HEALTH COMMITTEE

Thursday, 17 October 2019

Democratic and Members' Services
Fiona McMillan
Monitoring Officer

13:30

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1 Apologies for Absence

2 Declarations of Interest

Guidance for Councillors on declaring interests is available at:

http://tinyurl.com/ccc-conduct-code

3 Minutes - 19th September 2019 & Action Log **5 - 16**

4 Petitions and Public Questions

KEY DECISIONS

The Health Committee comprises the following members:

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

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

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

Clerk Name: Daniel Snowdon

Clerk Telephone: 01223 699177

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

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HEALTH COMMITTEE: MINUTES

Date: Thursday, 19 September 2019

Time: 1.30p.m. – 16.48 p.m.

Present: Councillors C Boden (Vice-Chairman), D Connor, L Dupre, L Harford, P Hudson (Chairman), L Jones, P Topping and S van de Ven

District Councillors D Ambrose-Smith and G Harvey

Apologies: County Councillor T Sanderson.

District Councillor J Taverner.

238. DECLARATIONS OF INTEREST

None.

239. MINUTES –11TH JULY 2019

The minutes of the meeting held on 11th July 2019 were agreed as a correct record and signed by the Chairman.

240. HEALTH COMMITTEE – ACTION LOG

The Action Log was noted.

241. PETITIONS

There were no petitions.

242. PUBLIC HEALTH RESERVES – FALLS PREVENTION PROGRAMME INVESTMENT

The Committee received a report that sought approval for a three year investment in the Falls Prevention Programme. The presenting officer began by drawing the Committee's attention to recommendation b) of the report which required amendment. The needs data supplied in appendix 5 to the report clearly identified Cambridge City and Fenland as the areas with highest need. South Cambridgeshire regarding hip fracture in particular was the third best performing region in the East of England. With the unanimous agreement of the Committee recommendation b) was amended to approve the pilot areas as Cambridge City and Fenland.

Members noted that the report sought approval for the investment of £804k over three years and targeted to prevent increases in hospital admissions relating to falls and for robust monitoring of the investment in order that future funding be secured on a solid evidence base. The investment was predicted to deliver savings of approximately £840k and have a significant impact on adult social care by reducing the number of care packages required. Resources were also being sought to increase physical activity levels in the community which was a key component to increasing individual's resilience to falls.

During discussion Members:

- Welcomed the report and the additional funding, commenting that the Public Health Directorate was ahead of the trend following an announcement by Public Health England that emphasised the importance of muscle strength in old age.

- Highlighted the importance of demonstrating statistically significant change in driving the programme forward and questioned whether sustainability had been considered thoroughly and how the programme could be integrated within the daily work of teams. Officers explained that regarding sustainability, roles for the existing falls prevention programme had been merged into the Public Health budget in order to maintain the budget and commented that the programmes were as sustainable as possible. There were issues regarding rurality and engagement that were being addressed with providers. Links were also being forged with existing funding in the Fenland area in order to add value.

- Drew attention to the wider significance of the programme, commenting that it should feed into similar programmes around the country and be presented to the Public Health Conference.

- Reminded the Committee of how the additional funding had been released through the establishment of a cross-party Working Group agreeing for the utilisation of reserves for a programme that would be transformative.

- Highlighted the impact on the quality of life for individuals that were affected by falls.

- Drew attention to Fenland District Council which had agreed to partially ring-fence the disabled facilities grant (DFG) in order to channel it into the programme.

- Questioned whether it was the role of providers to promote the programmes being offered and whether GPs were able to make referrals and the role of day centres and extra care centres in promoting the programme. Officers informed Members that the role of the Senior Partnership Manager was to co-ordinate across the whole system in order to develop effective pathways. Promotions of the programme was also being undertaken in the form of the Stronger for Longer campaign.

- Questioned the cost to the individual of the programme. It was explained that the first part of the pathway was free of charge and if an individual had experienced a fall in the last year. Services provided by external leisure services or third sector organisations generally required a financial contribution.

- Noted the opportunity to link with charities as many were specifically for older people.

- Clarified the return on investment when compared with bone density screening and calcium supplements. Officers explained that although osteoporosis services were significant, there was strong evidence for the interventions set out within the report.

- Noted the excellent partnership working with the Adults Committee. Members noted that the General Purposes Committee would be made aware of the additional funding through the budget setting process.

It was resolved unanimously to:

a) Approve a three year investment in the Falls Prevention Programme as detailed in paragraph 2.11 – 2.27 of the report;

b) Consider and approve Cambridge City and Fenland as the geographical area(s) for deployment of an intensive Multi-Factorial Falls Risk Assessment and home adaptations programme.

c) Authorise the Director of Public Health, in consultation with the Chairman and Vice-Chairman of the Health Committee to enter into a Section 75 agreement with Cambridgeshire and Peterborough NHS Foundation Trust to deliver the intensive Multi-Factoral Falls Risk Assessment and home adaptions programme; and

d) Authorise LGSS Law to draft and complete the necessary documentation to enter into the Section 75 agreement.

243. FINANCE MONITORING REPORT – JULY 2019

Members were presented the July 2019 iteration of the Finance Monitoring report for the Public Health Directorate. Members noted that following the July meeting of the General Purposes Committee, financial reporting for Policy and Service Committees would be revised and the report before the Committee was the first where finance reporting would be undertaken monthly and performance data would be provided quarterly.

Officers drew attention to the balanced overall forecast outturn for the Public Health Directorate

During discussion Members:

- Drew attention to the difference in accounting processes between the Council and the NHS and emphasised the importance of ensuring that the accruals process operated effectively.

- Sought clarity relating to measures regarding sexual health contraception prescribed and STI testing and treatment found in appendix 1 of the report. Members noted that sexual health contraception prescribed refers to work undertaken by GPs where the cost of implants was charged back to the Clinical Commissioning Group (CCG) where there were delays. The STI testing contract was held with Cambridgeshire Community Services (CCS).

- Drew attention to the Children 0-5 PH Programme and the Children 5-19 PH Programme contained in appendix 1 of the report and sought clarity. Officers undertook to provide further details. **ACTION**

It was resolved to:

Review and comment on the report and to note the finance position as at end of July 2019

244. PERFORMANCE REPORT QUARTER 1 2019/20

The Committee received the Public Health Performance report for quarter 1 2019/20. The report represented a new way of showing data. The report would be presented to the Committee on a quarterly basis in order to allow for more information and context for each indicator to be presented.

During discussion, Members:

- WeIcomed the presentation of the graphs presented within the report. However, requested that they began on the x axis at April and the y axis at zero as movement was not adequately displayed.

- Commented that although the report presented an initial group of indicators there was further work that needed to be undertaken to develop and define indicators that reflected the strategic priorities of the Committee.

- Noted that further development of the report and the measures requested by Members would be communicated through the circulation of a briefing note.

- Welcomed the careful attention the Committee had paid to the report and the measures contained within in it.

- Noted that regarding health visiting mandated checks there were good levels of contacts made. However, they remained low because of a specific issue in South Cambridgeshire. The issue had been addressed by the provider through increased numbers of student places that were now maturing and it was anticipated that capacity would reached at the end of September 2019 and expected to meet targets by June 2020 at the latest.

- Drew attention to indicators 58 and 60 which appeared to mirror one another, commenting that it was not clear which was the more important. Officers undertook to consider the measures further outside of the meeting. **ACTION**

- Questioned why the smoking cessation target varied so greatly. Officers explained that there were seasonal fluctuations in take up of smoking cessation services particularly in January following New Year resolutions and August when GP leave peaked. The targets were based on the experience of previous years.

It was resolved to:

note and comment on performance information and take remedial action as necessary

245. DRAFT JOINT BEST START IN LIFE STRATEGY

A report was presented that sought to ensure that there was co-ordinated and integrated multi-agency agreement on the delivery of pre-birth to 5 services, including public health services, that was tailored appropriately to local need.

The presenting officer explained that the strategy arose following a peer review that recommended a joint strategy. Attention was drawn to the integration and partnership working that had been achieved across the system between education and children's health services.

Members noted that the draft strategy had been approved by the Children's and Young Peoples Committee at its September meeting.

During the course of discussion Members,

- Noted the positive partnership working that had taken place in developing the strategy. However, concern was expressed regarding the lack of resources available to deliver the strategy. A Member queried further the increased online offer; specifically how effective it was and how it translated into benefits.

- Drew attention and expressed concern regarding the comments contained at paragraph 4.5 of the officer report and sought reassurance regarding self-checks. Officers explained that the programme was focussed on all families. The identification of families that were likely to struggle was difficult. The programme was developed to address the opportunities that were being missed by working separately and to support families more effectively.

- Expressed concern when commenting that with a depleted workforce it was difficult to achieve a best start in life. A Member drew attention to the similarities with the Sure Start programme and expressed concern that the strategy represented a barely adequate start in life. Officers explained that the process of working up options for delivery was underway and there would be updates provided to Members regarding service delivery models. It was explained further that the process had not reached the end of phase 2 and the final part included consultation with the workforce. Options would be developed at the end of September or beginning of October.

- Noted the broad work being undertaken that was focussed on talking with families that were not traditional users of services.

- The Committee agreed unanimously agreed to amend the recommendation and replace 'endorse' with 'note' and for the Committee's comments regarding the engagement of children's public health services to be passed on.

It was resolved to:

> Note the Draft Joint Best Start in Life Strategy 2019 – 2024 and pass on comments regarding the engagement of children's public health services in delivering the Strategy

246. CCG COMMUNITY SERVICES REVIEW UPDATE AND DELIVERY OF CCG FINANCIAL PLAN

The Chairman invited Jan Thomas, Accountable Officer and Jess Bawden, Director of External Affairs and Policy to address the Committee. The Accountable Officer

informed Members that the CCG was managing emerging risks to the budget totaling £3m. While there was no current plan to mitigate the risks, plans were being developed and it was entirely possible that the gap could be closed. There had been constructive discussions with the Sustainability and Transformation Partnership (STP) Health Care Executive Group to identify further opportunities within the ongoing Community Services Review.

Members noted that performance across Continuing Health Care funding (CHC) had improved greatly. However, packages had increased in cost by approximately 8% on the previous year. There were also large volumes of CHC funding assessment undertaken with a low conversion rate which was concerning due to the cost and providing people with potentially false hope that the cost of care may be fully funded through health.

Due to the pause in the Community Services Review there had been delay to some of the savings programmes set out within it which had impacted on spending.

During the course of discussion Members:

- Questioned whether the variance related to CHC funding was replicated across the country. Officers explained that tier rates were introduced in order to ensure the appropriate rate was being paid. Attention was drawn to the higher referral rate from the Peterborough area when compared with the Cambridge area.

- Noted that the referral rate in the north of the county was significantly higher for CHC funding and for Funded Nursing Care (FNC). Officers explained that there was work required regarding education and managing expectations through the CHC process. The CHC checklist was designed so as not to miss anything and if a patient scored sufficiently highly then a full assessment was undertaken. The conversion rate was less than 10%.

- Noted the learning from Delayed Transfers of Care (DTOC) and the desire to work with social workers and hospitals to ensure that more accurate assessments were achieved.

- Questioned what the outcome of the Phase 2 Decommissioning and Decommissioning Engagement Programme had been achieved. Member were informed that meetings had taken place with front-line staff where service provision was discussed and ideas sought regarding efficiency. Officers commented that the exercise had highlighted a surprising level of unknown local variation in service delivery.

- Drew attention to a BBC news article that focused attention on the Petals service that had funding withdrawn by the CCG, highlighting the essential work undertaken by the organisation. Officers explained that the service had never received funding from the CCG and the news item was inaccurate in its reporting. The service had received funding through the Addenbrooke's Charitable Trust. The CCG had been approached for funding by the service but in the context of the significant increases in funding provided to mental health services a decision was taken not to provide funding. Perinatal mental health services would continue to be provide through Cambridgeshire and Peterborough Foundation Trust (CPFT).

It was resolved to

Note the contents of the report

247. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP – LOCAL RESPONSE TO THE NHS LONG TERM PLAN

The Committee welcomed Jan Thomas, Accountable Officer, Clinical Commissioning Group (CCG) to inform the Committee of the Sustainability and Transformation Partnership (STP) Long Term Plan. Members were informed that the plan was released in January 2019 and contained a series of commitments throughout the document that required partnership working with clinicians and stake holders in order to be achieved. The plan moved forward the STP digital agenda and highlighted the need to make significant progress against health conditions such as mental health.

During discussion Members:

- Expressed concern regarding the speed at which the plan was to be delivered as it would be extremely difficult to meet timescales. Officers recognised that it was not possible to commit to achieving lots of different things as they wouldn't be achieved. Therefore, there was a strong focus on 5 areas that were achievable and would make the biggest difference.

- Noted that there was a level of incoherence in national requirements which is why the 5 areas of focus were so important. It was explained further that if localised care was successfully achieved then the contradictions in national requirements were somewhat covered.

- Highlighted the need to lobby the Government regarding the Health Funding Formula and requested an update regarding any progress. Officers explained that it was acknowledged that there was underfunding of the system but not in allocation cost per head. Officers were working with regulators to lobby for population data to be refreshed more regularly, on a quarterly basis.

- Drew attention to public engagement and questioned how it would be achieved successfully. Members were informed that some of the events taking place as part of the CCG's Big Conversation would feed into the public engagement for the Long Term Plan. Healthwatch had undertaken a survey of providers who had been directing their staff to the survey also.

- Commented that the global reputation of Addenbrooke's could be affected by resources being allocated to treating people who should not be there rather than focussing on research and questioned whether Delayed Transfers of Care (DTOC) were reducing. Officers confirmed that DTOC performance had improved greatly and was currently standing at 39 when compared with September 2018 when the rate was over 90. Continued support was required in order to manage DTOCs as there were ever increasing numbers of people arriving in hospital with increased needs therefore, the work relating to urgent care and provider alliances was essential to managing demand effectively.

- Noted that alternative dates for engagement were being arranged due to the original date coinciding with the meeting of the Health Committee.

It was resolved to:

a) Note the requirement for a local response to the NHS Long Term Plan, as well as the local approach to developing this response; and

b) Agree future engagement with the Health Committee, noting the national timescales and deadlines for finalising the Plan.

248. SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP – WORKFORCE UPDATE REPORT

The Chairman invited Stephen Legood, Director of People and Business Development at Cambridgeshire and Peterborough Foundation Trust (CPFT), David Wherrett, Director of Workforce at Cambridge University Hospital Foundation Trust (CUH) and David Parke, Associate Director of Primary Care at the Clinical Commissioning Group (CCG) to address the Committee and update Members regarding workforce planning.

Members were informed that the NHS had begun to bring together disparate parts of the workforce strategy and collaborate across the system in order to address issues regarding the recruitment and retention of staff.

During discussion Members:

- Sought greater clarity regarding the overall demand and requirement for staff. Officers explained that the strategy was a relatively crude document that sought to address the coming 5 – 10 years. A particular challenge was the inclusion of social care and the strategy was being expanded to include the broader system. A far more detailed plan would then be developed. Members noted that workforce growth continued partly because the system was more effective at recruiting to vacancies and vacancies that were being held had been recruited to.

- Questioned whether consideration had been given to using elements of the market to resolve recruitment issues, with particular regard to GPs. It was explained that procurement took place in an open market. Primary Care Networks (PCN) were designed to address some of the issues through practices merging with one another. There was a concern that private providers may simply extract efficiencies through contracts with little benefit for patients.

- Questioned the level of recruitment with particular reference to internal recruitment that leave positions that require filling. It was explained that there had been significant investment made regarding the nursing apprenticeship levy which had a very low attrition rate. The vacancy rate had reduced from approximately 20% to 7%. The investment while significant represented better value than agency staff and it was intended to replicate the programme with other staff groups.

- Questioned how work was being translated across the county, helping areas that might not have been so successful in reducing vacancy rates. Officers explained that learning was shared across the system. Staff turnover within Cambridgeshire and Peterborough Foundation Trust (CPFT) had reduced from 18% to 12% where significant work had been completed relating to the nursing programme. Staff sickness was generally low and satisfaction was generally increasing. However, there were certain areas of the organisation where the vacancy rate remained high

which is why it was vital to work as a system regarding recruitment in order to share and develop best practice.

- Noted the positive view of officers regarding internal recruitment and movement of staff so long as the staff were retained within the organisation. It was essential that strong career pathways were visible to staff. Officers drew attention to the significant cost associated with professional development that would have to be drawn from funding for front-line services.

- Drew attention to North West Anglia Foundation Trust (NWAFT) which had not been as successful as other areas and encouraged sharing of the successful ideas and strategies with them. Officers commented that although a year ago collaboration had improved greatly over the last year and discussions were taking place with NWAFT and the social care sector.

- Sought clarity regarding the aspirations for the future, and whether staffing levels would be maintained or grown to meet future needs. It was explained that clinical design work was required from which the workforce element would emerge. The workforce would remain relatively stable over the next 5 years and the Long Term Plan that focussed on developing Minor Injury Units and place based care would bring forward a different profile.

- Requested a greater understanding of the GP forward view. Officers provided significant details regarding the context of the GP forward view where many GPs were approaching retirement and new GPs wanted to enter a salaried profession that provided a healthy work-life balance. There was also a desire within new GPs to spend time in acute hospitals in order to develop their skills. Attention was drawn to the development of Primary Care Networks that sought to address some of the issues facing GPs.

- Requested a report be presented to the Health Committee at a future date regarding Primary Care Networks, the GP forward view and progress to date. **ACTION**

It was resolved to:

Note the contents of the report and requested a further update in 6 months' time.

249. HEALTH COMMITTEE TRAINING PLAN

The Committee received its Training Plan.

It was resolved to note the training plan.

250. HEALTH COMMITTEE AGENDA PLAN,

The Committee examined its agenda plan and the additions recommended at the Committee.

- November 2018 – STP Digital Strategy (Scrutiny Item)
- December 2018 – Best Start in Life Strategy
- March 2019 – GP Strategy (Scrutiny Item)
- March 2019 – STP Workforce Strategy (Scrutiny Item)

The Director of Public Health requested that authority be delegated to the Director of Public Health in consultation with the Chair, Vice Chair and Lead members, to submit the Health Committee's response to the Prevention Green Paper consultation by October 14th (including emailing the response to all Health Committee members for comment). The Committee agreed unanimously with the request for the delegation.

It was resolved to review the agenda plan

Agenda Item No: 3b

HEALTH COMMITTEE

Minutes-Action Log

Cambridgeshire County Council

Introduction:

This log captures the actions arising from the Health Committee up to the meeting on **11th July 2019** and updates Members on progress in delivering the necessary actions.

Minute No.	Item	Action to be taken by	Action	Comments	Status & Estimated Completion Date
Meeting of 17 January 2019					
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 19 September 2019					
243.	**Finance Monitoring Report**	**Liz Robin**	Members sought greater clarity regarding Children 0-5 PH Programme and the Children 5-19 PH Programme contained in appendix 1 of the report.		**Ongoing**
244.	**Performance Report – Q1 2019/20**	**Liz Robin**	Officers undertook to review and consider further the measures included in the report.	Further information has been prepared for initial consideration at the Heatlh Committee Chair/Vice Chair/Lead Member meeting	**Ongoing**

248.	**STP Workforce Update Report**	**Dan Snowdon / Kate Parker**	Members requested a scrutiny item regarding Primary Care Networks be added to the forward agenda plan		**Complete**

Agenda Item No: 5

COMMISSIONING INTEGRATED LIFESTYLE SERVICES

To:	**HEALTH COMMITTEE**
Meeting Date:	**October 17 2019**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	**2019/67** *Key decision:* **Yes**
Purpose:	**The Integrated Lifestyle Service is currently being re-commissioned for Cambridgeshire County Council and Peterborough City Council as one contract, with Cambridgeshire County Council acting as the lead commissioner. This paper is to secure the appropriate delegated authorities to award the contract following the competitive tender.**
Recommendation:	**The Health Committee is asked to support and approve the following.**

a) The establishment of a legal agreement between Cambridgeshire County Council (CCC) and Peterborough City Council (PCC) that assigns Cambridgeshire County Council as the lead commissioner.
b) Delegate sign off for the agreement to the Director of Public Health in consultation with the Chair and Vice Chair of the Committee.
c) Authorise the Director of Public Health, in consultation with the Chairman and Vice Chair of the Health Committee, to formally award the new shared contract, effective from April 2020, subject to compliance with all the 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.

	Officer contact:		***Member contacts:***
Name:	Val Thomas	Names:	Peter Hudson
Post:	Consultant in Public Health	Post:	Chair
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1. BACKGROUND

1.1 In May 2019 the Health Committee approved the re-commission of the integrated Lifestyle Service as one service working across the CCC and PCC areas under one contract with CCC acting as the lead commissioner. The CCC contract with SLM Ltd. /Everyone Health ends on the 31st May 2020, any extension is not an available option.

1.2 Currently PCC commissions a comparable Integrated Lifestyle Service from the company Solutions 4 Health that will also end on the 31 May 2020. It provides a similar range of services but it does not include specialist mental health or substance misuse health trainers.

1.3 The Integrated Lifestyle Service 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

1.4 Both the CCC and PCC services bring 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. The Integrated Lifestyle Services includes delivery of the following:

- Health Trainers – provide support for up to year for individuals to make changes to their health behaviours. It includes specialist health trainers who focus upon falls prevention, mental health and substance misuse
- 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

1.5 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.

1.6 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 joint procurement between CCC and PCC for a shared service to be delivered across Cambridgeshire and Peterborough with CCC as the lead commissioner will require a legal agreement between the two local authorities and provide the appropriate assurances.

2.2 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.

2.3 The procurement has commenced and includes consideration of number of factors in the development of the service model.

- 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.
- 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.

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

CCC annual value: £2,223,839
PCC annual value: £832,336 (this will be confirmed on publication of the PCC business plan at the end of October. Any change will not affect the Cambridgeshire service as each local authority only funds services in their areas.)

2.5 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 the Invitation to Tender is issued.

2.6 It is proposed that the new contract will have a maximum length of 5 years with potential breaks at the third and fourth years. The scheduled date for the contract award is February 2020 with the new contract commencing on June 1 2020.

2.7 The contract value exceeds £500,000 and therefore this proposal is a key decision and the Health Committee is required to authorise the appropriate delegated authorities to award the contract. In addition delegated authority is required for the legal agreement with PCC that will delegate authority to CCC to award the contract.

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 **1.3, 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 **1.3, 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 ***2.4 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:

- Any equality and diversity implications are being included in the consultation for the new Service.

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 Name of Financial Officer: Stephen Howarth
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Gus De Silva
Has the impact on statutory, legal and risk implications been cleared by LGSS Law?	Yes 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 Name of Officer: Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
None	.

Agenda Item No: 6

SERVICE COMMITTEE REVIEW OF DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2020-21 TO 2024-25

To:	**Health Committee**
Meeting Date:	**17 October 2019**
From:	**Director of Public Health** **Chief Finance Officer**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable** ***Key decision:*** **No**
Purpose:	**This report provides the Committee with an overview of the draft Business Plan Revenue Proposals for services that are within the remit of the Public Health Committee.**
Recommendation:	**a) That the Committee note the overview and context provided for the 2020-21 to 2024-25 Business Plan revenue proposals for the Service.** **b) That the Committee comment on the draft revenue proposals that are within the remit of the Public Health Committee for 2020-21 to 2024-25.**

	Officer contact:
Name:	Liz Robin
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Email:	liz.robin@cambridgeshire.gov.uk
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1. OVERVIEW

1.1 The Council's Business Plan sets out how we will spend the resources we have at our disposal to achieve our vision and priorities for Cambridgeshire, and the priority outcomes we want for people.

Priority Outcomes for Cambridgeshire Citizens

A good quality of life for everyone	Thriving places for people to live	The best start for Cambridgeshire's children
◆ Keeping vulnerable people safe in a way that draws on their own strengths and those of their communities. ◆ Nurturing healthily communities that have access to resources that enable them to support themselves, connect with others and become sustainable. ◆ Improving social and economic equality so that life expectancy, opportunity and social mobility are not determined by wealth or background. ◆ Encouraging and supporting people to choose healthy lifestyles to prevent problems in later life - focusing our help on those communities most at risk of poor health outcomes. ◆ Using our public assets wisely and raising money in a fair and businesslike way to generate social return for all citizens of Cambridgeshire.	◆ Growing financial and social capital place-by-place by stewarding local resources including public, private and voluntary contribution. ◆ Continuing to invest in the environment, infrastructure and services that are a vital part of everyday life for everyone in the county and for a thriving local economy. ◆ Putting more choice and more independence directly into the hands of individuals and communities. ◆ Working with District and Parish Councils, Public Sector Partners and other community organisations to provide local services which build supportive, resilient communities and great places to live.	◆ Focusing on what happens to children in their earliest years as the key to influencing positive outcomes in adult life. ◆ Working with children, their families and carers to develop positive attitudes to learning and health and wellbeing. ◆ Joining services across health, education and social care to address social inequalities in our most deprived communities. ◆ Intervening early and effectively to support and safeguard vulnerable children, young people and their families. ◆ Increasing stability in placements for children in care. ◆ Providing ongoing support for care leavers to help achieve positive educational outcomes and access to quality work opportunities.

1.2 To ensure we deliver our agenda, the focus will continue to be on getting the maximum possible value for residents from every pound of public money we spend, and doing things differently to respond to changing needs and new opportunities. The Business Plan therefore sets out how we aim to provide good public services and achieve better outcomes for communities, whilst also responding to the challenge of reducing resources.

1.3 Like many Councils across the country, we are facing a major financial challenge. Demand is increasing and funding is reducing at a time when the cost of providing services continues to rise significantly due to inflationary and demographic pressures. Through our FairDeal4Cambs campaign we are currently linking with the 36 Shire County areas who make up membership of the County Councils Network and who are raising the issue of historic underfunding of Shire Counties with our MPs and through them with Government. As one of the fastest growing Counties in the country, this financial challenge is greater in Cambridgeshire than elsewhere. We have already delivered £178m of savings over the last five years and have a strong track record of value for money improvements which protect front line services to the greatest possible extent. However, we know that there will be diminishing returns from existing improvement schemes and that the substantial pressure on public finances remains. It is therefore clear that we need to continue to work alongside local communities to build independence and co-produce solutions at pace.

1.4 We recognise the scale of change needed and propose a significant programme of change across our services, with our partners and, crucially, with our communities. To support this we have a dedicated transformation

fund as part of the Business Plan, providing the resource needed in the short term to drive the change we need for the future.

1.5 As the scope for traditional efficiencies diminishes, our plan is increasingly focused on a range of more fundamental changes to the way we work. Some of the key themes driving our thinking are;

- Income and Commercialisation - identifying opportunities to bring in new sources of income which can fund crucial public services without raising taxes significantly and to take a more business-like approach to the way we do things in the council.

- Strategic Partnerships – acting as 'one public service' with our partner organisations in the public sector and forming new and deeper partnerships with communities, the voluntary sector and businesses. The aim being to cut out duplication and make sure every contact with people in Cambridgeshire delivers what they need now and might need in the future.

- Demand Management – this is fundamentally about supporting people to remain as healthy and as independent as possible, for as long as possible. It is about working with people to help them help themselves or the person they care for e.g. access to advice and information about local support and access to assistive technology. Where public services are needed, it is about ensuring support is made available early so that people's needs don't escalate to the point where they need to rely heavily on public sector support in the long term.

- Commissioning – ensuring all services that are commissioned to deliver the outcomes people want at the best possible price – getting value for money in every instance.

- Modernisation – ensuring the organisation is as efficient as possible and as much of the Council's budget as possible is spent on front line services and not back office functions, taking advantage of the latest technologies and most creative and dynamic ways of working to deliver the most value for the least cost.

1.6 The Council continues to undertake financial planning of its revenue budget over a five year period which creates links with its longer term financial modelling and planning for growth. This paper presents an overview of the proposals being put forward as part of the Council's draft revenue budget, with a focus on those which are relevant to this Committee. Increasingly the emerging proposals reflect joint proposals between different directorate areas and more creative joined up thinking that recognise children live in families and families live in communities, so some proposals will go before multiple Committees to ensure appropriate oversight from all perspectives.

1.7 Funding projections have been updated based on the latest available information to provide a current picture of the total resource available to the Council. At this stage in the year, however, projections remain fluid and will be reviewed as more accurate data becomes available.

1.8 Equally, as our proposals become more ambitious and innovative, in many instances they become less certain. Some proposals will deliver more or less

than anticipated, equally some may encounter issues and delays and others might be accelerated if early results are promising. We have adapted our approach to business planning in order to manage these risks, specifically;

- Through the development of proposals which exceed the total savings/income requirement – so that where some schemes fall short they can be mitigated by others and we can manage the whole programme against a bottom-line position
- By establishing a continual flow of new proposals into the change programme – moving away from a fixed cycle to a more dynamic view of new thinking coming in and existing schemes and estimates being refined
- Taking a managed approach to risk – with clarity for members about which proposals have high confidence and certainty and which represent a more uncertain impact

1.9 The Committee is asked to comment on these initial proposals for consideration as part of the Council's development of the Business Plan for the next five years. Draft proposals across all Committees will continue to be developed over the next few months to ensure a robust plan and to allow as much mitigation as possible against the impact of these savings. Therefore these proposals may change as they are developed or alternatives found.

1.10 Committees will receive an update to the revenue business planning proposals in December at which point they will be asked to endorse the proposals to GPC as part of the consideration for the Council's overall Business Plan.

2. BUILDING THE REVENUE BUDGET

2.1 Changes to the previous year's budget are put forward as individual proposals for consideration by committees, General Purposes Committee and ultimately Full Council. Proposals are classified according to their type, as outlined in the attached Table 3, accounting for the forecasts of inflation, demand pressures and service pressures, such as new legislative requirements that have resource implications, as well as savings and investments.

2.2 The process of building the budget begins by identifying the cost of providing a similar level of service to the previous year. The previous year's budget is adjusted for the Council's best forecasts of the cost of inflation, the cost of changes in the number and level of need of service users (demand) and proposed investments. Should services have pressures, these are expected to be managed within that service where possible, if necessary being met through the achievement of additional savings or income. If this is not possible, particularly if the pressure is caused by legislative change, pressures are considered corporately. It should be noted, however, that there are no additional resources and therefore this results in an increase in the level of savings that are required to be found across all Council Services. The total expenditure level is compared to the available funding and, where this is insufficient to cover expenditure, the difference is the savings or income requirement to be met through transformational change and/or savings projects in order to achieve a set of balanced proposals.

2.3 The budget proposals being put forward include revised forecasts of the expected cost of inflation following a detailed review of inflation across all services at an individual budget line level. Inflation indices have been updated using the latest available forecasts and applied to the appropriate budget lines. Inflation can be broadly split into pay, which accounts for inflationary costs applied to employee salary budgets, and non-pay, which covers a range of budgets, such as energy, waste, etc. as well as a standard level of inflation based on government Consumer Price Index (CPI) forecasts. All inflationary uplifts require robust justification and as such general inflation is assumed to be 0%. Key inflation indices applied to budgets are outlined in the following table:

Inflation Range	2020-21	2021-22	2022-23	2023-24	2024-25
Non-pay inflation (average of multiple rates) where applicable	3.6%	2.7%	2.8%	2.7%	2.7%
Pay (admin band)	2%	2%	1%	1%	1%
Pay (management band)	2%	2%	1%	1%	1%

2.4 Forecast inflation, based on the above indices, is as follows:

Service Block	2020-21	2021-22	2022-23	2023-24	2024-25
People and Communities (P&C)	5,665	5,748	4,475	4,171	4,251
Place and Economy (P&E)	1,961	2,053	2,222	2,259	2,361
Commercial and Investments (C&I)	238	147	138	141	143
Public Health	51	51	24	24	24
Corporate and Managed Services	-275*	174	103	104	104
LGSS Operational	277	277	139	139	139
Total	**7,917**	**8,450**	**7,101**	**6,838**	**7,022**

*Includes reduction of additional pension contribution in relation to vacancies to be apportioned between Service Blocks

2.5 A review of demand pressures facing the Council has been undertaken. The term demand is used to describe all anticipated demand changes arising from increased numbers (e.g. as a result of an ageing population, or due to increased road kilometres) and increased complexity (e.g. more intensive packages of care as clients age). The demand pressures calculated are:

Service Block	2020-21 £'000	2021-22 £'000	2022-23 £'000	2023-24 £'000	2024-25 £'000
People and Communities (P&C)	10,771	11,252	12,811	13,295	13,008
Place & Economy (P&E)	199	225	179	192	202
Total	**10,970**	**11,477**	**12,990**	**13,487**	**13,210**

2.6 The Council is facing some cost pressures that cannot be absorbed within the base funding of services. Some of the pressures relate to costs that are

associated with the introduction of new legislation and others as a direct result of contractual commitments. These costs are included within the revenue tables considered by service committees alongside other savings proposals and priorities:

Service Block / Description	2020-21 £'000	2021-22 £'000	2022-23 £'000	2023-24 £'000	2024-25 £'000
New Pressures Arising in 20-21					
P&C: Increase in Older People's placement costs	4,458				
P&C: Home to School Transport - Special	800				
P&C: SEND Specialist Services – loss of grant	300				
P&C: SEND Specialist Service – underlying pressures	201				
C&I: East Barnwell Community Centre		100			
Existing Pressures Brought Forward					
P&C: Impact of National Living Wage on Contracts	3,367	3,091	3,015	3,015	3,015
P&C: Potential Impact of Changing Schools Funding Formula	1,579	1,500			
P&C: Libraries to serve new developments		49			
P&C: Supervised contact (numbers of children)	-35				
P&C: Independent reviewing officers (numbers of children)		-85			
P&E: Minerals and Waste Local Plan	-54	-54			
P&E: Guided Busway Defects	-1,300				
C&I: Renewable energy – Soham	4	5	40		
C&I: LGSS Law dividend expectation		-96			
Impact of Local Government Pay offer on CCC Employee Costs (combined)	174	174			
Total	**9,494**	**4,684**	**3,055**	**3,015**	**3,015**

3. SUMMARY OF THE DRAFT REVENUE BUDGET

3.1 In order to balance the budget in light of the cost increases set out in the previous section and reduced Government funding, savings or additional income of £24.6m are required for 2020-21, and a total of £74m across the full five years of the Business Plan. The following table shows the total level of savings necessary for each of the next five years, the amount of savings attributed from identified savings and the residual gap for which saving or income has still to be found:

Service Block	2020-21 £'000	2021-22 £'000	2022-23 £'000	2023-24 £'000	2024-25 £'000
Total Saving Requirement	24,561	14,916	12,280	12,697	9,050
Identified Savings	-10,711	-2,256	920	206	558
Identified additional Income Generation	-1,285	-2,225	-3,542	-365	133
Residual Savings to be identified	**12,565**	**10,435**	**9,658**	**12,538**	**9,741**

3.2 As the table above shows, there is still a significant level of savings or income to be found in order to produce a balanced budget for 2020-21. While actions are being taken to close the funding gap, as detailed below, it must be acknowledged that the proposals already identified are those with the lower risk and impact profiles and the further options being considered are those considered less certain, or with greater impact.

3.3 The actions currently being undertaken to close the gap are:

- Reviewing all the existing proposals to identify any which could be pushed further – in particular where additional investment could unlock additional savings
- Identifying whether any longer-term savings can be brought forward
- Reviewing the full list of in-year and 2020-21 pressures – developing mitigation plans wherever possible to reduce the impact of pressures on the savings requirement
- Bringing more ideas into the Transformation Pipeline – this work will continue to be led across service areas with support from the Transformation team – recognising that it is the responsibility of all areas of the Council to keep generating new proposals which help meet this challenge.

3.4 There are also a number of additional risks and assumptions with potential impacts on the numbers above and accompanying tables. These will be monitored closely and updated as the Business Plan is developed to ensure that any financial impacts are accurately reflected in Council budgets:

- The Business Plan includes a 2% inflationary uplift for administrative and management band staff pay. The National Joint Council pay scales have not been confirmed for 2020-21 onwards and it is possible than an uplift of greater than 2% will be agreed. A number of other groups of public sector workers including teachers, armed forces and police officers are expected to receive pay increases in excess of 2% in 2020-21.

- The result of schools funding reforms, in particular the control of the Dedicated Schools Grant shifting further toward individual schools, potential additional funding to be announced by government, and the local situation with a deficit held within the high needs block is still under discussion and the significant current pressure will be updated as the outcome of this discussion becomes clear.

- Movement in current year pressures – Work is ongoing to manage our in-year pressures downwards however any change to the out-turn position of the Council will impact the savings requirement in 2020-21. This is particularly relevant to demand led budgets such as children in care or adult social care provision.

- The inflationary cost increases set out in section 2.4 assume that inflation on the cost of bed-based care within Adults & Older People's Services will continue to be higher than general inflation in 2020-21. Additionally, the pressures within Older People's services included in section 2.6 assume that the local NHS continues to contribute funding to joint health and social care initiatives at current levels in 2020-21.

- The Government has confirmed that the introduction of 75% business rates retention and the review of relative needs and resources (fair funding review) will be delayed until 2021 to coincide with the next multi-year spending review. There is therefore a significant level of uncertainty around the accuracy of our funding assumptions from 2021/22 onwards.

- The Council has worked closely with local MPs in campaigning for a fairer funding deal for Cambridgeshire. The Chancellor announced the Government's spending plans for 2020-21 on 4th September, which included an additional £1bn of grant funding for social care. The financial implications for the Council are still as yet unclear as individual local authority allocations are yet to be announced. Notwithstanding any additional funding the Council may receive, it is expected that significant savings are required to balance the budget for 2020-21 and services continue to develop plans at pace.

- The Government has confirmed that The Winter Pressures and Social Care Support Grants, announced for the first time in 2019-20, will continue in 2020-21. These grants now support £4.4m of permanent spending across Adults and Children's Services as well as contributing £1.9m to the 2020-21 budget gap. We have assumed, in line with other Shire Counties, that these grants continue at their current levels throughout the period of the current Medium Term Financial Strategy (2020-21 – 2024-25). However, the Council will continue to develop options for further savings which will allow the authority to operate on a sustainable basis should this funding not be forthcoming in future years.

3.5 In some cases, services have planned to increase income to prevent a reduction in service delivery. For the purpose of balancing the budget these two approaches have the same effect and are treated in the same way.

3.6 This report forms part of the process set out in the Medium Term Financial Strategy whereby the Council updates, alters and refines its revenue and capital proposals in line with new savings targets. New proposals are

developed across Council to meet any additional savings requirement and all existing schemes are reviewed and updated before being presented to service committees for further review during December.

3.7 The level of savings required is based on a 2% increase in the Adults Social Care precept and a 0% increase in Council tax. The Government has confirmed that Local Authorities will be granted the continued flexibility to levy the ASC precept in 2020-21, however the Government has not yet announced the Council tax referendum limit for 2020-21. Local Authorities were permitted to increase general Council tax by a maximum of 2.99% in 2018-19 and 2019-20 without the requirement for approval from residents through a positive vote in a local referendum. It is likely, although not confirmed, that the Council will be presented with the option to increase Council tax by up to a further 2.99% in 2020-21. It is estimated that the cost of holding a referendum for increases deemed to be excessive would be around £100k, rising to as much as £500k should the public reject the proposed tax increase (as new bills would need to be issued).

3.9 Following October and December service committees, GPC will review the overall programme in December, before recommending the programme in January as part of the overarching Business Plan for Full Council to consider in February.

4.0 BUSINESS PLANNING CONTEXT FOR HEALTH COMMITTEE

4.1 The majority of public health grant funding (over 90%) is spent on external contracts, with organisations which provide services at individual client level, such as health visiting, school nursing, contraception and sexual health, drug and alcohol treatment, smoking cessation and weight management.

4.2 The transformation programme for Public Health Services focuses on the following key themes:

- Improving engagement with communities as part of the corporate 'Think Communities' approach, to promote behaviour changes which will improve health in both the short and long term.
- Influencing the social and environmental factors which are often the root causes of health and wellbeing, through working with wider Council services – a 'Health in All Policies' approach.
- Increasing our public health system leadership role and strategic impact on health outcomes across the local health and care system by working with system leaders through the Health and Wellbeing Board, Sustainable Transformation Partnership (STP) Board, and other key Boards and organisations.
- Further developing jointly commissioned and integrated services - both internally across Council directorates and with external organisations such as Peterborough City Council and NHS commissioners - where this can improve outcomes for residents and/or deliver savings for the Council.

4.3 Public Health services are funded by a ring-fenced grant from the Department of Health which currently totals approximately £25.6m. Following a period where the level of public health grant was increased in 2013/14 and 2014/15,

Central government made the decision to reduce the public health grant over a five year period from 2016/17. In 2016/17 the grant to CCC was reduced by £2.3m and from 2017/18 to 2019/20 the grant reduced by approximately £0.7m per year (a further £2.1m). These reductions have been addressed through savings programmes. The current assumption in the business plan is that the level of grant in 2020/21 will remain the same as 2019/20 at approximately £25.6m. There has been a recent announcement that there will be a real terms increase in the public health grant in 2020/21, and we are waiting to see the detail of this.

4.4 It is important to note that public health 'inflation' appears very low. The reason for this is that public health contracts with external providers have been agreed with no inbuilt year on year uplifts for inflation or demography - therefore providers are expected to absorb wage inflation and other inflationary or demographic pressures through their own cost improvement programmes, and there is no direct inflationary pressure on the Council's commissioning budgets.

4.5 As noted above, taking an integrated approach to commissioning across Council directorates and external organisations, which will improve outcomes and create savings for the health and care system, has been the main focus in developing new savings proposals for 2020/21. The table below outlines the cash savings which have been achieved since 2015 through public health efficiencies and transformation. These are in addition to absorbing demographic growth and inflation without additional cost, and forming a joint public health team across Cambridgeshire County Council and Peterborough City Council. The scope for further internal efficiencies is now very limited, and innovative joint approaches are required.

Service Category	Original Funding April 2015	Saving 2016/17	Saving 2017/18	Saving 2018/19	Saving 2019/20	% cash saving since 2015
Drug and alcohol services	£6269k	£289k	£100k	£154k	£162k	11.2%
Sexual Health & Contraception	£5692k	£280k	£100k	£140k	£60k	10.2%
Smoking Cessation & Tobacco Control	£1253k	£220k	£110k	£112k	-	35.3%
General Prevention: Obesity, Health Checks, Falls Prevention	£2465k	£125k	£101k	-	£91k	12.9%
Public Mental Health	£224k	£60k	£60k reinvested	£7k	-	3.1%
Children's 0-19 Public Health Services	£9527k (indicative)	£190k	£188k	£238k	£196k	8.5%
Public Health Directorate staffing & Income generation	£2567k	£524k	£75k	£49k	£80k	28.4%

4.6 Through its scrutiny role, the Health Committee has identified the recruitment and retention of the health and care workforce as a key risk issue for local services. This also applies to our commissioned public health services, so valuing and retaining front line staff is a key consideration when developing savings proposals.

5. OVERVIEW OF HEALTH COMMITTEE'S DRAFT REVENUE PROGRAMME

5.1 The list below provides the draft 2020/21 business planning proposals within the remit of the Health Committee. In each case the reference to the business planning table is included along with the anticipated level of financial saving or additional income. It is important for the Committee to note that the proposals and figures are draft at this stage and that work on the business cases is ongoing. Updated proposals will be presented to Committee again in December at which point business cases and the associated impact assessments will be final for the Committee to endorse. The savings proposals outlined below are in addition to 2020/21 savings proposals already agreed last year of £127k against the drug and alcohol contract (built into the contract trajectory) and £15k against the re-procurement of integrated sexual health services.

5.2 Additional resource is required to deliver transformation at this scale and some of the programme of savings described below may need to be supported by resource agreed through the Council's Transformation fund process. A report will be prepared for General Purposes Committee detailing any additional resource requirements, the associated savings and therefore the return on investment.

5.3 **Summary of proposals:**

5.3.1 **E/R.6.042 Joint re-procurement of sexual health services with Peterborough City Council and local NHS commissioners including digital delivery (-£50k)**

Integrated sexual health and contraception services provide testing and treatment services for sexually transmitted infections as well as access to a range of contraception methods, including long acting reversible contraception.

At its meeting in May 2018, the Health Committee agreed to support Public Health commissioners working with colleagues from Peterborough, City Council (PCC), the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England (NHSE) to develop a more efficient and cost-effective system wide approach to the commissioning of sexual health and reproductive services. In February 2019 the Committee agreed to award an interim contract to Cambridgeshire Community Services NHS Trust for sexual health and contraception services until March 2020 to allow time for a joint procurement approach, and in May 2019 the Committee approved 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.

It is intended that the new contract will be implemented in April 2020. Efficiencies are anticipated from having a single contract. These are currently in

development but they are likely to reflect the merging of managerial and administrative functions. In addition the Service has developed an on-line testing service for asymptomatic patients that is still being developed. There is the potential to explore other digital options for managing demand.

The proposed £50k saving is in addition to a £15k saving against the joint procurement already factored into budgets for 2020/21 from last year's business plan. It also assumes that demand growth and inflation will be managed by the successful provider, within the cost of the contract.

5.3.2 **E/R.6.043 Joint re-procurement of integrated lifestyle services with Peterborough City Council (-£50k)**

At its meeting in May 2019, the Committee approved 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.

The Integrated Lifestyle Service provides a range of services that aim to improve lifestyles and avoid ill health. In particular those conditions that create ongoing demand for health and social care services. Supporting lifestyle change amongst the population reduces the risk of associated conditions such as diabetes, cardio-vascular disease, respiratory disease, mental health conditions and obesity. The service also undertakes the National Child Weight Measurement Programme which is a mandated function of the Local Authority.

In order to re-commission the Integrated Lifestyle Service as one service across Cambridgeshire and Peterborough, Peterborough City Council will delegate authority to Cambridgeshire County Council to commission, contract and performance manage the service on its behalf. The service will include a range of health trainer behaviour change services, weight management services, outreach NHS Health Checks and the National Child Weight Management Programme. Savings are anticipated from the merging of management and administrative functions and economies of scale. They include the expectation that the costs associated with demographic growth and inflation will be managed by the successful provider, within the cost of the contract.

5.4 **Proposals for integrated working and savings across directorates:**

5.4.1 **Working to reduce Adults Social Care costs through an enhanced falls prevention pilot**

In September 2019 a paper was approved by Health Committee proposing investment in a business case, funded from public health reserves, to deliver an enhanced falls prevention programme in targeted areas of Cambridgeshire. The programme includes extending the number of Multi-factorial falls assessments integrated with home hazard assessments and home adaptions/equipment; expanding the Falls prevention health trainer team; introducing the FaME (Falls Management Exercise) programme and commissioning community providers to deliver this; promoting physical activity opportunities for muscle strength, bone health and balance for people aged 50+ including communications campaigns; and commissioning a formal evaluation

of the programme. The overall additional running costs per annum from this enhanced programme are approximately £157k. The additional (conservative) estimate of savings from the programme to NHS and social care services is £298k per annum, of which £164k is a saving to adult social care.

This programme will be delivered in an integrated way as a work stream within the Adults Positive Challenge Programme and will contribute to the existing Adults Positive Challenge recurrent savings target of £3.8M in 2020/21.

5.4.2 In addition to the proposals outlined above, the Public Health Directorate will work with Children's Social Care to ensure that adult drug and alcohol treatment services are fully engaged with the new Family Safeguarding model, which is expected to deliver savings through maximising support for vulnerable children and families and reduced numbers of children entering the care system.

6 LONGER TERM TRANSFORMATION TO CREATE A SUSTAINABLE SERVICE MODEL

6.1 This programme of work includes innovative approaches that will improve outcomes whilst continuing to deliver a further level of efficiency and significant savings.

6.2 A Transformation resource was established in 2016 to enable investment in longer term initiatives, identifying opportunities where better outcomes can be delivered at reduced cost and demand for services can be reduced. To date, savings of £23.8m have been released as a result of services using this resource.

7. NEXT STEPS

7.1 The high level timeline for business planning is shown in the table below.

December	Updated business cases and any additional business cases to be considered by committee
January	General Purposes Committee will review the whole draft Business Plan for recommendation to Full Council
February	Full Council will consider the draft Business Plan

8. ALIGNMENT WITH CORPORATE PRIORITIES

8.1 **A good quality of life for everyone**
The impact of these proposals is summarised in the business cases and equality impact assessments for each proposal, attached as appendix 1.

8.2 **Thriving places for people to live**
The impact of these proposals is summarised in the community impact assessments, attached as an appendix 1.

8.3 **The best start for Cambridgeshire's children**
The impact of these proposals is summarised in the community impact assessments, attached as an appendix 1.

9. SIGNIFICANT IMPLICATIONS

9.1 **Resource Implications**
Resource implications are outlined in paras 5.1-5.3

9.2 **Procurement/Contractual/Council Contract Procedure Rules Implications**
Any procurement undertaken will be in compliance with the County Council's Contract Procedure Rules and the LGSS Procurement Best Practice guide.

9.3 **Statutory, Legal and Risk implications**
Details of the ring-fenced public health grant are given in para 4.3.

9.4 **Equality and Diversity Implications**
The Business Cases for each savings proposal (appendix 1) describe their equality impact including any disproportionate impact on specific population groups. This aspect may need further development in some of the business cases.

9.5 **Engagement and Consultation Implications**
Our Business Planning proposals are informed by the CCC public consultation on the Business Plan and will be discussed with a wide range of partners throughout the process (some of which has begun already). The feedback from consultation will continue to inform the refinement of proposals. Where this leads to significant amendments to the recommendations a report would be provided to the Health Committee.

The re-procurements for sexual health and contraception services and for integrated lifestyles services have both included stakeholder and service user consultation as part of the procurement process.

9.6 **Localism and Local Member Involvement**
The savings related to re-procurement are for county-wide public health programmes and services. Elements of the enhanced falls prevention pilot will be focussed in Cambridge City and Fenland districts, on the basis of needs assessment data.

9.7 **Public Health Implications**
The savings proposals aim to achieve best value through public health services while minimising the risk of impact on public health outcomes.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Stephen Howarth
Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	Yes Name of Officer: Gus De Silva
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes Monitoring Officer: Fiona McMillan, LGSS Law
Are there any Equality and Diversity implications?	Covered in business case impact assessments Julia Turner
Have any engagement and communication implications been cleared by Communications?	Yes Matthew Hall
Have any localism and Local Member involvement issues been cleared by your Service Contact?	Yes Julia Turner
Have any Public Health implications been cleared by Public Health	Yes Liz Robin

SOURCE DOCUMENTS GUIDANCE

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

Source Documents	Location
Strategic Framework	*https://ccc-live.storage.googleapis.com/upload/www.cambridgeshire.gov.uk/council/finance-and-budget/Section%201%20-%20Strategic%20Framework%20-%2019-20.pdf?inline=true*

APPENDIX 1: Draft Business Cases for business planning proposals within the remit of Public Health Committee

APPENDIX 2: Financial summary – table 3

Business Case

E/R.6.042 - Joint re-procurement of Sexual Health Services including digital delivery

Project Overview			
Project Title	E/R.6.042 - Joint pre-procurement of Sexual Health Services including digital delivery		
Project Code	TR001533	**Business Planning Reference**	E/R.6.042
Business Planning Brief Description	This business case is for the re-commissioning of Integrated Sexual and Reproductive Health Services (SRH) for one service across Cambridgeshire and Peterborough. Peterborough City Council will delegate authority to Cambridgeshire County Council to commission, contract and performance manage the successful bidder on its behalf. Service efficiencies and transformational changes will secure the planned savings.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

Cash reductions in the Public Health Grant and financial pressures upon the Local Authority require efficiencies and cost-effective innovative approaches to delivering commissioned services. The re-commissioning of this service across Cambridgeshire County Council and Peterborough City Council will bring efficiencies and there will be further development of the transformational service redesign and efficiencies that have been taking place during the past three years in both areas.
In addition, Cambridgeshire and Peterborough were selected as one of two sites in the country by Public Health England to pilot collaborative commissioning with other commissioners of Sexual and Reproductive Health (SRH) services in the NHS. This is providing the opportunity to improve pathways and the patient experience.

What would happen if we did not complete this project?

If these services were not provided there would be the following consequences

- The Sexual and Reproductive Health (SRH) current contract ends on the 31st March 2020. It has already been extended and any further extensions are not possible.
- People with Sexually Transmitted Infections (STIs) would not be treated if the current Service contract ends and there is a very high risk that this would lead to outbreaks of STIs in the population.

Approach

Aims / Objectives

The aim to is recommission Sexual and Reproductive Health (SRH) Services for Cambridgeshire and Peterborough
Specific objectives are:

- to provide access to all SRH services across the county providing easy and acceptable access to high risk population groups to avoid increases in sexually transmitted infections and unplanned pregnancies
- to ensure there are robust pathways to related services
- to introduce efficiencies and transformational changes in service delivery that provide cost efficiencies and savings

Project Overview - What are we doing

Background
Cambridgeshire County Council and Peterborough City Council commission Integrated Sexual Health and Reproductive Health Services from Cambridgeshire Community Services. The clinics offer testing, treatment and contact tracing for people at risk of sexually transmitted infections along with the full range of contraception services. Services are 'open access' – i.e. people can refer themselves and are entitled to be seen.

They are a mandated local authority public health service under the Health and Social Care Act (2013). The Integrated Service was commissioned in 2014 and it brought together sexual health and contraception into the integrated service. The Service is delivered through a Hub and Spoke model whereby there are three hubs that offer the full range of clinical services and are Consultant led (Wisbech, Cambridge City and Huntingdon). In addition there are nurse led spoke clinics that provide less complex sexual health and contraception services.

It was commissioned to integrate sexual health and contraception services so that patients are able to address all their sexual health and contraception needs in one service and location and address the health inequalities and inequities of service provision between the north and south of the county. A key theme was the requirement to modernise the service to ensure that it is efficient and cost effective.

Current position
Over the past three years the Cambridgeshire Service has introduced a number of innovative approaches which includes using new technologies. In addition it has made savings and has streamlined the service but this has always been undertaken in areas where demand for service is low. The re-commission will have one contract for both Cambridgeshire and Peterborough. It is intended that the new contract will be awarded for commencement in April 2020. Efficiencies are anticipated from having a single contract. These are currently in development but they are anticipated to reflect the merging of managerial and administrative functions. In addition, the Service has introduced an on-line service for asymptomatic patients that is still being developed. There is the potential to explore other digital options for managing demand.

Collaborative Commissioning
Cambridgeshire and Peterborough were selected as one of two sites in the country by Public Health England to pilot collaborative commissioning with other commissioners of Sexual and Reproductive Health (SRH) services in the NHS. This was in response to the identified fragmentation of the commissioning of connected SRH services since 2013.This is providing the opportunity to improve pathways and the patient experience. The re-commission will include cervical screening and HIV treatment services on behalf of NHS England. Under discussion is the inclusion of early termination of pregnancy and minor gynaecological services with the Clinical Commissioning Group.

What assumptions have you made?

Providing services across both Cambridgeshire and Peterborough requires efficient management and administrative systems to ensure patient safety. Any savings would not compromise these areas.

What constraints does the project face?

The procurement must be completed by March 31st 2020 when the current contract ends. These services are one of the local authority mandated services and there is statutory requirement to ensure that they are commissioned and provided in the area.

Delivery Options

Has an options and feasibility study been undertaken?

Procurement options

The options were discussed with procurement and because of its value the full competitive option was chosen in view of the legal and procurement regulations.

Delivery model and costing options

Combining delivery model and cost to realise the best value service offer for our citizens, options being considered are:

1. Developments in clinics. This takes two forms;
2.
    i. the greater integration, through collaborative commissioning, of services in the field of sexual & reproductive health and HIV where the commissioning responsibility sits with another healthcare authority such as NHS England and the local NHS CCG. Such an approach supports service users, who will experience a 'one-stop-shop' style clinic, but also our local service by offering an opportunity to gain additional income. Services being discussed include Cervical Screening; HPV Vaccination for MSM; HIV Care & Treatment and early medical abortion services.

    ii. improving sign-posting for service users and triage, to educate those needing our services of the optimal route to receive the care that they need. In reality this would see those who are without symptoms; are not vulnerable; nor within higher and highest risk groups; and are seeking a standard set of tests and/ or advice directed towards our online offer.

3. Expansion of an 'eService', to include a wider range of testing-kit models; the potential of postal treatment for non-complex Chlamydia; the ability for women to be counselled on their choice of contraception online (leading to fewer clinic attendances to gain their method of choice); development of partner notification; and support and management in cases of people presenting with a safeguarding issue.

4. Development of a sustainable costing/ pricing model that will see funds 'following the patient' whilst delivering a dependable savings plan for the taxpayer. In reality, this would allow funds to be drawn out of physical delivery; then utilised to provide (i) a material investment into the eService and (ii) a cash saving in support of local government commissioning.

Scope / Interdependencies

Scope

What is within scope?

Community sexual health and reproductive services that are one of the Local Authority's mandated responsibilities.

What is outside of scope?

Contraception services (Long Acting Reversible Contraception - LARC) commissioned by the Local Authorities from GP practices.

Project Dependencies

Title

Cost and Savings

See accompanying financial information in Table 3

Non Financial Benefits

Non Financial Benefits Summary

Community Integrated Sexual and Reproductive Health (iSRH) services provide easy access to contraception for high risk vulnerable groups who would not attend their GP practice for contraception. Young people who have unplanned pregnancies have a higher risk of complex health and social issues affecting the mother and child. Often they will require above average use of health and social care services. Teenage pregnancies are also associated with poorer longer term health, educational and employment outcomes with high risks of poverty.

SRH services based in the community provide easy access to treatment for Sexually Transmitted Infections (STIs) especially for vulnerable groups such as the homeless, drug and alcohol users and sex workers. That is groups who are associated with non-compliance of treatment and poorer outcomes without easy access to services. Non-treatment increases the Public Health risk of increased spread of STIs in the population.

Easy access to HIV treatment services supports people seeking diagnosis following possible exposure to HIV infection. This is an issue for both Cambridgeshire and Peterborough as statistics show that both local authorities have rates of late diagnosis that are significantly higher than the national average. Early diagnosis and treatment can mean a normal life expectancy and very few health and social care needs. Late diagnosis can lead to ongoing use of health and social care services with poorer health outcomes.

Title

Risks

Title

Re-commissioning Sexual and Reproductive Health Services

Project Impact

Equality Impact Assessment

Who will be affected by this proposal?

All residents of Cambridgeshire

What positive impacts are anticipated from this proposal?

The re-commission of the Sexual and Reproductive Health (SRH) services will bring the following positive impacts.

- The Service is a county wide and will provide clinics throughout the county ensuring that the more rural residents in the north of the county are able to access the services.
- It will make sure that high risk groups such as young people, homeless, sex workers, men who have sex with men, those misusing drugs and alcohol know of the services and are able to access them easily.
- There will be bespoke services for young people.

What negative impacts are anticipated from this proposal?

No negative impacts anticipated as the service will seek to ensure that all those with protected characteristics receive information about the service and that the service is accessible and sensitive

to any particular needs.

Are there other impacts which are more neutral?

None

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

- **Age:** Young people are at a higher risk of acquiring a sexually transmitted infection or an unwanted pregnancy. There will be bespoke clinics for young people.
- **Sexual orientation:** Rates of sexually transmitted infections are higher in men who have sex with men. The Service will be promoted with these groups to encourage and support them to seek testing and treatment if they are at risk of acquiring a sexually transmitted infection.
- **Pregnancy and maternities:** The easy access to contraception provided by the Service will be promoted especially in groups at risk of unplanned pregnancies.
- **Rurality:** Services will be provided in the more rural areas in the north of the county.
- **Deprivation:** Services will be provided in the deprived areas in the north of the county.

Any efficiencies in the new service will not compromise the targeting and access to services for these groups. In addition the Prevention of Sexual Ill Health Service, which is also being re-commissioned, will promote these services with relevant groups.

Business Case

E/R.6.043 - Joint re-procurement of Integrated Lifestyle Services

Project Overview			
Project Title	E/R.6.043 - Joint re-procurement of Integrated Lifestyle Services		
Project Code	TR001538	**Business Planning Reference**	
Business Planning Brief Description	Re-commissioning of the integrated lifestyle services as one service across Cambridgeshire and Peterborough. Peterborough City Council will delegate authority to Cambridgeshire County Council to commission, contract and performance manage the new provider. Savings will be sought through efficiencies and transformational changes.		
Senior Responsible Officer	Val Thomas		

Project Approach

Background

Why do we need to undertake this project?

Cost-effective, innovative approaches to delivering commissioned services is of fundamental importance in a context of increasing financial pressure on local government and cash reductions in the Public Health Grant.

The re-commissioning of this service across Cambridgeshire County Council and Peterborough City Council will bring efficiencies, and there will also be further development of the transformational service redesign and efficiencies that have been taking place during the past three years in both areas.

What would happen if we did not complete this project?

The Integrated Lifestyle Service provides a range of services that aim to improve lifestyles and avoid ill health. In particular those conditions that create ongoing demand for health and social care services. Supporting lifestyle change amongst the population reduces the risk of associated conditions such as diabetes, cardio-vascular disease, respiratory disease, mental health conditions and obesity. The service also undertakes the National Child Weight Measurement Programme which is a mandated function of the Local Authority.

The contracts in both Cambridgeshire County Council and Peterborough City Council expire in March 2020 and cannot be further extended; if a new service is not commissioned these vital prevention services will not be provided.

Approach

Aims / Objectives

The overall aim of the procurement is to secure a lifestyle service that will provide residents with information, support and interventions that will enable them to make lifestyle choices that reduce the risk of and prevent ill prevent ill health and foster wellbeing.

Specific objectives for the new service are:

- Provide a health trainer service that supports behaviour change at population and targeted level. This will include Fall Prevention, Mental Health, Alcohol misuse and other areas to be defined following completion of the evidence review

- Provide weight management services for adults and children
- Undertake the annual National Child Weight Management Programme
- Provide outreach NHS Health Checks

Procurement Objectives

- Completion of the Procurement in line with the schedule
- Successful implementation of the service
- Value for money service commissioned that provides cost efficiencies and delivers the identified savings.

Project Overview - What are we doing

Re-commissioning the Integrated Lifestyle Service as one service across Cambridgeshire and Peterborough. Peterborough City Council will delegate authority to Cambridgeshire County Council to commission, contract and performance manage the service on its behalf. The service will include a range of health trainer behaviour change services, weight management services, outreach NHS Health Checks and the National Child Weight Management Programme.

What assumptions have you made?

That there is robust market for a competitive tender for the delivery of lifestyle services with bidders who want to make innovative changes to the Service.

What constraints does the project face?

Transformational changes are necessary but there is a limited evidence base for some of the proposed areas for development.

Delivery Options

Has an options and feasibility study been undertaken?

The options appraisal is in progress, however as there are no further contract extensions available beyond the contract expiration date of May 2020, some form of procurement is necessary; due to the contract value the likely option will be competitive procurement.

Scope / Interdependencies

Scope

What is within scope?

To re-commission the Integrated Lifestyle Services which includes the following:

- Health Trainer Behaviour Change Service that includes health trainers that work with targeted groups
- Adult and Child weight management
- Outreach NHS health Checks
- National Child Weight Management Programme

What is outside of scope?

The re-commissioning of any other Public Health Services.

Project Dependencies

Title

Cost and Savings

See accompanying financial information in Table 3

Non Financial Benefits

Non Financial Benefits Summary

Title

Lifestyle Services Specialist Carers Health Trainer

Risks

Title

Project Impact

Equality Impact Assessment

Who will be affected by this proposal?

All Cambridgeshire residents.

What positive impacts are anticipated from this proposal?

The aim of the Lifestyle Service is to identify and make behavioural change intervention with members of the population at risk of lifestyle associated ill health. The Service also promotes healthy lifestyle messages with the whole population though different media.

There are areas and certain populations groups that have poorer health outcomes. These are targeted by the service to ensure that they have increased access and appropriate services to meet their health improvement needs. These include those experiencing the following:

- deprivation
- rurality
- older people at risk of falling
- people with long term conditions such as diabetes and mental ill health
- carers
- people who misuse alcohol

What negative impacts are anticipated from this proposal?

There are no negative impacts anticipated as a result of this proposal. The service focuses upon supporting individuals and communities to make lifestyle changes. It includes supporting the development of community assets, leaders and volunteers who will develop and support lifestyle change in their communities.

Are there other impacts which are more neutral?

Supporting the Think Community initiative and community cohesion is central to how the Lifestyle service is delivered. The service focuses upon supporting individuals and communities to make lifestyle changes. It includes supporting the development of community assets, leaders and volunteers who will develop and support lifestyle change in their communities.

Disproportionate impacts on specific groups with protected characteristics

Details of Disproportionate Impacts on protected characteristics and how these will be addressed

Age: Certain age groups experience poorer health outcomes that are related to their health behaviours. These groups are targeted with specific programmes that focus on helping them address factors that are affecting their health.

- older people - falls prevention
- older people living with long term conditions e.g. diabetes
- young children - obesity

Disability: People living with disabilities have a higher risk of poorer outcomes. The new service will develop a behaviour change package specifically for people with a disability that will help them adopt healthier lifestyle that is suitable for them.

Pregnancy and maternity: Pregnant women will be supported to effectively manage their weight during their pregnancies through realistic lifestyle behaviours. Excessive weight gain during pregnancy is high risk for poorer outcomes for the mother and child.

Rural isolation: People living in rural isolation are often more deprived and have less access to opportunities that support a healthy lifestyle. The lifestyle services will be accessible in all the more rural areas of the county and shaped to suit the local needs of communities, for example locations and venues for activities.

Deprivation: People and communities that are more deprived experience poorer health outcomes. Lifestyle services will be weighted in these areas to target deprived individuals and communities at a scale, within resources, for meeting their higher level of need and behavioural change support requirements.

Community cohesion: Central to the lifestyle service will be to support individuals and communities to work together to develop their assets, leaders and volunteers to develop programmes in their own communities.

Section 3 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2020-21 to 2024-25

		Detailed Plans	Outline Plans					
Ref	**Title**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**2023-24 £000**	**2024-25 £000**	**Description**	**Committee**
1	**OPENING GROSS EXPENDITURE**	**25,492**	**25,354**	**25,344**	**25,370**	**25,396**		
E/R.1.001	Base Adjustments	51	-	-	-	-	Adjustment for permanent changes to base budget from decisions made in 2019-20.	**Health**
1.999	**REVISED OPENING GROSS EXPENDITURE**	**25,543**	**25,354**	**25,344**	**25,370**	**25,396**		
2	**INFLATION**							
E/R.2.001	Inflation	53	53	26	26	26	Forecast pressure from inflation in the Public Health Directorate, excluding inflation on any costs linked to the standard rate of inflation where the inflation rate is assumed to be 0%. Inflation appears low due to the majority of public health spend being committed to external contracts. Providers are expected to meet inflationary and demographic pressures within the agreed contract envelope.	**Health**
2.999	**Subtotal Inflation**	**53**	**53**	**26**	**26**	**26**		
3	**DEMOGRAPHY AND DEMAND**							
3.999	**Subtotal Demography and Demand**	**-**	**-**	**-**	**-**	**-**		
4	**PRESSURES**							
4.999	**Subtotal Pressures**	**-**	**-**	**-**	**-**	**-**		
5	**INVESTMENTS**							
5.999	**Subtotal Investments**	**-**	**-**	**-**	**-**	**-**		
6	**SAVINGS**							
	Health							
E/R.6.033	Drug & Alcohol service - funding reduction built in to new service contract	-127	-63	-	-	-	This saving has been built into the contract for Adult Drug and Alcohol Treatment Services which was awarded to Change Grow Live (CGL) and implemented in October 2018. The savings are being achieved through a new service model with strengthened recovery services using cost effective peer support models to avoid readmission, different staffing models, and a mobile outreach service.	**Health**
E/R.6.034	Recommissioning of the Integrated Contraception and Sexual Health (iCASH) Service contract	-15	-	-	-	-	This saving has been deferred from 2019/20 into 2020/21 and refers to the recommissioning of integrated sexual and reproductive health services described under saving E/R.6.042	**Health**
E/R.6.042	Joint re-procurement of Sexual Health Services	-50	-	-	-	-	The re-commissioning of Integrated Sexual and Reproductive Health Services (SRH) for one service across Cambridgeshire and Peterborough. Peterborough City Council will delegate authority to Cambridgeshire County Council to commission, contract and performance manage the successful bidder on its behalf. Service efficiencies and transformational changes will secure the planned savings.	**Health**

Section 3 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2020-21 to 2024-25

		Detailed Plans	Outline Plans					
Ref	**Title**	**2020-21 £000**	**2021-22 £000**	**2022-23 £000**	**2023-24 £000**	**2024-25 £000**	**Description**	**Committee**
E/R.6.043	Joint re-procurement of Integrated Lifestyle Services	-50	-	-	-	-	Re-commissioning of the integrated lifestyle services as one service across Cambridgeshire and Peterborough. Peterborough City Council will delegate authority to Cambridgeshire County Council to commission, contract and performance manage the new provider.	Health
6.999	**Subtotal Savings**	**-242**	**-63**	**-**	**-**	**-**		
	TOTAL GROSS EXPENDITURE	**25,354**	**25,344**	**25,370**	**25,396**	**25,422**		
7	**FEES, CHARGES & RING-FENCED GRANTS**							
E/R.7.001	Previous year's fees, charges & ring-fenced grants	-25,102	-25,155	-431	-433	-435	Fees and charges expected to be received for services provided and Public Health ring-fenced grant from Government.	Health
E/R.7.002	Changes to 2019-20 Fees and Charges	-51	-	-	-	-	Changes to fees and charges as a result of decisions in 2019-20.	Health
E/R.7.003	Fess and Charges Inflation	-2	-2	-2	-2	-2	Inflation on external income.	Health
	Changes to fees & charges							
E/R.7.201	Change in Public Health Grant	-	24,726	-	-	-	Grant reductions announced in the comprehensive spending review, and removal of the ring-fence in 2021-22.	Health
7.999	**Subtotal Fees, Charges & Ring-fenced Grants**	**-25,155**	**-431**	**-433**	**-435**	**-437**		
	TOTAL NET EXPENDITURE	**199**	**24,913**	**24,937**	**24,961**	**24,985**		

FUNDING SOURCES								
8	**FUNDING OF GROSS EXPENDITURE**							
E/R.8.001	Budget Allocation	-199	-24,913	-24,937	-24,961	-24,985	Net spend funded from general grants, business rates and Council Tax.	Health
E/R.8.101	Public Health Grant	-24,726	-	-	-	-	Direct expenditure funded from Public Health grant.	Health
E/R.8.102	Fees & Charges	-429	-431	-433	-435	-437	Income generation (various sources).	Health
8.999	**TOTAL FUNDING OF GROSS EXPENDITURE**	**-25,354**	**-25,344**	**-25,370**	**-25,396**	**-25,422**		

Agenda Item No: 7

FINANCE MONITORING REPORT – AUGUST 2019

To:	**Health Committee**
Meeting Date:	**17 October 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 August 2019 Finance Monitoring Report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial position as at the end of August 2019.**
Recommendation:	**The Committee is asked to review and comment on the report.**

	Officer contact:
Name:	Stephen Howarth
Post:	Strategic Finance Manager
Email:	stephen.howarth@cambridgeshire.gov.uk
Tel:	01223 714770

1.0 BACKGROUND

1.1 The revised Finance Monitoring Report will be at all scheduled substantive Committee meetings (but not reserve dates) to provide the Committee with the opportunity to comment on the financial position of the Public Health directorate.

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

2.0 MAIN ISSUES IN THE AUGUST 2019 FINANCE MONITORING REPORT

2.1 The August 2019 Finance Monitoring Report is attached at Appendix A.

2.2 A balanced budget was set for the Public Health Directorate for 2019/20, incorporating savings as a result of the reduction in Public Health grant.

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

2.4 The August 2019 FMR shows the forecast outturn for the Public Health Directorate as a £-86k underspend, as a result of a number of small variances being reported within Sexual Health & Contraception and Behaviour Change / Preventing Long-Term Conditions. Work is ongoing to identify any other areas that may underspend to add to this, or to mitigate any pressures that may appear.

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
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 FMR 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: Stephen Howarth
Date: 12/09/2019

Public Health Directorate

Finance Monitoring Report – August 2019

1 SUMMARY

1.1 Finance

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

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Outturn Variance (July) £000	Service	Budget for 2019/20 £000	Actual to end of August 19 £000	Forecast Outturn Variance £000	Forecast Outturn Variance %
0	Children Health	8,799	2,119	0	0.0%
0	Drugs & Alcohol	5,463	15	0	0.0%
0	Sexual Health & Contraception	5,097	990	-66	-1.3%
0	Behaviour Change / Preventing Long Term Conditions	3,720	883	-20	-0.5%
0	Falls Prevention	80	3	0	0.0%
0	General Prevention Activities	13	-2	0	0.0%
0	Adult Mental Health & Community Safety	256	50	0	0.0%
0	Public Health Directorate	1,926	948	0	0.0%
0	**Total Expenditure**	**25,355**	**5,005**	**-86**	**-0.3%**
0	Public Health Grant	-24,726	-12,780	0	0%
0	s75 Agreement NHSE-HIV	-144	0	0	0%
0	Other Income	-38	-10	0	0%
0	Drawdown From Reserves	-57	0	0	0%
0	**Total Income**	**-24,965**	**-12,790**	**0**	**0%**
0	**Net Total**	**390**	**-7,785**	**-86**	

The service level budgetary control report for 2019/20 can be found in appendix 1. Further analysis of any significant variances can be found in appendix 2.

2.2 Significant Issues

A balanced budget has been set for the financial year 2019/20. Savings totalling £949k have been budgeted for and the achievement of savings is monitored through the savings tracker process, with exceptions being reported to Heath Committee and any resulting overspends reported through this monthly Finance Monitoring Report.

A number of small expected underspends have been identified in August totalling £86k (0.3%) following a review of activity in the first part of the year.

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

The total Public Health ring-fenced grant allocation for 2019/20 is £25.560m, of which £24.726m 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. MEMORANDUM OF UNDERSTANDING (MOU)

On a regular basis, information will be reported on spend outside of the Public Health Directorate under MOUs.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Outturn Variance (July) £000's	Service	Budget 2019/20 £000's	Actual August 2019 £000's	Forecast Outturn Variance £000's	%
	Children Health				
0	Children 0-5 PH Programme	6,907	2,132	0	0%
0	Children 5-19 PH Programme - Non Prescribed	1,622	-14	0	0%
0	Children Mental Health	271	0	0	0%
0	**Children Health Total**	**8,799**	**2,119**	**0**	**0%**
	Drugs & Alcohol				
0	Drug & Alcohol Misuse	5,463	15	0	0%
0	**Drugs & Alcohol Total**	**5,463**	**15**	**0**	**0%**
	Sexual Health & Contraception				
0	SH STI testing & treatment - Prescribed	3,829	961	-40	-1%
0	SH Contraception - Prescribed	1,116	-37	-20	-2%
0	SH Services Advice Prevention/Promotion - Non-Prescribed	152	66	-6	-4%
0	**Sexual Health & Contraception Total**	**5,097**	**990**	**-66**	**-1%**
	Behaviour Change / Preventing Long Term Conditions				
0	Integrated Lifestyle Services	1,984	719	-5	0%
0	Other Health Improvement	408	156	5	1%
0	Smoking Cessation GP & Pharmacy	703	-153	-20	-3%
0	NHS Health Checks Programme - Prescribed	625	162	0	0%
0	**Behaviour Change / Preventing Long Term Conditions Total**	**3,720**	**883**	**-20**	**-1%**
	Falls Prevention				
0	Falls Prevention	80	3	0	0%
0	**Falls Prevention Total**	**80**	**3**	**0**	**0%**
	General Prevention Activities				
0	General Prevention, Traveller Health	13	-2	0	0%
0	**General Prevention Activities Total**	**13**	**-2**	**0**	**0%**
	Adult Mental Health & Community Safety				
0	Adult Mental Health & Community Safety	256	50	0	0%
0	**Adult Mental Health & Community Safety Total**	**256**	**50**	**0**	**0%**
	Public Health Directorate				
0	Children's Health	290	151	0	0%
0	Drugs & Alcohol	220	131	0	0%
0	Sexual Health & Contraception	158	50	0	0%
0	Prevention Long Term Conditions (Behaviour Change)	568	251	0	0%
0	General Prevention (Travellers)	209	125	0	0%
0	Adult Mental Health	22	14	0	0%
0	Health Protection	136	83	0	0%
0	Analysts	323	143	0	0%
0	**Public Health Directorate Total**	**1,926**	**948**	**0**	**0%**
0	**Total Expenditure before Carry-forward**	**25,355**	**5,005**	**-86**	**0%**
0	**Anticipated Carry-forward of Public Health Grant**	**0**	**0**	**0**	**0%**

Forecast Outturn Variance (July)	Service	Budget 2019/20	Actual August 2019	Forecast Outturn Variance	
£000's		£000's	£000's	£000's	%
	Funded By				
0	Public Health Grant	-24,726	-12,780		0%
0	s75 Agreement NHSE-HIV	-144	0		0%
0	Other Income	-38	-10		0%
0	Drawdown From Reserves	-57	0		0%
0	**Grant Funding Total**	**-24,965**	**-12,790**	**0**	**0%**
0	**Overall Total**	**390**	**-7,785**	**-86**	

APPENDIX 2 – Commentary on Expenditure Position

No budgets measured at service level require additional commentary – this happens when budget areas have a variance greater than 2% of annual budget or £100,000, whichever is greater.

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

Awarding Body: Department of Health

Grant	Business Plan £000	Adjusted Amount £000	Notes
Public Health Grant as per Business Plan	**25,560**	**25,560**	Ring-fenced grant
Grant allocated as follows:			
Public Health Directorate	24,726	24,726	
P&C Directorate	293	283	
P&E Directorate	120	130	
CS&T Directorate	201	201	
LGSS Cambridge Office	220	220	
Total	**25,560**	**25,560**	

APPENDIX 4 – Virements and Budget Reconciliation

No budget virements have been performed in year.

APPENDIX 5 – Reserve Schedule

Fund Description	Balance at 31 March 2019	2018/19		Forecast Closing Balance	Notes
		Movements in 2019/10	Balance at end August 2019		
	£'000	£'000	£'000	£'000	
General Reserve					
Public Health carry-forward	**1,683**	**0**	**1,683**	**1,683**	Usage of un-earmarked reserve to be considered by Member working group
subtotal	**1,683**	**0**	**1,683**	**1,683**	
Other Earmarked Funds					
Healthy Fenland Fund	199	0	199	99	Anticipated spend £100k per year over 5 years.
Falls Prevention Fund	271	0	271	171	Joint project with the NHS
NHS Healthchecks programme	270	0	270	270	Usage to be considered by Member working group
Implementation of Cambridgeshire Public Health Integration Strategy	463	0	463	363	'Let's Get Moving' physical activity programme has been extended.
subtotal	**1,203**	**0**	**1,203**	**903**	
TOTAL	**2,886**	**0**	**2,886**	**2,586**	

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

Fund Description	Balance at 31 March 2019	2018/19		Forecast Closing Balance	Notes
		Movements in 2019/20	Balance at end August 2019		
	£'000	£'000	£'000	£'000	
General Reserve					
Joint Improvement Programme (JIP)	128	0	128	128	
Improving Screening & Immunisation uptake	9	0	9	9	£9k from NHS ~England for expenditure in Cambridgeshire and Peterborough
TOTAL	**137**		**137**	**137**	

Agenda Item No: 8

CAMBRIDGE UNIVERSITY SCIENCE AND POLICY EXCHANGE (CUSPE) HEALTHY FENLAND EVALUATION

To: **Health Committee**

Meeting Date: **October 17 2019**

From: **Director of Public Health**

Electoral division(s): **Fenland**

Forward Plan ref: **N/A** *Key decision:* **No**

Purpose: **What is the Committee being asked to consider?**

Recommendation: **What is the Committee being asked to agree?**

a) **The Committee is asked to note and discuss the Healthy Fenland Fund (HFF) Evaluation Report findings.**

b) **To consider allocating funding to commission an external evaluation based on the findings of the evaluation report.**

c) **Consider the implications for the evaluation of public health and other Local Authority programmes**

	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 The Health Committee has previously received reports on the progress of the Healthy Fenland Fund (HFF). This initiative is funded from Public Health reserves and reflects the Health Committee's commitment to improving health outcomes and inequalities in Fenland. The aim of the Programme is to contribute to improvements in the health and wellbeing of communities in Fenland through supporting the development of strong and resilient communities that are fully engaged in identifying and addressing their needs.

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

1.3 A comprehensive report on the progress of the HFF was presented to the Health Committee in January clearly identified the impact that it is having on communities in Fenland. For example 74% of HFF groups have gone on to be self-sustaining, after receiving development and funding support from the community development team.

1.4 HFF is based on an Asset Based Community Development (ABCD) model. There is a body of academic work which has been undertaken to develop evaluation tools for capturing impact and outcomes but there are different approaches and issues such as fully capturing impacts and outcomes. Although evaluation information has been collected, a need to produce a more formal framework was identified if the full impact and range of outcomes of HFF are to be robustly demonstrated. Some progress had been made in capturing HFF's impact upon engagement and strengthening of community assets. However capturing impacts upon health outcomes has been difficult.

1.5 Public Health was invited to bid for support from the Cambridge University Science and Policy Exchange (CUSPE). This is a policy research programme which brings together researchers in Cambridge, Cambridgeshire County Council and elected councillors. The bid was successful and two researchers were assigned to develop an evaluation framework tool for the HFF. This would aim to meet the ideal evaluation benchmark of being reproducible, unbiased and comprehensive.

2. MAIN ISSUES

2.1 The Evaluation Report includes the following.

- A literature review.
- Information secured from similar programmes.

- Piloting some evaluation techniques identified through the literature review and from other similar projects through the use of questionnaires and focus groups with individuals involved in HFF activities.

2.2 The study identified the following key questions that any evaluation framework would need to address

1) Is the HFF working as expected e.g. the grant application process?
2) Is the HFF reaching the target population?
3) Is the HFF achieving the desired outcomes?

2.3 The Report recommends a number of elements for inclusion in any future evaluation framework.

- **Questionnaires:** containing open questions tailored to the type of activity being assessed, with separate questionnaires for group leaders and participants. People from the area, but not involved in HFF-supported activities should be considered. Questionnaires should be translated into other languages when required.
- **Focus groups and interviews:** should be conducted with group leaders and participants involved in HFF-supported activities and also with the administration team behind the HFF.
- **Case studies:** of individuals and of HFF-supported groups as a whole.
- **Indicative economic value analyses:** with a focus on social value, value of volunteering and, if possible, cost savings made by other service providers.

2.4 The Report also provides some detailed recommendations relating to the design and implementation of the evaluation

Set reasonable outcomes for the area of the initiative.

The study identified the main aspects to take into account from evaluations of similar initiatives as being:

- rural projects can rarely achieve the number of beneficiaries or cost effectiveness that similar projects in urban areas can, and
- the time needed for these initiatives to show results in terms of changes to service use is greater in rural areas.

These could influence the number of people expected to take part in HFF-supported initiatives or the savings expected by other service providers, such as GP surgeries. This should be considered when starting the evaluation through the setting of reasonable

expected outcomes from the outset, such as the number of individuals reached, health improvements to individuals and identification of community assets.

Identify barriers to the initiative.

- There are major barriers affecting the ability of individuals to participate in activities supported by the HFF still. Those identified through discussions in the focus groups and with individuals working in Fenland include both physical aspects (i.e., transportation) and attitude aspects (i.e., reluctance to enter in a group where they do not know anyone). The Report recognises it is a challenge to address all of these barriers, as they are influenced by a wide range of policies and organisations.

- Some communities within Fenland remain 'difficult to reach' such as the migrant communities and transient population. It is recommended that a section on the ability for the HFF to engage with these populations at present and in the future is included in any evaluation.

Changes to the distribution and content of the questionnaire.

- It is recommended that the questionnaire is distributed to all participants to ensure the highest number of respondents possible as it is likely that only a small proportion of people will actually complete them.

- The focus group information should be used to develop the questionnaire to ensure improved information is secured. For example to encourage people to think more about their health a question stating 'What does healthy mean to you?' could be included.

- Also recommended is a more thorough monitoring of the newly supported groups, with a questionnaire distributed at the beginning, middle and end of the activity to track the progress in health and wellbeing of the participants. It may also be beneficial to distribute a questionnaire 6 months after the end of the funding period to assess the sustainability of the projects.

- Language barriers for migrant communities may be overcome through the use of translated questionnaires or the presence of translators.

Consider all the different stakeholders.

- Based on other studies the importance of capturing a wide range of different viewpoints is seen as important. Time constraints meant it was not possible to conduct questionnaires, interviews or focus groups with the administration team or stakeholders involved in the HFF. This would enable perspectives on the administration processes of the HFF and strategic value to other organisations to be evaluated.

- It is also recommended that emphasis should be put on focus groups conducted in different areas of Fenland and with more groups to ensure the richness and diversity of groups supported by the HFF is highlighted as much as possible.

- Also recommended are questionnaires, focus groups and/or one-to-one interviews with people in Fenland not involved in the HFF or taking part in supported activities, to assess any differences in terms of health and wellbeing. Also, it would be beneficial to understand if other people are aware of the HFF, the groups or activities supported and to find out what, if anything, is preventing them from taking part.

Conduct one-to-one interviews with participants and group leaders.

- One to one interviews with participants and group leaders could be conducted to follow up on specific points emerging from the focus groups, such as the health benefits. One important point which emerged from the pilot study is that the health benefits associated with the activities are not always realised when completing a questionnaire, but the awareness of health benefits emerges more clearly during a conversion.

Consider the possibility of including an economic evaluation.

- A pilot economic value analysis was beyond the remit of this Report but it recommends that a comprehensive evaluation could include an assessment of the social value gained by the actions of the HFF. A guide to Social Return on Investment, published by the Cabinet Office is considered to be a good basis for an assessment of social value[1].

- Also recommended is an investigation into local service use, for example changes to the number of GP visits by individuals and the community as a whole. It is acknowledged that it may be difficult to link any observed changes directly to the HFF but it could give an indication of the health status of the whole population in a particular region, which would be valuable to an evaluation of health and wellbeing initiatives.

2.5 The Report notes that its preliminary data does suggest that the desired outcomes of the HFF are being realised. The most notable HFF impacts were a stronger sense of community and an apparent improvement in physical and mental health. However, it advises there are many further aspects of the HFF that need to be measured, such as changes to local service use, for a comprehensive evaluation to be achieved.

2.6 This evaluation clearly identifies some of the challenges that evaluation of ABCD and similar programmes present. It articulates clearly the need for an evaluation framework to be in place before any programme commences and provides some guidance on the tools that could be used to undertake any evaluation of these community based interventions.

[1] Nicholls, J. *et al.* 2012. A guide to Social Return on Investment.

2.6 However the Report states that due to the small and limited resources of the HFF administration team it is unlikely that there would be sufficient resources 'in-house' to complete a thorough evaluation of the HFF.

It observes that to obtain the best and most objective results, it is good practice to have a separate team performing the evaluation to the team running the project. In addition to keeping the workload manageable for the personnel, this will avoid conflicts of interest between the administration team and the evaluation of the initiative.

Consequently it recommends that any evaluation is outsourced to an external organisation to ensure a comprehensive and unbiased evaluation. Based on the feedback obtained from the questionnaire and focus groups, a company which focuses on case studies and alternative evaluation methods may be the best approach for the HFF evaluation.

2.7 The Report's findings indicate when and how any evaluation could be undertaken and the associated resource implications for public health and other Local Authority programmes. These factors need to be considered to ensure that interventions reflect and contribute to the evidence base along with securing the best value from the available resources.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 A good quality of life for everyone

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

Improving the health and wellbeing outcomes of the residents of Fenland is central to the Healthy Fenland Fund

3.2 Thriving places for people to live

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

The Healthy Fenland Fund focuses on developing community assets and strengthening communities to ensure that the opportunities for them to grow and flourish are maximised.

3.3 The best start for Cambridgeshire's children

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

Developing and strengthening community assets will support families and carers to ensure their children have the opportunities to develop and achieve.

4. SIGNIFICANT IMPLICATIONS

Report authors should evaluate any further significant implications using the seven sub-headings below. These significant implications should also be evaluated using the

questions detailed in the table below. Each specific implication must be signed off by the relevant Team within the Council before the report is submitted to Democratic Services.

Further guidance and a checklist containing prompt questions are included at Appendix 2.

4.1 Resource Implications

The report above sets out details of significant implications in ***2.3***

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 point set out details of significant implications identified by officers:

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

4.5 Engagement and Communications Implications

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

- HFF secure regular feedback from individuals and communities involved.

4.6 Localism and Local Member Involvement

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

- HFF reflects the differing needs found in Fenland and is tailored to address these through consultation with residents, stakeholders and partner organisations.

4.7 Public Health Implications

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

- The HFF evaluation presents growing evidence of its impact upon the health and wellbeing of the population
- The Programme also targets those most vulnerable and in need to address inequalities and improve the outcomes for these population groups.

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

Source Documents	Location
The Marmot Review: Fair Society: Healthy Lives 2010: Cabinet Office	http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

The Department of Work and Pensions: Wellbeing and civil society 2013	https://www.gov.uk/government/publications/wellbeing-and-civil-society
Public Health England: A guide to community-centred approaches for health and wellbeing 2015:	https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches
Public Health England: Health Matters – community approaches to health 2015 & 2018	https://publichealthmatters.blog.gov.uk/2018/02/28/health-matters-community-centred-approaches-for-health-and-wellbeing/
NICE Guideline 44 Community engagement: improving health and wellbeing and reducing health inequalities 2016	https://www.nice.org.uk/guidance/ng44

WHAT IS THE MOST APPROPRIATE EVALUATION METHOD FOR THE HEALTHY FENLAND FUND?

Cambridgeshire Policy Challenges 2019

Cecilia Castro and Orla Woodward

Cambridge University Science and Policy Exchange (CUSPE) in collaboration with Cambridgeshire County Council

October 2019

Contents

Abbreviations

ABCD – Asset-Based Community Development

CCC – Cambridgeshire County Council

CCF – Cambridge Community Foundation

CCVS – Cambridge Council for Voluntary Service

CNC – Care Network Cambridgeshire

CPSL – Cambridgeshire, Peterborough and South Lincolnshire

HFF – Healthy Fenland Fund

IMD – Index of Multiple Deprivation

LSOA – Lower Super Output Area

ONS – Office for National Statistics

RT – Resilient Together

WEMWS – Warwick Edinburgh Mental Wellbeing Scale

1. Introduction

1.1. Project Brief

In March 2019, the third annual Policy Challenges collaboration between Cambridgeshire County Council (CCC) and the University of Cambridge was initiated to enable academic researchers from the university to work with the council to address policy issues using an evidence-based approach. Our team was set up to address the question:

What is the most appropriate evaluation method for the Healthy Fenland Fund?

The council has previously attempted to evaluate the Healthy Fenland Fund (HFF) but, as yet, have not been able to define the exact data, and thus process, required to evaluate the HFF effectively. Over a six-month period we therefore aimed to:

1) Understand the background to the HFF
2) Understand the challenges associated with evaluating similar programmes
3) Explore previous evaluations of similar programmes
4) Develop a framework that can be used to evaluate the HFF

1.2. Project Approach

A number of approaches were used to address our proposed question. We started with a **literature review** of documents relating to health in Fenland, for example the CCC Joint Strategic Needs Assessment Report 2017 and information on Cambridgeshire Insight, and the background to the HFF (section 2). We also reviewed documents relating to the rationale for evaluating both a project in general and an asset-based community development (ABCD) initiative (section 3). We then looked at evaluation reports for initiatives similar to the HFF coordinated by charities and other councils (section 4).

Based on contacts found during literature reviews and online searches, we contacted individuals who had previously been involved in the evaluation of programmes like the HFF to develop an understanding of the approach used by different organisations, and the factors that need to be considered when developing an evaluation framework for a health-focussed ABCD programme. We were therefore able to develop and examine **case studies** of related projects (section 4).

Another approach used during this research project was to pilot some of the **evaluation techniques** we had identified during our literature searches and discussions with those involved in similar projects. We therefore developed a **questionnaire** based on those used in similar evaluations and ran **focus groups** with individuals participating in HFF-supported groups/activities to determine whether these would be appropriate methods of evaluation in this case (section 5).

2. The Healthy Fenland Fund

- Fenland is the most deprived district in Cambridgeshire and is statistically similar to, or worse, than the national average for many health indicators.
- HFF is delivered by Care Network Cambridgeshire (CNC) and Cambridge Community Foundation (CCF) with the aim of building strong and resilient communities and improving health in Fenland.

2.1. Background

Fenland is the northernmost district of Cambridgeshire. In 2018 the reported population was approximately 101,500 individuals. 22.7% of the Fenland population is over 65, with this proportion of the population predicted to increase to over 30% in the next 20 years[1]. Levels of socio-economic deprivation are high in Fenland with 72% of the Lower Super Output Areas (LSOAs) receiving an Index of Multiple Deprivation (IMD) score in Deciles 1-5, representing the most deprived LSOAs in England[2]. Fenland has a higher children's deprivation score than both Cambridgeshire and the national average with 18% of children living in low-income families. Education is also a concern in this area where school readiness and GCSE attainment are lower than average. Only 50% of pupils achieve at least 5A*-C grades and 31% of working age people have no qualifications at all[3].

Deprivation and education are inextricably linked with health outcomes. Fenland is statistically similar to, or worse than, the national average for many key indicators of health. Life expectancy at birth, one of the strongest indicators of health, is significantly worse than average[4]. There is high mortality from preventable causes with 130 avoidable deaths per 100,000 people each year, compared to 20 in Cambridge City. A high proportion of the population describe themselves as having bad health and report long term activity-limiting disabilities or illness[5]. The prevalence of many chronic diseases including asthma, chronic obstructive pulmonary disease, coronary heart disease, diabetes and cancer is significantly higher in Fenland than national averages. Mental health and wellbeing are a particular concern, especially in children and young people, with high rates of depression recorded. Specific lifestyle behaviours reflect a general poor awareness of health. The average portion of fruit and vegetables consumed daily as well as rates of physical activity are significantly worse in Fenland than the national average. In accordance with this, the proportion of overweight and obese adults is high with

[1] Cambridgeshire Insight (2019). Population Reports: Fenland.

[2] Cambridgeshire Insight (2019). Deprivation – Interactive Reports: Fenland.

[3] Cambridgeshire Insight (2019). Child, Young People and Education – Interactive Reports: Fenland.

[4] Cambridgeshire Insight (2019). May19 PHOF Summary Cambridgeshire.

[5] Cambridgeshire County Council (2019). Joint Strategic Needs Assessment Summary Report.

70% of adults carrying excess weight. Smoking and alcohol misuse are also high in Fenland, with a significantly high rate of alcohol-related hospital admissions[6].

There are particular challenges when working with populations in Fenland. Fenland is a rural area. It is well recognised that rurality can affect the health of individuals and presents unique challenges to healthcare providers[7]. The major challenges to health in rural areas include poor public transport links, making it difficult for individuals to access healthcare services which may be a great distance from the home. A trend towards an older population, as young people leave in search of better career prospects, is also a challenge as older people tend to be in worse health and have greater need for health and care services. In addition, the difficulty in attracting and retaining healthcare staff is a growing concern. Finally, the lack of community support and increasing isolation felt by many in rural areas can also negatively impact health, particularly mental and emotional wellbeing. These challenges can all be observed in Fenland. Another unique challenge in Fenland is the growing migrant population and large transient population who can struggle to engage with the local community. The migrant population come from all over the world and from different socioeconomic backgrounds resulting in discrete migrant communities within the wider community. However, the largest migrant populations in Fenland are from the A8 countries, the eight poorer countries who joined the EU in 2004, including Poland and Lithuania. Migrant communities present additional healthcare challenges with higher rates of smoking and alcohol consumption. Poor dental care and sexual health have also been identified as areas of concern[8].

2.2. Programme structure

The HFF reflects an asset-based community development (ABCD) model. In ABCD initiatives, communities drive development themselves through identifying and mobilising existing assets, skills and knowledge of local residents and organisations. Communities are regarded as the primary building blocks for change which builds confidence as they are able to engage with decisions about their health in a self-directed and sustainable way[9,10].

The HFF consists of a grant fund of £75,000 annually for five years, administered by Cambridgeshire Community Foundation (CCF), and funded community development team provided by Care Network Cambridgeshire (CNC). These mutually dependent elements support the initiation or development of small groups or activities aiming to use community assets to improve health, wellbeing and community involvement in Fenland. Those accessing support may be

[6] Cambridgeshire Insight (2019). May19 PHOF Summary Cambridgeshire.

[7] Local Government Association (2017). Health and Wellbeing in Rural Areas.

[8] Cambridgeshire County Council (2019). Joint Strategic Needs Assessment Summary Report.

[9] Public Health England (2015). A guide to community-centred approaches for health and wellbeing.

[10] Improvement and Development Agency (2010). A glass half-full: how an asset approach can improve community health and wellbeing.

an existing group aiming to expand or a member of the public aiming to start a new group. While this programme aims to target all residents in Fenland, there is a focus on those most in need, for example migrant communities and those vulnerable to social isolation or mental health concerns.

Different procedures are used to award the grants, according to their value. CCF is responsible for providing grants of between £1500 and £5000 with applications reviewed quarterly. Grants of below £1500 are delivered directly by CNC and the Healthy Fenland administration team. Applying groups or activities must aim to address mental, physical or emotional health or increase involvement in the community and must demonstrate future sustainability to enable the groups to become self-supporting once the grant period has finished.

The community development team works to support local community groups or individuals to identify their needs and develop new ideas to address these needs. The team support the initiation and running of the group through providing training and assistance on budgeting, marketing/publicity, constitutional policies and signposting other individuals, groups or organisations who may be able to develop the ideas further. A key role of the team is to assist with funding applications. The team also identify community connectors, i.e. individuals and organisations with extensive local knowledge and connections, and community enablers, i.e. individuals who are able to identify and use community physical and social assets. Together, these individuals strengthen trust in the HFF team and resilience in the communities.

2.3. Desired outcomes

The main goals of the HFF are:

1) To build strong and resilient communities in Fenland who are able to identify their own needs and make decisions to address those needs.
2) To improve physical, mental and emotional health and wellbeing of communities in Fenland.

2.4. Why is an evaluation framework needed?

An evaluation framework for the HFF must be developed to assess whether the desired outcomes of the programme are being met and thus whether support for the HFF should be continued. There are specific challenges associated both with the evaluation of ABCD programmes and with the population targeted by the HFF. Furthermore, it would be beneficial to have a framework on which other programmes of a similar nature and in a similar area could base their evaluation or refer to for guidance.

3. Methods of evaluation

3.1. Project evaluation – the basics

- Evaluation procedures should be carefully planned at the onset.
- Three main aspects that need to be considered are implementation, mechanism of impact and context.

An essential part of implementing a programme is its evaluation. An evaluation is needed to: understand if the expected outcomes were met, assess which aspects were effective and which less so, establish the impact on the target population, and learn lessons for future interventions in related areas. When we set to establish an evaluation framework for the HFF, our first task was to perform a literature review to understand the basics of how projects are evaluated. It is important to note while assessing the strategy, that the evaluation should be proportionate to the programme. This means that the time and resources allocated to the evaluation should be on the same scale as the initiative.

Generally speaking, there are three types of evaluation: process, impact and economic. Process evaluation is focussed on how the programme was run, to understand what worked well and what worked less well; impact evaluation is focussed on changes the programme generated in the area it was implemented; economic evaluation is focussed on the costs/benefits of the project[11].

A progressive scale for evaluation has been proposed. The three types of evaluation above aim to increase knowledge of an initiative from different perspectives, and could be merged into a unified model[12]. Such a model contains five levels:

1) the intervention and its rationale are described in a logical and convincing way;
2) data collected demonstrates whether the desired outcomes were met in the target area;
3) data collected demonstrates that the measured improvement is definitely related to the specific initiative;
4) data collected shows the initiative strategy worked in at least two independent cases;
5) finally, there is a procedure in place to ensure continued positive results from further implementation of similar initiatives.

[11] The Magenta Book. Guidance for evaluation. HM Treasury. April 2011

[12] Puttick, P. and Ludlow, J. (2012) 'Standards of evidence for impact investing'. Nesta

A process evaluation fulfils the requirements of level one, an impact evaluation progresses through levels two and three, while an economic evaluation reaches level four. The progression from one level to the next increases the evidence collected and confidence in the final outcome. Considering the resources, nature and number of people involved in the HFF, we recommend the evaluation to be a mixture of process and impact, in particular complying with levels one, two and three of the proposed ladder.

The structure of the evaluation should be planned at the onset. To obtain an evaluation that is effective in explaining the results obtained from the implementation of a programme, it is crucial to establish the evaluation structure early on in the process. A number of aspects should be considered and they include:

- establishing the users of the evaluation itself and how the results will be disseminated;
- building a logic model of the intervention;
- asking specific questions, keeping the focus on three or four key aspects;
- identifying a suitable counterfactual population, to try to tease out the real effect of the programme from other factors occurring at the same time;
- recognizing enablers and barriers in a clear and formal way;
- deciding what type of data is more appropriate to judge the intervention and how to capture it;
- assessing the available information and decide what new data need to be collected.

Care should be taken to include within the evaluation the wider effects and unintended consequences of the project. It is important to make space for an estimation of additional positive or negative consequences, beyond the desired outcomes, that may result from an initiative. These consequences may be directly relevant to the people involved in the programme, but may also be experienced by other people living in the same or neighbouring areas. Examples of these include: displacement, substitution, leakage and deadweight. Displacement refers to the possibility that positive outcomes generated by the project are offset by negative outcomes, generated by the same project, elsewhere. Substitution refers to the possibility that the effects of the initiative on a particular group only occur at the expense of other groups. Leakage indicates whether the initiative benefited others outside of the target group. Finally, deadweight measures how much of the initiative outcomes would have occurred anyway, without the support of the project. We recommend that the deadweight, and possibly leakage, associated with the Healthy Fenland Fund are estimated during the evaluation.

Different frameworks can be used according to the interests of the evaluators. One of the first steps when planning an evaluation is to build a logic model; however, this can vary according to the aspects of the project considered most important. Some common frameworks that can be used include: theory-based evaluation, theory of change evaluation and realistic evaluation. Theory-based evaluation is

focussed on why and under what condition a specific change was observed. In this case, starting with the rationale of the intervention then observing the final outcomes, the evaluators challenge each assumption to see if it matched the observed outcomes. A theory of change evaluation is focussed on the links between the different parts of the programme. Here, the evaluators explore the combination of factors that created the observed outcomes, to enable a map to be drawn to demonstrate which factors at which level combined to produce the final outcome. Finally, a realistic evaluation is focussed on capturing the triggers the programme pulled to change certain behaviours, paying particular attention to the context within which the intervention occurred. Here, the evaluators want to understand the parts of the programme that worked best.

A number of methods to evaluate projects have been developed, each identifying important aspects to consider. In each case, the actual number of variables captured differs, but many, including the quantity and quality of the interventions, are common to most. For example, Steckler and Linnan (2002)[13] identified six priority areas:

- the context, i.e., local factors that influence implementation;
- the fidelity, i.e., the extent to which the intervention is delivered as conceived;
- the dose delivered, i.e., the level of intervention offered to participants;
- the dose received, i.e., the extent of participants' engagement in the intervention;
- reach and recruitment.

A second example is the Oxford Implementation Index[14] that is focused on four domains:

- the intervention design, i.e., whether core components are clearly specified;
- the delivery by practitioners, i.e., staff qualifications, the quality and use of materials, dosage administered;
- the uptake by participants;
- contextual factors.

A simpler approach, focussed on implementation, mechanism of impact and context, has recently been proposed. The MRC aimed to establish clear guidelines on how to evaluate complex interventions and published their conclusions in 2018[15]. In this approach, heavily based on a realistic evaluation, the first domain

[13] Steckler, A. and Linnan, L. (2002) Process evaluation for public health interventions and research, Jossey-Bass.

[14] Montgomery, P., Underhill, K., Gardner, F., Operario, D. and Mayo-Wilson, E. (2013b) The Oxford Implementation Index: a new tool for incorporating implementation data into systematic reviews and meta-analyses, *Journal of Clinical Epidemiology*, 66, 8, 874-882.

[15] Moore, G., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., Wight, D., Baird, J. 2018. Process evaluation of complex interventions. UK Medical Research Council (MRC) guidance.

(implementation) aims to understand what is delivered and how; the second (mechanism of impact) aims to understand how participants responded to the intervention, testing mediators and identifying unintended consequences; finally, the third domain (context) aims to understand how the obtained outcome was related to the context in which the intervention occurred, to predict whether the same results can be obtained in a different context. We recommend following this last approach, as it seems most flexible, while also able to capture sufficient information. Moreover, aspects such as fidelity and dose delivered appear constant during the HFF grant period, and the programme appears to be on target concerning the people reached.

3.2. Evaluating asset-based community development (ABCD) projects

- The HFF, as an ABCD initiative, is challenging to evaluate, due to its dual nature: community and health.
- A mix of qualitative (such as case studies and focus groups) and quantitative (such as surveys and statistical analysis) methods are recommended for this type of projects.

When deciding what type of strategy to use, the nature of the programme must be considered. As described in section 2.2., the HFF is an ABCD programme in which the community recognises its own needs in terms of health and wellbeing, and develops solutions with the support of local government. As an ABCD initiative, the HFF aims to prevent rather than resolve issues and considers what is already present and working in a community, rather than what is missing. Through mobilisation and participation, people take control and manage their own activities, experiencing positive health and social outcomes as a result. As such, for this type of project three interrelated factors should be considered equally: health (physical and mental) of the individual; community wellbeing, including physical, social and economic environments; and community strength, including leadership, skills, civic participation, community representation.

This multifaceted nature of the HFF makes it difficult to focus the attention of the evaluation. Demonstrating both changes in health outcomes and increased resilience and strength in the community will require multiple levels of evaluation.

Building the logic model is the first step in the evaluation process. A specific model for ABCD initiatives has been developed by Rippon and Hopkins (2015)[16]. It is based on the theory of change framework and is divided into four stages:

[16] Hopkins, T., Rippon, S. 2015. Head, Hands and Heart: asset-based approaches in health care – A review of the conceptual evidence and case studies of asset-based approaches in health, care and wellbeing. The Health Foundation, London.

1. reframing towards assets;
2. recognising assets;
3. mobilising assets;
4. co-producing assets and outcomes.

The first stage takes into account the changes in organisational culture and in individual practice needed to shift towards asset-based approaches. The second stage includes a concerted effort in identifying the assets in the community and building relationships between local people, to create a shared vision for the future. The third stage involves utilising the recognised assets to work together for an agreed purpose. The last stage concerns a true partnership between communities and public services, as an effective strategy to improve health and wellbeing in individuals. Aspects of this model may be used to shape the evaluation for the HFF.

A framework for evaluating ABCD initiatives based on a realistic evaluation has been recently proposed. As previously mentioned, a promising framework to evaluate the HFF is the realistic evaluation approach, which tries to explain "what worked, for whom, in what context" focussing on three domains: context, mechanism and outcome. Translating this for ABCD programmes was not immediately obvious, but Blickem *et al.* (2018)[17] propose using assets as context, methodology as mechanism and then assessing outcome. The individual and collective assets present in a community represent the background against which the initiative occurs; the mechanism of the intervention is the method in which the assets are located and connected; the outcome is the nurturing of positive relationships and the improvement of social networks.

It is challenging to capture changes resulting from ABCD initiatives. Another aspect that has to be considered early when developing an evaluation of an ABCD initiative is that the mechanisms to "measure" its success may not be immediately obvious. An example of an objective measure could be the use of the four indexes, related to wellbeing, annually measured by the Office of National Statistics: life satisfaction; worthwhile (feeling that what one does in life is worthwhile); happiness and anxiety. However, the local nature of ABCD initiatives and/or the limited number of people involved, makes it difficult to relate specific initiatives to any change registered in wellbeing statistics. Furthermore, summarising information through numbers or statistics fails to capture the spirit of ABCD projects. In these initiatives, the focus is on the people and how they connect. The evaluation should, therefore, involve meeting participants in their own environments and hearing their stories and different points of view.

Many different informal and creative methods have been used in collecting data for the evaluation of ABCD initiatives. These include, but are not limited to:

[17] Blickem, C., Dawson, S., Kirk, S., Vassilev, I., Mathieson, A., Harrison, R., Bower, P., Lamb, J. 2018. What is Asset-Based Community Development and How Might It Improve the Health of People With Long-Term Conditions? A Realist Synthesis. SAGE Open, 8(3), 1-13.

interviews, case studies, questionnaires/surveys, focus groups, capturing casual moments, photographs, people mapping and service use mapping. The use of maps and how they change across time is particularly indicative for these initiatives, which aim to connect people in a community and build relationships with the available services.

Complementing stories with numbers and statistics enhances the evaluation of an initiative. Focussing attention solely on stories, however, may give an impression of outcomes that is too subjective. Time and resources available may not allow sufficient interviews to be conducted with people from the area not connected to the programme or with people from different areas with similar characteristics, creating a lack of a control group, detrimental to the validity of the evaluation. Moreover, the use of numbers and statistics may be crucial to give a representative view of the entire initiative.

The commonly used evaluation techniques for ABCD initiatives have been identified in a systematic review of the literature[18]. This review demonstrated that, in the majority of cases (ten out of sixteen), a mixture of qualitative and quantitative methods were applied, even if in two cases the quantitative information was minimal. In two cases, the evaluation included surveys to collect data on health behaviour or engagement pattern, while only one case had health statistics from census incorporated. As previously mentioned, the use of statistics from census in ABCD initiatives is not always straightforward, due to the number and groups of people involved. Surveys, interviews and questionnaires are often conducted to capture a more representative group of the target population.

Paramount importance must be given to the context in which the initiative occurs. The approach must be tailored to the needs and characteristics of the target area and the results must be put into context within that specific area. What works well in one area, may not necessarily work as well in another area, and this can be better understood by recognising the associated statistics for example population demographics, rurality and wealth. We recommend a mix of creative methods and statistics, suited to the Fenland population, to obtain a clear overview of the HFF in the evaluation.

A final element to consider when evaluating ABCD initiatives is that it takes time to see change. While some programmes can deliver visible changes in a short time frame, this is often not the case for ABCD initiatives. Due to their intrinsic nature, focussing on what already exists in a local area and building relationships between people and services, it could take years before tangible outcomes, particularly changes to local health statistics, can be measured. Therefore, when conducting an evaluation, care must be paid in setting reasonable questions and outcomes at the outset, to ensure the true achievements of the initiative can be highlighted.

[18] Cassetti, V., Powell, K., Barnes, A., Sanders, T. 2019. A systematic scoping review of asset-based approaches to promote health in communities: development of a framework. Global Health Promotion. In Press.

4. Case studies: evaluations of ABCD initiatives in South-East England

- A mixture of qualitative (interviews, case studies, reflective diaries and people mapping) and quantitative (surveys) methods were used to evaluate real-world ABCD initiatives.
- Evaluating individuals in the same region but distinct from those involved in the initiative is a valuable tool for measuring the impact of an initiative on the population reached.
- An economic analysis should focus on social value gained and cost savings made by other services.

We conducted a search for asset-based programmes to have first-hand examples of how they are evaluated. To complement the theoretical knowledge acquired from the literature review, we sought and identified several organisations/ charities running comparable initiatives. We contacted them to obtain two sets of information: the framework or model used during their evaluations, in particular for health-focused projects, and lessons learnt from conducting those evaluations.

As a result, we managed to obtain the final evaluations of two initiatives run in South-East England. "Resilient Together" and "Fit as a Fiddle" are two distinct initiatives sharing the same ABCD approach, therefore their evaluations were a rich source of information when exploring evaluation methods for the HFF.

4.1 Resilient Together (Mind)

The approach and target population make the "Resilient Together" (RT) initiative and its evaluation particularly relevant. RT was a three-year ABCD initiative, delivered by Cambridgeshire, Peterborough and South Lincolnshire (CPSL) Mind with funding from CCC, aimed at improving wellbeing and resilience in two specific areas of Cambridgeshire: Southern Fringe (Trumpington) of Cambridge and Wisbech in Fenland[19]. CPSL Mind worked with independent researchers from Associate Development Solutions Ltd to complete an evaluation report for RT.

During the evaluation, a range of methods, both qualitative and quantitative, were used to probe the outcomes of the initiative. These methods include: surveys, interviews, case studies, reflective diaries and people mapping. Residents in the different regions, both those taking part and those not involved in the project, RT staff and local professionals external to the RT team were all included to consider the different points of view.

[19] Key findings of the final evaluation of Resilient Together project- highlight report 2019

A "community wellbeing and resilience survey" was used in Year 1 and Year 3. Created at the beginning of the initiative to obtain information about the wellbeing of the respondents, it was administered to participants at different stages of the programme to evaluate changes across time. Responses to the same survey were also collected from residents in the area not taking part in RT to try to understand the actual impact of participation on individuals involved.

Twelve 30-60 minutes interviews were conducted with different stakeholders. Four community residents, four RT team members and four local professionals external to RT were asked about their experiences and opinions concerning the project, to consider all perspectives. The interviews were tailored to the different stakeholders and had a semi-structured nature, to balance the need for focusing the interest of the respondent while giving space for the person to express freely their point of view.

Case studies were collected across the years. Motivation, activities and results for individual residents and community groups were recorded to show the variety of interests supported by the project.

Reflective diaries, kept by RT team members, were included. The daily experiences recorded at Year 1 (n=2) and Year 3 (n=1) were sifted and considered to document progress, areas of success, barriers encountered and actions taken.

"People maps" were created by an illustrator. To portray the connections between people, a map for Trumpington and a map for Wisbech were drawn at the beginning of the initiative and reviewed at 6, 9 and 12 months, to show the progress made and include the new associations.

The key message from the evaluation is the positive effect of ABCD initiatives on mental health and resilience. Increasing meaningful social connections in the community boosts confidence allowing residents to identify and use their community assets. The involvement in the community and the reduction in isolation and loneliness improves mental health and wellbeing of participants, while also raising awareness of the problem.

4.2. Fit as a Fiddle (Age UK)

Although on a much bigger scale, the desired outcomes and ABCD approach of Fit as a Fiddle are comparable to the HFF. Fit as a Fiddle was a national programme run between 2007-2012 by Age UK with funding from the Big Lottery Fund. The programme was delivered across nine English regions with two national projects and 24 regional projects. The main aim of the programme was to improve healthy eating, levels of physical activity and mental wellbeing in people over 50 through locally led projects.

An evaluation report was prepared by a team based at Ecorys and the Centre for Social Gerontology, Keele University. Research was undertaken between October 2010 and August 2012 during the second half of the programme's funding period. A mixture of desk-based research and primary research methods were used

to provide quantitative and qualitative evidence to assess the impact of the programme and interventions at national and regional level. Each region was evaluated separately then combined to give an overall evaluation.

A paper-based survey was completed by participants at the beginning, end and three months after their involvement with the programme. Surveys were adapted from those used in wider wellbeing evaluations, such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWS), with additional questions about physical activity and healthy eating specific to Fit as a Fiddle's desired outcomes. A very small proportion of participants completed the surveys (881 out of approximately 375,000) and there was a marked decrease in the number of respondents for the three-month follow up survey. Statistical significance was calculated for responses and when all regions were considered together there were statistically significant increases in physical and mental health. Due to the relatively small number of responses it is difficult to determine whether this data effectively captures the experiences of participants as a whole.

A web- or paper-based survey was also completed by regional coordinators, project coordinators, volunteers and partner organisations. These surveys covered a range of themes including recruitment of participants, management of volunteers, volunteering activities conducted, e.g. mentoring, impact on volunteers and benefits to other organisations.

Case studies were used to add further detail to the quantitative data. One study from each of the 9 regions was completed and another 11 were selected to cover the variety of activities supported by the programme at a national level. The case studies enabled evaluators to hear stories from participants and project leaders about how projects had actually changed people's lives. While this qualitative evidence is essential to enable an understanding of the impact of the project on an individual level, this data is not statistically representative and the opinions of individuals may not reflect the views of the groups as a whole.

Interviews with both participants and stakeholders were conducted. 38 in-depth participant interviews were conducted by a team of specially trained community evaluators. Interviews were also conducted with key stakeholders including Age UK staff, volunteers, partner organisations, academic experts, funders and policy makers. These interviews were designed to assess the impact on each group involved in the Fit as a Fiddle programme and provide further detail on the administrative processes surrounding implementation of the programme.

Analysis of Age UK monitoring data enabled a full evaluation of the target population and characteristics of participants involved. Characteristics evaluated included age, gender, ethnic group and health status. A series of postcode maps showing beneficiary locations was also prepared.

Finally, an analysis of economic value was conducted. While a full cost benefit analysis was beyond the scope of the evaluation, evaluators followed HM Treasury guidelines when evaluating 'value for money' of the programme. Data collected during the projects enabled an exploration of the relationship between financial inputs and resulting outcomes. The cost per participant was calculated to assess the

efficiency of the programme. When considering the benefits of the programme, evaluators focussed on costs avoided as a result of the programme, for example cost savings made by other service providers due to reduced demand for services. Changes to the number of GP visits was investigated in one region. The social value of certain projects was assessed by ascribing financial values to social outcomes. The value from volunteering was explored through calculating the number of hours volunteers spent on projects and ascribing the financial value using an approach set out by Volunteering England[20]. An important point considered was whether the funded activities would have occurred without the support of Fit as a Fiddle, in line with point 3 on the progressive evaluation scale outlined in section 3.1.

There were some limitations to this evaluation. Data in this report was often gathered retrospectively and the counterfactual situation, what would have happened without the programme, has not been fully explored. A more comprehensive evaluation would also investigate changes within a population not involved in the programme as in the evaluation of RT (section 4.1). Email correspondence with the London Portfolio coordinator, Alice Westlake, provided insight into some of the challenges surrounding the evaluation of Fit as a Fiddle in London. The key issues raised were resistance from some participants to complete surveys, compounded by lack of time and resource on the part of local project officers. The fact that evaluators were removed from participants also meant it was difficult to ensure surveys were completed correctly. A high proportion of the groups were from disadvantaged backgrounds with many non-native English speakers making completion of surveys more of a challenge. Long term projects (>3 months) were also more difficult to assess using the surveys as projects had started before the evaluation began, meaning it was not possible to conduct a survey at the beginning of a project and assess improvements to health. It was suggested that, at least in London, face-to-face meetings between evaluators and project leaders/participants were a more effective way of collecting information than surveys.

4.3. Lessons learnt from case studies

The main lesson learnt from the evaluation of RT and Fit as a Fiddle is that a variety of methods are needed to capture data on a multifaceted ABCD programme. Quantitative surveys enable a relatively large amount of data to be gathered but do not capture individual experiences. Qualitative case studies and interviews provide a method for exploring individual outcomes in detail but may not reflect the wider views of other individuals involved. Incorporating both aspects into an evaluation framework is necessary to provide a full picture of the outcomes, significance and richness of an initiative.

Another lesson is the importance of including a comparable external population. Data about the general population in an area would help to extrapolate

[20] For an example see: https://www.volunteerscotland.net/media/254583/guidance_-_calculating_the_economic_value_of_your_volunteers.pdf

the real impact of an initiative on those participating. The evaluators of RT completed surveys with residents not taking part in RT but living in the same area enabling changes observed to be more readily linked to the intervention.

There were some key differences between the evaluations of RT and Fit as a Fiddle. Both projects outsourced the evaluation with slight differences in approach depending on the company chosen. The RT evaluation, by Associate Development Solutions ltd, focussed mainly on case studies and alternative methods of evaluation such as ‘people mapping’. There was a poor use of statistical analysis for some data and low ‘n’ numbers in some techniques, e.g. reflective diaries from only two individuals, leading to an overestimation of the success of the project. The Fit as a Fiddle evaluation, by Ecorys, focussed more heavily on numbers and statistics based on responses to surveys but the resistance to fill out surveys resulted in a relatively low number of responses.

5. Pilot evaluation of the HFF

Based on the information gathered through literature reviews and case studies, we wanted to pilot some of the evaluation techniques we had identified to see whether these would be effective methods to evaluate the HFF. We therefore developed a **questionnaire** and ran **focus groups** with individuals supported by the HFF to determine whether these would be appropriate methods of evaluation for these individuals.

5.1. Questionnaire

- Taking part in activities supported by the HFF increases the sense of belonging to the community and the ability to actively seek solutions to problems.
- Word of mouth, bring a buddy and advertisements in the local newspaper are the main ways participants learn about the existence of the groups and of the HFF.

We developed a questionnaire to assess the outcomes from the activities supported by the HFF. We wanted to collect feedback on the experiences of participants and group leaders involved in HFF-supported activities. We wanted to involve both participants and group leaders/committee members, to capture their different perspectives. We aimed to develop a comprehensive but short questionnaire to avoid discouraging people from filling it in due to its length. Here we discuss the development of the questionnaire and the preliminary data collected.

5.1.1. Development of the questionnaire

The questionnaire was broadly divided into four sections. Here we explain its rationale, Appendix 7.1 shows it in its entirety.

The first section consisted of general demographic questions. The demographic questions (including age group, gender and ethnicity) were mostly aimed at assessing the composition of the sample population. We also included questions about the role of the individual within the group and the duration of participation in the activity.

The second section aimed at evaluating the mental wellbeing of the respondents. As the questionnaire was not completed by participants before they were involved in HFF-supported activities we could not directly assess changes to mental wellbeing. However, we wanted to provide a snapshot of the current state of mental wellbeing of people participating in the activities and test whether this would be an effective measure in the future. During our research we found that most evaluations of mental wellbeing were based on a variation of the Warwick-Edinburgh

Mental Wellbeing Scale (WEMWS)[21]. As such, this section of our questionnaire follows the short WEMWS and consists of seven statements regarding positive thoughts and feelings. For each statement, five options are proposed to the respondents and a score is associated with each option: Strongly Agree=5; Agree=4; Neither Agree Nor Disagree=3; Disagree=2; Strongly Disagree=1. A sum of the scores from each statement gives an indication of the metal wellbeing of the respondent; this value can range between seven and thirty-five with high scores associated with good mental wellbeing. Scores can then be easily compared between individuals at different timepoints or between different groups of people, even those distinct from the current evaluation.

The third section probed deeper into the desired community and health outcomes of the HFF. The statements included in this section aimed to evaluate how the respondents perceived aspects of their health and social behaviour, after taking part in activities supported by the HFF. We followed-up some of the statements with open questions, to understand what they think they have gained from participation. To go deeper into the community aspect of the initiative and assess if better community connectedness is perceived, we included statements about self-confidence and actively seeking solutions to solve problems; while, to assess the health benefits, we included statements on aspects such as awareness of physical and mental needs, as well as changes to GP visits.

Finally, the fourth section consisted of three open questions about specific aspects of the HFF itself. Here, we were interested in understanding how the respondents learnt both about the group they were involved in and about the possibility of being supported by the HFF. We also wanted to understand how common it was for other family members to also participate in groups/activities supported by the HFF.

5.1.2. Results from the questionnaire

Twenty-eight questionnaires were completed and returned for consideration. These were completed by people participating in groups based in Wisbech (15 questionnaires) and in March (13 questionnaires) and included both group leaders/committee members and participants. Here, we present the most pertinent results from the analysis, further results are shown in Appendix 7.2.

Figure 1 summarises the general characteristics of the respondents. The number of group leaders to participants are well balanced, with 48% group leaders and 52% participants (Figure 1A). There was close to an even number of males (44%) and females (55%) (Figure 1B). Most respondents were older individuals, with only around 20% of respondents below 50 years (Figure 1C). With regards to this imbalance, it should be noted that these questionnaires were returned during focus groups run during the day, which may not have been convenient for working people

[21] Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Parkinson, J., Secker, J., Stewart-Brown, S. 2007. The Warwick-Edinburgh Mental Wellbeing Scale (WEMWS): development and UK validation. Health and Quality of Life. 5, 63

or those with families. The final pie chart (Figure 1D) shows the length of participation in HFF-supported activities. Both short- and long-term memberships of groups are represented in the responses.

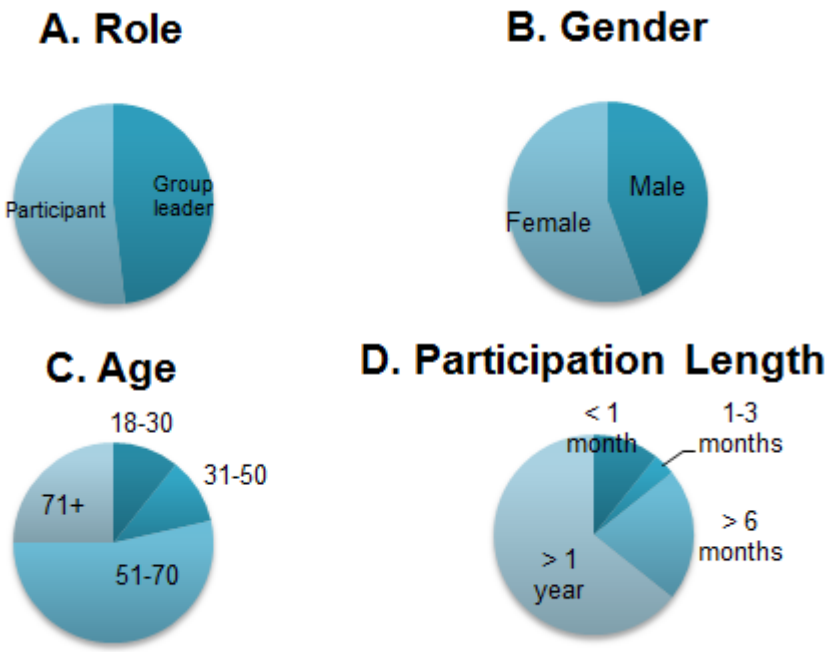


Figure 1. General characteristics of the respondents to the HFF questionnaire.

Results from the WEMWS illustrate good mental health on average for the respondents (Figure 2A). No significant difference is observed between Wisbech and March. No firm conclusions can be drawn on changes to mental wellbeing from prior to being involved in HFF-supported activities as we do not have that data. However, we made use of statistics collected by the Office for National Statistics (ONS) to gauge an idea about the wellbeing of Fenland residents in general. In fact, the ONS annually collects information about life satisfaction, worthiness, happiness and anxiety of populations in the UK. The question asked, in each case, is “On a scale from 1 to 10 how satisfied/worthy/happy/anxious were you yesterday?”, where high marks indicate high levels of satisfaction, worthiness, happiness and anxiety. Figure 2B depicts the results obtained for the Fenland district in the last 8 years. It is worth noting that these results show a picture similar to the one obtained from our questionnaire, suggesting that our sample population is a good representation of the Fenland as a whole. In fact, mapping our results on a scale from 1 to 10 gives an average value of 7.8 for the district. Moreover, the data obtained from these responses can be used as a baseline for comparison with follow-up questionnaires.

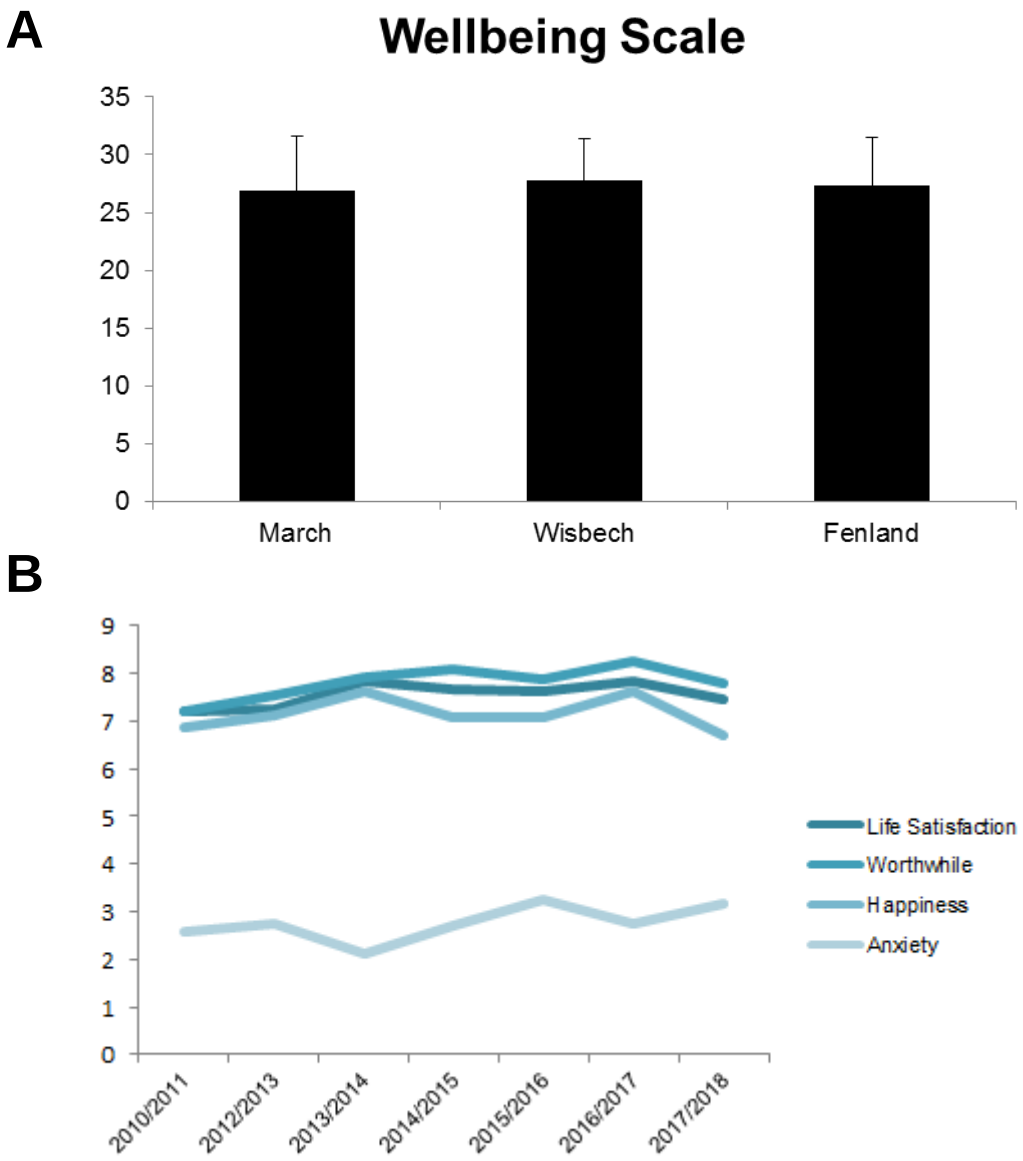


Figure 2. Assessing wellbeing in Fenland. A. *WEMWS test results for respondents in Wisbech and March* ***B.*** *Life Satisfaction, Worthwhile, Happiness and Anxiety in Fenland, according to data collected by the ONS.*

Overall the responses highlight strikingly positive effects on increasing the sense of belonging to the community. 97% of the participants agreed or strongly agreed with the fact that participating in activities supported by the HFF made them feel more connected to the community, as shown in Figure 3A. A positive consensus was also observed for the statement "I can identify concerns within my community and consider solutions", with 78% agreeing (Figure 3B).

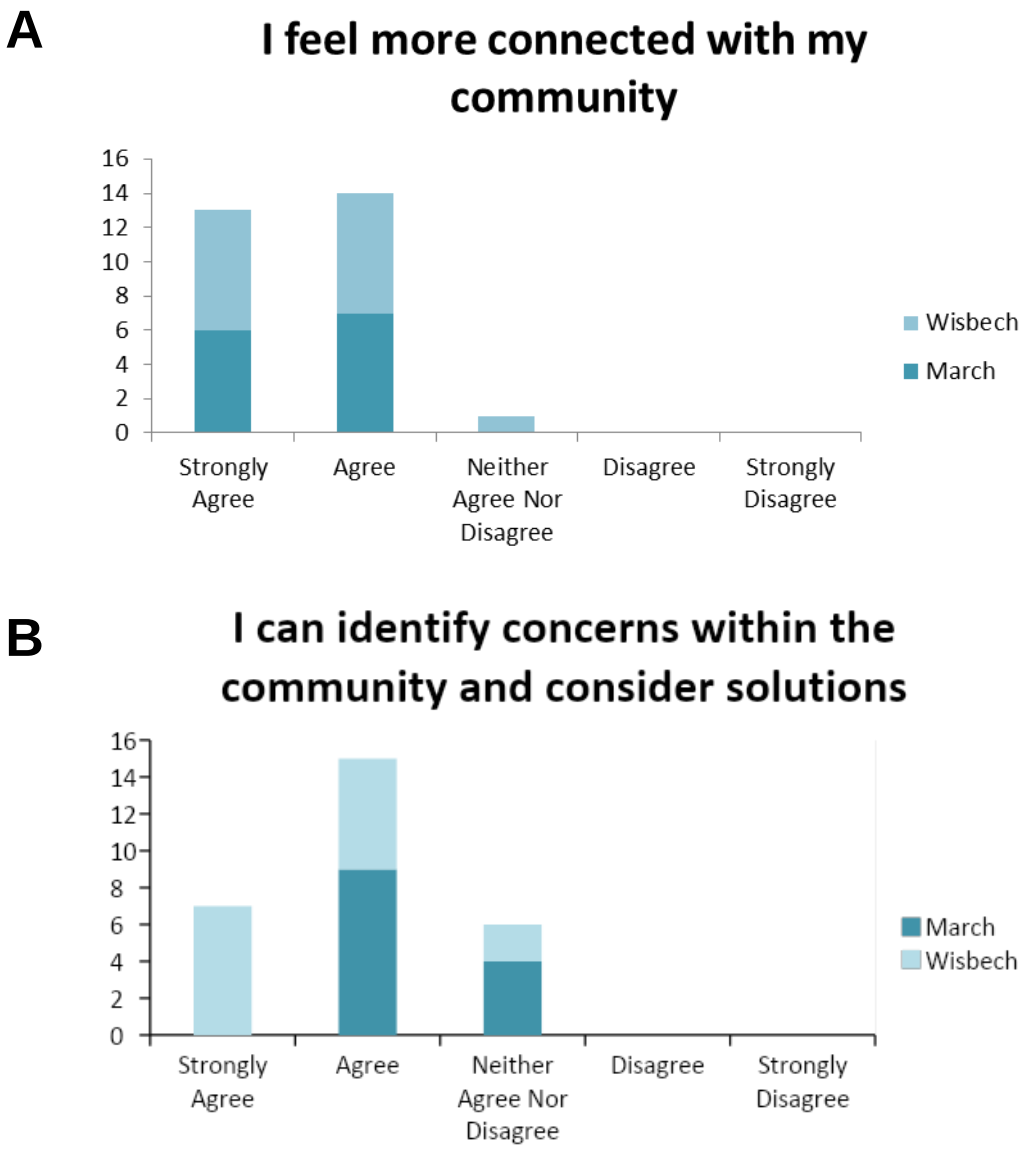


Figure 3. Attitudes towards the community by questionnaire respondents.

Perception of the health benefits is slightly more mixed. Respondents recognise positive effects on their health and well-being, agreeing with being more active (70%, Figure 4A) and more aware of their mental and physical health needs (58%, Figure 4B), as well as highlighting higher self-confidence and improved skills, as 68% agree in both cases (Figure 4C and 4D). However, there are no perceived effects to changes to use of services: for example 65% of respondents neither agreed or disagreed with the statement "The number of times I visited my GP has decreased". A potential beneficial question to include in future surveys would be 'What does healthy mean to you?' to help guide responses and understand whether people's responses change over the duration of their participation in the group.

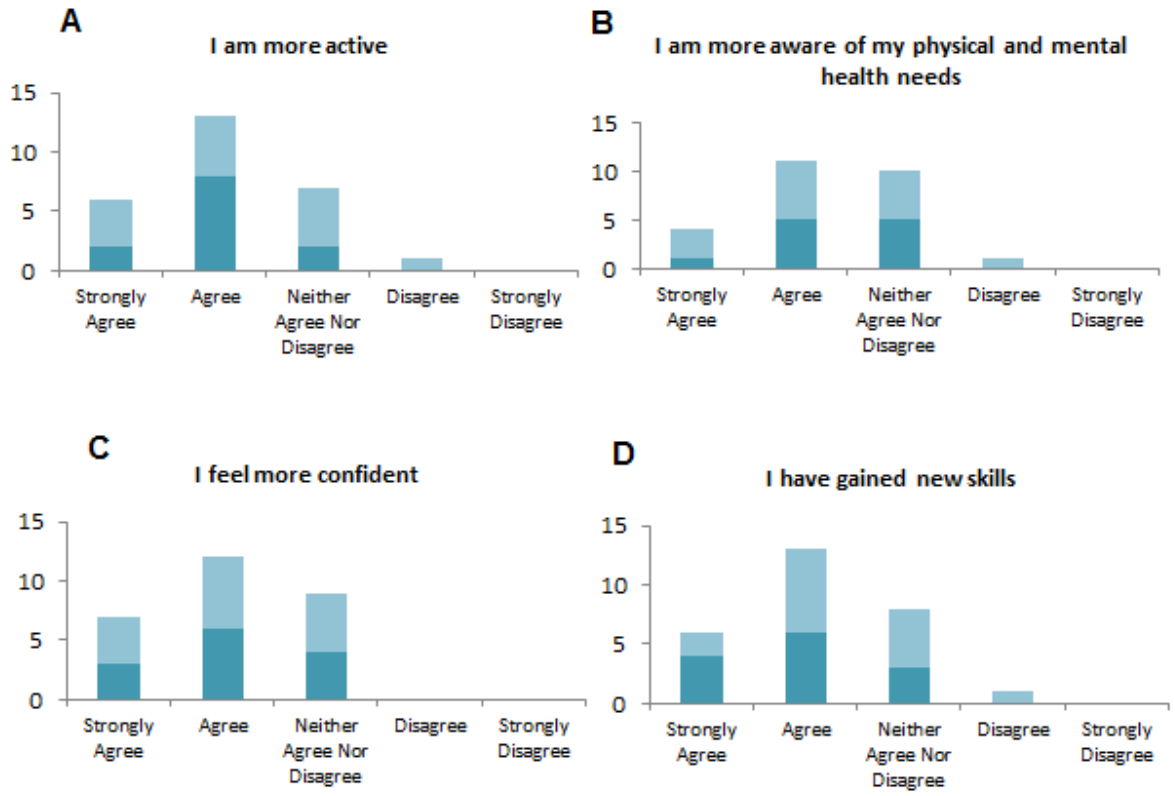


Figure 4. Attitudes towards health and wellbeing by questionnaire respondents. *Light blue columns refer to Wisbech, dark blue columns refer to March.*

People learnt about the existence of the group from three main sources: word of mouth, bring a buddy, advertisement in the local newspaper (Figure 5). When categorising responses to the open question on how individuals heard about the group they are part of, we differentiate between "word of mouth" and "bring a buddy" mainly through whether an individual heard through someone external to the group or whether the individual was brought into a group by a friend. Only one person mentioned social media (categorised here as "Others"), which may reflect the higher average age of respondents but seems pertinent as it mirrors the low level of engagement with HFF social media platforms.

Figure 5. How participants learnt about the group.

"Word of mouth" together with local authorities were the most common responses from group leaders/committee members, when asked how they learned about the HFF (Figure 6). This is in agreement with the lack of engagement with HFF social media platforms by the target population, and may encourage the HFF administrative team to think about additional ways to reach potential beneficiaries. Interestingly, some of the participants of groups who are now self-sustaining following initial support from the HFF stated they had 'only heard about [the HFF] today'. This fits well with the aims of the HFF as it demonstrates "empowerment" of the local communities, addressing their needs successfully and taking ownership of the results.

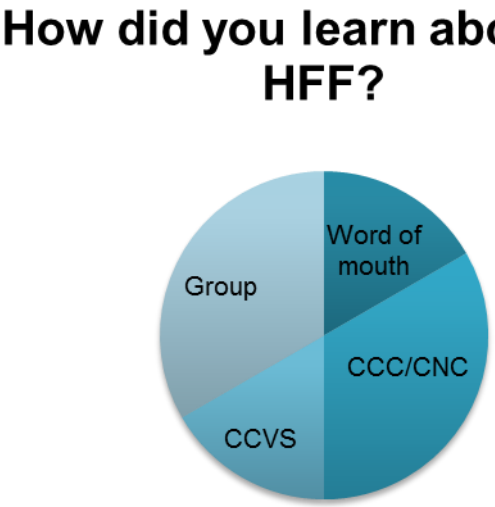


Figure 6. How committee members learnt about the HFF.

5.2. Focus groups

- Around thirty people participated in four focus groups in Wisbech and March.
- The main motivations to get involved in HFF-supported groups were interests or personal experiences (group leaders) and to increase their social circle (participants).
- Health benefits mentioned included both physical (e.g. keeping fit through playing sports) and mental (e.g. emotional support from the group).
- An improved sense of community was recognised by many attendees with a particular sense of reward felt when giving back to the community.
- Feedback on the questionnaire suggested it is currently too generic and needs more open questions, tailored to the different characteristics of the groups.

We organised and ran four focus groups across Fenland. Two in Wisbech on Thursday 4th of July 2019, facilitated by Brigitte McCormack, and two in March on Saturday 6th of July 2019, facilitated by Kelly Gilders. Both facilitators work for Everyone Health and have experience working with communities in Fenland. The facilitator topic guide is attached in Appendix 7.3. Here, we report the key points from discussions concerning the motivation of individuals to participate in HFF-supported activities, the health and community benefits perceived and the feedback on the questionnaire.

5.2.1. Participants

Four focus groups were attended by around thirty individuals, both group leaders/committee members and participants involved in a range of activities supported by the HFF. Some individuals did not complete a questionnaire but did attend the focus group. Most of this set of participants were from the migrant community who may not have sufficient skills in written English or did not feel confident enough to complete the questionnaire. To enable the views and experiences of non-English speakers to be gathered, we suggest that questionnaires are translated into other languages or a translator is present when filling in the questionnaires. The full list of the groups who participated in this pilot evaluation is shown in Appendix 7.4.

5.2.2. Motivation

The motivation for participating in HFF-supported activities differs between group leaders/committee members and participants. Group leaders tend to set up the groups based on personal interest or experiences that they want to share with

other people in the community. Participants are attracted by the social side of the activity, in addition to their personal interests.

Group leaders start groups to channel their interests. Love for a particular sport (such as netball, football, archery or goalball) was channelled into an outcome that could benefit the community. In some cases, the focus was on teaching young people (such as the Manea Strikers Youth Football Club), while in other cases, the focus was creating an environment where everyone of all abilities could enjoy it (such as a walking netball club).

Personal experiences, however, are equally important to starting a new activity. The triggers, in this case, included reasons such as being part of the migrant community or having overcome physical or mental health issues and wanting to help others in the same situation.

Participants often attend a group to improve their social life. Many of the focus group attendees were retired people, dealing with bereavement, solitude or illness, and took part in activities to help their mental wellbeing. As revealed from the questionnaire, they often learnt about the group from the local newspaper or from friends and decided to go along to enjoy the activity and more importantly be part of a community. A common theme established in the discussions is the difficulty in going to a group where all other participants are unknown, therefore often they were helped immensely by going there with a “buddy”.

However, health benefits were mentioned when asked about motivation. Playing a sport to improve health and singing in a choir to help with breathing difficulties were mentioned as reasons for joining a group.

The biggest hindrance to participation is transportation. Difficulties in moving around Fenland are the biggest barrier to the initiative. Moving around Fenland itself is a challenge due to a lack of public transport. Therefore, travelling to the meeting location for a specific time can be difficult, and the needs of caretakers who may need to travel long distances must also be considered. In fact, disabled people have an additional difficulty in participating in activities due to the need for another person to enable them to attend activities, with carers often working set shifts which may be incompatible with the times of the activities.

5.2.3. Health benefits

Unlike in responses to the questionnaire, health benefits from participating in HFF-supported activities are more readily perceived and reported during conversations. Benefits explicitly mentioned include both physical and mental health issues. Concerning physical health benefits, there was a consensus that sports including table tennis, netball, football and goalball increase levels of physical activity. It was appreciated by all focus group attendees that the different skill levels provided by sports clubs enabled a greater diversity of people to participate. Other physical health benefits recognised were improvements in breathing and lung capacity associated with singing, and raised awareness about healthy behaviours

(such as drinking more water or eating healthy snacks) acquired during group sessions.

In agreement with responses from the questionnaire, benefits to mental health and social life remain the most recognised aspects of HFF-supported activities. Being able to take part in a group, getting out on a regular basis and socialising with people are key reasons for improvement in participants' general wellbeing and mental health. "It's like being in a support group, without being in a support group" is how one attendee described being part of their group. Attendees to the focus groups gave value to the fact that many people within the groups shared similar experiences, for example being a widower, enabling people to support each other. Another important aspect of improving mental health touched on in the focus groups is that the activities helped participants in dealing with the anxiety and stress of their daily life.

Finally, participants were also aware and appreciative of the new skills learnt from the groups. Skills gained directly from the activities included singing, playing a sport or learning photography while wider skills included improved memory or management skills.

5.2.4. Community benefits

Participating in activities increases the sense of belonging to the community. To understand more about the improvements in sense of community as suggested from the questionnaire data, we asked focus group attendees about their sense of community as a result of being involved in a HFF-supported activity. Attendees described the fact that the groups allow people of different ages to come together for shared experiences through activities like table tennis, netball or singing.

Value is also given to the educational and social benefits for young people. Many participants described being worried about their children or grandchildren. One attendee suggested young people in Fenland to be in a "lose-lose situation" as they are isolated when at home or may get involved in antisocial behaviour when out of the house. It was proposed that HFF-supported group activities improve their skills, and improve their sense of belonging to the community. An example of how a group in Wisbech tried to improve this sense of community is the initiative "pack a bag", where young participants prepared bags of items to distribute to homeless people in the area.

A second major source of concern regarding young people in Fenland is access to sport for those who are home-schooled. Attendees were appreciative that groups supported by the HFF help keep children active, particularly if they are home-schooled.

The sense of giving back to the community also came out in the focus groups. Many groups take part in charity events, collecting funds for local initiatives (such as fixing the roof of the church or singing in care homes) and feel a sense of reward in helping their community in such a way.

Finally, group leaders were proud of the visibility of certain groups in their area. Group leaders discussed how the popularity of certain activities means they are well recognised in the community and people ask them for information about services in the area, allowing them to work as a hub and enabling a particular sense of reward by giving back to the community.

5.2.5. Feedback on the questionnaire

Many focus group attendees would have preferred more open questions in the questionnaire. A general consensus suggested the need for less structured questions and more space to express personal views and comments. Attendees enjoyed telling their experiences and opinions in the focus group setting and would have preferred a questionnaire more in line with the conversations developed in that context.

Suggestions were put forward on how to improve the current limitations to the questionnaire. In particular, separating physical and mental health improvements was recommended; more child-friendly questions were considered necessary for groups with young people; different sections to the questionnaires depending on the activity were suggested to take into account the variety of activities supported by the HFF; more specific questions should be asked, as many stated the present format is too generic. It was also noted that many participants still have health concerns despite being part of the group so it is important to consider this context when evaluating improvements in health.

Overall, it was considered most suited for participants and older people. Committee members felt that their experiences in setting up the groups were not considered. Groups aimed at younger people would also not suit this type of evaluation.

Most participants would be willing to take part in one-to-one interviews. Attendees appeared to greatly enjoy their involvement in HFF-supported activities and being able to share their experiences and views as part of a focus group. When asked if they would be willing to participate in one-to-one interviews as part of the evaluation process most attendees said they would be and suggested that other members of their group not in attendance would be too. Many attendees expressed a strong interest in following the outcomes of the evaluation, potentially reflecting their appreciation of the HFF initiative.

5.3. Lessons learnt from pilot evaluation

The pilot evaluation enabled us to explore which evaluation techniques would work best for the group leaders/committee members and participants involved in HFF-supported activities. We were also able to gather some preliminary data on whether the desired outcomes of the HFF were being achieved. Our key take home messages from this pilot evaluation are:

1) From questionnaire responses and focus group discussions, there does appear to be improvements in physical and mental health and a stronger sense of community as a result of HFF-supported activities suggesting that the desired outcomes of the HFF are being met, at least in this small sample of individuals.
2) Concerning the impact that participating in HFF-supported activities has on services, we asked in the questionnaire about access to support services and number of visits to the GP, without obtaining constructive responses. However, during the focus groups a strong link between activities and personal health and well-being emerges. Questions about impact on services should be rephrased and potentially allow a longer answer, to clarify the link between the activities and the use of services.
3) Focus groups and interviews appear to be the preferred method of evaluating the HFF from the perspective of the participants. This method also enables a greater sense of individual experiences to be appreciated and a better understanding of the impact on service usage.
4) The questionnaire should be adapted to provide different sections depending on the type of activity being assessed and be more comprehensive when covering physical and mental health needs.
5) There should be separate questionnaires for group leaders and participants.

6. Conclusion and recommendations

Key recommendations:

- Set reasonable objectives, in terms of number of people reached, health improvements for participants and savings for services
- A mixture of quantitative and qualitative data is required
- Consider outsourcing the evaluation
- Emphasis should be put on focus groups and interviews

This report has outlined the background to the HFF, the challenges associated with evaluating ABCD projects and the techniques used to evaluate similar programmes. A pilot evaluation was also conducted to assess which evaluation techniques would be most appropriate when evaluating the HFF.

Here we outline the most significant conclusions from this research.

Framework of the evaluation

The main questions that need to be addressed during the evaluation of the HFF are:

1) Is the HFF working as expected e.g. the grant application process?
2) Is the HFF reaching the target population?
3) Is the HFF achieving the desired outcomes?

To answer these questions, we recommend that the HFF evaluation follow a similar framework to those described in evaluations of RT and Fit as a Fiddle. This framework should include:

- **Questionnaires:** containing open questions tailored to the type of activity being assessed, with separate questionnaires for group leaders and participants. People from the area, but not involved in HFF-supported activities should be considered. Questionnaires should be translated into other languages when required.
- **Focus groups and interviews:** conducted with group leaders and participants involved in HFF-supported activities and also with the administration team behind the HFF.
- **Case studies:** of individuals and of HFF-supported groups as a whole.
- **Indicative economic value analyses:** with a focus on social value, value of volunteering and, if possible, cost savings made by other service providers.

Evaluation team

Due to the small nature of the HFF administration team it is unlikely that there will be sufficient resources ‘in-house’ to complete a thorough evaluation of the HFF.

Furthermore, to obtain the best and most objective results, it is good practice to have a separate team performing the evaluation to the team running the project. In addition to keeping the workload manageable for the personnel, this will avoid conflicts of interest between the administration team and the evaluation of the initiative. Therefore, we recommend that this evaluation is outsourced to an external organisation such as Associate Development Solutions Ltd or Ecorys to ensure a comprehensive and unbiased evaluation. Based on the feedback obtained from the questionnaire and focus groups, a company which focuses on case studies and alternative evaluation methods may be the best approach for the HFF evaluation.

Main recommendations for the evaluation of the HFF

- **Set reasonable outcomes for the area of the initiative.** Two main aspects to take into account from evaluations of similar initiatives are:
    - rural projects can rarely achieve the number of beneficiaries or cost effectiveness that similar projects in urban areas can, and
    - the time needed for these initiatives to show results in terms of changes to service use is greater in rural areas.

  This, for example, could influence the number of people expected to take part in HFF-supported initiatives or the savings expected by other service providers, such as GP surgeries. This should be considered when starting the evaluation through the setting of reasonable expected outcomes from the outset, such as the number of individuals reached, health improvements to individuals and identification of community assets.

- **Identify barriers to the initiative.** Major barriers to the ability of individuals to participate in activities supported by the HFF still remain. The major barriers we identified through discussions in the focus groups and with individuals working in Fenland include both physical aspects (i.e., transportation) and attitude aspects (i.e., reluctance to enter in a group where they do not know anyone). It is certainly a challenge to address all of these barriers, as they are influenced by a wide range of policies and organisations. Some communities within Fenland remain ‘difficult to reach’ such as the migrant communities and transient population. We recommend that a section on the ability for the HFF to engage with these populations at present and in the future is included in the evaluation.

- **Changes to the distribution and content of the questionnaire.** We recommend the questionnaire is distributed to all participants to ensure the highest number of respondents possible as, based on the evaluation of Fit as a Fiddle, it is likely that only a small proportion of people will actually complete them. In section 5, we explained the rationale behind our questionnaire and the feedback we received from focus group attendees. This feedback should be used to improve the information gained from the questionnaire, such as adding more open questions and leaving more space for comments. To encourage people to think more about their health a question stating ‘What does healthy mean to you?’ could be included. We recommend that the

wellbeing scale should remain but that the questionnaire be kept as brief as possible to encourage responses. We also recommend a more thorough monitoring of the newly supported groups, with a questionnaire distributed at the beginning, middle and end of the activity to track the progress in health and wellbeing of the participants. It may also be beneficial to distribute a questionnaire 6 months after the end of the funding period to assess the sustainability of the projects. Language barriers for migrant communities may be overcome through the use of translated questionnaires or the presence of translators.

- **Consider all the different stakeholders.** It is also important to encompass as many different viewpoints as possible. Due to time constraints it was not possible to conduct questionnaires, interviews or focus groups with the administration team or stakeholders involved in the HFF. Based on published literature and case studies, we recommend conducting interviews or focus groups with staff from the CCC, CNC, CCF and any partner organisations as part of the evaluation. This would enable perspectives on the administration processes of the HFF and strategic value to other organisations to be evaluated. Furthermore, emphasis should be put on focus groups conducted in different areas of Fenland and with more groups to ensure the richness and diversity of groups supported by the HFF is highlighted as much as possible. We also recommend that an effort is made to conduct questionnaires, focus groups and/or one-to-one interviews with people in Fenland not involved in the HFF or taking part in supported activities, to assess any differences in terms of health and wellbeing. It would also be beneficial to understand if other people are aware of the HFF, the groups or activities supported and to find out what, if anything, is preventing them from taking part.

- **Conduct one-to-one interviews with participants and group leaders.** These interviews could be conducted to follow up on specific points emerging from the focus groups, such as the health benefits. One important point which emerged from the pilot study is that the health benefits associated with the activities are not always realised when completing a questionnaire, but the awareness of health benefits emerges more clearly during a conversion. As said previously, a question focussing on people's own perceptions of their health and what healthy means in general may enable a more thorough evaluation of changes to health and health-related behaviour.

- **Consider the possibility of including an economic evaluation.** While a pilot economic value analysis was beyond the remit of this project, we suggest that a comprehensive evaluation could include an assessment of the social value gained by the actions of the HFF. A guide to Social Return on Investment has been published by the Cabinet Office and would be a good basis for an assessment of social value[22]. There could also be an investigation into local service use for example changes to the number of GP

[22] Nicholls, J. *et al.* 2012. A guide to Social Return on Investment.

visits by individuals and the community as a whole. While it may be difficult to link any observed changes directly to the HFF, it may give an indication of the health status of the whole population in a particular region, which would be valuable to an evaluation of health and wellbeing initiatives.

Our preliminary data suggests that the desired outcomes of the HFF are being realised. However, there are many further aspects of the HFF that need to be measured, such as changes to local service use, for a comprehensive evaluation to be achieved. This report has outlined the key challenges to consider during an evaluation and suggested an appropriate evaluation method for the HFF.

Acknowledgements

We would like to express our sincere gratitude to CUSPE and Cambridgeshire County Council for promoting and facilitating this project. We would especially like to thank Val Thomas, Joachim Dias and Alan Scott for their valuable advice and guidance during the course of the project. We are also thankful to the members of the Care Network Cambridgeshire team, particularly Julie Jeffryes, who provided us with an in depth understanding of the Healthy Fenland Fund and were instrumental in setting up the focus groups. We would like to thank Ian Manning, Woody Allen, Ivan Annibal, David Bailey, Brigitte McCormack, Kelly Gilders, Alice Westlake and the countless other individuals who have supported us and offered advice during this project. Finally, we would like to thank the focus group participants, without whom the key findings of this project would not have been realised.

7. Appendices

7.1. Questionnaire

Healthy Fenland Fund Group Leader/Participant Questionnaire

Name of group:

Role:
♦Group leader ♦Group participant

Age:
♦ less than 18 ♦18-30 ♦31-50 ♦51-70 ♦more than 71

Gender:
♦Male ♦Female ♦Prefer not to say

Ethnicity (please circle):
Asian / Asian British ♦ Asian / Bangladeshi ♦ Asian/Pakistani ♦ Asian / Indian ♦ Asian / Chinese British ♦Asian / Other Chinese ♦ Asian / Other Asian ♦ Black / Black British ♦ Black / Caribbean ♦ Black / African ♦ Black / Other Black ♦ White / White British ♦ White/Lithuanian ♦ White/Polish ♦ White/Russian ♦ White / Other White ♦ Mixed ♦ Prefer not to say

How long have you been involved in this group:
♦less than 1 month ♦1-3 months ♦3-6 months

♦more than 6 months ♦ more than 1 year

Since getting involved in this group:
Please circle the most appropriate statement

I feel optimistic about the future*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel useful*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel more relaxed*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am better at dealing with problems*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I think more clearly*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am more interested in other people*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am able to make decisions about my health*
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel better about myself
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I feel more confident
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I have more energy
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am more active
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I am more aware of my physical and mental health needs
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree
If so, are you doing anything differently which will benefit your health e.g. changed diet, reduced smoking, increased walking?

I have gained new skills
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree
If yes, could you name them e.g. speaking with others, leading groups?

I feel more connected with my community
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I can identify concerns within the community and consider solutions
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

I have found it easier to access support services
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

The number of times I visit my GP has decreased
Strongly Agree–Agree–Neither Agree Nor Disagree–Disagree–Strongly Disagree

How did you hear about this activity/group? What motivated you to take part?

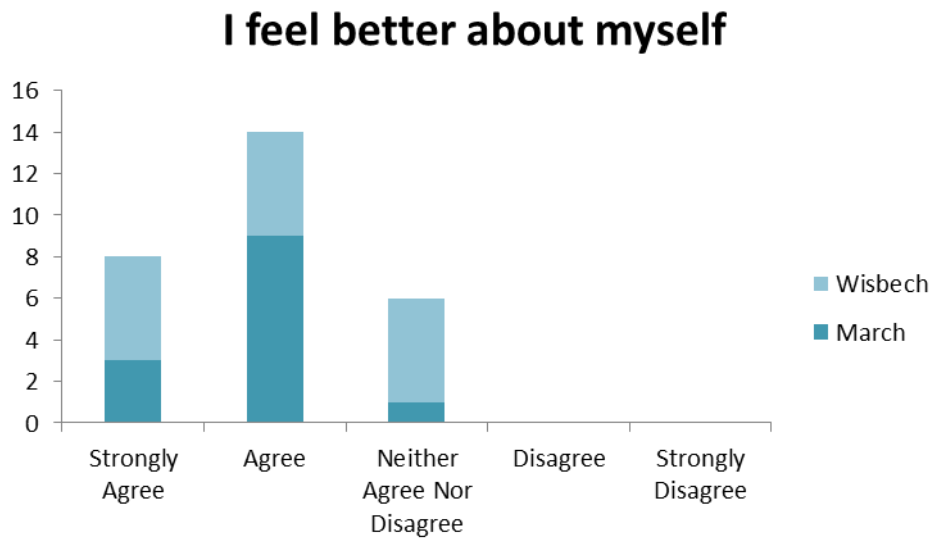
How did you hear about the Healthy Fenland Fund?

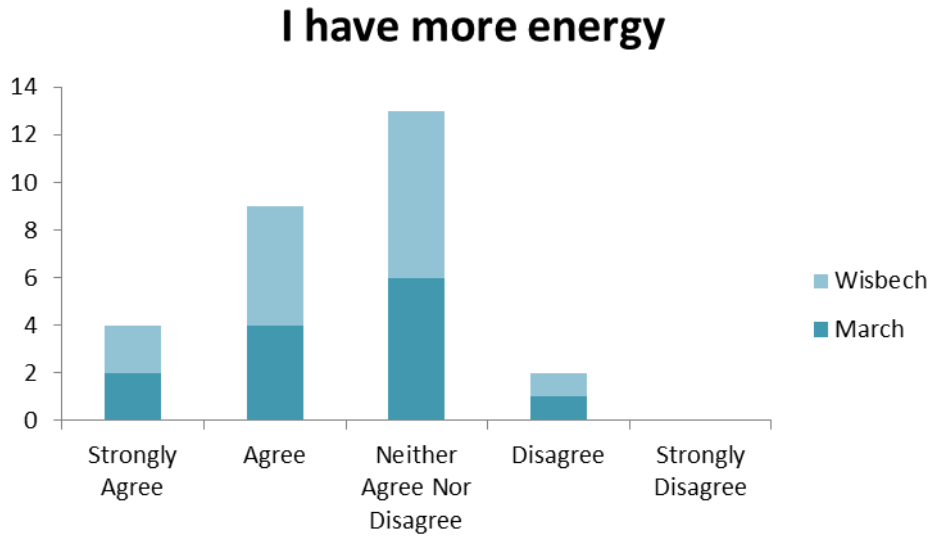
Are any other family members involved in this activity or any activity supported by the Healthy Fenland Fund?

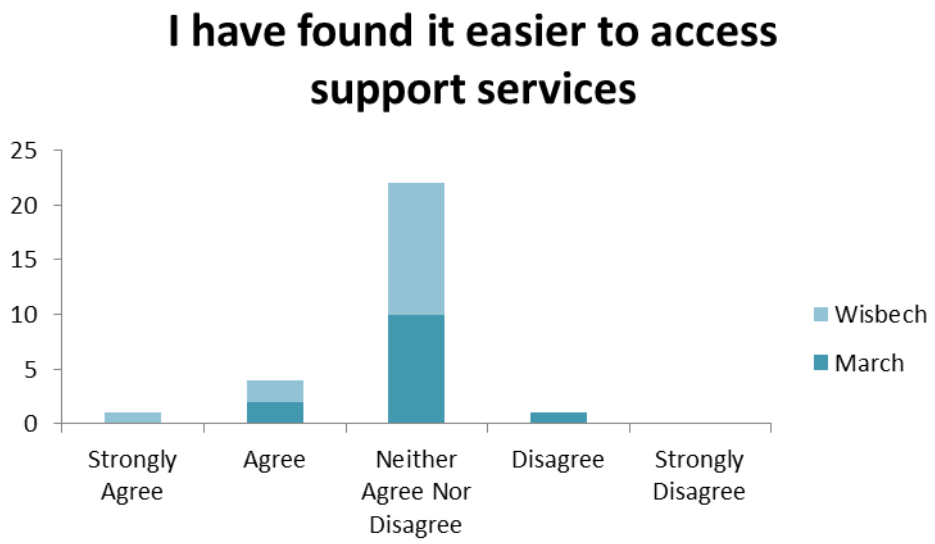
*Statements marked by an asterisk are based on the Short Warwick-Edinburgh Mental Wellbeing Scale

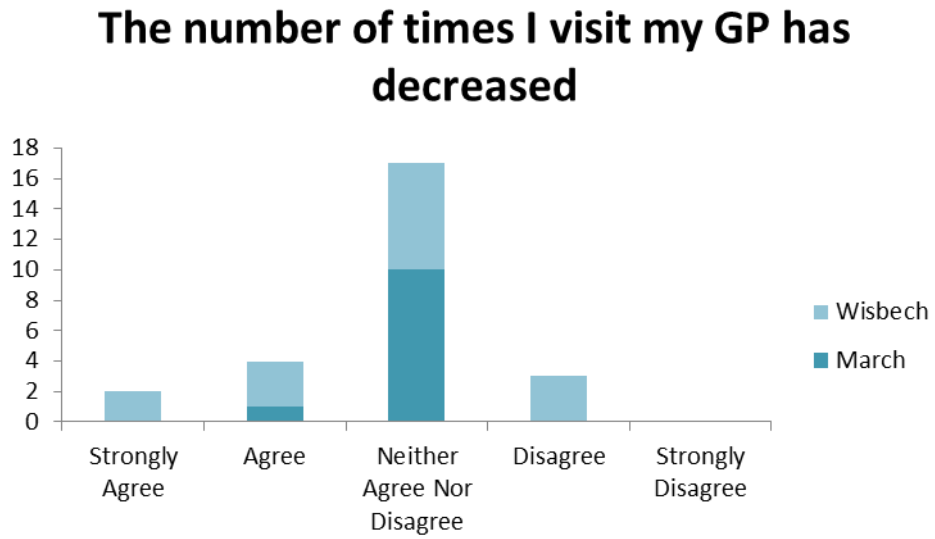
7.2. Supplementary results from HFF questionnaire analysis

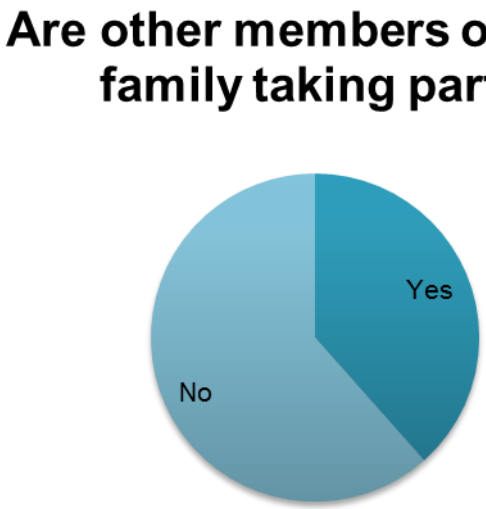
In these plots we report the results to the other questions in the questionnaire.






I have found it easier to access support services
25
20
15
10
5
0
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree
Wisbech
March


The number of times I visit my GP has decreased
18
16
14
12
10
8
6
4
2
0
Strongly Agree
Agree
Neither Agree Nor Disagree
Disagree
Strongly Disagree
Wisbech
March


Are other members of your family taking part?
Yes
No

7.3. Focus Group Topic Guide for Facilitators

Aims of the focus groups:

- To assess whether we are able to evaluate through the focus groups if the desired outcomes of the HFF are being met
- To determine which evaluation methods would work best for the participants and project leaders
- To get feedback on the questionnaire

Desired outcomes of the HFF:

- To build strong and resilient communities that are able to identify their own needs and make decisions to address their needs
- Improve mental and physical health and wellbeing

Focus group discussion points:

1. **Ice breaker** (5 mins)
   - Find out who everyone is including name, group they are part of and the best thing about being involved

2. **Motivation** (15 mins)
   - Why did you choose to take part in this activity?
   - What do you want to get out of this activity?
   - Would you have taken part if there wasn't funding?
   - For project leaders: Would you have been able to start this group without the support of the HFF grant and team?

3. **Health behaviours** (10 mins)
   - Has your attitude towards your health changed?
   - Have you changed your lifestyle in any way because of this e.g. diet, activity?

4. **Community** (15 mins)
   - Do you have a stronger sense of community?
   - Has your social life changed?
   - Do view your community/neighbours in a different way?
   - Are you more actively involved in your community e.g. community groups?

5. **Questionnaire** (15 mins)
   - What do you think of the questionnaire? E.g. was it easy or difficult to complete, too long or short.
   - Was there enough space to express your views? Would you prefer more or less open questions?
   - Do you think the questionnaire fully captured your experiences of the HFF?
   - Would you be willing to fill out a questionnaire like this once the funding for your group has ended?

- Are there any other questions you would like to be asked?
- Would you be willing to take part in one-to-one interviews?
- Would the other participants in your group be as willing to take part?

7.4. Groups with committee members and/or participants at the focus groups

Group Name	Activity	Number of participants	Notes
Black panthers	Fun activities for children (including family theatre-with 20 children and 10 mums), arts, drama science.	Attended by a growing number of people (organised a small event for Halloween, a bigger event for Christmas and very successful event for Pancake Day)	The group is now self-sufficient with the money earned selling tickets for events used to buy new equipment.
Click therapy	Teaches people about photography, helping them gain confidence and manage anxiety	Did not specify	Benefits on people with limited social interaction are tangible and rapid
Fen Tigers Goalball club	Goalball (sport for visually impaired and blind people)	Did not specify	Funds from HFF were used to buy essential equipment to play the sport
First Manea Rainbows	Activity group for young girls	23 children between 5 and 7 years old	Funds from HFF were used to buy equipment and secure the venue
Manea Strikers Youth Football Club	Children football teams (ages between 7 and 15)	Did not specify	Funds from HFF were used to increase the number of teams
March can't sing choir	Choir, singing along a karaoke	Around 50 people attend each session, from a pool of around 70, aged between 35 and 80	They perform at charity events and in care homes
Rima's ladies and families	Art clubs in foreign languages	50-60 participants, mainly young people	Many people take part in special events throughout the year (e.g., 200 attendees at the Christmas event)
Whittlesey sports association	Raises awareness of sporting opportunities in town and collates	Did not specify	Organised a fun day, which included 14 sport events and

	details of existing groups		involved between 200 and 400 people
Whittlesey table tennis club	Table tennis	74 people between 7 and 90 years old	4 sessions a week
Whittlesey warriors netball club	Netball	Did not specify	Funds from the HFF help set up a walking netball club
Wisbech PHAB club	Various activities for disabled people	Did not specify	
Wisbech Warblers Group	Singing group	12-15 core members	Perform at various events in the community.
Youths of Fenland	Young people (divided in two groups according to age - 8-13 and 13-18) come together for a range of activities, including crafts and intergenerational events	Did not specify	“Pack a bag” is an example of the activities organised and involved packing bags with food for homeless people in the area.

Agenda Item No: 9

HEALTH COMMITTEE WORKING GROUP Q1 UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	**17th October 2019**
From	**Head of Public Health Business Programmes**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**To inform the Committee of the activities and progress of the Committee's working groups since the last update.**
Recommendation:	**The Health Committee is asked to:**

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

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

Officer Contact:		***Chair Contact:***	
Name:	Kate Parker	Name:	Councillor Peter Hudson
Post:	Head of Public Health Business Programmes	Post:	Chair
Email:	Kate.Parker@cambridgeshire.gov.uk	Email:	Peter.Hudson@cambridgeshire.gov.uk
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1.0 BACKGROUND

1.1 The purpose of this report is to inform the Committee of the health scrutiny activities that have been undertaken or planned since the committee last discussed this at the meeting held on 11th July 2019

1.2 This report updates the Committee on the liaison meetings with health commissioners and providers. The report covers Quarter 1 (2019-20) liaison meetings with:

- Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) & Cambridgeshire & Peterborough Healthwatch
- Cambridgeshire & Peterborough Foundation Trust (CPFT)

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

2. MAIN ISSUES

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

A meeting was held on 29th August with Jessica Bawden (Director of Corporate Affairs, CCG), Jan Thomas (Accountable Officer CCG) and Sandie Smith (CEO) Healthwatch Cambridgeshire & Peterborough.

The liaison group members in attendance were Councillors Harford, Hudson, Jones and apologies were received from Cllr van de Ven

2.1.1 The group discussed the following items with the CCG

- Monitoring the impact of the CCG savings
- How the CCG is making use of the Healthwatch survey data on the Long Term Plan to inform their decision making
- CCG Community Services review update
- Update on the CCG Engagement plan around the CCGs financial plan.
- Doddington & Ely Out of Hours Service – wider Urgent Care update.
- Long Term Plan 5 year response

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

- Response to the NHS Long Term Plan entitled "What would you do?"

2.1.3 The next liaison meeting is scheduled Thursday, 28th November 2019

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

A visit to CPFTs Phoenix Unit (Ida Darwin Hospital grounds) was arranged for the 16th July with Councillors Susan van de Ven and District Councillor Geoff Harvey in attendance. Members were provided a tour by the following staff:

Rob Bode – Modern Matron (The Darwin Centre for Young People, The Phoenix Centre and the Croft Child and Family Centre)

Paul Millard – Clinical Director

Andy Burrows – Media Manager (CPFT)

Phoenix Centre

The centre provides specialist treatment for young people aged between 13-18 with complex eating disorders. The unit offers 12 inpatient beds including a high dependency room and also offers day patient and outreach treatment. The phoenix centre is a regional centre treating patients with eating disorders like anorexia nervosa from across the region. Recovery can take a long time so the goal of treatment at the Phoenix Centre is helping young people to improve the degree to which they can control their illness, rather than be controlled by it. This allows for a more "normal" family, social and educational experience.

The centre focuses on improving motivation for recovering (having things to get better for) and listening and including a young person's own goals as part of the way the team work. In some cases the goals have to be limited in treating the chronic illness and focused on saving life by restoring with an aim to help the young person see that more might be possible later.

The Darwin Centre for Young People

This is the main provider of residential care in the East of England offering a Tier 4 adolescent inpatient unit based in Cambridge, that offers assessment and treatment to young people (13-17 up to 18th Birthday) with severe mental health difficulties on both an inpatient and day patient basis.

The unit has places for 14 young people. During a young person's stay, they will be offered a comprehensive range of assessment and treatments by a multi-disciplinary team composed of psychiatrists, nurses, health care assistants, an occupational therapist, a clinical psychologist, a family therapist, an art therapist, support time recovery workers, a social worker, a dietitian and teaching team. The length of stay and type of admission depends on the young person's individual needs and circumstances; most young people stay for around 8-10 weeks.

The Croft Child and Family Unit

This a unique residential service that provides intensive work with families to quickly achieve beneficial change. During the day young people attend the on-site school within the unit whilst the parents or careers staying with the young person have access to psychological therapies. A programme of family therapy is provided that will included individual sessions as well as family sessions.

2.2.1 The next liaison meeting has been provisionally scheduled for Monday November 11th 2019.

2.3 Schedule of Liaison meetings

Organisation	**Liaison meeting Date**
Clinical Commissioning Group	28th November
Cambridge & Peterborough Foundation Trust	11th November (provisional)
North West Anglia Foundation Trust	Awaiting Dates
Cambridge University Hospital	Awaiting Dates

3.0 SIGNIFICANT IMPLICATIONS

3.1 **Resource Implications**

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

3.2 **Statutory, Risk and Legal Implications**

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

3.3 **Equality and Diversity Implications**

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

3.4 **Engagement and Consultation Implications**

There are likely to be engagement and consultation issues to be considered within the remit of the working groups.

3.5 **Localism and Local Member Involvement**

There may be relevant issues arising from the activities of the working groups.

3.6 **Public Health Implications**

Working groups will report back on any public health implications identified.

Source Documents	**Location**
None.	

HEALTH COMMITTEE TRAINING PLAN 2019/20 **Proposals**	Updated Sept 2019	**Agenda Item No: 10**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
	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. Business Planning updates were added to the training session	2	Sept 16th 2019	Public Health	Development session	Health Committee Members	4	40% **Completed**
	Business Planning 2020	To provide a development session on the Public Health Business Planning processes 2020	2	16th September	Public Health	Development Session		4	40% **Completed**
	STP – Long Term Plan Submission	To provide committee members with an overview of the STP's response to the Long Term Plan	2	24th October @ 9am	Public Health	Development Session	Health Committee Members (including		

							district members)		
	Mental Health Interventions	To provide committee members with an overview of public mental health focusing on local interventions and services.	4	Nov provisional	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	TBC	Public Health	Development Session			

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN

Published on 1st October 2019

Cambridgeshire County Council

Agenda Item No: 11

Notes

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

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
17/10/19	Finance & Performance Report	Liz Robin	Not applicable		
	Business Planning	Liz Robin	Not applicable		
	Quarterly Liaison Meeting Update Report	Kate Parker	Not applicable		
	CUSPE Challenges – Healthy Fenland Fund Evaluation	Val Thomas	Not applicable		
	Approval of Relevant Delegations to Award the Integrated Lifestyle Services Contract	Val Thomas	2019/067		
	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		
	Joint Strategic Needs Assessment and Joint Health and Wellbeing Board Strategy	Liz Robin	Not applicable		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	Prevention of Sexual Ill Health Service Re-Commission	Val Thomas	2019/74		
	Approval of Relevant Delegations to Award the Sexual Health Services Contract	Val Thomas	2019/066		
	Business Planning (Reserve item)	Liz Robin	Not applicable		
	STP Digital Strategy (Scrutiny Item)	STP	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		
	Business Planning	Liz Robin	Not applicable		
	Best Start in Life Strategy	Helen Freeman	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		
	STP Workforce Strategy	STP	Not applicable.		

Committee date	Agenda item	Lead officer	Reference if key decision	Deadline for draft reports	Agenda despatch date
	STP GP Strategy (Scrutiny Item)	STP	Not applicable		
	Agenda Plan and appointments to outside bodies	Daniel Snowdon	Not applicable		
[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		