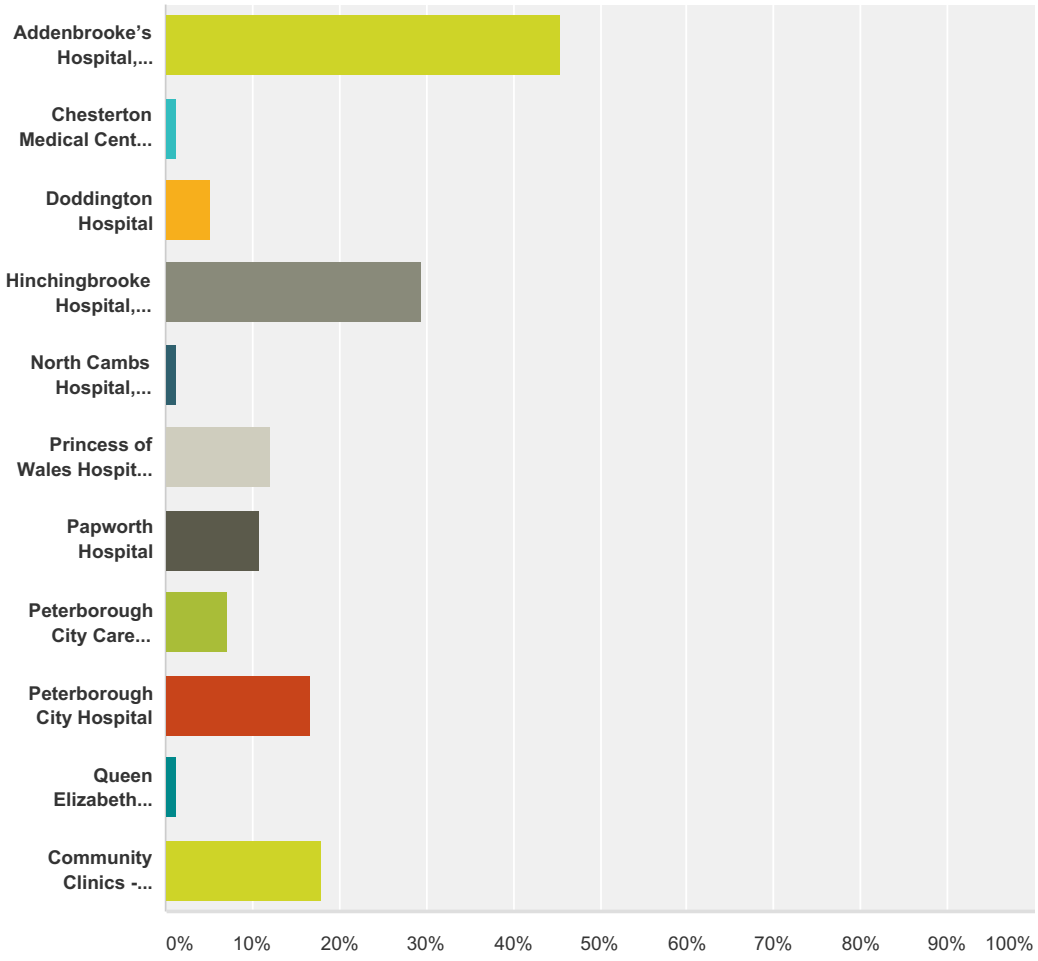
Answer Choices	Responses	
Good	**61.64%**	90
Average	**21.92%**	32
Poor	**16.44%**	24
Total		**146**

Q3 Do you have any suggestions for improving the service?(Please write them in this box)

Answered: 171 Skipped: 247

Q4 If you answered yes to Q1, which of the following did you visit? Please tick all that apply.

Answered: 156 Skipped: 262

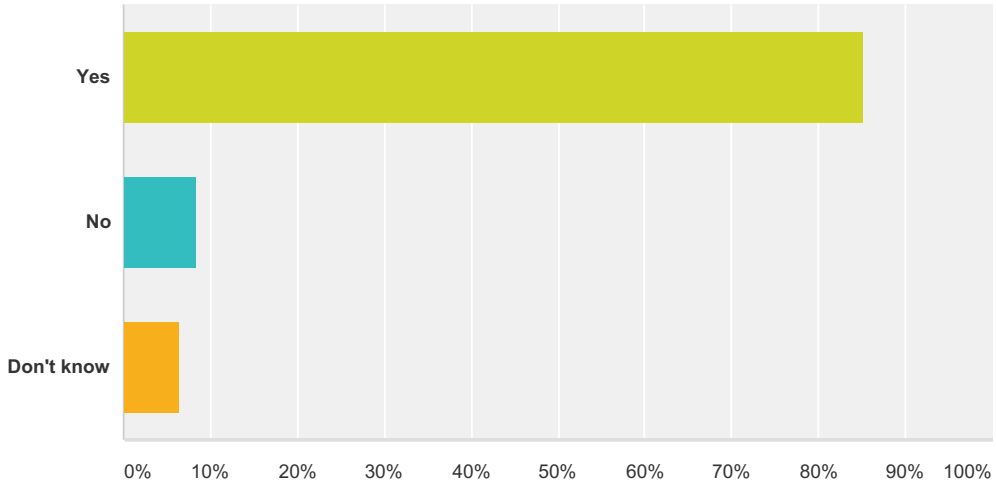


Answer Choices	Responses	
Addenbrooke's Hospital, Cambridge	**45.51%**	71
Chesterton Medical Centre, Cambridge	**1.28%**	2
Doddington Hospital	**5.13%**	8
Hinchingbrooke Hospital, Huntingdon	**29.49%**	46
North Cambs Hospital, Wisbech	**1.28%**	2
Princess of Wales Hospital, Ely	**12.18%**	19
Papworth Hospital	**10.90%**	17
Peterborough City Care Centre	**7.05%**	11
Peterborough City Hospital	**16.67%**	26
Queen Elizabeth Hospital, Kings Lynn	**1.28%**	2

Community Clinics - Please state the location of the community clinic in the box below	**17.95%**	28
Total Respondents: 156		

Q5 Would you, as a patient or health professional, be happy with one point of contact to book the transport?

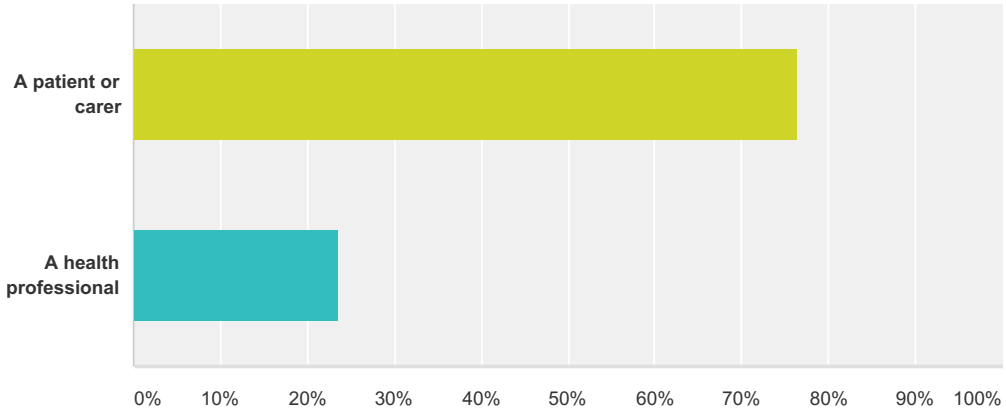
Answered: 337 Skipped: 81



Answer Choices	Responses	
Yes	**85.16%**	287
No	**8.31%**	28
Don't know	**6.53%**	22
Total		**337**

Q6 Are you?

Answered: 317 Skipped: 101



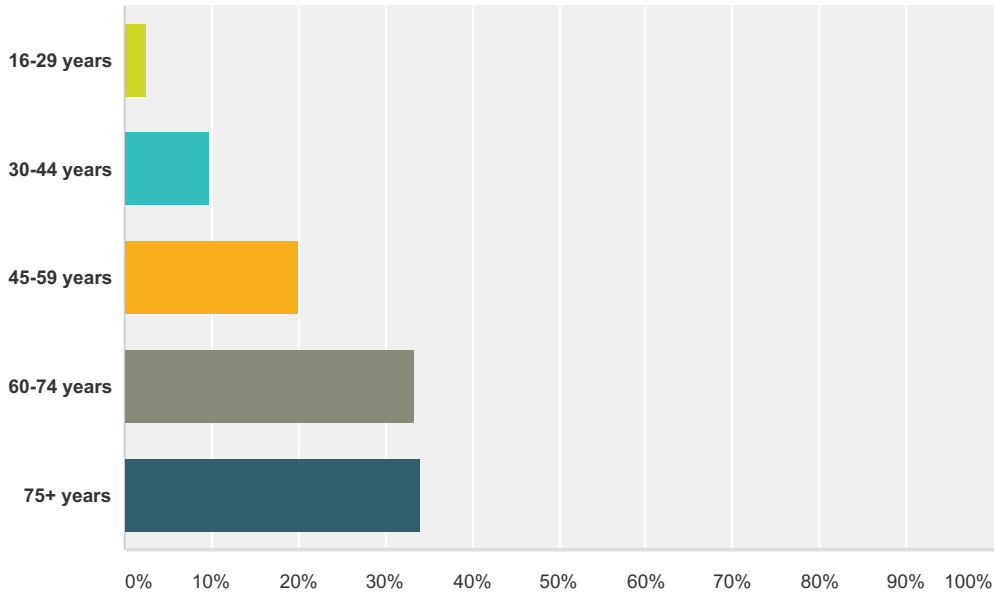
Answer Choices	Responses	
A patient or carer	**76.34%**	242
A health professional	**23.66%**	75
Total		**317**

Q7 If you have any other comments you would like to make please write them here.

Answered: 128 Skipped: 290

Q8 Can you tell us which of the following age bands you belong to?

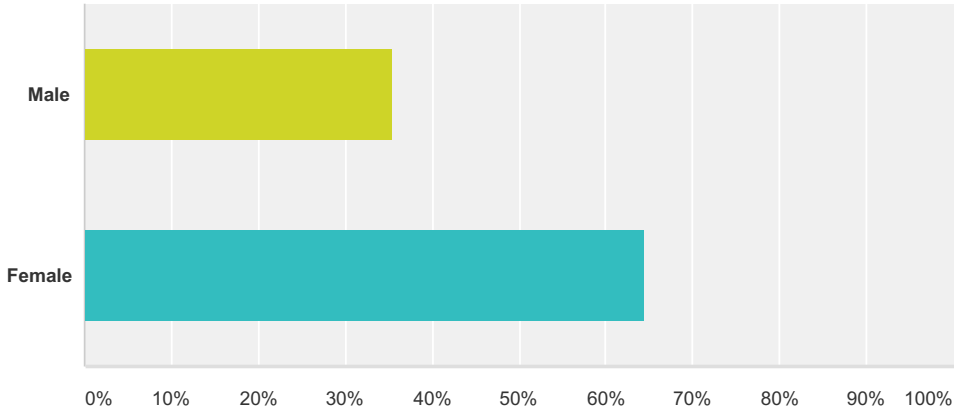
Answered: 323 Skipped: 95



Answer Choices	Responses	
16-29 years	**2.48%**	8
30-44 years	**9.91%**	32
45-59 years	**20.12%**	65
60-74 years	**33.44%**	108
75+ years	**34.06%**	110
Total		**323**

Q9 Are you...

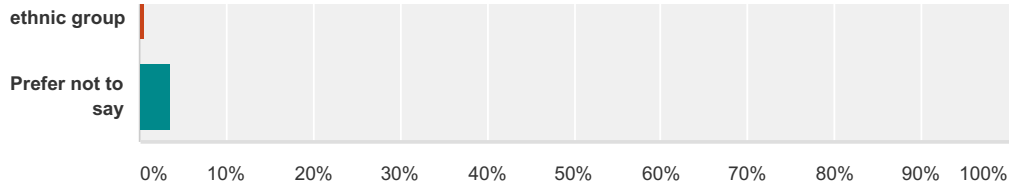
Answered: 299 Skipped: 119



Answer Choices	Responses	
Male	**35.45%**	106
Female	**64.55%**	193
Total		**299**

Q10 Which of the following best describes your ethnic background? White

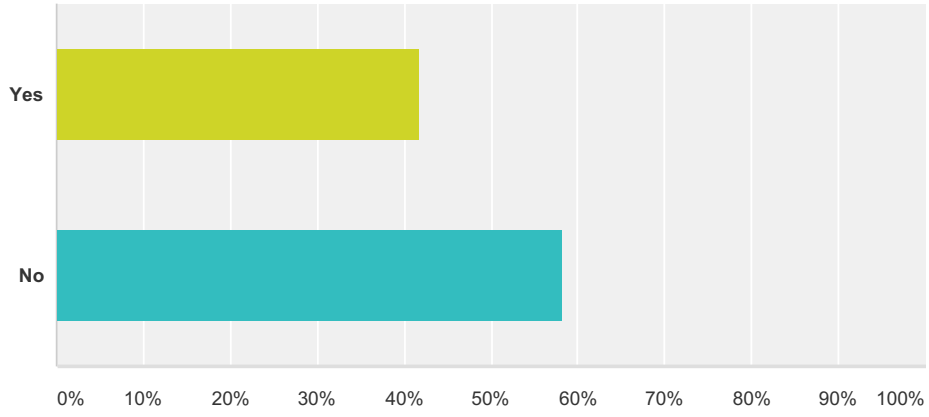
Answered: 317 Skipped: 101



Answer Choices	Responses	
English, Welsh, Scottish,Northern Irish or British	**89.59%**	284
Irish	**1.58%**	5
Gypsy or Irish Traveller	**0.00%**	0
Any other White backgroundMixed/multiple ethnic groups	**2.21%**	7
White and Black Caribbean	**0.32%**	1
White and Black African	**0.00%**	0
White and Asian	**0.00%**	0
Any other mixed/multiple ethnic backgroundAsian/Asian British	**0.00%**	0
Indian	**0.95%**	3
Pakistani	**0.32%**	1
Bangladeshi	**0.32%**	1
Chinese	**0.00%**	0
Any other Asian backgroundBlack/African/Caribbean/Black British	**0.32%**	1
Black, African Caribbean, Black British	**0.00%**	0
African	**0.32%**	1
Caribbean	**0.00%**	0
Any other Black, African, Caribbean backgroundOther Ethnic Group	**0.00%**	0
Arab	**0.00%**	0
Any other ethnic group	**0.63%**	2
Prefer not to say	**3.47%**	11
Total		**317**

Q11 Do you consider yourself to have a disability?

Answered: 304 Skipped: 114



Answer Choices	Responses	
Yes	**41.78%**	127
No	**58.22%**	177
Total		**304**

Q12 Do you have any particular needs with regard to Non-Emergency Patient Transport that you would like to make us aware of?

Answered: 123 Skipped: 295

Q13 Finally, please could you tell us the first part of your postcode? (first four characters only)

Answered: 315 Skipped: 103

NON-EMERGENCY PATIENT TRANSPORT SERVICES: CONSULTATION RESPONSE

To: **Economy and Environment Committee Spokes**

Date: **17 November 2015**

From: **Toby Parsons, Transport Policy & Operational Projects Manager**

1. Purpose

1.1 To update Spokespersons on Cambridgeshire & Peterborough Clinical Commissioning Group's (CCG) consultation on a future model for non-emergency patient transport services (NEPTS).

1.2 To propose a response to the consultation documents on behalf of Cambridgeshire County Council.

2. Background

2.1 The CCG spends more than £6.5m per year on providing NEPTS for those who have specific medical needs and have no other way of getting to and from their appointment.

2.2 The current contracts for NEPTS are coming to an end, and the CCG needs to tender a new service for September 2016. A 12-week consultation process is running through to 19 November 2015.

2.3 The Council spends around £20m per year on supported transport. The majority of this relates to home-to-school transport, however more than £1m is spent on both adult social care transport and bus services in isolated areas.

2.4 Cambridgeshire received £460k from central government in early 2015 in order to develop and pilot a Total Transport approach. This national concept recognises that efficiency savings may be possible if different types of transport provision can be integrated. This could help maintain service delivery levels despite reductions in funding.

2.5 The Cambridgeshire Transport and Health Joint Strategic Needs Assessment (JSNA) of April 2015 recommended "A system-level perspective on health and transport planning, specifically ensuring that transport issues are given sufficient prominence within the Cambridgeshire and Peterborough Clinical Commissioning Group System Transformation programme. "

3. Key Issues to Consider

Timing constraints

3.1 The CCG's obligation to comply with procurement regulations means that there is limited time to redesign NEPTS whilst completing a legal tender process for September 2016.

3.2 The Total Transport funding is for a defined period to March 2017, by which time the pilot project must have been fully implemented and evaluated. An implementation date of April 2016 is currently targeted.

3.3 Should the Total Transport concept prove to be a feasible way of maintaining service delivery despite reductions in funding, a wider roll-out would be possible from 2017 onwards. A rigid NEPTS contract with a longer duration would restrict the potential benefits available.

Does "one size fit all"?

3.4 The operating model proposed in the CCG's consultation documents would see a single point of access for booking and a single provider for delivery. This has certain attractions in terms of simplicity, and the consultation may reveal service user views on this.

3.5 A single provider creates a risk, as various contract management tools that can be used to address poor performance cease to be available. This approach may also freeze out smaller local operators and community transport providers, who are vital to the overall transport mix.

3.6 The Total Transport pilot from April 2016 will focus on a defined area. Integrating NEPTS within the pilot area (whilst at the expense of a single solution for the complete CCG area) would allow full exploration of the Total Transport concept.

4 Conclusion & Proposed Consultation Response

4.1 The Council welcomes a review of NEPTS and wishes to work closely with the CCG on the development of a new operating model for this service.

4.2 The Council acknowledges that transport barriers are a contributory cause of missed and cancelled health appointments, delays in care, and non-compliance with prescribed medication *[JSNA report]*. Older people living well independently and people with disabilities living well independently are two of the Council's intended outcomes; good access to transport is a vital enabler for achieving these, as it is to the further outcome of people leading a healthy lifestyle *[CCC operating model]*.

4.3 The Council considers that full exploration of the Total Transport concept is necessary, to establish if it can help mitigate the impact of funding reductions. In particular, the pilot scheme to be implemented in 2016 should include CCG-funded journeys as well as Council-funded journeys; it is recognised that this will require a break from the uniform model of NEPTS currently proposed.

4.4 The outcome of the pilot scheme and of further work to be undertaken in the coming months may allow a better model of integrated transport delivery to be implemented from 2017. The Council encourages the CCG to set a tender specification which allows flexibility in the type and number of journeys to be delivered, and in the purpose of the proposed booking centre. This flexibility should be sufficient that other journeys (e.g. home-to-school or adult social care) could be included within the new arrangements, or that some NEPTS journeys could be taken out of scope of the new contract.

HEALTH COMMITTEE: MINUTES

Date: Thursday 3rd September 2015

Time: 2.00 p.m. to 3.55 p.m.

Present: Councillors D Jenkins (Chairman), P Ashcroft, P Clapp, P Hudson, M Loynes, Z Moghadas, T Orgee, P Sales, M Smith, S van de Ven and J Wisson (substituting for A Dent)

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

Apologies: County Councillors A Dent and S Van de Kerkhove
District Councillor R Mathews (Huntingdonshire)

148. DECLARATIONS OF INTEREST

There were no declarations of interest.

149. MINUTES: 16th JULY 2015 AND ACTION LOG

The minutes of the meeting held on 16th July 2015 were agreed as a correct record and signed by the Chairman.

The Action Log was noted.

150. PETITIONS

No petitions were received.

151. NON-EMERGENCY PATIENT TRANSPORT SERVICES

The Committee received a report introducing the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) proposal for Non-Emergency Patient Transport Services (NEPTS) and the public consultation document. Sarah Shuttlewood, the CCG's Director of Contracting, Performance and Delivery, attended to present the report and respond to members' questions.

In the course of discussion, members raised various points of concern about the consultation document and process:

- The national eligibility criteria for NEPTS were very restricted; it might help patients if some illustration could be given of who was and who was not eligible, along with examples of rulings in cases of disputed eligibility.

- There was only sketchy advice in the consultation document for those who were not eligible for NEPTS and were unable to afford the cost of

transport; following the link to www.nhs.gov.uk ended eventually in advice to contact the local authority about community transport. It would be helpful to include information about what was available locally.

- Cambridgeshire Future Transport was concerned about maximising opportunities for using overlapping transport services to convey people to health-related appointments where this was being done from the public purse. It would be helpful if Future Transport could be included in future discussions about patient transport; there was potential for using postcode data to map transport need and provision, something which Addenbrooke's was already starting to do.

- The proposals seemed to be thinking in siloes, with separate categories of emergency and non-emergency transport, and those ineligible for NEPTS, as well as potential problems of incompatibility between transport availability and appointment times – it was important to view transport as a whole, and make best use of public money to provide the best possible service.

- Expecting patients to book their own appointments online could disadvantage patients who were not computer literate.

- Ease of access to services tended not to be the same across the county, with rural Fenland and East Cambridgeshire usually experiencing difficulties; would NEPTS provide as good coverage in all parts of the county.

- The report implied that there would only be one provider of NEPTS; would there be opportunities for smaller providers to be involved, or for smaller providers to form consortia, and would one central point of access be able to meet demand.

- The advertised programme of consultation meetings allowed for only a hour at each venue, which seemed rather short.

- The online response form gave little opportunity for non-users of NEPTS to comment on the proposals.

In response to their concerns, members were advised that:

- The CCG's Assistant Director of Communications and Engagement would be looking at the Committee's feedback and incorporating their comments, including addressing the question of the NHS website link, and the length of the consultation meetings. If experience of the first two sessions suggested it would be appropriate, the timings of subsequent sessions could be extended.

- Eligibility criteria were national and would not be changing; the consultation was about provision in Cambridgeshire and whether the right people were getting transport and how they accessed it. The intention had

been not to limit the range of people who could respond to the consultation.

- The CCG was keen to look, with the Council, at opportunities for integrating transport, and had initially approached the Council in April 2015 about this. From the Cambridgeshire Future Transport Member Steering Group meeting held on 2nd September, which a CCG officer had attended, the question had emerged, whether it would be possible for patients who were not eligible for NEPTS to book and use the service at their own expense.

- The intention was that the patient would be in control and could access and book NEPTS for themselves, but the option would be there for GPs to do the booking for patients who preferred this.

- Patients fed back that their hospital appointments did not align with when patient transport was available; it was hoped to remedy this. Electronic booking meant that it was possible to book transport and appointment together, so that appointment and transport times would fit together.

- The present service mainly provided transport to and from hospital appointments. As part of the proposed changes, the CCG was looking at bringing services out into the community, and supporting patients to travel not only to all the local hospitals but to treatment in community settings.

- Consideration would be given to building the point about equal access for all parts of the county into the service specification.

- The CCG was looking mainly at one provider managing the contract across the whole are, but this did not mean that they should not be working with voluntary organisations and smaller providers; this would be for discussion with the providers. It would be built into the procurement process that the provider would be expected to engage with current providers.

- Experience of other areas that already had similar arrangements for NEPTS in place, for example Norfolk, was that they managed the demand well.

The Chairman asked whether there was any scope for delaying the early December date for going out to procurement. He was assured that the date was not absolutely firm, and that opportunities for collaboration might emerge from conversations with district transport officers.

The Chairman thanked the CCG officer for attending the meeting and affirmed the aim of rationalising transport while saving money and providing a service that was fair to all users. He expressed concern that the present exercise touched on only a very small part of community transport, and asked that officers talk to the Committee again before going to procurement if efforts to

achieve greater integration were unsuccessful. The Director of Contracting, Performance and Delivery confirmed that the CCG was keen to maximise opportunities for public engagement and for integration, but added that it was necessary to maintain the pace of the project. The Chairman asked her to keep members informed of developments.

It was resolved unanimously to note the proposal for Non-Emergency Patient Transport Services and to note the public consultation.

EAST CAMBRIDGESHIRE DISTRICT COUNCIL

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Freepost Plus RSCR-GSGK-XSHK
Cambridgeshire and Peterborough CCG
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Clarendon Road
Cambridge
CB2 8FH

This matter is being dealt with by:

Sally Bonnett

Telephone: 01353 665555
E-mail: Sally.bonnett@eastcambs.gov.uk
My Ref:

17 November 2015

Dear Sir/Madam,

Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) for Cambridgeshire and Peterborough

Thank you for the opportunity to comment on the proposed changes to non-emergency passenger transport services (NEPTS).

East Cambridgeshire District Council acknowledges that the proposal for NEPTS to be accessed via one point of contact would result in a simpler, fairer, more transparent service where everyone is judged equally against the eligibility criteria.

However, the Council is concerned that this may result in a reduction in the number of patients who qualify for NEPTS. Combined with the expected cuts to community transport services, this could have a serious impact on patients living in rural areas such as East Cambridgeshire, where there are limited transport options for those without access to a car.

The Council seeks assurance from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) that safeguards have been put in place to protect vulnerable patients who no longer qualify and urges the CCG to monitor the number of patients who previously qualified for NEPTS but no longer do so under the new system. The CCG should commit to reviewing the eligibility criteria, giving priority to those living in rural areas, should the impact of the proposed changes to NEPTS be significant.

The Council also requests that the CCG gives serious consideration to providing more services locally to reduce the need for patients to travel long distances to access treatment.

Having a central booking point provides the opportunity to collect data on where people are travelling from and the services they access. Where the numbers are sufficient, a service should be provided locally. In addition to the advantages of this for the patient, this would also generate financial and environmental benefits.

Yours faithfully,

Cllr James Palmer
Leader of Council

John Hill
Chief Executive

Consultation Response from Fenland District Council on a future model for Non Emergency Patient Transport Services (NEPTS) for Cambridgeshire and Peterborough

Thank you for the opportunity to comment on the proposed future model for NEPTS.

As a Council we are keen to improve our links with a variety of health and social care services as we have recognised in the Council's Health and Well Being Strategy 2015 - 18 that a lot of what we do as Council core business prevents residents needing a non elective hospital admission.

Working as a partner of the new Uniting Care Partnership Integrated Care Board (ICB) for Ely and Wisbech we felt through our links with the Community and Voluntary Sector we could help improve the use of this sector to speed up hospital discharge, to be more flexible and react quicker than the current system.

The idea that is developing is to develop 2 pilot projects in the ICB area to provide out of core hours hospital transport that would link in with the Care Networks "Help at Home" service

From our conversations with various partners in developing the pilot projects we feel the following needs to be considered through the specification development of the NEPTS contract:

- The procurement should not be done in isolation. A systems approach is needed which we believe is currently being looked at by Public Health following the Joint Strategic Needs Assessment. Alongside a much more flexible and reactive NEPTS service there is a need for Workforce Development of hospital staff. The awareness of all available options by key hospital teams to get a patient out of an acute bed as soon as they are ready for discharge is crucial. For example we are not convinced that all discharge teams are aware of the Care Networks help at Home Service. Alongside the obvious importance of the discharge teams, pharmacies are also seen as having a crucial role to play to discharge a patient who is deemed fit to leave safely back to their home (even without a relative / carer readily available).

- The feeling from the Community and Voluntary Sector (CVS) that they have been excluded from offering cost efficient solutions during the current NEPTS contract period as it was not in the interests of the current NEPTS providers to be more flexible. This has resulted in patients remaining in a bed blocking situation where a days notice is needed to arrange NEPTS transport when we know a CVS solution could have been used. One piece of feedback given was that the hospital has paid for NEPTS already so cannot "double fund" another service even though that results in an extra night in hospital at a cost of hundreds of pounds when a service could have got the patient home for under £40.

- A perceived inability at the moment to secure a safe hospital discharge from 4pm to 8pm on the same day.

- The differing levels of service for NEPTS at Kings Lynn, Hinchinbrooke and Peterborough and the need for consistency.

- There are further opportunities if the contract is commissioned in a flexible way to increase the speed of flow from an acute bed at QE to a non acute bed at North Cambs Hospital.

In summary we continue to work with partners on developing 2 pilot projects in the Ely area and Fenland area whilst the new NEPTS contract is commissioned. We hope that the final specification can ensure that the current barriers in the system to prevent quick hospital discharge can be removed and ensure it offers incentives to the winning provider to be as flexible and creative as possible. This will ensure transport is not the reason for stopping a patient leaving hospital in the future.

Such flexibility is essential in meeting the challenging targets to improve 7 day hospital discharge as set out through the Better Care Fund.

FENLAND
STRATEGIC PARTNERSHIP

Fenland
CAMBRIDGESHIRE
Fenland District Council

Engagement Team
Cambs & Peterborough CCG
Via email

Cllr Simon King
Portfolio Holder for Equalities & Transport
Tel: 01354 654321
E-mail: sking@fenland.gov.uk

13 November 2015

Our Ref: TAG/Health/10.7.2

Dear Sir/Madam

Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) for Cambridgeshire and Peterborough

On behalf of the Fenland Transport and Access Group (TAG) this letter is our response to the above consultation. We welcome the opportunity to comment on this important matter.

Who is the Fenland TAG?

The TAG forms part of the Fenland Local Strategic Partnership and is a group made up of representatives from organisations that all have a key role in transport for Fenland, as policy makers, commissioners of services and service providers. By working together this group ensures that there is one transport approach for Fenland. Group members also work with the local community and use our meetings to raise issues of concern that reflect the views of residents. Transport for older people and access to health care is a key priority for our group.

The organisations who make up the TAG are Fenland District Council, Cambridgeshire County Council, Care Network, FACT, Wisbech Town Council and Stagecoach in Norfolk. Some members of the Fenland TAG are also part of the County Council Cambridgeshire Future Transport Project.

A future model for Non- Emergency Patient Transport Services in Cambridgeshire and Peterborough

The Fenland TAG has a number of issues and concerns that we would like to raise as part of this consultation. The headlines of these comments are as follows:

- We are disappointed that the consultation questions focus solely on user comments about the existing NEPTS service. As the consultation document makes clear that the CCG are looking to procure a new NEPTS contract we would have expected the consultation to also focus on this matter.

- We would like to see a comprehensive approach to the delivery of transport services including NEPTS. We would suggest that the CCG should work in partnership with Cambridgeshire County Council as part of the Total Transport project. Learning the lessons from the Total Transport project should assist the CCG to make more informed decisions about the future NEPTS contract.
- We would ask the CCG to consider the role of community transport in providing NEPTS. We would encourage you to offer community transport providers the opportunity to bid for work as part of the new NEPTS contract.
- We strongly support the commitment to provide NEPTS out of hours in the evenings and on weekends. Local transport in Fenland is very limited at these times making it very difficult for some people to access medical facilities if they need to during those times.
- The proposal for one call centre and a central booking system for NEPTS is supported by the Fenland TAG. Fairness and consistency in the application of NEPTS should be provided. A possible implication of such an approach could be that some local people are no longer entitled to NEPTS. We would want to ensure that such a decision does not negatively impact on existing local transport services, particularly community transport.

The Fenland Transport and Access Group would also welcome the opportunity to meet with the CCG to discuss these matters in more detail and to discuss how we might be able to assist you now and in the future. We would specifically welcome the opportunity to discuss comprehensive approaches to transport delivery, the use of community transport to deliver NEPTS and how the TAG might be able to assist the CCG through the promotion of transport services.

I attached a supporting document setting out in detail the main points that the Fenland TAG wish to raise as part of this consultation.

We hope that this consultation response is helpful to you. We also hope that you will take up our suggestion of a meeting and also regular meetings with your new NEPTS provider in order that we can all work together to deliver a more efficient transport service.

Should you have any further questions or queries then please get in contact with me at the above address. Alternatively you can contact Wendy Otter, Transport Development Manager at wotter@fenland.gov.uk or by telephone on 01354 622324.

Yours sincerely

Simon J. E. King

Cllr Simon King
Chairman of the Fenland TAG &
FDC Portfolio Holder for Equalities & Transport

CC: Fenland Health & Wellbeing Board Members

Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) for Cambridgeshire and Peterborough

Detailed comments from the Fenland Transport & Access Group

The Consultation and the Consultation Process

The consultation title clearly sets out that the CCG is seeking views about a future model for NEPTS. From our perspective we associate this with procurement and the design and concepts which should form part of the procurement. Your consultation document (page 6) makes clear that you will be undertaking a formal tendering process in the future because your current NEPTS contract is coming to an end. We were therefore surprised to see that the consultation questions are actually about patient experiences of the current model for NEPTS.

Whilst we accept that information about patient experiences can help to inform future models of a service, we are concerned that the questions do not allow patients and stakeholders to give a view about how the new service should be procured or designed. We are also concerned that the consultation questions do not readily enable transport providers and transport policy makers to be fully involved in the consultation process.

It is our view that the consultation questions should have enabled transport providers and practitioners to fully input into the process, providing information which could help design the future model for NEPTS. It is extremely disappointing that this has not happened.

The Procurement Process

Whilst the consultation document makes clear that the CCG intends to procure a new NEPTS contract there are no details about the approach or how the CCG intends to take forward this process. It is unclear as to whether you have had any thoughts about the procurement approaches and whether you are considering one contractor or several.

The Fenland TAG would suggest that any approach should offer patients the best choice of service. It should also offer a service that is value for money and that operates at a local level, understanding local transport needs. We would not want to see an approach where one provider operators services at arm's length. We appreciate that a procurement contract to one contractor may be easier for the CCG to manage. Should this be the model that is taken forward we would urge the CCG to ensure this provider has the ability to appoint many different providers as sub-contractors. This should then assist with the development of a comprehensive transport approach.

A comprehensive approach to transport delivery

For a number of years now the TAG has been involved in ongoing discussions with the PCT about local transport, NEPTS and the need for joined up thinking and a comprehensive approach. We are also aware of similar discussions between the PCT/CCG and other organisations such as Cambridgeshire County Council.

We welcome your consultation referring to the need for a new model for NEPTS but we are concerned that there are no references to working in partnership with others. It is our view that to achieve your objectives for the new contract around financial efficiencies, improved coordination and ensuring patients are discharged in a timely way this is essential.

To achieve value for money and make best use of the resources available it is our view that there should be one approach to transport provision including NEPTS. From work we have undertaken in the past we are aware that most patients needing transport to hospital would be capable of travelling in a range of vehicles and that they do not need an ambulance or

specialist vehicle. Local transport providers may easily be able to assist these patients to get them to hospital without the need for a specific hospital service. Where there is potential for a coordinated approach of existing and new services, an approach that is effective for the patient, that makes financial efficiencies for the CCG and assists local transport providers.

We are also aware that more recently Cambridgeshire County Council has been awarded funding for a Total Transport Project that will pilot integrated transport approaches in the Ely Area. It is our view that the CCG should take an active role in this project and ensure that the lessons learnt from this work can be incorporated into the new NEPTS service. We would like the CCG to ensure that good practice lessons from the Total Transport pilot project can be applied across Cambridgeshire including in Fenland District.

We would also welcome the opportunity to discuss with you the Doddington Hospital project. This is also a project about providing comprehensive transport for everyone. This is a potential pilot project aimed at improving transport between the market town of March and Doddington Hospital including NEPTS. We have previously had advanced discussions with the PCT about this project and we believe it offers significant potential to improve local transport to Doddington Hospital and to make financial savings of over £100,000 per year.

Partnership Working

The Fenland TAG and the local transport providers within our group would welcome the opportunity to work with your chosen contractor(s) for the new NEPTS model when they are appointed. Members of the group have significant experience of providing transport and as a group we have specific expertise about transport in the Fenland context, which is quite different to the rest of Cambridgeshire.

We also have a range of publications and information documents that we distribute to the public and key stakeholders, where we can provide additional information that can raise awareness about NEPTS and assist your provider(s).

We would welcome an opportunity to discuss this in more detail with you and to consider how we might be able to work together.

The role of Community Transport Providers to deliver NEPTS

The TAG previous involvement with the PCT has included discussions about NEPTS and specifically the potential for Community Transport providers to bid to deliver NEPTS work. Community transport meets travel needs at the very local level and is therefore often better placed than other providers to ensure transport is available quickly and easily. It is our view that community transport should be considered as part of the package of providing NEPTS.

Community Transport providers do however need to be made aware of the tendering and procurement process in order for them to decide whether to submit a bid for any work. We would ask the CCG to consider inviting community transport operators to bid for the work. We would also encourage the CCG to have discussions with community transport operators before any procurement of the new NEPTS contract is undertaken. This would help you to better understand how such providers could help the CCG and how this might be different to more conventional transport. The Fenland TAG can assist the CCG with contact details of community transport providers if this would be of assistance to you.

Providing Transport Out of hours and seven days a week

We note on page 6 of the consultation document that there is a commitment to provide transport out of hours through the new NEPTS contract. The Fenland TAG welcomes this approach which should help local people in Fenland significantly.

Local transport in Fenland is limited in the evenings and at weekends. People without access to a car have significant difficulties travelling during those hours. Any proposals which enable people who are unwell to access medical facilities at a hospital during those times are welcomed. This decision will help to address a known gap in the transport network that can have significant implications for those involved.

Proposal for a One Call Centre and Booking System including the impact of local transport providers

The Fenland TAG is fully supportive of an approach that brings together one call centre and booking system. From our ongoing work with the GP Surgeries in Fenland we are aware that the present system for arranging transport to hospitals causes confusion and is not very user friendly for patients. It is good to note that you are seeking to address this matter through the new NEPTS contract.

We would also welcome any approach that ensures fairness and consistency for people needing transport. We are aware that the system is inconsistent at present. If a central booking system is an approach which can achieve the same support for all patients across Cambridgeshire and Peterborough this is welcomed.

We would however, like to state a note of caution in this respect and also to bring to your attention the possible wider transport impacts of this approach. Whilst we note your intention not to change the eligibility criteria for NEPTS, one possible consequence of this is that some patients will no longer receive NEPTS. This will have implications for other transport providers and in the Fenland District context this is most likely to impact on the community transport providers which are FACT and the community car schemes. These schemes are already very busy and at certain times have capacity issues.

In 2012 the Fenland TAG was in discussion with the PCT about promoting transport. This linked with a reissue of the PCT Patient Transport Pack to GP Surgeries. This pack provided advice about booking NEPTS and stated the criteria for its use. The criteria did not change from the previous pack. The impact of the PCT reminding the GP Surgeries about their NEPTS obligations was that some patients were no longer eligible for the transport. In the months after the new packs were launched FACT and the Community Car Schemes reported a significant increase in members of the public needing their services. This put excessive pressure on the community transport system in Fenland. We would not want any approach for a new call centre to impact on community transport services in Fenland that are already stretched. We would again welcome the opportunity to discuss this with you in more detail and also to work together to address such issues in a more integrated way.

One role of the Fenland TAG is to try and address local transport needs and we achieve this through a range of methods. We would not want to see local residents struggling to access medical appointments if they can no longer access NEPTS. We would therefore welcome any new call centre also providing information about other forms of local transport. We think it is important that any call centre is able to sign post people towards transport that is available that might be able to meet a patient's needs. We do would however, want to work with you to ensure that this is planned and coordinated as detailed above.

MINUTES OF A MEETING OF THE SCRUTINY COMMISSION FOR HEALTH ISSUES HELD IN THE BOURGES / VIERSEN ROOMS, TOWN HALL ON 17 SEPTEMBER 2015

Present:	Councillors B Rush (Chairman), J Stokes, K Aitken, A Shaheed, R Ferris and J Knowles	
Also present for item 5 only	The following members of the Creating Opportunities & Tackling Inequalities Scrutiny Committee: Councillors B Saltmarsh, J Yonga, C Harper	
Also present	David Whiles	Healthwatch
	Mark Sheppard	Head of Supplier Management Specialised Commissioning, NHS England
	Geraldine Ward	General Manager Renal and Transplant, University Hospitals of Leicester
	Dr Graham Warwick	Consultant Nephrologist, University Hospitals of Leicester
	Sandy Lines MBE	East Midlands and East of England Advocacy Officer, British Kidney Patient Association
	Dr Kleeman	Clinical Lead, Renal Service at Peterborough City Hospital
	Stephen Graves	Chief Executive of Peterborough and Stamford Hospitals NHS Foundation Trust
	Mike Exton	Chairman of Peterborough Kidney Patients Association
	Kyle Cliff	Assistant Director Commissioning & Contracting Borderline and Peterborough, Local Commissioning Group
	Keith Spencer	Chief Executive Officer, UnitingCare Partnership
	Tracy Cannell	Chief Operating Officer, UnitingCare Partnership
	Jessica Bawden	Director of Corporate Affairs, C&PCCG
	Hani Mustafa	Youth Council Representative
	Oliver Sainsbury	Youth Council Representative
Officers Present:	Dr Liz Robin	Director of Public Health
	Wendi Ogle-Welbourn	Corporate Director, People and Communities
	Lee Miller	Head of Commissioning, Child and Adult Mental Health Services
	Paulina Ford	Senior Democratic Services Officer

1. Apologies

Apologies were received from Councillor Francis Fox.

2. Declarations of Interest and Whipping Declarations

There were no declarations of interest or whipping declarations.

3. Minutes of Meetings Held on 21 July 2015

The minutes of the meetings held on 21 July 2015 were approved as an accurate record.

4. Call-in of any Cabinet, Cabinet Member or Key Officer Decisions

There were no requests for Call-in to consider.

5. Children in Care: Health Outcomes, Emotional Health and Wellbeing Pathway

The report was introduced by the Corporate Director for People and Communities; also in attendance was the Head of Commissioning, Child and Adult Mental Health Services. The report provided the Commission with an update on the following:

- Latest statutory guidance regarding how the health needs and outcomes for Children in care (Children Looked After (CLA)) should be addressed.
- How the health team for CLA were identifying and meeting their needs.
- Current issues with Child and Adolescent Mental health (CAMHS) services and the emotional health and wellbeing pathway and how these were being addressed.

Observations and questions were raised and discussed including:

- Members sought clarification regarding the temporary closure of the waiting lists for Autistic Spectrum Disorders and Attention Deficit Hyperactivity Disorder referrals. *Members were informed that the residual group of people already on the waiting list was reducing. The waiting list was closed to enable new people to be seen in a more timely way.*
- It was noted that there were several transformation programmes and requested a timeline of all the different programmes.
- Who was looking at how mental and emotional health needs were responded to strategically in the longer term? *Members were informed that work was being done with parent carer groups and young people to identify their needs to be supported emotionally. Parent carers have said that it would be helpful to be in groups with other parents with professionals who could help them in terms of how they could talk to and manage some of the behaviours of their children. Consideration was therefore being given to a range of parenting programmes across the city that parents could attend for children with emotional and neurological difficulties. If support was provided at an early stage it was possible that not all children would need to be referred to specialist CAMHS services. It had also been identified that schools were in a position to identify at an early stage if a child needed support. Training to identify and recognise early stages of emotional behaviour was therefore being arranged for schools through the Pupil Referral Unit. Three psychiatric nurse posts had also been funded to go into schools to work with teachers to help them identify and address issues early.*
- If a child in care was displaying emotional behaviour where would they fit on the waiting list? Would they become an emergency? *Members were informed that the council did employ their own LAC psychologist. Difficulties arose if they required a particular type of treatment with a waiting list. They therefore would be part of the waiting list even though they had initially been seen as a priority.*
- Had there been any consideration given to putting on internet training courses for parents on how to deal with their disabled children and how to identify their children's disabilities. *Members were informed that there was e-learning for teachers but not sure if there was any available for parents. Parents did have access to a website called 'Local Offer' which provided support and services for children and young people with special educational needs or disabilities and their families.*

- Members responded that parents with disabled children often did not have time to access the internet. It would be more beneficial for social workers when visiting a family to signpost parents to services that they could access. *Members were advised that social workers would soon have access to a chrome book which would enable them to access the internet when visiting families and show them what services were available.*
- Was dentistry included under health outcomes for Looked after Children? *Members were advised that this was included and it was a performance indicator now being reported to the Corporate Parenting Panel.*

ACTIONS AGREED

The Commission noted the report and requested that the Corporate Director, People and Communities provide the following:

1. A timeline of all the different transformation programmes.
2. Investigate if there are any e-learning courses available for parents on how to deal with their disabled children and how to identify their children's disabilities.

At this point Councillors Saltmarsh, Yonga and Harper left the meeting.

6. Peterborough Renal Haemodialysis Capacity

The report was introduced by the General Manager Renal and Transplant, University Hospitals of Leicester. The purpose of the report was to brief the Commission on the tender process to provide renal dialysis services for patients in Peterborough. Members were informed that the objectives were:

- To repatriate approximately 30 displaced patients currently receiving dialysis at Lincoln, Leicester and Kettering;
- To make sure that the largest number of patients possible have access to local facilities;
- To meet national standards - Patients should travel less than 30 minutes of their home to access haemodialysis (i.e. repatriate displaced patients and reduce increased travel costs circ); and
- To provide and facilitate the delivery of high quality and most cost-effective care for the users.

Members were informed that University Hospitals of Leicester had been working closely with Peterborough City Hospital throughout the last year and a decision had been made to work outside of the tender framework to allow Peterborough City Hospital to bid for the tender.

Graham Warwick, Consultant Nephrologist, University Hospitals of Leicester also in attendance gave an overview of the dialysis service and informed Members that the priority was to provide a better service for Peterborough patients using the service.

Following the introduction the Chairman invited Stephen Graves, Chief Executive of Peterborough and Stamford Hospitals NHS Foundation Trust, Dr Kleeman, Clinical Lead Renal Service and Peterborough and Stamford Hospitals NHS Foundation Trust and Mike Exton, Chairman of Peterborough Kidney patients Association to address the Commission.

Dr Kleeman made the following points:
- The right decision was to bring patients back to Peterborough to receive their treatment so that they no longer had to travel.
- Patients surveyed agreed that the right solution would be to have the unit based at the existing dialysis unit at the Peterborough hospital site and supplemented with a smaller unit.

- Patients felt that by having a dialysis unit on the hospital site gave them the advantage of having a clinician on site if needed. This would also mean less admissions to A & E and less visits to their GP's.
- The solution also needed to be suitable to the nursing staff. Unless they were in agreement it could be difficult to retain the existing staff and recruit new staff.

Stephen Graves made the following points:

- Strategically bringing the patients back to Peterborough so they no longer had to travel to receive treatment was the right decision.
- Peterborough City Hospital had a fantastic facility but at a high cost per square metre. Moving a facility out of the hospital would mean vacant space with continued overhead costs. This would increase the cost to the NHS. The preferable option would therefore be to keep all the services on site with a smaller supplementary facility just across the car park.
- A better service could be offered to patients if clinicians were at the same site as the dialysis unit.
- Concerned that there will be a change in service but no consultation had been held.
- Supportive of the direction of travel and had been working with colleagues to try and find a solution on site at the hospital.

Mike Exton made the following points:

- He had been a patient on renal dialysis for six years, travelling from Stamford to Kettering for treatment returning home anytime between 10.30 and 11.00pm in the evening.
- Patients who worked full time found travelling to treatment an extra burden on their time.
- Three patients had to travel from Peterborough to Kettering for the dialysis twilight shift which started at 5.00pm and finished approximately at 11.00pm. If there had been a delay on any of the previous shifts this would cause a delay in the twilight shift making it even later for people to travel home to Peterborough.
- Dialysis helped people to live as normal life as possible but travelling to Kettering to the dialysis unit put a strain on people physically. Moving the 30 patients back to Peterborough would be a great help to the patients who did work as well as those who did not.

Observations and questions were raised and discussed including:

- Members were informed that the hospital was currently in the middle of the tender process and bids would close on 27 September 2015. Evaluation of the bids would take place at the beginning of October the results of which could be brought back to the Commission.
- Was the current dialysis unit staffed by University Hospitals of Leicester staff and would the new unit continue to be staffed by them. *Members were advised that the current staff would continue to staff the new unit. The staff from the University Hospitals of Leicester already worked very closely with the staff at the Peterborough Hospital site.*
- Had the costs increased at Peterborough Hospital since University Hospitals of Leicester had started a dialysis unit at Peterborough. *The General Manager Renal and Transplant responded that she did not have that information. The Chief Executive of Peterborough and Stamford Hospitals NHS Foundation Trust also responded advising that hospital costs had risen in line with the Retail Price Index and this was then passed on as part of any rental costs.*
- Members sought clarification as to why the Scrutiny Commission had not been consulted on the Stage One tendering process even though Peterborough patients had been involved. *Members were informed that those present at the meeting were clinicians and therefore did not have that information and would have to speak to Senior Management as to why the Scrutiny Commission had not been part of the consultation process.*
- Head of Supplier Management, Specialised Commissioning, NHS England further responded that the Stage One tendering process had been looked at as primarily for the patients of Northamptonshire. There had been an oversight in the process in not recognising that some patients from Peterborough had been affected.

- Members referred to paragraph 3.9 in the report and sought clarification regarding Lots 1 and 2 and asked if bidders could tender for both. *Members were informed that they could bid for either Lot 1 or Lot 2.*
- If patients had to travel would they rely on transport from the Clinical Commissioning Group or would they have to find their own transport. *Members were informed that there was a clinical criteria for the provision of transport and if the patient met that criteria they would be provided with patient transport even though they were within the six mile radius.*
- Members referred to paragraph 5, Consultation and the statement *"Feedback indicates that the overall UHL haemodialysis patent experience is very good*". Members asked for evidence of this. *Members were advised that patient experience feedback could be provided as evidence. Verbal feedback had also been obtained from one to one individual meetings with Peterborough patients at the Corby Dialysis Unit. All patients fed back verbally both to the nursing and medical staff at the dialysis units.*
- Sandy Lines, East Midlands and East of England Advocacy Officer, British Kidney Patient Association was in attendance and further responded that she visited all of the dialysis units periodically and talk to all of the patients. Patients have advised that they were very happy with their treatment. Patients were asked if they would prefer to remain at the same unit, have a bigger unit or have an additional smaller unit on the same site as the existing Peterborough site. Patients had overwhelmingly stated that they wished to stay at the Peterborough site.
- What sort of consultation had taken place with the patients? *The Advocacy Officer advised Members that there was no formal consultation and it had been done on a one to one basis through an informal chat as people tended to speak more freely.*
- Members asked the Chief Executive of Peterborough and Stamford Hospitals NHS Foundation Trust if it was the intention to have a dialysis unit within the hospital and an additional purpose built building on the hospital site or just a purpose built building outside of the hospital to accommodate all of the dialysis patients. *The Chief Executive responded that the present facility within the hospital would remain which catered for the existing 90 patients. There would then be an additional smaller unit on the other side of the car park to provide additional dialysis for the remaining 30 patients to enable them to come back to Peterborough. This would therefore be Lot 1.*
- How will the patient consultation views be factored into the tender process and the decision made. *Members were advised that as part of the evaluation process patient feedback was taken into account. The evaluation would be 60% quality and 40% finances.*

The Chairman asked Members if they would agree to support the tender process to provide renal dialysis services for patients in Peterborough. The Commission unanimously agreed to support the tender process.

The Chairman proposed that a recommendation be put forward to support Lot 1, the provision of a Small Renal Dialysis Managed Service Satellite Unit which would provide extra capacity for patients in Peterborough and that it be built near to the existing Renal Dialysis Ward at Peterborough City Hospital. The Commission unanimously agreed to support the recommendation.

RECOMMENDATION

The Commission AGREED to support the tender process to provide renal dialysis services for patients in Peterborough and AGREED to support the Lot 1 proposal of a Small Renal Dialysis Managed Service Satellite Unit which would provide extra capacity for patients in Peterborough. The Commission recommends that the additional unit be built near to the existing Renal Dialysis Ward at Peterborough City Hospital.

ACTION

The Commission requested that the University Hospitals of Leicester report back to the Commission on the outcome of the tender process when completed.

7. Proposal for Non-Emergency Patient Transport Services

The report was introduced by Director of Corporate Affairs, C&PCCG. The report provided the Commission with an introduction to the proposal for Non-Emergency Patient Transport Services and the public consultation document. The Assistant Director Commissioning & Contracting Borderline and Peterborough, Local Commissioning Group was also in attendance and provided further information and context to the Commission on the proposal.

Observations and questions were raised and discussed including:

- Members noted that the public meetings were all in the daytime and asked why none were being held in the evening. *Members were advised that historically attendance at evening meetings had been very low. Invitations had therefore been sent out to voluntary organisations and housing associations to ask if they would like someone to attend one of their local meetings. These would be in addition to the formal public meetings being held.*
- A member of the Youth Council asked how much money would be saved by recommissioning the service. *Members were informed that the current spend on patient transport was £6.5M. It was not know at this stage how much could be saved but the economies of scale should provide a saving. Members were also advised that the eligibility criteria would not change and therefore all patients currently eligible for transport would continue.*
- How would the patient transport service work with Peterborough City Council? *Members were informed that this had not been discussed as part of this particular procurement exercise as there was a need to move quickly as the current contracts were not fit for purpose. Any feedback through the consultation process that identified this as an issue would be taken into account.*
- Members noted that there appeared to be different call centres set up for each service. Would these be located in one building and using the same staff? *Members were informed that there had been a suggestion to use the 111 number for all calls or to use a new number as the point of contact. This would be for the provider to decide but any feedback through consultation would be taken into account.*
- Had consideration been given to the type of staff that would be employed to drive the transport and if they should be trained in first aid in case of emergencies. *Members were informed that this would become part of the contract with the provider. The level of vehicles used would range from use of volunteer car drivers to transport people to appointments to the use of ambulances. The level of training required would vary across the category of vehicle and the provider would need to take this into account.*

ACTION AGREED

The Commission noted the proposal for Non-Emergency Patient Transport Services and the public consultation.

8. UnitingCare Partnership – Quarterly Report

The report was introduced by the Chief Executive Officer and provided the Commission with an update on the UnitingCare Partnership. Members were provided with the following additional information:

- There were approximately 165,000 older people across Cambridgeshire and Peterborough;
- Last year around 20,000 older people had an emergency admission to hospital and of those 20,000 approximately 350 patients accounted for about 10% of the spend, 900 patients accounted for 20% of the spend and 3500 patients accounted for 50% of the spend of those admissions.
- UnitingCare was aiming to reduce admissions to hospital over the next two years by 19% and attendance at A & E by 20%.

Observations and questions were raised and discussed including:

- Members commented that people who lived on their own who were admitted to hospital had to be assessed before they could go home. Did this mean that they sometimes stayed in hospital longer than was necessary? *Members were informed that the assessment process needed to happen at the right point in time to understand correctly what the needs were for that person before returning home. Sometimes discharges were delayed because the right care package was not in place. UnitingCare would look at providing the assessment at the right time to better plan the persons return home.*
- Members were concerned that families were often not consulted regarding the discharge of patients and that appropriate follow up with families of the patient had not been provided. *Members were advised that this had sometimes been an issue and that UnitingCare were looking at how they could support the development of each care plan which would involve the patient and the people the patient would like involved as well. A good care plan identified all the key people that would need to be involved including such organisations as Cross Keys. Support for carers and family members would also be looked at. Work was being done by the Wellbeing Services on how to help patients, carers and family members navigate the care system and healthcare services.*
- How were the different service developments progressing in the rest of Cambridgeshire compared to Peterborough. *Members were informed that the Joint Emergency Team (JET) had been very successful as had the Hospice at home service which was specific to Peterborough. Peterborough was keeping pace with the rest of Cambridgeshire.*

Members of the Youth Council left at this point.

- Was there any reason why some care homes had more admissions to hospital than others? *Members were informed that there was a mixture of reasons. Some care homes looked after patients with more complex needs and therefore were likely to have more admissions to hospital and there were a few care homes with some management issues.*
- Regarding A & E and discharges, did UnitingCare receive good support from Peterborough City Hospital? *Members were advised that the hospital provided good support and worked collaboratively with UnitingCare.*
- Members asked if the challenge that UnitingCare had taken on when gaining the contract had been bigger than expected. *Members were informed that the challenge had been as expected but the bigger challenge had been getting organisations to work together.*
- Members sought clarification on what the new community led approach to the front door of the A & E department would look like. *Members were informed that UnitingCare were looking at what could be done to support people so that they did not need to go to A & E. Often patients ended up in hospital because there was no confidence that they could be supported at home, so the aim was to ensure support could be put in place quickly if clinically the patient was able to go home.*

The Chairman thanked the officers for attending and providing an informative report.

ACTION AGREED

The Commission noted the report.

9. Forward Plan of Executive Decisions

The Commission received the latest version of the Forward Plan of Executive Decisions, containing Executive Decisions that the Leader of the Council anticipated the Cabinet or individual Cabinet Members would make during the course of the following four months. Members were invited to comment on the Forward Plan of Executive Decisions and, where appropriate, identify any relevant areas for inclusion in the Commission's work programme.

ACTION AGREED

The Commission noted the Forward Plan of Executive Decisions.

10. Work Programme 2015-2016

Members considered the Committee's Work Programme for 2015/16 and discussed possible items for inclusion.

The Director of Public Health advised the Commission that the Health and Wellbeing Board Strategy would go through a drafting process and would be available for consultation between December and March 2016. It was therefore suggested that the Health and Wellbeing Board Draft Strategy item listed for the November agenda be moved to January 2016. The Commission agreed to this change.

ACTION AGREED

To confirm the work programme for 2015/16 and the Senior Governance Officer to include any additional items as requested during the meeting including moving the Health and Wellbeing Board Draft Strategy from the 5 November meeting to 13 January 2016 meeting.

The meeting began at 7.00pm and finished at 8.55pm CHAIRMAN

Borderline Local Commissioning Group
Improving Healthcare for our Community

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12th Novemeber 2015

MaryAnn Watson
Contract Support Manager
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Huntingdon
PE29 3TN
(sent by email)

Dear MaryAnn

Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) for Cambridgeshire and Peterborough

Please find feedback on behalf of the Peterborough SRG in response to the Non-Emergency Patient Transport Services consultation. For clarity, the headings provided in the consultation document have been used as a framework for response

What needs to change
"The consultation document specifies that the new contract will help to make sure that patients are discharged from Hospital in a timely way, so that they do not have to wait a long time for transport"

SRG repsonse:
The consultation does not make it clear if the new contract will require the new single provider to respond to 'on the day' requests
The new contract must be very clear on this point and ask the new provider how they intend to deliver this seven days a week

The SRG asks that the following are considered in the development of the spcification:

1. The task and finish group under the SRG have been exploring possible temporary solutions ahead of the new contract. Whilst it hasn't been possible to pursue these, the SRG would like to see a specification that allows innovative solutions that maximise the use of different vehicle types to meet demand in cost effective ways. Does the developing specification allow for these types of arrangements?

2. Will the role of the third sector in supporting discharges/transport be considered within the specification?

3. Will learning from improvements to the current provision to increase patient flow to services earlier in the morning for non-urgent journeys be part of the specification? This enables patients to be assessed and return home the same day which releases bed capacity and keeps patient flow which is essential in the PSHFT model to

support the Ambulatory Care Unit and the Medical Assessment Unit. The SRG considers this to be an important element within the specification

4. **'On the day' transport requests:**
   We must ensure that the providers don't use the availability of on the day provision for any other reason than intended. Clear criteria about when this situation applies are needed.
   Activity models need to be responsive to changing developments in the model of care throughout the life of the contract

5. **the relationship between care providers and transport providers**
   Thought needs to be given to how the services relate. How hospital/community and the transport provider manage advance warning of actual and potential delays on the day of transportation/discharge and ensure that wards are feeding discharge information in to the provider.

Yours sincerely

Simon Pitts
Urgent Care Lead Peterborough

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South Cambridgeshire District Council

Ms Sarah Prentice
CCG Engagement Team
Cambridgeshire and Peterborough CCG
Lockton House
Clarendon Road
Cambridge
CB2 8FH

Our ref: NEPTS Consultation
Your ref:
19 November 2015

Health and Environmental Services
Contact: Clare Gibbons
Email: clare.gibbons@scambs.gov.uk
Direct dial: 01954 713290

Dear Ms Prentice

Consultation on a future model for Non-Emergency Patient Transport Services (NEPTS) for Cambridgeshire and Peterborough

South Cambridgeshire District Council is represented on the Cambridgeshire Future Transport Steering Group led by Cambridgeshire County Council; the engagement of the CCG's representative with this advisory group was useful in arriving at our response to this consultation.

We recognise the drivers to bring the disparate contracts which currently deliver the NEPTS provision together, however it would appear that the contribution made by Community Transport operators in providing current NEPTS has not been adequately quantified. We contend that there should be scope for a single provider to work with Community Transport operators to deliver future NEPTS.

We understand there is a willingness on the part of the CCG to explore a single more comprehensive booking and scheduling system, as opposed to the minimum measure proposed in the model, i.e. signposting to specific community transport providers where eligibility criteria are not met. We hope that this will be reflected in the tender specification.

We would also suggest that the CCG be mindful of the County Council's Total Transport Pilot and alive to its potential to improve transport services whilst achieving cost savings and efficiencies for both the county council and the CCG – it is hoped that the CCG will engage fully with this pilot and that lessons learnt can be brought to bear within the lifetime of the NEPTS contract.

Yours sincerely

C. Gibbons

Clare Gibbons
Development Officer

Agenda Item No: 12

HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

To:	**HEALTH COMMITTEE**
Meeting Date:	**12th May 2016**
From	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To inform the Committee of the activities and progress of the Committee's working groups since the last Committee meeting.**
Recommendation:	**The Health Committee is asked to:**

1) **Note and endorse the progress made on health scrutiny through the liaison groups and the schedule of liaison meetings (Appendix A)**

2) **Review the membership lists for each liaison group including the use of reserve members.**

3) **Include the possible consultation on Hinchingbrooke Healthcare Trust collaboration with Peterborough & Stamford Foundation for the September forward agenda.**

	Officer contact:
Name:	Kate Parker
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Tel:	01480 379561

1. BACKGROUND

1.1 The purpose of this report is to inform the Committee of the health scrutiny activities that have been undertaken or planned since the committee last discussed this at the meeting held on 10th March 2016.

1.2 This report updates the committee on the joint liaison meeting with Cambridgeshire & Peterborough Clinical Commissioning Group (CPCCG) and Cambridgeshire Healthwatch, Cambridgeshire & Peterborough Foundation Trust (CPFT), Cambridgeshire University Hospital Foundation Trust (CUHFT) and Hinchingbrooke Healthcare NHS Trust. Further liaison meetings and working groups scheduled are detailed in Appendix A.

1.3 Liaison group meetings are precursors to formal scrutiny working groups. The purpose of a liaison group is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under their scrutiny function. It also provides the organisation with forward notice of areas that Health Committee members may want further information on or areas that may become part of a formal scrutiny.

2. MAIN ISSUES

2.1 Liaison Meeting with Cambridgeshire & Peterborough Clinical Commissioning Group & Healthwatch

2.1.1 The liaison group members in attendance were Councillors, Clapp, Jenkins & district councillor Ellington. Apologies were received from Cllr Orgee. A meeting was held on 14th April 2016 with Jessica Bawden (Director of Corporate Affairs) from Cambridgeshire & Peterborough CCG, Val Moore (Chair) and Sandie Smith (CEO) of HealthWatch Cambridge.

2.1.2 The CCG provided an overview of progress made on their Sustainability & Transformation plan and comments were made in regards to ensuring two way communication channels were indicated for information coming from and to the Health & Wellbeing Board. Areas of focus were listed as:-

- Sustainable General Practice
- Proactive Care & Prevention
- Urgent & Emergency Care
- Maternity & Neonatal care
- Children & Young People

The CCG informed members of the design principles that have been developed which should be considered when proposals for service changes are drawn up.

- High quality care
- Integrated care
- Right care, right time

- Right place
- Minimise inequality
- Maximise value for the tax payer

2.1.3 The CCG are working towards the national timetable to have the plan developed by the end of June 2016. It was agreed that the CCG would provide Health Committee members with a further workshop in June 2016 to discuss the final plan prior to its submission on 29th June 2016 and to review the proposed pre-engagement plan process which will be tested over summer 2016.

2.1.4 The CCG briefed members on the forthcoming Community In-Patient Bed Review and intermediate care provision across the system. There are proposals to bring this review to the Health Committee meeting in May for further discussion.

2.1.5 The CCG's turnaround position was discussed and the need to cut £1.7 million that results in difficult decisions that the organisation still has to decide upon. In addition the anticipated national Vanguard funding that was identified to alleviate some of the pressures in the health care system was significantly less than first anticipated.

2.2 Healthwatch Cambridgeshire Updates

2.2.1 Healthwatch Cambridgeshire & Healthwatch Peterborough in partnership with Cambridgeshire County Council and Peterborough City Council are planning a learning event in May to review the recommendations from the current published reviews from the CCG and NHS England on the termination of the Older People and Adults community services contract (OPACS). The learning event aims to also look at emerging plans for service organisation. Healthwatch were invited to update the committee on the event at the May meeting as an introduction to the OPACS scrutiny item.

2.2.2 Healthwatch have commissioned a Gypsy and Traveller Health Project report that was launched at an event in March for providers, commissioners and service users. The report is available from the website and the following link

http://www.healthwatchcambridgeshire.co.uk/news/local-decision-makers-sign-improve-care-gypsies-travellers

2.2.3 Healthwatch have had a youth worker post to support community engagement and the funding for the continuation of this post was in question. Healthwatch have now secured some joint funding from CCC, Peterborough City Council and the CCG to continue with a part time post.

2.3 Liaison meeting with Cambridgeshire & Peterborough Foundation Trust (CPFT).

2.3.1 The liaison group members in attendance were Councillors Jenkins, Orgee and Sales. A meeting was held on 18th April 2016 with Aidan Thomas (CEO) and Deborah Cohen (Director of Service Integration).

2.3.2 The Health Committee members requested an update from CPFT on how the organisation was managing the integrated care aspects of the OPACS contract that was within CPFT's remit. CPFT noted that the merging the Older People's team with the Mental Health teams so the teams are integrated. The new workforce will require some organisational changes around agile working to support further integration.

CPFT noted that there is an expectation to maintain and deliver on the following:

- Neighbourhood teams (x16)
- Integrated Care Teams (X4 locality bases)
- Joint Emergency (JET)

The JET is not working the original commissioned hours but this is due to an analysis of demand and adapting the service as a result of this intelligence. The key aspect of UCP contract was admissions avoidance which could be achieved via the JET and case management. CPFT reported that some key parts of the model were missing and they estimated that performance would be about 20% of admission avoidance. There was evidence that the JET team were having an impact but there are constraints now whist there is no impact on patient care the model has gone as far as it can. UCP had set up systems where analysis of admissions from neighbourhoods and practices was enabling a focus for case management. Whilst the data is available the analysts have now gone as part of the contract termination. Funding restrictions were reported i.e. the system was expecting £6million national vanguard funding which has now reduced to £1.5 Million.

2.3.3 Service User Figures

It was reported at the Health Committee meeting on 21st January *"The chief executive said that CPFT had about 15,000 service users at any one time across Cambridgeshire & Peterborough"*. CPFT provided to the liaison meeting a further breakdown of service user figures as requested. For March 2016 15,317 service users were seen and the service breakdown is as follows:

- Adult Services – 7,399
- Children's Services – 2,021
- Integrated Care RiO – 4,022
- Specialist Services – 1,875

2.3.4 Update on Future Service Consultations

CPFT reported that there were no planned consultations and such consultations would probably be led by CCG as the commissioning organisation. Learning disabilities and funding for community support & community hospital beds was raised as an area of concern by CPFT. Councillors were offered the opportunity by Aidan Thomas to visit some of CPFT sites.

2.3.5 Update on Children & Adolescent Mental Health Services (CAMH)

As reported at the January 21st Health Committee meeting the CAMH services issues have been resolved with additional funding from the CCG. The waiting lists are now within the new guidelines of 18 weeks.

The ADHD pathway was the only pathway closed as not a life threating condition and triage was put in place for families i.e. group of consultant medical staff reviewed case referrals and urgent cases were seen within 2 weeks. ADHD pathway is now open but this a different pathway with new arrangements including support from schools, third sectors and other health professionals e.g. Speech & Language therapists. Consequently this investment and new pathway should prevent a recurrence of the situation.

2.3.6 CPFT were asked about their three organisational priorities for this year.

- Capacity of adult mental health services given population growth.
- Continuation of Older Peoples and Adult Community Services integrated model.
- Internal cost-improvement programme.

2.4 Liaison meeting with Cambridge University Hospitals NHS Foundation Trust (CUHFT).

2.4.1 The liaison group members in attendance were Councillors Jenkins and district councillor Ellington. Apologies were received from Councillors Hudson and Orgee. A meeting was held on 20th April with Roland Sinker (CEO) and Kate Lancaster (Director of Corporate Affairs) from CUHFT.

2.4.2 Roland Sinker noted that the quality issues identified in the Care Quality Commission (CQC) inspection are largely addressed. Key issues still remain around clinical governance and cultural changes in leadership. The CQC are due to provide an update report on Friday 22nd April and a full inspection is scheduled for September 2016.

2.4.3 The trust has a £75 million deficit in 2015/16 and whilst exceeding its plan for delivery of Cost Improvement Programmes (CIPs) for 2015/16 the current years target is challenging £49 million where £11 million is still to be identified.

2.4.4 CUHFT are facing challenges with continuing pressure on the Emergency Department with increased attendances and the ongoing need for suitable alternative options in the community. Demand is high in A&E and the changes in the demand are not understood but it is becoming a national issue.

2.4.5 Delayed Transfer of Care (DTOC) are still an issue but CUHFT are working in partnership having recently met with the Tracey Dowling (CEO) CCG and Adrian Loades (Executive Director Children, Families & Adult Social Care) CCC, to develop approaches and work on ensuring resilience is in the system for winter pressures 2016.

2.4.6 It was agreed that the Health Committee in order to hold the system into account would receive the CEO monthly report to the Board of Directors. Further indictors were discussed around number of A&E referrals, Length of stay (i.e. all elements of care) and DTOC.

2.4.7 E-hospital update

It was reported that EPIC was now in a stable position and the focus was now to get the quality benefits out of the system as first anticipated. A pilot programme on "My Chart" is being rolled out allowing a selection of patients access to their records. Data quality improvements are evident so it is feasible to start getting payment by results because the quality of information into the system allows accurate return and provides transparency on activity and budgeting. Issues identified by CQC i.e. back log of change requests are being addressed.

2.4.8 Major Project Updates

- Papworth – continuing to work closely with Papworth Hospital relating the relocation and how best this works for both hospitals.
- The Forum – The trust is working with partners and regulators with respect to this development

2.4.9 Junior Doctors' Strike

CUHFT informed councillors of the contingency plans in place to address any issues and pressures as a result of the forthcoming strike action at the end of April. A major incident room will be set up and the approach has been on a service by service basis to identify resources and calling on senior doctors. Potential closures are likely and it was agreed that any early information would be passed onto the committee. The key focus is a redeployment to A&E where necessary.

2.5 <u>Liaison meeting with Hinchingbrooke Health Care NHS Trust.</u>

2.5.1 The liaison group members in attendance were Councillors Jenkins, Orgee and Wisson. Apologies were received from Councillors Ashcroft, David Brown, Peter Brown and district councillor Ellington. A meeting was held on 21st April with Alan Buns (Chairman), Cara Charles-Barks (COO and Deputy CEO) and Catherine Hubbard (Medical Director). Apologies were received from Lance McCarthy (CEO).

2.5.2 The Trust reported back on progress since the CQC inspection in September 2015. Issues still existed for Emergency Department with problems to recruit transition leadership in the department. New governance arrangements were in place but had not been implemented long enough at point of inspection. CQC will be returning for a further inspection of the Trust on 10-12th May 2016. Issues with staff recruitment specifically in the emergency department were discussed and the Trust reported that they now have 3/5 permanent consultant posts. Access to locums via CUHFT would support completing these gaps.

2.5.3 Collaboration with Peterborough& Stamford Foundation Trust & Hinchingbrooke Hospital was discussed in the context of a sustainable future for Hinchingbrooke. It was noted that difficulties the trust has to maintain specialities in a smaller hospital. The Hinchingbrooke Hospital Board will hold their board meeting in public on 23rd May at 11.00am to discuss the outline business case in regards to the collaborative working proposals. The next stage would be the development of a full business plan with a potential eight week public consultation starting in September 2016. The timescales are tight due to the developing work around the Sustainable & Transformation plan across the Cambridgeshire HealthCare System.

2.5.4 Recruitment and staffing issues were discussed and the Trust reported that in September 2015 they had more joiners than leavers to the organisation. The Trust reported a 10% vacancy rate and that a successful recruitment drive for nurses in the Philippians had recently taken place. There are plans to rebuild staff accommodation to help with recruitment.

2.5.5 The trust shared their plans to alleviate potential pressures from the expected Junior Doctors strike on 26/27th April 2016. Some elective work will stop to release anaesthetists for emergency operations.

3 LIAISON AND WORKING GROUP MEMBERSHIP ARRANGEMENTS

3.1 Membership of Liaison Groups

A schedule of meetings for 2016/17 has been set up and details are available in Appendix A.

It was also agreed that the Chairman/woman and Vice-Chairman/woman serve on all three liaison group, and all Members of the Committee be invited to attend liaison meetings. Core membership of the liaison meetings has been established for CCG, CPFT and CUHFT.

<u>Cambridgeshire & Peterborough Clinical Commissioning Group (CPCCG) & Health Watch Liaison group</u>

Current core membership Councillors: Orgee, Jenkins and Sales with district council representation from Councillor Ellington

With Councillor Clapp as an additional member

Date of next meeting: 21st July 2016

<u>Cambridgeshire & Peterborough Foundation Trust (CPfT) Liaison Group</u>

Current core membership Councillors: Brown, Orgee, Jenkins, Sales, Scutt and van De Ven

With Councillor Topping as an additional member

Date of next meeting 14th June 2016

Cambridge University Hospital NHS Foundation Trust (CUHFT)

Current Core membership Councillors: Clapp, Ellington, Hudson, Jenkins, Orgee and Topping.

Date of next meeting 24th June 2016

Hinchingbrooke Healthcare NHS Trust Liaison Group

Current Core membership Councillors: Peter Brown, Orgee, Jenkins and Wisson

With Councillors Ashcroft, David Brown, Ellington and Topping as additional members.

Date of next meeting: 20th July 2016

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

Working group activities will involve staff resources in both the Council and in the NHS organisations that are subject to scrutiny.

4.2 Statutory, Risk and Legal Implications

These are outlined in a paper on the Health Committee powers and duties, which was considered by the Committee on 29th May 2014

4.3 Equality and Diversity Implications

There are likely to be equality and diversity issues to be considered within the remit of the working groups.

4.4 Engagement and Consultation Implications

There are likely to be engagement and consultation issues to be considered within the remit of the working groups.

4.5 Localism and Local Member Involvement

There may be relevant issues arising from the activities of the working groups.

4.6 Public Health Implications

The outcomes from the activities of the working groups are likely to impact on public health

Source Documents	Location
None	

HEALTH COMMITTEE SCRUTINY MEETING PLAN 2016/17

		2016											2017				
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
FULL COUNTY COUNCIL					10		19			18		13		21 [24]	28		23
HEALTH AND WELLBEING BOARD	14		17		26		7		15		17		19		30		1 June
HEALTH COMMITTEE	21	[18]	10	[14]	12	[16]	14	[11]	8	[6]	10	[1]	12	[16]	16	[13]	
SPOKES		11	22	21	19	23	21	18	15	20	17	15	26	23	23	20	18
QUARTERLY LIAISON MEETINGS																	
CCG AND Healthwatch		8		14			21			20			26			20	
CPFT			17			14			13			14			15		
Hinchingbrooke				21			20			19			18				
Addenbrookes				20		24			23			2					
WORKSHOPS																	
Centre for Public Scrutiny - Health Scrutiny Inequalities workshop		11															
Development Session			3	14		[16]											

Agenda Item No: 13

FINANCE AND PERFORMANCE REPORT – March 2016

To:	**Health Committee**
Meeting Date:	**12th May 2016**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the March 2016 Finance and Performance report for Public Health. The report is presented to provide the Health Committee with the opportunity to comment on the financial and performance forecast outturn position as at the end of March 2016.**
Recommendation:	**The Committee is asked to review and comment on the report.**

	Officer contact:
Name:	Chris Malyon
Post:	Chief Finance Officer
Email:	Chris.malyon@cambridgeshire.gov.uk
Tel:	01223 699796

1. BACKGROUND

1.1 The Finance & Performance Report for the Public Health Directorate is produced monthly and the most recent available report is presented to Health 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.

1.3 The March Finance and Performance Report provides a forecast year end position that may change once the closedown of accounts is completed and any outstanding 2015-16 transactions have been finalised. A final 2015-16 Closedown Finance and Performance Report will be presented to July Health Committee.

2. MAIN ISSUES

2.1 The March 2016 Finance and Performance report is attached at Annex A.

2.3 Public Health Grant income will be £1.6m less than anticipated due to an in year reduction in Public Health Grant. Savings on expenditure budgets, and over achievement of income, totalling £1.7m have been identified. Therefore an anticipated surplus of £128k will be transferred into the Public Health Grant reserves to produce a balanced year end position. This is a positive change from the last Finance and Performance Report presented to Health Committee (January 2016), when it was forecast that £410k would need to be drawn down from the Public Health Grant reserve.

2.4 The Public Health Service Performance Management Framework for February 2016 is contained within the report. Of the thirty eight Health Committee performance indicators, twelve are red, six are amber, sixteen are green, and four currently have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 **Developing the local economy for the benefit of all**
There are no significant implications for this priority.

3.2 **Helping people live healthy and independent lives**
There are no significant implications for this priority.

3.3 **Supporting and protecting vulnerable people**
There are no significant implications for this priority.

4.0 SIGNIFICANT IMPLICATIONS

4.1 **Resource Implications**
This report sets out details of the overall financial position of the Public Health Service.

4.2 **Statutory, Risk and Legal Implications**
There are no significant implications within this category.

4.3 **Equality and Diversity Implications**
There are no significant implications within this category.

4.4 **Engagement and Consultation Implications**
No public engagement or consultation is required for the purpose of this report.

4.5 **Localism and Local Member Involvement**
There are no significant implications within this category.

4.6 **Public Health Implications**
This report provides an overview of the finance and performance position of the Public Health service.

Source Documents	Location
None	

From: Martin Wade **Annex A**

Tel.: 01223 699733

Date: 13 April 2016

Public Health Directorate

Finance and Performance Report – March 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
February (No. of indicators)	12	6	16	4	38

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Feb) £000	Directorate	Current Budget for 2015/16 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Mar) £000	Forecast Variance - Outturn (Mar) %
-730	Health Improvement	9,048	-1,612	-17.8%	-856	-9.5%
0	Children Health	5,606	-147	-2.6%	-132	-2.4%
-220	Adult Health & Well Being	979	-404	-41.3%	-279	-28.4%
0	Intelligence Team	26	-8	-31.5%	-7	-27.2%
-5	Health Protection	16	-16	-98.7%	-16	-98.7%
-25	Programme Team	153	-45	-29.4%	-45	-29.4%
-150	Public Health Directorate	2,567	-243	-9.5%	-261	-10.1%
-1,130	**Total Expenditure**	**18,395**	**-2,475**	**-9.5%**	**-1,596**	**-8.7%**
1,610	Public Health Grant	-18,209	1,536	8.4%	1,610	8.8%
-70	Other Income	-186	92	0%	-142	-76.3%
1,540	**Total Income**	**-18,395**	**1,628**	**-2.2%**	**1,468**	**8.9%**
410	**Subtotal**	**0**	**-847**		**-128**	
-410	Anticipated contribution to Public Health grant reserve				**128**	
0	**Net Total**	**0**	**-2,870**		**0**	**0%**

The service level budgetary control report for March 16 can be found in appendix 1. Further analysis of the results can be found in appendix 2.

2.2 Significant Issues

The outturn forecast for the Public Health Directorate has improved from last month by £538k, from a £410k adverse variance to -£128k positive variance.

The in-year reduction in Public Health grant of -£1,610k will be mitigated through a combination of in-year savings and additional income (currently forecast as £1,596k and £142k respectively).

Savings/underspends have been higher than anticipated in the in-year savings plan in the Health Improvement area:

i. In the Stop Smoking Service savings were planned at £295k but £473k is now forecast to be realised. This reflects reduced medication costs, reduced payments to pharmacies and GPs, and a reduction in expenditure on marketing and promotion.
ii. In the Sexual Health STI testing and treatment budgets, savings were planned at £170k but have been overachieved with the forecast underspend now £206k.

In addition the Public Health Directorate staffing budget is now predicting an underspend of £261k, against a savings target of £150k.

Details of variances from budget at this point in the year are explained at appendix 2.

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

The Public Health ring-fenced grant allocation is £22.2m, but an in-year cut has been announced. The grant increased from September 2015 by £3.9m (full year £7.7m) in respect of the transfer from NHS England of 0 – 5 funding.

This brings total grant income for 2015/16 to £26.1m. Of the £26.1m, £18.2m is allocated directly to the Public Health Directorate.

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE

4.1 The Public Health Service Performance Management Framework (PMF) for February 2016 can be found in Appendix 6.

Stop Smoking Programme:

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Smoking Cessation - four week quitters	2237	1475	1370	93%	A	106%	146	85%	↓

- Since 2013/14 there has been an ongoing drop in the percentage of the target number of smoking quitters achieved. In 2012/13 92% was achieved, in 2013/14 this fell to 76%. This fall continued in 2014/15 when 64% of the target was met. The drop locally mirrors the national picture for the past three years. A number of factors have been associated with the fall in quitters in recent years but e cigarettes are perceived as being the key factor across the country. During these years performance in GP practices and community pharmacies was especially poor and they report there is a consistent problem with recruiting smokers to make quit attempts.

- The most recent update to the Public Health Outcomes Framework has shown that the positive movement in smoking prevalence in the percentage of adults smoking across the County between 2012 and 2013 has been partially sustained between 2013 and 2014 – the percentage of adults smoking has increased from 13.5% in 2013 to 15.5% in 2014 (compared with 17.9% in 2012) . Inequalities in smoking rates remain, with the prevalence in Fenland, Cambridge City and amongst manual workers being higher than the Cambridgeshire average.

- The target number of quitters for the Stop Smoking Services has been revised for 2015/16 to reflect the fall in smoking prevalence in Cambridgeshire. The old target was based on the previous higher prevalence. Performance against the revised target is continuing to improve and compares well with the achievement against target for the same period in 2014/15 with 93% of the target to date achieved.

- There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit the core Stop Smoking service is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. During 2014/15 social marketing research was undertaken which is informing activities to promote Stop Smoking Services. Other activities introduced recently include a mobile workplace service, a migrant worker Health Trainer post that will target these communities where smoking rates are high and ongoing targeted promotion.

NHS Health Checks

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Number of Health Checks completed	18,000	13,500	10695	79%	R	77%	4500	82%	↑
Percentage of people who received a health check of those offered	45%	45%	41%	41%	A	36%	45%	41%	↑

- Reporting of Health Checks is quarterly. In 2014/15 83% of the target was achieved compared to 93% in the previous year. The % of health checks offered and converted into completed was comparable to 2014/15 at 38%.

- In Q1 2015/16 78% of the quarterly target was achieved with a conversion rate of 38%. Q2 saw no substantial improvement with the percentage against target completed Health Checks being 77% and the conversion rate of 36% Although there was a considerable improvement in the quality of data returned and numbers referred onwards to services following a health check; which has been attributed to the ongoing training programme.

- Q3 indicates an improvement in the percentage of completed Health Checks against the quarterly target to 82% and the conversion rate to 41%

- 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.

- Other activities include staff training from a commissioned Coronary Heart Disease specialist nurse, new data collection software for practices, Point of Care Testing (POCT) (which avoids patients having to return for their blood results) and additional staff support for practices. In addition in Fenland a mobile service has been established and is visiting factories to offer health checks especially to those more hard to reach groups. The new Lifestyle Service is commissioned to provide outreach health checks for hard to reach groups. This has not commenced due to delays in the contract with the company providing POCT which is required for outreach Health Checks. This has now been finalised and training of staff has commenced and POCT machines distributed. A promotional campaign has been launched which includes recruiting champions and local “advocates” who have had a NHS Health Check.

Background Information

- Health Checks is cardio vascular risk assessment offered to people between the ages of 40 to 74. There is a 5 year rolling programme and each year up to 20% of the eligible population should be invited to a health check. The important indicators are the number of health checks completed and the number of those invited who actually complete a health checks. The Health Checks Programme has been primarily provided by GP practices that are responsible for sending out invitations to the eligible population.

Integrated Lifestyle Service

- The new Countywide Integrated Lifestyle Service provided by Everyone Health commenced on June 1 2015. It includes the Health Trainer and Weight Management Services. The trajectories for many of the indicators reflect the fact that the Service is still recruiting and developing the Service. However those where performance is categorized as red are showing an upward improvement trend. Also some of outputs are not available in the timeframe as the interventions take place over several months.

Staff are still being recruited in the South of the county where it has been especially difficult to appoint staff. Interviews are booked and it is hoped that the outstanding vacant post will shortly be filled. Various community organisations have been approached to help with recruitment. Performance is being carefully monitored with the Provider. The Service has been later than anticipated due to the very short lead time of two months from contract award to commencement of the Service.

Health Visiting and School Nursing:

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD Actual RAG Status	Previous month actual	Current month targe	Current month actual	Direction of travel (from previous month)
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	54%	A	55%	58%	55%	⇐⇒
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	/	31%	A	56%	61%	42%	⇓
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%	92%	G	96%	90%	96%	⇐⇒
Health visiting mandated check - Percentage of children who received a 6 - 8 week review by 8 weeks	90%	90%	94%	A	94%	90%	88%	⇓
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	93%	A	91%	100%	92%	⇐⇒
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	86%	A	85%	90%	81%	⇓
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	249	N/A	52	N/A	50	⇑
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	1001	N/A	237	N/A	156	N/A

- Following transfer of the commissioning of health visiting to the Council in October 2015, performance data on mandated health visiting visits and checks is now provided regularly.

- A new service specification and Key Performance Indicators for School nursing have been agreed. Data has started to be provided against these which will provide a much better understanding of baseline activity and the type of work which school nurses are carrying out day to day.

4.2 The detailed Service performance data can be found in appendix 6.

4.3 Health Committee Priorities

Health Inequalities

Smoking Cessation

- The following describes the progress against the ambition to reduce the gap in the 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.

- The percentage of the smoking quit target achieved in December was higher among the least deprived 80% of practices in Cambridgeshire compared with the most deprived 20%.

- The target quit level was achieved by both groups in January. However this is likely to be associated with delayed outcomes reporting due to the Christmas period.

- In the least deprived 80%, 131 four-week quits were achieved, 115% of the monthly target of 114; in the most deprived 20% of practices, 73 four-week quits were achieved, 100% of the monthly target of 73.

- 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 88% and in the most deprived 20%, at 72%.

- The gap in performance in quits achieved between the two groups decreased in January compared to the gap seen in December due to a greater increase in quits achieved in the most deprived practices compared with the least deprived practices.

- There are targeted efforts in the more deprived areas to promote smoking which includes community events such as promotional session 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, January 2015/16

Practice deprivation category	Year end target	Year-to-date					January			Previous month	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	1,366	1,138	1,004	88%	12%		114	131	115%	75%	↑
Most deprived 20%	871	726	521	72%	28%		73	73	100%	41%	↑
All practices	2,237	1,864	1,525	82%	18%		186	204	110%	62%	↑

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	January	Previous month	Direction of travel
Percentage point gap	-16%	-15%	-34%	↑

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 2011 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2011
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 12/04/16

NHS Health Checks

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.

Quarterly:

- The percentage of the NHS health check target achieved in Quarter 3 was higher in the least deprived 80% of practices than in the most deprived 20%.
- In the least deprived 80%, 2979 NHS health checks were delivered, 93% of the quarterly target of 3214; in the most deprived 20% of practices, 720 health checks were delivered, 56% of the quarterly target of 1286.
- The gap in performance in health checks delivery between the two groups was 37 percentage points in Quarter 3.
- The gap in performance in NHS health checks achieved between the two groups increased in Q3 compared to the gap seen in Q2 due to both a decrease in health checks in the most deprived practices and an increase in health checks for the least deprived 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 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.

Year to date:

- Looking at performance data for the year to date, the percentage of the health check target achieved in the least deprived 80% of practices stands at 86% and in the most deprived 20%, at 63%.
- The percentage of the health check target achieved in the year to date is more than 10% away from the target in both groups.
- Performance for the most deprived 20% of practices is 23 percentage points behind performance in the least deprived practices.

Percentage of health check target achieved by deprivation category of general practices in Cambridgeshire, 2015/16 Quarter 3

Practice deprivation category	Year end target	Year-to-date					Quarter 3			Previous quarter	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	12,858	9,643	8,314	86%	14%		3,214	2,979	93%	80%	↑
Most deprived 20%	5,142	3,857	2,412	63%	37%		1,286	720	56%	69%	↓
All practices	18,000	13,500	10,726	79%	21%		4,500	3,699	82%	77%	↓

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 3	Previous quarter	Direction of travel
Percentage point gap	-23%	-37%	-11%	↓

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
Public Health England 2011 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2011
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 19/02/2016

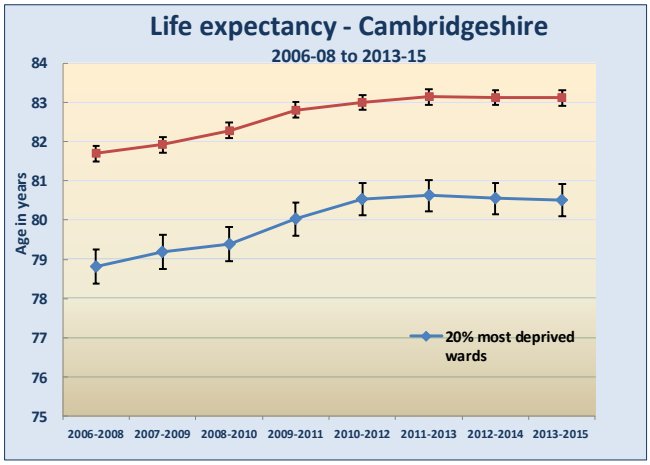
Life expectancy and healthy life expectancy

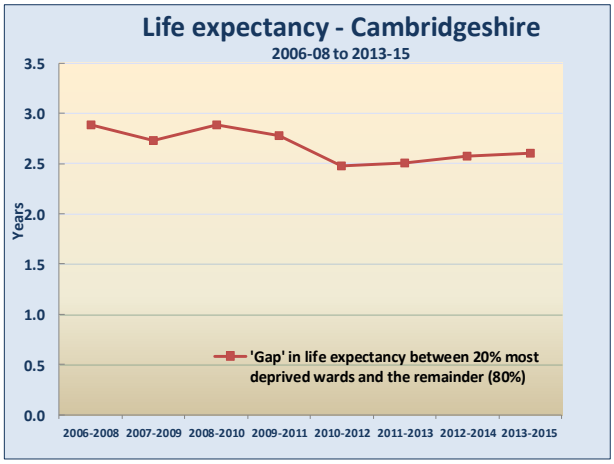
- Inequalities in life expectancy in the most deprived quintile of Cambridgeshire (monitored quarterly subject to data availability)
  - The indicator statistic is the gap in years of life expectancy between the best-off and worst-off within the local authority, based on a robust statistical model of the life expectancy and deprivation scores across the whole area.
  - The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% remainder of areas was 2.6 years for the period 2012-2014.
  - For the years 2013-2015 (provisional data to Q4 of 2015) the absolute gap was 2.6 years.
  - 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, 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.

- An annual indicator covering 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	Average Life Expectancy (95% confidence interval)				Gap (in years)	Relative gap (%)
	20% most deprived wards		80% remainder of wards			
2006-2008	78.8	(78.4 - 79.3)	81.7	(81.5 - 81.9)	-2.9	3.5%
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%

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)

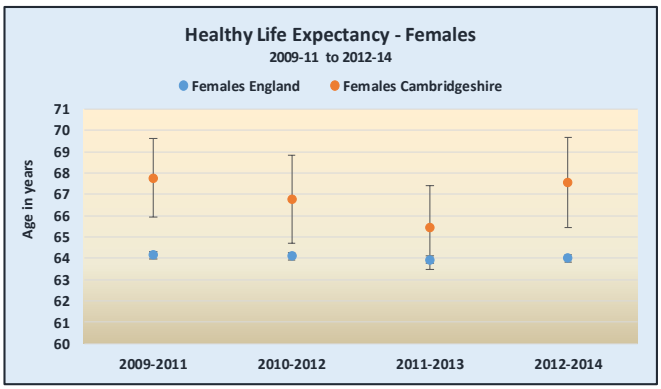


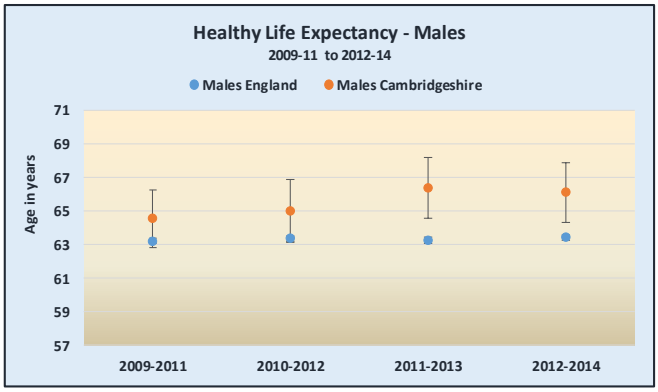


Calendar years	Cambridgeshire				England			
	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'
Males								
2009-2011	80.6	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 o	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

Interventions to address both childhood and adult obesity 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 in healthy lifestyle activities.

Mental health

Proposed indicators:

- **Number of schools attending funded mental health training:**
  - 16 out of 38 secondary schools and sixth form colleges have accessed the training commissioned from CPFT. Individuals from a further 12 schools have attended face-to-face training sessions. 9 of the schools have accessed the training this year 2015/16, including 4 new schools.
  - 21 primary schools have engaged with the training programme, plus 40 individuals have attended training from other schools. 9 primary schools have accessed the training this year and 8 have booked training for the summer term.

- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – *data not yet available as this is newly funded work as part of the public mental health strategy.*

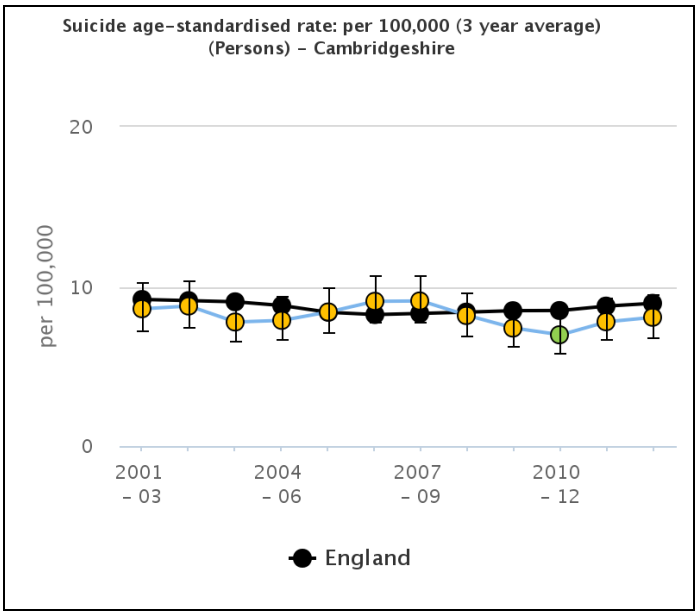
- **Number of front line staff that have taken part in MHFA and MHFA Lite commissioned training** (quarterly):

  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 (up until 29th January 2016):
  - MHFA (2 day course) attendance: 250
  - MHFA Lite (1/2 day) attendance: 113

  The contract is for a two year period from October 2014-October 2016. The annual target is to train 255 front line staff in full Mental Health First Aid and 126 staff from other groups in Mental Health First Aid Lite

- **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

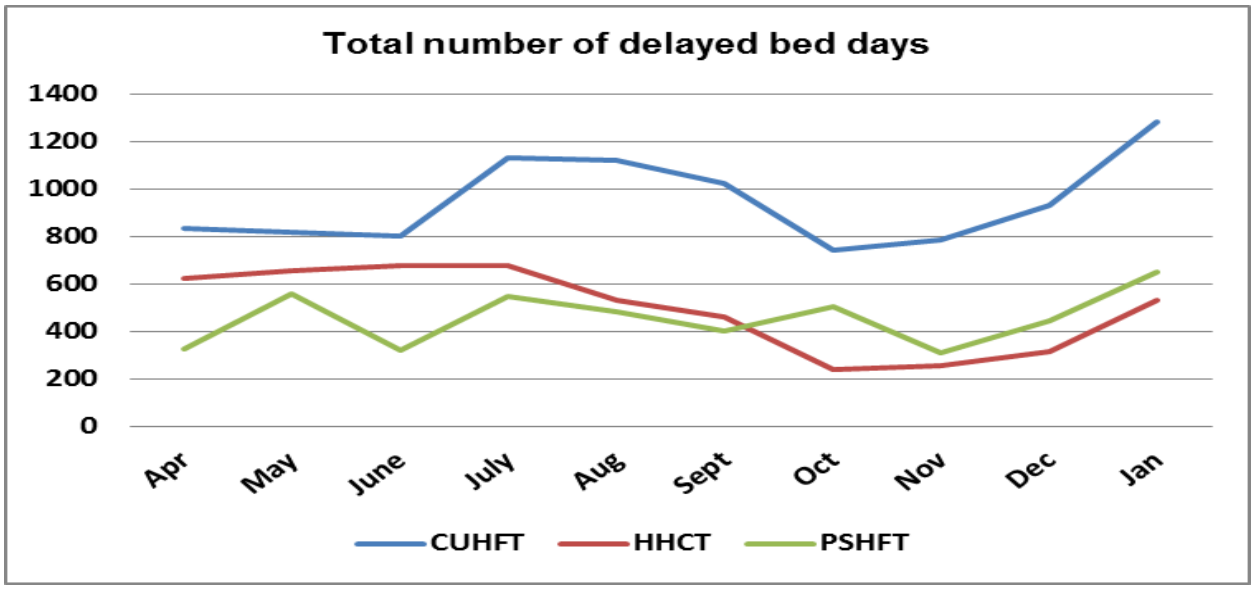
At the January meeting of the Health Committee, it was request that these indicators be reviewed. The Committee is advised that this review is now under way.

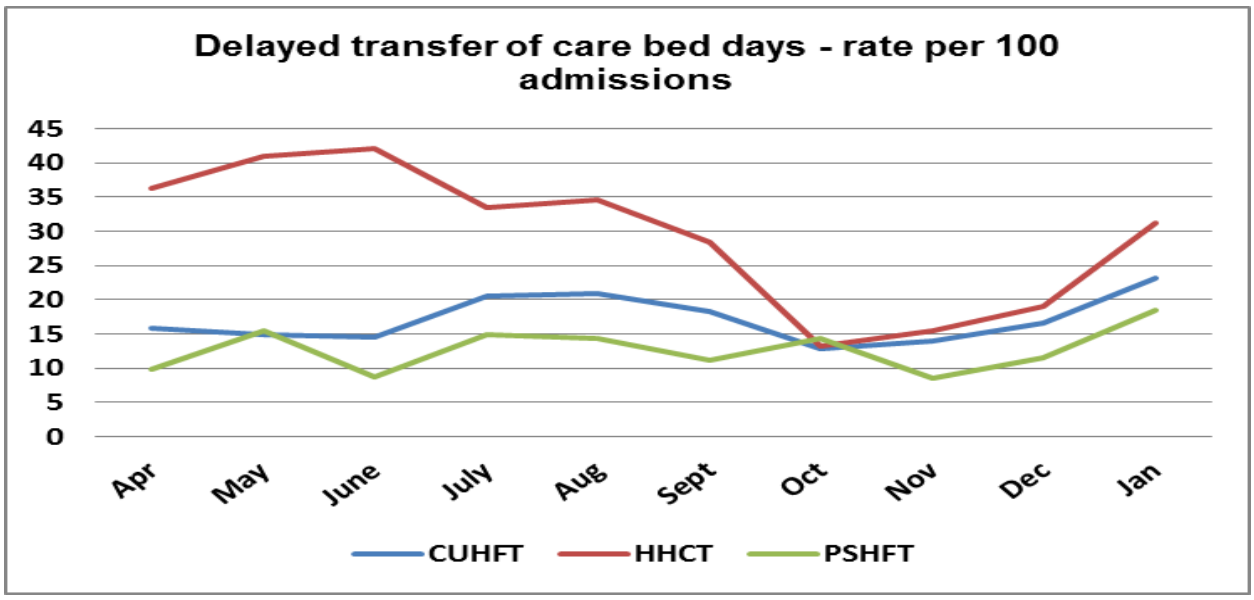
4.4 Health Scrutiny Indicators

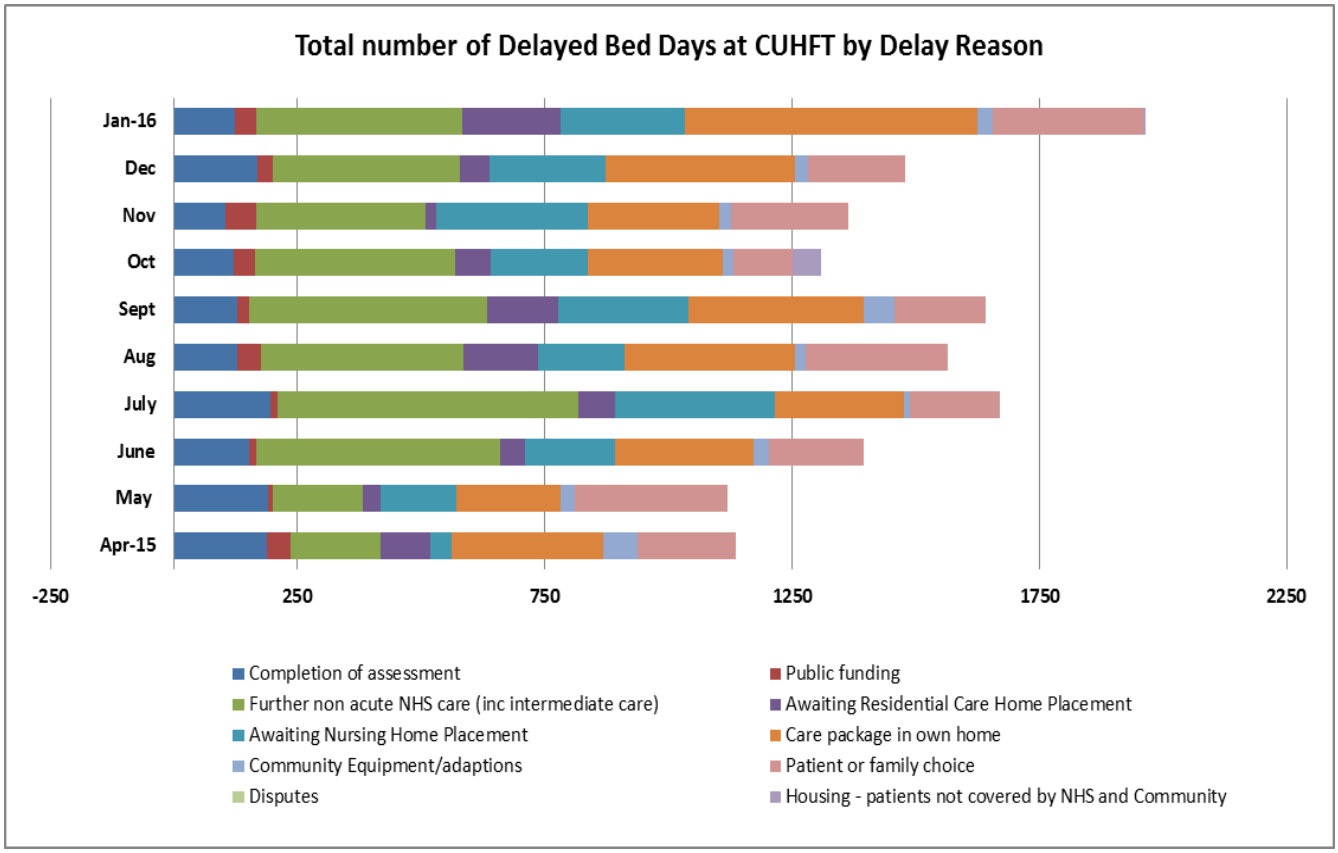
Updates on key indicators for NHS issues which have been scrutinised by the Health Committee are as follows:

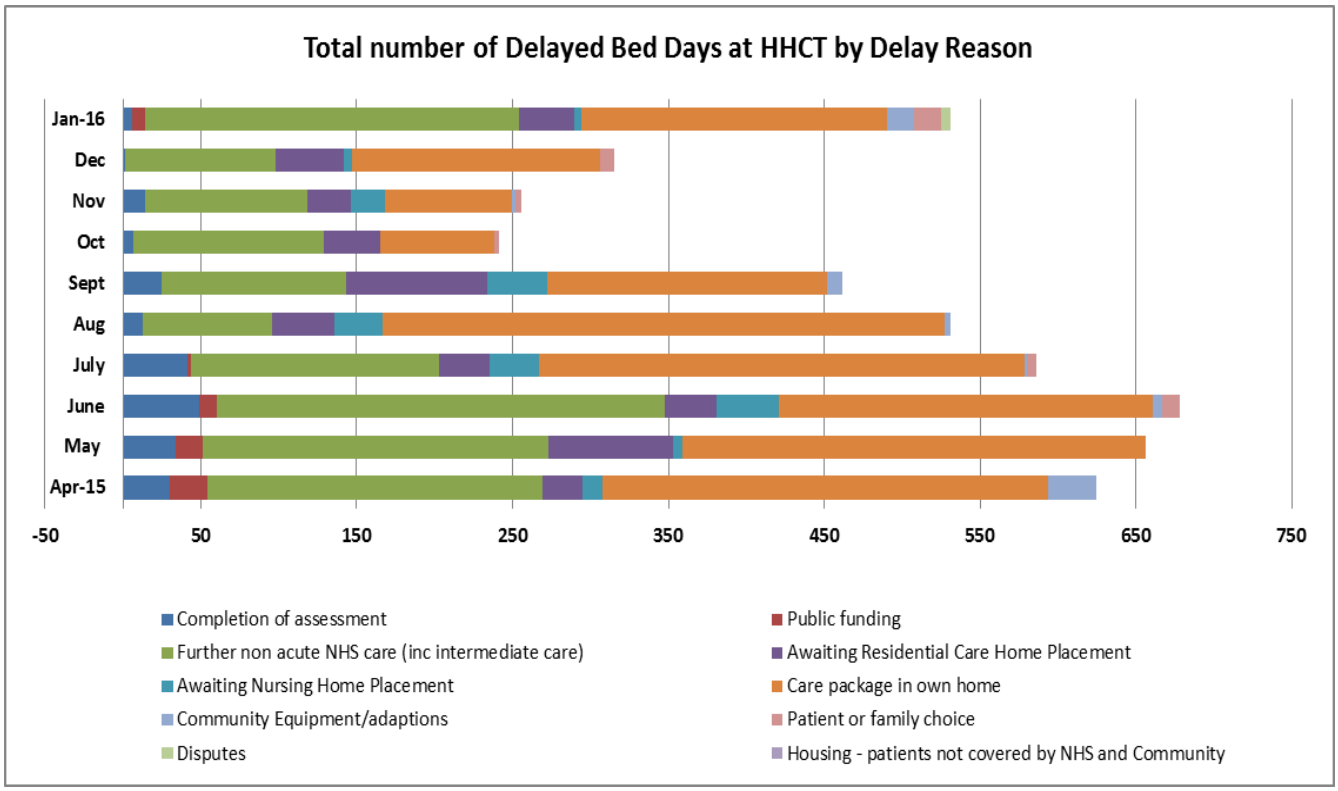
- **Delayed Transfer of Care (DTOC)**

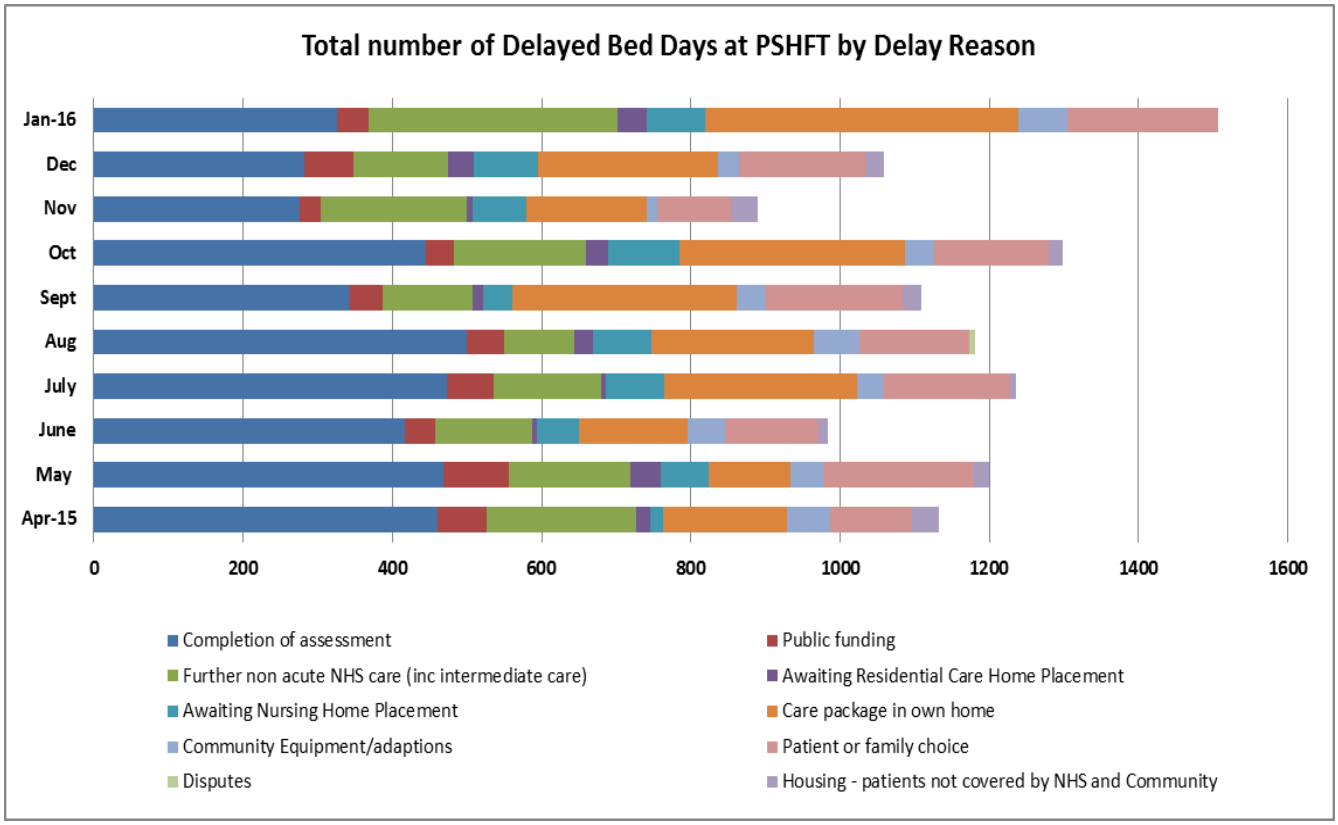
  The charts below are provided by the CCG and do indicate an expected winter pressures increase






Total number of Delayed Bed Days at CUHFT by Delay Reason
Jan-16
Dec
Nov
Oct
Sept
Aug
July
June
May
Apr-15
-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
Jan-16
Dec
Nov
Oct
Sept
Aug
July
June
May
Apr-15
-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



- **E-Hospital Programme**

  As part of their E-Hospital Programme, Cambridge University Hospitals NHS Foundation Trust (CUHFT) implemented a new clinical information system EPIC on 26th October 2014. The Health Committee considered an item on the E-Hospital system on 28th May 2015 following reports of substantial problems in the system. Members requested regular updates on the E-Hospital performance

  The Health Committee has now established regular quarterly liaison meetings with CUHFT of which EPIC updates will be reported on. The most recent meeting was held on 20th April. Information on EPIC will now be reported on in the Working Group / Liaison meeting reports. Assurances were given that EPIC is now in a stable position and technical issues identified by the Care Quality Commission (CQC) in their inspection have been addressed e.g. back log of change requests.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Feb) £'000		Service	Current Budget for 2015/16 £'000	Expected to end of Mar £'000	Actual to end of Mar £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Mar) £'000	Forecast Variance Outturn (Mar) %
		Health Improvement							
-155	**1**	Sexual Health STI testing & treatment	4,299	4,299	3,698	-601	-13.98%	-206	-4.80%
-100		Sexual Health Contraception	1,170	1,170	1,045	-125	-10.67%	-12	-1.06%
0		National Child Measurement Programme	0	0	19	19	0.00%	19	0.00%
-30		Sexual Health Services Advice Prevention and Promotion	223	223	146	-77	-34.66%	-77	-34.66%
0		Obesity Adults	0	0	47	47	0.00%	47	0.00%
0		Obesity Children	82	82	76	-6	-7.90%	-6	-7.90%
-15		Physical Activity Adults	100	100	63	-36	-36.37%	-36	-36.37%
-40		Healthy Lifestyles	1,464	1,464	1,448	-15	-1.04%	-15	-1.04%
0		Physical Activity Children	0	0	0	0	0.00%	0	0.00%
-295	**2**	Stop Smoking Service & Intervention	1,099	1,099	389	-709	-64.57%	-473	-43.07%
-40		Wider Tobacco Control	123	123	58	-65	-52.96%	-53	-43.11%
-5		General Prevention Activities	386	386	407	21	5.36%	21	5.49%
-50		Falls Prevention	100	100	39	-61	-60.98%	-61	-60.98%
0		Dental Health	2	2	0	-2	-100.00%	-2	-100.00%
-730		**Health Improvement Total**	**9,048**	**9,048**	**7,436**	**-1,612**	**-17.82%**	**-856**	**-9.46%**
		Children Health							
-		Children 0-5 PH Programme	3,861	3,861	3,800	-61	-1.58%	-46	-1.19%
		Children 5-19 PH Programme	1,745	1,745	1,659	-86	-4.93%	-86	-4.93%
-		**Children Health Total**	**5,606**	**5,606**	**5,459**	**-147**	**-2.62%**	**-132**	**-2.36%**
		Adult Health & Wellbeing							
-200	**3**	NHS Health Checks Programme	719	719	394	-325	-45.14%	-199	-27.64%
-20		Public Mental Health	224	224	144	-80	-35.69%	-80	-35.69%
0		Comm Safety, Violence Prevention	37	37	37	0	0.00%	0	0.00%
-220		**Adult Health & Wellbeing Total**	**979**	**979**	**575**	**-404**	**-41.29%**	**-279**	**-28.44%**
		Intelligence Team							
-		Public Health Advice	16	16	9	-7	-42.38%	-5	-35.18%
-		Info & Intelligence Misc	10	10	9	-2	-15.21%	-2	-15.21%
-		**Intelligence Team Total**	**26**	**26**	**18**	**-8**	**-31.51%**	**-7**	**-27.19%**
		Health Protection							
0		LA Role in Health Protection	11	11	0	-11	-100.00%	-11	-100.00%
-5		Health Protection Emergency Planning	5	5	0	-5	-95.92%	-5	-95.92%
-5		**Health Protection Total**	**16**	**16**	**0**	**-16**	**-98.68%**	**-16**	**-98.68%**

Forecast Variance Outturn (Feb) £'000		Service	Current Budget for 2015/16 £'000	Expected to end of Mar £'000	Actual to end of Mar £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Mar) £'000	Forecast Variance Outturn (Mar) %
		Programme Team							
0		Obesity Adults	0	0	-0	-0	0.00%	-0	0.00%
0		Stop Smoking no pay staff costs	31	31	27	-4	-13.13%	-4	-13.13%
-25		General Prev, Traveller, Lifestyle	121	121	81	-40	-33.21%	-40	-33.21%
-25		**Programme Team Total**	**153**	**153**	**108**	**-45**	**-29.41%**	**-45**	**-29.41%**
		Public Health Directorate							
		Health Improvement	449	449	321	-128	-28.51%		0.00%
		Public Health Advice	750	750	723	-27	-3.60%		0.00%
		Health Protection	150	150	146	-4	-2.67%		0.00%
-150	**4**	Programme Team	1,080	1,080	1,020	-60	-5.56%	-261	-24.17%
		Childrens Health	23	23	18	-5	-21.74%		0.00%
		Comm Safety, Violence Prevention	52	52	47	-5	-9.62%		0.00%
		Public Mental Health	63	63	49	-14	-22.22%		0.00%
-150		**Public Health Directorate total**	**2,567**	**2,567**	**2,324**	**-243**	**-9.45%**	**-261**	**-10.18%**
-1,130		**Total Expenditure before Carry forward**	**18,395**	**18,395**	**15,920**	**-2,475**	**-13.45%**	**-1,596**	**-8.67%**
-410		**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**128**	**0.00%**
		Funded By							
1,610	**5**	Public Health Grant	**-18,208**	-18,209	**-16,673**	1,536	-8.44%	**1,610**	-8.84%
		S75 Agreement NHSE - HIV	**-144**	-144	**0**	144	0%		0.00%
-70	**6**	Other Income	**-42**	-42	**-94**	-52	49.46%	**-142**	-76.34%
1,540		**Income Total**	**-18,394**	**-18,395**	**-16,767**	**1,628**	**-8.85%**	**1,468**	**-7.98%**
0		**Net Total**	**0**	**0**	**-847**	**-847**	**-**	**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 2015/16 £'000	Current Variance £'000	Current Variance %	Forecast Variance – Outturn £'000	Forecast Variance – Outturn %
1 Sexual Health STI testing & treatment	**4,299**	**-601**	**-13.98%**	**-206**	**-4.80%**
Part of 2015/16 savings plan. The planned target of £170k savings to be achieved through predicted underspend has been exceeded. The savings were based on a reduced use of the Peterborough Service, reduction in the contingency for unpredicted pressures and lower than expected uptake of the Chlamydia programme. The increase in savings reflects the lower uptake of Peterborough services and of the web-based Chlamydia Screening Programme than anticipated.					
2 Stop Smoking Service & Intervention	**1,099**	**-709**	**-64.57%**	**-473**	**-43.07%**
Part of 2015/16 savings plan. The planned savings target of £295k has been exceeded. These savings were based on the expected reduction in activity in the smoking cessation services. The reduction was in line with expectations however this has primarily taken place in GP and Community pharmacies that are paid for each person supported to quit. There is an additional reduction in medication costs, and a reduced in year spend on promotional activities compared with the previous year.					
3 NHS Health Checks Programme	**719**	**-325**	**-45.14%**	**-199**	**-27.64%**
This underspend was created due to the delay in completing and implementing the Point of Care Testing and Data Software procurements which reflects the complexities of introducing the new processes into the 77 GP practices with NHS support. This includes complicated information governance and secure interfaces with GP practice data systems. The new systems will greatly increase the patient experience, efficiency and data robustness of the Programme which should also improve performance of the GP practices that are main providers of the Programme.					
4 Public Health Directorate	**2,567**	**-243**	**-9.45%**	**-261**	**-10.18%**
Part of 2015/16 savings plan. £150k savings to be achieved through vacancy management strategy. The savings reflect additional in-year vacancies above plan.					
5 Public Health Grant	**18,209**	**1536**	**8.44%**	**1,610**	**8.84%**
The Department of Health has now published its response to the consultation on in-year savings to the public health grant in 2015-16. The response confirms the Government's initial proposal to reduce each local authority's overall public health allocation for 2015-16 by 6.2%, achieving a total £200m saving nationally. The 6.2% saving is based on each authority's share of the overall allocation of public health funding which for Cambridgeshire equates to a reduction of £1,610k.					
6 Other Income	**-186**	**92**	**49.46%**	**-142**	**-76.34%**
More income has been generated through the recharge of Public Health staff then budgeted for, including amounts from Peterborough City Council and the Clinical Commissioning Group.					

APPENDIX 3 – Grant Income Analysis
The tables below outline the allocation of the full Public Health grant, and includes an update for Quarter 3 of spend by other directorates
Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Forecast Outturn Expenditure £'000	Expected / Actual Transfer to PH Reserves	Notes
Public Health Grant as per Business Plan	22,155	22,155	22,155		Ringfenced grant (excluding 0 – 5 funding) - Income
Children's 0 – 5 grant (Oct – March)	3,861	3,861			In Public Health directorate
Grant allocated as follows;					
Public Health Directorate	**14,319**	**14,348**			As detailed in report. £29k increase ref the transfer of a post from CS&T
Public Health Directorate, Children 0-5	**3,861**	**3,861**			
CFA Directorate	**6,933**	**6,933**			See following tables for Q3 update
ETE Directorate	**418**	**418**			See following tables for Q3 update
CS&T Directorate	**265**	**236**			£29k decrease ref the transfer of a post from CS&T to PH. See following tables for Q3 updates
LGSS Cambridge Office	**220**	**220**			

PUBLIC HEALTH MOU 2015-16 UPDATE FOR Q3

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	DAAT	£6,269k	Susie Talbot	NB31001-NB31010 Jo D'Arcy/Ali Wilson	05/01/2016	At the end of Q3 there had not been any current spend for the allocated budget for GP Shared Care, Nalmefene, Recovery Hub Coordinator as this is work in progress. Joe Keegan (DAAT Alcohol Coordinator) is awaiting details of spend for GP Share Care & Nalmefene from Public Health. We were awaiting Inclusion Q2 20% performance related invoices which we received early January 2016 so this will now show at year end. Q3 performance related invoices will be paid once the performance meeting has taken place and this agreed by the DACG. The predicted Q3 spend is based solely on 3/4 of the overall allocated budget so the predicted and actual spend will vary during the year depending on when invoices are received but we anticipate that all contracted payments will be made by then end of Q4. 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 by the DACG members for payment. At the end of Q3 a prediction was made that there will be a possibility of an underspend in the PHG of around £78K. This is estimated from vacant posts which have not been filled and also from the Nalmefene & GP Shared care budget which to date has no current spend.	£ 1,469,654	£ 1,618,505	-£ 148,851	£ 6,199,000	**£4,606,154**	**£4,078,765**	**£527,389**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Reduction in Self Harm**	£189K			05/01/2016	**Training provision:** draft document covering local authority offer in terms of support for a whole school approach produced. Being circulated for comments and finalising **Training offer:** Ongoing. Governance meeting in January to promote staff wellbeing and CPFT training as well as Education Wellbeing Team services **Consistent sources of information:** CRC are undertaking this work and it will be ready Jan/Feb 2016 for launching **Costing and implementation of additional support:** This work is being implemented **Regular contributions to schools newsletters:** Ongoing, with regular input to CPFT training. Will be used to promote training offer document as well as links being made with Time to Change and Mind Campaigns Officer **Quality assurance framework:** Ongoing discussion to establish requirements **Diagramatic version of offer of support:** draft produced and circulated for feedback	£47,250	£45,249	£2,001	£189,000	**£141,750**	**£135,744**	**£6,006**
CFA	**Physical Activity in Older People**	£150k			05/01/2016	8/1/15 baseline data collection was completed with Day Centres. The main finding was that the current provision of physical activity is insufficient in quantity and quality in regards to NICE and CMO guidelines. Requirements re physical activity are not detailed in service specifications for day centres. However, many managers and trustees showed interest in increasing levels of provision, but will require more tailored support to enable this.					**£112,500**	**£112,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Childrens Centres**	£170k	Sarah Ferguson/Jo Sollars	CE10001 : Rob Stephens	05/01/2016	The overall aim of Cambridgeshire Children's Centres remains ensuring a healthy start to life for children aged 0-4 and ensuring readiness for school, whilst maintaining a focus on inequalities in the early years, and targeting support which will minimise the need to access specialist services where possible The Public Health funding is utilised as part of the total Children's Centre budget to improve health of children aged 0-5. In Q3 Children's Centres have been further involved in the planning and delivery of the winter 2015 Warm Homes programme. Representatives are working with Public Health to develop a cross-service breast feeding strategy for Cambridgeshire. Children's Centres have worked with Public Health to develop pilot sites for selling of Healthy Start Vitamins, to improve take up of vitamins, and raise wider awareness of Children's Centre services Close alignment and joint working with community health colleagues in Health Visiting, Family Nurse Partnership and Maternity Services is established for all Children's Centres. Work has been initiated to ensure arrangements with Health partners are consistent and functionally effective at a community level for families as service structural change is brought in across the system.	£42,500	£42,500	£0	£170,000	**£127,500**	**£127,500**	**£0**
CFA	**Education Well-Being Team : KickAsh, Life Education (LEC) and other tbc**	£56k	Amanda Askham	CB40401 : Adam Cook	05/01/2016	Kick-Ash : £25k confirmed spend (two additional schools) - on track Life Education : £15k confirmed spend - on track Training Days for school nurses : £2,500 - currently being negotiated - delayed due to reconfiguration of service/waiting to hear from SN service about training days Research and Development off resources on Health Relationships : £1,500 - on track HBT/SRE resources and training : £3k - on track SRE Theme-set for secondary schools : £9.100 - on track	£17,650	£14,650	£3,000	£56,100	**£42,700**	**£40,200**	**£2,500**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Chronically Excluded Adults (MEAM)**	£93k	Ivan Molyneux	MN92145 : Matt Moore	05/01/2016	The CEA Team continues to work hard to ensure that the co-ordinated approach is supported by relevant services. The service explansion into Peterborough has been successful with the service embedding the CEA approach to address the issues facing their complex needs population, the CEA team continue to work with colleagues in Peterborough on what promises to be an exciting partnership A three year strategy is currenty being put together to take forward the CEA work across Cambridgeshire and its continued explansion into Peterborough Work continues with voices from the frontline in partnership with MEAM. The CEA service is increasingly receiving referrals from complex needs, excluded adults at risk of homelessness and expects over the next year to increase work around homelessness prevention for 'repeat returner' clinets who have become excluded, as well as linking existing homeless service users to services This year the CEA Service will be aiming to produce an analysis of this approach to see where its application may benefit other service user groups or systems. CEA will also be looking at current and former clients to see where fairer and sustainable access may be achieved which will be done with no professional assumptions on what housing choices should be made This is with the aim not only of continuing to allow access to Chronically Excluded Adults safe accommodation, but to see how this can achieve longevity across the sector	£28,051	£28,211.95	-£160.95	£110,000	**£84,153**	**£82,246**	**£1,907**
CFA	**Housing related support**	£6k	Alison Bourne		05/01/2016	Huntingdonshire Floating Support Service continuing to provide support to avoid homelessness, and continues to meet set targets East Cambs Floating Support Service as above, and continues to meet set targets Ferry Project contract provides for single homless people in Fenland and is continuing to meeting targets Cambridge Cyrenians continues to meet targets Jimmy's continues to support homelessness with 22 beds. Metropolitan Cambridge Mental Health Cluster - Supported Housing/Visiting support, continues to provide 148 supported accommodation units	Total budget is £3,833,156.75, the Public Health element equates to 0.16% of the total, and as such is impossible to split out			£6,000	**£4,500**	**£4,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	Reducing Road Traffic Injuries	170k			05/01/2016	**Child Road Safety** **Childrens Traffic Club:** Total of 2365 registrations to end December 2015 (103 nurseries) **Advice and information to schools**: Safety Zone delivered in Ely and Cambridge - approx 800 Y5 pupils Since the end of September responded to requests for advice/support from the following schools/school communities about specific issues: Cambourne, Teversham, Foxton, Willingham, Cottenham VC, St Faiths, St Matthews, Hills Road, Trumpington Meadows, Over, Somersham, Brampton, St Ivo, Hinchgbrooke, St Peter's (Hunts), Wyton on the Hill, Thorndown, Wheatfields, St Helens, The Vine, Alderman Jacobs, Shirley, Morely Memorial, Wisbech St Mary and Elsworth Advice information provided to the following 3rd parties offering road safety/sustainable travel support to schools in Cambridgeshire: Luminous, Hegsons, Atkins, SUSTRANS, Peter Brett Associates LLP, Horizon Learning Foundation **Intensive work with 15-20 schools**: total of 9 schools signed up to Junior Travel Ambassador Scheme - 45 JTA's (Y5 pupils) Total delifery outcomes to end December. Walksmart delivered to 296 pupils (9 schools), ScootSmart delivered to 231 pupils (4 schools), PedalSmart delivered to 20 pupils (1 school) 6 volunteers trained to deliver TravelSmart schemes at three schools - not yet delivered any pupil training **Young Drivers/Riders** **Drive to arrive:** issue with available partner resource for Drive2Arive events meant two had to be cancelled in December. Planning underway for 'Fresher's Fair' style event to be held in June 2016 **Work with locality teams:** awaiting outcomes. **Explor additional interventions:** targeting profile has been completed and is appended. Work is underway to develop projects for delivery in 2016/17 based on this evidence **Vulnerable Road Users** Explore better interventions to improve the safety of motocyclists : no activity undertaken over the winter months. **Road User Behaviour Change** **Anti-Drink/Drug Driving campaigns**: waiting for analysis of Christmas Drink Driving Campaign. Planning for national drug driving campaign in Feb/March 2016 **Distraction campaigns (mobile phones) :** no additional work **Speed campaigns** : campaign planning for January **Seatbelt wearing campaigns**: no additional work **Explore research partnerships:** research proposal with CUH to be submitted in January. Internal research to be undertaken in Q4							

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ETE	Active Travel	£125			05/01/2016	**Market Town Strategies** PH and TIPF to enage communities in the consultation and ensure that active travel is involved in this Plan to run more detailed focus group style consultations with harder to reach groups which will have a gocus on public health **Active Travel** Interventions to overcome safety barriers: Currently 47 schools active on STARS with 26 achieving bronze and 1 achieving gold. Additional 9 schools undertaking travel plans for planning purposes (not using STARS) Explore better interventions to improve the safety of cyclists: Be Bright Be Seen campaign in October/November using a range of media Interventions to improve pedestrian safety: summary report compiled but more in depth investgation due in Q4	£44,050	£24,755	£19,295	£125,000	**£95,650**	**£63,195**	**£32,455**
ETE	Community Engagement in Fenland	£100			05/01/2016	Contract has now been awarded : refer to Val Thomas (Consulant in Public Health)							**£0**
ETE	Kick Ash	£31k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	05/01/2016	Emulf school have withdrawn from the programme, leaving 9 schools fully engaged in this school year, and two further schools (Longsands, St Neots and St Ivo) involved with a reduced delivery, including an education day and work within school with the year 8's. Business visits will be offered to St Ivo for the New Year Sessions with the schools involved discussion of the role of Trading Standards, its purpose within KickAsh and how they can influece and support local businesses in the campaign to prevent underage smoking and sales. We work with them to prepare their own preventative messages and design their own delivery approach to businesses. Discuss the new laws around the E-Cigarettes, nicotine inhaling products, smoking in cards with children present and plain packaging. Discuss with mentors ways in which the awareness display in schools can influence their peers with increased knowledge into the effects and dangers of smoking **Ely Community College**: completed 3 sessions with 19 mentors. Two mentors from Ely carried out visits to 6 premises within Ely and Littleport where they introduced and discussed the KickAsh project and the policies for the prevention of underage sales. **Cromwell Academy, Chatteris** : completed 3 sessions with 26 mentors **Cambridge North Academy** : completed 2 sessions with 19 mentors **Witchford Village College** : carred out visits to 6 premises with 5 mentors - using school mini bus Dates for future visits have been offered to 7 Schools: Cottenham, Cambridge North Academy and Bottisham schools have engaged in discussion and we have agreed they will receive 5 lunchtime visits to discuss actions for the various activities throughout the year. ensure they are on track and are working towards completing the activities required Organisation of the Rock Choir Flash mob in January is underway with commitment from 7 schools so far	£3,750	£4,240.46	-£490	£15,000	**£11,250**	**£9,292**	**£1,958**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	**Alcohol Underage Sales**	£15k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	05/01/2016	Review of new licence applications Challenge 25 - underage sales business advice and guidance issued to 13 new alcohol licenced businesses Licencing Act representation for two new licence applications Safety Zones activity includes underage sales information	£3,750	£2,775.55	£974	£10,000	**£11,250**	**£8,765**	**£2,485**
ETE	**Illicit Tobacco - joint working**	£7k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	05/01/2016	3 x Magistrates warrants obtained for entry to premises. All 3 shops raided 22 October, detection dogs used. 14,000 cigarettes seized from concealments within shops, one person arrested and interviewed under caution that day. Others interviewed post raids. Reports written and 3 court cases pending and one investigation ongoing. Financial investigations ongoing. Early preparation for proposed enforcement in mid-March 2016 and the summer Intelligence work completed for dissemination to Cambs police One alcohol licence objection on the grounds of illicit tobacco being found on 22 October	£1,750	£8,451	-£6,701	Exceeding £7k	**£5,250**	**£16,469**	**-£11,219**
CS&T	**Community Engagement in Fenland**	£28.5k			05/01/2016	Contract has now been awarded : refer to Val Thomas (Consulant in Public Health)							**£0**
CS&T	**Research**	£22k	Mike Soper	KH5000 : Maureen Wright	05/01/2016	The majority of the funding is used to maintain / develop the CambridgeshireInsight website include maintaining the content for Health Joint Strategic Needs Assessment (http://www.cambridgeshireinsight.org.uk/jsna). The contribution is also used to partly support the Research Team's work on population forecasting and estimating that is used heavily by Cambridgeshire Health Services. Work carried out during Q3 includes: Completion of the business plan consultation on behalf of all Cambridgeshire County Council directorates Roll out of Acorn Demographic profiling tool, making this available for use for all Public Health staff - this will be particularly useful in shaping Public Health Campaign work	£5,500	£5,500	£0	£22,000	**£16,500**	**£16,500**	**£0**

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CS&T	**Health & Wellbeing Board support**	£27k	Dan Thorpe	KA2000 : Maureen Wright	05/01/2016	With supervision from the Director of Public Health, approx 2.5 days per week of the Policy and Projects Officer's time, who sits within the Policy and Business Support Team of Customer Service and Transformation. Support during Q3 has included: Following up on actions and work arising from the development day held in October 2015, including the setting up of a working group and planning for its first meeting Supporting the effective functioning of the Health and Wellbing Board Supporting the effective functioning of the Health and Wellbeing Board Support Group Researching and preparing reports to the Health and Wellbeing Board, including on key policy/ strategy changes Presenting relevant reports at the Health and Wellbeing Board Support Group meetings, such as on the prevention strategy Agenda planning for HWB support group and (working with democratic services) the HWB meetings Co-ordinating and preparing the quarterly stakeholder newsletter - currently working on the January issue The above is in addition to ongoing, reactive support as required.	£6,750	£6,750	£0	£27,000	**£20,250**	**£20,250**	**£0**
CS&T	**Communications support**	£25k	Matthew Hall	KH60000 : Maureen Wright	05/01/2016	Q3 was a busy time with the lead up to some major campaigns around Christmas and New Year. Highlights include: Planning and delivering spectrum Public Health campaigns suc as Stoptober, Health Harms, Keep Warm Keep Well, dry January, Sugar Smart, Falls prevention, Volunteering to support older people. These include planning, developing material, working with the media, social media etc Supporting Public Health on the budget updates, including the media briefing, news release, staff briefings etc. Working closely with Val Thomas and other consultants on reactive media enquiries on subjects such as obesity, smoking etc Working with the meda to maximise opportunities for Public Health Supporting Health Committee	£6,250	£6,250	0	£25,000	**£18,750**	**£18,750**	**£0**
CS&T	**Strategic advice, strategy dev etc**	£22k	Sue Grace	KA20000 : Maureen Wright	05/01/2016	The main strategic activity continues to be the development of the new operating model. Most recently this has involved; the change of Chief Executive at the Council and the new vision for the Council that this has brought, responding to member impetus in fast-tracking implementation of an outcome based budgeting approach, and responding to Central Government accouncements that impact the Council's budget Activity in Q3 has also included assisting the Council in responding to unexpected Government accouncements regarding Public Health ring-fenced and savings targets. The Council's Business Planning Process has had to adapt swiftly in response in order to meet political budget-setting deadlines.	£5,500	£5,500	0	£22,000	**£16,500**	**£16,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CS&T	**Use of Contact Centre**	£6.5k	Joanne Tompkins	KD23500 : Maureen Wright	05/01/2016	Deivery of the Winter Warmth service is underway (from 1 October 2015) with a closure date of March 2016	£1,625	£1,625	0	£6,500	**£4,875**	**£4,875**	**£0**
CS&T	**Emergency Planning Support**	£5k	Stewart Thomas	KA40000 : Maureen Wright	05/01/2016	On-going close working with the Health Emergency Planning and Resilience Officer (HEPRO) on a number of emergency planning tasks: Close collaboration of the Emergency Management Team in detailing the outputs from Exercise Numbus which took place on 6/7 November 2015 Provision of emergency planning support when the HEPRO is not available Provision of out of hours support for the Director of Public Health (DPH), ensuring that the DPH is kept up to date on relevant incidents that occur, or are responded to, outside normal working hours as part of the 24/7 duty provision On-going intervention to secure a review of the 'Excess Deaths Plan' in support of the Pandemic Flu arrangements	£1,250	£1,250	0	£5,000	**£3,750**	**£3,750**	**£0**
CS&T	**LGSS Managed overheads**	£100k	Sue Grace	UQ10000 : Maureen Wright	05/01/2016	This continues to be supported on an ongoing basis, including: Provision of IT equipment, office accommodation, telephony and Members' allowances	£25,000	£25,000	0	£100,000	**£75,000**	**£75,000**	**£0**
LGSS Cambridge Office	**Overheads associated with public health function**	£220k	Maureen Wright	QL30000, RL65200, TA76000 : Maureen Wright	05/01/2016	This covers the Public Health contribution twoards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance 20k, HR 25k, IT 20k. The remaining £155k is a general contribution to LGSS overhead costs	£55,000	£55,000	£0	£220,000	**£165,000**	**£165,000**	**£0**

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	18,222	
Virements		
Non-material virements (+/- £160k)	0	
Budget Reconciliation		
Transfer of post from CS&T to PH	29	Contra CS&T Research grant income
S75 agreement with NHS(England) for £144,000 income to fund HIV commissioning which we have undertaken on their behalf	144	
Current Budget 2015/16	**18,395**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2015	2015/16		Forecast Balance at 31 March 2016	Notes
		Movements in 2015/16	Balance at 31 Mar 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	952	0	952	**1,080**	**Surplus of £128k to be transferred to reserve**
subtotal	**952**	**0**	**952**	**1,080**	
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	**0**	**Delayed 14/15 spend**
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	700	**2-3 years funding commence mid-year 15/16.**
Other Reserves (<£50k)	61	-61	0	0	**Service earmarked reserves**
subtotal	**2,081**	**0**	**2,020**	**1,300**	
TOTAL	**3,033**	**-61**	**2,972**	**1,842**	

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

Fund Description	Balance at 31 March 2015	2015/16		Forecast Balance at 31 March 2016	Notes
		Movements in 2015/16	Balance at 31 Mar 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	164	17	181	157	Expenditure anticipated over 2 years.
Improving Screening & Immunisation uptake	0	9	9	0	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**164**	**26**	**190**	**90**	

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 February 2016 can be seen within the tables below:

Measures										
Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month targe	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	98%	98%	G	98%	98%	98%	↔	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	91%	91%	G	91%	80%	91%	↔	
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	6600	10167	154%	G	134%	600	154%	↑	
Number of Health Checks completed	18,000	13,500	10695	79%	R	77%	4500	82%	↑	HCs reported quarterly (this is Q3 / end of Dec 15 data)
Percentage of people who received a health check of those offered	45%	45%	41%	41%	A	36%	45%	41%	↑	HCs reported quarterly (this is Q3 / end of Dec 15 data)
Number of outreach health checks carried out	450	75	13	26%	R	N/A	75	26%	↑	Training complete; equipment arrived; First health Check in Fenland booked for March 2016
Smoking Cessation - four week quitters	2237	1475	1370	93%	A	106%	146	85%	↓	December 2015 figures based on timelinesss trajectory

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	54%	A	55%	58%	55%	← →
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	/	31%	A	56%	61%	42%	↓
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%	92%	G	96%	90%	96%	← →
Health visiting mandated check - Percentage of children who received a 6 - 8 week review by 8 weeks	90%	90%	94%	A	94%	90%	88%	↓
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	93%	A	91%	100%	92%	← →
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	86%	A	85%	90%	81%	↓
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	249	N/A	52	N/A	50	↑
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	1001	N/A	237	N/A	156	N/A

Measure	Y/E Target 2015/16	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
School Nursing : Contacts made	9000	4154	4616	111%	G	119%	923	102%	↓	These are Sept 2015 figures. KPI format under review with Commissioners at Peterborough Joint Children's Health Commissioning Unit
School Nursing : Group activities	4784	2208	1947	88%	G	112%	490	4%	↓	
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	32%	38%	119%	G	29%	32%	38%	↑	This is reported on Annually. From June 2015 this service isprovided by SLM/Everyone Health. Measurements to commence in Dec 2015& Jan 2016.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	32%	32%	101%	G	23%	32%	32%	↑	
Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1167	992	1255	127%	G	96%	175	95%	↓	There have been ongoing issues with recruitment of Health Trainers. In addition there have been dificulties in securing baseline data on the patients transferred to the new contract so there is a degree of under reporting. This data factor is an issue in all of the Health Trainers from the pre-existing GP services.
Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	992	843	1040	123%	G	113%	149	86%	↓	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	632	538	576	107%	G	46%	95	40%	↓	Some of these clients will have been referred to and were seen initially by the former Service. Clients may be seen by a Health Trainer for up to a year
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	584	497	1013	204%	G	145%	86	128%	↓	

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of physical activity groups held **(Pre-existing GP based service)**	138	121	291	240%	G	323%	17	194%	↓	Service still recruiting to posts and priority has been given to the core Health Trainer Service Activity i.e. referrals for Health Plans
Number of healthy eating groups held **(Pre-existing GP based service)**	138	121	11	9%	R	15%	17	18%	↑	Service still recruiting to posts and priority has been given to the core Health Trainer Service Activity i.e. referrals for Health Plans
Recruitment of volunteer health champions **(Pre-existing GP based service)**	10	8	4	50%	R	0	1	400%	↑	Service still recruiting to posts and priority has been given to the core Health Trainer Service Activity i.e. referrals for Health Plans
Personal Health Trainer Service - number of referrals received (Extended Service)	556	442	156	35%	R	9%	100	19%	↑	Service was still recruiting to posts
Personal Health Trainer Service - number of initial assessments completed (Extended Service)	473	376	137	36%	R	12%	85	19%	↑	Service was still recruiting to posts
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	182	125	6	5%	R	2%	50	6%	↑	An individual may take up to year to complete a Personal Health Plan
Number of referrals from Vulnerable Groups (Extended Service)	278	221	100	45%	R	6%	50	16%	↑	
Number of physical activity groups held (Extended Service)	173	143	18	13%	R	0%	30	50%	↑	Service was still recruiting to posts and establishing itself and was not rag rated
Number of healthy eating groups held (Extended Service)	173	143	150	105%	G	210%	30	247%	↑	NCMP team commenced HE workshops to classes. 63 workshops in Jan has been added retrospectively.
Recruitment of volunteer health champions (Extended Service)	8	6	4	67%	R	0%	1	400%	↑	Service was still recruiting to posts and establishing itself and was not rag rated

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of behaviour change courses held	4	2	0	0%	R	0%	0	0%	↔	Programme scheduled to start in the February. Course currently being advertised.
%r of Tier 2 clients recruited who complete the course and achieve 5% weight loss	137	117	8	7%	R	5%	20	15%	↑	34.3% of completers with complete dataset achieved 3% weight loss; 22.9% of completers with complete dataset achieved 5% weight loss (target for both 30%)
% of Tier 3 clients recruited completing the course and achieve 10% weight loss	11	8	0			N/A	4	0%	N/A	Each patient goes through a 6 months course , Number of referrals clinically assessed by Addenbrookes – 73 . Awaiting outcome data from Addenbrookes
% of children recruited who complete the weight management programe and maintain or reduce their BMI Z score by agreed amounts	10	0	0			N/A	0	0%	N/A	First course running. 95% retention rate at halfway stage

* All figures received in March 2016 relate to February 2016 actuals with exception of Smoking Services, which are month behind and Health Checks 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.

Agenda Item No: 14

PUBLIC MENTAL HEALTH STRATEGY PRIORITY UPDATE – IMPROVING THE PHYSICAL HEALTH OF THOSE WITH SEVERE MENTAL ILLNESS

To: **Health Committee**

Meeting Date: **12th May 2016**

From: **Consultant in Public Health, Emma de Zoete**
Public Health Manager, Holly Hodge
Strategic Adult Mental Health Clinical Lead, Cambridgeshire and Peterborough CCG, Dr Emma Tiffin

Electoral division(s): **All**

Forward Plan ref: ***Key decision:*** **No**

Purpose: **To provide the Committee with an overview of work to improve the physical health of those with severe mental illness (SMI).**

Recommendation: **To comment on and endorse the public mental health work that is being undertaken.**

	Officer contact:
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1. BACKGROUND

1.1 Improving the physical health of those with Serious Mental Illness (SMI) was identified as one of 6 priorities in Cambridgeshire's Public Mental Health Strategy:

- Children and Young People
- Social Isolation and a wider environment that supports mental health
- Workforce mental health
- Anti-stigma
- Mental health of those with physical illness
- Physical health of those with mental illness.

1.2 In 2014 there were 4,986 patients registered in Cambridgeshire with a severe mental illness (SMI). This will typically include patients with a diagnoses involving psychosis or high levels of care, and which may require hospital treatment. Typically this includes schizophrenia and bipolar disorder1.

1.3 In general the life expectancy of people with a range of mental illnesses, such as schizophrenia and depression is less than that of people that are not living with a mental illness2. International evidence shows that people with learning disabilities or long-term mental health problems on average die 5 to 10 years younger than other citizens, often from preventable illnesses3. People with severe mental illness die up to 20 years younger than their peers in the UK.

1.4 Although suicide rates are higher in people with mental illness(es), this does not account for all of the differences seen2. In particular, health behaviours are important with smoking prevalence higher in those with serious mental illness – one study found 60% of people receiving secondary mental health care smoked4. Diet, physical activity and alcohol consumption all potentially have an important role too. It may also be the case that those with mental illnesses are less likely to seek help or access preventative services, such as screening2.

1.5 A range of work is underway to improve the physical health of those with SMI. Largely this work is being undertaken by the Clinical Commissioning Group (CCG) and Cambridgeshire and Peterborough Foundation Trust (CPFT), although Cambridgeshire County Council are also ensuring commissioned lifestyle services are equipped with the skills to work effectively with this population group.

2. LIFESTYLE SERVICES

2.1 Appendix 1 gives the extract from the public mental health strategy action plan that is relevant to improving the physical health of those with SMI. Summary updates are provided in the table and more detail is provided in the paragraphs below.

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[1] Mental Health Wales. (n.d.). What is serious mental illness? Retrieved February 2015, from Mental Health Wales: http://www.mentalhealthwales.net/mhw/whatis.php

[2] Hotopf, M., & McCracken, L. (2014). Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities; Investing in the Evidence (Chapter 13).

[3] Nocon, A. (2006). Background evidence for the DRC's formal investigation into health inequalities experienced by people with learning disabilities and/or mental health problems.

[4] Wu et al. (2013). Evaluation of Smoking Status Identification using Electronic Health Records and Open-Text Information in a Large Mental Health Case Register. PLoS one.

2.2 Public Health conducted a review of the evidence of tailored exercise programmes specific to those with SMI and found there was limited evidence of effectiveness. Therefore it was decided to improve the support provided by mainstream services and upskill in terms of the understanding of mental health.

2.3 The Lifestyle Service is commissioned by Public Health and provided by Everyone Health. The service provides a range of behaviour change initiatives including the Health Trainer Programme. Health Trainers provide support around healthy lifestyles including stop smoking, weight management, physical activity and alcohol. They also signpost individuals to a range of more specialised services such as the Increasing Access to Psychological Therapies (IAPT) service or CamQuit.

2.4 Upcoming work will focus on upskilling and existing Health Trainers via the 2 day Mental Health First Aid (MHFA) course. MHFA is an internationally recognised course that teaches people to identify, understand and help a person who may be developing a mental health problem.

2.5 To provide further expertise to the Health Trainer team a Specialist Health Trainer role will be created. The specialist would have more extensive knowledge of mental illnesses, for example the impact of specific medications on weight gain, and thus provide more tailored support to clients. In addition, they would provide further support to colleagues within the team and promote mental health as a whole. The post would be linked to, and take referrals from, the Enhanced Primary Care Service (see below) and would be funded through Public Mental Health funding.

3. ENHANCED PRIMARY CARE (EPC) SERVICE

3.1 The EPC service will provide additional mental health resource/capacity within primary care to manage patients who have mental health problems of moderate to high severity and disability but who are stable, and have risk levels that can be managed in a primary care based service. The EPC service will be supporting GPs with specialist Mental Health staff who have the knowledge, expertise and capacity to support the safe discharge/transfer of stable patients from Secondary to Primary Care.

3.2 Physical health monitoring and, where appropriate, physical and mental health interventions will be provided in collaboration with the wider multi-disciplinary team. There will be three teams across the CCG consisting of a nurse (providing mental health interventions and escalations to secondary care where needed), a healthcare assistant and a Peer Support Worker to enable access to community resources.

3.3 The service specification and model have now been agreed, with an initial proof of concept phase planned for 1 April 2016 in Fenland and Huntingdonshire areas to better understand how the model will work in practice. Following an evaluation, the aim is to roll out across Cambridgeshire and Peterborough from summer 2016.

4. PHYSICAL AND MENTAL HEALTH STRATEGIC GROUP

4.1 The Physical and Mental Health Strategic group, led by CPFT, focuses on improving the physical health of those with severe mental illness. The group oversees the implementation of an action plan which includes:

- Drafting, monitoring and implementing the physical healthcare policy for the trust (currently in draft form). This policy outlines the consistent approach that staff will take to assessing the physical healthcare needs of patients.
- Improving the skills and knowledge of physical health care assessment and treatment for staff.
- Creating a smoke free Trust (implementation date to be set).
- Develop and enhance the use of physical health champions on wards and within community teams.

The trust has recruited a physical health care lead nurse to support this work. In particular her role will focus on ensuring physical health assessments, which are recommended as part of NICE Guidance, are taking place consistently across the trust.

5. ALIGNMENT WITH CORPORATE PRIORITIES

5.1 Developing the local economy for the benefit of all

This work has potential benefits on the workplace and wider economy.

5.2 Helping people live healthy and independent lives

This work aims to support people with SMI to lead healthier and longer lives.

5.3 Supporting and protecting vulnerable people

This work focuses on the health of particularly vulnerable people - those with SMI and poor physical health.

6. SIGNIFICANT IMPLICATIONS

6.1 Resource Implications

None.

6.2 Statutory, Risk and Legal Implications

There are no significant implications within this category.

6.3 Equality and Diversity Implications

The work within this paper sets out a number of ways it may address equality and promote better health overall.

6.4 Engagement and Consultation Implications

None. During development to the public mental health strategy that guides the local authority portion of this work there was a six week consultation.

6.5 Localism and Local Member Involvement

There are no significant implications within this category.

6.6 Public Health Implications

This paper updates on progress on one aspect of the public mental health strategy which aims to promote mental health, and also to improve the physical health of those with SMI.

Source Documents	Location
Public Mental Health Strategy for Cambridgeshire	http://www.cambridgeshire.gov.uk/site/custom_scripts/cons_details.aspx?ref=361

Appendix 1

Theme	Action	Focus in year one of implementation	Timescale	Funding	Impact	Governance Board	Update April 2016
Physical and mental health	Increase uptake of smoking cessation training by community mental health teams.	Action plan to be developed by stop smoking team including numbers of advisors trained within community mental health teams, and actions to improve the number of referrals from secondary care mental health setting.	Action plan by September 2015 with in-year targets.		Long term impact is a reduction in the gap in life expectancy in those with SMI compared to the general population. This is measured in the Public Health Outcomes Framework. Short term impact measures are likely to include numbers of staff in Community Mental Health Teams trained as stop smoking advisors, numbers of referrals into stop smoking services and the proportion of these who are quitters at 4 weeks.	New governance board for Physical Health of those with SMI	26 people from mental health trust, IAPT team and mental health services have been trained to give brief advice and referral to the service with 8 receiving the full level 2 advice to be able to support someone through a quit attempt. Referrals to CAMQUIT from mental health settings: 6 (unable to breakdown as small numbers). Awaiting outcome of quit attempts. CAMQUIT core team data:
	Increase referrals to stop smoking service from secondary care mental health settings.	Action plan to be developed by stop smoking team including numbers of advisors trained within community mental health teams, and actions to improve the number of referrals from secondary care	Action plan by September 2015 with in-year targets. Mapping exercise complete	Funding will be needed to improve access cross county.	Long term impact is a reduction in the gap in life expectancy in those with SMI compared to the general population. This is measured in the Public Health Outcomes Framework. Short term impact measures are likely to	New governance board for Physical Health of those with SMI CCG Transformation Mental Health Workstream	

Theme	Action	Focus in year one of implementation	Timescale	Funding	Impact	Governance Board	Update April 2016
		mental health setting. Mapping of structured exercise provision and other initiatives to support the physical health of people with SMI, gaps identified and recommendations made on how/where to improve access. Development of enhanced primary care for those with SMI – CCG led.	by September 2015. Mapping work to feed into CCG transformation programme.		include numbers of staff in Community Mental Health Teams trained as stop smoking advisors, numbers of referrals into stop smoking services and the proportion of these who are quitters at 4 weeks.	Links to the new governance board for Physical Health of those with SMI	2014-15: 134 had a self-reported mental health issue of some kind listed. Of these people 80 became non-smokers when recorded at the four week stage.
	More coordinated, and consistent county-wide, approach to health improvement interventions for those with mental illness						Enhanced Primary Care Service model developed with proof of concept underway in Huntingdonshire and Fenland. MHFA training for Health Trainers and Specialist Role in development. Decision was made to focus on improving access to mainstream lifestyle services following an evidence review

Theme	Action	Focus in year one of implementation	Timescale	Funding	Impact	Governance Board	Update April 2016
							of more tailored support.
	Ensure physical health checks are undertaken consistently and that signposting to health improvement services is consistent.	Work to be taken forward through the CCG Transformation Programme.	In line with the CCG Transformation programme.	Funding implications to be considered in the CCG Transformation programme	Ensuring that there are consistent health checks undertaken across settings will enable better identification and signposting to appropriate health improvement provision.		This work is being undertaken by the physical and mental health strategic group.

ANNUAL PUBLIC HEALTH REPORT

To:	**Health Committee**
Meeting Date:	**12th May 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	***Key decision:*** **No**
Purpose:	**To present the Annual Public Health Report (2015/16) to the Health Committee**
Recommendation:	**The Committee is asked** • **to consider the information outlined in the Annual Public Health Report** • **to endorse the approach recommended in the Report of engaging with the three tiers of local government and the voluntary/community sector, to understand how we can best work with local communities to improve health building on activities and assets which already exist at local level.**

Officer contact:	
Name:	Dr Liz Robin
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1. BACKGROUND

1.1 The Health and Social Care Act (2012) includes a requirement for Directors of Public Health to prepare an independent Annual Public Health Report (APHR) on the health of local people.

1.2 Last year the APHR (2014/15) focussed on the changes and trends in public health outcomes over recent years. It identified three new opportunities for public health action:

- A focus on promoting the health of school age children, including mental health
- A whole system approach to healthy diet and physical activity – reversing the trend in obesity
- Supporting a positive approach to healthy ageing

1.3 The Annual Public Health Report 2015/16, attached as Annex A, updates progress against the opportunities for action identified in the APHR (2013/14) and the APHR (2014/15).

2. MAIN ISSUES

2.1 The Annual Public Health Report (2015/16) recognises that many of the factors which affect people's health exist at a very local level, based on the opportunities and lifestyles in the communities where we live. The report focusses on issues at this local level – providing health 'maps' of the County broken down into individual electoral wards. It also provides case studies of what is being done at the moment in communities in Cambridgeshire to support healthy lifestyles and wellbeing.

2.2 It is recommended that there should be a focus over the coming year on engagement with all three tiers of local government and with the voluntary and community sector, to understand how we can work with communities to improve health, building on activities and assets which already exist at local level.

2.3 The APHR (2015/16) has been laid out to be easily read by a range of audiences, and hard copies will be distributed to County Councillors, MPs, District Councils, GP surgeries, libraries and secondary schools. It will also be publicised internally and externally on the relevant websites.

2.4 Special thanks are due to Senior Public Health Analyst Helen Whyman and Public Health Analyst Elizabeth Wakefield for their work on the report.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The APHR provides information relevant to the health of the local workforce, which in turn impacts on productivity and the local economy.

3.2 Helping people live healthy and independent lives

The APHR provides information relevant to helping people live healthy and independent lives.

3.3 Supporting and protecting vulnerable people

The APHR provides a range of information relevant to vulnerable groups, including children and young people, people with mental health problems, people with disabilities, and older people.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no immediate resource implications from the APHR, although the recommended engagement process may require some future redirection of resources alongside service transformation.

4.2 Statutory, Risk and Legal Implications

Preparation of an independent Annual Public Health Report is a statutory duty of the director of public health.

4.3 Equality and Diversity Implications

There is information provided in the APHR about health inequalities in Cambridgeshire.

4.4 Engagement and Consultation Implications

The APHR recommends a process of engagement with all three tiers of local government and the voluntary/community sector as to how to best work with local communities to improve health.

4.5 Localism and Local Member Involvement

The APHR recommends an approach which involves local Members and communities.

4.6 Public Health Implications

These are covered in the main body of the report.

Source Documents	Location
Annual public health report (2014/15)	http://www.cambridgeshireinsight.org.uk/health/aphr

Cambridgeshire County Council

Annual Public Health Report 2015-2016

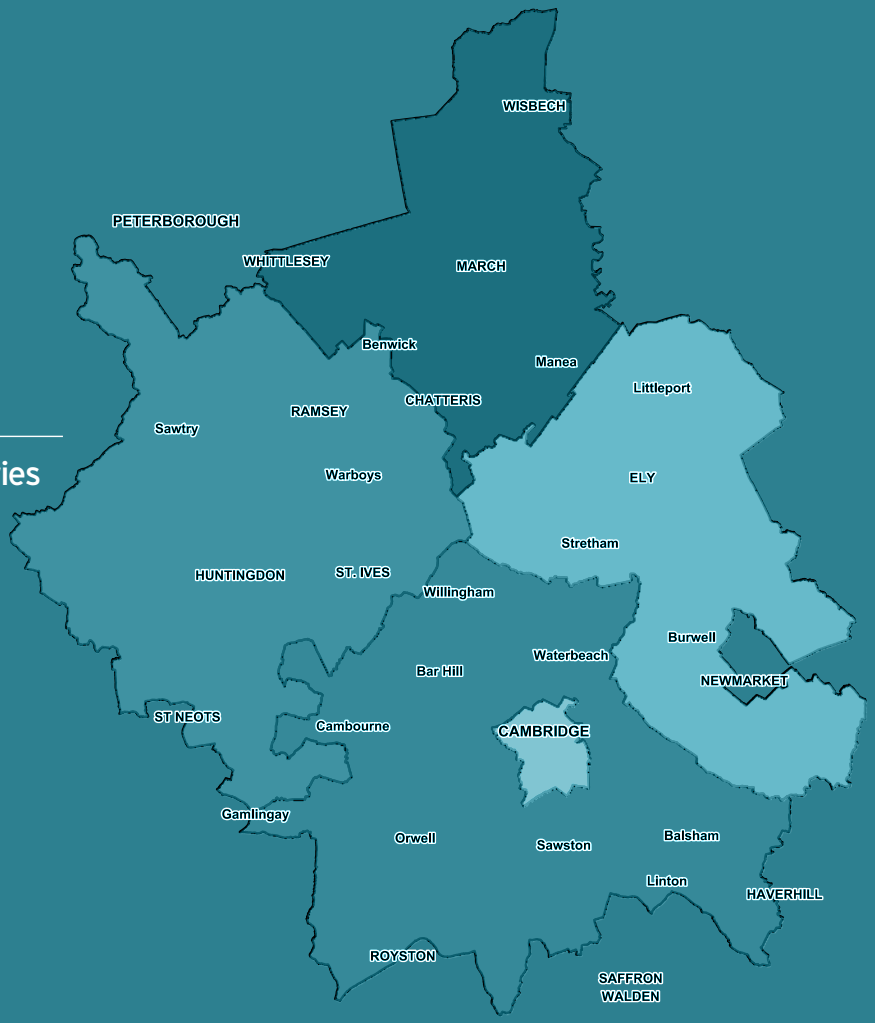
www.cambridgeshire.gov.uk

Cambridgeshire County Council

Annual Public Health Report 2015-2016

This report is based on ward level data. Labelled maps for current ward boundaries and for those pre May 2015 can be found at the back of this document.

- Significantly worse than England
- No difference to England
- Significantly better than England
- Healthy eating
- Physical activity
- Stop smoking
- Breastfeeding
- Accident prevention
- Reduce alcohol intake



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Introduction

"This Annual Public Health Report aims to be both interesting and readable for as many people as possible. So you'll find lots of information about health in Cambridgeshire in pictograms and maps rather than traditional text and tables. There are also some inspiring examples of what local communities are doing already, to improve the health of people who live here."

Foreward from Dr Liz Robin

My first Annual Public Health Report for Cambridgeshire County Council (2013/14) took a broad overview of population health across Cambridgeshire, mainly at county-wide or district-wide level. My second report (2014/15) focussed on recent trends – which public health outcomes were getting better or worse over time in the county. These reports are available on www.cambridgeshireinsight.org.uk/health/aphr

Many of the factors that affect people's health start at a very local level – based on the opportunities and lifestyles in the communities where we live. This report looks at health issues at a local level – providing 'health maps' of the county broken down into individual electoral wards. It also provides brief case studies of what can be done at community level to support healthy lifestyles and wellbeing.

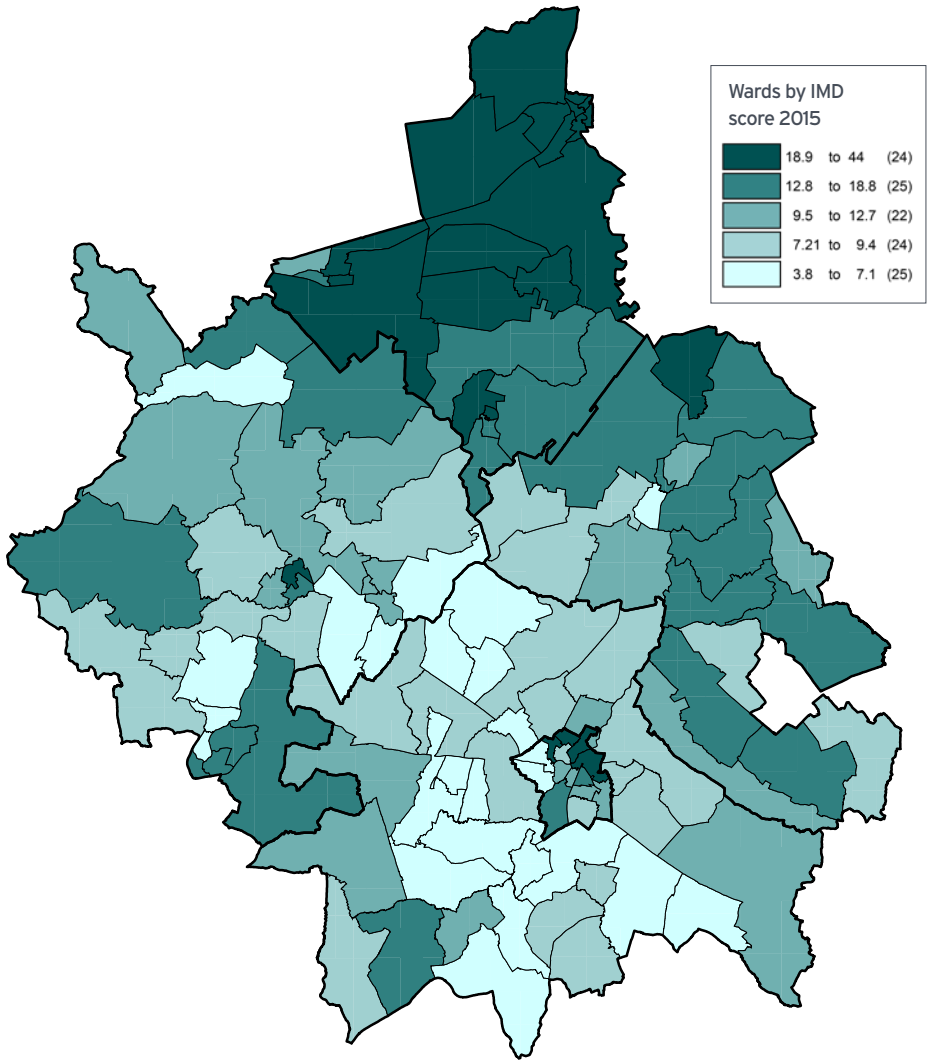
As a public health team we want to enter into a conversation over the coming year with all three tiers of local government and with the voluntary and community sector, understanding how we can work with communities to improve health, building on activities and assets which already exist at local level.

The information and case studies within the report provide a starting point for this conversation, which we look forward to continuing over the coming year.

Dr Liz Robin
Director of Public Health
liz.robin@cambridgeshire.gov.uk

I would like to thank Helen Whyman and Elizabeth Wakefield from the Council's Public Health Intelligence team for their work on this report

Socio-economic deprivation



The Index of Multiple Deprivation (IMD) is summary score to indicate the levels of relative deprivation in small areas. Higher scores suggest a greater level of relative deprivation and lower scores lower levels of relative deprivation. The scores comprise data relating to income, employment, education, skills and training, health deprivation and disability, crime, barriers to housing and services and living environment.

Child poverty

Cambridge City	14.3%	1 in 7	Huntingdonshire	11.2%	1 in 9
East Cambridgeshire	9.8%	1 in 10	South Cambridgeshire	8.0%	1 in 12
Fenland	20.3%	1 in 5	Cambridgeshire	12.1%	1 in 8

Older people living in poverty

Cambridge City	12.7%	1 in 8	Huntingdonshire	9.6%	1 in 10
East Cambridgeshire	11.7%	1 in 9	South Cambridgeshire	8.4%	1 in 12
Fenland	16.4%	1 in 6	Cambridgeshire	11.3%	1 in 9

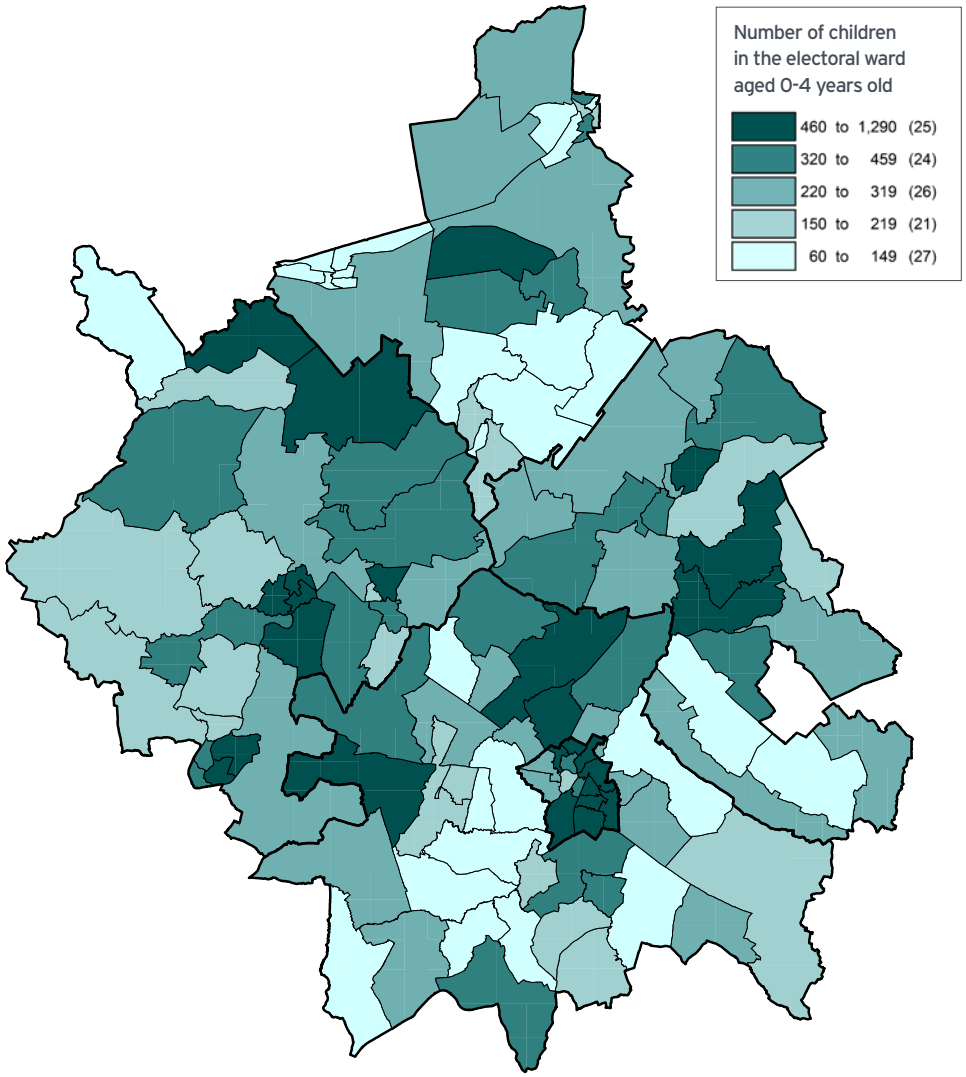
Case study

Healthy Fenland Fund

The Healthy Fenland Fund aims to build community resilience and reduce health inequalities in Fenland through engaging communities in taking steps to improve their health and wellbeing.

Small grants are available to enable the development of local projects and interventions. Community workers have been employed to enable communities to realise their assets and manage their needs, as well as to give guidance on accessing the Fund.

Children aged 0-4 years old



Note: Darker colours indicate higher **numbers** of population

7,500 births a year

Highest birthrates in East Cambridgeshire and Fenland

1 in 10 mothers smoke at time of delivery

6.8% increase in the preschool population Over next 5 years

83% 83% initiate breastfeeding falls to 56% by 6-8 weeks **56%**

Hospital admissions for accidental and deliberate injuries

HIGHEST IN HUNTINGDON & FENLAND

85% OF 5 YEAR OLD CHILDREN have completed MMR vaccinations

Case study

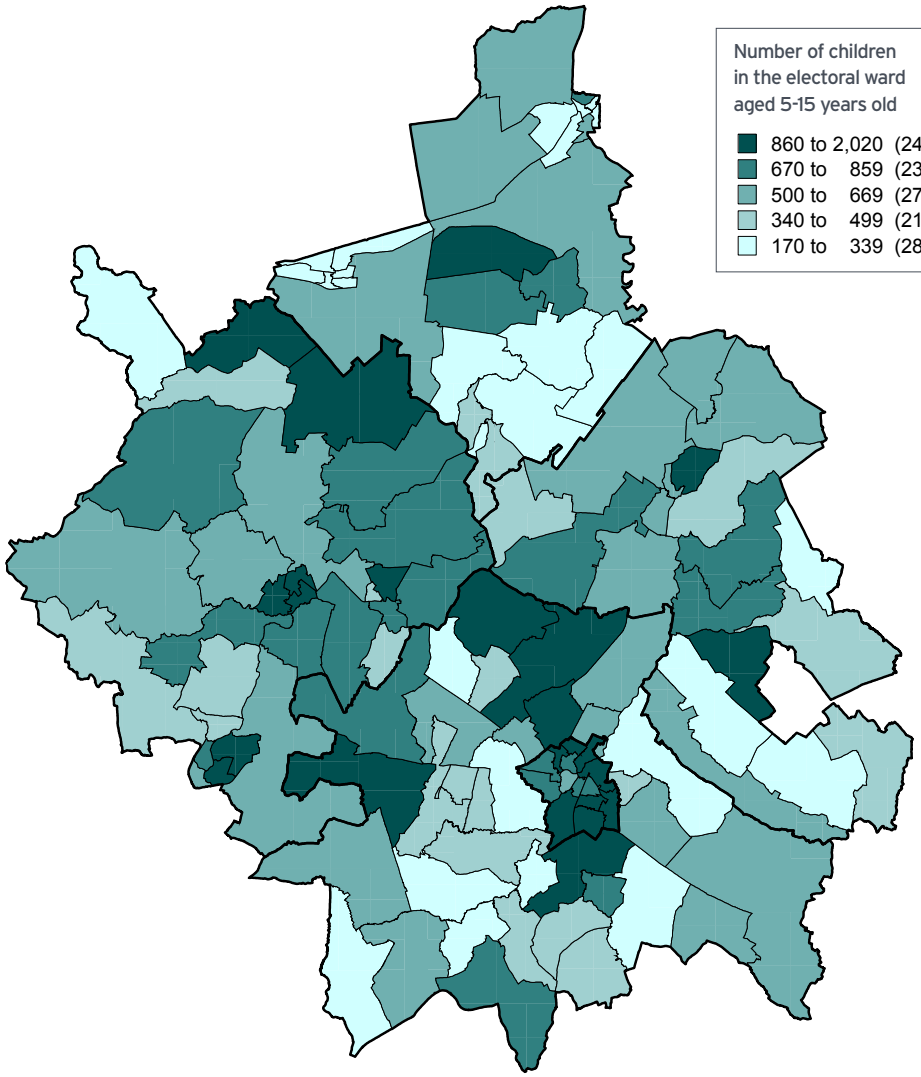
Breastfeeding Peer Support

Breastfeeding has considerable health benefits for the child and mother. Peer support groups are effective in helping women to start breastfeeding and breastfeed for longer. Peer supporters are volunteers, recruited from the local community who have breastfed themselves and successfully completely accredited training provided by Cambridgeshire's Public Health Team, which gives them the skills to help other women breastfeed.

Trained peer supporters go on to recruit new members, which in turn increases social networking opportunities, builds relationships with professionals, increases uptake in further education or training or other voluntary roles.

What can YOU & YOUR COMMUNITY do?

Children aged 5-15 years



Note: Darker colours indicate higher **numbers** of population

What can YOU & YOUR COMMUNITY do?

1 in 12 Year 8 pupils have nothing to eat for breakfast before lessons

1 in 8 Year 10 pupils have nothing to eat for breakfast before lessons

1 in 8 Year 8 pupils had an alcoholic drink in the past 7 days

1 in 3 Year 10 pupils had an alcoholic drink in the past 7 days

2.4% Year 8 smoke regularly

x5 increase between Year 8 & 10

11.8% Year 10 smoke regularly

50% of regular Year 8 & 10 smokers want to quit

79% **84%**

children aged five to fifteen do not meet the current physical activity recommendations of **60 minutes each day.**

Pregnancies for every **1,000 girls aged 15-17 years in 2014**

Cambridge City	23 in 1000
East Cambridgeshire	14 in 1000
Fenland	23 in 1000
Huntingdonshire	16 in 1000
South Cambridgeshire	10 in 1000

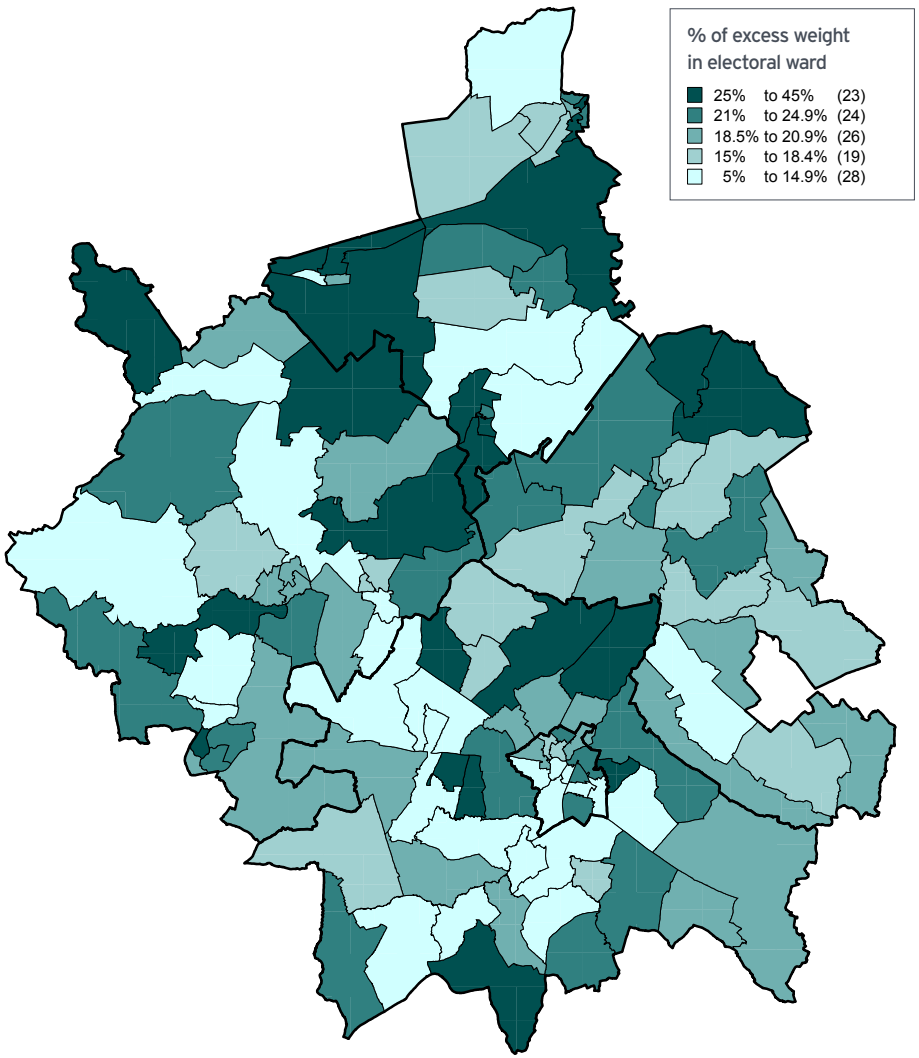
Case study

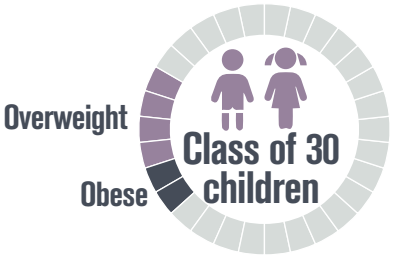
KickAsh

KickAsh is a school based programme that aims to reduce the prevalence of smoking amongst young people. Year 10 pupils are recruited as mentors to promote no-smoking messages to their peers. They also help design and influence the development of the programme for their school.

KickAsh is currently active in 10 schools in Cambridgeshire with over 150 mentors trained in the last year. The programme focuses on what influences pupil's decision making around smoking and related risk taking behaviours. Benefits include: building confidence, leadership opportunities, feeling valued, working with wider communities and working with professionals.

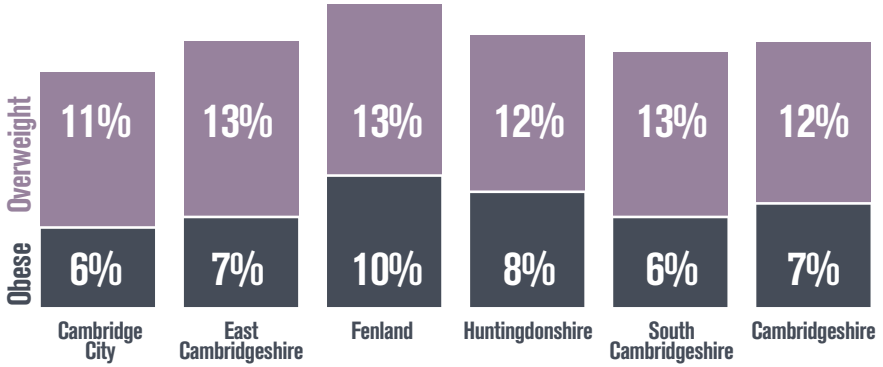
Childhood excess weight - Reception (age 4-5)





In an average class of 30 children, 2 will be obese and a further 4 will be overweight

Reception Excess Weight



Case study

Food for Life

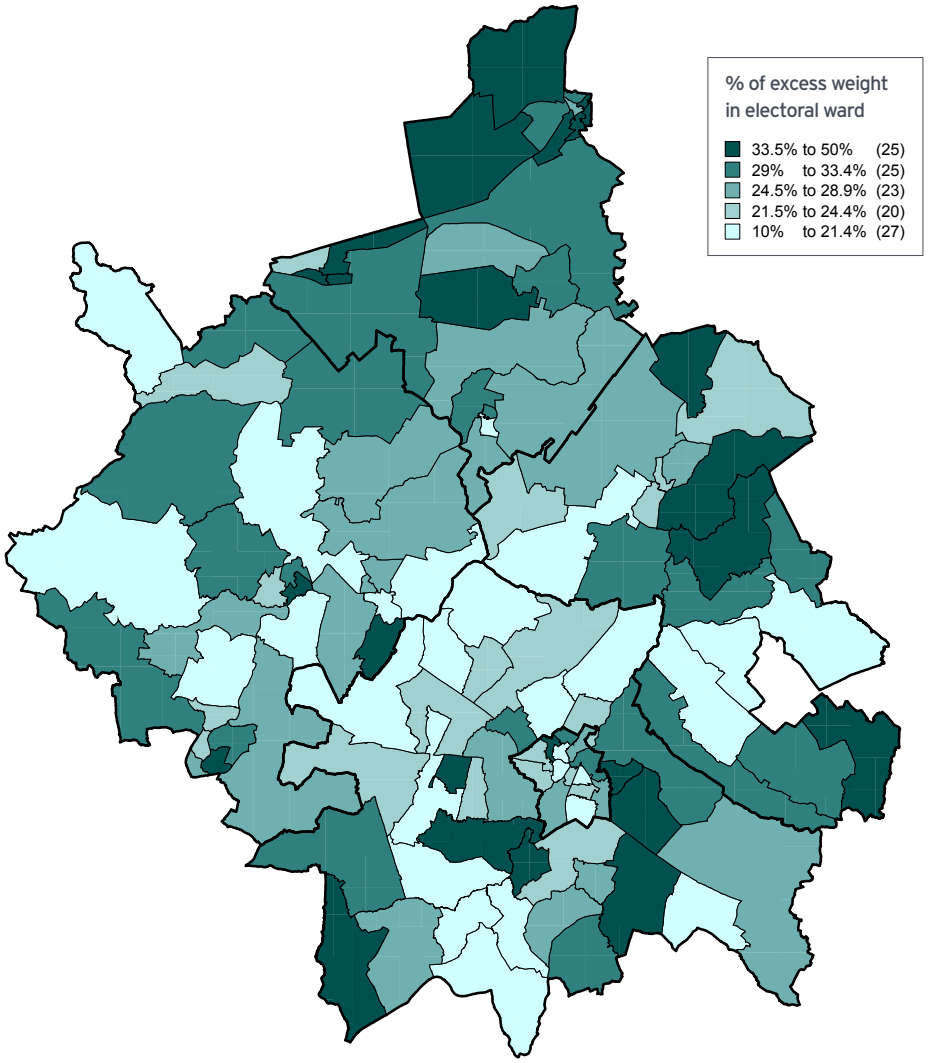
The Soil Association Food for Life (FFL) works with schools in Cambridgeshire to tackle health inequalities. FFL supports schools to make positive, sustainable changes around school meals and food education. FFL engages pupils and parents, teachers, caterers and the wider community and contributes to their health and wellbeing. Pupils learn where their food comes from, how it is grown and cooked and the importance of well-sourced ingredients. FFL schools benefit from a positive food culture across the whole school community.

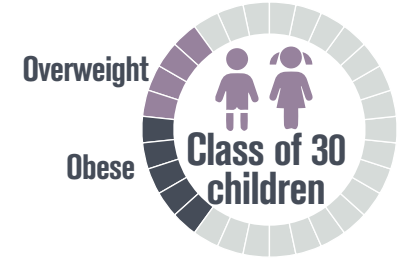
FFL encourages schools to support their local community. This spring it is promoting school gardening activities to engage with grandparents, carers and local residents to help get their gardens ready for growing. It also supports schools to support other local community events throughout the year.

FFL have also begun working with some nurseries across the county to encourage the health and wellbeing of younger children as well as school aged children.

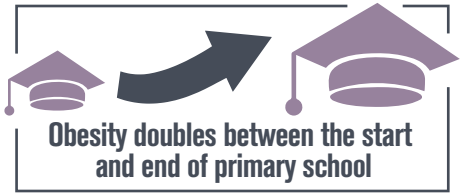
What can YOU & YOUR COMMUNITY do?

Childhood excess weight - Year 6 (age 10-11)



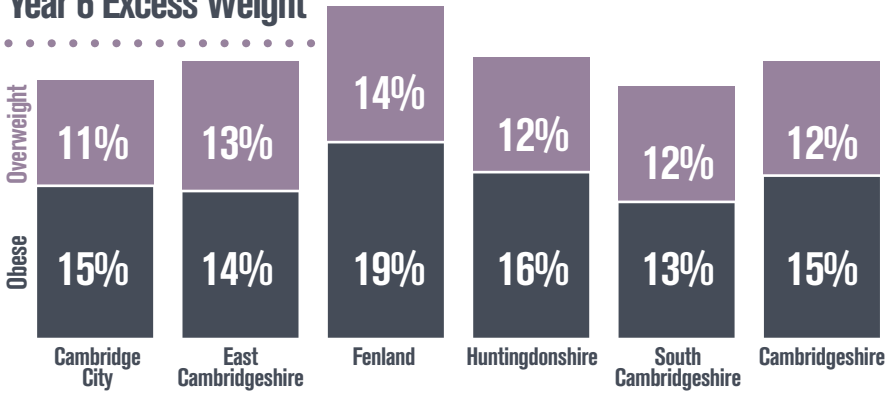


In an average class of 30 children, 5 will be obese and a further 4 will be overweight



Obesity doubles between the start and end of primary school

Year 6 Excess Weight



What can YOU & YOUR COMMUNITY do?

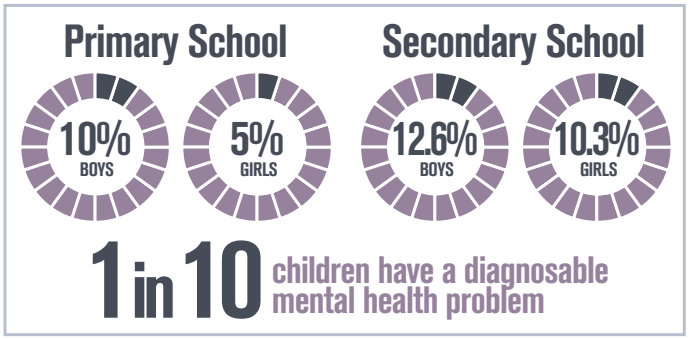
Case study

Change4Life

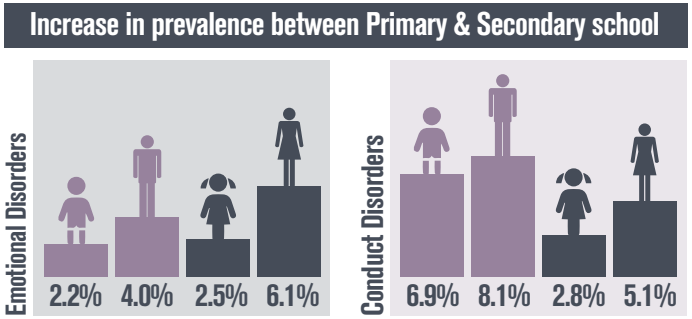
Change4Life is a national campaign that was set up in 2009 to inspire anyone working with families or individuals, including the NHS, local authorities, businesses, charities, schools, families, community leaders, to play a part in improving the nation's health and wellbeing by encouraging everyone to eat well, move more and live longer. The website (www.nhs.uk/change4life/) makes resources available for local supporters, such as communities, to use with their population.

Recently Cambridgeshire supported the Sugar Smart campaign, which encouraged families to cut back on sugar, as children consume three times more sugar than the recommended maximum daily amount. Residents could follow the campaign using local social media channels. Parents were encouraged to download the free Sugar Smart App to see quickly and easily how much sugar products contain. Free Sugar Smart packs for families were distributed across the county to local children centres, libraries and leisure centres. These were also given away to school pupils.

Child and adolescent mental health



Hospital admissions as a result of self-harm in children and young people aged 10 to 24 years are high in Cambridgeshire



Half of lifetime mental health problems start before the age of 14 years; 75% by 24 years old

Low to medium self esteem in Year 8 and 10 pupils higher in girls than boys

Year 8 and 10 pupils report worrying most about school work/exam/tests, careers, the way they look and relationships with friends

Less than half of pupils feel optimistic about their future

Children in the poorest households are 3 times more likely to have a mental health problem than those growing up in better-off homes.

What can YOU & YOUR COMMUNITY do?

Case study

Comberton Village College: A Whole School Approach to Mental Health

Cambridgeshire County Council commission a range of training for those working directly with children and young people locally to develop their knowledge and skills in understanding and responding to emotional wellbeing and mental health needs. The training is delivered by Cambridgeshire and Peterborough Foundation Trust and it includes a tailored package for schools.

One school that has accessed the training on a regular basis is Comberton Village College. Corinne Davidson, Assistant Principal, describes mental health as "the biggest challenge facing schools, especially at 6th form level".

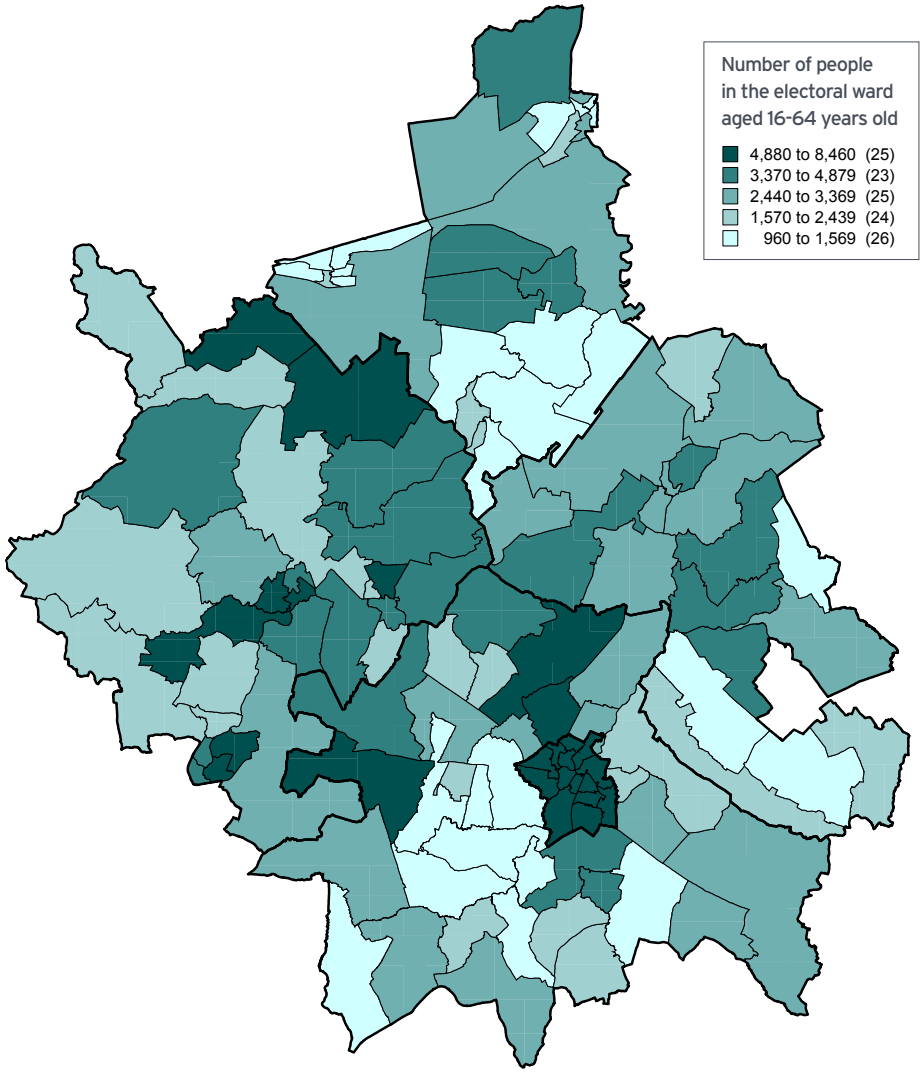
Senior staff are committed to the mental health agenda, and a large percentage of teaching and support staff have participated in the e-learning and face-to-face workshop. From this, a range of work has taken place to further ensure that there is a whole school approach to mental health, this includes:

- The Librarian has improved the availability of mental health materials and sign-posting in the library.
- Awareness posters can now be found on the back of toilet doors, flagging up mental health issues and where to get support.
- There is a mental health page in the pupil's school diaries.
- Termly support assemblies remind students about the care pathways available in the school and how to access them and who to talk to.
- A comprehensive support package of counselling.
- Mental health issues are on the agenda for certain training days for staff.
- Increased focus on mental health in the PSHE curriculum and tutor team meetings which are used by heads of year to raise awareness and discuss issues.

This greater visibility promotes more openness about mental health and stimulates conversations which will encourage young people to be more aware of their mental health needs and hopefully seek help earlier.

To find out more about the training visit: www.trainingcamh.net

People aged 16-64 years



Note: Darker colours indicate higher **numbers** of population

Cambridge City

Healthy eating	Excess weight	Physical activity	Smoking	Alcohol
61.4%	48.3%	76.8%	17.6%	

East Cambridgeshire

Healthy eating	Excess weight	Physical activity	Smoking	Alcohol
59.4%	68%	58%	14.9%	

Fenland

Healthy eating	Excess weight	Physical activity	Smoking	Alcohol
47.7%	73.1%	52.1%	21.2%	

Huntingdonshire

Healthy eating	Excess weight	Physical activity	Smoking	Alcohol
57.7%	67.3%	62.8%	14.4%	

South Cambridgeshire

Healthy eating	Excess weight	Physical activity	Smoking	Alcohol
64%	63.6%	67.3%	11.7%	

Healthy eating symbol
Proportion of the population meeting the recommended five fruit or vegetables per day, 16+ years, 2014

Excess weight
Percentage of adults classified as overweight or obese, 16+ years, 2012-2014

Physical activity
Percentage of adults achieving at least 150 minutes of physical activity per week, 16+ years, 2014

Smoking
Percentage of adults who smoke 18+ years 2014

Alcohol
Hospital admissions for alcohol-related conditions (narrow definition), all ages, 2013/14

Case study

Workplace Health Programme

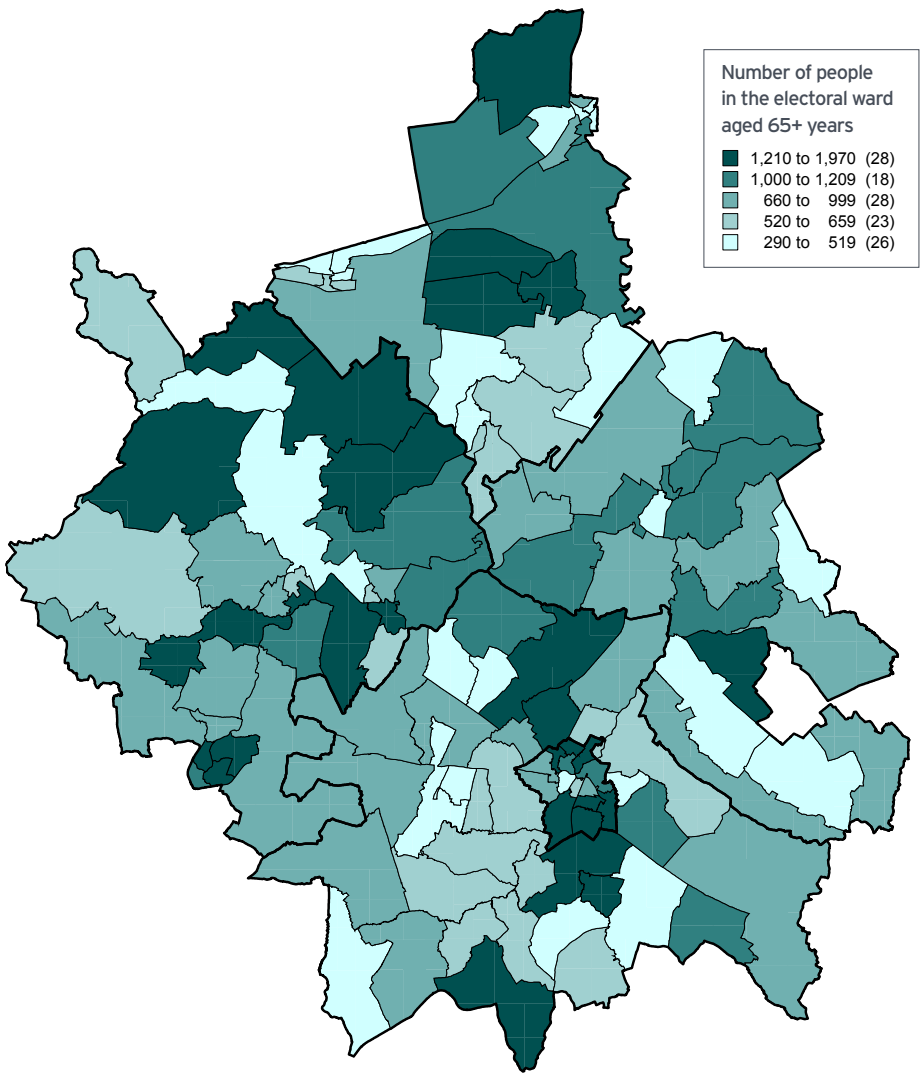
Workplace health programmes support improvements in employee health and can reduce sickness absence. Locally Business in the Community (BITC) works with private sector workplaces, particularly in the areas of higher deprivation. Volunteer Health Champions are recruited and trained to offer support to employers to improve the health of their workforce by organising initiatives that promote health and wellbeing, as well as signposting to relevant local services.

Sexual Health Champions

Through DHIVERSE community volunteers are trained as Sexual Health Champions to promote sexual health and HIV prevention, with notable success in Black, Asian and Minority Ethnic groups. Volunteers have recently been recruited from Men who have Sex with Men communities.

What can YOU & YOUR COMMUNITY do?

Older people aged 65+ years



Note: Darker colours indicate higher **numbers** of population

What can YOU & YOUR COMMUNITY do?

MALE AGE 65 Can expect to live a further 19.7 years

11.6 years in good health

FEMALE AGE 65 Can expect to live a further 22 years

13.4 years in good health

Deaths are **20% HIGHER** in winter for people aged **85+ YEARS**

People with long term health problem or disability

65+	75+	85+
1 in 5	1 in 3	1 in 2

7 in 10 Aged 65+ years have had their flu vaccination

2,500 admissions to hospital Due to injuries sustained in a fall

635 hip fractures

46% of emergency admissions to hospital are in people aged 65+ years

32% in people aged 75+ years

Estimated that **7,000 people living with dementia**

1 in 5 males and 1 in 3 females aged 90+ years

Case study

Dementia Friends

Dementia Friends is a national campaign to increase understanding and knowledge of dementia in communities. A Dementia Friend learns about what it's like to live with dementia and then turns that understanding into action by learning more about dementia and the ways to help. For example by telling friends about Dementia Friends or visiting someone living with dementia. A Dementia Friends Champion is a volunteer who encourages others to make a positive difference to people living with dementia in their community.

Information on training sessions and how to become a volunteer are available www.dementiafriends.org.uk

Adult mental health

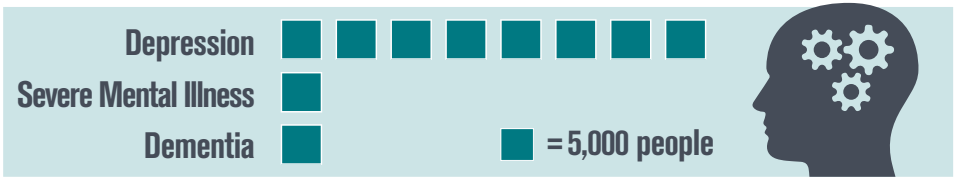
1 in 4 people will experience at least one mental problem in the year

over **125,000 adults** in Cambridgeshire

Experienced a common mental health problem, such as depression, anxiety and phobia in the last week.

1 in 10 ADULTS IN CAMBRIDGESHIRE WERE UNHAPPY WITH THEIR LIVES YESTERDAY

Almost 1 in 5 HAD HIGH ANXIETY LEVELS



Almost 38,000 people on GP depression registers;

Over 5,000 with severe mental illness (schizophrenia, bipolar disorder, or other psychosis) and 4,500 with dementia

50 suicides or deaths from undetermined intent a year

38% HIGHER Recorded depression in the most deprived areas

What can YOU & YOUR COMMUNITY do?

Case study

Resilient Together

Resilient Together is a three-year, Cambridgeshire County Council-funded project focused on Wisbech and the Southern Fringe of Cambridge.

This work started in October 2015 and aims to build resilience at a community level using the Asset Based Community Development Approach. It also aims to increase awareness of mental health issues, tackle stigma and increase capacity of the community to respond to mental-health related issues.

An example of how the project has supported one young woman is the case of Claire (fictitious name to maintain anonymity).

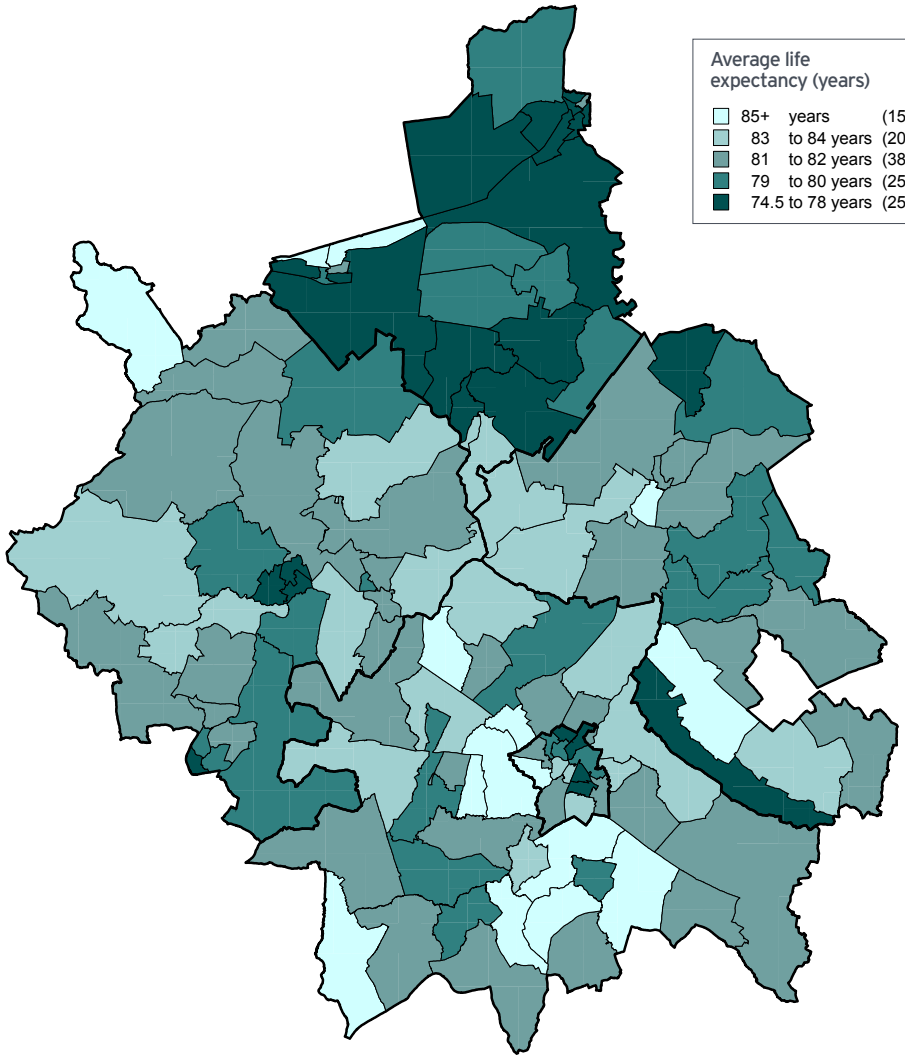
Claire has been in touch with the Resilient Together Team since January 2016, and has discussed the positivity of cultural diversity in Wisbech and how by regularly practising random acts of kindness she has come to build a strong set of local friendships.

Claire said she would like to support residents who want to develop their confidence in crafts and poetry skills.

Since the project's connection with Claire:

- She is now developing a craft workshop for residents to take part in.
- She has supported a resident feeling anxious with their confidence and they are now selling crafts out in the community and are earning from this.
- The Resilient Together Team are putting her in connection with 5 other local residents- 'connectors'. These connectors are interested in building on the existing strengths and assets of the community.
- Claire has put the project into contact with 3 other connectors who will be attending an upcoming meeting.
- Residents have helped Claire with her own personal challenges and she has helped/ helps others with their mental wellbeing and practical skills.
- Community resident connections can support with the 5 ways to wellbeing, e.g. in this case study there is evidence of residents 'learning', 'giving' and connecting'.

Male life expectancy



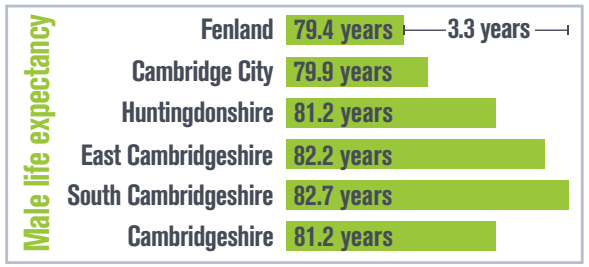
Average male life expectancy at birth is **81.2 years**

3.3 years LESS than females

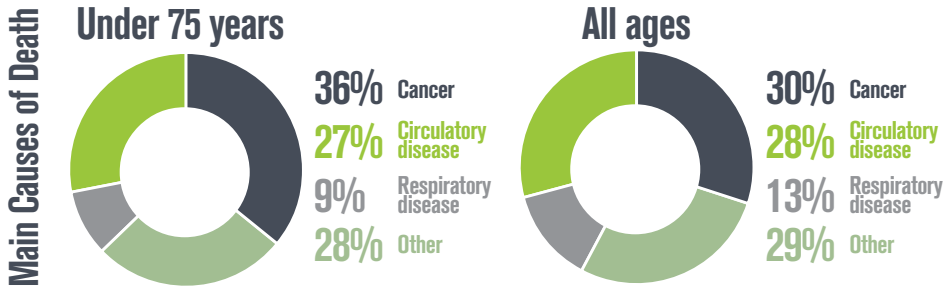
In 2015 there were 2,700 male deaths a year

35% AGED UNDER 75 YEARS

Male life expectancy



Main Causes of Death



Circulatory disease is a general term that describes a disease of the heart or blood vessels, such as coronary heart disease and stroke. Respiratory disease includes asthma, chronic obstructive pulmonary diseases (COPD) such as emphysema and bronchitis.

What can YOU & YOUR COMMUNITY do?

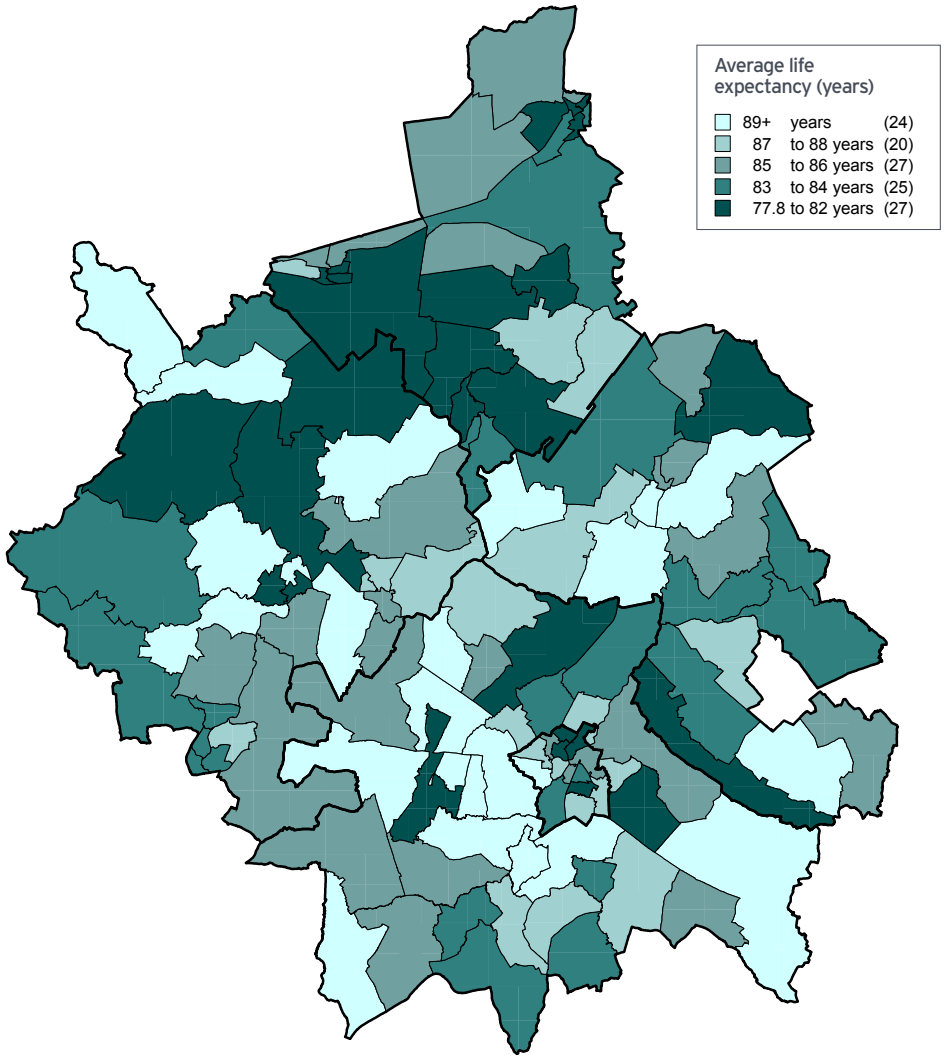
Case study

Gypsies and Travellers

Gypsies and Travellers are the largest ethnic minority group in Cambridgeshire; on average life expectancy for Gypsies and Travellers is about 10-12 years less than non-traveller residents and experience of ill health is five times more likely.

Cambridgeshire's Public Health Travellers Team work with the communities to improve their knowledge and skills in improving health and well-being. The Travellers Literacy Project has enabled learners to be more aware of how to access GP services, how to make health choices and has led to improved mental health, self-esteem and confidence.

Female life expectancy

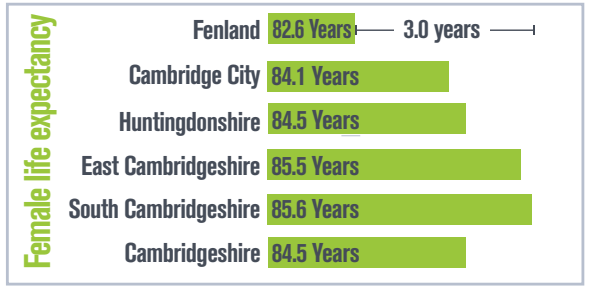


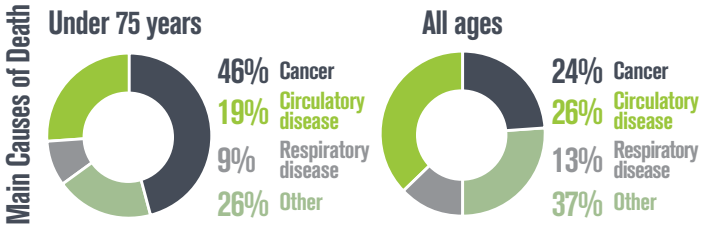
Average female life expectancy at birth is **84.5 years**

3.3 years MORE than males

In 2015 there were 2,700 female deaths a year

23% AGED UNDER 75 YEARS





Circulatory disease is a general term that describes a disease of the heart or blood vessels, such as coronary heart disease and stroke. Respiratory disease includes asthma, chronic obstructive pulmonary diseases (COPD) such as emphysema and bronchitis.

What can YOU & YOUR COMMUNITY do?

Case study

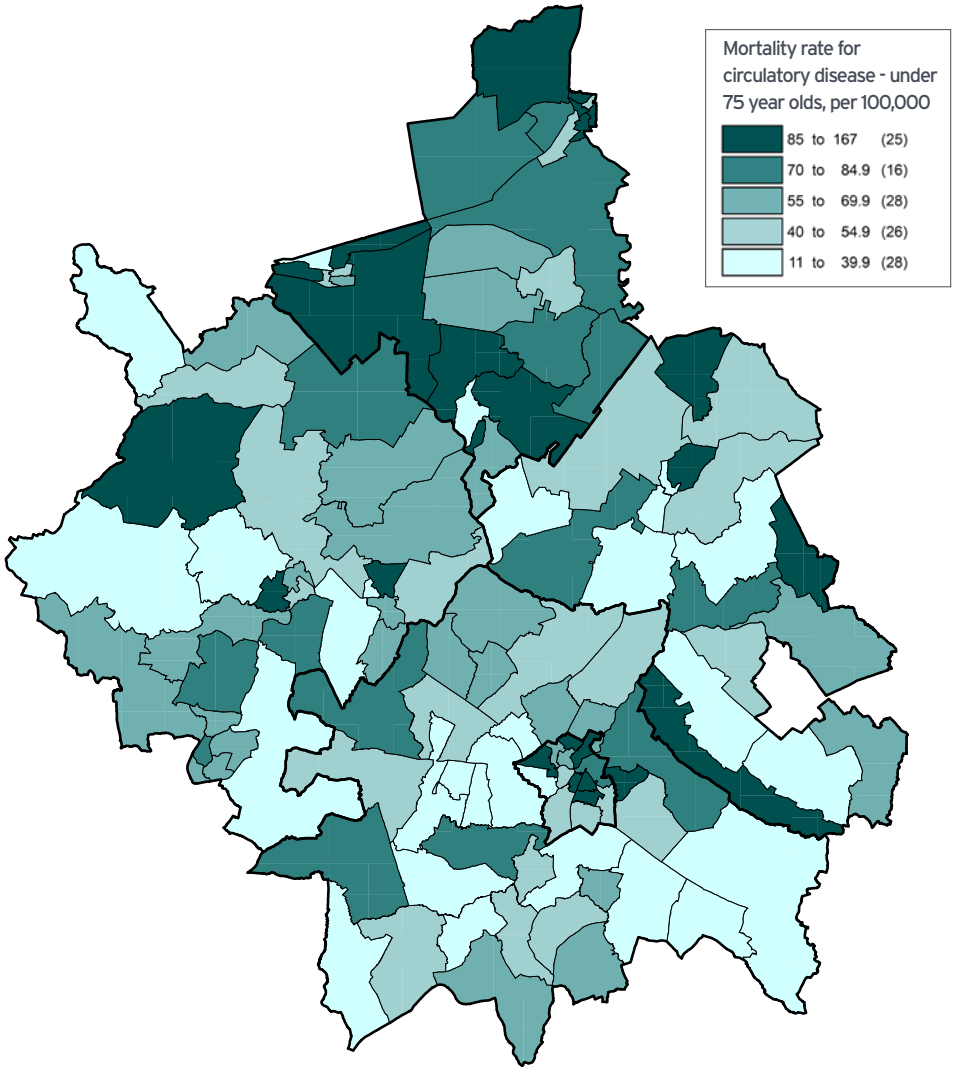
Health Walks

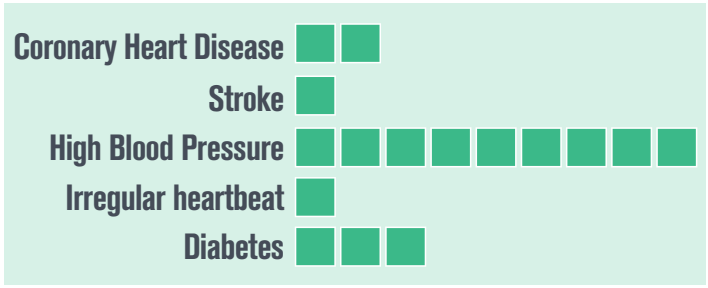
Health Walks are free evidence based interventions that support psychological wellbeing, as well as promoting physical activity. Regular walking has been shown to reduce the risk of chronic illnesses, such as heart disease, type 2 diabetes, asthma, stroke and some cancers. Organised local health walks bring together groups of up to 40 individuals who may have low levels of physical activity and/or be socially isolated.

The Fenland Explorer Project

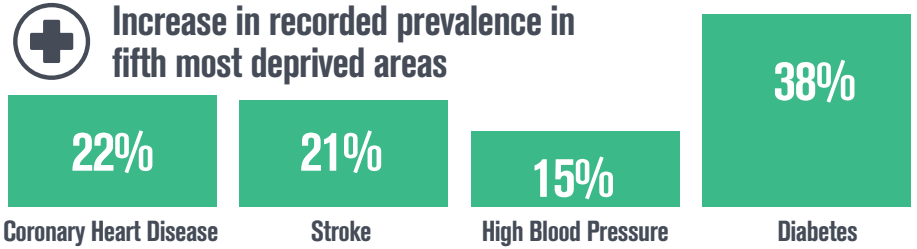
The Fenland Explorer Project trained volunteers from the community to undertake street based research in Wisbech, March, Chatteris, Whittlesey and the College of West Anglia with the aim of understanding high smoking prevalence in Fenland. The findings are being used for ongoing engagement of communities in smoking prevention and the Stop Smoking Services. The volunteers reported increased knowledge, communication skills and confidence.

Circulatory disease and diabetes





Increase in recorded prevalence in fifth most deprived areas



Mortality: in 2015 1,450 cardiovascular deaths a year

UNDER 75 YEARS 26% | 75-84 YEARS 28% | 85+ YEARS 46%

CORONARY HEART DISEASE 42% | STROKE 25% | HYPERTENSION 7%

Case study

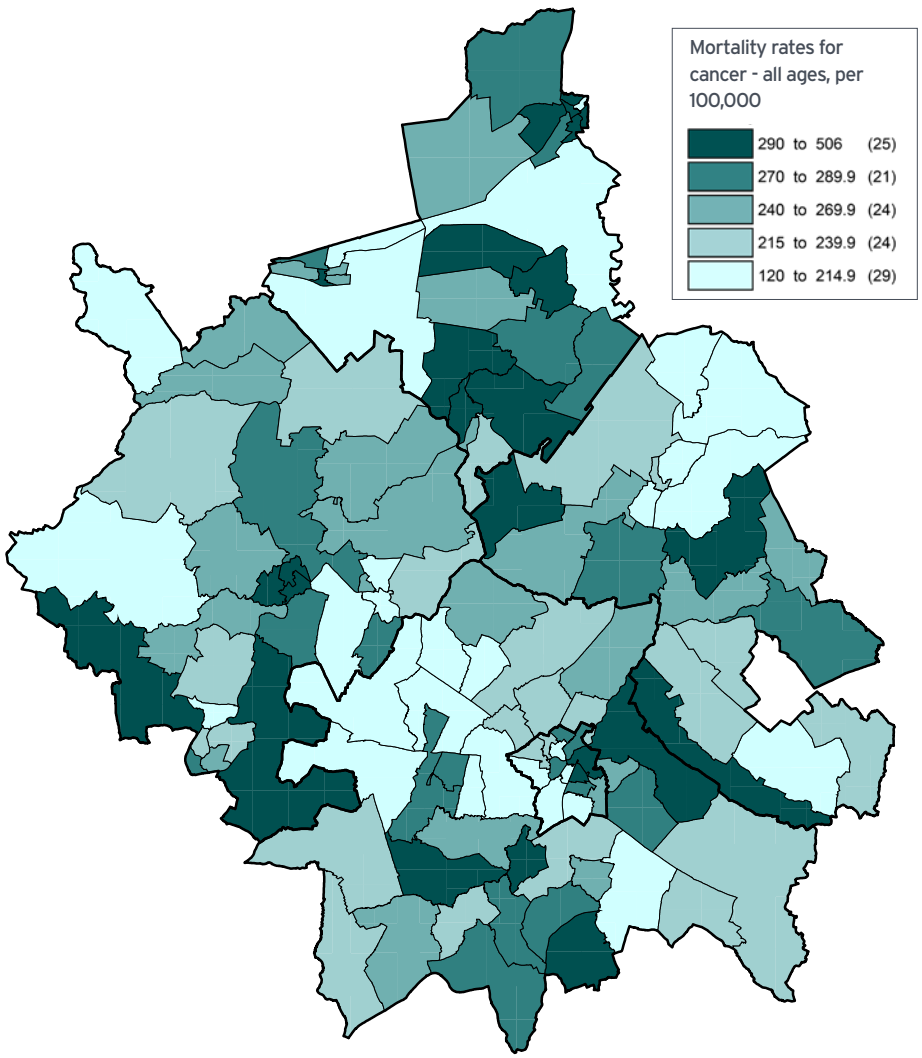
Health Trainers

Health Trainers offer tailored advice, motivation, skills and practical support to individuals who want to adopt healthier lifestyles. They focus on those in greatest need and in more disadvantaged communities.

The local integrated Lifestyles service includes community engagement workers who develop links with communities and health trainers, with the aim to increase the knowledge and skills needed to take responsibility for their own health. For example, healthy walks or cooking classes for parents.

What can YOU & YOUR COMMUNITY do?

Cancer



What can YOU & YOUR COMMUNITY do?

UPTAKE OF SCREENING

- Breast 75.3%
- Cervical 72.7%
- Bowel 58.1%

New cases (registrations) of cancer (per year)

3,400

Breast	16%
Lung	10%
Bowel	14%
Prostate	13%

Deaths from cancer (per year)

1,440

Breast	7%
Lung	17%
Bowel	10%
Prostate	8%

Case study

Healthy Options

Healthier Options is a local initiative to support local food businesses to provide healthier food and drink choices to customers. There are many benefits for both the business and the customer, including supporting better health outcomes.

Businesses are required to make a pledge to improve their menu. This may include reducing salt, fat and sugar content, increasing fruit and vegetables or making healthier choices the default option. Healthier Options Members are promoted via the website, helping customers to know where they can buy a healthier meal.

Healthier Options engages with the local community through its website, twitter and facebook. Some local residents have signed up to become Healthier Options Ambassadors and actively help promote the initiative to local businesses.

Visit **www.healthier-options.org.uk** for further information.

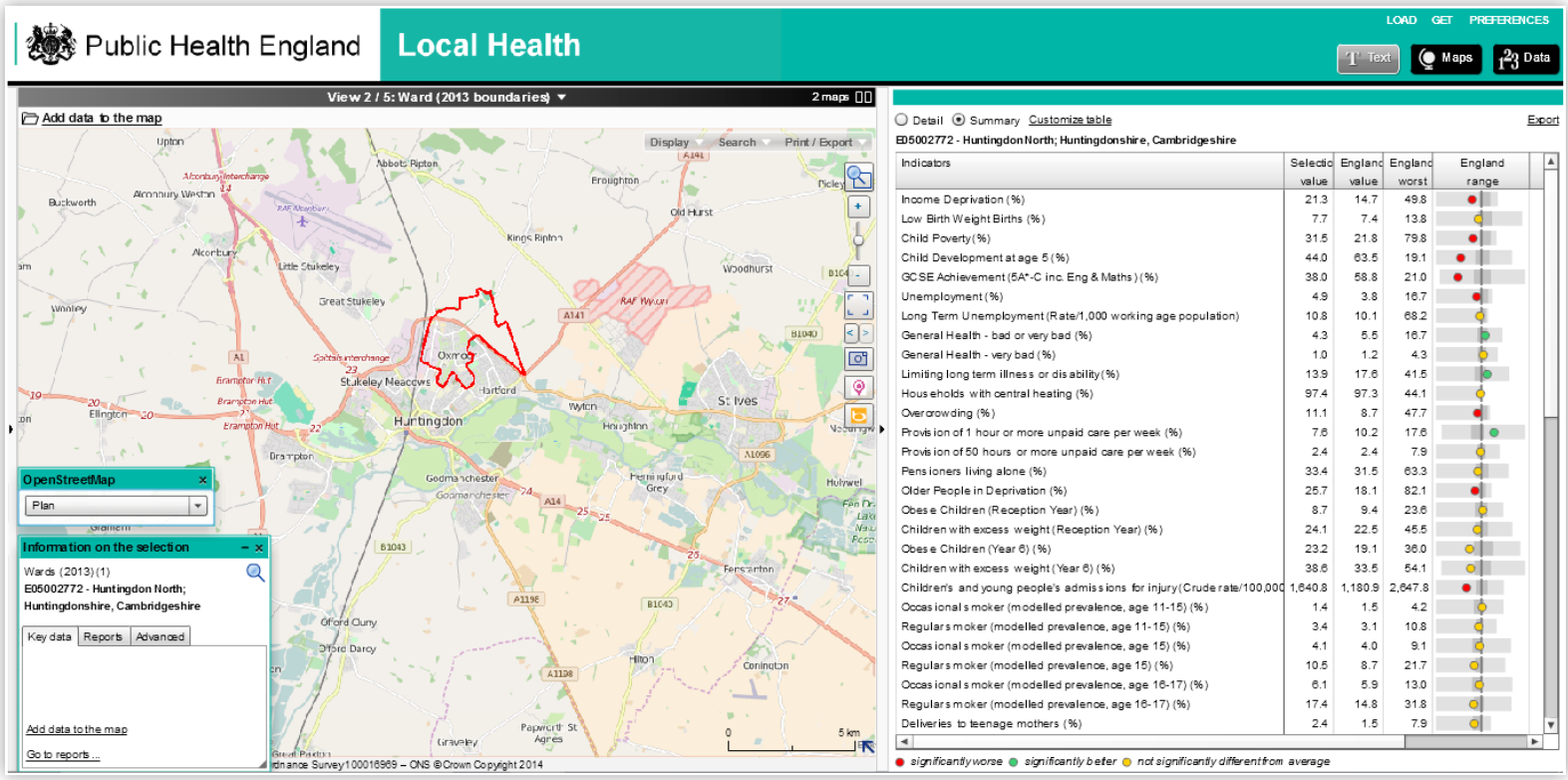
What data tools are available to help communities identify priorities for improving health and wellbeing of their population?

Local Health

Local Health presents data at ward level for a variety of health and health-related measures (www.localheath.org.uk). A summary of the data are shown in spine chart format, with a coloured dot presenting statistical difference to England. In general the red dots present areas to initially focus on, but it is important to note that there could be adverse trends in an area that aren't presenting in the data.

For example, a ward could be experiencing an increasing trend in childhood obesity but the latest data are not showing as different to England, but it is still important to take action.

There are currently 62 Indicators available at ward level, which include; demographics, deprivation, child development, education, employment, health and care indicators, housing, childhood obesity, adult lifestyle estimates, modelled smoking prevalence, hospital admissions, cancer incidence, causes of death and life expectancy. All indicators are presented in a spine chart or available in a downloadable ward report.



Examples of ward level outliers in health-related indicators from Local Health

High emergency hospital admissions for Coronary Heart Disease

Fenland	Huntingdonshire	South Cambridgeshire
Clarkson	Godmanchester	Bourn
Elm and Christchurch	Huntingdon East	
Hill	Huntingdon North	
Kirkgate	Ramsey	
March North	St Ives South	
Medworth	St Neots Eaton Socon	
Parson Drove and Wisbech St Mary	St Neots Eynesbury	
Peckover		
Roman Bank		
Staithe		
Waterlees		

High alcohol related hospital admissions

Cambridge City	Fenland	Huntingdonshire	South Cambridgeshire
Abbey	Clarkson	Huntingdon East	Sawston
Arbury	Elm and Christchurch	Huntingdon North	
Cherry Hinton	Hill	Ramsey	
Coleridge	Kirkgate	St Ives East	
East Chesterton	March East	St Neots Eaton Socon	
King's Hedges	March North	St Neots Eynesbury	
Romsey	March West	St Neots Priory Park	
	Medworth		
	Parson Drove and Wisbech St Mary		
	Peckover		
	Roman Bank		
	Staithe		
	Waterlees		

High emergency hospital admission for hip fracture in people aged 65 years and over

Cambridge City	Fenland	Huntingdonshire	South Cambridgeshire
King's Hedges	Bassenhally	St Neots Eaton Socon	Histon and Impington
	Benwick		
	Coates & Eastrea		
	Waterlees		

For further information please contact CCCPublicHealthIntelligenceTeam@cambridgeshire.gov.uk

Cambridgeshire Insight

Locally we have Cambridgeshire Insight, a web based tool that presents local health and wellbeing data at ward and district level. The Public Health Atlas includes maps, comparisons to other wards, rates and trends.

To date the indicators include; population estimates, housing-led population forecasts, deprivation, life expectancy and mortality, general health and long-term illness, lifestyles, sexual health, teenage pregnancy, mental health, fertility and births.

http://atlas.cambridgeshire.gov.uk/Health/atlas/atlas.html

Annex A: Progress on previous opportunities for action

This Annex reports on progress against opportunities for action identified in previous Annual Public Health Reports.

Annual Public Health Report 2015

A focus on promoting the health of school age children, including mental health

We are reviewing how best to promote the health of school age children with partner agencies, with services working in a more integrated way. We are working closely, with health colleagues in particular, around the redesign of children's mental health services, and the need to maximise prevention opportunities. Our Public Mental Health Strategy outlines how we plan to do this.

www.cambridgeshireinsight.org.uk/health/healthtopics/mh

A whole system approach to healthy diet and physical activity – reversing the trend in obesity

A whole system "Healthy Weight Strategy" is currently being developed with a wide group of local partner organisations, and will be launched in 2016. This will call for a range of initiatives that includes policy, practical interventions, community engagement and measures to support individuals and communities to adopt healthier behaviours.

Supporting a positive approach to healthy ageing

A new Long Term Conditions Joint Strategic Needs Assessment (JSNA) describes population needs for adults and older people living with multiple health conditions in Cambridgeshire. It provides important evidence and information to support the commissioning of services across health and social care.

The JSNA encourages awareness and signposting of available public health improvement programmes and services across Cambridgeshire.

www.cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecourse-2015

A recent Healthy Ageing and Prevention Summit focussed on action to sustain wellbeing in later life. The agreed local priorities were described and endorsed as:

- increasing physical activity and reducing injurious falls
- ensuring holistic approaches and care for older peoples' mental health
- strengthening a place-based approach to healthy ageing
- avoiding admissions for people with multiple conditions and complex needs

These local priorities have all been taken forward within multi-agency working groups, through the Better Care Fund and other major health and social care sector workstreams.

Annex A: Progress on previous opportunities for action

Annual Public Health Report 2014

Targeted work to understand and address high rates of smoking

The latest data available indicates that generally smoking prevalence has improved since 2012 but smoking rates remain higher in Fenland and for manual workers than the average for Cambridgeshire residents. The Cambridgeshire County Council Public Health Team are using intelligence from social marketing research commissioned in 2014/15 that provides an insight into community views on smoking to inform targeted approaches.

This includes campaigns and workplace initiatives focusing upon workplaces that have predominantly manual workers. Cambridgeshire is also working with neighbouring local authorities on tobacco related campaigns and engagement work, including a focus on illicit tobacco sales.

A focus across organisations on inequalities in the early years

Trend data shows that although the percentage of children in poverty in Cambridge has improved over the last few years, in Fenland it has remained static and is now significantly worse than the national average.

Although showing some improvement, the percentage of children receiving free school meals in Cambridgeshire who have achieved a good level of development at the end of reception remains below the national average.

Cambridgeshire Children's and Young People's services already have a strong focus on inequalities in the early years through a range of programmes and targeted activity. The commissioning of health visiting and 'family nurse partnership' services transferred from NHS England to the County Council in October 2015, providing further opportunities for joint working and addressing inequalities in early years health and development.

Working with communities in Fenland on health and lifestyles

The Healthy Fenland Fund has been established that both engages and strengthens communities alongside supporting them to take forward community led initiatives, as described in the case study earlier in this report.

Building a preventive approach to mental health in the county

The latest figures for suicide rates in the county (3 year average, 2012-14) have shown little change and are similar to the national average. Rates of self-harm amongst young people aged 10-24 have been increasing and were higher than the national average in 2013/14 (the latest available data). The Council, working with a wide range of organisations, has produced a Public Mental Health Strategy (2015-17) that focuses on promoting better mental health and preventing mental illness. The strategy has three areas of focus: a life course approach to promoting mental health; developing a wider environment that supports mental health; and addressing the links between physical and mental health.

An action plan has been produced as part of the strategy detailing the work that is being undertaken across these three areas. The strategy forms an important part of wider preventative work that is currently being undertaken by a range of statutory and voluntary sector agencies.

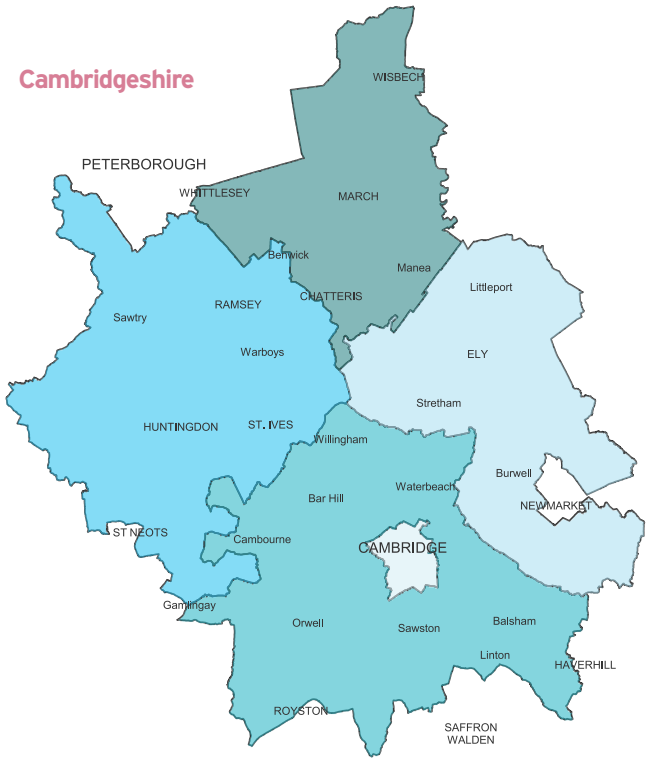
www.cambridgeshireinsight.org.uk/health/healthtopics/mh

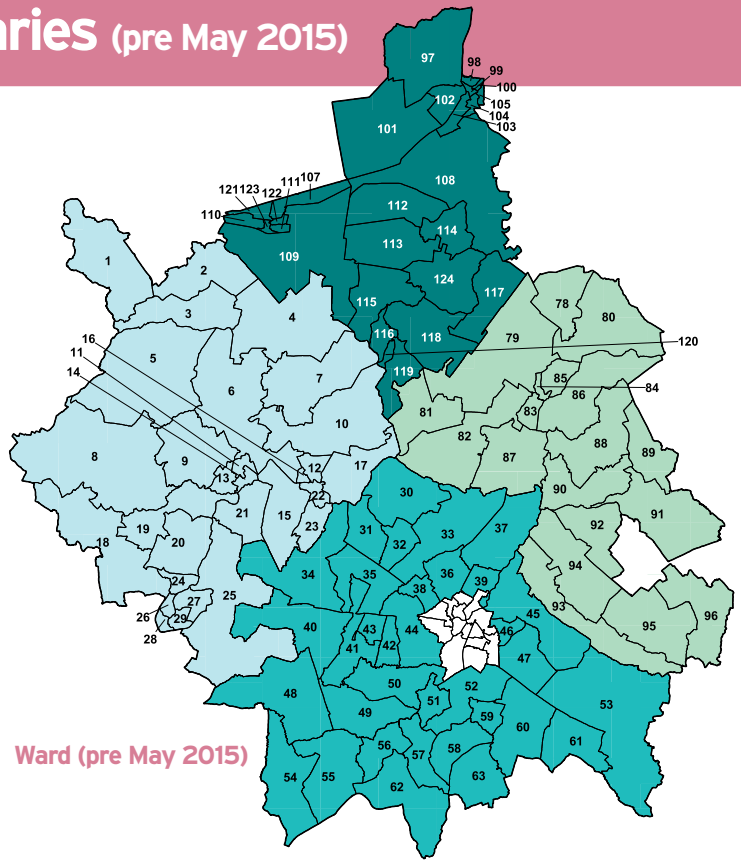
Reviewing reasons for lower coverage of individual vaccination and screening programmes and taking action to address this

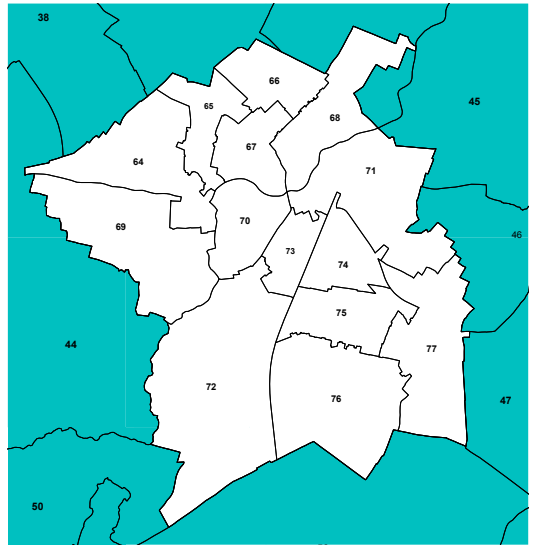
As the most recent figures show, adverse trends in coverage of childhood immunisation and cervical screening are continuing to cause concern in Cambridgeshire. Work to improve access has led to a welcome increase in breast screening uptake. For immunisations NHS England, which is the commissioner of childhood immunisation and adult screening programmes has set up a joint task group with the County Council to review why childhood immunisation coverage is falling and to develop solutions.

This follows on from earlier work to make sure that the database used to track childhood immunisation coverage is updated when children move in and out of the County, and that the data we are using is robust. Over the past year a task group convened by NHS England has met to identify issues that are affecting cancer screening uptake and work is in hand to address these issues. Funding is being provided by NHS England for targeted communications work for both immunisation and screening.

Annex B: Ward boundaries (pre May 2015)

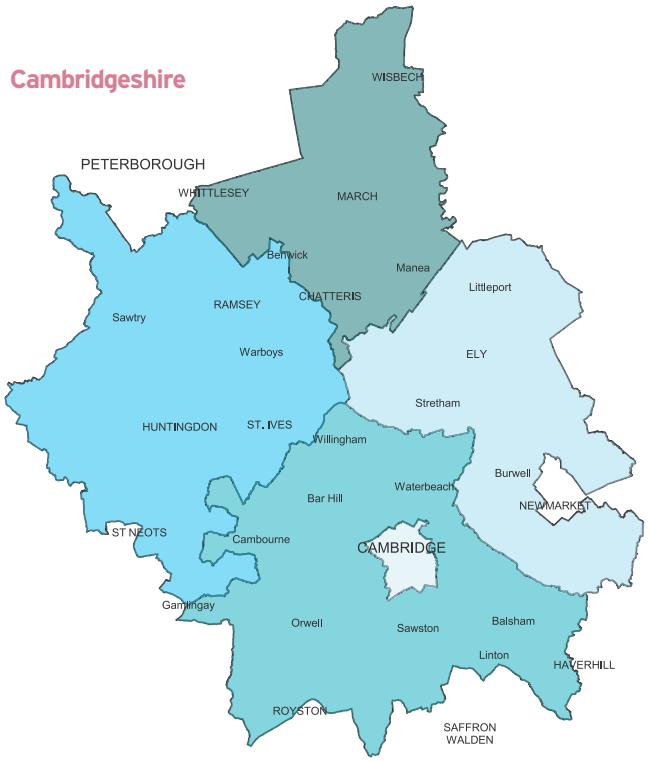


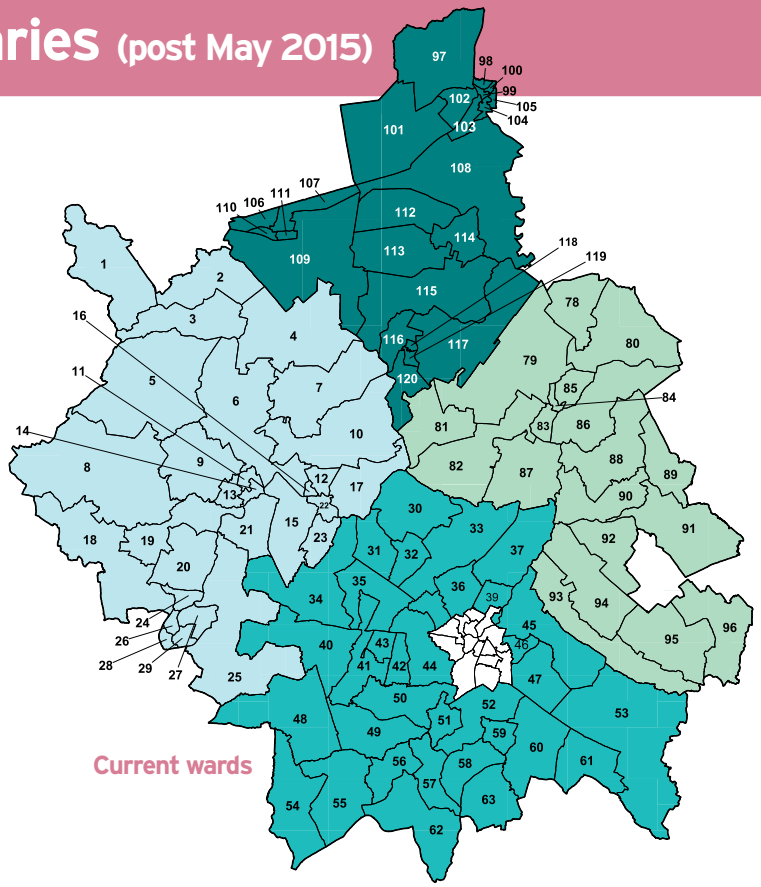


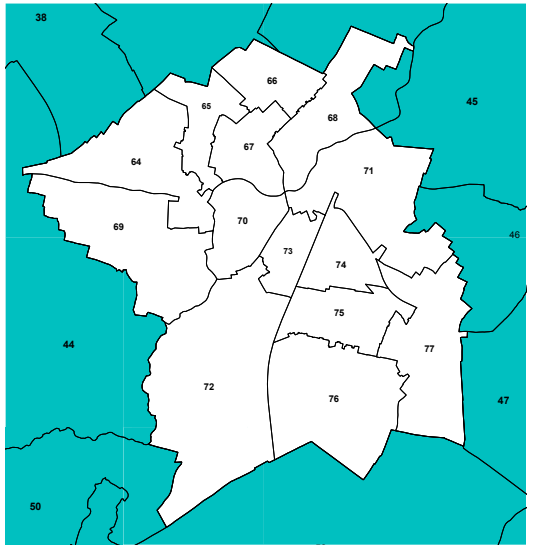


1. Elton and Folksworth
2. Yaxley and Farcet
3. Stilton
4. Ramsey
5. Sawtry
6. Upwood and The Raveleys
7. Warboys and Bury
8. Ellington
9. Alconbury and The Stukeleys
10. Somersham
11. Huntingdon North
12. St Ives East
13. Huntingdon West
14. Huntingdon East
15. The Hemingfords
16. St Ives West
17. Earith
18. Kimbolton and Staughton
19. Brampton
20. Buckden
21. Godmanchester
22. St Ives South
23. Fenstanton
24. Little Paxton
25. Gransden and The Offords
26. St Neots Eaton Ford
27. St Neots Priory Park
28. St Neots Eaton Socon
29. St Neots Eynesbury
30. Willingham and Over
31. Swavesey
32. Longstanton
33. Cottenham
34. Papworth and Elsworth
35. Bar Hill
36. Histon and Impington
37. Waterbeach
38. Girton
39. Milton
40. Bourn
41. Caldecote
42. Comberton
43. Hardwick
44. Barton
45. The Wilbrahams
46. Teversham
47. Fulbourn
48. Gamlingay
49. Orwell and Barrington
50. Haslingfield and The Eversdens
51. Harston and Hauxton
52. The Shelfords and Stapleford
53. Balsham
54. The Mordens
55. Bassingbourn
56. Meldreth
57. Fowlmere and Foxton
58. Whittlesford
59. Sawston
60. The Abingtons
61. Linton
62. Melbourn
63. Duxford
64. Castle
65. Arbury
66. King's Hedges
67. West Chesterton
68. East Chesterton
69. Newnham
70. Market
71. Abbey
72. Trumpington
73. Petersfield
74. Romsey
75. Coleridge
76. Queen Edith's
77. Cherry Hinton
78. Littleport West
79. Downham Villages
80. Littleport East
81. Sutton
82. Haddenham
83. Ely South
84. Ely West
85. Ely North
86. Ely East
87. Stretham
88. Soham North
89. Isleham
90. Soham South
91. Fordham Villages
92. Burwell
93. Bottisham
94. The Swaffhams
95. Dullingham Villages
96. Cheveley
97. Roman Bank
98. Waterlees
99. Clarkson
100. Kirkgate
101. Parson Drove and Wisbech St Mary
102. Peckover
103. Medworth
104. Hill
105. Staithe
106. Bassenhally
107. Elm and Christchurch
108. Benwick, Coates and Eastrea
109. St Andrews
110. Lattersey
111. March North
112. March West
113. March East
114. Doddington
115. Slade Lode
116. Manea
117. Birch
118. Wenneye
119. The Mills
120. Delph
121. Kingsmoor
122. St Marys
123. Wimblington

Annex B: Ward boundaries (post May 2015)







1. Elton and Folksworth
2. Yaxley and Farcet
3. Stilton
4. Ramsey
5. Sawtry
6. Upwood and The Raveleys
7. Warboys and Bury
8. Ellington
9. Alconbury and The Stukeleys
10. Somersham
11. Huntingdon North
12. St Ives East
13. Huntingdon West
14. Huntingdon East
15. The Hemingfords
16. St Ives West
17. Earith
18. Kimbolton and Staughton
19. Brampton
20. Buckden
21. Godmanchester
22. St Ives South
23. Fenstanton
24. Little Paxton
25. Gransden and The Offords
26. St Neots Eaton Ford
27. St Neots Priory Park
28. St Neots Eaton Socon
29. St Neots Eynesbury
30. Willingham and Over
31. Swavesey
32. Longstanton
33. Cottenham
34. Papworth and Elsworth
35. Bar Hill
36. Histon and Impington
37. Waterbeach
38. Girton
39. Milton
40. Bourn
41. Caldecote
42. Comberton
43. Hardwick
44. Barton
45. The Wilbrahams
46. Teversham
47. Fulbourn
48. Gamlingay
49. Orwell and Barrington
50. Haslingfield and The Eversdens
51. Harston and Hauxton
52. The Shelfords and Stapleford
53. Balsham
54. The Mordens
55. Bassingbourn
56. Meldreth
57. Fowlmere and Foxton
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95. Dullingham Villages
96. Cheveley
97. Roman Bank
98. Waterlees Village
99. Clarkson
100. Kirkgate
101. Parson Drove & Wisbech St Mary
102. Peckover
103. Medworth
104. Octavia Hill
105. Staithe
106. Stonald
107. Bassenhally
108. Elm & Christchurch
109. Benwick, Coates & Eastrea
110. St Andrews
111. Lattersey
112. March North
113. March West
114. March East
115. Doddington & Wimblington
116. Slade Lode
117. Manea
118. Birch
119. Wenneye
120. The Mills

Sources

Public Health Outcomes Framework – data as at March 2016

Income Deprivation Affecting Older People Index (IDAOPI), Indices of Deprivation 2015, Department for Local Communities and Local Government

Health Related Behaviour Survey 2014, School Health Education unit – data held by Cambridgeshire County Council

Conception Statistics, Under 18 years, 2014, Office for National Statistics

Child Health Profiles, 2016, National Child and Maternal Health Intelligence Unit (ChiMat), Public Health England

Admitted Patient Care SUS data, 2014/15, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)

National Child Measurement Programme, 2014/15, Health and Social Care Information Centre

Mental Health of Children and Young People in Great Britain, 2004, Office for National Statistics

Mental Health of Children and Young People in Great Britain, 2004, Office for National Statistics

Census 2011, Office for National Statistics

MRC CFAS II prevalence estimates, Cambridgeshire University and 2015 population, Population forecasts (2013 based), Research and Performance Team, Cambridgeshire County Council

Indicator portal, Health and Social Care Information Centre

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Kessler et al (2005). Lifetime Prevalence and Age-of-onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry 62 (6): 593 602

Primary Care Mortality Database, 2013-2015, Vital Statistics, Office for National Statistics – data held by Cambridgeshire County Council

ANNUAL HEALTH PROTECTION REPORT (2015)

To:	**Health Committee**
Meeting Date:	**12th May 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	***Key decision:*** **No**
Purpose:	**To present the Cambridgeshire Annual Health Protection Report (2015), which provides information on and assurance of the local delivery of health protection functions.**
Recommendation:	**The Committee is asked to note the information in the Annual Health Protection Report (2015).**

	Officer contact:
Name:	Dr Linda Sheridan
Post:	Consultant in Public Health Medicine
Email:	Linda.sheridan@cambridgeshire.gov.uk
Tel:	01223 706138

1. BACKGROUND

1.1 This is the third annual report on health protection produced in Cambridgeshire since the transfer of public health functions to local authorities.

1.2 The Health and Social Care Act 2012, from 1 April 2013, placed statutory responsibilities on the County Council, through the Director of Public Health (DPH), to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Clinical Commissioning Group (CCG) and City and District Councils.

1.3 The delivery of the health protection functions of the County Council must be publicly reported so that members can assure themselves that statutory responsibilities are being fulfilled. Members of the public can also access this information for their own reassurance or research.

1.4 It was agreed that the DPH would deliver an annual health protection report to provide a summary of relevant activity. This report would cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged.

1.5 The services that fall within Health Protection include :-

- Communicable disease and environmental hazards;
- Public health emergency planning
- Immunisation
- Screening
- Sexual health

1.6 The Cambridgeshire Health Protection Steering Group (HPSG) was established in April 2013, chaired by the DPH, to support the DPH in having oversight of health protection in Cambridgeshire. It meets quarterly in January, April, July and October. Starting in October 2015, the Cambridgeshire HPSG has joined with the Peterborough HPSG.

2. MAIN ISSUES

2.1 Items of particular interest in the Annual Health Protection Report (2015), attached as Annex A include:

- The ongoing use and updating of the Public Health England led Joint Communicable Disease Outbreak Management Plan and the Cambridgeshire Health Protection Memorandum of Understanding (AHPR para 2.5 and 2.6) .

- Levels of notifiable infectious diseases have generally remained stable over the past three years in Cambridgeshire with the exception of scarlet fever, which has shown a significant rise in the number of cases in line with national trends (AHPR para 3.1 and 3.3) .

- The work of the task groups on improving uptake of childhood immunisations (AHPR para 4.2), a low uptake of flu vaccination by people in risk groups aged under 65 including pregnant women, and uncertainty about uptake by adult social care staff (AHPR para 4.8 and 4.10).

- An improvement in breast screening uptake in Cambridgeshire, but ongoing concern about low uptake of cervical screening, which is being addressed through a task group implementation plan presented to Health Committee in March 2016 (AHPR para 5.2 and 5.3) .

- Testing of the updated Cambridgeshire and Peterborough Local Resilience Forum Pandemic Influenza Plan, through the multi-agency Exercise Corvus (AHPR para 6.6)

- Lower rates of diagnosed sexually transmitted infections and of teenage pregnancies than national rates, but a higher proportion of HIV infections being diagnosed at a late stage (AHPR paras 8.1-8.4) .

- Local East Anglia workshop recommendations for implementation of the national TB strategy (AHPR section 9.0)

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

Effective prevention of infectious disease outbreaks maintains workforce health and is therefore beneficial to the economy.

3.2 Helping people live healthy and independent lives

The report describes measures to protect people's health from infectious disease and public health emergencies.

3.3 Supporting and protecting vulnerable people

Some vulnerable groups of people have increased susceptibility to infectious disease – for example pregnant women, people with long term conditions and elderly people are more vulnerable to the effects of influenza and are entitled to free vaccinations.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no immediate resource implications from the Annual Health Protection Report.

4.2 Statutory, Risk and Legal Implications

Under the Health and Social Care Act (2012) the County Council has a duty 'to provide information and advice to certain persons and bodies within their area in order to promote the preparation of, or participation in, health protection arrangements against threats to the health of the local population,

including infectious disease, environmental hazards and extreme weather events.'

4.3 Equality and Diversity Implications

No significant implications .

4.4 Engagement and Consultation Implications

No significant implications

4.5 Localism and Local Member Involvement

No significant implications

4.6 Public Health Implications

Covered in the main body of the report.

Source Documents	Location
None	

Annex A

CAMBRIDGESHIRE HEALTH PROTECTION STEERING GROUP

ANNUAL HEALTH PROTECTION REPORT (2015)

1. INTRODUCTION

1.1 This is the third annual report on health protection to the Cambridgeshire County Council Health Committee.

1.2 The Health and Social Care Act 2012, from 1 April 2013, placed statutory responsibilities on the County Council, through the Director of Public Health (DPH), to advise on and promote local health protection plans across agencies, which complements the statutory responsibilities of Public Health England, NHS England, the Clinical Commissioning Group (CCG) and City and District Councils.

1.3 The delivery of the health protection functions of the County Council must be publicly reported so that members can assure themselves that statutory responsibilities are being fulfilled. Members of the public can also access this information for their own reassurance or research.

1.4 It was agreed that the DPH would deliver an annual health protection report to the Health Committee to provide a summary of relevant activity. This report would cover the multi-agency health protection plans in place which establish how the various responsibilities are discharged.

1.5 The services that fall within Health Protection include :-

- Communicable disease and environmental hazards;
- Public health emergency planning
- Immunisation
- Screening
- Sexual health

2.0 CAMBRIDGESHIRE HEALTH PROTECTION STEERING GROUP

2.1 The Cambridgeshire Health Protection Steering Group (HPSG) was established in April 2013, chaired by the DPH, to support the DPH in having oversight of health protection in Cambridgeshire.

2.2 The HPSG meets quarterly in January, April, July and October. Starting in October 2015, the Cambridgeshire HPSG has joined with the Peterborough HPSG. The meeting has separate sections for Cambridgeshire only and Peterborough only issues at beginning and end of the meeting and a middle section to discuss all those issues that are relevant to both local authorities. The middle section receives

reports on work across both areas on issues such as immunisation, screening, emergency planning and communicable diseases common to both authority areas.

2.3 Standing items have included:

- Immunisations – routine data as well as specific issues that have arisen – report from NHS England
- Screening – routine data and any specific issues that have arisen – report from NHS England
- Healthcare associated infection and antimicrobial resistance – reports from the CCG
- An update on health emergency planning and updates from the Local Health Resilience Partnership (LHRP)
- Tuberculosis including the new national strategy, BCG vaccination and incidents.

2.4 The three priority areas agreed by the HPSG to be standing agenda items are:

- Public communication to support uptake of immunisation and screening (e.g. cervical screening uptake is low in Cambridge City) and some other issues such as use of anti-microbial drugs.
- TB to include consideration of vulnerable people and the implementation of the national TB Strategy
- Pandemic flu planning including planning for excess deaths

2.5 Memorandum of Understanding

The 2014 Memorandum of Understanding (MOU) for health protection, developed to ensure agreement from all relevant organisations to provide reports and assurance to the Health Protection Steering group for Cambridgeshire and to collaborate with other partners in the response to any incident that affects public health in the county, has been reviewed and revised and is being re-issued to partner organisations for sign-off.

In practice this proved to be very helpful over the past two years during the response to public health incidents, as it clarified responsibilities, including financial responsibilities, in a number of public health incidents and meant that there were no delays while this clarification was sought.

2.6 Joint Communicable Disease Outbreak Management Plan

Development of this plan was led by Public Health England with support from the public health teams in local authorities. It has been in use since it was initially ratified in 2014 and has also been tested during exercises. Further to organisational and other changes, the plan was updated in April 2015.

3.0 SURVEILLANCE

3.1 Notifications of Infectious Diseases

Doctors in England and Wales have a statutory duty to notify suspected cases of certain infectious diseases. These notifications along with laboratory and other data is an important source of surveillance data. The table below shows the notifiable diseases reported to the HPT from 2013 - 2015.

Table 1: Notifiable Diseases in Cambridgeshire

Notifiable Disease*	2013†	2014†	2015†
Acute infectious hepatitis	27	20	25
Acute meningitis	17	8	8
Botulism	0	0	<5
Cholera	0	<5	0
Cryptosporidiosis		See below	
Enteric Fever	<5	<5	<5
Food poisoning	671	763	768
Infectious bloody diarrhoea	8	6	5
Invasive Group A streptococcal disease	13	23	18
Legionnaires' Disease	<5	0	<5
Malaria	11	10	9
Measles	53	23	13**
Meningococcal septicaemia	7	<5	9
Mumps	47	44	24**
Rubella	<5	11	5**
Scarlet fever	47	89	159
Whooping cough	84	108	80

SOURCE: East of England HPT (Thetford) HPZone

***** *Notifiable diseases with no reported cases during the three years are not listed here. These are notifications of infectious disease and are not necessarily laboratory confirmed.*

† *Because of the confidentiality risk associated with reporting very small numbers, where there are fewer than 5 cases they are reported as <5*

** *Single case of laboratory confirmed measles. Two laboratory confirmed cases of mumps and no laboratory confirmed cases of rubella*

3.2 It is particularly important to note the number of cases notified that are of illness which could have been prevented by immunisation, in particular mumps, measles, whooping cough, rubella (German measles), each of which can have serious long term health consequences, especially when also considering the childhood immunisation uptake data later in this report..

3.3 Scarlet fever

Scarlet fever is a common childhood infection caused by *Streptococcus pyogenes*, also known as group A streptococcus (GAS). It is most common between the ages of 2 and 8 years, although children and adults of all ages can develop it.

Similar to the rest of the country, scarlet fever seasonal activity has remained elevated across Cambridgeshire, following the increase in notifications seen last year. Since the start of 2015 there has been a rapid and higher than expected increase in notifications compared to the previous year.

Although scarlet fever is usually a mild illness, patients can develop complications such as an ear infection, throat abscess, pneumonia, sinusitis or meningitis. Clinicians should also be mindful of a potential increase in invasive GAS (iGAS) infection which tends to follow trends in scarlet fever. Early recognition and prompt initiation of specific and supportive therapy for patients with iGAS infection can be lifesaving.

3.4 Cryptosporidiosis increase

Most human infections are caused by *Cryptosporidium hominis*, for which humans are the only natural host, and *C parvum*, which infects bovines as well as humans.

There has been an exceedance of cryptosporidiosis cases reported for Norfolk, Suffolk and Cambridgeshire throughout the autumn months of 2015, which has also been seen across the country. The three week rolling average for 2015 has followed a similar distribution to previous years, but at a higher level between September and December. The numbers of cases decreased to normal levels by the end of December. The largest number of cases was from Norfolk (39%), followed by Cambridgeshire (26%) and Suffolk (20%). Mapping the cases did not identify any geographical clustering. Routine questionnaires identified that 25% cases reported contact with at least one other confirmed or suspected case of cryptosporidiosis, although this question was left blank on half of the questionnaires. The main contextual settings (potential sources) for cases were household (30%) and unknown (25%), with foreign travel only indicated for 22 (11%) cases. The predominant species changed over the autumn with more *C. hominis* in September and more *C. parvum* in November and December.

A national case control study, which the HPT is participating in, was initiated in January 2016 to identify risk factors for the cryptosporidiosis increase.

3.5 Outbreaks and Incidents

Table 2: Cambridgeshire, January - December 2015

Gastroenteritis	Healthcare-associated infection	Respiratory virus	TB	Environmental/ Chemical	Scabies	Other infectious disease	Total
34†	4	4	3	4*	2	3	**54**

SOURCE: East of England HPT (Thetford) HPZone

† *32 care-home outbreaks, 6 confirmed as norovirus; 1 workplace gastroenteritis outbreak and 1 food poisoning outbreak*

* *3 fires, 1 mercury spill*

4.0 PREVENTION

The focus of this section is Immunisation and Screening programmes. NHS England East Anglia Team leads on commissioning of the following programmes for the population of Cambridgeshire;

- Cancer Screening: Breast, Cervical and Bowel Cancer,
- Adult and Young People Screening: Abdominal Aortic Aneurysm (AAA) and Diabetic Eye Screening(DES),
- Antenatal and Newborn Screening programmes,
- Immunisation Programmes: neonatal and childhood, school age and adult immunisations

The team provides regular updates on screening and immunisations to the Cambridgeshire HPSG.

4.1 IMMUNISATION PROGRAMMES

Uptake of childhood immunisations is low in Cambridgeshire. A Task & Finish Group was established in December 2015 to review detailed data on immunisation uptake across the county, including mapping to identify areas in which uptake is particularly low. This will enable a targeted approach to the development of plans to address issues identified with a view to improving coverage.

4.2 Childhood Primary Vaccinations

The table 4 below clearly shows that the target for uptake of childhood immunisations which is 95% is yet to be met for all childhood primary immunisation programmes. This is the uptake level that ensures herd immunity in the local population. When a high percentage of the population is vaccinated, it is difficult for infectious diseases to spread because there are not many people who can be infected. For example, if someone with measles is surrounded by people who are vaccinated against measles, the disease cannot easily be passed on to anyone, and it will quickly disappear again. This is called 'herd immunity', and it gives protection to vulnerable people such as newborn babies, elderly people and those who are too sick to be vaccinated and to those whose immune system is weakened and prevents them developing a good level of immunity when vaccinated.

Analysis of the data has shown that there are pockets of poor uptake in Cambridgeshire which has led to the Health Protection Steering Group recommending that a Task & Finish Group undertake a piece of work to

understand the causes of the declining uptake and start setting out actions to reverse this downward trend. The Task and Finish group, led by PHE/NHS England in collaboration with Cambridgeshire County Council and other partners, has agreed terms of reference to identify areas of lower immunisation uptake, understand the cause and make recommendations to reverse this trend.

Table 3: Childhood vaccination uptake in Cambridgeshire 2015/16

12 months DTaP/IPV/Hib [target 95%]				
	Q4 2014/5	Q1 2015/6	Q2 2015/6	Q3 2015/6 Data not yet available
Cambs	94.8	93.1	94.7	
East Anglia	95.6	95.6	95.6	
12 months PCV [target 95%]				
Cambs	94.6	92.9	94.4	
East Anglia	95.3	95.4	95.4	
24 months DTaP/IPV/Hib [target 95%]				
Cambs	94.4	95.6	93.3	
East Anglia	96.4	95.6	95.7	
24 months PCV Booster [target 95%]				
Cambs	91.6	91.3	90.0	
East Anglia	93.9	93.6	93.0	
24 months Hib/Men C [target 95%]				
Cambs	91.5	91.9	89.4	
East Anglia	94.0	93.8	92.5	
24 months MMR 1 [target 95%]				
Cambs	91.4	91.7	89.1	
East Anglia	93.5	93.4	92.3	
5 years DTaP Hib [target 95%]				
Cambs	94.2	94.7	93.8	
East Anglia	95.8	96.2	95.3	
5 years MMR 1 [target 95%]				
Cambs	91.3	92.3	90.9	
East Anglia	94.1	94.2	93.1	
5 years MMR 2 [target 95%]				
Cambs	85.6	89.8	84.7	
East Anglia	89.7	91.4	88.8	
5 years DTaP/IPV Booster [target 95%]				
Cambs	86.3	85.7	85.4	
East Anglia	90.7	90.7	89.5	
5 years Hib/Men C [target 95%]				
Cambs	91.2	91.3	90.0	
East Anglia	93.4	93.1	93.0	

4.3 Rotavirus Vaccination programme

Rotavirus, a highly contagious virus that has been the most common cause of gastroenteritis in infants and very young children has reduced markedly since the introduction of a vaccine against the disease in July 2013. Rotavirus infection previously led to high demand on GP consultations and frequently led to hospital admission.

Uptake, while not yet over 95% is consistently high. The effectiveness of the vaccine has been demonstrated by surveillance data provided by the PHE Eastern Field Epidemiology Unit (EFEU), showing rates of infection have dropped to 0 – 3 cases per week across Anglia (Cambridgeshire, Peterborough, Norfolk and Suffolk) in March 2016 compared to around 60 cases per week in the same period prior to introduction of the vaccine.

Table 4: Rotavirus vaccination uptake

	April 2014 %	May 2014 %	June 2014 %	July 2014 %	August 2014 %	Sept 2014 %	Oct 2014 %	Nov 2014 %	Dec 2014 %	Jan 2015 %	Feb 2015 %	Mar 2015 %
CCG	90.9	90.5	90.6	91.2	92.3	92.5	90.4	88.5	91.2	91.3	90.3	90.3
East Anglia	92.5	90.1	90.7	91.8	91.9	92.5	92.5	89.3	90.6	91.0	91.3	91.5
	April 2015	May 2015	June 2015	July 2015	August 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	March 2016
CCG	91.0	92.0	92.1	92.1	91.8	NA	91.3	88.5	90.9	91.4	NA	NA
East Anglia	90.4	92.2	91.7	91.6	91.7	NA	92.2	90.7	91.9	91.6	NA	NA

4.4 BCG Vaccination

BCG vaccination is for prevention of Tuberculosis (TB). It confers some immunity, and is recommended for newborn babies who:

- Are born in an area with a high incidence of TB – high incidence is defined by the World Health Organisation as 40 or more new cases per 100,000 population per year (Cambridgeshire rate is 5.6/100,000/year)
- Have one or more parents or grandparents who were born in countries with a high incidence of TB

Maternity units have been responsible for giving BCG vaccination to eligible babies since April 2015. The model of good practice is that the baby should be vaccinated before discharge home from the maternity unit. Implementation was delayed due to the need to train midwives to administer the vaccine and then by a shortage of the vaccine in 2015. However both issues have now been resolved and the Screening and Immunisation Team (NHSE / PHE) has agreed to report uptake to each meeting of Cambridgeshire HPSG.

4.5 School based immunisation programmes

There is good evidence that, for school age children, uptake of vaccinations is higher when they are given at school. Cambridgeshire school children previously received HPV vaccination at school, and all other school age vaccinations from their GP. In 2015 NHS England awarded the contract for the delivery of all school based immunisation

programmes in East Anglia to Cambridgeshire Community Services. This contract includes administration of the new flu vaccinations that are being gradually introduced for school age children.

CCS was also commissioned to deliver school leaving booster (Td/IPV), HPV and Men ACWY. Data is not available for uptake rates prior to introduction of the new contract for school based immunisations but in January 2016 uptake of the year 10 (age 14+) Diphtheria, Tetanus and Polio booster was 71%, a very good start to the new contract arrangements.

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4.6 Human Papilloma Virus (HPV) programme

The Human Papilloma Virus (HPV) programme of vaccination of girls aged 12 – 13 has been very successful. HPV is a causative factor in Viral Warts, Cervical Cancer and other forms of cell morphological changes in the human body. Up until September 2014, this vaccine was given as three doses over the course of a school year. Since then the programme has been changed to provide two doses over the course of 6 to 24 months, usually given early in year 8 and year 9. The data below is for the first year of this new schedule, hence the apparently very low uptake of the second dose, as most will not receive it until at least a year after the first dose.

Table 5: HPV vaccination uptake in school year

2014/15 up to 31.8.15 *	Dose 1	Dose 2
Cambridgeshire	85.5	2.3
East Anglia	89.4	5.0

*As this programme runs over a school year, complete data for 2014/5 will not be available for some time

4.7 Seasonal Influenza vaccination programme - Children

A programme that will eventually see all children aged 2 - 16 offered Influenza (flu) vaccination each year began three years ago and so far has been rolled out to pre-school children age 2 – 4 years, who are vaccinated by their GPs and from 2015 children in years 1 and 2, vaccinated as part of the school immunisation programme

The flu vaccine for children is given as a single dose of nasal spray squirted up each nostril. Not only is it needle-free (a big advantage for children), the nasal spray works even better than the injected flu vaccine with fewer side effects. In the case of some children in the at risk groups, two doses of the nasal spray will be needed. For many years prior to introduction of this universal programme, children aged from 2 years who are identified as having health conditions that cause them to be at greater risk of complications from Flu have been offered

vaccination by injection each year. Although this vaccination programme reduces the incidence of Flu among children, it is also known to break transmission of the disease from children to vulnerable adults.

Table 6: Flu vaccination uptake age 2 to 4

Cambridgeshire & Peterborough CCG						
	2yrs not in clinical risk groups %	2 yrs in clinical risk groups %	All 2 yrs %	3 yrs not in clinical risk groups %	3 yrs in clinical risk groups %	All 3yrs %
Period to Jan 2014	40.9	53.2	41.3	40.6	53.8	41.2
Period to Jan 2015	39.1	52.7	39.6	42.6	54.2	43.1
Period to Jan 2016	36.6	49.9	37.1	38.7	54.1	39.5
East Anglia to Jan 2016	38.6	49.9		40.1	53.2	40.8

Table 7: Flu vaccination uptake age 4 – added in 2014/5 season

Cambridgeshire & Peterborough CCG			
	4yrs not in clinical %	**4 yrs in clinical %**	**All 4 yrs %**
Period to Jan 2015	33.5	51.6	34.5
Period to Jan 2016	28.6	47.2	29.8
East Anglia to Jan 2016	30.8	48.8	32.0

Table 8: Flu vaccination uptake for year 2015/16 which introduced school year 1 and 2,

Cambridgeshire & Peterborough CCG						
Period to Jan 2016	5 yrs not in clinical %	5 yrs in clinical %	All 5 yrs %	6yrs not in clinical %	6 yrs in clinical %	All 6 yrs %
CCG	57.2	67.1	57.9	54.4	64.6	55.2
East Anglia	57.7	67.9	58.5	54.9	65.9	55.8

4.8 Influenza vaccination uptake in clinical risk groups

In addition to the childhood groups mentioned above, the following groups are eligible for free annual seasonal flu vaccination, using an injected vaccine:

- those aged 65 years and over
- people aged from six months to less than 65 years of age with a serious medical condition such as:
  - chronic (long-term) respiratory disease, such as severe asthma, chronic obstructive pulmonary disease (COPD) or bronchitis
  - chronic heart disease, such as heart failure
  - chronic kidney disease at stage three, four or five
  - chronic liver disease
  - chronic neurological disease, such as Parkinson's disease or motor neurone disease, or learning disability
  - diabetes
  - splenic dysfunction
  - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
- pregnant women
- those in long-stay residential care homes
- carers

Table 9: Flu vaccination uptake in clinical risk groups

Cambridgeshire & Peterborough CCG			
	Influenza [target 75%]		
	Over 65yrs	Under 65yr at risk	Pregnant
Period to Jan 2014	74.1	50.3	43.4
Period to Jan 2015	70.6	48.7	43.3
Period to Jan 2016	72.4	42.7	32.2

It is of concern that those in the at risk groups and pregnant women have such low uptake, as flu can lead to serious long term complications and even death in these people. Each year detailed planning is undertaken to try to improve uptake and early planning for the 2016/17 vaccination season will soon commence

4.9 Influenza vaccination uptake in frontline healthcare workers

Flu vaccination has been recommended and provided free for many years to frontline health care workers as those who contract flu can put their patients at risk though cross transmission to patients whose health is already compromised by other medical conditions. The vaccination protects the staff who, in turn, can protect their patients and their families and friends by being immune to flu. This has the advantage of reducing the risk to vulnerable patients and also the risk

to the health services of losing staff to illness or family care responsibilities during the very busy winter season. Despite the many benefits of flu vaccination to healthcare staff and the huge efforts made by their employers, uptake is generally but remains disappointingly low in some organisations.

Table 10: Flu vaccination uptake – front line health care workers

Period to Jan 2015 [compared with 2012/13 and 2013/4]				
	Influenza Health Care Workers [target 75%]			
	2012/3	2013/4	2014/5	2015/6
CUHFT	45.6	49.3	47.5	53.5
CCS	37.0	51.5	52.6	59.2
Papworth	58.4	75.6	69.3	65.9
Hinchingbrooke	46.4	60.6	76.8	65.4
CPFT	23.7	54.2	51.2	61.9
PSHFT	71.5	75.3	69.5	62.9

4.10 Influenza vaccination uptake in frontline social care staff

The same arguments are made for vaccination of social care staff as for healthcare staff, as they are also in contact with very vulnerable groups. In 2014/5 flu season, Cambridgeshire County Council made flu vaccination available to employed staff who were identified as meeting the criteria for vaccination. The following groups of frontline staff were identified for vaccination:

- Older People front line staff
- Frontline LDP/PD staff
- Frontline Children's Disability staff
- Early years support frontline staff (children's centres)
- Staff in Children's residential homes

Table 11: Flu vaccination uptake, CCC employed front line social care staff

Service Area	No. eligible staff offered vaccine	No. staff vaccinated
LDP (3 teams) only one team responded (East)	No data provided	2
Physical Disability frontline staff	40	3
Frontline Children's Disability Staff	38	14
Early Support Frontline Staff (Children's Centres)	No data provided	No data provided
Staff in Children's Residential Homes	No data provided	*
Older People front line staff	approx. 190	17**

* only 1 of the 3 homes responded to request for data

** the 17 staff vaccinated received their vaccination while working in an acute clinical setting and not as part of the council programme

In 2014/5 season a decision was taken to offer financial reimbursement for the full cost of the vaccine to staff who obtained it independently through a local pharmacy. Information was distributed to staff, via their line manager, to promote awareness of the benefits of vaccination and to inform them of the process for reclaiming vaccine cost via their monthly expenses. When uptake was measured it was disappointingly low (table 12 above)

For 2015/6 season, a late agreement was reached with Cambridgeshire Community NHS Service trust that they give the vaccine to Cambridgeshire County Council employed front line staff. This was done as it had been reported that staff were less likely to have the vaccine when there was an up-front cost to them. Uptake data are awaited.

For front line social care staff not directly employed by the county council responsibility for funding and administering the seasonal flu vaccine to staff (other than those in clinical risk groups) lies with their employers. This has led to difficulty getting social care staff vaccinated, as there are no levers within contacts to require social care providers to offer flu vaccination to their front line staff. It was decided to take a different approach for staff employed by external, CCC commissioned, organisation, sending communication to employing organisations that:

- Requested that employers consider arrangements to offer flu vaccination to eligible staff
- Highlighted the responsibility of the employer in protecting the health of staff and vulnerable clients
- Highlighted the benefits of vaccination in improving organisational resilience
- Signposted employers to the resources available via the NHS Flu Fighters campaign site

There is no mechanism in place to assess whether this communication was successful by measuring uptake among these staff.

4.11 Shingles vaccination programme

Shingles is an infection of a nerve and the skin around it, caused by the varicella zoster virus, which also causes chickenpox. Shingles can occur at any age but is commoner after age 70 years. Its main symptom is a painful rash that develops into itchy blisters and lasts for two to four weeks. The main complication of shingles is post-herpetic neuralgia, a severe nerve pain that can last for several months after the rash has gone and is commoner in older people.

This vaccination programme was introduced in 2013, to protect elderly people who are at greatest risk of Shingles and its adverse consequences. Eventually everyone will be offered the vaccination at age 70, but in the early years a catch up programme is in place to cover as many of those aged over 70 but less than 80 years. In 2014/15 the

vaccine was routinely offered to those aged 70 and catch-up to those aged 78 years between 1st September 2014 and 31st August 2015. Uptake is fair, but could improve considerably.

Table 12: Shingles vaccination uptake to Feb 2016

Shingles Sentinel	Feb 2016 %	
	70 yrs	**78 yrs**
CCG	51.1	50.1
East Anglia	48.8	48.6

Source: Immform accessed 14.2.16

4.12 Pertussis vaccination in pregnancy

Following an outbreak among babies of Pertussis (Whooping cough) which led to a number of infant deaths, a programme to vaccinate pregnant women between 28 and 38 weeks of pregnancy was initiated in 2012/3. Evidence showed that immunity among women of child-bearing age had waned, and by vaccinating them, it would prevent them picking up whooping cough and passing it to their babies. Following introduction of this programme, there was a 79% drop in cases in 2013 and a decision was made to continue with this programme of vaccination in pregnancy.

The table below give data on uptake, data is reported for the Cambridgeshire and Peterborough CCG area, showing fair levels of coverage. However data capture for this programme has not been robust up to now but NHSE have introduced an improved data capture system.

Table 13: Pertussis vaccination uptake by pregnant women

	April 2014 %	May 2014 %	June 2014 %	July 2014 %	August 2014 %	Sept 2014 %	Oct 2014 %	Nov 2014 %	Dec 2014 %	Jan 2015 %	Feb 2015 %	Mar 2015 %
CCG	59.6	53.0	53.1	49.0	48.1	51.3	52.0	50.8	59.6	53.1	54.1	51.6
East Anglia	60.6	60.5	57.2	55.8	55.5	58.3	60.3	60.6	65.7	61.6	60.9	58.1
	April 2015	May 2015	June 2015	July 2015	August 2015	Sept 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	March 2016
CCG	49.8	45.9	52.7	50.5	51.2	50.5	54.1	52.5	50.7	50.3	NA	NA
East Anglia	56.8	53.8	58.9	56.3	58.5	67.2	60.3	61.4	60.3	59.3	NA	NA

5. SCREENING PROGRAMMES

5.1 Cancer screening programmes

There are three cancer screening programmes in the UK for Breast, Cervical and Bowel cancer and the data for these programmes was provided by NHS England

Uptake of the two established cancer screening programmes in women for breast and cervical cancer has been low in Cambridgeshire and for cervical screening it is showing a worrying downward trend. A Task and finish Group was established in May 2015, and completed its work in September 2015. The group has continued to meet to plan implementation of a series of recommendations to encourage uptake. The most recent cancer screening data is given below.

5.2 Breast Screening

The breast screening service which nationally commenced operation in 1987 was designed to invite eligible women aged 50 to 70 (47-73 if enrolled onto the National Age extension study) every three years using the call and recall system and any self-referrals for women over 73 years. Recently a referral pathway for high risk breast screening was commissioned and must only be taken from specialised services such as Genetics and Oncology.

A number of measures or quality standards are reported to evaluate the success of the screening programme and all are reported to the HPSG. Uptake data is usually reported annually and has not yet been reported for 2015/16, so the most recent annual data is given in Table 15 below. Other data for the breast screening programme are given in the figures below.

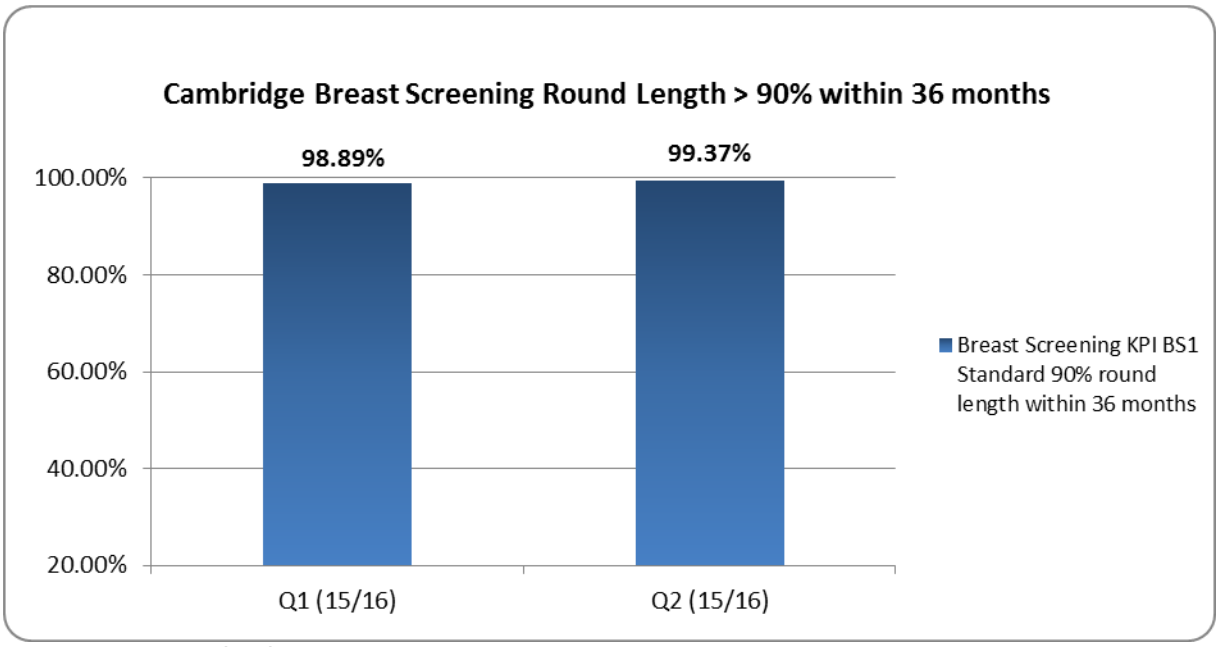
Table 14: Breast screening uptake in Cambridgeshire 2014/15

Age group	Uptake
50 – 70	74.6%
All ages	76.8%

Other important measures are the proportion of women who are screened within a 36 month period[1] and the time taken from screening to assessment if any abnormality is detected on the screening mammogram (The standard is to respectively achieve 90% within 36 months of previous screen and 90% of assessments within three weeks of being screened). The following two figures illustrate achievement in these two areas for Cambridgeshire women. The 36-month round length has significantly improved in 2015/16, with the standards now being met quarter on quarter. The proportion of women needing assessment who are seen within recommended timescales has improved but still below the 90% mark.

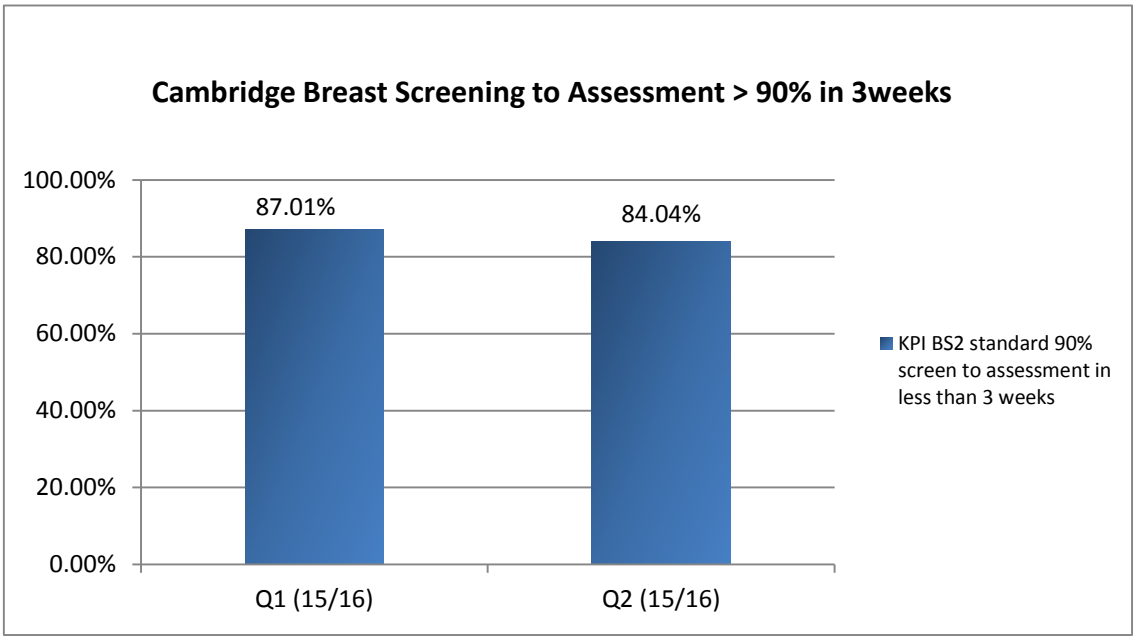
[1] The NHS Breast Screening programme aims to offer a first screening appointment to 90% or more women within 36 months of their previous screen.

Figure 1: Proportion of eligible women screened within 36 months



Source: NHS England

Figure 2: Proportion of women requiring assessment who are seen within 3 weeks of the screening test



Source: NHS England

The Breast screening uptake has seen an increase on the previous year's figure and is now similar to the national average. The issue of the difficulty with securing accessible venues in the Cambridge city and

Cambridge North areas and the shortage of trained radiographers have been a major challenge to effective service delivery. The screening service has worked collaboratively with the council and public health to identify suitably accessible sites to host the mobile screening van. The newly identified and agreed site is in the heart of Arbury and this site is now fully functional. It is expected that the introduction of the Arbury site, along with the additional capacity created through CUFHT putting on additional clinics on Saturdays, should support the improvement of uptake and coverage. Plans are underway to secure a further site North of Cambridge, in and around the Impington or Milton area.

5.3 Cervical Screening

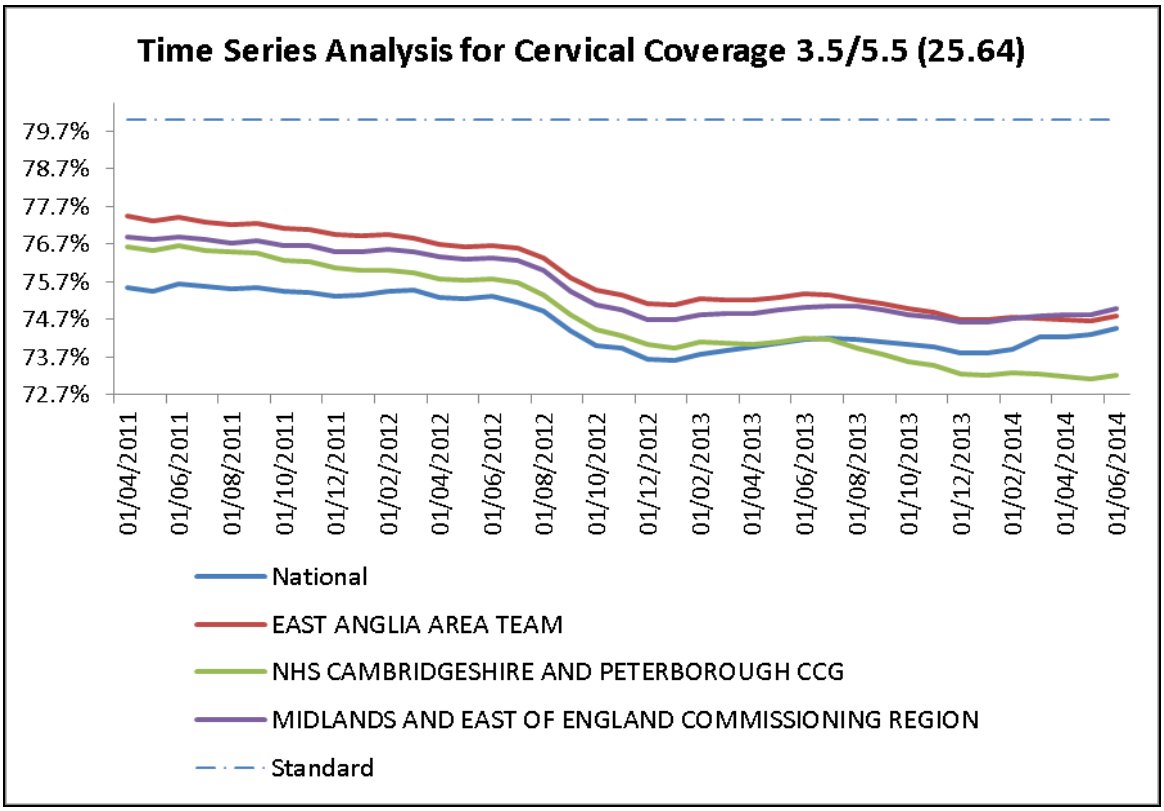
Cervical screening is offered to all women aged 25 to 49 years every three years and those aged 50 to 64 every five years. Screening takes place in GP practices and the samples are sent to the laboratories for testing. Upon testing, women are informed of the outcome of their screening episode and those with abnormal cervical screening tests are referred for colposcopy and possibly virology testing- a specialist test to further assess and treat the abnormalities detected. As with the other screening programmes aimed at early detection, the programme is monitored on uptake, coverage, the speed of getting results to service users who have been tested, as well as the timeliness of getting service users in for assessment and treatment.

From the most recent comparative data analysis available, the trend data below show a steady decline in coverage for the Cambridgeshire and Peterborough CCG area. (Coverage is a measure of the proportion of women aged 25 to 49 having an adequate sample taken in last 3 years, or in the last 5 years for those aged 50-64). The target for coverage is 80% and these trend data show that performance is now below the national (England) level. Coverage has fallen in all areas as shown in Figure 3 below; (England (national), Midlands and East Commissioning region, East Anglia Area Team (Norfolk, Suffolk, Cambridgeshire and Peterborough) and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). Also of note, is the fact that coverage remains considerably lower in the younger cohort (25 – 49) than in the 50 – 64 age group, where coverage too is now below the target of 80%. (Table 15).

Table 15: Latest Cervical screening data

Cervical Screening	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Coverage standard - % of women 25-64 yrs with adequate test in 5 years	68.9%	68.7%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited
standard 80% coverage for 25-49 yrs (3.5 yearly)	65.4%	65.2%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited
standard 80% coverage for 50-64 yrs. (5 Yearly)	76.8%	76.6%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited
Standard 98% 14 day turnaround time from date of test to receipt of result letter	90.47%	99. 47%	2015/16 Q3 Data awaited	2015/16 Q4 Data awaited

Figure 3: Cambridgeshire and Peterborough CCG Cervical Screening Coverage Trend 25 – 64 years



5.4 Cancer screening Task and Finish Group

This group established by NHS England at the request of the HPSG, met for the first time in May 2015. At the first meeting detailed analysis of the data for breast and cervical screening was presented that helped to identify pockets of poor uptake. Further analysis, evidence review and intelligence gathering have been undertaken; all of which have informed the recommendations for actions and interventions to address these issues. The group reported back to the HPSG and, with some change in membership has now become an Implementation Group with responsibility to oversee the delivery of the agreed recommendations, some of which include collaborative working with Cancer Research UK and Jo's Trust to deliver training to front line public health staff and primary care staff to ensure staff are confident and knowledgeable about discussing and promoting cancer screening and are able to appropriately signpost. Awareness campaigns on cancer screening and prevention have also been planned and agreed, with plans underway to work with specific practices in areas of poorer uptake to better understand the reasons for lack of engagement and high DNA rates.

5.5 Bowel Cancer screening

This national screening programme involves all those aged 60 and over receiving a testing kit by post in which they can return faecal samples for testing. The test looks for hidden (occult) blood which can indicate some problem in the bowels that is causing bleeding. The presence of Faecal Occult Blood (FOB) is not diagnostic of cancer but gives an indication that further testing is needed. The further tests are by endoscopy (examination of the bowel with a specialised scope and camera apparatus). A number of measures are reported to evaluate the success of the screening programme and these are reported in the table below.

Table 16: Bowel Cancer data for Cambridge Programme

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Bowel Screening ***(standard 52% completion of FOBT kit)***	61.8%	59.2%	**Data awaited**	**Data awaited**
Assessment by specialist screening practitioner (SSP) ***(standard 100% seen by SSP in 2 weeks*)**	100%	100%	100%	**Data awaited**
SSP assessment to endoscopy time ***(standard 100% endoscopy within 2 weeks of seeing SSP)***	100%	100%	100%	**Data awaited**

5.6 Non-cancer screening programmes

There are two national screening programme for non-cancer conditions, Diabetes Eye Screening (DES) provides an annual retinal check for people with diabetes; and Abdominal Aortic Aneurysm Screening (AAA) for men aged 65 and over (self-referral for those who have not been screened once).

As the data in Table 18 below indicates, the DES programme is performing well. However, recent capacity issues have resulted in delays with referred patients being seen and treated within specified timescales at some Trusts. This issue is being addressed contractually and with the support of the Clinical Commissioning Group.

The AAA screening programme reported coverage of 100% in the 2014/15 fiscal year. The coverage is an annually reported metrics and the 2014/15 data is the most up to date data available. It has been noted that lack of attendance is a growing problem and an action plan is in place to address this.

Table 17: Diabetes Eye Screening data 2015/16

Diabetic Eye Screening				
	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
standard 70% uptake (*% screened out of the total offered)*	78.5%	77.6%	Data awaited	Data awaited
standard 70% results received issued within 3 weeks of screening	99.1%	99.4%	Data awaited	Data awaited
standard 80% treatment within 4 weeks and 60% within 2 weeks of significant positive screen	2wks: 66.7% 4wks: 83.3%	2wks: 40% 4wks: 80%	Data awaited	Data awaited

Table 18: Abdominal Aortic Aneurysm data

KPI AA1 standard 90% (acceptable level) and 100% (achievable level)		
	14/15	15/16
	100%	Data awaited

5.7 Antenatal and newborn screening

A large number of screening tests are offered during pregnancy to screen for certain conditions that may impact on the health of the Mother and baby, in order that action can be taken during the pregnancy to minimise the potential effect and optimise the outcome for both.

Details of uptake levels for a number of these tests are given below. Data is submitted quarterly in the form of National Key Performance Indicators (KPI's) by the Hospital Trust's.
(https://www.gov.uk/government/collections/nhs-screening-programmes-national-data-reporting)

Screening data for Quarter 3 will not be available until later this year.

Ante-natal screening includes the routine offer of screening for a number of conditions that can adversely affect the health of the baby as well as the mother including:

Infectious Diseases:	• HIV • Hepatitis B • Syphilis • Rubella susceptibility
Sickle Cell and Thalassemia	
Down's syndrome	

Newborn screening includes testing for a number of conditions that are not obvious at birth but would have serious consequences for the baby if not detected and treated early, including:

Newborn infant physical examination		
Newborn Hearing screening		
Newborn blood spot test which detects conditions such as:	congenital hypothyroidism	
	sickle cell disease;	
	cystic fibrosis; and	
	Inherited Metabolic Disorders including:	phenylketonuria;
		medium chain acetyl-CoA dehydrogenase

		deficiency
		Maple syrup urine disease
		Homocystinuria
		Glutaric acidaemia type 1
		Isovaleric acidaemia

(see http://www.newbornbloodspot.screening.nhs.uk/ for explanations of each of these conditions.

Table 19: Ante-natal screening coverage

	Q2 Jul-Sep 2014	Q3 Oct-Dec 2014	Q4 Jan –Mar 2015	Q1 Apr-Jun 2015	Q2 Jul-Sept 2015
HIV screening ID1 (standard is to achieve >90%)					
CUHFT	No data	97	98.4	98.3	97.8
HHT	99.3	99.7	99.7	99.5	99.3
Infectious disease Hepatitis B (Standard >70-90% timely referral of hep B + women for specialist treatment)ID2					
CUHFT	100	100	100	100	100
HHT	100	100	*100	No cases	100
Down's Screening (standard >97%) FA1					
CUHFT	98.5	99.2	99.7	99.8	99.5
HHT	98.5	97.6	98.1	98.9	97.6
Sickle Cell and Thalassaemia screening (standard >95%) ST1					
CUHFT	No data	98.2	98.2	97.3	98.0
HHT	98.2	98.3	98.8	98.5	98.5
KPI ST2 Standard 50-75% Sickle Cell and Thalassaemia Tested within 8-10 weeks					
CUHFT	38.9	34.9	46.3	29.6	31.6
HHT	47.5	No data	No data	No data	No data
KPI ST3 Standard 90-95% Sickle Cell and Thalassaemia Completion of FOQ					
CUHFT	96.5	93.7	96	89.8	80.2
HHT	98.1	No data**	No data**	No data**	No data**

**Transfer of pathology services caused issue with extracting accurate data for ST2 & ST3 at Trust level; resolution still being sought. KPI stipulates data source should be the laboratory. Release of new amalgamated pathology form should go some way to address and HHT are looking at their own database to collect data.

Table 20: Newborn screening

	Q2 Jul-Sept 142014	Q3 Oct-Dec 1	Q4 Jan-Mar 15	Q1 Apr-Jun 15	Q2 Jul-Sept 15
Newborn Bloodspot test (standard 95-99%)					
(CCS)	100	100	99.9	98	98.0
Newborn Bloodspot – avoidable repeat tests (standard <2%)					
CUHFT	2.2	3.1	3	3.8	2.7
HHT	No data	No data	No data	No data	**9.0
Newborn blood spot timeliness of result (Standard 95-98%)					
CCS	100	99.9	99.9	***cease	***cease
** Laboratory unable to extract Trust level data until Q2 due to a software issue. HHT have action plan to address high repeat rate.					
***NB3 ceases from Q1					
New KPI: Apr 15 KPI NB4: Newborn blood spot screening – coverage (Movers In)					
CCS	NA	NA	NA	80	78.6
KPI NP1 Standard 95-100% Newborn & Infant physical coverage					
CUHFT	No data	No data	99.4	93.2	94.0
HHT		96.3	97.2	95.9	95.4
KPI NP2 Standard 95-100% Newborn & Infant physical timely assessment					
CUHFT	No data	No data	No data	57.1	0.0
HHT	No data	No cases	100	No cases	100
HHT have implemented the use of the National failsafe NIPE SMART IT system. CUHFT have been using their own internal system, but are in on-going discussions with the national team regarding the use of the NIPE SMART following on from some of the data extraction issues they have experienced. NIPE SMART offers a national failsafe solution for this programme.					
Newborn hearing coverage (standard 100%)					
CUHFT	97.5	93.6	96.8	98.6	98.0
HHT	99.6	99.6	99.6	100	100
Newborn hearing timely referral (standard 100%)					
CUHFT	93	69.2	100	75	78.9
HHT	33.3	80	100	100	100

6.0 HEALTH EMERGENCY PLANNING

6.1 Cambridgeshire County Council has always been a Category 1 responder under the terms of the Civil Contingencies Act 2004, As a result the council has an emergency planning/Resilience team that works in partnership with other organisations to lead emergency planning and response for the council. Some additional responsibility for health emergency preparedness passed with the move of Public Health into local authorities. In their role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR)
- Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP) as appropriate
- Identify and agree a lead DPH within the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) area to co-Chair the LHRP
- Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

6.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for the health organisations of the LRF area and are expected to:

- Assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need
- Set an annual EPRR work plan using local and national risk assessments and planning assumptions and learning from previous incidents
- Facilitate the production and authorisation of local sector-wide health plans to respond to emergencies and contribute to multi-agency emergency planning
- Provide a forum to raise and address issues relating to health EPRR
- Provide strategic leadership to planning of responses to incidents likely to involve wider health economies e.g. winter capacity issues
- Ensure that health is represented on the LRF and similar EPRR planning groups
- Delegate tasks to operational representatives of member organisations in line with agreed terms of reference.

6.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Cambridgeshire & Peterborough Director and the Cambridgeshire and Peterborough DPH. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the CPLRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH provides a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.

6.4 The DPH has been supported in this work by a consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Area Team and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and a Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.

6.5 The HSCEPG has membership from local acute hospitals, East of England ambulance service (EEAmb), community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England.

6.6 This year's deep dive for the EPRR core standards was planning for Pandemic Influenza. The working group delivered Exercise Corvus, a local adaptation of the PHE off-shelf exercise to test the arrangements for pandemic influenza. Follow up of the seven recommendations from this exercise forms part of the work plan for the working group this year. The other priorities for this group are to revise the local Mass Casualty Plan and put in place a plan for identifying vulnerable people in an emergency, both to be presented at the LHRP and CPLRF shortly.

6.7 Exercise Nimbus, a two day multiagency exercise to test eight CPLRF plans, was delivered on the 5th and 6th of November 2015. A total of 60 people from 27 agencies participated and a collated list of actions is being progressed by the CPLRF.

7.0 HEALTHCARE ASSOCIATED INFECTION (HCAI) AND ANTIMICROBIAL RESISTANCE (AMR)

7.1 MRSA bacteraemia

National mandatory reporting, in place since 2009, continues for Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile (C Diff), to tackle the previous very high numbers of cases being reported that contributed to patient mortality.

Zero tolerance of MRSA bacteraemia remains the national and local objective.

The arbitration process acknowledges that a number of providers, including all community and social care services, may be involved in the care of a patient so that a case may not be attributable to any one care provider or that the infection occurred despite no lapse in care. These are referred to as Third Party assigned cases and do not appear on the local objectives for either the acute provider or CCG.

For the period of 2015/16 the following were reported in Cambridgeshire:
Acute providers – 7 cases of which one was assigned to an acute Trust.
CCG – 4 cases of which one was assigned to the CCG. A local commissioned community service was identified to have learning and an action plan will be monitored.

7.2 Clostridium difficile

Following some years of significant reduction, the number of C Diff cases nationally continues to fall but at a slower rate than when mandatory reporting initially commenced in 2009. Every effort is made to ensure continued reduction and to broaden our knowledge of this disease and the best means to reduce the associated risks. We have a clear understanding of what best practice looks like but complex patient pathways across all our health systems leading to many professional staff groups and specialties being involved in the care of individual patients. Each professional must share ownership of this risk. Co-coordinating this pathway and joining up communication is complex and challenging, but important especially between primary and acute care.

Every case of C Diff, whether community or hospital onset, has a root cause analysis completed and scrutiny meetings are held. Improvements have been made in antibiotic prescribing and the challenges reduced to prevent onward transmission to other patients.

For a second year the national process to remove cases from the local objective where no lapses in care have been identified was used, the Post Infection Review (PIR) process. Using strict criteria and standards the arbitration decision is made at scrutiny meetings which have high level representation from Directors of Nursing, microbiologists, front line clinical staff and medical staff, infection control teams from provider services and the CCG. This process enables providers to review their practice and have an effective learning opportunity when cases occur. Providers are supported to achieve high standards of care providing a more positive patient experience. The aim is that providers do not become complacent with their achievements to date, ensuring that best practice continues to be embedded amongst staff. For the period of 2015/16, providers have slightly exceeded the actual number of cases against their national objectives and have also achieved to remain under this locally by the number of non-sanctioned cases. Approximately 53% of cases met this criterion as a result of the excellent work within provider services.

7.3 Antimicrobial Resistance

Antimicrobial resistance has been identified as a national and international risk to human health by the Chief Medical Officer, World Health Organisation and the Government as a whole. Antibiotics are widely used with many patients in the UK failing to complete the prescribed course or demanding antibiotics for viral or self- limiting conditions. These factors contribute to the development of antimicrobial resistance. In addition, no new class of antibiotics has been developed by the pharmaceutical industry in recent years. Each year on European Antibiotic Awareness day in November these problems are highlighted in the media, social media and posters.

The prescribing of antibiotics is monitored by the Medicines Management Team in the CCG for primary care and by hospital pharmacists for in-patients. Because antibiotic use is implicated in cases of C Diff, antibiotic prescribing is discussed at each scrutiny panel for C Diff, following completion of the root cause analysis. Concerns identified are either discussed with the GP or with the Medicines Management Team (MMT). High prescribing levels of two particular groups of antibiotics have been identified and a strategy is being developed to address the associated risks, one of which is an increased risk of C Diff infection. While general use of these groups of antibiotics should be limited, they must continue to be available and effective to treat infections caused by certain bacteria, which are sensitive to them.

This is an area under continual scrutiny and that will continue to be tackled by the CCG in collaboration with other local prescribers in acute, community and primary care

7.4 Other infections

Norovirus is a gastrointestinal infection that is self-limiting in nature but easily passes from person to person. The impact of outbreaks for hospitals is significant if ward closures are required to contain the situation. There have been a number of small outbreaks within the Cambridgeshire hospitals, that were quickly identified and managed. The challenges remain for the public to understand the actions of staying away from hospitals if they are symptomatic. There has been minimal impact this season to date that has the potential to cancel surgery and admissions through lack of beds.

Flu has been occurring in slightly higher numbers of both A and B strains. The impact on hospitals has been slightly less, with cohorts nursed in smaller bedded areas where possible. The importance for patients, staff and the public to have the annual flu jab is stressed regularly. Trusts in Cambridgeshire have achieved well against national data in vaccinating members of staff.

8.0 SEXUAL HEALTH

8.1 Cambridgeshire has a favourable rate of diagnosis of new sexually transmitted infections (STIs) at 481 diagnoses of STIs per 100,000 residents (compared to 829 per 100,000 in England, and is lower than the East of England PHE Region average rate which is 669 per 100,000).

8.2 Rates of HIV late diagnosis

Between 2012 - 2014, 52.8% of HIV diagnoses were made at a late stage of infection, compared to 42.2% in England and is a slight increase when compared to 51.7% in 2011 – 2013. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

8.3 Chlamydia diagnoses

In 2014, the rate of chlamydia diagnoses per 100,000 young people aged 15-24 years in Cambridgeshire was 1557 which is below 2014 national average for England. In 2013, the rate was 1548 in Cambridgeshire and national rate of 2072, and in 2012 the rate was 1620 in Cambridgeshire and the national rate was 2074, all of which are below the Public Health Outcome Indicator of 2300 per 100,000 of young people aged 15-24 years. This positivity rate resulted from screening 24.9% of the eligible 15 – 24 year old population which is similar to 24.3% overall rate in England.

8.4 Teenage pregnancy

Rates of teenage pregnancy in Cambridgeshire continue to show the downward trend of recent years (2010 to 2014). In 2014 the under 18 conception rate was 16.2 per 1,000 which compares favourably with the England rate of 24.3 per 1,000.

8.5 PHE Eastern Region Work

PHE Eastern Region noticed an unusual increase in gonorrhoea cases across Milton Keynes, Luton, Central Bedfordshire and parts of Hertfordshire. Following a review of gonorrhoea case across the whole of the Eastern Region most areas including Cambridgeshire were showing an increase in gonorrhoea case albeit not as significant as those in the areas mentioned previously.

PHE Eastern Region have organised a number of meetings with commissioners and providers in the area to develop an action plan to halt further increases in cases of gonorrhoea.

8.6 Sexual Health Service

In October 2014 an integrated sexual health service was launched with the aim of integrating the provision of sexual health and contraception services, increase accessibility, especially for hard to reach, high risk populations, and to address the inequity of service provision and the health inequalities between the north and the south of the county. Close monitoring of the new service shows it has been effective against these aims.

8.7 Cambridgeshire Sexual Health Network

To help maintain the momentum of the achievements of the integrated sexual health service we have reinstated the Cambridgeshire Sexual Health Network to act as a multi-agency network responsible for overseeing and implementing the Cambridgeshire Sexual Health Strategic Plan

The strategic plan identifies the following key themes for Cambridgeshire:

- Improved Chlamydia diagnosis for 15 to 24 year olds
- Improved early HIV diagnosis, reducing rates of late diagnosis

- Continued improvement in teenage pregnancy rates
- Improved access to sexual and reproductive health services for vulnerable groups
- All sectors of the population are informed about sexual health and how they can access services they require through an integrated sexual health communications plan.

9.0 LOOKING FORWARD

Commissioning TB services

A Collaborative TB Strategy for England was published in January 2015 and launched jointly by PHE and NHS England who are committed to working in partnership with the NHS, clinical commissioning groups (CCGs) and local authorities.

TB has major health and social impacts for those affected. In addition, it contributes to increasing health inequalities in already deprived populations. Each infectious case represents a risk of onward transmission and the failure to protect communities from TB transmission should be regarded as a failure of public health systems.

The strategy ambition is to make significant advances in TB control. To achieve this, improvements are needed in the following key areas:

1. Access to services and ensure early diagnosis
2. Universal access to high quality diagnostics
3. Treatment and care services
4. Comprehensive contact tracing
5. BCG vaccination uptake
6. Reduce drug-resistant TB
7. Tackle TB in under-served populations
8. Systematically implement new entrant latent TB screening
9. Strengthen surveillance and monitoring
10. Ensure an appropriate workforce to deliver TB control

When the strategy was launched in East Anglia, workshop discussions generated 4 common recommendations to implement the 10 action areas, which are:

1. Establish intelligent, clear and consistent commissioning of local TB services
2. Improve links between key social and medical services
3. Raise the profile of TB amongst professionals, organisations and the general public
4. Empower and improve support mechanisms for healthcare workers

GLOSSARY

AAA	Abdominal Aortic Aneurysm
AT	Area Team (part of NHS England)
BCG	Bacillus Camille Guerin (vaccine for TB)
CCC	Cambridgeshire County Council
CCA	Civil Contingencies Act 2004
CCDC	Consultant in Communicable Disease Control
CCG(s)	Clinical Commissioning Group(s)
CCS	Cambridgeshire Community Services
CPLHRP	Cambridgeshire and Peterborough Local Health Resilience Partnership
CUHFT	Cambridge University Hospital Foundation Trust
DH	Department of Health
DPH	Director of Public Health
DsPH	Directors of Public Health
EH	Environmental Health
EHO	Environmental Health Officer
EPRR	Emergency Preparedness, Resilience and Response
GP	General Practitioner
GUM	Genito-urinary medicine (sexual health)
HIV	Human Immunodeficiency Virus
HHT	Hinchingbrooke Hospital Trust
HPN	Health Protection Nurse
HPSG	Health Protection Steering Group
HPT	Health Protection Team (part of Public Health England)
HPV	Human Papilloma Virus
HSE	Health and Safety Executive
HWB	Health and Well-being Board
IMT	Incident Management Team
JHWS	Joint Health and Well-being Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LGA	Local Government Association
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MMR	Measles, Mumps and Rubella (vaccine)
MOU	Memorandum of Understanding
NHS	National Health Service
NHSE	NHS England
OIMT	Outbreak Incident Management Team
OOH	Out of Hours
NHS	National Health Service
NHSE	NHS England
PCT	Primary Care Trust
PHE	Public Health England
Q 1,2,3,4	Reporting quarters for each year
TB	Tuberculosis

HEALTH COMMITTEE TRAINING PLAN	Updated from 10th March Health Committee Meeting	

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
1.	System Transformation (Raised at Health Committee)	Provide members with an overview of the current System Transformation Programme led by CPCCG.	1	13th Aug 2015	Public Health	Training Seminar	Health Committee members & Subs		53% health committee members
2.	Business planning 2016/17	Provide members with an overview of the business planning decisions for the council	1	1st Oct 2015	Public Health	Training Seminar	Health Committee members & Subs		92% Health committee members (including substitutes)
2.	New legislation on the Care Act (Raised at spokes)	Members develop a clearer understanding of the Care Act and its implications in relation to Health.		TBC	Democratic Services	Information to be circulated to spokes	Health Committee members & Subs		
3.	Equality & Diversity Issues (Raised at spokes)	Members are provided with an overview of equality and diversity issues.		TBC	Democratic Services	Full members seminar	Health Committee members & Subs		
4.	County Council Directorate structures & Officer responsibility (Raised at Health Committee)	Members to understand variety of Council responsibilities		TBC	Democratic Services	Information available on Camweb	Health Committee members & Subs		Completed
5.	Primary Care & NHS funding & Commissioning responsibilities	Members understand the relationships with Primary care & various commissioning accountabilities within the	1	3rd March	Public Health	Training seminar	Health Committee members & Subs		

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
	(Raised at Health Committee) E-Hospital Update from CUHFT	NHS e.g. role of NHS England, CCG and Department of Health. To also now include the role of Community Pharmacists in the seminar							
6.	Mental Health Promotion and prevention activity (Raised at Health Committee)	Members to have an overview of the current Mental Health Promotion prevention work particularly partnership arrangements.	2	17th Dec 2015	Public Health	Update provided for December Health Committee	Health Committee Members		Completed
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	No Date	Public Health	Training Seminar	Health Committee members & Subs		
9.	Health Scrutiny Skills Part 2	To understand Health Scrutiny in the context of Health inequalities and the transformation agenda.	2	11th Feb 2016	Public Health & Centre for Public Scrutiny	Training seminar	Places for 3 committee members only	TBC	100% attendance of allocated places
10.	Health Scrutiny Skills Part 3 (East of England Scrutiny Conference)	Encouraging communication and joint working between scrutiny at different tiers of government and across political boundaries; Provide members with a toolkit for scrutiny		21st March 2016	Scrutiny without Boundaries Workshop (Essex CC)		Places for 3 committee members only.	2 spaces confirmed	100% attendance of confirmed places

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
11.	Sustainability & Transformation Plan (Pre-submission)	To provide health committee members with an overview of the Sustainability and Transformation Plan programme pre submission by CCG	1	16th June 2016 TBC	Public Health	Training seminar	Health Committee Members and subs		
12.	Public health 0-5 services	To improve understanding of public health 0-5 services (health visiting and family nurse partnership) transferred to CCC in October 2015 and proposals for joint children's health commissioning.	1	June/ July	Public Health	Training seminar (potentially a Friday Member's Seminar)	Potentially all County Councillors		

- 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.

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN

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
[16/06/16] Provisional Meeting	*Sustainability and transformation plan workshop*			19/05/16 3.30pm	*03/06/16*	*07/06/16*
14/7/16	Co-option of District Councillors	Ruth Yule		23/06/16 9.00am	01/07/16	05/07/16
	Public Health Finance and performance report	Chris Malyon/ Liz Robin				
	Effectiveness of smoking cessation services					
	0-19 Joint Commissioning of Children's Services (PCC,CCC & CCG)					

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Older People and Adult Community Services – update on developments since the termination of UnitingCare contract (provisional)	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	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				
[11/08/16] Provisional Meeting				21/07/16 3.30pm	*29/07/16*	*02/08/16*
08/09/16	Public Health Finance and performance report	Chris Malyon/ Liz Robin		18/08/16 3.30pm	25/08/16	30/08/16
	New Communities Joint Strategic Needs Assessment	Iain Green				
	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				
[06/10/16] Provisional Meeting				15/09/16 3.30pm	*23/09/16*	*27/09/16*
10/11/16	Public Health Finance and performance report	Chris Malyon/ Liz Robin		20/10/16 3.30pm	28/10/16	01/11/16
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report)	Kate Parker				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: update on the development of the integrated NHS 111 and Out of Hours service	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[01/12/15] Provisional Meeting				17/11/16 3.30pm	*18/11/16*	*22/11/16*
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				
	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: 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				
[13/04/17] Provisional Meeting				23/03/17 3.30pm	*31/03/17*	*04/04/17*

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
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		
	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				

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