HEALTH COMMITTEE

Date:Thursday, 17 January 2019

13:30hr

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

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-conduct-code*	
2	**Minutes - 6th December 2018**	**5 - 14**
3	**Health Committee Action Log**	**15 - 16**
4	**Petitions and Public Questions**	

SCRUTINY ITEMS

5	**Hinchingbrooke Hospital - CQC Inspection Update**	**17 - 26**
6	**Eating Disorders Service Update**	**27 - 32**

The Health Committee comprises the following members:

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

Councillor David Connor Councillor Lynda Harford Councillor David Jenkins Councillor Linda Jones Councillor Kevin Reynolds Councillor Simone Taylor Councillor Peter Topping and Councillor Susan van de Ven

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

Clerk Name: Daniel Snowdon

Clerk Telephone: 01223 699177

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

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HEALTH COMMITTEE: MINUTES

Date: Thursday 6 December 2018

Time: 1.30pm to 4.55pm

Present: Councillors C Boden (Vice Chairman), J Gowing (substituting for Cllr Connor, L Harford, M Howell (substituting for Cllr Reynolds), P Hudson (Chairman), D Jenkins, L Jones, P Topping and S van de Ven.

District Councillors M Cornwell, G Harvey, N Massey and J Tavener

Apologies: County Councillors D Connor and K Reynolds

166. DECLARATIONS OF INTEREST

There were no declarations of interest.

167. MINUTES AND ACTION LOG: 8th NOVEMBER 2018

The minutes of the meeting held on 8th November 2018 were agreed as a correct record and signed by the Chairman subject to the inclusion of St Neots within minute 161 to read, " Noted the events that had been and were due to take place in the St Neots and Huntingdon areas.

The Action Log was noted including the following updates:

Minute 161 – it was proposed with the unanimous agreement of the Committee for Councillor Harford as a member of the Highways and Community Infrastructure Committee, representing the Health Committee, request that the rolling programme be expedited promptly at its next meeting.

168. PETITIONS

There were no petitions.

169. THE ADOPTION OF A DYNAMIC PURCHASING SYSTEM (DPS) FOR PUBLIC HEALTH PRIMARY CARE COMMISSIONING

Following the deferral of the decision at the November meeting of the Committee, a report was received that provided Members with the additional information it requested in relation to the adoption of a Dynamic Purchasing System (DPS) for contractual arrangements that Cambridgeshire County Council Public Health has with primary care providers.

During the course of discussion Members:

- Drew attention to certain terminology such as "light touch" which gave concern because it could result in less stringent contract monitoring and emphasised the

importance of maintaining quality of services. Officers explained that the DPS system was increasingly common for health and social care contracts. Public accountability and transparency with providers was maintained however, the DPS provided greater flexibility and allowed providers to enter the DPS as various entrances which differed from a framework agreement. Providers were vetted at the start of the process and were monitored continuously. Where there were issues with a provider there were provisions within the contract for suspension.

- Sought clarity regarding the budgetary implications of the DPS if more services were contracted. It was explained that the pressures upon GP practices were such that there was a risk that due to the work required in annual tenders for contracts they would not bid. There was a greater risk of unwanted underspend if the current arrangements were maintained.

- Commented that the perceived advantage to the DPS was that providers were able enter and leave during the agreement. Officers informed Members that the current framework arrangement was too inflexible and there were significant risks of GPs dropping out during the framework tender process.

- Noted a pseudo DPS opened in tranches whereas the traditional DPS model remained open all the time.

- Expressed concern regarding the maintenance of the quality of services and sought assurance regarding the quality control system. Members noted the work of the Primary Care Commissioning Team that concentrated on contract monitoring and audit work. Officers undertook to supply a briefing note to Members regarding contract monitoring and quality. **ACTION**

- Noted that the DPS as a method of procurement was introduced prior to 2015 in a different format. Following changes in regulations in 2015 it made adaption to service requirements easier and therefore DPSs were used increasingly often.

Having reviewed the additional information, it was resolved to:

> Approve the proposal to adopt the Dynamic Purchasing System (DPS) contractual arrangements that Cambridgeshire County Council Public Health has with its primary care providers.

170. HEALTHY CHILD PROGRAMME UPDATE

The Committee were presented a report that provided an update regarding the workforce and financial issues that related to the 0-19 Healthy Child Programme (0-19HCP) and work undertaken to integrate the service across Cambridgeshire and Peterborough. The report also presented an options appraisal regarding the service model with a reduced budget.

Members noted the saving identified totalling £238k that had deferred to the current financial year in order for the detailed work set out in the report to be undertaken. It was also noted that the purpose of the report was to introduce the proposed service model and that a further report requesting the Committee's approval for a likely Section 75 agreement would be presented in the new year.

During discussion of the report Members:

- It was questioned whether the recommendation of the officer report constituted a key decision. It was explained that although the decision was an important one for the Committee it did not constitutionally represent a key decision.

- A Member drew attention to the challenges of recruiting Health Visitors in sufficient numbers and that the situation in Cambridgeshire had stabilised somewhat. However, concerns were expressed regarding the proposed model in that 90% of the work would be undertaken by nursery nurses. The model would result in Health Visitors spending far more time undertaking safeguarding work which was not why they joined the profession and was a key driver for Health Visitors to leave the profession. Officers explained that the appendix to the report set out the future of the service and did not represent the present picture. Officers provide assurance that the vast majority of the service would be undertaking deliver of the universal offering to all families. With a reduce cost envelope it was necessary to mix skills and deliver the service in a different way. It was also essential that specialised clinical staff were utilised appropriately. Officers were acutely aware of the issues affecting staff retention and were looking to developing staff from within the service.

- A Member questioned whether nursery nurses with less than 1 years' experience would have the sufficient skills necessary to identify issues when undertaking assessments. It was explained that when they were appointed nurses worked to a competency framework and received comprehensive training that equipped them to have constructive dialogues with families. Numerous tools including supervision were utilised in order to ensure competency In terms of the internal mood of women, assurance was provided that checks were undertaken.

- Members noted that the model was in use elsewhere in the country however evaluation feedback would have to be obtained regarding their success. Officers commented further that nursery nurses are highly skilled regarding assessments and arguably in some cases were more skilled than certain health visitors. The Benson model was used in 40 different healthcare sectors and had been developed over last decade. The model assisted modelling the level of workforce required for the service to operate.

- A Member welcomed the officer presentation that provided greater confidence in the model and commented that the skills of nursery nurses were often over-looked and under rated.

- Concerns were expressed that there was a possibility that issues could be missed and the varying quality of NVQ qualifications around the country and sought assurance that the training provided at NVQ level 3 was sufficient in terms of quality. Officers commented that no new recruit was the finished article when recruited and therefore required support in order to reach their full potential. Qualifications would be provided by various awarding bodies depending on the Further Education College the student attended. Candidates were assessed against an application and interview process and successful candidates were performance managed through support and regular supervision.

- It was noted there was a clear emphasis and allocation of resource to safeguarding which was welcomed. Members noted that there were staff shortages in the Fenland, Peterborough and Cambridge City areas which contained areas of high deprivation and questioned whether consideration had been given to targeted recruitment within the eastern European community. Officers informed Members that recruitment from such communities could be improved and alternative approaches were being assessed for the Wisbech area.

- A Member expressed support for the proposed Section 75 agreement. Performance would monitored closely and requested granularity of data split into District Council level. Officers also highlighted the importance of demonstrating outcomes which it was noted were more difficult to measure.

- Further information was sought regarding the support and supervision for the new teams. Officers informed Members that the supervision process was robust. Those undertaking supervision would not hold cases in order that they could fully focus on the caseloads held by staff. There was also restorative supervision undertaken which focussed burnout and anxiety of staff. Safeguarding leads also undertook specific safeguarding supervision.

- The level of engagement by parents through digital channels was queried and questioned the confidence of officers in difficult to reach parents utilising digital access. Officers drew attention to the success of the “Chat Health” service that had achieved a level of interaction that would not have been possible though the old model. Officers went on to provide examples of where digital access to services was able to provide better outcomes for people who were in need.

- A Member continued to express reservations regarding the model and commented that there was little evidence to support the view that the level of nursery nurse training was sufficient.

- It was noted that recruitment hotspots were areas where there were difficulties in recruiting staff.

- Noted that officers agreed to circulate to Members further information regarding the current students that were undertaking training and how the model projected the numbers required for the service. **ACTION**

- Drew attention to the pay levels of nursery nurses and expressed concern with regard to the high cost of living and transport. It was explained that newly appointed members of staff began at band 4 which was a starting salary of approximately £22k which was set nationally and deemed appropriate.

- Members questioned whether the required skill mix of staff, recruitment and demand for services had been addressed within the service design. Officers explained that all three were risks and had been addressed. Demand for services was an ongoing issue due to continued population growth.

- A Member sought further information regarding the level of team capacity was devoted to safeguarding. Officers drew attention to section 2.5 of the officer report that showed 18% of staff time would be spent on the safeguarding pathway. Members noted the multidisciplinary nature of safeguarding work and further work that had been undertaken to streamline the process.

It was resolved by majority to:

a) To note the workforce update on the Health Visiting and School Nursing service

b) To note the proposed service model for the 0-19 HCP, including the options for the delivery of support to teenage mothers, and to endorse the model for implementation from April 2019.

171. FINANCE AND PERFORMANCE REPORT – OCTOBER 2018

The Committee received the October 2018 iteration of the Finance and Performance Report which showed an increase in the overall underspend of £68k from September's reported position.

During discussion Members:

- Observed that it was welcome that there were more direction of travel arrows that indicated improving performance as opposed to negative ones.

- Drew attention to appendix 4b of the Healthy Child Programme report that suggested that across Cambridgeshire, Health Visitors were meeting their targets, yet performance had reduced according to the Finance and Performance report. Officers undertook to provide additional information in the next iteration of the report **ACTION**

- Commented that certain Section 75 monies had been directed to Adult Social Care. Officers undertook to provide a briefing note to Members. **ACTION**

- Noted that the overall underspend represented 2% of overall public health expenditure and that £281k related to an accounting issue from 2016/17.

- Commented that it was hoped that no further underspends occurred within the current financial year, expressing concerning that a further shift had occurred. Officers explained that due to the overall national Public Health Grant being reduced, contracts with GPs had been reviewed and had delivered savings earlier than anticipated. There were also posts that not been recruited to as it was known that the post would be deleted in the near future.

It was resolved to:

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

172. HEALTH COMMITTEE REVIEW OF DRAFT REVENUE AND CAPITAL BUSINESS PLANNING PROPOSALS FOR 2019/20 TO 2023/24

Members were presented an overview of the draft Business Plan revenue and capital proposals for services that area within the remit of the Health Committee. In introducing the report, the Director of Public Health drew attention to the changes set

out in the report that had been made since the business planning proposals were first presented to the Committee at its October 2018 meeting.

In discussing the report Members:

- Noted the modification of approach to certain budget lines that had been agreed with the Section 151 Officer. It was noted that the effect of these changes was not to create an additional reserve that could be deployed elsewhere but deliver savings without reducing services.

- Drew attention to the Public Health reserves and questioned how they could be better deployed and commented that reserves could be utilised to into areas such as oral health.

- Expressed concern that reserves could be recalled by central government.

- Suggested that discussions take place at the Chair and Lead Members briefing in order to be taken forward.

It was proposed with the unanimous agreement of the Committee that the wording of recommendations b) and c) be amended through the deletion of the word 'endorse' which was to be replaced by the word, 'forward'.

It was resolved to:

a) Note the overview and context provided for the 2019/20 to 2023/24 Business Plan revenue and capital proposals for the Service, updated since the last report to the Committee in October unanimous

b) Comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2019/20 to 2023/24, and **forward** them to the General Purposes Committee (GPC) as part of the consideration for the Council's overall Business Plan.

c) Comment on the changes to the capital programme that are within the remit of the Health Committee and **forward** them to the General Purposes Committee (GPC) as part of consideration for the Council's overall Business Plan

173. LET'S GET MOVING PHYSICAL ACTIVITY PROGRAMME

Following the deferral of the decision at the November meeting of the Committee, Members received a report that provided additional information requested by the Committee regarding the Let's Get Moving Physical Activity Programme. .

In discussing the report Members:

- Highlighted the importance of the public understand how the Council was spending money.

- Welcomed the additional information provided in the report and drew attention to the importance of the evaluation work, questioning whether there was sufficient resource budgeted to its evaluation.

- Highlighted the programmes undertaken by South Cambridgeshire District Council and their work regarding sustainability.

- Thanked and congratulated the facilitator at South Cambridgeshire District Council who had been so successful in driving the programme forward.

- Emphasised the importance of longer term evaluation of the programme and how the evaluation linked directly to the sustainability of the programme.

- Noted the importance of Members being kept informed with events and initiatives that were taking place in their divisions in order that they were able to evaluate it.

It was resolved to:

a) Extend the Let's Get Moving Programme Public Health Reserve funding for an additional year in line with the indicated timeline feature in the officer's report.

b) The introduction of the proposed interventions to strengthen the longer term monitoring of sustained behaviour change.

174. NHS DENTAL SERVICES ENTER AND VIEW VISITS BY HEALTHWATCH CAMBRIDGE AND PETERBOROUGH

Members received a report from Sandie Smith, Chief Executive Officer (CEO), Healthwatch Cambridgeshire and Peterborough. In introducing the report the CEO informed the Committee that the writing of the report had arisen from the reported difficulties the public had experienced in accessing NHS dental services. The public had reported many stories where urgent treatment had been difficult to access. Transport links especially in the Fenland areas were exacerbating accessibility issues and people with lower incomes and children were disproportionately affected. There was also little evidence of preventative work in terms of oral health.

During the course of discussion Members:

- Welcomed the report and drew attention to the apparent mis-match between the Oral Health Needs Assessment and the findings of the Healthwatch report. It was however noted that the Healthwatch report was a deep dive into a particular geographic area. Cambridgeshire performed well in terms of dental decay, however there were pockets of deprivation where oral health was much worse.

- Emphasised the importance of the relationship between good oral hygiene and health outcomes.

- Noted that overall Cambridgeshire performed well in terms of oral health, however drew attention to the disparity between the north and the south of the county, including certain areas of Cambridge City.

- Confirmed that a further report would be circulated to Members in January 2019.

It was resolved to note and commend the contents of the report.

175. NHS DENTISTRY PROVISION

The Chairman invited David Barter, Head of Commissioning NHS England Midlands to address the Committee.

Mr Barter began by informing Members that Dental Access Centres (DACs) were set up several years ago for the purpose of attending to patients in pain. A significant piece of work had since been undertaken in order to ascertain the benefits to the health of attendees. The results of the work found that patients will go to when they have pain however, the DAC provided no pathway for oral care and patients would not regularly attend a dentist. This was compounded by the banded courses of treatment that could be offered by a dentist. It was therefore intended that pilot areas were set up in areas of most need for providers to be paid an enhanced rate to provide a course of treatment that would build a relationship between the practice and the patient in order to improve regular attendance at a practice. The proposal had been presented to the Dental Strategy Group and service specifications were being drafted.

During the course of discussion:

- A Member highlighted the case of an elderly constituent who suffered a fractured hip and was having difficulty accessing domiciliary dentistry services. The Head of Commissioning confirmed that there had been no funding cuts to domiciliary services and offered to speak to the Member regarding the individual.

- Members endorsed paragraph 2.1 of the Oral Needs Assessment that stated oral health should be for life. In drawing attention to preventative care a Member questioned how dental hygienists were funded through the NHS. Members were informed that the majority of dental contracts underperformed in terms of activity. Contracts tendered annually to deliver a specified number of units underperformed regularly. The intention was to remind and help the profession understand that a key objective was to ensure children regularly attended the dentist through the development of pilot schemes which would directly influence the new dental contract which was more focussed on prevention. It was confirmed that anyone could attend an NHS dentist and request to be seen, what prevented them being seen was whether the dentist had sufficient units of activity. In order to see a hygienist a dentist would have to be seen first.

- It was noted that if the region was successful in having a dental school commissioned then it would of huge benefit in terms of work-force for the area.

- Attention was drawn to concerns regarding accessibility to NHS dental practices where patients were being turned away. It was confirmed that a practice could only refuse to see an NHS patient if they did not have units of activity left. There was therefore a need for robust discussions to reduce contracts in certain areas where they were underperforming in order to re-direct resources to areas of greatest demand.

- It was noted that the new model encouraged community outreach. There was a key objective to encourage families to attend practices in order that children entered the oral health pathway at the earliest opportunity.

- A Member questioned the numbers of multiple extractions that appeared to be increasing. The Head of Commissioning although unsure as to the accuracy of the data emphasised the importance of the approach to commissioning with providers to encourage children to attend the dentist and prevent poor oral hygiene.

- Attention was drawn to partnership working, in particular whether links could be forged with Health Visitors who were undertaking visits. It was confirmed that such partnership working was being pursued.

- Members noted that with regard to plans for new communities such as Northstowe, close work was undertaken with colleagues from NHS deliver to ensure that sufficient provision was in place. A Dental Strategy Group had been formed that would model what would need to be commissioned. The Head of Commissioning undertook to provide a written briefing to Members on the plans for Northstowe.

- A Member commented that the Cambridgeshire County Council's 'Be Well' website did not contain a dental health icon.

It was resolved to note the contents of the report

176. CAMBRIDGESHIRE AND PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP DIGITAL STRATEGY

The Head of Analytics and Evaluation, Clinical Commissioning Group, Chris Gillings was invited by the Chairman to address the Committee. Members were informed that a Digital Enabling Group had been meeting since July 2018 and had developed a strategy which was presented to the Committee.

Five key areas of the strategy were highlighted and the vital importance of transparency and governance was emphasised. Members noted that there were other parts of the country where digital integration was working.

During discussion of the report Members:

- Noted the work of the Digital Enabling Group and the work that had been undertaken at Addenbrooke's where a baseline had been built through which providers could begin to link data sets.

- Questioned whether the Ambulance Service had been included in the work. It was confirmed that they were taking part in the work and had been developing a system called Patient Picture.

- Drew attention to care homes which were an environment attended to regularly by the Ambulance Service and where patients had complex needs and many medications. It would therefore be vitally important for their inclusion.

- Noted the plan for wave 3 for local health care records which had a standardised method of drawing on information from across England. Members further noted that there was a model where the patient owned their own data and could give permission for that data to be seen by a GP online. Barriers regarding identification

had been overcome and further work was being undertaken to ascertain how it could be developed and used effectively.

- Thanked the Head of Analytics and Evaluation for his report and in noting the planned work, requested that he present an update to the Committee in the summer 2019.

It was resolved to note and comment on the contents of the report.

177. TRAINING PROGRAMME

Members received the Health Committee Training Programme and noted the updates provided at the meeting.

It was resolved to:

Note the Committee training programme

178. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES

The Committee examined its agenda plan.

It was resolved unanimously to:

Note the Forward Agenda Plan, the changes that arose during the course of discussion and the additional items requested.

Agenda Item No: 3

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee up to the meeting on **6 December 2018** and updates Members on progress in delivering the necessary actions.

Meeting of 12 July 2018

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
130	**Finance and Performance Report – May 2018**	**L Robin**	Emphasised the benefits of interventions for cycle and pedestrian safety as an investment in the future. It was requested that officers explore ways to find funds in order to avoid any reduction in the "Bikeability" scheme.	Work is continuing to bring together different streams of cycle safety and promoting active travel.	**Ongoing**
131	**Annual Public Health Performance Report 2017/18**	**Democratic Services**	Questioned whether regarding significant procurement exercises there was scope for greater Member involvement at an earlier stage of the procurement process. Officers agreed to investigate further the possibility of earlier Member involvement.	This query has been raised with the LGSS Procurement Team correspondence is continuing and an update will be provided.	**Ongoing**

Meeting of 13 September 2018

142	**Community First (Learning Disability Beds Consultation)**		Officers agreed to provide a spreadsheet detailing the funding of the project.	Update provided at November meeting. Awaiting further information from the CCG	**Ongoing**

Meeting of 8th November 2018

160	**Finance & Performance Report – September 2018**	**Liz Robin / Clare Andrews**	Requested that indicators within the report be reviewed in readiness for the new financial year.	An update will be provided on this piece of work in the new year.	**Ongoing (March 2019)**

Meeting of 6th December 2018

169	**The Adoption of a Dynamic Purchasing System for Public Health Primary Care Commissioning**	**Liz Robin / Val Thomas**	Officers undertook to supply a briefing note to Members regarding contract monitoring and quality		**Ongoing**
170	**Healthy Child Programme**	**Liz Robin**	Officers agreed to circulate to Members further information regarding the current students that were undertaking training and how the model projected the numbers required for the service		
171	**Finance & Performance Report – October 2018**	**Liz Robin / Clare Andrews**	Further information and narrative would be included in the report regarding Health Visitors.		
171	**Finance & Performance Report – October 2018**	**Liz Robin**	Officers undertook to provide a briefing note to Members regarding Section 75 funding and its direction.		

Agenda Item No: 5

HINCHINGBROOKE HOSPITAL - CQC INSPECTION REPORT UPDATE

To:	**Cambridgeshire County Council Health Committee**
Meeting Date:	**17 January 2019**
From:	**Jo Bennis, Chief Nurse, North West Anglia NHS Foundation Trust**
Electoral division(s):	**All**
Purpose:	**This report is provided to update the committee on the actions put in place at Hinchingbrooke Hospital following the publication of its Care Quality Commission Inspection Report in October 2018 which rated the North West Anglia NHS Foundation Trust overall as 'Requires Improvement'.**
Recommendation:	**The Committee is asked to note the contents of the report**

	Officer contact:
Name:	**Mandy Ward**
Post:	Head of Communications
Email:	Mandy.ward9@nhs.net
Tel:	01733 678017 / 01480 423175

1. BACKGROUND

North West Anglia NHS Foundation Trust, which runs Hinchingbrooke, Peterborough City and Stamford and Rutland Hospitals, was inspected by the Care Quality Commission over a period of five days in June and July 2018.

The Trust also runs Outpatient and Radiology Services at Doddington Hospital and the Princess of Wales Hospital, Ely. The Trust took on the running of these services in September 2017 and they were not included as part of the inspection regime.

This was the first inspection of the Trust since it was formed on 1 April 2017, as a result of the merger of Peterborough and Stamford Hospitals NHS Foundation Trust with Hinchingbrooke Health Care NHS Trust.

Inspectors reviewed our services to ensure they are Safe, Effective, Caring, Responsive and Well-Led (which are the CQC's five key lines of enquiry).

Prior to the merger, Peterborough and Stamford Hospitals was inspected in 2014 and was rated as 'Good', Hinchingbrooke Health Care NHS Trust was also rated 'Good' when it was re-inspected in 2016.

Inspectors reviewed the following core services at the Hinchingbrooke and Peterborough sites (Stamford Hospital was not inspected):

Hinchingbrooke Hospital	**Peterborough City Hospital**
Urgent and Emergency Care Medical Care Surgery Critical Care Maternity Services End of Life Care Outpatients	Urgent and Emergency Care Medical Care

All core services at Hinchingbrooke Hospital were inspected because its previous ratings were dissolved at the point of the merger. This meant that Hinchingbrooke Hospital did not have a rating for any of its core services prior to the inspection taking place.

In addition, inspectors carried out a Well-Led inspection to test the link between the overall management of the Trust and the quality of its services, and a Use of Resources inspection which was led by our regulator, NHS Improvement – these are new components to the inspection regime, which were introduced in 2017.

Inspectors provided high level verbal and written feedback at the time of the inspection, which enabled us to implement immediate actions, where necessary, plus develop, and subsequently work to, an action plan ahead of the report publication.

Following the inspection, in September, the Trust received a draft report for the purpose of factual accuracy checking prior to publication. We responded with more than 100 pages of factual

accuracy amendments, but were disappointed to see that many of these inaccuracies were still published in the final report.
The Hinchingbrooke Hospital CQC inspection report from June/July 2018 can be viewed here: https://www.cqc.org.uk/location/RGN90

2. MAIN ISSUES

2.1 Inspection outcome

The CQC published its report on our Trust inspection in October 2018. The CQC gave the Trust the overall rating of 'Requires Improvement'. The Trust did not receive a rating for its Use of Resources inspection. The CQC also rated each hospital site inspected and the core services it reviewed at the hospital sites.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Hinchingbrooke Hospital	Requires improvement Sept 2018	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
Stamford and Rutland Hospital	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Peterborough City Hospital	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018
Overall trust	Requires improvement ↓ Sept 2018	Requires improvement →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018

Hinchingbrooke Hospital core services ratings are displayed on the next page

Hinchingbrooke Hospital core services ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Sept 2018	Requires improvement Sept 2018	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
Medical care (including older people's care)	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Surgery	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Critical care	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Aug 2018
Maternity	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018
End of life care	Good Sept 2018	Requires improvement Sept 2018	Outstanding Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Outpatients	Good Sept 2018	N/A	Good Sept 2018	Good Sept 2018	Good Sept 2018	Good Sept 2018
Overall*	Requires improvement Sept 2018	Requires improvement Sept 2018	Good Sept 2018	Good Sept 2018	Requires improvement Sept 2018	Requires improvement Sept 2018

Peterborough City Hospital core services ratings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Good →← Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018	Requires improvement ↓ Sept 2018
Medical care (including older people's care)	Good ↑ Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018	Good →← Sept 2018	Good ↑ Sept 2018	Good ↑ Sept 2018
Surgery	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Critical care	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Maternity	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Services for children and young people	Good May 2014	Good May 2014	Good May 2014	Good Jul	Good May 2014	Good May 2014
End of life care	Good May 2014	Good Jul 2015	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Outpatients	Good May 2014	N/A	Good May 2014	Good May 2014	Good May 2014	Good May 2014
Overall*	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018	Good →← Sept 2018

The inspection report highlighted two specific areas of outstanding practice at Hinchingbrooke Hospital – one of which was reflected in the rating for the overall service for End of Life patients. This was noted in the inspection report as follows:

Outstanding practice – End of Life Care

- The trust was part of the Dying Well in Custody pilot with a local prison where specialist palliative consultants reviewed patients that were at the end of their life and worked with prison and hospital staff to ensure patients were safely admitted to the hospital or referred to the local hospice. As part of the pilot; an end of life register, multidisciplinary team (MDT) meeting and the use of Supportive and Palliative Care Indicators Tool, a tool designed to help health care professionals identify people who might benefit from better supportive and palliative care, was developed. This helped promote care quality and equality for patients who were in prison at the end of their life.
- There was an 'end of life companion' volunteer support service which was especially beneficial for patients who did not have close family.

Outstanding practice - Surgery

- There was a focus on reducing falls in the service supported by the falls specialist nurse. This included trialling a smaller, louder and more responsive falls alarm, and a monthly falls scrutiny panel where ward managers and matrons presented specific cases and any learning was discussed and then shared at team meetings to help mitigate the risk of falls where possible in the future.
- The service had achieved an 'outstanding' rating for general surgery and cancer in the 2018 'Getting It Right First Time' (GIRFT) report. Clinical leads told us they were particularly proud of achieving the highest rate of complication free day case surgery in the country.
- In general surgery, there was an audit programme ongoing for registrars to audit their own consultant's practice from the previous 12 months to identify and share ideas for improvement. This was good practice as it encouraged a culture of learning and using evidence to drive improvement among medical staff.

The inspection report detailed specific areas where each of the core services inspected must improve. There were 27 'must improve' recommendations for the seven core services at Hinchingbrooke Hospital. These were:

Urgent and Emergency Care

- The trust must ensure staff complete patient documentation including time of arrival; patient observation times, and maintain records to ensure they are contemporaneous.
- The trust must ensure that staff using the Manchester Triage System complete competency requirements for the safe use of the assessment system.
- The trust must ensure that the emergency department embed rapid assessment and treatment processes for patients arriving by ambulance and designate appropriately trained staff to the ambulance assessment area, and improve control and command of this process.
- The trust must ensure the designated mental health room is safe and fit for its designated purpose.
- The trust must ensure fridge temperatures and the temperature of the room where medicines are stored are routinely monitored and action taken to minimise any risks to patients.
- The trust must ensure that staff mandatory training and appraisals meet the trusts compliance target of 90%.
- The trust must ensure that effective systems and processes are in place to safeguard patients from abuse and improper treatment.

Medical Care

- The trust must ensure that Pear Tree ward is being run and monitored in a way that protects people's safety and ensures they are receiving care and treatment which meets their needs.
- The trust must ensure that medicine management arrangements are implemented in line with best practice.
- The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.
- The trust must ensure all staff are up to date with their advanced level life support training
- The trust must ensure staff receive an annual appraisal.

Surgery

- The trust must ensure there are consistent and reliable systems and processes for sharing learning from incidents across the surgery service, to help mitigate the risk of potentially avoidable incidents reoccurring, including sharing findings and lessons learned from never events or other serious incidents in a timely manner.

Critical Care

- The trust must ensure guidelines are reviewed in time and have oversight and sign off from a senior member of the team.
- The trust must ensure that ligature risks in patient rooms within critical care are reviewed and resolved.

Maternity

- The trust must ensure a robust process to identify women with safeguarding issues in the paper medical records.
- The trust must ensure the electronic patient system identifies all women with safeguarding issues.
- The trust must ensure that women's' weight is recorded on their prescription chart.
- The trust must ensure that maternity support workers are trained and competency assessed before they are able to perform physiological observations on patients.
- The trust must ensure guidelines are reviewed in time and have oversight and sign off from a senior member of the team.
- The trust must ensure all emergency equipment is available to use.
- The trust must ensure all medicines, including intravenous fluids are securely stored in locked cupboards.

End of Life Care

- The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.
- The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way this is documented within patients' notes.
- The trust must ensure the robust monitoring of end of life care, including the achievement of preferred place of care and death and the timeliness of discharge through local audit.

Outpatients

- The trust must ensure the proper arrangements for the security and handling of prescription pads throughout the department.
- The trust must ensure that medication is only prepared by those who have been assessed as competent to do so.

In addition, the inspection report listed 5 ‘must improve’ items for the Urgent and Emergency Care service inspected at Peterborough City Hospital.

The report also listed areas where it recommended the Trust should make improvements. This included 28 ‘should improve’ items for the seven core services at Hinchingbrooke Hospital. These were:

Urgent and Emergency Care

- The trust should ensure that paediatric waiting areas are audio and visually separated from adult waiting areas.
- The trust should ensure that reception staff are trained and competent in recognition of red flag signs and symptoms, to allow for timely escalation of critically unwell or injured patients who self-present to the emergency department.
- The trust should ensure they complete, monitor and update action plans in relation to the Royal College of Emergency Medicine (RCEM) audits.

Medical Care

- The trust should seek to improve its delayed transfer of care statistics.
- The trust should ensure there are enough staff to fill planned shifts.
- The trust should consider making improvements to the way in which the discharge planning team are enabled to support staff and patients with their discharge arrangements.
- The trust should ensure there are clear nursing competencies in place and that staff are supported to demonstrate these.

Surgery

- The trust should ensure all doors to side rooms in the ATSU are fully sealed when closed to help prevent the spread of airborne infections.
- The trust should have a member of staff trained in advanced life support (ALS) on each shift within recovery, in line with national guidance.
- The trust should monitor the length of time between screening and treatment times for sepsis on the wards, to have oversight of how often they are not meeting national guidance on this, and to act on any issues identified.
- The trust should review the staffing and escalation arrangements at night on Mulberry ward to ensure that if there is unexpected patient risk or deterioration, staff are able to access support promptly.
- The trust should ensure theatres staff change out of their theatre scrubs before leaving the department, in accordance with uniform policy and good practice for infection prevention and control.
- The trust should develop the local audit schedule within the theatres department to monitor and improve quality and performance.
- The trust should continue to improve complaints processes to ensure they are investigated and completed within 30 days, in line with trust policy.

Critical Care

- The trust should ensure that medical staffing meets Guidelines for the Provision of Intensive Care Services (GPICS) 2015.
- The trust should ensure that the risk register is regularly reviewed and risks to the service are appropriately managed.
- The trust should ensure that all equipment including the central venous pressure trolley is checked and restocked regularly according to trust policy.

- The trust should ensure that the critical care outreach team have a clear supervision pathway for appraisal.
- The trust should ensure that provision is made for the gap in service provision between the Critical Care Outreach Team finishing and the night medical team commencing.

Maternity

- The trust should ensure handovers are confidential and are uninterrupted.
- The service should ensure that community midwives carry the correct medication in line with trust policy.
- The service should review the risk of the second theatre on labour ward and include the risk on the maternity risk register.
- The trust should ensure staff are aware of the vision for the service and the trust's vision and values.
- The trust should consider a pathway of care to enable babies on transitional care to have full treatment in one area.
- The trust should consider a seven day maternity assessment day unit and triage area in line with national guidance and best practice recommendations.
- The trust should ensure all equipment is clean and there is a system in place to identify that equipment has been cleaned.
- The trust should regularly audit hand held maternity notes and medical records.
- The trust should ensure the milk fridge is locked to ensure breast milk cannot be tampered with or taken by the wrong mother.

The report also listed 3 'should improve' items for Urgent and Emergency Care services at Peterborough City Hospital.

2.2 **Post report actions**

Since the publication of the inspection report, we have been able to resolve most of the 'must improve' actions. The lessons learned from the recommendations can be applied across all our sites and we are using this approach to ensure we make positive improvements consistently across all core service areas at all hospital sites.

We continue to work to a detailed action plan of remaining improvements. Progress against this plan is reviewed at our monthly CQC Steering Group meetings, which are chaired by our Chief Executive, Caroline Walker. Our plan was submitted to the CQC on 3 December 2018 to show our compliance against key areas highlighted in the report. Our action plan is to be reviewed at the January 2019 meeting of our Trust board of Directors. We will not be sharing the action plan more widely than with our regulators as it is an internal operational plan to deliver the recommendations within the CQC Inspection Report.

The Trust is continuing with its own CQC-style internal inspections of ward areas (CREWS) across all three hospital sites to maintain assurance that services are consistently run to high standards of care. In addition, our Chief Nurse, Jo Bennis, leads senior-level walkabouts across our hospitals to see first-hand the improvements in action. Plus, we regularly welcome colleagues from other external organisations to conduct their own assurance visits. It is important to note that alongside this work, the Trust is also continuing with its post-merger integration plan and clinical strategy roll out to all clinical areas.

The Trust has since fed back to the CQC on aspects of the inspection that caused concern among our senior management team. These aspects included:

- We submitted more than 100 pages of feedback on the draft report with factual accuracies, most of which were not corrected before the report was published.
- Inspectors did not acknowledge the work still in progress as a result of our merger or that we are still in the early days of progressing on integration and our clinical strategy – in fact there were no inspectors on the inspection team that had previous experience of reviewing recently-merged trusts, which was a request made by the Trust ahead of the inspection.
- Looking at the areas of good within the report, it is hard to see how the overall aggregated rating of 'Requires Improvement' for the Trust was made.

The CQC has taken our feedback on board and we hope to receive some formal feedback.

Cambridgeshire and Peterborough NHS Foundation Trust

Report to Cambridgeshire Health Committee

Agenda Item No: 6

Eating Disorder Services - Follow-up to 12th July 2018 Report.

1.	**INTRODUCTION / BACKGROUND**
	The Health Committee requested a follow up report after the July 2018 meeting where Eating Disorder services provided by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) were discussed.
2.	**BODY OF REPORT**
	The Committee has requested an update in the following areas: • CPFT approach to service improvement in Eating Disorder services • Phoenix ED unit for children and young people • S3 adult in- patient ward service development progress • Eating Disorders community services update • Work with Universities • Regional Eating Disorders meetings • Complaints process • Update on Coronial process
2.1	**CPFT approach to service improvement in Eating Disorder services**
	CPFT provides community and inpatient eating disorders services for both children and young people, and for adults in Cambridgeshire and Peterborough. We also provide community eating disorder services in Norfolk. The community-based service for children and young people was developed in recent years. The other services have been long standing. There are significant challenges in providing eating disorder services, and many of these relate to the ability to recruit and retain specialist staff. The conditions treated are complex and these services have high mortality rates compared to other mental health services. They also have a physical health component and close integration with physical health services, both general practice and secondary care, is essential. Within CPFT we have been seeking to address the recruitment and retention issues through redesign and development of the services. This has been undertaken with active participation of service users and their families as well as from staff. The sections below highlight the service development work undertaken with the Phoenix Eating Disorders Unit for children and young people, the adult in-patient ward (S3) and the adult community service for Cambridgeshire and Peterborough. The updates highlight

	service developments which have taken place since the last report to the Committee in July 2018. In 2019 we are planning to commission, jointly with the CCG, a review of our Eating Disorders Services in order to assure the changes made to date; and to seek expert advice regarding the next phase of service development for both commissioning and provision.
2.2	**Update on Phoenix Eating Disorders Unit for Children and Young People**
	Following a six-month period of intense planning, recruitment, training and infrastructure modification, the Phoenix Unit reopened to young people on 8th October 2018. Phoenix Unit provides specialist eating disorder services for 13 to 18 year olds across the East of England. It is a 12 bedded ward which now includes a high dependency area and employs close to 40 members of staff. During the planning period between May and October, the Trust successfully recruited new staff; a new ward manager was seconded to the unit, five new nurses, an occupational therapist and seven health care assistants. In September, prior to re-opening, staff underwent a comprehensive training and development programme in support of the new treatment pathway which was being introduced in October. Project implementation workstreams led by the clinical staff on the Unit included: • Redevelopment of the clinical service model • Operational development of service delivery • Workforce planning • Training and development for all staff • Infrastructure to ensure the unit is well supported A phased re-opening and admission process has been undertaken since 8th October to ensure safe and sustainable services can be maintained. The plan was phased to increase admissions to 8 young people by December: Phoenix currently has 8 patients. An end of project review has been completed, including lessons learnt for the future, and in January, the clinical and leadership team will be reviewing the success of the model to date, the learning since the reopening and further improvements and developments for the future. The 'New Models of Care' proposals, led by NHS England, will be the next strategic phase of work for the both the inpatient and the community eating disorder service. This is aimed at increasing home treatment, supporting more young people in the community, shortening inpatient lengths of stay and reducing the need for inpatient beds in the future. In is also expected that the Phoenix Unit will relocate to the Children's Hospital as part of creating an integrated and research led physical and mental health hospital on the Biomedical Campus.
2.3	**S3 adult in- patient ward service development progress**
	S3 is a 14 bed unit and provides support with safe er-feeding and feeding regimes, medical monitoring, body image groups, psychological therapies as recommended by NICE and other psychological input such as motivational interviewing and Dialectic Behavioural Therapy (DBT).

	The team is multi-disciplinary and includes medical staff, psychology, nursing, dietetics, physiotherapy, occupational therapy and administrative support. In order to address recruitment difficulties, and to maintain safe service levels, it was agreed with NHS England (who commission the service as a specialist service), to temporarily reduce the bed occupancy to 12 beds until staffing levels improved. It is anticipated that the ward will return to full capacity in February 2019. In order to seek to sustainably address the staffing issues a full review of the service has been undertaken with the participation of service users and their carers. As a result of this work there is now a clear vision of what the ward will offer. This is a vision which has been developed with service users and now ensures a mutual expectation of the service. There have been changes to the environment of the ward to seek to make it a model therapeutic environment with new furniture and redecoration; there has been investment in staff training and development; there has been proactive efforts to recruit new staff and the development of new and attractive roles. Some examples of new roles include the addition of a housekeeper; an activities co-ordinator and a clinical nurse specialist post 9 currently in the process of recruitment). Additional appointments made to date include two new staff nurses, one occupational therapist, and one occupational therapy assistant. The staff development and training plan includes whole team training for DBT skills; multi-family therapy training, MBT (mentalisation) training for all staff; and specific additional psychological training for both nursing staff and psychology staff. Training the whole team will improve the consistency of the therapeutic environment. Pledges have been made to patients based on the changes they requested, and these are regularly updated in ward community meetings. The progress is good and we expect to be in a position to fully open all capacity by February 2019.
2.4	**Community Eating Disorders Services Update**
	The Community Eating Disorders Service (CEDS) team geographically covers Cambridge, Huntingdon and Peterborough providing community clinics and support for adults suffering from eating disorders. The team consists of medical staff, psychologists, nurses and a dietician. CEDS have managed to successfully recruit over the past 6 months and are up to establishment (with plans being made for upcoming maternity leave). The team has seen a decrease in waiting times and has successfully engaged families and cares in carer workshops, monthly carer groups and multi-family days which have received fantastic feedback. The consultant is also engaged in delivering GP training on eating disorders for GP's in the area. The team have developed weekly high-risk meetings to ensure their high-risk patients are closely monitored and weekly discussion meetings to discuss any other pressing clinical issues.

	The biggest challenge currently facing the team is an issue with GP's declining to provide routine medical monitoring for eating disorder patients due to risk involved and this not being seen as something GPs are commissioned to do. It is also not part of the service specification for the community service and discussions are taking place with the CCG to address this. This is a common issue across the region and was an item debated at the recent regional Eating Disorders meetings. This is an area not sufficiently well defined in NICE guidance. The community eating disorder service for children and young people was established in early 2017 across Cambridgeshire and Peterborough. The service accepts up to 100 referrals per year and sees urgent referrals within 1 week and routine referrals within 4 weeks. The biggest challenge for the service has been recruitment and efforts continue to attract specialist staff. The transition of young people from a family-based therapy service to the adults service is also a key priority and work continues across children and adults services to ensure that this transition is as smooth as possible.
2.5	**Discuss CPFT Policy regarding closer working with Universities**
	It is clear that the transition to University is a time of increased challenge and risk for patients with eating disorders. In Norfolk where many students are registered with the University medical centre there is a streamlined process in place and there is a high level of expertise within the practice. The lead GP presented this approach and work at the recent learning event. However, the practice is variable and Universities that do not have a campus medical practice will be more variable in both expertise and closeness to the local eating disorder service. CPFT has protocols for supporting the transition of patients who move out of Cambridgeshire to go to University elsewhere; we also ensure liaison when students with an eating disorder move into our universities in Cambridge. The high level of risk, and complexity of the transitions when patients move to University – often shopping and cooking for themselves for the first time - was an item discussed in detail at the recent learning event. The advice heard from one clinician was that patients should not be advised to go to University until it is clear that their illness has reached a good level of recovery; most specifically for patients with illness so severe as to have recently required a period of admission. There was also an identified need for a national framework to support care planning and support for patients who are at University and therefore often spending large parts of the year with fragmented care delivered across different services and GP practices in different parts of the country. It was agreed that this is an area of heightened risk and is a national issue.

2.6	**Regional Eating Disorders meetings**
	There have been two regional eating disorders events to raise awareness of best practice in eating disorders services; and to seek commitment to action across the east of England to improve the commissioning and provision of services for this vulnerable and high risk patient group. The first event was advertised as a learning event for the NHS and was held on 13th November 2018, hosted by CPFT. It was co-chaired by myself and Keith Grimwade, Chair of Governors at CPFT and Chair of the Regional Eating Disorders Network. The event was for NHS commissioners and providers, and over 100 people attended. The agenda covered the recommendations from the Parliamentary Health Services Ombudsman's Report into eating disorders titled 'Ignoring the alarms; how eating disorders services are failing patients' ; it then considered integration of services between primary and secondary care, with particular regard to establishment of medical monitoring arrangements; we heard how the University of East Anglia medical practice works with the Norfolk community eating disorders service; and discussed the challenges facing patients and eating disorder services when young people are in university; we considered acute hospital management of patients when they become physically unwell, and heard about the development of good practice in Norwich and Ipswich; and finally we heard about mechanisms which need to be established to ensure system learning from serious incidents; and how we need to organise serious incident investigations when care is delivered across a number of organisations. We concluded the event with the development of a set of commitments made across the east of England. These summary slides are attached in Appendix 1. The East of England Clinical Network held its first Eating Disorders Conference on 4th December which was attended by 100 delegates representing the full range of people who encounter people with an eating disorder and included a combination of presentations and workshops. Dr Dasha Nicholls, who chairs the Eating Disorders Faculty of the Royal College of Psychiatrists, gave the keynote presentation drawing attention to the significant progress that had been made with children and young people, whilst recognising the many challenges ahead, including parity for adult services. Presentations were given from the perspectives of schools, primary care, the voluntary sector, community services, inpatient provision and acute provision. A panel of service users and carers spoke powerfully about what most matters to them. Primary care medical monitoring was a key feature of the day as well as the need for schools and colleges to be better informed on how to recognise and support CYP with an eating disorder. The Eating Disorder Clinical Network has committed to setting up a Primary Care Medical Monitoring sub group to develop and agree options for Primary Care Medical Monitoring in the East of England. The network will also ensure that upskilling staff in schools and colleges on how to support CYP with an Eating Disorder is an integral part of the Mental Health Support Team offer, being rolled out as part of the Green Paper. The east of England will have a new regional director in April 2018. She will be accountable to both NHS England and NHS Improvement. Keith Grimwade and I have asked to meet with her to share our work and to ensure her oversight of this priority area of patient safety.
2.8	**Complaints Process**
	The complaints process in CPFT has been reviewed over the summer in order to reduce the time it is taking for complaints to be investigated and responded to. Turnover of staff had led

	to a backlog of responses. This has now been cleared. The average response time is not yet within the expected 30 days, and work led by the Director of Nursing and Quality continues to seek to ensure we respond on average, within this timescale. The trust receives approximately 17 complaints per month. Given the complexity of some of the services the trust provides, undertaking thorough investigations can take significant time if there are many staff to be interviewed; however the ambition is to meet this average response time standard before the end of FY19.
2.9	**Inquests regarding Eating Disorder deaths**
	The Cambridgeshire Coroner's Office has held pre-inquest review hearings for five deaths which include a diagnosis of eating disorder. The five cases include one case from 2012, one case from 2017 and three cases from 2018. It is expected that the Coroner will hear the cases in 2019.
3.0	**Conclusions**
	CPFT continues to actively develop the eating disorders services which we provide. We are leading the development of shared best practice across the east of England, and are committed to ensuring that the recommendations in the PHSO report are implemented in our region. It is clear from our learning and network events that the challenges we face are common. There is a need to continue to reduce the fragmentation in service delivery, especially regarding medical monitoring, and to ensure clear protocols in acute hospitals for the treatment of eating disorder patients when they become physically unwell. Work with Universities is important given the increased risk potential during this transition. We continue to work with our commissioners to address these issues, and to raise awareness at the regional level to ensure that the commitments made in our learning event are delivered.

Author: Tracy Dowling

Title: Chief Executive

Date: 18th December 2018

Agenda Item No: 7

PROVISION OF 111 OUT OF HOURS SERVICE FOR WISBECH

To: **HEALTH COMMITTEE**

Meeting Date: **17 January 2019**

From: **CCG**

Recommendation: **To note the contents of the report**

	Officer contact:
Name:	Ian Weller C&P CCG
Post:	Head of Urgent & Emergency Care
Email:	i.weller@nhs.net
Tel:	07506138759

1. BACKGROUND

1.1 In 2015, as part of a national programme to pilot new objectives set out in the NHS 5-year Forward View (5YFV) Cambridge & Peterborough was awarded Urgent and Emergency Care (UEC) Vanguard status. At the same time the CCG undertook a regional procurement to find a new provider of Integrated Urgent Care (IUC), which saw the coming together of NHS 111 and Out of Hours (OOHs) services under a single provider contract. This contract was awarded to Herts Urgent Care (HUC) which went live in Oct 2016.

Prior to the procurement specification being released the Wisbech Local Commissioning Group (LCG) Clinical Leads opted **not to** include their practice populations within the procurement. Their preferred option was to stay with the current provider (IC24) commissioned by Norfolk CCG. The main reasons for this decision was associated with;

- Maintaining a local service for local patients
- Familiar with the current provider
- Local knowledge of services
- Local GPs working for IC24
- Potential move to join the West Norfolk CCG Catchment

This in practice meant that the new CCG Integrated Urgent Care service excluded the Wisbech populations as these patients were covered IC24 meaning that a Wisbech patient calling NHS 111 would be routed through to IC24 who were responsible for the provision of the local NHS 111 and Out of Hours services (OOHs), the Wisbech OOHs base is located at the North Cambs Hospital site.

One of the key priorities for the UEC Vanguard programme was to design and deliver a 24/7 First Response Service (FRS) for Cambridgeshire and Peterborough patients experiencing a mental health crisis. The primary access route for service users was via NHS 111 and then, following the Interactive Voice Recordings (IVRs)and selecting Option 2, whereby the caller would automatically be transferred to the award winning FRS.

It is vital to understand that FRS was commissioned for all patients within the Cambridgeshire & Peterborough catchment, which includes Wisbech. However, (in line with national guidance) by making NHS 111 the primary access point for FRS meant that by default Wisbech patients were automatically excluded as their NHS 111 routeing telephony is linked to the IC24 service, which does not have an FRS Option 2 available as Norfolk CCG have not commissioned this type of service.

2. MAIN ISSUES

2.1 In light of the above background comments, the main issue for Wisbech patients is how do they directly access FRS when their telephony route to NHS111 automatically excludes them. Cambridgeshire and Peterborough CCG has been working closely with Norfolk commissioners and IC24 to resolve the issue by creating a simple and safe work around.

As a result, a patient living in Wisbech post code catchment experiencing a mental health crisis can access FRS by calling the Cambridge & Peterborough Foundation

Trust (CPFT) 24/7 crisis team on the number supplied, who will take their details name & contact number and pass this information onto FRS who phone the patient back.
In addition, if a Wisbech patient experiencing a mental health crisis does inadvertently call NHS 111 they will then be triaged using the national 'NHS Pathways' Clinical Decision Support System (CDSS) if suitable the Health Advisor (HA, call handler) can select FRS from the Directory of Services (DoS) at which time the HA will;

- Keep patient on the line and call FRS to inform them that they have a patient on the line requiring FRS

- FRS will take this call **OR** inform the 111 Health/Clinical Advisor that FRS will phone the patient back within ONE HOUR. An email will automatically be sent to First Response Service.

Agenda Item No: 8

FINANCE AND PERFORMANCE REPORT – NOVEMBER 2018

To:	**Health Committee**
Meeting Date:	**17th January 2018**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the November 2018 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 2018.**
Recommendation:	**1) The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of November 2018.** **2) The Committee is asked to approve the formation of a working group to carry out a review of the Public Health Reserves and are asked to nominate members of the Committee to sit on this group.**

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

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE NOVEMBER 2018 FINANCE & PERFORMANCE REPORT

2.1 The November 2018 Finance and Performance report is attached at Annex A.

2.2 The forecast outturn for the Public Health Directorate is currently an underspend of £459k, which is the same as the previously reported position to the end of October.

Any underspend within the Public Health directorate up to the level of corporate funding allocated on top of the public health grant funding (£391k) will be attributed to corporate reserves at year end.

A balanced budget was set for the Public Health Directorate for 2018/19, 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.

Further detail on the outturn position can be found in Annex A.

2.3 The Public Health Service Performance Management Framework for October 2018 is contained within the report. Of the thirty one Health Committee performance indicators, six are red, two are amber, twenty are green and three have no status.

2.4 Unspent Public Health Grant Funding is transferred to a ring-fenced Public Health grant reserve at the end of each financial year. Spend from carried forward public health grant is subject to grant conditions. The current reserves balances, and forecast balances as at the end of the 2018/19 financial year, can be found in Annex A, Appendix 5 – Reserve Schedule. It is proposed that a working group is formed from Health Committee members to review the planned expenditure and suggest options for future expenditure.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

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

cleared by Public Health?	

Source Documents	**Location**
As well as presentation of the F&PR to the Committee when it meets, the report is made available online each month.	https://www.cambridgeshire.gov.uk/council/finance-and-budget/finance-&-performance-reports/

From: Martin Wade

Tel.: 01223 699733

Date: 10 December 2018

Public Health Directorate

Finance and Performance Report – November 2018

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
Oct (No. of indicators)	6	2	20	3	31

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Outturn Variance (Oct) £000	Service	Budget for 2018/19 £000	Actual to end of Nov 18 £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Children Health	9,266	4,668	0	0%
0	Drug & Alcohol Misuse	5,625	3,920	0	0%
-331	Sexual Health & Contraception	5,157	2,386	-331	6%
-50	Behaviour Change / Preventing Long Term Conditions	3,812	1,800	-50	-1%
0	Falls Prevention	80	54	0	0%
-8	General Prevention Activities	56	29	-8	-14%
0	Adult Mental Health & Community Safety	256	149	0	0%
-70	Public Health Directorate	2,019	1,051	-70	-3%
-459	**Total Expenditure**	**26,271**	**14,057**	**-459**	**-2%**
0	Public Health Grant	-25,419	-19,271	0	0%
0	s75 Agreement NHSE-HIV	-144	144	0	0%
0	Other Income	-40	-12	0	0%
0	Drawdown From Reserves	-39	0	0	0%
0	**Total Income**	**-25,642**	**-19,139**	**0**	**0%**
68	**Contribution to/(Drawdown from) Public Health Reserve**	**0**	**0**	**68**	
-391	**Net Total**	**629**	**-5,082**	**-391**	**-73%**

The service level budgetary control report for 2018/19 can be found in appendix 1.

Further analysis can be found in appendix 2.

2.2 Significant Issues

A balanced budget has been set for the financial year 2018/19. Savings totalling £465k have been budgeted for and the achievement of savings will be monitored through the monthly savings tracker, with exceptions being reported to Heath Committee and any resulting overspends reported through this monthly Finance and Performance Report.

The total forecast underspend for the Public Health Directorate remains at £459k. Underspend within the Public Health directorate up to the level of corporate funding allocated on top of the public health grant funding (£391k) will be attributed to corporate reserves at year end.

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

The total Public Health ring-fenced grant allocation for 2018/19 is £26.253m, of which £25.541m is allocated directly to the Public Health Directorate.

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

Sexual Health (KP1 & 2)

- Performance of sexual health and contraception services is good.

Smoking Cessation (KPI 5)

This service is being delivered by Everyone Health as part of the wider Lifestyle Service.

- There has been an improvement in this month's performance with the trajectory moving up but indicators for people setting and achieving a four week quit remain still remain at red.
- Appendix 6 provides further commentary on the ongoing programme to improve performance

National Child Measurement Programme (KPI 14 & 15)

- The coverage target for the programme was met. Year end data for the 2017/18 programme will be available at the end of 2018.
- Measurements for the 2018/19 programme are taken during the academic year and the programme will re-commence in November 2018

NHS Health Checks (KPI 3 & 4)

- Indicator 3 for the number of health checks completed by GPs is reported on quarterly. Q2 is presented whilst this indicator is reporting as red it is an improvement on performance from this time last year.
- Indicator 4 for the number of outreach health checks remains red. Performance has dropped in the county this month as there was a fall in bookings with workplaces.

Lifestyles Services (KPI 5, 16-30)

- There are 16 Lifestyle Service indicators reported on, the overall performance is good and remains the same as last month with 13 green, 1 amber and 2 red indicators.
- Appendix 6 provides further explanation of the red indicators for smoking cessation and the personal health trainer service, proportion of Tier 2 clients completing weight loss interventions.

Health Visiting and School Nurse Services (KPI 6-13)

The performance data provided reports on Q2 (July – Sept 2018) for the Health Visiting and School Nurse services.

A summary was provided in last months report.

4.2 Public Health Services provided through a Memorandum of Understanding (MOU) with other Directorates (Appendix 7)

Appendix 7 provides an update on progress made against the MOU the financial summary position is highlighted below.

Directorate	YTD (Q2) expected spend	YTD (Q2) actual spend	Variance
P&C	£154,000	£149,995	£4,005
ETE	£60,000	£58,531	£1,469
CS&T	£100,500	£100,500	0
LGSS	£110,000	£110,000	0
TOTAL Q2	**£424,500**	**£419,026**	**£5,474**

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Previous Outturn (Oct) £'000	Service	Budget 2018/19 £'000	Actual to end of Nov £'000	Outturn Forecast £'000	%
	Children Health				
0	Children 0-5 PH Programme	7,253	1,837	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,706	2,524	0	0%
0	Children Mental Health	307	307	0	0%
0	**Children Health Total**	**9,266**	**4,668**	**0**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,625	3,920	0	0%
0	**Drugs & Alcohol Total**	**5,625**	**3,920**	**0**	**0%**
	Sexual Health & Contraception				
-281	SH STI testing & treatment – Prescribed	3,829	2,047	-281	-7%
-50	SH Contraception - Prescribed	1,176	306	-50	-4%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	34	0	0%
-331	**Sexual Health & Contraception Total**	**5,157**	**2,386**	**-331**	**-6%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	1,980	1,379	-0	0%
0	Other Health Improvement	413	78	0	0%
-50	Smoking Cessation GP & Pharmacy	703	5	-50	-7%
0	NHS Health Checks Prog – Prescribed	716	337	0	0%
-50	**Behaviour Change / Preventing Long Term Conditions Total**	**3,812**	**1,800**	**-50**	**-1%**
	Falls Prevention				
0	Falls Prevention	80	54	0	0%
0	**Falls Prevention Total**	**80**	**54**	**0**	**0%**
	General Prevention Activities				
-8	General Prevention, Traveller Health	56	29	-8	-14%
-10	**General Prevention Activities Total**	**56**	**29**	**-8**	**-14%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	149	0	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**149**	**0**	**0%**

Previous Outturn (Oct) £'000	Service	Budget 2018/19 £'000	Actual to end of Nov £'000	Outturn Forecast £'000	%
	Public Health Directorate				
0	Children Health	189	111	0	0%
0	Drugs & Alcohol	287	138	0	0%
0	Sexual Health & Contraception	164	85	0	0%
-50	Behaviour Change	753	397	-50	-7%
0	General Prevention	199	123	-20	-10%
0	Adult Mental Health	36	14	0	0%
-20	Health Protection	53	34	0	0%
0	Analysts	338	149	0	0%
-70		**2,019**	**1,051**	**-70**	**-3%**
-459	**Total Expenditure before Carry forward**	**26,271**	**14,057**	**-459**	**-2%**
68	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**68**	**0.00%**
	Funded By				
0	Public Health Grant	-25,419	-19,271	0	0%
0	S75 Agreement NHSE HIV	-144	144	0	0%
0	Other Income	-40	-12	0	0%
	Drawdown From Reserves	-39	0	0	0%
0	**Income Total**	**-25,642**	**-19,139**	**0**	**0%**
-391	**Net Total**	**629**	**-5,082**	**-391**	**-73%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Budget 2018/19 £'000	Forecast Outturn Variance	
		£'000	%
Sexual Health Testing and Treatment	**3,829**	**-281**	**-7%**
An underspend of £281k has been identified against the Sexual Health budget. This is as a result of an over-accrual which had been carried forward from a previous financial year in error. The over-accrual will be moved into Public Health ring-fenced grant reserve and will be used to fund £281k of Public Health eligible funding during 2018/19 in place of £281k of general CCC funding, producing an underspend against the CCC corporate funding.			

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

Awarding Body : DofH

Grant	Business Plan £'000	Adjusted Amount £'000	Notes
Public Health Grant as per Business Plan	**26,253**	**26,253**	Ring-fenced grant
Grant allocated as follows;			
Public Health Directorate	25,419	25,419	
P&C Directorate	283	293	£10k movement of Strengthening Communities Funding moved from P&E to P&C
P&E Directorate	130	120	£10k movement of Strengthening Communities Funding moved from P&E to P&C
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**26,253**	**26,253**	

APPENDIX 4 – Virements and Budget Reconciliation

	£'000	Notes
Budget as per Business Plan		
Virements		
Non-material virements (+/- £160k)		
Budget Reconciliation		
Current Budget 2018/19		

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2018	2018/19		Forecast Closing Balance	Notes
		Movements in 2018/19	Balance at end Nov 2018		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,040**	0	1,040	**870**	£238k fund Healthy Child Programme saving deferred to 2019/20. Anticipated 2018/19 underspend +£68k.
subtotal	**1,040**	**0**	**1,040**	**870**	
Other Earmarked Funds					
Healthy Fenland Fund	300	0	300	200	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	378	0	378	259	Planned for use on joint work with the NHS in 2017/18 and 2018/19.
NHS Healthchecks programme	270	0	270	270	This funding will be used to install new software into GP practices which will identify patients for inclusion in Health Checks. The installation work will commence in June 2017. Funding will also be used for a comprehensive campaign to boost participation in NHS Health Checks.
Implementation of Cambridgeshire Public Health Integration Strategy	579	0	579	300	£517k Committed to the countywide 'Let's Get Moving' physical activity programme which runs for two years from July 2017-June 2019.
subtotal	**1,527**	**0**	**1,527**	**1,029**	
TOTAL	**2,567**	**0**	**2,567**	**1,899**	

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

Fund Description	Balance at 31 March 2018	2018/19		Forecast Closing Balance	Notes
		Movements in 2018/19	Balance at end Nov 2018		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	136	0	136	136	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**145**		**145**	**145**	

APPENDIX 6 PERFORMANCE

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

The Public Health Service Performance Management Framework (PMF) for October 2018 can be seen within the tables below:

	Measures											
KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
1	GUM Access - offered appointments within 2 working days	Oct-18	98%	98%	100%	102%	G	100%	98%	100%	↔	
2	GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	Oct-18	80%	80%	94%	117%	G	91%	80%	94%	↑	
3	Number of Health Checks completed (GPs)	Q2 (Jul-Sept 18)	18,000	9000	7251	81%	R	77%	4500	3447	↔	This is an improvement on performance at this time last year.
4	Number of outreach health checks carried out	Oct-18	1,800	1050	694	66%	R	102%	162	52%	↓	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. This includes securing access to workplaces in Fenland where there are high risk workforces. Wisbech Job Centre Plus is receiving sessions for staff and those claiming benefits. In addition sessions in community centres in areas that have high risk populations are ongoing A mobile service has been piloted and will be introduced. Performance in Fenland continues to overachieve. Performance dropped in Fenland and the rest of the county this month as there was fall in bookings with workplaces. Although there is high number booked for November
5	Smoking Cessation - four week quitters	Sep-18	2154	960	787	82%	R	78%	170	100%	↑	• There is an ongoing improvement in performance in the past two months. There is an ongoing programme to improve performance that includes targeting routine and manual workers (rates are known to be higher in these groups) and the Fenland area. A new promotional campaign has been commissioned for January 2019 • This month the improvement reflects late data returns form the GP practices •The most recent Public Health Outcomes Framework figures released in July 2018 with data for 2017) suggest the prevalence of smoking in Cambridgeshire is statistically similar to the England figure , 14.5% v 14.9%. All districts are now statistically similar to the England figure. Most notable has been the improvement in Fenland where it has dropped from 21.6% to 16.3%, making it lower than the Cambridge City rate of 17.0%

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
6	Percentage of infants being breastfed (fully or partially) at 6 - 8 weeks	Q2 Jul-Sept	56%	56%	55%	98%	G	53%	56%	56%	↑	Despite being a challenging target, county breastfeeding statistics have seen a further 3% increase in Q2 on top of the 3% improvement in Q1. Cambs is now reaching target of 56% based on quarterly averages. Overall, breastfeeding rates in Cambridgeshire remains higher than the national average of 44%. Breastfeeding rates vary across the county however there has been a notable improvement in East Cambs & Fenland in Q2, raising from 33% to 43%, coming close to national average.
7	Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV from 28 weeks	Q2 Jul-Sept	50%	50%	23%	46%	R	20%	50%	23%	↑	In Cambridgeshire a local target has been set for 50%, with the longer term goal of achieving a target of 90% by 2020. The overall performance this quarter has improved by 3%. Locally, Huntingdon has increased it's antenatal visits from 38% in Q1 to 47% in Q2. However East Cambs & Fenland has dropped from 37% in Q1 to 24% in Q2 and South Cambs from 13% in Q1 to 5% in Q2. Steps to improve this include introduction of mobile working which is being rolled out across the patch and will be completed by the end of the calendar year. Incentives are also being offered to encourage staff to work across a wider geographic area. Progress has been made in securing agreement from all 4 hospitals to provide antenatal notifications.
8	Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	Q2 Jul-Sept	90%	90%	92%		G	90%	90%	92%	↑	The 10 - 14 new birth visit remains consistent each month and numbers are well within the 90% target.
9	Health visiting mandated check - Percentage of children who received a 6 - 8 week review	Q2 Jul-Sept	90%	90%	92%	102%	G	85%	90%	92%	↑	Performance for the 6 - 8 week review has continued to improve since Q4 17/18 and is now above target threshold of 90%. This has been achieved in each of the 3 local areas and notably with Huntingdon reaching 94%.
10	Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	Q2 Jul-Sept	95%	95%	81%	85%	A	85%	95%	77%	↓	Performance has reduced in Q2 from 85% to 77%, however there has been an improvement in the number of children receiving their 1 year check by their 1st birthday. Due to this we anticipate that there will be an improvement in this KPI for Q3. Including exception reporting takes performance to 94%. Exception reporting includes those that 'did not want' or 'did not attend' their appointment. However it also includes those who were not recorded (n=213 children in Q2). Work is being undertaken to clarify the definition of 'not recorded' and to improve data completeness in this regard. An additional challenge has been the delayed transfers in notifications from the Child Health Information System (CHIS) presenting a capacity issue to the service. This has now been resolved.
11	Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	Q2 Jul-Sept	90%	90%	69%	76%	R	67%	90%	72%	↑	Performance has improved from Q1 to Q2. Performance ranges from 67% in South Cambs, 73% in Huntingdon to 79% in East Cambs and Fenland. East Cambs & Fenland improved from 45% to 79%. Initiatives to continue to improve uptake of this mandated visit include 1.) Home visiting offer reinstated in deprived areas 2.) Additional Saturday morning clinics put on in Cambs City which have proven popular 3.) reviewed processes for sending out appointments to ensure they are sent out earlier to be able to offer second appointment within timeframe if needed.
12	School nursing - Number of young people seen for behavioural interventions - smoking, sexual health advice, weight management, emotional health and well being, substance misuse or domestic violence	Q2 Jul-Sept	N/A	N/A	208	N/A	N/A	100	N/A	108	N/A	The School Nursing service is actively delivering brief interventions for Healthy Weight, Mental Health, Sexual Health and Domestic Violence. The numbers of brief interventions for domestic violence are particularly high and are to be applauded. There have been no brief interventions for substance misuse or smoking cessation. This is worrying given the number of onwards referrals to substance misuse and smoking cessation services is very low too. Urgent review of school nursing service offer and pathways with young people's substance misuse and smoking cessation services being undertaken during November.
13a	School nursing - number of calls made to the duty desk.	Q2 Jul-Sept	N/A	N/A	1490	N/A	N/A	Not applicable	N/A	689	N/A	Numbers overall are lower in Q2 due to the summer school holidays. Emotional health is by far the most popular topic. Events promoting Chat Health have been well received across the area.
13b	School nursing - Number of children and young people who access health advices and support through Chat Health	Q2 Jul-Sept	N/A	N/A	1123	N/A	N/A	Not applicable	N/A	381	N/A	

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
14	Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	Oct-18	>90%	>90%	91.0%	91%	G	90.0%	91.0%	91.0%	N/A	The National Child Measurement Programme (NCMP) has been completed for the 2016/17 academic year. The coverage target was met and the measurement data has been submitted to the PHE in line with the required timeline. The 2018/19 measurement programme commences in November
15	Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	Oct-18	>90%	>90%	95.0%	95%	G	90.0%	95.0%	95.0%	N/A	
16	Overall referrals to the service	Oct-18	5300	2650	3509	132%	G	108%	417	101%	↓	Although downwards the number of referrals is still above target.
17	Personal Health Trainer Service - number of Personal Health Plans produced (PHP's) **(Pre-existing GP based service)**	Oct-18	1670	835	760	91%	G	116%	150	44%	↓	
18	Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	Oct-18	1252	626	739	118%	G	128%	113	112%	↓	
19	Number of physical activity groups held **(Pre-existing GP based service)**	Oct-18	730	365	620	170%	G	223%	66	171%	↓	
20	Number of healthy eating groups held **(Pre-existing GP based service)**	Oct-18	495	248	266	107%	G	53%	30	100%	↑	
21	Personal Health Trainer Service - number of PHPs produced (Extended Service)	Oct-18	800	400	501	125%	G	121%	48	101%	↓	
22	Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	Oct-18	650	325	320	98%	G	105%	59	74%	↓	
23	Number of physical activity groups held (Extended Service)	Oct-18	830	415	411	99%	G	114%	58	98%	↓	

KPI no.	Measure	Period data relates to	Y/E Target 2018/19	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous period actual	Current period target	Current period actual	Direction of travel (from previous period)	Comments
24	Number of healthy eating groups held (Extended Service)	Oct-18	570	285	281	99%	G	47%	16	100%	↑	
25	Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	Oct-18	30%	30%	24.0%	80%	R	30%	30%	25%	↓	There is an improvement this month but there has been an ongoing issue with staff changes. To address this Everyone Health has contracted with Weight Watchers (WW reimaged) and Slimming World to provide the services. The services that these organisations provide have been very well evaluated and they have robust evidence for the effectiveness of their services. These will commence in October.
26	Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	Oct-18	60%	60%	56.0%	93%	A	56%	60%	53%	↓	Generally this service performs well but it does have some very challenging complex patients that find meeting the 10% weight loss target difficult.
27	% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	Oct-18	80%	80%	80%	100.0%	G	0%	80%	0%	↔	A new programme has commenced.
28	Number of referrals received for multi factorial risk assessment for Falls Prevention	Oct-18	520	260	409	157%	G	309%	47	145%	↓	
29	Number of Multi Factorial Risk Assessments Completed - Falls Prevention	Oct-18	442	221	424	192%	G	244%	40	142%	↓	
30	Number clients completing their PHP - Falls Prevention	Oct-18	331	166	254	153%	G	385%	30	140%	↓	

* All figures received in November 2018 relate to October 2018 actuals with exception of Smoking Services, which are a month behind and Health Checks, some elements of the Lifestyle Service, School Nursing and Health Visitors which are reported quarterly.
** Direction of travel against previous month actuals
*** The assessment of RAG status for services where targets and activity are based on small numbers may be prone to month on month variation. Therefore RAG status should be interpreted with caution.

APPENDIX 7

PUBLIC HEALTH MOU 2018-19 UPDATE FOR Q2

PUBLIC HEALTH MOU 2018-19 UPDATE FOR Q2

Directorate	Service	Allocated	Q2 Update	YTD expected spend	YTD actual spend	Variance
P&C	**Counting every Adult (MEAM)**	£68k	CEA caseload update: Referrals received: 9 Accepted: 3 Declined: 2 Withdrawn: 1 Decision Pending: 5 Closed: 3 Active: 32 (at end of quarter) 16 in independent accommodation 4 in supported accommodation 1 in temporary accommodation 6 living with family / sofa surfing 3 rough sleeping 1 in HMP	£34,000	£34,000	0

P&C	**Education Wellbeing/PSHE KickAsh**	£15k	Transfer of KickAsh programme to new provider	£15,000	£15,000	0
P&C	**Children's Centres**	£170k	The Public Health funding is utilised as part of the total budget to improve health of children, with particular focus on the youngest children. (For context, the Public Health contribution of £170k makes up 3.89% of the overall budget of £4,372,159) During quarter 2, 677 separate activities were delivered from our Child and Family Centre providers across the county under the 'Child and Family Health' heading. These included ante and post- natal support, breastfeeding advice and support, clinics, first aid sessions, healthy eating and weaning support. In addition to the ongoing integrated health provision in our centres, we are also looking at some new pieces of work to improve our service to families including: • Establishment of 'community hubs' for maternity services in our buildings, linking the midwifery offer more effectively with Health Visiting services and other support available for new parents at our centres. • Piloting a new integrated Antenatal education programme delivered by professionals across services. • Reviewing the support and information we provide around Perinatal and maternal mental health with partners including the CCG.	£85,000	£85,000	0
P&C	**Strengthening Communities Service - KickAsh**	£23k	**July 2018** Time was spent during July gathering information for evaluation of Kick Ash 2017/18 and tidying up of the year end prior to recruitment of new Year 10 mentors for Sept . **Swavesey Village College** - Following the school's successful recruitment of new year 10 mentors before the end of the Summer term, training sessions were delivered to 30 very keen new mentors to take us forward in to 2018/19 Kick Ash. The training included information about the prevalence of Nicotine Inhaling Products that are becoming more popular with young people and those who are nicotine dependent. **Longsands** – met with the students to discuss their successes of the year's work and to invite them to be part of the recruitment of new year 10's for next year. Also met the new school lead (teacher) as it had changed recently. **Bottisham** – met the students for the last time to discuss their successful year. The school lead had planned and gained the interest of 20 of this year's year 9's	£11,500	£9,907	£1,593

			to be mentors once they commence in year 10 in the autumn. Led discussions about celebrating 10 years of Kick Ash in Bottisham in 2019. **End of July –** Was informed that the management will be changing for the Kick Ash programme going forward and was advised that future planning be put on hold. **August** – school holidays, no work carried out during this month as Kick Ash officer was on summer leave. **September** – Everyone Health have taken over the Healthy Schools contract and from 1st October will be leading the Kick Ash project, potentially delivering it in a different way. Work and commitment for the Trading Standards element is yet to be confirmed and meetings have been arranged to take place in October to discuss the way forward. Due to this state of flux, time was spent continuing with tidying of files and admin prior to changes and potential handover. **Safety Zone** – preparation was made for the forthcoming Safety Zones in Ely and Ramsey. The new flyers for "Keeping safe in your home" were updated and printed to ensure all pupils attending the Safety Zone events would receive information about the safety of certain products including cigarettes and nicotine inhaling products.			
P&C	**Strengthening Communities Service**	£10k	Business as usual continues in Fenland, below are a few of the highlights for this quarter. **Prevention at Scale** Normally a Health based initiative, in the case of Wisbech Prevention at Scale is being used to achieve greater impacts in Community Development and Engagement, the rationale being that if there is greater engagement from communities overall, if they are empowered to understand and commit to changes, if they begin to own projects or services and exert a voice and influence then, impacts are likely to be greater, whether that be in heath, well-being, skills, employment or educational attainment (or indeed any other broad theme). This project is about the population and communities of Wisbech and dovetails neatly with the overarching vision and themes of Wisbech 2020. Public and voluntary sector partners have agreed to embark on a joint community conversation in the autumn with the residents of Wisbech, starting with existing networks, about what people love about Wisbech, what people would change about Wisbech and what people are prepared to do about it, whilst connecting people to the resources to help make those ideas happen. **Wisbech Community Led Local Delivery (CLLD)**	£5,000	£2,588	£2,412

			Using ESF and partnership funding (including CCC) , Wisbech CLLD is a programme being delivered through a range of local projects which will help people facing multiple disadvantages to move closer to work, either into paid employment or into activities that may build their confidence and skills to help them find work. Project funding applications are considered by a Local Action Group which includes Strengthening Communities and as a result of our involvement, local community leaders who are representative of the town's demographics. **Time Credit networks** in Chatteris, March and Wisbech continue with support from officers in SCS. Work has progressed through the Joint Commissioning Board to seek funding for the ambitious plans for sustainable Time Credits work post Jan 2019 when the current contract with Spice ends and that has been agreed. Requests for Quote from prospective suppliers will be advertised in the next few weeks, seeking interest to deliver the programme from Jan 2019 through to March 2021. Officers will be aligning the programme to the emerging Tackling Poverty Strategy			
P&C	**Contribution to Anti-Bullying**	£7k	This is a nominal amount and is part of a large budget, it is therefore difficult to pull out exactly what the £7k covers, and difficult to apportion amounts. This will be spent in total.	£3,500	£3,500	£0
			SUB TOTAL : P&C Q2	**£154,000**	**£149,995**	
ETE	**Active Travel (overcoming safety barriers)**	£55k	102 schools are now using the Modeshift STARS system. Submissions for July are for 56 bronze accreditations, 2 silver, 3 gold. Barnabas Oley Primary School Great Gransden won the "National STARS School Travel Planning Primary School of the Year" for their efforts to increase walking, cycling and other forms of sustainable transport for the journey to school. Autumn Term events October is Walk to school month November 19th – 25th Road Safety Week 1 – 2 November Modeshift National Conference Sheffield one of our School Travel Champions Sue Mulley from Fourfields Primary school has been shortlisted 13th November Modeshift STARS School Regional Awards to be held in London. Hatton Park Primary School has been shortlisted and is one of 75 schools across the Country in the running for the award	£27,500	£27,500	

ETE	**Explore additional interventions for cyclist/ pedestrian safety**	£30k	Officers promoted “Bike Week “across the County Other activities during Bike Week included : All JTA’s held “Safe Cycling” assemblies in their schools and demonstrated the mini egg helmet experiment. All JTA schools took part in Pedsmart Adverts for students in Student Pocket Guide to promote safe cycling. Refresh cycling resources in preparation for Fresher’s Fair Procured extra resources for “Road Safety Day of Action” for the Lit Campaign” to be held in November Officers attended and helped out at Op Velo days in Cambridge City Looking at some additional analysis of collisions where close pass recorded as a factor.	£15,000	£15,000	
ETE	**Road Safety**	£20k	Junior Travel Ambassador is aimed at yr. 5 pupils and empowers them to make their own decisions about what they and their fellow pupils would like to do and identify what they think needs to change to improve road safety for their school. JTA also encourages pupils to get more active and lead healthier lifestyles. Junior Travel Ambassadors are so enthusiastic and keen to make their schools safer as well as feeling strongly about the need to improve the environment by using more sustainable travel, they find fun and innovative ways to get the messages across to their peers”. There are now 157 JTAs across the 26 schools. JTA’s held many competitions and had some really innovative and creative ideas over the summer months to promote sustainable travel here is just a snapshot: **Golden Lock** Competition JTA’s encouraged pupils to scoot or cycle to school for a week. At break time each day JTA’s would go out and put a golden lock on one of the bikes or scooters the pupil who had the golden lock won a Road Safety prize. **Walking is Fun** Competition pupils took photographs of interesting things on their way to school a prize for the best photo **Shoes Competition** JTA’s took photographs of pupils/staff shoes printed them out and ran a competition for pupils to guess whose shoes belonged to whom	£10,000	£10,000	0

			JTA's put Thank you notes on cars that were parked away from school each driver was entered into a competition and the winner was invited to a free school lunch. Other activities included Assemblies, Designing Road Safety Banners to put outside their schools 5 minute parking zone Pedometers **The first Cambridgeshire JTA conference is being planned for October 30th**			
ETE	**Illicit Tobacco**	£15k	• 1 case in the Magistrates Court. Guilty plea and fined £1200. Following arrest warrants being issued as defendants failed to appear, one person has been arrested and bailed to reappear at a hearing at a later date. • Intelligence work on going. Intelligence received on shops selling in various places across the county. • Considerable amount of information about one shop selling in Fenland area, which is resulting in joint working with HMRC and surveillance work to be carried. Surveillance forms completed and court attendance and sign off. • Test purchase exercise to determine if challenge 25 was being adhered too and to prove that illicit tobacco is being sold to younger people. 20 year old was requested to ask for cheap cigarettes. In general she was asked for ID but 7 sales out of 21. 5 off these were illicit tobacco for as little as £3.	£7,500	£6,031	£1,469
			SUB TOTAL : ETE Q2	**£60,000**	**£58,531**	**£1,469**
C&CS	**Research**	£22k	In reference to the previous quarter's report the team are in the process of analysing the Cambridge fringe development survey. A major milestone has been reached with the CambridgeshireInsight OpenData site. The latest version of the OpenData platform has gone live with enhanced data browsing and data stories. Work is now on going with partners to exploit the tools. *Focus on Health Data for Community Safety* Peterborough and Hinchingbrooke: Successful meeting with Jane Pigg (Company Secretary NWAnglia NHS) data sharing agreement refresh to cover Peterborough A&E and Hinchingbrooke A&E data is in the works. She proposed we present analysis back to their ED staff too which is good opportunity to feedback to data providers (details tbc).	£11,000	£11,000	0

			Kings Lynn: Links established with their analyst with initial report to follow. **Ambulance Trust**: Lack of engagement from trust, OPCC led contact has provided a referral to the same contact who has previously refused to discuss data sharing due to time availability.			
C&CS	**Transformation Team Support**	£27k	**Business Planning** The Transformation Team continues to lead the Council's Business Planning Process, ensuring that the 2018-19 Business Planning process sufficiently aligns with the work of the Public Health directorate, and supporting Public Health colleagues to engage with the Business Planning process. **Business Transformation** • The Transformation Team continue to collaborate with Public Health colleagues around the development of approaches to transforming programmes and practices, with the goal of working together to increasing Public Health Directorate's capacity to improve outcomes for children and families in Cambridgeshire. • The Transformation Team remain available to provide project management support and advice to Public Health; as well as operating a range of projects that include public health representation. • The authority's project management system continues to be refined; this includes Public Health projects and wider projects that public health colleagues are engaged in. **Links between Public Health, STP and Devolution** • The Transformation Team continue to engage and support the development of STP work led by Public Health. • Devolution work also continues, and the Transformation team will be involved in this work with the potential inclusion of public health activity.	£13,500	£13,500	0
C&CS	**Communications**	£25k	Development and delivery of • Development of the Stronger for Longer campaign, Stay Well, Stoptober, Drugs and substance abuse new commissioned service and the loneliness prevention '50,000 reasons' campaign • Delivery of the C4L 'Train like a Jedi' campaign, International Alzheimer's Day, World Suicide Prevention Day and social media for National Overdose Awareness Day	£12,500	£12,500	0

			Reactive enquiries included cuts to family planning funding, drop in smoking prevalence, breastfeeding and childhood obesity Support for the Health Committee			
C&CS	**Strategic Advice**	£22k	• Leading the corporate Health, Safety and Wellbeing Board to ensure that Public Health, & its role in supporting for staff wellbeing, is given greater focus • Support with specification and supply of analytical software • Managing the corporate risk management and corporate performance management frameworks and ensuring that Public Health is fully accounted for in these	£11,000	£11,000	0
C&CS	**Emergency Planning Support**	£5k	Ongoing close working with the Health Emergency Planning Officer (HEPRO) across a range of tasks • Provision of emergency planning support when the HEPRO is not available • Provision of out of hours support to ensure that the DPH is kept up to date with any incidents that may occur and have relevance to public health Assistance with emergency planning activity including further development of Vulnerable Persons Protocol	£2,500	£2,500	0
C&CS	**LGSS Managed Overheads**	£100k	This continues to be supported on an ongoing basis, including: • Provision of IT equipment • Office Accommodation • Telephony • Members allowances	£50,000	£50,000	0
			SUB TOTAL : CCS Q2	**£100,500**	**£100,500**	**0**
LGSS	**Overheads associated with PH function**	£220k	This covers the Public Health contribution towards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance £20k HR £25k IT £20k The remaining £155k is a general contribution to LGSS overhead costs	**£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
P&C	£154,000	£149,995	£4,005
ETE	£60,000	£58,531	£1,469
CS&T	£100,500	£100,500	0
LGSS	£110,000	£110,000	0
TOTAL Q2	**£424,500**	**£419,026**	**£5,474**

Agenda Item No: 9

PROGRESS REPORT: PROGRAMMES FUNDED FROM PUBLIC HEALTH RESERVES

To:	**Health Committee**
Meeting Date:	**January 17th 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** *Key decision:* **No**
Purpose:	**The purpose of this paper is to provide progress reports on three pilot programmes funded by the Health Committee from Public Health Reserves.**
Recommendation:	**The Committee is asked to review the progress reports and support the following recommendations.**

a) Acknowledge the positive progress achieved by the Healthy Fenland Fund programme.

	Officer contact:		***Member contacts:***
Names:	**Val Thomas**	Names:	Councillor Peter Hudson
Post:	Consultant in Public Health,	Post:	Chairman
Email:	Val.thomas@cambridgeshire.gov.uk	Email:	Peter.hudson@cambridgeshire.gov.uk
Tel:	01223 7013264, 01223 699405	Tel:	01223 706398

1. BACKGROUND

1.1 The Health Committee funded from Public Health Reserves three new public health initiatives. These programmes are being closely monitored to provide evidence of their impact, effectiveness and their potential cost benefits. They include:

- Falls Prevention Programme
- Let's Get Moving
- Healthy Fenland Fund

The first two programmes were discussed at the Health Committee meeting held on 8th November and Let's Get Moving was further reviewed at the meeting on 6th December. This report focuses on the Healthy Fenland Fund programme

1.2 Healthy Fenland Fund

The Health Committee approved funding for the Healthy Fenland Fund (HFF) which reflected its commitment to improving health outcomes and inequalities in Fenland. The aim of the Programme is to contribute to improvements in the health and wellbeing of communities in Fenland through supporting the development of strong and resilient communities that are fully engaged in identifying and addressing their needs.

Care Network successfully bid in a competitive tender for the delivery of the HFF, with the contract commencing in January 2016. HFF is funded for five years with a total value of £825,000, of which £500,000 is from a public health earmarked reserve, and has two mutually dependent elements. The "Fund" can be accessed by communities who want to develop activities to engage their members in activities that they think will improve their health and wellbeing. Care Network sub-contracted with the Cambridgeshire Community Foundation to administer the Fund. Care Network was also commissioned to provide a small team of community development workers to engage and develop the skills within communities for identifying their needs and assets along with how they could address these needs. This included supporting them to make bids against the HFF and also to other sources of funding.

2. MAIN ISSUES

2.1 The funding for these three programmes is non-recurring as it is from the Public Health Reserves. The objective of the funding was to develop new public health initiatives that would prove to be effective, bring cost benefits attracting other more secure funding sources.

2.2 The supporting paper for the Healthy Fenland Fund (HFF) describes its progress to date and suggests strongly that the HFF has engaged with and impacted upon communities in Fenland. The tangible evidence of this is number of community projects that have been supported and received grants. There is also evidence that community assets have been realised through the identification and energising of community connectors, peer support, volunteers and the impressive 74% of projects which continue to be self-sustaining after receiving development and funding from the HFF.

Based on analysis from other community development initiatives where an assets based approach has been adopted there is growing evidence that it has a range of benefits. However it is noted that the HFF evaluation could be strengthened by more fully understanding whether it is reaching those most in need along with identifying and capturing additional measures of community assets.

An economic analysis of the HFF has not been undertaken. However the report suggests that the approach to evaluation could be strengthened to demonstrate impact on health and cost benefits but there would be resource implications.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

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

All three programmes will contribute to reducing the costs to the local economy through reducing ill health

3.2 Helping people live healthy and independent lives

All three programmes aim to improve the health and wellbeing of the population and enable people to live independently.

3.3 Supporting and protecting vulnerable people

All three programmes have focus upon supporting and protecting those most in need and any associated health inequalities.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in ***2.1***

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

See wording under 4.1 and guidance in Appendix 2.

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

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

4.3 Statutory, Legal and Risk Implications

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

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

4.4 Equality and Diversity Implications

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

- The programmes are monitored to ensure that any equality and diversity implications are identified and any ensure that appropriate action is undertaken.

4.5 Engagement and Communications Implications

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

- The programmes secure regular feedback from their patients and clients
- All programmes involve ongoing engagement with individuals and communities

4.6 Localism and Local Member Involvement

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

- The programmes reflect the differing needs found across Cambridgeshire and are tailored to address these through consultation with residents, stakeholders and partner organisations.

4.7 Public Health Implications

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

- The programmes present growing evidence that they are preventing ill health and improving health of the population through the range of interventions that have been developed.

- The programmes also target those most vulnerable and in need to address inequalities and improve the outcomes for these population groups.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Clare Andrews:
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes or No Name of Officer:
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes or No Name of Legal Officer:
Have the equality and diversity implications been cleared by your Service Contact?	Yes Liz Robin:
Have any engagement and communication implications been cleared by Communications?	Yes Matthew Hall:
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes or No Liz Robin:
Have any Public Health implications been cleared by Public Health	Yes or No Liz Robin:

Source Documents	Location
References The Marmot Review: Fair Society: Healthy Lives 2010 Cabinet Office and The Department of Work and Pensions: Wellbeing and civil society 2013 Public Health England: A guide to community-centred approaches for health and wellbeing 2015	 http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review https://www.gov.uk/government/publications/wellbeing-and-civil-society https://www.gov.uk/government/publications/health-and-wellbeing-a-

	guide-to-community-centred-approaches
Public Health England: Health Matters – community approaches to health 2015 & 2018	https://publichealthmatters.blog.gov.uk/2018/02/28/health-matters-community-centred-approaches-for-health-and-wellbeing/
NICE Guideline 44 Community engagement: improving health and wellbeing and reducing health inequalities 2016	https://www.nice.org.uk/guidance/ng44
NHS England: NHS Five Year Forward View	https://www.england.nhs.uk/five-year-forward-view/

TO: **HEALTH COMMITTEE**

RE: **SUPPORTING INFORMATION FOR THE LET'S GET MOVING PROGRESS REPORT**

DATE: **NOVEMBER 8 2018**

FROM: **VAL THOMAS, CONSULTANT IN PUBLIC HEALTH**

1. PURPOSE

The following is a report on the progress of the Healthy Fenland Fund describing its background, outputs and impact during its first two years.

2. BACKGROUND

Fenland has a substantial number of health outcomes, health behaviours and health determinants that are worse than the national average. Specific issues that have been identified relate to mental health and isolation, lack of engagement with public services, social issues, language barriers, and income and child deprivation.

The Health Committee approved funding for the Healthy Fenland Fund (HFF) which reflected its commitment to improving health outcomes and inequalities in Fenland. Care Network successfully bid in a competitive tender for the delivery of the HFF, with the contract commencing in January 2016. The HFF is funded for five years with a total value of £825,000 and has two mutually dependent elements which is a small community grants fund and a community development team.

3. PROGRAMME DESCRIPTION

3.1 The Healthy Fenland "Fund" may be accessed by community individuals or groups who want funding to develop activities or projects that they think will improve their health and wellbeing. It also enables community members to engage other members of their communities to take forward community initiatives. The funding therefore aims to strengthen the community by supporting the "building blocks" or for a specific project that addresses a community issue. Care Network sub-

contracted with the Cambridgeshire Community Fund to administer the allocation of the Fund.

3.2 The remit of the small team of community development workers is to engage and develop the skills of community members for identifying their own community needs and assets along with how they could address these needs. This includes supporting communities to make bids to the HFF and also to other sources of funding.

3.3 The aim of the Programme is to contribute to improvements in the health and wellbeing of communities in Fenland through supporting the development of strong and resilient communities that are fully engaged in identifying and addressing their needs. Although the formal start date of the contract was January 2018, recruitment and training took several months, therefore the information presented here describes the impact of the HFF is from June 2016 until September 2018.

4. CHALLENGES FOR EVALUATING COMMUNITY PROGRAMMES

4.1 The HFF aims to support improvements in mental and physical health through facilitating community led health improving activity programmes. This acknowledges that there are different types of activities that can impact upon health and wellbeing. However the activities that bring the anticipated improvements are identified by the community.

4.2 This reflects the Assets Based Community Development (ABCD) approach of sustainable community driven development that has been adopted by the HFF. Asset Based Community Development's premise is that communities can drive the development process themselves by identifying, mobilizing existing, but often unrecognised assets and developing new ones. These assets enable communities to respond to their needs and challenges to create local health and social improvements.

Evaluating the impact of community programmes upon health is notoriously challenging. The core concepts that have been identified with community centred approaches to health and wellbeing are; voice and control, leading to people having a greater say in their lives and health; equity, leading to a reduction in avoidable inequalities, and social connectedness, leading to healthier more cohesive communities. These assets enable communities to become more resilient and better able to drive improvements in their health and well.

The following are the tangible community assets associated with health improvement.

- the skills, knowledge, social competence and commitment of individual community members
- friendships, inter-generational solidarity, community cohesion and neighbourliness

- local groups and community and voluntary associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles
- physical, environmental and economic resources
- assets brought by external agencies including the public, private and third sector

4.3 The information presented in this report describes specific health improving activities but it also indicates that the HFF is contributing to building the community assets that support improvements in health and wellbeing and reductions in health inequalities. The evaluation framework is still in development but the data that is being collected aims to capture both changes in health behaviours along with the assets associated with supporting of health and wellbeing.

5. THE DELIVERY MODEL

5.1 The HFF community development team invested a considerable amount of effort into becoming embedded within communities in Fenland to establish HFF as a trusted "brand". The aim was to identify the 'community connectors' who will take social action and use their community strengths, physical and social assets to make connections in their communities.

These community activities included:

1. Community confidence building e.g. helped community connectors to take an idea and turn it into reality, building confidence, providing encouragement and support to increase confidence

2. Skills development: provided training on group governance, book keeping and any other areas needed to achieve sustainability fundraising, poster design and generally acting as a 'go to' with any queries

3. Accessing grant funding: supported the community connectors to work with their communities to access funding from the Healthy Fenland Fund or other funding opportunities

4. Access to information: offered easy access and a single point of contact for communities though providing online and digital information which also increased the connectivity between relevant community groups and organisations.

5. Partnerships: built robust and effective collaboration for supporting communities at both strategic and operational levels.

6. COMMUNITY GROUPS

The headline figures for engaging with community groups are as follows.

- 108 groups have been supported by the team
- 2 groups have required community development support, but did not require funding.
- Actual number of beneficiaries reported to date 2,345 (95% of target)
- 1561 people who have participated in community groups and activities supported by HFP report improved physical, mental and emotional wellbeing
- 246 people reported increased participation in community activities
- 224 residents have gained new skills as a result of engaging with community groups supported by HFP
- 210 people have engaged with activities that promote healthy lifestyles, such as healthy eating and smoking cessation
- 52 beneficiaries have gone on to access additional support services to improve health and wellbeing following support from a HFF group
- 27 groups did not pursue support after initial engagement as they did not meet the criteria of the HFF, or the community leader/connector or group were not ready to take their idea forward or the community leader/connector identified that in the long term, the group would not be sustainable

7. DISTRIBUTION OF THE GRANT

7.1 The HFF grants are divided into three categories

- Start-up funding for up to £500 for groups in early development stages to try out their ideas.
- £1,500 available for new groups for equipment, venue hire, publicity)
- £5,000 available at quarterly application points for larger projects

Table 1 indicates that around £122k was awarded to communities in two years. This is 81% of the value of grant available for this period. Of these awards 20 organisations have received the small grant totalling £9,376.27.

It is anticipated that the demand will continue to increase for grants as the HFF becomes further embedded into Fenland communities.

Table 1: Summary of Activity

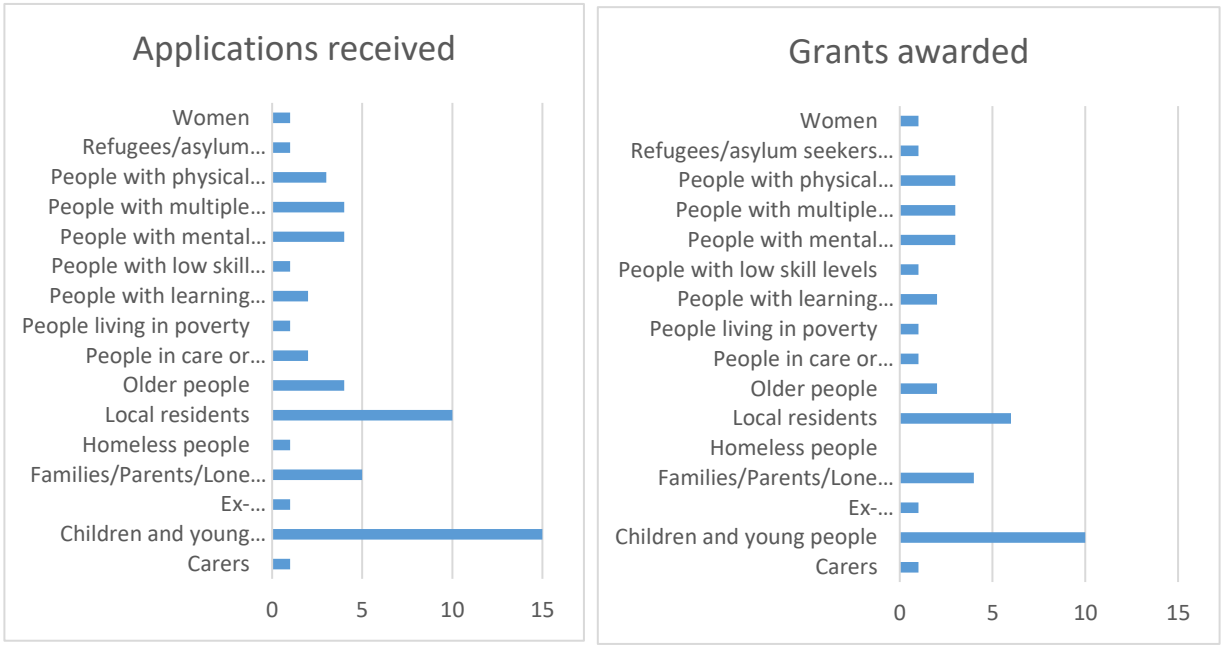
Application status	No. applications	Value (£)
No. received	56	£190,068
Withdrawn by CCF / applicant	9	£28,869*
Rejected	7	£23,877*
Grants awarded	40	£121,950*
Requests under review	0	£0
Projects complete, and reporting received	23	£66,309

**The value awarded, under review, rejected and withdrawn does not equal the amount requested because a number of applications were part funded, including four applications which received 50% or less of the amount they requested – highlighted in Table 2.*

** Please note that total applications (117) is larger than the 108 groups the HFF team have supported as some groups were applying directly for funding without engaging with support from the HFF team.*

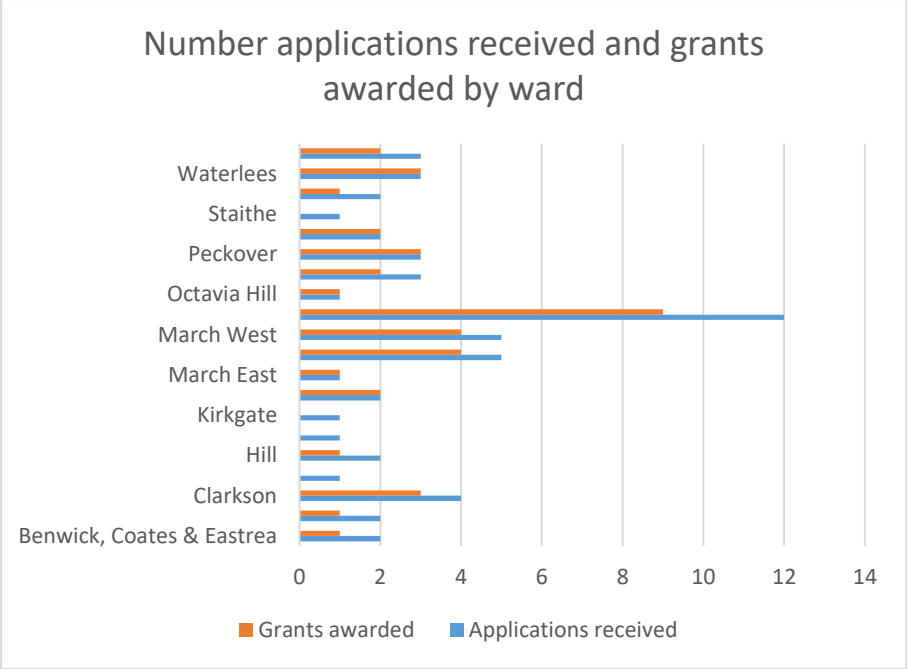
7.2 Figure one indicates the number of applications made and the grant awards by primary beneficiary group.

Figure 1: Number of Applications and Awards by Primary Beneficiary Group



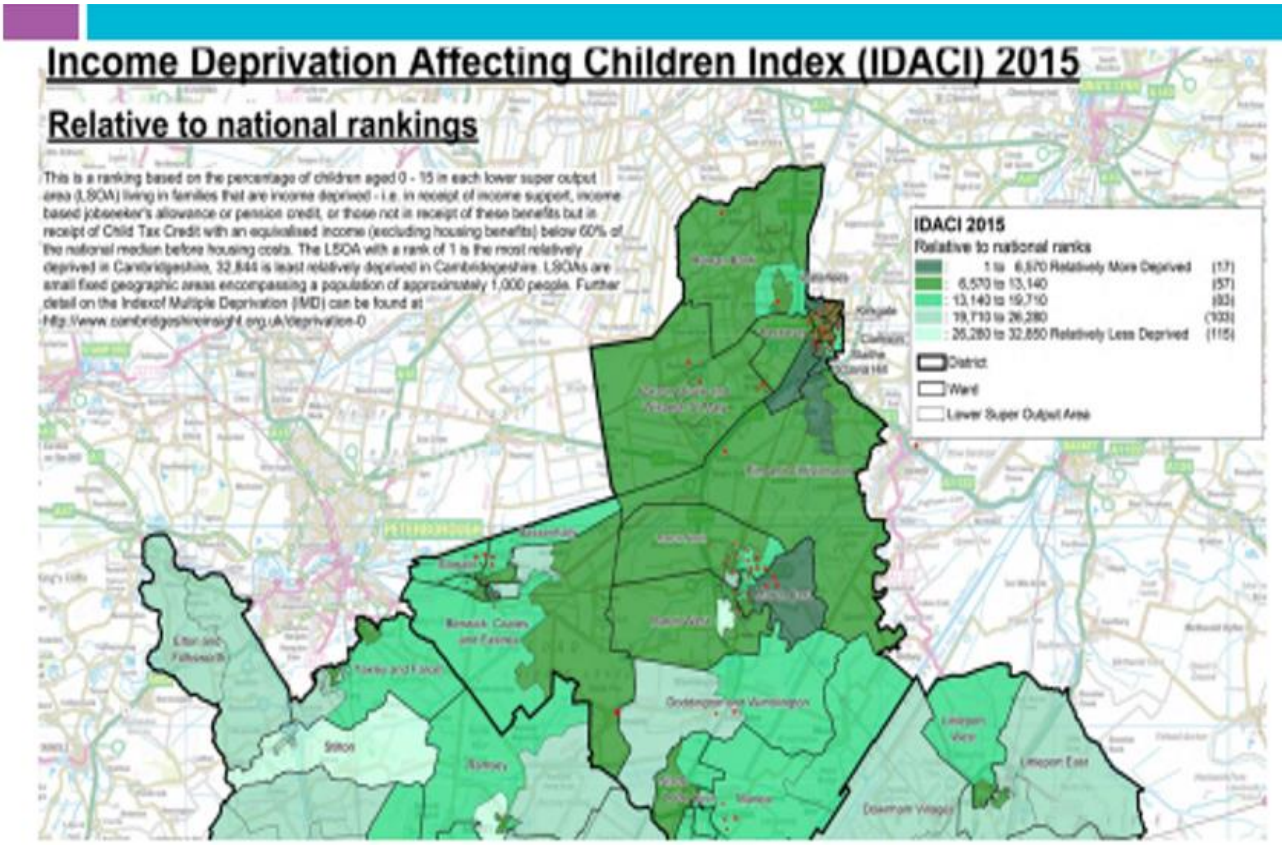
7.3 Figure 2 demonstrates that the applications for grants come in the main from the more deprived wards.

Figure 2. Spread of applications received and grants awarded across Fenland wards.



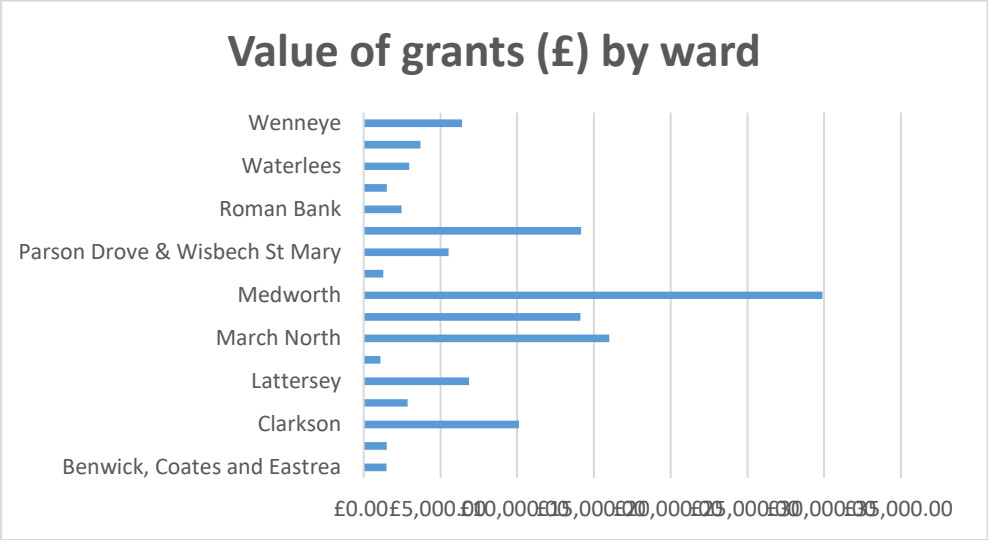
7.4 Figure 3 indicates the geographical spread of projects in relation to the more deprived areas in Fenland. The red dots indicate the location of projects

Figure 3: Geographical Location of Community Projects in Relation to Deprivation (red dots indicate project locations)



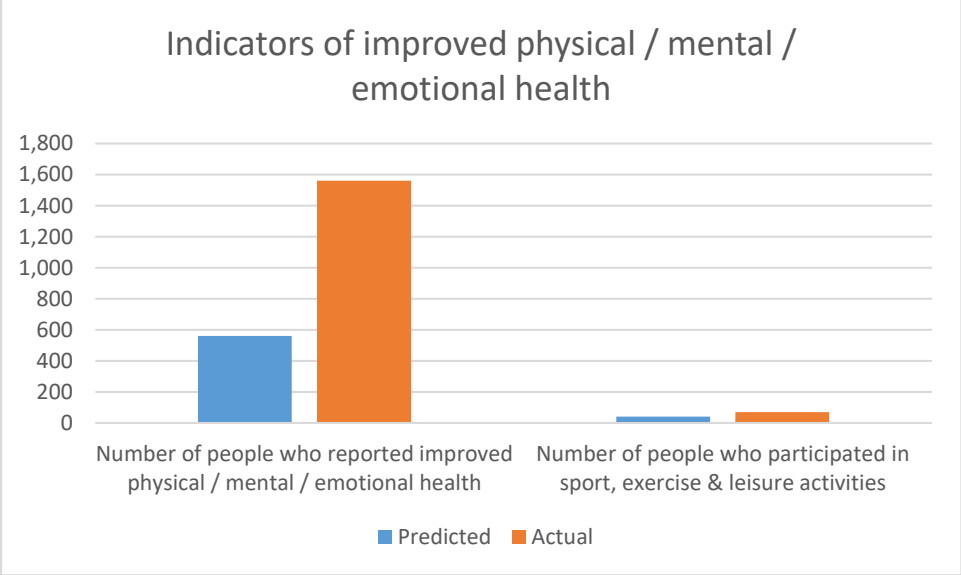
7.5 Figure 4 shows the total value of grants awarded in each ward in Fenland

Figure 4. Value of grants awarded across Fenland wards.



7.6 Key objectives for the HFF is to improve lifestyles and health. Figure 5 details the *reported* improvements on projects where reporting has been completed.

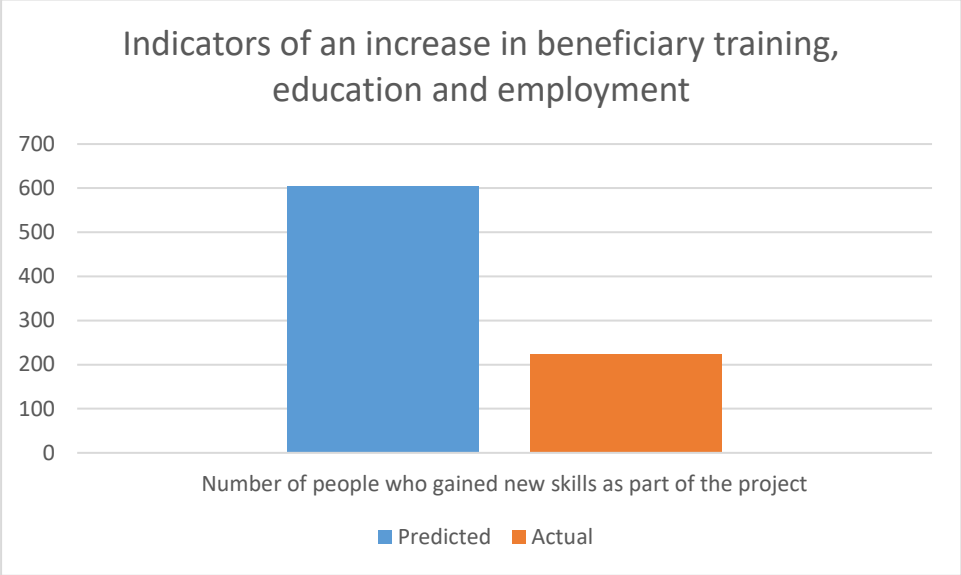
Figure 5. The Number of People who have Reported Improvements in Health (physical / mental / emotional)



Although fewer activities, groups and hours of activities provided have been reported than were initially predicted by funded groups, the number of people reporting improved health and participation in sport and exercise has exceeded predictions.

7.7 Along with improvements in health the HFF aims to increase the number of beneficiaries involved training, education, accreditation and employment opportunities as indicated in Figure 6 which shows the number of people reporting that they have acquired new skills on projects where reporting has been completed

Figure 6. The Number of People who have Reported that they have Gained New Skills.



8. STRENGTHENING COMMUNITY ASSETS

8.1 Each supported group is asked provide feedback information to the community development team about the impact of the support and funding that they have received. Additional information was also secured through a workshop which included the community development team and grant recipients. The responses are reported below and include increased opportunities and skills development.

- Increase in volunteering opportunities and volunteers
- Peer support and mentoring within groups
- Increase skill and experience which provides opportunities for local communities to share best practice through networking events facilitated by the HFF.

8.2 The strongest evidence for the impact that the HFF has had on building community assets is that 74% of HFP groups have gone on to be self-sustaining, after receiving development and funding support from the HFF.

9.2 ADDED VALUE OF CARE NETWORK

9.1 The organisation Care Network has a track record of working in Fenland and understands the community development approach as it is embedded into the delivery of many of their work programmes. This has enabled it to support the community development team in their efforts to engage with communities

9.2 The Care Network Management Team has supported the HFF at a strategic level and facilitates the flow of information from the HFF to the Care Network Leadership Team, commissioners and other key partners. This has resulted in building collaborative working between the HFF and other local initiatives or

services. For example the Diabetes Care Team Fenland Children's Centre and a Sheltered Housing Scheme for older people.

10. THE CHALLENGES AND LEARNING

10.1 Gaining the trust of local communities demanded considerable time and effort. In the first year the HFF community development team focused upon being visible in the community, for example having a weekly market stall in Wisbech, where HFF branded tea bags and plant seed packets were distributed. The team continues to have a presence at many community events to maintain its visibility.

10.2 There were especial challenges when engaging with migrant communities. Community development is not part of the migrant community culture and an unknown concept. Recruiting a member of the team from the migrant community, has helped overcome language barriers, as well as suspicion of the community development approach. There is a lack of confidence or understanding of how to participate and run a community group and new approaches are in development.

10.3 The introduction in year 2 of small easy to access £500 grants increased applications for larger value grants as groups developed the confidence and skills to expand their projects.

10.4 It is important that requests for funding are processed quickly. Groups become frustrated and lose the trust in the brand and can lose interest in continuing.

10. COST BENEFITS – THE EVIDENCE

10.1 NICE has stated that the understanding of the costs and economic benefits of community-centred approaches is limited, partly because it is difficult to assess and measure wider social impacts and compare areas. However community-centred approaches offer a different way to use local resources, and some studies have evidenced that there is good social return on investment.

10.2 The London School of Economics found that:

- timebanking has a return of £2.89 for every £1 invested
- befriending for older people gives a return of £3.75 for every £1 invested
- community navigators have a return of £3 for every £1 invested

The Cabinet Office and Department for Work and Pensions' report Wellbeing and Civil society found that:

- the value that frequent volunteers place on volunteering is around £13,500 per year

11. SUMMARY AND RECOMMENDATIONS

11.1 The information presented in this progress report suggests strongly that the HFF has engaged with and impacted upon communities in Fenland. The tangible evidence of this is number of community projects that have been supported and received grants.

11.2 There is also evidence that community assets have been realised through the identification and energising of community connectors, peer support, volunteers and the impressive 74% of projects who continue to be self-sustaining after receiving development and funding from the HFF.

11.3 Based on analysis from other community development initiatives where an assets based approach has been adopted there is growing evidence that it has cost benefits.

The information that is collected to evidence the impact of the Healthy Fenland Fund does not include the added value of its impact upon individual volunteers or any economic analysis.

The Well Being and Civil Society Report cited above suggests that there is evidence that individuals do place a positive value on participating in voluntary work but this was rarely assessed in monetary terms. The Report uses the "Wellbeing Valuation" concept which estimates the increase in wellbeing associated with a particular good or service and then calculates the equivalent amount of money necessary to give the same boost to well-being. In terms of valuing volunteering this approach takes the perspective of the participant and uses data on life satisfaction and volunteering status to estimate a wellbeing value that is attributed to volunteering.

Wellbeing is considered to be positive concept and associated with numerous health, economic and social benefits. For example individuals are more productive at work and have a longer life expectancy.

It is feasible that this type of wellbeing impact analysis could be undertaken through a Healthy Fenland Fund participant wellbeing survey and the type of economic analysis used in the Wellbeing and Civil Society Report could also provide additional evaluation evidence. However this does have some resource implications in terms of developing the tools and undertaking the analysis.

11.4 There is however a need to work to develop further to fully understand whether the HFF is reaching those most in need.

11.5 Additional measures of community assets need to be identified and captured to demonstrate more robustly its contribution to strengthening and developing the assets of the community in Fenland.

APPENDIX 1: All HFF Applications Received.

Grant Application: Grant Application Name	Date Received	Amount applied for	Amount Awarded	Status
Wisbech PHAB Club	28/04/2016	£1,486.00	£1,486.00	Fully Paid
Reuseful UK	28/04/2016	£6,000.00	£5,000.00	Complete
Hudson Indoor Bowls Club Wisbech	17/05/2016	£1,394.00	£0.00	Withdrawn
Young People March	23/05/2016	£3,725.00	£0.00	Withdrawn
Fen Tigers Goalball	28/06/2016	£1,444.00	£1,000.00	Fully Paid
Illuminate Charity CIO	06/07/2016	£4,710.00	£0.00	Withdrawn
Chatteris Town Youth FC	06/07/2016	£5,000.00	£2,534.00	Complete
People & Animals UK CIC	18/07/2016	£1,450.00	£0.00	Rejected
Viva	20/07/2016	£2,842.00	£0.00	Withdrawn
Rosmini Centre Wisbech	21/07/2016	£4,958.00	£4,958.00	Complete
March Community Can't Sing Choir	10/08/2016	£3,539.00	£3,539.00	Fully Paid
Wisbech Community Development Trust	17/08/2016	£1,488.00	£1,488.00	Fully Paid
Viva Families and Communities	14/09/2016	£2,862.00	£2,862.00	Complete
Something To Look Forward To Ltd	22/09/2016	£3,500.00	£0.00	Rejected
Positive People Care	30/09/2016	£1,499.00	£1,500.00	Fully Paid
The Ferry Project	30/09/2016	£5,000.00	£5,000.00	Complete
Cambridgeshire Invisible Illness Support	06/10/2016	£1,268.10	£0.00	Withdrawn
Whittlesey Beginners Running Group	25/10/2016	£2,666.71	£2,666.00	Complete
Fenland Communication and Connection Workshops	29/10/2016	£5,000.00	£0.00	Withdrawn
Chatteris Cricket Club	30/10/2016	£3,874.28	£3,874.00	Complete
Trinity Bowls Club	12/11/2016	£1,500.00	£1,429.00	Fully Paid
Centre 33	25/01/2017	£5,000.00	£5,000.00	Complete
Fenland Association for Community Transport	26/01/2017	£5,821.20	£0.00	Rejected
V.I.P. Club (formerly the K.I.T. club)	30/01/2017	£5,000.00	£1,000.00*	Fully Allocated
Arthur Rank Hospice Charity	01/02/2017	£3,900.00	£3,900.00	Fully Paid
Wisbech Warblers Singalong	09/02/2017	£1,500.00	£1,500.00	Complete
Wisbech Projects CIC	10/02/2017	£3,275.00	£1,500.00	Complete
Reuseful UK	15/02/2017	£5,000.00	£5,000.00	Fully Paid
Newton Bowls Club	21/02/2017	£1,320.00	£1,040.00	Fully Paid
Defibrillators for All	27/03/2017	£5,000.00	£0.00	Rejected
Fen Trek	04/04/2017	£1,500.00	£0.00	Withdrawn
Whittlesey Kurling Club	04/04/2017	£1,493.00	£1,493.00	Fully Paid
The Let's Cook Project CIC	24/04/2017	£7,930.00	£7,900.00**	Fully Allocated
March & District Model Railway Club	18/05/2017	£680.00	£680.00	Fully Paid
Whittlesey Table Tennis Club	19/05/2017	£1,500.00	£1,500.00	Fully Paid
Living Sport	02/06/2017	£5,000.00	£5,000.00	Complete
Bedazzle Projects	22/06/2017	£1,500.00	£1,500.00	Fully Paid
Friends of Rings End Nature Reserve	23/07/2017	£4,984.97	£2,000.00	Complete
Friends of Polish Supplementary School	27/07/2017	£4,505.00	£4,505.00	Fully Allocated

Chatteris Cycling Club	31/07/2017	£4,910.00	£0.00	Withdrawn
LEADA Cambs	01/08/2017	£3,520.00	£0.00	Withdrawn
Murrow Preschool	02/10/2017	£769.62	£540.00	Fully Paid
The Ferry Project	08/01/2018	£1,499.00	£0.00	Rejected
Rima's Ladies and Families	10/01/2018	£5,510.00	£4,710.00	Fully Paid
Fenland Villages Archery Club	24/01/2018	£1,417.00	£1,417.00	Fully Allocated
Benwick Street Pride Volunteer Group (Known as Benwick In Bloom)	31/01/2018	£1,501.60	£0.00	Rejected
Young Technicians CIC	31/01/2018	£4,195.00	£4,195.00	Fully Paid
Friends of Fenland Home Educators	31/01/2018	£4,199.84	£4,199.00	Fully Paid
CHS Group	01/02/2018	£5,105.00	£0.00	Rejected
Shedders and Fixers	01/02/2018	£5,000.00	£5,000.00	Fully Paid
Association of Mindfulness Arts	22/02/2018	£5,000.00	£5,000.00	Fully Paid
Fenland Breatheasy (March)	08/03/2018	£1,080.00	£1,080.00	Fully Allocated
Viva Families and Communities	26/04/2018	£1,280.00	£1,280.00	Fully Paid
Wisbech Street Pride Group	30/04/2018	£4,970.99	£4,970.00	Fully Allocated
Wisbech Women's Badminton Group	10/05/2018	£5,000.00	£5,000.00	Fully Allocated
Black Panther Events	28/07/2018	£4,995.00	£3,705.00	Fully Allocated
		£190,068.31	**£121,950.00**	

APPENDIX 2: Long Lasting Impact – Case Studies

Case Study 1: Migrant Community Engagement: Evidence of Migrant Engagement, Community Cohesion to Reduce Social Isolation, Sustainable Group Activity

There is a Russian Orthodox community based in Wisbech who meet together at the St. Peter's and St. Paul's Church on a regular basis. In the early days of the HFF, this group approached us for support, but because they were a religious closed group, the community did not qualify for funding.

We have been working together over the last 12 months to see how we could engage this community and make sure that they keep on meeting regularly as well as attract other members of public to promote community cohesion and integration.

Migrant Communities in Fenland do not have skills and experience in Community Development and therefore, struggle to come up with ideas on keeping a group together and sustainable. We tried to offer a model of local groups and suggested organising a Lunch Club inviting local members of the public and migrant communities. The community liked this idea and so in April of this year, it applied to our Small Grant Fund, which allowed them to organise a Russian Easter Lunch. The event enabled all members of migrant and local community to meet up, have a traditional Easter lunch together as well as socialising together. 52 people attended this event.

The Russian Orthodox Lunch Club was able to fundraise £100 from this event, by suggesting people leave a donation. There has now been further engagement between communities and there will be another migrant and locals lunch which will be covered by the funds raised from the Easter lunch.

The group hopes to have regular lunches 3-4 times a year which will give an opportunity for everyone else to join in in spite of their religion, race and language.

Case Study 2: Benefits of the Small Funding Pot, Evidence of Improved Mental Wellbeing, Collaborative working with local partner organisations

S contacted the HFF as he had an idea of starting up a club that would use photography as a conduit for peer support for those who felt socially isolated and or had mental health problems.

His idea was to encourage people to come together to share their enjoyment of photography by using their mobile phones to take the photographs rather than the normal camera (although these weren't excluded) and to then download and print their work.

S had previously had mental health issues and found that getting out and taking photographs with his phone, opened a whole new world to him. Initially he approached the staff at the Oasis Centre in Wisbech to help him develop his idea.

The Oasis Centre referred Steven to the HFF and one of the team met with him several times over the course of a couple of months to develop his idea and support with

funding. This was required for venue hire, refreshments and small equipment items, so he decided that the 'start up' fund would be sufficient for his initial needs.

S was granted the funding and his first 6 week course was at full capacity. He intends to continue these delivery blocks of his project from October, as there is plenty of demand within the local community to engage with his group.

We hope to work with S again very soon to help him with further funding to expand his project.

Case Study 3: March Carers Group: Evidence of Peer Support, Improved Health and Wellbeing, Challenges to local groups in achieving sustainability and the need for HFF community development support

This group was initially set up at the Cornerstone GP Practice in March in 2017 with an average attendance of approximately 10 people. The group was formed to reach out to carers who may be struggling to cope, feeling lonely or isolated. Although it began positively, there were operational issues, such as only being able to hold support sessions during lunch time, when the practice was closed, which meant attendance numbers declined.

The group decided to move to another location to overcome this challenge and moved to St Peters Church Hall on a Monday mornings 10.30 – 12.30 the third Monday of the month. This allowed them to meet for longer, have access to a kitchen for refreshments (thus raising funds to become financially sustainable), invite speakers in and be able to hold group activity sessions.

To facilitate this plan they approached the HFF for support and received a small grant award to facilitate this move. Despite this positive action and hard work to promote the group, attendance numbers dwindled.

They are now considering changing the structure of the group from just Family Carers to something more all-encompassing, to include people who may be lonely or isolated, may have mental health issues or may have lost their caring role.

The hope is that by doing this and also moving the group to a more central location in the town (within walking distance to the shops) that the group will grow and be able to become sustainable in their own right.

HFF will continue to support the group with these changes. The Small Grant fund is designed to enable groups to "have a go" and is flexible enough to allow them to develop the group at this early stage without too many restrictions.

Case Study 4 Bedazzle Project: Evidence of physical and social activity with impacts upon loneliness and social isolation.

This project was awarded a grant of £1,500 to set up a new theatre and dance group in Wisbech for at least 10 adults with additional needs. "A is a complex young man with mental health issues as well as being Downs Syndrome. He has faced various challenges being a part of a group, he finds it difficult to form relationships with his

peers as they don't fully understand him or his needs. He has challenging behaviour which is why he has a full-time support worker when he accesses the community. A has overcome his shyness with attending the Imagine show, although he found it difficult, being on stage was a huge success, we paired him up with a member of staff and he embraced his time on stage and overcame his nerves. When we decided to put on a pantomime he took on the role of two characters, he learnt his lines by memory as he cannot read, he surprised us all. He invited family and friends and has now found his place in the group. At lunch time he now chooses to sit with the other students and talks about his family and home life, he has come into his own and feels very much a part of the Bedazzle group."

Figure 6. Bedazzle theatre and dance group.

Case Study 5: March & District Model Railway Club: Evidence of addressing learning disabilities and mental health issues in community activities

The Club received a grant of £680 to engage with people who have learning difficulties and mental health issues. March & District Model Railway Club were invited to talk at the March Dementia Café meeting in February 2018. Their attendance at the Dementia Café was well received and promoted lots of memories and conversation. The chairman Keith Sharp talked about the model club, showed models and explained how to make buildings from "mounting card". "Two men who regularly attend the Dementia Café never speak when sitting around the table with others. After watching a demonstration of the Fenland Yard shunting puzzle, and having the opportunity to operate the shunting puzzle, one of the men started to chat about going train spotting when he was young. After a short time the other man who also hardly speaks, talked about his father being a train driver at March, then about biking to Whitemore Marshalling Yard (in March) to ride in the cab of a diesel shunter his father was driving."

Agenda Item No: 10

ANNUAL PUBLIC HEALTH REPORT 2018

To:	**Health Committee**
Meeting Date:	**17th January 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Key decision:	**No**
Purpose:	**To present the Annual Public Health Report for Cambridgeshire 2018 to the Health Committee, and to raise awareness of the national Chief Medical Officer (CMO) Report 2018.**
Recommendation:	**The Committee is asked to discuss and comment on the findings of Cambridgeshire Annual Public Health Report and national CMO (England) Report**

	Officer contact:		***Member contacts:***
Name:	Dr Liz Robin	Names:	Peter Hudson
Post:	Director of Public Health	Post:	Chairman
Email:	Liz.robin@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 703261	Tel:	01223 706398

1. BACKGROUND

1.1 The Health and Social Care Act (2012) includes a requirement for Directors of Public Health to prepare an independent Annual Public Health Report (APHR) on the health of local people.

Previous Annual Public Health Report for Cambridgeshire (2017)

1.2 The previous APHR (2017) focussed on the wider social and environmental factors affecting health and wellbeing in Cambridgeshire and how these are associated with local inequalities in health outcomes. The report also looked at key lifestyle behaviours which impact on longer term health and wellbeing, and at trends in life expectancy and preventable deaths in the county.

Four recommendations were made as follows:

- Where possible and statistically valid, we should be mapping more health and wellbeing indicators at the local neighbourhood level to help 'fine tune' the provision, targeting and monitoring of campaigns and services.
- That the disparity in educational outcomes between children receiving free school meals across the county and their peers should be a public health priority, given the impact of educational attainment on future health and wellbeing
- That the work taking place across the NHS and local authorities to improve early intervention and support for young people with mental health problems should lead to an improvement in current trends, and that the impact of this work needs careful monitoring.
- That a consistent and sustainable focus on the North Fenland and Wisbech area from a range of organisations is needed to address the determinants of health such as educational attainment and economic development, as well as a focus from health and care providers on delivering accessible prevention, treatment and support services to meet current needs.

National Chief Medical Officer (CMO) Reports

1.3 National professional leadership for local authority Directors of Public Health is provided by Chief Medical Officer (CMO) for England, who also produces an Annual Report. The CMO Report for 2018 was published on 21st December, and provides useful national context for local priorities.

2. MAIN ISSUES

Cambridgeshire Annual Public Health Report 2018

2.1 The APHR 2018 (Annex A) focusses on the following areas

- An introduction to publically available web-based sources of information, which can provide comprehensive and regularly updated information about the health of Cambridgeshire's population, including signposting to the relevant weblinks.
- Achieving the 'Best start in life' for babies and young children in Cambridgeshire, and reviewing some key factors which affect health and development up to the age of five.
- The international Global Burden of Disease study (GBD), which has been providing health statistics for national governments around the world for the past twenty years,

and which for the first time (funded by Public Health England) has provided an analysis of health and disease at English local authority level. The GBD emphasises the importance of smoking as an ongoing cause of premature deaths, and the importance of poor diet and high body mass index as a cause of both premature deaths and of disabling health conditions, with associated use of health and care services.

- A brief review of progress against recommendations from the APHR 2017.

2.2 The APHR 2018 proposes that recommendations from the previous APHR 2017 (see para 1.2) will take time to implement, and progress against them should continue to be monitored. In addition, there are two further recommendations:

- The recent Early Years Social Mobility Peer Review for Cambridgeshire and Peterborough provided a range of recommendations to support outcomes for children in their early years and reduce inequalities in school readiness, and these recommendations should be taken forward.
- The Global Burden of Disease study emphasised the importance of smoking and tobacco as a cause of premature death in Cambridgeshire, but with the exception of Fenland, progress in reducing smoking rates across the county has slowed. A new multi-agency strategy and action plan to address smoking rates in Cambridgeshire should be developed.

The recommendation to develop a multi-agency strategy for smoking and tobacco reflects the success of the multi-agency Cambridgeshire Healthy Weight Strategy, and Suicide Prevention Strategy, both of which have led to significant action across local organisations.

National Chief Medical Officer (CMO) Report 2018

2.3 The national CMO Report 2018 'Health 2040 - Better Health Within Reach' was published in December 2018 and provides a wider context to the local picture of public health priorities and outcomes. The executive summary is attached as Annex B. The CMO Report 2018 looks ahead to health in England in 2040 – potential best case and worst case scenarios, and how actions that we take now can influence this. The CMO Report draws on knowledge and ideas of a wide range of authors, drawn from academic and policy experts, and includes a focus on:

- **Health as one of the primary assets of our nation, contributing to both the economy and happiness**. The CMO Report proposes a composite 'Health Index' which is tracked alongside the nation's GDP that is inclusive of health outcome measures, modifiable risk factors and the social determinants of health. This part of the Report also analyses the links between health and the economy, the local health environment, social health and how the maintenance and treatment of health could be experienced in 2040. It emphasises the changing needs of an ageing population, and the need to develop healthcare infrastructure appropriate to managing 'multi-morbidity' (when people experience several diseases) rather than just focussing on individual disease pathways. It emphasises the importance of both physical and mental health.
- **The potential health gains and reduction in health inequalities that could be possible with a 'prevention first' approach.** A chapter on 'Changing Behaviour for a Healthy Population' edited by Prof Theresa Marteau of Cambridge University, emphasises the importance of creating environments which make healthy behaviour the easiest option, rather than just relying on 'willpower' to deliver behaviour change. The

chapter reiterates the four key health behaviours of smoking, diet, physical activity and alcohol use – with a particular focus on the increasing impact of unhealthy weight on both health and social care costs and the wider economy. With a strong focus on creating healthy policy and environments, the Report outlines implications for policy-makers, health advocacy organisations, businesses, researchers and the public.

- **Emerging technologies and their potential impact on health promotion, protection and treatment.** This section reviews the potential of machine learning for individualised medicine, the potential impact of emerging technologies on both population health outcomes and delivery of health care, and concludes by discussing the ethics of big data, emerging technologies and the fundamental role of mutual trust between the public and health institutions.
- **Current and future uncertainties in health.** The Report highlights the potential of 'futures thinking' methods such as scenario planning and visualising a cone of uncertainty - to inform and to some extent future-proof health policy.

Combining national and local priorities

2.4 If we consider scenarios for health in 2040 for Cambridgeshire, the issues and priorities raised are essentially the same as those outlined nationally. But the levers for change held by local government and other local organisations are different. Key messages from a local public health perspective are:

- The role of local government in shaping local land use, housing and transport infrastructure – and the need to influence this to create healthy environments in the long term which promote active travel for all ages, allow access to green space, and help to prevent growing health problems caused by sedentary lifestyles and unhealthy weight.
- The strong links between educational attainment, employment and health – and the increase in the number of working households in poverty, often with children. This is an issue which needs to be addressed nationally, but local influences on economic development, housing availability, and support services for more vulnerable families and children, including children's school readiness, can play a part.
- The role of the local authority in commissioning targeted public health programmes for individuals already at risk through smoking, obesity or alcohol/drug use – this is unlikely to solve issues at a population level but is effective at reducing individual risk.
- Building of local multi-agency coalitions and strategies, which involve key organisations and communities, and create a social environment which supports health.
- Readiness to adopt new technologies, including ways of using and combining health data - which may have been researched at a national level, but take time to introduce into existing organisational infrastructures, governance and culture.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The importance of links between health and the economy is referred to in para 2.3.

3.2 Helping people live healthy and independent lives

This is referred to throughout the paper.

3.3 Supporting and protecting vulnerable people

The importance of vulnerabilities associated with poor health, leading to premature death or disability is referred to in para 2.1

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

No significant implications

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

No significant implications

4.3 Statutory, Legal and Risk Implications

Under the Health and Social Care Act (2012) the Director of Public Health has a statutory duty to produce an annual report on the health of the population and the County Council has a duty to publish it.

4.4 Equality and Diversity Implications

No significant implications

4.5 Engagement and Communications Implications

No significant implications

4.6 Localism and Local Member Involvement

No significant implications

4.7 Public Health Implications

These are described throughout the Report

Source Documents	Location
Annual Public Health Report (2017)	http://cambridgeshireinsight.org.uk/health/aphr
Chief Medical Officer Annual Report (2018) Health 2040- Better Health Within Reach	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767549/Annual_report_of_the_Chief_Medical_Officer_2018_-_health_2040_-_better_health_within_reach.pdf

Cambridgeshire County Council

CAMBRIDGESHIRE'S

ANNUAL PUBLIC HEALTH REPORT

2018

TABLE OF CONTENTS

INTRODUCTION

When Annual Public Health Reports were first produced in the nineteenth century by local authority Medical Officers of Health, they were the main source of available information about health statistics in the local area.

This is no longer the case - as there are now excellent web based resources reporting on routine health statistics and outcomes both locally and nationally, which are available for any member of the public with an interest. Section 1 of this report provides information about and weblinks to these resources.

This Annual Public Health Report focusses on two topics where new information is available. For the first time, the national Health Profile for England (2018) includes a chapter about Health in the Early Years - and Section 2 of this report reviews similar information for Cambridgeshire about the health and development of children aged under five.

The Global Burden of Disease (GBD) Study is used by national policy makers across the world. For the first time, this year's GBD includes a breakdown of data on premature death and disability and their causes, at upper tier local authority level. Section 3 of this report briefly reviews the GBD study findings for Cambridgeshire.

Section 4 looks at the recommendations from last year's annual report and how these have been progressed, and makes further recommendations for the coming year.

Throughout the report I make use of infographics produced by Public Health England's 'Health Matters' resource, available on https://www.gov.uk/government/collections/health-matters-public-health-issues. This provides a range of easily understandable and accessible information on a range of important health issues, and is well worth a look.

In a time of limited resources, we need to ensure that as many organisations, communities and individuals as possible have good information about how we can improve health in our local communities – and I hope this report will help signpost those interested to some of the wealth of information available.

SECTION 1: FINDING INFORMATION ON PUBLIC HEALTH OUTCOMES

LOCAL INFORMATION

Cambridgeshire Insight is the main source of local information on a range of local outcomes, including public health.

Cambridgeshire Insight: Interactive map of Cambridgeshire https://cambridgeshireinsight.org.uk/ lets you click on your electoral ward or enter a postcode and see a short report on your area's population, economy, housing, education and health outcomes.

Cambridgeshire Insight: Joint Strategic Needs Assessment https://cambridgeshireinsight.org.uk/jsna/published-joint-strategic-needs-assessments/ provides an annually updated core dataset from the statutory joint strategic needs assessment (JSNA) across health and social care outcomes. The JSNA is led by the Cambridgeshire and Peterborough Health and Wellbeing Boards.

Cambridgeshire Insight: Health and Wellbeing https://cambridgeshireinsight.org.uk/health/ provides links to a range of detailed local and national information on public health outcomes, weekly updates on the latest national research, and other reports.

Cambridgeshire Insight: Children's health and wellbeing https://cambridgeshireinsight.org.uk/health/popgroups/cyp/ provides further information on children's health and outcomes in the county

Be Well in Cambridgeshire https://www.cambridgeshire.gov.uk/be-well/ provides information on how to look after your own health and wellbeing, including local services and opportunities which support you in maintaining a healthy lifestyle, and day to day social media communications.

NATIONAL INFORMATION

The Public Health Outcomes Framework https://fingertips.phe.org.uk/profile/public-health-outcomes-framework is the main portal for Public Health England's Knowledge and Intelligence service. It provides interactive profiles on a wide range of public health outcomes and is updated every three months. Through the easy to use interactive functions it is possible to:

- Compare public health outcomes in Cambridgeshire to national and regional averages, and to groups of similar local authorities
- Look at trends in public health outcomes in Cambridgeshire over time
- Create charts, profiles and maps of public health outcomes in the County.

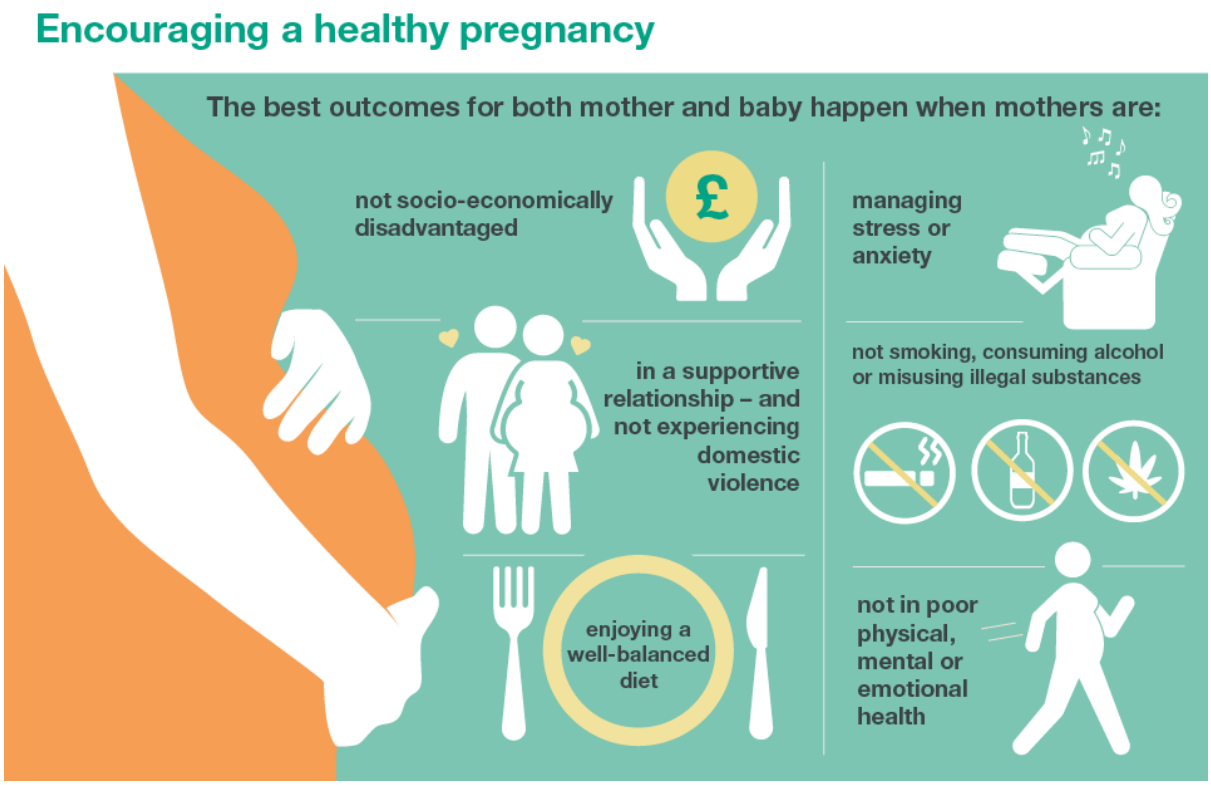
It is also possible to do this for individual District/City Council areas in Cambridgeshire, although for a more limited set of outcome indicators.

Local Health at www.localhealth.org.uk/ is the Public Health England portal which provides information at electoral ward level. It can be used to produce electoral ward health profiles and charts, or group wards together to make a health profile of a larger area.

SECTION 2: THE BEST START IN LIFE

HEALTH IN PREGNANCY

There are some factors which influence a child's health and wellbeing, even before they are born.



TEENAGE PREGNANCY

Teenage pregnancy (usually defined as conception under the age of 18) carries a number of risks for both mother and child. The baby is more likely to have a low birth weight and has a higher risk of infant death. Because of parenting responsibilities, young mothers are less likely to finish their education and this may put them at further economic disadvantage. Rates of teenage pregnancy have more than halved nationally over the last 20 years, as a result of a long-term evidence based teenage pregnancy strategy. In Cambridgeshire the teenage pregnancy rate in 2016 was the lowest in the East of England. Rates in Cambridge City, South Cambridgeshire and East Cambridgeshire were better than the national average and in Fenland and Huntingdonshire were similar to average.

2.04 - Under 18 conceptions 2016 — Crude rate - per 1000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	17,014	18.8	18.5	19.1
East of England region	↓	1,738	17.1	16.3	17.9
Peterborough	↓	99	29.8	24.2	36.3
Southend-on-Sea	↓	81	27.1	21.5	33.7
Luton	↓	86	21.7	17.4	26.8
Norfolk	↓	285	20.9	18.6	23.5
Thurrock	↓	54	18.4	13.8	24.0
Essex	↓	406	16.7	15.1	18.4
Suffolk	↓	194	16.0	13.8	18.4
Central Bedfordshire	↓	69	15.0	11.7	19.0
Bedford	↓	43	14.7	10.6	19.7
Hertfordshire	↓	295	14.4	12.8	16.1
Cambridgeshire	↓	126	12.2	10.2	14.5

Source: Office for National Statistics (ONS)

SMOKING IN PREGNANCY

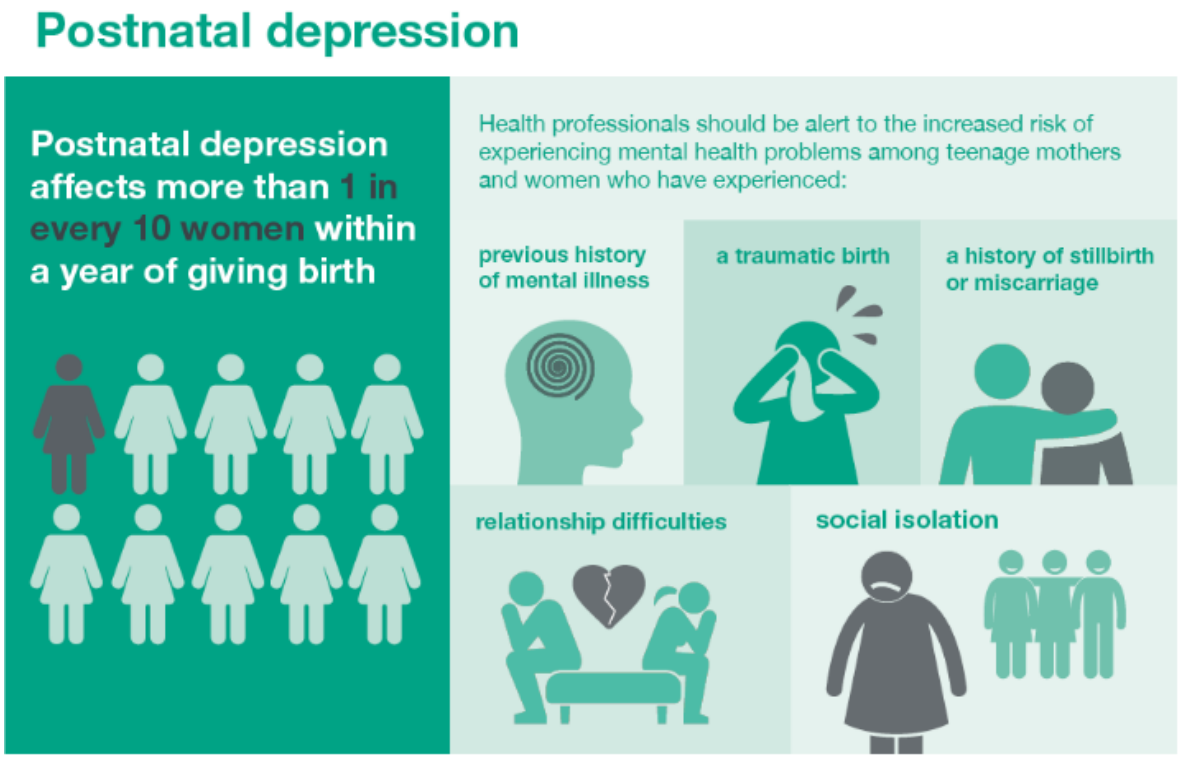
The proportion of mothers who are smokers at the time their baby is delivered is measured by hospital maternity units. The latest available national figures from 2016/17 showed that 10.7% of women were smokers at the time of delivery. The latest figures from local hospitals for April-Sept 2018 show major inequalities in the proportion of mothers smoking at the time of delivery in different parts of Cambridgeshire.

Maternity Unit	**Main area served (Cambs & Peterborough patients only)**	**Percentage of women smoking at time of delivery April-Sept 2018**
Rosie Maternity Unit Cambridge	Cambridge City, South Cambridgeshire, East Cambridgeshire	**6.2%**
Hinchingbrooke Hospital Maternity Unit	Huntingdonshire, South Fenland	**10.6%**
Peterborough City Hospital Maternity Unit	Peterborough, central and western parts of Fenland	**12.7%**
Queen Elizabeth Hospital, Kings Lynn	North Fenland (Wisbech area)	**22.8%**

HEALTH IN THE EARLY YEARS

MATERNAL MENTAL HEALTH

Mental health issues can impact on a mother's ability to bond with her baby and be sensitive and attuned to the baby's emotions and needs. This can affect the baby's ability to develop a secure attachment. But many women are thought to be 'falling through the cracks' and not getting the help they need for mental health problems during and after pregnancy. The Centre for Mental Health and the Royal College of GPs highlighted that the biggest barrier to providing better support to women experiencing poor mental health in the perinatal period is the low level of identification of need.



HEALTHY NUTRITION IN THE EARLY YEARS

BREASTFEEDING

Breastfeeding provides the best possible nutritional start in life for a baby, protecting the baby from infection and offering important health benefits for the mother. The government's advice is that infants should be exclusively breastfed, receiving only breastmilk for the first 6 months of life, following which other drinks and foodstuffs can be introduced. But many mothers find it challenging to sustain breastfeeding. National data from 2016/17 show that at 6 to 8 weeks of age the percentage of infants who were either exclusively or partially (when formula milk has also been introduced) breastfed was only 44.4%.

In Cambridgeshire, rates of breastfeeding at 6-8 weeks are better than the national and regional average with 56.1% infants breastfed.

2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method 2016/17 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	271,813	44.4*	44.3	44.6
East of England region	–	33,997	49.2	48.8	49.6
Luton	–	1,980	57.1	55.5	58.7
Cambridgeshire	–	3,978	56.1	55.0	57.3
Bedford	–	1,174	54.7	52.6	56.8
Central Bedfordshire	–	1,612	47.7	46.1	49.4
Thurrock	–	1,196	47.7	45.8	49.7
Peterborough	–	1,452	47.1	45.3	48.9
Suffolk	–	3,442	46.0	44.9	47.1
Norfolk	–	4,102	45.7	44.6	46.7
Essex	–	6,857	45.7	44.9	46.5
Southend-on-Sea	–	985	*	-	-
Hertfordshire	–	7,219	*	-	-

Source: Public Health England National Child and Maternal Health Intelligence Network

CHILDHOOD OBESITY

Increases in both childhood and adult obesity over the past 30 years are a major public health concern. Obesity is estimated to cost wider society £27 billion per year, and we spend more per year on treating obesity and diabetes than on the police, fire service and judicial system combined.

Although the causes of childhood obesity are complex, not all young children have a diet or undertake physical activity at levels which reflect national recommendations. Linked data shows that children who were overweight or obese in Reception year (aged 4 and 5 years) were also more likely to be overweight or obese in Year 6 (age 10 to 11 years) and then again more likely to go on to be overweight or obese adults.

In Cambridgeshire, the percentage of 4-5 year olds with excess weight has decreased over the past four years, and in 2016/17 was the lowest in the East of England at 18.5%. All Cambridgeshire districts, including Fenland, had lower percentages of 4-5 year olds with excess weight than the national average.

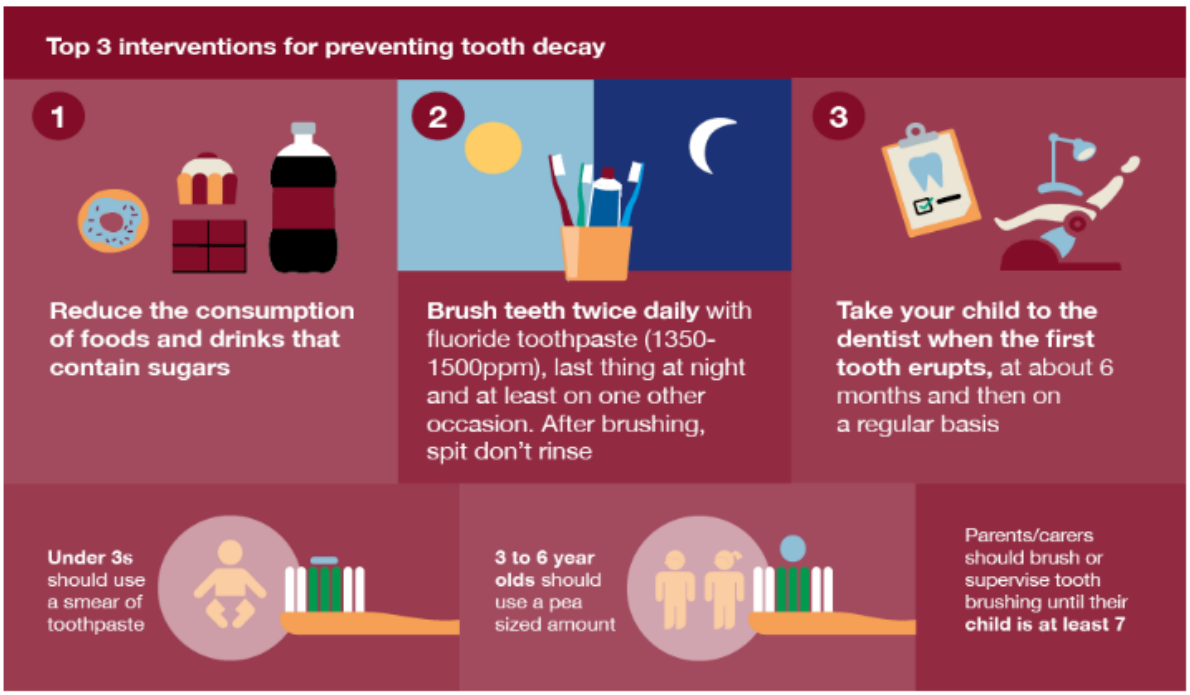
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds New data 2016/17 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	142,419	22.6	22.5	22.7
East of England region	↓	14,999	21.1	20.8	21.4
Peterborough	↓	603	23.2	21.6	24.9
Norfolk	→	2,108	22.7	21.9	23.6
Luton	↓	738	22.6	21.2	24.1
Suffolk	→	1,773	22.3	21.4	23.2
Thurrock	↓	553	22.1	20.5	23.7
Southend-on-Sea	→	445	21.4	19.7	23.2
Essex	→	3,456	20.9	20.3	21.6
Bedford	↓	449	20.4	18.8	22.2
Central Bedfordshire	→	701	20.4	19.1	21.8
Hertfordshire	↓	2,901	20.0	19.4	20.7
Cambridgeshire	↓	1,272	18.5	17.6	19.5

Source: NHS Digital, National Child Measurement Programme

ORAL HEALTH

The amount of sugar which young children eat and drink, together with whether they brush their teeth and visit their dentist regularly, determines their oral health.



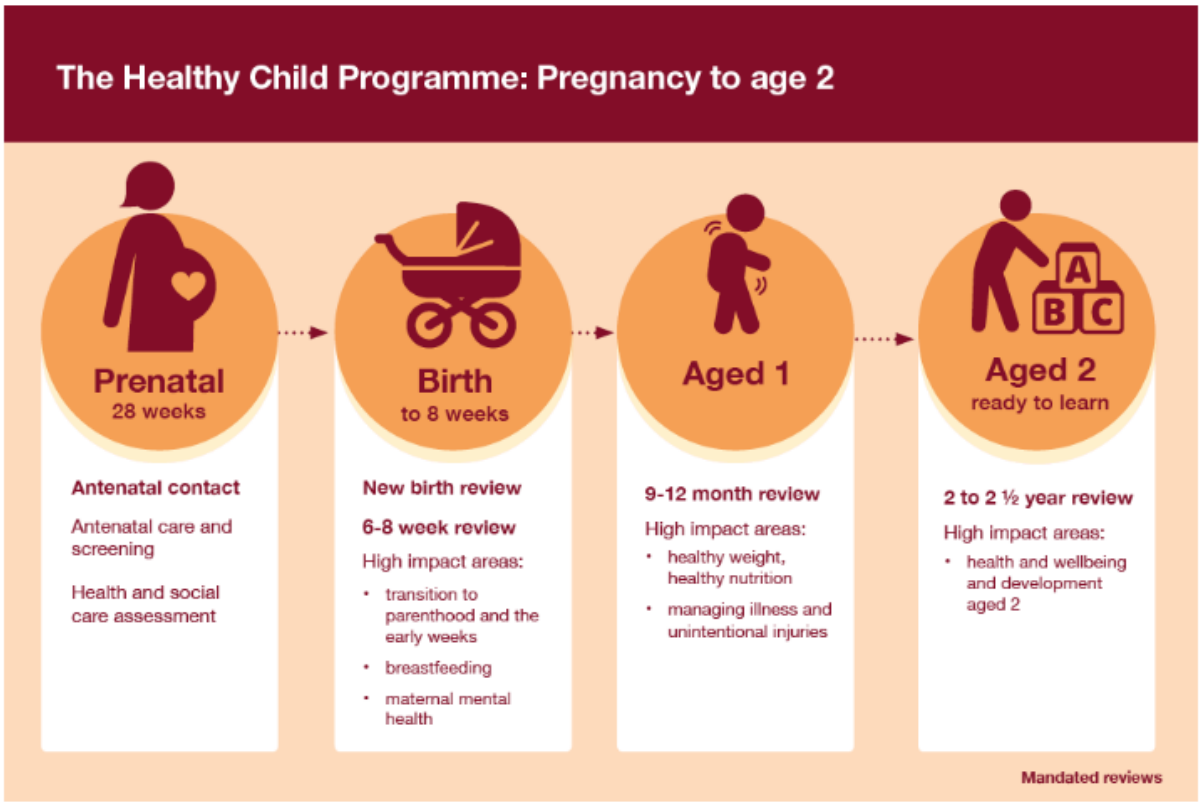
National survey data from 2016/18 shows that in Cambridgeshire, 87.1% of five year olds were free from dental decay. This was better than the national average and highest in the East of England.

THE HEALTHY CHILD PROGRAMME

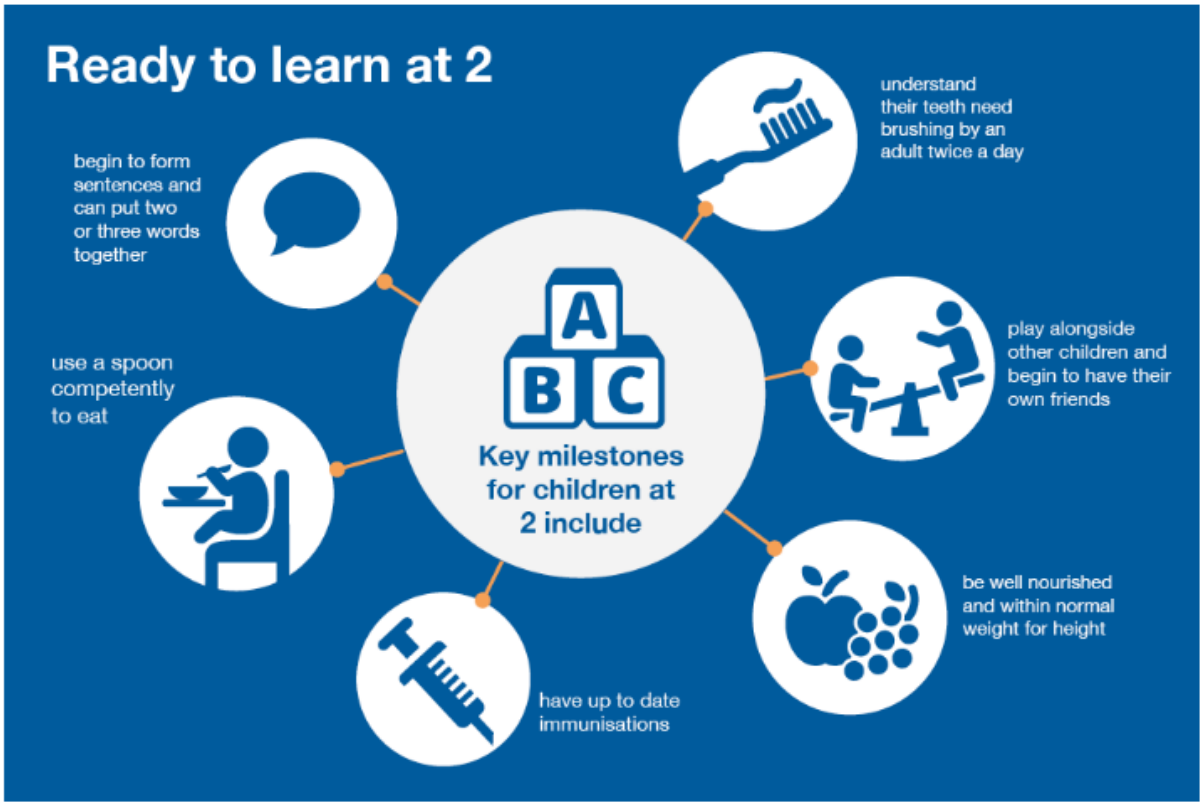
The Healthy Child Programme is the heart of public health services for children and families. It brings together the evidence on delivering good health, wellbeing and resilience for every child. It is delivered as a universal service for all new babies and young children, with additional services for families needing extra support, whether short-term intervention or ongoing help for complex longer-term problems.

The programme can ensure families receive early help and support upstream before problems develop further and reduce demand on downstream, higher cost specialist services. This programme is led by health visitors in collaboration with other health professionals and wider children's services such as child and family centres.

The five universal health and development reviews, most of which are directly delivered by health visitors (although some may be delivered by nursery nurses with health visitor supervision), are a key feature of the Healthy Child Programme and are nationally mandated:



READY TO LEARN AND READY FOR SCHOOL



The ASQ-3 ™ assessment is part of the healthy child programme review carried out at age 2-2½ years. It covers the development of children's physical (motor) skills, communication, problem solving and personal-social skills. The results vary by deprivation, with children from more disadvantaged backgrounds often showing lower scores – which is most noticeable in the development of communication skills. Poor communication skills in turn, are linked with more difficulty starting school and poor educational outcomes. All disadvantaged 2 year olds are entitled to 15 hours early years provision - and research shows high quality early education can reduce inequalities in educational outcomes for children living in disadvantage.

When children are aged 4-5 their 'school readiness' is measured in a school setting at the end of Reception year, using the Early Years Foundation Stage Profile (EYFSP). This generates an outcome score based on a rounded assessment of development. School readiness affects future health in that better development at this early age improves a child's ability to make the most of his or her learning opportunities, achieving higher grades and better employment prospects. These are then associated with economic prosperity and better health outcomes in the longer term

The proportion of Cambridgeshire children who achieve a good level of school readiness at the end of reception is similar to the national average, but Cambridgeshire children eligible for free school meals have significantly worse results.

Because poor 'school readiness' can lead to lower educational attainment and poorer employment prospects in the longer term, early development and school readiness is likely to be a significant driver of long term health inequalities in the county.

1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception 2016/17

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	473,626	70.7	70.6	70.8
East of England region	↑	53,470	71.4	71.0	71.7
Thurrock	↑	1,904	75.8	74.1	77.4
Southend-on-Sea	↑	1,627	74.1	72.2	75.9
Essex	↑	12,650	73.5	72.8	74.1
Hertfordshire	↑	10,749	72.2	71.4	72.9
Central Bedfordshire	↑	2,611	71.7	70.2	73.2
Suffolk	↑	5,901	71.1	70.1	72.1
Cambridgeshire	↑	5,394	70.7	69.6	71.7
Norfolk	↑	6,806	70.1	69.1	71.0
Luton	↑	2,284	68.2	66.6	69.8
Bedford	↑	1,543	66.7	64.8	68.6
Peterborough	↑	1,999	63.2	61.5	64.8

Source: Department for Education (DfE), EYFS Profile: EYFS Profile statistical series

1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception 2016/17

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	51,316	56.0	55.7	56.3
East of England region	↑	4,640	55.4	54.3	56.4
Luton	↑	290	62.4	57.9	66.7
Thurrock	↑	193	60.9	55.4	66.1
Southend-on-Sea	↑	201	60.7	55.4	65.8
Essex	↑	1,182	57.8	55.6	59.9
Peterborough	↑	244	57.3	52.5	61.9
Suffolk	↑	530	56.4	53.3	59.6
Norfolk	↑	672	53.7	50.9	56.5
Bedford	↑	130	53.3	47.0	59.4
Hertfordshire	↑	665	52.8	50.0	55.5
Central Bedfordshire	↑	108	51.9	45.2	58.6
Cambridgeshire	↑	429	47.9	44.7	51.2

Source: Department for Education, Early Years Foundation Stage Profile (EYFS Profile): Early Years Foundation Stage Profile statistical series

ADVERSE CHILDHOOD EXPERIENCES

A growing body of research is revealing the long-term impacts that experiences and events during childhood have on individuals' life chances. Adverse Childhood Experiences (ACEs) such as abuse, neglect and dysfunctional home environments have been shown to be associated with the development of a wide range of harmful behaviours including smoking, harmful alcohol use, drug use, risky sexual behaviour, violence and crime. They are also linked to diseases such as diabetes, mental illness, cancer and cardiovascular disease, and ultimately to premature mortality. Research among UK adults indicates that almost half report at least one ACE and over 8% of the population report four or more. The impact of ACEs and the best way to protect against or mitigate their longer term impact is currently the subject of research both within the UK and internationally and there is currently no standardised information on ACEs, collected across all local authority areas.

SUMMARY OF KEY FINDINGS – EARLY YEARS

This Annual Public Health Report chapter has reviewed health in the early years for Cambridgeshire children. While teenage pregnancy, maintenance of breastfeeding, child oral health, and childhood obesity are challenges for health in the early years both locally and nationally, Cambridgeshire children are generally doing well compared to other areas and we are seeing positive trends.

The main areas of concern requiring further close attention are the inequalities in health and development in the early years shown in local data, which are likely to have a long term impact on outcomes. These include higher rates of smoking in pregnancy in the North Fenland area, and the low rates of school readiness for children eligible for free school meals around the county.

SECTION 3: THE GLOBAL BURDEN OF DISEASE STUDY

National policy makers have used the global burden of disease (GBD) studies for many years to understand the health of the UK population. The GBD is mainly funded by the Bill and Melinda Gates Foundation and involves many academic institutions. The annual GBD report summarises the rates of early death and disability from different diseases in the UK (and internationally), and also quantifies the impact of different causes (risk factors) – such as smoking, poor diet, and air quality on the 'burden of disease' in the UK.

This year for the first time, Public Health England has co-funded a GBD study at upper tier local authority level, which means we can review our 'burden of disease' in Cambridgeshire for the year 2016, in a similar way to national policy makers.

KEY CONCEPTS

Some key concepts are needed to understand the global burden of disease study:

Years of life lost (YLL) is an estimate of the average **years** a person would have lived if he or she had not died prematurely. In the GBD study, the 'standard' to which life expectancy is compared is the best life expectancy observed internationally in a population of over 5 million people.

Years lived with a disability (YLD) **Years** lived with a **disability** (**YLD**) are the number of **years** with a lower quality of **life** due to the disease. These YLDs are weighted to reflect the extent of the reduction in quality of **life** across different diseases

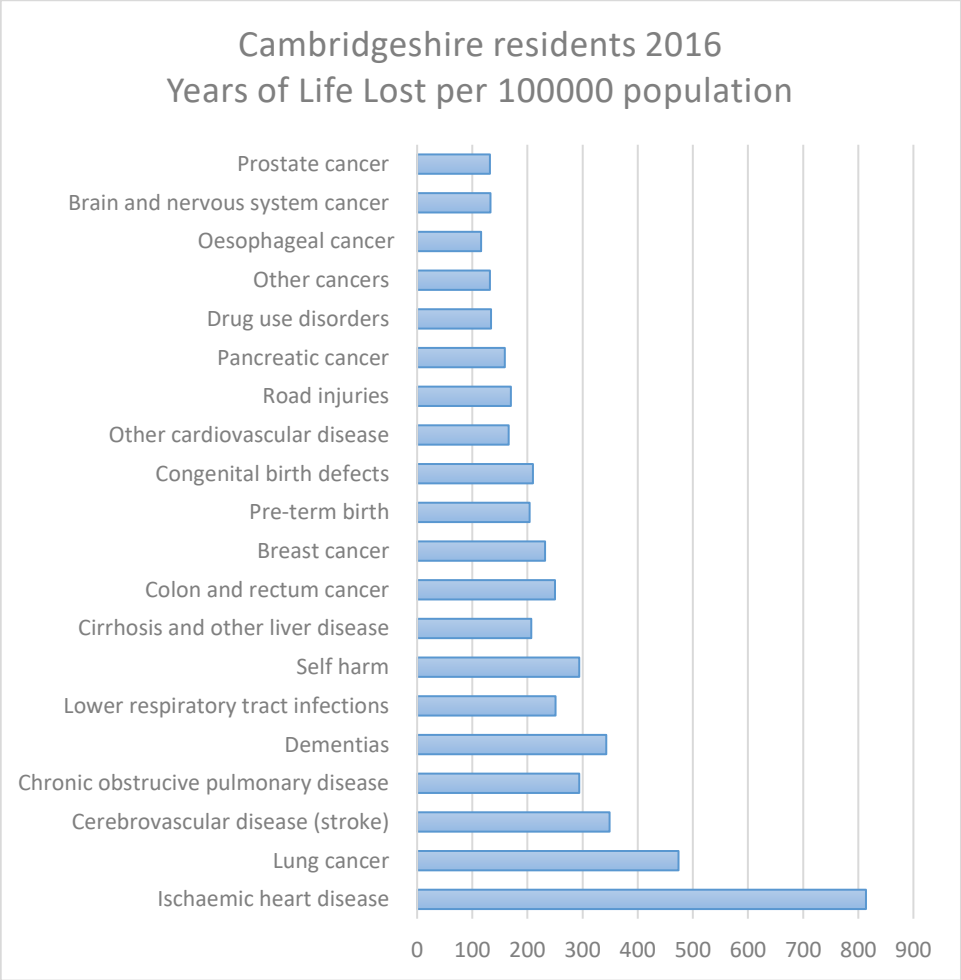
Population attributable fraction (PAF) for a risk factor (e.g. tobacco) is the proportional reduction in a population's diseases or deaths that would occur, if exposure to the risk factor were reduced to an alternative 'ideal' scenario (e.g. no tobacco use).

YEARS OF LIFE LOST

The chart below shows that in Cambridgeshire:

- Heart disease is the commonest cause of years of life lost (YLL) due to premature death, with over 800 years per 100,000 population in 2016.
- Lung cancer is the next commonest cause with nearly 500 years per 100,000 population.
- Stroke, chronic lung disease and dementia are the next three commonest causes
- Self-harm is the seventh most common cause of years of life lost, at almost 300 days per 100,000 population.

The total years of life lost to premature death in Cambridgeshire in 2016 (not shown on the chart) was 7,513 per 100,000 population compared to the national average of 8,941 per 100,000 population. Nationally the rates of YLL are closely related to the level of socio-economic deprivation. Overall the **pattern** of YLL for Cambridgeshire is very similar to the national picture, which also has heart disease as the most common cause of YLL, followed by lung cancer.



RISK FACTORS FOR YEARS OF LIFE LOST

The table below shows the Population Attributable Fraction (PAF) for risk factors for years of life lost due to premature death in Cambridgeshire in 2016. In essence it shows that

- About 15% (one in six) of years of life lost for Cambridgeshire residents in 2016 can be attributed to smoking
- Over 10% (one in ten) years of life lost can be attributed to dietary risks, over 10% to high blood pressure and over 10% to drug and alcohol use.
- High body mass index (obesity) follows close behind with around 9% of years of life lost attributable.
- Occupational (job related) risks account for around 4% of years of life lost and air pollution for over 3%

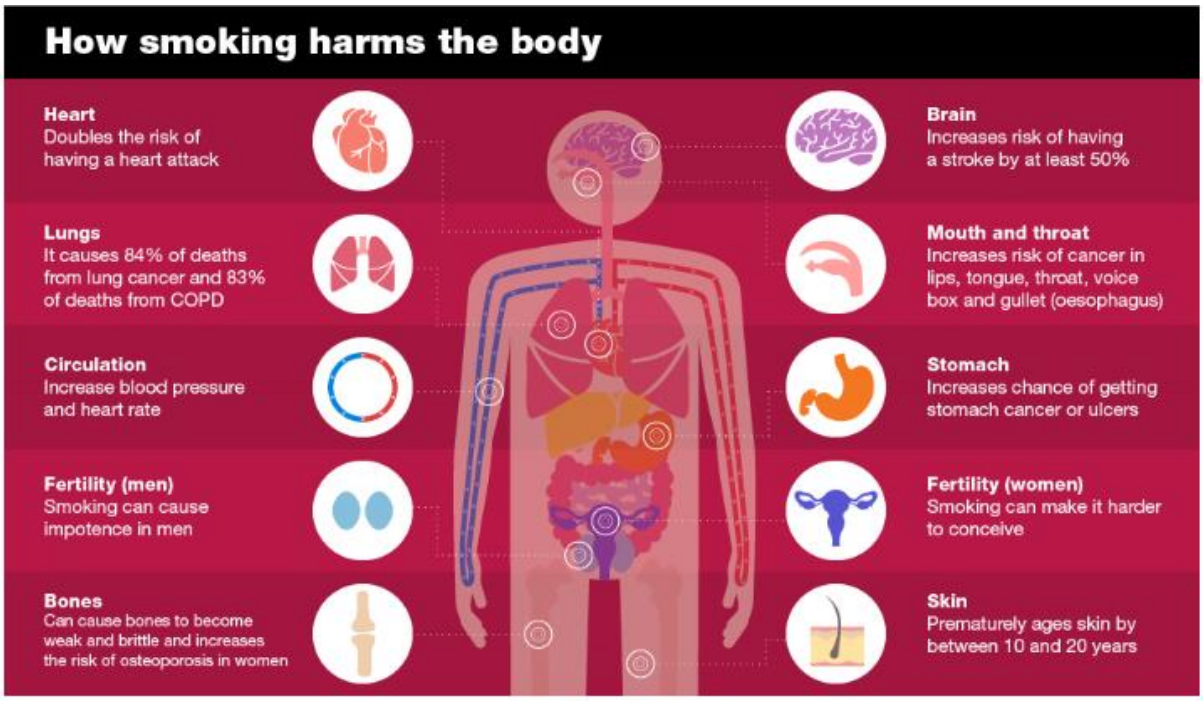
Risk factor	**PAF**
Tobacco	14.9%
Dietary risks*	12.3%
High systolic blood pressure	11.1%
Alcohol and drug use	10.6%
High body mass index	9.2%
High total cholesterol	6.3%
Occupational risks	4.2%
High fasting plasma glucose	4.5%
Air pollution	3.3%
Child and maternal malnutrition	3%
Low physical activity	1.8%
Impaired kidney function	1.5%
Unsafe sex	0.5%
Low bone mineral density	0.5%
Other environmental risks	0.2%
Sexual abuse and violence	0.1%
Unsafe water sanitation and handwashing	0.1%

* Dietary risks cover a wide range of different aspects of food and nutrition – such as diets low in fruits, vegetables, legumes, whole grains, nuts and seeds, fibre and some specific nutrients, and diets high in processed red meat, red meat, sugar sweetened drinks and salt.

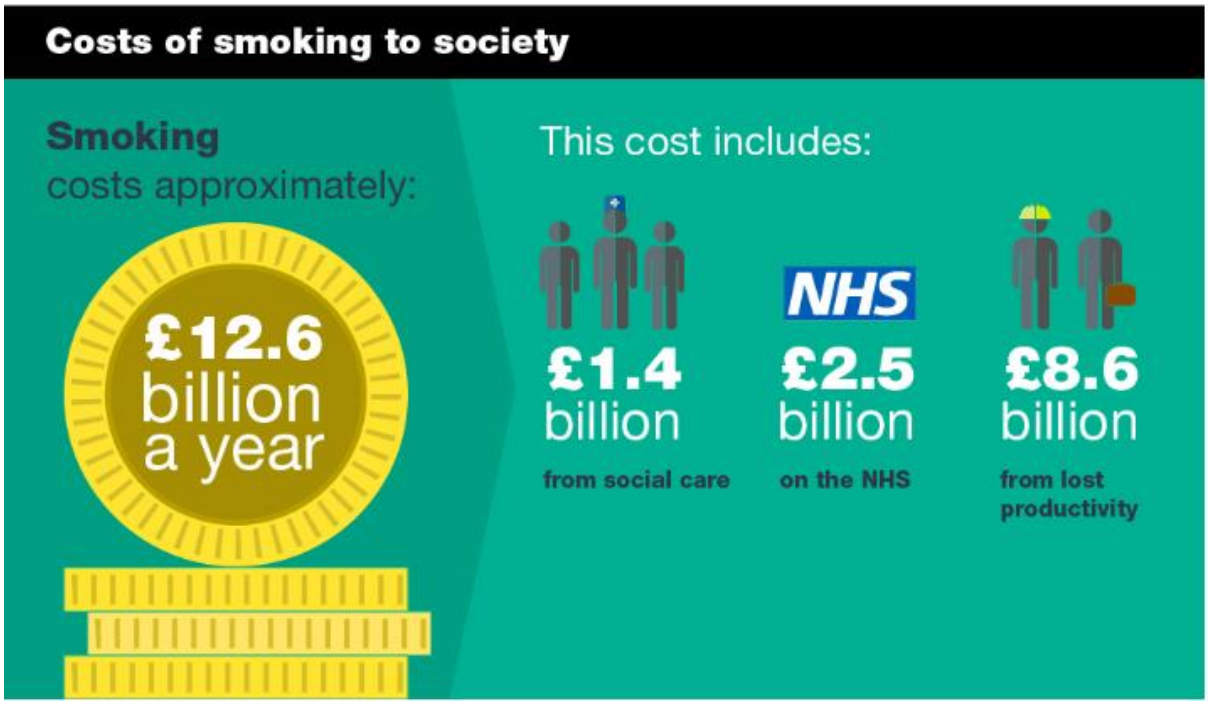
The authors of the national Global Burden of Disease Study are clear on the importance of preventable risk factors for population health. To quote from the recently published GBD findings for the UK: 'Two-thirds of the improvements to date in premature mortality can be attributed to population-wide decreases in smoking, cholesterol, and blood pressure, and about a third are due to improved therapies. Health services need to recognise that prevention is a core activity rather than an optional extra to be undertaken if resources allow.'

SMOKING AS A RISK FACTOR FOR PREMATURE DEATH

There are many reasons why smoking tobacco is the highest ranking risk factor for premature death.



Smoking also results in significant costs to wider society in the UK



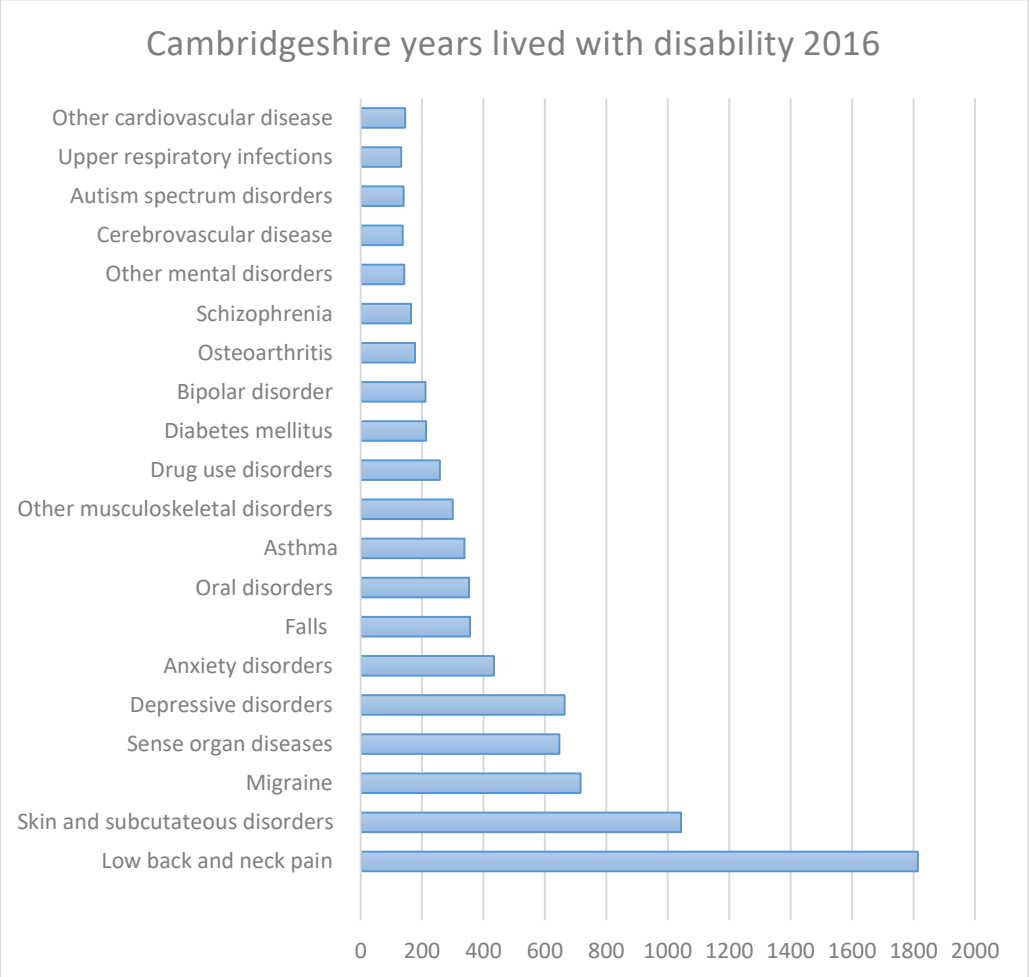
In Cambridgeshire, the proportion of adults who smoke is 14.5% or about one in six. While this is similar to the national average, Cambridgeshire has worse smoking rates than other counties with similar social and demographic profiles, ranking 13th out of 16 'CIPFA comparator' counties. There has been a lot of focus recently on providing support and encouragement for Fenland residents who want to stop smoking, and smoking rates in Fenland have improved. But rates in the rest of the county have not changed significantly for the past few years.

YEARS OF LIFE LIVED WITH DISABILITY

The chart below shows that in Cambridgeshire, as nationally – the diseases causing years of life lived with a disability are often different to the diseases causing premature death, although there is some overlap.

- Low back and neck pain is the most significant cause of years of life lived with a disability (YLD) at over 1800 days per 100,000 population
- Skin and subcutaneous diseases are the next most significant cause at just over 1000 YLD per 100,000 population
- The next two most significant causes are migraine and sense organ diseases (e.g. deafness, blindness)
- Depression and anxiety are also important causes of years lived with a disability, ranking fifth and sixth
- Falls are the seventh most significant cause of years lived with disability.

Total years of life lived with a disability in Cambridgeshire (2016) were estimated as 10,959 per 100,000 population compared with a national average of 11,054 per 100,000 population. For many diseases local data are not available, so national data have to be used – making the estimates less reliable than those for years of life lost.



The importance of musculo-skeletal problems such as low back and neck pain, and of mental health problems such as depression and anxiety are reflected by local and national statistics on out of work

benefits. These show that the most common health problems which cause people to be unable to work are in the 'musculoskeletal' and 'mental health' categories.

Many of the health problems leading to years lived with disability have preventable risk factors, although research on this is less well developed than for premature deaths. To quote again from the Global Burden of Disease study: 'In many cases, the causes of ill health and the behaviours that cause it lie outside the control of health services. For example, obesity, sedentary behaviour, and excess alcohol use all feature strongly in GBD as risk factors for diseases such as musculoskeletal disease, liver disease, and poor mental health. The GBD results, therefore, also argue for policies and programmes that deter the food industry from a business model based on cheap calories, that promote and sustain healthy built and natural environments, and that encourage a healthy drinking culture.'
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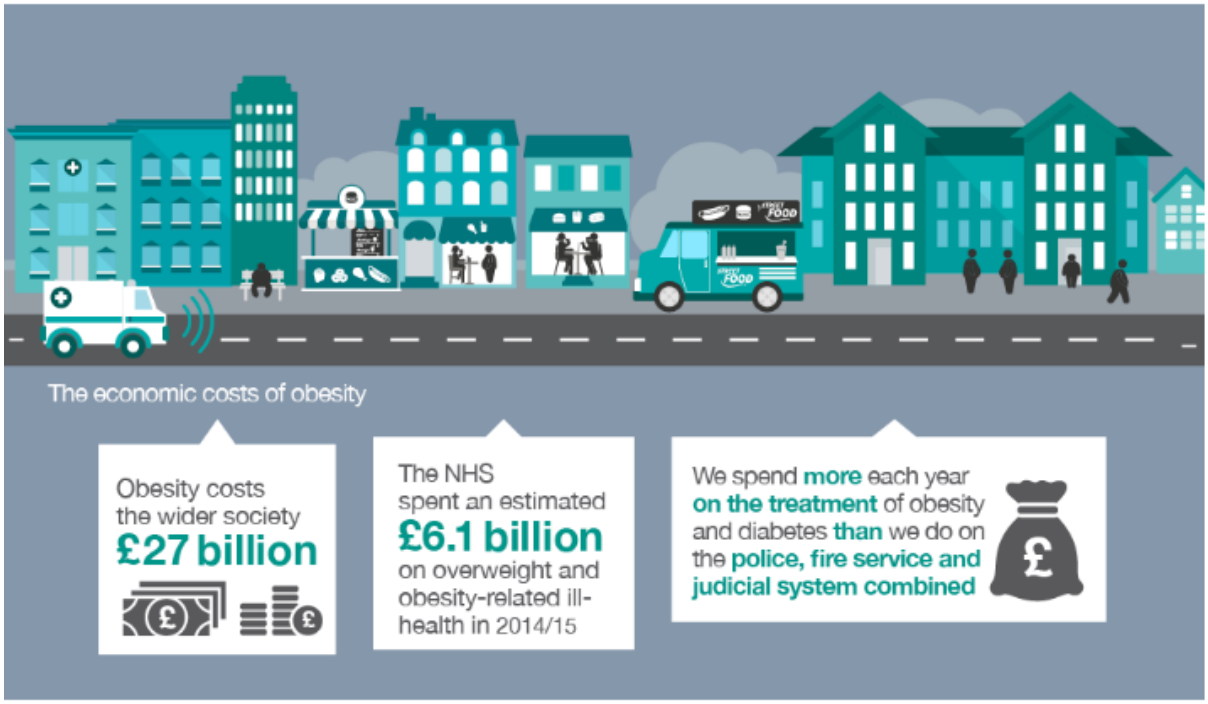


SECTION 4: PROGRESS AGAINST RECOMMENDATIONS FROM THE APHR 2017:

1. **Where possible and statistically valid, we should be mapping more health and wellbeing indicators at the local neighbourhood level to help 'fine tune' the provision, targeting and monitoring of campaigns and services.**

   The Sustainable Transformation Partnership (STP) is piloting the planning of health and care service on a 'neighbourhood' basis. This will ensure that local NHS services work closely with local authority social care and community services, and with wider voluntary sector services and community groups at a neighbourhood level. Local authority analysts are participating in a wider 'Health Analytics Community' which will map relevant health, wellbeing and service use indicators at neighbourhood level, as this work progresses.

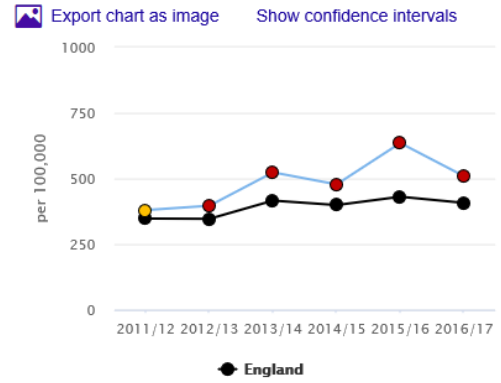
2. **The disparity in educational outcomes between children receiving free school meals and their peers of the same age is a county-wide issue, and is consistent from the measurement of school readiness in reception year right through to GCSE attainment at age 16. Addressing this should be a key public health priority due to the impact of educational attainment on future health and wellbeing.**

   Progress has been made on this issue through Cambridgeshire and Peterborough being one of only two areas selected to participate in a new Local Government Association Peer Review of Early Years Social Mobility. This took place in July 2018. Early years social mobility focuses on differences in early childhood development linked to more general socio-economic disadvantage, which are associated with inequalities in communication skills and readiness to start and succeed at school. The findings and recommendations of the LGA Peer Review are now being taken forward - including developing a multi-agency Early Years Strategy for Cambridgeshire and Peterborough.

3. **Joint work is already taking place across the NHS and local authorities to improve early intervention and support for young people with mental health problems, so we would hope to see these trends improving, and the impact of this work needs careful monitoring.**

   The progress made by multi-agency programmes to improve children and young people's mental health and wellbeing is overseen by the Cambridgeshire and Peterborough Children's and Young People's Emotional Wellbeing Board. New national NHS investment into local child and adolescent mental health services is channelled through the 'Local Transformation Plan' which is closely monitored through NHS data returns. There is ongoing democratic scrutiny by the County Council Health Committee. Rates of hospital admission of young people for self-harm showed some improvement in the most recent data from 2016/17, although still worse than average.

Hospital admissions as a result of self-harm (10-24 years) New data Cambridgeshire Directly standardised rate - per 100,000



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011/12		459	379.7	345.7	416.1	262.7	347.4
2012/13		474	396.2	361.3	433.6	291.2	346.3
2013/14		622	523.4	483.0	566.2	378.3	415.8
2014/15		567	477.6	439.0	518.6	354.7	398.8
2015/16		763	635.2	590.9	682.0	411.2	430.5
2016/17		606	509.1	469.3	551.3	353.0	407.1

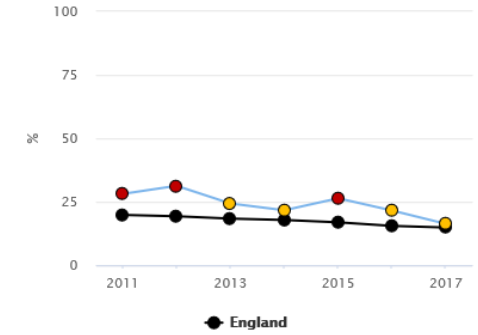
4. **The APHR 2017 demonstrated the health and wellbeing challenges for Fenland residents – in particular for the North Fenland and Wisbech area. The causes are complex, with no easy answers – but a consistent and sustainable focus on the area from a range of organisations will be needed to address the determinants of health such as educational attainment and economic development, as well as a focus from health and care providers on delivering accessible prevention, treatment and support services to meet current needs**.

   A range of work is taking place across agencies and communities to further improve outcomes in Fenland. For the Wisbech Area, the Wisbech 2020 steering group brings several partner agencies together, to make sure that this work doesn't happen 'in silos'. More information about Wisbech 2020 is available on http://www.wisbech2020vision.co.uk/.

   There has been positive progress on some important 'lifestyle' risk factors for poor health. The estimated number of adults in Fenland who smoke has reduced significantly between 2011 and 2017. The numbers of 4-5 year olds with unhealthy weight, and rates of teenage pregnancy have also improved. Challenges remain with higher than average numbers of adults having an unhealthy weight and low physical activity, and increasing rates of hospital admission for alcohol use. Life expectancy remains below the national average for both men and women.

2.14 - Smoking Prevalence in adults - current smokers (APS) New data Fenland Proportion - %

Export chart as image Show confidence intervals



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	East of England	England
2011		21,402	28.1	20.1	36.2	19.3	19.8
2012		24,044	31.3	24.5	38.1	18.3	19.3
2013		18,835	24.3	17.0	31.7	17.5	18.4
2014		16,943	21.7	14.4	28.9	17.7	17.8
2015		20,887	26.4	17.2	35.6	16.6	16.9
2016		17,219	21.6	15.0	28.1	14.4	15.5
2017		13,020	16.3	10.1	22.5	14.2	14.9

Source: Annual Population Survey (APS)

RECOMMENDATIONS FOR THE COMING YEAR

It takes time and ongoing focus to achieve public health outcomes, so the four recommendations from the APHR 2017 still stand and will be reviewed again next year. There are two new recommendations from this year's Report:

5. The recent Early Years Social Mobility Peer Review for Cambridgeshire and Peterborough provided a range of recommendations to support outcomes for children in their early years and reduce inequalities in school readiness, and these recommendations should be taken forward.

6. The Global Burden of Disease study emphasised the importance of smoking and tobacco as a cause of premature death in Cambridgeshire, but with the exception of Fenland, progress in reducing smoking rates across the county has slowed. A new multi-agency strategy and action plan to address smoking rates in Cambridgeshire should be developed.

Chapter 1

Chief Medical Officer's summary

Chapter lead and author
Sally Davies[1]

1 Chief Medical Officer, England

01 The future is here…

This year for my annual report, I have chosen to focus upon the health of the public in England in 2040. The NHS is often a source of national pride, but despite this, a narrative of health being a cost to society prevails. As the late Hans Rosling said, "When things are getting better we often don't hear about them. This gives us a systematically too-negative impression of the world around us, which is very stressful."

This report offers cause for optimism and I conclude that it is realistic to aspire to better and more equitable health in the next 20 years. As the NHS has developed its long-term plan for the coming ten years, this report looks at the strategic opportunities over the coming two decades for the health of the nation more broadly.

I believe we need to reposition health as one of the primary assets of our nation, contributing to both the economy and happiness. We also must measure and track progress in our development of health as a nation and our fairness as a society in delivering improving health outcomes. We need a composite Health Index developed that recognises this and is tracked alongside our nation's GDP.

We need to track progress in improving health and health outcomes, to and beyond 2040 with a new composite Health Index that reflects the multi-faceted determinants of the population's health and equity in support of ensuring health is recognised and treated as one of our nation's primary assets. This index should be considered by Government alongside GDP and the Measuring National Well-being programme.* We regularly collect most of the datasets that have the individual measures that could be combined.

Recommendation 1

I recommend that the Cabinet Office formally explores the development of a Health Index for England, where that index:

- could be a composite index that is inclusive of health outcome measures, modifiable risk factors and the social determinants of health;
- may be disaggregated by composition allowing tracking of performance of each component additional to the overall metric; and
- reflects the multi-faceted determinants of the population's health.

The investigation should involve the Office for National Statistics, which has experience in index development and should link to their work measuring the United Kingdom's progress on delivering the United Nations' agreed Sustainable Development Goals.

My report highlights that we know what we must do to improve health in 2040, and in many circumstances we are already doing it. Effective population prevention, such as the UK government's Soft Drinks Industry Levy, is already here. Big data and the computing power to make predictive analytics everyone's business is already here. Artificial intelligence that can diagnose disease earlier and improve prognosis is already here. We need to embed and build upon these innovations to accelerate and normalise implementation of what works across England.

Both prevention and the delivery of healthcare can contribute to a more equitable future. My report discusses the need for continued focus on the social determinants of health and as every cause of death, at every age, is more common in the most deprived, healthcare can directly deliver substantial gains too. For example, my report illustrates that achieving equitable cancer survival in England could avoid 10,000 deaths within 5-years of diagnosis (see 'Socio-economic inequalities in 5-year cancer survival: avoidable premature deaths among patients diagnosed in England in 2010" in Chapter 9 of this report).

To deliver the healthier future that is within our reach, we need a new paradigm for research. All health-related data, genomics to social determinants, and every patient contact need to be used to improve the experience, service and prevention for each individual. This dynamic learning and researching environment will require new approaches to evaluation and introduction of technologies that learn and iterate to deliver the best care to patients without delay.

This report has four sections that cover some of the biggest opportunities for health over the next two decades. The first section identifies health as one of England's primary assets through analysing the links between health and the economy, the local health environment, social health and how the maintenance and treatment of health could be experienced in 2040. The next section of this report identifies the potential health gains and reduction in health inequalities that could be possible with a 'prevention first' approach. The third section of this report explores emerging technologies and their potential impact on health promotion, protection and treatment. This section concludes by discussing the ethics of big data, emerging technologies and the fundamental role of mutual trust between the public and health institutions. Chapter 14 explores current and future uncertainties in health and identifying the potential of futures thinking methods to inform and 'future-proof' health policy.

* Office for National Statistics. *Measuring National Well-being: Quality of life in the UK, 2018*. Accessed at: https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/qualityoflifeintheuk2018

02 What is health and what could it be?

Ambition for 2040 That the health of the whole population is considered one of the nation's primary assets.

Health is generally used to mean the 'absence of ill-health'. Society has a focus on the NHS as an 'illness service' rather than acknowledging the complex interactions in society that influence our health as individuals. Healthcare is often spoken of as a cost to the state and society rather than an investment that generates returns for the individual, communities and the nation. The NHS and public health services are not a burden on our finances – they help to build our future. Moreover, the good health of our nation is the bedrock of our happiness and prosperity – as I have highlighted in my previous reports,† *prevention pays*. As the increases in life expectancy experienced over past decades have begun to plateau, I agree with the OECD‡ – there are a number of factors at play that are affecting many countries, which makes it difficult to ascribe slowing increases to any specific factor or policy.

Health is an asset that we must protect and promote and is affected by the conditions in which we live and work. These conditions can be health-promoting or health-harming, and often governments, industry, and societies are responsible for those conditions, not the individual. We all have some responsibility for our own health, but we are not individually responsible for the house or neighbourhood we are born into, the school we attended, nor the health environment we live in.

The health system must adapt for each individual and ensure both their environment and the care that they receive is helping them achieve 'good health'. One example of this is social prescribing, which acknowledges our expanded understanding of physical, mental and social health and is an opportunity for the traditional health service to utilise, enhance and amplify existing schemes (see Chapter 3 of this report, 'The Local Health Environment'). One size clearly does not fit all, and this requires different types of care accessed through different places and different ways.

03 An uncertain future

Ambition for 2040 That world-leading approaches to thinking about the future are developed and used to inform health and social policy impacting on 2040, creating the capability in the health system to adapt to emergent opportunities and threats to the health of the nation.

The future is uncertain; unless we consider the future and the uncertainties that could affect health, how can we plan effectively and know whether our current plans are 'future-proofed'?

'Futures thinking' is an important part of planning, helping us to imagine what different futures might bring. My report encourages consideration of activities and environments in the light of whether they are health-promoting or health-harming and how much uncertainty they contain as a form of prioritisation for research and policy. In Chapter 14, the authors introduce the 'cone of uncertainty', where they look through the 'lens of now' to health in 2040 to consider different futures for three exemplar areas of interest. The top of the cone represents the best-case or 'utopian' outcome that we might hope for. In contrast, the bottom of the cone represents the worst-case or 'dystopian' scenario. Such a process allows the identification of research and policy considerations to ensure we set the foundations to plan for and protect a healthier future for all.

Futures thinking is vital to planning effective and efficient health environments and services going forward. Strategic leaders in healthcare and public health organisations need to embed futures thinking (and specifically scenario planning) in the development process of long-term plans.

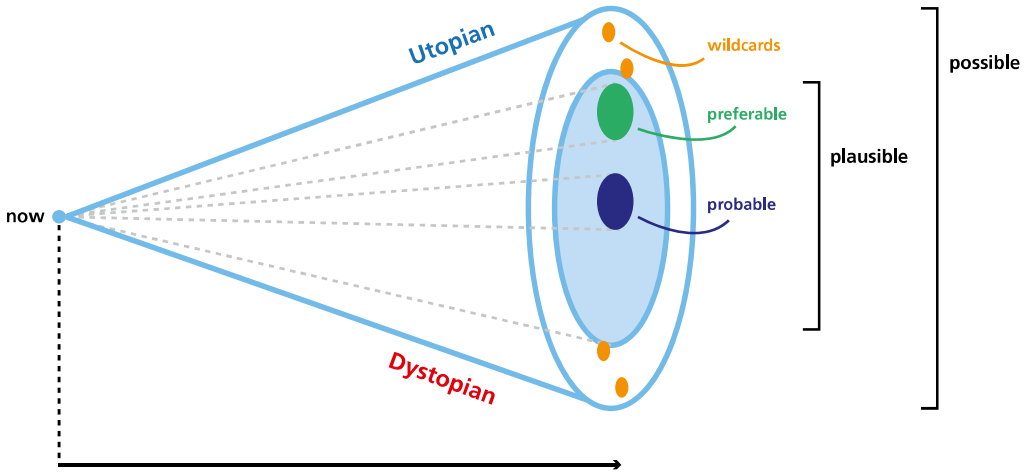
Recommendation 2

I recommend that the Department of Health and Social Care, and the health system, invest in capabilities for "futures thinking" in health, for example through Policy Research Units.

† All of my reports may be accessed online at https://www.gov.uk/government/collections/chief-medical-officer-annual-reports

‡ OECD/EU (2018), *Health at a Glance: Europe 2018: State of Health in the EU Cycle*, OECD Publishing, Paris. Available online: https://doi.org/10.1787/health_glance_eur-2018-en

Figure 14.2 The cone of uncertainty



Source The Policy Institute, King's College London

As we look to 2040, there are numerous scenarios for the health of England, some of which are explored in this report. The evidence throughout this report suggests we are currently at a fork in the road, with two vastly different pathways, both plausible for England in 2040. One scenario concerns me: if certain current trends were to continue and even worsen, we could live in a society where the most deprived are cut adrift from that society. The gap in life expectancy and healthy life expectancy could worsen substantially, aggravated by a digital divide – we must not let this unfair future be our reality.

Alternatively, our society could prioritise health as one of the nation's primary assets, making the health of our nation a source of national pride. This society would bring prevention to the public underpinned by a 'health-promoting environment' coupled with prevention that is personal to the individual. This is the future within our reach.

The final chapter (Chapter 14) in this report specifically looks at the uncertain future for three illustrative areas of varying uncertainty: anti-microbial resistance (AMR), obesity and the impact of technology on mental health.

In my 2011 Annual Report I identified AMR as a leading threat to our future infection prevention, diagnosis and appropriate effective treatment. This chapter states that we are now certain that without significant action, AMR will have a substantially damaging effect upon future health and the global economy.

The future is less clear for obesity. While a dystopian scenario where obesity is the greatest cause of preventable deaths and disability is possible, this is not inevitable; embracing and scaling up the population approaches to obesity and creating a health-promoting environment would allow England to lead the world in successfully changing behaviours and tackling obesity.

In contrast, the future impact of technology on mental health is very uncertain. There is concern about the potential harm of technologies, particularly social media on mental health and it is important to assess the evolving evidence. Further, we must remain cognisant of avoiding a 'digital divide', which could reshape health inequalities in coming decades. This report however, suggests that the 'connected world' has the potential to transform mental health services and address social isolation.

Despite the many uncertainties, we know that the population will age to 2040. We expect the most rapid period of population ageing to occur in the next 20 years, with the old age dependency ratio[§] rising from 0.27 now to 0.40 in 2040. It is therefore no surprise that estimates suggest a 50% increase in years of life lost due to Alzheimer's disease and other dementias by 2040. Estimates from the Global Burden of Disease Study in this report (see Chapter 14) forecast ischaemic heart disease will remain the leading cause of years of life lost in 2040, but we can expect the current transition of disease burden from cardiovascular disease to cancers to continue. Smoking and overweight/obesity are shared risk factors for both of these diseases and have the largest range between 'better' and 'worse' scenarios in these forecasts. This should be cause for optimism; the epidemic of smoking and obesity and sedentary-related diseases is reversible.

Health and society as a whole must prepare for the future by recognising this change in population. Futures thinking is one way to help challenge our current thinking and prepare.

§ The old age dependency ratio is the number of individuals aged 65 and older in the population as a proportion of those aged 16-64.

04 A culture of health for all

Ambition for 2040 That healthy life expectancy does increase by five years for all, with the gap in healthy life expectancy between the most and least deprived communities halved.

A healthier working-age population in 2040 is expected to translate into an economy with higher overall productive capacity, increased tax revenues and subsequently reduced spending on health-related social security payments, strengthening public finances (see Chapter 2). We know that investment in health, and the causes of ill-health, pays.

Inequalities in life expectancy have worsened from 2001-2016, with the gap in life expectancy between the most and least deprived deciles increasing from six to eight years in women, and from nine to ten years in men (see Chapter 9). Every cause at every age has a higher death rate in the most deprived communities despite our NHS. This demonstrates that both preventing ill-health through addressing the social determinants of health and the environment and the treatment of ill-health have great potential to deliver a more equitable future.

The majority of people living in poverty now are in working households (see Chapter 4). This report not only highlights the links between poor health, low educational attainment and poor job prospects but also the stark regional disparities and clustering of these links (e.g. the North East of England consistently has high claimant rates). Rebalancing the cost of living with income (earned or otherwise) presents as low hanging fruit to improve the health of the nation. Indeed, I am concerned that social determinants of health such as housing conditions could worsen for the most vulnerable, which would risk a re-emergence of communicable diseases that were eradicated from England decades ago.

Within our reach is an alternative for 2040. A person's health is an important component of 'human capital'** – indeed it is pivotal to other components including the development of educational attainment and productivity. The NHS is built upon a social contract: solidarity where we prioritise collective health security and collective wellbeing. Applying this approach of collective wellbeing to the causes of ill-health could have a marked change upon health in England in 2040.

05 Bringing prevention to the public

Ambition for 2040 That the health environment is health-promoting, incentivising and normalises healthy behaviours.

Fifty percent of the disease burden in England is due to four modifiable health behaviours – poor diet, tobacco, excessive alcohol and physical inactivity – which should be cause for optimism. However, projections to 2040 suggest that tobacco will continue to be the leading cause of years of life lost (see Chapter 14). This is not inevitable, and we must take measures now to eliminate tobacco-associated diseases and inequalities over the next two decades. Recent reductions in smoking prevalence in England over past decades are pleasing. However, there are shockingly vast disparities in smoking in pregnancy, with children born in one part of England having a 17-fold higher chance than the least deprived areas of their mother having smoked in pregnancy. This is one contributor to child health inequalities that can and must be addressed. Effectively tackling tobacco and other leading risk factors such as poor diet, obesity, physical inactivity, air pollution and excess alcohol consumption, would transform the health landscape and current inequities in drivers of ill-health such as obesity.

Smoking in pregnancy damages the health of children and contributes to child health inequalities. In 2017/18 there was a 17-fold difference between Clinical Commission Groups in smoking at childbirth.

Recommendation 3

I recommend that NHS England and Local Authorities commit to halving existing inequalities in smoking in pregnancy by geography by 2024.

Obesity and obesity-related diseases are among our greatest health challenges. Children and adults in the most deprived communities are at greatest risk of obesity and suffer the burden of obesity-related ill-health earlier, and for longer, than their least deprived peers. Obesity is an inequalities issue.

Recommendation 4

I recommend that the UK government ensure that future developments of the Childhood Obesity plan include a specific target to halve current inequalities in childhood obesity by 2030 or sooner, with support for Local Authorities to meet this target.

Chapter 8 of this report identifies interventions that alter the environment for health – 'structural' changes that require little or no action from individuals – are consistently more effective and see the largest population health gains in the most vulnerable communities when compared to individual-based approaches. One example is the innovative, tiered approach to the Soft Drinks Industry Levy, which resulted in

** Human Capital is a measure of the skills, education, capacity and attributes of labour which influence their productive capacity and earning potential.

50% of soft drink beverages reducing their sugar content before it was even implemented. These measures are effective and they are also equitable. We must not allow a situation where we look back on this era and regret allowing less effective policies to be implemented because they were either easier or avoided facing difficult trade-offs.

The Soft Drinks Industry Levy has been effective in reducing sugar consumption from soft drinks. In order to mitigate obesity and diet-related diseases, further sustained action is required.

Recommendation 5

I recommend that HM Government extend the Soft Drinks Industry Levy to sweetened milk-based drinks with added sugar and take action to eliminate added sugar in commercial infant and baby foods.

Recommendation 6

I recommend that HM Government review the use of fiscal disincentives in relation to foods that are high in sugar and salt and also incentives to increase fruit and vegetable consumption.

I welcome the Secretary of State's vision paper, 'Prevention is better than cure' [††] and his commitment to build upon past success in reducing salt consumption. From 2003 to 2011, an 11% reduction in population salt intake was achieved. This was attributable to the Food Standards Agency's approach to salt reduction, which was transparent, with close monitoring and evaluation, but holding the threat of sanctions to the food industry if reformulation targets in foods were not met. This policy has been emulated across the world. Since 2011, progress on reduction of salt consumption in England has stalled.

Recommendation 7

I recommend that in 2019, HM Government through Public Heath England, set more ambitious targets for salt reduction in food. This should apply equally to the out-of-home sector, which has lagged behind. If these targets are not met then they should be mandated and a range of other interventions considered, including mandating front of pack labelling.

Data driven public health, using predictive analytic models to test public health interventions in silico can allow decision makers both locally and nationally to compare policies. This can help provide sufficient evidence to act, thus encouraging evidence informed policy making for many complex public health challenges.

Those who shape the environment for health should be held to account. We have seen promising first steps, but to fiscally optimise the food environment from producer to plate in order to encourage healthy dietary patterns to be the norm for all, we need sustained and effective action. This approach has to encourage more focus upon the quality, rather than quantity of food produced and sold. Those sectors that damage health must pay for their harm or subsidise healthier choices.

Local Authorities need to be supported with legal powers and tool kits that allow them to improve the health environment for their populations, particularly in areas surrounding schools.

Recommendation 8

I recommend that the Ministry of Housing, Communities and Local Government explore, with the Local Government Association, how it can better support local government action to encourage healthier food options on the high street.

†† Department of Health and Social Care. *Prevention is better than Cure*. London 2018. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf

06 Data driven prevention to target those at highest risk

Ambition for 2040 That intelligent "predict and prevent" services, integrating advances in biomedicine, technology and behavioural science, are implemented progressively in order to match services to needs. These services enable everyone to have accurate information and support them to engage in positive change.

By 2040, we will be able to accurately predict chronic diseases a decade before they become symptomatic and thus enable individualised prevention measures. Vast progress in computing power and predictive analytics will be able to integrate unstructured data that sits outside of organised and traditional medical databases. This will improve disease progression prediction, allowing optimal preventative and treatment options for each individual.

Point of decision technologies that combine genetic information, nutritional guidelines, behavioural science and emerging technologies using 'nudges' in one's own environment offer the potential to achieve personal behaviour change in specific patient groups (see Box 'Personalised DNA-based dietary guidelines to nudge the public to better health' in Chapter 9).

This report identifies wearable technology with novel biosensors that offer continuous monitoring and titration as a way to transform chronic disease management outside of traditional settings (see Chapter 11). Diagnostics' high predictive value that combine novel biomarkers, genomics and wider clinical datasets will bring the diagnostics laboratory to the patient as part of their daily lives.

These impressive advancements in predictive analytics should be accompanied by tools and support that enable individuals to absorb the knowledge, be empowered and use it. This could make prevention of ill-health a routine part of daily life, particularly for those with chronic diseases.

07 The best care, in the best form, for the best you

Ambition for 2040 That healthcare is delivered through a segmented service that achieves equity of access and uptake through embracing emerging technologies based upon world-leading standards.

Chapter 7 of this report found that multimorbidity is common and will be more common in 2040. By then, we will identify multimorbidity as a non-random series of predictable clusters of conditions and health risks, identifying opportunities for early and effective intervention. I commend the ethnographic research by the Richmond Group's Taskforce on multiple long-term conditions ‡‡that seeks to understand the lived experience of patients with multimorbidity to ensure the individual is central to how care is delivered in a dynamic landscape. Indeed, by 2040 the current biomedical model of health will be transformed to integrate biomedicine, technology and behavioural sciences to provide personalised medicine in a service that remains personal to the individual.

Multimorbidity represents a substantial health challenge now and is expected to increase in prevalence to 2040. Prevention and treatment need to adapt to effectively manage the non-random series of predictable clusters of conditions and health risks within multimorbidity.

Recommendation 9

I recommend that research funders, led by NIHR and MRC, commission research to identify and understand the disease clusters that make up common multimorbidity.

Recommendation 10

I recommend that NICE, alongside specialist bodies, develop multi-disease guidelines for common clusters of disease to avoid multiple single disease guidelines applying to the same groups of patients.

We will evolve from Electronic Health Records to an individualised 'Electronic Health Engine' that integrates high dimensional data about the individual, including social and economic determinants of health, behavioural risks, biomedical, genomic and citizen-generated data, to generate real time dynamic risk trajectories (see Chapter 10). This will inform individualised prevention, management and treatment decisions accessible to both the patient and their clinical and prevention team. Interoperability will be an essential building block to achieving this step-change.

'Intelligent triaging' will have evolved by 2040 to learn how best to achieve uptake of services in each sub-population, ensuring the most rapid, effective and appropriate assessment and management. By 2040 we will have the technology to identify the best mode of accessing healthcare for each individual, whether that is by video call, virtual reality headset or in-person, day or night, as well empowering patients in self-management and control of their conditions. This could reduce inequities in accessing treatment and preventative services (see Chapter 5).

Interoperability will be central to the successful and equitable implementation of emerging technologies. Interoperability must also apply to non-NHS healthcare service providers, public health services and providers of preventative and ancillary services.

Recommendation 11

I recommend that NHS Digital should develop an open-source infrastructure that reduces the cost and complexity of integrating new technologies with existing healthcare systems, through the open Fast Healthcare Interoperability Resources standard.

†† https://richmondgroupofcharities.org.uk/sites/default/files/final_just_one_thing_after_another_report_-_singles.pdf

We are already seeing the potential of artificial intelligence delivering in practice, specifically in imaging and digital pathology. This report highlights many areas of promise for AI, particularly in imaging where quick gains could be achieved across England (see Chapter 12).

As discussed in my introduction, healthcare, as well as prevention, can deliver rapid improvements in health inequalities. AI in imaging is one example that has the potential to reduce geographical inequalities such as in diseases that depend upon time-sensitive imaging (such as stroke). One striking example in this report demonstrates that if cancer survival was equitable, 10,000 deaths within five years of diagnosis would be avoidable (see Chapter 9). Strategically harnessed, emerging technologies will standardise high quality care pathways. This will offer reductions in geographical disparities in the speed and effectiveness of diagnosis, access to and quality of care, to provide world-leading care for all across England.

08 New paradigm for research and partnership

Ambition for 2040 That England has a regulatory, evaluation and commercial framework for health research that embraces emerging technologies with ambition, relevance, and a high ethical standard.

The health system should be a dynamic learning and researching system, where all data and every patient contact is used to improve the experience and service provided to that individual, and to push the boundaries of new treatment and prevention approaches. Co-production with all stakeholders will be pivotal to this success; a health service that is learning with you, about you and for you.

England has long been a leader in both discovery science and applied health research, capturing the unique test-bed research ecosystem of the NHS. The randomised controlled trial is the 'gold standard' for clinical studies for medical interventions, but this approach is often not the most effective method for evaluating either emerging technologies or complex public health problems. Iterative research that allows in silico learning and improvement post-implementation and simulation modelling for complex public health challenges such as obesity, are key to moving fast to improve health.

This report identifies several opportunities for applied health research. To realise this potential requires a realignment of research and healthcare appreciating the interdependencies.

All advances in healthcare must continue to be evidence-based. As emerging technologies develop, a new research paradigm involving novel methods for research and evaluation must also be developed. Emerging technologies, especially those that are dynamic, provide new challenges; 'anticipatory regulation' that is proactive and 'future-proof', cognisant of emerging products and services, would provide a platform to deliver benefits to patients in a safe and expedient manner. Currently, most emerging technologies are classified in the lowest category of medical devices, along with Zimmer-frames and bandages; so, determination of safety and effectiveness is done by the company itself with no requirement for external validation. This holds some risk for patients while also stifling safe innovation that could result in large benefits to patients.

A new approach to the evaluation of emerging technologies that is relevant and proportionate to the intervention while commanding the trust and confidence of patients and clinicians is required. The recently published evidence standards framework for digital health technologies[§§] begins to outline the level of evidence required by innovators. We need a proportionate evaluation of the safety of patients before implementation, but then allows the technology to learn dynamically and improve in real time, building in evaluation, thus allowing patients to receive the best care without delay.

Emerging technologies are transforming delivery of health services and improving health outcomes. We need effective frameworks for regulation and evaluation of emerging technologies that while promoting safety allow timely implementation.

Recommendation 12

I recommend that the Secretary of State for Health and Social Care seeks advice on the best mechanism for developing, delivering and maintaining frameworks for regulation and evaluation of emerging technologies and devices. Decisions should be based upon the following principles:

a. Emerging technologies should have safety reviewed (do no harm) by an independent body.

b. Evaluation of effectiveness should be both iterative and proportionate to the purpose of the technology.

c. Exacerbation of health inequalities must be mitigated against.

As research is conducted on emerging technologies in healthcare, patients and professionals should have confidence in the standardised quality of such research. CONSORT[***] reporting standards for RCTs dramatically reduced issues arising from inadequate reporting and improved the interpretability and usability of research findings for clinicians and policy makers alike. Similar standards should be a cornerstone of emerging technologies research in health.

Specific research standards for emerging technologies are required to earn the trust of patients and clinicians, and to enhance interpretability of research findings.

Recommendation 13

I recommend that NHS Digital should work with the Office for Strategic Coordination of Health Research and Health Data Research UK to develop, consult on and agree an appropriate system for research standards in artificial intelligence health and care research studies for England.

The development of the proposed system should build on the work by the Collaborative Research Group (CRG) on Applied Artificial Intelligence in Healthcare led by the Institute of Global Health Innovation at Imperial College London.

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§§ National Institute for Health and Care Excellence. Evidence standards framework for digital health technologies. London. 2018. Available at: www.nice.org.uk/digital-evidence-standards

*** http://www.consort-statement.org

Large, representative and longitudinal datasets are essential to developing many such technologies in the NHS; incorporating integration with wider health determinants and citizens-generated data has the potential to be a unique test-bed for such technologies to be developed, and for the benefits to be reaped by patients. The Clinical Record Interactive Search (CRIS) system at the Maudsley Hospital (see Chapter 13) is an example of influential research using integrated electronic health records within a robust, patient-led data governance framework, funded by NIHR.

To ensure that the UK is a leader in emerging health technologies and that the benefits are delivered equitably across all of England, a commercial framework that is standardised across the NHS and health-related bodies is required. This should leverage our national assets, the NHS, and world-leading academia and the life sciences industry to deliver improved services for patients within a robust data governance framework that works for citizens, clinicians and researchers. This requires healthy partnerships, building on the Life Sciences Sector Deal[†††], that reduce the risk for partners through representative datasets to develop and improve technologies while delivering for the NHS and its patients.

Health-related data needs to be of a uniformly high standard to facilitate the timely development and implementation of many emerging technologies and predictive analytics. In order for AI-based technologies to effectively serve our population, the health data used to develop that product needs to be representative of us. The UK Government's Code of Conduct for data-driven health and care technology is a welcome and important step in guiding the development of emerging technologies.

Recommendation 14

I recommend that NHS Digital, with Public Health England and partners, develop and publish best practice standardised guidance for the NHS (hospital trusts, primary care, community hospitals, etc.) on data collection, standards, structure, handling, storage, and sharing for the development of AI tools.

Recommendation 15

I recommend that the Department of Health and Social Care ensure that 'data banks' are available which are representative of the population of England to allow testing, quality assurance and validation of AI-based tools at scale before implementation into service, and for calibration of AI-based tools developed overseas to the England population for use in the NHS and broader health arena.

The success and sustainability of a health and research ecosystem such as this depends upon the existence of a shared understanding, and acceptance of, reasonable expectations underpinning the relationship between the public, healthcare and research (see Chapter 13). This requires the NHS, research institutions and researchers to constantly prove their trustworthiness, whether from the public or private sector – that they act first and foremost in the best interests of the patients and public.

[†††] Department for Business, Energy, and Industrial Strategy. *Life Sciences Sector Deal 2, 2018*. London.

09 Conclusion

Nothing is inevitable about health in England in 2040. We have the potential to dramatically improve health for all and reduce health inequalities, creating a healthier and fairer future for our children and a stronger economy. To achieve this, and to avoid worsening of health inequalities, health must be seen as one of England's primary assets. We also need to start to measure and track progress through a new composite Health Index alongside GDP. I found in reading the chapters in this report, that now more than ever, an aspirational future is in our hands and that is a real cause for optimism.

If we harness the exciting potential to transform health and the delivery of healthcare, not only will this benefit the health of the nation, but it will also make the UK world leaders in healthcare technologies through an innovative ecosystem based upon world-leading standards that protect and promote the interests of patients and the NHS. The UK could export clinical leadership in emerging technologies globally, as a beacon nation in valuing health fairly in society and in effectively tackling the growing burden of behavioural and lifestyle diseases.

Agenda Item No: 11

HEALTH COMMITTEE WORKING GROUP Q3 UPDATE

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

1) **Note the content of the quarterly liaison groups and consider recommendations that may need to be included on the forward agenda plan.**

2) **Note the forthcoming schedule of meetings**

Officer Contact:		***Chair Contact:***	
Name:	Kate Parker	Name:	Councillor Peter Hudson
Post:	Head of Public Health Business Programmes	Post:	Chairman
Email:	Kate.Parker@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01480 379561	Tel:	01223 706398

1.0 BACKGROUND

1.1 The purpose of this report is to inform the Committee of the health scrutiny activities that have been undertaken or planned since the committee last discussed this at the meeting held on 11th October 2018

1.2 This report updates the Committee on the liaison meetings with health commissioners and providers. The report covers Quarter 3 (2018-19) liaison meetings with:

- Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) & Cambridgeshire & Peterborough Healthwatch
- Cambridgeshire & Peterborough Foundation Trust (CPFT)
- Cambridgeshire University Hospital Foundation Trust (CUH)
- North West Anglia Foundation Trust (NWAFT) – Hinchingbrooke Hospital

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

2. MAIN ISSUES

2.1 Liaison Meeting with HealthWatch Cambridgeshire & Peterborough and the Clinical Commissioning Group (CCG)

The liaison group members in attendance were Councillors Harford, Hudson Jones and ven de Ven. Apologies were received from Councillor Hudson and Connor.

A meeting was held on 18th October with Jessica Bawden (Director of Corporate Affairs, CCG),Sandie Smith (CEO) and Val Moore (Chair) of Healthwatch Cambridgeshire & Peterborough

2.1.1 The group discussed the following items with the CCG

- Brexit contingency plans for health commissioning including the impact of no deal on health services in Cambridgeshire.
- DTOC update from CCGs perspective
- Feedback from the CCG's consultation on "Community First" Learning Disability in-patient beds consultation
- Availability of flu vaccinations (specifically over 65s)
- Patient Participation Group – CCGs policy and procedures
- Briefing on future consultations e.g. Wider urgent care provision (including St.Neots walk in centre) and CPFT podiatry services sites.

- NHS England's CCG assurance rating moved from 'inadequate' to 'requires improvement'.
- CCGs improvement plan and new appointments
- Update on the International GP recruitment scheme that is being led nationally.

The CCG also advised members on the following:

- Updates on Senior Leadership team appointments in the CCG
- CCG Financial position update prior to the scheduled scrutiny item for Novembers Health Committee.
- Potential changes to the Podiatry service.

2.1.2 An update from Healthwatch was received on the following areas.

- Overview of the NHS Dental service provision report by healthwatch around access to NHS Dentists in Cambridgeshire NHS Dental Services . This will complement the scrutiny session with NHS England scheduled for December's Health Committee meeting.

2.1.3 The next liaison meeting is currently being re-scheduled for early 2019.

2.2 Liaison meeting with Cambridgeshire & Peterborough Foundation Trust (CPFT)

The liaison group members in attendance were Councillor Hudson and Harford and district Councillor Harvey. Apologies were received from Councillors van de Ven and Joseph

A meeting was held with Tracy Dowling (CEO) and Julie Frake-Harris (Director of Operations) from CPFT on 19th October 2018.

2.2.1 The group discussed the following items with CPFT.

- Podiatry Services relocation
- Update on Joint Emergency Team (JET) service
- Update on First Response Service
- IT Systems compatibility (preparation for scrutiny item at December Health Committee)

2.2.2 CPFT also advised members on the following:

- Overview of eating disorders in preparation for scrutiny item at January Health Committee including:
    - Phoenix centre
    - Eating Disorder summit in November

2.2.3 The next liaison meeting is currently being re-scheduled for March 2019.

2.3 Liaison meeting with Cambridgeshire University Hospital Foundation Trust (CUH)

The liaison group members in attendance were Councillors Harford, Jones, van de Ven. Apologies were received from Councillor Hudson and Roland Sinker (CEO-CUH)

A meeting was held on 14th December 2018 with Ian Walker (Director of Corporate Affairs - CUH).

2.3.1 The following topics were discussed at this meeting:

- Delayed Transfers of Care (focus on winter pressures)
- CQC Inspection feedback (report due Jan/Feb 2019)
- Key Worker Housing update
- Brexit Contingency Plan
- Capital Investment Programme

Under the Brexit Contingency plans Members heard from CUH about the staff immigration support sessions the Trust has run. Under the Capital Investment Programme item Members received further information on the recent announcement from the Secretary of State on £19 million award CUH will receive as part of an STP bid. The current plans for this funding will be the provision of a modular build on land on the Addenbrookes site. The aim is to help increase bed capacity by up to 60 beds, primarily to provide decant space for existing wards so vital fire safety and estates improvements can be undertaken.

2.3.2 Recommendation

- Consider calling CUH in for a formal update scrutiny session following publication of their CQC inspection report.

2.3.3 The next liaison meeting is scheduled for Friday 8th March 2019 at Addenbrookes Hospital.

2.4 Liaison Meeting with North West Anglia Foundation Trust (NWAFT)

The liaison group members in attendance were Councillors Connor, Harford and district councillor Tavener. Apologies were received from Cllr Hudson and Taylor

A meeting was held on 20th December with Caroline Walker (CEO- NWAFT) and Deborah Dearden (Health Records Project Manager EDM Project-NWAFT)

2.4.1 The following topics were discussed at this meeting:

- Delayed Transfer of Care – Winter Planning arrangements
- Brexit Contingency Plans

- Update on the Fracture Liaison Service (part of the falls prevention service)
- Capital Investment Programme for Hinchingbrooke Hospital
- CQC Inspection

Under the capital investment programme Members received further information on the plans for the £25 million award for Hinchingbrooke Hospital as part of the STP bid. The money will support improvements in existing facilities at the hospital in the face of a rapidly growing population. The Trust will focus on developing and improving clinical services with some focus on expanding A&E and developing stroke rehabilitation services. More information is available in the Trusts estates strategy that went to the November Board meeting: https://www.nwangliaft.nhs.uk/about-us/trust-board/board-papers-meetings/

The CQC Inspection report for NWAFT was discussed in preparation for the scrutiny item that is being presented at Health Committee on 17th January. It was confirmed that Dr. Kanchan Rege (Medical Director) would be in attendance and that the committee was specifically interested in the findings relating to Hinchingbrooke Hospital.

Members raised the following issues:

- Cllr Connor followed up on previous concerns raised over outpatient clinics provided by NWAFT at Doddington Hospital and ensuring that the site is actively used as a resource to support local residents. Representatives from NWAFT were to meet with Cllr Connor and district councillor Maureen Davis but these meetings have halted. Deborah Dearden provided members with details on the NWAFT out-patient services that run from Doddington Hospital site. It was agreed that this information would be forwarded onto members to allow Cllr Connor and Tavener to promote the services of Doddington Hospital with local GPs.

2.4.2 The next liaison meeting is scheduled for at Hinchingbrooke Hospital on 5th March 2019.

3.0 SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

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

3.2 Statutory, Risk and Legal Implications

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

3.3 Equality and Diversity Implications

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

3.4 **Engagement and Consultation Implications**
There are likely to be engagement and consultation issues to be considered within the remit of the working groups.

3.5 **Localism and Local Member Involvement**
There may be relevant issues arising from the activities of the working groups.

3.6 **Public Health Implications**
Working groups will report back on any public health implications identified.

Source Documents	**Location**
None.	

Appendix A

Health Committee Quarterly Liaison meetings and Schedule of Meetings 2018/19

Liaison Meeting	Current Membership	Meeting Dates
Cambridgeshire & Peterborough Clinical Commissioning Group and Cambridgeshire & Peterborough Healthwatch	Councillors: David Connor Lynda Harford Peter Hudson Linda Jones Susan van de Ven	~~23rd January 2019~~ (to be rescheduled) 1st May 2019
Cambridgeshire & Peterborough Foundation Trust (CPFT)	Councillors: Peter Hudson Lynda Harford Linda Joseph	~~18th January 2019~~ (to be rescheduled) 11th April 2019
Cambridge University Hospital Foundation Trust (CUH)	Councillors: Peter Hudson Lynda Harford Linda Jones Susan van de Ven	8th March 2019
North West Anglia Foundation Trust (NWAFT)	Councillors David Connor Lynda Harford Peter Hudson Simone Taylor District Councillor: Jill Tavener	5th March 2019

HEALTH COMMITTEE TRAINING PLAN 2018/19	Updated December 2018	**Agenda Item No: 12**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
7.	***Health in Fenland***	To provide a deep dive into reviewing and understand the key health inequalities in the Fenland District. To be held at FDC Boathouse, Wisbech	1	19th Sep 2018	Public Health	Development Session	All members of Health Committee	8	80%
1.	***Business Planning (Strategic)***	To provide the committee members with an overview of CCC strategic Business Planning timescales and deadlines	1	9th August	Public Health	Development session	All CCC Health Committee members	6	60%
2.	***Business Planning (Operational)***	To discuss the Public Health Business Planning priorities for 2019/20	1	13th Sept 2018	Public Health	Development Session	All CC Health Committee members + districts	8	53%
3.	***Delayed Transfers of Care – System wide perspective***	To provide the committee with an overview of DTOC specifically focusing on those attributed to the NHS	1	30th January 2019	Public Health	Development Session	All CCC Health Committee members + districts		
5.	***Health in Fenland***	To hold a follow up session from the Fenland Deep Dive that was held on 19th September	2	11th October	Public Health	Development Session	CCC Health Committee members	8	80%
6.	***Voluntary sector role in supporting public health outcomes***	To understand the local voluntary sectors role in delivering services that can	2	7th Feb 2019	Public Health	Development Session	All CCC Health Committee		

		have public health outcomes					members + districts		

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 on 2nd January 2019	Cambridgeshire County Council **Agenda Item No: 13**

Notes

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

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
17/01/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Update on Public Health Reserves – Fenland Fund	Val Thomas	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Annual Public Health Report	Liz Robin	Not applicable		
	Scrutiny Item: NWAFT CQC Inspection	Caroline Walker	Not applicable		
	Scrutiny Item: Eating Disorders Service	Tracy Dowling	Not applicable		
	Scrutiny Item: Provision of 111 Out of Hours service for Wisbech	CCG/CPFT	Not applicable		
	Quarterly Liaison Meetings Q3 Update	Kate Parker	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
07/02/19	Section 75 for Health Visiting and School Nursing Service	Liz Robin / Val Thomas	2019/015		
	Sexual Health Services Contract Exemption	Val Thomas	2019/029		
14/03/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Let's Get Moving – Evaluation Plans	Val Thomas	Not applicable		
	Scrutiny Item: CUH CQC Inspection Report	CUH	Not applicable		
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: CCG Finances update position	Jan Thomas	Not applicable		
	Scrutiny Item: GP Five Year Forward View	Jan Thomas	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Delegation for Quality Accounts	Kate Parker	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[11/04/19] Provisional meeting					
23/05/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker	Not applicable		
	Scrutiny Item: Minor Injury Unit Update		Not applicable		
	Scrutiny Item: STP Workforce Planning		Not applicable		
	Response to Quality Accounts Report	Kate Parker	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[20/06/19] Provisional Meeting					
11/07/19	Finance & Performance Report	Liz Robin			
	Scrutiny Item: STP Digital Strategy	STP			
	Health Committee Training Plan	Kate Parker			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			
[08/08/19] Provisional Meeting					
19/09/19	Finance & Performance Report	Liz Robin			
	Health Committee Training Plan	Kate Parker			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			
17/10/19	Finance & Performance Report	Liz Robin			

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Health Committee Training Plan	Kate Parker			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			
14/11/19	Finance & Performance Report	Liz Robin			
	Health Committee Training Plan	Kate Parker			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			
05/12/19	Finance & Performance Report	Liz Robin			
	Health Committee Training Plan	Kate Parker			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			
23/01/19	Finance & Performance Report	Liz Robin			
	Health Committee Training Plan	Kate Parker			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			
[06/02/19] Provisional Meeting					
19/03/19	Finance & Performance Report	Liz Robin			
	Health Committee Training Plan	Kate Parker			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			
[16/04/19] Provisional Meeting					
28/05/19	Finance & Performance Report	Liz Robin			

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Health Committee Training Plan	Daniel Snowdon			
	Agenda Plan and appointments to outside bodies	Daniel Snowdon			