HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 10 March 2016

Democratic and Members' Services
Quentin Baker
LGSS Director: Law, Property and Governance

14:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Kreis Viersen Room
Shire Hall
Cambridge
CB3 0AP

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

Apologies and Declarations of Interest

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

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Petitions

SCRUTINY ITEMS

Older People and Adult Community Services – termination of UnitingCare contract **19 - 22**

Update on actions to address low uptake of breast and cervical screening in Cambridgeshire **23 - 32**

The Health Committee comprises the following members:

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

Councillor Peter Ashcroft Councillor Barry Chapman Councillor Paul Clapp Councillor Adrian Dent Councillor Peter Hudson Councillor Mervyn Loynes Councillor Zoe Moghadas Councillor Paul Sales Councillor Mandy Smith Councillor Peter Topping and Councillor Susan Van de Ven

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

Clerk Name: Ruth Yule

Clerk Telephone: 01223 699184

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

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HEALTH COMMITTEE: MINUTES

Date: Thursday 21st January 2016

Time: 1.05pm to 4.35pm

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

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

Also present: Peterborough City Councillors Kim Aitken and Brian Rush (for agenda item 9, minute 192)

Apologies: County Councillor S van de Ven (Cllr Leeke substituting)
District Councillor M Cornwell (Fenland)

Before the start of business, the Chairman paid tribute to the late Councillor Steve van de Kerkhove, a member of the Committee who had died a few days before the meeting. He used to speak with humour, depth and knowledge, and would be greatly missed. The Committee stood in silence in his memory.

187. DECLARATIONS OF INTEREST

None.

188. MINUTES: 17th DECEMBER 2015 AND ACTION LOG

The minutes of the meeting held on 17th December 2015 were agreed as a correct record and signed by the Chairman.

The Action Log was noted. The Director of Public Health (DPH) said that Cambridge University Hospitals NHS Trust had undertaken to send the update reports in the third week of each month; the January report had been received and would be circulated to committee members electronically [minutes 167 and 175 refer]. **Action required**

189. PETITIONS

There were no petitions.

190. SERVICE COMMITTEE REVIEW OF DRAFT BUSINESS PLANNING PROPOSALS FOR 2016-17 TO 2020-21

The Committee received a report which set out an overview of the draft Business Plan Proposals for Public Health Grant (PHG) funded services that were within the Committee's remit; provided a summary of the latest available results from the budget consultation; and sought Members' endorsement for the proposed Key Performance Indicators for the Public Health Directorate.

Members noted that

- proposals for 2016-17 were given in detail, with indicative figures for the following four years
- proposals for making the considerable savings required had been prioritised on the basis of four criteria: evidence, efficiency, impact on inequalities, and the views of the Committee expressed at previous meetings
- because of the announcement in November 2015 that PHG funding would remain ring-fenced, the effect in Cambridgeshire was that further savings would have to be found from public health grant funded services, the majority of which sat within the Public Health Directorate, and correspondingly more funding would be available corporately
- additional corporate funding headroom meant that a number of savings originally planned in other directorates would no longer be required, including Children, Families and Adult (CFA) funding for older people's day services; Economy, Transport and Environment (ETE) funding for market town transport strategy; and Customer Services and Transformation (CS&T) funding for community engagement
- three proposals were being put forward for using the corporate funding headroom to partially mitigate proposed public health savings: Family Nurse Partnership and Health Visiting; public health intelligence/Joint Strategic Needs Assessment (JSNA) service; and the public health specialist nursing and immunisation function
- the Community Impact Assessments (CIAs) focussed on whether a proposal would affect some groups of people more severely than other groups; many showed as neutral because all groups were affected equally (including if all were adversely affected equally), or because mitigation measures formed part of the savings proposal.

In the course of examining the proposals, Members

- noted that, viewed from a public health perspective, older people's day centres were not an effective way of promoting physical activity, but the proposal was to use corporate headroom funding to ensure no loss of funding to day centres; General Purposes Committee would be discussing this alongside other Service Committee proposals for use of corporate headroom protection

- sought assurance that the brain injury unit at the North Cambridgeshire Hospital would still be funded. The DPH advised that this was not funded through the PHG, but offered to find out more for the Member **Action required**

- expressed concern that any reduction in the health visiting and school nursing services could have an adverse effect on the child members of gypsy and traveller families. Members noted that public health officers were working together with Cambridgeshire Community Services NHS Trust (CCS) on developing a more inclusive service than the present highly-targeted Family Nurse Partnership programme; this new service would reach a larger number of vulnerable women and children at a lower cost than the present arrangements

- expressed concern that where CIAs showed negative impact, as in the case of day care centres, immunisation programmes, and community engagement/timebanking, Fenland would be particularly affected because of the high levels of rural isolation and deprivation there. Members noted that all three areas were already included in the recommendations for corporate funding

- drew attention to the importance of preventative services as a constantly emerging theme at a recent workshop on regional working, attended by local authority chief executives and fire and police service representatives, and expressed frustration at the absurdity of being asked to make major cuts to prevention work.

The Committee went on to consider the proposed Key Performance Indicators (KPIs) for Public Health, which formed part of the Council's Strategic Framework, and which covered key services that Public Health commissioned or delivered. Discussing the KPIs, Members

- noted that the children's mental health indicator of admissions to hospital for self-harm in children and young people could act as an early indicator for more serious problems, and that it was possible to compare self-harm admissions across the country; the DPH offered to brief Members on this outside the meeting

Action required

- drew attention to the importance of long-acting reversible contraceptives (LARC), given the need to reduce the number of teenage pregnancies nationally, and of falls prevention in older people in view of the consequences of falls

- welcomed the KPIs being suggested, as reflecting each of the areas of public health expenditure.

The Chairman circulated a fifth recommendation for the Committee's consideration:

That the Committee resolve to recommend the following motion to Full Council

This Council:

- understands the impact of Public Health expenditure on health outcomes and future costs in the broader health economy in Cambridgeshire as evidenced by a comprehensive body of information including its own Prevention Strategy
- notes the Government's recent announcement to follow the 2015/16 mid-year cut in the Public Health Grant with a another cut for 2016/17 and further annual cuts in future years
- believes that these continuing cuts are ill-advised because they will result in higher long term health costs
- accepts that a broad approach to the Government through the Secretary of State for Health, its MPs and the Local Government Association is needed if these cuts are to be reversed

Resolves therefore to:

- ask the Chief Executive to write to the Secretary of State for Health and the Cambridgeshire MPs to brief them on the likely impact of the cuts, and to provide them with a copy of this County's Prevention Strategy
- ask the Chief Executive to table a motion at the LGA conference calling for the Government to rethink its approach to funding Public Health and to increase funding for public health interventions.

He explained that this had arisen from the discussion at the previous meeting about taking up the matter of public health funding with local MPs, and had been informed partly by subsequent discussion with Heidi Allen MP and Mark Lloyd, Chief Executive of the Local Government Association; he would also be meeting the MPs Lucy Fraser and Daniel Zeichner in the near future.

Some Members welcomed the motion as drafted, but others suggested that it was important to emphasise the need for preventative work across a whole range of services, including for example the Fire Service, and to point out that the prevention agenda, which Cambridgeshire had been developing for many years, was important and valuable, and that implementing it across the whole public service economy would lead to savings across the NHS and the social care budget. However, it was pointed out that the Committee's focus was on public health.

It was resolved by a majority:

a) to note the overview and context provided for the 2016/17 to 2020/21 Business Plan proposals for the Service, updated since the last report to the Committee in November

b) to endorse the draft revenue savings proposals that were within the remit of the Health Committee for 2016/17 to 2020/21 to the General Purposes Committee as part of consideration for the Council's overall Business Plan, including recommendations for corporate funding headroom outlined in paragraphs 3.6 and 3.7 of the report before Committee

c) to note the ongoing stakeholder consultation and discussions with partners and service users regarding emerging business planning proposals

d) to endorse the proposed Key Performance Indicators as part of the Strategic Framework alongside the 2016-21 Business Plan

e) to recommend the following motion to Full Council

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191. CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST – MENTAL HEALTH SERVICE PRESSURES – UPDATE

The Committee considered update reports on Mental Health Service pressures, as requested in July 2015, when it had previously considered the topic. In attendance to present the reports and respond to Members' questions were

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
  - Dr Neil Modha, Chief Clinical Officer (Accountable Officer)
  - Adele McCormack, Mental Health Commissioning & Contracts Manager
  - (for 8a) Dr Emma Tiffin, GP and Clinical Lead for Mental Health
  - (for 8b) Lee Miller, Head of Children and Maternity Commissioning & Transformation
- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
  - Aidan Thomas, Chief Executive
  - Andrea Grosbois, Communications Manager
  - (for 8b) Sarah Spall, General Manager, Children's Directorate

a) Adult Mental Health Service Pressures

The Committee first considered the report supplied by the CCG on pressures in adult mental health services. Members noted that population growth and the requirement for all NHS service providers to make efficiency savings were ongoing sources of pressure. The CPFT Chief Executive endorsed the report in its entirety. He said that for both CCG and CPFT, adults with seriously enduring mental health problems were of very great concern; they were severely affected by for example cuts in welfare benefits and cuts in social care, factors which might be partially responsible for the increase in referrals to secondary mental care services. He expressed concern if numbers were to continue increasing in future, and welcomed the acceptance of the CCG as a vanguard site for urgent and emergency care.

In the course of discussion, Members

- enquired what proportion of patients had a crisis plan in place, as an alternative to attending an Accident and Emergency department (A&E). Members were advised that the majority of patients being treated by CPFT in the community had a crisis plan, which would include risk factors which might cause a crisis, and ways for patient, family and healthcare team to manage a crisis. However, new patients, or those discharged from hospital some time ago, might not have a crisis plan

- noted that there was a smartphone crisis card app available as a source of support in a crisis, and that it was hoped to promote crisis planning through the Vanguard programme; a first response telephone service was being introduced, starting in Cambridge, with a single telephone number as a point of access

- in relation to the 12% increase in referrals to the Crisis Resolution and Home Treatment Team, asked what the baseline number was. The Chief Executive said that CPFT had about 15,000 service users at any one time across Cambridgeshire

and Peterborough, many of whom would not need to call on the crisis resolution team; he undertook to supply more detailed figures on numbers of service users

Action required

- noted that a patient presenting at one of the four local A&E departments in mental health crisis might, during working hours, and depending on which hospital it was, be seen by a psychologist in the liaison team. Out of hours, the local crisis team would be called in; crisis teams also had a range of responsibilities within the community setting

- enquired whether patients might be kept on a waiting list because of lack of resources. Members were advised that where an assessment at crisis point found that there was no urgent need, the patient would be referred on to another service, usually the locality mental health team. With some exceptions, such as Adult Attention Deficit Hyperactivity Disorder (ADHD), the patient would still be seen within NHS timescales.

It was resolved unanimously:

to note the current pressures and the measures put in place locally to mitigate these.

b) Child and Adolescent Mental Health Service Pressures

The Committee went on to consider reports from the CCG and CPFT on pressures in Child and Adolescent Mental Health Services (CAMHS). Members noted that

- because of the length of waiting time, it had been decided in about March 2015 to close the waiting lists for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals where there were no associated urgent mental health needs, and to redesign the pathways to ensure that patients received a timely service
- the CCG had invested an additional £600k recurrent and £150k non-recurrent funding in CAMHS for the current year, and a national uplift to CAMHS had also been made available to the CCG, resulting in a further £1.5m funding locally for the current and subsequent years
- some of the national funding had been targeted at, and used for, improvements in eating disorder services
- in December 2015, the waiting lists had been re-opened following pathway redesign
- the referral service for ADHD, which was a neurodevelopmental disorder, now had a pathway with less consultant engagement than previously, and closer to that seen elsewhere in the country
- the hope was that there would be no waiting list for the core CAMH pathway by the end of January 2016.

Discussing the reports, Members

- welcomed the progress made, particularly when compared with the position reported in July 2015

- enquired whether there was a gap in service for those aged 17 – 18, and noted that CPFT concentrated on children with ADHD and was working on the development of a 0 – 18 service and new commissioning process

- noted that the initial appointment for the family common assessment did not require specialist input and could be carried out by the health visitor or family support worker. CPFT, working with the CCG, sought to achieve an 18-week service, but some support services could be put in place quickly, for example behaviour support and school support; for many children, support at this lower level would be effective and sufficient

- asked whether parents and family would also receive support quickly. Members noted that the CCG was investing in parenting programmes and parent support; NICE guidance on ADHD recommended parent-training/education programmes as the first-line treatment, ahead of medication.

It was resolved unanimously:

to note the report on future plans outlined for Child and Adolescent Mental Health Services

The Chairman thanked all who had attended from the CCG and CPFT.

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

The Committee considered background information on the termination of the UnitingCare contract and questioned senior representatives of local health bodies. In attendance were

- from Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
  - Dr Neil Modha, Chief Clinical Officer (Accountable Officer)

- from Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
  - Aidan Thomas, Chief Executive
  - Andrea Grosbois, Communications Manager
  - Keith Spencer, Chief Executive of UnitingCare

- from Cambridgeshire Community Services NHS Trust (CCS)
  - Matthew Winn, Chief Executive

- from Cambridge University Hospitals NHS Foundation Trust (CUHFT)
  - Roland Sinker, Chief Executive Officer.

Apologies had been received from the Finance Director and the Locality Director at NHS England, and from Monitor's Senior Regional Manager, who had sent a briefing note (attached as Appendix A and circulated to the Committee before the meeting). The Chair of Peterborough City Council's Health Scrutiny Commission, Councillor Rush, and a Member of the Commission, Councillor Aitken, participated in the scrutiny of the Older People and Adult Community Services (OPACS) contract at the Chairman's invitation because the contract had covered the provision of services in Peterborough as well as in Cambridgeshire.

The Chairman welcomed all present, and asked the lead officers from the CCG, CPFT, CUHFT, UnitingCare and CCS to make brief statements in turn, before the Committee examined the contract establishment, start-up and collapse, and the future for OPACS. First, he invited a member of the public, Jean Simpson, to put her questions to the Committee.

The questioner said that she had raised many queries with the Committee in the past about the CCG's ability to manage the competitive contract process, and that the decision to terminate the contract had had huge financial consequences on the local Health Economy, with deficits being reported by the CCG and CUHFT. She referred to the reviews being conducted by the CCG and NHS England into the factors leading to the collapse of the contract, and pointed out that the CCG was still continuing with two further important procurement exercises, for Non-Emergency Patient Transport Services (NEPTS), and for the 111 and Out of Hours Service.

Ms Simpson's two questions were:

1. Will the Committee take steps to investigate how much public money has been spent on this whole exercise so far, and how the service is going to be securely financed from now on?
2. Can the Health Committee recommend that the CCG halt the two current procurements until they have assured themselves, and the Health Committee, that lessons have been learned from this failed exercise?

The Chairman thanked the questioner for highlighting that the Committee was independent of the contract process, and said that the answer to the first question was yes, the process of investigation had already started and would continue until the Committee felt it had an adequate answer to the OPACS contract. The answer to the second question was no, because the two current procurement exercises were different in scale and complexity from the OPACS one. The 111 and Out of Hours procurement was being conducted to a national specification, and the Council's Economy and Environment Committee had been involved in responding to the NEPTS proposals, which were on a much smaller scale than OPACS.

Dr Neil Modha, Chief Clinical Officer of the CCG, stressed that the provision of good quality local care for older people and adults continued to be a priority. He was convinced that the model developed by UnitingCare was the right one, and was anxious that none of the benefits of that model be lost. All the partners had done everything they could to maintain the contract; as a CCG, it was important for them to learn from the process. He assured the Committee that the CCG would be open with all the reviews. The report to the Committee had been written from a CCG perspective. The issues that had led to the end of the contract had all been matters of finance, not quality. He wished to reiterate to the staff in the service that the plan was to continue to build on the UnitingCare model.

Keith Spencer, Chief Executive of UnitingCare, spoke on behalf of CPFT and CUHFT. He offered to supply the full text of his remarks (attached as Appendix B) as he had not had the opportunity to supply a paper to the Committee in advance. He said that he supported the Chief Clinical Officer's point that nobody had wanted the contract to terminate; UnitingCare, CCG, CPFT and CUHFT had worked tirelessly to find the necessary funding, with support from NHS England (NHSE) and Monitor. The UnitingCare service model had been co-created with service users and care staff; since its implementation it had seen reductions in hospital admissions and in length of stay. UnitingCare's role had ended, but it was necessary to ensure that key elements of the service model were preserved for the benefit of local people.

In answer to the Committee's three questions (what happened, why, and what happens next), he said that the CCG and UnitingCare had signed a contract in November 2014 which had recognised that the CCG had been unable to answer all of the 71 questions of clarification that had been outstanding when the bid had been submitted; of these, 34

questions had remained unanswered at the time of signing the contract, so the contract was based on a large number of assumptions. The contract had nevertheless been signed because of the desire to transform services without delay, and had included clauses to protect both sides from financial destabilisation; it was recognised that work remained to be done. Monitor and NHSE permitted the contract to proceed with the protection clauses in place.

The contract had ended because it became clear that costs of £9.3m were emerging that the CCG was unable to cover. At UnitingCare's request, the CCG had approached NHSE at the end of November 2015 seeking support to enable the contract to continue, but NHSE was unable to provide this. Because UnitingCare had a legal obligation to remain solvent, its Board decided to terminate the contract on 2nd December 2015. It remained the case that only by transforming services would the local health economy become viable for patients, staff and local Trusts.

Aidan Thomas, Chief Executive of CPFT, said that while there might be disagreements around the detail of the break-up of the contract, for the health economy, the partners and the CCG it was important to resolve the reasons for the collapse. For the local health economy and the local people, what was of key importance was to concentrate on how all parties could work together to implement the new model of care and follow through the work that UnitingCare had started.

Roland Sinker, Chief Executive Officer of CUHFT, said that he agreed with everything the UnitingCare and CPFT Chief Executives had said. He had spent ten years working in the NHS in London; efforts to implement exactly these models of care were being made in London, about two years behind the Cambridgeshire work. He had worked a half shift in A&E at Addenbrooke's the previous evening and visited wards; he had been pleased to see A&E calm, beds available on the wards, and patients receiving appropriate care. For the first time in 22 months, the Emergency Department had exceeded the 95% target in December 2015.

Matthew Winn, Chief Executive of CCS, explained that he had been invited to attend because it had been CCS which, prior to UnitingCare, had previously employed the community healthcare staff who had been transferred (under TUPE) largely to CPFT. Some of the cost of these services had formed around 37% of the cost of the contract.

The Committee explored questions of the contract and its collapse:

- Asked to clarify the position on outstanding issues when the contract was signed, the Chief Clinical Officer of the CCG and the Chief Executive of UnitingCare explained that there had been 34 points of clarification outstanding when the contract had been signed; it had been intended to be a fixed value contract, and had recognised that resolutions to the outstanding issues needed to be financially neutral; it had recognised the unresolved issues and had included a range of ways in which the financial issues could be dealt with. The 34 issues could have increased in number as further issues emerged.

- The Chief Clinical Officer said that none of the parties had expected what happened, but it had become clear over the year that the cost of the service was greater than the contract value, and the CCG as commissioners was unable to put additional funding into it. He confirmed that the 34 issues were not in the public domain, but it would be possible to give Members of the Committee sight of them.

Action required

One reason for the 34 unanswered questions was that the contract had been signed after the successful bidder had been announced in September 2014, part-way through the financial year, so complete information for the financial year was not available.

- The UnitingCare Chief Executive explained that if a question was unanswered at the point of submitting a bid, an assumption had to be made. One of the assumptions had been that the income transferred to UnitingCare would meet costs, but UnitingCare had discovered that the costs were greater than the amount of funding transferred. At the time of signing the contract and entering the implementation phase, it had been clear that there was further work to be done. It was known that this was the first contract of its type, but it had only become clear in late November 2015 when NHSE had been approached that there would not be a solution.

- At no point had the participants felt that they were being treated as guinea pigs for future contracts; they had all been working hard together, and the contract had been set up to focus hearts and minds on integrating services.

- The CCS Chief Executive confirmed that CCS staff had cost more in the previous year than the income received. The CCG had undertaken its own due diligence of CCS's service lines along with other bidders (conducted by one of the big four accountancy firms) and had established that staff cost exceeded income; the reason for the new way of working was that it was not possible to continue to run services in their previous form.

- Asked whether the systems integration had been sufficiently resourced, the CPFT Chief Executive said that nationally this had been one of the first contracts of its type, so it was difficult to find experience of it elsewhere. However, CUHFT and CPFT when putting the bid together had drawn on the Trusts' prior experience – some officers had been involved in the development of community services, but none had developed this sort of bid before. The CUHFT Chief Executive Officer pointed out that one of the strengths of the model had been that the partners had recognised where their areas of expertise were and where they needed bolstering, for example, CPFT had better experience of integrated working than CUHFT.

- UnitingCare as an organisation would cease to exist at the end of January 2016. The CCG had no plans to re-let the contract at present; this was a period of stabilisation during which the CCG would work with its partners, including the County Council. Looking to the future, it was important to continue with outcome-based commissioning, working out which parts of the model had worked well and should be developed, and which parts had been less successful and should be dropped.

- Asked why it had not been possible for all involved to put in extra funding to keep the transformed services going, the Chief Clinical Officer said that all parties had tried to find a solution, but as statutory organisations, they had been unable to support UnitingCare further. The contract value had been the sum of money that the CCG had available to spend on out-of-hospital care. The CCG had gone from a position of predicted financial surplus of £4m to a year-end predicted deficit of £8.4m, but the cost had gone into patient services, not legal fees.

The UnitingCare Chief Executive added that there was a wider issue for the NHS, as the future lay in providers working together in a more joined-up way. For an outlay of £9.3m, the potential return had been £170m. However, the CCG Chief Executive pointed out that the figure would have been considerably higher than £9.3m because it was a matter of recurrent funding to fund staff; the annualised figure was of the order of five to seven times greater. The basis of the model had been fundamentally correct, but because the CCG had a finite amount to spend on care delivery, it was ultimately unable to bridge the gap caused by higher costs. For the future, the intention was to develop services to be as efficient and flexible as possible, making the best use of the additional funding recently announced for the CCG and the award of Vanguard funding. The CUHFT Chief Executive Officer agreed about the importance of investing in new ways of working; the alternative would be to expand hospital services.

The CPFT Chief Executive added that they were still at the start of the journey; there had still been other elements of the model to be put in place, including working with the Council to build social capital in the neighbourhood to support local people, and developing pathways for long-term conditions. He explained that CPFT had tried to supply additional funding, but as its income came entirely from the NHS, the Trust did not have money for this. The CUHFT Chief Executive Officer said that their hands had also been tied. The Chief Clinical Officer said that what had been set up had been a two to three year intense focus on improving older people's care and joining up out-of-hospital services; the contract value had been the amount available for looking after people out of hospital, and it had been hoped that by joining up service delivery this would be sufficient. The CCG as the accountable officers took responsibility for the situation, but their focus was on the future. The Chief Executives of CPFT and CUHFT confirmed that their trusts had also lost money, in the case of CPFT, the loss was understood to be around £4m, but it was a one-off loss, not recurrent. They added that they could have reduced their losses by not looking after the smaller service providers, but both had decided that they should look after them.

- The Chairman said that he accepted that all parties had been placed in an impossible position as a consequence of rising costs and insufficient funding. It appeared that UnitingCare had been given a situation which was impossible to manage given the constraints afforded by its own structure and by the limited ability of its parent organisations and the CCG to provide additional funding.

- Asked who had been the voice of caution saying that the parties were not ready to proceed, the Chief Clinical Officer said that in the case of the CCG it had been their own Governing Body holding them to account. The CCG had set up a joint board with UnitingCare to carry out the mobilisation process; they had believed it was the right thing to do, and it had been important to make sure that there were no gaps in the process for patients in March and April 2015. The CCG would take the lessons learned from their own review and the NHSE review of the termination of the contract, and share them with colleagues.

- It was pointed out that the Monitor risk rating had been published and was accessible to all. The Chairman requested a copy. **Action required**

- Asked why the CCG did not simply tell UnitingCare that they had signed the contract and the financial situation was UnitingCare's problem, the Chief Clinical Officer said that this would not have been the right thing to do. It had been a new contract and a challenge for all involved; fundamentally there had not been enough money to fund

the service. The UnitingCare Chief Executive added that the contract had said it was a shared responsibility to work through problems together; they had resolved a many problems in the course of the contract, and had wanted to get away from a contract that placed blame.

- Asked if the total cost of the procurement exercise had been calculated, officers said that each organisation was accounting for the impact on its own finances, but nobody had worked out the total. The costs including bidding and tender costs, and the costs of paying providers off. Providers would have had to be paid to deliver services anyway. In response to a suggestion from the Chairman that it would be helpful if they could come up with defensible general figures, the Chief Clinical Officer said that they would do so. **Action required**

- Asked whether there was anything that the County Council could do to help, and whether there was any risk of the CCG being put into special measures, the Chief Clinical Officer said that their regulators had been very supportive of the approach, and from a CCG perspective there was no suggestion of special measures. Sensible conversations were being held with the regulators about how to meet the deficit and how to spend their increased funding. It was fundamental to keep hold of this model of care; there was work to be done with input from the Committee on looking at what had gone well and what had not. The CCG and the Council commissioners needed to work together on the use of the Better Care Fund, understanding that this was not new money. He would ask for the Council's leniency and grace to allow the CCG to carry on using the money for care. Nursing homes represented a large area of spend; health and social care needed to work together on improving patient care.

  The CPFT Chief Executive added that it was important that the Committee in its scrutiny role held them all to account in the delivery of the model of care.

The Chairman thanked all the participants for their attendance and participation, and asked them to return for further scrutiny of the OPACS contract in July 2016..

It was resolved unanimously:

a) to accept that the clinical model of integrated care being pursued by the UnitingCare Partnership appeared to be the correct model

b) to welcome the progress that had been made in implementing this model with positive indicators already being evident

c) to note that full and correct financial information did not seem to have been available at the time the contract was being implemented

d) to recognise that commitments have been made to maintain patient care

e) to ask that programmes of improvement continue

f) to encourage all involved to continue to talk to each other and to the Committee with a view to securing sufficient funding

g) to review the termination of the contract again at the Committee's meeting on 14 July 2016.

193. FINANCE AND PERFORMANCE REPORT – November 2015

The Committee received a report setting out financial and performance information for the Public Health Directorate as at the end of November 2015. Members noted that the sum held in Public Health Grant reserves would diminish as the reserve was drawn on to partly offset the reduction in Public Health Grant.

The Chairman welcomed the inclusion of Health Committee priorities in the report, and welcomed the improvement in the Addenbrooke's Hospital delayed transfer of care figures, which were now closer to those of Hinchingbrooke Hospital. He said that it would be necessary to consider whether the indicators for transport and health were being reported in the best way possible.

It was resolved unanimously to note the report.

194. PUBLIC HEALTH RISK REGISTER UPDATE

The Committee received a report setting out details of Public Health Directorate risks. Members noted that the Public Health quality, safety and risk Group was now meeting jointly with Peterborough, in acknowledgement of the increasing amount of joint public health working undertaken by the two authorities. Because the report had been prepared in October, it did not include any of the potential risks arising from the recent cuts to public health funding.

In response to the report, Members

- sought reassurance that the needs of gypsies and travellers were being taken into account; they were a group which experienced racism and discrimination, in particular, those aged 16 – 19, who had often dropped out of secondary education then found themselves unable to get back in to education, with the result that their needs for health education – and indeed for literacy – were often overlooked. The DPH advised Members that the Council had a travellers' health team, but undertook to raise the matter with the public health risk group , and then bring a report back to Committee **Action required**

- noted that screening rates for newborn babies had improved, giving rise to the suggestion that the uptake of screening for breast and cervical cancers should be prioritised on the register instead; NHS England would be attending Committee in March 2016 for an item on this

- commented on the importance of childhood immunisation, noting that this service was commissioned by NHS England; there was a local public health task group examining the take-up of immunisation. The DPH offered to bring this report to Committee on completion. **Action required**

It was resolved unanimously:

(a) to note the position in respect of Public Health Directorate risk

(b) to endorse the amendments to the Public Health Risk Register since the previous update**.**

195. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan, noting that a seminar on the understanding of public health 0-5 services, possibly to be held jointly with members of the Children and Young People Committee, had been added following the last meeting.

It was resolved unanimously to note the training plan.

196. HOSPITAL CAR PARK CHARGES – Briefing Note

The Committee received a report setting out details of the charges for car parking at the four hospitals most commonly used by Cambridgeshire residents. Commenting on the report, Members suggested writing to the hospitals to urge them to ensure that all car park users were aware of the charges made and the concessions available. It was also pointed out that the chart was not entirely clear, giving the impression in some cases that shorter stays were free of charge when they were not; the report author undertook to update the chart. **Action required**

It was resolved unanimously to:

a) note the report and comparative charges

b) note the Healthcare Travel cost scheme (Appendix A of the report before Committee)

c) write to the four hospitals asking them to communicate their parking charges schemes visibly and actively to all users of their car parks.

Action required

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

The Committee considered its agenda plan, making several additions reflecting concerns raised in the course of the meeting.

It was resolved unanimously:

a) to note the agenda plan

b) to cancel the provisional meeting date of 18 February 2016

c) to add an item on the effectiveness of smoking cessation services to the agenda for 12 May 2016

d) to add a scrutiny item on the termination of the UnitingCare contract to the agenda for 14 July 2016

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

Chairman

Agenda Item No: 4

OLDER PEOPLE AND ADULT COMMUNITY SERVICES – TERMINATION OF UNITINGCARE CONTRACT

To:	**HEALTH COMMITTEE**
Meeting Date:	**10 March 2016**
From:	**The Monitoring Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To provide the Committee with background information relating to the termination of the Older People and Adult Community Services contract with the UnitingCare Partnership**
Recommendation:	**That the Committee considers the information provided in advance and at the meeting**

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

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

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

1.3 On 21 January 2016, the Health Committee considered questions around events when the contract was being established and when it was terminated. Representatives of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), Cambridgeshire and Peterborough NHS Foundation Trust (CPFT), Cambridgeshire Community Services NHS Trust (CCS) and Cambridge University Hospitals NHS Foundation Trust (CUHFT) were all questioned about events from their perspective. However, representatives of the regulatory bodies Monitor and NHS England were unable to attend, and sent apologies for the meeting.

1.4 Because they had been unable to attend on 21 January, representatives of NHS England and Monitor have been invited to attend on 10 March, and have accepted the invitation. Representatives of CCG, CPFT and CUHFT are also attending, as they may be able to contribute further background information to points raised in the course of the Committee's scrutiny of the contract.

2. QUESTIONS IDENTIFIED IN ADVANCE

2.1 Members of the Committee have identified the following questions to be addressed at the meeting on 10 March by representatives of NHS England and Monitor:

1. Before the contract was finalised,

    a) why did Monitor and NHS England allow the contract to be signed when there were still 34 questions to be clarified, and

    b) why did they regard a Limited Liability Partnership as an appropriate form of governance for UnitingCare?

2. When they became aware of the financial difficulties surrounding the contract in November 2015, what was the rationale for Monitor and NHS England's decision not to provide financial support?

3. INFORMATION SUPPLIED IN ADVANCE

3.1 David Dean, Senior Transformation and Turnaround Director at Monitor, is attending the meeting on 10 March, but members of the Provider Appraisal team who led the initial transaction review are unable to attend. Monitor has therefore supplied a letter (attached as Appendix A) in response to the questions raised.

3.2 Both the CCG and NHS England have been conducting reviews into the termination of the contract; extracts from the minutes of the Adults, Wellbeing and Health Overview and Scrutiny Committee and the Health Committee for the period July 2013 to January 2016 have been supplied to NHS England in response to the invitation to submit contributions to their review. Both reviews are due to report their findings soon, but had not done so at the time the committee agenda was published.

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

Agenda Item No: 5

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

To:	**HEALTH COMMITTEE**
Meeting Date:	**10 March 2016**
From:	**Dr Liz Robin, Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	***Key decision:*** **No**
Purpose:	**To describe the outcome of work undertaken by a Task & Finish Group set up to address low uptake of breast and cervical screening in Cambridgeshire. The report details the recommendations arising out of the work of the groups and initial actions that have been identified for implementation.**
Recommendation:	**The Committee is asked** **a) to receive this report; and** **b) tocomment on the actions taken to date by NHS England, supported by the County Council Public Health team, through the Task and Finish Group.**

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1. BACKGROUND

1.1 The purpose of this report is to provide an update further to the report in September 2015, on the outcome of work by a Task & Finish group set up by NHS England to identify issues leading to low uptake of screening in Cambridgeshire, to outline the main recommendations of that group and the initial work that is under way to implement action to address the recommendations.

1.2 Breast cancer screening using mammography has had an average uptake nationally of about 75%, and is estimated to have detected 5000 cancers each year nationally. Screening leads to early detection and treatment of cancer and better outcomes for those women. In Cambridgeshire uptake of screening had dropped from approximately 77% in 2011 to 71.7% in 2013/14, but increased to 75.3% in the year to31 March 2015 almost equal to the national average of 75.4%.

1.3 Cervical cancer screening detects pre-cancer changes that with treatment can prevent the development of cancer. Nationally screening rates have been reducing gradually for some years with a much faster decline in Cambridgeshire where uptake rates are below the national average – uptake in Cambridgeshire in 12 months to 31 March 2015, uptake was 72.7% compared to 74.4% nationally. These recent figures show that uptake in Cambridgeshire is static while it has reduced again nationally by 0.3%.

1.4 The section below summarises the recommendations of the group and afull report that has been produced by the Public Health England (PHE) Screening and Immunisation team working within NHS England on this work is available.

1.5 The Task & Finish group was established by the Screening and ImmunisationTeam, based in NHS England and the local authority team. The Health and Social Care Act 2012 gave the local leadership for improving and protecting the public's health to local government, and provided specific roles for NHS England and Public Heath England for the commissioning and system leadership of the national screening and immunisation programmes. NHS England commissions these services. Specialist public health staff employed by PHE are embedded in NHS England to provide accountability and leadership for the commissioning of the programmes and to provide system leadership. It is that specialist team that has led this work in Cambridgeshire.

1.6 The Task & Finish group had membership from NHS England, PHE, Cambridgeshire County Council Public Health team, the Clinical Commissioning Group (CCG) Cancer lead,representatives of Healthwatch, and staff representing the screening service providers. Healthwatch representatives undertook wider public consultation and reported back to the group. The Screening and Immunisation team undertook the GP survey.

2. OUTCOME OF THE WORK OF THE TASK & FINISH GROUP

2.1 Committee members asked for a report on the GP practice survey that was undertaken. Unfortunately the survey had a very poor return rate and the responses did not come up with any issues that had not already been identified - see below:

- 28 practices were targeted
- 9 (31%) responded

<u>General issues identified in GP survey that affects uptake</u>

- Lack of awareness of the importance and benefits of screening
- Culturally influenced health beliefs which results in a lack of cultural acceptance
- Complacency, apathy and indifference
- Busy lifestyles resulting in screening not being considered a priority
- Patients not taking responsibility for their own health and wellbeing.
- The undignified and unpleasant procedure involved with screening
- Transient nature of some migrant communities and the student and academic staff populations means that patient held information is not always up to date.
- Anecdotal evidence suggests some migrant communities returning home to have their screening done on a yearly basis.

Other key findings include:

- Responding practices confirmed good public access links to, and suitable car parking facilities at their premises.
- Inconsistent and non-systematic approach to following up patients once practices have been informed of non-attendance.
- For service users living with a learning disability, practices monitor screening uptake at the time of their yearly annual health check.
- Posters and leaflets are reportedly available on request.
- Proactive promotion of screening is not undertaken systematically, some believe that this should be done by commissioners.
- Due to the transient nature of some communities, it is unclear whether the Prior Notification List is always accurately and thoroughly validated to ensure it is accurate and reflects the true numbers eligible for screening.
- Reminder letters were sent by the practices with higher uptake
- 100% response rate to wanting to be notified in advance of the Breast screening van's scheduled visit to area and to promoting van presence when it arrives.
- Practices report that they update patients' records if they are informed that the patient has been privately screened.

2.2 These findings have informed the recommendations and plans for future actions

2.3 The key recommendations that arose from the work of the Task & Finish group are:

Themes	Recommendations
Community Engagement and screening awareness campaigns	1. Undertake a 1:1 patient engagement or run focus groups targeted at certain communities to better understand levels of engagement with screening programmes and the reasons underpinning this. 2. The outcome of the focus group or 1:1 would inform the programme of work/initiatives and interventions to be adopted to improve participation. 3. Incorporate opportunity to educate and raise awareness about cervical screening into HPV vaccination delivery. For example, leaflets could be handed out along with HPV consent forms for parents and young girls to read. However, due regard will need to be given for the cost benefit implication of this approach and as such, this would be run as a pilot targeted at areas of low uptake in the first instance. 4. Health promotion buses to incorporate cancer screening into their promotional activity. 5. Alignment of local campaigns with national campaigns and cancer awareness week. 6. Community pharmacies to support the delivery of local campaigns for Cervical and breast screening in February 2016. 7. Display of screening posters in public toilets 8. Encouraging and engaging with organisations to promote Health and Wellbeing in the workplace. 9. Screening publicity on council's website to raise awareness. 10. Engagement with colleagues and universities via the student representative groups.
Primary care-focused initiative	11. Breast van schedule to be circulated to practices in advance of the van visit to enable better publicity to patients at practice level and to allow practices to encourage their eligible patients to attend. 12. A cleansing exercise of the practices' clinical systems to be undertaken to ensure that practices hold accurate patient records and that patients who have moved out of area are effectively deducted. To support this, it is recommended that a Did Not Attend (DNA) data analysis exercise to be undertaken for a pilot practice, 1:1 contact made with the patients who have not attended screening to understand why as well as validate their continued residence in the area. The

Themes	Recommendations
	outcome of this exercise will inform plans to roll out to other practices and help understand resource implications - both human and financial - for undertaking a wider roll out. 13. The Group will draw learning from a small pilot in Peterborough which will look at sending letters from practices to patients who have DNA their Bowel screening appointments and see if this would encourage patients to attend. 14. Training and update to be undertaken with practices to ensure the regular and systematic validation and submission of the Prior Notification Lists for cervical screening, which will ensure the invites go out to the eligible women.
Integrated and collaborative initiatives	15. An integrated and opportunistic approach to delivering screening which will see eligible individuals offered screening in any care setting to enable those hard to reach women to be able access cervical screening service. 16. Breast Screening unit to undertake GP engagement through existing training and educational structures designed by CCGs for GPs. It was agreed that the Lab could also tap into these GP educational/training days to update on protocols and changes to pathway for cervical screening.

2.4 On 26 November a first meeting was held to commence planning for implementation of the recommendations.

Recommendation	Planned actions
1. Undertake a 1:1 patient engagement or run focus groups targeted at certain communities to better understand levels of engagement with screening programmes and the reasons underpinning this.	The group will work with GP leads to identify practices to undertake patient surveys. Ideally practices with low uptake now and/ or with high proportion of patients from backgrounds associated with poor access to services
2. The outcome of the focus group or 1:1 would inform the programme of work/initiatives and interventions to be adopted to improve participation.	
3. Incorporate opportunity to educate and raise awareness about cervical screening into HPV vaccination delivery. For example, leaflets	This is still under discussion. Those having HPV vaccine are aged 12 or 13 years and will not become eligible for cervical screening until age 25, so promotion of screening at this age may not be appropriate but information in the pack sent to parents could contain

Recommendation	Planned actions
could be handed out along with HPV consent forms for parents and young girls to read. However, due regard will need to be given for the cost benefit implication of this approach and as such, this would be run as a pilot targeted at areas of low uptake in the first instance.	information aimed at promoting cervical screening uptake by the mothers.
4. Health promotion buses to incorporate cancer screening into their promotional activity.	Initial positive discussion but we need to better understand the use of the bus and how it can help in this work.
5. Alignment of local campaigns with national campaigns and cancer awareness week. 6. Community pharmacies to support the delivery of local campaigns for Cervical and breast screening in February 2016.	This is in hand – we will hold a pharmacy campaign in February 2016 for screening which will commence at the end of Cervical Cancer Prevention Week from 24 – 30 January 2016 and linked to World Cancer Day on 4 February. Appropriate literature being sought to support pharmacy awareness campaign. Support to be sought from District Councils for this campaign.
7. Display of screening posters in public toilets	Advice will be sought from the health improvement team who are engaged in workplace health initiatives as to how we can engage with workplaces to promote cancer screening
8. Encouraging and engaging with organisations to promote Health and Wellbeing in the workplace.	This is agreed, although it is not clear that this is the best website to display this information, Discussions suggest that the best action is to have some information on the Council website with links to other reliable sources of information such as PHE, NHSEngland, NHS Choice and the various cancer charities
9. Screening publicity on council's website to raise awareness.	We are aware that each year information packs are sent out to incoming students at Cambridge University that includes a considerable amount of health information. However, the majority of students will not be eligible for screening as they are too young so we will be discussing how we can get information to mature students.
10. Engagement with colleagues and universities via the student representative groups.	
11. Breast van schedule to be circulated to practices in advance of the van visit to enable better publicity to patients at practice level	This is already in hand. As the route of the breast screening vans is planned, the breast screening service will send advance notice to practices to enable them to discuss with their patient opportunistically and to display

Recommendation	Planned actions
and to allow practices to encourage their eligible patients to attend.	information in their waiting rooms. The service will assist with poster information. This is an ongoing activity, and relevant to public health interventions such as other screening programmes and immunisations.
12. A cleansing exercise of the practices' clinical systems to be undertaken to ensure that practices hold accurate patient records and that patients who have moved out of area are effectively deducted. To support this, it is recommended that a Did Not Attend (DNA) data analysis exercise to be undertaken for a pilot practice, 1:1 contact made with the patients who have not attended screening to understand why aswell as validate their continued residence in the area. The outcome of this exercise will inform plans to roll out to other practices and help understand resource implications - both human and financial - for undertaking a wider roll out.	The more detailed work with individual practices will be planned in as part of action 1 above. With support from Cancer Research UK, and Jo's Trust, training will be delivered to practice champions and appropriate PH Promotion staff within the community so that they are better equipped to promote information and sign post on cancer screening issues.
13. The Group will draw learning from a small pilot in Peterborough which will look at sending letters from practices to patients who have DNA their Bowel screening appointments and see if this would encourage patients to attend.	There has been evidence produced some years ago that letters sent to patients and signed by their own GP are more effective in encouraging patients to take up preventive interventions. This evidence dates form the time when GPs operated personal lists. Now the call recall services do this on behalf of the screening programme, this pilot will help to understand if invitation letters endorsed by their GP will make a difference.
14. Training and update to be undertaken with practices to ensure the regular and systematic validation and submission of the Prior Notification Lists for cervical screening, which will ensure the invites go out to the eligible women.	This is already in hand. Training is delivered by clinical and administrative staff in the screening programme.
15. An integrated and opportunistic approach to delivering screening which will see eligible individuals offered screening in any care	This needs to be explored further by NHS England who commission screening services. At present cervical screening is commissioned ass part of the GP contract and every eligible woman gets invited to

Recommendation	Planned actions
setting to enable those hard to reach women to be able access cervical screening service. 16. Breast Screening unit to undertake GP engagement through existing training and educational structures designed by CCGs for GPs. It was agreed that the Lab could also tap into these GP educational/training days to update on protocols and changes to pathway.	attend cervical screening at her GP surgery. This work is in hand although some more work is needed to ensure coordination between training programmes.

2.5 The work of theimplementation group will continue for at least 6 months and further reports can be provided at that time.

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, being entirely focussed on prevention of ill health. .

3.3 Supporting and protecting vulnerable people

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

- Detailed analysis of the data indicates that some groups in the population have lower uptake rates
- It has been recognised that certain groups such as Travellers may have specific access issues
- Overall access to services, mainly the breast screening service, is an issue in some areas
- However the pattern is not a clear one of poor uptake among more deprived populations as there are also issues in more affluent areas

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no significant implications within this category.

4.2 Statutory, Risk and Legal Implications

Statutory responsibility to address equality. See wording under 3.3 and 4.3.

4.3 Equality and Diversity Implications

The report above sets out details of significant implications. The report and the work of the Task & Finish Group seeks to identify any equality and

diversity issues and address them to ensure good uptake of these preventative services by the whole female population.

4.4 Engagement and Consultation Implications

The report above sets out details of significant implications.

- Healthwatch Cambridgeshire are supporting this work with public surveys
- GPs will be surveyed to help identify issues faced by their patient populations

4.5 Localism and Local Member Involvement

There are no significant implications within this category

4.6 Public Health Implications

See wording under 3.2.

Source Documents	Location
Public Health Outcome Framework reports	http://www.phoutcomes.info/public-health-outcomes-framework

Agenda Item No: 6

NHS QUALITY ACCOUNTS – RESPONDING TO REQUEST TO COMMENT

To:	**HEALTH COMMITTEE**
Meeting Date:	**10 March 2016**
From	**The Monitoring Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To inform the Committee of the requirement, as part of its Health Scrutiny function, to comment on Quality Accounts provided by NHS Provider Trusts.**
Recommendation:	**The Health Committee is asked to note the requirement to comment on Quality Accounts and endorse the proposed process for doing so.**

a) Identify which NHS Provider Trusts Quality Accounts the Health Committee intends to respond to
b) Establish a member led task and finish group (identify which members to participate)
c) Finalise draft statements at 12th May Health Committee Meeting
d) Agree an approach for Quality Accounts received after 12th May 2016.

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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 In 2015 the Health Committee received a number of requests to respond to NHS Providers Quality Accounts but as no process was in place to compose and formally agree a response. Those submitted by the committee did not meet the NHS healthcare providers' deadline.

1.4 This paper outlines an approach to ensure that the Health Committee can respond to the Quality Accounts.

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 & 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 Monitor by 31st MayHowever each provider will have internal deadlines for receipt of any comments from relevant statutory consultees.

2.3 It is expected that the Health Committee will receive a number of requests to respond to their quality accounts from NHS Healthcare providers during the period1st to30th April 2016. However it is worth noting that in 2015 some quality accounts were received after this deadline.

Quality Accounts are expected from:

Cambridgeshire Community Services NHS Trust
Cambridgeshire & Peterborough NHS Foundation Trust
CambridgeUniversity HospitalsNHS Foundation Trust
East of England Ambulance Service NHS Trust
Hinchingbrooke Health Care NHS Trust
Papworth Hospital NHS Foundation Trust
Peterborough & Stamford Hospitals NHS Foundation Trust

3. ESTABLISHING A LOCAL PROCESS

3.1 The following process is suggested to ensure that statements from the Health Committee are included in the published Quality Account.

- The Health Committee should agree in advance which providers they will be prioritising in regards to preparing a response.
- The Health Committee support officer will make contact with identified providers requesting copies of the draft Quality Accounts from Foundation trust to be received by 14th April 2016 and from NHS Trusts no later than 30th April 2016
- Establish a task and finish groupthat can work on producing a draft statement (no more than 500 words in length) on the issues in the quality account that have received consideration by the Health Committee over the last year and if the report is a fair reflection of the full range of quality issues for that trust.
- Task & Finish Group to meet on 14thApril 2016 and 5th May 2016
- Agree draft statements for submission at the Health Committee meeting scheduled for the 12th May 2016

3.2 The Health committee needs to determine an approach for Quality Accounts that are submitted post 12th May 2016. This could include providing delegated authority to an officer, in consultation with the task and finish group, to respond to Quality Accounts on the Committee's behalf.

4. SIGNIFICANT IMPLICATIONS

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

4.2 Statutory, Risk and Legal Implications
These are outlined in a paper on the Health Committee powers and duties, which was considered by the Committee on 29th May 2014.

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

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

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

4.6 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

Agenda Item No: 7

EMERGING ISSUES IN THE NHS –
Update on self care and proposed pharmacy consultation

To:	**HEALTH COMMITTEE**
Meeting Date:	**10 March 2016**
From:	**Sati Ubhi, Chief Pharmacist, Cambridgeshire and Peterborough Clinical Commissioning Group.**
Electoral division(s):	**ALL**
Purpose:	**To update the committee of proposals for raising awareness of self care with the public and to consider the proposed consultation on changes to pharmacy services.**
Recommendation:	**1. Raising awareness of self-care amongst patients and professionals.** Out-of-hours, urgent care centres and A&E play an important role. Encouraging self care is not just exclusive to traditional primary care and all are vital in promotion and tackling doctor dependency. Examples of ways in which practices can support self-care are by giving information in consultations, surgery displays, leaflets and practice websites**.** **2. To consider the future of the current minor ailment schemes, gluten prescribing and the prescribing of infant formals through a period of managed engagement/ consultation with key stakeholder groups and the public.**

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1. BACKGROUND

1.1 Cambridgeshire and Peterborough health economy has been identified as one of England's 11 most challenged health economies. Our spend is currently above budget and if we do not change our health system substantially, then we face a funding shortfall of at least £250 million by 2019, making it harder to deliver good quality care for everyone who needs it.

The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is currently in deficit and is undertaking the turnaround process to achieve both a financially and deliverable sustainable position. To ensure we are making best use of the money available one of the areas we are looking at is which services from pharmacies or via a prescription are not considered essential to be paid for by the NHS.
This includes exploring the recommendation to prescribers to not prescribe if the medicine and treatment is freely available for patients to buy for themselves without a prescription e.g. linctus or paracetamol or Ibuprofen for coughs and colds.
Also to stop prescribing gluten-free foods and infant formula milks as discussed below.

2. MAIN ISSUES

2.1 Empowering people with the confidence and information to look after themselves when they can, and visit the GP when they need to, gives people greater control of their own health and encourages healthy behaviors that help prevent ill health in the long-term.

In many cases people can take care of their minor ailments, reducing the number of GP consultations and enabling GPs to focus on caring for higher risk patients, such as those with comorbidities, the very young and elderly, managing long-term conditions and providing new services.

The medicines used for self-care of self-limiting minor ailments can be purchased either through community pharmacies or where appropriate non-pharmacy outlets.

Many CCGs encourage patients to self-fund for these self-limiting ailments by encouraging them to keep a stock of certain drugs at home as well as advising GPs on when not to prescribe for minor ailments.

Whist Cambridgeshire & Peterborough CCG does promote self-care; it has also historically provided funding (£230k) for free medicines through community pharmacy minor ailment schemes for patients exempt from prescription charges. In addition, it is estimated that the CCG may spend up to £4 million each year on medicines for self care of minor ailments on prescription.

Whilst difficult funding and prioritisation issues are being considered in the CCG (Exceptional cases, Joint Prescribing Group and the Clinical Policies Forum) for more serious conditions, this paper asks the committee to consider how the CCG can best support our population to self care for minor ailments, whilst ensuring the adequate use of resources.

2.2 As part of the first round of reviews of service provision, the CCG is focussing on new ways to increase efficient and cost effective use of the finances allocated to the prescribing and delivery of medicines before having to potentially look at larger service de-commissioning.

After reviewing multiple initiatives across the country the CCG currently have 14 workstreams that range from medication waste to re-procurement exercises but some

of these workstreams involve changes in policies to what was previously allowed on a prescription or to services pathways previously agreed. These are the ones we want to get your agreement on today for consulting the public.

2.3 The areas we want to explain and discuss changes with the public are:
1) Community Pharmacy Minor Ailment Scheme
2) Gluten Free Products
3) Prescribed Baby Milks
4) Promotion of self care

The proposed consultation document is attached in appendix 1 The CCG is proposing a nine-week consultation running from 22 March 2016 to 24 May 2016.

2.4 **Self-care update**

The CGG has so far taken the following actions to promote self-care across the region:

- A CCG-wide policy was launched in November 2015 advising GPs on which medicines should not be prescribed routinely for self-limiting illnesses.
- Work is underway with the acute trusts, Out of Hours providers etc. to use this policy across the whole health system
- A series of condition-specific leaflets for patients are available to download from the CCG website for clinicians to use within their consultations.
- Hard copy leaflets have been provided to GP practices to display in their waiting areas
- A 'No Prescription Required' pad developed by PrescQipp has been circulated to all practices within the CCG so that these can be issued in place of FP10 prescriptions
- NHS England "Stay well this winter" and "A guide to childhood illnesses" – supporting self care, has been sent to GP's and Community pharmacies as well as other targeted locations such as nurseries and playgroups.
- Promotion of the self-care agenda has been supported by a radio broadcast by Dr Emma Tiffin
- Dr Cathy Bennett also re-enforced this within a TV Broadcast on 'Inside Out'.
- Clinicians have been encouraged to undertake the Royal College General Practice online course in 'How to undertake self-care aware consultations'.
- Each LCG now has a self-care implementation plan
- The CCG has developed data sets and graphs to map the uptake of the policy and track changes in prescribing. Epact data has a six week delay, so we only have December data currently which is still early.
- An additional patient leaflet and poster was sent to all practices to help promote the local CCG strategy on self-care.

2.5 Pharmacy consultation
The CCG proposes to stop the following areas of prescribing

Minor Ailments schemes

- ,'Pharmacy First for Children' in Peterborough
- Cambridgeshire 'Minor Ailment Scheme' in Cambridgeshire

The range of medicines that the Minor Ailment Scheme currently provides is commonly found in home medicine cabinets (paracetamol, anti-histamines etc.) or are easily available to buy at a low cost in pharmacies or where appropriate non-pharmacy outlets such as supermarkets. The Minor Ailments Schemes can be accessed irrespective of financial circumstances. A GP can still prescribe these medicines to people who need them for specific long term and significant illnesses. Currently the CCG spends £230,000 a year on the two Minor Ailment

Schemes. . Due to the serious financial problems, the CCG wishes to use this money to support front line services such as A&E departments, ambulances and operations.

Prescribing of gluten-free foods.

Currently it is possible for a GP to prescribe **gluten-free food** products on a prescription to patients diagnosed with gluten sensitivity. The prescriptions are for products such as gluten-free staples e.g. bread, flour or bread mix. Although this has historically been prescribed, this is not a medicine and gluten free food can easily be purchased from many supermarkets. Currently the CCG provides £370,000 worth of gluten free food prescriptions a year. It is felt that this disease can be managed directly by the patient through their food buying choices without the need for gluten-free substitute foods on prescriptions. The proposal is to stop prescribing gluten-free food to patients. Patients will be asked not to request gluten-free substitute foods on prescriptions and GPs will be asked not to provide gluten-free foods on prescription.

Advice and support from healthcare professionals will be made available throughout the consultation period as well as during and after the implementation of this proposal to support affected patients.

Prescribing of infant formula.

Infant formulas, commonly called Baby Milks, are manufactured food designed and marketed for feeding to babies and infants usually less than 12 months of age, prepared for bottle-feeding or cup-feeding from powder or liquid.

Whilst it can legitimately be provided on prescription for particular medical conditions, many formulas can actually be purchased without a prescription and most are available in supermarkets. For the treatment of chronic long term conditions such as renal or liver disease or receiving treatment for cancer, such supplements would be prescribed on the advice of a specialist clinician.

Historically, it was difficult for patient's parents to get hold of infant formula used for cow's milk protein allergy or lactose intolerance as there was a limited range available on the high street. Today, society and manufacturers are much more aware of cow's milk protein allergy and lactose intolerance in infants. So much so, every major supermarket has infant formulas on their shelves as standard, with even more options available on the internet. This means there is an ever growing, wide range of infant formulas available without the need of a prescription. Additionally alternatives to cow's milk such as soya, almond and goat milks are widely available as society seeks alternatives to traditional dairy production as well as lactose-free cow's milk also being freely available; all without a prescription.

The CCG is proposing to stop prescribing thickening formula, soya and stay down milks as these are also widely available to buy. The CCG spends £1million annually on prescribing baby milks. With the exception of specialised formula for particular medical conditions, it is felt that this should be managed directly by the patient's parents through their choices without the need for baby milks on prescriptions

3. SIGNIFICANT IMPLICATIONS

Cambridgeshire and Peterborough CCG do not believe there are any significant implications from this proposal and that the need for a consultation is for transparency as these are proposed changes to the CCG's existing policies.

4 FINANCIAL IMPACT

Supporting our patients to manage and fund their minor ailment treatments could help to ease the burden on the CCG budgets. Currently up to £4 million may be spent on medicines likely to

be used for minor ailments that could be purchased from pharmacies and much more in terms of GP consultation time. In addition at least £230k is paid to pharmacies through minor ailment schemes.

5 CONSULTATION AND ENGAGEMENT

Any changes to the current pharmacy services requires careful management and engagement/consultation with key stakeholder groups and the public. A consultation process plan is attached as appendix 2.

.

There would also need to be good engagement with the Patient Experience Team to ensure that any patient concerns or complaints are promptly handled.

Source Documents	Location
Cabinet Office Consultation Principles July 2012	www.gov.uk/government/publications/consultation-principles-guidance
Section 14Z2 Health and Social Care Act 2012	www.legislation.gov.uk/ukpga/2012/7/section/26/enacted
Lansley Criteria for Significant Service Change	www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CPCT/Corporate%20documents/CCG%20Constitution.pdf

Appendix 1 draft pharmacy consultation document
Appendix 2 draft consultation process plan

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Consultation on a future model for Pharmacy Services in Cambridgeshire & Peterborough

22 March 2016 – 24 May 2016

This 9 week consultation is to gather feedback on Community Pharmacy Minor Ailment Schemes, Prescribing of Gluten-free Foods, and Prescribing Baby Milk

V 10

This consultation is aimed at patients living in Cambridgeshire and Peterborough Clinical Commissioning Group's area.

This document is available in other languages and formats on request.

To request alternative formats, or if you require the services of an interpreter, please contact us on:

- 01223 725304 or
- capccg.engagement@nhs.net

Pokud byste požadovali informace v jiném jazyce nebo formátu, kontaktujte nás

જો તમને માહિતી બીજી ભાષા અથવા રચનામાં જોઈતી હોય તો, કૃપા કરી અમને વિનંતી કરો.

Se desiderate ricevere informazioni in un'altra lingua o in un altro formato, siete pregati di chiedere.

Jei norėtumėte gauti informaciją kita kalba ar formatu, kreipkitės į mus.

Jeżeli chcieliby Państwo uzyskać informacje w innym języku lub w innym formacie, prosimy dać nam znać.

Se deseja obter informação noutro idioma ou formato, diga-nos.

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔

Contents

This section will be completed last when the document is finalised and designed for print as the page numbers may vary along the way.

The consultation document and process

You can give your views in a number of ways:

• Fill in the questionnaire found online on the CCG's website www.cambridgeshireandpeterboroughccg.nhs.uk

• Fill in the paper copy of the questionnaire found on page XX of this consultation document and send it FREEPOST to Freepost Plus RSCR-GSGK-XSHK, Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge CB2 8FH. (You do not need a stamp).

• Phone the Engagement Team on 01223 725304.

• If you belong to a group or organisation, you can invite us along to one of your meetings by contacting our Engagement Team on 01223 725304 or by email to capccg.engagement@nhs.net, putting Pharmacy Consultation in the subject field.

Come along to one of the public meetings listed in Appendix 1.

Who we are and what we do

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is the organisation responsible for planning, organising and buying-in NHS-funded healthcare for people living in the Cambridgeshire and Peterborough area. It replaced NHS Cambridgeshire and NHS Peterborough (the Primary Care Trusts, or 'PCTs') on 1 April 2013.

We are one of the largest CCGs in England, by patient population, with 105 GP practices as members. We are organised into eight local groups, known as Local Commissioning Groups or LCGs, covering all GP practices in Cambridgeshire and Peterborough, as well as three practices in North Hertfordshire (Royston) and two in Northamptonshire (Oundle and Wansford).

We have a patient population of approximately 913,000 which is diverse, ageing and has significant inequalities. We manage a budget of around £940 million to spend on healthcare for the whole population of this area, which is just under £1,000 per person.

(Always check highlighted details as these do change regularly.)

We are responsible for commissioning GP prescribing and have continued to fund community pharmacy minor ailments schemes started by the 2 Primary Care Trusts

Introduction

Cambridgeshire and Peterborough health economy has been identified as one of England's 11 most financially challenged health economies.

If we do not change our health system substantially, then we face a funding shortfall of at least £250 million by 2019.

This will make it harder to deliver good quality care for everyone who needs it

To ensure we are making best use of the money available we are looking at which medicines and services from pharmacies and via prescriptions, are considered essential to be paid for by the NHS. Also whether or not it is appropriate for medicines and treatments which patients can buy themselves for minor illnesses should be routinely provided on prescription

What is the 'Community Pharmacy Minor Ailment Scheme'?

The CCG currently supports two minor ailment schemes

- ,'Pharmacy First for Children' in Peterborough
- Cambridgeshire 'Minor Ailment Scheme' in Cambridgeshire

The Pharmacy First for Children scheme in Peterborough provides free medicines for common childhood ailments without the need to see the GP. These can be infant paracetamol for colds, anti-histamines for mild hay fever etc. People currently need to be registered with the scheme and bring the child with them to the pharmacy in order to be given these medicines. If the pharmacist is in any doubt they will advise further medical help, this could be a visit to the GP.
The Minor Ailments scheme in Cambridgeshire is the same but for adults and children.
Both of these schemes will only provide approved, best value for money medicines, not branded varieties. These are available widely over the counter in all pharmacies and often in supermarkets at very low cost.

What are the issues that need to be addressed?
The local NHS wants to help patients to look after themselves when they can, and only visit the GP when they need to. This gives people control of their own health that help prevent ill health in the long-term.

The range of medicines that the Minor Ailment Scheme currently provides is commonly found in home medicine cabinets (paracetamol, anti-histamines etc). or are easily available to buy at a low cost in pharmacies or where appropriate non-pharmacy outlets such as supermarkets.

The Minor Ailments Schemes can be accessed irrespective of financial circumstances. A GP can still prescribe these medicines to people who need them for specific long term and significant illnesses.

Why are we consulting with you now?

Currently the CCG spends £230,000 a year on the two Minor Ailment Schemes. . Due to the serious financial problems, the CCG wishes to use this money to support front line services such as A&E departments, ambulances and operations.

Your feedback will be used to inform the decisions and recommendations of the CCG's Governing Body

What needs to change?

Our proposal is to stop the Minor Aliments Scheme for Cambridgeshire and the Pharmacy First for Children scheme in Peterborough. Patients will no longer be able to access free medications through the minor ailment schemes but will be able to continue to use their local pharmacy for confidential, expert advice but will be asked to purchase treatments for a range of common illnesses and complaints.

Patients can also get advice on a selection of essential medicines to purchase to keep at home. This can result in swift relief of symptoms and can avoid unnecessary trips to see the GP or even visits to A&E.

Patients will be asked to buy these medicines themselves. They will still be able to visit their GP if the patient feels unable to manage the condition themselves and the GP may decide to prescribe or recommend self purchase of the medicines.

What we are asking you.

The proposal for consultation is to stop the supply of free medications for minor and self limiting illnesses through the minor ailment schemes.

Patients and carers will in future use their local pharmacy to purchase medications.

We are asking for your thoughts on whether you think this is the right choice. Your feedback will be used to inform the decisions of the CCG's Governing Body.

What is 'prescribing Gluten-free food'?

Currently it is possible for a GP to prescribe **gluten-free food** products on a prescription to patients diagnosed with gluten sensitivity. Gluten is a mixture of proteins found in wheat and related grains, including barley and rye. Gluten gives elasticity to dough, helping it rise and to keep its shape and often gives the final product a chewy texture. If it is consumed by someone with Coeliac Disease, gluten can cause an adverse reaction in the gut such as diarrhoea, flatulence, bloating or abdominal pain.

The prescriptions are for products such as gluten-free staples e.g. bread, flour or bread mix. Although this has historically been prescribed, this is not a medicine and gluten free food can easily be purchased from many supermarkets.

What are the issues that need to be addressed?

Having to be gluten-free does not stop you being able to have a healthy, nutritious and balanced diet with all the necessary vitamins and minerals. You can still eat all naturally gluten-free foods such as meat, fish, fruit, vegetables, rice and potatoes.

Why are we consulting with you now?

Currently the CCG provides £370,000 worth of gluten free food prescriptions a year. It is felt that this disease can be managed directly by the patient through their food buying choices without the need for gluten-free substitute foods on prescriptions. The CCG wants to use this money to support front line services such as A&E departments, ambulances and operations.

What needs to change?

The proposal is to stop prescribing gluten-free food to patients. Patients will be asked not to request gluten-free substitute foods on prescriptions and GPs will be asked not to provide gluten-free foods on prescription.

Advice and support from healthcare professionals will be made available throughout the consultation period as well as during and after the implementation of this proposal.

What we are asking you.

This proposal is a change to what a specific group of patients have been able to access historically by recommending that gluten-free substitute foods are no longer prescribed by GPs and the CCG wants to hear your views on whether you think this is the right choice.

Your feedback will be used to inform the decisions and recommendations of the CCG's Governing Body.

What is 'Prescribed Baby Milks'?

Infant formulas, commonly called **Baby Milks**, are manufactured food designed and marketed for feeding to babies and infants usually less than 12 months of age, prepared for bottle-feeding or cup-feeding from powder or liquid.

Whilst it can legitimately be provided on prescription for particular medical conditions, (see list below) many formulas can actually be purchased without a prescription and most are available in supermarkets. For the treatment of chronic long term conditions such as renal or liver disease or receiving treatment for cancer, such supplements would be prescribed on the advice of a specialist clinician.

What are the issues that need to be addressed?

Historically, it was difficult for patient's parents to get hold of infant formula used for cow's milk protein allergy or lactose intolerance as there was a limited range available on the high street. Today, society and manufacturers are much more aware of cow's milk protein allergy and lactose intolerance in infants. So much so, every major supermarket has infant formulas on their shelves as standard, with even more options available on the internet. This means there is an ever growing, wide range of infant formulas available without the need of a prescription.

Additionally alternatives to cow's milk such as soya, almond and goat milks are widely available as society seeks alternatives to traditional dairy production as well as lactose-free cow's milk also being freely available; all without a prescription.

The CCG is proposing to stop prescribing thickening formula, soya and stay down milks as these are also widely available to buy.

Why are we consulting with you now?

The CCG spends £1million annually on prescribing baby milks. With the exception of specialised formula for particular medical conditions, it is felt that this should be managed directly by the patient's parents through their choices without the need for baby milks on prescriptions and that the CCG can use this saving to support front line services such as A&E departments, ambulances and operations.

What needs to change?.

This proposal is a change to what a specific group of patients have been able to access historically by recommending that infant formulas are no longer prescribed by GPs (unless it is a specialised formula for particular medical conditions unavailable on the high street.)

What we are asking you?

The CCG wants to hear your views on whether you think this is the right choice.

Your feedback will be used to inform the decisions and recommendations of the CCG's Governing Body.

Appendix 1 – Public Meetings

The number and location of public meetings will change for each consultation.

Huntingdon		
Peterborough		
Cambridge		
Isle of Ely		
Wisbech		
Whittlesey		
St Neots		
Royston		

We will also attend other meetings organised by groups who are interested in these proposed changes. If you would like us to attend your meeting please contact us on the number below.

Meetings may be subject to change, so please do check our website www.cambridgeshireandpeterboroughccg.nhs.uk or contact the Engagement Team:

- Phone: 01223 725304
- Email: capccg.engagement@nhs.net

Appendix 2 – Glossary of terms

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Cambridgeshire and Peterborough CCG is the organisation responsible for planning, organising and purchasing NHS-funded healthcare for residents. A CCG is clinically-led, meaning that decisions about local health services are made by local doctors and health professionals, alongside patients. Cambridgeshire and Peterborough CCG has a patient population of approximately 913,000. It is a diverse, ageing population with significant health inequalities. We manage a budget of around £940 million to spend on healthcare for the whole population of this area.

Commissioning
Identifying health needs of local people, planning and purchasing health services which respond to their needs. CCGs are responsible for deciding what services their local residents need from the NHS and buy these services with public money from the most appropriate providers.

Pharmacy – A shop or part of a shop in which medicines are prepared and sold

Minor Ailments Scheme - The Minor Ailment Service (MAS) allows eligible individuals to register with and use a community pharmacy as the first port of call for the treatment of common illnesses on the NHS

Coeliac Disease - A medical condition in which the intestine reacts badly to a type of protein contained in some grains.

Non-coeliac gluten sensitivity - a syndrome in which patients develop a variety of intestinal and/or extra-intestinal symptoms that improve when gluten is removed from the diet

Prescriptions - A piece of paper on which a doctor writes the details of the medicine or drugs that someone needs

Repeat prescriptions - a prescription for a medicine that is needed regularly that can be reissued without the patient having to see the doctor

Appendix 4 - Legal requirements

This consultation document has been drawn up in accordance with the following legal requirements and guidance:

Cabinet Office Consultation Principles July 2012
This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.

Policy makers should bear in mind the Civil Service Reform principles of open policy making throughout the process and not just at set points of consultation, and should use real discussion with affected parties and experts as well as the expertise of civil service learning to make well informed decisions. Modern communications technologies enable policy

makers to engage in such discussions more quickly and in a more targeted way than before, and mean that the traditional written consultation is not always the best way of getting those who know most and care most about a particular issue to engage in fruitful dialogue.

The full consultation principles document can be accessed via the Cabinet Office website at: https://www.gov.uk/government/publications/consultation-principles-guidance

Section 14Z2 Health and Social Care Act 2012

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2) (b) to the delivery of services is a reference to their delivery at the point when they are received by users.

For more on the Section 14Z2 Health and Social Care Act 2012 seehttp://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

Lansley Criteria for Significant Service Change
In May 2010, the Secretary of State for Health, Andrew Lansley, set four new tests that must be met before there can be any major changes to NHS Services:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice

You can read more about the CCG's duties to engage and consult in section 5.2 of the CCG's Constitution
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CPCT/Corporate%20documents/CCG%20Constitution.pdf

The questionnaire (to be formatted properly once the document if finalised. Also to be made available as an online survey.)

1. Do you understand why the CCG needs to make changes to the Pharmacy service?
   Yes ☐ No ☐ Not really ☐

   Comment

2. Do you think the changes outlined in this document will save money for the CCG?
   Yes No Not sure

   Comment

3. Do you agree with the proposal to stop the two minor ailments schemes?
   Pharmacy First for children in Peterborough. Yes No Undecided

   Minor Ailments scheme in Cambridgeshire. Yes No Undecided

   Comment

4. Do you understand that gluten-free food is not a medication that keeps you well?
   Yes No Not sure

   Comment

5. Do you agree with the proposal to stop prescribing gluten-free foods?
   Yes No Not sure

   Comment

6. Do you agree with the proposal to no longer prescribe infant formula, or baby milks, unless it is for a particular medical condition?
   Yes No Not sure

   Comment

Your feedback

You can send your feedback to us in many different ways:

- By filling in the online survey
  http://www.cambridgeshireandpeterboroughccg.nhs.uk/have-your-say/

- By filling in the survey attached to this document and returning it to:
  Freepost Plus RSCR-GSGK-XSHK
  Engagement Team
  Cambridgeshire and Peterborough Clinical Commissioning Group
  Lockton House
  Clarendon Road
  Cambridge
  CB2 8FH
- or email your completed survey to: capccg.engagement@nhs.net

You can also:

- write to us with your views (at the address above)
- phone us on 01223 725304
- email us your views to capccg.engagement@nhs.net
- attend one of the planned meetings to tell us what you think.

Through this public consultation your views will be fed into the development of the final proposal. All of the feedback received from all of the responses to this consultation will be collated into a report for the CCG's Governing Body to consider before it makes any decisions on the future of these services.

The closing date for receipt of responses to this consultation is 5pm on (insert date here)

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Consultation Process Plan
March 2016

Have your say on
A future model for Pharmacy
across Cambridgeshire and Peterborough

22 March 2016 – 24 May 2016

This 9 week consultation is to gather feedback on Community Pharmacy Minor Ailment Schemes, Prescribing of Gluten-free Foods, and Prescribing Baby Milk

Engagement Team, Cambridgeshire and Peterborough Clinical Commissioning Group
Lockton House, Cambridge, CB2 8FH. 01223 725304.
Engagement@cambridgeshireandpeterboroughccg.nhs.uk

Background

Cambridgeshire and Peterborough health economy has been identified as one of England's 11 most financially challenged health economies.

If we do not change our health system substantially, then we face a funding shortfall of at least £250 million by 2019.

This will make it harder to deliver good quality care for everyone who needs it

To ensure we are making best use of the money available we are looking at which medicines and services from pharmacies and via prescriptions, are considered essential to be paid for by the NHS. Also whether or not it is appropriate for medicines and treatments which patients can buy themselves for minor illnesses should be routinely provided on prescription

Process

Pre-consultation

Cambridgeshire and Peterborough CCG will:

- Prepare a full and comprehensive consultation document that explains the programme and the options for consultation in clear plain English.
- Ensure that drafts of the full consultation documents and questions for consultation are shared with the following groups:
    - Projects Team
    - CCG Governing Body
    - Health Scrutiny Committees from Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire.
    - The CCG Patient Reference Group (PRG)
    - Healthwatch organisations from Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire.
    - Local Pharmaceutical Committee (LPC)
    - Local Medical Committee (LMC)
- Ensure that the final consultation document reflects feedback from these groups.
- Plan a series of public meetings in accessible venues across the CCG area, as well as targeted meetings for specifically affected groups.
- Publicise these meetings within the consultation documents and on our website
- Share publicity materials with our partners and stakeholders.
- The CCG's meeting requirements form will detail for each meeting who is attending, roles, equipment and any risk assessments.

Consultation

Cambridgeshire and Peterborough CCG will:

- Have copies of the consultation documentation available on the website from the first day of the consultation and throughout the consultation.
- Have translations and rich text versions of the summary document available when requested.
- Have photocopies of the documentation prepared for distribution on the first day of the consultation.
- Have printed copies of the full document, as possible after the start of the consultation.
- Distribute hard copies of the documents to:
    - GP practices
    - Pharmacies
    - Local Pharmaceutical Committee (LPC)
    - Local Medical Committee (LMC)
    - Stakeholder database
    - Councils for Voluntary Services (Peterborough and Cambridgeshire).
    - Libraries
    - Cambridgeshire Community Services NHS Trust – particularly community nursing staff and other staff likely to be involved in providing care.
    - City and County Council staff involved in providing care – particularly Health Visitors.
    - Cambridge University Hospitals NHS Foundation Trust
    - Cambridgeshire and Peterborough NHS Foundation Trust
    - Hinchingbrooke Health Care NHS Trust
    - Peterborough and Stamford Hospitals NHS Foundations Trust (Edith Cavell site)
    - Queen Elizabeth Hospital NHS Trust
    - Unions
    - NHS England Area Team
    - Urgent Care Cambridgeshire
    - Herts Urgent Care (providers of C&P CCG NHS 111 service)
    - Lincolnshire Community Health Services NHS Trust / Peterborough Minor Illness and Injury Unit
    - North Cambridgeshire Hospital, Wisbech
    - Princess of Wales Hospital, Ely
    - Doddington Community Hospital
    - St. Neots Walk-in Centre
    - Brookfields
    - Other NHS organisations (on request)
    - Local Authorities
    - District Councils
    - Parish Councils

    - Health Scrutiny Commissions
    - Health and Wellbeing Boards
    - Local Health Partnerships
    - Local Voluntary Sector Organisations
    - Charities
    - CCG Patient Reference Group
    - Practice Patient Groups
    - Healthwatch organisations

- Ensure that further copies are distributed throughout the consultation.
- Ensure that translations are made available on request.
- Ensure that all translations are available on the CCG website when requested.
- Ensure that all responses received in other languages are translated into English and included in the response reports.
- Log all calls received with regard to the consultation.
- Collate all letters and emails received as part of the consultation and include in the response reports.
- Receive and report on all petitions received during the consultation.
- Ensure that all public meetings held have full meeting notes, recording comments and questions.
- Ensure that when we attend meetings we record a briefing note of the meeting and request full minutes when available.
- Collate all meeting notes, briefing notes and minutes and include in the response reports.
- Respond to requests for attendance at meetings to discuss the consultation.
- Attend meetings with the following key stakeholder groups during consultation:
    - Health Scrutiny Committees in Cambridgeshire, Peterborough and Huntingdon.
    - Health Scrutiny Committees in Northamptonshire and Hertfordshire on request.
    - Healthwatch organisations in Cambridgeshire and Peterborough. Attend in Northamptonshire and Hertfordshire on request.
    - Local Pharmaceutical Committee (LPC)
    - Local Medical Committee (LMC)
    - CCG Patient Reference Group
    - Targeted stakeholder groups, to include:
        - Baby clinics across the area
        - Coeliac Society local branch
        - Other key targeted groups
- Hold public meetings in venues across the region.
- Have interpreters at each community meeting where necessary or requested as well as sign language interpreters on request.
- Attend groups or events on request, if possible.

- Ask to attend events and groups in locations where we haven't been able to hold a public meeting.
- Advertise all public meetings via the website, local papers, and on social media, at least two weeks before the meetings.
- List all public meetings on our website, as well as in the consultation document.

Email/letter with link to/copy of consultation and list of public consultation meetings

- Stakeholder database
- CCG staff
- CCG Patient Reference Group
- Local Pharmaceutical Committee (LPC)
- Local Medical Committee (LMC)
- PPGs (where possible)
- GP Practices
- GP Members
- Healthwatch(s)
- Local Voluntary sector
- Parish Councils
- County and City Councils
- District Councils
- NHS organisations as listed
- Unions
- Groups and individuals that we have already engaged with throughout the process

Media

Media briefing pack for journalists – copies to be sent via email at launch or earlier if embargo agreed. To include:

- Copies of the consultation document
- About the CCG leaflet
- Link to consultation page on website
- Web address for consultation documents
- Public meeting dates

Limited number of hard copies to be available at Public Meetings for attending media.

Media release for distribution

Social Media

Facebook

- Media releases flow through automatically
- Post link to consultation on page with details of what it is about and an invitation to share the link to increase audience.
- Post details of each public meeting a week before, the day before, on the day

Twitter

- Tweet press releases
- Tweet link to consultation on page with details of what it is about and an invitation to re-tweet the link to increase audience. Repeat monthly throughout consultation
- Tweet details of each Public Meeting a week before, the day before, on the day.
- Tweet after each meeting thanking those who attended.

Updates

Staff

- Email to staff from prior to launch
- Email to staff launching consultation with link to consultation documents.
- Staff updates via Connect, staff briefings
- Staff can direct any questions that they may have to the Consultation/ Engagement mailbox?

GPs/practice staff

Email from Clinical Lead via the Membership mailbox prior to launch

- Email launching consultation with link to consultation documents.
- Updates via Members News
- Q&A session at Members' Meeting?
- Members' mailbox for questions

Stakeholder database

- Update taken from media release following Governing Body meeting
- Link to consultation on launch day
- Reminders for public meetings a week before
- stakeholder update via stakeholder news

Post Consultation

A report to be produced on the consultation responses

Cambridgeshire and Peterborough CCG Governing Body will review report and findings before making its decision on future of Minor Ailments schemes, prescribing of gluten-free foods and the prescribing of formula baby milks.

Communications to be sent via email/letter to stakeholders/and consultation respondents with link to consultation report and outcomes.

Feedback to staff via email, staff briefings and Connect

Feedback to members via, Members news and Members email

Legal requirements

This consultation document has been drawn up in accordance with the key consultation criteria as set out in the Cabinet Office Code of Practice on Consultation 2008.

1. When to consult
Formal consultation should take place at a stage when there is scope to influence the policy outcome.

2. Duration of consultation exercises
Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible.

3. Clarity of scope and impact
Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

4. Accessibility of consultation exercises
Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

5. The burden of consultation
Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees buy-in to the process is to be obtained.

6. Responsiveness of consultation exercises
Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

7. Capacity to consult
Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

The Code of Practice states that these criteria should be reproduced in all consultation documents.

Find out more about Cabinet Office Code of Practice on consultations: www.bis.gov.uk/policies/better-regulation/consultation-guidance/code-of-practice

Section 14Z2 Health and Social Care Act 2012

14Z2 Public involvement and consultation by clinical commissioning groups
(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").
(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
(a)in the planning of the commissioning arrangements by the group,
(b)in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
(c)in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
(3) The clinical commissioning group must include in its constitution—
(a)a description of the arrangements made by it under subsection (2), and
(b)a statement of the principles which it will follow in implementing those arrangements.
(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.
(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).
(6) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users.
For more on the Section 14Z2 Health and Social Care Act 2012 see http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

Criteria for Significant Service Change
In May 2010, the Secretary of State for Health, Andrew Lansley, set four new tests that must be met before there can be any major changes to NHS Services:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice

Agenda Item No: 8

HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

To:	**HEALTH COMMITTEE**
Meeting Date:	**10th March 2016**
From	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To inform the Committee of the activities and progress of the Committee's working groups since the last Committee meeting.**
Recommendation:	**The Health Committee is asked to:**

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

2) **Appoint core members to the Hinchingbrooke Liaison meetings.**

	Officer contact:
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1. BACKGROUND

1.1 The purpose of this report is to inform the Committee of the health scrutiny activities that have been undertaken or planned since the committee last discussed this at the meeting held on 5th November 2015.

1. 2 This report updates the committee on the joint liaison meetingwith Cambridgeshireand Peterborough Clinical Commissioning Group (CCG) and Cambridgeshire Healthwatch. Further liaison meetings and working groups scheduled are detailed in Appendix A.

2. MAIN ISSUES

Liaison Meeting with Cambridgeshire & Peterborough Clinical Commissioning Group & Healthwatch

2.1 The liaison group members in attendance were County Councillors Ashcroft, Clapp, Jenkins and Sales,and District Councillor Ellington. Apologies were received from Councillor Orgee. A meeting was held on 8th November 2016 with representatives from the CCG and Healthwatch.

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

2.3 The Health Committee members raised the following areas for discussion with representatives from CCG andHealthwatch:

- Older People and Adult Community Services contract (OPACS)
- Sustainability & Transformation Plan (previously known as System Transformation Programme)
- NHS England engagement in responding to district plans.
- Approach to CCG consultations (Non-Emergency Patient Transport Services and 111/Out of Hours service are currently at procurement) and Self-Care Policy.

2.3.1 In regards to the termination of the OPACS contract the CCG updated members on the current timescales in relation to the internal reviews and NHS England review which has a deadline of the 12th February 2017. It was agreed that a shared timetable of activities or key dates around OPACS review, stakeholder events and scrutiny meetings from all key organisations should be drawn up.

2.3.2 Healthwatch Peterborough and HealthwatchCambridgeshire, with the CCG and Cambridge County Council and Peterborough City Council have agreed to setting up a ”Learning Community Event” in May 2016 once the outcome of

the internal and external reviews are known. This event will involve local stakeholders, including patients who have experienced the services in the contract.

2.3.3 Sustainability and Transformation plans were discussed and CCG noted that the submission date for the plans was 29th June 2016. It was agreed that the CCG would provide further briefing at the Health Committee Development session scheduled for 3rd March 2016.

2.3.4 Cllr Ellington raised concern over NHS England lack of engagement when asked to respond to developers around Section 106 funding. To be raised at the Health Committee meeting on 10th March 2016.

3 LIAISON AND WORKING GROUP MEMBERSHIP ARRANGEMENTS

3.1 Health Committee Membership Changes – May 2015

Following the Health Committee meeting on 17th Decemberit was agreed to hold quarterly meetings with CUHFT, CPFT and Hinchingbrooke Healthcare NHS Trust at the offices of the relevant NHS organisation and require the Chief Executive of the organisation to attend.

A schedule of meetings for 2016/17 has been set up and details are available in Appendix A.

It was also agreed that the Chairman/woman and Vice-Chairman/woman serve on all three liaison group, and all Members of the Committee be invited to attend liaison meetings. Core membership of the liaison meetings has been established for CCG, CPFT and CUHFT.

<u>Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) &Healthwatch Liaison group</u>

Current core membership County Councillors: Orgee, Jenkins and Sales with district council representation from Councillor Ellington

<u>Cambridgeshire & Peterborough NHS Foundation Trust (CPFT) Liaison Group</u>

Current core membership Councillors: Brown, Orgee, Jenkins, Sales, Scutt and van De Ven

<u>Cambridge University Hospital Foundation Trust (CUHFT)</u>

Current Core membership Councillors:Clapp, Ellington, Hudson, Jenkins, Orgee and Topping.

<u>Hinchingbrooke Healthcare NHS Trust Liaison Group</u>

Core membership still needs to be established for this liaison group

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Statutory, Risk and Legal Implications

These are outlined in a paper on the Health Committee powers and duties, which was considered by the Committee on 29th May 2014

4.3 Equality and Diversity Implications

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

4.4 Engagement and Consultation Implications

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

4.5 Localism and Local Member Involvement

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

4.6 Public Health Implications

The outcomes from the activities of the working groups are likely to impact on public health

Source Documents	Location
None	

BUILDING COMMUNITY RESILIENCE

To:	**Health Committee**
Meeting Date:	**10 March 2016**
From:	**Sarah Ferguson, Service Director Enhanced and Preventative Services** **Val Thomas, Public Health Consultant – Health Improvement**
Electoral division(s):	**All**
Forward Plan ref:	***Key decision:*** **No**
Purpose:	**To introduce *Stronger Together – Cambridgeshire's Strategy for building resilient communities,* and to seek the views of Health Committee on the actions taking place in support of this strategy and how this could link with existing public health community resilience based work.**
Recommendation:	**Health Committee is asked to comment on the actions proposed to support the Community Resilience Strategy and how this could link with existing public health community resilience based work.**

	Officer contacts:	
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1. BACKGROUND

1.1 The public sector faces enormous challenges in the next few years. Rising demand together with significantly reduced resources makes redesigning public services imperative. Put simply, the public sector cannot continue delivering services in the way that it does now.

1.2 Alongside this, there is a growing body of research and evidence to show that local community-based support can be more effective in supporting some vulnerable people – and better at preventing some of the crises which necessitate costly Council services.

1.3 *Stronger Together – our strategy for building resilient communities* represents the culmination of work that has been happening across the Council on the back of these two immediate imperatives. It proposes a fundamental shift in the way that service provision and local communities interact; essentially, repositioning the Council as part of the wider community, with a real focus on building the capacity of local people to help us to meet local needs together.

1.4 The concepts and actions within this strategy have been informed by officers and Members across the Council, from a series of meetings, workshops, discussions, Member seminars and more latterly a more formal Programme Board with membership drawn from each directorate. It has been developed alongside the Council's new operating model, reflecting the cross-cutting nature of both the work and the potential impact. Community Resilience is an enabler within the operating model.

1.5 The Council's General Purposes Committee agreed to adopt this strategy at its meeting in October 2015. Since then officers and Members across the Council have been developing activity to make this strategy a reality.

2.0 FINANCIAL BENEFITS AND BUSINESS PLANNING

2.1 There is evidence to show that this approach can deliver improved services for less money. But it is difficult to accurately predict the savings that will accrue from fostering more resilient and supportive communities. Our business plans will consider the following:

- **Costs avoided** – for example, less costly care packages for older people, where neighbours and friends can do some of the things that we currently ask domiciliary care providers to undertake;
- **Helping to guide where savings could be made in front line services** – for example, where local parents step up to successfully offer peer support through children's centres or other community spaces and therefore reduce the need for services for parents in crisis, or where communities part-fund some highways improvement work or help to maintain local footpaths;
- **Mitigating the impact of cuts which will have to be made to front line services** – for example, by ensuring there is a greater wealth of volunteer capacity in local areas with people willing and able to give some time to help others including through more organised opportunities such as timebanks, or through raising awareness and perceptions of volunteering opportunities.

2.2 There is increasing emphasis on demand management within the Council's business plan. This strategy is central to our ability to manage demand for our services - through supporting families and communities to do more to prevent the escalation of need and also to support the most vulnerable. It will drive our work with local communities to help, for example, to support a network of opportunities for socialising to combat loneliness and isolation in older people, or to encourage local people to look out for their vulnerable neighbours. For the most vulnerable, this strategy articulates our intention to combine our own care delivery with that from local people, for example by building capacity locally to support carers with their caring, or including local community support within care plans for adults with disabilities.

2.3 Council staff will place additional focus on helping to create groups and networks of people who face (or have faced) similar issues or needs, for example, parents with children who have a disability, or people with caring responsibilities. In this way people will increasingly be able to get some of the help and advice they need without recourse to our services.

3.0. SUPPORTING ACTIVITY

3.1 Our strategy proposes six areas of activity. Each represents a specific part of the work we need to take forward, and there are developing action plans for each area. The six areas are:

- Communication
- People helping people
- Council members
- Our workforce
- Community spaces
- Partnerships

Further detail on each of these areas can be found within the strategy document itself, together with a clear articulation of what the Council aims to achieve by 2020.

3.2 **Communication**

A comprehensive Communications Strategy and Action Plan are in place to support the Community Resilience Strategy. In the meantime work has already started in raising awareness of the challenge being faced by the Council and ways we and the community can help one another as part of the Council's Budget Challenge Campaign.

A regular update is now being sent to Parish Councils and a letter has also been sent with supporting materials that they can use themselves or in local publications. A menu of ideas and support offers, case studies and online resources are now being developed to help Parish Councils, the community and other organisations to develop their own local activity that will mitigate the impact of our budget and service reductions. Communications to staff have begun and will increase with official launch of the Community Resilience Strategy, and we are increasingly publicising the good work that is already happening in local communities, with or without our support.

The way the Council is using social media has been changing in order to better place the Council and its services as part of the wider community rather

than a centralised provider of services. This means the Council can actively target communities in a geographic location but also communities who share an interest or need. This in turn allows a much more targeted and cost efficient approach as well as engaging with people where they are having the conversations rather than expecting them to come to the council.

3.3 **People helping people**

This workstream aims to facilitate people helping people in a range of capacities across the county. People help people in a broad range of ways – from very informal help for a neighbour, through to more facilitated volunteering such as peer-to-peer support. Within this workstream we will look at how the Council can support people helping people in both formal and informal ways. We aim to build on existing good practice across the Council, for example, in libraries, and develop the links between service provision where this is needed.

Activity planned includes:

- The delivery of three pilot learning sites aiming specifically to build community capacity. These will take place in Godmanchester, Ely and Littleport, and the Abbey area of Cambridge. The Godmanchester site will build upon the “mini-patches” work happening through Transforming Lives.
- Work on building peer support mechanisms across the county.
- Aligning our Voluntary and Community Sector (VCS) contracts around our Community Resilience strategy.
- Making available a toolkit for staff and Members, providing advice on sources of funding, support and training that community groups can access, useful tools, tips and techniques for building capacity in communities, and examples of successful activities and case studies.
- Identifying occasions where our staff may not feel they are able to link vulnerable people with sources of support from within the community – and making sure our policies and processes facilitate this whilst also keeping people safe from harm.
- Further development of Time Banks and Time Credits.

3.4 **Council Members**

The first Councillors as Community Connectors cohort is now complete. Two further cohorts are planned. The purpose of this group is for pro-active Members to work together to mutually improve knowledge of how to help build capacity within the communities in their divisions. The material they have covered includes: community engagement techniques, discussions with service leads regarding how the councillors’ community role can support services, and practical ideas to take forward. Attendance has been slightly lower than anticipated; of the 18 who signed up, 12 remain engaged with the programme. A number of councillors on the programme have initiated new activity including: holding a village meeting to ask how the community can do more, arranging for members to be trained as Community Navigators and instigating parish clusters.

The programme has been a conduit for the Cultivating Communities Small Grants pilot through which communities can work with their County Councillor to apply for a grant to fund local community-led partnership projects.

Stronger Together has stimulated positive conversations with local councils. Some have approached the council to ask what they could do to help mitigate the impact of the cuts, and a number of county members have started discussions with their parishes to stimulate ideas. Examples of activity include:

- Histon and Impington parish proactively working with a county officer to further develop their already substantial community offering
- Development of a Parish menu outlining examples and suggestions of ways our two councils can work together
- An invitation to officers to attend Huntingdonshire Joint Rural Forum to discuss 'Where will the axe fall and how can towns and parishes help?'
- Cllr Tew convening parish cluster meetings where parishes are now collaborating on projects
- Cllr Downes holding a Village Meeting explaining the situation and asking for ideas. These are now coming forward through their Community Plan.
- Monthly briefings of relevant information to all Local Councils from the County Council Communications team

At this early stage the approach we are adopting is to work with the willing, engaging with proactive local councils who approach us.

3.5 **Our workforce**

LGSS have the lead on this workstream, and due to other priorities they do not yet have plans in place. The draft Council Workforce Strategy is being revised to reflect the new direction of Customer First that the new Chief Executive is introducing and the final product will include the requirements of our work on community resilience.

In the meantime, there will be a workshop in the New Year to plan how we will support our staff to gain the skills and expertise they will need for this new way of working.

3.6 **Community spaces**

The use of the Council's assets will play a pivotal role in supporting an integrated approach to community resilience. At this point however there is still work to be completed before a detailed proposal can be developed that sets out how we will use our assets to help our communities become more resilient and self-sufficient. There are a number of stages that are necessary in this process. The first is to define exactly what the Council's service offer is. Work has been undertaken on this and it is starting to take shape. Once complete this will be mapped against an assessment of community need using the various data sets and forward projections to facilitate this process. Having determined the needs and priorities of communities a gap analysis will be undertaken by comparing this assessment to the location of the existing public estate. It is highly unlikely that the existing infrastructure and the identified infrastructure needs will be aligned and therefore the process will create some surplus assets and perhaps some investment requirements.

We have begun work on identifying those aspects – buildings, staff and activity – which we could potentially bring together across children's centres and libraries in a given geographical location. We will build on this over time to identify one community-facing hub space in each community (geographical size to be determined), which will be the local "front door" for the provision of

information and advice, preventative activities, developing and brokering community support, and networking and partnership working across all of our services. This will mean reducing our property portfolio as we join up across services, and will involve working with other Partner organisations who also desire a local presence.

3.7 **Partnerships**

A series of individual meetings are taking place with partners to explore the resonance of the strategy with their own objectives. Discussions are also taking place at partnership boards to establish any cross-cutting strategic links which need to be made. From these discussions, any countywide actions and goals will be developed as well as any specific local activity to take the work forward. These conversations will have been concluded by March 2016, with a proposal that they are presented back to Cambridgeshire Public Services Board for strategic sign up. In Fenland, initial discussions have been taking place under the auspices of the Fenland Strategic Partnership to look at whether rethinking the totality of the resource being allocated across agencies in a community through the lens of community resilience could assist the process of re-focussing services.

4. PUBLIC HEALTH SERVICES

4.1 Many public health services have been using the principles and practice of community resilience for some years. The Council's Community Resilience Strategy provides a positive opportunity to potentially build further links, particularly through Member training and Parish Councils.

The following are examples of Public Health interventions that involve engaging individuals and communities to develop the knowledge, skills and resilience to enable them to take responsibility for their health and well being. The interventions are delivered by members of the Public Health Directorate or through commissioned services. They include working with a range of different ages and communities in a variety of settings.

4.2 Healthy Fenland Fund

Public Health staff have worked to establish the Healthy Fenland Fund to build community resilience and reduce health inequalities in Fenland through engaging communities to take responsibility for their health and well-being. Communities in Fenland are able to access small grants that will enable them to develop local projects and interventions to address their health and well-being needs.

This funding may be used to strengthen the community by supporting the "building blocks" or for a specific project that addresses a community issue. Care Network in collaboration with Cambridgeshire Community Foundation has been commissioned to administer the Fund and to engage communities.

It has employed community workers who will be responsible for identifying "enablers" and supporting them to work with their communities to realise their assets and manage their own needs. Enablers are community members who identify and use their community strengths, physical and social assets and make connections in their communities to develop resilience and strengthen their communities. The Healthy Fenland Fund acts as an incentive and the

community workers will work with communities and advise them how best to access and best use the Fund.

4.3 Breastfeeding Peer Support Programme

Members of the Public Health Directorate facilitate a Peer Breastfeeding Programme that currently has Peer Breastfeeding Support Groups in Fenland, East Cambridgeshire and Huntingdonshire where there are lower rates of breastfeeding. There is evidence that breastfeeding has considerable health benefits for the child and mother. Peer support groups are acknowledged as being an effective means for initiating and increasing the length of time women breastfeed. Peer supporters are voluntary lay women, recruited from the local community who have breastfed themselves and successfully completely additional accredited breastfeeding training that is provided by Public Health. Trained peer supporters go on to recruit new members and form their own peer support groups.

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

4.4 KickAsh

Kick Ash Cambridgeshire is a health promotion programme that aims to reduce the prevalence of smoking amongst young people who are 16 and under. It is a school based programme that engages young people in promoting the no-smoking message with young mentors being recruited who represent a wide cross section of students from different social groups. The programme is currently active within 10 schools with over 150 mentors being trained this year (20115/16) and in excess of 500 during the life of the programme.

It is facilitated by Public Health, CAMQUIT (Stop Smoking Services), Personal Social Health Education (PSHE), Communications and Trading Standards. The mentors working with staff from these Departments influence the design and development of the programme within their school and in the wider community

The Programme is led by mentors from Year 10 (15/16 yrs. olds) who deliver bespoke PSHE units of work to year 8 (13 yrs. old) and year 5/6 (10/11 yrs. old) students. The units focus upon what influences their decision making around smoking and related risk taking behaviour. In addition they undertake a number of events in the community, raising awareness of the issues e.g. flash mob appearances in busy areas, training and workshop activities and communication that includes social media and press releases.

The mentors have expressed the following benefits: acquired new skills, gave them responsibilities which helped build their confidence, gave them leadership opportunities, good for their CVs, made them feel valued and gave them an understanding of the smoking related issues.

Schools have reported the following benefits: opportunities to work with other schools including primaries and the wider community with professional support from an outside agency, provides a focus upon health which is a priority for schools, participation in a high profile programme is good for school reputations and credibility. Those schools which are involved report that that the programme is now a school priority.

4.5 Gypsy and Traveller Health Team

The Public Health Directorate includes the Traveller Health Team that works to improve the life chances of Gypsies and Travellers across Cambridgeshire. As the largest ethnic minority group in Cambridgeshire, their life expectancy is approximately 10-12 years less than that of the non-Traveller residents and they are 5 times more likely to experience ill health (Travellers Joint Strategic Needs Assessment [JSNA], 2010). Activities focus on providing the communities with the knowledge and skills to improve their health and well-being.

Other funding has been secured by the team for specific projects. The Travellers Literacy Project targets those who have none or few literacy skills. The project enables learners to become more aware of how to access GP and other services. Improved literacy also helps with making health choices and the services that will help them with these choices. Literacy tutors report that participant mental health has improved through increasing their self-esteem and confidence building. A number of participants have progressed to employment or transferred to other skills development courses, which for many will be their first experience of achieving a qualification and a route to employability and independence

4.6 Health Explorers

A high smoking rate is one of the factors associated with the high numbers of smoking related deaths and illness in Fenland. In 2014 the voluntary organisation Our Life was commissioned by Public Health to facilitate a Citizen's Investigation into Smoking in Fenland.

Our Life specialise in community engagement and carry out high-quality public participation processes, research and training designed to involve local people in local decisions around issues that directly affect them and the areas in which they live. The starting point in Our Life's work was to discover the assets that the local communities already have and how to build on the existing strengths in the communities.

A "conversation" was held with 17 volunteers from Fenland (these were mainly made up from people who use the Rosmini Centre in Wisbech) about tobacco use in the local area. This informed the Fenland Explorer Project which recruited five volunteers from the community. They were trained and undertook street based research by interviewing over 150 local people from Fenland market towns. They used the findings to produce a final report which is being used for the ongoing engagement of communities in smoking prevention and the Stop Smoking Services. The volunteers became the Fenland Health Explorers who created their own identity, logo and reported that they had increased their knowledge, communication skills and confidence.

4.7 Health Walks

For a period of 12 years Public Health staff sometimes with partner agencies have trained and supported volunteers to lead Health Walks East Cambridgeshire.

Health Walks are evidence based interventions that support not only the promotion of physical activity but also psychological wellbeing. They bring together groups of up to 40 individuals who may have low levels of physical activity and/or be socially isolated. Local case studies have revealed the social impact of the walks with individuals not able to walk still meeting with the group for social gatherings.

4.8 Health Trainers

Public Health commissions Everyone Health to provide an integrated Lifestyles Service which includes Health Trainers. Historically in Cambridgeshire the Health Trainer Service was confined to the 20% most deprived areas but since 2015 the Service has been commissioned for the rest of the county.

Health Trainers offer tailored advice, motivation, skills and practical support to individuals who want help to adopt healthier lifestyles. They focus on those in greatest need and more disadvantaged communities. The Cambridgeshire Service also includes community engagement workers who develop links with communities to enable health trainers to work with them to develop their knowledge and skills for taking responsibility for their own health. For example they recruit and train volunteers to run Health Walks (expanding the East Cambridgeshire model to the rest of the county) and other community physical activity initiatives or provide cooking classes for mothers.

4.9 Workplace Health Programme

Public Health has a long standing Workplace Health programme which offers support to employers to improve the health of their workforces. There is evidence that workplace health programmes support improvements in employee health and provide financial savings through for example reduced sickness absence. Business in the Community (BITC) has been commissioned to develop the Programme, primarily with workplaces in the private sector in the more deprived areas over the next two years. Support is also being given to Local Authorities and the NHS by members of the Public Health Team.

Integral to the sustainability of the programme is ensuring that workplaces i.e. employers and employees are committed to and own their Programmes along

with the securing the skills to ensure that they are sustainable. Volunteer Health Champions are recruited and trained. Their role is to engage the ongoing support of employers and employee, play a lead role in organising initiatives that promote health and wellbeing, as well as signposting to relevant, local services. Employer networks have also been formed where peer support is available for employers who are taking forward workplace health programmes

4.10 Sexual Health Champions

Public Health commissions the a voluntary sector organisation DHIVERSE, to train community volunteers as Sexual Health Champions (SHCs) to work with their communities to promote sexual health and HIV prevention. The project has been especially successful with Black, Asian and Minority Ethnic (BAME) groups with the volunteers playing a key role in developing an awareness of HIV in their communities and ongoing sexual health promotion. More recent work has resulted in the recruitment of volunteers from the Men who have Sex with Men (MSM) communities.

4.11 Engaging Retailers - Healthy Options Project

The Healthier Options initiative engages local food businesses in Cambridgeshire to provide healthier food and drink options to customers. Environmental Health Teams from Cambridge, South Cambridgeshire and Fenland Councils have promoted the initiative to businesses in their areas and encouraged them to sign-up to the “Healthier Intention” pledge” to support their communities to make healthier food choices.

Social media, a website, a twitter account and a Facebook page are being used to engage not only with local businesses but also with the community. This has led to some local residents signing up to become Healthier Options Ambassadors and helping to promote the initiative to both local businesses and their communities.

4.12 Building Skills for Community Resilience - Public Health Training

Public Health provides various training courses for communities and professionals. These enable them to motivate and provide support for individuals and communities to take responsibility for their health and adopt healthier lifestyles. Examples of training are brief behavioural change interventions and motivational interviewing. More specifically Mental Health First Aid Training teaches people how to identify, understand and help a person who may be developing a mental health issue; this could be with their family, friends, workplaces or communities.

5. ALIGNMENT WITH CORPORATE PRIORITIES

5.1 Developing the local economy for the benefit of all

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

- The Bank of England estimates that around 15 million people volunteer regularly on a formal basis, and that the same amount of time is spent on informal volunteering, which might be running a neighbour to a doctor’s appointment or taking an elderly relative to do their shopping. They

calculate that the economic value of volunteering could exceed £50bn a year.

- Individuals benefit from doing things for others, though the balance of benefits differs across individuals. For example, younger people highlight the importance of acquiring new skills and enhancing employment prospects, while older volunteers benefit from increased social interaction and improved health. Enjoyment and satisfaction rank high across all volunteer types, and it is clear that there are economic benefits for the individual. The Bank of England estimates that the gains to the individual in terms of wellbeing, improved health and increased employability might exceed the £50bn-plus benefit to the recipients of volunteering.
- It is therefore reasonable to suggest that building and supporting increased volunteering across the county will have benefits for the local economy.

5.2 **Helping people live healthy and independent lives**

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

- There is evidence that community engagement and resilience supports the adoption of a healthy lifestyle as a community norm and engagement in health improving initiatives
- The benefits to those supported by volunteers include improvement in health, wellbeing and independence
- Supporting community resilience builds increased social capital; cohesion, empowerment, and improved relationship with organisations.

5.3 **Supporting and protecting vulnerable people**

The following bullet point sets out details of implications identified by officers:

- The County Council, along with other partners in the public sector, will have to make reductions in front line services in order to meet the significant financial challenges ahead. This strategy is a key aspect of the Council's approach to mitigating the impact of those cuts on those who need support but could manage without the intervention of statutory services.

6. SIGNIFICANT IMPLICATIONS

6.1 **Resource Implications**

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

- Implications for delivery of savings are outlined in paragraph 3. There are no significant additional costs incurred in the delivery of the overall strategy – though some actions may require short-term revenue input in order to achieve identified savings (invest to save). Delivery requires no additional staffing capacity, rather it asks our staff to work in different ways to secure support for people and places from within the local community.
- The strategy helps to establish how we best use our property assets to achieve the most value for Cambridgeshire residents.

6.2 **Statutory, Risk and Legal Implications**

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

- The strategy is designed to mitigate the impact of reductions in local government funding. As such it should help to guard against the risks identified in the corporate risk register around failure to deliver our five year business plan, namely:
    - Lack of capacity to respond to rising demand for service provision, in new and existing communities
    - Failure to produce a robust and secure business plan over the next 5 years
    - Failure to deliver the current five year business plan.
- There will be a continuing legal duty on local authorities to ensure that vulnerable people are not exposed to additional or unreasonable levels of risk as a result of the implementation of these strategic objectives.

6.3 **Equality and Diversity Implications**

The following bullet point sets out details of significant implications identified by officers:

- Evidence indicates that services delivered by local people within local communities can be more successful than statutory services at reaching people who may need support. Our strategy should therefore support more equal and diverse accessible provision locally.
- Our services will become increasingly more localised, less uniform and more bespoke, so that we can meet local and individual need within each specific community context.
- People identify themselves within different communities, not only the geographical community in which they live. People are also part of communities with shared interests (e.g. the Women's Institute, or the local Allotment Society) and this strategy will drive our approach to building relationships and harnessing capacity within these communities too.

6.4 **Engagement and Consultation Implications**

The following bullet point sets out details of significant implications identified by officers:

- We recognise that successful delivery of this strategy will hinge upon the relationships we have with other agencies in local communities – at a strategic planning level as well as between people working in local areas. There have been some early discussions with voluntary sector organisations and other statutory agencies further develop a partnership approach to developing and supporting community resilience..

6.5 **Localism and Local Member Involvement**

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

- The role of Members is critical to the success of this strategy – in engaging communities and in acting as community advocates. For this reason, this strategy has been circulated in draft form to all Members for comment prior to being considered at General Purposes Committee. The role of Members is further outlined on pages 11-12 of the strategy.
- A number of councillors have volunteered to become early adopters of this work, piloting this new and critical way of working. They have formed a "Councillors as Community Connectors" group, meeting as an action learning set, and the learning from their experience will inform our direction going forward. Councillors are invited to express an interest in joining cohort two of this programme, which will begin in January 2016.

6.6 **Public Health Implications**

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

- There is evidence that community resilience and engagement can have a positive effect on the health of Cambridgeshire residents, by supporting the adoption of a healthy lifestyle as a community norm and improving engagement in health improving initiatives. Targeting efforts where people have greater health needs will have the most impact. This would include focusing on more deprived areas, on those who are isolated and do not access services, or those where increased self-care or community support is required would have a larger impact on health.
- Building community resilience will impact on many of the needs identified in different Joint Strategic Needs Assessments (JSNAs), including the following:
    - Migrant communities
    - Long Term Conditions
    - New Communities
    - Homelessness and at risk of homelessness
    - Vulnerable children and adults
    - Autism, personality disorders and Dual Diagnosis
    - Carers
    - Older People's Mental Health

Source Documents	Location
Community Resilience Strategy *Stronger Together – Cambridgeshire County Council's strategy for building resilient communities*	http://www.cambridgeshire.gov.uk/info/20076/children_and_families_practitioners_and_providers_information/370/providing_children_and_families_services/5 (listed under 'Children, young people and families')
In giving, how much do we receive? The social value of volunteering. Andrew G Haldane, Chief Economist, Bank of England, speech on 9 September 2014	www.bankofengland.co.uk/publications/Pages/speeches/default.aspx
NICE Guidelines PH 9 Community Engagement	https://www.nice.org.uk/guidance/ph9/chapter/Appendix-C-the-evidence#evidence-statements
Joint Strategic Needs Assessments	http://www.cambridgeshireinsight.org.uk/jsna

Agenda Item No: 10

FINANCE AND PERFORMANCE REPORT – January 2016

To:	**Health Committee**
Meeting Date:	**10th March 2016**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To provide the Committee with the January 2016 Finance and Performance report for Public Health. The report is presented to provide the Health Committee with the opportunity to comment on the financial and performance forecast outturn position as at the end of January 2016.**
Recommendation:	**The Committee is asked to review and comment on the report.**

	Officer contact:
Name:	Chris Malyon
Post:	Chief Finance Officer
Email:	Chris.malyon@cambridgeshire.gov.uk
Tel:	01223 699796

1. BACKGROUND

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

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

2. MAIN ISSUES

2.1 The January 2016 Finance and Performance report is attached at Annex A.

2.2 Public Health Grant income will be £1.6m less than anticipated due to an in year reduction in Public Health Grant. Savings on expenditure budgets, and over achievement of income, totalling £1.2m have been identified. The £410k shortfall will be drawn down from Public Health Grant reserves to produce a balanced year end position.

2.3 The Public Health Service Performance Management Framework for December 2015 is contained within the report. Of the thirty eight Health Committee performance indicators, thirteen are red, four are amber, thirteen are green, and eight currently have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 **Developing the local economy for the benefit of all**
There are no significant implications for this priority.

3.2 **Helping people live healthy and independent lives**
There are no significant implications for this priority.

3.3 **Supporting and protecting vulnerable people**
There are no significant implications for this priority.

4.0 SIGNIFICANT IMPLICATIONS

4.1 **Resource Implications**
This report sets out details of the overall financial position of the Public Health Service.

4.2 **Statutory, Risk and Legal Implications**
There are no significant implications within this category.

4.3 **Equality and Diversity Implications**
There are no significant implications within this category.

4.4 **Engagement and Consultation Implications**
No public engagement or consultation is required for the purpose of this report.

4.5 **Localism and Local Member Involvement**
There are no significant implications within this category.

4.6 **Public Health Implications**
This report provides an overview of the finance and performance position of the Public Health service.

Source Documents	Location
None	

From: Martin Wade **Annex A**

Tel.: 01223 699733

Date: 9 February 2016

Public Health Directorate

Finance and Performance Report – January 2016

1. SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
December (No. of indicators)	13	4	13	8	38

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Dec) £000	Directorate	Current Budget for 2015/16 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Jan) £000	Forecast Variance - Outturn (Jan) %
-745	Health Improvement	9,048	-2,075	-28.1%	-700	-7.7%
0	Children Health	5,606	-295	-8.8%	0	0%
-220	Adult Health & Well Being	979	-398	-51.5%	-250	-25.5%
0	Intelligence Team	26	2	15.8%	0	0%
-5	Health Protection	16	2	15.5%	-5	-32.3%
-10	Programme Team	153	-40	-31.5%	-25	-16.4%
-150	Public Health Directorate	2,567	-926	-43.2%	-150	-5.9%
-1,130	**Total Expenditure**	**18,395**	**-3,730**	**-27.0%**	**-1,130**	**-6.2%**
1,610	Public Health Grant	-18,209	342	-1.9%	1,610	-8.8%
-70	Other Income	-186	51	0%	-70	0
1,540	**Total Income**	**-18,395**	**393**	**-2.2%**	**1,540**	**-8.4%**
410	**Subtotal**	**0**	**-3,337**		**410**	
-410	Anticipated use of carried forward Public Health grant				**-410**	
0	**Net Total**	**0**	**-3,337**		**0**	**0%**

The service level budgetary control report for January 16 can be found in appendix 1.

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

2.2 Significant Issues

The Department of Health has now published its response to the consultation on in-year savings to the public health grant in 2015-16. The response confirms the Government's initial proposal to reduce each local authority's overall public health allocation for 2015-16 by 6.2%, achieving a total £200m saving nationally. The 6.2% saving is based on each authority's share of the overall allocation of public health funding which for Cambridgeshire equates to a reduction of £1,610k. The reduction in grant will be mitigated through a combination of in-year savings/additional income (£1,130k and £70k respectively) and use of carried forward Public Health grant reserve (£410k).

Furthermore, in the Comprehensive Spending Review in November 2015, the Chancellor announced further reductions to the Public Health grant for 2016-17 to 2019-20 and additionally confirmed that the grant would remain a ring-fenced grant for two more years, to the end of March 2018. As a result of the grant remaining ring-fenced, the services funded by the public health grant are required to absorb pressures arising from the grant reduction, demography and inflation. Revised business planning proposals have been submitted to Health Committee endorsed to General Purposes Committee, and approved by Full Council as part of the Council's overall Business Plan.

Details of variances from budget at this point in the year are explained at appendix 2.

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

The Public Health ring-fenced grant allocation is £22.2m, but an in-year cut has been announced. The grant increased from September 2015 by £3.9m (full year £7.7m) in respect of the transfer from NHS England of 0 – 5 funding.
This brings total grant income for 2015/16 to £26.1m. Of the £26.1m, £18.2m is allocated directly to the Public Health Directorate.

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE

4.1 The Public Health Service Performance Management Framework (PMF) for December 2015 can be found in Appendix 6.

The following commentary should be read in conjunction with the PMF.

4.2 Stop Smoking Programme:

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Smoking Cessation - four week quitters	2237	1170	1078	92%	A	91%	173	98%	↑

- Since 2013/14 there has been an ongoing drop in the percentage of the target number of smoking quitters achieved. In 2012/13 92% was achieved, in 2013/14 this fell to 76%. This fall continued in 2014/15 when 64% of the target was met. The drop locally mirrors the national picture for the past three years. A number of factors have been associated with the fall in quitters in recent years but e cigarettes are generally seen as being the key factor across the country. During these years performance in GP practices and community pharmacies was especially poor and they report there is a consistent problem with recruiting smokers to make quit attempts
- The most recent update to the Public Health Outcomes Framework has shown that the fall in the percentage of adults smoking across the County between 2012 and 2013 to 13.5% has now risen again to 15.5%. Inequalities in smoking rates remain, with the prevalence in Fenland, Cambridge City and amongst manual workers being higher than the Cambridgeshire average.
- The target number of quitters has been revised for 2015/16 to reflect the fall in smoking prevalence in Cambridgeshire. The old target was based on the previous higher prevalence. Performance against the revised target is continuing to improve and compares well with the achievement against target for the same period in 2014/15
- There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit the core Stop Smoking service is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. During 2014/15 social marketing research was undertaken which is informing activities to promote Stop Smoking Services. Other activities introduced recently include a mobile workplace service, a migrant worker Health Trainer post that will target these communities where smoking rates are high and a wide ranging promotional campaign

4.2 NHS Health Checks

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Number of Health Checks completed	18,000	13,500	10695	79%	R	77%	4500	82%	↑
Percentage of people who received a health check of those offered	45%	45%	41%	41%	A	36%	45%	41%	↑

- Reporting of Health Checks is quarterly. In 2014/15 83% of the target was achieved compared to 93% in the previous year. The % of health checks offered and converted into completed was comparable to 2014/15 at 38%.

- In Q1 2015/16 78% of the quarterly target was achieved with a conversion rate of 38%. Q2 saw no substantial improvement with the percentage against target completed Health Checks being 77% and the conversion rate of 36% Although there was a considerable improvement in the quality of data returned and numbers referred onwards to services following a health check; which has been attributed to the ongoing training programme.

- Q3 indicates an improvement in the percentage of completed Health Checks against the quarterly target to 82% and the conversion rate to 41%

- The comprehensive Improvement Programme is continuing this year. Intelligence from the commissioned social marketing work clearly indicates a lack of awareness in the population of Health Checks. Actual health check numbers compare favourably to other areas but the issue is the conversion rate which is attributed to the poor public understanding of the Programme. There is a concerted drive to launch a promotion campaign as soon as possible.
  Other activities include staff training from a commissioned Coronary Heart Disease specialist nurse, new data collection software for practices, Point of Care Testing (POCT) (which avoids patients having to return for their blood results) and additional staff support for practices. In addition in Fenland a mobile service has been established and is visiting factories to offer health checks especially to those more hard to reach groups. The new Lifestyle Service is commissioned to provide outreach health checks for hard to reach groups. This has not commenced due to delays in the contract with the company providing POCT which is required for outreach Health Checks. This has now been finalised and training of staff has commenced and POCT machines distributed.

Background Information

- Health Checks is cardio vascular risk assessment offered to people between the ages of 40 to 74. There is a 5 year rolling programme and each year up to 20% of the eligible population should be invited to a health check. The important indicators are the number of health checks completed and the number of those invited who actually complete a health checks. The Health Checks Programme has been primarily provided by GP practices that are responsible for sending out invitations to the eligible population.

4.3 Integrated Lifestyle Service

- The new Countywide Integrated Lifestyle Service provided by Everyone Health commenced on June 1 2015. It includes the Health Trainer and Weight Management Services. The trajectories for many of the indicators for the initial months of the contract reflect the fact that the Service was still recruiting and developing the Service. Also some of outputs are not available in the timeframe as the interventions take place over several months.
- However the Service is now almost fully recruited but there are still delays due to training requirements for new staff and some outstanding posts remaining empty. Various community organisations have been approached to help with recruitment. Performance is being carefully monitored with the Provider. The Service has been later than anticipated due to the very short lead time of two months from contract award to commencement of the Service.

4.4 Health Visiting and School Nursing

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	54%	93%	G	57%	58%	54%	↔
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	/	31%	62%	R	26%	54%	44%	↑
Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	90%	90%	92%	102%	G	98%	90%	97%	↑
Health visiting mandated check - Percentage of children who received a 6 - 8 week review by 8 weeks	90%	90%	94%	104%	G	96%	90%	94%	↓
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	93%	93%	A	94%	100%	92%	↓
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	86%	96%	A	86%	90%	84%	↓
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	249	N/A	N/A	43	N/A	11	↓
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	1001	N/A	N/A	183	N/A	85	N/A

- Currently school nursing individual contacts continue to be above target while group contacts are below. The low figure for September can be accounted for by some degree by school holidays. However this data doesn't tell us anything about the value on these contacts or the outcomes for those involved.
- A new service specification and Key Performance Indicators for School nursing have been agreed. A new performance template has been developed and this will be used to understand baseline activity from October. Over the next year we will be able to agree targets in areas which contribute towards public health outcomes and reflect this in our reporting. This will also reflect the activity across different parts of the county.

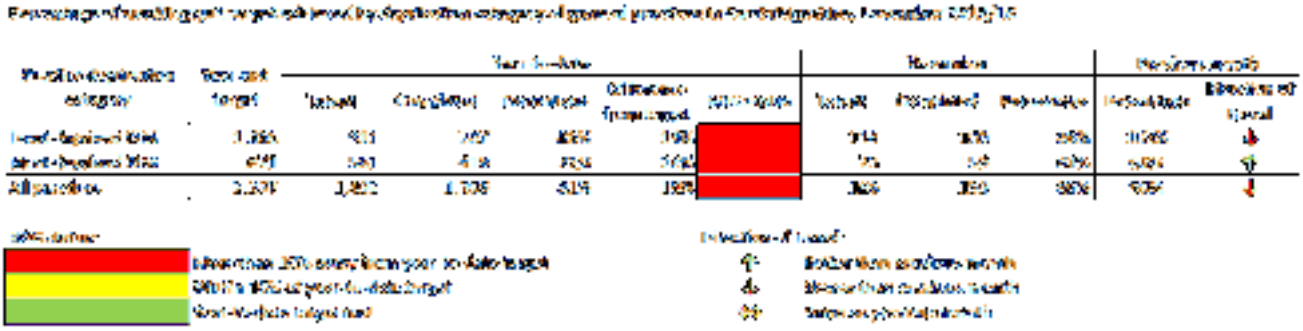
4.5 The detailed Service performance data can be found in appendix 6.

4.6 Health Committee Priorities

Health Inequalities

Smoking Cessation

- The following describes the progress against the ambition to reduce the gap in the smoking rates between patients of the most socio-economically deprived 20% of GP practices and the remaining 80% of GP practices in Cambridgeshire (monitored monthly). The GP practices in the 20% most deprived areas of Cambridgeshire are given more challenging smoking cessation targets and more support than other practices, to help reduce this gap.
- The percentage of the smoking quit target achieved in November was higher among the least deprived 80% of practices in Cambridgeshire compared with the most deprived 20%
- In the least deprived 80%, 100 four-week quits were achieved, 88% of the monthly target of 114; in the most deprived 20% of practices, 59 four-week quits were achieved, 81% of the monthly target of 73.
- Looking at performance data for the year to date, the percentage of the quit target achieved in the least deprived 80% of practices stands at 86% and in the most deprived 20%, at 72%.
- The gap in performance in quits achieved between the two groups decreased in November compared to the gap seen in October due to both a increase in quits achieved in the most deprived practices and an decrease in quits achieved for the least deprived practices.



Sources:
General practice returns to Cambridgeshire County Council Smoking Cessation Service
Public Health England 2011 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2011
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 01/02/16

NHS Health Checks

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

Quarterly:

- The percentage of the health check target achieved in Quarter 3 was higher in the least deprived 80% of practices than in the most deprived 20%.
- In the least deprived 80%, 2979 health checks were delivered, 93% of the quarterly target of 3214; in the most deprived 20% of practices, 720 health checks were delivered, 56% of the quarterly target of 1286.
- The gap in performance in health checks delivery between the two groups was 37 percentage points in Quarter 3.
- The gap in performance in health checks achieved between the two groups increased in Q3 compared to the gap seen in Q2 due to both a decrease in health checks in the most deprived practices and an increase in health checks for the least deprived practices.

Year to date:

- Looking at performance data for the year to date, the percentage of the health check target achieved in the least deprived 80% of practices stands at 86% and in the most deprived 20%, at 63%.
- The percentage of the health check target achieved in the year to date is more than 10% away from the target in both groups.
- Performance for the most deprived 20% of practices is 23 percentage points behind performance in the least deprived practices.

Percentage of health check target achieved by deprivation category of general practices in Cambridgeshire, 2015/16 Quarter 3

Practice deprivation category	Year end target	Year-to-date					Quarter 3			Previous quarter	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	12,858	9,643	8,314	86%	14%		3,214	2,979	93%	80%	↑
Most deprived 20%	5,142	3,857	2,412	63%	37%		1,286	720	56%	69%	↓
All practices	18,000	13,500	10,726	79%	21%		4,500	3,699	82%	77%	↓

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

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

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

	Year-to-date	Quarter 3	Previous quarter	Direction of travel
Percentage point gap	-23%	-37%	-11%	↓

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

Sources:
Practice returns to Cambridgeshire County Council Public Health Team
Public Health England 2011 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2011
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 19/02/2016

Life expectancy and healthy life expectancy

Life expectancy data have been updated to Q3 2013-2015 but there is currently no update to the Healthy Life Expectancy (HLE) annual figure. The next national update to HLE will be released March 10th 2016 so the update (2012-2014) will be provided in the next report.

- Inequalities in life expectancy in the most deprived quintile of Cambridgeshire (monitored quarterly subject to data availability)
  - The indicator statistic is the gap in years of life expectancy between the best-off and worst-off within the local authority, based on a robust statistical model of the life expectancy and deprivation scores across the whole area.
  - The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% remainder of areas was 2.6 years for the period 2012-2014.
  - For the years 2013-2015 (provisional data to Q3 of 2015) the absolute gap was 2.5 years.
  - There are significant inequalities nationally and locally in life expectancy at birth by socio-economic group. Certain sub-groups such as people with mental health problems, people who are homeless also have lower life expectancy than the general population. Key interventions to reduce this gap are in tackling lifestyle factors and ensuring early intervention and prevention of key diseases.

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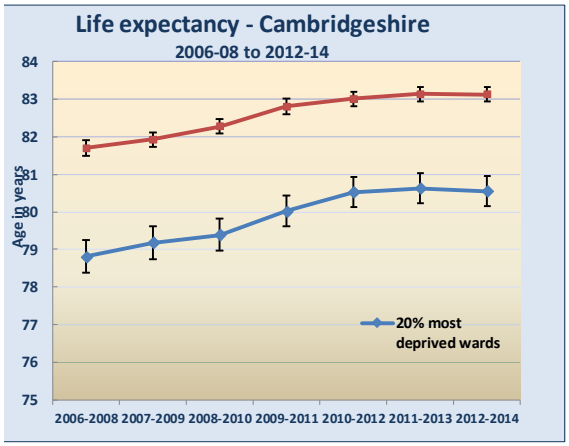
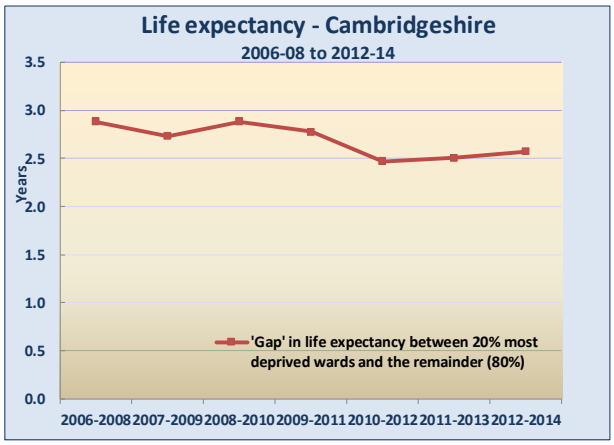
- An annual indicator covering healthy life expectancy.

- Healthy life expectancy for men for the period 2011-2013 in Cambridgeshire was 66.4 years. For females the figure was 65.5 years. The 'actual' figure for men (66.4 years) is higher than for females (65.5 years). No target has been set for this indicator. For the period 2011-2013 in England HLE for men was 63.3 years and for women 63.9 years.
- Healthy Life Expectancy (HLE) measures what proportion of years of life men and women spend in 'good health' or without 'limiting illness'. This information is obtained from national surveys and is self-reported (General Lifestyle Survey for example). Nationally the figures suggest that men spend 80% of their life in 'good health' with women spending a slightly lower proportion. Women experience a greater proportion of their lives lived at older ages and with a higher prevalence of disabling conditions. So although women live longer, they spend more time with disability. The fact that this information is "self-reported" may influence these figures as well. In many countries with lower life expectancies this difference between male and females is not so apparent.

Calendar years	Average Life Expectancy (95% confidence interval)				Gap (in years)	Relative gap (%)
	20% most deprived wards		80% remainder of wards			
2006-2008	78.8	(78.4 - 79.3)	81.7	(81.5 - 81.9)	-2.9	3.5%
2007-2009	79.2	(78.8 - 79.6)	81.9	(81.7 - 82.1)	-2.7	3.3%
2008-2010	79.4	(79.0 - 79.8)	82.3	(82.1 - 82.5)	-2.9	3.5%
2009-2011	80.0	(79.6 - 80.4)	82.8	(82.6 - 83.0)	-2.8	3.4%
2010-2012	80.5	(80.1 - 80.9)	83.0	(82.8 - 83.2)	-2.5	3.0%
2011-2013	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.5	3.0%
2012-2014	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.6	3.1%
2013-2015 to Q3	79.4	(78.9 - 79.8)	82.0	(81.8 - 82.2)	-2.6	3.2%

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)





Child obesity

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

Children aged 4-5 years classified as overweight or obese

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

decrease in Cambridgeshire, which meant the target was met (19.4% actual, 20.4% target) but that the gap between Fenland and Cambridgeshire had widened.

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

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

Source: NCMP, HSCIC

Children aged 4-5 years classified as obese

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

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

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

Source: NCMP cleaned dataset, HSCIC

Children aged 10-11 years classified as obese

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

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

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

Source: NCMP cleaned dataset, HSCIC

Excess weight in adults

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

Physically active and inactive adults

This target needs to be re-calculated as there was an error in the original data released in the PHOF. An incorrect weighting error had been used by Sport England.

Actions

Interventions to address both childhood and adult obesity include prevention and treatment though weight management programmes. Examples for promoting healthy eating include the commissioning of the Food for Life Partnership to work in schools to set policy, provide information and skills about healthy eating and growing healthy food, similar approaches are being used in children's centres and with community groups. The Workplace Health programme is another avenue for promoting health eating workplace policy.
There is a range of physical activity programmes provided in different settings across the county targeting all ages that are provided by CCC and district councils along with the voluntary and community sector.

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

Mental health

Proposed indicators:

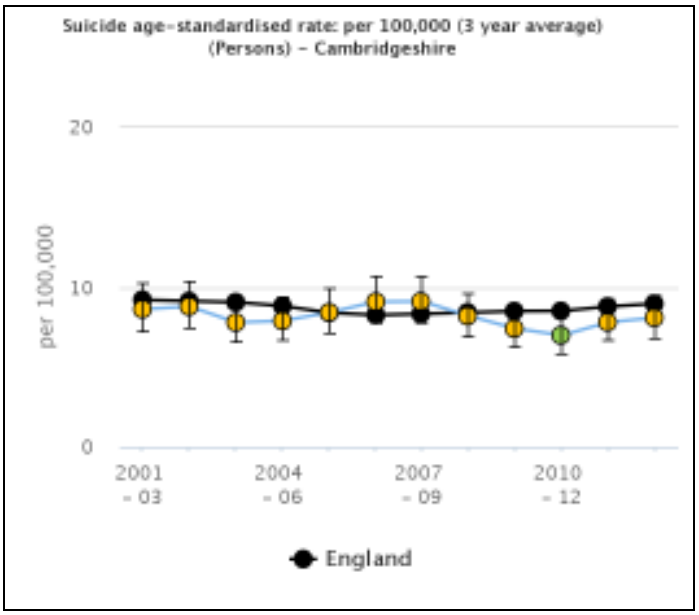
- **Number of schools attending funded mental health training:**
  Between 31st July 2015- 10th February 2016, 11 schools have had a whole school briefing with a total of 494 people in attendance. For most schools this is the first step to accessing further mental health training. An additional 8 schools are booked for spring and summer 2016 terms.
  Data collection for this training is currently under review so more detail will be provided in future updates.

- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – *data not yet available as this is newly funded work as part of the public mental health strategy.*

- **Number of front line staff that have taken part in MHFA and MHFA Lite commissioned training** (quarterly):
  Mental Health First Aid and Mental Health First Aid Lite are offered free of charge to front line staff within Cambridgeshire County Council and partner organisations (up until 29th January 2016):
  - MHFA (2 day course) attendance: 250
  - MHFA Lite (1/2 day) attendance: 113

  The contract is for a two year period from October 2014-October 2016. The annual target is to train 255 front line staff in full Mental Health First Aid and 126 staff from other groups in Mental Health First Aid Lite

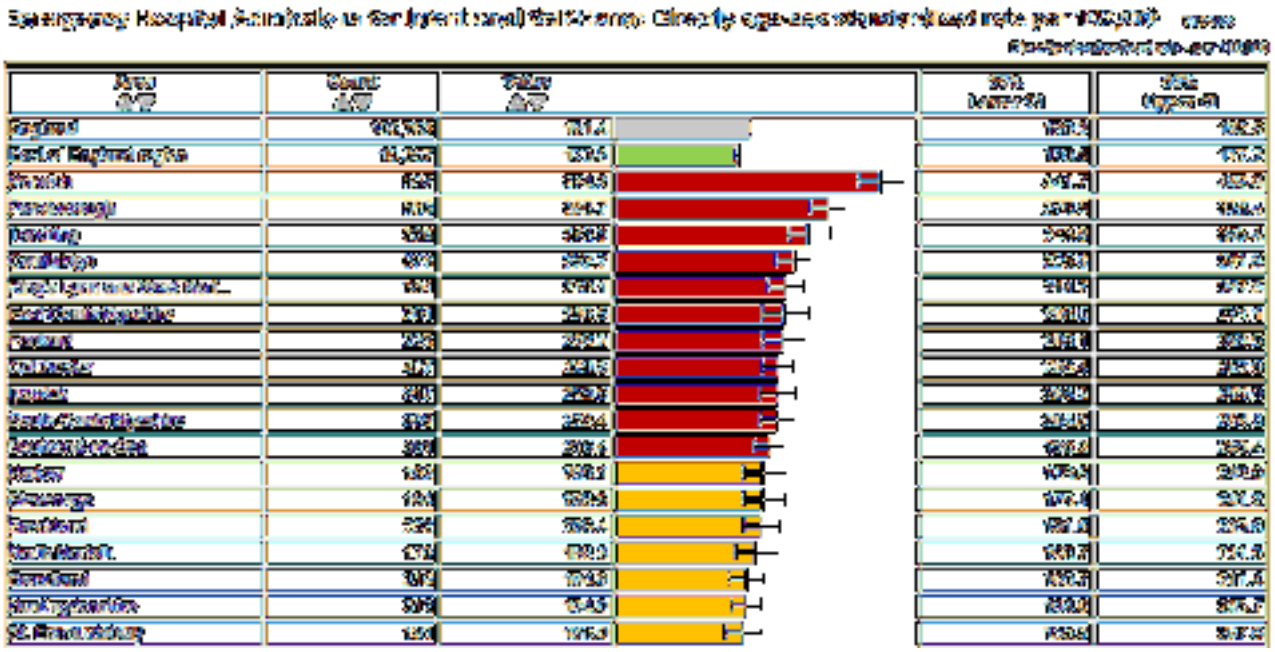
- **PHOF Indicator: Mortality rate from suicide and injury of undetermined intent** (annual):
  - In Cambridgeshire, the rate of suicide and injury of undetermined intent is 8.1 per 100,000 (3 year average, 2012-14), this is not significantly different to the England rate or the East of England rate.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



Source: Public Health Outcomes Framework

- **Emergency hospital admissions for intentional self-harm** (annual):

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



Source: Public Health Outcomes Framework

Transport and Health

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

4.7 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)**

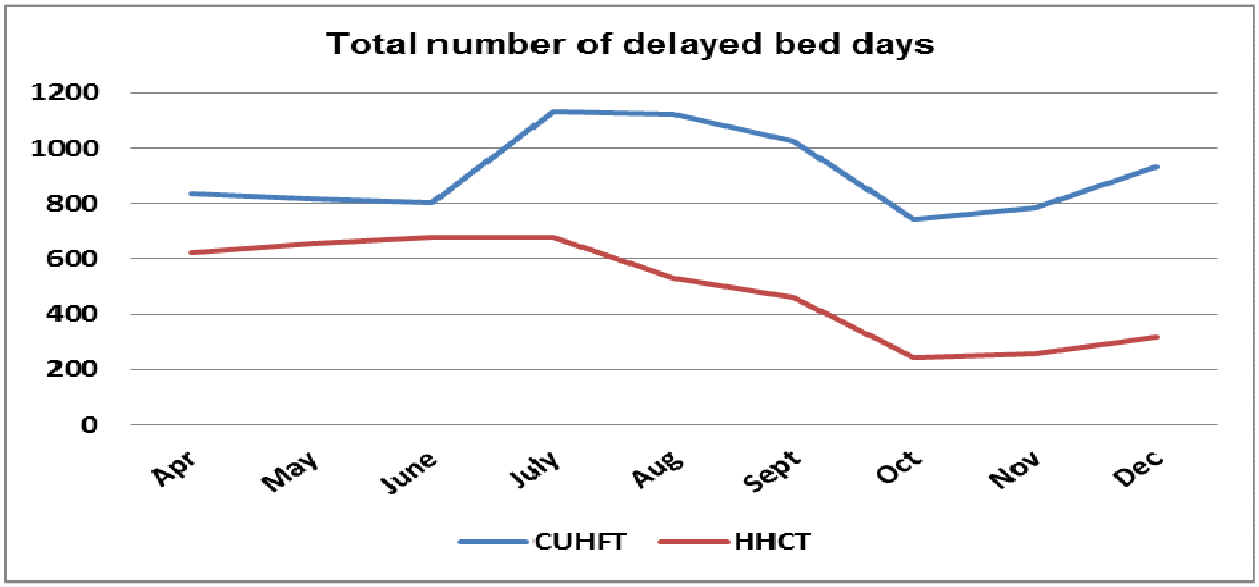
The Health Committee received an update from CPCCG on 28 May 2015 on the position regarding Delayed Transfers of Care (DTOC) in Cambridgeshire and Peterborough and requested regular updates on the current status of Delayed Transfer of Care.

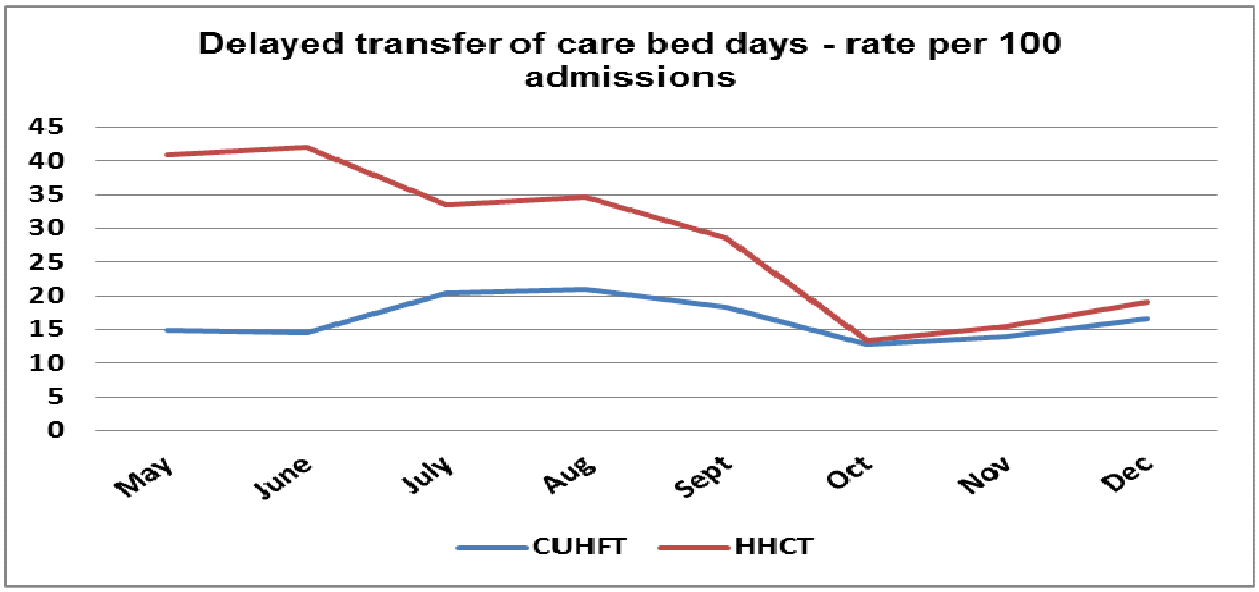
The reasons for DTOC are multi-factorial and need to be addressed by the whole system. Whilst it is not unusual to have delayed transfers of care, the numbers of DTOC across the CCG are higher than the system can manage. A concerted effort continues to be made by all providers in partnership with Commissioning and Local Authority leads to reduce the impact of DTOC.

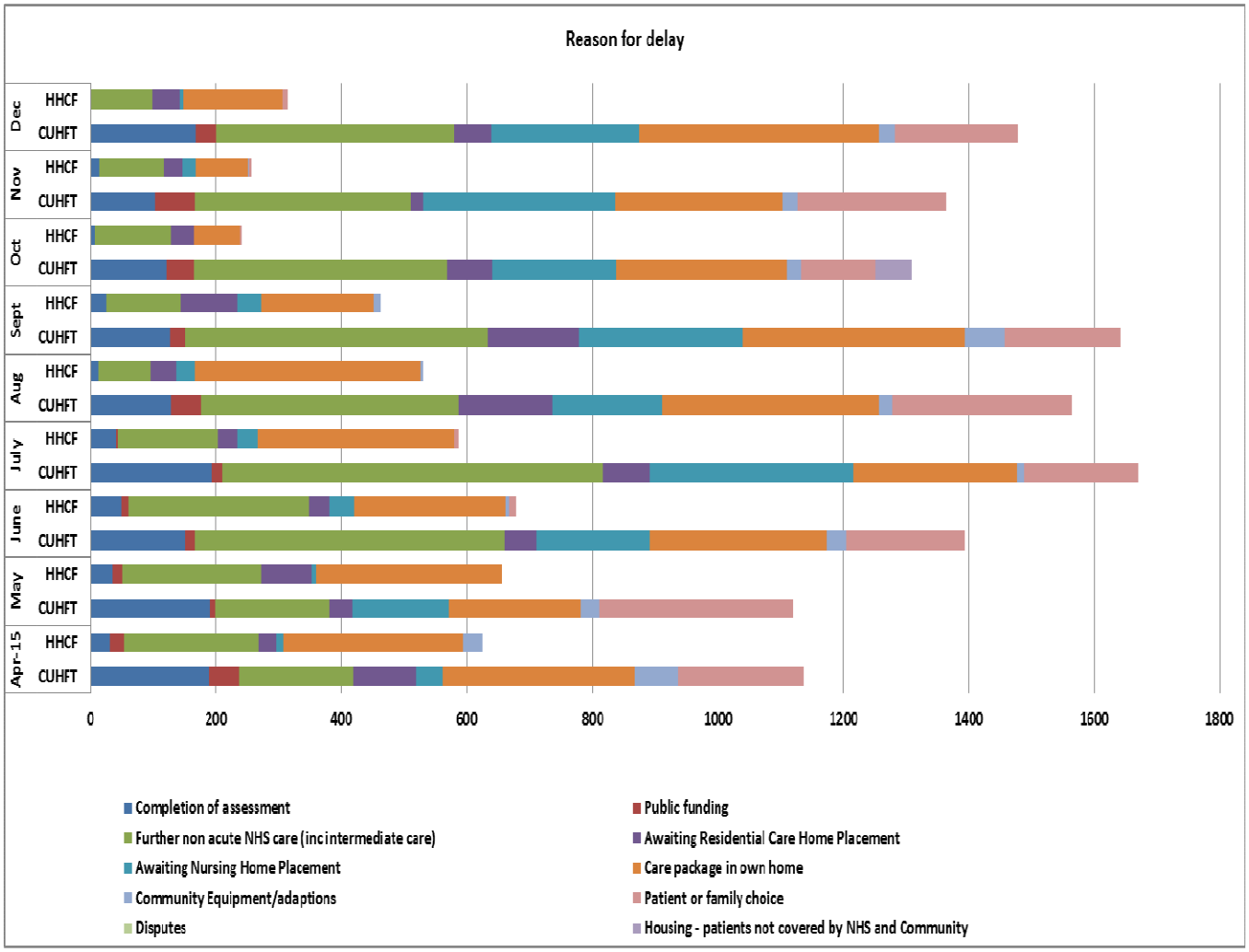
Following the Health Committee meeting in January 2016 reporting on DTOC now uses DToC bed days supplied by the Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) rather than NHS England data that was used for previous reports and provides just a patient count on the last Thursday of each month.

The report provides data from the 2015/16 winter period and there is an increase in total number of delayed bed days since the last report from October 2015. The

full winter effect should be considered in the data provided in the next performance report.







- **E-Hospital Programme**

  As part of their E-Hospital Programme, Cambridge University Hospitals NHS Foundation Trust (CUHFT) implemented a new clinical information system EPIC on 26th October 2014. The Health Committee considered an item on the E-Hospital system on 28th May 2015 following reports of substantial problems in the system. Members requested regular updates on the E-Hospital performance

  Cambridge University Hospital Foundation Trust (CUHFT) have provided the committee with a copy of the e-hospital progress report (January 2016).

  The Executive summary notes the following key issues.

  - There remain significant challenges to resolve, in particular relating to high cost drugs which will impede a full return to Payment by Results (PbR). Manual fixes are in place in the interim while longer term automated solutions are in development.
  - The eHospital teams continue to review and prioritise workload, however it would take a significant amount of time to complete the outstanding requests we have with current resource levels.
  - Accelerating the rate of development and optimisation will require investment. A eHospital workforce staffing paper is being prepared to be presented at the Management Executive on 11th February.

- The eHospital Benefits Mobilisation Group has been set up and meets monthly with increased operational input to ensure optimal use of Epic applications. Task and Finish Groups have been established to initially identify benefits with realistic savings; owners for the benefits will be identified and held to account by the Recovery Team.

The full report is provided as Appendix 7. The committee is reminded that a CUHFT will be providing further e-hospital updates at a workshop scheduled for 3rd March 2016.

- **CAMH Waiting Lists**

The Health Committee received a report on the service pressures in Children & Adult Mental Health Services on 16th July 2015. Cambridgeshire & Peterborough Clinical Commissioning Group (CPCCG) CG & Cambridge & Peterborough Foundation Trust were present at the committee to discuss the service pressures in particular relating to the Child and Adolescent Mental Health Services (CAMH).

Following receipt of a report to the Children's Health Joint Commissioning Board (CHJCB) due 7th September, the committee requested updates on the progress around rectifying the waiting list. An up to date position on the Child and Adolescent Mental Health Services (CAMH) and specifically the waiting lists was provided by representatives from CPCCG and CPFT as part of a formal Health Scrutiny session held on 21st January 2016.

Key points from the meeting are noted below:

- due to the length of waiting time, it had been decided in about March 2015 to close the waiting lists for Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) referrals where there were no associated urgent mental health needs, and to redesign the pathways to ensure that patients received a timely service

- the CCG had invested an additional £600k recurrent and £150k non-recurrent funding in CAMHS for the current year, and a national uplift to CAMHS had also been made available to the CCG, resulting in a further £1.5m funding locally for the current and subsequent years

- some of the national funding had been targeted at, and used for, improvements in eating disorder services

- in December 2015, the waiting lists had been re-opened following pathway redesign

- the referral service for ADHD, which was a neurodevelopmental disorder, now had a pathway with less consultant engagement than previously, and closer to that seen elsewhere in the country

- the hope was that there would be no waiting list for the core CAMH pathway by the end of January 2016.

Full details of the discussion are available through the Health Committee minutes of the meeting held on 21st January 2016.

http://www2.cambridgeshire.gov.uk/CommitteeMinutes/Committees/Meeting.aspx?meetingID=1038

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Dec) £'000		Service	Current Budget for 2015/16 £'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							
-170	**1**	Sexual Health STI testing & treatment	4,299	3,514	2,664	-850	-24.19%	-155	-3.61%
-100	**2**	Sexual Health Contraception	1,170	918	788	-131	-14.22%	-100	-8.55%
0		National Child Measurement Programme	0	0	19	19	0.00%	0	0.00%
-30		Sexual Health Services Advice Prevention and Promotion	223	213	142	-71	-33.30%	0	0.00%
0		Obesity Adults	0	0	47	47	0.00%	0	0.00%
0		Obesity Children	82	68	72	4	5.49%	0	0.00%
-15		Physical Activity Adults	100	100	63	-36	-36.37%	-15	-15.07%
-40		Healthy Lifestyles	1,464	1,193	1,045	-148	-12.39%	-40	-2.73%
0		Physical Activity Children	0	0	0	0	0.00%	0	0.00%
-295	**3**	Stop Smoking Service & Intervention	1,099	827	306	-521	-63.00%	-295	-26.85%
-40		Wider Tobacco Control	123	114	15	-99	-86.89%	-40	-32.50%
-5		General Prevention Activities	386	353	148	-206	-58.22%	-5	-1.29%
-50		Falls Prevention	100	83	0	-83	-100.00%	-50	-50.00%
0		Dental Health	2	0	0	0	0.00%	0	0.00%
-745		**Health Improvement Total**	**9,048**	**7,384**	**5,309**	**-2,075**	**-28.10%**	**-700**	**-7.74%**
		Children Health							
-		Children 0-5 PH Programme	3,861	1,875	1,875	0	0.00%	0	0.00%
		Children 5-19 PH Programme	1,745	1,462	1,167	-295	-20.18%	0	0.00%
-		**Children Health Total**	**5,606**	**3,337**	**3,042**	**-295**	**-8.84%**	**0**	**0.00%**
		Adult Health & Wellbeing							
-200	**4**	NHS Health Checks Programme	719	541	321	-220	-40.65%	-230	-31.99%
-20		Public Mental Health	224	196	54	-142	-72.26%	-20	-8.94%
0		Comm Safety, Violence Prevention	37	37	0	-37	-100.00%	0	0.00%
-220		**Adult Health & Wellbeing Total**	**979**	**774**	**375**	**-398**	**-51.47%**	**-250**	**-25.52%**
		Intelligence Team							
-		Public Health Advice	16	12	9	-3	-23.15%	0	0.00%
-		Info & Intelligence Misc	10	4	9	5	139.51%	0	0.00%
-		**Intelligence Team Total**	**26**	**15**	**18**	**2**	**15.81%**	**0**	**0.00%**
		Health Protection							
0		LA Role in Health Protection	11	9	15	6	68.16%	0	0.00%
-5		Health Protection Emergency Planning	5	4	0	-4	-95.10%	-5	-100.00%
-5		**Health Protection Total**	**16**	**13**	**15**	**2**	**15.52%**	**-5**	**-32.26%**

Forecast Variance Outturn (Dec) £'000	Service	Current Budget for 2015/16 £'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	20	-6	-23.23%	0	0.00%
-10	General Prev, Traveller, Lifestyle	121	101	68	-33	-33.13%	-25	-20.60%
-10	**Programme Team Total**	**153**	**127**	**87**	**-40**	**-31.47%**	**-25**	**-16.39%**
	Public Health Directorate							
	5 Health Improvement	448	374	285	89	23.86%		0.00%
	Public Health Advice	750	626	617	9	1.44%		0.00%
	Health Protection	150	125	124	1	0.80%		0.00%
-150	Programme Team	1,081	902	872	30	3.33%		0.00%
	Childrens Health	23	19	19	0	0.87%		0.00%
	Comm Safety, Violence Prevention	52	43	42	1	3.08%		0.00%
	Public Mental Health	63	53	43	10	18.10%		0.00%
-150	**Public Health Directorate total**	**2,567**	**2,142**	**2,002**	**-926**	**-43.23%**	**-150**	**-5.85%**
-1,130	**Total Expenditure before Carry forward**	**18,395**	**13,793**	**10,849**	**-3,730**	**-27.04%**	**-1,130**	**-6.15%**
-410	**Anticipated Carry forward of Public Health grant**	**0**	**0**	**0**	**0**	**0.00%**	**-410**	**0.00%**
	Funded By							
1,610	Public Health Grant	-18,209	-18,208	**-18,550**	342	-1.88%	**1,610**	-8.84%
	S75 Agreement NHSE - HIV	-144	0	**0**	0	0.00%		0.00%
-70	Other Income	-42	-21	**-72**	51	-242.86%	**-70**	166.67%
1,540	**Income Total**	**-18,395**	**-18,229**	**-18,622**	**393**	**-2.16%**	**1,540**	**-8.37%**
0	**Net Total**	**0**	**-4,436**	**-7,773**	**-3,337**	**-**	**0**	**0.00%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Current Budget for 2015/16 £'000	Current Variance £'000	Current Variance %	Forecast Variance - Outturn £'000	Forecast Variance - Outturn %
1 Sexual Health STI testing & treatment	**4,299**	**-850**	**-24.2%**	**-155**	**-3.61%**
Part of 2015/16 savings plan. £170k savings to be achieved through predicted underspend through reduced use of the Peterborough Service, reduction in the contingency for unpredicted pressures and lower than expected uptake of the Chlamydia programme. NHS England invoice re HIV (£72k) relating to 2014/15 still not paid					
2 Sexual Health Contraception	**1,170**	**-131**	**-14.22%**	**-100**	**-8.55%**
Part of 2015/16 savings plan. £100k non-recurrent in-year savings to be achieved due to reduced activity in delivering Long acting reversible contraception (LARCs) in GP practices.					
3 Stop Smoking Service & Intervention	**1,099**	**-521**	**-63.00%**	**-295**	**-26.85%**
Part of 2015/16 savings plan. £295k savings to be achieved due to reduced activity from smoking cessation services.					
4 NHS Health Checks Programme	**719**	**-220**	**-40.7%**	**-230**	**-31.99%**
This underspend was created due to the delay in completing and implementing the Point of Care Testing and Data Software procurements which reflects the complexities of introducing the new processes into the 77 GP practices with NHS support. This includes complicated information governance and secure interfaces with GP practice data systems. The new systems will greatly increase the patient experience, efficiency and data robustness of the Programme which should also improve performance of the GP practices that are main providers of the Programme.					
5 Public Health Directorate	**2,567**	**-926**	**-43.2%**	**-150**	**-5.85%**
Part of 2015/16 savings plan. £150k savings to be achieved through vacancy management strategy.					

APPENDIX 3 – Grant Income Analysis

The tables below outline the allocation of the full Public Health grant, and includes an update for Quarter 3 of spend by other directorates

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Forecast Outturn Expenditure £'000	Expected / Actual Transfer to PH Reserves	Notes
Public Health Grant as per Business Plan	22,155	22,155	22,155		Ringfenced grant (excluding 0 – 5 funding) - Income
Children's 0 – 5 grant (Oct – March)	3,861	3,861			In Public Health directorate
Grant allocated as follows;					
Public Health Directorate	**14,319**	**14,348**			As detailed in report. £29k increase ref the transfer of a post from CS&T
Public Health Directorate, Children 0-5	**3,861**	**3,861**			
CFA Directorate	**6,933**	**6,933**			See following tables for Q3 update
ETE Directorate	**418**	**418**			See following tables for Q3 update
CS&T Directorate	**265**	**236**			£29k decrease ref the transfer of a post from CS&T to PH. See following tables for Q3 updates
LGSS Cambridge Office	**220**	**220**			

PUBLIC HEALTH MOU 2015-16 UPDATE FOR Q3

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	DAAT	£6,269k	Susie Talbot	NB31001-NB31010 Jo D'Arcy/Ali Wilson	05/01/2016	At the end of Q3 there had not been any current spend for the allocated budget for GP Shared Care, Nalmefene, Recovery Hub Coordinator as this is work in progress. Joe Keegan (DAAT Alcohol Coordinator) is awaiting details of spend for GP Share Care & Nalmefene from Public Health. We were awaiting Inclusion Q2 20% performance related invoices which we received early January 2016 so this will now show at year end. Q3 performance related invoices will be paid once the performance meeting has taken place and this agreed by the DACG. The predicted Q3 spend is based solely on 3/4 of the overall allocated budget so the predicted and actual spend will vary during the year depending on when invoices are received but we anticipate that all contracted payments will be made by then end of Q4. The only exception to this being the Inclusion Contract where the contract is based on 80% in advance quarterly and the remainder 20% performance related which is normally paid during the next quarter following the performance meeting. This is to ensure that Inclusion have met their targets in line with the contract agreement, the 20% performance related invoices are then agreed by the DACG members for payment. At the end of Q3 a prediction was made that there will be a possibility of an underspend in the PHG of around £78K. This is estimated from vacant posts which have not been filled and also from the Nalmefene & GP Shared care budget which to date has no current spend.	£ 1,469,654	£ 1,618,505	-£ 148,851	£ 6,199,000	**£4,606,154**	**£4,078,765**	**£527,389**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Reduction in Self Harm**	£189K			05/01/2016	**Training provision:** draft document covering local authority offer in terms of support for a whole school approach produced. Being circulated for comments and finalising **Training offer:** Ongoing. Governance meeting in January to promote staff wellbeing and CPFT training as well as Education Wellbeing Team services **Consistent sources of information:** CRC are undertaking this work and it will be ready Jan/Feb 2016 for launching **Costing and implementation of additional support:** This work is being implemented **Regular contributions to schools newsletters:** Ongoing, with regular input to CPFT training. Will be used to promote training offer document as well as links being made with Time to Change and Mind Campaigns Officer **Quality assurance framework:** Ongoing discussion to establish requirements **Diagramatic version of offer of support:** draft produced and circulated for feedback	£47,250	£45,249	£2,001	£189,000	**£141,750**	**£135,744**	**£6,006**
CFA	**Physical Activity in Older People**	£150k			05/01/2016	8/1/15 baseline data collection was completed with Day Centres. The main finding was that the current provision of physical activity is insufficient in quantity and quality in regards to NICE and CMO guidelines. Requirements re physical activity are not detailed in service specifications for day centres. However, many managers and trustees showed interest in increasing levels of provision, but will require more tailored support to enable this.					**£112,500**	**£112,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Childrens Centres**	£170k	Sarah Ferguson/Jo Sollars	CE10001 : Rob Stephens	05/01/2016	The overall aim of Cambridgeshire Children's Centres remains ensuring a healthy start to life for children aged 0-4 and ensuring readiness for school, whilst maintaining a focus on inequalities in the early years, and targeting support which will minimise the need to access specialist services where possible The Public Health funding is utilised as part of the total Children's Centre budget to improve health of children aged 0-5. In Q3 Children's Centres have been further involved in the planning and delivery of the winter 2015 Warm Homes programme. Representatives are working with Public Health to develop a cross-service breast feeding strategy for Cambridgeshire. Children's Centres have worked with Public Health to develop pilot sites for selling of Healthy Start Vitamins, to improve take up of vitamins, and raise wider awareness of Children's Centre services Close alignment and joint working with community health colleagues in Health Visiting, Family Nurse Partnership and Maternity Services is established for all Children's Centres. Work has been initiated to ensure arrangements with Health partners are consistent and functionally effective at a community level for families as service structural change is brought in across the system.	£42,500	£42,500	£0	£170,000	**£127,500**	**£127,500**	**£0**
CFA	**Education Well-Being Team : KickAsh, Life Education (LEC) and other tbc**	£56k	Amanda Askham	CB40401 : Adam Cook	05/01/2016	Kick-Ash : £25k confirmed spend (two additional schools) - on track Life Education : £15k confirmed spend - on track Training Days for school nurses : £2,500 - currently being negotiated - delayed due to reconfiguration of service/waiting to hear from SN service about training days Research and Development off resources on Health Relationships : £1,500 - on track HBT/SRE resources and training : £3k - on track SRE Theme-set for secondary schools : £9.100 - on track	£17,650	£14,650	£3,000	£56,100	**£42,700**	**£40,200**	**£2,500**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CFA	**Chronically Excluded Adults (MEAM)**	£93k	Ivan Molyneux	MN92145 : Matt Moore	05/01/2016	The CEA Team continues to work hard to ensure that the co-ordinated approach is supported by relevant services. The service explansion into Peterborough has been successful with the service embedding the CEA approach to address the issues facing their complex needs population, the CEA team continue to work with colleagues in Peterborough on what promises to be an exciting partnership A three year strategy is currenty being put together to take forward the CEA work across Cambridgeshire and its continued explansion into Peterborough Work continues with voices from the frontline in partnership with MEAM. The CEA service is increasingly receiving referrals from complex needs, excluded adults at risk of homelessness and expects over the next year to increase work around homelessness prevention for 'repeat returner' clinets who have become excluded, as well as linking existing homeless service users to services This year the CEA Service will be aiming to produce an analysis of this approach to see where its application may benefit other service user groups or systems. CEA will also be looking at current and former clients to see where fairer and sustainable access may be achieved which will be done with no professional assumptions on what housing choices should be made This is with the aim not only of continuing to allow access to Chronically Excluded Adults safe accommodation, but to see how this can achieve longevity across the sector	£28,051	£28,211.95	-£160.95	£110,000	**£84,153**	**£82,246**	**£1,907**
CFA	**Housing related support**	£6k	Alison Bourne		05/01/2016	Huntingdonshire Floating Support Service continuing to provide support to avoid homelessness, and continues to meet set targets East Cambs Floating Support Service as above, and continues to meet set targets Ferry Project contract provides for single homless people in Fenland and is continuing to meeting targets Cambridge Cyrenians continues to meet targets Jimmy's continues to support homelessness with 22 beds. Metropolitan Cambridge Mental Health Cluster - Supported Housing/Visiting support, continues to provide 148 supported accommodation units	Total budget is £3,833,156.75, the Public Health element equates to 0.16% of the total, and as such is impossible to split out			£6,000	**£4,500**	**£4,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	Reducing Road Traffic Injuries	170k			05/01/2016	**Child Road Safety** **Childrens Traffic Club:** Total of 2365 registrations to end December 2015 (103 nurseries) **Advice and information to schools**: Safety Zone delivered in Ely and Cambridge - approx 800 Y5 pupils Since the end of September responded to requests for advice/support from the following schools/school communities about specific issues: Cambourne, Teversham, Foxton, Willingham, Cottenham VC, St Faiths, St Matthews, Hills Road, Trumpington Meadows, Over, Somersham, Brampton, St Ivo, Hinchgbrooke, St Peter's (Hunts), Wyton on the Hill, Thorndown, Wheatfields, St Helens, The Vine, Alderman Jacobs, Shirley, Morely Memorial, Wisbech St Mary and Elsworth Advice information provided to the following 3rd parties offering road safety/sustainable travel support to schools in Cambridgeshire: Luminous, Hegsons, Atkins, SUSTRANS, Peter Brett Associates LLP, Horizon Learning Foundation **Intensive work with 15-20 schools**: total of 9 schools signed up to Junior Travel Ambassador Scheme - 45 JTA's (Y5 pupils) Total delifery outcomes to end December. Walksmart delivered to 296 pupils (9 schools), ScootSmart delivered to 231 pupils (4 schools), PedalSmart delivered to 20 pupils (1 school) 6 volunteers trained to deliver TravelSmart schemes at three schools - not yet delivered any pupil training **Young Drivers/Riders** **Drive to arrive:** issue with available partner resource for Drive2Arive events meant two had to be cancelled in December. Planning underway for 'Fresher's Fair' style event to be held in June 2016 **Work with locality teams:** awaiting outcomes. **Explor additional interventions:** targeting profile has been completed and is appended. Work is underway to develop projects for delivery in 2016/17 based on this evidence **Vulnerable Road Users** Explore better interventions to improve the safety of motocyclists : no activity undertaken over the winter months. **Road User Behaviour Change** **Anti-Drink/Drug Driving campaigns**: waiting for analysis of Christmas Drink Driving Campaign. Planning for national drug driving campaign in Feb/March 2016 **Distraction campaigns (mobile phones) :** no additional work **Speed campaigns** : campaign planning for January **Seatbelt wearing campaigns**: no additional work **Explore research partnerships:** research proposal with CUH to be submitted in January. Internal research to be undertaken in Q4							

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	**Active Travel**	£125			05/01/2016	**Market Town Strategies** PH and TIPF to enage communities in the consultation and ensure that active travel is involved in this Plan to run more detailed focus group style consultations with harder to reach groups which will have a gocus on public health **Active Travel** Interventions to overcome safety barriers: Currently 47 schools active on STARS with 26 achieving bronze and 1 achieving gold. Additional 9 schools undertaking travel plans for planning purposes (not using STARS) Explore better interventions to improve the safety of cyclists: Be Bright Be Seen campaign in October/November using a range of media Interventions to improve pedestrian safety: summary report compiled but more in depth investgation due in Q4	£44,050	£24,755	£19,295	£125,000	**£95,650**	**£63,195**	**£32,455**
ETE	**Community Engagement in Fenland**	£100			05/01/2016	Contract has now been awarded : refer to Val Thomas (Consulant in Public Health)							**£0**
ETE	**Kick Ash**	£31k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	05/01/2016	Emulf school have withdrawn from the programme, leaving 9 schools fully engaged in this school year, and two further schools (Longsands, St Neots and St Ivo) involved with a reduced delivery, including an education day and work within school with the year 8's. Business visits will be offered to St Ivo for the New Year Sessions with the schools involved discussion of the role of Trading Standards, its purpose within KickAsh and how they can influece and support local businesses in the campaign to prevent underage smoking and sales. We work with them to prepare their own preventative messages and design their own delivery approach to businesses. Discuss the new laws around the E-Cigarettes, nicotine inhaling products, smoking in cards with children present and plain packaging. Discuss with mentors ways in which the awareness display in schools can influence their peers with increased knowledge into the effects and dangers of smoking **Ely Community College**: completed 3 sessions with 19 mentors. Two mentors from Ely carried out visits to 6 premises within Ely and Littleport where they introduced and discussed the KickAsh project and the policies for the prevention of underage sales. **Cromwell Academy, Chatteris** : completed 3 sessions with 26 mentors **Cambridge North Academy** : completed 2 sessions with 19 mentors **Witchford Village College** : carred out visits to 6 premises with 5 mentors - using school mini bus Dates for future visits have been offered to 7 Schools: Cottenham, Cambridge North Academy and Bottisham schools have engaged in discussion and we have agreed they will receive 5 lunchtime visits to discuss actions for the various activities throughout the year. ensure they are on track and are working towards completing the activities required Organisation of the Rock Choir Flash mob in January is underway with commitment from 7 schools so far	£3,750	£4,240.46	-£490	£15,000	**£11,250**	**£9,292**	**£1,958**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
ETE	**Alcohol Underage Sales**	£15k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	05/01/2016	Review of new licence applications Challenge 25 - underage sales business advice and guidance issued to 13 new alcohol licenced businesses Licencing Act representation for two new licence applications Safety Zones activity includes underage sales information	£3,750	£2,775.55	£974	£10,000	**£11,250**	**£8,765**	**£2,485**
ETE	**Illicit Tobacco - joint working**	£7k	Elaine Matthews or Aileen Andrews	JM12800 : John Steel	05/01/2016	3 x Magistrates warrants obtained for entry to premises. All 3 shops raided 22 October, detection dogs used. 14,000 cigarettes seized from concealments within shops, one person arrested and interviewed under caution that day. Others interviewed post raids. Reports written and 3 court cases pending and one investigation ongoing. Financial investigations ongoing. Early preparation for proposed enforcement in mid-March 2016 and the summer Intelligence work completed for dissemination to Cambs police One alcohol licence objection on the grounds of illicit tobacco being found on 22 October	£1,750	£8,451	-£6,701	Exceeding £7k	**£5,250**	**£16,469**	**-£11,219**
CS&T	**Community Engagement in Fenland**	£28.5k			05/01/2016	Contract has now been awarded : refer to Val Thomas (Consulant in Public Health)							**£0**
CS&T	**Research**	£22k	Mike Soper	KH5000 : Maureen Wright	05/01/2016	The majority of the funding is used to maintain / develop the CambridgeshireInsight website include maintaining the content for Health Joint Strategic Needs Assessment (http://www.cambridgeshireinsight.org.uk/jsna). The contribution is also used to partly support the Research Team's work on population forecasting and estimating that is used heavily by Cambridgeshire Health Services. Work carried out during Q3 includes: Completion of the business plan consultation on behalf of all Cambridgeshire County Council directorates Roll out of Acorn Demographic profiling tool, making this available for use for all Public Health staff - this will be particularly useful in shaping Public Health Campaign work	£5,500	£5,500	£0	£22,000	**£16,500**	**£16,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CS&T	**Health & Wellbeing Board support**	£27k	Dan Thorpe	KA2000 : Maureen Wright	05/01/2016	With supervision from the Director of Public Health, approx 2.5 days per week of the Policy and Projects Officer's time, who sits within the Policy and Business Support Team of Customer Service and Transformation. Support during Q3 has included: Following up on actions and work arising from the development day held in October 2015, including the setting up of a working group and planning for its first meeting Supporting the effective functioning of the Health and Wellbing Board Supporting the effective functioning of the Health and Wellbeing Board Support Group Researching and preparing reports to the Health and Wellbeing Board, including on key policy/ strategy changes Presenting relevant reports at the Health and Wellbeing Board Support Group meetings, such as on the prevention strategy Agenda planning for HWB support group and (working with democratic services) the HWB meetings Co-ordinating and preparing the quarterly stakeholder newsletter - currently working on the January issue The above is in addition to ongoing, reactive support as required.	£6,750	£6,750	£0	£27,000	**£20,250**	**£20,250**	**£0**
CS&T	**Communications support**	£25k	Matthew Hall	KH60000 : Maureen Wright	05/01/2016	Q3 was a busy time with the lead up to some major campaigns around Christmas and New Year. Highlights include: Planning and delivering spectrum Public Health campaigns suc as Stoptober, Health Harms, Keep Warm Keep Well, dry January, Sugar Smart, Falls prevention, Volunteering to support older people. These include planning, developing material, working with the media, social media etc Supporting Public Health on the budget updates, including the media briefing, news release, staff briefings etc. Working closely with Val Thomas and other consultants on reactive media enquiries on subjects such as obesity, smoking etc Working with the meda to maximise opportunities for Public Health Supporting Health Committee	£6,250	£6,250	0	£25,000	**£18,750**	**£18,750**	**£0**
CS&T	**Strategic advice, strategy dev etc**	£22k	Sue Grace	KA20000 : Maureen Wright	05/01/2016	The main strategic activity continues to be the development of the new operating model. Most recently this has involved; the change of Chief Executive at the Council and the new vision for the Council that this has brought, responding to member impetus in fast-tracking implementation of an outcome based budgeting approach, and responding to Central Government accouncements that impact the Council's budget Activity in Q3 has also included assisting the Council in responding to unexpected Government accouncements regarding Public Health ring-fenced and savings targets. The Council's Business Planning Process has had to adapt swiftly in response in order to meet political budget-setting deadlines.	£5,500	£5,500	0	£22,000	**£16,500**	**£16,500**	**£0**

Directorate	Service	Total	Contact	Cost Centre/ Finance Contact	Q3 Info requested	Q3 Update	Q3 expected spend	Q3 Actual Spend	Variance	Predicted spend Y/E	YTD Expected spend	YTD Actual spend	Variance YTD
CS&T	**Use of Contact Centre**	£6.5k	Joanne Tompkins	KD23500 : Maureen Wright	05/01/2016	Deivery of the Winter Warmth service is underway (from 1 October 2015) with a closure date of March 2016	£1,625	£1,625	0	£6,500	**£4,875**	**£4,875**	**£0**
CS&T	**Emergency Planning Support**	£5k	Stewart Thomas	KA40000 : Maureen Wright	05/01/2016	On-going close working with the Health Emergency Planning and Resilience Officer (HEPRO) on a number of emergency planning tasks: Close collaboration of the Emergency Management Team in detailing the outputs from Exercise Numbus which took place on 6/7 November 2015 Provision of emergency planning support when the HEPRO is not available Provision of out of hours support for the Director of Public Health (DPH), ensuring that the DPH is kept up to date on relevant incidents that occur, or are responded to, outside normal working hours as part of the 24/7 duty provision On-going intervention to secure a review of the 'Excess Deaths Plan' in support of the Pandemic Flu arrangements	£1,250	£1,250	0	£5,000	**£3,750**	**£3,750**	**£0**
CS&T	**LGSS Managed overheads**	£100k	Sue Grace	UQ10000 : Maureen Wright	05/01/2016	This continues to be supported on an ongoing basis, including: Provision of IT equipment, office accommodation, telephony and Members' allowances	£25,000	£25,000	0	£100,000	**£75,000**	**£75,000**	**£0**
LGSS Cambridge Office	**Overheads associated with public health function**	£220k	Maureen Wright	QL30000, RL65200, TA76000 : Maureen Wright	05/01/2016	This covers the Public Health contribution twoards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance 20k, HR 25k, IT 20k. The remaining £155k is a general contribution to LGSS overhead costs	£55,000	£55,000	£0	£220,000	**£165,000**	**£165,000**	**£0**

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	18,222	
Virements		
Non-material virements (+/- £160k)	0	
Budget Reconciliation		
Transfer of post from CS&T to PH	29	Contra CS&T Research grant income
S75 agreement with NHS(England) for £144,000 income to fund HIV commissioning which we have undertaken on their behalf	144	
Current Budget 2015/16	**18,395**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2015	2015/16		Forecast Balance at 31 March 2016	Notes
		Movements in 2015/16	Balance at 31 Jan 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	952	0	952	**542**	**To be part used to meet in-year PH grant reduction**
subtotal	**952**	**0**	**952**	**542**	
Equipment Reserves					
Equipment Replacement Reserve	0	0	0	0	
subtotal	**0**	**0**	**0**	**0**	
Other Earmarked Funds					
Healthy Fenland Fund	500	0	500	400	**Anticipated spend over 5 years**
Falls Prevention Fund	400	0	400	200	**Anticipated spend over 2 years**
NHS Healthchecks programme	270	0	270	**0**	**Delayed 14/15 spend**
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	700	**2-3 years funding commence mid-year 15/16.**
Other Reserves (<£50k)	61	-61	0	0	**Service earmarked reserves**
subtotal	**2,081**	**0**	**2,020**	**1,300**	
TOTAL	**3,033**	**-61**	**2,972**	**1,842**	

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

Fund Description	Balance at 31 March 2015	2015/16		Forecast Balance at 31 March 2016	Notes
		Movements in 2015/16	Balance at 31 Jan 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	164	17	181	90	Expenditure anticipated over 2 years.
Improving Screening & Immunisation uptake	0	9	9	0	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**164**	**26**	**190**	**90**	

APPENDIX 6 Performance

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

Below previous month actual
No movement
Above previous month actual

The Public Health Service Performance Management Framework (PMF) for December 2015 can be seen within the tables below:

Measures										
Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month targe	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	99%	99%	G	99%	98%	99%	← →	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	89%	89%	G	89%	80%	89%	← →	
Dhiverse : % of people newly diagnosed offered and accepted appointments	100%	100%	100%	100%	G	100%	100%	100%	← →	
Access to contraception and family planning (CCS)	7200	5400	8441	151%	G	152%	600	151%	↓	
Number of Health Checks completed	18,000	13,500	10695	79%	R	77%	4500	82%	↑	HCs reported quarterly (this is Q3 / end of Dec 15 data)
Percentage of people who received a health check of those offered	45%	45%	41%	41%	A	36%	45%	41%	↑	HCs reported quarterly (this is Q3 / end of Dec 15 data)
Number of outreach health checks carried out	1,050	0%	0%	0%	N/A	N/A	0	0%	N/A	This is part of the new Lifestyle Service contract that began on June 1 . Training commenced 18th Aug 2015. HC targets been revised to take into account mobilisation period.
Smoking Cessation - four week quitters	2237	1170	1078	92%	A	91%	173	98%	↑	October 2015 figures based on timelinesss trajectory

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	54%	93%	G	57%	58%	54%	↔	This contract was transferred to CCC on October 1st 2015 from NHSE. Performance figures continue from April 2015. * This 57% is a stretch target, England Q1 average for breastfeeding was 43.4%.
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	/	31%	62%	R	26%	54%	44%	↑	This is a new service this year and has stretch targets to increase coverage.
Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	90%	90%	92%	102%	G	98%	90%	97%	↑	
Health visiting mandated check - Percentage of children who received a 6 - 8 week review by 8 weeks	90%	90%	94%	104%	G	96%	90%	94%	↓	
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	93%	93%	A	94%	100%	92%	↓	Reflecting on figures for Q1 & Q2, if 'not wanted and not attended' figures included, YTD figure rises to 95%
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	86%	96%	A	86%	90%	84%	↓	Reflecting on figures for Q1 & Q2, if 'not wanted and not attended' figures included, YTD figure rises to 93%
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	249	N/A	N/A	43	N/A	11	↓	This data is part of new KPIs monitoring. No specific targets are set in the first year, the aim is to benchmark the service provided.
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	1001	N/A	N/A	183	N/A	85	N/A	This data is part of new KPIs monitoring. No specific targets are set in the first year, the aim is to benchmark the service provided.

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
School Nursing : Contacts made	9000	4154	4616	111%	G	119%	923	102%	↓	These are Sept figures. KPI format under review with CFA Commissioners.
School Nursing : Group activities	4784	2208	1947	88%	G	112%	490	4%	↓	
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	90%	92%	102%	G	N/A	90%	92%	N/A	This is reported on Annually. From June 2015 this service isprovided by SLM/Everyone Health. Measurements to commence in Dec 2015& Jan 2016.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	90%	95%	106%	G	N/A	90%	95%	N/A	
Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1675	1075	925	86%	R	71%	175	61%	↓	The new Lifestyles contract started June 1 2015. Many of the indicators were not populated in the initial months as the Service was recruiting and establishing itself or the outputs were not available in the timeframe as the interventions take place over several months.
Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	1424	914	735	80%	R	63%	149	58%	↓	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	908	583	493	85%	R	60%	95	33%	↓	Some of these clients will have been referred to and were seen initially by the former Service. Clients may be seen by a Health Trainer for up to a year

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	335	215	727	338%	G	211%	35	171%	↓	
Number of physical activity groups held **(Pre-existing GP based service)**	555	270	216	80%	R	47%	60	53%	↑	Service was still recruiting to posts and priority has been given to the core Health Trainer Service Activity i.e. referrals for Health Plans
Number of healthy eating groups held **(Pre-existing GP based service)**	555	270	6	2%	R	0%	60	0%	↔	Service was still recruiting to posts and priority has been given to the core Health Trainer Service Activity i.e. referrals for Health Plans
Recruitment of volunteer health champions **(Pre-existing GP based service)**	20	14	0	0%	R	0	2	0	↔	Service was still recruiting to posts and priority has been given to the core Health Trainer Service Activity i.e. referrals for Health Plans
Personal Health Trainer Service - number of referrals received (Extended Service)	625	250	125	50%	R	23%	100	12%	↓	Service was still recruiting to posts
Personal Health Trainer Service - number of initial assessments completed (Extended Service)	531	213	111	52%	R	23%	85	16%	↓	Service was still recruiting to posts
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	188	19	2	11%	R	0	19	0	↔	An individual may take up to year to complete a Personal Health Plan
Number of referrals from Vulnerable Groups (Extended Service)	125	50	83	166%	G	60%	20	10%	↓	
Number of physical activity groups held (Extended Service)	600	270	3	1%	R	3%	90	0	↓	Service was still recruiting to posts and establishing itself and was not rag rated

Measure	Y/E Target 2015/16	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of healthy eating groups held (Extended Service)	600	270	0			0	90	0	N/A	Service was still recruiting to posts and establishing itself and was not rag rated
Recruitment of volunteer health champions (Extended Service)	21	12	0			0	3	0	N/A	Service was still recruiting to posts and establishing itself and was not rag rated
Number of behaviour change courses held	30	15	0			N/A	4	0%	N/A	Programme scheduled to start in the February. Course currently being advertised.
%r of Tier 2 clients recruited who complete the course and achieve 5% weight loss	300	128	4	3%	R	0%	45	7%	↓	Please note that the minimum time for both children and adult weight management course is 3 months Unable to report weight loss on those patients who transfer from previous provider as no baseline data was provided. This figure therefore potentially underestimates the number achieving the weight loss.
% of Tier 3 clients recruited completing the course and achieve 10% weight loss	11	0	0			N/A	0	0%	N/A	Each patient goes through a 6 months course
% of children recruited who completie the weight management programe and maintain or reduce their BMI Z score by agreed amounts	TBD	0	0			N/A	0	0%	N/A	First course to start in January

* All figures received in January 2016 relate to December 2015 actuals with exception of Smoking Services, which are month behind and Health Checks which are reported quarterly.

** Direction of travel against previous month actuals

*** The assessment of RAG status for services where targets and activity are based on small numbers may be problematic on a month by month basation. Therefore RAG status should be interpreted with caution.

Agenda Item No: 11

HEALTH COMMITTEE TRAINING PLAN	Updated from 21 JanuaryHealth Committee Meeting	

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
1.	System Transformation (Raised at Health Committee)	Provide members with an overview of the current System Transformation Programme led by CPCCG.	1	13th Aug 2015	Public Health	Training Seminar	Health Committee members & Subs		53% health committee members
2.	Business planning 2016/17	Provide members with an overview of the business planning decisions for the council	1	1st Oct 2015	Public Health	Training Seminar	Health Committee members & Subs		92% Health committee members (including substitutes)
2.	New legislation on the Care Act (Raised at spokes)	Members develop a clearer understanding of the Care Act and its implications in relation to Health.		TBC	Democratic Services	Information to be circulated to spokes	Health Committee members & Subs		
3.	Equality & Diversity Issues (Raised at spokes)	Members are provided with an overview of equality and diversity issues.		TBC	Democratic Services	Full members seminar	Health Committee members & Subs		
4.	County Council Directorate structures & Officer responsibility (Raised at Health Committee)	Members to understand variety of Council responsibilities		TBC	Democratic Services	Information available on Camweb	Health Committee members & Subs		Completed

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
5.	Primary Care &NHS funding & Commissioning responsibilities (Raised at Health Committee) E-Hospital Update from CUHFT	Members understand the relationships with Primary care &various commissioning accountabilities within the NHS e.g. role of NHS England, CCG and Department of Health. To also now include the role of Community Pharmacists in the seminar	1	3rd March	Public Health	Training seminar	Health Committee members & Subs		
6.	Mental Health Promotion and prevention activity (Raised at Health Committee)	Members to have an overview of the current Mental Health Promotion prevention work particularly partnership arrangements.	2	17th Dec 2015	Public Health	Update provided forDecembe r Health Committee	Health Committee Members		Completed
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	3	14th April TBC	Public Health	Training Seminar	Health Committee members & Subs		
9.	Health Scrutiny Skills Part 2	To understand Health Scrutiny in the context of Health inequalities and the transformation agenda.	2	11th Feb 2016	Public Health & Centre for Public Scrutiny	Training seminar	Places for 3 committee members only	TBC	100% attendance of allocated places

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
10.	Health Scrutiny Skills Part 3 (East of England Scrutiny Conference)	Encouraging communication and joint working between scrutiny at different tiers of government and across political boundaries; Provide members with a toolkit for scrutiny		21st March 2016	Scrutiny without Boundaries Workshop (Essex CC)		Places for 3 committee members only.	2 spaces confirmed	
11.	Public health 0-5 services	To improve understanding of public health 0-5 services (health visiting and family nurse partnership) transferred to CCC in October 2015.	1	TBC May?	Public Health	Training seminar (potentially joint with CYP Committee)	Health Committee Members and subs		

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

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

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN

Cambridgeshire County Council

Agenda Item No: 12

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
[14/04/16] Provisional Meeting	*Workshop on scrutiny skills* *Quality Accounts*			22/03/16 9.00am	*01/04/16*	*05/04/16*
12/05/16	Co-option of District Councillors (and/or July)	Ruth Yule		21/04/16 3.00pm	28/04/16	03/05/16
	Public Health Finance and performance report	Chris Malyon/ Liz Robin				
	Provision of support for the physical health of those with severe mental illness					
	Effectiveness of smoking cessation services					
	Health System Transformation Board – voting authorisation	Liz Robin				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Annual Public Health Report	Liz Robin				
	Scrutiny Item: CUHFT Progress update from CQC Inspection	Kate Parker				
	Scrutiny Item: Quality Accounts sign off	Kate Parker				
	Scrutiny Item: update on the development of the integrated NHS 111 and Out of Hours service	Kate Parker				
	Scrutiny Item: Non-Emergency Patient Transport Services outcome of consultation	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[16/06/16] Provisional Meeting				19/05/16 3.30pm	*03/06/16*	*07/06/16*
14/7/16	Co-option of District Councillors (and/or May)	Ruth Yule		23/06/16 9.00am	01/07/16	05/07/16
	Public Health Finance and performance report	Chris Malyon/ Liz Robin				
	Scrutiny Item: Older People and Adult Community Services – update on developments since the termination of UnitingCare contract	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Public Health Risk Register (six-monthly update)	Tess Campbell				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Agenda plan and appointments to outside bodies	Ruth Yule				
[11/08/16] Provisional Meeting				21/07/16 3.30pm	*29/07/16*	*02/08/16*
08/09/16	Public Health Finance and performance report	Chris Malyon/ Liz Robin		18/08/16 3.30pm	25/08/16	30/08/16
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[06/10/16] Provisional Meeting				15/09/16 3.30pm	*23/09/16*	*27/09/16*
10/11/16	Public Health Finance and performance report	Chris Malyon/ Liz Robin		20/10/16 3.30pm	28/10/16	01/11/16
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report)	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[01/12/15] Provisional Meeting				17/11/16 3.30pm	*18/11/16*	*22/11/16*

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
12/01/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		15/12/16 3.30pm	03/01/17	29/12/16
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[16/02/17] Provisional Meeting				26/01/17 3.30pm	*03/02/17*	*07/02/17*
16/03/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		23/02/17 3.30pm	03/03/17	07/03/17
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[13/04/17] Provisional Meeting				23/03/17 3.30pm	*31/03/17*	*04/04/17*
08/06/17	Co-option of District non-voting Members	Ruth Yule		20/04/17 3.30pm	25/05/17	30/05/17
	Public Health Finance and performance report	Chris Malyon/ Liz Robin		18/05/17 3.00pm		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				

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

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

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

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

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

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

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