HEALTH COMMITTEE

Date:Thursday, 23 May 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

DECISIONS

SCRUTINY ITEM

DECISIONS

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

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

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HEALTH COMMITTEE: MINUTES

Date: Thursday, 14 March 2019

Time: 1.35p.m. – 4.00p.m.

Present: Councillors D Connor, J Gowing (substituting for Councillor Boden), L Harford, P Hudson (Chairman), D Jenkins, L Jones, K Reynolds, S Taylor, Topping and S van de Ven

District Councillor N Massey

Apologies: Councillors C Boden, G Harvey and J Tavener

The Chairman expressed his thanks to Cambridge News reporter Josh Thomas who had reported on the Health Committee regularly and was leaving to take up a new role in Westminster.

198. DECLARATIONS OF INTEREST

There were no declarations of interest.

199. MINUTES - 7TH FEBRUARY 2019

The minutes of the meeting held on 7th February 2019 were agreed as a correct record and signed by the Chairman.

200. HEALTH COMMITTEE – ACTION LOG

The Action Log was noted. Officers undertook to provide a written briefing note that updated Members on the outstanding actions.

201. PETITIONS

There were no petitions.

202. FINANCE AND PERFORMANCE REPORT – JANUARY 2019

The Committee considered the January 2019 Finance and Performance report. In presenting the report officers highlighted that the recommendation of the report should request that Members noted the finance position as at end of January 2019 not November 2018.

Members were informed that there was no overall change in the financial position and there was a forecast underspend of £459k of which £391k would be returned to corporate reserves.

Attention was drawn to paragraph 2.3 of the officer report which related to the S75 contract for 0-19 healthy child services. It was reported that there had been significant numbers of vacancies within the service and therefore it was possible that a portion of the value of the contract could be re-funded as a result. Members noted that £238k had

been earmarked from ring-fenced reserves in order to maintain the contract and that reserves would not have to be utilised to the same extent if a refund was received.

Members were informed further that due vacancies that had occurred within roles shared across Peterborough City Council and Cambridgeshire County Council could result in reduced costs and therefore money paid to Peterborough City Council.

During discussion Members:

- Questioned the impact of staffing underspend for the Healthy Child Programme and re-asserted concerns regarding the ability of Nursery Nurses to recognise issues such as abuse.

- Expressed concern regarding vacancy levels across the Public Health directorate, and relayed concerns of residents regarding a lack of Health Visitors.

- Noted the comments of a member that had attend a meeting of the Communities and Partnerships Committee and the discussions that had taken place with officers regarding health visiting and the concerns of Members.

- Drew attention to Appendix 5 of the officer report and questioned whether it would be possible to install new software into GP practices. Officers commented that improvements had been achieved in the number of health checks undertaken. Members were informed that software had been commissioned however due to General Data Protection Regulations (GDPR) had resulted in its decommissioning however, existing systems were able to be used.

- Noted the comments of a Member that had visited Health Visitors and saw them working as a team that would advise one another regarding any concerns relating to families.

- Drew attention to the length of time between the 9 month check, 2.5 year check and the next check which took place at school. Officers in response emphasised the importance effective monitoring that would identify any risks that could jeopardise children's health.

- Sought further clarification regarding the long term position of the Counting Every Adult (MEAM) project contained at Appendix 7 of the report. Officers undertook to provide further information. **ACTION**

It was resolved unanimously to:

> Review and comment on the report and to note the finance and performance position as at the end of January 2019.

203. CAMBRIDGESHIRE AND PETERBOROUGH CCG FINANCIAL POSITION AT MONTH 9

The Chairman invited Jess Bawden, Director of External Affairs and Policy together with Mark Sanderson, Medical Director and Wanda Kerr, Deputy Chief Finance Officer to update the Committee regarding the financial position of the Clinical Commissioning Group (CCG) at month 9.

Members were informed that month 10 figures had been received and the CCG remained on track to meet the forecast overspend of £35m. Members noted that if the target was achieved then NHS England would write the deficit off and would not have to be re-paid in future years.

Pressures relating to Section 117 cases were highlighted together with issues relating to Continuing Health Care funding.

Members were informed that the budget for 2019/20 totaled £1.3bn however, it would unlikely be sufficient to meet the predicted population growth for the area. Meetings with NHS England were taking place in order for a control deficit of £25m to be agreed.

During discussion Members:

- Congratulated the CCG on maintaining the target overspend of £35m and questioned whether the mild winter had assisted in achieving the target. Officers confirmed that the mild winter had helped operationally as seasonal flu had not been as severe as previous years and there had been limited snowfall. A significant amount of forward planning for the winter period and proactive management had been undertaken and as a result the system a whole managed winter pressures more effectively.

- Noted that previous years' overspends would continue to be carried forward into the new financial year however, the current £35m deficit would not be added to the cumulative deficit.

- Questioned to what extent areas in which overspends were likely to occur, such as Delayed Transfers of Care (DTOC) were within the control of the CCG. Officers explained that with regard to S117 cases, management of the costs had improved greatly together with more robust processes regarding case management implemented. Officers explained the penalties applied regarding DTOCs were done so on a sliding scale.

- Were informed that the Learning Disability Partnership (LDP) was a pooled budget managed by Cambridgeshire County Council. There were budgetary pressures within the LDP driven by the complexity of cases and increasing numbers of new clients.

- Noted the comments of officers regarding the potential end of special measures at the end of March 2019 which would afford greater autonomy.

- Noted the progress made against the CCG's Improvement Plan which was monitored by the CCG Board. Independent assurance was sought for the plan and positive comments were received regarding its progress. There was reasonable confidence that the organisation was moving in the right direction.

It was resolved unanimously to note the CCG's financial position.

203. GENERAL PRACTICE FORWARD VIEW – LOCAL IMPLEMENTATION UPDATE REPORT

The Medical Director, Mark Sanderson of the Clinical Commissioning Group (CCG) together with Jess Bawden Director of External Affairs and Policy were invited by the Chairman to update Members regarding the General Practice Forward View.

In presenting the report the Medical Director drew attention to paragraph 2.1 which set out the four main areas of work that supported the ambitions set out in the report. Work was being undertaken with the Sustainability and Transformation Partnership (STP) regarding local geography and conversations were taking place with GP practices regarding areas.

Members noted the challenges relating to recruitment and retention of GPs, in particular the difficulties experienced in recruiting internationally. The requirements relating to English language in order to be placed on the national performance list were particularly challenging. There were also substantial numbers of GPs forecast to leave the profession in the short to medium term and initiatives to mitigate and improve the position were being investigated.

During discussion, Members:

- Drew attention to the ambition for the recruitment of 30 GPs from overseas of which only 2 had been recruited. Members were informed that many applications had been received, however few met the required standards, particularly regarding English language. It was also noted that the concept of GPs differed overseas where in Eastern Europe for example, a thyroid issue would be referred to hospital where as in the United Kingdom the GP would undertake a variety of tests.

- Noted that 6 GPs from Australia had moved to England and begun practicing.

- Sought further understanding of how the coalescence of different GP practices was being encouraged, particularly for practices that did not have a natural inclination to coalesce. It was explained that Cambridgeshire was behind when compared with other areas. Examples of practices in Peterborough that had merged were provided and Members noted that 2 practices in St Ives and a practice in Somersham had merged. Officers explained that the direction of travel toward greater integration was well known amongst GP practices.

- Noted that for extended access to GP services over the weekend, there was a requirement for every patient to be provided access however, there was no requirement for every practice to deliver it. Therefore, hubs were used to provide services out of normal hours. In the future the extended access would be linked with the newly established networks.

- Noted the numbers of qualified nurses that were currently working as healthcare assistants and unable to work as nurses because they were unable to reach a level 7 standard of English.

- Questioned to what extent the national contract would provide a driver for change and sought greater clarity regarding timescales. It was explained that the contract influenced GP behaviour significantly as they were small businesses. Timescales were challenging and a clinical director would lead for each group in order to align staff to be able to establish networks. There would also be standardisation of

certain practices such as warfarin management and work was being undertaken with the University of Cambridge to produce a leadership programme. Members requested that any leadership programme encompass distributed leadership.

- Questioned how monitoring of the progress was measured including outcomes. Officers agreed to return to Committee to provide an update on progress which would include measures of progress and outcomes.

- Questioned whether the only driver for change was financial or was it to also improve patient access to services. It was explained that in Peterborough which would likely be the preferred model there was one large merged practice that enhanced patient access.

It was resolved to note the report and return 6 months.

204. REGIONAL CHILDREN'S HOSPITAL COMMUNICATION AND ENGAGEMENT PLAN

Representatives of NHS England including Jessamy Kinghorn, Head of Communications and Engagement NHS England Specialised Services (Midlands and East of England), Tracy Dowling, Chief Executive Cambridgeshire and Peterborough Foundation Trust (CPFT), Rob Horsecore, Clinical Lead for Children's Hospital, Alison Bailey, Director of Communications and Engagement Cambridge University Hospitals NHS Foundation Trust and Ian Mallet, Communications and Engagement Lead were invited by the Chairman to address the Committee.

Following the government announcement of £100m capital funding for the establishment of a new children's hospital officers were attending the Health Committee in order to provide details on how the public and patients would be engaged during the process.

Officers provided information regarding the scope of the proposed hospital and highlighted the opportunity to provide world leading paediatric services which would benefit from being located at the Addenbrooke's campus with its teaching and research facilities.

Officers explained that the historic separation of physical and mental health services was out-dated and it was vital to look at health as a whole mental and physical health were intrinsically linked.

The Committee was informed that integration was key to the hospital. The remit of the hospital was to support specialist services across the region and co-locate services at the Addenbrooke's campus. There was an ambition to work with providers in order that pathways be improved through an effective hub which utilised digital and telehealth services to ensure children remained local.

Members noted the ambition to build a hospital that was the pride of East Anglia similar in stature to Alder Hey children's hospital in Liverpool.

The report outlined the proposed approach to ensure that patients, families and the public were involved in co-developing the plans. Members noted that children and young people would be central to the proposed engagement. Initial discussions had taken place and the general view expressed was that it provided an opportunity

however, concerns were expressed regarding co-locating both mental health and physical services on one site.

Commenting on the report Members:

- Welcomed the proposed children's hospital and highlighted the importance of providing a dedicated facility for parents to stay at when their children were being treated.

- Suggested that parents of patients of other children's hospitals be engaged with in order to learn from their experiences together with past patient experiences.

- Emphasised the importance of creating a clear framework through which engagement was delivered, commenting that the public often became frustrated when it was not clear what was being consulted on.

- Expressed concern that there was a risk that the proposed hospital could detract from services patients currently used.

- Questioned what officers hoped to learn through the consultation exercise about patient experience. Officers explained that a formal 12 week consultation would not be undertaken because a two year involvement approach was considered to offer more meaningful engagement. There was a desire to work closely with children, families and clinical teams to produce pathways and identify current barriers. Members noted the concerns of patients of the Ida Darwin hospital that included concerns regarding green space at the Addenbrooke's campus and the busy environment that was found there.

- Highlighted the importance of transport and access to the campus.

- Emphasised the positive relationships the Committee enjoyed with many health partners and drew attention to the Liaison Group where information and support could be shared.

- Expressed support for the Children's Hospital and agreement with the proposed approach to engagement.

- Confirmed Councillor Lynda Harford to act as a lead Member relating to engagement for the new Children's Hospital.

It was resolved to note the report.

205. NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2018/19 REQUESTS

Members considered a report that sought to establish a process through which the Committee as part of its Health Scrutiny function, to agree the process to respond to statements on the Quality Accounts provided by NHS Provider Trusts. During discussion Members confirmed that they would appoint Councillors Connor, Hudson, Jones and Taylor to the proposed Task and Finish Group. Members also confirmed that they wished to respond to all Quality Accounts detailed in the officer report.

It was resolved to:

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

b) To note the improvements in the process introduced for responding to Quality Accounts in 2018 and feedback from the Trusts

c) To delegate approval of the responses to the Quality Accounts to the Head of Public Health Business Programmes acting in consultation with the views of members of the Committee appointed to the Task and Finish Group; and

d) To appoint Councillors Connor, Hudson, Jones and Taylor to the Task and Finish Group.

206. HEALTH COMMITTEE TRAINING PROGRAMME AND DRAFT TRAINING PROGRAMME 2019/20

Members received the Health Committee Draft Training Programme 2019/20. During the course of discussion Members suggested further discussion take place at the Chair and Lead Members meeting. Members highlighted the importance of undertaking evaluation of training sessions.

It was resolved to note the Training Programme and Draft Training Programme 2019/20.

207. HEALTH COMMITTEE FORWARD AGENDA PLAN

The Committee examined its agenda plan and noted that the CGL Contract Novation report would be presented to the May meeting of the Committee together with the Let's Get Moving – Evaluation Plans. It was therefore noted that that provisional meeting for April would be cancelled.

It was resolved unanimously to note the Forward Agenda Plan.

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
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 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. Being picked up as part of the training plan for 2019.	**Ongoing (May 2019)**

Meeting of 6th December 2018

171	**Finance & Performance Report – October 2018**	**Raj Lakshman**	Further information and narrative would be included in the report regarding Health Visitors.	This will be provided in the next quarterly update on health visiting performance in the public health FPR	**Completed**

Meeting of 17 January 2019

182.	**Hinchingbrooke Hospital – CQC Inspection Update**	**Chairman**	Chairman of the Health Committee to write to the Care Quality Commission (CQC) regarding the inspection	At January's Health Committee meeting when the Clinical Director of Hinchingbrook Hospital attended for an item regarding the CQC Report for NWAFT, some members requested that the Chairman of the Health Committee write to the CQC about concerns they had with regard to the inspection process. It was subsequently considered prudent to wait until there had been an opportunity for Health Committee to hear from Addenbrookes about its CQC inspection. During one of the very valuable quarterly liaison meetings that we have with the various trusts, four members attending had the opportunity to discuss the principles of their concerns about CQC inspections. Having gained further insight into the process and how it is	**Completed**

				carried out, those members recommend to their colleagues on the Health Committee that it would be inappropriate for the Chairman to write to the CQC at this time.	
185.	**Finance & Performance Report – November 2019**	**Liz Robin /**	Provide further information relating to the Ambulance Trust within C&CS Research	Research team has been asked for an update.	**Ongoing**

Meeting of 7th February 2019

196.	**Re-Commissioning of the Healthy Child Programme**	**Liz Robin**	Lead Members to do discuss how the Committee oversaw large amounts of performance data.	A review of performance data was being undertaken though which the views of Lead Members would be sought	**Ongoing March 2019**

Agenda Item No: 8

FINANCE AND PERFORMANCE REPORT – OUTTURN 2018/19

To:	**Health Committee**
Meeting Date:	**23rd May 2019**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**To provide the Committee with the Outturn 2018/19 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 2018/19.**
Recommendation:	**The Committee is asked to review and comment on the report and to note the finance and performance position as at the end of 2018/19.**

	Officer contact:		***Member contacts:***
Name:	Martin Wade	Names:	Councillor Peter Hudson
Post:	Strategic Finance Business Partner	Post:	Chairman Health Committee
Email:	martin.wade@cambridgeshire.gov.uk	Email:	peter.hudson@cambridgeshire.gov.uk
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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 OUTTURN 2018/19 FINANCE & PERFORMANCE REPORT

2.1 The Outturn 2018/19 Finance and Performance report is attached at Annex A.

2.2 The report shows the final outturn for the Public Health Directorate is an underspend of £604k, which is an increase of £130k since the previous forecast underspend (-£474k).

The main areas of underspend were the Public Health Directorate staffing budget (-£148k) and the Sexual Health and Contraception area (-£331k). More detail is available in Annex A, within paragraph 2.2 and Appendix 2.

Of the £604k underspend, £391k has been attributed to the Council's general reserve, and £213k has been attributed to the Public Health Grant ring-fenced reserve

Further detail on the outturn position can be found in Appendix 1.

2.4 The Public Health Service Performance Management Framework for March 2019 is contained within the report. Of the thirty one Health Committee performance indicators, nine are red, three are amber, sixteen are green and three have no status.

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

4.2.1 There are no significant implications for this priority

4.3 Statutory, Legal and Risk Implications

4.3.1 There are no significant implications within this category.

4.4 Equality and Diversity Implications

4.4.1 There are no significant implications within this category.

4.5 Engagement and Communications Implications

4.5.1 There are no significant implications within this category.

4.6 Localism and Local Member Involvement

4.6.1 There are no significant implications within this category.

4.7 Public Health Implications

4.7.1 There are no significant implications within this category.

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

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

From: Martin Wade **Agenda Item No: 8 – Appendix 1**

Tel.: 01223 699733

Date: 15th May 2019

Public Health Directorate

Finance and Performance Report – Closedown 2018/19

1 SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
Mar (No. of indicators)	9	3	16	3	31

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Outturn Variance (Feb) £000	Service	Budget for 2018/19 £000	Actual 2018/19 £000	Outturn Variance £000	Outturn Variance %
0	Children Health	9,266	9,230	-36	0%
0	Drug & Alcohol Misuse	5,625	5,583	-42	-1%
-331	Sexual Health & Contraception	5,157	4,826	-331	-6%
-50	Behaviour Change / Preventing Long Term Conditions	3,812	3,752	-59	-2%
0	Falls Prevention	80	73	-7	-9%
-8	General Prevention Activities	56	52	-4	-8%
0	Adult Mental Health & Community Safety	256	255	-1	0%
-85	Public Health Directorate	2,019	1,871	-148	-7%
-474	**Total Expenditure**	**26,271**	**25,642**	**-629**	**-2%**
0	Public Health Grant	-25,419	-25,419	0	0%
0	s75 Agreement NHSE-HIV	-144	-144	0	0%
0	Other Income	-40	-54	-14	-35%
0	Drawdown From Reserves	-39	0	39	100%
0	**Total Income**	**-25,642**	**-25,617**	**25**	**0%**
-474	**Net Total**	**629**	**25**	**-604**	**-96%**
83	Contribution to PH Reserve	0	213	213	-
-391	**Grand Total**	**629**	**238**	**-391**	**-62%**

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

As at the end of Closedown 2018/19, the Public Health Directorate have an underspend of -£604k. This is an increase of £130k compared to the previously forecast underspend of £474k.

Much of this underspend reflects preparation to deliver a FY £900k saving in the Public Health Directorate budget in 2019/20, which is required due to a further cash reduction in the national public health grant allocated to the Council. Where it made sense to implement 2019/20 savings early – for example not appointing to vacant posts where these were likely to be deleted in 2019/20, changing recharge arrangements for consumables in Long Acting Reversible Contraception services, and ceasing funding for a primary care health checks IT system that was not GDPR compliant – this was done in 2018/19.

An underspend of £148k in the Public Health Directorate staffing budget was largely as a result of posts (shared with Peterborough) which were proposed for 2019/20 savings relatively early 2018/19 and therefore held vacant for most of the year. In addition there were some posts which were vacant for part of the year and then reappointed to, which resulted in non-recurrent underspend.

An underspend of £331k in Sexual Health & Contraception was as a result of three main factors.

1. Access to Online Testing

A growing number of tests for Sexually Transmitted Infections (STIs) are available through ordering testing packs online and returning them for analysis. In Cambridgeshire for several years an online service has been commissioned for the 15 -24 year old Chlamydia Screening Programme.
In 2018/19 the Integrated Contraception and Sexual Health Service (iCaSH) commissioned from Cambridgeshire Community Services launched online testing for asymptomatic STIs. This service also included the online Chlamydia Screening Programme testing.
Funding from the online service for Chlamydia Screening Programme was released through decommissioning the previous online provider.
This funding will be transferred to CCS on confirmation of the supporting online data.

2. Long Acting Reversible Contraception.(LARC)

The cost of the recharges for the LARC devices have been re-negotiated with the Clinical Commissioning Group (CCG)

3. Out of Area GUM Activity

Additional funding had been allocated to out of area GUM activity which in 2017/18 had been overspent. However this increase was not sustained in 2018/19.

Several service areas identified small underspends at outturn including Children's Health, Drug & Alcohol and Behaviour Change/Preventing Long Term Conditions.

The County Council core budget allocated to the Public Health Directorate to supplement the national ring-fenced grant in 2018/19 was £391k, therefore the first call on any underspend up to that level is into the Council's general reserve. £391k underspend will therefore be transferred to the Council's general reserve, with a further £213k transferred to the Public Health Grant ring-fenced reserve.

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

The total Public Health ring-fenced grant allocation for 2018/19 is £26.253m, of which £25.419m 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.

- The indicators for people setting and achieving a four week quit remain still remain at red but with an upward trajectory. Everyone Health is exceeding its targets for quits for routine and manual workers but activity in primary care has been decreasing (See Appendix 6)
- Appendix 6 provides further commentary on the ongoing programme to improve performance and the impact of the new promotional campaign "missing moments" in Jan/Feb 2019 is being monitored.

National Child Measurement Programme (KPI 14 & 15)

- The coverage target for the programme was met in 2017/18 and data has been submitted to PHE. Updates on performance in last year's programme were provided in February 2019 performance report.
- Measurements for the 2018/19 programme are taken during the academic year and the programme commenced in November 2018.

NHS Health Checks (KPI 3 & 4)

- Indicator 3 for the number of health checks completed by GPs is reported on quarterly. Q4 is presented whilst this indicator is reporting as red it is comparable with performance from this time last year.
- The commentary provides more details on the outreach health checks provision measured in Indicator 4 which remains at red.

Lifestyles Services (KPI 5, 16-30)

- There are 16 Lifestyle Service indicators reported on, the overall performance is good with 9 green 2 amber and 5 red indicators.
- Appendix 6 provides further explanation of the red indicators for smoking cessation and the personal health trainer service. The commentary further explains performance against the proportion of Tier 2 clients completing weight loss interventions and subcontracting arrangements of which data from the first cohort is still pending.

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

The performance data provided reports on Q4 (Jan – March 2019) for the Health Visiting and School Nurse services.

Health Visiting

- Breast feeding rates in the county remain just above the challenging target of 56% and are significantly exceeding the national average of 45%. Performance for this indicator is green. Please see commentary for locality information.
- Health visiting mandated checks (face to face antenatal contact with HV from 28 weeks) quarter 4 shows an increase by 4% in performance of antenatal contacts achieved across the service in comparison to Q3.

Performance for this indicator is red. Appendix 6 provides a breakdown of performance across all localities.

- Health visiting mandated checks for new birth visits by a Health Visitor (within 14 days) and mandated checks for 6-8 week review are green. For the 6-8week checks the continuing good performance has meant the year to date performance has improved from 89% to 92%
- Health visiting mandated checks for 12-15 month review remain at amber for Q3. Performance has declined for Health Visiting mandated checks (% of children who receive a 2 – 2 ½ year review) with the indicator at red. The commentary provides further explanation of the performance issues for this target.

School Nursing

- Performance indicator 13 has been further broken down into number of calls made to the duty desk (13a) which has dropped this quarter (but still higher than Q2)
- The trajectory is showing an upward trend for indicator (13b) number of young people who access advise and support through Chat Health

Appendix 6 provides a more detailed analysis

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

The Q3 update was provided in the February finance and performance report. Q4 updated is pending.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Previous Outturn (Feb) £'000	Service	Budget 2018/19 £'000	Actual 2018/19 £'000	Outturn Variance £'000	%
	Children Health				
0	Children 0-5 PH Programme	7,253	7,253	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,706	1,670	-36	-2%
0	Children Mental Health	307	307	0	0%
0	**Children Health Total**	**9,266**	**9,230**	**-36**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,625	5,583	-42	-1%
0	**Drugs & Alcohol Total**	**5,625**	**5,583**	**-42**	**-1%**
	Sexual Health & Contraception				
-281	SH STI testing & treatment – Prescribed	3,829	3,596	-233	-6%
-50	SH Contraception - Prescribed	1,176	1,081	-95	-8%
0	SH Services Advice Prevn Promtn - Non-Presribed	152	149	-3	-2%
-331	**Sexual Health & Contraception Total**	**5,157**	**4,826**	**-331**	**-6%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	1,980	2,093	113	6%
0	Other Health Improvement	413	397	-16	-4%
-50	Smoking Cessation GP & Pharmacy	703	662	-42	-6%
0	NHS Health Checks Prog – Prescribed	716	601	-115	-16%
-50	**Behaviour Change / Preventing Long Term Conditions Total**	**3,812**	**3,752**	**-59**	**-2%**
	Falls Prevention				
0	Falls Prevention	80	73	-7	-9%
0	**Falls Prevention Total**	**80**	**73**	**-7**	**-9%**
	General Prevention Activities				
-8	General Prevention, Traveller Health	56	52	-4	-8%
-10	**General Prevention Activities Total**	**56**	**52**	**-4**	**-8%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	255	-1	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**255**	**-1**	**0%**

Previous Outturn (Feb) £'000	Service	Budget 2018/19 £'000	Actual 2018/19 £'000	Outturn Variance £'000	%
	Public Health Directorate				
0	Children Health	189	200	11	6%
0	Drugs & Alcohol	287	251	-36	-13%
0	Sexual Health & Contraception	164	153	-11	-7%
-75	Behaviour Change	753	697	-56	-7%
0	General Prevention	199	224	25	13%
0	Adult Mental Health	36	25	-11	-31%
-10	Health Protection	53	61	8	15%
0	Analysts	338	260	-78	-23%
-85		**2,019**	**1,871**	**-148**	**-7%**
-474	**Total Expenditure before Carry forward**	**26,271**	**25,642**	**-629**	**-2%**
83	**Contribution to Public Health grant reserve**	**0**	**0**	**213**	**-**
	Funded By				
0	Public Health Grant	-25,419	-25,419	0	0%
0	S75 Agreement NHSE HIV	-144	-144	0	0%
0	Other Income	-40	-54	-14	-35%
	Drawdown From Reserves	-39	0	39	100%
0	**Income Total**	**-25,642**	**-25,617**	**25**	**0%**
-391	**Net Total**	**629**	**238**	**-391**	**-62%**

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	Outturn Variance £'000	%
Sexual Health Testing and Treatment	**5,157**	**-331**	**-6%**
An underspend of £331k in Sexual Health & Contraception was as a result of three main factors. 1. Access to Online Testing A growing number of tests for Sexually Transmitted Infections (STIs) are available through ordering testing packs online and returning them for analysis. In Cambridgeshire for several years an online service has been commissioned for the 15 -24 year old Chlamydia Screening Programme. In 2018/19 the Integrated Contraception and Sexual Health Service (iCaSH) commissioned from Cambridgeshire Community Services launched online testing for asymptomatic STIs. This service also included the online Chlamydia Screening Programme testing. Funding from the online service for Chlamydia Screening Programme was released through decommissioning the previous online provider. This funding will be transferred to CCS on confirmation of the supporting online data. 2. Long Acting Reversible Contraception.(LARC) The cost of the recharges for the LARC devices have been re-negotiated with the Clinical Commissioning Group (CCG) 3. Out of Area GUM Activity Additional funding had been allocated to out of area GUM activity which in 2017/18 had been overspent. However this increase was not sustained in 2018/19.			
Public Health Directorate	**2,019**	**-148**	**-7%**
An underspend of £148k in the Public Health Directorate staffing budget was largely as a result of posts (shared with Peterborough) which were proposed for 2019/20 savings relatively early 2018/19 and therefore held vacant for most of the year. In addition there were some posts which were vacant for part of the year and then reappointed to, which resulted in non-recurrent underspend.			

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		Closing Balance 2018/19	Notes
		Movements in 2018/19	Balance at 31 March 2019		
	£'000	£'000	£'000	£'000	
General Reserve					Increase of +£643k, made up of:
					+£213k underspend 2018/19.
					+£668k prior year adjustments
					-£238k funding of delayed Healthy Child Programme saving to 19/20.
Public Health carry-forward	**1,040**	643	1,683	**1,683**	
subtotal	**1,040**	**643**	**1,683**	**1,683**	
Other Earmarked Funds					
Healthy Fenland Fund	300	-101	199	199	Spend £100k per year over 5 years.
Falls Prevention Fund	378	-107	271	271	Joint project with the NHS
NHS Healthchecks programme	270	0	270	270	
Implementation of Cambridgeshire Public Health Integration Strategy	579	-116	463	463	'Let's Get Moving' physical activity programme.
subtotal	**1,527**	**-324**	**1,203**	**1,203**	
TOTAL	**2,567**	**319**	**2,886**	**2,886**	

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

Fund Description	Balance at 31 March 2018	2018/19		Closing Balance 2018/19	Notes
		Movements in 2018/19	Balance at 31 March 2019		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	136	8	128	128	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**145**	**8**	**137**	**137**	

APPENDIX 6 PERFORMANCE

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

The Public Health Service Performance Management Framework (PMF) for March 2019 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+D9:O12	Mar-19	98%	98%	100%	102%	G	100%	98%	100%	↔	
2	GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	Mar-19	80%	80%	90%	113%	G	89%	80%	90%	↑	
3	Number of Health Checks completed (GPs)	Q4 (Jan-Mar)	18,000	18000	15498	86%	R	78%	4500	86%	↑	The focus this year has been on improving the quality of the data and this has led to more accurate recording of activity. There are currently many changes and increased demands being made upon primary care. GP practices. However this performance is comparable to last years
4	Number of outreach health checks carried out	Mar-19	1,800	1800	1221	68%	R	134%	108	81%	↓	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. This year has seen a range of innovative approaches which includes sessions in workplaces in Fenland where there are high risk workforces. Wisbech Job Centre Plus, community centres in areas that have high risk populations are ongoing, a mobile service and "pop up" shops opening.. Although there have been substantial efforts made to increase activity in Fenland there has been a overall percentage fall in Fenland from last year, though not to the levels in previous years.
5	Smoking Cessation - four week quitters	Feb-19	2154	1974	1489	75%	R	109%	156	99%	↓	• The main issue is the core Everyone Health service is exceeding its targets for number of quitters, from routine and manual groups, pregnant smokers and carbon monoxide verification rates. • In previous months quit rates from primary care have been falling some of this is due to poor data returns but generally activity has decreased. The Provider is asked to increase its support to practices to increase their engagement in delivering stop smoking services. .• The ongoing improvement represents work undertaken worth GP practices to improve their data returns by JCU staff. • There is an ongoing programme to improve performance that includes targeting routine and manual workers (rates are known to be higher in these groups) and the Fenland area. .• The new promotional campaign "missing moments" has secured a lot of local coverage. Any impacts upon Services will be monitored. •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% The end of year data will not be available until the end of June and this will include data from February and March in addition to the data trawls that are undertaken in practices..

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	Q4 Jan-Mar 2019	56%	56%	56%	100%	G	58%	56%	57%	↓	Despite being a challenging target and experiencing a 1 percentile decrease this quarter, county breastfeeding statistics remain just above the 56% target and significantly exceeding the national average of 45%. Across the year performance has fluctuated but has shown improvement over the last two quarters. Breastfeeding prevalence rates, which comprise of both exclusive breastfeeding and mixed feeding vary across the county. In February however, due to service redesign changes, the data for Huntingdonshire and Fenland have been amalgamated to form the North Locality area, whereas East Cambs has been included in the South Cambs and City data, therefore the disaggregated data cannot be comparable to previous quarters. Prevalence stands at 66% in the South Locality and 50% in the newly formed North Locality, it is expected that district level data will be available from Q1 2019/20. The Health Visiting service remains Stage 3 UNICEF Baby Friendly accredited, which demonstrates quality of care in terms of support, advice and guidance offered to parents/carers and the excellent knowledge that staff have in respect of responsive feeding.
7	Health visiting mandated check - Percentage of first face-to-face antenatal contact with a HV from 28 weeks	Q4 Jan-Mar 2019	50%	50%	21%	42%	R	19%	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. Service transformation, which has included use of the Benson Modelling tool to determine workforce required to deliver the service, has accounted for Health Visitors to be completing all antenatal contacts and will start to be worked against from April 2019. Quarter 4 shows an increase of 4% of antenatal contacts achieved across the service in comparison to quarter 3 and is comparable to Q2 performance. Despite these improvements, overall performance still remains significantly below target. Disaggregated into the two new Locality areas, the North team completed 38% of contacts, however the South Locality continues to face challenges, only achieving 5%. The provider reports that the South Cambs locality remains under pressure with its current staffing capacity and the staffing capacity tool has identified that for Q4 staffing reduced from 81% availability to 77%, which impacted on the mandated reviews. Staff engagement identified that the workforce do value the importance of this contact however feel processes challenges are an issue. These are being addressed and work is underway to streamline the waiting list to aid assessment and contact planning as well as improving communication with Maternity services. Monthly face to face HV/Midwifery meetings are being established to discuss identified vulnerable pregnant women and there is ongoing development to embed an electronic notification process. To mitigate the situation in the immediacy, a Business Continuity Plan has been implemented and a meeting has been scheduled to discuss next steps. Options include reviewing the frequency and delivery style of some clinics in the South Locality to include a greater skill mix, freeing up Health Visitors to complete more antenatal contacts and temporarily halting face to face contacts for universal families for the 12 month and 2-2.5 year reviews, instead offering them a letter containing an ASQ self-assessment, advising parents to get in contact if there are any concerns. It is anticipated performance will increase significantly from September, when 4 newly qualified Health Visitors come into post in the locality.
8	Health visiting mandated check - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days, by a health visitor	Q4 Jan-Mar 2019	90%	90%	94%	104%	G	95%	90%	93%	↓	The 10 - 14 day new birth visit remains consistent each month and numbers are exceeding the 90% target, despite a 2 percentile decrease this quarter. If those completed after 14 days are accounted for, the quarterly average increase to 97%.
9	Health visiting mandated check - Percentage of children who received a 6 - 8 week review	Q4 Jan-Mar 2019	90%	90%	91%	101%	G	93%	90%	93%	↔	Performance for the 6 - 8 week review has remained steady throughout the year and comparable to the previous quarter. The continuation of good performance has meant that the YTD performance has also improved, increasing from 89% to 92%, which is positive. During quarter 4, in some areas, as a temporary measure, universal pathway families have been invited to a clinic based appointment to build capacity elsewhere within the system. For universal plus/partnership plus families a home visit contact has been maintained.
10	Health visiting mandated check - Percentage of children who received a 12 month review by 15 months	Q4 Jan-Mar 2019	95%	95%	83%	87%	A	84%	95%	84%	↔	Performance has remained stable this quarter, standing at 84%; by comparison 79% of families received this visit by the time the child turned 12 months old. The inclusion of exception reporting would increase the quarterly performance to 97% of families having this review by the time the child turns 15 months, which would exceed the 95% target. Of all appointments offered this quarter, 156 were not wanted by the family and 86 were not attended. Assurances are in place to ensure vulnerable families (those on Universal Plus or Universal Partnership Plus pathways) are receiving this contact and an escalation plan is in place if these mandated visits are missed. A further 58 of contacts were 'not recorded'. The provider again cites pressures attributed to ongoing challenges in the South Locality and increased levels of short term sickness during the period.
11	Health visiting mandated check - Percentage of children who received a 2 -2.5 year review	Q4 Jan-Mar 2019	90%	90%	72%	80%	R	76%	90%	73%	↓	Despite demonstrating an upward trajectory over the course of the year, performance has declined from 76% to 73% over the duration of the quarter and continues to fall below the target threshold of 90%. The main cause of performance issues against this target was staffing and capacity challenges in the South Locality being exacerbated by short term sickness, resulting in performance reducing to 54% by this team in March, significantly impacting on overall figures. If exception reporting is accounted for, overall performance increases to 88%, a decrease of 7% from Q3. This quarter it was reported that 152 reviews were not wanted and 127 were not attended. 225 contacts were listed as 'not recorded', which has shown slippage compared to only 87 in Q3. The data indicates that non recorded contacts are predominantly an issue within the South Locality team and is being addressed with the provider through the Business Continuity Plan and options being considered in the Antenatal narrative.
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	Q4 Jan-Mar 2019	N/A	N/A	402	N/A	N/A	109	N/A	89	↓	The School Nursing service is actively delivering brief interventions for Healthy Weight, Mental Health, Sexual Health and Domestic Violence. There have also been 4 interventions in relation to immunisations undertaken this quarter. The numbers of brief interventions for Domestic Violence continues to be the highest recorded intervention young people are seeking support with (n=32), followed by Sexual Health (n=21) and Mental Health (n=19); there continues to be no young people seeking support for issues related to smoking or substance misuse. The provider reports that in the duration of the quarter, 573 CYP received a face-to-face intervention by the School Nursing team, however only 89 themed interventions were recorded. Work is to be conducted with the provider and their data analytics team to obtain a more rounded picture of what issues School Nurses are supporting young people with, including conducting an audit to check whether this is a recording issue.
13a	School nursing - number of calls made to the duty desk	Q4 Jan-Mar 2019	N/A	N/A	3269	N/A	N/A	1048	N/A	731	↓	The number of contacts to the Duty Desk made by telephone call, has dropped significantly this quarter, although it still higher than reported in Q2. In addition to phone contacts, this quarter there have been 2174 email contacts and 138 letter. This indicates that overwhelmingly email is the preferred method of communication into the duty desk, however further analysis is required to determine the proportion of professional contacts and those coming from young people or families. Furthermore, the provider has reported that there has been a 4.4% increase in the amount of young people requiring a 1:1 Intervention this quarter.
13b	School nursing - Number of children and young people who access health advices and support through Chat Health	Q4 Jan-Mar 2019	N/A	N/A	3936	N/A	N/A	1265	N/A	1548	↑	Chat Health continues to be well embedded as the universal offer for the School Nursing service and figures are showing continual improvement. Over the duration of the quarter there have been a total of 1548 text messages received from young people, resulting in 71 conversations. Analysis of contact attributes indicates that the majority of contacts relate to seeking emotional health and health wellbeing support (54%) and signposting to other services (31%), however further development is required to increase the number of attributes allocated to conversations - this will be picked up with the provider. Additionally, it is reported that the significant difference in figures are likely due to issues/queries being resolved by a singular message rather than requiring numerous message exchanges. ChatHealth is now available nationally to 2 million young people and CCS is the health provider nationally with the most usage of licences across the 4 Healthy Child Programme services the trust delivers, evidencing that it is the right service for this cohort of people and that you can deliver this service in non traditional ways.

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)	Mar-19	>90%	65%	68%	110%	G	57.0%	90%	57%	⇐⇒	The National Child Measurement Programme (NCMP) has been completed for the 2017/18 academic year. The coverage target was met and the measurement data has been submitted to the PHE in line with the required timeline. The current programme is on track. It is difficult to develop a trajectory for this as it depends on school availability for the measuring team to visit.
15	Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	Mar-19	>90%	55%	58%	105%	G	50.0%	90%	50%	⇐⇒	
16	Overall referrals to the service	Mar-19	5300	5300	6236	118%	G	218%	318	256%	↑	
17	Personal Health Trainer Service - number of Personal Health Plans produced (PHPs) **(Pre-existing GP based service)**	Mar-19	1670	1670	1244	74%	R	99%	100	182%	↑	Although this indicator is still red overall there has been a general improvement in recent months . This reflects the appointment of two new Health Trainers to fill two empty posts.. Lack of capacity had compromised the ability of the Service to develop PHPs. The increased performance has not been large enough to compensate for lack of capacity earlier in the year.
18	Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	Mar-19	1252	1252	1126	90%	A	82%	75	93%	↑	The continued improvement reflects the increase in capacity .
19	Number of physical activity groups held **(Pre-existing GP based service)**	Mar-19	730	730	1028	141%	G	120%	44	118%	↓	
20	Number of healthy eating groups held **(Pre-existing GP based service)**	Mar-19	495	495	479	97%	A	70%	30	116%	↑	
21	Personal Health Trainer Service - number of PHPs produced (Extended Service)	Mar-19	800	800	863	108%	G	119%	48	329%	↑	
22	Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	Mar-19	650	650	537	83%	R	61%	39	85%	↑	There is a continued upward trend but again lack of capacity earlier in the year has compromised end of year delivery.
23	Number of physical activity groups held (Extended Service)	Mar-19	830	830	869	105%	G	212%	50	300%	↑	
24	Number of healthy eating groups held (Extended Service)	Mar-19	570	570	572	100%	G	142%	50	216%	↑	Although still rated amber the Service is performing well and the trajectory remains upward.
25	Proportion of Tier 2 clients completing the intervention who have achieved 5% weight loss.	Mar-19	30%	30%	26%	86.7%	R	17%	30%	17%	⇐⇒	This has been an ongoing issue and in October Weight Watchers and Slimming World were subcontracted to provide a percentage of the Tier 2 service. The first cohorts completed courses in February. However clients were also asked to engage with some physical activity sessions. in line with NICE Guidance but not part of the Sliming World or Weight Watcher sessions These were not popular and a number of people did not continue. The course has now been re-modelled .
26	Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	Mar-19	60%	60%	59%	98%	G	71%	60%	75%	↑	

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
27	% of children recruited who complete the weight management programme and maintain or reduce their BMI Z score by agreed amounts	Mar-19	80%	80%	67%	84%	R	0%	80%	0%	←→	A new programme has commenced. A lot of work has been undertaken to increase engagement but it remains challenging. However there has been a recent improvement that reflects a more effective use of NCMP data to secure referrals.
28	Number of referrals received for multi factorial risk assessment for Falls Prevention	Mar-19	520	520	1109	213%	G	661%	31	671%	↑	
29	Number of Multi Factorial Risk Assessments Completed - Falls Prevention	Mar-19	442	442	710	161%	G	159%	27	181%	↑	
30	Number clients completing their PHP - Falls Prevention	Mar-19	331	331	355	107%	G	110%	20	160%	↑	

* All figures received in April 2019 relate to March 2019 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 Q3

Q4 (year-end) update to be provided on receipt of final Q4 returns from services.

SUMMARY

Directorate	YTD (Q3) expected spend	YTD (Q3) actual spend	Variance
P&C	£223,500	£220,889	£2,611
ETE	£90,000	£89,796	£204
CS&T	£150,750	£150,750	0
LGSS	£165,000	£165,000	0
TOTAL Q3	**£629,250**	**£626,435**	**£2,815**

Agenda Item No: 9

REPORT TITLE: RECOMMISSIONING SEXUAL HEALTH SERVICES

To:	**Health Committee**
Meeting Date:	**May 23rd 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**To secure the support of the Health Committee for undertaking a competitive tender for Integrated Sexual Health Services across Cambridgeshire and Peterborough as a shared service established through one contract.**
Recommendation:	**The Health Committee is asked to support and approve the following.** **a) The undertaking of a competitive tender for Integrated Contraception and Sexual Health Services as a shared service contracted to work across Cambridgeshire County Council and Peterborough City Council areas.** **b) The establishment of a legal agreement between Cambridgeshire County Council and Peterborough City Council that assigns Cambridgeshire County Council as the lead commissioner.** **c) Delegate sign off for the agreement to the Director of Public Health in consultation with the Chair and Vice Chair of the Committee.**

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

1.1 Since 1st April 2013, Local Authorities (LAs) have a statutory duty to commission a wide range of Sexual and Reproductive Health (SRH) services as part of their wider public health responsibilities.

1.2 In 2014 Cambridgeshire County Council (CCC) awarded the contract to Cambridgeshire Community Services (CCS) to establish a community based integrated service model that brought together contraception and sexual health into one service provided in one location, thereby improving accessibility to different related services. In addition the Integrated Contraception and Sexual Health Services (iCaSH) expanded delivery of the full range of the services to all areas of the County, including Fenland, where previously service users had to travel to Kings Lyne or Peterborough to access the full range of services.

2. MAIN ISSUES

2.1 The current CCC contract for iCaSH services ends on the 31st March 2020, there are no further contract extensions available.

2.2 Peterborough City Council (PCC) also has a contract with CCS to provide iCaSH services. Its contract also ends on the 31st March 2020, again without the option of any further contract extensions.

2.3 It is proposed to undertake a joint procurement between CCC and PCC for a shared service to be delivered across Cambridgeshire and Peterborough. CCC will be the lead commissioner and hold the contract with the successful bidder. A legal agreement between the two local authorities will capture this and provide the appropriate assurances for the new contract that will start in April 2020.

2.4 The rationale for establishing a shared contract with a lead commissioning organisation is that it affords the potential of a more cost-effective service model.

2.5 In addition Public Health England (PHE) invited Cambridgeshire and Peterborough local authorities to be one of two local systems that it is sponsoring to undertake a feasibility study of collaborative commissioning for Sexual and Reproductive Health (SRH) services. It invited commissioners from the two Local Authorities, the Clinical Commissioning Group (CCG) and NHS England (NHSE) from across Cambridgeshire and Peterborough to explore together opportunities for future alignment and collaborative commissioning opportunities for Sexual and Reproductive Health (SRH) services in the area.
The Health Committee previously approved in May 2018 PHE's invitation and authorised Public Health commissioners to work with colleagues from the CCG and NHSE to support the development of a more efficient and cost-effective system wide approach to the commissioning of SRH services.

2.6 The commissioners from these organisations have been exploring different collaborative options. Following a workshop attended by a range of commissioners and providers, a number of priority areas were agreed and are currently in development with the aim of reflecting them in a new iCaSH service model.

2.7 There are other factors that will require consideration during the procurement.

- Nationally there are many new developments that are influencing the delivery of iCaSH services that have the potential to deliver efficiencies but are also essential if mange any increase in demand for sexual health services. For example increased digitalisation of services.
- The CCC and PCC areas are very different in terms of needs and patient profiles, which demands a wider range of consultation events to ensure that the new service can address these needs and manage demand effectively.
- CCS is the main provider of sexual health services across the region and the market will require stimulation if there is to be robust competitive process.

2.8 The contract value exceeds £500,000 and therefore the award of contract will be a key decision, and a separate paper will be brought to Committee to approve the relevant delegations.

The current funding allocated to CCC and PCC iCaSH contracts are as follows.

- CCC annual contract value: £3,230,418
- PCC annual contract value: £1,566,298

It is proposed that the new contract will have a maximum length of 5 years with potential breaks at the third and fourth years.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The report above sets out the implications for this priority in **1.2 and 2.7**

3.2 Thriving places for people to live

The report above sets out the implications for this priority in **1.2 and 2.7**

3.3 The best start for Cambridgeshire's children

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

Young people are especially at risk of sexual ill health. The new Service will be required to responsive to the needs of young people and ensure that any service provision includes appropriate prevention messages.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

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

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

4.3 Statutory, Legal and Risk Implications

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

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

4.4 Equality and Diversity Implications

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

- Any equality and diversity implications will be included in the consultation for the new Service. A Community Impact Assessment will be completed.

4.5 Engagement and Communications Implications

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

- The new procurement will include consultation with service providers and users.

4.6 Localism and Local Member Involvement

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

- The commissioning of sexual health prevention services will involve working with individuals and communities to identify how they can best protect and improve their sexual health.

4.7 Public Health Implications

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

- The re-commission will improve the sexual health of the population through providing an accessible service that promptly treats sexual transmitted infections and provides contraception.

- The new service will be universal but will need to include targeted actions to address any inequalities and improve the outcomes for the most vulnerable and at risk populations.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes : 15 May 2019 Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes : 15 May 2019 Name of Officer: Gus de Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes : 15 May 2019 Name of Legal Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes : 15 May 2019 Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

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

Agenda Item No: 10

INTERIM CONTRACT FOR THE PREVENTION OF SEXUAL ILL HEALTH SERVICES

To: **Health Committee**

Meeting Date: **23 May 2019**

From: **Director of Public Health**

Electoral division(s): **All**

Forward Plan ref: **n/a** *Key decision:* **No**

Purpose: **To seek the support and approval of the Health Committee for the following.**

a) To award an interim contract for the delivery of the Prevention of Sexual Ill Health Services to the current provider, DHIVERSE. This Cambridgeshire County Council interim contract will run for six months commencing October 1 2019 and terminate on the 31 March 2020

b) To re-commission the Prevention of Sexual Ill Health Service as a shared service across Cambridgeshire County Council and PCC.

Recommendation: **The Health Committee is asked to agree the following.**

The award of an interim contract for the Prevention of Sexual Ill Health Service

a) Review the rationale for the request to award an interim contract.
b) Support the interim contract being awarded to DHIVERSE for the delivery of the Prevention of Sexual Ill Health Service in Cambridgeshire.

If the request is supported to agree the following.

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

d) **Authorise the Consultant in Public Health, Health Improvement, in consultation with the Executive Director of LGSS Law to approve and complete the necessary contract documentation.**

<u>Recommissioning The Prevention of Sexual Ill Health Services</u>

a) **Support a competitive procurement for the re-commission of the Prevention of Sexual Ill Health Service as a shared service contracted to work across the Cambridgeshire County Council and Peterborough City Council areas.**

If the request is supported to agree the following.

b) **The establishment of a legal agreement between Cambridgeshire County Council and Peterborough City Council that assigns Cambridgeshire County Council as the lead commissioner.**
c) **Delegate sign off for the agreement to the Director of Public Health in consultation with the Chair and Vice Chair of the Committee.**
d) **Authorise the Director of Public Health, in consultation with the Chairman and Vice Chairman of the Health Committee, to formally award the new shared contract, effective from April 2020, subject to compliance with all the required legal processes.**
e) **Authorise the Consultant in Public Health, Health Improvement, in consultation with the Executive Director of LGSS Law to approve and complete the necessary contract documentation.**

	Officer contact:		***Member contacts:***
Name:	Val Thomas	Names:	Peter Hudson
Post:	Consultant in Public Health	Post:	Chair
Email:	Val.Thomas@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 703265	Tel:	01223 706398 (office)

1. BACKGROUND

1.1 Cambridgeshire County Council (CCC) commissions the voluntary organisation DHIVERSE to provide the Prevention of Sexual Ill Health Service across Cambridgeshire. The aim of this Service is to contribute to the improvement of sexual health through enabling Cambridgeshire residents to make informed, healthy and responsible choices around their sexual health, as it relates to themselves and their sexual partners. It contributes to the achievement of a number of high level high level public health outcomes.

- Under 18's conceptions
- Improving late HIV diagnosis rates
- Reducing sexually transmitted infections and specifically HIV infection
- Reducing inequalities in sexual health
- Reducing the stigma associated with HIV and other sexually transmitted infections

For Cambridgeshire reducing the number of under 18s conception rate in Fenland and the number of late HIV diagnosis are particular challenges.

1.2 The contract also includes the requirement to provide HIV support services funded by CCC Adult Social care which Public Health commissions on its behalf.

1.3 Specific service deliverables are focused on the following activities.

- Provide general and targeted information to improve knowledge and awareness of sexual health and contraception issues through promotional activities and campaigns using appropriate media for the target population groups, which includes all age groups.
- Increase awareness and knowledge about late testing for HIV; targeting high risk groups.
- Build capacity and skills for improving sexual health by working with partner organisations, communities and target groups and through providing a range of interventions which include appropriate presentations/workshops/groups sessions/online fora.
- Provide advice, information and support to enable adults living with HIV to continue to live independently in the community.

1.4 The current DHIVERSE contract commenced in October 1st 2016 and will end on the 30th. September 2019. Throughout the course of the contract DHIVERSE has consistently achieved its key performance indicators.

2. MAIN ISSUES

2.1 The context for the request for an interim contract is that it will enable the CCC Prevention of Sexual Ill Health service contract to be aligned with the one held by Peterborough City Council (PCC) which ends on the 31st March 2020. Then secondly for a joint procurement and contract to be undertaken for a Prevention of Sexual Ill Health Service across the two local authority areas during 2019/20, commencing on April 1 2020.

2.2 Therefore the proposal is for the award of an interim contract to the current provider DHIVERSE from October 1st 2019 to March 31st 2020.

2.3 The current value of the DHIVERSE contract is £130,000 per annum. This includes the contribution of £27,000 from Adult Social Care. The value of the proposed interim contract is £65,000.

2.4 It is proposed to undertake a joint procurement between CCC and PCC for a shared service to be delivered across Cambridgeshire and Peterborough with CCC as the lead commissioner. A legal agreement between the two local authorities will capture this and provide the appropriate assurances for the new contract that will start in April 2020.

2.5 The value of the proposed new shared service contract for the Prevention of Sexual Ill Health Service across the CCC and PCC areas is below £500,000 for a three year contract. The funding allocations made by CCC and PCC are as follows.

- CCC annual value: £130,000 including the £27,000 contribution form Adult Social Care.
- PCC annual value: This is to be confirmed.

2.6 There are a number of benefits associated with this proposal.

- The rational for having one contract for both Authorities is that it has the potential for the more effective use of resources.
- During 2019/20 the Integrated Contraception and Sexual Health Services (iCaSH) are being commissioned as one contract for a shared service across the two Authorities. The Prevention and the iCaSH services work collaboratively in some aspects of their work. This will enable any synergies between the contracts to be considered in the development of the two service specifications.
- The focus of the Prevention of Sexual Ill Health Service is generally non-clinical and provision is usually from the voluntary sector. Across Cambridgeshire and Peterborough there are a small number of voluntary organisations, each have varied experiences and skills in relation to sexual health prevention and HIV support. A procurement that favours a collaborative approach between voluntary organisations would enable the best use of experience and skills.

2.7 The following alternative options have been considered

a) Do not award an interim contract but accelerate the commissioning process.
The advantages of shared contract with PCC would not be realised along with the opportunity to develop through consultation a new more collaborative approach amongst voluntary sector providers.

b) Undertaking a competitive tender for an interim period.
Completing a tender for a maximum contract length of 6 months raises a number of issues.
- Competitive retendering within the short time frame would be very challenging, impacting upon the quality of the exercise and award result.
- Multiple short term procurements are discouraged due to the destabilising effect on service provision and staffing.

2.8 The risks associated with this proposal for a direct award reflect the legal position Advice has been sought from the legal and procurement teams in both CCC and PCC and is summarised as follows.

a) It is only a short term arrangement and the intention is to proceed with a procurement process during 2019.
b) The Authority could issue a Voluntary Ex Ante Transparency Notice (VEAT) as a means of advertising the intention to let a contract without opening it up to formal competition. The VEAT notice would provide sufficient information for the justification of the decision and would allow potential providers the opportunity to challenge the approach. This reduces the risk of claims against a direct award of the contract by the Local Authorities being upheld and it does demonstrate transparency. The use of VEAT notice in this case was considered to be inappropriate for such a low value and short length contract.
c) The publication of similar notice, in the interest of transparency, on the procurement portal, Pro-Contract, was the recommended approach.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The report above sets out the implications for this priority in **1.1, 1.2 and 1.3**

3.2 Thriving places for people to live

The report above sets out the implications for this priority in **1.1, 1.2 and 1.3**

3.3 The best start for Cambridgeshire's children

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

Young people are especially at risk of sexual ill health. This Service targets young people with prevention messages and skills to avoid risk taking behaviour.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

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

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

4.3 Statutory, Legal and Risk Implications

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

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

4.4 Equality and Diversity Implications

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

- The current Service is required to demonstrate that it is accessible to the whole population including those groups hard to reach and high risk.
- Any equality and diversity implications will be included in the consultation for the new Service. A Community Impact Assessment will be completed.

4.5 Engagement and Communications Implications

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

- The current Service has remit to communicate and engage with communities and groups.
- The new procurement will include consultation with service providers and users.

4.6 Localism and Local Member Involvement

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

- The commissioning of sexual health prevention services will involve working with individuals and communities to identify how they can best protect and improve their sexual health.

4.7 Public Health Implications

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

- The re-commission will improve the sexual health of the population through interventions designed to prevent sexual ill health

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

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes : 15 May 2019 Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes : 15 May 2019 Name of Officer: Gus de Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes : 15 May 2019 Name of Legal Officer: Fiona McMillan
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 : 15 May 2019 Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Liz Robin

Source Documents	Location
None	

Agenda Item No: 11

COMMISSIONING INTEGRATED LIFESTYLE SERVICES

To:	**Health Committee**
Meeting Date:	**May 23rd 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**To secure the support of the Health Committee for undertaking a competitive tender for Integrated Lifestyle Services across Cambridgeshire County Council and Peterborough City Council as a shared service established through one contract.**
Recommendation:	**The Health Committee is asked to support and approve the following.**

a) The undertaking of a competitive tender for Integrated Lifestyle Services as a shared service contracted to work across Cambridgeshire County Council and Peterborough City Council areas.
b) The establishment of a legal agreement between Cambridgeshire County Council and Peterborough City Council that assigns Cambridgeshire County Council as the lead commissioner.
c) Delegate sign off for the agreement to the Director of Public Health in consultation with the Chair and Vice Chair of the Committee.

	Officer contact:		***Member contacts:***
Name:	Val Thomas	Names:	Peter Hudson
Post:	Consultant in Public Health	Post:	Chair
Email:	Val.Thomas@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01223 703264	Tel:	01223 706398

1. BACKGROUND

1.1 In 2015 Cambridgeshire County Council awarded the contract for Integrated Lifestyle Services to Sports and Leisure Management Ltd. (SLM) to be provided through its Public Health division Everyone Health.

1.2 The Integrated Lifestyle Service includes a number of services that support individuals and communities to adopt healthier lifestyle behaviours. It supports improvements in the following Public Health Outcomes Framework indicators.

- Smoking prevalence
- Excess weight in adults
- Excess weight in children
- Physical inactivity in adults and children
- Diabetes
- NHS Health Checks

1.3 The Service beings together a number of services that focus upon promoting the adoption of healthy lifestyle behaviours and the prevention of associated poor health outcomes at universal and individual levels. It is provided across the county but in areas in health inequalities there is a higher level of service delivery. These include the following:

- Health Trainers – provide support for up to year for individuals to make changes to their health behaviours.
- Specialist Stop Smoking Services
- The three tiers of Adult Weight Management Services.
- Children's Weight Management Services.
- Community based physical activity and healthy eating interventions
- Outreach Health Checks
- Motivational behaviour change interventions training
- National Child Measurement Programme

1.4 During the course of the contract services have been developed and "specialist" health trainers have been introduced in the Service. These focus on providing falls prevention, substance misuse and mental health promotion and training.

1.5 Tier three weight management services are specialised and treat patients with complex conditions. Everyone Health sub-contracts this service to Cambridge University Hospital (CUH). More recently since October 2018 it sub-contracted some of its Tier 2 service weight management for less complex services activity to Slimming World and Weight Watchers (now known as WW)

1.6 The rationale for integrating the different services is that it has enabled the development of pathways between the different types of provision. Consequently service users are able to move easily to different services as very often they have multiple needs or may require over time a less intensive service.

2. MAIN ISSUES

2.1 The CCC contract with SLM Ltd. /Everyone Health ends on the 31st March 2020, any extension is not an available option.

2.2 Currently PCC commissions a comparable Integrated Lifestyle Service from the company Solutions 4 Health. It provides a similar range of services but it does not include specialist mental health or substance misuse health trainers. It did until 2019/20 subcontract its tier 3 adult weight management services to CUH. This contract also ends on 31st March 2020.

2.3 It is proposed to undertake a joint procurement between CCC and PCC for a shared service to be delivered across Cambridgeshire and Peterborough with CCC as the lead commissioner. A legal agreement between the two local authorities will capture this and provide the appropriate assurances.

2.4 The rationale for establishing a shared contract with a lead commissioning organisation is that it affords the potential of a more cost-effective service model.

2.5 The procurement will include consideration of number of factors.

- Integrated Lifestyle Services support a number of key strategic drivers in the system, these include STP priorities and the focus upon integrated place based approaches. These will need to be explored to identify how the model could be developed and strengthened.
- Public Health has been commissioning integrated lifestyle services for ten years which has led to a range of service developments and learning that will need to reflected in any new service specification
- The CCC and PCC areas are very different in terms of needs and patient profiles, which demands a wider range of consultation events to ensure that the new service can address these needs and manage demand effectively.
- The provider landscape for lifestyle service delivery is changing and robust market testing will be required.

2.6 The contract value exceeds £500,000 and therefore the contract award is a key decision. A separate paper will be brought back to Committee to approve the appropriate delegations.

The current funding allocated to CCC and PCC is as follows.

CCC annual value: £2,223,839
PCC annual value: £832,336

2.7 The CCC value includes £142,866 funding for the tier 3 weight management services from the Clinical Commissioning Group (CCG) through a Section 256, which is just under 50% of the funding required for the Service.
Similarly the CCG funds100% of the PCC tier 3 weight management service, at a value of

£85,000. However this funding is currently being reviewed.
Any additional external funding will need to be agreed before tendering the Services.

2.8 It is proposed that the new contract will have a maximum length of 5 years with potential breaks at the third and fourth years.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The report above sets out the implications for this priority in **1.2, 1.3, 1.4, 1.5, and 1.6**

3.2 Thriving places for people to live

The report above sets out the implications for this priority in **1.2, 1.3, 1.4, 1.5, and 1.6**

3.3 The best start for Cambridgeshire's children

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

The Integrated Lifestyle Service provides child weight management services and also many of its other interventions adopt an approach that involves all members of the family.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in ***2.6 and 2.7***

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

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

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

4.3 Statutory, Legal and Risk Implications

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

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

4.4 Equality and Diversity Implications

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

- Any equality and diversity implications will be included in the consultation for the new Service. A Community Impact Assessment will be completed.

4.5 Engagement and Communications Implications

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

- The new procurement will include consultation with service providers and users.

4.6 Localism and Local Member Involvement

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

- The commissioning of Integrated Lifestyle Services will involve working with individuals and communities to identify how they can best protect and improve their health and wellbeing.

4.7 Public Health Implications

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

- The re-commission will improve the health of the population through providing support for individuals and communities to adopt healthier lifestyle behaviours to improve their health outcomes.
- The new service will be universal but will need to include targeted actions to address any inequalities and improve the outcomes for the most vulnerable and at risk populations.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes : 15 May 2019 Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes : 15 May 2019 Name of Officer: Gus de Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes : 15 May 2019 Name of Legal Officer: Fiona McMillan

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 : 15 May 2019 Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Liz Robin

Source Documents	**Location**
None	.

Agenda Item No: 12

LETS GET MOVING PHYSICAL ACTIVITY PROGRAMME UPDATE

To:	**Health Committee**
Meeting Date:	**May 23rd 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**The purpose of this paper is to provide further information regarding the Lets Get Moving physical activity Programme funded by the Health Committee from Public Health Reserves.**
Recommendation:	**The Committee is asked to review the progress report and support the following recommendations.**

a) Acknowledge the ongoing development and positive progress achieved by Let's Get Moving.
b) Acknowledge that Let's Get Moving is contributing to the establishment of sustainable physical activity programmes in Cambridgeshire communities.

	Officer contact:		***Member contacts:***
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Tel:	01223 703264	Tel:	01223 706398 (office)

1. BACKGROUND

1.1 In 2016 Health Committee approved £513,000 to fund over two years the countywide physical activity programme, Let's Get Moving from Public Health Reserves. The funding was scheduled to end in April 2019. However in December 2018 the Health Committee approved additional funding that would enable to Programme to run until June 2020.

1.2 The Programme is being closely monitored to provide evidence of its impact, effectiveness and its potential for cost benefits. This report provides an update on its ongoing development and progress to date along with information about its sustainability across the County.

1.3 The Lets Get Moving Programme proposal was developed as a collaborative initiative between the district councils, their partners and County Sports Partnership Living Sport, to provide a countywide physical activity that would increase levels of physical activity programme especially in areas of and groups with lower levels with high needs. It has a key role in the delivery of the Cambridgeshire Healthy Weight Strategy with its central themes of collaboration across the system to support healthy behavioural change and communities taking responsibility for their health and wellbeing. These themes and objectives are reflected in the Lets Get Moving Programme which focuses upon increasing levels of physical activity through engaging local communities in the use of the district council facilities to a level that will enable them to become self-sustaining.

2. MAIN ISSUES

2.1 The Health Committee received a paper in December 2018 that described the impact, innovation, increased opportunities and engagement of individuals and communities in physical activity through the LGM Programme. However demonstrating the impact of behaviour change programmes presents challenges. The data for the first year of the Programme was promising but it is difficult to capture behavioural change outputs from initiatives. The recommendation was to extend funding but to use the learning from the first period of the Programme to inform its ongoing development and more effective data capture that would provide a more robust analysis of the impact of LGM.

2.2 The attached supporting paper (Appendix 1) describes the impacts and outputs of the first eighteen months of the Programme. However it also describes the challenges that the Programme has faced and how the programme has evolved to increase participation and importantly the steps that have been taken to improve the collection of more robust data to evidence its impact. The LGM Programme is a new way of working in Cambridgeshire and its development has been an iterative process. Consequently this first period has acted as a pilot Programme. The extension of the funding is enabling this learning to be applied so that its positive impacts can be robustly demonstrated.

2.3 The supporting LGM paper presents evidence that offer support for the Programme's achievement of its objectives

Let's Get Moving Key Objectives and Outputs

- **Fewer inactive people in Cambridgeshire**: 51% of participants increased their physical activity levels.
- **More adults achieving Chief Medical Officer (CMO) guidelines for physical activity**: 37% of participants were achieving CMO recommended levels of physical activity 3 months after joining the Programme.
- **More opportunities to be physically active in deprived areas**: 85 new programmes developed, over half of which are in the most deprived areas in each district.
- **Communities taking ownership of their health and wellbeing**: 45% of new programmes developed are sustained, without ongoing support from LGM, 6 months after initiation through community ownership.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

The report above sets out the implications for this priority in **2.3**

3.2 Thriving places for people to live

The report above sets out the implications for this priority in **2.3**

3.3 The best start for Cambridgeshire's children

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

- The LGM Programme aims to increase the levels of physical activity in population especially amongst those individuals, families and children who are more inactive.

- Supporting children to become physically active is associated with physical and mental health benefits along with improvements in attainment.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in *1.1*

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There is no significant implications within this category in this paper. Any implications regarding it were addressed in an earlier when the funding was awarded.

4.3 Statutory, Legal and Risk Implications

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

- Physical inactivity can have a wide ranging negative impact on the health and wellbeing of the population. In the past 20 years rates have increased dramatically
- If this increase is not addressed there is very high risk that there will be an increased burden of related disease that ill impact heavily upon health and social care services.

4.4 Equality and Diversity Implications

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

- LGM is a universal programme but it includes targeted approaches in areas and with population groups that have the greatest needs.

4.5 Engagement and Communications Implications

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

- Central to LGM is the engagement of individuals and communities in the Programme, enabling them to take responsibility for their health

4.6 Localism and Local Member Involvement

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

- LGM works with individuals and communities across the whole of Cambridgeshire to support their engagement with the Programme**.**

4.7 Public Health Implications

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

- Physical inactivity is a major public health issue due to its substantial impact of health.
- It requires a wide range of interventions that address the varying needs of different communities
- These will need to include targeted actions that will address the inequalities associated with unhealthy weight and are indicated in the Strategy

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes : 15 May 2019 Name of Financial Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes : 15 May 2019 Name of Officer: Gus de Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes : 15 May 2019 Name of Legal Officer: Fiona McMillan
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 : 15 May 2019 Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Liz Robin

Source Documents	Location
Physical activity: applying All Our Health: Public Health England 2018	https://www.gov.uk/government/publications/physical-activity-applying-all-our-health/physical-activity-applying-all-our-health
Start Active Stay Active: Chief Medical Officer's Physical Activity Guidance 2011. Department of Health and Social Care	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf

Let's Get Moving Cambridgeshire

Pilot Study (Phase 1) Report

Roz Fitches

Insight Coordinator – Living Sport

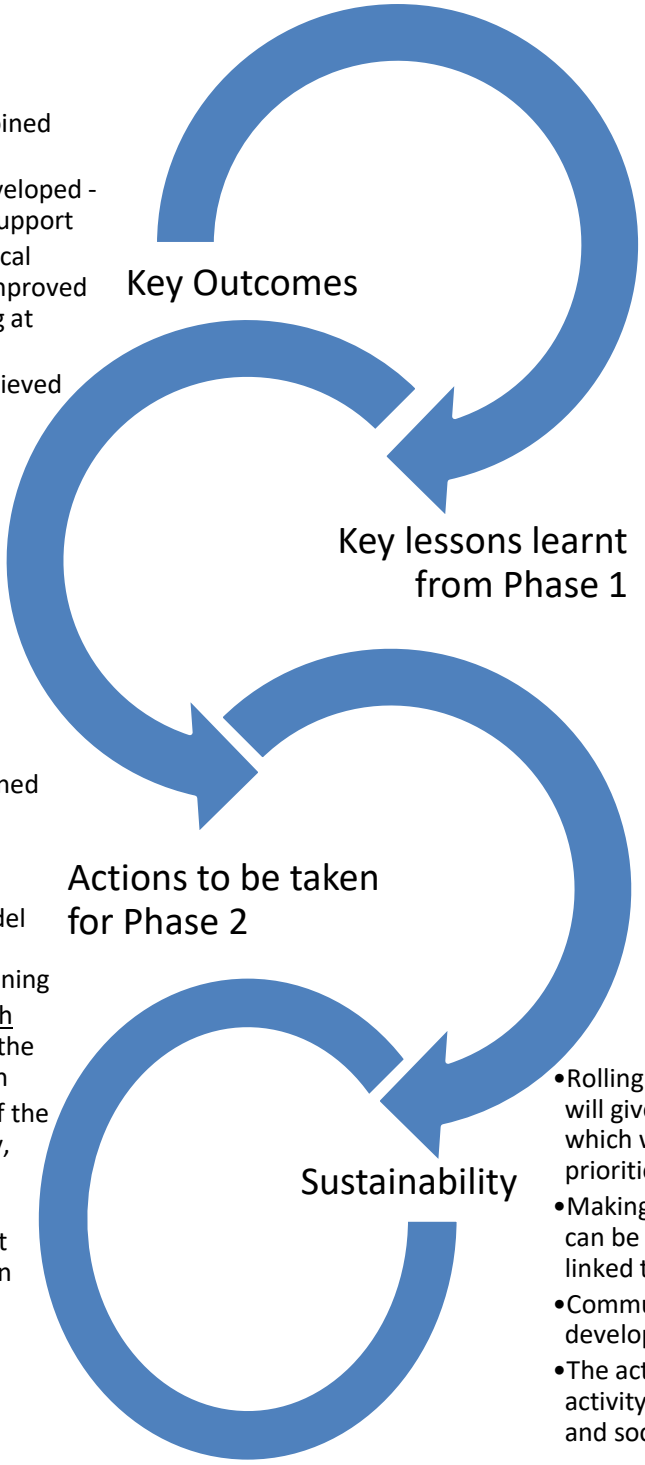
Michael Firek

Physical Activity Projects Manager – Living Sport

March 2019

This document provides an account of the first phase of the Let's Get Moving (LGM) Programme. It introduces LGM in terms of how it adds value to other priorities across the County, and identifies the impact it has had to date as a recipient of Health Committee funding. It presents both what has worked and what hasn't, and therefore highlights the key lessons learnt and the actions taken to enhance both the quality and quantity of Phase

Report Summary
Findings from the Pilot Study (Phase 1) of the
Let's Get Moving (LGM) Programme[1]



- 4079 new participants joined LGM
- 85 new programmes developed - 45% sustained without support
- 51% had improved physical activity level, 63% had improved level of mental wellbeing at follow-up
- 72% fully or partially achieved their goal at follow-up

- (1) A more pragmatic approach to data collection for physical activity programmes is needed
- (2) Using an established brand helps to share consistent messages around physical activity and mental wellbeing
- (3) Universal programmes of physical activity where there's an achievable entry level and progression pathway have been most successful
- (4) An asset-based approach is effective for community engagement
- (5) A whole system approach is needed, working with key partners that have a role to play in identifying and engaging with the least active

- (1) Behaviour change questionnaire to be simplified and data collection process tightened
- (2) Brand re-launch
- (3) Scaling up of programmes including developing a cycling model following success of that used for walking and running
- (4) Continue to work with communities to identify the right people to work with
- (5) Scale up the model of the physical activity pathway, embedded into social prescribing practice
- (6) Return on Investment analysis to be undertaken

- Rolling out of an online data collection model will give a more consistent, effective approach which will allow time for focus on other priorities
- Making brand visible and effective, ensuring it can be a platform for public health messages linked to physical activity
- Community ownership of activities, through developing leaders from within communities
- The actions we've taken have ensured physical activity is integral to the prevention agenda and social prescribing movement

[1] Results are based on those who responded to the questionnaire at baseline and 3 month follow-up

1. PURPOSE

This Report is to build on the information previously provided to the Health Committee of the progress that the Let's Get Moving programme has made in delivering its objectives. In 2016 the Health Committee approved £513,000 to fund over two years a countywide physical activity programme. The Let's Get Moving Programme proposal was developed as a collaborative initiative between the district councils, their partners and the Cambridgeshire and Peterborough Active Partnership Living Sport, to provide a countywide physical activity programme that would increase levels of physical activity, especially in areas of, and groups with, lower levels of physical activity with high needs. It has a key role in the delivery of the Cambridgeshire Healthy Weight Strategy with its central themes of collaboration across the system to support healthy behavioural change and communities taking responsibility for their health and wellbeing. These themes and objectives are reflected in the Let's Get Moving Programme which focuses upon increasing levels of physical activity amongst the inactive and engaging local communities in developing and owning initiatives that are sustainable.

2. KEY THEMES AND FINDINGS

2.1 Developing and Quality Improvement

Let's Get Moving is a new way of working in Cambridgeshire in terms of a collaborative programme involving all districts and importantly having a consistent approach to collecting data relating to impact and behavioural change outcomes.

Consequently the development has been an iterative process and considerable learning took place in the first 18 months of the Programme that has resulted in ongoing changes to improve the delivery and capture of impact and behavioural changes.

Since its inception the locality coordinators and the Living Sport coordinator have collaborated to share the learning with the aim of developing the Programme.

At the end of the first year the Programme leads carried out a review of the whole Programme through a 'reflection and development' day. This focused on successes and challenges identifying the best practice that led to high levels of engagement, achievement of behavioural change and sustainable programmes. In addition, Living Sport undertook one-to-one focused discussions with each locality coordinator to secure a better understanding of any specific factors associated with unexpected outputs and achievement of the outcomes.

The first 18 months of the Programme has effectively become a pilot study with the learning from this first phase stimulating changes in delivery and data capture to evidence the Programme outcomes in the remaining period. This report therefore includes:

- Programme description and development narrative
- Evidence of key outputs and behavioural change outcomes

- Evidence of sustainability
- Key learning from the first 18 months (July 2017 to December 2018)
- The changes made to improve the outcomes of the Programme in its remaining period

1.2 Key findings from Phase 1

- **Less inactive people in Cambridgeshire**: 51% of participants increased the amount of physical activity they do.
- **More adults achieving CMO guidelines for physical activity**: 37% of participants achieving CMO recommended levels of physical activity 3 months after joining.
- **More opportunities to be physically active in deprived areas**: 85 new programmes developed, over half of which are in the most deprived areas in each district.
- **Communities taking ownership of their health and wellbeing**: 45% of new programmes developed are sustained, without ongoing support from LGM, 6 months after initiation.

2. LET'S GET MOVING CAMBRIDGESHIRE DRIVERS

Let's Get Moving (LGM) is delivered by five city and district councils of Cambridgeshire (Cambridge City Council, East Cambridgeshire District Council, Fenland District Council, Huntingdonshire District Council and South Cambridgeshire District Council) with countywide coordination provided by Living Sport. It is a collaborative integrated countywide physical activity programme to support physically inactive people (or the least active) to become more active.

3.1 LGM Vision:

LGM has a broad vision of supporting the population to be healthier through physical activity by connecting with local people and communities.

Improving Outcomes:

LGM aims to support the delivery of the following local and national outcomes:

(1) Less inactive people in Cambridgeshire – *a reduction in the number of adults doing less than 30 minutes moderate intensity physical activity per week.*
(2) More adults doing enough physical activity that benefit their health – *an increase in the number of adults who are achieving Chief Medical Officers recommendations for physical activity per week to improve their health.*
(3) More people in areas of greatest need accessing physical activity opportunities – *an increase in the number of opportunities in the 20% most deprived areas per district according to Indices of Multiple Deprivation.*
(4) Strong resilient communities taking ownership of their health and wellbeing – *autonomous and sustainable physical activity opportunities owned and embedded in local communities.*

3.2 Let's Get Moving Cambridgeshire and Local Priorities**:**

LGM, as an integrated physical activity programme, reflects the following:

- Healthy Weight Strategy
- Think Communities
- System wide integration

4. LGM DELIVERY MODEL

4.1 Core Delivery Tools

* PROMOTION – by identifying and promoting opportunities for people to participate in sport and physical activity.

* DEVELOPMENT – by developing new opportunities, where needed, for people to be able to participate in sport and physical activity.

* SUPPORT – by supporting individuals that need it to become more active.

4.2 Programme Model

Each district and Living Sport has a shared service specification and within this there are a number of Key Performance Indicators (KPIs). During the first phase of the Programme the KPIs were refined and these are being used in the second phase of the programme (see appendix F).

4.2.1 Living Sport Functions

Living Sport has the countywide coordination responsibility for the LGM Programme, a role that entails:

- Responsibility and accountability for the overall delivery of the Programme, ensuring the aims and objectives are met along with ensuring consistency and quality standards of any of the interventions.
- Facilitating shared learning amongst the districts to inform Programme development.
- Responsibility for the coordinated marketing and promotion of the Programme, ensuring the brand is widely recognised.
- Monitoring the Programme and ensuring that the locality coordinators are delivering the key outputs and that the key performance indicators are met.
- Responsibility for ensuring that the Programme is evaluated.
- Seeking external and partnership funding to support the ongoing delivery and sustainability of the Programme.

4.2.2 District Functions

- Responsibility for co-ordinating the local delivery of the Programme in their respective areas.
- Developing, identifying and promoting local structured and unstructured activities for the identification and referral of individuals and communities with low levels of physical activity.
- Engaging communities in the development and ownership of sustainable activities.

- Local monitoring and reporting of the Programme outcomes to the countywide Programme coordinator.

4.3 Whole System Approach – Cambridgeshire Physical Activity Pathway

Central to LGM is the requirement to provide added value through its integration with other related services and initiatives with the objectives of:

- Improving access to opportunities
- Increasing awareness amongst key services and organisations that they can play an important role in promoting physical activity through referring people to local opportunities
- Sharing resources to deliver activities

The Cambridgeshire Physical Activity Pathway, or behaviour change pathway, illustrates the process of an individual accessing support to be more active. The entry routes into the pathway are varied and not exclusive, therefore as additional services or partners that have a role to play in supporting people to be healthy are identified, the access routes are consistent into LGM. The image on the following page illustrates this process.

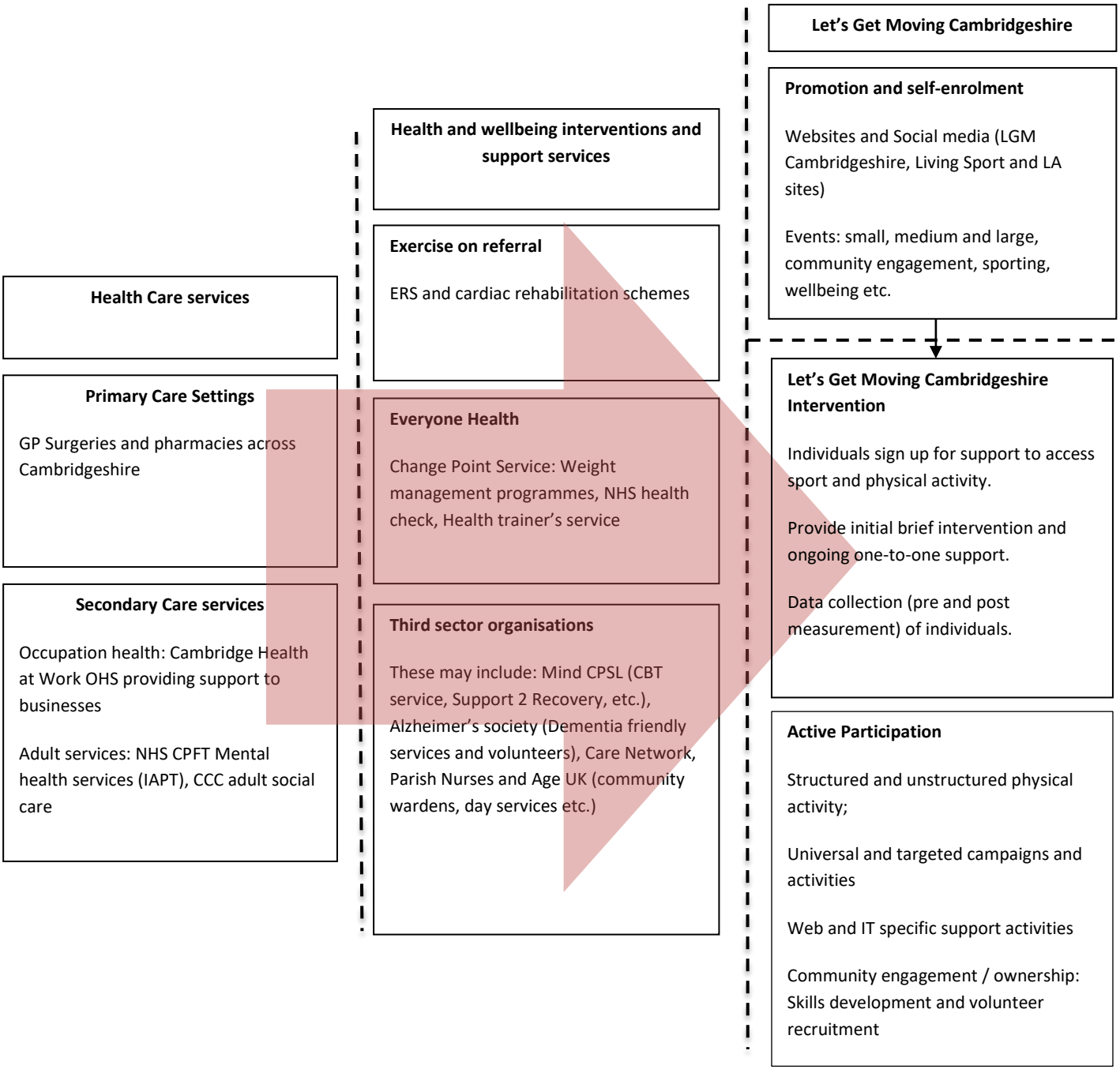
It identifies the process of primary care and potentially secondary care services referring patients into existing health and wellbeing interventions where needed, for example exercise on referral and weight management services. These services offering interventions are then better supported to offer exit routes to sustained healthy lifestyle choices through the support offered by LGM.

There is also the opportunity for health care services to directly refer patients into LGM, where their condition does not necessitate intensive support through the wellbeing interventions but they would benefit from increased physical activity and may, through being more active, avoid having to access those wellbeing intervention services at all.

Finally there is the self-referral or enrolment route into LGM where individuals that need support can sign up directly.

It must be made clear that this is a work in progress and while there have been examples of this working positively it is not yet universally adopted. Some examples of where this is happening in practice include:

- Granta Medical Practice – we are receiving direct referrals from the Social Prescribing Navigator employed by the practice and through the Long Term Medical Conditions (LTMC) nurse team.
- Everyone Health – a strong relationship has been developed and regular referrals are now made into LGM of individuals coming through the lifestyle programmes (weight management, smoking cessation etc.).
- Papworth cardiac rehabilitation – patients are directly recruited into LGM with the locality coordinator attending classes towards the end of the programme to support the transition into sustained physical activity.


Let's Get Moving Cambridgeshire
Promotion and self-enrolment
Websites and Social media (LGM Cambridgeshire, Living Sport and LA sites)
Events: small, medium and large, community engagement, sporting, wellbeing etc.
Health and wellbeing interventions and support services
Exercise on referral
ERS and cardiac rehabilitation schemes
Health Care services
Primary Care Settings
GP Surgeries and pharmacies across Cambridgeshire
Everyone Health
Change Point Service: Weight management programmes, NHS health check, Health trainer's service
Let's Get Moving Cambridgeshire Intervention
Individuals sign up for support to access sport and physical activity.
Provide initial brief intervention and ongoing one-to-one support.
Data collection (pre and post measurement) of individuals.
Secondary Care services
Occupation health: Cambridge Health at Work OHS providing support to businesses
Adult services: NHS CPFT Mental health services (IAPT), CCC adult social care
Third sector organisations
These may include: Mind CPSL (CBT service, Support 2 Recovery, etc.), Alzheimer's society (Dementia friendly services and volunteers), Care Network, Parish Nurses and Age UK (community wardens, day services etc.)
Active Participation
Structured and unstructured physical activity;
Universal and targeted campaigns and activities
Web and IT specific support activities
Community engagement / ownership: Skills development and volunteer recruitment

4.4 How the Programme Delivers

The following gives some examples of how LGM has contributed to high level outcomes and adopted a collaborative approach to developing and implementing physical activity opportunities across the county:

4.4.1 Improving Health and Wellbeing

There are programmes of activity, information, advice and guidance to encourage and support people to become more physically active. Some programmes have an additional focus, for example:

- Reducing weight – Man versus Fat in partnership with CUFC community trust.
- Addressing Isolation – activities in rural areas working with parish councils and housing associations.
- Improving mental wellbeing – Yoga and Mindfulness, workplace activities and SHAPE in partnership with CPFT.

4.4.2 Support Based on an Individual or a Specific Community Need

LGM has some capacity to deal with individual enquiries or requests for support which are received through the LGM website sign up form and directed to the locality coordinators. However, the focus has largely been on organising group activities, or open access activities. These are specifically organised based on an identified need – either general insight, or engagement with key local individuals and groups.

The partnership approach is key to understanding these needs as there are agencies that are best placed to identify what these are. An example of this includes the Rosmini Centre in Fenland that has a strong relationship with local migrant communities and it is able to communicate to LGM the community interests and identify key individuals to engage.

4.4.3 Help to Prevent, Reduce or Delay people from Needing Long Term Support from Services

The LGM Programme focuses upon primary prevention through providing opportunities to be active that engage people in becoming more active. These are considered to be universal approaches and include couch to 5k running groups, walking groups, walking sports and 'back to …' sports.

There are examples of a secondary prevention approach through some programmes that have been developed including SHAPE which provides physical activity to individuals on medication for psychosis gaining excess weight. Another similar programme of physical activity was developed in partnership with the social prescribing pilot in South Cambridgeshire, where individuals were signposted to activities as part of their treatment for a range of health conditions and social issues. In phase 2 of the LGM Programme we will evaluate what the outcome of this is, for example less GP visits, return to work, changes to medication etc.

4.4.4 Empower Individuals to Make Positive Choices

LGM works in specific areas of need and with identified priority groups with a view to making participation as easy as possible; giving them choice that they may not currently have and ensuring there is equality in opportunities. This is empowering communities and individuals to make decisions about what sort of lifestyle they want to have. For example, working through the County Ability Plus Group with disabled people, working with older age adults at risk of falls or other health conditions associated with older age (Dementia, Alzheimer's etc.).

4.4.5 Help Communities be Resilient and Sustainable

There are a range of volunteer opportunities and support for communities through LGM, including accessing wider Living Sport funding and other partners' services. These can play a key role when setting up activities that can be sustained longer term, in addition to volunteer support within club and community sport. Section 9.2 focuses on how LGM has helped towards these goals of resilience and sustainability.

5. PROGRAMME DEVELOPMENT

- Creation of a steering group, with representation from Living Sport and each district council, and a contract meeting group with the same representatives as well as the commissioning body Cambridgeshire County Council Public Health. These two groups were subsequently merged into one group.
- Employment of five locality coordinators and one Living Sport county coordinator (project manager) during Quarter 1 and Quarter 2. Once all coordinators were in place an operational group was developed to enable a more collaborative approach; sharing good practice, ideas, bitesize training and planning for universal programmes and events.
- Agreement with Public Health in Quarter 2 of the district level targets associated with the KPIs within the service spec (see Appendix F).
- Development of data collection questionnaires that would collect evidence of participation and behaviour change – this was an area of contention throughout phase 1, trying to find the right balance between robust data collection using validated questions and practicality for administration and to the end user. An initial approach that was taken was for there to be two questionnaires; one that was comprehensive but less user friendly (see Appendix B) and a short version that collected evidence of participation but no measure of change in physical activity or mental wellbeing levels (see Appendix C). This was done in order to collect some basic data of participation in activities where it was perceived to not be practical for participants to complete a longer questionnaire asking questions about physical behaviours and mental wellbeing; for example if there wasn't suitable amount of time to complete or the environment was not appropriate (i.e. swimming pool or running groups). The result of this was that the short version was used more regularly, hindering the amount of valuable data evidencing behaviour change. Therefore, in Quarter 6 a shared decision was made for a

more pragmatic approach to data collection and a new questionnaire (see Appendix E) and data collection process (see Appendix D) were developed.

A logic model (see Appendix A) was developed to illustrate how the programme would work. It clearly identifies the outputs and outcomes that the LGM programme expects to achieve. The results from Phase 1 are shown in section 6 and are presented as collected data versus the potential data that could have been collected.

6. PHASE ONE – OUTPUTS AND BEHAVIOURAL CHANGE OUTCOMES

6.1 Questionnaire Compliance

Table 1 shows the number of participants who completed questionnaires and the decline in those completing follow-up questionnaires. In addition, only 68% of those who handed in a baseline questionnaire completed it with useable data. Useable data in this instance is defined as that which allows both physical activity level (via IPAQ[2]) and mental wellbeing level (via WEMWBS[3]) to be calculated. This shows a lost potential of at least 200 more questionnaires that *could* have been analysed at baseline, and even more at follow-up. Unfortunately, only 112 questionnaires could be analysed in relation to short term behaviour change where both a baseline and a follow-up point are needed to assess change.

Table 1: Numbers completing questionnaires in Phase 1

LGM Participant Questionnaire	County-wide	Cambridge City	East Cambs	Fenland	Hunts	South Cambs
Baseline questionnaires collected	634	310	48	180	49	47
Baseline questionnaires with useable data	430	213	39	135	3	40
3 month follow-ups with useable data	112	59	5	19	2	27
6 month follow-ups with useable data	27	4	0	12	0	11
12 month follow-ups with useable data	6	0	0	6	0	0

The poor level of data collected is a concern that needed to be addressed. The issues around capturing data are system-wide in respect of the sport and physical activity sector.

[2] International Physical Activity Questionnaire: https://sites.google.com/site/theipaq/

[3] Warwick-Edinburgh Mental Wellbeing Scale: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/

6.2 Behaviour Change

Table 2 shows baseline and follow-up data based on those participants who completed questionnaires in full with useable data (i.e. 112 participants countywide). Follow-up data is based on the 3 month point where behaviour change could be assessed for the greatest number of people.

Although the results reflect only a proportion of participants who complete the programmes, the data in Table 2 suggests that the LGM Programme is engaging with those who it is aiming to target i.e. those who are either inactive or not active enough to benefit their health. More than four fifths of new participants across the County fall into this latter category. Very few individuals that join the LGM programme are active already compared to those who are not.

Table 2: Physical Activity Behaviour Change of those completing the forms with useable data at both time points in Phase 1 from Baseline to first follow-up at 3 months

LGM Participant Questionnaire	County-wide	Cambridge City	East Cambs**	Fenland	Hunts*	South Cambs
% inactive on joining LGM	30%	24%	39%	34%	33%	46%
% not active enough to benefit health on joining LGM	82%	90%	73%	71%	67%	85%
% reporting improvement in physical activity levels at follow-up	51%	54%	60%	58%	50%	37%
% undertaking limited physical activity on joining LGM who are now achieving CMO guidelines	37%	38%	40%	79%	0%	13%
% reporting an increase in level of mental wellbeing at follow-up	63%	59%	80%	63%	100%	67%
Change in WEMWBS from baseline to follow-up	+4	+3	+12	+4	+9	+3

Fully or partially achieved goal	72% (57% yes)	73% (63% yes)	50% (50% yes)	79% (53% yes)	50% (50% yes)	78% (56% yes)

* = All Huntingdonshire data is based on low numbers (<5) compared to other local authority areas

** = East Cambs follow-up data is based on low numbers (<5) compared to Cambridge City, Fenland and South Cambs

Both physical and mental wellbeing levels were reported as improved after 3 months following participation in LGM for more than half of the participants; 51% reported physical wellbeing improvements and 63% reported mental wellbeing improvements. The change in mental wellbeing scores from baseline to follow-up was meaningful[4] across all district areas.

A good proportion (37%) of those who did not meet the desired physical activity levels when they joined LGM were achieving the CMO guidelines within three months. Although more hadn't achieved this level of activity, a greater proportion (57%) across the county had fully achieved their goal within 3 months, with a further 15% having achieved their goal at least somewhat, indicating that the activity level itself is not always the primary motive for joining a programme like LGM.

6.3 LGM Activity – number of programmes

Table 3: Summary of LGM activity in Phase 1

LGM KPIs	County wide	Cambridge City	East Cambs	Fenland	Hunts.	South Cambs
PROGRAMMES						
Number of new programmes developed in Phase 1	85	25	21	14	13	12
Growth in number of new programmes between the last two quarters	+9	+2	+3	+2	0	+2
Number of new programmes sustained by/within the community after 6 months	38	5	5	13	3	12

[4] A meaningful change in WEMWBS is estimated to be from a 3 to 8 WEMWBS points difference between before and after time points: https://www.corc.uk.net/media/1244/wemwbs_practitioneruserguide.pdf

Number of community led programmes initiated (I)/supported (S) through the LGM brand	I = 33 S = 85	I = 5 S = 5	I = 13 S = 13	I = 7 S = 47	I = 5 S = 8	I = 3 S = 12
% of programmes in 20% most deprived wards of each LA area	?	51%	60%	89%	60%	70%
PARTICIPANTS						
Number of new participants in <u>all</u> programmes (excl. events)	4079	707	414	1230	817	911
% of programme completers in <u>formal</u> programmes	?	51%	60%	X	66%	52%
Number of mass participation (event) attendees	6712	644	1563	2177	2020	308
Number of new participants signposted (S) or self-signposted (SS) to the programme	S = 43 SS = 406	S = 19 SS = 0	S = 21 SS = 90	S = 1 SS = 196	S = 0 SS = 26	S = 2 SS = 94

? = average data for the county cannot be calculated for percentages as raw data was not released by the districts

X = no data available, I = initiated, S = supported

Table 3 provides a summary of activity against the main KPIs in Phase 1 of the Programme. There has been significant growth in the number of programmes, with an average of 14 per quarter (9 in the last). It should be noted that the lack of new programmes in Huntingdonshire was partly due to a change in locality coordinator part way through the programme. It is encouraging the number of community programmes that have been initiated by LGM; at least one in five per district. Of note is the greater number of community led programmes that the brand has supported indicating that there is a willingness in the communities to undertake such activities with support to get going and the added knowledge that the brand will then signpost to them where appropriate. A minimum of 50% of physical activity programmes have been successfully targeted in the 20% most deprived areas of each local authority, although not to the exclusion of other areas where there was a specific identified need.

Of the new programmes developed in Phase 1, 45% (38 out of 85) have been sustained by/within the community after 6 months of starting; an encouraging proportion. This shows the potential for what can happen during Phase 2 of this Programme as the LGM team continues to learn and understand the process needed to allow activities to move beyond LGM, from either initiation or support by LGM to begin with, resulting in communities taking responsibility for their own opportunities.

The high numbers of NEW participants across all programmes shows that the programmes are being targeted in the right places and to the right people. It does also highlight, however, the potential for a much higher rate of completion of the behaviour change questionnaire. High numbers at mass participation events shows the success of events such as the development of new Parkruns that have been supported by LGM through its ability to bring in additional funding.

In terms of formal programmes, the drop-out rate appears to be quite high. Excluding Fenland where no data has been recorded, between a third and a half of participants taking part do not complete their activity programme. In Phase 2 this will be an aspect that is investigated further to determine whether LGM can help in any way.

It will also be interesting to see in Phase 2 whether new participants join existing programmes of activity (highlighting the need for good signposting) or whether further new programmes are created based on additional need.

6.4 Brand Development

Alongside data collection, there was the launch and ongoing development of the LGM brand to promote the benefits of physical activity and opportunities available locally.

During Phase 1, the brand development included a countywide launch campaign and a number of others that all districts were involved in e.g. National Walking Month, Sport Relief, Change4Life Summer and Stronger for Longer. These were supplemented by local promotional events to embed the LGM brand and messaging into existing local activities and services to ensure a joined up approach to health and wellbeing across each area.

To enhance brand development, a marketing and communication plan was created and agreed by the steering group. This remained a working document to allow it to evolve as the LGM Programme developed. The plan used the following platforms to create successful social media campaigns:

- *Website* – to provide a landing page for referrals from health professionals; to direct individuals to information regarding opportunities available locally; to enable individuals to sign up for support from a physical activity coordinator in their locality or sign up to the newsletter that publishes useful information including news and advice
- *Facebook* – to provide a public profile and connect with local people and communities
- *Twitter* – to build brand awareness and communicate accurately, effectively and efficiently on topics of interest

Specific outputs that were considered relevant from the marketing and communication plan are shown in Table 4.

Table 4: Summary of LGM communication activity across the six quarters of Phase 1

Platform	Q1	Q2	Q3	Q4	Q5	Q6
Social Media (LGM county platforms)						
Facebook page follows (cumulative)	58	69	135	200	235	244
Facebook Reach	623	2815	3000	15000+	5900	2700
Engaged Fans – reactions, comments, shares etc.	17	100	141	295	112	81
Twitter Followers	n/a	n/a	n/a	21	26	31
Retweets	n/a	n/a	n/a	3	0	7
Tweets liked	n/a	n/a	n/a	9	0	13
Twitter link clicks	n/a	n/a	n/a	1	0	0
Email Marketing						
Total subscribers	n/a	n/a	14	36	53	64
Average open rate	n/a	n/a	n/a	92%	n/a	n/a
Average unsubscribe rate	n/a	n/a	n/a	0%	0%	n/a
Website Traffic						
Number of unique visitors	n/a	209	648	696	##	##
Number of pages per visit	n/a	2.70	2.14	2.17	##	##
Proportion return visitors	n/a	16.7%	14.1%	10.9%	##	##
Bounce Rate	n/a	45.43%	52.34%	54.73%	##	##
Online Goals						
Registered for further support	0	0	48	18	4	6

- Analytics unresponsive

It is evident from the data in Table 4 that the LGM brand has consistently grown over the first phase. For example, the number of Facebook and Twitter followers and subscribers to e-marketing has gradually increased across the 18 months. It is also apparent where specific social media campaigns have been undertaken as Facebook Reach and average e-marketing open rate peak at a certain time (quarter 4) and coincide with this. A relaunch event is planned for Phase 2 which will help grow these figures, and thus further improve connection to individuals and communities.

7. PHASE ONE CHALLENGES, LEARNING AND IMPROVEMENTS

As described above it was anticipated that the programme would be refined and developed during the initial period. The timeframe was originally planned for year 1 (quarter 1 to quarter 4), however due to a number of challenges that arose, this was extended to include the first 18 months (quarter 1 to quarter 6) as additional time was needed to agree how the key aspects of the programme needed to be developed and changes introduced. The following describes the challenges, the learning that has

been acquired and the improvements that have consequently been made along with the opportunities.

7.1 Data Quality and Collection.

The greatest challenge has come with respect to data quality and participant compliance which has meant that the full scale and scope of LGM impacts have not been captured. Trying to collect evidence of behaviour change is not simple, as change in physical activity level alone does not always tell the full story. For example, an individual's mental wellbeing might improve or they may have achieved their goals but their level of physical activity may have stayed the same.

7.1.1 Participant Compliance

- Having a 'short version' questionnaire that didn't collect evidence of behaviour change was a significant mistake. These became the default questionnaire to use for all activities by some locality coordinators because of the relative ease for participants to complete in comparison to the longer version, resulting in missed opportunities to collect evidence of behaviour change.

- . Knowing when to issue follow up questionnaires, and to whom, has been challenging for the coordinators and coaches alongside other parts of their role. Sports clubs, coaches, instructors etc. are out of their comfort zone when it comes to administering questionnaires and ensuring they are completed accurately and in full. Traditionally these partners are comfortable with registers of attendance but when it comes to collecting more comprehensive and detailed information from participants, such as questionnaires, they are much less competent and motivated.

- The feedback from locality coordinators and participants was that the questionnaires were too long and time consuming for them to be completed fully. Participants have been unwilling to fully complete questionnaires as although they were based on validated measures of physical activity (IPAQ) and mental wellbeing (WEMWBS), together they made the questionnaire long. Consequently a greater proportion of the coordinators time has been taken up with following up incomplete or incorrect questionnaire responses, needing to go out to activities regularly to get accurate responses. This has taken their time away from the three pillars of LGM: promoting, developing and supporting.

- An additional concern of the locality coordinators has been that if the questionnaire is too arduous then participants may disengage with the activity and a primary role for them is to support people to continue to be physically active.

A range of approaches were used to address these issues including:

- Additional support is provided to instructors on how the questionnaires should be completed and regarding the importance of the data being collected.

- Incentives are offered to participants if they attend a stated amount of sessions and complete pre and post (12 week) questionnaires. This was trialled in some programmes including the Man V Fat programme.

- The questionnaire has been simplified through using the Short Active Lives Survey (in place of IPAQ) and the four subjective mental wellbeing measure questions (in place of WEMWBS). Initial comments from locality coordinators are that these are being received better from participants and instructors. We look forward to seeing the outcome of this change at the end of the first quarter in Phase 2.

- Clarification has been provided on the process to follow when collecting data at baseline and at follow-up points, including how and when to retry contacting participants if no response received.

- The issue of understanding how and when questionnaires are administered has led to exploration of the option of an online system for data collection which would ultimately take the responsibility away from the locality coordinators through the use of an automated data collection process. This would provide consistency in data collection, remove personal error and improve efficiency including allowing locality coordinators to use their time more productively elsewhere. At the time of writing this report, the Project Manager has agreed the development of a modified online data collection process with Arkflux which will be trialled with Granta Medical Practice, with the plan being to roll it out across the whole Programme. Although there is an initial cost associated with this development, this has been absorbed through the in-kind support of Living Sport to the LGM Programme. There is an additional annual fee associated with using the Arkflux platform but this is minimal and will be covered by Living Sport who also use it for other programmes. The resource once created is free to use when login access is shared.

Data collection issues have had too much of an impact on service development and delivery and these challenges highlighted the need for more consistent and effective methods of data collection for Phase 2 of the Programme so during quarters 5 and 6 the questionnaire was discussed, revised and the steering group agreed to change to a new version from quarter 7. Details of the changes made can be found in section 8 below.

7.1.2 Data Set

- The guidance of what data to collect and in what way when it comes to evidencing the impact of physical activity behaviour change is somewhat flawed. We used the Standard Evaluation Framework (SEF) for physical activity interventions in order to develop our evaluation framework and design the questionnaires; however this same guidance would be used for both a Randomised Control Trial and an intervention such as LGM!

- At the start of the first phase of the Programme, the KPIs and targets were agreed between each district and Public Health. As the project moved forward, it

became clear that three of the KPIs needed revising as there was no consistency between each district as to how they were reporting against each.

- KPIs relating to programmes, participants and signposting were amended and an explanation sheet produced (see Appendix F) to ensure greater consistency in the methodology used. In addition some of the KPIs were divided into more than one to clarify what each means. The following changes were made:

  - *Programmes KPI 1.1*: originally the number of new and the number of existing programmes were reported. These were redefined as those that were developed through LGM and those that were supported through LGM, respectively. This would provide insight into how much involvement the coordinators were having. In addition, the number of new programmes/ activities continuing 6 months after initiation was added; not to be confused with KPI 3.4 - percentage of physical activity community led programmes continuing and led by community members after 6 months. The key difference between these two 'sustainability indicators' is the additional 1.1 refers to LGM activities that are sustained 6 months after initiation and 3.4 refers to community led activities that are sustained 6 months after initiation. These both show the sustainability of the programmes.
  - *Participants KPI 1.2*: the number of people who attend a programme of activity for the first time (i.e. new participants) and those who attend a mass participation event/activity have been split and are now reported separately. This allows a distinction to be made between those who attend on a one-off occasion compared to attending an ongoing activity. The former is more about raising awareness, the latter about engagement in physical activity.
  - *Signposting KPI 2.1*: the number of people signposted (referred) and self-signposted have been split and are now reported separately. This allows numbers who have been referred through a health professional route to be determined to ascertain how this section of the physical activity pathway is working.

7.2 Brand Development

- Throughout Phase 1 we discovered that a social media presence was a great tool to raise people's awareness of LGM. As such, the LGM website, Facebook and twitter platforms were created and have shown a cumulative positive effect on connecting with the public (see section 6.4). Feedback from a Coordinators Review at the end of the first year provides evidence of support for ongoing promotion using the LGM brand as a means of engaging people. In addition, linking with partner platforms (e.g. district and city council websites, Active Fenland, Everyone Health) has only enhanced this.

- A conscious effort has been made by the district and county coordination teams to ensure that all promotional resources and activity reference Cambridgeshire County Council as funder of the Programme. We have learnt that this can only enhance the development of the brand, linking the Programme directly to health, particularly when new relationships are being established.

- In addition, Living Sport have engaged a marketing and communication expert to carry out a review of the various platforms (LGM, district and Living Sport) in order to ensure consistency in how the Programme is promoted and identify opportunities for development and growth. She is providing ongoing support to the Programme as these changes are implemented. Living Sport is also working closely with Matthew Hall from CCC Communications in order to align the Programme with the county council communication plans. This is not an area of work we envisage reaching perfection in but rather a continued learning journey which will help with the wider promotion of physical activity and community engagement beyond the funded period.

- A countywide relaunch campaign is planned that would allow the positive trends in followers and users of the LGM brand seen already to continue in an upward direction. Marrying the campaign with a national event perhaps may give it an additional platform to drive off from. The relaunch campaign should work with communities to promote the culture that physical activity is a normal part of everyone's life.

7.3 Programme Development

- Phase 1 of the LGM Programme has shown that different approaches have been taken across districts based on need. For example, some rural localities combat social isolation and loneliness, developing opportunities within the community that brings the community together; urban areas have identified target groups relating to overweight and mental health. Unique circumstances need to continue to be addressed, whilst at the same time ensuring equality in the opportunities.

- It has become obvious that the programmes where there has been a successful increase in scale have been those with minimum ongoing costs, a simple flexible entry level and a progression pathway. Consequently walking and running programmes, which may be community led, have expanded more than other initiatives which are more resource intensive. LGM is developing a cycling scheme based on this effective model.

- During Phase 1, walking sports such as walking football and walking netball have also been effective at engaging a wide demographic of inactive participants. The feasibility of widening this beyond football and netball to other activities is being explored as the learnings from such programmes are invaluable when replicating across districts and the county. A number of examples of countywide and district level programmes can be seen in Appendix G.

- Following a Coordinators Review at the end of the first year, a common view was that engaging people in physical activity is about more than just improving their physical health but also about social and mental health benefits and a reduction in social isolation. Further to this, participants need to be involved from the beginning for them to take a greater ownership of the activities as becoming fitter or healthier is very often the by-product of people wanting to volunteer and lead

their communities. With local people involved in setting up the activity from the start, it is more likely that community leaders can be developed in tandem with the activity giving it a greater chance of sustainability. Let's Run Girls is a great example of this customer centric approach.

7.4 Systemic Approach

- We have learnt that a whole system approach is needed to make a difference to individuals and communities and affect behaviour change, and that achieving behaviour change is a long term process. Understanding the many factors that impact upon a person's life and considering the best way to promote and engage people in physical activity is much more challenging than developing new activities and hoping people attend. Phase 1 of the LGM Programme has identified this and developed strategies accordingly. It requires an ability to be able to adapt to adapt to changing priorities and an increase in referrals.
- LGM needs to continue to become an integrated service with partner organisations such as the Integrated Lifestyles programme provided by Everyone Health to (a) develop targeted programmes and link these programmes appropriately, and (b) enhance the referral and signposting of people from a range of organisations such as Care Network and other community and social care organisations to access the right programmes
- This clearly calls for a clear physical activity pathway that ensures that access to physical activity is enhanced by developing systems and relationships to improve signposting. We have identified a number of key partners within the 'whole system' which has allowed LGM to develop these relationships further, streamline resources and improve shared knowledge. The right partners, who are clear on their role and responsibility and understand the programme objectives, are essential to ensure diversity in the programme and sustainability of physical activity opportunities. The end-user (the participant) should be confident that however and wherever they join the pathway, they will be supported to access the best possible service for them.

- LGM has an essential role to play in this physical activity pathway and there is work underway:

- Embedding physical activity into the social prescribing agenda with Granta Medical Practice will aid this further. The pilot project in South Cambridgeshire with Granta Medical Practice is part of their social prescribing programme and is a key development for reaching the target audience of LGM. LGM is looking to proceed with this pilot project and then scale it up across Cambridgeshire. It will allow the LGM Programme to become further embedded into the local commissioning landscape

- Liaise closely with Public Health and appropriate partners and agendas, such as Everyone Health and lifestyles/workplace/schools contracts, to ensure LGM is streamlining resources and expertise. Communication between districts, and with other funded projects across the county, will also enable shared learning and an even greater collaborative approach to working.

- The central coordinating role played by Living Sport has been critical as it has enabled it to have an overview of the opportunities across the whole system, and feedback from a Coordinators Review showed that they valued the opportunity to work with colleagues across the county and share learning.

7.5 Expand analysis to include Return on Investment/Cost Benefit Analysis

Return on Investment (ROI) is an important area that was not considered in detail during Phase 1. The Sport England MOVEs tool was used to show that two separate activities (walking netball and couch to 5k running groups) that were replicated across the county provided a good ROI. However, this is an area of development.

Living Sport was successful in their bid to the Analytical Volunteer Programme for two analysts to come and work with the LGM team at Living Sport. Starting in May 2019, the work will involve the analysts completing ROI analysis of the Phase 1 data and sharing their knowledge and skills so that the methodology can be replicated in Phase 2.

8. LGM IMPACT AND SUSTAINABILITY

8.1 Behavioural Change

Phase 1 has provided valuable learning that will help improve the capture of the Programmes outputs and outcomes.

The results from Phase 1 should be treated as preliminary and with caution due to the small sample size compared to the potential larger sample size that could have been analysed. However, the results do give us an indication of the impact the activities are having on local areas: more than half were targeted in the most deprived wards, and those that follow-up data was successfully collected for have shown the positive behaviour change that was sought. The limitation of this data is that follow-ups on longer term behaviour change across 6 months and a year was not available but this should be addressed through the changes in the data processes.

As with all programmes that involve behaviour change and impact, this can only really be sufficiently evidenced across the longer term. In addition, short term commissions such as this only provide limited financial resource to allow sufficient data to be collected in order to carry out outcome evaluation – process evaluation is much more realistic. Therefore, a limitation in this study that could be addressed in the future would be the partnering of the programme with an evaluation partner (which would necessitate funding), to enable intensive data collection and ensure robust monitoring and evaluation can be carried out, taking away this responsibility from those delivering on the ground.

8.2 Sustainability

8.2.1 LGM activities. When considering the sustainability of LGM it is important to consider which elements of the Programme we are talking about: the development and continuation of activities (community ownership), the brand, the physical activity pathway, or the support for disengaged individuals to be more active.

- The development of new activities has been a key output in the first phase of the LGM Programme. Identifying where there were gaps in provision or additional need based on existing capacity being too low has resulted in an increase in participation from individuals that were not currently active. The focus here has been on building sustainability through community ownership where possible which has been effective; although the end of year 2 data will provide a clearer understanding of how many initiatives have been sustained.

- Sustaining initiatives that increase physical activity levels can be achieved through developing leaders from the community to take the activities forward and motivate existing and new participants to become the next leaders. One of the key learning points identified by LGM leads in all the districts is that the most successful programmes were those where someone from the community assumed a leadership role or a community asset such as a facility was part of the initiative.

- There are several examples of community ownership, volunteer upskilling and leadership throughout the programme. ‘Let’s Run Girls’ and ‘Run For Your Lives’ are two of the running groups that have scaled up their offer significantly through training new leaders and establishing running communities with LGM support. The Papworth New Age Kurling group is a good example of a completely new activity which, although initially supported by LGM, went on to be developed and owned by a village.

- The role of the locality coordinators shouldn’t be underestimated in working with these communities to support them to take ownership of these opportunities. While in most instances there are some funds provided through LGM to upskill, equip or facilitate the development of these activities, the value of a coordinator far exceeds the comparable set up costs particularly as these can be secured by alternative means through external grant awards.

8.2.2 LGM – The Future within the districts

- Developed and existing community groups and activities that have been sustained beyond 6 months stand a good chance of continuing without further support of the Programme, particularly with the continued promotion from the LGM brand. The growth and development of new activities will likely be affected based on which districts are able to self-fund or absorb the role of the locality coordinator (see Appendix H). This may result in some areas of the county having more opportunities to participate in local sport or physical activity than others as longer term internal investment of locality coordinators to carry out their role is likely to be different in each district, despite all districts seeing the value in

having them. Some will consider if there is financial capacity to sustain this role, some may be able to absorb this role into existing programmes, and others won't have the capacity to carry this out. At a locality level there is the opportunity to explore funding opportunities for capacity costs based on identified areas of need, however initial enquiries with larger funders have suggested that a whole county project support grant is unlikely to be successful.

- By adopting a customer centric approach to the Programme, locality coordinators are able to understand the motivators and barriers to participation then offer the support needed to enable them to access and maintain engagement in physical activity. This might be a light touch or a more significant amount of support. Ideally this would be an area of focus for the future given that in phase 1 of the programme a greater proportion of their time has been taken with data collection and the emergence of a new data collection model will reduce this time.

- To sustain the provision of support there is the need for continued investment in local level capacity, either through the district council (as with this Programme) or identifying partnership opportunities to carry this out. In April 2019 the Districts were asked what their positions were in relation to any ongoing support to LGM beyond the currently commissioned period. Their responses indicated a mixed picture but had the common themes that LGM is being successful in stimulating new programmes with many being sustained through community efforts. There is a consensus that Let's Get Moving will leave a strong legacy. However only three districts stated that they are committed to looking at funding opportunities for sustaining Let's Get Moving.

8.2.3 Brand sustainability

- The LGM brand has grown in authority and increased community awareness with consistency of use across all districts gradually being realised, which will ensure that the message of being active under the LGM brand will continue under the direction of Living Sport. The work being carried out in the main phase of the Programme will continue to strengthen the brand as a 'campaign' to get people moving more. The brand gives us a vehicle to drive forward future public health messages, specifically for physical activity.

- The upkeep of the website and domain subscription require ongoing investment which will be absorbed by Living Sport, as will the continued leadership working with key stakeholders to deliver a collaborative approach to improving the levels of physical activity across the County.

8.2.4 Physical Activity Pathway

- It is important to ensure that there is transformational leadership for the strategic development of the Physical Activity Pathway engaging with key stakeholders including primary and secondary health care, statutory services, voluntary & community services (VCS) and third-party organisations. Through this programme Living Sport have been able to provide that leadership which has resulted in early

stages of an integrated Physical Activity Pathway engaging with primary care receiving direct referrals of patients. By developing this process, LGM is primed to be a key partner for the upcoming surge of social prescribing across the health care sector including the 1000 new link workers for each 'Primary Care Network' through the STPs and the 'enabling communities' social impact bond secured through PCVS.

- Through the development of IT services for customer relationship management and monitoring & evaluation, the process of receiving referrals from key stakeholders is consistent, efficient and cost effective.

8.2.5 Legacy – what is transferable?

- The scalability of programmes such as walking and running programmes have been particularly successful as there is a simple entry level and progression pathway. We are working on a cycling scheme to follow this model.

- Walking sports have also been effective at engaging a wide demographic of inactive participants. There appears to be an opportunity to widen this beyond netball and football which Living Sport is already exploring.

- The whole system approach to the Physical Activity Pathway that we have been exploring has progressed with primary care and lifestyle behaviour change services. Integrating voluntary services into referral pathways and establishing the programme into MECC and social prescribing opportunities would add to the legacy of the Programme.

9. CONCLUSION – KEY POINTS

This report provides a summative account of progress through the LGM Programme at the halfway point of three years investment. This highlights achievements, key lessons learnt, and actions to be taken into the next phase of the Programme and offers thoughts into sustainability of the Programme.

The vision for LGM was for there to be more active people in Cambridgeshire leading to a healthier population, with four clear objectives to achieve this vision. Eighteen months into this Programme we are able to see some progress against these objectives:

- **Fewer inactive people in Cambridgeshire**: 51% of participants increased the amount of physical activity they do.
- **More adults achieving CMO guidelines for physical activity**: 37% of participants achieving CMO recommended levels of physical activity 3 months after joining.
- **More opportunities to be physically active in deprived areas**: 85 new programmes developed, over half of which are in the most deprived areas in each district.

- **Communities taking ownership of their health and wellbeing**: 45% of new programmes developed are sustained, without ongoing support from LGM, 6 months after initiation.

There were challenges faced by the LGM team and lessons learnt in phase 1 of the Programme. Moving into the second phase of the Programme it is important that we take some actions forward from what we have learnt.

- Through a considerable amount of 'try – learn – change – try again' with regards to collecting evidence of participation, it was concluded that a more pragmatic approach to data collection is needed for community based physical activity programmes. These should be simple to understand and complete for the end user whilst still collecting the necessary information to evaluate behaviour change.

- A new data collection questionnaire and process has been developed and implemented at the start of the second phase (quarter 7) based on the lessons learnt, and a new automated process for collecting data is being trialled through the social prescribing pilot with a view to scaling up to accommodate the wider programme in due course.

- A whole system approach is important to affect change, therefore working with key partners that have a role to play in identifying and engaging the least active people should be the priority. An asset based approach is effective for community engagement; identifying key individuals or facilities and supporting them to identify need, design and deliver activity and sustain the opportunities longer term. Communities taking ownership of their own health and wellbeing is an underlying objective of the Programme therefore upskilling volunteers to lead their own activities for themselves is key.

- Identifying sustainability within the programme is important in order to recognise what would continue without ongoing financial support. Developed and existing community groups and activities that have been sustained beyond 6 months stand a good chance of continuing without further support of the Programme, particularly with the continued promotion from the LGM brand. The role of coordination, at county level and district level, directly relates to the core offer – Promote, Develop and Support – therefore these areas will likely be affected based on which districts are able to self-fund or absorb the role of the coordinator which may result in inequality where some people, depending on where they live, have limited opportunities to participate in local sport or physical activity than others.

- Phase 2 will help cement physical activity and the LGM brand within the prevention agenda and social prescribing landscape of Cambridgeshire. The next 18 months will help create this legacy.

Health Committee Report May 2019

Let's Get Moving – Appendices A-G

APPENDIX A: LOGIC MODEL FOR LET'S GET MOVING CAMBRIDGESHIRE

Rationale	Aim	Input	Activities	Outputs	Outcomes	Impacts
There are high levels of physical inactivity in children, young people and adults across Cambridgeshire contributing to health inequalities and long term health conditions	Primary objective: Increase levels of physical activity throughout the County, with a specific focus on the least active, in order to improve the health of the population Secondary objectives: Identify improvements in signposting processes to increase physical activity levels across Cambridgeshire Community engagement and ownership leading to sustained physical activity opportunities	Programme (County) coordinator District coordinators x5 Marketing and Communications plan / budget Operational budget Training and development budget	Increase in opportunities to engage in structured and unstructured physical activity - Universal campaigns and activities - Targeted campaigns and activities Develop a clear and easily accessible physical activity pathway; to support signposting from partners and self enrolment Opportunities for personal development - Skills development - Volunteer opportunities Community development - Sustainable community activities - Community ownership	- Number of activities - Number of participants - Number of assessments - Number of programme completers - Number of people reporting improvements in PA levels (IPAQ-SF) - Number of people reporting they have achieved their objectives / goals - Number of activities in areas servicing populations in top two quintiles of IMD - Number of people signposted into pathway - Number of people undertaking training - Number of people gaining a qualification - number of people volunteering - number of community programmes initiated	- Reduction in the number of inactive people in Cambridgeshire - Increase in the number of adults who achieve incremental increases towards CMO guidelines for physical activity - Increase in the number of adults achieving CMO guidelines for physical activity - Contribute to reductions in; i) Excess weight in children, and ii) Excess weight in adults - Reduce inactivity levels in areas with particularly high levels of health inequalities (LSOA / MSOA) - Strengthen community resilience	Improved health and life expectancy of the population Lower preventable health and social care costs Decreases in preventable chronic diseases Decrease in morbidity, mortality and disabilities Sustainable health promotion and prevention system

				- Number of community programmes supported (existing) - Number of community programmes sustained by the end of funded programme		

Assumptions	External factors
All five District Councils contribute fully to the development and delivery of the programme The commissioner will support the development and delivery of the programme through sharing experience and utilising key contacts and relationships with partners; including, but not limited to, Everyone Health.	Existing Activities and programmes Resistance to change Ability to engage partners in signposting to the pathway (Primary Care, Secondary Care, Third party organisations etc.)

APPENDIX B1: BEHAVIOUR CHANGE – BASELINE QUESTIONNAIRE

Activity/Session/event attended:……
Date:……

About you

Full name:…… Date of birth:…… Gender: Male Female
Email:……
……
Postcode:…… Contact number:……..
Emergency contact: Name:……
Number:……
Do you consider yourself to have a disability? Yes No If Yes, please specify:……
Ethnicity (please circle)

White British	White Irish	White Gypsy or Irish Traveller	White (Any Other)
Mixed White and Black Caribbean	Mixed White and Black African	Mixed White and Asian	Mixed and multiple ethnic group (any other)
Asian or Asian British-Indian	Asian or Asian British – Pakistani	Asian or Asian British – Bangladeshi	Asian or Asian British – Chinese
Asian (Other)	Black Caribbean	Black African	Black (Other)
Arab	Other (please state)……		

Employment Status

Full Time Employed		Part Time Employed		Self – Employed	
Unemployed		Retired		Student	

How did you find out about Let's Get Moving / this session?……
Were you referred or signposted to Let's Get Moving Cambridgeshire? Yes No
If Yes, why were you referred to Let's Get Moving Cambridgeshire?

Weight management		High blood pressure		Mental wellbeing: including Stress, Anxiety, depression, ADHD etc.	
Social motivations: Bereavement, loneliness, etc.		injury prevention: trips and falls, strength and mobility		Exiting a healthy lifestyle service; for example exercise on referral or weight management programme	
Other (please state)……					

What are your goals or objectives associated with taking part in Let's Get Moving Cambridgeshire?(for example; to lose weight, make new friends, be able to play with my children without getting out of breath etc.)
……
Do you have any health considerations we ought to be aware of?……

Let's Get Moving Cambridgeshire has been developed to help communities become more active. As part of this, we need to evaluate the programme to help us provide the best possible service to suit the needs of our residents.

Below are some statements about **feelings** and **thoughts**. Please tick the box that best describes your experience of each over the last 2 weeks.

Statements	Never	Rarely	Sometimes	Often	Always
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

APPENDIX B2: BEHAVIOUR CHANGE FOLLOW UP QUESTIONNAIRE

Follow-up point (10 week, 6 months or 12 months etc.): ……..

Activity / Session attended:……
Date:……..

Full name:…….. Date of birth:……

What did you want to get out of coming to the Let's Get Moving sessions?

Weight loss Fitness New hobby Social aspect
Lifestyle change Improvement in medical condition
Other, please specify:_____

Have you achieved what you wanted to by coming to the Let's Get Moving sessions?

Yes No A little but want to achieve more

Are you planning on continuing with the activities?

Yes No Not sure

How would you rate this activity / session?

Poor Not good Ok Good Excellent

Below are some statements about **feelings** and **thoughts**. Please tick the box that best describes your experience of each over the last 2 weeks.

Statements	Never	Rarely	Sometimes	Often	Always
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5

I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

Below are some statements about **physical activity**. Please tick the statement which best describes you:

Statement	**Please tick**
I am not physically active and I don't plan on doing any physical activity in the near future	
I am not physically active at the moment but I am thinking about being more active	
I am preparing to do more physical activity and intend to start in the next month	
I have been physical active for less than six months	
I have been physically active for more than six months	

APPENDIX C: PHASE 1 SHORT PARTICIPATION QUESTIONNAIRE

About you

Full name:……

Date of birth:……

Gender: Male Female

Email:……

Postcode:…… Contact number:……

Emergency contact: Name:…… Number:……

Do you consider yourself to have a disability? Yes No
If Yes, please specify:…… ……

Ethnicity (please circle)

White British	White Irish	White Gypsy or Irish Traveller	White (Any Other)
Mixed White and Black Caribbean	Mixed White and Black African	Mixed White and Asian	Mixed and multiple ethnic group (any other)
Asian or Asian British- Indian	Asian or Asian British – Pakistani	Asian or Asian British – Bangladeshi	Asian or Asian British – Chinese
Asian (Other)	Black Caribbean	Black African	Black (Other)
Arab	Other (please state)……		

Employment Status

Full Time Employed		Part Time Employed		Self – Employed	
Unemployed		Retired		Student	

How did you find out about Lets Get Moving / this session?……
……
……

What are your goals or objectives associated with taking part in Let's Get Moving Cambridgeshire?(for example; to lose weight, make new friends, be able to play with my children without getting out of breath etc.)
……
……

Below are some statements about **physical activity**. Please tick the statement which best describes you:

Statement	**Please tick**
I am not physically active and I don't plan on doing any physical activity in the near future	
I am not physically active at the moment but I am thinking about being more active	
I am preparing to do more physical activity and intend to start in the next month	
I have been physical active for less than six months	
I have been physically active for more than six months	

Disclaimer – I understand that my/my child's participation in any of the Let's Get Moving sessions are entirely at my own risk and should consult my doctor if suffering from any condition that might make taking part detrimental to my health
Photo consent – Please tick this box if you consent to us taking photographs of you and/or your child and agreeing that they can be used for any lawful purpose including for example as publicity, illustration, advertising and web content.

Signature *Date*

Let's Get Moving Cambridgeshire is collecting your personal information in order to evaluate the effectiveness of the project; i.e. have you made improvements to your physical activity levels because of something we have done. The lawful purpose for us collecting this information is informed consent from each data subject. Your information will only be shared with the organisations contracted to the service; namely Living Sport and the five District Councils. Further details are available at www.letsgetmovingcambridgeshire.co.uk/privacy
In order for us to use this information we need you to provide your consent for us to collect, process and hold your data. Please provide your signature and date below to do this:

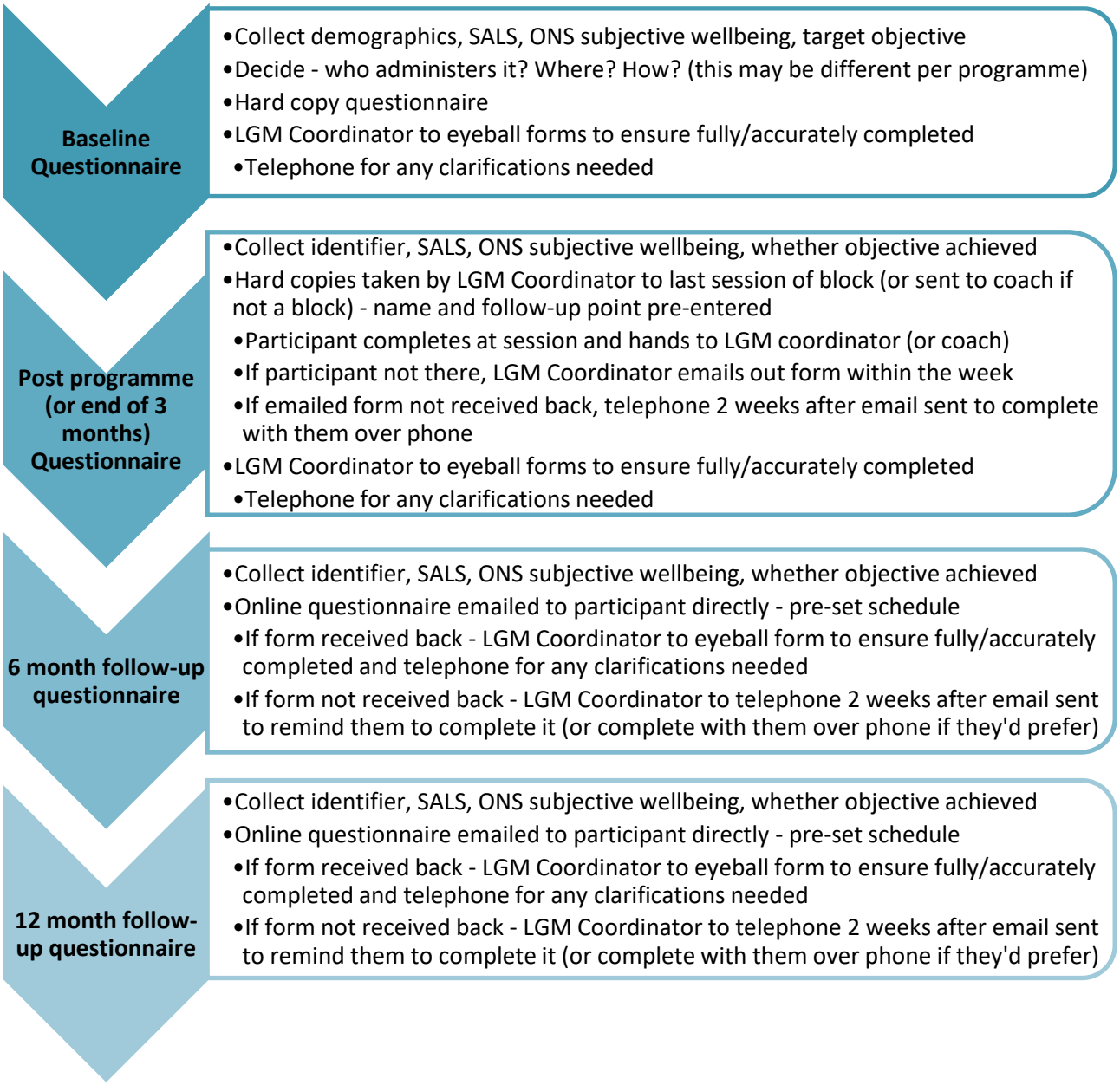
Signature *Date*

You can withdraw your consent at anytime by emailing data@livingsport.co.uk or if you have concerns about the processing of your personal data, please contact the Data Protection Officer, at Living Sport, Lakeside Lodge Health Club, Fen road, Pidley, Huntingdon, Cambridgeshire, PE28 3DF.

APPENDIX D: UPDATED DATA COLLECTION PROCESS

Following the Health Committee meeting on the 8th November 2018, a more consistent process for collecting data has been proposed as this was a significant point for improvement raised within that meeting. This process will enable more robust evidence to be captured to better show impact of the LGM programme on behaviour change.

The baseline questionnaire has been redesigned (as previously discussed and agreed with Public Health) to make it as short and as user friendly as possible and was rolled out in December ready for implementing in the New Year 2019 (Quarter 7). A newly formatted spreadsheet has been sent to all locality coordinators as physical activity levels will now be collected via the Short Active Lives Survey (SALS) and not the IPAQ, and level of mental wellbeing will now be collected via the 4 ONS subjective wellbeing measures and not WEMWBS.



If baseline questionnaires are not completed then follow-up data becomes irrelevant; and baseline questionnaires are not of use unless follow-ups are completed to show impact/behaviour change.

If the phone call is not successful at any follow-up stage then this will be recorded on the spreadsheet. This will allow us to monitor where participants leave the programme.

APPENDIX E1: PRE-ACTIVITY QUESTIONNAIRE

Cambridgeshire County Council

Let's Get Moving Cambridgeshire

About You

Full Name							
Date of Birth				Postcode			
Email address				Contact number			
Gender	Female	Male	Do you consider yourself to have a disability?		Yes	No	
Ethnicity	White British (Inc. English)		White Irish		White Other		
	Asian/Asian British		Black/Black British		Mixed		
	Other (please state)						

Name of Activity Session							
How did you find out about Let's Get Moving / this activity?							
Were you referred or signposted to Let's Get Moving Cambridgeshire?	Yes	No					
If Yes, **why** were you referred or signposted to Let's Get Moving Cambridgeshire?							
What are your goals in taking part in Let's Get Moving Cambridgeshire? (e.g. lose weight, meet people, get fit etc.)							

The questions below are about the time you spent being physically active in the last 7 days.

In the past 7 days, have you done a **continuous walk lasting at least 10 minutes**?	Yes				No			
If YES…								
In the past 7 days, on how many days did you do a walk lasting at least ten minutes? Please circle.	0	1	2	3	4	5	6	7
How much time did you usually spend walking on each day that you did the activity?	_____ hours and _____ minutes per day							
Was the effort you put into walking usually enough to raise your breathing rate?	Yes				No			

In the past 7 days, have you done a **cycle ride**?	Yes				No			
If YES…								
In the past 7 days, on how many days did you do a cycle ride? Please circle.	0	1	2	3	4	5	6	7
How much time did you usually spend cycling on each day that you did the activity?	_____ hours and _____ minutes per day							
Was the effort you put into cycling usually enough to raise your breathing rate?	Yes				No			

In the past 7 days, have you done **sport, fitness activity (such as gym or fitness classes) or dance**?	Yes				No			
If YES…								
In the past 7 days, on how many days did you do a sport, fitness activity (such as gym or fitness classes), or dance? Please circle.	0	1	2	3	4	5	6	7
How much time did you usually spend doing sport, fitness activities or dance on each day that you did the activity?	_____ hours and _____ minutes per day							

Was the effort you put into doing sport, fitness activities or dance usually enough to raise your breathing rate?	Yes	No

On a scale from 0 to 10 where 0 is 'not at all' and 10 is 'completely', please tick how you feel for each statement:

	Not at all → Completely										
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Overall, how satisfied are you with your life nowadays?	0	1	2	3	4	5	6	7	8	9	10
Overall, how happy did you feel yesterday?	0	1	2	3	4	5	6	7	8	9	10
Overall, how anxious did you feel yesterday?	0	1	2	3	4	5	6	7	8	9	10
Overall, to what extent do you feel the things you do in life are	0	1	2	3	4	5	6	7	8	9	10

Thank you for completing this questionnaire.

Insert Privacy Statement
[local authority] is collecting this information in order to evaluate the effectiveness of the programme; in other words, have you increased the amount of physical activity you do because of the programme and has this change in behaviour been sustained.

As data controller, [local authority] will ensure that your personal information is stored safely and only kept for the duration of your involvement in the programme which is up to one year. We will not use this data for any other reason than for the purpose of evaluating this programme. We will anonymise your data before sharing it with Living Sport who is carrying out the evaluation of this programme. Further details about how we are handling your information is available at; www.letsgetmovingcambridgeshire.co.uk/privacy

The legal basis for us asking for this information is informed consent, in other words we are asking for you to give us permission to use the information you provide. We will ask you to answer similar questions after 12 weeks by completing another questionnaire and then at 6 months and 12 months through an emailed questionnaire, which will help us to understand changes in behaviour. We may contact you by phone if we are unable to get a response through your email. Please tick the appropriate boxes below to allow us to do this:

Please tick if we can use the information you have provided to evaluate the effectiveness of the programme: |_|

We can contact you at the appropriate follow up points **by Email: |_|** **by Telephone: |_|**

Signature		Date	

If you have concerns about the processing of your personal data, or you wish to withdraw your consent at anytime, please email the Data Protection Officer, at [ ]: name@organisation.co.uk

APPENDIX E2: FOLLOW UP QUESTIONNAIRE

Cambridgeshire County Council

Let's Get Moving Cambridgeshire

About You

Full Name		Date of Birth	
Name of Activity Session			

The questions below are about the time you spent being physically active in the last 7 days.

In the past 7 days, have you done a **continuous walk lasting at least 10 minutes**?	Yes				No			
If YES…								
In the past 7 days, on how many days did you do a walk lasting at least ten minutes? Please circle.	0	1	2	3	4	5	6	7
How much time did you usually spend walking on each day that you did the activity?	_____ hours and _____ minutes per day							
Was the effort you put into walking usually enough to raise your breathing rate?	Yes				No			

In the past 7 days, have you done a **cycle ride**?	Yes				No			
If YES…								
In the past 7 days, on how many days did you do a cycle ride? Please circle.	0	1	2	3	4	5	6	7
How much time did you usually spend cycling on each day that you did the activity?	_____ hours and _____ minutes per day							
Was the effort you put into cycling usually enough to raise your breathing rate?	Yes				No			

In the past 7 days, have you done **sport, fitness activity (such as gym or fitness classes) or dance**?	Yes				No			
If YES…								
In the past 7 days, on how many days did you do a sport, fitness activity (such as gym or fitness classes), or dance? Please circle.	0	1	2	3	4	5	6	7
How much time did you usually spend doing sport, fitness activities or dance on each day that you did the activity?	_____ hours and _____ minutes per day							
Was the effort you put into doing sport, fitness activities or dance usually enough to raise your breathing rate?	Yes				No			

On a scale from 0 to 10 where 0 is 'not at all' and 10 is 'completely', please tick how you feel for each statement:

	Not at all → Completely										
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Overall, how satisfied are you with your life nowadays?	0	1	2	3	4	5	6	7	8	9	10
Overall, how happy did you feel yesterday?	0	1	2	3	4	5	6	7	8	9	10
Overall, how anxious did you feel yesterday?	0	1	2	3	4	5	6	7	8	9	10

Overall, to what extent do you feel the things you do in life are	0	1	2	3	4	5	6	7	8	9	10

What was your goal for taking part in Let's Get Moving Cambridgeshire? (e.g. lose weight, meet people, get fit etc.)
Have you achieved your goal?
What impact has Let's Get Moving had on you personally? (e.g. self confidence, friendships etc.)

Thank you for completing this questionnaire.

Insert Privacy Statement
[local authority] is collecting this information in order to evaluate the effectiveness of the programme; in other words, have you increased the amount of physical activity you do because of the programme and has this change in behaviour been sustained.

As data controller, [local authority] will ensure that your personal information is stored safely and only kept for the duration of your involvement in the programme which is up to one year. We will not use this data for any other reason than for the purpose of evaluating this programme. We will anonymise your data before sharing it with Living Sport who is carrying out the evaluation of this programme. Further details about how we are handling your information is available at; www.letsgetmovingcambridgeshire.co.uk/privacy

The legal basis for us asking for this information is informed consent, in other words we are asking for you to give us permission to use the information you provide. We will ask you to answer similar questions after 12 weeks by completing another questionnaire and then at 6 months and 12 months through an emailed questionnaire, which will help us to understand changes in behaviour. We may contact you by phone if we are unable to get a response through your email. Please tick the appropriate boxes below to allow us to do this:

Please tick if we can use the information you have provided to evaluate the effectiveness of the programme: |_|

We can contact you at the appropriate follow up points **by Email: |_|** **by Telephone: |_|**

Signature		Date	

If you have concerns about the processing of your personal data, or you wish to withdraw your consent at anytime, please email the Data Protection Officer, at [ ]: name@organisation.co.uk

APPENDIX F: KEY PERFORMANCE INDICATOR DEFINITIONS

KPI no.	Key Performance Indicators	Explanation of KPI's
1	**Programme projects**	
1.1	Number of new programmes developed through LGMC	Include new programmes you have developed this quarter only.
	Number of new activities continuing 6 months after initiation (sustained)	This is the number of new programmes/activities you have developed that are continuing after 6 months. Only count those that are still going in this quarter.
	Number of existing "LA" programmes supported through LGMC (added value)	The number of programmes/activities that you have supported in this quarter and you have added value to it - This may or may not have happened without you, but essentially you are not leading this activity.
1.2	Number of participants (individual)	NEW participants in activities / programmes this quarter
	Number of mass participation attendees	Number of people attending mass participation events or activities this quarter (for example parkrun, community events, etc.)
1.3	% of participants that undergo an assessment (where appropriate) (forms)	Consider what programmes it is achievable to administer questionnaire (assessments) to. Of those programmes count the number of participants that took part in the quarter. (P1) Now count the number of those participants that completed questionnaires. (P2) P2 / P1 * 100 = % of participants that undergo an assessment
1.4	% of programme completers (where appropriate)	Consider what programmes have a clear end (12 weeks, 9 weeks etc.) or it is manageable to track attendance for a set period (12 weeks). Of those programmes count the number of participants that took part in this quarter (P1) Now count the number of those participants that attended 60% or more of the sessions. (P2) P2 / P1 * 100 = % of participants that completed a programme
1.5	% of participants who report that they have achieved their physical activity objectives/goals	Using the data collection database, evaluate the follow up data and identify the number of participants that have completed post programme questionnaires. (P1) Now count the number of those participants that have responded with a positive answer for objectives achieved (e.g. Yes, Mostly, etc.). (P2) P2 / P1 * 100 = % of participants that have achieved their objectives

1.6	% of initiatives in areas with lowest levels of physical activity	Count the number of initiatives that you have developed or supported this quarter. (I1) Now count the number of those initiatives that are in the 20% most deprived wards/MSOA's/LSOA's for your area. (I2) I2 / I1 * 100 = % of initiatives in areas with lowest levels of physical activity
2	**External signposting**	
2.1	Number of people signposted to Let's Get Moving	Number of people that complete pre programme questionnaires and state that **they have been referred** to LGMC.
	Number of people self-signposted to Let's Get Moving	Number of people that complete pre programme questionnaires and state **how they heard** about LGMC, and the answer they have given refers to a clear sign posted by themselves action (e.g. attended having seen promotion through social media, poster, heard about it in conversation or through the radio etc.)
2.2	Reason for signposting or self-signposting	N/A - evidence of data collected in data report
3	**Community resilience**	
3.1	Number of community led physical activity programmes 'initiated' through the brand	The number of programmes or activities you have developed this quarter that the community/volunteers/club are leading.
3.2	Number of community led programmes 'supported' through the brand	The number of programmes you have supported (added value to) this quarter that the community/volunteers/club are leading
3.3	% of physical activity community led programmes continuing and led by community members after 6 months	Consider the number of community led programmes/activities you have initiated or supported that are continuing after 6 months. Only count those that are still going in this quarter. Now calculate this as a percentage of the total number of community led programmes/activities to date.
4	**District media and promotional activity**	
4.1	Number of promotional events in the district	
4.2	% that received media / social media coverage	
5	**Countywide media and promotional activity**	
5.1	Number of countywide promotional events supported by the district programme	
5.2	% that received media / social media coverage	
6	**Demographics core data set for specific formal projects only**	
	evidence of data collected in data collection spreadsheet	N/A
7	**Quality Indicators**	
7.1	*Range of programmes and their evidence base along with general progress overview*	N/A

8	Evaluation	
8.1	Evidence of full participation in the evaluation	All KPI's reported and data provided evidence of this
9.1	Key stakeholders are engaged in the ongoing development and governance of the programme	Further information each quarter detailing partners engaged and level of involvement in the project
9.2	Evidence of public engagement plans which affords public consultation and feedback	Further information each quarter detailing public engagement undertaken
9.3	Evidence of improvements made to programmes as a result of user feedback (including non-completers)	Further information each quarter detailing changes made to programmes as a result of user feedback
9.4	% of participants rate the programmes as good or excellent	
9.5	Number of service users making formal complaints about the programmes (verbal or written)	6 monthly written report detailing any issues and actions undertaken
10.1.	Evidence of action plan developed to address underrepresentation of protected characteristics identified in the Equality Act 2010 compared to local demographics.	

APPENDIX G: EXAMPLES OF PROGRAMMES

Countywide LGMC

- The Living Sport LGMC countywide function is to support local developments and disseminate good practice across the county.
    - An example of this was the Cambridge United Community Trust –Man V Fat programme. LGMC facilitated its development not just in Cambridge but across Cambridgeshire with locality level partnerships setting up walking football and disability sessions. This included LGMC reimbursing the registration fee of any Cambridgeshire residents who took part in Man V Fat, completed pre and post programme questionnaires and attended 60% of the sessions.
    - Another example is the Cycling Programme currently being developed which will be one cycling countywide scheme, with one name, but might operate slightly differently in some areas based on local need and demographic variances.
- LGMC has a close working relationship with the countywide Integrated Lifestyle Service provided by Everyone Health. This includes LGMC collaborating with the Lifestyle Service to develop and deliver a range of activities.
- LGMC has been central in the development of three new Parkruns (St Neots, Littleport and Coldhams Common) through undertaking the public consultations, land permission audits, recruitment of delivery teams and establishing facilitative partnerships (e.g. negotiating with One Leisure in St Neots to open the centre early on a Saturday morning for access to the changing rooms). In addition more generally LGMC intelligence has enabled Living Sport to focus its work with local parkrun ambassadors in areas of greater need.

Fenland LGMC

- Active Fenland is the physical activity programme that was funded for three years by Sport England. It had a focus on 14+ year olds engaging in sport and physical activity. The Active Fenland name and brand was established and is now widely accepted in Fenland, therefore the approach taken was to use Active Fenland 'in partnership with Let's Get Moving Cambridgeshire'. The joint working has enabled the Active Fenland programme to diversify its offer and target certain groups.
- Examples include those where local partners have provided funding to develop activities. LGMC worked with Clarion Housing which led to it providing funding to develop physical activity opportunities in the localities where its housing is situated.
- LGMC is working with the Richmond Fellowship on a countywide partnership which has already been initiated in Fenland that will target engaging those with mental health issues in walking and talking sessions.
- At the Oasis Community Centre in Wisbech LGMC has introduced a number of activities. As a community centre a wide range of people access the centre, many of whom do not take part in physical activities. The relationships the staff at the Oasis Centre have established with local people means they are trusted and respected. When they offer advice and signpost to activities this is often well received and many people have been signposted to LGMC by these types of partners. LGMC has also delivered or paid for an activity in the Centre and identified community members to continue the sessions if they are successful. In return the Centre provides discounted use of the facility and will continue to support the activities over the longer term.
- The Rosmini Centre is an important community partner for engaging people from Eastern Europe. The Centre assists with translation and works with LGMC to support the development of activities at the Centre.

East Cambridgeshire LGMC

- Littleport Leisure Centre has emerged as a particularly valuable partner in a priority area. It has an open and innovative approach that has enabled LGMC to try new ideas to engage the least active residents in physical activity.
- Millbrook House is a care home in Soham. The local LGMC Coordinator leads a bi-weekly walk from the Care Home with residents taking a brisk and manageable walk around the town. It is open to the wider community and promoted as such through various local routes. It is part of a new community based model for delivering social care which is being piloted in St Ives and Soham.

Huntingdonshire LGMC

- The local leisure service provider “One Leisure” has been proactive in enabling and sustaining activities.
- Papworth Hospital has provided LGMC with the opportunity of promoting local physical activity opportunities including exercise referral with cardiac patients completing the cardiac rehabilitation programme.
- Local Back to Netball and Walking Netball activities linking with England Netball have been developed, supported by Living Sport funding.

Cambridge City LGMC

- LGMC worked with a Physical Education teacher from the North Cambridge Academy who had identified a particular demographic (girls not engaging in PE) to develop an after school programme that would appeal to them.
- A partnership with the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) CAMEO is an early intervention service for people with mental ill health. It has developed a joint initiative for engaging patients in physical activity.
- Chesterton Sports Centre has been working with LGMC to try new approaches to engage local people in physical activity using the facilities at the Centre. It is piloting a number of new activities that includes Swim and Tone (a women only activity for those who experience anxiety, low self-confidence and body image concerns) and Try it for 10.

South Cambridgeshire LGMC

- LGMC worked with Cambridge United Community Trust on its Man V Fat initiative.
- The Forever Active Programme targets older people with appropriate physical activities and worked with LGMC to develop a number of new activities for older people in locations with limited access to leisure facilities.
- The Granta Medical Practice (Group of GP surgeries) has a social navigator to support the wide ranging needs of many of its patients. LGMC is developing a package of physical activity opportunities in conjunction with the practices.

ANNUAL HEALTH PROTECTION REPORT (2018)

To:	**Health Committee**
Meeting Date:	**23 May 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** ***Key decision:*** **No**
Purpose:	**To present the Cambridgeshire and Peterborough Annual Health Protection Report (2018), which provides information on and assurance of the local delivery of health protection functions.**
Recommendation:	**The Committee is asked to note the information in the Annual Health Protection Report (2018).**

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

BACKGROUND

1.1 The Annual Health Protection Report (2018) attached as Appendix 1 is the sixth annual report on health protection produced in Cambridgeshire since the transfer of public health functions to local authorities.

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

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

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

1.5 This year a joint report for Cambridgeshire and Peterborough has been produced, although data is presented separately for Cambridgeshire and Peterborough where available. The data presented in this report was current and accurate at the time of producing the report (January 2019).

2. MAIN ISSUES

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

- Communicable disease surveillance and reporting of infectious disease outbreaks.
- Immunisations which show a steady state for some and a gradual increase in uptake of many childhood immunisations and of seasonal flu vaccination.
- Screening in which cervical screening continues to have lower than ‘acceptable’ uptake in Cambridgeshire, corresponding with the national pattern.
- Healthcare associated infections and the work to reduce anti-microbial resistance.
- The Environmental Health role of city and district councils in protecting health including pollution control and air quality monitoring and advice.[1]
- The national TB strategy and local implementation of some key areas of the strategy, notably Latent TB Infection Screening (LTBI).

[1] This section of the report has been extended following feedback from the Cambridgeshire Health Committee in 2018.

- Sexual health including the reducing level of sexually transmitted infections diagnoses, greater than average rates of late HIV diagnosis and low rates of chlamydia detection. The teenage pregnancy rates in Cambridgeshire remain below the England average.
- Health emergency planning, the work completed in the past 12 months and the priorities for the coming year.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

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

3.2 Helping people live healthy and independent lives

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

3.3 Supporting and protecting vulnerable people

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

Source Documents	Location
None	

Cambridgeshire and Peterborough Annual Health Protection Report 2018

Produced by partner organisations of the Cambridgeshire and Peterborough Health Protection Steering Group on behalf of the Director of Public Health (February 2019)

Contents

1. Introduction

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

The services that fall within Health Protection include:

- The prevention and management of communicable (infectious) diseases;
- infection control;
- routine antenatal, new born, young person and adult screening;
- routine immunisation and vaccination;
- sexual health; and
- environmental hazards.

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

The Director of Public Health (DPH) produces an annual health protection report to the Health and Wellbeing Boards or Health Committee as appropriate, which provides a summary of relevant activity. This report covers multi-agency health protection plans that are in place to establish how the various responsibilities are discharged. Any other reports will be provided on an ad hoc or exceptional basis where a significant incident, outbreak or concern has arisen. Details of the legislative background to the role of DPH and the role of the County Council in relation to health protection have been included in previous annual health protection reports and will not be reproduced here.

2. Cambridgeshire and Peterborough Health Protection Steering Group

To enable the DPH to fulfil the statutory responsibilities in relation to health protection, the Cambridgeshire and Peterborough Health Protection Steering Groups were established in October 2013. These committees were replaced in October 2016 by a joint committee for Cambridgeshire and Peterborough that recognised the wider geography covered by many of the member organisations and the closer working on Public Health between the two local authorities. The Cambridgeshire and Peterborough Health Protection Steering Group (CP HPSG) enables all agencies involved to demonstrate that statutory responsibilities for health protection are being fulfilled; to have the means to seek assurance of this; and to have processes in place to address and escalate any issues that may arise. In addition, a memorandum of understanding (MOU) has been agreed with partner organisations. To ensure that the shared membership fully protected confidentiality of any sensitive items discussed, a Confidentiality / Non-disclosure Agreement was included with the Terms of Reference.

3. Surveillance of Infectious Diseases

3.1 Notifications of Infectious Diseases

Registered medical practitioners in England and Wales have a statutory duty to notify their local authority or local Public Health England Health Protection Team of suspected cases of certain infectious diseases. These notifications along with laboratory confirmed data enable surveillance of the diseases and for the Health Protection Team to take any required public health action to minimize risk to others.

TABLE 1: Numbers of cases of notifiable diseases, Cambridgeshire and Peterborough, 2015 – 2018 (Source: Public Health England, East of England Health Protection Team HP Zone)								
	Cambridgeshire				**Peterborough**			
Notifiable Disease†	**2015**	**2016**	**2017**	**2018***	**2015**	**2016**	**2017**	**2018**
Acute infectious hepatitis	25	20	39	36	17	14	13	9
Acute meningitis	8	12	10	8	<5	<5	<5	<5
Food poisoning (including the organisms below)	205	226	195	183	63	86	59	67
E coli O157 VTEC	5	<5	<5	<5	<5	<5	<5	<5
Cryptosporidium	90	85	90	68	18	19	15	11
Giardia	16	22	23	22	12	20	6	16
Salmonella	80	101	77	88	23	38	35	37
Infectious bloody diarrhoea	5	11	12	12	<5	6	<5	<5
Invasive group A streptococcal disease	18	20	34	25	<5	7	14	11
Legionnaires' disease	<5	6	<5	9	<5	<5	<5	<5
Malaria	9	13	7	7	<5	<5	0	<5
Measles**	13 (<5)	17 (6)	18 (0)	7 (0)	<5 (0)	<5 (0)	<5 (0)	<5 (0)
Meningococcal septicaemia	9	11	8	8	<5	<5	<5	<5
Mumps**	24 (<5)	39 (<5)	55 (10)	51 (10)	8 (<5)	11 (<5)	10 (<5)	11 (0)
Rubella**	5 (0)	5 (0)	5 (0)	<5 (0)	<5	0	<5	0
Scarlet fever	159	239	161	252	98	56	92	105
Whooping cough	80	203	157	88	15	49	33	10

NB. Figures for 2018 are provisional.

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

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

3.2 Outbreaks and Incidents

TABLE 2: Number of outbreaks and incidents in Cambridgeshire and Peterborough, 2018 (Source: Public Health England, East of England Health Protection Team, HP Zone)		
Type of incident	**Cambridgeshire**	**Peterborough**
Gastroenteritis in residential settings	29	7
Influenza / influenza-like illness in residential settings	24	2
Likely foodborne	4	1
Other	1	1

There were a number of outbreaks notified to the Public Health England Health Protection Team which were investigated. In **Cambridgeshire** this included:

- 29 gastrointestinal (GI) outbreaks in residential settings, which included care homes, a custodial institution and a youth hostel.
- 24 influenza or influenza-like illness outbreaks which were all in care homes. Seven of these were confirmed outbreaks of influenza A, three influenza B and one each of metapneumovirus, parainfluenza, and rhinovirus.
- There were four outbreaks of gastrointestinal infection that were likely to be foodborne illness. This included a cluster of salmonella cases linked by whole genome sequencing. There were two separate outbreaks of gastrointestinal illness possibly associated with restaurants and an outbreak of GI illness following a self-catered party. The causal organism was not identified for either of these outbreaks.
- There was also notification of an outbreak of scarlet fever at a nursery.

In **Peterborough**, this included:

- There were seven outbreaks of gastrointestinal (GI) infection in care homes, and one outbreak of GI infection linked to a catered wedding event.
- Peterborough also saw two outbreaks of Influenza-like illness in care homes, along with an outbreak of scabies in a care home.
- Two separate tuberculosis (TB) screening events were held in in Peterborough following identification of significant TB exposure with employees screened at a factory and a distribution centre. All active TB cases were treated for TB and are no longer infectious and people who screen positive for TB are clinically assessed by the local NHS respiratory clinicians and offered appropriate treatment.

3.3 Tuberculosis

TB is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It mainly affects the lungs, but it can affect any part of the body, including the abdomen glands, bones and nervous system. TB is a serious condition but it can be cured if it's treated with the right antibiotics. The Collaborative Tuberculosis Strategy for England (2015 to 2020) brings together best practice in clinical care, social support and public health to strengthen TB control, with the aim of achieving a year-on-year decrease in incidence, a reduction in health inequalities and, ultimately, the elimination of TB as a public health problem in England. The strategy aims to make improvements in a number of key areas including strengthening surveillance and monitoring, and systematically implementing new entrant latent TB screening.

3.3.1 Tuberculosis Surveillance

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

Official TB statistics are based on data extracted from ETS in April each year. The time to process and analyse this data takes a further six months, therefore the latest official statistics are for data to the end of 2017.

In 2017, 84 cases of TB were notified among residents of Cambridgeshire and Peterborough local authorities (figure 1). The TB rate in Cambridgeshire (6.2 per 100,000) remains below the East of England average (6.4 per 100,000). The rate in Peterborough (22.1 per 100,000) remains substantially higher than average, and increased between 2015 and 2017 following a decline from the peak in 2012 (31.6 per 100,000). The number of TB cases increased in both areas in 2017 compared to 2016.

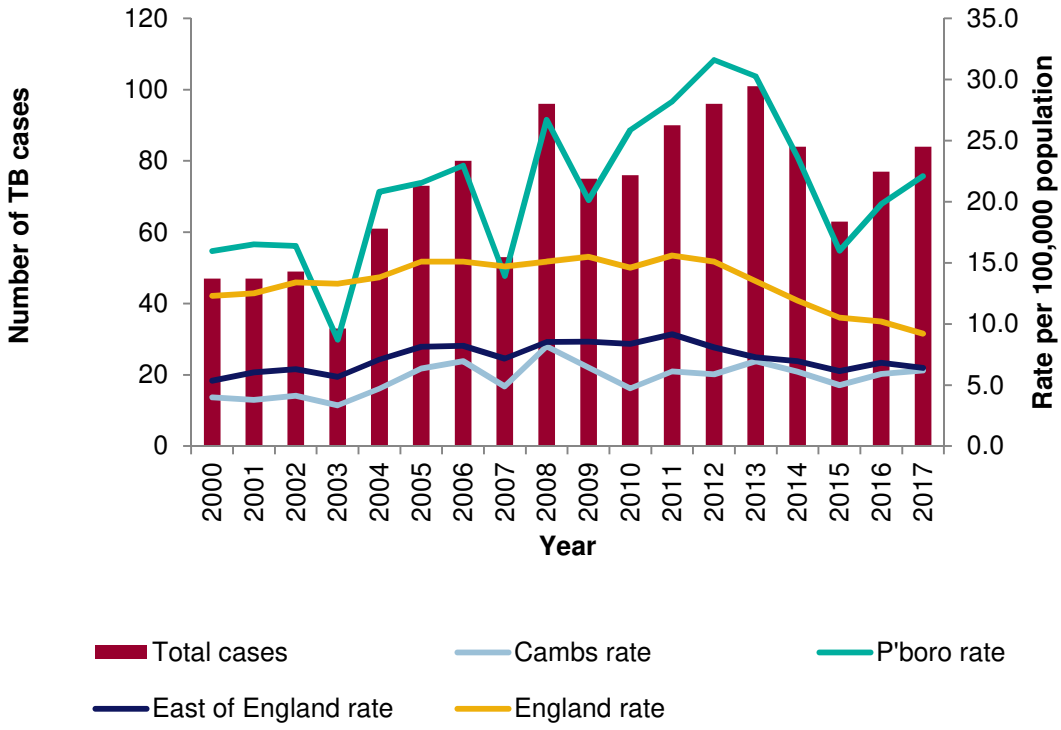


Figure 1: Annual TB notifications by area, 2000-2017 (Source: Public Health England ETS)

- Across Cambridgeshire and Peterborough, the majority of cases were aged 15-44 years, with a mean age of 39.8 years (figure 2).
- 77.1% of cases were non-UK born, with India, Lithuania, Pakistan and Timor-Leste being the most common non-UK countries of birth. In 2017, a similar number of cases were UK born as in 2016.
- In Cambridgeshire, a smaller proportion (8.8%) of patients had a social risk factor compared to the East of England region as a whole (11.3%), whereas a larger proportion of patients in Peterborough had social risk factors (22.9%).
- 4.5% of TB patients in Cambridgeshire, and 3.7% in Peterborough had multi-drug resistant TB. Across the East of England region as a whole, the percentage was 3.4%.
- In Cambridgeshire, 18.4% of TB patients received Directly Observed Treatment (DOT), compared to 4.9% in Peterborough. Across the East of England region as a whole 7.1% of TB patients received DOT.

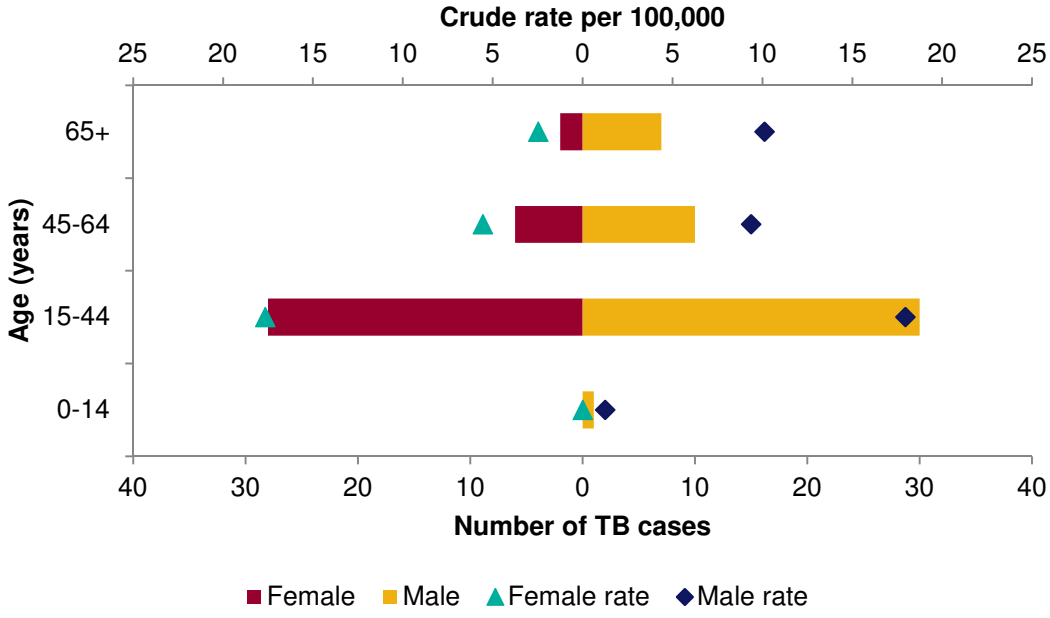


Figure 2: TB notifications by age and sex, Cambridgeshire and Peterborough, 2017 (Source: Public Health England ETS)

Further information on TB in Cambridgeshire and Peterborough can be found in the following resources:

- 2017 data on TB monitoring indicators for local authorities can be found on Fingertips: https://fingertips.phe.org.uk/profile/tb-monitoring.
- Tuberculosis East of England Annual Review 2018 (including data to the end of 2017): https://www.gov.uk/government/publications/tuberculosis-tb-regional-reports

3.3.2 Latent Tuberculosis Infection Screening Programme

3.3.2.1 Background

Latent TB infection (LTBI) is where a person has been infected with the TB bacteria but doesn't have any symptoms of active infection. In cases of LTBI, there is a risk that the infection may become active. The aim of the LTBI screening programme is to support the early diagnosis of latent TB and offer treatment of active disease.

Following the publication of the National Collaborative Tuberculosis Strategy, NHS England has committed £10 million for the establishment of testing for, and treatment of, LTBI in new entrants from countries of high TB incidence. Public Health England has committed £1.5 million for the establishment of the national TB office and support teams to the nine TB control boards. It is likely that the majority of TB cases in the UK are the result of 'reactivation' of LTBI, an asymptomatic phase of TB which can last for years. There is a 5% risk of a patient with LTBI becoming TB. LTBI can be diagnosed by a single, validated blood test and treated effectively with antibiotics, preventing TB disease in the future.

Following the publication of the national strategy, a review of TB services was undertaken in Cambridgeshire and Peterborough. The key epidemiology findings are summarised below which provide an overview of the impact of TB on the resident population of the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

- There were 999 cases of TB reported in Cambridgeshire and Peterborough residents between 2004 and 2014. Cambridgeshire had an average of 44 cases/year, and Peterborough had an average of 47 cases/year despite its smaller population.
- Almost three quarters (73%) of TB cases between 2004 and 2014 were in non-UK born individuals.
- The most common countries of origin of TB cases in Cambridgeshire & Peterborough in the last three years were UK, India, Pakistan, Lithuania, East Timor and Kenya. Public Health England recommend screening patients born or spent >6 months in high TB incidence country (150 cases per 100,000 or more/Sub- Saharan Africa).

3.3.2.2 Method

The eligibility criteria for the LTBI Screening Programme is any new patient registering with a practice or retrospectively identified by the practice as being:

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

A number of stakeholders from across the local system are involved in the programme. These include the CCG, a number of local GP practices, North West Anglia Foundation Trust (NWAFT), Cambridgeshire and Peterborough Foundation Trust (CPFT), Peterborough City Council, Public Health England, Oxford Immunotec and Novice.

GP practices with a high crude rate of TB cases were identified by Public Health England (PHE). Of these, practices with a crude annual rate of active TB ≥ 20 cases/100,000 have been prioritised for the LTBI screening programme. High active TB rates are used as a proxy for an anticipated high incidence of latent TB. Engagement of the designated practices is on-going and all have agreed to deliver the project. The CCG offers a Local Enhanced Service (LES) to all participating practices.

The project initially commenced in March 2016 and from 1 April 2018, 18 practices have signed up to deliver (17 Greater Peterborough Practices and Cornford House based in Cambridgeshire).
We are now conducting outreach and face to face work with community organisations, leaders and members of the public to inform them of TB and the Latent TB programme.

3.3.2.3 Communication and Engagement

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

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

The CCG has appointed a Project Support Officer to deliver the action plan and to carry out the face to face work with the public and community organisations. This will support the Latent TB programme and the identification of eligible people for screening. The main focus of the action plan is to target eligible people through community groups, educational settings, work place setting and the prison service.

3.3.2.4 Activity

TABLE 3: LTBI Screening Programme Activity to Date (until end of November 2018), Source: Cambridgeshire and Peterborough Clinical Commissioning Group

Activity	**Data**
Negative	475
Positives	90
Borderline negative	12
Borderline positive	11
Indeterminate	5
Non reportable insufficient cells	4
Technical error	3
Assay not run	5
Total screened	**605**

Oxford Immunotec continue to report the activity on a monthly basis and we also have confirmation of numbers via LES reporting and NWAFT. The CCG has acknowledged that there has been a reduction of activity due to exhaustion of eligible patient lists. However, numbers are continued to being picked up by the GP practices through new registrations and prospective searches. The CCG also anticipates that the uptake of screening will increase as a result of the targeted outreach and face to face work, alongside promotion of the screening programme.

3.3.2.5 Next Steps

There has been a positive response by the participating practices to the screening programme and the CCG is receiving positive feedback regarding the activity that is being seen and treated. The CCG has recruited a new Project Support Officer to conduct the outreach work. We will work closely with Public Health England to ensure that there is a coordinated approach to the outreach, which will ensure eligible people are targeted for the uptake of screening. The Project Support Officer will continue to work closely with representatives from community connectors, local Youth Support Team, colleges, employers, drug & alcohol service and rough sleepers in order to maintain the promotion and raising awareness of the screening programme.

4. Immunisation Programmes

The tables and figures in this section detail uptake of the various vaccination programmes over time and compared to the regional level of uptake. NHS England commissions various providers to deliver the vaccination programmes including GPs, pharmacies and school nursing teams. The full UK vaccination schedule can be found here: https://www.nhs.uk/Conditions/vaccinations/.

The Cambridgeshire and Peterborough Health Protection Steering Group receives regular reports on vaccination uptake and work that is happening to increase uptake for certain vaccines with lower uptake rates, which has recently included the pre-school booster, MMR and the flu vaccination. The aim for all childhood programmes is to achieve at least 95% uptake, the level which ensures herd immunity, although for many vaccinations, the target rate set by the Public Health Outcomes Framework is 90%.

Herd immunity occurs when the vaccination of a significant portion of a population provides a measure of protection for individuals who have not developed immunity. It arises when a high percentage of the population is protected through vaccination, making it difficult for a disease to spread because there are so few susceptible people left to infect. This can effectively stop the spread of disease in the community. It is particularly crucial for protecting people who cannot be vaccinated. These include children who are too young to be vaccinated, people with immune system problems, and those who are too ill to receive vaccines (such as some cancer patients). Details of the UK vaccination programme and what each vaccine protects against can be found on the NHS choices website.

The Cambridgeshire and Peterborough Immunisation Forum meets 3 – 4 times per year to discuss all issues relating to immunisations and to take forward the recommendations of a previous Immunisation 'Task and Finish' group that reported two years ago. The Task and Finish group had been set up to identify the reasons for lower immunisation uptake for childhood immunisation. Ongoing work includes:

- Close working with GP practices in some areas with particularly low uptake and high waiting lists to reduce the number of children waiting for their routine immunisations, including the pre-school booster; waiting lists have reduced by 65.7% [period Feb 2018 to Nov 2018].
- Immunisations targeted in a local campaign in March / April 2018 with specific focus on the pre-school booster, MMR2 and HPV vaccines.
- NHS England has commissioned Cambridgeshire Community Services to offer MMR vaccination to those school age adolescents who are partially or unimmunised, commencing in 2018-2019.
- Due to lower uptake rates of the shingles vaccination in Peterborough, a Shingles project was launched in October 2018, and will run until March 2019. GP practices voluntarily sign up to the project that involves reimbursement for sending 70 year old birthday cards with shingles vaccination reminders, additional training for their staff, and a resource pack for practices.

4.1 Childhood Primary Vaccinations

4.1.1 6-in-1 Vaccine (12 months)

TABLE 4: Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

12 months DTaP/IPV/Hib/Hep B [target 95%]	**Q1 2016/17 %**	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	93.8	94.1	94.2	94.2
Peterborough	93.5	93.8	93.9	94.3
East Anglia	95.0	95.2	95.2	95.0

	Q1 2017/18 %	Q2 2017/18 %	Q3 2017/18 %	Q4 2017/18 %
Cambridgeshire	93.1	93.8	94.7	93.6
Peterborough	93.6	94.3	90.9	91.3
East Anglia	94.6	95.3	94.6	94.5

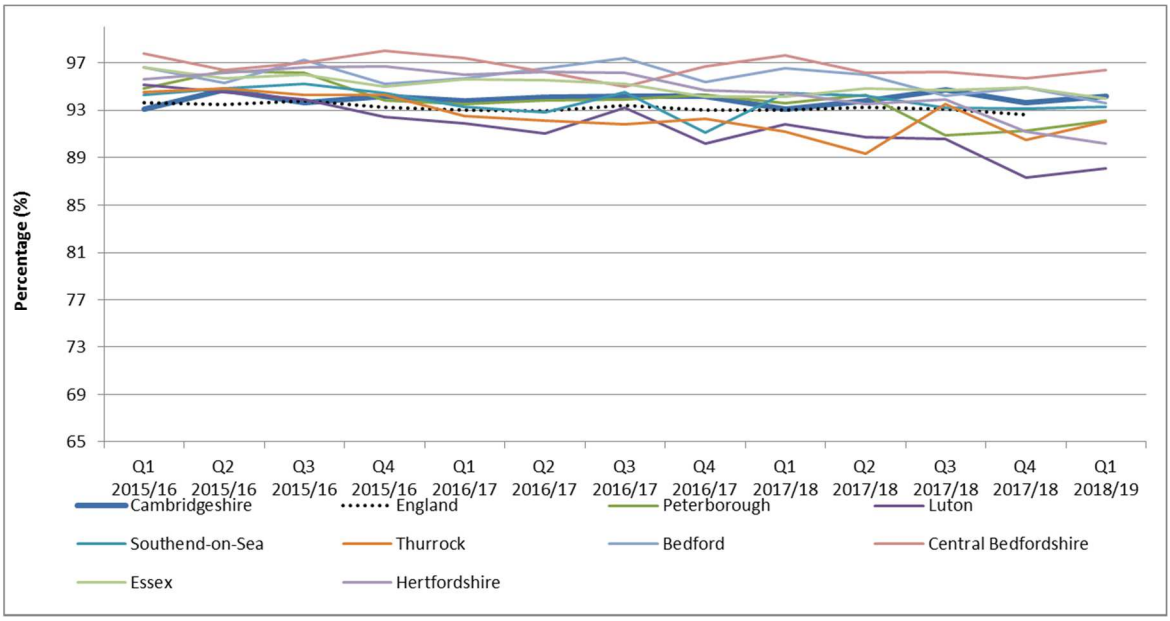


Figure 3: Uptake rates for 6-in-1 vaccine at 12 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B, hepatitis B – target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

4.1.2 Pneumococcal Vaccine (12 months)

TABLE 5: Uptake rates for pneumococcal (PCV) vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	Q2 2016/17 %	Q3 2016/17 %	Q4 2016/17 %
Cambridgeshire	94.3	94.3	94.3	95.2
Peterborough	93.6	93.6	93.5	94.2
East Anglia	95.4	95.3	95.3	95.1
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	93.8	94.4	95.0	94.3
Peterborough	93.6	94.5	91.1	91.8
East Anglia	94.9	95.5	94.9	95.0

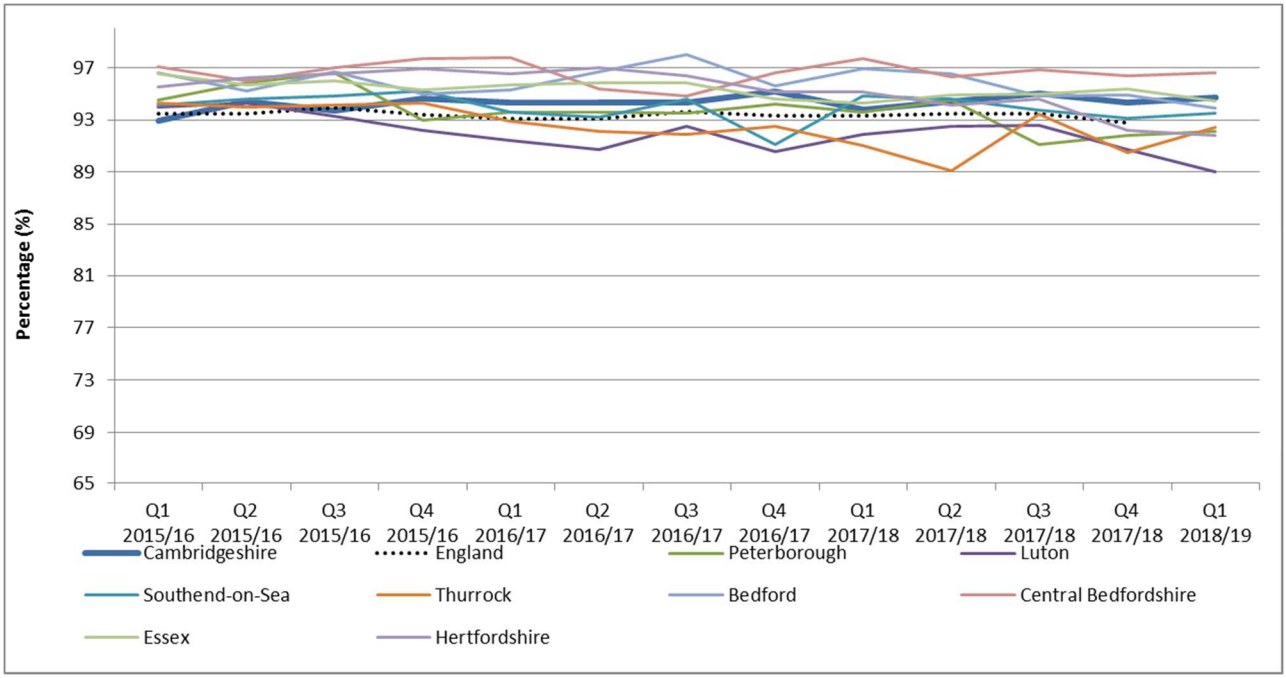


Figure 4: Uptake rates for pneumococcal vaccine at 12 months (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

4.1.3 5-in-1 Vaccine (24 months)

TABLE 6: Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	93.7	95.4	94.8	95.6
Peterborough	95.6	96.9	96.4	96.4
East Anglia	96.1	96.2	96.4	96.3
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	95.3	95.6	96.2	96.1
Peterborough	96.1	95.1	93.8	95.7
East Anglia	96.3	96.3	95.9	96.3

4.1.4 Pneumococcal Vaccine (24 months)

TABLE 7: Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	89.9	92.0	92.9	93.0
Peterborough	92.8	92.8	93.7	92.6
East Anglia	92.9	94.3	94.1	94.0
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	94.1	93.4	93.2	92.8
Peterborough	91.3	90.8	89.9	89.1
East Anglia	94.0	94.0	92.8	92.9

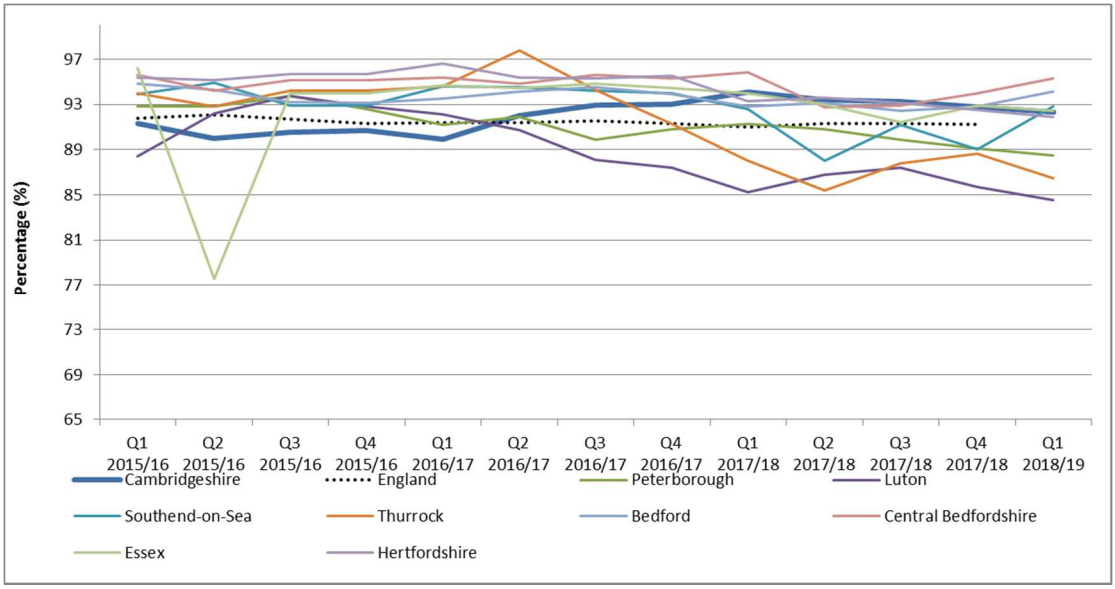


Figure 5: Uptake rates for pneumococcal vaccine at 24 months (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

4.1.5 Haemophilus influenza B and meningococcus C (24 months)

TABLE 8: Uptake rates for haemophilus influenza B and meningococcus C vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	89.6	92.0	92.7	93.0
Peterborough	90.8	92.6	89.5	90.7
East Anglia	92.8	94.3	94.1	94.0
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	94.2	93.3	92.6	93.1
Peterborough	91.0	91.4	90.1	88.9
East Anglia	94.0	93.9	92.5	92.8

4.1.6 Measles, mumps & rubella (MMR) Vaccine (24 months)

TABLE 9: Uptake rates for measles, mumps and rubella (MMR) vaccine at 24 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	89.4	91.6	92.9	92.8
Peterborough	91.8	92.2	89.2	91.6
East Anglia	92.7	93.8	93.9	94.0
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	93.8	93.1	92.8	92.6
Peterborough	90.7	90.9	90.3	88.7
East Anglia	93.7	93.7	92.6	92.5

4.1.7 5-in-1 Vaccine (5 years)

TABLE 10: Uptake rates for 5-in-1 vaccine at 24 months (diphtheria, tetanus, pertussis, polio, haemophilus influenza B – target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	93.1	93.7	93.9	95.0
Peterborough	95.7	96.4	97.5	97.1

East Anglia	96.0	96.9	96.2	96.2
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	94.6	94.0	96.1	96.4
Peterborough	97.0	96.6	95.1	96.3
East Anglia	96.1	96.1	96.6	96.8

4.1.7 Measles, mumps & rubella (MMR) Vaccine (5 years)

TABLE 11: Uptake rates for measles, mumps and rubella (MMR) vaccine – first dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Cambridgeshire	92.4	93.7	93.5	95.2
Peterborough	95.3	95.7	96.6	96.7
East Anglia	95.4	96.0	95.5	95.6
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	94.7	94.1	95.6	96.1
Peterborough	96.4	96.5	94.5	96.2
East Anglia	95.6	95.6	95.8	96.4

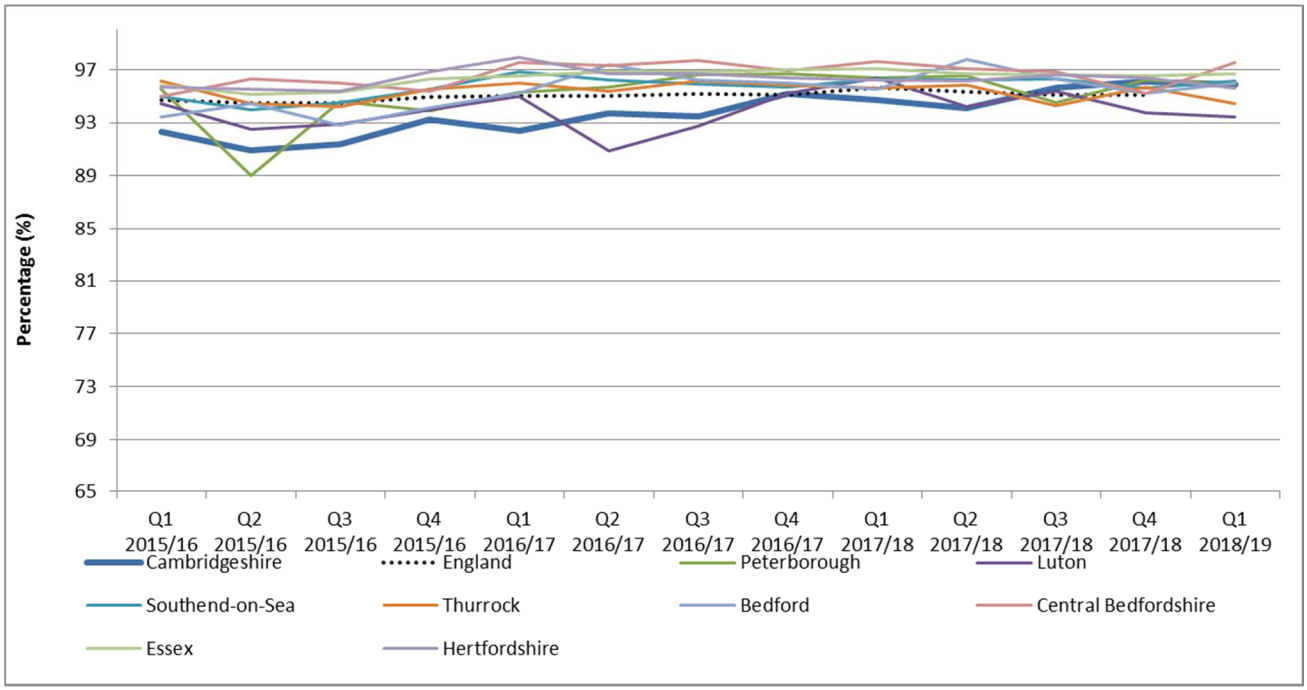


Figure 6: Uptake rates for MMR vaccine – **first dose** at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

TABLE 12: Uptake rates for measles, mumps and rubella (MMR) vaccine – second dose at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Cambridgeshire	82.7	83.8	85.1	88.8
Peterborough	89.8	91.6	92.6	88.6
East Anglia	88.2	89.8	90.1	90.1
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	85.6	86.8	89.6	91.0
Peterborough	89.3	90.6	88.5	89.3
East Anglia	89.3	90.0	89.9	90.7

Source: Cover, Public Health England

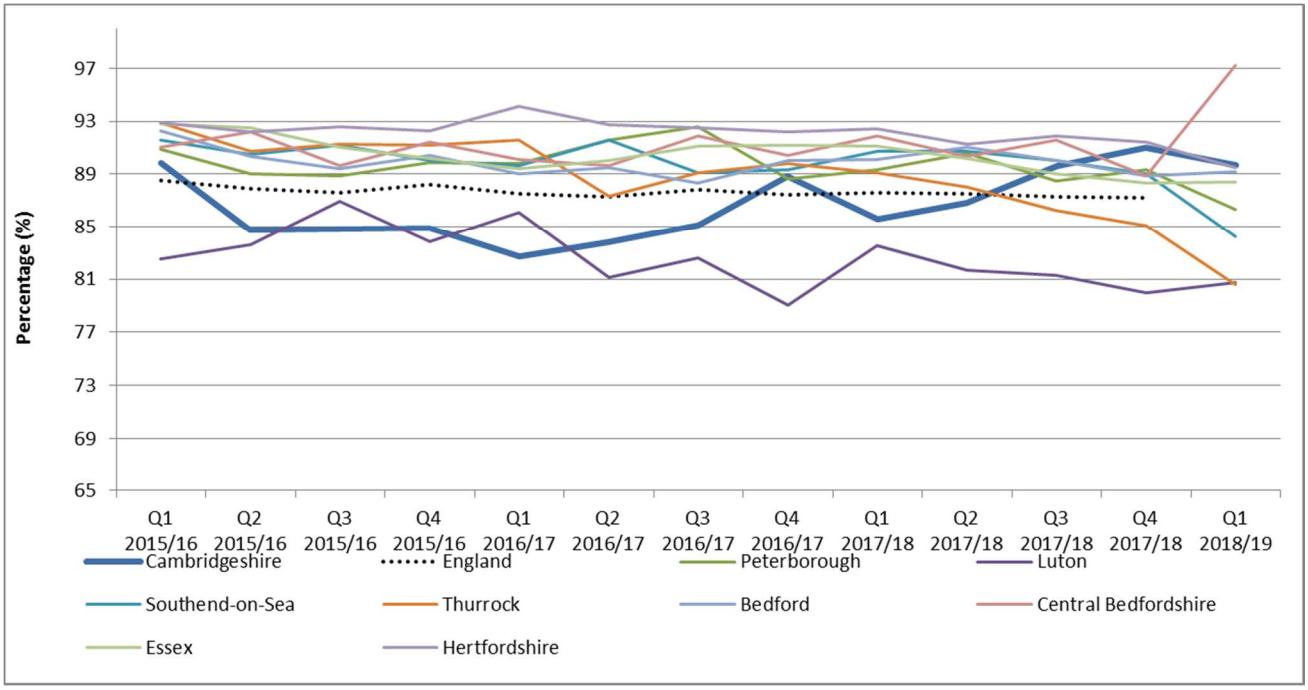


Figure 7: Uptake rates for MMR vaccine – **second dose** at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

4.1.8 4-in-1 Pre-School Booster Vaccine (5 years)

TABLE 13: Uptake rates for 4-in-1 preschool booster at 5 years (diphtheria, tetanus, pertussis, polio - target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17	**Q2 2016/17**	**Q3 2016/17**	**Q4 2016/17**
Cambridgeshire	82.6	82.1	84.1	86.4
Peterborough	86.4	88.2	90.3	86.5
East Anglia	87.6	88.7	88.8	89.1
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	83.9	85.1	88.3	88.8
Peterborough	87.3	86.8	85.5	86.0
East Anglia	88.3	88.7	88.7	89.2

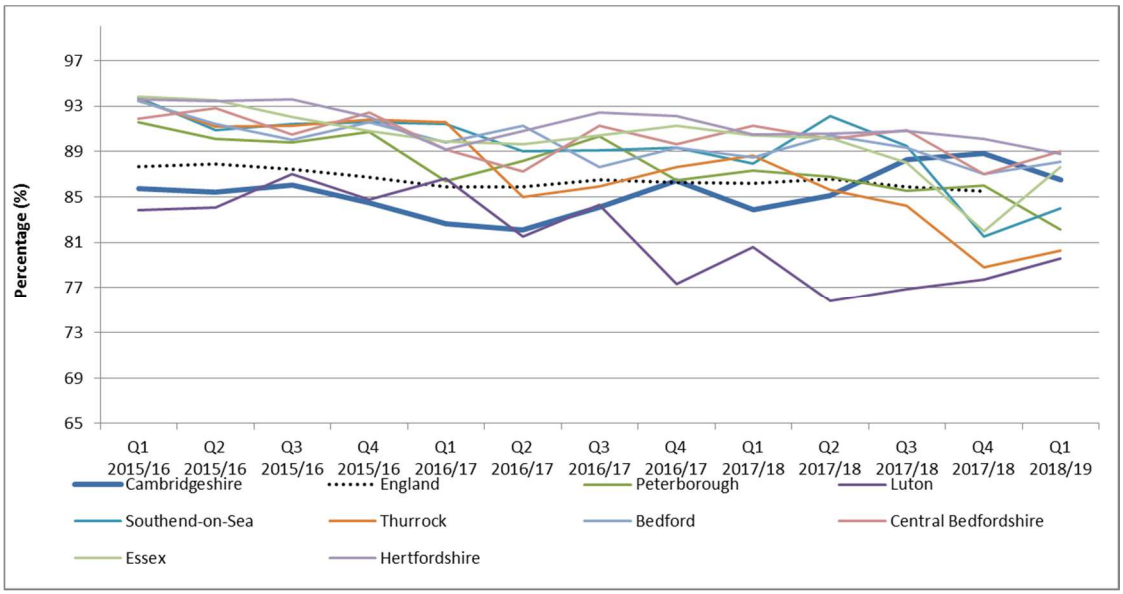


Figure 8: Uptake rates for 4-in-1 pre-school booster at 5 years (target 95%), Cambridgeshire, Peterborough and geographical neighbours, 2016/17 to 2017/18, *Source: Cover, Public Health England*

4.1.9 Haemophilus influenza B and meningococcus C Vaccine (5 years)

TABLE 14: Uptake rates for haemophilus influenza B and meningococcus C vaccine at 5 years (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	87.6	88.6	90.2	92.1
Peterborough	88.9	88.5	91.3	92.9
East Anglia	91.2	93.4	93.0	93.2
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	90.4	90.4	91.1	92.5
Peterborough	91.7	92.9	89.0	92.1
East Anglia	92.5	92.8	92.7	93.3

4.1.10 Meningococcus B (12 and 24 months)

TABLE 15: Uptake rates for meningococcus B vaccine at 12 months (target 95%), Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Cover, Public Health England*

	Q1 2016/17 %	**Q2 2016/17 %**	**Q3 2016/17 %**	**Q4 2016/17 %**
Cambridgeshire	**Data not collected**	**93.4**	**93.0**	**94.6**
Peterborough	**Data not collected**	**91.6**	**92.9**	**93.7**
East Anglia	**Data not collected**	93.7	94.4	94.6
	Q1 2017/18 %	**Q2 2017/18 %**	**Q3 2017/18 %**	**Q4 2017/18 %**
Cambridgeshire	93.0	93.7	94.2	93.9
Peterborough	92.9	93.7	90.8	91.0
East Anglia	94.3	95.1	94.4	94.6

TABLE 16: Uptake rates for meningococcus B booster at 24 months (target 95%), by local authority, 2017/18, *Source: NHS Digital*

	Cambridgeshire	**Peterborough**	**East of England**
Men B at 24 months (%)	77.3	72.6	75.1

4.1.11 Rotavirus Vaccination

TABLE 17: Rotavirus vaccination – 2 doses at 12 months (target 95%), Cambridgeshire & Peterborough, monthly uptake January 2016 to December 2018, *Source: Immform*

	Jan 2016	**Feb 2016**	**March 2016**	**April 2016**	**May 2016**	**June 2016**	**July 2016**	**Aug 2016**	**Sept 2016**	**Oct 2016**	**Nov 2016**	**Dec 2016**
Cambridgeshire	92.8	91.1	89.4	90.4	91.7	92.1	94.4	92.1	91.7	92.4	90.9	91.9
Peterborough	86.8	88.1	87.4	92.1	90.9	90.0	90.3	92.2	86.8	89.8	90.7	89.1
East Anglia	91.7	91.5	91.2	91.6	92.1	93.2	92.5	93.3	92.3	93.5	932.3	92.9
	Jan 2017	**Feb 2017**	**March 2017**	**April 2017**	**May 2017**	**June 2017**	**July 2017**	**Aug 2017**	**Sept 2017**	**Oct 2017**	**Nov 2017**	**Dec 2017**

Cambridgeshire	93.2	91.5	93.6	93.5	90.6	93.0	92.1	92.5	91.0	90.1	91.6	89.5
Peterborough	90.2	88.0	88.4	87.9	89.9	89.3	86.6	87.9	87.3	90.1	89.3	86.6
East Anglia	92.5	92.1	92.3	93.0	92.3	92.7	92.8	92.3	91.4	91.9	91.5	90.4
	Jan 2018	**Feb 2018**	**March 2018**	**April 2018**	**May 2018**	**June 2018**	**July 2018**	**Aug 2018**	**Sept 2018**	**Oct 2018**	**Nov 2018**	**Dec 2018**
Cambridgeshire	88.7	89.2	91.8	93.7	91.9	91.0	91.4	93.3	91.3	90.8	91.7	NA
Peterborough	84.7	92.2	85.7	86.5	90.2	89.2	89.4	86.6	83.9	89.3	89.5	NA
East Anglia	90.4	89.8	90.5	91.3	92.0	91.0	91.8	92.7	90.4	91.3	91.5	NA

4.1.13 Meningococcus ACWY (14 years)

TABLE 18: Uptake rates for meningococcus ACWY vaccine, Cambridgeshire and Peterborough, *Source: Immform*

Org Name	**Vaccine uptake %**
Cambridgeshire and Peterborough CCG	39.7
East Anglia Total	42.0

4.1.14 HPV Vaccine (Year 8 & Year 9)

TABLE 19: Uptake rates for HPV vaccine, by local authority and cohort, September 2017/18, *Source: Public Health England*

Local Authority		**Cambridgeshire**	**Peterborough**	**England**
Cohort 15: 12-13 Year Olds (Year 8) Birth Cohort: 1 September 2004 - 31 August 2005	Number of females in Cohort 15 (Year 8)	3,264	1,289	306,940
	No. vaccinated with HPV Vaccine at least one dose by **31/08/2018**	2,981	1,115	266,785
	% Coverage	91.3%	86.5%	86.9%
Cohort 14: 13-14 Year Olds (Year 9 Birth Cohort: 1 1 September 2003 - 31 August 2004	Number of females in Cohort 14 (Year 9)	3,205	1,310	300,464
	No. vaccinated with HPV Vaccine at least one dose by **31/08/2018**	2,954	1,188	267,689
	% Coverage	92.2%	90.7%	89.1%
	No. vaccinated with two doses by **31/08/2018**	2,728	1,118	251,919
	% Coverage	85.1%	85.3%	83.8%

4.1.15 School Immunisation Service

TABLE 20: School immunization service vaccinations, Cambridgeshire & Peterborough, end of school year 2017/18, *Source: CCS Immform*

	Cambridgeshire %	Peterborough %

Girls HPV vaccination by end of school year nine dose 2	85.1	85.3
Cohort 5 (13-14) Sept 2003 -August 2004 Td/IPV by end of school year 9	88.4	92.0
Cohort 4 (14-15) Sept 2002 –August 2003 Td/IPV by end of school year 10	88.2	85.4
Cohort 5 (13-14) Sept 2003 -August 2004 Men ACWY by end of school year 9.	88.4	91.5
Cohort 4 (14-15) Sept 2002 –August 2003 Men ACWY by end of school year 9.	88.4	85.9
Childhood Flu vaccination school years 1 and 2 and 3	67.0	48.0
Schools participating in the programme	259/260	70/70

4.2 Seasonal Flu Vaccination

TABLE 21: Flu vaccination uptake by key groups - adults, Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Immform*

Area	**Summary of flu vaccine uptake %**					
	65 and over		**Under 65 (at risk)**		**Pregnant women**	
	2016/17	**2017/18**	**2016/17**	**2017/18**	**2016/17**	**2017/18**
Cambridgeshire LA	72.6	74.4	47.4	49.8	48.5	49.1
Peterborough LA	69.2	71.3	46.3	47.3	39.9	38.4
Cambridgeshire & Peterborough CCG	72.1	73.9	47.2	49.3	46.7	46.7
East Anglia	71.0	72.6	47.1	48.9	47.9	47.2

TABLE 22: Flu vaccination uptake – pre-school children, Cambridgeshire and Peterborough, 2016/17 to 2017/18, *Source: Immform*

Area	**Summary of flu vaccine uptake %**			
	All aged 2		**All aged 3**	
	2016/17	**2017/18**	**2016/17**	**2017/18**
Cambridgeshire LA	42.6	45.5	44.7	47.1
Peterborough LA	30.3	25.5	32.9	30.0
Cambridgeshire & Peterborough CCG	39.7	40.5	42.0	42.7
East Anglia	42.1	42.8	43.9	44.2

TABLE 23: Flu vaccination uptake – healthcare workers, by NHS trust, 2016/17 to 2017/18, *Source: Immform*				
Org Name	No of HCW's with Direct Patient Care	Seasonal Flu doses since 1 September **2017-Jan 2018**		% Seasonal Flu doses given since 1 September **2016-Jan 2017**
		No	%	%
Papworth Hospital NHS Foundation Trust	1,510	1,143	75.7	75.4
Cambridge University Hospitals NHS Foundation Trust	7,755	6,696	86.3	72.6
North West Anglia Foundation Trust	4,612	3,156	68.4	NA
Cambridgeshire and Peterborough NHS Foundation Trust	3,036	1,983	65.3	52.4
Cambridgeshire Community Services NHS Trust	1,455	851	58.5	60.3
East of England Total	NA	NA	65.7	66.2

4.3 Prenatal Pertussis Vaccination

TABLE 24: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, monthly uptake April 2015 to March 2018, *Source: Immform*				
	Apr 2015 %	May 2015 %	Jun 2015 %	Jul 2015 %
Cambridgeshire & Peterborough CCG	49.8	45.9	52.7	50.5
East Anglia	**56.8**	**53.8**	**58.9**	**56.3**
	Aug 2015 %	Sept 2015 %	Oct 2015 %	Nov 2015 %
Cambridgeshire & Peterborough CCG	51.2	50.5	54.1	52.5
East Anglia	**58.5**	**67.2**	**60.3**	**61.4**
	Dec 2015 %	Jan 2016 %	Feb 2016 %	Mar 2016 %
Cambridgeshire & Peterborough CCG	50.7	50.3	NA	NA
East Anglia	**60.3**	**59.3**	**NA**	**NA**
	Apr 2016 %	May 2016 %	Jun 2016 %	Jul 2016 %
Cambridgeshire & Peterborough CCG	52.7	73.8	73.3	71.9
East Anglia	**60.2**	**73.6**	**74.4**	**74.7**
	Aug 2016%	Sept 2016 %	Oct 2016 %	Nov 2016%
Cambridgeshire & Peterborough CCG	70.6	72.8	71.4	72.3
East Anglia Total	**74.1**	**76.4**	**78.7**	**78.0**
	Dec 2016 %	Jan 2017 %	Feb 2017%	Mar 2017 %
Cambridgeshire & Peterborough CCG	76.2	78.9	76.2	75.5
East Anglia Total	**79.8**	**82.3**	**79.8**	**77.0**
	Apr 2017 %	May 2017 %	Jun 2017 %	Jul 2017 %
Cambridgeshire & Peterborough CCG	**77.0**	**70.2**	**72.1**	**73.8**
East Anglia Total	**78.8**	**75.4**	**77.3**	**75.8**
	Aug 2017 %	Sept 2017 %	Oct 2017 %	Nov 2017 %
Cambridgeshire & Peterborough CCG	**69.9**	**69.4**	**72.1**	**69.5**
East Anglia Total	**75.1**	**75.8**	**78.1**	**76.5**
	Dec 2017 %	Jan 2018 %	Feb 2018 %	Mar 2018 %
Cambridgeshire & Peterborough CCG	**75.3**	**73.1**	**70.3**	**68.6**
East Anglia Total	**79.8**	**76.9**	**75.6**	**73.2**

TABLE 25: Prenatal pertussis vaccination, Cambridgeshire & Peterborough, monthly uptake April 2015 to March 2018, *Source: Immform*	
Annual Data 1.4.2017 to 31.3.2018 %	
Cambridgeshire & Peterborough CCG	68.1
East Anglia	73.7

4.4 Shingles Vaccination

TABLE 26: Shingles vaccination – aged 70 & 78, Cambridgeshire & Peterborough, uptake July 2018, *Source: Immform*

Area	Vaccine coverage for the Routine Cohort since 2013			Vaccine coverage for the Catch- up Cohort since 2013		
	Registered Patients aged 70	Received Shingles vaccine		Registered Patients aged 78	Received Shingles vaccine	
		No of patients	% of patients		No of patients	% of patients
Cambridgeshire & Peterborough CCG	10158	4707	46.3	5246	2568	49.0
East Anglia Total	37108	17037	45.9	18615	9107	48.9

5. Screening Programmes

Screening is a way of identifying apparently healthy people who may have an increased risk of a particular condition. The NHS offers a range of screening tests to different sections of the population. The aim is to offer screening to the people who are most likely to benefit from it. For example, some screening tests are only offered to newborn babies, while others such as breast screening and abdominal aortic aneurysm screening are only offered to older people.

NHS England commission a number of screening programmes which are delivered by a range of NHS providers within Cambridgeshire and Peterborough. Current screening programmes include:

- Antenatal and newborn screening;
- Breast cancer screening;
- Bowel cancer screening;
- Cervical cancer screening;
- Abdominal Aortic Aneurysm screening; and
- Diabetic eye screening.

Key performance information for each screening programme is provided in the sections below.

5.1 Antenatal and Newborn Screening

5.1.2 Antenatal and Newborn Screening Key Performance Indicators

TABLE 27: Antenatal infectious disease screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

				2016-2017				2017-2018			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
ID1 Antenatal HIV test coverage	>95%	99%	CUH	97.3	99.5	99.4	98.9	97.4 %	99.0 %	98.2%	99.0 %
	>95%	99%	HHT	99.8	98.9	99.6	99.7	99.7	99.6	99.1	99.0

	>95%	99%	PCH	99.5	99.4	99.4	99.3	99.4	98.9	99.	99.6
ID2 Hep B timely referral for women found to be Hepatitis B	>70%	99%	CUH	No cases	100	100	No cases	No Cases	100%	100%	100
	>70%	99%	HHT	0	100	100	100	No Cases	100	100	No Cases
	>70%	99%	PCH	50	No cases	100	80.0	No Data	100	0.0	80.0

TABLE 28: Fetal anomaly screening KPIs, by provider, 2017/18, *Source: maternity services*

				2017-2018			
FA1: Completion of laboratory request forms	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**
	>97%	>100%	CUH	99.4	99.5	98.2	99.4
	>97%	>100%	HHT	95.7	97.3	97.7	99.0
	>97%	>100%	PCT	98.2	98.5	99.1	99.4
FA2: Fetal anomaly screening fetal anomaly ultrasound) – coverage *	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**
	>90%	>95%	CUH	99.5	98.5	99.9	99.9
	>90%	>95%	HHT	99.3	100.0	99.1	99.6
	>90%	>95%	PCT	99.6	99.3	No Data	99.6

TABLE 29: Antenatal sickle cell and thalassaemia KPIs, by provider, 2016/17 - 2017/18, *Source: maternity services*

				2016/-2017				2017-2018			
Indicator	**Standard**	**Achievable**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
ST1 Antenatal sickle cell and thalassaemia screening – coverage	>95%	99%	CUH	91.4	98.5	98.8	96.1	96.4	97.6	96.3	98.2
	>95%	99%	HHT	98.9	99.0	97.7	97.1	100.0	98.8	98.4	98.7
	>95%	99%	PCT	96.6	97.8	97.8	97.5	97.1	97.4	99.6	98.9
ST2 Antenatal sickle cell and thalassaemia screening Timeliness of Test	>50%	75%	CUH	31.7	43.3	43.5	30.1	57.9	55.7	54.9	54.6
	>50%	75%	HHT	49.4	52.0	55.2	29.9	48.5	50.8	53.1	54.0
	>50%	75%	PCT	69.1	65.5	68.0	61.4	63.8%	59.5 %	58.2 %	56.9 %

ST3 Antenatal sickle cell and thalassaemia completion of FOQ	99%	99%	CUH	76.6	90.9	97.8	98.2	99.2	98.3	97.4	98.0
	>95%	99%	HHT	98.6	97.5	97.7	100	98.3	96.4	96.1	97.5
	>95%	99%	PCT	98.3	98.7	98.1	98.6	99.4	98.1	98.0	97.7

TABLE 30: Newborn blood spot screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

				2016-17				201718			
Indicator	**Standard**	**Achievable**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NB1 Newborn blood spot screening coverage	>95%	99.9%	CCS	98.1	98.2	98.9	91.39	95.5	98.5	99.3	94.5
	>95%	99.9%	CPFT	99.6	97.5	98.8	98.8	98.8	99.5	99.7	93.9
NB2 Newborn blood spot screening avoidable repeats	<2%	0.5%	CUH	2.4	*3.1	3.1	2.4	2.5	1.1	2.3	1.7
	<2%	0.5%	HHT	3.4	**2.1	3.4	2.8	3.1	3.0	1.4	2.5
	<2%	0.5%	PCT	1.8	1.4	1.4	1.6	1.9	1.8	0.9	1.8
NB4 Newborn blood spot screening coverage-movers in	>95%	99.9%	CCS	88.2	*80.1	84.1	85.0	90.2	91.2	76.1	76.3
	>95%	99.9%	CPFT	82.4	84.5	78.0	79.7	85.4	92.6	91.5	89.3

TABLE 31: Newborn hearing screening KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

				2016-17				2017-18			
Indicator	**Accpt.**	**Ach.**	**Provider**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NH1 Newborn hearing screening coverage	>97%	99.5%	CUH	99.2	98.6	98.3	99.0	98.7	99.8	99.2 %	99.2
	>97%	99.5%	HHT	99.7	99.2	99.9	99.8	99.6	99.7	99.6 %	99.7
	>97%	99.5%	PCT	99.8	99.9	99.5	100	99.9	99.8	99.9 %	99.9

NH2 Newborn hearing screening timely referral for assessment	>90%	95%	CUH	77.8	*93.8	88.0	94.4	90.0	93.8	100%	89.5
	>90%	95%	HHT	100	No cases	83.3	100	100	50.0	44.4	100
	>90%	95%	PCT	100	100	100	92.9	100.	76.9	85.7	100

TABLE 32: Newborn and infant physical examination KPIs, by provider, 2016/17 – 2017/18, *Source: maternity services*

				2016-17				2017-18			
Indicator	Accpt.	Ach.	Provider	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
NP1 Newborn and Infant Physical Examination- coverage newborn	>95%	99.5%	CUH	97.3	94.5	94.5	95.2	95.3	94.	95.5%	93.9
	>95%	99.5%	HHT	99.7	96.5	95.8	95.2	97.2	94.8	94.5	94.1%
	>95%	99.5%	PCT	96.9	97.4	97.3	97.6	96.8	97.2	96.1	97.1
NP2 Newborn and Infant Physical Examination timely assessment	>95%	100%	CUH	100	*66.7	28.6	66.7	75.0 %	100	0.0%	77.8 %
	>95%	100%	HHT	25	No cases	No cases	100	100	100	75	0.0
	>95%	100%	PCT	33.3	**50. 0	No cases	No cases	100.	100	80.	No cases

5.1.3 Antenatal and Newborn Screening Programme Updates

The Cambridge and Peterborough Programme board meet quarterly to review key performance indicators (KPIs) and performance. With the merger of Hinchingbrooke and Peterborough hospitals to form North West Anglia Foundation Trust, a programme board will be introduced for Cambridge and another programme board will be formed for North West Anglia foundation Trust.

- **Fetal anomaly:** KPIs and standards met. Introduction of coverage KPI for Patau's, Edwards and Downs (FA3) introduced from quarter 1 2018. There is no intention to publish this KPI by individual maternity service. Thresholds are not set for this KPI, performance between providers should not be compared. FASP supports informed choice for women.
- **Infectious diseases:** KPIs and standards met. Introduction of coverage KPIs for hepatitis B and syphilis introduced from quarter 1 2018.
- **Newborn hearing:** Smart for hearing IT system introduced successfully. Coverage KPIs met, with some slippage in the referral KPI, but appointments were offered in timely fashion.
- **Non-invasive prenatal testing:** the roll out of non-invasive prenatal testing has been delayed nationally due to unforeseen circumstances.
- **Newborn bloodspot:** there have been continued efforts to reduce the avoidable repeat rate on this programme.
- **Newborn and infant physical examination**: all trusts are compliant and using the Smart IT system. There have been some on-going issues with meeting the referral pathway KPI and this is currently under review nationally.

5.2 Cancer Screening programmes

5.2.1 Breast Screening

The two breast screening centres have regularly achieved the acceptable target for their KPIs in the last year. Both screening centres have plans in place to ensure more women get screened within the required 36 months including more advanced ways of booking appointments for women.

TABLE 33: Breast screening - % of women who attend for screening (aged 50 – 70), by screening centre, 2016/17 – 2017/18, *Source: Oracle Business Intelligence Enterprise Edition (OBIEE)*

Cambs. & Hunts. Screening Centre		**2016-2017**				**2017-2018**			
Acceptable	**Achievable**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
≥ 70.0%	≤ 80.0%	73.3	75.1	72.8	74.0	70.6	70.4 %	68.5	69.8 %
Peterborough Screening Centre		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
≥ 70.0%	≤ 80.0%	75.8	71.31	69.87	74.1	74.5 %	72.5 %	71.0	71.0

TABLE 34: Breast screening round length - % of women first offered an appointment within 36 months, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*
BS2 - Percentage of women first offered an appointment within 36 months

Cambs. & Hunts. Screening Centre		**2016-2017**				**2017-2018**			
Acceptable	**Achievable**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
≥ 90.0%	≤ 100.0%	99.5	98.9	98.6	95.6	70.5 %	70.4 %	68.5	69.6 %
Peterborough Screening Centre		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
≥ 90.0%	≤ 100.0%	98.1	98.3	98.9	98.2	92.3 %	81.0	74.7 %	56.2 %

TABLE 35: Breast screening waiting time for assessment - % of women who attend for assessment within 3 weeks of attending for screening mammogram, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*

Cambs. & Hunts. Screening Centre		**2016-2017**				**2017-2018**			
Acceptable	**Achievable**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
≥ 90.0%	≤ 100.0%	93.6	93.0	97.2	94.0	99.6	91.6	100.00	99.3
Peterborough Screening Centre		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
≥ 90.0%	≤ 100.0%	97.6	99.4	99.6	95.3	90.2	96.4	65.7	92.8

5.2.2 Cervical Cancer Screening

There has been a decline in the in the coverage in cervical screening which corresponds with the pattern which is seen nationally. The NHS England Screening and Immunisation team is working with a number of stakeholders on a project to improve access to screening for women and improve the quality of different aspects of the screening pathway. It is hoped that this project, along with national initiatives will help promote cervical screening for women in Cambridgeshire and Peterborough.

TABLE 36: Cervical cancer screening coverage of eligible population, by local authority and age group, 2017/18, *Source: Screening Quality Assurance Service (SQAS) and Open Exeter*

Acceptable	Achievable	Provider	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18
CS2 - Coverage of eligible population (all women) every 5 years						
≥ 80%	≥ 95.0%	Cambridgeshire Upper Tier LA	68.2	66.6	68.2	70.9
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	66.3	65.3	66.3	72.0
CS2a - Coverage of eligible population, all women aged 25-49 every 3 years						
≥ 80%	≥ 95.0%	Cambridgeshire Upper Tier LA	64.5	62.9	64.5	68.0
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	63.4	62.4	63.4	70.0
CS2b - Coverage of eligible population, all women aged 50-64 every 5 years						
≥ 80%	≥ 95.0%	Cambridgeshire Upper Tier LA	76.1	74.7	76.1	77.0
≥ 80%	≥ 95.0%	Peterborough Upper Tier LA	74.1	72.9	74.1	76.0

5.2.3 Bowel Cancer Screening

Although the uptake for bowel screening has remained consistently good in Cambridgeshire and Peterborough, the screening units have not been achieving the diagnostic waiting times KPIs. The NWAFT Screening Centre is working to address Specialist Screening Practitioner (SSP) and diagnostic waiting times. CUHFT has put in plans to address the diagnostic waiting times and both trusts are showing improvements in the waiting times for patients.

TABLE 37: Bowel cancer screening KPIs, by screening centre, 2016/17 – 2017/18, *Source: OBIEE*

CUHFT Screening Centre			2016-2017				2017-2018			
	Acc.	Ach.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BCS4 – Uptake	≥52%	≥70%	61.7	59.9	59.1	60.0	No Data	60.4	57.4	57.9
BCS7– SSP Waiting Times	100% within 14 days ≤1.0%		100	100	100	100	100	99.7	100	100
BCS8 - Diagnostic test waiting times	100% within 14 days		100	94.8	87.8	70.1	75.5	45.3	26.3	49.4

NWAFT Screening Centre			2016-2017				2017-2018			
	Acc.	Ach.	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
BCS4 – Uptake	≥52%	≥70%	59.9	58.4	55.4	58.1	59.7	57.3	56.8	59.1
BCS7– SSP Waiting Times	100% within 14 days ≤1.0%		100	100	100	100	88.4	60.9	52.1	50.7
BCS8 - Diagnostic test waiting times	100% within 14 days		89.9	89.6	65.9	20.0	5.2	30.1	10.2	20.6

5.3 Adult and Young People Screening

5.3.1 Diabetic Eye Screening Programme

The KPI data for the diabetic eye screening programme carried out through Health Intelligence shows that for DE1 (uptake) and DE2 (results issued within 3 weeks) the achievable targets are regularly met for the population of Cambridgeshire and Peterborough, with good uptake of the screening programme. There are ongoing issues which are being addressed at hospital eye clinics affecting DE3 (timely assessment for R3A screen positive). This is for patients who are referred with a screen positive result to hospital eye services, who should be seen within the eye clinic within 13 weeks of referral. CUHFT has ongoing issues with capacity within eye clinics which has seen them regularly not meet this target for the whole of 2017-18. The Trust is trying to address this. NWAFT has met the target for 3 of the 4 quarters.

TABLE 38: Diabetic eye screening KPIs for Cambridgeshire & Peterborough CCG through East Anglia DESP, by 2016/17 – 2017/18, *Source: Health Intelligence*								
Indicator & Target	**2016-2017**				**2017-2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Acceptable 70% Achievable 80%								
DE1-Uptake of routine digital screening event	85.7	87.6	85.6	83.8	84.3	84.8	85.4	90.8
Acceptable 70% Achievable 80%								
DE2-Results issued within 3 weeks of screening	99.8	99.7	99.8	99.8	98.5	99.8	100	100
Acceptable 80% Achievable 95%								
DE3 - Timely assessment for R3A screen positive	80.0	75.0	58.3	70.0	70.8	75.0	75.0	80.0

5.3.2 Abdominal Aortic Aneurysm (AAA) Screening

The Cambridgeshire, Peterborough and West Suffolk AAA screening service has an eligible population of approximately 5,583. The service offers screening to all eligible men in the year they turn 65 years of age in line with national guidance. This is delivered by screening technicians in community settings such as GP practices and community hospitals. The service performs well against AA2 (coverage of initial screen) and AA3 (coverage of annual surveillance screen). AA4 (coverage of quarterly surveillance screen) is slightly under the acceptable level and this is monitored at the programme board with breaches discussed on an individual basis. Patients breach if they move their appointment forward as well as backwards, which affects this KPI, so patients breaching AA4 may be being seen earlier rather than later. The service also screened 176 self-referrals during 2017 to 2018. Self-referrals can be received via telephone or completion of a self-referral form.

TABLE 39: AAA screening completeness of offer, Cambridgeshire population, 2015/16 – 2017/18					
Indicator	**Acceptable**	**Achievable**	**2015-16**	**2016-17**	**2017-18**
AA1 Completeness of Offer	≥ 52%	≥ 70%	99.9	99.9	retired

TABLE 40: AAA screening KPIs, Cambridgeshire screening cohort, 2017/18				
AAA Data - Cambridgeshire Screening Cohort				**2017-2018**
Indicator		**Accpt.**	**Ach.**	
Coverage of Initial Screen	**AA2**	≥ 75%	≥85%	80.6%
Coverage of Annual Surveillance screen	**AA3**	≥ 85%	≥95%	89.7%
Coverage of Quarterly Surveillance screen	**AA4**	≥ 85%	≥95%	83.6%

6. Healthcare Associated Infections

Healthcare associated infections (HCAI) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections, including methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile).

HCAIs pose a serious risk to patients, staff and visitors, can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS.

6.1 MRSA bacteraemia

MRSA is a type of bacteria that is resistant to several widely used antibiotics and mainly affects people who are staying in hospital. The term MRSA bacteraemia refers to an MRSA blood stream infection.

The government considers it unacceptable for a patient to acquire an MRSA blood stream infection while receiving care in a healthcare setting and therefore has a zero tolerance approach (NHS Improvement March 2018). From April 2018, the requirements for reporting and monitoring through a post infection review (PIR) changed. Mandatory reporting remains in place, however only those organisations with the highest rates of infection are required to hold formal reviews, with the remainder of trusts adopting a local process, though still required to be a robust clinical review. The threshold for formal reviews was the top 15% of CCGs and non-specialist trusts with a rate of 1.6 or more community onset MRSA bacteraemia per 100,000 population and trusts with a rate of 1.7 per 100,000 bed-days or more. The rate in 2016/17 was 1.5. NHS England will maintain oversight of CCG performance and NHS Improvement the acute providers' performance. These are to be reviewed on a rolling 12-month basis. Cases have previously been assigned according to the outcome of the PIR, however since April, an onset of infection >2 days after admission is considered hospital onset and all other cases community onset.

Neither Cambridgeshire and Peterborough CCG or its local acute hospital providers were in the top 15% requiring formal reviews, but have continued to conduct the PIR process as before, to ensure any timely learning is actioned or problem areas quickly identified.

Locally, numerous interventions aimed at reducing the incidence of MRSA bacteraemia have been introduced and targeted to the acute care setting. However, with shorter hospital stays which should reduce the risk of acquiring a hospital onset infection, patients may have acquired infections within the hospital but not manifested the symptoms at the point of discharge. An admission to hospital would then be less than 2 days and according to the definition, community onset. Early detection of MRSA bacteraemia is improving with advanced diagnostics and increased clinical awareness of sepsis; this could possibly result in an increase of isolates found to be community onset.

TABLE 41: Numbers of MRSA bacteraemia cases, by area, 2017-18

	2017/18	2018/19 up to December 2018
National	846	n/a
Cambridgeshire and Peterborough CCG	11	16

Of the 16 cases reported to date this year, 5 were classed as hospital onset (one of which was a contaminant) and 11 community onset for the CCG (2 cases were for the same patient).

6.2 Clostridium difficile

C. difficile is a bacterial infection that affects the bowel and most commonly occurs in people who have recently been treated with antibiotics, especially broad-spectrum antibiotics.

During 2017/18, 13,286 cases of C. difficile were reported nationally which demonstrates a slight increase of 3.4%. The division of cases between community and hospital onset does not capture a recent admission/discharge of a patient or take into account complex healthcare pathways. The result of this is leading to a further change in the reporting process from April 2019 when the algorithm will be broken down into four categories. The objectives for each organisation were reduced by one case with plans for 2019/20 remaining unknown at this time.

Locally, scrutiny panel meetings continue to be held in each provider organisation for each individual case reported. At this meeting there is an agreement with the CCG Infection Control Lead as to whether there were any lapses in care to be addressed. Where lapses have been identified, this then becomes a sanctioned case. Lapses may include delay in sending a specimen, lack of isolation facility and no escalation, and poor documentation.

In Cambridgeshire and Peterborough:

- There were 135 cases of C. difficile reported between April to December 2018. This compares to 142 at the same point in 2017.
- The number of sanctioned cases for all hospital trusts cases is 26.
- The number of sanctioned cases for Cambridgeshire and Peterborough CCG registered patients is 17.
- Where trusts have seen more than 10 cases in a given month, support has been requested from NHS Improvement in conjunction with the CCG.

6.3 Escherichia coli bacteraemia

The term E. coli bacteraemia refers to a blood stream infection by E. coli bacteria. April 2017 saw the introduction of a Quality Premium for CCGs to reduce the number of E. coli cases by 10% during the period of 2017/18 which equated to 53 cases for Cambridgeshire and Peterborough CCG. Our total number for this period was 557 cases which was an increase of 6%. Overall a 5% increase between July to Sept 2017 and July to Sept 2018 has been reported.

Data published for the full year of 2017/18 identified that the rates are still high, in particular with the over 85-year old age group and greater in men than women. The source of these infections has changed little over time with urinary tract infection (UTI) the most frequent with 45-49% reported as the source.

Unlike MRSA bacteraemia and C. difficile, this infection is more challenging to reduce the incidence in number. The majority of these cases develop in the community in patients who may or may not have been receiving healthcare and therefore difficult to identify until the infection develops.

NHS Improvement developed a UTI collaborative and have been working with a number of hospital trusts over the past 9 months to make an impact where the reported number of cases is considered high. This has included CUHFT. To support the work and learning, we have brought together a wide multi-professional group from our health economy that includes infection control nurses, community continence service leads, acute hospital continence leads, consultant urologists, care home team and other senior practitioners along with the CCG contract leads for Urgent and Emergency Care to examine the service pathways for urinary catheters. This work remains in progress, with the main focus ensuring that urinary catheters are only used when absolutely required and removed as soon as possible. A positive impact from this work is anticipated during the year of 2019/20. A gap in team resources is being addressed by trusts to enhance the patient experience and reduce unwanted variation in practice across the health economy.

Between April and December 2018, 426 cases of E. coli bacteraemia have been reported, which is a rise of 5 cases for the same period last year.

6.4 HCAI further information and references

- Annual epidemiological commentary: Gram-negative bacteraemia, MSSA bacteraemia and *C difficile* infections, up to and including financial year April 2017 to March 2018. Public Health England. 12 July 2018
- Quarterly epidemiological commentary. Mandatory MRSA, MSSA, Gram-negative bacteraemia and *C. difficile* infections data (up to July to September 2018). Public Health England. December 2018
- Technical guidance for NHS planning 2017/18 and 2018/19 – Annex B, Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups

7. Antimicrobial Resistance

Antimicrobial resistance has been described as one the greatest threats to human kind. The overuse and incorrect use of antibiotics are major drivers of the development of antimicrobial resistance. The continued

threat from the development of antimicrobial resistance and a drastic reduction in the number of new antibiotics being developed, make the need to preserve the antimicrobials we currently have a local, national and global priority. Local targets, set nationally, for reducing the amount and certain types of antimicrobial drugs prescribed across all health care sectors are in place and achieving these requires co-operation from prescribers, patients and the public.

Research has shown that antibiotic stewardship programmes could halve the number of infections due to antibiotic-resistant bacteria compared with unguided prescribing. Locally, there has been a reduction in the number of antibiotics prescribed by GPs which will contribute to conserving the antibiotics we currently use. This has been achieved through the introduction of antibiotic stewardship programmes across all health sectors, use of educational materials for GPs and patients, provision of comparative antibiotic prescribing data to GP practices, peer group review, and public education programmes. Trimethoprim, an antibiotic used to treat infections such as urinary tract infections, is an effective treatment where infections have been shown to be susceptible and in situations where alternatives would be less suitable. However, the inappropriate use of trimethoprim, has been associated with the development of serious, life-threatening gram-negative bloodstream infections, particularly in vulnerable patients where their urine infection has been resistance to trimethoprim. 25.8% of urine community E. coli (or coliform) samples tested in quarter 3 2018 in the Cambridgeshire and Peterborough CCG area were found to be non-susceptible to trimethoprim. This figure has reduced compared to the same quarter in 2017-2018. Local and national targets have been introduced aimed at reducing the inappropriate use of this trimethoprim compared to alternatives and specifically for use in in patients over 70 years old who are the most vulnerable. Local targets for reducing the use of trimethoprim have been met through effective antibiotic stewardship initiatives and the addition of new antibiotic formulary choices which offer prescribers more alternatives to trimethoprim. Focusing on reducing inappropriate use of trimethoprim in urinary tract infections continues into 2019-20.

Broad spectrum antibiotics include the groups of antibiotics the quinolones, cephalosporins, and co-amoxiclav. They should normally only be used when narrow-spectrum antibiotics have not worked or are resistant to the infection being treated. Inappropriate use increases the risk of producing a resistant type of bacteria known as MRSA, other resistant urinary tract infections and may cause an unpleasant life-threatening infection, Clostridium difficile, to develop. Local and national targets have been set aimed at reducing the amount of broad spectrum antibiotics prescribed compared to all types of antibiotics. Locally, use of broad spectrum antibiotics continues to be higher than the National target. A system wide approach using antibiotic stewardship programmes with provision of prescribing data, audit, provision of education, peer group review and support to GPs in reducing their use of unwarranted broad spectrum antibiotics has been implemented to address this. Very limited success has been seen in the reduction of broad spectrum prescribing in 2018-2019 and further improvement is needed during 2019-2020 and will require the co-operation of prescribers, patients and the public.

7.1 AMR references and further information

1. The UK AMR Strategy High Level Steering Group. UK 5 Year Antimicrobial Resistance (AMR) Strategy 2013-2018. Third Annual progress report, 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/662189/UK_AMR_3rd_annual_report.pdf and accessed 17.1.2019.
2. National Institute for Healthcare and Clinical Excellence (NICE). Key therapeutic topic [KTT9] Antimicrobial stewardship: prescribing antibiotics. Published date: January 2015. Last updated: January 2017. Available at: https://www.nice.org.uk/advice/ktt9/chapter/evidence-context and accessed 17.1.19.
3. Public Health England. East Region. AMR Local Indicators. Available at: http://fingertips.phe.org.uk/ and accessed 17.1.19.

4. Public Health England. English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) 2018 and accessed 17.1.19.

8. Environmental Health

Environmental Health teams and Regulatory Services play an important role in protecting the health of the Cambridgeshire and Peterborough population. Principal Environmental Health Officers sit on the Cambridgeshire and Peterborough Health Protection Steering Group reporting key environmental health issues by exception.

Environmental health is the responsibility of district and unitary councils and is delivered by the following councils within Cambridgeshire and Peterborough: Cambridge City Council, East Cambridgeshire District Council, Fenland District Council, Huntingdonshire District Council, Peterborough City Council and South Cambridgeshire District Council.

Although the role of environmental health staff vary between each council, the following regulatory services are usually delivered by environmental health teams or equivalent:

- Food safety
- Health and safety
- Pollution control – including noise pollution and contaminated land
- Private sector housing and houses of multiple occupation (HMOs)
- Licensing
- Trading standards

The work of regulatory services and environmental health teams helps to keep people healthy and safe, reduce health inequalities and contributes to the local economy.

8.1 Food safety

This includes carrying out hygiene inspections of food establishments, investigating complaints, regulating private water supplies, and working closely with Public Health England to manage infectious diseases. Food safety teams aim to protect consumers through the assessment or investigation of business compliance with relevant food legislation and centrally issued guidance, and/or to offer advice and guidance to businesses. These activities help to protect the community from ill health associated with poor food hygiene and safety practices.

Food Safety teams within Environmental health operate the national Food Hygiene Rating Scheme which helps consumers choose where to eat or shop for food by providing information about hygiene standards. In 2017/18, the proportion of food establishments across the country achieving broad compliance was 90.2% (broadly compliant is equivalent to a hygiene rating of 3, generally satisfactory, or above). Table 42 below shows the proportion of broadly compliant establishments locally:

Table 42: Proportion of food establishments achieving broad compliance, by local authority, 2017/18, *Source: Food Standards Agency LAEMS*

	Total number of establishments	**Proportion of food establishments achieving broad compliance (equivalent to a hygiene rating of 3 or above), including those not yet rated**
Cambridge City	1523	90.5%
East Cambridgeshire	786	92.9%
Fenland	842	95.3%

Huntingdonshire	1386	90.2%
Peterborough City	1932	87.5%
South Cambridgeshire	1306	90.8%

Recent examples of work carried out by local food safety teams include:

- **Improving hygiene ratings at East Cambridgeshire District Council:** in order to improve hygiene ratings of food premises and public confidence within the district, the environmental health team set up a new scheme. Poorly performing businesses were identified and signed up to the scheme via a 'contract'. These businesses were offered a package of support including: an advisory visit, a good safety management system – Safer Food Better Business pack and diary sheets, an allergen pack and verbal advice on training, cleaning, labelling, structural advice and how to comply with and maintain management systems. Premises were then given three months to rectify identified issues during which time they were able to access the further support from the environmental health team. Businesses then received a further advisory visit before being inspected unannounced. The environmental health team then provide support to the businesses to help them maintain their improved ratings.

- **Investigating food fraud at Fenland District Council (FDC):** the environmental health team have been working closely with the Food Standards Agency (FSA) to investigate a significant amount (> 100 tonnes) of frozen meat detained by FDC environmental health officers. This meat did not meet hygiene standards due to suspected labelling issues. FDC officers have been working with the FSA to identify the origins of the meat product, its date of processing and whether it was fit to release back into the market place. The complex investigation has revealed common practices within the meat product industry which has helped both the council and FSA understand the risks associated with the onward sale products which may change hands many times over a period of months. The investigation confirmed breaches of hygiene standards and the company has agreed to dispose of the meat.

- **Pest infestations at Cambridge City Council and Peterborough City Council:** the food safety teams in these teams have been dealing with cockroach and rodent infestations at various premises including food businesses and a school. The teams have been taking necessary action to deal with the infestation including inspection and in some instances closure, to ensure there is no risk to public health.

- **Managing cases and outbreaks of infectious diseases:** environmental health officers throughout Cambridgeshire and Peterborough continue to work closely with Public Health England to provide an essential role in the management of complex cases of infectious diseases. Cambridge City Council have worked closely with Public Health England to assist with a case of TB which required the issuing of a warrant and a Part 2A order to prevent the patient from seconding into the community. Peterborough City Council (PCC) worked with Public Health England to investigate a gastroenteritis outbreak, providing support to the business in terms of infection prevention and control advice, providing advice to the public and working to identify the source of infection. South Cambridgeshire District Council worked closely with Public Health England to investigate a cluster of salmonella cases which had potential links to a local nursery. E coli gastrointestinal infections can be very serious and require a number of public health actions to minimise the risk to the public. PCC have dealt with a small number of cases of E. coli this year which has involved working with involved businesses, supporting the cases and their families, and liaising with Public Health England.

8.2 Health and safety

Health and safety teams within the district councils and Peterborough City Council are responsible for enforcing health and safety regulations in businesses which including catering and hospitality, hairdressing and beauty, motor vehicles, working in an office, retail and warehousing to make sure they are safe for employees and visitors. The health and safety teams carry out investigations into complaints, reportable accidents and ill health in relation to the workplace.

This year, the PCC health and safety team conducted a routine visit to a Shisha Bar in the City Centre, where officers observed that the smoking shelter was no longer compliant in that it had been altered to become an enclosed space.

Since 2006 smoking is not permitted inside workplaces. Smoking can take place in a smoking shelter as long as the shelter is more than 50% open. Shisha smoking is dealt with in the same manner as tobacco smoking and must also take place in a compliant shelter. At the time of the visit a number of customers were observed to be smoking in the now enclosed space. Officers worked with the business and the business returned the shelter to a compliant shelter by being more than 50% open. The business received a written warning to prevent making the shelter enclosed again.

8.3 Pollution control

Pollution control includes investigation of a wide range of statutory nuisances, air quality assessment, hoarding and infestations of vermin in domestic and commercial premises, and the issuing of permits for industrial processes. It also includes the inspection of potentially contaminated land where current or previous industrial activity may have had an impact on the condition of the land and left it contaminated with chemicals or other substances. All of these environmental hazards can have significant harmful effects on health; the pollution control teams therefore play a vital role in protecting the public's health from such hazards.

Recent examples of work carried out by pollution control teams include Cambridge City Council environmental health officers who have been working closely with Marshalls Airport to provide advice on noise, air quality, odour and contaminated land issues in relation to the new engine testing. The council have also been working on a challenging contaminated land case in the city, supporting planning colleagues to ensure the development is fit for purpose and does not pose a risk to human health.

Case Study – Pollution Control at Peterborough City Council

The PCC Pollution Team has a significant input into the development control process, acting as a statutory consultee for planning applications and for the discharge of conditions. The Pollution Team are consulted on approximately 500 development sites each year, recommending conditions and agreeing mitigation measures where noise, contaminated land, air quality and other such environmental issues may be of concern. Typical applications that are considered and advised upon in the development process are:

- New transport routes and industrial/commercial activities proposed in/near residential locations;
- Applications for residential development adjacent to noise sources such as industry or road/rail traffic;
- Proposed developments on brownfield sites when previous uses may have contaminated soils or produce ground gases with potential health impacts; and
- Major developments that may have air quality impacts upon the locality, for example by emissions from associated transport or particulates.

Examples of developments considered in the previous 12 months include:

- Developments in Hampton considering road and rail traffic impacts for proposed and existing development, the impact of new traffic routes or increased traffic flows on existing development in terms of noise and air quality; mitigation measures that may be required to protect residential and other developments from any soil contamination or ground gases that may be present; considering any potential impacts upon new schools proposed on brownfield sites adjacent to major traffic routes.
- Site for 104 affordable houses Former Perkins Engines Site Newark Road Fengate. Advice on measures to mitigate potential impact from noise sources from industrial premises, and to mitigate ground contamination and gas emissions associated with previous landfilling of the site.
- Upgrade of Werrington Gas Compressor assessed for air quality and noise impacts. Notices served to control noise levels and hours of work for the construction phase of the project which are programmed for completion in 2020.
- Werrington Grade Separation "Dive-Under" proposals. The railway at Werrington Junction is to undergo major redevelopment which is scheduled to be completed by mid-2021. The noise resulting from this significant construction scheme will impact on local residents. Officers worked with Network Rail for the agreement of work procedures and service of notices primarily to ensure the impacts of construction noise of the civil engineering project will be controlled so far as reasonably practicable.
- Energy from Waste and Biomass Generating Station, Storeys Bar Road, Fengate - Advice and recommendations have been provided in relation to emissions of pollutants to air from the plant, odour potential, operational noise, construction noise and dust, impacts of transport upon air quality and noise, and controls to mitigate lighting impacts.
- Consideration of potential noise and air quality impacts associated with proposed duelling of A47 Wansford-Sutton
- Assessment of impacts from Alwalton Hill commercial developments and their potential cumulative impacts upon future residential developments in Hampton and for Haddon.
- Consideration of proposals for industrial and commercial use on 166440 square metres of land at Red Brick Farm Fengate, advising upon controls for day and night time noise that may impact upon residents, additional traffic noise, air quality impacts, development on potentially contaminated land and lighting control
- Discharge of planning condition in relation to remediation requirements for ground contamination and required levels of ground gas protection for Sand Martin House, Fletton Quays
- Review of development proposals for housing that may be affected by the nearby Stanground Landfill and Fletton Parkway. The site has been assessed for potential impacts of landfill gas migration, contaminated land, air quality and noise.
- Stanground South: Tranches for housing development adjacent to the Stanground bypass have come forward and been assessed for noise impacts associated with traffic. Recommendations for the protection of indoor and outdoor amenities have been made as part of the planning consultation process.

Contaminated Land at Burton Street: the PCC Pollution Team identified significant levels of carcinogenic chlorinated solvents in the ground, potentially affecting some residential properties in the area. The presence of the contaminant was most likely associated with the historic industrial land use of a casting works in the locality. It was therefore necessary to establish if the chlorinated solvent levels in the soil amounted to unacceptable risk to human health. Following initial investigations by officers, environmental consultants were appointed who carried out investigations at locations agreed with affected residents. This identified that the measured concentrations were all below the vapour screening values that had been previously determined by risk modelling. Therefore the risk to occupants in the identified area, from vapour intrusion associated with subsurface contamination, is acceptable and does not constitute significant possibility of significant harm and land is not deemed to be 'contaminated'.

8.4 Private Sector Housing

Private sector housing teams within environmental health departments of district and unitary authorities undertake statutory housing and public health functions. They work with owner occupiers, private landlords and social housing providers to protect the health, wellbeing and safety of residents and visitors. This may involve taking action to deal with issues such as disrepair, fire safety, overcrowding inadequate facilities and issues relating to damp, mould or condensation. Many private sector housing teams also work to improve the health and safety of houses in multiple occupation (HMOs) including issuing HMO licenses. Some housing officers also provide advice to homeowners and landlords about energy efficiency issues such as insulation and availability of grants.

This year, for example, the Cambridge City Private Sector Housing Team worked with a number of different agencies to deal with a complex case of hoarding. The team identified a number of category 1 hazards under the Housing Health and Safety Rating System (HHSRS) which affected the safety and suitability of the housing and worked in partnership to resolve these issues.

8.5 Licensing Service

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

This year, a number of local councils have reviewed their Statement of Licensing Policy in relation to the Licensing Act 2003. A Cumulative Impact Policy is a local policy which introduce a presumption against new licences to sell alcohol from bars, shops, pubs or clubs in a designated area. They can be adopted where there is evidence that the number or concentration of premises give rise to a harmful impact on the promotion of the licensing objectives and where a licensing authority has consulted local people and businesses. Cumulative impact policies are in place in Cambridge City, Fenland and Peterborough City. In 2018, both Cambridge City Council and PCC reviewed the use of cumulative impact policies in their districts and it was agreed to continue with them.

A further example of local work in this area is the revocation of an alcohol licence of a convenience store in Peterborough following the seizure by trading standards of illicit cigarettes and tobacco. Cambridge City Council have also heightened enforcement in this area to ensure the licence holders, including taxi licensing, are adhering to the requirements of their licenses.

8.6 Trading standards:

On 1st April 2017 Cambridgeshire County Council's Trading Standards Service merged with Peterborough City Council's Trading Standards Service, becoming 'Cambridgeshire and Peterborough Trading Standards'. The service plays a vital role in enhancing and safeguarding the local economy, as well as protecting its residents. Through the effective delivery of its statutory duties it helps to ensure businesses based and operating in Cambridgeshire and Peterborough are aware of and comply with their legal obligations.

Trading Standards has a critical role in ensuring consumer safety, through its enforcement and advisory activities in the areas of product safety, food safety, upholding the integrity of the food chain, protecting the most vulnerable from rogue trading activity, and effective explosives and petroleum licensing. The service plays a crucial role in protecting the rural economy from animal disease outbreaks and continues to be a primary responder in the case of such an outbreak, as well as upholding animal health and welfare standards.

A key area of work is tackling illicit tobacco which can cause significant harm to the public's health due to unregulated sales of cheap cigarettes to children and high levels of contaminants in fake tobacco products. Trading Standards plays a role locally by detecting and seizing illegal tobacco products.

Cambridgeshire and Peterborough Trading Standards Service have been working on the following important issues which can pose a risk to the public's health:

- **Rabies:** the trading standards service have been working hard to disrupt the illegal importation of animals for onward sale which can present a risk of rabies when these animals come from countries with a high risk of rabies. A number of successful prosecutions have been undertaken against illegal importers (with one defendant receiving a 34 month prison sentence). This has provided a media platform allowing the service to raise awareness, educate the public and disrupt the importers resulting in a substantial drop in complaints in 2018.

- **Allergens:** the trading standards service has responsibility for food labelling including the correct labelling of allergens in food. Previous work has included sampling and analysis from takeaways but more recently the service has been focusing on caterers and hotels. Following a serious incident where a customer received food which contained nuts and had a severe allergic response, a series of inspections have taken place where controls were checked and advice given to ensure adequate controls were in place. Officers from across the councils have also provided training to caterers on allergens.

- **Illicit tobacco:** the service continues to work with partners across Cambridgeshire and Peterborough to disrupt the sale of illicit cigarettes, tobacco and alcohol. This is resource intensive work as often these products are concealed in shops or nearby vehicles so sniffer dogs are needed to find hiding places. These products are sold cheaply (£3 for packet of 20 cigarettes) thereby counteracting the Government initiatives of discouraging smoking through taxation and harming legitimate business. From four visits in Peterborough 32,000 cigarettes and 3.2kg hand rolling tobacco were seized. Licence reviews are underway against all these premises, with one premise having their licence revoked. Investigations are currently being carried out for possible court action. The trading standards service has also recently invested in new equipment to improve testing of seized cigarettes for 'reduced ignition propensity' requirements – an important safety feature on regulated cigarettes.

- **Vaping safety project:** As part of a Department of Health funded project, trading standards officers have been assessing compliance with the Tobacco and Related Products Regulations 2016. A range of premises were inspected and at each one approximately ten products (e-liquids and vaping merchandise) were inspected for compliance. Numerous non-compliances were seen around labelling and officers advised businesses on what they needed to do to comply with legal requirements. Issues found were referred to the Trading Standards departments where the suppliers were based. In addition to the funded work, 16 samples of e-liquids were taken and analysed in the laboratory of a Primary Authority Partner business for the presence of undesirable substances and nicotine strength. Of the 16 samples taken, one had high levels of acetyl propionyl and acetoin, which are both flavour ingredients that the Medicines and Healthcare Regulatory Agency (MHRA) have advised against. All nicotine strengths were within tolerance of that declared. This project has identified a range of issues facing consumers and businesses on how to comply with the law, and has fed into a larger national project.

- **Underage sales:** the trading standards service are responsible for age restricted products such as tobacco, alcohol, fireworks, knives and petrol. We, like many other authorities, do not receive many complaints about this, but recognise that it is a problem. In order to generate intelligence to target our action we have conducted a set of Challenge 25 test purchases, where a 20 year old was sent into shops claiming to operate a 21 or 25 age check policy and asked to buy cigarettes. From 46 premises visited 21 (45%) sold without asking for ID and of these 17 (80%) were illicit tobacco. This provides evidence for the perception that underage sales are still a problem, made worse by the fact many of the cigarettes were also illicit, and further work is planned.

- **Counterfeit alcohol:** Following a complaint from a consumer, trading standards officers examined a bottle of vodka purchased from a local off license. The labelling and smell of the vodka raised concerns that it may not be genuine. As a result inspections were conducted at 2 linked premises and further bottles seized. These were sent for analysis to determine whether the products are genuine or unsafe. In the past, counterfeit vodka has been found to contain industrial alcohol, such as isopropanol and ethanol, both of which can be very harmful.

9. Air Quality

9.1 Responsibility for improving air quality

The air quality agenda in Cambridgeshire and Peterborough is not owned by a single organisation or department. Cambridge City, Peterborough City Council and the four district councils have statutory requirements to assess and monitor air quality, and where required develop action plans; they also have plan making powers which can effect air quality. The Cambridgeshire County Council, Peterborough City Council and the combined authority and Greater Cambridgeshire Partnership are responsible for actions and intervention's (mainly relating to transport) which can mitigate or reduce air pollution.

The role of the public health directorate is to provide the evidenced based health implications of air quality at a population level. The public health directorate facilitate this by bringing together key stakeholders who may not normally meet for air quality issues or may only be considering the environmental aspects, for example Public Health have contributed to the Transport needs review of the Cambridge Biomedical Campus (one of the Greater Cambridge Partnership Projects) following concerns raised by members of the Cambridgeshire County Council Health Committee and officers at the Cambridge City Council, the Combined Authority's Strategic Bus Review, the Local Transport Plan and district/city level Local Plans.

There are number of challenges which need to be considered when developing a joined up county wide approach to air quality. As stated above the ownership of the air quality agenda rests with many organisations with responsibility for monitoring and mitigation held by different organisations, this makes a system wide response more challenging.

Last year the public health directorate identified a gap in the knowledge of air quality and its impact among transport and planning officers as transport planners and local planners are not experts in air quality, and in two tier areas do not have access to air quality expertise in their organisations, therefore Public Health commissioned a training programme for these officers to raise awareness of air quality and to foster closer working relationships.

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

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

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

9.2 Monitoring air quality

Cambridge City Council, Peterborough City Council and the four district councils are required to assess the air quality in their area as part of the Air Quality Standards Regulations 2010 legislation. Levels of air pollutants such as benzene, carbon monoxide, nitrogen dioxide, industrial emissions and sulphur dioxide are assessed.

The assessment process is undertaken in a series of stages by using an updating and screening assessment of air quality which are produced every three years. The updating and screening assessment of air quality identifies the pollution levels within the local authority area. In between these publications, annual status reports (ASR) are produced which highlight any changes which might have occurred over the previous year. The guidance from DEFRA requires these ASRs to be signed off by the Director of Public Health.

Should any pollutants be suspected or shown to be above the objective level, the responsible local authority is required undertake a detailed assessment. If the detailed assessment shows that there is an area which exceeds the relevant air quality objective, the Council shall declare an air quality management area.

The burden of poorer air quality varies across Cambridgeshire and Peterborough. Currently, the main pollutants of concern in Cambridgeshire and Peterborough, as in most areas of the UK, are associated with road traffic, in particular NO_2 and particulate matter (PM) at locations close to busy, congested roads where people may live, work or shop. Air Quality Management Areas (AQMAs) have been declared in Cambridge City, Fenland, Huntingdonshire, Peterborough City and South Cambridgeshire; East Cambridgeshire currently do not have an AQMA. By nature this means that air quality does not have the same level of focus for all local authorities.

In areas with declared Air Quality Management Areas (AQMAs) the focus continues to be to support the authorities to bring forward measures to improve air quality and ensure that the most vulnerable are protected e.g. children and those with health conditions.

In addition to responsibility for monitoring air quality, the district and city councils also have plan making powers which can affect air quality. Recent examples of work by district and city councils to improve air quality include the introduction of a zero/ultra-low taxi vehicle policy and the introduction of electric vehicle charge points for taxis in Cambridge City Council.

9.3 Cambridgeshire and Peterborough Combined Authority

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

The combined authority has also produced a Non Statutory Spatial Plan which focuses on providing a county perspective on infrastructure, linking up local plans and the LTP. Air quality has been considered as part of this process. The Combined Authority are reviewing and refreshing the Quality Charter for Growth which will take air quality into account. These plans will enable Public Health to indirectly influence air quality in those localities where air quality is not deemed to be a priority.

9.4 Cambridgeshire and Peterborough Air Quality Action Plan

The public health directorate are coordinating a Cambridgeshire and Peterborough Air Quality Action plan to address key concerns on air quality raised locally. The draft headline actions are:

- Review what resources have already been developed locally and nationally – develop / localise specific resources for planners and councillors on planning committee, councillors more broadly, children and young people, and make resources available on local authority air quality pages and Cambridgeshire Insight to address communication/key messages on air quality. There is a lack of local resources and key messages on air quality which can leave a vacuum and creates potential for inappropriate narrative.
- Examine current content on Cambridgeshire insight on Air Quality as there is a lack of links between districts air quality pages and Cambridgeshire insight and vice versa
- Identify resources from elsewhere and localise/develop resources for citizen scientists locally
- Apply for NHS sustainability fellow to work locally to better understand impact of the NHS (health service) on air quality and identify opportunities to change ways of working.
- Feed into the Combined Authority's Local Transport Plan and Quality Charter for Growth.

9.5 Air Quality – Further Information

Local authorities are required to publish regular air quality reports which can be found on their local websites and the Cambridgeshire Insight website.

10 Sexual Health

The following key indicators for sexual health in Cambridgeshire and Peterborough raise concerns about trends in population level sexual health.

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

The rate of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) is below the England average for Cambridgeshire, with a downward trend. The rate of new diagnoses of sexually transmitted infections (excluding <25 chlamydia) for Peterborough has fluctuated in recent years. The Peterborough rate in 2017 declined from 2016 to a level statistically similar to the national average (876 to 761 per 100,000).

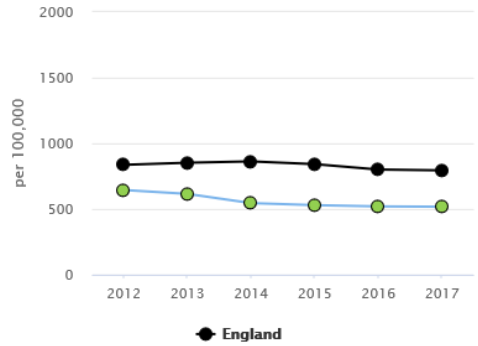


Figure 9: New STI diagnoses (excluding <25 chlaymdia), Cambridgeshire, 2012-2017, *Source: Sexual Health Profiles Public Health England (2018)*

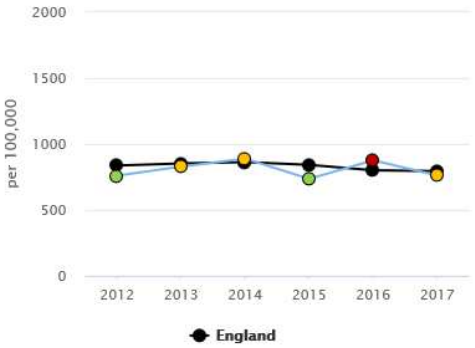


Figure 10: New STI diagnoses (excluding <25 chlaymdia), Peterborough, 2012-2017, *Source: Sexual Health Profiles Public Health England (2018)*

10.2 New HIV Diagnosis Rate

There has been an overall downward trend in the rate of new HIV diagnosis in England and Cambridgeshire. However, the rate for Cambridgeshire in 2017 increased from 2016 (6.8 to 7.3 per 100,000) to a level statistically similar to the England average.

Peterborough has remained statistically significantly similar to England since 2011, although the Peterborough rate for this indicator declined between 2016 and 2017 (from 14.9 to 13.5 per 100,000) line with the England trend.

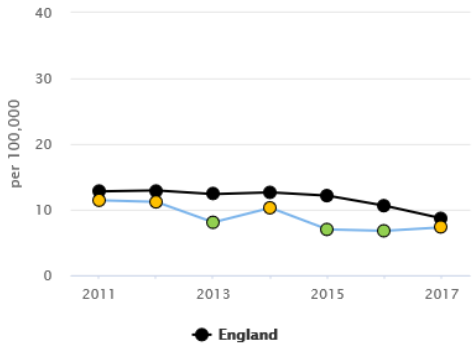


Figure 11: New HIV Diagnosis Rate, Cambridgeshire, 2011-2017, *Source: Sexual Health Profiles Public Health England 2018)*

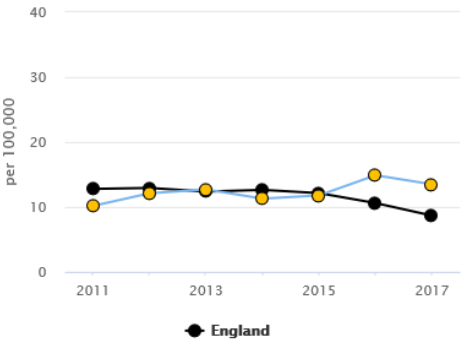


Figure 12: New HIV Diagnosis Rate, Peterborough, 2011-2017, *Source: Sexual Health Profiles Public Health England (2018)*

10.3 Late HIV Diagnosis

England has a downward trend of HIV late diagnosis. Earlier diagnosis leads to an improved outcome of treatment and reduced risk of onward transmission.

The rate of HIV late diagnosis for Cambridgeshire was worse than the benchmarking goal (defined as ≥ 50%) at 51.1% in the period 2015-17 (shown below) and statistically significantly similar to England. Since 2009 it has been statistically significantly similar or above both the benchmarking goal and England.

The rate of late HIV diagnosis for Peterborough has been worse than the benchmarking goal (defined as ≥ 50%) at 51.2% during 2015-17 (shown below). Since 2013 the Peterborough rate for late diagnosis has been statistically worse than the England figure.

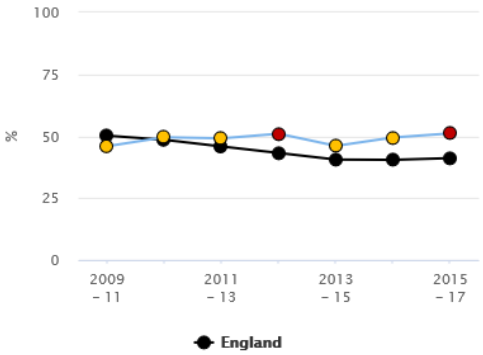


Figure 13: HIV Late Diagnosis (%)[1], Cambridgeshire, 2009/11-2015/17, *Source: Sexual Health Profiles Public Health England (2018)*

[1] *These graphs show the Cambridgeshire/Peterborough rate RAG-rated compared to the **benchmark** for this indicator, not England.

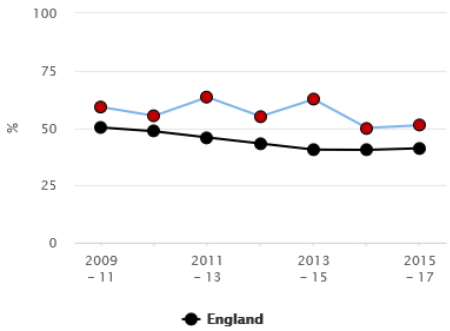


Figure 14: HIV Late Diagnosis (%)[2], Peterborough, 2009/11-2015/17, *Source: Sexual Health Profiles Public Health England (2018)*

10.4 HIV diagnosed prevalence

The HIV diagnosed prevalence rate for Cambridgeshire has remained statistically significantly better than England since 2011. The HIV diagnosed prevalence rate for Peterborough was statistically significantly better than England from 2011 to 2015. For the periods 2016 and 2017 the HIV diagnosed prevalence rate for Peterborough has increased to a level statistically similar to England. The HIV diagnosed prevalence rate has exceeded 2 per 1,000, therefore defining the authority as a high HIV prevalence local authority according to 2017 NICE and PHE guidelines. For Peterborough, the increased rate is expected to be in part due to improved testing, diagnosis, and treatment.

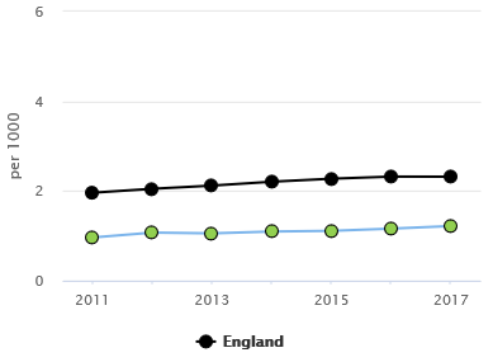


Figure 15: HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Cambridgeshire, 2011 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

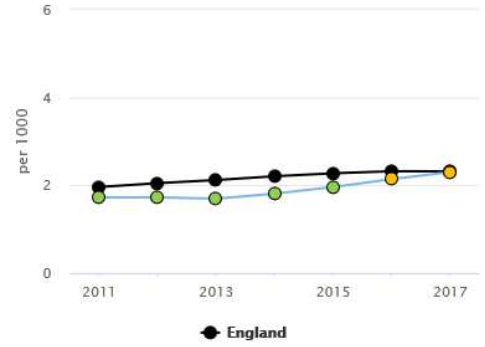


Figure 15: HIV diagnosed prevalence rate per 1000 (people aged 15 – 19 yrs), Peterborough, 2011 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

10.5 Chlamydia Diagnosis

Nationally, there has been a continued decline in Chlamydia detection amongst 15-24 year olds since 2012. For Cambridgeshire, the rate of chlamydia detection has remained significantly worse than the national average, and worse than the PHE recommended benchmarking goal of 2,300 per 100,000, since 2012. However it is difficult to interpret this as generally the rate of STIs in the Cambridgeshire population is below the national average.

[2] *These graphs show the Cambridgeshire/Peterborough rate RAG-rated compared to the **benchmark** for this indicator, not England.

The rate of chlamydia detection in Peterborough has remained significantly better than the national average, and better than the PHE recommended benchmarking goal of 2,300 per 100,000, since 2012. Continuing to exceed the national benchmarking goal is considered positive in terms of identifying and treating the infection in the population, however, it indicates clearly that there is high level of infection in the population despite the high detection and treatment rate.

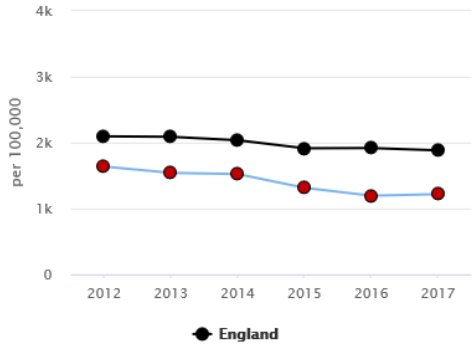


Figure 17: Chlamydia detection rate 15-24 yrs, Cambridgeshire, 2012 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

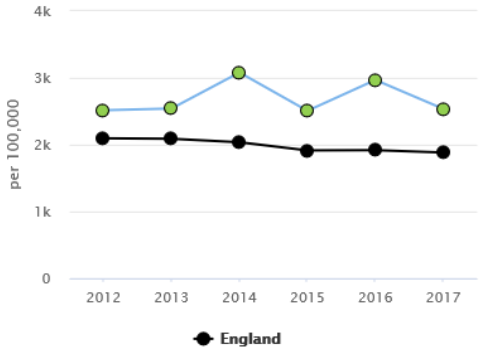


Figure 18: Chlamydia detection rate 15-24 yrs, Peterborough, 2012 - 2017, *Source: Sexual Health Profiles Public Health England (2018)*

10.6 Teenage Pregnancy (conceptions)

The under 18 conception rate per 100,000 has improved dramatically between 1998 and 2016 in Cambridgeshire and in Peterborough. The under 18 conception rate in Cambridgeshire continues to have a downward trend and it remains below the national average. The Fenland district, within Cambridgeshire, has a downward trend but remains statistically similar to England. Peterborough also has a downward trend in the under 18 conception rate, however it remains statistically significantly worse than the national average for the sixth consecutive year.

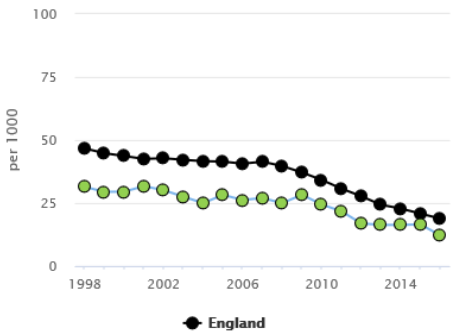


Figure 17: Under 18s Conception Rate, Cambridgeshire, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

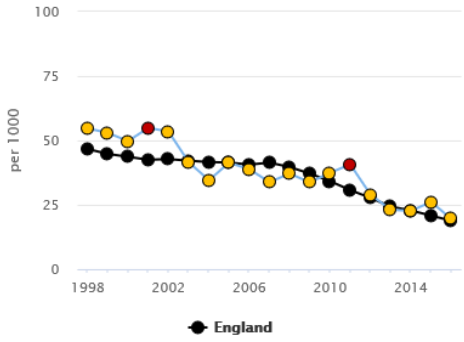


Figure 18: Under 18s Conception Rate, Fenland, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

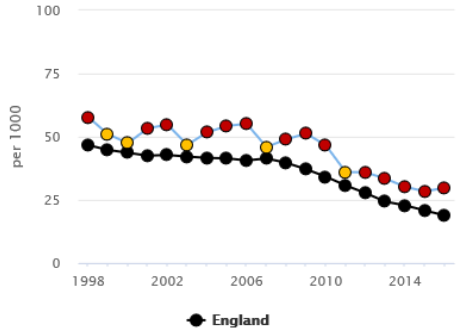


Figure 19: Under 18s Conception Rate, Peterborough, 1998 - 2016, *Source: Sexual Health Profiles Public Health England (2018)*

10.7 Sexual Health Services

The Integrated Sexual Health Service (ICaSH) in both Cambridgeshire and Peterborough is provided by Cambridgeshire Community Services. Both areas have since 2014 has seen a continuous increase in demand for its services. In Cambridgeshire during the last year this increase has been around 5% above the activity level commissioned in 2014. In Peterborough this increase has been substantially greater at around 25% above the 2014 commissioned levels. These increases in activity are found in both contraception and sexual health services.

In Cambridgeshire the Service is generally meeting its key targets. The historical Department of Health access target for GUM services was for securing access to sexual health treatment within 48 hours or two working days to reduce the risk of onward transmission of infection has consistently been met.

However the activity increase in Peterborough has contributed to a decrease in the percentage of patients being offered and accessing the sexual health services within 48 hours to around 70% on average for both measures. Measures have been taken to address the increase in activity. From October 2018 there were six clinic closures but also additional ongoing funding was secured from Peterborough City Council to address the increase in demand that had created substantial funding issues for the provider. In addition the contractual key performance indicators for the access targets were changed from being a contractual mandatory requirement to a reporting requirement. This will be reviewed regularly.

In Cambridgeshire chlamydia screening is commissioned from GPs for 15-25 year olds. And although numbers are low they have a high positivity rate which is associated with targeted opportunistic screening. Peterborough does not have comparable GP contract and the majority of screening is undertaken by the iCaSH clinic.

Community pharmacies provide Emergency Hormonal Contraception (EHC) and demand for this remains unchanged. Pharmacies who provide EHC are also required to offer access or provide advice on chlamydia screening Pharmacies are located in areas where access to other services is limited and where there are high risk groups are targeted for providing the service. In Cambridgeshire the service performs well and meeting its targets.

The Peterborough EHC Service was re-commissioned in 2017/2018 and a significant amount of work was undertaken to ensure pharmacies received the relevant training. There has been a doubling in six months in the number of pharmacies, with sixteen now providing the service in the high need areas.

10.8 Prevention

In both Cambridgeshire and Peterborough the voluntary organisations continue to provide a range of prevention services that range from outreach work with hard to reach/high risk groups, chlamydia screening to working in schools. The iCaSH service in Peterborough also provides an outreach service. Throughout the year a number of campaigns are also undertaken in line with the national programmes.

10.9 Cambridgeshire and Peterborough Sexual Health Delivery Board

The Cambridgeshire and Peterborough Sexual Health Delivery Board was established in 2017. This followed the formation of the Cambridgeshire and Peterborough Public Health Joint Commissioning Unit (JCU). The JCU is responsible for commissioning Public Health services across the two local authorities. The Sexual Health Delivery Board brings together commissioners and providers from across the two areas to set the strategic direction for sexual health and to implement collaborative partnership interventions to address issues. A Delivery Action Plan has been developed and the following priorities have been adopted by the Board to address initially.

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

The Public Health England (PHE) lead for Teenage pregnancy led a multi-agency Workshop in 2018 that lead to the identification of priorities for organisations to take forward to address teenage pregnancy in Peterborough and Fenland.

There is a group working to address late HIV diagnosis which includes exploring the demographic characteristics associated with late diagnosis to ensure that interventions are appropriately targeted.

PHE invited sexual and reproductive health commissioners from the Cambridgeshire and Peterborough local authorities, Clinical Commissioning Group and NHS England to be one of two national pilot sites for a sexual health commissioning feasibility study. The aim is for local sexual heath commissioning organisations explore opportunities for future alignment and collaborative commissioning opportunities for sexual health services in the area, which would future proof, quality assure and optimise sexual health service pathways, better address needs and potentially realising system efficiencies where appropriate. This has been taken forward during 2018 with work including a multi-agency workshop that identified five priorities for development that are being taken forward. The progress has been reported to PHE Advisory Board.

There have been concerns in Peterborough about the prevention and support for people living with HIV from vulnerable groups. Sex workers and those misusing drugs have raised particular concerns. This has brought together a wide range of agencies to successfully address the particular acute health and social needs of an individual and this group is now working to look at the issues more widely to develop a more strategic approach across organisations.

9. Health Emergency Planning

Cambridgeshire County Council and Peterborough City Council are Category 1 responders under the terms of the Civil Contingencies Act 2004. As a result there is an emergency planning / resilience team that works in partnership with other organisations to lead emergency planning and response for the councils, along with some additional

responsibilities for health emergency preparedness passed with the move of Public Health into local authorities. In the role within local authorities the DPH is expected to:

- Provide leadership to the public health system for health Emergency Preparedness, Resilience and Response (EPRR).
- Ensure that plans are in place to protect the health of their population and escalate concerns to the Local Health Resilience Partnership (LHRP) as appropriate.
- Co-chair the Cambridgeshire and Peterborough LHRP with NHS England Locality and represent at Cambridgeshire and Peterborough Local Resilience Forum Strategic Board.
- Provide initial leadership with PHE for the response to public health incidents and emergencies. The DPH will maintain oversight of population health and ensure effective communication with local communities.

LHRPs provide strategic leadership for health organisations in the Local Resilience Forum (LRF) area and are expected to assess local health risks and priorities to ensure preparedness arrangements reflect current and emerging needs. Member agencies share responsibility for oversight of health emergency planning in this forum. It is for the LRF and/or the LHRP to decide whether LHRP plans should be tested through a multi-agency exercise as a main or contributory factor. The DPH reports health protection emergency resilience issues to the LHRP on a regular basis. The DPH provides a brief update report on the activities of the LHRP to the HPSG to ensure sharing of cross cutting health sector resilience issues.

- The DPH has been supported in this work by a consultant in public health who co-chairs the Health and Social Care Emergency Planning Group (HSCEPG) with the Head of EPRR from the NHS England Midlands and East (East) and has oversight of all health protection issues. The function is supported by the shared Health Emergency Planning and Resilience Officer (HEPRO) based within Public Health. The HEPRO reports into the LHRP and the LRF through the DPH.
- The HSCEPG has membership from local acute hospitals, East of England ambulance service, community services, mental health services, social care services, other NHS funded providers, Public Health England and NHS England.

The LHRP leads on the annual EPRR assurance process. The aim is to assess the preparedness of the NHS commissioners and providers, against common NHS EPRR Core Standards. All NHS funded organisations have completed their self-assessment against the EPRR Core Standards for 2018-2019. All organisations were either full or partially compliant.

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

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

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

- PHE Health Protection audit;
- Cyber security;
- CPLRF Pandemic influenza Plan; and
- CPLRF CBRN Plan.

The LRF Pandemic Influenza Plan has been exercised and validated by the CPLRF Executive Board. The CBRN plan has been exercised and is going through the process of validation.

The period from 1 January 2018 to the date of this report has seen a very wide and varied training and exercise programme delivered by the CPLRF. Of significance were three exercises:-

1. Exercise Gallus: The discussion based table top exercise took place on the 24 July 2018 to test the arrangements within Cambridgeshire and Peterborough for Pandemic Influenza. Thirty six attendees from sixteen organisations took part in the exercise.
2. Exercise North Sea: This was a 'walk and talk' followed by 'question and answer' exercise that took place on 26 June 2018. The aim of the exercise was to assess, test and validate the procedures stated in the East Coast Flood plan for the tidal River Nene.
3. Exercise Green Cloud: This was a table top exercise that took place on the 18 and 19 September 2018. The overarching aim of the exercise was to rehearse working in a Tactical Coordinating Group (TCG) and Strategic Coordinating Group (SCG) environment and conduct a review of the recovery phase. The exercise was designed and facilitated by the Cabinet Office Emergency Planning College

The priorities for the year ahead have been agreed as:

- Actions from Health Protection audit;
- Winter Resilience; and
- Cambridgeshire and Peterborough Hospital Evacuation Plan.

10. Glossary

AAA	Abdominal Aortic Aneurysm
AMR	Antimicrobial Resistance
AQMAs	Air Quality Management Areas
ASR	annual status reports
CBRN	Chemical, biological, radiological & nuclear
C. difficile	Clostridium difficile
CCG	Clinical Commissioning Group
CCS	Cambridgeshire Community Services NHS Trust
CP HPSG	Cambridgeshire and Peterborough Health Protection Steering Group
CPFT	Cambridgeshire and Peterborough NHS Foundation Trust
CUHFT	Cambridge University Hospitals NHS Foundation Trust
DEFRA	Department for Environment, Food & Rural Affairs
DOT	Directly Observed Treatment
DPH	Director of Public Health
DTaP	Diptheria, tetanus and pertussis (vaccine)
EHC	Emergency Hormonal Contraception
EPRR	Emergency Preparedness, Resilience and Response
ESPAUR	English Surveillance Programme for Antimicrobial Utilisation and Resistance
ETS	Enhanced Tuberculosis Surveillance
FDC	Fenland District Council
FSA	Food Standards Agency
GI	gastrointestinal
GNBSIs	Gram Negative Bloodstream Infections
GP	General Practice
HCAI	Healthcare Associated Infections
Hep B	Hepatitis B virus
HEPRO	Health Emergency Planning and Resilience Officer
HHSRS	Housing Health and Safety Rating System
Hib	Haemophilus influenzae type B
HIV	human immunodeficiency virus
HMOs	Houses of Multiple Occupation
HPV	Human papillomavirus
HSCEPG	Health and Social Care Emergency Planning Group
ICaSH	The Integrated Sexual Health Service
IPV	Polio (vaccine)
JCU	Cambridgeshire and Peterborough Public Health Joint Commissioning Unit
KPIs	key performance indicators
KTT9	Key therapeutic topic
LA	Local authority
LES	Local Enhanced Service
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
LTBI	Latent TB infection
LTP	Local Transport Plan
MHRA	Medicines and Healthcare Regulatory Agency
MMR	Measles, Mumps & Rubella vaccine
MOU	Memorandum of Understanding
MRSA	methicillin-resistant Staphylococcus aureus
NICE	National Institute for Healthcare and Clinical Excellence
NOIDs	Notification of Infectious Diseases
NWAFT	North West Anglia NHS Foundation Trust
PCC	Peterborough City Council

PCV	Pneumococcal vaccine
PHE	Public Health England
PIR	post infection review
PM	particulate matter
SCG	Strategic Coordinating Group
SSP	Specialist Screening Practitioner
STIs	Sexually Transmitted Infections Diagnoses
TB	Tuberculosis
TCG	Tactical Coordinating Group
UTI	urinary tract infection
VTEC	Vero cytotoxin-producing

Agenda Item No: 14

PUBLIC HEALTH SYSTEM LGA PEER REVIEW

To:	**Health Committee**
Meeting Date:	**23rd May 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**n/a** *Key decision:* **No**
Purpose:	**To ask the Committee to consider and comment on the findings of the Local Government Association peer review of the Cambridgeshire and Peterborough public health system, carried out earlier this year, and to endorse the associated multi-agency action plan, which has been approved by the Cambridgeshire and Peterborough Health and Wellbeing Board.**
Recommendation:	**The Committee is asked to:** **a) Comment on the findings of the Cambridgeshire and Peterborough public health system peer review attached as Annex A.** **b) Endorse the multi-agency action plan attached as Annex B.**

	Officer contact:		***Member contacts:***
Name:	**Liz Robin**	Names:	Peter Hudson
Post:	Director of Public Health	Post:	Chair
Email:	Liz.robin@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
Tel:	01733 207176	Tel:	01223 706398

1. BACKGROUND

1.1 The Local Government Association (LGA) carried out a peer review of the public health system in Cambridgeshire and Peterborough, which took place over the three days Wednesday February 6th- Friday February 8th

1.2 The purpose of the peer review was to get an outside view from knowledgeable 'peers' about how well we are working to improve the health of the public in Cambridgeshire and Peterborough. The peers had experience as a Councillor, a local authority Chief Executive, a Director of Public Health and an NHS Chief Executive.

1.3 The peer review gathered information and views on the following four 'key lines of enquiry'.

1. **To what degree is there whole system ownership for the health of the public - including clarity about the outcomes required and what is required to achieve them?**
2. **To what extent have the Councils embraced the role of custodians of the public's health?**
3. **How effective is public health activity in improving outcomes?**
4. **How effective is the reach and communication with communities in order to positively affect population health**

1.4 The peer reviewers reviewed relevant documents and carried out several interviews with staff and stakeholders, in order to get feedback and views on the wide range of activities which the Councils' public health team, wider Council, external partners and contractors carry out to improve the health of the public. At the end of the three days, the peer reviewers provided structured feedback on what is going well in Cambridgeshire and Peterborough and what could be further developed.

2. MAIN ISSUES

2.1 The presentation providing the key findings of the LGA Peer Review is attached as Annex A.

2.2 A number of local strengths were identified – including the commitment of the two Health and Wellbeing Boards to work together; the quality of public health data and strong joint working across analytics teams; impactful system wide programmes such as falls prevention, best start in life, and suicide prevention; good delivery of core public health services such as sexual health and smoking cessation; commitment from district councils; locality initiatives such as the Healthy Fenland Fund and the Can Do area in Peterborough; STP preventive projects for older people; and a strong and vibrant voluntary sector.

2.3 The 'key messages' identified by the Peer reviewers are:

- The whole system is financially challenged which makes it an imperative to do more around demand management/prevention with Public Health playing a key role
- Councils have made a start but need to fully embrace the important role they have as champions of the health and wellbeing of the population, to do more to influence the wider determinants of health and tackle health inequalities
- The Public Health Team need to have a more expansive view of its role and whilst remaining as a separate team, officers need to be aligned to the business of the other directorates and be full members of the management teams
- Scale of housing growth and planning for new communities provides an opportunity for public health to focus on the wider determinants of health and create healthy communities
- You have a massive opportunity as a system to elevate the prevention and population health and wellbeing agenda and wider determinants of health through the response to the NHS Long Term Plan and new Joint Health and Wellbeing Strategy for Cambridgeshire & Peterborough and the Health and Wellbeing Boards (HWBs)
- Scope for public health to be more visibly strategic:
  - Recognition of deprivation and health inequalities – good examples in Fenland but there other areas in Cambridge and Peterborough that need targeted interventions to help people and save money in the long term
  - examples of good public health projects but fragmented & missed opportunities by public health for a more expansive role

2.4 The final recommendations for the Cambridgeshire and Peterborough 'system' from the Peer Reviewers are:

- Develop across your senior politicians and clinicians a shared vision and narrative and long term ambition for Cambridgeshire & Peterborough
- Enable collective leadership and accountability through a rationalised governance and partnership structure
- Use your new JHWS to promote prevention, tackle the wider determinants of health and influence partners to drive improvements in population health and wellbeing
- Ensure the wider role of Public Health is impacting on all aspects of the system in order to promote the health and wellbeing of the population
- Develop a coherent and consistent model for integrated delivery in neighbourhoods
- Develop your commissioning architecture with partners to realise the investment ambition to deliver place based solutions at scale e.g. further scope joint commissioning with the CCG

2.5 A draft system action plan has been developed to address these recommendations which is attached as Annex B (to follow).

2.6 The Health and Wellbeing Boards will play a lead role in establishing the joint vision, priorities and strategy for Cambridgeshire and Peterborough, and

overseeing the joint action plan. It is key that the Health Committee ensures strong communication and links between its work and the work of the Cambridgeshire and Peterborough Health and Wellbeing Boards, which have a multi-agency remit for healthcare, social care and public health integration across the system.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

Good health and wellbeing, supported by a strong local public health system, is a core aspect of quality of life for Cambridgeshire residents.

3.2 Thriving places for people to live

The public health peer review draws attention to the need for strategic public health input into the wider determinants of health in Cambridgeshire, which include economic and infrastructure strategies.

3.3 The best start for Cambridgeshire's children

Children's public health staff and commissioned services play an integral part in delivering this corporate priority, working closely with wider Council directorates and external partners.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

Staff time and potentially some limited non-recurrent resource to deliver specific actions will be required to fully implement the peer review action plan, which is wide ranging. There will be a multi-agency approach to this and resource requirements will be addressed on a case by case basis for the relevant actions.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category

4.3 Statutory, Legal and Risk Implications

There are no significant implications within this category

4.4 Equality and Diversity Implications

There are no significant implications within this category

4.5 Engagement and Communications Implications

Developing a communication strategy for the wider public health role of the Council is included in the public health peer review action plan.

4.6 Localism and Local Member Involvement

There are no significant implications within this category

4.7 Public Health Implications

These are addressed in the main body of the paper.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes : 15 May 2019 Name of Officer: Clare Andrews
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes : 10 May 2019 Name of Officer: Gus de Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes : 10 May 2019 Name of Officer: Fiona McMillan
Have the equality and diversity implications been cleared by your Service Contact?	Yes : 10 May 2019 Name of Officer: Tess Campbell

Have any engagement and communication implications been cleared by Communications?	Yes : 14 May 2019 Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Tess Campbell
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Tess Campbell

Source Documents	Location
None	

Local Government Association

Cambridgeshire and Peterborough

Feedback from the Peer Challenge
6 - 8 February 2019

The Peer Challenge Team

- **Chris Williams,** LGA Contractor (previously Chief Executive at Buckinghamshire County Council) **(Lead Peer)**
- **Cllr Stuart Barker,** Cabinet Member, Economy, Growth and Skills, Devon County Council
- **Tony Hill -** Independent Public Health Consultant and Health Strategist (previously Director of Public Health for Lincolnshire)
- **Martin Phillips,** LGA Contractor, (previously Chief Officer, NHS Darlington CCG)
- **Kay Burkett,** LGA **(Peer Challenge Manager)**
- **Katherine Mitchell,** LGA Advisor

The purpose of Peer Challenge

- Peer challenges are improvement focussed and tailored to the needs of the system/place
- They are designed to complement and add value to your own performance and improvement focus
- We have used our experience and knowledge of local systems to reflect on the information presented to us by people we have met
- We are providing feedback as critical friends, not as assessors, consultants or inspectors
- We have ‘held up the mirror’

The process of Peer Challenge

- Peers reviewed a range of information to ensure we were familiar with Cambridgeshire & Peterborough, the challenges it is facing and plans for the future
- We have spent three days on site and during the whole process which we:
  - spoke to more than 60+ people including a range of leaders, councillors, managers, staff and partners
  - gathered information and views from more than 49 meetings
  - additional research and reading –over 50 documents
  - collectively spent more than 284 hours to determine our findings – the equivalent of one person spending seven weeks here
  - Feedback session at end of on-site visit and follow up activity

A thank you from us

- People have been open and honest
- Preparation, planning and organisation has been impressive

In particular a special thank you to Liz Robin, Kate Parker, Mary Leen, Claire Dorans, Jo McGlashan & Jackie Adamson who co-ordinated all the local arrangements on your behalf and supported us admirably through the visit

A thank you from us

Scope and ‘brief’ for the peer challenge

The peer team were been asked to look at the following questions:

1.To what degree is there whole system ownership for the health of the public - including clarity about the outcomes required and what is required to achieve them?

2.To what extent have the Councils embraced the role of custodians of the public’s health?

3.How effective is public health activity in improving outcomes?

4.How effective is the reach and communication with communities in order to positively affect population health?

Context - 1

- All partners in the system are financially challenged - it is imperative that steps are taken to make financial savings and reduce demand for services
- Councils are having to consider new ways of delivering services for example, on commissioning
- Increasing numbers of children, young people and older people are placing a strain on the two Councils and there is a need to consider ways of managing demand and promoting the health and wellbeing of the population
- Significant housing growth is planned and there is a need to create healthy communities and plan for an aging population

Context - 2

- There are significant areas of deprivation and health inequalities in Fenland, parts of Peterborough and north Cambridge which need to be addressed
- The two Councils are developing place based models of service delivery – it will be important to agree a common set of localities amongst all of the partners
- It is increasingly important for elected members to have a good understanding of measures which can improve the health and wellbeing of the population
- The organisational landscape is very complex with a large number of boards and committees with priorities which are often not aligned
- There has been churn of some key personnel across the system with the consequentially adverse impact on the collective capacity to maintain effective partnerships

Key messages

- Whole system is financially challenged which makes it an imperative to do more around demand management/prevention with Public Health playing a key role
- Councils have made a start but need to fully embrace the important role they have as champions of the health and wellbeing of the population, to do more to influence the wider determinants of health and tackle health inequalities
- The Public Health Team need to have a more expansive view of its role and whilst remaining as a separate team, officers need to be aligned to the business of the other directorates and be full members of the management teams
- Scale of housing growth and planning for new communities provides an opportunity for public health to focus on the wider determinants of health and create healthy communities
- You have a massive opportunity as a system to elevate the prevention and population health and wellbeing agenda and wider determinants of health through the response to the Long Term Plan and new Joint Health and Wellbeing Strategy for Cambridgeshire & Peterborough and the Health and Wellbeing Boards (HWBs)
- Scope for public health to be more visibly strategic:
  - Recognition of deprivation and health inequalities – good examples in Fenland but there other areas in Cambridge and Peterborough that need targeted interventions to help people and save money in the long term
  - examples of good public health projects but fragmented & missed opportunities by public health for a more expansive role

1. *To what degree is there whole system ownership for the health of the public - including clarity about the outcomes required and what is required to achieve them?*

Strengths

- Shared strategic roles across PCC & CCC are building blocks for whole system ownership
- Health & Wellbeing Boards committed to working together and a shared health and wellbeing strategy could drive ownership
- New JSNA & JHWS provides a vehicle to elevate the prevention and population health and wellbeing agenda
- Impressive amount of data/intel that describes the area, needs and challenges with an opportunity to maximise/rationalize/ look at synergies to shape inform & strategic priorities and focus action (got the Health Analytic Community (HAC) group to do this)
- System wide approaches having an impact e.g. 'Stronger for Longer', 'Best Start in Life' and Suicide Prevention Strategy
- Examples of data and insights informing strategy and commissioning e.g. Active Transport; local health and wellbeing strategies
- District councils have a strong ownership of the health of their local population and a range of activities to support health improvement supported by Public Health e.g. 'Health is Eveyone's Business' workshops, Workplace Health Programme and 'Making Every Contact Count' training
- Good examples in the Sustainability and Transformation Partnership (STP) of partnership working on preventative issues for older people e.g. Delayed Transfers of Care (Use It or Lose It Campaign); Falls Prevention and community service offer
- Combined Authority (CA) has launched an independent commission on public service reform and commissioned work on achieving a stronger health and care system

1. To what degree is there whole system ownership for the health of the public - including clarity about the outcomes required and what is required to achieve them?

Areas for further consideration - 1

- Lacking an overarching shared system narrative and vision to set out what the future looks like for integration and reform outside of the hospital & growth agendas – this is needed to harness/focus prevention activity (CA/STP/new JHWS)
- Complexity within the system that is not helping to focus capacity and action:
  - the number of boards
  - the number of priorities, some that are conflicting
- Capitalise on people's understanding of the need to collaborate to continue to build trust in order to go further with joint commissioning (place based) and enable risk sharing
- Multiple locality footprints: STP; Think Communities; GP Networks; Community Services Neighbourhood Teams
- Major cost drivers of Children and Young People services and & Adult Social Care - so how do you incorporate the population health and wellbeing agenda and the contribution of public health to help manage demand e.g. obesity and diabetes in children and young people
- Language not based on common interpretation and understanding e.g. integration; prevention; public health; health; population health; healthy communities

1. To what degree is there whole system ownership for the health of the public - including clarity about the outcomes required and what is required to achieve them?

Areas for further consideration - 2

- Partners to agree how best to use the JSNA in order to systematically drive change and inform decision making across the whole system – including rationalising reports and content
- System not being driven by improving health and wellbeing outcomes or ‘size of the prize’ e.g. role of prevention is recognised as important but not given sufficient profile and priority at STP level
- Voluntary and community sector is underused and could be better joined up

2. *To what extent have the Councils embraced the role of custodians of the public's health?*

Strengths

- The Director of Public Health and Public Health staff are well regarded both internally and externally for their experience, knowledge and skills
- Good examples of collaboration between Public Health and other council services e.g. transport, licensing and externally
- Public Health appear to be very good at delivering core services such as falls, sexual health services and smoking cessation
- Public Health are very good at understanding the area and aspects of need – more to be done to communicate the findings consistently
- Some people in other directorates have an appreciation of what Public Health contribute and where they could do more
- Cambridgeshire are acting as the custodians of the public's health in Fenland but it appears limited to Fenland – it should be quickly applied to elsewhere and apply the lessons learned

2. *To what extent have the Councils embraced the role of custodians of the public's health?*

Areas for further consideration

- The importance of all elected members and officers understanding the role of Public Health - and their own contribution - in improving the health of the population needs to be tackled systematically
- Public Health seem to have a very narrow view of the role of public health and the influencing role and contribution they can make
- We received mixed messages about how well Public Health works with other partners – there are missed opportunities for Public Health staff to use to their status and intellectual rigour to influence other partners - more needs to be done to influence other parts of the council and partners on the wider determinants of health
- There is an opportunity to join up the traditional Public Health activities with Care Act prevention responsibilities e.g. tackling social isolation
- There needs to be a culture change across all organisations to enable a Health In All Policies approach

3. *How effective is public health activity in improving outcomes?*

Strengths

- Quality of public health data and experience of analytics staff is recognised across the system including how they work with other business intelligence teams
- Public health supporting district councils to make use of data/intel to inform decision making e.g. licensing and local planning
- Successful projects where Public Health have been involved e.g. Falls Prevention, AF, Active Families, Can do (Lincoln Road)
- Commissioning targeted interventions based on need e.g. Integrated Lifestyles services; sexual health services in Wisbech; drug & alcohol services

3. *How effective is public health activity in improving outcomes?*

Areas for further consideration

- Lots of public health activity and projects but not aligned to system wide agreed outcomes and often not joined up
- Public health not always at the table early enough for some key initiatives therefore missed opportunities for the important influencing role about population health and wellbeing
- Consideration should be given to strengthening communication and alignment across the commissioning teams of People & Communities and Public Health, in the context of the broader joint commissioning agenda with the NHS, in order to:
  - Improve efficiency
  - Improve outcomes
  - Enable Public Health capacity to help address wider determinants
- Public Health role in connectivity and facilitation needs to be recognised and developed

4. *How effective is the reach and communication with communities in order to positively affect population health?*

Strengths

- Some excellent locality schemes, initiatives and projects targeted to improving health and wellbeing of local people e.g. Healthy Fenland Fund; Let's Get Going; and Can Do areas
- Enabling role of Public Health on social media campaigns e.g. running and cycling in Peterborough
- A vibrant and engaged VCS that is building a track record of successful delivery through exploring community assets e.g. Living Sport, 'Needless Needles'

4. *How effective is the reach and communication with communities in order to positively affect population health?*

Areas for further consideration

- Empower/enable VCS and other partners to help shape and deliver more on neighbourhood priorities
- Consider how all elected members can best be supported to champion health and wellbeing in their communities e.g. resources to pump prime mainstream or spread good work (Timebank)
- How best to engage with partners to break down barriers and build confidence and trust to improve health and wellbeing e.g. getting a link into primary care
- Better exploit the opportunities to join up the dots by connecting people and processes to tackle inequalities more effectively e.g. networking
- Be more open to opportunities from partners to address wider determinants of health e.g. social prescribing initiatives
- Consider how commissioning can be harnessed to secure improved health and wellbeing and tackling health inequalities e.g. longer contacts, shared outcomes, build resilience
- Consider opportunities to align across the system to focus efforts to improve health and wellbeing and tackling health inequalities:
  - JHWB strategy and STP
  - Combined Authority
  - Releasing resources

Recommendations

- Develop across your senior politicians and clinicians a shared vision and narrative and long term ambition for Cambridgeshire & Peterborough
- Enable collective leadership and accountability through a rationalised governance and partnership structure
- Use your new JHWS to promote prevention, tackle the wider determinants of health and influence partners to drive improvements in population health and wellbeing
- Ensure the wider role of Public Health is impacting on all aspects of the system in order to promote the health and wellbeing of the population
- Develop a coherent and consistent model for integrated delivery in neighbourhoods
- Develop your commissioning architecture with partners to realise the investment ambition to deliver place based solutions at scale e.g. further scope joint commissioning with the CCG

LGA PUBLIC HEALTH DRAFT PEER REVIEW ACTION PLAN **Agenda Item No: 14 – Appendix 2**

FEBRUARY 2019

The action plan is framed around the final recommendations of the LGA Public Health Peer Review report, taking into account other points

It's cross referenced to the 2018 LGA Health and Social Care Integration Peer Review Action Plan, so that actions can be delivered jointly where possible.

GB=Gillian Beasley; WoW= Wendi Ogle-Welbourn; LR=Liz Robin; KP=Kate Parker; DL= David Lea; TB=Tom Barden; JT= Jan Thomas; GH= Gary Howsam; CB=Christine Birchall; JB=Jessica Bawden; AF=Aidan Fallon; RS=Roland Sinker; CP=Cathy Pollard; CBo = Catherine Boaden; NC = Natalie Clennell PH=Cllr Peter Hudson; CB= Cllr Chris Boden; RH= Cllr Roger Hickford; LG=Lawrence Gibson; CBl=Charlotte Black; SK= Stuart Keeble; JF = Julie Farrow; SG = Sue Grace; KJ=Katie Johnson; AA= Amanda Askham; ML= Mary Leen; AC=Adrian Chapman; VT=Val Thomas; RL=Raj Lakshman

	Recommendation	Activity	Lead	Deadline	Outcome/Impact	RAG rating
1	Develop across your senior politicians and clinicians a shared vision and narrative and long term ambition for Cambridgeshire & Peterborough *Note: Cross reference to Health and Social Care Peer Review Action Plan recommendation 1: Develop a single vision that is person focused and co-produced with people and stakeholders, with*	Scope key politicians, clinicians and boards which need to be involved.	GB/WoW/LR	Feb 2019	Joint HWB Board (brings together views of CCC committees, PCC portfolio holders, and all HWB Board member organisations), STP Board (brings together views of NHS Trusts, GP Networks, all member organisations and the Joint Clinical Group), plus input from Combined Authority, Office of the Police and Crime Commissioner, Cambridgeshire Public Service Board.	

	supplementary communications strategy and campaign	Scope existing plans and vision statements from relevant Boards/Leaders.	WoW/ LR/KP	March 2019		
		Bring together simple summary of key outcomes and how Cambridgeshire and Peterborough are currently performing.	DL/TB/ LR	March 2019	Start with JSNA core dataset	
		Use HWB Boards stakeholder event on 28th March to start visioning work	WoW/ LR/JT/ GH	March 2019		
		Engagement strategy to develop and consult on the vision and narrative with stakeholders.	CB/JB/ CBo	May 2019		
		Agree vision statement and narrative	HWB Board/ STP Board	Sept 2019		
2	Enable collective leadership and accountability through a rationalised governance and partnership structure. *Note: Cross reference to Health and Social Care Peer Review Action Plan recommendation 3:*	Define relationship between HWB Board and STP Board – starting with HWB workshop March 28th. Clarifying and principles	RS/CP /JT/GH /WoW/ LR	June 2019		
		Define relationship between Health Committee and HWB – start with Chair/Vice chairs meeting across the two boards.	PH/CB /RH/L R	May 2019		

	Strengthen the system leadership role of HWB's and clarify supporting governance					
		Map supporting partnership infrastructure at: • Cambs & Peterborough level • Cambs or Peterborough level • Local Level	KP/JB/NC ?LA Transformation Team to support	Sept 2019		
		Bring back report and recommendations on partnership infrastructure to senior officers network, CPSB, Health Care Exec and then HWB Board/STP Board.	? KP/JB/NC ? LA Transformation Team to support	Sept 2019		
3	Use your new JHWS to promote prevention, tackle the wider determinants of health and influence partners to drive improvements in population health and wellbeing	Assign capacity for preparing and consulting on the JHWS (identified author plus multi-agency steering group)	LR/SMT/JT/RS	May 2019		
		Clear action plan to combine STP NHS Plan submission	RS/CP/LR/WoW	Sept 2019		

	Note: Cross reference to Health and Social Care Peer Review Action Plan recommendation 3: Strengthen the system leadership role of HWB's and clarify supporting governance	'prevention' elements with Joint HWB Strategy				
		Ensure JHWS clarifies the impact of public health preventive interventions on future health and social care demand.	LG/CBl	Sept 2019		
		Ensure JHWS highlights the role of the community and voluntary sector.	SK/JF/ SG	Sept 2019		
		Timetable agreed for JHWS development, consultation and approval.	LR/KP	May 2019		
		(a)Communication and (b) implementation strategy for JHWS – including agreed branding across STP Plan and JHWS	CB/JB/ AF/TB C	Dec 2019		
4	Ensure the wider role of Public Health is impacting on all aspects of the system in order to promote the health and wellbeing of the population *Note: Cross reference to Health and Social Care Peer Review Action Plan recommendation 18:*	Develop training and OD plan to support the public health role of Members and officers e.g. Health is Everybody's Business Workshops	LGSS OD/KJ/ KP	July 2019		
		Allocate public health specialists to work strategically with (a) adult social care (b) Communities and Safety (c) Place and Economy (d)	SMT/L R	April 2019		

	As a system develop a multi organisational development programme that reflects the whole system vision and supports staff in new ways of working	Commercial/Transformation Directorates, by joining their management teams as full members and jointly identifying priority pieces of work for public health staff to support commissioning and delivery of services.				
		Develop OD/Training programme for PH staff working with Council directorates	LGSS OD/KJ	July 2019		
		Visit other authorities to learn more about good practice, starting with joint PH/P&C visit to Hertfordshire CC.	CBl/LR	June 2019		
		Prepare a quarterly update report on the full range of PH work to share with P&C management team (? and others) .	LR	June 2019		
		Work with Communications teams on a a strategy to communicate the wider public health functions of the Councils more effectively. Includes a communication plan for new JSNA core dataset. to maximise its use across directorates and agencies.	CB/LR DL/TB/	May 2019		

		Build on the new ways of joint working for PH intelligence and CCC/PCC Business Intelligence staff, and the wider joint working through the 'Health and Care Analytics Community (HAC)' group with the NHS, which were flagged as areas of strength in the peer review.	AA/LR/ TB/DL	Ongoing		
		Plan workshop to share and build on results of the public health peer review with participants and wider staff groups.	KP/ML	July 2019		
5	Develop a coherent and consistent model for integrated delivery in neighbourhoods *Note: Cross reference to Health and Social Care Peer Review Action Plan recommendation 17: Ensure there is a collective understanding and consistency of approach to neighbourhood / place based models*	Clarify governance for locality models of joint working as part of workstream for recommendation 2.	LR/Wo W/NM CW JM NA/JT/ CP	May – Sept 2019		
		Ensure public health involvement in Think Communities programme and STP integrated neighbourhoods/primary care networks programmes – and support bringing the programmes into full alignment.	AC/ LR	Ongoing		

		Agree public health staff support to Think Communities Core Service	LR/AC	March 2019		
		Agree how PH commissioned front-line services will deliver to the Think Communities/ Integrated Neighbourhood model	AC/VT/ RL	April – Sept 2019		
6	Develop your commissioning architecture with partners to realise the investment ambition to deliver place based solutions at scale e.g. further scope joint commissioning with the CCG *Note: Cross reference to Health and Social Care Peer Review Action Plan recommendation 8 Develop and implement a system wide commissioning strategy to deliver the Cambridgeshire and Peterborough vision and work jointly to better understand capacity and demand.*	Public health representative to join existing work to develop strategic joint commissioning architecture with the CCG.	WP/AA /LR/VT JT	March 2019		
		P&C and PH commissioners embed operational joint working through P&C joint commissioning board and Children's JCU.	VT/RL/ WP	Ongoing		

Agenda Item No: 15

UPDATE AND PROGRESS ON THE DEVELOPMENT OF THE MINOR INJURY UNITS IN EAST CAMBS & FENLAND

To:	**Health Committee**
Meeting Date:	**23 May 2019**
From:	**Matthew Smith, Senior Responsible Officer, Urgent & Emergency Care, Cambridgeshire & Peterborough CCG**
Electoral division(s):	**East Cambridgeshire and Fenland**
Forward Plan ref:	**n/a** *Key decision:* ***No***
Purpose:	**This paper provides an update and progress report on the development of the three Minor Injury Units within East Cambridgeshire and the Fens.**
Recommendation:	**The Committee is asked to note the contents of this report**

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

1.1 There are three Minor Injury Units (MIUs) within East Cambridgeshire and Fenland; at Ely; Doddington; and Wisbech.

The CCG has been piloting models of care within the Ely and Wisbech MIUs that help to support the delivery of the national Urgent Treatment Centre developments. The pilots provide GP support to the MIUs using different models. The models are designed to increase the scope of conditions that can be managed within the MIUs and therefore provide an expended urgent care service.
The new expanded services are called the Local Urgent Care Service (LUCS).

There is a national policy expectation that MIUs will need to meet national standards and a consistent service specification for 'Urgent Treatment Centres'. At the same time, the CCG has been working with all local providers on a programme to transform all out of hospital urgent care across Cambs & Peterborough, sometimes referred to as the 'roundtable' process. The aims of the programme are to simplify the current services and create a clear 24/7 out of hospital urgent care offer for patients, making more effective use of workforce and reducing demand on acute hospital emergency services.

2. MAIN ISSUES

2.1 LUCS Model

The LUCS provides an extended local, more accessible urgent care service for the population of East Cambridgeshire and Fenland, meaning that they do not have to travel a longer distance to the nearest hospital A/E department.

There is evidence that the LUCS model is containing growth in A/E attends, reducing Non-Elective hospital admissions and is also supporting 111 clinical validations, which in turn is reducing A/E attends. There is also evidence of high levels of patient satisfaction with the service.

The CCG is obligated to ensure that all urgent care services such as the Fenland and East Cambs MIUs meet the National criteria for UTCs. Currently the East Cambridgeshire and Fenland MIUS do not meet the criteria, but he LUCS pilot has given an opportunity to test a variety of models to help the MIUs to meet the criteria for UTCs.

2.2 Ely LUCS

The LUCS at Ely started in May 2017 and is also providing GP expertise to validate 111 calls that have resulted in a recommendation for the patient to attend an A/E department. 111 decides how a patient should be managed by the use of algorithms. However, it is widely recognised that these algorithms are likely to recommend more people to attend an A/E than is necessary. For this reason, using an experienced GP to check these referrals to A/E significantly reduces the number of 111 referrals to A/E.

2.3 Wisbech LUCS

The Wisbech LUCS commenced in January 2019, and is testing a model of GP support provided by the North Brink practice, directly supporting the MIU Nurse Practitioners.

2.4 Doddington MIU

The CCG is working on an alternative model for the Doddington LUCS, exploring the potential to add a telemedicine or digital service. This offers an opportunity to develop a new and innovative option for Urgent Care services in the South Fenland area, which (if successful) could be rolled out more widely.

2.5 Out of Hospital Urgent Care ('roundtable') Programme

The Out of Hospital Urgent Care ('roundtable') programme is due to complete its design phase in June 2019, with a view to piloting more integrated services from October 2019. In this context, funding for the LUCS pilots has been agreed for 6 months to fit in with this programme. Currently the CCG commissions A&Es; MIUs; GP Streaming in A&Es; the Ambulance Service who can 'see & treat', extended access for GPs, GPs to undertake minor injury treatment in their practices; GP out of hours; 111 and additional clinical support to 111. There is general agreement that with limited workforce availability this needs to be reviewed with a view to also making it clearer to patients about where to go to get advice and treatment.

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:

- The service will provide a local extended urgent care service that delivers an alternative to travelling to a hospital A/E department. This delivers benefit to the local population by reducing the distance they need to travel to access urgent care
- The rest of the local health services will have another means to manage patients in the locality
- Fewer journeys create less environmental impacts
- Ambulances have access to a local urgent care service thereby offering an alternative to a conveyance to a more distant hospital
- The LUCS model is containing growth in A/E attends, reducing Non-Elective hospital admissions and is also supporting 111 clinical validations, which in turn is reducing A/E attends. This releases resource currently spent in acute district hospitals

3.2 Helping people live healthy and independent lives

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

- The service will provide a local extended urgent care service that delivers an alternative to travelling to a hospital A/E department.
- People will be able to access an extended range of locally provided urgent care services
- Local urgent care services will be more accessible

3.3 Supporting and protecting vulnerable people

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

- An expanded local urgent care services is more accessible than distant A/E departments
- Vulnerable people will be able to access a local, smaller and less crowded service than those of an A/E department in a busy district hospital

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The Out of Hospital Urgent Care ('roundtable') programme is due to complete its design phase in June 2019, with a view to piloting more integrated services from October 2019. In this context, funding for the LUCS pilots has been agreed for 6 months to fit in with this programme.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications

There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications

There are no significant implications within this category.

4.4 Equality and Diversity Implications

The report above sets out details of significant implications in section 3.2 and 3.3. The service is open to all of the population and this is not dependent upon any aspect of diversity

4.5 Engagement and Communications Implications

The LUCS pilots have involved members of the public / patients in their development. Healthwatch have supported development of a patient questionnaire. There will be further engagement and reports relating to the wider Out of Hospital Urgent Care Programme.

4.6 Localism and Local Member Involvement

There are no significant implications within this category.

4.7 Public Health Implications

There are no significant implications within this category.

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

To: **Health Committee**

Meeting Date: **23 May 2019**

From: **Chief Executive**

Electoral division(s): **All**

Forward Plan ref: **Not applicable** *Key decision:* **No**

Purpose: **To review the Committee's agenda plan and training plan, and to consider appointments to outside bodies and internal advisory groups and panels.**

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

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

(ii) review its training plan attached at Appendix 2;

(iii) agree the appointments to outside bodies as detailed in Appendix 3; and

(iv) agree the appointments to Internal Advisory Groups and Panels as detailed in Appendix 4.

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

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

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

- Authority to nominate representatives to Outside Bodies other than the Combined Authority, Greater Cambridge Partnership, Cambridgeshire and Peterborough Fire Authority, the County Councils Network Council and the Local Government Association

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

1.3 Appointments to Internal Advisory Groups and Panels are agreed by the relevant Policy and Service Committee.

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

2. APPOINTMENTS

2.1 The outside bodies where appointments are required are set out in **Appendix 3** to this report. The current representative(s) is indicated. It is proposed that the Committee should agree the appointments to these bodies.

2.2 The internal advisory groups and panels where appointments are required are set out in **Appendix 4** to this report. The current representative(s) is indicated. It is proposed that the Committee should agree the appointments to these bodies.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

There are no significant implications for this priority.

3.2 Thriving places for people to live

There are no significant implications for this priority.

3.3 The best start for Cambridgeshire's children

There are no significant implications for this priority.

4. SIGNIFICANT IMPLICATIONS

4.1 There are no significant implications within these categories:

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

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

Source Documents	Location
Health Committee Agenda and Minutes – 29 May 2018	https://cambridgeshire.cmis.uk.com/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/6/Default.aspx

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN

Published on 1st May 2019

Cambridgeshire County Council

Notes

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

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

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
23/05/19	Public Health Finance and performance report	Chris Malyon/ Liz Robin	Not applicable		
	Health Protection Annual Report	Katie Johnson	Not applicable		
	Let's Get Moving – Evaluation Plans	Val Thomas	Not applicable		
	Public Health Peer Review and Action Plan	Liz Robin	Not applicable		
	Integrated Contraception and Sexual Health Procurement	Val Thomas	Not applicable		
	Integrated Lifestyle Procurement	Val Thomas	Not applicable		
	Scrutiny Item: Minor Injury Unit Update	CCG	Not applicable		
	Committee training plan (standing item)	Kate Parker/ Daniel Snowdon	Not applicable		
	Agenda plan and appointments to outside bodies	Daniel Snowdon	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
[20/06/19] Provisional Meeting					
11/07/19	Finance & Performance Report	Liz Robin	Not applicable		
	Finance & Performance 2018/19 Outturn Report	Liz Robin	Not applicable		
	CGL Contract Novation in Cambridgeshire	Val Thomas	2019/021		
	Quarterly Liaison Meeting Update Report	Kate Parker	Not applicable		
	Joint Strategic Needs Assessment and Joint Health and Wellbeing Board Strategy	Liz Robin	Not applicable		
	Scrutiny Item: CUH CQC Inspection Report	CUH	Not applicable		
	Scrutiny Item: STP Digital Strategy	STP	Not applicable		
	Scrutiny Item: STP Workforce Planning	STP	Not applicable		
	Response to Quality Accounts Report	Kate Parker	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[08/08/19] Provisional Meeting					
19/09/19	Finance & Performance Report	Liz Robin	Not applicable		
	Best Start in Life Strategy	Liz Robin	Not applicable		
	CUSPE Challenges – Healthy Fenland Fund Evaluation	Val Thomas	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
17/10/19	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
14/11/19	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
05/12/19	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
23/01/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[06/02/20] Provisional Meeting					
19/03/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Kate Parker	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
[16/04/20] Provisional Meeting					
28/05/20	Finance & Performance Report	Liz Robin	Not applicable		
	Health Committee Training Plan	Daniel Snowdon	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		

HEALTH COMMITTEE TRAINING PLAN 2019/20

Updated May 2019

Agenda Item No:16

Proposals

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
	Public Health Peer Review	Provide a feedback session on the LGA peer review and developing action plan Note item coming to Health Committee 23rd development session may not be required.	1	May 23rd	Public Health	Development Session			
	Public Health Performance reporting	To provide committee members with an increased understanding of the key performance indicators used in the F&PR To review current reporting and an opportunity to discuss what information members receive in future Performance reports.	2		Public Health	Development session			
	Mental Health Interventions	To provide committee members with an overview of public mental health focusing on local interventions and services.	4		Public Health	Development Session			

	School Nursing Service Overview	To provide a development session that specifically focusing on the provisions within the school nursing service and associated trend data around access. To agree specific objectives for the session and outline to service providers	3		Public Health	Development Session			

Appendix 3

CAMBRIDGESHIRE COUNTY COUNCIL
APPOINTMENTS TO OUTSIDE BODIES: POLICY & SERVICE COMMITTEES

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS	GUIDANCE CLASSIFICATION	COMMITTEE TO APPROVE
Cambridge University Hospitals NHS Foundation Trust Council of Governors The Board of Governors represents patients, public and staff. The majority of the Governors are elected by the membership. Governors provide a direct link to the local community and represent the interests of members and the wider public in the stewardship and development of the Trust.	4	1	Councillor M Howell (Con)	Martin Whelan Assistant Trust Secretary 01223 348567 martin.whelan@addenbrookes.nhs.uk	Other Public Body representative	Health

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS	GUIDANCE CLASSIFICATION	COMMITTEE TO APPROVE
Cambridgeshire and Peterborough NHS Foundation Trust Provides mental health and specialist learning disability services across Cambridgeshire and Peterborough. Also provides some specialist services on a regional and national basis. Partners are Cambridgeshire County Council, Peterborough City Council, NHS Cambridgeshire and NHS Peterborough.	4	1	Councillor G Wilson (LD)	Louisa Bullivant Corporate Governance Manager 01223 219477 Ext 19477 louisa.bullivant@cpft.nhs.uk	Partner Governor on the Council of Governors	Health
North West Anglia NHS Foundation Trust Council of Governors The North West Anglia NHS Foundation Trust was formed on 1 April 2017. The trust runs three busy hospitals – Peterborough City Hospital, Hinchingbrooke Hospital and Stamford and Rutland Hospital. Governors are the 'voice' of members of partner organisations in the running of the hospitals, so that hospital services always reflect the needs and expectations of local people.	TBC	1	Councillor J Gowing (Con) Happy for someone else to do.	Jane Pigg Company Secretary North West Anglia Foundation Trust 01733 677926 (direct dial) jane.pigg@pbh-tr.nhs.uk PA Jackie Bingley 01733 677953 (Weds) 01480 418755 (rest of week)	Other Public Bodies [Partner Governor]	Health

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS	GUIDANCE CLASSIFICATION	COMMITTEE TO APPROVE
Royal Papworth Hospital NHS Foundation Trust Council of Governors NHS Foundation Trusts are not-for-profit, public benefit corporations. They are part of the NHS and provide over half of all NHS hospital and mental health services. The County Council is represented on the Council as a nominated Governor.	4	1	Councillor L Jones (Lab)	Anna Jarvis Trust Secretary Chief Executive's Office Royal Papworth Hospital NHS Foundation Trust Papworth Everard Cambridge CB23 3PE anna.jarvis4@nhs.net Direct Line 01480 364555	Other Public Bodies	Health

As at 13th March 2019

Appendix 4

APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS	COMMITTEE TO APPROVE
Cambridge University Hospital NHS Foundation Trust (Addenbrooke's Hospital) Liaison Group The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its scrutiny function. It also provides the organisation with forward notice of areas that Health Committee members may want further information on or areas that may become part of a formal scrutiny.	4	4	Councillor L Harford (C) Councillor P Hudson (C) Councillor L Jones (L) Councillor S van de Ven (LD)	Kate Parker Head of Public Health Business Programmes 01480 379561 Kate.Parker@cambridgeshire.gov.uk	Health

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS	COMMITTEE TO APPROVE
Cambridgeshire & Peterborough NHS Foundation Trust (CPFT) Liaison Group, The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its scrutiny function. It also provides the organisation with forward notice of areas that Health Committee members may want further information on or areas that may become part of a formal scrutiny.	4	4	Councillor L Harford (Con) Councillor P Hudson (Con) Councillor G Harvey (Con) Councillor van de Ven (Lib)	Kate Parker Head of Public Health Business Programmes 01480 379561 Kate.Parker@cambridgeshire.gov.uk	Health

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS	COMMITTEE TO APPROVE
Clinical Commissioning Group and Cambridgeshire Healthwatch Liaison Group The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its scrutiny function. It also provides the organisation with forward notice of areas that Health Committee members may want further information on or areas that may become part of a formal scrutiny.	4	5	Councillor D Connor (C) Councillor L Harford (C) Councillor P Hudson (C) Councillor L Jones (L) Councillor S van de Ven (LD)	Kate Parker Head of Public Health Business Programmes 01480 379561 Kate.Parker@cambridgeshire.gov.uk	Health

NAME OF BODY	MEETINGS PER ANNUM	REPS APPOINTED	REPRESENTATIVE(S)	CONTACT DETAILS	COMMITTEE TO APPROVE
North West Anglia NHS Foundation Trust (Hinchingbrooke Hospital) Liaison Group The purpose is to determine any organisational issues, consultations, strategy or policy developments that are relevant for the Health Committee to consider under its scrutiny function. It also provides the organisation with forward notice of areas that Health Committee members may want further information on or areas that may become part of a formal scrutiny.	4	3	Councillor Connor (Con) Councillor Harford (Con) Councillor S Taylor (Ind) Councillor J Tavener (Con)	Kate Parker Head of Public Health Business Programmes 01480 379561 Kate.Parker@cambridgeshire.gov.uk	Health

As at 2nd January 2019