HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 16 March 2017

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

14:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**Minutes – 12th January 2017 and Action Log**	**5 - 34**
3	**Petitions**	

OTHER DECISION

4	**Finance and Performance Report – January 2017**	**35 - 74**

KEY DECISION

5	**Proposal to transfer the in house Stop Smoking Services to an external provider**	**75 - 84**

The Health Committee comprises the following members:

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

Councillor Paul Clapp Councillor Lorna Dupre Councillor Lynda Harford Councillor Peter Hudson Councillor Gail Kenney Councillor Mervyn Loynes Councillor Zoe Moghadas Councillor Paul Sales Councillor Mandy Smith Councillor Peter Topping and Councillor Susan Van de Ven

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

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HEALTH COMMITTEE: MINUTES

Date: Thursday 12 January 2017

Time: 2.00pm to 5.25pm

Present: Councillors Sir Peter Brown (substituting for Councillor G Kenney), P Clapp, D Connor (substituting for Councillor M Loynes), L Dupre, L Harford, P Hudson, D Jenkins (Chairman), Z Moghadas, T Orgee (Vice-Chairman), M Smith and S van de Ven

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

Apologies: County Councillors G Kenney, M Loynes and P Sales

CONSTITUTIONAL MATTERS

291. VARIATION OT THE ORDER OF BUSINESS

With the agreement of the Committee, the Chairman announced his intention to vary the order of business from the published agenda to take the item on the Cambridgeshire and Peterborough Sustainability and Transformation Plan as the first substantive item. This would allow the officers presenting the report to attend another meeting elsewhere later in the afternoon. In doing so he noted that the Committee took its responsibilities for scrutiny very seriously and expected those invited to attend for scrutiny to do so. However, the Committee also recognised the significant demands on the time of senior managers and clinicians and was willing to show the flexibility to accommodate these competing demands where possible.

292. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies were noted as recorded above. There were no declarations of interest.

293. MINUTES OF THE MEETING ON 15 DECEMBER 2016 AND ACTION LOG:

The minutes of the meeting held on 15 December 2016 were approved as a correct record and were signed by the Chairman.

The following updates to the Action Log were noted:

1. **Minute 282: Proposal to transfer the in-house stop-smoking services to an external provider**
   The Director of Public Health would provide further detail on how the contract was laid out to the next meeting of Health Committee Spokes on 26 January 2017.
2. **Minute 261: Immunisation task and finish group update report**
   Production of the implementation plan had been delayed due to staff sickness, but was now with officers.

294. PETITIONS

No petitions had been received.

295. CO-OPTION OF A HUNTINGDONSHIRE DISTRICT COUNCILLOR AS A NON-VOTING MEMBER OF THE COMMITTEE

The Committee resolved to co-opt Councillor Jill Tavener of Huntingdonshire District Council as a non-voting member of the Health Committee. The Chairman recorded his thanks to her predecessor, Councillor Angie Dickinson, for her positive contribution to the Committee's work during her time as a co-opted member.

SCRUTINY ITEMS

296. SUSTAINABILITY AND TRANSFORMATION PLAN

The Chairman noted that two public questions had been received on this item from local residents and he invited Jean Simpson and Jeremy Caddick to put their questions to the Committee.

Ms Simpson said that the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) had published its Sustainability and Transformation Plan (STP) on 21 November 2016. Within this Plan there was no evidence of how the proposed savings would be achieved other than through the downgrading of Hinchingbrooke Hospital. A freedom of information (FOI) request had been made to the CCG asking to see the entire STP documentation and appendices which had been submitted to NHS England as in other parts of the country the workforce and financial appendices had disclosed more detail on how it was proposed savings would be achieved. Specifically, Ms Simpson wanted to know:

1. How the Health Committee could scrutinise the STP published on 21 November 2016 when, according to the reply to the FOI, this was not the final document?
2. Were members of the Committee aware that this was not the final document?
3. When the Committee expected to make a decision about whether the proposals were in the interests of the Health Service and the community it serves?
4. When the Committee expected to make a decision on the adequacy of the consultation process and whether sufficient time had been allowed, given that detailed information was being released in stages?

The Chairman thanked Ms Simpson and said that a written response to her questions would be provided (copy attached at Appendix A). He wished to make clear that the Health Committee held no executive function (decision-making powers) in relation to the implementation of the STP. However, the Committee took its responsibility for scrutiny very seriously and if Members perceived there to be problems with the STP they would make this clear publicly.

Mr Caddick said that as a Cambridgeshire resident and user of local health services he was extremely concerned by the STP. He acknowledged that the County Council did not have responsibility for implementing the Plan, but noted that the Council had signed a memorandum of understanding with NHS services which committed it to working closely on the implementation of projects. Mr Caddick believed that there had been a deterioration in health and care services in Cambridgeshire in recent years and he wished to highlight to the Committee that a number of local authorities had chosen to reject the STP's published for their regions. Specifically, Mr Caddick wanted to know:

1. Could the County Council and the Health Committee assure the residents of Cambridgeshire that they would refuse to endorse the region's STP if it was clear

that the savings required could not be delivered without threatening the availability and safety of NHS treatment?

2. If the Health Committee and the County Council decided that the STP could not be implemented safely would they join local campaigns to publicly call for adequate funding for local health services?

The Chairman thanked Mr Caddick for his questions and said that a written response would be provided (copy attached at Appendix B). He did though see the memorandum of understanding as a very positive aspect of the STP as it committed all signatories to working together for the benefit of the communities which they served. The achievability of the savings proposed in the STP was indeed a key question and if individual councillors, the Committee or the County Council as a whole judged that funding levels would not be adequate they would draw attention to this publicly through the democratic process as they had done previously, for example at the meeting of Full Council on 18 October 2016 when members voted in favour of a motion presented by Councillor Count for the Chief Executive of Cambridgeshire County Council to write to the Secretary of State for Health and local Members of Parliament to:

> 'call upon national government to provide significant transitional funding and transformational support to Cambridgeshire's NHS, to strengthen preventive community services and care closer to home and reduce the pressure on local hospitals'.

The Chairman invited David Astley, Independent Chair, Scott Haldane, Interim Programme Director, Joel Harrison, Finance Analytics and Evaluation Director, Dr Gary Howsam, Clinical Chair and Chief Clinical Officer and Jessica Bawden, Director of Corporate Affairs to the table in their capacity as representatives of Cambridgeshire and Peterborough Clinical Commissioning Group and to update the Committee on the STP. He asked that they address where possible the questions raised by the members of the public attending the meeting.

Mr Astley thanked the Chairman for the invitation to brief the Committee in person and for re-arranging the order of business to accommodate their attendance. Mr Harrison said that the version of the STP produced in October 2016 and which was publicly available on-line contained all of the information which had been provided to NHS England. The only document which had not been published was an Excel spreadsheet which was a live document which spoke to the documentation in the public domain; there was no other set of information which was not being shared. Should any member of the Committee wish to see the spreadsheet he would be very happy to take them through its content in detail. Overall, the financial challenge remained to address a projected NHS deficit across Cambridgeshire and Peterborough of £504m by 2020/21 if no remedial action was taken. It was expected that the requirement on the NHS to make savings year on year would account for half of this sum so the focus was on how to release the remaining £250m of savings needed to ensure that a balanced budget was achieved by the end of the period. The timing of how these savings would be released across the five year period of the Plan remained subject to some re-working as operational plans were updated, but the overall picture remained unchanged.

The following points were raised in discussion and in response to questions from Members:

- The Chairman thanked representatives of the CCG for attending a private briefing session on the STP the previous week which had been open to all County Councillors. Members had found this most useful and he anticipated more private

briefing sessions and public discussions of the STP in the coming months as the proposals continued to take shape;

- The CCG representatives emphasised that they were committed to genuine engagement with the public, voluntary sector organisations and all other interested parties. Numerous public engagement sessions had already been held and more were planned for the future. Dr Howsam emphasised that public engagement would be an iterative and evolving process rather a single event;
- There were no plans to close any hospitals. However, options for using premises more imaginatively such as through the co-location of services might be explored;
- There was concern that District Councils did not feel that they had been sufficiently involved in the STP process given their key role in supporting the health and wellbeing of their local communities. The Director of Public Health accepted this point, but highlighted the work being taken forward on the Local Authority Appendix to the STP Memorandum of Understanding (MOU). The Cambridgeshire Health and Wellbeing Board was meeting next on 19 January 2017 and would be invited to agree a clear process of engagement with District Councils prior to final sign-off of the STP MOU;
- Assurances were given that development of the STP had taken full account of the input from service users, the Public Health Directorate, GPs and other partner organisations;
- The savings envisaged within the STP included those which could be achieved through investment in primary and community services to reduce in the longer term the higher costs associated with acute care;
- The Chairman emphasised the importance of continued engagement with the full range of stakeholders and of tailoring the nature and content of this engagement to meet the needs of each group. The Committee would be interested to see a copy of the proposed communication plan in relation to each stakeholder group, including the objectives for the engagement and the outcomes it was intended to achieve; (**Action**: CCG)
- An invitation was extended to all members of the Committee to meet with administrators and clinicians to discuss any workstreams in which they had a particular interest. The CCG would contact Councillor Moghadas direct to arrange a meeting to discuss the possible impact on the number and duration of patient journeys to access specialist care;
  (**Action:** CCG)
- A detailed impact assessment would be carried out before the implementation of any of the proposals contained within the STP;
- Known population increases such as those relating to proposed developments in the Wisbech area had been taken into account in producing the STP;
- All present acknowledged the importance of encouraging behavioural change within the population from childhood onward to improve health outcomes;
- The Chairman noted that there was no signatory to the STP representing GPs. Dr Howsam explained that each GP practice represented an individual business and as such there was no single representative to sign up on their behalf. He acknowledged that there might be a variation to the timescales in which individual GP practices came on-board with the proposals, but ultimately all GPs were committed to delivering the best possible care to their patients and he was confident that the momentum existed to ensure the required buy-in. The Chairman said that he did not yet see the pathway between how GP services were constituted and in the future. Both the Chairman and Councillor Harford said that they would welcome a more detailed briefing on this in the next few weeks and it was agreed that this would be arranged;
  (**Action:** CCG)

- The Chairman confirmed his understanding that the Excel spreadsheet described by Mr Harrison was a fluid rather than fixed document which would be revised on an on-going basis as operational plans were updated. He felt it would be helpful if some members of the Committee would take up Mr Harrison's offer to provide a more detailed briefing on this.
  (**Action:** CCG)

The Chairman concluded the discussion by thanking the representatives of the CCG for attending and said that he looked forward to further meetings in the coming months to drill down into the detail of the proposals.

It was resolved to note and comment on the Sustainability and Transformation Plan update.

297. CAMBRIDGE GP OUT OF HOURS SERVICE AND EMERGENCY DEPARTMENT CO-LOCATION

The Chairman welcomed Dr Vaz Ahmed, Consultant in Emergency Medicine at Cambridge University Hospitals NHS Foundations Trust (CUHFT), Dr Gary Howsam, Clinical Chair and Chief Clinical Officer at Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Jessica Bawden, Director of Corporate Affairs at the CCG, Ian Weller, Head of Transformation and Delivery, Urgent and Emergency Care at the CCG and Dr Andrew Anson, a GP and the CCG lead on Urgent Care.

Ms Bawden apologised for the late submission of her report which set out proposals for a consultation on the plan to move the Out of Hours base from Chesterton Medical Centre to Clinic 9 at the CUHFT site where it would form part of an integrated urgent care package alongside the existing Accident and Emergency department. The consultation would include open meetings in the areas which would be affected by the proposals, consultation with patient groups and publicity campaigns in the local media. Copies of the publicity material would be provided to members of the Committee for information.
(**Action**: Director of Corporate Affairs, CCG)

The following points were raised in discussion of the report:

- The cost of parking at Addenbrooke's hospital was currently £3.50 per hour and it was acknowledged that this would represent an increased cost to some patients. Councillor Clapp asked to be provided with details of how the money raised by car-parking charges was spent;
  (**Action**: Director of Corporate Affairs, CCG)
- Members emphasised the importance of clear sign-posting of services and ease of access and it was agreed that an opportunity would be arranged for Members to visit the site and inspect the arrangements;
  (**Action:** Director of Corporate Affairs, CCG)
- The proposed co-location of Out of Hours services and Accident and Emergency services on the same site meant that patients could be re-directed as appropriate between the two services, ensuring them ready access to the right clinicians and level of care;
- This model had already been operated in Peterborough and had not led to an increase in patient numbers beyond the existing upward trend;

- There was a strong focus on improving the 111 non-emergency telephone service so that patients would choose to use this and reduce demand for Out of Hours appointments or visits to the Accident and Emergency department;
- An electronic prescription service was being set up so that prescriptions could be sent direct to a patient's local pharmacy;
- Members commended the pilot project which allowed callers to the 111 service to speak directly to a mental health practitioner (111 option 2);
- Councillor Ellington offered the opportunity for CCG representatives to speak to the local health partnership in South Cambridgeshire.

It was resolved to:

1. Approve the process for public consultation on the proposed relocation of the Cambridge Out of Hours base;

2. Comment on the related Clinical Commissioning Group (CCG) Governing Body paper and appendices attached to the report before Committee.

The Committee adjourned from 3.30pm to 3.40pm for a short break.

KEY DECISION

298. RE-COMMISSIOINING OF THE HEALTHY CHILD PROGRAMME: PROPOSED SECTION 75 AGREEMENT FOR HEALTH VISITING, FAMILY NURSE PARTNERSHIP AND SCHOOL NURSING (KD2017/008)

The Committee considered a report by Raj Lakshman, Consultant in Public Health Medicine and Janet Dullaghan, Head of Commissioning, Child Health and Wellbeing which sought the Committee's approval to develop a Section 75 agreement to replace the existing Section 75 agreement for School Nursing and to incorporate Health Visiting and the Family Nurse Partnership into the same arrangement. The existing agreements relating to these services would expire on 31 March 2017 and it was necessary to put measures in place to ensure continuity of service while the longer term integration of 0-19 provision was finalised. It was proposed that the delivery model and staff in post would remain unchanged with only the internal contractual arrangements being revised.

The following points were raised in discussion and in response to questions from Members:

- Control of the services remained with the Public Health team and so Members could have confidence that the delivery model would remain unchanged;
- Work was already underway on the detailed service specifications and officers deemed that the proposed two year timescale to complete the planned work by March 2019 was achievable. However, with any project of this size there would always be the possibility of slippage;
- The Director of Public Health said that legal advice had been obtained on the extent of consultation required for this change in contractual arrangements and officers had been advised that discussion between key stakeholders and providing information via staff newsletters was sufficient. Should any changes to services be proposed a wider consultation would be carried out which would include service users;

- An additional £60,000 would be invested in the School Nursing Service in 2017/18 to provide school nursing support in Cambridgeshire's special schools;
- Some Members expressed concern that the Family Nurse Partnership (FNP) did not have the capacity to work with all teenaged mothers. The Director of Public Health said that the FNP had always been constrained in the number of young mothers it was able to support. From April 2017 a new, more targeted approach would ensure that support was focused on the most vulnerable teenaged mothers. Around 50% of teenaged mothers would receive support from the FNP whilst those not reached by this service would still receive support through the Health Visiting Service. Councillor Clapp noted that additional support was also available through charitable organisations such as NACRO.

In light of the discussion it was resolved to:

1. Confirm the Committee's approval for the development and implementation of a new Section 75 Agreement for School Nursing, Health Visiting and Family Nurse Partnership services until March 2019;

2. Delegate authority to the Director of Public Health in consultation with the Chair and Vice Chair of the Health Committee to complete the negotiation of the proposed Section 75 agreement, finalise arrangements and to enter into the proposed agreement.

OTHER DECISIONS

299. FINANCE AND PERFORMANCE REPORT: NOVEMBER 2016

The Committee received a report by the Chief Finance Officer and presented by the Group Accountant providing the financial and performance position as at the end of November 2016.

A balanced budget had been set for the Public Health Directorate in 2016/17 which incorporated savings as a result of the reduction in the Public Health Grant. A forecast underspend of £115,000 had been identified across the Public Health budgets.

The following points were raised in discussion of the report and in response to Members' questions:

- The Director of Public Health highlighted a number of points contained in the performance summary including that performance of contract sexual health and contraception services remained good with all monthly key performance indicators achieved and smoking cessation performance had improved against the previous month's results;
- Councillor Dupre requested more information on how outcomes of Mental Health First Aid and Mental Health First Aid Lite training to front line staff was measured;
  (**Action:** Director of Public Health)
- The Group Accountant confirmed that any monies not used by the end of the current financial year would be retained and recycled within the Public Health Directorate.

It was resolved to review and comment on the report.

300. SYSTEM WIDE REVIEW OF HEALTH OUTCOMES IN CAMBRIDGESHIRE

The Committee received a report by the Director of Public Health which provided a system wide review of health outcomes in Cambridgeshire. The review focused on health inequalities and life expectancy across the county and in particular on concerns about health outcomes in Fenland in comparison to the rest of the county. A private development session had been held earlier in the day for members of the Committee to brief them on the complex data contained within the report.

The following points were raised in discussion of the report and in response to Members' questions:

- There was strong evidence of the long-term benefits of early interventions to reduce health inequalities;
- Possible access issues to services in Fenland;
- The significance of Devolution 2 in tackling health inequalities and deprivation. The Director of Public Health was leading work on considering how strategic working across Cambridgeshire and Peterborough could improve outcomes for those experiencing deprivation. Work in two pilot areas including Wisbech had included seeking evidence-based information from local experts on what worked in their areas, holding community events and collating existing data within local communities. Information was being worked up on the fiscal benefits of tackling deprivation as well as the health and social benefits and improvements to quality of life. Both the Chairman and the Director of Public Health had committed to attending follow-up meetings in Wisbech and the Chairman emphasised the importance of listening to local residents and finding solutions which would work for them. Following evaluation of the pilot projects work was underway to look at how the lessons learned could be applied strategically across the county as a whole;
- Councillor Clapp offered his thanks to the Chairman and the Director of Public Health for visiting Wisbech and allowing him the opportunity to show them first hand some of the issues being faced by local residents;
- Members welcomed the wealth of information contained in the report, but suggested that the graphs used to present the data might be slightly revised to make them easier to interpret;
- There was some concern that successful projects might be discontinued due to the time taken for the positive impact of some interventions to become clear;
- Members felt it was important that the report's findings should be shared more widely with Members of the County Council and beyond to other stakeholders.

Following discussion of the report it was resolved to:

1. Note and comment on the system wide review of health outcomes in Cambridgeshire;

2. Support the Devolution 2 Public Health-led project to address deprivation in the county with an initial focus on Wisbech;

3. Circulate the paper to all Members of the County Council and other stakeholders, including District Councils.
   (**Action:** Democratic Services Officer)

301. VARIATION OT THE ORDER OF BUSINESS

With the agreement of the Committee, the Chairman announced his intention to vary the order of business from the published agenda to take the item on the East of England Ambulance Trust (EEAST): Care Quality Commission Inspection of Local Delivery as the officers delivering the report were already present.

SCRUTINY ITEM

302. EAST OF ENGLAND AMBULANCE TRUST (EEAST): CARE QUALITY COMMISSION INSPECTION OF LOCAL DELIVERY

The Chairman welcomed Luke Squibb, Locality Officer and Gill Briggs, Locality Business Manager for the East of England Ambulance Service NHS Trust (EEAST). Whilst the Committee had the right of scrutiny Members liked to offer challenge in a constructive fashion and he thanked both officers for coming along and preparing a slide presentation.

Mr Squibb gave a presentation providing an insight into the role and experience of the EEAST in Cambridgeshire and Peterborough (copy attached at Appendix C). This included levels of demand across the region year on year, performance in relation to key clinical indicators and patient car and, the findings of the Care Quality Commission (CQC) inspection in August 2016.

The following points were raised during the presentation and in response to Members' questions:

- Members offered their thanks to the staff of the EEAST for all of their hard work on behalf of the residents of Cambridgeshire;
- Call volume had increased significantly over the period 28 December to 10 January compared to the same period last year;
- Red 1 Performance (the response to patients in cardiac arrest) was improving month on month and, although still below target levels, the EEAST's performance level was currently fifth out of the ten ambulance trusts in England;
- Ambulances were located dynamically and strategically around the region according to experience in order to best meet local need;
- The availability of community defibrillators for use in appropriate cases was viewed as a positive development by the EEAST;
- In response to the observation in the CQC report that information had not been shared sufficiently widely to enable lessons to be learned such information was now made available in all ambulance stations;
- Attendance levels at mandatory training courses remained good at around 95% and from February 2017 safeguarding training would be included within the training package. The levels for the completion of workbooks was lower at around 35-40% and was attributed in part to the pressures on officers' time;
- Some difficulties had been experienced with staff appraisal and personal development reviews in the previous year due in part to pressures on time, but Members welcomed assurances that plans were in place to address this in the forthcoming year;
- Work was being undertaken in conjunction with the region's acute hospitals to tackle delays in patient handover which would free up ambulance crews more quickly to attend other incidents;

- Over 94% of the EEASTs patients rated the Service's response as satisfactory or better;
- Protocols had been put in place to ensure that staff who attended a distressing incident were contacted during the following week to see how they were responding and offered additional support if required;
- Around 62-65% of ambulance call-outs in Cambridgeshire result in the patient being conveyed to hospital. In response to a question from the Vice Chairman on alternative responses to deploying an ambulance crew it was reported that some calls had been referred to the Joint Emergency Team (JET), although only a proportion had been accepted. The 111 NHS non-emergency telephone helpline could divert appropriate cases away from an emergency response, although in Cambridgeshire around 400-600 calls per week to the 111 service resulted in an ambulance being dispatched. A first response from the mental health team was now available via the 111 helpline via option 2 and it was hoped that this would lead to some callers being more appropriately directed to mental health services rather than resulting in an ambulance being dispatched. The EEAST was also working closely with the Cambridgeshire Care Homes Group to implement a falls protocol which would identify which cases required an ambulance to be dispatched and which might be dealt with safely via a non-emergency response;
- There had been quite a high turnover of staff during the past year as new opportunities opened up for qualified paramedics, for example in the JET, some GP practices and in lecturing opportunities at Anglia Ruskin University. Some staff who had left the Service to pursue other opportunities had subsequently returned, but turnover of staff was generally quite high. Conditional offers of employment had been made to 21 recent graduates and they were due to join the Service in 2017. Staff vacancy levels across Cambridgeshire stood at around 3% and were attributed in part to the high cost of housing in some parts of the county;
- Staff sickness levels had spiked during the Christmas period at around 10% which was attributed to the high workload during the period;
- Some use was made of private ambulance companies and staff. The performance of these companies was monitored closely and their staff were required to undertake induction training.

The Chairman offered warm thanks on behalf of the Committee for an informative presentation and response to questions. The Committee would like to see representatives of the EEAST again in around six months' time for a further update. The venue and format would be decided nearer the time, but it might take the form of a visit to the EEAST.
(**Action:** Head of Public Health Programmes/ Democratic Services Officer)

It was resolved to note the information received in the presentation given by the East of England Ambulance Trust (EEAST).

OTHER DECISIONS

303. PUBLIC HEALTH RISK REGISTER UPDATE

The Committee received a report by the Director of Public Health providing information on the Public Health Risk Register for the period to October 2016. The Risk Register was subject to quarterly review by the Public Health Directorate Management Team and to half-yearly review by the Health Committee. The Chairman noted that an

additional factor related to the risk of failing to influence behaviour change and requested that officers reflect on whether this might be included in the Risk Register.

(**Action:** Director of Public Health)

It was resolved:

1. To note the position in respect of Public Health Directorate risk;

2. To comment on the Public Health Risk Register and endorse the amendments since the previous update;

3. That the risk of failure to influence behaviour change be reviewed and added to the Public Health Risk Register if appropriate.

304. HEALTH COMMITTEE TRAINING PLAN

The Head of Public Health Programmes advised that a half day regional training event led by the Centre for Public Scrutiny would be held on the morning of 6 February and would focus specifically on scrutiny of Sustainability and Transformation Plans (STPs). Places would initially be offered to the Chair and Vice Chair of each Scrutiny Committee in the region, but as hosts of the event she was hopeful that additional places might become available to Cambridgeshire representatives. Details of the event would be circulated to all members of the Committee for information and expressions of interest in attending the session were invited.
(**Action**: Head of Public Health Programmes)

A further development session on the Cambridgeshire and Peterborough STP would be held on 16 February 2017 and the content of the session would be discussed by Spokes on 26 January 2017.

It was resolved to note the training plan.

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

It was resolved to note that no appointments were required.

306. HEALTH COMMITTEE FORWARD AGENDA PLAN

The Committee resolved to note the agenda plan, subject to the following possible changes to February 2017:

1. Possible deferral of the item on 0-19 Joint Commissioning of Children's Services;

2. Possible deferral of the item on the Award of the Contract for the Provision of Stop Smoking Services to March 2017.

Chairman

Appendix A

Questions to the Health Committee. 12 January, 2017 from Jean Simpson

The Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG) published the Cambridgeshire and Peterborough Health Care System Sustainability and Transformation Plan (STP) (including appendices) on the 21 November 2016.

The CPCCG state that they have to save £500 million pounds from the Cambridgeshire and Peterborough health care system by 2020. However in the STP documents there is no evidence whatsoever about how they are going to save this amount of money, apart from beginning the downgrading of Hinchingbrooke Hospital. In order to try to understand where the cuts in services are to be made, Margaret Ridley (Chair of Keep Our NHS Public, Cambridge), sent a Freedom of Information request to the CCG asking to see the entirety of the STP submission that had gone to NHS England, including the workforce and financial appendices. In other geographical areas, the examination of STP appendices has revealed the extent of proposed job losses and cuts to local services.

The CPCCG has declined the request saying that "the financial details of the plan are still under discussion with NHS England". The response to the request is attached.

Questions.

1) How can the Health Committee scrutinise the STP published on the 21st November 2016 when, according to the FOI request reply, this is not the final document?

   The Health Committee can scrutinise the document that was presented to them at the December meeting but would expect to have sight and the option to scrutinise a final version of the STP. The Health Committee will ask the CCG to clarify its position on the documents provided.

2) Were the members of the Committee aware that this was not the final document?

   Members sought clarification with representatives from the CCG at the meeting on the 15th December as to which document they should be scrutinising, clarification was given that it was the “Fit for the Future” document published on the 21st November. http://www.fitforfuture.org.uk/what-were-doing/publications/. At no time during this meeting were members told that this was not the final document however the CCG did refer to missing appendix(s) that still required sign off through the appropriate NHS channels. Assurances were given that the Health Committee would receive these once they were finalised.

3) When is the Committee expected to make a decision about whether the proposals are in the interests of the health service and the community it serves?
4)

   The Health Committee in its scrutiny role is not a decision making body, this can be confusing as it has a duel role as an executive committee for the councils public health function in which decisions are made often at the same meetings.

   Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. The primary aim of health scrutiny as stated by the Department of Health in guidance is to strengthen the voice of local people ensuring that their needs and experiences are considered as an integral part of

the commissioning and delivery of services and that those services are effective and safe (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf)

As I noted at the December Health Committee we intend to conduct a robust scrutiny that will require looking in depth at specific elements within the STP proposals. It is also important to note that any "significant service changes" that result from the proposals in the STP are subject to independent statutory consultation with the Health Committee on each service change. Members of the Health Committee will then be able to provide clear recommendations for each proposal.

5) When is the Committee expected to make a decision the adequacy of the consultation process and whether sufficient time has been allowed for, given the fact that detailed information is being released in stages?

It is our understanding that the CCG is conducting an "engagement process" rather than a formal consultation. The CCG was provided with questions from the Health Committee for the meeting on 15th December. Responses received have indicated that there is five strands to the engagement. We will be focusing our meeting today on GP and Public engagement.

- Patient engagement in specific work streams
- Wider public engagement about awareness raising of the challenges the NHS is facing
- Wider engagement or consultation about specific areas of change
- Clinical engagement
- Staff engagement

Appendix B

Public Question to Cambridgeshire County Council Health Scrutiny Committee about the region's 'Sustainability and Transformation Plan'

To **Councillor David Jenkins**, and the Council's Health Committee, from Jeremy Caddick, Resident of Market, Cambridge

As a resident of Cambridge, and a user of local health and care services, I am extremely concerned by the 'Sustainability and Transformation Plan', developed by the NHS and local government officers, for Cambridgeshire and Peterborough, that has recently been published.

Thank you to Councillor Jenkins for responding to my question about the STP to the whole council last year.

I was concerned to read in your reply, however, that you could not give assurances to the public about delivering the STP without rationing of care or worsening quality of treatment.

I understand the county does not have direct responsibility for implementing the plan. However, the council has signed a memorandum of understanding with NHS services to work closely together on the project and councillors have a duty to represent their constituents and their wishes.

Many NHS officials have given warnings about the ability of regions to deliver the STP's without making huge cuts to services. Only a small minority of NHS Finance Directors think their financial targets are achievable.

I believe most residents of Cambridgeshire, who have seen health and care services deteriorate in recent years, will share my concern about the deliverability of these plans.

I would like to highlight to the committee, and to the councillors present, that a number of other local authorities have chosen to reject the STP's published for their region. Local authorities such as Ealing, Hammersmith and Fulham, Wirral Borough Council, Shropshire Council, Telford and Wrekin Council, have chosen to reject the STP's published for their region.

Oxford City Council has passed a motion which rejects the notion that £200 million can safely be saved from the local NHS budget by 2020-2021.

Yet the STP for Cambridgeshire aims to save £543 million.

I ask;

- Can the council, and this committee, assure the residents of Cambridgeshire, that they will refuse to endorse the region's STP, if it is clear the demanded savings cannot be delivered without threatening the availability and safety of NHS treatment?

  Rather than endorsing the STP it is the role of health scrutiny to ensure that the STP is robust, effective and inclusive. If the Health Committee doubts the effectiveness of the proposals it will say so. The Health Committee has a statutory role to scrutinise any

"significant service changes" that result from the proposals in the STP and members of the Health Committee will provide clear recommendations for each proposal.

We still need to see detailed financial plans to understand how the savings are being delivered and we have asked the CCG to provide us with more transparency around the risk register to understand the associated risk with each proposal.

- If the committee, and the council, decide the STP cannot safely be implemented, will they join local campaigns to publicly call for adequate funding for local health services?

  Through the use of democratic process local councillors are able to publically call for adequate funding for the local health services through formal channels. At the Council meeting on 18th October 2016 members voted in favour on a motion presented by Cllr Count for the CEO to write to the Secretary of State for Health and local MPs to

  > "call upon national government to provide significant transitional funding and transformational support to the Cambridgeshire's NHS, to strengthen preventive community services and care closer to home and reduce the pressures on local hospitals".

  https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/171/Committee/20/Default.aspx

  The Health Committee has previously had success with getting a motion about understanding the impact of Public Health expenditure on health outcomes and future costs in the broader health economy in Cambridgeshire. Further, the motion was passed at the Local Government Association's conference

Background Information - Time Scale of Health Scrutiny on STP

Date	Theme	In attendance
16TH June 2016	Training Session: To provide health committee members with an overview of the Sustainability and Transformation programme pre-submission by the CCG	Health Committee members
2nd Dec 2016	Overview session: on published STP with Cambridgeshire Health Watch in attendance	Members of STP Task & Finish group
15th Dec 2016	Health Committee: Introduction to published plans with CCG / STP programme representatives	Health Committee members
6th Jan 2017	Overview session: Representatives fro STP programme in attendance. Focus on Finance, Workforce Planning, Primary care engagement	Health Committee members invited
12th Jan 2017	Health Committee: GP & public engagement	Health Committee members
6th Feb 2017	Training Session: Centre for Public Scrutiny providing regional training around Scrutiny of STP	Hosted by Cambs County Council: 3 places to HC members
16th Feb 2017	Development Session: Representatives from STP programme Theme to be confirmed	Health Committee members
16th March 2017	Health Committee: Workforce planning with representatives from STP programme	Health Committee members

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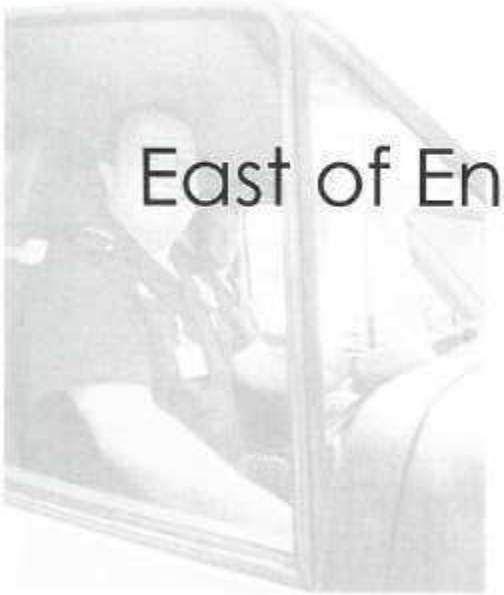

East of England Ambulance Service

Luke Squibb and Gill Briggs
Cambridgeshire and Peterborough

Twitter: @EastEnglandAmb
Like us on facebook

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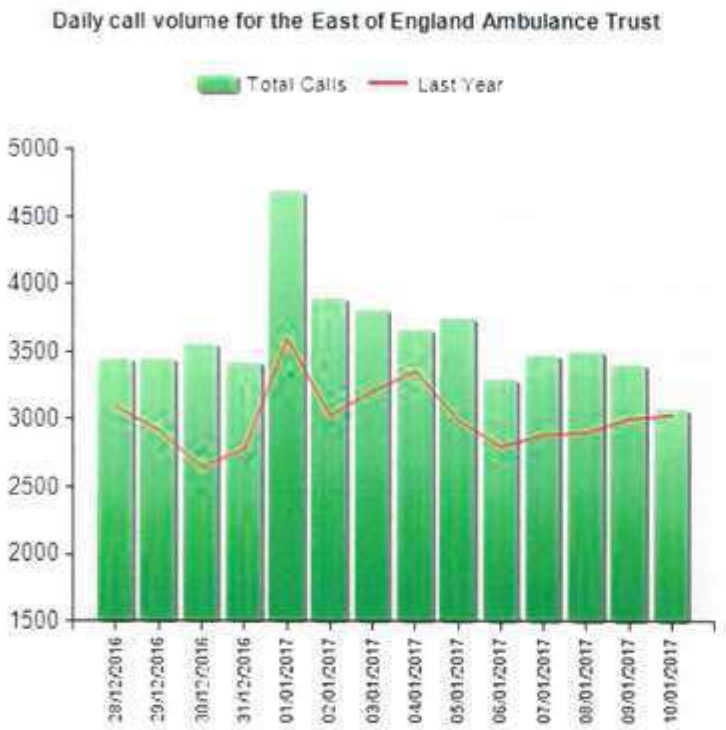
Hospitals covered across Cambridgeshire and Peterborough

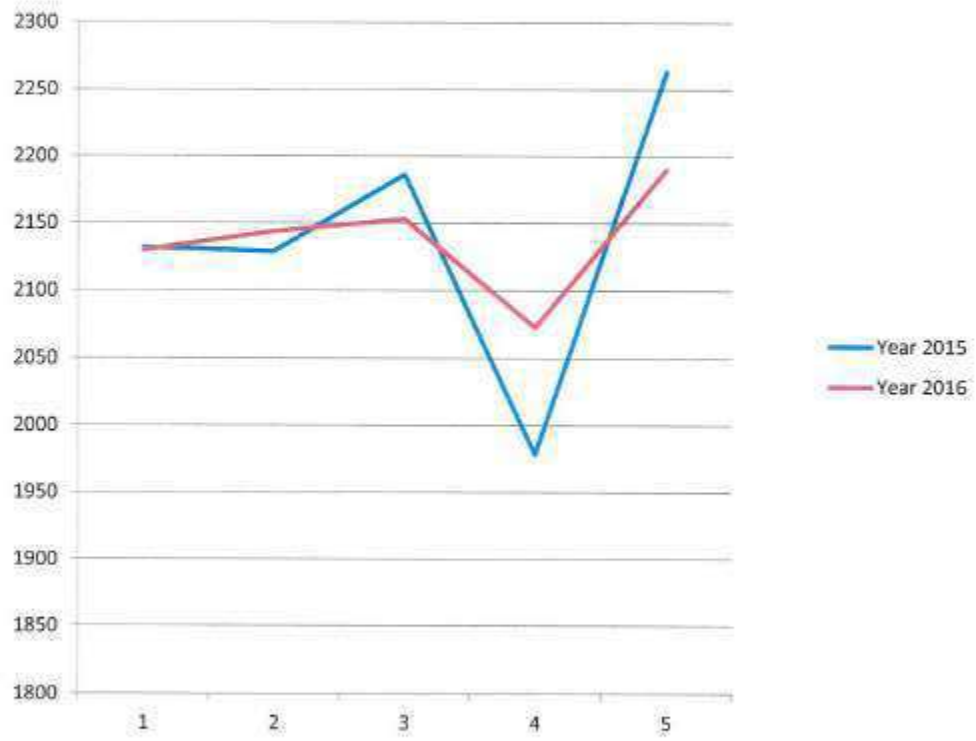
What has the demand been for EEAST?



Year on year increase in call volume

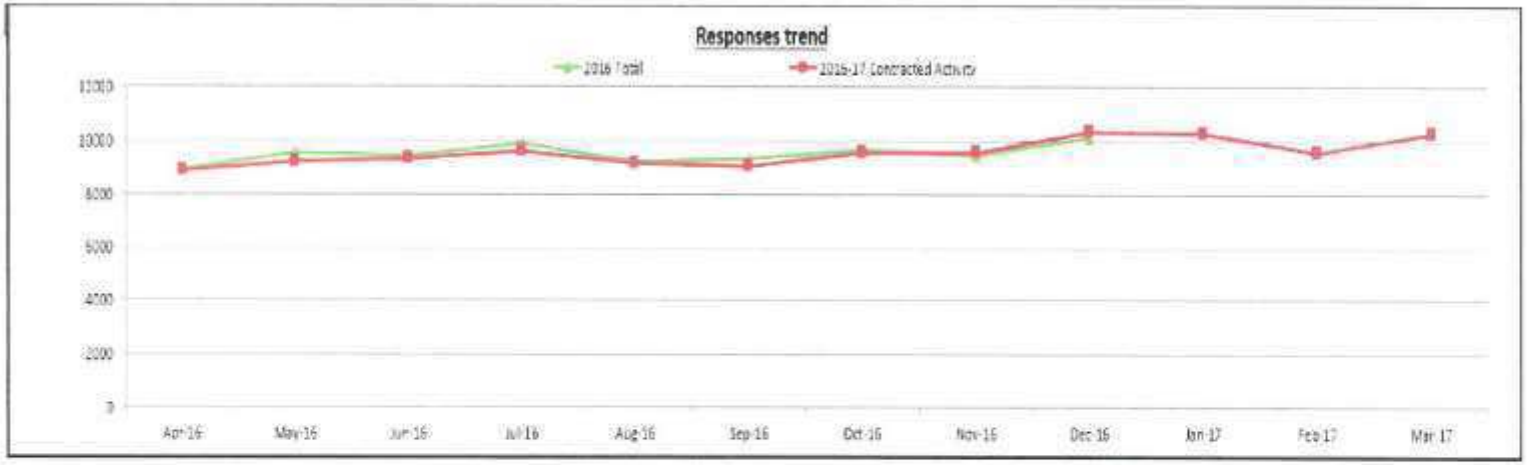
New years day saw 1000 extra calls compared to 2016

Demand across Cambridgeshire



- Comparing the 5 week period over December the 999 demand has been similar to 2015
- There was a sharp inrease this year the week before Christmas

How does this fit in with the contract?



Current demand is remaining in line with our contracted activity for 2016/17

Red 1 performance

Infographic Report

In-depth Report

1. RED 1 PERFORMANCE

A Red 1 priority is assigned to patients in cardiac arrest. A cardiac arrest happens when your heart stops pumping blood around your body. If someone has collapsed, is not breathing normally and is unresponsive, they are in cardiac arrest. This is a time critical priority.

Ambulance services are expected to reach 75% of Red 1 calls within 8 minutes

Last 12 months

Performance across EEAST is improving month on month and EEAST's performance national is currently 5th out of the 10 Ambulance Trusts in England

East of England Ambulance Service NHS
NHS Trust

How does our performance relate to patient care?

Infographic Report | In-depth Report

5. RETURN OF SPONTANEOUS CIRCULATION

This is a measure of the number of patients who have suffered a cardiac arrest, but as a result of life-support started or continued by the ambulance service, had a pulse again by the time they arrivec at hospital.

JULY 2016

NATIONAL AVERAGE
27%

RESULT
31%

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How does our performance relate to patient care?

Infographic Report

In-depth Report

6. RETURN OF SPONTANEOUS CIRCULATION – UTSTEIN

This is a measure of the number of patients who have suffered a cardiac arrest, but as a result of life-support started or continued by the ambulance service, had a pulse again by the time they arrived at hospital, and went on to be discharged from hospital.

JULY 2016

NATIONAL AVERAGE
53%

RESULT
65%

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How does our performance relate to patient care?

Infographic Report

In-depth Report

7. CARDIAC ARREST – SURVIVAL RATES

This is a measure of the overall number of patients suffering a cardiac arrest, but as a result of life-support started or continued by the ambulance service, and treatment in hospital, they were successfully resuscitated and survived.

JULY 2016

NATIONAL AVERAGE
9%

RESULT
10%

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In-depth Report

9. TREATMENT OF A HEART ATTACK – ARRIVAL AT A SPECIALIST CENTRE

This is a measure of the number of patients who have suffered a specific type of heart attack and need what's called a 'stent' fitted to free a blockage in their heart. This graph shows the percentage that were fitted with a stent at a specialist hospital within 2½ hours of their 999 call.

JULY 2016

NATIONAL AVERAGE 87%

RESULT 91%

Infographic Report

In-depth Report

10. TREATMENT OF A HEART ATTACK BY AMBULANCE CREW

This is a measure of the proportion of patients who have suffered a specific type of heart attack (called a ST-elevation myocardial infarction, or STEMI), and received the correct treatment in line with ambulance guidelines. This includes certain drugs being given and observations being taken and recorded.

JULY 2016

NATIONAL AVERAGE 80%

RESULT 95%

East of England Ambulance Service NHS Trust

How does our performance relate to patient care?

Infographic Report — **In-depth Report**

11. STROKE – ARRIVAL AT STROKE CENTRE

Patients who have suffered a confirmed stroke can be eligible for treatment with a clot-busting drug. This is called stroke thrombolysis. This graph is a measure of the percentage of patients that arrived at a thrombolysis centre within 60 minutes of their 999 call.

JULY 2016

NATIONAL AVERAGE **55%**

RESULT **52%**

Infographic Report — **In-depth Report**

12. STROKE – CARE AND TREATMENT BY AMBULANCE CREW

This is a measure of the percentage of suspected stroke patients who were assessed and received the correct treatment in line with ambulance guidelines. This includes certain observations being taken and recorded.

JULY 2016

NATIONAL AVERAGE **98%**

RESULT **100%**

Cambridgeshire continues to perform well in the Ambulance Care Quality indicator care bundles with Stroke and STEMI care bundles regular receiving 100% compliance.

Arrival at HASU within 60 minutes of 999 call remains a challenge due to the geography of EEAST

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CQC report

CareQuality Commission

Last rated
9 August 2016

East of England Ambulance Service NHS Trust

East of England Ambulance Service NHS Trust Headquarters

No services within EEAST were rated as inadequate.

Overall rating: Requires improvement

	Safe	Effective	Caring	Responsive	Well led	Overall
Emergency operations centre (EOC)	Requires improvement	Good	Outstanding ☆	Good	Good	Good
Patient transport services (PTS)	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Emergency and urgent care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

CQC report

CareQuality Commission

Last rated
9 August 2016

East of England Ambulance Service NHS Trust

East of England Ambulance Service were the only ambulance service in the country to achieve outstanding for caring.

Overall rating	Requires improvement
Are services	
Safe?	Requires improvement
Effective?	Requires improvement
Caring?	Outstanding ☆
Responsive?	Requires improvement
Well led?	Requires improvement

Agenda Item No: 4

FINANCE AND PERFORMANCE REPORT – January 2017

To:	**Health Committee**
Meeting Date:	**16 March 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 January 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 January 2017.**
Recommendation:	**The Committee is asked to review and comment on the report**

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

1.0 BACKGROUND

1.1 A Finance and 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 JANUARY 2017 FINANCE & PERFORMANCE REPORT

2.1 The January 2017 Finance and Performance report is attached at Annex A.

2.2 A balanced budget was set for the Public Health Directorate for 2016/17, incorporating savings as a result of the reduction in Public Health grant.

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

A forecast underspend of £171k has been identified across the Public Health budgets. Further detail can be found in Annexe A.

2.3 The Public Health Service Performance Management Framework for December 2016 is contained within the report. Of the thirty three Health Committee performance indicators, two are red, seven are amber, twenty two are green and two have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Statutory, Risk and Legal Implications

4.2.1 There are no significant implications for this priority

4.3 Equality and Diversity Implications

4.3.1 There are no significant implications within this category.

4.4 Engagement and Consultation Implications

4.4.1 There are no significant implications within this category.

4.5 Localism and Local Member Involvement

4.5.1 There are no significant implications within this category.

4.6 Public Health Implications

4.6.1 There are no significant implications within this category.

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

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

From: Martin Wade

Tel.: 01223 699733

Date: 9 February 2017

Public Health Directorate

Finance and Performance Report – January 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
December (No. of indicators)	2	7	22	2	33

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Dec) £000	Directorate	Current Budget for 2016/17 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Jan) £000	Forecast Variance - Outturn (Jan) %
-160	Health Improvement	8,459	-721	-3.0%	-160	-1.9%
0	Children Health	9,276	-59	-0.8%	0	0%
-50	Adult Health & Well Being	916	-123	-25.8%	-50	-5.5%
0	Intelligence Team	13	1	8.3%	0	0%
0	Health Protection	6	3	55.2%	0	0%
-26	Programme Team	136	-52	-44.9%	-26	-19.1%
71	Public Health Directorate	2,395	82	4.0%	65	2.7%
-165	**Total Expenditure**	**21,202**	**-320**	**-2.0%**	**-171**	**-0.81%**
0	Public Health Grant	-20,457	-1,855	-9.1%	0	0%
0	Other Income	-319	181	57%	0	0%
0	**Total Income**	**-20,776**	**-1,674**	**-0.1%**	**0**	**0%**
0	Planned drawdown from Public Health Reserves	-244	-1	0%	0	0%
-165	**Net Total**	**182**	**-1,995**		**-171**	

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

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

2.2 Significant Issues

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

There has been a minor increase to the anticipated forecast underspend, which is now -£171k (from -£165k last month). Forecast underspends are expected in Adult Health and Wellbeing (-£50k), Health Improvement (-£160k) and the Programme Team (-£26k), with a forecast overspend in the Public Health Directorate budgets of £65k, bringing the Directorate to an overall expected position of £-171k underspent at year end.

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

The total Public Health ring-fenced grant allocation for 2016/17 is £27.6m, of which £20.457m is allocated directly to the Public Health Directorate.

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

Sexual Health

- Performance of contract sexual health and contraception service remains good with all monthly key performance indicators achieved.

Smoking Cessation

- Smoking cessation performance has improved and the 4 week quitter monthly target remains at Amber following movement in January.

National Child Measurement Programme

- The measurements undertaken as part of the National Child Measurement Programme (School Year) can now be reported on as measurements took place in November. Both targets for number of children measured to date are green but it is not possible to formulate a trajectory as this is dependent on school timetabling.

Health Checks

- The number of Health Checks completed has moved from a red indicator to Amber as data is now being received.

Lifestyle Services

- Performance of the Integrated Lifestyles Service provided by Everyone Health has made encouraging improvements.
- All the datasets have been reviewed and a number of recording errors were identified, consequently amendments were made. To ensure that the correct data is aligned to indicators some of them have been re-worded. The data collected as evidence of referrals, referred to post triage numbers. All referral data is now amalgamated for reporting as one indicator to better reflect the overall activity volume and is now green.
- From the 17 Lifestyle Service indicators reported there is one red and one amber indicators.
- The number of healthy eating groups held has moved from red to amber in January and now the number of Personal Health Plans from the Health trainer service has moved from amber to green.
- Indicators reported on for the first time in January are: Tier 3 weight management services (clients achieving 10% weight loss) and % of children completing a weight management programme (maintaining or reducing BMI). Both indicators are green. The reporting timetable reflects the length of the interventions.
- The two falls prevention indicators remain green.

Health Visiting and School Nursing data

- Health Visiting and School Nursing data remains the same as reported last month.

4.2 Health Committee Priorities (Appendix 7)

- Smoking Cessation performance in the most deprived 20% of areas in Cambridgeshire stands at 80% of target. This is better than the remainder of the county where performance is 74%
- 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 3 years (80.3 years in the most deprived 20% of wards v. 83.3 years in the least deprived 80%). Further analysis is provided on pg.17 and provides an explanation in regards to interpreting this data with caution.

- Childhood Obesity: 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%). 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. Further details are available on pg.20

4.3 Health Scrutiny Indicators (Appendix 8)

- The trend of increasing Delayed Transfer of Care is indicated from the December 2016 data received from the acute trusts which represents the peak period of winter pressures. DTOC's have increased in comparison to this time period last year however this does reflect the national increase in winter pressures and demand for A&E services.

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

All Quarter 3 reports for the Public Health MOU services are now complete and included in Appendix 9. Spend is in line with expectations and no significant end of year variances are currently predicted. The Children Families & Adults directorate - Chronically Excluded Adults Team received 14 referrals in Q3. CEA were invited to present their work at CHS Group's annual conference and also the Integrated Offender Management annual conference at HMP Peterborough.

Both CFA and ETE Business and Communities directorate have continued to deliver a number of projects working with schools as detailed in the report. Highlights include: Junior Travel Ambassador Scheme with 7 new schools involved, Kick Ash 206/17 academic year programme commencing and CAMH Trainer providing 60 individuals with a whole school briefing around awareness raising on mental health.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Dec) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of Jan £'000	Actual to end of Jan £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Jan) £'000	Forecast Variance Outturn (Jan) %
	Health Improvement							
-30	Sexual Health STI testing & treatment	4,074	2,743	2,719	-24	-0.89%	-30	-0.74%
-50	Sexual Health Contraception	1,170	770	688	-82	-10.62%	-50	-4.27%
0	National Child Measurement Programme	0	0	0	0	0.00%	0	0.00%
0	Sexual Health Services Advice Prevention and Promotion	152	128	139	10	8.02%	0	0.00%
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Obesity Children	82	70	79	10	13.86%	0	0.00%
0	Physical Activity Adults	84	71	63	-8	-10.80%	0	0.00%
0	Healthy Lifestyles	1,605	1,295	1,245	-50	-3.86%	0	0.00%
0	Physical Activity Children	0	0	0	0	0.00%	0	0.00%
-80	Stop Smoking Service & Intervention	907	377	293	-85	-22.46%	-80	-8.82%
0	Wider Tobacco Control	31	26	21	-5	-19.81%	0	0.00%
0	General Prevention Activities	272	230	303	72	31.38%	0	0.00%
0	Falls Prevention	80	68	59	-9	-13.51%	0	0.00%
0	Dental Health	2	2	0	-2	-100.00%	0	0.00%
-160	**Health Improvement Total**	**8,459**	**5,780**	**5,607**	**-172**	**-2.98%**	**-160**	**-1.89%**
	Children Health							
0	Children 0-5 PH Programme	7,531	5,678	5,678	0	0.00%	0	0.00%
0	Children 5-19 PH Programme	1,745	1,476	1,417	-59	-3.98%	0	0.00%
0	**Children Health Total**	**9,276**	**7,154**	**7,095**	**-59**	**-0.82%**	**0**	**0.00%**
	Adult Health & Wellbeing							
-50	NHS Health Checks Programme	716	306	282	-24	-7.71%	-50	-6.98%
0	Public Mental Health	164	139	70	-68	-49.21%	0	0.00%
0	Comm Safety, Violence Prevention	37	31	0	-31	-100.00%	0	0.00%
-50	**Adult Health & Wellbeing Total**	**916**	**475**	**352**	**-123**	**-25.84%**	**-50**	**-5.46%**
	Intelligence Team							
0	Public Health Advice	13	11	12	1	8.33%	0	0.00%
0	Info & Intelligence Misc	0	0	0	0	0.00%	0	0.00%
0	**Intelligence Team Total**	**13**	**11**	**12**	**1**	**8.33%**	**0**	**0.00%**
	Health Protection							
0	LA Role in Health Protection	0	0	8	8	0.00%	0	0.00%
0	Health Protection Emergency Planning	6	5	0	-5	-100.00%	0	0.00%
0	**Health Protection Total**	**6**	**5**	**8**	**3**	**55.19%**	**0**	**0.00%**

Forecast Variance Outturn (Dec) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of Jan £'000	Actual to end of Jan £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Jan) £'000	Forecast Variance Outturn (Jan)
	Programme Team							
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking no pay staff costs	31	26	11	-16	-59.90%	0	0.00%
-26	General Prev, Traveller, Lifestyle	105	89	53	-36	-40.44%	-26	-24.78%
-26	**Programme Team Total**	**136**	**115**	**64**	**-52**	**-44.88%**	**-26**	**-19.10%**
	Public Health Directorate							
71	Health Improvement	633	532	579	49	9.13%	65	633
0	Public Health Advice	742	622	612	-10	-1.66%	0	742
0	Health Protection	182	154	197	43	28.20%	0	182
0	Programme Team	635	533	550	17	3.16%	0	635
0	Childrens Health	76	63	46	-17	-27.37%	0	76
0	Comm Safety, Violence Prevention	72	61	67	6	9.84%	0	72
0	Public Mental Health	55	46	41	-5	-10.55%	0	55
71	**Public Health Directorate total**	**2,395**	**2,010**	**2,092**	**82**	**4.07%**	**65**	**2,395**
-165	**Total Expenditure before Carry forward**	**21,202**	**15,551**	**15,231**	**-320**	**-2.06%**	**-171**	**-0.81%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0.00%**
	Funded By							
0	Public Health Grant	-20,457	-20,457	-22,312	-1,855	-9.07%	**0**	0.00%
0	S75 Agreement NHSE - HIV	-144	0	144	144	0.00%	**0**	0.00%
0	Other Income	-175	-148	-111	37	25.00%	**0**	0.00%
	Drawdown From Reserves	-244	-221	-222	-1	-0.45%	**0**	0.00%
0	**Income Total**	**-21,020**	**-20,826**	**-22,501**	**-1,675**	**-8.04%**	**0**	**0.00%**
-165	**Net Total**	**182**	**-5,275**	**-7,270**	**-1,995**	**-37.83%**	**-171**	**-93.81%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Current Budget for 2016/17 £'000	Current Variance		Forecast Variance - Outturn	
		£'000	%	£'000	%
Health Improvement	**8,459**	**-172**	**-3.0%**	**-160**	**-1.9%**
The overall forecast underspend of £160k against health improvement is a combination of £80k on stop smoking services and £80k on sexual health. The underspend on smoking represents the decreased payments to GPs for their provision of stop smoking services. This activity is being picked up by the core CAMQUIT Service. Secondly the Clinical Commissioning Group(CCG) re-charges us for the GP prescriptions for medication to help support people to quit smoking. We have not yet received all the up to date invoices for this from the CCG The underspend on sexual health reflects the continued decrease in the uptake of the online Chlamydia Screening Programme and secondly the Public Health England laboratory services that we commission for the Chlamydia Screening Programme has not yet invoiced the Local Authority at all this year. Invoices have been requested.					

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

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Outturn Expenditure £'000	Expected / Actual Transfer to PH Reserves	Notes
Public Health Grant as per Business Plan	**27,627**				Ringfenced grant
Grant allocated as follows;					
Public Health Directorate	20,457		20,457	0	Including full year effect increase due to the Children 0-5 transfer into the LA, the 16/17 confirmed decrease and consolidation of the 15/16 in-year decrease.
CFA Directorate	6,422		6,422	0	
ETE Directorate	327		327	0	
CS&T Directorate	201		201	0	
LGSS Cambridge Office	220		220	0	
Total	**27,627**		**27,627**	**0**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	20,948	
Virements		
Non-material virements (+/- £160k)	0	
Budget Reconciliation		
Current Budget 2016/17	**20,948**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2016	2016/17		Forecast Balance at 31 March 2017	Notes
		Movements in 2016/17	Balance at 31 Jan 2017		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,138**	176	962	**638**	**Estimated use of reserves to fund part year 16-17 savings not made, redundancy costs and one off funding agreed for previously MOU funded activity. (Estimated £500k pending review of commitments)**
subtotal	**1,138**	**0**	**962**	**638**	
Equipment Reserves					
Equipment Replacement Reserve	0	0	0	0	
subtotal	**0**	**0**	**0**	**0**	
Other Earmarked Funds					
Healthy Fenland Fund	500	0	500	400	**Anticipated spend £100k per year over 5 years.**
Falls Prevention Fund	400	0	400	200	
NHS Healthchecks programme	270	0	270	170	**Estimated spend, depending on timescale of developments.**
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	770	**Anticipated spend on PH Reference Group projects during 2016-17.**
Other Reserves (<£50k)	0	0	0	0	
subtotal	**2,020**	**0**	**2,020**	**1,445**	
TOTAL	**3,158**	**0**	**3,982**	**2,083**	

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

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

APPENDIX 6 PERFORMANCE

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

Below previous month actual
No movement
Above previous month actual

The Public Health Service Performance Management Framework (PMF) for December 2016 can be seen within the tables below:

Measures										
Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	100%	100%	G	100%	98%	100%	↔	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	87%	87%	G	87%	80%	87%	↔	
Dhiverse : % of people newly diagnosed offered and accepted appointments	100%	100%	100%	100%	G	100%	100%	100%	↔	
Access to contraception and family planning (CCS)	7200	5400	8015	148%	G	149%	600	148%	↓	
Number of Health Checks completed	18,000	13,500	12,926	96%	A	87%	4500	94%	↑	• The comprehensive Improvement Programme is continuing this year. Intelligence from the commissioned social marketing work clearly indicates a lack of awareness in the population of Health Checks. Actual health check numbers compare reasonably well to other areas but the issue is the conversion rate which is attributed to the poor public understanding of the Programme. • All the key CCG and CCC processes required to introduce the new software into practices are completed and we are waiting for the sign off of the contract. • Other activities include staff training and a new media campaign • Pease note that the data for this period is incomplete as a large number of practices returned incomplete datasets. Currently staff are working with practices to ensure all data is captured
Percentage of people who received a health check of those offered	45%	45%	41%	41%	A	33%	45%	41%	↑	
Number of outreach health checks carried out	1,900	1425	865	61%	R	49%	158	31%	↓	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. This commenced in February and started gaining momentum. Initial recruitment difficulties meant that this programme was slow to develop. The programme targets workplaces especially in Fenland. Workplaces in the South of the county are performing well, however it has not been possible to secure access to the factories in Fenland where there are high risk workforces. This has affected performance . The service being delivered outside of Fenland is close to target. Engaging workplaces in Fenland however is challenging. where in excess of 100 workplaces and community centres have been contacted with very little uptake. Everyone Health are working with Public Health to develop different methods of engagement in an attempt to increase the number of NHS Health Checks delivered.
Smoking Cessation - four week quitters	2249	1316	1210	92%	A	133%	177	86%	↓	• The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) suggest the prevalence of smoking in Cambridgeshire has increased slightly in the last few years, returning to a level statistically similar to the England average (16.4% v. 16.9%), although the trend is not statistically significant. Smoking rates in routine and manual workers are consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where routine and manual smoking rates have returned to a level worse than the average for England (39.8%). There has been ongoing performance improvement this year. • There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area.

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	56%	N/A	G	56%	58%	57%	↑	A stretch target for the percentage of infants being breastfed was set at 58%, - above the national average for England. The number of infants recorded as breastfed (fully or partially) at 6 weeks for Q2 has increased slightly to 57% in Q2, and the figure is one of the highest statistics in the Eastern region in published Public Health England data (2015/16).
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	/	47%	N/A	A	47%	50%	38%	↓	Of note, all of the health visiting data is reported quarterly. The data presented relates to the Q2 period (Jul - Sept) 2016-2017 and is compared to Q1 2016-2017 data for trend. Since Q1 there has been a fall in the antenatal contacts from 47% completed to 38%, and is due to staffing levels. Priority is being given to those parents who are assessed as being most vulnerable. This KPI will be monitored over the next quarterly period.
Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	90%	90%	96%	N/A	G	96%	90%	96%	↔	
Health visiting mandated check - Percentage of children who received a 6 - 8 week review	90%	90%	94%	N/A	G	94%	90%	94%	↔	94% received a review at 6-8 weeks, well above the 90% targets.
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	92%	N/A	A	92%	100%	91%	↓	The target of 100% for percentage of children who received a 12 month review by age 15 months has not been met, however if 'not wanted and not attended' figures are included, the figure rises to 96%.
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	77%	N/A	A	77%	90%	80%	↑	The target of 90% for percentage of children who received a 2-2.5 year review has not been reported as met, although the proportion has increased since the last reporting period. However, if 'not wanted and not attended' figures are included, Q2 figure rises to 91% which falls within a range of 10% tolerance.
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	169	N/A	N/A	168	N/A	20	↓	Whilst this seems a significant drop in the number of young people seen, the Q2 period includes the summer holiday period, where the school nurses are not delivering services in the school settings. Therefore there is expectation that the Q2 data will be significantly lower than any other period
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	513	N/A	N/A	513	N/A	123	↓	

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	18.6%	23.1%	124%	G	117%	18.6%	124%	↑	The National Child Measurement Programme is undertaken during school term times. It is not possible to formulate a trajectory as this is dependent on school timetabling. Measurements commenced in November 2016.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	18.6%	24%	128%	G	121%	18.6%	128%	↑	
Overall referrals to the service	4611	3384	3414	101%	G	73%	239	111%	↑	The Countywide Integrated Lifestyle Service provided by Everyone Health has now successfully recruited to all areas . Training was completed in September and the Service was fully operational in November. Currently we have been working with EH on their data returns supported by the Chief Executive Officer and reviewing all areas to ensure that measures are being put in place to address those areas where there is under achievement. A factor is also the additional Health Trainer Services for Falls and more recently Mental Health which has led to the more experienced and skilled health trainers moving to these new areas for career development.
Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	1433	1055	1005	95%	A	83%	72	85%	↑	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1075	790	890	113%	G	199%	53	500%	↑	This intervention can take up to one year. Therefore there are cyclical changes. Measures to identify why the completion rate was low identified incomplete date processes and a substantial improvement in the monthly report
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	992	731	890	122%	G	62%	50	108%	↑	
Number of physical activity groups held **(Pre-existing GP based service)**	581	416	441	106%	G	150%	30	93%	↓	
Number of healthy eating groups held **(Pre-existing GP based service)**	290	216	253	117%	G	192%	24	133%	↓	
Personal Health Trainer Service - number of PHPs produced (Extended Service)	534	375	377	101%	G	106%	28	79%	↓	This reflects the recruitment issue which was resolved in November when the new staff were trained.
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	400	280	148	53%	R	57%	21	267%	↑	This intervention can take up to one year. The poor performance reflects the recruitment issues in year 1 of the contract and the associated lower number of PHPs produced.
Number of physical activity groups held (Extended Service)	578	410	536	131%	G	115%	30	163%	↑	

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of healthy eating groups held (Extended Service)	726	531	571	108%	G	231%	45	198%	↓	
Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	42%	140%	G	121%	30%	167%	↑	
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	60%	60%	61%	102%	G	107%	60%	83%	↓	
% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	80%	80%	88%	110%	G	n/a	80%	113%	↑	
Falls prevention - number of referrals	386	242	262	108%	G	72%	15	93%	↑	
Falls prevention - number of personal health plans written	279	175	210	120%	G	71%	11	82%	↑	

* All figures received in January 2017 relate to December 2016 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.

Monthly update:

- The percentage of the smoking quit target achieved in December has increased compared to the previous month in least deprived 80%. In the most deprived 20% of practices in Cambridgeshire the percentage of the smoking quit target achieved has decreased.
- In the least deprived 80%, 103 four-week quits were achieved, 89% of the monthly target of 116; in the most deprived 20% of practices, 64 four-week quits were achieved, 89% of the monthly target of 72.
- Looking at performance data for the year to date, the percentage of the quit target achieved in the least deprived 80% of practices stands at 74% and in the most deprived 20%, at 80%.

Year-to-date:

- The RAG statuses for the year-to-date smoking quit targets are red indicating that the targets for both the least deprived 80% and most deprived 20% of practices remain more than 10% away from the targets.
- Although year-to-date targets are not met within either group, the performance in the most deprived 20% of practices is currently better than in the least deprived 80%.

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, December 2016/17

Practice deprivation category	Year end target	Year-to-date					December			Previous month	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	1,388	1,041	767	74%	26%		116	103	89%	66%	↑
Most deprived 20%	861	646	514	80%	20%		72	64	89%	103%	↓
All practices	2,249	1,687	1,281	76%	24%		187	167	89%	80%	↑

RAG status:

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

Direction of travel:

↑ Better than previous month
↓ Worse than previous month
↔ Same as previous month

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

	Year-to-date	December	Previous month	Direction of travel
Percentage point gap	6%	0%	37%	*

* Achievement of the quit target the same in both groups - direction of travel for reducing the gap not assessed

Direction of travel:

↑ Better than previous month
↓ Worse than previous month
↔ Same as previous month

Sources:
General practice returns to Cambridgeshire County Council Smoking Cessation Service
Public Health England 2015 Indices of Multiple Deprivation for general practices, based on the Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 17/02/17

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.

Quarter 3

- The percentage of the health check target achieved in Quarter 3 was higher in the least deprived 80% of practices than in the most deprived 20%.
- In the least deprived 80%, 3152 health checks were delivered, 99% of the quarterly target of 3173; in the most deprived 20% of practices, 1077 health checks were delivered, 81% of the quarterly target of 1327.
- The gap in performance between the two groups was 18 percentage points in Quarter 3.
- The gap in performance between the two groups decreased in Q3 compared to the gap seen in Q2 due to a greater increase in health checks for the most deprived practices and a decrease in health checks for the least deprived 80%.

Year-to-date

- Looking at performance data for the year to date, the percentage of the health check target achieved is more than 10% away from the target in the most deprived 20% of practices (at 75%) but is meeting the year-to-date target in the least deprived 80% (at 104%)
- The gap in performance between the two groups is 29 percentage points.

Percentage of health check target achieved by deprivation category of general practices in Cambridgeshire, 2016/17 Quarter 3

Practice deprivation category	Year end target	Year-to-date					Quarter 3			Previous quarter	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	12,691	9,518	9,943	104%	-4%		3,173	3,152	99%	104%	↓
Most deprived 20%	5,309	3,982	2,995	75%	25%		1,327	1,077	81%	78%	↑
All practices	18,000	13,500	12,938	96%	4%		4,500	4,229	94%	97%	↓

RAG status:

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

Direction of travel:

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

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

	Year-to-date	Quarter 3	Previous quarter	Direction of travel
Percentage point gap	-29%	-18%	-27%	↑

Direction of travel:

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

Sources:
Practice returns to Cambridgeshire County Council Public Health Team
Practice level index of multiple deprivation (IMD) Public Health England/Kings College London, 2015
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 16/02/2016

There is an intensive programme of support given to GP practices that deliver the majority of NHS Health Checks. However practices in these areas have experienced staff losses that affect their capacity. Outreach NHS Health Checks provided by the Integrated Lifestyle Service Everyone Health have a focus upon Fenland working in community settings including workplaces. However it ahs been challenging securing the engagement of employers which is currently being discussed by the Health Committee.

Life expectancy and healthy life expectancy

Due to time restrictions and pressing deadlines life expectancy has not been updated

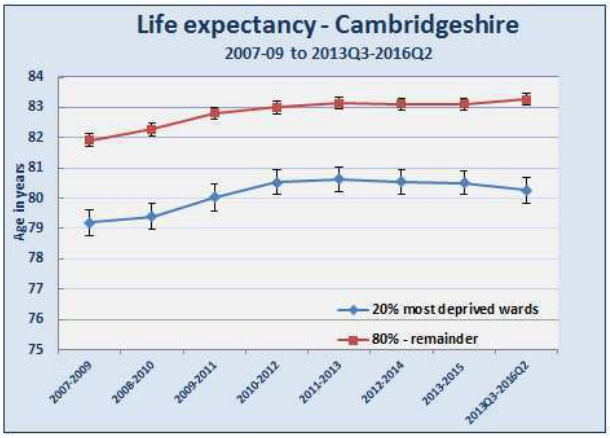
Inequalities in life expectancy: aiming to reduce the gap in years of life expectancy between residents of the 20% most deprived and the 80% least deprived electoral wards in Cambridgeshire.

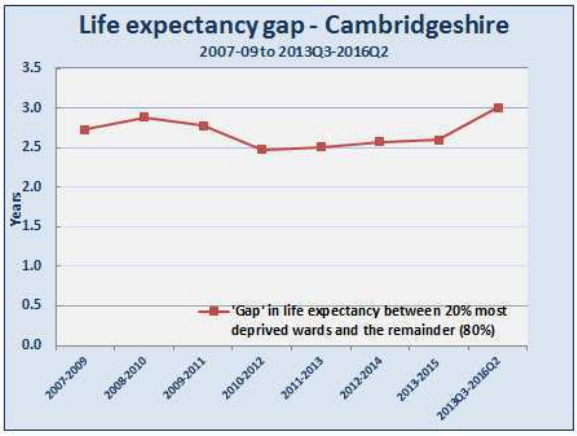
- The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% least deprived was 2.6 years for both 2012-2014 and 2013-2015.
- For the latest 3-year period available, covering 2013 Q3 to 2016 Q2, the absolute gap was 3 years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

people who are homeless, also have lower life expectancy than the general population. Key interventions to reduce this gap are in tackling lifestyle factors and ensuring early intervention and prevention of key diseases.

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

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





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

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

Healthy life expectancy.

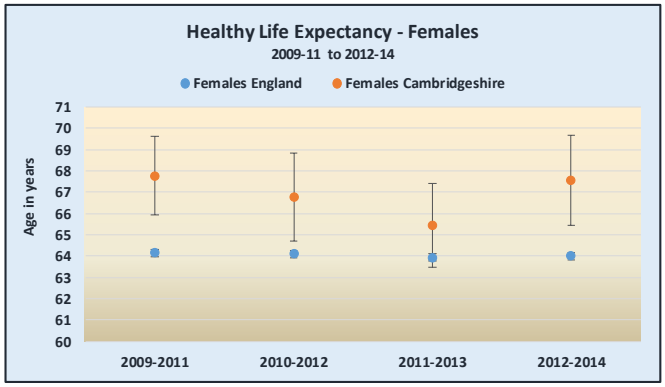
- Healthy life expectancy for men for the period 2012-2014 in Cambridgeshire was 66.1 years. For females the figure was 67.6 years. The 'actual' figure for men (66.1 years) is lower than for females (67.6 years). No target has been set for this indicator. The local value reported is to be assessed in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

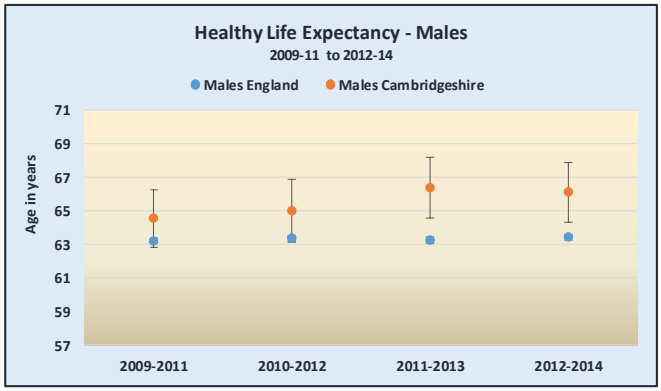
influence these figures as well. In many countries with lower life expectancies this difference between male and females is not so apparent.

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

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

NB: chart axes do not start at zero.

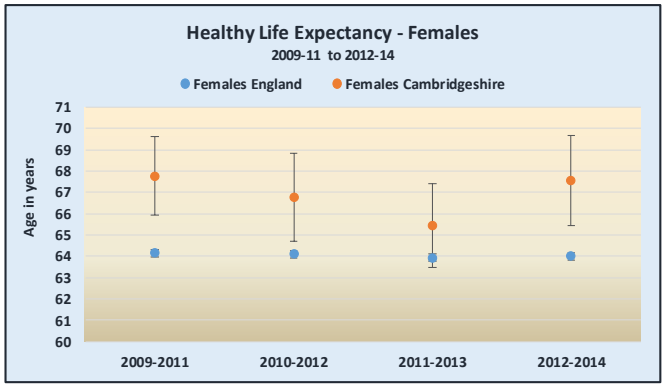


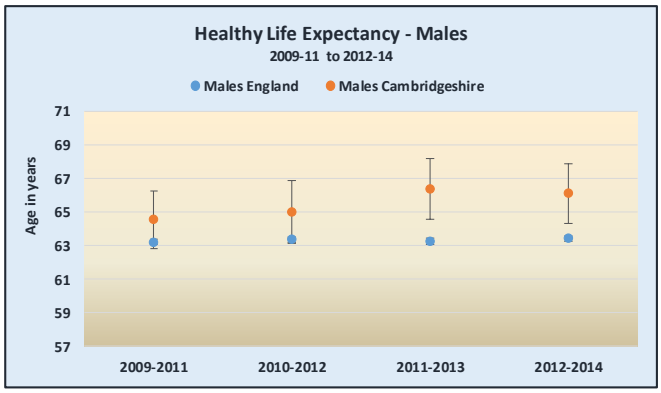


Calendar years	Cambridgeshire				England			
	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'
Males								
2009-2011	80.6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

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

NB: chart axes do not start at zero.





Child obesity

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

Children aged 4-5 years classified as overweight or obese

The target for Reception children in Fenland is to reduce the proportion of children with excess weight (overweight and obese) by 1% a year, whilst at the same time reducing the proportion for Cambridgeshire by 0.5%. In 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 Oct 2016-30th January 2017 6 secondary schools had a whole school briefing (146 people attending).
- A further 7 schools (104 individuals) have accessed other face-to-face training, such as youth mental health awareness training.
- There have been 106 new e-learning accounts registered by people working in schools between 1st October-31st December 2017.

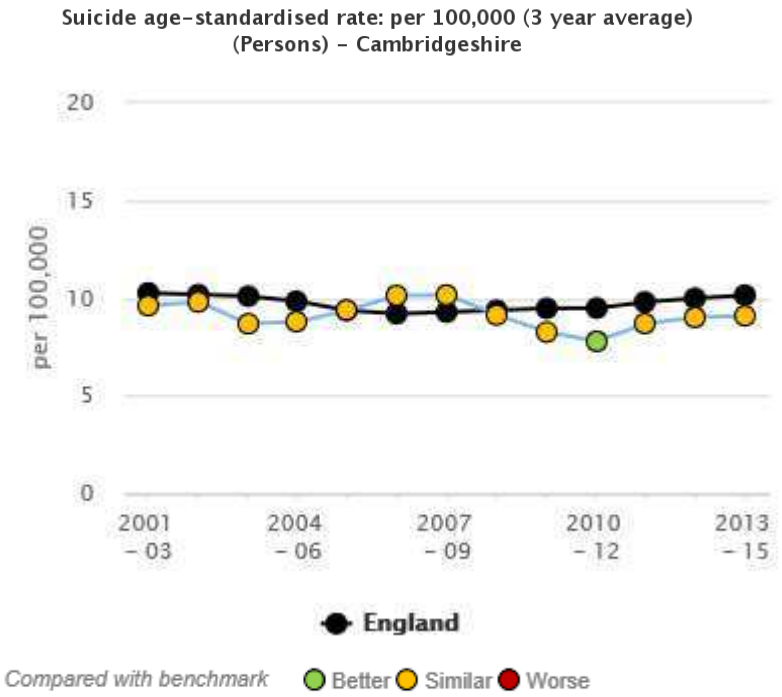
- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – To date (June 2016), 21 out of 30 secondary schools have taken up the offer of a consultancy visit.
  This piece of work was funded for the 2015/16 academic year only.

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

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

Directly standardised rate - per 100,000

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

Source: Public Health Outcomes Framework

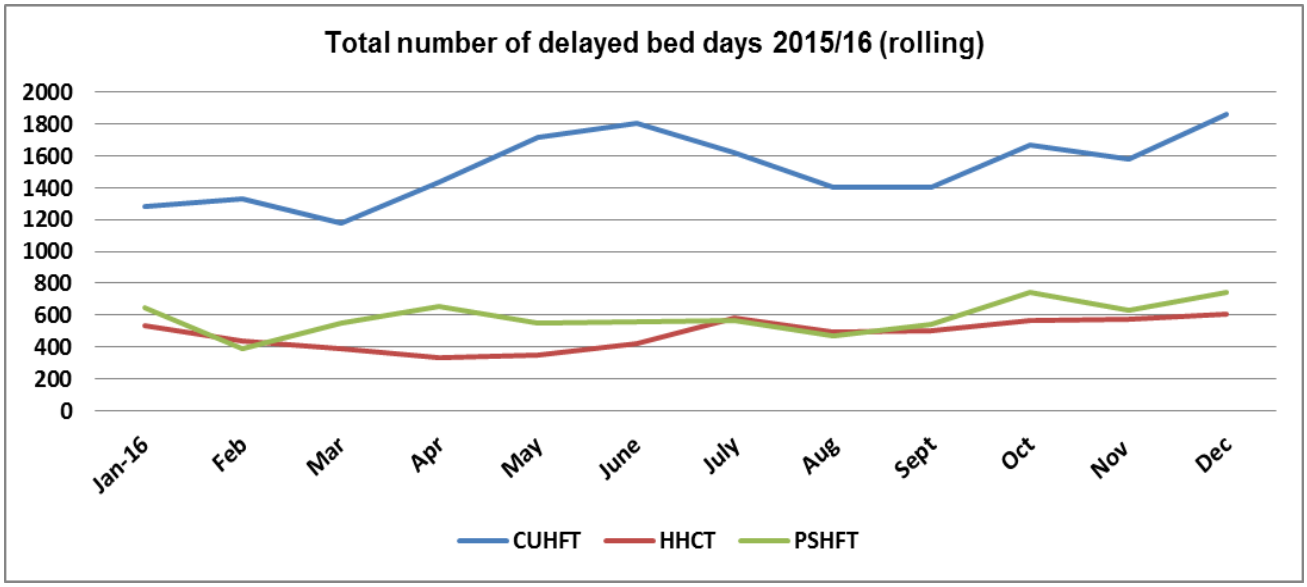
APPENDIX 8

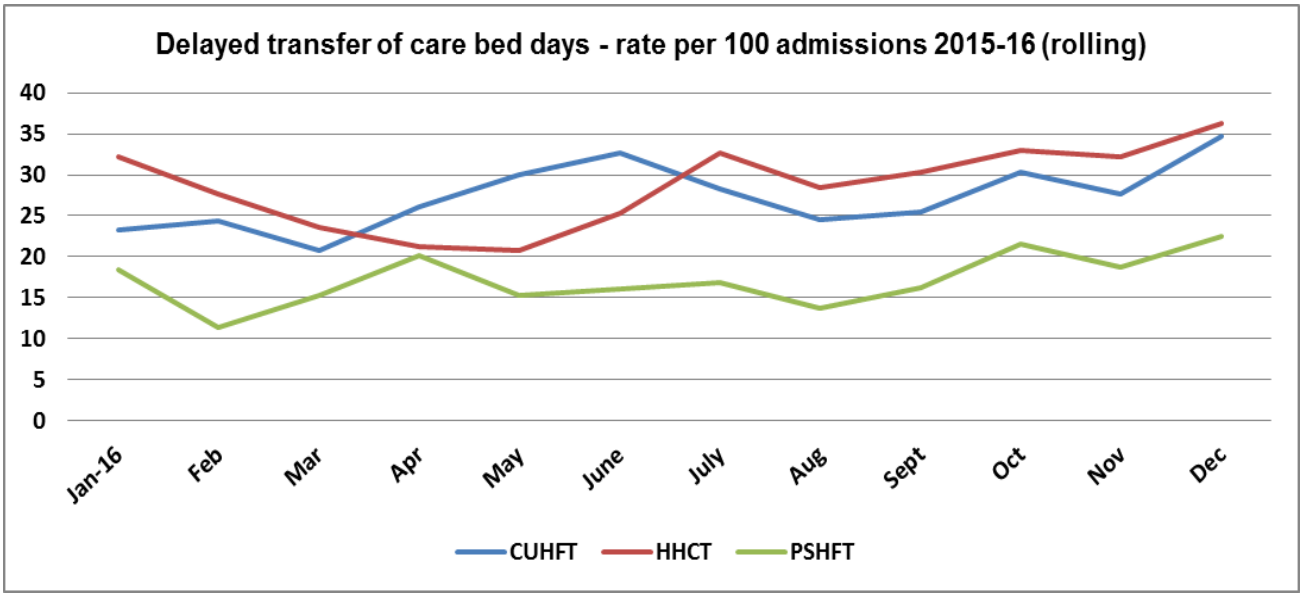
Health Scrutiny Indicators

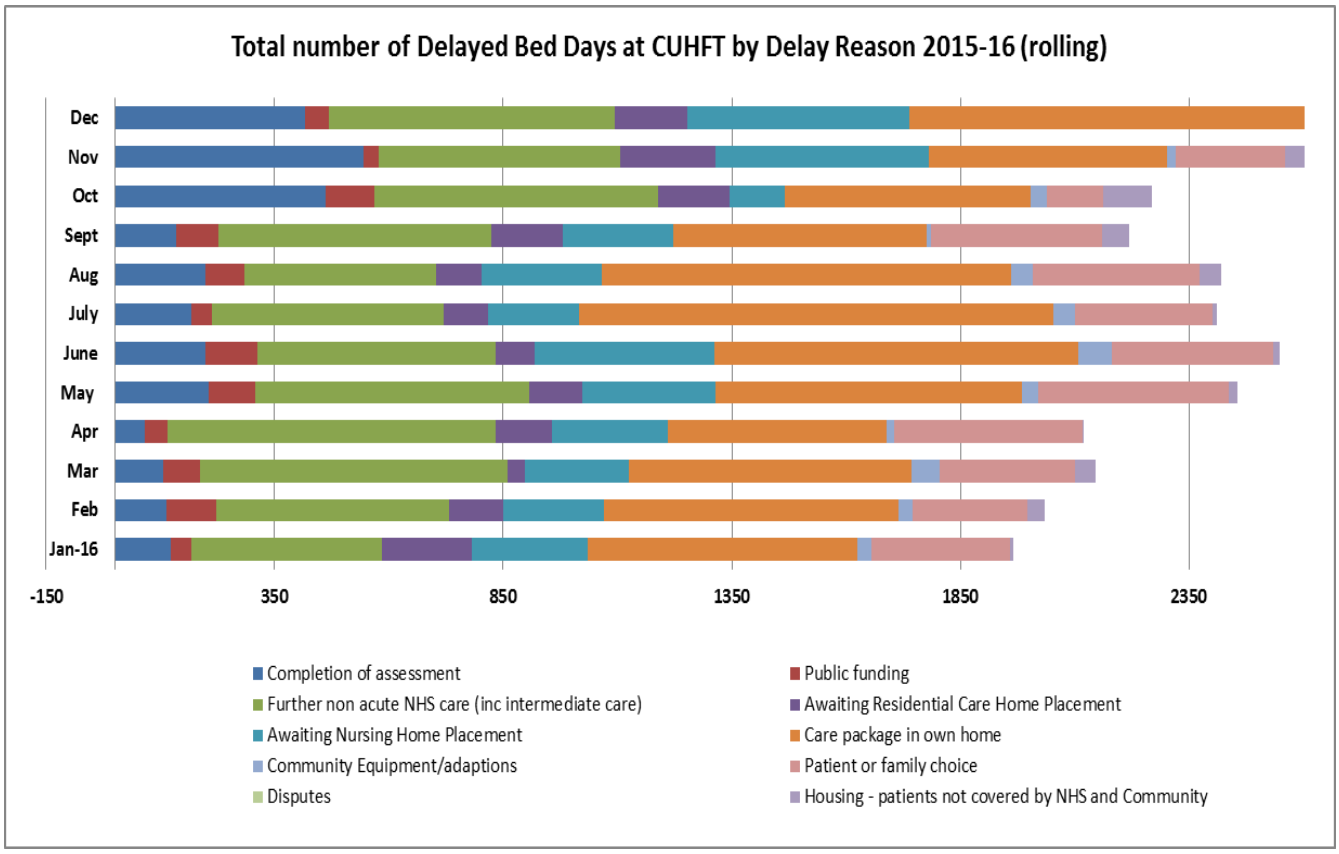
Updates on key indicators for NHS issues which have been scrutinised by the Health Committee are as follows:

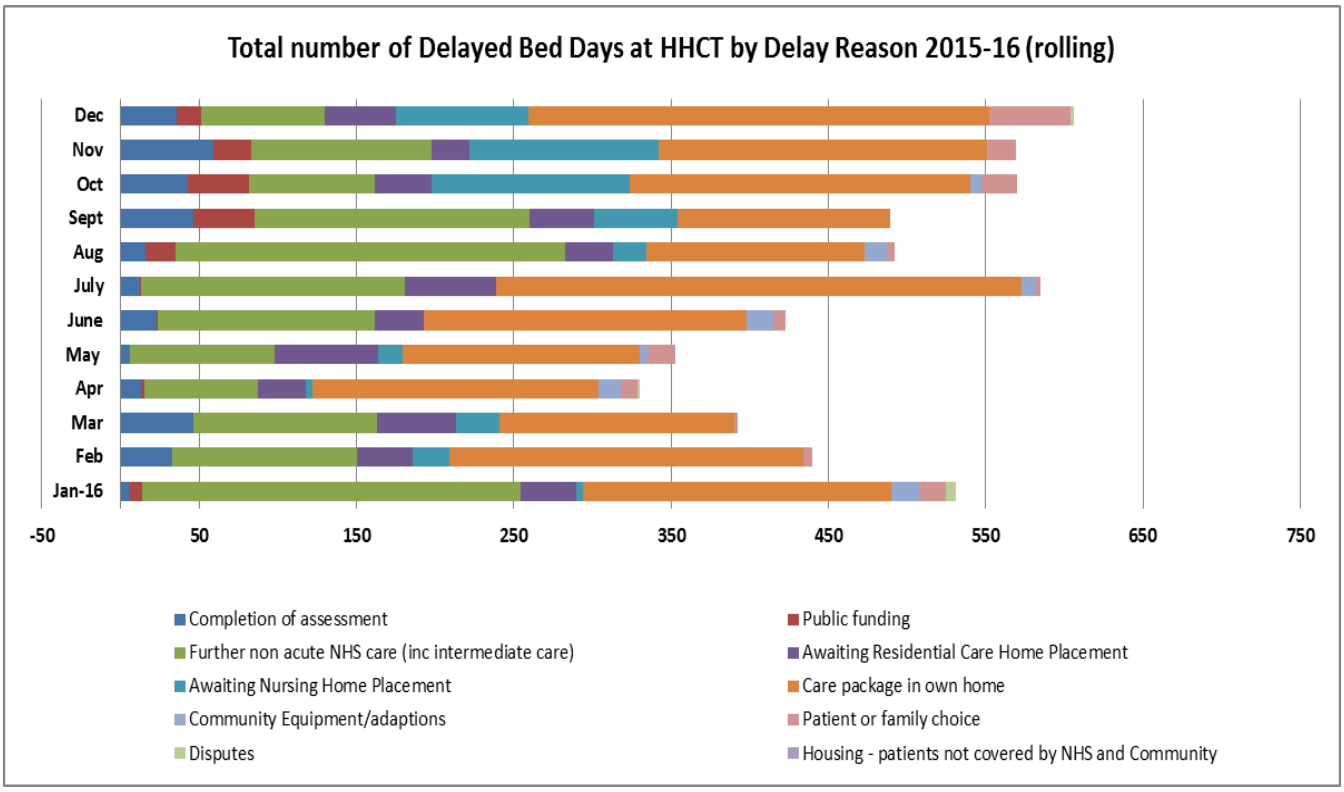
- **Delayed Transfer of Care (DTOC)**

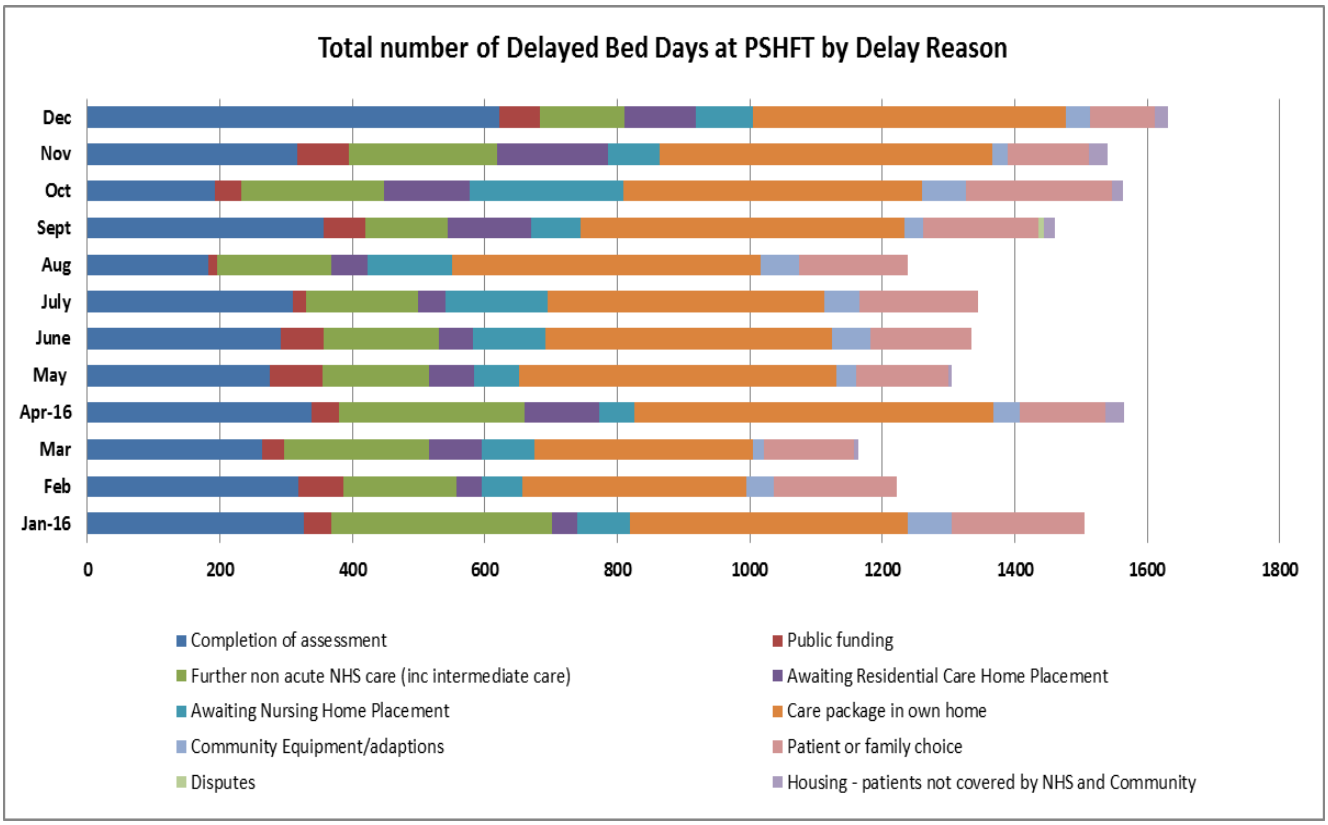
The trend of increasing DTOC continues from the previous report to Health Committee. The data provided for December 2016 for DTOC for both Hinchingbrooke Health Care NHS Trust and CUHFT indicates a significant increase in DTOC. This is now data taken from the winter pressure period for acute trusts. There has been significant national and local media coverage around the pressures the trusts are experiencing in both A&E and the impact that DTOC has on emergency department's capacity. Both trusts report that they continue to work with system partners to address the large scale impact of DTOCs.






Total number of Delayed Bed Days at CUHFT by Delay Reason 2015-16 (rolling)
Dec
Nov
Oct
Sept
Aug
July
June
May
Apr
Mar
Feb
Jan-16
-150
350
850
1350
1850
2350
Completion of assessment
Public funding
Further non acute NHS care (inc intermediate care)
Awaiting Residential Care Home Placement
Awaiting Nursing Home Placement
Care package in own home
Community Equipment/adaptions
Patient or family choice
Disputes
Housing - patients not covered by NHS and Community


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


Total number of Delayed Bed Days at PSHFT by Delay Reason
Dec
Nov
Oct
Sept
Aug
July
June
May
Apr-16
Mar
Feb
Jan-16
0
200
400
600
800
1000
1200
1400
1600
1800
Completion of assessment
Public funding
Further non acute NHS care (inc intermediate care)
Awaiting Residential Care Home Placement
Awaiting Nursing Home Placement
Care package in own home
Community Equipment/adaptions
Patient or family choice
Disputes
Housing - patients not covered by NHS and Community

APPENDIX 9

PUBLIC HEALTH MOU 2016-17 UPDATE FOR Q3

Directorate	Service	Allocated	Q3 Update	YTD expected spend	YTD actual spend	Variance
CFA	**Chronically Excluded Adults (MEAM)**	£68k	During Q3 we received 14 referrals and were able to start work with five new complex needs clients. Two clients have been closed. One of these had demonstrated that she was not wishing to change her current situation. The other is doing well in her tenancy with support that we have brought in. In addition to this CEA continues to provide support and advice to non CEA clients and agencies. Various level of brief intervention were given to 14 non CEA clients, as well as supporting 4 professionals meetings. A new worker has joined the CEA tem in a post funded by Cambridge City Council, to support street based clients with a focus on those perpetrating Anti-Social Behaviour. The worker has already drawn up a referral process and started work with a caseload of 9 clients. Her early work has identified the difficulty for street based clients to access treatment for substance misuse, at the same time as accessing accommodation. We have instigated conversation with the treatment misuse service in Cambridgeshire, which we will progress in Q4. We continue to lead on the Housing First strategy in Cambridgeshire and have also presented nationally at a workshop hosted by Homelesslink. CEA were invited, and attended, a round table at MEAM to examine the national strategy going forward, and what contributions we could make locally. The conversations covered the following areas: • Increase the number of MEAM Approach areas • Develop an evaluation framework that can 'compare and contrast'	£51,000	£51,000	0

			findings across the two networks • Create opportunities for cross-network learning • Support more people with multiple needs to live fulfilling lives and create a stronger legacy for both networks at the end of the funded period CEA were invited to present its work at CHS Group's annual conference and also the Integrated Offender Management annual conference at HMP Peterborough. CEA contributed to the local application to the national 'Trailblazer' find. The multi-agency application achieved a national grant of £400,000 which is to be spent on the provision of a dual diagnosis outreach team, to support rough sleepers. CEA will be attending the steering group starting in January.			
CFA	**PSHE KickAsh**	£15k	• Ten secondary schools recruited to the programme • All mentor training completed in all for participating secondary schools • Primary school visits commenced January 2017	£11,250	£11,250	0
CFA	**Children's Centres**	£170k	The overall aim of Cambridgeshire Children's Centres remains ensuring a healthy start to life for children aged 0-4, and ensuring readiness for school whilst maintaining a focus on inequalities in the early years, and targeting support which will minimise the need to access specialist services where possible. The Public Health funding is utilised as part of the total Children's Centre budget to improve health of children aged 0-5. Close alignment and joint working with community health colleagues in Health Visiting, Family Nurse Partnership and maternity Services is established for all Children's Centres. Work continues to ensure arrangements with Health partners are consistent and functionally effective at a community level for families as structural service change is introduced across the system.	£127,500	£127,000	0
CFA	**Mental Health Youth Counselling**	£111k	Youth Counselling services are provided by Centre 33 and YMCA covering the whole of Cambridgeshire for 13-25 year olds. This quarter's contract monitoring meeting is upcoming. There continues to be a high number of young people accessing these counselling services, in 2015/16 550 young people accessed the services. There remains a waiting list for counselling in certain areas. As part of a wider re-design of child and adolescent mental health	£83,250	£83,250	0

			services, this service is being re-tendered this year. The existing contracts have been extended to December 2017 to align with the tendering timeline, and to ensure that there is no gap in provision. The service will be re-commissioned across Cambridgeshire and Peterborough, with additional funding from Peterborough City Council and Cambridgeshire and Peterborough Clinical Commissioning group.			
CFA	**CAMH Trainer**	£71k	The CAMH trainer is employed by CPFT, and delivers specialist mental health training for a range of roles working with children and young people. Training specifically tailored to the needs of schools is also provided with a new 1 day Youth Mental Health Awareness course for the 2016/17 academic year. Between October-December 2016, 60 individuals attended a whole school briefing (designed to raise awareness of mental health and to lead into specific schools training) across 3 schools. Training was delivered in a further 2 schools (one school undertook the Youth Mental Health Awareness training with 14 members of staff) 106 people from school setting have newly registered for an e-learning account between October-December 2016. A CPD day on 'LGBT Mental Health' was also delivered (14 attendees) and a 1 hour CPD Seminar on 'Managing Self-Harm' (6 attended). A range of individuals from education settings and from the local authority (ie Family workers) attended the training. 14 people have begun the foundation module course that is delivered; this is a more extensive course over 13 days, spread across the year. A range of professionals are engaged in this training including Family Workers and Young People's workers.	£53,250	£53,250	0
CFA	**DAAT**	£5,980k	At the end of Qtr 3 there had not been any current spend for the allocated budget for GP Shared Care & Nalmafene, this information is passed through for recharge by PH and to date no financial information has been received for processing any payments. The inpatient detox beds contract is paid up to end November and Decembers invoice has been sent for payment but did not go through procurement system in time to show at the end of Qtr3 report so this will show in Qtr4. The Service User Contract is paid to end Qtr 3 as per agreements.	£4,485m	£4,205,786	£279,214

			Qtr 1, Qtr 2 and Qtr 3 80% invoices from Inclusion for the Drug & Alcohol Contracts have been received and paid as well as the Qtr 1 invoice for the 20% performance element of the contract. Qtr 3 of the young people's contract has now been paid and this will show in Qtr 4's report. The predicted Q3 spend is based solely on 3/4 of the overall allocated budget so the predicted and actual spend will vary during the year depending on when invoices are received. It is anticipated the budget will be spent by year end with the exception of the predicted underspend of £35K already reported to Public Health which is made up £15K commissioning (admin post), £10K GP Shared Care/Nalmafene and £10K substance misuse interventions. Currently the only invoices we are expecting which will not be paid by year end and will be put on reserves list is the Inclusion Contract where the contract is based on 80% in advance quarterly and the remainder 20% performance related which is normally paid during the next quarter following the performance meeting. This is to ensure that Inclusion have met their targets in line with the contract agreement, the 20% performance related invoices are then agreed for payment.			
CFA	**Contribution to Anti-Bullying**	£7k	This is a nominal amount and is part of a large budget, it is therefore difficult to pull out exactly what the £7k covers, and difficult to apportion amounts. This will be spend in total.	£5,250	£5,250	0
			SUB TOTAL : CFA Q3	**£4,816,500**	**£4,537,286**	**£279,214**
ETE	**Active Travel (overcoming safety barriers)**	£55k	Currently 66 schools are actively engaged in the school travel planning process through STARS, 32 accredited to Bronze level and 2 Gold. Awaiting further update on accreditations submitted in December. Since the beginning of April: • Walk Smart has been delivered to 132 pupils • Scoot Smart has been delivered to 1,118 pupils • Pedal Smart has been delivered to 120 pupils Delivery October to February is limited due to weather, so limited during Q3 and Q4. Work has been focussed on booking schools for	£41,250	£41,250	0

			Spring/Summer 2017 and training volunteers to deliver Scoot Smart at 5 schools. Exhibits/education resources have been reviewed and serviced/ updated			
ETE	**Explore additional interventions for cyclist/ pedestrian safety**	£30k	'Be Bright Be Seen' promotion ran just before and after the clocks changed in October and in to November. Data and intelligence continues to be interrogated to produce a profile for collisions involving cyclists. Exploring possibility of repeating intervention used successfully in London, where signs stating 'most cyclists stop at red lights' are placed at key junctions in the city. This may run in the Spring/ Summer 2017.	£22,500	£22,500	0
ETE	**Road Safety**	£20k	15 Schools are now signed up to the Junior Travel Ambassador Scheme, with not all the ones who expressed an interest in September having fully taken up the scheme. The 7 new schools this academic year have appointed JTA's and there are now approximately 90 JTA's across the 15 schools. Additional schools will continue to be added as appropriate. Schools took part in a poster competition to design a poster that would encourage others to keep safe when the clocks changed in October. The majority of entries came from JTA schools demonstrating the value of this scheme and the winning posters have been made available for all schools in the county to use.	£15,000	£15,000	0
ETE	**Trading Standards KickAsh**	£23k	Kick Ash got off to a good start for the new school year of the programme, and we continued with training in schools and planning the year going forward. **<u>October</u>**: • Delivered training to 20 pupils at Longsands Academy. Focusing on the Nicotine Inhaling Products (NIPs) that are becoming popular among young people and those who are nicotine dependent. Working with a new link within the school, will plan the group's work over the coming months to get the best from the keen volunteer pupils. • Training delivered to 40 pupils at Cromwell Community College. Aim to get a proportion of those pupils to visit businesses in March	£17,250	£16,663	£587

			and wider Fenland to talk about Kick Ash, NIPs and attempted underage purchases. • New contact established within Cottenham Village College, so visits made to discuss the project in full and to attend a Year 10 assembly to help recruit pupils to co-ordinate the project. • Meeting dates planned for three schools to discuss and plan the work for the year ahead. This includes awareness displays for Christmas events in school, the big event for all mentors across the country in January, No Smoking Day events, primary school visits and work on behalf of Trading Standards. • Met with Bottisham VC and mentors to discuss the year ahead – appointing a lead person in school to communicate with others. **November:** • Training delivered to a total of 25 pupils at Cottenham and Witchford Village Colleges • Attended meetings with mentors from Longsands, Cottenham and Bottisham to plan the year ahead and discuss work and targets • Meetings with Kick Ash resource team to discuss the big event in January for all the schools to come together and be creative in sharing their smoke free messages by way of graffiti art on large canvases that will be displayed within their schools – following a large display of finished items to help raise awareness on No Smoking Day. Resource gathering and dissemination of materials for school displays and events. **December:** • Mentor training for new school Sawtry Village College. Also planning for year ahead; supporting the new school link in her new role as co-ordinator for Kick Ash. • Eight days were covered by staff from the Community Resilience Development team for the Ramsey and Ely Safety Zones – supporting the messages about underage sales and shop policies, and sharing information with approximately 700 children aged 9/10 about E-Cigarettes, the effects of those and tobacco on their health. • Continued work on improving the communication between the school leads and mentors. Developing an individual programme of events and expectations for each of the four schools (Cottenham Village College, Longsands Academy, Bottisham Village College and Sawtry) within our area of responsibility.			

ETE	**Illicit Tobacco**	£15k	• Following the 6 Magistrates warrants executed late March and all 6 premises yielding illicit tobacco, the financial investigations were ongoing, court hearings therefore ongoing so delaying sentencing for affected defendants. • Interview of owner of the premises raided in Wisbech in September (hand rolling tobacco seized which was concealed in roof behind light fitting) • 4 Public Houses visited with regard to alleged sales of illicit tobacco by customers in the premises. All premises licence holders and breweries received a warning letter. • Intel gathering on suspected premises selling.	£11,250	£14,589	-£3,339
ETE	**Business and Communities Team**	£10k	***Prioritised work completed by Community Resilience Development Team (CRD) focusing on improving lives in Fenland*** **Libraries and Older People Project – Fenland:** Work continues to increase the ability of some residents to improve their lives through use of digital media. Bid submitted to Arts Council East for extension to Tea & Tablets sessions (digital skills for older people). Focus on digital art through library innovation fund to include Wisbech & March libraries. **Stay Warm and Well Health Packs:** Q3 – 870 packs delivered to Fenland libraries and 50 to library at home service volunteers who support Fenland housebound residents. Library displays in all Hub libraries and packs available in all Fenland libraries and via the mobile library service. **Mental Health Support for young people in Fenland:** 'Shelf Help'. Part of the Reading Well Books on Prescription scheme, which provides 13-18 year olds with high quality information, support and advice on a wide range of mental health issues such as anxiety, depression, eating disorders, self-harm and difficult life pressures, such as bullying and exams. Q3 – loan stats: 501 **Dementia Awareness and local support:** • Delivery of sessions and support to Dementia Friends and Dementia Alliance. Increased available information and book collections in all Fenland libraries, running dementia friends' sessions across Fenland. Health & Wellbeing training for frontline	£8,686	£8,363.59	£322.41

			staff now completed as of November 2016. • Initial discussions held with musician delivery music for dementia session in libraries, linking with existing partnership work with Dementia Action Alliance work in Fenland libraries. • Developing Dementia group sessions in conjunction with Museum colleagues/volunteers. Further meeting to be held during January 2017. **Community Protection Service:** • 'Scams Aware'; training sessions delivered in March library, Wisbech library, Wisbech Age UK day centres and Libraries Home Service (March). Attendees included library staff, volunteers, library service users (all age), Age UK day centre service users, staff and volunteers, carers and older/vulnerable people. • The role of the wider community in supporting the more vulnerable is a key element of the awareness raising and prevention agenda • Good Neighbours Schemes: Visits to Fenland communities where there have previously been concerns with unwanted trades people and rogue traders, resulted in two new volunteer Community Co-ordinators being set up to manage their own No Cold Calling Zones/Good Neighbour Schemes in March and Parsons Drove • Cybercrime and Internet protection: Officers co-delivered prevention and protection awareness at three events in Wisbech (Queen Mary Centre), Whittlesey (Silver Linings) and Manea (Over 60's)			
ETE	**Fenland Learning Centres**	£90k	Contract awarded and all funds allocated.	£67,500	£67,500	0
			SUB TOTAL : ETE Q3	**£183,436**	**£185,865**	**-£2,429.59**
CS&T	**Research**	£22k	For Q3 the activity remains as it was for the previous quarters. Nominally this money is set against the hosting of public health related content on Cambridgeshire Insight, the development of further tools to enhance the presentation of Public Health data, ie Instant Atlas. Cambridge Insight development continues – most recently we have added the social mobility index to the site. The money is also set against a proportional contribution to the development of the County's population estimates forecasts	£16,500	£16,500	0

			Both forecasting and estimates are being delivered in accordance with the agreed timescales			
CS&T	**H&WB Support**	£27k	No longer in post, but funding is being used to support input to public health programmes from the CCC Transformation Team.	£20,250	£20,250	0
CS&T	**Communi-cations**	£25k	Continued campaign work around the following: • Stop Smoking • Obesity • Alcohol • Stay Well – including comms strategy • Physical Activity	£18,750	£18,750	0
CS&T	**Strategic Advice**	£22k	Strategic Advice over the third quarter has involved: • Inputting strategically into the business planning process, ie Member Workshops, Committee meetings, SMT meetings and CLT meetings – which have all progressed the business planning process • Inputting into the ongoing devolution negotiations with Government – and in particular ensuring that the diverse range of needs of this Council (including Public Health) are reflected within those. • Liaison with Public Health over the Corporate Capacity Review and the best way to position Public Health resources within that process/change	£16,500	£16,500	0
C&CS	**Emergency Planning Support**	£5k	Ongoing close working with Health Emergency Planning Officer (HEPRO) on a number of emergency planning tasks: • Provision of emergency planning support when the HEPRO is not available • Provision of out of hours support for Public Health ensuring that the DPH is kept up to date with any incidents of relevance that occur, or are responded to, outside 'normal working hours' • Drafting of new Excess Deaths plan in support of Pandemic Flu arrangements • Delivery of Business Continuity exercise to test BC arrangements prepared within Public Health	£3,750	£3,750	£0
CS&T	**LGSS Managed Overheads**	£100k	This continues to be supported on an ongoing basis, including: • Provision of IT equipment • Office Accommodation • Telephony • Members Allowances	£75,000	£75,000	0
			SUB TOTAL : CS&T Q3	**£150,750**	**£150,750**	**£0**

LGSS	**Overheads associated with PH function**	£220k	This covers Public Health contribution towards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance £20k HR £25k IT £20k The remaining £155k is a general contribution to LGSS overhead costs	**£165,000**	**£165,000**	**0**
			SUB TOTAL : LGSS Q3	**£165,000**	**£165,000**	**0**

SUMMARY

Directorate	YTD (Q3 expected spend	YTD (Q3) actual spend	Variance
CFA	£4,816,500	£4,537,286	£279,214
ETE	£183,436	£185,866	-£2,430
CS&T	£150,750	£150,750	0
LGSS	£165,000	£165,000	0
TOTAL Q3	**£5,315,686**	**£5,038,902**	**£276,784**

Agenda Item No: 5

PROPOSAL TO TRANSFER THE IN HOUSE STOP SMOKING SERVICES TO AN EXTERNAL PROVIDER

To:	**Health Committee**
Meeting Date:	**16th March 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	2017/027 *Key decision:* **Yes**
Purpose:	**The purpose of this paper is to secure Health Committee approval for the proposal to transfer the in house Stop Smoking Services to the external provider of integrated lifestyle services.**
Recommendation:	**That the Health Committee approves the following key elements found in the proposal.**

a) **To contract with an external provider the in house core Stop Smoking Service that is currently part of the Public Health Directorate**
b) **To integrate the Stop Smoking Service into lifestyle services.**
c) **To support the procurement approach of transferring the Stop Smoking Service to Everyone Health, the Integrated Lifestyle Service provider currently commissioned by Cambridgeshire County Council.**
d) **That the Health Committee delegates authority to the Director of Public Health in consultation with the Chair and Vice Chair of the Health Committee to award the contract to Everyone Health, the Integrated Lifestyle Service provider, subject to a successful outcome of the Voluntary Transparency Notice.**

Officer contact:	
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1. BACKGROUND

1.1 Camquit is Cambridgeshire County Council's (CCC) local evidence based Stop Smoking Service. This means that smokers are offered behavioural therapy (which may be either individual or group counselling) which involves scheduled face-to-face meetings between the smoker and an advisor from the Stop Smoking Services trained in smoking cessation. A quit date is set initially and typically, this is followed by weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with nicotine replacement therapy/drug therapy. The Camquit Service is delivered through a number of different providers.

1.2 The core team is an in house provider and is part of the Public Health Provider Team. The core team includes smoking cessation specialists and data staff support staff. It is responsible for the overall co-ordination of the Service. The staff provide support to smokers wanting to quit, delivering specialist services such as the smoking in pregnancy and young persons' programmes, service marketing, targeted project work, managing data processing, analysis and reporting. It also provides support to other commissioned providers through delivering training in line with national guidance and practice visits if required.

1.3 Cambridgeshire County Council (CCC) also has contracts with all 77 GP practices within Cambridgeshire to deliver stop smoking support to smokers registered with their practice. The GP based services are delivered by practice staff such as the practice nurse or healthcare assistant. As demands on practices have increased there are a growing number of practices that have chosen to have Camquit advisors to deliver their services. Each practice has an annual target number of smoking quitters based on the number of smokers they have registered within the practice and the local district's smoking prevalence. Community pharmacies are also contracted to deliver stop smoking cessation, but the number has been declining steadily in recent years. They do not have any quitter targets.

1.4 The delivery and provision of Stop Smoking Services have been evolving locally and nationally. Local authorities have increasingly moved away from the model where their stop smoking services are part of their in house public health teams. This has been facilitated by the development of lifestyle services across the country and they increasingly include core stop smoking services. This integration has not been associated with any falls in performance. The increasing focus of local authorities upon becoming robust commissioning organisations has also supported the move towards externally commissioned stop smoking services.

1.5 In the context of these changes it is proposed that the core Stop Smoking Service, Camquit, is commissioned from an external provider with the aim of it becoming part of an integrated lifestyle service. The second part of the proposal is that the core Stop Smoking Service is transferred to the current Integrated Lifestyle Service provider, Everyone Health. This proposal was taken to the Health Committee in December 2016 when the transfer of the Stop Smoking Services to an external provider of Integrated Lifestyle Services was supported. However it requested further information about the performance of Everyone Health, the robustness of its parent company Sports and Leisure Services Ltd (SLM) and an assurance that the contractual arrangements are robust with adequate financial penalties and the option of premature termination if necessary. Spokes were requested to

review this information and the final decision regarding the full proposal would be based on their recommendation.

2. MAIN ISSUES

2.1 The proposal requires that the externally commissioned stop smoking service would be responsible for providing the full range of functions, indicated above, that the core service currently provides. This would include providing support to GP and community pharmacies for them to deliver services.

2.2 However the contracts with the GPs and community pharmacists would continue to be commissioned and performance managed by CCC. Stop smoking services are one of five public health services commissioned from GPs. Transferring the commissioning responsibility to the provider would create duplication of performance management processes, practices could perceive the additional system as time wasting and undermine the good relationships that they have with Public Health. The current Stop Smoking Service function of managing the data and payments for the GP and community pharmacy contracts would also remain within Public Health.

2.3 Appendix 1 indicates the range of options in terms of Stop Smoking Service delivery and procurement approach along with describing their benefits and disadvantages. The key benefits that would be required is improved access to Stop Smoking Services, an holistic approach to lifestyle change that would enable individuals to receive all lifestyle advice in one place, cost savings opportunities and the potential for service developments.

2.4 The value of the core Stop Smoking Service that would be transferred is circa £400k per annum. This represents staff costs, with the exception of a small non-pay budget for staff training and promotional activities. It is anticipated that a £50k saving would be found from streamlining management costs through the senior co-ordination role of the Service being absorbed into the management of the new provider. Additional savings could be secured through increased integration of the core Stop Smoking Service with other lifestyle services. However experience in other areas where integration has been implemented indicates that it is more productive if initially the core Stop Smoking Service independent within the wider integrated lifestyle service.

2.5 The value of the Service means that procurement regulations apply. The Everyone Health contract was commissioned from June 2015 for five years with a potential break after three, if there are any concerns regarding the Service. Following consultation with LGSS legal and procurement teams the only option other than immediate progression to a full tender would be for CCC to provide information through the procurement portal about its intention of transferring the core Stop Smoking Service to Everyone Health (Voluntary Transparency Notice). Potential providers would have the opportunity to object on the basis of a lack of fair competition. This scenario would then demand a full tender process. The benefits and disadvantages of this approach are found in Appendix 1.

2.6 Spokes were provided with the following information in January 2017

- The current trading position of SLM in terms of current contracts but not the total value of the contracts, details of is Nottinghamshire contract for the provision of Obesity

Prevention and Weight Management Services that indicated a satisfactory level of performance.

- Information relating to the Everyone Health's Key Performance Indicators (KPIS) demonstrated that with the exception of one, progress was being made against the target trajectory.
- Clauses from the contract between Cambridgeshire County Council and SLM for the provision of an Integrated Lifestyle Service were also provided to Spokes. These indicated that there are penalties for poor performance and mechanisms for the premature termination of the contract if the poor performance or any other concerns are not addressed.

2.7 Spokes concluded that this information gave them the assurance to recommend that the proposal to transfer the Stop Smoking Services to Everyone Health should be approved.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

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

- Smoking is associated with a range of health conditions that create high level costs for health and social care services along with high absenteeism from work. Stop smoking interventions are cost saving to the NHS and other parts of the system.

3.2 Helping people live healthy and independent lives

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

- Smoking is a major public health issue due to its substantial impact of health.
- The provision of Stop Smoking Services has a strong track record of supporting smokers to quit smoking and decrease their risks of ill health and premature death. This proposal will strengthen the Stop Smoking Services through integration that will improve referrals and the capacity to provide the Services.

3.3 Supporting and protecting vulnerable people

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

- Smokers are highly vulnerable to debilitating poor health. This proposal has the potential to strengthen services and provide more support to smokers to help them quit.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The immediate resource implications of this proposal for Cambridgeshire County Council and partner agencies are laid out in para 2.4.

4.2 Statutory legal and risk implications

These are described in Appendix 1 section 4.

4.3 Equality and Diversity

- The current Stop Smoking Services and the Integrated Lifestyle Service address equality and diversity issues.

- Smoking can have a wide ranging negative impact on the health and wellbeing of the population and there is still a substantial proportion of the population that smokes with rates being higher in the routine and manual groups.

- The Stop Smoking Services and the Integrated Lifestyle Service target the routine and manual groups where smoking and other unhealthy lifestyles rates are higher. This proposal will strengthen efforts to target these high risk groups through a more focused strategic approach and a more coordinated offer of support that will improve access.

4.4 Engagement and communications

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

- The engagement of individuals and communities is a fundamental principle of both Stop Smoking Services and other Lifestyle Services. The Services aim to enable individuals and communities to take responsibility for their health, supporting them to make their own lifestyle changes.

- The proposal may see an increase in the level of engagement with smokers and other local residents through the Stop Smoking Services being part of the Integrated Lifestyle Services that reaches a bigger proportion of the population.

4.5 Localism and local Member engagement

T*here are no significant implications within this category.*

4.6 Public Health Implications

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

- The purpose of this programme is to improve and develop Stop Smoking Services in Cambridgeshire which will increase the number of people who stop smoking.

- Tobacco smoking is a major public health issue due to its substantial impact on health. The Stop Smoking Services provide an evidence based 4/6 week intervention whereby trained advisors support individuals to stop smoking. This proposal will create a clear referral pathway for the Lifestyle Service to refer its users who smoke to the Stop Smoking Service. It is able to offer additional behavioural change support during the quit attempt and afterwards for up to year to help prevent relapse.

- Both the Stop Smoking Services and the Integrated Lifestyle Service address health inequalities through targeting populations that have a high rate of unhealthy lifestyle behaviours.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes 24/2/17 Name of Financial Officer: Clare Andrews
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes 27/2/17 Name of Legal Officer: Virginia Moggridge
Are there any Equality and Diversity implications?	Yes, see 4.3 above 28/2/17 Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes 21/2/17 Name of Officer: Matthew Hall
Are there any Localism and Local Member involvement issues?	No 28/2/17 Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes 28/2/17 Name of Officer: Liz Robin

Source Documents	Location
'Public Law Today'	http://www.publiclawtoday.co.uk/local-government/procurement/308-procurement-and-contracts-articles/31175-voluntary-transparency-notices
'Public Contract Regulations 2015':	http://www.legislation.gov.uk/uksi/2015/102/contents/made

APPENDIX 1: Table 1: Stop Smoking Services March 2017: Options for service delivery and procurement

	Stop Smoking Services – Service Delivery Options		
		Benefits	**Disadvantages**
1.	**Maintain the "status quo" – no change**	1. The core Stop Smoking Team has a close working relationship with the Public Health Team with the staff being committed public health objectives. 2. The core Stop Smoking Team is able to respond quickly to any service developments/changes without requiring any time consuming contract changes. 3. Past experience of contracting the core Stop Smoking Team out to another organisation led to poor performance, although this was not to a specialist lifestyle service.	1. The core Stop Smoking Service has a management structure and its own promotional programme. If the core Service is part of a wider Integrated Lifestyle Service it would have the potential to release savings through combining management and promotional overheads with the other lifestyle services. 2. The core Stop Smoking Service currently stands alone and although it works with the Integrated Lifestyle Service there are missed opportunities for client referrals from health trainers and other elements of the Lifestyle Service. The number of referrals to the Stop Smoking Services has fallen and this could be improved through greater integration with lifestyle services. 3. The current core Stop Smoking Service is small and coping with sickness, staff leaving etc. is challenging. As part of a larger lifestyle service such pressures may be mitigated through the use of staff with similar skills. 4. As Public Health commissions the Stop Smoking Services staff from the core service can be diverted into supporting commissioning and performance management of the other providers.
2.	**Commission a "stand alone" Stop Smoking Service.**	1. This would ensure that the core Stop Smoking Service remained focused upon providing support for smokers and that staff skills would continue to develop.	1. A stand alone core Stop Smoking Service would be small. A proportion of its costs would require allocation to infrastructure/management leaving less resource for direct service delivery. 2. There are very few examples currently of stand alone core Stop Smoking Services and therefore

			there could be limited market opportunities to commission this model of service delivery. 3. Referrals to Stop Smoking Services have decreased in recent years. Good referral pathways to Stop Smoking Services are important for generating clients who want to stop smoking. A Stop Smoking Service that is part of a wider lifestyle service would have better access to direct referrals than a stand alone service that would have to rely on existing or developing new pathways.
3.	**Commission Stop Smoking Services as part of an integrated lifestyle service.**	1. There is the potential for management/overhead cost savings in the short term. In the longer term additional savings could be achieved through other integrated lifestyle service staff supporting smokers to quit as they will already be trained in lifestyle behavioural change techniques. 2. Lifestyle services have a central focus of supporting lifestyle behavioural change. All staff are trained to deliver behaviour change interventions and are able to motivate smokers to quit and refer to services, but also have the potential to support a full quit attempt. The integration of the Stop Smoking Services with general lifestyle services would increase the capacity for initiating referrals and supporting quit attempts. Although it is recommended from other areas that this is more effective if it is part of phased approach to integration. 3. Clients of lifestyle services often have multiple lifestyle issues. Most prefer to focus upon one issue but if successful they may be prepared to look more holistically at their lifestyle. Stop Smoking Services as part of an integrated Lifestyle Services could be embedded into a range of pathways and ensure easy appropriate access for their clients to a range of different lifestyle support options.	1. This could potentially dilute the evidence based Stop Smoking Services model.

		4. A larger lifestyle services brings advantages in terms of the management staff sickness, retirement etc. (see 1.3 above). 5. In addition a larger lifestyle workforce facilitates service development overall. For example the current Integrated Lifestyle Service in Cambridgeshire provided by Everyone Health now has "specialist health trainers" that focus upon falls and mental health. All health trainers are able to give advice and support on these areas but the "specialists" address more complex problems or provide training.	
	Commissioning Approaches: Due to the value of the Services there are procurement considerations.		
4.	**Under the Voluntary Transparency Notice (see note below) procurement process transfer the Stop Smoking Services to Everyone Health, the current provider of integrated Lifestyle Services. This contract runs to May 2018 with a potential extension for another two years.**	**Supportive procurement rules** "*Contracts and framework agreements may be modified without a new procurement procedure in accordance with this Part in any of the following cases:—* *b) for additional works, services or supplies by the original contractor that have become necessary and were not included in the initial procurement, where a change of contractor—* *(i) cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, services or installations procured under the initial procurement, or* *(ii) would cause significant inconvenience or substantial duplication of costs for the contracting authority,* *provided that any increase in price does not exceed 50% of the value of the original contract"* (i)This applies in this instance as a change of provider would need to meet the requirement of being part of an integrated service. This would not be possible in Cambridgeshire due to the current contract with Everyone Health. There is no other commissioned integrated lifestyle service.	1. Due to the current contractual arrangements with Everyone Health the core Stop Smoking Service would not benefit from any of the advantages of being fully integrated into the local Lifestyle Services until these services are re-tendered. Any successful bidder would have to demonstrate how it would integrate the core Stop Smoking Service into other lifestyle services to ensure that the benefits of referral pathways are maximised. 2. Most areas have commissioned their Stop Smoking Services as part of an integrated lifestyle service. Therefore there is uncertainty as to whether there is a robust market for the provision of stand alone stop smoking services in an area 3. If the voluntary transparency notice approach was challenged then this would necessitate a full procurement process. This would delay the process although a Voluntary Transparency Notice would be published for 10 calendar days.

		(ii) By integrating the core Stop Smoking Service into a wider Lifestyle Service this would avoid duplication of management costs. The identified savings reflects the removal of one of the management posts. The functions of the post would be picked up by the Everyone Health management structure. In addition the total value of the Everyone Health contract over five years is £8m. The value of the Stop Smoking Services if the Everyone Health contract was extended to the full five years would be £1,137,500, less than 50% of the contract value. **There are other considerations however these do not influence any procurement rules.** 1. It would secure savings in the next financial year. 2. The core Stop Smoking Service staff have experienced a number of recent management changes. In addition when services transfer to a different organisation there is usually a fall in performance. The Stop Smoking Services are familiar with Everyone Health and previous members of the Public Health provider team were transferred to Everyone Health following the Lifestyle Service tender.	
5.	Undertake a full tender	1. This would ensure that there is a full competitive process and the potential for identifying a service that offers high quality, value for money services.	1. This is time–consuming and any savings would be delayed. 2. Also the risk of undermining staff morale.

A Voluntary Transparency Notice may be published by a contracting authority where a contract has been awarded without prior publication of a contract notice in accordance with the Public Contracts Regulations 2015, SI 2015/102, Pt 2 (i.e. a direct award). A contracting authority may opt to publish a voluntary transparency notice in these circumstances in order to resist challenge on grounds of ineffectiveness under the Public Contracts Regulations 2015, SI 2015/102, reg. 99(2). The Public Contracts Regulations 2015, SI 2015/102, reg. 99(3) provides that the above ground for ineffectiveness will not apply if the contracting authority:

- considers the contract award (without prior publication of a contract notice) to be permitted by the Public Contracts Regulations 2015, SI 2015/102, Pt 2
- publishes a voluntary transparency notice in the OJEU indicating its intention to enter into the contract, and observes a standstill period of at least ten days beginning with the day after the date the voluntary transparency notice was published in the OJEU.

Agenda Item No: 6

REPORT ON THE CONSULTATION ON A FUTURE MODEL FOR AN INTEGRATED OUT OF HOURS BASE AT CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (ADDENBROOKE'S)

To:	**HEALTH COMMITTEE**
Meeting Date:	**16 March 2017**
From:	**Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has recently consulted on moving the current GP Out of Hours base from Chesterton Medical Centre to the integrated Clinic 9 at Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's). This paper updates the committee on that consultation.
Recommendation:	The Committee is to note the consultation themes at this point.

Officer contact:		***Member contact:***	
Name:	Jessica Bawden	Name:	Councillor David Jenkins
Contact:	Teresa Johnson, Executive Assistant, 07534 101165, teresa.johnson4@nhs.net	Chairman:	Health Committee
		Email:	ccc@davidjenkins.org.uk
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1. BACKGROUND

1.1 The CCG has commissioned and mobilised a new Integrated Urgent Care (IUC) service which sees the coming together of NHS 111 and Out of Hours (OOH) urgent primary care services, supported by a clinical hub, under a single provider contract with Herts Urgent Care (HUC).

1.2 The CCG currently has five GP out of hours bases, run as part of the IUC contract by HUC. They are as follows:

- Chesterton, Cambridge
- Princess of Wales Hospital, Ely (co located with the Ely Minor Injuries Unit, [MIU])
- Doddington Hospital, Doddington (co located with the Doddington MIU)
- Hinchingbrooke Hospital, Huntingdon (co located with the A&E)
- Peterborough, Peterborough City Care Centre (co located with the MIIU)
- The base at Wisbech is run by the 111 and OOH provider for Norfolk, IC24.

1.4 When HUC took on the services, the location of the Cambridgeshire OOH base at Chesterton Medical Centre (CMC) was reviewed and HUC suggested that this was not the most clinically effective site for patients and that a co-located OOH base on the Cambridge University Hospitals Foundation Trust (CUHFT) site as part of an integrated urgent care offer with the A&E department would be more effective as part of the whole urgent care system. All other OOH bases are alongside other facilities such as Minor Injury Services or A&E.

1.5 Over recent months, the CCG has been reviewing patient flows in Cambridge alongside the Keogh Review recommendations and the Royal College of Medicine's research.

1.6 The IUC service went live on 16 October 2016 on the existing OOH site at Chesterton, as one of four sites (Wisbech is run by IC24). System wide discussions between the CCG, HUC and CUHFT have agreed that there is a strong clinical case for bringing these services closer together on the same site.
The main drivers for this review have been

- National research recommending co-location or urgent and emergency care services, so that primary care patients can have easy access to diagnostics and specialist services if they are needed
- The ability to make the two GP led urgent care services in Cambridge – Clinic 9 at CUH and the GP OOH base at Chesterton
- The opportunity to reduce pressure on the Emergency Department at CUH.

2. MAIN ISSUES

2.1 The CCG ran a public consultation from 23 January to 6 March 2017. The CCG committed to bringing back the key findings from the consultation on 16 March and to take forward the comments from the Health Committee for consideration by the CCG Governing Body on 21 March.

2.2 During the consultation 11 000 consultation documents were printed and distributed along with electronic versions emailed to a variety of stakeholders and members of the public.

Posters advertising the public meetings were printed and distributed. The CCG made all consultation documents available on the CCG website. The CCG held six public meetings in five locations in the Cambridge areas. The CCG also attended other meetings to discuss the consultation held by other organisations.

2.3 The six week consultation was to gather feedback from meetings, online survey, letters, emails and telephone calls. The presentation sets out the high level themes and responses received by the CGG during this six week consultation.

3. SIGNIFICANT IMPLICATIONS

These are set out in the Impact Assessments

SOURCE DOCUMENTS GUIDANCE

Source Documents	Location
Papers to **10 January 2017** meeting of CCG Governing Body; items 02.3 (Annex A) – 02.3f (Appendices 1-6)	***http://www.cambridgeshireandpeterboroughccg.nhs.uk/about-us/governing-body/governing-body-meetings/governing-body-papers-2016-17/***

Agenda Item No: 7

AIR QUALITY IN CAMBRIDGESHIRE – IMPLICATIONS FOR POPULATION HEALTH

To:	**Health Committee**
Meeting Date:	**16 March 2017**
From:	**Director of Public Health**
Electoral division(s):	***All***
Forward Plan ref:	*Key decision:* **No**
Purpose:	**To bring to the attention of the Health Committee current concerns regarding air quality in Cambridgeshire and the opportunities locally to address poor air quality.**
Recommendation:	**The Health Committee is asked to:** **a) note and comment on the current air quality issues in Cambridgeshire, local opportunities/initiatives to improve air quality and the NICE Draft National guidance** **b) request that Director of Public Health draws this report to the attention of the Chairman/woman and Spokes for the Economy and Environment Committee and the Highways and Community Infrastructure Committee, with a recommendation that the Committees consider the potential impact on air quality as part of their decision making process.**

	Officer contact:
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1. BACKGROUND

1.1 What is air pollution?

1.2 A detailed description of air quality and its effects on human health can be found in the "Cambridgeshire Transport and Health Joint Strategic Needs Assessment 2015", but in summary air pollutants are generated by a mixture of natural and man-made processes and are released into the air. The distribution of these pollutants depends on the size of the particles and weather patterns, some pollutants being deposited locally and some affecting sites in other world regions. For example, in spring 2014 there were two peaks of air pollution in the East and South East of England caused by high levels of air pollution already existing in urban areas and exacerbated by Saharan dusts and pollutants from mainland Europe brought by easterly winds. These resulted in a significant increase in respiratory conditions presenting to health care services including NHS111, GP services, and emergency departments. It was estimated that the national excess consultations for wheeze or breathlessness was 1,200 GP consultations during the first episode and 2,300 excess consultations in the second.

1.3 In England, the most deprived wards tend to experience the highest concentrations of pollutants, although the least deprived wards also experience above average concentrations of pollutants. This can mainly be explained by the higher proportion of both deprived communities and very wealthy communities in urban areas and the levels of pollution due to road transport sources. (Appendix A contains a Fact Sheet On Particulate Matter)

2. MAIN ISSUES

2.1 Snapshot of air pollution in Cambridgeshire

2.1.1 Even though most annual average concentrations of air pollutants may not be over Air Quality Thresholds, there are levels of air pollution in Cambridgeshire that impact health.

- A Public Health England Report 'Estimating local mortality burdens associated with particulate air pollution' published in 2014, estimated that 5.5% of mortality (age 25+) in Cambridgeshire could be attributed to particulate air pollution. This is similar to the national average of 5.6% and equates to an estimated 257 deaths.
- Air pollution also impacts respiratory and cardiovascular hospital admissions and incidence of respiratory disease.
- "Hot spots" of pollution include urban areas and transport corridors such as the city centre and the A14.
- New housing developments in Cambridgeshire are sometimes sited near poor air quality areas.
- There are higher levels of nitrogen dioxide in the winter months and peaks of larger particulate matter in the spring, which may lead to seasonal health impact.
- Small particulates from traffic also contribute to indoor air pollution, where people spend most of their time and receive most of their exposure to air pollutants.

2.1.2 In Cambridge City and South Cambridgeshire the major roads and urban centres have the highest levels of pollution with specific issues at congested roads and junctions such as Milton Road, or where there is a lot of standing traffic and buses e.g. Drummer Street.

2.1.3 In Huntingdon air pollution is concentrated around the A14 and the ringroad, some central sections of St Neots are also affected e.g. the High Street, which is both canyon-like and congested.

2.1.4 In Fenland (Wisbech) an assessment of source apportionment showed that HGVs and single occupancy car trips make up a large proportion of the total pollution concentrations. This could be reduced by changing short car trips to walking and cycling, as both walking and cycling levels in Wisbech have been shown to be low.

2.2 National Issues

2.2.1 There has been a lot of interest in the national and local media recently from the issue of poor air quality in London to the car manufacturers' diesel emission test cheating.

2.2.2 Earlier policies to reduce air pollution from vehicles relied solely on improvements in diesel vehicle technology via EURO (EU) engine standards. These proved ineffective in real operation. Whilst the gains should have been substantial on paper, up to a 50% cut in emissions between EU2 and EU4 for buses, the reality was a very mixed picture with some in service EU2 buses out performing EU4.

2.2.3 Cambridge City Council's long-term field evidence backed-up by the Cambridge Real Emissions Project support this view, with only a 5% improvement in ambient air quality as a result of moving approximately 400 buses up to EURO standards with the majority of buses moving from EU2 to EU4 or EU5.

2.2.4 However, new low emission vehicles are either fully electric with no emissions at the point of use or hybrid vehicles which have significantly reduced emissions for periods of the drive cycle and may be capable of some zero emission running. Therefore, with new low emission vehicle technology there is the potential for real substantial cuts in emissions.

2.3 Draft NICE Guidance

2.3.1 The National Institute for health and Care Excellence have produce draft guidance for consultation on air pollution (Air Pollution: outdoor air quality and health December 2016), (A link to the guidance can be found at the end of this report).

2.3.2 The Guidance is for local authority staff working in:

- Transport
- Planning
- local air quality management
- public health, including environmental health
- Local government elected members

2.3.3 The guidance contains 6 recommendations grouped around the following themes:

- **Planning**
- **Clean air zones**
- **Reducing emissions from public sector transport services and vehicle fleets**
- **Smooth driving and speed reduction**
- **Cycle routes**
- **Awareness raising**

2.3.4 The main recommendations of relevance to the Council are as follows:

2.3.5 Planning

- Take air quality issues into account in the Local Plan for new developments e.g. include air pollution in strategic planning across local authority departments and different tiers of local government

- Provide an infrastructure to support low- and zero-emission travel e.g. provide cycling and walking routes and charge points for electric vehicles in residential areas and commercial developments.

2.3.6 Clean air zones

- Consider introducing clean air zones in areas outside those targeted by the national plan. It could include restrictions for polluting vehicles and/or action to encourage the use of less polluting ways to travel.
- Consider support for low- and zero-emission travel e.g:
    - encouraging walking and cycling
    - encourage uptake of low- and zero-emission vehicles, for instance, electric charging points or use of low- or zero-emission vehicles for deliveries to retail, office, residential or other sites in the zone
    - specifying emission standards for private hire and other licensed vehicles.
- Consider fuel-efficient driving initiatives such as:
    - bylaws and other action to support 'no vehicle idling' areas, particularly outside schools, hospitals and care homes
    - driver training to reduce emissions
    - actions to smooth traffic flow
    - Where traffic congestion is contributing to poor air quality, consider incorporating a congestion charging zone within the clean air zone.

2.3.7 Reducing emissions from public sector transport services and vehicle fleets

- Consider introducing fuel-efficient driving as part of any test carried out when appointing or re-appraising staff who drive as part of their work.
- Consider training staff drivers to reduce their vehicle emissions
- Consider making the minimisation of vehicle emissions a factor when making procurement decisions.

2.3.8 Smooth driving and speed reduction

- Consider using variable speed limits and average speed technology on the roadside to promote a smoother driving style and incorporating real-time information to tell drivers what the current optimum driving speed is.
- Where speed reduction is needed to reduce road danger and injuries take account of the potential adverse impact on air pollution.
- Consider 20-mph zones in residential areas characterised by stop–go traffic where this will reduce accelerations and decelerations.
- Where physical measures are needed to reduce speed, such as speed bumps, ensure they are designed to minimise sharp decelerations and consequent accelerations.
- Consider using signs that display a driver's current speed to reduce unnecessary accelerations.

2.3.9 Cycle routes

- Avoid siting cycle routes on highly polluted roads. Ideally use off-road routes or quiet streets.
- Where busy roads are used consider:
    - Providing as much space as possible between the cyclist and motorised vehicles.
    - Using dense foliage to screen cyclists from motor vehicles, without reducing street ventilation so that air pollution can disperse.
    - Reducing the time cyclists spend at busy sites, including some junctions, where this can be done without increasing the time that other groups spend exposed to poor air quality.

2.3.10 Awareness raising

- Consider providing information on air quality with weather forecasts and the pollen index. Provide this through local, national and social media.
- Consider providing the public with information on how:
    - health is affected by exposure to air pollutants
    - travel choices contribute to pollution and exposure to levels of local pollution
    - engine 'idling' affects air quality in the vehicle as well as outside
    - to minimise exposure by altering travel habits e.g. restricting time spent with an engine 'idling'.
- Make businesses aware that they can reduce road-traffic-related air pollution and improve fuel efficiency e.g. scheduling deliveries to minimise congestion, and encouraging employees to cycle to work
- For at risk groups:
    - Consider making healthcare professionals aware of the UK Daily Air Quality Index, and that they understand the health effects of long-term exposure to air pollution.
    - Healthcare professionals could raise awareness of poor outdoor air quality and advise high risk groups on how to minimise their exposure and its impact

2.4 District Council Duties – Annual Air Quality Status Reports and Air Quality Action Plans

2.4.1 The Environment Act 1995 provides that every local authority shall review the air quality within its area, both at the present time and the likely future air quality. It requires local authorities to designate an Air Quality Management Area (AQMA) where air quality objectives are not being achieved, or are not likely to be achieved. Once an area has been designated the local authority is required to develop an Action Plan detailing remedial measures to tackle the problem within the AQMA. In addition each District Council in Cambridgeshire 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.

2.4.2 The Public Health Outcome Framework includes an indicator, based on the effect of $PM_{2.5}$ on mortality. This is intended to enable Directors of Public Health to prioritise action on air quality in their local area to help reduce the health burden from air pollution.

2.4.3 DEFRA expects the highest level of support from local authorities (e.g. Chief Executive and Council level) to ensure that all parts of a local authority are working effectively together. The public can be given further confidence that the work being taken forward to tackle air quality is supported at the highest level through engagement in and sign-off of Action Plans and annual reports by both the Chief Executive and also the heads of the main departments involved e.g. environmental health, planning, transport and public health.

2.4.4 To date the Director of Public Health has “signed off” the Annual Status Reports for Cambridge City Council and East Cambridgeshire District Council.

2.5 What are we already doing?

- The Public Health directorate are working with Cambridge City Council as part of their Air Quality Action Plan Steering Group.
- The Smart Cambridge programme (see 2.5.1 below)
- Promoting dialogue between the Clinical Commissioning Group and the City Deal Project.
- Health impacts of air quality are considered as part of the requirement for public health to sign off the significant implications section of relevant committee papers.

- The Cambridgeshire Local Transport Plan 2011-2031 aims to address existing transport problems while at the same time catering for the transport needs of new communities and improving air quality.

2.5.1 The Smart Cambridge programme

The University of Cambridge, Cambridge Environmental Research Consultants and Cambridge City Council are working on a project assessing low cost air quality sensors with the ambition of developing a real time air quality network across the city. The first phase of the project compared results from a network of nodes with an urban air quality model and results from the existing monitoring stations. Twenty sensors were deployed for a four month period (June-October, 2016) and focussed on three areas:

- the rapidly developing biomedical campus to the south of the city;
- a key transport corridor (Hills Rd) ;
- and a new development in north-west Cambridge adjacent to a busy motorway (M11).

The sensors measured CO, NO, NO_2, O_3, SO_2, PM_1, $PM_{2.5}$ and PM_{10} temperature and relative humidity at 1 minute intervals. The results of the test were positive with the sensors performing well.

2.5.2 The second phase of the project will look at whether we can use the sensors to establish source attribution by combing additional data such as traffic flow and meteorological data. This will also include cross referencing spikes in pollution with CCTV footage to see if we can attribute these spike to individual vehicles.

2.5.3 An important part of the project going forward will be looking at how we can use this data to give better real time AQ data to residents, change behaviours and design interventions within the city to improve Air Quality e.g. using real time data to text patients who are susceptible to poor air quality.

2.6 Opportunities

2.6.1 There are opportunities to include air quality as a priority/or consideration in the City Deal project and the transport deal as part of the Devolution Agreement for Cambridgeshire and Peterborough.

2.6.2 There is further scope to work with Huntingdonshire, Fenland, and South Cambridgeshire District Councils on their Annual Air Quality Status Reports and Air Quality Action Plans.

2.6.3 There is scope to develop a text alert system for patients who are susceptible to poor air quality (see 2.5.3 above).

2.6.4 The Council could explore where there are opportunities to implement the NICE Air Quality Guidance when it is formally adopted (due for publication June 2017)

2.6.5 The Transport and Health Joint Strategic Needs Assessment (JSNA) recommends a future focus on:

- Switching to a low emission passenger fleet and vehicles.
- Encouraging walking and cycling rather than car use.
- Further assessment of shorter-term measures to reduce person exposure, for example:
    - Text alerts to vulnerable people.
    - Monitoring of building filters.
    - Further use of health impact of air pollution during planning process for new developments.
    - Further understanding around the seasonal impact of air pollution and potential measures that could reduce this.

2.6.6 During the production of the JSNA several areas were highlighted by stakeholders from all districts as important areas of focus to continue the control and potential improvement of air quality in Cambridgeshire.

2.6.7 **Lower emissions from vehicles**. A significantly lower emission passenger transport fleet will be required to make air quality improvements in central Cambridge and beyond. This is dependent on accelerating and stimulating the shift to lower emission vehicles with continued traffic restraint.

2.6.8 Buses are the main source of air pollution from traffic, especially in the City Centre, so a significant reduction in emissions from the buses in operation is required. Buses are a large proportion of the fleet and they make repeat journeys. Renewing a small number of vehicles with cleaner technology will lead to more improvement than with any other category of vehicle.

2.6.9 Incentives for low emission vehicles for taxis. The District Councils are the Licensing Authority for taxis and can make a difference by tailoring Taxi Licensing Policy to incentivise low or zero emission vehicles.

2.6.10 **Switching car journeys to active transport**. Switching journeys from cars to walking, cycling and public transport not only has a large beneficial impact on the individual's health, but a wider benefit to the population health as there are corresponding decreases in overall air pollution levels.

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

The report above sets out the implications for this priority in **Section 1** of this report.

3.3 Supporting and protecting vulnerable people

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

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Statutory, Risk and Legal Implications

There are no significant implications within this category.

4.3 Equality and Diversity Implications

The report above sets out details of significant implications in Section 1.3 of this report

4.4 Engagement and Consultation Implications

There are no significant implications within this category.

4.5 Localism and Local Member Involvement

There are no significant implications within this category.

4.6 **Public Health Implications**

The report above sets out details of significant implications in Section 2 of this report

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes : 6/3/17 Name of Financial Officer: Clare Andrews
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes : 6/3/17 Name of Legal Officer: Fiona McMillan
Are there any Equality and Diversity implications?	No Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes : 1/3/17 Name of Officer: Matthew Hall
Are there any Localism and Local Member involvement issues?	No Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
Draft NICE Guidance - Air pollution: outdoor air quality and health draft for consultation, December 2016	https://www.nice.org.uk/guidance/GID-PHG92/documents/draft-guideline
Transport and Health JSNA 2015	http://cambridgeshireinsight.org.uk/JSNA/Transport-and-Health-2014/15
DEFRA Local Air Quality Management Policy Guidance (PG16) 2016	https://consult.defra.gov.uk/communications/laqm_changes/supporting_documents/LAQM%20Policy%20Guidance%202016.pdf

Appendix A – Fact Sheet On Particulate Matter

Fact sheet on particulate matter: PM_{10} and $PM_{2.5}$

What are PM_{10} and $PM_{2.5}$?
Particulate matter is a mixture of solid particles and liquid droplets in the air. PM_{10} are particles of material that are 10 micrometres across or smaller, $PM_{2.5}$ are particles of material that are 2.5 micrometres across or smaller

Why PM_{10} and $PM_{2.5}$?
These have been chosen as these sizes are likely to be inhaled into the lungs. The smaller the particles the greater the potential impact because of their ability to penetrate deeper into the lung. Particulate matter affects both respiratory and cardiovascular diseases.

Sources of Particulate Matter
Particles in the air arise from a variety of natural and man-made sources and are classed as either primary or secondary sources.

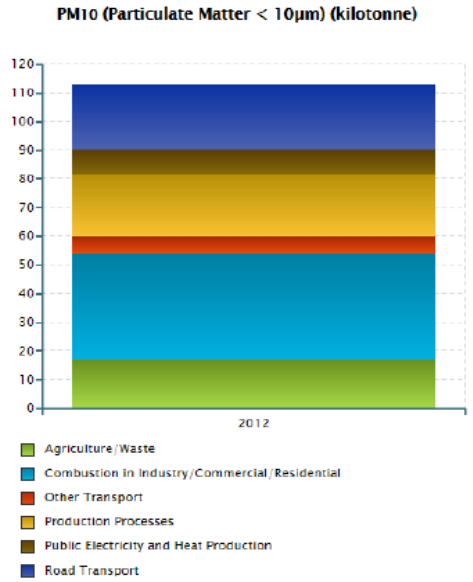
Natural sources
- Sea Spray.
- Erosion of soil and rocks.

Man-made sources
- Combustion processes – both domestic combustion (wood/coal burners) and industrial (power generation).
- Transportation – primarily diesel emissions.
- Transportation – Non-exhaust emissions (attrition of road surfaces and wear and tear of tyres and brakes).
- Industrial sources – construction, waste, aggregates (mining/quarrying), agricultural.

Primary
- Released directly into the air.

Secondary
- Formed in the atmosphere by the chemical reaction of gases, first combining to form less volatile compounds which in turn condense into particles.

For $PM_{2.5}$ not all sources are local as in some weather conditions, air polluted with $PM_{2.5}$ from the continent may circulate over the UK (long range transportation) especially the East and South East of England.



Source: National Atmospheric Emissions Inventory (2013)

Particulate matter in the UK
Emissions of particles have been dropping in the UK for the last 40+ years. It was estimated in 1970 there was 491 kilotonnes of particles emitted into the UK atmosphere whereas in 2012 114 kilotonnes of particulates were emitted into the UK atmosphere.

Air quality standards
PM_{10}: The United Kingdom has a standard of 40 microgrammes (µg) per cubic metre (m^3) of air as an annual average, with a 24 hour average of 50µg/m^3 not to be exceeded more than 35 times a year (to be met by 31 December 2004).

$PM_{2.5}$: The United Kingdom has a target value of 25µg/m^3 of air as an annual average to be reached by 2010, with an additional national exposure reduction target for 2020 based on the levels of $PM_{2.5}$ in 2010. Only areas with initial concentrations equal to or less than 8.5µg/m^3 have no reduction target.

For UK, the average $PM_{2.5}$ level for the base year was 13µg/m^3 resulting in a required 15% reduction necessary by 2020.

Particulate matter monitoring in Cambridgeshire:
Cambridge City:
- Gonville Place (PM_{10} and $PM_{2.5}$)
- Montague Road
- Parker Street
- Newmarket Road ($PM_{2.5}$ only)

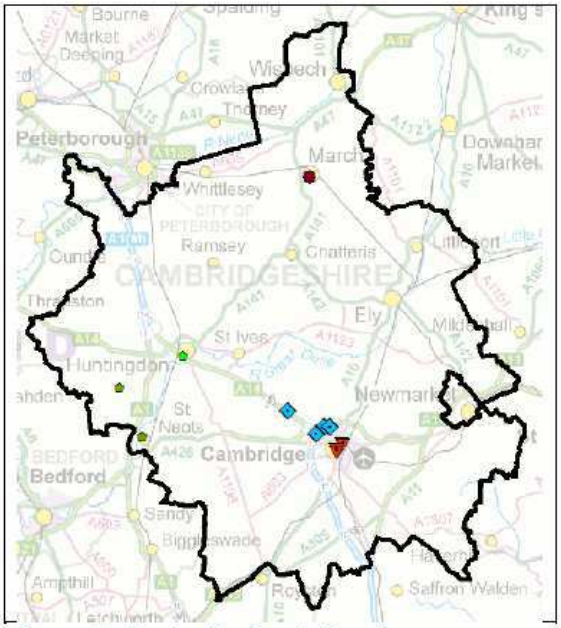
South Cambridgeshire:
- Impington
- Orchard Park, Girton (PM_{10} and $PM_{2.5}$)
- Bar Hill (Decommissioned) (PM_{10} and $PM_{2.5}$)

Huntingdonshire District Council:
- Pathfinder House
- Mobile (Decommissioned)

Fenland District Council:
- None

East Cambridgeshire District Council:
- None

All monitors assess PM_{10} unless stated



Source: Huntingdonshire County Council

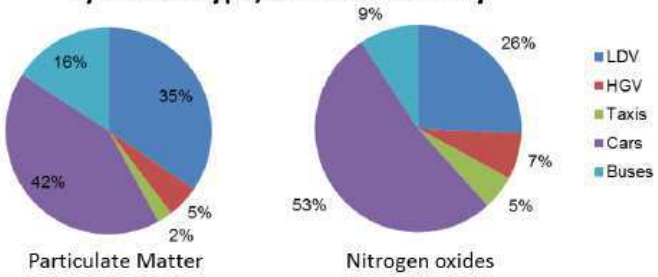
Fact sheet on nitrogen dioxide (NO_2)

Nitrogen dioxide (NO_2) is primarily a secondary pollutant produced by the oxidation of nitric oxide (NO) by ground level ozone. Nitric oxide is produced by the reaction of nitrogen and oxygen in the combustion process. The major source of this pollutant in the UK is the combustion of fossil fuels, particularly by motor transport and non-nuclear power stations. It is estimated that some 75% of oxides of nitrogen are emitted from motor vehicle exhausts in urban areas. Of the transport sources, petrol combustion in cars is currently responsible for a greater proportion than diesel, though this relationship is changing with the progressive introduction of the catalytic converter into petrol vehicles.

Nitrogen dioxide is an irritant gas which has serious and, sometimes, fatal effects on health when inhaled in the very high concentrations associated with accidental exposures. Its properties as an oxidising agent can damage cell membranes and proteins. At relatively high concentrations it causes acute inflammation of the airways.

Air Quality Standards recommend a standard of 40µg/m^3 as an annual average with an hourly mean of 200µg/m^3 not to be exceeded more than 18 times a year (to be met by 31 December 2005). Nitrogen dioxide is measured continuously at the active monitoring sites in Cambridgeshire and monthly at the passive diffusion sites.

Examples of contributions of pollutants, by vehicle type, for Elizabeth Way



Source: Cambridge City Council. LDV- light duty vehicle, HGV – Heavy goods vehicle

Agenda Item No: 8

PRISM (NEW PRIMARY CARE SERVICE FOR MENTAL HEALTH)
FIRST RESPONSE SERVICE (MH CRISIS SUPPORT SERVICE)

To:	**HEALTH COMMITTEE**
Meeting Date:	**16th March 2017**
From:	**Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Cambridgeshire and Peterborough Foundation Trust (CPFT)**
Electoral division(s):	***All***
Purpose:	**For comment and for information**
Recommendation:	**The Committee is recommended to note and comment upon the recent updates on Mental Health services for the Cambridgeshire and Peterborough health system.**

Officer contact:		***Member contact:***	
Name:	CCG Communications and	Name:	Councillor David Jenkins
Post:	Engagement Team	Chairman:	Health Committee
Email:	capccg.contact@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	01223 725304	Tel:	01223 699170

1. BACKGROUND

PRISM

The current GP interface with specialist mental health (MH) services is primarily through a single point of contact, the Advice and Referral Centre (ARC). Evidence suggests that approximately 10% of patients currently referred to the ARC will ultimately be taken on to a specialist secondary care mental health caseload. The ratio of assessment to acceptance for treatment is almost 3:1 and the significant number of assessments undertaken impacts on the clinical capacity of locality teams to provide direct care and support for service users.

In conjunction with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and other key stakeholders, a service model has been developed that will increase the presence of mental health specialists in primary care, promote early assessment, treatment and / or onward referral and be recovery-focused. The 'step-up' function of onward referral into secondary care mental health services will support service users in a timely way and service users will be supported to 'step-down' into primary care when a period of treatment in secondary care has been completed. This model has become known as Prism. Prism teams will work with GP surgeries as a primary-care facing mental health service supporting GPs across the CCG area.

The project is supported by 11 work streams that are drawn together under a robust project structure. Work streams include: GP engagement, locality teams, ARC, proof of concept, design group, research, finance, IT systems and informatics, HR and workforce planning, estates and communications.

First Response Service (MH Crisis Care)

The First Response Service (FRS) provides a comprehensive crisis assessment pathway, covering all ages, and providing a genuine alternative to A&E – safe places in the community setting.

On 19 September 2016 the MH Crisis project moved to the last implementation stage. The Service expanded its remit to cover the whole of Cambridgeshire and Peterborough and opened to self-referral by patients via 111 telephone route.

To date the FRS has demonstrated that it can reduce A&E attendance and therefore provide savings for the urgent and emergency care system, as well as improve patient care and safety. National guidance relating to Mental

Health Provision, and to Urgent and Emergency Care emphasise the requirement to provide a 24/7 pathway for mental health crisis by 2019/2020.

2. MAIN ISSUES

PRISM

Prism benefits and design principles:
Prism is evidence-based, people- focused, based on need, capable, integrated and collaborative, accessible, outcomes-focused recovery-focused and community linked. Prism is intended to create capacity across primary and secondary care.

Proof of Concept:
On 15 August 2016 Proof of Concept Prism (PoC) was launched to test some of the principles and challenges of community mental health delivery within primary care.

Proof of Concept Prism contains one Band 6 Prism worker and a Band 3 Support Worker covering 5 GP Practices (6 surgeries) in the Huntingdon and Fenland area.

Between 15 August and 30 Jan 2017 300 people were referred to the PRISM service by GPs, the majority of whom were able to receive appropriate and timely interventions in a primary care setting including signposting, education and advice. Although some PoC surgeries also continued to make some referrals to ARC early indicators suggest that onward referrals to secondary care from PoC surgeries are significantly reduced.

Logistics of Implementation:
PRISM Proof of Concept will continue to inform the full model roll-out with proposed additional resource providing additional data for evaluation. The roll-out of Phase 1 of the full model will begin in March 2017.

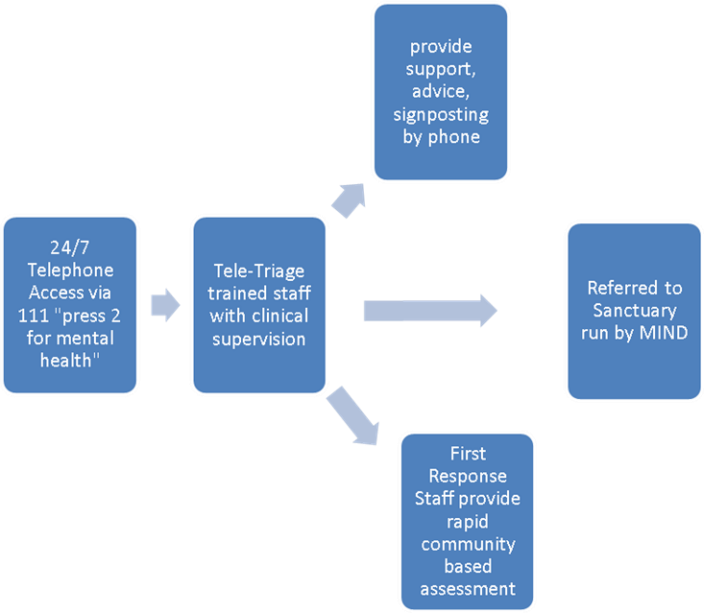
The second phase will include alignment of the voluntary sector portfolio across the CCG and the Local Authorities (including Public Health) to support Prism capacity. This phase will run throughout 2017/2018, going live on 01 April 2018. During this phase we will explore social care integration.

We envisage the full model be operating from 01 April 2018.

First Response Service (FRS)

The model is live and operating. The FRS provides immediate telephone triage and support for mental health crisis. The service welcomes referrals

from people of all ages in the CCG area, and is accessed through 111 and selecting option2 (which diverts directly to the service, avoiding the need to go through usual 111 triage pathway).



Calls are taken by telephone triage staff who have been trained to use a validated mental health triage scale, (the UK Mental health triage scale - see https://ukmentalhealthtriagescale.org/) and who are supervised and supported at all times by a band 7 mental health practitioner.

Patients who require an urgent psychiatric assessment will be offered this at home or close to home with one of the FRS band 6 nurses, or with the team's consultant if appropriate. They can then be referred directly into Cambridgeshire and Peterborough Foundation NHS Trust (CPFT) services if needed. Many people contacting the service do not need assessment but rather can be supported with phone support and advice and referral to voluntary sector organisations.

A vital part of the FRS model is the availability of a Sanctuary, run by the third sector in partnership with FRS. The Sanctuary provides a safe space to provide support and de-escalation for people in mental health crisis. Every evening FRS staff are able to refer suitable patients, after triage, to use the Sanctuary, with one centre open in Cambridge and one in Peterborough through the night from 18.00 – 01.00 the next morning. (See http://www.mindincambs.org.uk/what-we-do/the-sanctuary/). Visitors to the Sanctuaries have also been referred to numerous other voluntary sector organisations for further work, helping to reduce their need for crisis support in the longer term.

Impact so far:

- The service has demonstrated an immediate decline in the use of Emergency Departments (ED) for Mental Health (MH) with a 20% reduction in attendance despite the local context of many years of rapidly increasing figures.

- There has also been a 26% reduction in numbers of MH patients admitted to Acute Hospitals from ED

- Reduced ambulance call outs, assessments and conveyances to ED for MH patients

- Reduced need for Out of Hours (OOH) GPs to see MH emergencies

- Impact on the urgent and emergency system is predicted to increase once the service becomes more established.

- The service is now responding to people previously unknown to traditional mental health services meaning we are starting to treat our future mental health populations today. This has created a public expectation on the health system to achieve parity of esteem for mental health.

- The service has changed the way that our patients and professionals are using services. Health visitors, drug and alcohol services, GPs now have a service that they can refer people to which means a reduction in their time.

Next Steps:
As part of the updated Crisis Care Concordat action plan the emphasis going forward will be on further development of the MH Vanguard projects for both adult & Children and Young People (CYP) pathways, followed by further work with Black Asian Minority Ethnic (BAME) population, frequent attenders, patient flow and links to wider MH system.

3. SIGNIFICANT IMPLICATIONS

3.1 Statutory, Risk and Legal Implications

There are no statutory risks and legal implications which the project team would not be able manage.

3.2 Equality and Diversity Implications

Both services' configuration will need to be adjusted to every locality to support equality duty. The service will collect information in terms of access and outcomes for particular protected characteristics groups.

3.3 Engagement and Consultation Implications

Prism

A public consultation was not required in this instance but affected staff working in the ARC has been consulted with. This process concluded 7 February 2017.

The engagement strategy includes staff news, communications bulletins for GPs, attendance at key strategic and multi-agency meetings. A GP Engagement lead is focusing on face-to-face meetings with GPs across the CCG patch and is supported by 3 GP colleagues @ 1 session each per week. The service user network (SUN) has been engaged in Prism Proof of Concept.

First Response Service

Service is live and operating, therefore implementation engagement phase is concluded.

3.4 Public Health Implications

Prism

A Health Trainer has been employed to work with the Prism service specifically with the health needs of people with a severe and enduring mental illness living in the Cambridgeshire County Council area.

First Response Service

The service provides early intervention in crisis management thus allowing treatment of MH crisis at much earlier opportunity, delivering better outcomes and supporting secondary and tertiary prevention.

Source Documents	Location
Five Year forward View for Mental Health	https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
Guidance for Commissioners of Primary Mental Health Care Services	http://www.jcpmh.info/good-services/primary-mental-health-services/

Agenda Item No: 9

CAMBRIDGESHIRE AND PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PLAN – WORKFORCE OVERVIEW

To:	**HEALTH COMMITTEE**
Meeting Date:	**16 March 2017**
From:	**Lucy Dennis, Health Education England**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	The Health Committee requested a report from the Cambridgeshire and Peterborough Sustainability & Transformation Plan (STP) delivery programme (Fit for the Future) which describes the workforce planning considerations within the STP
Recommendation:	Report provided for information and discussion at the 16 March Health Committee meeting.

Officer contact:		***Member contact:***	
Name:	Aidan Fallon	Name:	Councillor David Jenkins
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1. WORKFORCE AND ITS ROLE IN THE STP

1.1 The Cambridgeshire and Peterborough STP covers hospitals, community healthcare, mental health, social care and GP services. It has been led and developed by our workforce, with local clinicians working with staff and patients to provide the solutions to the county's challenges to deliver the best possible care to keep the population fit for the future and to take joint responsibility for improving their health and wellbeing. This is the first time a whole system transformation plan and commitment to its aims has been designed.

1.2 Cambridgeshire and Peterborough has a NHS workforce of approximately 37,000 and a social care workforce of approximately 19,000. This does not include the number of students, trainees, and volunteers working across the system. The STP is proud to have a diverse workforce which includes a number of overseas employees and trainees.

The four priorities of the STP (at home is best; safe & effective hospital care, when needed; we're only sustainable together; and supported delivery) require a workforce with the right skills and competencies, working in the right roles, at the right time, and in the right place.

1.3 To support delivery of the STP's four priorities, new models of care have been designed which have significant implications for the workforce. Delivery Groups for Urgent and Emergency Care, Primary Care and Integrated Neighbourhoods, Stroke, Planned Care, and Women's and Children's, have developed business cases describing new models of care. These business cases describe how collaborative working with better utilisation of resources, estates, technology, and the workforce will support the population to be fit for the future.

2 NEW MODELS OF CARE

To date the new models of care for Urgent & Emergency Care, Stoke and Primary Care & Integrated Neighbourhoods, have each identified a need for significant increases in both support workforce and expert workforce. The reasons for these increases are:

- To enable more care to be delivered in community based settings
- To aid identification and intervention of patients who have risk factors which will lead to an episode of acute care
- To ensure that patients and service users who have health or social care needs may receive the care that best meets their need in a more effective and efficient way and in the most appropriate setting
- To ensure that there is an adequate and sustainable population of health and care staff to ensure that the system can meet demand

The new models of care describe a more collaborative integrated way of working across sector boundaries, between acute, community settings and practitioners. They place greater emphasis on enhancing community and primary care skills and capacity around the case management of individuals with one or more long term condition. There will be a greater occurrence of knowledge, information and resource sharing across the system which will enhance practice within the workforce and achieve a better understanding between professionals. To achieve this there is a need for shared

education and development to focus on collective problem solving, quality improvement and modernising working cultures.

The workforce profile indicates that we will need to implement robust action plans to ensure that these workforce changes are achievable. Our supply in skilled, experienced and specialist clinicians will be a challenge as will the training and retention of a strong support workforce. Areas under particular demand pressures such as primary care will need infrastructure support to be in a position to implement these new ways of working.

However these plans offer the opportunity to achieve a more integrated system which can create a workforce with the capability, competence and level of autonomy to be able to work across pathways and around the needs of the patient or service user.

3 WORKFORCE MITIGATIONS

In order to maximise the impact of the Urgent & Emergency Care (UEC), Stoke and Primary Care & Integrated Neighbourhood (PCIN) models, care has been taken to ensure that workforce requirements are viable in light of the STPs current profile. It is important that current workforce capacity and capability is considered, as well as the change required to develop a workforce which is capable, competent, motivated, and supported to provide the best care for the population in future.

The workforce proposals in the new models consider where approaches can be taken to develop expert generalist skilled support workers verses specialist roles. This takes shape in two parts:

- Recruitment to specialist posts, with the acknowledgement of current recruitment challenges and the likelihood that newly recruited specialist posts could likely be populated by members of the existing Neighbourhood Team workforce. This requires immediate consideration of a commissioning plan to increase supply of new registrants (particularly adult nursing and therapy) to fill gaps and provide a sustainable flow of staff at registrant level.

- Development of new supporting roles with a broader range of core skills and competence built into a flexible career pathway. This will be supported by a framework which provides the opportunity for rotations and development in areas such as mental health, social care, and therapy. This should recruit and retain a workforce which is more flexible and motivated to work across traditional boundaries.

In order to provide a workforce model which is able to support the new models, the following factors have been considered as critical for success:

- Development of Integrated Care Workers across the whole system, starting with recruitment in UEC and PCIN. Development of a national Trailblazer bid will allow the system to design apprenticeship standards tailored to the needs of our local system. The standards will provide generalist competencies but with the expectation of rotation and experience in a range of clinical settings, particularly for those seeking advancement in their role. By creating a large workforce which is agile, flexible, and competent in a range of areas to support our specialist staff and deliver basic care to our patients, we should be better equipped to manage changes in demand for care.

- Consideration of new roles to close the supply gap. Medical Assistants could work in general practice surgeries reducing administrative burden, coordinating referrals and communication with services, and other high level administrative tasks. The Physician Associate role can be designed to provide high level support to acute consultants so that they could offer a community service and intervene according to consultant protocols.

- Increasing commissions of newly qualified nurses and therapists to mitigate against losses of staff through progression into specialist roles. Recruitment to specialist posts could mean intense movement of staff at band 5 and 6 from our neighbourhood teams. It is vital that plans are made with our local universities to increase commissions so that the flow of newly qualified nurses, therapists and district nurses support a cycle of progression for registrant roles from 18/19 onwards.

- Education and training programmes will incentivise staff into specialist roles. This supports the cycle of progression, provides career enhancement opportunities, and increases the competency and capability of our workforce. Programmes have been costed for MSc level, in house competency packages, and will maximise levy opportunities.

- Partnership working to achieve a PCIN-UEC-Stroke combined workforce plan will mitigate against the current workforce shortages and the challenge and complexity associated with large scale workforce redesign and recruitment.

4. SIGNIFICANT IMPLICATIONS

4.1 Statutory, Risk and Legal Implications

This paper is linked to the ambitions of the Cambridgeshire and Peterborough Sustainability and Transformation Plan.

4.2 Engagement and Consultation Implications

Our member organisations and local stakeholders are co-designers and owners of workforce interventions across the STP. We are working with individuals from across the STP to ensure the system designs and owns delivery plans to achieve the workforce ambitions of the STP.

Source Documents	Location
• Cambridgeshire and Peterborough Sustainability and Transformation Plan • Sustainability and Transformation Plan summary document • Frequently Asked Questions	All available at www.fitforfuture.org.uk/what-were-doing/publications/

Authors:
Emma Wakelin, Strategic Development Manager, Health Education England
Lucy Dennis, Head of Workforce Partnership, Health Education England
7 March 2017

Agenda Item No: 10

CONSULTATION ON PROPOSED CHANGES TO THE FUTURE PROVISION OF SPECIALIST FERTILITY TREATMENT IN THE CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP AREA.

To:	**HEALTH COMMITTEE**
Meeting Date:	**16 March 2017**
From:	**Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group, Jessica Bawden** **Director of Transformation & Delivery: Primary & Planned Care, Cambridgeshire and Peterborough Clinical Commissioning Group, Sue Watkinson**
Electoral division(s):	**Countywide.**
Forward Plan ref:	**Not applicable**
Purpose:	Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) currently commissions specialist fertility treatments via the East of England Fertility Consortia. Each member CCG of the group applies its own eligibility criteria and the number of treatment cycles it is able to commission. The CCG currently provides one cycle of IVF treatment. As part of plans to manage its financial situation the CCG is consulting on a proposal to stop routinely commissioning any specialist fertility services other than for two specified exceptions.
Recommendation:	The Committee is asked to respond to the consultation document. See Appendix 1, consultation document. To follow after 13 March once the consultation has started.

CCG contact:		***Member contact:***	
Name:	Jessica Bawden	Name:	Councillor David Jenkins
Contact:	Teresa Johnson, Executive Assistant, 07534 101165, teresa.johnson4@nhs.net	Chairman:	Health Committee
		Email:	ccc@davidjenkins.org.uk
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1. BACKGROUND

1.1.1 In December 2016, the CCG reported to the committee our proposals for a consultation on Specialist Fertility treatments. This consultation has now begun and the CCG is presenting this report along with the consultation document for the committee to give feedback on these proposals.

1.1.2 Approximately 200 people accessed IVF services in 2015/16. Although this is a small number of patients the CCG understands that this will have a significant impact on those affected by this change.

Whatever decision is made around this proposal will be reviewed at the end of this funding formula period of three years.

2. MAIN ISSUES

2.1 **The Proposal:**

To stop the routine commissioning of any specialist fertility services other than two specified exceptions set out later in the paper

GP and clinical leaders have come to the difficult conclusion that when looking at the prioritisation of funds this is an area that we should review. The CCG has finite resources to fund a whole range of health services and treatments.

Specialist fertility services are expensive treatments. There is a real need to consider the value of funding for this treatment at the current time compared with all other NHS treatments/services.

Other investigations and clinical interventions that can improve fertility for couples are widely available via NHS services before the need to access specialist fertility services and these services will not be affected by this proposal.

Patients with genetic disorders requiring pre-implantation diagnosis and embryo selection based on this are commissioned by NHS England and are not affected by this consultation.

In the year 2015/16 the CCG spent £1,037,000 on specialist fertility treatment. This includes those who were eligible for more than one cycle prior to the existing changes. If these proposals are adopted the saving to the CCG in 2017/18 will be approximately £700,000.

2.2 **Exceptions to the proposal**

Under the new proposal, specialist fertility services will no longer be commissioned except for the following two exceptions listed below:

- Fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile.
- Sperm washing will be provided to men who have a chronic viral infection (primarily HIV and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral conditions such as HIV to the woman and therefore potentially her unborn baby.)

2.3 **Exceptional Funding Request Process**
Should this proposal be accepted it is important to note that the Exceptional Funding Request (EFR) process is still available for patients who believe that they have exceptional circumstances.
Any application needs to be made on behalf of the patient by a clinician, and the key point to remember is the need to demonstrate the exceptionality of the case - i.e. why the patient should receive treatment which is outside the CCG's current funding arrangements.

2.4 **Please Note:**
It is only in cases where patients' eggs and/or sperm need retrieving and laboratory fertilisation techniques are needed that there is onward referral to the specialist centres (IVF clinics).

2.5 **Infertility services still to be provided and not included in this consultation**
The CCG will continue to support the local gynaecological services and access to these is not being restricted. There is a range of services available to people who need help with fertility issues, both in primary care and in our local hospitals.
The hospital clinics have always had close links to the specialist IVF providers and will continue to provide patients with information on accessing the specialist services.
Services provided by the gynaecology clinics in the local hospitals include:

- the standard investigation of causes of infertility
- non-specialist treatments such as physical and hormonal therapy
- management of ovulation disorders
- management of tubal and uterine abnormalities
- medical and surgical management of endometriosis
- medical and surgical management of male infertility
- management of ejaculatory failure.

The care pathway for fertility services will be on the CCG website during the consultation.:

It is proposed that patients who have already been referred from secondary care (hospital services) to tertiary care (specialist fertility services) under the existing policy would complete their treatment.

3. SIGNIFICANT IMPLICATIONS

3.1 **Financial:** If these proposals are adopted the saving to the CCG in 2017/18 will be approximately £700,000.

3.2 **Governance:** The normal CCG policies development process has been followed in recommending that Assisted Conception should no longer be a priority for funding.

3.3 **Equality and Diversity:** Cessation of NHS funding for Assisted Conception will affect all childless couples equally, regardless of race, gender or sexual orientation. A full equality impact assessment has been completed and published on the CCG website; http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2016-17/20160913/Agenda%20Item%2002.1b%20-%20IVF%20Equality%20Impact%20Assessment.pdf

3.4 **Legal:** Legal advice has been sought.

3.5 **Consultation Implications** The consultation will run for 13 weeks from 13 March to 12 June 2017

4.0 **Appendices**

Appendix 1 –Consultation document.to follow after 13 March once the consultation has started

Source Documents	**Location**
NONE	.

HEALTH COMMITTEE WORKING GROUP UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	**16th MARCH 2017**
From	
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To inform the Committee of the activities and progress of the Committee's working groups since the last Committee meeting.**
Recommendation:	**The Health Committee is asked to:**

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

2) **Note the update from the Joint Health Scrutiny Committee – Collaboration of Hinchingbrooke Hospital with Peterborough & Stamford Hospital.**

3) **To discuss and agree a work programme for the continued scrutiny of the Sustainable Transformation Programme**

Officer contact:	
Name:	Kate Parker
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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 15th December 2016.

1.2 This report updates the committee on the joint liaison meeting with Cambridgeshire & Peterborough Clinical Commissioning Group (CPCCG) and Cambridgeshire Healthwatch, Cambridgeshire & Peterborough Foundation Trust (CPfT), Hinchingbrooke Health Care NHS Trust and Cambridge University Hospitals NHS Foundation Trust (CUHFT).

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. A schedule of meetings for 2017/18 will be presented at the Health Committee in June where membership for the liaison meetings will also be reviewed.

1.4 This report will also update the Health Committee on the outcomes of the Joint Health Scrutiny Committee (Cambs County Council and Peterborough City Council) in regards to the implementation plans for the merger of Hinchingbrooke HealthCare NHS Trust with Peterborough and Stamford Hospitals NHS Foundation Trust.

1.5 An overview of the various activities undertaken by members to support continual scrutiny of the CCG's Sustainability and Transformation Programme is provided in Section 4.

2. MAIN ISSUES

2.1 <u>Liaison meeting with Cambridge University Hospitals Foundation Trust</u>

The liaison group members in attendance were Councillors: Clapp, Orgee and Jenkins. A meeting was held on 2nd December 2016 with Kate Lancaster (Director of Corporate Affairs)

2.1.2 The following topics were discussed at this meeting:

- CEO report 9th November
- Finances & 5 year strategic plan to regain financial sustainability
- Emergency Flow through in the hospital
- Care Quality Commission (CQC) Inspection report was due imminently.
- Organisational Development Programme launched with staff survey.
- Rosie Maternity update on staffing

Members were provided with more detail around demand which continues to increase and is 4% on last years, with 12% of paediatric attendance increase

and 10% of mental health. One measure, the percentage of discharged by midday figures is improving. At the day of the meeting the hospital had a 100% bed occupancy, the hospital is at its most efficient when running to an 80% occupancy level.

The following actions were agreed:

- Meeting to be set up to visit the Rosie Maternity Unit

2.1.3 The next liaison meeting was rescheduled as it clashed with the Hospitals Quality Summit meeting from CQC and is now scheduled for 31st March 2017.

2.2 Liaison Meeting with Cambridgeshire & Peterborough NHS Foundation Trust (CPFT)

2.2.1 The liaison group members in attendance were Councillors: Jenkins, Orgee and van de Ven. A meeting was held on 14th December 2016 with Aidan Thomas (CEO) and Deborah Cohen (Director of Service Integration).

2.1.2 The following topics were discussed at this meeting:

- Sustainability and Transformation Plan (Aidan Thomas leading on Primary Care & integrated neighbourhoods work stream of the STP).
- Financial agreements
- CCG Financial Position
- Recruitment Strategy at CPFT
- Update on PRISM service (Primary Care service for Mental Health) http://www.cpft.nhs.uk/services/prism-service.htm
- Learning disability service (potential CQC inspection in March) links to transforming care programme.

2.1.3 Actions from this meeting:

- Members to consider including scrutiny of learning disabilities on the forward plan.

2.3 Liaison Meeting with Healthwatch Cambridgeshire and the Clinical Commissioning Group

2.3.1 The liaison group members in attendance were Councillors Orgee, Jenkins and Connor and District Councillor Ellington. A meeting was held on 26th January 207 with Val Moore (Chair) and Sandie Smith (CEO) of Healthwatch Cambridgeshire and Jessica Bawden (Director of Corporate Affairs) Mathew Smith (Associate Chief Officer), Sue Last (Head of Communications and Engagement)

2.3.2 An update from the CCG was received on the following areas.

- Sustainability and Transformation plan (arrangements for development session)

- Consultation proposal on new model for the referral and provision of NHS hearing aids.
- Consultation on Fertility Treatment services.

2.3.3 An update on East Cambs & Fenland Minor Injury Unit was provided by Matthew Smith. An Invitation to attend for this item was extended to all East Cambridgeshire & Fenland County Councillors. The key discussion points were as follows:

- Local Urgent Care Service (LUCS) Hub model was described.
- Proposals for LUCS hubs to be developed in the East Cambridgeshire & Fenland localities in: Ely, Doddington & Wisbech.
- Phased pilot programme expected to run Spring 2017-2018

2.3.4 Actions from this meeting:

As the proposals for the LUCS hubs are pilot programmes, Councillors expressed concerns over how the CCG would evaluate the hubs.

It was agreed that as the LUCS hub model was in early development the CCG would provide the following information to members once it had been agreed.

- Copy of the evaluation criteria for the LUCS hubs
- Copy of communication plans

2.3.5 Val Moore provided members with an update on a project to look at joint working between Cambridgeshire and Peterborough Healthwatch. The project will look at joint working from a spectrum of colloboration to full integration. The Healthwatch organisations receive funding from Cambridgeshire County Council and Peterborough City Council respectively and both local authorities have approved this project.

Sandie Smith reported on current activities from Healthwatch Cambridgeshire.

- Enter and View visits at A&E departments in both Addenbrooke's Hospital and Hinchingbrooke Hospital. The final reports are available on Healthwatch website.

http://www.healthwatchcambridgeshire.co.uk/our-enter-view-reports

The next liaison meeting date is April 20th 2017.

2.4 Liaison meeting with Hinchingbrooke Health Care NHS Trust.

The liaison group members in attendance were Councillors: Ashcroft, P Brown, and Jenkins and District Councillor Ellington. A meeting was held on 18th January 2017 with Lance McCarthy (CEO) and Phil Walmsley (COO).

2.4.1 The focus of the liaison meeting was around the merger proposals of HHCT with PSHFT.

Lance McCarthy provided the following updates for members:-

- The merger of PSHFT & HHCT is legally referred to as an acquisition of HHCT by PSHFT as the latter has "Foundation Trust" status.
- New Executive Directors announced 12th December 2016 in shadow form.
- Non-Executive Director (NED) appointments made (5 NEDs from Peterborough, 3 NEDs from Hinchingbrooke Hospital)
- Voting process was in place for the new organisations and the Department of Health have agreed to "North West Anglia NHS Foundation Trust" where each hospital will retain its current name.
- Staff consultation launched in the first week of January in regards to Transfer of Undertakings (Protection of Employment) (TUPE) to the new organisation on 1st April 2017.
- Organisational consultation launched in the first week of January. There were no changes proposed to clinical roles but support services will be affected with some jobs moving sites e.g. the possibility of HR to be located at Hinchingbrooke Hospital and IT at Peterborough City Hospital.
- Update on the IT System changes and clarity was provided that this is not the same as the installation of the EPIC system that Addenbrooke's purchased.

2.4.2 Lance McCarthy explained that understandably transition and change were impacting on staff but the Trust was managing the staff concerns through good communication and open conversations. Support had been provided for staff through the chaplaincy service and occupational health.

2.4.3 As this would be the last liaison meeting with representatives from HHCT before the official transfer to North West Anglia NHS Foundation Trust on 1st April, Councillor Jenkins thanked Lance McCarthy and the executive team for their time.

3 JOINT HEALTH SCRUTINY COMMMITTEE – MERGER OF HINCHINGBROOKE HEALTH CARE NHS TRUST (HHCT) WITH PETERBOROUGH & STAMFORD HOSPITALS NHS FOUNDATION TRUST (PSHFT)

3.1 The Joint Health Scrutiny Committee with Cambridgeshire County Council and Peterborough City Council have held three scrutiny committee meetings with the Chief Executive Officers and executive team representatives from both HHCT & PSHFT on 17th October, 9th November 2016 and 27th February 2017. The first meeting focused on clarity regarding the proposals in relation to both the financial and clinical sustainability business cases. The second meeting called representatives from KMPG and Loretti who had been commissioned by the hospital trusts to provide them with a financial overview for the full business case and outline of the Information Technology Clinical System upgrades that any merger would require.

3.2 The recent meeting on 27th February 2017 focused on discussing the merger plans leading up to 1st April 2017 when the new trust "North West Anglia NHS Foundation Trust" will be formed (Subject to approval by the Secretary of State).

Minutes of these meetings are available on:
https://cmis.cambridgeshire.gov.uk/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/37/Default.aspx

3.3 At the time of publication of this report minutes for the 27th February 2017 meeting were not available. Stephen Graves (CEO PHSFT), Lance McCarthy (CEO HHCT), Caroline Walker (CFO PHSFT), Mandy Ward (Head of Communications PSHFT) were in attendance. Caroline Walker and Stephen Graves provided a presentation to members on key aspects of the merger. A summary of the discussions is provided below.

- Clinical Services at risk HHCT: An overview of clinical services at risk at HHCT was provided and how the merger will support future clinical service delivery. Examples of merger success already being seen were given for haematology and HHCT A&E department.
- Governance Arrangements: Stephen Graves confirmed that a shadow board for the new trust was in place which did not have decision making responsibilities for HHCT but was able to start planning for the 1st April 2017. Executive team have been appointed from PSHFT following legal advice that staff on permanent contracts rather than interim contracts would have greater rights to positions. The Chief Nurse role went through a competitive process. Staff representation is equal for PSHFT & HHCT hospitals each with 3 staff members and Stamford has 1 staff member.
- Staff Consultations: Staff TUPE consultation and organisational restructure consultations were launched in January 2017. The organisational consultation deadline was extended due to responses. Whilst staff will TUPE on 1st April it was anticipated that appointments to posts will be completed by the 1st July.
- Replacement of IT systems: Members raised concerns over the IT systems given experiences of the EPIC system in Addenbrooke's Hospital. Stephen Graves explained that EPIC was a whole product. The new IT system at HHCT & PSHFT is building on top of an existing basic system which has already been rolled out in a number of UK hospitals rather than introducing a USA system as a first trial. Caroline Walker explained this is still challenging and it is not expected that the hospitals will go into a paperless system straight away and it is intended as a 3-5 year roll out plan.
- Changes to location of services: Members asked if assurances would be given that there would not be an expectation to travel to a less local hospital to receive treatment. Stephen Graves confirmed that the merger was not about moving services, formal consultation would be required with any service changes. However it was recognised that some hospitals may have capacity and patients could be given the choice where to receive treatment.

- STP Proposals: Members asked about the impact of the merger on proposals in the STP to have one unit within Cambridgeshire for both cardiology and stroke. It was agreed that both scrutiny committees would pick this up in their scrutiny of the STPs.

3.4 There will be a further meeting of the Joint Health Scrutiny committee in June 2017 to scrutinise the mobilisation plans of the newly formed North West Anglia NHS Foundation Trust.

3.5 Agreement was given from Stephen Graves to continue with the quarterly liaison arrangements for Hinchingbrooke Hospital which were set up by Cambridgeshire County Council's Health Committee.

4. OVERVIEW OF SCRUTINY OF THE SUSTAINABILITY AND TRANSFORMATION PROGRAMME

4.1 The CCG published its Sustainability and Transformation plan, "Fit for the Future" on 23rd November 2016. The Health Committee had started initial scrutiny of the developing plans back in March 2016 when the "Evidence for Change" supportive information document was produced. The approach taken to scrutinising the STP has been through the formal Health Committee meetings in public, development sessions for members and informal follow up meetings with members from the STP unit.

Full details of the STP plans can be found on the following link:
http://www.fitforfuture.org.uk

Table 1: Cambridgeshire Health Committee - Scrutiny of STP

Health Committee Meetings	**Health Committee Training & Development Sessions**	**Informal meetings**
Pre-Publication STP		
November 10th 2016 STP Overview & MOU	March 3rd 2016 CCG Planning for 2016/17 and beyond Introduction to "Fit for the Future"	
	June 16th 2016 CCG Development of the STP	
Post Publication of STP		
December 15th 2016 STP Update	January 6th 2017 STP Overview	December 2nd 2016 Meeting Healthwatch Cambridgeshire to discuss published STP
January 12th 2017 STP (Finance & Primary Care)	February 16th 2017 STP (Workforce Planning / Engagement)	February 22nd 2017 Meeting with Dr.Howsam to discuss GP engagement

March 16th 2017 STP (Workforce Planning / Engagement)		March 30th 2017 (Provisional) Meeting with Joel Harrison to discuss procurement and STP financial plan.
		Week Commencing 6th March / 13th March TBC Meeting with Scott Haldane and Aidan Fallon to discuss STP engagement plans.

4.2 Consideration to developing a full programme of scrutiny of the STP for 2017/18 will be given at the Health Committee's priority-setting meeting scheduled for June 8th 2017.

5. SIGNIFICANT IMPLICATIONS

5.1 **Resource Implications**

Working group activities will involve staff resources in both the Council and in the NHS organisations that are subject to scrutiny.

5.2 **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

5.3 **Equality and Diversity Implications**

There are likely to be equality and diversity issues to be considered within the remit of the working groups.

5.4 **Engagement and Consultation Implications**

There are likely to be engagement and consultation issues to be considered within the remit of the working groups.

5.5 **Localism and Local Member Involvement**

There may be relevant issues arising from the activities of the working groups.

5.6 **Public Health Implications**

Working groups will report back on any public health implications identified.

Source Documents	Location
NONE	.

Agenda Item No: 13

NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2016-17 REQUESTS

To:	**HEALTH COMMITTEE**
Meeting Date:	**16th March 2017**
From	**The Monitoring Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**For the Committee, as part of its Health Scrutiny function, to agree the process to respond to statements on the Quality Accounts provided by NHS Provider Trusts.**
Recommendation:	**The Health Committee is asked to note the requirement to comment on Quality Accounts and to**

a) delegate approval of the responses to the Quality Accounts to the Head of Public Health Business Programmes acting in consultation with, and in accordance with the views of, members of the Committee (where a response is required before 4th May) or (for later response deadlines) such members of the present Committee as are still elected members of Council following the elections on 4th May.

b) prioritise which Quality Accounts the Committee wishes to respond to.

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

1.1 NHS Healthcare providers are required under the Health Act 2009 to produce an annual Quality Account report. A Quality Account is a report about the quality of services by an NHS healthcare provider.

1.2 Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.

1.3 This paper outlines the proposed response to the Quality Accounts received by the Health Committee and the internal deadlines to respond to the NHS Trusts.

2. MAIN ISSUES

2.1 It is a requirement for NHS Healthcare providers to send to the Health Committee in its Overview and Scrutiny function a copy of their Quality Account for information or comment. Statements from Healthwatch and Health Overview and Scrutiny Committees must be included in the published version.

2.2 NHS Healthcare providers are required to submit their final Quality Account to the Secretary of State by 30th June each year. For foundation trusts the Quality Accounts are required to be submitted to NHS Improvement by 31st May. However each provider will have internal deadlines for receipt of any comments from relevant statutory consultees.

2.3 As discussed at the Health Committee meeting on 12th May 2016, the timing of the Quality Account deadlines puts the Committee in a difficult position to provide an adequate response. The difficulty is particularly acute in 2017 because of County Council elections. The Committee resolved at that meeting to 'consider a process for responding to Quality Accounts in 2017 in detail at the Committee's meeting in March 2017 taking into consideration the dates of Annual Council and Health Committee in May/June 2017.'

3. PROCESS FOR RESPONDING TO NHS QUALITY ACCOUNTS

3.1 Following the County Council elections on 4th May and the start of the a new four-year Council, the Health Committee will not be meeting until 8th June 2017, well past the deadline for submission of a response to the quality accounts. The membership of the Health Committee will not be known until after the Annual Meeting of Council on 23rd May 2017.

3.2 Under the committee system of governance, it is not possible to delegate decisions to individual elected members or groups of members, but scrutiny regulations require that scrutiny be carried out by elected members and not delegated to officers.

3.3 At its meeting on 12th May 2016 the Committee noted a suggested approach to accommodate these restrictions of timing and delegation. It was suggested that at the last meeting in the current municipal year (16th March), the Committee delegate approval of the responses to the Quality Accounts to the Director of Public Health acting in consultation with, and in accordance with the views of, such members of the present Committee as were still elected members of Council following the elections on 4th May.

3.4 The responses could then be reported to the incoming Committee at its meeting on 8th June.

4.0 EXPECTED DEADLINES FOR RECEIPT OF QUALITY ACCOUNTS

4.1 In preparation for this new local process to responding to NHS Quality Accounts the following deadlines have been provided from NHS Trusts.

4.2 Members should note that the timescales to respond to Quality Accounts vary for each trust and can be very tight. Table 1 indicates the timescales the Committee worked on in 2016.

Table 1: Quality Account Timeline

Organisation	Statutory Submission date for the Trust	Agreed date to receive draft Quality Account	Agreed date to submit response to Trust	Additional Notes
Cambridge University Hospital Foundation Trust (CUHFT)	**31st May 2017**	**3rd April 2017**	**13th April 2017**	Previously received on 15th April 2016. Response requested 12th May 2016.
Peterborough & Stamford Hospital Foundation Trust (PSHFT)	**31st May 2017**			Previously received on 21st April 2016. Response requested 4th May 2016 Members may not wish to respond to PSHFT as covered by PCC
Cambridgeshire & Peterborough Foundation Trust	**31st May 2017**			Previously received on 27th April 2016

Queen Elizabeth Hospital Kings Lynn (NHS Foundation Trust)	**31st May 2017**			Previously received on 7th May 2016. Response requested 12th May 2016. CCC is not the local scrutiny committee for QE. The Quality Account was received at members request. We have not had any scrutiny involvement with QE Trust in 2016/17
Papworth Hospital (NHS Foundation Trust)	**31st May 2017**			Previously received on 18th April 2016. Response requested 13th May 2016. Members may not wish to respond to Papworth's QA as we have not had any scrutiny involvement with the trust in 2016/17.
Hinchingbrooke Health Care NHS Trust	**30th June 2017**			Previously received on 3rd May 2016. Response requested 15th May 2016. This may be the last opportunity for members to comment directly on HHCT as it will be part of PSHFTs Quality Account in 2017/18
Cambridgeshire Community Services	**30th June 2017**			Previously received on 29th April 2016. Response requested by 30th June 2016. Members may wish to consider if they wish to respond. We have not had any direct scrutiny involvement with CCS in 2016/17

SIGNIFICANT IMPLICATIONS

5.1 Resource Implications
Officer time in preparing a paper for the Committee.

5.2 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.

5.3 Equality and Diversity Implications
There may be equality and diversity issues to be considered in relation to the quality accounts.

5.4 Engagement and Consultation Implications
There may be engagement and consultation issues to be considered in relation to the quality accounts.

5.5 Localism and Local Member Involvement
There may be relevant local issues in relation to the quality accounts.

5.6 Public Health Implications
The quality of services at local healthcare providers will impact on public health

Source Documents	Location
NHS Choices information on Quality Accounts	http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx
Reports to and minutes of Health Committee	https://cmis.cambridgeshire.gov.uk/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/6/Default.aspx

HEALTH COMMITTEE TRAINING PLAN	Updated following Health Committee training seminar 16th Feb 2017	**Agenda Item No: 14**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
8.	**Health Scrutiny Skills Part 1**	To understand the roles and responsibilities of members conducting health scrutiny and to provide members with scrutiny skills and techniques Centre for Public Scrutiny led training specifically on STP	1	6th Feb 2017	Public Health	Training Seminar	Chair & Vice Chair. Places made available to 3 other members	5	100%
15.	***Sustainability and Transformation Plan (Updated 8th Sept)***	To hold the session on the CCG's Sustainability and Transformation Plan (STP) in December, following publication of the STP in November	1	16th Feb	Public Health	Training Seminar	Health Committee members & Subs	15	75%
17.	***Health Inequalities (Updated 8th Sept)***	To provide members with background information around Health Inequalities in preparation for January Health Committee item.	1	12th Jan	Public Health	Training Seminar	Health Committee Members	12	71%

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
18.	***Part 1*** ***Children & Young People's Mental Health*** ***Part 2*** ***Health Committee Priorities overview of 2016/17***	To provide members with background information on the current issues around children and young people's mental health To provide members with an overview of the progress on the Health Committee priorities for 2016/17	2	13th April TBC	Public Health	Training seminar			
19.	***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	25th May TBC	Public health	Training seminar			

- 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 1st March 2017 Updated 8th March	Cambridgeshire County Council

Agenda Item No: 16

Notes

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

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

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

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
[13/04/17] Provisional Meeting	*Development session on Children and Young People's Mental Health*			*23/03/17 3.30pm*	*31/03/17*	*04/04/17*
08/06/17	Co-option of District non-voting Members	Ruth Yule		20/04/17 3.30pm	25/05/17	30/05/17
	Public Health Finance and performance report	Chris Malyon/ Liz Robin		18/05/17 3.00pm		
	0-19 Joint Commissioning of Children's Services	Meredith Teasdale				
	Update on pilot harm reduction project for stopping smoking	Val Thomas				
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report) *[provisional]*	Kate Parker/ NHS England				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Update from Cambridge University Hospitals NHS Foundation Trust (CUHFT) on EPIC IT Service	CUHFT				
	Scrutiny Item: NHS Quality Accounts	Kate Parker/ Ruth Yule				
	Scrutiny Item: Development of Primary Care Provision for Northstowe	Kate Parker/ CCG				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny item: Non-Emergency Patient Transport Services performance update six months after September 2016 commencement	Kate Parker				
	Scrutiny Item: 111 Out of Hours Service – Review of First Five Months Delivery	Kate Parker				
	Update on Health Committee priorities (or March)					
	Scrutiny Item: Health Committee Working Groups – establishment of and appointment to working groups	Kate Parker				
	Update on Health Committee priorities 2016/17					
	Planning future priorities for Health Committee 2017/18					
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
20/07/17	Co-option of District non-voting Members	Ruth Yule		29/06/17 3.30pm	07/07/17	11/07/17
	Public Health Risk Register update	Tess Campbell				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: East Of England Ambulance Trust (EEAST): CQC Inspection of Local Delivery follow-up	Kate Parker				
	Scrutiny Item: Suicide Prevention Strategy	Kate Parker				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[17/08/17] Provisional meeting				*27/07/17 11.00am*	*04/08/17*	*08/08/17*
07/09/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		17/08/17 11.30am	26/08/17	30/08/17
	Scrutiny item: Suicide Prevention Strategy – update	Kate Parker / Kathy Hartley				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
19/10/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		28/09/17 3.30pm	06/10/17	10/10/17
	Business Planning 2017-18 (provisional)	Chris Malyon/ Liz Robin				
	Immunisation Task and Finish Group report, to include whether the drop in take up of flu immunisations by pregnant women was a single year anomaly or whether it was repeated in the figures for the following year (12-month follow-up)					

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
16/11/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		26/10/17 3.30pm	03/11/17	08/11/17
	Business Planning 2017-18 (provisional)	Chris Malyon/ Liz Robin				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
14/12/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		23/11/17 3.30pm	01/12/17	05/12/17
	Business Planning 2017-18 (provisional)	Chris Malyon/ Liz Robin				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
Tuesday 16/01/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin		14/12/17 11.30am	03/01/18	05/01/18
	Public Health Risk Register update					
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[08/02/18] Provisional meeting				*18/01/18 11.30am*	*26/01/18*	*30/01/18*
15/03/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin		22/02/18 3.30pm	02/03/18	06/03/18

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[19/04/18] Provisional meeting				*20/03/18 11.00am*	*06/04/18*	*10/04/18*
17/05/18	Notification of Chairman/woman and Vice-Chairman/woman	Ruth Yule		26/04/18 3.30pm	04/05/18	08/05/18
	Co-option of District non-voting Members	Ruth Yule				
	Public Health Finance and performance report	Chris Malyon/ Liz Robin				
	Scrutiny Item: NHS Quality Accounts (provisional)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				

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

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

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

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

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

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

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