HEALTH COMMITTEE

Date:Thursday, 17 May 2018

13:30hr

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

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Notification of Chairman/woman and Vice-Chairman/Woman**	
2	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-conduct-code*	
3	**Minutes & Action Log 15th March 2018**	**5 - 18**
4	**Co-option of Distict Members**	
5	**Petitions**	

DECISIONS

6	**Finance & Performance Report - Outturn 2017-18**	**19 - 38**

The Health Committee comprises the following members:

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

Councillor Lorna Dupre Councillor Lynda Harford Councillor David Jenkins Councillor Linda Jones Councillor Kevin Reynolds Councillor Tom Sanderson Councillor Peter Topping and Councillor Susan van de Ven

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

Clerk Name: Daniel Snowdon

Clerk Telephone: 01223 699177

Clerk Email: Daniel.Snowdon@cambridgeshire.gov.uk

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Public speaking on the agenda items above is encouraged. Speakers must register their intention to speak by contacting the Democratic Services Officer no later than 12.00 noon three working days before the meeting. Full details of arrangements for public speaking are set out in Part 4, Part 4.4 of the Council's Constitutionhttps://tinyurl.com/ProcedureRules.

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HEALTH COMMITTEE: MINUTES

Date: Thursday 15th March 2018

Time: 1:30pm to 4:30pm

Present: Councillors C Boden, D Connor (substituting for Councillor K Reynolds), L Dupre, L Harford, P Hudson (Chairman), D Jenkins, L Jones, T Sanderson and S van de Venn.

District Councillor S Ellington (South Cambridgeshire)

Apologies: County Councillor K Reynolds and District Councillor Cornwell.

95. DECLARATIONS OF INTEREST

None.

96. MINUTES – 8TH FEBRUARY 2018 AND ACTION LOG:

The minutes of the meeting held on 8th February 2018 were agreed as a correct record and signed by the Chairman.

The action log was noted. A Member drew attention to the Air Quality Conference that had been requested by the Committee and requested an update regarding the progress made in making arrangements. Officers confirmed that planning for the conference was taking place and a date would be finalised in the coming weeks. Officers had identified several national speakers that would be invited to attend the event and drew attention to the desire to hold the event to coincide with the national air quality day. Members requested that the

97. PETITIONS

No petitions were received.

The Chairman read a statement provided by the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) regarding the financial position of the CCG for 2017/18. A copy of the statement is attached at Appendix A to these minutes.

Commenting on the statement a Member expressed concern that regarding the timing and that the financial position had not been alerted to earlier and drew attention to the increasing demand for services that had to be balanced against a fixed budget that had little flexibility.

Members noted that budgetary pressures had been flagged by the CCG at liaison meetings, however detail regarding level of the overspend was unavailable at the time.

98. CAMBRIDGESHIRE DRUG AND ALCOHOL TREATMENT SERVICES PROCUREMENT

The Committee received a report that sought to ensure that arrangements were in place to award the contract for the Cambridgeshire Adult Drug and Alcohol Treatment

Services. The report also summarised the procurement and the results of the consultation that was part of the tender process. Officers drew attention to the key areas of feedback received through the consultation and the summary of requirements in the service specification that addressed them.

During discussion of the report Members:

- Clarified what constituted successful completion of treatment for drug and alcohol addiction. Officers explained that successful completion was defined as abstinence during a defined time period. There was discussion taking place nationally regarding the measures as they should reflect more effectively the complex nature of the condition.

- Confirmed the duration of the consultation and the scope of organisations consulted and requested in future that the procurement process be clearly demonstrated within the report. Officers reported that the consultation took place between October and December 2017 included GP practices and focus groups with several hundred responses received.

- Highlighted the importance of harm reduction within treatment for drug and alcohol addiction and questioned the balance between the two within the contract. Officers advised that the contract had been designed to be flexible in order to meet the varying and complex needs of patients. It was an integrated service with a multi-skilled staff which also facilitated flexibility.

- Drew attention to the Crime and Disorder Reduction Partnership and the concern expressed by the Police regarding the growth of organised crime relating to drugs and questioned whether the Police had been consulted. Officers confirmed that consultation had taken place and emphasised the close working relationship with the Police. The Drugs and Alcohol Team worked closely with agencies across the criminal justice system and the Police and Crime Commissioner also provided funding.

- Welcomed the provision for older people within the contract and questioned why as stated in the report they did not ‘fit’ in a service. Officers explained that there was a large amount of group work that included a broad cross-section of society and could be unsettling for older people.

- Drew attention to the consultation regarding the potential move of Cambridge Magistrates Court which could affect accessibility.

- While acknowledging the pressures upon GPs; expressed disappointment at the response of the majority of GPs not wanting to be involved in a shared model of drug and alcohol treatment, drawing attention to the levels of prescribed drug abuse and that it was a community issue that they were in a position to facilitate treatment of. Officers informed Members that the CCG was conducting a review and

emphasised that individuals that misused prescription drugs often had extremely complex conditions that impacted upon their treatment.

It was resolved to:

a) Authorise the Director of Public Health, in consultation with the Chairman and Vice-Chairman of the Health Committee, to formally award the contract subject to compliance with all required legal processes

b) Authorise the Director of Law and Governance to approve and complete the necessary documentation.

99. FINANCE AND PERFORMANCE REPORT – JANUARY 2018

Members were presented the January 2018 iteration of the Finance and Performance report. Officers drew attention to the increase in the forecast underspend across the Public Health budgets for 2017/18 of £113k due to further underspends being identified against staffing budgets in the Public Health Directorate. Members were informed that the level of underspend would reduce following the appointment of an interim position.

During the course of discussion Members:

- Noted the decline in the percentage of infants being breastfed and questioned whether the trend was understood. Officers explained that further research was required as it was not clear whether there was a long term decline in the rate and deterioration in the recording of rates could have also affected the figure.

- Sought reassurance regarding the Personal Health Trainer Service that reported a negative direction of travel in relation to performance. Members noted that there were challenges to the reporting of the performance due to the measures and conditions. Work had been completed with the service but there was a consistently high turnover off staff due to the nature of role. Succession planning was therefore critical in managing that.

- Noted the level of non-recurrent underspend that had arisen partly from two periods of maternity leave.

- Requested legal assurance regarding the return of underspend amounts to the County Council's general reserve. In particular, assurance regarding the practice of treating the underspend figure as a gross amount that would be returned to Cambridgeshire County Council (CCC) general reserves up to the level of core funding. **ACTION**

- Emphasised the importance of investment in public heath by the Council and expressed disappointment at the lack of incentive for greater efficiency through being able to bid for unspent funding. Officers drew attention to the Public Health reserve that was available for one off expenditure and the Council's Transformation Fund.

- Requested an update regarding Children Centres within two weeks. **ACTION**

- Highlighted the number of schools on the waiting list regarding road safety. Officers explained that although a saving had been made against the service, funding was available from a variety of sources. Activity had also changed with certain interventions focussed on travelling to school differently rather than just road safety.

It was resolved to:

Review and comment on the report and to note the finance and performance position as at end of January 2018.

100. NHS ENGLAND DENTISTRY

The Chairman invited representatives of NHS England to address the Committee regarding the provision of NHS dentistry in Cambridgeshire. The Head of Primary Care, NHS England spoke of the need to ensure that primary and secondary dental care met the needs of the community. NHS England worked closely with 750 dental practices to ensure that the needs of the population were met through a robust Oral Needs Analysis.

It was explained that the national contract with practices was closely monitored in order that the correct level of activity was commissioned and where appropriate funding was claimed back if a practice was providing less activity than commissioned for. Where NHS England was aware of population growth through new and existing developments then additional units of activity would be commissioned at existing practices or a new NHS practice would be commissioned if appropriate.

During discussion Members:

- Questioned how growth areas of the county such as Northstowe and planned new developments at Bourne and Waterbeach would have their dentistry needs met. Officers explained that the Oral Needs Analysis assesses areas of growth and from that analysis it is determined the point at which existing practices were no longer able absorb any new patients and a new practice was required. The process took around nine months to complete.

- Confirmed that there were no current plans for an NHS practice at the new development of Northstowe.

- Expressed concern that when information was requested regarding the setting up of a NHS dental practice in Northstowe, none was received. Officers explained the commissioning process during which if there were current practices in the area then it would be assessed whether the current contract could be uplifted to provide sufficient provision. The process was also governed by procurement legislation and if it was identified that a new practice was required then the contract would need to go to tender.

- Noted the engagement with local communities at the Local Dental Forum, at which concerns were raised.

- Clarified which set of population growth forecasts were used when assessing dental provision as there were significant differences between the figures provided by the

Office of National Statistics and local housing growth forecasts. Officers confirmed that the more localised data sets were being used and that often they would be approached by local dentists where they saw new business opportunities.

- Emphasised that oral health should not simply focus on teeth and there was a need for partnership working so that effective preventative care was provided.

- Questioned whether NHS dentistry failed to meet the needs of communities which was why there were so many private practices. Officers did not agree with the assessment and highlighted that the NHS provided a number of ways to maintain oral health.

- Sought clarification regarding units of dental activity. Officers explained that a contract would specify the number of units needed to be delivered against bands. Band 1 included a check-up, x-rays, scaling and polishing and that equated to 1 unit. Band 2 treatment which included fillings and extractions equated to 3 units. In response to concern regarding the incentivisation of escalating treatment officers assured Members that dentists worked within National Institute of Clinical Excellence (NICE) guidelines to provide appropriate treatment.

- Drew attention to dental health inequality across the county and social groups and requested that data be included in future reports. Officers confirmed that the data was available and being used to target areas. Accessibility was highlighted by officers, in particular making dental practices welcoming and friendly environments in order to remove the fear of the dentist.

- Noted the challenges faced by dentistry regarding recruitment and retention nationally and aim within Cambridgeshire to have as many trained practices as possible for newly qualified dentists to complete their training locally and remain in the area.

- Highlighted Section 106 money received from developers. Officers agreed to provide further information regarding Section 106 and confirmed that the estates team worked actively regarding Section 106 money.

- Drew attention to smaller housing developments in established communities and the cumulative impact of such developments upon local services. NHS England were a consultee during planning applications but greater clarity was required regarding the process.

- It was proposed by Councillor Jenkins with the unanimous agreement of the Committee to request the Director of Public Health to monitor the development of Section 106 agreements related to large developments including Northstowe where there was money allocated for primary health care to ensure that appropriate consideration is given to the provision of dental health facilities

It was resolved to:

a) Note the contents of the report;

b) Invite representatives of NHS England Dentistry to a future meeting of the Health Committee; and

c) Request the Director of Public Health to monitor the development of Section 106 agreements related to large developments including Northstowe where there is money allocated for primary health care to ensure that appropriate consideration is given to the provision of dental health facilities

101. NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2017-18 REQUESTS

The Committee received a report that requested the agreement of the Committee to a process for the collation and submission of comments on the Quality Accounts provided by NHS Provider Trusts. The issue we have is responding to foundation trusts.

During discussion of the report Members:

- Expressed dissatisfaction with the process regarding responding to the Quality Accounts in particular Cambridgeshire University Hospital Foundation Trust and their deadline for response. It was suggested that future meetings of the Health Committee be scheduled in order that they be fully considered.

- Noted that Quality Accounts from East of England Ambulance Trust (EEAST) had not been received but officers now had a contact through whom the Council could ensure they were received.

- Drew attention to the quarterly liaison meetings and the ability for Members to raise the Quality Accounts at such forums.

- The Committee requested that the following Quality Accounts be prioritised for response:

    - Cambridge University Hospital Foundation Trust;
    - Peterborough and Stamford Hospital Foundation Trust;
    - Cambridgeshire and Peterborough Foundation Trust; and
    - Hinchingbrooke Health Care NHS Trust.

- The Committee resolved to appoint Councillors Dupre, Hudson and Jones to a Member Task and Finish Group that would consider feedback on the Quality Accounts.

It was resolved to note the requirement for NHS Provider Trusts to request comment from Health Scrutiny Committees and;

a) To consider if the Committee wishes to respond to Quality Accounts and if so prioritise which Quality Accounts the Committee will respond to.

b) Establish and appoint to a Member Task and Finish Group that will provide feedback on the Quality Accounts.

c) Delegate the approval of the responses to the Quality Accounts to the Head of Public Health Business Programmes and Democratic Services acting in consultation with members of the Committee appointed to the Task and Finish Group.

102. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

The Chairman invited the Head of Transformation and Commissioning (Children and Maternity) at the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) to address the Committee.

During the course of discussion Members:

- Noted that there were a range of services including online counselling which was anonymous that young people could access if they did not wish to include parents or teachers; though the involvement of parents and teachers should be encouraged as often they were part of the solution.

- Commented that from the report it was not clear whether services were improving and what the additional £2.4m of funding provided when national targets were not being met. Members questioned the level of integration with other services. It was explained that a joint commissioning unit oversaw local authority and CCG spending. There was investment in early intervention and preventative services. Online counselling services had increased in capacity together with investment in reducing the waiting lists for sufferers of Attention Deficit Hyperactivity Disorder (ADHD) which were now below 18 weeks and represented a significant improvement in performance.

- Questioned why the target for the percentage of children and young people with a diagnosable mental health condition receiving treatment from a NHS-funded community mental health service was so low at 35%. It was explained that not all patients required specialist services and there may also be reasons that treatment through therapy or medication would not be appropriate. Specialist services were only effective in 50% of cases and therefore joint working was undertaken in other areas such as education.

- Confirmed that children that suffered from Attention Deficit Hyperactivity Disorder (ADHD) were usually diagnosed around 5 years old and the waiting list for treatment was a maximum of 18 week.

- Expressed concern regarding the 4 challenges set out in the report and requested that data be presented in a future report that underpinned the challenges.

- Questioned which areas workforce pressures were the most acute and why. Members were informed that each Clinical Commissioning Group (CCG) had been provided an uplift to the Mental Health budget and there were significant challenges in recruiting children's psychiatrists which was an area that that had declined in popularity. The cost of living in Cambridge City posed significant recruitment challenges and also posts that required unsocial hours to be worked. Levels of agency staff were monitored and there were national programmes paid for by NHS England regarding recruitment.

- Noted the role of Emotional Well-being Practitioners that were based in localities that to support GPs schools and community groups, each district would have at least one practitioner that could provide advice, training and support in order to prevent escalation of issues.

It was resolved to:

a) Note the contents of the report; and

b) Request an update for the committee including the data requested by Members in 6 months' time. .

103. HEALTH COMMITTEE WORKING GROUPS UPDATE

The Committee was presented an update regarding the various Health Committee Working Groups.

In discussion Members:

- Requested that all groups be listed regardless of whether they had met.
- Considered at length whether quarterly liaison meetings should move to a 4 monthly arraignment. Whilst it was acknowledged that attendance had been difficult to achieve at recent meetings, the liaison meeting were important in terms of maintaining relationships across the health service. It was therefore agreed for the liaison meetings to remain quarterly and to review in 6 months' time.

It was resolved to:

a) Note and endorse the progress made on the Healthy Schools working group and the liaison groups

b) Note the forthcoming schedule of meetings

c) Consider any items from the quarterly liaison meetings that may need to be included on the forward agenda plan.

104. HEALTH COMMITTEE TRAINING PLAN

In presenting the Health Committee Training Plan officers drew attention to a potential issue regarding purdah and a training event scheduled to take place on 27th April. Confirmation of whether the event would take place would be provided.

In response to a Member question officers explained that the decision not to include Members in a recent workshop with Public Health England was taken due to the highly specialised training required to score the priorities effectively and would not have been best use of Member time.

It was resolved to note the training plan.

104. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES

Members received the Health Committee agenda plan and noted the following update provided at the meeting.

Additions for May –

- Children and Young People's Drug and Alcohol Treatment Services Procurement.

It was resolved to:

Note the agenda plan and the update provided at the meeting

Chairman

Agenda Item No: 3a

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee on **16th January 2018** and updates Members on progress in delivering the necessary actions.

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
17.	**Public Health Finance and Performance Report** **a) Health visiting mandated checks whether geographical / social reasons for lack of take-up**	**L Robin**	Health visiting mandated checks - the percentage of children who received 12 month review by 15 months – with reference to the decline in performance, a question was raised regarding whether there was a geographical / social pattern to them not being wanted or not attended?	Meeting scheduled with CCS for Jan 2018 update will be provided at the February Health Committee	**On-going – Jan 2018**
32.	**Finance & Performance Report – July 2017**	**V Thomas**	Information would be provided to Members regarding engagement with outreach health checks following a meeting with Fenland District Council's senior management team.	A meeting had been scheduled with the Wisbech 2020 Steering Group. An update will be provided to the February meeting of the Health Committee.	**On-going**

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
48.	**Finance & Performance Report**	**L Robin / K Parker**	Members requested that an in depth analysis be undertaken and presented to the Committee of all the initiatives taking place in the Fenland area and whether they were successful in achieving their goals.	Provisional dates for the meeting will be circulated to Members in advance of the 17th May meeting.	**On-going May 2018**
72.	**Health Committee Update Regarding the Cambridge GP Out of Hours Base Move from Chesterton to Addenbrooke's Including the Co-location of GP Streaming**		Members requested that the development of the re-tendering process for the pharmacy and the results of the travel survey be reported to the Committee.	Officers have been reminded to provide the information	**Ongoing** **June 2018**
85.	**Finance and Performance Report November 2017**	**L Robin**	Clarification of the tables within the risk register sought.	A briefing note to Members is being prepared.	**Ongoing** **May 2018**
93.	**EEAST**	**EEAST**	Provide information regarding the performance in Cambridgeshire relating to delays of more than 1 hour in the handover of patients at A&E	Email update provided to Members	**Complete**
93.	**EEAST**	**EEAST**	Provide information regarding the Community First Responder scheme	Email update provided to Members	**Complete**
61.	**Air Quality in Cambridgeshire**		Members requested an Air Quality Conference	A date has now been set – 20th June 2018 and an invite has been issued to Members	**Complete**
99.	**Finance & Performance Report January 2018**	**L Robin**	Assurance was sought regarding the treatment of underspends.	Legal opinion has been sought. Update will be provided at Committee	**Ongoing May 2018**

Agenda Item No: 6

FINANCE AND PERFORMANCE REPORT – Outturn 2017/18

To:	**Health Committee**
Meeting Date:	**17th May 2018**
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 Outturn 2017/18 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 2017/18.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of 2017/18.**

	Officer contact:		***Member contacts:***
Name:	Martin Wade	Names:	Councillor Peter Hudson
Post:	Strategic Finance Business Partner	Post:	Chairman Health Committee
Email:	martin.wade@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 699733	Tel:	01223 706398

1.0 BACKGROUND

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

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

1.3 More detailed information on performance of public health services in 2017/18 is provided in the Annual Public Health Performance Report, which will be an agenda item at the July Health Committee.

2.0 MAIN ISSUES IN THE OUTTURN 2017/18 FINANCE & PERFORMANCE REPORT

2.1 The Outturn 2017/18 Finance and Performance report is attached at Annex A.

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

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

The Outturn 2017-18 Finance and Performance report (F&PR) is attached at Annex A and shows the final outturn for the Public Health Directorate is an underspend of £336k, which is a small decrease since the last report to Health Committee in March which showed the forecast underspend at the end of January as £283k.

As outlined in paragraph 2.2 of the F&PR report, the underspend has been transferred into the Council's general reserve, as the total underspend is below the amount of core funding allocated to the PH Directorate.

2.3 The Public Health Service Performance Management Framework for March 2017 is contained within the report. Of the thirty Health Committee performance indicators, seven are red, five are amber, sixteen 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 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	N/A
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	N/A
Have the equality and diversity implications been cleared by your Service Contact?	N/A
Have any engagement and communication implications been cleared by Communications?	N/A
Have any localism and Local Member involvement issues been cleared by your Service Contact?	N/A
Have any Public Health implications been cleared by Public Health?	N/A

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.	https://www.cambridgeshire.gov.uk/council/finance-and-budget/finance-&-performance-reports/

From: Martin Wade

Tel.: 01223 699733

Date: 23 Apr 2018

Public Health Directorate

Finance and Performance Report – Closedown 2017/18

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
Mar (No. of indicators)	7	5	16	2	30

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Feb) £000	Service	Budget for 2017/18 £000	Actual £000	Outturn Variance £000	Outturn Variance %
-46	Children Health	9,200	9,163	-38	-0.5%
-9	Drug & Alcohol Misuse	5,845	5,809	-35	-0.5%
0	Sexual Health & Contraception	5,297	5,212	-84	-1.6%
-50	Behaviour Change / Preventing Long Term Conditions	3,910	3,914	4	0.1%
-8	General Prevention Activities	56	45	-11	-20.2%
0	Adult Mental Health & Community Safety	263	261	-2	-0.7%
-146	Public Health Directorate	2,149	1,927	-222	-10.3%
-259	**Total Expenditure**	**26,720**	**26,332**	**-388**	**-1.5%**
0	Public Health Grant	-26,041	-26,041	0	0%
0	s75 Agreement NHSE-HIV	-144	-144	0	0%
0	Other Income	-149	-97	52	35.0%
0	Drawdown From Reserves	0	0	0	0%
0	**Total Income**	**-26,334**	**-26,282**	**52**	**0.2%**
-259	**Net Total**	**386**	**51**	**-336**	**-87.0%**

The service level budgetary control report for 2017/18 can be found in appendix 1.

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

2.2 Significant Issues

At the end of Closedown 2017/18, the Public Health Directorate have an underspend of £336k. This is an increase of £77k compared to the previously reported forecast underspend of £259k.

A significant component is an underspend of £222k in Public Health Directorate staffing and non-pay budget, partially offset by a reduction in Public Health Directorate income of £52k. The reduced income is mainly from Peterborough City Council – and results from a change in the balance of staffing across Cambridgeshire County Council and Peterborough City Council in the joint public health team. Vacancies in the PH Directorate also contributed to the underspend, including a vacant substance misuse post, and some additional underspend on substance misuse staffing and non-pay budgets transferred to the PH directorate in May 2017. Further non-recurrent underspend were as a result of supervised 'acting up' of senior public health specialist trainees to cover maternity leave of two public health consultants. ('Acting up' is generally seen as beneficial to the career progression of specialist trainees in the final year of their five year training, who are placed with local authorities by the regional public health training scheme).

There were changes to forecast out-turns in some other parts of directorate expenditure, including an underspend in payments to GP practices for provision of long acting reversible contraception (LARCs) and an overspend on recharges for attendance at out-of-area sexual health clinics.

The County Council core budget allocated to the Public Health Directorate to supplement the national ring-fenced grant in 2017/18 was £386k, therefore the first call on any underspend up to that level is into the County Council's general reserve. The full £336k underspend will therefore be transferred to the County Council's general reserve.

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

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

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

The performance data reported on relates to activity in March 2018.

Sexual Health (KP1 & 2)

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

Smoking Cessation (KPI 5)

- This service is being delivered by Everyone Health as part of the wider Lifestyle Service. Performance indicators for people setting and achieving a four week quit have moved to Red which is slightly lower that at the same time last year. The commentary in Appendix 6 provides further explanations.

National Child Measurement Programme (KPI 14 & 15)

- Performance remains good with both indicators green although below previous months actual figures.
- Measurements for the 2017/18 programme are taken during the academic year and the programme commenced in September 2017. The final figures will only be available at the end of the 17/18 academic year.

NHS Health Checks (KPI 3 & 4)

- The data presented for the NHS Health Checks completed and the number of outreach health checks carried out remains the same as last month with both indicators at red but with an upward trajectory.
- The commentary in Appendix 6 focuses on improvements in Health Checks completed in Fenland this year with 82% of the Fenland target being met.

Lifestyle Services (KPI 5, 16-30)

- There are now 16 Lifestyle Service indicators reported on, the overall performance is very good and shows 11 green, 2 amber and 3 red indicators.
- Direction of travel from the previous month is mixed with 10 indicators moving up.

Health Visitor and School Nursing Data (KPI 6-13)

Health Visiting and School Nursing data is reported on quarterly and the data provided reflects the Quarter 4 period for 2017/18 (Jan-March).

- The new data for Quarter 4 shows 1 green, 3 amber and 2 red indicators (KPI data is not available at this time for indicators 12 & 13 school nursing but the commentary provides an update)
- Performance for Health Visiting mandated checks for 6-8 months is amber but Cambridgeshire does exceed the national average for this visit. The performance indicator for Health Visiting mandated check at 2- 2 ½ years is red but includes data from checks that are not wanted resulting in a high did not attend rate. The commentary provides further explanation to the analysis and plans to address this in the immediate future.
- Breastfeeding prevalence rates fluctuate but are higher than the national average. Details of localised actions to increase breastfeeding are provided in the commentary.

4.2 Health Committee Priorities

Priorities identified on 7 September 2017 are as follows:

- Behaviour Change
- Mental Health for children and young people
- Health Inequalities
- Air pollution
- School readiness
- Review of effective public health interventions
- Access to services.

4.3 Health Scrutiny Indicators

Priorities identified on 7 September 2017 are as follows

- Delayed Transfer of Care (DTOCs)
- Sustainable Transformation Plans
    - Work programme, risk register and project list
    - Workforce planning
    - Communications and engagement
    - Primary Care developments

The Health Committee has requested routine monthly data reports on the “Fit for the Future” programme circulated prior to meetings, these are being received sporadically. The remaining scrutiny priorities around communications and engagement and Primary Care Developments requires further consideration from the committee on reporting requirements.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Previous Outturn (Feb) £'000	Service	Budget 2017/18 £'000	Actual 2017/18 £'000	Outturn Variance £'000	%
	Children Health				
0	Children 0-5 PH Programme	7,253	7,253	0	0.00%
-46	Children 5-19 PH Programme - Non Prescribed	1,707	1,669	-38	-2.25%
0	Children Mental Health	240	241	1	0.27%
-46	**Children Health Total**	**9,200**	**9,163**	**-38**	**-0.41%**
	Drugs & Alcohol				
-9	Drug & Alcohol Misuse	5,845	5,809	-35	-0.60%
0	**Drugs & Alcohol Total**	**5,845**	**5,809**	**-35**	**-0.60%**
	Sexual Health & Contraception				
0	SH STI testing & treatment – Prescribed	3,975	4,109	134	3.38%
0	SH Contraception - Prescribed	1,170	988	-182	-15.55%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	115	-37	-24.08%
0	**Sexual Health & Contraception Total**	**5,297**	**5,212**	**-84**	**-1.59%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	2,006	2,058	52	2.57%
0	Other Health Improvement	279	314	35	12.45%
-30	Smoking Cessation GP & Pharmacy	828	811	-17	-2.04%
0	Falls Prevention	80	87	7	8.66%
-20	NHS Health Checks Prog – Prescribed	716	644	-72	-10.08%
-50	**Behaviour Change / Preventing Long Term Conditions Total**	**3,910**	**3,914**	**4**	**0.11%**
	General Prevention Activities				
-8	General Prevention, Traveller Health	56	45	-11	-20.19%
-8	**General Prevention Activities Total**	**56**	**45**	**-11**	**-20.19%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	263	261	-2	-0.66%
0	**Adult Mental Health & Community Safety Total**	**263**	**261**	**-2**	**-0.66%**

Previous Outturn (Feb) £'000	Service	Budget 2017/18 £'000	Actual 2017/18 £'000	Outturn Variance £'000	%
	Public Health Directorate				
0	Children Health	315	294	-21	-6.67%
-111	Drugs & Alcohol	265	223	-42	-15.85%
0	Sexual Health & Contraception	189	194	5	2.65%
-35	Behaviour Change	723	572	-151	-20.89%
0	General Prevention	152	155	3	1.97%
0	Adult Mental Health	43	42	-1	-2.33%
0	Health Protection	140	143	3	2.14%
0	Analysts	322	305	-17	-5.28%
-146		**2,149**	**1,927**	**-222**	**-10.31%**
-259	**Total Expenditure before Carry forward**	**26,720**	**26,332**	**-388**	**-1.45%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0.00%**
	Funded By				
0	Public Health Grant	-26,041	-26,041	0	0.00%
0	S75 Agreement NHSE HIV	-144	-144	0	0.00%
0	Other Income	-149	-97	52	34.90%
	Drawdown From Reserves	0	0	0	0.00%
0	**Income Total**	**-26,334**	**-26,282**	**52**	**0.20%**
-259	**Net Total**	**386**	**50**	**-336**	**-86.98%**

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	Budget 2017/18 £'000	Outturn Variance	
		£'000	%
Public Health Directorate	**2,149**	**-222**	**-10.3**
There is an underspend of £222k in Public Health Directorate staffing and non-pay budget, partially offset by a reduction in Public Health Directorate income of £52k. The reduced income is mainly from Peterborough City Council – and results from a change in the balance of staffing across Cambridgeshire County Council and Peterborough City Council in the joint public health team. Vacancies in the PH Directorate also contributed to the underspend, including a vacant substance misuse post, and some additional underspend on substance misuse staffing and non-pay budgets transferred to the PH directorate in May 2017. Further non-recurrent underspend was the result of supervised 'acting up' of senior public health specialist trainees to cover maternity leave of two public health consultants. ('Acting up' is generally seen as beneficial to the career progression of specialist trainees in the final year of their five year training, who are placed with local authorities by the regional public health training scheme).			

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

Awarding Body : DofH

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

APPENDIX 4 – Virements and Budget Reconciliation

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

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2017	2017/18		Closing Balance 2017/18	Notes
		Movements in 2017/18	Balance at Close 2017/18		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,040**	0	1,040	**1,040**	
subtotal	**1,040**	**0**	**1,040**	**1,040**	
Other Earmarked Funds					
Healthy Fenland Fund	400	-100	300	300	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	400	-22	378	378	Planned for use on joint work with the NHS in 2017/18 and 2018/19.
NHS Healthchecks programme	270	0	270	270	This funding will be used to install new software into GP practices which will identify patients for inclusion in Health Checks. The installation work will commence in June 2017. Funding will also be used for a comprehensive campaign to boost participation in NHS Health Checks.
Implementation of Cambridgeshire Public Health Integration Strategy	850	-271	579	579	£517k Committed to the countywide 'Let's Get Moving' physical activity programme which runs for two years 2017/18 and 2018/19.
subtotal	**1,920**	**-393**	**1,527**	**1,527**	
TOTAL	**2,960**	**-393**	**2,567**	**2,567**	

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

Fund Description	Balance at 31 March 2017	2017/18		Closing Balance 2017/18	Notes
		Movements in 2017/18	Balance at Close 2017/18		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	59	77	136	136	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**68**		**145**	**145**	

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 March 2018 can be seen within the tables below:

	Measures											
KPI no.	Measure	Period data relates to	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
1	GUM Access - offered appointments within 2 working days	Mar-18	98%	98%	100%	102%	G	99%	98%	100%	← →	
2	GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	Mar-18	80%	80%	93%	116%	G	89%	80%	93%	↑	
3	Number of Health Checks completed (GPs)	Q4 Oct - Dec 17	18,000	18,000	15,898	88%	R	74%	4500	104%	↑	The comprehensive Improvement Programme is continuing this year. The introduction of the new software into some practices has commenced which is increasing the accuracy of the number of invitations that are sent out for NHS Health Checks. There has been considerable work with the CCG Data teams and issues regarding templates have been resolved which is also supporting improvements in data quality. and returns. .However the full benefits cannot be realised as the NHS has made a major change to its IT connectors, so the Health Checks software cannot be fully utilized until changes have been made in the bespoke server for the programme. However performance is better than last year's. and not all data has been collated at the time of this report.
4	Number of outreach health checks carried out	Mar-18	2,000	2000	1144	57%	R	58%	220	114%	↑	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. There has been considerable improvement in the number of health checks completed in Fenland this year with 82% of the Fenland target being met. This is a consequence of providing the service in community venues such as the Job Centre Plus and community centres. Although workplaces remain a challenge. .However performance in the rest of county has fallen and currently only 49% of its target has been achieved. This does reflect to some degree the targeting of resources in Fenland. However there has been limited improvement in recent months.
5	Smoking Cessation - four week quitters	Feb-18	2278	2088	1563	75%	R	83%	188	76%	↓	• Performance is slightly lower than at the same time last year. This has been attributed to staff leaving and long term sickness. Some posts have now been filled so improvement are anticipated • There is an ongoing programme to improve performance that includes targeting routine and manual workers (rates are known to be higher in these groups) and the Fenland area. •The most recent Public Health Outcomes Framework figures (June 2017 data for 2016) suggest the prevalence of smoking in Cambridgeshire remains at a level statistically similar to the England average (15.2% v. 15.5%). Rates remain higher in Fenland (21.6%) than the Cambridgeshire and England figure.

KPI no.	Measure	Period data relates to	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
6	Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	Q4 Jan-Mar 2018	56%	56%	53%	53%	A	49%	56%	50%	↑	The breastfeeding prevalence target has been set locally 56%, although performance against this fluctuates. The target has been missed over the last three quarters, including this quarter but remains within the 10% tolerance limit. Over the 2017/18 period the breastfeeding prevalence is an average of 53.25%. The Health Visitor Infant Feeding Lead is developing an action plan to address localised issues where breastfeeding rates are below target. The breastfeeding rates in Cambridgeshire are higher than the national breastfeeding rates (national average 44%), however prevalence will continue to be monitored closely, with the aim of achieving the 56% target.
7	Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV at >28 weeks	Q4 Jan-Mar 2018	50%	50%	25%	25%	R	22%	50%	20%	↓	In Cambridgeshire a local target has been set for 50%, with the longer term goal of achieving a target of 90% in 2 years. The contact is currently low as it is currently targeted at first time mothers and those who are vulnerable, rather than universally offered. Additionally, the notification process between Midwifery and the Healthy child programme (HCP) has not been robust and poses a challenge in achieving the target. Since the last quarter, a locality workshop has been held to engage with the staff on how to work differently in order to build capacity to meet this mandated target. The provider clinical lead and service lead are working with the acute midwifery units to establish an electronic notification syatem so that there is assurance that health visitors are notified of every expectant woman to enable the ante natal contact to take place. Furthermore Health Visitors are being asked to complete incident forms when a new birth visit is carried out but they weren't notified of the pregnancy to understand the extent of the problem.
8	Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	Q4 Jan-Mar 2018	90%	90%	95%	95%	G	94%	90%	96%	↑	The 10 - 14 new birth visit remains consistent each month and numbers are well within the 90% target.
9	Health visiting mandated check - Percentage of children who received a 6 - 8 week review	Q4 Jan-Mar 2018	90%	90%	88%	88%	A	88%	90%	84%	↓	The performance for the 6 - 8 week reviewhas fallen to 84% . A staffing deficit in East Cambs & Fenland and Cambridge City has affected the overall performance this quarter. Engagement workshops undertaken in April was undertaken to support staff to work consistently across caseloads, including the implementation of a review tool which will support staff to focus work where there are identified health needs, thus increasing capacity to support mandated contacts. The provider achieved an average of 88% over 2017/18, and Cambridgeshire continues to exceed the national average for this visit, which in 2016/17 was 82.5%.
10	Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	Q4 Jan-Mar 2018	100%	95%	85%	85%	A	81%	95%	85%	↑	The 12 month visit by 15 months has increased this quarter from 81% to 85%. Service Leads will review this assessment with the staff to ensure that the planning of this development assessment is completed within a 12 month timeframe, to ensure that this target is achieved.
11	Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	Q4 Jan-Mar 2018	90%	90%	79%	79%	R	80%	90%	77%	↓	The number of two year old checks completed this quarter is 77%. Iif data is looked at in terms exception reporting, which includes parents who did not want/attend the 2 year check then the average percentage achieved for this quarter increases to 90%. During quarter 4,144 appointments were not wanted and 116 were not attended. Performance in March has reduced the overall figures for this quarter as only 67% checks were completed. Three Nursery Nurses were supported during this period to undertake their nurse training, resulting in reduced staffing capacity in March. Moving forward, to ensure that the 2 year old checks are completed, additional staff hours are being offered and positions are being advertised for bank staff to fill this shortfall in the interim.
12	School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management or substance misuse	Q4 Jan-Mar 2018	N/A	N/A	249	N/A	N/A	81	N/A	29	N/A	The School Nursing service has introduced a duty desk to offer a more efficient and accessible service, which does mean that there is an expected reduction in children and young people attending clinic based appointments in school. This figure is only representative for those seen in clinics. The duty desk has received 1082 calls during the quarter 4 period and feedback from school regarding the introduction of the duty desk has been positive, identifying the value of immediate access to staff for support, referral and advise. Chat Health has also been introduced, a text based support for children and young people. This service is now starting to establish itself, in increasing access to health support and advise for young people. Following the promotion of the service, there has been an increase in usage.
13	School nursing - number of young people seen for mental health & wellbeing concerns	Q4 Jan-Mar 2018	N/A	N/A	2381	N/A	N/A	666	N/A	385	N/A	By far the largest number of referrals is for mental health and wellbeing, which is mirroring a national trend. To address staffing and capacity issues, an action plan has been implemented, including the county wide duty desk and the Chat Health service, which offers text based support to young people and launched in March. This quarter has witnessed the introduction of CHUMS Counselling and Talking Therapies service and Emotional Wellbeing Practitioners. It is anticipated that these organisations will work with the School Nursing team to reduce pressures. The reduction in the volume of pupils seen this quarter for emotional health concerns may be attributed to this.

KPI no.	Measure	Period data relates to	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
14	Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	Mar-18	90%	53.0%	65.0%	123%	G	111.0%	53.0%	68.0%	↓	The National Child Measurement Programme (NCMP) runs in line with the academic year. The final figures will only be available at the end of 17/18 school year.
15	Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	Mar-18	90%	53.0%	58.0%	109%	G	111.0%	53.0%	58.0%	↓	
16	Overall referrals to the service	Mar-18	5100	5100	8586	168%	G	106%	425	244%	↑	
17	Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	Mar-18	1517	1517	1234	81%	R	35%	167	91%	↑	There has been considerable improvement in the number of PHPs produced. However discussion with the provider has indicated that the data is not complete and it is being revisited.
18	Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	Mar-18	1138	1138	1189	104%	G	92%	125	158%	↑	
19	Number of physical activity groups held **(Pre-existing GP based service)**	Mar-18	664	664	676	102%	G	127%	73	170%	↑	
20	Number of healthy eating groups held **(Pre-existing GP based service)**	Mar-18	450	450	472	105%	G	117%	50	228%	↑	
21	Personal Health Trainer Service - number of PHPs produced (Extended Service)	Mar-18	723	723	745	103%	G	41%	8	375%	↓	

KPI no.	Measure	Period data relates to	Y/E Target 2017/18	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
22	Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	Mar-18	542	542	642	118%	G	80%	60	85%	↑	
23	Number of physical activity groups held (Extended Service)	Mar-18	830	830	792	95%	A	92%	69	90%	↓	This result is surprising. The service is bing encouraged to work other organisations to acquire more referrals
24	Number of healthy eating groups held (Extended Service)	Mar-18	570	570	673	118%	G	100%	48	102%	↑	
25	Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	Mar-18	30%	30%	18.0%	60.0%	R	37%	30%	17%	↓	The 60% completion rate is low and this is being investigated with clients who have dropped out to try and understand the reasons. Most occur at around 6 weeks into course.
26	Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	Mar-18	60%	60%	54.0%	90.0%	A	44.0%	60%	67.0%	↑	There is considerable improvement in the weight loss outcomes this month. The drop in recent months in performance has been concerning and is being addressed contractually by the Lifestyle provider Everyone Health with CUHFT which provides the Tier 3 service through a sub-contractual arrangements. Although there has been a considerable improvement this month.
27	% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	Mar-18	80%	80%	88%	110.0%	G	N/A	80%	82%	↔	
28	Number of referrals received for multi factorial risk assessment for Falls Prevention	Mar-18	386	386	523	135%	G	174%	42	174%	↔	
29	Number of Multi Factorial Risk Assessments Completed - Falls Prevention	Mar-18	164	164	296	180%	G	200%	19	295%	↑	
30	Number clients completing their PHP - Falls Prevention	Mar-18	209	209	230	110%	G	44%	23	139%	↑	

* All figures received in April 2018 relate to March 2018 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

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

ANNUAL HEALTH PROTECTION REPORT (2017)

To:	**Health Committee**
Meeting Date:	**May 2018**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** ***Key decision:*** **No**
Purpose:	**To present the Cambridgeshire Annual Health Protection Report (2017), which provides information on and assurance of the local delivery of health protection functions.**
Recommendation:	**The Committee is asked to note the information in the Annual Health Protection Report (2017).**

	Officer contact:	***Cllr Contact***
Name:	Katie Johnson	Name: Cllr Peter Hudson
Post:	Consultant in Public Health	Post: Health Committee Chair
Email:	Katie.Johnson@cambridgeshire.gov.uk	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 699266	01223 706398

1.1 The Annual Health Protection Report (2017) attached as Annex A is the fifth annual report on health protection produced in Cambridgeshire since the transfer of public health functions to local authorities.

1.2 This report is submitted to the Board from the Cambridgeshire County Council Public Health Directorate, and is produced using data and information provided by partner organisations including Public Health England, NHS England and Cambridgeshire and Peterborough Clinical Commissioning Group. These organisations meet together on a quarterly basis at the Cambridgeshire and Peterborough Health Protection Steering Group, chaired by the DPH.

1.3 The services that fall within Health Protection include:
i. communicable diseases – their prevention and management
ii. infection control
iii. routine antenatal, new born, young person and adult screening
iv. routine immunisation and vaccination
v. sexual health
vi. environmental hazards.
vii planning for public health emergencies

1.4 It is important that there is publicly available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise.

2. MAIN ISSUES

2.1 This report provides an update on all key areas of health protection for Cambridgeshire including:

- Communicable disease surveillance including information on the increased levels of infectious Hepatitis, Invasive Group A Streptococcal and Mumps infections in the past year.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination
- Screening in which there is continued below average uptake of cervical screening in Cambridgeshire, although breast and bowel cancer screening uptake is better than average.
- Healthcare associated infections and the work to reduce anti-microbial resistance
- The Environmental Health role of city and district councils in protecting health including pollution control and air quality monitoring and advice
- The national TB strategy and successful local implementation of some key areas of the strategy notably Latent TB Infection Screening (LTBI)
- Sexual health including the level of late HIV diagnosis, reducing level of chlamydia diagnoses and a slowdown in the rate of reduction of teenage pregnancy, while still below the national average, work on prevention in sexual health and the establishment of the Sexual Health Delivery Board in 2017.

- Health emergency planning, the work completed in the past 12 months and the priorities for the coming year.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

Effective prevention of infectious disease outbreaks maintains workforce health and is therefore beneficial to the economy.

3.2 Helping people live healthy and independent lives

The report describes measures to protect people's health from infectious disease and public health emergencies.

3.3 Supporting and protecting vulnerable people

Some vulnerable groups of people have increased susceptibility to infectious disease – for example pregnant women, people with long term conditions and elderly people are more vulnerable to the effects of influenza and are entitled to free vaccinations.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

There are no immediate resource implications from the Annual Health Protection Report.

4.2 Statutory, Risk and Legal Implications

Under the Health and Social Care Act (2012) the County Council has a duty 'to provide information and advice to certain persons and bodies within their area in order to promote the preparation of, or participation in, health protection arrangements against threats to the health of the local population, including infectious disease, environmental hazards and extreme weather events.'

4.3 Equality and Diversity Implications

No significant implications .

4.4 Engagement and Consultation Implications

No significant implications

4.5 Localism and Local Member Involvement

No significant implications

4.6 Public Health Implications

Covered in the main body of the report.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Not Applicable
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes: Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer : Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any public health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
None	

CAMBRIDGESHIRE COUNTY COUNCIL

ANNUAL HEALTH PROTECTION REPORT 2017

Table of Contents

Annual Health Protection Report for Cambridgeshire 2016-2017

1. INTRODUCTION

This report provides an annual summary of activities in Cambridgeshire to ensure health protection for the local population.

The services that fall within Health Protection include:

i. communicable (infectious) diseases – their prevention and management
ii. infection control
iii. routine antenatal, new born, young person and adult screening
iv. routine immunisation and vaccination
v. sexual health
vi. environmental hazards.

It is important that there is publicly available information that demonstrates that statutory responsibilities for health protection have been fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise.

The Director of Public Health (DPH) produces an annual health protection report to the Health Committee, which provides a summary of relevant activity. This report covers multi-agency health protection plans that are in place to establish how the various responsibilities are discharged. Any other reports will be provided on an ad hoc or exceptional basis where a significant incident, outbreak or concern has arisen.

Details of the legislative background to the role of DPH and the role of the County Council in relation to health protection have been included in previous annual health protection reports and will not be reproduced here.

2. CAMBRIDGESHIRE AND PETERBOROUGH STEERING GROUP

To enable the DPH to fulfil the statutory responsibilities in relation to health protection, the Cambridgeshire Health Protection Steering Group (HPSG) was established in October 2013 and is chaired by the DPH or nominated deputy. This committee was replaced in October 2016 by a joint committee for Cambridgeshire and Peterborough that recognised the wider geography covered by many of the member organisations and the closer working on Public Health between the two local authorities. The Cambridge shire and Peterborough Health Protection Steering Group (CP HPSG) enables all agencies involved to demonstrate that statutory responsibilities for health protection are being fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise. In addition, a memorandum of understanding (MOU) has been agreed with partner organisations.

To ensure that the shared membership fully protected confidentiality of any sensitive items discussed, a Confidentiality / Non-disclosure Agreement was included with the terms of Reference.

3. SURVEILLANCE

3.1 Notifications of Infectious Diseases (NOIDs)

Doctors in England and Wales have a statutory duty to notify suspected cases of certain infectious diseases. These notifications along with laboratory and other data are an important source of surveillance data. The table below shows the main notifiable diseases reported to the Public Health England (PHE) Health Protection Team (HPT) from 2014 - 2017.

Table 1: Notifiable Diseases in Cambridgeshire 2014-2017

Notifiable Disease*	**2014†**	**2015†**	**2016†**	**2017†**
Acute infectious hepatitis	20	25	20	39
Acute meningitis	8	8	12	10
Enteric fever	<5	<5	<5	<5
Food poisoning (excluding campylobacter**, but including the organisms below)	174	205	226	195
Botulism	0	0	0	0
E. coli O157 VTEC	<5	5	<5	<5
Cryptosporidium	48	90	85	90
Giardia	13	16	22	23
Salmonella	92	80	101	77
Infectious bloody diarrhoea	6	5	11	12
Invasive group A streptococcal disease	23	18	20	34
Legionnaires' disease	0	<5	6	<5
Malaria	10	9	13	7
Measles*	23 (<5)	13 (<5)	17 (6)	18 (0)
Meningococcal septicaemia	<5	9	11	8
Mumps*	44 (15)	24 (<5)	39 (<5)	55 (10)

Rubella*	11	5	5	5
Scarlet fever	89	159	239	161
Whooping cough	108	80	203	157

SOURCE: East of England HPT HPZone

***** *These are notifications of infectious disease and are not necessarily laboratory confirmed. Numbers in brackets indicate confirmed cases. Figures for 2017 are provisional.*

† *Because of the confidentiality risk associated with reporting very small numbers, where there are fewer than 5 cases they are reported as <5.*

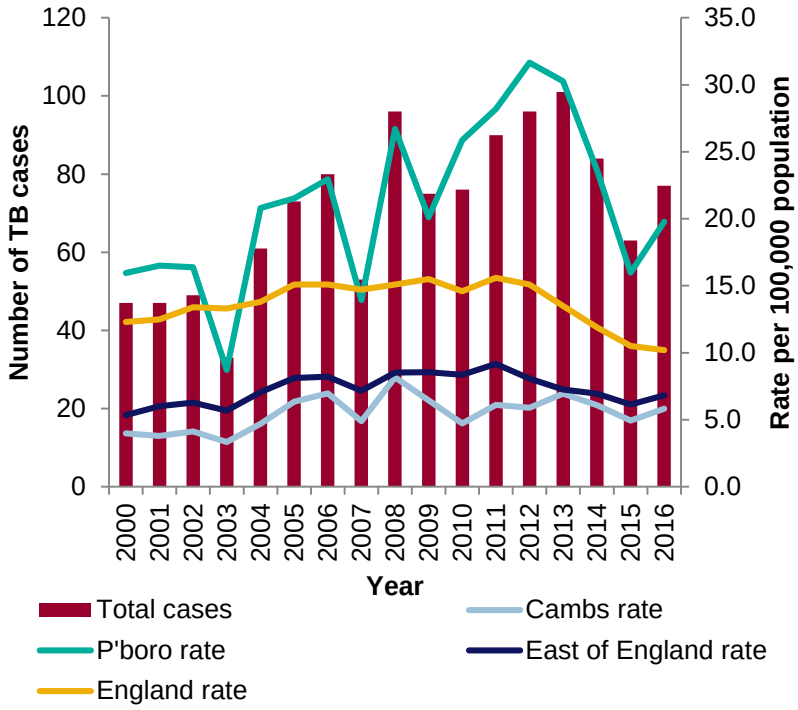
** *During 2016, the HPT stopped importing laboratory reports of campylobacter into its HPZone database as public health follow up is not undertaken for individual cases and there is a national system for laboratory surveillance.*

3.2 Tuberculosis surveillance

The minimal dataset collected through the NOIDs system affords no possibility to monitor trends within subgroups in the population. The increasing incidence of TB in E&W, particularly affecting subgroups within the population, led to the introduction, on 1 January 1999, of continuous Enhanced Tuberculosis Surveillance (ETS). This aims to provide detailed and comparable information on the epidemiology of TB by collecting a minimum dataset on all cases of TB reported by clinicians.

Official TB statistics are based on data extracted from ETS in April each year. The time to process and analyse this data takes a further six months, therefore the latest official statistics are for data to the end of 2016.

Figure 1: Annual TB notifications 2000-2016



- In 2016, 77 cases of TB were notified among residents of Cambridgeshire and Peterborough local authorities (Fig. 1). The TB rate in Cambridgeshire (5.8 per 100,000) remains below the East of England average (6.8 per 100,000), whereas the rate in Peterborough (19.8 per 100,000) has declined since 2012 (31.7 per 100,000) but remains substantially higher than average. TB cases increased in both areas in 2016 compared to 2015.
- The majority of cases were aged 15-44 years, with a mean age of 41.7 years.
- 77.6% of cases were non-UK born, with India, Pakistan, Timor-Leste and Lithuania being the most common non-UK countries of birth. In 2016, substantially more cases were UK born than in 2015.
- A larger proportion of patients in Peterborough had social risk factors (34.4%) compared to the national average (15.4%), whereas Cambridgeshire cases showed no notable difference (15.6%).

3.3 Outbreaks and Incidents

Table 2: Cambridgeshire, January - December 2017

Gastroenteritis	Respiratory virus	TB	Other
23*	14**	2†	4††

SOURCE: East of England HPT HPZone

* *These include 19 care home norovirus outbreaks (4 laboratory confirmed and 15 suspected), 1 confirmed prison norovirus outbreak, a household cluster of cryptosporidiosis and 2 food poisoning outbreaks*

** *These include 11 outbreaks in care homes (2 influenza A, 2 respiratory syncytial virus, 1 metapneumovirus and 1 rhinovirus, 2 suspected influenza A and 3 cause unknown). Others are confirmed Flu A in a prison and 2 healthcare associated outbreaks*

† *TB screening undertaken in healthcare and school settings following identification of a smear-positive TB case in each of these settings*

†† *These include a toxigenic Corynebacterium diphtheriae case and a cluster of Group A streptococcus infections among people who inject drugs (PWID), see below*

3.4 Toxigenic *Corynebacterium diphtheriae* case

A UK born individual presented to their GP with sore throat, enlarged tonsils and two skin ulcers on the right foot three weeks after returning from a trip to Ghana. The case was fully immunised against diphtheria and had last received a diphtheria containing vaccine in 2013.

A swab from the ulcer identified *C. diphtheriae* at the local laboratory. The PHE reference laboratory confirmed the species and demonstrated expression of toxin.

The East of England HPT investigated the case and undertook contact tracing to inform a risk assessment. Public health actions included organising pre-antibiotic screening (nasopharyngeal and throat swabs), chemoprophylaxis and booster immunisation with a diphtheria toxoid containing vaccine for identified contacts.

The case was treated with clarithromycin and given a booster vaccination. Six close contacts (family and household) were initially identified: one (a person of uncertain immunisation status who had not recently travelled) had a positive swab for toxigenic *C. diphtheriae* and reported a history of mild coryzal symptoms. Seven GP staff screened negative for *C. diphtheriae*.

This is the first documented case of transmission of toxigenic diphtheria within the UK in 30 years, where diphtheria remains a rare disease due to an effective immunisation programme. While diphtheria immunisation of the UK population remains high, the risk of large outbreaks remains low. Transmission from cases of cutaneous infection can occur to individuals without up-to-date immunization, including people born prior to the introduction of routine diphtheria immunisation.

3.5 Group A streptococcus infection among people who inject drugs (PWID)

Group A streptococcus (*Streptococcus pyogenes*; GAS) commonly causes skin infections, pharyngitis and scarlet fever. It can also cause more serious invasive infection (iGAS), including necrotising fasciitis, toxic shock syndrome, septicaemia, pneumonia and myositis.

First identified in September 2016, there is an ongoing outbreak of invasive and non-invasive disease due to GAS type *emm* 66.0 among homeless and PWID in England and Wales.

In February 2017, 2 cases of iGAS among PWID were identified by the East of England HPT, one each in Cambridgeshire and Peterborough. Key public health messages were

disseminated to local drug and alcohol teams that aimed to raise awareness among staff and PWID.

In total, in 2017, there were 34 laboratory-confirmed cases of iGAS infection in Cambridgeshire. Of these, 12 cases were among PWID. Ten of the 12 isolates were typed and there were 7 type *emm* 66.0, 2 type *emm* 81.0 and 1 type *emm* 11.0. Ten of the 12 cases were homeless.

4. PREVENTION

4.1. Immunisation programmes

The tables below detail uptake of the various vaccination programmes over time and compared to the regional level of uptake. Overall uptake is stable or has increased for most of the childhood programmes and for the seasonal influenza vaccination programme, which appears to indicate some success from the work we have undertaken with partner organisations to improve uptake. The aim for all childhood programmes is to achieve at least 95% uptake, the level which ensures Herd Immunity. However the target uptake as outlined in the Public Health Outcomes Framework is 90%.

Herd immunity occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity. It arises when a high percentage of the population is protected through vaccination, making it difficult for a disease to spread because there are so few susceptible people left to infect.

This can effectively stop the spread of disease in the community. It is particularly crucial for protecting people who cannot be vaccinated. These include children who are too young to be vaccinated, people with immune system problems, and those who are too ill to receive vaccines (such as some cancer patients). Details of the UK vaccination programme and what each vaccine protects against are included at Annex 1 at the end of this report.

4.1.1. Childhood Primary Vaccinations

Table 3: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

12 months DTaP/IPV/Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**93.1**	**94.7**	**93.6**	**94.2**
East Anglia	95.6	95.6	95.4	95.5
	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Cambridgeshire	**93.8**	**94.1**	**94.2**	**94.2**
East Anglia	95.0	95.2	95.2	95.0

Source: Cover, Public Health England

Figure 2: 12m DTaP/IPV/Hib % in Cambridgeshire and Surrounding Geographical Area

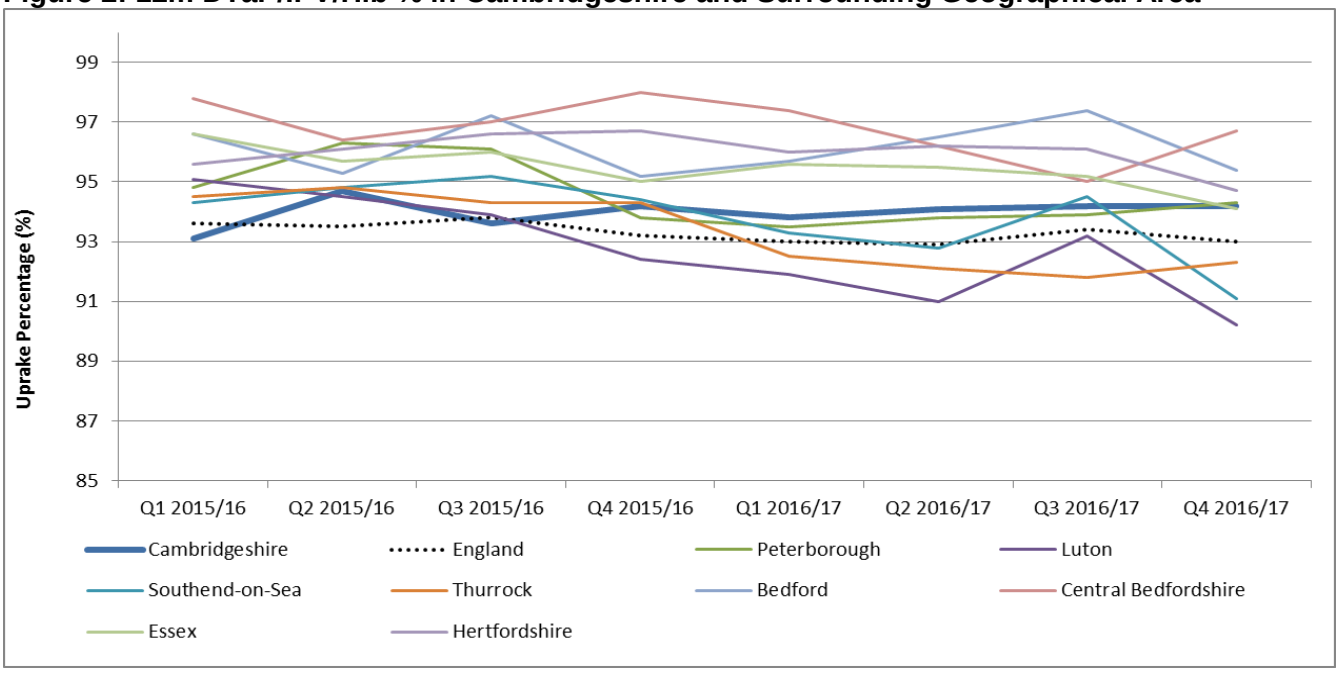


Table 4: **Pneumococcal Vaccine**

12 months PCV [target 95%] [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**92.9**	**94.4**	**93.7**	**94.6**
East Anglia	95.4	95.4	95.5	95.6
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**94.3**	**94.3**	**94.3**	**95.2**
East Anglia	95.4	95.3	95.3	95.1

Source: Cover, Public Health England

Figure 3: 12m PCV % in Cambridgeshire and Surrounding Geographical Area

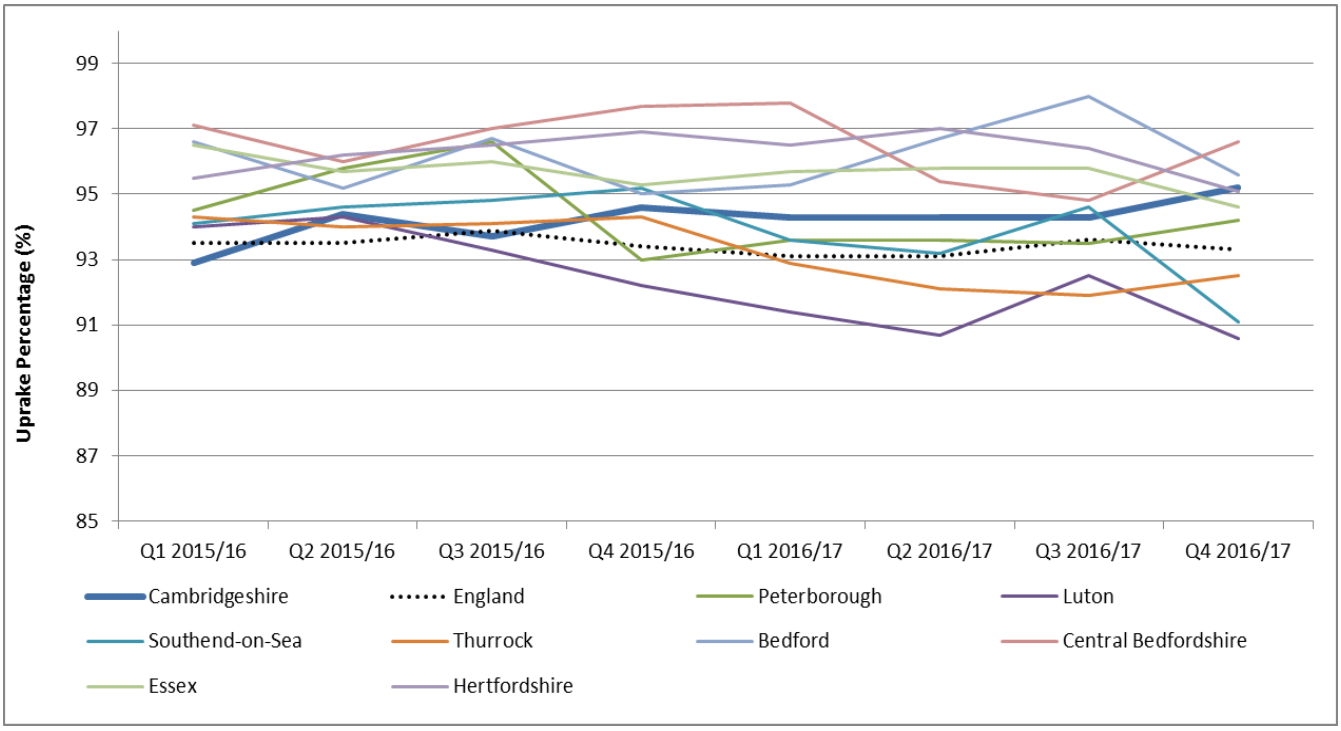


Table 5: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

24 months DTaP/IPV/Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**95.6**	**93.3**	**93.6**	**93.5**
East Anglia	96.5	95.7	96.2	96.0
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**93.7**	**95.4**	**94.8**	**95.6**
East Anglia	96.1	96.2	96.4	96.3

Source: Cover, Public Health England

Table 6: Pneumococcal vaccine

24 months PCV Booster [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**91.3**	**90.0**	**90.5**	**90.7**
East Anglia	93.6	93.0	93.5	93.3
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**89.9**	**92.0**	**92.9**	**93.0**
East Anglia	92.9	94.3	94.1	94.0

Source: Cover, Public Health England

Figure 4: 24m PCV Booster % in Cambridgeshire and Surrounding Geographical Area

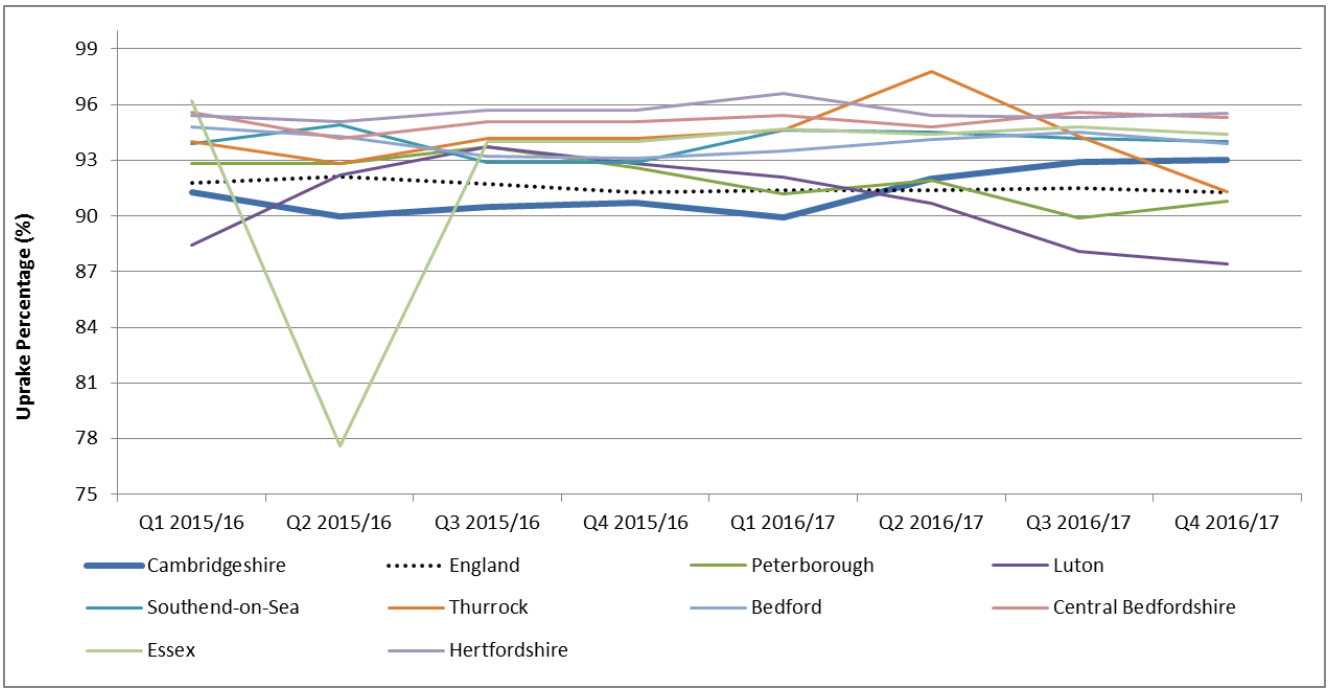


Table 7: Haemophilus Influenza B and Meningoccus C

24 months Hib/Men C [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**91.9**	**89.4**	**90.2**	**91.0**
East Anglia	93.8	92.5	93.4	93.3
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**89.6**	**92.0**	**92.7**	**93.0**
East Anglia	92.8	94.3	94.1	94.0

Source: Cover, Public Health England

Table 8: Measles, Mumps and Rubella

24 months MMR 1 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**91.7**	**89.1**	**90.2**	**91.0**
East Anglia	93.4	92.3	93.1	93.4
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**89.4**	**91.6**	**92.9**	**92.8**
East Anglia	92.7	93.8	93.9	94.0

Source: Cover, Public Health England

Table 9: Diphtheria, Tetanus, Pertussis, Polio and Haemophilus Influenza B

5 years DTaP IPV Hib [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**94.7**	**93.8**	**94.1**	**93.4**
East Anglia	96.2	95.3	95.6	96.2
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**93.1**	**93.7**	**93.9**	**95.0**
East Anglia	96.0	96.9	96.2	96.2

Source: Cover, Public Health England

Table 10: Measles, Mumps and Rubella (first dose)

5 years MMR 1 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**92.3**	**90.9**	**91.4**	**93.2**
East Anglia	94.2	93.1	93.8	95.2
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Cambridgeshire	**92.4**	**93.7**	**93.5**	**95.2**
East Anglia	95.4	96.0	95.5	95.6

Source: Cover, Public Health England

Figure 5:5yr MMR1 Percentage Uptake in Cambridgeshire & Surrounding Geographical Area

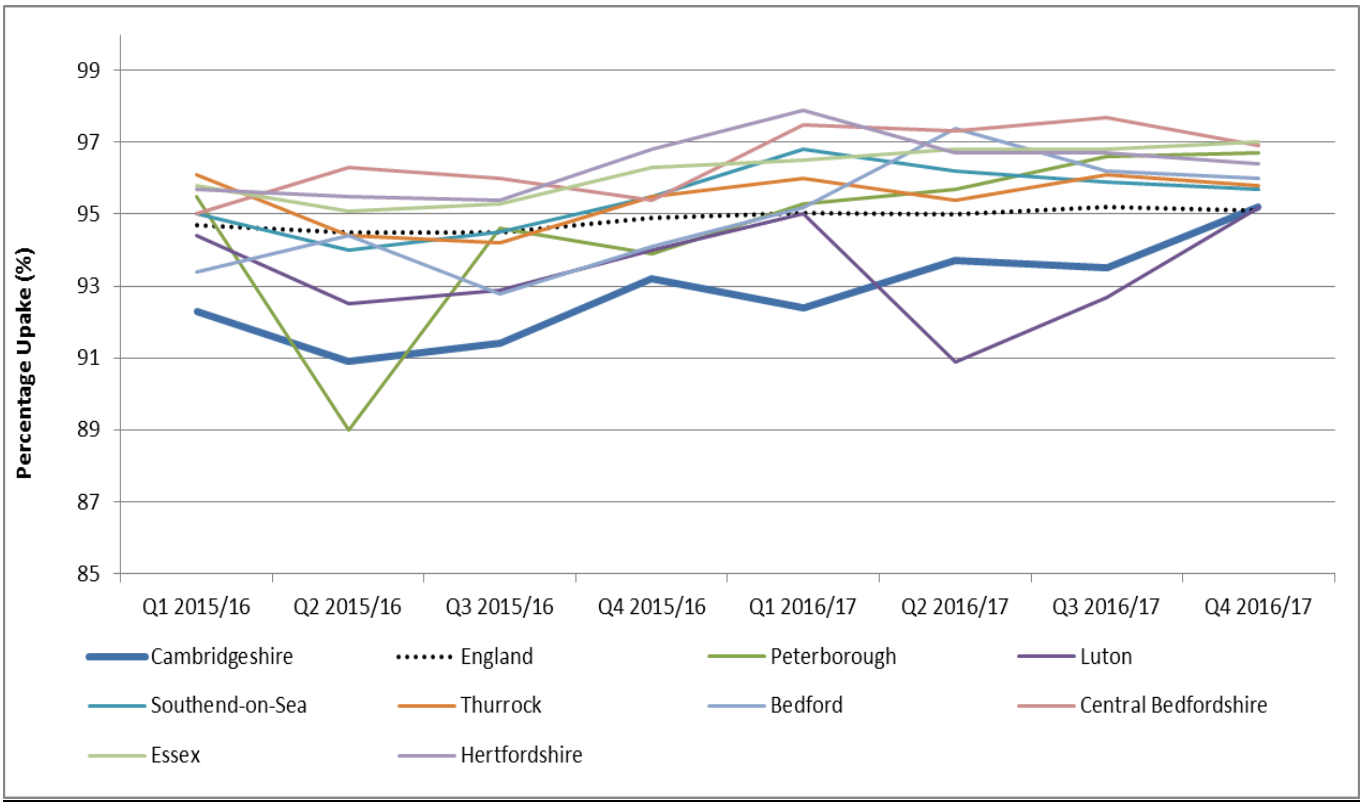


Table 11: Measles, Mumps and Rubella (second dose)

5 years MMR 2 [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**89.8**	**84.7**	**84.8**	**84.9**
East Anglia	91.4	88.8	89.4	90.8
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Cambridgeshire	**82.7**	**83.8**	**85.1**	**88.8**
East Anglia	88.2	89.8	90.1	90.1

Source: Cover, Public Health England

Figure 6:5yr MMR2 Percentage Uptake in Cambridgeshire & Surrounding Geographical Area

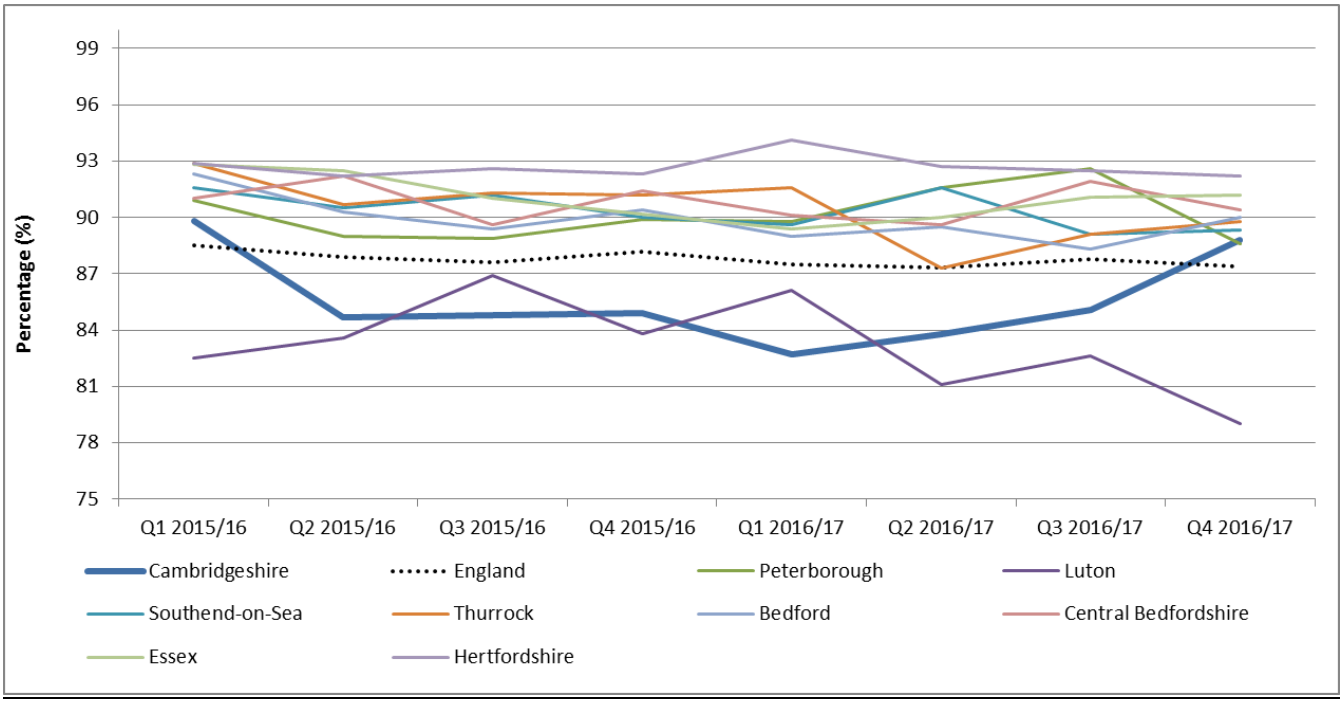


Table 12: Diphtheria, Tetanus, Pertussis, Polio

5 years DTaP/IPV Booster [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**85.7**	**85.4**	**86.0**	**84.5**
East Anglia	90.7	89.5	90.4	89.0
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Cambridgeshire	**82.6**	**82.1**	**84.1**	**86.4**
East Anglia	87.6	88.7	88.8	89.1

Source: Cover, Public Health England

Figure 7: 5yDTaP/IPV Booster % in Cambridgeshire and Surrounding Geographical Area

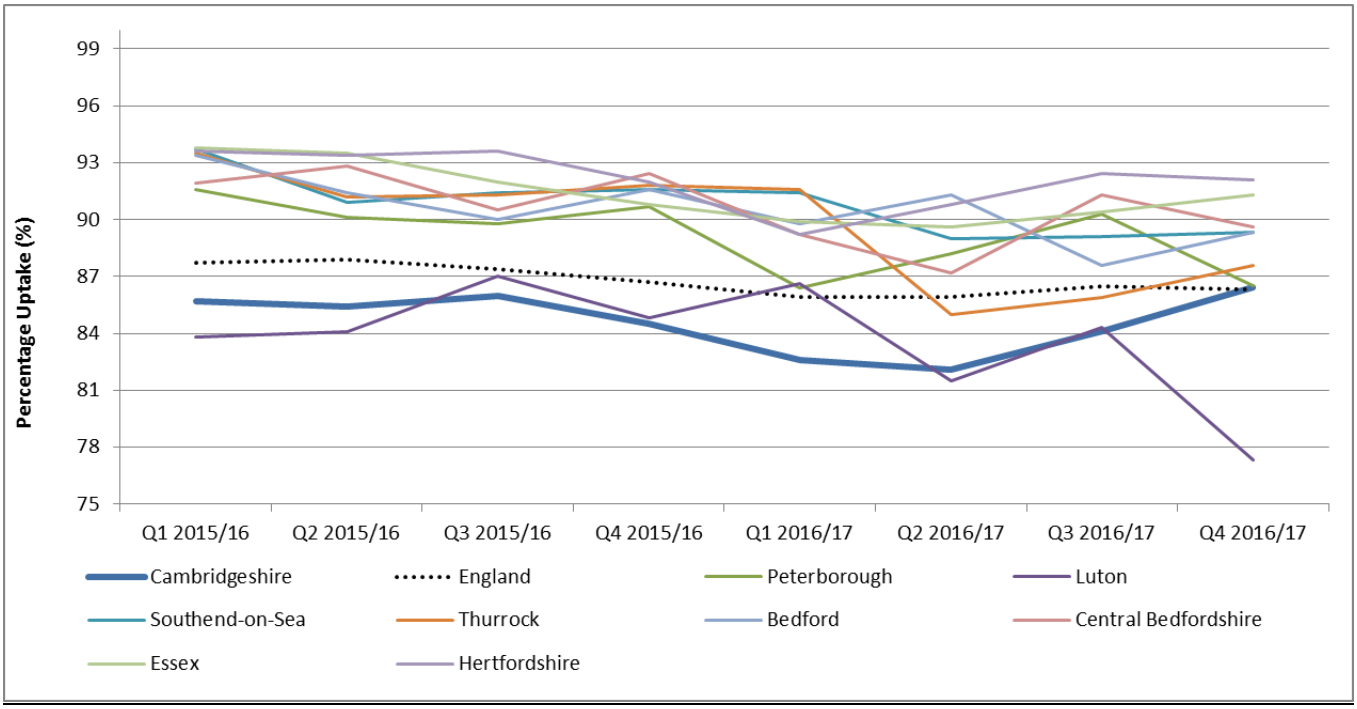


Table 13: Haemophilus Influenza B and Meningococcus C

5 years Hib/Men C [target 95%]	Q1 2015/16 %	Q2 2015/16 %	Q3 2015/16 %	Q4 2015/16 %
Cambridgeshire	**91.3**	**90.0**	**90.6**	**89.5**
East Anglia	93.1	93.0	92.9	92.2
	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**87.6**	**88.6**	**90.2**	**92.1**
East Anglia	91.2	93.4	93.0	93.2

Source: Cover, Public Health England

https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2013-to-2014-quarterly-figures
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2014-to-2015-quarterly-data
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2015-to-2016-quarterly-data

4.1.2. Meningitis B

New vaccines introduced include **Meningitis B** vaccine as part of the primary vaccination for infants. This commenced **1st September 2015**. It is offered to all babies when they attend for their first and third routine vaccinations, at 2 months and again at 4 months. A booster is offered at 12/13 months.

Table 14: Meningitis B

12 months Men B [target 95%]	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Cambridgeshire	**Data not collected**	**93.4**	**93.0**	**94.6**
East Anglia	**Data not collected**	93.7	94.4	94.6

Source: Cover, Public Health England

4.1.3. Men ACWY

Men ACWY was introduced following an increase in Men W infections. This is being delivered to adolescents by school immunisation providers. The 17-18 year old catch up offered through primary care started in August 2015.

Table 15: Men ACWY

Org Name	Vaccine uptake – December 2017					
	Becoming 18 (born 1st Sep 1997 to 31st Aug 1998	**No. of patients that have received the MenACWY**	**% Uptake**	**Becoming 19 (born 1st Sep 1996 to 31st Aug 1997 inclusive)**	**No. of patients that have received the MenACWY**	**% Uptake**
Cambridgeshire & Peterborough CCG	11839	3799	32.0%	12099	4686	38.7
East Anglia Total	**29607**	**8880**	**30.0**	**30253**	**11710**	**38.7**

Source: ImmForm

Table 16: Annual HPV Vaccine Coverage Data September 2016-17

Local Authority		Cambridgeshire County Council	England
Cohort 13: 13-14 Year Olds (Year 9) Birth Cohort: 1 September 2002 - 31 August 2003	Number of females in Cohort 13 (Year 9)	3122	289499
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2017	2833	257201
	% Coverage	**90.7%**	**88.8%**
	No. vaccinated with two doses by 31/08/2017	2671	240590
	% Coverage	**85.6%**	**83.1%**
Cohort 12: 13-14 Year Olds (Year 10) Birth Cohort: 1 September 2001 - 31 August 2002	Number of females in Cohort 12 (Year 10)	3005	281685
	No. vaccinated with HPV Vaccine at least one dose by 31/08/2017	2862	254554
	% Coverage	95.2	90.4
	No. vaccinated with two doses by 31/08/2017	2682	240929
	% Coverage	**89.3%**	**85.5%**

Source: Public Health England

4.1.4. Seasonal Flu Vaccination

Flu vaccination uptake improved this year for most groups but especially for the younger at risk groups and for NHS staff

Table 17: Flu vaccination uptake by key groups

Area	Summary of flu vaccine uptake %					
	65 and over		Under 65 (at risk)		Pregnant women	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Cambridgeshire & Peterborough CCG	**72.4**	**72.1**	**42.7**	**47.2**	**32.2**	**46.7**
East Anglia	71.3	71	42.8	47.1	36.7	47.9

Source: ImmForm

Table 18: Seasonal flu vaccination uptake by age 2, 3 and 4 year olds

Area	Summary of flu vaccine uptake %					
	All aged 2		All aged 3		All aged 4	
	2015/6	2016/7	2015/6	2016/7	2015/6	2016/7
Cambridgeshire & Peterborough CCG	**37**	**39.7**	**39.3**	**42.0**	**29.7**	**33.3**
East Anglia	39.1	42.1	40.8	43.9	32.0	35.4

Source: ImmForm

Table 19: Front line healthcare workers in Trusts

Org Name	No. of HCWs with Direct Patient Care	Seasonal Flu doses given since 1st September 2016		% Seasonal flu doses given since 1st September 2015
		No.	%	%
Papworth Hospital NHS Foundation Trust	1510	1114	73.8	64.9
Cambridge University Hospitals NHS Foundation Trust	7833	5400	68.9	41.8
Hinchingbrooke Health Care NHS trust	1215	920	75.7	63.6
Cambridgeshire and Peterborough NHS Foundation Trust	3375	1358	40.2	35.8
Cambridgeshire Community Services NHS Trust	1041	568	54.6	54.8
East Anglia Total	**50249**	**29012**	**57.7**	**43.1**

Source: ImmForm

4.1.5. Prenatal Pertussis Vaccination

Following increased pertussis activity in all age groups, including infants under three months of age, and the declaration of a national pertussis outbreak in April 2012, pertussis vaccine has been offered to pregnant women since 1 October 2012. The prenatal pertussis vaccination programme aims to minimise disease, hospitalisation and deaths in young infants, through intra-uterine transfer of maternal antibodies, until they can be actively protected by the routine infant programme with the first dose of pertussis vaccine scheduled at eight weeks of age.

Reported pertussis activity was higher in 2016 than in any year between 2013 and 2015 but did not reach the overall peak levels recorded in 2012. The increase in 2016 was consistent with pre-existing cyclical trends with peaks in disease every 3 or 4 years.

(Source: Public Health England, Health Protection Report Volume 12 Number 1 5 January 2018)

Pregnant women should be offered the prenatal pertussis vaccination between 20 and 32 weeks of pregnancy, as this is a safe and highly effective way to protect their baby from birth.

Table 20: Prenatal Pertussis Vaccination Uptake

Pertussis	Apr 2015 %	May 2015 %	Jun 2015 %	Jul 2015 %
Cambridgeshire & Peterborough CCG	49.8	45.9	52.7	50.5
East Anglia	**56.8**	**53.8**	**58.9**	**56.3**
Pertussis	Aug 2015 %	Sept 2015 %	Oct 2015 %	Nov 2015 %
Cambridgeshire & Peterborough CCG	51.2	50.5	54.1	52.5
East Anglia	**58.5**	**67.2**	**60.3**	**61.4**
Pertussis	Dec 2015 %	Jan 2016 %	Feb 2016 %	Mar 2016 %
Cambridgeshire & Peterborough CCG	50.7	50.3	NA	NA
East Anglia	**60.3**	**59.3**	**NA**	**NA**
Pertussis	Apr 2016 %	May 2016 %	Jun 2016 %	Jul 2016 %
Cambridgeshire & Peterborough CCG	52.7	73.8	73.3	71.9
East Anglia	**60.2**	**73.6**	**74.4**	**74.7**
Pertussis	Aug 2016%	Sept 2016 %	Oct 2016 %	Nov 2016%
Cambridgeshire & Peterborough CCG	70.6	72.8	71.4	72.3
East Anglia Total	**74.1**	**76.4**	**78.7**	**78.0**
Pertussis	Dec 2016 %	Jan 2017 %	Feb 2017%	Mar 2017 %
Cambridgeshire & Peterborough CCG	76.2	78.9	76.2	75.5
East Anglia Total	**79.8**	**82.3**	**79.8**	**77.0**

Source: ImmForm

4.1.6. Rotavirus Vaccination

Rotavirus is a highly infectious stomach bug that affects babies and young children. Infections are routinely reported in surveillance data provided by PHE which demonstrates the effectiveness of this programme as cases have dropped to tiny numbers since the vaccine was introduced.

Table 21: Rotavirus vaccination

12 months Rotavirus 2 doses [target 95%]				
	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Cambridgeshire	**87.6**	**89.5**	**87.5**	**89.1**
East Anglia	92.5	92.6	91.6	92.1

Source: ImmForm

4.1.7. School Immunisation Service

Table 22: Data for end of school year 2016-17

	Target	**Cambridgeshire**
HPV vaccination by end of school year nine dose 2	90%	85%
School leaver booster (Td/IPV) by end of school year 9 and 10	80%	83%
Men ACWY by end of school year 10.	80%	84%
Childhood Flu vaccination school years 1 and 2 and 3	60%	61%
Schools participating in the programme	100%	99%

Source: CCS

4.1.8. Shingles

The data for the Shingles vaccination programme is shown in the table below. The data is cumulative and is up to end August 2017. This is the fourth year of the shingles vaccination programme in England and data from September 2016 to August 2016 shows a continued decline in coverage in the routine (70 year old) and catch up (78 years old) cohorts (from 59.0% in 2015/16 to 54.0% in 2016/17 and from 59.8% in 2015/16 to 57.2% in 2016/17, respectively). PHE note several factors may have contributed to the decline, including:

- difficulties in practices identifying the eligible patients – during busy influenza immunisation clinics
- lack of call/re-call in the service specification to allow mop up of those who missed immunisation during the flu season
- possible lowering of patients' awareness of the vaccine since its introduction in 2013.

PHE are promoting the need for shingles vaccine through professional channels and considering a range of possible approaches to simplify the programme and associated eligibility criteria.

Table 23: Shingles vaccination uptake August 2017

Area	Vaccine coverage for the Routine Cohort since 2013			Vaccine coverage for the Catch-up Cohort since 2013		
	Registered Patients aged 70	Received Shingles vaccine		Registered Patients aged 78	Received Shingles vaccine	
		No of patients	% of patients		No of patients	% of patients
Cambridgeshire & Peterborough CCG	8284	4389	53.0	5110	2842	55.6
East Anglia Total	**29332**	**14947**	**51.0**	**18338**	**9753**	**53.2**

Source: ImmForm

4.1.3 Cambridgeshire and Peterborough Immunisation network

This groups meets 3 – 4 times per year to discuss all issues relating to immunisations and to take forward the recommendations of a previous Immunisation 'Task and Finish' group that reported two years ago. That group had been set up to identify the reasons for lower immunisation uptake for childhood immunisation. Ongoing work includes close working with GP practices in some areas with particularly low uptake.

Immunisations are being targeted in a Healthy Peterborough campaign in March / April 2018 with specific focus on the pre-school booster, MMR2 and HPV vaccines.

5. SCREENING PROGRAMMES

5.1. Antenatal and Newborn Screening

From Q1 there have been some changes to the Key Performance Indicators (KPIs). The parameters for acceptable/achievable levels have been revised for some KPIs, resulting in some KPIs that may have been previously achieved, now moving to acceptable.

A new KPI FA2 has been introduced; Fetal Anomaly Screening coverage (at 18+0 to 20+6 weeks of pregnancy a Fetal Anomaly ultrasound examination is carried out) and is reported on for the first time with all Trusts able to report and achieving the achievable standard.

Table 24: ID1 Antenatal infectious disease screening HIV Coverage + ID2 Hep B timely referral for women found to be Hepatitis B

2015-2016								2016-2017			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
ID1 Antenatal HIV test coverage	>95%	99%	CUH	97.0	97.8	96.7	98.0	97.3	99.5	99.4	98.9
	>95%	99%	HHT	99.5	99.3	99.0	99.2	99.8	98.9	99.6	99.7
ID2 Hep B timely referral for women found to be Hepatitis B	>70%	99%	CUH	100	100	83.3	33.3	No cases	100	100	No cases
	>70%	99%	HHT	No cases	100	100	No cases	0	100	100	100

Source: Maternity Unit

Table 25: Fetal anomaly screening – Coverage

				2016-2017			
FA2: Fetal anomaly screening fetal anomaly ultrasound) – coverage *	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**
	>90%	>95%	CUH	100	94.4	93.4	86.6
	>90%	>95%	HHT	Not reported	99.5	99.7	99.7

Source: Maternity Unit

CUH have addressed the issue of timely scan appointments to meet the requirements of the standard.

Table 26: ST1 Coverage, ST2 Timeliness of Test, ST3 Completion of FOQ

				2015/-2016				2016/-2017			
Indicator	**Standard**	**Achievable**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
ST1 Antenatal sickle cell and thalassaemia screening – coverage	>95%	99%	CUH	97.3	98.0	97.6	96.9	91.4	98.5	98.8	96.1
	>95%	99%	HHT	98.5	98.5	98.4	99.0	98.9	99.0	97.7	97.1
ST2 Antenatal sickle cell and thalassaemia screening Timeliness of Test	>50%	75%	CUH	29.6	31.6	32.1	30.1	31.7	*43.3	43.5	60.3
	>50%	75%	HHT	No data	No data	No data	29.9	49.4	52.0	55.2	98.6
ST3 Antenatal sickle cell and thalassaemia completion of FOQ	>95%	99%	CUH	89.8	80.2	96.9	77.3	76.6	90.9	97.8	98.2
	>95%	99%	HHT	No data	No data	No data	96.8	98.6	97.5	97.7	100

Source: Maternity Unit

CUH have addressed the issues around early booking and now meet the acceptable standard for ST2. Data extraction has been improved to accurately reflect activity.

Table 27: Newborn Bloodspot Screening Coverage, Avoidable Repeats, Coverage (movers in)

				2015-16				2016-17			
Indicator	**Standard**	**Achievable**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NB1 Newborn blood spot screening coverage	>95%	99.9%	CCS	98.0	98.0	98.1	99.4	98.1	98.2	98.9	91.39
NB2 Newborn blood spot screening avoidable repeats	<2%	0.5%	CUH	No data	2.7	2.7	4.9	2.4	*3.1	3.1	2.4
	<2%	0.5%	HHT	No data	9.0	3.6	4.5	3.4	**2.1	3.4	2.8
NB4 Newborn blood spot screening coverage- movers in	>95%	99.9%	CCS	80.0	78.6	89.5	72.7	88.2	*80.1	84.1	85.0

Source: Maternity Unit

Both Trusts have avoidable repeat rates exceeding the acceptable level. Both Trusts have action plans in place and are being monitored by the screening and immunisation team.

NB4 -This KPI is impacted by the small denominator and refers to children who move into the area being seen and offered the NBBS within 3 weeks of being notified to CHIS. The numerator is impacted by declines of babies who have received screening in their own country, those transferring in very near to the cut off for screening and those experiencing slight delays whilst appropriate interpreter arrangements are made to facilitate the appointment.

Table 28: Newborn Hearing – Coverage, Referral to Assessment

				2015-16				2016-17			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NH1 Newborn hearing screening coverage	>97%	99.5%	CUH	98.6	98.0	98.7	99.4	99.2	98.6	98.3	99.0
	>97%	99.5%	HHT	99.9	100	99.8	99.5	99.7	99.2	99.9	99.8
NH2 Newborn hearing screening timely referral for assessment	>90%	95%	CUH	78.9	78.9	72.7	94.1	77.8	*93.8	88.0	94.4
	>90%	95%	HHT	100	100	100	60	100	No case	83.3	100

Source: Maternity Unit

CUH: Attendance rates in audiology have been addressed with an improvement in the way appointments are arranged prior to discharge and compliance has improved.

Low denominators impact on this KPI and actual figures are monitored by the screening and immunisation team.

Table 29: Newborn and Infant Physical Examination – Coverage and Timely Assessment

				2015-2016				2016-17			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NP1 Newborn and Infant Physical Examination- coverage newborn	>95%	99.5%	CUH	93.2	94.0	96.4	94.6	97.3	94.5	94.5	95.2
	>95%	99.5%	HHT	95.9	95.4	93.3	92.8	99.7	96.5	95.8	95.2
NP2 Newborn and Infant Physical Examination timely assessment	>95%	100%	CUH	57.1	0.0	50	75	100	*66.7	28.6	66.7
	>95%	100%	HHT	No Case	100	0	20	25	No cases	No cases	100

Source: Maternity Unit

CUH: The newborn infant physical programme has been under close scrutiny and recommendations for the implementation of the NIPE failsafe: NIPE SMART.

5.1.1. Programme Updates

Cambridge university hospital had a Quality assurance visit in January 2017, with a resultant action plan that is being monitored by the quality assurance team. Improvements specifically in the KPIs ST2, NB2 and NP2 have been targeted and improvements have now been achieved.

5.1.1.1. FASP

A new KPI (FA3) is being piloted to monitor coverage of trisomies 13 and 18.

All maternity units are required to report fetal & congenital anomalies to the National congenital anomaly and rare disease registration service. (NCARDRS). A further KPI on referral for prenatal diagnosis is also being piloted on this programme.

5.1.1.2. Infectious Diseases

Coverage KPIs for Hepatitis B and Syphilis will be collected from April 2017.
The use of NIPE SMART became mandatory; the Trusts are compliant.

5.1.1.3. Newborn hearing

A new screener qualification was launched and is a mandatory requirement for all new unregistered staff from April 2017.

5.1.1.4. Non Invasive Prenatal Testing

It is likely that the new non- invasive screening test for Downs, Edwards and Patau's syndrome will be commissioned in 2018/19. The highly sensitive screening test will be offered to all women who have a high risk result following the combined test. It is expected that the rates of diagnostic procedures will fall as a result. Further information is still awaited from the national team.

5.2. Cancer Screening programmes

5.2.1. Breast Screening

Uptake of breast screening is satisfactory and had reached a much improved level in 2016/7. We will continue to closely monitor uptake.

Table 30: Breast screening Uptake

BS1 - Percentage of eligible women who attend for screening (aged 50-70)									
Cambs. & Hunts. Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 70.0%	≤ 80.0%	66.2	71.3	67.0	76.9	73.3	75.1	72.8	74.0

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

Table 31: Breast Screening Round Length

BS3 - Percentage of women first offered an appointment within 36 months									
Cambs. & Hunts. Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	98.89	99.37	99.0	99.2	99.5	98.9	98.6	95.6

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

Table 32: Waiting Time for Assessment

BS11 – Percentage of women who attend for assessment within 3 weeks of attending for screening									
Cambs. & Hunts. Screening Centre		2015-2016				2016-2017			
Acceptable	Achievable	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
≥ 90.0%	≤ 100.0%	87.01	84.04	87.4	99.4	93.6	93.0	97.2	94.0

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

5.2.2. Cervical Cancer Screening

We have been advised by NHSE that actual uptake data for the cervical screening programme is only available annually although process data for the programme are available quarterly, see below. The most recent uptake data for Cambridgeshire shows that 63.0% of women aged 25–49 have taken up their invitation to be screened.

Table 33: CS2, CS2a and CS2b - Coverage of eligible population

Acceptable	Achievable	Provider	Q1 2016-17	Q2 2016-17	Q3 2016-17	Q4 2016-17
CS2 - Coverage of eligible population (all women) every 5 years						
≥ 80%	≥ 95.0%	Cambridgeshire Upper Tier LA	68.2	68.1	67.4	66.8
CS2a - Coverage of eligible population, all women aged 25-49 every 3 years						
≥ 80%	≥ 95.0%	Cambridgeshire Upper Tier LA	64.5	64.5	63.7	63.0
CS2b - Coverage of eligible population, all women aged 50-64 every 5 years						
≥ 80%	≥ 95.0%	Cambridgeshire Upper Tier LA	76.1	75.9	75.5	75.0

Source: Screening Quality Assurance Service (SQAS) and Open Exeter

5.2.2.1. Improving uptake in Cancer screening programmes

We are currently working on a project where we are looking to improve Cervical Screening uptake in the Cambridgeshire and Peterborough area for 25 to 49 year olds. Nationally, the uptake for cervical screening is decreasing and we are working with GP Practices, McMillian GPs, Cancer research UK and the local CCG to try and improve uptake in this area. We will be focusing on two separate areas, how to improve knowledge of cervical screening in 25 to 49 year olds and how to develop and improve GP surgeries procedures.

5.2.3. Bowel Cancer Screening

The Cambridge Bowel cancer screening service has been performing well over the last two years. The diagnostic waiting times have been affected recently due to workforce pressures within the endoscopy services. This is being addressed jointly by the providers and commissioners.

Table 34: Bowel screening data

Cambridgeshire Screening Centre			**2015-2016**				**2016-2017**			
	Acc.	**Ach.**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
BCS4 – Uptake	≥52%	≥70%	61.5	59.2	53.8	58.2	61.7	59.9	59.1	60.0
BCS7– SSP Waiting Times	100% within 14 days ≤1.0%		100	100	100	100	100	100	100	100
BCS8 - Diagnostic test waiting times	100% within 14 days		100	100	100	100	100	94.8	87.8	70.1

Source: OBIEE (Oracle Business Intelligence Enterprise Edition)

6. Adult and Young People Screening

6.1. Diabetic Eye Screening Programme

Diabetic retinopathy is one of the most common causes of sight loss among people of working age. It occurs when diabetes affects small blood vessels, damaging the part of the eye called the retina. Diabetic retinopathy doesn't usually cause any noticeable symptoms in the early stages. If retinopathy is detected early enough, treatment can stop it getting worse. Otherwise, by the time symptoms become noticeable, it can be much more difficult to treat. This is why the NHS Diabetic Eye Screening Programme was introduced.

Table 35: Diabetic Eye Screening

Cambridgeshire & Peterborough CCG through East Anglia DESP								
Indicator & Target	**2015-2016**				**2016-2017**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Acceptable 70% Achievable 80%								
DE1-Uptake of routine digital screening event	91.0	90.5	78.3	77.1	85.7	87.6	85.6	83.8
Acceptable 70% Achievable 80%								
DE2-Results issued within 3 weeks of screening	99.9	100	99.0	99.0	99.8	99.7	99.8	99.8
Acceptable 80% Achievable 95%								
DE3 - Timely assessment for R3A screen positive	50.0	77.8	65.3	63.2	80.0	75.0	58.3	70.0

Source: Health Intelligence

Achievement of the KPI DE3 is affected by the capacity issues in Hospital eye services within the acute Trusts in the region and is also affected by low numbers.

6.1.1. Abdominal Aortic Aneurysm (AAA) Screening Annual Data

Table 36: Annual Data AA1 Completeness of Offer

AAA Annual Data - Cambridgeshire and Peterborough population					
Indicator	**Acceptable**	**Achievable**	**2014-15**	**2015-16**	**2016-17**
AA1 Completeness of Offer	≥ 52%	≥ 70%	100	99.9	99.9

7. Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR)

7.1 Methicillin Resistant Staphylococcus Aureus (MRSA)

Nationally the rate of MRSA bacteraemia for 2016/17 remained steady at 1.5 cases per 100,000 population and in the two years prior. Reductions have been seen in the time to onset for admitted patients, with a greater proportion of cases having a time to onset that would be considered community onset. This is likely to reflect improved clinical awareness by NHS staff but could also be an artefact of declining durations of hospital stay (PHE, 2017).

The introduction of third party cases in April 2014 recognised the complexity of some MRSA cases and where no breach in key policy was evident as part of that patient's care. These cases are not reflected against an acute Trust or CCG on the data capture system but recorded separately within the system as part of the ongoing surveillance and identification of themes and trends of causes.

Table 37: MRSA bacteraemia

Assigned	National No. 2016/17	Local No. 2016/17	National No. 2017 (Apr 17 to Nov 17)	Local No. 2017/18 (to 31/12/17)
	823	11	547	10
CCG		1		0
Trust		4		4
Third Party		6		6

7.2 Clostridium difficile

During 2016/17, 12,840 cases were reported nationally, a decrease of 9.2% on the previous year. Of these 36% were trust-apportioned and mirrors the trend of incidence of all cases declining, though overall the decline in rate has slowed. The separation of cases into trust-apportioned and non-trust apportioned is recognized to ignore relevant information on prior health exposure. For example, some cases classed as community onset are likely to be among patients who were recently discharged from hospital. The current algorithms do not take into account complex healthcare pathways patients may have.

Locally each individual case is discussed at Scrutiny panel meetings held by the Trust's. The recognition of the fact that some cases occur even if best practice is followed and the patient receives flawless care, these are non-sanctioned cases, i.e. not counted against the annual Trust objective.

In line with the national findings, the rate of local cases has slowed down however at the same time we have seen an increase. Between April and December 2016 there were a total of 104 cases reported. In the period April to December 2017 this has risen to 142. Of these cases only 21 from

our Trusts have been identified to have breached some element of key policy and sanctioned against the annual objective.

The annual objectives have not been changed by the Department of Health for the past three years but we do expect this to be reviewed prior to the 2018/19 guidance being released around February/March 2018.

7.3: *Escherichia coli* bacteraemia

Between 2012/13 and 2016/17 the national rate of e coli cases has risen from 22% to 73.9% with a total of 40,580 cases reported in 2016/17. The highest rates were among patients over the age of 85 years and greater in men than among women. The most likely primary focus over time continues to be urinary tract infections accounting for 47% in 2016/17.

April 2017 saw the introduction of a Quality Premium for CCGs to reduce the number of E coli cases by 10% during the period of 2017/18 which equates to 53 cases for Cambridgeshire and Peterborough CCG.

All CCGs have been faced with a number of challenges due to resource limitations, patient identifiable data access and engagement from primary care to collect core data for the national data capture system.

The CCG is to lead on a project from January 2018 working across the whole health economy to develop and implement a bladder bundle toolkit alongside the specialist continence and urology nurses, community and primary care services and to engage with patients, in order to address the local population needs. Removing unwarranted variations of care will identify where patient risks of infection are reduced.

Between April and December 2017 we have 403 cases reported against 407 in the same period of 2016. To reach the Quality Premium we would need to have a maximum of 481 cases by the end of March 2018. Measures put in place by in-patient settings for all types of healthcare associated infections are able to have a more significant impact than when patients are in the community setting, hence the work to be undertaken will be to identify all patients with urinary catheters and frequent non-catheter related infections across our local health economy.

References:

1. Annual Epidemiological Commentary Mandatory MRSA, MSSA, *E coli* bacteraemia and *C difficile* infection data 2016/17. Public Health England. 6 July 2017
2. Technical guidance for NHS planning 2017/18 and 2018/19 – Annex B, Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups

7.4 Antimicrobial Resistance

Antimicrobial resistance has been described as one the greatest threats to human kind. The overuse and incorrect use of antibiotics are major drivers of the development of antimicrobial resistance. The continued threat from the development of antimicrobial resistance and a drastic reduction in the number of new antibiotics being developed, make the need to preserve the antimicrobials we currently have a local, national and global priority. Local targets, set nationally, for reducing the amount and

certain types of antimicrobial drugs prescribed across all health care sectors are in place and achieving these requires co-operation from prescribers, patients and the public.

Research has shown that antibiotic stewardship programmes could halve the number of infections due to antibiotic-resistant bacteria compared with unguided prescribing. Locally, there has been a reduction in the number of antibiotics prescribed by GPs which will contribute to conserving the antibiotics we currently use. This has been achieved through the introduction of antibiotic stewardship programmes across all health sectors, use of educational materials for GPs and patients, provision of comparative antibiotic prescribing data to GP practices, peer group review, and public education programmes.

Trimethoprim, an antibiotic used to treat infections such as urinary tract infections, is an effective treatment where infections have been shown to be susceptible and in situations where alternatives would be less suitable. However, the inappropriate use of trimethoprim, has been associated with the development of serious, life-threatening gram-negative bloodstream infections, particularly in vulnerable patients where their urine infection has been resistance to trimethoprim. 33.2% of urine community E. coli (or coliform) samples tested between October and December 2017 in the Cambridgeshire and Peterborough CCG area were found to be resistant to trimethoprim. This figure was higher than other Clinical Commissioning Groups (CCGs) in the East region. Local and national targets have been introduced aimed at reducing the inappropriate use of this trimethoprim compared to alternatives and specifically for use in in patients over 70 years old who are the most vulnerable. Local targets for reducing the use of trimethoprim have been met through effective antibiotic stewardship initiatives and the addition of new antibiotic formulary choices which offer prescribers more alternatives to trimethoprim. Focusing on reducing inappropriate use of trimethoprim in urinary tract infections continues into 2018-19.

Broad spectrum antibiotics include the groups of antibiotics the quinolones, cephalosporins, and co-amoxiclav. They should normally only be used when narrow-spectrum antibiotics have not worked or are resistant to the infection being treated. Inappropriate use increases the risk of producing a resistant type of bacteria known as MRSA, other resistant urinary tract infections and may cause an unpleasant life-threatening infection, Clostridium difficile, to develop. Local and national targets have been set aimed at reducing the amount of broad spectrum antibiotics prescribed compared to all types of antibiotics. Locally, use of broad spectrum antibiotics has been higher than the local target. A system wide approach using antibiotic stewardship programmes has addressed this along with provision of prescribing data, peer group review and support to GPs in reducing their use of unwarranted broad spectrum antibiotics. Some success has been seen, but this still needs to be improved during 2018-19 and will require the co-operation of prescibers, patients and the public.

7.5 AMR References:

The UK AMR Strategy High Level Steering Group. UK 5 Year Antimicrobial Resistance (AMR) Strategy 2013-2018. Third Annual progress report, 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662189/UK_AMR_3rd_annual_report.pdf and accessed 25/2/18,

National Institute for Healthcare and Clinical Excellence (NICE). Key therapeutic topic [KTT9] Antimicrobial stewardship: prescribing antibiotics. Published date: January 2015. Last updated:

January 2017. Available at: https://www.nice.org.uk/advice/ktt9/chapter/evidence-context and accessed 25/2/18.

Public Health England. East Region. AMR Local Indicators. Available at: http://fingertips.phe.org.uk/ and accessed 25/2/18.

8. Environmental Health

8.1 Membership of the Health Protection Steering Group includes a senior environmental health lead from a district council, who meets regularly with colleagues in the other councils and reports, by exception, on environmental health issues

8.2 Environmental health has a strong focus on health protection and is a responsibility of city and district councils and unitary authorities. The roles of the environmental health staff in each council can vary considerably but most include:

- food safety and inspection of food premises
- Health and safety.
- Statutory nuisance – including noise nuisance
- Licensing
- Contaminated land
- issues around private sector housing and houses in multiple occupation

8.3 Food Safety, Health and Safety, Pollution Control, Licensing and Trading Standards are part of Regulatory Services. The purpose of the service is to carry out interventions to check compliance with legal requirements and where appropriate take enforcement action. The service also has a role supporting businesses to help them comply with the law. The work of Regulatory Services helps to keep people healthy and safe, reduces health inequalities and contributes to the national and local economy.

8.4 Some of this work includes food inspections, investigating food complaints and infectious diseases and regulating private water supplies. District and city councils operate the National Food Hygiene Rating scheme which helps consumers choose where to eat or shop for food by providing information about hygiene standards. .

8.5 Licensing staff regulate the carrying on of all licensable activities by the appropriate control of licensed premises, temporary events and personal licence holders. Areas of licensing include alcohol, gambling, pet shops, petroleum sites, tattooists and skin piercing, dangerous animals and adult entertainments.

8.6 Trading Standards deal with product safety, animal health and fair trading and credit. A Joint Eastern Region Illicit Tobacco Control Project aims to increase the understanding of and raise awareness of illicit tobacco. Roadshows have been carried out with detection dogs to show the public how they find concealments and with experts on hand to offer help to those who wish to quit smoking. The project will provide support visits to businesses, intelligence led surveillance and follow up investigations and will result in seizure operations and prosecutions where necessary.

8.7 Pollution control incudes investigation of a wide range of statutory nuisances, air quality assessment, hoarding and infestations of vermin in domestic and commercial premises and the issuing of permits for industrial processes.

8.8 Air quality is a significant public health issue and responsibility for air quality rests with city and district councils but is not always within the remit of the environmental health staff in view of the major contribution of traffic to reducing air quality. A recent paper was presented to the Health Committee on air quality in Cambridgeshire, highlighting the main areas of concern and actions being taken.

8.9 Membership of the Health Protection Steering Group includes a senior environmental health lead from a district council, who meets regularly with colleagues in the other councils and reports, by exception, on environmental health issues

9. Air Quality

9.1 The air quality agenda in Cambridgeshire is not owned by a single organisation or department. Instead the districts and city have statutory requirements to assess, monitor and develop action plans on air quality where required; they also have plan making powers which can effect air quality. The county council, combined authority and Greater Cambridgeshire Partnership are responsible for actions and intervention's (mainly relating to transport) which can mitigate or reduce air pollution.

9.2 The role of the public health team is to provide the health based implications of air quality at a population level. We facilitate this by bringing together key stakeholders who may not normally meet for air quality issues or may only be considering the environmental aspects, for example Public Health are now contributing to the Transport needs review of the Cambridge Biomedical Campus (one of the Greater Cambridge Partnership Projects) following concerns raised by members of the Cambridgeshire County Council Health Committee and officers at the Cambridge City Council.

9.3 There are number of challenges which need to be considered when developing a more joined up county wide approach to air quality. The ownership of the air quality agenda is fragmented, and is not owned by a single organisations or group with responsibility for monitoring and mitigation held by different organisations, this makes a system wide response more challenging.

9.4 The burden of air quality varies across Cambridgeshire with levels of recorded air pollution varying across Cambridgeshire with Air Quality Management Areas (AQMA) declared in Cambridge City, South Cambridgeshire, Huntingdonshire and Fenland; East Cambridgeshire currently does not have an AQMA. By nature this means that air quality does not have the same level of focus for all authorities.

9.5 The knowledge of air quality and its impact among transport and planning officers is a gap as transport planners and local planners are not experts in air quality, and in two tier areas do not have access to air quality expertise in their organisations, therefore Public Health are commissioning a training programme for these officers to raise awareness of air quality and to foster closer working relationships.

9.6 There is a lack of air quality specialist capacity in many of the district councils, which means the majority of their focus is on their statutory duties, with little capacity for broader advocacy work or influencing planning and transport decisions.

9.7 There are co-benefits from wider interventions, as air quality should not be seen in isolation as health modelling shows that interventions to increase active travel can result in significantly greater benefits from increased physical activity, compared to direct interventions targeting air quality overall – so greater health benefits will be achieved by people switching to walking and cycling than by switching to electric cars.

9.8 The approach therefore is to focus on those areas of the county most effected by poor air quality whilst at the same time directly informing broader strategic plans and programmes, such as transport plans and local plans, which have considerable impact on air quality across the whole of the county.

9.9 In Districts with declared Air Quality Management Areas (AQMA) the focus is continuing to support the authorities to bring forward measures to improve air quality and ensure that the most vulnerable are protected e.g. children and those with health conditions.

9.10 At a strategic level the Combined Authority will be developing a new Cambridgeshire and Peterborough Local Transport Plan (LTP). As transport is one of the main contributors to air quality this will be considered in the LTP. Public Health will play a role in bringing together stakeholders on air quality to provide a more comprehensive joined up response. The development of the LTP would also provide an opportunity to champion and influence opportunities for more active travel within the plan.

9.11 The combined authority is also developing a Non Statutory Spatial Plan which will focus on providing a county perspective on infrastructure, linking up local plans and the LTP. Air quality will be considered as part of this process and could be a consideration for a new Quality Charter for Growth which is currently being considered.

9.12 These plans will enable Public Health to indirectly influence air quality in those localities where air quality is not deemed to be a priority.

10 NATIONAL TUBERCULOSIS STRATEGY

10.1 Latent TB Identification Project

The aim of this project is to continue to support the early diagnosis of Latent TB and offer treatment of active disease.

10.2 NHS England and Public Health England jointly published the collaborative tuberculosis strategy on 19 January 2015. NHS England has committed £10 million for the establishment of testing for, and treatment of, latent tuberculosis (TB) in new entrants from countries of high TB incidence. Public Health England has committed £1.5 million for the establishment of the national TB office and support teams to the nine TB control boards. It is likely that the majority of TB cases in the UK are the result of 'reactivation' of latent TB infection (LTBI), an asymptomatic phase of TB which can last for years. There is a 5% risk of a patient with LTBI

developing active TB infection. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

10.3 Following the publication of the national strategy a review of TB services was undertaken in Cambridgeshire and Peterborough. The key Epidemiological findings are summarised below and provide an overview of the impact of TB on the resident population of the CCG.

- There were 999 cases of TB reported in Cambridgeshire and Peterborough residents between 2004 and 2014.
- Almost three quarters (73%) of TB cases between 2004 and 2014 were in non-UK born individuals.
- The most common countries of origin of TB cases in Cambridgeshire & Peterborough in the last three years were UK, India, Pakistan, Lithuania, East Timor and Kenya. PHE recommend screening people who were born in or who had spent >6 months in high TB incidence country (150 cases per 100,000 or more)

10.4 The eligibility criteria for the service are any new patient registering with a practice or retrospectively identified by the practice as being:

- Born or spent > 6 month in a country of high TB incidence
- Entered the UK within the last 5 years
- Aged 16-35 years
- No history of TB either treated or untreated
- Never screened for TB in the UK

10.5 Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) led this work supported by representatives from:

- North West Anglia Foundation Trust (NWAFT)
- 18 Greater Peterborough GP Practices because the incidence of TB is much higher in Peterborough
- 2 Cambridgeshire GP Practices
- Public Health England (PHE)
- Cambridgeshire and Peterborough Foundation Trust
- Cambridgeshire County Council – Public Health

10.6 GP Practices with a high crude rate of TB cases were identified by PHE. Of these, practices with a crude annual rate of active TB ≥ 20 cases/100,000 have been prioritised for the LTBI screening programme.

10.7 The project commenced in March 2016 and to date 18 Peterborough Practices have been identified and have signed up, and 2 practices in Cambridgeshire. Using a Local Enhanced Service (LES) agreement. Training was provided by Oxford Immunotec, the provider for blood sample analysis as part of the screening.

10.8 Practices are expected to identify new patients on registration. PHE have provided the CCG with materials and letters to support the project.

10.9 There is a comprehensive action plan to cover the communication and engagement elements of this project. This aims to:

- Raise awareness of Latent TB and the need for screening
- Get people to visit their GP practice for screening
- Get people to register with a practice if not already
- To dispel myths and beliefs about TB

10.10 Communications work so far has included an article and social media posts targeted at encouraging prospective patients to come forward. These were sent to specific community contacts obtained through partnership working with the councils, as well as posted from the CCG's social media channels.

10.11 News of the project and its progress has also been shared with stakeholders on the CCG Newsletter distribution list, as well as with GP members of the organisation. Press releases were issued in September and December 2016. King's Lynn FM provided radio coverage in October, and the December release was picked up by BBC Radio Cambridgeshire and BBC Look East. Look East's coverage was particularly in depth, focusing on TB as well as Latent TB, and aired in January 2017. Future engagement with prospective patients and the public is planned for later in 2017.

10.12 Practices identify patients and invite them for blood screening. Bloods are taken and sent off for testing. All those with positive results are seen and treated by Secondary Care Services

Table 38: ACTIVITY TO DATE (Cumulative May 2016 – end January 2018)

Activity	**Data**
Negative	397
Positives	65
Borderline negative	8
Borderline positive	11
Indeterminate	5
Non reportable insufficient cells	4
Assay not run	2
Technical error	2
Total Screened	**494**

10.13 This activity is higher than other pilot areas in the region. There has been a positive response by the Practices to the screening programme and the CCG is receiving positive feedback regarding the activity that is being seen and treated.

10.14 The CCG is intending to roll out to other practices and will continue to work closely with the existing practices to ensure they will identify and screen eligible people.

10.15 The Communication and Engagement Plan is also being refreshed to ensure the CCG is engaging with communities and stakeholders effectively.

10.16 For 2018/19 the CCG will continue to support all the GP Practices involved, to continue with the Programme as we have a continued flow of new migrants into the area.

10.17 The CCG will also be looking to extend screening to the other populations such as student populations that meet the eligibility criteria, employees in work environments and the prison population.

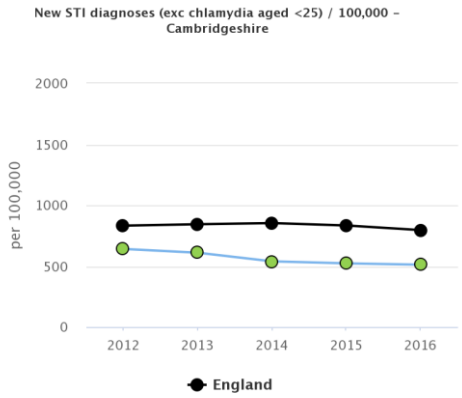
11. SEXUAL HEALTH

Overall sexual health in Cambridgeshire compares well to England with many indicators being statistically significantly better than the England average. However there are some areas for concern.

11.2. New Sexually Transmitted Infections Diagnoses (STIs) (excluding <25 chlamydia)

The rate of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) is below the English average and the trend is downward.

Figure 8: New STI diagnoses (excluding <25 chlamydia)

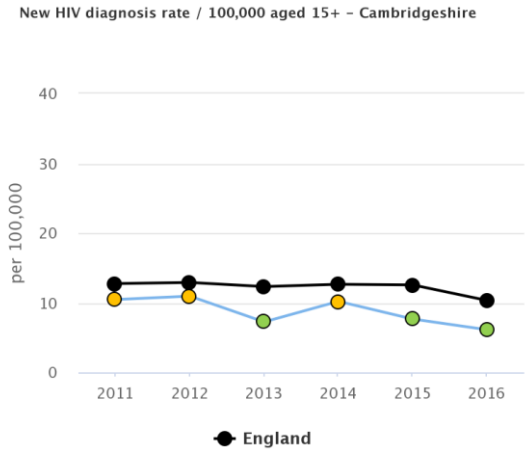


Source: Sexual Health Profiles Public Health England (2017)

11.3 New HIV Diagnosis

There has been an overall downward trend in the rate of new HIV diagnosis in Cambridgeshire and it has remained statistically significantly better than the England average.

Figure 9: New HIV Diagnosis Rate

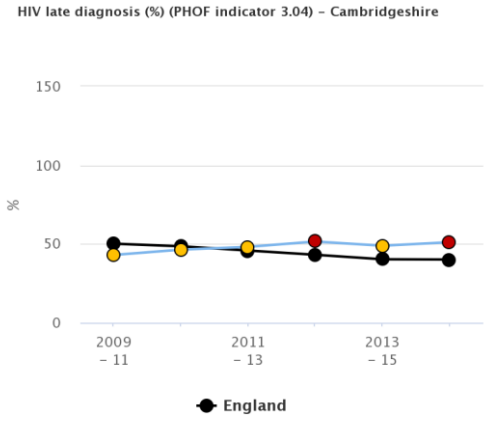


Source: Sexual Health Profiles Public Health England (2017)

11.4 Late HIV Diagnoses

Between 2009 and 2013 the rate of late HIV diagnoses per 100,000 was similar to the English figure. Between 2013 and 2016 the trend has been upwards. The latest figure which is for 2014/16 gives a rate that is statistically significantly worse than the England average, 47 compared to 40.1 per 100,000. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

Figure 10: HIV Late Diagnosis (%)



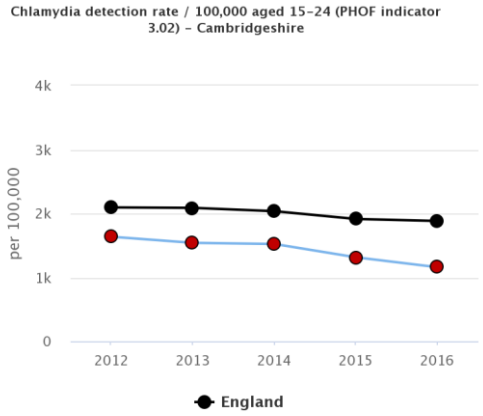
Source: Sexual Health Profiles Public Health England (2017)

11.5 Chlamydia Diagnosis

The rate of chlamydia detection amongst 15-24 year olds has remained significantly worse than the national average. In 2016 the rate was 1159 per 100,000 compared to the England average of 1882 per 100,000. This is below the Public Health England recommended target of 2,300 per 100,000, which is considered positive in term of identifying and treating the

infection in the population. However it is difficult to interpret this as the general level of STIs in the population is below the national average.

Figure 11 Chlamydia Detection Rate 15-24 years

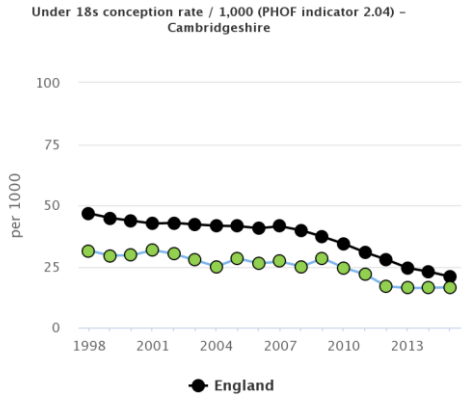


Source: Sexual Health Profiles Public Health England (2017)

11.6 Teenage Pregnancy (conceptions)

The under 18 conception rate per 100,000 has improved dramatically since 1998 in Cambridgeshire. Although it has levelled off since 2013 it remains below the national average. In 2015 the Cambridgeshire rate was 16.5 per 100,000 conceptions compared to 20.8 per 100,000 English average.

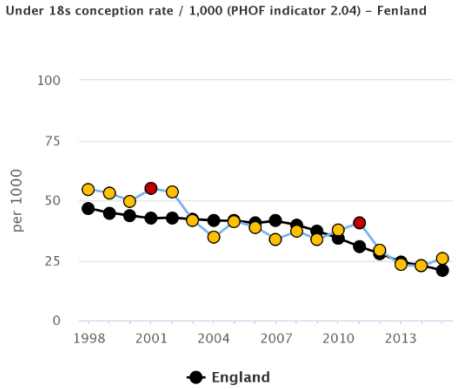
Figure12: Under 18s Conception Rate



Source: Sexual Health Profiles Public Health England (2017)

In Fenland the under 18 conception rate was in 1998 was above the national rate but since then it has improved considerably, dropping for periods to rates below or similar to the national average. However since 2012 the rate has remained similar to the England and the continuous improvement has not been sustained.

Figure 13: Under 18s Conception Rate in Fenland



Source: Sexual Health Profiles Public Health England (2017)

11.7 Sexual Health Services

The Integrated Sexual Health Service (ICaSH) provided by Cambridgeshire Community Services has seen a continuous increase in demand for its services. Currently this stands at around a circa 10% increase above the activity level commissioned in 2014. This increase in activity is found in both contraception and sexual health service activity.

Currently the Service is meeting its key access to service targets. Securing access to sexual health treatment within 48 hours or two working days is the recommended target for decreasing the onward transmission of infection by the Department of Health and professional bodies.

Chlamydia screening for 15-25 year olds is commissioned from GPs and although numbers are low they have a high positivity rate which is associated with targeted opportunistic screening.

Community pharmacies provide Emergency Hormonal Contraception and demand for this remains unchanged. Pharmacies are located in areas where access to other services is limited and where there are high risk groups are targeted

11.8 Prevention

The voluntary sector organisations DHIVERSE and the Terence Higgins Trust continue to provide a range of prevention services that range from outreach work with hard to reach/high risk groups, chlamydia screening to working in schools. Currently their service performance indicators are being net. Throughout the year a number of campaigns are also undertaken in line with the national programmes.

11.9 Sexual Health Delivery Board

The Cambridgeshire and Peterborough Sexual Health Delivery Board was established in 2017. This followed the formation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU). The JCU is responsible for commissioning Public Health services across the two local authorities. The Sexual Health Delivery Board brings together

commissioners and providers from across the two areas to set the strategic direction for sexual health and to implement collaborative partnership interventions to address issues. A Delivery Action Plan has been developed and the two following priorities have been adopted by the Board to address initially.

- Under 18 conceptions in Peterborough and Fenland (has a trend similar to Peterborough).
- Improving pathways across different services (both clinical and non-clinical). This includes pathway design and closer alignment of commissioning across the three different commissioners of sexual health services i.e. the Local Authorities, the Cambridgeshire and Peterborough Clinical Commissioning Group and NHS England.

To complement this Public Health England has invited the Cambridgeshire and Peterborough local authorities and NHS commissioners to be one of two national pilot sites for a sexual health commissioning feasibility study. The aim is that the local sexual heath commissioning organisations will explore opportunities for future alignment and collaborative commissioning opportunities for sexual health services in the area, which would future proof, quality assure and optimise sexual health service pathways, better address needs and potentially realising system efficiencies where appropriate.

12. HEALTH EMERGENCY PLANNING

12.1 The County Council is a Category 1 responder under the terms of the Civil Contingencies Act 2004, as a result there is an emergency planning/Resilience team that works in partnership with other organisations to lead emergency planning and response for the council. Some additional responsibility for health emergency preparedness passed with the move of Public Health into local authorities. In their role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR)
- Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP) as appropriate
- Identify and agree a lead DPH within the Cambridgeshire and Peterborough Local Resilience Forum (CPLRF) area to co-Chair the LHRP. Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

12.2 Local Health Resilience Partnerships (LHRPs) provide strategic leadership for health organisations in the LRF area and are expected to assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging need.

12.3 The Cambridgeshire and Peterborough Local Health Resilience Partnership (CP LHRP) is co-chaired by the NHS England Locality Director and the Cambridgeshire and Peterborough DPH. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the CPLRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor. The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH

provides a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.

- The DPH has been supported in this work by a consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Midlands and East (East) and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.

- The HSCEPG has membership from local acute hospitals, East of England ambulance service (EEAmb), community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England.

12.4 The LHRP leads on the annual EPRR assurance process. The aim is to assess the preparedness of the NHS commissioners and providers, against common NHS EPRR Core Standards. All NHS funded organisations have completed their self-assessment against the EPRR Core Standards for 2017-2018. In respect of the deep dive into EPRR Organisational Governance, the Cambridgeshire and Peterborough system completed the assurance checklists and rated themselves against the standards. All organisations were either Full or Substantially Compliant.

The Cambridgeshire and Peterborough health system is, at this point in time, well prepared to deliver the EPRR core standards including planning for and responding to a wide range of emergencies and business continuity incidents that could affect health or patient safety.

There is strong engagement across health partners and a common aim to contribute and share best practice across the LHRP, LRF and East EPRR leads forum within the East Locality. There are also links into the Cambridgeshire & Peterborough Health & Wellbeing and A & E Delivery Boards through the Co-Chairs of the LHRP.

12.5 The LRF and LHRP priorities for the past year were validation of:

- CPLRF Pandemic influenza Plan;
- CPLRF Vulnerable People Protocol; and
- CPLRF Mass Casualty Plan

All the three plans have been validated by the CPLRF Executive Board.

12.6 The priorities for the year ahead is validation of:

- CPLRF CBRN Plan;
- C&P Hospital Evacuation Plan; and
- CPLRF Excess Deaths Plan.

12.7 The period from 1st January 2017 to the date of this report has seen a very wide and varied training and exercise programme delivered by the CPLRF. Of significance were four exercises:-

1. Exercise Falmouth: This tabletop and live exercise took place on the 22nd Feb and 19th May respectively, to test the arrangements for Marauding Terrorist Firearms Attack (MTFA). Sixty attendees from nineteen organisations took part in the exercise.

2. JESIP exercises: Joint Emergency Services Interoperability Protocol (JESIP) awareness and table top exercises for the strategic members took place between June and October.

3. Mass Casualty plan validation: A table top exercise took place on 20th October, 2017 to validate the CPLRF Mass Casualty Plan. Thirty attendees from eight organisations took part.

4. CPLRF Tactical Emergency Management course(s): The CPLRF in collaboration with the Cabinet Office Emergency Planning College delivered three, one and a half day, bespoke Tactical Emergency Management courses between the 6th and 10th November, 2017. Forty attendees took part in the courses.

11 Summary

This report has provided and update on all key areas of health protection for Cambridgeshire including:

- Communicable disease surveillance including information on the increased levels of infectious Hepatitis, Invasive Group A Streptococcal and Mumps infections in the past year.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination
- Screening in which there is continued below average uptake of cervical screening in Cambridgeshire
- Healthcare associated infections and the work to reduce anti-microbial resistance
- The Environmental Health role of city and district councils in protecting health including pollution control and air quality monitoring and advice
- The national TB strategy and successful local implementation of some key areas of the strategy notably Latent TB Infection Screening (LTBI)
- Sexual health including the level of late HIV diagnosis, reducing level of chlamydia diagnoses and a slowdown in the rate of reduction of teenage pregnancy, while still below the national average, work on prevention in sexual health and the establishment of the Sexual Health Delivery Board in 2017.
- Health emergency planning, the work completed in the past 12 months and the priorities for the coming year.

12 Annex 1

12.1 UK Vaccination Programme

Age 2 months

5-in-1 (DTaP/IPV/Hib) vaccine – this single jab contains vaccines to protect against five separate diseases: diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza type b (Hib, a bacterial infection that can cause severe pneumonia or meningitis in young children)

Pneumococcal (PCV) vaccine – pneumococcus can cause various infections including pneumonia

Rotavirus vaccine - Rotavirus is a highly infectious stomach bug that typically strikes babies and young children. This is an oral vaccine

Men B vaccine – Meningococcus B is responsible for approximately 90% of meningitis in young children

Age 3 months

5-in-1 (DTaP/IPV/Hib) vaccine - second dose

Rotavirus vaccine - second dose

Age 4 months

5-in-1 (DTaP/IPV/Hib) vaccine - third dose

Pneumococcal (PCV) vaccine - second dose

Men B vaccine – second dose

Between 12 and 13 months

Hib/Men C booster - administered as a single jab containing meningococcus C (another cause of meningitis) and Hib (fourth dose)

Measles, Mumps and Rubella (MMR) vaccine - administered as a single jab. Measles, mumps and rubella are highly infectious conditions that can have serious, and potentially fatal, complications, including meningitis, swelling of the brain (encephalitis) and deafness. They can also lead to complications in pregnancy that affect the unborn baby, and can lead to miscarriage

Pneumococcal (PCV) vaccine - third dose

Men B vaccine – third dose

Age 2 to 7 years including school years 1, 2 and 3

Seasonal influenza (Flu) vaccine - administered as a nasal spray and needs to be given annually – this programme is being gradually extended to include all children up to age 16 years.

3 years and 4 months, or soon after

Measles, mumps and rubella (MMR) vaccine, second dose

4-in-1 (DTaP/IPV) pre-school booster - administered as a single jab containing vaccines against diphtheria, tetanus, whooping cough (pertussis) and polio

Around 12-13 years

HPV vaccine, which protects against the Human Papilloma Virus which causes cervical cancer, it is given to girls only – two jabs are given 6 – 12 months apart

Age 14 years

3-in-1 (Td/IPV) teenage booster - administered as a single jab which contains vaccines against diphtheria, tetanus and polio

Men ACWY – School children aged 14 (year 9) are now offered this vaccination routinely and students going to university or college for the first time, including overseas and mature students up to the age of 25, are advised to contact their GP to have the Men ACWY vaccine, ideally before the start of or in the first few weeks of the academic year. Cases of meningitis and septicaemia (blood poisoning) caused by Men W bacteria are rising, due to a particularly deadly strain. The highest risk of meningitis is in the first year of university, particularly the first few months.

65 and over

Flu (every year)

Pneumococcal (PPV) vaccine

70 years

Shingles vaccine (from September 2013)

Vaccines for special groups

There are some vaccines that aren't routinely available to everyone on the NHS but which are available for people who fall into certain risk groups, such as pregnant women, people with long term health conditions and healthcare workers. These extra vaccines include **hepatitis B vaccination, TB vaccination and chickenpox vaccination**.

AGENDA ITEM No: 8

CAMBRIDGESHIRE YOUNG PEOPLE'S DRUG AND ALCOHOL SERVICES PROCUREMENT

To:	**Health Committee**
Meeting Date:	**May 17th 2018**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Key Decision** No
Purpose:	The paper describes the rationale and benefits of procuring Cambridgeshire Young People's Drug and Alcohol Treatment Service through a competitive tender.
Recommendation:	The Health Committee is asked to approve the following

a) Initiating a competitive tender for the procurement of a Cambridgeshire integrated Young People's drug and alcohol service.

b) The scope of service to be included in the tender.

c) A transformation approach that reflects the findings of the recent Drugs and Alcohol Joint Strategic Needs Assessment and the National Drugs Strategy, is evidence based and provides value for money.

d) Increased integration with other young people's services to provide both universal prevention and a targeted approach for 'at risk' and vulnerable young people.

Officer Contact:		***Chair Contact:***	
Name:	Val Thomas	Name:	Councillor Peter Hudson
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1. BACKGROUND

1.1 Young People's Drug and Alcohol specialist treatment provision across Cambridgeshire falls under two separate arrangements. The primary young people's contract is provided by Cambridgeshire and Peterborough Foundation Trust (CPFT) and the service is referred to locally as CASUS. The second element to the service is the specialist substance misuse Youth Offending provision which is provided by Cambridgeshire County Council and forms part of the wider Youth Offending Service (YOS).

1.2 Both elements of the service work closely together. The current service model has been in place since 2013 and provides prevention, early help, targeted interventions for 'at risk' groups and specialist clinical treatment provision for young people across Cambridgeshire. The service is closely aligned with CAMH and the current team includes a child and adolescent psychiatrist.

1.3 Drug and alcohol prevention and treatment services are included in local authority public health commissioning categories that fall under the Public Health grant. The services are not specifically mandated, as mandated services are generally those which central government wants to be delivered in a standard way across the country. However, the public health grant conditions include the following statement: A local authority must, in using the grant, "…have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services…"

1.4 Historically the commissioning was undertaken by the Drug and Alcohol Team (DAAT) that sat in the former Children, Families and Adults Directorate, although the services are funded from the Public Health Grant. The recent creation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU) has brought together the majority of public health services that are commissioned, including Drugs and Alcohol Services.

1.5 Both contractual arrangements will shortly expire, the CASUS contract commenced on 1st April 2013 and is due to terminate on the 31st March 2019. The YOS contractual arrangement is reviewed on an annual basis. It is proposed to formally commence the procurement in June 2018 after securing support from the Health Committee, which has responsibility for the Council's public health services and policies. Contract award is planned for November, 2018 with a contract start date of the 1st April, 2019.

2. MAIN ISSUES

2.1 There are far ranging effects upon the physical and mental health of those young people who are affected by the misuse of drugs and alcohol. These effects also have a significant impact upon individuals, families, communities and across wider society which are captured in Figures 1 and 2.

Figure 1: The prevalence of drug and alcohol harm for families

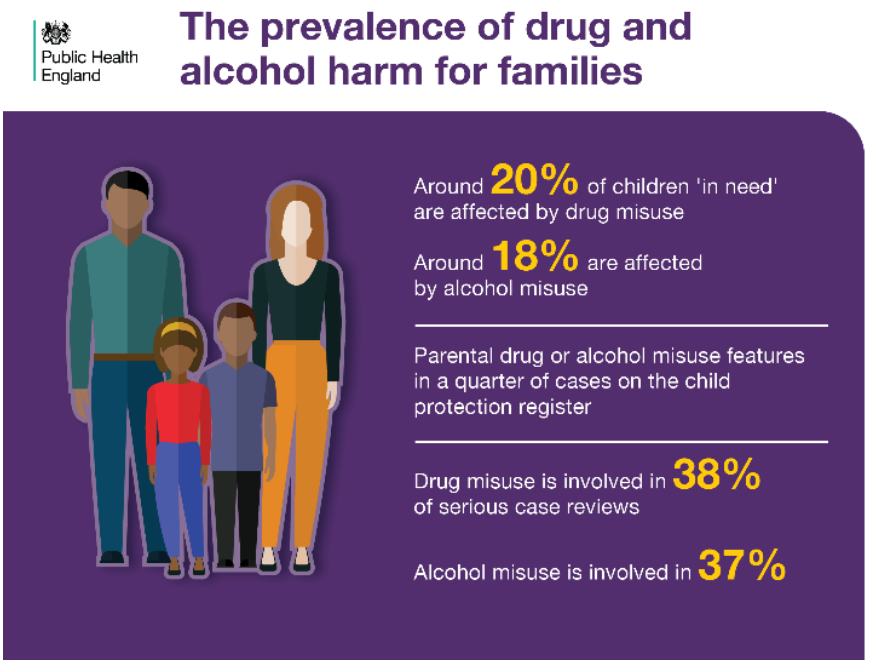

Figure 2: The impact of drug & alcohol misuse on families

2.2 The central objective of young people's drug and alcohol services is to prevent young people continuing to misuse drugs and alcohol as they enter into adulthood.

Problematic substance use remains symptomatic of difficulties facing young people. Some young people are particularly vulnerable to substance misuse including young offenders, those with poor mental and emotional health, those

who have experienced parental substance misuse, those experiencing child sexual exploitation and abuse. Specialist young people's substance misuse services play a pivotal role in delivering and coordinating a multi-agency response, accurately assessing and meeting need to ensure that young people are heard and protected.

The development of specialist services for young people need to reflect the intrinsic differences between adults and children and between children of different ages. In addition young people's substance misuse is changing both in terms of reported prevalence and complexity of the problems faced by young people who use specialist services. It is important that services are able to reflect this changing landscape of need.

2.3 Evidence based treatment and recovery services are essential to motivate and support people with drug and alcohol problems. They should provide a range of interventions, according to the level and type of dependency and an individual's assessed need (See Figure 3)

Figure 3: Specialist treatment and recovery

2.4 Partnership work between treatment services and local children's health and social care agencies is crucial. Parental drug and alcohol treatment can be a protective factor for children and can enable parents to engage with support agencies (See Figure 4).

Figure 4: Interventions and outcomes for families

2.5 In addition there are socio-economic costs to society and services, which include health services, social care, the criminal justice system, employers and housing services. The harms of drug and alcohol misuse have been modelled to show the costs of treatment and addressing them. (Figures 5, 6 & 7)

Figure 5: Annual cost of drug misuse and alcohol related harm

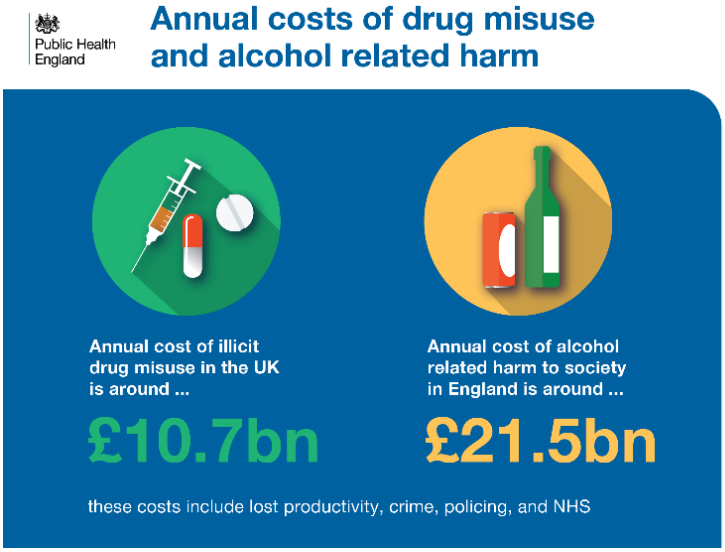

Figure 6: Specialist interventions for young people-savings

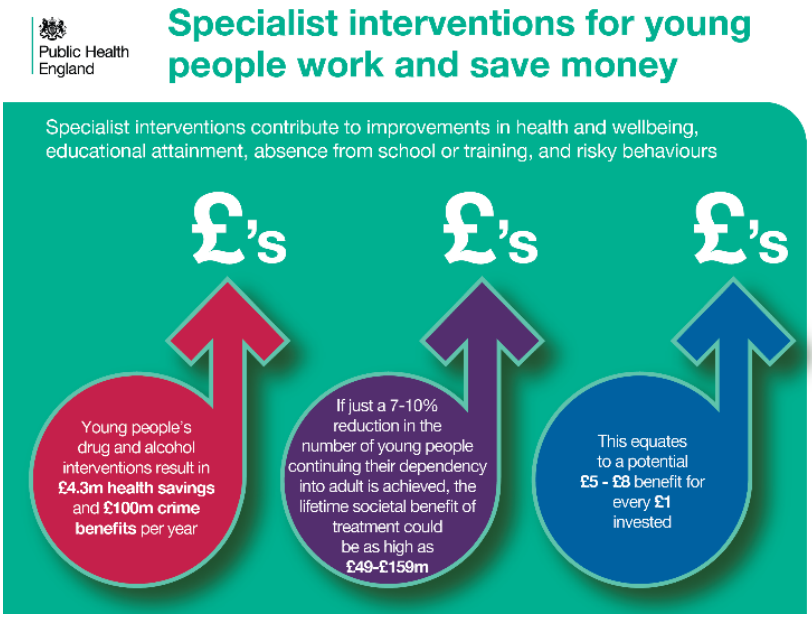

Figure 7: Investing in drug & alcohol treatment-savings

2.6 Only the Cambridgeshire Children and Young People's Specialist Drug and Alcohol Treatment services are in scope. The Peterborough treatment contracts were let in 2015/16 with its new integrated treatment service (young people and adult) commencing on the 1st April 2016 and the Cambridgeshire Specialist Adult Drug and Alcohol treatment service contract is currently in the latter stage of procurement with contract award planned for 1 June, 2018.

Going forward, break clauses in the new Cambridgeshire contracts (Adult and Young People) will be aligned with Peterborough's contract to provide future options for integration across both geographical areas.

The YOS element of the service is currently in scope and will be included in the comprehensive pre-tender evaluation work, the findings of which will help inform a future delivery model.

The scope includes exploring the evidence for increasing the integration of the Children and Young People's Drug and Alcohol services with other related children and young people's services and will include consideration of different service and commissioning models which will include the following.

1. Aligning or embedding within the 0-19 Children and Young People's pathway.
2. Integration within other child health services (e.g. sexual health services).
3. A standalone Children and Young People's Service.

2.7 The re-tendering of the Children and Young People's Drug and Alcohol Treatment service in Cambridgeshire will provide the opportunity for transformational change that will more effectively address the emerging needs found in the recent Drugs and Alcohol Joint Strategic Needs Assessment and National Drugs Strategy. This includes the changing demographic of service users who have different needs, vulnerabilities and complexities. The aim is to secure evidence based services which have the following deliverables.

- An integrated specialist drug and alcohol young people's treatment system across Cambridgeshire.
- Services that reflect the specific needs of people and families that use them.
- Increased alignment and integration with related services to ensure that multiple vulnerabilities, complex needs and risky behaviours are addressed holistically and in a child centred way (including mental health, sexual health, domestic abuse, child sexual exploitation)
- A service reflecting the intrinsic differences, and transitional requirements, between adults and children and between children of different ages
- A service rooted in a strengths approach, delivering interventions focused on substance misuse itself and also developing confidence and enhancing personal resilience.
- Targeted interventions to young people at risk of developing problems with substances (alongside specialist services)
- Early intervention and harm reduction interventions.

2.8 The funding allocated to the Cambridgeshire tender totals £410,267 (£315,267 CASUS & £95,000 YOS) per annum. The contract proposed will start on April 1st 2019 and will be for 3 years with the option of extending it for one or two years, which will align it with the Peterborough contract.

2.9 On the 1st May, 2017 the new Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU) was created, establishing a new joint structure across the two local authorities. The new Public Health JCU structure provides an opportunity to develop wider collaborative strategic and commissioning initiatives at the same time as creating efficiencies.

2.10 The tender will be undertaken by the Public Health JCU and overseen by organisational governance structures, which includes the Cambridgeshire and Peterborough Joint Commissioning Board, an officer board with relevant expertise, which covers commissioning by the People & Communities Directorate and Public Health Directorate. The Joint Commissioning Board meets on 9th May, and will be asked to endorse and recommend the approach identified in the paper to the Health Committee. Verbal feedback will be provided at the Health Committee meeting. Delegated authority to award the contract will be sought through a further paper to Health Committee at the appropriate time.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The report above sets out the implications for this priority in paragraph 2.6

3.2 Helping people live healthy and independent lives

The report sets out the implications for this priority in paragraphs 2.1, 2.2, 2.3, 2.4, 2.5

3.3 Supporting and protecting vulnerable people

The report sets out the implications for this priority in paragraph 2.2

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in **2.6, 2.9**

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report above sets out details of significant implications in **1.5, 2.9, and 2.11**

The Cambridgeshire and Peterborough Joint Commissioning Board has been asked to approve the proposal.

4.3 Statutory, Legal and Risk Implications

The report above sets out details of significant implications in **1.3, 1.5**

4.4 Equality and Diversity Implications

The report above sets out details of significant implications in **2.2 and 2.8**

4.5 Engagement and Communications Implications

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

- An integral element of the procurement process will be the consultation with stakeholders, service users and the public. The information secured from these processes will influence the service specification and ongoing development of the services.

4.6 Public Health Implications

The report above sets out details of significant implications in **2.1, 2.2, 2.3, 2.4, 2.5, and 2.6**

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

- Failure to provide effective young people's drug and alcohol treatment services will increase the risk of significant poor health and social outcomes for those affected.
- Patterns of alcohol and drug use have changed in recent years and different types of interventions and integrated models are required if treatment and management of all associated needs are to be effective.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Paul White

Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Karim Allis
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	**Location**
Cambridgeshire Drugs and Alcohol Joint Strategic Needs Assessment	*http://www.cambridgeshireinsight.org.uk/jsna*
National Drugs Strategy 2017, Home Office	https://www.gov.uk/government/publications/drug-strategy-2017
Public Health England: Guidance ***Alcohol and drug prevention, treatment and recovery: why invest? 2018***	https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

AGENDA ITEM No: 9

CONTROLLED DRINKERS SERVICE PROCUREMENT

To:	**Health Committee**
Meeting Date:	**May 17th 2018**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** **Key Decision** No
Purpose:	The paper is to inform the Health Committee about the procurement of a 6 bed Controlled Drinkers Accommodation Service
Recommendation:	The Health Committee is asked to approve the following: a) Initiating a competitive tender for the procurement of a Controlled Drinkers Service in Cambridge City. b) The scope of service to be included in the tender. c) A more flexible service model that will better address the needs of the treatment population.

Officer Contact:		***Chair Contact:***	
Name:	Val Thomas	Name:	Councillor Peter Hudson
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Email:	Val.Thomas@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 703264	Tel:	01223 706398

1. BACKGROUND

1.1 The Controlled Drinkers Service is a housing related support service which provides 24 hour accommodation based support focused initially on harm reduction, then as people progress in controlling their drinking, helps them to develop independent living skills and move to more permanent independent accommodation. The Service is aimed at people who are vulnerable with multiple needs. These are homeless, have a long-term alcohol misuse problems, often with a mental health condition and are seeking to stabilize their alcohol use and/or move towards abstinence.

1.2 The Controlled Drinker Service is funded from the Public Health grant. The current contract for the Service is provided by Jimmy's and ends on March 31 2019. Jimmy's is a local third sector organisation providing a network of accommodation services to homeless people in Cambridge City.

1.3 Funding for housing related support services was formerly provided under the Supporting People Programme which ran until 2013. From 2014 funding for the Controlled Drinking Service along with two other housing services for offenders has been provided by Public Health. The two other housing services for offenders are not included in the tender as their contract end dates are not aligned to the Controlled Drinkers Servic**e**. The Offender Services cover a different client group and went out to competitive tender in autumn 2016, with new contracts being in place from the 1st of April 2017 and ending on the 31st of March 2020.

1.4 There is a planned broader review of supported housing by the County Council, as it funds a number of facilities, (outside of public health grant) which will provide opportunities to explore further developments of this service.

1.5 Historically the commissioning for the Controlled Drinking Service was undertaken by the Drug and Alcohol Team (DAAT) which sat in the former Children, Families and Adults Directorate. The recent creation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU) has brought together the majority of commissioned public health services.

1.6 During the current contract there has been a requirement for the Service to work in close co-operation with Inclusion the adult substance misuse treatment provider. This has resulted in very close partnership working between housing and treatment services. Each Service user is also signed up to receive treatment/support from the adult Substance Misuse Service.

1.7 The key outcomes of the Service are the number of service users who move-on successfully from the Service into more independent accommodation. It should be noted that these are clients with complex needs and are likely to be long term misusers of alcohol. Clients are recommended for move-on when they have either become abstinent from alcohol or have managed to control their drinking whilst in the Service.
The Service has an annual Key Performance Target to move at least 2 of the 6 residents onto more independent accommodation positively. Over the past 4 years of the contract this target has been met or exceeded in 3 of the 4 years. In the most recent year 17/18, 4 people moved out of the Service positively. All four clients managed to address their alcohol misuse which was a condition of them moving into more independent accommodation. The service also measures the outcomes achieved by each service user against the ten outcome domains ranging from managing money through to managing their physical and mental health.

1.8 The current contract for the Controlled Drinkers Service is due to terminate on the 31st of March 2019. It is proposed to formally commence the procurement in June 2018 with the contract award in December 2018 and a start date for the new Service on the 1st of April 2019.

2. MAIN ISSUES

2.1 The costs of alcohol and drug related harm is estimated to be £32.2bn including the NHS, lost productivity, crime, policing. 24,000 people died from alcohol related causes in 2016 at an average age of only 54. Deaths from liver disease have increased by 400% since the 1970's. Long-term alcohol use is known to contribute to a wide range of other complex and expensive to treat health problems. Further details are given in Figures 1, 2 and 3.

Figure 1 – Costs of drug and alcohol use

Figure 2: Deaths from alcohol use

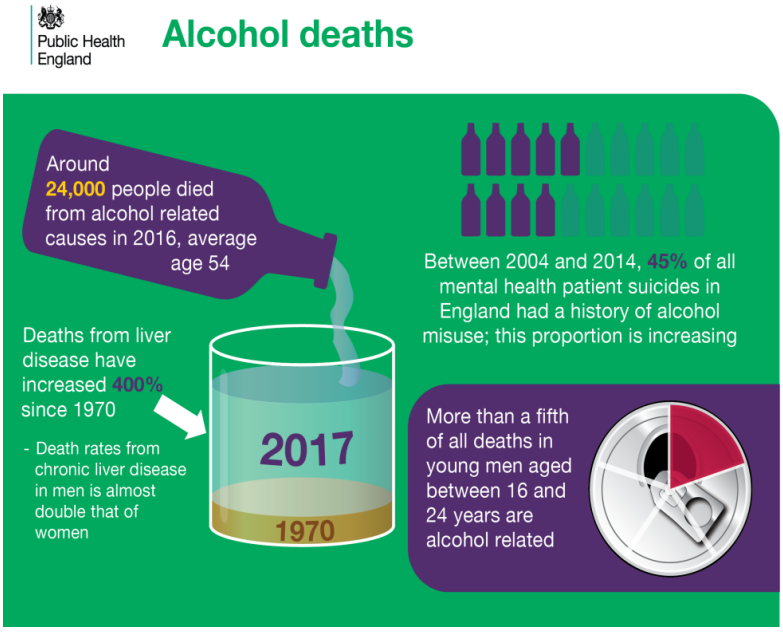
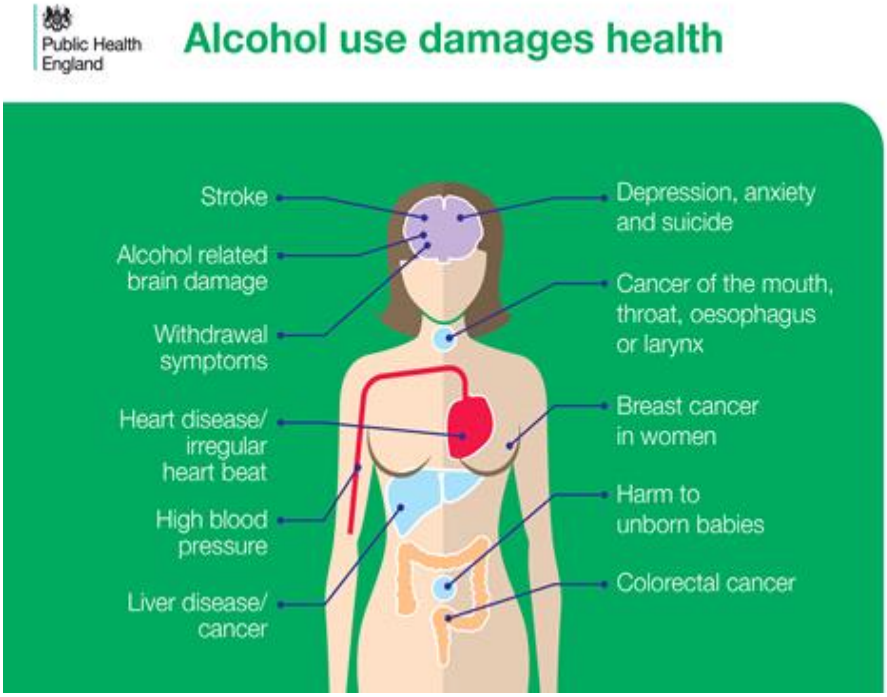


Figure 3 – Health impacts of long-term alcohol use

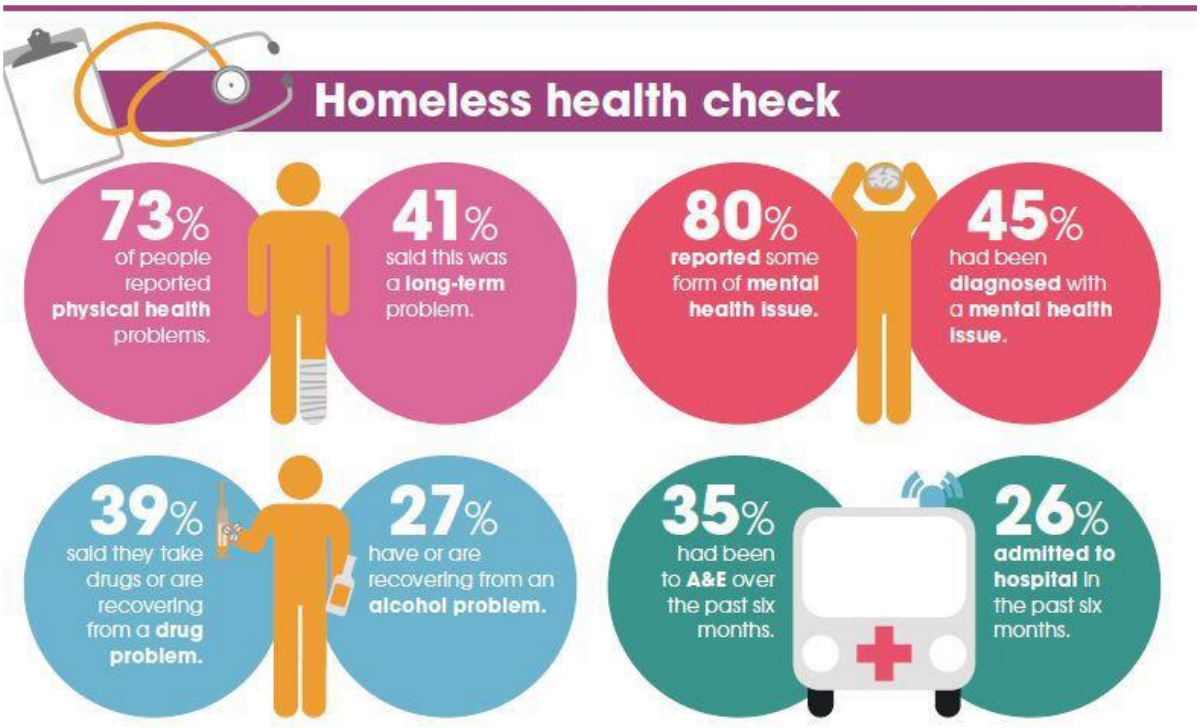


2.2 There is clear evidence that housing and homelessness is a contributor to substance misuse and securing positive treatment outcomes. The Joint Strategic Needs Analysis (JSNA) in 2016 for Substance Misuse looked at housing and homelessness issues and substance misuse. It identified that Cambridge City has high levels of substance misuse along with high house prices and there are problems with the supply of housing. The JSNA included evidence (Chartered Institute of Housing 2012, Milby et al 2010 and Rutter 1994) that as a general rule, stable housing is beneficial to those with drug or alcohol dependence. It helps them to reduce substance misuse and achieve drug- and alcohol-related recovery outcomes. In terms of homelessness, the JSNA found Cambridge City had the highest rate of homelessness in the county at 3.6 acceptances per 1000, higher than the countywide figure of 2.7 and the England figure of 2.5.There are only a few substance misuse accommodation Services in the country and the Controlled Drinkers Service provides a specialist resource in Cambridge, an area with a housing shortage, high levels of homelessness and substance misuse.

2.3 The homelessness population is known to have poorer health outcomes. Homelessness Link carried out an audit of health problems across the homeless population in 2014 showing the homeless people are 13% more likely to have a long-term health problem and 20% more likely to have a diagnosed mental health problem than the general population. More details are shown in Figure 4 below. The Controlled Drinkers Service works closely

with all health partners to address physical and mental health issues to assist the residents to access the services of the wider general population.

Figure 4 – Homeless Link Audit of Homeless Health Problems (2014)



Worse than the general public	Health issue	Homeless population	General population
Physical, mental and substance misuse issues remain prevalent among the homeless population and at levels that are much higher than those experienced by the general population.	Long term physical health problems	41%	28%
	Diagnosed mental health problem	45%	25%
	Taken drugs in the past month	36%	5%

2.4 The retendering of the Controlled Drinkers Service will provide an opportunity to improve the current model and secure the following deliverables:

- A model which is more flexible for drinkers at different stages of their recovery journey and help them progress towards more independent living via move-on pathways.

- Opportunities to align with any of the proposals from the planned review of supported housing that will improve the service outcomes.

- The service will continue to be supported by the adult substance misuse treatment service which is currently being recommissioned.

2.5 The current public health funding allocated to the Controlled Drinkers Service is £79,382 per annum. The proposal is that the new contract will run for 3 years with the option to extend by one or two years. The total contract value over the lifetime of a five year contract will be £396,910.

2.6 The tender will be undertaken by the Public Health Joint Commissioning Unit. Approval for the tender is being sought from the Commissioning Board and for it to endorse and recommend the approach identified in this paper.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The report sets out the implications in paragraph 2.1.

3.2 Helping people live healthy and independent lives

The report sets out the implications in paragraphs 1.2 and 2.3.

3.3 Supporting and protecting vulnerable people

The report sets out the implications for this priority in paragraph 1.1 & 2.2.

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in 2.1 and 2.5.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

The report above sets out details of significant implications in 1.5, 2.5, and 2.6.

Cambridgeshire and Peterborough Joint Commissioning Board has been asked to approve the proposal.

4.3 Statutory, Legal and Risk Implications

The report above sets out details of significant implications in 1.5.

4.4 Equality and Diversity Implications

The report above sets out details of significant implications in 2.2 and 2.4.

4.5 Engagement and Communications Implications

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

- An integral element of the procurement process will be the consultation with stakeholders, service users and the public. The information secured from these processes will influence the service specification and ongoing development of the services.

4.6 Public Health Implications

The report above sets out details of significant implications in 1.1, 1.2, 2.1, 2.2 & 2.3...

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

- Failure to recommission the Controlled Drinkers Service will impact on homelessness and rough sleeping levels in Cambridge City and make it harder for vulnerable people with addictions to find a route out of homelessness.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes – 1/5/18 Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Gus de Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes – 2/5/18 Name of Legal Officer: Catherine Wilson
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

SOURCE DOCUMENTS GUIDANCE

It is a legal requirement for the following box to be completed by the report author.

Source Documents	Location
Cambridgeshire Drugs and Alcohol Joint Strategic Needs Assessment	*http://www.cambridgeshireinsight.org.uk/jsna*

Agenda Item No: 10

PUBLIC HEALTH ENGLAND SEXUAL HEALTH SERVICES COMMISIONING PILOT

To:	**Health Committee**
Meeting Date:	**17th May 2018**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not Applicable** *Key decision:* **No**
Purpose:	**To inform and secure the support of the Health Committee for Public Health England's (PHE) invitation to Cambridgeshire County Council and Peterborough City Council to work other local commissioners of sexual health (including HIV) and reproductive health services to develop a local collaborative commissioning model for these services.**
Recommendation:	**The Health Committee is requested:**

a) To discuss the PHE invitation to take part in the Sexual Health and Reproductive Services Commissioning Feasibility Study.

b) To support Public Health commissioners working with colleagues from the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England (NHSE) to develop a more efficient and cost-effective system wide approach to the commissioning of sexual health and reproductive services.

Officer Contact:		***Chair Contact:***	
Name:	Val Thomas	Name:	Councillor
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Tel:	01223 703264	Tel:	01223 706398

1. BACKGROUND

1.1 Public Health England (PHE) is currently sponsoring sexual health and reproductive commissioning feasibility studies across the country. It has invited commissioners across Cambridgeshire and Peterborough to explore together opportunities for future alignment and collaborative commissioning opportunities for sexual health and reproductive services in the area. The Health and Social Care Act 2013 established the current commissioning arrangements for sexual and reproductive health which is divided between Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England (NHSE). The other area involved is Cheshire & Merseyside which includes nine local authorities and six CCGs. The 2013 Health and Social Care Act mandated Local Authorities to ensure that there is provision of sexual health services in their areas.

1.2 The work would involve commissioners from the CCG, Cambridgeshire County Council, Peterborough City Council and NHS England who are responsible for commissioning sexual health and reproductive services across community, primary and secondary care. The scope would include sexual health, HIV, contraception, termination, gynaecology pathways and services along with consideration of workforce issues. Options for collaborative commissioning opportunities are also included in the scope of the pilot study.

1.3 There are a number of factors both nationally and locally that have driven this work which reflect the commissioning responsibilities of different organisations, and the drive to improve services to make them more efficient and improve outcomes. The objectives are to help identify the opportunities for aligning sexual health and reproductive services to future proof, quality assure and optimise service pathways. It has the potential to realise system efficiencies, more cost-effective services and improve health outcomes. The work would also consider the flexibility needed to respond to emerging footprint systems such as Integrated Care Systems. However any solution would be local; based on the needs in the area and solutions that reflect available resources and flexibilities.

2. MAIN ISSUES

2.1 There is robust evidence that sexual health and reproductive services are both cost-effective and cost saving. For example every £1 invested in contraception saves £11.09 in averted outcomes and this increases to £13.42 for Long Acting Reversible Contraception (LARC). In the maternity service pathways there are no or limited commissioning arrangements for contraception following a hospital delivery. Improving and aligning pathways to contraception services, identifying opportunities for adopting alternative delivery models such as online contraception access will aim to increase integration, the cost effectiveness of services and improve outcomes.

2.2 In 2017 PHE and the Department of Health (DH) surveyed commissioners of sexual health services across the country to gather feedback on their commissioning experiences. The survey reported fragmentation of commissioning that was associated with the spread of commissioning responsibilities across three main commissioning bodies (Local Authorities, NHSE and CCGs) established by the Health and Social Care Act in 2013.

2.3 Sexual Health is a national priority for PHE and this work is supported by the Local Government Association, NHSE, and Health Education England (HEE). This initiative is being sponsored by PHE's Deputy Chief Executive and its staff are fully involved in providing data and evidence. Alongside this the National Sexual Health Service Specification is being updated by PHE and NHS England, along with work to review best practice for the management of Out of Area GUM (Genito Urinary Medicine) payments and "Cross Charging" arrangements for the open access sexual health services.

2.4 Nationally there are examples where areas have completed transformational commissioning of their sexual health and reproductive services. These include the Greater London Boroughs and Greater Manchester and their work will also be used to inform local this study.

2.5 Locally it is planned to tender the Local Authority commissioned sexual health services for Cambridgeshire and Peterborough during 2018/19 with a new service starting mid 2019/20.This feasibility work could help resolve many of local issues arising from the fragmentation of sexual health commissioning and provide opportunities for a more robust new service model that is more integrated with other sexual health and reproductive services, cost-effective and improves outcomes for the population.

2.6 It is proposed that local Public Health staff will lead the development and production of the sexual health and reproductive commissioning feasibility study with other organisations supplying any necessary information about the services that they commission. The Study will be overseen by a Steering Group representing commissioners, PHE and HEE that will formulate options for future delivery working with providers and stakeholders. Reporting will be through each organisation's appropriate governance processes.

2.7 A local multi-agency group has met with representation from the CCG, local authorities, PHE and Health Education England (HEE). In addition children and young people commissioners attended to ensure that any synergies between the services they are currently commissioning and sexual health services are considered. The PHE Deputy Chief Executive has spoken to leads in the local CCG and NHSE. A paper will be taken to the Clinical Executive Committee of the CCG in June, to discuss/confirm organisational sign-up. NHSE has engaged with the pilot and further discussions at senior level are currently being undertaken. Subject to agreement by all organisations involved, it is planned to complete the pilot by December 2018.

3. ALIGNMENT WITH CORPORATE PRIORITIES

Report authors should evaluate the proposal(s) in light of their alignment with the following three Corporate Priorities.

3.1 Developing the local economy for the benefit of all

The report above sets out the implications for this priority in **1.4 and 2.6**

3.2 Helping people live healthy and independent lives

The report above sets out the implications for this priority in **2.6**

3.3 Supporting and protecting vulnerable people

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

- The development of the new commissioning model will enable any health inequalities or inequities in service provision to be addressed through identification of needs and the better alignment of services that target vulnerable high risk populations.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in ***1.4 and 2.6***

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

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

- Any implications for procurement/contractual/Council contract procedure rules will be considered with the appropriate officers from these Departments and presented to the Health Committee before proceeding.

4.3 Statutory, Legal and Risk Implications

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

- Any legal or risk implications will be considered with the appropriate officers from these Departments and presented to the Health Committee before proceeding.

4.4 Equality and Diversity Implications

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

- Any equality and diversity implications will be included in the pilot study; a Community Equality Impact Assessment will be completed.

4.5 Engagement and Communications Implications

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

- The pilot study will include consultation with service providers and users; a Community Impact Assessment will be completed.

4.6 Localism and Local Member Involvement

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

- The pilot study will inform commissioning of sexual and reproductive health services, this will involve working with individuals and communities to identify how that can best protect and improve their sexual health.

4.7 Public Health Implications

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

- The pilot has the potential to improve the sexual health of the population through ensuring that the different commissioned pathways and services are integrated and support the improvement of outcomes

- These service developments will need to include targeted actions that will address any inequalities and improve the outcomes for the most vulnerable and at risk populations.

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

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

SOURCE DOCUMENTS GUIDANCE

Source Documents	Location
Public Health England: Making it work: A guide to whole system commissioning sexual health, reproductive health and HIV 2015	https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services
Public Health England: Sexual Health, Reproductive Health and HIV: A Review of Commissioning 2017	https://www.gov.uk/government/publications/sexual-health-reproductive-health-and-hiv-commissioning-review

Agenda Item No: 11

Update on progress made by the Children's Health Joint Commissioning Unit (CHJCU) on the integration of children, young people and families (CYPF) service and the plan for the Healthy Child Programme (0-19 yrs)

To:	**Health Committee**
Meeting Date:	**17th May 2018**
From:	**Liz Robin and Wendi Ogle-Welbourn**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* **No**
Purpose:	**To update Members on progress made by the CHJCU in developing an Integrated Children Young People and Families (CYPF) service and awareness of the plan to include the Public Health grant funded Healthy Child Programme (HCP 0-19) within this**
Recommendation:	**To note the work done to date and what the CHJCU is trying to achieve** **To note the plans for inclusion of the Healthy Child Programme (HCP 0-19) in an integrated CYPF service**

Officer contact:		***Officer contact:***
Name:	Wendi Ogle-Welbourn	Name: Dr Liz Robin
Post:	Executive Director people and communities	Post: Director of Public Health
Email:	wendi.ogle-welbourn@peterborough.gov.uk	Email:liz.robin@cambridgeshire.gov.uk
Tel:	01733 863749	Tel: 01223 703261

1. BACKGROUND

1.1 The Commissioning of children's and young people's health and care services including the 0-19 service in Cambridgeshire and Peterborough is strategically managed by the Children's Health Joint Commissioning Unit (CHJCU). Membership of the CHJCU consists of senior commissioners from Cambridgeshire County Council (CCC) Peterborough City Council (PCC) and Cambridgeshire and Peterborough Clinical Commissioning Group (CPCCG), and a children's public health specialist. The lead is the Executive Director People & Communities Cambridgeshire & Peterborough, Wendi Ogle-Welbourn. The CHJCU was set up with the following vision.

"That all children and families in Cambridgeshire and Peterborough have the right to be kept safe and healthy, have excellent health services, enjoy school, play and family, helped to help themselves and are part of strong and inclusive networks of support."

1.2 To fulfil this vision, the aim and outcomes for this joint approach to commissioning are:

- Truly integrate health and care services
- Better outcomes for children and their families in Cambridgeshire and Peterborough
- High quality experiences when children and families access the service
- Investment in prevention and moving care to lower cost settings
- Where possible integrate and rationalise contracts for children
- Having the right service, in the right place, at the right time.

1.3 It is driven by the understanding that better integration between different types of health and care services is universally accepted as the right direction of travel for meeting the changing and growing needs of children, young people and families. Recognising that fragmented and disjointed services and poor alignment of health and care interventions can have a negative impact on children and families and lead to poor outcomes.

1.4 This aligns with the collective vision for Cambridgeshire's and Peterborough's transformation plans for children and young people's emotional and mental health needs over the next 5-years:

We will work together with children, young people and their families/carers, connecting with schools and communities to improve the lives, health and emotional wellbeing of Cambridgeshire's and Peterborough's children and young people.

2 NATIONAL CONTEXT

2.1 The Public Sector is experiencing unprecedented pressure, which presents as high demand for some health and wellbeing services in a climate of diminishing funding and cultural dependency on public services.

2.2 These issues have developed incrementally over many years and although significant efforts have been made to improve capacity and maintain quality, layering over long established services such as the NHS have created highly complex services which are not as effective as they could be and are often difficult to navigate.

2.3 The Government recognises this and in 2014, published the 5-year forward view which describes transformational models of health and care. Implementation of the 5-year forward view is managed by 44 Sustainability and Transformation Partnerships (STPs) across the country which are made up of local commissioners and providers charged with developing whole system Sustainability and Transformation Plans. Cambridgeshire and Peterborough is one of the 44 STPs. The CHJCU is a critical part of the STP Governance and provides leadership to the design and implementation of plans related to children's health and wellbeing, and upward reporting of progress to the STP board.

2.4 The role of the Children's Health Joint Commissioning Unit has involved bringing together a range of existing contracts across the three commissioning organisations (CCC, PCC, and CPCCG). The majority of these contracts are with two providers - Cambridgeshire Community Services (CCS) and Cambridgeshire and Peterborough Foundation Trust (CPFT) and a few are with the Voluntary sector. It is acknowledged that delivering a project of this size and complexity needs careful planning and time required to ensure that the appropriate specifications are developed**.**

2.5 The Public Health grant funded Healthy Child Programme (HCP 0-19 yrs) is a core part of this integrated CYPFs service with a significant contribution to the total budget. This includes:

- Health Visiting and Family Nurse Partnership (HCP 0-5 yrs, £7,253,199 per annum)
- School Nursing and Vision screening (HCP 5-19 yrs, £1,506,540 and £167,000 per annum respectively)

2.6 Health Committee are aware that the proposed savings to the HCP 0-19 yrs budget in 2018/19 (total budget approximately £9 million) were deferred, in order to enable this transformation work to be undertaken over the year.

3. PROGRESS TO DATE

3.1 The CHJCU has made good progress to formalise joint commissioning arrangements and work with providers to identify an exciting programme that will deliver transformation of the CYPF services to an integrated model in line with policy directives, improving the quality of services for children and families including:

- **Speech and language therapy** (SALT)– total review of services with investment and alignment across the county resulting in 9 month waitings list now 6 weeks for the majority of children
- Jointly delivering **Emotional Health and Wellbeing Practitioners Service** to help and support EHWB in schools – service is now in place with complete joint arrangements, single management over staff from both organisations (CCS & CPFT), shared approach and fully thought through and defined governance/accountability.
- **Neurodevelopmen**t – joint clinics Psychiatrist and Paediatricians for defined children and backed up through a service level agreement for children with Autistic Spectrum

Disorder **(ASD)** and Attention Deficit Hyperactivity Disorder (**ADHD)**. CPCCG funded joint **ADHD training.**

- **Physiotherapy / Occupational therapy review** – now completed and will be implemented along the same lines as SALT
- **CCS infant mental health training** for CPFT Health Visitors (HVs) in place and will happen on an ongoing basis
- **Parenting groups** for children with behavioural problems – alignment and support across geographical boundaries
- **CCS dietitian** working fully within the CPFT Child and Adolescent Mental Health (CAMH) eating disorders team
- **Joint training for Children's Community Nursing across** Cambs and Peterborough
- **Joint / cross-organisational training** for Health Visitors
- **Collaboration when Healthy Child Programme** moved to Local Government as the LA boundaries necessitated transfer of children's cases seamlessly between the organisations
- Through CCG transformation investment and a pooling of budgets (CCC, PCC and CPCCG) to develop a **comprehensive Mental Health and Emotional Wellbeing Service** (counselling service**)** across the county. Contract awarded to CHUMS and service started in January 2018.

3.2 The CHJCU is receiving good feedback and improved performance from the work that has been jointly undertaken, but there is more that we need to do. We know from feedback that children and young people continue to have issues with accessing some services, and continue to be referred from one service to another sometimes without a satisfactory conclusion.

3.3 Over the last 2-years there has been considerable engagement with children, young people, families, staff and provider organisations. For example:

- Countywide workshops
- Attendance at key meetings such as schools' forum and patient participation groups
- One to one meetings with parents, GPs, children's groups and staff.

3.4 Additionally, whenever the CHJCU have re-commissioned or re-configured services, it has sought involvement from service users, patients, the public and staff.

4. WHAT HAVE PEOPLE SAID

4.1 Feedback from events and consultations has been consistent and can be summarised as: People want access to services when they need them, don't want to repeat their story time and time again and want their information to be shared. They want to be involved in decisions about them and want to be kept informed about their progress.

5. WHAT THE CHJCU WANTS TO ACHIEVE; NEXT STEPS

5.1 We are seeking a much closer working arrangement between commissioners and providers to deliver services within the defined budget, flexing services to manage local need and peaks within demand. Given national and local financial pressures, we need to have open and transparent financial accounting and focus efforts on solutions that ensure that we maintain high quality, safe and accessible services.

5.2 The CHJCU would like to move to 'one point of contact' for all organisations providing Children's services in the community to ensure consistency and continuity of services across both areas (CCC and PCC)

5.3 We plan to do this by coming together as commissioners through the CHJCU under a more formal section 75 arrangement rather than the current memorandum of understanding and aligning budgets and staff to commission a single specification across providers. Transforming service provision from multiple complex pathways to a less complicated streamlined provision where the emotional and physical health and wellbeing of a child, young person and their family is everyone's business.

5.4 Over the next year, we will be working intensively with providers to transform services based on these approaches:

- Children, Young People and Families Focused
- 'Think Family' whole family approach, Multi-disciplinary team (MDT) with lead professional
- Focus on health promotion, prevention, early intervention
- Need-led using i-THRIVE principles
- Integrated, accessible, flexible (Integrated front door/Single Point of Access, sharing information)
- Single service ethos, no hand-offs, thresholds & criteria minimised
- Outcomes focused
- Evidence based
- Consistent across the two Local Authorities (CCC & PCC)

5.5 In addition to an improved service for children and young people, we are planning to achieve savings from the current portfolio of contracts valued at almost £39m (subject to confirmation of the CCG's 2018/19 budget) and would envisage the majority of this to be achieved through the reduction of back office costs/costs to serve and the development of multi-disciplinary teams that reduce duplication. Commissioners and providers are working together to identify the level of savings possible.

5.6 The CHJCU has developed and shared a high level specification based on the principles above (section 5.4) and an outcomes framework with CCS and CPFT working together to design how they will deliver the outcomes. In addition, key performance indicators will be developed to provide assurance that the activities required to achieve the outcomes are being delivered. The overarching outcomes for the integrated CYPF service are:

- The very youngest children have the best start in life with a good pregnancy and birth
- Children experience good development in the early years and are school ready
- Families, Communities and services have high aspirations for all children
- Children and young people (CYP) are in good physical health and can make healthy lifestyle choices

- Children and young people live free from harm in their families and communities
- Children and young people and their parents have good emotional wellbeing and mental health
- Children are supported to be resilient in the face of adversity
- The outcomes for vulnerable CYP is as good as their peers

5.7 Progress will be driven through a robust programme management framework which will be operationally monitored through a Transformation Board including commissioners, providers and public health and strategically through the CHJCU.

6. FUTURE UPDATES

6.1 Officers will continue to provide updates to Health committee on the implementation of this integrated CYPF service.

7. ALIGNMENT WITH CORPORATE PRIORITIES

7.1 Developing the local economy for the benefit of all

Children contribute to the future economy. Good physical and mental health of children is important to make the NHS and the economy sustainable.

7.2 Helping people live healthy and independent lives

The outcomes and vision the integrated CYPF service is trying to achieve is to promote health and self-help (sections 1.1 & 5.6).

7.3 Supporting and protecting vulnerable people

One of the outcomes for the CYPF service is to narrow the gap in outcomes between the most vulnerable children and their peers

8. SIGNIFICANT IMPLICATIONS

8.1 Resource Implications

Provided savings are made as expected, this will result in a saving to the public health ring-fenced grant. 2018/19 saving have been deferred and funded through reserves in order to allow the transformation to happen.

8.2 Procurement/Contractual/Council Contract Procedure Rules Implications

Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies to exercise certain local authority functions and for local authorities to exercise various NHS functions. The Partners (CHJCU, CCS and CPFT) are committed to better integration of the

NHS Functions and the Authority Health-Related Functions, and therefore could legally enter into a Section 75 agreement.

8.3 Statutory, Legal and Risk Implications

There is always a possibility that the Council may be challenged by another NHS, Voluntary or Private Sector provider.

8.4 Equality and Diversity Implications

Each service change has an impact assessment as part of the process.

8.5 Engagement and Communications Implications

Over the last 2-years there has been considerable engagement with children, young people, families, staff and provider organisations (section 3.3, 3.4). Healthwatch, Family Voice and Pin Point will be involved in the Transformation.

8.6 Localism and Local Member Involvement

Health Committee and Children and Young Peoples committee will be provided with updates.

8.7 Public Health Implications

The foundations for virtually every aspect of human development including physical, intellectual and emotional; are established in early childhood. Professor Sir Michael Marmot and the Chief Medical Officer have highlighted the importance of giving every child the best start in life and reducing health inequalities throughout life through universal provision and targeted support. Public Health is responsible for commissioning the Healthy Child Programme 0-19 yrs included in this integrated children's service and the 18/19 budget is approximately £9 million in CCC. The success of this transformation programme in achieving improved outcomes for children while also delivering on the savings will be essential to improving population health now and in the future.

The Health and wellbeing strategy seeks to ensure a positive start to life for children, young people and their families. The provision of high quality, integrated CYPF will be fundamental to this.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS	Not Applicable

Head of Procurement?	
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes Name of Officer: Kathryn McFarlane
Have the equality and diversity implications been cleared by your Service Contact?	Each service change has an impact assessment as part of the process
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Wendi Ogle-Welbourn
Have any public health implications been cleared by Public Health	Yes Name of Officer: Raj Lakshman/ Liz Robin

Source Documents	**Location**
Best start in life and beyond: Improving public health outcomes for children, young people and families Guidance to support the commissioning of the Healthy Child Programme 0-19: Health visiting and school nursing services. Public health contribution of nurses and midwives: Guidance:	https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning https://www.gov.uk/government/collections/developing-the-public-health-contribution-of-nurses-and-midwives-tools-and-models#pregnancy-to-child-aged-5

Agenda Item No: 12

CAMBRIDGESHIRE AND PETERBOROUGH'S GENERAL PRACTICE FORWARD VIEW STRATEGY 2017 – 2020: DELIVERY OF PLAN & ASSOCIATED CHALLENGES

To:	**CAMBRIDGESHIRE HEALTH COMMITTEE**
Meeting Date:	**17th May 2018**
From:	**Sue Watkinson, Director of Transformation and Delivery – Primary and Planned Care, Cancer, and Medicines Optimisation**
Electoral division(s):	**ALL**
Forward Plan ref:	**N/A** *Key decision:* ***No***
Purpose:	**The purpose of this report is to update the Committee on the current general practice landscape, future development, and associated challenges, as discussed at the development session on 8 February 2018.**
Recommendation:	**The Committee is asked to note the current general practice landscape, future development, and associated challenges.**

1. BACKGROUND

1.1 The Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) presented an overview of the General Practice Forward View (GPFV) Strategy to the Health Committee on 8 February 2018. This paper includes detail from the original presentation and specifically addresses questions raised by the Committee.

1.2 Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has been tasked, under the National Operational Planning and Contracting Guidance (2017-2019) with the development of a local GPFV strategy. We currently have 102 practices in Cambridgeshire and Peterborough, with dedicated staff finding new and innovative ways of delivering high quality, responsive care for our patients. However, demand continues to grow and patient needs are changing and becoming more complex: this is reflected in practices struggling with operational, clinical, and financial challenges. General practice has been at a crossroads and subsequently must evolve to meet the needs of both patients and the workforce.

1.3 Our strategy has been developed with engagement from multiple stakeholders. Its six ambitions reflect the priorities for the future of general practice built around a vision of practices working together to engage a wide range of staff to deliver proactive, standardised, and integrated care. The strategy describes key strategic actions aligned to each ambition and to our overall vision. Our ambitions are set out below:

Models of Care:

1. **Ambition One:** Our new care model will be enabled by practices working increasingly at scale, with redesigned incentives for better ways of working and full population coverage.
2. **Ambition Two:** Working closely with clinicians and patients, redesign how care is delivered, with a particular focus on patients in care homes, patients with multiple long term conditions, and patients with urgent care needs

Improving Access:

3. **Ambition Three:** Determine how we will improve access to primary care over evenings and weekends and ensure this access is used to support patients with the greatest need aligned to the care model (as required by NHS England). This would include a trajectory around access to be delivered at 100% by 1 October 2018.

Workforce:

4. **Ambition Four:** Deliver a workforce programme that will support our primary care staff in working safely through recruitment and retention, leadership development, and capacity creation.

Workload:

5. **Ambition Five:** Support the creation of capacity in primary care, finding strength and resilience by enabling practices to adopt proven methods of addressing workload challenges and through working together more effectively. This will include a CCG commitment to provide additional support to general practice from early 2017, including annual submission for any GP Resilience funding as advised by NHS England.

Infrastructure:

6. **Ambition Six:** Maximise the benefits of modern information technology and develop a clear approach to premises investment linked to service and provider developments, in line with the digital and estates strategy.

1.4 Our health and care system rests on the foundation of general practice. Our patients want, and need, general practice to be resilient and sustainable. We believe we have an ambitious plan which will allow us to achieve our ambitions by 2020-21 whilst providing a responsive, high quality service which will serve our patients well.

2. MAIN ISSUES

2.1 Local landscape and strategic overview

Cambridgeshire and Peterborough is currently in year two of delivering its GPFV strategy. The context for the change required, and the challenges we face as a result of this, is ongoing. It requires both systemic and individual practice engagement and investment. It will require a collaborative effort from all system partners to deliver fully on the vision and the six key ambitions as outlined above. Some of the challenges we face are discussed in the following sections of this report.

2.1.1 Demography

As elsewhere in the United Kingdom, Cambridgeshire and Peterborough has a growing and aging population. However, unlike the majority of other local authority areas, the size of the growth is significant, best illustrated by the number of planning applications and housing developments in the area.

This growth is consistent across Cambridgeshire and Peterborough however the demography is very different, which means that a one-size-fits-all approach does not work. The strategy therefore needs to be tailored across the geographies as defined within the STP footprint, that is: Greater Peterborough, Huntingdon and the Fens, and Cambridge/Ely.

2.1.2 General practice financial sustainability

General practice income has decreased over time and a consequence of this is that the partnership business model has become increasingly less attractive. This is because the differential between take home pay for partners and salaried GPs has reduced. As GP partners retire there is increasing pressure on the remaining partners who carry the liability of the business, with no-one wanting to be the ‘last man standing’.

The national direction for general practice is to be ‘at scale’, that is serving a population of a minimum of 30,000 to 50,000 people. This does not necessarily mean that practices need to formally merge but that they are able to provide commissioned services at that level.

The majority of our 102 practices are engaged to some degree in conversations about merging and/or working at scale. For smaller practices merging provides them with an opportunity to help strengthen their resilience.

2.1.3 Workforce and workload challenges

Resilience issues are also the result of limited workforce and increasing workload. In our CCG’s area 20% of our GPs are over the age of 54 years. Cambridgeshire has a relatively younger GP profile, with only 18% of GPs over the age of 54 years. In Peterborough this rises to 25%, higher than the England average of 21%.

The statistics for nursing in general practices are also worth noting. Approximately a third

of Practice Nurses are aged over 54 years. Attracting nurses to work in primary care is particularly challenging with a significant nursing shortage across the UK.

Whilst we have a high level picture of our workforce, we do not have the detailed view of how our workforce is changing and what this looks like across the area. This is important as the challenges are not equal. For example, it is more difficult for practices in Greater Peterborough and Fenland to recruit GPs in comparison to Cambridge practices.

A key piece of work that we are planning to undertake over the next three months is to gather workforce information that allows us to build on what we know. This will also allow us to understand better the number of GPs who are planning to retire over the next two to three years and what might incentivise GP trainees working in the system to stay in our system.

Managing supply, flow, and retention across the whole clinical and non-clinical workforce is the overarching aim of our workforce strategy for general practice. The strategies we will be implementing to achieve a sustainable and engaged workforce include offering flexible careers, GP Portfolio posts, introducing new roles such as the clinical pharmacist and physician associate, and GP international recruitment.

Workforce is one of the top two priorities for the CCG/STP, alongside implementing improved access to general practice. The CCG is required to commission for 100% population coverage by 1 October 2018. Whilst this is for routine bookable appointments, and includes the wider clinical workforce in general practice, the same GP workforce required to deliver this also supports current out of hours and GP streaming services. The risk therefore cannot be underestimated in terms of managing to provide the required cover across all services.

Some of this risk may be mitigated by utilising 'hubs' that incorporate a combined service model.

Workforce

Deliver a workforce programme that will support our primary care staff in working safely, through recruitment and retention, leadership development and capacity creation

Project	**Summary**
Improving supply and retention *Ensure the future supply of GPs, primary care nurses and the wider workforce through a number of planned local and national initiatives.*	• Range of initiatives focused on GPs, General Practice Nurses and Health Care Assistants (HCAs) • GP international recruitment, range of initiatives focused on GPs, General Practice Nurses and HCAs • GP international recruitment, GP Fellowship, GP Retention scheme, retention of GP trainees, GP nurse strategy, preceptorship, apprenticeship schemes, HCA development
New Role Development	• Physician Associates, Clinical pharmacists, Mental health workers, Medical assistants, Care navigators, in addition to GPs, Advanced Nurse Practitioners, Practice Nurses and Practice Managers
Scaling up new ways of working & upskilling *Upskill the current primary*	• Practice Manager: Delivering Practice Manager development, opportunities funded through HEE and supported by Local Medical Committee

care workforce, including both clinical and non-clinical roles	• Upskilling HCAs and reception staff under Medical Assistants Programme • Promoting & delivering for apprenticeships including supporting HCAs to train as GP Nurses
Leadership	• CCG offers a number of development opportunities for GPs within the system e.g. Chief Resident & Clinical Leadership Programme • Mary Seacole Leadership Programme – places for available for Practice Manager • To Support delivery of GP Nurse Strategy aligned to National 10 point plan – work in progress

2.1.4 Premises and estates planning

Estates is a key enabler to support key elements of the CCG/STP's GPFV strategy. As discussed above it is linked to new care models and primary care at scale working, as well as integration of improved access with urgent care.

This portfolio incorporates what is considered as 'business as usual' capacity planning and planning for the new growth developments such as Northstowe. This area of the strategy is also linked into the wider STP estates strategy/workbook and therefore needs to be incorporated within a wider STP decision-making process.

The CCG has to make decisions in the short term and over the longer term without necessarily having the new care models or primary care at scale working consistently in place. The key consideration is not so much the capital investment required but the ongoing revenue consequences of any new development, whether it be improvements and/or an extension to a practice or, with some of the larger new housing developments, a new practice build.

The CCG is supported by NHS England Estates colleagues who play a role in responding to all new planning/development applications. In addition, we work with NHS Property Services (NHSPS) where a building is owned by them. The decision making process in place ensures that any investment made by NHS England meets all the building, planning, and clinical safety requirements for delivery of all work completed. The process, whilst not overly cumbersome, is detailed and unfamiliar to practices who are not skilled in this area.

Due to the size of the portfolio and the work required by the CCG, the Primary Care Team will be recruiting an additional post to help us manage the planning and decisions that are required to support the wider GPFV and STP strategy.

3. ALIGNMENT WITH CORPORATE PRIORITIES

The aspirations and plans in the GPFV strategy are in line with both the GPFV and the Cambridgeshire and Peterborough STP which details how we – as a whole system - propose to improve services and become clinically and financially sustainable.

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

As with Northstowe, new care models such as the Primary Care Home in South Cambridgeshire incorporate a focus on supporting people to live healthy and independent lives.

The STP Fit for the Future Strategy has a key priority for change of 'At Home is Best', which focuses on people-powered health and wellbeing.

3.3 Supporting and protecting vulnerable people

The GPFV strategy does not specifically focus on supporting and protecting vulnerable people, however new care models and improved access will be assessed for quality and inequality impacts across our population.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications with regards to workforce and estates specifically.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications for this priority.

4.3 Statutory, Legal and Risk Implications

As discussed above, workforce challenges in primary care are well documented. Options to consider new models with a broad skill mix provide a level of mitigation for this risk.

Managing the significant growth and the impact financially is very challenging for the STP as the ongoing revenue costs associated with infrastructure are as yet unknown. Under existing primary care contract regulations, rental costs for space to deliver primary medical services are reimbursed by the CCG. These costs may not be incurred under a new contract model but would be reflected in the service delivery costs.

Service delivery costs under both traditional and integrated care models will need to be costed to take in planned growth.

Integrated models of care require budgetary transparency and identification of population level costs for joint commissioning across organisations.

4.4 Equality and Diversity Implications

Commissioning for new services requires us to undertake further impact assessments that cover quality impact, privacy, and sustainability.

4.5 Engagement and Communications Implications

The GPFV strategy has a communications and engagement plan. Patient engagement and communication is part of the contractual merger process as well as service changes such as improved access. The CCG has been working with Healthwatch Cambridgeshire and Peterborough and patient participation groups in delivery of its strategy.

4.6 Localism and Local Member Involvement

CCG and STP representatives will continue to keep local members informed as and when required.

4.7 Public Health Implications

Public Health information is taken into consideration as part of the implementation process.

Agenda Item No: 13

CAMBRIDGESHIRE AND PETERBOROUGH CCG 2017/18 FINANCIAL POSITION AND PLANNING FOR 2018/19

To:	**Cambridgeshire Health Scrutiny Committee**
Meeting Date:	**17 May 2018**
From:	**CCG Acting Interim Accountable Officer and Chief Clinical Officer/Clinical Chair**
Electoral division(s):	**All**
Forward Plan ref:	**N/A** *Key decision:* ***No***
Purpose:	**To provide the Committee with a briefing on the CCG's 2017/18 financial position and 2018/19 financial plan.**
Recommendation:	**The Committee is asked to note the update on the CCG's financial performance and the challenging yet achievable plan for 2018/19.**

1. BACKGROUND

1.1 The CCG reported a £42.1m deficit in 2017/18 against the £15.5m control deficit agreed with NHSE prior to the commencement of the year. This report explains to the committee the main reasons driving this deterioration and also provides an update on the financial plan development for 2018/19.

2. MAIN ISSUES

2017/18 Financial Performance

2.1 The CCG's budget for 2017/18 was £1 billion. It started the year with an agreed control total deficit (agreed overdraft) with its regulators, NHS England (NHSE) of £15.5m. At the time this was acknowledged as a challenging plan, with a £46.4m QIPP (annual savings) plan required to deliver this deficit, and £12.1m net risks identified but not included in the position. These risks related predominantly to the growth of activity being higher than included within the contract, NHS Continuing Healthcare (CHC) activity being higher than forecast, the possibility of savings plans under delivery and prescribing cost pressures in respect of unanticipated national price changes.

2.2 The risks outlined at the time of plan sign off materialised throughout the year, and at a higher level than anticipated. In addition to this, a CHC backlog was identified of cases that had not been processed within the national timeframe. The CCG is responsible for funding if the individual is CHC or Funded Nursing Care (FNC) eligible. The result of the backlog is that these costs were not recognised in the financial position at the time they should have been, resulting in a more significant recognition of these costs late in the financial year.

2.3 The main reasons for the CCG's deterioration in financial position for 2017/18 were:

- A greater demand for acute care than had been planned for, costing an additional £19million
- A £6million increase in prescribing costs, due to national pricing changes
- A rise in the number of NHS Continuing Healthcare patients, fast track patients and s.117 patients, as well as a need to address a large backlog of assessments, causing an additional cost of approximately £14million
- Under delivery of QIPP (savings plans) standing at £7.6 million

The CCG utilised underspends from other areas and contingencies to bring this figure to a year end position of £42.1million deficit.

2.4 As many of these cost pressures are recurrent in nature, the CCG have taken care to ensure that the deficit position agreed with regulators for 2018/19 took all of these into account and allowed for the agreement of a realistic plan that the CCG can deliver. In order to avoid a recurrence of the mismatch between financial planning and delivery, the CCG commissioned a capacity and capability review and this has made a number of recommendations that we are taking forward in an improvement plan. The review also recommends one off investment in leadership and financial management, and NHS Continuing Healthcare, which we are implementing.

2018/19 Financial Plan

2.5 NHS England and NHS improvement published guidance for refreshing NHS Plans in February 2018 and NHS Operational Planning and Contracting Guidance 2017-2019 published in September 2016 and reflected in the March 2017 document *Next Steps on the NHS Five Year Forward View*.

The CCG has used the guidance as a basis for its planning for 2018/19. The guidance sets out priorities for our planning and these have been:

- Focus is on financial planning
- System financial alignment between providers and commissioners
- Recognition of growth in non-elective and ambulance activity
- Whole system solutions and planning – system 'control total'

The guidance also sets out five service areas where improvements are expected. These are the following and how we have addressed them:

- Mental Health – meeting the investment standard
- Cancer – implementing regional Cancer alliance strategy with associated funding
- Primary Care – supporting new models of care and extended access
- Urgent and Emergency Care – focus on reducing hospital admissions and delayed transfers of care
- Learning Disabilities – planning for growth.

In terms of our financial position to start the year, the CCG have been in extensive discussions over the past 4 months with NHSE both regionally and nationally to agree a deliverable plan for 2018/19. At the time of writing, the plan, approved by the Governing Body is for a £35.1m deficit position. This includes £35m of QIPP (savings) delivery.

2.6 The starting point for the 2018/19 financial plan is the 2017/18 outturn position, adjusted for non-recurrent cost pressures and in year slippage. This gives an underlying deficit of £49.1m (including an assumption that a 0.5% contingency/risk reserve is maintained). Anticipated and known changes for 2018/19 are then applied to this position to determine the gross position prior to the application of QIPP schemes.

2.7 In drawing up its 2018/19 financial planning assumptions, the CCG has referred to the NHS national technical planning guidance. The plan also reflects the locally agreed growth assumptions contained in the system's Sustainability and Transformation Plan**,** however Acute activity growth assumptions have been refined based on activity levels seen in 2017/18 and the Acute providers and CCG view of likely activity increases for 2018/19.

2.8 The assumptions within the plan are shown in the table below.

Planning Assumptions	
National Assumptions	**%**
Tariff Uplift	
PbR Activity	0.8%
Non-national tariff acute services	0.1%

Non Acute	0.1%
Reserves	
Contingency	0.5%
Local Growth Assumptions	
Acute	
Non Elective	3.1%
Elective	5.1%
Daycases	5.6%
First Outpatient	3.1%
Follow Up Outpatient	2.8%
A&E	3.3%
Mental Health	2.6%
Community	3.4%
Complex Cases	4.5%
Prescribing	4.8%
Primary Care (including Delegated Commissioning)	2.7%

2.9 The resource uplift for the CCG is more than in previous years and is more than the previously notified 2.6% for 2018/19 as a result of the additional funding invested in the NHS as part of the Autumn budget statement (November 2017), with part of this being passed to CCG's in their allocation. This resulted in an increase of 3.48% (excluding running costs and primary care delegated commissioning).

2.10 The CCG has received a £34.8m uplift to its core allocation in 2018/19. Of this £8.6m is the increased funding made available in the Autumn budget statement. Delegated Commissioning allocation has increased by 1.73%, an increase of £2.137m.

2.11 The final version of the plan is based on having Guaranteed Income Contracts with Cambridge University Hospital NHS Foundation Trust, North West Anglia NHS Foundation Trust and Royal Papworth NHS Foundation Trust, with all organisations in principle having agreed to this position subject to final confirmation of terms and conditions of the contracts and Board ratification.

2.12 This is the first year the CCG has agreed Guaranteed Income Contracts (GICs) with its providers. These have been negotiated on the basis of looking at the likely activity for the year, less the realistic level of QIPP that can be delivered by the system to calculate a fixed income figure for the year. Each step of this process has been carried out in collaboration with providers.

2.13 A core advantage of Guaranteed Income Contracts is the change in system behaviours they facilitate as well as removing a key element of risk from the CCG's position. This allows both the CCG and providers to work collaboratively to reduce as far as possible the levels of activity seen within the Trust's, ensuring that patients are treated in the most appropriate settings and removing the potentially adversarial elements of contract enforcement present under payment by results.

2.14 The GICs are however constructed in such a way that outcomes required by the population of C&PCCG are delivered, with monitoring of key performance metrics within the contracts (e.g. maintenance of 18 week wait performance, and delivery of A & E targets).

2.15 The current plan satisfies the Mental Health Investment Standard, in which Mental Health services must receive increased funding of at least the CCG's overall uplift (3.48%). It also delivers the £3 per head funding required under the GP 5 Year Forward View.

2.16 From this gross position, QIPP is then applied, based on the CCG's view of the likely amount deliverable. This produces the following plan for the year;

£m	2017/18 Recurrent Exit position	Increase in allocation	Tariff Inflator/ Inflation	Growth	MHIS & GPFV	Other recurrent investments	Non-recurrent investments	Contingency	Other reserves	Planned QIPP	2018/19 Plan
Allocation	1,143,103	37,919									1,181,022
Expenditure											
Acute	581,292		4,668	23,367		5,456				-13,969	600,814
Mental Health	88,299		85	2,218	1,429					-300	91,731
Community Health Services	128,336		231	4,410						-5,500	127,477
Continuing Care	72,736		73	3,273						-7,500	68,582
Prescribing	115,533		116	5,550			500			-5,700	115,999
Primary Care Services	29,831		119	671	1,395					-520	31,496
Primary Care Co-commissioning	117,292			3,541						-1,500	119,333
Other programme	34,815		30	543					-391		34,997
Contingency	-							5,230			5,230
Non Recurrent headroom	5,059							-5,059			0
Running Costs	19,022		190				1,358		-138		20,432
Unidentified QIPP											-
Total spend	1,192,215	0	5,512	43,573	2,824	5,456	1,858	171	-529	-34,989	1,216,091
Surplus/(deficit)	-49,112										-35,069

2.17 Much of the Community QIPP is delivered through management of contracts which sit within this area of spend, asking providers to maintain service delivery within existing contract envelopes.

2.18 As part of the financial recovery of the organisation, a more robust process around the development, governance, delivery and accountability of QIPP schemes has been implemented, along with a strengthening of the Project Management Office.

CONCLUSION

The Committee are asked to note the contents of the report. It is clear that the significant financial challenge faced by the CCG this year continues into 2018/19. The QIPP requirement for 2018/19 is £34.989m. Delivery of this level of QIPP still results in a deficit plan for the financial year of £35.1m, however the CCG are of the view that this is an achievable plan, and are currently focused on ensuring delivery of this, alongside assuring the safe delivery of services are its key areas of focus.

Agenda Item No: 14

NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2017-18 REQUESTS

To:	**HEALTH COMMITTEE**
Meeting Date:	**17th May 2018**
From	**The Monitoring Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To provide an update to the Committee on responses submitted to NHS Provider Trusts in regards to their Quality Accounts 2017/18. It is a requirement for NHS Provider Trusts to request comment from Health Scrutiny Committees on their Quality Accounts.**
Recommendation:	**The Health Committee is asked to**

a) note the statements and responses sent to the NHS Provider Trusts; and

b) note any Quality Accounts that are outstanding

	Officer contact:	***Member contact:***
Name:	Kate Parker	Cllr Peter Hudson
Post:	Head of Public Health Business Programmes	Chairman
Email:	Kate.parker@cambridgeshire.gov.uk	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01480 379561	01223 699170

1. BACKGROUND

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

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

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

1.4 This Health Committee on 16th March 2018 delegated approval of the responses to the Quality Accounts, received from NHS Providers, to the Head of Public Health Business Programmes in consultation with the views of members of the Task and Finish Group.

2. MAIN ISSUES

2.1 Councillors Dupre, Hudson and Jones were appointed to the Task and Finish Group on 16th March 2018. Table 1 details Quality Accounts that have been received at the time of this report was compiled.

Table 1

Organisation	Quality Account Received	Deadline to respond	Response Made
Cambridge University Foundation Trust	3rd April 2018	27th April 2018	27th April 2018 Appendix 1
North West Anglia Foundation Trust	20th April 2018	4th May 2018	4th May 2018 Appendix 2
Cambridgeshire Community Services	27th April 2018	28th May 2018	Pending

2.2 North West Anglia Foundation Trust also provided members with the opportunity to attend a stakeholder event on 8th May 2018 to review all feedback received from stakeholders. The Trust responded to all comments made by members of the Task & Finish group and adjusted the final version of their Quality Account to reflect these.

2.2 Further Quality Accounts are expected from the following organisations with the timescales advised in Table 2. At the point of completion of this report we were not in receipt of these quality accounts.

Table 2

Organisation	Quality Account Received	Deadline to respond	Response Made
Cambridgeshire & Peterborough Foundation Trust	Expected 3rd May 2018 No report as of 8th May 2018	No date advised yet.	No Report
East of England Ambulance Service Trust	Expected at beginning of May 2018	Advised of 30 day consultation period.	No Report

SIGNIFICANT IMPLICATIONS

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

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

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

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

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

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

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

Appendix 1

CAMBRIDGE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST - QUALITY ACCOUNT 2017/18

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL - HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has not called on representatives from Cambridgeshire University Hospital over the last year to attend scrutiny committee meetings. However, committee members have maintained an open dialogue with senior leadership at the Trust through the valuable quarterly liaison meetings which are seen as an essential part of the scrutiny function.

In response to the Quality Report 2017/18 members have found the "other Information section" very helpful in setting out targets, measurements and degree of success in reaching targets. The Committee would welcome further conversations to understand the links between not meeting targets and the challenges the Trust faces in terms of staffing. The Committee has paid a particular interest in workforce development and recruitment and retention issues across the whole health care sector and specifically scrutinising this under the Sustainable Transformation Programme (minutes can accessed via the link below).

https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/538/Committee/6/Default.aspx

There are four objectives, of which one is 'Strengthening the Organisation'. The goal is admirable and the Committee would welcome further clarity about how this is being achieved. It would be interesting to understand the impact of this on patient journeys and organisational strength. Engaging patients in improvement is important and more information of patient involvement would be welcomed.

The Committee would like to comment on how impressive that in the staff survey over two-thirds of staff would recommend CUH as a place to work. A deeper understanding would be helpful about why there was less confidence shown by staff in their responses to taking actions over errors, near misses and incidents.

Evidence of the pressure the Trust is under through rising demand for services and vacancy rates is evident in the missed target for cancelled operations and delayed transfers of care. The Health Committee recognised that this is a whole system issue involving health and social care and acknowledge the work that CUH are undertaking in working within a partnership framework to address this local pressure.

The Committee has provided some clarification comments separately, recognising the Quality Accounts are a technical document but would like to conclude that this is a helpful report in explaining the Trusts stance on issues and what is being done though the year to make improvements.

Appendix 2

NORTH WEST ANGLIA FOUNDATION TRUST

QUALITY ACCOUNT 2017/18

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has welcomed the opportunity to comment on the Quality Account for North West Anglia Foundation Trust (NWAFT) during its first year of existence. We recognise that the Trust has had a number of challenges during the merger of the Peterborough and Stamford NHS Foundation Trust (PSHFT) and Hinchingbrooke Healthcare Trust (HHCT). Previously the Health Committee has examined a number of issues with the former HHCT as it moved out of special measures.

The Health Committee within its scrutiny capacity has not called on representatives from NWAFT over the last year to attend scrutiny committee meetings, recognising that the Trust needed time to address the impact of the merger. However, committee members have maintained an open dialogue with senior leadership at the Trust through the valuable quarterly liaison meetings which are seen as an essential part of the scrutiny function.

The report highlights the significant staffing challenges the Trust faces and how recruitment for nursing staff is being addressed both internally through programmes like “Aspiring Clinical Managers” and through overseas nurse recruitment. The committee welcomes continued dialogue with the Trust around wider medical workforce issues. We have paid a particular interest in workforce development and recruitment and retention issues across the whole health care sector and specifically scrutinising this under the Sustainable Transformation Programme (minutes can accessed via the link below).

https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/538/Committee/6/Default.aspx

At the time of reviewing NWAT’s Quality Account a final figure was not available for the target set for developing and retaining the workforce and the committee await this with interest as part of their wider scrutiny of workforce planning in both the health and social care sector.

The Committee was particularly impressed with the Trusts progress around CQUIN on Healthy Eating working with the Trusts suppliers of food and drink in the hospitals, to assist them in making changes to their outlets to offer staff and visitors healthier choices.

Of concern the Health Committee has noted that the volume of complaints has increased and it will be interesting to see next year if this changes i.e. how much of it

is related to the impact of the merger and how much is managing increased demand on the health care system.

In recognising that the Quality Accounts are a technical document the Committee has provided some clarification comments separately. The committee has been encouraged to see how the Trust has actively responded to this feedback, inviting members to a stakeholder meeting and incorporating suggestions in the final Quality Account. This is an excellent example of listening to ones stakeholders.

HEALTH COMMITTEE TRAINING PLAN	Updated March 2018	**Agenda Item No: 15**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
7.	***Health in Fenland***	To provide a deep dive into reviewing and understand the key health inequalities in the Fenland District. To be held at FDC March office.	1	May 2018 Date to be confirmed	Public Health	Development Session	All members of Health Committee + Fenland Members + FDC + Wisbech Town Council		
8. a	***Public Health Strategy PHE Prioritisation – 1***	To further develop the Public Health Strategy for the Health Committee PHE providing support around Prioritisation framework	3	Jan 30th pm 2018	Public Health	Development Session	All members of Health Committee	9	**Completed** 60% of Health committee
8. b	***Public Health Strategy PHE Prioritisation – 2***	PHE Prioritisation Workshop 2 – Scoring Programme This workshop has been converted to officer only.	2	8th March 13:00	Public Health	Development Session	Officer Only	Not Applicable	**Completed** Officer only.
8. c	***Public Health Strategy PHE Prioritisation – 3***	PHE Prioritisation Workshop 3 – Scoring Local Evidence	2	27h April 13:00	Public Health	Development Session	All members of		

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
							Health Committee		
8 d.	***Public Health Strategy PHE Prioritisation – 4***	PHE Prioritisation Workshop 4 - recommendations	2	10th May 2pm	Public Health	Development Session	All members of Health Committee		
9.	***STP: STP developments to support general practice.***	To provide the committee members with an overview of STP work to develop and support GP led primary care.	2	Feb 8th TBC	Public Health	Development Session	All Health Committee members		

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 COMMITTEE AGENDA PLAN, TRAINING PLAN AND APPOINTMENTS TO OUTSIDE BODIES, PARTNERSHIP LIAISON AND ADVISORY GROUPS, AND INTERNAL ADVISORY GROUPS AND PANELS

To:	**Health Committee**
Meeting Date:	**17 May 2018**
From:	**Democratic Services**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**To review the Committee's agenda plan, and to consider appointments to outside bodies, internal advisory groups and panels, and partnership liaison and advisory groups.**
Recommendation:	**It is recommended that the Health Committee:**

(i) review its agenda plan attached at Appendix 1;

(ii) agree the appointments with a yellow background and in bold italics, and continue to refer appointments to the other internal advisory groups and panels, as detailed in Appendix 2, to the relevant policy and service committee.

(iii) agree the appointments with a yellow background and in bold italics, and continue to refer appointments to the other partnership liaison and advisory groups, as detailed in Appendix 3, to the relevant policy service committee.

	Officer contact:
Name:	Daniel Snowdon
Post:	Democratic Services Officer
Email:	Daniel.Snowdon@cambridgeshire.gov.uk
Tel:	01223 699177

1. BACKGROUND

1.1 The Health Committee reviews its agenda plan at every meeting.

1.2 The County Council's Constitution states that the Health Committee has

- Authority to nominate representatives to Outside Bodies other than the Cambridgeshire and Peterborough Fire Authority, the County Councils' Network Council and the Local Government Association.

- Authority to determine the Council's involvement in and representation on County Advisory Groups. The Committee may add to, delete or vary any of these advisory groups, or change their composition or terms of reference.

1.3 The Committee has previously agreed to refer appointments to Internal Advisory Groups and Panels, and Partnership Liaison and Advisory Groups to the relevant Policy and Service Committee. All the appointments are attached for the Committee's attention. However, the Committee only needs to focus, at the meeting, on the appointments with a white background and in bold italics.

1.4 On 14 June 2017, the Committee agreed to delegate, on a permanent basis between meetings, the appointment of representatives to any outstanding outside bodies, groups, panels and partnership liaison and advisory groups, within the remit of the Health Committee, to the Director of Public Health in consultation with the Chairman of the Health Committee.

2. APPOINTMENTS

2.1 The internal advisory groups and panels where appointments are required are set out in **Appendix 2** to this report (appointments with a yellow background and in bold italics). The previous representative(s) is indicated. It is proposed that the Committee should agree the appointments to these bodies.

2.3 The partnership liaison and advisory groups where appointments are required are set out in **Appendix 3** to this report (appointments with a yellow background and in bold italics). The previous representative(s) is indicated. It is proposed that the Committee should agree the appointments to these bodies.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

There are no significant implications for this priority.

3.3 Supporting and protecting vulnerable people

There are no significant implications for this priority.

4. SIGNIFICANT IMPLICATIONS

4.1 There are no significant implications within these categories:

- Resource Implications
- Procurement/Contractual/Council Contract Procedure Rules Implications
- Statutory, Legal and Risk Implications
- Equality and Diversity Implications
- Engagement and Communications Implications
- Localism and Local Member Involvement
- Public Health Implications

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Not applicable
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by Finance?	Not applicable
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Not applicable
Have the equality and diversity implications been cleared by your Service Contact?	Not applicable
Have any engagement and communication implications been cleared by Communications?	Not applicable
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Not applicable
Have any Public Health implications been cleared by Public Health	Not applicable

Source Documents	Location
Health Committee Agenda and Minutes – 14 June 2017	https://cmis.cambridgeshire.gov.uk/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/6/Default.aspx

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 1st May 2018	Cambridgeshire County Council

Appendix: 1

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.

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

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
[14/06/18] Provisional meeting					
12/07/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Public Health Performance Annual Report	Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Health Care Public Advice Service	David Lea	Not applicable		
	Healthcare Public Health Memorandum of Understanding	Liz Robin (David Lee)	Not applicable		
	Scrutiny Item: Eating Disorder Service Update.	Tracy Dowling.	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[09/08/18] Provisional meeting					
13/09/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Children and Young People's Drug and Alcohol Treatment Services Procurement.	Val Thomas	Yes		
	Child and Adolescent Mental Health Services (scrutiny item)	Lee Miller	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
11/10/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
08/11/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
06/12/18	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	NHS Dentistry Provision (Scrutiny Item)		Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
17/01/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[07/02/19] Provisional meeting					
14/03/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[11/04/19] Provisional meeting					
23/05/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		

Appendix 2

APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS

Key to approval of appointment:

General Purposes Committee	
Adults Committee	
Children and Young People Committee	
Commercial and Investment Committee	
Communities and Partnership	
Economy and Environment Committee	
Health Committee	
Highways and Community Infrastructure Committee	

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Accelerating the Achievement of Vulnerable Groups Steering Group The Group steers the development and implementation of the Accelerating Achievement Action Plan, which aims to rapidly improve the educational achievement of vulnerable groups.	6	2	Councillor A Costello (Con) Councillor L Joseph (Con)	Jonathan Lewis Service Director Education 01223 507165 Jonathan.Lewis@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Adult Accommodation Member Reference Group The purpose of this Group is to provide challenge and steer for the Care Homes Implementation Project, as well as being a conduit for feedback to the appropriate Committees and to highlight the work taking place.		1	Councillor T Rogers (Con)	Shauna Torrance Head of Commissioning for Adult Social Care 01223 714697 shauna.torrance@cambridgeshire.gov.uk
Cambridgeshire Culture Steering Group The role of the group is to give direction to the implementation of Cambridgeshire Culture, agree the use of the Cambridgeshire Culture Fund, ensure the maintenance and development of the County Art Collection and oversee the loan scheme to school and the work of the three Cambridgeshire Culture Area Groups.	3	3	Councillor S Bywater (Con) Councillor N Kavanagh (Lab) Councillor L Joseph (Con)	Jonathan Lewis Service Director Education 01223 507165 Jonathan.Lewis@cambridgeshire.gov.uk
Cambridgeshire Music Members' Reference Group.		6	Councillor S Bywater (Con) Councillor D Jenkins (LD) Councillor L Every (Con) Councillor P Raynes (Con) Councillor J Schumann (Con) Councillor J Whitehead (Lab)	Matthew Gunn (01480) 373870 Matthew.Gunn@cambridgeshire.gov.uk
Cambridgeshire Schools Forum The Cambridgeshire Schools Forum exists to facilitate the involvement of schools and settings in the distribution of relevant funding within the local authority area	6	3	Councillor S Bywater (Con) Councillor P Downes (LD) Councillor J Whitehead (Lab)	Richenda Greenhill Democratic Services Officer 01223 699171 Richenda.greenhill@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Cambridgeshire Waste PFI Member Steering Group A Steering Group to consider reports from officers on the negotiation of disputed matters and future savings of the Waste PFI contract	12	3	Councillor S Count (Con) Councillor R Hickford (Con) Councillor M Shuter (Con)	Daniel Sage Strategic Project Manager (Waste) 07587 585457 daniel.sage@cambridgeshire.gov.uk
Cycling Safety Working Group An ad-hoc working group to review and suggest improvements to cycling safety within the County. The Group consists of four Members and representatives from Road Safety, Transport Strategy, Road Engineering and Public Health.	As required	5	Councillor S Criswell (Con) Councillor N Kavanagh (Lab) Councillor J Schumann (Con0 Councillor A Taylor (LD) Councillor S van de Ven (LD)	road.safety@cambridgeshire.gov.uk
Diversity Group Exists to act as the co-ordinating body to further the Council's role as a community leader, helping build a stronger, healthier, more inclusive society, which values diversity and recognises the contribution that those from different groups and backgrounds can make by championing and supporting the delivery of the Council's Single Equality Strategy and underpinning action plan across all parts of the organisation.	Quarterly	4	Councillor D Adey (LD) Councillor S Hoy (Con) Councillor J Scutt (L) Ind. Rep needed	
Educational Achievement Board		5	Councillor S Bywater (Con) Councillor P Downes (Lib Dem) Councillor S Hoy (Con) Councillor S Taylor (Ind) Councillor J Whitehead (L)	Jonathan Lewis Service Director Education 01223 507165 Jonathan.Lewis@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Fostering Panel Recommends approval and review of foster carers and long term / permanent matches between specific children, looked after children and foster carers.	2 all-day panel meetings a month	2	Councillor S King* (Con) Councillor P Topping* (Con) (*Subject to completing the Panel's own application process)	Fiona Van Den Hout Fiona.VanDenHout@cambridgeshire.gov.uk 01223 518739
Innovate and Cultivate Fund Bid Assessment Panel To consider bids to the Innovate and Cultivate Fund which will result in the commissioning of services being delivered by others to communities in Cambridgeshire.		5	Councillor S Criswell (Con) Councillor K Cuffley (Con) Councillor L Every (Con) Councillor L Dupre (Lib Dem) Councillor E Meschini (Lab) Substitutes: Councillor I Manning (Lib Dem)	Elaine Matthews Elaine.Matthews@cambridgeshire.gov.uk 01223 706385
Libraries Steering Group		5	Councillor Raynes Councillor Criswell Councillor Joseph Councillor A Taylor Councillor J Scutt	Christine May, Interim Service Director (Infrastructure Management)
Highways and Improvement Panels Established to consider and make recommendations to the Highways and Community Infrastructure Committee on the allocation of funds for locally led minor highway improvements.			See listings below – Previous appointments listed	Andy Preston Highways Projects & Road Safety Manager andrew.preston@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
East Cambridgeshire LHI Panel	1	6 (subs allowed)	Councillor D Ambrose Smith (Con) Councillor A Bailey (Con) Councillor L Dupre (LD) Councillor B Hunt (Con) Councillor P Raynes (Con) Councillor J Schumann (Con)	
Fenland Rural LHI Panel	1	6 (subs allowed)	Councillor D Connor (Con) Councillor S Count (Con) Councillor J Gowing (Con) Councillor S Hoy (Con) Councillor S King (Con) Councillor S Tierney (Con)	
Huntingdonshire LHI Panel	1	7 (subs allowed)	Councillor S Bywater (Con) Councillor S Criswell (Con) Councillor P Downes (LD) Councillor I Gardener (Con) Councillor M McGuire (Con) Councillor T Sanderson (Ind) Councillor G Wilson (LD)	
South Cambridgeshire LHI Panel	1	6 (subs allowed)	Councillor H Batchelor (LD) Councillor R Hickford (Con) Councillor D Jenkins (LD) Councillor S Kindersley (LD) Councillor M Smith (Con) Councillor T Wotherspoon (Con)	

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Member Development Panel Oversees training and development for Members.	As required	6	Councillor I Bates (Con) Councillor S Criswell (Con) Councillor D Giles (Ind) Councillor L Nethsingha (LD) Councillor M Smith (Con) Councillor J Whitehead (Lab)	Michelle Rowe Democratic Services Manager 01223 699180 michelle.rowe@cambridgeshire.gov.uk
New Street Ragged School Trust Management of the Cambridge Learning Bus, which provided enhanced curriculum support to Cambridge City nursery and primary schools. It travels to the schools where the Learning Bus teacher and teaching assistant deliver workshops.	2	2	Councillor L Nethsingha (LD) Councillor J Whitehead (Lab)	Jonathan Lewis Service Director Education 01223 507165 Jonathan.Lewis@cambridgeshire.gov.uk
Outcome Focused Reviews These reviews are an opportunity for the Council to have a deep look at what it does, why it does it, and how it does it. 1. Adult Early Help 2. Cambridgeshire Catering and Cleaning Service (CCS) 3. Cambridgeshire Music 4. Contact Centre 5. County Farms 6. Education ICT 7. The Learning directorate 8. Outdoor Education 9. Professional Centre Services (PCS) 10. Property Services 11. School Admissions and Education Transport 12. Total Transport			1.Councillor A Bailey (Con) 2.Councillor T Wotherspoon (Con) 3.Councillor P Hudson (Con) 4.Councillor S Criswell (Con) 5.Councillor R Hickford (Con) 6.Councillor J Gowing (Con) 7.Councillor S Hoy (Con) 8.Councillor S Bywater (Con) 9.Councillor A Hay (Con) 10.Councillor J Schumann (Con) 11.Councillor L Every (Con) 12. Councillor I Bates (Con)	Owen Garling Transformation Manager 01223 699235 07963 775645 owen.garling@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Standing Advisory Council for Religious Education (SACRE) To advise on matters relating to collective worship in community schools and on religious education.	3	3	Councillor S Hoy (Con) Councillor C Richards (Lab) Vacancy	Amanda Fitton Business Support Assistant Cambridgeshire County Council Stanton House Stanton Way Huntingdon PE29 6XL Amanda.Fitton@cambridgeshire.gov.uk
Strategic Collaboration Board **[Previously Highway Transformation Board]** The Strategic Collaboration Board has overall responsibility for the success of the highway service (excluding street lighting). The Board provides strategic direction and decision making, developing the service vision, values and principles through a collaboration charter. Leading by example, the Board will maintain a long-term focus (3-5 year plan), developing and agreeing a suite of strategic performance indicators aligned to strategic outcomes. Monitoring delivery of a transformational route map.	4	2	Member representatives: 1. Chair of H&CI 2. Chair of E&E (Subs will be the vice-chairs of both committees)	Contacts: Richard Lumley Emma Murden

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Virtual School Management Board The Virtual School Management Board will act as “governing body” to the Head of Virtual School, which will allow the Member representative to link directly to the Corporate Parenting Partnership Board.		1	Councillor A Costello (Con)	Jonathan Lewis Service Director Education 01223 507165 Jonathan.Lewis@cambridgeshire.gov.uk Edwina Erskine Business Support Officer – Administration Services Team Cambridgeshire’s Virtual School for Looked After Children (ESLAC Team) 01223 699883 edwina.erskine@cambridgeshire.gov.uk

Appendix 3

CAMBRIDGESHIRE COUNTY COUNCIL
APPOINTMENTS TO PARTNERSHIP LIAISON AND ADVISORY GROUPS

Key to approval of appointment:

General Purposes Committee	
Adults Committee	
Children and Young People Committee	
Commercial and Investment Committee	
Communities and Partnership Committee	
Economy and Environment Committee	
Health Committee	
Highways and Community Infrastructure Committee	
Committee Approval Not Required	

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS

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A47 Alliance Steering Group To act as a special interest group to support the strategic case for improvements on the A47 corridor between the port at Great Yarmouth and the A1. The A47 Alliance shall support the transport authorities along the route, the New Anglia Local Enterprise Partnership (LEP) and the Greater Cambridge Greater Peterborough LEP. **A47 Corridor Feasibility Study: Stakeholder Reference Group Meeting** The role of the Group is to ensure that stakeholders' views are captured and considered during the Department for Transport's study process, particularly at key points in its work and during the development of the study's key outputs.	2 TBC	1	Councillor Bates (Con) Councillor Bates (Con)	Democratic Services Norfolk County Council 0344 800 8020 information@norfolk.gov.uk Nigel Allsopp Highways England Nigel.Allsopp@highwaysengland.co.uk
A428/A421 Alliance To act as a lobby group of key partners from County and District Councils as well as MPs and Local Enterprise Partnerships along the length of the corridor. • To build a compelling case for improvements to the route to support economic growth, locally and nationally • To work with Highways England to develop a comprehensive improvement package and associated investment plan	2 or as business dictates	3	Councillor I Bates (Con) Councillor D Wells (Con) Councillor J Wisson (Con) Subs: Councillor D Giles (Ind.) Councillor S Taylor (Ind.)	Nikki Holland Office Manager Jonathan Djanogly MP 01480 437840 Hollandn@parliament.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Anglian (Central) Regional Flood and Coastal Committee The Regional Flood and Coastal Committee is a body through which the Environment Agency carries out its work on flood risk management and is responsible for: • maintaining or improving any watercourses which are designated as main rivers; • maintaining or improving any tidal defences; • installing and operating flood warning systems; • controlling actions by riparian owners and occupiers which might interfere with the free flow of watercourses; • supervising Internal Drainage Boards.	2	2	Councillor M Smith (Con) Councillor T Wotherspoon (Con)	Stephanie North Regional Flood and Coastal Committee Secretariat –Anglian Central AnglianRFCCs@environment-agency.gov.uk
Anglian (Northern) Regional Flood and Coastal Committee See above description. Cambridgeshire shares a seat on this Committee with Peterborough City Council and Rutland County Council. Cambridgeshire County Council currently attends these meetings as an observer only – as stated it's a shared seat and voting rights for the year 1 April 2017 – 31 March 2018 are held by the Peterborough City Council Member. The RFCC however encourages all members (whether they are able to vote or not) to attend all Committee meetings.	4 – 5	1	Councillor D Connor (Con)	Abigail.Jackson Regional Flood and Coastal Committee Secretariat – Anglian Northern 020302 55877 07789 271322 abigail.jackson@environment-agency.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Barrington Cement Works and Quarry Liaison Group The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	2-3	2	Councillor S Kindersley (LD) Councillor P Topping (Con)	Ian Southcott UK Community Affairs Manager Cemex 01788 517323 Ian.southcott@cemex.com
Barrington Light Railway Sub group The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	As required	2	Councillor S Kindersley (LD) Councillor P Topping (Con)	Ian Southcott UK Community Affairs Manager Cemex 01788 517323 Ian.southcott@cemex.com
Cambridge BID Board A five-year initiative set up by Cambridge businesses/organisations to ensure continued investment in Cambridge City Centre	6	1	Councillor M Shuter (Con)	Emma Thornton Head of Tourism and City Centre Management Cambridge City Council 01223 457446 Emma.Thornton@cambridge.gov.uk
Cambridge Council for Voluntary Service Cambridge CVS is an independent registered charity, set up by local organisations as an infrastructure and network organisation to help and support community and voluntary groups in Cambridge City and South Cambridgeshire.	4	1 Observer Status	Councillor L Nethsingha (LD)	Mark Freeman Chief Executive 01223 464696 enquiries@cambridgecvs.org.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Cambridge & District Citizens Advice Bureau Management Committee To provide free, independent, confidential and impartial advice to the public. Its aims are to provide the advice people need for the problems they face and improve the policies and practices that affect people's lives.	4 – 6	1	Councillor L Jones (L)	Rachel Talbot Chief Executive 01223 222660 rachelT@cambridgecab.org.uk
Cambridge Local Health Partnership ***The Partnership has been established to identify local health and social care priorities in Cambridge and to feed these back into the network and develop local actions.***	***6***	***1***	***Councillor L Jones (Lab)***	***Yvonne O'Donnell*** ***Cambridge City Council*** ***Yvonne.ODonnell@cambridge.gov.uk***
Cambridge University Hospitals NHS Foundation Trust Council of Governors ***The Board of Governors represents patients, public and staff. The majority of the Governors are elected by the membership. Governors provide a direct link to the local community and represent the interests of members and the wider public in the stewardship and development of the Trust.***	***4***	***1***	***Councillor M Howell (Con)***	***Martin Whelan*** ***Assistant Trust Secretary*** ***01223 348567*** ***martin.whelan@addenbrookes.nhs.uk***

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Cambridgeshire and Peterborough Association of Local Councils (CAPALC) District Committees: • East Cambridgeshire • Fenland • Huntingdonshire • South Cambridgeshire The District Associations have a direct feed into the strategic direction and governance of CAPALC as each of the District Association chairmen have a seat on the CAPALC Board.	4	1 to each	Councillor L Every (Con) Councillor J Gowing (Con) Councillor A Costello (Con) Councillor K Cuffley (Con)	Ian Dewar (County Executive Officer) 01480 375629 ceo@capalc.org.uk
Cambridgeshire and Peterborough Road Safety Partnership Strategic Management Board The Partnership (CPRSP) is a public sector initiative formed in April 2007 to provide a single point of contact for the provision of road safety work and information.	4	1	Councillor M Shuter (Con)	Matt Staton Road Safety Education Team Leader 01223 699652 matt.staton@cambridgeshire.gov.uk
Cambridgeshire Consultative Group for the Fletton Brickworks Industry (Whittlesey) The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	2	1	Councillor D Connor (Con)	Diane Munday Secretary, Forterra 01733 359148 Diane.munday@forterra.co.uk

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Cambridgeshire Flood Risk Management Partnership The partnership is required by legislation - namely the Flood and Water Management Act 2010.	4	1	Councillor T Wotherspoon (Con)	Sass Pledger – Head of Growth & Economy 01223 728353 Sass.pledger@cambridgeshire.gov.uk
Cambridgeshire Horizons Board Cambridgeshire Horizons still exists as a Limited company to oversee three “live” Rolling Fund investments, two loans and one equity investment, with an initial total value of £20.5m, to support a number of growth projects and developments around Cambridgeshire.	1	1	Councillor I Bates (Con)	Graham Hughes Executive Director Economy, Transport and Environment 01223 715660 graham.hughes@cambridgeshire.gov.uk
Cambridgeshire Music Hub A partnership of school music providers, led by the County Council, to deliver the government’s National Plan for School Music.	3	2	Councillor L Every (Con) Councillor S Taylor (Ind.) Substitute	Jonathan Lewis Service Director Education 01223 507165 Jonathan.Lewis@cambridgeshire.gov.uk Matthew Gunn Head of Cambridgeshire Music 01480 373500/373830 Matthew.Gunn@cambridgeshire.gov.uk

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Cambridgeshire and Peterborough NHS Foundation Trust ***Provides mental health and specialist learning disability services across Cambridgeshire and Peterborough. Also provides some specialist services on a regional and national basis. Partners are Cambridgeshire County Council, Peterborough City Council, NHS Cambridgeshire and NHS Peterborough.***	***4***	***1***	***Councillor G Wilson (LD)***	***Louisa Bullivant*** ***Corporate Governance Manager*** ***01223 219477 Ext 19477*** ***louisa.bullivant@cpft.nhs.uk***
Cambridgeshire & Peterborough NHS Foundation Trust (CPFT) Liaison Group, ***The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its 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.***	***4***	***3***	***Councillor L Harford (Con)*** ***Councillor L Joseph (Con)*** ***Councillor S van de Ven (LD)***	***Kate Parker*** ***Head of Public Health Business Programmes*** ***01480 379561*** ***Kate.Parker@cambridgeshire.gov.uk***
Cambridgeshire School Improvement Board To improve educational outcomes in all schools by ensuring that all part of the school improvement system work together.	6	2	Councillor S Bywater (Con) Councillor C Richards (L)	Jonathan Lewis Service Director Education 01223 507165 Jonathan.Lewis@cambridgeshire.gov.uk

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Cambridge University Hospital NHS Foundation Trust (Addenbrooke's Hospital) Liaison Group ***The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its 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.***	***4***	***3***	***Councillor L Harford (C)*** ***Councillor L Jones (L)*** ***Councillor S van de Ven (LD)***	***Kate Parker*** ***Head of Public Health Business Programmes*** ***01480 379561*** ***Kate.Parker@cambridgeshire.gov.uk***
Carers Partnership Board Aims to maintain a strategic overview of the support provided by Family Carers across Cambridgeshire.	6	1	Councillor Kevin Cuffley (Con)	Graham Lewis Partnership Board Development Officer 0300 111 2301/07507 473813 graham@cambridgeshirealliance.org.uk
Centre 33 Centre 33 is a longstanding charity supporting young people in Cambridgeshire up to the age of 25 through a range of free and confidential services.	4	1	Councillor E Meschini (Lab)	Melanie Monaghan Chief Executive 01223 314763 help@centre33.org.uk
Chesterton Station Interchange (Cambridge North) The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	As required	1	Councillor I Manning (LD)	Adrian Shepherd Project Manager 01223 728110 Adrian.J.Shepherd@cambridgeshire.gov.uk

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Clay Farm Centre Advisory Group The Advisory Group will support and make recommendations to the Centre Manager and /or Partnership review meetings.	4	1	Councillor D Adey (LD)	Sally Roden, Neighbourhood Community DevelopmentManager, Cambridge City Council Sally.roden@cambridge.gov.uk 01223 457861 mobile 07920210957
Clinical Commissioning Group and Cambridgeshire Healthwatch Liaison Group ***The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its 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.***	***4***	***3***	***Councillor D Connor (C)*** ***Councillor L Harford (C)*** ***Councillor S van de Ven (LD)***	***Kate Parker*** ***Head of Public Health Business Programmes*** ***01480 379561*** ***Kate.Parker@cambridgeshire.gov.uk***
College of West Anglia Governing Body One up to sixteen members who appear to the Corporation to have the necessary skills to ensure that the Corporation carries out its functions under article 3 of the Articles of Government.	5	1	Councillor Lucy Nethsingha (LD) [4 year appointment]	Rochelle Woodcock Clerk to the Corporation College of West Anglia 01553 815288. Ext 2288 Rochelle.Woodcock@cwa.ac.uk

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County Advisory Group on Archives and Local Studies The County Archives and Local Studies Advisory Group exists to provide a forum for those who share an interest in the preservation and use of the documentary heritage of Cambridgeshire (including the historic county of Huntingdonshire).	2	4	Councillor T Sanderson (Ind) Councillor J Scutt (L) Councillor A Taylor (LD) Councillor P Topping (Con) Councillor N Harrison (LD) (substitute)	Alan Akeroyd Archives & Local Studies Manager 01223 699489 alan.akeroyd@cambridgeshire.gov.uk
Community Safety Partnerships Statutory Crime and Disorder Reduction Partnerships (CDRPs, also known as Community Safety Partnerships) were set up in each district council area of Cambridgeshire in 1998. The partnerships are responsible for carrying out a three yearly audit to review the levels and patterns of crime, disorder and misuse of drugs, to analyse and consult on the results, and subsequently develop a three-year strategy for tackling crime and disorder and combating the misuse of drugs. • Cambridge City • East Cambridgeshire • Fenland • Huntingdonshire • South Cambridgeshire (Crime Reduction Partnership)	3-4	1 on each	Councillor E Meschini (Lab) Councillor L Every (Con) Councillor J French (Con) Councillor A Costello (Con) Councillor L Joseph (Con)	Sarah Ferguson Service Director 01223 729099 Sarah.Ferguson@cambridgeshire.gov.uk Nicky Phillipson Head of Strategic Partnerships and Commissioning Cambridgeshire Office for the Police & Crime Commissioner 0300 333 3456 nicky.phillipson@cambs.pnn.police.uk

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Eastern Agri-Tech Programme Delivery Board Oversees the spending of the grant funding to develop the agritech industry in the corridor from Cambridge to Norwich	12	1	Councillor M Shuter (Con) Substitute – Councillor P Raynes (Con)	Martin Lutman Agri-Tech Programme Manager Greater Cambridge/Greater Peterborough Enterprise Partnership (LEP) 01480 277180 07715 408281 martin.lutman@gcgp.co.uk
East-West Rail Consortium Central Section Member Steering Group	To be agreed	1	Councillor I Bates (Con) Substitutes: Councillor D Adey (LD) Councillor T Wotherspoon (Con)	Bob Menzies Service Director for Strategy and Development 01223 715664 Bob.Menzies@cambridgeshire.gov.uk
Ely Southern Bypass Project Board To oversee the continued development and delivery of the scheme and provide a forum for key issues to be considered. The Board comprises stakeholders, local County and District Members and officers	4	2	Councillor A Bailey (Con) Councillor L Every (Con)	Brian Stinton Team Leader Highway Projects 01223 728330 Brian.stinton@cambridgeshire.gov.uk
England's Economic Heartland Strategic Alliance – Strategic Transport Forum	TBC	2	Councillor I Bates (Con) Councillor S Count (Con) Substitute: Councillor L Joseph (Con)	Graham Hughes Executive Director – Economy, Transport and Environment 01223 715660 graham.hughes@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Enterprise Zone Steering Group Established to review progress in the delivery of the Enterprise Zone at Alconbury with the developers, both urban and civic.	6	1	Councillor I Bates (Con) Substitute Councillor R Fuller (Con)	Graham Hughes Executive Director – Economy, Transport and Environment 01223 715660 graham.hughes@cambridgeshire.gov.uk
European Metal Recycling (EMR) Liaison Group (Snailwell) The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	As and when required. No more than twice a year. See note.	2	Councillor S Tierney (Con) No second appointment.	Peter Vasey Operations Manager EMR Newmarket 111 Fordham Road Snailwell NEWMARKET CB8 7ND 01638 720377 Peter.Vasey@emrgroup.com
F40 Group F40 (http://www.f40.org.uk/)represents a group of the poorest funded education authorities in England where government-set cash allocations for primary and secondary pupils are the lowest in the country.	TBC	1 +substitute	Councillor P Downes (LD) Substitute Councillor S Hoy (Con)	**To be confirmed**

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Fenland Association for Community Transport (FACT) Board The purpose of the Board of FACT is (a) to monitor current progress to date, to have an overview of current services and provide advice where required, suggest improvements, and (b) to steer FACT (and HACT, its parallel service in Huntingdonshire) towards meeting future need, including new initiatives, projects, potential sources of funding	4	1	Councillor M McGuire (Con)	Jo Philpott Fenland Association for Community Transport Ltd 01354 661234 www.fact-cambs.co.uk
Fenland Strategic Partnership The Fenland Strategic Partnership aims to make a difference by working better together across different sectors. The partnership has consulted extensively with the local community to identify the most important issues specific to Fenland.	2	1	Councillor S Count (Con)	Fenland District Council Fenland Hall County Road MARCH
Great Fen Steering Committee Steering Group to oversee and guide the development of the Great Fen Project.	6 approx	1 Observer status	Councillor A Costello (Con)	Kate Carver Great Fen Project Manager 01954 713513 Kate.Carver@wildlifebcn.org

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Greater Cambridgeshire Greater Peterborough Local Enterprise Partnership Management Board The LEP Board comprises 14 leaders of industry, education and the public sector. With a business Chair, six further business representatives from a range of locations and backgrounds, five local authority representatives, one education representative and one voluntary sector/ social enterprise representative.	9 approx	1	Councillor S Count (Con) *This single appointment is through competitive voting open to the leaders of the 13 councils involved. It is therefore not in Cambridgeshire County Council's gift to appoint a representative.*	Greater Cambridge Greater Peterborough Enterprise Partnership, The Incubator, Alconbury Weald Enterprise Campus, Alconbury Airfield, Huntingdon, Cambridgeshire, PE28 4WX
Growth Delivery Joint East Cambridgeshire District Council/Cambridgeshire County Council Member Liaison Group Members & officers from both authorities advising on growth and infrastructure issues for East Cambridgeshire including Section 106 & Community Infrastructure Levy funding.	4 but see note.	3	Councillor A Bailey (Con) Councillor I Bates (Con) Councillor L Every (Con) Substitute Councillor P Raynes (Con)	Juliet Richardson Head of Growth and Economy 01223 699868 juliet.richardson@cambridgeshire.gov.uk **Note.** This group is not currently meeting, but meetings may be resumed when the North Ely Development commences.
Hinchingbrooke Country Park Joint Group To monitor the operation of Hinchingbrooke Country Park.	2	1	Councillor A Costello (Con)	Melanie Sage Huntingdonshire District Council melanie.sage@huntingdonshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Huntingdonshire Area Partnership Meetings are chaired by Daniel Beckett, (daniel.beckett@godmanchesterbaptist.org) also attends them. Cambridgeshire County Council's Children and Young People's Area Partnerships' Manager is Gill Hanby (gill.hanby@cambridgeshire.gov.uk).	3-4	1	Councillor A Costello (Con)	Dawn Shepherd Business Support Officer St Ives Locality/Hunts SEND SS/ PA for Sarah Tabbitt Unit 7 The Meadow, Meadow Lane St Ives PE27 4LG dawn.shepherd@cambridgeshire.gov.uk 01480 699173
Huntingdon Association for Community Transport (HACT) Board The purpose of the Board of HACT is to (a) monitor current progress to date, to have an overview of current services and provide advice where required, suggest improvements, and (b) to steer HACT (and FACT, its parallel service in Fenland) towards meeting future need, including new initiatives, projects, potential sources of funding.	4	1	Councillor M McGuire (Con)	Jo Philpott Fenland Association for Community Transport Ltd Tel: 01354 661234 www.hact-cambs.co.uk
Huntingdon BID Board BID is the town management vehicle for Huntingdon. It is an arrangement where businesses in a defined area agree improvements they want to make, over and above what the public agencies have to do. The fund is ring fenced and used solely to deliver the agreed set of projects and activities voted on by the businesses within the BID area.	10	1	Councillor D Giles (Ind)	Sue Wing BID Huntingdon Manager 01480 450250 sue@bidhuntingdon.co.uk or info@bidhuntingdon.co.uk http://www.huntingdonfirst.co.uk/bid-huntingdon/

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Hunts Forum of Voluntary Organisations Hunts Forum of Voluntary Organisations is an umbrella body for voluntary and community groups in Huntingdonshire. It is an independent, non-profit making group formed from a coalition of local voluntary organizations and run by an elected committee of voluntary sector representatives. It supports voluntary and community organisations with information, advice and training.	4	2	Councillor S Criswell (Con) Councillor A Costello (Con)	Julie Farrow Hunts Forum of Voluntary Organisations 01480 420601 julie@huntsforum.org.uk
Huntingdonshire Growth & infrastructure Group Member/ officer & key infrastructure partners group (3 from CCC and 3 HDC) advising on infrastructure and growth issues for Huntingdonshire including Community Infrastructure Levy & Section 106 funding. The Group will also discuss the Huntingdonshire District Council Local Plan.	4	3	Councillor I Bates (Con) Chair E&E Committee Councillor R Fuller (Con) Councillor K Reynolds (Con)	Clara Kerr Planning Services Manager Huntingdonshire District Council clara.kerr@huntingdonshire.gov.uk
Huntingdonshire Health & Wellbeing Group	***4***	***1***	***Councillor J Wisson (Con)***	***Huntingdonshire District Council***
Joint Consultative Committee (Teachers) The Joint Committee provides an opportunity for trade unions to discuss matters of mutual interest in relation to educational policy for Cambridgeshire with elected members.	2	6	*(appointments postponed pending proposals on future arrangements)*	Richenda Greenhill Democratic Services Officer 01223 699171 richenda.greenhill@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Joint East Cambridgeshire District Council and Cambridgeshire County Council Member and Officer Steering Group for Planning and Transport The purpose of the Group is to discuss the development of the Transport Strategy for East Cambridgeshire and the Community Infrastructure Levy. The Group may in the future be needed to discuss the District Council's emerging Local Plan.	4	3	Councillor D Ambrose Smith (Con) Councillor I Bates (Con) Councillor J Schumann (Con)	Jack Eagle Lead Transport and Infrastructure Officer 01223 703209 Jack.Eagle@cambridgeshire.gov.uk
Joint Strategic Transport and Spatial Planning Group Provides co-ordination of spatial planning and integrated transport strategy for Cambridge City and South Cambridgeshire and an oversight of Growth Strategy.	4	3	Councillor L Harford (Con) Two place to be confirmed. *[no appointments made by Committee this year as has not met for several years.]*	Democratic Services Cambridge City Council PO Box 700 CAMBRIDGE CB1 0JH 01223 457169 Democratic.Services@cambridge.gov.uk
King's Dyke Project Board To oversee the continued development and delivery of the Scheme and provide a forum for key issues to be considered. The Board comprises stakeholders, local County and District Members.	4	1	Councillor D Connor (Con)	Brian Stinton Team Leader Highway Projects 01223 728330 Brian.stinton@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Learning Disabilities Partnership Board Membership of the Board comprises clients, service users, carers and staff from the County Council, social care, National Health Service and voluntary sector organisations	6	1	Councillor Adela Costello (Con)	Tracy Gurney Head of Learning Disability 01223 714692 tracy.gurney@cambridgeshire.gov.uk
LGSS Joint Overview and Scrutiny Working Group The role of the Joint Working Group (JWG) is to hold the LGSS Joint Committee to account for the discharge of its functions and to investigate issues associated with LGSS and make recommendations that seek to improve the quality of services delivered through LGSS.	3	3	Councillor M Howell (Con) Councillor D Jenkins (LD) Councillor J Whitehead (Lab)	James Edmunds Democratic Services Assistant Manager and Statutory Scrutiny Officer Northamptonshire County Council Room 144 County Hall Northampton NN1 1DN 01604 366053 jedmunds@northamptonshire.gov.uk
Local Access Forum Cambridgeshire County Council has established a Local Access Forum, as required under the Countryside Rights Of Way Act (CROW) 2000. The Forum represents the interests of everyone who lives and works in the countryside and is trying to strike a balance between conserving it, working it and helping people to enjoy it.	4	2	Councillor S King (Con) Councillor M Smith (Con)	Philip Clark Community Greenspaces Manager 01223 715686 philip.clark@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Local Safeguarding Children's Board LSCBs have been established by the government to ensure that organisations work together to safeguard children and promote their welfare. In Cambridgeshire this includes Social Care Services, Education, Health, the Police, Probation, Sports and Leisure Services, the Voluntary Sector, Youth Offending Team and Early Years Services.		1	Councillor S Bywater (Con)	Andy Jarvis, LSCB Business Manager 01480 373582 07827 084135 andy.jarvis@cambridgeshire.gov.uk
Making Assets Count Reference Group MAC is governed by a Programme Board, which has representation from all the main partners. A Members Reference Group steers and inputs to the programme, and is made up of Councillors and other key representatives from partner organisations.	Quarterly	1	Councillor S Count (C) Councillor M McGuire (C). Substitute. *(Membership is automatically leader with leader to nominate his or her sub)*	David Bethell Programme Manager – Making Assets Count (MAC) 01223 715687 david.bethell@cambridgeshire.gov.uk
Mental Health Governance Board Provide the strategic governance overview of the delegated Service as set out in the Section 75 Agreement.	Bi-monthly	1	Councillor D Wells (C)	Charlotte Wolstenholme Business Support Assistant Older People's Mental Health Team 01223 715940 charlotte.wolstenholme@cambridgeshire.gov.uk

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
Mobilising Local Energy Investment (MLEI) in Cambridgeshire and Peterborough – Project Advisory Board The Partnership includes Cambridgeshire County Council, Peterborough City Council, Cambridge City Council, South Cambridgeshire District Council, Huntingdonshire District Council and Cambridge University. The project provides capacity in the local authorities involved to pilot public sector projects to deliver energy-generating schemes and retrofit projects.		1	Councillor T Wotherspoon (Con)	Sheryl French Project Director, Energy Investment Unit (EIU) Cambridgeshire County Council 01223 728552 sheryl.french@cambridgeshire.gov.uk
Natural Cambridgeshire Natural Cambridgeshire consists of a broad range of local organisations, businesses and people whose aim is to bring about improvements in their local natural environment.	4	1	Councillor L Joseph (Con)	Phil Clark Community Green Spaces Manager 01223 715686 philip.clark@cambridgeshire.gov.uk
Needingworth Quarry Liaison Group The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	2	4	Councillor S Criswell (Con) Councillor P Hudson (Con) Councillor K Reynolds (Con) Councillor M Smith (Con) Substitute Councillor T Wotherspoon (Con)	Hilton Law Unit Manager – Cambridgeshire Hanson Aggregates hilton.law@hanson.com Direct dial – 01487 849026 07773 313194

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS
North West Anglia NHS Foundation Trust Council of Governors ***Peterborough & Stamford Hospitals NHS Foundation Trust and Hinchingbrooke Health Care Trust are due to merge. The implementation date for the enlarged organisation is 1 April 2017 and from that date, the Trust have a reformed Council of Governors that reflects the wider catchment of both organisations and which includes representation from Cambridgeshire County Council as a statutory partner required by the Health and Social Care Act 2012 and NHS Act 2006.***		***1***	***Councillor J Gowing (Con)***	***Jane Pigg*** ***Company Secretary*** ***North West Anglia Foundation Trust*** ***01733 677926 (direct dial)*** ***jane.pigg@pbh-tr.nhs.uk*** ***PA Jackie Bingley*** ***01733 677953 (Weds)*** ***01480 418755 (rest of week)***
North West Anglia NHS Foundation Trust (Hinchingbrooke Hospital) Liaison Group ***The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its 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.***	***4***	***2***	***Councillor Connor (Con)*** ***Councillor Harford (Con)***	***Kate Parker*** ***Head of Public Health Business Programmes*** ***01480 379561*** ***Kate.Parker@cambridgeshire.gov.uk***

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Older People's Partnership Board The OPPB brings together Older People, their representatives, the public and third sector, to work together to ensure the highest quality and best value services for older people across Cambridgeshire.	6	1	Councillor Anna Bailey (Con)	Leisha O'Brien Development Officer Older People's Partnership Board 0300 111 2301 leisha@cambridgeshirealliance.org.uk
Papworth Hospital NHS Foundation Trust Council of Governors ***NHS Foundation Trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital and mental health services. The County Council is represented on the Council as a nominated Governor.***	***4***	***1***	***Councillor S Ellington (SCDC representative on Health Committee)***	***Mary MacDonald*** ***Trust Secretary*** ***Mary.macdonald9@nhs.net*** ***Liz Bush*** ***Office Manager and EA to Chief Executive and Medical Director*** ***Direct Line 01480 364585*** ***liz.bush@nhs.net***
Peterborough and Cambridgeshire Community Covenant (Military) Board The Armed Forces Covenant Board aims to improve the outcomes and life choices of military personnel, reservists, their families and veterans living in Cambridgeshire and Peterborough. The Covenant Board also aims to enhance the relationship between civilian and military communities.	4	1	Councillor M McGuire (Con)	Sue Grace Director of Corporate and Customer Service 01223 715680 sue.grace@cambridgeshire.gov.uk

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Physical Disability and Sensory Impairment Partnership Board The Board comprises people with physical disability and sensory impairments, carers, local voluntary organisations and staff from the Adults Department within the County Council		1	Councillor Mark Howell (Con)	Linda Mynott Head of DisabilityServices 01480 373252 Linda.Mynott@cambridgeshire.gov.uk
RECAP Board RECAP (Recycling in Cambridgeshire & Peterborough) is a partnership of authorities across Cambridgeshire & Peterborough working together to provide excellent waste and recycling services to meet local needs. The RECAP Board is the Member level group of this partnership.	4	1	Councillor M Shuter (Con) Councillor W Hunt (Con) – substitute	Neil Slopes neil.slopes@huntingdonshire.gov.uk
St Neots Master Plan Steering Group		1	Councillor D Wells (Con) Councillor I Gardiner (Con) – substitute	Dan Thorp dan.thorp@cambridgeshire.peterborough-ca.gov.uk
Soham Station Project Board			Councillor B Hunt (Con) Councillor P Raynes (Con) Councillor J Schumann (Con)	Adrian Shepherd Project Manager Public Transport Projects 01223 728110 Adrian.J.Shepherd@cambridgeshire.gov.uk

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Total Transport Policy Member Steering Group (Formerly Cambridgeshire Future Transport (CFA) The purpose of the Group is to assist members in gaining a detailed understanding of some of the opportunities and challenges relating to transport, and of the possible consequences of decisions regarding service levels, fares, etc. The Total Transport project represents the next iteration of the CFT work. It is based on the simple idea that, on the ground, it doesn't make sense for different vehicles to collect neighbouring residents who are making similar journeys but for different purposes (healthcare, education, social care, etc). In rural areas in particular, integrating the provision of transport will allow scarce resource to be used more efficiently, so that the impact of reduced budgets can be softened.	2	8	Councillor A Bailey (Con) Councillor D Giles (Ind.) Councillor B Hunt (Con) Councillor D Jenkins (LD) Councillor L Joseph (Con) Councillor M McGuire (Con) Councillor S van de Ven (LD) Councillor J Whitehead (Lab) Substitute Cllr T Wotherspoon (Con)	Paul Nelson Interim Head of Passenger Transport Services 01223 715608 paul.nelson@cambridgeshire.gov.uk

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Transport Strategy for Fenland Member Steering Group The Transport Strategy for Fenland will form part of the suite of district-wide transport strategies which support the Local Transport Plan (LTP) for Cambridgeshire. It will seek to outline a transport vision and emerging transport infrastructure requirements for Fenland. It will develop the high level policies of the LTP and seek to highlight how they can be adapted for Fenland. It will also build on the existing Market Town Transport Strategies, and seek to integrate them into other existing transport plans. The role of the member steering group will be to advise on the strategy's development. This will include, but not be limited to, the strategy's vision, challenges, policies, as well as commenting on any consultation work that is undertaken.	4	2	Councillor D Connor (Con) Councillor J Gowing (Con)	James Barwise James.Barwise@cambridgeshire.gov.uk
Traffic Penalty Tribunal The Traffic Penalty Tribunal is an independent tribunal whose impartial, independent Adjudicators consider appeals by motorists and vehicle owners whose vehicles have been issued with penalty charges, removed or towed away or immobilised by a Council in England or Wales (excluding London) that enforces parking contraventions under the Traffic Management Act 2004.	As required	1 + substitute	Councillor M McGuire (Con) Substitute – Councillor A Taylor (LD)	Philip Hammer Parking Operations Manager 01223 727903 Philip.hammer@cambridgeshire.gov.uk

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Visit Cambridge and Beyond Destination Management Company (DMO) - Board of Directors This is a new delivery mechanism led by Cambridge City for the future provision of tourism services in Cambridge and the surrounding area. **Governance:** It is to be governed by a Board of Directors. **Representation**: The representation includes **one** councillor appointment to the full board from Cambridge City, South Cambridgeshire District Council (SCDC) and Cambridgeshire County Council.	12	1	Cllr M Shuter (Con)	Emma Thornton Head of Tourism and City Centre Management The Tourist Information Centre Peas Hill Cambridge CB2 3AD Tel 01223 457464 Mobile: 07712788550 emma.thornton@cambridge.gov.uk
Warboys Landfill Site Liaison Group The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	1-2	1	Councillor T Rogers (Con)	Mark Farren Managing Director, Woodford Waste Management Services Ltd 01487 824240 Mark.Farren@woodfordrecycling.co.uk
Waterbeach Waste Management Park Liaison Group The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	2-3	1	Councillor A Bradnam (LD)	Tim Marks Planning Manager Amey LG Ltd Direct line: 01223 815463 Mobile: 07917 731076 tim.marks@amey.co.uk

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Whitemoor Distribution Centre, March (Network Rail) The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	As required	1	Councillor S Count (Con)	Tony Masciopinto Site Manager Whitemoor Material Handling Depot 01733 559729 Tony.masciopinto@networkrail.co.uk
Wisbech Access Strategy Steering Group Growth Deal Funding of £1 million has been allocated to the Wisbech Access Strategy, with a further £10.5 million conditional upon delivery of an acceptable package of measures. The Steering Group, set up Oct 2016, will make recommendations to the Economy and Environment Committee and to Fenland District Council's Cabinet, who will in turn make recommendations to the LEP (Local Enterprise Partnership) Transport Body or Greater Cambridge Greater Peterborough LEP Board.	6	2	Councillor S Hoy (Con) Councillor S Tierney (Con)	Jack Eagle Lead Transport & Infrastructure Officer 01223 703269 jack.eagle@cambridgeshire.gov.uk
Woodhatch Farm Waste Recycling Site Liaison Group (Ellington) The aim of this group is to develop and maintain lines of communication between the site operator, the County Council & other regulatory bodies and the local community in order that matters of concern can be resolved in a timely and non-confrontational manner.	As required	2	Councillor P Downes (LD) Councillor I Gardener (Con)	Kelly Howe Planning Assistant Mick George Ltd 07824 991151 Kellyh@mickgeorge.co.uk