HEALTH COMMITTEE

Cambridgeshire County Council

Date:Thursday, 15 December 2016

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

14:00hr

Shire Hall
Castle Hill
Cambridge
CB3 0AP

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

AGENDA

Open to Public and Press

CONSTITUTIONAL MATTERS

1	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**Minutes – 10th November 2016 and Action Log**	**5 - 18**
3	**Petitions**	

DECISIONS

4	**Finance and Performance Report – October 2016**	**19 - 48**
5	**Health Committee review of draft Revenue Business Planning proposals for 2017-18 to 2021-22**	**49 - 108**
6	**Proposal to transfer the in house Stop Smoking services to an external provider**	**109 - 118**

SCRUTINY ITEMS

DECISIONS

The Health Committee comprises the following members:

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

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

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

Clerk Name: Ruth Yule

Clerk Telephone: 01223 699184

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

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HEALTH COMMITTEE: MINUTES

Date: Thursday 10 November 2016

Time: 2.00pm to 4.20pm

Present: County Councillors P Clapp, L Dupre, L Harford, P Hudson, D Jenkins (Chairman), G Kenney, Z Moghadas, T Orgee (Vice-Chairman), M Smith, and S van de Ven.

District Councillors A Dickinson (Huntingdonshire) and S Ellington (South Cambridgeshire).

Apologies: County Councillors M Loynes, P Sales and P Topping.

265. APOLOGIES AND DECLARATIONS OF INTEREST

Apologies were noted as recorded above. There were no declarations of interest.

266. MINUTES OF THE MEETING ON 6 OCTOBER 2016 AND ACTION LOG

The minutes of the meeting held on 6 October 2016 were agreed as a correct record and signed by the Chairman.

The following updates to the published Action Log were reported:

- Minute 259: Work on re-drafting paragraph 4.7 to make it more accessible was in hand. The revised version would be included in the Business Planning report submitted to the Committee in December 2016;
- Minute 260: Officers would look to include case studies in future reports where appropriate;
- Minute 261: To be followed up with the Immunisation Task and Finish Group;
- Minute 262: A letter setting out the findings of the CCG Urgent and Emergency Care Review Task Force had been signed by the Chairman and sent to the CCG.

267. PETITIONS

There were no petitions.

KEY DECISIONS

268. PROPOSAL FOR A LOCALITY DELIVERY MODEL TO INCREASE PHYSICAL ACTIVITY LEVELS ACROSS CAMBRIDGESHIRE (KD 2016/058)

The Committee received a report by Val Thomas, Consultant in Public Health, seeking approval to fund a collaborative county-wide physical activity programme for an initial two year period with a view to identifying on-going funding streams after this period if identified positive outcomes were achieved.

The Consultant in Public Health highlighted that the status of this proposal as a Key Decision recognised the importance of increasing physical activity not only for the health benefits that this would deliver but the wider impact these could have, for

example on social care costs and avoidable unemployment. It was a collaborative project involving all of Cambridgeshire's districts, but with county-wide support and evaluation. Interventions would be monitored and outcomes evaluated in relation to both individuals and communities through the use of key performance indicators (KPIs). Initial examination of the potential return on investment was encouraging, although it was noted that economic modelling in relation to increased physical activity was not yet as robust or well-developed as with more established initiatives such as smoking cessation.

The following points were raised in discussion:

- District councillors welcomed the involvement of the districts in the project;
- Members questioned whether funding this project from the Public Health reserve would leave sufficient funds to meet the pressures created by population growth. The Director of Public Health said that some Public Health reserves were held in earmarked reserves, one of which was specifically designed to be spent strategically working with the wider public sector. This proposal was very much in keeping with that objective;
- The Chairman emphasised the need to identify future funding streams in good time before the end of the initial two year period if it proved successful in delivering the required outcomes;
- Members highlighted the importance of ensuring a joined-up approach with other local physical activity initiatives and welcomed the role which district co-ordinators would play in identifying and supporting schemes generated by local communities;
- The cost of employing the district co-ordinators for the two years of the initial programme were included in the total project costs;
- The importance of changing attitudes to support sustained behavioural change was acknowledged as a key issue across the public health sector;
- The Vice-Chairman noted the difficulties in providing robust projections for financial outcomes due to the lack of established financial modelling tools at this time, but said that it was important to find some way to demonstrate the benefits in financial terms for public information and reassurance.

  The Chairman thanked the Consultant in Public for her report and response to questions. He suggested that it would be useful to establish a small working group to work with officers on taking the project forward and asked that the Committee be provided with a follow-up report in six months' time.
  (Action: The Consultant in Public Health).

  It was resolved to:

  i. Approve and support the implementation of the collaborative countywide physical activity programme 'Cambridgeshire Let's Get Moving';
  ii. Approve use of Public Health reserves to fund the programme at a total cost of £513,000 for an initial two years, with a view to identifying on-going sources of funding after the initial two years, if positive evaluation outcomes were achieved;
  iii. Establish a working group consisting of Councillors Lorna Dupre, Peter Hudson, Zoe Moghadas and Tony Orgee to work with officers and help steer implementation.

269. RE-COMMISSIONING COUNSELLING CONTRACTS FOR CHILDREN AND YOUNG PEOPLE (KD 2016/063)

The Committee received a report by Emma de Zoete, Consultant in Public Health, on the planned re-commissioning of children's counselling services for Cambridgeshire. The total cost to Cambridgeshire County Council of the contract would be over £500k making it a Key Decision. It was proposed to tender jointly with Peterborough City Council and Cambridgeshire and Peterborough Clinical Commissioning Group through the Joint Commissioning Unit.

The Consultant in Public Health said that the proposal established one service model across Cambridgeshire and Peterborough, providing both economies of scale and addressing some gaps in provision. It was possible that services could be delivered by a single service provider, but it was more likely to be a consortium arrangement. Current providers were all aware of the proposals.

The following points were raised in discussion:

- Around 25% of children and young people with a diagnosable mental health condition in Cambridgeshire were currently accessing mental health provision. This was in line with national figures;
- Officers had focused both on a re-design of the services offered to better meet the needs of children and young people with mental health issues as well as scaling up the support available;
- A member said that they would like to see more targeted mental health support for younger children and welcomed confirmation that officers were looking at some possible support for children of primary school age;
- The importance of a whole-school approach to supporting children and young people with mental health needs was noted;
- Members agreed that it would be useful to have a training session looking at the age spectrum of children and young people with mental health needs to ensure that support was targeted as efficiently and effectively as possible;
  (Action: Head of Public Health Business Programmes)
- The Consultant in Public Health confirmed that officers were looking at identified need in different parts of the county and that provision would explicitly be linked to these needs.

Following discussion of the report it was resolved to:

i. Agree to the tender of counselling services jointly with Peterborough City Council and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) through the Joint Commissioning Unit;
ii. Agree to delegating authority to the Director of Public Health, in consultation with the Chairman and Vice-Chairman of the Health Committee, to commit funding at the time of the award of the contract.

DECISIONS

270. CAMBRIDGESHIRE AND PETERBOROUGH HEALTH AND CARE SYSTEM SUSTAINABILITY AND TRANSFORMATION PROGRAMME MEMORANDUM OF UNDERSTANDING

The Committee received a report from the Director of Public Health presenting the Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme (STP) Memorandum of Understanding (MOU) and seeking approval of Appendix A: Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan.

The Director of Public Health said that in view of the significance of the STP the Monitoring Officer had advised that the Local Authority Appendix should be considered by both the Adults Committee and the Health Committee before being passed to the Health and Wellbeing Board and the Chief Executive for final sign-off. With the agreement of the Chairman a revised version of Appendix A was tabled at the meeting showing amendments requested by the Adults Committee on 3 November 2016 (copy attached at Appendix A).

The Director of Public Health said that as part of a national initiative NHS organisations across Cambridgeshire and Peterborough had been working together under the leadership of the Health and Care Executive to draw up a five year strategic plan. As part of this work, local NHS organisations were being asked to sign up to an MOU setting out significant changes to working practices across the NHS including looking to NHS Chief Executives to function as a single leadership team, enhanced collaborative working arrangements and system controls and the sharing of financial risk. Whilst it was not deemed appropriate for local authority organisations to sign up to the full MOU it had been agreed to add an additional local authority appendix to the MOU setting out the relationship between local authorities and NHS organisations and the behaviours and principals on which this relationship was based.

The following points were raised in discussion:

- Members were content to accept the additions to the Appendix requested by the Adults Committee;
- Members emphasised the importance of enshrining in the document councillors' unique role and responsibility with regard to advocacy for their constituents.

In light of the discussion it was resolved to:

i. Note the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding for NHS organisations in Cambridgeshire and Peterborough;
ii. To approve Appendix A: 'Local Authorities and the Cambridgeshire and Peterborough Sustainability and Transformation Plan', subject to the inclusion of the amendments made by the Adults Committee on 3 November 2016 and the addition of the following words to the final bullet point on page 3 of the amended text: 'Councillors have a unique responsibility of advocacy with respect to their constituents. Nothing in this memorandum should undermine that' prior to submission to the Health and Wellbeing Board.

271. PUBLIC HEALTH FINANCE AND PERFORMANCE REPORT

The Committee considered a report by the Director of Public Health and the Chief Finance Officer which provided an update on the financial and performance position for Public Health as of the end of September 2016.

The Group Accountant reported that there had been no change to the forecast outturn position. Further work was in hand on the Reserves position and the outcome of this would be reported at the Committee's next meeting in December 2016.

The following points were made in discussion:

- One Member found the mixture of whole numbers and percentages in Appendix 6 unhelpful and noted that some other local authorities included arrows showing the desired direction of travel as well as the actual direction of travel as a clear indicator of performance against target;
- Members questioned whether the financial savings relating to smoking cessation could be built into future reports. The Director for Public Health felt that it might be difficult to generate this information on a monthly basis, but undertook to consider whether its inclusion might be trialled in the End of Year Performance Report;
  (Action: Director of Public Health)
- The Chairman said that it would be useful for officers to give some thought to indicators which would provide quick feedback on the impact of measures taken;
- It was noted that a mechanism would need to be established before May 2017 to re-consider the Committee's current three priorities, including a possible workshop or training session.
  (Action: Director of Public Health/ Head of Public Health Business Programmes)

It was resolved to:

i. Review and comment on the report.

The Committee adjourned at 3.10pm for a 10 minute break prior to considering the scrutiny items.

SCRUTINY ITEMS

272. OLDER PEOPLE AND ADULT COMMUNITY SERVICES (OPACS) SIX MONTH UPDATE

The Chairman welcomed Aidan Thomas, the Chief Executive Officer of Cambridgeshire and Peterborough NHS Foundation Trust, to the meeting and invited him to provide an update on Older People and Adult Community Services (OPACS) and the implementation of the UnitingCare model. He also invited Matthew Smith, the Clinical Commissioning Group's Local Chief Officer for the Isle of Ely and Wisbech, to address the Committee.

Mr Thomas said that both commissioners and providers remained committed implementing the UnitingCare model and he emphasised that no individual patient's care had been affected by the closure of UnitingCare. However, funding difficulties had led to slower and reduced implementation which had impacted in the short term on Accident and Emergency and community services. In describing progress to date he said that new integrated neighbourhood teams had been established and four of the sixteen teams were in new co-located team bases. Information technology was now working well following some initial difficulties and in the longer term it was envisaged that more work would be devolved to the neighbourhood teams, such as counselling services and long term conditions. Mr Thomas acknowledged that some elements of

the UnitingCare model had not yet been delivered. These included social care support to the Joint Emergency Team (JET), the provision of a mobile information viewer for front-line staff, voluntary sector integrated support in neighbourhoods, new long term condition and end of life care pathways and an integrated information analysis system. Looking forward, Mr Thomas reported that the Sustainability and Transformation Programme (STP) included a £40m investment in community and primary care over the next five years, pilot projects to support closer links between neighbourhoods, general practices and federations and between the JET, the ambulance service and Accident and Emergency departments. A review of intermediate care (community beds and hospital at home) was also planned.

The following points were raised in discussion:

- The Vice Chairman highlighted the importance of creating the right structures, such as the new integrated neighbourhood teams and the JET, and providing these with appropriate support through information analysis and data sharing systems. Mr Thomas reported that a potential supplier for information and data sharing was currently being considered. Work on data sharing across the health and social care sectors was also being progressed at officer level under the leadership of Cambridgeshire County Council's Service Director for Older People's Services and Mental Health, in the context of both local and national data protection and data sharing requirements;
- Mr Thomas and Mr Smith confirmed that nothing planned under the UnitingCare model had been forgotten;
- The difficulty in balancing the competing demands on limited resources required to meet existing health demands whilst seeking to invest in longer term preventative strategies;
- The NHS was facing its toughest financial targets yet in the coming year with growth of around 0.1% anticipated assuming all cost improvement targets were met;
- Mr Thomas acknowledged the difficulties which existed within the NHS and the frustrations which these caused, but emphasised that the NHS remained one of the most effective healthcare systems in the western world;
- Mr Thomas reported that staff turnover across the Cambridgeshire and Peterborough NHS Foundation Trust was around 8-9% per annum which was slightly less than the national average for the NHS and that sickness levels were also lower than the NHS average. He undertook to provide figures for staff turnover in neighbourhood teams and the JET;
  (Action: Aidan Thomas)

The Chairman thanked Mr Thomas for his presentation and for answering the Committee's questions. He noted that some of these issues would be considered again in the New Year in the context of the STP.

It was resolved to:

i. Note a presentation and response to questions by Aidan Thomas, Chief Executive of Cambridgeshire and Peterborough NHS Foundation Trust.

273. EMERGING ISSUES IN THE NHS

The Chairman invited Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group, to brief the Committee on emerging

issues including the current status of the Cambridgeshire and Peterborough Sustainability and Transformation Programme (STP) and the timing of its publication.

Cambridgeshire and Peterborough Sustainability and Transformation Programme (STP)

Ms Bawden said that the draft STP had been submitted to NHS England in late October, but no formal response had yet been received. She noted that some areas had already published their STPs and said that it was hoped that the Cambridgeshire and Peterborough Programme would be published within the next two weeks. Ms Bawden confirmed that the published document would be made as user-friendly as possible and said that consideration was being given to the possible production of an easy-read version. A Member commented that the inclusion of correct medical terminology in relation to specific conditions could be helpful, but it was the inclusion of jargon and acronyms which made reports more difficult for a wider audience to understand.

The Chairman thanked Ms Bawden for her update. He welcomed the collaborative approach which had been taken in producing the STP, but emphasised the importance of ensuring that it was published as soon as possible. There was considerable concern and uncertainty about the possibility of the STP including the reduction or withdrawal of local services. The Committee would be very disappointed if it should not prove possible to publish the STP before the end of November and he asked that Ms Bawden should ensure that this view was fed back in the clearest terms.

Other Issues

Ms Bawden said that work on Community Hubs was continuing in relation to community services and GPs. The review of the Minor Injuries Unit (MIU) had taken longer than planned, but it was hoped that a clearer picture would have emerged by January 2017. Following collaborative work with social care an announcement was also expected shortly on the use of Doddington Court to provide nine new intermediate care beds accommodated within separate flats.

It was resolved to:

i. Note updates from the Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) on the Cambridgeshire and Peterborough Sustainability and Transformation Programme, the review of the Minor Injuries Unit (MIU) and the use of Doddinghurst Court;
ii. Write to the CCG in the strongest terms if the Cambridgeshire and Peterborough Sustainability and Transformation Programme was not published by the end of November 2016.

DECISIONS

274. AGENDA PLAN AND APPOINTMENTS TO INTERNAL ADVISORY GROUPS AND PANELS AND PARTNERSHIP LIAISON AND ADVISORY GROUPS

The Committee noted that the timing of scrutiny of the Cambridgeshire and Peterborough Sustainability and Transformation Programme (STP) might be revised subject to the publication date. This would be considered by Spokes and the Agenda Plan revised as necessary.
(Action: The Director of Public Health/ Democratic Services Officer)

It was resolved to:

i. Note the Health Committee Agenda Plan, subject to the addition of the following item in June 2017: A progress report on the implementation of the collaborative countywide physical activity programme 'Cambridgeshire Let's Get Moving;
ii. Note that no appointments were currently required to Internal Advisory Groups and Panels or to Partnership Liaison and Advisory Groups.

275. HEALTH COMMITTEE TRAINING PLAN

The Chairman noted that a public question had been received on the Health Committee Training Plan from Ms Jean Simpson, a resident of Cambridge (copy attached at Appendix B).

Ms Simpson said that the Health Committee Training Plan contained an item titled 'Health Scrutiny Skills Part 1'. This was described as focusing on understanding the roles and responsibilities of Members conducting health scrutiny and providing them with the necessary scrutiny skills. This training was shown as priority three and had been on the training plan for over a year. In view of the significant issues to be scrutinised by the Health Committee in the near future including the Cambridgeshire and Peterborough Sustainability and Transformation Programme Ms Simpson asked that this training should be given a higher priority and carried out as soon as possible. She emphasised the importance of Committee's role in scrutinising and providing input into the NHS on behalf of the public given that she felt the direction of travel was sometimes decided in advance of wider public consultation.

The Director of Public Health said that a written response would be sent to Ms Simpson on the points she had raised. However, she emphasised that scrutiny skills training formed a key element of the Health Committee Training Plan. Scrutiny Skills Training Parts 2 and 3 had been delivered in early 2016, but details of completed training were no longer routinely included on the published plan. An induction pack was also sent out to all new members of the Committee at the time of their appointment which contained further information.

The Chairman thanked Ms Simpson for her question and said that given that there had been a number of new appointments to the Committee in recent months it would be timely to look again at the delivery of scrutiny skills training.
(Action: Head of Public Health Business Programmes)

It was resolved to:

i. Continue to deliver the training required to enable the Health Committee to discharge its statutory scrutiny function, including any training necessary for the scrutiny of the Cambridgeshire and Peterborough Sustainability and Transformation Programme;
ii. Send a written response to Ms Jean Simpson's question about Health Committee scrutiny training.
(Action: Democratic Services Officer)

276. DATE OF NEXT MEETING

The Committee noted that there had been a change to the planned meeting date in December. The Committee would now meet next on Thursday 15 December at 2.00pm in the Kreis Viersen Room, Shire Hall, Cambridge.

Chairman

Appendix A

CAMBRIDGESHIRE AND PETERBOROUGH
SUSTAINABILITY AND TRANSFORMATION PROGRAMME
MEMORANDUM OF UNDERSTANDING

Showing tracked change requested by the Adults Committee on 3 November 2016 in red text:

Appendix 1: Local Authorities and the C&P Sustainability and Transformation Plan
Introduction

- The local health economy within the Cambridgeshire & Peterborough Clinical Commissioning Group area has agreed a single Sustainability and Transformation Plan (STP) for 2016 – 2021, which has been approved by NHS England and NHS Improvement.

- All partners share an ambition to return the health and care system in Cambridgeshire and Peterborough to financial, clinical and operational sustainability, coordinating System improvements for the benefits of local residents and healthcare users by:
  - Supporting local people to take an active and full role in their own health
  - Promoting health, preventing health deterioration and promoting independence
  - Using the best, evidence-based, means to deliver on outcomes that matter
  - Focussing on what adds value (and stopping what doesn't)

Cambridgeshire County Council (CCC) and Peterborough City Council (PCC) are key stakeholders in the development and delivery of the STP and will act as partners in the STP by working together to find solutions to ensure that healthcare, public health and social care services are aligned ~~aligning their public health and social care services to support its delivery~~. However the Councils will only be able to do this in line with their statutory responsibilities, democratic and constitutional duties in the local authorities' governance arrangements

- The Cambridgeshire District and City Councils, which are members of the Cambridgeshire Health and Wellbeing Board, exercise a number of relevant functions including housing, land use planning, leisure services etc, which may also align to the wider STP Programme, and which are subject to their own democratic and constitutional arrangements.

- All partners across local authorities and the NHS are expected to support local Health and Wellbeing Strategies and Better Care Fund Plans. NHS partners will ensure that STP delivery is aligned with these wider partnership strategies and plans.

- An agreed set of behaviours and principles has been developed in order for CCC, PCC and the wider local authority membership of the HWB Board to support (and be supported) in the contribution to and delivery of the STP.

- These behaviours and principles outline how CCC, PCC and the wider local authority HWB Board membership will work together with the Health system, whilst adhering to their statutory duties and democratic and constitutional duties in the local authorities' governance arrangements

Key Behaviours:

CCC, PCC and the wider local authority Health and Wellbeing Board membership recognise the scale of change required to deliver the STP and that cultural change applies from leadership level to front line staff.

CCC, PCC and the wider local authority Health and Wellbeing Board membership will continue to build and promote trusting relationships, mutual understanding and where feasible take decisions together with the health system.

CCC and PCC representatives on the Health and Care Executive (HCE) will take full responsibility for making sure their staff are well briefed on system improvement work, drawing from system messages and materials. The HCE will ensure that relevant system messages and materials are shared with the wider HWB Board membership.

All members of the Health Care Executive and the Health and Wellbeing Boards will support and promote system behaviours for the benefit of local residents and healthcare users including:

- Working together and not undermining each other
- Behaving well, especially when things go wrong
- Engaging in honest and open discussion
- Keeping our promises – small and large
- Seeing success as collective
- Carrying through ~~Sticking to~~ decisions once made

Key Principles:

The key principles of local authorities working with partners to deliver the STP plan are:

- Commitment to implementation at pace
- Use collective commissioning and buying opportunities to improve delivery outcomes and/or system savings
- Where appropriate, HCE representatives and other senior local authority officers to act as if part of a single executive leadership team, to coordinate system improvements for the benefits of local residents in line with the STP.
- Influence the view of regulators and external assurance bodies regarding the primacy of System sustainability enshrined in the STP and the joint commitment to it.
- Highlight and work to prevent cost shunting to other partners, subject to statutory requirements on both partners.
- Adopt an invest to save approach
- Share information on new major service developments, savings, closures or relocations, and more generally share information in a timely manner when needed to support development of partnership business cases and savings plans. This should comply with existing information sharing agreements and protocols.
- Align human, financial, estate and digital resources to deliver these changes where this adds value, delivers people-centred outcomes and saves money.

Democratic requirements and local authority governance

- CCC and PCC will participate in the Health and Care Executive (HCE) arrangements through their senior officer representatives acting as non-voting members of the HCE. This arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, with are led by elected Councillors.

- CCC, PCC and Cambridgeshire District and City Councils will also participate in and support the STP through their local Health and Wellbeing Boards and shared programme management arrangements. Again, this arrangement will recognise that local authority policy and financial decisions are subject to the constitutional decision making arrangements within their respective authorities, which are led by elected Councillors.

- Local authorities support the commitment to longer-term planning, but the Partners recognise that local authorities are subject to democratic governance. Therefore the LAs must reserve the right to change their priorities in accordance with the priorities of their elected Councils

- CCC, PCC and wider local authority HWB Board membership cannot commit to sharing the opening financial risk in the STP, given that local authorities have a statutory requirement to balance their budgets and cannot operate at a deficit. Likewise, NHS partners are not expected to commit to meeting the financial risk of meeting statutory social care requirements.

- CCC and PCC ~~also~~ have a particular statutory requirement to scrutinise proposals for NHS service changes as elected representatives of their communities, and must ensure the independence and integrity of those arrangements.

- The role of all Councillors to represent the views of their local constituents and speak up on their behalf is recognised.

Appendix B

Question to the Health Committee 10 November 2016 from Jean Simpson.

Health Committee Training Plan

The Health Committee Training Plan has an item called Health Scrutiny Skills Part 1. The planned outcome measures from this training are
To understand the roles and responsibilities of members conducting health scrutiny and to provide members with scrutiny skills and techniques.
This is categorised as priority 3 and has been on the Training Plan schedule for over a year. In November; December 2015 and January; March 2016 it was listed as taking place in April 2016, but this did not happen, and in May;July;September;October and the current November agenda the course is now to be given at to a date “to be advised”.

The Sustainability and Transformation Plan for Cambridgeshire and Peterborough is designed to address the funding shortfall of at least £250 million by 2019. This will mean radical changes to local services and the way they are delivered. In a survey of CCG Chairs and Accountable Officers of England conducted by the Health Services Journal, and cited in the Daily Telegraph on 31 October 2016, the following planned or likely changes are identified.

Closing or downgrading of community hospitals	52%
Overall reduction in hospital beds	46%
Closing of or downgrading full A&E	31%
Losing urgent care centre or similar	30%
Reduction in staff in acute services	23%
One or more hospital to end consultant-led maternity	21%

As one of the 11 most challenged health economies in England, this is the scale of cuts which will be made locally. STPs have been called “high level aspiration” by a local Trust board member, and there are few concrete plans on how the local STP is going to save 5% of it's budget. For instance, it is difficult to see how the CCG plans to reduce bed utilisation and provide “Care Closer to Home” when there are still gaps in the OPACS service.

Health scrutiny, “has a legitimate role in **proactively** seeking information about the performance of local health services and institutions; in **challenging** the information provided to it by commissioners and providers of services for the health service (“relevant NHS bodies and relevant health service providers”) and in **testing** this information by drawing on different sources of intelligence” (my emphasis) (DoH June 2014) The Sustainability and Transformation Plan is the most important document the Health Committee has,so far,been asked to scrutinise, and is vital for the future of the local health economy. This committee will find it difficult to fulfil their role without adequate training and support in the **critical** appraisal of the STP.

I therefore request that the training of the Health Committee in scrutiny skills is given a much higher priority, and that this course takes place as soon as possible. This will support the committee in the effective fulfilment of its statutory obligations, and its obligations to the local community.

Jean Simpson

Appendix C

Response to Public Question on the Health Committee Training Plan

Health Committee members have had the option to attend a number of training session on Health Committee Scrutiny skills which were on the training plan as Part 2 & Part 3 for example:

Date	Topic	Purpose
11th Feb 2016	Health Scrutiny Skills (Part 2) Centre for Public Scrutiny	To understand Health Scrutiny in the context of Health Inequalities and the Transformation agenda.
21st March 2016	Health Scrutiny Skills (Part 3) "Scrutiny without Boundaries" workshop East of England Scrutiny Conference	Encouraging communication and joint working between scrutiny at different tiers of government and across political boundaries. Provide members with a toolkit for Joint scrutiny

Information on past training events was previously made available to the public and health committee members please see the Health Committee council meeting https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/10/Committee/6/Default.aspx

However at members request training sessions that had expired were removed from the plan to avoid any confusion. In addition to specific health scrutiny training offered to Health Committee members specific development sessions on relevant scrutiny topics have been delivered throughout the year to complement the generic training on offer. These include:

3rd March 2016	E-Hospital From CUHFT	Update on progress of E-Hospital system introduced by CUHFT
16th June 2016	Sustainability & Transformation Plan (Pre-submission)	To provide health committee members with an overview of the Sustainability and Transformation Plan programme
16th June 2016	Public Health 0-5 Services	To improve understanding of public health 0-5 services (health visiting and family nurse partnership) transferred to CCC in October 2015
13th October 2016	Transport & Health JSNA	To provide an overview of the Transport & Health JSNA in relation to Primary Care Capacity to support the scrutiny session scheduled for December.

New members when joining the committee receive an induction pack on the executive function and scrutiny function of the committee. In the last two months membership of the committee has changed and it was felt that the "Health Scrutiny Skills" Part 1 should be re-visited when the full complement of new committee members had been finalised.

Agenda Item No: 4

FINANCE AND PERFORMANCE REPORT – OCTOBER 2016

To:	**Health Committee**
Meeting Date:	**15 December 2016**
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 October 2016 Finance and Performance report for Public Health.** **The report is presented to provide the Committee with the opportunity to comment on the financial and performance position as at the end of October 2016.**
Recommendation:	**The Committee is asked to review and comment on the report**

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

1.0 BACKGROUND

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

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

2.0 MAIN ISSUES IN THE SEPTEMBER 2016 FINANCE & PERFORMANCE REPORT

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

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

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

A forecast underspend of £190k has been identified against the Stop Smoking Service and Intervention policy line.

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

3.0 ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

3.1.1 There are no significant implications for this priority.

3.2 Helping people live healthy and independent lives

3.2.1 There are no significant implications for this priority

3.3 Supporting and protecting vulnerable people

3.3.1 There are no significant implications for this priority

4.0 SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 Statutory, Risk and Legal Implications

4.2.1 There are no significant implications for this priority

4.3 Equality and Diversity Implications

4.3.1 There are no significant implications within this category.

4.4 Engagement and Consultation Implications

4.4.1 There are no significant implications within this category.

4.5 Localism and Local Member Involvement

4.5.1 There are no significant implications within this category.

4.6 Public Health Implications

4.6.1 There are no significant implications within this category.

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

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

From: Martin Wade **Annex A**

Tel.: 01223 699733

Date: 9 November 2016

Public Health Directorate

Finance and Performance Report – October 2016

1 SUMMARY

1.1 Finance

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

1.2 Performance Indicators

Monthly Indicators	Red	Amber	Green	No Status	Total
September (No. of indicators)	9	7	13	6	35

2. INCOME AND EXPENDITURE

2.1 Overall Position

Forecast Variance - Outturn (Sep) £000	Directorate	Current Budget for 2016/17 £000	Current Variance £000	Current Variance %	Forecast Variance - Outturn (Oct) £000	Forecast Variance - Outturn (Oct) %
0	Health Improvement	8,459	-175	-4.8%	-190	-2.3%
0	Children Health	9,276	16	-0.3%	0	0%
0	Adult Health & Well Being	916	-50	-16.8%	0	0%
0	Intelligence Team	13	-8	-100.0%	0	0%
0	Health Protection	6	1	22.5.8 %	0	0%
0	Programme Team	136	-37	-45.1%	0	0%
0	Public Health Directorate	2,395	109	7.8%	0	0%
0	**Total Expenditure**	**21,202**	**-145**	**-1.4%**	**-190**	**-0.9%**
0	Public Health Grant	-20,457	-61	-0.4%	0	0%
0	Other Income	-343	165	157.1%	0	0%
0	**Total Income**	**-20,776**	**104**	**1.4%**	**0**	**0%**
	Planned drawdown from Public Health Reserves	-244	-58	-40.3%	0	0%
0	**Net Total**	**182**	**-99**	**-1.4%**	**-190**	**-104.4%**

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

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

2.2 Significant Issues

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

An in year underspend of £190k has been identified in the Stop Smoking and Intervention budgets due to a reduction in activity through pharmacies.

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

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

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

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

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

3. BALANCE SHEET

3.1 Reserves

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

4. PERFORMANCE SUMMARY

4.1 Performance overview (Appendix 6)

- Performance of contract sexual health and contraception service remains good with all monthly key performance indicators achieved.
- Smoking cessation performance, whilst still a red indicator has improved with 85% of the quitter target achieved, compared with 70% the previous month.
- Performance of the Integrated Lifestyles and Weight Management contract remains mixed. From the 15 KPIs that are reported on this month 6 green KPIs, 3 amber KPIs and 6 red KPIs (with 5 of the red indicators on an upward trend).
- There are no changes to the Health Checks KPIs but quarter 2 data is reported on in Appendix 6.
- Health Visiting and School Nursing quarter 2 performance is available. From the 6 KPIs that are reported on we have an improved position of 3 green KPIs and 3 amber KPIs with improved performance around the percentage of infants being breastfed at 6-8 weeks.

4.2 Health Committee Priorities (Appendix 7)

Quarterly reporting due in January 2017

4.3 Health Scrutiny Indicators (Appendix 8)

Quarterly reporting due in January 2017

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

The update provided remains unchanged from Novembers Health Committee meeting. Quarterly reporting is due in January 2017.

APPENDIX 1 – Public Health Directorate Budgetary Control Report

Forecast Variance Outturn (Sep) £'000		Service	Current Budget for 2016/17 £'000	Expected to end of Oct £'000	Actual to end of Oct £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Oct) £'000	Forecast Variance Outturn (Oct) %
		Health Improvement							
0		Sexual Health STI testing & treatment	4,074	1,640	1,571	-69	-4.23%	0	0.00%
0		Sexual Health Contraception	1,170	369	377	8	2.18%	0	0.00%
0		National Child Measurement Programme	0	0	0	0	0.00%	0	0.00%
0		Sexual Health Services Advice Prevention and Promotion	152	90	71	-19	-21.31%	0	0.00%
0		Obesity Adults	0	0	0	0	0.00%	0	0.00%
0		Obesity Children	82	49	41	-8	-16.63%	0	0.00%
0		Physical Activity Adults	84	50	63	13	26.61%	0	0.00%
0		Healthy Lifestyles	1,605	959	918	-40	-4.22%	0	0.00%
0		Physical Activity Children	0	0	0	0	0.00%	0	0.00%
0	**1**	Stop Smoking Service & Intervention	907	91	-10	-101	-111.08%	-190	-20.95%
0		Wider Tobacco Control	31	19	20	2	10.01%	0	0.00%
0		General Prevention Activities	272	360	409	49	13.71%	0	0.00%
0		Falls Prevention	80	48	39	-9	-18.15%	0	0.00%
0		Dental Health	2	1	0	-1	-100.00%	0	0.00%
0		**Health Improvement Total**	**8,459**	**3,675**	**3,500**	**-175**	**-4.77%**	**-190**	**-2.25%**
		Children Health							
0		Children 0-5 PH Programme	7,531	3,782	3,782	0	0.00%	0	0.00%
0		Children 5-19 PH Programme	1,745	900	916	16	1.73%	0	0.00%
0		**Children Health Total**	**9,276**	**4,682**	**4,698**	**16**	**0.33%**	**0**	**0.00%**
		Adult Health & Wellbeing							
0		NHS Health Checks Programme	716	180	211	30	16.89%	0	0.00%
0		Public Mental Health	164	98	39	-59	-60.19%	0	0.00%
0		Comm Safety, Violence Prevention	37	22	0	-22	-100.00%	0	0.00%
0		**Adult Health & Wellbeing Total**	**916**	**300**	**249**	**-50**	**-16.77%**	**0**	**0.00%**
		Intelligence Team							
0		Public Health Advice	13	8	0	-8	-100.00%	0	0.00%
0		Info & Intelligence Misc	0	0	0	0	0.00%	0	0.00%
0		**Intelligence Team Total**	**13**	**8**	**0**	**-8**	**-100.00%**	**0**	**0.00%**
		Health Protection							
0		LA Role in Health Protection	0	0	4	4	0.00%	0	0.00%
0		Health Protection Emergency Planning	6	3	0	-3	-100.00%	0	0.00%
0		**Health Protection Total**	**6**	**3**	**4**	**1**	**22.54%**	**0**	**0.00%**

Forecast Variance Outturn (Sept) £'000	Service	Current Budget for 2016/17 £'000	Expected to end of Oct £'000	Actual to end of Oct £'000	Current Variance £'000	Current Variance %	Forecast Variance Outturn (Oct) *£'000*	Forecast Variance Outturn (Oct)
	Programme Team							
0	Obesity Adults	0	0	0	0	0.00%	0	0.00%
0	Stop Smoking no pay staff costs	31	19	9	-10	-53.44%	0	0.00%
0	General Prev, Traveller, Lifestyle	105	63	36	-27	-42.68%	0	0.00%
0	**Programme Team Total**	**136**	**81**	**45**	**-37**	**-45.13%**	**0**	**0.00%**
	Public Health Directorate							
0	Health Improvement	633	369	428	59	15.91%	0	0.00%
0	Public Health Advice	742	433	432	-1	-0.19%	0	0.00%
0	Health Protection	182	106	136	30	28.10%	0	0.00%
0	Programme Team	635	370	378	8	2.05%	0	0.00%
0	Childrens Health	76	44	45	1	1.50%	0	0.00%
0	Comm Safety, Violence Prevention	72	42	55	13	30.95%	0	0.00%
0	Public Mental Health	55	32	32	-0	-0.26%	0	0.00%
0	**Public Health Directorate total**	**2,395**	**1,397**	**1,506**	**109**	**7.78%**	**0**	**0.00%**
0	**Total Expenditure before Carry forward**	**21,202**	**10,147**	**10,002**	**-145**	**-1.43%**	**-190**	**-0.90%**
0	**Anticipated contribution to Public Health grant reserve**	**0**	**0**	**0**	**0**	**0.00%**	**0**	**0.00%**
	Funded By							
0	Public Health Grant	-20,457	-17,116	-17,177	-61	-0.36%	**0**	0.00%
0	S75 Agreement NHSE - HIV	-144	0	144	144	0.00%	**0**	0.00%
0	Other Income	-175	-105	-84	21	20.00%	**0**	0.00%
	Drawdown From Reserves	-244	-144	-202	-58	-40.28%		
0	**Income Total**	**-21,020**	**-17,365**	**-17,319**	**46**	**0.26%**	**0**	**0.00%**
0	**Net Total**	**182**	**-7,218**	**-7,317**	**-99**	**-1.37%**	**-190**	**-104.40%**

APPENDIX 2 – Commentary on Expenditure Position

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

Service	Current Budget for 2016/17 £'000	Current Variance £'000	Current Variance %	Forecast Variance - Outturn £'000	Forecast Variance - Outturn %
(1) Stop Smoking Service & Intervention	**907**	**-101**	**-111%**	**-190**	**-21%**
The underspend relates to GP and Community Pharmacy providers of stop smoking who are paid for each quit attempt they support. Their activity has fallen but it is being picked up by the core CAMQUIT Stop Smoking Team. Consequently fewer payments are made. Secondly the Clinical Commissioning Group re-charges Public Health for the prescribed medications that support quit attempts and these invoices have been late.					

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

Awarding Body : DofH

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

APPENDIX 4 – Virements and Budget Reconciliation

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

APPENDIX 5 – Reserve Schedule

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

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

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

APPENDIX 6 PERFORMANCE

More than 10% away from YTD target
Within 10% of YTD target
YTD Target met

Below previous month actual
No movement
Above previous month actual

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

Measures										
Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
GUM Access - offered appointments within 2 working days	98%	98%	98%	98%	G	99%	98%	98%	↓	
GUM ACCESS - % seen within 48 hours (% of those offered an appointment)	80%	80%	93%	93%	G	95%	80%	93%	↓	
Dhiverse : % of people newly diagnosed offered and accepted appointments	100%	100%	100%	100%	G	100%	100%	100%	↔	
Access to contraception and family planning (CCS)	7200	3600	5233	145%	G	149%	600	145%	↓	
Number of Health Checks completed	18,000	9,000	7783	87%	R	n/a	4500	87%	↔	• The comprehensive Improvement Programme is continuing this year. Intelligence from the commissioned social marketing work clearly indicates a lack of awareness in the population of Health Checks. Actual health check numbers compare reasonably well to other areas but the issue is the conversion rate which is attributed to the poor public understanding of the Programme. • The introduction of new software into practices has been delayed due to the extensive work that needs to be undertaken to introduce it into the 77 practices. This involves close working with the Clinical Commissioning Group, Information Governance and LGSS. Its purpose is to support the invitation system and to ensure that the data collection system is comprehensive. • Other activities include staff training from a commissioned Coronary Heart Disease specialist nurse. Currently working with the CCG to improve the NHS Health Checks performance which it has identified as a target area for improvement..
Percentage of people who received a health check of those offered	45%	45%	33%	33%	A	n/a	45%	33%	↔	
Number of outreach health checks carried out	2,633	1336	573	43%	R	52%	223	44%	↓	The Lifestyle Service is commissioned to provide outreach Health Checks for hard to reach groups in the community and in workplaces. This commenced in February and started gaining momentum.However due to recruitment delays/changes the number completed has remained low Recruitment has now improved and improvements can be expected.
Smoking Cessation - four week quitters	2249	797	656	82%	R	70%	163	85%	↑	• The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) suggest the prevalence of smoking in Cambridgeshire has increased slightly in the last few years, returning to a level statistically similar to the England average (16.4% v. 16.9%), although the trend is not statistically significant. Smoking rates in routine and manual workers are consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where routine and manual smoking rates have returned to a level worse than the average for England (39.8%). • There is an ongoing programme to improve performance that includes targeting routine and manual workers and the Fenland area. CamQuit the core Stop Smoking service is providing increasingly higher levels of support to the other providers along with promotional activities. Practices and community pharmacies are regularly visited with poor performers being targeted. Other activities introduced recently include a , a migrant worker Health Trainer who targets the communities where smoking rates are high . It shoudl be noted that quitters are always reduced during the summer holidays. The smoking figures are for August as they are reported two months behind the reporting period.

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

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Childhood Obesity (School year) - 90% coverage of children in year 6 by final submission (EOY)	90%	0%	0%	0%	N/A	0%	0%	0%	↔	The National Child Measurement Programme is undertaken during school term times. It is not possible to formulate a trajectory as this is dependent on school timetabling.
Childhood Obesity (School year) - 90% coverage of children in reception by final submission (EOY)	90%	0%	0%	0%	N/A	0%	0%	0%	↔	
Personal Health Trainer Service - number of referrals received **(Pre-existing GP based service)**	1983	1013	914	90%	A	116%	175	84%	↓	The Countywide Integrated Lifestyle Service provided by Everyone Health has now successfully recruited to all areas The South of the county had been problematic and there was limited Health Trainer service in this area. However staff recruitment was not completed until the end of August. The KPIs that are not on target generally have an upward trend.
Personal Health Trainer Service - number of initial assessments completed **(Pre-existing GP based service)**	1686	861	849	99%	A	125%	149	80%	↓	
Personal Health Trainer Service - Personal Health Plans completed **(Pre-existing GP based service)**	1075	550	370	67%	R	71%	95	83%	↑	Quarterly reporting. This intervention can take up to one year. Therefore there are cyclical changes and reporting quarterly.
Number of referrals from Vulnerable Groups **(Pre-existing GP based service)**	992	508	705	139%	G	151%	88	131%	↓	
Number of physical activity groups held **(Pre-existing GP based service)**	581	288	309	107%	G	88%	86	88%	↓	
Number of healthy eating groups held **(Pre-existing GP based service)**	290	144	136	94%	A	60%	24	88%	↑	

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
Personal Health Trainer Service - number of referrals received (Extended Service)	739	353	302	86%	R	81%	66	94%	↑	
Personal Health Trainer Service - number of initial assessments completed (Extended Service)	628	298	258	87%	R	106%	56	66%	↓	This reflects the recruitment issue which should shortly be resolved.
Personal Health Trainer Service - Personal Health Plans completed (Extended Service)	400	185	35	19%	R	17%	36	39%	↑	This intervention can take up to one year. Consequently the target KPI s are being reviewed. This is reported quarterly.
Number of physical activity groups held (Extended Service)	578	276	372	135%	G	127%	52	104%	↓	
Number of healthy eating groups held (Extended Service)	726	356	301	85%	R	33%	65	69%	↑	
Number of behaviour change courses held	34	16	5	31%	R	0%	3	33%	↑	Courses not delivered in June, July and August. Five courses set up to be delivered in September and October 2016. 11 courses currently booked over next 3 months.
Proportion of of Tier 2 clients completing the intervention who have achieved 5% weight loss.	30%	30%	34%	113%	G	71%	30%	200%	↑	This is reported quarterly as the intervention takes 3 - 6 months
Proportion of Tier 3 clients completing the course who have achieved 10% weight loss	60%	60%	n/a	n/a	N/A	n/a	n/a	n/a	↑	No data is currently available for 16/17. Each course is a minimum of 6 months

Measure	Y/E Target 2016/17	YTD Target	YTD Actual	YTD %	YTD Actual RAG Status	Previous month actual	Current month target	Current month actual	Direction of travel (from previous month)	Comments
% of children recruited who complete the weight management programe and maintain or reduce their BMI Z score by agreed amounts	80%	80%	N/A	N/A	**N/A**	100%	80%	n/a	⇐⇒	No programmes completing in September hence no completers
Falls prevention - number of referrals	386	149	179	120%	G	209%	39	85%	↓	
Falls prevention - number of personal health plans written	279	108	118	109%	G	181%	28	96%	↓	

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

** Direction of travel against previous month actuals

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

APPENDIX 7 – HEALTH COMMITTEE PRIORITIES

These are presented to Health Committee bi-monthly, with the next set to be presented as part of November F&PR to the January Committee.

APPENDIX 8 – HEALTH SCRUTINY INDICATORS

These are presented to Health Committee bi-monthly, with the next set to be presented as part of November F&PR to the January Committee.

APPENDIX 9 - PUBLIC HEALTH MOU 2016-17 UPDATE FOR Q2
PUBLIC HEALTH MOU 2016-17 UPDATE FOR Q2

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

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

<table>
<tr>
<td>CFA</td>
<td>CAMH Trainer</td>
<td>£71k</td>
<td>Holly Hodge/ Emma De Zoete</td>
<td>CD20901

Clare Andrews</td>
<td>The CAMH trainer is employed by CPFT and delivers specialist mental health training for a range of roles working with children and young people. Training specifically tailored to the needs of schools is also provided with a new 1 day mental health course for the 2016/17 academic year.

Most recent data (July 1016) shows 63 schools and colleges have been engaged in the training programme as shown below:
2012-16
<table>
<tr><th>District</th><th>No. Schools</th><th>%</th></tr>
<tr><td>Cambridge City</td><td>8</td><td>22</td></tr>
<tr><td>East Cambridgeshire</td><td>14</td><td>39</td></tr>
<tr><td>Fenland</td><td>9</td><td>23</td></tr>
<tr><td>Huntingdonshire</td><td>18</td><td>26</td></tr>
<tr><td>South Cambridgeshire</td><td>14</td><td>19</td></tr>
<tr><td>Grand Total</td><td>63</td><td>25</td></tr>
</table>
A range of other courses are run for professionals working with children and young people and attendees have included school nurses, family workers, social workers, young people’s workers and health visitors among other roles. A broad range of topics are included within this training for example, understanding and responding to self-harm.</td>
<td>£35,500</td>
<td>£35,500</td>
<td>0</td>
</tr>
<tr>
<td>CFA</td>
<td>DAAT</td>
<td>£5,980k</td>
<td>Susie Talbot</td>
<td>NB31001-NB31010

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

Qtr 2 of the young people’s contract has now been paid and this will show in Qtr 3’s report.</td>
<td>£2,990,000</td>
<td>2,564,890</td>
<td>£425,110</td>
</tr>
</table>

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

ETE	**Road Safety**	£20k	Matt Staton	HG03560 Jonathan Trayer	17 schools are now signed up to the Junior Travel Ambassador Scheme, including 9 schools who were engaged last academic year. The 8 new schools are appointing JTAs during September/October with the total number expected to reach 80-85 JTAs.	£10,000	£10,000	0
ETE	**Trading Standards KickAsh and Alcohol Advice**	£23k	Elaine Matthews/ Jill Terrell	LC44590 John Steel	*A dedicated post has been created to fulfil this funded KickAsh role within Community Protection Team in Community and Cultural Services. This post holder (employed term time only) fulfils the specified activities on behalf of Trading Standards and supports the wider KickAsh team to deliver improved outcomes.* **July:** Certificates for the 2015/16 mentors. Collating feedback and gathering information for evaluation. Administrative work completing year end reports and setting up systems for school year 2016/17 ahead. Preparation for recruitment of new Year 10 mentors for September. Attended the Safety Zone in Parkside, Cambridge – delivery messages about underage sales and shop policies and sharing information with approximately 450 9-10 year olds about E-cigarettes, the effects of those and tobacco with their health. **August:** School holidays, no work carried out during this month **September:** Launched straight in to the delivery of training to the first pupils recruited to be mentors and take part in the delivery of KickAsh for 2016/17. **Swavesey Village College:** • Met 44 very keen year 10's to deliver the messages of being proud to be smoke free. • Enhanced the delivery to include more information on Nicotine Inhaling Products that are becoming more popular with young people and those who are nicotine dependent. **Bottisham Village College:** • A group of very able and enthusiastic year 10'2 gathered to receive the training. Bottisham VC is one of the link schools that will receive 5 half termly visits to support them to stay on track to deliver messages and events throughout the year.	£11,500	£10,752	-748

					St Peter's College, Huntindon: • Facilitated a group of 14/15 year olds gathered to discuss the issues affecting them and their peers, and to increase their awareness of the effects of smoking in young people. • They took part in visits to local shops selling tobacco and nicotine inhaling products, advising shopkeepers of the dangers smoking has on their peers, checking Challenge 25 ID and completing the mentor's questionnaire devised for this purpose. • Three members visited three shops to complete the questionnaire and to take part in the Trading Standards Illicit tobacco Awareness roadshow, helping to deliver the messages about plain packaging, illicit tobacco etc. **Sir Harry Smith, Whittlesey:** • Met with 45+ Year 10's to talk about the KickAsh programme and to deliver the messages about plain packaging, illicit tobacco etc. **Other work:** • Continued work to support and improve the communication between the school leads and mentors. Developing an individual programme of KickAsh events and expectations for three schools (Cottenham Village College, Longsands Academy, Bottisham Village College), which fall within wider responsibilities for the duration of the year.			
ETE	**Illicit Tobacco**	£15k	Aileen Andrews	JM12800 John Steel	• Following the 6 Magistrates warrants executed late March and all 6 premises yielding illicit tobacco, investigation work was concluded and cases prepared for court with cases in court. • Financial Investigations ongoing. • The one week illicit tobacco roadshow was during September (not calculated in to the actual spend as part of a regional project). • Intelligence work on going and intelligence received about sellers within county during roadshow week.12,974 • One premises raided in Wisbech. Hand rolling tobacco seized which was concealed in roof behind a light fitting. • The simple caution was signed by takeaway owner	£7,500	£12,974	£5474

					(mentioned as being offered in quarter one document.) • 5 cases have been through the courts, results – 1. Defendant fine reduced to £1500 and victim surcharge £120 after sentencing appeal hearing. 2. Defendant fined £250 and victim surcharge £25. 3. Defendant fined £465 4. Two defendants (directors of one shop) sentenced to 120 hours unpaid work each. 5. One defendant still going through court (hearings in this qtr.) as proceeds of crime hearings taking place. Regional Project - Costs not within this allocation. Most of the work going forward will be against the regional tobacco project funding.			
ETE	**Business and Communities Team**	£10k	Elaine Matthews		*ETE Shared Priority: Engaging with communities in Fenland* **Prioritised work completed by Community Resilience Development Team (CRD) focusing on improving lives in Fenland.** <u>Libraries and Older People project – March town</u> Bringing together a range of internal and external partners and volunteers who work on front line with older people in March to maximise use of resources, resulting in improved knowledge and intelligence of the service users, increasing knowledge and information for sharing by front line workers for residents on available services and social/local support groups. Development of a shared 'Older peoples promise', using evaluation of Fenland projects to roll out in 2 new areas. <u>Community Green Spaces: Rings End Nature Reserve</u>. CRD engagement with a large national locally based employer resulted in 120 hours of volunteer time by their employees at Rings End Nature reserve in September. These capable volunteers were joined by learning disability service users and people from the local community and led by our Green Spaces Manager, working together to create new pathways, cleared a large pond, removed overgrown shrubs and trees and built new deadwood fencing which has opened up the nature reserve to far more visitors from the community and schools, learning disability groups and Forest Schools. The company has donated or pledged useful equipment and supplies for the nature reserves, further man power and loan of heavy duty equipment.	£7,300	£7,372	£72

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

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

					• Review of the Excess Deaths Planning in support of the Pandemic Flu arrangements • Collaboration on the Business Continuity arrangements developed for Public Health			
CS&T	**LGSS Managed Overheads**	£100k	Dan Thorpe	UQ10000 Maureen Wright	This continues to be supported on an ongoing basis, including: • Provision of IT equipment • Office Accommodation • Telephony • Members Allowances	£50,000	£50,000	0
					SUB TOTAL : CS&T Q2	**£100,500**	**£100,500**	**0**
LGSS	**Overheads associated with PH function**	£220k	Dan Thorpe	QL30000 RL65200 TA76000 Maureen Wright	This covers Public Health contribution towards all of the fixed overhead costs. The total amount of £220k contains £65k of specific allocations as follows: Finance £20k HR £25k IT £20k The remaining £155k is a general contribution to LGSS overhead costs	**£110,000**	**£110,000**	**0**
					SUB TOTAL : LGSS Q2	**£110,000**	**£110,000**	**0**

SUMMARY

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

Agenda Item No: 5

HEALTH COMMITTEE REVIEW OF DRAFT REVENUE BUSINESS PLANNING PROPOSALS FOR 2017/18 TO 2021/22

To:	**Health Committee**
Meeting Date:	**15th December 2016**
From:	**Dr Liz Robin** **Chris Malyon, 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 and capital proposals for Public Health that are within the remit of the Health Committee.**
Recommendation:	**a) It is requested that the Committee note the overview and context provided for the 2017/18 to 2021/22 Business Plan revenue proposals for the Service, updated since the last report to the Committee in October.** **b) It is requested that the Committee comment on the draft revenue savings proposals that are within the remit of the Health Committee for 2017/18 to 2021/22, and endorse them to the General Purposes Committee as part of consideration for the Council's overall Business Plan.**

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

1. OVERVIEW

1.1 The Council's Business Plan sets out how we will spend our money to achieve our vision and priorities for Cambridgeshire. Like all Councils across the country we are facing a major challenge. Our funding continues to reduce whilst our costs continue to rise. Those increases are driven by inflationary and demographic pressures. As the fastest growing county in the country the pressures of demography are far greater in this county than elsewhere.

1.2 The Council has now experienced a number of years of seeking to protect frontline services in response to reducing Government funding. Looking back, we have saved £68m in the last two years and are on course to save a further £41m this year (2016/17). As a result, we have had to make tough decisions over service levels during this time. Over the coming five years those decisions become even more challenging. That is why this year the Council has adopted a new approach to meeting these financial challenges, which builds upon the outcome-led approach that was developed last year.

1.3 The Council last year established the strategic outcomes it will be guided by throughout the Business Planning process, which are outlined on the right. Early in the process this year, a number of Transformation Programmes have been established to identify the specific proposals that will meet these outcomes within the resources available to the Council.

1.4 These Transformation Programmes are the lens through which this year's Business Planning Process has been approached, and will feature in the material considered by Members in workshops and Committees. There are 11 Programmes, made up of "vertical" service-based Programmes, and "horizontal" cross-cutting Programmes:

1. Adult Services	**2. Children's Services**	**3. Economy, Transport and Environment**	**4. Corporate and LGSS**	**5. Public Health**
6. Finance and Budget Review				
7. Customers and Communities				
8. Assets, Estates and Facilities Management				
9. Commissioning				
10. Contracts, Commercial and Procurement				
11. Workforce Planning and Development				

1.5 In July 2016 General Purposes Committee considered and endorsed a report which summarised the role that the new approach to transformation has played so far this year. In particular, this table captured precisely how transformation – in line with the Council's strategic outcomes – will contribute towards balancing the budget:

Base Budget		Year 0
Review of Outturn		
Corporately agreed changes to	Inflation	X
	Demography	X
	Capital Financing	X
	Service Pressures	X
		Year 1
Base budget (new business plan)		
Projected Resource Envelope		A
Savings Challenge		Y1 – A = B
Transformation Programme		
"Horizontal" Cross-cutting programmes	X	
"Vertical" Service-based programmes	X	
Total Transformation Proposals		C
Revised Savings Challenge		B – C = D
Savings Challenge applied to Budgets		D

1.6 Within this new framework, the Council continues to undertake financial planning of its revenue budget over a five year timescale 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, which are relevant to this Committee.

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 The main cause of uncertainty is the upcoming Comprehensive Spending Review and Local Government Finance Settlement. General Purposes Committee resolved not to accept the multi-year grant settlement that was being offered by the Government and therefore this uncertainty will be an annual event.

1.9 The Committee is asked to endorse these initial proposals for consideration as part of the Council's development of the Business Plan for the next five years.

2. FINANCIAL OVERVIEW

2.1 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 £33.6m are required for 2017-18, and a total of £99m across the full five years of the Business Plan. The level of savings required do change each year as cost projections are updated to reflect the latest information available including the latest service pressures that have been identified. The

following table shows the total amount necessary for each of the next five years, separating Public Health in 2017-18 as it is ring-fenced:

Service Block	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Council	-33,002	-19,440	-16,892	-18,495	-10,583
Public Health	-606	-	-	-	-
Total	**-33,608**	**-19,440**	**-16,892**	**-18,495**	**-10,583**

2.2 There are also a number of risks which are not included in the numbers above, or accompanying tables. These will be incorporated (as required) as the Business Plan is developed. Estimates are given below where possible.

	2017-18 £'000	Risk
Dedicated Schools Grant funding	4,300	This potential pressure is the result of a consultation on national funding reforms and review by Schools Forum.
Business rates revaluation	-	The Business Rates re-valuation is due to take effect from 1st April 2017, which could see significant rises in business rate liabilities in some areas and for some types of property.
Local Government Finance Settlement	-	Risk that the Council's funding is lower than budgeted.
Total	**4,300**	

2.3 In some cases services have planned to increase locally generated income instead of cutting expenditure. For the purpose of balancing the budget these two approaches have the same effect and are treated in the same way.

2.4 Delivering the level of savings required to balance the budget becomes increasingly difficult each year. Work is still underway to explore any alternative savings that could mitigate the impact of our reducing budgets on our front line services, and Business Planning proposals are still being developed to deliver the following:

Service Block	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Council	-	-1,823	-12,224	-12,168	-9,879
Public Health	-	-	-	-	-
Total	**-**	**-1,823**	**-12,224**	**-12,168**	**-9,879**

Note, this assumes the Public Health Grant is un-ring-fenced from 2018-19 onwards.

2.5 The level of savings required is based on a 2% increase in Council Tax, through levying the Adults Social Care precept in all years it is available (up to and including 2019-20), but a 0% general Council Tax increase. This assumption is built into the MTFS which was discussed by GPC in July. For each 1% more or less that Council Tax is changed, the level of savings required will change by approximately +/-£2.5m.

2.6 There is currently a limit on the increase of Council Tax of 2% and above. Should councils wish to increase their council tax above this it can only do so having sought the views of the local electorate in a local referendum. It is estimated that the cost of holding such a referendum would be around £100k, rising to as much as £350k should the public reject the proposed tax increase (as new bills would need to be issued). The MTFS assumes that the council tax limit of 2% and above will remain in place for all five years.

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

3. TRANSFORMATION UPDATE

3.1 In response to recognising that the traditional method of developing budgets and savings targets through departmental based cash limits was unsustainable in the long term, the Council has agreed a new approach that will result in an outcome focussed method to Business Planning.

3.2 As a consequence it was agreed that the Council would establish a fund that would be used to supplement base budgets, ensuring that finance is not seen as a barrier to the level and pace of transformation that can be achieved.

3.3 All savings proposals have been aligned with one of the eleven transformation workstreams and £7,387k has been requested from the transformation fund to support the delivery of these savings in 2017-18.

Investments requested:

Transformation Workstream	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Finance & Budget Review	-	133	-46	-87	-	-
Customer & Communities	-	-	-	-	-	-
Assets, Estates & Facilities Management	-	-	-	-	-	-
Commissioning	73	1,412	-1,042	-332	-38	-
Contracts, Commercial & Procurement	-	-	-	-	-	-
Workforce Planning & Development	-	-	-	-	-	-
Adult Services	146	5,442	-4,646	-796	-	-
Children's Services	-	-	-	-	-	-
Economy, Transport & Environment	800	-	-	-	-	-
Corporate & LGSS	-	-	-	-	-	-
Public Health	-	-	-	-	-	-
Total	**1,019**	**7,387**	**-6,134**	**-1,215**	**-38**	**-**

Absolute	**1,019**	**7,387**	**1,253**	**38**	**-**	**-**
Cumulative	**1,019**	**8,406**	**9,659**	**9,697**	**9,697**	**9,697**

Savings aligned to workstreams:

Transformation Workstream	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000
Finance & Budget Review	-5,041	-5	2,283	-10	-
Customer & Communities	-687	-606	-168	-27	-
Assets, Estates & Facilities Management	-174	-19	-19	-561	2
Commissioning	-8,429	-5,223	-2,506	-2,752	-
Contracts, Commercial & Procurement	-4,717	-3,978	-1,000	-	-
Workforce Planning & Development	-4,589	-3,668	-	-	-
Adult Services	-2,836	-1,457	-1,062	-1,057	-
Children's Services	-2,108	-1,834	-1,414	-1,157	-
Economy, Transport & Environment	-459	-135	-134	-127	-127
Corporate & LGSS	-468	-706	-619	-607	-566
Public Health	-606	-	-	-	-
Changes to fees, charges & ring-fenced grants	-1,154	14	-29	-29	-13
Proposals to be finalised	-2,340				
Subtotal	**-33,608**	**-17,617**	**-4,668**	**-6,327**	**-704**
Unidentified savings		-1,823	-12,224	-12,168	-9,879
Total	**-33,608**	**-19,440**	**-16,892**	**-18,495**	**-10,583**

4. OVERVIEW OF PUBLIC HEALTH SERVICE DRAFT REVENUE PROGRAMME

4.1 Following the Health and Social Care Act (2012) and the transfer of public health functions, budgets and staff from the NHS in 2013, the County Council now has a statutory duty to improve the health of local residents. It achieves this through preventive work which promotes people's health and wellbeing and reduces their longer term risk of illness and disability. The public health functions of the Council are delivered through

- provision of information and advice to the public
- provision of specialist public health advice to local NHS commissioners and other organisations
- commissioning a range of preventive public health services including health visiting and school nursing services, sexual health and contraceptive services, drug and alcohol misuse services, NHS health checks, and integrated lifestyle and weight management services
- directly providing some services including smoking cessation counselling, mental health promotion, and Traveller health services.
- considering the public health impact of wider County Council policies and services when decisions are made.

Transformation programme

4.2 As part of the wider transformation of the County Council, there is a public health transformation programme which focusses on the following three key themes.

- Improving engagement with communities to support behaviour changes which will improve health in the longer term.

- Strengthening the role of all three tiers of local government in providing environments and services which support health and wellbeing
- Maximising efficiency through our commissioning and procurement of services, including working in partnership with other organisations where this can improve outcomes or reduce commissioning costs.

The draft revenue proposals for 2017/18, combined with some internal changes in staff alignment and objectives, reflect the themes of the transformation programme.

Public Health Grant Allocation

4.2 The national ring-fenced public health grant allocation for Cambridgeshire reduces from £27,627k in 2016/17 to an indicative allocation of £26,946k in 2017/18, a total 'cash' reduction of £681k. The savings and efficiencies proposed for public health directorate budgets must cover the PH directorate's share of this reduction in PH grant, the costs of inflation and demography, a small reduction in income from other sources, and a small reduction in core Council funding allocated to the directorate, as part of wider corporate savings targets. The total savings requirement for the Public Health Directorate as a result of these factors is £606k.

4.3 There were significant savings of approximately £2.7M made to Public Health budgets in 2016/17. In order for the Health Committee to take an overview and place proposed 2017/18 savings in context, Annex C outlines the cumulative percentage saving against the major areas of public health spend, across both 2016/17 and 2017/18.

Changes to the 2016/17 Business Plan

4.3 Proposals for savings to be made in 2017/18 were included in the 2016/17 Business Plan. There have been a number of changes since the 2016/17 Business Plan was written, both to the way in which demography and inflation figures are calculated corporately, and to the savings proposals themselves. More detail is given in the paragraphs below.

2016/17 Business Plan proposals which remain unchanged

4.4 Some savings proposals for 2017/18 were already published in the Council's 2016/17 Business Plan and the financial value has not changed significantly, although more details can now be provided. These include:

Ref No	2017/18 savings which have not changed significantly since the published 2016/17 business plan	Value of saving £k
E/R 6.003	Reduction in contract value for sexual health and contraceptive services	-50
E/R 6.019	Public health programmes team restructure/vacancy management: This has been developed into a proposal to integrate in-house smoking cessation services with externally commissioned integrated lifestyle services, subject to a Voluntary Ex-Ante Transparency (VEAT) notice.	-50
E/R 6.013	Reduction in contract value for age 0-5 public health services: The value of this saving remains unchanged. However it has been broadened to include public health services for children and young people aged 0-19, as contracts for 0-5 and 5-19 public health services are both held by Cambridgeshire Community Services. It is proposed to make a saving of £150k to 0-5 public health services, through a thorough benchmarking review of skill mix and current activities, while investing £60k in a public health school nursing service for Special Schools.	-90
E/R 6.012	Public health commissioning – explore joint work with other organisations: A proposal to create a joint public health commissioning unit with Peterborough City Council is being taken forward as part of the public heatlh transformation programme. The value of the saving has increased from £50k to £57k	-57
	TOTAL	**-247**

4.5 In addition, the 2016/17 Business Plan included the following 2017/18 savings proposals for public health grant spent by other County Council directorates which remain unchanged.

- Reduction in contract value for drug and alcohol services (£100k) – this is covered in the Children, Families and Adults Executive Directorate 2017/18 revenue programme proposals.
- The public health grant funding for the Fenland Learning Service (£90k), which is a service commissioned by Economy, Transport and Environment Executive Directorate, will be replaced by other corporate funding.

Changes to the 2016/17 Business Plan: Unachievable savings

4.6 Some of the public health directorate savings for 2017/18 published in the 2016/17 business plan were identified as unachievable and will **not** be taken forward. These are a pressure on the 2017/18 budget and require alternative savings to be found. These include:

Savings in 2016/17 business plan which will NOT be taken forward in 2017/18	**Pressure on 2017/18 budget £k**
Child and adolescent mental health counselling services: The demand for these services is high, so Health Committee decided in November 2016 to maintain funding and go out to procurement for these services jointly with Peterborough City Council and the Clinical Commissioning Group.	50
Recommissioning of age 0-19 children and young people's public health services: This savings proposal was based on a redesign of children and young people's health services across services commissioned by Cambridgeshire County Council, Peterborough City Council and the Cambridgeshire & Peterborough Clinical Commissioning Group. The aim is to create a more 'joined up' service for children and their families, and use our combined resources more efficiently. This work is ongoing, but will not be ready for implementation in 2017/18.	250
TOTAL	**300**

Changes to the 2016/17 Business Plan: Demography, Inflation and Pressures

4.7 The approach to demography (forecast population growth) has changed for this 2017/18 business planning round. In the 2016/17 Business Plan tables, it was estimated that an additional £325k 'demography' funding would be required by the Public Health Directorate in 2017/18, to meet the service pressures of increased demand resulting from population growth. In the 2017/18 Business Plan tables, it is assumed that this demand pressure will be absorbed within Services' current budgets, so the 2017/18 Business Plan tables 'demography' pressures have been reduced to zero.

4.8 Similarly there is a new approach to inflation in the 2017/18 business planning round. In the 2016/17 Business Plan tables, it was estimated that general inflationary pressures would result in an increased funding requirement of £373k for the Public Health Directorate in 2017/18. In the 2017/18 Business Plan tables this has been recalculated using an expected inflation rate of 0% for general inflation. Inflation due to known increases in in-house staff costs is still included, leading to a £14k inflationary pressure, plus an additional £4k pressure for changes to the management pay structure, which has an inflationary effect for the Public Health Directorate, although cost neutral for the wider Council.

4.9 Due to the changes in the calculation of 'demography' and 'inflation' funding pressures, between the 2016/17 Business Plan and the 2017/18 Business Plan, the overall savings requirement for the Public Health Directorate has reduced by £680k. Because the majority of Public Health Directorate funding is spent on external contracts, and therefore demography and inflation pressures are mainly allocated to external contractors, there was a £660k saving described in the 2016/17 Business Plan as '(E/R.6.023) No uplift for

demography/inflation/pressures for externally provided public health contracts'. This saving has been removed from the 2017/18 Public Health business planning tables, as the new treatment of 'demography' and 'inflation' pressures means that it is no longer required.

Changes to the 2016/17 Business Plan: Additional Savings Proposals

4.8 The total savings requirement for the public health directorate as outlined in para 4.2 is £606k. Due to some 2017/18 savings identified in the 2016/17 business plan being unachievable, together with some reductions in external income, this leaves an additional £359k of savings for 2017/18 to be found in addition to those outlined under para 4.4. Additional or extended proposals identified to date are:

Ref No	New savings for 2017/18 which were not included in the 2016/17 business plan, or were significantly extended	Value of saving £k
E/R. 6.006	The 2017/18 saving of £30k against review of exercise referral schemes, which was in the 2016/17 business plan, has been increased to a total value of £48k. In addition, the ending of a workplace physical activity pilot at the County Council premises 'Scott House' from which the learning has been mainstreamed, and the identification of additional physical activity project budget which is not currently allocated has provided additional savings of £23k. The Health Committee at its November meeting approved two years transformational funding of £513k from public health reserves, for a large scale county-wide physical activity programme, involving all Districts, which is more equitable across the County.	-71
E/R 6.025	The Smoking Cessation service spend on nicotine replacement therapy and on GP practice/Pharmacy payments has been reviewed for the first two quarters of 2016/17. It has been concluded that a saving of £110k can be made on these budgets, while meeting the current level of demand for smoking cessation services.	-110
E/R 6.026	The demand for on-line Chlamydia screening has reduced, and this is also associated with a reduction in laboratory costs for Chlamydia testing,	-50
E/R 6.028	It is proposed that the current Food in Schools public health programme will be recommissioned jointly with Peterborough City Council, and integration will enable some saving.	-25
E/R 6.029	The Traveller Health Team has identified new ways of working, leading to an overall saving of £5k. This involves a reduction of the contract value with Ormiston, to reflect current levels of community worker input, and a small increase in input from the Traveller health team specialist nurse.	-5
6.031	A three year Cambridgeshire County Council contract for a voluntary sector Homestart programme ended in September 2016. The public health grant contribution to funding this contract will no longer be required in 2017/18, creating a revenue saving	-98
	TOTAL	**-359**

More detail is provided in Annex B

Key risks

4.9 The savings requirement resulting from reductions in the national public health grant is challenging. Risks are being mitigated by our contracted services working collaboratively with public health commissioners to identify savings, while maintaining key service outcomes.

4.10 The picture for 2018/19 and beyond is less clear. Although the further percentage reductions in the national public health grant for 2018/19 and 2019/20 have been announced, there is still national debate about the future of the public health grant ring-fence, and whether in the longer term, public health services should be fully funded from business rates.

4.11 Detailed figures for revenue savings going forward in 2018/19 and beyond have not yet been proposed. Since the majority of the public health budget is spent on externally commissioned services, the main part of these savings will need to be identified through recommissioning of large external contracts as outlined in the Council's transformation plans. Work to develop the programme plan for of recommissioning of these contracts is ongoing.

Further developments

4.12 All proposals outlined are draft at this stage. Full Council in February 2016 is the point at which proposals become the Council's business plan.

5. NEXT STEPS

January	General Purposes Committee will review the whole draft Business Plan and review again in late January for recommendation to Full Council
February	Full Council will consider the draft Business Plan

6. ALIGNMENT WITH CORPORATE PRIORITIES

6.1 Developing the local economy for the benefit of all

Public health services help to maintain a healthy and productive workforce in the County, which in turn supports the local economy.

6.2 Helping people live healthy and independent lives

Public health services have a key role in helping people to live a healthy lifestyle and stay healthy for longer. The savings proposals identified aim to protect, as far as possible, front line public health services which deliver this outcome.

6.3 Supporting and protecting vulnerable people

Public health services are often in contact with vulnerable people, who require additional support to maintain their health. The savings proposals identified aim to protect, as far as possible, front line public health services which have this role.

7. SIGNIFICANT IMPLICATIONS

7.1 **Resource Implications**
These savings proposals are focussed on providing best value for money. Resource implications are outlined within the document and accompanying tables.

7.2 **Statutory, legal and risk implications**
Due to continuation of the public health ring-fence during 2017/18, public health grant spend must continue to meet the grant conditions. Key risks and mitigations are outlined in paragraphs 4.9, 4.10 and 4.11.

7.3 **Equality and Diversity**
Equality and diversity implications are considered in the Community Impact Assessments (CIAs) provided in Annex B.

7.4 **Engagement and Communications**
In addition to the wider engagement and consultation on the County Council's Business Plan, ongoing engagement with service providers, stakeholder organisations, and across Council directorates has taken place during development of these proposals.

7.5 **Localism and Local Member Involvement**
There are no significant implications.

7.6 **Public Health**
The impact of each proposal on public health outcomes has been considered as part of the prioritisation process, aiming to minimise negative impacts

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes 5th Dec 2016 Clare Andrews
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes 6th Dec 2016 Fiona McMillan
Are there any Equality and Diversity implications?	Any equality and diversity implications are covered in the Community Impact Assessments in Annex B
Have any engagement and communication implications been cleared by Communications?	Yes 6th Dec 2016: Matthew Hall
Are there any Localism and Local Member involvement issues?	There are no significant localism or local Member involvement issues
Have any Public Health implications been cleared by Public Health	Yes 6th Dec Val Thomas

Source Documents	Location
Transformation Programme General Purposes Committee, 26.07.16, agenda item 9	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/182/Committee/2/Default.aspx
Demography Update General Purposes Committee, 20.09.16, agenda item 8	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/183/Committee/2/Default.aspx
Cambridgeshire County Council Business Plan 2016/17	http://www.cambridgeshire.gov.uk/info/20043/finance_and_budget/90/business_plan_2016_to_2017

Section 3 – Finance Tables

Introduction

There are six types of finance table: tables 1-3 relate to all Service Areas, while only some Service Areas have tables 4, 5 and/or 6. Tables 1, 2, 3 and 6 show a Service Area's revenue budget in different presentations. Tables 3 and 6 detail all the changes to the budget. Table 2 shows the impact of the changes in year 1 on each policy line. Table 1 shows the combined impact on each policy line over the 5 year period. Some changes listed in Table 3 impact on just one policy line in Tables 1 and 2, but other changes in Table 3 are split across various policy lines in Tables 1 and 2. Tables 4 and 5 outline a Service Area's capital budget, with table 4 detailing capital expenditure for individual proposals, and funding of the overall programme, by year and table 5 showing how individual capital proposals are funded.

TABLE 1 presents the net budget split by policy line for each of the five years of the Business Plan. It also shows the revised opening budget and the gross budget, together with fees, charges and ring-fenced grant income, for 2017-18 split by policy line. Policy lines are specific areas within a service on which we report, monitor and control the budget. The purpose of this table is to show how the net budget for a Service Area changes over the period of the Business Plan.

TABLE 2 presents additional detail on the net budget for 2017-18 split by policy line. The purpose of the table is to show how the budget for each policy line has been constructed: inflation, demography and demand, pressures, investments and savings are added to the opening budget to give the closing budget.

TABLE 3 explains in detail the changes to the previous year's budget over the period of the Business Plan, in the form of individual proposals. At the top it takes the previous year's gross budget and then adjusts for proposals, grouped together in sections, covering inflation, demography and demand, pressures, investments and savings to give the new gross budget. The gross budget is reconciled to the net budget in Section 7. Finally, the sources of funding are listed in Section 8. An explanation of each section is given below.

- **Opening Gross Expenditure:** The amount of money available to spend at the start of the financial year and before any adjustments are made. This reflects the final budget for the previous year.

- **Revised Opening Gross Expenditure:** Adjustments that are made to the base budget to reflect permanent changes in a Service Area. This is usually to reflect a transfer of services from one area to another.
- **Inflation:** Additional budget provided to allow for pressures created by inflation. These inflationary pressures are particular to the activities covered by the Service Area.
- **Demography and Demand:** Additional budget provided to allow for pressures created by demography and increased demand. These demographic pressures are particular to the activities covered by the Service Area. Demographic changes are backed up by a robust programme to challenge and verify requests for additional budget.
- **Pressures:** These are specific additional pressures identified that require further budget to support.
- **Investments:** These are investment proposals where additional budget is sought, often as a one-off request for financial support in a given year and therefore shown as a reversal where the funding is time limited (a one-off investment is not a permanent addition to base budget).
- **Savings:** These are savings proposals that indicate services that will be reduced, stopped or delivered differently to reduce the costs of the service. They could be one-off entries or span several years.
- **Total Gross Expenditure:** The newly calculated gross budget allocated to the Service Area after allowing for all the changes indicated above. This becomes the Opening Gross Expenditure for the following year.
- **Fees, Charges & Ring-fenced Grants:** This lists the fees, charges and grants that offset the Service Area's gross budget. The section starts with the carried forward figure from the previous year and then lists changes applicable in the current year.
- **Total Net Expenditure:** The net budget for the Service Area after deducting fees, charges and ring-fenced grants from the gross budget.
- **Funding Sources:** How the gross budget is funded – funding sources include cash limit funding (central Council funding from Council Tax, business rates and government grants), fees and charges, and individually listed ring-fenced grants.

TABLE 4 presents a Service Area's capital schemes, across the ten-year period of the capital programme. The schemes are summarised by start year in the first table and listed individually, grouped together by category, in the second table. The third table identifies the funding sources used to fund the programme. These sources include prudential borrowing, which has a revenue impact for the Council.

TABLE 5 lists a Service Area's capital schemes and shows how each scheme is funded. The schemes are summarised by start year in the first table and listed individually, grouped together by category, in the second table.

TABLE 6 follows the same format and purpose as table 3 for Service Areas where there is a rationale for splitting table 3 in two.

Section 4 - E: Public Health

Table 1: Revenue - Summary of Net Budget by Operational Division

Budget Period: 2017-18 to 2021-22

Net Revised Opening Budget 2017-18 £000	Policy Line	Gross Budget 2017-18 £000	Fees, Charges & Ring-fenced Grants 2015-16 £000	Net Budget 2017-18 £000	Net Budget 2018-19 £000	Net Budget 2019-20 £000	Net Budget 2020-21 £000	Net Budget 2021-22 £000
	Health Improvement							
4,074	Sexual Health STI testing & treatment	3,975	-	3,975	3,975	3,975	3,975	3,975
1,170	Sexual Health Contraception	1,170	-	1,170	1,170	1,170	1,170	1,170
-	National Child Measurement Programme	-	-	-	-	-	-	-
151	Sexual Health Services Advice Prevention and Promotion	152	-	152	152	152	152	152
-	HI - Obesity Adults	-	-	-	-	-	-	-
82	Obesity Children	57	-	57	57	57	57	57
84	Physical Activity Adults	39	-	39	39	39	39	39
1,605	Healthy Lifestyles	1,605	-	1,605	1,605	1,605	1,605	1,605
-	Physical Activity Children	-	-	-	-	-	-	-
907	Stop Smoking Service & Intervention	797	-	797	797	797	797	797
31	Wider Tobacco Control	31	-	31	31	31	31	31
273	General Prevention Activities	273	-	273	273	273	273	273
80	Falls Prevention	80	-	80	80	80	80	80
2	Dental Health	2	-	2	2	2	2	2
8,459	**Subtotal Health Improvement**	**8,181**	**-**	**8,181**	**8,181**	**8,181**	**8,181**	**8,181**
	Children Health							
7,531	Children 0-5 PH Programme	7,433	-	7,433	7,433	7,433	7,433	7,433
1,745	Children 5-19 PH Programme	1,656	-	1,656	1,656	1,656	1,656	1,656
9,276	**Subtotal Children Health**	**9,089**	**-**	**9,089**	**9,089**	**9,089**	**9,089**	**9,089**
	Adult Health & Wellbeing							
716	NHS Health Checks Programme	716	-	716	716	716	716	716
164	Public Mental Health	164	-	164	164	164	164	164
37	Comm Safety, Violence Prevention	37	-	37	37	37	37	37
917	**Subtotal Adult Health & Wellbeing**	**917**	**-**	**917**	**917**	**917**	**917**	**917**
	Intelligence Team							
14	Public Health Advice	14	-	14	14	14	14	14
-	Info & Intelligence Misc	-	-	-	-	-	-	-
14	**Subtotal Intelligence Team**	**14**	**-**	**14**	**14**	**14**	**14**	**14**
	Health Protection							
-	LA Role in Health Protection	-	-	-	-	-	-	-

Section 4 - E: Public Health

Table 1: Revenue - Summary of Net Budget by Operational Division

Budget Period: 2017-18 to 2021-22

Net Revised Opening Budget 2017-18 £000	Policy Line	Gross Budget 2017-18 £000	Fees, Charges & Ring-fenced Grants 2015-16 £000	Net Budget 2017-18 £000	Net Budget 2018-19 £000	Net Budget 2019-20 £000	Net Budget 2020-21 £000	Net Budget 2021-22 £000
6	Health Protection Emergency Planning	6	-	6	6	6	6	6
6	**Subtotal Health Protection**	**6**	**-**	**6**	**6**	**6**	**6**	**6**
	Programme Team							
-	PT - Obesity Adults	-	-	-	-	-	-	-
31	Stop Smoking no pay staff costs	31	-	31	31	31	31	31
105	General Prevention, Traveller, Lifestyle	96	-22	74	74	74	74	74
136	**Subtotal Programme Team**	**127**	**-22**	**105**	**105**	**105**	**105**	**105**
	Public Health Directorate							
-18,135	Public Health - Admin & Salaries	2,166	-20,338	-18,172	1,878	1,878	1,878	1,878
-18,135	**Subtotal Public Health Directorate**	**2,166**	**-20,338**	**-18,172**	**1,878**	**1,878**	**1,878**	**1,878**
	Future Years							
-	Inflation	-	-	-	23	44	65	85
-	Savings	-	-	-	-	-	-	-
673	**PUBLIC HEALTH TOTAL**	**20,500**	**-20,360**	**140**	**20,213**	**20,234**	**20,255**	**20,275**

Note: *Public Health - Admin & Salaries* includes direct delivery of health improvement programmes, health protection, and specialist healthcare public health advice services by public health directorate staff.

Section 4 - E: Public Health

Table 1: Revenue - Summary of Net Budget by Operational Division

Budget Period: 2017-18 to 2021-22

The above Public Health Directorate does not constitute the full extent of Public Health expenditure. The reconciliation below sets out where the Public Health grant is being managed in other areas of the County Council.

-	**Children, Families and Adults Services** Public Health expenditure delivered by CFA	6,322	-6,322	-
-	**Subtotal Children, Families and Adults Services**			**-**
-	**Economy, Transport and Environment Services** Public Health expenditure delivered by ETE	153	-153	-
-	**Subtotal Economy, Transport and Environment Services**			**-**
-	**Corporate Services** Public Health expenditure delivered by CS	201	-201	-
-	**Subtotal Corporate Services**			**-**
-	**LGSS - Cambridge Office** Overheads associated with Public Health function	220	-220	-
-	**Subtotal LGSS - Cambridge Office**			**-**
-	**PUBLIC HEALTH MANAGED IN OTHER SERVICE AREAS TOTAL**	**6,896**	**-6,896**	**-**

-42	Less Fees & Charges / Contributions	-310	310	
631	**EXPENDITURE FUNDED BY PUBLIC HEALTH GRANT TOTAL**	**27,086**	**-26,946**	**140**

Section 4 - E: Public Health

Table 2: Revenue - Net Budget Changes by Operational Division

Budget Period: 2017-18

Policy Line	Net Revised Opening Budget £000	Net Inflation £000	Demography & Demand £000	Pressures £000	Investments £000	Savings & Income Adjustments £000	Net Budget £000
Health Improvement							
Sexual Health STI testing & treatment	4,074	1	-	-	-	-100	3,975
Sexual Health Contraception	1,170	-	-	-	-	-	1,170
National Child Measurement Programme	-	-	-	-	-	-	-
Sexual Health Services Advice Prevention and Promotion	151	1	-	-	-	-	152
HI - Obesity Adults	-	-	-	-	-	-	-
Obesity Children	82	-	-	-	-	-25	57
Physical Activity Adults	84	-	-	-	-	-45	39
Healthy Lifestyles	1,605	-	-	-	-	-	1,605
Physical Activity Children	-	-	-	-	-	-	-
Stop Smoking Service & Intervention	907	-	-	-	-	-110	797
Wider Tobacco Control	31	-	-	-	-	-	31
General Prevention Activities	273	-	-	-	-	-	273
Falls Prevention	80	-	-	-	-	-	80
Dental Health	2	-	-	-	-	-	2
Subtotal Health Improvement	**8,459**	**2**	**-**	**-**	**-**	**-280**	**8,181**
Children Health							
Children 0-5 PH Programme	7,531	-	-	-	-	-98	7,433
Children 5-19 PH Programme	1,745	1	-	-	-	-90	1,656
Subtotal Children Health	**9,276**	**1**	**-**	**-**	**-**	**-188**	**9,089**
Adult Health & Wellbeing							
NHS Health Checks Programme	716	-	-	-	-	-	716
Public Mental Health	164	-	-	-	-	-	164
Comm Safety, Violence Prevention	37	-	-	-	-	-	37
Subtotal Adult Health & Wellbeing	**917**	**-**	**-**	**-**	**-**	**-**	**917**
Intelligence Team							
Public Health Advice	14	-	-	-	-	-	14
Info & Intelligence Misc	-	-	-	-	-	-	-
Subtotal Intelligence Team	**14**	**-**	**-**	**-**	**-**	**-**	**14**
Health Protection							
LA Role in Health Protection	-	-	-	-	-	-	-

Section 4 - E: Public Health

Table 2: Revenue - Net Budget Changes by Operational Division

Budget Period: 2017-18

Policy Line	Net Revised Opening Budget £000	Net Inflation £000	Demography & Demand £000	Pressures £000	Investments £000	Savings & Income Adjustments £000	Net Budget £000
Health Protection Emergency Planning	6	-	-	-	-	-	6
Subtotal Health Protection	**6**	**-**	**-**	**-**	**-**	**-**	**6**
Programme Team							
PT - Obesity Adults	-	-	-	-	-	-	-
Stop Smoking no pay staff costs	31	-	-	-	-	-	31
General Prevention, Traveller, Lifestyle	105	-	-	-	-	-31	74
Subtotal Programme Team	**136**	**-**	**-**	**-**	**-**	**-31**	**105**
Public Health Directorate							
Public Health - Admin & Salaries	-18,135	10	-	4	-	-51	-18,172
Subtotal Public Health Directorate	**-18,135**	**10**	**-**	**4**	**-**	**-51**	**-18,172**
Public Health Ring-fenced Grant and Fees & Charges	-	-	-	-	-	-	-
PUBLIC HEALTH TOTAL	**673**	**13**	**-**	**4**	**-**	**-550**	**140**

Note: *Public Health - Admin & Salaries* includes direct delivery of health improvement programmes, health protection, and specialist healthcare public health advice services by public health directorate staff.

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

Detailed Plans	Outline Plans

Ref	Title	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	Transformation Workstream	Description
1	**OPENING GROSS EXPENDITURE**	**20,948**	**20,500**	**20,523**	**20,544**	**20,565**		
E/R.1.004	One-off use of Public Health reserve funding	84	-	-	-	-		This is the removal of a Public Health grant to Economy, Transport and Environment. This funded specific work and campaigns which have now ended and so the money is no longer required.
E/R.1.005	Increase in spend funded from external sources	56	-	-	-	-		Increase in expenditure budgets (compared to published 2016-17 Business Plan) as advised during the budget preparation period and permanent in-year changes made during 2016-17.
1.999	**REVISED OPENING GROSS EXPENDITURE**	**21,088**	**20,500**	**20,523**	**20,544**	**20,565**		
2	**INFLATION**							
E/R.2.001	Inflation	14	23	21	21	20		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%.
2.999	**Subtotal Inflation**	**14**	**23**	**21**	**21**	**20**		
3	**DEMOGRAPHY AND DEMAND**							
3.999	**Subtotal Demography and Demand**	**-**	**-**	**-**	**-**	**-**		
4	**PRESSURES**							
E/R.4.001	Professional and Management Pay Structure	4	-	-	-	-		The revised management band pay structure was implemented in October 2016. The revised pay grades will not be inflated during 2017-18, as the inflation funding was factored into the available funding for the new pay structure. This pressure replaces inflation and funds the additional cost of the new pay structure expected to be incurred in 2017-18.
4.999	**Subtotal Pressures**	**4**	**-**	**-**	**-**	**-**		
5	**INVESTMENTS**							
5.999	**Subtotal Investments**	**-**	**-**	**-**	**-**	**-**		

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

Detailed Plans	Outline Plans

Ref	Title	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	Transformation Workstream	Description
6	**SAVINGS**							
	Health							
E/R.6.003	CCS contract for integrated contraception and sexual health services	-50	-	-	-	-	Public Health	Continued move to a more demand led model which means that although there will be a small reduction in clinic sessions the service will be even more targeted where there is most need. Specific proposals that reflect this approach are being discussed with Cambridgeshire Community Services.
E/R.6.006	Review exercise referral schemes	-71	-	-	-	-	Public Health	As part of the Public Health drive to promote and increase physical activity to benefit everyone across the County the service is discontinuing investment in the current district based exercise referral schemes by £48k (recurrent). There is inequity in the current investment in exercise referral schemes as only two areas are funded. However the Health Committee approved at its November 2016 meeting a countywide physical activity programme which includes all the Districts. An additional £23k saving (recurrent) results from the end of a workplace physical activity pilot at County Council premises Scott House, from which the learning is now mainstreamed, and from ceasing other currently unallocated physical activity project budgets.
E/R.6.012	Public health services contract for children and young people aged 0-19	-90	-	-	-	-	Public Health	Reducing the cost of the contract for age 0-19 public health services with Cambridgeshire Community Services, while investing in public health school nursing services for Special Schools. Review of skill mix and ways of working in 0-5 public health services, including health visiting and family nurse partnership, which should enable saving of £150k. Existing staff will be working in a more integrated way with other Council services, such as Children's Centres and Together for Families Programme. Invest £60k to provide a public health school nursing service for Special Schools.
E/R.6.019	Public health programmes team restructure/vacancy management	-50	-	-	-	-	Public Health	Explore the potential for closer working across smoking cessation and other healthy lifestyle services without a reduction in service.
E/R.6.021	Public health commissioning - explore joint work with other organisations	-57	-	-	-	-	Public Health	Create a joint Public Health commissioning unit with Peterborough City Council in order to drive best value across both areas, building on the existing Children's Health Joint Commissioning Unit and existing joint work across the two Councils by the public health specialist team.
E/R.6.025	Smoking Cessation : Reduced spend on NRT and GP Payments	-110	-	-	-	-	Public Health	After review of smoking cessation spend on nicotine replacement therapy (NRT) and payments to GP practices and pharmacies in the first two quarters of 2016-17, it has been established that this level of saving can be withdrawn while meeting the current level of demand for the smoking cessation service.

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

Detailed Plans	Outline Plans

Ref	Title	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	Transformation Workstream	Description
E/R.6.026	Chlamydia Screening : Online Testing and reduction in lab costs	-50	-	-	-	-	Public Health	Demand for the online chlamydia screening service has declined. This is partially due to adopting a more targeted screening model. This also results in a lower spend on laboratory tests.
E/R.6.028	Food for Life : Jointly commission across Cambridgeshire and Peterborough	-25	-	-	-	-	Public Health	The Food for Life programme aims to promote a healthier eating lifestyle and reduce childhood obesity. Currently the Council and Peterborough City Council separately commission this programme. The proposal is to reduce costs by recommissioning jointly with Peterborough City Council the programme which will promote healthy eating and physical activity while targeting areas that are more deprived with higher levels of childhood obesity.
E/R.6.029	Traveller Health Team : Changed ways of working	-5	-	-	-	-	Public Health	Reduce value of contract with Ormiston Trust so that it reflects current level of community worker input, while funding additional input from Traveller Health specialist nurse.
E/R.6.031	Contribution to CCC 0-5 voluntary sector contract no longer required	-98	-	-	-	-	Public Health	The Council's three year contract with Homestart ceased in September 2016 as part of a wider refocussing of preventive services for children aged 0-5. Public Health made a contribution to the overall budget for this contract, which is no longer required.
6.999	**Subtotal Savings**	**-606**	**-**	**-**	**-**	**-**		
	TOTAL GROSS EXPENDITURE	**20,500**	**20,523**	**20,544**	**20,565**	**20,585**		
7	**FEES, CHARGES & RING-FENCED GRANTS**							
E/R.7.001	Previous year's fees, charges & ring-fenced grants	-20,766	-20,360	-310	-310	-310		Fees and charges expected to be received for services provided and Public Health ring-fenced grant from Government.
E/R.7.002	Increase in fees and charges income compared to 2016-17 published business plan	-56	-	-	-	-		Adjustment for permanent changes to income expectation from decisions made in 2016-17.
	Changes to fees & charges							
E/R.7.101	Fess and Charges Inflation	-1	-	-	-	-	Finance & budget review	Income from teaching medical students.
E/R.7.102	Reduction in income	56	-	-	-	-		Reductions in income from Cambridgeshire and Peterborough Clinical Commissioning Group for management of joint Health Intelligence Unit. A reduction in Public Health Consultant sessions of medical student teaching.

Section 4 - E: Public Health

Table 3: Revenue - Overview

Budget Period: 2017-18 to 2021-22

	Detailed Plans	Outline Plans			

Ref	Title	2017-18 £000	2018-19 £000	2019-20 £000	2020-21 £000	2021-22 £000	Transformation Workstream	Description
	Changes to ring-fenced grants							
E/R.7.201	Change in Public Health Grant	407	20,050	-	-	-		Grant reductions announced in the comprehensive spending review, and removal of the ring-fence in 2018-19.
7.999	**Subtotal Fees, Charges & Ring-fenced Grants**	**-20,360**	**-310**	**-310**	**-310**	**-310**		
	TOTAL NET EXPENDITURE	**140**	**20,213**	**20,234**	**20,255**	**20,275**		

FUNDING SOURCES								
8	**FUNDING OF GROSS EXPENDITURE**							
E/R.8.001	Budget Allocation	-140	-20,213	-20,234	-20,255	-20,275		Net spend funded from general grants, business rates and Council Tax.
E/R.8.101	Public Health Grant	-20,050	-	-	-	-		Direct expenditure funded from Public Health grant.
E/R.8.102	Fees & Charges	-310	-310	-310	-310	-310		Income generation (various sources).
8.999	**TOTAL FUNDING OF GROSS EXPENDITURE**	**-20,500**	**-20,523**	**-20,544**	**-20,565**	**-20,585**		

ANNEX B

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Val Thomas.....
Service / Document / Function being assessed		Job Title: Consultant in Public Health .....
Cambridgeshire Community Services contract for Integrated Sexual Health Services		Contact details: val.thomas@cambridgshire.gov.uk .....
		Date completed: 26th September 2016 .....
Business Plan Proposal Number (if relevant)	E/R.6.003	Date approved: 6th December 2016 .....

Aims and Objectives of Service / Document / Function

The Local Authority commissions an Integrated Sexual Health and Contraception Service from Cambridgeshire Community Services. Sexual health clinics offer testing, treatment and contact tracing for people at risk of sexually transmitted infections 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 (2012). The Integrated Service commissioned in 2014 brought together sexual health and contraception services.

It was commissioned to meet the following main objectives.

- 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.
- Address the health inequalities and inequities of service provision between the north and south of the county
- Modernise the service to ensure that it is efficient and cost effective.

What is changing?

There will be reduction in the contract value for 2016/17 and 2017/18.
CCS has been asked to find efficiencies. Initial discussions indicate that these will focus upon the following areas.

- Reviewing and identification of clinics where uptake is low and there are other services locally which are accessible.
- Reviewing of clinic opening times to identify if the out of hours services are fully utilized. Out of hours clinics cost more to operate due to increased staff costs.

There have been changes in the demand for some of the Sexual Health and Contraception clinics across Cambridgeshire.

A review of some of the service locations has resulted in limited changes to some clinics in terms of number and opening hours in 2016/17 to accommodate cost savings.
Further review of the demand for clinics in different locations will inform any changes in 2017/18. This is currently being formulated with Cambridgeshire Community Services.

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

This CIA was completed by Council Officers

What will the impact be?

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

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

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

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

Positive Impact
None
Negative Impact
None
Neutral Impact
The aim will be to ensure that services will meet current demand and that any service efficiencies will be based on an assessment of service demand and what is known about local needs. Priority will be given to realising savings from services in the less deprived areas where residents are more likely to be able to access services in other areas.
Issues or Opportunities that may need to be addressed
If intelligence indicates that sexual health needs are not being met in the more deprived areas then alternative savings would be required. The potential for co-locating services in the new Wisbech Clinic could be considered. Drug and Alcohol Services could be s possible option to co-locate with Sexual Health Services.

Community Cohesion

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

N/A

Version Control

Version no.	Date	Updates / amendments	Author(s)
2	26/09/16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	Officer undertaking the assessment
Public Health	Name: Val Thomas.....
Service / Document / Function being assessed	Job Title: Consultant in Public Health .....
Review exercise referral schemes and potential to joint fund with the NHS	Contact details: val.thomas@cambridgeshire.gov.uk 01223 703264
Business Plan Proposal Number (if relevant) E/R.6.006	Date completed: 5th December 2016 .....
	Date approved: .....

Aims and Objectives of Service / Document / Function

Exercise Referral Schemes

Exercise referral schemes seek to increase someone's physical activity levels on the basis that physical activity has a range of positive health benefits. Currently Public Health provides a grant to Huntingdonshire District Council and to Cambridge City Borough Council that contribute to the exercise referral schemes that they provide through their Leisure Services. Patients are assessed by their local GP and if they do not meet the guidelines for levels of physical activity and have a long term health condition they are able to be referred to their local scheme. There a personal assessment by a physical activity specialist determines what programme of physical activity would best suit their needs.

This approach reflects current evidence found in NICE Guidance for Exercise Referral Schemes.
http://www.nice.org.uk/guidance/ph54/

This Guidance states that referrals should only be made for people who are sedentary or inactive and have existing health conditions (Long Tern Conditions) that put them at risk of ill health. They are should not be adopted as a public health promotion intervention to increase levels of physical activity in the general population

Workplace I Physical Activity Programme
A pilot workplace physical activity programme based on the NICE business case "promoting physical Activity in the Workplace (2008) was delivered for 18 months (commencing September 2014). The importance of workplace wellbeing is becoming increasingly recognised in the UK and locally in the Authority. The "Fit4Life" project aimed to increase staff retention and reduce sickness absence rates for employees based at Scott House, Huntingdon. This was to be accomplished by increasing employee participation in physical activity; providing opportunities to be more active within the workplace whilst raising the profile of other physical activity opportunities.

https://www.**nice**.org.uk/guidance/ph13/.../**business-case**-65652733

What is changing?

Exercise Referral Schemes

The funding of exercise referral schemes has been reviewed and in view of the inequitable funding amongst the districts and that exercise referral is not an intervention that affects population uptake of physical activity it is

proposed to discontinue funding of £48k to the two local district authorities.

In addition in line with the rules of the Public Health Grant all services funded by it are free at the point of delivery but it should be noted that exercise referral is provided by all District Authorities but there is a fee to clients. However Huntingdonshire District Council provides a free service to all those referred by GPs with around 25% of referrals being funded by Public Health. The funding that Public Health gives to Cambridge City enables is to offer a limited number of free exercise referral courses in areas of deprivation.

The proposal is in the context of the Health Committee agreeing funding of £513k over two years for a countywide physical activity programme that will be implemented in all the districts by the local councils. This will be focused on improving population levels of physical activity through new programmes and building pathways between the different services and opportunities for people to be physically active.
In addition Public Health has raised the issue of Exercise Referral schemes with the CCG in view of the number of referrals that GPs make to the schemes across the county so that it might consider at some stage allocating funding to support the schemes.

Workplace Physical Activity Programme

An additional 16k recurrent saving has been identified which has resulted from the end of the workplace physical activity pilot at the County Council premises Scott House. The evaluation and learning from implementing the pilot programme is now mainstreamed as part of a wider Healthy Workplace initiative that is being delivered across the whole organisation. This is in accordance with the recommendations from the NICE (2015). These new guidelines on workplace and management practices to improve the health and wellbeing of employees highlighted the need for leadership and senior management involvement in supporting the health and wellbeing of employees.

https://pathways.nice.org.uk/pathways/workplace-health-policy-and-management-practices
https://www.nice.org.uk/guidance/ph13

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

This CIA was complied by Council officers

What will the impact be?

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

Exercise referral scheme

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

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

Workplace Physical Activity Programme

Impact	Positive	Neutral	Negative

Age	x		

Disability	x		
Gender reassignment		x	
Marriage and civil partnership		x	
Pregnancy and maternity		x	
Race		x	

Religion or belief		x	
Sex		x	
Sexual orientation		x	
The following additional characteristics can be significant in areas of Cambridgeshire.			
Rural isolation	x		
Deprivation	x		

Impact	**Positive**	**Neutral**	**Negative**

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

Positive Impact

Exercise Referral Schemes

None. There are no positive impacts in terms of the exercise referral schemes, however there is the opportunity to develop countywide schemes for physical activity in the whole population that will improve access and reduce inequity of provision.
In the longer term the CCG may provide funding that is more equitable across the county.

Workplace Physical Activity Programme

Workplace Physical Activity Programmes aim to embed physical activity into workplace activities and provide an opportunity to take part in different activities. The Project is now embedded into the Scott House workplace. Those employees who through age, disability, rural isolation and deprivation have less access or opportunities to take part in physical activity have benefitted for this now established Programme.

Negative Impact

Exercise Referral

Public Health funded exercise referral schemes will continue but district councils will charge a fee, which will impact most upon the deprived, those who are more rurally isolated who already have higher travel costs, and the young, older age groups and those with disabilities who are more likely to be impoverished.

Workplace Physical Activity Programme

No negative effects were identified in terms of equity as the workplace initiative is accessible to anyone and takes into consideration those with particular needs.

Neutral Impact

Exercise Referral

The potential introduction of fees will affect all people previously not being charged. However it will not affect gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation in terms of equity.

Workplace Physical Activity Programme

There will a neutral impact on gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation as the physical activity programme does not discriminate in any way that could create inequalities for these groups.

Community Cohesion

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

Exercise Referral – N/A

Workplace Physical Activity Programme – This has helped bring together staff at Scott House on an ongoing basis to take part in shared activities.

Version Control

Version no.	Date	Updates / amendments	Author(s)
V.1	26/09/16		Val Thomas
V2	5/12/16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Dr Raj Lakshman/ Janet Dullaghan .....
Service / Document / Function being assessed		Job Title: Consultant in Public Health Medicine .....
Healthy Child Programme 0-19: Health Visiting (HV), Family Nurse Partnership (FNP), School Nursing (SN)		Contact details: raj.lakshman@cambridgeshire.gov.uk
Business Plan Proposal Number (if relevant)	ER 6-012	Date completed: 8th November 2016 ..... Date approved: 6th December 2016 .....

Aims and Objectives of Service / Document / Function

Public Health is responsible through the Children's Health Joint Commissioning Unit for commissioning the 0- 19 Healthy Child Programme which consists of Health Visiting, Family Nurse Partnership and School Nursing. **School Nursing continues to be commissioned by the Local Authority. Commissioning arrangements of Health Visiting and FNP transferred to the Local Authority in October 2015.**

Health Visiting Service:

- Health Visitors are a workforce of specialist community public health nurses who provide evidenced based advice, support and interventions to families with children under the age of 5. Health visitors lead the delivery of the 0-5 Healthy Child Programme, the evidence-based, preventive, universal-progressive service for children in the early years of life. The work with families is needs led to help empower parents to make decisions that affect their families' future health and wellbeing. Health visitors manage and supervise skill mix teams whilst working in partnership with other partner agencies.
- The universal-progressive service is delivered at 4 levels: Community, Universal (five mandated checks), Universal Plus (single agency involvement), Universal Partnership Plus (multi-agency involvement).
- The six high impact areas for the 0-5 Healthy Child Programme are
  - Transition to parenthood and the early years (0-5)
  - Maternal mental health
  - Breastfeeding (initiation and duration)
  - Healthy weight, healthy nutrition and physical activity
  - Managing minor illness and reducing hospital attendance and admission
  - Health, wellbeing and development of the child age 2 – 2.5 year old review (integrated review) and support to be 'ready for school'.
- The HV service uses a national service specification whereby specific elements of universal service provision are mandated for the first 5 years to ensure that there is universal coverage to a national standard format.
- The five mandated universal checks are:
  - Antenatal visit;
  - New baby review;
  - 6-8 week assessment;
  - 1 year assessment;
  - 2 to 21/2 year review.

  Health visitors assess families' needs at the universal contacts and then work in partnership with the family to provide a package of care and improve outcomes for the child, young person and family.
- Between 2011 and 2015, in line with the 'Government's Call to Action' the Government increased the number of Health Visitors nationally, and almost doubled the number of health visitors in Cambridgeshire.
- In October 2016, the Government's 'Call to Action' ceased and commissioning responsibility transferred from NHS England to the Local Authority. Although HV numbers were no longer protected the status quo was maintained in the service.

Family Nurse Partnership

- The Family Nurse Partnership (FNP) is a national preventive programme for vulnerable, young first-time mothers under 19 years of age.
- It is a structured home visiting parenting programme, delivered by specially trained family nurses, from early pregnancy until the child is two. The family nurse and the young parent(s) commit to an average of 64

planned home visits over two and a half years. The team work in partnership with other health professionals, social care professionals and other agencies to ensure the best possible outcomes for young people, their children and families.

- The FNP was developed in the USA and has over 35 years of extensive research behind it. It requires a license in the UK with fidelity to a specific model. This includes restrictions on when teenagers can be enrolled (before 28 weeks), how long the programme lasts and when visits are scheduled. Challenges of the FNP licensing requirements are that it requires fidelity to the specific FNP model to ensure consistency in its delivery.
- The current FNP programme in Cambridgeshire supports 20% of the teenage population pregnancies. Once caseloads are full this means that some vulnerable teenagers may miss the window of opportunity from this intervention, regardless of need. This also potentially excludes some teenage parents who are leaving care or who are looked after. These limitations mean that some vulnerable teenagers may 'miss the window of opportunity' for help and support from this intervention. These teenage families would then be supported by the universal Healthy Child Programme offer which is less structured.
- In 2016/17 a modelling exercise was carried out by a multi- agency team to look at the impact of reducing/stopping FNP or revising the eligibility criteria to provide FNP to the most vulnerable teenagers.
- The outcome and recommendation of the group was to keep the FNP programme with the following changes:

  - Make it a core part of the HCP pathway for very vulnerable first-time mothers aged 19 years or under who are pregnant and meet at least one of the following 'fixed' criteria or at least four of the 'high risk' criteria.

The fixed criteria are:

- Very young mothers – all first-time pregnant women aged 16 or under
- Currently in the care system as a Looked After Child (LAC), Child in Need (CIN), on Child Protection Plan (CPP) or recent care leavers.

'High-risk' criteria (any four or more of the following risk factors):

- Not living with their own mother or baby's father or partner
- No or low educational qualifications, i.e. no GCSEs or equivalent, low grade GCSEs
- Currently not in education, employment or training (NEET)
- Has mental health problems (need to clarify/define further)
- Ever 'looked after' as a child; or lived apart from parents for more than three months when under the age of 18
- Current smoker (and doesn't plan to give up during pregnancy)
- Living in disadvantaged area
- History/risk of abuse

Note: Some flexibility and judgement will be used in applying the criteria. Early graduation (before 2 years of age) and flexibility of programme delivery are also possible.

Other recommendations:

- Ensure the FNP service is integrated within the HCP service to support HV working with vulnerable teenagers who are pregnant on the partnership plus pathway so that the transition of support is seamless. Participation in the National FNP knowledge exchange will support transfer of knowledge from FNP to the wider HV workforce.
- It is unclear of the number of young parents who will access the family nurse partnership programme therefore it will be essential to closely monitor the data and impact this will have upon the healthy child programme.
- It is essential that the notification pathway from midwifery is robust for ALL teenage women. Each case could be assessed by a multi-disciplinary team including FNP, Midwifery, Health Visitor, Early Help & Social Care to determine the level of support required. This could be FNP, universal, universal plus or partnership plus pathway for this group of vulnerable teenagers.

School Nursing Service

The School Nursing Service is a workforce of specialist public health nurses who work in skill mix teams to provide child-centered evidence based advice, support and interventions to school age children (5-19) and their families. School nurses are qualified nurses who hold an additional specialist public health qualification, which is recordable with the Nursing and Midwifery Council. School nurses are clinically skilled in providing holistic, individualised and population health needs assessment, to provide Tier 1 and Tier 2 health interventions. The service is central to the delivery of the 5-19 Healthy Child Programme aims which are to:

• Help parents develop and sustain a strong bond with children;
• Encourage care that keeps children healthy and safe;

• Protect children from serious disease, through screening and immunisation;
• Reduce childhood obesity by promoting healthy eating and physical activity;
• Identify health issues early, so support can be provided in a timely manner;
• Make sure children are prepared for and supported in education settings;
• Identify and help children, young people and families with problems that might affect their chances later in life.

What is changing?

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

Health Visiting and FNP

The total budget in 2015/16 was **£7,593,199**. With the £340K reduction (£190K in 16/17 and £150K in 17/18), the contract value in 017/18 would be **£7,253,199** (4.5% reduction). This CIA describes the overall changes in service between 2015/16 and 2017/18, as the savings are being made in an integrated way over the two years.

In order to make the £340K savings:

- The service have used a strategic, evidenced based workforce model to analyse the clinical workload with workforce requirements based on the needs of the population within Cambridgeshire. The model showed that only 43% of time is available to deliver the universal offer, 16% is available for Universal Plus and a disproportionately high 41% time is required to deliver Partnership Plus. The model also identified capacity tensions in areas and plans are in progress to ensure that each offer is delivered by the right skill set of staff. A reduction in numbers within the Healthy Child Programme workforce to meet budget requirements uses this model while aiming for minimal impact.
- Internal service efficiencies have been identified to increase the percentage of face-to-face time with children, young people and families. A number of proposals are under consideration and are in their initial stages of discussion. For example attendance at child protection and child in need conferences could cease where a child has no health need (to be discussed with CFA); A&E notifications could no longer be processed and this instead could go, for instance, through the Child Health Information System (CHIS); Follow-up appointments and clinics will be rationalised.
- Redesign of the FNP service- targeted to the most vulnerable teenagers and consideration of a single service across Cambridgeshire & Peterborough if procurement rules allow. A Band 7 FNP has been removed from the establishment following the FNP review
- Working in a more integrated way with other Council Services e.g. Children's Centres and Together for Families Programme

School Nursing

The current budget is **£1,446,540** and an additional 60K investment is proposed, taking the contract value to **£1,446,600** (4.1% increase).

The 60K additional investment is for

- Extension of the universal school nursing service to special schools: Additional funding for 1.5 wte school nurses to provide the 'universal offer' for the 6 special schools which currently do not receive this service.

Other service changes proposed are

- Medicines Management training: the school nursing service provides training for schools regarding management of 4 chronic/acute conditions (epilepsy, anaphylaxis, asthma, diabetes). Although ensuring staff are trained is the responsibility of the schools, how well the schools are trained has a knock on effect on the wider health system. The school nursing service currently provide this training face-to-face in individual schools and propose to change to a model of online training to enable an increased improved offer to schools. The final decision as to implementation of this new model and the nature of its roll out will be taken in consultation with stakeholders, particularly head teachers of both primary and secondary schools. Introduction of a texting service for secondary school age pupils (Chat health): the pilot in Fenland has evaluated that the school nursing service is more responsive and accessible to young people. All appointments in school will be by 'Chat health' referral reducing missed appointments and triaging according to need. 'Chat health' could be made available to children not in the school system (home schooled) and possibly to parents of children in primary schools. Service improvements are a continual process and the service is working to enhance its primary school offer and ensure consistency and equity.

Other relevant factors:

- In 2015, the service changed from separate Health Visiting and School Nursing services to the Healthy Child Programme; aiming for equitable and appropriate provision of services across the 0 – 19 age range.
- The impact of the transformation of Children's services in the Council and the NHS (including transformation of mental health services) will be kept under review.

Who is involved in this impact assessment? E.g. Council officers, partners, service users and community representatives.
Cambridgeshire County Council, Peterborough City Council and Cambridgeshire & Peterborough CCG through the Joint Commissioning Unit and Cambridgeshire Community Services NHS Trust (current service provider).

What will the impact be?

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

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

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

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

Positive Impact

A new Universal Offer to 6 Special Schools in Cambridgeshire

There will be an introduction of digital technology in some areas of the service, i.e. Chat Health. This will improve the accessibility of the service for a greater number of young people

An enhanced, equitable and consistent offer to primary schools

Closer working relationships with Children Centres, Localities and Emotional Health & Wellbeing (Early Help) will enhance synergy and maximise resource usage

Negative Impact

There will be a reduction in the Healthy Child Programme (HCP) workforce as a result of the reduced budget, therefore services will be reduced accordingly as described in 'what is changing' above

Health visiting students are scheduled to no longer receive a salary from Health Education England from 2017/18. This drop in income will need to be considered when delivering services

Neutral Impact

The status quo will be maintained across some of the service

Issues or Opportunities that may need to be addressed
Sharing good practice including training will enhance the interface between FNP and HCP and the offer to families. The National FNP knowledge exchange available to the wider HCP. Service improvement / redesign opportunities will be taken.

Community Cohesion

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

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

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	20.09.16	First Draft	Raj Lakshman
2	14.10.16	Second Draft	Fleur Seekin & Raj Lakshman
3	08.11.16	Third Draft	Raj Lakshman & Nicola McLean

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health	Name: Val Thomas.....
Service / Document / Function being assessed	Job Title: Consultant in Public Health .....
The proposal to transfer the in house core Stop Smoking Services (CAMQUIT) to an external provider.	Contact details: val.thomas@cambridgeshire.gov.uk Date completed: 28 November 2016 ..... Date approved: 6th December 2016 .....
Business Plan Proposal Number (if relevant) **6.019**	

Aims and Objectives of Service / Document / Function

Camquit is Cambridgeshire County Council's (CCC) local evidence based core Stop Smoking Service that supports smokers to quit. This means that smokers are offered behavioural therapy (which may be either individual or group counselling) which involves scheduled face-to-face meetings between the smoker and a practitioner from the Stop Smoking Services trained in smoking cessation. A quit date is set initially and typically, this is followed by weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with NRT/drug therapy. The Camquit Service is delivered through a number of different providers.

The core team is an in- house provider and is part of the Public Health Provider Team. It includes smoking cessation specialists and data staff support staff. It is responsible for the overall co-ordination of the Service. The staff provide support to smokers wanting to quit, delivering specialist services such as the smoking in pregnancy and young person's programmes, service marketing, targeted project work, managing data processing, analysis and reporting. It also provides support to other providers through delivering training in line with national guidance and practice visits if required.

In addition Cambridgeshire County Council (CCC) also has contracts with all 77 GP practices within Cambridgeshire to deliver stop smoking support to smokers registered with their practice. The GP based services are delivered by practice staff such as the practice nurse or healthcare assistant. As demands on practices have increased there are a growing number of practices that have chosen to have Camquit advisors to deliver their services.

Community pharmacies are also contracted to deliver stop smoking cessation, but the number has been declining steadily in recent years. They do not have any quitter targets. They also receive training and support from the Camquit core Team.

What is changing?
The delivery and provision of Stop Smoking Services have been evolving nationally but also locally. This is in response to an increased focus upon commissioning within Public Health and also more widely within Cambridgeshire County Council. Secondly there has been the development generally of lifestyle services across the country and these usually include stop smoking services. In the context of these changes this paper proposes that the core Stop Smoking Service is commissioned from an external provider with the aim of it becoming part of an integrated lifestyle service which provides a number of advantages. The externally commissioned stop smoking service would be responsible for providing the full range of functions, indicated above, that the core service currently provides. This would include providing support to GP and community pharmacies for them to deliver services. It will be specified to provide the same service that is currently provided. There will be cost saving of circa £50k. Currently the core Stop Smoking Service has a senior co-ordinator role which has overall responsibility for managing the Service but also plays a key role in the commissioning of the other stop smoking providers. It is proposed that this post is not transferred and that its functions are absorbed into the management function of new provider organisation. However the deputy co-ordinator would not be transferred and this post currently plays a large part in the co-ordination of the service and daily operational aspects of delivery. However the contracts with the GPs and community pharmacists would continue to be commissioned and performance managed by CCC. The current core Stop Smoking Service function of managing the data and payments for the GP and community pharmacy contracts would remain within Public Health.
Who is involved in this impact assessment? E.g. Council officers, partners, service users and community representatives.
This CIA was compiled by Council officers

What will the impact be?

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

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

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

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

Positive Impact
None identified
Negative Impact
None identified

Neutral Impact
There should not be any impact in equalities as there is no planned change in service delivery. Services are open to all members of the community. However the current service has a focus upon communities where there are high rates of smoking and consequent health inequalities. There is the possibility over time to use commissioning levers to enhance this focus on health inequalities.
Issues or Opportunities that may need to be addressed
The new Service will require careful monitoring to ensure that its performance does not fall during the transfer and the initial change period when it will be establishing itself as part of another organisation. Over the longer term if the Service is established in an integrated lifestyle service this will provide the opportunity to use other staff such as health trainers to support the delivery of Stop Smoking Services.

Community Cohesion

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

Stop Smoking Services do provide some of their services in community venues and sometimes peer support groups form amongst smokers who have quit with the help of the service. These groups support each other to remain quit.

Version Control

Version no.	Date	Updates / amendments	Author(s)
V.1	28/11/16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health Directorate, also involving CFA Enhanced and Preventative Services Directorate	Name: Liz Robin Job Title: Director of Public Health Contact details: liz.robin@cambridgeshire.gov.uk
Service / Document / Function being assessed	
Creation of a Joint Public Health Commissioning Unit across Cambridgeshire County Council and Peterborough City Council	
Business Plan Proposal Number (if relevant) E/R.6.021	

Aims and Objectives of Service / Document / Function

The Public health commissioning function commissions sexual health and contraception services, drug and alcohol misuse services, smoking cessation services, integrated lifestyle services, health checks and other relevant public health services from external providers, with the objectives of meeting the needs of Cambridgeshire residents, improving population health, reducing health inequalities and achieving best value from available resources.

In addition the Local Authorities in Peterborough and Cambridgeshire fund leadership functions which drive the development and delivery of key strategic plans in relation to, for example, Domestic Abuse.

What is changing?

Currently, public health commissioning in Cambridgeshire County Council (CCC) and Peterborough City Council (PCC) is carried out by different public health commissioning teams in the two Councils, although the 'subject matter expert' public health staff advising and supporting commissioners are now working jointly across CCC and PCC.

Within Children Families and Adults Services (CCC), commissioning functions are currently dispersed across the Directorates. A separate consultation will consider the wider opportunities to bring these functions together. As part of these current arrangements, the Safer Communities Team within CFA leads on a wide range of Community Safety functions, including the commissioning of drug and alcohol misuse and some domestic abuse services. . In PCC drug and alcohol commissioning is integrated within the wider public health commissioning team.

This proposal is to create a joint public health commissioning unit across Cambridgeshire County Council and Peterborough City Council, learning from the existing Joint Children's Health Commissioning Unit. The new joint public health commissioning unit would combine the functions of CCC public health commissioning, CCC drug and alcohol commissioning and PCC public health commissioning, potentially including the commissioning of domestic abuse services.

Wider functions within Cambridgeshire currently undertaken by the Safer Communities Team, will be considered in parallel as part of the wider work to look at the Community and Safety functions across Cambridgeshire and Peterborough going forward.

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

This CIA was compiled by CCC council officers.

What will the impact be?

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

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

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

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

Positive Impact
Negative Impact
Neutral Impact
The proposal only affects commissioning functions of the two Councils, therefore should not directly impact on front line service delivery and communities.
Issues or Opportunities that may need to be addressed
The development and alignment of commissioning functions set out in this CIA needs to be considered in the wider strategic context of the two Local Authorities, and Community and Safety functions going forward. The wider strategic partnership for both domestic abuse and drug and alcohol services needs to be considered and involved as part of these arrangements. In this context, the current work of the Safer Communities Team (CFA) will need to be carefully reviewed to ensure that any non-commissioning functions which the team delivers continue to be appropriately delivered.

Community Cohesion

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

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Val Thomas Job Title: Consultant in Public Health Contact details: val.thomas@cambridgeshire.gov.uk ... Date completed: 23 September 2016 Date approved: 6th December 2016 .....
Service / Document / Function being assessed		
Smoking Cessation		
Business Plan Proposal Number (if relevant)	E/R 6.025	

Aims and Objectives of Service / Document / Function

The County Council commissions 'level 2' smoking cessation services from GP practices and pharmacies. These services support people who wish to stop smoking and provide a combination of medication such as nicotine replacement therapy (NRT) on prescription, and evidence based one to one or group support for behaviour change. People are four times more likely to succeed in quitting when they use this service than if they try to quit without support or medication. When people succeed in stopping smoking is results in significant improvement to their health and in overall savings to the NHS due to their reduced risk of heart and circulatory disease, lung disease and cancers. It is important that smoking cessation services are easily accessible for people to use, so in Cambridgeshire we have tried to ensure that every GP practice offers a smoking cessation service – either through their own staff, for which payment is made, or through County Council CAMQUIT staff going into the GP practice to deliver clinics.

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

The demand for smoking cessation services in GP practices and pharmacies has reduced over the past few years. There has been a fall in the overall percentage of adults who smoke in the county and increased usage of electronic cigarettes. Because GPs and pharmacies are paid per person receiving the service, the spend on these services has therefore reduced. Fewer people vising the service also means lower medication costs. Due to other pressures, an increased number of GP practices have asked CAMQUIT staff to come in and provide an on-site clinic, which means they are no longer paid. These factors mean that the predicted spend against budgets for smoking cessation services and GP practices have reduced. The saving is therefore made against a predicted reduction in demand on the smoking cessation budget, but smoking cessation services will continue to be easily accessible around the County.

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

This CIA was compiled by Council officers

What will the impact be?

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

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

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

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

Positive Impact
None
Negative Impact
None
Neutral Impact
Because this saving is based on observed demand being lower than allowed for, and local residents are still able to attend smoking cessation services it should not impact on equalities groups. The scale of the saving is such that funding should still be available to promote smoking cessation services in areas of higher deprivation which also have higher smoking rates, and to pilot a harm reduction model for smokers who wish to quit more gradually, in accordance with NICE guidance.
Issues or Opportunities that may need to be addressed
Because this saving relies on a forecast reduction in demand, if demand rises unexpectedly then in-year savings may need to be found from alternative sources.

Community Cohesion

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

N/A

Version Control

Version no.	Date	Updates / amendments	Author(s)
V1	22 09 16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Public Health		Name: Val Thomas..... Job Title: Consultant in Public Health ..... Contact details: val.thomas@cambridgeshire.gov.uk ... Date completed: 22 09 16 ..... Date approved: .....
Service / Document / Function being assessed		
Laboratory testing for the Chlamydia Screening programme		
Business Plan Proposal Number (if relevant)	**6.026**	

Aims and Objectives of Service / Document / Function

Chlamydia Screening Programme

The Chlamydia Screening Programme is a national programme that offers opportunistic chlamydia testing for the sexually active under 25year olds. Chlamydia is the most common bacterial sexually transmitted infection, with sexually active young people at highest risk. Chlamydia often has no symptoms and can have serious health consequences.

1. Preventing and control chlamydia through early detection and treatment of infection;
2. Reduce onward transmission to sexual partners;
3. Prevent the consequences of untreated infection;
4. Ensure all sexually active under 25 year olds are informed about chlamydia, and have access to sexual health services that can reduce risk of infection or transmission;

Locally Public Health commissions chlamydia screening mainly from Cambridgeshire Community Services (CCS) through its countywide Integrated Sexual Health Service. CCS sub-contracts with the Terence Higgins Trust to provide outreach screening with high risk groups that have high prevalence of chlamydia infection.

Screening is also commissioned from GPs. These screens are sent to the Public Health England laboratories at Cambridge University Hospitals Foundation Trust for analysis.

An online screening programme is commissioned from Source Bioscience that enables young people to order a screening kit online and to return the completed screening pack to Source Bioscience for analysis.

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

There has been a decrease in the number of screens analysed at the Public Health England (PHE) and Source Bioscience laboratories. This is a consequence of the following.

- Although it is difficult to confirm prevalence of chlamydia infection it is likely that it is low in Cambridgeshire given the overall general sexual health of the population which compares favourably to other areas. Consequently the programme has in recent years adopted the strategic approach of targeting population groups that have a high risk of testing positive. This means the actual numbers of screens have declined but the detection of positive screens has increased.

- An online Service has been commissioned the company, Source Bio-Science to send out kits to young people that have requested them online and to analyse their returned samples. There has been decline in demand for the online service over the past two years.

- GP practices are commissioned to provide chlamydia screening and have in recent years adopted a more targeted approach which has led to decrease in overall screens but an increase in the detection of positive screens. GP screens are analysed at the PHE laboratories

- Cambridgeshire Community Services (CCS) as part of the Integrated Sexual Health Service has sub-contracted with the Terence Higgins Trust to provide outreach chlamydia screening to high risk populations. This started when the new Service was launched in September 2014. The laboratory costs are absorbed into the block contract with CCS.

The decrease in predicted demand is based on the 2015/16 outturn. It is reflected in the underspend on the allocated funding to the PHE laboratories and the Source Bio Science services for 2015/16. Activity to date (September 2016) confirms that the fall in activity has been sustained.
Therefore a consultation is not proposed as the savings have been created by fall in demand.

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

This CIA was completed by Council officers

What will the impact be?

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

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

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

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

Positive Impact

The positive impact of the ongoing changes to the Chlamydia Screening Programme is that it targets those groups most at risk either through age, deprivation, disability or rural isolation.

Negative Impact

None identified. The identification and treatment of chlamydia is associated with the avoidance of gynaecological complications.

Neutral Impact

The likelihood of a low chlamydia prevalence and the changes to the Chlamydia Screening programme that have already been introduced have not had any observed impact on those groups indicated above in this category.

Issues or Opportunities that may need to be addressed
There is the opportunity to further review the strategic approach of the Chlamydia Screening Programme to ensure that the most cost-effective approaches are being used and that the service reflects need.

Community Cohesion

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

N/A

Version Control

Version no.	Date	Updates / amendments	Author(s)
V1	22.09/16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	**Officer undertaking the assessment**
Public Health	Name: Val Thomas.....
Service / Document / Function being assessed	Job Title: Consultant in Public Health .....
Joint Commission Food for Life Programme across Cambridgeshire County Council(CCC) and Peterborough County Council (PCC)	Contact details: val.thomas@cambridgeshire.gov.uk ...
	Date completed: 22 09 16 .....
Business Plan Proposal Number (if relevant) 6.028	Date approved: 6th December 2016 .....

Aims and Objectives of Service / Document / Function

The aim of the Food for Life Programme is to promote a healthy eating lifestyle and contribute to reduction in childhood obesity.

Currently both CCC and PCC commission separately Food For Life to deliver a programme in schools. The Food for Life Programme is part of the Soil Association and works with schools helping them build knowledge and skills through a 'whole setting approach'. This engages children and parents, staff, patients and visitors, caterers, carers and the wider community to adopt a healthier eating lifestyle. It has been operational in Cambridgeshire for four years, focusing upon schools in more deprived areas where there are higher rates of childhood obesity. Over 1 in 4 children in Year 6 are either obese or overweight; this increases in the more deprived areas of the county.

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

The proposal is to procure new schools based Programme that will promote healthy eating and also physical activity. This will be through a joint procurement with PCC. Any Programme commissioned will focus upon areas that are more deprived with higher levels of childhood obesity.

The Programme will be implemented across the two local authorities through the employment of one co-ordinator which will create savings through reducing duplication and facilitating the sharing of resources, for example shared events. Currently the Programme has a strong focus in Fenland and other more deprived areas. This will remain unchanged; however innovative approaches that are cost-effective and enable the Programme to be rolled out more widely will be sought through the procurement.

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

This CIA was compiled by CCC officers.

What will the impact be?

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

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

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

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

Positive Impact
The programme will target schools in areas of deprivation, rurally isolated areas and where there is high level of disability amongst students.
Negative Impact
None
Neutral Impact
There would a neutral impact on a number of the groups, indicated above. As the focus on the Programme and its activities will not change in any way that would affect the equality of any of these groups.
Issues or Opportunities that may need to be addressed
It might prove difficult for Programme to be managed effectively across CCC and PCC with one coordinator. The demand from more schools for the Programme could exceed its capacity to provide support. This could be addressed through additional funding or the development of model where schools contribute to the funding of the Programme, as is the case in other areas.

Community Cohesion

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

The Programme can contribute to building closer links between families, communities and schools

Version Control

Version no.	Date	Updates / amendments	Author(s)
V1	22 09 16		Val Thomas

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area	Officer undertaking the assessment
Public Health / Gypsy & Traveller Health Team	Name: Kate Parker Job Title: Head of Public Health Programmes Contact details: Kate.Parker@cambridgeshire.gov.uk Date completed: 15th October 2016 Date approved: 6th December 2016
Service / Document / Function being assessed	
2017/18 Public Health Programmes Savings: Review of	
Business Plan Proposal Number (if relevant) E/R.6.029	

Aims and Objectives of Service / Document / Function

Project Aim

The project aim is to improve the health and well-being of Gypsies and Travellers in Cambridgeshire, thereby decreasing health inequalities by providing a dedicated team of health and community development staff.

Findings show that life expectancy within Gypsy and Travellers communities is likely to be 10-12years shorter than the rest of the population.

Background

The Gypsy & Traveller Health Team were established in 2008/9. To build on the existing work Ormiston Children & Families Trust had developed around the Gypsy & Traveller communities a Memorandum of Understanding (MOU) was set up between Ormiston Children & Families Trust and Public Health Team (previously based in Cambridgeshire Primary Care Trust). The MOU set out that the Ormiston Trust would provide set up links to the communities as well as funding admin support and a senior worker.

In 2016/17 additional funding was released from the team which included a 10k reduction from the public health programmes budget set aside as non-pay to support the team in providing small scale project support work particularly around literacy training. It was determined that reducing non-pay by 10k would have a minimum impact on the team as the current literacy tutoring work is being provided through the access to grants from the Community Adult learning fund. In addition further savings were found last year through the removal of the Public Health Specialist Nurse post who had responsibility for management of the Gypsy & Traveller Health Team. These management responsibilities were integrated into the Gypsy & Traveller Senior Lead Nurse's role.

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

Service Provision
Since 2009 the Gypsy & Traveller Health team has developed and now has excellent partnership links and established sound relationships with the Gypsy & Traveller community. The Gypsy & Traveller Health Team as a service has evolved. As the Senior Gypsy & Traveller Nurse has taken on more work the emphasis with this community is supporting those with long standing health needs in line with the original objectives of the programme. The Gypsy & Traveller Community Development worker now works more in a support role for adults who are chronically ill (both mentally and physically). This work involve supporting clients with attending medical appointments and complying with treatment plans under the supervision of the lead nurse. The community development worker has developed knowledge and experience of the wider health system and is able to support individuals with housing issues, debt management and benefit applications. The team as a whole works towards supporting clients to access mainstream support where possible e.g. floating support services. More recently the team has experience increasing demand for mental health support for the community.

Proposed changes
Public Health currently fund a Senior Practitioner post that is employed directly by Ormiston Children & Family Trust. The current funding arrangement has been reviewed and a reduction in funding for his post has been agreed releasing £12,800 savings to reinvest. Ormiston Trust have agreed to make up the shortfall.

The current funding of 32,880k to Ormiston Trust has primarily been focused on providing advocacy support work to the Gypsy and Traveller Community e.g. supporting with benefit appeals and housing issues. The reduction in funding allows the team to make savings and to look at reinvestment into developing more sustainable partnerships with statutory services & mainstream voluntary services. This will also allow the team to look at developing further support and partnership working around the provisional of mental health support systems for this community.

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

The CIA was compiled by Council Officers

What will the impact be?

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

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

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

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

Positive Impact

Negative Impact

Neutral Impact
The Gypsy & Traveller communities are the largest ethnic minority in the county. The savings noted above will not result in any service changes to the current provision for this community however the reinvestment may result in longer term opportunities identified in the section below.
Issues or Opportunities that may need to be addressed
It is expected that in the long term the changes will enable reinvestment into the service to develop a more sustainable programme that is through partnership working will be more responsive to the emerging health needs of the population e.g. increase focus on mental health support.

Community Cohesion

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

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	15-10-16		Kate Parker
2	11-11-16		Kate Parker

COMMUNITY IMPACT ASSESSMENT

Directorate / Service Area		**Officer undertaking the assessment**
Strategy and Commissioning		Name: Helen Andrews.....
Service / Document / Function being assessed		
Home and Community Support Service contract delivered by Home Start Cambridgeshire		Job Title: VCS Market manager .....
Business Plan Proposal Number (if relevant)	ER 6.031	Contact details: Helen.andrews@cambridgeshire.gov.uk .....

Aims and Objectives of Service / Document / Function

Home Start Cambridgeshire provides home visiting, peer support and practical assistance to families with children under the age of 5 years old with additional needs and experiencing parenting problems across Cambridgeshire. In addition to this service, the contractor also provides some volunteer-led activities at Children's Centres and/or community settings

What is changing?

The Home and Community Support Service contract awarded to Homestart was for 3 years, with an end date of 31st March 2016. The value of the contract is £266,194.00 per annum. This had been jointly funded by Cambridgeshire County Council with NHS England who contributed £98,448. At the point that the contract for delivery of Health Visiting transferred from NHS England to Public Health, within the Local Authority in 2015, responsibility for this element of the contract also transferred to Public Health.

Discussions have been underway for the last year of the contract with Homestart, highlighting that it was scheduled to end as no further extensions or exemptions were technically possible. Taking this into account Homestart were given a 6 month extension in order for them to apply for other sources of funding in order to continue the service.

All work with families has been joint working with in the main the LA. Over the remaining year of the contract this activity was scaled back to ensure families were receiving support from the partner agency if required in the long term.

Homestart have also been successful in being awarded grants from a number of organisations including Child in Need and Comic Relief which whilst not meeting the total amount of the contract has ensured they are sustainable and continuing to provide services

Who is involved in this impact assessment? e.g. Council officers, partners, service users and community representatives.
Council officers, referrers to Home Start. A Smart Survey was opened to general public. Service users, parents and referrers to Home Start Cambridgeshire services were also invited to do the survey and make comments.

What will the impact be?

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

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

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

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

Positive Impact
.
Negative Impact
A survey of parents using the Homestart services when asked about the future and what would happen if Home Start ended said they would access support from Children's Centres (14%), preschool provision (9%), church based activities (8%) and most significantly web based information There is an opportunity here to ensure parents receive the right information and advice, signposting and direction to local networks and activities, and it is critical to build this into the Council's Transformational work The population is increasingly active online, and whilst this requires challenge for those providing services to adapt, it presents a significant opportunity to explore alternative and more efficient approaches to deliver services

Rural isolation and deprivation was the area of most concern to responders to the survey. This is an important issue that the whole Council must address. Home start continues to have funding which has ensured its sustainability and the links with key charitable organisations support their work in tackling deprivation and reducing rural isolation.

Neutral Impact

Whilst Homestart is no longer funded by the County Council it has ensured it is funded through alternative means – Comic Relief and Children in Need being two charitable organisation supporting them. This has meant that activity around Group Work and Peri-natal mental health continues and Home Start also continues to play a key role for families and communities.

Community Cohesion

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

Version Control

Version no.	Date	Updates / amendments	Author(s)
1	29 sept 2016	CIA created	Helen Andrews and Jo Sollars
2	23rd November 2016	Home Start Cambridgeshire report they have successfully secured the following grants for the next 2 years: Evelyn Trust, Children in Need and Comic Relief. Home Start Cambridgeshire is awaiting news on their application to the Big Lottery Fund.	Helen Andrews

ANNEX C: OVERVIEW OF PUBLIC HEALTH SAVINGS PROPOSALS FOR 2017/18 AND SAVINGS IN 2016/17

Savings against public health grant managed by public health directorate

Service Category	Ref no	Title of savings proposal	Description
Sexual health and contraception	E/R.6.003	CCS contract for integrated contraception and sexual health services Saving £50k	Continued move to a more demand led model which means that although there will be a small reduction in clinic sessions the service will be even more targeted where there is most need. Specific proposals that reflect this approach are being discussed with Cambridgeshire Community Services.
	E/R.6.026	Chlamydia Screening : Online Testing and reduction in lab costs Saving £50k	Demand for the online chlamydia screening service has declined. This is partially due to adopting a more targeted screening model. This also results in a lower spend on laboratory tests.
Total sexual health and contraception		**Total budget April 2015: £5692k** **Total saving 2016/17: £280k** **Total saving 2017/18: £100k** **% saving: 6.7%**	
Smoking cessation and tobacco control	E/R.6.025	Smoking Cessation : Track 2016/17 spend on NRT and GP Payments Saving TBC	In 2015/16 smoking cessation targets were achieved while the budget for Nicotine Replacement Therapy and payments to GP surgeries for these services was underspent. Therefore, further work was carried out to forecast exactly how much could be saved going forward while still meeting these targets.
Total smoking cessation and tobacco control		**Total budget April 2015: £1253k** **Total saving 2016/17: £220k** **Total saving 2017/18: £110k** **% saving to 2017/18: 26.3%**	

Service Category	Ref no	Title of savings proposal	Description
General prevention obesity, health checks, falls prevention	E/R.6.006	Review physical activity schemes Saving £71k	As part of the Public Health drive to promote and increase physical activity to benefit everyone across the County the service is reducing the investment in the the current exercise referral schemes. This current scheme sees some parts of the County and communities losing out. Public Health has invested in a more equitable physical activity scheme across the whole County and Districts. Savings have also been identified due to the ending of a workplace physical activity pilot (CCC Scott House) from which the learning has been mainstreamed, and identification of other physical activity project budget not currently allocated.
	E/R.6.029	Traveller health team Saving £5k	Change to funding of the Traveller Health Team, with a reduction in funding to the Ormiston Trust, to reflect the current hours worked by their staff member, and a small increase in Traveller Health specialist nurse time.
	E/R.6.028	Food for Life : Jointly commission across Cambridgeshire and Peterborough [EI] Saving £25k	The Food for Life programme aims to promote a healthier eating lifestyle and reduce childhood obesity. Currently the Council and Peterborough City Council separately commission this programme. The proposal is to reduce costs by recommissioning jointly with Peterborough City Council the programme which will promote healthy eating and physical activity while targeting areas that are more deprived with higher levels of childhood obesity.
Total general prevention, obesity, diet and physical activity, health checks , falls prevention		**Total budget April 2015: £2465k** **Total saving 2016/17: £125k** **Total saving 2017/18: £101k** **% saving: 9.3%**	
Total public mental health:		**Total budget April 2015 £224k** **Total saving 2016/17 £60k** **No 2017/18 saving** **% saving 27%**	**Note: 2016/17 savings were reductions in planned investment, not reductions in existing programmes.**

Service Category		Title of savings proposal	Description
Health protection and emergency planning non-pay budgets:		Health protection and Emergency planning non-pay budgets **Total budget April 2015 £16k** **Total saving 2016/17 £10k** **No 2017/18 saving** **% saving 63%**	
Total PH directorate staffing budget including income generation	E/R.6.019	Public health programmes team restructure/vacancy Management	Explore the potential for closer working across smoking cessation and other healthy lifestyle services without a reduction in service.
	E/R.6.021	Public health commissioning - explore joint work with other organisations	Explore the potential of creating a joint Public Health commissioning unit with Peterborough City Council. In order to drive best value across both areas.
Total public health directorate staffing budget including income generation		**Total budget April 2015: £2567k** **Total saving 2016/17: £524k** **Total saving 2017/18: £75k** (may include cross directorate saving) **% saving 23.2%**	
Children's 0-19 public health services	E/R.6.012	Health visiting and family nurse partnership Saving £90k	Reducing the cost of the contract for age 0-5 public health services with Cambridgeshire Community Services. Review of skill mix and ways of working for health visitors leading to some changes described more comprehensively in the CIA (Annex B). The overall saving is combined with some Investment in public health school nursing in special schools. Existing staff will also be working in a more integrated way with other services, such as Children's Centres.
	E/R.6.031	Contribution to CCC 0-5 voluntary sector contract no longer required Saving £98k	The Council's three year contract to support Homestart services ceased in September 2016 as part of a wider refocussing of preventive services for children aged 0-5. Public Health made a contribution to the overall budget for this contract, which is no longer required.
Total budget for children and young people's age 0-19 public health		**Total budget April 2015* £9527k** **2016/17 saving £190k** **2017/18 saving ££188k** **% saving 4.0%** *Indicative as function was transferred in October 2015	
In addition £170k of savings were avoided through allocation of core Council funding to PH services.			

Savings against public health grant managed in other directorates through Public Health Memorandum of Understanding (PHMOU)

Directorate	Title of savings proposal	Description
CFA drug & alcohol services	Reduction in contract value drug and alcohol misuse services contract Saving £100k	The NHS trust 'Inclusion' provides countywide specialist drug & alcohol treatment services. Currently there are separate treatment contracts for alcohol and drugs. In order to deliver savings, Inclusion have agreed to commence full service integration in 2016/17. This will require fewer service leads employed in management grades and reduces the overall management on-costs in the existing contract agreement. It is also proposed to reduce Saturday clinics and/or move to a volunteer/service user led model for these clinics
Total drug and alcohol services	**Total budget April 2015 £6269k** **Total savings 2016/17: £289k** **Total savings 2017/18: £100k** **% saving 6.2%**	
Total PHMOU services except drug and alcohol services across directorates	**Total budget April 2015 1567k** **Total saving 2016/17 £207k** **No saving in 2017/18** **% saving 13%** **In addition, £314.5k of PHMOU savings have been avoided by service funding being transferred back to core Council funding.**	

Agenda Item No: 6

PROPOSAL TO TRANSFER THE IN HOUSE STOP SMOKING SERVICES TO AN EXTERNAL PROVIDER

To:	**Health Committee**
Meeting Date:	**15th December 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	*Key decision:* *No*
Purpose:	**The purpose of this paper is to present and secure Health Committee approval and support for the proposal to transfer the in house Stop Smoking Services to an external provider.**
Recommendation:	**That the Health Committee supports and approves the following key elements found in the proposal.** • **To contract with an external provider the in house core Stop Smoking Service that is currently part of the Public Health Directorate** • **To integrate the Stop Smoking Services into lifestyle services.** • **To support the procurement approach of transferring the Stop Smoking Services to Everyone Health, the integrated lifestyle service provider currently commissioned by Cambridgeshire County Council.**

Officer contact:	
Name:	Val Thomas
Post:	Consultant in Public Health
Email:	Val.thomas@cambridgeshire.gov.uk
Tel:	01223 703264

1. BACKGROUND

1.1 Camquit is Cambridgeshire County Council's (CCC) local evidence based Stop Smoking Service. This means that smokers are offered behavioural therapy (which may be either individual or group counselling) which involves scheduled face-to-face meetings between the smoker and a practitioner from the Stop Smoking Services trained in smoking cessation. A quit date is set initially and typically, this is followed by weekly sessions over a period of at least 4 weeks after the quit date and is normally combined with NRT/drug therapy. The Camquit Service is delivered through a number of different providers.

1.2 The core team is an in house provider and is part of the Public Health Provider Team. The core team includes smoking cessation specialists and data staff support staff. It is responsible for the overall co-ordination of the Service. The staff provide support to smokers wanting to quit, and deliver specialist services such as the smoking in pregnancy and young person's programmes, service marketing, targeted project work, managing data processing, analysis and reporting. The core team also provides support to other providers through delivering training in line with national guidance and practice visits if required.

1.3 Cambridgeshire County Council (CCC) also has contracts with all 77 GP practices within Cambridgeshire to deliver stop smoking support to smokers registered with their practice. The GP based services are delivered by practice staff such as the practice nurse or healthcare assistant. As demands on practices have increased there are a growing number of practices that have chosen to have Camquit advisors to deliver their services. Each practice has an annual target number of smoking quitters based on the number of smokers they have registered within the practice and the local district's smoking prevalence. Community pharmacies are also contracted to deliver stop smoking cessation, but the number has been declining steadily in recent years. They do not have any quitter targets.

1.4 Nationally local authorities have increasingly moved away from the model where their stop smoking services are part of their in house public health teams. More recently stop smoking services have been widely commissioned as part of integrated lifestyle services which is currently the most popular model for lifestyle and behaviour change service delivery. This integration has not been associated with any falls in performance.

2. MAIN ISSUES

2.1 The delivery and provision of Stop Smoking Services have been evolving locally and nationally. This is in response to an increased focus upon commissioning within Public Health and also more widely within Cambridgeshire County Council. Secondly there has been the development generally of lifestyle services across the country which usually includes core stop smoking services.

2.2 In the context of these changes this paper proposes that the core Stop Smoking Service is commissioned from an external provider with the aim of it becoming part of an integrated lifestyle service, which provides a number of advantages. The externally commissioned stop smoking service would be responsible for providing the full range of functions, indicated above, that the core service currently provides. This would include providing support to GP and community pharmacies for them to deliver services.

2.3 However the contracts with the GPs and community pharmacists would continue to be commissioned and performance managed by CCC. Stop smoking services are one of five public health services commissioned from GPs. Transferring the commissioning responsibility to the provider would create duplication of performance management processes, and GP practices could perceive the additional system as time wasting, undermining the good relationships that they have with Public Health. The current Stop Smoking Service function of managing the data and payments for the GP and community pharmacy contracts would also remain within Public Health.

2.4 Table 1 below indicates the range of options in terms of Stop Smoking Service delivery and procurement approach along with describing their benefits and disadvantages. The key benefits that would be required is improved access to Stop Smoking Services, an holistic approach to lifestyle change that would enable individuals to receive all lifestyle advice in one place, cost savings opportunities and the potential for service developments.

2.5 The value of the core Stop Smoking Service that would be transferred is circa £400k per annum. This represents staff costs, with the exception of a small non-pay budget for staff training and promotional activities. It is anticipated that £50k savings would be found from streamlining management costs. Additional savings could be secured through increased integration of the core Stop Smoking Service with other lifestyle services. However experience in other areas where integration has been implemented indicates that it is more productive if initially the core Stop Smoking Service is independent within the wider integrated lifestyle service.

2.6 The value of the Service means that procurement regulations apply. However there is a potential option to transfer the core Stop Smoking Service to the current local Integrated Lifestyle Service provider, Everyone Health, which would have some benefits. The Everyone Health contract was commissioned from June 2015 for five years with a potential break after three, if there are any concerns regarding the Service. Following consultation with LGSS legal and procurement teams the only option other than immediate progression to a full tender would be for CCC to provide information through the procurement portal about its intention of transferring the core Stop Smoking Service to Everyone Health. (Voluntary Transparency Notice). Potential providers would have the opportunity to object on the basis of a lack of fair completion. This scenario would then demand a full tender process. The benefits and disadvantages of this approach are found in Table 1.

Table 1: Stop Smoking Services December 2016: Options for service delivery and procurement

	Stop Smoking Services – Service Delivery Options		
		Benefits	**Disadvantages**
1.	**Maintain the "status quo" – no change**	1. The core Stop Smoking Team has a close working relationship with the Public Health Team with the staff being committed public health objectives. 2. The core Stop Smoking Team is able to respond quickly to any service developments/changes without requiring any time consuming contract changes. 3. Past experience of contracting the core Stop Smoking Team out to another organisation led to poor performance, although this was not to a specialist lifestyle service.	1. The core Stop Smoking Service has a management structure and its own promotional programme. If the core Service is part of a wider Integrated Lifestyle Service it would have the potential to release savings through combining management and promotional overheads with the other lifestyle services. 2. The core Stop Smoking Service currently stands alone and although it works with the Integrated Lifestyle Service there are missed opportunities for client referrals from health trainers and other elements of the Lifestyle Service. The number of referrals to the Stop Smoking Services has fallen and this could be improved through greater integration with lifestyle services. 3. The current core Stop Smoking Service is small and coping with sickness, staff leaving etc. is challenging. As part of a larger lifestyle service such pressures may be mitigated through the use of staff with similar skills. 4. As Public Health commissions the Stop Smoking Services, staff from the core service can be diverted into supporting commissioning and performance management of the other providers.
2.	**Commission a "stand alone" Stop Smoking Service.**	1. This would ensure that the core Stop Smoking Service remained focused upon providing support for smokers and that staff skills would continue to develop.	1. A stand alone core Stop Smoking Service would be small. A proportion of its costs would require allocation to infrastructure/management leaving less resource for direct service delivery. 2. There are very few examples currently of stand alone core Stop Smoking Services and therefore there could be limited market opportunities to commission this model of service delivery.

			3. Referrals to Stop Smoking Services have decreased in recent years. Good referral pathways to Stop Smoking Services are important for generating clients who want to stop smoking. A Stop Smoking Service that is part of a wider lifestyle service would have better access to direct referrals than a stand alone service that would have to rely on existing or developing new pathways.
3.	**Commission Stop Smoking Services as part of an integrated lifestyle service.**	1. There is the potential for management/overhead cost savings in the short term. In the longer term additional savings could be achieved through other integrated lifestyle service staff supporting smokers to quit as they will already be trained in lifestyle behavioural change techniques. 2. Lifestyle services have a central focus of supporting lifestyle behavioural change. All staff are trained to deliver behaviour change interventions and are able to motivate smokers to quit and refer to services, but also have the potential to support a full quit attempt. The integration of the Stop Smoking Services with general lifestyle services would increase the capacity for initiating referrals and supporting quit attempts. Although it is recommended from other areas that this is more effective if it is part of phased approach to integration. 3. Clients of lifestyle services often have multiple lifestyle issues. Most prefer to focus upon one issue but if successful they may be prepared to look more holistically at their lifestyle. Stop Smoking Services as part of an integrated Lifestyle Services could be embedded into a range of pathways and ensure easy appropriate access for their clients to a range of different lifestyle support options. 4. A larger lifestyle services brings advantages in terms of the management staff sickness, retirement etc. (see 1.3 above).	1. This could potentially dilute the evidence based Stop Smoking Services model.

		5. In addition a larger lifestyle workforce facilitates service development overall. For example the current Integrated Lifestyle Service in Cambridgeshire provided by Everyone Health now has "specialist health trainers" that focus upon falls and mental health. All health trainers are able to give advice and support on these areas but the "specialists" address more complex problems or provide training.	
	Commissioning Approaches: Due to the value of the Services there are procurement considerations.		
4.	**Under the Voluntary Transparency Notice (see note below) procurement process transfer the Stop Smoking Services to Everyone Health, the current provider of integrated Lifestyle Services. This contract runs to May 2018 with a potential extension for another two years.**	**Supportive procurement rules** "*Contracts and framework agreements may be modified without a new procurement procedure in accordance with this Part in any of the following cases:—* *b) for additional works, services or supplies by the original contractor that have become necessary and were not included in the initial procurement, where a change of contractor—* *(i) cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, services or installations procured under the initial procurement, or* *(ii) would cause significant inconvenience or substantial duplication of costs for the contracting authority,* *provided that any increase in price does not exceed 50% of the value of the original contract"* (i)This applies in this instance as a change of provider would need to meet the requirement of being part of an integrated service. This would not be possible in Cambridgeshire due to the current contract with Everyone Health. There is no other commissioned integrated lifestyle service. (ii) By integrating the core Stop Smoking Service into a wider Lifestyle Service this would avoid duplication of management costs. The identified savings reflects the removal of one of the management posts. The functions of	1. Due to the current contractual arrangements with Everyone Health the core Stop Smoking Service would not benefit from any of the advantages of being fully integrated into the local Lifestyle Services until these services are re-tendered. Any successful bidder would have to demonstrate how it would integrate the core Stop Smoking Service into other lifestyle services to ensure that the benefits of referral pathways are maximised. 2. Most areas have commissioned their Stop Smoking Services as part of an integrated lifestyle service. Therefore there is uncertainty as to whether there is a robust market for the provision of stand alone stop smoking services in an area 3. If the voluntary transparency notice approach was challenged then this would necessitate a full procurement process. This would delay the process although a Voluntary Transparency Notice would be published for 10 calendar days.

		the post would be picked up by the Everyone Health management structure. In addition the total value of the Everyone Health contract over five years is £8m. The value of the Stop Smoking Services if the Everyone Health contract was extended to the full five years would be £1,137,500, less than 50% of the contract value. **There are other considerations however these do not influence any procurement rules.** 1. It would secure savings in the next financial year. 2. The core Stop Smoking Service staff have experienced a number of recent management changes. In addition when services transfer to a different organisation there is usually a fall in performance. The Stop Smoking Services are familiar with Everyone Health and previous members of the Public Health provider team were transferred to Everyone Health following the Lifestyle Service tender.	
5.	Undertake a full tender	1. This would ensure that there is a full competitive process and the potential for identifying a service that offers high quality, value for money services.	1. This is time–consuming and any savings would be delayed. 2. Also the risk of undermining staff morale.

A Voluntary Transparency Notice may be published by a contracting authority where a contract has been awarded without prior publication of a contract notice in accordance with the Public Contracts Regulations 2015, SI 2015/102, Pt 2 (i.e. a direct award). A contracting authority may opt to publish a voluntary transparency notice in these circumstances in order to resist challenge on grounds of ineffectiveness under the Public Contracts Regulations 2015, SI 2015/102, reg. 99(2).

The Public Contracts Regulations 2015, SI 2015/102, reg. 99(3) provides that the above ground for ineffectiveness will not apply if the contracting authority:

- considers the contract award (without prior publication of a contract notice) to be permitted by the Public Contracts Regulations 2015, SI 2015/102, Pt 2
- publishes a voluntary transparency notice in the OJEU indicating its intention to enter into the contract, and
- observes a standstill period of at least ten days beginning with the day after the date the voluntary transparency notice was published in the OJEU

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

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

- Smoking is associated with a range of health conditions that create high level costs for health and social care services along with high absenteeism from work. Stop smoking interventions are cost saving to the NHS and other parts of the system

3.2 Helping people live healthy and independent lives

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

- Smoking is a major public health issue due to its substantial impact of health.
- The provision of Stop Smoking Services has a strong track record of supporting smokers to quit smoking and decrease their risks of ill health and premature death. This proposal will strengthen the Stop Smoking Services through integration that will improve referrals and the capacity to provide the Services.

3.3 Supporting and protecting vulnerable people

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

- Smokers are highly vulnerable to debilitating poor health. This proposal has the potential to strengthen services and provide more support to smokers to help them quit.

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The immediate resource implications of this proposal for Cambridgeshire County Council and partner agencies are laid out in para 3.4.

4.2 Statutory legal and risk implications

These are described in Table 1 section 4

4.3 Equality and Diversity

The current Stop Smoking Services address equality and diversity issues and this would be a requirement for any new provider organisation. A Community Impact Assessment has been completed and is included in Annex B of the Health Committee Review of draft Revenue Business Planning Proposals 2017/18 – 2020/21 (December Health Committee).

4.4 Engagement and communications

The proposal requires an increase in the level of engagement with smokers and other local residents through the Stop Smoking Services being part of wider organisation that reaches a bigger proportion of the population.

. **4.5 Localism and local Member engagement**

There are no immediate implications for localism and local Member engagement.

4.6 Public Health

The purpose of this programme is to improve and develop Stop Smoking Services in Cambridgeshire which will increase the number of people who stop smoking.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	Yes 28 November 2016 Name of Financial Officer: Clare Andrews
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes 28 November 2016 Name of Legal Officer: Virginia Moggridge
Are there any Equality and Diversity implications?	Covered by CIA 6th Dec 2016 Name of Officer: Liz Robin
Have any engagement and communication implications been cleared by Communications?	Yes 24 November 2016 Name of Officer: Matthew Hall
Are there any Localism and Local Member involvement issues?	No 6th Dec 2016 Name of Officer: Liz Robin
Have any Public Health implications been cleared by Public Health	Yes 6th Dec 2016 Name of Officer: Liz Robin

Source Documents	**Location**
Community Impact Assessment, included in Annex B of the Health Committee Review of draft Revenue Business Planning Proposals 2017/18 – 2020/21 (December Health Committee).	**https://cmis.cambridgeshire.gov.uk/ccc abid/70/ctl/ViewMeetingPublic/mid/397/I mmittee/6/Default.aspx**

Agenda Item No: 7

SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE

To:	**HEALTH COMMITTEE**
Meeting Date:	**15 December, 2016**
From:	**Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	**The Committee is asked to consider the latest Sustainability and Transformation Plan (STP), published by the Sustainability and Transformation Programme team on 21 November, 2016.**
Recommendation:	**The Committee is asked to note and comment on the STP.**

	Officer contact:		***Member contact:***
Name:	CCG Engagement Team	Name:	Councillor David Jenkins
Post:	Lockton House Clarendon Road Cambridge CB2 8FH	Chairman:	Health Committee
Email:	capccg.contact@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	01223 725304	Tel:	01223 699170

1. BACKGROUND

1.1 This report highlights the publication of Cambridgeshire and Peterborough Sustainability and Transformation Plan on 21 November 2016, as an update to the Sustainability and Transformation Programme.

2. SUSTAINABILITY AND TRANSFORMATION PLAN

2.1 Cambridgeshire and Peterborough's latest five-year Sustainability and Transformation Plan (STP) to improve local health and wellbeing was published on 21 November 2016.

2.2 Led by local clinicians, the STP has been developed by all local NHS organisations and local government officers, and through discussion with our staff and patients. It aims to provide solutions to the county's challenges to deliver the best possible care to keep the population fit for the future and take joint responsibility for improving health and wellbeing.

2.3 The plan addresses the issues highlighted in our Evidence for Change (March 2016) and the main reasons why changes are needed in the local health and care system. It details how we propose we could improve services and become clinically and financially sustainable for the future.

2.4 Following on from the interim STP summary published in July where we forecasted that as a system we will have a £250m financial deficit by 2020/21, the STP outlines that this is in addition to £250m of savings and efficiency plans individual Trusts and the Clinical Commissioning Group (CCG) need to deliver over the same period. This makes a total system-wide financial challenge of £500m over the next four years. It also estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge from £500m to £543m.

2.5 The scale of the changes required is significant and we all recognise the delivery will be challenging. However, all of the leaders across the system, have now signed a Memorandum of Understanding (MoU) as a demonstration of their commitment to work together, share budgets, deliver agreed clinical services and ensure that together we provide health and care services that are clinically and financially sustainable.

3. PRIORITIES AND AREAS OF FOCUS

3.1 Through discussion with our staff, patients, carers, and partners we have identified four priorities for change as part of the Fit for the Future programme, and developed a 10-point plan to deliver these priorities:

At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

3.2 Our priorities will be delivered through eight delivery groups, responsible to Chief Executive Officers from across the health and social care system. The groups cover clinical services, workforce and support services. The clinical delivery groups include public health and social care services. They are:

- Urgent and Emergency Care
- Elective (planned) Care
- Primary Care and Integrated Neighbourhoods
- Women and Children's services

These delivery groups are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do.

4. ANTICIPATED OUTCOMES

4.1 If the Trusts and CCG meet their savings and efficiency plans, and all aspects of the STP are delivered, this will achieve the savings and efficiency target (of £500m) and produce a small NHS surplus of £1.3m (by 2020/21).

4.2 Due to the high levels of acute hospital activity, and resulting deteriorating financial position in our system, we are looking at ways to accelerate the pace of change and focus early investment on the areas that will have greatest impact on reducing hospital activity levels.

4.3 Our priorities are to increase the amount of care delivered closer to home and to keep people well in their communities.

5. SIGNIFICANT IMPLICATIONS

5.1 Engagement and Consultation Implications

There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change and to be involved with any formal consultation process.

The proposals will be further developed over the next few months. If anyone wants to be part of the discussion please contact the team via email: contact@fitforfuture.org.uk

Source Documents	Location
• Sustainability and Transformation Plan – October 2016 • STP summary document – November 2016 • Frequently Asked Questions – November 2016	These, plus other related documents, are all available at: www.fitforfuture.org.uk/what-were-doing/publications/

APPENDIX 1

Cambridgeshire and Peterborough Sustainability and Transformation Plan Summary – please see accompanying document.

Fit for the Future

Working together to keep people well

How health and care services in Cambridgeshire and Peterborough are changing

This is an update to the Sustainability and Transformation Plan Interim Summary, published in July 2016

@fitforfuturenhs
fitforfuturenhs
fitforfuture.org.uk

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

NHS

1 Why do we need to change?

Our health and care services face challenges

Ours is one of the most, if not ***the*** most, challenged health systems in England, making it essential that we work together to develop robust plans for long-term change.

The population of Cambridgeshire and Peterborough is growing rapidly. Our population is diverse, it is ageing, and it has significant inequalities. There are also more people with long term conditions, such as diabetes, and there are higher levels of obesity.

In addition, we are facing practical challenges:

- healthcare is not as good in some places as in others, and does not always meet the standards that it should
- recruiting and retaining staff is a challenge for all health and care services
- our health, local authority, and other care services are not always joined up. They do not always meet people's individual needs, and they do not always balance physical health with mental health and wellbeing
- local needs are growing and changing. Our average age and levels of sickness are all growing, and faster than in other parts of the country
- overall, we spend too much of our time and resources treating illnesses which can be prevented or kept under control in better ways
- The current health system is financially unsustainable. The local system has a total annual budget of more than £1.7billion for NHS services, but we spend about £160million more than that each year. We need to deliver our current plans and radically change the way we provide services. If we don't do both of these things the deficit is projected to increase to £500million by 2020/21.

The Sustainability and Transformation Plan (STP) proposes ways in which we can deliver the best possible care to keep our population fit for the future, and address our service and financial challenges.

What you've told us so far

During the last 18 months, we held listening events across our area to seek your views on the health and care system. We heard that:

- you want to be empowered to stay healthy
- you want easy access to information about health
- you want to understand how to use the right health and care service at the right time
- when you need care urgently, you would rather use a local service than be sent to A&E
- you want consistent access, such as opening hours for services
- you want care as close to home as possible
- children's services need to be co-ordinated better
- you would be happy to be sent home from hospital sooner if you had visits from a nurse to support you
- you do not want to be sent home too early with no support – you are concerned about needing to be readmitted
- you need better communication and planning before you leave hospital
- you want the people who provide health and care services to collaborate and work more closely together.

2 Our five-year plan to make Cambridgeshire and Peterborough Fit for the Future

This document tells you about our proposals, both to meet your ambitions for health and care and to make services financially and clinically sustainable.

The NHS and local government officers have come together to develop a major new proposed plan to keep Cambridgeshire and Peterborough Fit for the Future. We have also been asking you how you think we can manage our challenges. Our plan aims to:

- improve the quality of the services we provide
- encourage and support people to take action to maintain their own health and wellbeing
- ensure that our health and care services are financially sustainable and that we make best use of the money allocated to us
- align NHS and local authority plans.

It has been developed by our health and care organisations. We are working together and taking joint responsibility for improving our population's health and wellbeing, with effective treatments and consistently good experiences of care. The work is being led by local doctors and other medical professionals, supported by NHS England and NHS Improvement.

Fit for the Future sets out a single overall vision for health and care, including:

- supporting people to keep themselves healthy
- primary care (GP services)
- urgent and emergency care
- planned care for adults and children, including maternity services
- care and support for people with long term conditions or specialised needs, including mental ill health.

We are well placed to make the changes we need and have a lot to be proud of. Cambridgeshire and Peterborough has a committed and expert health and care workforce. We provide some excellent services to which people travel from other parts of the country. We host groundbreaking research and deliver excellent medical education and training. We have a resourceful voluntary sector, strong organisations, active local communities, and we work alongside research and technology industries which are world leaders in improving healthcare.

3 What are the priorities?

Through discussion with our staff, patients, carers, and partners we have identified four priorities for change and we have developed a 10-point plan to deliver these priorities.

Fit for the Future programme	
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

1 People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses so that people of all ages have good health, social, and mental wellbeing support.

Our first aim is to prevent illness and support people to take control of their own health and wellbeing. We will develop health services which work alongside patients and carers, social care, and housing providers, and which help to build strong communities.

We want patients to become equal partners with those caring for them, make more decisions about their own treatment and, with advice and support, become increasingly confident to manage their own conditions, supported by technology.

Summary of what we propose to deliver.

Housing and business - working in partnership with communities and businesses to provide employment, housing in new developments, and an environment to keep people healthy.

Where possible, we are influencing the design of new housing developments to reinforce active lifestyles and introduce smart technology that promotes independence for older people.

Prevention - helping people to keep healthy, dealing with problems earlier, and making sure people who are likely to fall ill are supported to keep well.

We will do this by implementing our Health System Prevention Strategy for Cambridgeshire and Peterborough. The strategy sets out practical steps to make this happen.

Psychological wellbeing - making support and treatment for people with mental ill health as available as it is for those with physical health conditions, mainstreaming mental health and prevention.

We will reduce stigma, support employers to have healthy workplaces, and reduce suicides.

Starting young - working together to ensure that there is support for children and young people with mental health and physical health problems, whatever their age.

We are joining up children's services across the NHS and local authorities, including Child and Adolescent Mental Health Services (CAMHS) and emotional health and wellbeing services, children's community health services, and local authority services for those aged 0-19 (which may include children's centres).

Reaching out - engaging those at high risk through the third sector and trusted networks.

Our neighbourhood teams, primary care, and social care will work with the voluntary and community sector to identify those at risk of poor or deteriorating health. Community-based workers will support those with a severe mental illness or dementia, migrant workers, travellers, and our wide range of diverse communities who may need help to access services in a different way.

Self-care - supporting patients to make decisions about their own treatment and become more confident to manage their own conditions.

Our GPs, consultants, and nurses will make it easier for people with long term conditions to manage their own care by adopting best practice for supporting self-care.

Ageing well - we must improve independence and wellbeing in older age and prevent health and care needs from escalating.

To achieve this, we will focus on physical activity and reducing falls, holistic approaches, and care for older people's mental health.

We need to link up health and social care.

Peterborough Public Workshop

2 Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

We aim to coordinate care better so that it meets the needs of the individual. We aim to pay close attention to the health and care services necessary to keep people living at home successfully, because we know this is the best way to keep people healthy and to maintain their independence.

When people become unwell, we will take every opportunity to spot warning signs and focus local support to help people live with long term health conditions.

We would like to see more joint working between local health and social care, with GPs playing a central role, supported by hospital clinical teams.

As much care as possible must be led by primary care (GPs). We are supporting our GPs to share best practice, work together, access advice from hospital consultants and to provide the enhanced primary and community care that our local people need.

Summary of what we propose to deliver.

Time to care - testbeds to support GPs.

Our 'Time to care' programme aims to support our 105 GP practices to manage increasing patient demand, help them to become more efficient, and to provide better quality of care to their patients. It also aims to improve the way in which GP practices work with local hospital, community, social care, and voluntary sector providers to provide proactive care close to the patients' home.

Neighbourhood teams - multi-disciplinary teams, led by GPs targeting those at risk (such as those with long term conditions, frail, elderly).

We aim to build on our neighbourhood teams which are staffed by district nurses, matrons, social workers, therapists, and pharmacists to provide integrated, proactive care for those with long term conditions, such as the dying, care home residents, and mental health service users.

Community experts - specialist clinicians will support neighbourhood teams.

To support the neighbourhood teams we need an integrated team of community-based experts to care for the more complex patients and provide advice and education. However, more needs to be done to ensure that access to the teams is fair, that the teams can access advice, and clinicians are able to review complex patients together to agree a management plan.

Sharing knowledge - this is a central role of the patient care plan, and electronic access to patient information across the system.

Proactive and person-centred care relies on there being one single care plan, owned by the patient and their family; one electronic care record accessible by all; one set of best practice protocols all can adopt; and one route through which expert opinion can be accessed day or night.

Embedded mental health - ensure community mental health is within neighbourhood teams, and that there are links to liaison psychiatry and recovery.

Our neighbourhood teams already provide joined up community mental health services. We want to join up our community and mental health teams further to make sure the psychological needs of people with long term conditions and the physical health needs of patients with severe mental illness are met consistently.

Learning disabilities – implementing 'transforming lives'.

We have been working closely with the councils to implement 'transforming lives' for people with learning disabilities. The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) is evaluating the use of integrated personal health and care budgets for people with learning disabilities.

Your own bed, not a hospital bed - for end of life and intermediate care.

We aim to provide more rehabilitation closer to, or at, home to retain a patient's independence, and provide more end of life care at home, rather than in hospital.

3 Responsive urgent and expert emergency care

We will offer a range of support for care and treatment which is easily accessible, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life-threatening.

This will be supported by better co-ordination, for example referral through NHS 111, close working with the ambulance service, and clear information provided to patients about which services are available - and how to reach them - when they have an urgent health need.

It is not good for patients to stay in hospital for longer than they need to be there, as it can have a negative impact on their recovery and ability to maintain independence. We must therefore make sure patients in hospital beds really need to be there, and that they are not delayed when moving through the steps on their care plan.

We have been through a process to designate our three A&E departments against the national Keogh urgent care definitions. As a result of this process, we have determined that it is in the best interests of our local population to maintain the current levels of provision, namely a specialist emergency centre at Addenbrooke's Hospital and an emergency department at Peterborough City Hospital. Hinchingbrooke Hospital will retain its A&E department and will continue to be able to manage the current caseload of minor injury and major medical cases, with a physician-led service.

Since our three hospitals are already struggling to meet existing levels of emergency demand, and our volume of planned hospital procedures is significantly above that of similar health systems, we need to improve our community-based urgent care and our emergency services radically such that hospital is a last resort. There are several strands to this improvement work.

Summary of what we propose to deliver.

Ambulance services - alternatives to hospital admission.

We are working with our ambulance teams to make sure that only patients who really need to be transferred to hospital are taken there. We are implementing 'hear and treat', 'see and treat', and 'see, treat, and convey' systems which allow paramedics, supported by other medical professionals, to decide whether options other than transfer to hospital are more appropriate.

Right call, first time - integrated urgent care and clinical hub.

From October 2016, if you call 111 and you need to speak to a clinician you will be able to do so. This service is provided by our expanded integrated urgent care service and clinical hub. The aim is to make sure that patients receive the most appropriate care that best meets their needs. This will ensure that our hospitals' emergency services are reserved for serious/life threatening injuries or illnesses.

Minor injury - walk-in minor injury services.

Following our review of the three Minor Injury Units, (MIUs), in East Cambridgeshire and Fenland, we have undertaken extensive engagement with the public, providers, and other stakeholders on a range of options for the future. Taking this feedback into account, we have identified significant opportunities to deliver more joined-up, effective, and efficient local urgent primary care services which reflect the rural geography, deprivation, and demography.

Whilst no formal decisions have been taken, we are now working with local stakeholders to develop the details behind a number of options, including the development of three rural urgent primary care hubs which will focus initially on integrating local primary, minor injury, and community services. This will move on to include development of point of care testing and consultant support, via telemedicine links. We intend to develop and test the first phase of any new urgent primary care model over the next 12 months, which will inform further engagement and, potentially, consultation. We are also doing an analysis of all options put forward as part of our early engagement work.

Right call, first time for mental health concerns - dial 111 - press 2 if you have a mental health concern.

We are embedding mental health including community crisis services, liaison psychiatry, and Suicide Prevention Strategy. We are investing £2m of urgent and emergency care funding in an evidence-based, community first response service which provides urgent out of hours assessment and support to people in mental health crisis.

More support for people leaving hospital - we have a very high level of people staying in our hospitals for longer than they need to be.

We believe it is not good for any patient to stay in hospital for longer than medically necessary and we are putting in place processes to ensure that patients are discharged on time, including on-site social care staff to support discharge from hospital.

24/7 standards – in consultant-led services

Our three urgent and emergency care hospital departments will meet the government's seven-day service standards with early and daily consultant input to reduce the length of time people spend in hospital.

4 Systematic and standardised care

Doctors, nurses, and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

Where it is important to provide services from several sites across the area, we believe we can use our skills and expertise collectively to achieve better results through doctors and nurses working across more than one hospital site and sharing their expertise.

We expect that maternity services will also remain at the Rosie Hospital in Cambridge, at Hinchingbrooke Hospital, and at Peterborough City Hospital.

Evidence tells us that standardised care is often higher quality and lower cost. Networking between medical professionals will help us to deliver savings, as well as helping to ensure that the additional costs associated with increased clinical standards, especially seven day services, are minimised.

Summary of what we propose to deliver.

Networks of care - where services are provided from more than one site, we will use specialised skills and expertise collectively to raise quality everywhere.

Medical professionals at our hospitals are beginning to agree how to work as operational networks for planned, unplanned, routine, and specialised care. These networks will share information about appropriate patient referrals and the best treatment, and building workforce resilience through better career development and shared out of hours arrangements.

Patient choice hub - improving quality of referrals and align capacity and demand.

A new patient choice hub is being developed with the aim of improving quality of referrals, ensuring that clinical thresholds are adhered to, that capacity and demand are lined-up across available providers, and managing procedures across the health system rather than in organisations.

Centres of clinical excellence - clinical consistent pathways across all providers to improve outcomes and efficiency, with fewer, more specialist centres across our hospitals.

We need to create centres of clinical excellence that use consistent procedures and policies across all service providers. We have identified some quality and efficiency benefits from combining procedures.

- Orthopaedics: We are considering centralising specialised orthopaedic trauma services (such as fragility fractures from falls) at Peterborough City Hospital and Addenbrooke's Hospital, to achieve a higher standard of care.

  We are also investigating the case for reconfiguring planned orthopaedic services, by increasing the number of low-complex procedures at Hinchingbrooke Hospital (such as routine knee and hip replacements), to improve the quality and sustainability of services at all three hospitals. We expect to consult on these proposals in 2017.

- Stroke: National stroke indicators show that we perform below the national average on a number of stroke areas, including access to specialist rehab and early-supported discharge. In addition, inpatient and community bed-based stroke and neurological rehabilitation care is fragmented across multiple sites.

  In order to improve the services offered to our patients we are considering providing all bed-based stroke and neurological rehabilitation on a single site and to establish an enhanced early-support discharge team, so many more patients can receive rehabilitation and support at home. We expect to consult on these proposals in 2017.

  We have also considered whether we need one or two hyperacute stroke units (we have one in Cambridge and one in Peterborough), and have concluded that at present we should retain our two hyperacute stroke units.

Modern maternity - improving quality, choosing home births, standardisation and continuity.

For obstetric and neo-natal services we have considered the viability of our three obstetric (maternity) units, each with a co-located midwife-led unit, and concluded that all three should remain. However, we need to enhance networking between the three units to share knowledge and improve care for expectant mothers and women in labour.

Acute paediatrics - supported by strengthened community services.

Hospital stays for children and young people should be kept to a minimum. We will develop community care with enhanced community nursing, and with GPs and paediatricians working better together.

5 Continued world-famous research and services

We have world-class specialised care, but we are always looking for ways to be better. We will work together with our local research organisations and businesses to make this happen.

We believe we can achieve consistently better results for people with more serious needs, such as for heart and lung services or complex surgery, in fewer, specialist units which make best use of the world-class expertise of our specialist consultants.

Much specialised care is already centred at our two world renowned hospitals: Addenbrooke's Hospital and Papworth Hospital for cardio-thoracic care. For this reason, major changes to specialised services do not feature significantly in our plan. However, there are some specific areas where we can improve, especially due to growing demand.

Summary of what we propose to deliver.
Cancer - improvements in waiting times and best practice services. We are working to implement the recommendations of the Cancer Taskforce Strategy and to achieve world-class cancer outcomes. The establishment of 'Cancer Alliances' is crucial to this.
Specialised mental health - We provide limited specialised mental health locally in a small number of low secure beds and Child and Adolescent Mental Health Services. The East of England region has been identified as one of three areas without a mother and baby unit for those with severe mental health problems following childbirth. We aim to address this, and our mental health strategy also prioritises the development of perinatal mental health services in the community.
Cardiology - Cardiology services will be provided across Cambridgeshire and Peterborough. Papworth Hospital which, following its move to the Cambridge Biomedical Campus next to Addenbrooke's Hospital, will lead the service across both organisations. Together with Peterborough and Stamford Hospitals NHS Foundation Trust, it will provide a vital role in supporting improved 24/7 access to cardiology opinion, as well as community-based services that focus on prevention.

How does the NHS support carers?

Cambridge Public Workshop

Ely Public Workshop

Most of us prefer to travel 100 miles for an operation for someone who's done it before.

Patient stories - how things could look in the future

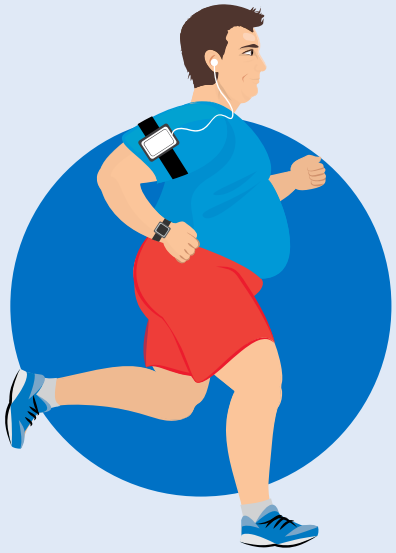
Better safe than sorry

When, on a Sunday morning outing, eight year old Olivia fell off her bike and banged her head, her mother Gemma didn't know what to do. She thought about driving to A&E or dialling 999 but remembered seeing posters saying that 111 was a better option for injuries that were not serious or life threatening.

She called 111 and they arranged for Olivia to see a GP later that morning. The GP, Martin, examined Olivia and advised Gemma about what to look out for following a head injury, and what to do if Olivia's condition changed. Martin directed Gemma to the NHS Choices website for further information.

In the afternoon, and using the information that she had been given, Gemma became concerned that Olivia was getting worse, not better. Following the advice that GP Martin had given her earlier she took Olivia to the hospital. The specialist children's team could access Olivia's notes and details of what had happened so Gemma didn't need to repeat her story. Olivia was observed for six hours and discharged fit, well, and keen to get back to playing with her friends.

Looking forward – keeping active



Mark gave up playing rugby after a broken wrist and had become an armchair fan at the age of 39. He still enjoyed regular evenings out, and was ashamed to admit that his smoking had increased since he gave up sport. But Mark remained convinced he was still fit and healthy – with nothing to worry about.

Aisha, Mark's GP, was not so sure. Responding to an invitation for a regular check-up, Mark was told that he was significantly overweight, with warning signs suggesting he was at risk of developing diabetes. Aisha knew that persuading Mark to make the lifestyle changes he needed would require both a plan and support.

First, she connected him to the local smoking cessation service, which organised drop-in sessions Mark could easily get to, and put him in touch with a fitness coach who could recommend an exercise programme to suit him.

She also realised that Mark's smartphone was his window on the world, and suggested some websites and a wellbeing app to help him plan and stick to his diet and fitness regime.

Care shaped around the patient

After she turned 80, Doreen found her health deteriorating. Doreen has diagnoses of diabetes and emphysema (COPD), as well as early stage dementia. She lives with her husband, Roy, who is 82, who also has diabetes but is otherwise fit and cares for her.

Paul, her GP, invited Doreen for her annual assessment. Based on her increasing frailty, he accepted her onto the caseload for complex, case-managed patients who are supported by a multidisciplinary team in the community. Angela, a member of the community team, is her care coordinator.

Paul and Angela worked with Doreen and Roy to create two plans. The first was a care plan which summarised Doreen's health needs according to her preferences and priorities, and what she and Roy would want in the event of a crisis or deterioration in health. The second, a self-care plan, allowed Doreen to describe her goals and needs for caring for herself safely at home, and identified how she could be supported in doing so by Roy and the health system.

Living beyond psychosis

Jack was becoming increasingly isolated; he had stopped attending school and seeing his friends, and had complained of hearing voices. Following a comprehensive assessment at which he was considered to have developed an early onset psychosis, he was referred to the early intervention service. He began a three-year programme tailored to his needs. The service worked with Jack to deliver a holistic care plan.

Family therapy enabled Jack and his family to understand more about his experiences and to begin to resolve them.

Jack is now aware that he can choose to access a wealth of insight and to share experiences through social media. He is actively involved in monitoring his state of mind, has discussed in advance what he would like to happen in a crisis, and understands what to do if he becomes unwell again. His GP and the practice team are very involved with the care plan and can call on a range of support for Jack. Perhaps the most important connection was with an employment project which supported Jack through his college application. Now, in the second year of his course, Jack can see a much brighter future.

Priority one - At home is best

Neighbourhood care hubs

More health and care services will be provided closer to people's homes and we will help people stay at home when they're unwell.

People powered health and wellbeing

We will help people to make healthy choices, keep their independence, and shape decisions about their health and care. We will work with community groups and businesses, so people of all ages have good health, social, and mental wellbeing support.

Partnership worki

Everyone who provi
social and mental h
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plan together and w

Priority three - We're or

Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards. We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

Priority four -

Responsive urgent and expert emergency care

We will offer a range of easily accessible support for care and treatment, from telephone advice for urgent problems to the very best hospital emergency services when the situation is life threatening.

Systematic and standardised care

Doctors, nurses and other health and care professionals will work together across Cambridgeshire and Peterborough to use the best treatments and technology available.

Continued world-famous research and services

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A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

6 Partnership working

Everyone who provides health, social, and mental health care across Cambridgeshire and Peterborough will plan together and work together.

We believe we must work across boundaries: between NHS and local authority social care; GPs and hospital care; and physical health and mental health.

None of our organisations can be sustainable acting alone; our financial challenge is too great. We need to work together in a way that we have never done before. In addition to new ways of working, and a new relationship between medical professional and patient, we can do more to collaborate in our non-patient facing services, including back office and clinical support services, and reduce duplication.

Collaboration between commissioners, including the Clinical Commissioning Group and local councils, NHS providers, and general practices, is crucial. There are examples in our system of where this is already happening and members of these organisations have already begun to work together as equal partners to a far greater extent than ever before.

Summary of what we propose to deliver.

Larger general practices - Many of our GP practices recognise the benefits for sustainability of working together as federations and larger primary care teams. We believe this will enable better access to resources through sharing and specialisation and closer working between GPs and their colleagues in hospitals. Development of the primary care workforce (GPs) is an important part of this.

We also recognise that people are supported by a network of formal and informal care, and aim to work in partnership with local organisations, such as faith groups and the voluntary sector.

Hospitals joining together - Hinchingbrooke Hospital and Peterborough and Stamford Hospitals are looking at coming together to bring about financial efficiencies and also meet their clinical and workforce challenges. They will be making a decision in late November, and, if it is agreed, they will join together in April 2017.

Papworth Hospital is preparing to move onto the Cambridge Biomedical Campus in 2018. This will lead to further formal collaboration with Addenbrooke's Hospital in due course.

Back office - We have started to rationalise overheads and support services. We will establish a shared HR back office that includes healthy workforce. We will also develop a single approach to procurement during 2017/18 and pilot this new approach within orthopaedics through joint procurement of all joint kits.

Financial incentives

Having committed to shared planning and transparency in tracking cost improvements and Quality, Innovation, Productivity, and Prevention (QIPP) delivery in 2016/17, we will look at ways to share risk and align financial incentives.

Health and social care

The Clinical Commissioning Group and local authorities are collaborating with the aim of aligning commissioning arrangements for mental health and healthy child services.

Working with the voluntary and community sector, and support for carers - Key to reduction of hospital admissions is coordinating support for people. Many relevant services and interventions are provided by voluntary and community sector organisations. All commissioners are seeking to work more closely with the voluntary and community sector.

Case Study: Peterborough is leading the way

In Peterborough, an Area Executive Board has been established to oversee nine programmes of work that will integrate care for all ages, spanning child health, ageing healthily, and how hospital is accessed. The programme brings together local GP practices in Greater Peterborough, Peterborough City Council, Peterborough and Stamford Hospitals NHS Foundation Trust, and Cambridgeshire and Peterborough NHS Foundation Trust, and is supported by an external company.

To enable the required change, improvements, and efficiencies in this plan to be delivered we have identified four key things that will need to happen to underpin our work across the system.

7 A culture of learning as a system

We are committed to sharing knowledge across the whole health and care system, so the people working in our health and care organisations know they are part of the big picture.

We want to develop a culture of learning. This means our staff developing a shared understanding of our services, priorities, and challenges, a common approach to analysing opportunities and problems, and finding solutions together.

We believe we can share knowledge and expertise from the specialist services in Cambridgeshire and Peterborough, making the most of our world-class medical and healthcare education and training, and using research to drive improvement.

We know we must invest in system-wide quality improvements. To be successful, our system must develop a shared understanding of all the interrelated issues and must be able to explain what it means to us as individuals and as organisations. Our plans must be understood by all our staff and patients.

We are developing a system-wide quality improvement and organisational development plan which will focus on a common culture and set of values across Cambridgeshire and Peterborough. Ultimately we want our staff to not only identify with their professional group and employer, but as a key partner to the Cambridgeshire and Peterborough health and care system's long-term sustainability.

We need to build on our research heritage and be at the forefront of adopting new therapies and delivery models for the patients of tomorrow.

8 Workforce: growing our own

We have wonderful, talented people working in our health and care system. We aim to offer rewarding and fulfilling careers for our staff, with opportunities for them to develop their skills and grow professionally. This way we can develop staff, including for those areas where we have some staff shortages.

We want staff to choose to work here and to see themselves as part of the whole health and care service in Cambridgeshire and Peterborough - this will help us where we have services that have staffing shortages.

Workforce data and intelligence from other parts of the country has provided us with the building blocks to design a workforce and transformation strategy.

In the short-term we have developed a whole systems approach to 'grow your own' and 'earn as you learn'. We are building on existing programmes and developing career pathways that begin at apprenticeship level and take individuals all the way through to registrant or advanced practitioner level. Our goal is for Cambridgeshire and Peterborough to provide high quality placements for those in training and to become one employer of choice, enabling us to retain those we train.

Over the longer term our system needs to work differently to ensure our staff are supported appropriately and retained. We need to ensure that the contribution of our mature workforce is retained and that they help us to develop competence and confidence in newer members of the workforce.

Many of the emerging new models of care, including our aspiration to operate in networks of care, require both the current and future workforce to work more flexibly across locations, in line with the demand for our services. Our human resources model will need to become more flexible and, where possible, we will do things in common to enable staff to move between organisations more easily.

Case Study: Skills for people-powered care

We have made progress towards training and developing our staff to deliver new roles:

- Funding from Health Education England supports training and research on integrated working in Neighbourhood Teams.
- Cambridgeshire County Council's Early Help Team helps individuals at an early stage, in the community.
- Cambridgeshire Better Care Fund's care home educators are learning from a local pilot and the Care Home Vanguards.

9 Using our land and buildings better

We want to bring all our NHS and local government sites up to modern standards.

We want to make better use of our out-of-hospital sites, which may mean selling some buildings to invest in other modern, local facilities.

We want to explore how we can work together to get more value from our land and buildings, and bring all our sites up to modern standards.

There is a great deal of building development in Cambridgeshire and Peterborough so we see opportunities for new strategic partnerships, such as the planned Hinchingbrooke Health Campus.

We have many community estates, some of which are poorly used, which provides us with the opportunity to reduce the number of buildings used and potentially develop new primary and community care facilities on the larger sites.

We want to promote co-location and shared working spaces which can bring teams together and foster integrated care delivery across health and social care agencies.

We have already started to work in a more coordinated way, not only across health and care but also with partner agencies including the fire and police services.

We want to use our estates to support new models of care. This could be through the creation of larger, modern, family and frailty-friendly hubs, where GPs can work side by side with community and social care staff, have direct access to diagnostics and specialist advice, and are enabled to diagnose and care for more patients without the need to refer to hospital. Over time we expect these hubs to replace much of outpatient care.

Local authority plans to bring NHS and local health and care resources together under one social/community/mental health/primary care roof, will go a long way to providing proactive care, rather than reactive care in hospital.

Similar changes are possible as back office services begin to collaborate more. The sites at Princess of Wales Hospital in Ely and North Cambridgeshire Hospital in Wisbech could be locations for these new neighbourhood hubs. Outline plans, which will help us respond to a growing population, local health needs, and poor current infrastructure, have already been drawn up for these two sites.

10 Using technology to modernise health

Good information and advice helps people take control of their health. We will use apps and online tools to provide more rapid and reliable information.

Shared information will help medical professionals in hospitals, GP practices, community teams, and social care to work together more effectively.

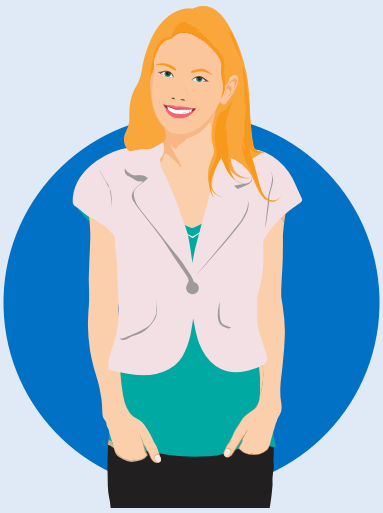
Technology will also help us to provide more reliable information for patients more quickly, and our clinicians will make sure technology is built in to new services.

Our ambition, supported by the 'Local Digital Roadmap' vision, is that by 2020 'patients and citizens, health and social care staff have access to quality, timely, and accurate information, regardless of place or time, to enable improved decision making and ultimately better outcomes for both the individual and the community'. We will deliver this in six themes:

- Data and information sharing
- Health apps
- Telehealth/remote monitoring
- Access
- Real-time information
- Health analytics

Staff stories – how things could look in the future

Making the right call



Joanne supports several people with long term health conditions, enabling them to continue to live independently at home. She has built up a lot of knowledge about signs to look out for and urgent care options, and has always felt that she has valuable insight into how the emergency admission process works and whether it could provide a better experience for patients and carers.

Now working within a larger, multi-disciplinary team she can play a greater role. For example, she has received coaching from a local hospital consultant from whom she can also access immediate support and advice. This includes examples of symptoms which should raise concerns, so Joanne has the reassurance that she knows when it is right to call an ambulance and how she can help to prevent emergencies.

Hospital care at home

Maqsood leads a newly-established team in St Neots. It helps to keep people living independently by providing intensive nursing input at home - so avoiding hospital admission or enabling earlier discharge.

Maqsood knows that the research evidence is clear. Too often, on admission to hospital the care and support networks on which older people depend fall away and with them their ability to live independently. He helped to co-design the service and has worked hard to develop his team, which brings together professionals across several organisations and focuses on each individual patient's needs.

For example, Mrs Barlow was one of the team's first patients, after she was discharged from hospital much sooner than she would have been before it was in place. She was able to recover at home, at first with high-level healthcare and daily contact with support workers, which then stepping down to every other day contact with a nurse. She even received home visits from the pharmacist to make sure her medication was correct.

To stop people going to A&E you must provide alternatives.

Huntingdon Public Workshop

Wisbech Public Workshop

People would be happy to be treated at home if they could get good support.

Peterborough Public Workshop

Ensure health staff on the ground are involved.

Mental Health is a key element to all patient pathways.

Wisbech Public Workshop

Staff stories – how things could look in the future

Joining up physical and mental health

Greg leads part of the liaison psychiatry service, which joins up mental health and physical health care when people need hospital treatment or urgent care. His team works in hospitals across Cambridgeshire and Peterborough.

As well as helping to make sure that the NHS meets its commitment to give mental health the same priority as physical health, Greg believes that his service is based on principles which are fundamental to transforming care services.

When people are admitted to hospital, the liaison psychiatry service focuses on helping them to recover and how they can be supported to return home. This requires a holistic approach - working across mental health and different hospital specialties, in partnership with the patient, and alongside carers, advocates, and social care providers - because keeping people well requires a team effort.

As a clinician, Greg wants to help shape new ways of working and sees his role as a great opportunity – both to help bring about better outcomes for patients, and to develop his own professional skills.

World-class hospital care – delivered closer to home

Visha, a Geriatrician, has always strived to provide the very best care available anywhere and, although they handle an enormous number of patients, she is proud of the outstanding results achieved by her hospital-based team.

Visha was recruited onto the transition team which managed the set up of a new service running satellite clinics. Working with Paul, one of the GP leads, she realised that this challenging change could mean even better treatment and an improved experience for patients. By setting up a buddying system, Visha's specialist expertise and Paul's broader experience were combined and Paul was supported to take on monitoring and care which would previously have required a hospital visit. Visha's team is now on rota to advise local GPs 24/7 via a hotline, so reducing the number of patients reaching them through A&E.

The practice at which Paul is based proved an ideal location for outpatient clinics. As a community 'hub', it is well-equipped and a new IT system enables Visha to access patient records and communicate with specialist colleagues - whether she is in the practice or on her ward.

What these changes mean for our finances

We have reviewed our finances thoroughly, including making comparisons with national figures and looking for opportunities to make savings and organise services more efficiently.

As reported in the summer, by 2020/21 we predict a system-wide £250m financial deficit. This is in addition to £250m of savings and efficiency plans individual trusts and the Clinical Commissioning Group (CCG) need to deliver over the same period. This makes a total system-wide financial challenge of £500m over the next four years.

If the trusts and Clinical Commissioning Group meet their plans, and all aspects of the Sustainability and Transformation Plan are delivered, this will achieve the savings and efficiency target of £500m and will actually produce a small NHS surplus of £1.3m (by 2020/21).

To enable all the proposed service improvements and developments within the STP to be delivered it will require an estimated additional investment of £43m. If this investment is to be locally funded it will need to be paid back, and therefore would increase the total system-wide financial challenge from £500m to £543m.

We believe that success lies in reducing demand, meeting the ambulatory care needs of sick children, people with long term conditions, and the frail elderly, in primary and community care settings, reducing hospital length of stay, improving our workforce utilisation and reducing our overhead costs.

We are confident that there is significant scope to both improve the efficiency of patients being admitted and discharged from hospital by reducing the differences in the care provided and to deliver care more effectively outside of hospitals.

We feel that there is also opportunity to reduce clinical support services costs, through sharing back office costs and organisational mergers, where beneficial.

There are a number of areas that we believe should produce additional benefits, including growing income from commercial opportunities, and by reducing the cost of debt repayments.

Our approach to implementation

Why this time is different

We know that there have been times in the past when we have not delivered plans in the way we intended to. This time it will be different because we have been able to work together, as equal partners across the system, to build collective awareness that a problem exists, to fully understand the root causes of this, and to use this information to identify solutions and build commitment for implementation and action.

We are committed to behaving differently, listening more, being clearer about principles for decision making, and getting better at making whole-system decisions together.

System leadership, system working

We recognise the importance of partnership working in order to implement the changes described in our Sustainability and Transformation Plan. This includes partnership working across our organisations as we move towards greater joint health and social care commissioning and services.

We have made the public commitment to return the health and care system to a sustainable position, and improve care for local residents and healthcare users – through a Memorandum of Understanding. The Memorandum of Understanding (MoU) states:

- **One ambition:** to return Cambridgeshire and Peterborough to financial, clinical and operational sustainability by acting as a single leadership team, with mutual understanding, aligned incentives and coordinated action with external parties (e.g. regulators).
- **One set of behaviours:** all partners agree to exhibit the beneficial behaviours of a single leadership team.
- **One long-term plan:** we are collectively responsible for delivering the plan that will achieve our long-term ambition, including capturing the savings opportunities identified that will enable us collectively and individually to return to financial sustainability.
- **One programme of work:** all system projects will be aligned to the Sustainability and Transformation Plan and under supervision of a Chief Executive Officer-sponsored delivery or design group.
- **One budget:** within NHS contracting, a number of financial incentive options will be considered.
- **One set of governance arrangements:** the Chief Executive leadership group, and the groups reporting to it, will be the vehicle through which system business is conducted.
- **One delivery team:** we have ensured that resources are in place to deliver our system's plan.
- **One assurance and risk management framework:** Strengthening trust and creating a sense of shared accountability.

What these changes mean for local people

We have considered the impact that the changes outlined in our Sustainability and Transformation Plan will have on the different groups within our local population. In particular, we have considered the impact on the patient groups who we feel could receive better services from us, namely those in relatively more deprived areas, those with multiple long term conditions, and the frail.

We have engaged with the public, patients, and carers when thinking about solutions to the problems we face, and worked with them to come up with proposals that are beneficial to our population. This is the beginning of our engagement and we want to do more to involve local people and staff in developing and delivering our plans.

We published our interim Sustainability and Transformation Plan summary in July, 'How health and care services in Cambridgeshire and Peterborough are changing', which was provided to staff, stakeholders, and the public.

Our forthcoming engagement with the public has three key aims:

1. **Publicising our plan:** We will continue to tell people about our vision for health and care, describing what it means for patients in more detail.
2. **Co-designing care models**: We will continue to work with patients and the public to ensure that the care we design has the patient at its heart and promotes independence. We will need to engage fully with the public about service redesign that will change how and where they access services.
3. **Supporting behavioural change among patients and the public:** We will work with the public to promote healthy behaviours and taking individual responsibility for health and wellbeing, stressing to our population the importance of leading healthy lives. We will provide education around appropriate and effective ways of using services including self-care, urgent care, and A&E.

Regional centres make sense, seeing a specialist who does it often.

Huntingdon Public Workshop

What do the changes mean for our staff?

We have worked through our solutions as a single leadership team. The staff we have involved in developing solutions have been tasked with putting patients first, over and above organisational or professional interests. With the Sustainability and Transformation Plan now developed, it is important that we are clear about what the changes mean for us as individual organisations.

The biggest change will be for the 20,000+ staff employed by our providers. The proposals have been developed by approximately 200 frontline staff and we have already started to plan how we will engage with staff more widely. By putting our patients at the centre, now and in the future, we are confident our staff will respond positively and feel that the opportunities presented are career enhancing.

We know that our workforce will need to grow in order to cope with our increasing population and growing numbers of people with complex health needs. This means that there will be an increase in staff numbers over the next five years, but this growth in head count will be less than it would need to be if we were not working together as a system.

The type of skills we will recruit will also differ in recognition of the need to supplement primary care with non-clinical staff who can focus on care coordination and provide social support. We need to make the best use of our most expensive, and often scarce, consultant workforce by sharing posts where appropriate.

Staff often train in our organisations but do not choose to stay because housing is too expensive, particularly in Cambridge. We are keen to address this and will seek to influence the planned new housing developments so that they include sufficient affordable homes.

Our move towards working as one network will see significantly greater collaboration between organisations. This may mean that we ask staff to work in different locations or with different working patterns. We will work with staff to alleviate any concerns they might have around this and we will ensure that the benefits of this new approach are made clear.

How you can get involved

There will be more opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change.

We are committed to being as inclusive and open as possible. We will listen to all contributions and use these contributions to influence the decisions we make. You will be able to have a say in key decisions, including formal consultation.

If you want to be part of the discussion and work with us to develop solutions, please contact us via email on **contact@fitforfuture.org.uk**

You can also register on our website **www.fitforfuture.org.uk**

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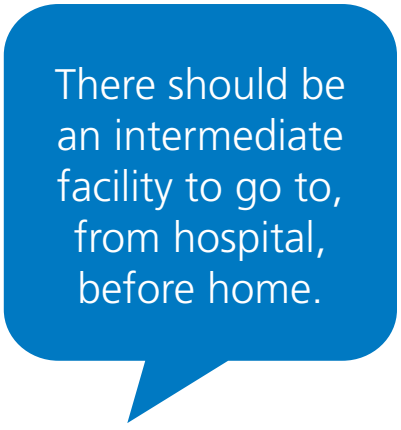
Ely Public Workshop



Cambridge Public Workshop

Our Partners

Cambridgeshire Community Services NHS Trust

Cambridgeshire and Peterborough NHS Foundation Trust

Peterborough and Stamford Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust

Hinchingbrooke Health Care NHS Trust

Papworth Hospital NHS Foundation Trust

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

Cambridgeshire County Council

PETERBOROUGH CITY COUNCIL

Fit for the Future

Working together to keep people well

Produced by Cambridgeshire and Peterborough Sustainability and Transformation Programme.
November 2016

Agenda Item No: 9

GENERAL PRACTICE FORWARD VIEW – FOCUS ON GP RECRUITMENT AND RETENTION IN CAMBRIDGESHIRE

To:	**HEALTH COMMITTEE**
Meeting Date:	**15 December 2016**
From:	**Jessica Bawden, Director of Corporate Affairs, Cambridgeshire and Peterborough CCG**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	The Health Committee requested information from the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) on the General Practice Forward View (GPFV), with a focus on GP recruitment and retention in Cambridgeshire. Information provided in this report is for the whole of Cambridgeshire and Peterborough as moving forward it is essential to work as a whole system, however, where appropriate, specific data or information on Cambridgeshire has been included.
Recommendation:	Report provided for information and discussion at the 15 December Health Committee meeting.

	Officer contact:		***Member contact:***
Name:	CCG Engagement Team	Name:	Councillor David Jenkins
Post:	Lockton House Clarendon Road Cambridge CB2 8FH	Chairman:	Health Committee
Email:	Capccg.contact@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	01223 725304	Tel:	01223 699170

1. BACKGROUND

1.1 General Practice Forward View (GPFV)

Called 'the most significant announcement for general practice since the 1960's'[1], the GPFV was published in April 2016 as a response to the pressures facing general practice and outlines how the government plans to act. It contains specific, practical and funded steps on five areas: investment, workforce, workload, infrastructure and care redesign[2]. A brief overview of these areas can be seen in Appendix A.

The GPFV sets ambitious workforce aspirations to address the gaps and issues relating to the aging workforce. As well as aiming to recruit GPs, the GPFV also supports the development of new roles in General Practice to improve skill mix and to maximise the GP resource available.

The following paragraphs provide further information about some of the investment areas for which more detail is becoming increasingly available:

- *General Practice Resilience Programme - Nationally investing £40 million over 4 years, £16m identified for 16/17*

This programme is about buying direct support for practices who are defined as "good but challenged", and for whom support from a menu of interventions should support sustainability. It is managed by NHS England local teams with the commitment that it will be deployed as flexibly as possible. Practices have indicated whether they wish to be considered for this fund and the CCG and NHS England locally are working closely to maximise the support available.

- *General practice national development programme - £30million nationally over 3 years.*

This investment is about managing workload differently and supporting groups of practices to implement the published 10 High Impact Actions. This is for less-challenged practices and will be wider in its application.
Practices or their CCG can submit an expression of interest form any time until summer 2018. They will be allocated an expert development advisor, who will help them plan their own Time for Care programme. It is expected that over the course of a typical 9-12 month programme, most practices could expect to release about 10% of GP time.
NHS England is also providing a new £45m fund over the next five years to support training for reception and clerical staff – it was stated that this would be devolved to CCGs and therefore sourced locally.

- *GP Access Fund*

This funding is being targeted at those areas of England which had successful pilot sites in 2015/16, known as the "Prime Minister's Challenge Fund" or "General Practice Access Fund" sites. Peterborough has been such an area and investment continues in 2016/17. The CCG is planning to receive additional funding in 17/18 and 18/19 to commission the associated additional access across the rest of Cambridgeshire.

- *Estates and Technology Transformation Fund*

This fund supports improvements in estate and technology. The schemes which have been supported in principle have now been confirmed by NHS England. Schemes

[1] RCGP (2016) Maureen Baker, Chair comment on release of General Practice Forward View
[2] NHS England (2016) General Practice Forward View

supported for cohort 1 funding will need to complete by end of March 2017 rather than the previous expectation that resource will more closely reflect the length of time that premises improvement and technology developments take to implement. The CCG is working with practices to maximise the utilisation of confirmed resource across this and the subsequent two cohorts of funding.

The CCG is working closely with NHS England locally to ensure that the funding opportunities and support that the General Practice Forward View offers are accessed and used to their full potential for primary care in Cambridgeshire and Peterborough.

1.2 General Practice in Cambridgeshire and Peterborough

The CCG covers a diverse patient population of over 900,000. In common with other areas we have an aging population with significant inequalities and a mix of urban and rural districts.

The CCG has 105 member practices, making it one of the biggest CCGs in the country – it is also one of the most financially challenged. The local population is growing with people migrating to new developments in Huntingdonshire and established cities such as Cambridge and Peterborough. The population is also aging, resulting in patients increasingly developing complex and longer term conditions. The local workforce is not growing at the rate required to support demand and there is recognition from the system that the current model for the delivery of primary care needs to change from a GP delivered system to a multi-professional GP led system.

The CCG has been supporting local general practices to consider and develop organisational structures and models of care that enable them to work more closely and at scale. Three GP Federations are now operating across the county, including the Cambridge GP Network Ltd which consists of 32 member practices and 282,000 patients. The recent development of the local Sustainability and Transformation Plan (STP) builds on this and recognises the requirement to ensure the sustainability of Primary Care as the foundation of a strong and resilient health system. Integration with acute and community health services, social care and voluntary sector provision are an essential factor of future care models.

A Sustainable Primary Care Strategy Development Group has been meeting regularly to identify the wider strategy as well as shorter term steps that need to be taken to develop a sustainable future for primary care across Cambridgeshire and Peterborough. Key to delivery is implementation of the General Practice Forward View (GPFV), maximising the resource available through the committed investment and ensuring the engagement of local practices in the processes.

1.3 Workforce Development

Working in collaboration with the CCG, the Cambridgeshire and Peterborough Workforce Partnership (part of Health Education England, HEE) implemented a workforce development programme in 2015 to address some of the pressing workforce issues across the local system. In its first year it saw 54 per cent of the nursing workforce accessing Continuing Professional Development and 13 Practice Nurses commence an Advanced Nursing Practice Masters (MSc) at Anglia Ruskin University. The programme also saw 66 new apprenticeships starts across primary care; with 73 percent (n=48) of those being in general practice. A GP Fellowship programme was

developed, supported by two of our provider Trusts, recruiting (over 2 years) 8 GPs to the local system (5 to Cambridge). The programme received recognition by the Health Service Journal by being shortlisted for its work in the 2016 HSJ Value in Healthcare Awards. A Workforce and Organisational Development plan for general practice forms part of the Sustainability and Transformation Plan for Cambridgeshire and Peterborough.

2. MAIN ISSUES

2.1 Pressures in General Practice

The challenges facing general practice are widely reported. Practices across Cambridgeshire and Peterborough are not immune to these pressures. As part of the work to understand the current issues and improve the sustainability, the CCG held two workshops in the summer of 2016 for member practice representatives to attend. In addition to the workforce challenges that this report covers, issues relating to increased demand and complexity of caseload; demanding practice administration and bureaucracy, navigating patients between the different health and social care provision; and having the space and time to plan for future service delivery, were identified as impacting on current capacity and ongoing sustainability. Perceived and actual pressures in general practice are a deterrent to recruitment. Local management to support new care models and implementation of the aspirations of the GPFV are key to addressing these service delivery and small business pressures.

2.2 Workforce Profile

The profiles for Cambridgeshire versus Peterborough differ significantly with the cost of living and local demographics among key factors having a noticeable impact on the workforce profile in each area.

The General Practice workforce across Cambridgeshire and Peterborough has a relatively young GP profile with only 18% of GPs over the age of 54. The age profile for GPs under the age of 35 in Cambridgeshire is below national average, at 13%, however Peterborough is in a more precarious position with just 6%. The general practice workforce in Cambridgeshire is GP dominated with 53% of the workforce being GPs. There are 0.51 nurses for every GP, which is in stark contrast to Peterborough where there are 0.9 nurses for every GP.

The aging General Practice Nurse (GPN) profile for Cambridgeshire is significantly higher than for Cambridgeshire and Peterborough, and nationally, with 44% aged over 54 years old. Here there are more GPNs aged over 60 than there are aged under 40. Just 5% of GPNs are aged under 35 years old. It is worth considering that there is likely a cycle of experienced nurses moving into General Practice after years in NHS Trusts, particularly Addenbrooke's, therefore the retiring workforce is being replaced with experienced and older nurses rather than recently qualified nurses. This does require further exploration but would explain why GP nurses are much older in Cambridgeshire – again, the price of living will also factor.

The percentage of the workforce that are classed as direct patient care (DPC) staff (e.g. Health Care Assistants, pharmacists, therapists, phlebotomists, administration) is in proportion to the rest of the country. Cambridgeshire and Peterborough has 39% of DPC staff in Health Care Assistant roles, which provide opportunities for staff development into professional roles, to address issues with an aging GPN population.

Patient demographics are positive, with lists being around 5% smaller per whole time equivalent GP than the national average.

2.3 Workforce Demand and Supply

The GPFV has set a national target of 5,000 more GPs by 2020 which equates to approximately 600 GPs in the east of England (using a population share of 10.6%). Assuming good retention, the supply pipeline has the potential to make good progress towards this requirement. It is important to note however, that to become a GP requires 5 years at medical school, 2 years in foundation training and then at least 3 years in GP specialty training. Therefore achieving the increase of 5,000 doctors in primary care cannot be achieved through increasing training places alone. There is work being undertaken nationally to attract UK-trained GPs working abroad back to UK practice. This work encourages retention of current GPs and the return of those who have stopped clinical practice.

In Cambridgeshire and Peterborough, 54 GP specialty training posts have been allocated and filled in 2016. This is a 3 year programme (4 years for the 3 academic posts available in Cambridgeshire). The Cambridgeshire training scheme has an allocation of 22 posts which have all been filled.

It is more difficult to provide a supply forecast for general practice nurses as general practice isn't a defined branch of nursing, meaning that it is not possible to track university starters through training to completion. However, as suggested earlier, general practice nurses tend to have trained in the adult branch of nursing and generally move to general practice after they have spent time working in secondary or community care and are seeking a more traditional 9-5 work life.

2.4 Recruitment and retention

There are around 137 current GP vacancies across Cambridgeshire and Peterborough, with a high proportion of these in Peterborough, not Cambridgeshire.

Retention of GP specialist trainees (GPSTs) post completion of training in Cambridgeshire doesn't tend to be an issue with around 84% remaining taking employment opportunities here post completion of training (CCT). For the nursing workforce, historically practices have sought to employ experienced practice nurses rather than newly qualified; however with the aging GPN workforce profile this is changing. More practices are becoming open to the idea of recruiting newly qualified nurses and supporting them to develop general practice specific competencies as part of their induction or preceptorship. The high cost of living may have a negative impact on retention of newly qualified nurses in the local system, as would the draw from Addenbrooke's.

When compared to Peterborough, Cambridgeshire has a lower percentage of Advanced, Specialist or Extended nurses, at just 19%. This might suggest that the need to employ advanced, specialist or extended scope nurses hasn't been required as the Cambridgeshire system doesn't face the same challenges as Peterborough in plugging the gap left by GP recruitment challenges. However, with the aging GPN workforce; offering more opportunities linked to a career pathway would enhance the systems offer for career development which should contribute to increased recruitment of retention of a younger workforce. In addition, the future of general practice will look very different with an emphasis on a wider skill mix in teams – so considering the

opportunities for expanding the multi professional and speciality team, not just in nursing, but in pharmacy, therapies and wider community care roles, is something that must be considered now as part of the recruitment and retention strategy.

2.5 Training

This year saw a significant reduction in Continuing Professional Development (CPD) for the non-medical workforce across both primary and secondary care nationally. Practices recognise the value in developing their staff; however pressures on small practice teams often prevent staff being released from practice as they are unable to cover patient appointments. Practice nurse forums have been well established in the past and provided opportunities for group learning; however these have become less frequent recently. Moving forward, delivering primary care at scale and developing federations, there should be more opportunities to enable staff to be released for training.

The Peterborough and Huntingdon GP Federations secured funding from HEE to establish Community Education Provider Networks (CPENs). CEPNs are a mechanism for local systems to take ownership for a number of local workforce issues including workforce planning, education commissioning, new role development, and staff development. It is understood that should funding become available again, the Cambridgeshire system will apply for funding to establish their own CEPN. At the start of the year, the Cambridgeshire system surveyed their GPN workforce to understand the skills, competencies and training needs of their system. This information was feedback into the wider Cambridgeshire and Peterborough system, and helped to shape CPD training options for the whole area. Going forward, the assumption is that the Cambridge GP Network will use this information to shape the direction of their CEPN if established.

There is also insufficient change management and leadership capability across the system to manage the successful delivery of primary care at scale. In Cambridgeshire, the Cambridge GP Network has utilised external consultancy expertise to establish themselves as an entity but it is unknown if that support will continue.

2.6 Workload

Increasing patient demand and a reduced workforce has resulted in significant administration activities for GPs, many of whom spend a considerable amount of time responding to referral letters and the review and management of patient medications. The worried well, those undiagnosed but with rising risk, also contribute to the workload for both GPs and advanced nurses as more time is required to support these patients. Different types of appointments are increasingly offered, including telephone and online consultations. From a management perspective, back office functions are localised to practices and require time to manage effectively. GP Federations are exploring solutions that can be delivered at scale to address some of the local duplications of effort.

3. SOLUTIONS

3.1 Primary Care Strategy

The development of a local primary care strategy will combine the requirements of the national GPFV and the context of the local STP to set a sustainable direction for

general practice in Cambridgeshire and Peterborough. The workforce challenges are just one illustration of the need for primary care to embrace new models of care, to maximise the resource that is available to meet the growing and more complex needs of the population. Solutions that see greater integration between practices and across health care providers will result in new roles and utilisation of the primary care workforce. The emphasis will be on creating efficient ways of working and directing clinical staff to clinical functions and away from administration and bureaucracy.

3.2 Workforce Plan

A workforce plan is being developed and will be finalised once the outcomes of the primary care strategy are published. The following are interventions which have been implemented since the start of this work in 2015 or areas being considered as key to the final plan:

- Understanding our supply pipeline. Develop a greater understanding of what newly qualified clinicians want and expect from careers which will allow the system to better tailor career opportunities
- Growing Our Own. Development routes which support unregistered staff into registrant roles should increase retention rates and improve the clinical competence of the local workforce. Apprenticeships, foundation degrees and flexible nursing pathways are some of the options already being utilised within the system.
- Retention of organisational knowledge. Ways to retain mature GPs and GPNs within the local system are being considered, for example flexible working, support with indemnity costs and new roles in education, mentoring, and commissioning
- Integration. Proving opportunities for portfolio working which will enable clinicians to work across settings to deliver care will not only provide varied career options for GPs but also enable GPs to enhance competencies in specific areas e.g. dermatology, palliative care etc., and improve relationships between primary and secondary care
- Centralisation of back office functions – for example outsourcing payroll, HR, and other activities would release practice workload and drive down costs if a number of practices shared a contract.
- Establishing true integrated care across the system is a key component of the STP plan to ensure patients are most efficiently supported along their pathway. The integration of both health and social care, and between general practice and wider neighbourhood, community teams, and secondary care should improve working relationships and the patient pathway.

Reviewing skill mix will be a key part of the strategy. Emerging clinical models must consider whether clinicians are being used to their fullest potential; and if the workforce has the required skills, knowledge and competencies to address our population's needs. We will be working with practices, taking direction from the General Practice Forward View and local initiatives, to consider how expansion of the multi-professional workforce and new roles will support appropriate delegation of tasks. Nationally, the General Practice Forward View, Health Education England and NHS England have committed to place and train: 1,000 Physician's Associates (PAs), an extra 1,500 Clinical Pharmacists, and 3,000 Mental Health therapists.

- To date, Cambridgeshire and Peterborough have supported clinical placements for three PAs in two of our practices.

- Practices chose not to engage in the first Clinical Pharmacy pilot; however we have 6 clinical pharmacists employed in practice at present, with more practices keen to understand the cost and quality benefits.
- Mental health therapists can work across a number of areas in primary care and it is important for general practice to work with the wider system, to understand how these roles can best be grown. Expansion of the traditional GP team may also bring opportunities to attract clinicians into primary care roles from other specialities which may be over supplied at present.

4. SIGNIFICANT IMPLICATIONS

4.1 Statutory, Risk and Legal Implications

This paper is linked to and informed by the GP Forward View as referenced.

4.2 Engagement and Consultation Implications

As noted, our member practices and local stakeholders have been included in the design and delivery of workforce interventions to date. We are working with our local system to shape and design the STP Sustainable Primary Care Strategy which is due for submission on 23 December 2016.

SOURCE DOCUMENTS GUIDANCE

Source Documents	Location
General Practice Forward View	***NHS England (2016) https://www.england.nhs.uk/ourwork/gpfv/***

Authors:
Emma Wakelin, Strategic Development Manager, Health Education East of England
Alice Benton, Head of Primary Care, Cambridgeshire and Peterborough CCG
Andrea Patman, Head of Commissioning, NHS England Midlands and East - East
02 December 2016

Appendix A – General Practice Forward View on a page
See attached PDF.

Appendix B – Primary Care Workforce Development Programme leaflet
See attached PDF.

General Practice Forward View: On A Page

Maureen Baker (RCGP President) called this **"the most significant announcement for general practice since the 1960s."**

CHAPTER 1: £

- Investing a further **£2.4 billion by 2020/21 into general practice services**.
- This means that investment will rise from **£9.6 billion a year in 2015/16 to over £12 billion a year by 2020/21**.
- This includes recurrent and transformational funding
- Additionally a review on Carr-Hill formula in progress to ensure it reflects derivation and workload etc.

CHAPTER 2: WORKFORCE

- Create an extra **5,000 additional doctors working in general practice by 2020**
- Attract an extra 500 GPs from abroad and targeted £20,000 bursaries that have found it hardest to recruit.
- **A minimum of 5,000 other staff working in general practice by 2020/21**
  - ❖ *3,000 mental health therapists*
  - ❖ *1,500 pharmacists*
- **£206 million in support for the workforce through:**
  - ❖ ***£112 million (in addition to £31m already committed)*** *for the clinical pharmacist programme to enable a* ***pharmacist per 30,000 population***
  - ❖ ***£15 million national investment for nurse development support*** *including improving training capacity in general practice, increases in the number of pre-registration nurse placements and measures to improve retention of the existing nursing workforce and support for return to work.*
  - ❖ ***£45 million*** *benefitting every practice to support the training of current reception and clerical staff to play a greater role in navigation.*
  - ❖ *Investment by HEE in the training of* ***1,000 physician associates to support general practice.*** *Introduction of pilots of new medical assistant roles that help support doctors.*
  - ❖ ***£6 million investment*** *in practice manager development, alongside access for practice managers to the new national development programme.*

CHAPTER 3: WORKLOAD

Support for GPs to manage demand, unnecessary work, bureaucracy and integration with wider system

- **£16 million extra investment** in specialist mental health services to support GPs with burn out and stress.
- **£30 million** 'Releasing Time for Patients' development programme
- new standard contract measures for hospitals to stop work
- new four year **£40 million** practice resilience programme (plus an **additional £16m in 2016/17**)
- move to five yearly CQC inspections for good/outstanding practices
- introduction of a simplified system across NHS E, CQC and GMC, streamlining of payment for practices,& automation of common tasks.

CHAPTER 4: INFRA-STRUCTURE

- **£900m for premises and IT** (this is the continuation of the Primary Care Transformation Fund, now renamed)
- **£45m** for e-consultation support
- New rules to allow up to **100% reimbursement of premises developments**
- Over **18% increase in allocations to CCGs** for provision of IT services and technology for general practice

CHAPTER 5: CARE REDESIGN

- **Support to strengthen & redesign general practice by c**ommissioning and funding of services to provide extra primary care capacity across every part of England, backed by over **£500 million of funding by 2020/21** incl.**£171 million one-off investment** by CCGs starting in 2017/18, for practice transformational support, introduction of new voluntary Multi-speciality Community Provider contract from April 2017.
- **New national three year 'Releasing Time for Patients' programme to reach every practice in the country to free up to 10 percent of GPs' time (£30m),** building on recent NHS England and BMA roadshows.

Cambridgeshire and Peterborough Clinical Commissioning Group

Health Education England

2016 and beyond

Focus on

Practice Nurse Supply

- Placement capacity
  - Mentoring
- Flexible pathways
- Preceptorship

Skill mix

- Pharmacy
  - ANP
- GP Fellowships
- Apprenticeships

System transformation

- Sustainable Transformation Programme
- Community Education Provider Networks'

Cambridgeshire and Peterborough Clinical Commissioning Group

Health Education England

Primary Care Workforce Development Programme – helping people reach their potential in Cambridgeshire and Peterborough

A collaborative programme between Cambridgeshire and Peterborough Workforce Partnership (Health Education England) and Cambridgeshire and Peterborough Clinical Commissioning Group.

"The PCWDP has had a great first year. Working in collaboration, the Workforce Partnership and the Clinical Commissioning Group have engaged stakeholders to design a programme to support and develop a sustainable Primary Care workforce capable of delivering new models of quality patient care. The solution was to design a multi-faceted programme of workforce transformation interventions which enables the local system to be in a position to deliver its new models of quality patient care whilst ensuring the sustainability of its workforce. The PCWDP has had a successful first year and is now working towards enhanced delivery and moving to a system owned programme."

Dr David Roberts
Chair, Primary Care Board
Cambridgeshire and Peterborough Clinical Commissioning Group

Our area

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) has 105 GP practices as members across Cambridgeshire, Peterborough and parts of Hertfordshire and Northamptonshire.

We are the third largest CCG in England, responsible for providing NHS services to our 922,857 patient population.
The CCG is organised into six local groups (known as Local Commissioning Groups or LCGs). The six LCGs are part of the wider Clinical Commissioning Group

Programme enablers

- Collaborative working
  has enabled us to pool expertise from commissioners and providers
- Engagement
  our workforce have informed the strategic direction of the programme
- Whole workforce
  The programme recognises value of multi-disciplinary teams and skill mix

Reach your potential in Cambridgeshire and Peterborough

Cambridgeshire and Peterborough Clinical Commissioning Group

Health Education England

2015/16 Outcomes

Focus on supply and sustainability

Increasing competency

Increasing competency levels of our support workforce; developing skill mix within practice teams to enhance patient care, enhancing and promoting the development of skill mix within practice teams:

- **3 'Super HCA' programmes**
  "It has made me excited to learn again"
  A package combining an apprenticeship with 5 days of competency based training, and the care certificate for new staff. 26 HCAs on programme to date.

- 

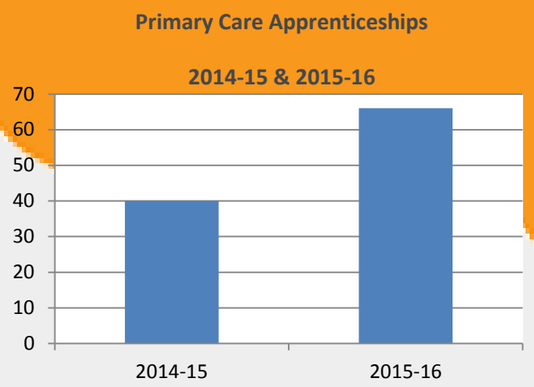
  Recruitment of Widening Participation Officer.
  Sallyann is the point of contact for support staff and Practices.
  She works closely with primary care, training providers and schools to encourage young people into roles in healthcare

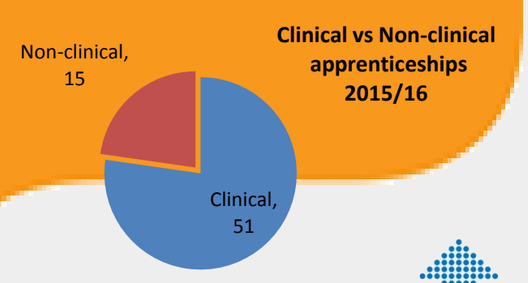
- **Modernising pharmacy roles**
  Practices are realising the impact on service and resource savings employing Pharmacists in Practice can provide. We have supported education of staff on local non-medical prescribing programmes and we are developing apprenticeship routes in to provide immediate support to teams and a new development pathway for support staff.

Infrastructure

Developing the infrastructure to increase the supply of future workforce:

- We have increased apprenticeships by 30% with the majority being clinical posts
- We have developed a streamlined process to engage practices with supporting pre-registration students and increased active placements. Work continues to provide great placement period to pre-reg nursing students.
- Development of GP Fellowship programme with links to secondary care.
  3 GPs employed in 15/16 with 10 applications received so far for 16/17.
- We established baseline data of our workforce by enhancing the results of the nWMDs with a qualitative survey





Reach your potential in Cambridgeshire and Peterborough

Cambridgeshire and Peterborough Clinical Commissioning Group

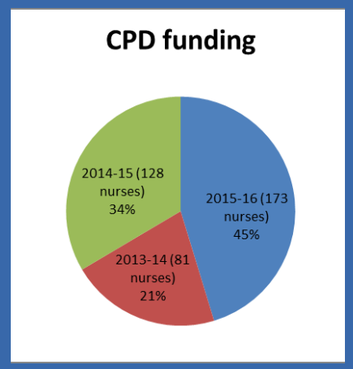
Health Education England

Mechanisms

Increasing the mechanisms available to Practice Nurses for accessing education, training and career development to enhance the provision of patient care and lead to increased levels of workforce competency and satisfaction:

- Recruitment of Nurse Tutors

- Full utilisation of £180k CPD fund
  Significant increases in access to CPD from nurses can be attributed in part to tour Nurse Tutors actively promoting and supporting people to develop



- Successful delivery of educational programmes to support recruitment retention and returners in both GPN and GP – Fundamentals, ANP MSc and GP Fellowship
- Promotion of career development opportunities
  Our activities have been locally welcomed and nationally adopted with support from @WeGPNs, HEE nationally and Health Careers featuring our work on their careers pages.

"Being a General Practice Nurse" Film link

System engagement

To increase system engagement, enabling stakeholders contribute and benefit from the design, delivery and outcomes of the PCWDP

- PCWDP sub group – meets bi monthly and provides a multi professional forum to develop the programme
- Quantitative survey – a 44% return was received, very good for a survey of this type. This enhanced the national Minimum Data Set (nWMDs) and provided local intelligence about system issues and solutions which could then be shared.
- Team presence – significant presence and engagement at local nurse, GP, Practice manager and stakeholder forums
- Stakeholder support

Anglia Ruskin University

annie barr associates

Cambridgeshire LMC

Agenda Item No: 10

PROPOSED CONSULTATION ON PROPOSED CHANGES TO THE FUTURE PROVISION OF SPECIALIST FERTILITY TREATMENT IN THE CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP AREA.

To:	**HEALTH COMMITTEE**
Meeting Date:	**15 December 2016**
From:	**Director of Corporate Affairs, Cambridgeshire and Peterborough Clinical Commissioning Group, Jessica Bawden**
Electoral division(s):	**Countywide.**
Forward Plan ref:	**Not applicable**
Purpose:	Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) currently commissions specialist fertility treatments via the East of England Fertility Consortia. Each member CCG of the group applies its own eligibility criteria and the number of treatment cycles it is able to commission. The CCG entered into this consortium offering 2 cycles of IVF treatment in 2014. As part of plans to manage its financial situation the CCG reduced this to one cycle from May 2016. This paper sets out proposals for consultation to stop routinely commissioning any specialist fertility services other than for two specified exceptions.
Recommendation:	The Committee is asked to approve the process for public consultation on future provision of specialist fertility treatments, and comment on the draft consultation document. See appendix 1, consultation process plan, and appendix 2, draft consultation document.

	CCG contact:		***Member contact:***
Name: Contact:	Jessica Bawden Teresa Johnson, Executive Assistant,	Name: Chairman:	Councillor David Jenkins Health Committee
Email:	teresa.johnson4@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	07534 101165	Tel:	01223 699170

1. BACKGROUND

1.1 Specialist fertility services, or IVF as these services are more commonly known, only became available on the NHS in this area, in September 2005. Prior to this, patients had to pay for their own IVF treatment.
In July 2016 the CAPCCG governing body took the decision to reduce the number of cycles of IVF available to patients in this area. Patients may now receive one cycle of IVF if aged between the ages of 23 and 42, and meet all the necessary eligibility criteria.
131 people accessed IVF services in 2015/16. Although this is a small number of patients the CCG understands this will have a significant impact on those affected by this change.

What ever decision is made around this proposal will be reviewed at the end of this funding formula period of three years.

2. MAIN ISSUES

2.1 **The Proposal:**
To stop the routine commissioning of any specialist fertility services other than two specified exceptions below.
GP and clinical leaders have come to the difficult conclusion that when looking at the prioritisation of funds this is an area that we should review. The CCG has finite resources to fund a whole range of health services and treatments.
Specialist fertility services are expensive treatments. There is a real need to consider the value of funding for this treatment at the current time compared with all other NHS treatments/services.
Other investigations and clinical interventions that can improve fertility for couples are widely available via NHS services before the need to access specialist fertility services, these other services will not be affected by this proposal.
What is the cost of specialist fertility services to the CCG?
In the year 2015/16 CAPCCG spent £1,108,000 on treatment for 131 cycles of IVF.

2.2 **Exceptions to the proposal**
Under the new proposal, specialist fertility services will no longer be commissioned except for the following two exceptions listed below:

- Fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile.
- Sperm washing will be provided to men who have a chronic viral infection (primarily HIV and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral conditions such as HIV to the woman and therefore potentially her unborn baby.)

2.3 **Exceptional Funding Request Process**
Should this proposal be accepted it is important to note that the Exceptional Funding Request (EFR) process is still available for patients who believe that they have exceptional circumstances.
Any application needs to be made on behalf of the patient by a clinician, and the key point to remember is the need to demonstrate the exceptionality of the case - i.e. why the patient should receive treatment which is outside the CCG's current funding arrangements.

2.4 **Please Note:**
It is only in cases where patients' eggs and/or sperm need retrieving and laboratory fertilisation techniques are needed that there is onward referral to the specialist centres (IVF clinics).

2.5 **Infertility services not included in this consultation.**
The CCG will continue to support the local gynaecological services, access to these is not being restricted. There is a range of services available to people who need help with fertility issues, both in primary care and in our local hospitals.
The hospital clinics have always had close links to the specialist IVF providers and will continue to provide patients with information on accessing the specialist services.
Services provided by the gynaecology clinics in the local hospitals include:

- The standard investigation of causes of infertility.
- Non-specialist treatments such as physical and hormonal therapy
- Management of ovulation disorders
- Management of tubal and uterine abnormalities
- Medical and surgical management of endometriosis
- Medical and surgical management of male infertility
- Management of ejaculatory failure

The full care pathway for fertility services can be found on the CCG website here.
Patients with genetic disorders requiring pre implantation diagnosis and embryo selection based on this are commissioned by NHSE and are not affected by this consultation.
What ever decision is made around this proposal will be reviewed at the end of this funding formula period of three years.

3. SIGNIFICANT IMPLICATIONS

3.1 **Financial:** Projected cost reduction of cessation of Assisted Conception Services is £1million.

3.2 **Governance:** The normal CCG policies development process has been followed in recommending that Assisted Conception should no longer be a priority for funding.

3.3 **Equality and Diversity:** Cessation of NHS funding for Assisted Conception will affect all childless couples equally, regardless of race, gender or sexual orientation. A full equality impact assessment has been completed and published on the CCG website;
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2016-17/20160913/Agenda%20Item%2002.1b%20-%20IVF%20Equality%20Impact%20Assessment.pdf

3.4 **Legal:** Legal advice has been sought.

3.5 **Consultation Implications** Consultation process plan attached as appendix 1.
Draft consultation document attached as appendix 2.

Source Documents	Location
NONE	.

4.0 Appendices

Appendix 1 – Draft consultation process plan
Appendix 2 – Draft consultation document.

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

WORKING DOCUMENT,

APPENDIX 1

Consultation Process Plan

For Specialist Fertility Services (IVF)

Proposed consultation 19 January 2017 to 13 April 2017

V6
14/11/16

Engagement Team, Cambridgeshire and Peterborough Clinical Commissioning Group
Lockton House, Cambridge, CB2 8FH. 01223 725304.
Engagement@cambridgeshireandpeterboroughccg.nhs.uk

Background

On 25 May 2016 the Cambridgeshire and Peterborough Clinical Commissioning group took the decision to reduce the number of cycles of IVF available to patients in this area. Patients can now receive one cycle of IVF if aged between the ages of 23 and 42. At this meeting the Governing Body were also asked to consider a proposals to stop funding for IVF cycles on the NHS in this area. The Governing Body agreed to consider this proposal following further public engagement. As this would be a decommissioning of a service the CCG is proposing to hold a public consultation in order to give people the opportunity to tell us what they think of these proposals.

Why are we consulting now?

Specialist fertility services, or IVF as these services are more commonly known, only became available on the NHS in this area, in September 2005. Prior to this, patients had to pay for their own IVF treatment.

Cambridgeshire and Peterborough's health economy has been identified as one of England's 11 most financially challenged health economies.
If we do not change our health system substantially, then we face a funding shortfall of at least £500 million by 2020/21. This will make it harder to deliver good quality care for everyone who needs it.

GP and clinical leaders have come to the difficult conclusion that when looking at the prioritisation of funds this is an area of service that we should revisit. The CCG has finite resources to fund a whole range of health services and treatments. Specialist fertility services are expensive treatments which can often prove unsuccessful. There is a real need to balance funding for this treatment with all other treatments/services across the NHS in the CCG area. Other investigations and clinical interventions that can improve fertility for couples are widely available via NHS services before the need to access specialist fertility services.

The CCG funded 131 cycles of IVF in 2015/16. Although this is a small number of patients the CCG understands this will have a significant impact on those affected by this change.

Exceptions to the proposal

Patients currently in NHS funded IVF treatment (defined as having been referred to the contracted tertiary specialist IVF provider prior to the date that this policy change is made if approved by the governing Body) will be treated under the current policy.

NHS patients requiring cryopreservation/embryo storage based on current provision for cancer patients will continue to receive retrieval and storage services but, should IVF be required after cancer treatment, cancer patients will need to meet the policy criteria in place at the time that fertilisation/embryo implantation are requested.

Process

Pre-consultation

Cambridgeshire and Peterborough CCG will:

- Prepare a full and comprehensive consultation document that explains the programme and the options for consultation in clear plain English.
- Prepare a summary of this consultation document for people who are not able, or do not want, to able to read the full consultation document
- Translate the summary consultation documents into key community languages, explaining that more information is available if people want it.
- Prepare text rich and plain text versions of all of the consultation documents for people with sensory disabilities to download.
- Ensure that drafts of the full consultation documents and questions for consultations are shared with the following groups:
    - CCG Governing Body
    - Health Scrutiny Committees from Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire and Norfolk.
    - The CCG Patient Reference Group (PRG)
    - Healthwatch organisations from Cambridgeshire, Peterborough, Northamptonshire, Hertfordshire and Norfolk.
    - Fertility Network UK

- Ensure that the final consultation document reflects feedback from these groups.
- Plan public meetings in accessible venues in the CCG area.
- Publicise these meetings within the consultation documents.

Consultation

Cambridgeshire and Peterborough CCG will:

- Have copies of the consultation documentation available on the website from the first day of the consultation and throughout the consultation.
- Have translations and rich text versions of the documentation on the CCG website as close to the start of the consultation as possible.
- Have photocopies of the documentation prepared for distribution on the first day of the consultation.
- Have printed copies of the full document, summary document and translations as soon as possible after the start of the consultation.
- Distribute these documents to:
    - GP practices
    - Pharmacies
    - Stakeholder database
    - MPs
    - Councils for Voluntary Services (Peterborough and Cambridgeshire).
    - Health Scrutiny Commissions, Cambridgeshire, Peterborough, Hertfordshire, Northamptonshire, Norfolk.
    - Health and Wellbeing Boards, Cambridgeshire, Peterborough, Hertfordshire, Northamptonshire, Norfolk.
    - Local Health Partnerships, Fenland, S.Cambs, E.Cambs, Cambridge City, NE Northants, Hunts.

- District, Town and Parish councils
- CCG Patient Reference Group
- Patient Forum Groups
- Healthwatch organisations, Peterborough, Cambridgeshire, Northamptonshire, Hertfordshire, Norfolk.
- Libraries
- Cambridgeshire Community Services NHS Trust
- Cambridge University Hospitals NHS Foundation Trust, Maternity Unit, IVF unit.
- Cambridgeshire and Peterborough NHS Foundation Trust
- East of England Ambulance Service MNHS Trust
- Hinchingbrooke Health Care NHS Trust
- Peterborough and Stamford Hospitals NHS Foundations Trust, Maternity, IVF unit
- Queen Elizabeth Hospital NHS Trust
- Bourn Hall Clinic (current provider of services)
- Unions
- NHS England Area Team
- Herts Urgent Care
- Lincolnshire Community Health Services NHS Trust / Peterborough Minor Illness and Injury Unit
- BICA (British Infertility Counselling Association)
- Cambridge IVF
- Maternity Services Liaison Committees
- Health Visiting teams
- Infertility Network UK

- Send media release to all local media outlets at the start of the consultation and at strategic points in the consultation to ensure widespread media coverage.
- Use Facebook and Twitter to raise awareness of the consultation
- Ensure that translations are made available on request as well as in key community languages.
- Ensure that all translations are available on the CCG website when requested.
- Ensure that all responses received in other languages are translated into English and included in the response reports.
- Log all calls received with regard to the consultation
- Collate all letters and emails received as part of the consultation
- Ensure that all public meetings held have full meeting notes, recording comments and questions.
- Ensure that when we attend meetings we record a briefing note of the meeting and request full minutes when available.
- Collate all meeting notes, briefing notes and minutes
- Publish frequently asked questions on our website during the consultation.
- Respond to requests for attendance at meetings to discuss the consultation.
- Attend meetings with the following key stakeholder groups during consultation:
    - Health Scrutiny Commissions in Cambridgeshire, Peterborough
    - Health Scrutiny Committees in Northamptonshire and Hertfordshire on request.

- Healthwatch organisations in Cambridgeshire and Peterborough. Attend in Northamptonshire and Hertfordshire on request.
- CCG Patient Reference Group
- Health and Wellbeing Boards in Cambridgeshire, Peterborough, Northamptonshire and Hertfordshire(on request).
- Local Health Partnerships in Cambridge City, South Cambs, East Cambs, Fenland, Hunts, East Northants.

Post Consultation

A report to be produced on the consultation responses

Cambridgeshire and Peterborough CCG Governing Body will review report and findings before making its decision.

Press release on the outcome of the consultation, emphasising the changes made to the procurement following consultation feedback

Communications to be sent via email/letter to stakeholders/and consultation respondents with link to consultation report and outcomes.

Feedback to staff via email, staff briefings and Connect

Feedback to members via, Members news and Members email

Continued communication as project progresses.

Legal requirements

The consultation documents will be drawn up in accordance with following legal requirements and guidance:

Cabinet Office Consultation Principles July 2012
This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.
Policy makers should bear in mind the Civil Service Reform principles of open policy making throughout the process and not just at set points of consultation, and should use real discussion with affected parties and experts as well as the expertise of civil service learning to make well informed decisions. Modern communications technologies enable policy makers to engage in such discussions more quickly and in a more targeted way than before, and mean that the traditional written consultation is not always the best way of getting those who know most and care most about a particular issue to engage in fruitful dialogue.

The full consultation principles document can be accessed via the Cabinet Office website at:
https://www.gov.uk/government/publications/consultation-principles-guidance

Section 14Z2 Health and Social Care Act 2012
14Z2 Public involvement and consultation by clinical commissioning groups
(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").
(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.
(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2) (b) to the delivery of services is a reference to their delivery at the point when they are received by users.
For more on the Section 14Z2 Health and Social Care Act 2012 see http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

Four Criteria for Significant Service Change
In May 2010, the Secretary of State for Health, Andrew Lansley, set four new tests that must be met before there can be any major changes to NHS Services:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice

CCG Constitution Section 5.2.

5.2. General Duties - in discharging its functions the NHS C& P CCG will:

5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by:

a) ensuring that individuals to whom the services are being or may be provided are involved:

(i) in the planning of the CCG's commissioning arrangements;
(ii) in the development and consideration of the proposals by the CCG for changes in commission arrangements;
(iii) in the decisions of the CCG affecting the operation of commissioning arrangements, where the decisions would, if made, impact on the manner in which the services are delivered to the individuals or the range of health services available to them;

b) in order to understand the views of patients and the public and to disseminate relevant information to them, establishing and working closely with:

(i) a Patient Reference Group which is constituted as a subcommittee of the Governing Body in accordance with this Constitution;
(ii) Local Commissioning Groups which are constituted as subcommittees of the Governing Body in accordance with this Constitution;
(iii) the Patient Safety and Quality Committee which is constituted as a subcommittee of the Governing Body and considers patient experience, complaints and feedback;
(iv) Patient Participation Groups which will seek the views of local populations and assist with the dissemination of information, and representatives of which will sit on each Local Commissioning Group's patient forum;

c) in order to understand the views of patients and the public and to disseminate relevant information to them, ensuring regular liaison and the development of close working relationships with each of the following bodies:

(i) Patient Forums, which are intended to give individuals the opportunity to raise questions or concerns about the provision of healthcare services at the wider county level;

(ii) Healthwatch, which gathers views of local people on local health services;
(iii) Health Overview and Scrutiny Committees which review the planning, commissioning and delivery of health services;
(iv) Health and Wellbeing Boards, each of which is a group of key leaders representing health and care organisations who work together to understand what their local communities need from health and care services and to agree priorities;

d) publishing a Communications Membership and Engagement Strategy, approved by its Governing Body and regularly revised to take into account any new guidance published by NHS England, which will be designed to ensure that the CCG involves patients and the public by a range of means that are suitable to different aspects of its commissioning arrangements, those means to include as appropriate:

(i) the publication of documents to disseminate relevant information about the commissioning arrangements;
(ii) regular attendance at key meetings, forums and events for the purpose of listening to the views of patients and the public, providing information about and explaining actions being taken or considered by the CCG, and answering questions;
(iii) the dissemination of information by means of the CCG website, emails, newsletters targeted at specific groups, media campaigns, advertising, and targeted engagement events;
(iv) the provision of an opportunity for patients and the public to make their views known via the CCG website, emails and other suitable means;
(v) the publication of consultation documents in relation to certain planning and commissioning activities, and the creation of specific engagement opportunities such as the use of public surveys and feedback forms;

e) in the implementation of the arrangements described above, acting consistently with the following principles:

(i) ensuring that appropriate time is allowed for the planning of activities and commissioning arrangements;
(ii) proactively seeking engagement with the communities which experience the greatest health inequalities and poorest health outcomes;
(iii) commencing patient and public involvement as early as possible and allowing appropriate time for it;
(iv) using plain language, and sharing information as openly as is reasonably practicable;
(v) treating with equality and respect all patients and members of the public who wish to express views;
(vi) carefully listening to, considering and having due regard to all such views;
(vii) providing clear feedback on the results of patient and public involvement.

You can read more about the CCG's duties to engage and consult in section 5.2 of the CCG's Constitution
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CPCT/Corporate%20documents/CCG%20Constitution.pdf

DRAFT

Consultation on proposed changes to the future provision of specialist fertility treatment in the Cambridgeshire and Peterborough Clinical Commissioning Group area.

19 January 2017 to 13 April 2017

This consultation is aimed at patients living in Cambridgeshire and Peterborough Clinical Commissioning Group's area.

This document is available in other languages and formats on request.

This document will be downloaded in full as a page on our website where the browse aloud facility is available.

To request alternative formats, please contact us on:

- 01223 725304 or capccg.engagement@nhs.net

Pokud byste požadovali informace v jiném jazyce nebo formátu, kontaktujte nás

જો તમને માહિતી બીજી ભાષા અથવા રચનામાં જોઈતી હોય તો, કૃપા કરી અમને વિનંતી કરો.

Se desiderate ricevere informazioni in un'altra lingua o in un altro formato, siete pregati di chiedere.

Jei norėtumėte gauti informaciją kita kalba ar formatu, kreipkitės į mus.

Jeżeli chcieliby Państwo uzyskać informacje w innym języku lub w innym formacie, prosimy dać nam znać.

Se deseja obter informação noutro idioma ou formato, diga-nos.

اگر آپ کو معلومات کسی دیگر زبان یا دیگر شکل میں درکار ہوں تو برائے مہربانی ہم سے پوچھئے۔

Background

Who we are and what we do

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) is the local organisation responsible for planning, organising and buying NHS-funded healthcare for the 930 ,000 people who live in this area, which includes parts of Hertfordshire and Northamptonshire as well as Cambridgeshire and Peterborough. This includes: hospital services, community health services and mental health services.

The CCG is run by GPs, nurses and other clinicians – the people you see whenever you come into contact with the NHS. All 105 GP practices in the area are members of the CCG.

In 2016-2017, the CCG has a budget of £1 billion to spend on healthcare services for the people of this area, which is just over £1,000 per person. We are one of the largest CCGs in England by patient population.

What is this document about?

The NHS receives a fixed budget to buy and provide health services for the entire local population. When commissioning (buying) health services we do so specifically for the health needs which have been identified locally for our population. We make decisions about which health services to purchase, based on these identified needs.

Like all CCGs up and down the country, there is greater demand on our budget than we have the budget to spend.

The challenge faced by all organisations across the NHS is how to spend the available budget in ways that most benefit the health of the whole population and delivers good value for money. Cambridgeshire and Peterborough CCG has been identified as one of England's 11 most financially challenged health economies. It has a growing population, which is also an ageing population that is diverse and has significant inequalities. We have a limited budget and a growing demand for all types of healthcare services, as well as a financial deficit that needs to be cleared. The CCG has to evaluate every service that it commissions to see if it offers good quality, good outcomes, good value for money and also whether it is an effective and equitable way of allocating our resources for the benefit of the whole population.

What has the CCG already done?

The CCG has already made some significant prioritisation decisions, resulting in restrictions to procedures provided on the NHS. The CCG is ensuring that all referrals for treatment strictly adhere to clinical thresholds and /or meet clinical criteria, this is to ensure that all services are delivered equitably across the CCG area.

We also introduced a prior approval process for clinical procedures where there is evidence to show they have limited benefit to patients. This is in line with regional guidance.

It includes procedures such as: cosmetic surgery, laser treatment for skin conditions, varicose veins and benign skin lesions.

CCG now has some more difficult decisions to make about the prioritisation of funds for 2016 and beyond.

The Proposal

To stop routinely commissioning any specialist fertility services other than for two specified exceptions.

In this document, we will explain why we want to make these changes and how you can tell us your views on the proposals.

The case for change

Specialist fertility services, or IVF as these services are more commonly known, only became available on the NHS in this area, in September 2005, following national guidance. Prior to this, patients had to pay for their own IVF treatment.

In July 2016 the CCG governing body took the decision to reduce the number of cycles of IVF available to patients in this area. Patients may now receive one cycle of IVF if aged between the ages of 23 and 42, and meet all the necessary eligibility criteria.

131 people accessed IVF services in 2015/16. Although this is a small number of patients the CCG understands this will have a significant impact on those affected by this change.

The CCG's existing policy on funding for specialist fertility services was developed in April 2015 in collaboration with the East of England Fertility Services Consortium, the CCG commissions the following treatments as appropriate for couples who meet evidence based eligibility criteria:

- 1 cycle of IVF, with or without intracytoplasmic sperm injection (ICSI)
- Surgical sperm removal
- Up to 6 cycles of donor sperm insemination with intrauterine insemination (IUI)
- Treatment using egg donation
- Egg, sperm or embryo cryopreservation for men and women undergoing
    - cancer treatment which is likely to cause infertility
- ICSI with or without sperm washing for men who have a chronic viral infection (primarily HIV) and whose female partner does not.

This policy is specifically for those couples who live in the CCG area, and do not have a living child from their current or any previous relationships prior to starting NHS funded treatment, regardless of whether the child resides with them. This includes any adopted child within their current or previous relationships.

Any person who has already been referred for IVF treatment and is waiting for that treatment to begin will receive that treatment regardless of the outcome of this consultation.

Specialist fertility treatments, or IVF services, are known by several names within the NHS. You may also see the terms, assisted conception services, or infertility treatments used to describe theses services.

Please Note:

It is only in cases where patients' eggs and/or sperm need retrieving and laboratory fertilisation techniques are needed that there is onward referral to the specialist centres (IVF clinics).

Infertility services not included in this consultation.

The CCG will continue to support the local gynaecological services, access to these is not being restricted. There is a range of services available to people who need help with fertility issues, both in primary care and in our local hospitals.

The hospital clinics have always had close links to the specialist IVF providers and will continue to provide patients with information on accessing the specialist services.

Services provided by the gynaecology clinics in the local hospitals include:

- The standard investigation of causes of infertility.
- Non-specialist treatments such as physical and hormonal therapy
- Management of ovulation disorders
- Management of tubal and uterine abnormalities
- Medical and surgical management of endometriosis
- Medical and surgical management of male infertility
- Management of ejaculatory failure

The care pathway for fertility services can be found on the website

Link to insert here

Patients with genetic disorders requiring pre implantation diagnosis and embryo selection based on this are commissioned by NHSE and are not affected by this consultation.

What ever decision is made around this proposal will be reviewed at the end of this funding formula period of three years.

The Proposal:

To stop the routine commissioning of any specialist fertility services other than two specified exceptions below.

GP and clinical leaders have come to the difficult conclusion that when looking at the prioritisation of funds this is an area that we should review. The CCG has finite resources to fund a whole range of health services and treatments.

Specialist fertility services are expensive treatments. There is a real need to consider the value of funding for this treatment at the current time compared with all other NHS treatments/services.

Other investigations and clinical interventions that can improve fertility for couples are widely available via NHS services before the need to access specialist fertility services, these other services will not be affected by this proposal.

What is the cost of specialist fertility services to the CCG?

In the year 2015/16 the CCG spent £1,108,000 on treatment for 131 cycles of IVF

Exceptions to the proposal

Under the new proposal, specialist fertility services will no longer be commissioned except for the following two exceptions listed below:

- Fertility preservation will be offered to patients undergoing cancer treatment, or who have a disease or a condition requiring medical or surgical treatment, that has a significant likelihood of making them infertile.
- Sperm washing will be provided to men who have a chronic viral infection (primarily HIV and whose female partner does not where intrauterine insemination is being considered. This is a risk reduction measure to limit the transmission of a serious, pre-existing viral conditions such as HIV to the woman and therefore potentially her unborn baby.)

Individual Funding Request Process

Should this proposal be accepted it is important to note that the Individual Funding Request (IFR) process is still available for patients who believe that they have exceptional circumstances.

Any application needs to be made on behalf of the patient by a clinician, and the key point to remember is the need to demonstrate the exceptionality of the case - i.e. why the patient should receive treatment which is outside the CCG's current funding arrangements. Further information can be found on the CCG website: http://www.cambsphn.nhs.uk/CCPF/ExcptnalandIFR.aspx

£1 million of NHS money can buy the following services:

- Psychological therapies treatment of six sessions for 2754 people (IAPT/PWS)
  or
- Four primary care based teams for mental health serving 25% of the population of the CCG area (for one year)
  or
- 26 full time working district nurses for a year (costed at mid band 6 with on-costs)
  or
- 12.5 salaried GPs for one year (based on the average salary for a salaried GP)
  or
- perinatal mental health services for mothers and babies across the area (for one year)
  or
- 1290 cataract operations.

The above list has been included to demonstrate how much other NHS services costs in comparison to specialist fertility services.

People who are already in the treatment pathway for NHS funded IVF treatment will continue to receive their treatment.

How to tell us your views.

You can give your views in a number of ways:

- Fill in the questionnaire found online on our website: www.cambridgeshireandpeterboroughccg.nhs.uk

- Fill in the paper copy of the questionnaire found on page XX of this consultation document and send it FREEPOST to Freepost Plus RSCR-GSGK-XSHK, Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge CB2 8FH. (You do not need a stamp).

- Telephone the Engagement Team on: 01223 725304.

- By attending one of the public meetings detailed below and telling us what you think:

  Insert public meeting dates here once finalised.

The Questionnaire

1. Do you understand why the CCG has proposed this change?

Yes ☐ No ☐ Undecided ☐ I need more information ☐

Comment

2. Do you agree with the proposal to stop the routine commissioning of specialist fertility services other than two specified exceptions?

Yes ☐ No ☐ Undecided ☐

Comment

3. Do you agree that the two exceptions proposed in this consultation document are appropriate?

Yes ☐ No ☐ Undecided ☐

Comment

4. How would you prioritise NHS spending for the people in this CCG area?

5. Are there any other comments you would like to make in relation to the proposals outlined in this consultation document?

If organisations or groups would like to respond to this consultation we are happy to receive letters or emails using the contact information below. In our end of consultation report we enclose full copies of these responses so please indicate if you wish your organisation or group response to remain private.

By post: (no stamp required)

Freepost Plus RSCR-GSGK-XSHK, Cambridgeshire and Peterborough CCG, Lockton House, Clarendon Road, Cambridge CB2 8FH. (You do not need a stamp).

By email:
CAPCCG.contact@nhs.net

Finally, to understand who has given their views, we would like to collect some details.

Any information provided in this section will only be used by Cambridgeshire and Peterborough Clinical Commissioning Group for the purpose of understanding who has responded to this consultation.

Can you tell us which of the following age bands you belong to?

	16-29 years		30-44 years		45-59 years		60-74 years		75+ years

How would you describe your gender?

How would you describe your ethnic background?

Do you consider yourself to have any disabilities and/or impairments?

Yes ☐ No ☐ Prefer not to answer ☐

Finally, please could you tell us the first part of your postcode?

Thank you for taking the time to complete this questionnaire.

Legal requirements

This consultation document has been drawn up in accordance with the following legal requirements and guidance:

Cabinet Office Consultation Principles July 2012

This guidance sets out the principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation. It replaces the Code of Practice on Consultation issued in July 2008. The governing principle is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken, and thought should be given to achieving real engagement rather than merely following bureaucratic process. Consultation forms part of wider engagement and decisions on whether and how to consult should in part depend on the wider scheme of engagement.

Policy makers should bear in mind the Civil Service Reform principles of open policy making throughout the process and not just at set points of consultation, and should use real discussion with affected parties and experts as well as the expertise of civil service learning to make well informed decisions. Modern communications technologies enable policy makers to engage in such discussions more quickly and in a more targeted way than before, and mean that the traditional written consultation is not always the best way of getting those who know most and care most about a particular issue to engage in fruitful dialogue.

The full consultation principles document can be accessed via the Cabinet Office website at: https://www.gov.uk/government/publications/consultation-principles-guidance

Section 14Z2 Health and Social Care Act 2012

14Z2 Public involvement and consultation by clinical commissioning groups

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

(3) The clinical commissioning group must include in its constitution—

(a) a description of the arrangements made by it under subsection (2), and

(b) a statement of the principles which it will follow in implementing those arrangements.

(4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.

(5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).

(6) The reference in subsection (2) (b) to the delivery of services is a reference to their delivery at the point when they are received by users.

For more on the Section 14Z2 Health and Social Care Act 2012 see
http://www.legislation.gov.uk/ukpga/2012/7/section/26/enacted

Criteria for Significant Service Change

In May 2010, the Secretary of State for Health, Andrew Lansley, set four new tests that must be met before there can be any major changes to NHS Services:

1. Support from GP commissioners
2. Strengthened public and patient engagement
3. Clarity on the clinical evidence base
4. Consistency with current and prospective patient choice

CCG Constitution Section 5.2.

5.2. General Duties - in discharging its functions the NHS C& P CCG will:

5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by:

a) ensuring that individuals to whom the services are being or may be provided are involved:

(i) in the planning of the CCG's commissioning arrangements;
(ii) in the development and consideration of the proposals by the CCG for changes in commission arrangements;
(iii) in the decisions of the CCG affecting the operation of commissioning arrangements, where the decisions would, if made, impact on the manner in which the services are delivered to the individuals or the range of health services available to them;

b) in order to understand the views of patients and the public and to disseminate relevant information to them, establishing and working closely with:

(i) a Patient Reference Group which is constituted as a subcommittee of the Governing Body in accordance with this Constitution;
(ii) Local Commissioning Groups which are constituted as subcommittees of the Governing Body in accordance with this Constitution;
(iii) the Patient Safety and Quality Committee which is constituted as a subcommittee of the Governing Body and considers patient experience, complaints and feedback;
(iv) Patient Participation Groups which will seek the views of local populations and assist with the dissemination of information, and representatives of which will sit on each Local Commissioning Group's patient forum;

c) in order to understand the views of patients and the public and to disseminate relevant information to them, ensuring regular liaison and the development of close working relationships with each of the following bodies:

(i) Patient Forums, which are intended to give individuals the opportunity to raise questions or concerns about the provision of healthcare services at the wider county level;
(ii) Healthwatch, which gathers views of local people on local health services;
(iii) Health Overview and Scrutiny Committees which review the planning, commissioning and delivery of health services;
(iv) Health and Wellbeing Boards, each of which is a group of key leaders representing health and care organisations who work together to understand what their local communities need from health and care services and to agree priorities;

d) publishing a Communications Membership and Engagement Strategy, approved by its Governing Body and regularly revised to take into account any new guidance published by NHS England, which will be designed to ensure that the CCG involves patients and the public by a range of means that are suitable to different aspects of its commissioning arrangements, those means to include as appropriate:

(i) the publication of documents to disseminate relevant information about the commissioning arrangements;
(ii) regular attendance at key meetings, forums and events for the purpose of listening to the views of patients and the public, providing information about and explaining actions being taken or considered by the CCG, and answering questions;
(iii) the dissemination of information by means of the CCG website, emails, newsletters targeted at specific groups, media campaigns, advertising, and targeted engagement events;
(iv) the provision of an opportunity for patients and the public to make their views known via the CCG website, emails and other suitable means;
(v) the publication of consultation documents in relation to certain planning and commissioning activities, and the creation of specific engagement opportunities such as the use of public surveys and feedback forms;

e) in the implementation of the arrangements described above, acting consistently with the following principles:

(i) ensuring that appropriate time is allowed for the planning of activities and commissioning arrangements;
(ii) proactively seeking engagement with the communities which experience the greatest health inequalities and poorest health outcomes;
(iii) commencing patient and public involvement as early as possible and allowing appropriate time for it;
(iv) using plain language, and sharing information as openly as is reasonably practicable;
(v) treating with equality and respect all patients and members of the public who wish to express views;

(vi) carefully listening to, considering and having due regard to all such views;
(vii)providing clear feedback on the results of patient and public involvement.

You can read more about the CCG's duties to engage and consult in section 5.2 of the CCG's Constitution
http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CPCT/Corporate%20documents/CCG%20Constitution.pdf

HEALTH COMMITTEE WORKING GROUP UPDATE AND MEMBERSHIP

To:	**HEALTH COMMITTEE**
Meeting Date:	**15th December 2016**
From	
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 Committee meeting.**
Recommendation:	**The Health Committee is asked to:**

1) **Note and endorse the progress made on health scrutiny through the liaison groups and the schedule of liaison meetings**

2) **Note the update from the Joint Health Scrutiny Committee – Collaboration of Hinchingbrooke Hospital with Peterborough & Stamford Hospital.**

3) **To authorise the Joint Committee to comment on behalf of the Health Committee on the mobilisation and implementation phases of any merger plans that the Trust Boards approve**

Officer contact:	
Name:	Kate Parker
Post:	Head of Public Health Programmes
Email:	Kate.parker@cambridgeshire.gov.uk
Tel:	01480 379561

1. 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 8th September 2016.

1.2 This report updates the committee on the joint liaison meeting with Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) and Cambridgeshire Healthwatch, Cambridgeshire & Peterborough Foundation Trust (CPFT).

1.3 Liaison group meetings are precursors to formal scrutiny 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 their 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.

1.4 Liaison visits with Cambridge University Hospitals NHS Foundation Trust (CUHFT) and Hinchingbrooke Health Care NHS Trust have been rescheduled.

1.5 This report will also update the Health Committee on the outcomes of the Joint Health Scrutiny Committee (Cambs County Council and Peterborough City Council) of the proposed merger of Hinchingbrooke Health Care NHS Trust with Peterborough and Stamford Hospitals NHS Foundation Trust.

2. MAIN ISSUES

2.1 <u>Liaison meeting with Cambridgeshire & Peterborough Foundation Trust (CPFT)</u>

2.1.1 The liaison group members in attendance were Councillors; Clapp, Jenkins, Orgee and Sales. A meeting was held on 13th September 2016 with Aidan Thomas, Chief Executive of CPFT.

2.1.2 The following topics were discussed at this meeting:

- Attendance at the Public Accounts Committee on 14th September (Re: UnitingCare contract)
- Financial position updates
- Update on Integrated Care Services – trying to implement part of UnitingCare model but at a slower pace.
- Primary Care based MH services (PRISM) timetable for implementation
- Mental Health Vanguard update

The following actions were agreed:

- CPFT to send Judge Business School independent review to Health Committee when it is published.

- Updates on Integrated Care Services scheduled for next liaison meeting.

The next liaison meeting is scheduled for 14th December 2016.

2.2 Liaison Meeting with Cambridgeshire & Peterborough Clinical Commissioning Group & Healthwatch Cambridgeshire.

2.2.1 The liaison group members in attendance were Councillors Clapp and Jenkins, and District Councillor Ellington. A meeting was held on 20th October with Jessica Bawden (Director of Corporate Affairs) from the CCG and Sandie Smith (CEO) of Healthwatch Cambridge. Apologies were received from Councillors Orgee and Sales, and from Val Moore ofsssss Healthwatch.

2.1.2 The following topics were discussed at this meeting:

- Sustainability and Transformation Plan
- Minor Injury Unit Update
- CCG Financial Position

2.2. Healthwatch Cambridgeshire Updates

Sandie Smith reported on

- Proposed Merger of Hinchingbrooke Health Care NHS Trust with Peterborough & Stamford Hospitals NHS Foundation Trust. Healthwatch notified members of a public meeting they were hosting which would have a debate format scheduled for 7th November.

  http://www.healthwatchcambridgeshire.co.uk/news/healthwatch-wants-patient-involvement-heart-plans-future-hinchingbrooke

- "Sitting Comfortably" - Wheelchair users' report

  http://www.healthwatchcambridgeshire.co.uk/news/healthwatch-calls-improvements-local-wheelchair-services

- Children's Work – working to support the Child and Mental Health Services redesign by targeting schools around emotional health and wellbeing.

The next liaison meeting is scheduled for 26th January 2017.

2.3 Liaison meeting with Cambridge University Hospitals NHS Foundation Trust (CUHFT).

Meeting postponed in October. The next liaison meeting is scheduled for 2nd December 2016.

2.4 Liaison meeting with Hinchingbrooke Health Care NHS Trust.

Meeting postponed in October due to the Joint Health Scrutiny meetings that took place in October and November (see section 3). The next liaison meeting is scheduled for 18th January 2017.

3 JOINT HEALTH SCRUTINY COMMMITTEE – MERGER OF HINCHINGBROOKE HEALTH CARE TRUST (HHCT) WITH PETERBOROUGH & STAMFORD FOUNDATION TRUST (PSHFT)

3.1 The Joint Health Scrutiny Committee with Cambridgeshire County Council and Peterborough City Council have held two meetings with the Chief Executive Officers from both HHCT & PSHFT on 17th October and 9th November 2016. The first meeting focused on clarity regarding the proposals in relation to both the financial and clinical sustainability business cases. The second meeting called representatives from KMPG and Loretti who had been commissioned by the hospital trusts to provide them with a financial overview for the full business case and outline of the Information Technology Clinical System upgrades that any merger would require.

Minutes of these meetings are available on:

https://cmis.cambridgeshire.gov.uk/ccc_live/Committees/tabid/62/ctl/ViewCMIS_CommitteeDetails/mid/381/id/37/Default.aspx

3.2 The Joint committee concluded to support the proposed merger subject to a number of recommendations that are outlined below. If the Hospital Trust Boards agree to proceed with merger plans at their November Board meetings, the Joint Health Scrutiny committee agreed to continue to scrutinise any merger proposals during the implementation phase.

The Joint Committee responded to the public engagement exercise, raising the following issues

1. the Committee stressed that it was important that local concerns be taken into account at all stages of the process. It recognises the engagement that has taken place already and encourages the two Trusts to continue in this manner;

2. the Committee agreed to reiterate the following commitment as outlined in the Memorandum of Understanding: Cambridgeshire & Peterborough Health and Care system which is a Partnership for implementing the Sustainability & Transformation Plan:

   “People first: solutions that best meet the needs of today and tomorrow’s local residents and heath care users must be the guiding principle on which decisions are made. This principle must over-ride individual or organisational self-interest. Embedding the voice and views of service users in service improvement will be key to ensuring this principle is not forgotten”

If the two Hospital Trusts Boards agree to continue with the merger proposals which will be decided at their board meetings later this month the Committee has responded with the following considerations

3. the Committee recommended that not only the Council of Governors of the merged Foundation Trust include members from Huntingdonshire, as set out in the Full Business Case, but that the merged Trust Board also include Non-Executive Directors appointed from the former Hinchingbrooke catchment area;

4. the Committee is especially concerned that the merger is not initiated prematurely and that due and visible attention be given to relevant indicators at the decision point and during the merger process;

5. the Committee would continue its scrutiny into the implementation phase of the project, as the work of the next six months would be vital to the success of the merged trust. Meetings in 3 and 6 months' time would seem to be appropriate;

6. the Committee recommended that local scrutiny arrangements are maintained e.g. Cambridgeshire County Council will continue with their liaison meetings with Hinchingbrooke Health Care Trust and will continuously monitor the progress of the merger at these meetings;

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

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

4.2 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

4.3 Equality and Diversity Implications

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

4.4 Engagement and Consultation Implications

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

4.5 Localism and Local Member Involvement

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

4.6 Public Health Implications

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

HEALTH COMMITTEE TRAINING PLAN	Updated from Health Committee Spokes Meeting 10th November	**Agenda Item No: 12**

Ref	Subject	Desired Learning Outcome/Success Measures	Priority	Date	Responsibility	Nature of training	Attendance by:	Cllrs Attending	Percentage of total
8.	**Health Scrutiny Skills Part 1**	To understand the roles and responsibilities of members conducting health scrutiny and to provide members with scrutiny skills and techniques	1	No Date	Public Health	Training Seminar	Health Committee members & Subs		
15.	***Sustainability and Transformation Plan (Updated 8th Sept)***	To hold the session on the CCG's Sustainability and Transformation Plan (STP) in December, following publication of the STP in November	1	Dec	Public Health	Training Seminar	Health Committee members & Subs		
17.	***Health Inequalities (Updated 8th Sept)***	To provide members with background information around Health Inequalities in preparation for January Health Committee item.	1	Dec 15th	Public Health	Training Seminar			
18.	***Children & Young People's Mental Health***	To provide members with background information on the current issues around children and young people's mental health	2	TBC	Public Health	Training seminar			

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

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

HEALTH POLICY AND SERVICE COMMITTEE AGENDA PLAN	Published 1 December 2016 Updated 6 December	Cambridgeshire County Council **Agenda Item No: 14**

Notes

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

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

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

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

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

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
12/01/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		01/12/16 3.30pm	29/12/16	03/01/17
	Re-commissioning the Healthy Child Programme – Proposed Section 75 for Health Visiting and School Nursing Services	Raj Lakshman	2017/008			
	System wide review of Health Outcomes in Cambridgeshire	Liz Robin				
	Public Health Risk Register (six-monthly update)	Tess Campbell				
	East of England Ambulance Trust (EEAST) – Care Quality Commission Inspection Local Delivery	Kate Parker				
	Scrutiny Item: Fertility Treatment Services	Dr Richard Spiers				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: Bed-based Intermediate Care and Minor Injuries consultation plan	Kate Parker/ CCG				
	Scrutiny Item: Sustainability and Transformation Plan	Kate Parker/ CCG				
	Scrutiny Item: NHS England Liver Metastasis Services at Addenbrooke's Hospital (1 year on report)					
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
16/02/17	*Development session on the Sustainability and Transformation Plan following short formal meeting*			*26/01/17 3.30pm*	*03/02/17*	*07/02/17*
	Award of the contract for the provision of Stop Smoking Services	Val Thomas	2017/027			
16/03/17	Public Health Finance and performance report	Chris Malyon/ Liz Robin		23/02/17 3.30pm	03/03/17	07/03/17
	Scrutiny item: Non-Emergency Patient Transport Services performance update six months after September 2016 commencement	Kate Parker				
	Update on Mental Health Vanguard and PRISM [primary care mental health service]	Kate Parker				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny Item: Health Committee Working Groups Quarterly update (including Joint Health Committee on merger of HHCT & PSHFT)	Kate Parker				

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
	Scrutiny Item: 111 Out of Hours Service – Review of First Five Months Delivery	Kate Parker				
	Scrutiny Item: Update from Cambridge University Hospitals NHS Foundation Trust (CUHFT) on EPIC IT Service	CUHFT				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
[13/04/17] Provisional Meeting				*23/03/17 3.30pm*	*31/03/17*	*04/04/17*
08/06/17	Co-option of District non-voting Members	Ruth Yule		20/04/17 3.30pm	25/05/17	30/05/17
	Public Health Finance and performance report	Chris Malyon/ Liz Robin		18/05/17 3.00pm		
	Update on pilot harm reduction project for stopping smoking	Val Thomas				
	Scrutiny Item: emerging issues in the NHS (standing item)	Kate Parker				
	Scrutiny Item: Health Committee Working Groups – Update	Kate Parker				
	Committee training plan (standing item)	Kate Parker/ Ruth Yule				
	Agenda plan and appointments to outside bodies	Ruth Yule				
20/07/17					07/07/17	11/07/17

Committee date	Agenda item	Lead officer	Reference if key decision	Spokes meeting date	Deadline for draft reports	Agenda despatch date
[17/08/17] Provisional meeting					*04/08/17*	*08/08/17*
07/09/17					26/08/17	30/08/17
19/10/17					06/10/17	10/10/17
	Immunisation Task and Finish Group report, to include whether the drop in take up of flu immunisations by pregnant women was a single year anomaly or whether it was repeated in the figures for the following year (12-month follow-up)					
16/11/17					03/11/17	08/11/17
14/12/17					01/12/17	05/12/17
Tuesday 16/01/18					03/01/18	05/01/18
[08/02/18] Provisional meeting					*26/01/18*	*30/01/18*

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

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

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

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

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

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

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

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