HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 08 September 2016

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

14:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**Minutes – 14 July 2016 and Action Log**	**4 - 15**
3	**Petitions**	

DECISIONS

4	**Finance and performance report – July 2016**	**16 - 57**

SCRUTINY ITEMS

5	**Mental Health Vanguard update (Plus Appendix on PRISM; new primary care service for Mental Health)**	**58 - 63**

The Health Committee comprises the following members:

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

Councillor Paul Clapp Councillor Adrian Dent Councillor Lynda Harford Councillor John Hipkin Councillor Peter Hudson Councillor Mervyn Loynes Councillor Lucy Nethsingha 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 14th July 2016

Time: 2.00pm to 16.40pm

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

District Councillors M Abbott (Cambridge City Council), A Dickinson (Huntingdonshire District Council)

Apologies: County Councillors L Harford, J Hipkin, P Hudson, S van de Venn and District Councillors, M Cornwell (Fenland), S Ellington (South Cambridgeshire), and C Sennitt (East Cambridgeshire)

The Chairman drew Members attention to the release of the National Audit Office report on the ending of the Uniting Care Contract and offered to speak with Members on the matter outside of the meeting.

229. DECLARATIONS OF INTEREST

There were no declarations of interest.

230. MINUTES – 10 MARCH 2016 AND ACTION LOG:

The minutes of the meeting held on 12th May 2016 were agreed as a correct record and signed by the Chairman.

The Action Log was noted.

231. CO-OPTION OF DISTRICT COUNCIL REPRESENTATIVES

It was resolved to co-opt as non-voting members of the Committee:

- From Cambridge City Council: Councillor Margery Abbott
- From East Cambridgeshire District Council: Councillor Carol Sennitt
- From Fenland District Council: Councillor Mike Cornwell
- From Huntingdonshire District Council: Councillor Angie Dickinson.

232. PETITIONS

There were no petitions.

233. FINANCE AND PERFORMANCE REPORT – CLOSEDOWN 2015/16.

The Committee received the Closedown 2015/16 Finance and Performance report for Public Health. Officers highlighted that the Public Health Grant income was £1.6m less than anticipated due to an in year reduction to the Public Health Grant. Savings on expenditure budgets had been achieved together with greater income received than had been forecast. Therefore, the surplus of £198k had been transferred to the Public Health Grant reserves which produced a balanced year end position.

In the course of discussion, Members:

- Queried whether the surplus at year end could be utilised by other areas of the Council. Officers explained that the Public Health Grant was ring-fenced and therefore could only be used for public health purposes and did not form part of the Council's overall budget.

- Questioned whether the chlamydia screening programme would result in problems in the future with fewer individuals being tested. It was explained by officers that screening programmes were more targeted, focussed on areas of high risk and prevalence. There were also savings realised from the renegotiation of the testing contract.

- Urged caution regarding achieving a budget surplus as it may lead to higher costs in the future.

- Requested greater clarity regarding performance in terms of outcomes in future year end reports. **ACTION**

It was resolved to review and comment on the report.

234. FINANCE AND PERFORMANCE REPORT – MAY 2016

The May 2016 Finance and Performance report was presented to the Committee. Members' attention was drawn to the budget set for the Public Health Directorate for 2016/17 that incorporated savings as a result of the reduction in Public Health grant for 2016/17 and consolidated the in-year reduction made to the grant in 2015/16. Members noted that it was forecast that the Public Health budget would balance at year end. Officers explained that the May iteration of the Finance and Performance Report was a more effective tool for analysing the previous year's performance as more information was available than when the closedown report was produced. Key areas of performance were highlighted to Members including; smoking cessation services that had been affected in previous years due to the uptake of electronic cigarettes had now stabilised and there was confidence that the services added value, the integrated lifestyle services suffered from recruitment issues that had now been resolved and there was a visible improvement in performance, childhood obesity rates were falling ahead of the national trend, there was some improvement in life expectancy rates but there were issues regarding hitting targets for health inequalities in more deprived areas.

During discussion Members:

- Sought greater clarity regarding life expectancy and health outcome rates across the county and questioned whether there was data available at Division level. Officers explained that life expectancy varied across Divisions for a number of reasons including; demographics and variances of wealth across Divisions, there was also a problem with statistical reliability and small numbers, and that up to date data was not always available at that level. The majority of the county exceeded the national average for life expectancy; Fenland was lower but in line with the national average and had improved in recent years. Members noted that there were areas within Fenland, Cambridge City and Huntingdonshire that had poorer life expectancy.

- Noted that work had been undertaken to improve access to health care in order that individuals that suffered with terminal conditions could increase their life expectancy. Attention was drawn to advice from the World Health Organisation (WHO) that identified that the lifestyle factors such as smoking, drinking, diet and exercise were very important in life expectancy.

- Requested a system wide review of health outcomes, including life expectancy across Cambridgeshire that focussed on the reasons for inequalities be presented to the Committee at its January meeting. **ACTION**

- Questioned why some health inequalities appeared to be widening across the county. Officers explained that although targets were being achieved in some cases, it was a far more challenging environment to work in. Evidence highlighted that more deprived areas required more resources to achieve desired outcomes, with people requiring more support to quit smoking for example, than in more affluent areas.

- Emphasised poor diet as a contributory factor in health outcomes.

It was resolved unanimously to note the report.

235. PLANNED CONSULTATION ON COLLABORATION BETWEEN HINCHINGBROOKE HEALTH CARE NHS TRUST AND PETERBOROUGH AND STAMFORD NHS FOUNDATION TRUST

The Committee received a report and presentation providing background information relating to the current proposals for collaboration between Hinchingbrooke Healthcare NHS Trust and Peterborough and Stamford NHS Foundation Trust.

In attendance to respond to Members' questions and comments were

- Alan Burns, Chairman, Hinchingbrooke Health Care NHS Trust
- Lance McCarthy, Chief Executive, Hinchingbrooke Health Care NHS Trust
- Stephen Graves, Chief Executive, Peterborough NHS Trust.

The position at Hinchingbrooke Hospital had been very difficult for more than a decade. The proposals for collaboration between Hinchingbrooke and Peterborough were trying to build a clear sustainable future for the hospital.

In response to Members' questions officers:

- Highlighted a work stream regarding core elective surgery with 200 patients have received care at Hingchingbrooke hospital however, this alone would not achieve viability for the hospital.

- Confirmed that following detailed analysis and scoring of the possible options a merger between Hinchingbrooke and Peterborough was the best option for recurrent savings and the effective integration of services.

- Confirmed that if the merger took place then it was permanent and therefore was a key driver to making the plans work.

- Noted the public perception of the proposals and how important the services provided by Hinchingbrooke Hospital were to residents in across the county. Officers explained that savings were to be realised through the sharing of back office functions such as IT, human resources and the Trust Board. Sharing of those functions would provide greater economies of scale and the organisation would therefore be able to negotiate far more effectively when undertaking procurement exercises.

- Provided details on the difficulties Hinchingbrooke Hospital was experiencing regarding the recruitment of doctors. In the last year 22 jobs had been advertised in total, 42 times which resulted in a significant number of the vacant positions being filled by locums and agency staff at great cost. Small hospitals were not able to attract candidates due to a lack of ability for doctors to specialise and poor shift rotas. A merged organisation would create large departments with better rotas and therefore would be a more attractive place to work.

- Noted that effective communication had to take place with the public and that the presentation slides appeared to suggest that services would move between the 2 hospitals.

- Confirmed that approximately 90% of the clinical services offered were the same at both hospitals with some additional services provided at Peterborough Hospital and that the medial treatments currently available at each site would continue to be available following a merger. Officers explained that changes would take place as treatments develop and new priorities emerged.

- Confirmed that the Clinical Commissioning Group (CCG) had been involved throughout the development of the proposals but a quality impact analysis had not yet been undertaken because the plans were not sufficiently developed for one to take place.

- Accepted that both hospitals had a difficult public image to be overcome and it would therefore be challenging to attract staff. However, improvements were taking place and the next Care Quality Commission (CQC) report would demonstrate that.

- Explained that if a merger did not take place then further work would have to be undertaken regarding the possible options regarding the sustainability of the hospitals.

- Confirmed that Stamford Hospital was approximately 15 miles north of Peterborough and explained that services were provided at other hospitals across the county including Doddington and Ely. Officers explained that doctors and specialist nurses would move between the hospitals rather than patients moving between hospitals.

- Drew Members attention to the level of staff engagement that had taken place during the development of the proposals. Clinicians had met numerous times across the county to discuss the proposals and the vast majority of staff welcomed the proposals.

- Noted that it was important for the public message to be clear and concise, but explained that any decisions regarding the provision of services at either hospital, while views were able to be expressed by the hospitals, was a matter for the CCG.

The Chairman emphasised the importance of communication and the high level of public interest in the matter and requested greater clarity for the future on what the changes meant for individual patients.

The Chairman proposed with the agreement of the Committee that further proposals regarding a joint scrutiny arrangements with Peterborough City Council and other Local Authorities be progressed subject to their agreement.

It was resolved

a) to consider the information provided

b) to proceed with further joint scrutiny of the proposals in collaboration with Peterborough City Council and other Local Authorities subject to their agreement.

236. PUBLIC HEALTH RISK REGISTER UPDATE

The Committee received the Public Health Risk Register. Officers drew the attention of Members to paragraph 2.5 of the report which confirmed that the Committee's request that Risk 11: Failure to address health inequalities, particularly in the north of the county had been added to the Corporate Risk Register. Risk 13: Childhood Immunisation Targets – rates of immunisations, below national average with potential risk to public health of children, was highlighted to Members; childhood immunisations were behind target but work was taking place that would address the issue.

During discussion Members:

- Highlighted the Healthy Weight Strategy and the potential risks to it if organisations failed to cooperatively work together. Members therefore requested that the risk of organisations not working effectively together be placed on the register. **ACTION**

- Requested that a risk be added to the Risk Register regarding bullying in schools. Officers confirmed that an anti-bullying strategy was being developed in conjunction with Children, Families and Adult Services (CFA). Officers agreed to discuss the matter further with the Member concerned following the meeting. **ACTION**

- Noted the Public Health England initiative regarding lung health and early cancer diagnosis.

- Questioned whether concerns should be raised with Public Health England regarding immunisations. Officers explained that childhood immunisations targets were now mainly being met but targets for administering the flu vaccination to at risk groups was not. It was therefore proposed with the Committee's agreement that the Committee expressed its concern regarding immunisation and requested that it was placed on the scrutiny programme. **ACTION**

- Questioned whether follow up work took place regarding the effectiveness of immunisations for vulnerable groups. Officers explained that national statistics were compiled on the effectiveness of the vaccine and drew attention to one particular year where the vaccine was less effective against a particular strain of flu.

It was resolved to

a) Note the position in respect of Public Health Directorate Risk

b) Comment on the Public Health Risk Register and endorse the amendments since the previous update

c) Express concern regarding immunisation and request that it is placed on scrutiny programme.

237. THE EFFECTIVENESS OF STOP SMOKING SERVICES

The Committee received a report providing it with an overview of the effectiveness of the Stop Smoking Services including the impact of e-cigarettes and demand management processes. Evidence backed the model used and it produced the best outcomes for individuals to quit smoking. Officers highlighted the evidence regarding e-cigarettes that endorsed their use as a means to quit smoking.

Commenting on the report, Members

- Sought further information regarding the costs of the proposed pilot scheme for a harm reduction approach. Officers informed Members that the pilot, lasting approximately 2 years would target an area of high prevalence and would cost £10 - £20k.

- Questioned, with regard to paragraph 2.11 of the report, the legal position regarding electronic cigarettes and when they have to be licensed. Officers explained that when licensed the product could be prescribed by doctors as part of a smoking cessation programme.

- Confirmed that doctors have been able to prescribe nicotine replacement therapies since 1999 and electronic cigarettes could form part of the replacement therapy although only one type was currently licensed.

- Questioned whether cigarettes having been removed from public display in shops had made a difference to smoking rates. Officers explained that there had not yet been a conclusive study, however information from areas where the approach had been adopted many years ago confirmed there was a benefit.

- Noted that low paid workers were often purchasing cigarettes at a reduced cost off the “Black Market”. Support offered was designed to make it easy as possible to quit smoking and therefore reduce the long-term costs to the NHS.

It was proposed with the agreement of the Committee that in advance of a pilot harm reduction model being undertaken, a briefing paper be provided to the Committee informing Members of the costings.

It was resolved to confirm the Committee’s support for the Stop Smoking Services.

238. HEALTHY WEIGHT STRATEGY

The Committee received a report that provided an overview of the Healthy Weight Strategy and the implications for its implementation. Officers highlighted the

importance of a system wide approach and the strategy attempted to achieve a joined up, whole systems approach.
The strategy considered the impact of the increase in the prevalence of unhealthy weight along with evidence based interventions for prevention through to treatment for the associated poor health outcomes. There was a focus on diet and physical activity as the key factors that influenced a healthy weight.

The role of the private and voluntary sectors was emphasised by officers in order for the strategy to be effective.

During the course of discussion Members

- Questioned how food manufacturers could be influenced or instructed to reduce levels of salt and sugar within their products. It was explained that national policy largely influenced product content but confirmed that at a local level work took place with retailers regarding what products they stocked. Attention was drawn to the "Sugar Smart" app that was available from the "change for life" website. The app was able to scan items for their sugar content and through market demand could in time shape what was stocked in shops and super-markets.

- Emphasised the importance of good quality, healthy food being produced by public sector organisations at hospitals and other public buildings. Officers confirmed that part of the strategy was focussed on the public sector offering.

- Highlighted the importance of cooperation and working together across all organisations to ensure the success of the strategy.

- Questioned why obesity levels were so much lower in Cambridge City. It was explained that there was a high level of awareness regarding healthy eating in the city and the demographic of Cambridge was predicated to a healthier lifestyle and that the overall population was younger, which is associated with lower levels of obesity. There was also a wider variety of foods available within the city.

- Welcomed the essential strategy and noted the number of allotments and home grown vegetables in Cambridge city. Members drew attention to education and gardening clubs for children that promoted healthy eating and living. Officers confirmed that allotments were being designed into some new developments within the Cambridge area at the planning stage.

It was resolved to

a) Approve the Healthy Weight Strategy as a draft document for further engagement and consultation

b) Endorse a system wide event to enable engagement of organisations and communities for finalising and implementing the Strategy.

239. HEALTH AND CARE EXECUTIVE GOVERNANCE FRAMEWORK

The Committee received the Health and Care Executive Governance Framework. Cambridgeshire County Council and Peterborough City Council participated in the programme with the intention to align their public health and social care services in an integrated way. The Governance Framework set out the governance arrangements for

the Executive. Membership includes the Council's Chief Executive. Group of officers working together to pull together a 5 year strategic plan for the NHS in Cambridgeshire.

It was resolved to

a) Endorse the Cambridgeshire and Peterborough Health and Care Executive Governance Framework

b) Approve the alignment of service planning for Council Public Health Services with relevant aspects of NHS system transformation work.

240. HEALTH COMMITTEE TRAINING PLAN

The Committee considered its training plan. Officers reminded Members of the Task & Finish Group set up to review the Public Health budget for 2017/18 at 9am 28th July. Councillors Sales, Jenkins, Clapp and Orgee confirmed their attendance.

It was resolved unanimously to note the training plan.

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

Members were informed that Councillor Nethsingha was no longer able to represent the Council as a governor on the Cambridgeshire and Peterborough NHS Foundation Trust.

The Trust provided mental health and specialist learning disability services across Cambridgeshire and Peterborough.

It was resolved to appoint Councillor Graham Wilson to the Trust.

242. HEALTH COMMITTEE AGENDA PLAN

The Committee considered its agenda plan and the oral update provided.

It was resolved unanimously:

a) to note the agenda plan

b) to move the item on 0-19 Joint Commissioning of Children's Services from the agenda for 8 September to the agenda for 6 October

c) to remove the provisional item on the possible consultation on collaboration between Hinchingbrooke Health Care NHS Trust and Peterborough & Stamford NHS Foundation Trust to the agenda for 8 September 2016.

d) to add a scrutiny item regarding the immunisation programme to the agenda for 6 October

e) to add a system wide review of Health Outcomes across Cambridgeshire, focussing on the reasons for inequalities across the county to the agenda for 12 January.

f) to add a report relating to the governance for a joint scrutiny arrangement regarding the collaboration between Hinchingbrooke Health Care NHS Trust and Peterborough NHS Trust.

g) to add the Community Led Physical Activity Proposal to the agenda for 8 September.

h) to add a briefing paper on the costings of a pilot smoking cessation harm reduction model for 8 September

Chairman

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on 14 July 2016 and updates members on the progress on compliance in delivering the necessary actions.

This is the updated action log as at 31 August 2016 .

Minutes of 14 July 2016

Minute No.	Item	Action to be taken by	Action	Comments	Completed
233.	**Finance and Performance Report – Closedown 2015/16**	M Wade	Requested greater clarity regarding performance in terms of outcomes in future year end reports	Noted for 2016/17 closedown report	Yes
234.	**Finance and Performance Report – May 2016**	R Yule	System wide review of health outcomes, to be presented to the Committee at its January meeting.	Added to agenda plan for 12 January 2017	Yes
236.	**Public Health Risk Register update**	T Campbell	Add to the register the risk of organisations not working effectively together	This has been added to the agenda for discussion at the Public Health Quality, Safety & Risk Group on 19 October 2016	Yes
		H Hodge	Officers to discuss anti- bullying strategy outside the meeting	Meeting being arranged with Cllr Clapp, Holly Hodge (Public Health) and Diane Fenner (Education Wellbeing Team) to provide an update on local authority anti-bullying work.	Yes

Minute No.	Item	Action to be taken by	Action	Comments	Completed
		K Parker	Committee's concern regarding immunisation targets be placed on scrutiny programme	On agenda plan for 10 November 2016 meeting	Yes

Agenda Item No: 4

FINANCE AND PERFORMANCE REPORT – JULY 2016

To:	**Health Committee**
Meeting Date:	**8 September 2016**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the July 2016 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of July 2016.**
Recommendation:	**The Committee is asked to review and comment on the report**

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

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE JULY 2016 FINANCE & PERFORMANCE REPORT

2.1 The July 2016 Finance and Performance report is attached at Appendix A.

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

Savings are tracked on a monthly basis, with any significant issues reported to the Health Committee, alongside any other projected under or overspends. There are no financial exceptions reported in Public Health at the end of July.

2.3 The Public Health Service Performance Management Framework for June 2016 is contained within the report. Of the thirty eight Health Committee performance indicators, twelve are red, nine are amber, fifteen are green and two have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Statutory, Risk and Legal Implications

4.2.1 Significant financial risk owing to the nature of demand led budgets and savings targets.

4.3 Equality and Diversity Implications

4.3.1 There are no significant implications within this category.

4.4 Engagement and Consultation Implications

4.4.1 There are no significant implications within this category.

4.5 Localism and Local Member Involvement

4.5.1 There are no significant implications within this category.

4.6 Public Health Implications

4.6.1 There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Martin Wade
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	No Martin Wade confirmed
Are there any Equality and Diversity implications?	No Name of Officer: Dan Thorpe
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Simon Cobby
Are there any Localism and Local Member involvement issues?	No Name of Officer: Dan Thorpe
Have any Public Health implications been cleared by Public Health?	Yes Name of Officer: Val Thomas

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

From: Martin Wade

Tel.: 01223 699733

Date: 10 August 2016

Public Health Directorate

Finance and Performance Report – July 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
June (No. of indicators)	12	9	15	2	38

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Jun) £000	Directorate	Current Budget for 2016/17 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Jul) £000	Forecast Variance - Outturn (Jul) %
0	Health Improvement	8,459	-190	-12.5%	0	0%
0	Children Health	9,276	-91	-3.0%	0	0%
0	Adult Health & Well Being	916	-60	-60.4%	0	0%
0	Intelligence Team	13	-6	-124.1%	0	0%
0	Health Protection	6	1	50.9 %	0	0%
0	Programme Team	136	-33	-70.8%	0	0%
0	Public Health Directorate	2,175	139	19.2%	0	0%
0	**Total Expenditure**	**20,982**	**-241**	**-4.4%**	**0**	**0%**
0	Public Health Grant	-20,457	-87	0.7%	0	0%
0	Other Income	-343	213	308.7%	0	0%
0	**Total Income**	**-20,800**	**126**	**-1.1%**	**0**	**0%**
0	**Net Total**	**182**	**-115**	**1.8%**	**0**	**0%**

The service level budgetary control report for July 2016 can be found in appendix 1.

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

2.2 Significant Issues

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

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

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

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE

4.1 The Public Health Service Performance Management Framework (PMF) for June 2016 can be found in Appendix 6.

Stop Smoking Programme:

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Smoking Cessation - four week quitters	2249	295	262	89%	R	N/A	N/A	N/A	↑	No previous months actual as start of 2016/17 reporting (April and May data combined)

- Since 2013/14 there has been an ongoing drop in the percentage of the target number of smoking quitters achieved. In 2012/13 92% was achieved, in 2013/14 this fell to 76%. This fall continued in 2014/15 when 64% of the target was met. The drop locally mirrors the national picture for the past three years. A number of factors have been associated with the fall in quitters in recent years but e cigarettes are perceived as being the key factor across the country. During these years performance in GP practices and community pharmacies was especially poor and they report there is a consistent problem with recruiting smokers to make quit attempts

- The target number of quitters for the Stop Smoking Services has been revised for 2015/16 to reflect the fall in smoking prevalence in Cambridgeshire. The old target was based on the previous higher prevalence. The target was exceeded in 15/16

- The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) suggest the prevalence of smoking in Cambridgeshire has increased slightly in the last few years, returning to a level statistically similar to the England average (16.4% v. 16.9%). Smoking rates in routine and manual workers are consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where smoking rates have returned to a level worse than the average for England (39.8%).

- There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit the core Stop Smoking service is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. During 2014/15 social marketing research was undertaken which is informing activities to promote Stop Smoking Services. Other activities introduced recently include a mobile workplace service, a migrant worker Health Trainer post that will target these communities where smoking rates are high and ongoing targeted promotion.

NHS Health Checks

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)
Number of Health Checks completed	18,000	4,500	3686	82%	R	n/a	4500	82%	
Percentage of people who received a health check of those offered	45%	45%	37%	37%	A	n/a	45%	37%	

- Reporting of Health Checks is quarterly. In 2014/15 83% of the target was achieved compared to 93% in the previous year.

- The end of 15/16 performance was 84% of the target number of Health Checks completed, the conversion rate remained the same at 39%.

- The comprehensive Improvement Programme is continuing this year. Intelligence from the commissioned social marketing work clearly indicates a lack of awareness in the population of Health Checks. Actual health check numbers compare reasonably well to other areas but the issue is the conversion rate which is attributed to the poor public understanding of the Programme.

- The introduction of new software into practices has been delayed due to the extensive work that needs to be undertaken to introduce it into the 77 practices. This involves close working with the Clinical Commissioning Group, Information Governance and LGSS. Its purpose is to support the invitation system and to ensure that the data collection system is comprehensive.

- Other activities include staff training from a commissioned Coronary Heart Disease specialist nurse. The new Lifestyle Service is commissioned to provide outreach health checks for hard to reach groups in the community and in workplaces. This commenced in February and has started gaining momentum. A promotional campaign has been launched which includes recruiting champions and local “advocates” who have had a NHS Health Check.

Background Information

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

Integrated Lifestyle Service:

- The new Countywide Integrated Lifestyle Service provided by Everyone Health commenced on June 1 2015. It includes the Health Trainer and Weight Management Services. The Service has now successfully recruited to all areas The South of the county had been problematic and there was limited Health Trainer service in this area. However staff training will not be completed until the end of August. The KPIs that are not on target have an upward trend.

Health Visiting:

- Of note, all of the health visiting data is reported quarterly. The data presented here for July 2016 is data for Q1 (Apr-Jun) 2016-2017 and is compared to Q4 2015-2016 data for trend.
- A stretch target for the percentage of infants being breastfed was set at 58%, - above the national average for England. This target was almost met with 56% of infants recorded as breastfed (fully or partially) at 6 weeks for Q1 and the figure is one of the highest statistics in the Eastern region in the recently published Public Health England data (Q4 2015/16).
- The target of 100% for percentage of children who received a 12 month review by age 15 months has not been met, however if 'not wanted and not attended' figures are included, the figure rises to 96%. This is being discussed with the provider.
- The target of 90% for percentage of children who received a 2-2.5 year review has not been reported as met. However, if 'not wanted and not attended' figures are included, Q1 figure rises to 88% which falls within a range of 10% tolerance.
- 96% of mothers received a face to face visit with 14 days of birth and 94% received a review at 6-8 weeks, well above the 90% targets.
- The number of antenatal contacts increased for Q1 compared to Q4 of last year. Although below the quarterly target, this has remained fairly static in most areas and priority is given to contacting parents who are assessed as being most vulnerable.

School Nursing:

- These new KPIs should help to gain better understanding of baseline activity and the type of work which school nurses are carrying out day to day, in order to improve health outcomes for children, young people and their families.
- Two Key Performance Indicators (KPIs)—number of young people seen for behavioural interventions (smoking, sexual health advice, weight management or substance misuse) and number of young people seen for mental health & wellbeing concerns, are currently recorded and provided. These data are part of new KPIs monitoring. Data from the first year are used to benchmark the service. This quarter shows significant increase in numbers of contacts reported compared with Q4 last year although it is noted that there was a recording issue last quarter.

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

4.3 Health Committee Priorities

Health Inequalities

Smoking Cessation:

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

Monthly update:

- The percentage of the smoking quit target achieved during June was higher among the most deprived 20% of practices in Cambridgeshire compared with the most deprived 80%.
- In the least deprived 80%, 77 four-week quits were achieved, 66% of the monthly target of 116; in the most deprived 20% of practices, 50 four-week quits were achieved, 69% of the monthly target of 72..
- The gap in performance in quits achieved between the two groups decreased in June compared to the gap seen in April/May (3 percentage points compared to 8) due to a decrease in quits achieved in the both the most and least deprived practices.

Year-to-date:

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

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

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

Practice deprivation category	Year end target	Year-to-date					June			*Previous month	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	1,388	347	227	65%	35%		116	77	66%	65%	↑
Most deprived 20%	861	215	155	72%	28%		72	50	69%	73%	↓
All practices	2,249	562	382	68%	32%		187	127	68%	68%	↔

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

RAG status:

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

Direction of travel:

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

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

	Year-to-date	June	Previous month	Direction of travel
Percentage point gap	7%	3%	8%	↑

Direction of travel:

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

Sources:
General practice returns to Cambridgeshire County Council Smoking Cessation Service
Public Health England 2015 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2015
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 18/08/16

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 update:

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

There is an intensive programme of support given to GP practices that deliver the majority of NHS Health Checks. However practices in these areas have experienced staff losses that affect their capacity. Outreach NHS Health Checks provided by the Integrated Lifestyle Service Everyone Health have now commenced that focus upon the deprived areas working in community settings including workplaces.

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

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

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

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

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

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

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

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

Life expectancy and healthy life expectancy:

There is no update due this time due to delays with mortality data access (now resolved but insufficient time to process and analyse latest data)

- Inequalities in life expectancy in the most deprived quintile of Cambridgeshire (monitored quarterly subject to data availability)
    - The indicator statistic is the gap in years of life expectancy between the best-off and worst-off within the local authority, based on a robust statistical model of the life expectancy and deprivation scores across the whole area.
    - The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% remainder of areas was 2.6 years for the period 2012-2014.
    - For the years 2013-2015 (provisional data to Q4 of 2015) the absolute gap was 2.6 years.
    - There are significant inequalities nationally and locally in life expectancy at birth by socio-economic group. Certain sub-groups such as people with mental health problems, people who are homeless also have lower life expectancy than the general population. Key interventions to reduce this gap are in tackling lifestyle factors and ensuring early intervention and prevention of key diseases.

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

- Inequalities in life expectancy in the most deprived quintile of Cambridgeshire (monitored quarterly subject to data availability)
    - The indicator statistic is the gap in years of life expectancy between the best-off and worst-off within the local authority, based on a robust statistical model of the life expectancy and deprivation scores across the whole area.

- The absolute gap in life expectancy at birth for all persons between the 20% most deprived electoral wards in Cambridgeshire and the 80% remainder of areas was 2.6 years for the period 2012-2014.
- For the years 2013-2015 (provisional data to Q4 of 2015) the absolute gap was 2.6 years.
- There are significant inequalities nationally and locally in life expectancy at birth by socio-economic group. Certain sub-groups such as people with mental health problems, people who are homeless also have lower life expectancy than the general population. Key interventions to reduce this gap are in tackling lifestyle factors and ensuring early intervention and prevention of key diseases.

- An annual indicator covering healthy life expectancy.
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  - These figures represent some change in both male and female figures on the previous year and in comparison with the England figure. For male HLE the general trend is slightly upward although the annual change is 0.3 of a year less and this difference is not important statistically. For female HLE there has been an increase of +2.3 years although this is not statistically significant. Both male and female HLE in Cambridgeshire remain higher than that of England in both men and women. Note that data fluctuates annually for a variety of reasons but is impacted by seasonal patterns of mortality which vary year by year.
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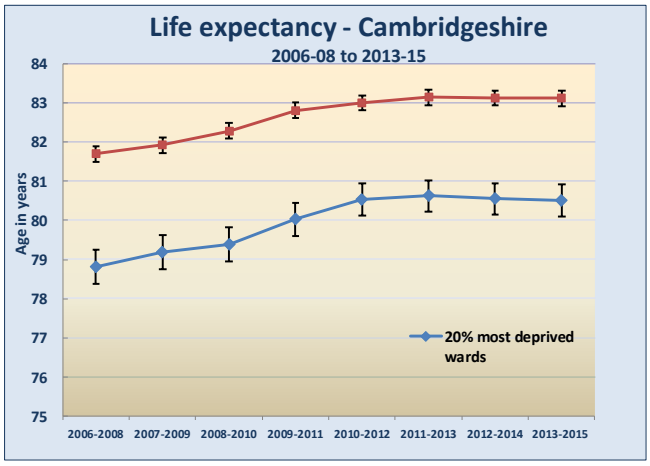
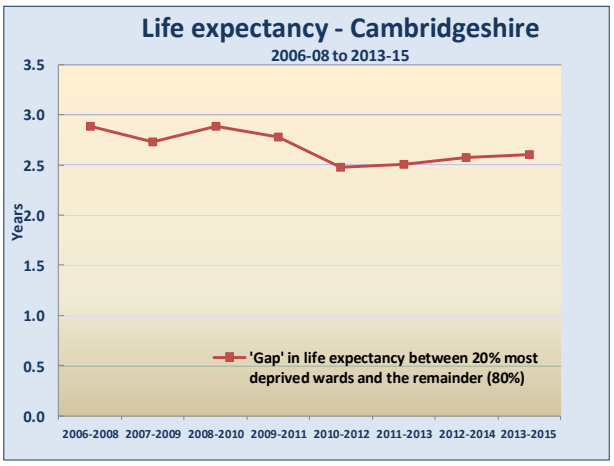
Calendar years	Average Life Expectancy (95% confidence interval)				Gap (in years)	Relative gap (%)
	20% most deprived wards		80% remainder of wards			
2006-2008	78.8	(78.4 - 79.3)	81.7	(81.5 - 81.9)	-2.9	3.5%
2007-2009	79.2	(78.8 - 79.6)	81.9	(81.7 - 82.1)	-2.7	3.3%
2008-2010	79.4	(79.0 - 79.8)	82.3	(82.1 - 82.5)	-2.9	3.5%
2009-2011	80.0	(79.6 - 80.4)	82.8	(82.6 - 83.0)	-2.8	3.4%
2010-2012	80.5	(80.1 - 80.9)	83.0	(82.8 - 83.2)	-2.5	3.0%
2011-2013	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.5	3.0%
2012-2014	80.6	(80.2 - 81.0)	83.1	(82.9 - 83.3)	-2.6	3.1%
2013-2015	80.1	(80.1 - 80.9)	83.1	(82.9 - 83.3)	-2.6	3.1%

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

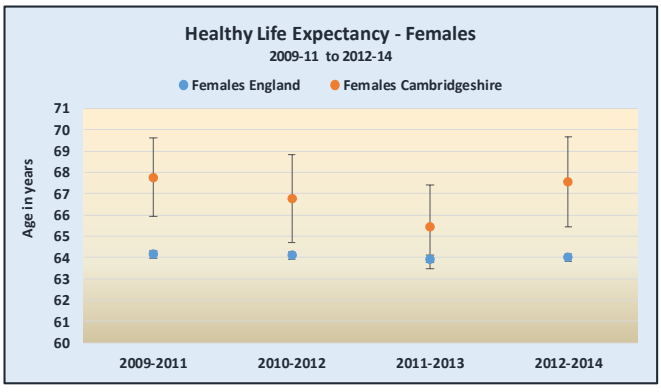


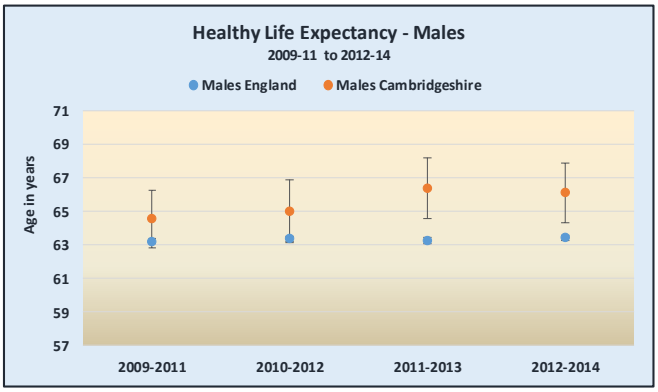


Calendar years	Cambridgeshire				England			
	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'
Males								
2009-2011	80.6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

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

NB: chart axes do not start at zero.

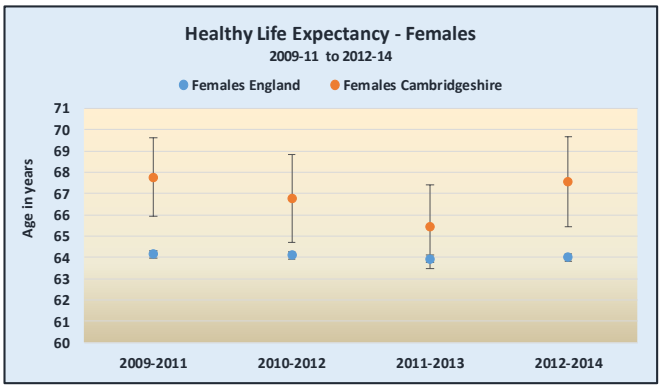


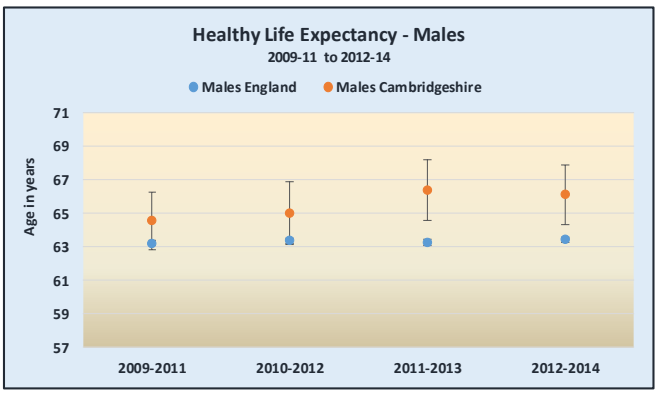


Calendar years	Cambridgeshire				England			
	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'
Males								
2009-2011	80.6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

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

NB: chart axes do not start at zero.





Child obesity

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

Children aged 4-5 years classified as overweight or obese

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

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

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

Source: NCMP, HSCIC

Children aged 4-5 years classified as obese

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

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

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

Source: NCMP cleaned dataset, HSCIC

Children aged 10-11 years classified as obese

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

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

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

Source: NCMP cleaned dataset, HSCIC

Excess weight in adults

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

Physically active and inactive adults

Physically inactive adults

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

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

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

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

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

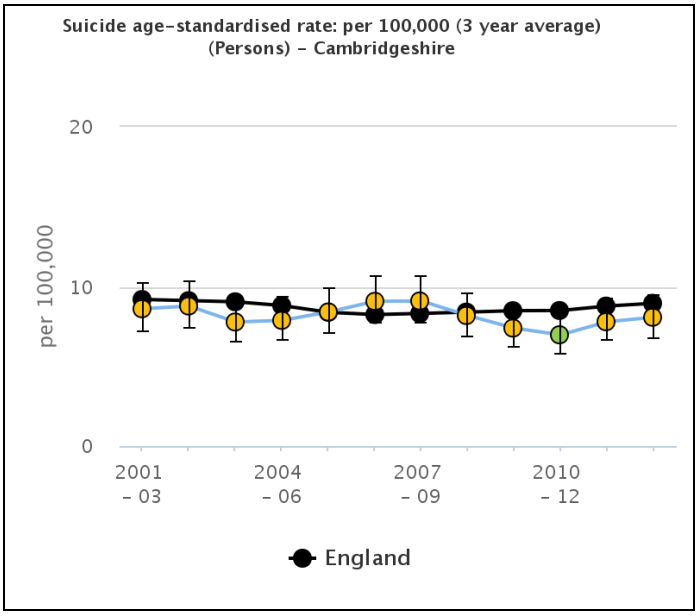
Mental health
Proposed indicators:

- **Number of schools attending funded mental health training:**
  - 16 out of 38 secondary schools and sixth form colleges have accessed the training commissioned from CPFT. Individuals from a further 12 schools have attended face-to-face training sessions. 9 of the schools have accessed the training this year (2014/15), including 4 new schools.
  - 21 primary schools have engaged with the training programme, plus 40 individuals have attended training from other schools. 9 primary schools have accessed the training this year and 8 have booked training for the summer term.
- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – To date (June 2016), 21 out of 30 secondary schools have taken up the offer of a consultancy visit.

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

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

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



Source: Public Health Outcomes Framework

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

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

Directly standardised rate - per 100,000

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

Source: Public Health Outcomes Framework

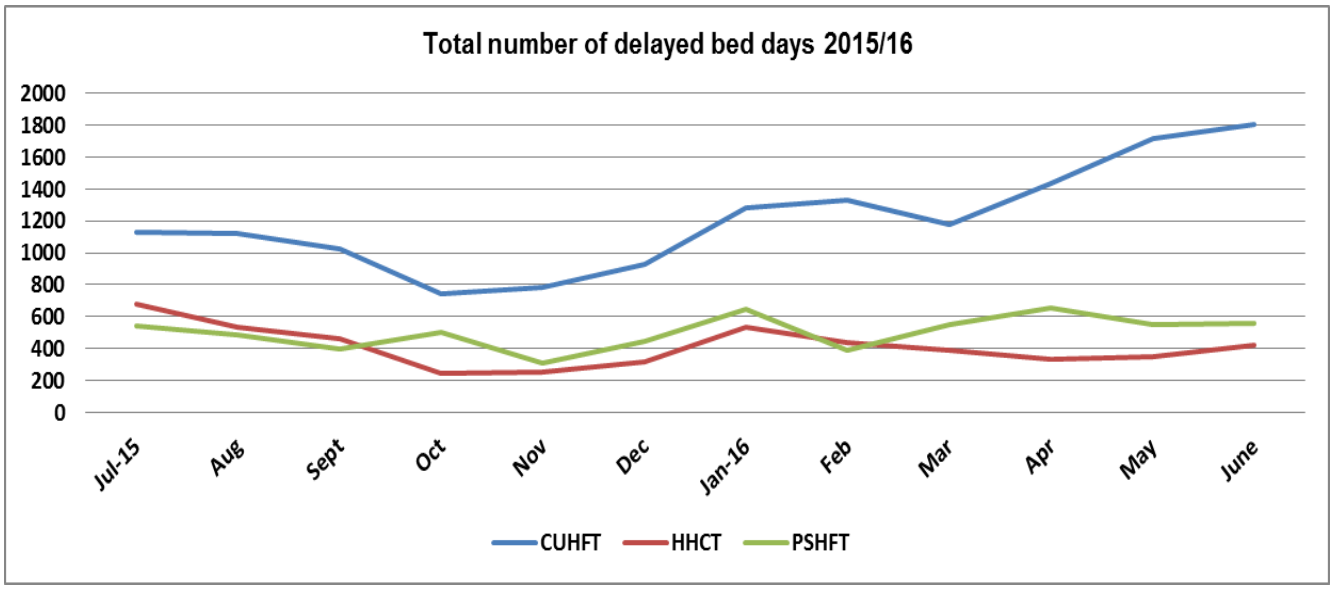
Transport and Health

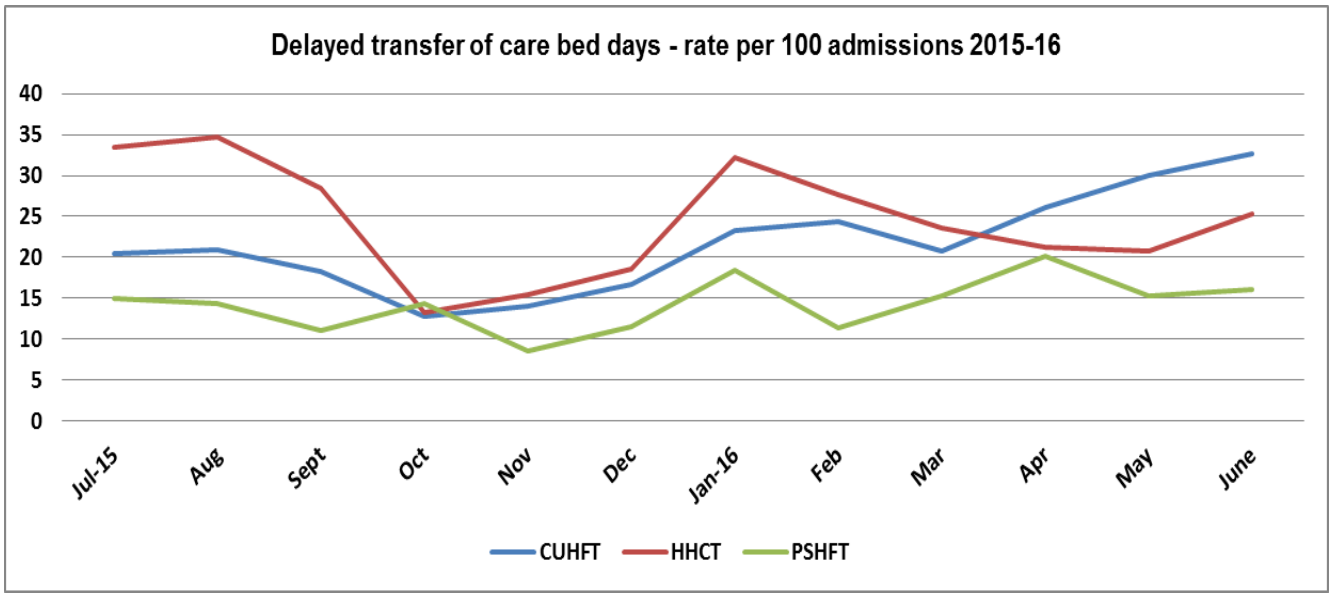
At the January meeting of the Health Committee, it was request that these indicators be reviewed. The Committee is advised that this review is now under way.

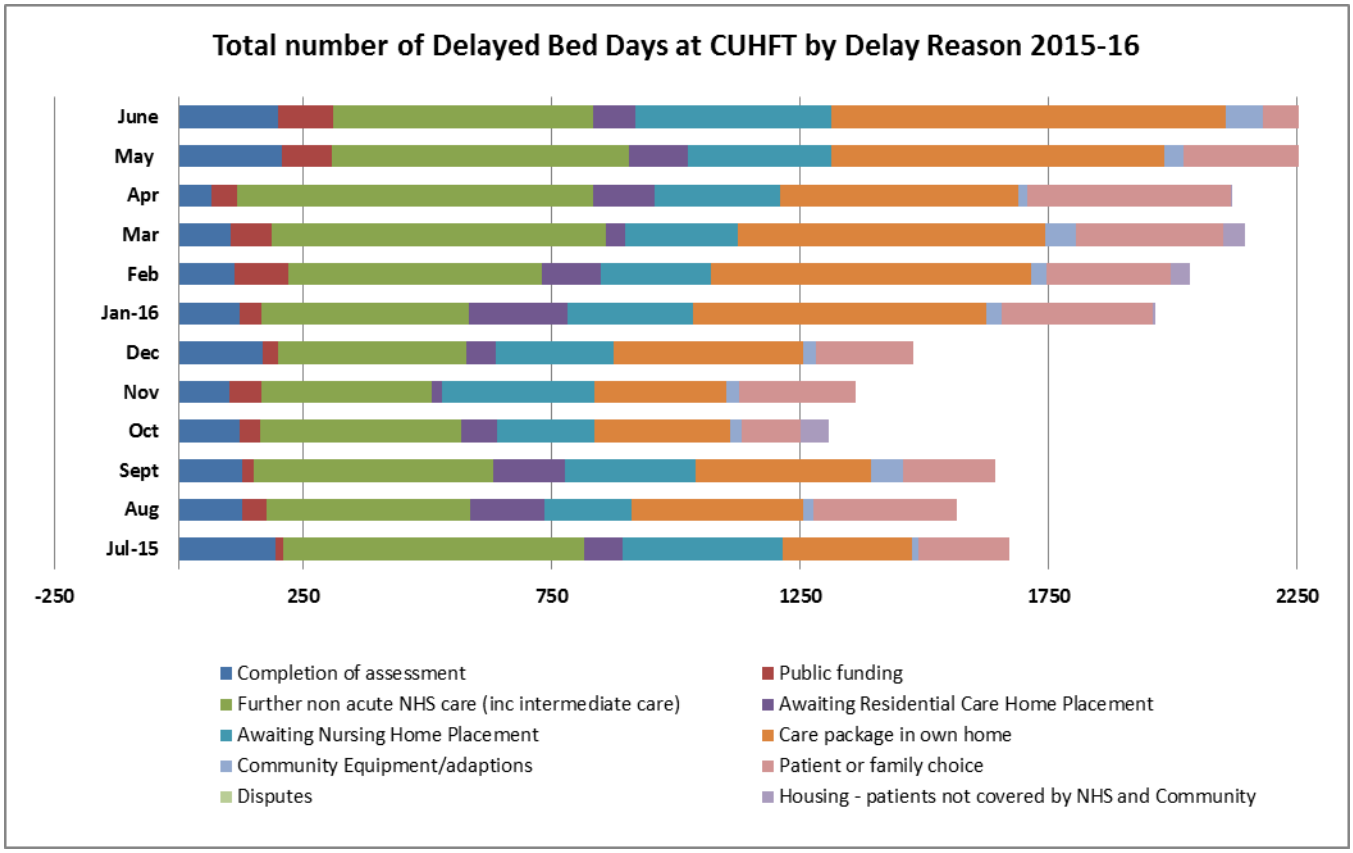
4.4 Health Scrutiny Indicators

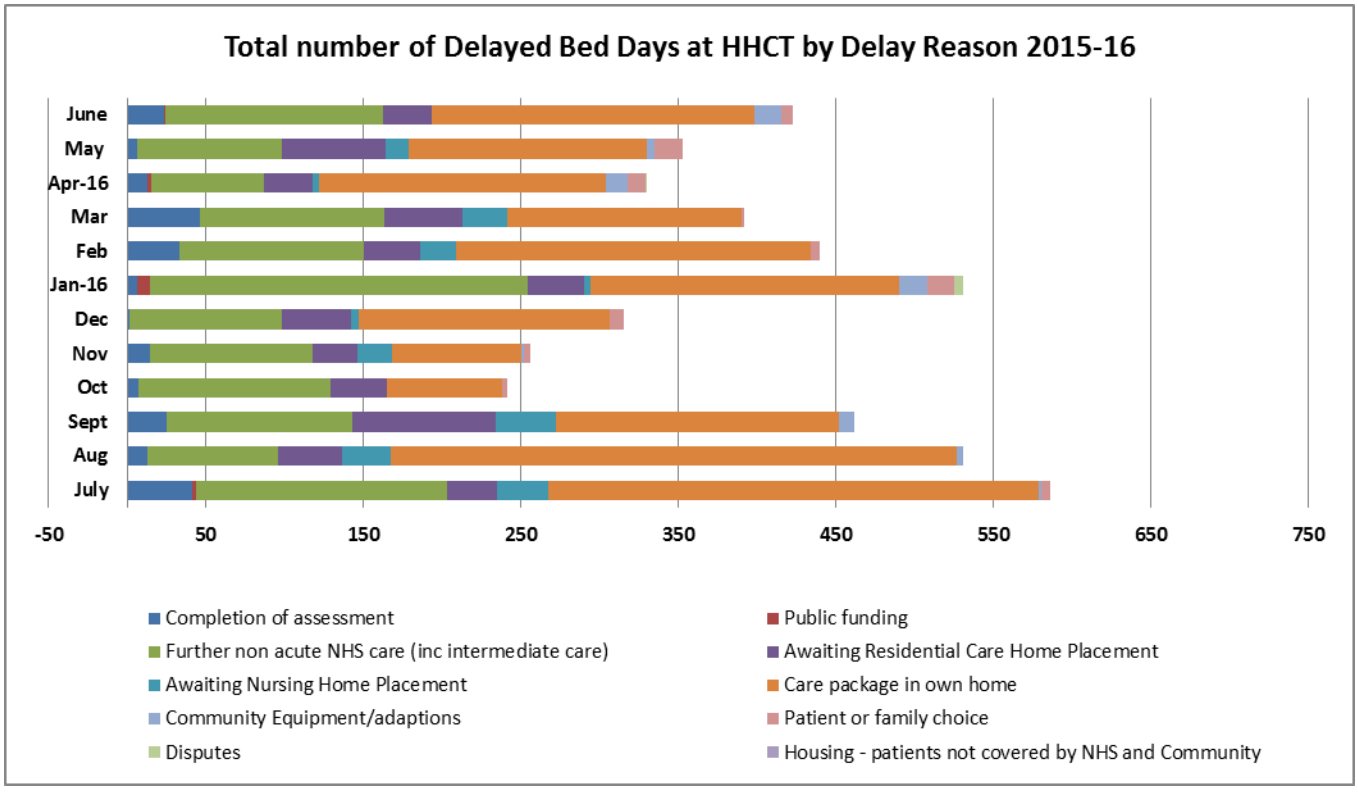
Updates on key indicators for NHS issues which have been scrutinised by the Health Committee are as follows:

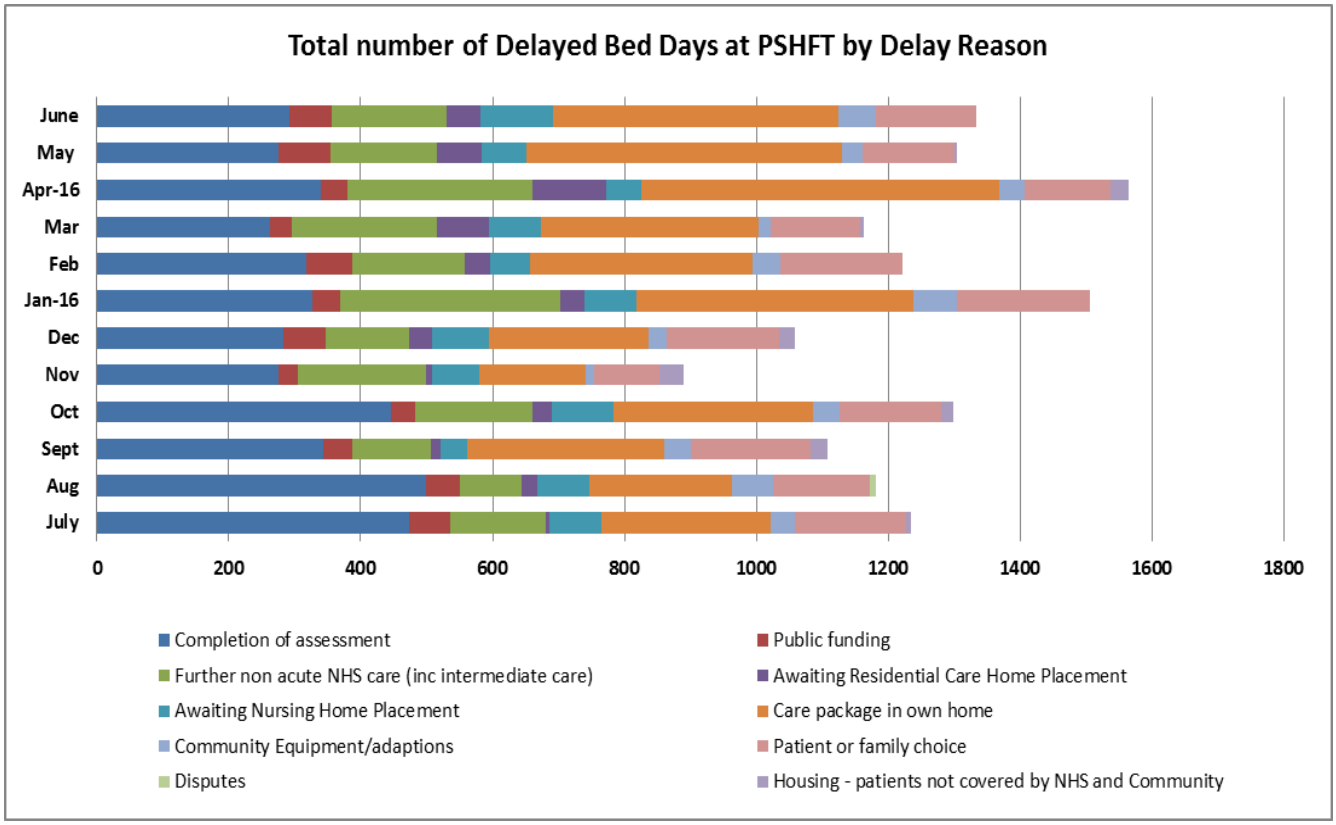
- **Delayed Transfer of Care (DTOC)**






Total number of Delayed Bed Days at CUHFT by Delay Reason 2015-16
June
May
Apr
Mar
Feb
Jan-16
Dec
Nov
Oct
Sept
Aug
Jul-15
-250
250
750
1250
1750
2250
Completion of assessment
Public funding
Further non acute NHS care (inc intermediate care)
Awaiting Residential Care Home Placement
Awaiting Nursing Home Placement
Care package in own home
Community Equipment/adaptions
Patient or family choice
Disputes
Housing - patients not covered by NHS and Community


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



The date provided indicates that the current trend is that delayed transfers of care in Cambridgeshire are increasing. It is important to note that some of the acute trusts are experiencing higher levels of delay than in the previous year. This trend is significant as the trust go into the winter planning months.

Concern over the high levels of delayed transfers of care as experienced by Cambridge University Hospital Foundation Trust was raised at the Health Committees recent liaison meeting with the trust on 24th June. More detailed actions were discussed on how the trust is working collaboratively with partner organisation i.e. Clinical Commissioning Group, Cambridgeshire County Council (Adult social care) and Cambridgeshire & Peterborough Foundation Trust.

Representatives from Hinchingbrooke Health Care NHS Trust also raised concerns over tackling the current DTOC issues with members at the liaison meeting on 20th July.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Jun) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of July £'000	Actual to end of July £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (July) £'000	Forecast Variance Outturn (July) %
	Health Improvement							
0	Sexual Health STI testing & treatment	4,074	660	571	-90	-13.56%	0	0.00%
0	Sexual Health Contraception	1,170	179	153	-26	-14.31%	0	0.00%
0	National Child Measurement Programme	0	0	0	0	0.00%	0	0.00%
0	Sexual Health Services Advice Prevention and Promotion	152	52	71	19	35.35%	0	0.00%
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Obesity Children	82	28	19	-9	-31.45%	0	0.00%
0	Physical Activity Adults	84	29	63	34	118.10%	0	0.00%
0	Healthy Lifestyles	1,605	424	426	2	0.41%	0	0.00%
0	Physical Activity Children	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking Service & Intervention	907	-83	-147	-64	76.64%	0	0.00%
0	Wider Tobacco Control	31	11	-15	-26	-237.39%	0	0.00%
0	General Prevention Activities	272	195	192	-3	-1.70%	0	0.00%
0	Falls Prevention	80	28	0	-28	-100.00%	0	0.00%
0	Dental Health	2	1	0	-1	-100.00%	0	0.00%
0	**Health Improvement Total**	**8,459**	**1,524**	**1,334**	**-190**	**-12.49%**	**0**	**0.00%**
	Children Health							
0	Children 0-5 PH Programme	7,531	2,456	2,453	-3	-0.12%	0	0.00%
0	Children 5-19 PH Programme	1,745	604	516	-88	-14.55%	0	0.00%
0	**Children Health Total**	**9,276**	**3,060**	**2,969**	**-91**	**-2.97%**	**0**	**0.00%**
	Adult Health & Wellbeing							
0	NHS Health Checks Programme	716	31	31	0	1.14%	0	0.00%
0	Public Mental Health	164	57	9	-48	-84.89%	0	0.00%
0	Comm Safety, Violence Prevention	37	13	0	-13	-100.00%	0	0.00%
0	**Adult Health & Wellbeing Total**	**916**	**100**	**40**	**-60**	**-60.41%**	**0**	**0.00%**
	Intelligence Team							
0	Public Health Advice	13	5	-1	-6	-124.08%	0	0.00%
0	Info & Intelligence Misc	0	0	0	0	0.00%	0	0.00%
0	**Intelligence Team Total**	**13**	**5**	**-1**	**-6**	**-124.08%**	**0**	**0.00%**
	Health Protection							
0	LA Role in Health Protection	0	0	3	3	0.00%	0	0.00%
0	Health Protection Emergency Planning	6	2	0	-2	-100.00%	0	0.00%
0	**Health Protection Total**	**6**	**2**	**3**	**1**	**50.91%**	**0**	**0.00%**

Forecast Variance Outturn (Jun) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of July £'000	Actual to end of July £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (July) *£'000*	Forecast Variance Outturn (July)
	Programme Team							
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking no pay staff costs	31	11	2	-9	-79.33%	0	0.00%
0	General Prev, Traveller, Lifestyle	105	37	12	-25	-68.27%	0	0.00%
0	**Programme Team Total**	**136**	**47**	**14**	**-33**	**-70.78%**	**0**	**0.00%**
	Public Health Directorate							
0	Health Improvement	531	177	273	96	54.24%	0	0.00%
0	Public Health Advice	710	236	241	5	2.26%	0	0.00%
0	Health Protection	151	50	71	21	41.06%	0	0.00%
0	Programme Team	613	203	200	-3	-1.64%	0	0.00%
0	Childrens Health	67	22	24	2	7.46%	0	0.00%
0	Comm Safety, Violence Prevention	50	17	36	19	116.00%	0	0.00%
0	Public Mental Health	53	18	17	-1	-3.77%	0	0.00%
0	**Public Health Directorate total**	**2,175**	**723**	**862**	**139**	**19.24%**	**0**	**0.00%**
0	**Total Expenditure before Carry forward**	**20,982**	**5,461**	**5,220**	**-241**	**-4.41%**	**0**	**0.00%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0.00%**
	Funded By							
0	Public Health Grant	-20,457	-11,957	-12,044	-87	0.73%	**0**	0.00%
0	S75 Agreement NHSE - HIV	-144	0	144	144	0.00%	**0**	0.00%
0	Other Income	-199	-69	0	69	-100.00%	**0**	0.00%
0	**Income Total**	**-20,800**	**-12,026**	**-11,900**	**126**	**-1.05%**	**0**	**0.00%**
0	**Net Total**	**182**	**-6,565**	**-6,680**	**-115**	**1.75%**	**0**	**0.00%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Current Budget for 2016/17 £'000	Current Variance		Forecast Variance - Outturn	
		£'000	%	£'000	%

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

Awarding Body : DofH

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

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan	20,948	
Virements		
Non-material virements (+/- £160k)	0	
Budget Reconciliation		
Current Budget 2015/16	**20,948**	

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2016	2016/17		Forecast Balance at 31 March 2017	Notes
		Movements in 2016/17	Balance at 31 Jul 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,138**	0	1,138	**638**	**Estimated use of reserves to fund part year 16-17 savings not made, redundancy costs and one off funding agreed for previously MOU funded activity. (Estimated £500k pending review of commitments)**
subtotal	**1,138**	**0**	**1,138**	**638**	
Equipment Reserves					
Equipment Replacement Reserve	0	0	0	0	
subtotal	**0**	**0**	**0**	**0**	
Other Earmarked Funds					
Healthy Fenland Fund	500	0	500	400	**Anticipated spend over 5 years**
Falls Prevention Fund	400	0	400	200	**Anticipated spend over 2 years**
NHS Healthchecks programme	270	0	270	170	
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	675	
Other Reserves (<£50k)	0	0	0	0	
subtotal	**2,020**	**0**	**2,020**	**1.445**	
TOTAL	**3,158**	**0**	**3,158**	**2,083**	

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

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

PUBLIC HEALTH MOU 2016-17 UPDATE FOR Q1

Directorate	Service	Allocated	Contact	Cost Centre Finance Contact	Q1 Update	YTD expected spend	YTD actual spend	Variance
CFA	**Chronically Excluded Adults (MEAM)**	£68k	Tom Tallon	MN92145 Stephen Howarth	During Quarter one we have started work with seven new complex needs clients. Five clients have been closed. Of those three were living more positively and safely, one had left the area and one where CEA could not provide any further assistance. The CEA approach has been recognised as bringing effective results with those that are hardest to reach and engage. It continues to disseminate good practice to partners in other areas, most recently Leicester and Bristol. Cambridge City Council have also approached CEA to start some work on engaging and supporting members of the Street Life community for which they will fund an additional post. Discussion has been had with the police, particular in respect of the change in the Police & Crime Commissioner to see what opportunities and commonalities can be found and how the CEA approach can support them to reach those hardest to engage. This dialogue is ongoing but there does seem to be some areas of practice around working with Domestic Abuse cases that may be effective. One very positive result this quarter has enabled a victim to leave her partner following 8 months of work to engage and support. She is currently reunited with family and we hope she will flourish. The CEA team contribute to support the set up work on Peterborough CEA by attending operational and strategic meetings. CEA has recently been put on the action plan for the Safer Peterborough partnership. CEA has been tasked by the Homelessness Strategic Implementation Partnership (HSIP) led by Cambridge City Council, to “Evaluate and address demand for training flats available for people accessing the county council’s Making Every Adult Matter (MEAM) service”. The City Council would like CEA to evaluate and if possible expand the ‘Housing First’ programme to enable chances to be open to a greater number of clients	£17,000	£17,000	£0

					The CEA team continued its work on the national stage contributing to the paper produced by MEAM (link below) on how back-to-work support can be improved for people experiencing multiple needs. As well as contributions from the staff team, two service users were interview by the author for their thoughts. http://meam.org.uk/wp-content/uploads/2016/07/Steps-towards-employment-FINAL.pdf CEA also contributed via interview to the MEAM coalition review published earlier this year. The establishment of a three year strategy has been delayed due to changes in staff, however this remains part of the action plan for 2016/17.			
CFA	**PSHE KickAsh**	£15k	Diane Fenner	CB40101 Adam Cook	• Primary School visits completed for academic year 2015-2016 • Recruitment of secondary schools (10) for 2016-2017 completed. • Kick Ash training for autumn term 2016 planned and organised.	£3,750	£3,750	£0
CFA	**Children's Centres**	£170k	Jo Sollars/ Sarah Ferguson	CE10001 Rob Stephens	The overall aim of Cambridgeshire Children's Centres remains ensuring a healthy start to life for children aged 0-4 and ensuring readiness for school, whilst maintaining a focus on inequalities in the early years, and targeting support which will minimise the need to access specialist services where possible. The Public Health funding is utilised as part of the total Children's Centre budget to improve health of children aged 0-5. Close alignment and joint working with community health colleagues in Health Visiting. Family Nurse Partnership and Maternity Services is established for all Children's Centres. Work continues to ensure arrangements with Health Partners are consistent and functionally effective at a community level for families as structural service change is introduced across the system.	£42,500	£42,500	£0
CFA	**Mental Health Youth Counselling**	£111k	Holly Hodge/ Emma De Zoete	CD20901 Clare Andrews	Cambridgeshire Youth Counselling Services • Youth counselling services are provided by Centre 33 and YMCA covering the whole of Cambridgeshire. • This quarter's contract monitoring meeting is upcoming, however the most recent data is shown below: Centre 33 (2015/16) [figures will change as they only include those that have completed counselling so there is a time lag] ○ 504 young people contacted the service ○ 336 had an assessment (face to face)	£27,750	£27,750	£0

					○ 251 went on to ongoing counselling£27 YMCA (2015/16) ○ 304 young people contacted the service ○ 280 had an assessment (telephone) ○ 215 went on to ongoing counselling. The waiting list for Centre 33 in the Cambridge area is a concern for both provider and commissioners, but work is ongoing to reduce this. A new delivery model is being piloted by Centre 33 which is more flexible to accommodate the variety of clients that they see. The model reflects the varied needs of clients, which may range from advice to more complex individuals that require multiple appointments.			
CFA	**CAMH Trainer**	£71k	Holly Hodge/ Emma De Zoete	CD20901 Clare Andrews	The CAMH trainer is employed by CPFT and delivers specialist mental health training for a range of roles working with children and young people. Training specifically tailored to the needs of schools is also provided and there will be a greater focus on this in the coming year. To increase uptake to training a re-design of the packages of training available to schools is underway. The service is also looking at developing a mental health literacy course that can be delivered in a train-the-trainer model with teaching staff. Most recent data (2014/15) 16 out of 38 secondary schools and sixth form colleges have accessed the training. Individuals from a further 12 schools have attended face-to-face training sessions. 9 of the schools have accessed the training in 2014/15, including 4 new schools. 21 primary schools have engaged with the training programme, plus 40 individuals have attended training from other schools. 9 primary schools have accessed the training in 2014/15 and 8 have booked training for the summer term.	£17,750	£17,750	£0
CFA	**DAAT**	£5,980 k	Susie Talbot	NB31001-NB31010 Jo D'Arcy	At the end of Qtr 1 there had not been any current spend for the allocated budget for GP Shared Care, Nalmefene, Recovery Hub Coordinator and BBV as this is work in progress. The inpatient detox beds contract is paid up to date for Qtr 1 along with the Service User Contract. We have now received Qtr 1 80% invoice from Inclusion for the Drug & Alcohol Contracts which will now show on Qtr 2 report. The predicted Q1 spend is based solely on a quarter of the overall allocated budget so the predicted and actual spend will vary during the year depending on when invoices are received however we anticipate	£1,567,250	£192,660	£1,374,590

					the budget will be fully spent by year end. The only exception to this being the Inclusion Contract where the contract is based on 80% in advance quarterly and the remainder 20% performance related which is normally paid during the next quarter following the performance meeting. This is to ensure that Inclusion have met their targets in line with the contract agreement, the 20% performance related invoices are then agreed for payment.			
CFA	**Contribution to Anti-Bullying**	£7k	Sarah Ferguson		This is a nominal amount and is part of a large budget, it is therefore difficult to pull out exactly what the £7k covers, and difficult to apportion amounts. This will be spent in total.	£1,750	£1,750	£0
					SUB TOTAL : CFA Q1	**£1,677,750**	**£303,160**	**£1,374,590**
ETE	**Active Travel (overcoming safety barriers)**	£55k	Matt Staton	HG03560 Robert Emery	Currently 73 schools are engaged in the school travel planning process through STARS. It is expected that by the end of July there will be 33 accredited to Bronze level, 1 Silver and 2 Gold. Since the beginning of April: • Walk Smart has been delivered to 115 pupils • Scoot Smart has been delivered to 1002 pupils • Pedal Smart has been delivered to 80 pupils	£13,750	£13,750	£0
ETE	**Explore additional interventions for cyclist/ pedestrian safety**	£30k	Matt Staton	HG03560 Robert Emery	A cycle safety campaign based around the strapline 'Let's look out for each other' will be launched by the Road Safety Partnership on 11 July. A further intervention(s) is being explored to be delivered in the spring. At present data and intelligence around cycle collisions is being collated to understand who the other drives involved in cycle collisions are.	£7,500	£7,500	£0
ETE	**Road Safety**	£20k	Matt Staton	HG03560 Robert Emery	Junior Travel Ambassador Scheme has continued in 9 primary schools, with 45 Junior Travel Ambassadors across the 9 schools. All 9 schools will continue the scheme into the new term and an additional 7 primary schools have already committed to join the scheme in September. Safety Zones have been delivered for approximately 1700 Year 5 pupils from schools in Huntingdon, St Ives, St Neots, Whittlesey and Wisbech. A young road user event designed to help young people make informed decisions around travel choices and learning to drive was held at Huntingdon Racecourse. Around 1,000 students from 6th forms around the County came to the event across two days. The event was	£5,000	£5,000	£0

					covered on ITC Anglia news.			
ETE	**Trading Standards KickAsh and Alcohol Advice**	£23k	Elaine Matthews	LC44590 John Steel	Prior to 1st April this funded activity was carried out by an officer in Supporting Businesses and Communities with the generic job description of Level 2 Community and Business Support Officer. Following the service restructure a dedicated post has been created to fulfil this funded Kick Ash role within Community Protection team in Community and Cultural Services. Sarah Freeman has been appointed to this post and will carry out the specified activities on behalf of Trading Standards. As we approach the end of the school year all 11 schools have received training, encouragement and support for their mentors and have delivered a number of different activities including raising awareness with their peers on No Smoking Day, Flash mob event, participating in Year 8 career or personal development days in school, lunchtime peer advice and Kick Ash Mentors carrying out business visits on behalf of Trading Standards. As well as usual administration and contact with schools and parents, specific activity during Quarter 1 of 2016_17 includes: ***April*** **Bottisham:** meetings with Mentors to discuss their personal and team progress. Training mentors to carry out the Business Visits on behalf of Trading Standards, advising businesses on the legislation for tobacco sales and why Kick Ash volunteers encourage their peers to stop smoking. Within the Community Resilience team new colleagues took part in the Safety Zone in Huntingdon – supporting the messages about underage sales and shop policies and sharing information with 9/10 year olds about E-cigarettes, the effects of those and tobacco on their health. ***May*** **Longsands**: meetings with mentors to discuss and plan their three catchment Primary School visits to talk to Year 6's about the effects of smoking and their involvement in Kick Ash. **Bottisham Village College**: Accompanied mentors who visited 6 local shops to talk to businesses about Kick Ash and their underage sales policies. **Cottenham VC:** Supported mentors involved in their school year 8 development day where they invited pupils to take part in an interactive game about smoking and choices to be made.	£5,750	£4,347	£403

					Sir Harry Smith, Whittlesey: Accompanied and advised 6 mentors who visited 10 shops over 2 days. **St Neots Fire Station** taking part in a Safety Zone over 4 days. ***June*** **St Ivo:** Accompanied six pupils who carried out 11 shop visits over 2 days. Three shops were found to have not been displaying the Statutory Tobacco notice so further advice was given and follow up visits done to ensure compliance. **Longsands and Cottenham Village College**: Evaluation focus group meetings with mentors from both schools. Establishing what they have got out of their involvement with the programme, the effectiveness of programme and mentor support and what can may be improved for future. **Bottisham VC**: Further email contact made and evaluation forms awaited.			
ETE	**Illicit Tobacco**	£15k	Aileen Andrews	JM12800 John Steel	• Following the 6 Magistrates warrants executed late March and all 6 premises yielding illicit tobacco, investigation work has continued. Pace interviews conducted and cases prepared for court. One case is proving particularly problematical as ownership of the tobacco cannot easily be proved. • Financial Investigations ongoing. • Officers trained on new labelling legislation, standardised packaging and Tobacco Products Directive. • Intelligence work on going. • One alcohol licence reviewed as a consequence of the raids, licence revoked. • Two cases have been in the courts, one of which is concluded with defendant given 100 hours unpaid work. Court hearings arranged for the cases, which are in the court system, (Hearings on 15 July and 20 July). One defendant offered a simple caution, as only a small quantity found and main business is takeaway and restaurant and unlikely to re-offend. Regional Project - Costs not within this allocation. • Preparation for proposed education, intelligence and enforcement in the Autumn and Winter 2016. Meeting being arranged to discuss week long illicit and tobacco education campaign, including illicit	£3,750	£6,041	-£2,291

					education trailer in the county.			
ETE	**Business and Communities Team**	£10k	Elaine Matthews		Update awaited			
ETE	**Fenland Learning Centres**	£90k			Contract awarded and all funds allocated.	£22,500	£22,500	£0
					SUB TOTAL : ETE Q1	**£58,250**	**£59,165**	**£915**
CS&T	**Research**	£22k	Adrian Lyne	KH50000 Maureen Wright	The majority of the funding is used to maintain/develop the Cambridgeshire Insight 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. No additional work was carried out during Q1 in addition to that listed above.	£6,250	£6,250	£0
CS&T	**H&WB Support**	£27k	Adrian Lyne	KA20000 Maureen Wright	With supervision from Director of Public Health, approximately 2.5 days per week of the Policy and Project Officer's time, who sits within the Policy and Business Support Team of Customer Service and Transformation. Support during Q1 has included: • Working with the Local Government Association to plan for a development session on 14 June. • Work with HealthWatch Cambridgeshire and HealthWatch Peterborough on planning for a stakeholder event around the learning from the termination of the Older People's and Adult Community Services contract. • Supporting the effective functioning of the Health and Wellbeing Board • Supporting the effective functioning of the Health and Wellbeing Board Support Group • Researching and preparing reports for the Health and Wellbeing Board, including on key policy/strategy changes • Presenting relevant reports at the Health and Wellbeing Board Support Group meeting, such as on the HWB Working Group and persons story items • Presenting a report to the HWB on the June development session	£6,250	£6,250	£0

					• Agenda Planning for HWB support group and (working with democratic services) the HWB meetings • Co-ordinating and preparing the quarterly stakeholder newsletter – latest newsletter issues in June 2016 This is in addition to ongoing, reactive support as required.			
CS&T	**Communications**	£25k	Adrian Lyne	KH60000 Maureen Wright	Highlights include: • Continued support for PH campaigns such as warm homes • Working closely with Val Thomas and other consultants on reactive media enquiries • Supporting PH in the development of a new website • Developing a workshop for the PH away day • Working with the media to maximise opportunities for Public Health • Supporting Health Committee	£6,250	£6,250	£0
CS&T	**Strategic Advice**	£22k	Adrian Lyne	KA20000 Maureen Wright	Continuing on from the last quarter, the focus of strategic resource has been on developing the Transformation Programme into the 16/17 Business Planning Process. This has involved supporting a number of SMT Away Days ad GPC/SMT workshops. As well as the strategic nature of the Business Planning Process referenced above, there is a wide array of practical elements to the process – which strategic colleagues have been involved in ensuring aligns with the work of the Public Health Directorate. Devolution work also continues, as a potential Cambridgeshire and Peterborough deal gets the support of local partners and awaits response from Government.	£5,500	£5,500	£0
CS&T	**Emergency Planning Support**	£5k	Adrian Lyne	KA40000 Maureen Wright	Ongoing close working with the Health Emergency Planning and Resilience Officer (HEPRO) on a number of Emergency Planning tasks: • Provision of emergency planning support when the HEPRO is not available • Provision of out of hours support for 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 • CCC EMT has taken over the running of the review of the 'Excess Deaths Plan' and will being the work shortly in support of the Pandemic Flu arrangements • DECC return and work on Fuel Support Shortage Planning • Initial work on Public Health Business continuity review, and	£1,250	£1,250	£0

					including of Public Health details in the new emergency contact mechanism currently being completed			
CS&T	**LGSS Managed Overheads**	£100k	Adrian Lyne	UQ10000 Maureen Wright	This continues to be supported on an ongoing basis, including: • Provision of IT equipment • Office Accommodation • Telephony • Members Allowances	£25,000	£25,000	£0
					SUB TOTAL : CS&T Q1	**£50,500**	**£50,500**	**£0**
LGSS	**Overheads associated with PH function**	£220k	Adrian Lyne	QL30000 RL65200 TA76000 Maureen Wright	This covers the Public Health contribution towards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance £20k HR £25k IT £20k The remaining £155k is a general contribution to LGSS overhead costs	**£55,000**	**£55,000**	**£0**
					SUB TOTAL : LGSS Q1	**£55,000**	**£55,000**	**£0**

SUMMARY

Directorate	YTD (Q1) expected spend	YTD (Q1) actual spend	Variance
CFA	£1,677,750	£303,160	£1,374,590
ETE	£58,250	£59,165	£915
CS&T	£50,500	£50,500	£0
LGSS	£55,000	£55,000	£0
TOTAL Q1	**£1,841,500**	**£467,825**	**£1,373,675**

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 June 2016 can be seen within the tables below:

Measures										
Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	99%	99%	G	98%	98%	99%	↑	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	93%	93%	G	91%	80%	93%	↑	
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	1800	2638	147%	G	139%	600	147%	↑	
Number of Health Checks completed	18,000	4,500	3686	82%	R	n/a	n/a	n/a	↔	HCs reported quarterly . Only Q1 data available at present. .
Percentage of people who received a health check of those offered	45%	45%	37%	37%	A	n/a	n/a	n/a	↔	HCs reported quarterly
Number of outreach health checks carried out	2,633	667	313	47%	R	27%	222	74%	↑	
Smoking Cessation - four week quitters	2249	295	262	89%	R	n/a	n/a	n/a	↔	No previous months actual as start of 2016/17 reporting (April and May data combined)

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	58%	58%	56%	N/A	A	57%	58%	56%	↓	The current month actual represente the Q1 position for 2016/17 and compares with the Q4 actual (2105/16). This is a slight reduction since the last quarter. However, PHE are now collecting pilot information based on the health visiting data. 56% is one of the highest proportion of breastfeeding mothers in the Eastern region, when looking at the latest published date (Q4 2015/16)
Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	50%	/	47%	N/A	A	44%	61%	47%	↑	This has increased between Q4 (2015/16) and Q1 (2016/17). This was a new service for 2014-2015 and had stretch targets to improve coverage. It has remained fairly constant in each quarter between 44-49%. The target of 50% remains in place for 2016/17.
Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	90%	90%	96%	N/A	G	96%	90%	96%	↔	Whilst this figure remains the same as the previous month, and continues to remain well within the target
Health visiting mandated check - Percentage of children who received a 6 - 8 week review	90%	90%	94%	N/A	G	95%	90%	94%	↓	Whilst this figure is lower than the previous month, it remains well within the target
Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	100%	100%	92%	N/A	A	91%	100%	92%	↑	For Q1, if 'not wanted and not attended' figures are included, both Q1 and YTD figure rises to 96%
Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	90%	90%	77%	N/A	A	84%	90%	77%	↓	For Q1, if 'not wanted and not attended' figures are included, Q1 figure rises to 88% which falls within the 10% tolerance.
School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	N/A	N/A	169	N/A	N/A	38	N/A	169	↑	This data is part of new KPIs monitoring. No specific targets have been set, the aim is to benchmark the service provided. This quarter has seen an increase in interventions by the school nursing team - although there was a recording issue last quarter which resulted in a low figure for interventions.
School nursing - number of young people seen for mental health & wellbeing concerns	N/A	N/A	513	N/A	N/A	166	N/A	513	↑	This data is part of new KPIs monitoring. No specific targets have been set for the year as the aim is to benchmark the service provided. This qurter has seen an increase in the number of young people seen fro mental health and well being concerns.

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	80%	82%	102%	G	69%	80%	82%	↑	15/16 year coverage target achieved..New Measurement Programme will start in 16/17 academic year
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	80%	88%	109%	G	74%	80%	88%	↑	
Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1983	518	474	92%	A	101%	170	86%	↓	Slight dip in numbers this month -service promotion at various events planned.
Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	1686	440	398	90%	A	101%	144	72%	↓	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1075	281	145	52%	R	n/a	n/a	n/a	↔	Quarterly reporting. This intervention can take up to one year. Therefore there are cyclical
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	992	260	335	129%	G	151%	85	114%	↓	
Number of physical activity groups held **(Pre-existing GP based service)**	581	138	165	120%	G	144%	45	107%	↓	
Number of healthy eating groups held **(Pre-existing GP based service)**	581	138	50	36%	R	36%	45	27%	↓	This target is being revisited as this service has been delivering healthy eating sessions for 6 years and the needs are being reviewed
Recruitment of volunteer health champions **(Pre-existing GP based service)**	20	4	1	25%	R	0%	1	0%	↔	

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Personal Health Trainer Service - number of referrals received (Extended Service)	945	220	131	60%	R	68%	75	80%	↑	Targets were not being met because of recruitment issues. New staff in place but still being trained so inpyt limited. However, significant imprvements in referrals seen over past 2 months.
Personal Health Trainer Service - number of initial assessments completed (Extended Service)	803	188	91	48%	R	44%	64	63%	↑	Targets were not being met because of recruitment issues. New staff n place but still being trained so input limited. However, significant imprvements in referrals seen over past 2 months.
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	512	119	5	4%	R	n/a	n/a	n/a	↓	There was a low number of referrals in previous months due to the ongoing issues of the Service being unable to recruit and therefore low referrals in previous months. This intervention can take up to one year. Consequently the target KPI is being reviewed. Thsi is reported quarterly
Number of referrals from Vulnerable Groups (Extended Service)	472	111	61	55%	R	71%	38	68%	↓	Again this reflects the recruitment issue described above
Number of physical activity groups held (Extended Service)	726	171	193	113%	G	113%	56	143%	↑	
Number of healthy eating groups held (Extended Service)	726	171	252	147%	G	136%	56	209%	↑	
Recruitment of volunteer health champions (Extended Service)	24	6	4	67%	R	100%	2	100%	↔	Recruitment of volunteers requires the Extended Service to be fully staffed - see information about recruitment issues
Number of behaviour change courses held	34	7	4	57%	R	100%	2	0%	↓	Courses not delivered in June. Commissioners to assist with organisations to deliver to.

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Proportion of of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	38%	125%	G	n/a	n/a	n/a	↔	This is reported quarterlu as the intervention takes 3 - 6 months
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	30%	30%	0%	0%	G	n/a	n/a	n/a	↔	No data is currently available for 16/17. Each course is 6 months.
% of children recruited who complete the weight management programe and maintain or reduce their BMI Z score by agreed amounts	80%	N/A	N/A	N/A	G	n/a	n/a	n/a	↔	No data currently available for 16/17 as courses run intermittently throughout the year and last up to 6 to 9 months.
Falls prevention - number of referrals	386	66	65	98%	A	82%	22	91%	↑	
Falls prevention - number of personal health plans written	279	54	53	98%	A	106%	16	44%	↓	

* All figures received in July 2016 relate to June 2016 actuals with exception of Smoking Services, which are a month behind and Health Checks, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

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

Agenda Item No: 5

MENTAL HEALTH VANGUARD UPDATE (PLUS APPENDIX ON PRISM; NEW PRIMARY CARE SERVICE FOR MENTAL HEALTH)

To:	**HEALTH COMMITTEE**
Meeting Date:	**8 September 2016**
From:	**Mental Health Vanguard Project Team and PRISM Project Team: Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and Cambridgeshire and Peterborough Foundation Trust (CPFT)**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**For comment and for information**
Recommendation:	**The Committee is recommended to note and comment upon the recent updates on Mental Health services for the Cambridgeshire and Peterborough health system.**

	Officer contact:		***Member contact:***
Name:	CCG Engagement Team	Name:	Councillor David Jenkins
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1. BACKGROUND

In July 2015, Cambridgeshire and Peterborough CCG was awarded status to become one of eight national Urgent and Emergency Care Vanguard sites.

As part of a national NHS England programme, Vanguard sites are designed to test, evaluate and accelerate change, by piloting a range of new models of care.

The local Vanguard programme has been split into five workstreams, which are clinically-led and involve patients and their carers throughout their development and implementation.

The five workstreams are:

1. 111/out of hours clinical hub
2. Admission avoidance/community access
3. In-hospital emergency care
4. Post hospital discharge
5. **Urgent and emergency mental health care**

The CCG and CPFT partnership is leading on the Vanguard programme, which relates to urgent and emergency mental health care.

2. MAIN ISSUES

Before 4 April 2016, out of hours there was minimal support for emergency services to respond and provide a timely and effective support for people in mental health crisis. For most patients there was also no alternative for help in a crisis other then attending A&E.

Progress has been made in enhancing the psychiatric liaison provision in the emergency departments in recent years. However there is continued concern that mental health presentations to all A&E sites have been increasing year on year. There is an identified need for an effective crisis pathway in the community for mental health if this trend is going to be addressed. There have also been reports of long waiting times for assessment and poor patient and colleague experience.

The Vanguard project aims to provide an age-inclusive, self-referral, 24/7 crisis pathway for mental health – which will facilitate an assertive community-based response, allowing patients to be diverted from A&E and managed appropriately in the community. The crisis response and assessment service has been developed in parallel with a project involving our voluntary sector organisations, who are commissioned to provide alternative locations where patients in crisis can attend and be provided with support as an alternative to statutory services where appropriate. The overall objectives are: to reduce A&E attendance and acute hospital admission for patients with non-medical mental health problems by diverting patients from A&E; and to provide a fast response to mental health crisis in order to prevent escalation and improve patient and carer experience.

3. SIGNIFICANT IMPLICATIONS

3.1 Currently

Non-recurrent winter monies funds were used to fund a six month pilot, to support a limited component of a community-based Mental Health crisis service. This has and

will inform the roll out of the proposed full vanguard service model CCG-wide by 19 September 2016.

Components of the phase 1 pilot currently in place:

- **First response service:** With referrals triaged by the new system-wide co-ordinator, the first response service team dealt with 158 referrals in the first month of operation alone. Based in Cambridge, the team provide assessments in the community out-of-hours and respond to urgent referrals from emergency services.
- **Sanctuary:** The Sanctuary, based in Cambridge, opened on 4 April 2016 and allows people to get practical and emotional support during mental health crisis out of hours. Since opening feedback from patients and professionals has been very encouraging. Staffed by mental health charity Mind in Cambridgeshire, the Sanctuary can help patients link up with clinicians from CPFT's services or support from other organisations.
- **MiDos:** MiDos is a new mobile app that allows professionals to view a directory of services available locally and the service's live capacity. This will help professionals from different organisations better understand what is available, and then refer people on to the right service first time.

A new integrated mental health team also launched on 29 March 2016 to provide mental health advice and support to the police. The team was part of the partnership response to the Crisis Care Concordat and is funded by the Cambridgeshire Police and Crime Commissioner and Peterborough City Council. In the first month they received 752 referrals from police across the county and were able to support the calls with advice or signposting to other services.

3.2 Next steps – Mental Health Crisis Response Service, CCG-wide from 19 September, to include the following:

- **First Response Service** will expand to cover the whole of Cambridgeshire and Peterborough out of hours. The service will provide face-to-face assessment and crisis support within one hour, before diverting patients to a range of social, health and independent sector services, and urgent prescribing.
- **A second Sanctuary**, run by the third sector, will open in Peterborough to support people in the north of the county. There will also be an outreach service in Huntingdon, where people in crisis will be seen by the Sanctuary staff in a Huntingdon venue to work through their crisis and potentially be diverted from an unnecessary hospital attendance.
- **Patients will be able to self-refer** by telephone to urgent mental health services. Tele-coaches (experienced Psychological Wellbeing Coaches) will provide initial assessment and support via one point of telephone contact. They will then be able to signpost patients to the most appropriate service for them. They will be aided in this by the **UK Mental Health Triage Scale** – a new tool to assess over the telephone how quickly someone needs to receive mental health care. For more information please visit https://ukmentalhealthtriagescale.org/

It should be noted that the Mental Health Vanguard funding is non-recurrent but that any success within the programme could lead to these services being commissioned longer term.

3.3 Next steps: integrated mental healthcare for all

In addition to the Mental Health Vanguard Project which focuses on urgent mental healthcare, the CCG and CPFT are also working together on another project; PRISM, the new primary care service for mental health (please see Appendix 1 for details).

Source Documents	Location
UK Mental Health Triage Scale (webpage)	***https://ukmentalhealthtriagescale.org/***

Appendix 1

PRISM – the new primary care service for mental health

Cambridgeshire and Peterborough CCG and Cambridgeshire and Peterborough Foundation Trust (CPFT) are working together on a pilot to improve the wellbeing and care of people with mental health conditions; who are either transitioning from secondary care (provided by CPFT) to primary care, or who need more mental health support than primary care can provide.

The new enhanced primary care mental health service (known as PRISM) is being trialled in a small number of practices, in Huntingdon and Fenland.

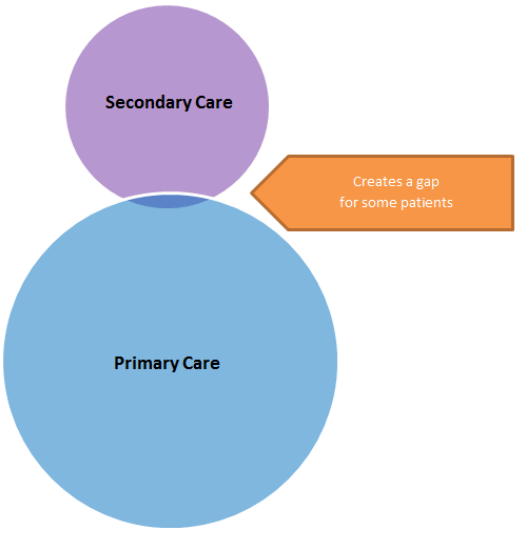
Staffed by CPFT, the team will include a mental health nurse, a peer support worker, and a health care assistant. The service, based in GP practices, will offer appointment slots for patient assessments and provide mental health support and advice to GPs.

People that would be suitable to use the service are likely to have stable mental health problems of moderate to high severity, and have risk levels that can be managed in a primary care-based service. The service is for people aged 17-65 years.

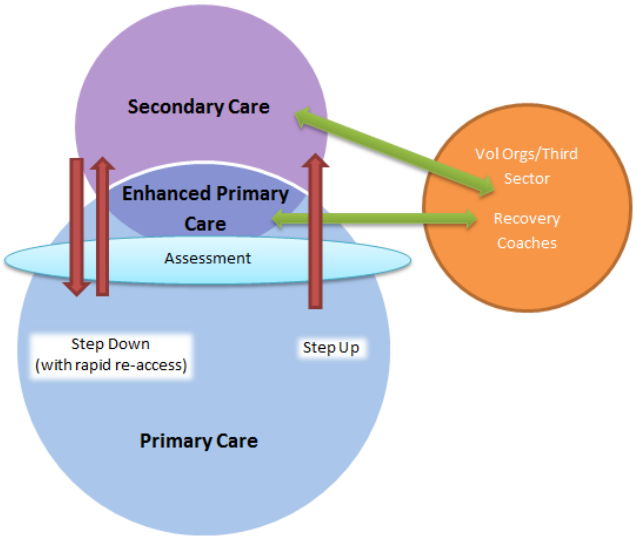
Interventions will include medication management and regular proactive reviews or assessments.

The pilot aims to provide a service that is based on a person's needs rather than their diagnosis. By providing greater support in primary care it will allow secondary services to focus on patients with the greatest and most complex needs. The service will also ensure prompt re-access to secondary care for people when needed, with additional signposting to third sector services.

Current model:



Future model:



If the pilot is successful, we hope to launch the service across the whole of Cambridgeshire and Peterborough.

Agenda Item No: 6

OUTPATIENT SERVICES AT COMMUNITY HOSPITALS

To:	**HEALTH COMMITTEE**
Meeting Date:	**8th September 2016**
From:	**Tracy Dowling, Chief Officer, Cambridgeshire and Peterborough Clinical Commissioning Group**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**For comment and for information**
Recommendation:	**The Committee is recommended to note the update on Outpatient Services in Cambridgeshire and Peterborough**

	Officer contact:		***Member contact:***
Name:	CCG Engagement Team	Name:	Councillor David Jenkins
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1. BACKGROUND

1.1 The purpose of this report is to provide the committee with an update on the East Cambridgeshire and Fenland review of some of the health care services delivered from the community hospitals.

2. MAIN ISSUES

2.1 There are three community hospitals located in the location of East Cambridgeshire and Fenland. These are Doddington Community Hospital (located in Doddington), Princess of Wales Community Hospital (POW) (located in Ely) and North Cambridgeshire Hospital (located in Wisbech).

2.2 The CCG is reviewing specific services that are provided from these sites in the context of the wider STP, current local assessed health needs and future population growth. Fenland and some parts of East Cambs have particular challenges associated with deprivation and rurality. The Sustainability Transformation Programme (STP) is looking at which services are best provided locally and which services require to be delivered from an acute setting. The draft STP plan that was submitted to NHS England end of June is setting out an ambitious programme to ensure high quality services are provided from the most appropriate care setting. The focus is to support 'home is best', keeping services local where this is clinically and economically appropriate. It also looks at ensuring that the NHS pound is spent as effectively as possible ensuring there isn't unnecessary duplication of services.

2.3 The CCG is looking at how local services can be integrated within a community hub type setting where benefits can be achieved through closer working. This could involve larger GP federations and community based services such as services for the elderly and long term conditions, and minor injury services.

2.4 Community outpatient clinics are delivered from all three community hospital sites. At the North Cambs site services are run by Queen Elizabeth Hospital (QEH). The Doddington and POW are currently run by Cambridgeshire Community Services however they have served notice which ends 31 March 2017. Radiography services are run by CPFT which has also served notice. The CCG is working with local providers to ensure a provider can take over both outpatient and x-ray services from April 2017. These conversations are near completion and a procurement process will take place if there isn't sufficient local interest.

2.5 A number of different clinics run from the different sites. These include a range of specialties such as ENT, Ophthalmology, Orthopaedics, paediatrics, gynaecology etc. Access to all sites is good with free parking too. Some of the clinics are not being used as much as we would expect. We are working to increase use of local services, and will be working with the new provider and local GPs to look at ways to enable greater numbers of people to access the clinics.

2.6 The three Minor Injury Units are part of a wider discussion about the provision of Urgent and Emergency Care services in Cambridgeshire and Peterborough through the Sustainability and Transformation Programme. The vision for urgent and emergency care in Cambridgeshire and Peterborough is for highly responsive and effective services for urgent but non-life threatening conditions to be provided away from an acute hospital setting. A Clinical Advisory Group has been set up to review potential models which have been developed in line with Professor Sir Bruce Keogh's

review of NHS urgent and emergency care system. The options which have been proposed are:

Option 1	Continue with existing MIU, Out of Hours (OOH), community and primary care arrangements (Do Nothing
Option 2	Close all MIUs and require primary care and local A&E departments to manage the activity previously managed within the MIUs
Option 3	Reconfiguration of services in the Fens and East Cambs and use local primary care, Out of Hours (OOH) GP services, Joint Emergency Team (JET) capability and capacity and MIU staff to create an integrated local urgent care service
Option 4	Close all but one of the MIUs in the Fens and East Cambs but develop this into an Urgent Care Centre and use local primary care, OOH, JET capability and capacity and MIU staff to create an integrated local urgent care service in the areas affected by the closures
Option 5	Close all but two of the MIUs and develop these into Urgent Care Centres and use local primary care, OOH, JET capability and capacity and MIU staff to create an integrated local urgent care service in the area affected by the closure
Option 6	Develop all MIUs into Urgent Care Centres

After significant media interest about our review of minor injury services in the early part of August we set up a number of meetings to explain the work we were doing. We wanted to hear views early before we went to full public consultation if the recommendations would mean significant change.

Over 400 local people attended public meetings in August to discuss minor injury and outpatient services across East Cambridgeshire and Fenland. An additional four meetings have been booked in September, to ensure that more local people have an opportunity to have their say and feed into the review of services, before we come back out to people with recommendations as part of any formal consultation.

Turn out at the meetings has exceeded expectations, and regrettably the CCG did have to turn some people away as the venues were not large enough to accommodate everyone. As such additional meetings have been arranged for:

- Thursday 8 September, March Community Centre, PE15 8LE, 6.30-8.00pm
- Tuesday 20 September, Queen Mary Centre, Wisbech, PE13 2PE, 6.30-8.00pm
- Wednesday 21 September, Chatteris Parish Church, PE16 6BA, 6.30-8.00pm
- Tuesday 27 September, The Maltings, Ely, CB7 4BB, 6.30-8.00pm

Additional dates will be booked in autumn 2016 and publicised widely, and the CCG website has full details of upcoming public meetings, at **www.cambridgeshireandpeterboroughccg.nhs.uk**. Presentation slides and notes from each meeting will also be available on our website shortly so people can see the

key themes from each meeting so far.

The CCG welcomes the contributions that have been made so far and will continue to listen to what people have to say over the coming months.

No decisions have been made about the future of the minor injury services in East Cambridgeshire and Fenland. The CCG is looking at how these services relate to recommendations from the national review of urgent care services and how we might deliver minor injury services locally, working alongside other services including GPs and community services.

The CCG is at an early stage of its review and if any significant changes are considered necessary as a result of these discussions then a formal public consultation will take place.

2.7 There has also been a temporary pause on admissions to the extra care unit at Doddington Court, on patient safety grounds. The CCG's priority is the safety of patients, and at the present time there are concerns around the levels of care which can be safely provided to support patients with more complex needs.

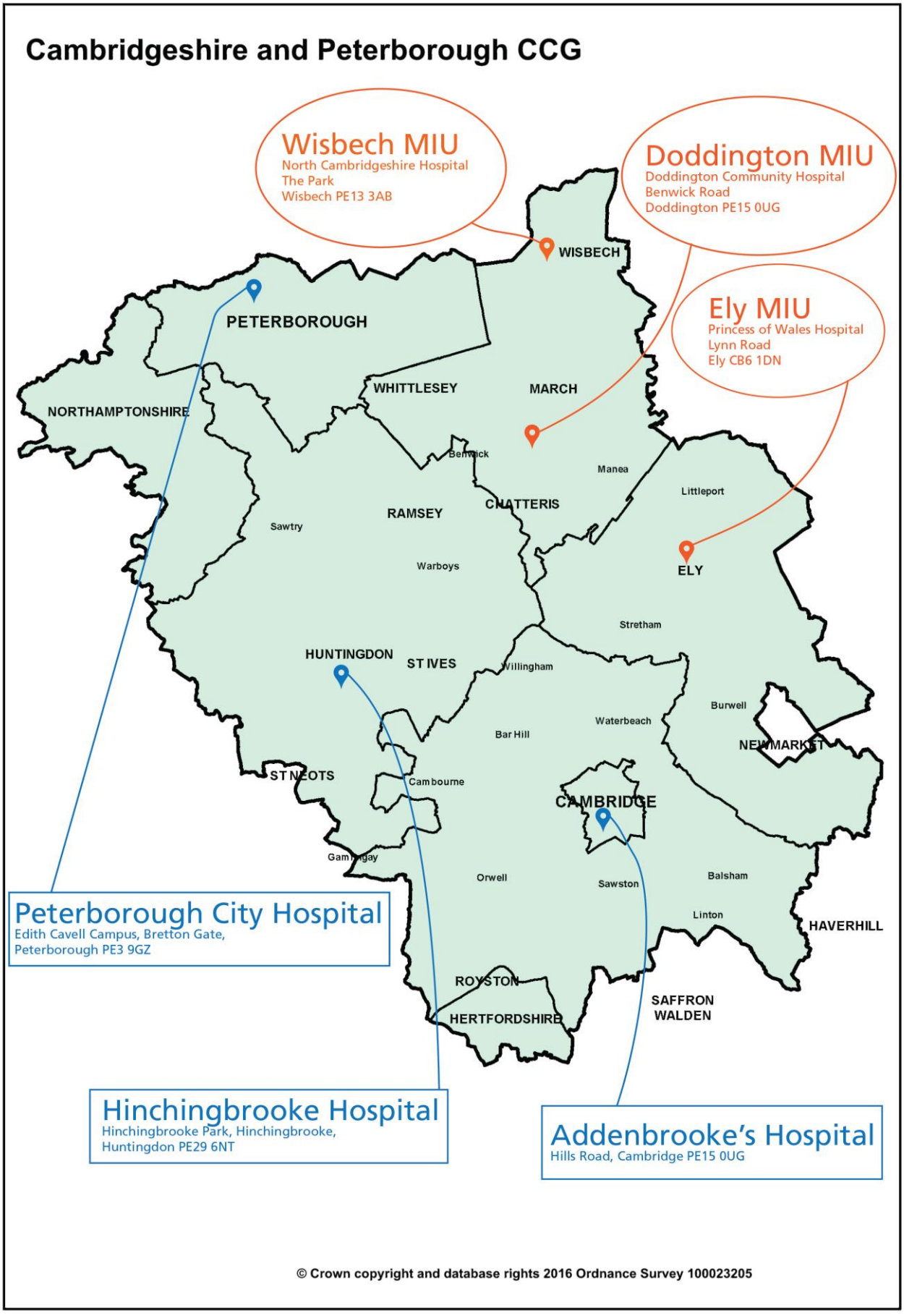
As we updated the Committee in July, we are also working to review and assess the current community bed provision across Cambridgeshire and Peterborough, and what types of beds are likely to be needed going forward. This work is almost completed but the CCG will engage on any future proposals and hopes to have a solution in place as soon as possible.

2.8 Continued work across the urgent care system is taking place as part of the Sustainability and Transformation Plan (STP). Further work on considering the options outlined above will take place between now and October 2016, as well as an NHS senate and clinical gateway review.

If any options are supported then a public consultation could take place from November/December 2016 until February 2017. The CCG would then make a decision following this process and after reviewing all the options and feedback.

A future service will provide a local service for minor injuries and illnesses, but this may be in a different way to the current model of services.

2.9 **Location of hospitals and Community hospitals in Cambridgeshire and Peterborough:**



3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

The work being done is testing value for money and that the services are sustainable.

3.2 Equality and Diversity Implications

This review takes account of other key pieces of work in particular:

Project	Lead Organisation
Urgent Care Vanguard	Cambridgeshire and Peterborough CCG
Sustainability and Transformation Programme	Clinical Advisory Group
Migrant & Refugee JSNA	Cambridgeshire County Council

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3.3 Engagement and Consultation Implications

See wording under 2.6

3.4 Public Health Implications

The population of East Cambs and Fenland have high levels of deprivation therefore the work being undertaken will factor this issue into the options going forward.

Source Documents	Location
Cambridgeshire and Peterborough CCG website	*www.cambridgeshireandpeterboroughccg.nhs.uk*

Agenda Item No: 8

PROPOSAL TO FORM A JOINT COMMITTEE TO SCRUTINISE THE PROPOSED MERGER OF PSHFT WITH HHCT

To: **HEALTH COMMITTEE**

Meeting Date: **8 September 2016**

From: **The Monitoring Officer**

Electoral division(s): **All**

Forward Plan ref: **Not applicable**

Purpose: **To consider establishing a joint scrutiny committee between Cambridgeshire County Council and Peterborough City Council to scrutinise proposals to merge Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) with Hinchingbrooke Health Care NHS Trust (HHCT).**

Recommendation: **The Committee is asked to**

a) **decide whether to support the establishment of a joint scrutiny committee with Peterborough City Council to scrutinise proposals for the merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust**

and, if it is decided to support the establishment of such a joint committee, to

b) **decide on the preferred size of the joint committee**
c) **appoint members of the Health Committee to serve as members and substitutes on the joint committee**
d) **authorise the joint committee to respond on behalf of the Health Committee to the public engagement / consultation proposals**
e) **consider whether a joint committee would be required to scrutinise the implementation and governance arrangements, should the proposed merger be agreed by the two NHS Trust Boards**
f) **comment on the draft terms of reference.**

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

1.1 On 23 May and 24 May 2016 respectively, the Boards of Hinchingbrooke Health Care NHS Trust (HHCT) and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) met to discuss proposals about collaborative working between the two trusts.

1.2 Both trusts face significant sustainability challenges, not only financially but also from a quality and clinical perspective. The Outline Business Case (OBC) has determined that closer colloboration will not only support the ongoing provision of services locally at HHCT but will improve quality of care and enable significant financial benefits to be achieved through the integration of back office functions.

1.3 An options appraisal was conducted as part of the OBC which concluded Option 4: to create a single organisation, as the preferred option to deliver the most benefits in terms of financial and clinical suitability. The Health Committee met on 14 July to discuss with Chief Executives from both PSHFT and HHCT the current proposals about collaborative working between the two trusts. Members were informed that both Trust Boards have agree to a Full Business Case (FBC) for the merger of HHCT and PSHFT to be produced and presented at the September 2016 board meetings.

1.4 This report will discuss the principles behind establishing a Joint Overview and Scrutiny committee (OSC) between Cambridgeshire County Council (CCC) and Peterborough City Council (PCC). The PCC Scrutiny Commission for Health Issues is expected to consider a similar report at its meeting on 15 September.

2. MAIN ISSUES

2.1 <u>Legislative and Constitutional Basis</u>

Under regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, two or more local authorities may appoint a discretionary joint OSC to carry out all or specified health scrutiny functions, for example in relation to health issues that cross local authority boundaries. The same regulation also requires that a joint OSC must be established if a local NHS body consults more than one local authority on any proposal for a substantial development of the health service in the local authorities' area, or for a substantial variation in the provision of such a service.

The present HHCT and PSHFT merger proposals do not constitute a substantial development or variation of the health service, so the establishment of a joint OSC to examine them would be at the discretion of the local authorities involved. Both CCC's Health Committee and PCC's Scrutiny Commission for Health Issues would be authorising the joint OSC to respond to the proposals on their behalf, and would not make any separate response as an individual committee.

The County Council's Constitution authorises the Health Committee to delegate its functions to a joint overview and scrutiny committee when this is required by legislation or is conducive to the efficient scrutiny of proposals affecting more than one local authority area. The Committee is also authorised to appoint members to such a joint committee, in which case political balance requirements apply to the appointments.

2.2 Benefits of Joint Overview and Scrutiny

There is a clear benefit of efficiency in regards to establishing a Joint OSC, both for the local authorities involved in scrutinising the NHS and also for the health service organisations under scrutiny. In deciding whether to establish a Joint OSC, it is necessary to consider whether it would complement rather than duplicate work for all partners. Appendix A sets out a recommended test to enable a quick assessment of whether to undertake joint scrutiny activity. The test is very simple – if the considered response to the majority of questions in the table is "Yes" then some form of joint scrutiny is likely to be appropriate.

At its meeting on 14 July 2016, the Health Committee considered the matter and decided 'to proceed with further joint scrutiny of the proposals in collaboration with Peterborough City Council and other Local Authorities subject to their agreement.' The Committee did not decide what form that this joint scrutiny would take.

2.3 Purpose and Powers

A Joint OSC is recommended to scrutinise the proposals of PSFHT and HHCT working collaboratively. Alternative approaches could include the two OSCs (Cambridgeshire Health Committee and the Peterborough Scrutiny Commission for Health Issues) each scrutinising the matter separately, or holding a shared evidence-gathering session, after which each OSC would make its own response to the engagement exercise.

The purpose of the Joint Committee would be to scrutinise the Full Business Case (FBC) for the proposed merger of PSHFT and HHCT, recognising that PHSFT would be the acquiring organisation as an established "Foundation Trust".

Key areas of focus would include review of and comment on:

- Arrangements and process for effective Public Engagement
- Joint Clinical Vision
- Long Term Financial models for the merger.

When establishing the joint committee, it is also necessary to consider in advance whether the joint committee's remit should be extended beyond the merger decision to scrutinise the mobilisation phase, should the merger be agreed.

2.4 Membership and Co-option

When CCC and PCC established a joint OSC in 2011, it consisted of five members from each of the two authorities, with three substitutes from each. Members are asked to consider what number would be appropriate on this occasion.

In deciding the size of the joint committee, members should note that practical considerations mean that political proportionality will have to apply. Only Full Council can waive the proportionality requirement, and Cambridgeshire's next meeting is not until 18 October (12 October for Peterborough), when two weeks of the six-week engagement period will already have passed.

The Cambridgeshire membership of the joint OSC would be calculated separately from the Peterborough membership. The table below sets out the allocation based on different numbers of Cambridgeshire members.

Total	Conservative	Lib Dem	UKIP	Labour	Independent
3	1	1	1	0	0
4	2	1	1	0	0
5	2	1	1	1	0
6	3	1	1	1	0

Co-option

If its terms of reference permit, the joint OSC can co-opt other people as non-voting members. Given the concerns expressed by Huntingdonshire residents and District Councillors, it is recommended that provision be made for the joint OSC to co-opt a member of Huntingdonshire District Council. Because some of their residents are potentially affected by the proposals, consideration should also be given to the co-option of a member of Bedford Borough Council and of Lincolnshire County Council.

It may also be appropriate to co-opt representatives of organisations with an interest or expertise in the issue being scrutinised. For example, Healthwatch Cambridgeshire and Peterborough would potentially be able to provide relevant information on concerns expressed by patients.

2.5 Supporting the Joint OSC

Informal discussions have been underway in regards to determining the lead authority. It is proposed that Cambridgeshire County Council would assume this role, perhaps with some assistance from Peterborough officers. The lead authority will act as secretary to the Committee. This will include:

- Appointing a lead officer to advise and liaise with the Chairman and committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned
- Providing administrative support
- Organising and minuting meetings.

2.6 Establishing Timescales

Both Trusts are working to very tight timescales around the proposals. This has implications for potential members of the Joint OSC, as it is envisaged that at least two meetings will be needed during the period 12 October to 11 November, including developing a formal response to be submitted by the Joint OSC as part of the engagement process. The Joint OSC may also want to consider the report that is presented to both the HHCT and PSHFT Boards to ensure it captures the recommendations proposed by the Joint OSC.

- FBC to be discussed at PSHFT Board 27 September
- FBC to be discussed at HHCT Board 29 September
- Public Engagement commences 3 October
- Public Engagement responses deadline 11 November
- Final approval of proposals HHCT Board 24 November
- Final approval of proposals PSHFT Board 29 November
- Implementation of merger (subject to approval) 1 April 2017

The Memorandum of Understanding agreed by the Chief Executives of HHCT and PSHFT is attached as Appendix B. It includes information on time line and work streams.

2.7 Powers and Terms of Reference

In summary, a Joint OSC would have authority to:

- Require officers of appropriate local NHS bodies to attend and answer questions
- Require appropriate local NHS bodies to provide information about the proposals
- Obtain and consider information and evidence from other sources, such as patient groups, members of the public, expert advisers and other agencies
- Make a report and recommendations to the appropriate NHS bodies and other bodies that it determines
  and potentially
- Consider the NHS response to its recommendations.

Draft terms of reference are being developed, to be supplied as Appendix C to this report. They are based on the terms of reference used for the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee for Liver Resection Services in 2013, which in turn were based on model terms of reference agreed by all the Health OSCs in the region in 2010.

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

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

- Officer support and administration in regards to establishing a joint committee. Details are outlined in section 2.5

3.2 Statutory, Risk and Legal Implications

No significant implications

3.3 Equality and Diversity Implications

No significant implications

3.4 Engagement and Consultation Implications

No significant implications

3.5 Localism and Local Member Involvement

There may be the need to involve local members from Huntingdonshire as the proposals affect the management of local district general hospital. Provision for this has been identified in section 2.4

3.6 Public Health Implications

No significant implications

Source Documents	Location
Outline Business case – Merger of Hinchingbrooke Health Care NHS Trust and Peterborough and Stamford Hospitals NHS Foundation Trust	http://www.hinchingbrooke.nhs.uk/working-with-peterborough-stamford-hospitals/
Step by Step to Joint Scrutiny: A handbook for Scrutineers *Ashworth R. & Downe J. (2015)*	http://business.cardiff.ac.uk/news/cardiff-business-school-launches-handbook-help-councils-collaborate-accountability
Local Authority Health Scrutiny (guidance document)	https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013	http://www.legislation.gov.uk/uksi/2013/218/made
County Council Constitution (Part 3B)	https://cmis.cambridgeshire.gov.uk/ccc_live/Documents/PublicDocuments.aspx

Table 1: Should we work jointly with other councils?	
Criteria	*Response*
Are citizens in two or more council areas likely to be affected by a regional/ partnership policy decision?	Yes/No
Will the regional/partnership policy decision have strategic implications for two or more councils?	Yes/No
Will joint scrutiny complement (rather than duplicate) reviews conducted by audit, inspectorate and regulatory bodies?	Yes/No
Will it be cost effective to pool scrutiny talent and resource, rather than to scrutinise separately?	Yes/No
Does the regional/partnership policy decision significantly impact on the resource spend for two or more councils?	Yes/No
Will joint scrutiny produce 'added value' for two or more councils?	Yes/No
Will joint scrutiny be timely in terms of having maximum impact on decision-making?	Yes/No
Will joint working reduce duplication for partners and prevent organisations giving similar input to two or more local scrutiny committees?	Yes/No
Are there adequate resources to conduct effective joint scrutiny?	Yes/No

MEMORANDUM OF UNDERSTANDING

DEVELOPING A FULL BUSINESS CASE FOR MERGER OF HINCHINGBROOKE HEALTHCARE NHS TRUST AND PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

BETWEEN THE "TRUSTS" LISTED BELOW:

HINCHINGBROOKE HEALTH CARE NHS TRUST (HHCT)

PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST (PSHFT)

1. The project

1.1 The trusts agree to work together to develop a full business case, and implementation plan for merger of the two trusts to support the future delivery of sustainable services for the benefit of patients and taxpayers and reduce duplication of corporate and back office costs.

1.2 The project will continue until the merger is transacted, or until the respective boards decide not to proceed based on the full business case.

1.3 The full business case will consider the potential benefits and define an implementation plan to merger. The legal process to achieve this will be by acquisition of HHCT by PSHFT.

2. Timescales

2.1 The project will commence on 1 June 2016

2.2 The full business case will be presented for decision to each board in September 2016

2.3 If an FBC recommendation for merger is accepted by both Boards, the trusts will engage with the public to develop the implementation plan by November 2016.

2.4 If supported by the boards and regulators, the merger will be transacted on 1st April 2017

2.5 A timeline for development of the FBC through to implementation is provided in Appendix 1

3. Background

3.1 As part of the Cambridgeshire and Peterborough System Transformation Programme both trusts have approved an outline business case for merger.

3.2 In supporting the OBC, both Boards have agreed to work positively and in a committed way to jointly develop a Full Business Case (FBC) for merger to enable the future delivery of sustainable services for the benefit of patients and taxpayers and reduce duplication and cost.

3.3 The Boards and NHS Improvement identified areas for focus which will be addressed in the FBC approval process.

3.4 The FBC will include:

3.4.1 confirmation of the case for change;

3.4.2 confirmation of the economic assumptions in the outline business case, including the base case, potential savings opportunities, and implementation costs;

3.4.3 detailed back office integration plans;

3.4.4 in the context of the sustainability and transformation plan, develop detailed clinical integration plan for services which are currently unsustainable, including:

- clinical haematology,
- diagnostic imaging,
- stroke,
- cardiology,
- Emergency Department,
- respiratory;

and a high level plan for all other services with a shared clinical vision for the merged trust.

3.4.5 quality and clinical governance plan;

3.4.6 workforce/TUPE plan;

3.4.7 an organisational development plan to align culture in the new trust;

3.4.8 an assessment of the impact on competition;

3.4.9 financial management of the merged trust including reporting and accounting arrangements, and an assessment of the assets and liabilities to be transferred;

3.4.10 corporate governance of the merged organisation, including membership, board constitution, appointment of key board level posts, corporate governance arrangements and standing orders;

3.4.11 comms and engagement plan from 24 June; and

3.4.12 opportunities for the rationalisation of estates across sites in the merged trust to maximise clinical capacity and save costs

4. Purpose and Commitment

4.1 The trusts will assess in detail the opportunities to improve clinical sustainability across both trusts whilst reducing duplication in corporate and back office services. Subject to board agreement, they will develop an implementation plan to transact a merger by April 2017, and an implementation plan to deliver full integration after that date.

4.2 Although the project will proceed to the dates identified in section 2, where early opportunities are identified to strengthen clinical services for patients through clinical collaboration, or to improve back office services, these will be delivered at the earliest opportunity.

4.3 The trusts agree to provide management/project resource, and share relevant workforce, non-pay and other budget and relevant data connected with the services in scope and for this information to be shared between trusts.

5. Project arrangements

5.1 Both CEO's will support this project, and the CEO of HHCT will chair the transition board

5.2 The project will be supported and led by relevant expertise from within each trust, the Sustainability and Transformation Plan (STP) and external support from and through NHS Improvement.

6. General principles

6.1 This project will:

- above all, work to the timescales defined in section 2 above.
- remain compatible with other work streams in the system transformation programme, as far as they are known at the time.

6.2 Both trusts will provide access to relevant information in the preparation of the FBC and implementation plan.

6.3 Both parties agree to ensure value for money during the preparation of the full business case and will limit strategic decision making and avoid

incurring short term costs which may need to be reversed depending on the outcome of the business case.

6.4 Both trusts agree to avoid entering any additional long term strategic or financial commitments without the prior approval of both CEO's including :

- Approval of new major capital projects
- Strategic partnerships
- Appointment of senior clinical posts

6.5 Before appointing to senior clinical posts both Medical Directors will discuss the potential to share posts, develop joint roles and ensure that job descriptions include the potential to work across the sites of both trusts.

6.6 Both trusts agree to not make any substantive appointments to any non-clinical post i.e. all corporate (including clinical corporate roles), administrative and / or managerial posts. Any exception to this approach has to be approved by the two Directors of Workforce.

7. Confidentiality

7.1 Any information already available in the public domain is not exempt from disclosure under the Freedom of Information Act (2000)

7.2 Sensitive information (including confidential and commercially sensitive information,) will be shared when it is necessary for the purposes of the merger, but access will be restricted to individuals who need to know the information for that purpose, such as advisers, the core programme team/programme board, proposed board, work stream leads and finance leads or members of their teams as appropriate.

7.3 Information will be transferred securely (NHS.net to NHS.net, secure FTP, or secure information sharing portal (Box.com))

7.4 Information transferred will be stored securely and safely, (e.g. on a restricted access backed up server)

7.5 Information will not be used for purposes other than the merger

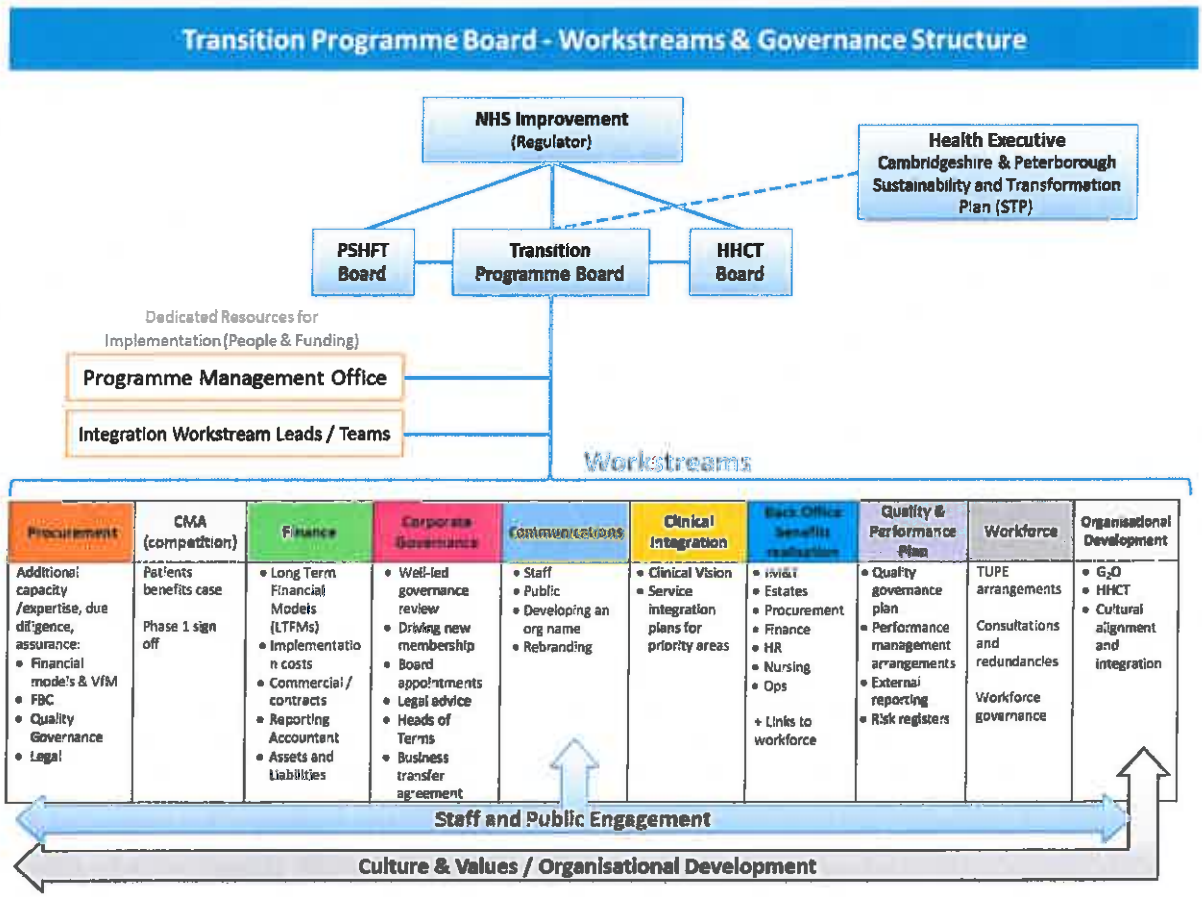
7.6 If the merger is abandoned, confidential or commercially sensitive information that has been shared for this purpose will be returned or destroyed

7.7 Individuals with access to commercially sensitive will need to sign a non-disclosure agreement reflecting the conditions above. If either party suspects that this is breached, they will inform the other party as soon as is practically possible.

8. Governance

8.1 The project will be led by a transition programme board which will form part of the governance arrangements for the system wide transformation programme shown in diagram 1. The Programme Director is the PSHFT Deputy CEO.

Diagram 1



8.2 The transition programme board will report to the Health Executive Group.

8.3 The lead CEO will report every two weeks, updating system leaders, NHS Improvement and NHS England on progress, including any risks or issues requiring clarification or support from trusts.

8.4 Each CEO will report to their individual Boards and Governors as applicable.

8.5 The project will be established and operated on PRINCE principles.

8.6 Membership of the programme board will comprise both CEO's, the Programme Director, MD for HHCT, NED representaives,with individual work stream leads from within each trust and representation from NHS Improvement and the STP/CCG.

9. Business case structure

9.1 The full business case will be based on the Five Case Model template for business case development (HM Treasury 2007), described below.

Five case model FBC	Proposed HHCT/PSHFT FBC
1. Strategic case – to demonstrate that the proposals are supported by a robust case for change.	a. Confirm the case for change in the OBC and develop a further level of detail b. Competition impact assessment
2. Economic case – to demonstrate the options appraisal of potential benefits compared to costs, and that value for money has been optimised for society as a whole	a. Refresh the corporate and back office savings b. Confirm the OBC options c. Confirm implementation costs
3. Commercial case – to demonstrate that the proposals are commercially viable	Not included
4. Financial case – to demonstrate that the proposals are financially affordable	a. Confirm the financial base case for both trusts and the merged organisation b. Set out the sources of funding to implement the merger c. Due diligence d. Assets and liabilities to be transferred
5. Management case – to demonstrate that the proposals can be delivered successfully	a. Finalise project management arrangements and plans b. Clinical vision and detailed clinical integration plan for a small number of services which are currently unsustainable, and a high level plan for all other services c. Detailed back office and IT integration plans d. Quality governance plans e. Workforce/TUPE plan f. Organisational development plan g. Corporate governance of the merged organisation h. Comms and engagement plan i. Commissioner and regulator support j. Business transfer agreement k. Risk management arrangements l. Post project evaluation arrangements and plans m. Independent assurance of the FBC including independent assurance of the LTFM
6. Recommendations	a. Recommend whether or not to merge, implementation plan to transact and benefits realisation plan for 1-2 years

10. Resources

10.1 As far as possible, both organisations will utilise in-house resources with external support as required.

10.2 PSHFT resource will include:

- Deputy Chief Executive (Programme Director)
- Assistant Director of Strategy
- Assistant Director System Transformation and Stamford Redevelopment
- Deputy Director of Finance - Planning
- Deputy Director System Transformation
- Clinical expertise for specific areas of work

10.3 HHCT resource will include:

- Chief Operating Officer/Deputy CEO
- Senior Finance Managers
- Senior Quality Lead
- Board Secretary
- Clinical expertise for specific areas of work
- Senior Strategy Lead

10.4 Other resources to cover essential work in HR, OD, activity modelling, contract developments, information technology and services will be made available in both organisations for the specific areas of work, and may at times be supported by external expertise where required.

10.5 NHS Improvement will provide guidance and support to the project throughout FBC development and (FBC approval dependant) through transaction and implementation planning, via the Provider Support Team.

10.6 Specific support on the FBC outputs will be provided from NHS Improvement transaction review team, and on competition issues as related to the Competition and Markets Authority (CMA) via the Cooperation and Competition Department.

10.7 In agreement with NHSI, procure financial analytic and competition analysis support.

11. Work streams

11.1 The transition programme board will oversee ten work streams to develop the full business case. These are described in more detail in Appendix 2.

11.2 The full business case will be developed from the Outline Business Case.

11.3 Responsibility for writing the business case rests with both organisations with the lead author being the Programme Director.

11.4 The work streams to develop the FBC include:

- Clinical integration
- Back office benefits
- Workforce

- Organisational development
- Quality and performance
- Finance and due diligence
- Corporate governance
- Competition
- Communication and engagement
- External support (procurement)

12. Funding

12.1 Both trusts will work together to identify and secure the required funding to support the successful development of the FBC and, if a decision to proceed to merger is supported, to transact and implement full integration.

12.2 The trusts agree to work with NHS Improvement to finalise the funding requirements and then secure that funding.

13. Agreement

Signed by:

HHCT Chief Executive:

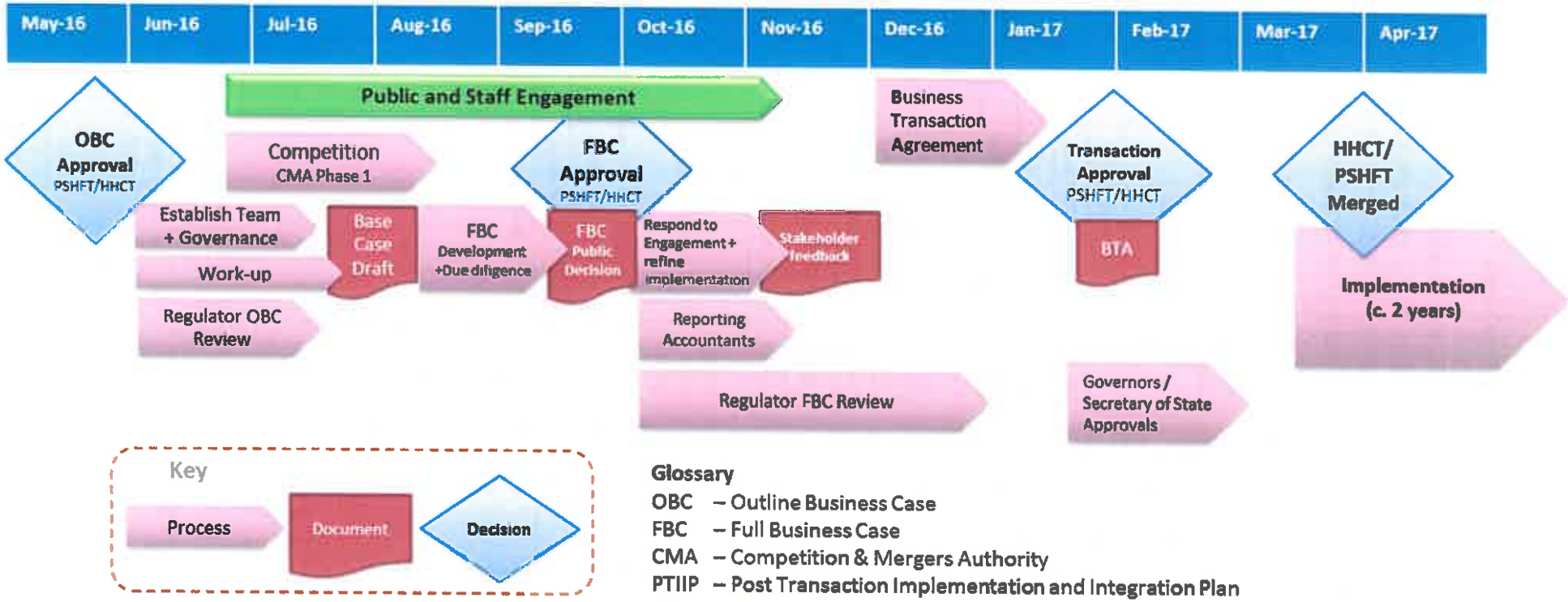
(L.McCarthy)

PSHFT Chief Executive:

(S.Graves)

July 2016

Appendix 1 –High level timeline for development of the full business case and implementation plan



Glossary

OBC – Outline Business Case
FBC – Full Business Case
CMA – Competition & Mergers Authority
PTIIP – Post Transaction Implementation and Integration Plan
BTA – Business Transaction Agreement

Appendix 2 Work streams to develop the full business case

The Transition Board will work to the timescales detailed below to develop the FBC by September. Tasks in **Bold** are dates when each chapter will be reviewed by the Transition Programme Board. Tasks in normal font require the Board to review information which will contribute to each chapter.

Key supporting tasks required to support delivery of the FBC are also identified in the table.

FBC Timeline for September FBC	Date	FBC chapter	Paper/**chapter** to Transition Board
Case for change review	Jun-16	3 – Strategic case	Jun-16
Regulator OBC review	Jul-16	3 – Strategic case	Jul-16
Competition review complete	Aug-16	3 – Strategic case	Aug-16
Commissioner and regulator support	Aug-16	**3 – Strategic case**	**Aug-16**
Independent assurance	Sep-16	3 – Strategic case	Sep-16
Refresh corporate and back office costs	Jun-16	4 – Economic case	Jun-16
Confirm options	Jul-16	4 - Economic case	Jul-16
Refresh implementation costs	Jul-16	**4 – Economic case**	**Jul-16**
Clinical vision, integration plan for five services, and a high level plan for all other services	Aug-16	**5 – Clinical case**	**Aug-16**
Detailed back office integration plan	Aug-16	**6 – Benefits**	**Aug-16**
LTFM prepared including - base case - merged trust pre-due diligence - merged trust – post due diligence	Jun-16 Jul-16 Sep-16	7 – Financial case	Jun-16 Aug-16 Sep-16
Sources of funding for transition and implementation	Jul-16	7 – Financial case	Jul-16
Assets and liabilities	Aug-16	7 – Financial case	Aug-16
Due diligence - Commercial - Estates - Finance (including LTFM) - Governance (non-clinical) - Governance (Clinical) - Governance (corporate) - IM&T - Legal - Workforce	 Sep-16 Sep-16 Jul-16 Aug-16 Aug-16 Aug-16 Aug-16 Sep-16 Aug-16	**7 – Financial case**	**Sep-16**
Workforce/TUPE	Jul-16	**8 – Workforce**	**Jul-16**
Organisational development plan	Jul-16	**8 – Workforce**	**Jul-16**
Engagement plan	Jun-16	**9 – Listening and valuing feedback**	**Jun-16**
Quality governance plan	Jul-16	10 – Governance	Jul-16
Corporate governance of merged trust	Aug-16	10 – Governance	Aug-16
Risk management arrangements			

FBC Timeline for September FBC	Date	FBC chapter	Paper/chapter to Transition Board
- In the merged trust	Jul-16	**10 – Governance**	**Jul-16**
- During integration	Jul-16	**11 – Integration plan**	**Aug-16**
Business transaction agreement (process)	Jul-16	**12 – Transition plan**	**Jul-16**
Post project benefits evaluation process	Aug-16	**13 – Benefits realisation**	**Aug-16**
Supporting key tasks			
Project governance and resource agreed	**Jun-16**		
External resource procured	Jul-16		

Agenda Item No: 9

HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

To:	**HEALTH COMMITTEE**
Meeting Date:	**8 September 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:** **Note and endorse the progress made on health scrutiny through the liaison groups and the schedule of liaison meetings (Appendix A)**

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Post:	Head of Public Health Programmes
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Tel:	01480 379561

1. BACKGROUND

1.1 The purpose of this report is to inform the Committee of the health scrutiny activities that have been undertaken or planned since the committee last discussed this at the meeting held on 12th May 2016.

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

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

2. MAIN ISSUES

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

2.1.1 The liaison group members in attendance were Councillors, Clapp, Jenkins, Orgee & Sales and District Councillor Ellington. A meeting was held on 21st July 2016 with Jessica Bawden (Director of Corporate Affairs) from Cambridgeshire & Peterborough and Ian Weller (Urgent & Emergency Care Vanguard Programme Director) and Sandie Smith (CEO) of Healthwatch Cambridgeshire.

2.1.2 The following topics were discussed at this meeting:

- Update on CCG Financial Position and NHS England 'inadequate' rating
- 111 & Out of Hours Launch (19th October)
- Minor Injury Units
- Community radiography services
- Fit for the Future
- Prescriptions
- Older people's services – progress

2.2. Healthwatch Cambridgeshire Updates

Sandie Smith reported on

- Healthwatch Cambridgeshire's "Enter & View Visits" to Cambridge University Hospital a summary report of findings will be produced. Details of this programme are available from: http://www.healthwatchcambridgeshire.co.uk/enter-view

- Work commencing on a review of Hinchingbrooke Health Care NHS Trust A&E patient experience

- Priorities for the year:
    - Mental health
    - Children & Young People
    - Primary Care
    - Discharge from Hospital

  More information can be found from the following link: http://www.healthwatchcambridgeshire.co.uk/sites/default/files/strategy_15_18_refresh_2016_final_01_08_16_2.pdf

2.3 Liaison meeting with Cambridgeshire & Peterborough NHS Foundation Trust (CPFT).

2.3.1 The liaison group members in attendance were Councillors Jenkins and Orgee. A meeting was held on 22nd July 2016 with Aidan Thomas (Chief Executive –CPFT). Apologies were received from Cllr Topping and Cllr van de Ven.

2.3.2 The following topics were discussed at the meeting.

- Update on the Older People & Adult Community Services
- Delayed Transfer of Care
- Community Services

Members requested the following information from the Trust

- JET performance figures
- Copy of "Home's Best" document

2.4 Liaison meeting with Cambridge University Hospitals NHS Foundation Trust (CUHFT).

2.4.1 The liaison group members in attendance were Councillors Jenkins and Orgee, and District Councillor Ellington. A meeting was held on 24th June 2016 with Roland Sinker (Chief Executive – CUHFT) and Kate Lancaster (Director of Corporate Affairs). Apologies were received from Cllr Hudson

2.4.2 The main focus of the meeting discussed the Chief Executive's Board Report for May 2016. The key issues for the meeting were:

- Delayed Transfer of Care (DTOC)
- Accident & Emergency
- Length of Stay
- Update on how the Trust dealt with 26/27 April Industrial Action

Members requested the following information from the Trust:

- Copies of the CEO's report to Board Directors on a monthly basis.

2.5 Liaison meeting with Hinchingbrooke Health Care NHS Trust.

2.5.1 The liaison group members in attendance were Councillors Jenkins, Orgee, P Brown and District Councillor Ellington. Apologies were received from Cllr Wisson. A meeting was held on 20th July with Lance McCarthy (CEO), Alan Burns (Chairman) and Phil Wandsley (Interim COO).

The main issues for discussion were around:

- Update on CQC Inspection Report
- Colloboration with HHCT & PSHFT
- Delayed Transfers of Care

3 LIAISON AND WORKING GROUP MEMBERSHIP ARRANGEMENTS

3.1 Membership of Liaison Groups

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

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

Cambridgeshire & Peterborough Clinical Commissioning Group (CPCCG) & Health Watch Liaison group

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

With Councillor Clapp as an additional member

Date of next meeting: 20th October 13:00-15:00

Cambridgeshire & Peterborough Foundation Trust (CPfT) Liaison Group

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

With Councillor Topping as an additional member

Date of next meeting: 13th September 16:00-17:00

Cambridge University Hospital Foundation Trust (CUHfT)

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

Date of next meeting: 26rd September 14:30-16:00

Hinchingbrooke Healthcare NHS Trust Liaison Group

Current Core membership Councillors: Peter Brown, Orgee, Jenkins and Wisson

With Councillors Ashcroft, David Brown, Ellington and Topping as additional members.

Date of next meeting: 19th October 10.00-11.30

Appendix A

		2016											2017				
MEETING	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
FULL COUNTY COUNCIL					10		19			18		13		21 [24]	28		23
HEALTH AND WELLBEING BOARD	14		17		26		7		15		17		19		30		1 June
HEALTH COMMITTEE	21	[18]	10	[14]	12	[16]	14	[11]	8	[6]	10	[1]	12	[16]	16	[13]	
SPOKES		11	22	21	19	23	21	18	15	20	17	15	26	23	23	20	18
QUARTERLY LIAISON MEETINGS																	
CCG AND Healthwatch		8		14			21			20			26			20	
CPFT				18			22		13			14			15		
Hinchingbrooke				21			20			19			18				
Addenbrookes				20		24			23			2					
WORKSHOPS																	
Centre for Public Scrutiny - Health Scrutiny Inequalities workshop		11															
Development Session			3	14		[16]											

Agenda Item No: 11

COSTED PROPOSAL TO IMPLEMENT A PILOT HARM REDUCTION PROJECT FOR STOPPING SMOKING

To: **Health Committee**

Meeting Date: **8th September 2016**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: *Key decision:* **No**

Purpose: **The purpose of this paper is to provide the Health Committee with the proposed approach and costs of an evidence based harm reduction pilot project to enable smokers who have not been successful in quitting using the existing quit smoking model.**

Recommendation: **The health Committee is asked to approve the following.**

- **The approach and costs of the pilot**
- **Implementation of the model in this financial year.**

	Officer contact:
Name:	Val Thomas
Post:	Consultant in Public Health
Email:	val.thomas@cambridgeshire.gov.uk
Tel:	012223 703264

1. BACKGROUND

1.1 In July 2016 the Health Committee received a review paper of the Stop Smoking Services. This included the evidence and a request for support for a pilot harm reduction pilot. There is now considerable evidence for the effectiveness and cost-effectiveness of these interventions. They have been found to increase the number of people who stop from particular groups who find quitting smoking especially challenging and require additional support. The evidence and cost effectiveness evidence is attached again in Appendix 1.

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1.2 The Health Committee supported the request to undertake a pilot but wanted further details of scale and costs before it was undertaken by the Stop Smoking Service, CAMQUIT.

2. MAIN ISSUES

2.1 Harm reduction approaches are targeted at those smokers that require an alternative approach and are used with smokers who may be unwilling or unable to stop in one step. The evidence based model currently in use involves setting an abrupt stop smoking date, combined with support for the next four to twelve weeks from a trained advisor and in the majority of cases the use of medicines to assist with the attempt (Nicotine Replacement Therapy (NRT)). Harm reduction approaches involve a “cut down to quit pathway”. This involves following a structured programme of cutting down with NRT over a relatively short time period (e.g. six or twelve weeks) leading up to a quit date. Some models use a two year programme which involves the long term use of NRT. Appendix 2 lays out “abrupt” and “cut down” to quit models of stopping smoking

2.2 The harm reduction model proposed as a pilot would offer a structured programme of cutting down with the help of support from an advisor and NRT. After a period of up to 12 weeks the current model would then be used with a quit date being set and the usual support available for a period of four to six weeks.

2.3 Analysis of the profile of smokers who access the Stop Smoking Services suggests that there are two groups of smokers who would benefit from a harm reduction approach. Factors to be considered include prevalence in certain groups and quit rate success. In Cambridgeshire 51% of those who set a quit date are successful which is comparable to national quit rates but varies with different groups within the county.

<u>Routine and Manual Workers in Fenland</u>

The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) suggest the prevalence of smoking in Cambridgeshire has increased slightly in the last few years, returning to a level statistically similar to the England average (16.4% v. 16.9%). Smoking rates in routine and manual workers are consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where smoking rates have returned to a level worse than the average for England (39.8%).

The figures in Table 1 set out the set a quit date and quit rates for all service users and the routine and manual groups for the county as whole and for routine and manual workers.

Table 1: Smoking set a quit date and quitting rates in Cambridgeshire and Fenland 2015/16 (all service users & routine and manual)

	Set a quit date	Quit	% quit rate
Cambridgeshire			
All service users	4445	2261	51%
Routine and Manual	1242	651	52%
Fenland			
All service users	1021	567	56%
Routine and Manual	320	199	62%

The figures indicate that the Stop Smoking Services in 2015/16 were being accessed by routine and manual smokers and this group has a higher quit rate than the average rate for Cambridgeshire.

However the high prevalence rate of this group in Fenland suggests that there are many smokers who are not using the services which could be attributed to a reluctance to adopt the abrupt stop smoking approach. The use of the harm reduction approach could be twofold by attracting smokers to making a quit attempt and also increasing the success rate of those using the Services.

Home Carers and Never Worked/Long Term Unemployed

The second group to be considered are home carers in Fenland.

Table 2: Smoking set a quit date and quitting rates in Cambridgeshire and Fenland 2015/16 (including home carers & never worked/long term unemployed

	Set a quit date	Quit	% quit rate
Cambridgeshire			
All service users	4445	2261	51%
Routine and Manual	1242	651	52%
Fenland			
	1021	567	56%
Home carers	122	56	46%
Never worked/long term unemployed	112	52	46%

Home carers and those who have never worked/long term unemployed have poorer health outcomes. In addition maintaining the health of those who are carers is an important factor in terms of demand for health and social care services.

2.4 The challenge of calculating the cost of introducing a harm reduction approach is identifying how many smokers would be attracted to using this type of intervention. The evidence for harm reduction does not indicate the impact of their introduction upon the numbers accessing services. Table 3 indicates the percentages and numbers of smokers in Fenland amongst the different groups.

Table3: Estimated numbers of smokers in harm reduction target groups, Fenland

Total population aged 16+, Fenland, 2015		81,756		
Target group		Routine and manual workers	Never worked / long-term unemployed	Carers
Population in target group	Percentage	44.8%	5.4%	13.2%
	Number	36,593	4,440	10,805
Smokers in target group	Prevalence	39.8%	26.4%	26.4%
	Number	14,554	1,173	2,856

Notes and sources:
Total population aged 16+ based on Office for National Statistics mid-year 2015 population estimates
Percentage of population aged 16+ from routine and manual occupations, based on NS-SeC categories 5-7, Office for National Statistics Census 2011, DC6114EW
Percentage of population aged 16+ never worked / long-term unemployed, based on NS-SeC category 8, Office for National Statistics Census 2011, DC6114EW
Percentage of population aged 16+ providing unpaid care, Office for National Statistics Census 2011, LC3304EW
Smoking prevalence taken from Public Health Outcomes Framework indicator 2.14, based on Annual Population Survey data
Smoking prevalence estimates for never worked / long-term unemployed and carers based on estimates for the general population

2.5 The above table demonstrates the challenge for Fenland. Surveys consistently find that a majority of smokers want to quit In 2008, 68% of current smokers in Great Britain reported that they wanted to quit, with 22% saying they would very much like to give up and a further 23% saying they wanted to stop "quite a lot". However, only about 30-40% of smokers attempt to quit in a year. In 2014 39% of smokers attempted to quit and 19% were successful. Support for quitting with the help of the Stop Smoking Services increases the success rate by four but only 2-3% smokers access the services in the England per year.

2.6 In this context the preferred option for the harm reduction pilot would be to focus upon those smokers who have accessed the Stop Smoking Services and failed to quit smoking using the abrupt method, in one or both of the targeted groups. It is known that smokers who are motivated to quit (already accessed the Service) are more likely to be successful when trying to stop smoking. Pragmatically having clear criteria for recruitment to the pilot would make it easier for the GP practices to implement the pilot.

2.7 The following estimated costs have been used to identify the funding required for implementation. Current staff and NRT costs are applied.

- Harm reduction cutting down £171 for support programme + £199 medication costs = £370
- Structured abrupt quit attempt £93 for the support programme + £199 medication costs = £292
- **TOTAL cost of harm reduction programme estimate for one smoker = £662**

Please note that this is not the cost per quitter as that calculation takes into account the quit rate and the marketing for the whole service.

The Stop Smoking Service data indicates that there were in 2015/16 303 unsuccessful quitters with 163 from the targeted groups.

Table 4: Costs for targeted pilot for harm reduction for quitting smoking

Fenland	**Number of targeted smokers**	**Harm reduction cutting down to quit £**	**Abrupt quit attempt**	**Total cost**
Routine and manual	94	£34,780	£27,448	£62,228
Home carers	36	£13,300	£10,512	£23,812
Never worked/long term unemployed	33	£12,210	£9,636	£21,846
Totals	**163**	**£60,290**	**£47,596**	**£107,886**

The cost of the abrupt quit attempt would not be an additional cost, so the additional funding for implementing the pilot would be £60,290

2.8 To summarise it is proposed that the pilot will have the following key elements

- Routine and manual, home carers and never worked/long term unemployed in Fenland to be targeted.
- Smokers from these groups who have failed to quit, who present to or have contacted the services will be offered a harm reduction approach to stopping smoking.
- If the numbers recruited are small then the offer will be made to those who contact the core service for support from the targeted groups.
- The pilot will run for a year and reviewed after six months in terms of numbers accessing the pilot service.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The report above sets out the implications for this priority in 1.1, 2.7 and Appendix1

3.2 Helping people live healthy and independent lives

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

- Tobacco smoking is the single greatest cause of illness and premature death in England with, 78,000 deaths estimated to be attributed to smoking in 2014.
- The number of deaths attributable to smoking remains greater than the total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections combined
- Smoking kills about 754 people in Cambridgeshire each year, which is on average nearly 15 deaths every week

3.3 Supporting and protecting vulnerable people

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

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

- There is robust evidence that harm reduction approaches are a cost effective intervention for reducing smoking. This is detailed in Appendix 2.
- The cost benefits vary according to the service costs and the stop smoking rates and these vary in different population groups. The outcomes of the pilot will be modelled to identify any costs.
- Funding for implementing the pilot is from the public health grant

4.2 Statutory, legal and risk implications

- There are no significant statutory, legal and risk implications

4.3 Equality and Diversity

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

- This pilot will target routine and manual, carers and never worked/long term unemployed smokers in Fenland.
- These groups have higher rates of smoking and can require a longer period of support to quit than smokers in other population groups.

4.4 Engagement and communication implications

- There is no significant engagement and communication implications as the smokers targeted with the intervention are those who have already accessed the services and have had a failed quit attempt.

4.5 Localism and Local Member

- There are no localism or local member issues

4.6 Public Health

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

- This has a significant public health impact. Stopping smoking is the prevention intervention which has the greatest impact on health.
- This intervention targets those groups which have a high prevalence of smoking and in general find it challenging to stop smoking.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Kerry Newson
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Virginia Moggridge
Are there any Equality and Diversity implications?	Yes Name of Officer: Dan Thorpe
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Ed Strangeways
Are there any Localism and Local Member involvement issues?	No Name of Officer: Wendy Lansdowne
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
NICE guidelines [PH45] Smoking: harm reduction	https://www.nice.org.uk/guidance/PH45
Lader D, Goddard, E. Smoking-related behaviour and attitudes. 2004.	Office for National Statistics
Smoking-related behaviour and attitudes, 2008.	Office for National Statistics
Lader D. Opinions Survey Report No. 40 Smoking-related behaviour and attitudes, 2008/09. Office for National Statistics	Office for National Statistics
Public Health England Health matters: smoking and quitting in England, 2015	https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england

Appendix 1: Evidence of Effectiveness and Cost Effectiveness

1. Harm-reduction refers to any attempt to reduce the harm, psychological or physical, from smoking without complete cessation (West *et al*, In Press). NICE has outlined evidence-based harm reduction recommendations within their Public Health Guidance 45 (NICE, 2013). This guidance is supported by Public Health England (PHE), the Department of Health (DH), Action on Smoking and Health (ASH), and the National Centre for Smoking Cessation and Training (NCSCT). Interventions can involve behavioural support and medication to support quitting (Nicotine Replacement Therapy). It generally takes three forms;

    - Temporary abstinence: (e.g. longer-term in situations where smoking may not be an option such as in hospital or prison, or shorter term such as during the working day) with or without the help of medication (Nicotine Replacement Therapy –NRT) or behavioural support

    - Cut-down to quit: reducing smoking with medication (NRT) and behavioural support. (Or possibly e-cigarettes.

    - Longer term medication (NRT) used as a replacement for some or all of smoking and behavioural support

2. There is a well-established evidence base for harm reduction interventions. Although abrupt quitting remains the best option for smokers but reducing levels of smoking is able to provide some benefits.

    - Not all smokers are able, or willing to successfully quit smoking over the long term. These approaches could offer greater benefit to these heavier and more addicted smokers. It is known that people from routine and manual groups, who tend to be more dependent on nicotine, are more likely to cut down first, rather than stop 'abruptly' (Siahpush *et al*, 2010).

    - Low-level smokers (i.e. those smoking fewer than 15 cigarettes per day) have been found to have a 17% reduced mortality risk than other smokers (Doll 2004).

    - Smokers who reduce their level of tobacco intake are significantly likely to attempt a quit attempt in the near future and more likely to quit after six months

3. NICE PH 45 Guidance 2013 is underpinned by a number of economic reviews of harm reduction interventions for stopping smoking. They provide evidence that all harm reduction interventions are cost effective when compared to doing nothing. The level of cost effectiveness will depend upon the cost, duration and outcome of the intervention i.e. cut down or quit.

- For interventions that lead to cutting down or quitting the cost per quality-adjusted life year (QALY) was modelled at £437 to £8464. For temporary abstinence the cost per QALY was modelled at £765 to £8464 (Below the NICE threshhold of cost-effectiveness of £20,000).

- Providing licensed nicotine-containing products (i.e. NRT) for a period of up to 10 years is considered a cost-effective use of resources for an intervention that achieves a quit rate of 6%, and this falls to five years for an intervention with a 4% quit rate (NICE, 2013).

- Compared with other smokers, a person aged 25 years who reduces (defined as reducing to less than 15 per day), their smoking levels will live for an additional two years and will save the NHS £882.

- A smoking intervention that achieves one additional 'reducer' aged 50 will save the NHS approximately £767 over the person's lifetime. An intervention that leads to one quitter will save the NHS £1,412 over the same period

4. Harm reduction approaches will incur an additional cost in terms of staff time and medication (NRT). Although the cost is dependent on the product price, dosage, duration of use and existing local commissioning arrangements.

Appendix 2: Potential Camquit Model that Incorporates Harm Reduction Interventions

HEALTH COMMITTEE TRAINING PLAN	Updated from Health Committee Spokes Meeting 19th August 2016	

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
14	Budget Planning 16/17 Members to note rescheduled date.	To understand the budget proposals for public health for the forthcoming year.	1	1st Sept	Public Health	Training Seminar	Health Committee Members & Subs		
8.	Health Scrutiny Skills Part 1 (to be rescheduled)	To understand the roles and responsibilities of members conducting health scrutiny and to provide members with scrutiny skills and techniques	3	No Date	Public Health	Training Seminar	Health Committee members & Subs		
15.	Sustainability and Transformation Plan	To improve the understanding of the Public Health elements of the STP.	1	No Date	Public Health	Training Seminar	Health Committee members & Subs		
16.	JSNA New Communities	To provide an overview to members in regards to the recommendations from the JSNA to inform further scrutiny around primary care capacity	1	Sept/ Oct	Public Health	Training Seminar	Health Committee members & Subs		

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

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

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 1st August 2016 updated 31st August	Cambridgeshire County Council

Notes

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

The definition of a key decision is set out in the Council's Constitution in Part 2, Article 12.
* indicates items expected to be recommended for determination by full Council.
+ indicates items expected to be confidential, which would exclude the press and public. Additional information about confidential items is given at the foot of this document.

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

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
06/10/16	Community Led Physical Activity Proposal	Val Thomas	2016/058	15/09/16 3.30pm	*23/09/16*	*27/09/16*
	Scrutiny Item: Promoting Immunisation Uptake	Kate Parker				
	Scrutiny Item: update on the Bed Based Intermediate Care Review CCG	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item) - Minor Injuries (CCG)	Kate Parker				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Business Planning 2017-18	Liz Robin				
10/11/16	Public Health Finance and performance report	Chris Malyon/ Liz Robin		20/10/16 3.30pm	28/10/16	01/11/16
	Business Planning 2017-18	Liz Robin				
	Scrutiny Item: GP Capacity	Iain Green/ Alice Benton				
	Update on flu vaccination rates (following on from Annual Health Protection Report)					
	Scrutiny Item: Older People and Adult Community Services – arrangements for service delivery	Kate Parker				
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report TBC)	Kate Parker				
	Scrutiny Item: update on the development of the integrated NHS 111 and Out of Hours service	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[01/12/15] Provisional Meeting	Business Planning 2017-18	Liz Robin		17/11/16 3.30pm	*18/11/16*	*22/11/16*
	Scrutiny Item: Health Committee Working Groups – Quarterly update	Kate Parker				

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				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	System Wide Review of Health outcomes In Cambridgeshire	Liz Robin				
	Public Health Risk Register (six-monthly update)	Tess Campbell				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[16/02/17] Provisional Meeting				26/01/17 3.30pm	*03/02/17*	*07/02/17*
16/03/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		23/02/17 3.30pm	03/03/17	07/03/17
	Scrutiny item: Non-Emergency Patient Transport Services performance update six months after September 2016 commencement	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
[13/04/17] Provisional Meeting				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				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				

To be scheduled 0-19 Joint Commissioning of Children's Services (PCC,CCC & CCG; lead authors CCC)

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