HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 12 January 2017

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

14:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1 Apologies for absence and declarations of interest

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

2 Minutes – 15th December 2016 and Action Log

3 Petitions

4 Co-option of a Huntingdonshire District Councillor as a non-voting member of the Committee

KEY DECISIONS

5 Re-commissioning the Healthy Child Programme – Proposed Section 75 Agreement for Health Visiting, Family Nurse Partnership, and School Nursing **5 - 16**

OTHER DECISIONS

6	**Finance and Performance Report – November 2016**	**17 - 56**
7	**System Wide Review of Health Outcomes in Cambridgeshire**	**57 - 80**
8	**Public Health Risk Register Update**	**81 - 96**

SCRUTINY ITEMS

9	**East of England Ambulance Trust (EEAST) – Care Quality Commission Inspection Local Delivery**	
10	**Sustainability and Transformation Plan**	
11	**Cambridge GP Out of Hours Service and Emergency Department co-location**	

OTHER DECISIONS

12	**Health Committee Training Plan**	**97 - 98**
13	**Appointments to internal Advisory Groups and panels, and Partnership Liaison and Advisory Group**	
14	**Health Committee Agenda Plan**	**99 - 104**

The Health Committee comprises the following members:

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

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

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

Clerk Name: Ruth Yule

Clerk Telephone: 01223 699184

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

The County Council is committed to open government and members of the public are welcome to attend Committee meetings. It supports the principle of transparency and encourages filming, recording and taking photographs at meetings that are open to the public. It also welcomes the use of social networking and micro-blogging websites (such as Twitter and Facebook) to communicate with people about what is happening, as it happens. These arrangements operate in accordance with a protocol agreed by the Chairman of the Council and political Group Leaders which can be accessed via the following link or made available on request: http://tinyurl.com/ccc-film-record.

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 Constitution http://tinyurl.com/cambs-constitution.

The Council does not guarantee the provision of car parking on the Shire Hall site and you will need to use nearby public car parks http://tinyurl.com/ccc-carpark or public transport

Agenda Item No: 5

RE-COMMISSIONING THE HEALTHY CHILD PROGRAMME - Proposed Section 75 Agreement for Health Visiting, Family Nurse Partnership, and School nursing

To: **HEALTH COMMITTEE**

Meeting Date: **12 January 2017**

From: **DIRECTOR OF PUBLIC HEALTH**

Electoral division(s): **ALL**

Forward Plan ref: 2017/008 *Key decision:* **Yes**

Purpose: **What is the Committee being asked to consider?**
To agree development of a Section 75 agreement to replace the existing Section 75 for School Nursing, and to incorporate Health Visiting and the Family Nurse Partnership into the same arrangement.

Recommendation: **It is recommended that the Committee:-**

a) Confirm its approval for the development and implementation of a new Section 75 Agreement for School Nursing, Health Visiting and Family Nurse Partnership services until March 2019

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

	Officer contact:
Name:	Raj Lakshman/Janet Dullaghan
Post:	Consultant in Public Health Medicine/Head of Commissioning, Child Health and Well-Being
Email:	raj.lakshman@cambridgeshire.gov.uk/ janet.dullaghan@peterborough.gov.uk
T:	01223 715633/ 0173863730

1. BACKGROUND

1.1 In April 2013, commissioning arrangements for school nursing transferred from the NHS to Cambridgeshire County Council and from 1 September 2014, the Local Authority entered into a Section 75 agreement with Cambridgeshire Community Services to deliver the school nursing service across Cambridgeshire. In October 2015, the commissioning arrangements for the Health Visiting Service and the Family Nurse Partnership (FNP) changed, and the responsibility for commissioning these services was transferred from NHS England to the Local Authority. At this time the existing NHS contract was novated to Cambridgeshire County Council (as commissioner) and Cambridgeshire Community Services (as provider) to deliver the Health Visiting and Family Nurse Partnership services across Cambridgeshire.

1.2 Both agreements are due to expire on 31 March 2017, and arrangements need to be put in place to continue to operate the services, which constitute the Healthy Child Programme (0-19) as outlined in brief in Appendix 1, whilst the longer term integration of 0-19 years provision is finalised:

2. MAIN ISSUES

Current position

2.1 Savings of £340 000 had been identified from the 2015/16 and 2016/17 budget from health visiting and FNP service. However, an additional £60 000 is to be invested in the school nursing service to provide school nursing support in Cambridgeshire's special schools. Therefore the 2017/18 budget position is as follows, and the 2018/19 budget will be agreed as part of the Council's Business Planning process:

2017/18		
Service	**Provider**	**Total Contract Value**
Health Visiting and Family Nurse Partnership	Cambridgeshire Community Services	£7 253 199
School Nursing	Cambridgeshire Community Services	£1 446 600

3. What is proposed?

3.1 Cambridgeshire County Council has been working closely with Peterborough City Council and the Cambridgeshire and Peterborough Clinical Commissioning Group to bring together a countywide age 0 – 19 service. The aim is to develop a streamlined service, based on local population needs, which reduces duplication in service delivery.

3.2 This involves bringing together a range of existing contracts across the three commissioning organisations which equates to more than 20 contracts and total contract value exceeding £50m. It is acknowledged that delivering a project of this size and complexity will need careful planning and time required to ensure that the appropriate specifications are drawn up as well as robust procurements routes confirmed.

3.3 The existing Section 75 agreement for school nursing services and the contract for the health visiting and FNP services expire on 31 March 2017, which is before the development of the streamlined service will be finalised. In order to ensure the ongoing service provision, it is proposed that all these services are continued under a Section 75 agreement between Cambridgeshire County Council and Cambridgeshire Community Services.

4. ALIGNMENT WITH CORPORATE PRIORITIES

4.1 Developing the local economy for the benefit of all

Giving children the best start in life will ensure they reach their full potential and contribute to society and the economy.

4.2 Helping people live healthy and independent lives

The health visiting, family nurse partnership and school nursing services support all families to live healthy lives, and promote independence

4.3 Supporting and protecting vulnerable people

The health visiting, family nurse partnership and school nursing services support and protect vulnerable families. Section 1 of this report outlines key aspects of the service which includes enhanced services for vulnerable people and safeguarding responsibilities.

5. SIGNIFICANT IMPLICATIONS

Resource Implications
There are no significant implications within this category.

Statutory, Legal and Risk
An agreement under section 75 of the NHS Act 2006 enables the local authority to enter into an arrangement with a prescribed body in the NHS in relation to prescribed health-related local authority functions if it is likely to lead to an improvement in the way in which the services are provided; this includes the exercise by an NHS body of those health related local authority functions in conjunction with the NHS body's prescribed functions. Users of the service will be consulted before the arrangement is entered into.

The arrangement differs from a procurement which would need to be carried out in accordance with the Public Contracts Regulations 2015 because it is a joint working arrangement whereby the NHS carries out the functions of the local authority on Cambridgeshire County Council's behalf in conjunction with its own NHS functions. There is a corresponding transfer of the budget to the NHS, rather than the payment for a service.

If a section 75 agreement is not put in place, there is a risk of having a period without local authority funded Health Visiting, FNP and School Nursing services.

Equality and Diversity
A Community Impact Assessment has been completed and is summarised in Appendix 2.

Engagement and Communications
The service provider, Cambridgeshire Community services (CCS) engages with stakeholders as an ongoing part of their service development proposals. Information on

this proposal was provided for the CCS newsletter. The impact of the transformation of Children's services in the Council and the NHS as part of the Sustainability and Transformation Plan (including transformation of mental health services) will be kept under review. Service user views will be taken into consideration during this wider consultation.

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

Public Health
This report has been compiled by public health and all public health significant implications are addressed in the report.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Clare Andrews
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Catherine Wilson
Are there any Equality and Diversity implications?	Community impact assessment has been completed Name of Officer: Dr Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes : 7 December 2016 Name of Officer: Matthew Hall
Are there any Localism and Local Member involvement issues?	No Name of Officer: Dr Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Dr Raj Lakshman

Source Documents	Location
Healthy Child Programme Commissioning Guides:	https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning
Health Visitor service specification:	https://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf
Maximising the school nursing team contribution to the public health of school-aged children. Guidance to support the commissioning of public health provision for school aged children 5-19.	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf
Health Committee Review of draft Revenue Business Planning Proposals for 2017/18 to 2021/22 (Health Committee December 2016)	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/524/Committee/6/Default.aspx

APPENDIX 1: The Healthy Child Programme 0-19

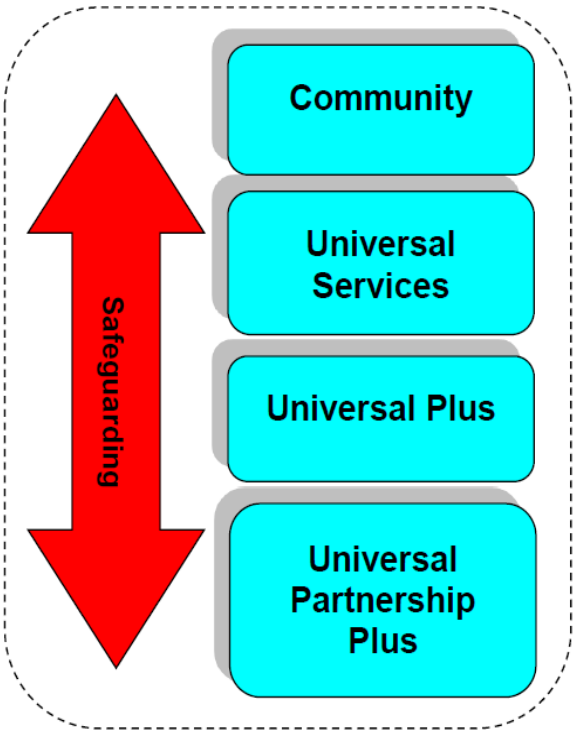
Healthy Child Programme (0-19)

1.1 The foundations for virtually every aspect of human development – physical, intellectual and emotional – are established in early childhood. In 2009, the Department of Health set out an evidence-based programme of best practice, the Healthy Child Programme, with the ambition of making everywhere as good as the best by developing improvements in health and wellbeing for children and young people. The public health commissioned services included are Health Visiting (0-5), Family Nurse Partnership (for vulnerable teenagers), School Nursing (5-19)

1.2 The Healthy Child Programme provides a framework to support collaborative work and more integrated delivery. The Programme aims to:

- Help parents develop and sustain a strong bond with children
- Encourage care that keeps children healthy and safe
- Protect children from serious disease, through screening and immunisation
- Reduce childhood obesity by promoting healthy eating and physical activity
- Identify health issues early, so support can be provided in a timely manner
- Make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five.

1.3 The Healthy Child programme is a universal-progressive, needs based service delivered at four levels: Community; Universal Services; Universal Plus; and Universal Partnership Plus.



Your Community describes a range of health services (including GP and community services) for children and young people and their families. Health visitors and school nurses will be involved in developing and providing these and making sure you know about them.
Universal Services from your health visitor and school nursing team provides the Healthy Child Programme to ensure a healthy start for every child. This includes promoting good health, for example through education and health checks and protecting health eg by immunisations and identifying problems early
Universal Plus provides a swift response from your health visitor and school nurse service when you need specific expert help which might be identified through a health check or through providing accessible services that you can go to with concerns. This could include managing long-term health issues and additional health needs, reassurance about a health worry, advice on sexual health, and support for emotional and mental health wellbeing.
Universal Partnership Plus delivers on-going support by your health visitor and school nursing team as part of a range of local services working together and with you/your family to deal with more complex problems over a longer period of time

Health Visiting Service (0-5)

1.4 The Health Visiting service consists of a workforce of specialist community public health nurses and teams who provide expert information, assessments and interventions for babies, children and families including first time mothers and fathers and families with complex needs. Health visitors (HVs) help to empower parents to make decisions that affect their family's health and wellbeing and their role is central to improving the health outcomes of populations and reducing inequalities.

1.5 The Health Visiting service lead on the delivery of services for babies and children 0 – 5 years and their families to improve public health outcomes. The six high-impact areas for the service are:

- Transition to parenthood and the early years (0-5)
- Maternal mental health
- Breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition and physical activity
- Managing minor illness and reducing hospital attendance and admission
- Health, wellbeing and development of the child age 2 – 2.5 year old review (integrated review) and support to be 'ready for school'.

1.6 The Health Visiting service is a critical service in supporting pregnant women, babies and young children (0 – 5 years) and their families, supporting them in the early years of the child's development. The service ensures that any issues are identified as early as possible and appropriate support provided, reducing the need for later more specialist intervention. The health visitors deliver 5 mandated visits for all families – an antenatal health promoting visit, a new baby review, a 6 – 8 week assessment, a 12 month visit and a 2 – 2½ year review.

Family Nurse Partnership (FNP)

1.7 The FNP is an in-depth, structured, home visiting programme, aimed at first time parents under the age of 19 at time of conception. The FNP aims to improve pregnancy outcomes by supporting mothers-to-be to make informed choices about healthy pregnancy behaviours, as well as improving the future life course of young mothers, by supporting them to make changes to their lives and providing them and their babies with a better future.

1.8 The FNP programme consists of structured home visits from early on in pregnancy until the child is two, delivered by family nurses. The programme of visits as specified by FNP includes:

- 1 per week first month
- Every other week during pregnancy
- 1 per week first 6 weeks after delivery
- Every other week until 21 months
- Once a month until age 2

1.9 Visits last approximately one hour and cover the following domains:

- Personal health – women's health practices and mental health
- Environmental health – adequacy of home and neighbourhood
- Life course development – women's future goals
- Maternal role – skills and knowledge to promote health and development of their child
- Family and friends – helping to deal with relationship issues and enhance social support
- Health and human services – linking to other services

1.10 In Cambridgeshire the FNP service does not have the capacity to work with all teenage mothers and from April 2017 will be offering a more targeted approach, focusing on those meeting specified high risk criteria. The FNP will be the core offer to those meeting the eligibility criteria.

School Nursing Service (5-19)

1.11 The School Nursing Service is a workforce of specialist public health nurses who provide child-centred expert advice, support and interventions to school age children (5-19) and their families. The School Nursing team provides a young people focused service either in schools, the family home or a clinic environment between the hours of 09.00 – 17.00, Monday to Friday.

1.12 The school nursing service provides a range of activities that include:

Health Promotion:

- Promoting health and wellbeing
- Supporting accident prevention and reducing risk taking behaviours
- Contributing to Personal, Social and Health Education (PSHE)
- Offering information, signposting and appropriate guidance

Identifying individual and population health needs:

- Assessing the child's, young person's and family's strengths, needs and risks
- Assessing physical health, growth and development and immunisation status
- Obesity prevention, interventions and referrals working with the National Child Measurement Programme (delivered by a different provider- 'Everyone Health' in Cambridgeshire)
- Developing school health profiles and working with school health improvement services to address needs
- Identification of health needs through individual health needs assessment
- Providing children, young people and parents/carers the opportunity to discuss their health concerns and aspirations
- Identifying any mental or emotional health issues; providing early intervention, timely referral and support to school to manage need
- Ensuring that appropriate support is available to meet health needs such as speech, language and communication

The **Children and Families Act (2014)** provides that governing bodies must make arrangements for supporting pupils at school with medical conditions. The school nursing service will contribute to identifying support to schools as they take on this new statutory responsibility

Health protection:

- Identifying and reducing barriers to high coverage for all childhood immunisations in order to prevent serious communicable disease, particularly targeted at vulnerable groups
- Supporting school-based screening programmes e.g. chlamydia screening
- Emergency planning, including outbreak response in schools

Safeguarding:

- Providing universal public health interventions and preventative measures to reduce risk
- Working in partnership with other key stakeholders to safeguard and protect children and young people
- Working collaboratively to support children and young people where there are identified health needs, or where they are in the child protection system, providing therapeutic public health interventions for the child and family and referring children and families to specialist medical support where appropriate
- Working together to provide support for vulnerable groups, including Children in Care, young carers, children with disabilities, NEET and young offenders
- Working collaboratively to ensure there is clarity regarding respective roles and responsibilities of appropriate health as identified within local protocols and policies

in line with 'Working Together to Safeguard Children' and using the Safeguarding Pathway for health visitors and school nurses to provide clarity on roles and responsibilities

- Supporting safeguarding and access and contribution to targeted family support, including active engagement in the Together for Families (Troubled Families) Programme

Supporting children, young people and families:

- Ensuring that children, young people and families receive support that is appropriate for their needs with the most vulnerable families receiving interventions and coordinated integrated support, including support for Children in Care, children with disabilities, NEET (not in employment, education or training) and young offenders
- Supporting the development and strengthening of key interfaces across organisations, practitioners, children, young people and families, and their local communities
- Ensuring children not in employment, education or training, or children educated at home receive the universal offer

APPENDIX 2: Community Impact Assessment

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Dr Raj Lakshman Job Title: Consultant in Public Health Medicine Contact details: raj.lakshman@cambridgeshire.gov.uk ..... Date completed: 23rd December 2017 ..... Date approved: .....
Service / Document / Function being assessed		
Recommissioning the Healthy Child Programme 0-19: Health Visiting (HV), Family Nurse Partnership (FNP), School Nursing (SN)		
Business Plan Proposal Number (if relevant)	ER 6-012	

Aims and Objectives of Service / Document / Function

In April 2013, commissioning arrangements for school nursing transferred from the NHS to Cambridgeshire County Council and from 1 September 2014, the Local Authority entered into a Section 75 agreement with Cambridgeshire Community Services to deliver the school nursing service across Cambridgeshire. In October 2015, the commissioning arrangements for the Health Visiting Service and the Family Nurse Partnership (FNP) changed and the responsibility for commissioning these services was transferred from NHS England to the Local Authority. At this time the existing NHS contract was novated to Cambridgeshire County Council (as commissioner) and Cambridgeshire Community Services (as provider) to deliver the Health Visiting and Family Nurse Partnership services across Cambridgeshire.

Both agreements are due to expire on 31 March 2017, and arrangements need to be put in place to continue to operate the services, which constitute the Healthy Child Programme (0-19), whilst a the longer term integration of 0-19 years provision as part of the Cambridgeshire & Peterborough Sustainability & Transformation Plan (STP) is finalized.

What is changing?
Where relevant, consider including: how the service/document/function will be implemented; what factors could contribute to or detract from this; how many people with protected characteristics are potentially impacted upon; who the main stakeholders are; and, details of any previous or planned consultation/engagement to inform the CIA.

The Health Visiting and FNP contract is being changed to a section 75 agreement with the same provider, Cambridgeshire Community Services (CCS) and we have been working closely with the provider to agree the Service Specifications, Outcomes and Key Performance Indicators. Savings of £340 000 had been identified from the 2015/16 and 2016/17 budget from health visiting and FNP service. A new Section 75 agreement will be drawn up for the school nursing service and an additional £60 000 is to be invested in the school nursing service to provide school nursing support in Cambridgeshire's special schools. Therefore the 2017/18 budget position is as follows: Health Visiting and FNP £7 253 199 and school nursing £1 446 600. A Community Impact Assessment for the savings, and details of service changes, were presented in the 2017-2021 Public Health Business Planning paper which was approved by Health Committee in December 2016.

CCS are talking with head teachers of schools (stakeholders) regarding changes to the school nursing service. Discussions are ongoing between CFA, CCS and Public Health to facilitate better integration.
The Cambridgeshire & Peterborough STP refers to an integrated child health service (the future model) http://www.fitforfuture.org.uk/what-were-doing/publications/ .

This recommissioning is an interim arrangement to provide continuity of care till the future model is consulted on and agreed.

Who is involved in this impact assessment?
E.g. Council officers, partners, service users and community representatives.

Cambridgeshire County Council, Peterborough City Council and Cambridgeshire & Peterborough CCG through the Joint Commissioning Unit and Cambridgeshire Community Services NHS Trust (current service provider).

What will the impact be?

Tick to indicate if the expected impact on each of the following protected characteristics is positive, neutral or negative.

Impact	Positive	Neutral	Negative
Age		X	
Disability	X		
Gender reassignment		X	
Marriage and civil partnership		X	
Pregnancy and maternity		X	
Race		X	

Impact	Positive	Neutral	Negative
Religion or belief		X	
Sex		X	
Sexual orientation		X	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation		X	
Deprivation		X	

For each of the above characteristics where there is a positive, negative and / or neutral impact, please provide details, including evidence for this view. Consider whether the impact could be disproportionate on any particular protected characteristic. Describe the actions that will be taken to mitigate any negative impacts and how the actions are to be recorded and monitored. Describe any issues that may need to be addressed or opportunities that may arise.

Positive Impact
A new Universal Offer to 6 Special Schools in Cambridgeshire There will be an introduction of digital technology in some areas of the service, i.e. Chat Health. This will improve the accessibility of the service for a greater number of young people An enhanced, equitable and consistent offer to primary schools Closer working relationships with Children Centres, Localities and Emotional Health & Wellbeing (Early Help) will enhance synergy and maximise resource usage
Negative Impact
If the HV, FNP and SN services were not recommissioned to ensure continuity, there would be a gap in service provision for an essential component of services for children, young people and families in Cambridgeshire. It would also lead to the loss of a skilled workforce. However this proposal avoids this potential negative impact.
Neutral Impact
The status quo will be maintained across some of the service while work is progressed towards a new fully integrated model for Children's services.
Issues or Opportunities that may need to be addressed
Service improvement / redesign opportunities will be taken.

Community Cohesion

If it is relevant to your area you should also consider the impact on community cohesion.

Providing integrated Children, Young People and Families Health service across the Council has the potential to improve community cohesion.

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	23.12.16	First Draft	Raj Lakshman
2	3.1.17	Second draft	Raj Lakshman/Liz Robin

Agenda Item No: 6

FINANCE AND PERFORMANCE REPORT – November 2016

To:	**Health Committee**
Meeting Date:	**12 January 2017**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the November 2016 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of November 2016.**
Recommendation:	**The Committee is asked to review and comment on the report**

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

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE NOVEMBER 2016 FINANCE & PERFORMANCE REPORT

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

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

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

A forecast underspend of £115k has been identified across the Public Health budgets. Further detail can be found in Annex A.

2.3 The Public Health Service Performance Management Framework for October 2016 is contained within the report. Of the thirty five Health Committee performance indicators, eight are red, six are amber, fourteen are green and six have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Statutory, Risk and Legal Implications

4.2.1 There are no significant implications for this priority

4.3 Equality and Diversity Implications

4.3.1 There are no significant implications within this category.

4.4 Engagement and Consultation Implications

4.4.1 There are no significant implications within this category.

4.5 Localism and Local Member Involvement

4.5.1 There are no significant implications within this category.

4.6 Public Health Implications

4.6.1 There are no significant implications within this category.

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

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

From: Martin Wade

Tel.: 01223 699733

Date: 9 December 2016

Public Health Directorate

Finance and Performance Report – November 2016

1 SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
October (No. of indicators)	8	6	14	6	34

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Oct) £000	Directorate	Current Budget for 2016/17 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Nov) £000	Forecast Variance - Outturn (Nov) %
-190	Health Improvement	8,459	-163	-3.6%	-160	-1.9%
0	Children Health	9,276	43	0.8%	0	0%
0	Adult Health & Well Being	916	-44	-12.8%	0	0%
0	Intelligence Team	13	-0	-1.0%	0	0%
0	Health Protection	6	0	8.5%	0	0%
0	Programme Team	136	-41	-44.5%	-26	-19.1%
0	Public Health Directorate	2,395	68	4.2%	71	3.0%
-190	**Total Expenditure**	**21,202**	**-136**	**-1.1%**	**-115**	**-0.5%**
0	Public Health Grant	-20,457	-1,834	-12.0%	0	0%
0	Other Income	-343	178	28.8%	0	0%
0	**Total Income**	**-20,776**	**-1,656**	**-10.6%**	0	0%
0	Planned drawdown from Public Health Reserves	-244	0	0%	0	0%
-190	**Net Total**	**182**	**-1,792**	**-51.0**	**-115**	**-63.3%**

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

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

2.2 Significant Issues

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

Expected forecast outturn variances have been added to Health Improvement (-£160k), Programme Team (-£26k) and Public Health Directorate (£71k) this month, bringing the Directorate to an overall expected position of £-115k underspent.

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

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

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

- Performance of contract sexual health and contraception service remains good with all monthly key performance indicators achieved.
- Smoking cessation performance, whilst still a red indicator has improved with 101% of the 4 week quitter monthly target achieved compared with 85% the previous month.
- Performance of the Integrated Lifestyles and Weight Management contract remains mixed. From the 14 KPIs that are reported on this month there are 7 green KPIs which includes the number of healthy eating groups moving from amber to green and both falls prevention indicators are green. There are 3 amber KPIs and 5 red KPIs (some improvements expected in the next few months to reflect increased activity).
- Health Visiting and School Nursing data is reported quarterly. Quarter 2 (Jul-Sep) data is presented here so there are no changes to these indicators from last month's report.

4.2 Health Committee Priorities (Appendix 7)

- Smoking cessation performance in the most deprived 20% of areas in Cambridgeshire stands at 86% of the monthly target this is in line with the remainder of the county where performance was 85% of target.
- The contract with the external provider has finished and final data for front line staff taking part in commissioned training on Mental Health First Aid is available with MHFA (2 day course) attendance 398 and MHFA lite (1/2 day course) attendance 216.
- Since the last quarter reporting a further 4 secondary schools and 8 primary schools have attended funded mental health training.

4.3 Health Scrutiny Indicators (Appendix 8)

- Both Cambridge University Hospital Foundation Trust (CUHFT) & Hinchingbrooke Health Care Trust are indicating an increase in Delayed Transfers of Care compared with last few months. This is an early indication of winter pressures on our acute hospital trusts and health & social care system.

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

Quarter 2 reports for the Public Health MOU services are complete and included in Appendix 9. Spend is in line with expectations with no significant end of year variances currently predicted. A more detailed update will be provided when Quarter 3 data is available.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Oct) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of Nov £'000	Actual to end of Nov £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Nov) £'000	Forecast Variance Outturn (Nov) %
	Health Improvement							
0	Sexual Health STI testing & treatment	4,074	2,333	2,305	-28	-1.20%	-30	-0.74%
0	Sexual Health Contraception	1,170	587	510	-77	-13.11%	-50	-4.27%
0	National Child Measurement Programme	0	0	0	0	0.00%	0	0.00%
0	Sexual Health Services Advice Prevention and Promotion	152	102	104	2	2.27%	0	0.00%
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Obesity Children	82	55	41	-14	-25.63%	0	0.00%
0	Physical Activity Adults	84	56	63	7	12.13%	0	0.00%
0	Healthy Lifestyles	1,605	959	909	-50	-5.22%	0	0.00%
0	Physical Activity Children	0	0	0	0	0.00%	0	0.00%
-190	Stop Smoking Service & Intervention	907	189	115	-74	-39.26%	-80	-8.82%
0	Wider Tobacco Control	31	21	20	-1	-2.57%	0	0.00%
0	General Prevention Activities	272	183	265	82	44.65%	0	0.00%
0	Falls Prevention	80	54	46	-8	-15.44%	0	0.00%
0	Dental Health	2	1	0	-1	-100.00%	0	0.00%
-190	**Health Improvement Total**	**8,459**	**4,542**	**4,379**	**-163**	**-3.58%**	**-160**	**-1.89%**
	Children Health							
0	Children 0-5 PH Programme	7,531	4,350	4,399	49	1.13%	0	0.00%
0	Children 5-19 PH Programme	1,745	1,174	1,168	-6	-0.55%	0	0.00%
0	**Children Health Total**	**9,276**	**5,524**	**5,567**	**43**	**0.77%**	**0**	**0.00%**
	Adult Health & Wellbeing							
0	NHS Health Checks Programme	716	209	257	48	23.01%	0	0.00%
0	Public Mental Health	164	110	43	-67	-61.12%	0	0.00%
0	Comm Safety, Violence Prevention	37	25	0	-25	-100.00%	0	0.00%
0	**Adult Health & Wellbeing Total**	**916**	**344**	**300**	**-44**	**-12.78%**	**0**	**0.00%**
	Intelligence Team							
0	Public Health Advice	13	9	9	-0	-0.96%	0	0.00%
0	Info & Intelligence Misc	0	0	0	0	0.00%	0	0.00%
0	**Intelligence Team Total**	**13**	**9**	**9**	**-0**	**-0.96%**	**0**	**0.00%**
	Health Protection							
0	LA Role in Health Protection	0	0	4	4	0.00%	0	0.00%
0	Health Protection Emergency Planning	6	4	0	-4	-100.00%	0	0.00%
0	**Health Protection Total**	**6**	**4**	**4**	**0**	**8.53%**	**0**	**0.00%**

Forecast Variance Outturn (Oct) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of Nov £'000	Actual to end of Nov £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Nov) *£'000*	Forecast Variance Outturn (Nov)
	Programme Team							
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking no pay staff costs	31	21	9	-12	-57.17%	0	0.00%
0	General Prev, Traveller, Lifestyle	105	71	42	-29	-40.70%	-26	-24.78%
0	**Programme Team Total**	**136**	**92**	**51**	**-41**	**-44.46%**	**-26**	**-19.10%**
	Public Health Directorate							
0	Health Improvement	633	422	477	55	13.03%	71	11.22%
0	Public Health Advice	742	495	494	-1	-0.13%	0	0.00%
0	Health Protection	182	121	156	35	28.57%	0	0.00%
0	Programme Team	635	423	434	11	2.52%	0	0.00%
0	Childrens Health	76	51	46	-5	-9.21%	0	0.00%
0	Comm Safety, Violence Prevention	72	48	59	11	22.92%	0	0.00%
0	Public Mental Health	55	37	35	-2	-4.55%	0	0.00%
0	**Public Health Directorate total**	**2,395**	**1,633**	**1,701**	**68**	**4.17%**	**71**	**2.96%**
-190	**Total Expenditure before Carry forward**	**21,202**	**12,148**	**12,011**	**-136**	**-1.12%**	**-115**	**-0.54%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0.00%**
	Funded By							
0	Public Health Grant	-20,457	-15,343	-17,177	-1,834	-11.95%	**0**	0.00%
0	S75 Agreement NHSE - HIV	-144	0	144	144	0.00%	**0**	0.00%
0	Other Income	-175	-118	-84	34	28.81%	**0**	0.00%
	Drawdown From Reserves	-244	-202	-202	0	0.00%	**0**	0.00%
0	**Income Total**	**-21,020**	**-15,663**	**-17,319**	**-1,656**	**-10.57%**	**0**	**0.00%**
-190	**Net Total**	**182**	**-3,515**	**-5,308**	**-1,792**	**-50.98%**	**-115**	**-63.26%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Current Budget for 2016/17 £'000	Current Variance £'000	Current Variance %	Forecast Variance - Outturn £'000	Forecast Variance - Outturn %
Health Improvement	**8,459**	**-163**	**-3.6%**	**-160**	**-1.9%**
The overall forecast underspend of £160k against health improvement is a combination of £80k on stop smoking services and £80k on sexual health. The underspend on smoking represents the decreased payments to GPs for their provision of stop smoking services. This activity is being picked up by the core CAMQUIT Service. Secondly the Clinical Commissioning Group(CCG) re-charges us for the GP prescriptions for medication to help support people to quit smoking. We have not yet received all the up to date invoices for this from the CCG The underspend on sexual health reflects the continued decrease in the uptake of the online Chlamydia Screening Programme and secondly the Public Health England laboratory services that we commission for the Chlamydia Screening Programme has not yet invoiced the Local Authority at all this year. Invoices have been requested.					

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

Awarding Body : DofH

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

APPENDIX 4 – Virements and Budget Reconciliation

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

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2016	2016/17		Forecast Balance at 31 March 2017	Notes
		Movements in 2016/17	Balance at 30 Nov 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,138**	155	983	**638**	**Estimated use of reserves to fund part year 16-17 savings not made, redundancy costs and one off funding agreed for previously MOU funded activity. (Estimated £500k pending review of commitments)**
subtotal	**1,138**	**0**	**983**	**638**	
Equipment Reserves					
Equipment Replacement Reserve	0	0	0	0	
subtotal	**0**	**0**	**0**	**0**	
Other Earmarked Funds					
Healthy Fenland Fund	500	0	500	400	**Anticipated spend £100k per year over 5 years.**
Falls Prevention Fund	400	0	400	200	
NHS Healthchecks programme	270	0	270	170	**Estimated spend, depending on timescale of developments.**
Implementation of Cambridgeshire Public Health Integration Strategy	850	0	850	770	**Anticipated spend on PH Reference Group projects during 2016-17.**
Other Reserves (<£50k)	0	0	0	0	
subtotal	**2,020**	**0**	**2,020**	**1.445**	
TOTAL	**3,158**	**0**	**3,003**	**2,083**	

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

Fund Description	Balance at 31 March 2016	2016/17		Forecast Balance at 31 March 2017	Notes
		Movements in 2016/17	Balance at 30 Nov 2016		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	158	-47	111	111	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**158**	**-24**	**144**	**144**	

APPENDIX 6 PERFORMANCE

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

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

Measures										
Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	98%	98%	G	98%	98%	98%	↔	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	93%	93%	G	93%	80%	93%	↔	
Dhiverse : % of people newly diagnosed offered and accepted appointments	100%	100%	100%	100%	G	100%	100%	100%	↔	
Access to contraception and family planning (CCS)	7200	4200	6103	145%	G	145%	600	145%	↔	
Number of Health Checks completed	18,000	9,000	7783	87%	R	n/a	4500	87%	↔	• The comprehensive Improvement Programme is continuing this year. Intelligence from the commissioned social marketing work clearly indicates a lack of awareness in the population of Health Checks. Actual health check numbers compare reasonably well to other areas but the issue is the conversion rate which is attributed to the poor public understanding of the Programme. • The introduction of new software into practices has been delayed due to the extensive work that needs to be undertaken to introduce it into the 77 practices. This involves close working with the Clinical Commissioning Group, Information Governance and LGSS. Its purpose is to support the invitation system and to ensure that the data collection system is comprehensive. • Other activities include staff training from a commissioned Coronary Heart Disease specialist nurse. Currently working with the CCG to improve the NHS Health Checks performance which it has identified as a target area for improvement.. Please note that the data for this period is incomplete as a large number of practices returned incomplete datasets. Currently staff are working with practices to ensure all data is captured
Percentage of people who received a health check of those offered	45%	45%	33%	33%	A	n/a	45%	33%	↔	
Number of outreach health checks carried out	2,633	1559	704	45%	R	44%	223	56%	↑	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. This commenced in February and started gaining momentum.However due to recruitment delays/changes the number completed has remained low Recruitment has now improved and improvements can be expected.
Smoking Cessation - four week quitters	2249	959	819	85%	R	85%	162	101%	↑	• The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) suggest the prevalence of smoking in Cambridgeshire has increased slightly in the last few years, returning to a level statistically similar to the England average (16.4% v. 16.9%), although the trend is not statistically significant. Smoking rates in routine and manual workers are consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where routine and manual smoking rates have returned to a level worse than the average for England (39.8%). • There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit the core Stop Smoking service is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. Other activities introduced recently include a , a migrant worker Health Trainer who targets the communities where smoking rates are high . It shoudl be noted that quitters are always reduced during the summer holidays. The smoking figures are for August as they are reported two months behind the reporting period.

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

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	0%	0%	0%	N/A	0%	0%	0%	↔	The National Child Measurement Programme is undertaken during school term times. It is not possible to formulate a trajectory as this is dependent on school timetabling. Measurements commenced in November 2016.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	0%	0%	0%	N/A	0%	0%	0%	↔	
Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1983	1188	1019	86%	R	84%	175	60%	↓	The Countywide Integrated Lifestyle Service provided by Everyone Health has now successfully recruited to all areas . Training was completed in September and the Service was fully operational in November. Referrals from practices have fallen this month however.
Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	1686	1010	976	97%	A	80%	149	81%	↑	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1075	645	442	69%	R	83%	95	72%	↓	Quarterly reporting. This intervention can take up to one year. Therefore there are cyclical changes.
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	992	596	783	131%	G	131%	88	85%	↓	
Number of physical activity groups held **(Pre-existing GP based service)**	581	338	341	101%	G	88%	86	64%	↓	
Number of healthy eating groups held **(Pre-existing GP based service)**	290	168	175	104%	G	88%	24	163%	↑	
Personal Health Trainer Service - number of referrals received (Extended Service)	739	420	385	92%	A	94%	67	124%	↑	
Personal Health Trainer Service - number of initial assessments completed (Extended Service)	628	355	315	89%	R	66%	57	98%	↑	This reflects the recruitment issue which was resolved in November and activity is improving
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	400	222	71	32%	R	39%	37	81%	↑	This intervention can take up to one year. Consequently the target KPI s are being reviewed.

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Number of physical activity groups held (Extended Service)	578	328	427	130%	G	104%	52	106%	↑	
Number of healthy eating groups held (Extended Service)	726	421	332	79%	R	69%	65	48%	↓	Big push given to this in October. In excess of 80 sessions booked for November.
Proportion of of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	35%	118%	G	200%	30%	185%	↓	This is reported quarterly as the intervention takes 3 - 6 months
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	60%	60%	n/a	n/a	N/A	n/a	n/a	n/a	← →	No data is currently available for 16/17. Each course is a minimum of 6 months
% of children recruited who complete the weight management programe and maintain or reduce their BMI Z score by agreed amounts	80%	80%	N/A	N/A	N/A	100%	80%	n/a	← →	No programmes completing in October hence no completers.
Falls prevention - number of referrals	386	188	220	117%	G	85%	39	105%	↑	
Falls prevention - number of personal health plans written	279	136	181	133%	G	96%	28	129%	↑	

* All figures received in November 2016 relate to October 2016 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.

** Direction of travel against previous month actuals

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

APPENDIX 7

Health Committee Priorities

Health Inequalities

Smoking Cessation

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

Monthly update:

- The percentage of the smoking quit target achieved in September has improved from the previous month in both the least deprived 80% and most deprived 20% of practices in Cambridgeshire
- In the least deprived 80%, 99 four-week quits were achieved, 85% of the monthly target of 116; in the most deprived 20% of practices, 62 four-week quits were achieved, 86% of the monthly target of 72.
- Looking at performance data for the year to date, the percentage of the quit target achieved in the least deprived 80% of practices stands at 70% and in the most deprived 20%, at 74%.

Year-to-date:

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

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

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

Practice deprivation category	Year end target	Year-to-date					September			Previous month	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	1,388	694	489	70%	30%		116	99	85%	75%	↑
Most deprived 20%	861	431	317	74%	26%		72	62	86%	67%	↑
All practices	2,249	1,125	806	72%	28%		187	161	86%	72%	↑

RAG status:

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

Direction of travel:

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

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

	Year-to-date	September	Previous month	Direction of travel
Percentage point gap	4%	1%	-8%	*

* Achievement of the quit target higher in the most deprived 20% - direction of travel for reducing the gap not assessed

Direction of travel:

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

Sources:
General practice returns to Cambridgeshire County Council Smoking Cessation Service
Public Health England 2015 Indices of Multiple Deprivation for general practices, based on the Index of Multiple Deprivation, Department for Communities and Local Government, 2015
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 15/12/16

NHS Health Checks

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

Quarter 2

- The percentage of the health check target achieved in Quarter 2 was higher in the least deprived 80% of practices than in the most deprived 20%.
- In the least deprived 80%, 3311 health checks were delivered, 104% of the quarterly target of 3173; in the most deprived 20% of practices, 1033 health checks were delivered, 78% of the quarterly target of 1327.
- The gap in performance between the two groups was 27 percentage points in Quarter 2.
- The gap in performance between the two groups decreased in Q2 compared to the gap seen in Q1 due to a greater increase in health checks for the least deprived practices.

Year-to-date

- Looking at performance data for the year to date, the percentage of the health check target achieved is more than 10% away from the target in the most deprived 20% of practices (at 70%) but is meeting the year-to-date target in the least deprived 80% (at 102%)
- The gap in performance between the two groups is 32 percentage points.

Percentage of health check target achieved by deprivation category of general practices in Cambridgeshire, 2016/17 Quarter 2

Practice deprivation category	Year end target	Year-to-date					Quarter 2			Previous quarter	
		Target	Completed	Percentage	Difference from target	RAG status	Target	Completed	Percentage	Percentage	Direction of travel
Least deprived 80%	12,691	6,346	6,480	102%	-2%		3,173	3,311	104%	98%	↑
Most deprived 20%	5,309	2,654	1,864	70%	30%		1,327	1,033	78%	59%	↑
All practices	18,000	9,000	8,344	93%	7%		4,500	4,344	97%	86%	↑

RAG status:

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

Direction of travel:

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

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

	Year-to-date	Quarter 2	Previous quarter	Direction of travel
Percentage point gap	-32%	-27%	-39%	↑

Direction of travel:

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

Sources:
Practice returns to Cambridgeshire County Council Public Health Team
Practice level index of multiple deprivation (IMD) Public Health England/Kings College London, 2015
Health and Social Care Information Centre Organisation Data Service
Office for National Statistics Postcode Directory
Prepared by:
Cambridgeshire County Council Public Health Intelligence, 15/12/2016

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

Life expectancy and healthy life expectancy

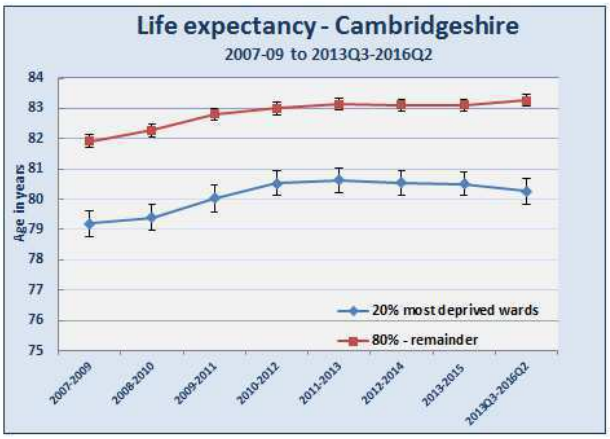
Due to time restrictions and pressing deadlines life expectancy has not been updated

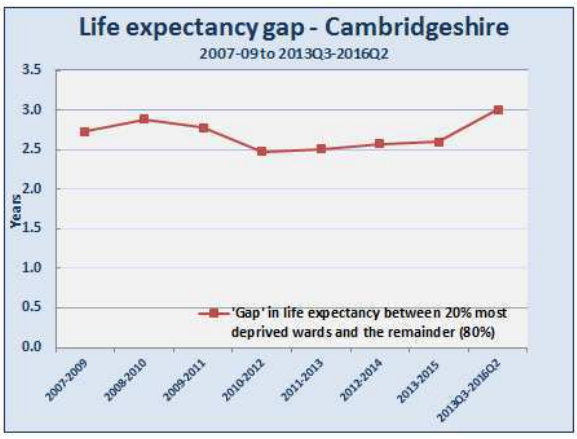
Inequalities in life expectancy: aiming to reduce the gap in years of life expectancy between residents of the 20% most deprived and the 80% least deprived electoral wards in Cambridgeshire.

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

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

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





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

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

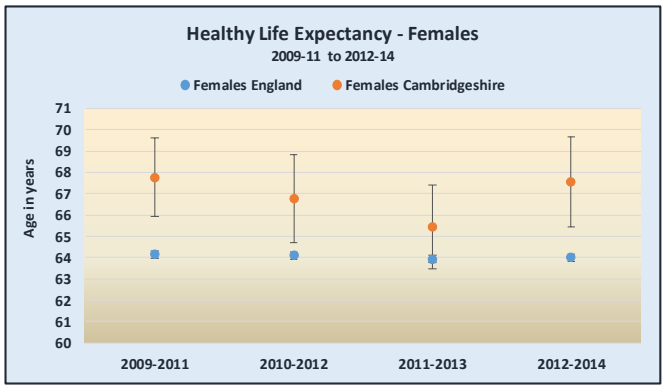
Healthy life expectancy.

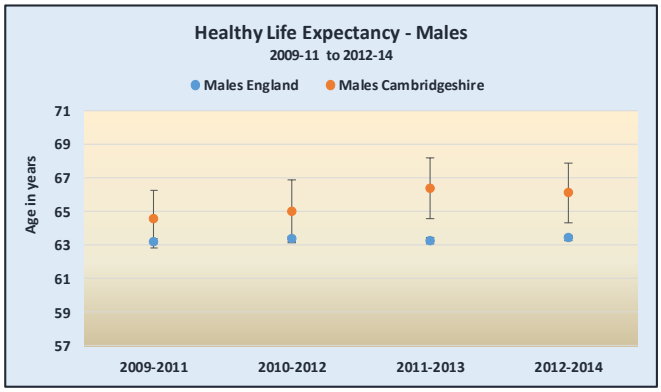
- Healthy life expectancy for men for the period 2012-2014 in Cambridgeshire was 66.1 years. For females the figure was 67.6 years. The 'actual' figure for men (66.1 years) is lower than for females (67.6 years). No target has been set for this indicator. The local value reported is to be assessed in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

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

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

NB: chart axes do not start at zero.

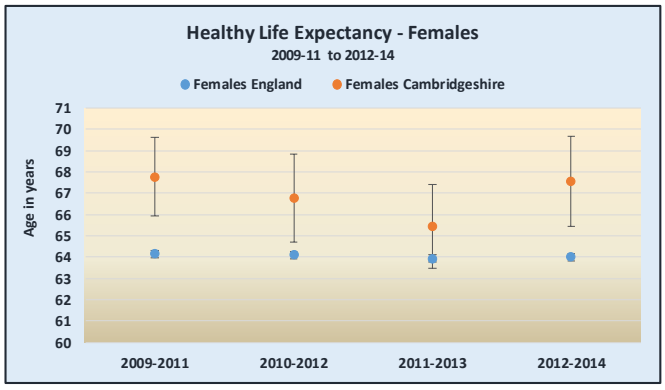


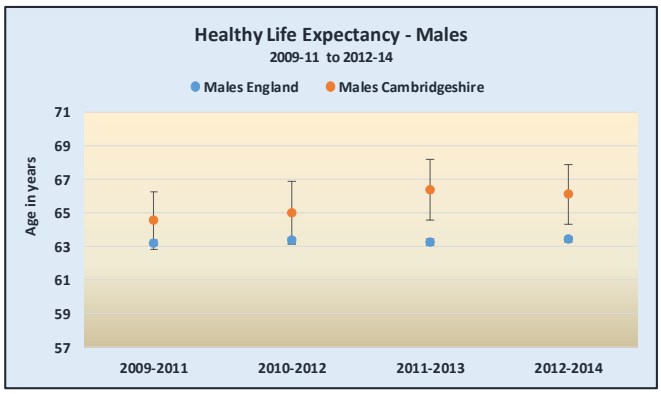


Calendar years	Cambridgeshire				England			
	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'	Life expectancy (years)	Healthy Life Expectancy (95% confidence interval) years		% of life spent in 'good health'
Males								
2009-2011	80.6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

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

NB: chart axes do not start at zero.





Child obesity

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

Children aged 4-5 years classified as overweight or obese

The target for Reception children in Fenland is to reduce the proportion of children with excess weight (overweight and obese) by 1% a year, whilst at the same time reducing the proportion for Cambridgeshire by 0.5%. In 2015/16 Fenland did not meet this target (21.4% actual against 19.6% target), but there was a reduction from the previous year (22.4%). There continues to be a downward trend in Cambridgeshire as a whole, which meant the target was met (18.7% actual, 19.8% target). The gap between Fenland and Cambridgeshire had reduced in 2015/16.

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

Area		Actual			2014/15		2015/16	
		2011/12	2012/13	2013/14	Actual	Target	Actual	Target
Fenland	Number	262	248	224	237	-	222	-
	%	26.8%	24.9%	21.6%	22.4%	20.6%	21.4%	19.6%
Cambridgeshire	Number	1,399	1,318	1,392	1,326	-	1,270	-
	%	22.5%	20.2%	20.8%	19.4%	20.3%	18.7%	19.8%
Gap		4.3%	4.7%	0.8%	3.0%	0.3%	2.7%	-0.2%

Source: NCMP, HSCIC

Note : The target and actual data has changed to reflect changes in the PHOF. Local authority is now determined by the postcode of the pupil rather than the postcode of the school.

Children aged 4-5 years classified as obese

There was a decrease in the recorded obesity prevalence in Reception children in Cambridgeshire between 2014/15 and 2015/16 (7.3% to 6.9%). The target (described below) to reduce the recorded child obesity prevalence in Reception children in the 20% most deprived areas in Cambridgeshire was met in 2015/16 (9.6% actual, 9.6% target). The proportion remained the same as in 2014/15. The target for the remaining 80% of areas was also met (6.2% actual, 6.9% target).

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

Area		Actual			2014/15		2015/16	
		2011/12	2012/13	2013/14	Actual	Target	Actual	Target
20 most deprived	Number	148	156	157	146		137	
	Total	1,310	1,444	1,477	1,521		1,420	
	%	11.3%	10.8%	10.6%	9.6%	10.1%	9.6%	9.6%
80 least deprived	Number	344	327	372	344		326	
	Total	4,819	4,997	5,108	5,177		5,300	
	%	7.1%	6.5%	7.3%	6.6%	7.1%	6.2%	6.9%
Total (CCC only)	Number	492	483	529	490		463	
	Total	6,129	6,441	6,585	6,698		6,720	
	%	8.0%	7.5%	8.0%	7.3%		6.9%	

Source: NCMP cleaned dataset, HSCIC

Children aged 10-11 years classified as obese

There was a noticeable decrease in the recorded obesity prevalence in Year 6 pupils in the 20% most deprived areas in Cambridgeshire between 2014/15 and 2015/16 (19.6% to 18.4%), and the target was met. There was a slight increase in the remaining 80% of areas, but the target was also met.

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

Area		Actual			2014/15		2015/16	
		2011/12	2012/13	2013/14	Actual	Target	Actual	Target
20 most deprived	Number	245	217	226	232		199	
	Total	1,107	1,117	1,136	1,182		1,081	
	%	22.1%	19.4%	19.9%	19.6%	19.4%	18.4%	18.9%
80 least deprived	Number	613	623	671	596		622	
	Total	4,174	4,207	4,411	4,345		4,474	
	%	14.7%	14.8%	15.2%	13.7%	15.0%	13.9%	14.8%
Total (CCC only)	Number	858	840	897	828		821	
	Total	5,281	5,324	5,547	5,527		5,555	
	%	16.2%	15.8%	16.2%	15.0%		14.8%	

Source: NCMP cleaned dataset, HSCIC

Excess weight in adults

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

Physically active and inactive adults

There was a noticeable decrease in the proportion of physically active adults in Fenland between 2014 and 2015, and the target (described below) was not met. Cambridgeshire as a whole also experienced a decline in the proportion of physically active adults and also did not meet the target in 2015.

Physically active adults
Target: Improve Fenland by 1% a year and Cambridgeshire by 0.5%.

Area	Actual			2015		2016	
	2012	2013	2014	Actual	Target	Actual	Target
Fenland	50.5%	51.1%	52.1%	47.9%	53.1%		54.1%
Cambridgeshire	60.3%	60.2%	64.5%	58.6%	65.0%		65.5%
Gap	-9.8%	-9.1%	-12.4%	-10.7%	-11.9%	0.0%	-11.4%

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

Actions

There is a range of programmes and services that address both childhood and adult obesity which include prevention and treatment though weight management programmes. Examples for promoting healthy eating include the commissioning of the Food for Life Partnership to work in schools to set policy, provide information and skills about healthy eating and growing healthy food, similar approaches are being used in children’s centres and with community groups. The Workplace Health programme is another avenue for promoting health eating workplace policy.

There is a range of physical activity programmes provided in different settings across the county targeting all ages that are provided by CCC and district councils along with the voluntary and community sector.

CCC commissions an integrated lifestyle service which includes a Health Trainer Service which supports individuals to make healthy lifestyle changes, children and adult weight management

service and community based programmes that focus up on engaging groups and communities in healthy lifestyle activities.

Mental health

Proposed indicators:

- **Number of schools attending funded mental health training:**

The whole school briefing delivered by CPFT offers an introduction to thinking about mental health with a focus on ethos and culture around mental health in schools. This foundational training to all staff.

- Between 1st June-30th September 2016 4 secondary schools had a whole school briefing (230 people attending).
- Between 1st June-30th September 2016 8 primary schools had a whole school briefing (215 people attending).
- There have been 72 members of staff accessing e-learning, many of whom will have registered following the whole school briefing.

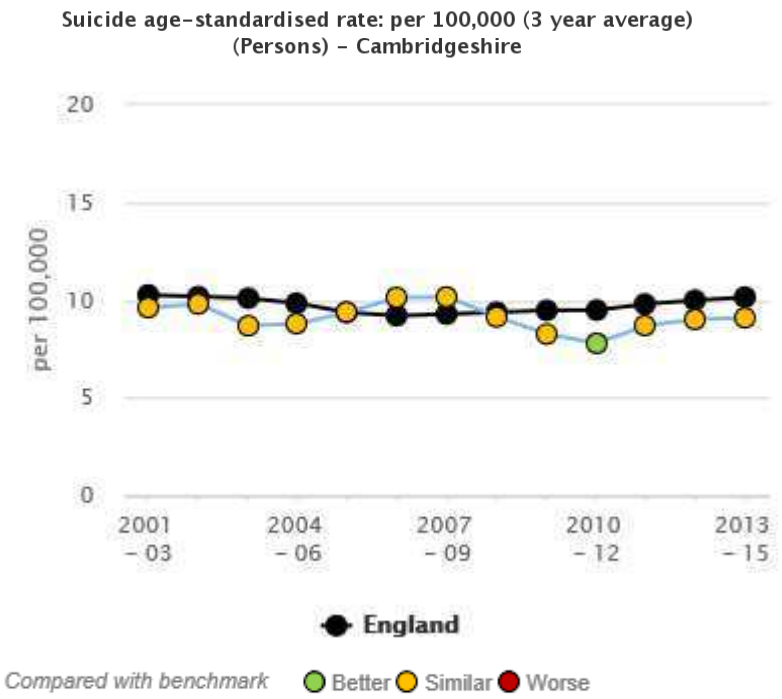
- **Number of secondary schools taken up offer of consultancy support around mental and emotional wellbeing of young people** (annual) – To date (June 2016), 21 out of 30 secondary schools have taken up the offer of a consultancy visit.
  This piece of work was funded for the 2015/16 academic year only.

- **Number of front line staff that have taken part in MHFA and MHFA Lite commissioned training** (quarterly):

Mental Health First Aid and Mental Health First Aid Lite are offered free of charge to front line staff within Cambridgeshire County Council and partner organisations. The contract with an external provider to deliver this training finished at the end of October 2016, however a range of training will continue to be offered via different channels and models of delivery.

- MHFA (2 day course) attendance: 398
- MHFA Lite (1/2 day) attendance: 216

- **PHOF Indicator: Mortality rate from suicide and injury of undetermined intent** (annual):
  - In Cambridgeshire, the rate of suicide and injury of undetermined intent is 9.1 per 100,000 (3 year average, 2013-15), this is not significantly different to the England rate or the East of England rate. The chart below shows the trend in recent years; the rate has remained fairly stable in Cambridgeshire.



Source: Public Health Outcomes Framework (Benchmark is England)

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

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

Directly standardised rate - per 100,000

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

Source: Public Health Outcomes Framework

Transport and Health

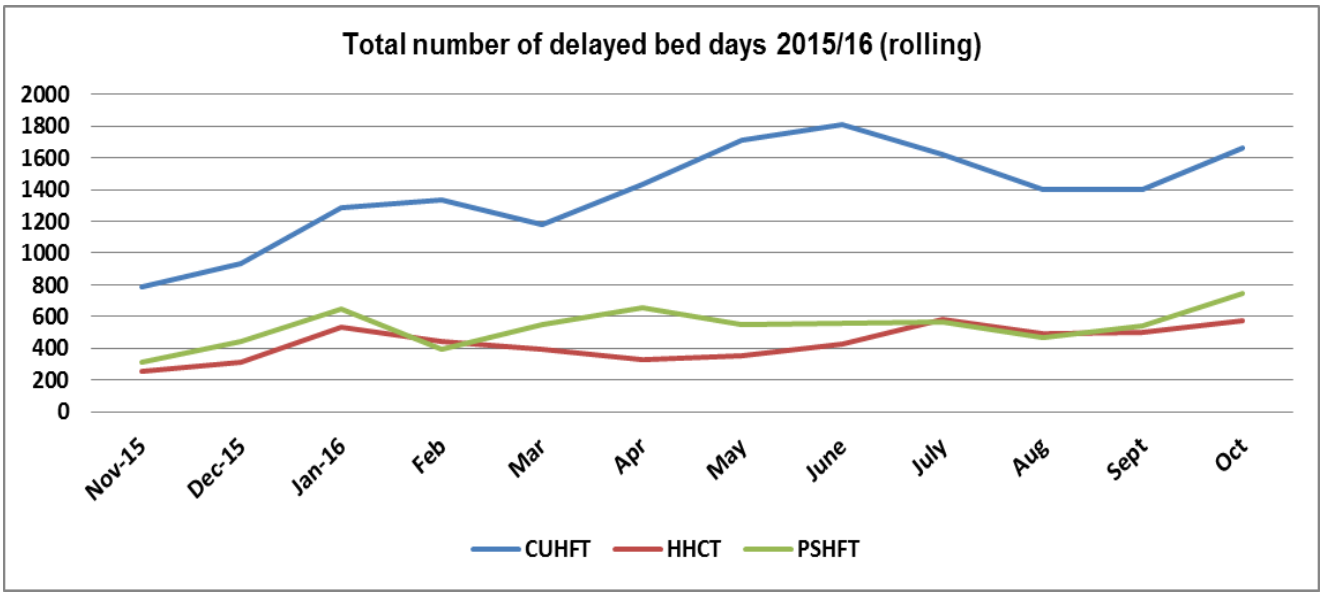
At the January meeting of the Health Committee, it was request that these indicators be reviewed. The Committee is advised that this review is now under way.

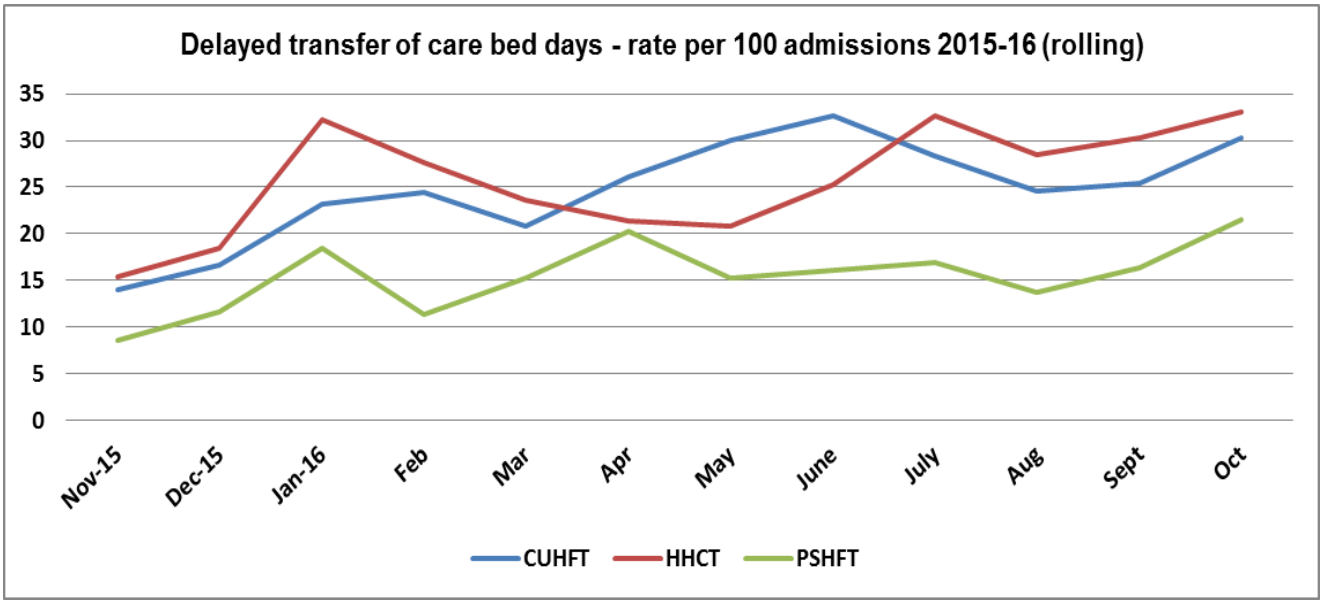
APPENDIX 8

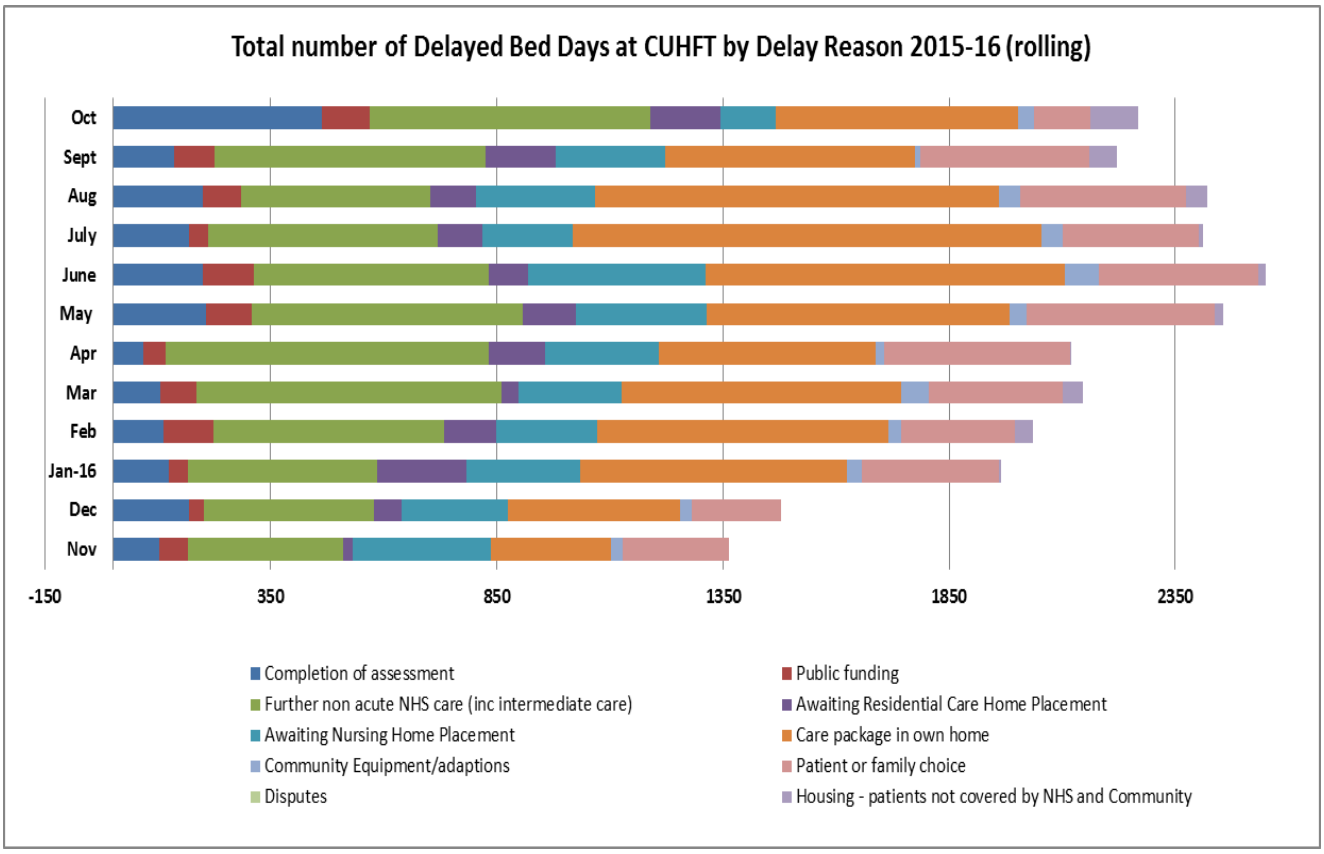
Health Scrutiny Indicators

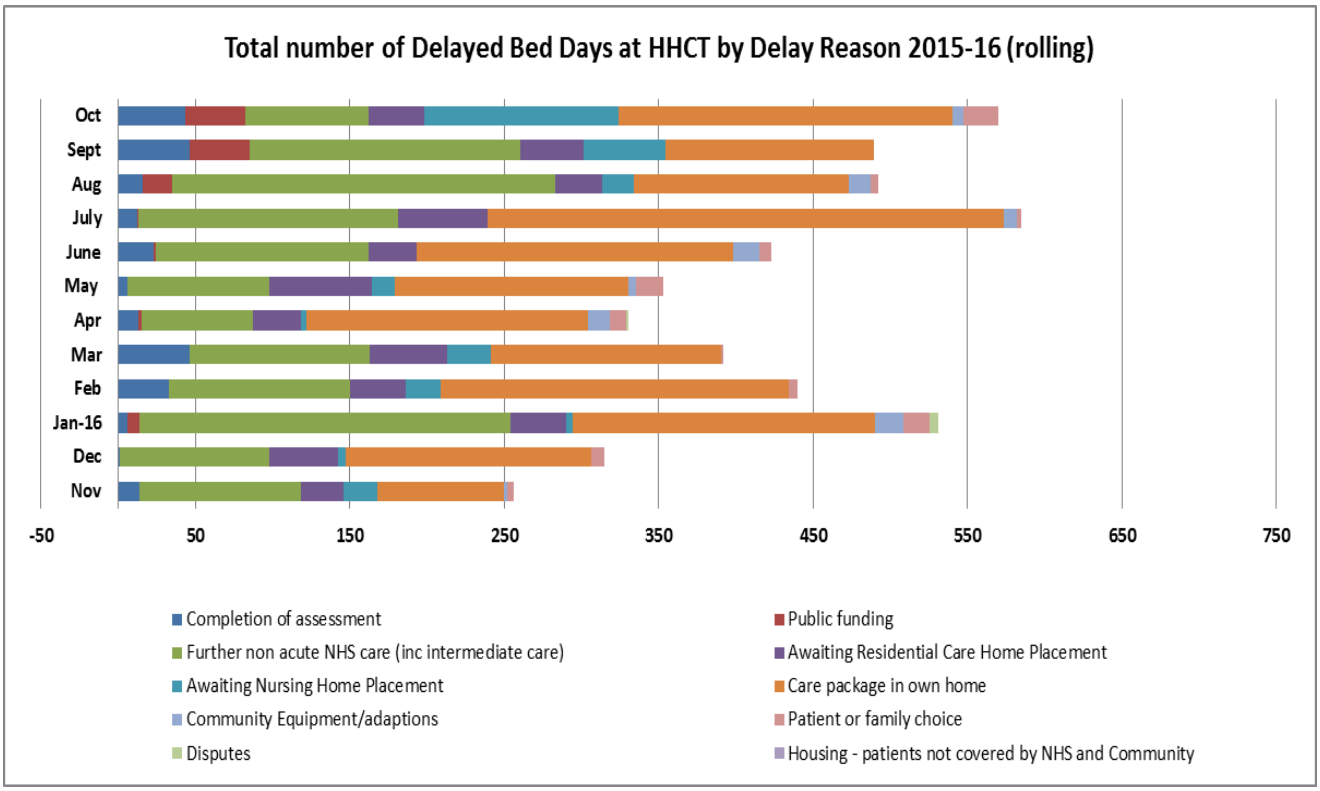
Updates on key indicators for NHS issues which have been scrutinised by the Health Committee are as follows:

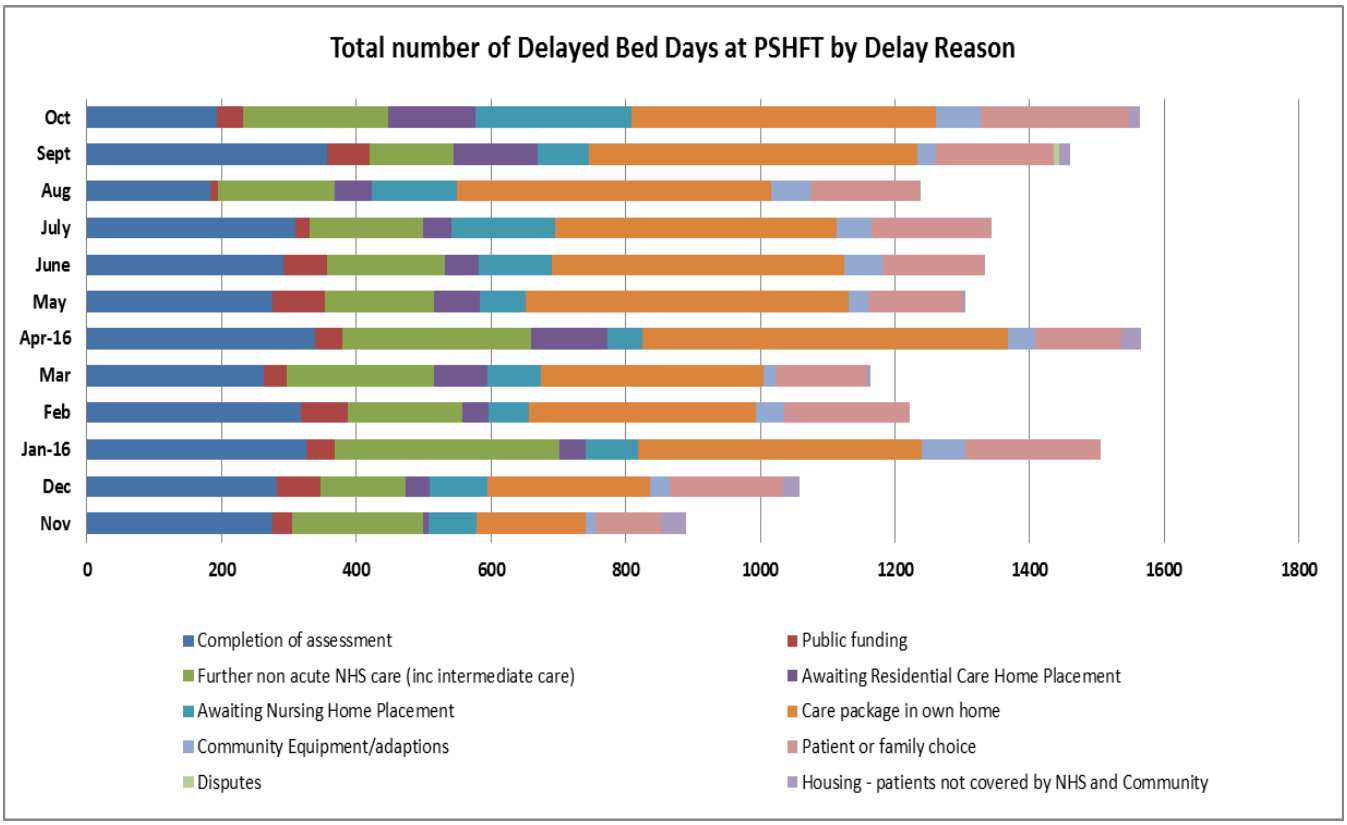
- **Delayed Transfer of Care (DTOC)**






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


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



The data provided for October 2016 for DTOC for both Hinchingbrooke Health Care NHS Trust and CUHFT see a significant increase in DTOC which is of concern as we are entering into the winter pressure period for acute trusts. For CUHFT this is a reversal of the improving trend seen over the last three months. The figures for October 2016 show a 1,257 increase in bed days lost compared to October 2015 (1,150 bed days). The trust report that they continue to work with system partners to address the large scale impact of DTOCs.

APPENDIX 9

PUBLIC HEALTH MOU 2016-17 UPDATE FOR Q2

Directorate	Service	Allocated	Contact	Cost Centre Finance Contact	Q2 Update	YTD expected spend	YTD actual spend	Variance
CFA	**Chronically Excluded Adults (MEAM)**	£68k	Tom Tallon	MN92145 Stephen Howarth	During quarter two we have started work with four new complex needs clients. Five clients have been closed. Of those three were living more positively and safely and were accommodated, one had left the area and one where CEA could not provide any further assistance. One closed client was now doing some voluntary work. CEA have had information sharing sessions were our approach was discussed with Oxford. We have also had a practice session with Bristol on the theme of engaging with the most marginalised clients. We have recruited and appointed, Heather Yeadon, formerly senior project worker at Wintercomfort to the new post working with the street based community. Heather is due to start at the end of October. A review of our referral process has led to a change in practice with one person, Ben Harwin, now triaging all referrals and allocating after acceptance by the Case Group. Preliminary results from the Peterborough project indicate that savings have been made to the criminal justice system as mirrored with the Cambridgeshire work. CEA have assembled a small working group to look at expansion of the training flat model. We have been asked to present at a Homelesslink event on this work. The first social work student that was placed with the CEA team finished his placement and successfully passed. Following discussions between Making Every Adult Matter (MEAM)	£34,000	£34,000	0

					and CEA, MEAM have asked FTI consultancy to produce a 5 year evaluation of the CEA work. We are currently pulling together the data for this.			
CFA	**PSHE KickAsh**	£15k	Diane Fenner	CB40101 Jenny Simmons	• Ten secondary schools in the programme • Kick Ash training for secondary school has commenced • Primary visits planned for spring term 2-017	£7,500	£7,500	0
CFA	**Children's Centres**	£170k	Jo Sollars/ Sarah Ferguson	CE10001 Rob Stephens	The overall aim of Cambridgeshire Children's Centres remains ensuring a healthy start to life for children aged 0-4 and ensuring readiness for school, whilst maintaining a focus on inequalities in the early years, and targeting support which will minimise the need to access specialist services where possible. The Public Health funding is utilised as part of the total Children's Centre budget to improve health of children aged 0-5. Close alignment and joint working with community health colleagues in Health Visiting, Family Nurse Partnership and Maternity Services is established for all Children's Centres. Work continues to ensure arrangements with Health partners are consistent and functionally effective at a community level for families as structural service change is introduced across the system.	£85,000	£85,000	0
CFA	**Mental Health Youth Counselling**	£111k	Holly Hodge/ Emma De Zoete	CD20901 Clare Andrews	Cambridgeshire Youth Counselling Services: Youth counselling services are provided by Centre 33 and YMCA covering the whole of Cambridgeshire for 12-25 year olds. This quarter's contract monitoring meeting is upcoming. There continues to be a high number of young people accessing these counselling services and responding positively to the interventions offered. As part of a wider re-design of child and adolescent mental health services this service is likely to be re-tendered in 2017. The existing contracts are currently going through the exemption process to be extended for an additional 6-9months. The service will be re-commissioned across Cambridgeshire and Peterborough with additional funding from Peterborough City Council and Cambridgeshire and Peterborough Clinical Commissioning Group.	£55,500	£55,500	0
CFA	**CAMH Trainer**	£71k	Holly Hodge/	CD20901	The CAMH trainer is employed by CPFT and delivers specialist mental health training for a range of roles working with children and	£35,500	£35,500	0

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>Emma De Zoete</td>
<td>Clare Andrews</td>
<td>young people. Training specifically tailored to the needs of schools is also provided with a new 1 day mental health course for the 2016/17 academic year.

Most recent data (July 1016) shows 63 schools and colleges have been engaged in the training programme as shown below:
2012-16
<table>
<tr><th>District</th><th>No. Schools</th><th>%</th></tr>
<tr><td>Cambridge City</td><td>8</td><td>22</td></tr>
<tr><td>East Cambridgeshire</td><td>14</td><td>39</td></tr>
<tr><td>Fenland</td><td>9</td><td>23</td></tr>
<tr><td>Huntingdonshire</td><td>18</td><td>26</td></tr>
<tr><td>South Cambridgeshire</td><td>14</td><td>19</td></tr>
<tr><td>Grand Total</td><td>63</td><td>25</td></tr>
</table>
A range of other courses are run for professionals working with children and young people and attendees have included school nurses, family workers, social workers, young people’s workers and health visitors among other roles. A broad range of topics are included within this training for example, understanding and responding to self-harm.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CFA</td>
<td>DAAT</td>
<td>£5,980k</td>
<td>Susie Talbot</td>
<td>NB31001-NB31010

Jo D’Arcy</td>
<td>At the end of Qtr 2 there had not been any current spend for the allocated budget for GP Shared Care & Nalmefene, this information is passed through for recharge by PH and to date no information has been received. The inpatient detox beds contract is paid up to end August, Septembers invoice has also now been paid but does not show on the grid, all payments are up to date to the end of Qtr 2. The Service User Contract is also paid to end Qtr 2.
Qtr 1 & Qtr 2 80% invoices from Inclusion for the Drug & Alcohol Contracts have been received and paid. We are currently awaiting invoices for the Qtr 1 20% performance element of the contract.

Qtr 2 of the young people’s contract has now been paid and this will show in Qtr 3’s report.

The predicted Q2 spend is based solely on half of the overall allocated budget so the predicted and actual spend will vary during</td>
<td>£2,990,000</td>
<td>2,564,890</td>
<td>£425,110</td>
</tr>
</table>

					the year depending on when invoices are received however we anticipate the budget will be fully spent by year end. The only exception to this being the Inclusion Contract where the contract is based on 80% in advance quarterly and the remainder 20% performance related which is normally paid during the next quarter following the performance meeting. This is to ensure that Inclusion have met their targets in line with the contract agreement, the 20% performance related invoices are then agreed for payment.			
CFA	**Contribution to Anti-Bullying**	£7k	Sarah Ferguson		This is a nominal amount and is part of a large budget, it is therefore difficult to pull out exactly what the £7k covers, and difficult to apportion amounts. This will be spend in total.	£3,500	£3,500	0
					SUB TOTAL : CFA Q2	**£3,211,000**	**£2,785,890**	**£425,110**
ETE	**Active Travel (overcoming safety barriers)**	£55k	Matt Staton	HG03560 Jonathan Trayer	Currently 66 schools are actively engaged in the school travel planning process through STARS. 32 accredited to Bronze level and 2 Gold. Since the beginning of April: Walk Smart has been delivered to 132 pupils Scoot Smart has been delivered to 1018 pupils Pedal Smart has been delivered to 120 pupils	£27,500	£27,500	0
ETE	**Explore additional interventions for cyclist/ pedestrian safety**	£30k	Matt Staton	HG03560 Jonathan Trayer	Partnership campaign 'Let's look out for each other' ran in July Planning is underway for a 'Be Bright Be Seen' promotion after the clocks change in October and into November. Data and intelligence continues to be interrogated to produce a profile for collisions involving cyclists. Discussions have been held with Anglia Ruskin University to see whether any of their research projects looking at eye-tracking and road user behaviour are relevant to cycle safety or if they could be extended to include potential cycle safety elements, particularly in relation to driver search patterns and eye-contact between road users.	£15,000	£15,000	0
ETE	**Road Safety**	£20k	Matt Staton	HG03560	17 schools are now signed up to the Junior Travel Ambassador Scheme, including 9 schools who were engaged last academic year.	£10,000	£10,000	0

				Jonathan Trayer	The 8 new schools are appointing JTAs during September/October with the total number expected to reach 80-85 JTAs.			
ETE	**Trading Standards KickAsh and Alcohol Advice**	£23k	Elaine Matthews/ Jill Terrell	LC44590 John Steel	*A dedicated post has been created to fulfil this funded KickAsh role within Community Protection Team in Community and Cultural Services. This post holder (employed term time only) fulfils the specified activities on behalf of Trading Standards and supports the wider KickAsh team to deliver improved outcomes.* **July:** Certificates for the 2015/16 mentors. Collating feedback and gathering information for evaluation. Administrative work completing year end reports and setting up systems for school year 2016/17 ahead. Preparation for recruitment of new Year 10 mentors for September. Attended the Safety Zone in Parkside, Cambridge – delivery messages about underage sales and shop policies and sharing information with approximately 450 9-10 year olds about E-cigarettes, the effects of those and tobacco with their health. **August:** School holidays, no work carried out during this month **September:** Launched straight in to the delivery of training to the first pupils recruited to be mentors and take part in the delivery of KickAsh for 2016/17. **Swavesey Village College:** • Met 44 very keen year 10's to deliver the messages of being proud to be smoke free. • Enhanced the delivery to include more information on Nicotine Inhaling Products that are becoming more popular with young people and those who are nicotine dependent. **Bottisham Village College:** • A group of very able and enthusiastic year 10'2 gathered to receive the training. Bottisham VC is one of the link schools that will receive 5 half termly visits to support them to stay on track to deliver messages and events throughout the year. **St Peter's College, Huntindon:** • Facilitated a group of 14/15 year olds gathered to discuss the	£11,500	£10,752	-748

					issues affecting them and their peers, and to increase their awareness of the effects of smoking in young people. • They took part in visits to local shops selling tobacco and nicotine inhaling products, advising shopkeepers of the dangers smoking has on their peers, checking Challenge 25 ID and completing the mentor's questionnaire devised for this purpose. • Three members visited three shops to complete the questionnaire and to take part in the Trading Standards Illicit tobacco Awareness roadshow, helping to deliver the messages about plain packaging, illicit tobacco etc. **Sir Harry Smith, Whittlesey:** • Met with 45+ Year 10's to talk about the KickAsh programme and to deliver the messages about plain packaging, illicit tobacco etc. **Other work:** • Continued work to support and improve the communication between the school leads and mentors. Developing an individual programme of KickAsh events and expectations for three schools (Cottenham Village College, Longsands Academy, Bottisham Village College), which fall within wider responsibilities for the duration of the year.			
ETE	**Illicit Tobacco**	£15k	Aileen Andrews	JM12800 John Steel	• Following the 6 Magistrates warrants executed late March and all 6 premises yielding illicit tobacco, investigation work was concluded and cases prepared for court with cases in court. • Financial Investigations ongoing. • The one week illicit tobacco roadshow was during September (not calculated in to the actual spend as part of a regional project). • Intelligence work on going and intelligence received about sellers within county during roadshow week.12,974 • One premises raided in Wisbech. Hand rolling tobacco seized which was concealed in roof behind a light fitting. • The simple caution was signed by takeaway owner (mentioned as being offered in quarter one document.) • 5 cases have been through the courts, results – 1. Defendant fine reduced to £1500 and victim surcharge £120 after sentencing appeal hearing.	£7,500	£12,974	£5474

					2. Defendant fined £250 and victim surcharge £25. 3. Defendant fined £465 4. Two defendants (directors of one shop) sentenced to 120 hours unpaid work each. 5. One defendant still going through court (hearings in this qtr.) as proceeds of crime hearings taking place. Regional Project - Costs not within this allocation. Most of the work going forward will be against the regional tobacco project funding.			
ETE	**Business and Communities Team**	£10k	Elaine Matthews		*ETE Shared Priority: Engaging with communities in Fenland* **Prioritised work completed by Community Resilience Development Team (CRD) focusing on improving lives in Fenland.** <u>Libraries and Older People project – March town</u> Bringing together a range of internal and external partners and volunteers who work on front line with older people in March to maximise use of resources, resulting in improved knowledge and intelligence of the service users, increasing knowledge and information for sharing by front line workers for residents on available services and social/local support groups. Development of a shared 'Older peoples promise', using evaluation of Fenland projects to roll out in 2 new areas. <u>Community Green Spaces: Rings End Nature Reserve</u>. CRD engagement with a large national locally based employer resulted in 120 hours of volunteer time by their employees at Rings End Nature reserve in September. These capable volunteers were joined by learning disability service users and people from the local community and led by our Green Spaces Manager, working together to create new pathways, cleared a large pond, removed overgrown shrubs and trees and built new deadwood fencing which has opened up the nature reserve to far more visitors from the community and schools, learning disability groups and Forest Schools. The company has donated or pledged useful equipment and supplies for the nature reserves, further man power and loan of heavy duty equipment. <u>Winter Warmth Packs,</u> inputting to the development of the packs, the distribution and promotion.	£7,300	£7,372	£72

					Mental Health support for young people in Fenland 'Shelf Help' Part of the Reading Well Books on Prescription scheme, which provides 13-18 year-olds with high-quality information, support and advice on a wide-range of mental health issues such as anxiety, depression, eating disorders and self-harm, and difficult life pressures, like bullying and exams. Dementia Awareness and local support: delivery of sessions and support to Dementia Friends and Dementia Alliance. Increased available information and book collections in all Fenland libraries, running dementia friends sessions across Fenland as part of health & wellbeing training for front line workers and several DF sessions across the district with more planned up to Christmas *Note: Costs in Q3 and Q4 anticipated to be lower due to planning carried out in Q1 and Q2. Annual spend on target in line with allocation*			
ETE	**Fenland Learning Centres**	£90k			Contract awarded and all funds allocated.	£45,000	£45,000	0
					SUB TOTAL : ETE Q2	**£123,800**	**£128,598**	**£4798**
CS&T	**Research**	£22k	Dan Thorpe	KH50000 Maureen Wright	The funding is used in two parts: To maintain Cambridgeshire Insight Website, which continues the host enhanced content for the JSNA and other PH material. The funding also contributes to the development of our population estimates/forecasts. We are in the process of developing a new set of these and I hope to be able to report in Q3 that this work has been completed.	£11,000	£11,000	0
CS&T	**H&WB Support**	£27k	Dan Thorpe	KA20000 Maureen Wright	With supervision from the Director of Public Health, approximately 2.5 days per week of the Policy and Projects Officer's time, who site within Policy and Business Support Team of Customer Services and Transformation. Support during Q2 has included: • Supporting the effective functioning of the Health and Wellbeing Board • Supporting the effective functioning of the Health and Wellbeing Board Support Group	£13,500	£13,500	0

					• Researching and preparing reports for the Health and Wellbeing Board, including key policy/strategy changes • Presenting relevant reports at the Health & Wellbeing Board Support Group meetings, such as on the HWB Working Group • Agenda planning for the HWB support group and (working with democratic services) the HWB meetings. This is in addition to ongoing, reactive support as required.			
CS&T	**Communi-cations**	£25k	Dan Thorpe	KH60000 Maureen Wright	Q2 Update: • Supporting a range of campaign developmental work around Stoptober and the Stay Well campaign • Supported consultations, such as the Healthy Weight strategy • Helped with the development of web resources for the Heads Up website and the PH web presence • Provided advice and support in PH steering groups and meetings	£12,500	£12,500	0
CS&T	**Strategic Advice**	£22k	Dan Thorpe	KA20000 Maureen Wright	Strategic advice over the second quarter has involved: • Inputting strategically into the business planning process, e.g. Member workshops, Committee meetings, SMT meetings and CLT meetings – which have all progressed the business planning process • Inputting into the ongoing devolution negotiations with Government – and in particular ensuring that the diverse range of needs of this Council (including Public Health) are reflected within those	£11,000	£11,000	0
CS&T	**Emergency Planning Support**	£5k	Dan Thorpe	KA40000 Maureen Wright	Ongoing close working with the Health Emergency Planning and Resilience Officer (HEPRO) on a number of Emergency Planning tasks: • Provision of emergency planning support when the HEPRO is not available • Provision of out of hours support for the Director of Public Health (DPH) ensuring that the DPH is kept up to date on any incidents of relevance that occur, or are responded to outside 'normal working hours' • Review of the Excess Deaths Planning in support of the Pandemic Flu arrangements • Collaboration on the Business Continuity arrangements developed for Public Health	£2,500	£2,500	0
CS&T	**LGSS Managed**	£100k	Dan Thorpe	UQ10000	This continues to be supported on an ongoing basis, including:	£50,000	£50,000	0

	Overheads			Maureen Wright	• Provision of IT equipment • Office Accommodation • Telephony • Members Allowances			
					SUB TOTAL : CS&T Q2	**£100,500**	**£100,500**	**0**
LGSS	**Overheads associated with PH function**	£220k	Dan Thorpe	QL30000 RL65200 TA76000 Maureen Wright	This covers Public Health contribution towards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance £20k HR £25k IT £20k The remaining £155k is a general contribution to LGSS overhead costs	**£110,000**	**£110,000**	**0**
					SUB TOTAL : LGSS Q2	**£110,000**	**£110,000**	**0**

SUMMARY

Directorate	YTD (Q2) expected spend	YTD (Q2) actual spend	Variance
CFA	£3,211,000	£2,785,890	£425,110
ETE	£123,800	£128,598	-£4,798
CS&T	£100,500	£100,500	0
LGSS	£110,000	£110,000	0
TOTAL Q2	**£3,545,300**	**£3,124,988**	**£420,312**

Agenda Item No: 7

SYSTEM WIDE REVIEW OF HEALTH OUTCOMES IN CAMBRIDGESHIRE

To:	**Health Committee**
Date:	**12 January 2017**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**System wide review of health outcomes in Cambridgeshire**
Recommendation:	**It is recommended that the Health Committee:**

(a) Note and comment on the system wide review of health outcomes in Cambridgeshire

Officer contact:	
Name:	Dr Liz Robin
Post:	Director of Public Health
Email:	Liz.robin@cambrigeshire.gov.uk
Tel:	01223 703261

1. BACKGROUND

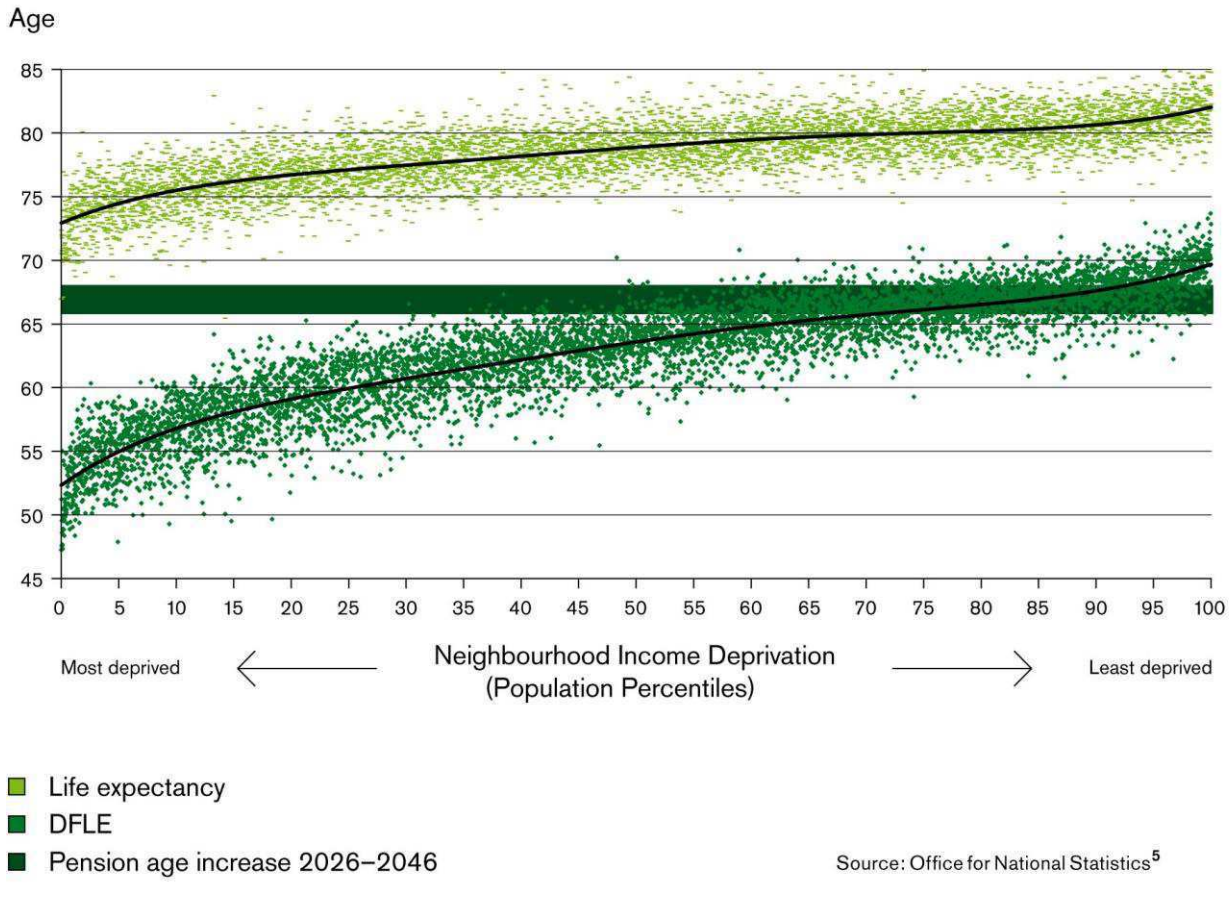
1.1 In July 2016, the Health Committee agreed to add a System Wide Review of Health Outcomes across Cambridgeshire to the forward agenda, focussing on health inequalities and life expectancy across the county. This reflected in particular, concerns about health outcomes in Fenland in comparison to the rest of the county.

1.2 Health is determined by a complex mix of factors including income, housing and employment, lifestyles, and access to health care and other services. There are significant inequalities in health between individuals and different groups in society

1.3 The most comprehensive research on health inequalities in England has been carried out by the Institute of Health Equity, based at University College, London, and led by Professor Michael Marmot. The findings of the Marmot strategic review of health inequalities in England 'Fair Society, Healthy Lives (2010)' were based on a widespread review of research literature and nationally collected data, and remain relevant today.

1.4 The Marmot review demonstrated clearly that both life expectancy and 'disability free life expectancy' in a 'neighbourhood' are closely correlated with income levels of the people who live in that neighbourhood. This isn't just relevant to people living in the most deprived areas, as the gradient continues throughout the income spectrum.

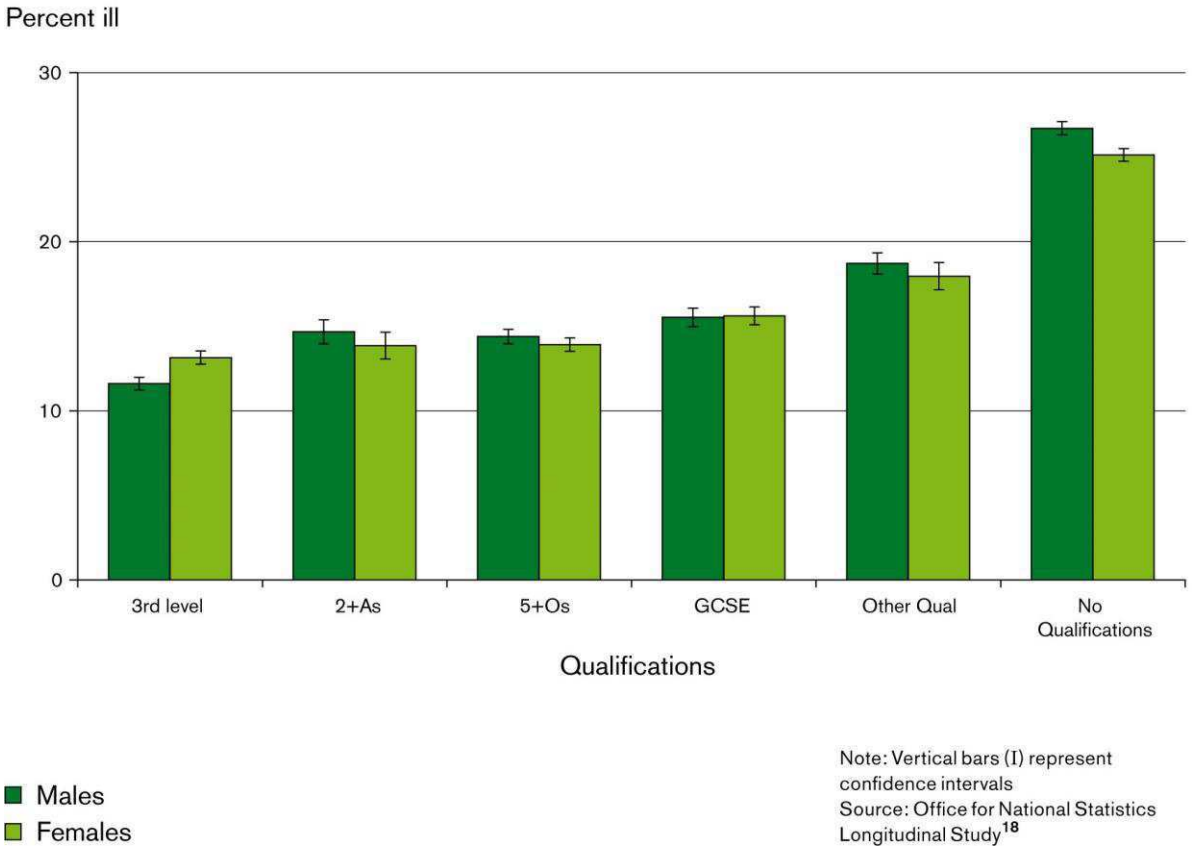
Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003



This has a significant economic impact - It is estimated that nationally, inequality in illness accounts for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion per year9, and additional NHS healthcare costs associated with inequality are well in excess of £5.5 billion per year.

1.5 There is also a strong correlation between educational attainment and health as shown in the graph below which assesses the rate of 'limiting illness' (illness which has an effect on people's daily activities) among people in England with different levels of educational attainment. Educational attainment is closely related with income, and in addition there is evidence that people with higher levels of educational attainment are more likely to make healthy lifestyle choices.

Figure 7 Standardised limiting illness rates in 2001 at ages 16–74, by education level recorded in 2001



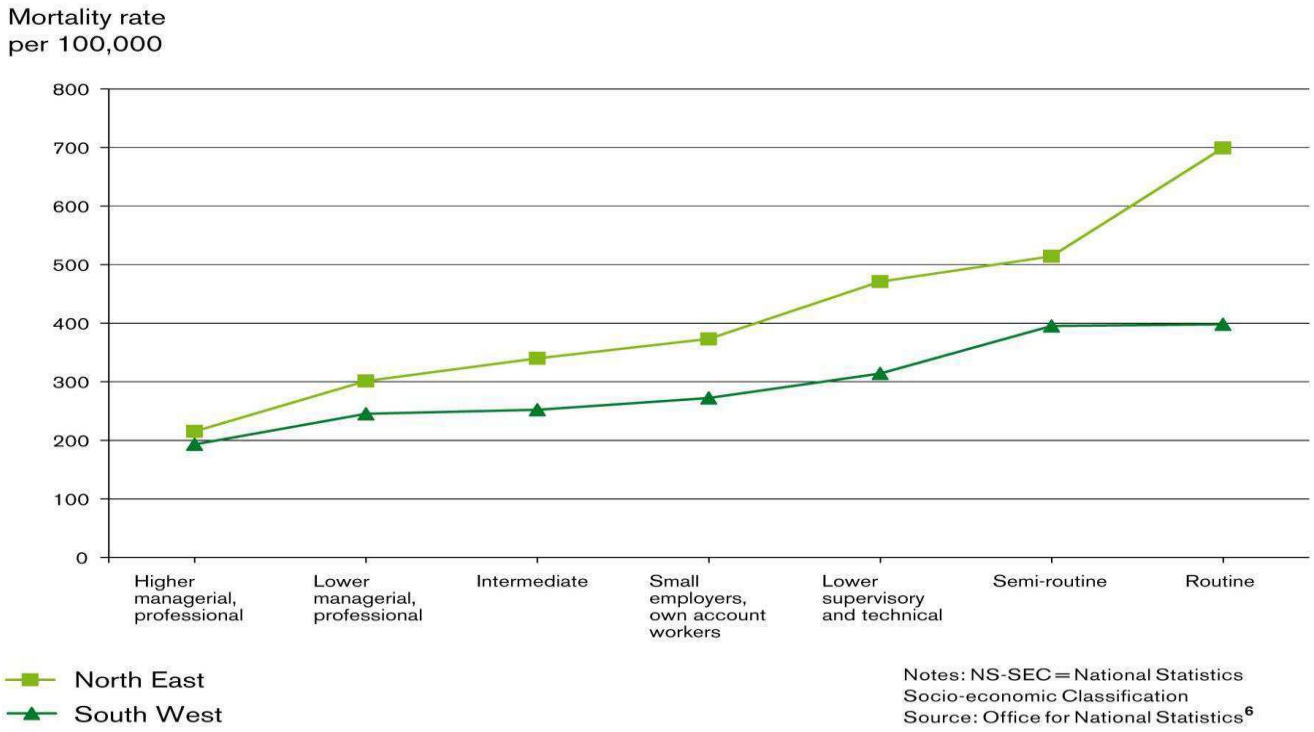
1.6 As well as describing current data and information, the Marmot review looked at the evidence for interventions to reduce health inequalities and as a result made six overarching policy recommendations:

A. Give every child the best start in life (highest priority recommendation)
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives
C. Create fair employment and good work for all
D. Ensure a healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill health prevention

Further detail of the interventions to support these recommendations can be found in the 'Fair Society Healthy Lives' available on weblink www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

1.7 Despite the strong relationship between income level, life expectancy and healthy life expectancy demonstrated by the graph in para 1.4 there is also evidence that the relationship between income deprivation and life expectancy is not 'absolute' and can be shifted. One piece of evidence is that there is strong regional variation in the relationship between type of employment and mortality rates (see graph below) with the impact of employment type on health being greater in the North East than the South West of England.

Figure 2 Age standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003



1.8 Further evidence that the relationship between life expectancy and income deprivation can be shifted came from work on health inequalities by the Kings Fund (Buck 2015), which used more recent data at small area level to look at 'neighbourhood' inequalities in life expectancy. The key findings of this review were that:

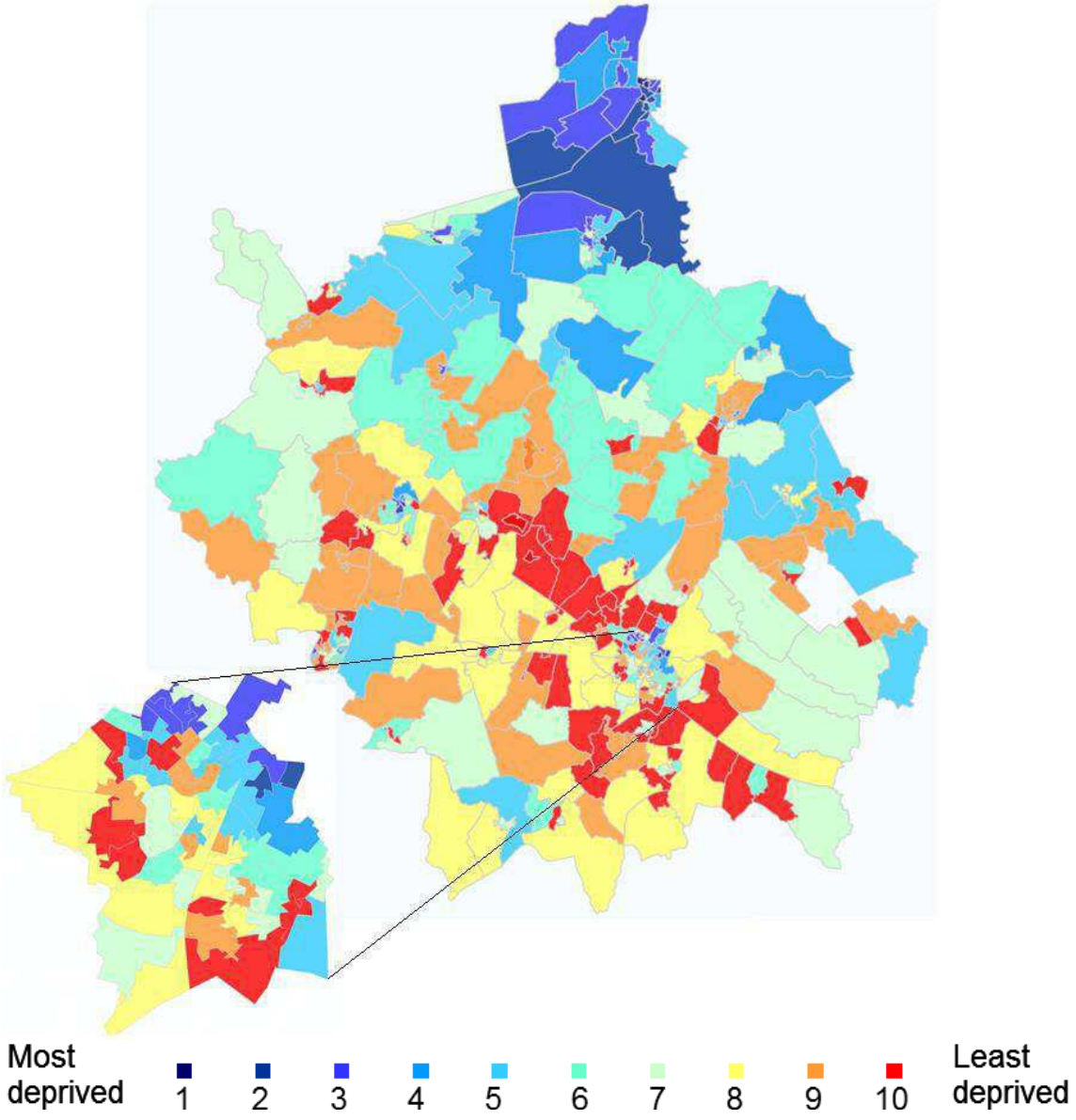
- The Marmot curve for life expectancy got flatter between 1999–2003 and 2006–10, which implies that the relationship between income deprivation and life expectancy got weaker over that period.
- Other factors, in particular employment, housing deprivation, and income deprivation among older people and some lifestyle factors such as binge drinking and fruit and vegetable consumption were the most important in explaining differences in life expectancy between areas in 2006-10.
- Low employment, housing deprivation and smoking are among the factors that distinguish areas with persistently low life expectancy over time. 'Place' remains important over and above these general findings and relationships.

2. HEALTH INEQUALITIES IN CAMBRIDGESHIRE

2.1 As is clear from the national research outlined in section 1, health inequalities in Cambridgeshire should be looked at in the context of wider socio-demographic factors such as educational attainment, employment, income, housing and quality of living environments. A generally accepted way of summarising these factors is the Index of Multiple Deprivation (IMD) (2015), which is measured at 'lower super output area' level (neighbourhoods of about 1500 people) and has seven domains:

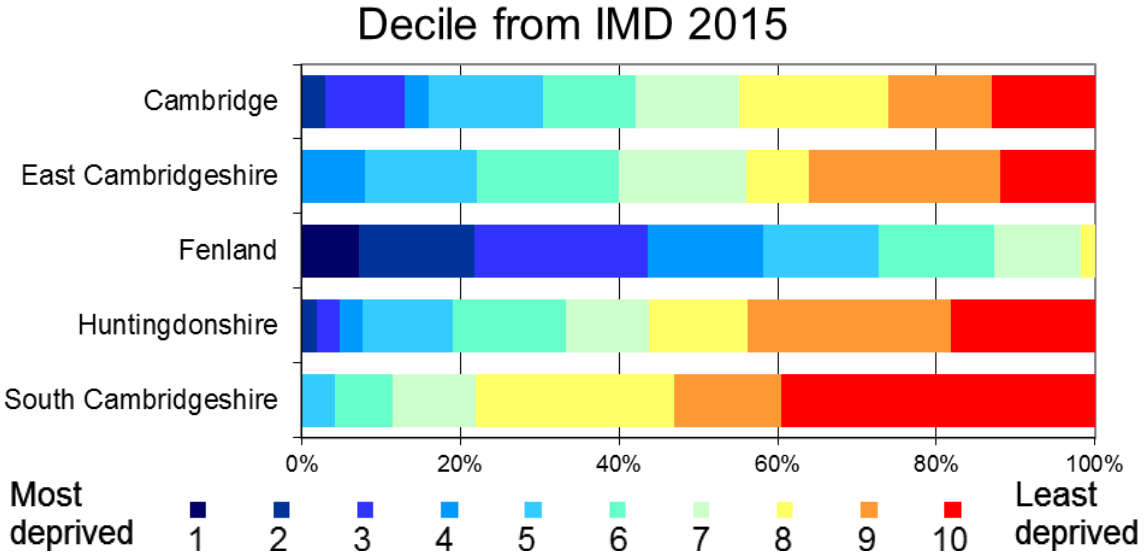
- Income
- Employment
- Education, Skills and Training
- Health deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment

2.2 The map below shows the IMD ranking of 'lower super output areas' in Cambridgeshire. It is colour coded by the IMD rank of each area, with the darkest blue areas being in the 10% most deprived nationally, and the red areas being in the 10% least deprived nationally.



The map demonstrates that, in general, areas of higher deprivation cluster in the north of the county and areas of lower deprivation in the rural areas around Cambridge City. Cambridge itself mirrors this pattern with some areas of higher deprivation in the north and east of the City

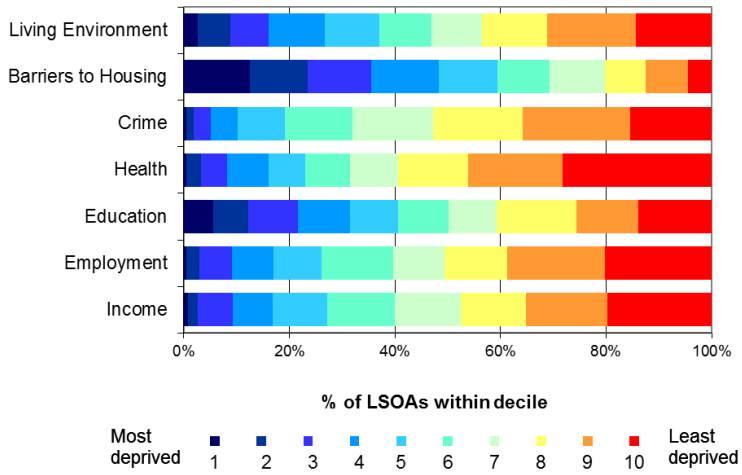
2.3 Cambridgeshire County Council Research Group has plotted the number of 'lower super output areas' (LSOAs) in each of the national deciles of deprivation (IMD 2015) for each district in the County. The chart below gives an indication of the range of deprivation in LSOAs within each district, rather than just giving an average deprivation score. It shows that in Fenland over 70% of LSOAs have a higher deprivation score than the national average (median) while in South Cambridgeshire this is less than 10%. Fenland is the only district with LSOAs in the most deprived 10% nationally, while Cambridge and Huntingdon have a small percentage in the most deprived 20%.



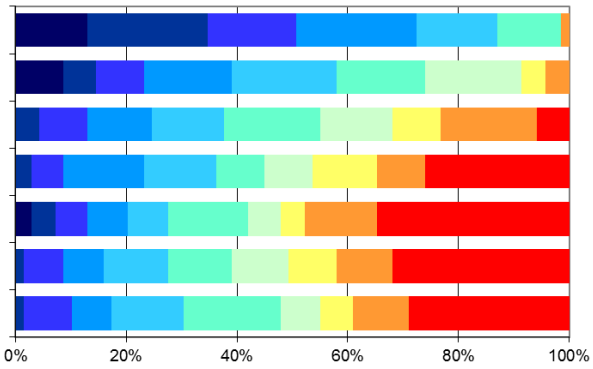
2.4 The charts overleaf provide more detail for each district about each of the domains of Index of Multiple Deprivation (2015) which make up the overall deprivation score. It can be seen that the 'Barriers to Housing and Services' domain is generally the worst scoring domain throughout the county with around 60% of LSOAs in the county scoring worse than the national average (median) - reflecting the relatively high costs of housing in relation to incomes, and the rural population. All other IMD (2015) domains score better than the national average (median) when the county as a whole is considered and the overall ranking for 'health deprivation and disability is good, with over a quarter of LSOAs ranking in the top ten percent nationally.

2.6 In contrast, Fenland scores poorly for 'Education, Skills and Training' with over 90% of LSOAs ranked below the national average (median). 'Health Deprivation and Disability' in Fenland has over 80% of LSOAs ranked as below average, although fewer are in the worst 20% nationally than for 'Education'. For both 'Income' and 'Employment' deprivation, Fenland has over 70% of LSOAs ranked as below average. Relating this back to the 'Marmot' research described in Section 1, it is clear that a number of the factors associated with health inequalities are present in Fenland – and health outcomes cannot be considered in isolation.

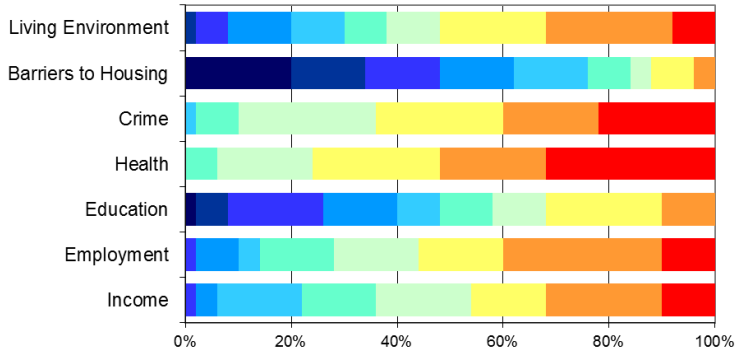
Cambridgeshire County



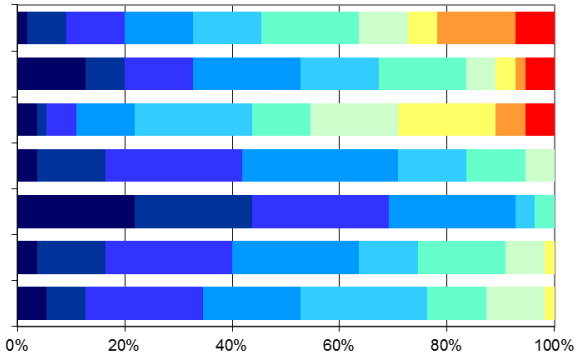
Cambridge City



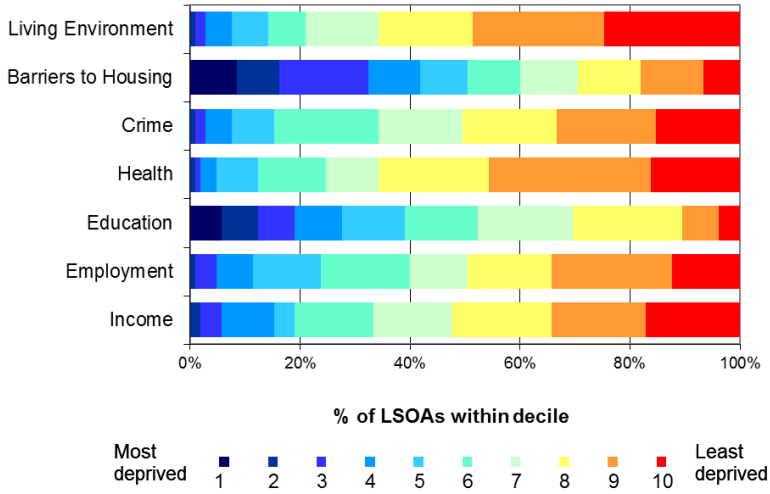
East Cambridgeshire



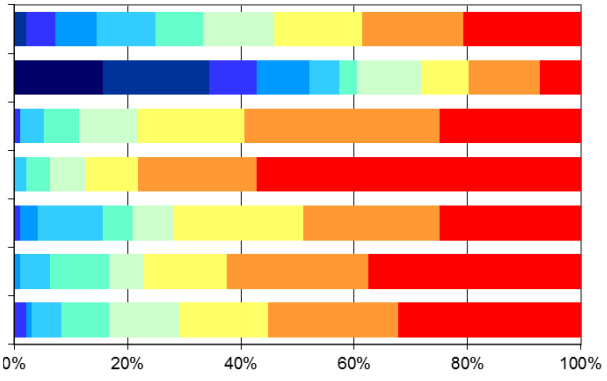
Fenland



Huntingdonshire



South Cambridgeshire



3. HEALTH INEQUALITIES – A FOCUS ON FENLAND

3.1 Given the high 'Health Deprivation and Disability' IMD (2015) ranking for Fenland, compared with the rest of Cambridgeshire, this section focusses in more detail on health inequalities in Fenland, including geographical variation within the Fenland area itself.

3.2 The table overleaf provides key statistics from Public Health England's Local Health Profiles (attached at Annex A) for

- England: providing the national benchmark
- Cambridgeshire: providing the county-wide benchmark
- Fenland District
- Wisbech: the town in Fenland with the highest level of deprivation

For some statistics, the Local Health Profile provides information on whether differences between the local area and the England average are statistically significant (5% level). For these, the figures in the table are colour coded green (better than average), amber (similar to average) and red (worse than average).

3.3 The first page of the table describes the 'determinants' of health – relating back to the emphasis the Marmot's report on the relationship between early years development, educational attainment, income and employment, and health. Key points working down from the top of the table include:

- Fenland district has a higher percentage of people aged 65 and over than both the England and the Cambridgeshire average. Because ageing is associated with increasing risk of illness and disability, this means that a higher percentage of the Fenland population are likely to be in poor health, independent of any effect of deprivation. Wisbech also has a higher proportion of older people than England.
- Fenland district has a lower than average percentage of people whose ethnicity is 'not white British' (2011 census data), whereas Wisbech is similar to the England average. However a higher than average proportion of residents in Wisbech cannot speak English well or at all – indicating a population of 'non white British' with additional needs for targeted communication and translation.
- Income deprivation and childhood deprivation are significantly worse than the England average in Fenland, whereas deprivation amongst older people is similar to average.
- Two key statistics relating to educational achievement – stage of development at age 5 which reflects a child's readiness for school; and the standard measure of GCSE achievement, are significantly worse than the national and Cambridgeshire average in Fenland District, and this is more marked in Wisbech.
- Unemployment and long term unemployment rates as measured by 'job seekers allowance' are significantly better in Fenland than the England average, although below the Cambridgeshire average. However rates of people claiming Employment Support Allowance

and incapacity benefits are above the England average in Fenland. In Wisbech unemployment rates (JSA) are similar to the England average.
- Overall – the relatively positive statistics for unemployment indicate that issues in Fenland relate more to low incomes and to illness/disability leading to people being unable to work, than to the overall quantity of employment.

3.4 In summary, key inequalities in **determinants of health** in Fenland include:

- Above average levels of child poverty and income deprivation among working age adults
- Below average school readiness amongst young children in the area, and below average educational achievement at GCSE, in turn associated with a lower level of skills in the local workforce.
- Relatively good levels of employment, but with below average income levels, and potentially other job quality issues outlined in the Marmot research on health inequalities, which are more common for unskilled and low-wage employment.
- Higher levels of 'non white British' residents with poor English language skills in Wisbech.
- A higher proportion of older people in the Fenland population – which will lead to greater needs for health care, independent of deprivation levels.

3.5 The second page of the table describes some **overarching health outcomes** in Fenland and Wisbech, compared with England and Cambridgeshire averages. Key points include:

- The percentage of the population who described themselves as having bad general health, very bad general health, and/or limiting long term illness or disability in the 2011 Census was higher than the England average in Fenland and Wisbech. It is difficult to disentangle the effect of the higher proportion of older people in Fenland and Wisbech from other factors influencing people's general health. However it does mean that needs for easily accessible NHS services will be higher.
- Emergency admission rates to hospital are higher than the England average in Fenland, and increase further in Wisbech. This increase in emergency admissions associated with deprivation is particularly marked for coronary heart disease and chronic obstructive pulmonary disease (which is closely linked with smoking rates). In contrast, emergency hospital admission rates for Cambridgeshire as a whole are well below average. These admission rates are adjusted statistically, to remove any effects from the age of the population.

Determinant of Health	England average	Cambridgeshire average	Fenland average	Wisbech average
Population aged 65+ (%) *2014*	**17.5%**	17.7%	21.8%	18.9%
Population whose ethnicity is not white UK (%) *2011*	**20.2%**	15.5%	9.6%	19.8%
Population who cannot speak English well or at all (%) *2011*	**1.7%**	1.1%	2.1%	6.1%
IMD (2015) score – all domains	**21.8**	13.4	25.4	N/A
IMD (2015) Income deprivation	**14.6**	**9.1**	**15.7**	N/A
IMD (2015) children in poverty (%)	**19.9%**	**12.7%**	**22.4%**	N/A
IMD (2015) Older people in deprivation (%)	**16.2%**	**11.3%**	**16.4%**	N/A
Children with a good level of development at age 5 (%) *2013/14*	**60.4%**	**61.3%**	**53.5%**	**47.9%**
Achieving 5A*-C (incl. Eng & Maths) GCSE, *2013/14*	**56.6%**	**56.4%**	**48.7%**	**39.8%**
Unemployment (JSA claimants %) *2015/16*	**1.8%**	**0.7%**	**1.2%**	**1.8%**
Long term unemployment (JSA) rate per 1000 *2015/16*	**4.3**	**1.1**	**1.9**	**3.3**
Employment support allowance and incapacity benefits % *2015/16**	**6.2% (GB)**	4.1%	7.0%	

Health outcome	England average	Cambridgeshire average	Fenland average	Wisbech average
General health very bad (%) *2011*	**1.2%**	**0.9%**	**1.4%**	**1.6%**
General health bad or very bad (%) *2011*	**5.5%**	**4.1%**	**6.2%**	**6.8%**
Limiting long term illness or disability (%) *2011*	**17.6%**	**15.3%**	**21%**	**21.5%**
Emergency hospital admissions – all causes: standardised admission ratios (SAR) *2010/11-2014/15*	**100**	**84.1**	**101.4**	**114.7**
Emergency hospital admissions for coronary heart disease: SAR *2010/11-2014/15*	**100**	**93.7**	**125.9**	**146.6**
Emergency hospital admissions for chronic obstructive pulmonary disease: SAR *2010/11-2014/15*	**100**	**79.5**	**103.0**	**150.6**
Premature deaths under age 65: standardised mortality ratio *2010-2014*	**100**	**78.8**	**107.3**	**132.4**
Premature deaths under age 75: standardised mortality ratio *2010-2014*	**100**	**82.5**	**104.2**	**123.2**
Life expectancy at birth: males 2009-13	**79.1**	**80.8**	**78.8**	**N/A**
Life expectancy at birth: females 2009-13	**83**	**84.4**	**82.8**	**N/A**
Disability free life expectancy at birth males 2009-13	**64.1**	**66.9**	**63**	**N/A**
Disability free life expectancy at birth females 2009-13	**65**	**67.4**	**64**	**N/A**

Source http://www.localhealth.org.uk/ * source https://www.nomisweb.co.uk/reports/lmp/la/contents.aspx

3.5 (cont)

- Premature death rates under the age of 65 and under the age of 75 also increase markedly with deprivation – starting from the Cambridgeshire figure which is well below the national average, through Fenland which is similar to the national average, to Wisbech which is above the national average. However a note of caution is required here – a total of 213 of the 3530 deaths under the age of 65 which occurred in Cambridgeshire between 2010 and 2014 were in Wisbech. So while risks are higher in areas of deprivation, measures to address premature deaths should not be limited only to these areas.
- Life expectancy in Fenland is similar to the national average, but disability free life expectancy is significantly worse than average. This would be expected from the graph in para 1.3, which shows a marked relationship between income deprivation and disability free life expectancy.

3.6 In summary, key inequalities in **health outcomes** in Fenland include

- A higher than average percentage of people with poor self-perceived general health and limiting illness or disability – which may be related to the higher proportion of older people in Fenland as well as to deprivation.
- Disability free life expectancy which is worse than the England average (although life expectancy is not significantly worse).
- Emergency hospital admission rates for Fenland (adjusted for age) which are significantly above the England and Cambridgeshire averages, and which show a further increase in Wisbech.
- Premature death rates which are similar to the national average in Fenland, but significantly above the national average in Wisbech.

3.7 The Local Health Profiles lack up to date information on **lifestyle behaviours,** which affect health and the development of long term conditions. This is because these lifestyle behaviours are measured through sample surveys which are only valid at district level. This information is instead reported on the Public Health Outcomes Framework website. The table overleaf shows those lifestyle behaviours for which the most recent measurement for Fenland is significantly worse than the national average. Key points include:

- Breast feeding has benefits for infant health and may be associated with reduced obesity in later life. Rates of starting breast feeding (measured in hospital) are lower than the England average in Fenland.
- Excess weight in adults, and rates of physical inactivity are worse than average in Fenland. Some of this effect may be due to the higher proportion of older people in the district – but this is insufficient to explain the full difference.
- The percentage of adults who smoke is well above the national average as is the percentage of routine and manual workers who smoke. This will have a significant impact on residents' future risk of heart disease, cancer and chronic obstructive pulmonary disease.
- Alcohol use leading to hospital admission is higher than the England average.
- Cancer screening uptake is poorer than the England average, with the exception of breast cancer screening, which is at the national average.

Lifestyle behaviour	England	Cambridgeshire	Fenland
Breastfeeding initiation *2014/15*	**74.3%**	Not published for data quality reasons	**68.8%**
Excess weight in adults *2013-15*	**64.8%**	**63.2%**	**72.9%**
Physically active adults *2015*	**57%**	**58.6%**	**47.9%**
Physically inactive adults *2015*	**28.7%**	**25.3%**	**38.4%**
Smoking prevalence adults *2015*	**16.9%**	**16.4%**	**26.4%**
Smoking prevalence – routine and manual workers *2015*	**26.5%**	**27.2%**	**39.8%**
Admission episodes for alcohol related conditions (narrow definition) *2014/15*	**641**	**611**	**706**
Cancer screening coverage – cervical cancer *2015*	**73.5%**	**72.7%**	**72.5%**
Cancer screening coverage – bowel cancer *2015*	**57.1%**	**58.1%**	**51.6%**

Source: http://www.phoutcomes.info/

3.8 In summary, the table above shows that there are a number of adverse lifestyle behaviours which are more common than average in Fenland – notably smoking, physical inactivity and unhealthy weight, and some alcohol problems. Services to support people in changing these behaviours and adopt a healthier lifestyle are commissioned by the County Council through the public health grant, and should be appropriately targeted in line with Marmot report recommendations. It is encouraging that there are some lifestyle behaviours in Fenland which are not worse than average, including childhood obesity rates, teenage pregnancy, and fruit and vegetable consumption, shown in the Fenland Public Health Outcomes Framework 'Health Improvement' profile in Annex B.

4.0 CONCLUSIONS

4.1 This paper provides a brief review of health outcomes across the system in Cambridgeshire, with a particular focus on Fenland. Going back to the evidence base from the Marmot Report on health inequalities, the following points are likely to be relevant for any future work to develop key strategies and actions:

Proportionate universalism: Marmot argued strongly that health inequalities occurred throughout society, and could not be addressed only by targeting the most disadvantaged populations. The data presented in this paper generally supports this view, with gradations in health inequalities between areas, rather than a sharp 'cut off'.

The importance of the wider determinants of health: The links between childhood development, educational attainment, income deprivation, employment and health described in the Marmot Report, are also apparent in the data for Cambridgeshire. Commitment is needed from a range of agencies including early years providers, schools, employers, the Local Enterprise Partnership, and the NHS – in order to address the wider range of factors leading to local inequalities in health outcomes.

Addressing lifestyle behaviours One of Marmot's recommendations was to 'strengthen the role and impact of ill health prevention' and it is important that the behaviour change services commissioned through the public health grant are appropriately targeted in relation to need and are locally sensitive. But services to address lifestyle behaviours will not work on their own to tackle health inequalities, given the impact of wider aspects of disadvantage and deprivation..

An ageing population From a local perspective it is important to recognise that health issues and needs in Fenland are not just a result of socio-economic and 'health inequalities' issues, but also a direct result of the higher proportion of older people in the area. This leads to a higher demand for NHS services, which given Fenland's rurality, need to be easily accessible.

5.0 ALIGNMENT WITH PRIORITIES AND WAYS OF WORKING

5.1 Developing the local economy for the benefit of all

The links between income, employment and health inequalities have been outlined in the main body of the paper.

5.2 Helping people live healthy and independent lives in their communities

The main body of the paper addresses factors which affect people's health and independence in their communities.

5.3 Supporting and protecting vulnerable people when they need it most

A number of factors which affect vulnerability to poor health outcomes are described in the main body of the paper.

6. SIGNIFICANT IMPLICATIONS

6.1 Resource and Performance Implications

This paper is provided for information but may lead to further policy and/or actions which have resource and performance implications.

6.2 Statutory, Risk and Legal Implications

This paper is provided for information but may lead to further policy and/or actions which have resource and performance implications.

6.3 Equality and Diversity Implications

This paper reviews some aspects of equality and diversity – in particular inequalities associated with socio-economic deprivation.

6.4 Engagement and Consultation

This paper is provided for information but may lead to further policy and/or actions which have resource and performance implications.

6.5 Localism and Local Member involvement

This paper is provided for information but may lead to further policy and/or actions which have resource and performance implications at a local level.

6.6 Public Health

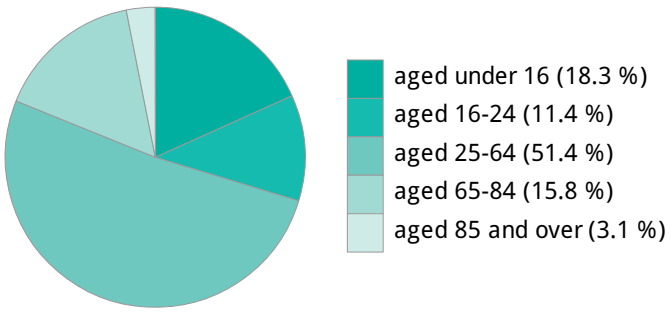
This paper is provided for information, but may have future impact on policy or actions delivered through the public health functions of the Council.

Source Documents	Location
'Fair Society Healthy Lives' the Marmot Review	http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
Local Health website	http://www.localhealth.org.uk/
Public Health Outcomes Framework	http://www.phoutcomes.info/

Report - Wisbech

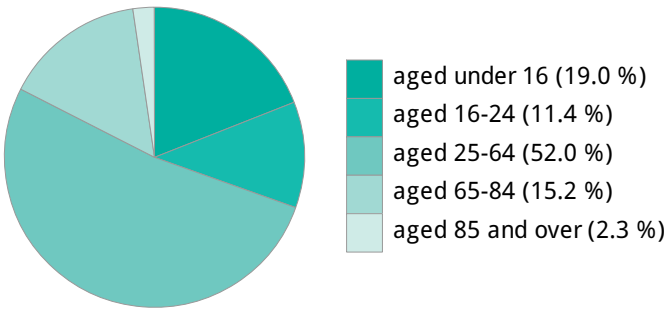
Population

Population by age group, 2014
Selection



Source: ONS ø Crown copyright 2015 - total: 23,692

Population by age group, 2014
England



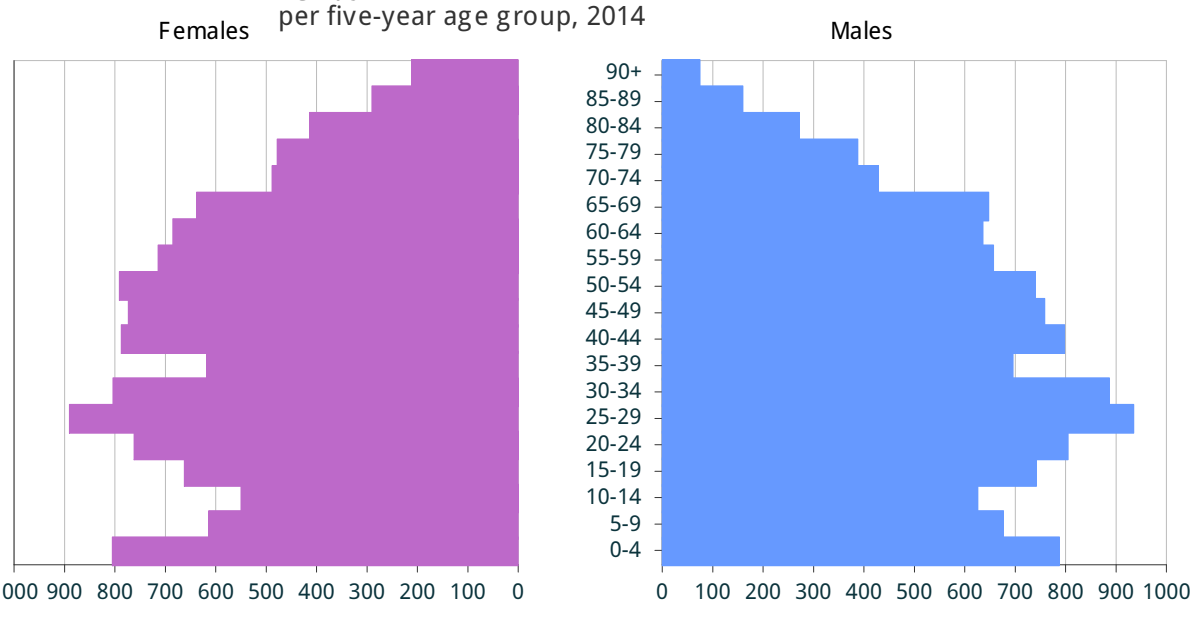
Source: ONS ø Crown copyright 2015

Population by age group, 2014, numbers

Ages	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
aged under 16	4,333	17,139	116,858	10,303,556
aged 16-24	2,698	9,713	75,272	6,210,192
aged 25-64	12,170	49,520	334,149	28,265,162
aged 65-84	3,755	18,502	97,958	8,262,192
aged 85 and over	736	2,858	15,581	1,275,516
Total	23,692	97,732	639,818	54,316,618

Source: ONS ø Crown copyright 2015

Age pyramid for selection: male and female numbers per five-year age group, 2014



Source: ONS ø Crown Copyright 2015

Report - Wisbech

Ethnicity & Language

Ethnicity & Language indicators, 2011, numbers

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
Black and Minority Ethnic (BME) Population	749	2,631	46,223	7,731,314
Population whose ethnicity is not 'White UK'	4,513	9,111	96,593	10,733,220
Population who cannot speak English well or at all	1,338	1,902	6,415	843,845

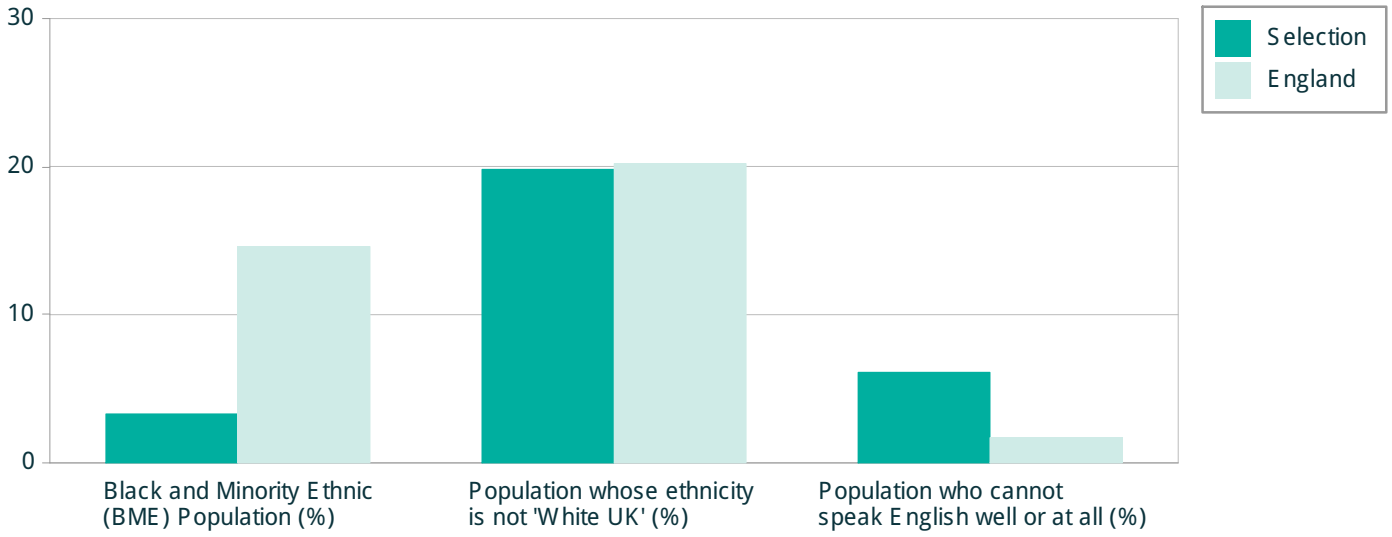
Source: ONS Census

Ethnicity & Language indicators, 2011, %

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
Black and Minority Ethnic (BME) Population (%)	3.3	2.8	7.4	14.6
Population whose ethnicity is not 'White UK' (%)	19.8	9.6	15.5	20.2
Population who cannot speak English well or at all (%	6.1	2.1	1.1	1.7

Source: ONS Census

Ethnicity & Language indicators, 2011, %, Selection



Source: ONS Census

Child Development, Education and Employment

Child development, education and employment indicators, numbers (estimated from MSOA level data)

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
Low birth weight births, 2010-2014	138	421	2,443	248,184
A good level of development at age 5, 2013/14	145	595	4,399	387,000
Achieving 5A*-C (incl. Eng & Maths) GCSE, 2013/14	98	524	3,395	315,795
Claiming job seekers allowance, 2015/16*	266	687	3,021	612,166
Claiming job seekers allowance for > 1 year, 2015/16	50	110	445	147,990

Source: Public Health England, ONS, NOMIS, DfE

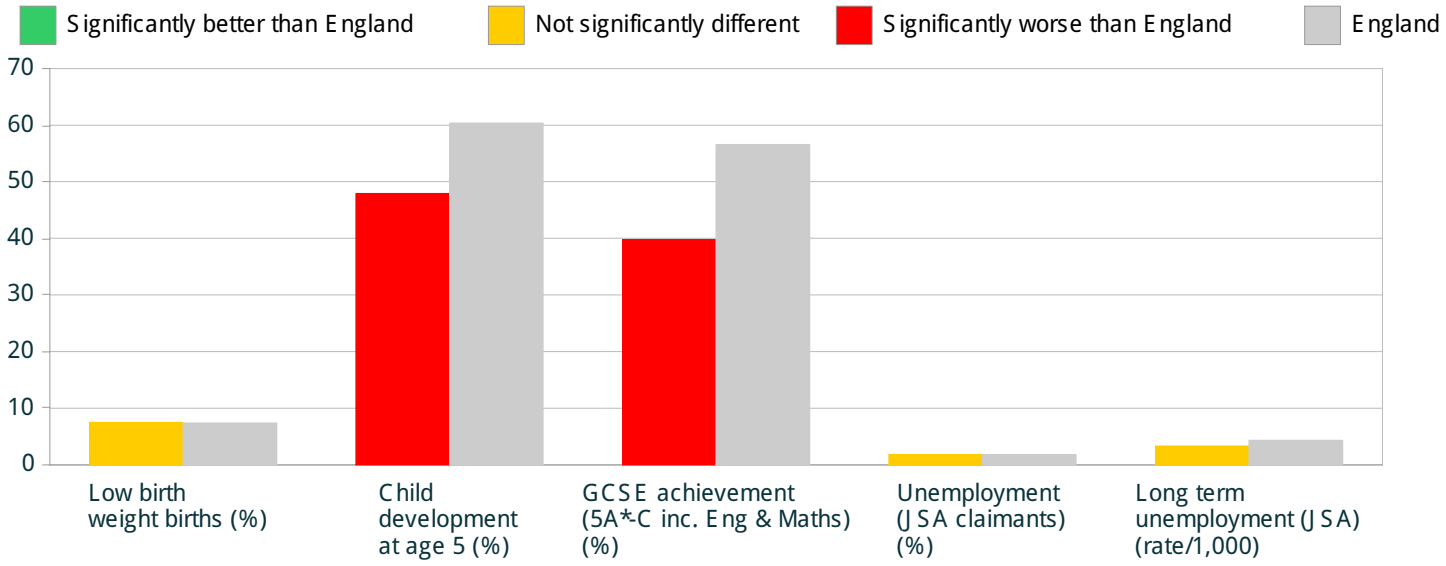
*Monthly average

Child development, education and employment indicators, values (estimated from MSOA level data)

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
Low birth weight births (%)	7.5	7.3	6.5	7.4
Child development at age 5 (%)	47.9	53.5	61.3	60.4
GCSE achievement (5A*-C inc. Eng & Maths) (%)	39.8	48.7	56.4	56.6
Unemployment (JSA claimants) (%)	1.8	1.2	0.7	1.8
Long term unemployment (JSA) (rate/1,000)	3.3	1.9	1.1	4.3

Source: Public Health England, ONS, NOMIS, DfE

Child development, education and employment indicators, Selection (comparing to England average)



Source: Public Health England, ONS, NOMIS, DfE

Health and Care

Health and care indicators, 2011, numbers

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
General health: very bad	361	1,293	5,453	660,749
General health: bad or very bad	1,553	5,883	25,168	2,911,195
Limiting long term illness or disability	4,919	20,030	95,027	9,352,586
Provides unpaid care for 1 or more hours per week	2,313	10,594	60,176	5,430,016
Provides unpaid care for 50 or more hours per week	751	2,944	12,078	1,256,237

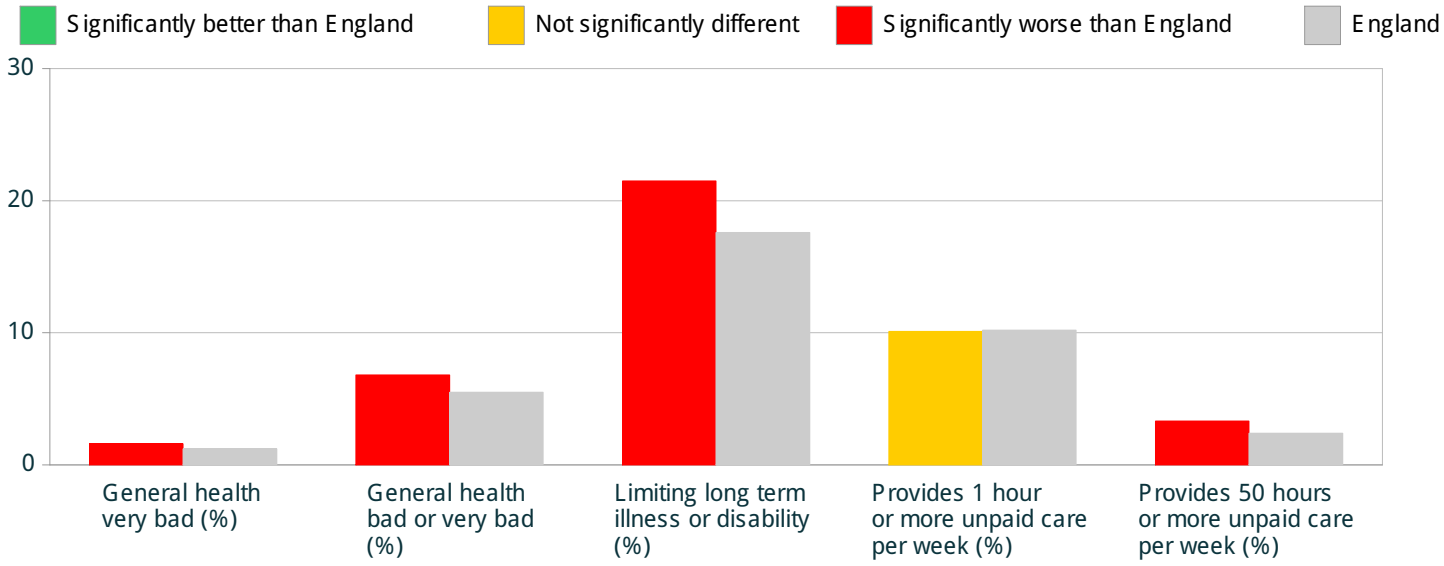
Source: ONS Census

Health and care indicators, 2011, %

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
General health very bad (%)	1.6	1.4	0.9	1.2
General health bad or very bad (%)	6.8	6.2	4.1	5.5
Limiting long term illness or disability (%)	21.5	21	15.3	17.6
Provides 1 hour or more unpaid care per week (%)	10.1	11.1	9.7	10.2
Provides 50 hours or more unpaid care per week (%)	3.3	3.1	1.9	2.4

Source: ONS Census

Health and care indicators, 2011, %, Selection (comparing to England average)



Source: ONS Census

Emergency hospital admissions

Emergency Hospital Admissions, numbers, 2010/11 to 2014/15 (estimated from MSOA level data)

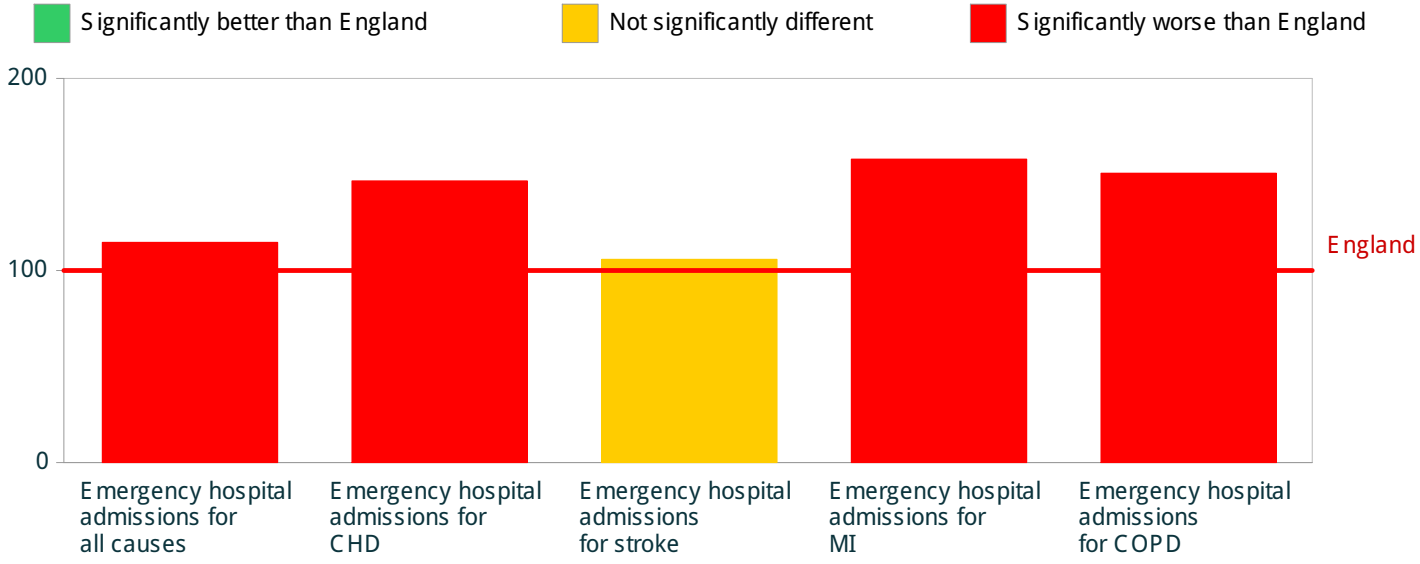
Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
Emergency hospital admissions for all causes	14,004	51,885	260,650	26,462,290
Emergency hospital admissions for CHD*	476	1,847	7,605	690,158
Emergency hospital admissions for stroke	204	830	3,810	389,174
Emergency hospital admissions for MI*	242	827	3,523	322,544
Emergency hospital admissions for COPD*	411	1,286	5,341	572,993

*CHD: Coronary Heart Disease; MI: Myocardial Infarction (heart attack); COPD: Chronic Obstructive Pulmonary Disease

Emergency Hospital Admissions, Standardised Admission Ratios (SARs), 2010/11 to 2014/15 (est. from MSOA data)

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
Emergency hospital admissions for all causes	114.7	101.4	84.1	100
Emergency hospital admissions for CHD	146.6	125.9	93.7	100
Emergency hospital admissions for stroke	105.8	98.3	83.4	100
Emergency hospital admissions for MI	157.9	120.4	92.8	100
Emergency hospital admissions for COPD	150.6	103	79.5	100

Emergency Hospital admissions, SARs, 2010/11 to 2014/15, Selection (comparing to England average)



Mortality and causes of death - premature mortality

Causes of deaths - premature mortality, numbers, 2010-2014

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
All causes, aged under 65	213	772	3,530	391,312
All causes, aged under 75	399	1,613	7,325	762,945
All cancer, aged under 75	145	672	3,257	310,346
All circulatory disease, aged under 75	96	381	1,566	176,217
Coronary heart disease, aged under 75	50	213	822	99,575

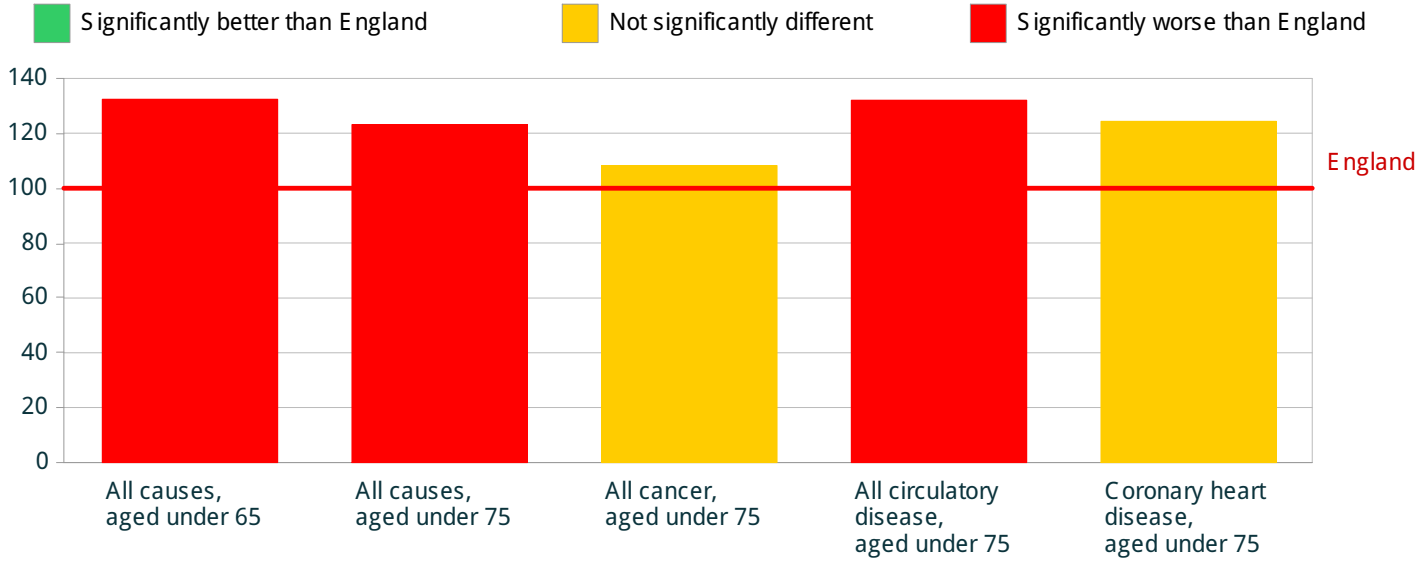
Source: Public Health England, produced from ONS data Copyright ø 2016

Causes of deaths - premature mortality, Standardised Mortality Ratios (SMRs), 2010-2014

Indicator	Selection	Lower Tier Local Authority (Fenland)	Upper Tier Local Authority (Cambridgeshire)	England
All causes, aged under 65	132.4	107.3	78.8	100
All causes, aged under 75	123.2	104.2	82.5	100
All cancer, aged under 75	108.3	103.1	88.6	100
All circulatory disease, aged under 75	132	108.1	78.7	100
Coronary heart disease, aged under 75	124.3	108.4	74.6	100

Source: Public Health England, produced from ONS data Copyright ø 2016

Causes of deaths - premature mortality, SMRs, 2010-2014, Selection (comparing to England average)



Source: Public Health England, produced from ONS data Copyright ø 2016

ANNEX B - Fenland Public Health Outcomes Framework 'Health Improvement' profile

Compared with benchmark ● Better ● Similar ● Worse ● Lower ● Similar ● Higher ○ Not Compared

Indicator	Period	Fenland			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
2.01 - Low birth weight of term babies	2014	➡	30	2.9%	2.7	2.9	5.8%		1.1%
2.02i - Breastfeeding - breastfeeding initiation	2014/15	-	856	68.8%	76.6	74.3	47.2%		92.9%
2.02ii - Breastfeeding - breastfeeding prevalence at 6-8 weeks after birth - historical method	2014/15	-	487	37.3%	*	43.8	-	*Insufficient number of values for a spine chart*	-
2.04 - Under 18 conceptions	2014	⬇	38	22.5	20.2	22.8	43.0		5.2
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2014/15	⬇	237	22.4%	20.7	21.9	30.7%		14.9%
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2014/15	➡	290	32.6%	30.7	33.2	43.2%		21.1%
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2014/15	➡	200	125.0	99.0	109.6	199.7		56.0
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2014/15	➡	90	155.9	121.5	137.5	292.4		45.0
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	2014/15	➡	141	130.0	121.4	131.7	287.1		56.8
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	2014/15	-	223	236.2	173.8	191.4	629.9		58.9
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	2015	-	-	55.8%	54.5	52.3	36.5%		69.2%
2.11ii - Average number of portions of fruit consumed daily (adults)	2015	-	-	2.55	2.55	2.51	2.11		2.98
2.11iii - Average number of portions of vegetables consumed daily (adults)	2015	-	-	2.39	2.34	2.27	1.70		2.87
2.12 - Excess weight in Adults	2013 - 15	-	-	72.9%	65.6	64.8	76.2%		46.5%
2.13i - Percentage of physically active and inactive adults - active adults	2015	-	-	47.9%	57.8	57.0	44.8%		69.8%
2.13ii - Percentage of physically active and inactive adults - inactive adults	2015	-	-	37.4%	27.6	28.7	43.7%		14.7%
2.14 - Smoking Prevalence in adults - current smokers (APS)	2015	-	-	26.4%	16.6	16.9	32.3%		7.5%
2.14 - Smoking Prevalence in adult in routine and manual occupations - current smokers (APS)	2015	-	-	39.8%	26.4	26.5	64.6%		6.3%
2.15iv - Deaths from drug misuse	2013 - 15	-	13	*	3.4	3.9	-	*Insufficient number of values for a spine chart*	-
2.17 - Recorded diabetes	2014/15	⬆	7,297	7.8%	6.1	6.4	3.3%		9.2%
2.18 - Admission episodes for alcohol-conditions - narrow definition (Persons)	2014/15	-	698	706	580	641	1,223		374
2.18 - Admission episodes for alcohol-conditions - narrow definition (Male)	2014/15	-	421	872	728	827	1,544		493
2.18 - Admission episodes for alcohol-conditions - narrow definition (Female)	2014/15	-	277	554	450	474	920		254
2.19 - Cancer diagnosed at early stage (experimental statistics)	2014	-	269	55.6%	56.6	50.7	36.3%		67.2%
2.20i - Cancer screening coverage - breast cancer	2015	⬇	9,055	75.3%	76.4	75.4	56.3%		85.5%
2.20ii - Cancer screening coverage - cervical cancer	2015	⬇	17,767	72.5%	74.4	73.5	56.5%		83.1%
2.20iii - Cancer screening coverage - bowel cancer	2015	-	8,416	51.6%	59.0	57.1	37.3%		68.4%
2.20iv – Abdominal Aortic Aneurysm Screening – Coverage	2014/15	-	518	84.5%	80.7*	79.4	59.0%		90.5%
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2014/15	-	452	2,027	1956	2125	3,462		1,212
2.24i - Injuries due to falls in people aged 65 and over (Male)	2014/15	-	141	1,635	1573	1740	3,046		793
2.24i - Injuries due to falls in people aged 65 and over (Female)	2014/15	-	311	2,419	2340	2509	3,903		1,556
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Persons)	2014/15	-	140	921	874	1012	1,923		553
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Male)	2014/15	-	55	748	696	826	1,754		422
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 (Female)	2014/15	-	85	1,095	1051	1198	2,092		683
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (Persons)	2014/15	-	312	5,233	5096	5351	8,611		2,697
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (Male)	2014/15	-	86	4,208	4113	4391	7,459		1,217
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ (Female)	2014/15	-	226	6,259	6079	6312	10,519		3,726

Agenda Item No: 8

PUBLIC HEALTH RISK REGISTER UPDATE

To:	**Health Committee**
Date:	**14 July 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**To provide the Health Committee with details of Public Health Directorate risks.**
Recommendation:	**It is recommended that the Health Committee:**

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

(b) The Committee is asked to comment on the Public Health Risk Register and endorse the amendments since the previous update.

	Officer contact:
Name:	Tess Campbell
Post:	Performance and projects manager
Email:	Tess.campbell@cambridgeshire.gov.uk
Tel:	01223 703853

1. BACKGROUND

1.1 In accordance with best practice the Council operates a risk management approach at corporate and directorate levels across the Council seeking to identify any key risks which might prevent the Council's priorities, as stated in the Business Plan and in service plans, from being successfully achieved.

1.2 The Council's approach to the management of risks is encapsulated in two key documents:

- Risk Management Policy (Appendix 1)

  This document sets out the Council's Policy on the management of risk, including the Council's approach to the level of risk it is prepared to countenance as expressed as a maximum risk appetite. The Risk Management Policy is owned by the General Purposes Committee.

- Risk Management Procedures

  This document details the procedures through which the Council will identify, assess, monitor and report key risks. Risk Management Procedures are owned by Strategic Management Team (SMT).

1.3 The respective roles of the General Purposes Committee and the Audit and Accounts Committee in the management of corporate risk are:

- The General Purposes Committee has an executive role in the management of risk across the Council in its role of ensuring the delivery of priorities

- The Audit and Accounts Committee provides independent assurance of the adequacy of the Council's risk management framework and the associated control environment.

1.4 Service committees also have a role, on a half yearly basis, in the management of service risk of:

- ensuring service risk registers are maintained on a timely basis, i.e. subject to quarterly review by service management
- ensuring that actions designed to better manage risk are implemented on a timely basis
- to discuss specific risk issues as appropriate

1.5 Risk Identification

The Council's approach to risk identification, which is, in some ways, the most difficult part of the risk management process, is described in the following extract from the Council's Risk Management Policy as previously approved by the General Purposes Committee:

- Risk management should operate within a culture of transparency and openness where risk identification is encouraged and risks are escalated where necessary to the level of management best placed to manage them effectively;

- Risk management should be embedded in everyday business processes;

- Officers of the Council should be aware of, and operate, the Council's risk management approach where appropriate;

- Councillors should be aware of the Council's risk management approach and of the need for the decision making process to be informed by robust risk assessment, with General Purposes Committee members being involved in the identification of risk on an annual basis;

1.6 There are two distinct elements to risk scoring:

- The probability of a risk event occurring.
- The impact on the Council if the risk does occur

These are represented on a scoring matrix as attached at Appendix 2. In order to assist managers in the scoring of impact risk and to ensure consistency across the Council, a set of impact descriptors has been designed across five impact types which can be viewed at the second page of Appendix 2. The scoring of probability is left to the discretion of risk owners based upon their experience.

1.7 This report is supported by:

- Risk Management Policy **(Appendix 1)**
- Risk Scoring Matrix **(Appendix 2)**
- The Public Health Risk Register (**Appendix 3**)

2. PUBLIC HEALTH DIRECTORATE RISK REGISTER

2.1 The Public Health Directorate operates risk management in accordance with the Council's Risk Management Procedures document whereby risks are reviewed at Directorate and service team level on a quarterly basis. It should be noted that there are some specific aspects to the way the Public Health Directorate scores its risks compared to the remainder of the Council, as some risks to the health of the public are included for which the Directorate has a monitoring and influencing role, as well as those where the County Council directly commissions or delivers services.

2.2 The Directorate's Corporate Risk Group member co-ordinates risk management across the Directorate liaising with representatives from services and teams to ensure this approach functions effectively.

2.3 Risk registers are maintained at each level of the Directorate as appropriate, in accordance with the requirement of the Procedures document to manage risk at the lowest appropriate level. Risks are identified on the basis that if the risks were to occur they would severely impact on the Directorate's ability to meet its defined objectives. The key stages of the detailed risk management process once a risk is identified are:

- possible causes of the risk are recorded. This stage helps to identify the mitigations required to manage the risk effectively.
- impacts on the Council if the risk was to occur are recorded. This highlights the significance of the risk and aids its scoring.
- mitigations in place are identified and the risk is scored
- management review the risk score to determine if that level of risk is appropriate having regard to the Council's defined risk appetite of a maximum risk score of 15.
- if the level of risk is deemed to be inappropriate, management will determine actions which when implemented will move the risk level to an appropriate level. Each action will be assigned an owner and a target date for delivery. This will be reviewed on regular basis as part of the quarterly review of risk registers.
- as actions are implemented, management will update the residual risk score as appropriate.

2.4 Following the review of Public Health Directorate risks by the Quality, Safety and Risk Group on 19 October 2016, the Directorate Management Team (DMT) is confident that the Public Health Risk Register is a comprehensive expression of the main risks faced by the Directorate and that mitigation is either in place, or in the process of being developed, to ensure that each risk is appropriately managed.

2.5 The Public Health Directorate Risk Register to October 2016 is presented at Appendix 3 and illustrates that there are 22 current Directorate risks. There are 3 new Public Health Risks as detailed below. The Residual Risk Scores for these risks are: 22 amber, 0 green and 0 red. There are a total of 61 individual actions associated with the overarching risks. Of the individual actions 0 are red, 29 are amber, 26 are green and 6 are under review with no current action status.

- ***Risk 8 (amber risk): Lack of compliance and appropriate data protection and information governance legislation and good practice***. The majority of the mitigating actions associated with this risk have now been completed, and as such have been removed and replaced with current, relevant mitigating actions.

New Risks

Risk No	Risk	Probability	Impact	Comments
29	Failure to deliver transformation and maintain key aspects of the business	3	4	Amber Risk. Mitigating actions have been agreed for programme planning for Public Health transformation, and also to contribute to the consultation on the Corporate Review, which has now been completed.
30	Inability to identify, agree and implement savings	3	4	Ongoing work continues to be taken in developing any and all savings proposals to be discussed with Committee
31	Failure to deliver health outcomes or manage resources due to partner organisations not working together effectively	2	4	Amber Risk. A risk which was originally discussed at July Committee, and further discussed during QSR meeting. Mitigating actions have been identified which includes support to our existing partnership arrangements. Any review of partnership working will ensure that there are sufficient key controls for public health functions

3. ALIGNMENT WITH PRIORITIES AND WAYS OF WORKING

3.1 Risk management seeks to identify and to manage any risks which might prevent the Council from achieving its three priorities of:

- Developing the local economy for the benefit of all
- Helping people live healthy and independent lives in their communities
- Supporting and protecting vulnerable people when they need it most

4. SIGNIFICANT IMPLICATIONS

4.1 Resource and Performance Implications

Effective risk management should ensure that the Council is aware of the risks which might prevent it from managing its finances and performance to a high standard. The Council is then able to ensure effective mitigation is in place to manage these risks.

4.2 Statutory, Risk and Legal Implications

The Risk Management process seeks to identify any significant risks which might prevent the Council from achieving its plans as detailed in the Council's Business Plan or from complying with legislative or regulatory requirements. This enables mitigation to be designed to control each risk, either to prevent the risk happening in the first place or if it does to minimise its impact on the Council.

4.3 Equality and Diversity Implications

The risk associated with failure to address health inequalities is described in para 2.5.

4.4 Engagement and Consultation

The Corporate Risk Register has been subject to review by the Officer Risk Champions Group and Strategic Management Team

4.5 Public Health

This paper describes risks associated with the Council's public health functions.

Source Documents	Location
Corporate Risk Register	Internal Audit and Risk Management OCT 1108 Shire Hall, Cambridge

APPENDIX 1

CAMBRIDGESHIRE COUNTY COUNCIL

RISK MANAGEMENT POLICY

1. INTRODUCTION

We want Cambridgeshire to be the best county in England in which to live and work. We aim to deliver this vision by focusing on our priorities:

- develop the local economy for the benefit of all
- help people live healthy and independent lives
- support and protect vulnerable people

We are a large, complex organisation and we need to ensure the way we act, plan and deliver is carefully thought through both on an individual and a corporate basis.

We have a plan for achieving this vision and, as an organisation; we need to make sure we are ready for the challenge.

There are many factors which might prevent the Council achieving its plans, therefore we seek to use a risk management approach in all of our key business processes with the aim of identifying, assessing and managing any key risks we might face. This approach is a fundamental element of the Council's Code of Corporate Governance.

The Risk Management Policy is fully supported by the Council, the Chief Executive and the Strategic Management Team, who are accountable for the effective management of risk within the Council. On a daily basis all officers of the Council have a responsibility to recognise and manage risk in accordance with this Policy.

The Accounts and Audit Regulations, 2003 state:

- The relevant body shall be responsible for ensuring that the financial management of the body is adequate and effective and that the body has a sound system of internal control which facilitates the effective exercise of that body's functions and which includes arrangements for the management of risk.

(Additionally, the Civil Contingencies Act, 2004 places a statutory duty on local authorities to establish business continuity management arrangements to ensure that they can continue to deliver business critical services if business disruption occurs. The Emergency Planning Camweb site http://camweb/cd/cst/demmembserv/cemt/bcp/default.htm details the Council's approach to business continuity management which is a key aspect of effective risk management)

2. WHAT IS RISK?

The Council's definition of risk is:

"Factors, events and circumstances that may prevent or detract from the achievement of the Council's corporate and service plan priorities".

3. RISK MANAGEMENT OBJECTIVE

The Council will operate an effective system of risk management which will seek to ensure that risks which might prevent the Council achieving its plans are identified and managed on a timely basis in a proportionate manner.

4. RISK MANAGEMENT PRINCIPLES

- The risk management process should be consistent across the Council, clear and straightforward and result in timely information that helps informed decision making;

- Risk management should operate within a culture of transparency and openness where risk identification is encouraged and risks are escalated where necessary to the level of management best placed to manage them effectively;

- Risk management arrangements should be dynamic, flexible and responsive to changes in the risk environment;

- The response to risk should be mindful of risk level and the relationship between the cost of risk reduction and the benefit accruing, i.e. the concept of proportionality;

- Risk management should be embedded in everyday business processes;

- Officers of the Council should be aware of, and operate, the Council's risk management approach where appropriate;

- Councillors should be aware of the Council's risk management approach and of the need for the decision making process to be informed by robust risk assessment, with General Purpose Committee members being involved in the identification of risk on an annual basis;

5. APPETITE FOR RISK

As an organisation with limited resources it is inappropriate for the Council to seek to mitigate all of the risk it faces. The Council therefore aims to manage risk in a manner which is proportionate to the risk faced based on the experience and expertise of its senior managers. However, the General Purpose Committee has defined the maximum level of residual risk which it is prepared to accept as a maximum risk score of 15 as per the Scoring Matrix attached at Appendix A.

6. BENEFITS OF RISK MANAGEMENT

- Risk management alerts councillors and officers to the key risks which might prevent the achievement of the Council's plans, in order that timely mitigation can be developed either to prevent the risks occurring or to manage them effectively if they do occur.

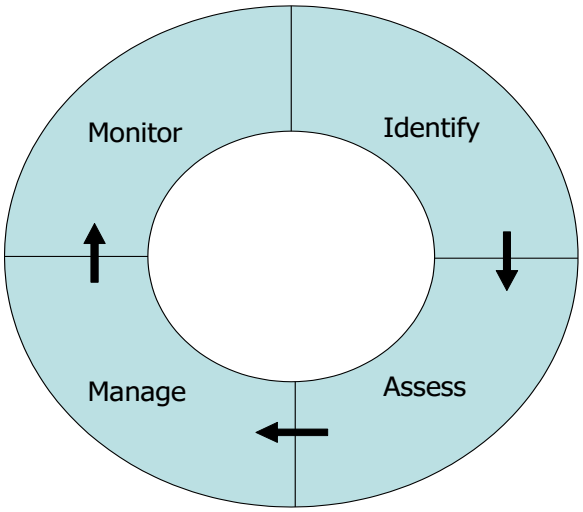
- Risk management at the point of decision making should ensure that councillors and officers are fully aware of any key risk issues associated with proposals being considered.

- Risk management leads to greater risk awareness and an improved and cost effective control environment, which should mean fewer incidents and other control failures and better service outcomes.

- Risk management provides assurance to councillors and officers on the adequacy of arrangements for the conduct of business. It demonstrates openness and accountability to various regulatory bodies and stakeholders more widely.

7. RISK MANAGEMENT APPROACH

The risk management approach adopted by the Council is based on identifying, assessing, managing and monitoring risks at all levels across the Council:



The detailed stages of the Council's risk management approach are recorded in the Risk Management Procedure document which is reviewed by Strategic Management Team on an annual basis. The Procedure document provides managers with detailed guidance on the application of the risk management process.

The Risk Management Procedures document can be located on Camweb at

Additionally individual business processes, such as decision making, council planning and project management will include guidance on the management of risk within those processes.

8. AWARENESS AND DEVELOPMENT

The Council recognises that the effectiveness of its risk management approach will be dependent upon the degree of knowledge of the approach and its application by officers and councillors.

The Council is committed to ensuring that all councillors, officers and partners where appropriate, have sufficient knowledge of the Council's risk management approach to fulfil their responsibilities for managing risk. This will be delivered through formal training programmes, risk workshops, briefings and internal communication channels.

9. CONCLUSION

The Council will face risks to the achievement of its plans. Compliance with the risk management approach detailed in this Policy should ensure that the key risks faced are recognised and effective measures are taken to manage them in accordance with the defined risk appetite.

APPENDIX 2

RISK SCORING MATRIX

VERY HIGH (V)	5	10	15	20	25
HIGH (H)	4	8	12	16	20
MEDIUM (M)	3	6	9	12	15
LOW (L)	2	4	6	8	10
NEGLIGIBLE	1	2	3	4	5
IMPACT / LIKELIHOOD	VERY RARE	UNLIKELY	POSSIBLE	LIKELY	VERY LIKELY

Red scores - excess of Council's risk appetite – action needed to redress, quarterly monitoring
Amber scores – likely to cause the Council some difficulties – quarterly monitoring
Green scores – monitor as necessary

Descriptors to assist in the scoring of risk impact are on the following page.

Likelihood scores are left to the discretion of managers as it is very subjective.

IMPACT DESCRIPTORS

The following descriptors are designed to assist the scoring of the impact of a risk:

	Negligible (1)	Low (2)	Medium (3)	High (4)	Very High (5)
Legal and Regulatory	Minor civil litigation or regulatory criticism	Minor regulatory enforcement	Major civil litigation and/or local public enquiry	Major civil litigation setting precedent and/or national public enquiry	Section 151 or government intervention or criminal charges
Financial	<£0.5m	<£1m	<£5m	<£10m	>£10m
Service provision	Insignificant disruption to service delivery	Minor disruption to service delivery	Moderate direct effect on service delivery	Major disruption to service delivery	Critical long term disruption to service delivery
People and Safeguarding	No injuries	Low level of minor injuries	Significant level of minor injuries of employees and/or instances of mistreatment or abuse of individuals for whom the Council has a responsibility	Serious injury of an employee and/or serious mistreatment or abuse of an individual for whom the Council has a responsibility	Death of an employee or individual for whom the Council has a responsibility or serious mistreatment or abuse resulting in criminal charges
Reputation	No reputational impact	Minimal negative local media reporting	Significant negative front page reports/editorial comment in the local media	Sustained negative coverage in local media or negative reporting in the national media	Significant and sustained local opposition to the Council's policies

Cambridgeshire County Council

CORPORATE RISK REGISTER

Public Health

Version Date: October 2016

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
1	Inability to manage the budget effectively, and utilise resources available	1. Health Committee oversight 2. Business Planning Process 3. Monthly Finance Meetings 4. Shared Priorities Steering Group 5. SMT	2	4	8	1. Close monitoring of savings plan implementation through use of savings tracker 2. Ensure delivery of savings through Shared Priority/MOU Steering Group, DMT and F&PR	LR	Mar-17 Mar-17		A A
2	Disruption to business of Public Health Directorate	1. Public Health Business Continuity Plan	3	3	9	2. Test BCP 3. Update and test BCP	SG	~~Mar-16~~	Mar-16 Mar-17	G A
3	Excess pressure on staff due to mis-match of workload and capacity	1. HR polices and processes 2. DMT 3. Work Plan 4. Line Management 5. Monitoring of work for HPHAS and Peterborough	3	4	12	1. Finalise work plan 2. Revise monthly monitoring 3. Focus of quarterly work plan reviews on staff workload/capacity match	LR	May-16 Mar-17 Mar-17		G
4	Failure to achieve performance targets as set out in the 2016/17 Business Plan	1. Robust Service Planning in place, established and functioning 2. Performance monitoring, established and functioning and feedback incorporated into the F&PR process 3. Routine monitoring of delivery to identify any required interventions	3	3	9	1. Poor performers are visited and remedial action plans agreed or additional support offered, ie staff training 2. Additional providers commissioned to access hard to reach groups 3. Review of targets for 2016/17	VT	Mar-15		G G G
5	Programmes Team Delivery	1. Contracts meeting including performance measures 2. CamQuit leadership meeting	3	4	12	1. Options for service delivery including review of clinics	VT	~~Mar-16~~	Mar-17	A
6	The Council has assurance that Health Protection Systems to control communicable diseases and environmental hazards, function effectively across all responsible organisations	1. Written reports from relevant organisations to the Health Protection Steering Group 2. Engagement of Local Authority Public Health leads in Incident Management Teams (IMT) for health protection incidents 3. TB : Assurance role through Health Protection Steering Group and TB commissioning group 4. Continuation of TB Network (led by PHE) and TB cohort reviews to learn from cases and better understand the challenges. 5. Implementation of 2015 National TB Strategy with establishment of East of England TB Control Board	2	4	8	5. Re-issue of the MOU 6. TB network reviewed, revised ToRs, membership updated and attendance improved for network meetings and cohort reviews. However need to ensure current enthusiasm is sustained 7. Launch of collaborative TB strategy in Jan 2015. Clarity about role fo TB network and relationship to new TB Control Board (East of England). Launch of LTBI screening. 8. Development of commissioning plan for TB	LS	~~Dec-15~~ ~~Mar-16~~ ~~Mar-16~~ ~~Sep-15~~	~~01/04/2016~~ Nov 16 Mar-17 Apr-17 Mar-17	A A A A
		1. Annual compliance with HSCIC information governance toolkit				1. Follow up on improvement plan for 15/16 toolkit - now incorporated in 2016/17 plan.		Oct-16		G

County Council

CORPORATE RISK REGISTER

Public Health

Version Date: October 2016

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
8	Lack of complaince and appropriate data protection and information governance legislation and good practice	2. Contract management and monitoring	2	4	8	2. Plan 16/17 toolkit work - meeting held on 15 September and revised plan agreed and initial actions underway 3. Conduct 2016/17 project work in line with agreed plan. 3. HSCIC toolkit submission made by deadline of 31/3/2017, including corporate plans and IG toolkit project plan	LR / DL	Oct-16 Feb-17 Mar-17		G A G
9	Public Health Services will not meet quality safety and risk standards	1. Quarterly meetings of QS&R Group 2. Quality measure in contracts 3. Contract monitoring meetings 4. Internal Policies including Safeguarding 5. Support from CCG on clinical governance health information issues	3	4	12	1. Escalation policy for public health incidents	TC	Mar-16		G
10	Child Health Information System (CHIS)	Information awaited	3	4	12	Actions awaited				
11	Failure to address health inequalities	1. Joint Strategic Needs Assessment (JSNA) 2. Health & Wellbeing Strategy and Action Plan (HWB) 3. Local Health Partnership Action Plans/Public Services Board in Fenland 4. Targetted Public Health programmes 5. Annual Public Health Report 6. Shared priorities work 7. Business Plan Targets and Inequalities Indicators 8. Traveller Strategic Co-ordination Group	3	4	12	1. Ensure 'improving the healfh of the poorest fastest' principle in Health & Wellbeing Board (HWB) Strategy and Action Plan continues to receive high level of focus 3. Ensure monitoring and reporting of inqualities including through routine performance monitoring in F&PR and annual DPH report 4. Monitoring - eg of benefits changes impact (CFA) and of PH outcomes framework 5. Ensure ongoing inequalities are addressed within Children's 0-19 commissioning 8. Implementation of new investments such as Fenland Fund, Tobacco Control and Workplace Health 9. Lifestyle Service procurement will target areas with greatest health inequalities and provide services in areas where residents have previously been unable to access any support for improving high risk health behaviours 10. Ensure feedback on traveller health through the CCC Traveller Health Team, and ensure feedback to Public Health DMT on traveller health.	LR KW VT VT KP	Mar-15 ~~Aug-14~~ ~~Jul-14~~ Jun-15 Sep-17	Mar-16 Feb-15	G G A G G A
13	Childhood Immunisation Targets - Rates of immunisations, below national average with potential risk to public health of children	1. NHS England leading task and finish group has reported - group continues to oversee implementation of regulations 2. Assurance role through Health Protection Steering Group 3. Annual Health Protection Report to HWB Board 4. Engagement of CC Communications team to support messaging on the benefits of immunisation *Note: CHIS service being recommissioned. We need to be aware as we move forward what is happening to those children not invitetd for immunisation, and that the new system covers any risks like this.*	5	3	15	2. Support to local initiatives - eg through LA Public Health team and LA childrens centres 3. Ongoing close monitoring and public communication of local imms rates through appropriate channels 4. Implementation of recommendations of immunisation task and finish group 5. Continued oversight of the BCG vaccination programme through the Health Protection Steering Group 6. Improive flu vaccination uptake funded by CCC	LS	Mar-17 Mar-17 Mar-17 Mar-17 May-17		A A A A A
16	Impact of removal of On-Call Rota	1. Health Protection Steering Group 2. LHRP 3. ADsPH	2	3	6	2. Make arrangements for emergency capacity in a major incident 3. On-going discussions with PHE planned	LR	Nov-15 Mar-17		G

County Council

CORPORATE RISK REGISTER

Public Health

Version Date: October 2016

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
17	Awareness of legislation, training and legal requirements		2	4	8	1. Public Health session on the law 2. Escalate Contract issues to DPH 3. Escalate Contract issues to Head of Legal and LGSS	VT	 Mar-17 Mar-17		A G G
18	Multi Agency Emergency plans require updating - plans for emergencies need to take account of ongoing organisational changes in te health sector	1. Plans to be reviewed through LHRP and LRF health and social care working group 2. Health Protection Steering Group (HPSG) to have oversight of plan development especially plans for Public Health incidents	2	4	8	3. Pandemic flu plan to be taken to Health & Social Care Emergency Planning Group (H&SCEPG) and the LHRP. Tested and approved in Exercise Corvus and approved but subject to ongoing review, and clarification from the centre 4. Learning from Exercise Corvus to be included in plan, but awaiting clarification on National Issues. 5. Fuel plan has been developed but awaiting clarification from revised national plan 6. Protocol for identifying vulnerable people - working group developing this 7. On-going discussions with PHE planned	LS	Mar-17 Mar-17 Mar-17 Mar-17		G A A A
21	Directorate support to Health Committee (Scrutiny Function) and CCG: risk of conflict of interest or breaching information barriers	1. Healthcare Public Health advice service MOU includes confidentiality requirements. 2. Honorary contracts for staff handling very sensitive issues 3. Confidentiality agreements on specific sensitive issues (ie major procurements) 4. Committee scrutiny support (ie attendance at meetings, preparation of briefings) carried out by staff not involved in HPHAS 5. Discussion of issues with Chair and Spokes at regular Chair's meetings/Spokes meetings	3	3	9	1. Further discussion with legal team 2. Review during 16/17 3. Consider in light of Health Executive Governance	LR	Jan-15 Mar-17 Mar-17		G A G
22	Cancer Screening	1. Regular writing reporting to Health Protection Steeting Group by NHS England 2. Task and finish group 3. Key Stakeholder working	3	4	12	1. Task and finish group have reviewed data and are now working on implementing recommendations for improvement 2. Training of frontline HIMP staff to improve their knowledge and understanding, in order to enable communication of the benefits of screening	LS	Mar-17 Mar-17		A
23	Vision Screening Service not implemented	1. Hand over group to provide support and early identification of issues 2. Communication between commissioners and providers	2	3	6	1. Start date for services agreed 2. Monitor for three months to identify any gaps in pathway	VT	Apr-15 Jul-16		G A
25	DAAT : Managing budget pressures	1. Financial risk plan and spend review. Contingency plan and contract review 2. P&CC Star Chamber 3. Internal group identifying risks and outcomes of external peer review	2	3	6	1. Early notification from PH/CFA regarding intended budget reduction to be applied to existing contracts 2. Planning for PH/DAAT savings of £58k YOS and £100k 3. Attend P&CC Star Chamber: provide cost/benefit analysis to support continued investment as agreed 4. Peer Review and procurement of data	ST/CT/JK	Oct-16		A A G G

County Council

CORPORATE RISK REGISTER

Public Health

Version Date: October 2016

Details of Risk		Key Controls	Residual Risk			Actions				
Risk No.	Risk Description		Probability	Impact	Residual Score	Actions	Action Owner	Target Date	Revised Target Date	Action Status
27	Emerging demand for weight management services	1. Negotiations with NHS to regulate or fund addition additional requirements 2. Performance management meetings 3. Performance management monitoring	3	4	12	1. Establish joint commissioning forums 2. Secure funding from CCG to meet increased demand 3. Monitor demand carefully	VT	Mar-16 May-16 Mar-17		G G A
29	Failure to deliver transformation and maintain key aspects of the business	1. CCC SMT 2. PH DMT 3. Business Planning Co-ordination Steering Group	3	4	12	1. Programme planning for public health transformation 2. Contribute to consultation on the Corporate Review	LR LR	Mar-17 Aug-16		A G
30	Inability to identify, agree and implement savings	1. Business Planning Co-ordination Steering Group 2. Health Committee 3. Public Health DMT	3	4	12	1. Continue to develop savings plans to present to committee	LR	Nov-16		A
31	Failure to deliver health outcomes or manage resources due to partner organisations not working together effectively	1. Health and Wellbeing Board 2. Public Health Reference Group 3. Healthcare Public Health Advice Service 4. Health Protection Steering Group 5. Health and Care Executive 6. Local health partnerships	2	4	8	1. Maintain support to existing partnership arrangements 2. Ensure that any forthcoming review of partnerships maintains sufficient key controls for public health functions	LR	Sep-17		

HEALTH COMMITTEE TRAINING PLAN	Updated from Health Committee Meeting 15th December 2016	**Agenda Item No: 12**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
8.	**Health Scrutiny Skills Part 1**	To understand the roles and responsibilities of members conducting health scrutiny and to provide members with scrutiny skills and techniques Centre for Public Scrutiny led training specifically on STP	1	Provisional date 6/7 Feb 2017	Public Health	Training Seminar	Health Committee members & Subs		
15.	***Sustainability and Transformation Plan (Updated 8th Sept)***	To hold the session on the CCG's Sustainability and Transformation Plan (STP) in December, following publication of the STP in November	1	6th Jan + 16th Feb	Public Health	Training Seminar	Health Committee members & Subs		
17.	***Health Inequalities (Updated 8th Sept)***	To provide members with background information around Health Inequalities in preparation for January Health Committee item.	1	12th Jan	Public Health	Training Seminar			

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
18.	***Children & Young People's Mental Health***	To provide members with background information on the current issues around children and young people's mental health	2	13th April TBC	Public Health	Training seminar			
19.	***Finance Training***	To provide members with a background information around the council's finance process and familiarise new members with the specific details of the Public Health Directorate budgets	2	May TBC	Public health	Training seminar			

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

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

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 3rd January 2017 Updated 4th January 2017	Cambridgeshire County Council

Agenda Item No: 14

Notes

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

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

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

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
16/02/17	*Development session on the Sustainability and Transformation Plan following short formal meeting*			*26/01/17 3.30pm*	*03/02/17*	*07/02/17*
	0-19 Joint Commissioning of Children's Services *[provisional]*					
	Award of the contract for the provision of Stop Smoking Services	Val Thomas	2017/027			
16/03/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		23/02/17 3.30pm	03/03/17	07/03/17
	Scrutiny Item: Fertility Treatment Services	Dr Richard Spiers				
	Scrutiny item: Non-Emergency Patient Transport Services performance update six months after September 2016 commencement	Kate Parker				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Update on Mental Health Vanguard and PRISM [primary care mental health service]	Kate Parker				
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report) *[provisional]*	Kate Parker				
	Scrutiny Item: Bed-based Intermediate Care and Minor Injuries consultation plan *[provisional]*	Kate Parker/ CCG				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny Item: Health Committee Working Groups Quarterly update (including Joint Health Committee on merger of HHCT & PSHFT)	Kate Parker				
	Scrutiny Item: 111 Out of Hours Service – Review of First Five Months Delivery	Kate Parker				
	Scrutiny Item: Update from Cambridge University Hospitals NHS Foundation Trust (CUHFT) on EPIC IT Service	CUHFT				
	Scrutiny Item: Consideration of mechanism for responding to requests to comment on NHS Quality Accounts (minute 220 from meeting of 12 May 2016 refers)	Kate Parker/ Ruth Yule				
	Consideration of mechanism to reconsider Committee's current priorities					
	Committee training plan (standing item) including new members' training	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
[13/04/17] Provisional Meeting	*Development session on Children and Young People's Mental Health*			*23/03/17 3.30pm*	*31/03/17*	*04/04/17*
08/06/17	Co-option of District non-voting Members	Ruth Yule		20/04/17 3.30pm	25/05/17	30/05/17
	Public Health Finance and performance report	Chris Malyon/ Liz Robin		18/05/17 3.00pm		
	Update on pilot harm reduction project for stopping smoking	Val Thomas				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
20/07/17				29/06/17 3.30pm	07/07/17	11/07/17
[17/08/17] Provisional meeting				*27/07/17 3.30pm*	*04/08/17*	*08/08/17*
07/09/17				17/08/17 11.30am	26/08/17	30/08/17

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
19/10/17				28/09/17 11.30am	06/10/17	10/10/17
	Immunisation Task and Finish Group report, to include whether the drop in take up of flu immunisations by pregnant women was a single year anomaly or whether it was repeated in the figures for the following year (12-month follow-up)					
16/11/17				26/10/17 3.30pm	03/11/17	08/11/17
14/12/17				23/11/17 3.30pm	01/12/17	05/12/17
Tuesday 16/01/18				14/12/17 11.30am	03/01/18	05/01/18

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
[08/02/18] Provisional meeting				*18/01/18 3.30pm*	*26/01/18*	*30/01/18*
15/03/18				22/02/18 3.30pm	02/03/18	06/03/18
[19/04/18] Provisional meeting				*22/03/18 3.30pm*	*06/04/18*	*10/04/18*
17/05/18				26/04/18 3.30pm	04/05/18	08/05/18

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

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

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

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

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

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

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