HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 07 September 2017

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

13:30hr

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

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3.	**Petitions** Standing item. No petitions received at time of publication.	

KEY DECISION

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DECISIONS

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The Health Committee comprises the following members:

Councillor Peter Hudson (Chairman) Councillor Chris Boden (Vice-Chairman)

Councillor Lorna Dupre Councillor Lynda Harford Councillor David Jenkins Councillor Linda Jones Councillor Kevin Reynolds Councillor Tom Sanderson 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

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Agenda Item No: 2

HEALTH COMMITTEE: MINUTES

Date: Thursday 20th July 2017

Time: 2.00pm to 5.40 pm

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

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

Observer: Councillor Topping

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

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

13. DECLARATIONS OF INTEREST

There were no declarations of interest.

14. MINUTES – 14th JUNE AND ACTION LOG:

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

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

The oral update highlighted:

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

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

Minute 8 - Annual Health Performance Report - In respect of the action to provide performance information for the health trainer role, giving evidence of changes in health behaviour in easily readable headline graphs Dr Liz Robin indicated as an oral update that the intention would be to include this information as an appendix to the September Committee's Finance and Performance report.

It was resolved:

a) To note the revised Action Log.

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

15. CO-OPTION OF DISTRICT COUNCIL REPRESENTATIVES

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

16. PETITIONS

No petitions were received.

17. PUBLIC HEALTH FINANCE AND PERFORMANCE REPORT

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

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

Attention was drawn to:

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

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

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

In respect of performance the following updates were provided:

- Sexual Health - Performance remained good with all indicators green.
- Smoking Cessation – as an oral update it was indicated that the annual target for 2016-17 had been achieved.

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

In Discussion:

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

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

- That as the report suggested that some of the performance problems highlighted were due to recruitment issues, a question was asked that where services had

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

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

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

That having reviewed and commented on the report

It was resolved:

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

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

18. EMERGING ISSUES IN THE NHS

Fire safety at Peterborough City and Hinchingbrooke Hospitals

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

In his presentation Stephen Graves gave assurance that fire safety at the hospitals run by North West Anglia NHS Foundation Trust was top of their agenda. He explained that two years ago there had been fire issue concerns at Peterborough City Hospital which had involved an enforcement order being issued by the Fire Authority for remedial

works. He explained, the Trust held monthly meetings with the Fire Service to closely manage the remedial works required with good progress being made. In addition, more than 90% of staff had completed their annual mandatory fire training, which highlighted the various escape routes and the evacuation processes in an emergency situation. A full-time Fire Officer was employed to work across all three of their hospitals (Peterborough City, Hinchingbrooke and Stamford and Rutland) delivering training in fire prevention and precaution.

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

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

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

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

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

- In answer to a question raised regarding issues of ongoing maintenance and the checks in place, this was the responsibility of the owner of the building and would

be dealt with by the estates team with sign off by the clerk of works. As a result of the recent tragic experience at Grenfell Tower there would no doubt be a high level of scrutiny of any future works undertaken.

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

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

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

Stephen Graves was thanked for attending.

It was resolved:

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

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

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

The CE highlighted / provided details that:

- The CQC had now changed its rating for the hospital to a rating of 'good'.
- For the first time since the summer of 2014 Cancer and 18 weeks referral to treatment was on track.
- Accident and emergency had greatly improved and was now at a 95% performance level.

- The financial target had been achieved for the second year with the deficit having reduced from £80m to £50m and was on target in the current year to be reduced to £40m.
- The staff survey results had improved from being the bottom rating for teaching hospitals to now having moved up to third or fourth place, while still recognising that there was further improvement to be made.
- Waiting times had improved since the CQC had last visited.
- feedback from staff highlighted issues terms of patients' journeys, the need to improve governance and take steps to empower staff to make improvements, as well as the need for far more work to be undertaken with partners regarding improved transport links and affordable housing.
- In terms of concerns on fire safety, the hospital did not have any cladding that had caused a concern.
- Regarding ehospital (EPIC) preparations - the move away from paper in the hospital went live in October 2014. Clinical staff are now able to quickly and securely access all of a patient's records on internet enabled devises. The current system was winning awards nationally.
- Regarding the Liver Metastases Service – which had been a concern to the Committee in terms of patient travel and patient choice - statistical information on slide 13 highlighted that the clinical outcomes were very strong, which had to be balanced with patient travel and their experience.

Questions / issues raised included:

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

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

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

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

- Infection control had been highlighted as a concern, with a Member asking whether it was the result of people being less systematic about hand washing hygiene and standards slipping. In reply it was stated that performance in infection control was working very well, but improvements were still being sought in

ensuring the organisation's staff routinely hand washed, as there was considerable concern regarding infection as a result of bugs becoming antibiotic resistant.

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

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

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

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

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

Having noted the presentation, the Committee resolved:

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

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

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

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

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

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

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

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

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

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

period of transition had been positive and there had been a significant reduction in the number of complaints received.

Issues raised in debate included:

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

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

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

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

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

- Another Member expressed his concern that the quantity in the tender had been incorrect and the tenderer had responded to incorrect information and agreed a

price and therefore asked that in order to address the revised quantities, would it not be the case that the CCG will have to pay more? In reply it was indicated that in fact that there was 30% less journeys than had been assumed was going to happen. The issues were in relation to their being more out of area journeys and more wheel chair required transport rather than car journeys. There was therefore the need to look to recycle the journeys and starting some vehicles later in the day in order to meet peak demand.

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

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

Having commented on the report

a) It was resolved to note the action plans.

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

21. PUBLIC QUESTION:

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

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

Question

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

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

It was resolved:

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

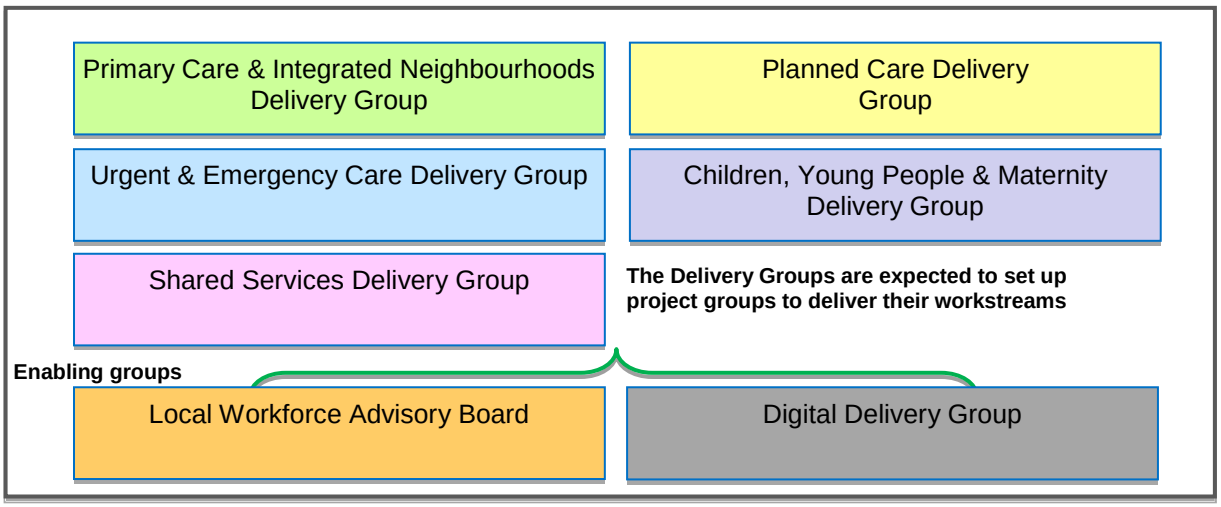
22. SUSTAINABILITY AND TRANSFORMATION PLAN (STP) UPDATE

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

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

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

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



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

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

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

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

In discussion issues raised included:

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

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

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

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

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

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

It was resolved

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

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

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

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

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

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

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

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

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

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

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

In discussion, issues raised included:

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

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

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

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

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

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

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

It was resolved:

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

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

b) mode of transport used,

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

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

24. DEVELOPMENT OF PRIMARY CARE IN NORTHSTOWE

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

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

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

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

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

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

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

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

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

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

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

In discussion the following issues / questions were raised;

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

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

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

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

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

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

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

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

It was resolved:

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

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

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

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

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

It was resolved:

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

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

26. COMMITTEE TRAINING PLAN

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

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

It was resolved:

To note the current Training Plan.

27. COMMITTEE FORWARD AGENDA PLAN

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

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

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

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

It was resolved:

a) To note the Committee Training Plan.

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

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

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

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

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

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

Chairman
7th September 2017

Appendix 1

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

Introduction

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

Item No. 11.

Mitigation Measures for Nth Area Residents

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

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

Report – Out of Hours Relocation …

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

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

Mitigation Measures

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

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

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

Conclusion

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

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

Dr Jocelynne A. Scutt
County Councillor for Arbury

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

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on **20th July 2017** and updates Members on progress in delivering the necessary actions. Updated 30 August 2017.

Minute No.	Item	Action to be taken by	Action	Comments	Status
14.	**Minutes of 14 June 2017 and Action Log**	**Val Thomas**	Minute 8. Annual Health Performance Report - Health trainers outcomes: To include this information as an appendix to the September Finance and Performance report.	Information relating to outcomes will be included as an appendix to the September Finance and Performance report.	**Completed**
17.	**Public Health Finance and Performance Report** **a) Health visiting mandated checks whether geographical / social reasons for lack of take-up**	**L Robin**	Health visiting mandated checks - the percentage of children who received 12 month review by 15 months – with reference to the decline in performance, a question was raised regarding whether there was a geographical / social pattern to them not being wanted or not attended? **Action: Dr Robin to find out and report back with more detail.**	Under investigation.	**On-going**

Minute No.	Item	Action to be taken by	Action	Comments	Status
	b) Additional inequalities information to highlight the scale of the issue of non-take up of outreach health checks in Fenland to be provided on quarterly basis.	**V Thomas**	In discussion on health checks it was explained that the outreach health checks had achieved the target apart from in Fenland. As follow up, the Vice Chairman suggested that in order to ascertain the scale of the problem future reports indicators should be split in two, to show Fenland and the rest of the County. It was confirmed that health and inequalities supplementary information had been produced in the past on a quarterly basis and this information could be added. **Action: This additional inequalities information to highlight the scale of the issue on health checks take up in Fenland to be provided on quarterly basis.**	Work is in hand with local academics to develop an evaluation framework to capture these outcomes.	**On-going**
	c) Clarification on what sanctions there were for non-performance of Section 75 or joint contracts such as Health visitors / School Nursing	**L Robin/ Raj Lakshman**	In discussion on poor performance against contracts and the admission that financial penalties could not be imposed on Section 75 or joint contracts such as Health visitors / School Nursing, there was a request **to clarify what if any, sanctions applied in these type of contracts.**	**18.08.18**: Awaiting feedback from LGSS Law Ltd.	**On-going**
19.	**Update from Cambridge University Hospitals NHS Foundation Trust (CUHFT)**	**Councillor Hudson**	**a) Delayed Transfers of Care, (DTOCs)** The Chairman to discuss with the Chairwoman of the Adults Committee	Councillor Hudson has discussed this issue with Chairwoman of the Adults Committee.	**Completed**

Minute No.	Item	Action to be taken by	Action	Comments	Status
			the role which the County Council could play with partners going forward to address delayed transfers of care as part of a whole system approach.		
		Kate Parker	**b)** To request consideration that one of the quarterly liaison meetings with CUHFT being held at the Granta medical centre / practice.	Awaiting feedback from CUHFT on the most appropriate time to schedule this meeting.	**On-going**
20.	**Non-Emergency Patient Transport (NEPT) Service Performance Update**	**Democratic Services**	A request for a further progress report in six months.	Added to the Health Committee agenda plan for January 2017.	**Completed**
21.	**Public Question**	**Democratic Services**	Question from Mrs Jean Simpson: "How can Cambridgeshire County Council work together with CPCCG on delivering the STP when the scale of the cuts to our health service have not been made clear?	A response was sent to Mrs Simpson on 2 August 2017. A copy is attached at Appendix 1.	**Completed**
22.	**Sustainability and Transformation Plan (STP) Update** **a) Request for each Delivery Group to include a Health Committee Member**	**Scott Haldane / Aidan Fallon**	It was suggested that each of the delivery groups should include a representative from the Health Committee. The report leads agreed to take this suggestion away.	This suggestion by the Health Committee has been taken back by the report leads and is currently being considered. A further update will be available for the Health Committee meeting on 7th September 2017.	**On-going**
	b) STP information seminar /	**Kate Parker to lead on**	In discussion it was requested that an STP session/s should be scheduled, to include the following themes:	Included in the committee training plan.	**Completed**

Minute No.	Item	Action to be taken by	Action	Comments	Status
	session (s) requested	**liaison arrangements**	• delayed transfers of care • primary care models • Communication with the public on ways to use the NHS • Risk Register • governance structure and key performance and key performance indicators monitoring. • Workforce issues.		
23.	**GP Out of Hours Base Relocation from Chesterton Medical Centre (CMC) to Addenbrooke's Clinic 9**	**Democratic Services**	To ask the CCG to provide a further report for the Committee in December following analysis of the first three months monitoring data. This should include: a) Information on where people are attending from (including the uptake from CB4 compared to the Chesterton usage), b) mode of transport used, c) details of the number of patients who try to walk in without an appointment, d) comprehensive information on the mitigation measures to be undertaken for Chesterton residents.	Added to the committee agenda plan for December 2017.	**Completed**

Minute No.	Item	Action to be taken by	Action	Comments	Status
24.	**Development of Primary Care in Northstowe**	**Democratic Services**	To receive a further report in December with details of a vision for the future for the Healthy New Town for the next five to ten years and how the programme may be evaluated.	Added to forward agenda plan	**Completed**
25.	**Appointment of a Member Champion for Mental Health**	**Action: Liz Robin / Democratic Services**	To consider a mechanism to provide updates from other committees on mental health issues.	The Health Committee will be provided with links to relevant reports submitted to other committees.	**Completed**
27.	**Committee Forward Agenda Plan**	**Liz Robin/ Democratic Services**	a) Add re-letting of the Procurement of Drug and Alcohol Service Contract report adding to the agenda plan.	On the agenda for September 2017.	**Completed**
		Democratic Services	b) Updates of the STP to remain a standing item on the Health Committee agenda.	Added to forward agenda plan.	**Completed**
		Democratic Services	c) To establish whether it was practicable for future Health Committee meetings to start at 1.30pm rather than 2.00pm.	The meeting on 7 September has been rescheduled to start at 1.30pm. Democratic Services are reviewing subsequent meetings to try to accommodate a 1.30pm start time.	**On-going**
		Democratic Services	d) To consider whether it would be practicable to include timings on future agendas.	Members of the Committee will be provided with single page summary of the agenda with provisional timings in advance of the meeting. However, it is noted that these should be used for guidance only as times may still	**Completed**

Minute No.	Item	Action to be taken by	Action	Comments	Status
				vary on the day in response to the flow of debate.	

Appendix 1

Text of the response to Mrs Jean Simpson:

Thank you for attending and presenting the following question to the Health Committee held on 20th July 2017:

How can Cambridgeshire County Council work together with CPCCG on delivering the STP when the scale of the cuts to our health service have not been made clear?

Following your question and the discussion undertaken in respect of the Sustainable Transformation Plan scrutiny item, the Committee requested that the STP unit provides more information on performance indicators and milestones to measure outcomes. The Committee have also asked to see more detail on the delivery aspects of the STP and the relevant implications. We will be asking the STP to provide more information on the following areas:

- Primary Care models
- Risk Register
- Governance structure and key performance & key indicators.
- Engagement plans with the public on how to use the NHS
- Workforce Planning
- Delayed Transfer of Care

At the meeting representatives from the STP Delivery Unit mentioned they would be developing a stakeholder forum and planned to also involve elected members more, going forward. The Health Committee will be actively pursuing further involvement of elected members through its scrutiny function and will continue to ask for more information on the delivery aspects of the plan.

Agenda Item No: 4

HEALTHY WEIGHT STRATEGY

To:	**Health Committee**
Meeting Date:	**September 7th 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**KD2017/35** *Key decision* **Yes**
Purpose:	**To provide an overview of the Healthy Weight Strategy and feedback on the consultation that was taken across the system**
Recommendation:	**The Health Committee is asked to:** **a) The Health Committee is asked to approve the Healthy Weight Strategy and the Implementation Plan** **b) To endorse partners taking forward the Implementation Plan.**

Officer Contact:	*Member Contact:*
Name: Val Thomas **Post: Consultant in Public Health** **Email: Val.Thomas@cambridgeshire.gov.uk** **Tel: 01223 703264**	**Name: Councillor Peter Hudson** **Post: Chairman** **Email: Peter.Hudson@cambridgeshire.gov.uk** **Tel: 01223 706398**

1. BACKGROUND

1.1 Achieving a Healthy Weight for the population is a major public health challenge. Healthy weight is fundamental for good health and wellbeing and demands a joined up collaborative whole systems wide approach if it is to be addressed effectively. The Cambridgeshire Healthy Weight Strategy supports delivery of the five strategic objectives of the Cambridgeshire Health and Wellbeing Strategy 2012-17 and it is firmly embedded into the Cambridgeshire and Peterborough System Transformation Prevention Strategy. It has been developed with the support of the Cambridgeshire Public Health Reference Group (PHRG).

1.2 The Healthy Weight Strategy considers the impact of the increase in the prevalence of unhealthy weight along with evidence based interventions for prevention through to treatment for the associated poor health outcomes. There is a focus on diet and physical activity as the key factors that influence a healthy weight. Nationally and locally, there is a considerable emphasis upon obesity and excess weight dominates the focus of the Strategy. However, information is also included on malnutrition (referring to underweight for the purposes of this Strategy) and how it is affecting health in Cambridgeshire and Peterborough. Please note that although this Strategy was developed predominantly by Cambridgeshire, partner Peterborough's information is included reflecting the Cambridgeshire and Peterborough Clinical Commissioning Group's involvement in its development. The full Draft Healthy Weight Strategy is attached as Appendix 1.

1.3 In July 2016 the Health Committee was asked to approve the Healthy Weight Strategy as a draft document for further engagement and consultation. Secondly to endorse a system wide event to engage organisations and communities in finalising and agreeing the Implementation Plan. The system wide event had national level "experts" presenting and was attended by representatives from a wide range of organisations. Participants were asked to prioritise areas that could be taken forward in an implementation plan. The identified priorities have been central to the development, with partners, of the attached Implementation Plan, (Appendix 2) which reflects the key areas of the Strategy. The Healthy Weight Strategy and its Implementation Plan was subsequently approved by the PHRG.

2. MAIN ISSUES

Prevalence – Childhood Obesity

2.1 An unhealthy weight includes malnutrition but the focus nationally and locally is currently upon overweight and obesity, which are seen as a major public health challenges. The last twenty years has seen an unprecedented increase in levels of overweight and obesity. The poor health associated with overweight and obesity and the cost of addressing these are the drivers behind this Strategy.

2.2. The National Child Measurement Programme (NCMP) annually measures all children in reception and year 6 classes in schools across the country. In 2015/16 the NCMP data shows that nationally 12.8% of Reception children are overweight and a further 9.3% are obese. In Year 6, 14.3% of

children are overweight and an additional 19.8% (double the 9.3% rate in reception) are obese.

In 2015/16 nearly one in five Reception, children in Cambridgeshire start school overweight or obese (18.7%). In Year 6, over one in four Year 6 children is overweight or obese. (28.2%). Prevalence data is more varied within Cambridgeshire districts with Fenland consistently having the highest prevalence of excess weight year on year, 21.4% in Reception and 33.9% in Year 6

2.3 Since 2007/2008 the prevalence of child overweight and obesity in Cambridgeshire has been below the national figure with some variation from year to year. However, there are persistent differences between the Cambridgeshire districts. Table 1 indicates the differences in percentages of obesity between the districts with Fenland having the highest levels in Cambridgeshire. It also shows that obesity doubles between reception and Year 6 schoolchildren.

Table 1- Recorded Obesity Prevalence in Cambridgeshire Districts and Peterborough 2015/16

Area	Reception (%)	Year 6 (%)
Cambridge	6.0%	11.3%
East Cambridgeshire	6.8%	15.3%
Fenland	8.7%	20.0%
Huntingdonshire	7.3%	15.8%
South Cambridgeshire	5.9%	12.6%
Cambridgeshire	6.9%	14.9%
Peterborough	9.3%	19.8%
England	9.3%	19.8%

Source: HSCIC, NCMP 2015/16

Prevalence - Adults

2.4 The majority of the adult population in England are overweight or obese (64.8% 2013-15). Adult obesity prevalence has increased from 14.9% in 1993 to 25.6% in 2014. Morbid obesity (the most severe category of obesity) has more than tripled in this time, affecting 2% of men and 4% of women in 2014. Modelling suggests obesity levels could increase to 60% of men, 50% of women and 25% of children by 2050. Using current trends, adult overweight and obesity will reach 72% by 2035 - almost three in four UK adults. In Cambridgeshire and Peterborough, modelling indicates that these figures will increase by 2031 to 69.4%

2.5 It was estimated that in 2013-15 in Cambridgeshire 63.2% of local adults were either overweight or obese, slightly lower than the national average of 64.8%

2.6 There are differences in adult prevalence of excess weight between Cambridgeshire districts. In 2013-15 Fenland had the highest percentage of adults with excess weight (72.9%) followed by East Cambridgeshire (68.1%) and Huntingdonshire (67.3%). All three districts were significantly above the

national average for this measure. Cambridge (47.6%) is the only district to have significantly lower estimated levels of excess weight than England (64.8%), which is likely to be affected by the higher proportion of young adults in the city.

Table 2: Adult excess weight in Cambridgeshire & Peterborough. Source: Public Health Outcomes Framework (data based on 2013-15)

Area	% Unhealthy Weight
Fenland	72.9%
East Cambridgeshire	68.1%
Huntingdonshire	67.6%
South Cambridgeshire	63.6%
Cambridge City	47.6%
Cambridgeshire	63.2%
Peterborough	70.8%
England	64.8%

Prevalence - Malnutrition

2.7 There is a poor understanding of the rates of malnutrition but it is estimated that over three million people in the UK are thought to be malnourished or at risk of malnutrition. Around 1.3 million older people aged over 65 years are estimated to be within this figure. The majority of these people are thought to be living in the community (93%) with a minority in care homes (5%) or in hospital (2%). Local estimates are determined by applying national estimates to the population, which means that in Cambridgeshire and Peterborough there are 13,000 to 18,300 older residents who are malnourished. By also considering lifestyle and psychosocial risk factors, there may be an estimated 29,000 older people at increased risk of malnutrition in Cambridgeshire.

Physical Activity

2.8 Regular physical activity is a key factor in achieving a healthy weight and reducing the risk of obesity. Activity levels have declined and England is now 24% less active than in 1961. Current trends predict this will increase to 35% by 2030. Just over half of all adults (57% in 2015) currently meet physical activity guidelines (67% of men and 55% of women). Two in ten (22% in 2015) 5 to 15 year olds meet recommended levels of exercise (23% of boys and 20% of girls). The proportion of children meeting the weekly guidelines has fallen since 2008 (28%) although physical activity levels have improved since 2012. Activity levels decrease in older children, and girls show the lowest levels of physical activity across all age groups in 5-15 year olds.

2.9 There are fewer inactive adults in Cambridgeshire (25.3%) compared to England (28.7%). There are differences amongst the districts. Cambridge City has the lowest levels of physical inactivity (14.7%), East Cambridgeshire (29.7%) is similar to the England average and Fenland (37.4%) has higher inactivity levels than the rest of the county and England.

Unhealthy Weight and Inequalities

2.10 There are unhealthy weight inequalities amongst different population groups.

Deprived communities, certain ethnic groups, people with disabilities, long-term conditions or mental illness, children with obese parents and looked after children have a higher risk of an unhealthy weight, which is reflected by higher rates of poor health outcomes.

Unhealthy Weight and Health

2.11 Unhealthy weight has considerable implications for health, social care and the economy. Excess weight in adults reduces life expectancy by three years on average, increasing to eight to ten years in morbid obesity. It increases the risk of developing serious diseases, including diabetes, heart disease and some cancers. Childhood obesity has physical and mental health consequences and increases the risk of being an overweight adult. Health, social care and the economy are also impacted by malnutrition, which has serious health effects and makes people more vulnerable to disease.

The Costs of Unhealthy Weight

2.12 High levels of unhealthy weight places substantial demands on health, social care services and the wider economy. An additional £2.51 billion a year in direct health costs are predicted by 2035. This is for treatment for excess cases of coronary heart disease (CHD), type 2 diabetes, stroke and cancer resulting from increasing prevalence of obesity. By 2035, the indirect costs of excess weight are predicted to be £13.98 billion.
Diseases associated with excess weight relate to sixteen percent of NHS costs. Of these, 60% relate to diabetes, coronary heart disease and stroke; 30% to osteoarthritis and 10% to cancers.

Figure 1: Obesity Harms Communities. Public Health England 2015, Making the case for tackling obesity

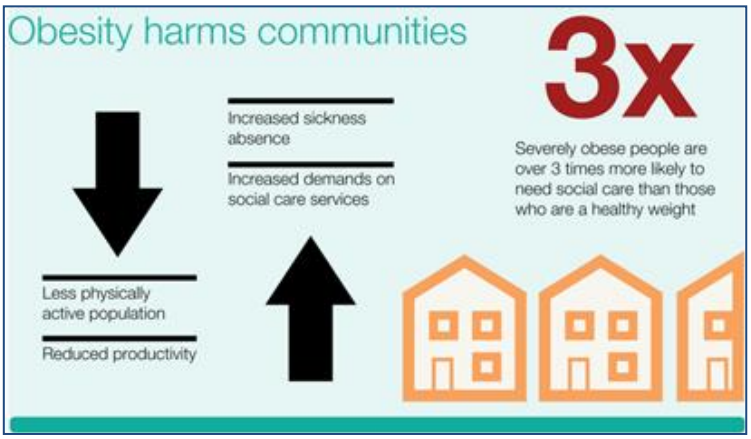
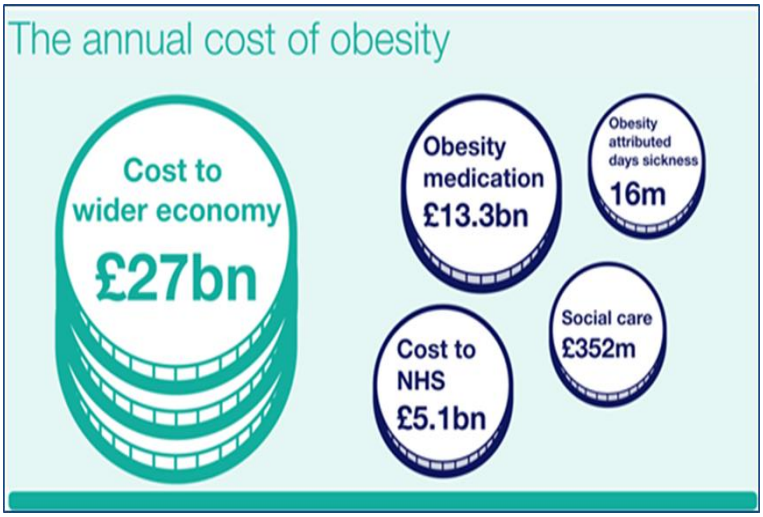


Figure 2: Annual Cost of Obesity. Public Health England 2015

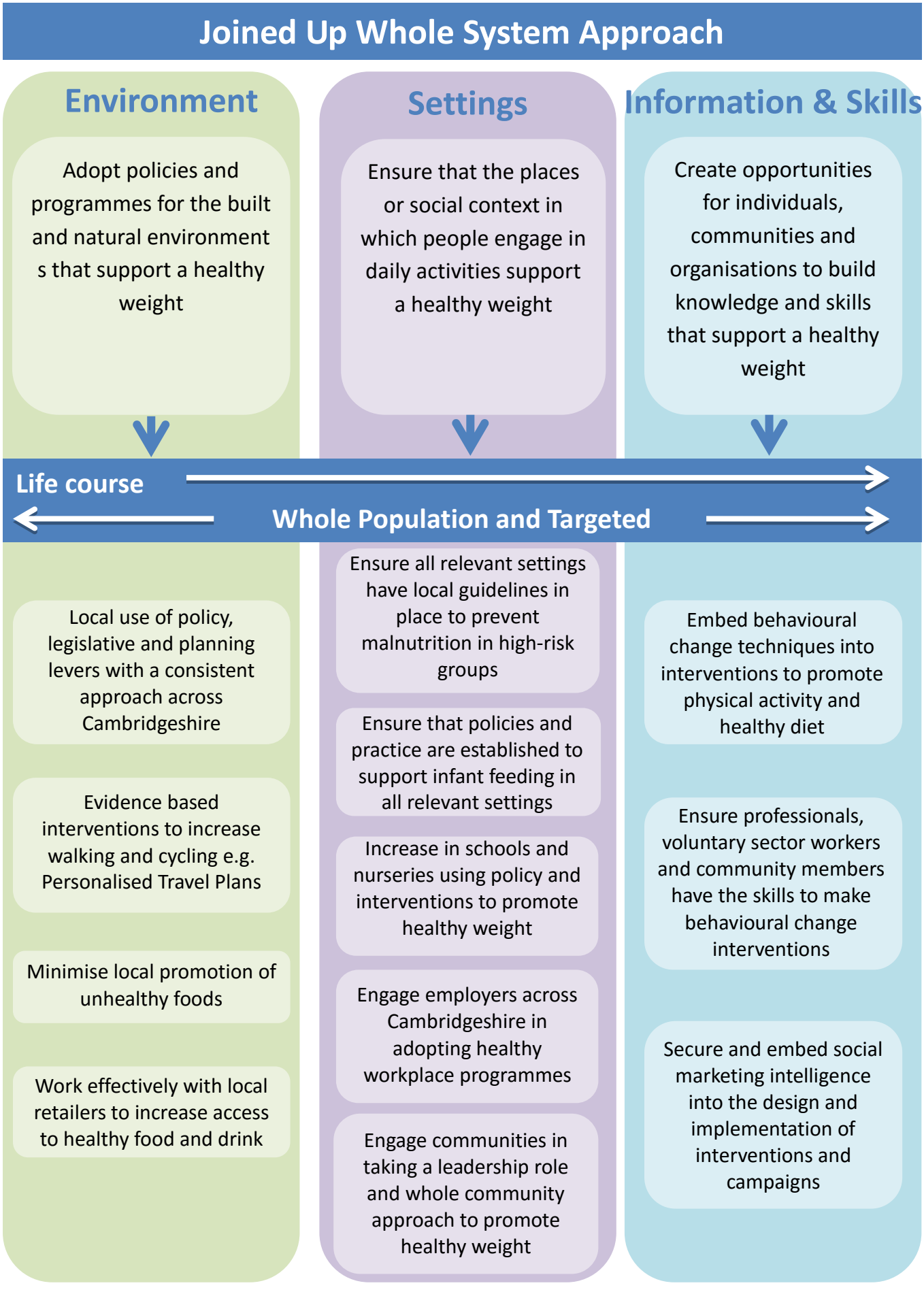


The Healthy Weight Strategy

2.13 The Strategy describes the extent of the issue and its effect upon health in terms of outcomes and the costs to health and social care.
Figure 3 is a high level summary of the Healthy Weight Strategy. It has been developed from the best available evidence. The underpinning theme of the Strategy is that addressing unhealthy weight requires a multi-factorial approach; interventions need to be system wide, holistic and joined up across all sectors. Action to address unhealthy weight needs to be embedded into policies and strategies at a local level. It requires population wide interventions but also targeted approaches for specific groups with a high risk of or with existing high unhealthy weight prevalence. A life course approach is essential with interventions being divided into three areas, the environment, place based or settings and through information and skills development to support behavioural change.

2.14 The Strategy indicates the types of evidence based interventions that will need to be implemented. It provides examples of good practice from local and national areas as indicators of how work can be carried forward.

Figure 3 – Healthy Weight Strategic Framework for Action



Next Steps

2.15 Addressing the issue of unhealthy weight, especially obesity, will only be possible through the joint efforts of organisations and communities across the whole of Cambridgeshire. This Strategy and its Implementation Plan was developed with partners and has secured support from many parts of the system. Taking forward the Implementation Plan will require the collaborative use of resources to ensure that the Implementation is effective.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The report above sets out the implications for this priority in paragraph 2.18

3.2 Helping people live healthy and independent lives

The report above sets out the implications for this priority in paragraphs 2.17, 2.19 and 2.20

3.3 Supporting and protecting vulnerable people

The report above sets out the implications for this priority in paragraphs 2.11, 2.13, 2.16, 2.17, 2.19 and 2.20

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

- The costs of unhealthy weight are indicated in paragraphs 2.19
- Implementing the strategy will require funding to implement many of the system wide evidence based interventions that will affect the resource allocation of organisations across the county.
- The interventions recommended reflect the current cost-effectiveness evidence.

4.2 Statutory, Risk and Legal Implications

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

- Unhealthy weight can have a wide-ranging negative impact on the health and wellbeing of the population. In the past 20 years rates have increased dramatically
- If this increase is not addressed, there is a very high risk that there will be an increased burden of obesity related disease that ill impact heavily upon health and social care services.

4.3 **Equality and Diversity Implications**
The following bullet points set out details of significant implications identified by officers:

- The Strategy indicates the unhealthy weight inequalities and how these would need to be addressed.
- Targeted approaches are indicated.

4.4 **Engagement and Consultation Implications**
The following bullet points set out details of significant implications identified by officers:

- Members are being asked to approve the Healthy Weight Strategy and the Implementation Plan.

4.5 **Localism and Local Member Involvement**
The following bullet points set out details of significant implications identified by officers:

- Implementation of the Strategy will involve working with communities to support them to engage with the agenda through community action**.**

4.6 **Public Health Implications**
The following bullet points set out details of significant implications identified by officers:

- Unhealthy weight is a major public health issue due to its substantial impact on health.
- It requires interventions at community and organisational levels i.e. across the whole system.
- These will need to include targeted actions that will address the inequalities associated with unhealthy weight and are indicated in the Strategy

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes 16 Aug 2017 Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes 22nd Aug 2017 Name of Officer: Paul White
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes 17 Aug 2017 Name of Legal Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes 18/ Aug 2017 Name of Officer: Liz Robin

Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Joanne Dickson
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes 18 Aug 2017 Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes 18 Aug 2017 Name of Officer: Liz Robin

Source Documents	**Location**
Cambridgeshire and Peterborough Healthy Weight Strategy Links to all the information provided in this paper can be found in the Strategy Public Health Reference Group – Membership details	\\ccc.cambridgeshire.gov.uk\data\CFA Public Health\Shared\Health Improvement\Obesity\PHRG Obesity Strategy from 201 ..\..\..\..\Shared\Director of Public Health\Director of Public

	Health\Meetings\PHRG

Cambridgeshire and Peterborough

Healthy Weight Strategy 2016-2019

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1 Executive Summary

2 Introduction

2.1 Background

Achieving a healthy weight for the population is a major public health challenge. Healthy weight is fundamental for good health and wellbeing and demands a joined up collaborative whole systems wide approach if it is to be addressed effectively. This Strategy is underpinned by the Cambridgeshire Health and Wellbeing Strategy 2012-17 and supports delivery of its five strategic objectives. It is firmly embedded into the Cambridgeshire and Peterborough System Transformation Prevention Strategy.

The Strategy has been developed through the Cambridgeshire Public Health Reference Group (PHRG). The PHRG provides whole system leadership and multi-agency co-ordination for public health initiatives in Cambridgeshire and Peterborough. It is accountable to the Cambridgeshire Health and Wellbeing Board and provides reports for a number of strategic boards. Its focus is upon improving outcomes for residents and reducing health inequalities. The PHRG has a broad membership representing a range of organisations including local academic institutions.

2.2 Why do we need a Healthy Weight Strategy?

The prioritisation of healthy weight by the PHRG reflects its considerable impact upon health across the life course. There is a particular concern with how obesity is associated with a high risk of long term conditions such as: diabetes; high blood pressure; coronary heart disease; stroke and some cancers. Another major concern is poor nutrition and underweight for older age groups in England. These unhealthy weight statuses are placing an unsustainable demand on health and social care systems. How we prevent and manage them is a priority if we are to have sufficient resources to address needs in the future.

3 Strategic Vision, Aim and Objectives

3.1 Vision

To take a system-wide approach to healthy weight in Cambridgeshire and Peterborough, empowering and supporting residents to achieve and maintain a healthy weight throughout their life.

3.2 Strategic Aim

To increase the proportion of healthy weight children and adults in Cambridgeshire and Peterborough.

3.3 Strategic Objectives

The five key strategic objectives of the Strategy for achievement of healthy weight are supported by themes of environment, the life course, information and skills which are reflected in the evidence base.

1. **Create an environment which promotes and supports a healthy weight.**
2. **Encourage healthy lifestyle behaviours for nutrition and physical activity.**
3. **Ensure everyone is supported throughout their life to maintain a healthy weight.**
4. **Engage and enable individuals and communities to take responsibility for their health.**
5. **Address healthy weight inequalities.**

3.4 Strategic Targets

To see locally, in line with the national ambition set out in the Childhood Obesity: A Plan for Action (2016) and in previous targets from the Healthy Lives, Healthy People: A Call to Action on Obesity in England (2011):

- Significant reduction in the rate of childhood obesity within the next 10 years (2026).
- Downward trend in the level of excess weight averaged across all adults by 2020.

4 Scope

This Strategy considers prevention through to treatment for unhealthy weight and the associated poor health outcomes. There is a focus on diet and physical activity as the key factors that influence a healthy weight. Nationally and locally there is considerable emphasis upon obesity and excess weight dominates the focus of the Strategy. Information on malnutrition (referring to underweight for the purposes of this Strategy) is also included to provide an understanding of how it impacts on health in Cambridgeshire and Peterborough.

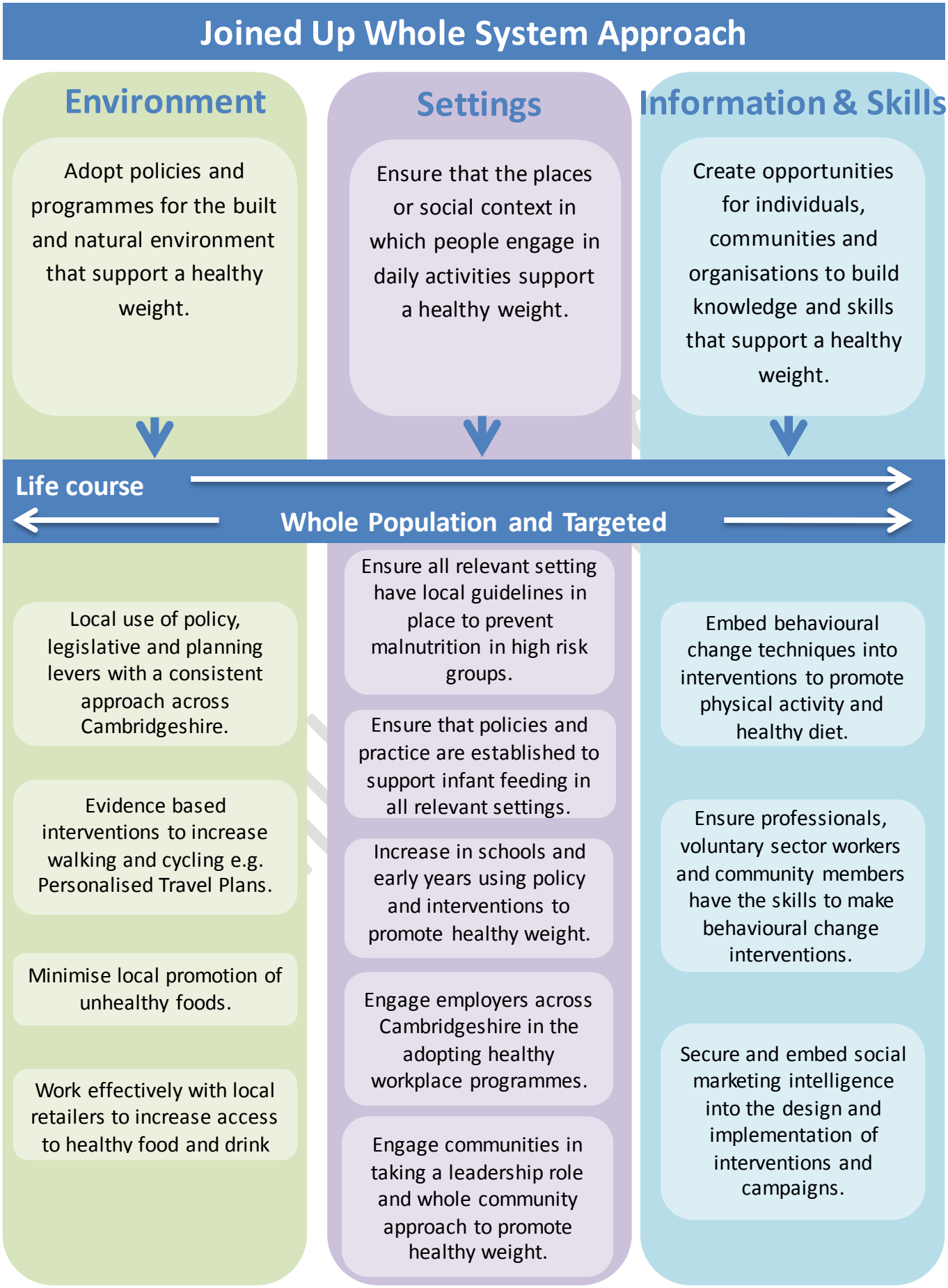
Current needs and trends are presented to show the prevalence of excess weight and malnutrition and how these affect health. It identifies population groups at a high risk of being an unhealthy weight. It has a strong focus on prevention in terms of how a healthy weight can be achieved and maintained. Treatment of unhealthy weight is also included in the Strategy acknowledging that a holistic approach is required if the associated poor health outcomes are to be addressed.

The Strategy is conceptualised around three main themes as the main contributors to a healthy weight across the life course: the built and natural environment; settings plus information and skills. Within the life course there are key stages where people make critical decisions that can influence long term lifestyle behaviours. Interventions are not particularly successful at any one point; instead a life course approach offers opportunities to address factors that contribute to an unhealthy weight. The overarching theme is that efforts to address unhealthy weight need to be collaborative and across the whole system. Key evidence based areas are identified which call for well evaluated interventions. Figure 1 captures the main themes and key areas for action that have been identified from the evidence. An action plan will be developed that reflects these key areas.

A section within the Strategy presents the evidence base for addressing unhealthy weight and identifies interventions that have been evaluated as effective. Many of the examples are from across the county and give an insight into the wide range of existing local work. Nationally there are a growing number of well evaluated evidenced based interventions. It is good practice to ensure that any interventions are evaluated so they can contribute to our understanding of what influences a healthy weight.

However there are overall challenges associated with securing evidence for a healthy weight due to the many variables that are known to have an impact upon behaviour, along with long timeframes for measuring outcomes and any cost savings. The Strategy includes and endorses the strongest evidence but also calls for any new initiatives to be well evaluated.

Figure 1 – Healthy Weight Strategic Framework for Action.



5 Strategic Framework Tool

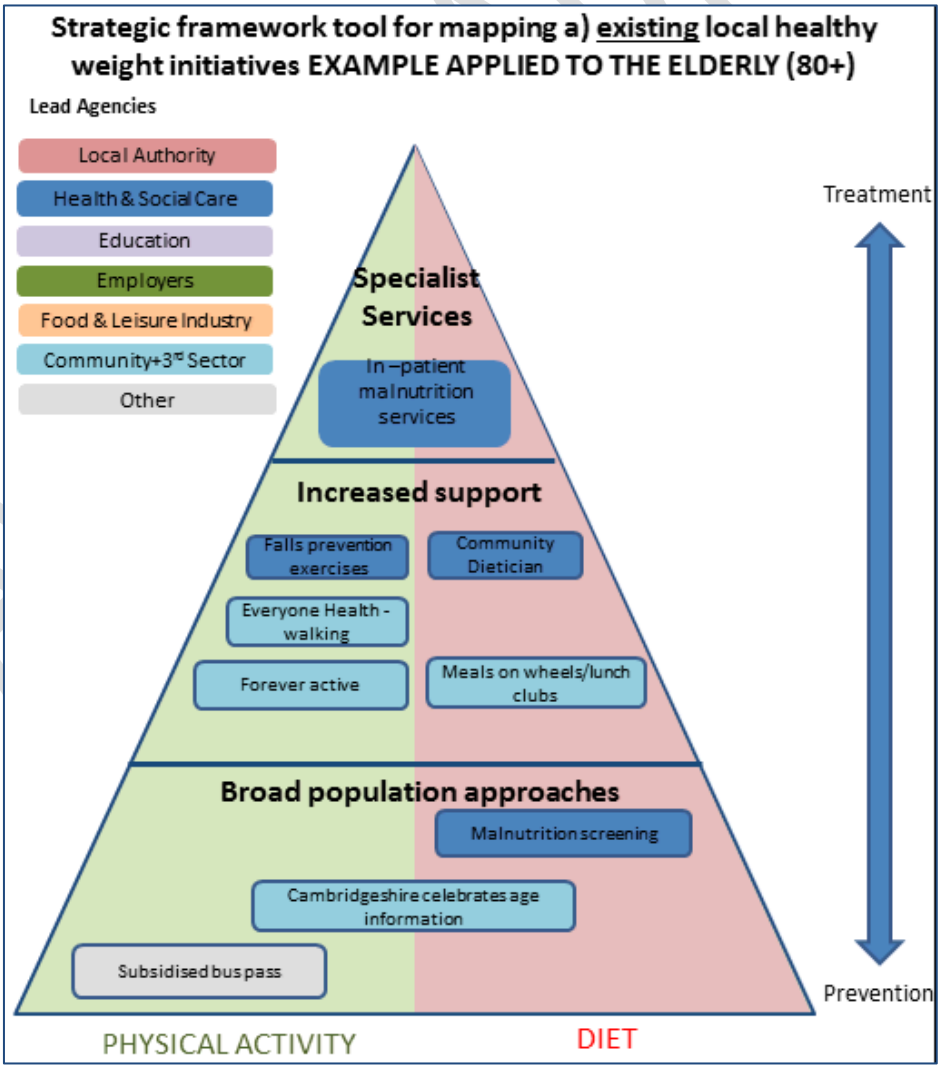
The Strategic Framework (Appendix 1) is a tool to help identify current initiatives and also gaps in local services and interventions which can support people to achieve and maintain a healthy weight.

The framework can be applied by all local organisations; lead agencies are identified in the strategic framework and will encompass a wider number of organisations within each lead agency. The framework enables lead agencies and organisations to recognise work they currently undertake to support healthy weight. It also allows for any gaps to be identified and addressed.

The framework considers key stages in the life course for action, from the early years through to the elderly. It separates local initiatives into broad population approaches aimed at achieving a healthy weight; increased support for higher risk groups and specialist services for groups in need of further support to achieve a healthy weight.

Using the framework tool lead agencies, both together or individually, can consider current healthy weight initiatives for each life course and map these on the framework. Then following the same process lead agencies can use the framework to map any gaps in healthy weight initiatives. An example of mapping the current provision of services for the elderly is given below in Figure 2. The framework will be used to develop the supporting action plan to the Strategy.

Figure 2 - Example of strategic framework tool for mapping existing local healthy weight initiatives in Cambridgeshire for the elderly.

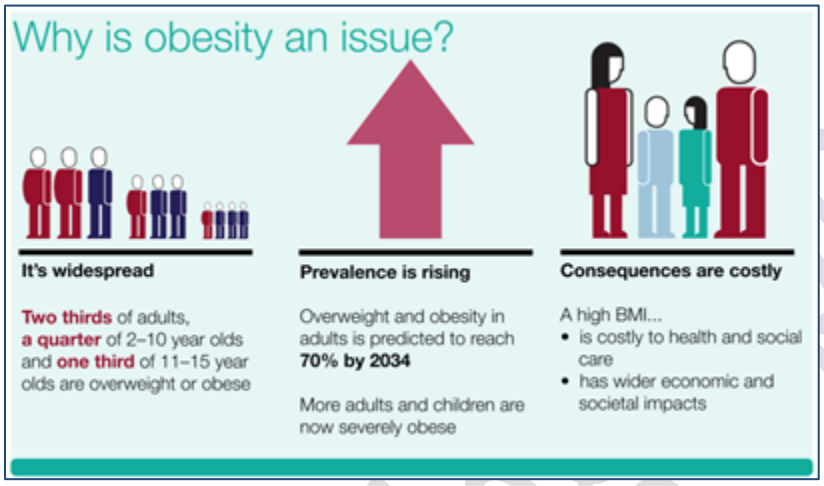


6 Unhealthy Weight – Why does it matter?

Being overweight or malnourished increases risk of poor health. Unhealthy weight has substantial implications for health, social care and the economy. Obesity has a significant impact to the individual and the wider society as it is wide spread and prevalence has continued to increase since 1993. Malnutrition is also estimated to be increasing, particularly with an increasingly ageing population.

Obesity reduces life expectancy by three years on average, increasing to eight to ten years in morbid obesity. It increases the risk of developing serious diseases, including diabetes, heart disease and some cancers. This places substantial demands on health and social care services. Childhood obesity also has serious physical and mental health consequences and increases the risk of being an obese adult. Health effects of malnutrition are also serious and makes people more vulnerable to disease, impacting on health, social care and the economy.

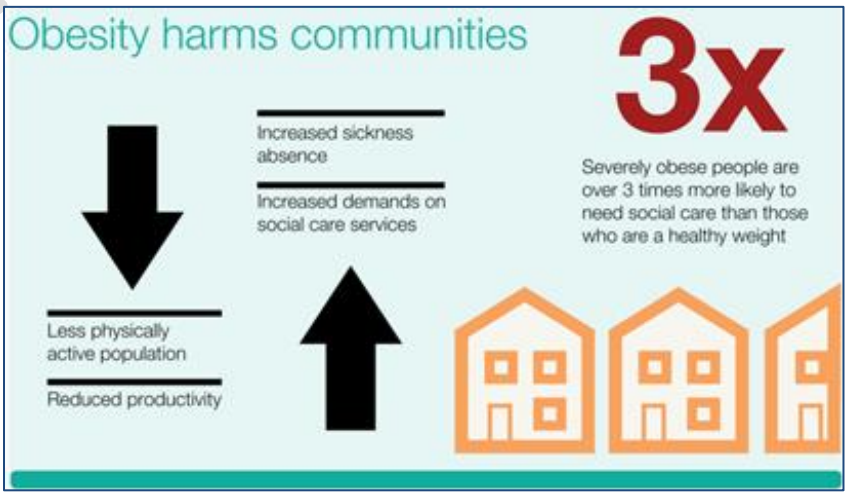
Figure 3 - Why is Obesity an Issue?



Source: Public Health England 2015, Making the case for tackling obesity.

Figure 4 - Obesity Harms Communities.

The direct costs of obesity on health services are well known, however, there are wide impacts on communities too which result in substantial additional costs.



7 The Costs of Unhealthy Weight

7.1 Cost of Obesity

Obesity incurs significant direct annual costs of £5.1 billion, with Public Health England (PHE) reporting further indirect costs including £27 billion to the wider economy[1].

Obese individuals have 30% higher health costs than healthy weight individuals[1].

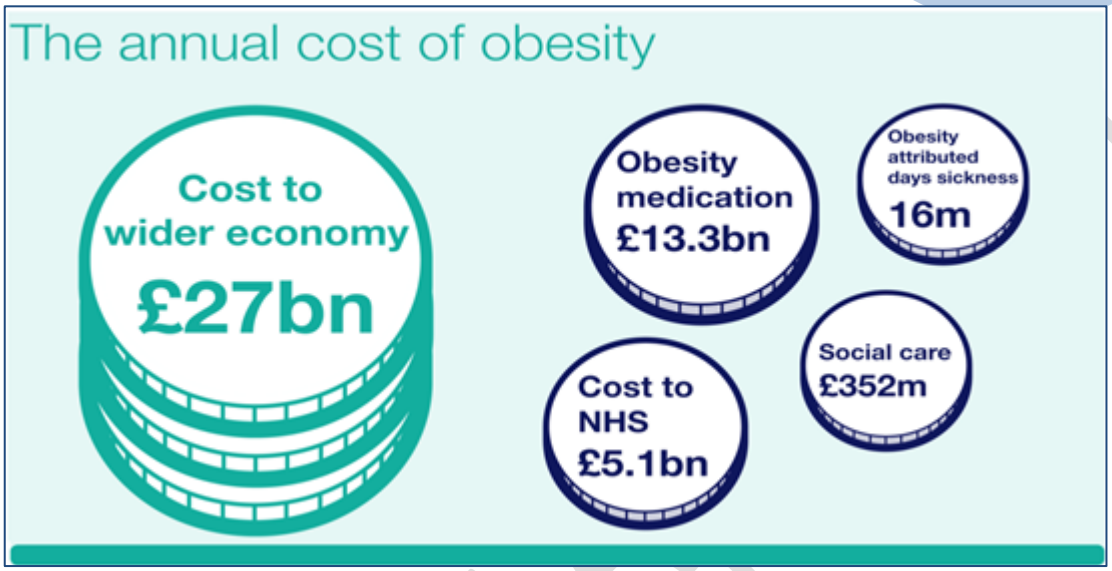


Figure 5 - Annual Cost of Obesity.

Source: Public Health England 2015, Making the case for tackling obesity.

The continuing increase in prevalence of excess weight will have a significant impact on the annual cost of obesity. An additional £2.51 billion a year in direct health costs alone are predicted by 2035[2]. This is for

[1] Withrow, D., Alter DA. (2011) 'The economic burden of obesity worldwide: a systematic review of the direct costs of obesity'.

[2] Cancer Research UK and UK Health Forum Report. (2016). *Tipping the Scales: preventing obesity makes economic sense.* Available at: http://www.cancerresearchuk.org/sites/default/files/tipping_the_scales_-_cruk_full_report11.pdf (Accessed: 31 March 2016)

treatment for excess cases of coronary heart disease (CHD), type 2 diabetes, stroke and cancer resulting from increasing prevalence of obesity. By 2035 the indirect costs of excess weight are predicted to be £13.98 billion[2].

Diseases associated with excess weight relate to 16% of NHS costs. Of these diseases 60% relate to diabetes, coronary heart disease and stroke; 30% to osteoarthritis and 10% to cancers[3]. These diseases are complex and their causes are multi-factorial. While around 80% of the disease burden due to diabetes can be attributed to overweight or obesity, for heart disease and stroke the proportion is closer to one third and for osteoarthritis it is around 20%. No single disease accounts for the majority of obesity-related NHS costs.

Physical inactivity increases risk of obesity and costs the NHS £1.1 billion a year as a direct cost[4]. This increases to £8.2 billion when indirect costs to society are considered. Physical inactivity directly contributes to 1 in 6 deaths in the UK. Life expectancy is reduced by three years in people who are physically inactive compared to those who are active.

7.2 Cost of Malnutrition

Malnourished individuals require more GP visits, prescriptions and hospital admissions.

Malnutrition cost an estimated £19.6 billion in 2011/12 in England[5]. This included the associated costs of health care and social care primarily due to more frequent and expensive in-patient hospital stays, more primary care consultations and greater long-term care needs. Of the total figure, older adults accounted for 52%, younger adults for 42% and children for 6%.

Around two thirds of cases of malnutrition are not recognised; the impacts are an increased burden of disease and treatment costs. The estimated cost has increased significantly from the previous estimate of £13 billion in 2007[5]. The cost of malnutrition is anticipated to increase with an ageing population and rise in health and social care costs.

In 2013 The National Institute for Health and Care Excellence (NICE) identified malnutrition as the sixth largest source for potential NHS saving[6]. Savings to the NHS of £45.5 million a year could be made through early identification and treatment of malnutrition in adults, even after training and screening costs[7].

8 Factors that contribute to unhealthy weight

8.1 Obesity - Multi-Factorial

No single influence dominates the cause of obesity; the causes are a complex system of biology and society.

The influential Foresight Report (2007) provided clear evidence that unhealthy weight is associated with multiple factors which involve

[3] Cambridgeshire and Peterborough CCG (2016). *Health system prevention strategy for Cambridgeshire and Peterborough.* Available at: http://cambridgeshireinsight.org.uk/health/healthcare/prevention (Accessed: 31 March 2016)

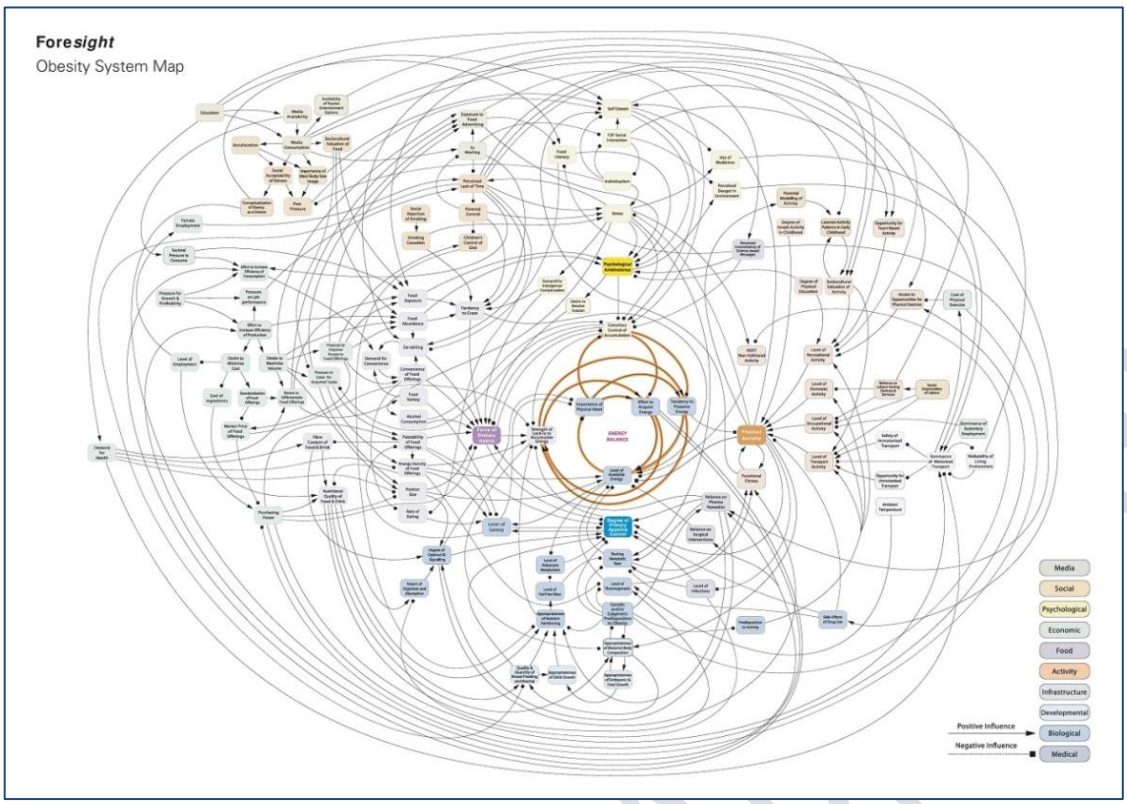
[4] All-Party Commission (2014). *Tackling Physical Inactivity – A Coordinated Approach.* Available at: https://parliamentarycommissiononphysicalactivity.files.wordpress.com/2014/04/apcopa-final.pdf (Accessed: 31 March 2016)

[5] BAPEN and National Institute for Health Research. (2015). *The cost of malnutrition in England and potential cost savings from nutritional interventions*. Available at: http://www.bapen.org.uk/information-and-resources/publications-and-resources/bapen-reports/cost-of-malnutrition-in-england (Accessed: 31 March 2016)

[6] National Institute of Clinical Excellence (2013). *Benefits of Implementation: Cost saving guidance*.

[7] National Institute of Clinical Excellence (2006). *National cost impact report to accompany CG32*..

many levels of interactions between people, their determinants and the social and physical environment.



The complexity of these factors in contributing to obesity is depicted in the following map (Figure 6).

Figure 6 - The complex web of obesity influence.

Source: Foresight Tackling Obesity Future Choices 2007.

The Foresight map (Figure 6) is divided into seven cross-cutting predominant themes that are key factors associated with obesity (Figure 7).

Figure 7 - Foresight thematic causation of obesity.

Source: Foresight system map 2007, Reproduced by Public Health England 2015.

The Foresight Report calls for these seven cross cutting themes to be addressed if a healthy lifestyle is to be adopted and maintained.

8.2 Environmental Factors

The environment has an important influence on dietary choices and physical activity levels. It therefore has a key impact on healthy weight. Different populations will have different requirements of their environment, depending for example on their age, ethnicity or income.

The risk of malnutrition is increased when a person moves away from their usual environment and cultural norms are different. For example, the food environment in hospitals or care homes may not provide food meeting specific cultural or religious needs which therefore increases the risk of malnutrition. Or if the environment does not support a person to access local conveniences and supermarkets the risk of malnutrition will be higher. For example, where there is limited access to public transport to purchase food.

Environment (social, cultural and infrastructural) influences energy intake/expenditure which determines healthy weight.

The 'obesogenic environment' is thought to be a driving force behind high obesity prevalence, influencing both dietary and physical activity behaviours. This term refers to environmental factors and the role they may play in determining energy intake and energy expenditure. The environment affects dietary choices and behaviours, for example access to healthy food outlets. Physical activity is associated with availability, access, convenience, safety and supportiveness of the local environment.

8.3 Socio-Economic Factors

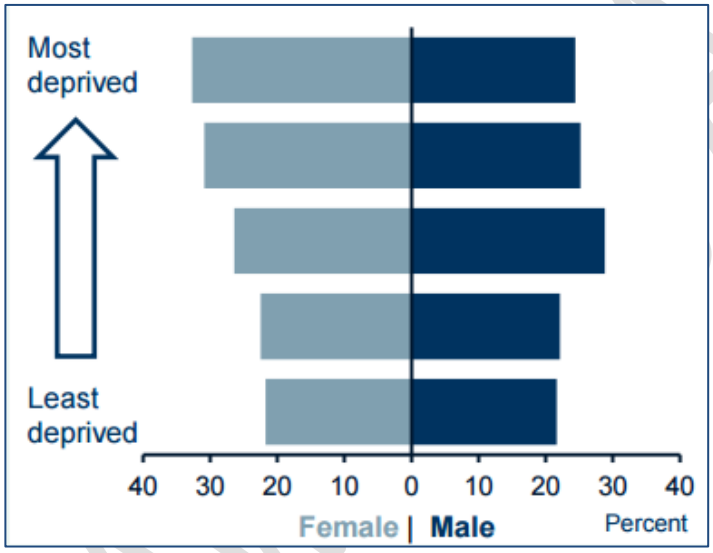
Societal inequalities increase poor health outcomes for individuals in lower social positions, including higher risk of unhealthy weight.

Social and economic conditions create inequalities between societal groups that result in health differences including prevalence of healthy weight. There is an unequal distribution of overall poor health between the rich and poor. In general, evidence shows that the lower an individual's socio-economic position the worse their health.

Certain socio-economic factors increase the risk of malnutrition including deprivation and social isolation. There is a close relationship between social inequalities and excess weight. Income and social deprivation in particular have an important impact on the risk of obesity[8].

The National Child Measurement Programme (NCMP) shows a strong correlation exists between deprivation and obesity in children. Child obesity prevalence in the most deprived areas is more than double that in the least deprived areas, with the deprivation gap having increased over time. In 2015/16 obesity in Reception children was 12.5% in the most deprived areas compared with 5.5% in the least deprived areas[9]. In Year 6 children these figures were 26% and 11.7% respectively.

Figure 8: Adult obesity prevalence by deprivation.



Source: HSCIC 2016, Statistics on obesity, physical activity and diet (HSE 2014).

Women in the highest household income group have the lowest level of obesity. Obesity prevalence in women increased by 11% from the least deprived to the most deprived areas (Figure 8). The association between socioeconomic deprivation and obesity prevalence is observed to be stronger for women than men.

Data from the Whitehall II Study showed that women who reported persistent financial hardships gained more excess weight compared to those who did not. EPIC-Norfolk data showed a greater likelihood of

[8] The Marmot Review (2010). *Fair Society, Healthy Lives - Strategic Review of Health Inequalities in England Post-2010.*
[9] NHS Digital (2016). *National Child Measurement Programme: England, 2015/16 school year.* Available at: http://content.digital.nhs.uk/catalogue/PUB22269/nati-chil-meas-prog-eng-2015-2016-rep.pdf

obesity for older men and women who reported hardships. Financial hardships were also associated with less healthy eating in older women and men[10].

Poorer educational attainment is associated with higher risk of obesity. Child obesity prevale nce is higher in schools in more deprived areas, and prevalence has increased over time between children attending schools in the most and least deprived areas[Error! Bookmark not defined.]. In adults, those with fewer qualifications are more ikely to be obese and those with no qualifications have the highest obesity levels. Less than a fifth of adults with degree level qualifications are obese compared to around a third of adults who leave school with no qualifications[11]. Adults in professional occupations have the lowest levels of obesity, while adults in lower income households are more likely to be obese.

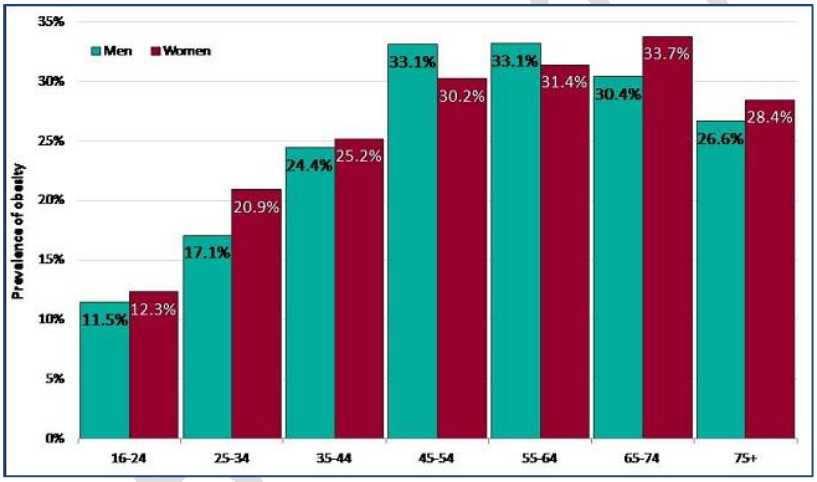
8.4 Obesity and Age

Obesity generally increases with age; between children starting and finishing primary school, and through adult age groups.

Prevalence of excess weight changes with age, generally increasing as children and adults get older. Child obesity more than doubles between Reception (1 in 10 children) and Year 6 (1 in 5 children)[Error! Bookmark not defined.].

Adult obesity increases by around one fifth between the youngest age group (16-24 year olds) and the older age groups (45-74 year olds)[11] (Figure 9). This trend has continued over time. There is a decline in prevalence in the oldest age group of over 75 years, seen especially in men.

Figure 9 - Adult obesity prevalence by age and sex.



Source: PHE Obesity 2016 (data from Health Survey for England 2008-12).

8.5 Obesity and Ethnicity

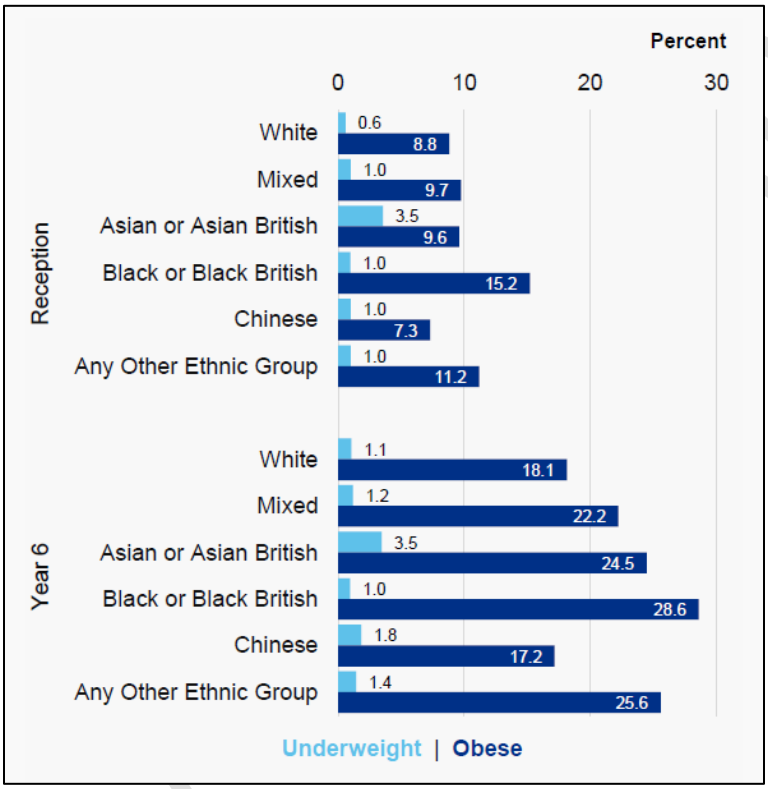
[10] Centre for Diet and Activity Research (2014). Financial hardships, diet & obesity - Findings from the Whitehall II and EPIC-Norfolk studies. Available at: http://www.cedar.iph.cam.ac.uk/resources/evidence/eb8-financial-hardships-diet-obesity/#sthash.dTYsT6Fh.dpuf (Accessed: 31 March 2016).

[11] Public Health England (2016). *Health Inequalities*. Available at: https://www.noo.org.uk/NOO_about_obesity/inequalities (Accessed: 31 March 2016).

Obesity prevalence varies between ethnicities, although more understanding of this relationship is needed.

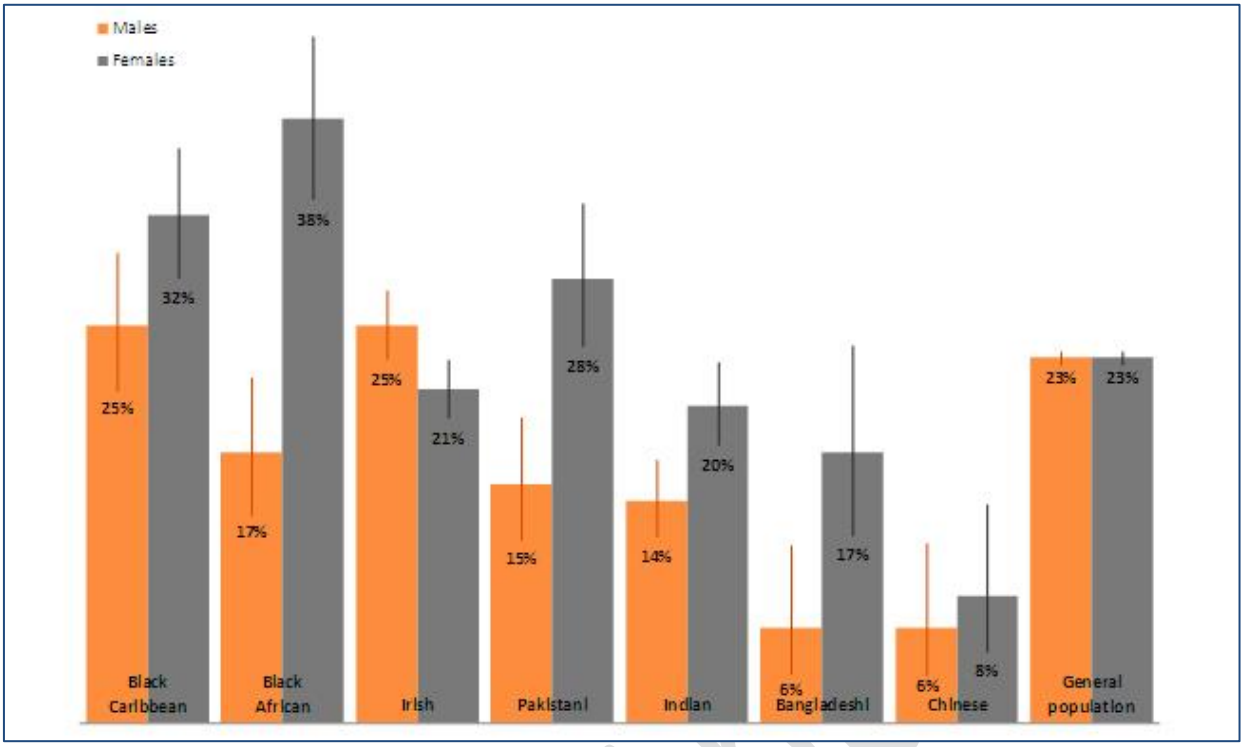
There is variation in obesity prevalence in different ethnic groups. Child obesity is significantly higher in certain ethnic groups in both Reception and Year 6 (Figure 10). Obesity is highest in ethnic group 'Black or Black British' for both year groups[Error! Bookmark not defined.].

Figure 10 - Obesity prevalence by ethnic group, for children in Reception and Year 6 NCMP 2015/16.



Source: NHS Digital 2016, NCMP England, 2015/16 school year.

Figure 11 - Obesity prevalence by ethnic group, for adults in England.



Source: Public Health England Obesity, 2016 (data Health and Social Care Information Centre 2004).

Adult ethnicity data also shows variation in obesity prevalence, with additional variations between men and women within ethnic groups (

Source: NHS Digital 2016, NCMP England, 2015/16 school year.

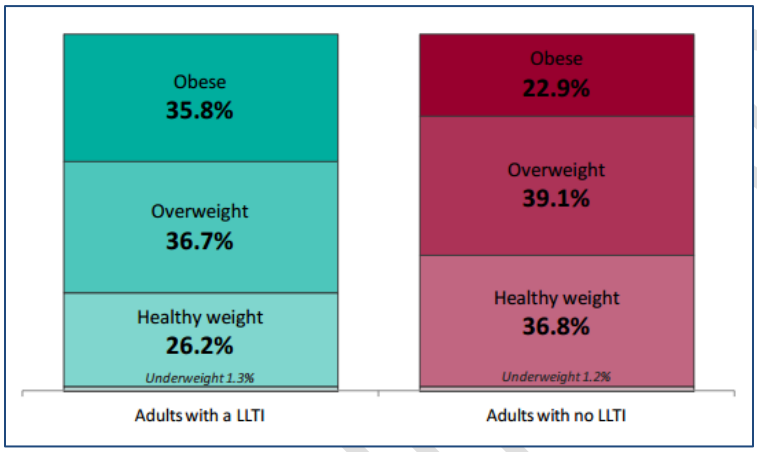
Figure 11). Women have a higher prevalence of obesity in almost every minority ethnic group; this is highest in ethnic group 'Black African'[11]. However there is little nationally representative data on obesity prevalence in adults from minority ethnic groups in the UK.

8.6 Obesity and Disability

People with a disability are at higher risk of obesity and of having lower levels of physical activity than the general population[11]. People with a disability tend to be concentrated in more deprived areas as a result of lower incomes and the social housing allocations policy[12]. Children with a limiting illness are more likely to be overweight or obese, especially if they also have a learning disability[11]. Adults with a learning disability are more likely to be either malnourished or obese. In adults with a limiting long term illness or disability obesity rates were 12.9% higher than those without (Figure 12). However there is limited data on obesity and disability.

Obesity is more prevalent in adults with a disability than those without.

Figure 12 - BMI category of adults (aged 18+) with and without a limiting long-term illness or disability (LLTI) in England.



Source: Public Health England Obesity 2016 (data Health Survey for England, combined data from2006-2010).

8.7 Obesity and Mental Health

A complex relationship exists between mental health and obesity. An association between obesity and poor mental health is seen in teenagers and adults[13].

Children with excess weight are more likely to experience bullying and stigma, which can affect their self-esteem and school performance. Stigma also impacts obese adults.

Obesity prevalence among adults with severe mental illness has been reported to be as high as 55%.

People with serious mental illness have mortality rates up to three times as high as the general population. The primary cause of death in this group is cardiovascular disease, which is strongly associated with obesity.

[12] Papworth Trust (2013). *Disability in the United Kingdom 2013 Facts and Figures*. Available at: http://www.papworthtrust.org.uk/sites/default/files/Facts%20and%20Figures%202013%20web.pdf (Accessed: 31 March 2016).

[13] National Obesity Observatory (2011). *Obesity and mental health.* Available at: http://www.noo.org.uk/uploads/doc/vid_10266_Obesity%20and%20mental%20health_FINAL_070311_WEB.pdf (Accessed: 31 March 2016).

Compared with the rest of the population, people with mental health have less healthy diets and make poorer dietary choices. They eat less fresh fruit and vegetables and are less likely to eat breakfast, compared to those with no mental health problems. Antipsychotic, mood-stabilizing and antidepressant medications can cause significant weight gain[14].

8.8 Risk Factors and Dietary Intake

Recommended dietary intakes are not met by children and adults for multiple food groups.

Poor diet is a contributing factor of unhealthy weight. A prolonged energy imbalance - where energy intake from food and drink exceeds energy expenditure through metabolism and physical activity – leads to fat accumulation and consequently weight gain.

Recommended dietary intake for a balanced diet in England is depicted by the Eatwell Guide[15]. Data from the National Diet and Nutrition Survey (NDNS) show dietary intakes are below recommendations for; fruit and vegetables; fibre and oily fish[16]. Intakes of saturated fat and sugar are above recommended amounts. Adult men also exceed red and processed meat. For most nutrients there has been little or no change in consumption between 2008/09-2009/10 (years 1/2) and 2012/13-2013/14 (years 5/6).

In 2012/13-2013/14 national intake of fruit and vegetables remain below the recommended 5-a-day in all age groups. Just 8% of 11-18 year olds meet the recommendation with and have a mean consumption of 2.8 portions. 27% of 19-64 year olds and 35% of 65 and overs meet the recommendation, average consumption is four portions and 4.2 portions respectively.

Children and adults (except women aged 65 and over) consume more than the maximum recommended level of non-milk extrinsic sugars (NMES) (no more than 11% food energy)[16]. Intake has reduced significantly in 4-10 year olds, although NMES intake remains highest in this age group (13.4%) and 11-18 year olds (15.2%). Intakes in 19-64 year olds are 12.3% and 11.1% in older adults. Current intakes of NMES greatly exceed the new 2015 guidance that free sugars should provide no more than 5% of total energy intake.

8.9 Risk Factors and Physical Activity

Regular physical activity is a key determinant in achieving a healthy weight and in reducing the risk of obesity. Activity levels have declined in England are now 24% less active than in 1961. Current trends predict people will become 35% less active by 2030[17].

Reduced physical activity and increased sedentary behaviour leads to unhealthy weight.

[14] National Institute for Health and Care Excellence (2014). *Obesity: identification, assessment and management {CG189}*. Available at: https://www.nice.org.uk/guidance/cg189 (Accessed: 31 March 2016).

[15] Public Health England (2016). The *Eatwell Guide Booklet.* Available at: https://www.gov.uk/government/publications/the-eatwell-guide (Accessed 31 March 2016).

[16] Public Health England (2014). *National Diet and Nutrition Survey: Results from Years 5 and 6 combined of the rolling programme for 2013 and 2013 to 2013 and 2014.* Available at: https://www.gov.uk/government/statistics/ndns-results-from-years-5-and-6-combined (Accessed: 31 October 2016).

[17] All-Party Commission (2014). *Tackling Physical Inactivity – A Coordinated Approach.* Available at: https://parliamentarycommissiononphysicalactivity.files.wordpress.com/2014/04/apcopa-final.pdf (Accessed: 31 March 2016).

Two in ten (22%) 5-15 year olds meet recommended levels of exercise (23% of boys and 20% of girls in 2015) (See Appendix 2: Chief Medical Officer's recommended activity levels for children and adults.) The proportion of children meeting the weekly guidelines has fallen since 2008 (28%), though physical activity levels have improved from 2012. Activity levels decrease in older children, with girls more likely than boys to reduce their activity levels as they move from childhood to adolescence[18].

Just over half of all adults (57%) meet physical activity guidelines (67% of men and 55% of women). Physical activity in adults declines with increasing age for both genders (Figure 13). 'Active' adults achieving physical activity guidelines each week declines from 71% at age 16-25yrs, to 40% by age 65 and over. Certain ethnic groups have lower levels of physical activity than others; Asian populations are the least physically active. Participation in sport once a week declines from 39% of adults in higher socioeconomic groups compared to 26% in lower socioeconomic groups.

Figure 13: Physical Activity by Age Group Data.

		Time period		
		2012 (Mid-January 2012 to Mid-January 2013)	2013 (Mid-January 2013 to Mid-January 2014)	2014 (Mid-January 2014 to Mid-January 2015)
Age Range	16 - 19	72.3%	70.9%	72.1%
	20 - 25	68.0%	67.4%	68.9%
	16 - 25	70.0%	69.2%	70.5%
	26 - 34	63.1%	62.5%	63.3%
	35 - 44	61.0%	61.3%	62.0%
	45 - 54	57.4%	58.5%	59.4%
	55 - 64	51.4%	52.3%	53.5%
	65 and over	36.7%	37.9%	39.9%

Measure
Active

Time periods
2012 (Mid-January 2012...
2013 (Mid-January 2013...
2014 (Mid-January 2014...

Activity
All physical activities

Geography
England

Demographics
16 - 25
16 - 19
20 - 25
26 - 34
+4 others

Source: Active People Survey, 2015.

Participation in activity is lower in those who are disabled; half of disabled people are likely to be active compared to non-disabled people. Only 7% of disabled adults participate in at least 30 minutes of moderate intensity sport three times per week compared to 35% of all adults. Over the course of a month just one in four people with learning disabilities take part in physical activity.

Over one in four women and one in five men are physically inactive.

Sedentary behaviour is a separate risk factor for obesity. It damages health; even in people who are physically active but spend long periods being sedentary there is an increased risk of obesity. Physical inactivity[19] is the fourth largest cause of disease and disability in the UK[5] and accounts for one in six deaths in the UK.

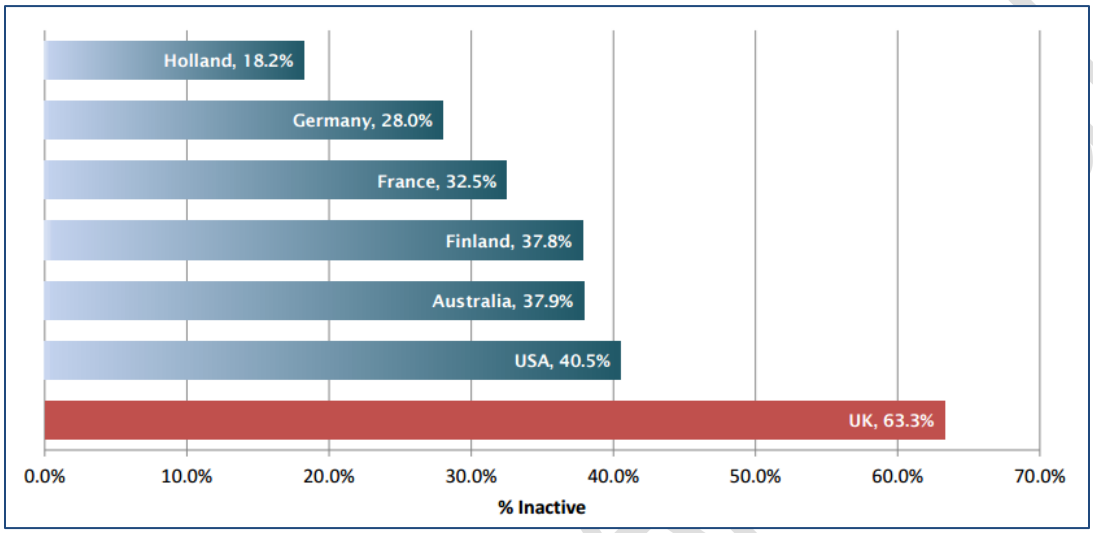
Children in poorer households are more likely to engage in sedentary behaviours. Just a third of children in the highest-income households have low levels of physical activity (defined as less than 30 minutes of daily physical activity), rising to nearly half

[18] Statistics on Obesity, Physical Activity and Diet: England 2014, Health and Social Care Information Centre.
[19] Department of Health (2011). Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers. Available at: https://www.gov.uk/government/publications (Accessed: 31 March 2016).

(48.0%) for children in households in the lowest income quintile[20]. The average time spent being sedentary was highest in 13-15 year olds.

Almost a fifth of men (19%) and over a quarter of women (26%) are considered to be physically inactive. Inactivity increases with age, being lowest in 16-24 year olds and highest in those 85 and over (8% men and 22% women vs 74% and 76% respectively)[17]. Inactivity is higher in adults in the lowest socioeconomic group compared to those in the highest group. The UK has much higher levels of physically inactivity than some other countries in the Western World (Figure 14).

(Figure 14 - International comparison of physical inactivity (at ages 15 and over).



Source: Public Health England 2014, Everybody Active Everyday

8.10 Other Risk Factors of Obesity

Breastfeeding and good infant feeding practices are associated with reduced risk of obesity in later life. Breastfeeding can also offer support for a mother to lose weight after birth (breastfeeding expends around 500 calories per day). Breastfeeding rates in the UK are some of the lowest in the world.

Breastfeeding reduces the risk of obesity

74.3% initiate breastfeeding in the first 48hours, this falls to 43.2% by 6-8 weeks.

Parental obesity is the most significant predictor of child obesity. Children who have one or more parents who are obese are significantly more likely to become obese themselves. Maternal pre-pregnancy BMI is a risk factor for child overweight/obesity.

Looked After Children (LAC) have been found to be at higher risk of obesity. A study investigating the weight of LAC in the Midlands, UK found that LAC are more likely to be overweight and obese compared with standard norms, and there are a number of children (35%) whose BMI increases once in care[21].

[20] Health and Social Care Information Centre (2012). *Health Survey for England 2012.* http://content.digital.nhs.uk/catalogue/PUB13218

[21] Hadfield, S C., Preece, P M. (2008). *Obesity in looked after children: is foster care protective from the dangers of obesity?* Child: Care Health and Development , Vol 34 (6) 710-712.

The Foresight Report identifies the biological and societal factors that influence excess weight; this Strategy has highlighted a number of these key determinants. Age, gender and ethnicity have a role in determining an individual's weight classification. The environment has an important influence on diet and physical activity behaviours which enable people to achieve a healthy weight. Socio-economic status also has a critical influence on weight, as there is an association between increasingly poor health and increasing deprivation. By recognising and understanding these factors this Strategy can identify groups of people more likely to have an unhealthy weight than others. Through addressing some of these key determinants at a local level unhealthy weight prevalence can be addressed.

8.11 Risk Factors and Malnutrition

The risk of malnutrition increases with age. The higher risk is due to a combination of physiological changes and an increased burden of disease in older people. There are many medical, lifestyle and psychological factors which can increase the risk of malnutrition in the community, and which are more common in older people. Additionally, there are risk factors which can occur specifically in hospital settings and further increase the likelihood of malnutrition.

Many people at risk of malnutrition live in the community. Those in hospital, care homes, mental health units and sheltered housing are also at risk.

Some population groups at higher risk of malnutrition include;

- Older adults over 65 years living alone.
- Older adults over 65 years in a care home or admitted to hospital.
- People in the most deprived areas.
- People who abuse drugs or alcohol.
- Adults with a learning disability.
- People with long-term conditions, such as diabetes, kidney disease, chronic lung disease.
- People with chronic progressive conditions, such as dementia or cancer.

9 Unhealthy Weight – The National Picture

9.1 National Malnutrition Trends

Over three million people in the UK are thought to be malnourished[22] or at risk of malnutrition. Around 1.3 million older people aged over 65 years are estimated to be within this figure. The majority of these people are thought to be living in the community (93%) with a minority in care homes (5%) or in hospital (2%)[22].

Malnutrition increases the risk of disease for individuals, as well as poor psycho-social function. The many clinical effects of malnutrition include; impaired ability to fight infection; longer recovery time from surgery; increased risk of falls; specific nutrient deficiencies and depression or self-neglect.

Malnourished individuals in the community see their GP twice as often, had three times the number of hospital admissions and stayed in hospital more than three days longer, compared with well-nourished people.

Just under 2% of adults are estimated to be underweight according to the Health Survey for England (2013)[23]. Underweight children are identified through the National Child Measurement Programme (NCMP). In 2015/16 prevalence of underweight children in England was 1% in Reception (4-5 years) rising to 1.3% in Year 6 (10-11 years)[24]. National trends show an overall decline in prevalence of underweight in Reception between 2007/08 to 2015/16 (1.25% to 1%). 2015/16 saw a decline in prevalence of underweight (to 1.3%) in Year 6, after a slight overall increase between 2007/08 to 2014/15 (1.41% to 1.42%).

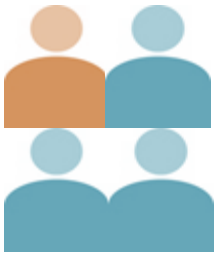
The NCMP data for 2015/16 show a number of factors that influence the prevalence of underweight children. Underweight prevalence was higher in Year 6 than in Reception. It was highest amongst boys in Reception and girls in Year 6. There were higher numbers of underweight children in the most deprived areas for both year groups. Ethnicity also showed differences in prevalence of underweight. Children in

[22] BAPEN (2016). *Introduction to Malnutrition.* Available at: http://www.bapen.org.uk/malnutrition-undernutrition (Accessed: 31 March 2016).
[23] Health and Social Care Information Centre (2014). *Health Survey for England – 2013.* Available at: http://digital.nhs.uk/catalogue/PUB16076 (Accessed: 31 March 2016).
[24] Health and Social Care Information Centre (2015). *National Child Measurement Programme: England, 2014/15 school year*. Available at: http://www.hscic.gov.uk/catalogue/PUB19109 (Accessed: 31 March 2016).

'Asian or Asian British' groups had a significantly higher prevalence, whereas those in 'White' groups had significantly lower prevalence.

9.2 National Obesity Trends

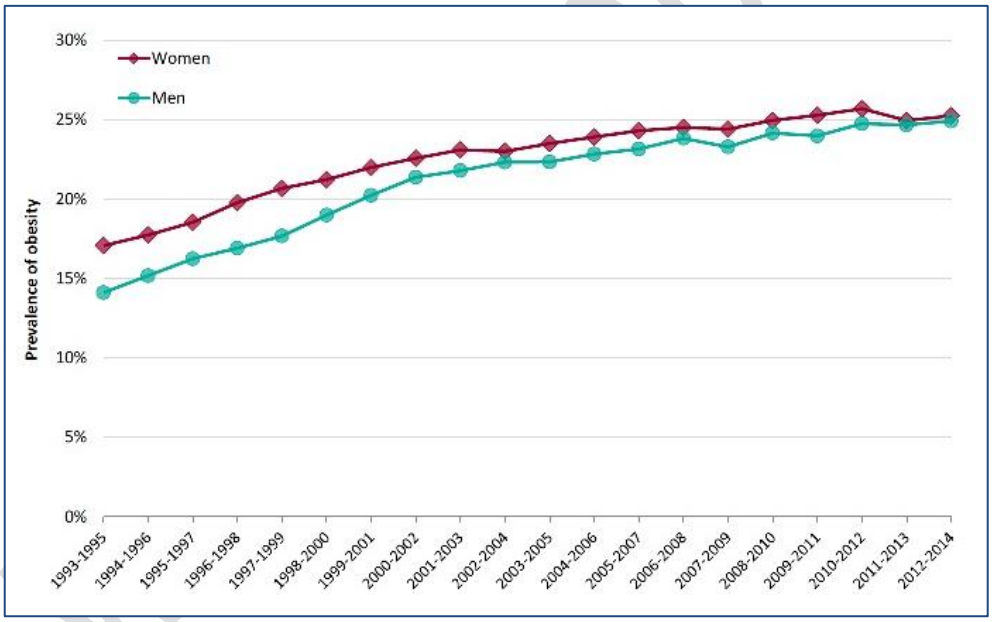
The majority of the adult population in England are overweight or obese (64.8% 2013-15[25]). Excess weight has continued to increase in the past 20 years. The proportion of healthy weight adults has declined, with 8% fewer men and 9% fewer women reporting a healthy BMI between 1993 and 2014.



One in four adults are obese (24.4% 2013-15). This has increased from 14.9% in 1993 (Figure 15: Prevalence of obesity in adults aged 16 years and overFigure 15). After a steep rise in obesity prevalence between 1993 and 2000, the rate of increase has slowed since 2001 but continues to increase. Morbid obesity (the most severe category of obesity) has more than tripled in this time. Obesity prevalence is higher in women (27%) compared to men (24%) in 2014.

Absolute levels of obesity are very high and the UK ranks as one of the most obese nations in Europe. The UK has the highest obesity levels in Northern and Western Europe, above levels in countries such as France, Germany, Spain and Sweden[26].

Figure 15: Prevalence of obesity in adults aged 16 years and over



Source: Public Health England Obesity 2016 (data HSE 1993-2014 (3-year average)

Excess weight has also risen rapidly in children in England over the past 10 years. In 2015/16 the NCMP data shows that 12.8% of Reception children are overweight and a further 9.3% are obese[24]. In Year 6 14.3% of children are overweight and an additional 19.8% are obese. Child obesity more than doubles between

[25] Public Health England (2016). *Public Health Outcomes Framework.* Available at: http://www.phoutcomes.info/ (Accessed: 31 March 2016).
[26] Food and Agriculture Organization of the United Nations (2013). *The State of Food and Agriculture.* Available at: http://www.fao.org/economic/es-home/sofa/en/#.V7wTfVsrJMx (Accessed: 31 March 2016).

Reception (9.3%) and Year 6 (19.8%). The proportion of healthy weight children decreases between children starting and finishing primary school, from 76.9% to 64.6%.

Over one in five Reception children is overweight or obese, increasing to one in three Year 6 children.

Trend data for NCMP between 2006/07 to 2015/16 shows a downward trend in obesity in Reception boys and a stability in Reception girls. There is an upward trend in obesity in Year 6 for both boys and girls, although this is highest in girls. Year 6 obesity prevalence has remained relatively stable in the past five years.

More adults and children are classified severely obese than ever before, and prevalence continues to increase. Modelling suggests obesity levels could increase to 60% of men, 50% of women and 25% of children by 2050[27]. Using current trends adult overweight and obesity will reach 72% by 2035 - almost three in four UK adults[28].

Obesity doubles between Reception and Year 6 from one in 10 children to one in five.

10 The Local Challenge

10.1 Children's Unhealthy Weight Trends

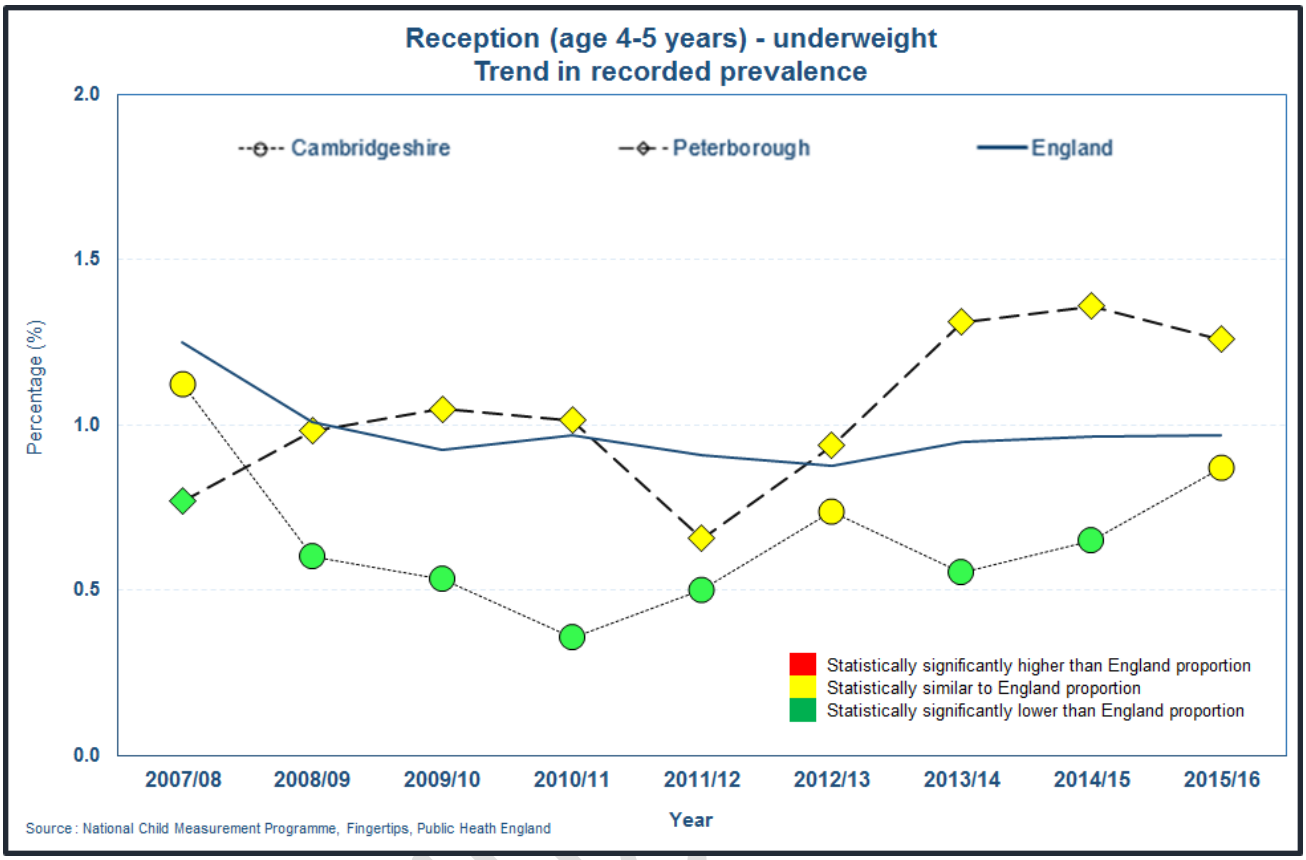
Underweight

National Child Measurement Programme (NCMP) data 2015/16 shows the prevalence of underweight Reception children in Cambridgeshire (0.87%) is statistically similar to England (0.97%). Locally, prevalence appears to have increased year on year since 2013/14 (Figure 16).

[27] Department of Health (2011). *Healthy Lives, Healthy People: A call to action on obesity in England*. Available at: https://www.gov.uk/government/publications/healthy-lives-healthy-people-a-call-to-action-on-obesity-in-england (Accessed: 31 March 2016).

[28] Cancer Research UK (2016). *Tipping the Scales: preventing obesity makes economic sense.* Available at: http://www.cancerresearchuk.org/sites/default/files/tipping_the_scales_-_cruk_full_report11.pdf (Accessed: 31 March 2016).

Figure 16: Reception Children Underweight Prevalence.



Source: National Child Measurement Programme, Fingertips, Public Health England.

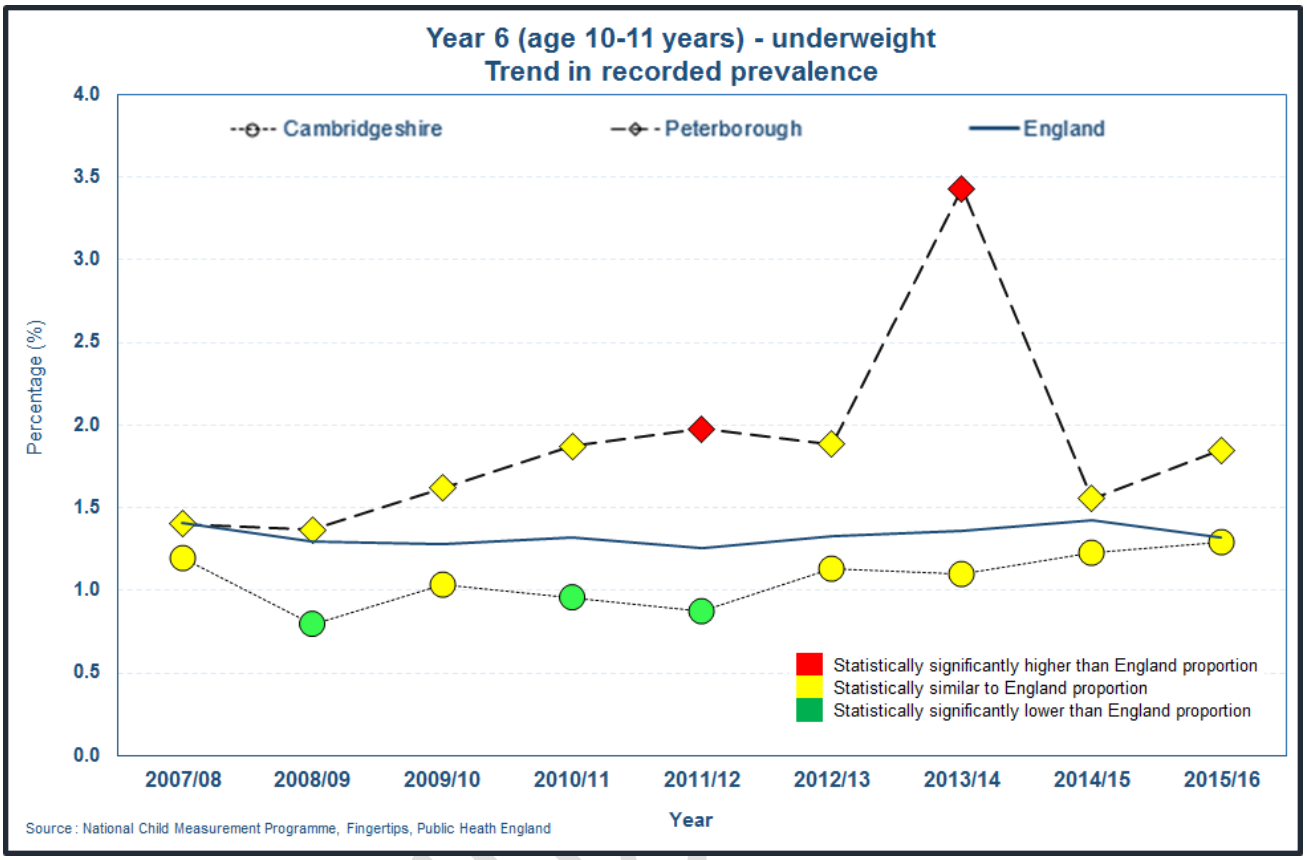
Prevalence of underweight Reception children varies within Cambridgeshire. In Huntingdonshire prevalence of underweight children in Reception is generally better than England (0.46% vs 0.97% in 2015/16) and has been since 2012/13. In South Cambridgeshire prevalence of underweight children (1.22%) was similar to England in 2015/16, but there have been annual increases since 2013/14. There is not enough data to allow for trend comparisons in Cambridge, East Cambridgeshire or Fenland.

In Peterborough prevalence of underweight children in Reception is similar to England in 2015/16 (1.26% and 0.97%). This is a continuing trend with prevalence data similar to England since 2008/09 (Figure 16).

Year 6 children in Cambridgeshire show a similar prevalence of underweight to England (1.29% vs 1.32% 2015/16) (Figure 17) throughout the NCMP programme. In 2015/16 underweight prevalence in all of the Cambridgeshire districts show similar percentages to England.

Year 6 children in Peterborough have a similar prevalence of underweight to England (1.85% vs 1.32% 2015/16). In 2011/12 and 2013/14 prevalence peaked to be significantly worse than the national average, after a prior trend of being similar to England since 2008/09 (Figure 17).

Figure 17: Year 6 Children Underweight Prevalence.



Source: National Child Measurement Programme, Fingertips, Public Health England

Excess Weight – Overweight & Obesity

Nearly one in five Reception children in Cambridgeshire start school overweight or obese. Prevalence of excess weight in Cambridgeshire for this age group (18.7%) remains significantly better than England (22.1%) in 2015/16 (Figure 18). This trend has continued from 2007/08 to 2014/15. Prevalence data is more varied within Cambridgeshire districts.

Fenland continues to have the highest prevalence of excess weight year on year (21.4% 2015/16). The highest prevalence was seen in 2010/11 and was significantly worse than England (27.1% vs 22.6%). A noticeable decline is observed from 2010/11 to date, showing similar prevalence to England since 2013/14.

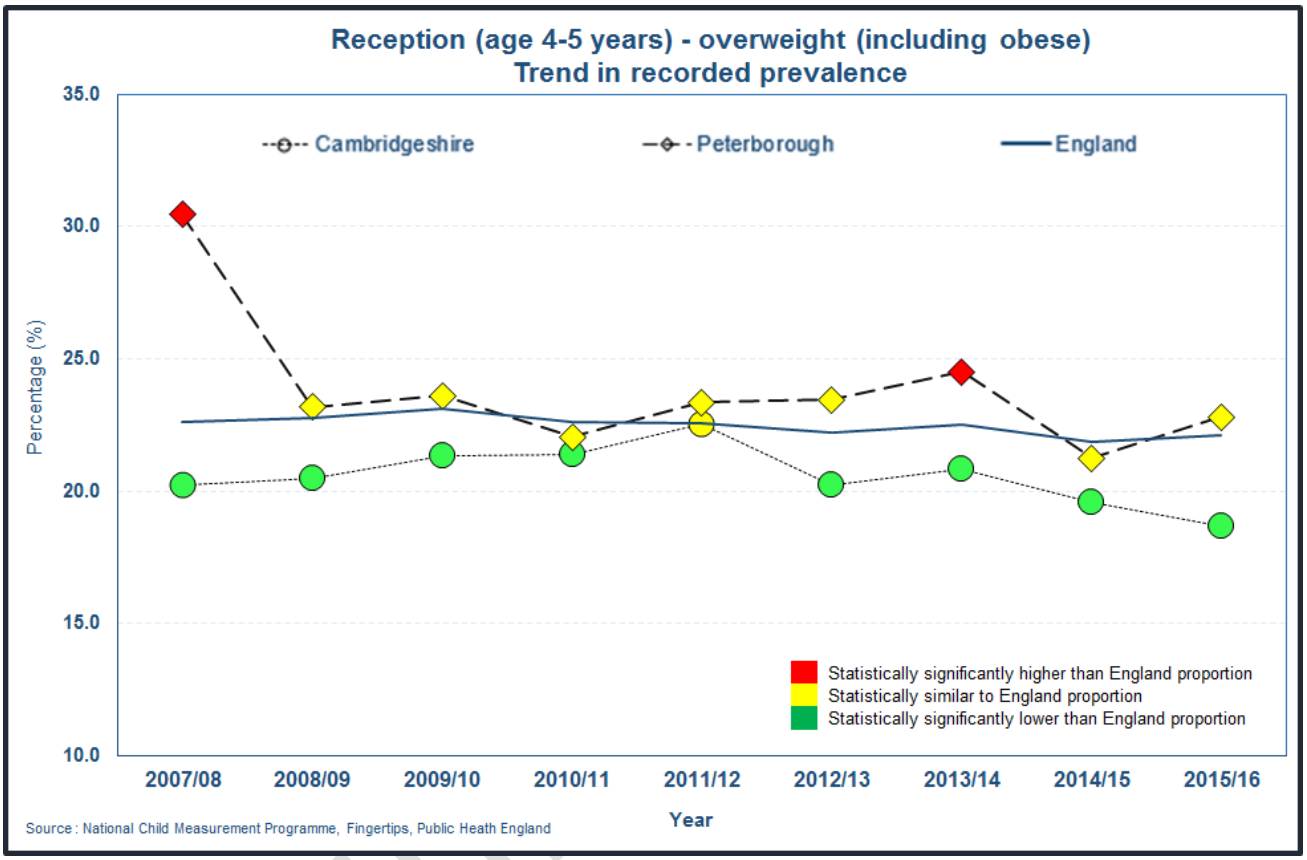
In 2015/16 excess weight in East Cambridgeshire (19.7%) remained similar to England and fairly stable throughout the data collection period. Huntingdonshire (19.0%) has showed a decrease in prevalence of excess weight since 2013/14 (22.2%).

In Cambridge, prevalence of excess weight continued to be significantly better than England since 2011/12. Prevalence has noticeably decreased by 7.7 percentage points between 2007/08 and 2015/16. South

Cambridgeshire prevalence (17.3% 2015/16) showed a noticeable decrease from 2014/15 (18.8%) and has been consistently better than the England annual proportions.

Over one in five Reception children in Peterborough were overweight or obese in 2015/165. Excess weight in Reception children (22.8%) remains similar to the national prevalence (22.1%). This overall trend has generally continued in Peterborough since 2008/09 (Figure 18).

Figure 18: Reception Children Overweight and Obesity Prevalence.



Source: National Child Measurement Programme, Fingertips, Public Health England

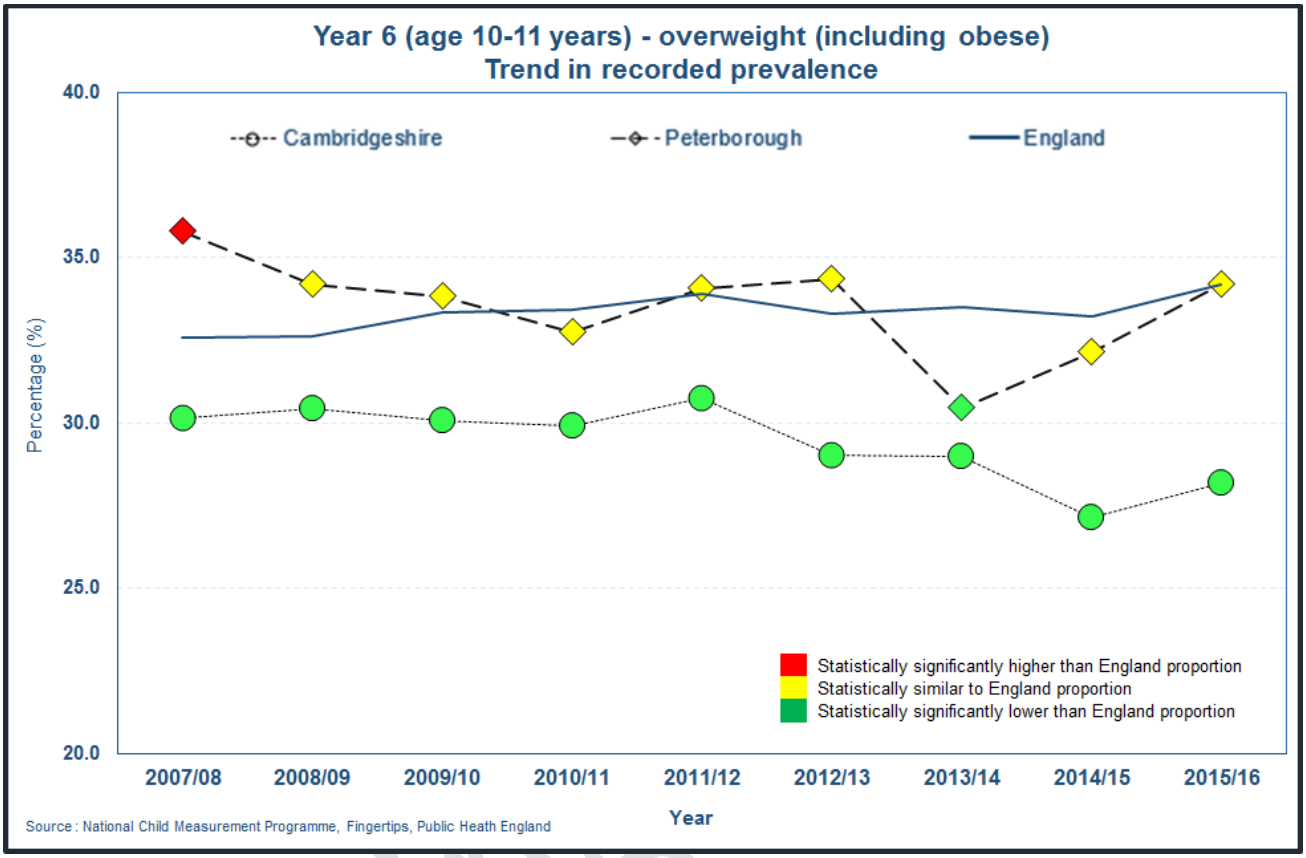
Over one in four Year 6 children in Cambridgeshire is overweight or obese. Year 6 prevalence of excess weight in Cambridgeshire has remained significantly lower than the national average since 2007/8 (28.2% vs 34.2% 2015/16) (Figure 19). There are variations in the data between the individual districts.

Prevalence of overweight and obesity in Fenland (33.9% 2015/16) continues to be the highest in the county, with data following the national trend in recent years.

In East Cambridgeshire (29.2% 2015/16) prevalence has been significantly better than England (34.2% 2015/16) since 2010/11. Prevalence in Cambridge (23.2% 2015/16) has shown notable decreases since 2012/13, with a decrease of 6.9 percentage points over this time period. In Huntingdonshire (30.0% 2015/16) prevalence of excess weight is also seen to be generally better than England, but there was an increase from 27.5% in 2014/15. South Cambridgeshire (25.1% 2015/16) levels have remained better than England since the start of the NCMP.

In Peterborough over one in three Year 6 children are overweight or obese. Prevalence of excess weight in Year 6 has remained similar or better than England since 2008/09 (Figure 19). In 2015/16 prevalence was 34.2%, the same as the national average.

Figure 19: Year 6 Children Overweight and Obesity Prevalence.



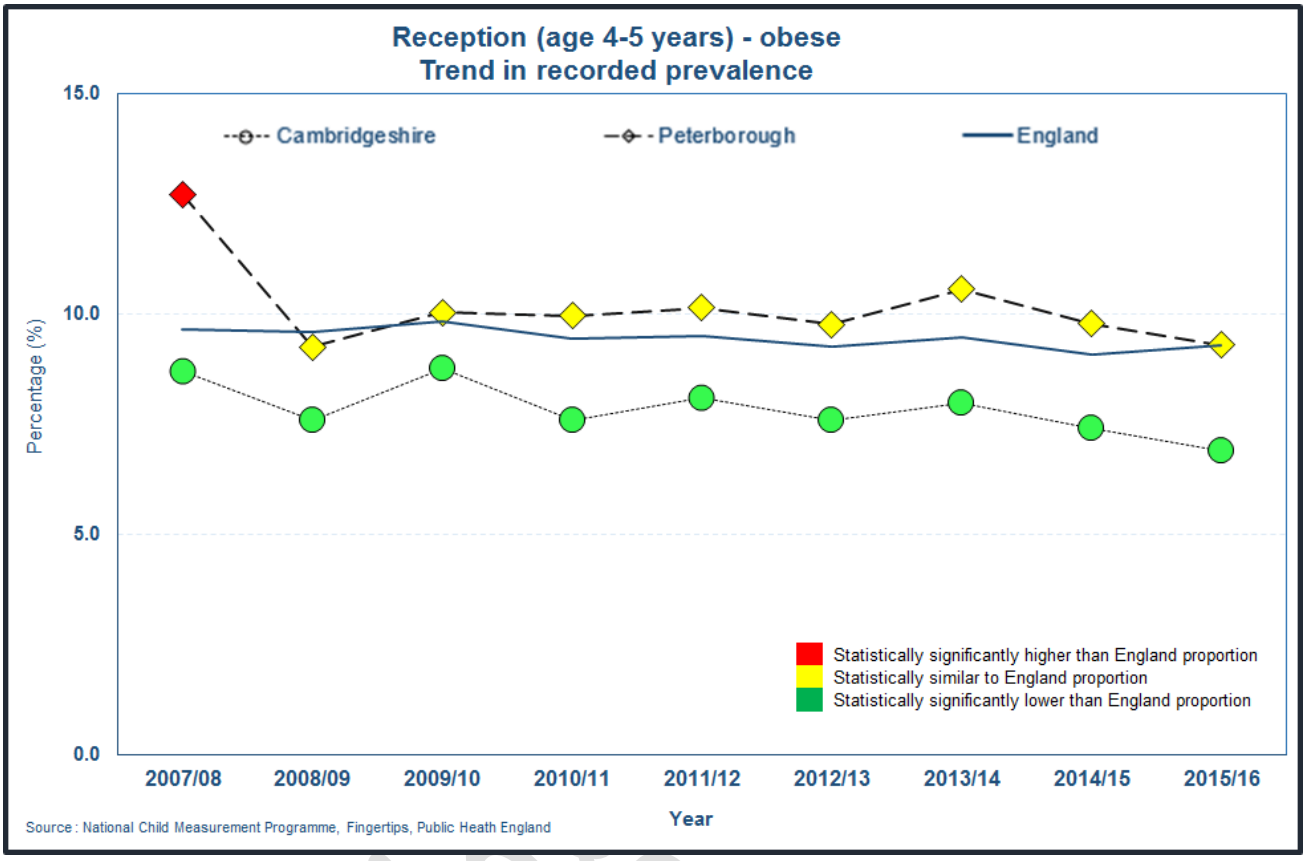
Source: National Child Measurement Programme, Fingertips, Public Health England

Excess weight - Obesity

In Cambridgeshire 6.9% of Reception children were obese in 2015/16. This declined from 8.0% in 2013/14. Obesity rates have been significantly better than England since NCMP data collection started (Figure 20).

In Peterborough, 9.3% of Reception children were obese in 2014/15, with annual decreases since 2013/14 (10.6%). Since 2008/09 prevalence rates have been similar to England (Figure 20).

Figure 20: Reception Children Obesity Prevalence.

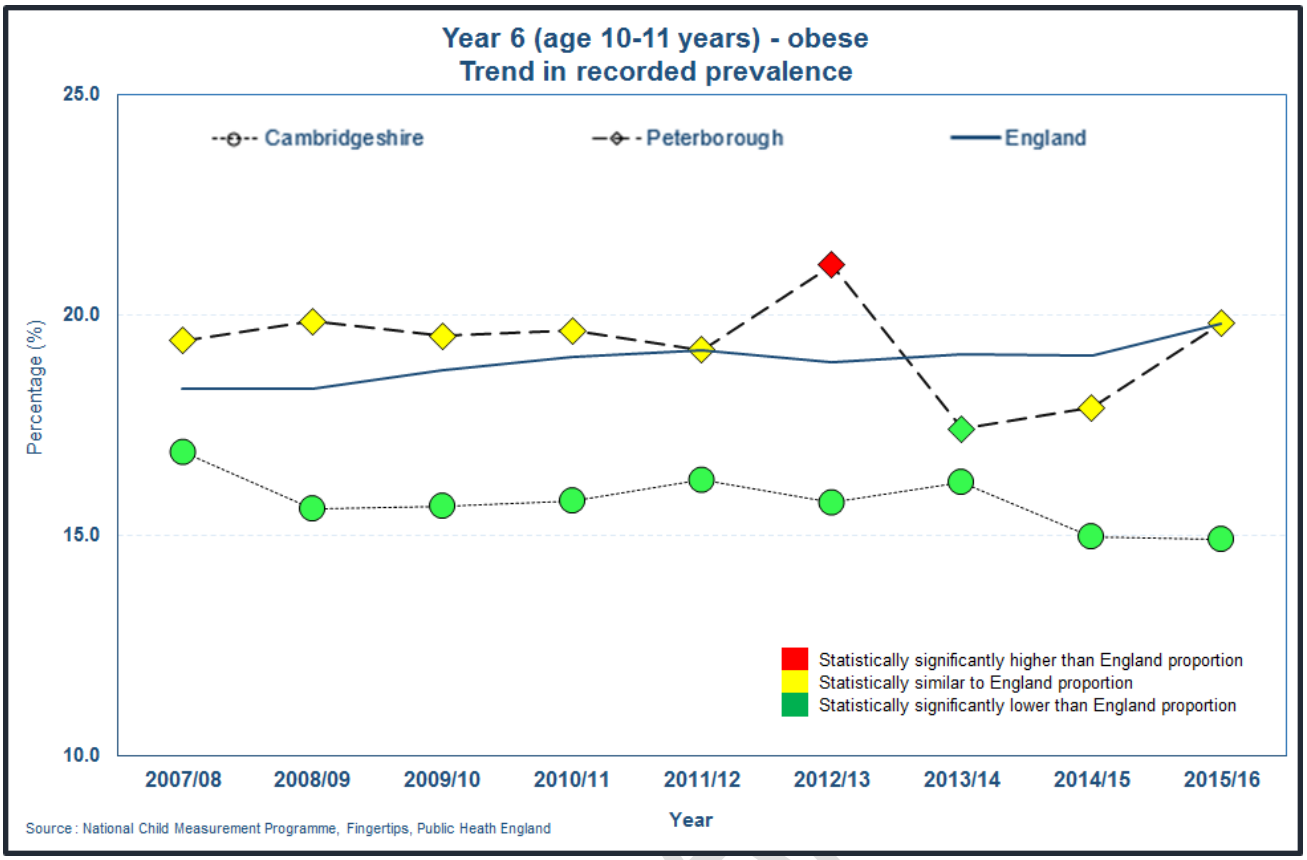


Source: National Child Measurement Programme, Fingertips, Public Health England

Obesity prevalence in Year 6 children in Cambridgeshire was 16.2% in 2013/14 and declined to 14.9% in 2015/16. The data trend has remained significantly better than England since 2007/08 (Figure 21).

Year 6 obesity prevalence in Peterborough increased from 17.4% in 2013/14 to 19.8% in 2015/16, but remained statistically similar to England (Figure 21).

Figure 21: Year 6 Children Obesity Prevalence.



Source: National Child Measurement Programme, Fingertips, Public Health England

The obesity prevalence for both Reception and Year 6 is shown for the Cambridgeshire districts and Peterborough in Table 1. Fenland continues to show the highest prevalence in Cambridgeshire and Peterborough has slightly higher levels; both are above the rates for England.

Table 1- Recorded Obesity Prevalence in Cambridgeshire Districts and Peterborough 2015/16

Area	Reception (%)	Year 6 (%)
Cambridge	6.0%	11.3%
East Cambridgeshire	6.8%	15.3%
Fenland	8.7%	20.0%
Huntingdonshire	7.3%	15.8%
South Cambridgeshire	5.9%	12.6%
Cambridgeshire	6.9%	14.9%
Peterborough	9.3%	19.8%
England	9.3%	19.8%

Local childhood obesity levels double between Reception and Year 6

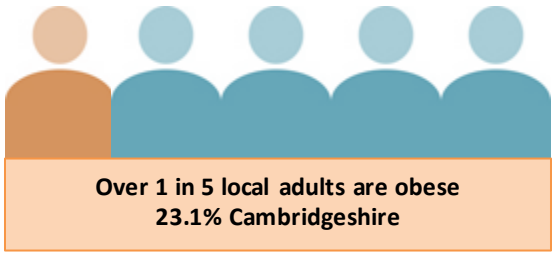
Source: HSCIC, NCMP 2015/16

10.2 Adults Unhealthy Weight Trends

There is a scarcity of local data about the prevalence of malnutrition, so local estimates are determined by applying national estimates to the population. It is estimated that 10-14% of the population in England aged 65 years and over are malnourished. It is therefore estimated that in Cambridgeshire and Peterborough there are 13,000 to 18,300 older residents who are malnourished[3].

In Cambridgeshire, an estimated 10,000 to 14,000 older residents (about one in fifty in the general population) are malnourished. By also considering lifestyle and psychosocial risk factors there may be an estimated 29,000 older people at increased risk of malnutrition in Cambridgeshire, as approximately 29% of older people in the county live alone. In Peterborough, an estimated 3,000 to 4,300 older people are indicated to be malnourished, with 15% of the population aged 65 years and over in 2016 (30,416 people).

In Cambridgeshire the majority of the adult population is either overweight or obese. In 2013-15 63.2% of local adults were classified as such. This is better than the England average of 64.8% and has declined slightly from prevalence similar to the national average in 2012-14 (63.6% vs 64.6% respectively).

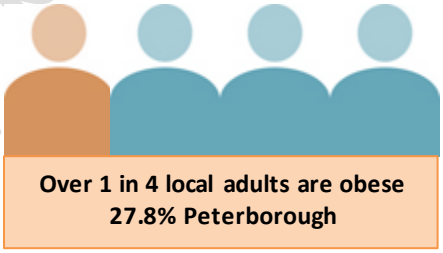


In Cambridgeshire over one in five adults (23.1%) are obese compared to 24.4% nationally. Being overweight carries a strong risk of becoming obese. The percentage of overweight adults is similar to England (40.1% vs 40.4%). Only around a third of Cambridgeshire adults (35.9%) are a healthy weight.

Source: Public Health England, Public Health Outcomes Framework, 2016 (Based on 2013-2015 data).

In Peterborough over two thirds of adults are either overweight or obese. The percentage of overweight and obesity adults in Peterborough in 2013-15 is significantly worse than for England (70.8% vs 64.8% respectively). This has increased from 2012-14 when prevalence was 68.9% locally.

Adult obesity prevalence in Peterborough is over one in four (27.8%) and above England (24.4%). The percentage of overweight adults is also above the national average (43% vs 40.4%). Less than a third of Peterborough adults (28.7%) are a healthy weight.



Source: Public Health England, Public Health Outcomes Framework, 2016 (Based on 2013-2015 data).

Prevalence of excess weight within Cambridgeshire districts varies. In 2013-15 Fenland had the highest percentage of adults with excess weight (72.9%) followed by East Cambridgeshire (68.1%) (Table 2). Cambridge (46.7%) is the only district to have lower estimated levels of excess weight than England (64.8%). Peterborough has the highest percentage of excess weight adults in the East of England region.

Table 2: Adult excess weight in Cambridgeshire & Peterborough.

Area	Fenland	East Cambridgeshire	Huntingdon-shire	South Cambridgeshire	Cambridge	Cambridgeshire	Peterborough	England
% unhealthy weight	72.9%	68.1%	67.6%	63.6%	46.7%	63.2%	70.8%	64.8%

Source: Public Health Outcomes Framework (data based on 2013-15).

Adult excess weight in England is predicted to reach 72% by 2035[2]. Local prevalence of overweight in Cambridgeshire and Peterborough is projected to rise from 65.1% in 2012 to 69.4% in 2031; there will also be an increase in obesity (Table 3). The greatest increase in obesity will occur in the 45-54 and over 75 age groups, while prevalence in adults aged 25-44 years will remain relatively stable. Table 3 and Table 4 show the

proportional increase and the number of people locally who are expected to be classified with excess weight.

Table 3 – Projected prevalence of obesity (BMI>30) and overweight (BMI>25) in Cambridgeshire and Peterborough (% of >16s).

	2012	2013	2014	2015	2016	2017	2018	2021	2026	2031
% adults with BMI >30	22.2	22.5	22.8	23.1	23.3	23.6	23.8	24.6	26.0	27.7
% adults with BMI >25	65.1	65.4	65.6	65.8	66.0	66.1	66.3	66.9	68.1	69.4

Source: Health system prevention strategy for Cambridgeshire and Peterborough, 2015.

Table 4 – Estimated number of obese people in Cambridgeshire and Peterborough by 2021.

2012 Actual	2013	2014	2015	2016	2017	2018	2019	2020	2021
165,820	167,839	171,389	174,991	178,687	182,265	185,789	189,287	192,874	196,502

Source: Health system prevention strategy for Cambridgeshire and Peterborough, 2015.

10.3 Physical Activity Trends

As a county Cambridgeshire has a similar percentage of active adults compared to England (58.6% vs 57%). There is variation within the county, Cambridge has the highest number of active adults (69.8%) (Table 5). Active adults in East Cambridgeshire, South Cambridgeshire and Huntingdonshire are all similar to the England average. While Fenland has the lowest number of active adults (47.9%), with less than half of all adults being active, and is lower than the national average (Table 5). Peterborough has similar numbers of adults who are physically active (54.7%) to England (Table 5).

Table 5 – Percentage of Active Adults in Cambridgeshire & Peterborough.

Area	Fenland	East Cambridgeshire	Huntingdon-shire	South Cambridgeshire	Cambridge	Cambridgeshire	Peterborough	England
% inactive	47.9%	53.8%	57.9%	59.5%	69.8%	58.6%	54.7%	57.0%

Source: Public Health Outcomes Framework 2015.

1 in 4 Cambridgeshire adults are inactive.

While over 1 in 3 Peterborough adults are inactive.

There are fewer inactive adults in Cambridgeshire (25.3%) compared to England (28.7%). While Cambridge has the lowest levels of physical inactivity (14.7%), East Cambridgeshire (29.7%) is close to the England average and Fenland (37.4%) has higher inactivity levels than the rest of the county and England average

(Table 6). In Peterborough the percentage of inactive adults is worse than the England average (28.9% vs 27.7%).

Area	Fenland	East Cambridgeshire	Huntingdon-shire	South Cambridgeshire	Cambridge	Cambridgeshire	Peterborough	England
% inactive	37.4%	29.7%	25.6%	23.8%	14.7%	25.3%	34.3%	28.7%

Table 6 - Percentage of Inactive Adults in Cambridgeshire compared with England.

Source: Public Health Outcomes Framework 2015.

11 Local Healthy Weight and Health Inequalities

The relationship between prevalence of unhealthy weight and health inequalities have been highlighted. Social determinants have a critical impact on health inequalities and unhealthy weight. Poor health outcomes increase as social standing decreases. Biological differences such as gender, age and ethnicity are also related to weight classification.

The Strategy has identified certain individuals and groups within Cambridgeshire and Peterborough as a higher risk of being at an unhealthy weight. It is not an exhaustive list and different areas will be able to identify specific high risk groups. The Strategy will consider existing services and new interventions to support those groups at higher risk of unhealthy weight.

11.1 Deprivation

The Index of Multiple Deprivation (IMD) combines seven indices to measure deprivation, including; income, employment, education and health. The latest IMD data 2015 show Fenland is the most deprived district in Cambridgeshire (Figure 22). It is the only district where deprivation measures at Local Super Output Areas (LSOA) fall in the 10% most deprived nationally in 2015. Deprivation is then highest in Cambridge City, East Cambridgeshire, Huntingdonshire and South Cambridgeshire is the least deprived. Peterborough also shows the highest levels of deprivation against national rankings, with LSOA in the top 10%.

To address inequalities in Cambridgeshire and Peterborough, it is important that services and interventions target areas of higher deprivation.

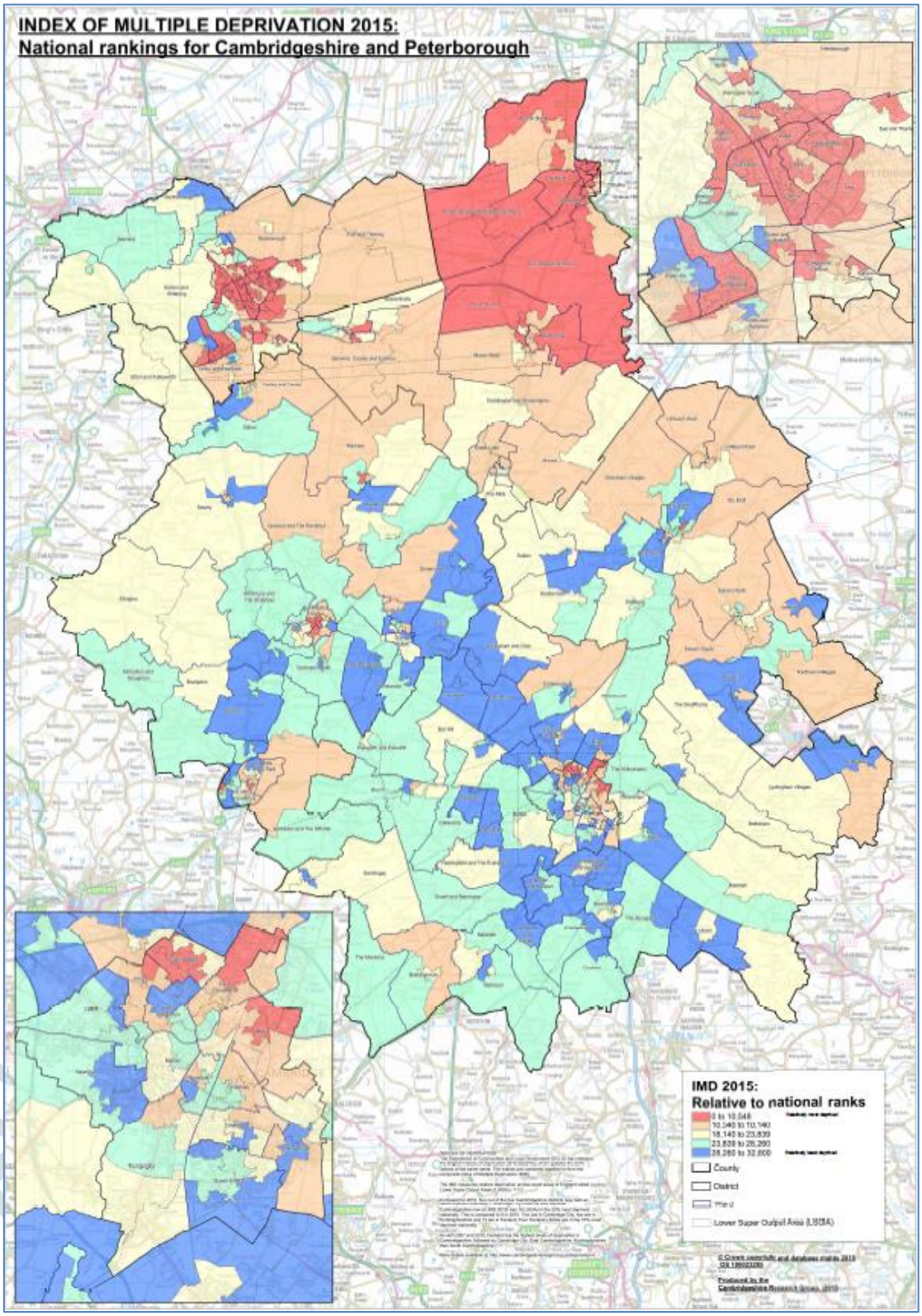


Figure 22 – Index of Multiple Deprivation 2015: National Rankings for Cambridgeshire and Peterborough.

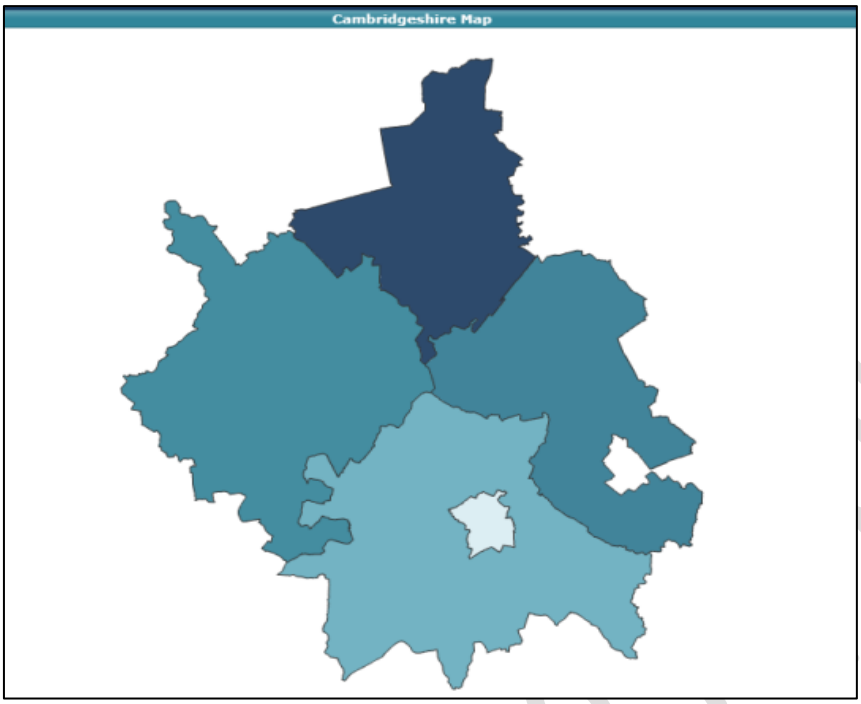
Source: Cambridgeshire Insight.

The percentage of children under 16 who live in poverty is significantly fewer in Cambridgeshire than the national average (12.1% vs 18.6% 2013). In Fenland however more children live in low income families (20.3%) and is significantly worse than in England. More children in Peterborough live in poverty compared

to in England (21.9% vs 18.6%). This is the highest percentage of children in low income families (under 16s) in the East of England.

Overweight and obesity prevalence is higher in certain areas, often in higher areas of deprivation. The following maps show excess weight by geographical area in adults and the distribution of recorded child obesity prevalence at Lower Super Output Area (LSOA) level.

Figure 23: Excess weight by geographical area for Adults (darker colour = higher % excess weight).

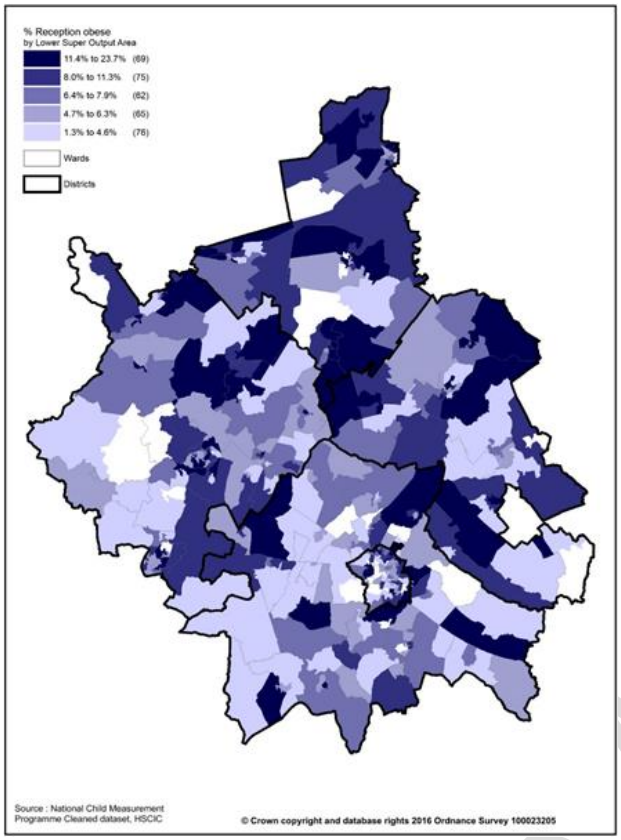


Source: Cambridgeshire Insight (data based on Public Health Outcomes Framework 2012-14)

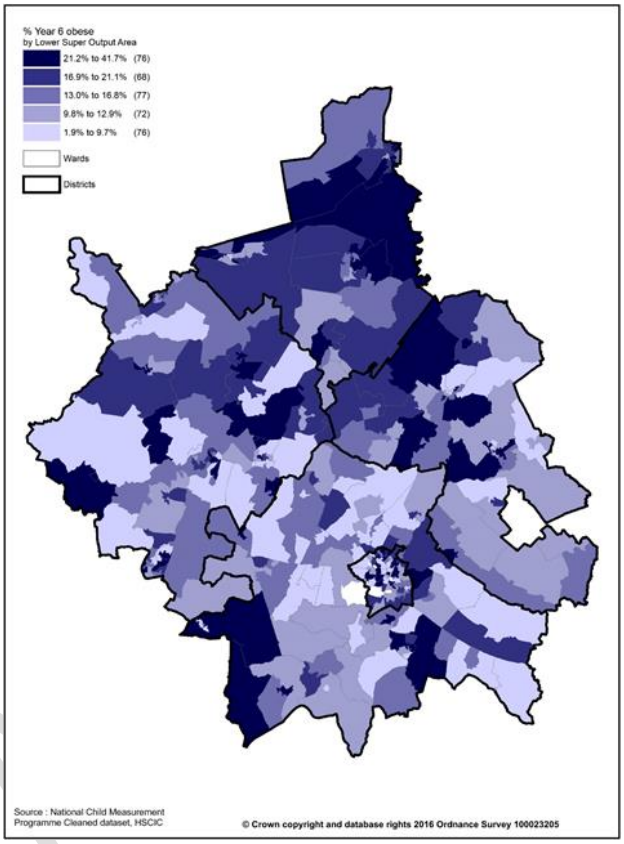
Obesity prevalence in Cambridgeshire was statistically significantly higher in the three most deprived quintiles for Reception children and the second and third most deprived quintiles for Year 6 (Figure 24). In comparison the fifth least deprived areas had statistically significantly lower obesity prevalence for both year groups and the fourth least deprived areas were also statistically significantly lower for Reception pupils.

Figure 24: Child Obesity Prevalence at LSOA level in Cambridgeshire.

Map 1: Cambridgeshire recorded obesity prevalence, Reception, LSOA, 2012/13 to 2014/15



Map 2: Cambridgeshire recorded obesity prevalence, Year 6, LSOA, 2012/13 to 2014/15

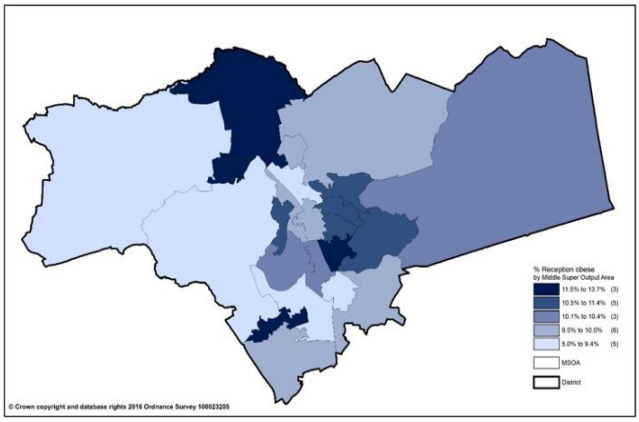


Source: 2011/12 to 2013/14 data from www.noo.org.uk and 2014/15 from National Child Measurement Programme (cleaned dataset), The NHS Information Centre

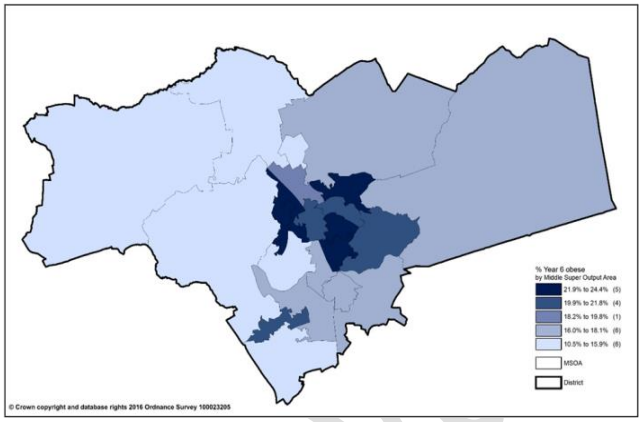
In Peterborough obesity prevalence was statistically significantly lower in the 20% least deprived areas for Year 6 pupils when compared to the Peterborough average. It was also lower in the 20% least deprived areas in Peterborough for Reception. The 20% most deprived areas and third most deprived areas had higher obesity prevalence for Reception pupils, when compared to the Peterborough average, and the 20% most deprived areas and second most deprived areas had higher prevalence for Year 6 pupils although not statistically significantly higher.

Figure 25: Child Obesity Prevalence at MSOA level in Peterborough.

Map 3 : Peterborough recorded obesity prevalence Reception, MSOA, 2012/13 to 2014/15.



Map 4: Peterborough recorded obesity prevalence, Year 6, MSOA, 2012/13 to 2014/15.



Source: 2011/12 to 2013/14 data from www.noo.org.uk and 2014/15 from National Child Measurement Programme (cleaned dataset), The NHS Information Centre.

11.2 Long Term Conditions

Obesity is associated with a number of Long Term Conditions (LTCs) including diabetes, cardiovascular disease and some cancers and can be a contributory factor to LTCs[29]. LTCs are more common in lower socio-economic groups. Multi-morbidity is also more common in higher areas of deprivation.

The Cambridgeshire JSNA: Long Term Conditions across the Lifecourse[30] found nearly a third of people in Cambridgeshire (31.7%) reported having at least one long term condition. Between 36,000 to 42,000 people in Cambridgeshire aged 18-64 years are estimated to have two or more long term conditions (Figure 26).

Figure 26 - Number and proportion of people with long standing illness aged 18-64 years, 2015, Cambridgeshire (Health Survey for England (2012) estimates applied to CCC Research Group 2012 based population forecast for 2015)

Number of illnesses	%	95% CI	Estimate of number of people in Cambridgeshire aged 18-64 years (2015) and range (95% CI)	
No longstanding illnesses	71.3	(70.1 - 72.5)	283,300	(278,500 - 288,100)
One longstanding illness	18.8	(17.8 - 19.9)	74,800	(70,800 - 79,000)
Two or more longstanding illnesses	9.8	(9.1 - 10.7)	39,100	(36,100 - 42,300)
Total	100			

Source: Cambridgeshire Insight, Long Term Conditions across the Lifecourse JSNA 2015.

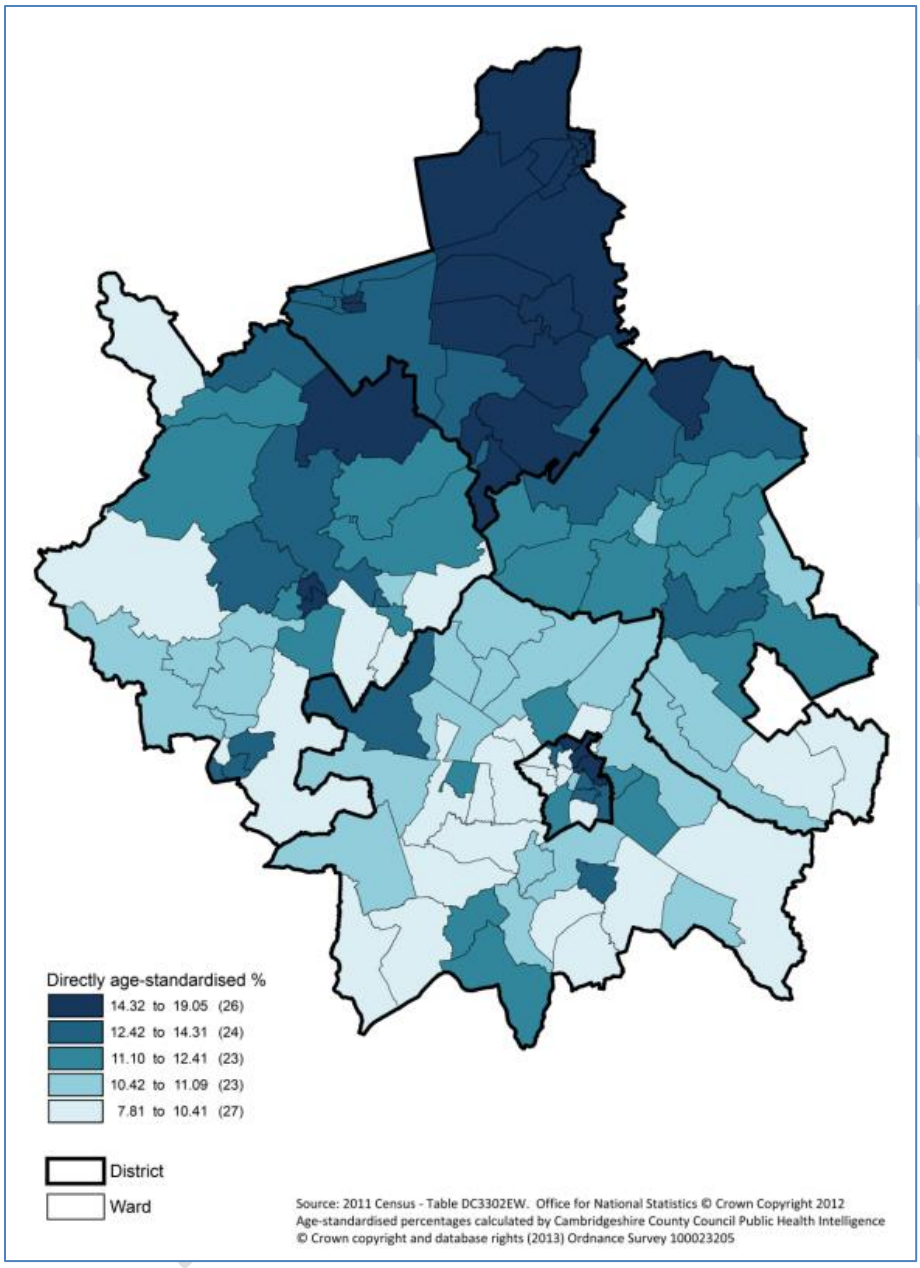
Obesity is more prevalent in people with a Limiting Long Term Illness (LLTI) than in those without a LLTI[29]. The 2011 census found that 90,420 people (15.1% of household residents) reported a long-term activity limiting illness in Cambridgeshire. The percentages reporting LLTI were highest in the oldest age groups.

[29] Public Health England (2016). *Social care.* Available at: http://www.noo.org.uk/LA/impact/social (Accessed: 31 March 2016).

[30] Cambridgeshire Joint Strategic Needs Assessment: Long term Conditions across the Lifecourse 2015 http://www.cambridgeshireinsight.org.uk/JSNA/LTCs-across-the-lifecourse-2015

After adjusting for age, the percentage reporting long-term activity-limiting illness was statistically significantly higher than the England average in Fenland (15.5% v 14.4%)[31]. In all other districts and for Cambridgeshire as a whole these percentages were statistically significantly lower than the England average; the lowest percentages were seen in South Cambridgeshire.

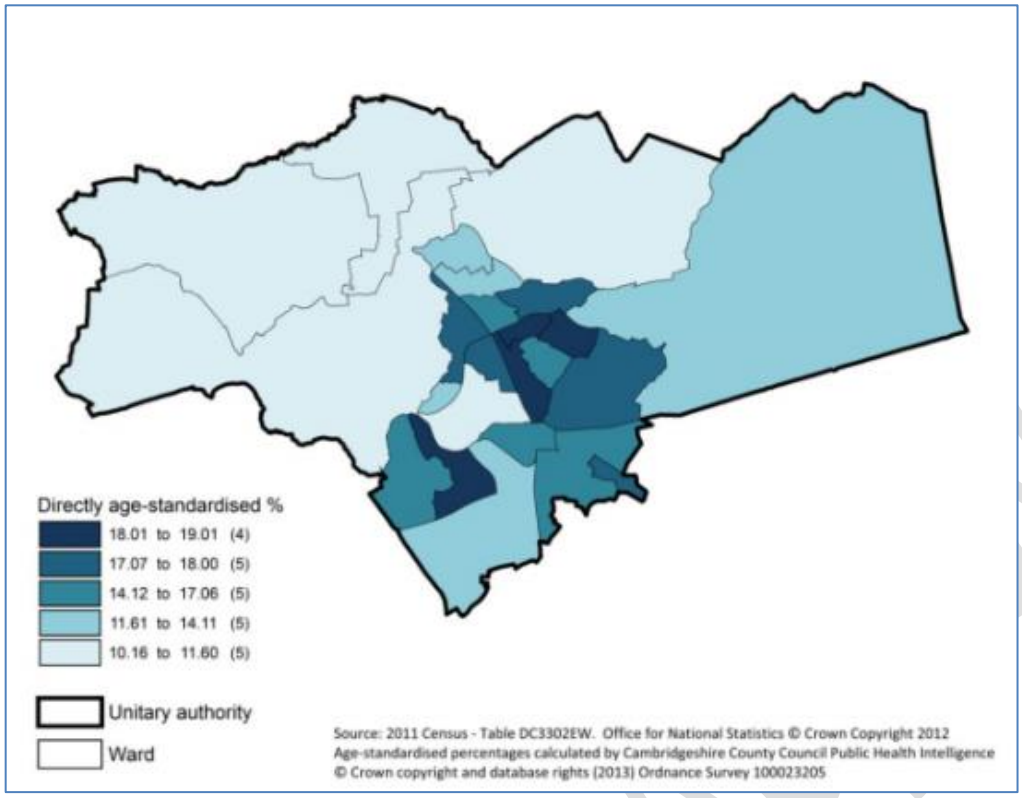
Figure 27 - Directly Age Standardised Percentage of the Population with a Long-Term Activity-Limiting Illness, by ward, Cambridgeshire, 2011.



Source: Cambridgeshire Insight, Census 2011 - Age Standardised Health Data for Cambridgeshire, 2013.

[31] Cambridgeshire County Council (2013). *Census 2011 - Age-standardised health data for Cambridgeshire (Report).* Available at: http://cambridgeshireinsight.org.uk/health/healthtopics/census (Accessed: 31 March 2016).

Figure 28 - Directly Age Standardised Percentage of the Population with a Long-Term Activity-Limiting Illness, by ward, Peterborough, 2011.



Source: Cambridgeshire Insight, Census 2011 - Age Standardised Health Data for Peterborough, 2013.

In Peterborough, 29,699 people (16.3% of household residents) reported a long-term activity limiting illness[32]. Although the percentages reporting long-term illness were highest in the oldest age groups, 51% of all people with a long-term illness in Peterborough are of working age (aged 16-64 years). After adjusting for age, the percentage reporting long-term activity-limiting illness was statistically significantly higher than the England average in Peterborough (15.1% v 14.4).

11.3 Disability

The Cambridgeshire JSNA: Physical and Learning Disability through the Lifecourse 2012-13[33] found in 2012 an estimated 11,066 children in Cambridgeshire met the Equality Act (2010) definition of disability. In February 2013, 868 children were receiving direct social care support, with needs beyond those of a non-disabled child of the same age. In Peterborough in 2016 an estimated 3,558 children had a disability, as defined in the Equality Act.

Within the Cambridgeshire adult population in 2012 11,424 adults (18+ years) were predicted to have a learning disability. 1,922 adults were on Cambridgeshire GP practice-based learning disability registers and 1,630 adults with learning disability received social care services.

[32] Cambridgeshire County Council (2013). *Census 2011 - Age-standardised health data for Peterborough (Report)*. Available at: http://cambridgeshireinsight.org.uk/health/healthtopics/census (Accessed: 31 March 2016).
[33] The Cambridgeshire Joint Strategic Needs Assessment: Physical and Learning Disability through the Lifecourse 2012-13

38,319 Cambridgeshire adults (18-64 years) were predicted to have a moderate or severe physical disability. The Countywide Physical Disability Team supported 808 adults with a physical disability in January 2013, plus a further 24 with HIV.

The Cambridgeshire JSNA: Physical and Learning Disability through the Lifecourse 2012-13 reported that people with disabilities may be less able to access leisure services, and people with learning disability and their carers may have poor knowledge of healthy eating. As the Cambridgeshire population grows and ages, the number of children and adults with disabilities is also expected to rise.

11.4 Looked After Children

Looked After Children (LAC) and young people are a particularly vulnerable group at greater risk of some health outcomes. Many LAC will already have experienced deprivation and poor health before coming in to care, and had fewer opportunities to access health promotion information. In March 2015 there were 535 LAC in Cambridgeshire[34]. In December 2014 there were 372 LAC in Peterborough[35].

In England, around 60% of children and young people who are looked after are reported to have emotional and mental health problems and a high proportion experience poor health, educational and social outcomes after leaving care (NICE, 2013). In Cambridgeshire, 48.6% of care leavers aged 19 years were in Education, Employment or Training (March 2015), compared to 85% of Cambridgeshire's general 19 year old population (December 2014).

11.5 Infants who are Breastfed

Rates of breastfeeding initiation were the highest recorded in Cambridgeshire at 83% in 2013/14, after a slight decline over the previous three years fairly static data. At 6-8 weeks after birth breastfeeding rates decline to 58.3% in Cambridgeshire. There has been a continuous increase locally in breastfeeding at 6-8 weeks after birth since 2011/12, with levels at the greatest since data was first reported. Breastfeeding rates remain higher than the overall trends for England in both incidences (Table 7: Breastfeeding rates in Cambridgeshire & Peterborough.).

Breastfeeding in Peterborough is similar to England for initiation and prevalence at 6-8 weeks after birth (Table 7). The trend in breastfeeding initiation remained similar to national averages since 2011/12. While prevalence at 6-8 weeks after birth has increased, this was significantly worse than England in 2012/13 and improved the following year from which prevalence similar to England has been maintained from 2013/14.

Table 7: Breastfeeding rates in Cambridgeshire & Peterborough.

	Cambridgeshire	Peterborough	England
Breastfeeding initiation (48 hours after birth)	83%	72.8%	74.0%
Breastfeeding prevalence 6-8 weeks after birth	56.2%	44.4%	45.8%

Source: Public Health Outcomes Framework 2013/14.

[34] Cambridgeshire County Council Corporate Parenting Strategy 2015-2018
[35] Peterborough city Council Children & Young People Joint Strategic Needs Assessment June 2015

12 The Evidence Base, what should we be doing?

12.1 System Wide Approach

System Wide Approach – Join up policies and interventions across the whole system

The inter-relationship between the environment, the settings in which people live and work and human behaviour is complex. Addressing unhealthy weight will not be achieved by single interventions (Foresight Report[36]). It requires a complex web of inter-related interventions focused upon the environment, different settings and human behaviour across the whole system. Evidence based interventions that address these factors and contribute to positive outcomes will be wide ranging and will include policy through to psychology.

The Foresight Report used a systems mapping approach using evidence from many disciplines to demonstrate the complexity of obesity. This approach indicates that weight is determined by a complex multifaceted system of determinants where four different influences upon weight were identified: physiological factors, eating habits, activity levels and psychosocial influences. Approaches are therefore complex and interrelated.

The report cites evidence for public policy change for food production, food manufacturing, healthcare, retail, education, culture, trade and opportunities for personal travel. The focus is that individual policies are not sufficient to have the influence and impact they need on different parts of the system.

The NICE Guidelines Obesity: working with local communities, PH42 [37] recommends that an integrated systems wide approach with clear leadership is necessary for the reduction of obesity. Although the supporting evidence[38] for the guidelines acknowledges that it is difficult to evaluate any of the system wide programmes but there are some examples of good practice.

[36] The Foresight Report
[37] NICE Guidelines Obesity: working with local communities [PH42]: 2012 http://www.nice.org.uk/guidance/PH42
[38] The effectiveness of Whole System Approaches to prevent obesity: Hunt H.; Coelho H.F.; Garside R.; Batliss S.; Fry Smith A.; Systematic review undertaken by the Peninsula Technology Assessment Group (PenTAG) for NICE 2011

Sandwell Healthy Urban Development Unit (SHUDU)

SHUDU is a cross agency group with the aim of 'creating healthy and sustainable places and communities in Sandwell'. Work of the group is in line with the Black Country Core Strategy (the local plan). Membership includes a number of local authority departments: public health, planning, environmental health, trading standards and economic regeneration. Objectives of SHUDU are to:

- Provide a formal route for engagement between health, local authority planning services and other stakeholders that have influence over the wider determinants of health.
- Develop healthy environments and places to support people in changing their be havior to a healthier lifestyle.
- Influence policy at local, regional and national levels.

Key areas of recent work include developing a supplementary planning document to control hot food takeaways; working with food policy colleagues to influence the provision of healthier food in hot food takeaway outlets; mapping of access to healthy food; exploring the development of 20mph zones across Sandwell and contributing to the national Town and Country Planning Association handbook on reuniting health and planning.

13 The Healthy Environment

Key Interventions

- **Local use of policy, legislative and planning levers with a consistent approach across Cambridgeshire.**
- **Evidence based interventions to increase walking and cycling e.g. Personalised Travel Plans.**
- **Minimise local promotion of unhealthy foods.**
- **Work effectively with local retailers to increase access to healthy food and drink.**

The environment in which people live affects what they eat and their physical activity levels. This applies to where they live, work and socialise[39].

Evidence-based policies and strategies are required to create and sustain an environment that supports a healthy weight. These need to impact upon transport, public open spaces, buildings and schools and access to healthy affordable food.

Local authorities have a range of legislative and policy levers at their disposal, alongside wider influences on healthy lifestyles that can help to create places where people are supported to maintain a healthy weight[40,41]. The most influential policy lever is the National Policy Planning Framework (NPPF) which makes it clear that local planning authorities (LPAS) have a responsibility to promote healthy communities. Local plans should "take account of and support local strategies to improve health, social and cultural wellbeing for all". NICE guidance[42] on physical activity and the environment emphasises that local authorities prioritise the creation and maintenance of environments that encourage people to be active. Doing this can bring added benefits, such as reduced traffic congestion, the revitalisation of local shops and services and increased community cohesion and social interaction. It identifies features of the environment that have an impact on physical activity, including:

- location, density and mix of land use;
- street layout and connectivity;
- physical access to public services, employment, local fresh food;
- safety and security;
- open and green space;
- affordable and energy-efficient housing;
- air quality and noise;
- resilience to extreme weather events;
- community interaction;
- transport.

An economic analysis[43] of interventions in the built environment that support physical activity found that for urban planning and design the QALY cost was £130-£1260. Cost for transport was £289-£2831 and for building design was £219-£2087.

13.1 Active Communities and the Environment

Walking and cycling is an easy way of increasing an individual's daily activity. There are broad health benefits with reduced incidence of type 2 diabetes, dementia, cerebrovascular disease (stroke), depression and cancer and reduced mortality[44]. Those who are the most inactive have the greatest benefit, even from small increases in physical activity. Wider benefits include reduced absenteeism, improved journey quality, reduced congestion and air pollution and improved road safety. The benefit cost ratios for active travel has

[39] Evidence-based intervention in physical activity: lessons from around the world. Heath GW et al., 2012
[40] Dr Foster Intelligence and Land Use Consultants. Tackling the Takeaways: a new policy to address fast-food outlets in Tower Hamlets. London 2011.
[41] Department for Communities and Local Government. National Planning Policy Framework. London 2012
[42] NICE public health guidance 8. Physical activity and the environment 2008
[43] Beale, Bending, Trueman : An economic analysis of environmental interventions that promote physical activity (2007)
[44] Jarrett, J., et al, Effect of increasing active travel in urban England and Wales on costs to the National Health Service, Lancet, 2012 Jun 9;379(9832):2198-205. doi: 10.1016/S0140-6736(12)60766-1

been estimated by the Department for Transport (DfT) as being approximately 6:1[45] and in the long-term there is the potential for cost savings to the NHS. Cavill[46] also reports that they may be more cost-effective than other initiatives that promote exercise, sport and active leisure pursuits.

NICE PH Guidance 41 Physical Activity: walking and cycling 2012[47] identifies in the supporting evidence base specific planning considerations that need to be upheld to promote walking and cycling.

- **Ensure planning applications for new developments always prioritise the need for people (including those whose mobility is impaired) to be physically active as a routine part of their daily life.**
- **Ensure pedestrians, cyclists and users of other modes of transport that involve physical activity are given the highest priority when developing or maintaining streets and roads.**
- **Plan and provide a comprehensive network of routes for walking, cycling and using other modes of transport involving physical activity.**
- **Ensure public open spaces and public paths can be reached on foot, by bicycle and using other modes of transport involving physical activity.**

Local Transport Plans are being used to promote walking and cycling through creating an environment where people actively choose to walk and cycle as part of everyday life.

Jarrett (2012)[48] estimated the NHS costs that could be averted by a large shift towards active travel in England and Wales, based on reducing incidence of key diseases and therefore the costs of treating these conditions. A shift in walking from an average of 0.6 km/day to 1.6 km/day, and in cycling from an average of 0.4 km/day to 3.4 km/day (similar to current levels in Copenhagen) could result in changes in numbers of incident cases of type 2 diabetes, dementia, cerebrovascular disease, breast and colorectal cancer, depressions and ischaemic heart disease. The study estimated that over 20 years the NHS expenditure averted would be over £17 billion.

Levels of walking and cycling are influenced by both environmental and individual factors. Shorter distance, convenience, pleasant routes, tailored household/individual interventions all tend to increase levels of walking and cycling. Barriers include factors such as safety/perceived safety issues, parental behaviours and perceptions and availability of workplace car parking.

13.1.1 Interventions that increase levels of cycling and walking

Distance is one of the most consistent environmental influences on walking[49] and cycling[50]. Direct routes that are well connected are considered to be valuable. A Cambridge-specific study showed that convenient

[45] Department for Transport, *Claiming the Health Dividend*, 2014. Available at https://www.gov.uk/government/publications/economic-case-for-active-travel-the-health-benefits
[46] Cavill N. Increasing walking and cycling: a briefing for directors of public health. 2013. www.noo.org.uk/slide_sets/activity.)
[47] NICE PH Guidance 41 Physical Activity: walking and cycling 2012
[48] Jarrett, J., et al, Effect of increasing active travel in urban England and Wales on costs to the National Health Service, Lancet, 2012 Jun 9;379(9832):2198-205. doi: 10.1016/S0140-6736(12)60766-1
[49] Saelens B, Handy S, *Built Environment Correlates of Walking: A Review*. Medicine and Science in Sports and Exercise. 2008;40(7S):S550-S66.

cycle routes were found to predict uptake of cycling whilst pleasant routes predicted maintenance of walking to work[51].

A study by CEDAR[52] found that workplace car parking provision was a strong and consistent predictor of increased likelihood of car commuting[53] and decreased likelihood of incorporating walking or cycling into a longer car commuting journey and walking or cycling the entire journey (Panter 2011[54]).

However a key factor where there is well established infrastructure, are the personal perceived barriers. Interventions to promote walking which tailored to individuals or households are more effective than non-personalised methods targeted at larger populations (Ogilvie et al, 2007)[55].

Whether children actively commute to school may be determined by parents' perception of safety of the mode of transport, lack of time in the morning and social factors such as no other children to walk with[56]. Furthermore 'walk to school' interventions involving educational lessons and goal setting tasks aimed at eight to nine year olds have not shown to increase walking to school[57], highlighting the importance in influencing parents' behaviour and perceptions.

Personalised Travel Planning[58]

[50] Panter, J.R, Jones, A.P., van Sluijs, E.M. Griffin, S.J, *Attitudes, social support and environmental perceptions as predictors of active commuting behaviour in schoolchildren*. Journal of Epidemiology and Community Health, 2010;***64:****41-48*.
[51] Panter, J., Griffin, S, & Ogilvie, D, *Active commuting and perceptions of the route environment: A longitudinal analysis,* Prev Med, 2014; 67: 134–140.
[52] Commuting and Health in Cambridge website http://www.cedar.iph.cam.ac.uk/research/directory/cahic/
[53] Goodman, A., et al, H*ealthy travel and the socio-economic structure of car commuting in Cambridge, UK: A mixed-methods analysis*, Social Science Medicine, 2012; 74(12): 1929–1938.
[54] Panter, J., Griffin, S, & Ogilvie, D, *Active commuting and perceptions of the route environment: A longitudinal analysis,* Prev Med, 2014; 67: 134–140.
[55] Ogilvie, D et al, *Interventions to Promote Walking: systematic review*, BMJ, 2007 Jun 9; 334(7605): 1204.
[56] Jo Salmon, Louisa Salmon, David A. Crawford, Clare Hume, and Anna Timperio, *Associations Among Individual, Social, and Environmental Barriers and Children's Walking or Cycling to School*. American Journal of Health Promotion, 2007: November/December 2007, Vol. 22, No. 2, pp. 107-113
[57] David McMinn et al, *Predicting active school travel: The role of planned behavior and habit strength*, International Journal of Behavioural Nutrition and Physical Activity, 2012;2012; 9: 65.

[58] NICE public health guidance 41 (2012)
http://pathways.nice.org.uk/pathways/walking-and-cycling#path=view%3A/pathways/walking-and-cycling/walking-and-cycling-programmes.xml&content=view-node%3Anodes-personalised-travel-planning

In Cambridgeshire, Personal Travel Planning (PTP) is being used to overcome the habitual use of the car, enabling more journeys to be made on foot, bike, bus, train or in shared cars. This is achieved through the provision of information; incentives and motivation directly to individuals to help them voluntarily make more informed travel choices.

The Local Sustainable Transport Fund funded the Getting Cambridgeshire to Work programme – targeted at circa 21,000 households in Cambridgeshire between April 2013 and March 2015. An evaluation of the effectiveness of residential PTP projects in Cambridgeshire at Orchard Park and Kings Hedges in Cambridge indicated that the projects were successful in terms of raising awareness of sustainable travel modes, encouraging participation in the PTP process, increasing the sustainable travel choices made by residents and providing valuable feedback on local infrastructure barriers.

In support of PTP, Transport Planners encourage developers to produce Travel Plans as part of residential and business developments. Colleagues cross the region are developing monitoring mechanisms, fees and charges for the implementation of Travel Plans. Work is also being undertaken with employers to support PTP.

13.2 The Food Environment

The typical adult diet exceeds recommended dietary levels of sugar and fat. Less than a third of adults currently meet the five a day target and around one in five children aged five to 15 meets the target, with the average being just three portions a day[59]. Healthy eating is associated with a reduced risk of being overweight or obese and of chronic diseases, including type 2 diabetes, hypertension, and certain cancers[60].

13.2.1 National Policy

Evidence [61] [62] suggests that raising the price of foods and drinks such as sugar-sweetened beverages and fast food at a population level (for example, through taxation) appears to reduce their overall consumption, whereas nationally subsidising healthier foods such as fruits and vegetables appears to increase consumption of these foods. Fiscal and regulatory measures also appear to be cost effective in the long-term for preventing obesity.

13.2.2 The Sugar Effect

Current estimates of UK sugar intakes from the National Diet and Nutrition Survey programme (NDNS)[63] show that mean intakes are three times higher than the new 5% maximum recommended level in school-aged children and teenagers (14.7% to 15.6% of energy intake) and around twice the maximum recommended level in adults (12.1% of energy intake).

[59] National Obesity Observatory. Determinants of obesity: child diet. 2012. www.noo.org.uk/uploads/doc/vid_14864_NOOchilddiet2012.pdf

[60] Public Health England. About obesity 2013. www.noo.org.uk/NOO_about_obesity/lifestyle

[61] Lehnert T, Sonntag D, Konnopka A et al. (2012) The long-term cost-effectiveness of obesity prevention interventions: systematic literature review. Obesity Reviews 13: 537–53

[62] An R (2013) Effectiveness of subsidies in promoting healthy food purchases and consumption: a review of field experiments. Public Health Nutrition 16: 1215–28

[63] Bates B LA, Prentice A, Bates C, Page P, Nicholson S, Swan G. (Eds). (2014) National Diet and Nutrition Survey: Headline results from Years 1 to 4 (combined) of the rolling programme from 2008 and 2009 to 2011 and 2012. Online. Available from: https://www.gov.uk/government/statistics/national-diet-and-nutrition-survey-results-from-years-1-to-4-combined-of-the-rolling-programme-for-2008-and-2009-to-2011-and-2012

There is evidence that a high sugar intake is associated with deprivation. The NDNS found higher sugar intakes in adults in the lowest income compared to all other income groups. Consumption of sugary soft drinks was also found to be higher among adults and teenagers in the lowest income group.

There are potential health impact and wider cost savings to the NHS if the 5% sugar recommendations are met. After five years of working to achieve the target there should be a saving of £576 to the NHS from the associated health[64].

Consuming too much sugar and too many foods and drinks high in sugar can lead to weight gain[65] and is linked to tooth decay[66]. The Scientific Advisory Committee on Nutrition (SACN) report 'Carbohydrates and health' in July 2015[67] following a review of the evidence, concluded that the average population intake of sugar should not exceed 5% of total dietary energy for the population aged two years upwards and that consumption of sugar sweetened drinks should be minimised by both adults and children. Public Health England developed the SDAC review in its Sugar Reduction: evidence for action report (2015) that includes evidence based recommendations for action[68]. There are three key areas which are recommended for achieving a reduction in sugar intake in the report:

Influencers: This includes marketing and fiscal measures that can influence sugar intake. The review by PHE of a large number of research studies found evidence which suggests that increasing the price of high sugar foods and non-alcoholic drinks, whether through taxation or other means, is likely to reduce purchases of these products at least in the short term[69].

The food supply: This includes food purchased in retail outlets for home, in restaurants etc. the workplace and school canteens. Food choices are habitual and automatic. There is limited uptake of healthy food ranges and there is evidence that improved nutrition information on labels has limited influence unless a weight loss is being attempted or there is a particular health issue[70]. There is now more choice than ever in the food and drink market with the food environment being filled with food outlets and in real terms food is cheaper than ever[71] [72] [73].

Knowledge, education, training and tools: The Report refers to its own evaluation evidence that campaigns such as Change4Life, the childhood obesity campaign, influence healthy diet choices and improving

[64] Weight Management Economic Assessment Tool. Online. Available from: http://www.noo.org.uk/visualisation/economic_assessment_tool
[65] The Scientific Advisory Committee on Nutrition. (2015) Carbohydrates and Health. Online. Available from: https://www.gov.uk/government/groups/scientific-advisory-committee-on-nutrition
[66] Department of Health. (1989) Dietary Sugars and Human Disease. Report on the panel on dietary sugars, 37. London: HMSO.
[67] The Scientific Advisory Committee on Nutrition. (2015) Carbohydrates and Health. Online. Available from: https://www.gov.uk/government/groups/scientific-advisory-committee-on-nutrition
[68] Public Health England Sugar Reduction: evidence for action report (2015)
[69] Joint Teeside University and Public Health England Sugar Reduction: The evidence for action
Annexe 2: A mixed method review of behaviour changes resulting from experimental studies that examine the effect of fiscal meas
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1. Reduce and rebalance the number and type of price promotions in all retail outlets.
2. Significantly reduce opportunities to market and advertise high sugar food and drink products to children and adults across all media and through sponsorship.
3. The setting of a clear definition for high sugar foods.
4. Introduction of a broad, structured and transparently monitored programme of gradual sugar reduction in everyday food and drink products, combined with reductions in portion size.
5. Introduction of a price increase of a minimum of 10-20% on high sugar products through the use of a tax or levy such as on full sugar soft drinks.
6. Adopt, implement and monitor the government buying standards for food and catering services (GBSF) across the public sector, including national and local government and the NHS to ensure provision and sale of healthier food and drinks in hospitals, leisure centres etc.
7. Ensure that accredited training in diet and health is routinely delivered to all of those who have opportunities to influence food choices in the catering, fitness and leisure sectors and others within local authorities.

knowledge in relation to the risks associated with consuming too much sugar. However campaigns are short term and consequently dietary changes run the risk of being short term. Any new behaviours are challenged by the ongoing promotion by the food and drinks industries. The UK food industry spent £256 million promoting 'unhealthy' foods sold in retail alone in 2014 compared to a total Change4Life spend the same year of just £3.9m. The provision of good clear information about the risks of sugar to the public, professionals, employers and the food industry to support practical steps that people can take to lower their own and their families sugar intake. The report makes a number of recommended actions for addressing these three areas but emphasises evidence that demands that a whole system approach is required.

These evidence based actions call for changes at national policy level but also local interventions that focus on promotion marketing, knowledge and training along with ongoing awareness raising are possible.

13.2.3 Fast Food Outlets

One of the dietary trends in recent years has been an increase in the proportion of food eaten outside the home, which is more likely to be high in calories[74]. Of particular concern are hot food takeaways, which tend to sell food that is high in fat and salt, and low in fibre, fruit and vegetables[75].

Figure 29 shows the density of outlets varies between 15 and 172 per 100,000 population. This data shows a strong association between deprivation and the density of fast food outlets, with more deprived areas having a higher proportion of fast food outlets per head of population than others.

Children who eat school meals tend to consume a healthier diet than those who eat packed lunches or takeaway meals[76]. However initiatives that have improved school food are only affecting four out of 10

[74] Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J, et al. Tacking obesities: future choices – project report. London 2007.
[75] London Food Board and Chartered Institute of Environmental Health. Takeaways toolkit. A London Food Board and Chartered Institute of Environmental Health publication based on a consultancy report by Food Matters. London 2012.
[76] Stevens L, Nelson M. The contribution of school meals and packed lunch to food consumption and nutrient intakes in UK primary school children from a low income population. Journal of human nutrition and dietetics: the official journal of the British Dietetic Association. [Comparative Study Research Support, non-U.S. Gov't]. 2011 Jun;24(3):223-32.

children[77 78]. In addition, uptake of school meals decreases when children move from primary to secondary school (46.3% compared to 39.8%), and in many cases secondary school pupils are allowed to leave the school premises at lunchtime. Improving the quality of the food environment around schools has the potential to influence children's food-purchasing habits, potentially influencing their future diets[79].

The research into the link between fast food availability and obesity is still relatively undeveloped. (Although there is some evidence that there is an association between fast food and obesity[80]. It is only in recent years that local authorities have started to use the legal and planning systems to regulate the growth of fast food restaurants, including those near schools. Consequently, there is an unavoidable lack of evidence that clearly demonstrates the relationship between fast food outlets and their proximity to schools. However, there are examples in England of local authorities using policy and regulatory approaches.

Fast Food Local Strategic Planning

Example of what could be included in a Fast Food Local Strategic Planning Document (SPD)

No new fast food (Class A5 Hot Food) outlets:

- **Within a 400m radius of schools, youth centres, leisure centres and parks *(very common).***
- **In areas (e.g. wards) where more than 10% of year 6 pupils classified as obese.**
- **In areas where the number of fast food per head already exceeds the UK national average per head of population.**
- **Where on any one street takeaway use would exceed 5% of retail frontage *(very common).***
- **Where the proposed new location would be adjacent, within two non-food outlets, of an existing fast food outlet.**

Waltham Forest Borough Council has recorded that 83% of planning applications for fast food outlets have been rejected since implementation of their SPD in 2009. It also reports that applications for fast food outlets generally are down. This suggests that businesses have moved to alternative locations which would call for a consistent approach to policies across Cambridgeshire.

There are other statutory environmental and licensing levers that local authorities are able to use in addition to planning policies.

- street trading policies to restrict trading from fast food vans near schools;
- policies to ensure that menus provide healthier options;
- enforcement on other issues such as disposal of fat, storage of waste, and litter;
- food safety controls and compliance;
- restrictions on opening times;
- using Section 106 agreements and the Community Infrastructure Levy to contribute to work on tackling the health impacts of fast food outlets.

(However, it is important to note that taking action on hot food takeaways is only part of the solution, as it does not address sweets and other high-calorie food that children can buy in shops near schools.)

[77] Butland B, Jebb S, Kopelman P, McPherson K, Thomas S, Mardell J, et al. Tacking obesities: future choices – project report. London 2007.
[78] School Food Plan. 2013. www.schoolfoodplan.com/
[79] School Food Trust. Take up of school lunches in England 2011-2012. London 2012.
[80] Kruger DJ, Greenberg E, Murphy JB, Difazio LA, Youra KR. Local concentration of fast food outlets is associated with poor nutrition and obesity. American journal of health promotion: AJHP. 2013 Aug 13.

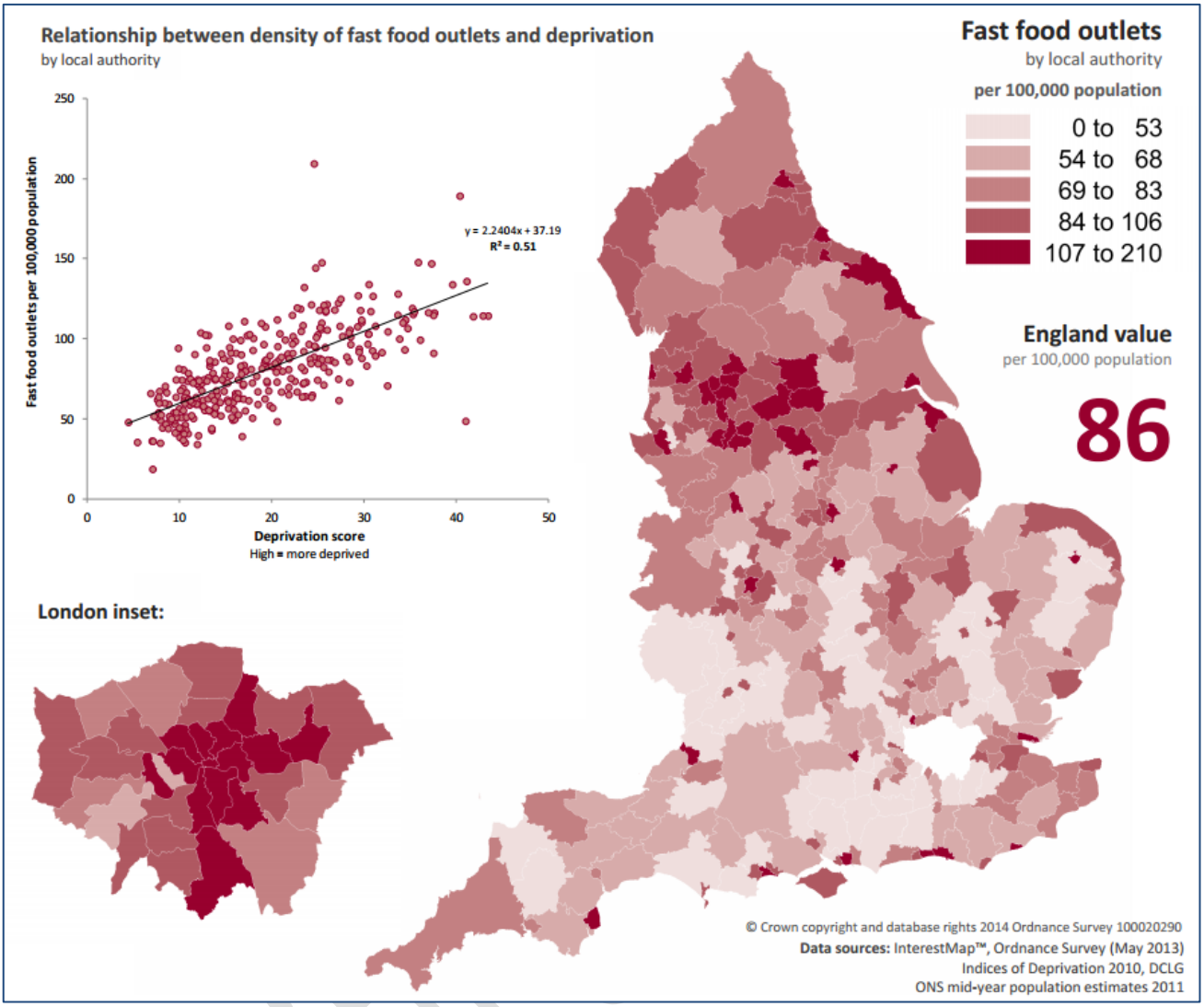

Figure 29- Fast Food Outlets and the Index of Multiple Deprivation.

Source: Public Health England, 2016.

13.3 Public Health Responsibility Deal (PHRD)

The PHRD (2011)[81] aims to utilize the potential for businesses and other organisations to contribute to improving public health through a supportive environment. The PHRD encourages voluntary action from businesses and organisations to commit to addressing alcohol, food, health at work and physical activity to reduce health inequalities. Action includes collective pledges for action within a given sector, for example all major supermarkets and the over 70% of the major retail market agreed to removing artificial trans fats, while over 75% of the retail market and over 60% of caterers pledged to reduce salt[82]. Organisations within a sector can also make individual pledges to support change.

The PHRD recognises that healthier employees have an increased productivity and reduced costs of sickness absence. Changes can be economically stimulating for businesses as these can be cost saving and could

[81] Department of Health (2011). *The Public Health Responsibility Deal.* https://responsibilitydeal.dh.gov.uk/wp-content/uploads/2012/03/The-Public-Health-Responsibility-Deal-March-20111.pdf

[82] Department of Health (2013).*Localising the Public Health Responsibility Deal – a toolkit for local authorities.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193106/130408-RD-Toolkit-Web-version.pdf

potentially widen customer base by appealing to a broader market. Healthier choices for customers can also help to reduce the cost of poor health on society and the economy.

Local businesses are recognised for their potential to contribute to the aims of the PHRD too. Engagement with small local businesses is thought to be best led through local authorities at a local level. Local schemes can encourage small businesses to make their products healthier, including by reducing salt, using healthier oils and increasing fruit and vegetables.

The Responsibility Deal in Cambridgeshire – Healthier Options Project

Healthier Options is a locally branded initiative which aims to improve the healthfulness of food offered in local food businesses. It is a collaboration between the County Council and District and City Councils, delivered by Environmental Health Officer teams, which harnesses the potential for businesses to support customers to make healthier choices.

This involves restaurant and takeaway sector businesses changing their existing menu (e.g. reducing salt) and increasing healthy choice options (e.g. adding fruit or vegetables). Businesses pledge to improve the nutritional content of food and increase the availability and promotion of healthier food choices. The project targets food businesses that concentrate on the lunchtime food economy, to make healthier food options more available and raise the awareness of consumers to the types of foods available.

The pilot has tested the model in different geographical locations and socio-demographic profiles across the county to assess whether the model can be effective within different environments. The brand is widely promoted through social media channels. Healthier Options aims to engage with existing and potential customers through these channels. And support of the initiative from the local community is encouraged through Healthier Options Ambassadors. The initiative has been independently evaluated by the University of Hertfordshire.

14 Healthy Settings

Key Interventions

- **Ensure that policies and practice are established to support infant feeding in all relevant settings.**
- **Increase in schools and nurseries "whole settings" approach using policy and interventions to promote physical activity and healthy diet.**
- **Engage employers across Cambridgeshire in the adoption of a healthy workplace programmes.**
- **Engage communities in taking a leadership role and whole community approach to promoting physical activity and a healthy diet.**
- **Ensure all relevant settings have local guidelines in place to prevent malnutrition in high risk groups.**

the implementation of comprehensive strategies and provides an infrastructure for improving health. It

lends itself to the life course approach often targeting a certain population group such as the Healthy Schools or Healthy Workplace Programmes. Though it can also be used to target whole communities such as Healthy Village or Healthy Town Programmes.

14.1 Under 5s Settings

14.1.1 Baby Friendly Settings

Decisions around infant feeding influence body weight as infants progress through childhood and in to adulthood. Infants who are breastfed are less likely to become obese later in life. Mothers who breastfeed expend around 500 additional calories per day, and can offer support to them to lose weight. A multi-faceted approach across a range of settings should be adopted to increase breastfeeding rates. Breastfeeding peer support programmes should be among the services provided. UNICEFs Baby Friendly Initiative provides the minimum standard to encourage breastfeeding. The Department of Health recommend exclusive breastfeeding for up to six months, and then continued breastfeeding (with the introduction of appropriate complementary food) for up to one year and beyond. In England, approximately 1% of babies are exclusively breastfed at six months. For mothers who chose not to breastfeed, there should also be access to independent advice around infant formula. Settings should ensure that an infant feeding policy is in place.

Baby Friendly at The Rosie Hospital, Addenbrookes

The Rosie Hospital, Addenbrookes provides breastfeeding support and information to mothers and families through implementation of the UNICEF Baby Friendly Initiative. In October 2015 The Rosie achieved Stage 2 accreditation which focuses on educating staff in implementing the Baby Friendly standards. The hospital setting is now continuing to work towards the third and final stage, ensuring that standards are implemented for all pregnant women and new mothers.

14.1.2 Early Years Settings

Unhealthy weight in the pre-school years can impact throughout the life course. Obesity and excessive weight gain in the pre-school years are independently associated with higher blood pressure, recurrent wheezing, and other adverse physical and psychosocial health conditions in childhood. Nearly two-thirds of UK children under five years of age are routinely cared for outside of the home, organised childcare has become an important setting for the promotion of a healthy weight and key to the prevention of obesity. Research has indicated that policies which support healthy eating and physical activity in pre-school settings such as nurseries are associated with obesity prevention ([83]CEDAR). The challenge is to identify how policies can be effectively applied in practice and there are examples which indicate the key levers for influencing behaviors.

Early Years Physical Activity and Nutrition (EYPAN) Programme - Cambridge[84]

The EYPAN created a new staff role in nurseries and pre-school settings, The Physical Activity and Nutrition Co-ordinator (PANCo), which took a similar role to the SENCo (Special Educational Needs Coordinator) i.e. improving early years workers' knowledge of children's physical activity and diet to enable them to promote it in their settings focusing upon:

- building practitioner skills and confidence by providing training support and continuous professional development;
- supporting the wellbeing of children, families and staff by developing a framework and knowledge base using current research and national guidelines;
- work collaboratively with others by establishing close working relationships with a

[83] CEDAR ...ractices-survey/# Space: S...

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14.1.3 Physical activity and children and young people.

Emerging evidence[85] is revealing factors that influence children to be more physically active e.g. the type of play equipment. Locally in Cambridgeshire the voluntary organization Living Sport is piloting a physical activity programme in pre-school settings. Children's Centres are another pre-school setting which affords the opportunity of creating a whole settings approach where children, their families and carers can engage in different activities. In Cambridgeshire the whole settings approach has been adopted in some Children's Centres.

St. Neots Children's Centre Group

St Neots Children's Centre group is a cluster of three Children's Centres covering St Neots, Eaton Socon and rural communities around St Neots.

The children's centre group has adopted a whole Centre approach to promoting healthy lifestyles and includes a range of drop-in activities, such as Little Explorers, On the Move, Physical Fun and Shake & Wiggle at various locations. Activities are family based and involve parents/carers and children together, promoting physical activity and showing parents that physical activity does not require specialist equipment or going to organised leisure facilities. The centre offers buggy walks – 'Strut & Stroll', delivered in partnership with Everyone Health. They are also running cookery courses, 'Cook Together', using resources available through the Change 4 Life campaign and aimed at some of the more vulnerable families living in the area. Food for these cookery sessions is provided by the local Tesco supermarket.

The centre provides healthy snacks at all activities and has occasional visits from Dental Health staff, to promote good dental health. The centre makes a small charge for these activities to cover costs but low-income families receive free places.

The Programme is linked to the diet and physical activity assessment which is part of the holistic Family Common Assessment Framework and the Early Years Foundation Stage. Where necessary, support is offered to families to advise then on diet and physical activity, with the aim of enabling families to feel confident in joining in with other community activities.

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14.2 The School Setting

Alongside the physical and mental health benefits of physical activity for children and young people there is a clear link with academic attainment. Research has shown physical activity provides cognitive benefits for children with disabilities by turning on the attention system including sequencing, working memory, the ability to prioritise. One study (Corder et al) has found [86] an inverse relationship between time spent being sedentary at age 14 years and GCSE results by age 17.

A recent review of the evidence [87] (CEDAR for the Department of Health) for addressing physical activity in the school setting identified the need for supportive policies that influence the physical features of the school and its surrounding area, the wider culture and ethos as being the key to improvement.

Recommendations for addressing physical activity in the school setting, schools need to ensure that policies support the following:

- **Specific settings and sufficient space for physical activity that are seen as adequate and accessible by students - both in the physical education (PE) environment and at the whole school level.**
- **Teaching behaviours within and beyond PE that create a positive climate for physical activity promotion - including enthusiasm and social support for physical activity, and the presence of role models.**
- **The wider 'culture' of physical activity promotion within the school - including the extent to which physical activity and health is prioritised and teaching behaviours which requires good leadership.**
- **Changes to the wider school environment involve consulting with students and allowing them to design and lead initiatives taking into account gender and ethnic differences.**

However the CEDAR evidence review found limited evidence base for interventions that increase physical activity in school settings and those found are mostly from primary schools. Yet it identified some characteristics of interventions that have been found to be influential:

[86] Corder K, Atkin AJ, Bamber DJ, Brage S, Dunn VJ, Ekelund U et al (2015) Revising on the run or studying on the sofa: prospective associations between physical activity, sedentary behaviour, and exam results in British adolescents. International Journal of Behavioral Nutrition and Physical Activity, 2015; 12 (1) DOI: 10.1186/s12966-015-0269-2

[87] Department of Health/CEDAR
Creating Active School Environments for Adolescents - Evidence Review (2016)
http://www.cedar.iph.cam.ac.uk/resources/evidence/eb-11-making-the-case/#schoolenv

- For adolescents, programmes that include a PE component should be targeted at boys and girls separately. Evidence shows that when targeted at both girls and boys together, they are only effective in promoting physical activity in boys. However, programmes with a PE component increase physical activity in girls where they have been targeted alone.
- Physical activity programmes in children under 12 years do not appear to have different effects on boys and girls.
- There is no consistent evidence to suggest that children and adolescents of different ethnicity, socioeconomic status, or initial weight status respond differently to school-based physical activity programmes. However, those with lower initial physical activity levels do often respond better to programmes.

Areas that need further development based on qualitative research are:

- Increasing the length of break time, and improving access to physical activity facilities and equipment during breaks.
- Making changes to the school uniform policies, such as less restrictive uniforms and fewer clothing rules that discourage activity during break times.
- Active travel policies to promote walking or cycling.

Public Health England [88] has identified eight promising principles that schools should embed in any interventions designed to improve the levels of physical activity amongst its students, their families and carers (Figure 30).

[88] Public Health England: What Works in Schools and Colleges to Increase Physical Activity https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469703/What_works_in_schools_and_colleges_to_increas_physical_activity.pdf (2015)

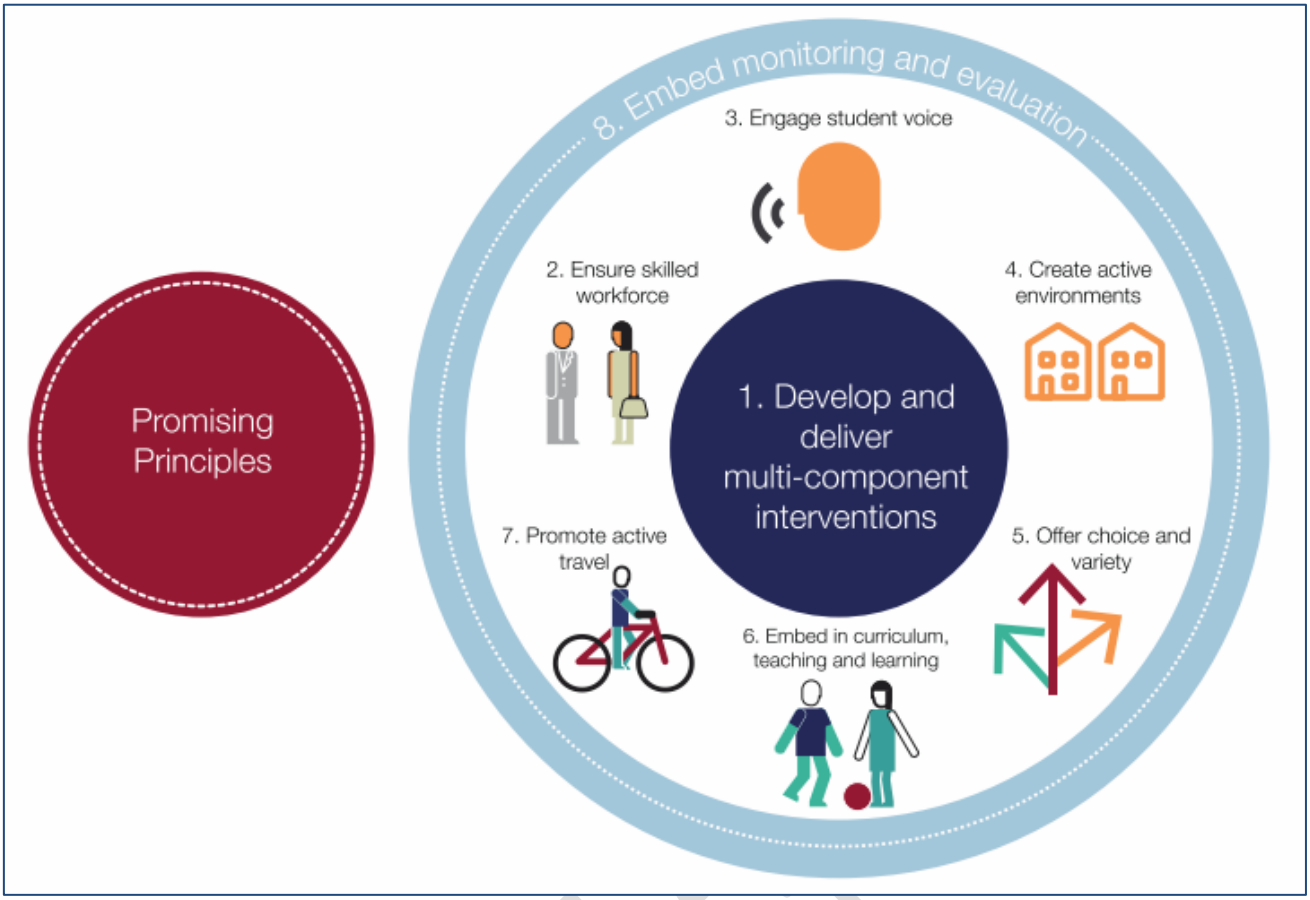


Figure 30 - Promising principles for practice: what works in schools and colleges to increase physical activity.

Source: Public Health England, 2015.

Across the country and in Cambridgeshire there are some promising examples of interventions that have an impact on levels of physical activity in schools that reflect these principles.

Change4Life Sports Club: A Multi-Component Approach[89]

The Featherstone Primary School in Birmingham with 278 students used the Change4Life Sports Club programme to develop its "Activ8" concept that is targeted at the least active children and their parents. By developing a unique and inspiring club environment it has been able to provide engaging and fun activities that build the confidence and competence of children to be more physically active.

The club helped engender a positive partnership with families, helping them to understand the wider benefits of physical activity and the links with learning. This has led to opportunities for parents and young people to be leaders in the club. The club is seen as an integral part of the wider curriculum offer for pupils, alongside the school food and PE curriculum and the school is now evaluating the impact on pupil achievement and attainment.

Positive reported outcomes include improvements in pupil attendance and behaviour, as well as greater levels of parental engagement and support for their children's learning. The children are increasing their levels of physical activity and self-esteem/resilience; they are making more progress in writing and reading, and are engaging more proactively with PE and after school clubs. Some children are also putting themselves forward for school council roles. The school is now developing the concept of its club to include celebration events and award ceremonies and is planning to expand the reach of the club to more year groups.

In Cambridgeshire there are a number of examples of physical activity interventions in the school setting. Cambridgeshire's County Sports Partnership – Living Sport, in partnership with Cambridgeshire County Council Public Health are delivering Change4life after-school clubs similar to the Featherstone School example. Schools with high obesity figures as recorded by the National Child Measurement Program (NCMP) are targeted. The clubs strive to create an exciting and inspirational environment for children to engage in school sport. Living Sport deliver an initial 10 weeks of sessions and provide training for school staff members to empower them to continue delivering these clubs themselves, with ongoing mentoring support.

14.2.1 Schools as a Healthy Food Environment

A number of school factors have been found to be effective in improving the diet of children[90].

- **Interventions need to be wide ranging reflecting a wide definition of the environment e.g. the curriculum or the locating of vending machines in schools.**
- **Adhering to National School Food Standards help provide children with a good overall diet. Nationally 85% of students reportedly eat school meals at lunchtime.**
- **Combining teaching about food in the curriculum and the use of school gardens has been shown to have positive effects of children's food consumption.**

School lunches have been identified as important in providing children with a good diet and should meet national school standards. [91]

[89] www.starttomovezone.com

[90] CEDAR: http://www.cedar.iph.cam.ac.uk/resources/evidence/eb-diet-and-schools-web/#sthash.q0pMdIYV.dpuf (2012)

Speedy Study - CEDAR

> The SPEEDY Study led by CEDAR used food diaries for identifying the benefits of school lunches. It found that food choices at school lunchtime made a significant contribution to overall diet, providing around a third of daily energy intake among children of primary school age. On average those usually taking school meals met current food-based standards for school lunches, whilst the food choices of packed lunch eaters were typically less healthy.

Vending machines can be used to influence children's snacking habits. The type of foods that should be available from vending machines is covered by the national standards, and pricing has been shown to influence purchases.

Nutritional education coupled with practical gardening lessons in a school garden has been seen to increase children's preference for fruit and vegetable intake. One study reported total fruit and vegetable consumption increasing from 1.9 to 4.5 servings following a combined intervention.

Studies which have changed the food provided by schools as well as implementing additional health education have seen decreases in percentage energy intake from fat.

"Top Grub"[92] an innovative approach to improving children's knowledge of food

> Researchers developed a healthy eating curriculum for primary schools that included a card game 'Top Grub'. The game comprises cards featuring different foods, their nutritional values and fun food facts. The result showed improvement in nutrition knowledge as well as diet, children enjoyed playing the game and teachers considered it to be useful.

Soil Association Food for Life (FFL)[93]

In Cambridgeshire the Food for Life Programme operates in a number of primary schools and offers a wide ranging programme. It is now piloting interventions in a number of nurseries.

[91] CEDAR http://www.cedar.iph.cam.ac.uk/resources/evidence/eb-diet-and-schools-web/#sthash.q0pMdIYV.dpuf
[92] Lakshman R.R., Sharo J., Ong K.K., Forouhi N.G. A novel school-based intervention to improve nutrition knowledge in children: cluster randomised controlled trial (2010)
[93] Food for Life Programme http://www.foodforlife.org.uk/what-is-food-for-life/our-impact

The Soil Association Food for Life Programme (FFL) is an evidence-based programme which across the country works in early year's settings, schools, hospitals and care homes helping them build knowledge and skills through a whole setting approach.

It adopts a practical approach focusing upon making good food the norm for everyone, reconnecting people with where their food comes from, teaching them how it is grown and cooked and championing the importance of well sourced ingredients.

It aims to engage professionals and the wider community in championing for long-term change.

All schools can enrol online for FFL membership or awards packages but in Cambridgeshire FFL is commissioned to provide 20 funded support packages to targeted schools in areas of higher need in the county. FFL schools benefit from a positive food culture across the whole school community.

14.3 The Workplace

The Workplace is an excellent setting to target the working age population, and provide interventions that promote physical activity and a healthy diet. Being active and having a healthy diet reduces the risk of ill health in all ages. Recent evidence from NICE[94] indicates a healthy lifestyle in those aged between 40 and 60, forming part of the workforce, is especially effective at reducing the risk of ill health in later life including dementia. The workplace is identified as an area where support should be offered to this age group.

Workplace programmes can help promote a healthy lifestyle and weight and is seen as a key setting for preventing and managing obesity. On average obese people take four extra sick days per year leading to considerable costly losses in productivity. For example in an organisation of 1000 employees who work the national average week of 39.1 hours and are paid the national average hourly wage of £15.52 there would be a loss of £126,000 per annum in productivity.

There is evidence that creating healthy workplace policies, leadership, champions, management framework, culture and interventions can create an environment that can improve employee health[95].

Workplace Programmes include a variety of interventions that support a healthy lifestyle and weight e.g. access to healthy food, physical activity programmes. The most robust evidence is for physical activity and mental health interventions. Mental health is associated with the adoption of a healthy lifestyle in terms of improving confidence and self-esteem which may be enabling for some individuals to make behavioural changes.

Both physical activity and mental health programmes in the workplace can be effective and cost saving. Increased levels of physical activity they are associated with increased productivity. The NICE Return on Investment (ROI) Tool found that a programme to increase physical activity amongst the inactive by 10% is able to produce savings[96]. Typical programmes are the previous mentioned travel plans, walking and cycling campaigns, a health check and brief interventions.

[94] NICE guidelines NG 16: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (2015) https://www.nice.org.uk/guidance/ng16
[95] Nice Guidelines NG 13: Workplace health: management practices 2015. https://www.nice.org.uk/guidance/ng13
[96] NICE Physical Activity ROI Tool

The NICE[97] tool for promoting mental health at work found that for an organisation of 1000 employees the annual cost of mental ill health was £835,000. Identifying problems and putting in interventions early is associated with savings of 30%. Typical programmes are the evidence based Mental Health First Aid and ACAS Training for managing a return to work after long term sickness.

There is an emerging evidence base of interventions to promote physical activity in the workplace which includes, for example, behavioural change approaches and different physical activities taking place in the workplace.

County Sports Partnership Network (CSPN) Workplace Challenge

The CSPN Workplace Challenge is a national programme supported by Sport England which aims to engage workplaces in sport and physical activity.

A motivational tool is used to encourage participants to be more active through online activity and the promotion of offline opportunities for participation.

The evaluation found that it had increased the uptake of physical activity amongst inactive individuals, increased communication in the workplace and motivated participants to try new activities.

In Cambridgeshire there is a Workplace Health Programme that involves Local Authorities, the NHS and the private sector. Workplaces are offered a number of interventions that includes those addressing physical activity. For example Travel Planning and Living Sport is offering workplaces a similar scheme to the CSPN Workplace Challenge

Cambridgeshire Workplace Challenge

Companies and organisations across Cambridgeshire and Peterborough are invited to take part in the 'Workplace Challenge'. The aim of the programme is to promote sport, physical activity and health improvements across the UK's workplaces. The Workplace Challenge is being delivered locally by Living Sport – Cambridgeshire's County Sports Partnership Network on a phased national roll out.

Businesses can sign up to record their sport and physical activity online to receive points – and points make prizes! But it's not about winning; 'spot prizes' are offered during the national eight week Activity Log challenge as part of a draw simply by taking part. During March 2015 to April 2016, the Cambridgeshire and Peterborough Workplace Challenge saw over 12,000 activities logged covering 54,000 miles 'travelled' in 13,000 hours across hundreds of different users and workplaces.

14.4 The Community Setting

Creating a whole community culture and ethos for a healthy lifestyle where individuals and communities take responsibility for their health requires building community capacity and skills. It is about creating a

[97] NICE Mental Health Business Tool

social environment that supports and enables community members to adopt healthy behaviours. People are more likely to be active if it is seen as 'normal', and if their friends and peers are also active.[98]

Actions that promote collaboration between community members have been found to be effective for promoting and the adoption of being physically active and healthy eating. A recent comprehensive series of evidence reviews found they have been especially effective where women and low income families have been involved.[99] [100] It also indicated that approaching health holistically and not focusing on one specific topic has been effective for engaging communities. However it should be noted that the evidence base for health outcomes from community engagement approaches is relatively undeveloped.

Key factors for engaging communities in health[101] [102]

- **Provision of support to build community partnerships and infrastructure for community engagement and delivery of interventions.**
- **Community-led or community collaboration projects which design, deliver and evaluate health interventions are associated with larger behavioural outcomes. Peer or lay delivery were especially effective.**
- **Good communications that support collective decision making.**
- **Professional support for training to build capacity and enable community delivery of interventions.**
- **Building and understanding of health issues in communities which could be through events.**

14.4.1 Physical Activity

Large, community-wide campaigns have been effective in increasing physical activity but only when supported by local level community activities.[103] These may be using local community venues to promote messages. Notices encouraging people to walk upstairs instead of taking a lift have been effective[104].

There are examples of evidence based interventions of which some are being offered in Cambridgeshire.

Parkruns

[98] Bauman AE, Reis RS, Sallis JF, Wells JC, Loos RJF, Martin BW (2012) Correlates of physical activity: why are some people physically active and others not? The Lancet 380: 258 - 271

[99] Brunton G., Caird J., Stokes G., Stansfield C., Kneale D., Richardson M., Thoms J., Community engagement for health via coalitions, collaborations and partnerships A systematic review Institute of Education EPPI-Centre report Review 1(2016)

[100] Brunton G. Caird J., Kneale D., Thomas J., Richardson M. A systematic review Institute of Education EPPI-Centre report Review 2(2016)

[101] Bagnell AM., South J., Trigwell J., Kinsella K., White J., Harden A. : Community engagement – approaches to improve health: map of the literature on current and emerging community engagement policy and practice in the UK. Centre for Health Promotion Research, Leeds Beckett University and Institute for Health and Human Development, University of East London . NICE Review 4 (2016)

[102] Harden A., Sheridan K., McKeown A., Dan-Ogos I., Bagnall AM. Evidence review of barriers to, and facilitators of, community engagement approaches and practices in the UK Review 5 (2016)

[103] Heath GW, Parra DC, Sarmiento OL, Andersen LB, Owen N, Goenka S, Montes F, Brownson RC (2012) Evidence-based intervention in physical activity: lessons from around the world. The Lancet 380: 272-81

[104] NICE (2008) Physical activity and the environment: NICE public health guidance 8.

Parkruns are organized, free, weekly, 5km timed runs around the world and there are a number in Cambridgeshire. They are open to everyone and are safe and easy to take part in.

These events take place in pleasant parkland surroundings and encourage people of all abilities to take part; from those taking their first steps in running to Olympians; from juniors to those with more experience.

Once established, these events are run wholly by volunteers and generate huge local community support, and interest to participate from those who would not normally look to join a running club.

In Cambridgeshire there are already a growing number of parkrun events, including Cambridge, Huntingdon, and Wimpole Estate each with hundreds of participants every week.

Walking that is linked to appropriate infrastructure should also be encouraged through community level walking programmes, promotions and events such as mass participation walking groups, community challenges and group community led walks[105].

Other interventions that have been found to be effective are free community classes such as fitness/ aerobics or fun activity sessions for children and young people. These have found to be especially effective for more deprived areas and older adults[106]. Cycling for transport and recreational purposes has been found to be effective if linked to national and local initiatives[107].

14.4.2 Healthy Eating in the Community

NICE[108] recommends working with shops, supermarkets, restaurants, cafes and voluntary community services to promote healthy eating choices that are consistent with existing good practice guidance and to provide supporting information. Local partnerships should encourage all local shops, supermarkets and caterers to promote healthy food and drink, for example by signs, posters, pricing and positioning of products.

There are examples of peer working to promote healthy eating though the creation of groups led by local community members. It is well evidenced that breastfeeding has a positive effect upon nutrition and health; it is also considered to be protective against obesity in childhood. It has been estimated that if 45% of babies were breastfed for four months and 75% breastfed on discharge from hospital £17 million could be saved per annum in treatment costs.

The strongest evidence for interventions to promote and increase breastfeeding uptake is for peer led support groups. Studies in Wigan and Bristol found breastfeeding rates had increased through the

[105] NICE (2012) Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation NICE public health guidance 41.
[106] Heath GW, Parra DC, Sarmiento OL, Andersen LB, Owen N, Goenka S, Montes F, Brownson RC (2012) Evidence-based intervention in physical activity: lessons from around the world. The Lancet 380: 272-81
[107] NICE (2012) Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation
[108] Obesity: working with local communities Public Health Guidelines 42 (2012)
https://www.nice.org.uk/guidance/ph42

introduction of peer led interventions[109]. Another study found that a net investment of £20,000 in a peer support scheme resulted in £5,500 in net societal benefits[110].

Cambridgeshire Breastfeeding Peer Groups

Currently there are Peer Breastfeeding Support Groups in Fenland, East Cambridgeshire and Huntingdonshire where there are lower rates of breastfeeding.

The peer supporters are voluntary lay women, recruited from the local community who have breastfed themselves and successfully completely additional accredited breastfeeding training that is provided by professionals. Trained peer supporters go on to recruit new members and form their own peer support groups.

In addition to supporting mothers to breastfeed. the peer programme also increases social networking opportunities, provides opportunities for the peer supporters to undertake further education or training and other voluntary roles in the community. It also builds relationships with professionals making them more aware of the contribution that the peer supporters make to the number of women who successfully breastfeed.

14.4.3 Disadvantaged Communities

Those with lower socioeconomic status are more likely to be overweight and obese. Research from CEDAR found that financial hardship (not having enough money to meet your needs or difficulty paying bills) is also associated with less healthy diets and obesity. The study part of the EPIC-Norfolk study focuses on the over 50s who experience economic hardship. Older people in particular were found to be vulnerable to financial hardships, commonly resulting from events they are more likely to experience such as divorce, death of spouse, or job loss. This could make them more susceptible to unhealthy diets leading to unhealthy weight. CEDAR recommends that well as wider strategies to tackle general health inequalities, interventions such as fuel assistance and money management programmes may be required to reduce th e impact of financial hardships on health[111].

[109] https://www.nice.org.uk/sharedlearning/wigan-breastfeeding-network-peer-support-service
[110] https://www.nice.org.uk/guidance/ph11/evidence/economic-report-modelling-the-cost-effectiveness-of-breast-feeding-369849855
[111] http://www.cedar.iph.cam.ac.uk/resources/evidence/eb8-financial-hardships-diet-obesity/#sthash.dTYsT6Fh.dpuf

15 Information and Skills for Healthy Behaviours

Key Interventions

- **Embed behavioural change techniques into interventions to promote physical activity and healthy diet e.g. brief interventions, motivational interviewing.**
- **Ensure that professionals, voluntary sector workers and community members have the skills to make behavioural change interventions to support healthy behavioural changes.**
- **Secure and embed social marketing intelligence into the design and implementation of campaigns and other promotional interventions.**

Central to the whole systems approach to healthy weight is behaviour change. Creating a supportive built and natural environment along with facilitative settings does not always result in the required behavioural changes in levels of physical activity and healthy eating. Evidenced based interventions for behavioural change focus upon the role of communications and professionals. They reflect underlying psychological models of human behaviour[112] that describe the interface between knowledge, attitudes and behaviour.

Changing behaviours at the individual, targeted/community or whole population level are addressed in the evidence to support behavioural change interventions. In NICE Guidance 6[113] a number of interventions were found to be effective in promoting behaviour change/encouraging positive behaviour across different health behaviours. These were counselling, physician advice, motivational techniques and mass media interventions.

15.1 Behavioural Change Interventions

The underpinning evidence in the NICE Public Health Guidance 49 identified learning, observational opportunities and problem solving interventions as being effective to promote the adoption of healthier eating habits. Tailoring interventions were found to be particularly important for pregnant women along with the provision of written materials and ongoing support[114].

Looked After Children and Community Chef

The Community Chef enterprise has been commissioned to work with Carers in Fostering and Adoption in Cambridgeshire to support healthy eating for Looked After Children (LAC).

Community Chef provides fun interactive cookery workshops and demonstrations to carers of LAC in Cambridgeshire. Adults have the opportunity to improve their cookery and nutrition skills. The session also provides them with the knowledge and confidence to prepare healthy food for their families. They get to eat the food prepared in the session too!

The three hour workshop is a chance to engage with other carers and understand the importance of supporting themselves and LAC to achieve a healthy diet. First delivered locally in 2015, the workshops proved to be popular and are being offered again in 2016.

[112] https://www.nice.org.uk/guidance/ph6/chapter/Appendix-C-the-evidence
[113] https://www.nice.org.uk/guidance/ph6/evidence/behaviour-change-review-1-effectiveness-review-369664525
[114] https://www.nice.org.uk/guidance/ph49/evidence/evidence-reviews-430402861

There are a range of interventions promoting physical activity that have behavioural change components. The NICE Public Health Guidance evidence indicates that they may include one or a combination of brief intervention, motivational techniques, specialist support, formal measurement and monitoring. Associated factors are the duration of the interventions and the level of support. There is also support although still equivocal for the use of pedometers in increasing physical activity[115].

The strongest evidence is for brief interventions in primary care there is also good evidence for home-based, group-based, and educational physical activity interventions on increasing physical activity among older people. Brief interventions are considered to be cost effective against doing nothing at cost of £20.19 to £19.44 per QALY[116].

Let's Get Moving Programme

'Let's get moving' is an evidenced based programme based on the provision of brief interventions in primary care to increase physical activity. The Department of Health developed and launched the 'Let's get moving' physical activity care pathway in 2009.This care pathway endorses use of the general practitioner physical activity questionnaire (GPPAQ) to identify inactive patients in primary care. It includes a brief intervention based on the principles of motivational interviewing to help all those classified as less than active to change their behaviour along with a referral to an appropriate physical activity programme.

Most of Cambridgeshire has an exercise referral scheme which is targeted at those with an underlying medical condition. See below for Treatment Interventions

Making Every Contact Count (MECC) [117] is based on behavioural change theory. Its approach is to utilize interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations.

Cambridgeshire Behaviour Change Training Programme

In Cambridgeshire there is MECC or Behaviour Change Training Programme (BCTP) that is embedded within the countywide Lifestyle Service, provided by Everyone Health. The training incorporates MECC along with other behaviour change models and theories.

BCTP is open to professionals and non-professionals across Cambridgeshire. In particular any front-line staff – those in direct contact with the general public - are a key group to attend training. It is based around healthy lifestyles and encourages people to motivate others to change through very brief interventions which fit easily alongside their full-time role.

The BCTP will also be further developed to offer a Train-the-Trainer approach. This will create an opportunity to train a wider number of people and thus reach a greater number to elicit positive lifestyle changes. BCTP is a three hour session with signposting to further, more specific topics via e-learning.

[115] N
[116] h
[117] Public Health England Making Every Contact Count (MECC): implementation guide (2016)

15.2 Campaigns and Communications

Social Marketing

The use of social marketing techniques for changing health behaviour has become increasing common and reflects a supportive evidence base. Social marketing is used in the design and implementation of interventions usually using segmenting techniques. They identify what are motivating factors for people and the different channels and activities that could be used to elicit behaviour change. Reviews [118] of social marketing have found that its principles can be effective. Although the evidence for social marketing techniques influencing physical activity is deemed to be less effective than the strong evidence that it can increase fruit and vegetable consumption and improve dietary knowledge and psychosocial factors associated with diet.

There is also evidence that interventions have had some effects on the behaviour of retailers, and to have encouraged adoption of policies and other environmental-level changes.

16 Recommended Actions

A range of actions are needed to address unhealthy weight and to reduce the current levels of obesity. Whilst some action requires national intervention the Strategy actions will focus on local interventions.

Strategic support for the recommended actions will be secured from local boards. An implementation plan will be developed with and agreed by partners and resource identified.

[118] Stead M., McDermott L., Hastings K.& A.& G.: Marketing Review Stirling University for NICE 2006

17 Glossary

Active Adult: Adults doing at least 150 minutes moderate activity per week.

Body Mass Index (BMI): Body mass index is defined as a person's weight in kilograms divided by the square of their height in metres and is reported in units of kg/m2. Specific cut-off points are used to assess whether a person is; underweight, healthy weight, overweight or obese.

In adults the following table shows the cut-off points for adult weight classifications.

Classification	BMI (kg/m^2)
Underweight	Less than 18.5
Heathy Weight	18.5 – 24.9
Overweight	25 – 29.9
Obese	30 or more

In children and young people BMI centiles are used to indicate weight classifications. Cut-off points for weight classifications are calculated related to age and gender using UK 1990 BMI charts for children.

Excess weight: Excess weight includes overweight and obese persons. Excess weight in adults is a Body Mass Index (BMI) of 25 kg/m2 or more. In children this is a BMI greater than or equal to 85 centile on UK 1990 BMI charts for children.

Healthy Weight: Healthy weight in adults is classified as a Body Mass Index (BMI) between 18.5 kg/m2 to 24.9 kg/m2. In children healthy weight BMI centiles are between the 2nd and 85th centile using UK 1990 BMI charts for children.

Inactive Adult: Adults not achieving at least 30 minutes moderate activity per week.

Malnutrition: For the purposes of this Strategy malnutrition refers to under nutrition (consuming too few nutrients). An adult is considered to be malnourished if they have any of the following;

- A BMI of less than 18.5kg/m2.
- Unintentional weight loss greater than 10% within the last three to six months.
- A BMI of less than 20kg/m2 and unintentional weight loss greater than 10% within the last three to six months.

In Children underweight is below the 2nd centile using UK 1990 BMI charts for children.

National Child Measurement Programme (NCMP): The National Child Measurement Programme (NCMP) measures the weight and height of children in Reception (aged four to five) and Year 6 (aged 10 to 11) in England on an annual basis. The aim is to assess the prevalence of obesity and overweight among children of primary school age by local authority area. These data can be used at a national level to support local public health initiatives and inform local services for children.

Obesogenic Environment: This term refers to environmental factors and the role they may play in determining nutrition and physical activity.

Overweight or Obese Adults: Body Mass Index (BMI) is commonly used to assess adult weight. The following table shows the cut-off points for adult weight classifications; underweight, healthy weight, overweight and obese.

Overweight or Obese Children: More than one classification system is used in the UK to define

whether children are overweight or obese.

The National Child Measurement Programme (NCMP) for primary care states that Body Mass Index (BMI) should be plotted onto a gender-specific BMI chart for children (UK 1990 chart for children older than four years). Children over the 85th centile and on or below the 95th centile are categorised as overweight. Children over the 95th centile are classified as obese. Other surveys such as the Health Survey for England also use this system.

In clinical practice the 91st and 98th centiles may be used to define 'overweight' and 'obese' respectively. Children on or above the 98th centile may also be described as very overweight. See Public Health England's 'A simple guide to classifying body mass index in children'.

Physical Activity: The full range of human movement, from active hobbies, walking, cycling and the other physical activities involved in daily living, such as walking upstairs, gardening and housework to competitive sport and exercise. (**See Appendix 2**).

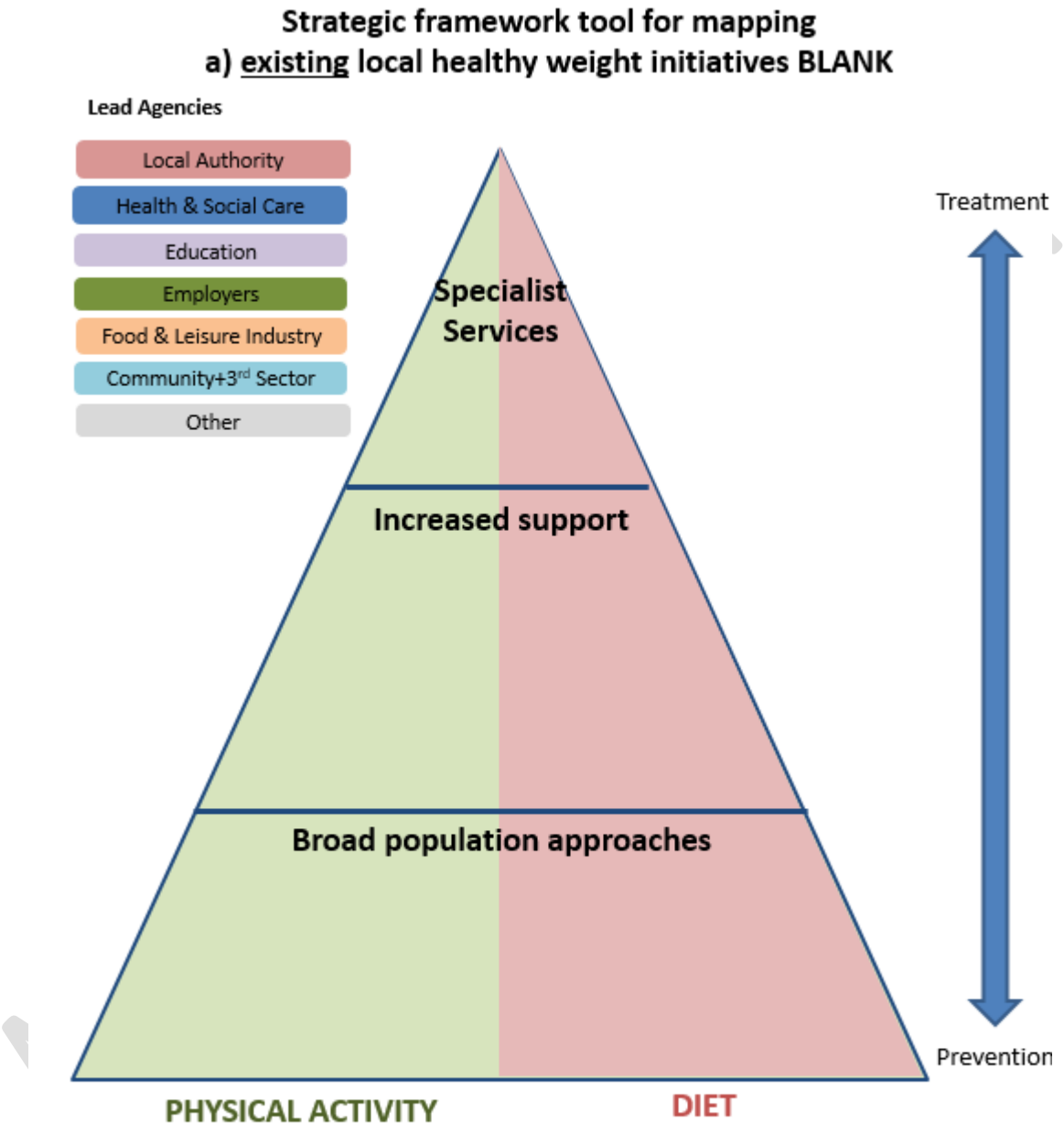
Physical Inactivity: 'Inactive' is defined as not currently meeting the Chief Medical Officer's recommendation for physical activity as outlined in 'Start active, stay active: a report on physical activity from the four home countries' Chief Medical Officers (Department of Health, 2011). (**See Appendix 2**).

Sedentary Behaviour: Sedentary behaviour describes activities that do not increase energy expenditure much above resting levels. Sedentary activities include sitting, lying down and sleeping. Associated activities such as watching television are also sedentary.

18 Appendices

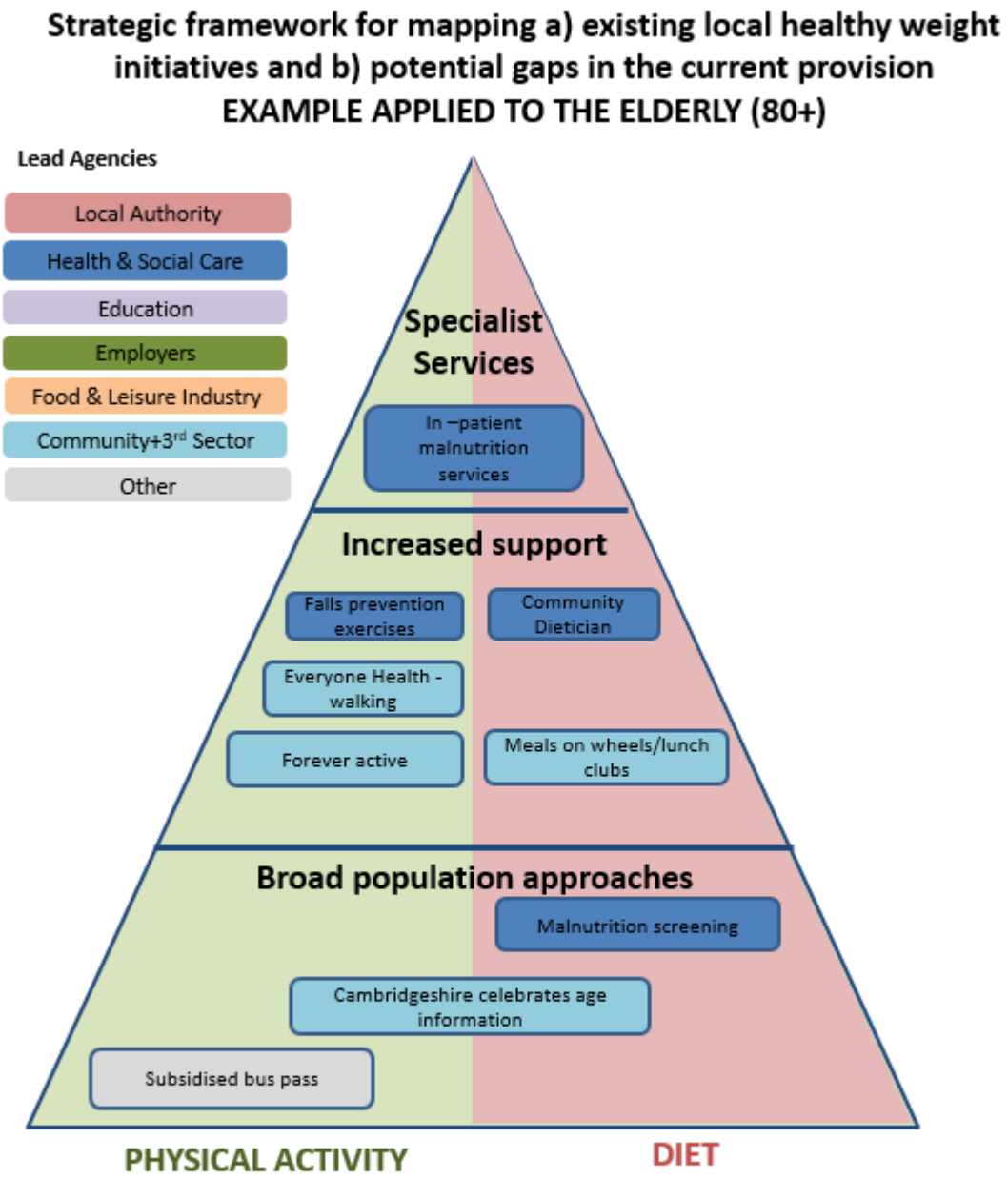
18.1 Appendix 1: Strategic Framework Tool

18.1.1 Strategic Framework Tool Blank



Key stages across the life course					
Early Years	Children & Young People	Adults	Mid life Adults	Older Adults	Elderly
0-5 years	- 5-11 years - 12-18 years	19-39	40-64	65-79 years	80+ years

18.1.2 Strategic Framework Tool Example Applied to the Elderly



Gaps

- Community knowledge around health weight in the elderly
- Primary care knowledge and identification
- Dental health and identification of malnutrition
- Nutrition and dementia
- Hospital discharge support
- Local, easy access shops

18.2 Appendix 2: The Chief Medical Officer's Guidelines on Physical Activity[119]

For early years (under-fives)

1. Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.
2. Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (three hours), spread throughout the day.
3. All under-fives should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

These guidelines are relevant to all children under five, irrespective of gender, race or socio-economic status, but should be interpreted with consideration for individual physical and mental capabilities.

For children and young people (five to 18 years):

1. All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.
2. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week.
3. All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

Based on the evidence, the guidelines can be applied to disabled children and young people, emphasising that they need to be adjusted for each individual based on that person's exercise capacity and any special health issues or risks.

For adults:

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2. 5 hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least five days a week. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.
2. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
3. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Based on the evidence, the guidelines can be applied to disabled adults, emphasising that they need to be adjusted for each individual, based on that person's exercise capacity and any special health or risk issues.

[119] Department of Health (2011). *Start Active, Stay Active: A report on physical activity from the four home countries'* Chief Medical Officers. Available at: https://www.gov.uk/government/publications/start-active-stay-active-a-report-on-physical-activity-from-the-four-home-countries-chief-medical-officers

Most of the interventions highlighted have been shown to be effective and achievable Everybody active, every day – the evidence (PHE (2014) From evidence into action: opportunities to protect and improve the nation's health. PHE)

For older adults (65-plus years):

1. Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.

2. Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (two hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least five days a week.

3. For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.

4. Older adults should also undertake physical activity to improve muscle strength on at least two days a week.

5. Older adults at risk of falls should incorporate physical activity to improve balance and coordination on at least two days a week.

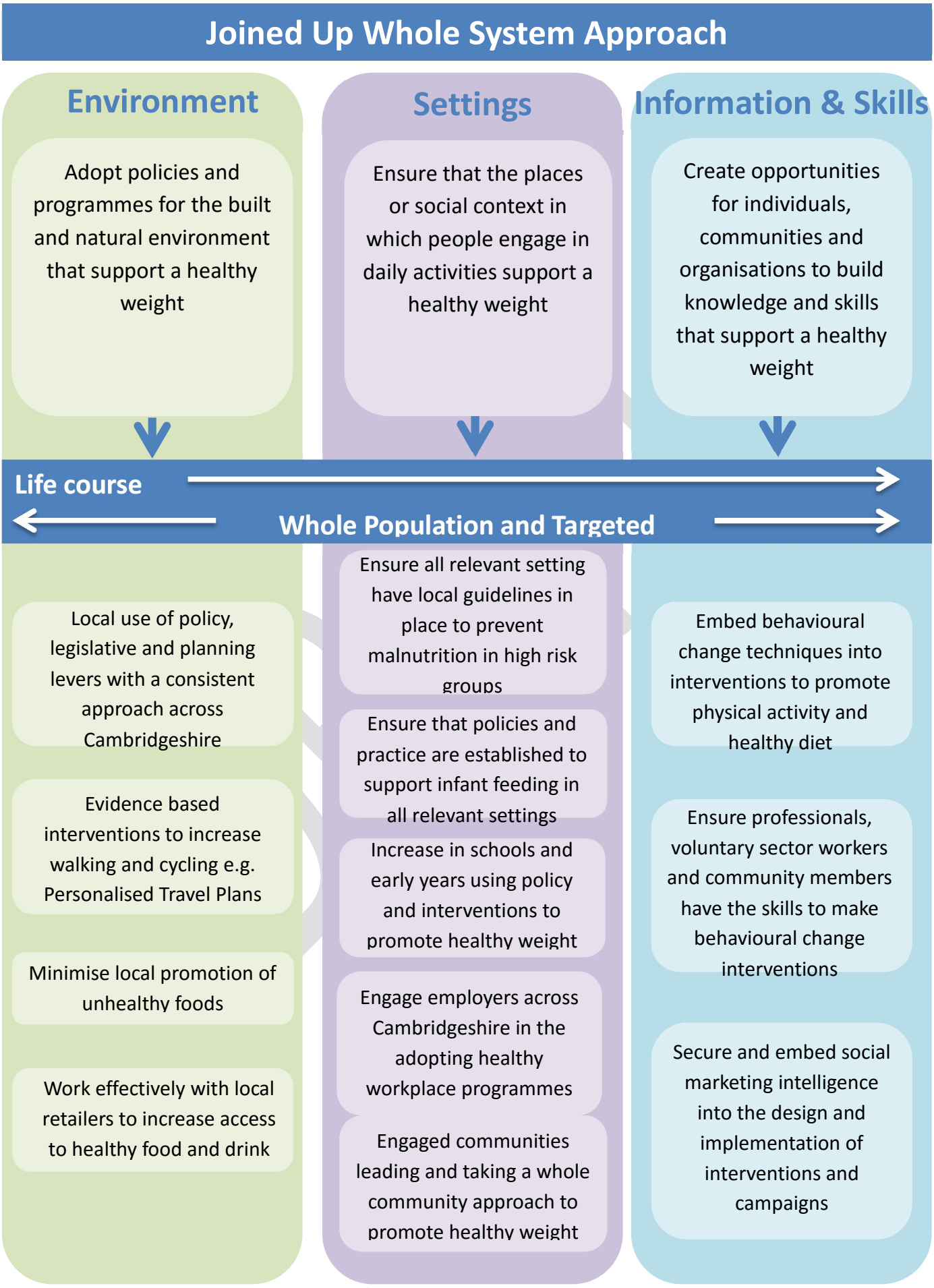
6. All older adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

Based on the evidence, the guidelines can be applied to disabled older adults emphasising that they need to be adjusted for each individual based on that person's exercise capacity and any special health or risk issues.

CAMBRIDGESHIRE HEALTHY WEIGHT STRATEGY – IMPLEMENTATION PLAN
Year 1

Below is the "Strategy on a page" that captures the central approach of the Cambridgeshire Healthy Weight Strategy.

This document describes the key actions that have been identified for taking forward the implementation of the Healthy Weight Strategy during its first year.


Joined Up Whole System Approach
Environment
Adopt policies and programmes for the built and natural environment that support a healthy weight
Settings
Ensure that the places or social context in which people engage in daily activities support a healthy weight
Information & Skills
Create opportunities for individuals, communities and organisations to build knowledge and skills that support a healthy weight
Life course
Whole Population and Targeted
Local use of policy, legislative and planning levers with a consistent approach across Cambridgeshire
Evidence based interventions to increase walking and cycling e.g. Personalised Travel Plans
Minimise local promotion of unhealthy foods
Work effectively with local retailers to increase access to healthy food and drink
Ensure all relevant setting have local guidelines in place to prevent malnutrition in high risk groups
Ensure that policies and practice are established to support infant feeding in all relevant settings
Increase in schools and early years using policy and interventions to promote healthy weight
Engage employers across Cambridgeshire in the adopting healthy workplace programmes
Engaged communities leading and taking a whole community approach to promote healthy weight
Embed behavioural change techniques into interventions to promote physical activity and healthy diet
Ensure professionals, voluntary sector workers and community members have the skills to make behavioural change interventions
Secure and embed social marketing intelligence into the design and implementation of interventions and campaigns

CAMBRIDGESHIRE HEALTHY WEIGHT STRATEGY 2016-2019 IMPLEMENTATION PLAN YEAR 1

Environment *Adopt policies and programmes for the built and natural environment that support a healthy weight.*					
	Action	**Organisations**	**Timescales**	**Outputs**	**Resources**
Overarching Priority- System Wide Approach	a) Identify where Healthy Weight Strategy supports other key strategies and initiatives across the whole system e.g. STP, Older People, 0-19 Programme, New Communities	Whole system	Year 1	Evidence of initiatives that support the Healthy Weight Strategy and other key developments in the system identified e.g. training Alignments and subsequent action agreed.	Within existing resources
Priority 1. *Local use of policy, legislative & planning levers with a consistent approach across Cambridgeshire*					
1.1.	Build on current work of developing public health policies in district councils. Identify opportunities in local planning legislation for strengthening policies that support healthy lifestyles e.g. open spaces, fast food outlets. Initial focus upon: a) New communities/building developments b) Standardised requirements for new building requirements c) Environmental health policies	CC ECDC FDC SCDC HDC Public Health	Evidence of a minimum of two policy changes in year 1	Introduction of supportive planning policies	Minimal possible training costs.

Priority 2. Evidence based interventions to increase walking & cycling					
2.1	a) Deliver the countywide Physical Activity Programme over the next two years. b) Attract additional funding for physical activity programmes. c) Evaluate the Programme	CC ECDC FDC SCDC HDC Living Sport CCC Public Health	May 2017 – April 2019	Programme KPIs achieved Evaluation completed	Finding already allocated
2.2	Travel to work programmes have been established for some time in Cambridgeshire. a) Map out where these have been provided, uptake and whether there has been any evaluation b) Complete the commissioned TTW Plans commissioned from Atkins. c) Develop the publicity of these schemes to improve take up.	CCC Public Health CCC ETE Local statutory and private sector employers	Year 1	Review of previous work completed and areas for development identified. All commissioned work completed Link TTW to Healthy Workplace Programme	Funding allocated for commissioned work Staff time to co-ordinate review
Priority 3. Work effectively with local retailers to increase access to healthy food & drink					
3.1	a) Expand the existing Healthier Options initiative countywide and increase the number and range of food outlets engaged by 10% per annum. 4% in Fenland. b) Look for opportunities to develop HO for other settings e.g. early years, children's centres, clubs. c) Brand already sold to other LA's that will support the expansion of the Programme. Increase the number of LAS buying the brand.	CC ECDC FDC SCDC HDC CCC Public Health Local retailers Organisations across the system e.g. NHS hospitals	Year 1	10% increase in Healthier options outlets. Minimum of 1 new setting introduced	Funding secured

Priority 4. Minimise local promotion of unhealthy foods					
4.1	a) Communication plan developed that will ensure an ongoing programme that supports all elements of the Healthy Weight Strategy and is countywide as well as local. b) Range of media and proactive social media used regularly	CCC Communications and Public Health Partner organisations – communication teams	Year 1	Communications plan supported by key partner organisations.	Could require some funding but should use established channels.
Settings *Ensure that the places or social context in which people engage in daily activities support a healthy weight*					
	Action	**Lead Organisation**	**Timescales**	**Outputs**	**Resources**
Priority 1. Increase in schools and early years using policy and interventions to promote healthy weight (see priority 4)					
1.1	a) Establish the daily mile initiative in a number of early years settings and schools across the county.	Living Sport CCC Children's Innovation and Development Service CCC Public Health	Year 1	Minimum of five schools and five nurseries recruited	None perhaps a small amount to promote the scheme
Priority 2. Engage communities in taking a leadership role and whole community approach to promote healthy weight					
2.1	a) Introduce healthy weight behaviours through time credits and time banking programmes.	CCC Community Engagement team	Year 1	% TBC of time credits and timebanking awarded for activities that support the Healthy Behaviours	No additional resources though could require PH time to support this development initially
2.2	a) Embed policies and actions into district council community engagement plans to encourage healthy weight behaviours.	CC ECDC FDC SCDC HDC CCC Public Health	Year 1	Evidence in all the districts of community engagement plans that support a healthy weight	Some public health support to districts to identify opportunities and provide the

					evidence
2.3	a) Local community clubs including sports clubs to ensure that they provide clear healthy eating and physical activity messages e.g. snack provision at clubs.	CCC Public Health Living Sport	Year 1	Evidence of a minimum of 5 community initiatives that have made changes in support of healthy eating.	CCC Public Health District Councils provide support to communities
2.4	a) Work with food banks to develop healthy food options for users using the available products. b) Provide information and training for staff to enable them to give advice about healthy eating within foodbank constraints. c) Provide information for donors about appropriate healthy foods	CCC Public Health Local Foodbank leads e.g. Churches	Year 1	Information and training provided to a minimum of 50% of the foodbanks	CCC Public Health time to develop programme Everyone Health Countywide Lifestyle Service to deliver training etc.(currently commissioned-in service specification)
2.5	The Healthy Fenland Fund supports communities to develop activities that support health improvement including healthy eating and physical activity a) The Programme supports communities to develop projects that support a healthy weight	Care Network Cambridgeshire Community Foundation CCC Public Health	Year 1	20% of projects funding support a healthy weight	Funding allocated

Priority 3. Engage employers across Cambridgeshire in the adopting healthy workplace programmes					
3.1	Work Healthy Cambridgeshire already includes the promotion of healthy eating in the workplace a) Local employers take up offer of support to introduce healthy eating policies into their workplaces	CCC Public Health Workplace Programme	Year 1	A minimum of 3 employers introduce healthy eating initiatives	Funding allocated
Priority 4. Ensure that policies and practice are established to support infant feeding and healthy eating amongst school children					
4.1	a) Develop a service specification for a school based programme that will promote a range of healthy lifestyles (incorporate the Food for Life programmes and other physical activity initiatives) to be commissioned for 2018/19 b) Secure support and agreement to establish a community Baby Friendly Initiative c) Expand the peer breastfeeding programme	CCC Public Health	Year 1	Service commissioned to start in 2018/19	Additional funding may be required for the breastfeeding initiatives.
Priority 5. Ensure all relevant setting have local guidelines in place to prevent malnutrition in high risk groups					
	TBC				

Information & Skills *Create opportunities for individuals, communities and organisations to build knowledge and skills that support a healthy weight*					
	Action	**Lead Organisation**	**Timescales**	**Outputs**	**Resources**
Priority 1. Ensure professionals, voluntary sector workers and community members have skills to make behavioural change interventions					
1.1	a) Increase take up of Making Every Contact Count/Behaviour Change training across all sectors for frontline staff. b) Provide training to frontline staff to enable them to support individuals to think about changing their health behaviours	Public Health All organisations statutory and voluntary in the system	Year 1	Training Provided to: NHS LAs Vol Orgs. Number TBC	Training provided by Everyone Health (currently commissioned - in service specification)
Priority 2. Embed behavioural change techniques in to interventions to promote physical activity and healthy diet					
2.1	a) Target training for staff working in settings that provide opportunities to promote a healthy diet and physical activity - Leisure services - Early years and schools - Voluntary sector programmes - Specific mental health services to promote physical activity	DAs Private leisure providers CCC CFA Early Years Vol Orgs MH Services Catering services – schools etc.	Year 1	Training provided to minimum of 5 different settings	Training provided by Everyone Health (currently commissioned - in service specification)
Priority 3. Secure and embed social marketing intelligence in to the design and implementation of intervention and campaigns					
3.1	a) Develop a communications plan to include a toolkit for supporting communities and organisations to share key messages of the Strategy.	CCC Public Health	Year 1	Evidence that partners have used the toolkit to help them introduce initiatives that support the Healthy Weight Strategy	No additional resources required for the resource production

Agenda Item No: 5

FINANCE AND PERFORMANCE REPORT – JULY 2017

To:	**Health Committee**
Meeting Date:	**7 September 2017**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the July 2017 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of July 2017.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of July 2017.**

Officer contact:		***Member contact:***
Name:	Chris Malyon	Name: Councillor Peter Hudson
Post:	Chief Finance Officer	Post: Chairman
Email:	LGSS.Finance@cambridgeshire.gov.uk	Email: Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 507126	Tel: 01223 706398

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE JULY 2017 FINANCE & PERFORMANCE REPORT

2.1 The July 2017 Finance and Performance report is attached at Appendix 1.

2.2 A balanced position is forecast for the Public Health Directorate for 2017/18.

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

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

The July 2017 Finance and Performance report (F&PR) is attached at Appendix 1 and shows the forecast outturn for the Public Health Directorate is a balanced position.

Further detail on the outturn position can be found in Appendix 1.

2.3 The Public Health Service Performance Management Framework for June 2017 is contained within the report. Of the twenty nine Health Committee performance indicators, three are red, six are amber, seventeen are green and three have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Statutory, Risk and Legal Implications

4.2.1 There are no significant implications for this priority

4.3 Equality and Diversity Implications

4.3.1 There are no significant implications within this category.

4.4 Engagement and Consultation Implications

4.4.1 There are no significant implications within this category.

4.5 Localism and Local Member Involvement

4.5.1 There are no significant implications within this category.

4.6 Public Health Implications

4.6.1 There are no significant implications within this category.

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

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

From: Martin Wade

Tel.: 01223 699733

Date: 09 Aug 2017

Public Health Directorate

Finance and Performance Report – July 2017

1 SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
Jun (No. of indicators)	3	6	17	3	29

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Jun) £000	Service	Current Budget for 2017/18 £000	Current Variance £000	Forecast Variance - Outturn (Jul) £000	Forecast Variance - Outturn (Jul) %
0	Children Health	9,200	-17	0	0%
0	Drug & Alcohol Misuse	5,845	-11	0	0%
0	Sexual Health & Contraception	5,297	-25	0	0%
0	Behaviour Change / Preventing Long Term Conditions	3,638	23	0	0%
0	General Prevention Activities	56	-8	0	0%
0	Adult Mental Health & Community Safety	263	-0	0	0%
0	Public Health Directorate	2,421	-165	0	0%
0	**Total Expenditure**	**26,720**	**-203**	**0**	**0%**
0	Public Health Grant	-26,041	0	0	0%
0	s75 Agreement NHSE-HIV	-144	216	0	0%
0	Other Income	-149	51	0	0%
0	Drawdown From Reserves	0	0	0	0%
0	**Total Income**	**-26,334**	**267**	**0**	**0%**
0	**Net Total**	**386**	**64**	**0**	**0%**

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

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

2.2 Significant Issues

There are currently no over or underspends expected within the Public Health Directorate. A balanced budget was been set for the financial year 2017/18. Savings totalling £606k have been budgeted for and the achievement of savings will be monitored through the monthly savings tracker, with exceptions being reported to Heath Committee and any resulting overspends reported through the monthly Finance and Performance Report.

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

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

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

Sexual Health

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

Smoking Cessation

- The smoking cessation target was met for 2016/17. The data records 4186 people setting a quit date with 2,249 people stopping smoking. Locally this translates to a 54% quit rate which is comparable to the national quit rate.
- The performance indicators for 2017/18 are green.

National Child Measurement Programme

- The programme has been completed for 2016/17 academic year and the coverage target was met.
- The measurement programme for 2017/18 will commence in September 2017, measurements are undertaken during school term.

NHS Health Checks

- From the indicators reported on this month the number of NHS Health Checks completed is red but the number of outreach health checks carried out is amber.
- The introduction of new software will increase the accuracy of the number of invitations sent out for NHS health checks. The commentary provides further explanation.

Lifestyle Services

- From the 14 Integrated Lifestyle Service indicators reported the overall performance shows ten green, three amber and one red indicators. There is a marked improvement on the previous months performance.
- Performance around falls prevention has improved from last month with the number of referrals indicator moving from red to green.

Health Visitor and School Nurse Data

- The overall performance indicators for Health Visiting and School Nursing show three green, two amber and one red indicator.
- Health Visiting data is reported on quarterly and this data provided reflects the quarter 1 period for 2017/18 (April-June). The antenatal checks have fallen below the 50% target resulting in a red indicator. The commentary provides explanations on how this is being addressed.

4.2 Health Committee Priorities (Appendix 7)

Health Inequalities – Smoking Cessation

- Provisional end of year data for 2016/17 was analysed for smoking cessation, although this did not include late returns.
- The percentage of the smoking quit target achieved was:
  - 86% in the least deprived 80% of GP practices
  - 91% in the most deprived 20% of GP practices
  - 88% overall (not including late returns)
- Because the most deprived 20% of GP practices are given more challenging smoking cessation targets than others and have a higher level of achievement

against target, the figures indicate that smoking cessation resources are being appropriately targeted to address health inequalities.

Health Inequalities – Health Checks

- End of year date for 2016/17 has been analysed
- The RAG status for health check target achievement overall was amber (within 10% of the target), but red (more than 10% away from the target) for the most deprived 20% of practices.
- The percentage of the health check target achieved was:
  - 106% in the least deprived 80% of practices
  - 81% in the most deprived 20% of practices
  - 98% overall.

Mental Health - Number of front line staff that have taken part in Mental Health First Aid(MFHA) and MHFA Lite commissioned training

- The contract with an external provider to deliver this training finished at the end of October 2016, however a range of training will continue to be offered via different channels and models of delivery.
  - MHFA (2 day course) attendance: 398
  - MHFA Lite (1/2 day) attendance: 216

4.3 Health Scrutiny Indicators (Appendix 8)

- The data format presented for Delayed Transfer of Care has changed. The data for Hinchingbrooke Hospital & Peterborough & Stamford Hospital shows a declined in DTOCs, increases in DTOC for Cambridgeshire residents are still evident for Addenbrookes Hospital.

4.4 Public Health Services provided through a Memorandum of Understanding with other Directorates

Directorate	YTD (Q1) expected spend	YTD (Q1) actual spend	Variance
CFA	£82,750	£82,750	0
ETE	£30,000	£30,359	-£359
CS&T	£58,500	£58,500	£0
LGSS	£55,000	£55,000	£0
TOTAL Q1	**£226,250**	**£226,609**	**-£359**

- The Q1 figures for CFA may change, as we are still awaiting information on spend from Children's Centres.
- The overspend shown against ETE is based on work undertaken on Illicit Tobacco. This quarter is higher than predicted due to the follow up from raids in February and at the end of March. 3rd quarter spend likely to be mainly on co-ordinated project work with Peterborough based TS colleagues and HMRC.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Jun) £'000	Service	Current Budget for 2017/18 £'000	Expected to end of Jul £'000	Actual to end of Jul £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Jul) £'000	Forecast Variance Outturn (Jul) %
	Children Health							
0	Children 0-5 PH Programme	7,253	1,887	1,887	0	0.00%	0	0.00%
0	Children 5-19 PH Programme - Non Prescribed	1,947	513	496	-17	-3.32%	0	0.00%
0	Children Mental Health	0	0	0	0	0.00%	0	0.00%
0	**Children Health Total**	**9,200**	**2,400**	**2,383**	**-17**	**-0.71%**	**0**	**0.00%**
	Drugs & Alcohol							
0	Drug & Alcohol Misuse	5,845	1,258	1,247	-11	-0.88%	0	0.00%
0	**Drugs & Alcohol Total**	**5,845**	**1,258**	**1,247**	**-11**	**-0.88%**	**0**	**0.00%**
	Sexual Health & Contraception							
0	SH STI testing & treatment – Prescribed	3,975	712	705	-7	-1.03%	0	0.00%
0	SH Contraception - Prescribed	1,170	-49	-62	-13	-27.21%	0	0.00%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	38	34	-4	-11.15%	0	0.00%
0	**Sexual Health & Contraception Total**	**5,297**	**701**	**676**	**-25**	**-3.54%**	**0**	**0.00%**
	Behaviour Change / Preventing Long Term Conditions							
0	Integrated Lifestyle Services	1,732	44	43	-1	-1.80%	0	0.00%
0	Other Health Improvement	281	39	34	-5	-13.51%	0	0.00%
0	Smoking Cessation GP & Pharmacy	828	-63	-36	28	43.72%	0	0.00%
0	Falls Prevention	80	0	0	0	0.00%	0	0.00%
0	NHS Health Checks Prog – Prescribed	716	186	187	1	0.54%	0	0.00%
0	**Behaviour Change / Preventing Long Term Conditions Total**	**3,638**	**206**	**228**	**23**	**10.98%**	**0**	**0.00%**
	General Prevention Activities							
0	General Prevention, Traveller Health	56	33	25	-8	-23.22%	0	0.00%
0	**General Prevention Activities Total**	**56**	**33**	**25**	**-8**	**-23.22%**	**0**	**0.00%**
	Adult Mental Health & Community Safety							
0	Adult Mental Health & Community Safety	263	0	0	-0	0.00%	0	0.00%
0	**Adult Mental Health & Community Safety Total**	**263**	**0**	**0**	**-0**	**0.00%**	**0**	**0.00%**

Forecast Variance Outturn (Jun) £'000	Service	Current Budget for 2017/18 £'000	Expected to end of Jul £'000	Actual to end of Jul £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Jul) *£'000*	Forecast Variance Outturn (Jul)
	Public Health Directorate							
0	*Public Health - Admin & Salaries*							
0	Health Improvement	462	186	174	-12	-6.45%	0	0.00%
0	Public Health Advice	713	238	219	-19	-7.85%	0	0.00%
0	Health Protection	221	74	79	5	7.24%	0	0.00%
0	Childrens Health	58	19	21	2	8.62%	0	0.00%
0	Comm Safety, Violence Prevention	22	7	3	-4	-59.09%	0	0.00%
0	Public Mental Health	127	42	29	-13	-31.50%	0	0.00%
0	Drug & Alcohol Misuse	151	50	11	-39	-78.15%	0	0.00%
	Cross Directorate Costs	667	222	138	-84	-37.93%	0	0.00%
0		**2,421**	**839**	**674**	**-165**	**-19.65%**	**0**	**0.00%**
0	**Total Expenditure before Carry forward**	**26,720**	**5,437**	**5,234**	**-203**	**-3.73%**	**0**	**0.00%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0.00%**
	Funded By							
0	Public Health Grant	-26,041	-13,247	-13,247	0	0.00%		0.00%
0	S75 Agreement NHSE HIV	-144	0	216	216	0.00%		0.00%
0	Other Income	-149	-51	0	51	100.00%		0.00%
	Drawdown From Reserves				0	0.00%		0.00%
0	**Income Total**	**-26,334**	**-13,298**	**-13,031**	**267**	**2.01%**	**0**	**0.00%**
0	**Net Total**	**386**	**-7,861**	**-7,797**	**64**	**0.82%**	**0**	**0.00%**

APPENDIX 2 – Commentary on Expenditure Position

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

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

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

Awarding Body : DofH

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

APPENDIX 4 – Virements and Budget Reconciliation

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

APPENDIX 5 – Reserve Schedule

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

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

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

APPENDIX 6 PERFORMANCE

More than 10% away from YTD target	Below previous month actual
Within 10% of YTD target	No movement
YTD Target met	Above previous month actual

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

Measures										
Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	99%	99%	G	99%	98%	99%	↔	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	91%	91%	G	92%	80%	91%	↓	
Number of Health Checks completed	18,000	4,000	3,810	85%	R	N/A	4500	85%	↔	The comprehensive Improvement Programme is continuing this year with an extensive promotional campaign in high risk areas and the introduction of the new software into practices has commenced which will increase the accuracy of the of the number of invitations that are sent for NHS Health Check. There is also ongoing training of practice staff.
Number of outreach health checks carried out	2,000	245	235	96%	A	67%	60	85%	↑	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. Workplaces in the South of the county are performing well. However it has not been possible to secure access to the factories in Fenland where there are high risk workforces. This has affected overall performance. Engaging workplaces in Fenland is challenging with in excess of 100 workplaces and community centres contacted with very little uptake. There is a need to secure high level support that could be from an economic development perspective, if employers are to be effectively engaged.This would reflect the evidence that supporting employee health and well being brings cost benefits to businesses.
Smoking Cessation - four week quitters	2278	126	152	121%	G	N/A	126	121%	↔	The smoking cessation target number was met for 2016/17 with 4186 people setting a quit date and 2249 people actually stopping smoking. A 54% quit rate which is roughly the same as the national figure • The most recent Public Health Outcomes Framework figures (June 2017data for 2016) suggest the prevalence of smoking in Cambridgeshire has decreased remaining at a level statistically similar to the England average (15.2% v. 15.5%). Smoking rates in routine and manual workers remain consistently higher than in the general population (26.8% in Cambridgeshire), and notably in Fenland where routine and manual smoking rates remain above the national rate. • There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area.

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	56%	56%	56%	G	57%	56%	56%	↓	A stretch target for the percentage of infants being breastfed was set at 58% for 2016/17, - above the national average for England. The number of infants recorded as breastfed (fully or partially) at 6 weeks for Q4 has increased to 57%, and has decreased slightly to 56% for this quarter, meeting the revised target. This figure is one of the highest statistics in the Eastern region in published Public Health England data (2015/16) and Cambridgeshire continues to exceed the 45% national target.
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	50%	28%	28%	R	33%	50%	28%	↓	All of the health visiting data is reported quarterly. The data presented relates to the Q1 period (April to July 2017). The proportion of antenatal contacts continues to fall well below the 50% target and a strategy is in place to improve the notification process between maternity services and health visiting to remedy this. If we take into account exceptions the figure for Q1 increases to 31%. Priority is being given to those parents who are assessed as being most vulnerable. Since the same period last year, staffing levels are down by 16%. There has been recruitment days, and posts have been recruited to as a result. New staff are expected to start in the next 3 months.
Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	90%	90%	96%	96%	G	95%	90%	96%	↑	The number of New Birth Visits completed within 14 days of birth continues exceed the 90% target.
Health visiting mandated check - Percentage of children who received a 6 - 8 week review	90%	90%	92%	92%	G	95%	90%	92%	↓	The proportion of 6-8 week development checks completed within 8 weeks has declined slightly this quarter but continues to be above the 90% target.
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	87%	87%	A	91%	100%	87%	↓	This figure is below the set target. However if we take into account exception (which included visits not wanted or "did not attend") reporting the figure for Q1 increases to 91%, although this is still below target and need to be monitored.
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	78%	78%	A	82%	90%	78%	↓	The number of 2-2.5 year reviews being completed is below the set target. However if exception reporting (which included visits not wanted or "did not attend") is accounted for, the figure for Q1 increases to 92% which is above target.
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	100	100	N/A	59	N/A	100	↑	The School Nursing service has introduced a duty desk this quarter to offer a more efficient service. The figures reported are for those that have been seen in clinics in relation to a specific intervention.
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	733	733	N/A	305	N/A	733	↑	The School Nursing service has introduced a duty desk this quarter to offer a more efficient service. The figures reported are for those that have been seen in clinics in relation to a specific intervention. There has been a sharp increase in the number of children being seen for issues relating to their emotional health and wellbeing.

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	83.7%	91.4%		G	78%	83.7%	91%	↑	The National Child Measurement Programme (NCMP) has been completed for the 2016/17 academic year. The coverage target was met and the measurement data has been submitted to the DH. The cleaned measurement data will be available at the end of the year. The new measurement programme for 2017/18 will start in September.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	83.7%	94.8%		G	77%	83.7%	94.8%	↑	
Overall referrals to the service	5100	1090	1094	100%	G	81%	350	107%	↑	This is an area that is closely monitored and the Provider has put in place promotional campaign to encourage referrals and self referrals.
Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	1517	315	319	101%	G	66%	104	112%	↑	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1138	170	172	101%	G	48%	78	65%	↑	
Number of physical activity groups held **(Pre-existing GP based service)**	664	130	162	125%	G	151%	55	116%	↓	
Number of healthy eating groups held **(Pre-existing GP based service)**	450	130	145	112%	G	107%	40	115%	↑	
Personal Health Trainer Service - number of PHPs produced (Extended Service)	723	145	148	102%	G	70%	48	88%	↑	
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	542	110	111	101%	G	92%	36	119%	↑	

Measure	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of physical activity groups held (Extended Service)	830	125	115	92%	A	68%	35	94%	↑	
Number of healthy eating groups held (Extended Service)	830	215	266	124%	G	130%	90	133%	↑	
Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	27%		A	78%	30%	115%	↑	The objective percentage of participants who achieve the recommended weight loss is affected by the severity of the obesity. As part of demand management for the Tier 3 service patients are directed to Tier 2, these patients are more complex and have higher levels of obesity.
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	60%	60%	40%		R	55%	60%	0%	↓	No data was available from Addenbrookes for this month. This ahs been attributed to the fact that none of their Weight Management courses ended during this period. Everyone health sub-contracts the Tier 3 service to Addenbrookes and currently there are very regular meetings to review Addenbrookes data reporting process that appear incomplete.
% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	80%	0%	0%	0%	N/A	n/a	80%	n/a	↔	No courses completed during this period
Falls prevention - number of referrals	386	70	71	101%	G	58%	20	150%	↑	
Falls prevention - number of personal health plans written	279	45	42	93%	A	31%	14	143%	↑	This reflects the number of referrals that too place in the preceding months. Referrals originate from the wider falls prevention Service which was being re-organised and consequently the referral number fell.

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

** Direction of travel against previous month actuals

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

APPENDIX 7

Health Committee Priorities

Health Inequalities

Smoking Cessation

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

Since the previous report to Health Committee, provisional end of year data have been received and analysed for 2016/17, including the final months of the year although not including all late returns:

- Looking at provisional performance data at the end of 2016/17, the percentage of the smoking quit target achieved was:
    - 86% in the least deprived 80% of practices
    - 91% in the most deprived 20% of practices
    - 88% overall.
- The percentage point gap between the two groups in 2016/17 was +5%, in favour of a higher performance against the target in the most deprived practices. This represents a successful closing of the gap and reversal of the pattern seen in 2015/16 when performance in the most deprived was 16 percentage points below the least deprived practices.
- Monthly patterns in performance show that achievement was higher in the most deprived practices than in the least deprived practices in most months. Target achievement across all practices increased towards the end of the year.

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

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

Practice deprivation category	Year end target	End of Year				
		Target	Quits	Percentage	Difference from target	RAG status
Least deprived 80%	1,388	1,388	1,195	86%	14%	
Most deprived 20%	861	861	782	91%	9%	
All practices	2,249	2,249	1,977	88%	12%	

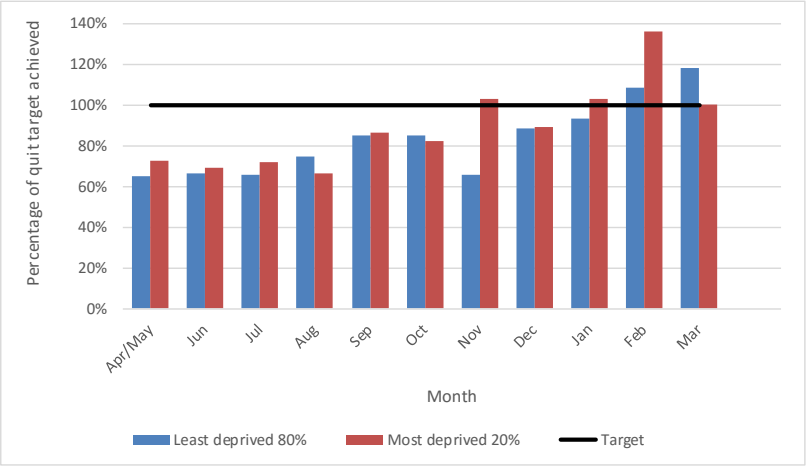
RAG status:

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

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

	End of Year
Percentage point gap	5%

Monthly patterns in smoking quit target achievemet by deprivation category of general practice in Cambridgeshire, 2016/17



Sources:
General practice returns to Cambridgeshire County Council Smoking Cessation Service
Public Health England 2015 Indices of Multiple Deprivation for general practices, based on the
NHS Digital Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 04/08/2017

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.

Since the previous report to Health Committee, quarter 4 and end of year data have been received and analysed for 2016/17:

Quarter 4:

- The percentage of the health check target achieved in quarter 4 was higher in the least deprived 80% of practices than in the most deprived 20%, but the targets were met in both groups and improved compared to quarter 3.
- In the least deprived 80%, 3478 health checks were delivered, 10% above the quarterly target of 3173; in the most deprived 20% of practices, 1372 health checks were delivered, 3% above the quarterly target of 1327.
- The gap in performance between the two groups was 7 percentage points in Quarter 4.

End of year:

- Looking at performance data at the end of 2016/17, the percentage of the health check target achieved was:
    - 106% in the least deprived 80% of practices
    - 81% in the most deprived 20% of practices
    - 98% overall.
- The RAG status for health check target achievement overall was amber (within 10% of the target), but red (more than 10% away from the target) for the most deprived 20% of practices.
- In 2015/16, 84% of the quit target was achieved, 93% in the least deprived 80% of practices, 63% in the most deprived 20%.
- The percentage point gap between the two groups in 2016/17 was -25%. This represents a small closing of the gap seen in 2015/16 when performance in the most deprived was 30 percentage points below the least deprived practices. Performance against the targets overall have increased in both groups.
- Quarterly patterns in performance show that achievement was higher in the least deprived practices than in the most deprived practices in all quarters. However, target achievement in the most deprived practices notably increased and the gap narrowed over the year.

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.

Percentage of health check target achieved by deprivation category of general practices in Cambridgeshire, 2016/17 Quarter 4 (End of Year)

Practice deprivation category	Year end target	End of Year					Quarter 4			Previous quarter	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	12,691	12,691	13,416	106%	-6%		3,173	3,478	110%	99%	↑
Most deprived 20%	5,309	5,309	4,313	81%	19%		1,327	1,372	103%	81%	↑
All practices	18,000	18,000	17,729	98%	2%		4,500	4,850	108%	94%	↑

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

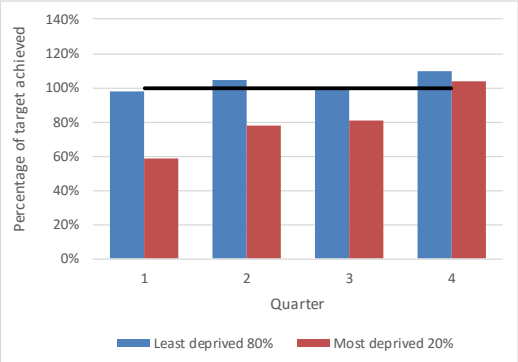
Percentage point gap between the percentage of the target reached in the most deprived 20% compared with the least deprived 80%

	End of Year	Quarter 4	Previous quarter	Direction of travel
Percentage point gap	-25%	-7%	-18%	↑

Direction of travel:

- ↑ Better than previous quarter
- ↓ Worse than previous quarter
- ↔ Same as previous quarter

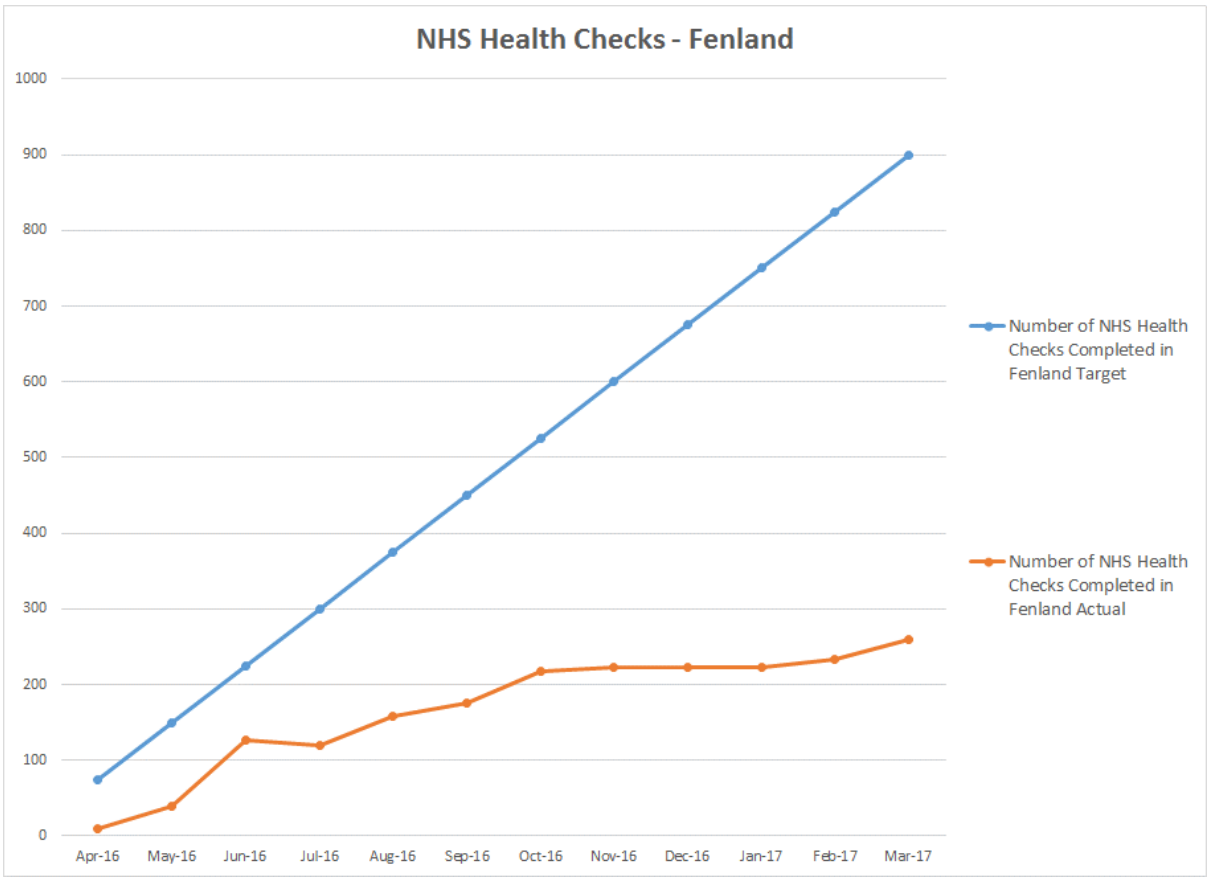
Quarterly patterns in health check target achievemet by deprivation category of general practice in Cambridgeshire, 2016/17

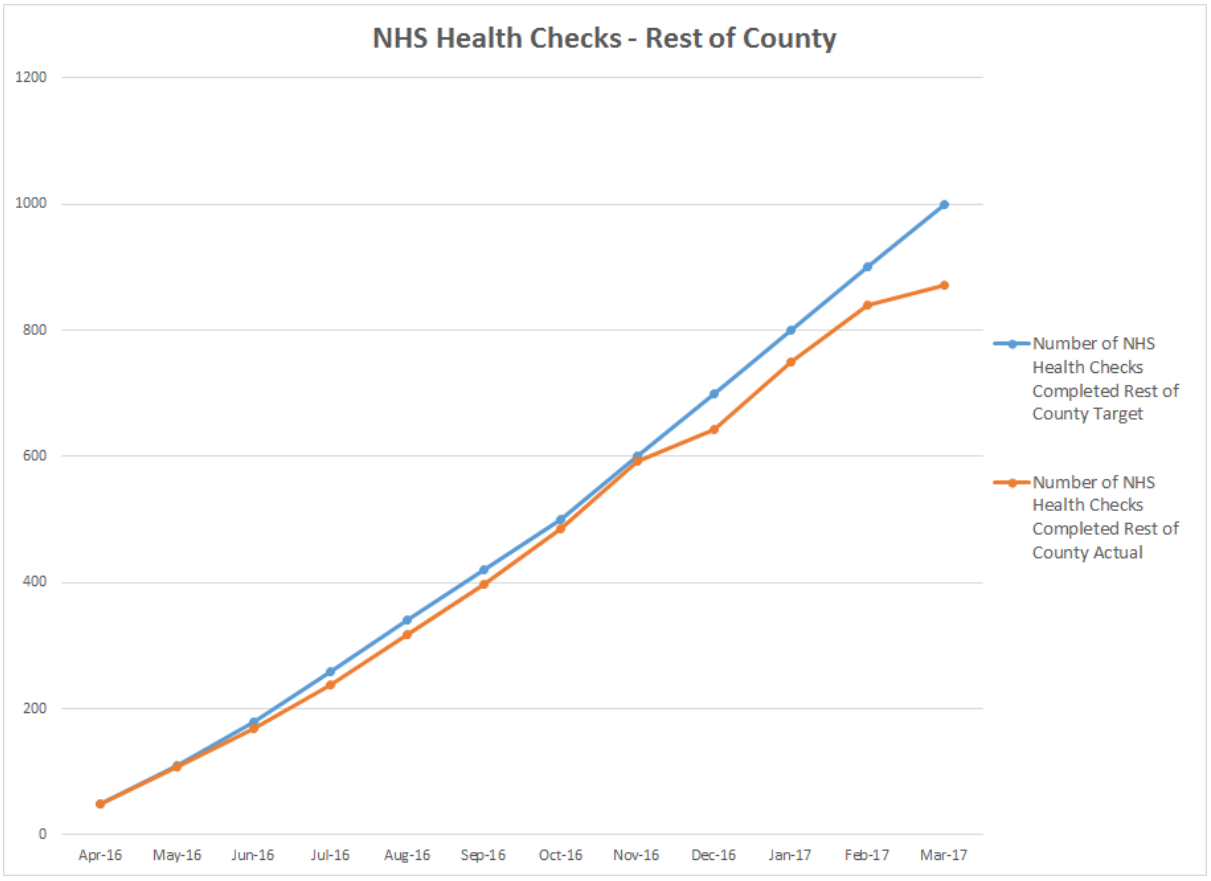


Sources:
Any discrepancy between figures in tables is due to rounding error.
Practice returns to Cambridgeshire County Council Public Health Team
Practice level index of multiple deprivation (IMD) Public Health England/Kings College London, 2015
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 04/08/2017

Outreach Health Checks

In order to address health inequalities, Outreach NHS Health Checks provided by the Integrated Lifestyle Service Everyone Health have a focus upon Fenland – and are delivered in community settings including workplaces. Ambitious targets for Outreach NHS Health Checks in Fenland were set. However it has been challenging securing the engagement of employers in this area and the targets have not been met, unlike the targets for Outreach NHS Health Checks in other parts of the County.


NHS Health Checks - Fenland
1000
900
800
700
600
500
400
300
200
100
0
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Number of NHS Health Checks Completed in Fenland Target
Number of NHS Health Checks Completed in Fenland Actual


NHS Health Checks - Rest of County
1200
1000
800
600
400
200
0
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Number of NHS Health Checks Completed Rest of County Target
Number of NHS Health Checks Completed Rest of County Actual

Life expectancy and healthy life expectancy

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

Since the previous report to Health Committee, updated population estimates and deprivation data have become available and so life expectancy data for all years have been refreshed as well as updated to 2014-16.

- The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% least deprived was 2.6 years for both 2012-14 and 2013-15.
- For the latest 3-year period available, covering 2014-16, the absolute gap was 3 years (80.4 years in the most deprived 20% of wards v. 83.4 years in the least deprived 80%). Although this appears to be an increase in the gap, this should be interpreted with caution. Ward level population estimates are not currently available for 2016 and so 2015 population estimates have been used for the calculations for this periods. This may adversely affect the calculated life expectancies as increases in numbers of deaths may reflect increases in population size that have not been taken into account. Deaths data for 2016 are also provisional. Updated small area population estimates are due to be released by the Office of National Statistics in October 2017.

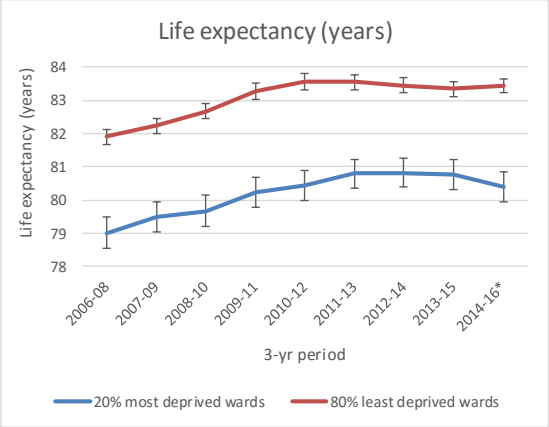
There are significant inequalities nationally and locally in life expectancy at birth by socio-economic group. Certain sub-groups, such as people with mental health problems and people who are homeless, also have lower life expectancy than the general population. Key interventions to reduce this gap are in tackling lifestyle factors and ensuring early intervention and prevention of key diseases.

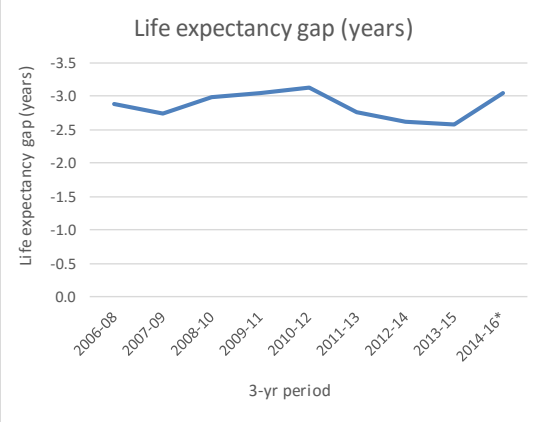
Average life expectancy at birth by deprivation category of ward, Cambridgeshire, 2006-08 to 2014-16

3-yr period	Deprivation category of ward						LE gap (years)	Relative LE gap (%)
	20% most deprived wards			80% least deprived wards				
	LE	Lower 95% CI	Upper 95% CI	LE	Lower 95% CI	Upper 95% CI		
2006-08	79.0	78.6	79.5	81.9	81.7	82.1	-2.9	-3.5%
2007-09	79.5	79.0	80.0	82.2	82.0	82.5	-2.7	-3.3%
2008-10	79.7	79.2	80.1	82.7	82.4	82.9	-3.0	-3.6%
2009-11	80.2	79.8	80.7	83.3	83.0	83.5	-3.0	-3.7%
2010-12	80.4	80.0	80.9	83.6	83.3	83.8	-3.1	-3.8%
2011-13	80.8	80.4	81.2	83.6	83.3	83.8	-2.8	-3.3%
2012-14	80.8	80.4	81.3	83.5	83.2	83.7	-2.6	-3.1%
2013-15	80.8	80.3	81.2	83.3	83.1	83.6	-2.6	-3.1%
2014-16*	80.4	79.9	80.8	83.4	83.2	83.6	-3.0	-3.6%

LE - Life Expectancy, CI - Confidence Interval

* Ward level population estimates are not currently available for 2016 so 2015 population estimates have been used for this period. A mismatch between the source years of population estimates and deaths may adversely affect the calculated life expectancies as increases in numbers of deaths may reflect increases in population size that have not been taken into account.





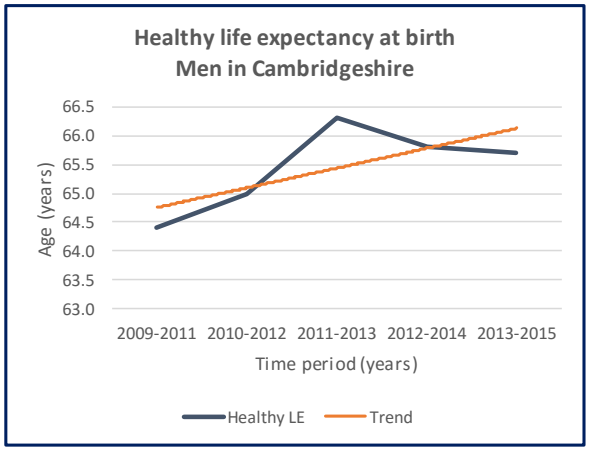
Sources:
NHS Digital Primary Care Mortality Database (Office for National Statistics death registrations)
Office for National Statistics mid-year population estimates
Local Government Association / Cambridgeshire County Council Public Health Intelligence Index of Multiple Deprivation 2015

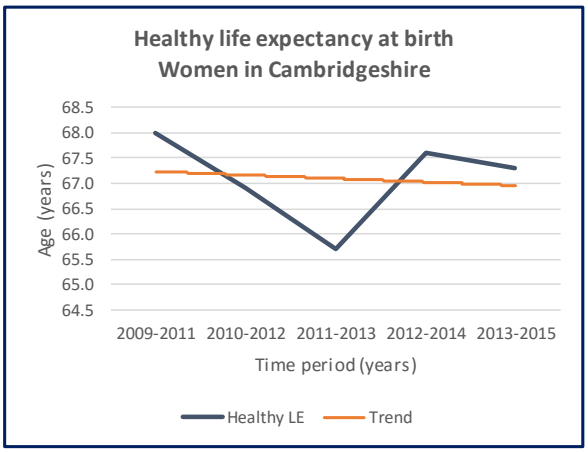
Healthy life expectancy.

- Healthy life expectancy at birth for men in Cambridgeshire in 2013-15 was 65.7 years, statistically significantly higher than the average for England (63.4 years).
- Healthy life expectancy at birth for women in Cambridgeshire in 2013-15 was 67.3 years, statistically significantly higher than the average for England (64.1 years).
- There is an increasing trend in male healthy life expectancy and a slightly decreasing female trend.
- For both men and women, healthy life expectancy in Cambridgeshire is statistically significantly higher than in England for all the time periods above other than for men in 2009-2011 where there is no significant difference.
- Female healthy life expectancy was statistically significantly higher than male healthy life expectancy for the first data period here, but there is no longer a statistical difference.
- Males also now appear to spend more time in self-reported good health (not statistically assessed).
- Over the last two years the percentage of time males spend in good health has decreased slightly, but the trend since 2009-2011 is positively upward.
- The trend in the percentage of time females spend in good health has remained static.

Healthy life expectancy at birth, Cambridgeshire, 2009-11 to 2013-15

Calendar year / gender	Cambridgeshire			England
	Healthy life expectancy (years)	95% CI*	% time spent in good health	Healthy life expectancy (years)
Males				
2009-2011	64.4	(62.6-66.1)	80.1	63.0
2010-2012	65.0	(63.3-66.6)	80.2	63.2
2011-2013	66.3	(64.7-67.9)	81.7	63.2
2012-2014	65.8	(64.2-67.5)	81.4	63.4
2013-2015	65.7	(64.1-67.3)	81.2	63.4
Females				
2009-2011	68.0	(66.5-69.5)	80.2	64.1
2010-2012	66.9	(65.3-68.5)	79.0	64.1
2011-2013	65.7	(64.1-67.4)	77.4	63.9
2012-2014	67.6	(65.9-69.3)	80.0	63.9
2013-2015	67.3	(65.6-69.0)	79.8	64.1





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 2015/16 Fenland did not meet this target (21.4% actual against 19.6% target), but there was a reduction from the previous year (22.4%). There continues to be a downward trend in Cambridgeshire as a whole, which meant the target was met (18.7% actual, 19.8% target). The gap between Fenland and Cambridgeshire had reduced in 2015/16.

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	262	248	224	237	-	222	-
	%	26.8%	24.9%	21.6%	22.4%	20.6%	21.4%	19.6%
Cambridgeshire	Number	1,399	1,318	1,392	1,326	-	1,270	-
	%	22.5%	20.2%	20.8%	19.4%	20.3%	18.7%	19.8%
Gap		4.3%	4.7%	0.8%	3.0%	0.3%	2.7%	-0.2%

Source: NCMP, HSCIC

Note : The target and actual data has changed to reflect changes in the PHOF. Local authority is now determined by the postcode of the pupil rather than the postcode of the school.

Children aged 4-5 years classified as obese

There was a decrease in the recorded obesity prevalence in Reception children in Cambridgeshire between 2014/15 and 2015/16 (7.3% to 6.9%). 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 2015/16 (9.6% actual, 9.6% target). The proportion remained the same as in 2014/15. The target for the remaining 80% of areas was also met (6.2% actual, 6.9% 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		137	
	Total	1,310	1,444	1,477	1,521		1,420	
	%	11.3%	10.8%	10.6%	9.6%	10.1%	9.6%	9.6%
80 least deprived	Number	344	327	372	344		326	
	Total	4,819	4,997	5,108	5,177		5,300	
	%	7.1%	6.5%	7.3%	6.6%	7.1%	6.2%	6.9%
Total (CCC only)	Number	492	483	529	490		463	
	Total	6,129	6,441	6,585	6,698		6,720	
	%	8.0%	7.5%	8.0%	7.3%		6.9%	

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 the 20% most deprived areas in Cambridgeshire between 2014/15 and 2015/16 (19.6% to 18.4%), and the target was met. There was a slight increase in the remaining 80% of areas, but the target was also met.

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	245	217	226	232		199	
	Total	1,107	1,117	1,136	1,182		1,081	
	%	22.1%	19.4%	19.9%	19.6%	19.4%	18.4%	18.9%
80 least deprived	Number	613	623	671	596		622	
	Total	4,174	4,207	4,411	4,345		4,474	
	%	14.7%	14.8%	15.2%	13.7%	15.0%	13.9%	14.8%
Total (CCC only)	Number	858	840	897	828		821	
	Total	5,281	5,324	5,547	5,527		5,555	
	%	16.2%	15.8%	16.2%	15.0%		14.8%	

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

There was a noticeable decrease in the proportion of physically active adults in Fenland between 2014 and 2015, and the target (described below) was not met. Cambridgeshire as a whole also

experienced a decline in the proportion of physically active adults and also did not meet the target in 2015.

Physically active adults
Target: Improve Fenland by 1% a year and Cambridgeshire by 0.5%.

Area	Actual			2015		2016	
	2012	2013	2014	Actual	Target	Actual	Target
Fenland	50.5%	51.1%	52.1%	47.9%	53.1%		54.1%
Cambridgeshire	60.3%	60.2%	64.5%	58.6%	65.0%		65.5%
Gap	-9.8%	-9.1%	-12.4%	-10.7%	-11.9%	0.0%	-11.4%

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

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

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

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

Mental health
Proposed indicators:

- **Number of schools attending funded mental health training:**

The whole school briefing delivered by CPFT offers an introduction to thinking about mental health with a focus on ethos and culture around mental health in schools. This foundational training to all staff.

- Between 1st April 2017-27th June 2017 2 primary schools attended a whole school briefing 1 secondary school.
- A further 2 Youth Mental Health Awareness Training courses were held in schools and two further courses were held on the Ida Darwin site for staff to attend.
- Two schools were supported to run workshops with staff where a whole school approach action plan was developed for their school.
- There have been 203 new e-learning accounts registered between 1st April 2017-27th June 2017.
- The 14 day Child and Adolescent Mental Health Foundation Module for 2017 began in May. This course aims to improve confidence in responding to the symptoms of a range of mental health issues, and better equip people to build resilience in young people.

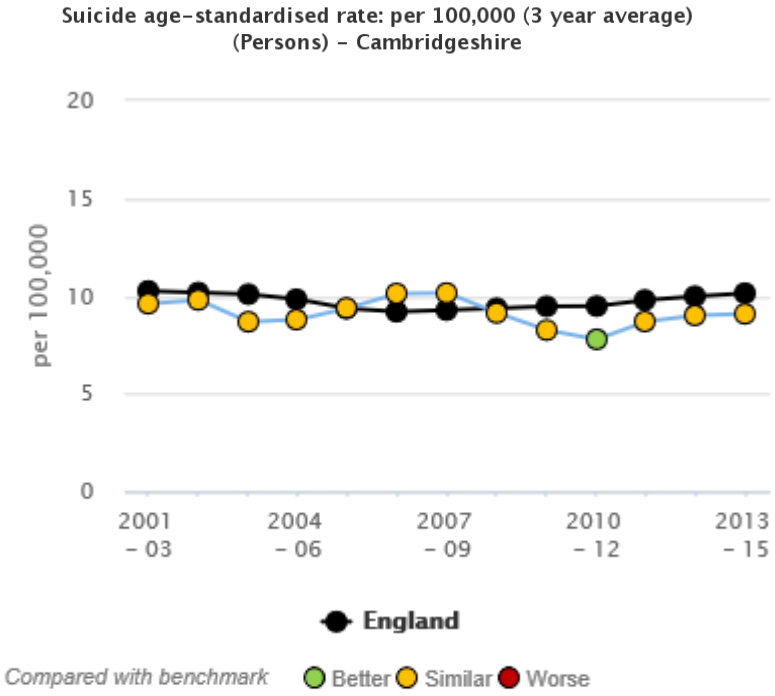
- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – To date (June 2016), 21 out of 30 secondary schools have taken up the offer of a consultancy visit.
  This piece of work was funded for the 2015/16 academic year only.

- **Number of front line staff that have taken part in MHFA and MHFA Lite commissioned training** (quarterly):

Mental Health First Aid and Mental Health First Aid Lite are offered free of charge to front line staff within Cambridgeshire County Council and partner organisations. *The contract with an external provider to deliver this training finished at the end of October 2016, however a range of training will continue to be offered via different channels and models of delivery*.

  - MHFA (2 day course) attendance: 398
  - MHFA Lite (1/2 day) attendance: 216

- **PHOF Indicator: Mortality rate from suicide and injury of undetermined intent** (annual):
  - In Cambridgeshire, the rate of suicide and injury of undetermined intent is 9.1 per 100,000 (3 year average, 2013-15), 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 (Benchmark is England)

- **Emergency hospital admissions for intentional self-harm** (annual) (Source: Public Health England, Public Health Profiles):

In 2015/16 the Cambridgeshire rate for emergency hospital admissions for intentional self-harm was 264.9 per 100,000 population (in 2014/15 it was 221.5 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, Huntingdonshire and East Cambridgeshire. Further analysis has been undertaken by the Public Health Intelligence Team which shows a small number of individuals account for a large number of the admissions, further investigation is required into these cases.

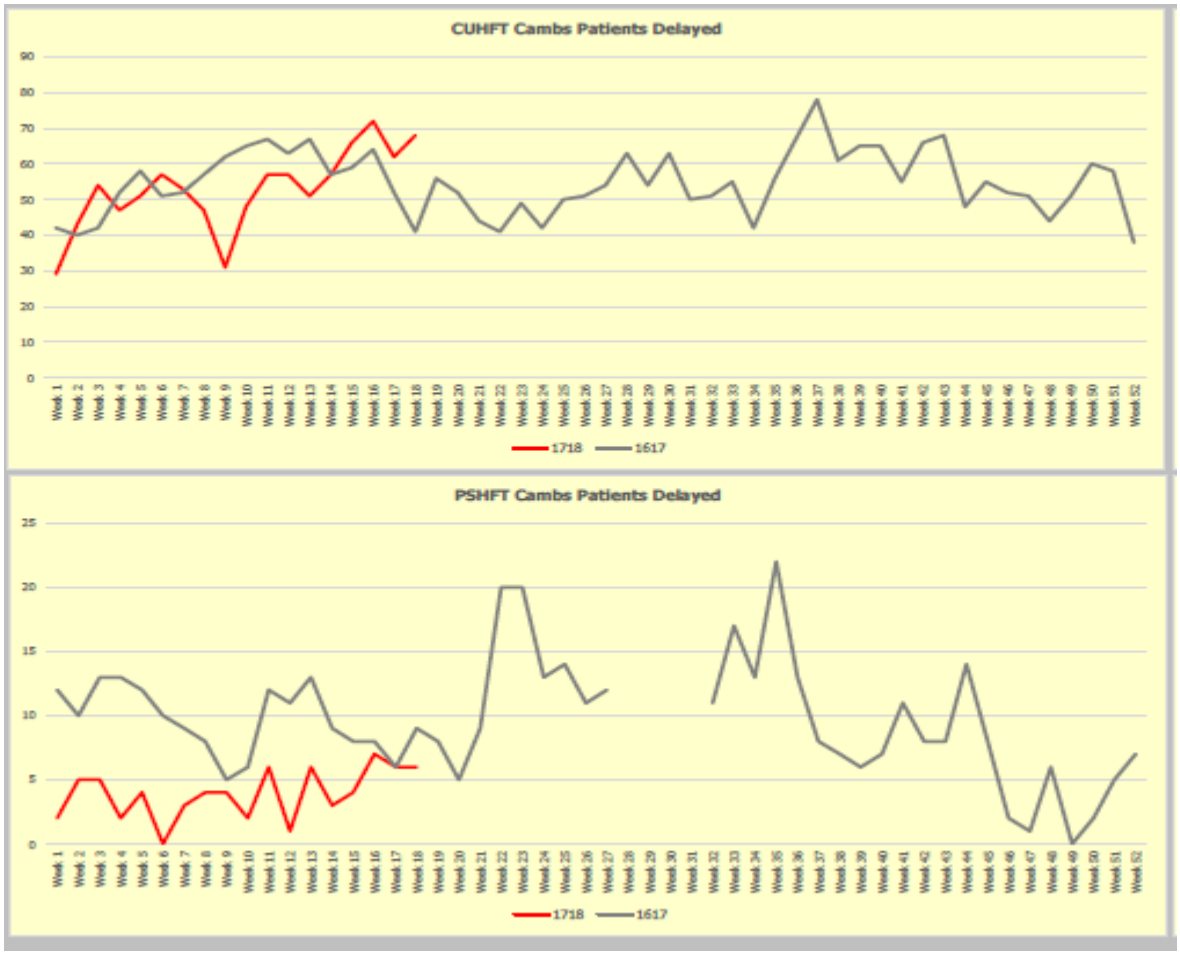
APPENDIX 8

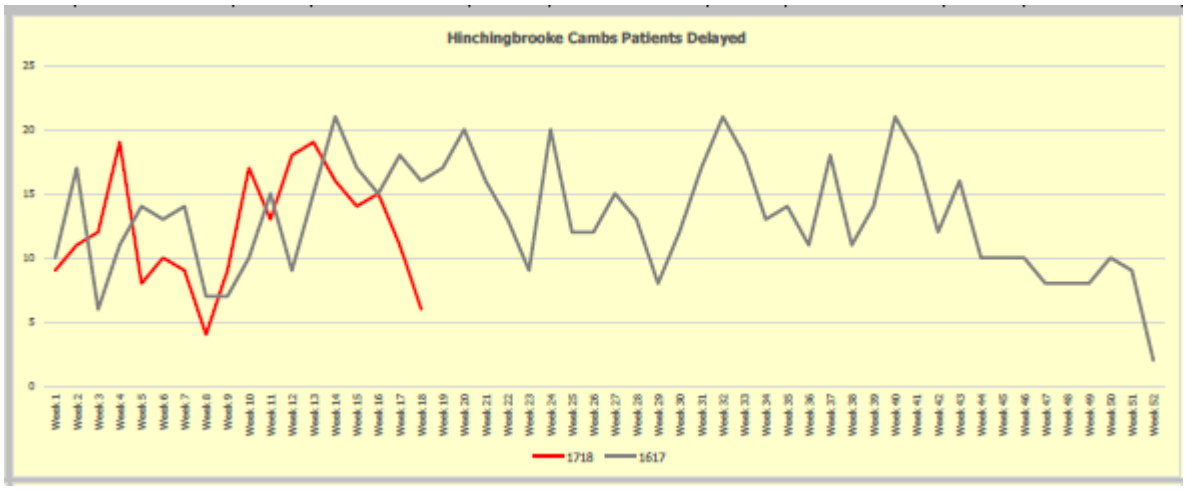
Updates on key indicators for NHS issues which have been scrutinised by the Health Committee are as follows:

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

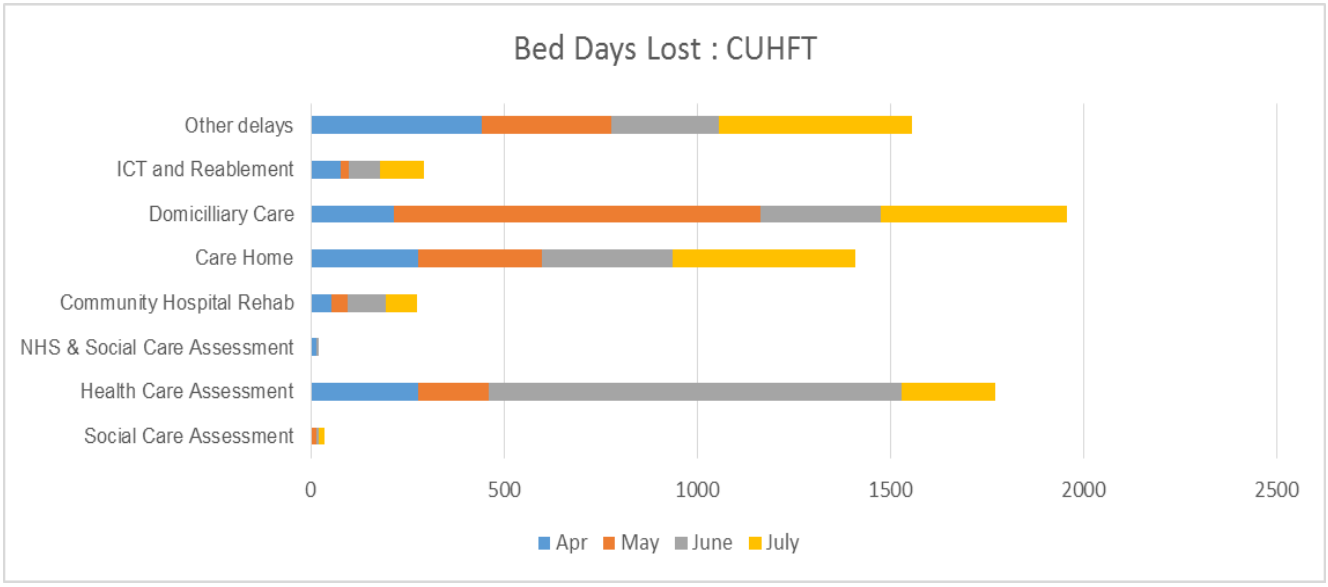
  The data profiles submitted to the Health Committee from the CCG has changed since the last report and data is now presented as weeks. Increases in DTOC's is evident for Cambridgeshire patients attending Cambridge University Hospital (Addenbrookes) and illustrates an increase compared to the previous year. However both Hincingbrooke Hospital and Peterborough & Stamford Hospital data indicates a decline in DTOCs. Both Trusts through the liaison meetings report that they continue to work with system partners to address the large scale impact of DTOCs

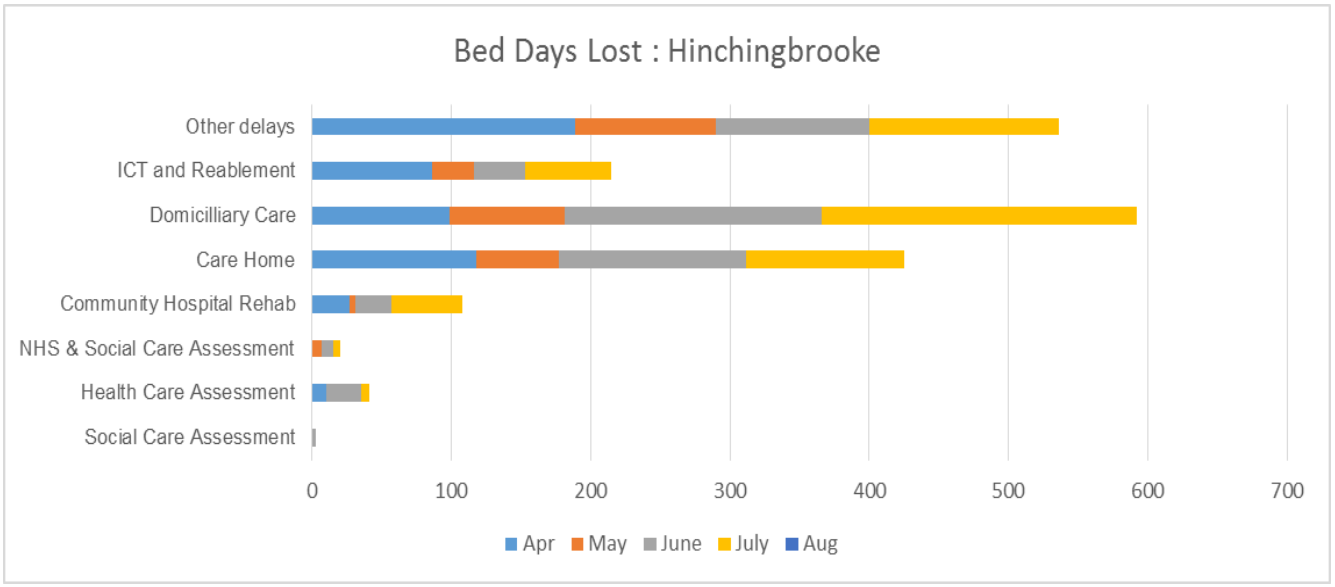
  Patients Delayed





Bed Days Lost





APPENDIX 9: Outcomes of Integrated Lifestyle Health Trainer Service

EVERYONE HEALTH INTEGRATED LIFESTYLE SERVICE – SERVICE OUTCOMES 2016/17

Health Trainer Service - 20% most deprived areas

Table 1: The Health Trainers deliver services in 15 GP practices across Cambridgeshire in the 20% most deprived areas.

City & South	Central	Fenland
Arbury Road Surgery	Acorn Surgery	Clarkson Surgery
East Barnwell Health Centre	Charles Hicks Surgery	Cornerstone Surgery
Nuffield Road Medical Centre	Priory Fields Surgery	Mercheford House Surgery
	St Georges Medical Centre	New Queen Street Surgery
		North Brink Surgery
		Parson Drove Surgery
		Riverside Surgery
		Trinity Surgery

Table 2: Aggregated changes for those patients completing the Health Trainer Programme

	Mean Pre	Mean Post	Change
Anthropometrics			
Weight (kg)	101.45 kg	98.27 kg	-3.18kg
BMI	36.07 kg/m^2	34.77 kg/m^2	-1.3 kg/m^2
Waist Circumference (cm)	112.50 cm	109.74 cm	-2.76 cm
Physical Activity			
Light	243.78 minutes	302.76 minutes	+58.98 minutes
Moderate	25.67 minutes	95.24 minutes	+69.57 minutes
Vigorous	3.01 minutes	8.94 minutes	+5.93 minutes
Dietary			
Fruit Portions (per day)	1.82	2.64	+0.82
Vegetable Portions (per day)	1.98	2.91	+0.93
Psychological			
General Health (out of 100)	62.47	69.41	+6.94
Self-Efficacy (max score 32)	20.84	22.37	+1.53
WHO-Five-Wellbeing (max score 25)	11.85	14.56	+2.71

Figure 1: Programme Highlights

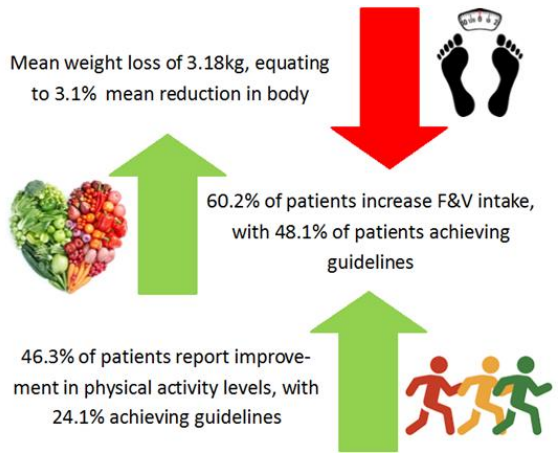


Figure 2: Personal Health Plans Completed : Each client sets a personal plan for achieving their behavioural change goals

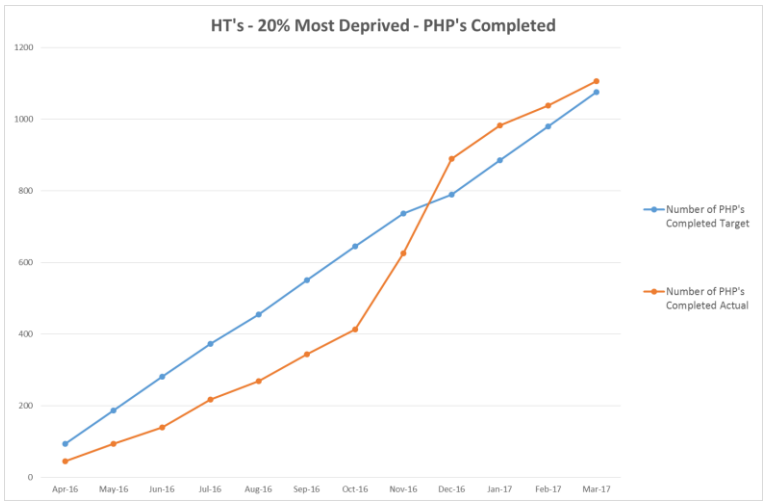


Figure 3: Personal Health Plans Achieved

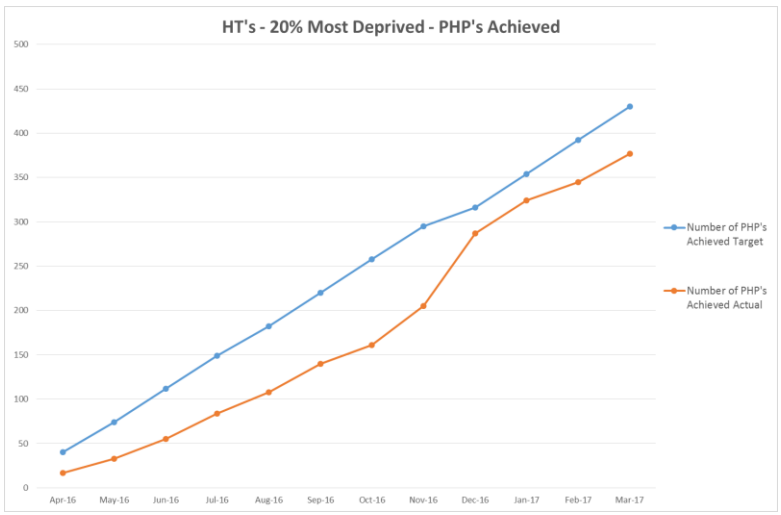


Figure 4: Personal Health Plans Part Achieved

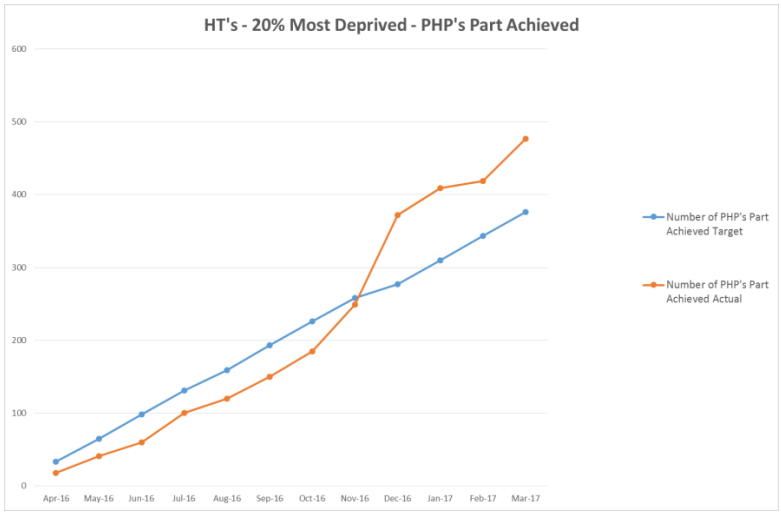
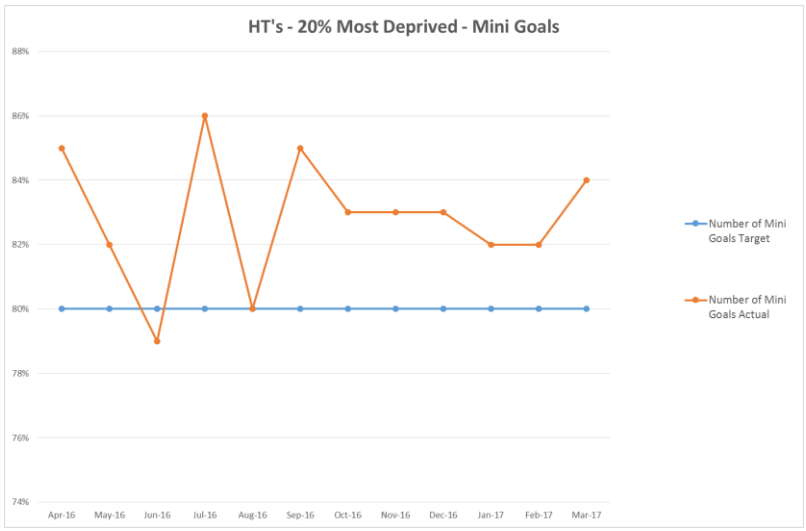


Figure 5: Mini-Goals Achieved: Mini Goals are additional goals that clients set alongside their primary behavioural change challenge


HT's - 20% Most Deprived - Mini Goals
88%
86%
84%
82%
80%
78%
76%
74%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Number of Mini Goals Target
Number of Mini Goals Actual

Health Trainer Service – Rest of the County Service

Table 3: Aggregated changes for those patients completing the Health Trainer Programme

	Mean Pre	Mean Post	Change
Anthropometrics			
Weight (kg)	105.85 kg	102.96 kg	-2.89 kg
BMI	38.17 kg/m^2	37.06 kg/m^2	-1.11 kg/m^2
Waist Circumference (cm)	116.8 cm	115.1 cm	-1.7 cm
Physical Activity			
Light	123.84 minutes	152.67 minutes	+28.83 minutes
Moderate	38.75 minutes	95.37 minutes	+56.62 minutes
Vigorous	5.16 minutes	9.45 minutes	+4.29 minutes
Dietary			
Fruit Portions (per day)	1.62	2.78	+1.16
Vegetable Portions (per day)	1.85	2.98	+1.13
Psychological			
General Health (out of 100)	57.58	68.23	+10.65
Self-Efficacy (max score 32)	22.04	23.65	+1.61
WHO-Five-Wellbeing (max score 25)	12.85	15.06	+2.21

Figure 6: Progrmme Highlights

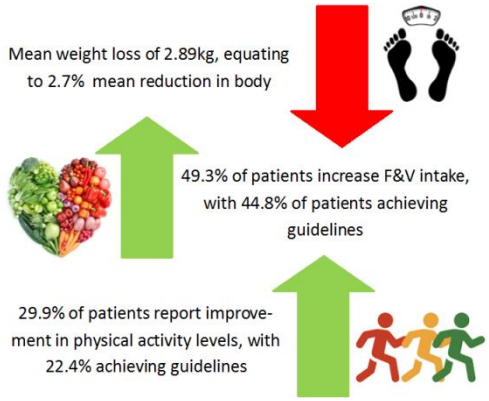


Figure 7: Personal Health Plans Completed : Each client sets a personal plan for achieving their behavioural change goals

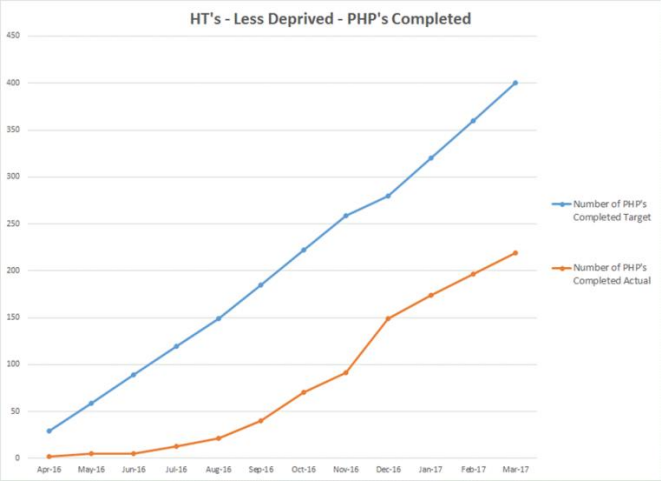


Figure 8: Personal Health Plans Achieved

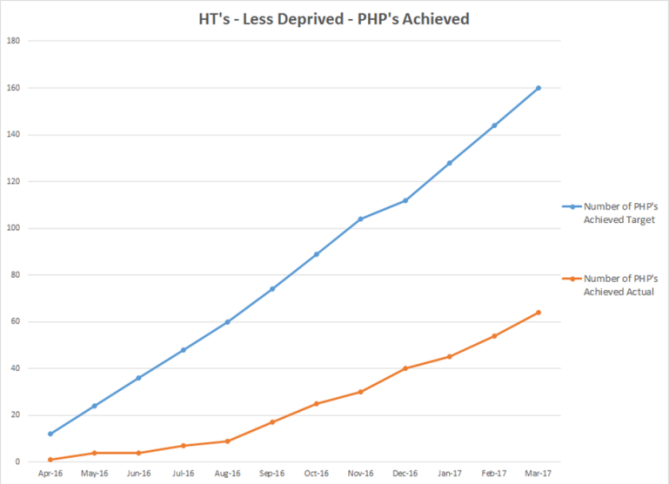


Figure 9: Personal Health Plans Part Achieved

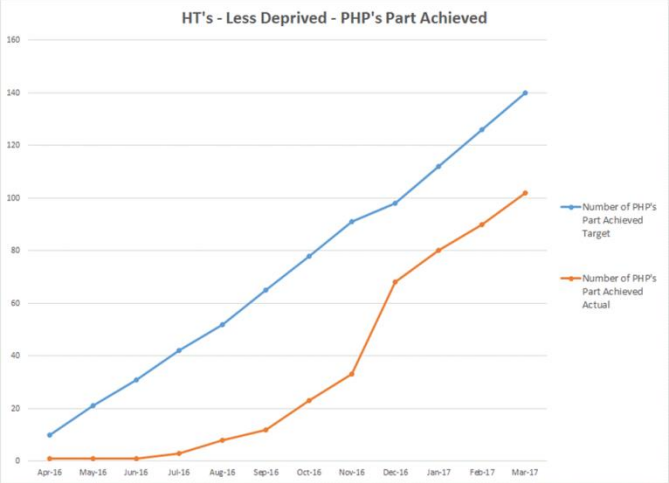
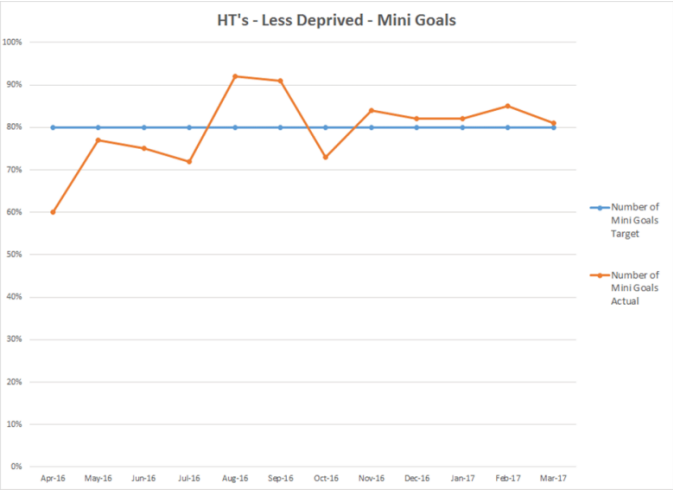


Figure 10: Mini-Goals Achieved: Mini Goals are additional goals that clients set alongside their primary behavioural change challenge



Weight Management Services

Figure 11: Tier 2 Weight Management Services

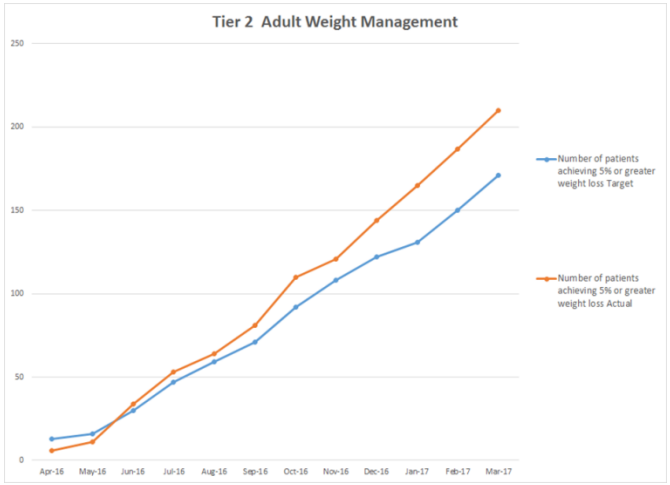
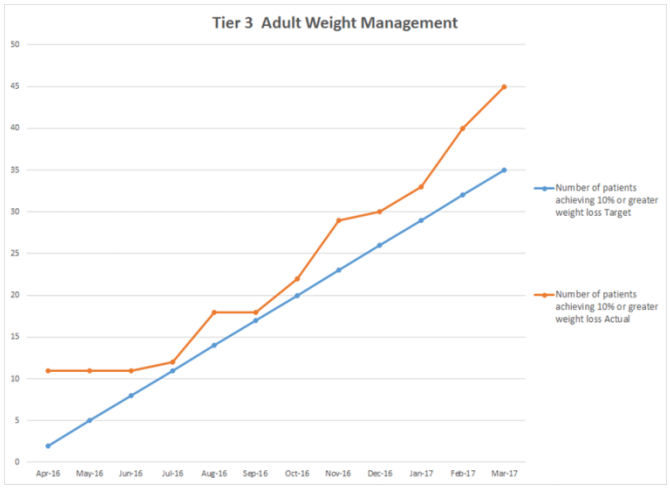


Figure 12: Tier 3 Weight Management Services



<u>Weight Loss Differences between Fenland and the Rest of the County (Tier 2 Services)</u>

Figure 15: Average Weight Loss (kg) – Fenland and the Rest of the County

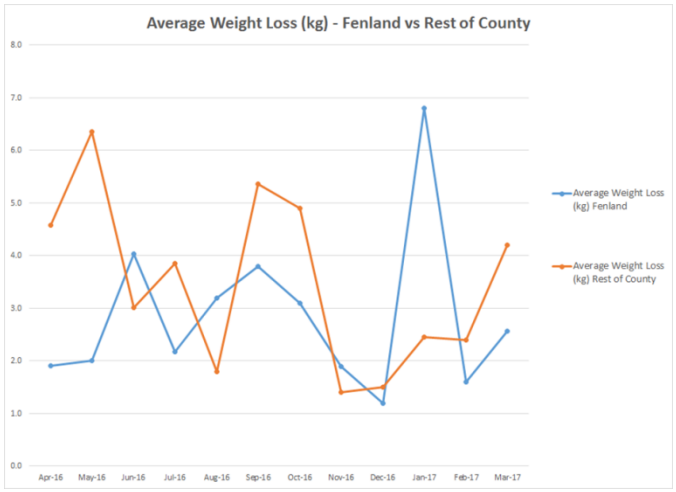
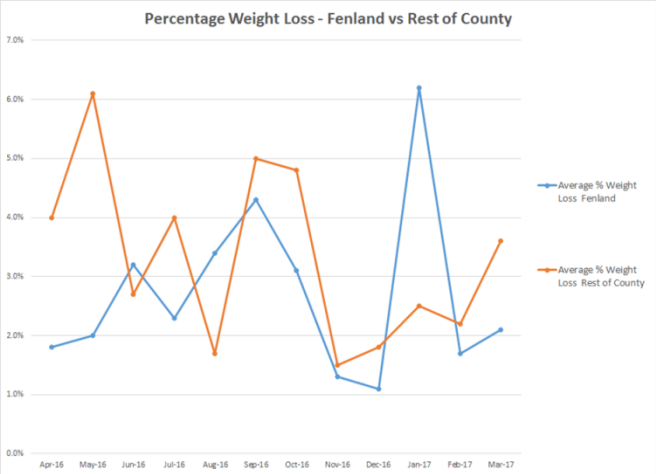
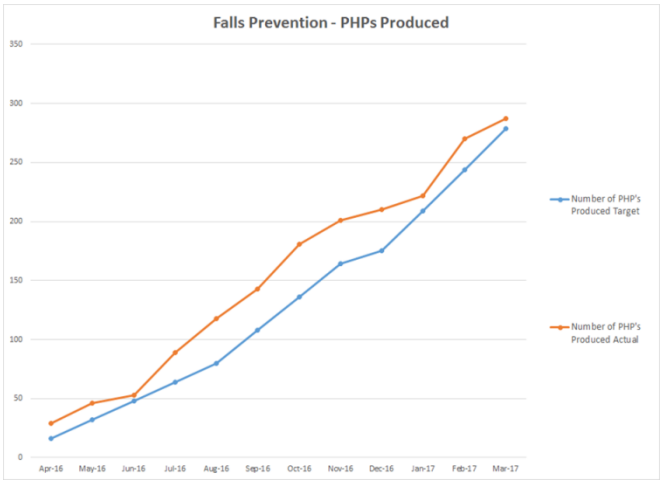


Figure 14: Average Percentage Weight Loss in Fenland and the Rest of the County



Fall Prevention

Figure 15: Personal Health Plans Produced for the Prevention of Falls



Agenda Item No: 6

CAMBRIDGESHIRE ADULT DRUG AND ALCOHOL TREAMENT SERVICES PROCUREMENT

To:	**Health Committee**
Meeting Date:	**September 7th 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**To describe the rationale and benefits of procuring a new Cambridgeshire Adult Drug and Alcohol Treatment Services through a competitive tender.**
Recommendation:	**The Health Committee is asked to approve the following:**

a) Initiating a competitive tender for the procurement of a Cambridgeshire integrated drug and alcohol service.

b) The scope of service to be included in the tender.

c) A transformation approach that reflects the findings of the recent Drugs and Alcohol Joint Strategic Needs Assessment and the National Drugs Strategy, is evidence based and provides value for money.

Officer Contact:		***Chair Contact:***
Name:	Val Thomas	Name: Councillor Peter Hudson
Post:	Consultant in Public Health	Post: Chairman
		Email: Peter.Hudson@cambridgeshire.gov.uk
Email:	Val.Thomas@cambridgeshire.gov.uk	Tel: 01223 706398
Tel:	01223 703264	

1. BACKGROUND

1.1 Adult Drug and Alcohol specialist treatment provision across Cambridgeshire falls under two separate contracts provided by the same organisation, namely South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT). Although there are two separate contracts, the two services have operationally become increasingly integrated, driven in part by the need to realise savings due to a reduction in the Public Health grant. Locally the services are referred to as 'Inclusion'.

1.2 The contracts were let at different times due to historical funding arrangements that reflect the transfer of commissioning responsibilities from the NHS to Local Authorities.
Drug and alcohol prevention and treatment services are included in local authority public health commissioning categories that fall under the Public Health grant. The services are not specifically mandated, as mandated services are generally those which central government wants to be delivered in a standard way across the country. However, the public health grant conditions include the following statement: A local authority must, in using the grant, "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…"

1.3 Historically the commissioning was undertaken by the Drug and Alcohol Team (DAAT) that sat in the former Children, Families and Adults Directorate, although the services are funded from the Public Health Grant. The recent creation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU) has brought together the majority of public health services that are commissioned, including Drugs and Alcohol Services.

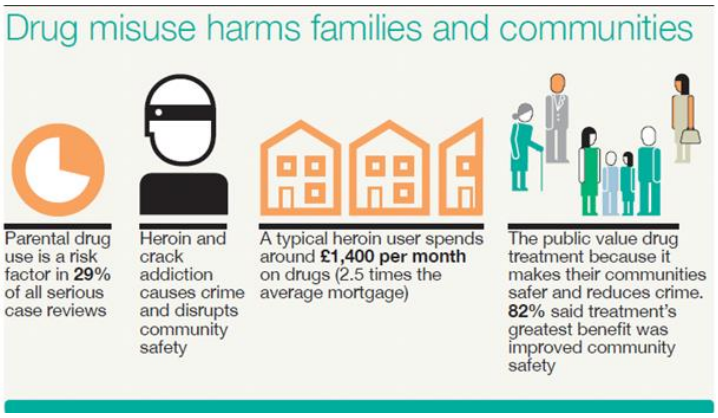
1.3 Both contracts will shortly expire, the Drug Treatment Contract commenced on 1st April 2012 and the Alcohol Treatment Contract on 1st April 2014. They have both now been aligned in terms of end dates and are due to terminate on the 30th September 2018. It is proposed to formally commence the procurement in September 2017 after securing support from the Health Committee, which has responsibility for the Council's public health services and policies. Contract award is planned for June 2018 with a contract start date of the 1st October 2018.

2. MAIN ISSUES

2.1 There are far ranging effects upon the physical and mental health of those who misuse drugs and alcohol, which impact upon their families and communities and across wider aspects of their lives that are captured in Figures 1 and 2.

Figure 1: Alcohol harms for families and communities

Figure 2 Drug misuse harms for families and communities



2.2 In addition there are socio-economic costs to society and services, which includes health services, social care, the criminal justice system, employers and housing services. The harms of drug and alcohol misuse have been modelled to show the costs of treating and addressing them. (Figures 3 and 4)

Figure 3: Annual cost of alcohol to society

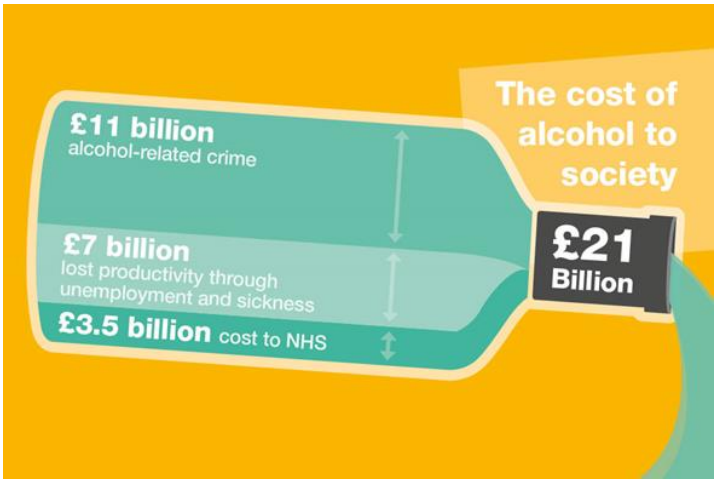
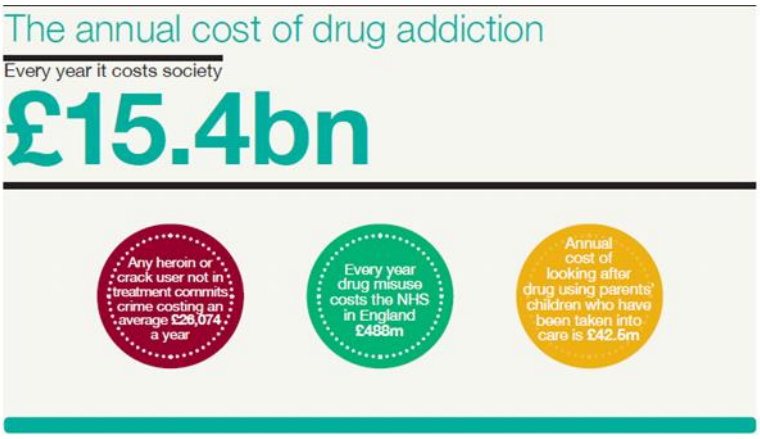


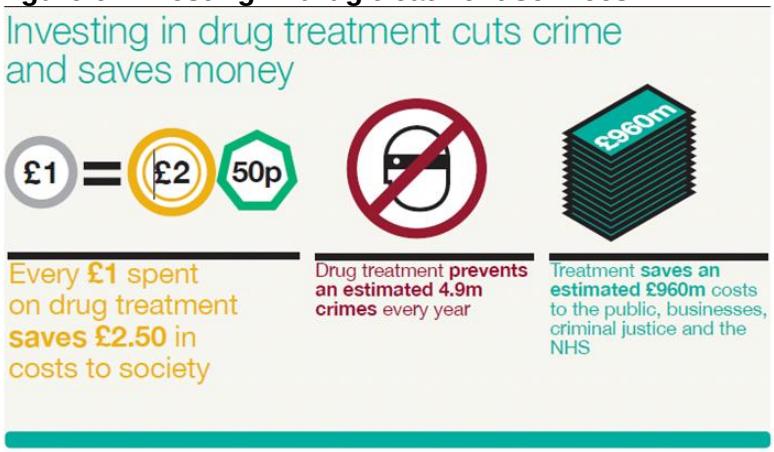
Figure 4: Annual cost of drug addiction to society



2.3 There is considerable evidence that investment in effective drug and alcohol treatment services can bring a range of benefits.

Figure 5: Investing in alcohol interventions

Figure 6: Investing in drug treatment services



2.4 Only the Cambridgeshire Adult Drug and Alcohol specialist treatment contracts are in scope for this procurement. This includes Tier 4 in-patient and residential services. The Peterborough treatment contracts were let last year with its new integrated treatment service commencing on the 1st April 2016 and are not in scope for the tender.

Although the treatment contracts across both Peterborough and Cambridgeshire are not currently coterminous, it is envisaged that going forward break clauses in the new contract will be aligned with Peterborough's contract to provide future options for integration across both geographical areas.

The Children and Young People's Service, CASUS provided by Cambridgeshire and Peterborough Foundation Trust is also not in scope for the tender. This reflects in part that the contract end date does not align with those of the adult services, but also the need to look at transformational service models that would enable increased integration with other young people's services. For example, there is evidence that the integration of young people's services for drugs and alcohol with sexual health services improves outcomes. This requires further exploration with a range of services, which will be undertaken prior to re-commissioning the Service.

2.5 The re-tendering of the Adult Drug and Alcohol treatment system in Cambridgeshire will provide the opportunity for transformational change that will more effectively address the emerging needs found in the recent Cambridgeshire Drugs and Alcohol Joint Strategic Needs Assessment and National Drugs Strategy. This includes the changing demographic of service users who have different needs, recovery, and the particular requirements of vulnerable groups. The aim is to secure evidence based, better value services which have the following deliverables:

- An integrated specialist drug and alcohol treatment system across Cambridgeshire.
- Increased alignment and integration with related services to ensure that the complex needs (most notably poor mental and physical health, homelessness, unemployment) of service users are effectively addressed with treatment and recovery outcomes achieved.
- Robust recovery focused treatment approaches.
- A long-term condition treatment model, which decreases demand for acute treatment services and ensures that needs are appropriately addressed.
- Early intervention and harm reduction interventions.

2.6 Currently the adult drug and alcohol specialist treatment system spend in Cambridgeshire totals £5.3 million. Ongoing savings are required from the Public Health Grant, which potentially will affect the contract value. These will be identified in the business planning processes currently being undertaken.

2.7 On the 1st May 2017 the new Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU) was created, establishing a new joint structure across the two local authorities. The new Public Health JCU structure provides an opportunity to develop wider collaborative strategic and commissioning initiatives at the same time as creating efficiencies.

The tender will be undertaken by the Public Health JCU and overseen by organisational governance structures, which include the Cambridgeshire and Peterborough

Commissioning Board. The Commissioning Board has approved the tender being taken forward and recommends that the Health Committee endorses the approach identified in this paper.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The report above sets out the implications for this priority in paragraphs 2.2 and 2.3

3.2 Helping people live healthy and independent lives

The report sets out the implications for this priority in paragraphs 2.1 and 2.3.

3.3 Supporting and protecting vulnerable people

The report sets out the implications for this priority in paragraph 2.1.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in **2.2, 2.3, *2.5 and 2.6***

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report above sets out details of significant implications in **1.3, 2.4, 2.5 and 2.7**

The proposal to undertake the procurement has been approved by the Cambridgeshire and Peterborough Joint Commissioning Board. It has not been reviewed by the Commercial Board

4.3 Statutory, Legal and Risk Implications

The report above sets out details of significant implications in **1.2**

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

- Failure to provide effective drug and alcohol treatment services will result in significant poor health and social outcomes for those affected.
- Patterns of alcohol and drug use have changed in recent years and different types of interventions and services are required if treatment and management of all associated needs are to be effective.

4.4 Equality and Diversity Implications

The report above sets out details of significant implications in **2.4 and 2.5**

4.5 Engagement and Communications Implications

The report above sets out details of significant implications in **2.4 and 2.5**

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

- An integral element of the procurement process will be the consultation with stakeholders, service users and the public. The information secured from these processes will influence the service specification and ongoing development of the services.

4.6 Localism and Local Member Involvement

There are no significant implications within this category.

4.7 Public Health Implications

The report above sets out details of significant implications in **2.1, 2.2, 2.3, 2.4 and 2.5**

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes 16 Aug 2017 Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes 22nd Aug 2017 Name of Officer: Paul White
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes 17 Aug 2017 Name of Legal Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes 18/ Aug 2017 Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Joanne Dickson
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes 18 Aug 2017 Name of Officer: Liz Robin

Have any Public Health implications been cleared by Public Health	Yes 18 Aug 2017 Name of Officer: Liz Robin

Source Documents	Location
Cambridgeshire Drugs and Alcohol Joint Strategic Needs Assessment	http://cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015
National Drugs Strategy 2017, Home Office	https://www.gov.uk/government/publications/drug-strategy-2017

Agenda Item No: 7

ANNUAL PUBLIC HEALTH REPORT 2017

To:	**Health Committee**
Meeting Date:	**7th September 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**To present the Annual Public Health Report 2017 to the Health Committee**
Recommendation:	**The Committee is asked to:** **a) discuss and comment on the information outlined in the Annual Public Health Report.** **b) to consider any recommendations the Committee may wish to make based on the content of the Report.**

	Officer contact:		***Member contacts:***
Name:	Dr Liz Robin	Names:	Peter Hudson
Post:	Director of Public Health	Post:	Chair
Email:	Liz.robin@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 703261	Tel:	01223 706398

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's Annual Public Health Report focussed on health and wellbeing issues at a very local level – providing health 'maps' of the County broken down into individual electoral wards. It also provided case studies of what is being done at the moment in communities in Cambridgeshire to support healthy lifestyles and wellbeing.

2. MAIN ISSUES

2.1 This year's Annual Public Health Report 2017 has a new focus – concentrating on the wider social and environmental factors affecting our health and wellbeing, and how these influence the differences in health outcomes we see across the county. The report also looks at key lifestyle behaviours which impact on longer term health and wellbeing, and at trends in life expectancy and preventable deaths in the county.

2.2 The overall picture is of a county with generally positive health outcomes and improvement in many long term trends. However, there are specific issues of concern including significant health inequalities across the county, and between neighbourhoods at a more local level.

2.3 The summary and recommendations of the report include the following:

- Where possible and statistically valid, we should be mapping more health and wellbeing indicators at the local neighbourhood level to help 'fine tune' the provision, targeting and monitoring of campaigns and services.
- That the disparity in educational outcomes between children receiving free school meals across the county and their peers should be a public health priority, given the impact of educational attainment on future health and wellbeing
- That the work taking place across the NHS and local authorities to improve early intervention and support for young people with mental health problems should lead to an improvement in current trends, and that the impact of this work needs careful monitoring.
- That a consistent and sustainable focus on the North Fenland and Wisbech area from a range of organisations is needed to address the determinants of health such as educational attainment and economic development, as well as a focus from health and care providers on delivering accessible prevention, treatment and support services to meet current needs.

2.4 The Microsoft Word version of the Annual Public Health Report attached at Appendix 1 includes the full content of the Report. The Report will undergo some further design work before it is published, and we hope to have hard copies available for Members at the Health Committee meeting on 7th September.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The APHR provides information on the relationship between employment, income and health including data at a local level. Much of the content of the report is 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 is focussed on many factors which help people to live healthy lives, and will enable them to remain independent for longer.

3.3 Supporting and protecting vulnerable people

The APHR reviews data on neighbourhoods and communities which experience multiple deprivation are vulnerable to a range of poor outcomes

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

As an independent report on the health of the population there are no immediate resource implications from this report. However taking forward any recommendations based on the findings of the Report could require reallocation of resources.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category

4.3 Statutory, Legal and Risk Implications

Under the Health and Social Care Act (2012) the Director of Public Health has a statutory duty to produce an annual report on the health of the population and the County Council has a duty to publish it.

4.4 Equality and Diversity Implications

There is information provided in the APHR about health inequalities in Cambridgeshire.

4.5 Engagement and Communications Implications

Copies of the APHR will be distributed to stakeholders and to venues such as libraries and GP surgeries.

4.6 Localism and Local Member Involvement

The report may be of interest to local community groups, but there are no specific significant implications within this category.

4.7 Public Health Implications

The public health implications of the information presented are clarified throughout the main body of the Annual Public Health Report.

Source Documents	Location
Annual Public Health Report (2015/16)	http://cambridgeshireinsight.org.uk/health/aphr
Public Health Outcomes Framework	http://www.phoutcomes.info/
Fair society heatlhy lives: The Marmot Review Institute of Health Equity	http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Cambridgeshire County Council

Cambridgeshire

Annual Public Health Report 2017

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INTRODUCTION

The purpose of this Annual Public Health Report 2017 is to provide a clear picture of the main health issues and trends in Cambridgeshire. Sitting behind the report is a wealth of web-based statistics and information, which can be accessed through the website for Public Health England's Outcomes Framework www.phoutcomes.info/ and Local Health www.localhealth.org.uk/

My Annual Public Health Report for 2016 focussed on health at a very local electoral ward level – providing information through pictograms and maps rather than traditional text and tables. It was designed to start a conversation with all three tiers of local government and the voluntary and community sector, understanding how we can work with communities to improve health and building on activities and assets which already exist at local level. The 2016 Report is available on http://cambridgeshireinsight.org.uk/health/aphr

This year's report has a different focus – concentrating on the wider social and environmental factors affecting our health and wellbeing, and how these influence the differences in health outcomes we see across the county. A brief report such as this can only skate across the surface of these complex issues, but can reflect some of the main findings and trends. The report also looks at key lifestyle behaviours which impact on longer term health and wellbeing, and at trends in life expectancy and preventable deaths in the county.

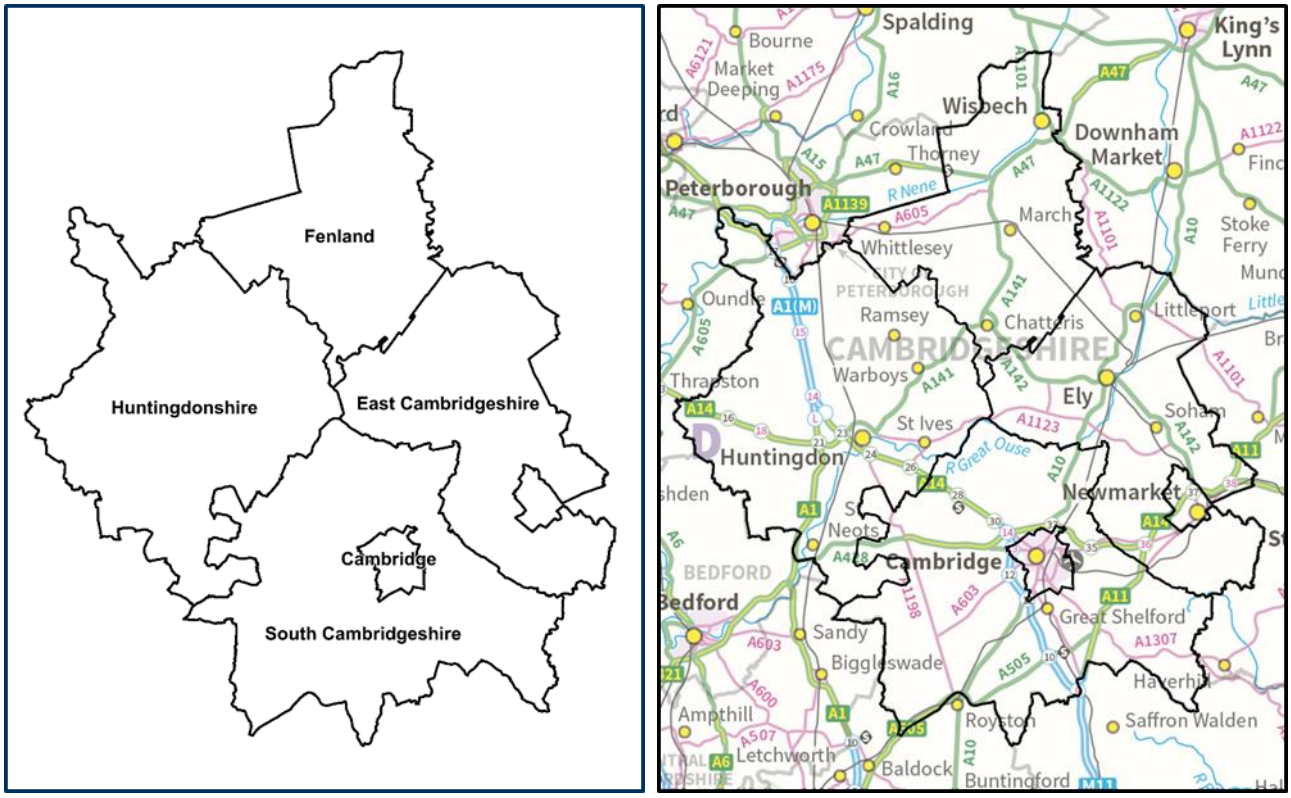
While issues of population growth and increasing demand on health and care services are critical issues for Cambridgeshire, these are covered in some depth in the Joint Strategic Needs Assessment Core Dataset available on http://cambridgeshireinsight.org.uk/jsna so are not duplicated in this report.

I'd like to thank the local Public Health Intelligence Team for their work in extracting and interpreting the key health information for Cambridgeshire and its districts, and for carrying out more detailed local analyses.

MAPPING HEALTH IN CAMBRIDGESHIRE

Because much of the information in this report is based on the five District/City Councils in Cambridgeshire, it's important to understand the geography of the county. The map below shows the boundaries of the District/City Councils within Cambridgeshire and the main towns and villages which sit within each district. .

Map 1: Local authority districts and major market towns, Cambridgeshire



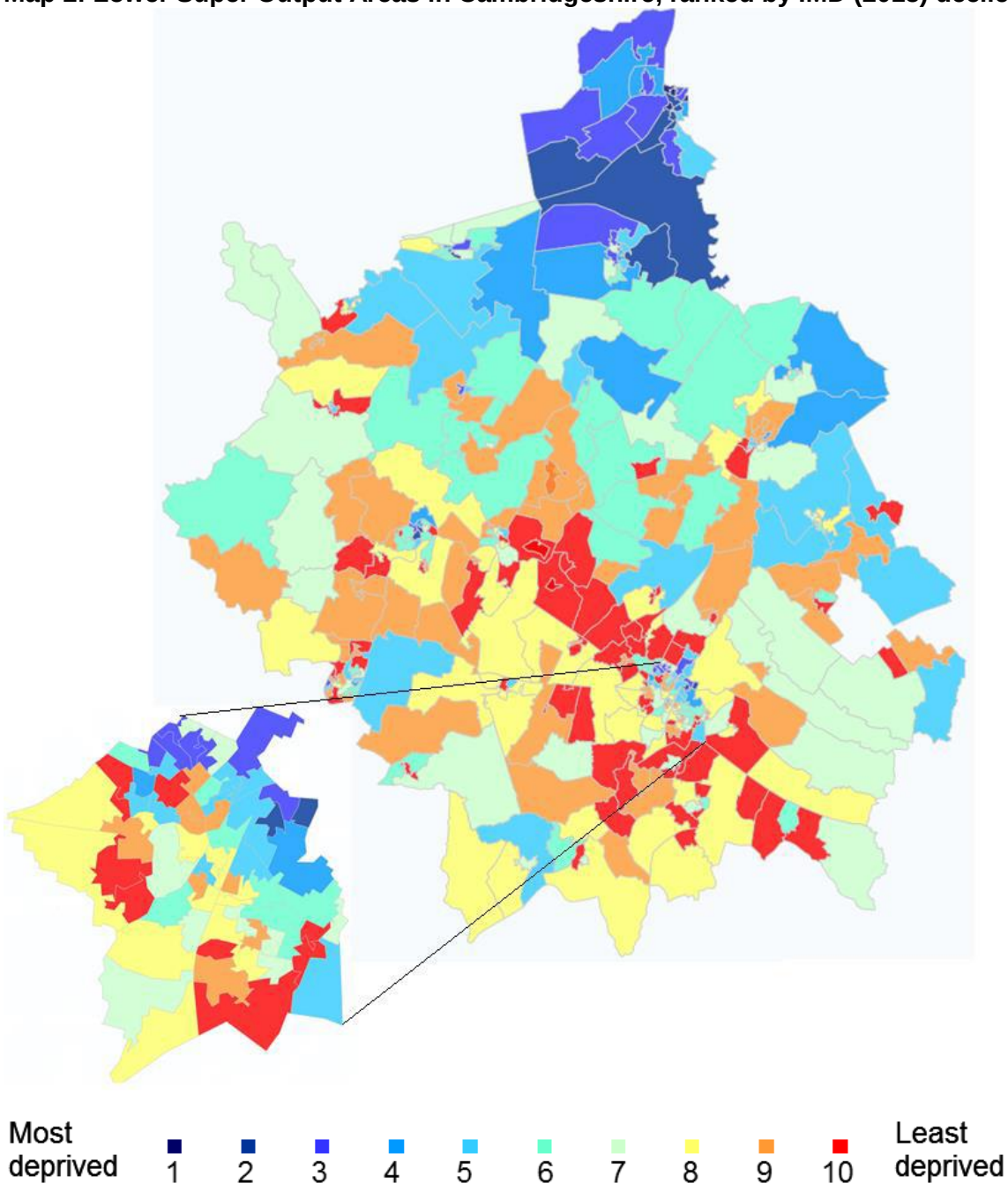
SECTION 1: THE DETERMINANTS OF HEALTH AND HEALTH OUTCOMES

1.1 The Index of Multiple Deprivation (2015)

An accepted way to look at the multiple factors which influence outcomes across communities and combine these into a single measure, is the 'Index of Multiple Deprivation' (IMD) which was last updated in 2015. The IMD (2015) calculates scores for neighbourhoods of about 1,500 people (called lower super output areas or 'LSOAs) for a range of factors, and then ranks all LSOAs in the country for their level of socio-economic deprivation.

The map of Cambridgeshire below shows neighbourhoods (LSOAs) in the county with their IMD (2015) ranks. Neighbourhoods among the most deprived 10% in the county are coloured dark blue, and those among the least deprived are coloured red. Cambridge City is expanded for clarity.

Map 2: Lower Super Output Areas in Cambridgeshire, ranked by IMD (2015) decile



It is clear that there is a north-south gradient in Cambridgeshire, with neighbourhoods with higher levels of deprivation concentrated in the north of Fenland district, while the most socio-economically advantaged neighbourhoods cluster in the southern part of the county. But there is also significant variation between neighbourhoods in each district.

IMD (2015) DNA charts

An alternative way of presenting information shown on the map above is called a ‘DNA chart’ because the bars on the chart look like pieces of DNA. Instead of putting each neighbourhood (LSOA) onto the geographical map of an area, the LSOAs from that area are lined up in rank order, and colour coded by the

national decile (10% banding) in which they fall. The national DNA chart would have ten colour coded bands of equal size (10% each). The DNA chart below for the districts of Cambridgeshire shows most districts have more neighbourhoods in the least socio-economically deprived deciles than the national average, although all have some neighbourhoods in more deprived deciles. The notable exception is Fenland district, which has no neighbourhoods in the most socio-economically advantaged 20%, and a higher proportion in the most deprived deciles.

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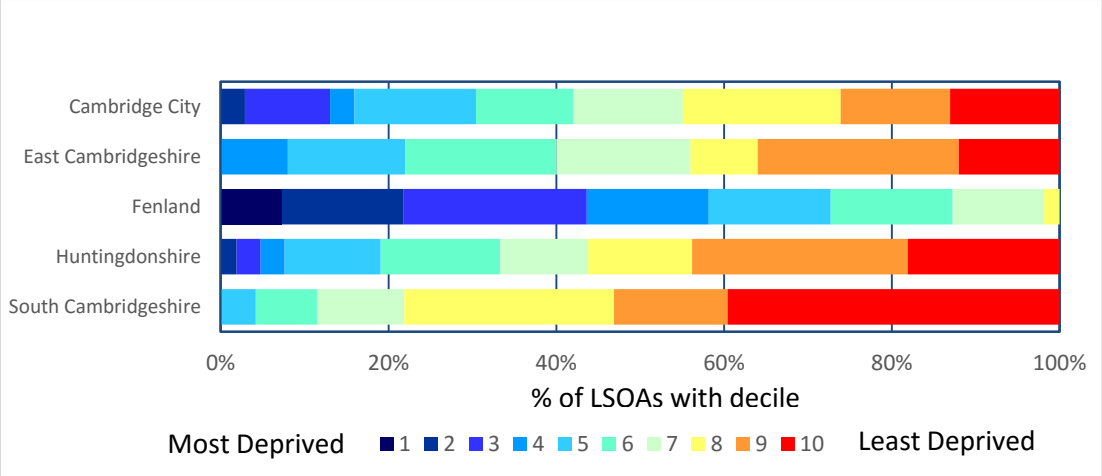
Figure 1: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.2 What is the impact of socio-economic deprivation on health?

This section of the report breaks down the key components of the IMD (2015) in order to look in more detail at the impact of socio-economic deprivation on health. The IMD (2015) score for each neighbourhood (LSOA) is created from a range of data summarised into seven 'domains as follows. The percentage next to each domain, shows its contribution to the overall IMD (2015) score.

IMD (2015) Domains

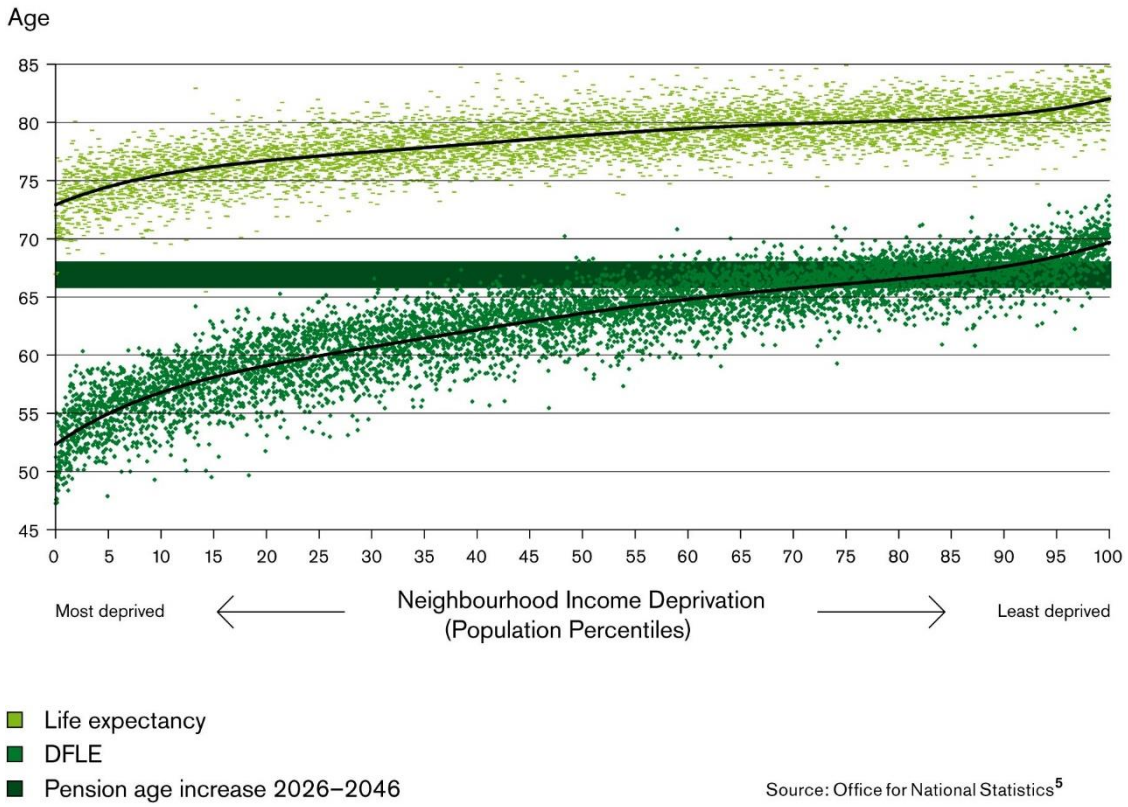
- Income (22.5%)
- Employment (22.5%)
- Education, Skills and Training (13.5%)
- Health deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment (9.3%)

More detail of the data included in each of these IMD (2015) domains is provided in Appendix A.

1.3 Income and health

We know that income levels are strongly linked with overall health and wellbeing. National research by the Institute of Health Equity showed that while there was a difference of around 10 years in overall life expectancy between neighbourhoods with the lowest and the highest incomes, the difference in 'disability free life expectancy' was closer to 20 years. This indicates that people who live in neighbourhoods with low average levels of income are likely to experience significant illness and disability at an earlier stage in their lives.

Figure 2: Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England 1999-2003

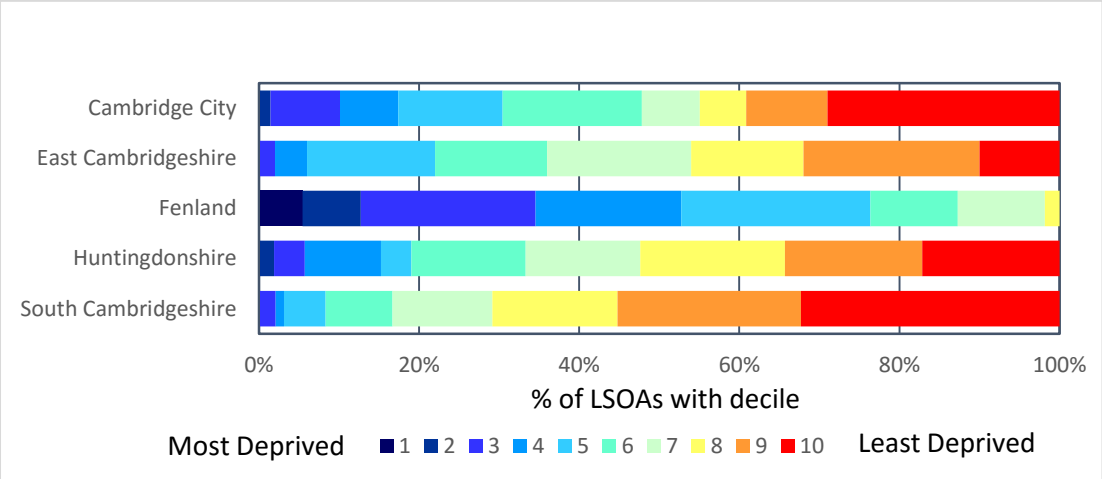


Source: Office for National Statistics[5]

1.4 Income levels in Cambridgeshire districts

The following DNA chart shows the 'Income' domain scores for IMD (2015) for each Cambridgeshire district. Most districts have more neighbourhoods with low income deprivation. It's clear that Fenland has a higher proportion of income deprived neighbourhoods than other districts. The research from the Institute of Health Equity would predict that Fenland would have shorter average life expectancy and 'disability free life expectancy' than the rest of the county.

Figure 3: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Income)



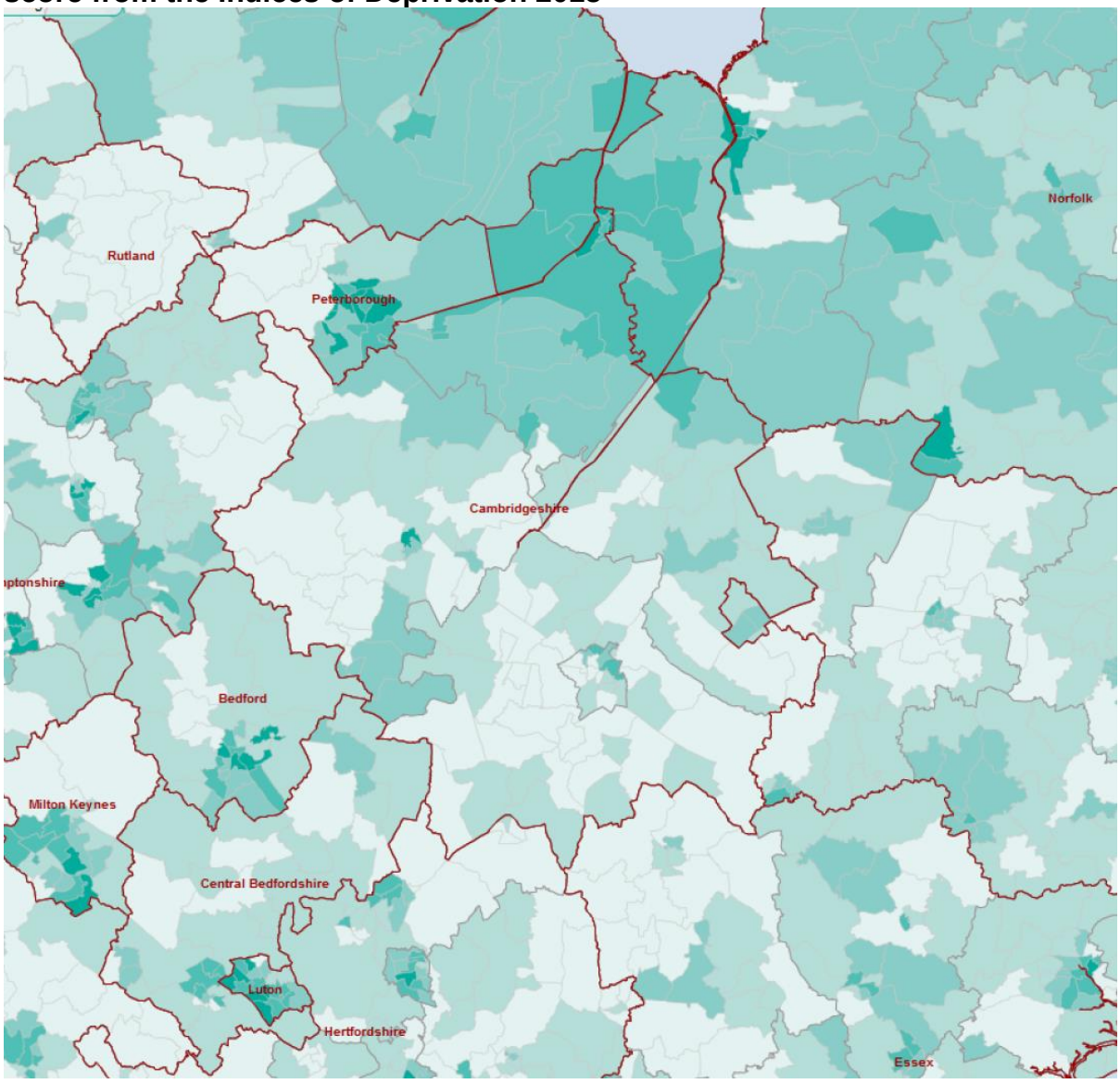
Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

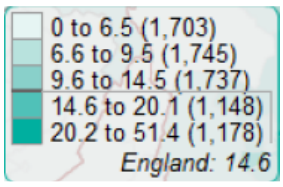
1.5 Factors affecting income deprivation

Income deprivation is related to the proportion of low paid work in the local economy, which in turn depends on the types of employment available. This varies across the county, with a higher dependence on farming and associated industries such as food processing and packing in the northern rural areas. The map below shows the IMD (2015) income deprivation domain for Cambridgeshire and surrounding areas. It's clear that the higher levels of income deprivation in North Fenland form part of a wider picture, extending into West Norfolk and Lincolnshire. Conversely the low levels of income deprivation in South Cambridgeshire district are part of a wider picture extending into Suffolk, Essex and Hertfordshire.

It is also important to note that for people on low incomes living in the south of the county including Cambridge City, high housing costs can significantly limit the income they have available to meet other needs. More sophisticated economic analyses would also include measures of income deprivation after allowing for housing costs.

Map 3: Cambridgeshire and surrounding areas - % living in income deprived households reliant on means tested benefit, income domain score from the Indices of Deprivation 2015

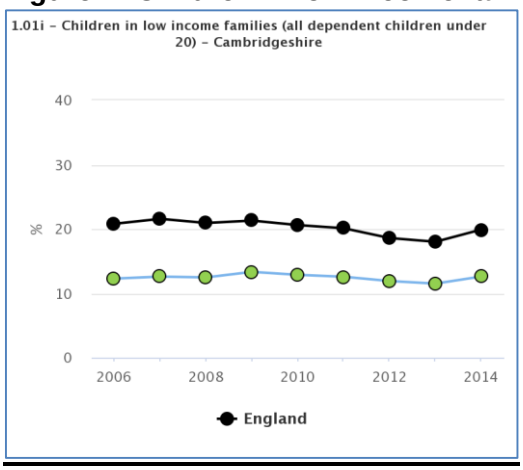


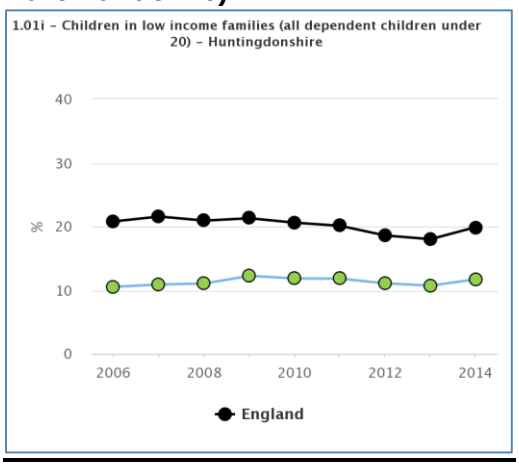


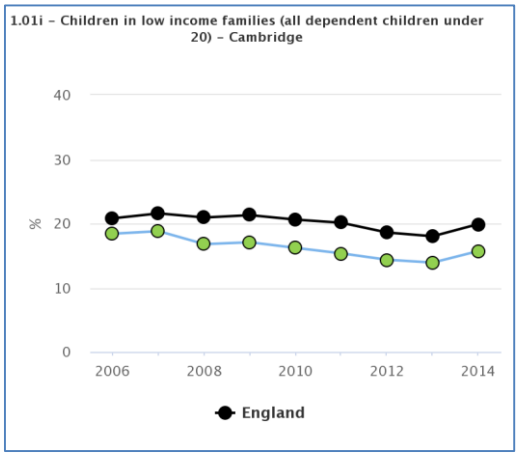
1.6 Children in low income families

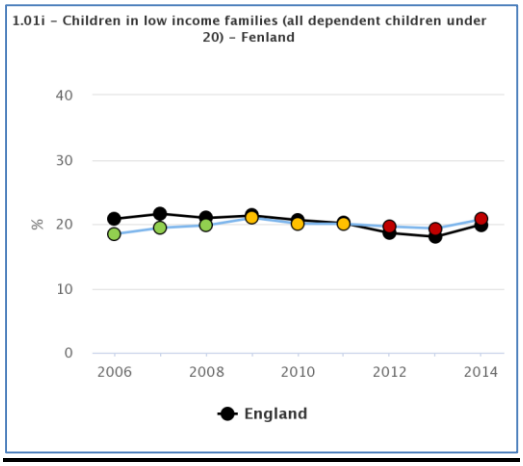
While the IMD (2015) is a useful overall measure of deprivation across the county it describes one point in time and it is also useful to look at long term trends. One measure that is routinely presented as part of the national Public Health Outcomes Framework is the proportion of children under 20 living in low income families. The following charts show the trend in this measure for Cambridgeshire as a whole and for each of its district/city councils, against the average for England.

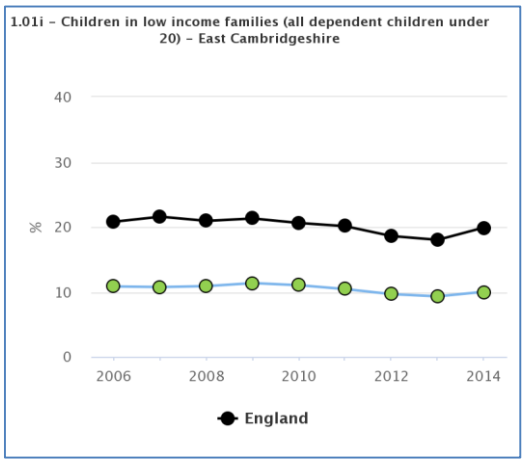
Figure 4: Children in low income families (children under 20)

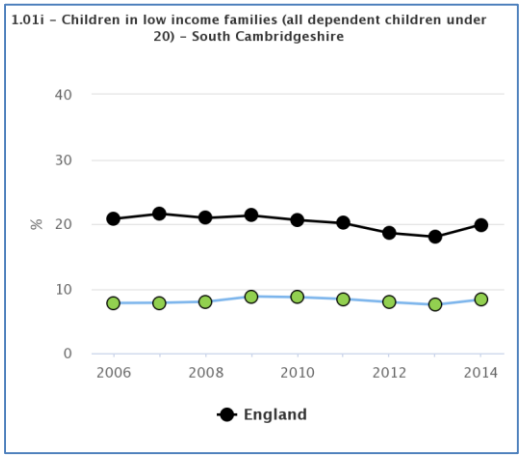












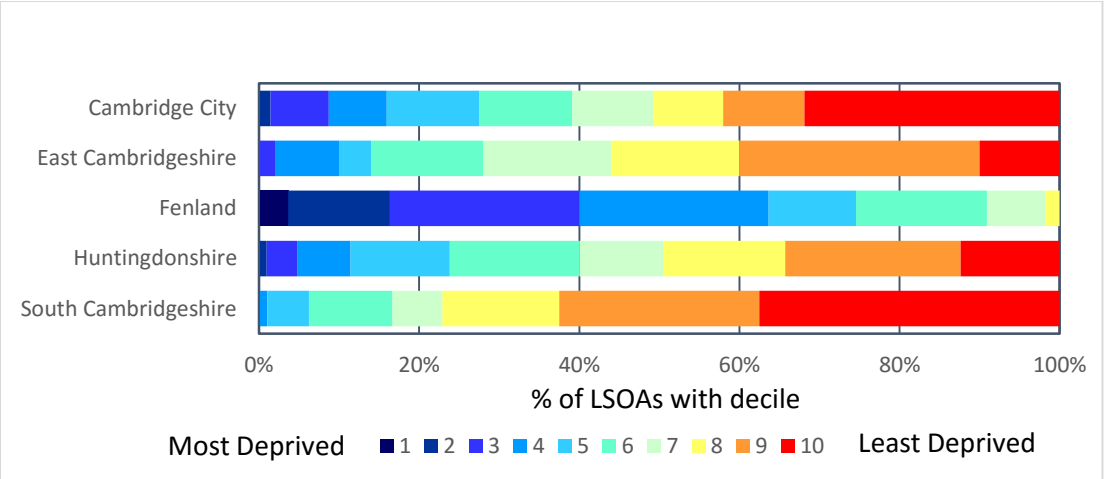
Source: Public Health Outcomes Framework

For Cambridgeshire and most of its districts, the percentage of children in low income families has remained well below the national average. While the proportion of children in low income families was similar in Cambridge City and in Fenland in 2006, the two areas have since diverged – with Cambridge City now having significantly fewer children in income deprived families than the national average, while in Fenland the percentage has increased and is now significantly above average. However the impact of high housing costs in Cambridge City on lower income families should also be considered.

1.7 Employment and health

The IMD (2015) DNA chart for employment for Cambridgeshire districts, which is based on the proportion of residents receiving out of work benefits, is very similar to that for income. As for other measures, there is a high proportion of neighbourhoods (LSOAs) in the least deprived 20% nationally in most Cambridgeshire districts, but Fenland has no neighbourhoods in the least deprived 20% and a higher proportion in the more deprived deciles.

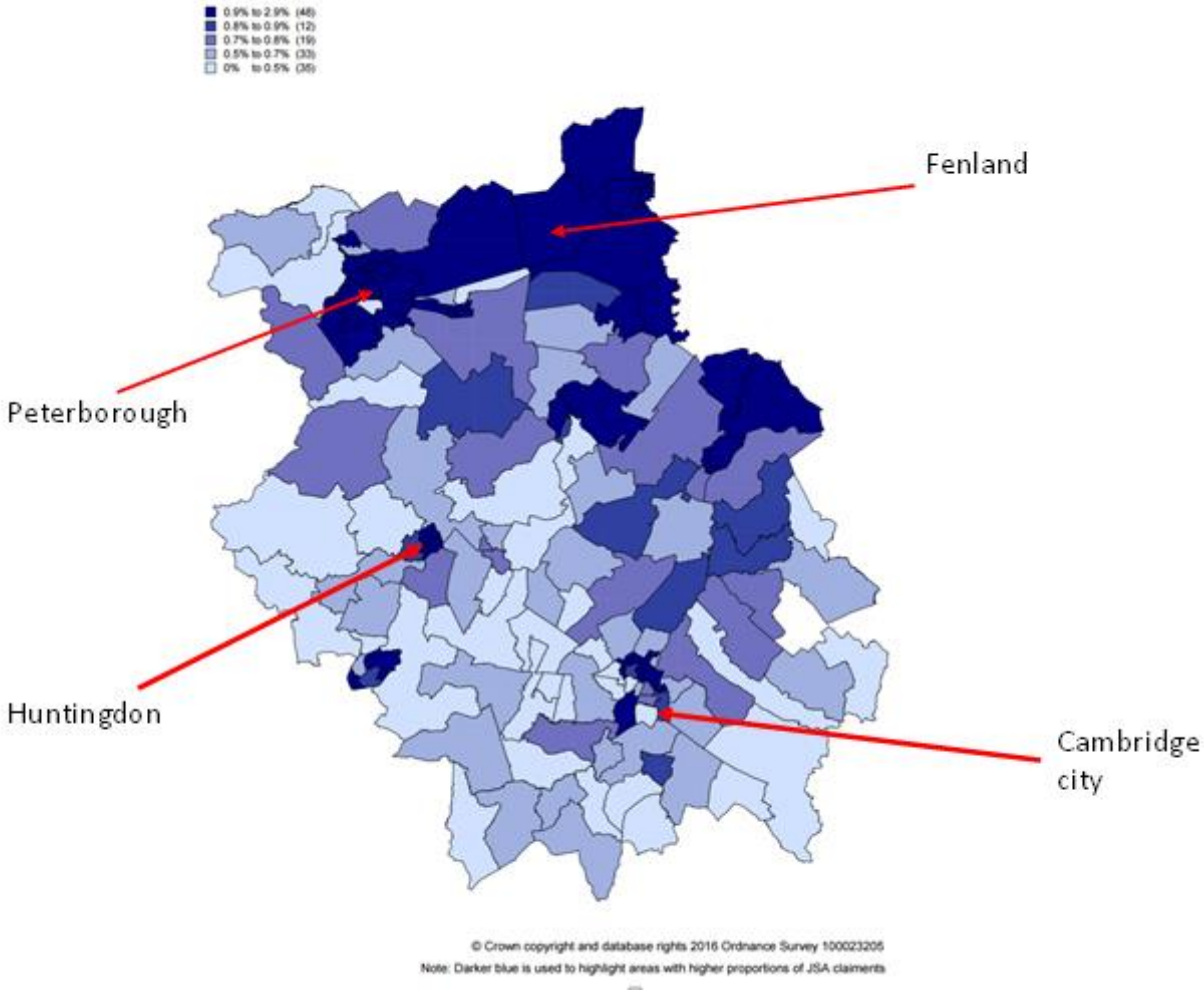
Figure 5: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Employment)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

The most common out of work benefit claimed is Employment Support Allowance (ESA) which provides financial support to people with illness and disability who are unable to work or are receiving personalised support to help them return to work. There is a complex relationship between work and health – where unemployment and low income are known to be risk factors for poorer health outcomes, but poor health can in turn lead to reduced productivity, unemployment or reduced income. The map below shows the rates of ESA claimants for neighbourhoods in Cambridgeshire and Peterborough, with closely mirrors the picture for wider IMD (2015) deprivation levels.

Map 4: Rate of Employment Support Allowance (ESA) claimants in Cambridgeshire, May 2016

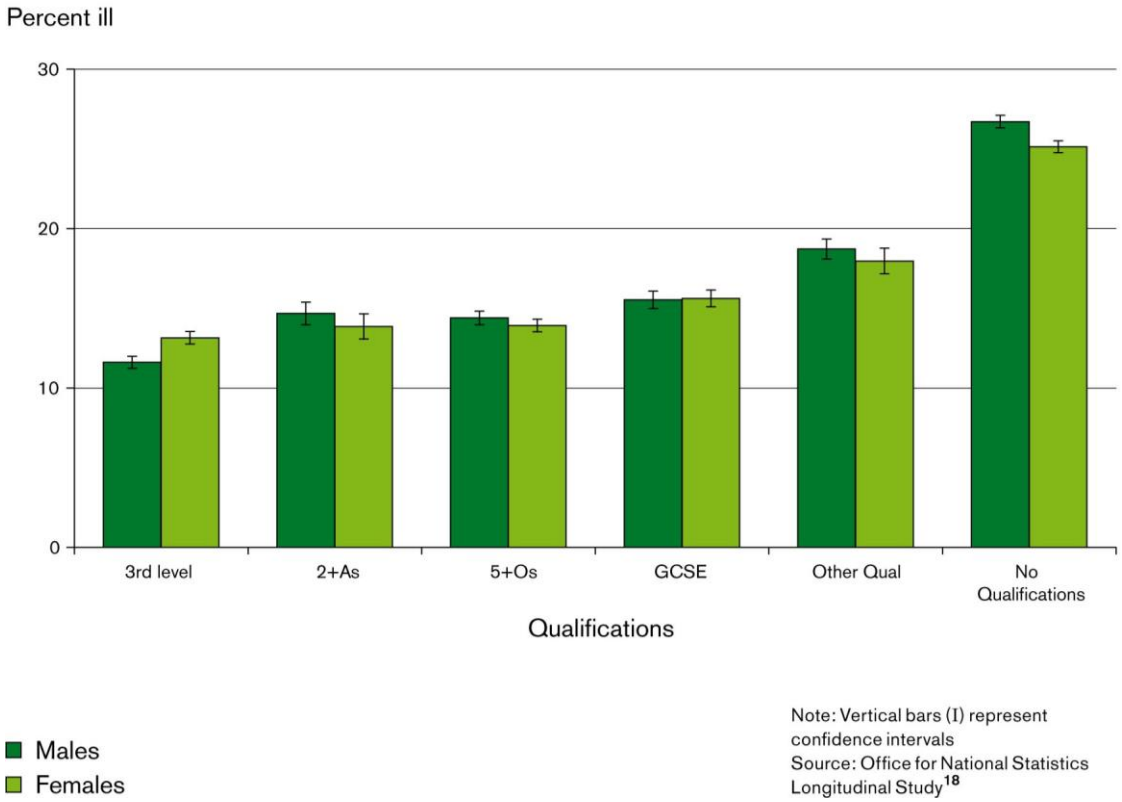


Source: DWP Data and Analytics

1.8 Education and health

We know that levels of education are closely related to health. Much of this relationship is likely to be the result of better employment prospects and incomes for people with higher qualifications. But there is also evidence that education is linked to better 'health literacy' and adoption of healthier lifestyles. The graph below shows that nationally, for adults up to the age of 75, people with no educational qualifications are more than twice as likely to have an illness which limits their daily life than people with degree level or similar qualifications.

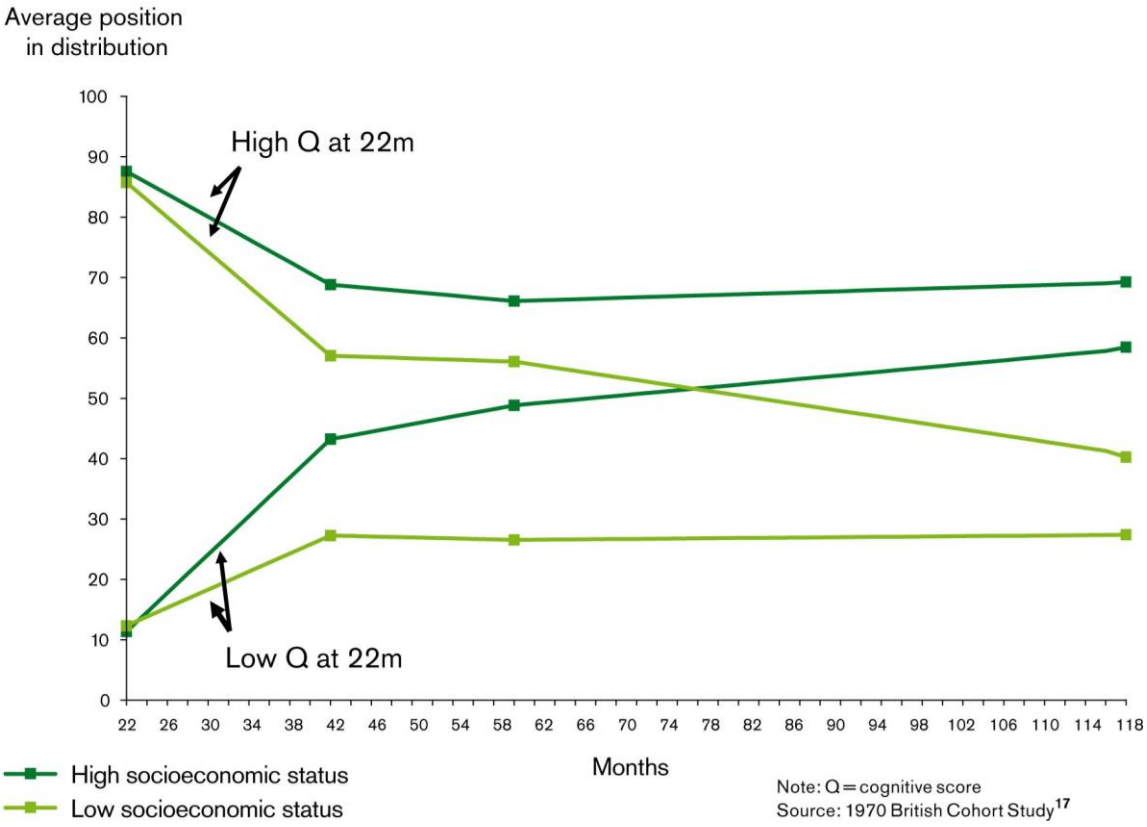
Figure 6: Standardised limiting illness rates in 2001 at ages 16-71, by education level recorded in 2001



Note: Vertical bars (I) represent confidence intervals
Source: Office for National Statistics Longitudinal Study[18]

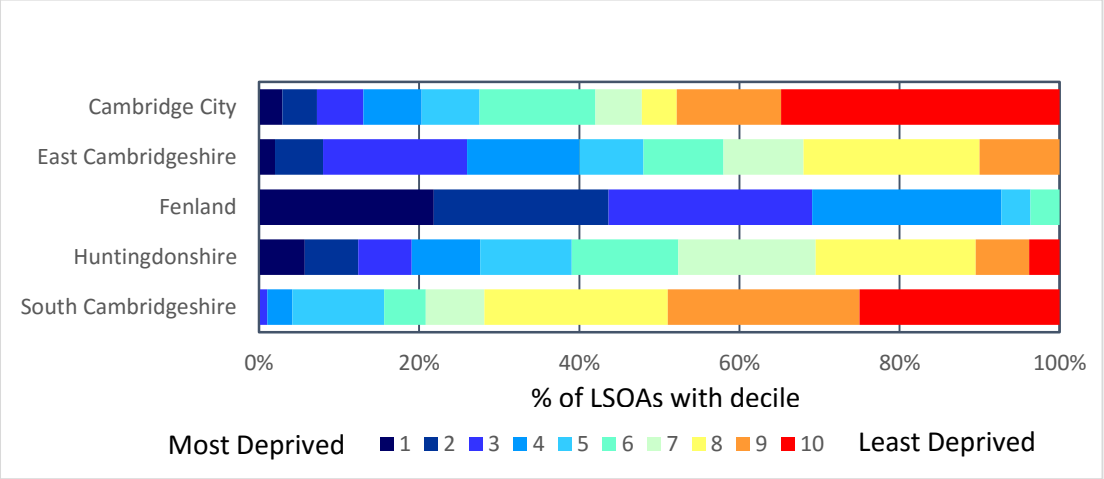
We also know that as children grow, their cognitive ability - which will enable them to do well at school, is strongly influenced by their social background. The following graph, based on a study of children born in 1970, shows that children from disadvantaged social backgrounds who had some of the highest (best) cognitive scores (Q) at age two, had moved to below average cognitive scores by age ten. Children from the most advantaged backgrounds with poor cognitive (Q) scores at age two, had moved to better than average scores by age 10.

Figure 7: Inequality in early cognitive development of children in the 1970 British Cohort Study, at ages 22 months to 10 years



The Cambridgeshire DNA chart for the IMD (2015) Education Skills and Training, shows that some Cambridgeshire districts score less well for this domain than for income and employment. While Cambridge City and South Cambridgeshire have relatively high numbers of neighbourhoods in the least deprived 20% for this domain, the proportion in both Huntingdonshire and East Cambridgeshire in the top deciles is lower than the national average. Fenland has no neighbourhoods (LSOAs) in the top 40% nationally, and nearly half of its LSOAs are in the lowest 20%. There are also significant inequalities within districts. Huntingdonshire, Cambridge City and East Cambridgeshire all have neighbourhoods (LSOAs) in the lowest 10% nationally. Educational attainment, including its future impact on health and wellbeing is therefore a particular concern for Cambridgeshire.

Figure 8: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Education, Skills and Training)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.9 School readiness

The first step to good educational attainment is for children to be ready to start school, so that they are prepared for learning and can enjoy lessons. The 'school readiness' of pupils is assessed in primary schools at the end of Reception year and involves a range of assessment areas: personal, social and emotional development; physical development; and communication and language; as well as the specific areas of mathematics and literacy. Figures for the 2015/16 school year showed that for Cambridgeshire as a whole, the percentage of children who were 'school ready' at age five was 69.7% - similar to the England average of 69.3%. However, a more detailed breakdown figures from the 2014/15 school year showed that only 49.3% of Cambridgeshire children from more disadvantaged backgrounds who were eligible for free school meals were 'school ready', lower than the England average of 54.4% for this group.

CASE STUDY – MAKING A DIFFERENCE

Waterlees (Wisbech) Community Literacy Project

This project ran from 2012 to 2014. The total funding was £77,000, provided by Cambridgeshire County Council. The project aimed to develop a community approach to literacy development. The focus was the youngest children and their families, and any people with low literacy within the community, supported by initiatives that drew on local skills and capacity.

In 2013 in Wisbech only 31% of Reception children achieved a good level of development at the end of Reception year, using the national 'school readiness' measure. Two years later in 2015 this had risen to 57%, showing an increase of 26%. This was almost double the national rate of improvement.

Because of the good results seen the County Council has agreed to fund a further community literacy project in Wisbech and a small number of other areas around the county, and planning is underway for this.

1.10 GCSE attainment

In 2015/16, 61.2% Cambridgeshire children achieved five or more GCSEs at grade A-C including English and Maths. This was better than the national average of 57.8% and Cambridgeshire ranked sixth out of a comparator group of 16 County Councils with similar social and economic characteristics.

However in in the more detailed national analysis of GCSE results from 2014/15, only 23.4% of Cambridgeshire children eligible for free school meals achieved five or more GCSEs grade A-C. The national average for children eligible for free school meals was considerably higher than this at 33.3%. Cambridgeshire children eligible for free school meals had the worst results in our comparator group of similar local authorities.

Figure 9: Children who attained five A*-C GCSE's and who are eligible for free school meals, Cambridgeshire compared to similar local authorities (2014/15)

Area	Value	Lower CI	Upper CI
England	33.3	33.0	33.6
Hertfordshire	35.3	32.3	38.4
Essex	32.3	29.8	34.8
Buckinghamshire	32.2	27.6	37.2
West Sussex	31.9	28.5	35.6
Warwickshire	31.3	27.3	35.7
Oxfordshire	31.2	27.2	35.5
Staffordshire	30.3	27.2	33.5
North Yorkshire	30.0	25.8	34.5
Gloucestershire	29.2	25.4	33.4
Leicestershire	29.0	25.4	32.9
Worcestershire	28.3	24.7	32.3
Suffolk	27.7	24.7	30.9
Somerset	27.4	23.6	31.6
Northamptonshire	27.2	24.4	30.3
Hampshire	26.3	23.7	28.9
Cambridgeshire	23.4	20.0	27.2

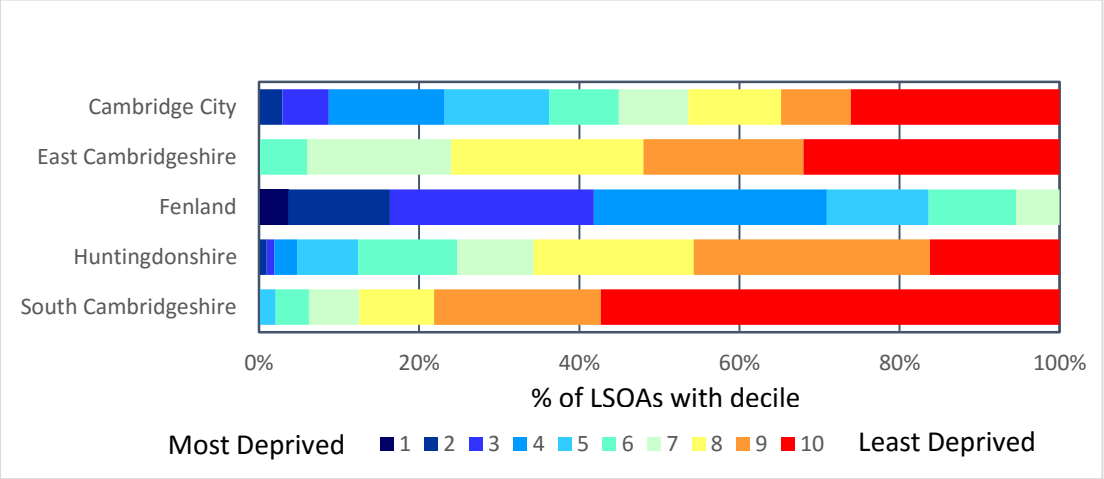
Source: Department for Education

This is a county-wide issue which isn't confined to one geographical area, and demonstrates the risk that economic disadvantage associated with reduced health and wellbeing can continue across generations.

1.11 Health deprivation and disability

The health domain of IMD (2015) combines information on life years lost through premature death, illness and disability ratios, acute illness leading to emergency hospital admission, and mental health. The majority of areas in Cambridgeshire show very good scores on this domain, with nearly 80% of South Cambridgeshire neighbourhoods in the least deprived 20% nationally, and all neighbourhoods in East Cambridgeshire in the least deprived 50%. This does make the difference between Fenland and the rest of the county more striking, as over 80% of Fenland neighbourhoods are in the most deprived 50% nationally. Cambridge City and Huntingdonshire also have internal inequalities, with a small number of neighbourhoods in the lowest 20% nationally. As expected, the DNA chart shows that health deprivation and disability is closely linked with and shows a similar picture to, other aspects of the IMD (2015) in Cambridgeshire.

Figure 10: Cambridgeshire & Districts LSOAs, Index of Multiple Deprivation Deciles 2015 (Health)



Source: Index of Multiple Deprivation, Department for Communities & Local Government, https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

1.12 Other IMD Domains

The three remaining IMD (2015) domains which together account for 28% of the overall IMD score are 'crime', 'barriers to housing and services', and 'living environment'. Of these 'barriers to housing and services' is an area which generally scores poorly across Cambridgeshire.

Figure 11: Public Health England's framework for understanding the relationship between health and housing

Source: Public Health England

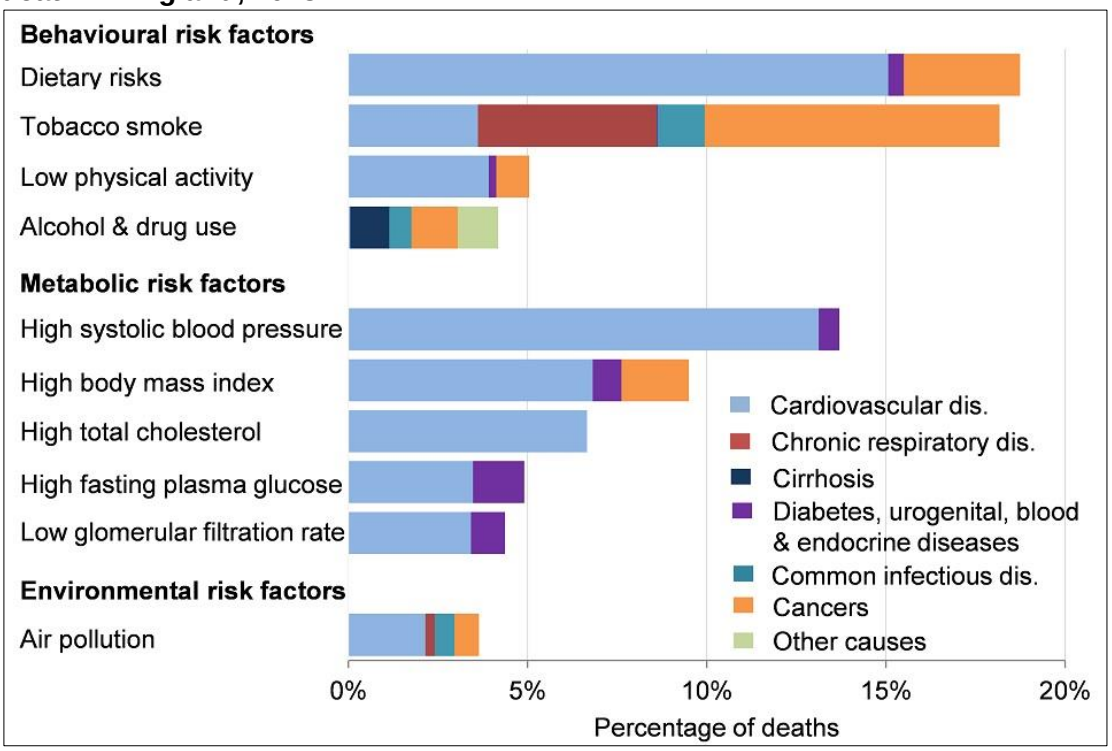
It is a composite of the distance of neighbourhoods from services such as primary schools and GP surgeries, which is often higher in rural areas; together with factors indicating reduced access to housing such as overcrowding, homelessness and housing affordability.

Housing affordability is a particular issue across much of Cambridgeshire, and can increase the risk of homelessness. There are a number of issues for areas with high private sector market rents such as Cambridge City, which can accentuate disadvantage for people on low incomes and significantly reduce the money they have available to spend on needs other than housing.

SECTION 2: KEY LIFESTYLE AND HEALTH BEHAVIOURS - HOW DOES CAMBRIDGESHIRE COMPARE WITH OTHER AREAS?

It is increasingly recognised that a set of key lifestyle and health behaviours influence people's risk of developing long term health conditions earlier in life and of dying prematurely. The chart below indicates that almost one in five deaths in England can be attributed to dietary factors and almost one in five to smoking. Lack of physical activity and alcohol/drug use are also important risk factors.

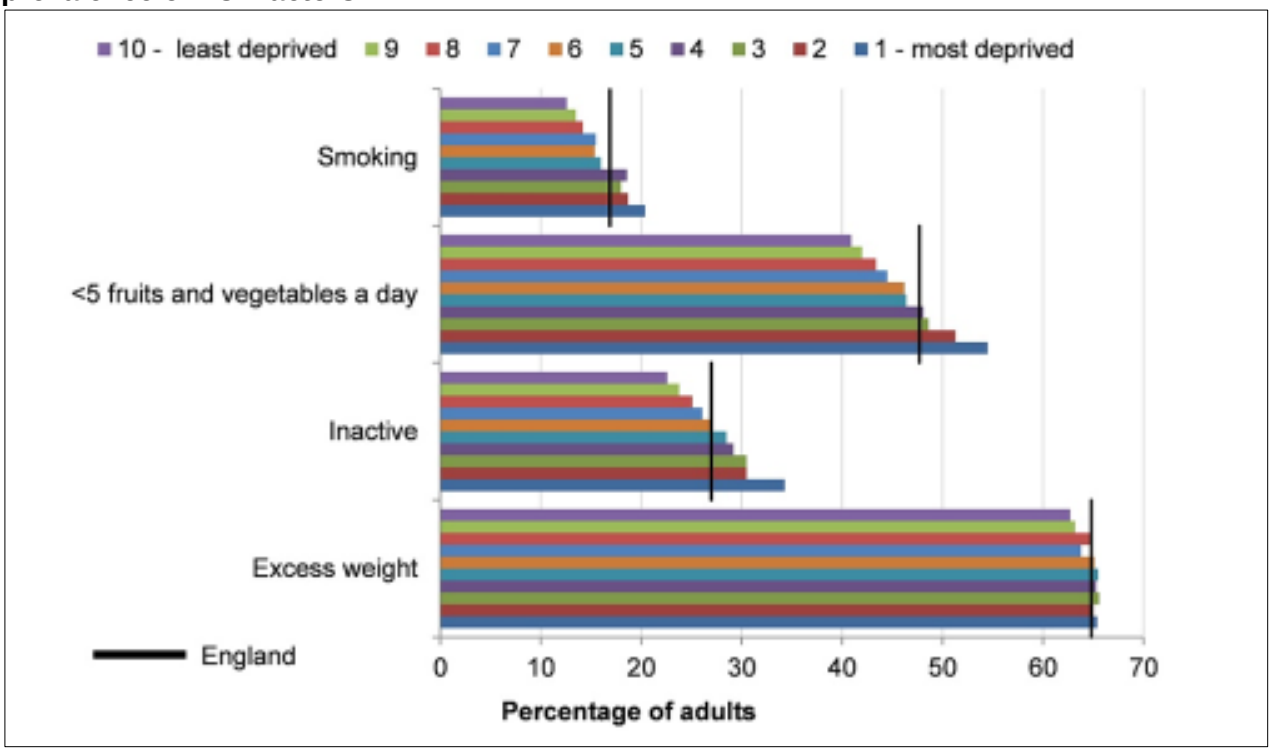
Figure 12: Attribution of deaths to risk factors and broken down by broad causes of death in England, 2013



Source: Public Health England 'Health Profile for England' 2017

It is also known that people's social and environmental circumstances are linked with their lifestyle behaviours and this has recently been mapped at local authority level by Public Health England.

Figure 13: The prevalence of risk factors varies across upper tier local authorities grouped into deprivation deciles, whereby the least deprived areas had the lowest prevalence of risk factors



Source: Public Health England 'Health Profile for England' 2017

2.1 Smoking and tobacco in Cambridgeshire

The table below shows that the percentage of adults who smoked in Cambridgeshire in 2016 was similar to the national average in most District/City Council areas and for Cambridgeshire as a whole. In Fenland the smoking prevalence was significantly worse than the national average, at 21.6% compared with 15.5% nationally.

Figure 14: Percentage of adults who smoked, Cambridgeshire & Districts 2012-2016

Area	Smoking Prevalence (%)				
	2012	2013	2014	2015	2016
Cambridge City	13.4	9.2	16.5	17.7	15.1
East Cambridgeshire	19.6	18.9	16.2	14.4	15.3
Fenland	31.3	24.3	21.7	26.4	21.6
Huntingdonshire	18.8	12.7	15.2	13.9	14.0
South Cambridgeshire	15.5	11.5	11.6	12.8	12.8
Cambridgeshire	18.9	14.4	15.7	16.4	15.2
England	19.3	18.4	17.8	16.9	15.5

Source: Public Health Outcomes Framework

Key

	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

By comparing Fenland with local authorities which are socially and economically similar, we can see whether the rate of smoking is at the expected level, given the local socio-economic circumstances, or whether it still seems high. Fenland has the second highest smoking prevalence in its 'nearest neighbour' group of local authorities, which indicates there is potentially more local work to be done to encourage a reduction in smoking.

Figure 15: Smoking prevalence in adults – current smokers (APS) 2016

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	15.5	15.3	15.7
Boston	–	10	-	24.9	16.9	32.9
Fenland	–	-	-	21.6	15.6	27.5
Mansfield	–	12	-	20.9	15.1	26.7
East Staffordshire	–	14	-	20.2	14.6	25.7
South Holland	–	1	-	19.0	13.4	24.7
West Lancashire	–	13	-	16.5	11.0	21.9
Newark and Sherwood	–	7	-	16.3	11.2	21.5
South Kesteven	–	15	-	16.0	11.5	20.4
Wyre Forest	–	4	-	15.6	10.3	21.0
King's Lynn and West Norf...	–	9	-	15.5	11.2	19.8
Bassetlaw	–	3	-	14.9	9.8	19.9
Carlisle	–	8	-	14.2	10.1	18.2
Kettering	–	11	-	13.2	7.9	18.4
Breckland	–	2	-	11.9	7.7	16.2
Amber Valley	–	5	-	10.7	6.3	15.1
Erewash	–	6	-	10.7	5.6	15.7

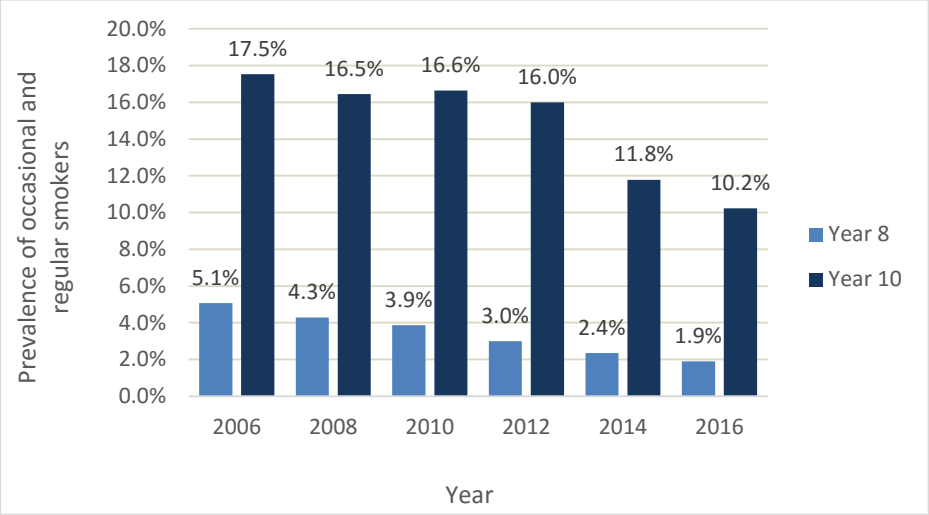
Source: Annual Population Survey (APS)

Source: Public Health Outcomes Framework (August 2017)

2.2 Smoking: children and young people

Two thirds of smokers start before they reach the age of 18, so when looking to the future it's important to understand current smoking behaviour among teenagers. In Cambridgeshire we are lucky to have data collected over several years from the Health Related Behaviour Survey carried out for school years 8 and 10 in nearly all Cambridgeshire secondary schools. These data show that since 2006, there has been a signifcant reduction in the percentage of children who say that they either occasionally or regularly smoke, both among children in year 8 (12-13 year olds) and year 10 (14-15 year olds).

Figure 16: Health Related Behaviour Survey – smoking – occasional and regular smokers (%), Cambridgeshire, 2006-2016



Source: Health Related Behaviour Survey

CASE STUDY – MAKING A DIFFERENCE

Kick Ash – A young person led smoke free programme in Cambridgeshire schools

Cambridgeshire's young person led smoke free programme, Kick Ash, has been running in selected schools since 2009/10, working with support from a range of staff including public health, Personal, Social, Health, Education (PSHE), trading standards and communications experts. Year 10 peer mentors lead and deliver the programme, focusing on smoking-related decision-making and promoting a smoke free lifestyle to Years 5, 6 and 8.

Initial analysis suggests that the percentage of Year 10 students currently smoking in Kick Ash schools has fallen significantly since the programme began, and the percentage never having smoked has increased. Whilst we know that young people's smoking has fallen across the county, our findings suggest that the rate of decline in Kick Ash schools has been faster than in other schools.

The results are particularly encouraging as schools included in the Kick Ash programme have been those in areas where a higher proportion of both young people and adults are smokers. The programme reports many additional benefits, including increased confidence and communication skills from the mentors and improved transitioning from primary to secondary school.

2.3 Unhealthy weight and obesity

There has been national concern for some time about the long term rising trend in both childhood and adult obesity, the implications that this has for individual health and wellbeing, and the potential for increased demands on the health service due to obesity related illness such as diabetes, joint problems and heart disease.

In Cambridgeshire a lower proportion of adults have an unhealthy weight than the national average. When this is reviewed at a district level it's clear that while Cambridge City, with its young population, has a very low proportion of people with unhealthy weight, East Cambridgeshire, Huntingdonshire and in particular Fenland all have proportions of people with unhealthy weight which are significantly above the national average. Fenland also has a high rate of people with recorded diabetes (associated with overweight and obesity) at 7.8% of adults, compared with 6.4% nationally.

Figure 17: Percentage of adults with excess weight, Cambridgeshire & Districts, 2012/14 – 2013/15

Area	Excess weight in adults, %	
	2012/14	2013/15
Cambridge City	48.3	46.7
East Cambridgeshire	68.0	68.1
Fenland	73.1	72.9
Huntingdonshire	67.3	67.6
South Cambridgeshire	63.6	63.6
Cambridgeshire	63.6	63.2
England	64.6	64.8

Source: Public Health Outcomes Framework

Key

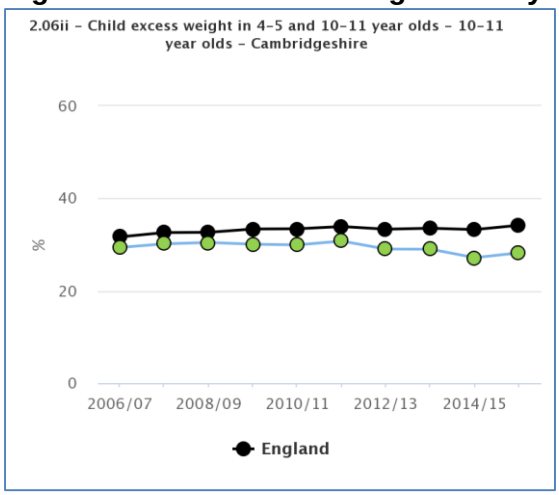
	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

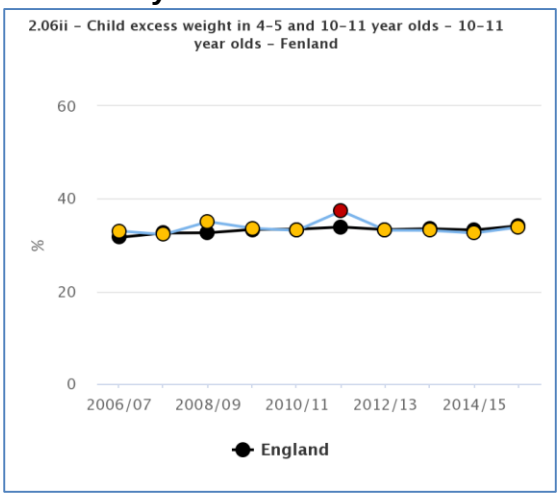
2.4 Unhealthy weight and obesity: children and young people

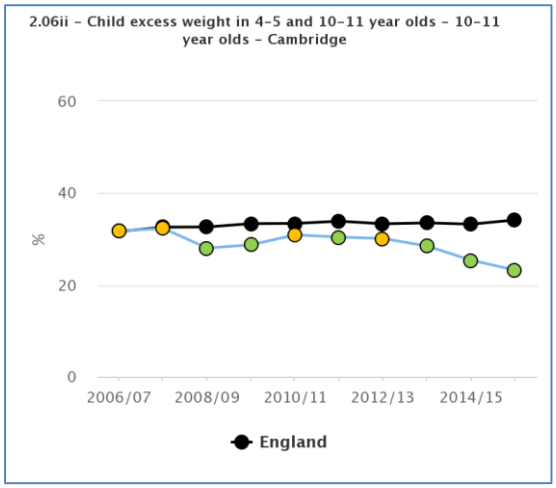
The weight of children in reception (age 4-5) and year 6 (age 10-11) is now measured at school as part of the National Childhood Measurement Programme (NCMP).

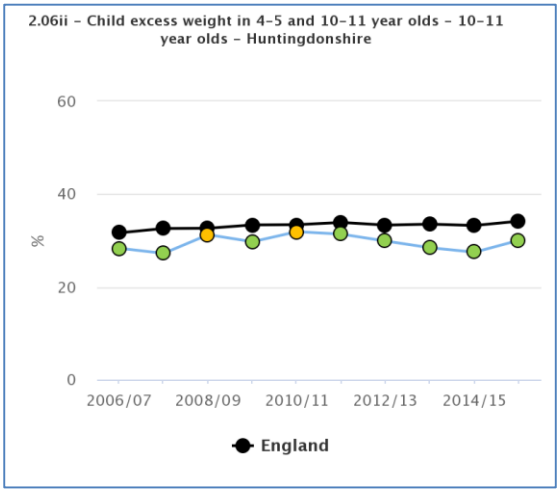
The following trend graphs from 2006/07 through to 2015/16 show that the percentage of children in year 6 in Cambridgeshire with an unhealthy weight has fallen slightly from 29.4% to 28.2% between 2006/07 and 2015/16, compared with a national increase from 31.7% to 34.2%. In Fenland rates have stayed similar to the national average.

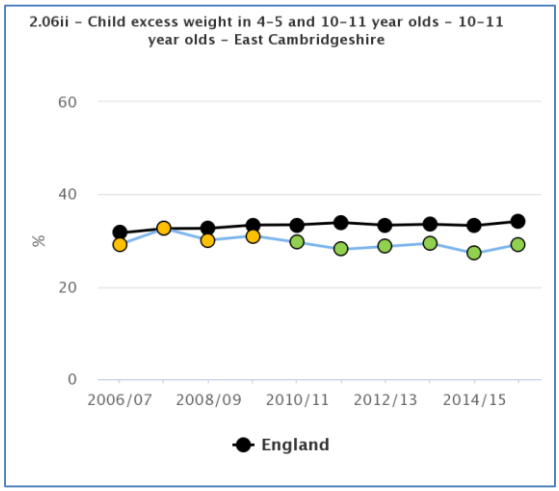
Figure 18: Child excess weight in 4-5 year olds and 10-11 year olds

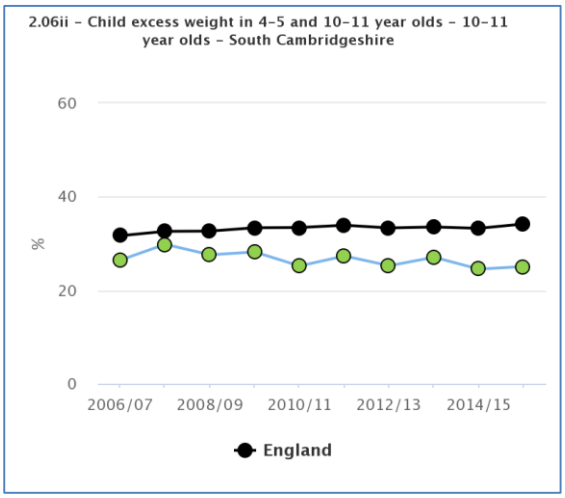












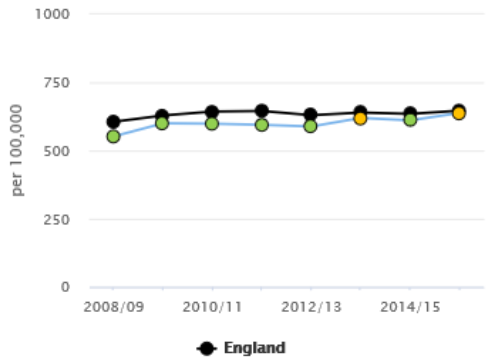
Source: Public Health Outcomes Framework August 2017

2.5 Alcohol and drug use

While alcohol and drug misuse have a smaller impact on overall population mortality than smoking and diet, they cause a higher proportion of deaths under the age of 50, and are associated with significant costs to wider society, including the criminal justice system.

Hospital admissions for alcohol related conditions have been increasing slightly in Cambridgeshire as a whole and are now similar to the national average. Both Cambridge City and Fenland have alcohol related hospital admission rates which are significantly above the national average and which have risen in recent years. Rates in the other districts of Cambridgeshire remain below the national average.

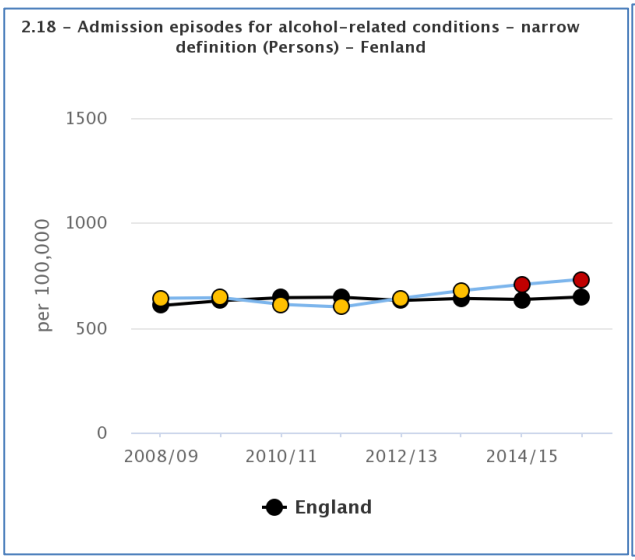
Figure 19: Cambridgeshire - admission episodes for alcohol-related conditions - narrow definition (persons), 2008/09 to 2015/16

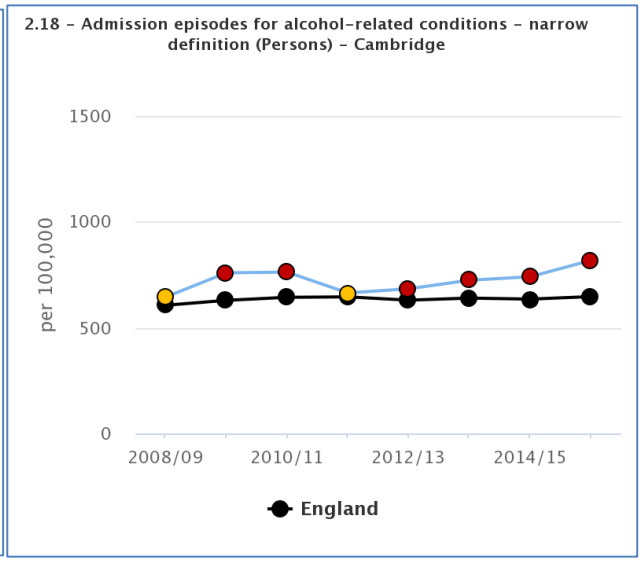


Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2008/09		3,168	552	533	572	490	606
2009/10		3,464	600	580	621	531	629
2010/11		3,503	599	579	619	542	643
2011/12		3,536	595	575	615	559	645
2012/13		3,526	589	569	608	552	630
2013/14		3,782	620	600	640	582	640
2014/15		3,772	611	591	631	580	635
2015/16		3,981	638	618	658	588	647

Source: Calculated by Public Health England: Risk Factors Intelligence team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.



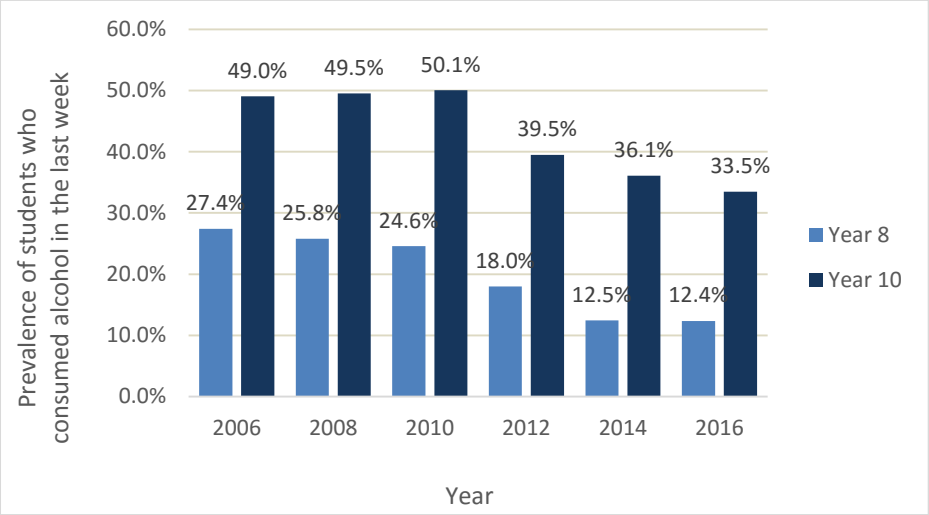


Source: Public Health Outcomes Framework August 2017

2.6 Alcohol use: children and young people

The Health Related Behaviour Survey carried out every two years in Cambridgeshire for school children in year 8 and year 10, shows that the proportion of children who have had an alcoholic drink in the week before the survey has fallen significantly since 2006.

Figure 20: Health Related Behaviour Survey – alcoholic drink consumed in the past seven days (%), Cambridgeshire



Source: Health Related Behaviour Survey

SECTION 3: MENTAL HEALTH TRENDS IN CAMBRIDGESHIRE

3.1 Suicide

Suicide is always a very sad and distressing event, and is the commonest cause of death nationally for men under 50 and women under 35. The suicide rate in Cambridgeshire is similar to the national average. While in the past, suicide rates in both Cambridge City and Fenland have sometimes been significantly above the national average, more recently suicide rates in Cambridgeshire and all its districts have been similar to the national picture.

Figure 21: Suicide rate, persons, directly age-standardised rate per 100,000, Cambridgeshire & Districts, 2001/03 – 2013/15

Area	Suicide rate, directly age-standardised rate per 100,000, persons												
	2001-03	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15
Cambridge City	15.3	15.7	13.0	14.6	14.2	15.6	12.8	12.1	11.3	11.9	9.6	9.4	7.6
East Cambridgeshire	*	*	*	*	*	*	*	*	*	*	*	*	*
Fenland	11.1	*	*	*	11.4	14.4	15.7	14.6	10.2	9.9	*	12.0	12.7
Huntingdonshire	*	*	6.6	8.8	9.5	8.4	7.7	6.9	8.0	7.2	9.0	8.9	9.2
South Cambridgeshire	10.2	13.0	10.5	7.8	*	6.9	8.7	8.0	7.2	*	8.3	7.9	9.7
Cambridgeshire	9.6	9.8	8.7	8.8	9.4	10.1	10.2	9.1	8.3	7.8	8.7	9.0	9.1
England	10.3	10.2	10.1	9.8	9.4	9.2	9.3	9.4	9.5	9.5	9.8	10.0	10.1

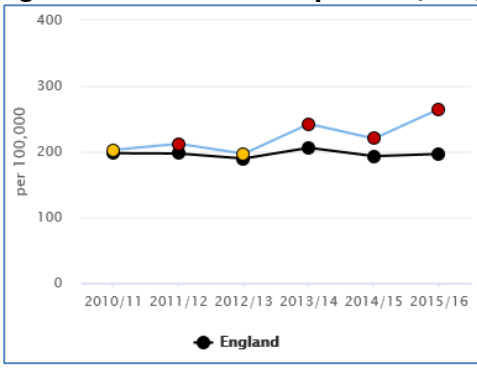
Source: Public Health Outcomes Framework

Key

	Statistically significantly lower (better) than England
	Statistically similar to England
	Statistically significantly higher (worse) than England

Unlike the suicide rate, emergency hospital admissions for self-harm have been increasing recently, and are now higher than the national average in all Cambridgeshire districts apart from South Cambridgeshire. Some caution is needed in interpreting rising admissions for self-harm as these may be partly dependent on better recording and coding by hospitals. But the rise is of concern and needs further careful investigation.

Figure 22: Emergency hospital admissions for intentional self-harm, persons, directly age-standardised rate per 100,000, Cambridgeshire, 2010/11 – 2015/16



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2010/11		1,311	202.8	191.9	214.1	150.7	197.6
2011/12		1,386	212.1	201.0	223.6	154.1	197.2
2012/13		1,296	196.8	186.2	207.8	153.5	189.6
2013/14		1,598	242.3	230.5	254.5	183.5	205.9
2014/15		1,454	220.0	208.8	231.6	173.0	193.2
2015/16		1,777	264.9	252.6	277.5	179.5	196.5

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to Public Health England Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

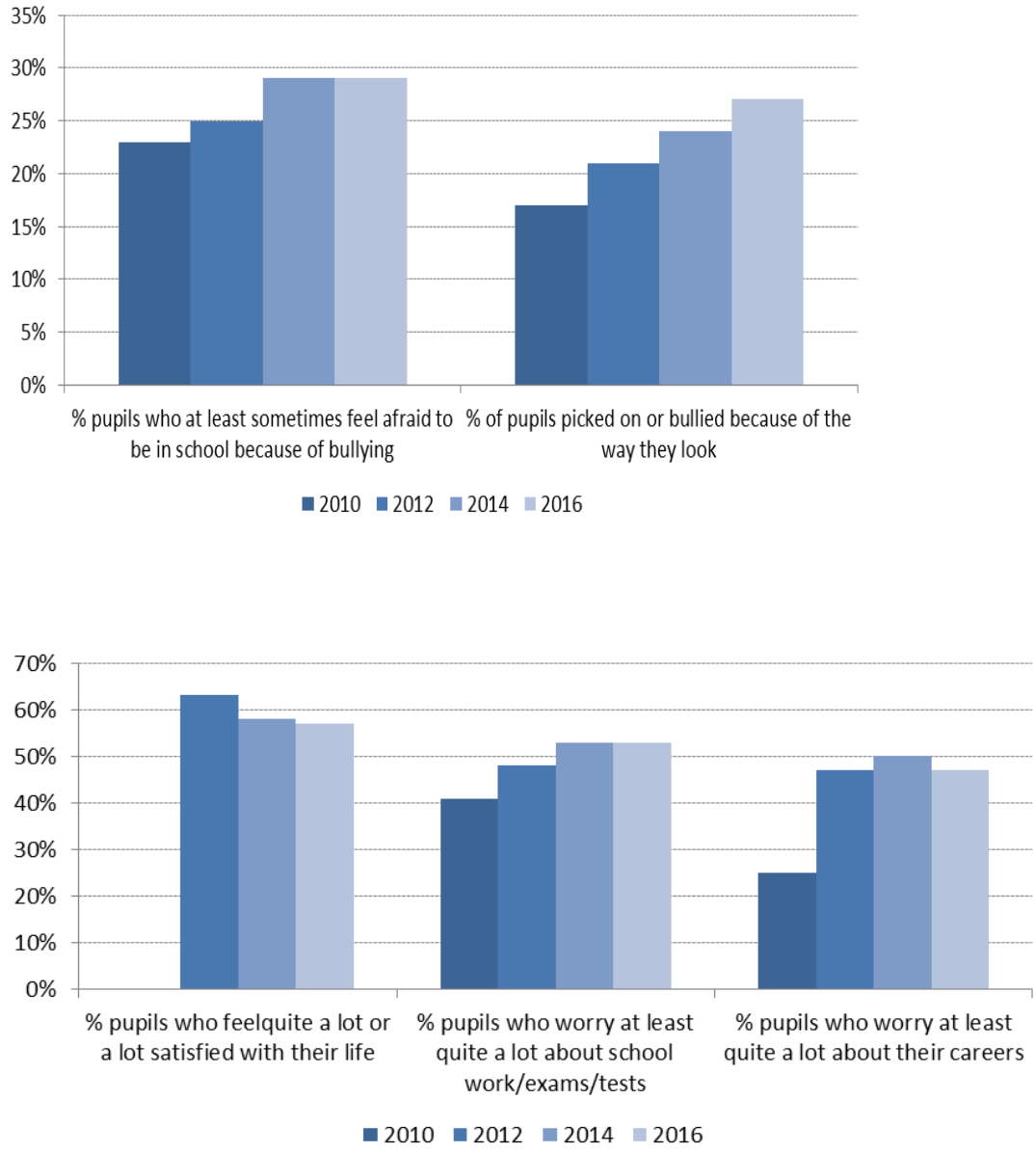
Source: Public Health England 'Fingertips' website

3.2 Children and young people's mental health

There has been concern nationally about children's and young people's mental health and access to appropriate mental health services, with a national commitment to invest more in these services.

In Cambridgeshire, the Health Related Behaviour Survey of children in years 8 and 10 of secondary schools indicates some adverse trends in emotional wellbeing since 2010, although these appear to have levelled out. Since 2010 the proportion of children who describe themselves as sometimes afraid to go to school because of bullying has increased, and the proportion of children worried about exams and their future careers is also higher.

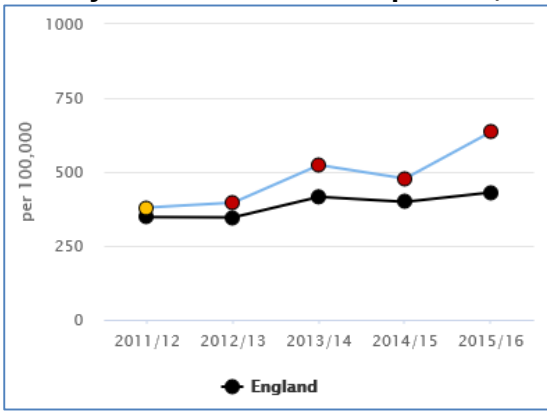
Figure 23: Cambridgeshire Schools Health Related Behaviour Survey findings 2010-2016



Source: Health Related Behaviour Survey

Rates of hospital admissions for self-harm amongst young people aged 10-24 have a rising trend in Cambridgeshire between 2011/12 and 2015/16, and are well above the national average. Some caution is required as trends may be the result of improved recording and coding by hospitals, but the issue is of significant concern and requires further investigation.

Figure 24: Hospital admissions as a result of self-harm (10-24 years) Cambridgeshire. directly standardised rate – per 100,000



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12		459	379.7	345.7	416.1	262.7	347.4
2012/13		474	396.2	361.3	433.6	291.2	346.3
2013/14		622	523.4	483.0	566.2	378.3	415.8
2014/15		567	477.6	439.0	518.6	354.7	398.8
2015/16		763	635.2	590.9	682.0	411.2	430.5

Source: Public Health England Child and maternal health profiles

CASE STUDY – MAKING A DIFFERENCE

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Mental Health Crisis First Response Service (FRS) and Sanctuaries

What was the problem?

Before this service was launched in September 2016 there was no capacity to see people in need of mental healthcare out of hours except via A&E, and no self-referral route, meaning many sought help direct from A&E. Service users told us that it was very difficult and stressful trying to get help when in a mental health crisis and they found the emergency department a stressful environment.

What was the solution?

- A new community-based crisis mental health service – 'first response' – provides timely access to safe, effective, high quality care for people in mental health crisis.
- The first response service provides assertive and responsive support and triage for anyone experiencing mental health crisis, including face-to-face assessment if needed.
- Open 24/7 for people of all ages throughout Cambridgeshire and Peterborough.
- Welcomes self-referrals via dialing 111 and asking for option2 as well as urgent referrals from carers, GPs, ambulance crews, police (anyone!) and the emergency department.

What were the results?

- The service has demonstrated an immediate decline in the use of hospital emergency departments for mental health needs with a 21% reduction in attendance despite the local context of many years of rapidly increasing figures.
- A 26% reduction in the number of people with mental health needs being admitted to acute hospitals from the emergency department.

SECTION 4: LIFE EXPECTANCY AND PREVENTABLE DEATHS

Life expectancy is an important summary measure for the overall health outcomes in an area. It is generally quoted as an average over three years to make the statistic more reliable. Life expectancy in Cambridgeshire as a whole has been consistently above the national average since 2001-03 and has improved by over three years for both men and women between 2001-03 and 2013-15. However life expectancy in the county has 'plateaued' more recently, with no improvement for men since 2010-12 and only a small improvement for women.

There are inequalities in average life expectancy across the county, reflecting differences in the wider determinants of health and lifestyle 'risk' behaviours described in earlier sections. Average life expectancy for men in Fenland in 2013/15 was 78.6 years (significantly worse than the national average), while all other districts in Cambridgeshire have above average male life expectancy, the highest being South Cambridgeshire at 82.1 years. For women life expectancy in Fenland is similar to the national average at 82.6 years, and again above average in all other districts, the highest being South Cambridgeshire at 85.2 years.

Figure 25: Cambridgeshire and districts average life expectancy by gender, 2013 to 2015

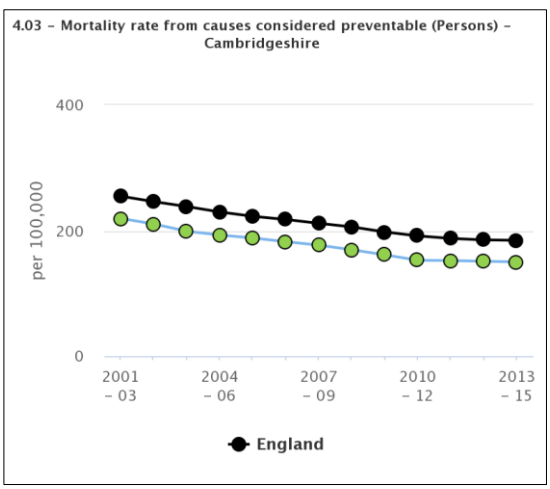
Indicator	Data period	Cambs Value	England value	Cambridgeshire Districts				
				Cambridge	E Cambs	Fenland	Hunts	S Cambs
Life expectancy at birth (Males), years	2013-15	80.9	79.5	80.3	81.6	78.6	81.0	82.1
Life expectancy at birth (Females), years	2013-15	84.4	83.1	84.1	84.8	82.6	84.7	85.2

Source: Public Health Outcomes Framework

	Statistically significantly higher (better) than England
	Statistically similar to England
	Statistically significantly lower (worse) than England

4.1 Trends in preventable deaths

Public Health England calculates a summary measure of deaths considered preventable through public health interventions in their broadest sense, and Cambridgeshire as a whole has shown a positive trend on this measure since 2001- 03. However there has been a worrying upward movement in the most recent data on preventable mortality in Fenland, associated with an upturn in preventable deaths under the age of 75 from cardiovascular disease (heart disease and stroke).



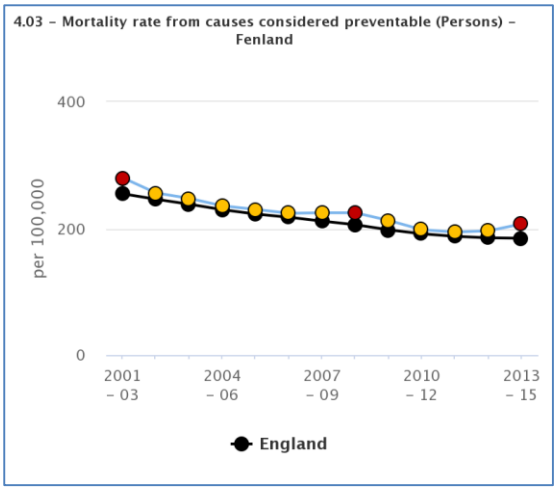
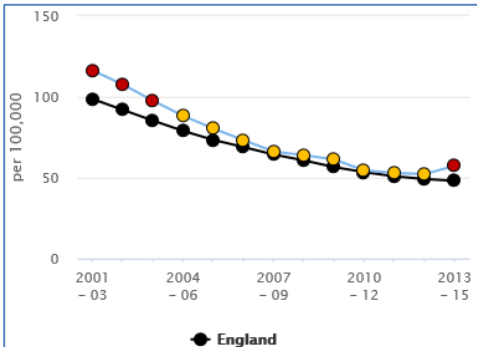


Figure 26: Under 75 mortality rate from cardiovascular diseases considered preventable (persons), directly age-standardised rate per 100,000, Fenland, 2001-03/2013-15



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2001 - 03	●	264	116.3	102.6	131.2	84.2	98.6
2002 - 04	●	250	107.6	94.7	121.9	78.5	91.9
2003 - 05	●	231	97.6	85.4	111.0	73.3	85.3
2004 - 06	●	214	88.3	76.8	100.9	68.5	78.9
2005 - 07	●	198	80.4	69.6	92.4	63.3	73.4
2006 - 08	●	183	73.2	63.0	84.7	59.3	68.9
2007 - 09	●	169	66.1	56.5	76.9	55.2	64.3
2008 - 10	●	166	64.0	54.6	74.5	53.5	60.7
2009 - 11	●	160	61.3	52.1	71.5	50.3	56.6
2010 - 12	●	144	54.5	46.0	64.2	48.1	53.5
2011 - 13	●	143	52.9	44.6	62.4	45.2	50.9
2012 - 14	●	144	52.3	44.0	61.6	43.5	49.2
2013 - 15	●	162	57.3	48.8	66.9	42.0	48.1

Source: Public Health England (based on ONS source data)

Source: Public Health Outcomes Framework

SUMMARY AND RECOMMENDATIONS

This Annual Public Health Report 2017 has attempted to give a brief overview of some of the factors and circumstances which affect the health and wellbeing of Cambridgeshire residents. It is clear that there are significant differences in health and the factors affecting health, both across the County as a whole and between neighbourhoods within individual districts. One recommendation for the future is that where possible and statistically valid, we should be mapping more health and wellbeing indicators at the local neighbourhood level to help 'fine tune' the provision, targeting and monitoring of campaigns and services.

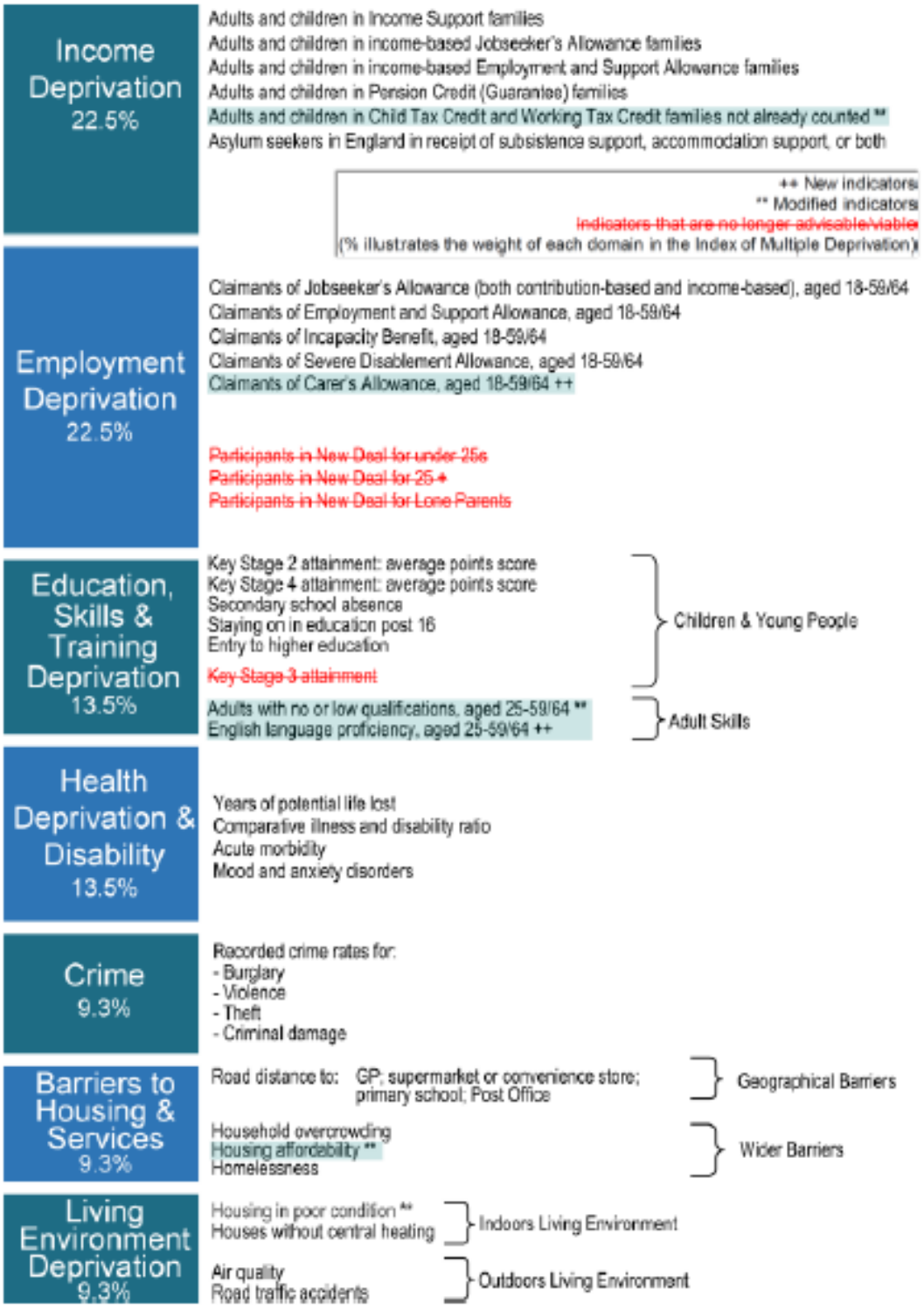
It is often difficult to obtain data which is defined by circumstances other than geography, but this is possible for data on educational outcomes. The disparity in educational outcomes between children receiving free school meals and their peers of the same age is a county-wide issue, and is consistent from the measurement of school readiness in reception year right through to GCSE attainment at age 16. Addressing this should be a key public health priority due to the impact of educational attainment on future health and wellbeing.

Another county-wide issue is young people's emotional wellbeing – with some adverse trends seen since 2010 in the school based Health Related Behaviour Survey, and more recently a rising trend in hospital admissions for self-harm. Joint work is already taking place across the NHS and local authorities to improve early intervention and support for young people with mental health problems, so we would hope to see these trends improving, and the impact of this work needs careful monitoring.

Finally, there are a wealth of statistics throughout this report which demonstrate the health and wellbeing challenges for Fenland residents – in particular for the North Fenland and Wisbech area. The causes are complex, with no easy answers – but a consistent and sustainable focus on the area from a range of organisations will be needed to address the determinants of health such as educational attainment and economic development, as well as a focus from health and care providers on delivering accessible prevention, treatment and support services to meet current needs.

APPENDIX A

Domains and indicators for the updated Index of Multiple Deprivation IMD (2015) showing changes from the IMD (2010). ***DCLG 2014***



Agenda Item No: 8

PLANNING FUTURE PRIORITIES FOR HEALTH COMMITTEE

To: **Health Committee**

Meeting Date: **7th September 2017**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: **n/a** *Key decision:* **No**

Purpose: **The Committee is being asked to review and agree its priorities for 2017/18.**

Recommendation: **The Committee is asked to:**

a) Discuss the priorities recommended in paragraph 2.3 and 2.4 following a development session for Committee members held in July;

b) Agree Health Committee priorities for 2017/18;

c) Consider what reporting mechanisms the Committee would like to see put in place to monitor progress against identified priorities.

Officer contact:		*Member contact:*	
Name:	Dr Liz Robin	Name:	Peter Hudson
Post:	Director of Public Health	Post:	Chair
Email:	Liz.robin@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:		Tel:	01223 706398

1. BACKGROUND

1.1 In July 2014 the Health Committee agreed five priorities, to be addressed through both its Executive and Scrutiny roles. The five priorities were:

- Mental Health
- Health Inequalities
- Transport and Health
- Effectiveness of Public Health
- Public Health Business Planning

1.2 In November 2015 an additional section of the regular Finance and Performance Report was added, to report routinely on Health Inequalities and Mental Health performance indicators.

1.3 In 2015 the Health Committee also identified some Scrutiny priorities on which regular reporting was requested

- Issues with the EPIC system at Cambridge University Hospitals NHS Foundation Trust
- Delayed transfers of care across the system.

1.4 Progress against these priorities was regularly reviewed at Health Committee through a combination of routine Finance and Performance Reporting, specific papers to Health Committee and the maintenance of a Health Committee action log. In addition a summary paper on progress against the key priorities was discussed at a Health Committee development session on 13 April 2017.

2. MAIN ISSUES

2.1 On 14 July, the Health Committee met for a further development session to identify priorities for 2017 and potentially beyond. A presentation given at the development session, providing information to support the discussion is attached at Appendix 1.

2.2 Members present at the development session identified the following factors as important criteria when considering priorities:

- Terms of reference of the Health Committee
- The Council's duties to improve health and reduce health inequalities
- Fit with the three corporate priorities of the Council
- Value for money and evidence of effectiveness, including quality adjusted life years (QALYs)
- Focus on things we can change
- Split out approaches for Health Scrutiny / Public Health
- Assessing the following dimensions:
    - Easy –vs- difficult
    - Big –vs- small
    - Pragmatic –vs- dogmatic
    - Local –vs- county wide
    - Ethical issues

2.3 The following items were identified as potential priorities for 2017/18. The starred items are those which both discussion groups at the development session identified as priorities:

Public health priorities:

- Behaviour change*
- Mental health for children and young people
- Health inequalities*
- Air pollution
- School readiness*
- Review of effective public health interventions
- Access to services

Scrutiny Priorities:

- Delayed transfers of care
- Sustainable Transformation Plans:
    - Work programme, risk register and project list
    - Workforce issues
    - Communications and engagement
    - Primary care developments

2.4 More detailed suggestions were made in relation to health inequalities as a priority – including the potential for joint scrutiny of geographical inequalities in health with Fenland District Council, the importance of school readiness, and the balance between a geographical focus and an approach of proportionate universalism. It was suggested that every Health Committee paper should identify clearly how it will address / impact on Health Inequalities.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

Para 2.2. identifies the three corporate priorities of the Council as one of the criteria to be considered when identifying Health Committee priorities.

3.2 Helping people live healthy and independent lives

Para 2.2 identifies the Council's duties to improve health and address health inequalities as one of the criteria to be considered when identifying Health Committee priorities.

3.3 Supporting and protecting vulnerable people

Para 2.2 identifies the three corporate priorities of the Council as one of the criteria to be considered when identifying Health Committee priorities. .

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no immediate implications within this category although the priorities identified by the Health Committee will influence the allocation of public health resources.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
There are no significant implications within this category

4.3 Statutory, Legal and Risk Implications
The statutory duties of the Council in relation to public health functions are laid out in the Health and Social Care Act (2012) and associated regulations.

4.4 Equality and Diversity Implications
The Health Committee development session output clearly indicates health inequalities as a priority for Committee members.

4.5 Engagement and Communications Implications
There are no immediate implications within this category

4.6 Localism and Local Member Involvement
There are no immediate implications within this category

4.7 Public Health Implications
Public health implications are outlined in the main body of the Report.

Source Documents	Location
'Review of Health Committee Priorities' – summary paper on progress against the Health Committee's pre-existing priorities, taken to HC development session, April 13th 2017	Public Health Administrative office Room 111 Shire Hall, Cambridge

Review of Health Committee Priorities

Prioritisation: Context and Methods

What could being a Health Committee Priority mean?

- Setting policy and strategy
- Overseeing transformation
- Monitoring delivery
- Allocating budget
- Scrutiny of other organisations

What resources do we have?

- Money
- Officer time
- Councillor time
- Influence within wider partnerships

How do we select priorities?

- Review data and information
  - what are our ‘biggest’ problems?
  - Where are we an outlier?
- Community concerns
  - What are people worried about?
- Where can we make the most difference?
  - Evidence of effectiveness and cost effectiveness
- National policies/inspection regimes

What's the bigger picture?

We work within/with systems which have their own priorities:

- The wider County Council
- The national Public Health system
- The Sustainable Transformation Partnership (STP)
- The national NHS
- The Health and Wellbeing Board
- The Local Health Resilience Partnership/Local Resilience Forum
- The Combined Authority

What can we learn from previous sessions?

Scrutiny of NHS		Behaviour change		Wider determinants of health
List priorities within this area		Eg: Obesity		List priorities within this area
Mental Health				
Health Weight Strategy				
Active Travel				
Inequalities				

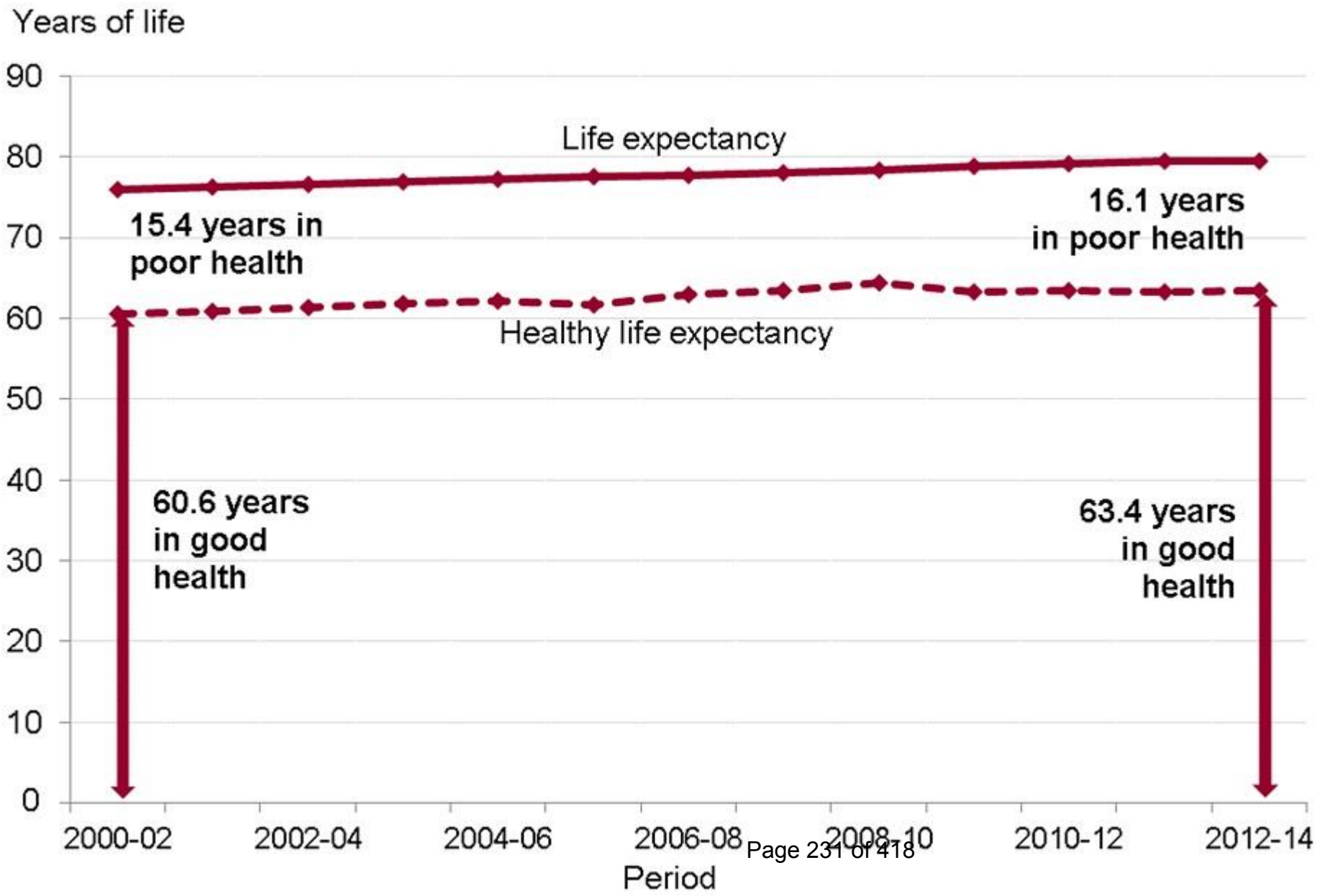
Prioritisation methodologies

- Cost benefit analysis – the Oregon Experiment (1990)
- Numerical scoring system covering key issues
- ‘Accountability for reasonableness’ – transparency, relevance, revisability

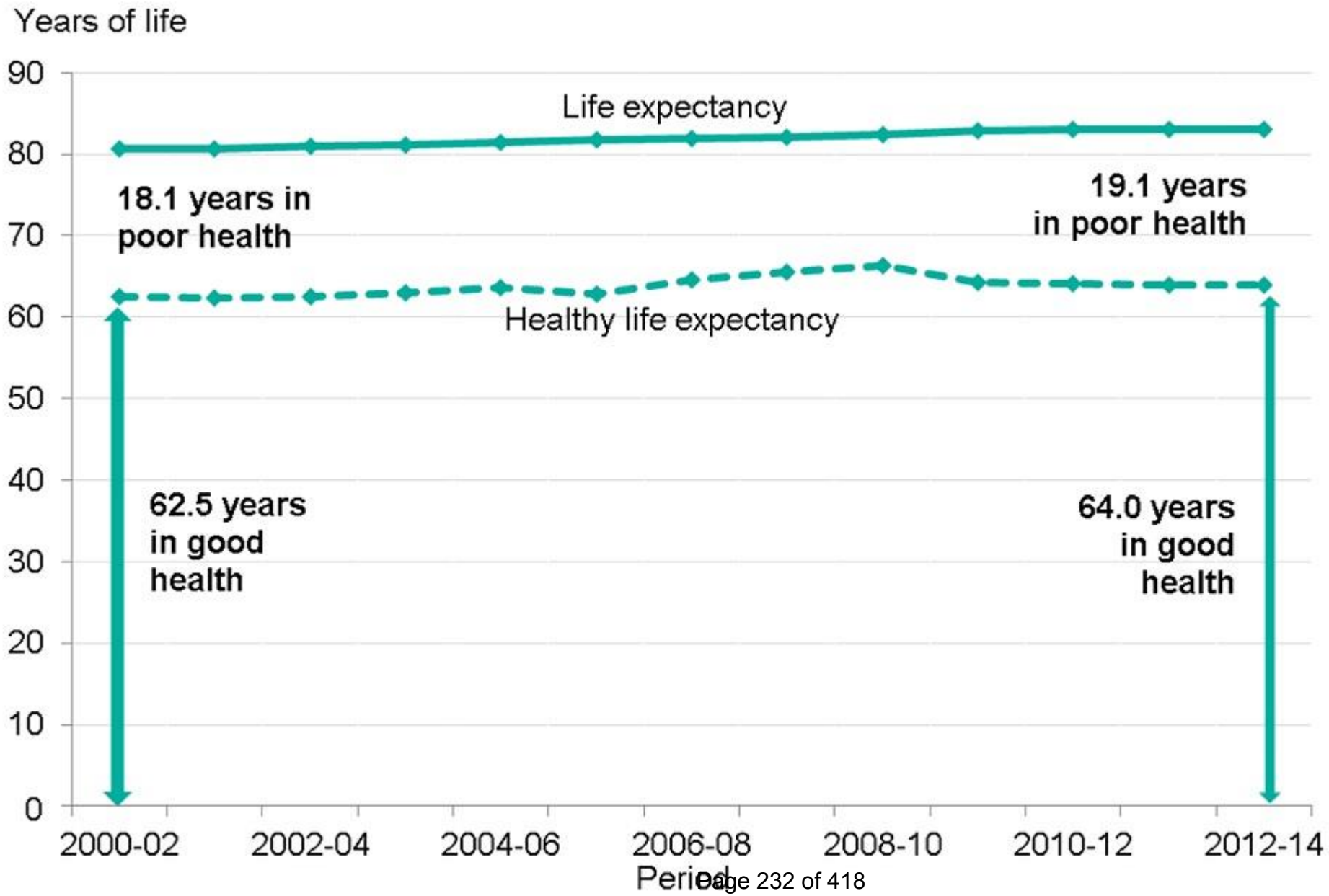
Review of Health Committee Priorities

National and local information to inform priorities

For males, years in good health and poor health have increased



For females, years in good health and poor health have increased



Leading causes of death vary by age for males

External Cancer Circulatory Respiratory Other

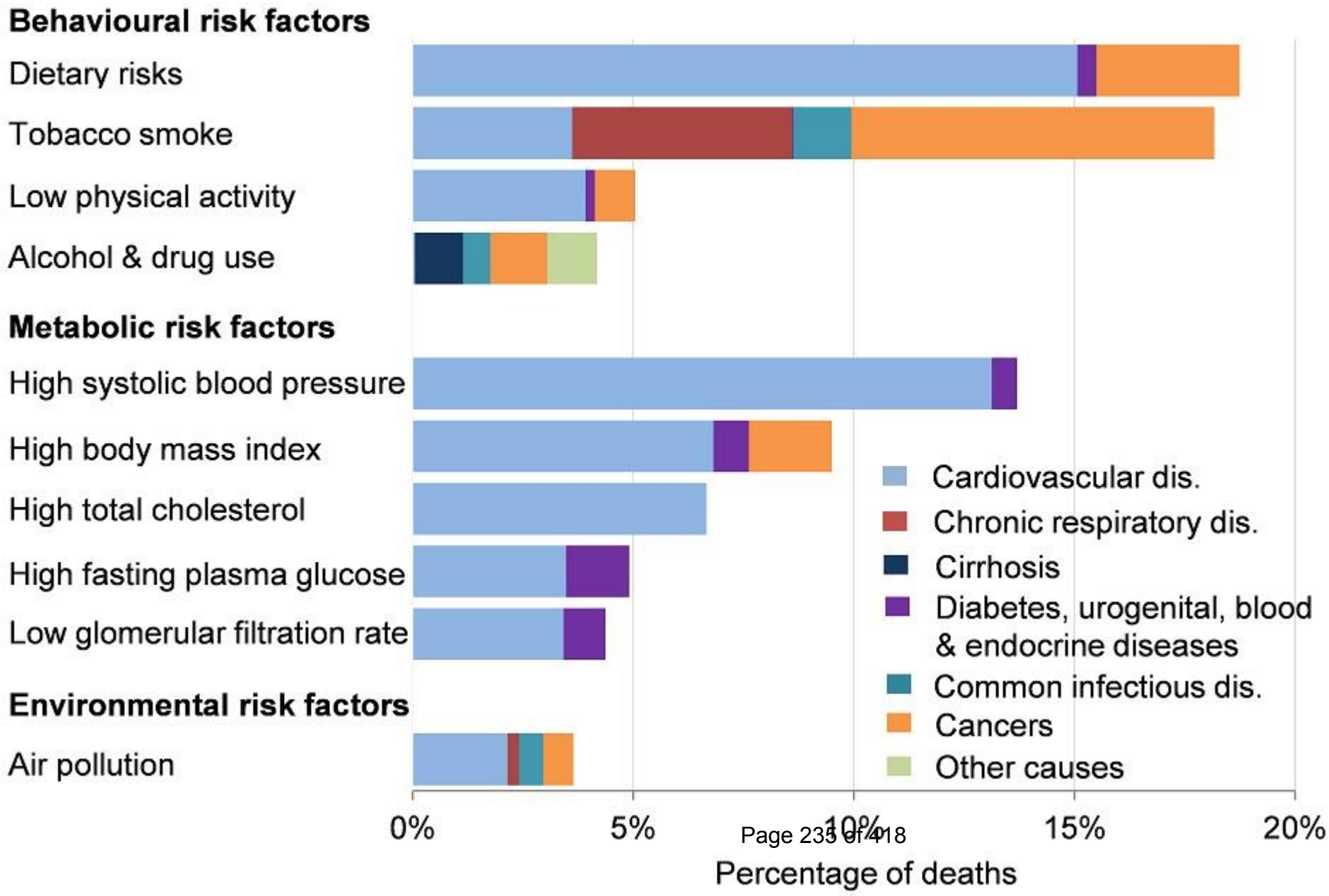
Age	1st	2nd	3rd	4th	5th
1-4	Perinatal & congenital	Influenza and pneumonia	Brain cancer	Meningitis and meningococcal infection	Vaccine preventable disease
5-19	Suicide	Transport accidents	Homicide	Leukaemia and lymphomas	Brain cancer
20-34	Suicide	Accidental poisoning	Transport accidents	Homicide	Cirrhosis and other liver disease
35-49	Suicide	Heart disease	Accidental poisoning	Cirrhosis and other liver disease	Stroke
50-64	Heart disease	Lung cancer	Cirrhosis and other liver disease	Colorectal cancer	Chronic lower respiratory diseases
65-79	Heart disease	Lung cancer	Chronic lower respiratory diseases	Stroke	Prostate cancer
80+	Dementia and Alzheimer's disease	Heart disease	Influenza and pneumonia	Stroke	Chronic lower respiratory diseases

Leading causes of death vary by age for females

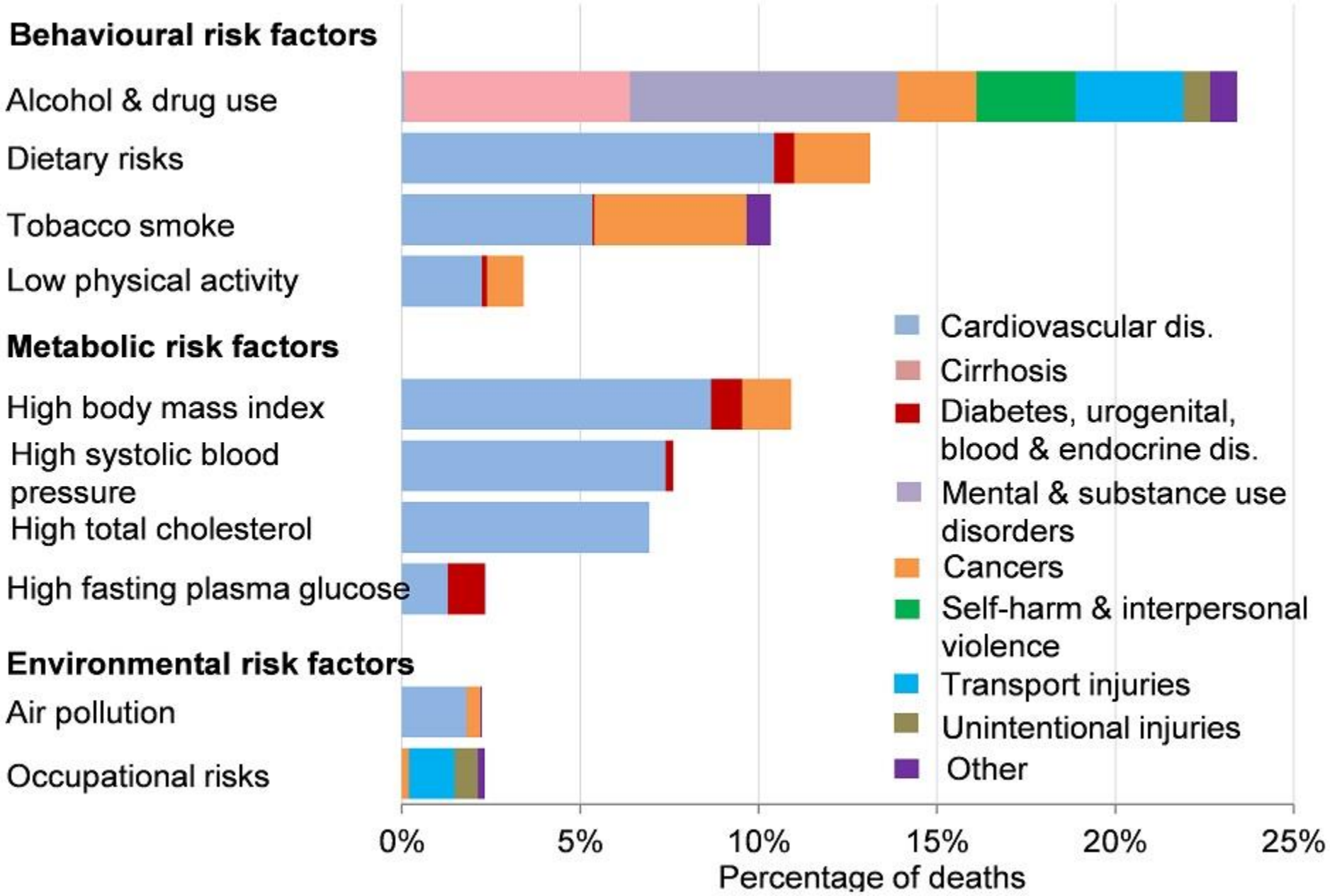
External | Cancer | Circulatory | Respiratory | Other

Age	1st	2nd	3rd	4th	5th
1-4	Perinatal & congenital	Homicide	Influenza and pneumonia	Septicaemia	Other acute respiratory diseases
5-19	Suicide	Transport accidents	Perinatal & congenital	Leukaemia and lymphomas	Brain cancer
20-34	Suicide	Accidental poisoning	Transport accidents	Breast cancer	Cirrhosis and other liver disease
35-49	Breast cancer	Cirrhosis and other liver disease	Accidental poisoning	Suicide	Heart disease
50-64	Lung cancer	Breast cancer	Heart disease	Chronic lower respiratory diseases	Cirrhosis and other liver disease
65-79	Lung cancer	Chronic lower respiratory diseases	Heart disease	Dementia and Alzheimer's disease	Stroke
80+	Dementia and Alzheimer's disease	Heart disease	Stroke	Influenza and pneumonia	Chronic lower respiratory diseases

Attribution of deaths to risk factors and broken down by broad causes of death in England, 2013

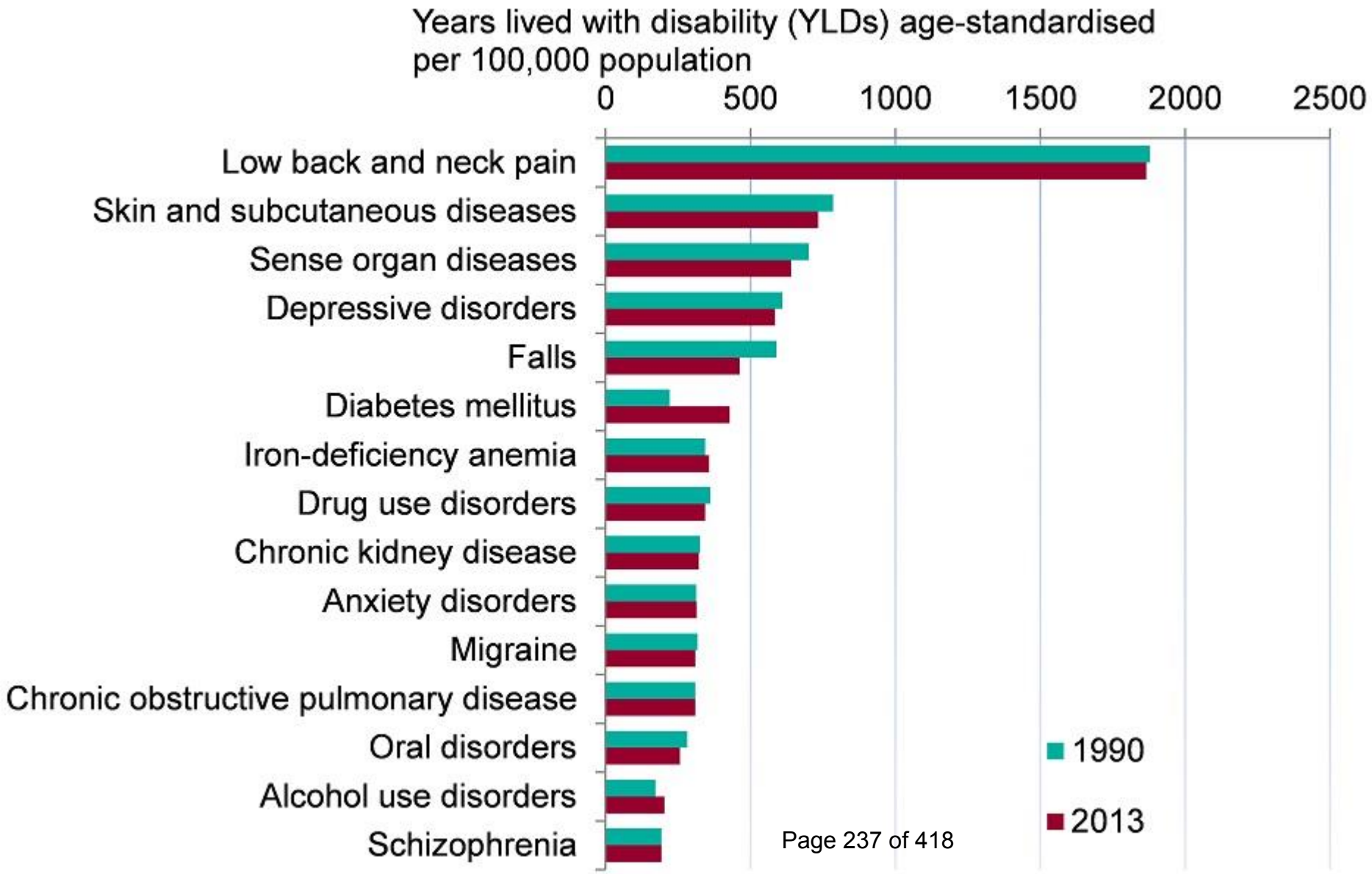


Attribution of deaths in ages 15 to 49 to risk factors and broken down by broad causes of death in England, 201

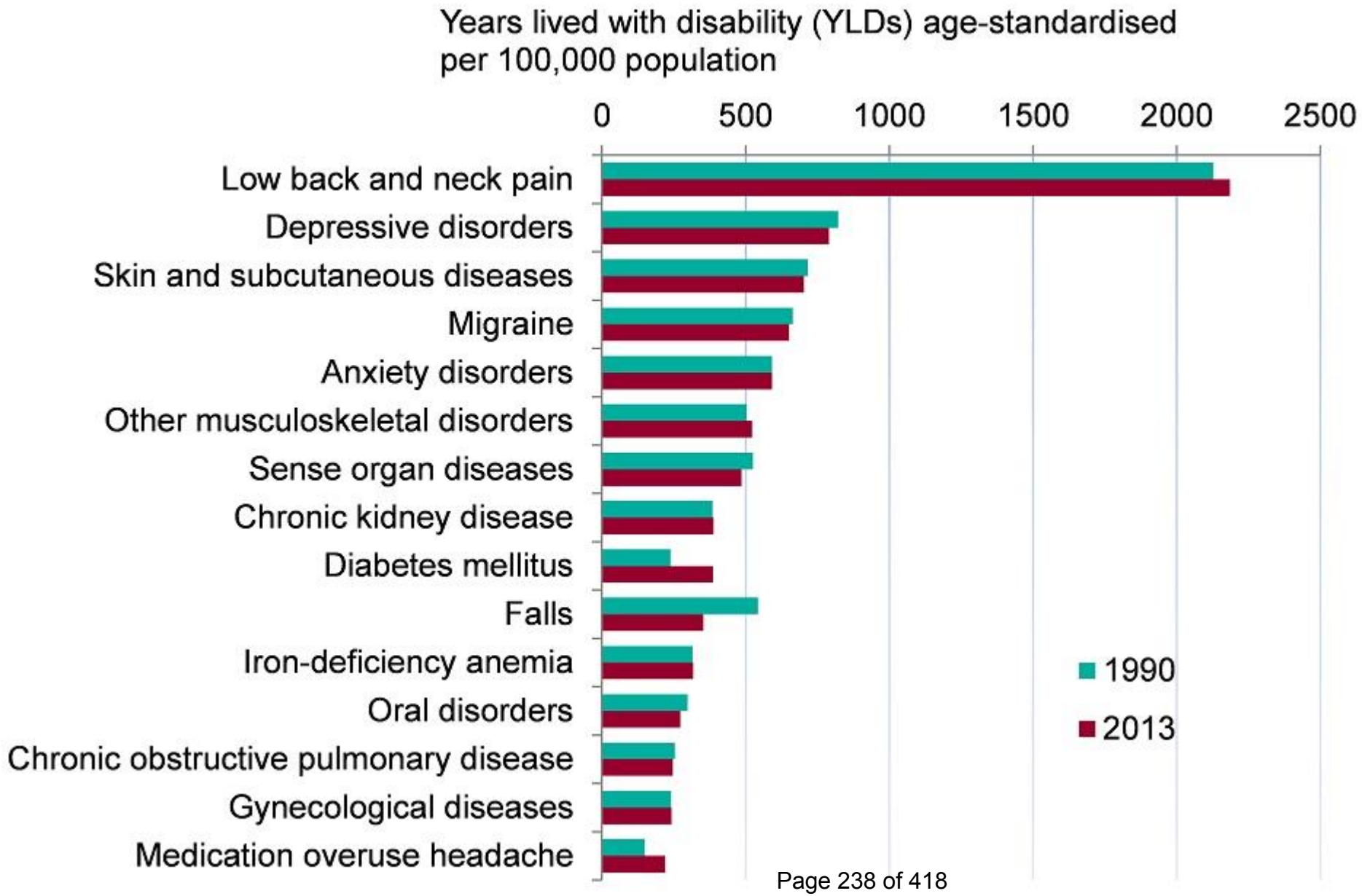


alcohol and drug use

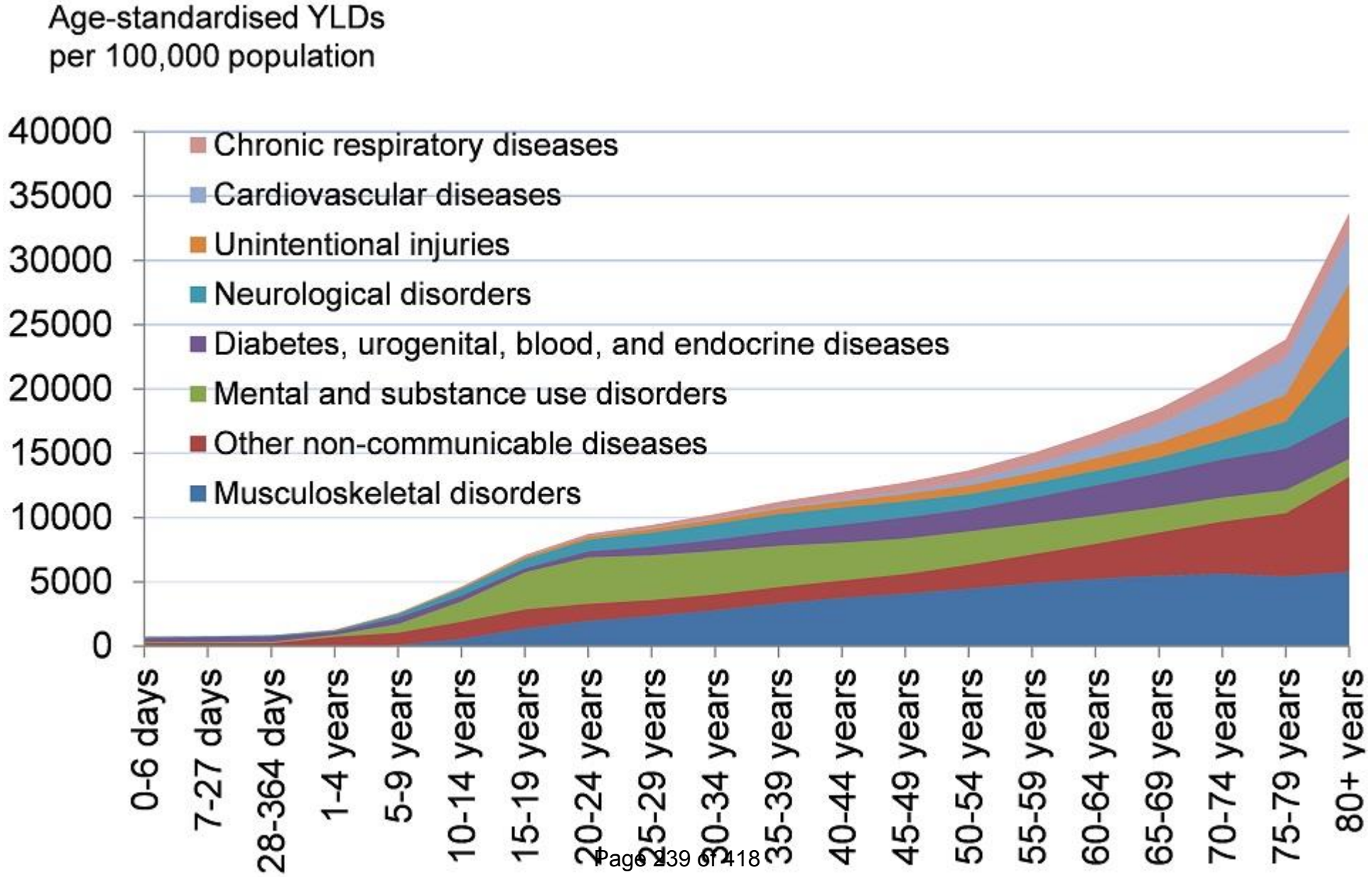
MALES


Years lived with disability (YLDs) age-standardised per 100,000 population
0
500
1000
1500
2000
2500
Low back and neck pain
Skin and subcutaneous diseases
Sense organ diseases
Depressive disorders
Falls
Diabetes mellitus
Iron-deficiency anemia
Drug use disorders
Chronic kidney disease
Anxiety disorders
Migraine
Chronic obstructive pulmonary disease
Oral disorders
Alcohol use disorders
Schizophrenia
1990
2013

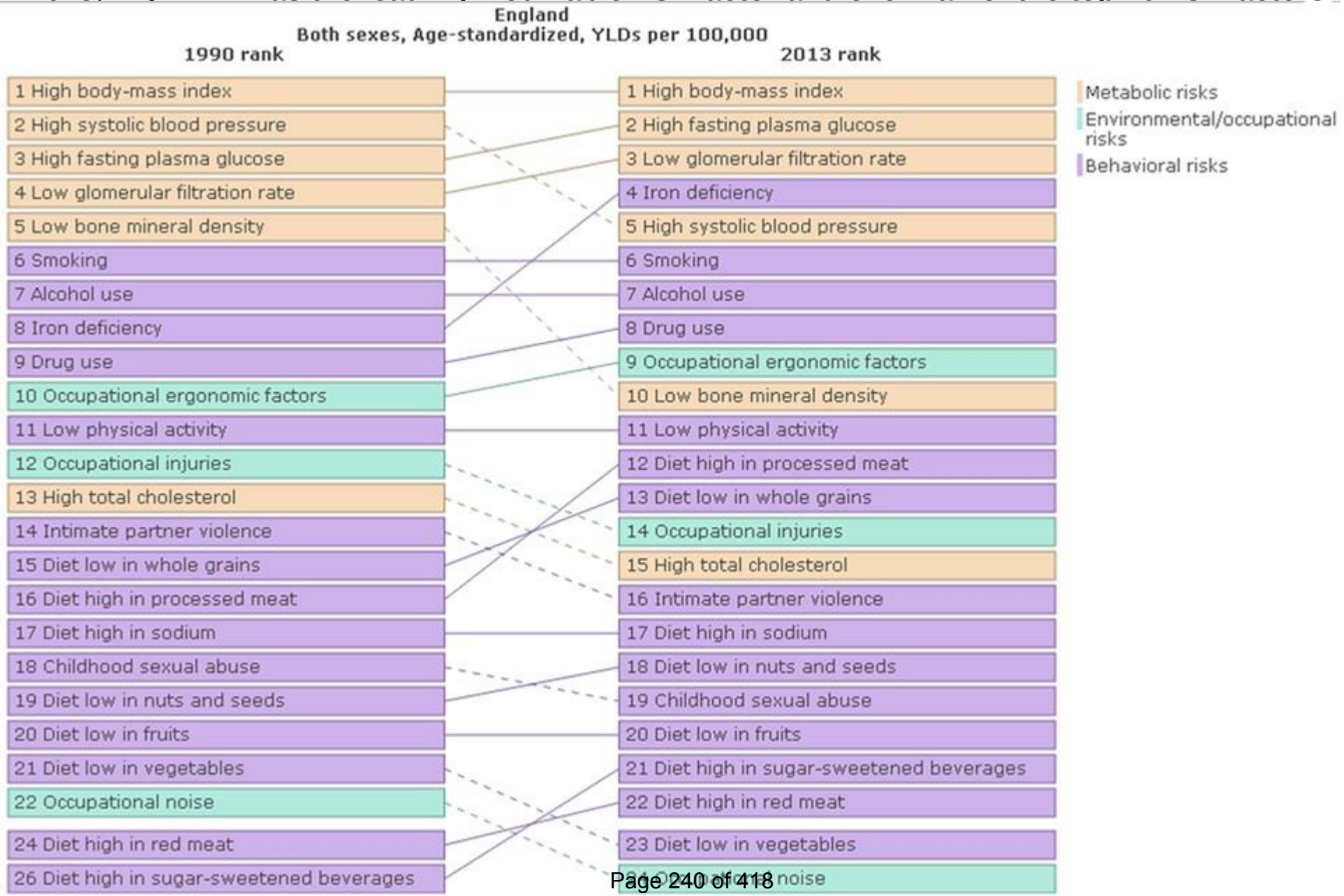
FEMALES


Years lived with disability (YLDs) age-standardised per 100,000 population
0
500
1000
1500
2000
2500
Low back and neck pain
Depressive disorders
Skin and subcutaneous diseases
Migraine
Anxiety disorders
Other musculoskeletal disorders
Sense organ diseases
Chronic kidney disease
Diabetes mellitus
Falls
Iron-deficiency anemia
Oral disorders
Chronic obstructive pulmonary disease
Gynecological diseases
Medication overuse headache
1990
2013

In 2013, the morbidity burden increased steadily to mid-life, then more rapidly into old age



In 2013, high BMI was the leading modifiable risk factor and over half of the top 20 risk factors related to diet



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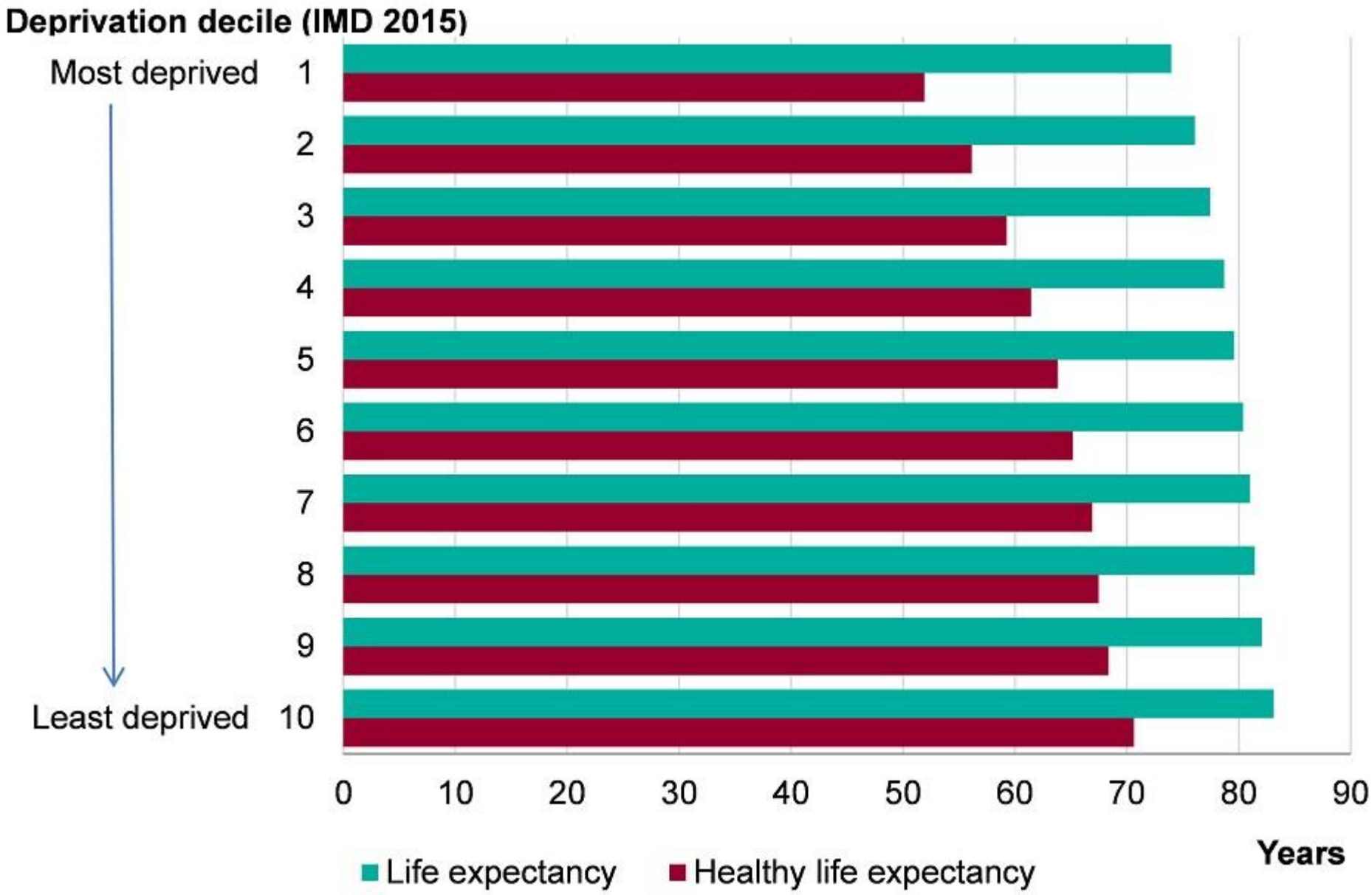
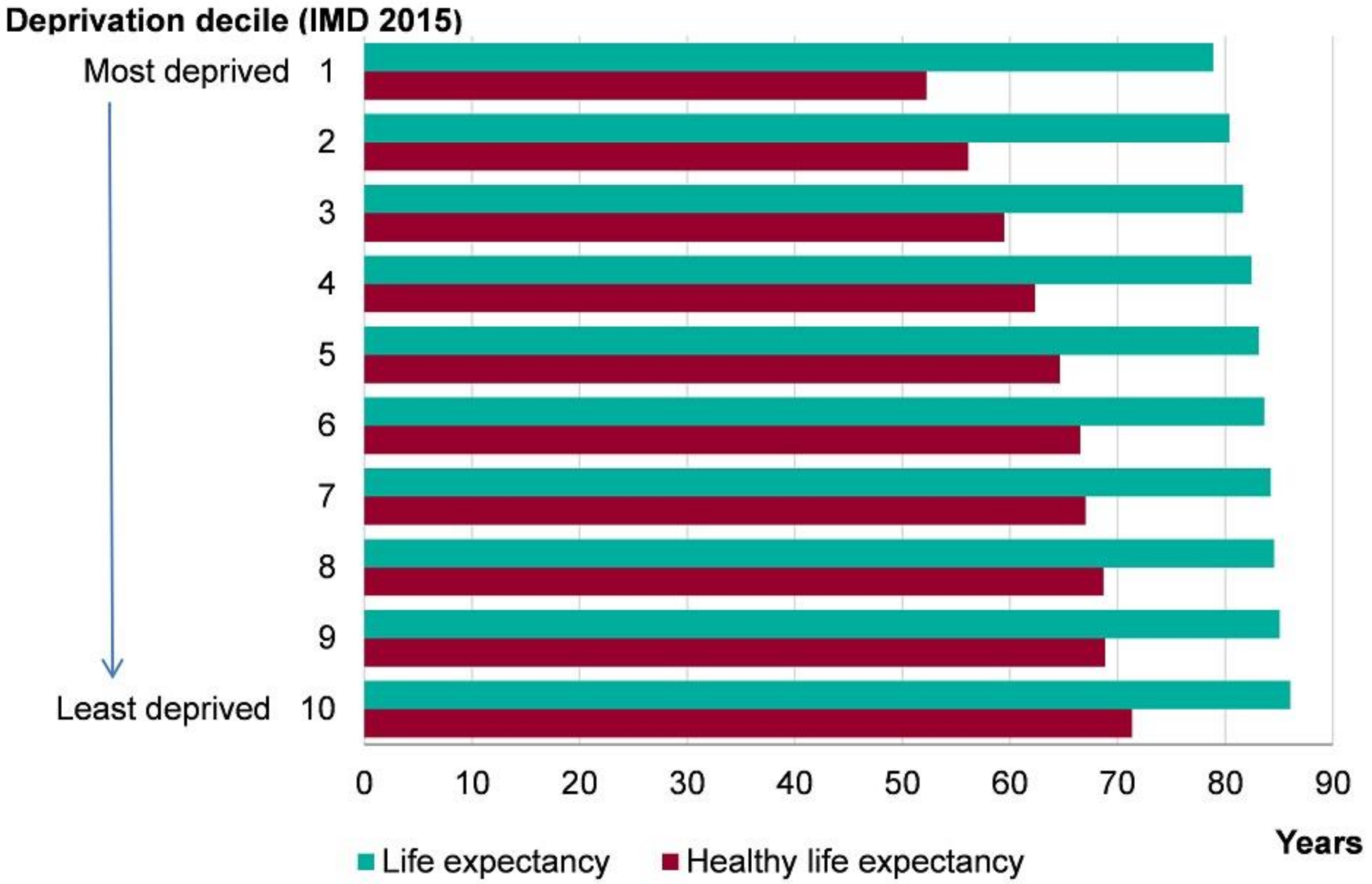
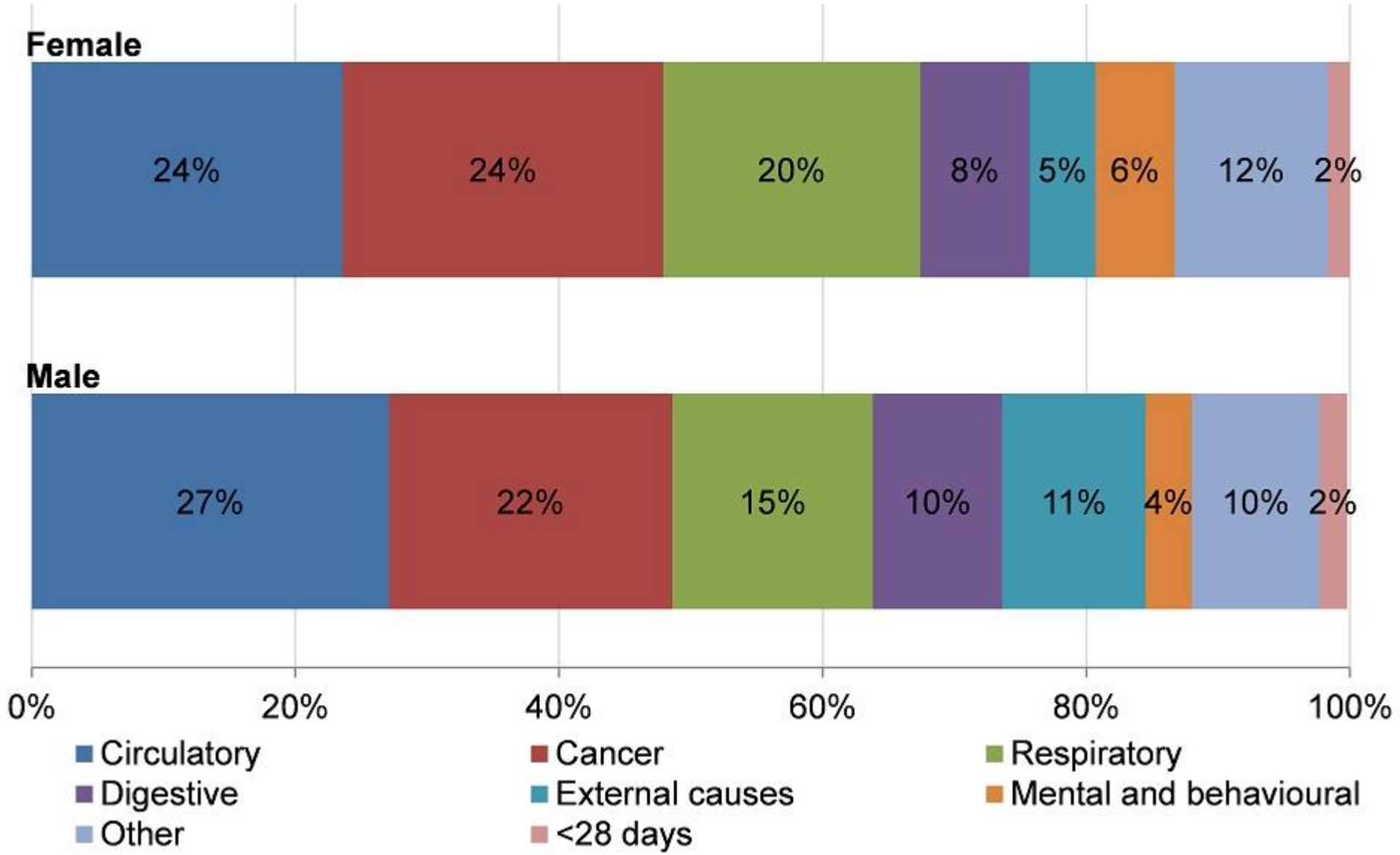

Deprivation decile (IMD 2015)
Most deprived
1
2
3
4
5
6
7
8
9
Least deprived
10
0
10
20
30
40
50
60
70
80
90
Years
Life expectancy
Healthy life expectancy

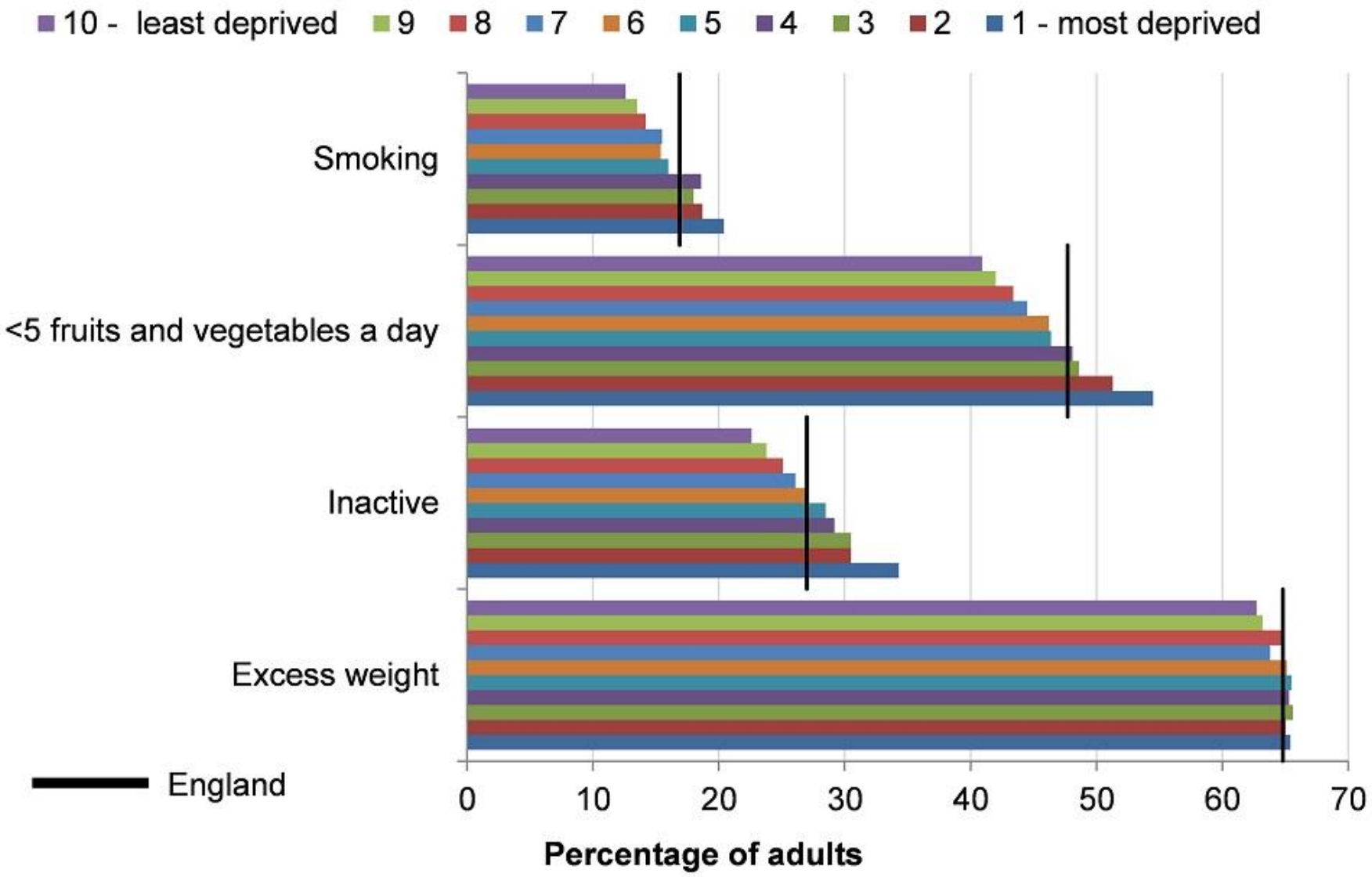

Deprivation decile (IMD 2015)
Most deprived
1
2
3
4
5
6
7
8
9
Least deprived
10
0
10
20
30
40
50
60
70
80
90
Years
Life expectancy
Healthy life expectancy

tiles in England

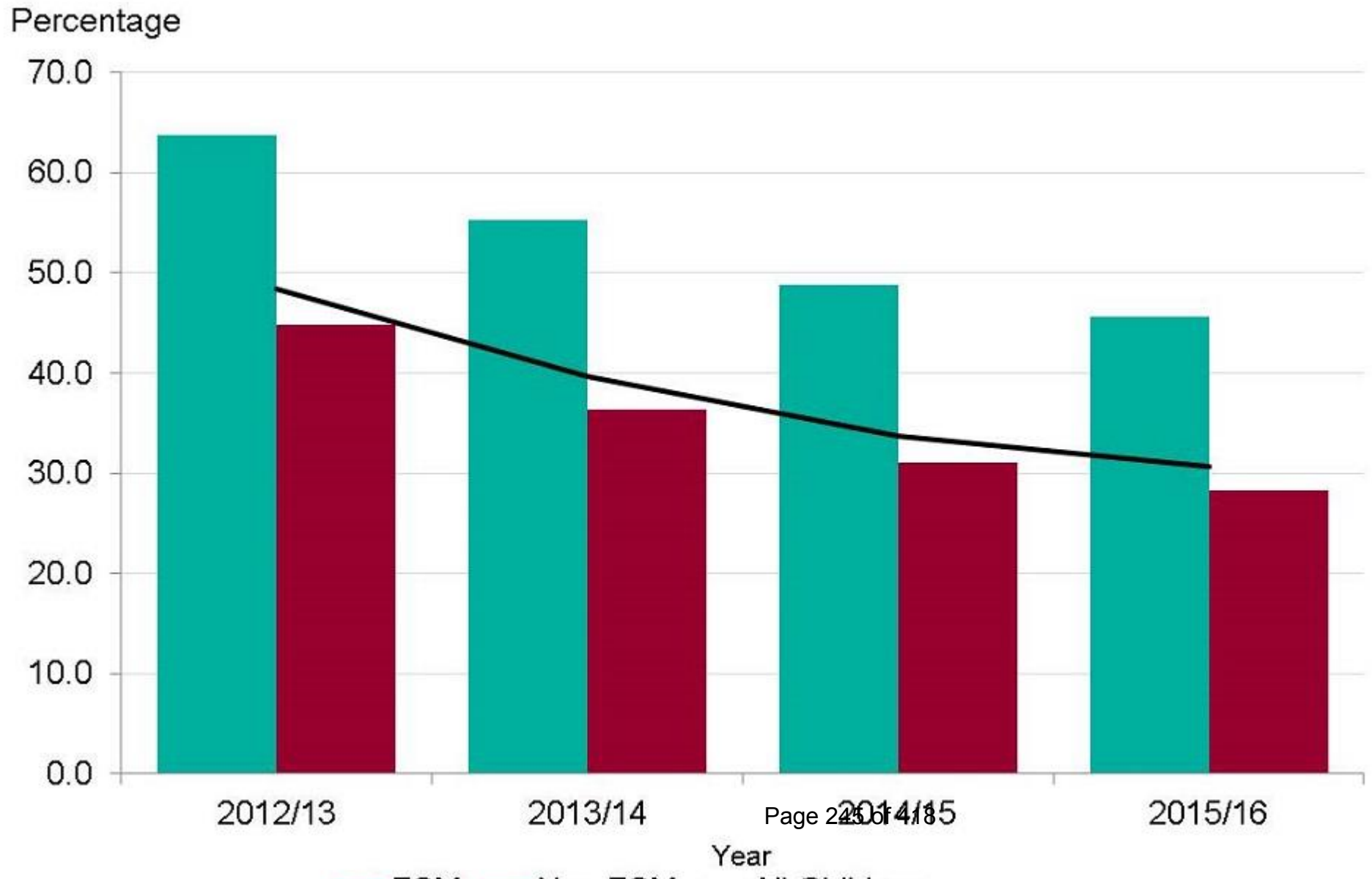
Percentage of gap in life expectancy between the most and least deprived quintile



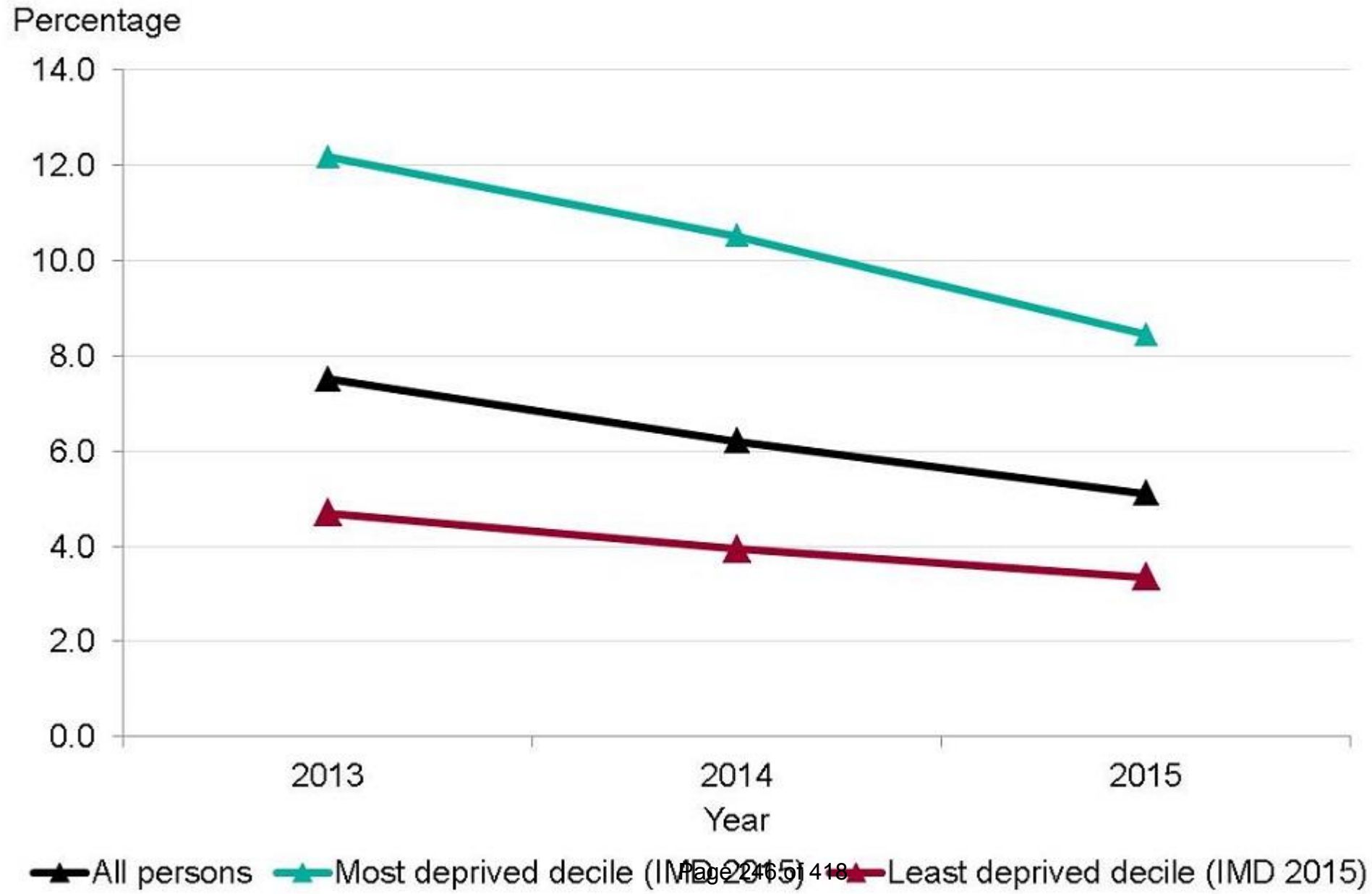
The prevalence of risk factors varies across upper tier local authorities grouped into deprivation deciles, whereby the least deprived areas had the lowest prevalence of risk factors



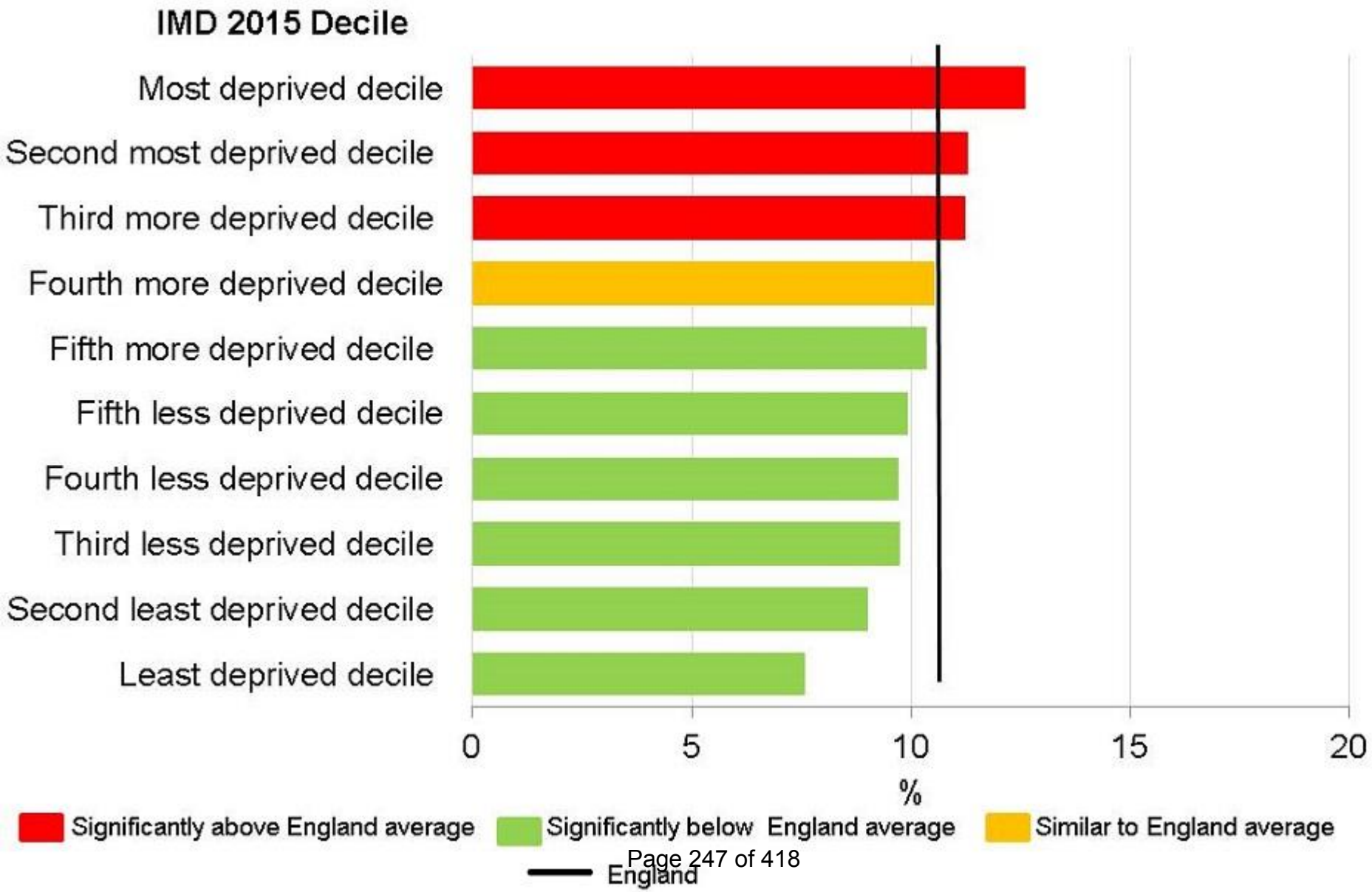
3.1 Figure 2: percentage of children who are not achieving a good level of development at the end of Reception Year (age 5) by free school meal stat



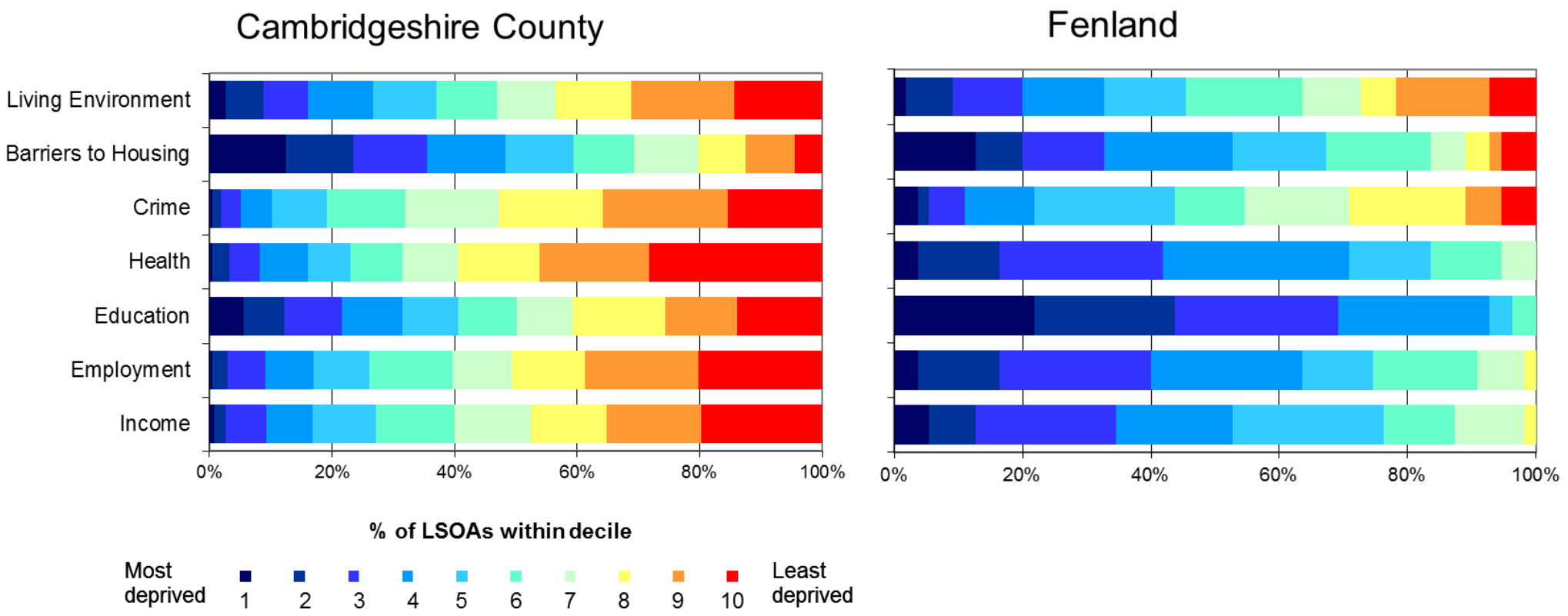
4.2 Figure 5: unemployment rate in persons (16+ years) by deprivation decile, England, 2013 to 2015

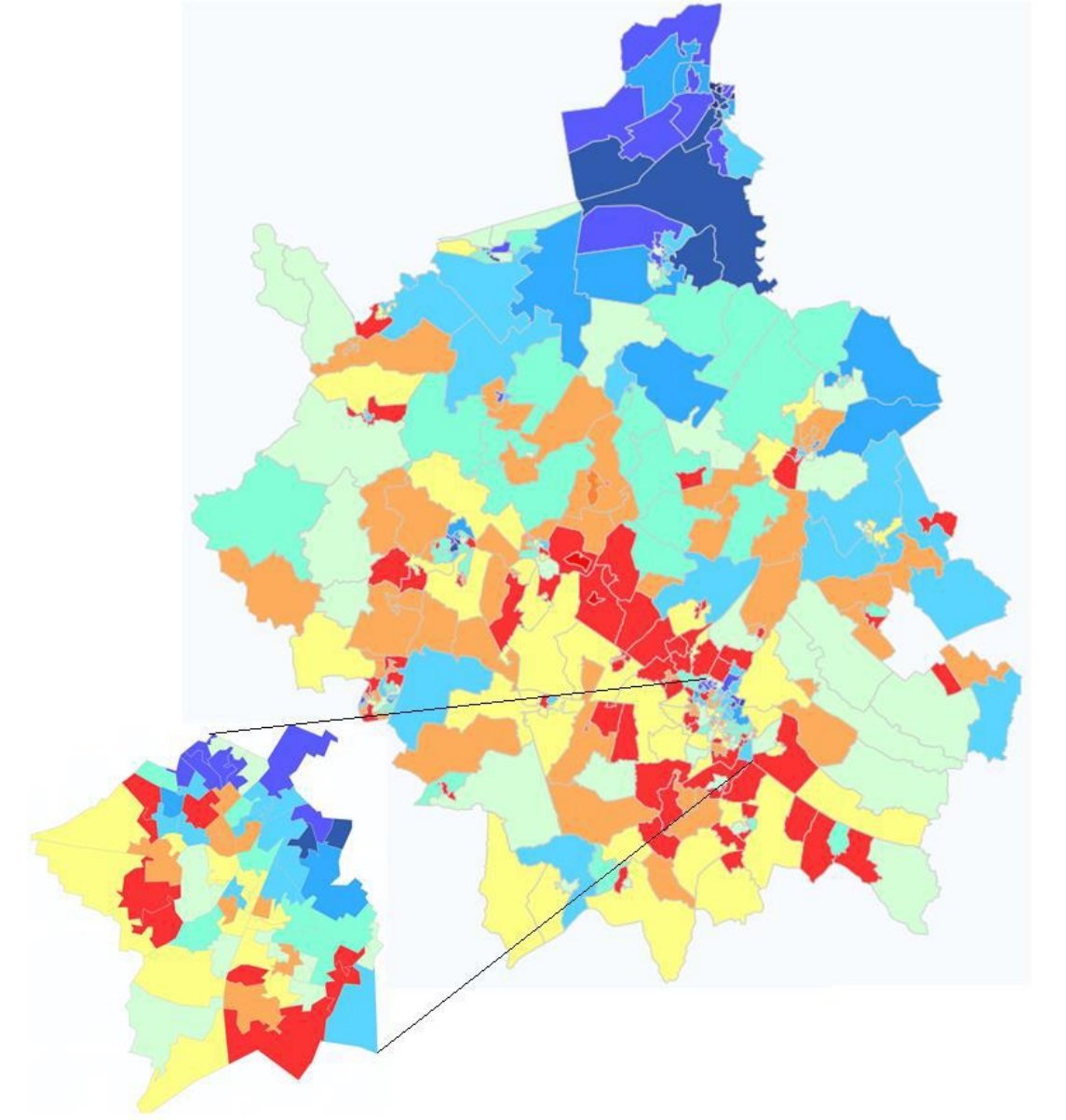


5.1 Figure 6: proportion of households living in fuel poverty by deprivation decile, England, 2014



The IMD(2015) is made up of seven domains which vary across the county

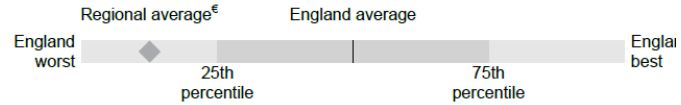



Most deprived
1
2
3
4
5
6
7
8
9
10
Least deprived

Health summary for Cambridgeshire

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate f
England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means
that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	13.4	21.8	42.0		5.7
	2	Children in low income families (under 16s)	2014	14,155	12.9	20.1	39.2		7.0
	3	Statutory homelessness	2015/16	131	0.5 ~[0]	0.9	8.9		0.1
	4	GCSEs achieved	2015/16	3,552	61.2	57.8	44.8		74.6
	5	Violent crime (violence offences)	2015/16	6,951	10.9	17.2	36.7		6.7
	6	Long term unemployment	2016	436	1.1 ^[20]	3.7 ^[20]	13.8		0.7
Children's and young people's health	7	Smoking status at time of delivery	2015/16	x[1]	x[1]	10.6 $[1]	26.0		1.8
	8	Breastfeeding initiation	2014/15	4,180	x[1]	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	840	14.9	19.8	28.5		11.0
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	152	38.5	37.4	115.1		10.8
	11	Under 18 conceptions	2015	172	16.5	20.8	43.8		5.7
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	15.2	15.5	24.2		7.4
	13	Percentage of physically active adults	2015	n/a	58.6	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	63.2	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	1,412	56.8	52.4	41.6		60.4
	16	Hospital stays for self-harm†	2015/16	1,777	264.9	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	3,981	638.2	647	1,163		390
	18	Recorded diabetes	2014/15	30,007	5.5	6.4	8.9		3.7
	19	Incidence of TB	2013 - 15	115	6.0	12.0	85.6		1.2
	20	New sexually transmitted infections (STI)	2016	2,145	511.3	795	3,288		344
	21	Hip fractures in people aged 65 and over†	2015/16	681	583.2	589	820		391
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	80.9	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	84.4	83.1	79.4		86.4
	24	Infant mortality	2013 - 15	68	3.1	3.9	7.9		2.0
	25	Killed and seriously injured on roads	2013 - 15	911	47.5	38.5	74.0		11.8
	26	Suicide rate	2013 - 15	155	9.1	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	2,391	227.8	283.5	509.0		183.3
	28	Under 75 mortality rate: cardiovascular	2013 - 15	1,018	63.5	74.6	137.6		45.4
	29	Under 75 mortality rate: cancer	2013 - 15	1,932	120.3	138.8	194.8		105.8
	30	Excess winter deaths	Aug 2012 - Jul 2015	868	16.7	19.6	33.0		10.2

Health summary for Fenland

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

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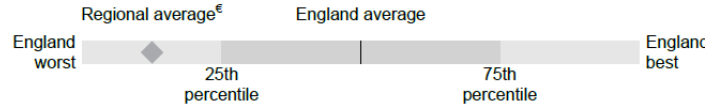
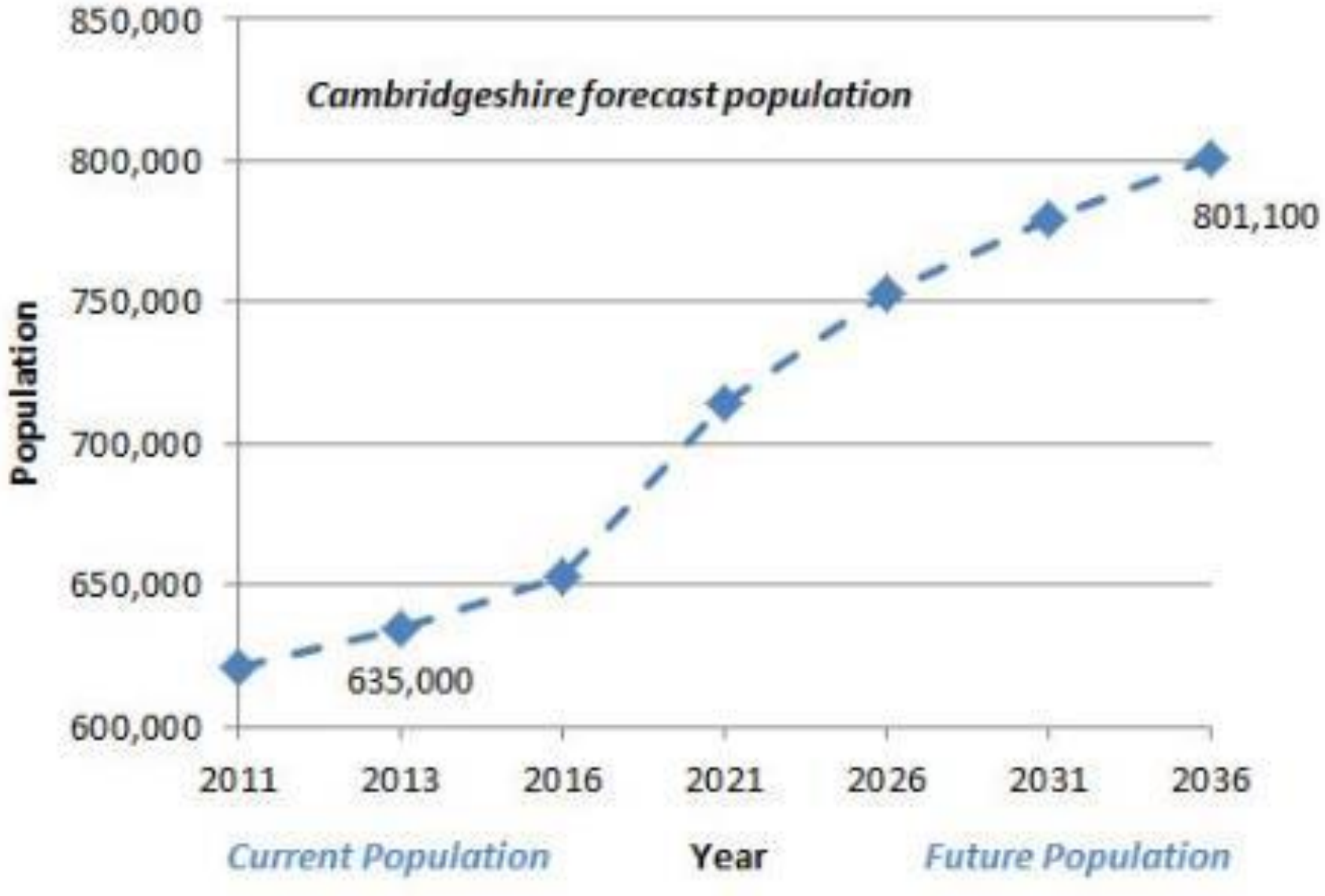


Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	25.4	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	3,745	21.3	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	*[1]	*[1]	0.9			
	4	GCSEs achieved	2015/16	531	52.2	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	1,424	14.6	17.2	36.7		4.5
	6	Long term unemployment	2016	86	1.4 ^[20]	3.7 ^[20]	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	x[1]	x[1]	10.6 $[1]	26.0		1.8
	8	Breastfeeding initiation	2014/15	856	68.8	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	174	20.0	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	22	37.6	37.4	121.3		10.5
	11	Under 18 conceptions	2015	43	26.0	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	21.6	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	47.9	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	72.9	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	272	55.9	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	293	310.7	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	729	731.1	647	1,163		374
	18	Recorded diabetes	2014/15	7,297	7.8	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	23	7.8	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	290	475.3	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	146	666.9	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	78.6	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	82.6	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	15	4.3	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	131	44.7	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	32	12.7	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	n/a	n/a	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	233	83.5	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	413	145.4	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	197	19.7	19.6	36.0		6.9


Cambridgeshire forecast population
850,000
800,000
750,000
700,000
650,000
600,000
Population
801,100
635,000
2011
2013
2016
2021
2026
2031
2036
Current Population
Year
Future Population

Current Health Committee Priorities

- Mental health
- Health inequalities
- Transport and Health
- Effectiveness of Public Health
- Public Health Business Planning
- Issues with the EPIC system at CUHFT
- Delayed transfers of care across the system

STP – Priorities for Scrutiny

- Delayed transfers of care
- Primary care models
- Workforce in general
- Communication with the public on ways to use the NHS
- STP risk register
- STP governance structure and key performance indicators monitoring

Reactive Scrutiny

The committee can identify ongoing health scrutiny priorities e.g. DTOC

Some aspects of Health Scrutiny can not be planned for E.g.

- Unitingcare Partnership termination of contract (2015)
- Merger of Hinchingbrooke Hospital & PSHFT (2016)
- Public reaction to service changes e.g. Out of Hours (2017), Arts Therapy Services (2014)

Approaches to Reactive Scrutiny

Approaches that can increase the committee's capacity to effectively scrutinise in these situations

- ¼ Liaison meetings – keeping on open dialogue with NHS commissioners and providers
- Working Groups – delegating responsibility to a group to continue in depth scrutiny and bring recommendations back to committee
- Joint Health Scrutiny Committees – formally establish a joint arrangements with other councils that have statutory scrutiny responsibilities
- Development Sessions – more detailed information can be provided from a range of sources / organisations to provide a detailed overview to inform scrutiny

Deciding on future priorities

What are the key priorities that the Health Committee may want to adopt for

- Population health
- NHS Scrutiny

Agenda Item No: 9

UPDATE ON THE JOINT CAMBRIDGESHIRE AND PETERBOROUGH SUICIDE PREVENTION STRATEGY

To: **Health Committee**

Meeting Date: **7 September 2017**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: **n/a** *Key decision:* **No**

Purpose: **To ask the Committee to comment on the progress to date and draft refresh of the suicide prevention strategy.**

Recommendation: **The Committee is asked to:**

a) **Note and comment on progress to date against the suicide prevention strategy 2014/17.**

b) **Comment on the draft suicide prevention strategy 2017-2020.**

	Officer contact:		***Member contacts:***
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Tel:	07795557595	Tel:	01223 706398

1. BACKGROUND

1.1 This report presents the progress to date on the 2014-2017 Joint Cambridgeshire and Peterborough Suicide Prevention Strategy and proposes a refresh of the strategy (2017-2020) - see Appendix 1. The 'refresh' is an early draft, but includes updates on national and local suicide statistics, initiatives, evidence and forward planning. Incorporated as a main thread throughout the strategy is an ambition towards ZERO Suicide, as agreed through the multi-partner suicide prevention implementation board in 2017. This enhances the work already underway to prevent suicide locally, including 'STOP Suicide' and the 111(2) First Response Service (FRS) for mental health crisis.

1.2 The strategy builds on and supports the National Suicide Prevention Strategy – 'Preventing suicide in England', Dept. of Health 2012. The key purpose is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of suicide prevention services that is tailored appropriately to local need and is driven by the involvement and feedback from service users. With a focus on Zero suicide, the strategy emphasises the requirement for senior level engagement with all relevant organisations to ensure quality improvement across the pathways of care for suicide prevention.

1.3 The report is being presented to the Health Committee upon request, partly due to normal processes that would require the strategy to be presented as it is being reviewed and refreshed for the coming years and partly as the result of consultation and conversations with constituents who have been affected by suicide.

1.4 The six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in the Suicide Prevention Action Plan attached at Appendix 2.

2. MAIN ISSUES

2.1 Suicide is a major public health issue as it marks the ultimate loss of hope, meaning and purpose to life and has a wide ranging impact on families, communities and society. Suicides more frequently occur in the younger age group and account for a larger proportion of years of life lost compared to deaths from other causes. However, the National Suicide Prevention Strategy – Preventing Suicide in England[1] states that suicides are not inevitable and many can be prevented, thus supporting a call for action to reduce suicide and the impact of suicide both at national and local level.

2.2 A recommendation in the 2014-2017 Strategy was to conduct a local suicide audit annually for monitoring purposes and to inform the Suicide Prevention Implementation Group of any information about concerns, or risk factors that could help focus the prevention work. The local suicide audit for 2014 and 2015 showed there were 65 and 66 suicides and unexplained deaths respectively for these years in Cambridgeshire and Peterborough

2.3 The suicide rate in Peterborough has decreased steadily since 2010-2012 when the rate was significantly above both the England and East of England rates and is now similar to the England average. The suicide rate in Cambridgeshire has remained similar to or slightly below the England average for the last five time periods.

When the data for Cambridgeshire is broken down to smaller local authority areas, all districts have recently had rates of suicide which are similar to the England average, although in the past Cambridge City and Fenland have both had periods of statistically higher suicide rates than average. No data is shown for East Cambridgeshire due to small numbers.

2.4 The 2014-2017 Suicide Prevention Strategy set out six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions in each priority area. Implementation of the Strategy and accompanying action plan was overseen by the Joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group – comprising a partnership of multiple organisations involved in mental health care.

3.0 **Progress to Date – (2014-2017 Suicide Prevention Strategy and Action Plan)**
Details presented below provide an update on the progress made as a result of the Suicide Prevention Strategy and Action Plan 2014-2017. Progress is reported for each priority area as described in the strategy.

3.1 **Priority area 1 – Reduce the risk of suicide in high risk groups**

3.1.1 **Provide Suicide Prevention Training**

- **Applied Suicide Intervention Skills Training (ASIST)**
  - Three ASIST trainers trained
  - ASIST Courses delivered across Cambridgeshire and Peterborough targeting 'Gate Keeper' roles including those working with migrant communities and bereavement support workers.
  - An ASIST course was funded and delivered to peer support workers in Peterborough prison.
  - 258 people trained in ASIST between October 2015 and January 2017

- **STOP suicide training -** Locally developed ½ day STOP suicide course has been developed and delivered. 21 STOP suicide workshops have been delivered reaching 236 people (From Oct 2015 to Jan 2017).

- **GP Training in suicide prevention -**Funding has been secured through the STP for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from the Autumn 2017

3.1.2 **Develop and promote suicide prevention resources**

- Since October 2015, STOP suicide Campaign Makers, partners and other local organisations have distributed resources to at least 70 different locations across the county i.e. pubs, leisure/sport centres, community centres, local shops.

- The Blue Light Programme which is for emergency services has given out leaflets to people working within the emergency services

- Great Northern Railways displayed STOP Suicide resources at its key railway stations from end of July 2016 onwards

- Keep Your Head (Children's and Young People's mental health website) has been developed; www.keep-your-head.com. This includes a page designed with, and for, GPs. Crisis information and preventive suicide and self-harm information. Wide promotion of this resource has taken place and is continuing.

- A directory of Services App (MyHealth App) for the public and a professional directory of services App (Midos) are being developed. These will be available along with the directory of services produced by Lifecraft via 'Keep Your Head'.

- The development of an adult version of the 'Keep Your Head' website has been agreed with funding secured from the 'Better Care Fund'. This will be developed from September 2017 with partner organisations and the Service User Network working together to create content.

3.1.3 **Awareness raising in suicide prevention**

- **STOP suicide website and pledge**

  The STOP suicide website and pledge were developed as a result of funding from the NHS Strategic Clinical Network in 2014. As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 Facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately 3000 one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of 10 new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

- **STOP suicide promotion through the media:**

  The following indicates the media coverage that the issue has received.

  - 'No Shame In Talking' video on ITV News Anglia – Fixers, 5 October 2016
  - 'Health Secretary Jeremy Hunt visits Cambridge's 'groundbreaking' mental health services' – Cambridge News, 28 October 2016
  - CRC radio interview – talk about current campaigns, 2 December 2016
  - 'Cambridgeshire dad welcomes Theresa May's pledge to 'transform' attitudes to mental health' – Cambridge News, 10 January 2017
  - Promotion of suicide prevention awareness coincided with suicide prevention day on September 10th 2016 via a discussion hosted by radio Cambridgeshire

3.1.4 **Develop Integrated services for those at risk of suicide**

- The Vanguard/Crisis Care Concordat work has been successful at creating an integrated mental health team with mental health nurses based in the police control room.

- A First Response service (FRS)with crisis telephone number (111 option 2) was established in September 2016 to help prevent people with mental health crisis going to A&E and being

admitted or sectioned under section 136 of the mental health act. In addition voluntary sector led places of safety (sanctuaries) have been established in Peterborough, Cambridge and Huntingdon for people in mental health crisis to access via the FRS. This service has been shortlisted for the Positive Practice in Mental Health Awards in the 'Crisis and Acute Services' category. In addition, the FRS and Sanctuaries have been evaluated by the 'Service User Network' (SUN) against its 'five values' of Empathy, Honesty, Inclusion, Personalisation and Working Together and have awarded the FRS 3 stars (good rating) and Sanctuaries 4 stars (outstanding).

- **Data sharing** - Information Sharing Agreements are in place across organisations to support a Frequent Attenders Commissioning for Quality and Innovation (CQUIN), in addition to MH and Acute Trusts this includes 111, ambulance service, substance misuse, primary care (Work carried out through the Crisis Care Concordat).

3.2 Priority area 2 – Tailored approaches to improve mental health in specific groups

3.2.1 Anti-stigma work and mental health promotion targeting specific groups at higher risk

Public engagement events through the 'anti-stigma work' contract with Cambridgeshire, Peterborough and South Lincolnshire (CPSL) MIND - a range of events including:

- Mental Health crisis support for young people event, Cambourne – 22 Sept and 23 November 2016
- Shelf Help launch, Huntingdon library – 28 Sept
- World Mental Health Day stand at South Cambs Council – 10 Oct
- HRC Freshers' Fair – 20 October 2016
- Hunts Forum AGM stand – 10 November 2016
- Meeting with Cambs Football Association – 12 Jan 2017

3.2.2 Children young people anti stigma/bullying in schools and tackling self-harm

- Between October 2015 and January 2017 CPSL Mind have engaged approximately 555 young people via workshops at Hills Road Sixth Form College, Kimbolton School, College of West Anglia, Milton, Oliver Cromwell College, Chatteris, Thomas Clarkson Academy, Wisbech and Ramsey College. Centre 33 have also been delivering mental health awareness sessions in schools. Between September 2016 - March 2017 mental health awareness sessions had taken place in 11 schools with sessions booked for a further 7 other schools. 821 students engaged in the workshops. These sessions aim to challenge stigma and build understanding of mental health.

- The Stress LESS campaign launched in April 2016, supports young people to manage stress through the examination period. A range of resources were produced with over 6,500 being downloaded and 2,695 website page views. Over 130 Stress LESS Action plans were made to encourage people to 'Take 5' when revising.

- A range of workshops are being run to enable school staff to deliver 'Stress LESS' sessions within their schools with pupils. As of spring 2017 over 21 schools had been involved in this training and a further 90 individuals were being trained over the summer term. These

workshops have been expanded to include information on how to respond to a young person in distress (including discussion around self-harm and suicide).

- Small grants are available to pupils who have ideas they would like to develop to support the wellbeing of other students. These ideas are taken forward by 'Stress LESS' champions in schools.

- Training is provided by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) to upskill the children and young people's workforce, this includes responding to self-harm as well as a 14 day Child and Adolescent Mental Health (CAMH) foundation course. 'Whole school briefings' offer an introduction to mental health with a focus on the ethos and culture around mental health in schools. Since 2015, 49 schools have held a whole school briefing, with 1,616 staff.

- A self-harm conference was held in 2015 in Cambridgeshire for professionals and a guide to 'understanding and responding to self-harm' has been produced and is freely available via the Keep Your Head website. A self-harm support group for parents has been run by PinPoint with support from local authority teams.

- Community based youth counselling services are run across Cambridgeshire and Peterborough, with a bereavement service offered in Cambridgeshire also. These services offer face-to-face counselling and support to young people. The Kooth online counselling service for young people was commissioned in September 2016 to broaden the mental health support available for young people.

3.2.3 **Early interventions to prevent suicide**

- **GP training –** NHS Funding has been obtained through the STP for suicide prevention training for GPs. Funding is supplemented by CCC public mental health budget. A bespoke GP training package will be designed and implemented hoping to cover 20-30% of GPs or practices within the next twelve months (from September 2017) – see priority area 1. The training will help to improve GP recognition and management of mental illness and use early intervention techniques to prevent escalation to mental health crisis.

- **Money management/debt advice** - debt prevention work is being funded with care leavers to improve money management skills and ensure vulnerable young people know where to access support if in financial trouble. A contract has also been awarded to support debt prevention and money management support to those with a severe mental illnesses in Cambridgeshire. Both of these pilot projects will be evaluated with a view to expanding provision in the future if successful.

- **Preventative work in schools** -please see priority 2.2.2 for further details. In 2017/18 training is being offered to schools staff to develop peer mediation skills. This work aims to support anti-bullying work locally. In addition a range of anti-bullying resources have been developed locally by the PSHE service working together with schools in Cambridgeshire. http://www5.cambridgeshire.gov.uk/learntogether/homepage/352/anti_bullying/

- Drop in services for young people in Huntingdon and Peterborough and Cambridge as part of Centre 33 and local authority partnerships. Delivering broad support as well as counselling.

3.3 Priority area 3 – Reduce access to the means of suicide

3.3.1 Car park barriers

The 2014-2017 Strategy identified a need to reduce access to the means of suicide in car parks. There have been suicides in car parks in both Cambridgeshire and Peterborough. There is strong evidence for reducing access to the means of suicide in preventing suicide, particularly barriers at sites where suicide has been frequent. Locally in Peterborough the Suicide Prevention Implementation group, including the coroner, were successful in persuading the owners of the Queensgate car parks to erect barriers on all the car parks they operate in the city centre. Since completion 2017 there have been no further suicides from car parks in Peterborough.

3.3.2 Suicide prevention on railways

A range of work is being undertaken nationally as part of the railway Suicide Prevention Pan – Samaritans, Network Rail and British Transport Police. This includes printed messages on tickets and posters at stations. Some local stations are also displaying STOP Suicide resources.

3.3.3 Safer medicines management

Following Child Death Overview Panel reports there was a communication to GPs regarding safe prescribing to young people, this was also re-circulated.

3.4 Priority area 4 – Provide better information and support to those bereaved or affected by suicide

3.4.1 Establishing a bereavement support service for people affected by suicide

NHS Sustainability and Transformation Plan (STP) Funding was granted in July 2017 to set up a reactive support service for people who have been bereaved as a result of suicide. The service will be managed by a family liaison officer who will offer support to families in the first weeks after bereavement. They will also signpost people to follow-up services and peer support groups. Part of this work will be to set-up SOBS (Survivors of bereavement due to suicide) or similar groups in Cambridge and Peterborough and connect with CRUSE bereavement counselling services.

3.4.2 **Bereavement support resources**

- **Access to the 'help is at hand' leaflet for people bereaved as a result of suicide**

  Help is at hand booklet shared with The Coroner's Office (Feb15) and circulated to all GP practices in Cambridgeshire and Peterborough. Electronically shared with Funeral directors. Information on 'help is at hand' circulated via the GP bulletin in 2015 and 2017.

- Bereavement support resources are promoted via the Stop Suicide Pledge website and Keep Your Head website. These resources include specific sites for young people who are bereaved.

3.5 **Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior**

- Communication with Cambridge News on the responsible reporting of suicide, including information advice created by The Samaritans – this was initiated after a suspected suicide incident was poorly reported by the Cambridge News. CCC Communications team have been involved in this work.

- Visits were made to Radio Cambridgeshire to promote the responsible reporting of suicides and guidelines on suicide reporting were provided to the editor.

3.6 **Priority area 6 - Support research, data collection and monitoring**

- **Surveillance: suicide audit**

  An annual suicide audit was undertaken in 2015 (of deaths in 2014) and 2016 (of deaths in 2015).The audits have helped to shape targeting of local work. The audit will continue to be undertaken annually, with a detailed case review of a sample of files. Work has been carried out together with the Coroner's Office to improve the standardised regular information received on deaths throughout the year. The quality of the information received has improved.

- **Surveillance from British Transport Police**

  Data is received from BTP through an annual report and a warning system (national system).

- **Local, real-time surveillance system**

  A local real-time surveillance system has been established. This shares information from Police/Coroner to Public Health on suspected suicides as they occur. This information is essential to establish a bereavement support service**.** The Coroner flags any notable patterns with the group or public health. The surveillance system will also help to identify any concerns in terms of geographic/temporal patterns/clusters.

3.7 **Moving forward with suicide prevention**

A draft 'refresh' of the suicide prevention strategy and action plan (2017 – 2020) with the inclusion of a ZERO suicide ambition follows on from the progress to date (2014-2017 strategy, detailed above). This follows the same six priority areas with suggested interventions building on areas of work already in progress. For details please refer to the draft documents provided with this report.

4. ALIGNMENT WITH CORPORATE PRIORITIES

4.1 Developing the local economy for the benefit of all

The economic cost of each death by suicide in England for those of working age is estimated to be £1.67 million (2009 costs). This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

Given these economic costs, preventing suicide locally will inevitably benefit the economy and benefit all

4.2 Helping people live healthy and independent lives

The work of the suicide prevention implementation group is fundamental to helping people improve their mental health, prevent mental illness and crisis leading to suicide. Effective Crisis care support and management as well as many of the other initiatives proposed and offered in the implementation plan will enable people with mental health problems live independently.

4.3 Supporting and protecting vulnerable people

People at high risk of suicide are by definition vulnerable people but certain vulnerable groups of people have higher risk of suicide, including homeless, looked after children, gypsies and travellers, migrants and asylum seekers. The strategy prioritises work that supports these vulnerable groups to reduce the risk of suicide.

5. SIGNIFICANT IMPLICATIONS

5.1 Resource Implications

- The STOP suicide/anti stigma work is funded by CCC and PCC with a contract awarded to CPSL MIND for three years (from April 2017) at an annual cost of £37,691 from CCC Public Mental Health.

- The debt/ money management work is funded by CCC for a pilot one year period (from July 2017) - £15K for the adult service. The contract was awarded to Lifecraft.

- Better Care Fund money: £8K is being used to support development of the adult 'Keep Your Head' website

- £10K for one year (from August 2017) is being used from the public mental health budget (CCC) to support GP training and setting up the bereavement support service – funded mostly through the STP (£70K)

- Anti-bullying work - £15K per annum

- Support to PHSE - £10K per annum

- Emotional wellbeing tender – £10K per annum

5.2 Procurement/Contractual/Council Contract Procedure Rules Implications

- Procurement processes were followed before the award of the contract for the STOP suicide/anti stigma work

- Procurement processes were followed before the award of the contract for the debt/ money management work

- Contract variation process needs to be followed for the £10K support towards GP training and the bereavement support service.

5.3 Statutory, Legal and Risk Implications

- There is a legal requirement to keep any person identifiable information confidential and therefore, when data is received about suicide, this is held securely by Public Health.

5.4 Equality and Diversity Implications

- The work of the suicide prevention implementation group will be all inclusive for the benefit of the community but will focus on groups at higher risk of suicide. This will take account of equality and diversity issues as it identifies the most vulnerable groups in society.

5.5 Engagement and Communications Implications

- Engagement across all sectors is crucial for the delivery of suicide prevention interventions and this is why the implementation group is made up of a partnership between many organisations.

- The suicide prevention strategy was agreed in 2014 upon wide consultation and engagement with stakeholders and service users. The refresh of the strategy will go through the same consultation process over the coming months – including workshop/stakeholder events. Service Users have been involved in the evaluation process for some of the work – STOP suicide and the Crisis care services, for example.
- The continuing roll-out of suicide prevention initiatives, including promotional events, working with the media and the ZERO suicide ambition will require Communications support from the Local Authority and other partner Communication teams.

5.6 Localism and Local Member Involvement

- The suicide prevention strategy recommends initiatives that encourage community participation, awareness raising and self-help, therefore promoting the localism agenda.

- The intention of the ZERO suicide ambition is to engage individuals and communities to work with the suicide prevention implementation group and therefore with the County Council in furthering this agenda.

5.7 Public Health Implications

- The Cambridgeshire and Peterborough Suicide Prevention Group is led by the two Local Authority Public Health teams, with involvement from a wide range of stakeholders. The suicide prevention implementation initiatives aim to reduce suicide and prevent mental health problems that may lead to a risk of suicide

- Many of the interventions focus on people at higher risk of suicide and these include people with mental health problems, those affected adversely by the wider determinants of health including, economic disadvantage, unemployment, being looked after, for example.

- The suicide prevention strategy will help support the key priorities of the Cambridgeshire Joint Strategic Needs Assessments for Adult Mental Health and for Child and Adolescent Mental Health

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Martin Wade
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Sarah Fuller
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Fiona McMilllan
Have the equality and diversity implications been cleared by your Service Contact?	Yes 18 Aug 2017 Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes 18 Aug 2017 Name of Officer: Liz Robin

Have any Public Health implications been cleared by Public Health	Yes 18 Aug 2017 Name of Officer: Liz Robin

Source Documents

1. National Strategy: Preventing Suicide in England, 2012: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf
2. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives: https://www.gov.uk/government/publications/suicide-prevention-third-annual-report
3. Cambridgeshire and Peterborough Clinical Commissioning Group Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016 http://www.cpft.nhs.uk/Downloads/rod%20files/2013_0816_CCG_Adult_MH_Commissioning_Strategy_2013_FINAL.pdf
4. JSNA Cambridgeshire – health and wellbeing strategy see: http://www.cambridgeshire.gov.uk/info/20116/health_and_wellbeing_board
5. JSNA Peterborough Mental Health http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Mental%20Health.pdf
6. Suicide Prevention Strategy CPFT 2013-2016 (closed document) – for details please contact author or CPFT
7. Emotional well-being and mental health strategy for children and young people 2014-2016 (draft strategy)
8. Suicides in students http://www.ons.gov.uk/ons/about-ons/what-we-do/publication-scheme/published-ad-hoc-data/health-and-social-care/november-2012/index.html
9. National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2013 http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf
10. Samaritans report –men suicide and society: http://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf
11. No health without mental health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf
12. Public Health Outcomes Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf
13. Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis, February 2014. Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
14. Annual Report of the Chief Medical officer 2013 – Public Mental Health Priorities: Investing in the Evidence https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf
15. Saving Lives: Our Healthier Nation; Department of Health, 1999: https://www.gov.uk/government/publications/saving-lives-our-healthier-nation
16. Detroit model for suicide prevention: http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionalliance

forsuicideprevention.org/files/PerfectDepressionCarearticles.pdf
17. ASIST suicide prevention training: http://www.chooselife.net/Training/asist.aspx
18. Mental Health First Aid training England: http://mhfaengland.org/
19. Suicide in primary care in England 2002-2011[18] http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/SuicideinPrimaryCare2014.pdf
20. Knapp et al 2011, Mental health promotion and prevention: The economic case. http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf
21. The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation Social research: The Scottish Government, http://www.chooselife.net/uploads/documents/19-ASISTEvaluationFullReport.pdf
22. Bickley, H et al 2013; Suicide within two weeks of discharge from psychiatric inpatient care. A case control study Psychiatric Services 2013 http://ps.psychiatryonline.org/article.aspx?articleID=1673604
23. Cox et al 2013; Interventions to reduce suicides at suicide hotspots: a systematic review BMC Public Health 2013, 13:214 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606606/pdf/1471-2458-13-214.pdf
24. Mann et al, 2005 Suicide Prevention Strategies: A systematic Review. *JAMA.* 2005;294(16):2064-2074
25. Support after a suicide: A guide to providing local services https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services
26. We are in your corner – Samaritans: http://www.samaritans.org/media-centre/our-campaigns/were-your-corner
27. MHRA – Best practice for the sale of medicines for pain relief - http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con065560.pdf
28. Hawton K, Bergen H, Simkin S et al (2010) Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose. *British Journal of Psychiatry* 196: 354-358
29. 'Help is at hand' a resource for people bereaved by suicide and other sudden, traumatic death http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
30. Preventing Suicide - A Resource for Media Professionals: A resource guide produced by the Department of Mental Health at the World Health Organization in 2000. http://www.who.int/mental_health/media/en/426.pdf
31. Media guidelines for reporting suicide – Samaritans: http://www.samaritans.org/sites/default/files/kcfinder/files/press/Samaritans%20Media%20Guidelines%202013%20UK.pdf
32. NHS England and Public Health England 'A call for Action: Commissioning for Prevention' November 2013. Available at: www.england.nhs.uk
33. WHO For which strategies of suicide prevention is there evidence of effectiveness http://www.euro.who.int/__data/assets/pdf_file/0010/74692/E83583.pdf

DRAFT Joint Cambridgeshire and Peterborough Suicide prevention strategy

2017-2020

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ORGANISATIONAL SIGNATORIES

To be added

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The joint Cambridgeshire and Peterborough suicide prevention strategy is the result of discussions between partner organisations and individuals. We are grateful for the continuing support and input from the following:

ACRONYMS AND ABBREVIATIONS

ARC	Advice and Resource Centre
ASIST	Applied Suicide Intervention Skills Training
CAB	Citizens Advice Bureau
CAF	Clinical Assessment Framework
CCG	Clinical Commissioning Group
CMET	Clinical and Management Executive Team
CMO	Chief Medical Officer
CO	Carbon monoxide
CPFT	Cambridgeshire & Peterborough Foundation Trust
CR/HT	Crisis Resolution/Home Treatment
CREDS	Cambridgeshire Race Equality and Diversity Service
GPs	General Practitioners
ICD10	International Classification of Diseases version 10
LAC	Local Area Coordination
MHFA	Mental Health First Aid
MHRA	Medicines and Healthcare products Regulatory Authority
NICE	National Institute for Health & Clinical Excellence
ONS	Office for National Statistics
PCAS	Peterborough Community Assistance Scheme
QALY	Quality Adjusted Life Year
SCN	Strategic Clinical Network
STP	Sustainability and Transformation Plans
SUN	Service User Network

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'Keep your face always to the sunshine and shadows will fall behind you'
Walt Whitman

1. EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

The Cambridgeshire and Peterborough suicide prevention strategy 2017-2020 is a refresh of the 2014-2017 strategy with updates on national and local suicide statistics, initiatives, evidence and forward planning. Incorporated as a main thread throughout the strategy is an ambition towards ZERO suicide, as agreed through the multi-partner suicide prevention implementation board in 2017. This enhances the work already underway to prevent suicide locally, including 'STOP Suicide' and the 111(2) First Response Service (FRS) for mental health crisis.

The strategy builds on and supports the National suicide prevention strategy – 'Preventing suicide in England, Dept. of Health 2012'[1] but also includes a drive to aim for ZERO suicide. The key purpose is to ensure that there is co-ordinated and integrated multi-agency agreement on the delivery of suicide prevention services that is tailored appropriately to local need and is driven by the involvement and feedback from service users. With a focus on Zero suicide, the strategy emphasises the requirement for senior level engagement with all relevant organisations to ensure quality improvement across the pathways of care for suicide prevention.

Six priority areas for suicide prevention in Cambridgeshire and Peterborough with recommendations for actions are set out in sections 9-14 and accompanying action plan. A summary of the recommendations is provided below.

Table 1 – Summary of suicide prevention priority areas and recommendations for actions

Priority area 1 – Reduce the risk of suicide in high risk groups
Recommendations **1.1** Continue to implement suicide prevention training (STOP suicide and ASIST) to professionals, organisations and individuals in contact with people at risk of suicide. Develop and implement suicide prevention training for GPs **1.2** Continue to develop and tailor suicide prevention resources for professionals, agencies and vulnerable groups **1.3** Continue to raise awareness of STOP suicide and suicide prevention in community settings and to high risk groups **1.4** Ensure access to resources to aid self-help in those at risk of suicide **1.5** Continue to develop integrated, appropriate and responsive services for those at risk of suicide – including pathways for vulnerable groups such as those with co-occurring drug and alcohol and mental health problems. **1.6** Reassess pathways for young people and adults known by mental health services at risk of suicide **1.7** Improve pathways and support for people taken into custody and newly released from custody at risk of suicide

Priority area 2 – Tailor approaches to improve mental health in specific groups

Recommendations

2.1 Continue to work with partners who are delivering the 'Emotional wellbeing and mental health strategy for children and young people' to

- Raise awareness and campaigning around self-harm
- provide access to self-help resources that focus on building resilience in young people
- Raise awareness on preventing bullying
- assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Support initiatives that work with families to address children and young people's mental health

2.3 Promote early interventions to aid prevention of mental health problems that could lead to suicide in particular risk groups.

2.4 Promote training in mental health awareness, particularly with professional groups such as GPs to recognise mental health issues and risk of suicide

Priority area 3 – Reduce access to the means of suicide

Recommendations

3.1 In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

3.2 Continue to reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car-parks

3.3 Continue work to reduce the risk of suicide on railway lines

3.4 Work with Medicines Management teams at the CCG to ensure safe prescribing of some toxic drugs

3.5 Work with health and care professionals to establish and reinforce safety plans for individuals with mental health problems

Priority area 4 – Provide better information and support to those bereaved or affected by suicide

Recommendations

4.1 Ensure bereavement information and access to support is available to those bereaved by suicide

4.2 Implement a bereavement support service and pathway for those affected by suicide

Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior

Recommendations

5.1 Encourage appropriate and sensitive reporting of suicide

- Continue to provide information to professionals on the sensitive reporting of suicide
- Continue to work with local media to encourage reference to and use of guidelines for the reporting

of suicide
Priority area 6 - Support research, data collection and monitoring
6.1 Monitor real-time information on suspected suicides as they occur. Link this information to suicide data provided on a quarterly basis by Cambridgeshire and Peterborough coroners. Include data from the Police on suicides and near suicides. **6.2** Continue to conduct an annual audit of local suicides **6.3** Continue to disseminate current evidence on suicide prevention to all partner organisations **6.4** Evaluate and report on the suicide prevention implementation plan

1.1 Zero Suicide

The ambition towards Zero suicide as the 'backbone' of the strategy requires commitment by organisations and individuals to create a cultural change in suicide prevention as summarised below.

Table 2 – Outline of the zero suicide ambition

Zero Suicide Ambition
Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police
Improve quality - Create a learning culture not a blaming culture that will review both suicide information and information from people with lived experience to learn lessons and implement good practice.
Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems
Strengthen the suicide prevention implementation plan with a stronger emphasis on campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people

2. PURPOSE

This document sets out the strategic priorities and recommendations to prevent suicide in Cambridgeshire and Peterborough between 2017 and 2020. Accompanying the strategy is an action plan that is updated from the previous suicide prevention strategy. The action plan is intended to be used as a framework by key stakeholders for implementing the recommendations and for measuring and evaluating suicide prevention outcomes.

Suicide is a major public health issue as it marks the ultimate loss of hope, meaning and purpose to life and has a wide ranging impact on families, communities and society. Suicides more frequently occur in the younger age group, and account for a larger proportion of years of life lost compared to deaths from other causes. However, the National Suicide Prevention Strategy – Preventing Suicide in

England[1] states that suicides are not inevitable and many can be prevented, thus supporting a call for action to reduce suicide and the impact of suicide both at national and local level.

In line with national guidelines on preventing suicide, and to oversee the implementation of the local strategy, a multi-agency suicide prevention implementation group meets on a quarterly basis with input and membership from many organisations across public, charitable and voluntary sectors, including:

- Cambridgeshire County Council
- Peterborough City Council
- Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) - including CCG GP leads for mental health and commissioning support
- Police
- Coroners
- Cambridgeshire and Peterborough Foundation Trust
- MIND
- Lifecraft
- Service User Engagement Network (SUN)
- MindEd Trust
- Youth Offender service
- Rethink Carers
- Prison and probation service
- Samaritans
- Individuals with lived experience

The strategy is refreshed as a result of the following key considerations:

Nationally

- The National drive to prevent suicide – highlighted by the report "Preventing suicide in England - a cross-government outcomes strategy to save lives HM Government September 2012"[1] with progress reports including the most recent publication 'Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives'[2]
- Public Health England's guidance on 'Local suicide prevention planning - a practice resource'
- *National momentum for Zero suicide including plans to* create a Zero Suicide foundation.
- *Government commitment to improve mental health* - a comprehensive package of measures to transform mental health support in schools, workplaces and communities – as announced in January 2017

- *Public Health England Guidelines to develop bereavement support services for those affected by suicide:* 'Support after a suicide: a guide to providing local services'
- The findings from the National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

Locally

- Suicide prevention is specified in the STP improvement plan within the Primary Care and Integrated Neighbourhoods (PCIN) delivery group, Mental Health Prevention and promotion of mental wellness priority. This stipulates the continued implementation of the suicide prevention strategy and findings of suicide audit.
- The five year forward view on mental health states within the key priorities for investment and focussed work 2016/17 and 2017/18 (primary prevention section): A local focus on Continued implementation of multi-agency suicide prevention strategy and findings of suicide audit (2016/17). By 2020/21 the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels.
- The Peterborough Health and Wellbeing Strategy identified five priorities to improve the health and wellbeing of everyone in Peterborough including 'to enable good child and adult mental health through effective, accessible health promotion and early intervention services'. The suicide prevention strategy includes areas that focus on mental health promotion and early intervention. The findings of the Peterborough JSNA on the mental health and mental illness of adults – 2015/2016 are also considered and help to focus the suicide prevention action plan.
- The development and implementation of a local Mental Health Crisis Concordat Declaration and Action Plan. This work is being led by the Police, but is supported by members across the partnership of organisations including the suicide prevention implementation group. The suicide prevention strategy includes recommendations that link directly to the work developed in the Crisis Concordat Action Plan.
- Feedback consistently received from individuals affected by suicide and local agencies that there is a need for:
    - better support for those bereaved or affected by suicide
    - clearer guidance where to seek help and advice for people who are worried that someone they know might be at risk of suicide, or are presented with somebody threatening suicide
    - improved information sharing across the pathway of care for people at risk of suicide
    - improvements to training for GPs and other health professionals to identify and manage those at risk of suicide

In developing recommendations and action plans for each priority area within the strategy, evidence and information is drawn from national guidance and publications on what is effective in preventing suicide. An emphasis is placed on local needs assessments and intelligence gathered from coroner data. Consultation is made with service users and other organisations or groups including British Transport Police, Probation services, Drug and Alcohol services, Public Health England and

Cambridge University Student welfare officers to identify groups at higher risk of suicide and gaps in service provision.

Implementation of the recommendations and action plan are managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area. It is envisaged that working groups will be established to address priority areas or particular recommendations and these will report to the joint implementation group. The joint implementation group will be accountable for delivering the strategy and will report progress on an annual basis to the various partner organisations; Peterborough Adult Mental Health Stakeholder Group, Public Health Board and Health and Wellbeing Board in Peterborough, the Health Committee in Cambridgeshire and the Cambridgeshire and Peterborough Clinical Executive Group.

2.1 Outcomes of the implementation of the suicide prevention strategy 2014-2017

The table below lists the progress made to date as a result of the suicide prevention strategy, implementation plan and partnership working since 2014:

Table 3 – Summary of progress of the suicide prevention strategy 2014-2017

Priority area 1 – Reduce the risk of suicide in high risk groups

Suicide Prevention Training

Applied Suicide Intervention Skills Training (ASIST) Training

- Three ASIST trainers trained
- ASIST Courses delivered across Cambridgeshire and Peterborough targeting 'Gate Keeper' roles including those working with migrant communities and bereavement support workers.
- An ASIST course was funded and delivered to peer support workers in Peterborough prison.
- 258 people trained in ASIST between October 2015 and January 2017

Bespoke stop suicide training - Locally developed ½ day STOP suicide course has been developed and delivered. 21 STOP suicide workshops have been delivered reaching 236 people (From Oct 2015 to Jan 2017). These have included sessions with the following:

- CAB
- Three Homeless Charities
- Oasis Community Centre (East European migrants)
- NCS Programme (Peterborough)
- UNISON
- Junior Drs
- Carers Trust

- Cruse
- Colleges (Impington, Homerton, Huntingdon, Ely, Peterborough)

Courses are also offered to the **emergency services** as part of MIND's **Blue Light Activity**.

GP Training in suicide prevention

Funding has been secured through the STP for training of GPs across Cambridgeshire and Peterborough in suicide prevention, which will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from the Autumn 2017

Suicide prevention resources

Since October 2015 the STOP suicide Campaign Makers, partners and other local organisations have helped us to distribute resources to at least 70 different locations across Fenland, Peterborough, Melbourn, Cambridge i.e. pubs, leisure/sport centres, community centres, local shops.

The Blue Light Programme team have also been giving out leaflets to emergency services across Cambs and Peterborough.

In addition, Great Northern agreed to display STOP Suicide resources at its key railway stations from end of July 2016 onwards

A website aimed at promoting mental health in children and young people has been developed – 'Keep Your Head' www.keep-your-head.com This includes a page designed with, and for, GPs. Crisis information and suicide and self-harm information. Wide promotion of this resource has taken place and is continuing.

A directory of Services App (MyHealth App) for the public and a professional directory of services App (Midos) are being developed. These will be available along with the directory of services produced by Lifecraft via 'Keep Your Head'.

The development of an adult version of the 'Keep Your Head' website has been agreed with funding secured from the 'Better Care Fund'. This will be developed from September 2017 with partner organisations and the Service User Network working together to create content.

Awareness raising in suicide prevention

Stop suicide website and pledge

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately **3000** one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of **10** new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

Promoting suicide prevention across the county:

- 'No Shame In Talking' video on **ITV News Anglia** – Fixers, 5 October 2016 http://www.fixers.org.uk/index.php?module_instance_id=11312&core_alternate_io_handler=view_fixer_news_video&data_ref_id=14785&news_data_ref_id=14784&video_no=1 – talk about STOP Suicide
- 'Health Secretary Jeremy Hunt visits Cambridge's 'groundbreaking' mental health services' – **Cambridge News**, 28 October 2016 http://www.cambridge-news.co.uk/news/health/health-secretary-jeremy-hunt-visits-12095230
- **CRC radio** interview – talk about current campaigns, 2 December 2016
- 'Cambridgeshire dad welcomes Theresa May's pledge to 'transform' attitudes to mental health' – **Cambridge News**, 10 January 2017 http://www.cambridge-news.co.uk/news/cambridge-news/cambridgeshire-dad-welcomes-theresa-mays-12431838
- 'Crisis cafes and community clinics among plans to improve mental health services in Cambridgeshire' – **Ely Standard**, 11 Jan 2017 http://www.cambstimes.co.uk/news/crisis_cafes_and_community_clinics_among_plans_to_improve_mental_health_services_in_cambridgeshire_1_4844482
- **Promotion of suicide prevention awareness to coincide with suicide prevention day on September 10th 2016 via a discussion hosted by radio Cambridgeshire**

Develop Integrated services for those at risk of suicide

Vanguard/Crisis Care Concordat work has been successful at creating an integrated mental health team with mental health nurses based in the police control room.

A First Response service (FRS)with crisis telephone number (111 option 2) was established in September 2016 to help prevent people with mental health crisis going to A&E and being admitted or sectioned under section 136 of the mental health act. In addition non health places of safety (sanctuaries) have been established in Peterborough, Cambridge and Huntingdon for people in mental health crisis to access via the FRS. This service has been shortlisted for the Positive Practice in Mental Health Awards in the 'Crisis and Acute Services' category. In addition, the FRS and Sanctuaries have been evaluated by the 'Service User Network' (SUN) against it's 'five values' of Empathy, Honesty, Inclusion, Personalisation and Working Together and have awarded the FRS 3 stars (good rating) and Sanctuaries 4 stars (outstanding).

Data sharing - Information Sharing Agreements are in place across organisations to support the Frequent Attenders CQUIN, in addition to MH and Acute Trusts this includes 111, ambulance service, substance misuse, primary care (Work carried out through the Crisis Care Concordat).

PRISM (enhanced primary care) service for people with mental health problems is in place for many areas across Cambridgeshire. This provides access to support and care for people struggling with mental illness through referral via the GP or through 'step down' from secondary care. The PRISM service is proving effective at reducing referrals to secondary care as people are managed in the community.

Priority area 2 – Tailor approaches to improve mental health in specific groups

Anti-stigma work and mental health promotion targeting specific groups at higher risk

Funding to deliver courses to bar staff in Fenland as well as scoping work to assess feasibility of training barbers/hair dressers. A need for mental health awareness and suicide prevention for men working in the construction industry has been identified (through national data and suicide surveillance) and will be a focus for the anti-stigma/suicide prevention work commissioned from CPSL MIND

Other public engagement events through the 'anti-stigma work:

- Mental Health crisis support for young people event, Cambourne – 22 Sept
- Shelf Help launch, Huntingdon library – 28 Sept
- World Mental Health Day stand at South Cambs Council – 10 Oct
- CCG Development Day stand – 13 October 2016
- HRC Freshers' Fair – 20 October 2016
- Meeting a group of potential Campaign Makers, Wilbrahams Memorial Hall – 1 November
- Hunts Forum AGM stand – 10 November 2016
- Young people's follow up event, Cambourne – 23 November 2016
- Meeting with Cambs Football Association – 12 Jan 2017
- TASC meeting, London – 13 Jan 2017

Children young people anti stigma/bullying in schools

Between October 2015 and January 2017 CPSL Mind have engaged approximately 555 young people via workshops at Hills Road Sixth Form College, Kimbolton School, College of West Anglia, Milton, Oliver Cromwell College, Chatteris, Thomas Clarkson Academy, Wisbech and Ramsey College. Centre 33 have also been delivering mental health awareness sessions in schools. Between September 2016 - March 2017 mental health awareness sessions had taken place in 11 with sessions booked for a further 7 other schools. Across the 11 schools a total of 821 students engaged in the workshops. These sessions aim to challenge stigma and build understanding of mental health.

The Stress LESS campaign launched in April 2016, aiming to support young people to manage stress through the exam period. A range of resources were produced with over 6,500 being downloaded and 2,695 website page views. Over 130 Stress LESS Action plans were made to encourage people to 'Take 5' when revising.

Alongside the campaign a range of workshops are being run to enable school staff to deliver 'Stress LESS' sessions within their schools with pupils. As of Spring 2017 over 21 schools had been involved in this training and a further 90 individuals were being trained over the summer term. These workshops have been expanded to include information on how to respond to a young person in distress (including discussion around self-harm and suicide).

Within schools that engage in the Stress LESS workshops, small grants are available to pupils who have ideas they would like to develop to support the wellbeing of other students. These ideas are taken forward by 'Stress LESS' champions in schools.

A range of training is provided by CPFT to upskill the children and young people's workforce, this includes specific training courses on areas such as responding to self-harm as well as a 14 day CAMH foundation course. There is also tailored training for schools which includes the whole school briefing which offers an introduction to mental health with a focus on the ethos and culture around mental health in schools. Since 2015 there have been 49 schools that have held a whole school briefing, which equates to 1,616 staff.

Tackling self-harm in young people

A self-harm conference was held in 2015 in Cambridgeshire for professionals and locally a guide to 'understanding and responding to self-harm' has been produced and is freely available (download via the Keep Your Head website http://www.keep-your-head.com/CP-MHS/need-help-now/suicide-and-self-harm-support). A self-harm support group for parents has been run by PinPoint with support from local authority teams.

A range of training is provided by CPFT aimed at upskilling the children and young people's workforce in terms of mental health. Self-harm is covered within a number of courses, including specific training on responding to self-harm. This training is free to access for many professionals.

Community based youth counselling services are run across Cambridgeshire and Peterborough, with a bereavement service offered in Cambridgeshire also. These services offer face-to-face counselling and support to young people. The Kooth online counselling service for young people was commissioned in September 2016 to broaden the mental health support available for young people.

Early interventions to prevent suicide

GP training

Funding obtained through STP for suicide prevention training for GPs. Funding is supplemented by CCC Public mental health budget. A bespoke GP training package will be designed and implemented hoping to cover 20-30% of GPs or practices within the next twelve months (from September 2017) – see priority area 1. The training will help to improve GP recognition and management of mental illness and use early intervention techniques to prevent escalation to mental health crisis.

Money management/debt advice - debt prevention work is being funded with care leavers to improve money management skills and ensure vulnerable young people know where to access support if in financial trouble. A contract has also been awarded to support debt prevention and money management support to those with a severe mental illnesses in Cambridgeshire. Both of these pilot projects will be evaluated with a view to expanding provision in the future if successful.

Preventative work in schools (please see priority 2 for further details of training for school staff and mental health awareness sessions with pupils).

In 2017/18 training is being offered to schools staff to develop peer mediation skills. This work aims to support anti-bullying work locally. In addition a range of anti-bullying resources have been developed locally by the PSHE service working together with schools in Cambridgeshire. http://www5.cambridgeshire.gov.uk/learntogether/homepage/352/anti_bullying/

Drop in services for young people in Huntingdon and Peterborough and Cambridge as part of Centre 33 and local authority partnerships. Delivering broad support as well as counselling.

Priority area 3 – Reduce access to the means of suicide

Car park barriers

The 2014-2017 strategy identified a need to reduce access to the means of suicide in Peterborough carparks. There had been a number of suicides from Queensgate car park and incidences of suicide at Northgate car park, both close to the city centre. There is strong evidence for reducing access to the means of suicide in preventing suicide, particularly barriers at sights where suicide has been frequent.

The suicide prevention implementation group along with other parties including the coroner in Peterborough were successful in working with the owners of the Queensgate car parks to reach a decision to erect barriers on all the car parks they operate in the city centre.

Car park barrier construction began in 2015 and was completed in 2017. There have been no suicides from car parks in Peterborough since the start of the barrier construction.

It still remains a priority for the suicide prevention group to influence the owners of Northgate car park in Peterborough and the Queen Anne car park in Cambridge to erect barriers

Suicide prevention on Railways

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – Samaritans, Network Rail and British Transport Police.

-Samaritans/Network Rail campaign on the railway including printed messages on tickets and posters at stations.

Some local stations are also displaying STOP Suicide resources.

-Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).

-Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

Safer medicines management

Following Child Death Overview Panel reports there was a communication to GPs regarding safe prescribing to young people, this was also re-circulated.

Priority area 4 – Provide better information and support to those bereaved or affected by suicide

Bereavement support - access to the 'help is at hand' leaflet for people bereaved as a result of suicide:

- Help is at hand booklet shared with Coroners Office (Feb15) and electronically shared with Funeral directors. Information on 'help is at hand' circulated via the GP bulletin in 2015 and 2017.
- Help is at Hand booklets circulated to all GP practices in Cambridgeshire and Peterborough with instructions on how to re-order them.

Establishing a bereavement support service for people affected by suicide

STP Funding was granted in July 2017 to set up a reactive support service for people who have been bereaved as a result of suicide. The service will be managed by a family liaison officer who will offer support to families in the first weeks after bereavement. They will also signpost people to follow-up services and peer support groups. Part of this work will be to set-up SOBS (Survivors of bereavement due to suicide) groups in Cambridge and Peterborough and connect with CRUSE counselling services.

Bereavement support resources

Bereavement support resources are promoted via the Stop Suicide Pledge website and Keep Your Head website. These resources include specific sites for young people who are bereaved.

Priority area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior

Communication with Cambridge News on the responsible reporting of suicide, including information advice created by The Samaritans – this was initiated after a suspected suicide incident was poorly reported by the Cambridge News. CCC Coms team have been involved in this work.

Two visits were made to Radio Cambridgeshire to promote the responsible reporting of suicides. Guidelines on suicide reporting were provided to the editor.

Support research, data collection and monitoring

Surveillance: suicide audit

An annual suicide audit was undertaken in 2015 (of deaths in 2014) and 2016 (of deaths in 2015) The audits have helped to shape targeting of local work. The audit will continue to be undertaken annually, with a detailed case review of a sample of files.

Work has been carried out together with the Coroner's Office to improve the standardised regular information received on deaths throughout the year. The quality of the information received has improved.

Surveillance from British Transport Police

Data is received from BTP through an annual report and a warning system (national system).

Local, real-time surveillance system

A local real-time surveillance system has been established – This shares information from Police/Coroner to Public health on suspected suicides as they occur. This information is essential to establish a bereavement support service

The Coroner flags any notable patterns with the group or public health. The surveillance system will also help to identify any concerns in terms of geographic/temporal patterns/clusters.

Suicide rates C&P

The suicide audit for 2014 showed 65 deaths as a result of suicide or unexplained deaths in Cambridgeshire and Peterborough. A similar audit of suicides for 2015 showed there were 66 deaths.

3. NATIONAL CONTEXT

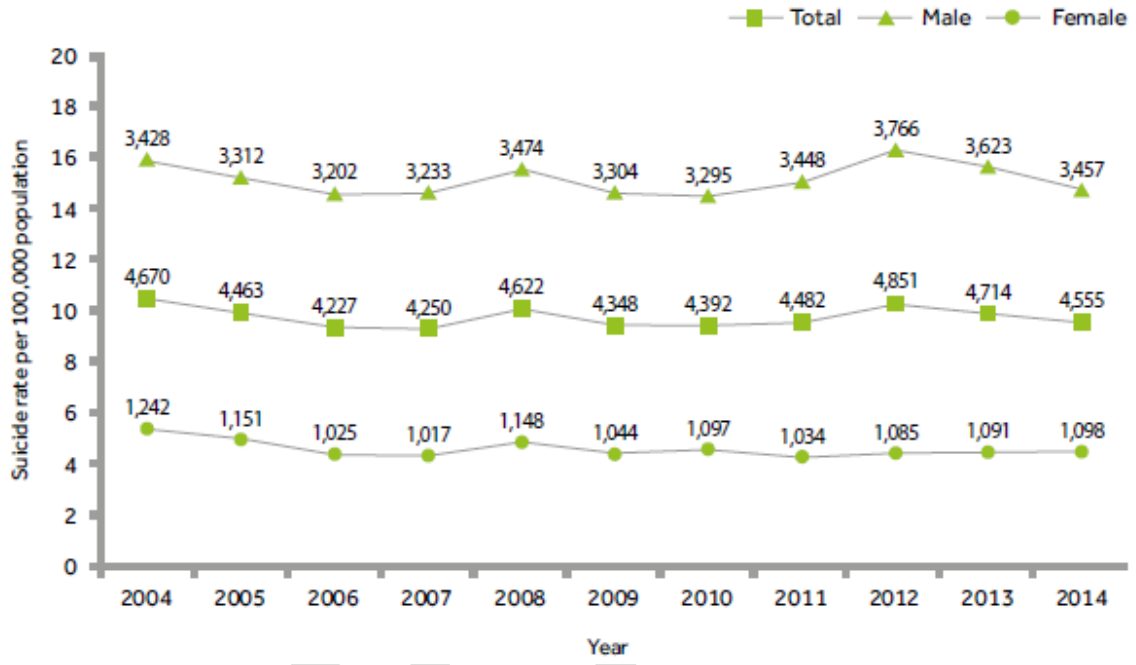
This section reviews and reflects upon nationally available data on suicides in order to place local information on suicides in context. With national reference points that include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section summarises key findings from national data on suicides and is intended to be used as a guide to draw comparisons with local data and information presented in section 5.

Suicide is defined in England and Wales as a death with an underlying cause of intentional self-Harm and/or an injury/poisoning of undetermined intent (ICD10 codes X60-X84 - all ages and Y10-Y34 – for ages over 15 years). It is assumed that most injuries or poisonings of undetermined intent are self-inflicted, but there is insufficient evidence to prove that the person intended to take their own life. This assumption however cannot be applied to children due to the possibility that these deaths were caused by other situations – neglect or abuse for example. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and may under-report deaths as a result of suicide in children.

3.1 Suicide rates and Trends

Data from the Office for National Statistics (ONS) The pattern of suicide since 2004 is a continued fall from previous years, reaching a historical low in 2006 and 2007, a rise in 2008 and 2012, with intervening years being lower, influenced by under-recording of "narrative" verdicts. Suicide rates have reduced since the peak in 2012. Suicide rates are volatile from year to year and are influenced by and reflect social and economic circumstances. Periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.

Figure 1 – Rates of suicide in the general population in England, by gender.
Number of suicides included on the figure



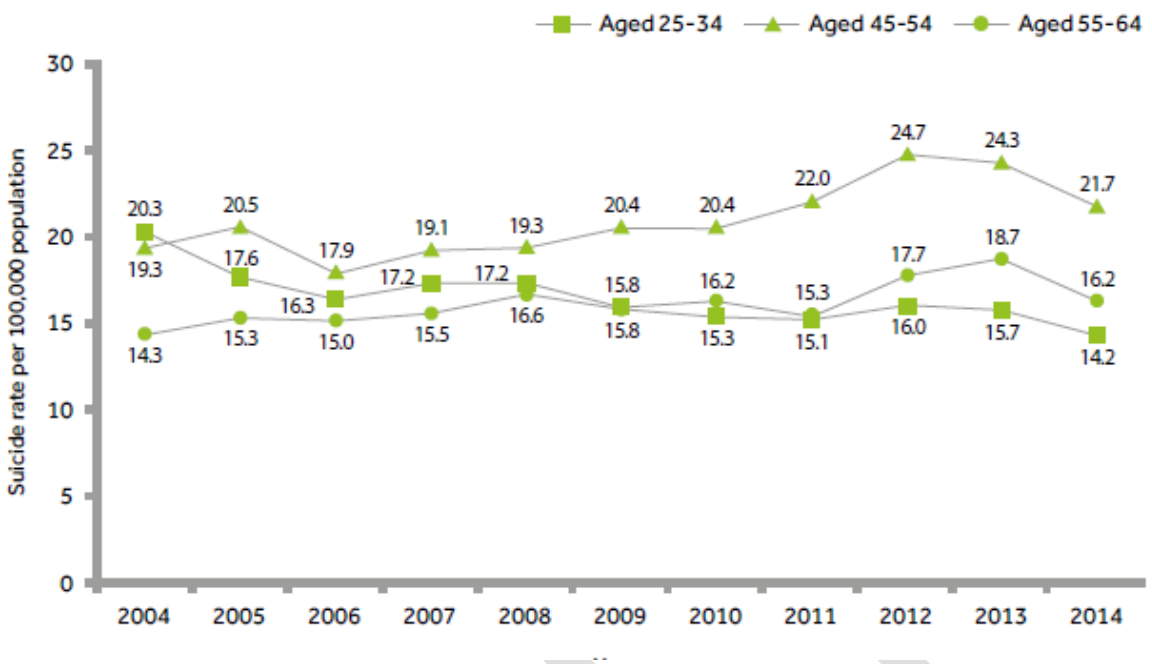
Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

3.2 Suicides by sex and age

Suicide in males is currently about three times the rate of suicide in females across all ages in England. Of the total number of suicides in 2014, 3,457 were males and 1,098 were females.

Suicide occurs at all ages, however since 2006 the suicide rate was highest in men between the ages of 45 and 54 years and has increased by 27%. In contrast, the suicide rate in younger men, aged 25-34 has fallen since 2004 by 30% (figure 2). Middle-aged men are recognised as a one of the high-risk groups and should be a focus for suicide prevention strategies. Suicide rates fell in women aged 25-34 and rose in women aged 55-64 years.

Figure 2 – Male suicide rates in the general population in England in those aged 25-34, 45-54 and 55-64



Source: National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8]

3.3 Methods of suicide

National data from the 'National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2016[8] on methods of suicide over the last decade show that the most common methods of suicide were hanging/strangulation, followed by self-poisoning (overdose) and jumping/multiple injuries - mainly jumping from a height or being struck by a train

Less frequent methods were drowning, carbon monoxide (CO) poisoning, firearms, and cutting/stabbing

Between 2001 and 2011, there were changes in method of suicide. Suicide deaths by hanging increased, whilst those by self-poisoning and jumping decreased. Of the less common methods, deaths by drowning, carbon monoxide poisoning, and firearms decreased.

3.4 Suicide Risk factors

Preventing Suicide in England, 2012[1] identifies groups of people at higher risk of suicide as follows:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- Physically disabling or painful illnesses including chronic pain
- Alcohol and drug misuse
- Stressful life events:
    - Loss of a job
    - Debt
    - Living alone, or becoming socially excluded or isolated
    - Bereavement
    - Family breakdown and conflict including divorce and family mental health problems
    - Imprisonment
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

Middle-aged men are identified as one of the high-risk groups and a priority for suicide prevention. A recent report by the Samaritans suggested that middle-aged men, especially those from poorer socio-economic backgrounds are particularly at risk of suicide due to a combination of factors. These include social and cultural changes (for example, rising female employment and greater solo living) that have particularly impacted on the lives of the cohort of men who are now in mid-life[9]

However, the greatest risk of suicide is found in people known to mental health services and particularly in people during the four week period following discharge from psychiatric hospital care[8,21]. It is important that the strategy focuses on identifying weaknesses in the system of care for people with mental health problems and works towards reducing risk in these groups – See section 9 and 9.9 for details.

4. LOCAL CONTEXT

4.1 Local suicide rates

Analysis of suicide rates at a local level for national purposes, uses pooled data on suicides over three year periods to provide a more consistent format to analyse suicide rates and trends when small numbers are given annually. Standardised rates are used in order to make comparisons with other regions.

4.2 Local suicide rates as measured by Public Health Indicator 4.10

The Public Health Outcomes Framework – 2013-2016[11] sets out the opportunities to improve and protect health across the life course and to reduce inequalities in health. The Outcomes Framework includes the Public Health Indicator 4.10 'Suicide Rate' and reflects the importance to keep the suicide rate at or below current levels.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

A baseline suicide rate (deaths by suicide and injury of undetermined intent) is set for the period 2009-2011 using pooled three year average data. It is expected that each area will report and compare the suicide rate on a yearly basis based upon pooled three year data.

4.3 Trends in local suicide rates

Data on pooled three-year rates for suicide are published on the Public Health Outcomes Framework website: http://www.phoutcomes.info/ and show current indicators as measured against England rates as well as recent trends in suicide rates. . The suicide rate in Peterborough has decreased steadily since 2010-2012 when the rate was significantly above both the England and East of England rates and is now similar to the England average. The suicide rate in Cambridgeshire has remained similar to or slightly below the England average for the last five time periods. When the data for Cambridgeshire is broken down to smaller local authority areas, all districts have recently had rates of suicide which are similar to the England average, although in the past Cambridge City and Fenland have both had periods of statistically higher suicide rates than average. No data is shown for East Cambridgeshire due to small numbers.

Figure 3 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for PETERBOROUGH compared with England

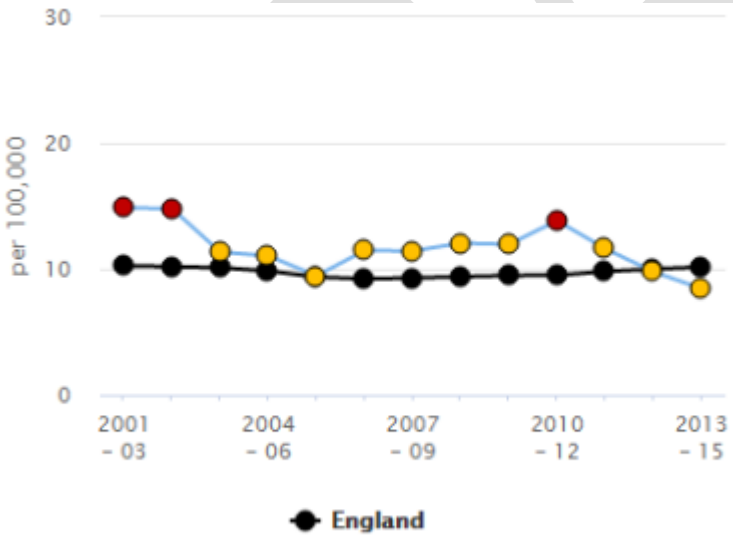


Figure 4 - Peterborough suicide rates (2013 -2015) with nearest CIPFA comparators

4.10 - Suicide rate (Persons) 2013 - 15

Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,429	10.1	10.0	10.3
Bedford	–	12	32	7.5	5.1	10.6
Luton	–	10	40	7.7	5.4	10.6
Peterborough	–	-	42	8.4	6.0	11.5
Milton Keynes	–	3	54	8.6	6.3	11.3
Swindon	–	2	53	9.3	6.9	12.2
Coventry	–	4	83	10.0	7.9	12.5
Derby	–	6	65	10.2	7.8	13.0
Bolton	–	5	78	10.7	8.4	13.4
Telford and Wrekin	–	7	50	11.0	8.1	14.5
Oldham	–	11	63	11.0	8.4	14.1
Rochdale	–	8	62	11.2	8.6	14.4
Thurrock	–	1	47	11.3	8.3	15.1
Medway	–	9	83	11.7	9.3	14.5
Bury	–	15	58	12.0	9.1	15.6
Calderdale	–	13	71	12.9	10.1	16.3
Stockton-on-Tees	–	14	68	13.6	10.5	17.3

Although not significantly lower than the England rates, Peterborough has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

Figure 5 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGESHIRE compared with England

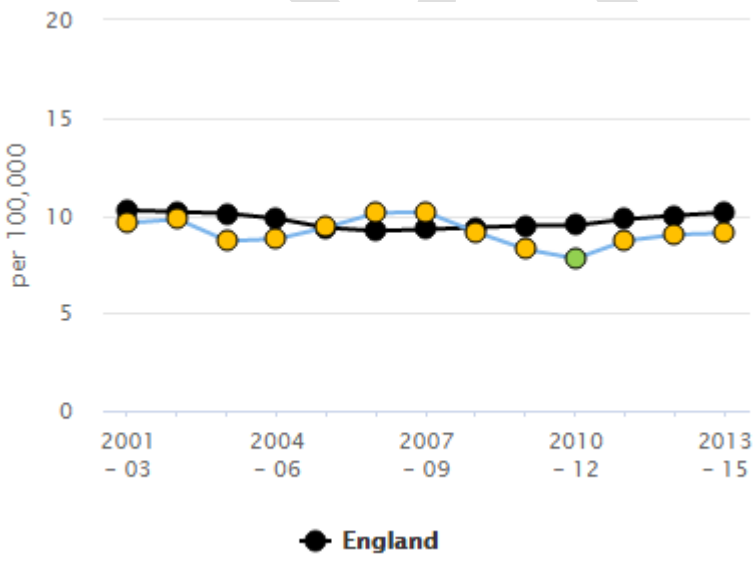


Figure 6 -Cambridgeshire suicide rates with nearest CIPFA comparators

4.10 - Suicide rate (Persons) 2013 - 15 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,429	10.1	10.0	10.3
Hertfordshire	–	14	197	6.6	5.7	7.6
Buckinghamshire	–	7	113	8.5	7.0	10.2
Hampshire	–	8	313	8.7	7.7	9.7
Cambridgeshire	–	-	155	9.1	7.7	10.6
Suffolk	–	5	181	9.3	8.0	10.8
Leicestershire	–	4	164	9.3	7.9	10.9
Oxfordshire	–	1	164	9.4	8.0	10.9
North Yorkshire	–	13	164	10.0	8.5	11.6
West Sussex	–	15	220	10.1	8.8	11.5
Worcestershire	–	6	152	10.1	8.5	11.8
Staffordshire	–	11	240	10.4	9.1	11.8
Essex	–	12	394	10.4	9.4	11.5
Gloucestershire	–	3	171	10.6	9.0	12.3
Northamptonshire	–	9	197	10.6	9.2	12.2
Somerset	–	10	165	11.6	9.9	13.5
Warwickshire	–	2	175	11.8	10.2	13.7

Source: Public Health England (based on ONS source data)

Although not significantly lower than the England rates, Cambridgeshire has lower suicide rates than most of the CIPFA comparators for the latest data collection time period (2013-2015). Comparators are chosen as nearest and most similar local authority areas in terms of demographics and socio-economic information.

Figure 7 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for CAMBRIDGE CITY compared with England

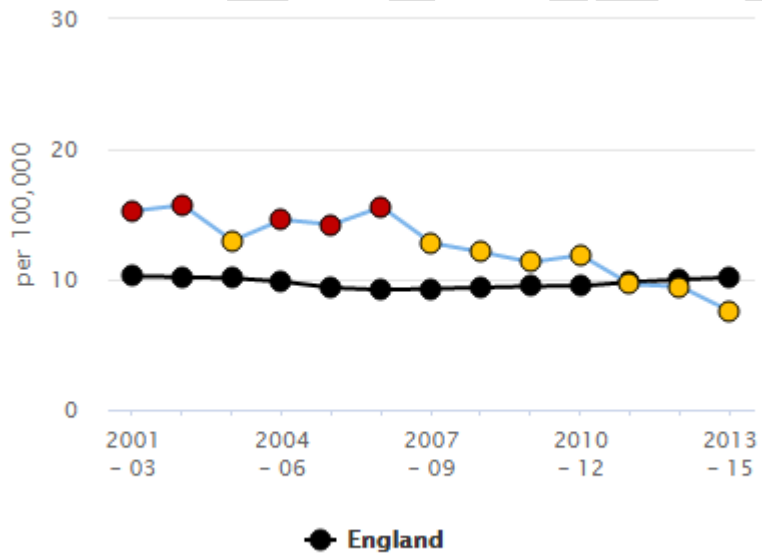


Figure 8 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for FENLAND compared with England

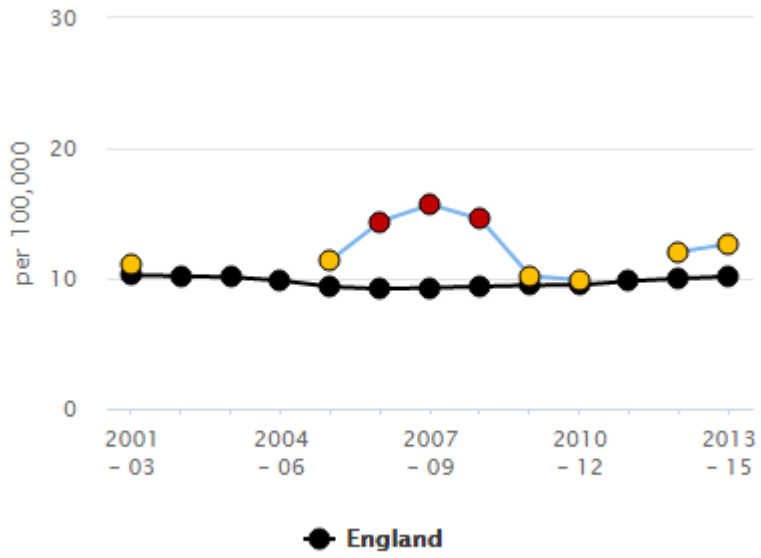


Figure 9 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for HUNTINGDONSHIRE compared with England

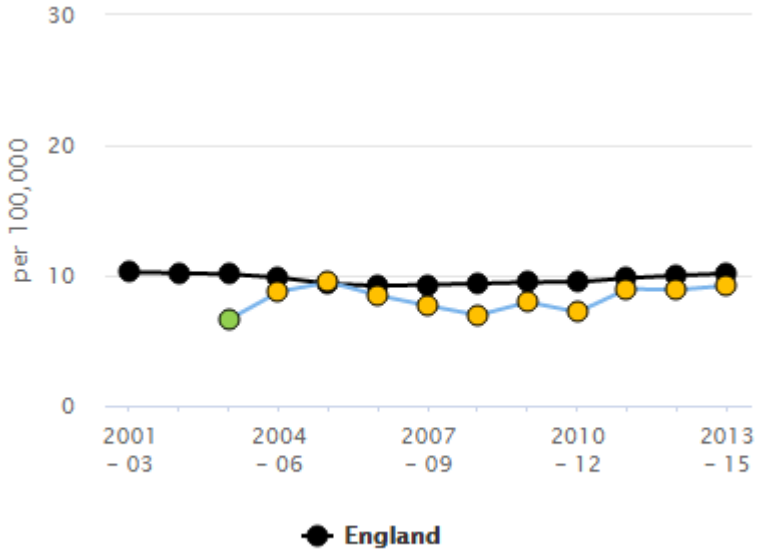
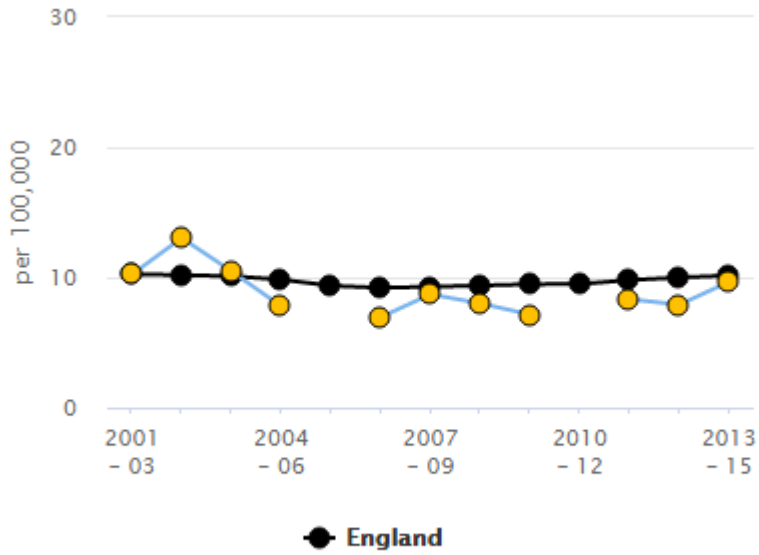


Figure 10 – PHOF Indicator 4.10 – Suicide Rate. Directly age-standardised suicide rate per 100,000 for SOUTH CAMBRIDGESHIRE compared with England



Source: Figure 10 data is taken from The Public Health Outcomes Framework information on indicator 4.10 – suicide rate. Rates are based upon pooled data for the three year periods shown.

Rates are age- standardised and show the number of deaths per 100,000 population from suicide and injury undetermined - ICD10 codes X60-X84 (all ages) and Y10-Y34 (for ages 15 and over) registered in the respective calendar years, aggregated into quinary age bands (0-4, 5-9,…, 85-89, 90+). Counts of deaths for years up to and including 2010 have been adjusted where needed to take account of the ICD-10 coding change introduced in 2011. The detailed guidance on the implementation is available at http://www.apho.org.uk/resource/item.aspx?RID=126245.

4.4 Local annual suicide audit

A recommendation in the 2014-2017 strategy was to conduct a local suicide audit annually for monitoring purposes and to inform the suicide prevention implementation group of any information about concerns, or risk factors that could help focus the prevention work. Two full local suicide audits have taken place so far – for 2014 and 2015 and an audit of suicides for 2016 is expected to be initiated in the Autumn of 2017. It is important that the annual audit continues, particularly as interventions are focused as a result of audit findings. This will allow data to be gathered to understand effectiveness of interventions and where gaps and need may present. With 'zero suicide' as an overall ambition, the suicide audit will become embedded in the learning culture as case notes are examined for lessons to be learned on a regular basis.

The local suicide audit for 2014 and 2015 showed there were 65 and 66 suicides and unexplained deaths, respectively for these years in Cambridgeshire and Peterborough.

The main findings from the 2014 and 2015 Suicide audits are summarised below. Due to the sensitive nature of the information, details cannot be published.

In Peterborough there were 19 deaths in 2014 and 18 deaths in 2015 classified as suicide or unexplained. The majority of suicides or unexplained deaths were by males (67%). 63% (2014) and 42% (2015) had current or previous contact with mental health services and 30% in 2015 had contact within six months of death with mental health services.

In 2015, there was a noticeably high number of deaths in under 30 year olds in Peterborough and Eastern European populations were overrepresented.

The 2015 audit results for Cambridgeshire & Peterborough showed:

- In males the highest number of deaths was in under 25 year olds and 50-59 year olds.
- In females the age pattern was more mixed, with highest numbers in 30-39 year olds and 70-74 year olds.
- The highest rate locally was in Peterborough, but Fenland and South Cambridgeshire also have high rates compared to the Cambridgeshire and Peterborough average. None of the areas were statistically significantly above that of Cambridgeshire and Peterborough as a whole though.
- Around 30% had been in contact with mental health services within the 6 months prior to death.
- Where a mental illness diagnosis was recorded in the audit records, almost three-quarters mentioned depression, as well as 29% with recorded anxiety.
- Two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death.
- 19 people were found to have physical health problems, including 12 with long term conditions (such as diabetes).
- Alcohol misuse was noted in 9 records and 7 mentioned drugs, such as cannabis, cocaine, amphetamine and crystal meth.
- Bereavement was noted in 10 records.

4.5 CPFT Suicide Audit report 2013/14 and 2014/15 data

In 2015, a comprehensive audit on all suicides and possible suicides reported by the CPFT 'Datix' system during the period 2013/14 and 2014/15 was completed by the Trust. This covered suicides and possible suicides of people who have been in contact with care of secondary mental health within twelve months prior to death.

The audit identified 29 deaths in 13/14 with a 3:1 ratio of men to women. 32 deaths were identified in 14/15 with a 1:1 ratio of men to women. Nationally, there is a 3:1 ration of men to women who have died due to suicide, known to mental health services and therefore the 14/15 CPFT data shows a divergence from the national trend.

For men the highest risk factors in both years were being single, unemployed, living alone and experiencing relationship problems. For women, the highest risk factors were being unemployed,

and/or experiencing relationship problems. Behavioural risk factors included a history of self-harm and previous suicide attempts.

31% (13/14 data) and 25% (14/15 data) had had contact with CPFT within seven days prior to death. In both years, the majority of suicides were *nCPA* (Care Programme Approach) patients (55% in 2013/14 and 59% in 2014/15).

In 2013/14 14% had been referred to CPFT and were awaiting assessment at the time of death, another 14% had been assessed as not requiring CPFT services, and another 14% had been assessed and refused CPFT services. In 2014/15, the proportion was smaller for those who had been referred to CPFT and were awaiting assessment at the time of death or had been assessed as not requiring CPFT services. However, in 2014/15, 41% had been discharged from CPFT at the time of death.

National data has shown an increase in suicides from CRHT services and as of 2013 there were three times as many suicides in CRHT services as in inpatient care in England. CPFT audit data also reflects this national information.

5. NATIONAL AND LOCAL PUBLICATIONS AND GUIDANCE RELEVANT TO SUICIDE PREVENTION

The local suicide prevention strategy must reflect the latest national information, evidence and guidance on improving mental health and preventing suicide for the population. In addition, the suicide prevention strategy must reflect, support and build upon other local strategies that support mental health. This section summarises the latest national and local publications that underpin the suicide prevention strategy.

5.1 No health without Mental Health

Suicide prevention starts with a better understanding of mental health and improving the mental health of populations, particularly those at high risk of mental health problems. No *health without mental health*, published in 2011[10], is the government's mental health strategy. Published alongside this is an implementation framework to set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported.

5.2 Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2]

Our local Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age provides detailed information on the commissioning intentions and objectives for the next three years. Four key priority areas are identified and within these, priority objectives are listed. Many of the objectives are relevant to suicide prevention in our local area and are listed in table 2 below – extracted from the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2].

Table 4 – Extract from 'the Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016' showing key priority areas and objectives that are relevant to suicide prevention

Key Commissioning Priority Area	Objectives relevant to suicide prevention
1. Prompt Access to Effective Help	• Introduce a **single-point of access** Advice and Resource Centre (ARC) to local mental health services for referrers, carers and service users CCG-wide. • Seek to expand the range of treatment options available – including self-help, online resources, counselling, etc. for people experiencing **mild-to-moderate** mental health problems that could be effectively helped without the need to access specialist mental health services; • Improve the help and support offered throughout the CCG to **offenders** with mental health problems • Ensure more equal access to voluntary sector services throughout the CCG.
2. The "Recovery" Model.	• Improve support for **Carers** and engagement in care planning of loved ones. • Robust **discharge planning** processes • Ensuring there is access to a specialist community-based **forensic** mental health service for former offenders throughout the CCG. • Improved partnership working between primary care, secondary services, and voluntary organisations to strengthen the local response to people who may be at risk of **suicide** • Ensure that there is appropriate **training** in mental health for key stakeholders such as GPs
3. The Inter-Relationship between Physical Health and Mental Health	• Support the introduction of **Liaison Psychiatry** Services at Hinchingbrooke and Peterborough hospitals. • Ensure people with **Dual Diagnosis** promptly receive the help they need for both their mental health and substance misuse problems
4. Improve Our Commissioning Processes	• Ensure that the services we commission are safe, effective and value-for-money

5.3 Preventing suicide in England[1]

Preventing suicide in England is the national strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy builds on the successes of the earlier strategy published in 2002. The overall objective of the strategy is to reduce the suicide rate in the general population in England and to better support for those bereaved or affected by suicide. It sets out key areas for action and brings together knowledge about groups at higher risk as well as effective interventions and resources to support local action.

The main changes from the previous national suicide prevention strategy are the greater prominence of measures to support families - those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

The Six key areas for actions to prevent suicide are listed as follows:

- Reduce risk of suicide in key high risk groups
- Improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

The strategy outlines a range of evidence based local approaches and good practice examples are included to support local implementation. National actions to support these local approaches are also detailed for each of the six areas for action.

The inclusion of suicide as an indicator within the Public Health Outcomes Framework - 4.10[11] will help to track national and local progress against the overall objective to reduce the suicide rate.

5.4 Key findings for England from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]:

This report analyses data on deaths by suicide and undetermined cause in people known to mental health services. Data is compared with that obtained for the general population. Factors leading to or contributing to suicide are analysed and recommendations for service improvements are made as a result of these findings.

The main findings on suicides by people known to mental health services are:

- During 2004-14, 18,172 deaths (28% of suicides in the UK general population) were by people under mental health care
- In the UK in 2014, around 460 patient suicides were recorded - in acute care settings – in-patient and post-discharge care and crisis teams.

[1] http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

- In-patient suicides have continued to fall with a decrease of around 60% during 2004-14. This fall is partly attributed to the removal of ligature points to prevent deaths by hanging but there has been a reduction in suicides on and off the ward by all methods. However, despite this success, there were 62 suicides by in-patients in the England in 2014.
- There are three times as many suicides by patients under the care of the Crisis Resolution Home Treatment service CHRT - in the community, as there are in in-patients.
- Of the patients who died by suicide who were under the care of CRHT services, a third were known by the service for less than one week and a third had recently been discharged from hospital. 43% of those who died by suicide lived alone. The report suggests that CRHT may not be a suitable setting for their care and raise concerns that CRHT has become the default option for acute mental health care because of pressure on other services, particularly beds.
- Suicide risk is high in the first three months post discharge with highest risk during the first two weeks. Deaths are associated with preceding short term admissions and lack of care planning. However, there has been a fall in postdischarge deaths occurring before first service contact, and this points to a recognition of the need for early follow-up.
- Of the patients who died by suicide, over 50% had a history of alcohol or drug misuse.
- Hanging, followed by self poisoning were the most common methods used for suicide in patients. However, jumping from a height or in front of a train was the third most common method . Suicide prevention initiatives by mental health services should consider how to address the physical safety of their local environment
- Economic challenges were seen to have an impact on patient suicide as 13% of patients who died by suicide had experienced serious financial difficulties in the previous 3 months.
- New migrant status is noted in 5% of patient suicides - people who had been living in the UK for less than five years. 20 deaths over a four year period were recorded in people who were seeking permission to stay in the UK

Recommendations made by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

The following table is taken from the National Confidential Inquiry report and lists recommendations for safer patient care to avoid suicide:

Table 5 – Recommendations by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

Key elements of safer care in mental health services:

1. Safer wards
   - Removal of ligature points
   - Reduced absconding
   - Skilled in-patient observation
2. Care planning and early follow-up on discharge from hospital to community
3. No 'out of area' admissions for acutely ill patients
4. 24 hour crisis resolution/home treatment teams
5. Community outreach teams to support patients who may lose contact with conventional services
6. Specialised services for alcohol and drug misuse and "dual diagnosis"
7. Multidisciplinary review of patient suicides, with input from family
8. Implementing NICE guidance on depression and self-harm
9. Personalised risk management, without routine checklists
10. Low turnover of non-medical staff

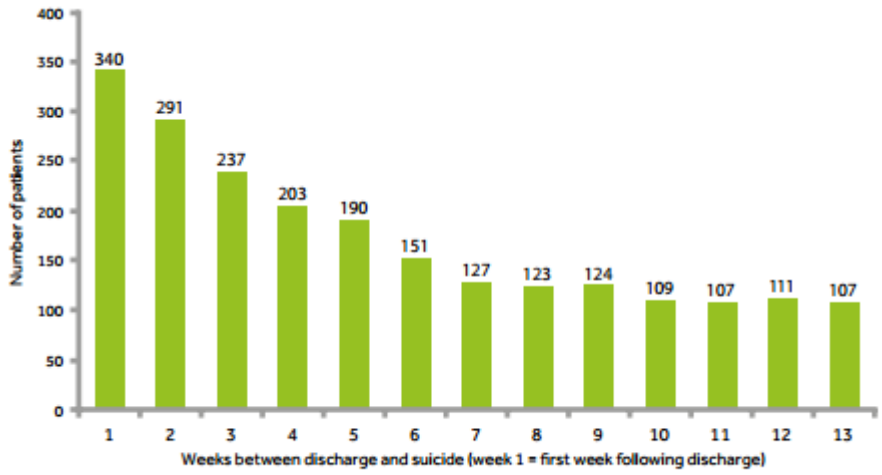
Key elements of safer care in the wider health system:

1. Psychosocial assessment of self-harm patients
2. Safer prescribing of opiates and antidepressants
3. Diagnosis and treatment of mental health problems especially depression in primary care
4. Additional measures for men with mental ill-health, including services online and in non-clinical settings

Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

The findings above are used to strengthen recommendations for local interventions as part of the action plan that accompanies this strategy.

Figure 11 - Number of patient suicides by week following discharge, England?, 2004-2014



Source: the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2016[8]

5.5 Cambridgeshire and Peterborough Emotional well-being and mental health draft strategy for children and young people 2014-2016[6]

The suicide prevention strategy takes account of recommendations made in the Cambridgeshire and Peterborough CCG 'Emotional well-being and mental health strategy for children and young people 2014-2016'. This document recognises that the mental health and wellbeing of children and young people is everybody's business and by partnership working, more efficient use of resources to provide the right intervention at the right time to the right people will result.

The specific areas for action listed in this draft strategy are:

1. The commissioning of mental health services will be outcome-focussed, maximising the capacity of statutory and voluntary sector organisations
2. Mental health support will be everyone's business, all partners will understand the role they can play and support will be co-ordinated, integrated, evidence based and cost effective.
3. There will be clear pathways of care across agencies, with the right level of expertise and a shared professional knowledge
4. Services will be available for all levels of need, maximising the opportunities for early intervention and prevention, whilst also providing for those with severe and enduring mental health problems
5. Ensure that children and young people's mental health needs are identified early and support is easy to access and prevents problems getting worse
6. Standardised principles of practice will be adopted across all organisations

5.6 Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis – February 2014[12]

The Mental Health Crisis Care Concordat is a national agreement between 22 national bodies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. The concordat sets out how partners will work together to ensure that people receive the help they need when they are in mental health crisis.

The Concordat focuses on four main areas:

- **Access to support before crisis point** – making sure people with mental health problems can access help 24 hours a day and are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – people are treated with dignity and respect, in a therapeutic environment.
- **Recovery and staying well** – preventing future crises by ensuring that people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by

partners to work together in preventing and managing crises. To this end, members of the suicide prevention strategic group will support the development of the mental health crisis care concordat declaration and action plan to ensure a joined-up approach to effective crisis management and prevention.

5.7 Annual Report of the Chief Medical Officer 2013 – Public Mental Health Priorities: Investing in the Evidence

The report from the Chief Medical officer focuses on epidemiology and the quality of the evidence base for public mental health and includes a chapter on suicide prevention[13]. The report highlights the recent increase in both the suicide and self-harm rates (since 2006/7), and suggests that the economic recession is the most likely cause for the increase. The risk of suicide in the year following self-harm is much greater than that of the general population. In addition, risk of suicide is high in people who are admitted for psychiatric treatment and remains high in the immediate post-discharge period. However, around three quarters of suicides occur in people not known to psychiatric services.

Suicide prevention should be based on evidence of what is effective. To improve safety of mental health services, access to 24 hour crisis services, policies for patients with dual diagnoses (drug/alcohol problems in combination with mental illness) and multidisciplinary reviews after suicide are effective strategies. Suicide prevention in the general population should focus on restricting of access to means of suicide, population approaches to reduce depression and improvements in detecting and managing psychiatric disorders with increased voluntary sector and internet based support. It is also recommended that work is carried out with media and internet providers to ensure responsible reporting of suicide. Self-harm should be followed up with a psychosocial assessment and access to psychological therapy upon discharge and screening for dual diagnoses. Importantly, it is recommended that surveillance should be in place to ensure that information about changes and trends in suicides are identified to enable public health action.

This strategy learns from the recommendations made in the CMO report, and this is reflected in the details contained within the accompanying action plan.

6. LOCAL ACTIVITY TO PREVENT SUICIDE - MAPPING SUICIDE PREVENTION SERVICES PROVIDED IN CAMBRIDGESHIRE AND PETERBOROUGH

It is important to understand the current services and pathways with regard to suicide prevention in order to form a map of available interventions with which to identify any gaps and weaknesses in the system. A summary of the available services is provided in the following sections:

6.1 Services for people with mental health problems

NHS Cambridgeshire and Peterborough CCG currently commissions services for local adults with mental health problems on a pathway basis from the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). In addition, NHS Cambridgeshire and Peterborough CCG along with Cambridgeshire County Council and Peterborough City Council commission mental health services

from a range of local independent and voluntary sector organisations. Some mental health services are commissioned as part of the mental health Crisis care work that includes police.

- CPFT Locality Teams; IAPT, Psychosis, Affective Disorders, Assertive Outreach
- Acute Care Pathway (including crisis resolution and home treatment (CRHT) and Psychiatric Intensive Care Pathway). The acute pathway may include contact with liaison psychiatry services
- PRISM
- 111 (2) mental health crisis telephone line with First Response Service (FRS)support into the community.
- Community Sanctuaries (in Cambridge, Peterborough and Huntingdon) for people to be referred to by the FRS if in mental health crisis
- CAMEO (NHS service that provides specialised assessment, care and support to young people experiencing a first episode of psychosis)
-

Third sector organisations involved in supporting people known to have mental health problems and suicidal risk include:

- MIND in Cambridgeshire
- Group Therapy Centre
- Cambridge Counselling Services
- Choices
- Oakdale
- Relate Counselling
- LIFECRAFT
- The Richmond Fellowship
- Rethink Carers

6.2 Services for people at risk of suicide not known by mental health services

- **Independent and Voluntary Sector Services** Voluntary sector organisations play a significant role in local mental health service provision, often for people who may struggle to access the "mainstream" services
    - Samaritans
    - Lifecraft
    - Lifeline
    - MIND
    - Richmond Fellowship
    - Bereavement services – CRUSE bereavement

6.3 Gap analysis in suicide prevention service provision – information from the 2014-2017 strategy

Service user feedback is crucial in determining where the gaps in service provision lie for suicide prevention across Cambridgeshire and Peterborough

NHS Cambridgeshire and Peterborough CCG Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016[2] consulted with service users, carers, HealthWatch, GPs and the Patient Experience Team to identify gaps in service provision relevant to suicide prevention as follows:

- Raising awareness and mental health promotion to ensure better access to services, and linking between physical and mental health services. Make the best use of existing campaigns to raise awareness
- Improved information and services for carers
- Improved crisis support
- Prompt access to appropriate services
- Prompt and appropriate response by services – particularly in crisis
- acknowledge the role of carers in supporting people with severe and enduring mental illness
- Commissioners and providers review practice to ensure recipients of mental health support services always have details of who they can contact when in distress 24 hours a day.
- greater emphasis throughout services upon prevention, early intervention, support and self-management
- prompt access for GPs to obtain advice and effective help for patients presenting at surgeries in distress or "crisis"
- partnership working across local service providers (including the voluntary sector) in order that patients receive an integrated and seamless service across all interfaces

These issues were used to inform the suicide prevention implementation plan 2014-2017. Some of the needs are being addressed through workplans initiated in the last few years and details can be found in the implementation plan and summary of suicide prevention work to date. However, many of the needs are still relevant and additional needs are identified through consultation work through the suicide prevention implementation group

- Access to sanctuaries during mental health crisis in all areas of Cambridgeshire, including an unmet need in Fenland
- Better working relationships between and across the statutory services and third sector agencies to ensure sharing of information and timely and appropriate response to those requiring mental health support and crisis resolution
- Faster access to therapy, particularly for those with depression.
- Support for drug and alcohol users with mental health problems who do not meet the threshold for treatment under the dual diagnosis pathway
- Walk in centres – there is a lack of walk in voluntary centres that offer support and help to people at risk of suicide. Cambridge has Lifecraft and Centre 33 (for people aged below 25 years). No similar walk in centres exist in Fenland, Peterborough or Huntingdon.
- Bereavement support services for people bereaved as a result of suicide
- Mental health promotion targeted to men at higher risk of suicide

7. A STRATEGIC LOCAL PARTNERSHIP APPROACH TO SUICIDE PREVENTION IN PETERBOROUGH AND CAMBRIDGESHIRE

In line with National guidelines on preventing suicide, and in recognition that an effective local public health approach is fundamental to suicide prevention**,** a multi-agency local suicide prevention group was established to provide input and recommendations to develop and refresh this strategy. The group is formed from partner organisations and stakeholders and includes representatives from the NHS – GPs and clinical commissioners, public health, mental health trusts, police, coroners and charitable organisations –such as The Samaritans, Lifecraft and MIND (see section 2 for details). An important aspect to developing a local strategy for suicide prevention will be engagement with 'service users' – those who have been affected by suicide or at risk of suicide. With service user input and feedback, the strategy should reflect what is needed and what would work to minimise suicide risk in the population.

Note: service user and stakeholder consultations on this strategy and action plan are scheduled for the Autumn of 2017

8. THE ZERO SUICIDE AMBITION

There has been national and local interest to embrace what is termed as a 'zero suicide initiative'. Zero suicide was conceived through the 'Detroit model' for suicide prevention[15], which has been successful in America - creating a cultural shift in how patients with mental health problems are cared for with the emphasis on an ambition to achieve a zero rate of suicides as a core responsibility of the 'caring' organisations. The core principles and values of the 'Detroit model' are based on six dimensions and ten rules for perfect care:

Table 6 – Six dimensions and ten rules of perfect care according to the 'Detroit Model'

Six Dimensions of Perfect Care	**Ten rules of perfect care**
1. Safe 2. Effective 3. Patient Centred 4. Timely 5. Efficient 6. Equitable	1. Care is relationships 2. Care is customised 3. Care is Patient centred 4. Share knowledge 5. Manage by Fact 6. Make safety a system priority 7. Embrace transparency 8. Anticipate patient needs 9. Continually reduce waste 10. Professionals Cooperate

More information about zero suicide nationally and internationally

Mersey care

Zero suicide foundation

The suicide prevention group has also agreed to endorse the Detroit principle to aim to work towards zero suicides in our local area. This will form the overarching principle for all suicide prevention as outlined in this strategy. Zero suicide requires high level commitment by all partner organisations and support by individuals to drive through the cultural change required to make this a success.

A Workshop in July 2017 consulted key stakeholders on the zero suicide ambition and what this means locally to support the suicide prevention implementation plan. The themes that emerged are presented in the box below.

As Cambridgeshire and Peterborough have already established the 'STOP suicide campaign' , which is now recognised widely across the county and has the support of all major organisations involved in mental health care, the ambition towards 'zero suicide' will not be viewed as a new initiative but embedded as the core principle for the local strategy and STOP suicide campaign.

Table 7 – Local goals for the zero suicide ambition

Zero Suicide Ambition – Main goals for implementation locally
Top level (Chief executive) engagement and commitment towards zero suicide for the main organisations involved – CCG, CPFT, PCC, CCC, Police
Improve quality at the organisational level- Engagement with organisational workforce to create a learning culture not a blaming culture. Part of this process will involve reviewing both suicide information and information from people with lived experience to learn lessons and implement good practice.
Improve quality at the individual level – win over 'hearts and minds' for zero suicide so it is at the forefront of peoples' minds during day to day organisational business and becomes part of life.
Review and improve information sharing across agencies involved in the pathway of care of individuals with mental health problems
Strengthen the local STOP suicide campaign and suicide prevention implementation plan with a stronger emphasis on campaigns and initiatives that raise awareness, educate and promote mental health across the population, but with a focus on young people

9. SUICIDE PREVENTION PLAN

The zero suicide ambition will provide the main thread for suicide prevention and its work will be embedded in all areas within the plan. The suicide prevention plan is divided into six priority areas based upon the national guidance 'Preventing suicide in England, 2012[1]:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behavior

6. Support research, data collection and monitoring.

In tackling each priority area, evidence and information is taken from national guidance and publications on what is effective in preventing suicide, but an emphasis is placed on local needs and information gathered from the suicide audit and stakeholders that identify groups at higher risk of suicide and gaps in service provision. In all areas there will be encouragement of multi-partnership working across all sectors from NHS and mental health professionals to voluntary organisations that will utilise expertise from these organisations to implement the proposed initiatives. Continuing engagement between the dedicated members of the Cambridgeshire and Peterborough suicide prevention group and service users and their carers is essential for the successful design, development, implementation and delivery of initiatives in each priority area.

Each priority area is discussed in detail and recommendations for action are made in the following sections of this strategy document.

10. PRIORITY 1 - REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

Data presented in 'Preventing suicide in England[1]' identified particular groups at higher risk of suicide – see section 3.4. It is important to compare and contrast the high risk groups identified nationally with local data on suicides as well as local information based upon health and wellbeing needs assessment in order to focus suicide prevention resources appropriately to those in greatest local need.

10.1 Identifying People at higher risk of suicide

The suicide prevention strategic group includes Peterborough and Cambridgeshire coroners who are providing comprehensive local suicide data to the group on a regular basis. Analysis of the local data on suicides has enabled the identification of local suicide risk factors and emerging issues. In particular, men from Eastern European migrant populations – Polish and Lithuanian nationals residing in Peterborough and Fenland regions are emerging as a high risk group for suicide. In addition, unemployment, bereavement, drug or alcohol use are factors that have been recognised through the local suicide audits as potential risk factors. Groups of people, such as middle aged men (particularly those working in building and construction or IT), people in custody, gypsies and travellers and homeless are also identified as at increased risk of mental health issues and suicide.

Cambridge has a higher proportion of students in the population compared with similar sized cities as it is home to both the university of Cambridge and Anglia Ruskin University. Although the risk of suicide in the Cambridge student population has not been established, ONS data has shown a substantial increases in both male and female suicides in the student population from 2007-2011[7]

Based upon the evidence above of people at high risk of suicide both nationally and locally, the following groups of people will form the basis for targeted interventions (table 3):

Table 8 - Groups at high risk of suicide – Cambridgeshire and Peterborough

• New migrants – Polish and Lithuanian people • People in contact with mental health services – including people recently discharged from psychiatric hospital care

- Unemployed people and those in financial difficulties
- Students
- Middle-aged men
- Gypsies and travellers
- Young offenders
- People in custody
- People who self-harm and have had a history of self-harm
- Alcohol/drug users
- Bereaved people and those bereaved by suicide
- Veterans
- Gay, lesbian, transsexual people
- Children with mental health problems at risk of self-harm

The strategy recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the group will be vulnerable to suicide. Other risk factors, such as loneliness, social circumstances and physical illness, must also be considered within the wider context or risk *Preventing suicide in England, Department of Health, 2012*[1]

10.2 Creating tools and resources to aid suicide prevention in high risk groups

The evidence base for suicide prevention highlights particular interventions that have been shown as effective in reducing risk or raising awareness of suicide. The best suicide prevention strategies use a combination of tools and interventions.

Based on the evidence of what is effective in preventing suicide, the following tips have been developed to aid the development of the suicide prevention strategy:

- Emphasise self-help and provide solutions for self-help
- Emphasise that suicide is preventable - there are preventative actions individuals can take if they are having thoughts of suicide or know others who are at risk of suicide.
- The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support.
- Don't glorify or romanticize suicide or people who have died by suicide. Vulnerable people, especially young people, may identify with the attention and sympathy garnered by someone who has died by suicide.
- Teach people how to tell if they or someone they know may be thinking of harming themselves and how to protect them from this harm.

10.3 Recommendations to prevent suicide in high risk groups

This strategy reflects what is known from the evidence base on suicide prevention and uses knowledge of local gaps in service provision to make the following recommendations for actions in preventing suicide in high risk groups:

1. Suicide prevention training – for professionals and other front-line workers in contact with vulnerable groups at risk of suicide
2. Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help
3. Promote awareness raising campaigns to prevent suicide
4. Ensure integrated, appropriate and responsive services to those at risk of suicide
5. Reassess pathways for people known by mental health services at risk of suicide – ensure follow-up provision of care upon discharge from services.
6. Improve pathways and support for offenders and people taken into custody at risk of suicide.

Each of these recommendations for action is discussed in detail below, highlighting how they will reach out to the target groups at high risk of suicide across Cambridgeshire and Peterborough

10.4 Recommendation 1.1 - Suicide Prevention Training

The recommendation is to enable mental health and suicide prevention training throughout Cambridgeshire and Peterborough for professional groups and third sector organisations in regular contact with adults who are at risk of suicide. The training will equip people in recognising the signs and symptoms of mental health problems and suicidal behaviour in people they encounter through the work they do. Moreover, it will give them the skills and confidence to respond appropriately to affected individuals – to support and refer them appropriately.

From 2017 -2020 suicide prevention training will continue after initial funding in 2014 from the Strategic Clinical Network. This helped to set-up the local STOP suicide initiative, that included training. From 2015, funding for suicide prevention training was provided by Cambridgeshire County Council (CCC) with support funding from Peterborough City Council (PCC) to continue the work of the STOP Suicide initiative. MIND in Peterborough and Cambridgeshire with support from Lifecraft in Cambridge deliver the suicide prevention training on behalf of the partnership.

Training in suicide prevention aims to reach beyond “traditional” models of suicide prevention by engaging with a much wider range of agencies, including voluntary organisations and faith groups who are likely to come into contact with the two thirds of suicides who are not in contact with mainstream mental health services.

Suicide prevention training is provided from a recognised and evidence-based source such as ‘Applied Suicide Intervention Skills Training’ **(**ASIST)[16]. ASIST is a two-day suicide prevention course that aims to help both professionals and lay people to become more willing, ready and able to recognise and help persons at risk of suicide. ASIST is intended as ‘suicide first-aid’ training, and is focused on teaching participants to recognise risk and learn how to intervene effectively to reduce the immediate risk of suicide. A study by the London School of Economics estimated the cost-effectiveness of implementing ASIST training to GPs and concluded that the cost per QALY (Quality Adjusted Life Year) saved was £1,573 – extremely cost effective in terms of medical interventions

A bespoke, half day ‘STOP suicide’ suicide prevention training course has been developed by MIND and Lifecraft and is offered as an alternative to the two day ASIST training.

In addition, Cambridgeshire County Council continues to support Mental Health First Aid (MHFA)[17] training, in order to promote general mental health awareness in professional groups and organisations likely to be in contact with people with a broad range of mental health needs is recommended.

CPFT also offer suicide prevention training as do Samaritans – details to be added

Suicide prevention training will be targeted to individuals and organisations who are most likely to encounter people at risk of suicide, with priorities given to people working with those with recognised risk locally, for example, Eastern European migrants or men working in the building/construction industry.

In order to create a culture that encourages an understanding and appreciation of the roles and responsibilities of other agencies, suicide prevention training, where possible will be offered to mixed groups of professionals. This would promote partnership working between agencies and deliver consistent messages on suicide prevention across the professional groups. Mixed groups will also facilitate a better understanding of each other's roles and responsibilities when dealing with people in crisis.

GP Training in suicide prevention

Funding has been secured through the STP with some support from CCC and PCC for training of GPs across Cambridgeshire and Peterborough in suicide prevention. GPs are most likely to have contact with people at risk of suicide in many of the 'high risk' categories listed in Table 3.The 2015 audit of suicides and deaths from undetermined intent for Cambridgeshire and Peterborough found that two thirds of people had been in touch with primary care in 2015 or within a maximum of 6 months prior to death. Suicide prevention training for GPs can potentially enable greater identification of those at risk, and earlier referral to evidence based treatment services (Suicide in primary care in England 2002-2011[18]. Training will focus on the patient/GP interaction, risk identification, compassion and empathy as well as safety plans and follow-through care. Training will be implemented from the Autumn 2017.

10.5 Recommendation 1.2 - Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help

Different professional groups and organisations with direct contact with people at risk of suicide will have differing responsibilities towards these people. Often there is a lack of clarity or understanding about what is appropriate in terms of responding to a person who may be suicidal or in signposting that person to sources of self-help. In order to bridge this gap, it is recommended that resources be developed for professional groups and organisations that will act as protocols and provide signposting information in any circumstances where professionals are in contact with people at risk of suicide. Resources will help to empower organisations with information to help vulnerable people in mental health crisis. Examples of suicide prevention protocols for GPs and for people working for MIND are provided in Appendix 1

A variety of resources and information was developed and collated as a result of the 2014-2017 suicide prevention implementation plan. These included the development and promotion of the STOP suicide initiative, including the STOP suicide website: http://www.stopsuicidepledge.org/. The

development of the local 'Keep Your Head' website with resources and information aimed at young people, their carers and professionals: http://www.keep-your-head.com/CP-MHS. Wide promotion of the Crisis (111/2) service has been undertaken by the partnership. The suicide bereavement support leaflet has been distributed via GPs, police, coroners and will be promoted on a regular basis.

There has been support and agreement by partners involved in suicide prevention work to create an adult version of the 'keep your head' website, which will contain information, resources and self-help guides for people experiencing mental health problems or suicidal thoughts. This work will be initiated in the Autumn of 2017, with funding in place to support (through the Better Care Fund).

A directory of services has been produced by Lifecraft in Cambridge and a professional and service user App (MiDos and MyHealth), are being created to contain information about mental health support and services with funding through the Mental Health Delivery Board. These will be promoted through the various websites mentioned above.

An opportunity exists to work with professionals to develop care plans for people known by mental health organisations to ensure up-to-date self-help resources and contact information is included to help prevent escalation of mental health problems into crisis. This can be facilitated through the proposed GP training.

10.6 Recommendation 1.3 – Awareness-raising campaigns and the Cambridgeshire and Peterborough Pledge to reduce suicide

The 2014-2017 suicide prevention strategy recommended the development of a range of awareness raising initiatives and campaigns in collaboration with service users through focus group feedback. Service users representing particular high-risk or hard to reach groups should be sought to ensure resources and advocacy services are developed appropriately. Resources will need to be translated into other languages, including Polish and Lithuanian and be culturally appropriate if they are to reach out to all vulnerable groups.

In addition the development of the 'Cambridgeshire and Peterborough STOP suicide Pledge' to reduce suicide was recommended. The pledge is intended to raise awareness in individuals and organisations about responding to the risk of suicide by encouraging self-help and helping others. Development and roll-out of the 'Peterborough and Cambridgeshire Pledge' to reduce suicide was initially supported by funding from the SCN Pathfinder programme and is now receives continuing support and funding from CCC and PCC.

As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. In addition, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Approximately 3000 one to one conversations with individuals around the subjects of mental health and suicide since September 2015. The campaign has recruited a total of 10 new Campaign Makers - four in Peterborough, five in Cambridge and one in St Neots.

The Samaritans run a national campaign 'We're in your corner' that raises awareness of the issue of men and suicide and encourages these men to seek help – see https://www.samaritans.org/media-centre/our-campaigns/were-your-corner. It would be beneficial for local campaigns targeted at reducing suicide in men (such as STOP suicide) work with the Samaritans to share idea and resources in order to maximise benefits.

Continuing support for campaign work and promotion of the STOP suicide pledge is recommended.

It is recommended that awareness-raising will be supported by promotion of 'World Suicide Prevention Day' each year on September 10th and world 'mental health awareness day on October 10th in addition to local initiatives throughout the year.

10.7 Recommendation 1.4 – Aspire to develop integrated, appropriate and responsive services to those at risk of suicide

This work is the backbone to suicide prevention with an aspiration to create a seamless pathway of care that has no cracks for people to fall between. Service improvement and driving up quality of care is the key theme behind the zero suicide ambition. A first step to achieving this is to create a culture of learning across the system. Learning from case reviews of suicides is recommended as a pilot but also learning from people with 'lived experience' to determine what works as well as what has gone wrong.

The last year has seen the implementation of initiatives to improve the pathway of care for people in mental health crisis (through the work of the Crisis Care Concordat partnership). The suicide prevention strategy endorses and continues to support this work:

- Continue support for Integrated Mental Health teams – Mental health nurses in police control rooms
- Continue support for Crisis 111(2), First Response Service and the continuing roll-out of sanctuaries or places of safety in the community for people in mental health crisis to use.
- Ensure suicide prevention initiatives link to Crisis Concordat work and include pathways of care for people pre crisis, during crisis and post crisis
- Develop and expand data sharing agreements and protocols (see recommendation 1.6 below)

A recent audit of drug and alcohol related deaths highlighted the high rate of mental health problems in people who have died as a result of drug and/or alcohol abuse. Likewise, the suicide audit highlighted drug and/or alcohol problems in a proportion of deaths. It is clear that there are gaps in services that do not cater sufficiently for people who do not meet the thresholds for a 'dual diagnosis' of concurrent drug/alcohol abuse and severe mental illness. These may be people who are substance or alcohol users with common mental health disorders such as depression. They may be treated for their substance use but their mental health needs are overlooked. A recommendation in this strategy is to encourage and facilitate systems that allow engagement with other services where appropriate – particularly with drug and alcohol teams.

Other recommendations in this section include:

- The development of guidance for GPs and primary care – resources, sign posting and self-referral as well as safety plans and links with PRISM
- Develop bereavement support services for those affected by suicide – see Recommendation 4.1
- Improve data sharing between agencies– The Vanguard and Concordat work has required data sharing protocols. Data flow following a bereavement is being reviewed.
- Continue work to map and update pathways and ensure all partners are aware of contacts and resources for self-help as well as pathways and how they operate
- Encourage professionals and organisations to work together in identifying gaps and opportunities in pathways to prevent suicide – particularly at points where services meet when a person is transferred from one service to another

10.8 Recommendation 1. 6 - Reassess pathways for people known by mental health services at risk of suicide

Approximately 30% of people who die as a result of suicide are known to the mental health services. People recently discharged from psychiatric care are the group with the highest risk of suicide, particularly within the first two weeks post discharge[8]. A retrospective case control study showed that 55% of suicides by people known by psychiatric services, died within a week of discharge from a psychiatric unit[21]. The study concluded that factors associated with increased suicide risk during this period included hospitalization of less than 1 week, recent adverse events, older age, and comorbid psychiatric disorders. Factors associated with decreased risk included patients receiving enhanced aftercare. Based on these findings, work should be conducted in partnership with CPFT to identify gaps or weaknesses and areas for improving the care of people upon discharge from psychiatric care.

To assess and improve pathways of care for people known to mental health services, it will be important to work in partnership with CPFT and the Mental Health Crisis Care Concordat Working group. To this end, the following are recommended:

- Ensure Crisis Concordat work aligns with this priority area. Pathways of care to be assessed include those pre crisis, during crisis and post crisis.
- Assess pathways to ensure that information is shared across agencies in the patient's best interest
- Assessment of pathways for people who are discharged from psychiatric care. This would include ensuring that careful and effective careplans and follow-up arrangements are in place. Link with PRISM as a 'step down' or 'step up' process in community settings
- Explore models for strong community and joined-up support at locality level for people pre and post crisis as part of the 'Neighbourhood model'.

- Consider a Suicide prevention audit of Accident and Emergency Departments – a toolkit for an audit of this type has been developed by the NHS Mental Health Network – NHS Confederation – see: http://www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-emergency-departments.pdf

- Engage with Rethink Carers group – for carers of people with mental health illnesses – understand concerns about pathways of care and provide information to carers in order to support them in their care role for someone at risk of suicide
- Engage with service users to establish the strengths and weaknesses in pathways of care in response to crisis – including a review of the use of Police section 136 and the use of places of safety
- Encourage development of pathways that are comprehensive and organised around the patient – particularly where organisations meet during transition points – acute sector transition into the community, for example
- Enable ongoing support for people with mental health issues and for those people in the community who do not meet the threshold for secondary mental health services – through links with PRISM

10.9 Recommendation 1.7 - Improve pathways and support for people taken into custody and newly released from custody at risk of suicide.

Prisoners and people taken into custody have been identified as a group with specific requirements due to the nature of the crisis that has increased their risk of suicide. To this end, the following is proposed:

- Liaise with NHS England and Public Health England to work with probation, prison and police staff to understand the screening risk assessment procedure at court and upon reception of prisoners and people taken into custody to include risk of suicide/self-harm.
- In partnership with NHS England, liaise with prison managers to promote the use of prison listeners to prevent suicide.
- Assess pathways of care for people in police custody and working with NHS England, assess pathways of care for people in prisons at risk of suicide. Review self-help advice and information, screening and risk assessment upon reception into custody
- Promote access to the Samaritans in custody suites.
- Continue to support suicide prevention training of prison staff and prison listeners (section 9.4).
- Promote access to support from drug and alcohol services for people in custody with mental health and drug/alcohol problems.
- Assess discharge pathways for people who have been in custody, including a review of care plans for people with mental health problems. Recognise the need to promote joined-up services with an understanding of the roles and responsibilities of other organisations including the probation service.

11 PRIORITY 2 - TAILOR APPROACHES TO IMPROVE MENTAL HEALTH IN SPECIFIC GROUPS

The Preventing Suicide in England strategy identified specific groups of people for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
- survivors of abuse or violence, including sexual abuse

- veterans
- people living with long-term physical health conditions
- people with untreated depression;
- people with autism or Asperger's spectrum disorders
- people who are especially vulnerable due to social and economic circumstances
- people who misuse drugs or alcohol
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

The Cambridgeshire and Peterborough CCG Commissioning Strategy for Mental Health and Well-being of Adults of Working Age 2013-2016[2] sets out an implementation plan with four themes as follows:

Theme 1 – Easier and prompt access to effective help

This includes a section on addressing the barriers to access to 'main stream' services for marginalised groups

Theme 2 – The Recovery Model

Theme 3 – The inter-relationship between physical health and mental health

Theme 4 – Improve our commissioning processes

The National publication 'No health without mental health' 2011 set out six mental health objectives:

- More people will have good mental health – this included a statement to continue to work to reduce the national suicide rate
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm – includes fewer people self-harming and safeguarding children and young people and vulnerable adults
- Fewer people will experience stigma and discrimination

11.1 Recommendations to improve mental health in specific groups

Recommendation 2.1 Assess pathways of care for children and adults who self-harm

Emergency admissions for self-harm in young people remains a concern in Cambridgeshire and Peterborough with data showing rates of admission above those for England and the East of England. It will be important to work in partnership highlight strengths, gaps and weaknesses within the pathways of care for children and adults who self-harm and identify areas for improvement, particularly with respect to follow-up care for people discharged from services.

- Monitor admissions to the Accident and Emergency departments for self-harm to assess any impact on service developments. Repeat admissions of people who self-harm would be

particularly useful to monitor as the strategy should focus on the best interventions to prevent repeat episodes of self-harm

- assess pathways for support for children who are at risk of self-harm , particularly in vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems
- Promote the 'Keep Your Head' website for children and young people to professionals including liaison psychiatry to highlight resources and directory of services for self-help and signposting
- Develop an adult version of the 'Keep Your Head'website to contain information about resources, services and self-help guidance for people with mental health problems
- Ensure follow-up care plans are robust for people discharged from services
- Assess plans for people who self-harm if mental health services are not involved. Link this work to the PRISM service (Enhanced primary care service for people with mental health issues).

11.2 Recommendation 2.2 Work with partners who are developing the 'Emotional wellbeing and mental health strategy for children and young people' to promote the following:

- Continue to raise awareness and campaigning around self-harm
- Continue to provide access to self-help resources that focus on building resilience in young people, including the 'Keep Your Head' website
- Continue work that raises awareness and develops resources aimed at preventing bullying and promoting mental wellbeing in schools and colleges- see 'beat bullying' teaching resources – www.beatbullying.org/dox/resources.html
- Support and promote the projects that work with families to address self-harm, for example Pinpoint.

11.3 Recommendation 2.3 – Promote early interventions to aid prevention of mental health problems that could lead to suicide

Prevention interventions to promote good mental health and avoid decline towards suicidal tendencies are essential to this strategy:

- Review access to support in the community before crisis situations arise.
- Work with communities and community liaison teams to raise awareness of sources of help, for example, debt management, relationship counselling, housing organisations parent/children centres
- Promote Information and provide training to health professionals including GPs and health visitors to encourage use of signposting, advice and self-help resources (through the Keep Your Head websites, for example
- Engage with service users and public to understand gaps in service provision and focus efforts on improving the system to support individuals where appropriate
- Review the potential to provide a tangible presence of a mental health drop-in facility in Peterborough city centre

11.4 Recommendation 2.4 - Promote training in Mental Health Awareness

For detailed information – see section 9.4. Continue to roll-out training that promotes mental health awareness and prevention of mental health problems that could lead to suicide. Implementation of bespoke training packages in mental health awareness and suicide prevention began in 2014. This work is continuing to be funded as well as additional training in suicide prevention aimed at GPs. Training for General Practice staff should include awareness around risk assessment for mental health issues by assessing patient histories, particularly around a past history of self-harm.

12 PRIORITY 3 - REDUCE ACCESS TO THE MEANS OF SUICIDE

The 2014-2017 strategy reported that the most common method for suicide was hanging but there was considerable concern about information on deaths as a result of multiple injuries associated with falling from height from car parks in both Peterborough and Cambridge. The strategy made clear recommendations to help address these issues but vigilance is still required and more work can be done as follows:

12.1 Recommendation 3.1 – In line with regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings

Most suicides are the result of hanging. It is therefore important to remove potential ligature points in places likely to have people at high risk of suicide – including places of custody, prisons and hospitals in line with national regulations and guidance -
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/117555/safer-detention-guidance-2012.pdf
http://www.rcpsych.ac.uk/pdf/AIMS-PICU%20Standards%20-%20Second%20Edition%20-%20FINAL%20new%20template.pdf

Regular audit of potential ligature points should continue as good practice in places of safety including psychiatric hospitals and places of custody taking into account recommendations made by coroners.

12.2 Recommendation 3.2 Reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car parks

Preventing access to the means of suicide by physical barriers in locations where people may choose to jump is one of the most effective mechanisms for preventing suicide[22,23]. There is no evidence to suggest that people will find an alternative mechanism for suicide if one method is made inaccessible[23]

The suicide prevention implementation group fully endorses the erection of barriers at all multi-storey car parks in Cambridge and Peterborough to ensure safety by preventing access to any area with a sheer drop that could lead to a suicide attempt. This would make a clear statement and showcase Peterborough and Cambridge as places that take positive steps to prevent suicide.

The suicide prevention implementation group is delighted with progress to date; barriers have been erected on all the Queensgate shopping centre car parks in Peterborough. No deaths have been reported as a result of jumping from car parks since the work began to construct the barriers. However, there remains concern that Northminster car park in Peterborough does not have protective barriers. In Cambridge, the Queen Anne car park in Cambridge should to be reviewed in terms of protective measures to prevent people from jumping from the building.

Training in suicide prevention has been provided to staff working at both Peterborough and Cambridge shopping centres by the Samaritans. Similar training should be considered for all staff working in the multi-storey car parks in Peterborough and Cambridge.

12.3 Recommendation 3.3 – Reduce the risk of suicide on railway lines

A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – involving Samaritans, Network Rail and British Transport Police. There have also been local initiatives to support this work:

- Samaritans/Network Rail campaign on the railway includes printed messages on tickets and posters at stations. Some local stations are also displaying Stop Suicide resources.
- Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally).
- The Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/

Continuing implementation of these initiatives is supported by this strategy

In addition, the annual suicide audit will be used to assess whether there are any 'black spots' for suicide on railway lines locally. An assessment of any requirements for physical barriers should be made at any location with heightened risk of suicide.

12.4 Recommendation 3.4 – Work with Medicines Management team at the CCG to ensure safe prescribing of some toxic drugs

Self-poisoning accounts for about a quarter of deaths by suicide in England and is the second most common method for suicide in men and women. Safe prescribing regulations were introduced in 1998 to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication (MHRA, 2009[25]).

The National Institute for Health and Clinical Excellence (NICE) will be developing a quality standard on safe prescribing, as part of a library of approximately 170 NHS Quality Standards covering a wide range of diseases and conditions.

The suicide prevention implementation group should work with the CCG Medicines Management team chief pharmacist to ensure that there is a focus on suicide prevention as part of implementation of forthcoming NICE guidance – quality standard on safe prescribing. Further consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available[26]

Promotion of suicide prevention through pharmacies and with pharmacists is recommended to raise awareness of suicide risk due to some forms of prescription medication.

12.5 Recommendation 3.5 - Whenever possible, medical professionals should be reinforcing safety plans for individuals with mental health problems

Promote the adoption of personal safety plans for people with mental health illness, or who have

previously suffered from mental illness and/or are at risk of suicide as identified by GPs and other health professionals. This includes those who have never been in Secondary Care services.

Personal safety plans are essential as part of the process of care and need to cross over organisational boundaries and be person held. There is an opportunity to promote the use of safety plans with GPs and other health professionals through the suicide prevention training from the autumn of 2017 (funded with STP money). Included in the safety plan is an assessment of access to means of suicide and dialogue should be promoted between the health professional and patient about how to eliminate access to the means of suicide. This should include exploring and adopting best models for reducing hanging in the community.

Educational resources and information for GPs will continue to be disseminated by engagement with GP leads and clinical networks through the CCG.

13 PRIORITY 4 - PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY SUICIDE

It was recognized in the 2012 Preventing Suicide in England strategy that bereavement by suicide was an area poorly covered by previous suicide prevention strategies.

Public Health England have published a suite of recent guidelines on supporting people after suicide. These highlight the need for change to ensure all suicide prevention strategies include postvention (activities for people bereaved by suicide to support their recovery and prevent adverse outcomes). The guidelines include several case studies of reactive approaches to postvention support as well as information on how to implement and evaluate similar initiatives.
https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providinglocal-services
Locally, no specific bereavement support service exists for people and families who have been affected by suicide. Bereavement is in itself a risk factor for suicide and a conservative estimate is that 10 people are directly affected by each suicide death. Friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss. When compared with people bereaved through other causes, those bereaved by suicide are also at an increased risk of psychiatric admission and depression.

There are several bereavement charities and organisations, some of which specialize in helping those affected by suicide.

- CRUSE – a charity dealing with bereavement in general – supported by the CCG
- Survivors of bereavement by suicide
- Compassionate Friends – a charity dedicated to helping families of children who have died

In addition, The 'Help is at hand' booklet produced by the Department of health[27] is designed for people affected by the loss of a loved one through suicide.

13.1 Recommendations to support those who are bereaved and bereaved as a result of suicide

Recommendation 4.1 Ensure bereavement information and access to support is available to those

bereaved by suicide

Funding has been approved through the Systems Transformation Programme (STP) to implement a local, county wide suicide bereavement support service (approved in July 2017). A pathway will be developed so that bereaved individuals will be asked whether they would like to be contacted by a support officer upon initial contact (usually by a police informing the family of the death by suicide of a loved one). If they consent to be contacted, this information will be passed to the family support officer and they will make contact with the family or bereaved individual within the first week after bereavement to offer support and signposting to services (such as CRUSE a charity to help bereaved people) and self-help resources. It may be important to ascertain whether there are any other individuals outside the family context (friends, colleagues for example) who may be affected by the suicide.

The bereavement support service will also help facilitate the setting up of local 'Survivors of Bereavement due to Suicide (SOBS) groups, that will be run as friendship or 'peer support' groups for people affected by suicide.

Information for those bereaved as a result of suicide will continue to be made available through professionals and other organisations in first contact with bereaved people (Police Officers, coroners, GPs, death registration professionals and funeral directors).

- Continue to distribute 'help is at hand' leaflets to these professionals.
- Provide details of local bereavement charities if not included in 'help is at hand' leaflet. A local bereavement support leaflet should be developed to signpost people to locally available services and resources for self-help. This should be provided to individuals who have been affected by suicide.

The families of people who have died as a result of suicide who are known to mental health services may be particularly vulnerable after bereavement. It will be important to review and map the processes in place to ensure that appropriate support is available to families and close contacts after bereavement. Any gaps in the services should be highlighted and recommendations made to improve outcomes.

14 PRIORITY 5 - SUPPORT THE MEDIA IN DELIVERING SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOR

It is known that the reporting of suicides by the media can promote other suicides – particularly using the same method or at the same location and that responsible reporting of suicide or reduced reporting can decrease suicides at 'hotspot' locations[28].

There are media guidelines on the reporting of suicide from 'The Samaritans'[29] that set out clear instructions and recommendations on what an article should contain when it reports a death by suicide.

14.1 Recommendation 5.1 – Encourage the appropriate and sensitive reporting of suicide

- Ensure all professionals in contact with the media are aware of guidelines for reporting

suicide. Some professionals such as coroners and police may be contacted by journalists after a suicide in order to obtain details for an article to report the suicide.

- Continue to work with local media to encourage reference to and use of guidelines for the reporting of suicide. Work with Communications teams within the local authorities to encourage responsible reporting of suicide by the local newspapers.
  Highlight the following:
    - Media guidelines produced by Samaritans
    - Encourage a positive report on the deceased person
    - Do not sensationalise the suicide or suicide method
    - Protect bereaved families from intrusion – press complaints commission
    - Use of language by the media - Avoid referring to suicide in the headline of a story – it is more sensitively reported in the body of the story.
    - Avoid terms such as “successful”, “unsuccessful”, or “failed”.

15 PRIORITY 6 - SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

Suicide prevention relies on information about local suicides to determine who is at risk of suicide and where and how suicides happen locally. This data is important in order to focus resources. It is also important to monitor local suicides and reports of self-harm by assessing up-to-date information. This will enable appropriate response to any changes in rates of suicides and self-harm and will help to understand the impact of implementing the recommendations set out in this strategy.

To this end, the following recommendations are made:

15.1 Recommendation 6.1 Continue to collect detailed suicide data on a quarterly basis and carry out an annual audit of local suicides

Data should continue to be collected from Cambridgeshire and Peterborough coroners and include information on age, sex, nationality, occupation, marital status, contact with mental health services, contact with primary care services and in particular services in two weeks prior to death, place of death, resident address, method of suicide.

A suicide audit will be conducted on an annual basis and used to inform development of initiatives targeted to people at risk locally. The information contained in the audit will also be used as part of the evaluation process for this strategy.

Real-time suicide surveillance has been implemented that sends information on suspected suicides as they occur from police to public health. This enables the suicide prevention implementation group to react if necessary to any concerns, for example linked suicides, or suicide in young people that may affect other young people at school or colleges.

In addition, and as part of the Zero suicide ambition, it is proposed that a sample of suicide case files be reviewed on a quarterly basis to learn lessons and identify preventative actions that could be implemented locally.

All data is held securely by public health analysts as part of the suicide prevention partnership.

15.2 Recommendation 6.2 Disseminate current evidence on suicide prevention to all partner organisations

As evidence emerges on the best practice interventions and measures to reduce the risk of suicide, there should be a mechanism for ensuring that this is disseminated to all partner organisations working to prevent suicide. This may be facilitated through the suicide prevention group meetings with an assigned person responsible for checking the evidence base on a regular interval.

15.3 Recommendation 6.3 Coroners should notify the Suicide Prevention Strategic Group about inquest evidence that suggests patterns and suicide trends and evidence for service development to prevent future suicides

Coroners are best placed to review and assess evidence during the year as inquests to suicides occur. This may provide opportunities to identify concerns about local suicides – patterns or trends, for which action may be required. In addition, coroners may highlight concerns about services or opportunities to improve services where failings have occurred.

16 EVALUATION – HOW WILL WE KNOW WE ARE MAKING PROGRESS? Recommendation 6.4 - Evaluate and report on the suicide prevention implementation plan

Evaluation is an important component to this strategy and will provide essential information and evidence on what is effective in suicide prevention and what areas require more work or are ineffective.

A set of Key Performance Indicators will be developed to monitor the progress against the strategy and aligned with the suicide prevention implementation plan 2017 - 2020.

Public health outcome indicator 4.10[11] expects suicide rates to be reported annually based on three year rolling average rates for local populations. A baseline has been set as the average rate of suicides for the period 2009-2011 and this should be used to compare future statistics and the impact of implementing this strategy.

Evaluation should also include surveys of various groups for effectiveness of particular actions or interventions.

- Survey of GPs
- Survey of mental health professionals
- Survey of people trained in suicide prevention
- Survey of service users

Soft data should be used as part of the evaluation – data collected by each implementation sub-group. For example; actions taken, resources disseminated or used and numbers of people reached by the initiative.

16.1 RESOURCES FOR IMPLEMENTING INITIATIVES TO PREVENT SUICIDE AND SUSTAINABILITY

The implementation of the strategy will require a mixture of input and work from partner organisations, cultural and organisational change and funding for the delivery of specific initiatives.

Implementation of the recommendations and action plan will be managed by a joint Cambridgeshire and Peterborough Suicide Prevention Implementation Group. Multi-agency working across all sectors, from NHS and mental health professionals to voluntary organisations, will be encouraged in order to utilise expertise from these organisations to implement the proposed initiatives.

Continuing engagement with service users and their carers is expected for the successful development, implementation and delivery of initiatives in each priority area.

17 REFERENCES

1. National Strategy: Preventing Suicide in England, 2012: http://www.dh.gov.uk/health/files/2012/09/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf
2. Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives https://www.gov.uk/government/publications/suicide-prevention-third-annual-report

   Support after a suicide: A guide to providing local services https://www.gov.uk/government/publications/support-after-a-suicide-a-guide-to-providing-local-services
3. Cambridgeshire and Peterborough Clinical Commissioning Group Commissioning Strategy for the Mental Health and Well-Being of Adults of Working Age 2013 – 2016 http://www.cpft.nhs.uk/Downloads/rod%20files/2013_0816_CCG_Adult_MH_Commissioning_Strategy_2013_FINAL.pdf
4. JSNA Cambridgeshire – health and wellbeing strategy see: http://www.cambridgeshire.gov.uk/info/20116/health_and_wellbeing_board
5. JSNA Peterborough Mental Health http://www.peterborough.gov.uk/pdf/HealthAndSocialCare-JSNA-Mental%20Health.pdf
6. Suicide Prevention Strategy CPFT 2013-2016 (closed document) – for details please contact author or CPFT
7. Emotional well-being and mental health strategy for children and young people 2014-2016 (draft strategy)
8. Suicides in students http://www.ons.gov.uk/ons/about-ons/what-we-do/publication-scheme/published-ad-hoc-data/health-and-social-care/november-2012/index.html
9. National Confidential Enquiry into Suicide and homicide by people with Mental Health illness – Annual report 2013 http://www.bbmh.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/reports/AnnualReport2013_UK.pdf
10. Samaritans report –men suicide and society: http://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf
11. No health without mental health: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf
12. Public Health Outcomes Framework https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf
13. Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis, February 2014. Department of Health

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
14. Annual Report of the Chief Medical officer 2013 – Public Mental Health Priorities: Investing in the Evidence https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf
15. Saving Lives: Our Healthier Nation; Department of Health, 1999: https://www.gov.uk/government/publications/saving-lives-our-healthier-nation
16. Detroit model for suicide prevention: http://zerosuicide.actionallianceforsuicideprevention.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/PerfectDepressionCarearticles.pdf
17. ASIST suicide prevention training: http://www.chooselife.net/Training/asist.aspx
18. Mental Health First Aid training England: http://mhfaengland.org/
19. Suicide in primary care in England 2002-2011[18] http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/SuicideinPrimaryCare2014.pdf
20. Knapp et al 2011, Mental health promotion and prevention: The economic case. http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUfeb2011.pdf
21. The Use and Impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: An Evaluation Social research: The Scottish Government, http://www.chooselife.net/uploads/documents/19-ASISTEvaluationFullReport.pdf
22. Bickley, H et al 2013; Suicide within two weeks of discharge from psychiatric inpatient care. A case control study Psychiatric Services 2013 http://ps.psychiatryonline.org/article.aspx?articleID=1673604
23. Cox et al 2013; Interventions to reduce suicides at suicide hotspots: a systematic review BMC Public Health 2013, 13:214 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606606/pdf/1471-2458-13-214.pdf
24. Mann et al, 2005 Suicide Prevention Strategies: A systematic Review. *JAMA.* 2005;294(16):2064-2074
25. We are in your corner – Samaritans: http://www.samaritans.org/media-centre/our-campaigns/were-your-corner
26. MHRA – Best practice for the sale of medicines for pain relief - http://www.mhra.gov.uk/home/groups/pl-p/documents/websiteresources/con065560.pdf
27. Hawton K, Bergen H, Simkin S et al (2010) Toxicity of antidepressants: rates of suicide relative to prescribing and non-fatal overdose. *British Journal of Psychiatry* 196: 354-358
28. 'Help is at hand' a resource for people bereaved by suicide and other sudden, traumatic death http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf
29. Preventing Suicide - A Resource for Media Professionals: A resource guide produced by the Department of Mental Health at the World Health Organization in 2000. http://www.who.int/mental_health/media/en/426.pdf
30. Media guidelines for reporting suicide – Samaritans: http://www.samaritans.org/sites/default/files/kcfinder/files/press/Samaritans%20Media%20Guidelines%202013%20UK.pdf
31. NHS England and Public Health England 'A call for Action: Commissioning for Prevention' November 2013. Available at: www.england.nhs.uk
32. WHO For which strategies of suicide prevention is there evidence of effectiveness http://www.euro.who.int/__data/assets/pdf_file/0010/74692/E83583.pdf

APPENDIX 1

Examples of Suicide Prevention Protocols for specific professional groups

1. **Suicide Prevention Pathway developed by Peterborough MIND -**Peterborough and Fenland Mind Suicide Protocol

Who should you call is you are faced with a Suicidal Person (SP)?

Rarely a SP may behave out of control on in a way suggesting harm to themselves or others. If this is the case you should call the Police on 999. See *point 1* if this is the case

Normally the SP will speak of thoughts or plans of suicide alone and appear distressed. If this is the case see *point 2* for the key questions you need to ask

Point 1
The police are able to detain someone under the Section 136 of the Mental Health Act if they believe the SP to have a 'mental disorder' and are in need of immediate need of care and control.

They will first remove the SP to a place of safety, preferably a hospital or police station where they will be held until approved by an Approved Mental Health Professional. One or two doctors will also assess the SP for up to 72 hours.

Point 2
If you feel the person is distressed and can be spoken through what they are experiencing you should stay calm, show interest and concern, not show judgement or shock. You should be positive that the right help they can feel better.

You should then encourage them to see their GP as a matter of priority whilst still addressing non-medical concerns. The agreed response you need here is for the person to let you contact their GP. The SP may suggest this is pointless but nevertheless it should be the first port of call unless consent is firmly withheld. If you are given

Point 3
If the SP refuses for you to get in contact with their GP then you must respect their request for confidentially. You should then offer the SP a 'Feeling on the Edge' leaflet and tell them they can return to you if they decide they want help from the service to access their GP. The expectations to this strict rule are (a) Imminent threat of self- harm, then call the police (b) Vulnerable Adult such as Dementia, Learning Disability or Abused Domestic Violence when a SOVA approach is required

Point 4
If you are given consent you should then ring the GP and explain to the receptionist who you are, who the SP is and why you are calling. They should use a password (perhaps a Suicide Prevention Alert) and ask to speak to the Duty GP.
The GP will speak to you and they should use their professional judgement and personal knowledge to decide on the best pathway which will often result to a same day appointment. If the GP cannot speak to you immediately then you are to ask for a ring back and an urgent same day appointment for the SP.

If the surgery is uncooperative or unresponsive and you feel they are still carrying the risk then they should log the experience and feedback to the Administrators as a possible Quality Issue and also ring ARC for assistance.

2. Example of suicide prevention protocol for GPs

Cambridgeshire and Peterborough
Clinical Commissioning Group

GP Suicide Prevention Guide – Cambridgeshire & Peterborough

Resource	*Organisation*	*Contact*	*Information*
Self-help organisation	Samaritans	0845 790 9090 jo@samaritans.org	24/7 A 24 hour helpline service which gives you a safe space where you can talk about what is happening, how you are feeling, and how to find your own way forward
Self-harm pathway	NICE	http://pathways.nice.org.uk/pathways/self-harm	Summarises both short and long term self-harm guidance using a flowchart based approach
Local Mental Health Provider	CPFT	http://www.cpft.nhs.uk/	
Suicide Prevention Toolkits	NPSA	www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx	The toolkits support clinicians and managers to understand what they can do to reduce the suicides.
Self-Harm Top Tips	NHS Cambridgeshire and Peterborough CCG		Top tips - Self Harm.pdf
Risk Assessment Top Tips	NHS Cambridgeshire and Peterborough CCG		Top tips - Risk Assessment.pdf
The National Self-Harm Network	Self-Harm	0800 622 6000 (7pm-11pm Thursday-Saturday, 6.10pm-10.30pm Sunday) support@nshn.co.uk http://www.nshn.co.uk/	A forum and resource for those who self-harm and their families, and for professionals who support them.
Handbook on CAMH self-harm	CHIMAT	www.chimat.org.uk/resource/view.aspx?RID=105602	The National CAMHS Support Service produced a self-harm in children and young people handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children's services can respond.
Self-help organisation	PAPYRUS Hope Line UK	0800 068 4141 (Monday – Friday 10am-5pm & 7pm-10pm, Weekends – 2pm-5pm) pat@papyrus-uk.org http://www.papyrus-uk.org/	Papyrus aims to prevent young people taking their own lives.

Self-help organisation	Get Connected	0808 808 4994 Open from 1pm - 11pm every day Text 80849 for free - Texts will usually be answered within 24 hours http://www.getconnected.org.uk/	Offers help by telephone and e-mail to those under 25 who self-harm.
How to respond to suicide risk in older clients info sheet	The Staffordshire University Centre for Ageing and Mental Health	http://www.staffs.ac.uk/assets/Suicide_and_older_people_tcm44-32414.pdf	The Staffordshire University Centre for Ageing and Mental Health has developed a set of information sheets to help health and social care providers respond to suicide risk in older clients
Rural Stress Helpline	Rural Stress	Helpline 0845 094 8286 (Mon-Fri 9am-5pm); email help@ruralstresshelpline.co.uk	Offers a confidential, non-judgemental listening service to anyone in a rural area feeling troubled, anxious, worried, stressed or needing information.
Bereavement Resources			
Help is at Hand		http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf or order from www.orderline.dh.gov.uk	A resource for people bereaved by suicide and other sudden, traumatic death. This provides advice and information for anyone directly affected by suicide. It also has advice for people in contact with those bereaved through suicide, either because of their work or because they are part of the same community
The Inquest Handbook	INQUEST	http://inquest.gn.apc.org/website/help-advice/the-inquest-handbook	A guide for bereaved families, friends and their advisors. This booklet includes specialist sections dealing with deaths in police or prison custody and when detained under the Mental Health Act 1983.
SOBS (Survivors of Bereavement by Suicide)		0844 561 6855 (open 9am – 9pm every day) sobs.admin@care4free.net http://www.uk-sobs.org.uk/	Meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend.
E-learning			
E-learning on Domestic Violence	RCGP	www.elearning.rcgp.org.uk/course/view.php?id=88	To enable them to identify and respond to victims of domestic violence more effectively.
Websites			
www.selfharm.co.uk	A project dedicated to supporting young people who are affected by self-harm		
http://www.getselfhelp.co.uk/			

DRAFT Joint Cambridgeshire and Peterborough Suicide Prevention Three Year Action Plan

2017-2020

The joint Cambridgeshire and Peterborough suicide prevention three year action plan accompanies the refresh of the Joint Suicide Prevention Strategy (2017-2020) and builds upon the work undertaken between 2014-2017. The action plan is a working document and will be adjusted and updated as work proceeds to implement the recommendations.

Implementation of the strategy according to the action plan will be the responsibility of partner organisations as described in the suicide prevention strategy. A joint Cambridgeshire and Peterborough Suicide Prevention implementation group oversees the implementation of the action plan.

The joint suicide prevention strategy document provides detail for each recommendation and should be used for cross-reference when implementing the action plan.

Funding to support recommendations and actions will depend upon on-going support from the partner organisations.

DETAILED ACTION PLAN FOR SUICIDE PREVENTION

Recommendation	Actions	Timescale	Suggested performance measure	Responsibility/Involvement of partners	Progress to date
Priority 1 - Reduce the risk of suicide in high risk groups					
Recommendation 1.1 - Suicide Prevention Training	Continue ASIST and STOP suicide training as follows: • ASIST courses delivered to individuals and priority organisations identified (as agreed in contract with CPSL MIND)– ensuring training reaches out to people working or	Training funded through CCC and PCC and contract awarded to CPSL MIND	Numbers of people trained List of organisations receiving training and numbers of	CPSL MIND – STOP Suicide On-going support from Cambridgeshire and	Three ASIST trainers trained ASIST Courses delivered across Cambridgeshire and Peterborough targeting 'Gate Keeper' roles including those working with migrant

	in contact with the most vulnerable or hard-to-reach groups at risk of suicide • STOP suicide courses delivered with agreed target for participation • Evaluation of training effectiveness – at the end of each course (by survey) and follow-up. Develop and deliver GP suicide prevention training programme (funded through STP with support from CCC Continue delivery of MHFA through workplace health – funded by CCC (Cambridgeshire only)	Ongoing delivery of ASIST and STOP suicide training Evaluation of training – on an annual basis On-going training supported by Samaritans GP training in suicide prevention from Autumn 2017 for one year	staff trained within each organisation- 80% satisfaction with training	Peterborough suicide prevention group	communities and bereavement support workers. An ASIST course was funded and delivered to peer support workers in Peterborough prison. 258 people trained in ASIST between October 2015 and January 2017 Locally developed ½ day STOP suicide course has been developed and delivered. 21 STOP suicide workshops have been delivered reaching 236 people (From Oct 2015 to Jan 2017). Funding to deliver courses to bar staff in Fenland as well as scoping work to assess feasibility of training barbers/hair dressers. ASIST course funded for peer support workers in Peterborough prison. Evaluation forms are completed by participants and feedback is collected following courses (see details

					in Suicide Prevention Strategy).
Recommendation 1.2 – Develop suicide prevention resources for professionals in contact with vulnerable groups and for self-help	• Collect and collate available resources and a directory of services • Provide access to resources and information – via the STOP suicide and Keep Your Head (CYP)website • Continue to distribute 'help is at hand' bereavement support leaflet through partner organisations • Develop an adult version of 'Keep Your Head' website with information and resources for signposting and self-help • Work with GP and CPFT professionals to develop care plans for people known by mental health organisations to ensure up-to-date self-help resources and contact information is included (through GP training and CPFT training) • Promote and update the directory of services (created by Lifecraft) –through existing apps/websites e.g. Keep your Head, MyDOS, MyHealth and STOP suicide • Continue to promote resources to support people bereaved as a result of suicide – including distribution of 'Help is at hand' leaflet and a local information leaflet on bereavement services and support • Facilitate the setting up of SOBS (Survivors of Bereavement due to Suicide) self-help groups managed by bereaved individuals – to link with the bereavement support service	Ongoing updates and maintenance to STOP suicide and Keep Your Head (CYP)websites – CPSL MIND, Public Health Keep Your Head (adult version) website to be developed from September 2017 with Launch in spring 2018 Autumn 2017 onwards – GP training with promotion of resources for signposting and self-help as well as development of care plans	Evaluation of STOP suicide and 'Keep Your Head' Website visitor statistics and monitoring – including resource pages 'hits' Directory of services developed and used by partner organisations Feedback from GP training and bereavement support service – including leaflets disseminated Survey of service users and carers to evaluate awareness of resources	CPSL MIND – STOP suicide resources Public Health and partner organisations – 'You're your Head' websites Report to Cambridgeshire and Peterborough suicide prevention implementation group	STOP suicide website developed. As of January 2017, STOP Suicide had 1,343 twitter followers and 394 facebook fans. The STOP suicide website has had 17,598 visitors and 45,047 page views. Further development of resources to enhance STOP suicide (including beer mats in March 2017). In addition the www.keep-your-head.com website has been developed to support children and young people's mental health. This includes a page designed with, and for, GPs. Crisis information and suicide and self-harm information is included. Wide promotion of this resource has taken place and is continuing. Self-help resources including apps included on the Keep Your Head website for children and young people. In addition Stress LESS

	• Continue to promote the 111(2) FRS/Sanctuary service through multiple media connections. Include promotion to BME communities, using the FRS video in other languages				campaign promoted during exam time in schools. Directory of Services (MyHealth app) and plans to further develop central point of information for adult mental health (linked to Keep Your Head). Update to Lifecraft Directory of services (Spring 2017). GP referral document updated (mental health services) by Claire Harris and promoting to GPs via bulletin. Patient version also updated.
Recommendation 1.3 – Awareness-raising campaigns and promote the Cambridgeshire and Peterborough STOP Suicide pledge to reduce suicide	• Continue to engage with and consult service users on how to reduce risk in high risk and hard to reach groups – developing appropriate resources and advocacy services ensuring appropriateness to different vulnerable groups. Resources will need to be translated if they are to reach out to the Polish and Lithuanian population at higher risk of suicide. • Make use of partnership working when targeting campaigns aimed at reducing suicide in men. Samaritans and STOP suicide share idea and resources in order to maximise benefits.	Ongoing through contract with CPSL MIND for STOP suicide	Number of individuals signing pledge Number of organisations signing pledge Survey to assess awareness in the community	Public health will continue to develop and manage the KYH CH and YP site and oversee the development of KYH adults with the Service Users Network. CPSL MIND with support from Lifecraft will oversee STOP	STOP suicide: As of January 2017 there were 1,220 personal pledges and 51 organisational pledges for STOP Suicide. Website statistics given above. Approximately 3000 one to one conversations with individuals (mental health and suicide) since September 2015. The campaign has recruited a total of 10 new Campaign Makers - four in Peterborough, five in

	• Continue work by STOP suicide to use public events and other community opportunities to promote the STOP suicide pledge and raise awareness of suicide prevention • Continue to Identify localities for specific awareness raising and special events such as suicide prevention day (10th September) and world mental health awareness day (10th October) • Continue development of the STOP suicide website and create a website for adults to promote mental health (Keep Your Head (adults)) • Explore use of social media in awareness raising • Include suicide prevention in other mental health awareness campaigns • Include awareness raising and suicide prevention material in bulletins that are sent out to GPs • Link with local media partners and 'time to change' campaigns			suicide website, GP training and bereavement support Link with Samaritans' 'We're in your corner' campaign targeted at men	Cambridge and one in St Neots. National recognition has been received for work. Webinars including suicide prevention developed as part of 'keep your head'
Recommendation 1.4 –Aspire to develop integrated, appropriate and responsive services for those at risk of suicide	**Link to learning through the ZERO suicide ambition.** Create a culture of learning from case review of suicides Develop a cultural expectation that people receive appropriate and timely services • Continue support for Integrated Mental Health teams – Mental health nurses in police control rooms	Ongoing work carried over from Suicide Prevention Strategy 2014-2017 GP training from Autumn 2017	Survey of service users on integrated pathways for suicide prevention. Consider an audit of pathways used by each service – police, ambulance,	All Partners as part of the Crisis Concordat team, including Police, CPFT, CCG primary care and public health support.	Vanguard/Crisis Care Concordat work including: -Integrated Mental Health Team – mental health nurses based in the police control room. -First Response service with crisis telephone number (111 option 2).

	• Continue support for Crisis 111(2), FRS and sanctuaries. • Ensure suicide prevention initiatives link to Crisis Concordat work and include pathways of care for people pre crisis, during crisis and post crisis • Develop and expand data sharing agreements and protocols (see recommendation 1.6 below) • Encourage systems that allow engagement with other services where appropriate – particularly with drug and alcohol teams • Refer to GP training (See Recommendation 1.1) to ensure development of guidance for primary care – resources, sign posting and self-referral as well as safety plans and links with PRISM • Develop bereavement support services for those affected by suicide – see Recommendation 4.1		A&E, liaison psychiatry Consider an audit of information sharing protocols, once agreed	Ensure partnership support from Crisis Concordat group	-The Sanctuaries – non-health based places of safety. -Sharing data – continued work as a system to improve data sharing and establish agreements. Vanguard work and Concordat work has required data sharing protocols. Data flow following a bereavement now being reviewed. This work undertook a range of mapping and pathways work in terms of crisis support.
Recommendation 1. 6 - Reassess pathways for people known by mental health services at risk of suicide	**Link to learning through the ZERO suicide ambition.** Create a culture of learning from case review of suicides • Ensure Crisis Concordat work aligns with this priority area. Pathways of care to be assessed include those pre crisis, during crisis and post crisis. • Refer to Crisis concordat recommendations on developing information sharing processes across the mental health system but particularly for people in mental health	On-going Work in partnership with Crisis Concordat group - Local Authority - MOSAIC & BTP Link with prisons and Offending, Prevention and Management Strategic Needs Assessment CPFT to identify gaps or weaknesses and areas for improving the care of people Pre, during and post crisis including	Evaluation of 111(2), FRS and Sanctuaries by SUN Report use of 111 (2) and Sanctuaries with outcome measures compared with A&E attendances for CRISIS Assess use of Section 136 and places of safety	Crisis concordat Modestas Kavaliauskas CPFT Zero suicide work will assess pathways of support post discharge and learning from case reviews Engagement with service	CPFT sub group to develop strategy and action plan under the Zero Suicide initiative Work through the Crisis Care Concordat: Information Sharing Agreements are in place across organisations to support the Frequent Attenders CQUIN, in addition to MH and Acute Trusts this includes 111, ambulance

	crisis - across agencies in the patient's best interest *Sharing Agreements are in place across organisations to support the Frequent Attenders CQUIN* • Assessment of pathways for people who are discharged from psychiatric care and A&E care/liaison psychiatry – review of care plans and information contained within care plan, including consent to share information between agencies *CPFT to review all the ISA's in place or ISA's being established to support MH crisis care pathway and explore how information could be further shared shared between organisations (Cambridgeshire Information Sharing Framework)* • Explore models for community and joined-up support at locality level for people post crisis –and ongoing support for people with mental health issues in the community who do not meet the threshold for secondary mental health services - link with the PRISM service • Continue to engage with service users to establish the strengths and weaknesses in pathways of care in response to crisis – including the FRS service and Sanctuaries – see outcomes (SUN evaluation) • Training to GPs, and CRISIS professionals on pathways and risk identification • Engage with Rethink Carers group – for carers of people with mental health	upon discharge from psychiatric care. Training to GPs and other CRISIS professionals from October 2017 (as part of STP funding)	GP training evaluation – referrals, awareness of services and avoiding CRISIS Consider an audit of Care plans in place for people discharged from services Consider a survey to assess the resources and support offered to those in community settings who do not meet the threshold for secondary mental health services	users and carers through the mental health stakeholders group – quarterly meetings across Cambridgeshire and Peterborough	service, substance misuse, primary care. the FRS and Sanctuaries have been evaluated by the 'Service User Network' (SUN) against it's 'five values' of Empathy, Honesty, Inclusion, Personalisation and Working Together and have awarded the FRS 3 stars (good rating) and Sanctuaries 4 stars (outstanding).

	illnesses – through the mental health stakeholders group				
Recommendation 1.7 - Improve pathways and support for people taken into custody at risk of suicide and for people newly released from custody.	Link with prisons and Offending, Prevention and Management Strategic Needs Assessment - understand the screening risk assessment procedure at court and upon reception of prisoners and people taken into custody (including police custody) to include risk of suicide/self-harm. • Continue to work with prison managers to promote and train peer support 'prison listeners'. • Broaden and promote access to the Samaritans in custody suites and in courts by raising awareness and supporting partnerships, learning from good practice • Promote access to support from drug and alcohol services for people in custody with mental health and drug/alcohol problems. Raise awareness and promote partnership working • Assess discharge pathways for people who have been in custody, including a review of care plans for people with mental health problems.	Ongoing work with police, prisons and probation	Reduction in suicides in people in custody – baseline 2009-2011 Suicide audit of case files to ensure inclusion of people released from custody Prisons and Offending, Prevention and Management Strategic Needs Assessment Consider evaluation survey to show use of Samaritans in custody suites Numbers of police custody, prison staff and prison listeners trained in suicide prevention	CPFT, police, probation, Samaritans and custody staff as members of the suicide prevention implementation group NHS England to lead on suicide prevention initiatives in prisons with support from the suicide prevention implementation group Engagement with Public Health England for support	ASIST course funded for peer supporters in Peterborough prison. A number of issues were highlighted as part of the Substance Misuse JSNA (criminal justice section) and support is being given to the upcoming needs assessment being undertaken by the Office of the Police and Crime Commissioners Office. Work is being done to look into issues around transfer of health information at point of entry to prison.
Priority 2 - Tailor approaches to improve mental health in specific groups					

Recommendation 2.1 Work in partnership with CPFT to assess pathways of care for children (10-24 year olds) and adults who self-harm	• Signpost CYP to 'Keep Your Head' website and directory of services at the point of contact (through liaison psychiatry). • Review the use of follow-up care plans for people discharged from services • Assess plans for people who self-harm if mental health services are not involved • Review resources to help people who self-harm or have a history of self-harm, for example; 'Harmless' http://www.harmless.org.uk A national organisation based in Nottingham	Ongoing work linked with pathway design for suicide prevention and Emotional well-being and mental health group for children and young people.	Report on pathways available to children and adults who self-harm Including recommendations for improvements Admission rates for self –harm reported to suicide prevention group Trends in admission rates recorded	CPFT lead (to be agreed) Input from CCG and voluntary organisations	-Directory of services – Keep Your Head (includes specific information on self-harm) and MyHealth app. -Public Health are currently reviewing self-harm admissions data to establish if there are any data reporting errors (Cambs). - Providing a psycho social assessment and safety plan for Emergency Department (ED) patients is at the heart of what the Liaison Psychiatry ED teams provide, and also would would provide through FRS if needed. -Commissioning of Kooth and expansion of face-to-face counselling services for young people.
Recommendation 2.2 Work with partners who are developing the 'Emotional wellbeing and mental health strategy for children and young people*	• Raise awareness and promote campaigns to address self-harm • provide access to self-help resources that focus on building resilience in young people • raise awareness and develop resources aimed at preventing bullying in schools and colleges • assess pathways for support for children who are at risk of self-harm , particularly in	Ongoing work	Data on self-harm in children Training delivered for emotional wellbeing support of children Partnership working to deliver resources and	CCG, local authority children and family services, Public Health advice and support	Holly Gilbert to be a link and provide updates between the two groups. Self-harm initiatives and anti-bullying work being reviewed at CCC and PCC. PCC identified key schools to engage based on self-harm

	vulnerable groups of children and young people – youth offenders, children in care, children under the care of people with mental health problems • assess pathways for teenagers and young adults who have attended A&E due to self-harm, particularly upon discharge		awareness raising – Number of workshops and events run and feedback obtained Achieve zero suicides in children	from suicide prevention implement ation group	data. A steering group of the emotional health and wellbeing board for Peterborough is taking the actions forward. Videoscribe work on mental health. CCC ran a self-harm workshop, primarily focused at school representatives. Actions are being taken forward and include improving communication with schools and improving uptake to training opportunities and supporting whole school approach to mental health. Self-harm support groups for parents have been run by PinPoint and support from Locality Teams (Cambs). Training delivered by CPFT (free of charge) – understanding and responding to self-harm.
Recommendation 2.3 Promote early interventions to aid prevention of mental health problems that could lead to suicide	Prevention interventions to promote good mental health and avoid decline towards suicidal tendencies. • Promote 'Keep Your Head' website for CYP to raise awareness and promote early interventions and signpost to support	Ongoing and continuing work on 'Keep Your Head' CYP Autumn 2017 – development of 'Keep	Consider survey of service users and the public to assess awareness of prevention resources.	Suicide Prevention implement ation group to lead -	-Broader range of information provided through counselling services (advice). -In 17/18 there will be debt management (preventative)

	• Develop 'Keep Your Head' adult website to raise awareness of sources of help, for example, debt management, relationship counselling, housing organisations parent/children centres • Training and Information to health professionals including GPs and health visitors to promote resources and advice services • Engage with service users and public to understand gaps in service provision and focus efforts on improving the system to support individuals where appropriate Consider the potential to provide a tangible presence of a mental health drop-in facility in Peterborough city centre	Your Head' adult mental heal website Debt and money management services to be developed from Sept 2017 Ongoing preventative work in schools			work funded with care leavers as well as those with mental illnesses in Cambridgeshire. -Preventative work in schools includes training to improve understanding of Mental Health in teaching/pastoral staff. Aiding identification of those who need support. Drop in services for young people in Huntingdon and Peterborough and Cambridge as part of Centre 33 and local authority partnerships. Delivering broad support as well as counselling.
Recommendation 2.4 **Promote training in mental health awareness, particularly with professional groups such as GPs to recognise mental health issues and risk of suicide**	See recommendation 1.1 as this is a subset of 'suicide prevention training' Training for GPs to include awareness around risk assessment for mental health issues by assessing patient histories, particularly around a past history of self-harm	Training for professionals including GPs is ongoing	Number of people trained in Mental Health Awareness and suicide prevention	CPSL MIND and CCC	-ASIST training and Stop Suicide workshop training delivered to a range of professionals (delivered by Mind). Also Children's Mental Health training delivered to a range of professionals, delivered by CPFT. GP training funded through STP with support from CCC
Priority 3 – Reduce access to the means of suicide					
Recommendation 3.1 **– In line with**	• CPFT audit of ligature points and other suicide risks in inpatient settings and	This is ongoing - on a yearly basis	Audit of potential ligature points is	CPFT lead for	

regulations, ensure the removal of potential ligature points – particularly in places of custody and in-patient settings	residential care settings in line with regulations • Audit of ligature points in places of custody • Share information on identifying potential ligature points between agencies (CPFT, Coroners, Police and Prisons)		conducted annually in inpatient wards and places of custody Potential ligature points removed or made safe	inpatient audit Police lead for audit of police custody suites NHS England lead for audit in prisons	
Recommendation 3.2 – Reduce the risk of suicide by jumping from high buildings accessible by the public including multi-storey car-parks	• Support training provided by Samaritans to identify risk of suicide in people on high buildings • Work with coroners to continue to lobby car park owners where there is still a risk of suicide to erect barriers as a mechanism to restrict the means to suicide • Assess information designed to offer help to those at risk to prevent suicide - posters displayed in car parks and shopping centres to aid self-help (to Samaritans for example)	Ongoing work following the success of barriers at Queensgate shopping centre in Peterborough. Advocate for construction of barriers at remaining car parks where there is a risk of suicide	Achieve zero suicides at car parks in Cambridge and Peterborough Barriers to be erected at multi-storey car parks with suicide risk	Joint suicide prevention Implementation group to lead.	Barriers erected at Queensgate shopping centre in Peterborough following discussions and lobbying by the suicide prevention implementation group, including the coroner. No suicides reported from Peterborough car parks since the work began to construct barriers
Recommendation 3.3 – Reduce the risk of suicide on railway lines in Cambridgeshire and Peterborough	• Support the national railway Suicide Prevention plan and initiatives by British Transport Police to reduce suicides on railways • Use the annual suicide audit to assess whether there are any 'black spots' for suicide on railway lines locally. An assessment of any requirements for physical barriers should be made at any location with heightened risk of suicide.	Ongoing work	Training of rail staff in suicide prevention Posters available to aid self-help in railway locations Achieve zero suicides on railway lines	Joint suicide prevention Implement ation group to lead. Link with British Transport Police	-A range of work is being undertaken nationally as part of the railway Suicide Prevention plan – Samaritans, Network Rail and British Transport Police. -Samaritans/Network Rail campaign on the railway including printed messages

	• Continue to promote STOP suicide at local railway stations				on tickets and posters at stations. -Some local stations are also displaying Stop Suicide resources. -Staff training has been provided to railway employees to look out for and offer support to people who may be considering taking their own life on the railway (provided by Network Rail nationally). -Rail505 app – enables other passengers/anybody to report someone they are worried about or to seek help themselves on the railway. https://www.rail505.com/
Recommendation 3.4 – Work with Medicines Management team at the CCG to ensure safe prescribing of some toxic drugs	• Continue to make contact with the CCG medicines management team chief pharmacist to ensure quality standards on safe prescribing. Further consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available. (Hawton et al 2010) • Promotion of suicide prevention through pharmacies and with pharmacists is recommended to raise awareness of suicide risk due to some forms of prescription medication.	Update on an annual basis to the Suicide prevention implementation group	Prescribing data to reflect safe prescribing guidance	Suicide Prevention Implementation Group to liaise with Chief pharmacist at the CCG	-Following Child Death Overview Panel reports there was a communication to GPs regarding safe prescribing to young people, this was also re-circulated.

Recommendation 3.5 - Whenever possible, medical professionals should be reinforcing safety plans for individuals with mental health problems	Education and training for health professionals including General Practice staff on use of personal safety plans for patients with mental health problems. This includes plans for those who have never been in secondary care services – see section 1.1 – GP training	Ongoing through training of professional staff and GP training in suicide prevention	Number of GPs trained Consider an audit of safety plans	CPFT and CPSL MIND	Some training of GPs and mental health specialists through the training offered by CPSL MIND and CPFT
Priority 4 – Provide better information and support to those bereaved or affected by suicide					
Recommendation 4.1 - Ensure bereavement information and access to support is available to those bereaved by suicide	Ensure availability of 'Help is at hand booklet 'for those bereaved as a result of suicide (GP surgeries, coroners offices, police and funeral directors). Create and disseminate a local bereavement support leaflet to signpost people to services and self-help support information. Develop and implement a bereavement support service for people affected by suicide. Link this to existing groups such as CRUSE bereavement services Facilitate the formation of Survivors of Bereavement due to Suicide (SOBS) groups in Cambridge and Peterborough – run by people with experience of bereavement due to suicide. Link with other East of England suicide prevention groups to develop a self-help networks for people bereaved by suicide.	Ongoing work to disseminate 'Help is at Hand' leaflet Funding approved through STP to create a bereavement support service for people affected by suicide. This should be available towards the end of 2017 SOBS groups to be set up from the end of 2017	Help is at hand leaflets are available to police, coroners, funeral directors and GP practices Establishment SOBS groups and numbers attending meetings Bereavement support service in place. Number of contacts made. Evaluation survey	Joint suicide prevention Implementation group to lead CPSL MIND and Lifecraft to lead bereavement support service implementation	Help is at hand booklet shared with Coroners Office. Feb15. Electronically shared with Funeral directors. Information circulated via the GP bulletin in 2015 and 2017. Help is at Hand booklets circulated to all GP practices in Cambridgeshire and Peterborough with instructions on how to re-order them. Focus in 2017 will be establishing a bereavement support pathway post-suicide. Bereavement support resources are promoted

					via the Stop Suicide Pledge website and Keep Your Head website. These resources include specific sites for young people who are bereaved.
Priority 5 - Support the media in delivering sensitive approaches to suicide and suicidal behavior					
Recommendation 5.1 –Encourage appropriate and sensitive reporting of suicide	Continue to liaise with local media to encourage reference to and use of guidelines for the reporting of suicide. Ensure the involvement of Comms teams in LAs and CCG.	Ongoing work initiated in 2014. Ad hoc contact with local media	Sensitive and responsible reporting of suicide by local media based on Samaritans guidelines	Joint suicide prevention Implementation group	Liz Robin has liaised with Editor of Cambridge News, looking at how engage other local papers with the comms team. Two visits were made to Radio Cambridgeshire to promote the responsible reporting of suicides and to ensure that discussions around Peterborough car park suicides were handled sensitively. Guidelines on suicide reporting were provided to the editor.
Priority 6 - Support research, data collection and monitoring					
Recommendation 6.1 Collect detailed suicide data on a quarterly basis from	Form sub-group to ensure data collection and audit. Quarterly collection of data.	On-going quarterly collection of data and full audit on a yearly basis	Public Health Indicator 4.10 – Baseline period = 2009-2011	Joint suicide prevention Implementation group to lead	Suicide Audit undertaken for 2014 and 2015 with case files reviewed for all those

Cambridgeshire and Peterborough coroners and carry out an annual audit of local suicides	Audit on a yearly basis to report changes to suicide numbers, methods, demographics, risk factors. Report on suicide rates in relation to public health outcome: 'Reduce the rate of suicide in the population' Encourage data gathering and consent to collect and share data – self harm in A&E Departments. Audit of self-harm data if available to identify those at risk As part of the zero suicide ambition – consider reviewing a sample of suicide case files on a quarterly basis to create a culture of learning		Achieve 10% reduction in suicide rate by 2020 Suicide statistics on three year rolling basis	Sub-group Public health data analysts to lead Coroners to supply data	available in 2015. This audit has shaped targeting of local work. The audit will be undertaken annually, although the detailed case review will be of a sample of files. Work has been carried out together with the Coroner's Office to improve the standardised regular information received on deaths throughout the year. The quality of the information received has improved. Data is now received from BTP through an annual report and a warning system (national system). A local real-time surveillance system has been established – This shares information from Police/Coroner to Public health on suspected suicides as they occur.

Recommendation 6.2 Disseminate current evidence on suicide prevention to all partner organisations	Ensure membership of implementation groups by all partners with correspondence list kept up to date for sharing resources Agenda item for suicide prevention implementation group	On-going sharing of information with partner organisations	Implementation group meeting minutes and email records	Public health to lead, collate and ensure dissemination of evidence	Relevant national publications and evidence is circulated via group distribution list.
Recommendation 6.3 Coroners should notify the Suicide Prevention Strategic Group about inquest evidence that suggests patterns and suicide trends and evidence for service development to prevent future suicides	Ongoing updates to the suicide prevention strategic group by the coroners as required	Ongoing	Data is sent on a quarterly basis to public health lead analyst in Cambridgeshire	Coroners to lead – liaising with the Suicide Prevention Strategic Group	The Coroner flags any notable patterns with the group or public health. The 'real time' surveillance system will also help with this in terms of geographic/temporal patterns.
Recommendation 6.4 Evaluate and report on the suicide prevention implementation plan	Evaluation methods created for each area of suicide prevention as listed in the recommendations above. Evaluation of suicide audit data – changes to suicide methods or risk of suicide. Changes to rates of suicide	Report to Health Committee and HWB as requested	Collation and analysis of any evaluation and survey data Analysis of suicide audit data Evaluation and outcomes from all recommendations listed above	Public Health to lead	See columns above

* When referring to 'children and young people', the definition from the emotional wellbeing and mental health of children strategy is used; "all children and young people and their families in Cambridgeshire and Peterborough, from conception to their 18th birthday or their 25th year if disabled or have complex needs".

This is a live action plan that was last updated on 8th August 2017.

- The Cambridgeshire and Peterborough Clinical Commissioning Group 5 year Mental Health Strategy, which will be developed in 2014/15

Agenda Item No: 10

AIR QUALITY IN CAMBRIDGESHIRE: UPDATE

To:	**Health Committee**
Meeting Date:	**7 September 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**To update the Health Committee on the measures to address current concerns regarding air quality in Cambridgeshire following the Health Committee recommendations agreed at the 16th March meeting**
Recommendation:	**The Health Committee is asked to**

a) note and comment on progress since the meeting of the 16th March

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

1.1 A report on the current air quality issues in Cambridgeshire, local opportunities/ initiatives to improve air quality and the National Institute for Clinical Excellence (NICE) Draft National guidance was presented to the Health committee on 16 March 2017. The Committee recommended that the Director of Public Health draw this report to the attention of the Leader and Chief Executive of the Council and to the Chairmen/women of and Spokes for its Policy and Service Committees with a recommendation that the committees consider the potential impact on air quality as part of their decision-making process. In addition she was asked to draw this report to the attention of the Chairmen/women and Chief Executives of the Greater Cambridge City Deal, the Cambridgeshire & Peterborough Combined Authority, Cambridgeshire's district councils and Cambridge City Council with a recommendation that they consider the potential impact on air quality as part of their decision-making process and for those named above to actively bring forward projects which will improve air quality.

1.2 This report highlights the progress to date on achieving the actions above and suggests areas for further development.

2. MAIN ISSUES

2.1 Following the committee recommendation the Director of Public Health wrote to the bodies mentioned in paragraph 1.1 above. The report was well received with requests from the following bodies and organisations for further support and/or to present the main findings to their respective organisations:

- Huntingdonshire District Council Overview and Scrutiny Panel (Communities and Environment).
- The local villages' Joint Heavy Commercial Vehicles Group in East Cambridgeshire.
- The Combined Authority with respect to Market Town master planning.

2.3 The public health department is working actively with Cambridge City Council and is part of its air quality action plan steering group, and is working with the Mayor's office on the "blueprint" for St. Neots.

2.4 At the request of Cambridge City Council a joint letter from the Director of Public Health and the Strategic Director of Cambridge City Council was sent to all schools within the city asking the headteacher/principal to disseminate the message to students and parents about the importance of switching off their engines at drop off and pick up times.

2.5 District Council Duties – Annual Air Quality Status Reports and Air Quality Action Plans:
As stated in the previous report the Environment Act 1995 provides that every local authority is required to submit an Annual Status Report each year, it is also recommended that all local authorities should consider drawing up an Air Quality Strategy.

2.6 The Department for Environment, Food and Rural Affairs (DEFRA) expects the highest level of support from local authorities (for example, Chief Executive and Council level) to

ensure that all parts of a local authority are working effectively together, and that the public can be given further confidence that the work being taken forward to tackle air quality is supported at the highest level. Although not statutory, it is recommended by national guidance that Action Plans and annual reports should be signed off by Chief Executive and heads of the main departments including the Director of Public Health.

2.7 For this year's reports (covering 2016-2017) the Director of Public Health has "signed off" the Annual Status Reports for Cambridge City and South Cambridgeshire District Council only, so there is further work to be done to engage all the district Councils within Cambridgeshire on the importance of addressing poor air quality.

2.8.1 Since the previous discussion in March the Government has published:

A) A new UK plan for tackling roadside nitrogen dioxide concentrations[1]. This places the emphasis on local authorities in tackling poor air quality including, exploring new technologies in order to reduce emissions in a way that best meets the needs of their communities and local businesses; changing road layouts at congestion and air pollution pinch points; encouraging public and private uptake of Ultra Low Emission Vehicles; using innovative retrofitting technologies and new fuels; and, encouraging the use of public transport. If these measures are not sufficient, local plans could also include access restrictions on vehicles, such as charging zones or measures to prevent certain vehicles using particular roads at particular times.

B) The final Air Quality NICE guidance (which was at draft stage when it was last brought to the attention of the committee). The main recommendations cover the following areas:
- Planning,
- Development management,
- Clean air zones,
- Reducing emissions from public sector transport services and vehicle fleets,
- Smooth driving and speed reduction,
- Walking and cycling,
- Awareness raising.

2.9 A Consultant in Public Health, appointed to Peterborough City Council, and working across Cambridgeshire and Peterborough as part of the joint public health team, will have lead responsibility for strategic public health input to planning, transport and health inequalities, including the impact of transport on air quality, and will be working with districts. Furthermore, the post will be co-located with the Combined Authority one day per week which will provide the opportunity to inform and advise on health impact of policies and options which may affect issues such as air quality.

[1] https://www.gov.uk/government/publications/air-quality-plan-for-nitrogen-dioxide-no2-in-uk-2017

3. 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

It has been estimated that over 5% of Cambridgeshire's population mortality is attributed to air pollution, equivalent to 257 deaths attributable to air pollution in Cambridgeshire in 2010. Air pollution also impacts respiratory and cardiovascular hospital admissions and incidence of respiratory disease.

3.3 Supporting and protecting vulnerable people

In England, the most deprived wards experience the highest levels of air pollution and there is a high proportion of children living in these areas. It is worth noting that some new developments in Cambridgeshire are sited near to poor air quality areas.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications

There are no significant implications within this category.

4.4 Equality and Diversity Implications

There are no significant implications within this category.

4.5 Engagement and Communications Implications

There are no significant implications within this category.

4.6 Localism and Local Member Involvement

There are no significant implications within this category.

4.7 Public Health Implications

See main body of the report.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes 16 Aug 17 Name of Financial Officer: Clare Andrews

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes 22 Aug 17 Name of Officer: Paul White
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes 16 Aug 17 Name of Legal Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes 18 Aug 17 Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes 22 Aug 17 Name of Officer: Joanne Dickson
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes 18 Aug 17 Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes 18 Aug 17 Name of Officer: Liz Robin

Source Documents	Location
Health Committee Paper 16 March 2017 - AIR QUALITY IN CAMBRIDGESHIRE – IMPLICATIONS FOR POPULATION HEALTH, and associated Minutes	Web Link to Committee Paper Web link to minutes
UK plan for tackling roadside nitrogen dioxide concentrations	https://www.gov.uk/government/publications/air-quality-plan-for-nitrogen-dioxide-no2-in-uk-2017

Agenda Item No: 11

PUBLIC HEALTH RISK REGISTER UPDATE

To: **Health Committee**

Date: **7 September 2017**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: **Not applicable** *Key decision:* **No**

Purpose: **To provide the Health Committee with details of Public Health Directorate risks.**

Recommendation: **It is recommended that the Health Committee:**

(a) Notes the position in respect of Public Health Directorate risk

(b) The Committee is asked to comment on the Public Health Risk Register and endorse the amendments since the previous update.

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1. BACKGROUND

1.1 In accordance with best practice the Council operates a risk management approach at corporate and directorate levels across the Council seeking to identify any key risks which might prevent the Council's priorities, as stated in the Business Plan and in service plans, from being successfully achieved.

1.2 The Council's approach to the management of risks is encapsulated in 2 key documents:

- Risk Management Policy (Appendix 1)

  This document sets out the Council's Policy on the management of risk, including the Council's approach to the level of risk it is prepared to countenance as expressed as a maximum risk appetite. The Risk Management Policy is owned by the General Purposes Committee.

- Risk Management Procedures

  This document details the procedures through which the Council will identify, assess, monitor and report key risks. Risk Management Procedures are owned by Strategic Management Team (SMT).

1.3 The respective roles of the General Purposes Committee and the Audit and Accounts Committee in the management of corporate risk are:

- The General Purposes Committee has an executive role in the management of risk across the Council in its role of ensuring the delivery of priorities

- The Audit and Accounts Committee provides independent assurance of the adequacy of the Council's risk management framework and the associated control environment.

1.4 Service committees also have a role, on a half yearly basis, in the management of service risk of:

- ensuring service risk registers are maintained on a timely basis, i.e. subject to quarterly review by service management
- ensuring that actions designed to better manage risk are implemented on a timely basis
- to discuss specific risk issues as appropriate

1.5 Risk Identification

The Council's approach to risk identification, which is, in some ways, the most difficult part of the risk management process, is described in the following extract from the Council's Risk Management Policy as previously approved by the General Purposes Committee:

- Risk management should operate within a culture of transparency and openness where risk identification is encouraged and risks are escalated where necessary to the level of management best placed to manage them effectively;

- Risk management should be embedded in everyday business processes;

- Officers of the Council should be aware of, and operate, the Council's risk management approach where appropriate;

- Councillors should be aware of the Council's risk management approach and of the need for the decision making process to be informed by robust risk assessment, with General Purposes Committee members being involved in the identification of risk on an annual basis;

1.6 There are 2 distinct elements to risk scoring:

- The probability of a risk event occurring.
- The impact on the Council if the risk does occur

These are represented on a scoring matrix as attached at Appendix 2. In order to assist managers in the scoring of impact risk and to ensure consistency across the Council, a set of impact descriptors has been designed across five impact types which can be viewed at the second page of Appendix 2. The scoring of probability is left to the discretion of risk owners based upon their experience.

1.7 This report is supported by:

- Risk Management Policy **(Appendix 1)**
- Risk Scoring Matrix **(Appendix 2)**
- The Public Health Risk Register (**Appendix 3**)

2. PUBLIC HEALTH DIRECTORATE RISK REGISTER

2.1 The Public Health Directorate operates risk management in accordance with the Council's Risk Management Procedures document whereby risks are reviewed at Directorate and service team level on a quarterly basis. It should be noted that there are some specific aspects to the way the Public Health Directorate scores its risks compared to the remainder of the Council, as some risks to the health of the public are included for which the Directorate has a monitoring and influencing role, as well as those where the County Council directly commissions or delivers services.

2.2 The Directorate's Corporate Risk Group member co-ordinates risk management across the Directorate liaising with representatives from services and teams to ensure this approach functions effectively.

2.3 Risk registers are maintained at each level of the Directorate as appropriate, in accordance with the requirement of the Procedures document to manage risk at the lowest appropriate level. Risks are identified on the basis that if the risks were to occur they would severely impact on the Directorate's ability to meet its defined objectives. The key stages of the detailed risk management process once a risk is identified are:

- possible causes of the risk are recorded. This stage helps to identify the mitigations required to manage the risk effectively.
- impacts on the Council if the risk was to occur are recorded. This highlights the significance of the risk and aids its scoring.
- mitigations in place are identified and the risk is scored
- management review the risk score to determine if that level of risk is appropriate having regard to the Council's defined risk appetite of a maximum risk score of 15.
- if the level of risk is deemed to be inappropriate, management will determine actions which when implemented will move the risk level to an appropriate level. Each action will be assigned an owner and a target date for delivery. This will be reviewed on regular basis as part of the quarterly review of risk registers.
- as actions are implemented, management will update the residual risk score as appropriate.

2.4 Following the review of Public Health Directorate risks by the Quality, Safety and Risk Group on 11 July 2017, the Directorate Management Team (DMT) is confident that the Public Health Risk Register is a comprehensive expression of the main risks faced by the Directorate and that mitigation is either in place, or in the process of being developed, to ensure that each risk is appropriately managed.

2.5 The Public Health Directorate Risk Register to July 2017 is presented at Appendix 3 and illustrates that there are 17 current Directorate risks. There are no new Public Health risks. The Residual Risk Scores for these risks are: 16 amber, 1 green and 0 red.

- ***GRACE Risk Management System*** does not provide a download of the individual action updates, other than that there are actions in place.

3. ALIGNMENT WITH PRIORITIES AND WAYS OF WORKING

3.1 Risk management seeks to identify and to manage any risks which might prevent the Council from achieving its three priorities of:

- Developing the local economy for the benefit of all
- Helping people live healthy and independent lives in their communities
- Supporting and protecting vulnerable people when they need it most

4. SIGNIFICANT IMPLICATIONS

4.1 Resource and Performance Implications

Effective risk management should ensure that the Council is aware of the risks which might prevent it from managing its finances and performance to a high standard. The Council is then able to ensure effective mitigation is in place to manage these risks.

4.2 Statutory, Risk and Legal Implications

The Risk Management process seeks to identify any significant risks which might prevent the Council from achieving its plans as detailed in the Council's Business Plan or from complying with legislative or regulatory requirements. This enables mitigation to be designed to control each risk, either to prevent the risk happening in the first place or if it does to minimise its impact on the Council.

4.3 Equality and Diversity Implications

The risk associated with failure to address health inequalities is described in para 2.5.

4.4 Engagement and Consultation

The Corporate Risk Register has been subject to review by the Officer Risk Champions Group and Strategic Management Team

4.5 Public Health

This paper describes risks associated with the Council's public health functions.

Source Documents	Location
Corporate Risk Register	Internal Audit and Risk Management

APPENDIX 1

CAMBRIDGESHIRE COUNTY COUNCIL

RISK MANAGEMENT POLICY

1. INTRODUCTION

We want Cambridgeshire to be the best county in England in which to live and work. We aim to deliver this vision by focusing on our priorities:

- develop the local economy for the benefit of all
- help people live healthy and independent lives
- support and protect vulnerable people

We are a large, complex organisation and we need to ensure the way we act, plan and deliver is carefully thought through both on an individual and a corporate basis.

We have a plan for achieving this vision and, as an organisation; we need to make sure we are ready for the challenge.

There are many factors which might prevent the Council achieving its plans, therefore we seek to use a risk management approach in all of our key business processes with the aim of identifying, assessing and managing any key risks we might face. This approach is a fundamental element of the Council's Code of Corporate Governance.

The Risk Management Policy is fully supported by the Council, the Chief Executive and the Strategic Management Team, who are accountable for the effective management of risk within the Council. On a daily basis all officers of the Council have a responsibility to recognise and manage risk in accordance with this Policy.

The Accounts and Audit Regulations, 2003 state:

- The relevant body shall be responsible for ensuring that the financial management of the body is adequate and effective and that the body has a sound system of internal control which facilitates the effective exercise of that body's functions and which includes arrangements for the management of risk.

(Additionally, the Civil Contingencies Act, 2004 places a statutory duty on local authorities to establish business continuity management arrangements to ensure that they can continue to deliver business critical services if business disruption occurs. The Emergency Planning Camweb site http://camweb/cd/cst/demmembserv/cemt/bcp/default.htm details the Council's approach to business continuity management which is a key aspect of effective risk management)

2. WHAT IS RISK?

The Council's definition of risk is:

"Factors, events and circumstances that may prevent or detract from the achievement of the Council's corporate and service plan priorities".

3. RISK MANAGEMENT OBJECTIVE

The Council will operate an effective system of risk management which will seek to ensure that risks which might prevent the Council achieving its plans are identified and managed on a timely basis in a proportionate manner.

4. RISK MANAGEMENT PRINCIPLES

- The risk management process should be consistent across the Council, clear and straightforward and result in timely information that helps informed decision making;

- Risk management should operate within a culture of transparency and openness where risk identification is encouraged and risks are escalated where necessary to the level of management best placed to manage them effectively;

- Risk management arrangements should be dynamic, flexible and responsive to changes in the risk environment;

- The response to risk should be mindful of risk level and the relationship between the cost of risk reduction and the benefit accruing, i.e. the concept of proportionality;

- Risk management should be embedded in everyday business processes;

- Officers of the Council should be aware of, and operate, the Council's risk management approach where appropriate;

- Councillors should be aware of the Council's risk management approach and of the need for the decision making process to be informed by robust risk assessment, with General Purpose Committee members being involved in the identification of risk on an annual basis;

5. APPETITE FOR RISK

As an organisation with limited resources it is inappropriate for the Council to seek to mitigate all of the risk it faces. The Council therefore aims to manage risk in a manner which is proportionate to the risk faced based on the experience and expertise of its senior managers. However, the General Purpose Committee has defined the maximum level of residual risk which it is prepared to accept as a maximum risk score of 15 as per the Scoring Matrix attached at Appendix A.

6. BENEFITS OF RISK MANAGEMENT

- Risk management alerts councillors and officers to the key risks which might prevent the achievement of the Council's plans, in order that timely mitigation can be developed either to prevent the risks occurring or to manage them effectively if they do occur.

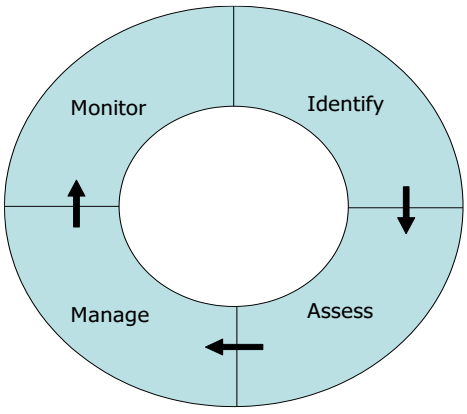
- Risk management at the point of decision making should ensure that councillors and officers are fully aware of any key risk issues associated with proposals being considered.

- Risk management leads to greater risk awareness and an improved and cost effective control environment, which should mean fewer incidents and other control failures and better service outcomes.

- Risk management provides assurance to councillors and officers on the adequacy of arrangements for the conduct of business. It demonstrates openness and accountability to various regulatory bodies and stakeholders more widely.

7. RISK MANAGEMENT APPROACH

The risk management approach adopted by the Council is based on identifying, assessing, managing and monitoring risks at all levels across the Council:



The detailed stages of the Council's risk management approach are recorded in the Risk Management Procedure document which is reviewed by Strategic Management Team on an annual basis. The Procedure document provides managers with detailed guidance on the application of the risk management process.

The Risk Management Procedures document can be located on Camweb at

Additionally individual business processes, such as decision making, council planning and project management will include guidance on the management of risk within those processes.

8. AWARENESS AND DEVELOPMENT

The Council recognises that the effectiveness of its risk management approach will be dependent upon the degree of knowledge of the approach and its application by officers and councillors.

The Council is committed to ensuring that all councillors, officers and partners where appropriate, have sufficient knowledge of the Council's risk management approach to fulfil their responsibilities for managing risk. This will be delivered through formal training programmes, risk workshops, briefings and internal communication channels.

9. CONCLUSION

The Council will face risks to the achievement of its plans. Compliance with the risk management approach detailed in this Policy should ensure that the key risks faced are recognised and effective measures are taken to manage them in accordance with the defined risk appetite.

APPENDIX 2

RISK SCORING MATRIX

VERY HIGH (V)	5	10	15	20	25
HIGH (H)	4	8	12	16	20
MEDIUM (M)	3	6	9	12	15
LOW (L)	2	4	6	8	10
NEGLIGIBLE	1	2	3	4	5
IMPACT / LIKELIHOOD	**VERY RARE**	**UNLIKELY**	**POSSIBLE**	**LIKELY**	**VERY LIKELY**

Red scores - excess of Council's risk appetite – action needed to redress, quarterly monitoring
Amber scores – likely to cause the Council some difficulties – quarterly monitoring
Green scores – monitor as necessary

Descriptors to assist in the scoring of risk impact are on the following page.

Likelihood scores are left to the discretion of managers as it is very subjective.

IMPACT DESCRIPTORS

The following descriptors are designed to assist the scoring of the impact of a risk:

	Negligible (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Legal and Regulatory	Minor civil litigation or regulatory criticism	Minor regulatory enforcement	Major civil litigation and/or local public enquiry	Major civil litigation setting precedent and/or national public enquiry	Section 151 or government intervention or criminal charges
Financial	<£0.5m	<£1m	<£5m	<£10m	>£10m
Service provision	Insignificant disruption to service delivery	Minor disruption to service delivery	Moderate direct effect on service delivery	Major disruption to service delivery	Critical long term disruption to service delivery
People and Safeguarding	No injuries	Low level of minor injuries	Significant level of minor injuries of employees and/or instances of mistreatment or abuse of individuals for whom the Council has a responsibility	Serious injury of an employee and/or serious mistreatment or abuse of an individual for whom the Council has a responsibility	Death of an employee or individual for whom the Council has a responsibility or serious mistreatment or abuse resulting in criminal charges
Reputation	No reputational impact	Minimal negative local media reporting	Significant negative front page reports/editorial comment in the local media	Sustained negative coverage in local media or negative reporting in the national media	Significant and sustained local opposition to the Council's policies

CCC Public Health : July 2017

Risk	Control Description	Residual Risk Level	Action Plan Description	Action Plan Owner	Review Date
1. Budget significantly over/under spent	Health Committee Oversight Business Planning Process Monthly Finance Meetings Shared Priorities/MOU Steering Group SMT	4			14/11/2017
2. Disruption to business of Public Health Directorate	Public Health Business Continuity Plan	9			14/11/2017
3. Excess pressure on staff due to mis-match of workload and capacity	1. HR policies and processes 2. Directorate Management Team 3. Work Plan 4. Line Management 5. Monitoring of work for HPHAS and Peterborough	12	2. Revise monthly monitoring 3. Focus of quarterly work plan reviews on staff workload/capacity match 4. Maintain work plan for 2017/18 5. Recruit to vacancies and ensure 'Acting Up' arrangements in place or interim support	Liz Robin Liz Robin Tess Campbell Liz Robin	14/11/2017
4 (6). The Council has assurance that Health Protection Systems to control communicable diseases and environmental hazards, function effectively across all responsible organisations	1. Written reports from relevant organisations to the Health Protection Steering Group 2. Engagement of Local Authority Public health leads in incident Management Teams (IMT) for health protection incidents 3. TB: Assurance role through Health Protection Steering Group and TB Commissioning Group 4. Continuation of TB Network (led by PHE) and TB cohort reviews to team from cases and better understand the challenges 5. Implementation of 2015 National TB Strategy with establishment of east of England TB Control Board	8	6. TB network reviewed, revised ToRs, membership updated and attendance improved for network meetings and cohort reviews. Good attendance and engagement in this work. 7. Launch of collaborative TB strategy in Jan 2015. TB Control Board (East of England) established and CP network represented on Board by CCG. LTBI screening very successful, mainly in Peterborough due to higher prevalence 8. Development of commissioning plan for TB with a focus on specialist nursing staff and on discharge plan 9.MOU to 2020 issued in 2016 - some signed MOU's still awaited. Some confusion caused by the development of the PHE MOU.	Linda Sheridan Linda Sheridan Linda Sheridan	14/11/2017
5(8). A lack of Compliance and appropriate data protection and information governance legislation and good practice	1. Annual compliance with HSCIC information governance tools 2. Contract management and monitoring	8	2. Introduce more documentation and process into the Tool Kit, ie following up on actions, once NHS Digital release new toolkit 3. We still await the 2016/17 IG Toolkit score from NHS Digital - delays due to NHS Digital being 'busy' 4. Planning for 2017/18 IG Toolkit to begin in late summer/autumn once new NHS Digital Toolkit released CCC to make a decision as to whether it also submits a tool kit for 2017/18, however this is an action for Corporate IG 9. Run a session at a Public Health Away Day to raise understanding of the requirements of the tool kit, key terms and requirements in year (once new toolkit is produced by NHS Digital)	David Lea David Lea David Lea	14/11/2017
6 (9). Public Health Services will not meet quality safety and risk standards	1. Quarterly meetings of QS&R Group 2. Quality measure in contracts 3. Contract monitoring meetings 4. Internal Policies including Safeguarding 5. Support from CCG on clinical governance health information issues	8	1. Ensure all aspects of our commissioning are managed smoothly through the Joint Commissioning Unit and Children's JCU	Liz Robin	14/11/2017

Risk	Control Description	Residual Risk Level	Action Plan Description	Action Plan Owner	Review Date
7 (10). Child Health Information System (CHIS)	1. NHS England/PHE screening and immunisations Team 2. Cambridgeshire and Peterborough immunisations network provide progress reports	12	1. Follow up through screening and immunisations teams *Note: CHIS has now been re-commissioned and new provider in place* 2. Monitor situation as new provider takes over	Linda Sheridan Linda Sheridan	14/11/2017
8 (11). Health inequalities that can be addressed by the Health & Wellbeing Board and Public Health services do not reduce	1. J Strategic Needs Assessment (JSNA) 2. Health and Wellbeing Strategy and Action Plan (HWB) 3. Local Health Partnership Action Plans 4. Annual Public Health Report 5. Targeted Public Health Programmes 6. Shared priorities work 7. Business Plan Tragets and Inequalities Indicators 8. Traveller Strategic Co-ordination Group	8	1. Ensure 'improving the health of the poorest fastest' principle in Health & Wellbeing Board (HWB) Strategy and Action Plan continues to receive high level of focus 2. Ensure monitoring and reporting of inequalities including through routine performance monitoring in F&PR land annual DPH 3 Monitoring of PH outcomes framework 7 Ensure feedback on traveller health through the CCC Traveller Health Team, and ensure feedback to Public Health DMT on traveller health	Liz Robin Liz Robin Liz Robin Kate Parker	14/11/2017
9 (4). Performance targets for School Nursing and Health Visiting as set out in the 2016/17 business plan not met	1. Robust Service Planning in place, establishing and functioning 2. Performance monitoring, established and functioning and feedback incorporated into the F&PR process 3. Routine monitoring of delivery to identify and required interventions	12	3. Review of targets for 2017/18. 3. Having low staffing levels in school nursing and health visiting, regular monitoring meetings to be held with provider	Raj Lakshman Raj Lakshman	14/11/2017
10 (13). Childhood Immunisation Targets - Rates of immunisations, below national average with potential risk to public health of children	1. NHS England leading task and finish group has reported - group continues to oversee implementation of regulations 2. Assurance role through Health Protection Steering Group 3. Annual Health Protection Report to Health Committee CHIS Services are currently being re-commissioned	10	2. Support to local initiatives - eg through LA Public Health team and LA Childrens centres. NHS has worked with practices o data and on access to clinics - more open clinics 3. Ongoing close monitoring and public communication of local imms rates through appropriate channels 4. Implementation of recommendations of immunisation task and finish group 5. Continued oversight of the BCG vaccination programme through the Health Protection Steering Group 6. Improve flu vaccination uptake funded by CCC. Project successful. Detailed data analysis being carried out but 15% increase in uptake in target group of Pregnant Women	Linda Sheridan Linda Sheridan Linda Sheridan Linda Sheridan	14/11/2017
11 (16). Impact of removal of On-Call Rota	2. LHRP 3. ADsPH	8	3. On-going discussions with PHE. New rota in place for over a year with no evidence of adverse consequences, but some concerns about de-skilling generic PH consultants who may be needed in the event of any major outbreak such as flu pandemic	Linda Sheridan	14/11/2017
12 (17). Awareness of legislation, training and legal requirements	1 Mandatory training on Information Governance 2. Access to legal advice from LGSS 3. Legal checks on Committee Papers (significant implications)	8	1 Public Health session on the law	Liz Robin	14/11/2017
	1. Plans to be reviewed through LHRP and LRF health and social care working group 2. Health Protection Steering Group (HPSG) to have oversight of plan development especially plans for Public Health incidents		4. Tested pandemic plan in exercise Corvus. Implementing identified actions, with some actions awaiting clarification from the centre. 5. Fuel plan has been developed but awaiting clarification from revised national plan which has just been issued (13/3/2017)	Linda Sheridan Linda Sheridan	

Risk	Control Description	Residual Risk Level	Action Plan Description	Action Plan Owner	Review Date
13 (18). Multi Agency Emergency plans require updating - plans for emergencies need to take account of ongoing organisational changes in the health sector		**8**	6. Protocol for identifying vulnerable people has been completed and now needs to be tested. IG issues raised being addressed and staff training planned 7. Ongoing discussions with PHE planned. PHE due to release revised STAC plan - LS has attended PHE STAC training (23/11/16) 9. CBRN Plan 10. Hospital Evacuation Plan	Linda Sheridan Linda Sheridan Linda Sheridan Linda Sheridan	14/11/2017
14 (22). Cancer Screening	1. Regular writing reporting to Health Protection Steering Group by NHS England 2. Task and finish group 3. Key Stakeholder working	**12**	1. Task and finish group have reviewed data and are now working on implementing recommendations for improvement 2. Training has been provided to frontline staff to improve their knowledge and understanding, in order to enable communication on the benefits of screening	Linda Sheridan Linda Sheridan	14/11/2017
15 (31). Partner organisations do not work together effectively to deliver health outcomes	1. Health and Wellbeing Board 2. Public Health Reference Group 3. Healthcare Public Health Advice Service 4. Health Protection Steering Group 5. Health and Care Executive 6. Local Health Partnership	**8**	1. Maintain support to existing partnership arrangements 2. Ensure that any forthcoming review of partnerships maintains sufficient key controls for public health functions 3. New Place Based Partnerships to be explored.	Liz Robin Liz Robin Liz Robin	14/11/2017
16 (29). Transformation not delivered/or key aspects of the business not maintained	1. CCC SMT 2. PH DMT 3. Business Planning co-ordination steering group	**8**	1. Programme planning for public health transformation	Liz Robin	14/11/2017
17 (32). Legal or public challenge to Health & Wellbeing Board Pharmaceutical Needs Assessment (PNA) findings	1. Public Consultation and Engagement of Stakeholders 2. Regular review of pharmaceutical needs required given population growth forecast and new housing development	**8**	Pharmaceutical needs may change due to predicted increased population growth or potential pharmacy mergers/closures due to national pharmacy contract changes. Requirement for PNA supplementary statements if need changes. KW/KJ as lead Consultant will review 6 monthly. NSH England will advise if any changes and IG will ensure pharmaceutical needs reviewed within planning process	Katie Johnson	14/11/2017

NHS England

Fit for the Future
Working together to keep people well

NHS Improvement

Cambridgeshire & Peterborough

Sustainability & Transformation Partnership

Cambridgeshire County Council Health Committee

7 September 2017

NHS Cambridgeshire and Peterborough Clinical Commissioning Group
NHS Cambridgeshire and Peterborough NHS Foundation Trust
NHS Cambridgeshire Community Services NHS Trust
NHS Cambridge University Hospitals NHS Foundation Trust
NHS North West Anglia NHS Foundation Trust
NHS Papworth Hospital NHS Foundation Trust
Cambridgeshire County Council
PETERBOROUGH CITY COUNCIL
East of England Ambulance Service NHS Trust

Context

This Health Committee, at the July 2017 meeting, requested that future reporting by the Sustainability & Transformation Partnership (STP) should focus on the following areas:

1. STP operational performance;
2. STP programme delivery; and
3. Risk management approach and STP strategic risks

The purpose of this presentation, to be delivered at the 7th September Committee meeting, is to provide the Committee with information relating to the above areas in order to stimulate discussion and seek agreement regarding the range and depth of reporting to be routinely provided, as well as to clarify a schedule of areas for focus at future meetings.

In addition to the above, the STP is briefing the Committee in relation to a further item:

4. Review of STP leadership

STP Operational Performance

STP Operational Performance

Overview

The following four slides set out current Cambridgeshire & Peterborough system operational performance against key standards in:

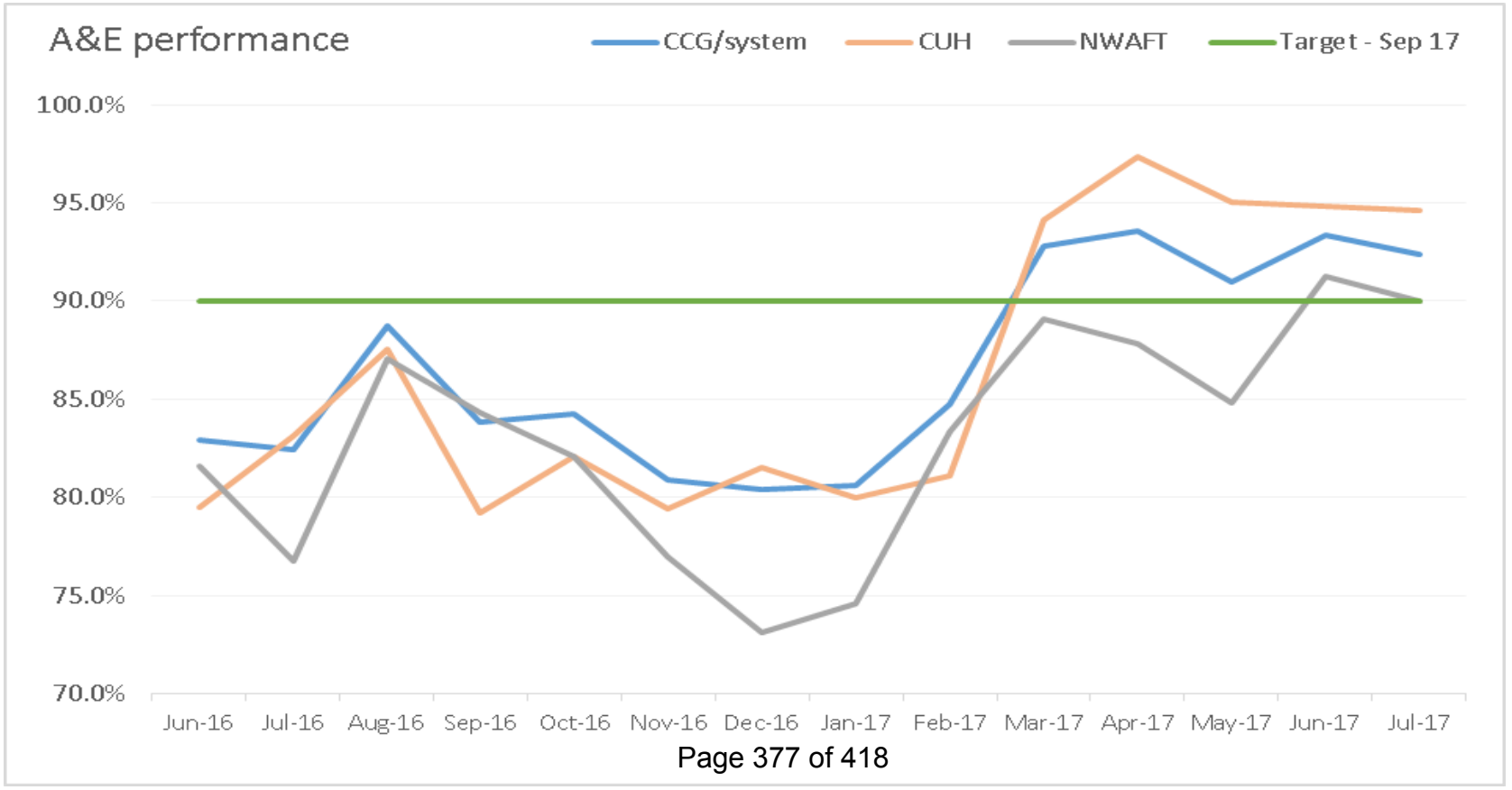
- Accident & Emergency Performance;
- Delayed Transfers of Care (DToC) i.e. delays in discharging patients from hospital who are ready and safe to leave;
- Referral to Treatment (RTT) i.e. the time from when a GP refers a patient to treatment commencing; and
- Cancer – 62 day first definitive treatment.

Accident & Emergency Performance

The national target is that 95% of patients must be seen within four hours and Cambridgeshire & Peterborough has a system target set by national bodies of achieving and maintaining 90% by September 2017.

Over the last four months, this target has already been met for Cambridgeshire & Peterborough.

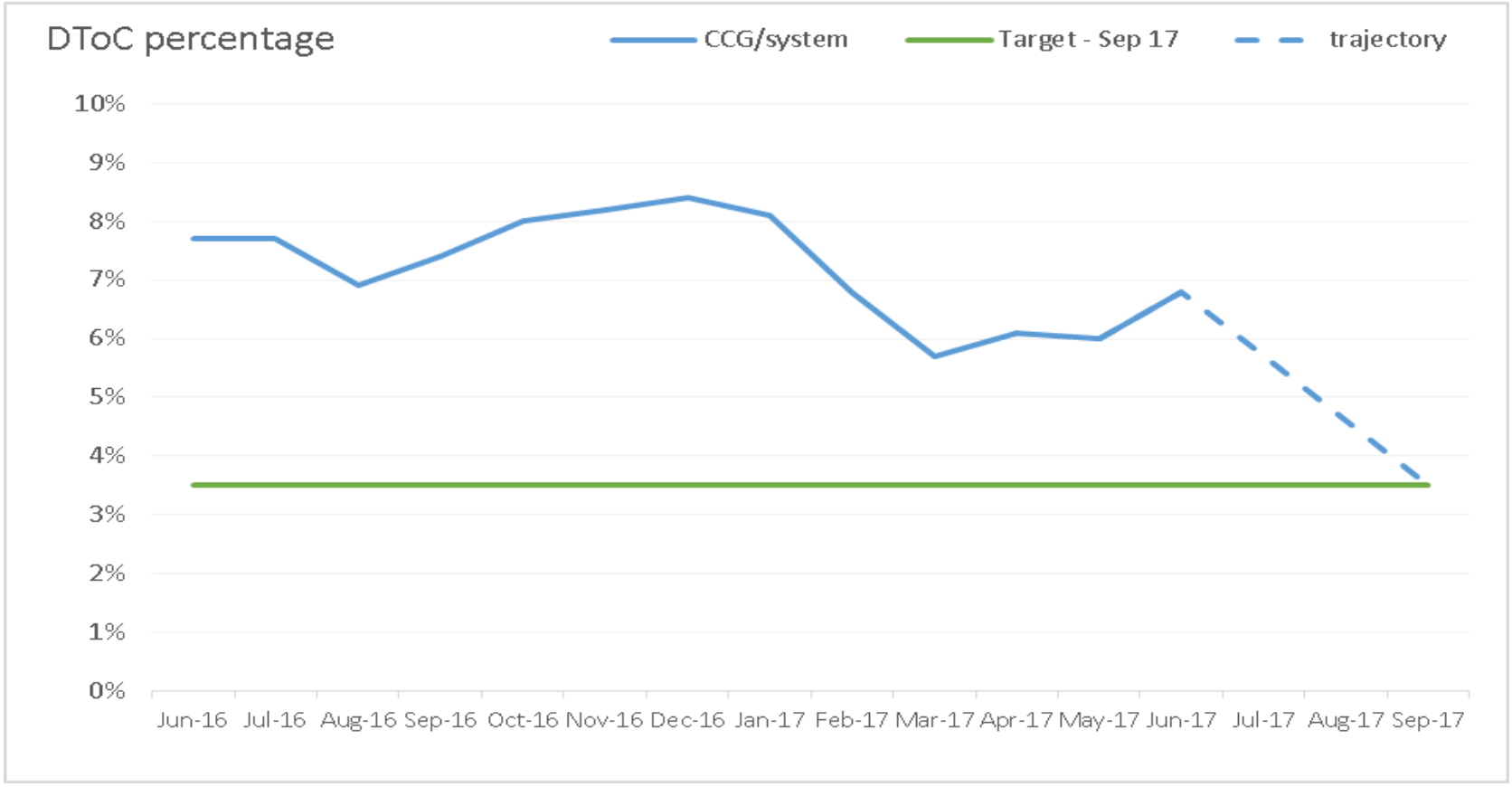
In that time period, Cambridge University Hospitals Foundation NHS Trust (CUHFT) has also met the target and North West Anglia Foundation Trust (NWAFT) crossed the 90% threshold in June and has stayed above it.



Delayed Transfers of Care (DToC) Performance

DToC percentage had stabilised since March 2017, but there has been an increased in June to 6.8%.

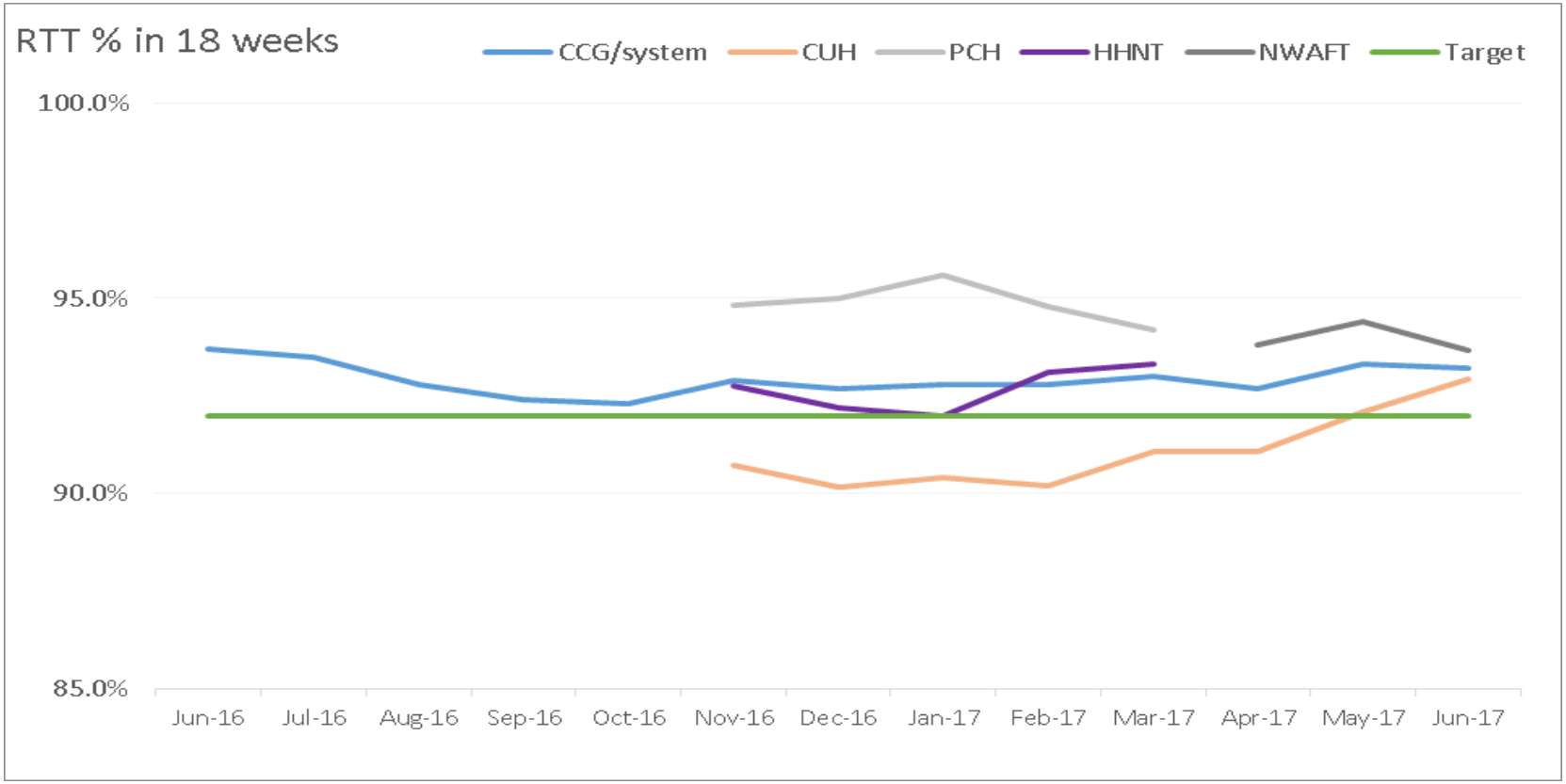
In order to meet the national target of 3.5% by September 2017, DToC percentage would need to decrease by about 1.1% per month.



Referral to Treatment (RTT) Performance

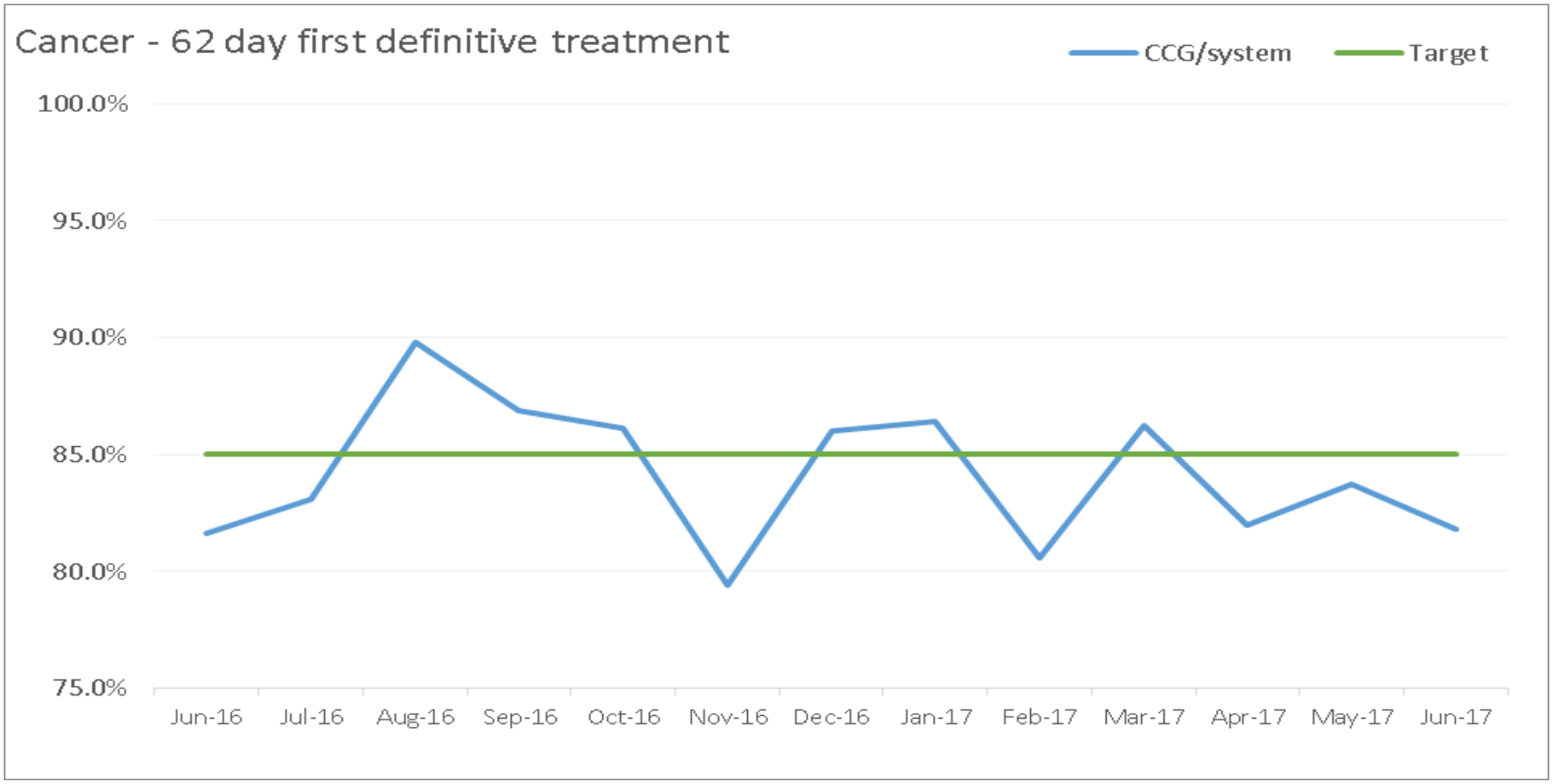
In the last year, the system's RTT% in 18 weeks was above the national target of 92%.

CUHFT has improved its RTT performance and has been above the standard since May 2017.



Cancer Treatment Performance

In June 2017, 81.8% of cancer patients had their first definitive treatment within 62 days, therefore, performance deteriorated from the previous month and the system missed its target of 85%.



STP Operational Performance

Other key indicators

- The indicators within the tables on the following two slides show performance at STP or Clinical Commissioning Group (CCG) level for other key metrics linked to the delivery of STP plans.

- These metrics are a combination of performance metrics e.g. waits in A&E and activity metrics e.g. the number of A&E attendances.

- Each STP Delivery Group has further metrics that focus on specific project outcomes e.g. the Falls Prevention Project will look at the number of admissions related to falls per 1000 population to confirm their project is reducing the number of falls.

- Shown are recent trend as well as a comparison with the same month last year and a Year-To-Date comparison. Green items are areas where performance has improved or activity has reduced, amber shows a stable position, red is a deterioration or increased activity.

STP Operational Performance

	Indicator	Provider	Target / Threshold	Previous 6 months: Earliest					Latest	Latest month	c/w same month last year	Same month last year	YTD	c/w YTD last year	YTD last year	Latest month is:	Trend
Urgent & Emergency Care	A&E Attendances	STP	n/a	27464	25615	29724	28888	30681	30416	30741		30897	116978		118430	Jul-17	
	A&E Performance	STP	95%	80.6%	84.8%	92.8%	93.6%	91.0%	93.9%	93.6%		82.4%	93.1%		83.8%	Jul-17	
	Emergency Admissions	CCG	n/a	6819	6895	6479	7503	6869	7424	7270		6739	21563		20281	Jun-17	
	Emergency admissions crude monthly rate per 1000 registered population	CCG	n/a	6.7	6.9	6.9	6.2	7.7	7.0	7.5		7.1	14.5		13.8	May-17	
	Total bed day crude monthly rate per 1000 registered population	CCG	n/a	36.8	36.7	39.3	35.3	40.9	34.8	37.5		38.6	72.3		76.5	May-17	
	DToC Average Daily Bed Days per 100,000 population 18+	CCG	n/a	18.9	19.5	18.2	15.6	13.7	14.5	13.5		17.2	14.0		17.1	May-17	
	DToC Percentage (DToC bed days/occupied bed days)	CCG	3.5%	8.2%	8.4%	8.1%	6.8%	5.7%	6.1%	6.0%		7.2%	6.0%		7.1%	May-17	
	Cat A < 8 minutes - Red 1	EEAST (CCG)	75%	71.7%	65.2%	64.6%	70.3%	70.2%	70.4%	66.1%		58.8%	68.9%		57.8%	Jun-17	
	Cat A < 8 minutes - Red 2	EEAST (CCG)	75%	60.0%	58.9%	61.3%	63.2%	62.7%	58.8%	55.1%		54.0%	58.8%		54.2%	Jun-17	
	Cat A < 19 minutes	EEAST (CCG)	95%	89.2%	89.7%	90.5%	92.9%	92.5%	89.6%	88.4%		85.5%	90.1%		86.9%	Jun-17	
	111 - number of calls triaged per day	HUC	n/a	605.0	570.0	548.0	507.0	592.0	523.0	502.0		476.0	1617.0		502.7	Jun-17	
Planned Care	Referrals	CCG	n/a	24127	27407	26082	28049	25278	29697	30633		26473	85608		79370	Jun-17	
	First Outpatient Attendances	CCG	n/a	25399	27762	26036	29670	24567	29347	29111		27630	83025		83532	Jun-17	
	Follow Up Outpatient Attendances	CCG	n/a	31151	35321	31468	36173	30354	35784	34845		36959	100983		116989	Jun-17	
	Elective Admissions	CCG	n/a	1517	1440	1475	1642	1441	1572	1464		1687	4477		5305	Jun-17	
	Daycase Admissions	CCG	n/a	6047	6564	6229	7342	6792	7478	7341		6220	21611		19177	Jun-17	
	RTT % in 18 weeks	CCG	92%	92.7%	92.8%	92.8%	92.9%	92.7%	93.3%	93.2%		93.7%	93.1%		93.4%	Jun-17	
	Diagnostics - < 6 weeks	CCG	99%	97.7%	97.7%	99.3%	99.4%	99.0%	99.0%	99.3%		96.4%	99.1%		97.3%	Jun-17	
	Cancer - 2 week wait	CCG	93%	95.3%	91.1%	93.5%	95.5%	95.0%	95.7%	95.8%		96.2%	95.5%		94.8%	Jun-17	
	Cancer - 2 week wait breast	CCG	93%	95.3%	96.1%	95.7%	95.8%	93.9%	90.6%	96.2%		92.7%	93.5%		93.7%	Jun-17	
	Cancer - 31 day first definitive treatment	CCG	96%	98.6%	96.6%	98.9%	98.3%	97.5%	97.5%	98.3%		97.9%	97.8%		98.4%	Jun-17	
	Cancer - 31 day subsequent surgery	CCG	94%	100.0%	94.1%	95.8%	96.6%	95.2%	96.6%	97.4%		100.0%	96.7%		98.4%	Jun-17	
	Cancer - 31 day subsequent drug	CCG	98%	100.0%	100.0%	100.0%	100.0%	98.4%	96.7%	100.0%		100.0%	98.4%		99.5%	Jun-17	
	Cancer - 31 day subsequent radiotherapy	CCG	94%	96.1%	98.1%	96.9%	96.8%	94.2%	98.5%	97.7%		96.1%	96.9%		97.6%	Jun-17	
	Cancer - 62 day first definitive treatment	CCG	85%	86.0%	86.4%	80.6%	86.2%	82.0%	83.8%	81.8%		81.6%	82.6%		84.6%	Jun-17	
	Cancer - 62 day screening	CCG	90%	89.5%	100.0%	96.3%	87.0%	100.0%	92.9%	90.0%		96.4%	93.1%		90.8%	Jun-17	

STP Operational Performance

	Indicator	Provider	Target / Threshold	Previous 6 months: Earliest					Latest	Latest month	c/w same month last year	Same month last year	YTD	c/w YTD last year	YTD last year	Latest month is:	Trend
Quality and Safety	Number of unit/Labour suite closures (no target set)	STP	n/a	1	3	0	7	1	3	4		3	4		7	May-17	
	Safety - Incidence of MRSA (CCG/Trust Assigned)	STP	0	0	0	1	0	0	0	0		0	2		0	May-17	
	Safety - Incidence of C difficile (Sanctioned Cases)	STP	94	6	2	3	4	3	2	3		2	10		2	May-17	
	Safety - Never events	STP	0	1	0	1	0	1	0	2		0	1		1	Jun-17	
Mental Health	MH - completed therapy and are moving to recovery	CCG	50%	46.9%	51.5%	52.9%	53.8%	50.8%	50.0%	51.8%		47.7%	50.7%		45.5%	Jun-17	
	MH - early intervention in psychosis (EIP) starting treatment within 2 weeks of referral - rolling 3 months	CCG	n/a	87.5%	75.0%	85.7%	73.7%	62.5%	57.1%	73.1%		78.6%	57.1%		64.3%	May-17	
	Out of area placements for acute mental health inpatient care transformation - self assessed level of compliance	CCG	n/a							Full		Partial	Full		Partial	Mar-17	

STP Operational Performance

Conclusion

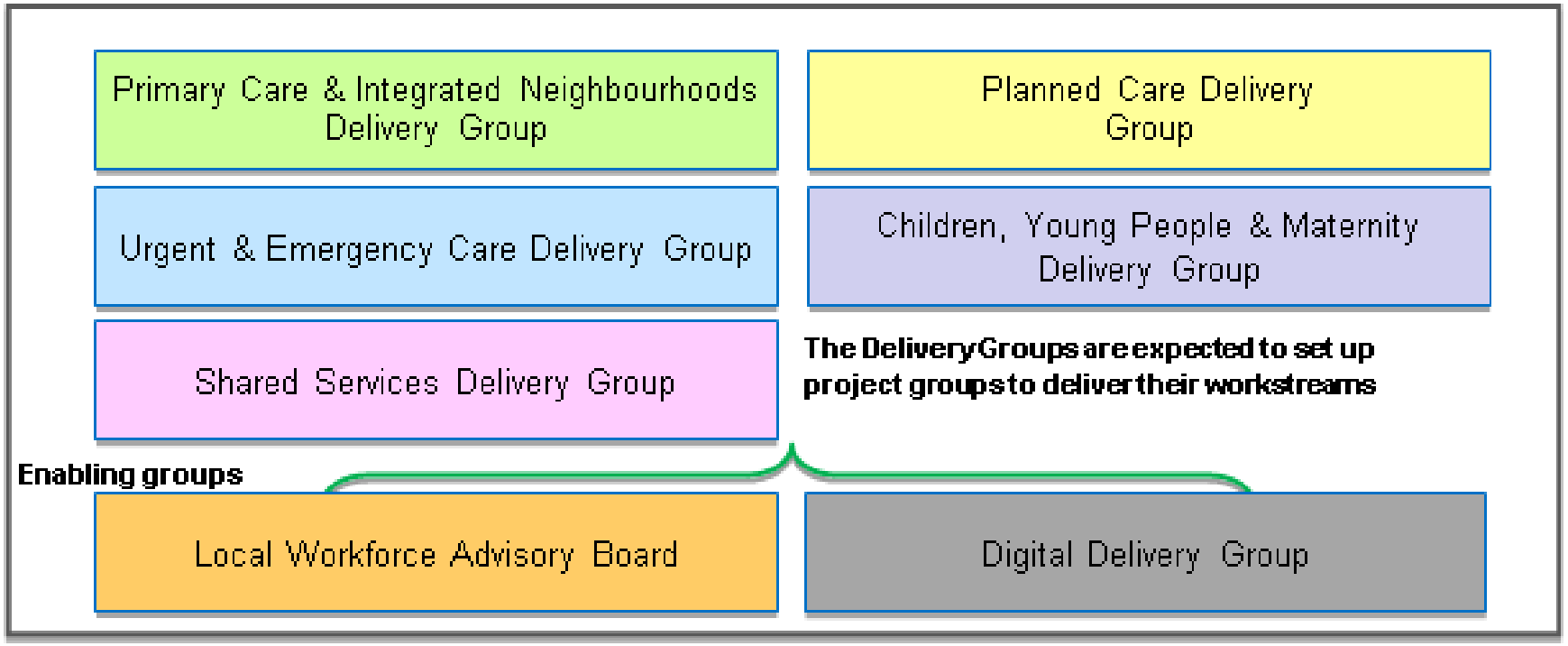
- The performance metrics in the preceding slides can routinely be made available to Committee members.

- Members are asked to confirm if and how they wish to receive this operational performance information

STP Programme Delivery

STP Programme Delivery

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

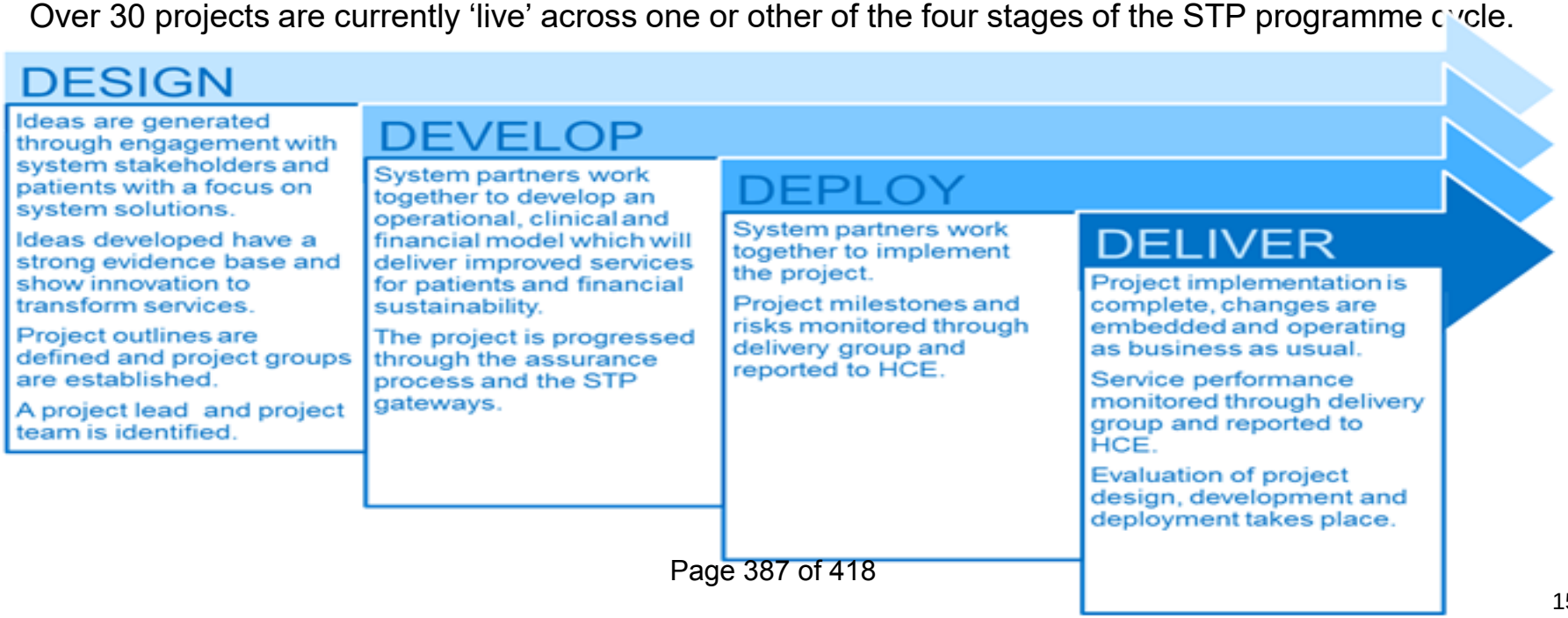


STP Programme Delivery

- The Delivery Groups cover clinical services, workforce and support services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do..

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

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



STP Programme Delivery

Urgent & Emergency Care (UEC)

- This presentation focusses on UEC delivery in order to demonstrate progress and illustrate the type and level of information available to share with the Committee.

- Members are asked to note that the format and content of any routine reporting to the Committee would need to be consistent with that currently utilised for internal STP delivery, in order to ensure consistency and minimise duplication of effort.

- Committee members can request to schedule specific Delivery Groups for a ‘deep dive’ focus at future meetings.

- Committee members are asked to note that STP officers attending this meeting are not UEC subject experts and that there will be a need to schedule attendance of appropriate clinical and managerial colleagues to support detailed discussion of specific Delivery Group progress at future meetings.

- The following slide provides a summary of progress for the UEC Delivery Group and includes information on:
  - Key Performance Indicators (KPIs);
  - Key risks; and
  - Savings Plan.

- The subsequent slides provide a one page summary of progress for each of the two UEC Improvement Projects currently in the ‘deployment’ stage.

Urgent & Emergency Care

JULY

4yr Target	£ 28.02m	17/18 Target	£ 10.5m	18/19 Target	£ 7.37m

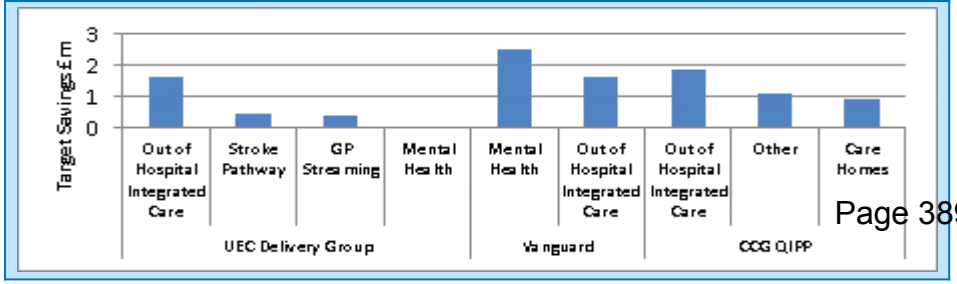
Accountable Officer	Roland Sinker	HR Lead	David Wherrett	Comms Lead	Dail Maudsley-Noble	Finance Lead	Jonathan Rowell

Improvement Area Summary

System Owner	Improvement Area	Project	SRO	Project Lead	Point in Cycle	Gross 17-18 savings (£m)			
						Invest-ment	Target savings	Identified savings	Variance
UEC Delivery Group	GP Streaming	GP Streaming	Ruth Derrett	Ian Weller	Design		0.40		
	Mental Health	Psych Liaison	Cathy Walsh	Katerina Lagoudaki	Develop	TBC	TBC		
	Out of Hospital Integrated Care	Extendend JET	Ruth Derrett	Katie Morrish	Deploy	1.87	1.61		
		Intermediate Care Tier	Ruth Derrett	Sara Rodriguez-Jimenez	Develop	TBC	TBC		
	Stroke Pathway	ESD	Debbie Morgan	Katie Morrish	Deploy	0.47	0.47		
		Rehab	Debbie Morgan	TBC	Design	TBC	TBC		
		Thrombectomy	Debbie Morgan	TBC	Design	TBC	TBC		
UEC Delivery Group Total						2.34	2.48		
CCG QIPP	Care Homes	Care Homes	Ruth Derrett	Ian Weller			0.65		
		Frailty	Ruth Derrett	Simon Pitts			0.28		
	Out of Hospital Integrated Care	IUC Contractual QIPP associated with Yr 2&3 of the contract	Ruth Derrett	Gareth Cairns			0.35		
		Ambulatory Care Sensitive Conditions	Ruth Derrett	Liz Phillips			0.00		
		Ambulatory Care	Ruth Derrett	Mark Evans			0.91		
		EEAST - Hear & Treat and See & Treat	Ruth Derrett				0.62		
	Other						1.09		
CCG QIPP Total						0.00	3.90		
Vanguard	Mental Health	Mental Health	Ruth Derrett	Simon Pitts		3.00	2.49		
	Out of Hospital Integrated Care	NHS 111 / IUC	Ruth Derrett	Ian Weller			0.41		
		Frequent Attends	Ruth Derrett	Simon Pitts			0.00		
		JET	Ruth Derrett	Katie Morrish			1.21		
Vanguard Total						3.00	4.11		
TOTAL					0	5.34	10.49	0	0

Note: Vanguard Mental Health Funding is via MRET

Savings Plan



KPIs

Indicator	Provider	Target / Threshold	Latest month	c/w same month last year	Same month last year	YTD	c/w YTD last year	YTD last year	Latest month is:	Trend
A&E Attendances	STP	n/a	30416		28957	86237		87533	Jun-17	
A&E Performance	STP	95%	93.9%		82.9%	92.9%		84.2%	Jun-17	
Emergency Admissions	CCG	n/a	7362		6995	6770		6547	May-17	
Emergency admissions crude monthly rate per 1000 registered population	CCG	n/a	7.5		7.1	14.5		13.8	May-17	
Total bed day crude monthly rate per 1000 registered population	CCG	n/a	37.5		38.6	72.3		76.5	May-17	
DToC Average Daily Bed Days per 100,000 population 18+	CCG	n/a	13.5		17.2	14.0		17.1	May-17	
DToC Percentage (DToC bed days/occupied bed days)	CCG	3.5%	6.0%		7.2%	6.0%		7.1%	May-17	
Cat A < 8 minutes - Red 1	EEAST (CCG)	75%	66.1%		58.8%	68.9%		57.3%	Jun-17	
Cat A < 8 minutes - Red 2	EEAST (CCG)	75%	55.1%		54.0%	58.8%		54.4%	Jun-17	
Cat A < 19 minutes	EEAST (CCG)	95%	88.4%		85.5%	90.1%		87.6%	Jun-17	
111 - number of calls triaged per day	HUC	n/a	502.0		476.0	1115.0		516.0	Jun-17	

Top 3 Achievements

1. JET posts out to advert and 13 posts recruited
2. Clear recruitment plan in place for JET and ESD
3. Agreement and approval of Discharge to Assess

Areas of focus

- Mobilisation of Discharge to Assess project team and creation of project plan
- Integrated Care Worker (ICW) recruitment fair 05/08/17
- Psychiatric Liaison Business Case to Care Advisory Group (CAG) and FPPG
- Development of Outline Business Case for Thrombectomy service
- Identify project lead and project team for Inpatient rehabilitation

Key Risks

- Current poor utilisation of JET service particularly in Cambridge
- Failure to recruitment sufficient ICW's, JET practitioners and Allied Health Professionals (AHP)
- System resource to support projects (for example, Discharge to Assess, regional stroke rehab unit)

Extended JET Update

DEPLOY

17/18 Target Savings	£1.40m	17/18 Forecast Savings	£1.40m	17/18 Variance	£0m

SRO	Ruth Derrett	Project Lead	Katie Morrish	Clinical Lead	Ben Underwood	HR Lead	Cathy Mayes	Comms Lead	Mark Cole	Finance Lead	Tracey Shepherd

Financial Benefits and Expenditure Profile

	April	May	June	July	August	September	October	November	December	January	February	March	12 months
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Investment	0	0	£9,983	£9,983	£47,920	£151,786	£235,665	£262,278	£263,673	£270,648	£270,648	£270,648	£1,793,231
Forecast Savings	0	0	-£20,386	-£40,772	-£61,158	-£81,544	-£119,710	-£151,721	-£183,732	-£215,743	-£247,754	-£273,610	-£1,396,131

Milestones

Milestone ID	Milestone	Owner	Start Date	Due Date	Status
Extended JET	SRO	Implementation Lead			Go live date
	Ruth Derrett	Katie Morrish			01/06/2017
Extended JET M1	Identify options for bases for extended JET service	Alison Manton	20/03/2017	27/03/2017	C
Extended JET M2	CFPT sign off preferred model for ICW	John Martin	27/03/2017	12/04/2017	C
Extended JET M3	Communications plan developed to relaunch JET offer	Mark Cole	08/05/2017	26/05/2017	C
Extended JET M4	Sign off ED to JET referral pathway and referral criteria	JET Board	15/06/2017	08/08/2017	G
Extended JET M5	sign off revised JET service specification	JET Board	01/08/2017	01/09/2017	G
Extended JET M6	Recruitment of vacant posts completed and in post	John Martin	01/06/2017	01/09/2017	G
Extended JET M7	Go live with additional posts in Cambridge	John Martin	01/06/2017	01/09/2017	G
Extended JET M8	Go live with additional posts in Ely	John Martin	01/06/2017	01/10/2017	G
Extended JET M9	Go live with additional posts in Hunts	John Martin	01/06/2017	*TBC*	not started
Extended JET M10	Go live with additional posts in Peterborough	John Martin	01/06/2017	*TBC*	not started

Key Meetings/ Next Steps	31-Jul	07-Aug	14-Aug	21-Aug
JET Delivery Board (monthly)		X		
CPFT JET task and finish group (fortnightly)	X		X	
CPFT STP transformation meeting (monthly)				X

Top 3 Achievements

1. Triage Lead and JET dispatcher roles out to advert
2. Senior Manager appointed and commences 31 July
3. Recruitment of 13 ICWs

Areas of focus

- Ongoing recruitment plan for all JET posts
- CPFT ICW recruitment fair on 5th August in Huntington
- IT changes to SystmOne templates for triage and assessment
- Communications on agreed pilot with ED regarding admission avoidance for patients from care homes
- Review of KPIs including Patient Outcome measures

Key Risks

- Current poor utilisation of existing JET, particularly Cambridge area, although utilisation is improving
- High use of agency staff in triaging & existing vacancies across JET service
- Recruitment to ICWs in context of current and forthcoming recruitment to other services – reducing risk – good level of applicants so far.
- Shortcomings in GP engagement linked to service utilisation

Stroke ESD Update

DEPLOY

17/18 Target Savings	£0.124m	17/18 Forecast Savings	£0.124m	17/18 Variance	£0m

SRO	Debbie Morgan	Project Lead	Katie Morrish	Clinical Lead	Charlie Dorer	HR Lead	Cathy Mayes	Comms Lead	Mark Cole	Finance Lead	Tracey Shepherd

Financial Benefits and Expenditure Profile

	April	May	June	July	August	September	October	November	December	January	February	March	12 months
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Investment	0	0								TBC	TBC	TBC	TBC
Forecast Savings	0	0								-£41,333	-£41,333	-£41,333	-£124,000

Milestones

Milestone ID	Milestone	Owner	Start Date	Due Date	Status
Stroke ESD	SRO	Implementation Lead			Go live date
	Debbie Morgan	Charlie Dorer			08/01/2018
Stroke ESD M1	Clinical workshop with CPFT and all acute stakeholders to map pathways	Stroke Network	27/03/2017	01/09/2017	G
Stroke ESD M2	Agree clinical pathways	Stroke Network	27/03/2017	01/10/2017	G
Stroke ESD M3	Sign off final ESD service specification	Stroke Network	01/05/2017	01/10/2017	G
Stroke ESD M4	Implement wider communications plan	Sue Last	18/04/2017	15/12/2017	G
Stroke ESD M5	Induction capable of go live for ICWs and other clinical posts	John Martin	01/05/2017	01/09/2017	G
Stroke ESD M6	Go Live Cambridge	John Martin	01/06/2017	08/01/2018	G
Stroke ESD M7	Go Live Hunts	John Martin	01/06/2017	08/01/2018	G
	Go Live East Cambs and	John			
Stroke ESD M8	Fenlands	Martin	01/06/2017	08/01/2018	G
Stroke ESD M9	Go Live Peterborough		01/06/2017	08/01/2018	G

Key Meetings/ Next Steps

Key Meetings/ Next Steps	31-Jul	07-Aug	14-Aug	21-Aug
Stroke Network Meeting (monthly)	X			
CPFT Stroke ESD task and finish group (ad hoc)			X	
Systemwide Stroke T&F Group	X			

Top 3 Achievements

1. Clinical Lead (Charlie Dorer) is now in post.
2. Undertaken workshop with SALT and Dietetics to further review details of ESD criteria and rotation options
3. Workshop booked for 31st July across footprint to review detail of acute to ESD and acute to Neuro rehab referral and discharge process

Areas of focus

- Ongoing recruitment to new ESD posts.
- Ongoing engagement with acute trusts regarding new service and clinical pathways, options for staffing new posts across ESD
- Meeting with SystmOne team regarding S1 change requirements for new ESD pathways
- Work with D2A delivery team to ensure alignment of ICW model across projects
- Work with staff involved with working up stroke skilled care into 5 beds Camb. & P'boro

Key Risks

- Interdependency with future model for IP Stroke Rehab
- Recruitment to Allied Health Professionals roles
- Recruitment to Integrated Care Workers in context of current and forthcoming recruitment to other services
- No agreement to date from Acute providers in rotation of AHP staff
- Provision of sufficient community bed capacity

STP Programme Delivery

Conclusion

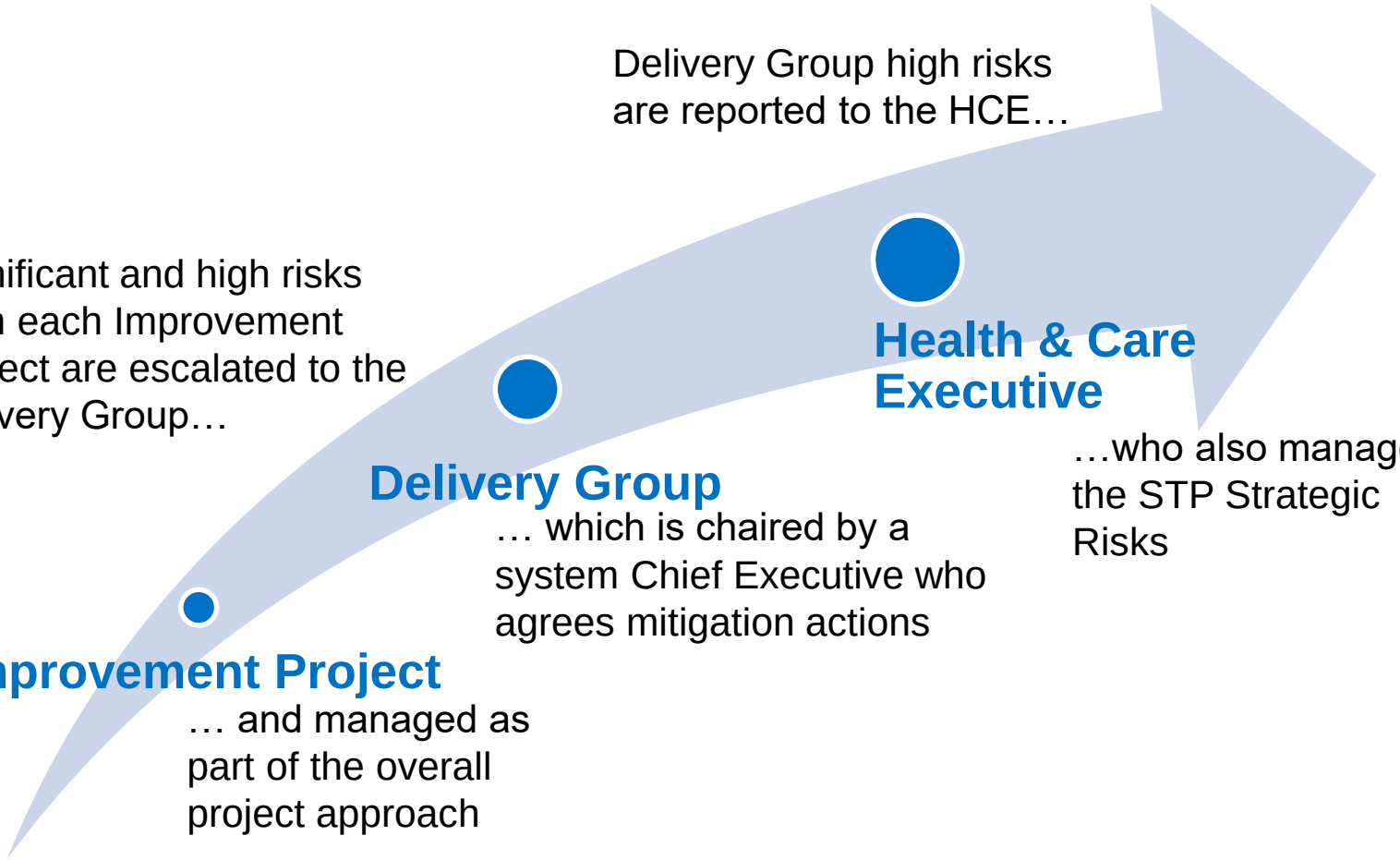
- The preceding slides illustrate the type and level of information available to share with the Committee in order to support discussion on progress with STP delivery.

- The Committee is asked to consider and agree to detailed briefings on specific Delivery Group progress at future meetings.

- The Committee is asked to consider and agree any routine STP Programme Delivery summary information it wants to receive, subject to the format and content being consistent with that currently utilised for internal STP delivery, in order to ensure consistency and minimise duplication of effort.

Risk Management Approach and STP Strategic Risks

Risk Management Approach



Risk Assessment

Risk Scoring

The STP uses the NHS National Patient Safety Agency's Model Risk Matrix to evaluate and score its programme risks. In short this involves identifying and scoring the potential consequence(s) of a risk and assessing and scoring the likelihood of that risk occurring. For reference an extract of the guidance that is used to calculate these scores is set out below:

	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Insignificant	**Minor - GREEN**	**Moderate - YELLOW**	**Major - AMBER**	**Catastrophic - RED**
Impact on the safety of patients, staff or public (physical/psychological harm)	• Minimal injury requiring no/minimal intervention or treatment. • No time off work	• Minor injury or illness, requiring minor intervention • Requiring time off work for >3 days • Increase in length of hospital stay by 1-3 days	• Moderate injury requiring professional intervention • Requiring time off work for 4-14 days • Increase in length of hospital stay by 4-15 days • RIDDOR/agency reportable incident • An event which impacts on a small number of patients	• Major injury leading to long-term incapacity/disability • Requiring time off work for >14 days • Increase in length of hospital stay by >15 days • Mismanagement of patient care with long-term effects	• Incident leading to death • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients

	Likelihood score				
Descriptor	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely - GREEN**	**Possible - YELLOW**	**Likely - AMBER**	**Almost certain - RED**
Frequency (How often might it/does it happen)	• This will probably never happen/recur	• Do not expect it to happen/recur but it is possible it may do so	• Might happen or recur occasionally	• Will probably happen/recur but it is not a persisting issue	• Will undoubtedly happen/recur, possibly frequently

Risk Assessment

Risk Scoring – continued

The consequence(s) score and likelihood score are then multiplied to provide an overall risk score.

Likelihood	X	Consequence				
		Insignificant - 1	Minor - 2	Moderate - 3	Major - 4	Catastrophic - 5
Rare – 1		1	2	3	4	5
Unlikely – 2		2	4	6	8	10
Possible – 3		3	6	9	12	15
Likely – 4		4	8	12	16	20
Almost Certain – 5		5	10	15	20	25

STP Strategic Risks

The Health and Care Executive (HCE) has responsibility for managing the STP strategic risks.

The STP strategic risks (summarised on the slides 25 and 26) are reviewed by the HCE monthly by the following exceptions:

1. By the Risk Review Date;
2. Any Risks which have changed; and
3. Following discussion at HCE for inclusion of any new risks

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Working together to keep people well

STP Strategic Risks (1/2)

Ref No.	Risks/Issue Description	Risk Score	Mitigating/resolution/ Actions	Post Risk Score
R-06	There is a risk that deterioration of our core financial position may lead to failure to access additional monies such as sustainability funds.	20	CCG Financial turnaround plan aligned to STP delivery plan. CUHFT and NWAngliaFT financial recovery plans and operational Plan assumptions aligned to STP. Delivery of QIPP and CIP.	16
R-08	There is a risk that, if we do not effectively engage with patients, members of the public and other stakeholders, STP implementation may be compromised due to lack of support.	20	Communication & Engagement Strategy in place and to be routinely refreshed. Training & guidance in how to effectively engagement with stakeholders provided to all STP staff and clinicians. Active patient involvement in STP Delivery Groups and Improvement Areas. Routine stakeholder communication via, for example, STP Website, newsletter, social media and proposed Stakeholder Group.	12
R-15	There is a risk that Clinicians will not engage with STP implementation if they believe that clinical conclusions and agreed care models will not be implemented.	20	Clinical Engagement Strategy that 1) establishes Strategic Clinical Networks to lead clinical planning and proposed care models in areas such as Cardiovascular and Stroke 2) ensures clinical leaders are in place for every significant implementation area 3) puts in place Evaluation Task & Finish Groups and 4) strengthens, in collaboration with communication colleagues, engagement with specific clinical groups e.g. GPs.	12
R-16	There is a risk that proposed solutions are not supported by MPs, councillors and other elected representatives.	25	Engagement with councillors via Health Committee, Health & Wellbeing Board and processes, specific meetings and fora to ensure two-way dialogue that informs elected representatives of the case for change and ensures that there is an opportunity for councillors to influence solutions. Routine meetings with MPs, individually and collectively, to brief on issues.	20
R-17	There is risk that Primary Care as providers are not engaged or included in system wide leadership conversations.	25	Sustainable General Practice strategy group to provide assurance over implementation of GP Forward View. CCG investment in GP time to support GPs to be involved in redesign work. Communications Cell to devise system-wide GP engagement strategy.	20
R-20	There is a risk the system will not have the ability to capture sufficient savings opportunities in 2017/18 due to the lack of dedicated delivery resources.	16	Prioritise where to focus effort and response for 2017/18. CCG have realigned staff to priority projects. Focussed oversight of delivery by SDU.	12
R-25	There is a risk that negotiations with national bodies (Department of Health, Treasury) are un-coordinated among system partners, reducing negotiating leverage and likelihood of getting desired changes (e.g. to Market Forces Factor, for estates / infrastructure investment)	20	Application of MOU behaviours regarding sharing intelligence about strategic intent, via updates to HCE and/or FPPG. CEO commitment to speaking as a system, with one voice when negotiating with national bodies. HCE & CPSB meeting quarterly with shared agenda priorities agreed.	16

STP Strategic Risks (2/2)

Ref No.	Risks/Issue Description	Risk Score	Mitigating/resolution/ Actions	Post Risk Score
R-26	There is a risk that ineffective STP Governance may lead to failure to deliver on agreed actions.	20	Revision of Governance Framework underway and seeks to strengthen accountability and decision making.	16
R-27	There is a risk of delivery of STP wide projects due to capacity of teams and SROs alongside business as usual pressures.	20	Accountable Officer to actively monitor delivery of STP objectives, seek to resolve any delivery issues and escalate unresolved issues to HCE.	12
R-29	There is a risk that competing pressures placed on the CCG and Providers from National Bodies to deliver short term turnaround could be at the detriment of longer turn sustainability and deliverability of the STP.	20	HCE to monitor delivery of programme and to raise concerns honestly and openly in the HCE meetings in the first instance and escalate any unresolved issues to Bi-partite meeting with NHS England and NHS Improvement.	12
R-30	There is a risk that the system will be unable to secure external funding required to support delivery and this will result in the programme failing to achieve its objectives.	25	Deploy appropriate resource to ensure bids for national monies are completed to a high standard to maximise opportunity to be awarded funds. Utilise the virtual task and finish group to support the process. Seek other funding sources. If funding is not granted reassess STP objectives and identify other opportunities to deliver savings and objectives. Engaging with local MPs.	20
R-31	There is a risk that if a number of business cases all rely on recruiting new staff it may be difficult to recruit to all positions and if they are recruited from within the system this may cause problems for existing services	25	Delivery Groups to work closely with their Workforce lead to develop an appropriate recruitment strategy. Workforce leads to liaise to maintain an overview of Workforce requirements to ensure the needs of all business cases do not conflict and to ensure that the impact of large scale recruitment may have on other parts of the system is understood.	20
R-32	There is a risk that current transformation staff within all organisations aren't fully aligned to the STP and could result in the programme failing to achieve its objectives.	25	Accountable Officers to actively monitor delivery of STP objectives, seek to resolve and any unresolved issues to be escalated to HCE. Review engagement and communication strategy within organisations to ensure understanding and awareness of the STP.	20
R-33	The is a risk that as a consequence of being drawn into the Capped Expenditure Process (CEP) the system will be required to focus on short term actions and/or restrict the systems ability to focus on delivery of the STP programme of work.	20	Accountable Officers to continue to engage national bodies to understand and, where possible, influence the CEP.	12

Risk Management Approach and STP Strategic Risks

Conclusion

- The STP Strategic Risks in the preceding slides can routinely be made available to Committee members.

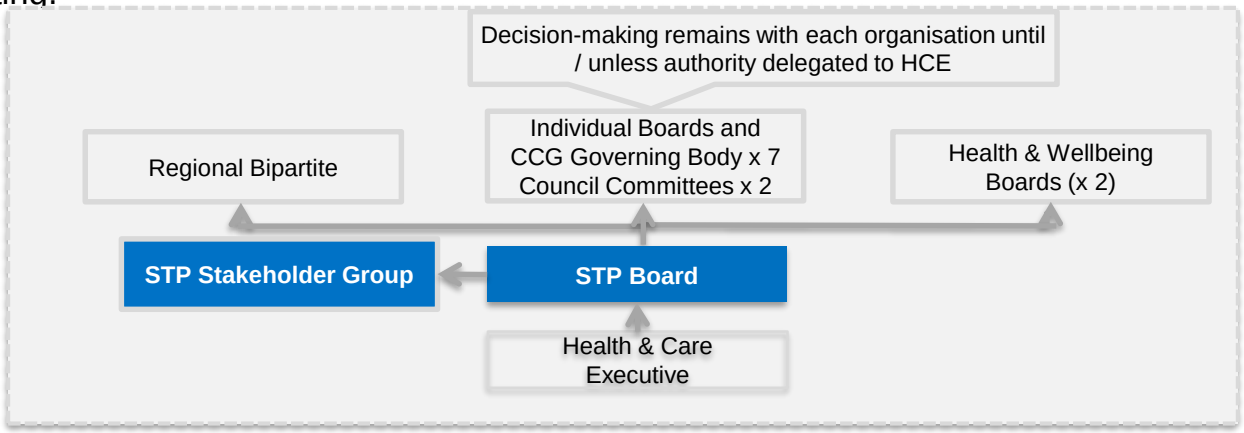
- Members are asked to confirm if and how they wish to receive this information

Review of STP Leadership

Review of STP Leadership

STP Board

- There is universal support from both the NHS partner Chairs and HCE for the formation of an STP Board which will have Non-Executive Director (NED) membership from across the system as well as Local Authority elected representation
- The first meeting will take place on 14 September. Meetings will then take place on a bimonthly basis.
- Key documentation, including the ToRs and the STP Governance Framework, is being revised to clarify the respective responsibilities of the STP Board and the HCE.
- A process is underway to appoint an Independent Chair. The post holder is expected to be in post by the November meeting.



Proposed membership	
• Chair: Independent Chair • CCG: Clinical Chair and Accountable Officer • CPFT: Chair and Chief Exectuive • NWAngliaFT: Chair and Chief Executive • CUHFT: Chair and Chief Executive • CCS: Chair and Chief Executive • Papworth: Chair and Chief Executive	• EEAST Chair and Chief Executive • Local Authority Representative • Executive Programme Director • CAG Chair • FPPG Chair • STU Secretariat

Review of STP Leadership

STP Board (Continued)

Key documentation, including the ToRs and the STP Governance Framework, is being revised to clarify the respective responsibilities of the STP Board and the HCE. Broadly, the HCE will be operationally focused while the STP Board will be responsible for setting medium and long term STP strategy; as follows:

Area	STP Board
Strategic decision making	• Responsible for **medium and long term STP strategy**, including ensuring the system has in place a process for working towards **Accountable Care**
Operational delivery	• **Holds to account HCE** for delivery of the STP, ensuring accountability and reporting arrangements are in place
Governance	• Ensures adherence to collective **governance** arrangements
Risk management	• Reviews/ addresses **strategic programme risks**
Engagement	• Ensures there is a process in place to understand how the system manages the expectations of **service users and the general public and members of the STP Stakeholder Group**
Accountability	• Receives brief update from the HCE regarding STP delivery. Chair attends Bipartite meetings.

STP Executive Leadership

- Tracy Dowling, the current Accountable Officer for the STP, will continue in the role for the medium term
- Catherine Pollard has been appointed as Executive Programme Director and will replace Scott Haldane who will resume his full-time responsibilities as Finance Director at CPFT

Review of STP Leadership

Conclusion

- The Committee is asked to note:
  - The changes to STP leadership including the establishment of the STP Board; and
  - That Local authority colleagues are currently considering appropriate elected representation to sit on the STP Board

Agenda Item No: 14

HEALTH COMMITTEE WORKING GROUP UPDATE

To:	**Health Committee**
Meeting Date:	**7th September 2017**
From	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key Decision:* **No**
Purpose:	**To inform the Committee of the activities and progress of the Committee's working groups since the last update.**
Recommendation:	**The Health Committee is asked to:**

a) Note and endorse the progress made on health scrutiny through the liaison groups.

b) Note the forthcoming schedule of quarterly liaison meetings (Appendix 1).

c) Consider any items from the quarterly liaison meetings that may need be included on the forward agenda plan.

Officer Contact:		***Member Contact:***
Name:	Kate Parker	Name: Councillor Peter Hudson
Post:	Head of Public Health Business Programmes	Post: Chairman
Email:	Kate.Parker@cambridgeshire.gov.uk	Email: Peter.Hudson@cambridgeshire.gov.uk
Tel:	01480 379561	Tel: 01223 706398

1.0 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 16th March 2017.

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), and Cambridge University Hospitals NHS Foundation Trust (CUHFT) and North West Anglia NHS Foundation Trust (NWA)

1.3 Liaison group meetings are precursors to formal scrutiny and/ or 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 <u>Liaison meeting with Cambridgeshire and Peterborough Foundation Trust</u>

The liaison group members in attendance were Councillors: Harford and district Councillor Abbott. A meeting was held on 24th March 2017 with Aidan Thomas (CEO). Apologies were noted from Deborah Cohen (Director of Service Integration) and Councillors Hudson, Joseph and van de Ven.

2.1.1 The following topics were discussed at this meeting:

- CEO Retirement and Management changes
- Learning Disability Service – update on service consultation
- Eating Disorder Service
- National Requirements for Mental Health providers
- Investments in CPFT from STP
    - Expansion of Joint Emergency Team
    - Long Term Conditions
    - Case Management
    - Discharge to Asses

2.1.2 Future potential items for the Health Committee's forward agenda plan were noted.

- Expansion of PRISM service
- Consultations on service changes e.g. Learning Disability
- Development of First Response Service

The next liaison meeting date with CPFT is scheduled for 9th November 2017.

2.2 Liaison Meeting with HealthWatch Cambridgeshire and the Clinical Commissioning Group

The liaison group members in attendance were Councillors Harford, Jones, van de Ven and District Councillor Ellington. Apologies were received from Councillors Hudson and Connor. A meeting was held on 20th July with Sandie Smith (CEO) of Healthwatch, Val Moore (Chair) Healthwatch and Jessica Bawden (Director of Corporate Affairs, CCG)

2.2.1 An update from the CCG was received on the following areas.

- Minor Injury Units (requested by Cllr Connor)
- Update on Chief Officer's Replacement
- Capped Expenditure Process
- Future consultations to be considered by the Health Committee
    - Fertility Services consultation extended to close on 31st July
    - Provision of Hearing Aids – consultation deferred

2.2.2 Val Moore provided members with an overview of Healthwatch as well as an update of the merger between Healthwatch Cambridgeshire and Peterborough which took place on 1st April 2017. Members were also informed of key issues that the public were raising with Heatlhwatch. Sandie Smith shared the Annual Report for Healthwatch with members.

2.2.3 Actions from this meeting:

- Minor Injury Unit Briefing to be circulated to all Health Committee Members.

The next liaison meeting date is 19th October 2017.

2.3 Liaison Meeting with Cambridge University Hospitals NHS Foundation Trust (CUHFT)

The Liaison group members in attendance were Councillors Harford, Hudson and van de Ven. A meeting was held on 28th June March 2017 with Roland Sinker (CEO) and Ian Walker (Director of Corporate Affairs). Apologies were received for Councillor Jones and District Councillor Ellington

2.3.1 The following topics were discussed at the meeting:

- Content for the Health Committee Item 20th July
    - CQC Inspection Update
    - E-Hospital update
        - Liver Metastasis Service (progress on first year of service relocation for the region)
- Relocation of Out of Hours Service to Addenbrookes site (requested by Cllr Jones)
- Access to the Hospital site (requested by Cllr van de Ven)
- A & E Triage System (requested by Cllr van de Ven)
- Delayed Transfers of Care (DTOCs)
    - Hospice (requested by Cllr Ellington)

- Papworth relocation & the Forum Development

2.3.2 Actions from the meeting:

- Cllr van de Ven to send email regarding concerns for A&E to Mr. Sinker
- Mr Sinker to share CUH Transport Access Plan.
- Kate Parker to send Ian Walker Cllr Ellington's email

The next liaison meeting date is 29th September 2017.

3.0 SIGNIFICANT IMPLICATIONS

3.1 **Resource Implications**
Working group activities will involve staff resources in both the Council and in the NHS organisations that are subject to scrutiny.

3.2 **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

3.3 **Equality and Diversity Implications**
There are likely to be equality and diversity issues to be considered within the remit of the working groups.

3.4 **Engagement and Consultation Implications**
There are likely to be engagement and consultation issues to be considered within the remit of the working groups.

3.5 **Localism and Local Member Involvement**
There may be relevant issues arising from the activities of the working groups.

3.6 **Public Health Implications**
Working groups will report back on any public health implications identified.

Source Documents	Location
http://www.healthwatchcambridgeshire.co.uk/	

Item 14 - Appendix 1 – Health Committee Liaison Meetings

Meeting	2017							2018		
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Health Committee	14	20	17 (reserve)	7	19	16	14	16	8 (reserve)	15
Quarterly Liaison Meetings										
CCG & Healthwatch		20			19 (tbc)			26		
CPFT		24				9				7
Addenbrookes Hospital (CUH)	28			29			22			
Hinchingbrooke Hospital (NWA)		27				7		TBC		
Development / Training Sessions										
Induction Training	14									
Finance Training		14								
Scrutiny: STP						Provisional				
Health Committee Priority setting 2017-18		21		22						
PH Business Planning (part 1)						Provisional				

HEALTH COMMITTEE TRAINING PLAN	Updated August 2017	

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

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
4.	***Health Committee Priorities 2017-18***	To develop and identify Public Health priority areas for the Health Committee to focus for 2017-18	1	21st July 2-4pm	Public Health	Development session	All members of Health Committee	8	**Completed** 53% of full committee
5.	***Public Health Business Planning (part 1)***	To discuss and advice on proposals for public health savings for 2018/19 as part of the councils business planning	1	22nd Sept 10-11.30	Public Health	Development Session	All members of Health Committee		
6.	***Public Health Business Planning (part 2)***	To review final proposals for public health savings for 2018/19. Please note that this session may not be necessary and may be used for STP training.	2	Nov tbc	Public Health	Development Session	All members of Health Committee		

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

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

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 3rd July 2017 Updated 23.08.17	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	Deadline for draft reports	Agenda despatch date
07/09/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	26/08/17	30/08/17
	Healthy Weight Strategy	Val Thomas	2017/035		
	Public Health Finance & Performance Report	Liz Robin	Not applicable		
	Annual Report of the Director of Public Health	Liz Robin	Not applicable		
	Air Quality in Cambridgeshire – implications for population health –update from March 2017 meeting	Liz Robin	Not applicable		
	Public Health Risk Register update	Tess Campbell	Not applicable		
	Planning future priorities for Health Committee 2017/18	Liz Robin	Not applicable		
	Scrutiny item: Suicide Prevention Strategy – update	Kathy Hartley	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Kate Parker Aidan Fallon (STP Unit)	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
19/10/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	06/10/17	10/10/17
	Business Planning 2018-19 (provisional)	Chris Malyon/ Liz Robin	Not applicable		
	Pressures in the school nursing services	tbc	Not applicable		
	Immunisation Task and Finish Group report	tbc	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Update on pilot harm reduction project for stopping smoking	Val Thomas	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
16/11/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	03/11/17	07/11/17

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Business Planning 2018-19 (provisional)	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
14/12/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	01/12/17	05/12/17
	Business Planning 2018-19 (provisional)	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: Development of Primary Care in Northstowe	Sue Watkinson	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Update on Relocation of Out of Hours Service	Jessica Bawden, CCG	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
16/01/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	03/01/18	05/01/18
	Public Health Risk Register update		Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Non-Emergency Patient Transport (NEPT) Service Performance: Six Month Update	Kyle Cliff, CCG	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
[08/02/18] Provisional meeting			Not applicable	*26/01/18*	*30/01/18*
15/03/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable	02/03/18	06/03/18
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]		Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		
[19/04/18] Provisional meeting				*06/04/18*	*10/04/18*
17/05/18	Notification of Chairman/woman and Vice-Chairman/woman	Ruth Yule	Not applicable	04/05/18	08/05/18
	Co-option of District non-voting Members	Ruth Yule	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: NHS Quality Accounts (provisional)	Kate Parker	Not applicable		
	Scrutiny Item: Sustainability and Transformation Plan (STP) update [standing item]	Scott Haldane	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Ruth Yule	Not applicable		
	Agenda plan and appointments to outside bodies	Ruth Yule	Not applicable		

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